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## RESEARCH BRIEF

### Early Childhood/Child Welfare Service Partnerships: The Challenges and the Potential<sup>1</sup>

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*Numerous studies have shown the importance of intervening with maltreated or at-risk infants and young children before health, emotional, developmental, and cognitive deficits become entrenched. Although some early childhood interventions for at-risk children have demonstrated decades-long benefits, interagency partnerships that integrate multiple services may be necessary to address the complex needs of maltreated children and their families. Providing infants and young children with essential pediatric care and improving parents' coping skills have been major accomplishments of some recent interagency initiatives. However, demonstrating positive long-term outcomes has been more challenging and inconsistent follow-through with services is a common implementation barrier. In addition, different problems often respond better to different service delivery models. In all cases a successful partnership requires considerable investments of time, effort, and human and fiscal resources. Despite these obstacles it is worth the investment to provide holistic care for our nation's most vulnerable yet potentially most resilient children.*

#### Introduction

Social science research conducted in recent years has established the urgent need for coordinated educational, developmental, medical, mental health, and social services for infants and children under three years of age who are involved with the child welfare service (CWS) system (Cohen, Cole, & Szrom, 2011; Dicker, 2009; Shonkoff & Phillips, 2000). Babies and young children are the largest group of children reported to CWS; in general, the younger children are, the more likely they are to be victims of child abuse or neglect (U.S. DHHS, 2010). In addition, infants and younger children are particularly vulnerable to certain impacts of maltreatment (Wulczyn, Ernst, & Fisher, 2011). Maltreatment affects multiple developing and interactive physical, cognitive, emotional, behavioral, and social systems in children. For example, one-third of children under age three who have had contact with CWS are significantly behind their peers in language and other cognitive skills (Office of Planning Research and Evaluation [OPRE], n.d.). Without intervention, these assaults on a child's development can set the foundation for a lifetime of deficits (Center on the Developing Child

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at Harvard University, 2010; Cozolino, 2006; Dicker 2009; National Scientific Council on the Developing Child, 2005, 2006, & 2008; Shonkoff & Phillips, 2000).

Although abuse and neglect occur in all types of families, particular family characteristics are correlated with child maltreatment. Parents of low socio-economic status, defined as (1) earning less than \$15,000 annually, (2) having less than a high school diploma, or (3) being a recipient of public assistance, are three times more likely to have had a report of child abuse and seven times more likely to have had a report of child neglect than parents of socio-economic status (Sedlak, et al., 2010). Children living with single parents who cohabit with a partner are 10 times more likely to have been reported to have been abused and eight times more likely to be reported to have been neglected than children of married biological parents (Sedlak et al., 2010). Parents who suffer from drug abuse and/or mental illness, including depression, are more likely to provide inadequate care for their children (Gebhard, 2009). Families experiencing these risk factors need accessible services before they lead or contribute to additional child maltreatment. Children who are already experiencing maltreatment are in even more urgent need of services not only to ensure their safety and well-being but to detect and correct any resulting cognitive, emotional, or behavioral issues (Dicker, 2009).

## Research on the Benefits of Early Childhood Programs

Children under four years of age are the most vulnerable to maltreatment, yet are also the most malleable and potentially resilient (Center on the Developing Child at Harvard University, 2010; Quality Improvement Center on Early Childhood [QIC-EC], 2009). A variety of studies show that early service interventions for at-risk children and their families not only may prevent child maltreatment, but help improve children's cognitive and behavioral development, and ultimately lead to more tax-paying adults and fewer people in the criminal justice system (Bartik, 2011; Duncan & Magnuson, 2011; Wang & Holton, 2007). For this reason, numerous economists believe that high-quality early childhood (EC) programs are not only important from a social and ethical standpoint, but would constitute one of the country's most fruitful economic investments (Bartik, 2011; Isaacs, 2007). The Center on the Developing Child at Harvard University (2010) listed child care and child welfare just under public health in its list of eight national policy levers for improving the health and well-being of not only young children but citizens of all ages.

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There is ample evidence that high-quality programs for at-risk infants and toddlers can have long lasting positive impacts. One recent study found that high-quality child care can promote substantive behavioral and cognitive gains for children from suboptimum home environments (Watanabe, Phillips, Morrissey, McCartney, & Bub, 2011). However, good home environments were more influential than good child care, as children with good parenting but poor child care fared somewhat better than those with poor home environments but high-quality child

care. Not surprisingly, those with poor home environments *and* poor child care had the worst outcomes, while those with high-quality care in the home and child care environment fared the best (Smith & Fox, 2003; Watamura et al., 2011).

