

Bridging the Gap Between Child Welfare and Communities

***Lessons Learned from the Family Preservation and
Family Support (FP/FS) Services Implementation
Study***

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A. Summary

In 1994, James Bell Associates was awarded a contract by the U.S. Department of Health and Human Services, Administration for Children and Families, to study the implementation of the Family Preservation and Family Support (FP/FS) services program. The purpose of the study is to examine how states and communities chose to implement the 1993 legislation creating the FP/FS program and the subsequent expansion of the program under the Adoption and Safe Families Act of 1997 (ASFA).¹ The major study activities were in-depth case studies of 15 states and 20 localities within these states,² and an annual review of the 50 state FP/FS Five-Year Plans and Annual Progress and Services Reports.

Areas examined in the Implementation Study include planning and decision-making processes, funding allocations, program models of service delivery, collaborative arrangements and consumer involvement. The study also focused on the relationship between the child welfare agency, especially frontline staff, and the newly funded FP/FS programs. To supplement the individual case studies and the synthesis reports, a series of issue papers addressing topics of special interest are being developed. In the course of this study, states and communities faced many challenges and found innovative approaches to implementing new programs. These papers are focused on lessons learned from their experiences that are applicable to a broad range of family services implementation efforts.

The focus of this particular paper is the effect the FP/FS program had on the relationship between traditional child welfare services and the communities served. Examples are drawn from a number of state and local efforts that addressed some or all of the subtle and difficult issues involved with bridging this gap. As explained in this paper, although FP/FS funding enabled child welfare agencies to fund or augment community services, these services

¹Two companion outcomes studies also carried out under contract to the U.S. Department of Health and Human Services are studying the impact of family support and family preservation programs.

² The states participating in the Implementation Study are: Alabama, Arizona, California, Colorado, Florida, Georgia, Kentucky, Louisiana, Minnesota, Missouri, Oregon, Texas, Vermont, Virginia, and West Virginia.

remained separate and distinct from child welfare in the vast majority of sites visited for this study.

However, a number of sites used FP/FS funding to partially bridge this gap. Within these sites, it was evident that staff from both child welfare and community based organizations had reached the following conclusions:

- **Each agency was limited in the actions it could take with families:** In sites that developed a service continuum, staff from community-based organizations realized their limitations with respect to addressing family environments in which child endangerment was probable. Similarly, CPS staff were blunt in their assessment of their own limitations with respect to interacting with families' in a mutually constructive manner.
- **The perspectives of both organizations fulfilled a critical role in approaching families:** Staff from both organizations noted instances in which they realized the two agencies efforts could complement one another; for instance, collaborating on investigations of abuse/neglect.
- **The missions of both agencies were better met when the two agencies collaborated in the development of a service continuum.** For instance, brokering a case plan workable for all involved meant that families were more likely to comply with the requirements specified and permanency could be achieved in a timely manner.

In short, these experiences proved to be a learning experience for staff in both agencies.

B. Background

A unique feature of the FP/FS legislation was that it allowed each state to spend up to \$1 million of its first-year FP/FS allocation on planning efforts and needs assessment without the requirement that federal funds be matched by each state. Initially, FP/FS funds were provided to child welfare agencies with the requirement that both family preservation and community-based family support services be developed. Broadly defined, these services were to enhance family functioning, and help prevent child abuse/neglect and foster care placement. At the time, FP/FS funding was unique in that it was the only federal child welfare funding stream exclusively focused on prevention. In the legislation and subsequent regulations, program definitions were kept purposely broad to provide states maximum latitude to plan and implement programs.

Under ASFA, Congress reauthorized the FP/FS program as the Promoting Safe and Stable Families Program (PSSF). The reauthorization added two additional program categories

to be funded—time-limited family reunification, and adoption promotion and support. These program categories are consistent with the intent of ASFA to limit the time children spend in out-of-home placement and to expedite permanency. The FP/FS Implementation Study was extended in 1999 to permit an analysis of changes in implementation in response to these new program requirements.

C. Bridging the Gap Between Child Welfare and Communities

Historically, the tensions between child welfare agencies and the communities they serve have been substantial. The public agency's core mission of child protection explains the underlying cause of this tension. Although this mission can encompass the provision of preventive and supportive services, it also includes actions that are invariably viewed as hostile by families. Investigating allegations of abuse and neglect made against families, and removing children and placing them in alternative care arrangements create perceptions that are lasting and difficult to overcome. In community after community visited for this study, stakeholders informed us that "here, child welfare is seen as the agency that takes kids away from their parents."

