Building a 21st-Century Research Agenda: Using Evidence to Promote Better Outcomes for Families

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Executive Summary

Purpose and Collaborators

The purpose of building a 21st-century research agenda to support child and family well-being is to:

1. Form a broad-based coalition of research partners to identify research gaps to support child welfare;
2. Articulate clear research questions relevant for jurisdiction leaders and policy-makers that need to be addressed;
3. Identify and implement strategies for conducting research that will close the gaps and answer those key questions; and
4. Help agencies use the research findings to improve policy, program, and practice strategies.

While previous efforts have been made to convene researchers and reports have been written on specific topic areas, there have been no recent efforts to create a comprehensive national research agenda for a modern-day child welfare system that addresses key knowledge gaps. Casey Family Programs (CFP), the Annie E. Casey Foundation (AECF), and the William T. Grant Foundation have partnered with philanthropic organizations; researchers; diversity, equity, and inclusion experts; policy analysts; agency leaders; and people with lived experience in the child welfare system to form three expert workgroups to identify research gaps and to support the use of findings in decision-making to improve practice and policy. Organizations in this effort include Black Administrators in Child Welfare, the National Indian Child Welfare Association, the Child Trends Hispanic Institute, the American Public Human Services Association, the Child Welfare League of America, and the American Academy of Social Work and Social Welfare.

High-Priority Research Gaps

While over 300 research gaps have been identified, which of the gaps appear most urgent to address? The answer to this question depends on context and perspective, and so we offer the gaps discussed here for consideration in the spirit of *"If everything is important, then nothing is important."* These high-priority gaps are clustered in three areas that align with the expert workgroups:

1. Community-Based Prevention ("CBP")
2. Child Protective Services and Prevention of Foster Care ("CPS")
3. Out-of-Home Care ("OOHC")

Within each area, gaps are presented as questions (rather than statements) and are listed in no particular order. The research gaps are numbered to align with their order in the main report; thus, for community-based prevention and out-of-home care, the numbers are not sequential. (The CPS group identified eight high-priority gaps.) For sub-questions that accompany many of the research gaps, see the main report.

Community-Based Prevention

CBP 1. What are the core components, effectiveness, sustainability, and transferability of community mobilization efforts for increasing access and use of supports and services?

CBP 5. What are the core components, effectiveness, sustainability, and transferability of efforts to embed prevention programs and services within settings visited by families for increasing access and use of supports and services?

CBP 7. What are the impacts of local and federal policies, supports, and programs that attempt to address inequities in systems (e.g., lack of access to high-quality childcare, the criminalization of poverty) on community, family, and child well-being?

CBP 9. What policies, programs, services, and supports can help increase access to safe, stable, and affordable housing and how do they impact maltreatment and child, family, and community well-being?

CBP 10. How can Community-Based Child Abuse Prevention (CBCAP) and other funding sources be leveraged to support the infrastructure needed to implement and sustain community-based prevention efforts?

Child Protective Services and Prevention of Foster Care

CPS 1. What is the level of effectiveness among existing practice and policy interventions that are aimed at preventing initial and recurrent child protective services (CPS) contact and out-of-home placement?

CPS 2. What can we learn from cultural practices, best practice models, and models considered less adversarial (e.g., ICWA courts, Healing to Wellness Courts) used with subpopulations (e.g., ICWA and active efforts) that can help transform our approach to child welfare?

CPS 3. What is the effectiveness of innovative and transformative programs and interventions that are currently in place but have not yet undergone a full-scale outcome evaluation and comparison to traditional intervention methods?

CPS 4. To what extent are risk factors commonly associated with CPS involvement (e.g., domestic violence, parental mental health, trauma histories, extreme poverty) experienced differently by families with varying dimensions of family diversity?

CPS 5. Are helplines more effective than hotlines at reducing CPS involvement, reducing out-of-home placement, and improving parent and caregiver well-being?

CPS 6. To what extent do income supports (e.g., universal basic income, antipoverty programs, paid family leave, tax credits) prevent CPS involvement and out-of-home placement?

CPS 7. How are partnerships between child welfare agencies formed with other entities, including researchers and community and institutional partners (e.g., public health, schools, legal advocates, courts, faith-based organizations, parents, foster care alumni/parents) in order to reduce CPS involvement and out-of-home placement and improve parent and caregiver well-being?

Out-of-Home Care

OOHC 1. Which child welfare and related policies and practices contribute to the most successful outcomes for children and youth placed in out-of-home care? This includes children and youth of all identities, acknowledging that there are certain groups that the data tell us are more vulnerable to experiencing inequities in services and outcomes, such as American Indian/Alaska Native, Black, Latinx, and GLBTQQ children.

OOHC 2. Does the involvement and consultation of foster care alumni, youth who are currently in care, parents, kinship parents, and other caregivers help improve the quality and safety of out-of-home care?

OOHC 3. What are ethnic-racial patterns of out-of-home care (e.g., type, quality, restrictiveness)? What factors drive these patterns, and how do they affect child well-being?

OOHC 4. What child welfare services are effective in promoting safe, stable, and timely reunification, adoption. and legal guardianship? Reunification services include intervention models and strategies that are based on a set of shared values concerning the centrality of family in practice.

OOHC 5. What are effective strategies to reduce re-entry to care for different age groups, such as infants or teens in out-of-home care? How might the provision of post-reunification services (e.g., timely in-home crisis intervention services or other services) promote stable reunification and prevent re-entry?

OOHC 8. What are effective strategies to promote permanency outcomes for infants and very young children in out-of-home care (including situations in which infants and young children are in out-of-home care with their mothers)? Are there any inequities in services or outcomes for these young children and their families?

OOHC 9. How can we develop evidence-based recruitment, screening, and matching practices to engage highly effective resource parents for children in out-of-home care? (The meaning of "highly effective" would be defined in the RFP but might include such dimensions as the ability of the resource parents to support the overall case plan, coordinate with birth parents, and support child development and well-being.)

Summary

The full report contains a large array of research gaps that need to be addressed to inform a 21st-century system to support children and their families. While we call out the need for greater housing, income, mental health, and substance abuse treatment supports for families, these are areas where other systems beyond child welfare need to do more to help families and to do so in a more coordinated manner. This report also contains recommendations for ***how*** research should be undertaken. It should be viewed as a starting place for the field: a research agenda to be refined and updated over time. While the lack of replication studies poses a significant challenge across many areas of child welfare, we do have a foundation of research to build on for many of them. But given geographic and other population variability, many research questions must be framed in the context of local communities, and interventions need to be tested in multiple jurisdictions. Because of advances being made in child welfare and other related fields, we are confident that with the proper research funding, many of these knowledge gaps can be addressed over the next 10 years.

Introduction

Background

This document presents a research agenda for a 21st-century approach to child and family well-being by listing gaps in knowledge and research questions that need to be addressed to better support youth and families. The purpose of building this research agenda—grounded in diversity, equity, and inclusion—is (1) to form a broad-based coalition of research partners to identify research gaps to support child welfare as it is transformed for the 21st century; (2) to articulate clear research questions that are relevant for families, jurisdiction leaders, policy-makers, and practitioners; (3) to identify research strategies that will close the research gaps and answer those key questions; and (4) to help agencies use research findings to improve policy, program, and practice strategies through technical assistance and other means of support.[1]

Child welfare services affect many families in the United States. Fully one-third of U.S. children, and one-half of Black children, will be investigated for maltreatment at some point during childhood.[2] Analyses of data from the Adoption and Foster Care Analysis and Reporting System (AFCARS) indicate that nearly 6% of all U.S. children experience foster care between birth and age 18; among Black children, this estimate exceeds 11%.[3]

Although there was a 15% reduction in the use of out-of-home care from 2005 to 2019 (487,042 to 413,540) with no appreciable increase in child maltreatment recurrence, a 50% reduction in the use of group/congregate care (85,599 to 42,861), and a 40% reduction in the number of Black children in care (154,451 to 92,780),[4] many of the child and family outcomes as currently defined for the today's child welfare system are poor,[5] and these outcomes are not likely to appreciably improve with current policies, organizational structures, and program strategies. In addition, because most families who are reported to CPS and investigated do not receive services, we need more information about how they do after the investigation. Parents involved with child welfare often struggle with untreated mental health and substance misuse problems, along with poverty and inadequate housing. These are some of the "root causes" of child maltreatment that must be addressed if we are to keep children safe and support families to thrive.

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[1] With respect to research utilization, the William T. Grant Foundation has been publishing issue papers and reports that discuss effective and promising strategies. See http://wtgrantfoundation.org/focus-areas

[2] Kim, H., Wildeman, C., Jonson-Reid, M., & Drake, B. (2017). Lifetime prevalence of investigating child maltreatment among US children. *American Journal of Public Health*, 107(2), 274-280. https://doi.org/10.2105/ajph.2016.3035

[3] Wildeman, C., & Emanuel, N. (2014). Cumulative risks of foster care placement by age 18 for U.S. children, 2000 2011. *PLOS ONE*, 9(3), e92785. https://doi.org/10.1371/journal.pone.0092785

[4] Statistics based on state data submitted to the Federal government and include Puerto Rico. The numbers are for children less than age 18, and they are a point in time as of 09/30 of each federal fiscal year.

[5] See for example, U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. (2018). *Child welfare outcomes 2016: Report to Congress*. https://www.acf.hhs.gov/cb/resource/cwo-2016

These concerns have been noted in federal legislative testimony,[6] the final report from the Federal Commission to Eliminate Child Abuse and Neglect Fatalities (2016),[7] and the circumstances leading to the passage of the Family First and Prevention Services Act of 2018 (FFPSA; P.L. 115-123). Consequently, the U.S. Children's Bureau, agency leaders, and advocates are planning for major system redesign, and they need to know what research is needed to address key gaps in empirical knowledge and to build evidence about what works, so that agencies can more effectively meet the needs of the people they serve and determine what might be possible for those who are not being served.[8]

With a 21st-century approach, this redesigned system should strive to achieve several key outcomes:

- Ensure that sufficient community and family supports promote key protective factors for child, parent, and family well-being. These supports address risk factors such as poor child health, adult mental health problems, poverty, discrimination, and other factors outlined in the CDC's social determinants of health framework and other social welfare and public health frameworks. They also help families recognize and build upon their strengths and resources.[9]
- Eliminate inequities by addressing discrimination and other social determinants of health while honoring family diversity and promoting culturally appropriate services.
- Improve child safety. If we define *child safety* as the absence of harm or threat of serious harm, then to evaluate safety, we need a detailed definition and consistent measurement of harm.
- All children live in family settings. While we prioritize children living in family settings, there are times when a child or family needs intervention or treatment services in a different type of setting (such as a family-based residential treatment center for parental substance abuse treatment). We should aspire for these services to be of good quality, be the least restrictive possible, and provided only for the amount of time needed for that treatment to succeed.