Watamura and his colleagues thoroughly documented the quality of various child care programs but did not champion any particular program. A review of the relevant literature highlights several specific educational and enrichment programs for at-risk infants and young children that have demonstrated positive developmental outcomes that continued for decades (Bartik, 2011; Isaacs, 2007). Three of the most oft-cited programs, which were implemented in the mid-1960s to early 1970s, include Perry/High Scope Preschool (Schweinhart et al., 2005); the Carolina Abecedarian Project (Winton, Buysse, & Hamrick, 2006); and the Chicago Child-Parent Center Program (Reynolds, 1997; Reynolds, Chan, & Temple, 1998; Reynolds, Temple, Robertson, & Mann, 2001). Another ongoing program with roots in the late 1970s is the Nurse Family Partnership (NFP) home visiting program (Olds et al., 1998). All four of these programs have been rated as “proven” by RAND’s Promising Practices Network (2011) since they involved rigorous evaluations that compared the outcomes of their participants to the outcomes of a control group and found significant differences with ample effects sizes.<sup>2</sup> The effectiveness of several other federally funded home visiting programs was recently assessed by HHS through the Home Visiting Evidence of Effectiveness (HomeVEE) study, which in addition to NFP identified several other home visiting programs with moderate to high ratings of effectiveness, including Family Check-up, Healthy Families America, Healthy Steps, Home Instruction for Parents of Preschool Youngsters, and Parents as Teachers (Paulsell, Avellar, Sama Martin, & Del Grosso, 2010).

The programs cited above were by and large implemented by one organization and focused primarily on one type of core service, i.e., preschool, child care, or home visits. However, these programs often involved combinations of multiple ancillary services, such as home visits with Perry Preschool, free transportation with the Abecedarian Project, and numerous opportunities for intensive parental involvement with the Chicago Parent-Child Program. Among home visiting programs, ancillary services have included job training for Healthy Families America and well-child visits for Healthy Steps (U.S. DHHS, n.d.).

## **Rationale for Interagency Partnerships for Young Children Involved with the Child Welfare System**

The aforementioned evidence-based programs focused on children who were “at risk” of maltreatment and/or delayed cognitive or social development. Infants and young children who have already been identified as abused or neglected have much greater risks of significant physical, cognitive, emotional, and behavioral impairments than those who are merely “at risk” due to poverty and associated factors (OPRE, n.d.). However, maltreated infants and toddlers are rarely enrolled in enriching child care or educational programs, thus placing them in “double jeopardy” (Watamura et al., 2011). Furthermore, maltreated children and their biological and/or foster families may require a more intensive array of services than a single service agency can provide.

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<sup>2</sup>See <http://www.promisingpractices.net/criteria.asp#evidence> for more information on how the Promising Practices Network defines a “proven practice.” There is currently no consensus in the early childhood and child welfare fields on the definition of an “evidence based” or “proven” practice.

Typically, children and their families become formally involved with CWS after an allegation of abuse or neglect has been substantiated. These systems were originally intended to protect the safety of children; eventually, permanency for children in foster care and still later “well-being” also became goals of CWS agencies (The Adoption and Safe Families Act [ASFA], 1997). Children’s well-being involves a complex and delicate balance of physical health, cognitive, emotional, and social developmental factors (Dicker, 2009; Shonkoff & Phillips, 2000). More recently, attention to infants’ and young children’s mental health has been acknowledged as essential to their well-being. However, most CWS agencies lack the resources to provide quality mental health services directly or to match children with appropriate services, and there is often little or no standardization in the administration of mental health assessments (Cooper, Banghart, & Aratani, 2010). In addition, children’s developmental trajectories are impacted by their caregivers’ emotional and developmental functioning, as well as by a variety of interpersonal, financial, legal, and logistical factors (Cooper et al., 2010; Marsh, Ryan, Choi, & Testa, 2006; Gebhard, 2009). Families with multiple serious problems may need the services of more than just one program, even if that primary program is evidence based and addresses multiple issues (Berlin, O’Neal, & Brooks-Gunn, 1998).

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The Keeping Children and Families Safe Act of 2003 authorizes funding for demonstration projects that create collaborative triage systems to prevent child abuse and neglect, assess reports of abuse or neglect, and provide intensive intervention when a child’s safety is in jeopardy. Child welfare agencies generally do not become directly involved in providing services to families until a report of abuse or neglect has been indicated or substantiated. However, CWS caseworkers investigating suspected abuse or neglect often find salient risk factors even when maltreatment is not substantiated. If caseworkers could refer at-risk families to other beneficial services before maltreatment has been confirmed, abuse or neglect could be prevented more readily (Stepleton, McIntosh, & Corrington, 2010). In addition to preventing maltreatment, partnerships between CWS and other service providers hold the promise of promoting significant developmental, mental health, and social benefits for children. For these reasons, Federal funding agencies such as the Children’s Bureau and the Health Resources and Services Administration (HRSA) strongly encourage partnerships among multiple child- and family-serving agencies (HSRA, 2010a, b). However, studies have shown that cross-agency referrals alone are only the first step; ensuring that infants and young children receive the services they need often requires the development of intensive interagency partnerships (Dicker, 2009; Kahn, et al., 2009).

### **Types and Levels of Interagency Partnerships**

High-needs children and their families often require a wide variety of services; however, in practice families often receive services in a fragmented and disconnected manner that results

in excessive paperwork, overlapping services, contradicting advice from various agencies, and a sense of frustration and hopelessness (Smith & Fox, 2003). In addition, service providers sometimes find the uncoordinated maze of agencies and programs to be counterproductive. In response, many social service organizations have recently made efforts to streamline services through joint case management, “wraparound” service models, and other integrated service models involving interagency partnerships (Substance Abuse and Mental Health Services Administration [SAMHSA], 2010; Smith & Fox, 2003).