However, in the sites we visited it was also clear that additional differences prevailed as well, heightening tensions. Child welfare staff were often perceived as culturally insensitive, unaccepting of alternative methods of child rearing and unresponsive to the underlying problems that may have led to child maltreatment. These issues were further exacerbated by the fact that child welfare agency staff tended to be better educated and less ethnically diverse than the communities in which the majority of investigations and child removals occurred. Questions of cultural bias often prevailed. In fact, one of the key findings of the National Study of Protective, Preventive and Reunification Services Delivered to Children and Their Families was that "minority children, and in particular African American children, are more likely to be in foster care placement than receive in-home services, even when they have the same problems and characteristics as white children" (HHS, Children's Bureau, 1994, pg. xi).

Within this context, it is not surprising that child welfare agencies and community-based organizations each view the other with some suspicion. Neighborhood-based child and family serving agencies are often deeply rooted within the community. As a result, they share families' suspicions of child welfare agencies as outside entities whose actions can be excessive and misguided. Similarly, child welfare agency staff often view community-based organizations as

lacking perspective in instances of potential child endangerment. Although these stereotypes are not without basis, in reality, each of these entities has a unique and valuable role to play in providing services to children and families. Examples are presented in this paper.

Building upon the concept that multiple interventions and services options are needed, the intent of the FP/FS program was to create a continuum of services to bridge the gap between child welfare and the communities it served. While the requirement that states develop a broad continuum of services—from primary prevention through adoption support—is not unusual in and of itself, it is unusual to provide funds to states with the stipulation that *the state child welfare agency* support a diverse array of programs. The November 18, 1996 Final Rule provided direction to states in accomplishing the following:

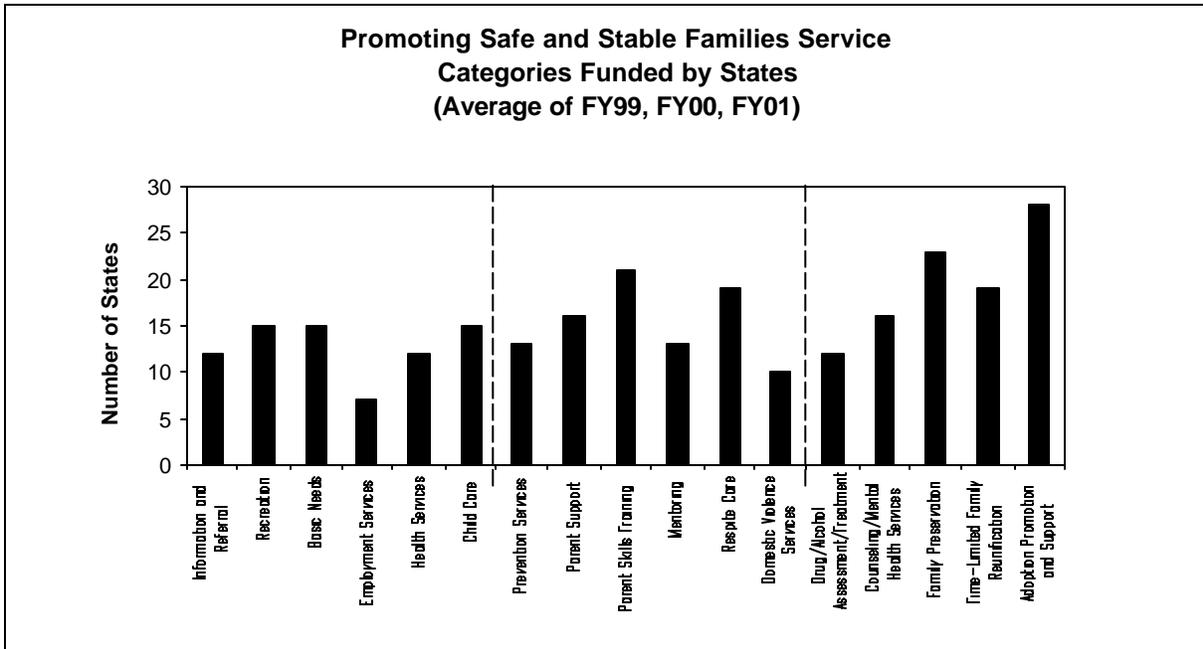
“establishing comprehensive community-based family support programs and short-term crisis intervention family preservation programs, and working across the child and family services system to design a continuum of services responsive to the diverse needs of children and families” (45 CFR Parts 1355, 1356, and 1357, Summary).