While special commissions, research reports, systematic reviews, and paper series have identified needed policy change, program reforms, and necessary research (see Table E1 in Appendix E), a comprehensive national research agenda for a transformed child welfare system for the 21st century is still needed. The development of such an agenda is critical as many experts—including people with lived child welfare experience—are calling for a significant redesign of the current child welfare system, including more robust economic programs for families and upstream community-based family supports that address the limitations of the current system. While the process to date has involved people with backgrounds in health care, law, psychology, public health, social work, and sociology, continued refinement of the research agenda needs

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[6] See for example:

- https://www.hhs.gov/about/agencies/asl/testimony/2018-07/opioid-crisis-implementation-ffpsa.html
- https://www.texmed.org/Template.aspx?id=49884
- www.congress.gov/115/bills/hr1892/BILLS-115hr1892enr.pdf

[7] Commission to Eliminate Child Abuse and Neglect Fatalities. (201). *Within our reach: A national strategy to eliminate child abuse and neglect fatalities*. Government Printing Office. Retrieved from https://www.acf.hhs.gov/sites/default/files/cb/cecanf_final_report.pdf

[8] See the Thriving Families, Safer Children initiative: https://www.acf.hhs.gov/cb/success-story/thriving-families-safer-children

[9] Note that the community supports that families often need are actually interventions and services that are part of other systems, and have separate outcomes related to them.

to involve more people from other disciplines to more completely assess both community and personal well-being.

A particularly relevant and recent research agenda to consider is from the Office of Policy, Research and Evaluation (OPRE) and the Administration for Children and Families (ACF). The *Child Welfare Research and Evaluation: Overview* offers sample questions for a broad research agenda in child welfare and related areas:[10]

1. What are promising approaches and strategies for establishing and maintaining primary prevention strategies to improve the safety, stability, and well-being of all families? What factors promote or impede implementation of primary prevention?
2. What is the incidence of child abuse and neglect across states? What risk and protective factors are associated with the incidence of child maltreatment? Why does incidence of child abuse and neglect vary across states?
3. Who are the children and families that come into contact with the child welfare system? What programs and services are being provided to the children and families involved with the child welfare system? What are the short- and longer-term outcomes for these children and families?
4. How effective are the programs and services currently available and/or being provided to children and families involved with the child welfare system? How do these programs and services support improved outcomes for children and families?
5. How can programs, services, and judicial oversight for children and families involved with the child welfare system be improved?

Reassuringly, exploring the research gaps identified by the national research agenda project workgroups and the national product advisory committee reviewers reflect these federal research priorities while contributing additional insight, nuance, and considerations. These gaps also match or complement many of the research objectives of the Violence Prevention Branch of the CDC and the reports issued by the American Academy of Pediatrics, the American Academy of Social Work and Social Welfare, the National Research Council/Institute of Medicine, the National Institutes of Health, and the Substance Abuse and Mental Health Administration (SAMHSA).

Partners to Support This Effort

Philanthropic Sponsors

Casey Family Programs, the Annie E. Casey Foundation, and the William T. Grant Foundation are collaborating to identify and address critical research gaps to support child and family well-being, and to support the use of findings to improve practice and policy. While previous efforts have been made to

[10] Administration on Children and Families. (2021). *Child welfare research and evaluation: Overview.* Washington, D.C.: Author. Retrieved from https://www.acf.hhs.gov/sites/default/files/documents/opre/Child%20Welfare%20%28Snapshot%29-508_0.pdf

convene researchers, a comprehensive research agenda that addresses knowledge gaps across a wide array of family needs and program areas has remained elusive.

We drafted such a research agenda by involving a broad array of stakeholders, including child welfare leaders, tribal leaders, policymakers, people with diverse child welfare system experience (e.g., diversity, equity, and inclusion [DEI] experts; kinship and foster caregivers; birth parents; alumni of foster care; and others) as well as researchers. Ahead of three national consensus convenings, the research agenda was refined by working with a cross-section of leading national associations of public and private providers, additional people with child welfare system experience, and other experts. The agenda was then revised in November-December of 2021 based on the additional feedback from the consensus convenings.

Contributions of Experts with Child Welfare System Experience (Constituent Consultants)

To support identification of research gaps, six constituent consultants were full contributing members of the workgroups, with two on each of the three groups. The constituent consultants represented a broad array of child welfare system experience across multiple states and multiple contexts, including parents who had one or more children placed into foster care or who had had other interactions with the child welfare system, resource/foster parents, kinship caregivers, and young adults who experienced foster care. Constituent consultants used their experiences, expertise, and wisdom to help identify, refine, and prioritize key research questions and knowledge gaps. Specifically, constituent consultants:

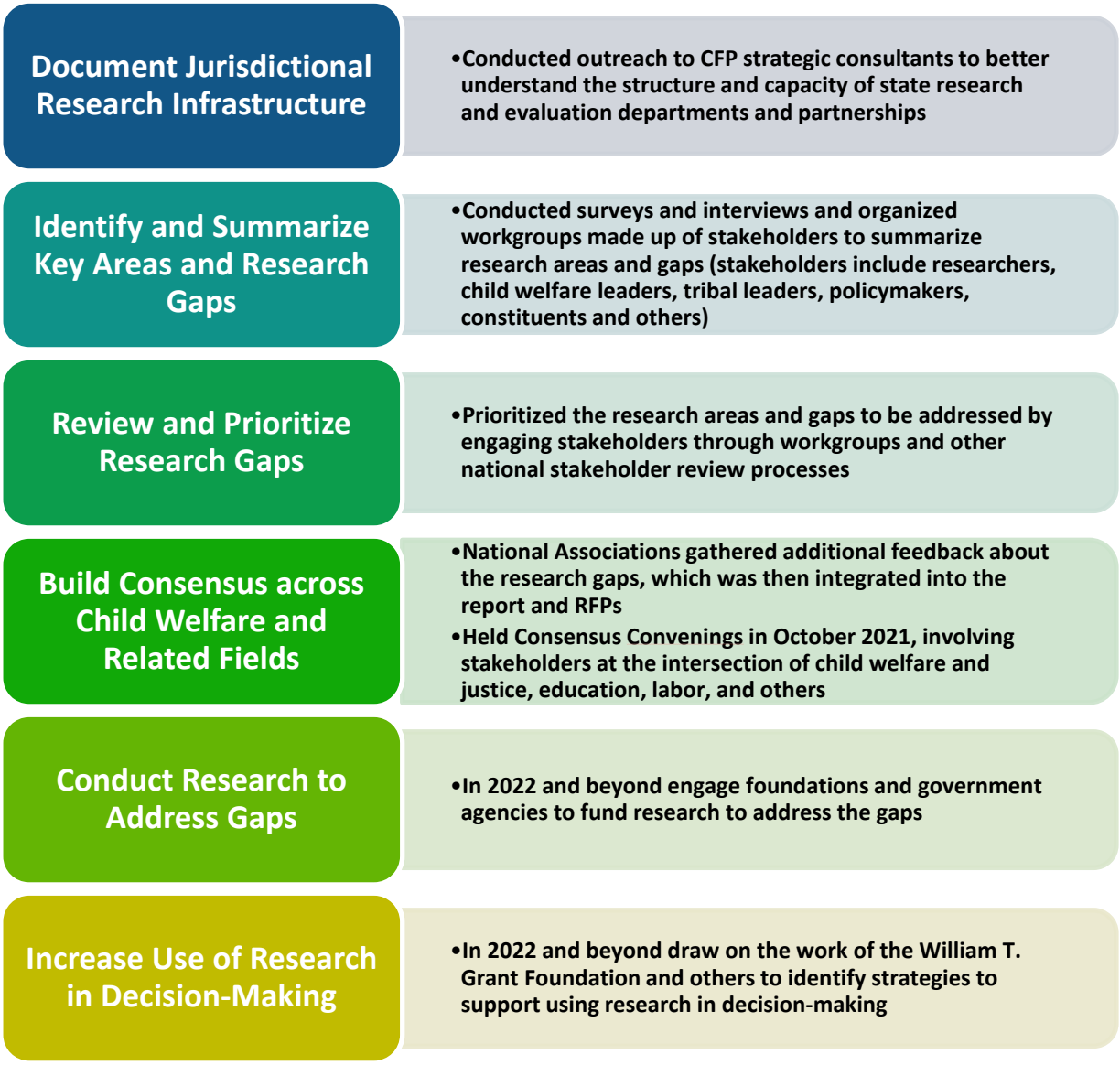
- Participated in four to five workgroup meetings, reviewing and refining the initial list of research gaps that were identified by subject matter experts, drafting text for newly identified research gaps, and prioritizing gaps the workgroup identified.
- Participated on bi-monthly constituent consultant calls to discuss their experiences with the project's process and to share ideas between workgroups.
- Served on the project leadership team.
- Co-presented the drafted research gaps to foundations.

Moving forward, constituent consultants will review and provide additional insights as new feedback is provided. They will play a pivotal role in the phases to follow (refining the research gap lists, guiding new research projects, and helping the new research findings get translated into policy, program, and practice design).

Steps to Building a Research Agenda and Addressing the Research Gaps

The steps we have taken to build a research agenda are depicted in Figure 1 and described in more detail in the following sections and in Appendix E. The national survey methods, respondents, and results are summarized in a separate report.[11]

Figure 1. Steps to Building a Research Agenda



[11] Brewsaugh, K. et al. (2021). *Research and knowledge gaps in child welfare: A national survey of agency staff, allied disciplines, tribal leaders, and people with lived child welfare experience.* Baltimore: Annie E. Casey Foundation.

Principles Driving Our Work

Overview

One of the key philosophical and ethical debates in the realm of child protection has centered around determining the proper balance between issues of children's rights to safety and parents' rights to autonomous childrearing: "Until we are able to recognize that all parents need support in caring for their children and that the allocation of these supports is vastly different across populations, we will never generate public will to offer the types of basic supports families truly need, [thus] creating a child welfare system that simply waits until parents fail before offering adequate assistance," says child abuse prevention expert Deborah Daro.[12]

Diversity, Equity, and Inclusion (DEI) Principles

Diversity, equity, and inclusion (DEI) experts Kristine Andrews, PhD (formerly of Child Trends and currently of Ideas to Impact); Jessica Elm, PhD (formerly of John Hopkins University and currently at the Centers for Disease Control) and Marla McDaniel, PhD (of the Urban Institute) proposed a set of principles to help guide efforts in constructing a 21st-century research agenda. (Their bio-summaries are included below.)