Partnerships among agencies can occur at numerous levels. The loosest level includes “networking”, which involves communication among agencies about their respective programs. Networked agencies may make informal or formal referrals to other agencies. Coordination and cooperation are respectively deeper levels of interaction. The highest level is often characterized as “full collaboration” in which two or more agencies partner together to create a jointly owned and run program (QIC-EC, 2009). Table 1 on the following page synthesizes various perspectives regarding different levels of interagency partnerships as well as their benefits and limitations, and provides generic examples of partnerships involving EC and CWS agencies (Frey, Lohmeier, Lee, & Tollefson, 2006; Gajda, 2004; James Bell Associates, 2011; QIC-EC, 2009).

Although collaboration is often considered the ideal level of partnership, it is also the most complex and time consuming to develop and implement. Partnerships generally work best when they start at less intensive levels; as sustained mutual effort increases interpersonal trust and inter-organizational understanding, higher levels of partnership can be considered. An interagency partnership may also involve numerous levels of partnership within the same initiative. For example, an EC agency may collaborate with a substance abuse agency to create a new program that serves substance-abusing parents and their children, and within this new program referrals are made to additional outside agencies such as infant mental health services. Over time, the new program may develop more intensive coordination or cooperation with the infant mental health agency. Furthermore, two agencies may have a collaborative relationship for specific aspects of a particular program, while maintaining a more independent albeit cooperative relationship within other programmatic areas.

### **Early Comprehensive Early Childhood Initiatives**

Early examples of initiatives that sought to coordinate the delivery of EC and other services often incorporated many of the elements of earlier successful EC programs, including child care and parent education. Two of the most studied initiatives are the Infant Health and Development Program (IHDP) and the Comprehensive Child Development Program (CCDP). Initiated in 1985, IHDP was a multi-agency initiative for premature infants (Berlin et al., 1998). While infants in both the treatment and control groups received pediatric follow-up assessments and referrals for other needed services, the treatment group also received regular home visits, center-based child care based on the Abecedarian model, and parent group meetings. The CCDP was a national multi-site demonstration primarily consisting of case management services while also including early childhood education, adult education, job training, parenting education, and child care components (Gilliam, Ripple, Zigler, & Leiter, 2000; St. Pierre, Layzer, Goodson, & Bernstein, 1999).

**Table 1: Levels of Interagency Partnerships**

Level of Partnership	Benefits	Limitations	Examples
<b>Networking:</b> Information about services is shared among agencies	Essential stepping stone for all higher levels of partnering  Involves less time and effort than other levels of partnership	Necessary but often insufficient  Too many organizations and individuals are on “information overload”	EC informs CWS agency about its free services for children in foster care
<b>Coordination:</b> Agencies work to align their respective services	More service integration than simple networking	Does not ensure follow-through with services	EC agency provides case management services to CWS-involved families of young children
<b>Cooperation:</b> Agencies maintain independence while working together toward a common goal	Agencies work together on common goal more closely than with coordination alone  More opportunities for ensuring follow through	Fewer opportunities for innovative new projects than in a full collaboration	EC and CWS have joint case planning meetings to address families’ needs and to share information regarding follow-through with families
<b>Collaboration:</b> Agencies work together to create a new or enhanced project or program	Innovations that one agency cannot do alone may become possible (whole > sum of parts)	Takes a large amount of time and effort to achieve successfully  Works best with limited numbers of partners (2-4)	CWS and EC agencies work together to create a new program for substance-abusing mothers of young children with each agency playing a specific role  Joint case management, administrative, and supervisory functions

Neither initiative demonstrated large overall effects. However, further analyses showed that some sites or subgroups showed substantial benefits. For example, within the CCDP one high-performing site enjoyed the benefits of stable leadership, low staff turnover, prior integration within the community, and also appeared to have somewhat less needy participants. When compared to a control group, children at this site showed more improvements in vocabulary while families had less need for public assistance over time. For its part, IHDP was associated with substantial cognitive benefits over a three-year period for larger low-birth weight babies and for children from moderate-risk families; however, there were fewer benefits for the lowest birth weight babies and for the neediest multi-problem families. Both initiatives experienced a frequent lack of follow-through with recommended services, while their

limited success in meeting the needs of the highest-risk children and families suggest that additional or more effectively integrated services may have been necessary.

### Early Head Start Program

Early Head Start (EHS), a Federal program funded through the Office of Head Start within the U.S. Department of Health and Human Services (HHS), was not conceived of as an interagency collaborative *per se* but does involve multiple systems that impact young children. Commencing in 1995 with a specific focus on children ages birth through three, EHS is a two-generational (i.e., services are provided to both the child and the mother) comprehensive program that places more explicit emphasis on child development services than the earlier CCDP initiative noted above.

Although local EHS programs exercise considerable discretion in selecting a primary service delivery model (e.g., primarily home-based services or center-based services with child care), each program must adhere to a comprehensive list of Federal Head Start Program Performance Standards (EHS National Resource Center, 2005; Love et al., 2002; Vogel et al., 2006). By attending to multiple factors affecting young children’s lives—including family, staff training, and community development—EHS includes numerous interactive elements. In addition to early childhood education, EHS provides referrals to primary health care providers (a “medical home”), nutritional advice, and also emphasizes infant mental health (Vogel et al., 2006). EHS directly promotes family development via parent involvement, with home visits serving as a common service component.