State expenditures were to be based on a comprehensive planning process which included a needs assessment of services. Although Federal Guidance specified that FP/FS funds alone were not expected to fund and support the entire continuum of child welfare preventive services, there was the expectation that FP/FS funds were to be used strategically to fill gaps in each state’s existing continuum and/or leverage additional funding and support. For this reason, funds were provided to states with maximum flexibility.

States clearly embraced the opportunity to support an array of services. Analysis of the Annual Progress and Services Reports (APSRs) submitted by states to the federal government in recent years shows a fairly even distribution of services funded—from primary prevention to more traditional child welfare preventive and supportive services. The following chart shows the number of states funding each service, averaged over the three years since the changes instituted by ASFA went into effect. The service categories shown in the chart can be grouped into three broad categories:

- Primary prevention programs far removed from traditional child welfare concerns: information and referral, recreation, basic needs, employment services, health services and child care.
- Preventive programs more closely aligned with child welfare: prevention services, parent support, parent skills training, mentoring, respite care and domestic violence prevention and treatment.

- Traditional child welfare preventive and support services: drug/alcohol assessment/treatment, counseling/mental health services, family preservation, time-limited family reunification, and adoption promotion and support.



Although currently states are investing fairly evenly in these three categories, some of this results from changes instituted by ASFA. Prior to the time period shown in this chart (FY99 – FY01), states were much more focused on investing in primary preventive and preventive services programs—service categories on the lower end of the risk continuum.

However, this analysis raises as many questions as it answers. Within the study sites, funding alone was insufficient to alleviate the existing mistrust between the child agency and the community. In fact, in a number of sites, FP/FS funding established or supplemented community-based organizations which, if not openly hostile to child welfare, were unwilling to collaborate with the child welfare agency on coordinating services or activities.

In addition to simply funding community-based services, a number of sites attempted to integrate services across agencies and establish a continuum of services. For the purposes of this paper, a service continuum is defined as including the following elements:

- Each entity in the continuum being aware of all other partner entities.

- A comprehensive assessment of child and family needs upon initial referral.
- A systematic referral process *among* continuum members based on the assessment.
- A process for coordinating joint case management and planning, thereby avoiding unnecessary duplication of services.
- A system of periodic re-evaluation and a process for transferring children and families to more or less intensive services as needed.
- A positive working relationship that rests on a basic understanding of, and respect for, the unique contribution of each continuum member.

The purpose of this paper is to examine a number of the state and local efforts that developed some or all of these service continuum elements. These study sites actively sought ways to foster better relationships and create a more seamless and integrated service delivery system. Key questions in assessing FP/FS implementation in this regard include:

- *Did the planning strategy consider existing child welfare and community-based services when determining the nature of services to be delivered?*
- *Was there a comprehensive assessment process to determine the range and intensity of family needs and identify situations in which externally provided services, such as Child Protective Services (CPS), might be essential?*
- *Was there a process of referring cases between community-based programs and family preservation programs or other child welfare services, including CPS?*
- *Were policies and procedures in place that allowed staff of all agencies to understand relationships between agencies and protocols for joint service delivery?*
- *Did community-based programs and child welfare agencies build working relationships that rested on a basic understanding, and respect for, the unique contributions of each?*

Each of these questions is addressed in the remainder of this paper.

1. Did the planning strategy consider existing child welfare and community-based services when determining the nature of services to be delivered?

During the planning process, virtually all sites gave some consideration to existing services and took these into account when making FP/FS funding decisions. However, only a very few thought strategically about how the existing array of services might be augmented to form a continuum by identifying and filling gaps. Two sites provide examples in this regard,

proposing additional services, supports, and referral and screening processes to help begin to build a continuum of care.

Just prior to FP/FS implementation, the Santa Clara County child welfare agency established four family resource centers. Each had a specific cultural focus, reflective of the ethnic communities served. Although each center was highly successful in engaging the targeted community, the centers were not entirely successful at providing a bridge between the child welfare agency and the community. Primarily, the centers focused on primary prevention issues far removed from child welfare, such as providing after-school and recreation programs as well as English language classes.