The development of the DEI principles and supporting rationale was coordinated with project leaders and workgroups to form a DEI framework. Workgroup members were asked to reflect on the framework and to consider applying the principles as the research gaps were prioritized and questions were constructed. Although a broad set of perspectives and people were involved in building this research agenda to help ensure that the voices of young people, parents, kinship caregivers, and resource/foster parents were heard, it was not possible to fully consider or vet all community and researcher viewpoints. Prioritizing DEI in this work requires the genuine inclusion of diverse and divergent voices and perspectives, including but not limited to diversity in ability, race, ethnicity, culture, sexual orientation, and gender identity and expression (SOGIE), socioeconomic class, religion, and geography (e.g., rural, urban).

DEI Consultation Team and Bios

Dr. Kristine Andrews is co-founder and Senior Director of Ideas to Impact, a social science policy and research consulting firm. She has established her career building the capacity of practitioners and other researchers by delivering strong training and technical assistance; working with communities to authentically engage with and share the stories of those most directly impacted by systems; and translating research and findings into actionable programmatic recommendations. Most importantly in all her work, Dr. Andrews acknowledges the current and historical context of race and racism in American society. Among her many accomplishments leading racial equity in research, Dr. Andrews has presented or led trainings for foundations, federal agencies, and practitioners on how to integrate a culturally responsive and racial equity lens in philanthropy, research, and practice. Dr. Andrews is also a Visiting Distinguished Fellow at Child Trends. She earned her PhD in Family and Child Ecology and her Master's in Marriage and Family Therapy from Michigan State University.

[12] Personal communication, Deborah Daro, December 30, 2020.

Dr. Jessica Elm is a citizen of the Oneida Nation and eligible for citizenship with the Stockbridge-Munsee Band of the Mohicans. Her research is centered on addressing social and health inequities in tribal communities. This involves theoretically driven research that acknowledges American Indian-specific historical and contemporary sociopolitical determinants of inequities. Toward this end, her writings and work experience have focused on substance misuse policy and programming, strengthening resilience, child maltreatment/adverse childhood experiences, suicidality, and contemporary social stressors (e.g., discrimination) as risk factors. Dr. Elm is committed to serving tribal communities through translational research and capacity building.

Dr. Marla McDaniel is a senior fellow in the Center on Labor, Human Services, and Population at the Urban Institute. Dr. McDaniel's research focuses on racial disparities; low-income children, youth, and families; and the programs and policy environments that touch families' lives. She is interested in the relationships between vulnerabilities and in how inequities across systems—including health, education, and employment—have a compounding effect on overall health and well-being. Dr. McDaniel earned a Bachelor's degree in psychology from Swarthmore College and worked as a case manager for youth in foster care before earning a doctorate in human development and social policy from Northwestern University.

DEI Framework

The DEI framework, posted on the project website and available from any of the sponsoring foundations, highlights four key principles:

1. Recognize, assess, reassess, and respond to the internal biases (implicit and explicit), assumptions, and privileges that we bring to identification of research questions.
2. Avoid further harm, marginalization, and oppression.
3. Contextualize differences across groups when analyzing data.
4. Scrutinize policy, programming, and services through a DEI lens.

In developing the four DEI principles, it was acknowledged that prioritizing DEI in this work requires the genuine inclusion of diverse and divergent voices and perspectives, including but not limited to diversity in ability, race, ethnicity, culture, sexual orientation and gender identity and expression (SOGIE), socioeconomic class, religion, and geography (e.g., rural, urban). DEI experts have also recognized that some scholars suggest a need to address racism, inequity, and exclusion; and they propose that middle-class, Christian, White, heteronormative attitudes, norms, and expectations continue to influence institutions and decisions that impact families.

An initial set of experts in child welfare and related fields (the national product advisory committee) reviewed the materials in the summer of 2020, and they also commented on how the DEI framework could be considered. One committee member suggested approaching this work with ***research humility***. This requires respecting culture and people with lived experience while conceding the power and privilege

inherent in setting a research agenda that studies the real-life experiences, needs, and well-being of others. Without research humility, cautions Ramona Denby-Brinson, "some might perceive that we are engaging in an academic exercise about life-altering issues that are so critical to thousands of children and parents who lack power and [the] standing to effect real change."[13]

As this proposed research agenda is refined, RFPs are designed, and new research is undertaken, additional diverse community and stakeholder voices should be brought to the table for meaningful conversations. The aim of this process should involve further vetting and ideally confirming that the proposed research gaps and questions are aligned with *their* needs as *they* see them. Community member and stakeholder voices should also be considered when decisions are made about *how* the research will be conducted. Researchers should always strive to build the trust of families and communities as they co-design studies with key stakeholders and strengthen inclusion in ways that improve equity and scientific validity.

Black people, Latinx people~~,~~ other people of color, and American Indians and Alaska Natives are among the groups who have been historically marginalized from informing science including insufficient (or no) stakeholder involvement, and insufficient (or no) investments in community infrastructure and essential family supports. It is important that research methodologies and plans draw from diverse knowledge systems to consider "evidence." Advocates of culturally appropriate practice-based evidence (PBE)—also termed *community-defined evidence* (CDE)—emphasize the value of cultural knowledge as evidence and a cornerstone of healing and recovery. Fundamental to PBE and CDE are the following:

- Knowledge of the function of cultural help-seeking patterns
- Understanding the cultural context of problem identification
- Use of culturally informed therapeutic intervention(s)
- Provision of therapeutic interventions and supports in a manner that consistently recognizes the value of the cultural self to wellness and recovery
- Engaging the local community and/or cultural resources to achieve and sustain the long-term positive effects from the intervention[14]

Valuing this type of diversity advances equity and knowledge, aids in development of interventions, and leads to promise for addressing outcomes across all populations. An example of why honoring diverse ways of knowing is important comes from contemporary experiences in many tribal communities. Often, it is not feasible to conduct quasi-experimental or Randomized Control Trial studies (RCTs) that demonstrate long-term impacts among American Indians and Alaska Natives—as required by FFPSA. In fact, in tribal communities it is very rare that this challenge can be met, simply because of lack of resources and capacity—often resulting from funding decisions—and difficulty with practical research tasks such as following up with study participants who may be transient.

These reasons, combined with acknowledgment that there is well-established community and cultural knowledge about "what works," has uncovered one of the most pressing research-related needs in tribal

[13] Personal communication, Ramona Denby-Brinson, December 17, 2020.

[14] See Echo-Hawk, H. (2018). *Family First Prevention Services Act of 2018 background: Culturally based and emerging evidence-based practice*. Paper prepared for Casey Family Programs. Seattle, WA, p. 2.

communities: establishing a better, more inclusive pathway to certify interventions eligible for FFPSA reimbursement. Although some tribal nations can exercise their sovereign rights to implement PBE/CDE practices, those practices have not been certified for the FFPSA list of eligible interventions. Consequently, states do not have access to a sufficient pool of interventions appropriate for American Indian and Alaska Native families.[15] This situation may also be true for other historically marginalized populations. Thus, we need more culturally appropriate interventions that are recognized as effective by the communities being served.

Further conversations are needed to confirm whether the research and knowledge gaps in the national research agenda meaningfully represent what is needed or valued at this time. Another consideration is that Black people, Latinx people,[16] other people of color, and American Indians and Alaska Natives have been poorly studied in many respects—with insufficient or no stakeholder involvement, and insufficient investments in community infrastructure and essential family supports. As this research agenda is refined, as RFPs are designed, and as new research is undertaken, additional conversations are needed to understand shifting landscapes for various specific diverse communities, including what kinds of research areas and processes will best address *their* needs as *they* see them.

Values

Using the DEI principles described above, the expert workgroups and expert reviewers were urged to think in bold and transformative ways in identifying both the gaps in knowledge and the research needed to address those gaps. In addition, workgroups were encouraged to explicitly state the values and assumptions that informed their reviews, deliberations, and syntheses. Specific values varied by topic area and are listed at the beginning of the request for proposal (RFP) rationale statement for each topic area. A summary of the primary value statements is presented below.

Gap ideas should be bold and transformative. One challenge of the current system is the scarcity of programs and policies that allow for the imagining of a transformed environment or approach. However, there are pockets of innovation that must be evaluated more, elevated, and scaled up. As new innovations arise, research priorities must evolve to meet additional needs. Our work should also include high standards of rigor so findings can be translated into policies and practices that support child and family well-being.

Note that in the research gaps prioritized there is a common set of outcomes to be assessed. Currently, much community-based prevention focuses on reducing child maltreatment (often defined by initial or subsequent contact with the child welfare system), but that focus is inadequate for a more comprehensive prevention-oriented system, lacking sufficient attention to both inequities and holistic ideas of child and family well-being. Therefore, we wish to expand the realm of outcomes to include the following:

- Reducing child maltreatment (initial and subsequent)
- Narrowing inequities in addressing child maltreatment

[15] See O'Brien, J., Evans, J., Heaton, L., Hyland, S., & Weiner, D. (2021). *Elevating culturally specific evidence-based practices*. Chapin Hall at the University of Chicago. and Pecora, P.J., Klein, R., Simon, J., & Foster, L.J.J. (2021). *Interventions Relevant to Children and Families Being Served with Family First Funding that Have Been Shown to be Effective with Families of Color: Research Brief (First Edition)* Seattle: Casey Family Programs.

[16] We recognize that there is not firm consensus about the value of using the term Latinx in place of Latina or Latino.

- Promoting community, child, and family well-being (i.e., via strengths-based rather than deficit-focused assessments). This includes helping families build skills so they can care for their children.
- Reducing inequities through increased supports for community, child, and family well-being

Research should include an examination of racial and other inequities (e.g., economic inequities) that are important for communities in which the research is taking place.[17] It is also important to note that while broad conceptions of child and family well-being will be discussed, we are unable to provide a uniform/universal definition of *well-being*, as we feel that is best defined by individual communities. However, the definition of child maltreatment should encompass different forms of mistreatment including emotional, physical, and sexual abuse as well as various forms of neglect. These forms of child maltreatment are different, with distinct etiologies, distinct risk factors, differing state definitions, and distinct consequences; and they require different prevention and treatment responses.