Thus far EHS has shown more successful outcomes than the CCDP; it has also been rated as “proven” by RAND’s Promising Practices Network (2011). Specifically, one study (Love et al., 2002) observed that by age three EHS participants demonstrate better cognitive and language skills, less aggressive behavior, and better health outcomes than children assigned to a control group. Additional observed benefits of EHS include more positive and fewer negative parent-child interactions observed during play (for both mothers and fathers), home environments that were more supportive of children’s language and cognitive development (e.g., parents were more likely to read daily to their children), and less punitive behavior by both fathers and mothers. The EHS home-based service option was recently identified as an evidence-based early childhood home visiting model in HHS’ HomVEE study (Paulsell et al., 2010).

Early Head Start also provided the foundation for one of the earliest Federal efforts to encourage direct and formal partnerships between EC and CWS agencies. Begun in 2002 as a joint effort of the Children’s Bureau and the Office of Head Start, the Early Head Start/Child Welfare Service (EHS/CWS) Initiative funded small-scale collaborative demonstrations involving local EHS programs and CWS agencies in 24 sites nationwide that varied considerably in terms of geographic location, population, service structures, and other factors (EHS National Resource Center, 2005; James Bell Associates, 2009a,b). Some sites operated primarily home-based EHS programs, some were primarily center-based, and some integrated combinations of home and center-based services. Despite these differences in service models, the demonstration projects in all 24 sites had some form of the following content:

- Creation of Family Partnership Agreements for each family served
- Parent education and training activities

- Semi-structured socialization activities
- Screenings and assessments (developmental, medical, and dental; home safety when applicable)
- Medical/dental services
- Mental health treatment/counseling

The specific content of services provided by the EHS/CWS grantees varied widely, with five grantees hosting particularly unique collaborative programs with local CWS agencies and other service providers. Examples of services provided by these five grantees in collaboration with other service agencies included:

- Services for babies and toddlers who had been exposed to alcohol or other drugs *in utero*.
- Use of “mentor” families to model positive parenting skills and behaviors for new mothers.
- Child care for infants and toddlers at a local emergency shelter.
- Residential substance abuse treatment with onsite EHS services.
- Dyadic therapy for parents and infants.

Implementation results, such as the number of families served, varied widely among the EHS/CWS grantees. Due to resource constraints some grantees could provide families with only a limited range of services, whereas some grantees’ success in serving families depended to some extent on the quality of interagency partnerships. Several grantees—especially those implementing home-based service models—struggled with enrollment attrition, which was exacerbated by the geographic transience of the populations targeted for services. Outcomes also varied substantially among the grantees. On a programmatic level, staff professional skills and inter-organizational awareness and communication generally improved, while families had improved access to health and social services as well as more timely receipt of child health/developmental screenings, checkups, and immunizations. For example, fully 87 percent of children enrolled in EHS/CWS projects that reported health screening and immunization data were current on checkups and immunizations. Other positive outcomes reported by some grantees included safer homes (e.g., fewer home health and safety hazards), improved caregiver coping skills, and improved parenting knowledge and skills.

In general the grantees reported somewhat higher maltreatment rates among participating families than among non-participating families, although this finding may have resulted from the higher level of scrutiny experienced by participating families rather than actual increases in maltreatment risk. As a whole the programs showed some evidence of sustainability, with all 16 grantees that responded to a survey at the end of their five-year grants reporting their intention to continue partnering with local CWS agencies and other service providers; of these, 13 grantees planned to continue reserving EHS program slots for CWS children.

### **Other Early Childhood Interagency Initiatives**

During the past decade several local communities and child-serving agencies throughout the country have explored the potential of intensive interagency partnerships to meet the needs of maltreated and at-risk children. Selected examples of these initiatives, along with their findings and challenges, are outlined below.