In its initial FP/FS plan, the county proposed placing family advocates at each center. Their primary responsibility would be to divert families from becoming more deeply involved with the child welfare system. They were to advocate on behalf of child welfare agency involved families and broker case management plans acceptable to all, while engaging families in needed supportive services such as counseling and parenting courses. The concept was one of the most concrete examples of bridging the gap—in essence, creating a position with a foot in both camps. However, it proved challenging to implement. Differences in perceived roles, responsibilities, assignments and the physical locations of the Advocates eventually shifted their focus away from child welfare concerns and toward primary prevention.

Planning and service delivery in San Antonio, Texas provides an interesting example of an attempt to maximize the impact of FP/FS funds by reaching out to those not traditionally served who have a high probability of eventual child welfare involvement. Stakeholders noted that child welfare preventive programs available in San Antonio prior to FP/FS implementation—such as family preservation—were limited to families at the highest risk of foster care placement. In addition, a number of community-based organizations provided supportive services. Although these were targeted at those with high needs, they were not necessarily targeted at those identified as being at high risk of abuse/neglect or foster care placement.

To bridge this gap, a collaborative of community-based organizations successfully proposed coordinating their home-visiting and parenting services by creating a single point of entry and assessment. On a voluntary basis, mothers giving birth at a hospital with a high percentage of Medicaid births were assessed on the Kempe Family Stress Checklist for life

stressors and parenting skills. Those shown to be at probable risk of abuse/neglect were referred to one of the participating providers in the collaborative, based on the family's needs and the agency's particular area of expertise. Once referred, cross-checks were conducted with the child welfare agency. If the family was also involved with child welfare services, a conference was called to determine which set of services should continue and which should end. Program administrators justified this as a means of avoiding duplicate efforts and maximizing the potential impact of the few funds available for preventive purposes within the community.

2. Was there a comprehensive assessment process to determine the range and intensity of family needs and identify situations in which externally provided services, such as Child Protective Services (CPS), might be essential?

For the most part, the community-based programs funded through FP/FS operated separately and independently from child welfare. Although community-based programs might assess client needs within the scope of their services, generally they did not assess families for needs that could only be met through externally provided services such as CPS. At the same time, we found that for the most part CPS staff were uninformed of the family support programs potentially available to the families they served. As a result, referrals to—and from—child welfare were rarely made. The important point is that although a de facto continuum of services may have been created, this was unknown to families and providers. Families were unable to access different levels and intensities of services in a seamless manner.

However, among the study sites there were a number of exceptions, including Caring Communities in St. Louis, MO. The school-based program was composed of the following five components, encompassing both family preservation and family support:

- Clinical component: consisting of in-school detention, substance abuse prevention and counseling (designed to support families during the time they wait to access formal treatment services) and weekly home visiting and case management services.
- Intensive family preservation services.
- Before- and after-school tutoring, snacks and recreation.
- Additional staffed positions: health liaisons who conduct health promotion activities and outreach, and assist school nurses in dispensing behavior-control medications; and cultural enrichment coordinators who provide classroom presentations on heritage and culture.

- Other community activities: including assuring safe passages to and from school, drug marches on known drug houses and markets, and respite nights for parents.

Upon referral, a comprehensive assessment determined the needs of families. Representatives from the above components jointly developed case plans. The plans were revisited on a periodic basis and progress was tracked. Program administrators noted that the program's components were meant to meet the multi-faceted needs of families and take into account the fact that these may change over time. For instance, a family might be assessed as needing both family preservation services and after-school tutoring. Following completion of family preservation, families were often stepped down to less-intensive case management services consisting of bi-weekly in-home visits.

Additionally, the assessment might reveal that the family had needs that could only be met through referral to externally provided services, such as substance abuse treatment. The program's substance abuse component assisted families by referring them to treatment slots dedicated by the city to Caring Communities. After placing a family on the waiting list for treatment, the program provided interim counseling and support. As described under the following question, the program also had specific policies and linkages governing referral to CPS.

The Marley House program located in the Sunnyslope community of Phoenix, Arizona provided another example of a comprehensive assessment process. Based in a family resource center, Marley House oversaw a network of service providers collectively encompassing a broad range of human services. A family outcomes assessment instrument—designed specifically for the program—measures each family's status in 16 separate areas. These areas include environmental safety, housing stability, access to health care, stress management and financial management, as well as interactions between adults, between adults and children, and appropriateness of discipline. Referrals were made both within—and outside—the network as indicated by the assessment.