The research gaps we identified should reflect the reality that the community, family, and individual risks and strengths also vary. Researchers should not study maltreatment as a single construct. When the differences and nuances of different types of child maltreatment are not recognized, it can result in, among other things, the over-reporting of situations that do not merit a CPS response—as well as incorrect analyses and conclusions. Some advocates believe that we need a national and more specific definition, which might begin to be addressed in the new National Council of Family and Juvenile Court Judges Model Child Welfare Code project.

Finally, as these research gaps are included in RFPs, respondents will have to outline how they will co-design the research effort with local residents and people with lived child welfare experience, including operationalizing outcomes across the lifespan. Potential well-being domains that respondents may want to explore are listed in Figure 2. These include adult well-being as well as child well-being related to intellectual and other disabilities, life and job skills development, and living in a healthy environment.

[17] One example of this from a national association is the recent Council on Social Work Education statement of accountability and reconciliation for harms done to indigenous and tribal people (Weaver at al., 2021).

Figure 2. Well-Being Life Domains

Well-Being Life Domains	
Educational & Economic	Gain access to quality early learning, schools, job training, and learning that promote the skills and ability to attain employment, self-sufficiency, and personal fulfillment.
Social & Emotional	Maximize individual growth and development and promote wellbeing by cultivating resilience and supportive, nurturing relationships.
Mental Health & Wellness	Support and manage mental health and wellness through appropriate, timely, accessible, and quality services, supports, and activities.
Physical Health	Maximize physical health, strengths, and functioning through access to green spaces, active environments, nutritious food, safe water, adequate housing, and effective preventive and curative health care
Safety	Be physically, mentally, and emotionally safe and free from violence, fear of harm, abuse, and neglect
Spiritual	Establish a state of harmony with oneself and others while appreciating the diversity of beliefs and cultures that enrich the community in which they live
Justice	Gain access to a sensitive, fair, financially accessible justice system to ensure individuals can thrive in communities and engage with organizations that understand the implications of inequities and injustice and intentionally support practice and policy efforts designed to eliminate both
Equity	Live in an environment free of discrimination that provides equal access to services, opportunities, and resources; promotes self-determination; and allows individuals to realize their full potential

Source. Casey Family Programs. (2021). *The path to transformation: A framework to promote family and child well-being.* Seattle, WA: Author. Reprinted with permission.

Gaps should be identified and filled by engaging individuals with lived experience.[18] In a transformed system, power is shared with communities, including people with experience as recipients of the child welfare system and closely related services, such as behavioral health, developmental disability, economic assistance, veteran services, housing, or substance misuse treatment. As described above, communities must be engaged to co-design practice, policy, and research, including in determining how findings can best be used to support them.

Research gaps should be filled by research teams that engage consumers of child welfare services, and who engage the line staff who are charged with implementing the policies and programs. As research teams are being assembled, they should detail how individuals with child welfare system experience will be engaged (1) as part of the research team and (2) how this will be done as part of the protocols for soliciting and employing community input. These individuals should be fairly compensated for their efforts and not asked to do the work as an unpaid service. Lived experience expertise is valuable and, we argue, necessary for conducting high-quality, impactful research; therefore, it is worthy of investment—not unlike other forms of expertise/consultation often built into research budgets. In addition, there should be significant

[18] People with lived experience are individuals or families who have been reported for child maltreatment, subject to a child protective services investigation, or received a child welfare or closely related service. Line staff and supervisors should also be involved in research teams because they are the people implementing the policies and programs.

investments in the training and coaching of constituent consultants so that they leave these experiences with marketable skills, such as research design, interviewing, data coding, and report-writing.

Power sharing is critical, both as part of the research process and in the co-design of practices and policies supporting communities.[19] However, the term itself still reflects a system that is designed with one group of people who have had the power sharing it with those who "need" it. A more transformative step in our current child welfare system might be to acknowledge at the outset the power of people with system experience.[20] To help make this more feasible, research projects need additional funding to engage these stakeholders *and* extended project timelines to accomplish this work.

Research to address gaps in knowledge should prioritize diversity, equity, and inclusion (DEI). While more detail is available in the project's DEI framework from any of the sponsoring foundations, we highlight a few points here. First, how to best integrate DEI into the research gaps was part of every workgroup discussion as the teams identified and framed the research gaps. Second, when research is conducted, we expect the research team to reflect the diversity of the communities in which the research takes place. Third, it is incumbent upon researchers to engage communities in operationally defining child maltreatment and child/family well-being outcomes through community representatives who also represent the diversity of the community. Last, researchers must explicitly identify and address the potential impact of systemic racism on the communities in which the research is occurring.

Challenges and Caveats

General Challenges and Caveats

To address research gaps, the child welfare field and allied agencies such as behavioral health must better track who is served in child welfare systems, why people become involved with child welfare authorities and systems, what service delivery dynamics exist, and what outcomes such as child safety, permanency, and child and family well-being are feasible. These essential data should be collected and examined over time to address system design problems and to improve family engagement and family well-being outcomes.[21]

Multi-sector data are increasingly being recognized as valuable.[22] While understanding the value of data tracking by related fields is not identified as a specific research gap in this report, we recognize that the research data provided by allied fields are also crucial. For example, we need to track families that are involved with multiple systems to better understand the needs and experiences of these families. Many of the families that come to child welfare are already involved with multiple systems, whether for issues of the parent, the child(ren), or the family. We need to better understand what is happening or not happening in

[19] Personal communication, Ramona Denby-Brinson, December 17, 2020.

[20] Personal communication, Robyn Robbins, February 12, 2021.

[21] See for example, Font, S., & Maguire-Jack, K. (2019). The organizational context of substantiation in child protective services cases. *Journal of Interpersonal Violence*. doi: 10.1177/0886260519834996

[22] Weigensberg, E., Leininger, L., Stagner, M., LeBarron, S., MacIntyre, S., Chapman, R., Cornwell, D., Maher, E., Pecora, P.J., & O'Brien, K. (2018). *Superutilization of child welfare, Medicaid, and other services among those in the child welfare system.* Washington, DC and Seattle: Mathematica Policy Research and Casey Family Programs. Report: https://www.mathematica-mpr.com/our-publications-and-findings/publications/superutilization-of-child-welfare-medicaid-and-other-services Web-based interactive brief: https://www.casey.org/building-the-bridge/

those other systems that might lead families to involvement with the child welfare system. Also, we need to better understand how those other systems might be impacting how child welfare does its work.

Adopting this approach would mean bridging "practice silos"—where the field is learning from other disciplines and integrating practice strategies instead of proliferating multiple practice models. One innovation is the use of a *core components approach*: "Core components are the parts, features, attributes, or characteristics of a program that a range of research techniques show influence its success when implemented effectively. These core components can serve as the unit of analysis that researchers use to determine 'what works,' and they become the areas practitioners and policymakers seek to replicate within and across a range of related programs and systems in order to improve outcomes."[23] For example, in treating anxiety, depression, trauma, and conduct problems, such an approach helps clinical staff more efficiently learn the practice skills common to each of these interventions before learning the techniques that are uniquely part of that intervention.[24]

While there is a good foundation of studies to build on, more research is needed to determine which community-based preventive interventions are most desirable, engaging, and effective for various sociodemographic groups, especially families and communities of color. This includes building on previous research that has explored the specific factors that are causing families to become involved in child welfare.[25] If inequities in a particular research area have already been well established, it may be

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[23] Office of The Assistant Secretary for Planning and Evaluation (ASPE). (2020). *Core components approaches to building evidence of program effectiveness.* Washington, D.C.: Author. Retrieved from https://aspe.hhs.gov/reports/core-components-approaches-building-evidence-program-effectiveness

[24] See for example:

- Francis, K., Wilson, S. J., Hyra, A., Weiss, C. & Norvell, J. (2020). *Improving programs for children and youth that address behavioral problems: Recommendations for aligning programs with evidence on core components.* Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.
- Francis, K., Wilson, S. J., Hyra, A., Weiss, C. & Norvell, J. (2021). *Improving programs for children and youth that address self-regulation: Recommendations for aligning programs with evidence on core components*. Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services.
- Weisz, J.R., & Chorpita, B.F. (2011). Mod squad for youth psychotherapy: Restructuring evidence-based treatment for clinical practice. In P.C. Kendall (Ed.), *Child and adolescent therapy: Cognitive-behavioral procedures, 4th edition.* New York: Guilford, pp. 379-397.
- Weisz, J.R., Chorpita, B.F., Palinkas, L.A., Schoenwald, S.K., Miranda, J., Bearman, S.K., Daleiden, E.L., Ugueto, A.M., Ho, A., Martin, J., Gray, J., Alleyne, A., Langer, D.A., Southam-Gerow, M.A., Gibbons, R.D., and the Research Network on Youth Mental Health. (2012). Testing standard and modular designs for psychotherapy with youth depression, anxiety, and conduct problems: A randomized effectiveness trial. *Archives of General Psychiatry, 69,* 274-282.

[25] There has been an increasing amount of research in this area. See for example:

- Barth, R.P., Duerr-Berrick, J., Garcia, A.R., Drake, B., Jonson-Reid, M., Gyourko, J.R. & Greeson, J.K.P. (in press). Research to consider while effectively re-designing child welfare services, *Research on Social Work Practice.*
- Dettlaff, A.J., & Boyd, R. (2020). Racial disproportionality and disparities in the child welfare system: Why do they exist, and what can be done to address them? *The ANNALS of the American Academy of Political and Social Science*. 692(1):253-274. doi:10.1177/0002716220980329
- Drake, B., Jolley, J.M., Lanier, P., Fluke, J., Barth, R.P., & Jonson-Reid, M. (2011). Racial bias in child protection? A comparison of competing explanations using national data. Pediatrics, 127(3), 471–478. Retired from https://doi.org/10.1542/peds.2010-1710
- Feely, M., Raissian, K.M., Schneider, W. & Bullinger, L.R. (2021). Creating systems synergy across the social welfare policy landscape. *Focus on Poverty*, 37(2), 21-28.

counterproductive to compare their outcomes to the outcomes of people who are White. Instead it would be wise to consider within-group differences. Finally, the workforce necessary to carry out this research must be considered. While efforts have been made to develop a pipeline of future child welfare researchers, more needs to be done. The new RFPs that result from this project should help support other efforts to attract and train new and diverse cohorts of researchers.