- Cuyahoga County Early Childhood Initiative. (Coulton, 2005; Daro, Howard, Tobin, & Hardin, 2005). The Cuyahoga County Early Childhood Initiative was a public-private partnership that ran from 1999 to 2004 and involved both universal and targeted services across multiple areas. Services included home visits (shortly after birth) provided by one agency and home-based services provided by another agency for up to three years if needed. The initiative also worked to increase the availability of certified family child care, as well as training in providing child care for children with special needs. In addition, the initiative sought to expand subsidized health insurance coverage, as well as efforts to increase public awareness of early childhood issues. Evaluation findings indicate that the initiative helped reduce parents' stress levels, improved health care coverage for children, and increased children's enrollment in EHS and early intervention (EI) services. However, findings on child maltreatment prevention were mixed, while one of the two agency's home-based service programs struggled with low retention rates.
- Philadelphia Department of Human Services Child Welfare Early Intervention Initiative. This initiative provided EI services to children aged zero through five with suspected disabilities who were involved in CWS (Alexander, n.d.; Dicker, 2009). The initiative was developed in response to the Keeping Children and Families Safe Act of 2003, which stipulates that all children under age three with a substantiated case of abuse or neglect must be screened for eligibility for EI services funded under Part C of the Individuals with Disabilities Education Act (Child Welfare Information Gateway, 2007; Dicker, 2009). Evaluation findings indicated that the initiative resulted in the improved identification and monitoring of children eligible for EI services, as well as improved training for child welfare staff in screening children for EI eligibility. This was in contrast to numerous other CWS-EI partnerships in which EI screenings were mandated but follow-through with screening and/or recommended services was very inconsistent (Dicker, 2009).
- Court Teams for Maltreated Infants and Toddlers Project. (James Bell Associates, 2009c; Zero to Three, n.d.). Building upon work conducted in the Miami Dade Juvenile Court, the Court Teams project was spearheaded in 2005 by Zero to Three and was eventually piloted in 11 communities throughout the country. Each Court Team is presided over by a family court judge who works in partnership with CWS, health professionals, child advocates and community leaders to meet the multiple needs of CWS-involved families. An assessment of 186 children in the first 3 sites showed that 99 percent avoided additional maltreatment, 97 percent received needed services, and 95 percent of closed cases achieved permanency (James Bell Associates, 2009c). Overall impacts across all 11 sites have included increased receipt of needed services by babies and young children (e.g., health care, EI); fewer out-of-home placements overall accompanied by more placements with kin, and more parental visits when children are in temporary custody (Zero to Three, n.d.).
- Model Development or Replication to Implement the CAPTA Requirement to Identify and Serve Substance-Exposed Newborns - Discretionary Grant Cluster. This discretionary grant cluster was funded by the Children's Bureau in 2005 to demonstrate innovative strategies to fulfilling a requirement of the Child Abuse Prevention and Treatment Act to identify and provide services to newborns exposed prenatally to substances (SENs). Examples of collaborative partners involved in the four projects funded under this grantee cluster included hospitals, CWS, and drug courts; one site employed mothers in recovery to serve as "peer mentors" to pregnant women and new mothers struggling with substance abuse. Examples of progress reported by these grantees has included more prompt detection of

infant substance exposure (although many organizational and technical challenges remain to developing fully streamlined identification and referrals systems); greater awareness among foster parents of SENs and how to care for them; greater awareness across organizations of their respective programs, policies, and procedures; greater interagency collaboration; and more effective teamwork on individual SEN cases (James Bell Associates, 2010).

- Comprehensive Community Mental Health Services Program (“Systems of Care”) for Children. In 1993 SAMHSA established its Comprehensive Community Mental Health Services Program, and since then has provided multi-year grants to 144 communities at various levels of government (including state, county, and tribal agencies) to provide comprehensive services to children with mental health needs and their families (SAMHSA, n.d.). SAMSHA defines the essential activities of these interagency “Systems of Care” (SOC) partnerships as “families partner[ing] with [teams of] public and private organizations to develop individualized service plans for their children that build on child and family strengths to establish effective services and supports in the least restrictive settings possible” (SAMHSA, 2010). Each grantee may choose the population of focus, and numerous sites have focused on early childhood.

Among SOC partnerships focusing on early childhood, the scope and depth of collaboration among partnering agencies has varied by site but usually involve organizations such as educational service providers, CWS, primary medical care providers, and mental health providers. Across these sites, about 12 percent of participating children were referred by CWS (SAMSHA, 2010). Many sites implemented wraparound service models in which representatives from various agencies, as well as informal support networks chosen by the caregiver’s family (e.g., relatives, friends, clergy) form teams to develop strength-based service plans for their children. Reported outcomes to date have included fewer changes in child care programs due to behavioral problems, better emotional and behavioral health among participating children, reduced family stress, and parents missing less work as a result of their child’s emotional or behavioral problems (SAMHSA, 2010).

- Strengthening Families Program. Originally funded by the Doris Duke Charitable Foundation in the early 2000s, Strengthening Families is an innovative approach to preventing child maltreatment based on fortifying five protective factors: (1) parental resilience and coping ability; (2) families’ social connections; (3) knowledge of parenting and child development; (4) concrete support (e.g., housing, food, etc.); (5) children’s social and emotional development (Stepleton et al., 2010). Early childhood education is an established venue for promoting the aforementioned protective factors and effectively reducing the incidence of child maltreatment (Horton, 2003). Fostering positive social connections among child care staff and parents, and between participating parents, appears to promote healthier parenting. Parents can learn reasonable expectations for infant and child development, hygiene, behavior, and discipline in a non-stigmatizing environment (Horton, 2003). The Strengthening Families approach has been piloted in three states, which resulted in the following *Guiding Principles for Strengthening Families in Child Welfare*:
  - Families are essential to children's development.
  - Restoring protective factors, as well as minimizing risk factors, empowers a family to raise their children effectively.

- Positive relationships—within and between families, providers, and systems—are crucial for promoting change.
- Deliberate, methodical coordination among systems promotes healthy relationships and enhances their ability to assist children and families.
- All involved systems and services must share accountability for promoting family functioning.