3. Was there a process of referring cases between community-based programs and family preservation programs or other child welfare services, including CPS?

The lack of a comprehensive needs assessment, as explained above, was only one factor contributing to the lack of cross-referrals. Even more fundamentally, few sites made

concerted efforts to inform staff from child welfare and community-based agencies of each other's programs and resources. This impacted referrals between the two entities in both directions:

- **Referrals from community-based programs to child welfare:** Despite the fact that they were mandated reporters of suspected abuse/neglect and that their positions were funded with FP/FS monies passed through by the child welfare agency, community-based program administrators and staff remained reluctant to refer families to CPS in most sites. Except for the most egregious circumstances, their reluctance extended to instances in which they suspected abusive or neglectful situations existed. Staff defended their actions by insisting it would only make a bad family situation worse. They maintained families would stop confiding in them or using their services if they felt they might be referred to child welfare, or assessed for signs of child endangerment. Further, staff from community-based agencies often maintained they were better equipped to provide assistance. They were much more intimately involved with the family—they “knew” their families and their “tipping points.” Thus, they could ensure child safety while continuing to work with the family on methods for handling stress and alleviating problem behaviors.
- **Referrals from child welfare to community-based programs:** Similarly, while frequently acknowledging the shortage of supportive services available within families' communities, child welfare agency staff were often unaware of programs funded through FP/FS. Alternatively, staff knew of the programs, but believed they were to be used solely as a resource for the community. Therefore, child welfare was not to refer cases to these resources.

However, a few sites effectively bridged this gap. Noting the boundaries of their expertise and focus, community-based organizations acknowledged the need to refer to CPS under any circumstances in which there were suspicions of abuse or neglect. Most frequently, the process of referring to CPS fell to programs or program components targeting families at the highest risk of child welfare involvement. Typically, these were intensive family preservation programs, which by definition were more directly linked to child welfare. Similarly, community-based programs were utilized by child welfare as a support for families in need of ongoing services, or as a step-down from more intensive child welfare services.

Alabama provides one such example. The state's FP/FS program is based on two models—Family Resource Centers that deliver community services and an intensive family preservation program (Family Options) for child welfare involved families. One of Alabama's central goals was for Family Options programs to refer families that had completed the intensive intervention to the Resource Centers as part of a step-down process. This model was further expanded in 1998 when Family Options providers began offering intensive family reunification

services in order to meet ASFA requirements. Many of the state's Family Centers expanded their less intensive services in order to provide aftercare services for these families as well. However, it is important to note that the consistency with which referrals were made between programs varied by community, underscoring the need to continually train and emphasize best practices with staff.

One site in the state, Dothan, provides an example of how ongoing training and local collaborative meetings between the child welfare agency, family preservation, and the Family Resource Center could result in a nearly seamless continuum of care. Child welfare workers reported using the Family Center for GED classes, career counseling and reunification aftercare. Both child welfare and employment and training workers from the county noted that if they were able to involve their high-risk families with the center, "it would wrap itself around the family, offering both case management and supportive services." Once the family was fully engaged, child welfare reported they could close the case, assured there were many sets of eyes monitoring and supporting the family.

In Pinellas, Florida, technical assistance was used as a bridge to build trust and understanding. In this site, FP/FS funded a case manager who provided counseling to families and parent education at the Neighborhood Family Center located in a public housing project. FP/FS funds were also used by the family preservation program to provide family preservation services as well as technical assistance to the resource center. In addition to technical assistance, family preservation staff provided direct services, such as parent education and stress management classes. Family preservation staff acted as chaperones for several evening youth events.

Eventually, these activities created a positive working relationship, easing the way for the resource center case manager and family preservation staff to feel comfortable making cross-referrals. Increasingly, the Neighborhood Family Center referred families for which they observed services of greater intensity were needed to the local family preservation provider. In turn, family preservation staff were advised by Center staff on the need to call child welfare in instances in which child protection was compromised.

Under the recent privatization of child welfare services throughout the state, the counties of Pinellas and Pasco built upon the lessons learned under FP/FS and expanded them. Now,

family preservation staff are physically located in the same office as child welfare case managers. They provide short-term, intensive preservation and reunification services to open child welfare cases. Additionally, FP/FS funds now support five foster care diversion workers who support the child welfare case managers by assessing and linking cases to community resources in instances in which abuse/neglect is unfounded or in which the risk to the child is low.