Data Challenges

An absence of essential data may impede the answering of many of the research questions in the draft agenda. The gaps in knowledge posed by the inadequate capacity of some public and voluntary agencies to collect and analyze information on the families they serve may seriously limit the ability to carry out some of the research referenced in this document.[26] For example, even the new AFCARS data design does not address the fact that many American Indian/Alaska Native children are not classified accurately, and are too often lumped in to the "two or more race" category.[27] In general, data gathering has not been a priority in our child welfare system. They haven't been used regularly, and they have been disregarded because sometimes they are not accurate. It takes a concerted effort to shift the culture towards valuing data and relying on data in decision-making.

The field also needs better data-monitoring systems at the population level to understand community profiles of risk and protection. Data must be readily available for coalition members to disaggregate by meaningful subgroups and to use for prevention planning and impact analysis. There are many gaps in understanding how best to collect and use population-level data. This includes (1) leveraging technology to efficiently aggregate, analyze, and visualize high-quality information for precision public health, while integrating individual, family, community, and environmental information about risk and protection; and (2) maintaining privacy and not disparately surveilling or stigmatizing population segments.[28] There are many issues to be explored and resolved with respect to using predictive risk modeling and other forms of data analytics in child welfare.[29]

- Jonson-Reid, M., Emery, C.R., Drake, B. & Stahlschmidt, M.J. (2010). Understanding chronically reported families. *Child Maltreatment*, 15(4) 271-28.
- Lorthridge, J., McCroskey, J., Pecora, P. J., Chambers, R., & Fatemi, M. (2011). Strategies for improving child welfare services for families of color: First findings of a community-based initiative in Los Angeles. *Children and Youth Services Review*. 34, 281-288.
- Marts, E.J., Lee, R. McCroy, R. & McCroskey, J. (2008). Point of engagement: Reducing disproportionality and improving child and family outcomes. *Child Welfare, 87(2),*335-358.

[26] Personal communication, Mark Courtney, January 17, 2021. In addition, data quality in many systems remains a problem: if we don't know the full scope of any problem or the true needs of children and families because of data quality issues, how can we plan adequately?

[27] The field would benefit from more culturally responsive and equitable collection of demographic data -- including race, ethnicity, sexual orientation, and gender identity.

[28] Personal communication, Valerie Shapiro, December 22, 2020.

[29] See for example:

- Allegheny County Department of Human Services. (2019b). Impact evaluation summary of the Allegheny Family Screening Tool. Available from https://www.alleghenycountyanalytics.us/wp-content/uploads/2019/05/Impact-Evaluation-Summary-from-16-ACDHS-26_PredictiveRisk_Package_050119_FINAL-5.pdf.
- Church, C. E., & Fairchild, A. J. (2017). In search of a silver bullet: Child welfare's embrace of predictive analytics. *Juvenile and Family Court Journal*, 68 (1): 67–81.

In addition, researchers could draw upon impending improvements to data collection in AFCARS 2.0 that will permit more comprehensive and reliable analysis of systemic trends.[30] But, as mentioned above even this upgrade to AFCARS does not fully address the inadequacies of these data related to ICWA data elements for the American Indian/Alaska Native population. The power of data linkages across service systems that will be supported by the Comprehensive Child Welfare Information Systems (CCWIS) under development could be integral to supporting research proposed in many of the areas. Finally, more longitudinal studies should be conducted to inform practices and policies by identifying what types of supports are helping families over the long term, and how variations in each family's life course and the sequence of services can lead to different kinds of outcomes.[31]

Research Translation and Implementation

A research agenda must also be accompanied by viable approaches to research translation. Thus, we propose a multiphase approach, in which RFPs are designed, research is funded, and an explicit effort is made to maximize the use of research findings to inform policy, program design, practice, and funding patterns. Partnerships between government agencies, public and private service providers, and universities or private research organizations can help child welfare agencies and communities not only address research gaps and data management challenges but also help translate the research findings into improved policy and practice designs.

Transforming Research Is a Core Component of Building a 21st-Century Research Agenda

Throughout the process of identifying research gaps, a consistent theme in conversations was the need to transform how we approach research. In other words, *how* we address the research gaps is critical to effectively answering research questions. We provide some insights from the conversations around transforming research; however, there is much more to be fleshed out. In the upcoming months, the project team and some national associations will engage individuals with lived expertise and other stakeholders to identify audiences and messaging around transforming research. The sections below are meant to highlight some key areas for research transformation. Last, the inclusion of this section is not meant to imply that

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- Drake, B., Jonson-Reid, M., & Ocampo, M.G. et al. (2021). A practical framework for considering the use of predictive risk modeling in child welfare. *The Annals of the American Academy of Political and Social Science,* https://doi.org/10.1177/0002716220978200
- Oldham, D.; Foster, Nathan; & Berezovski, M. (2019) Data Mining and Machine Learning to Improve Northern Florida's Foster Care System," *Beyond: Undergraduate Research Journal*: 3 article 3. Retrieved from https://commons.erau.edu/beyond/vol3/iss1/3
- Samant, A. Horowtiz, A., Xu, K. & Beiers, S. (2021). Family surveillance by algorithm: The rapidly spreading tools few have heard of. Retrieved from https://imprintnews.org/opinion/family-surveillance-by-algorithm-the-rapidly-spreading-tools-few-have-heard-of/59224
- Vaithianathan, R., Putnam-Hornstein, E., Chouldechova, A., Benavides-Prado, D., & Berger, R. (2020). Hospital injury encounters of children identified by a predictive risk model for screening child maltreatment referrals: evidence from the Allegheny Family Screening Tool. *JAMA pediatrics*, *174*(11), e202770-e202770

[30] Efforts to improve the quality and use of administrative data are a critical component of any child welfare research agenda. These data, available to every jurisdiction, would provide a key starting point for all child welfare agencies in better understanding how their system is operating and an empirical basis for identifying key leverage points for change. The quality of these data has been very uneven (Personal communication, Deborah Daro, December 30, 2020).

[31] For example, what is the long-term research say about post-service involvement outcomes? Do services really make a difference for families five, 10, or even 25 years post-involvement? To what extent are differential sequencing in families addressed in assessing outcomes?

good work is not happening; rather, the field has been a little uneven in its application of the ideas below, and improvements will always be needed.

Meaningfully Engage People with Lived Expertise. A transformative approach to research will include engaging, involving, and compensating individuals with lived experiences from the questions we ask to the dissemination of findings. For the field to excel in this area, more work will need to be done, including educating researchers on how to co-design evaluation studies and share power. Individuals with lived experience need to be viewed as research partners, not just research participants. Including individuals with lived experience is not currently a shared value across the research community. For example, there are few (if any) journals and clearinghouses that require individuals with lived experience be part of the research team and be an author on papers and reports.

Use Participatory Research Methods. Additional suggestions for methods are provided below, but, participatory methods could be used more – it was identified as an underutilized research method. Community-Based Participatory Research (CBPR) is not a new method, but it has been perceived as less rigorous. Increased careful use of CBPR has the potential to dispel such notions and support re-thinking what is considered "evidence." CBPR has the potential to increase relevance, rigor, and reach.[32] Including members of the community as co-researchers has the potential to improve the questions we ask, the way we answer questions, and how we disseminate findings.

Ensure That Research Is Culturally Responsive and Promotes Racial Justice. It is important for researchers to adopt a DEI framework to ensure research is culturally responsive and promotes racial justice (see the DEI Framework summary above). While more and more resources are becoming available to support equity in research,[33] we offer just a few comments although these will not do the topic justice. First, researchers must examine their own biases, which can affect the questions asked, and examine the measures used to collect data, how data are interpreted, and how findings are disseminated. Second, the composition of the research team needs to be diverse and reflect the community(ies) in which the research is being conducted. There is a significant lack of diversity among researchers, and research teams need to intentionally seek out, mentor, and insist on diversifying their teams. Third, using participatory methods is an equity strategy as they interject diversity in thought into the research process. Fourth, in addition to research questions being informed by a diverse community, we must ask questions that address implicit biases that factor in systemic racism. This means moving beyond breaking down data by race/ethnicity and moving towards understanding why differences persist. Last, we must be intentional in how we disseminate findings. Traditional approaches to dissemination (e.g., publication in academic publications) is not a sufficient mechanism to provide communities with actionable information. Engaging communities, decision-makers, funders, and others in dissemination efforts is key.[34]

Revisit Funding Processes. Funders carry a lot of power. This power comes with responsibility to examine patterns that may disempower communities. First, funders need to continuously examine their own

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[32] Balazs, C. S., & Morello-Frosch, R. (2013). The Three R's: How community based participatory research strengthens the rigor, relevance and reach of science. *Environmental justice, 6(1)*.

[33] See for example:

- Andrews, K., Parekh, J., and Peckoo, S. (2019). *How to Emded a Racial and Ethnic Equity Perspective in Research: Practical Guidance for the Research Process.* Bethesda, MD: Child Trends.
- Hawn Nelson, A., Jenkins, D., Zanti, S., Katz, M., Berkowitz, E., et al. (2020). *A Toolkit for Centering Racial Equity Throughout Data Integration*. Actionable Intelligence for Social Policy, University of Pennsylvania.

[34] See William T Grant resources for increasing the use of research evidence in decision-making, http://wtgrantfoundation.org/.

processes to determine if they have fallen into patterns that don't support communities. For example, advisory boards can be created to provide funders with feedback on their funding processes. Second, funders need to diversity the researchers they fund so it's not always the same organizations receiving dollars. There are new generations of researchers who may approach things differently and who are in touch with the community in novel ways. Third, funders need to share power by engaging community members and individuals with lived experience in decisions around who gets funded. Last (and related), funders need to examine how they evaluate proposals. Are they emphasizing proposals that include (1) methods that support community involvement (CBPR) and (2) approaches to address equity?

Use Innovative Research Methods. Randomized controlled trials (RCTs) are perceived as the gold standard of research methods. However, they may be insufficient to answer some research questions in a meaningful way. Clearinghouses perpetuate the importance of RCTs by elevating programs that may meet the research design standard but not include the voice of lived experience or address equity. New standards of methods are needed that elevate small samples, use qualitative research, and incorporate human-centered design. Further, we must ask how we can engage communities around what success looks like, such as family and community strengths and de-emphasize family deficits.