### **Challenges to the Establishment and Implementation of EC-CWS Partnerships**

The examples of interagency initiatives described above illustrate both the promise and challenges to the more widespread development and implementation of partnerships among early childhood service providers, CWS agencies, and other social service organizations. Many of these challenges have their roots in systemic factors and organizational dynamics that are endemic to both early childhood service providers and CWS agencies. For example, early childhood programs often experience numerous challenges to their organizational stability, which can in turn present challenges for interagency partnerships. A major cause of instability is staff turnover at various levels, especially among direct care staff (Vogel et al., 2006). This turnover not only affects vulnerable children and families directly but also hampers interagency partnerships. Developing or maintaining partnerships is challenging when new staff must continually be kept abreast of quality standards, referral processes, and communication protocols. It may be not be a coincidence that the most successful site in the CCDP initiative described earlier was the one with stable leadership and high staff retention.

Some early childhood programs such as EHS have detailed, well-established quality standards and required professional development programs to help staff achieve these standards (EHS National Resource Center, 2005; Love et al., 2002). However, not all early childhood programs have these stringent standards or requirements. Basic standards vary from state to state and programs do not always fully implement them. Indeed, a study led by the University of Colorado at Denver in the 1990s indicated that 40 percent of reviewed EC education programs were rated as “poor” in quality (Helburn, 1995). Early childhood programs with less rigorous standards, or programs that have strict standards but are unable to fulfill them, may not make ideal partners for child welfare or other agencies.

In turn, CWS agencies face particular organizational and systemic barriers to greater interagency collaboration. As in the case of EC programs, staff turnover rates are often very high at between 20 and 40 percent annually (National Council of Crime and Delinquency, 2006). An immediate challenge to expanded inter-organizational partnerships is the fact that CWS agencies generally work with more severely dysfunctional families than other service providers such as EC education and EI programs. In addition, while CWS agencies are paying increasing attention to child well-being from the standpoint of policy and professional philosophy, they still focus primarily on immediate threats to the health or safety of children. Although this different emphasis is not in direct opposition to the longer-term goals of other agencies that serve infants and young children, it may cause conflict when it comes to planning interventions and prioritizing the delivery of various services.

Potential conflicts between CWS agencies and other service providers regarding the service needs and priorities of vulnerable families may be exacerbated by the sometimes mistrustful, “us against them” mentality of parents involved with CWS. Parents often view not only CWS involvement, but also the external services to which CWS refers them, as a “punishment”

rather than as an ongoing benefit to their children and families. Thus, parents are often unwilling to follow through with non-mandated services or only follow through until their perceived “sentence” has been served (Chamberlin, 2009). Greater participation in services may also be hampered by the factors that lead many parents to abuse or neglect their children, such as mental health issues, substance abuse, or developmental immaturity, which can cause parents to forget or disregard service appointments. Transportation can be an additional major barrier, as parents may lack reliable vehicles, valid driver’s licenses, or funds for public transportation (Berlin et al., 1998; EHS National Resource Center, 2005).

The complex and sometimes hazy legal relationships among CWS, children, biological parents, and service providers can create additional challenges to effective service partnerships. For example, in the case of children in out-of-home placement it is not always clear who the child’s primary “parent” is for the purposes of service delivery, i.e., whether the focus should be on serving the child’s foster parent or his or her biological parent. These ambiguities are further complicated when the child’s permanency goal or ultimate placement disposition remains uncertain. Biological parents sometimes have limited visitation rights, a situation that creates barriers to participation in center-based services (James Bell Associates, 2006). In ambiguous situations, ideally both the foster and biological parent should participate, and frequent parental visits should be encouraged (Dicker, 2009). These visits help cement or re-establish fragile parent-child bonds and provide parents experience and guidance in parenting. Conversely, these visits can help staff discern whether a parent is unable or unwilling to make the necessary changes to justify reunification and pursue a termination of parental rights if warranted (EHS National Resource Center, 2005).

Other legal complexities involve how staff from partnering social service agencies should address possible child maltreatment. Serious maltreatment must be reported to CWS immediately, but less severe maltreatment or suspicions thereof may require more discerning responses. At times, reporting families to CWS provides relief to overburdened parents desperate for help (EHS National Resource Center, 2005). In other cases, parents may feel betrayed and withdraw their children from ongoing services. It is important for partnering agencies to create an agreed-upon protocol for reporting and address various levels of alleged maltreatment.

### **Implications for the Further Development of EC-CWS Partnerships**

Despite extensive research on individual EC service projects that have displayed substantial and sustained results and high returns on investments, thus far there has been considerably less evidence regarding the effectiveness of interagency partnerships that serve infants and young children. Indeed, several high-profile studies implemented in the 1990s suggested, somewhat counter-intuitively, that interagency initiatives for at-risk families, including wraparound services and joint case management, are no more effective than fragmented “business as usual” services (Bickman, 1996; St. Pierre et al., 1999). The challenges to effective EC-CWS partnerships documented above may explain in part this lack of positive results. Follow-up research in this area has focused on understanding why these initial collaborative efforts were less effective than anticipated and what can be done to enhance the effectiveness of future partnerships (Kahn et al., 2009).