St. Louis Caring Communities provides an example of a community-based organization with developed policies and procedures for assessing needs and directly referring families to CPS when needed. Program administrators noted their program approach rests on an important principle—a respect for families regardless of their needs and regardless of how these may change over time. This perspective also governed the process by which referrals were made to CPS. Caring Communities staff were instructed to be open, honest and supportive of families at all times, regardless of their strengths and needs. Criteria for CPS referral were clearly articulated to families. When calls were made to the state hotline, the family was encouraged to be present. If this was not possible, families were instructed on all aspects of the call, both before and after it was placed to the child welfare agency.

However, the support offered to the family did not end after the call was made. It was the program's policy that a Caring Communities' staff member be present with the family during the CPS investigation, both to act as a resource for the family and to help broker a case plan acceptable to everyone, if possible. For instance, Caring Communities staff noted that often they were able to arrange for children to stay with relatives while a case plan was agreed to and initial progress was documented. Regardless of the outcome of the investigation, Caring Communities staff continued to help identify, address and alleviate family stressors so that the children could remain at home, or could return home as soon as possible if removed.

4. Were policies and procedures in place that allowed staff of all agencies to understand relationships between agencies and protocols for joint service delivery?

In two sites, individual resource centers went further than specifying referral processes and criteria between agencies. These sites devoted efforts to building processes to help define policies and procedures governing direct interaction with other agencies, thereby creating a

seamless continuum of services. The two centers were the Siegel Center in St. Louis, Missouri and a resource center in Kentucky.

The Siegel Center is a public elementary school in a predominantly African American neighborhood of St. Louis. On-site programs within the school included the Caring Communities program discussed earlier and outstationed child welfare agency staff. Within the center, child welfare agency staff fulfilled a number of functions. These included investigating allegations of abuse and neglect within the community and providing assessment and services to reports that were screened out under the state's CPS reform initiative (the reform created a dual track for incoming reports which were screened into one of two categories—investigation or services assessment). Caring Communities referrals were formally made through the school, although they might originate in the child welfare agency.

Within the Siegel Center, two staff positions were shared between the child welfare agency and Caring Communities. One CPS worker and one worker from Caring Communities conducted weekly home visits and case management activities for families referred from two sources: (1) those screened out by CPS but referred for services assessment; and (2) those cases assessed by Caring Communities as needing weekly home-visiting and case management services. Both workers carried ten cases referred from each source.

What is singularly unique about the site was the degree of cooperation and collaboration between three primary collaborating entities—the school, Caring Communities and outstationed child welfare agency staff. The three formed a close working relationship that recognized the unique strengths of each partner. The partnership was defined by the following:

- The three entities met on a monthly basis to staff cases that were emerging as troublesome and might need to be referred for services as well as those cases that were being served jointly (for instance, a child might be receiving in-school detention and counseling from the school psychologist, while the family was receiving case management services from the child welfare agency).
- To provide cross-training, joint sessions on topics such as building self-esteem in children, violence reduction and educational neglect were held with staff each week.
- School staff depended on the child welfare agency to serve chronic truancy cases that were formally reported to CPS as educational neglect. In turn, the child welfare agency often depended on Caring Communities to help reach out to those families and provide services once the case was stabilized.

- From the child welfare agency, Caring Communities could access more intensive services—such as family preservation—and concrete assistance.
- Outstationed child welfare agency staff noted that if a child divulged abuse to a staff member while participating in a Caring Communities program, often the initial interview could be conducted in the Caring Communities office. For cases that were hotlined, child welfare staff noted that often the entire investigative process could be much more cooperative and open with family members when it was physically handled “on Caring Communities turf” or in the family’s home with Caring Communities staff present. For instance, a parent might be more forthcoming about the use of inappropriate discipline or substance abuse.
- Teachers, who during the school day might rely on Caring Communities staff to reach a student whose behavior was posing a problem, reported that as a result of their interaction with Caring Communities, they had become better at recognizing problems symptomatic of—or directly related to—abuse or neglect.

A family resource center in Lexington, Kentucky provided a second example of attempts to define policies and procedures governing interaction with CPS. The center’s efforts also involved a shared staffing arrangement—a full-time CPS worker was out stationed in the family center in an attempt to build better connections between the two entities.