Engage Academia to Reinforce and Reward Working with Communities. There are several areas where academia plays a role in research transformation. First, academia needs to engage in efforts to diversify its researchers. This extends beyond diversifying its faculty. Greater outreach to undergrads, providing scholarships and internships, rewarding diverse research teams, and requiring mentoring of future researchers of color are all things universities need to encourage. Second, academia needs to re-visit its reward structure. Is it over-weighting academic publications at the expense of engaging in community engagement around research and disseminating findings? Third, do universities have expectations around addressing equity and engaging individuals with lived experience? Fourth, because academic publications are intertwined with academic institutions, we suggest this model be re-visited as well. Journals should revisit their requirements, including asking the following questions of research:

1. Is there diversity in the research team?
2. Has the research team included the voice of lived expertise? Do any of the authors have lived expertise?
3. How has the research addressed equity?

Additionally, journals should consider their own publication review processes. For example, is there diversity among the reviewers on the journal editorial board? For those chosen to review each submitted manuscript? Do any of the manuscript reviewers have lived expertise? Lastly, do any of the journal staff have lived expertise in one or more of the areas covered by the journal?

Recap and Next Section Overview

This document thus far has outlined the need and rationale for a national research agenda, the partners and the processes involved, the principles and other values that guided the work, and some cautions and challenges inherent in the planning and research process. Next, we list the most pressing research gaps in three broad topic areas: (1) community-based prevention, (2) child protective services and prevention of foster care, and (3) out-of-home care. These research gaps were ranked as the most pressing through consensus-building discussions among the workgroups, project leadership team review, advice from the

National Product Advisory Committee, and three recent national consensus convenings. (See Appendix E for an overview of the planning process and the workgroup members.) In Appendices A-D, we list the lower-ranked/less urgent but still important research gaps that should be addressed. While these research questions were ranked lower in priority, they nevertheless represent important gaps in knowledge that deserve to be explored.

Note that some of the research gaps might be addressed by intervention comparison or effectiveness studies, while others might be addressed through qualitative review of case records, interviews, participatory action research, other qualitative studies, administrative data review, business process mapping, meta-analyses, or systematic research reviews. This may be seen in how some of the research gaps were phrased, and the research methods that are reflected in the RFPs.

Overarching Research Gaps

Overview

Many of the research gaps need to be conceptualized and the studies need to be carried out in a way that addresses individual and intersecting identities based on (1) ethnicity and race, (2) sexual orientation, gender identity, and expression (SOGIE), (3) ability/disability status, (4) immigration status, (5) parenting status, (6) juvenile justice status, and (7) family incarceration status.

Children and youth who identify with one or more marginalized identities may experience community-based family supports and other prevention services, child protective services, and out-of-home care differently depending on the county or state where they reside. In this section, we list research gaps that could apply to many or all of the areas related to a 21st-century system to support children and their families. Note that the lack of replication studies poses a significant challenge across many areas of child welfare. Given geographic and other population differences, research questions must be explored and interventions tested in multiple communities. In this section we list 14 overarching research gaps (OVRs) that appear to relate to more than one major program area. Note that research gaps related to the juvenile court and court stakeholders are contained in the CPS and out of home care sections.

OVR 1. How might contemporary child welfare and related policies and practices (e.g., structural racism and other forms of discrimination) contribute to—and be changed to eliminate—differences in service access, quality, and outcomes for families and their children who are Black, Brown, and Indigenous or who are marginalized?

OVR 2. How does the ***structure*** of the child welfare services system influence outcomes for children and families? How might other systems and their structures be impacting child welfare? What are the potential unintended consequences of federal, state, county, and city legislation, policies, and guidance for families of color and for the child welfare system in terms of what it is mandated to provide?[35]

[35] Three aspects of the existing structure deserve particular attention:

- The division of responsibility for policy, funding and administration of child welfare services between the federal government, states and counties. For example, Fred Wulczyn has demonstrated the impact that group care bed day availability may be

OVR 3: How can American Indian/Alaska Native cultures, as well as the policies and practices included in the Indian Child Welfare Act (P.L. 95-608), inform all of child welfare, including prevention of child maltreatment, child protective services, out-of-home care, and post-permanency services? For example:

- What can we learn from tribes and other Indigenous communities about what an equitable, culturally specific, inclusive community approach to child welfare could look like? (This is sometimes phrased as using "ICWA as the gold standard for child welfare policy and practice.")
- What can tribes learn from each other about what an equitable, culturally specific, and inclusive community approach to child welfare looks like? Of the existing Tribal Title IV-E programs, what is working and what would it take to adapt successful approaches for other tribal communities?

OVR 4. The largest group of children of color in the United States today are Latinx. This multifaceted racial/ethnic group has different rates of maltreatment and child well-being outcomes, depending on the particular community studied or on what other racial/ethnic groups they are compared to.[36] Immigrant families and undocumented persons represent special groups, and policy as well as practice research is needed to determine what will best support these families. Other research questions include the following:

- What are the risk and protective factors and effective interventions for Latinx children and their families? What inequities exist in the services they are provided and their outcomes?
- What are the risk and protective factors and effective interventions for children and families who are Latinx, taking into consideration country of origin; legal status; whether first, second or third generation; and the area they are living in?
- What inequities exist in the services provided to children and families who are Latinx and their outcomes taking into consideration country of origin, legal status, whether first, second or third generation, and the area they are living in?

OVR 5. How can service (case) plans be better developed to prevent child maltreatment and recurrence of child maltreatment, and to support improved safety and permanency for children?

OVR 6. How do leaders use research evidence to make decisions regarding strategies to prevent maltreatment and promote well-being? What strategies are most effective for increasing the use of research information by child welfare practitioners?

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having on group care admissions; and that system dynamics that we cannot directly measure can be detected in terms of their influence on allocations of services, including out of home care placements.

- The division of responsibility for providing services to families among the public sector, private (primarily not-for-profit) social services sector, and other sectors such as business and the faith-based communities.
- What can we learn from families who don't come to the attention of child welfare? What is it about them, who/what system is serving them and how does that make the difference for why they are not coming to the attention of/being involve with child welfare? What can we learn that would help us do things differently in a transformed child welfare system?

[36] The field is seeing a large amount of within-group variability. For example, work by Alan Dettlaff and others shows that recently immigrated Latinx populations were under-represented and had better outcomes, whereas those who had lived in the United States for longer were over-represented. The underlying causes, consequences and how (or to what extent) to tailor services are unknown (Personal communication, Antonio Garcia, December 24, 2020).

OVR 7. How can a 21st-century system of child and family services better protect commercially or sexually exploited youth from being re-exploited as they heal and grow?

OVR 8. How can model fidelity be measured in practical and cost-effective ways for child maltreatment prevention strategies and other interventions?

OVR 9. It can be very difficult to create access to interventions after the fact. How do we improve the design of prevention and treatment interventions so they are inherently scalable (i.e., easy to provide to many people and easy for those people to access)?[37] How can technology support access and scale?[38] Related to this is what was mentioned earlier -- researching *common elements of effective interventions* as compared to procuring/adopting/researching packaged evidence-based practices. (This may be the direction that evidence-based practice is likely to move in the future as packaged programs/interventions become overwhelming in number and cost.)

OVR 10. ***Workforce issues:*** Some child welfare workers achieve better outcomes than others with their clients and families. As the common denominator in the child welfare system, these workers represent a key intervention "platform" that is already established. Some agencies have been more successful in hiring staff from the local communities. How can we study child welfare workers and their effectiveness, with an eye toward learning and implementing effective practices? For example, can we identify their most effective strategies – focusing initially on the most everyday and fundamental practice aspects (an inductive approach) (See Appendix A for additional research gaps in this area.)

OVR 11. ***Rural and tribal community workforce issues:***

- Are the supports that are available to staff in urban communities also available to rural child welfare staff? In what ways are urban and rural workforces treated differently? Are they expected to achieve the same outcomes even with longer distances to drive and fewer resources?
- What are the challenges to finding and obtaining qualified employees in rural areas? How can we improve the training and education of child welfare staff and frontline workers so they are well informed and confident when reaching out to families in tribal communities?

To what extent is the difficulty in acquiring and maintaining an adequate workforce in tribal communities affecting the availability and delivery of services for children and families? (See Appendix A for additional research gaps in this area.)

OVR 12. ***Worker and system collaboration dynamics:*** How effective are the partnerships between the various entities involved in a child's case? To what extent is communication and information

[37] From a population-health perspective, the population impact of any intervention is a combination of how effective the intervention is (e.g., its effect size on key outcomes) combined with its reach (i.e., how many individuals in the population will receive the intervention). From a psychological-care perspective, evidence-based psychotherapies have almost exclusively emphasized the former, but what implementation science has shown over the last 20 years is that those interventions have very limited reach, because the interventions (a) can be complicated; (b) require multiple if not many in-person sessions, burdening receiving services; (c) are expensive to implement; (d) have variable quality or fidelity in real-world settings; and (e) have no economy of scale (Personal communication, David Atkins, December 30, 2020).

[38] Technology can help scaffold interventions by nonprofessionals such as peers or parents (see, for example, global health work on *task-shifting*). Technology can also play a role in stepped-care interventions, where simple interventions (e.g., app-based educational materials) can be delivered at scale, and more intensive, human-based interventions can be delivered as needed for those who need to 'step up' in care. Technology is not a cure-all, nor a replacement for human interventionists, but it is often scalable (Personal communication, David Atkins, December 30, 2020).

sharing efficient? In what ways can those processes be improved? (See Appendix A for additional research gaps in this area.)

OVR 13. ***Use of interdisciplinary and multidisciplinary teams:*** Due to the complexity of factors that create the need for child welfare services, interdisciplinary responses are important. Future research should address how to use team-based care in building 21st-century child welfare service systems—using the best of what works well in health care and other interdisciplinary/multidisciplinary settings.[39]

OVR 14. ***Effects of COVID 19:*** At the onset of COVID-19 when K–12 schools all across the country suddenly pivoted to fully remote operations, many jurisdictions experienced a substantial decrease in child maltreatment reporting rates. Some of the research questions in this area include the following:

- Are school systems effective and equitable reporters of child maltreatment? What are the various reasons that school personnel have for reporting? What types of trainings do mandated reporters need?
- What are effective mechanisms for diverting reports in ways that preserve child safety?[40]
- Were there differences in reductions in maltreatment rates based on whether alternative services existed in communities and whether mandated reporters knew about the services?

Community-Based Prevention

What Do We Mean by Community?