Different levels of inter-organizational cooperation and coordination are appropriate at different times under varying circumstances. Although full collaboration is often regarded as the ideal level of partnership, not every child-serving agency can effectively collaborate with multiple organizations simultaneously. Organizations must take ample time to develop effective interdependent relationships, usually starting with looser and more independent decision-making and service delivery structures. When more intensive and collaborative partnerships are appropriate, such relationships are often limited to just two organizations while coordination with other organizations occurs at looser levels. Problems occur when the level of partnership is insufficient to meet the agencies' mutual goals. For example, in some partnerships in which a CWS agency is tasked with referring families to other service agencies, the partnership goes no further than a referral without formal follow-up (Dicker, 2009). The literature on inter-agency collaboration highlights several recommendations for developing ideal organizational partnerships, some of which are identified by Sanchez-Fuentes & Samuels (2010) as specifically applicable to EC-CWS collaborations.

*Although full collaboration is often considered to be the ideal level of partnership, not every child-serving agency can effectively collaborate with multiple organizations simultaneously.*

Involve key service providers from the beginning. Involving the providers of key health and social services from the earliest planning stages can be critical to the success of an interagency service initiative (Graham & DeSantis, 2005; Kahn et al., 2009). In addition to EC and CWS agencies, it may be appropriate to include other organizations in service planning and delivery depending on the needs of the target population or the issues addressed by the initiative, including family courts, primary health service providers, early intervention programs (Child Welfare Information Gateway, 2007), and infant mental health service providers (Cooper et al., 2010). In addition, interagency initiatives may be strengthened by including agencies that address substance abuse (Dicker, 2009; James Bell Associates, 2009a), domestic violence, employment, child care, and housing (Marsh et al., 2006; Osterling & Austin, 2008).

Start with an assessment of community needs and resources. A needs assessment identifies the issues in the community that are not sufficiently addressed with existing services (Wandersman, Sullins, & Manteuffel, 2010). Although surveys of stakeholders' perceived needs are the most common method for conducting needs assessments, a more accurate method involves examining the status of young children in the child welfare system and determining which unmet needs are the most prevalent and severe (Witkin, 1994). In addition to assessing the needs of vulnerable populations, partnering agencies should assess community resources and assets that can be assembled to effect successful project implementation (Wandersman et al., 2010). This process involves identifying family-serving agencies, faith-based organizations, organizational and community leaders, and untapped human and material resources that can support or directly contribute to the project's implementation. A thorough needs and resource assessment can help identify an initiative's specific population of focus; optimal service formats (e.g., home-based or center-based services); organizational, cultural, or resource barriers that must be addressed; and potential partnering agencies.

Attend to the whole child, family, and environment. A needs and resource assessment can explore deficits, barriers, and facilitators within the community to be served, as well as general characteristics of the target community's culture, socio-demographic make-up, and economic or political realities that may affect project implementation. However, services for individual families must be designed to address the needs and strengths of each particular child and his or her family. Joint case planning or service planning meetings, in accordance with information-sharing regulations, is a cooperative process in which staff from various agencies can work together to discuss a family's needs and how to best meet them (Sanchez-Fuentes & Samuels, 2010).

Establish and maintain clear expectations for, and communication among participating agencies. Different levels of partnership require different levels of communication and teamwork, but open and trusting communication must be fostered at all levels. Beyond traditional Memoranda of Understanding or Memoranda of Agreement, collaborative partners may need to develop more specific and detailed policies, protocols, and procedures to facilitate effective service referrals, enrollment, and case planning and coordination. Some changes to communication protocols may be quite simple, such as adding questions regarding a child's foster care status and the name of his/her caseworker to program enrollment forms (Sanchez-Fuentes & Samuels, 2010). Although the development of more complex protocols can be labor intensive, this investment can ultimately minimize the time and complications involved in referring and communicating about participating families (Kahn et al., 2009). Federal laws such as the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA) can provide a legal framework for developing protocols that govern inter-organizational communication about program participants. While ensuring compliance with these laws, protocols must also be as clear and concise as possible to minimize data collection burdens on project stakeholders.

*Assess the community's resources that can be assembled to effect successful implementation, including family-serving agencies, faith-based organizations, organizational and community leaders, and untapped human and material resources.*

Implement cross-system trainings. Joint trainings among participating agencies on topics concerning young CWS-involved children can be an essential component of a successful interagency collaborative (James Bell Associates, 2009a). Training may include informational sessions in which project staff learn about the history, mission, organization, and services available through each respective agency. Training may also address specific clinical or case management topics that are pertinent to all partnering agencies, such as working with multi-problem families (Sanchez-Fuentes & Samuels, 2010).

Appoint an EC liaison for CWS. A liaison from an EC program to a CWS program can attend family court hearings, educate CWS workers about EC programs and their benefits, facilitate communication regarding children involved in both service systems, and invite CWS staff to become reciprocally involved in EC committees and work groups (Sanchez-Fuentes & Samuels, 2010).