Working closely with the center director, the CPS worker provided services to families and children accessing the center that were involved with child welfare by:

- Providing services/oversight to families enrolled in the center that were open CPS cases.
- Investigating new hotline reports for families already assigned to him.
- Transporting foster children who were enrolled in the center’s day care facility to visits with their families of origin and medical appointments at the pediatric clinic.

Additionally, the out stationed CPS worker was able to perform an especially valuable function by following up on concerns raised by pediatric clinic staff and center staff when their reports of abuse/neglect were screened out. In the past, when a resident physician of the clinic filed a CPS report that was screened out as not meeting the criteria for investigation, the resident felt frustrated, and the center’s staff felt thwarted in their attempts to train physicians in detecting abuse and neglect. (The clinic is a training site for medical residents in pediatrics, and family resource center staff hope to train residents to become community sentinels of abuse and neglect.) Through the CPS worker, clinic personnel could receive clarification of CPS policies and the agency’s reasoning behind a decision not to investigate. Similarly, the CPS worker was

able to prevent frustration among the resource center staff by meeting monthly with them, along with his supervisor; to review cases that were screened out or that otherwise had caused concern among the staff.

If the CPS worker became concerned while following up on a report declined for investigation, he could contact the hotline staff and ask them to re-screen it. Also, the worker contacted the hotline if the center's staff noted something relevant about a family that the hotline worker did not (e.g., other human service providers, such as a child's school, also were concerned about a particular family).

5. Did community-based programs and child welfare agencies build working relationships that rested on a basic understanding, and respect for, the unique contributions of each?

In the vast majority of sites visited for this study, community services were separate and distinct from child welfare. Because this gap was not bridged, there was little possibility for FP/FS to facilitate the creation of working relationships between child welfare and communities. Although child welfare provided funds for establishing or augmenting community-based programs, most programs and consumers either were not aware of this or chose not to acknowledge it. Most community programs that were awarded FP/FS funds either referred to it as “their money” or were under the impression that the child welfare agency was obligated to provide them with funding. It is clear that simply passing funding through the child welfare agency to community-based programs did not improve relationships between the child welfare agency, community-based organizations and the families served.

However, the few sites that engaged in truly collaborative efforts showed some early signs of success. Although cultural and philosophical differences were often substantial, and progress could be uneven, the process of building and defining working relationships led to increased respect and trust.

For instance, in the St. Louis Caring Communities site, all involved reported improved perceptions of others:

- Child welfare agency staff, acknowledging that when they became involved parents inevitably perceived the intervention as “more punitive,” were thankful for the state’s dual track CPS reform and the presence of Caring Communities programs for supportive services. They noted these changes allowed them to divert many cases toward a more preventive approach.

- Caring Communities staff felt they had the basic resources necessary to support families. In those instances where the family situation continued to deteriorate and/or more intensive services were needed, Caring Communities staff consistently noted that they felt assured that families had been provided every possible preventive option. All agreed that CPS was called upon only as a “last resort.” Even then, the goal was to provide supportive services during and immediately following an investigation so as to avoid removing children from their families. For instances in which placement was unavoidable, services were provided to help return children as quickly as possible.
- Families interviewed said they appreciated the cooperation and involvement of both agencies. They reported their interests were better met when child welfare, along with Caring Communities, developed their case plan. That process, along with changes within the child welfare agency related to internal agency reform, allowed families to see the necessity of child welfare involvement in their life in certain instances.

Similarly, as discussed earlier, in the Florida counties of Pinellas and Pasco, generally good working relations were noted between the community-based neighborhood center and the family preservation program. However, those interviewed on-site acknowledged that the learning process could be slow and painful. Substantial cultural and ethnic differences existed. Located in a public housing project, the Neighborhood Family Center was primarily African American in focus, while white professionals primarily staffed the family preservation program. Initially, the family preservation provider had no experience providing assistance and support to a community-based organization. However, in the end, several lessons were learned and relationships improved.

Specifically, the administrators of the family preservation noted that when first approaching a community group, it was important to arrive ready to listen, asking the group what it wanted to undertake, how far along they were in accomplishing their goals and what they were struggling with. They summed it up as “don’t do **to** the community, do **with** the community.” Staff noted the importance of making sure the community program stayed “out in front.”