While there are many ways to define community, we chose to include a broad definition provided by MacQueen et al. (2001): "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings." Different communities will place more or less emphasis on different components of such a definition, and most will connect to some part of this definition. Community supports are those efforts organized by the community (family, friends, neighbors, faith-based programs, cultural programs, etc.) that provide support to community members.

We believe that the research questions included here apply to different communities including rural, urban, and tribal communities. Funders hope to receive RFP responses from these communities and others.

Research Gap Drivers

Before outlining the gaps, we present key drivers that led our discussions of research gaps and supported our decisions in which gaps to prioritize. For example, the members of the workgroup that developed the research questions were pushed to be bold and to focus on transformation. A transformative approach to supporting children and families is co-designed with individuals with lived experience; centers on diversity, equity, and inclusion; and is grounded in values. Last, we emphasized areas where there is little or no

[39] Personal communication, Ramona Denby-Brinson, December 17, 2020.

[40] It is hypothesized that rates of maltreatment did not suddenly decrease, but rather, mandated reporters were less visible in children and families' daily lives. Some observers believe that the system, albeit temporarily, saw a "right-sizing" effect, related in particular to children of color being referred for suspicions of maltreatment. This issue is worthy of research given the significant number of reports that are unfounded but still do harm to children and families of color because they place families under the suspicion of child welfare systems (Personal communication, Ramona Denby-Brinson, December 17, 2020).

research underway. There are some areas where research is underway (e.g., home visiting) and the gap is being filled by others in the field.

Gap Solutions Should Be Bold and Transformative. While the current system is hamstrung by a scarcity of programs and unhelpful policies, a transformed environment would provide all families with what they need to thrive. The relatively poor outcomes for children and families, and the trauma associated with involvement with the child welfare system demand that we do better. In addition, there are pockets of innovations that need more research, and that is what we have put forward: building on what is innovative and effective while major redesign is undertaken for everything else. As more innovations occur, additional research needs will arise and research priorities must evolve.

Of particular note in the prioritized research gaps are a common set of outcomes. In our current situation, much of community-based prevention focuses on reducing maltreatment; however, that focus is insufficient for future change on two fronts. First, it does not focus on community-based inequities that contribute to maltreatment and second, it does not focus on child, family, and community well-being. Therefore, we emphasize the need to focus on the following outcomes, which should be identified and operationalized by the community in which the research takes place:

1. Reducing child maltreatment
2. Narrowing inequities in child maltreatment
3. Promoting child, family, and community well-being
4. Narrowing inequities in child, family, and community well-being

Research on inequities should include an examination of race and other inequities important for communities in which the research is taking place (e.g., socioeconomic factors). To that end, the field needs better population-level data. For example, what are the characteristics of families and their communities who are *not* involved in child welfare? How does the overall rate of poverty among different ethnic groups and the proportion of families of color in a community interact in ways that are associated with different rates of disparity in reports to CPS, services received, and other key outcomes?

It is incumbent upon researchers to work closely with communities to operationalize child maltreatment and child and family well-being.

As these research gaps are developed into RFPs, respondents will need to outline how they will co-design the research effort (including operationalizing outcomes) with a diverse group of community members.

While one of the primary outcomes of interest is child maltreatment, the identified research gaps likely have relevance to the prevention of other forms of violence (e.g., intimate partner violence, youth violence, and sexual violence) given their shared risk and protective factors (see CDC's Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence). Accordingly, in addition to child maltreatment, it may be of interest to collect data on the prevention of other types of violence as well.

Gaps Should Be Identified and Filled by Engaging Individuals with Lived Experience. In a transformed system, power is shared with communities, including those with lived experience (e.g., those who have interacted with child welfare services). As described above, communities must be engaged to co-design practice, policy, and research, including how findings can best be used to support communities. As research

teams are being assembled, they should detail how individuals with lived experience will (1) be engaged as part of the research team and (2) how they will be engaged as part of community input. Power sharing is critical, both as part of the research process and in the co-design of practices and policies supporting communities.

Gaps Should Prioritize and Address Diversity, Equity, and Inclusion. More information is available on the DEI framework from any of the sponsoring foundations for this project. We highlight a few points here. First, how to best integrate DEI into the research gaps was part of every discussion. As described above, we decided to integrate inequities as a part of every question that must be examined. Second, when research is conducted, we expect diversity among the research team members that is reflective of the communities in which the research takes place. Third, the community representatives who are engaged must represent the diversity of the community. Last, the researchers must explicitly identify and address the potential impact of systemic racism on the communities in which research is occurring.

Gaps Should Be Grounded in Values. As we were beginning our conversations, a workgroup member volunteered to ground us in values as a critical component of how we prioritize the research in which we engage. These values are as follows:

1. Evidence-based practices are important components of an effective service array, but they cannot be the lead intervention. Responding to every need with a narrow core service fails to support the response of “the village,” which may have common sense solutions and wisdom.
2. Control is a foundational issue, whether it be prescribing evidence-based practices, implementing regulatory decisions and laws, or maintaining ongoing practices. Lodging the vast majority of that control and funding to local families and communities with some basic structure may be discomforting to funders.
3. Nearly all families are doing the best that they can with the resources and supports that they have available to them.
4. Government should focus on a nonpartisan, locally based structure (e.g., systems of care, place-based strategies, non-stigmatized and universal services) with parents, not institutions, as agents of change. Professionals cannot assume they know better. This may be akin to integrated community hubs collaborating to bring about positive community change for families (versus institutional surveillance).
5. Child welfare promotes collaboration to achieve family well-being, but its overt focus on acute child welfare indicators (e.g., entries into care, re-entry into care) thwarts meaningful collaboration. Rather than focusing exclusively on deficit-based indicators, we should track and support families’ holistic strengths (e.g., indicators of family and community well-being), which can promote collaboration. Success as currently measured is too narrowly defined.

Community-Based Prevention Research Gaps

The table below provides the gaps and why each was prioritized. Additional rationale is provided after the table. Under each gap several areas are described (description, effectiveness, etc.). Depending on need, communities may choose to take on two, three, or four of these areas. We anticipate *Description* will always need to be addressed, and community need will drive the selection of one or all of the remaining areas.

Community-Based Prevention Gaps	Why is this gap a priority?
Research Gaps in Access to Community Supports and Services	
CBP1: What are the core components, effectiveness, sustainability, and transferability of *community mobilization* efforts for increasing access and use of supports and services? a. (Description) What are the core components of effective community mobilization efforts to improve access and use of supports and services that (1) increase child, family, and community well-being; (2) reduce child maltreatment; and (3) narrow inequities for both? b. (Effectiveness) What is the impact of community mobilization efforts to improve access to supports and services on (1) child, family, and community well-being; (2) child maltreatment; and (3) inequities for both? c. (Sustainability) How do you sustain effective community mobilization efforts to improve access to supports and services? d. (Transferability) How well do effective community mobilization efforts to improve access to supports and services transfer from one community to another? What adaptations need to be made so core components transfer between communities?	• Uses community expertise to select services and supports that are most important for the community • Centers community involvement in the solution
CBP2: What are the core components, effectiveness, sustainability, and transferability of *culturally appropriate community-based prevention* efforts for increasing access and use of supports and services? a. (Description) What are the core components of effective culturally appropriate community-based prevention efforts to improve access and use of supports and services that (1) increase child, family, and community well-being; (2) reduce child maltreatment; and (3) narrow inequities for both? b. (Effectiveness) What is the impact of culturally appropriate community-based prevention efforts to improve access to supports and services on (1) child, family, and community well-being; (2) child maltreatment; and (3) inequities for both? c. (Sustainability) How do you sustain effective, culturally appropriate community-based prevention efforts to improve access to supports and services? d. (Transferability) How well do effective, culturally appropriate community-based prevention efforts to improve access to supports and services transfer from one community to another? What adaptations need to be made so core components transfer between communities?	• Considers community-specific culture to shape the solution • Allows for more families and communities to use and benefit from services driven by what is appropriate for the community
CBP3: What are the core components, effectiveness, sustainability, and transferability of *community reinvestment* efforts for increasing access and use of supports and services? a. (Description) What are the core components of effective community reinvestment efforts to improve access and use of supports and services that (1) increase child, family, and community well-being; (2) reduce child maltreatment; and (3) narrow inequities for both? b. (Effectiveness) What is the impact of community reinvestment efforts to improve access to supports and services on (1) child, family, and community well-being; (2) child maltreatment; and (3) inequities for both? c. (Sustainability) How do you sustain effective community reinvestment efforts to improve access to supports and services? d. (Transferability) How well do effective community reinvestment efforts to improve access to supports and services transfer from one community to another? What adaptations need to be made so core components transfer between communities?	• Evidence of under-investment but not re-investment in communities • Re-investment works for other areas (e.g., crime prevention) • Has the potential to break the cycle of generational trauma • Invests in what the community needs, not a specific program

Community-Based Prevention Gaps	Why is this gap a priority?
CBP4: What are the core components, effectiveness, sustainability, and transferability of *preventive legal advocacy* efforts for increasing access and use of supports and services? a. (Description) What are the core components of effective preventive legal advocacy efforts to improve access and use of supports and services that (1) increase child, family, and community well-being; (2) reduce child maltreatment; and (3) narrow inequities for both? b. (Effectiveness) What is the impact of preventive legal advocacy efforts to improve access to supports and services on (1) child, family, and community well-being; (2) child maltreatment; and (3) inequities for both? c. (Sustainability) How do you sustain effective preventive legal advocacy efforts to improve access to supports and services? d. (Transferability) How well do effective preventive legal advocacy efforts to improve access to supports and services transfer from one community to another? What adaptations need to be made so core components transfer between communities?	• The legal and judicial system has a disproportionate amount of influence over the well-being of youth, family, and community (e.g., health, housing, and employment) and has the potential to support and stabilize families under stress.[41]
Research Gaps in Delivery of Community Supports and Services	
CBP5: What are the core components, effectiveness, sustainability, and transferability of efforts to embed *prevention programs and services within settings visited by families* for increasing access and use of supports and services? a. (Description) What are the core components of effective efforts to embed prevention programs and services within settings visited by families to improve access and use of supports and services that (1) increase child, family, and community well-being; (2) reduce child maltreatment; and (3) narrow inequities for both? b. (Effectiveness) What is the impact of efforts to embed prevention programs and services within settings visited by families to improve access to supports and services on (1) child, family, and community well-being; (2) child maltreatment; and (3) inequities for both? c. (Sustainability) How do you sustain effective efforts to embed prevention programs and services within settings visited by families to improve access to supports and services? d. (Transferability) How well do effective efforts to embed prevention programs and services within settings visited by families to improve access to supports and services transfer from one community to another? What adaptations need to be made so core components transfer between communities?	• Provides support without stigma • Co-locating services can reduce barriers to service access and usage • Leverages non-traditional partners for service provision • Leverages trust associated with settings already frequented by parents and children