Reframe the goals and benefits of family participation. As some prior EC and CWS initiatives demonstrate, getting families to enroll and remain in services for the recommended timeframe can be challenging. To promote the active and sustained participation of families, services must be framed as opportunities that benefit parents and their children rather than as punishment for inadequate parenting (Filene, Lutzker, Hecht, & Silovsky, 2005; James Bell Associates, 2009a). Encouraging participation and achieving long-term family goals can be facilitated by the *Strengthening Families* approach (2008), which involves fortifying these five protective factors: (1) parental resilience and coping ability; (2) families' social connections; (3) knowledge of parenting and child development; (4) concrete support (e.g., housing, food, etc.); and (5) children's social and emotional development. Exploring and attending to each family's expressed needs, strengths, culture, and preferences are essential steps in attaining meaningful family participation (SAMHSA, 2010).

Secure appropriate resources to facilitate family participation, especially child care. High-quality child care can help foster the development of the *Strengthening Families* protective factors described above. In addition to facilitating children's social and emotional development, child care can help parents achieve broader educational, employment, and life goals (Knox, London, & Scott, 2003). Reliable access to child care can enable parents to attend services such as job training, counseling, substance abuse treatment, and parenting classes, which in turn will improve their capacity to earn income, cope with stress, and parent effectively. For infants and young children in out-of-home placement, diligent efforts should be made to maintain them in the same child care setting when a change in placement becomes necessary (Administration for Children and Families [ACF], 2011; Stepleton et al., 2010).

Consider logistics. Logistical factors, particularly lack of access to reliable transportation and high rates of residential mobility among low-income families (Scanlon & Devine, 2001), often create barriers to families' participation in services, especially large families with multiple needs. The critical role of transportation in facilitating successful program implementation is exemplified by the Carolina Abecedarian Project described earlier, which provided free transportation to all enrolled children. Home-based services may eliminate the immediate need for transportation; on the other hand, center-based programs give parents more flexibility to work, attend school, and participate in services. Some families may require a mix of home-based and center-based services. Scheduling may also be problematic for many families; therefore, providers should offer services during times and in venues that accommodate the busy lives and schedules of primary caregivers and their children.

Improve the rigor of program evaluations. Given their complex and systemic nature, collaborative projects involving multiple organizations are notoriously difficult to evaluate; however, rigorous and useful evaluations are possible when adequate time is invested in identifying an optimal research design and data collection methods, securing buy-in from key stakeholders, and assessing the availability and quality of data from various sources. Although experimental research designs with random assignment are generally regarded as the "gold standard" for measuring the effects of human service programs, they can be particularly difficult to implement in the context of inter-agency collaboratives. One challenge involves maintaining the integrity of the experimental and control groups. For example, families assigned to the control group may receive services elsewhere that are similar to those available to experimental group families through the inter-agency collaborative. In addition, children and families assigned to the experimental group may not fully participate in the services available through the initiative, while lack of follow-through with services at particular sites may skew results reported for the initiative as a whole (Berlin et al., 1998;

Gilliam et al., 2000). Conversely, overall program effects often obscure differences among sites. This is especially true when sites have discretion to select or develop flexible programs that are responsive to families' needs, or when the populations served at each site differ substantially in terms of their demographic and case characteristics or service needs. Therefore, when examining outcomes it is important to look for exemplars among sites and to explore factors that serve as facilitators of success (Gilliam et al., 2000).

## Conclusion

It is crucial to intervene with maltreated infants and young children before health, emotional, developmental, and cognitive deficits become entrenched. Some pioneering early childhood interventions from the 1960s and 1970s that incorporated preschool, child care, and home visiting programs for at-risk children have shown decades-long benefits for their participants as well as high economic and social returns on investment. However, most of these early initiatives involved just one organization or service provider. Ultimately interagency collaboratives involving multiple service partners—including EC and CWS agencies—may be necessary to address the complex and multifaceted needs of maltreated or vulnerable infants, young children, and their families (Gebhard, 2009). These partnerships should integrate components of evidence-based programs whenever feasible. As indicated by the matrix of levels of interagency partnerships described earlier, a fully collaborative initiative must involve deeper levels of service coordination and integration than cross-agency service referrals. Building trusting relationships—both among agency staff and between service providers and families—must be front and center in developing effective interagency initiatives.

Interagency collaborations take considerable investments of time, effort, and human and fiscal resources (Cohen et al., 2011; Kahn et al., 2009; Gebhard, 2009). Moreover, both CWS and EC agencies have specific organizational characteristics and operate in particular political and professional contexts that pose unique challenges to the development of such partnerships. It is imperative that all organizations participating in a service collaborative understand and adapt to these challenges accordingly (EHS Start National Resource Center, 2005).

The evaluations of interagency initiatives involving EC and CWS that were implemented in the 1990s and 2000s demonstrated success in some outcome areas, such as getting infants and young children essential pediatric care (e.g., immunizations, health screenings) and reducing parental stress. However, demonstrating the longer-term impacts of these initiatives has been more challenging due to multiple systemic and organizational issues affecting CWS and EC agencies, inconsistent or incomplete participation in services by targeted families, and barriers to the effective evaluation of complex inter-organizational efforts. Complicating the matter is the fact that different problems respond best to subtly different service delivery models (Berlin et al., 1998). Nonetheless, a review of studies over the past several decades suggests that there is strong potential for EC and CWS agencies—working in tandem with the providers of other health and social services—to develop holistic interventions that improve developmental, behavioral, well-being, and safety outcomes for our nation's most vulnerable yet potentially most resilient children.



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