As the working relationship between the two programs was built, the impact on families was immediate. Families who accessed family preservation via the family resource center were introduced to the more intensive services with staff from both programs present. In addition to

easing the transition, it allowed families to see firsthand the trust that existed between the two organizations. As a result, families noted they felt they could trust the family preservation staff.

The lessons gained from these examples continue to be relevant. With changes introduced in the FP/FS program by the Adoption and Safe Families Act, there is an even greater focus on providing services to the child welfare population as traditionally conceived. In turn, this creates an even greater need to bridge the gap between the child welfare agency and the communities served. As the PSSF program continues to develop, methods for improving relationships need to be identified and further developed. Supports need to be provided for instituting policies and procedures that create a true continuum for families to move effortlessly from more intensive to less intensive services as their life circumstances change.

It is also helpful to consider the larger context of reform simultaneously occurring in child protective services agencies across the country. Currently, CPS agencies are struggling to accommodate the increased focus on child safety with efforts to create systems that are sensitive and engaging of communities. As noted in this paper, increasingly states and localities are implementing two types of reform:

- **Creating dual-track systems:** in an attempt to better target resources, incoming abuse/neglect reports are screened into an investigatory, or services assessment, track.
- **Outstationing staff:** rather than only visiting neighborhoods when a report has been made, workers are outstationed in community settings where they are more accessible to families. By maintaining an active presence within communities, there is a greater probability of addressing issues before they reach the crisis point.

By coordinating the efforts of FP/FS or other preventive efforts with CPS reforms, the opportunity to positively impact families, communities and service systems can be greater than if only one of these reforms were carried out in isolation.

D. Lessons Learned

As explained in this paper, although FP/FS funding enabled child welfare agencies to fund or augment community services, these services remained separate and distinct from child welfare in the vast majority of sites visited for this study. This represented a missed opportunity to lessen the gap between child welfare agencies and the communities they serve.

However, this paper also provided examples from a number of sites that used FP/FS funding to partially bridge this gap. Within these sites, it was evident that staff from both child welfare and community based organizations had reached the following conclusions:

- **Each agency was limited in the actions it could take with families:** In sites that developed a service continuum, staff from community-based organizations realized their limitations with respect to addressing family environments in which child endangerment was probable. Apart from their lack of authority and expertise on these issues, staff from community-based organizations revealed that becoming too enmeshed in these family dynamics was inconsistent with their agencies' purposes. Similarly, CPS staff were blunt in their assessment of their own limitations with respect to interacting with families' in a mutually constructive manner.
- **The perspectives of both organizations fulfilled a critical role in approaching families:** Staff from both organizations noted instances in which they realized the two agencies efforts could complement one another. Staff in one site jokingly referred to the "good cop/bad cop" routine which staff from child welfare and community-based organizations sometimes assumed with families. However, these staff also revealed a deeper and more complex interaction. For example, Caring Communities staff in St. Louis were trained to engage CPS when abuse or neglect was suspected. In turn, CPS staff relied on Caring Communities staff to help facilitate the investigation in a number of ways. Most immediately, Caring Communities often provided a less threatening environment for children to divulge abusive or neglectful incidents and for CPS staff to question children. Second, by actively participating during interviews with parents, Caring Communities staff could help facilitate arrangements that met the needs of all involved—for instance, a temporary placement with kin. Caring Communities staff could also work with families, in order to alleviate concerns that led to child placement.
- **The missions of both agencies were better met when the two agencies collaborated in the development of a service continuum:** As noted earlier, the existence of a strong preventive services component with mechanisms for referring families to more intensive services, including CPS when necessary, provided staff with the assurances that all reasonable actions had been taken to attempt to avoid child welfare involvement. Similarly, the ability of community-based services to provide supportive services to families wait-listed for more formalized services such as substance abuse treatment, and as a follow-up upon completion of these services, helped ensure that families received the treatment they needed and lessened the possibility they would relapse once formal treatment ended. Finally, brokering a case plan workable for all involved meant that families were more likely to comply with the requirements specified and permanency could be achieved in a timely manner.

In short, these experiences proved to be a learning experience for staff in both agencies. Staff from child welfare and community-based organizations learned to recognize the expertise of their counterparts. Formalized systems of assessment and referral enabled them to rely upon staff from other agencies, and engage families in needed services when appropriate. By combining their services and expertise, staff noted that their options with families were broadened.