[41] https://www.casey.org/preventive-legal-advocacy/

Community-Based Prevention Gaps	Why is this gap a priority?
CBP6: What are the core components, effectiveness, sustainability, and transferability of *remote (online) prevention programs* for increasing access and use of supports and services? a. (Description) What are the core components of effective remote prevention programs to improve access and use of supports and services that (1) increase child, family, and community well-being; (2) reduce child maltreatment; and (3) narrow inequities for both? b. (Effectiveness) What is the impact of remote prevention programs to improve access to supports and services on (1) child, family, and community well-being; (2) child maltreatment; and (3) inequities for both? c. (Sustainability) How do you sustain effective remote prevention programs to improve access to supports and services? d. (Transferability) How well do effective remote prevention programs to improve access to supports and services transfer from one community to another? What adaptations need to be made so core components transfer between communities?	• Ease of access • Cost-effective • Extends reach of effective services • Reduces stigma • Can provide services that are most suited for online delivery
Research Gaps in Policy and Economic Supports	
CBP7: What are the impacts of local and federal policies, supports, and programs that attempt to address inequities in systems (e.g., lack of access to high-quality childcare, the criminalization of poverty[1]) on community, family, and child well-being? a. (Description) What are constellations of local and federal policies, supports, and programs that aim to reduce inequities in systems and society (e.g., lack of access to high-quality childcare, lack of affordable housing, the criminalization of poverty) and promote community, family, and child well-being? b. (Effectiveness) What is the impact of constellations of local and federal policies and programs that aim to reduce inequities in systems and society (e.g., lack of access to high-quality childcare, lack of affordable housing, the criminalization of poverty) on (1) child, family, and community well-being (2) child maltreatment; and (3) inequities for both? c. (Transferability) How well do constellations of local and federal policies, supports, and programs that attempt to reduce inequities in systems and society transfer across communities?	• While there is a growing body of evidence that policies are effective in promoting social determinants of health, we know little about how such policies work together to address conditions and how their implementation affect well-being. • Potential to reduce family stress and inequities in outcomes
CBP8: What are the impacts of local and federal economic support policies (e.g., SNAP, tax credits, childcare allowance, direct payment to families), constellation of policies, or aspects of economic support policy implementation that are related to the promotion of child, family, and community well-being? a. (Description) How do economic support policies (e.g., SNAP, tax credits, childcare allowance, direct payment to families) and their implementation work together to reduce poverty and inequities in systems and society? b. (Effectiveness) What is the impact of economic support policies (e.g., SNAP, tax credits, childcare allowance, direct payment to families) or combinations thereof on child maltreatment and child, family, and community well-being? c. (Transferability) Are economic support policies (e.g., SNAP, tax credits, childcare allowance, direct payment to families) or combinations thereof equally effective across communities and demographic groups?	• While there is a growing body of evidence that economic support policies are effective in reducing poverty, we know little about how the constellation of policies and their implementation affect well-being.

Community-Based Prevention Gaps	Why is this gap a priority?
CBP9: What policies, programs, services, and supports help increase access to safe, stable, and affordable housing and how do they impact maltreatment and child, family, and community well-being? a. (Description) What policies, programs, services, and supports help increase access to safe, stable, and affordable housing? b. (Effectiveness) How do policies, programs, services, and supports that help increase access to safe, stable, and affordable housing impact (1) child, family, and community well-being; (2) child maltreatment; and (3) inequities for both? c. (Transferability) How well do policies, programs, services, and supports that help increase access to safe, stable, and affordable housing transfer to other communities?	• Housing is one of the most important social determinants of health and we need more evidence on effective programs. • Housing is not affordable; what works to make it affordable and what is the impact on well-being?
Research Gaps in Primary Prevention Investment and Infrastructure	
CBP10: How can Community-Based Child Abuse Prevention (CBCAP) and other funding sources be leveraged to support the infrastructure needed to implement and sustain community-based prevention efforts? a. (Description) What are the approaches to leveraging Community-Based Child Abuse Prevention (CBCAP) and other funding sources to support the core components of the infrastructure to implement and sustain community-based prevention efforts that (1) promote child, family, and community well-being (2) reduce child maltreatment; and (3) narrow inequities for both? b. (Effectiveness) What is the relationship between the approaches to leveraging Community-Based Child Abuse Prevention (CBCAP) and other funding sources to support the infrastructure to implement and sustain community-based prevention efforts and (1) child, family, and community well-being; (2) child maltreatment; and (3) inequities for both? c. (Transferability) How well do effective approaches to leveraging Community-Based Child Abuse Prevention (CBCAP) and other funding sources to support the infrastructure to implement and sustain community-based prevention efforts transfer to other communities? What adaptations need to be made so core components transfer across communities?	• CBCAP is underfunded yet it plays a central role in prevention. • Its scope is not broad and evidence about its effectiveness could expand its reach.
CBP11: What strategies help build and sustain the public and political will to support and fund primary prevention and investments in the social determinants of health? a. (Description) What are the core components of strategies that aim to build and sustain public and political will to support and fund primary prevention and investments in the social determinants of health? b. (Effectiveness) How effective at establishing the infrastructure for implementing primary prevention are strategies that aim to build and sustain public and political will to support and fund primary prevention and investments in the social determinants of health ? c. (Transferability) How well do strategies that aim to build and sustain public and political will to support and fund primary prevention and investments in the social determinants of health transfer to other communities?	• While public and political will play key roles in supporting policies, we know little about which strategies support building and sustaining that will around prevention efforts. • Requires a generational change process…has to be committed to long-term solutions, not focused on crisis-management

Research Gaps in Access and Delivery of Community Supports and Services: Context and Rationale

Risk and protective factors for child maltreatment exist at all levels of the social ecology. As a result, preventive interventions must be comprehensive and intentional about addressing the risk factors present in a given context or setting. Interventions must also be developed with a keen understanding of the population(s) served. Universal prevention programs are intended for the whole of a population and are thought to lessen risks that most or all of that population experience. For example, a lack of affordable housing and child care, low-quality education, and limited access to health care services are risk factors for poor family functioning and child maltreatment. Poverty, social isolation of families, low cohesion among residents of a community, high residential turnover, and housing instability are well-established risk factors for child maltreatment at the community level (Herrenkohl, Hemphill, Florent, & Dee, 2014; Herrenkohl, Kim, & Anderson, 2018; Klevens et al., 2015; Klevens & Metzler, 2019).

Racism and discrimination are also implicated in the etiology of child maltreatment insofar as they contribute to high levels of stress and disparities in health and limited opportunities for education and employment (Yochay, Spilsbury, & Korbin, 2015). Within families, risk factors include poor and inconsistent parenting, drug and alcohol abuse, mental illness, and domestic violence (Herrenkohl et al., 2018). There is also evidence of an intergenerational transmission of maltreatment within families in that parents who experienced maltreatment and other forms of violence as children are more likely to maltreat their own children (Herrenkohl et al., in press; Madigan et al., 2019).

Evidence emerging from etiological and community-based and primary prevention strategies shows the promise of universal and more targeted (selective or indicated) interventions and supports that focus on lessening risks and increasing protection against the occurrence of child maltreatment (Herrenkohl, Higgins, Merrick, & Leeb, 2015). For example, normalizing positive parenting activities and skill-building partnerships within the community could support parenting needs. When people have not been exposed to healthier and culturally relevant strategies for connecting with their children in a way that might be different from what they have experienced in their own childhood results in the repetition of unhealthy cycles. When child abuse does occur, some level of therapeutic services should be provided for the entire family to support the prevention of future instances of child abuse. However, critical questions remain about which programs have potential to prevent and sustain reductions in child maltreatment. Many prevention programs have not been rigorously evaluated or tested with heterogeneous and non-White samples, or with families at imminent risk for child welfare system involvement. Additionally, programs are often limited by their reach across systems and their potential cross-sector collaboration to prevent child maltreatment.

Effects for more well-established programs and intervention approaches (e.g., home visitation, positive parenting) are inconsistent and lack replication (Donelan-McCall, Eckenrode, & Olds, 2009). Further, it is not well understood whether programs thought to hold promise for preventing child maltreatment are culturally responsive and help to advance goals for racial equity, which are important for the overall health of a population (Andrews, Parekh, & Peckoo, 2019).

Community-Based Prevention Strategies

Prevention programs based in community settings have potential to lessen child maltreatment by ameliorating known risk factors for child maltreatment in the community and family domains and by harnessing strengths to improve child outcomes. However, given a long history of disinvestment in communities and inequities in the distribution of resources, supports, and services to communities of color, there is little infrastructure in many communities upon which to implement, and sustain prevention programs

capable of producing lasting changes in child well-being. Additionally, given the highly localized and contextualized nature of community-based child maltreatment prevention, there is little evidence that community-based initiatives can be scaled and replicated in different geographic, demographic, and cultural contexts.

While research on community-based prevention strategies is limited, several community-based prevention programs are considered "promising" by standards used by organizations like Blueprints for Healthy Youth Development, the California Evidence-Based Clearinghouse for Child Welfare (CEBC), and the Title IV-E Prevention Services Clearinghouse. These programs have received certification, which means they meet a general minimum standard of effectiveness. In addition, a number of initiatives are underway in states across the U.S. that are intended to deepen engagement in community-based prevention funded by grants from the Community-Based Child Abuse Prevention program, originally authorized under CAPTA (https://friendsnrc.org/cbcap/annual-summary-state-exemplary-practices/).

Communities That Care (CTC) has been adapted to lessen risk for child maltreatment. CTC was originally designed to reduce youth antisocial behavior and substance use by providing communities with tools and technical assistance to assess, plan, and deliver evidence-based programs at a local level. A recent pilot with families of children ages 0-5 who were at risk for child maltreatment showed success in mobilizing communities for prevention (e.g., engaging community leaders, coordinating with child welfare agencies), but it offered only limited evidence of actual reductions in child maltreatment cases (Salazar et al., 2018; Salazar et al., 2019; Salazar et al., 2016).

Strong Communities for Children offers an alternative "ground-up" community-based prevention strategy, which focuses on strengthening and connecting systems so that families have access to services and supports (Melton, 2014). The Strong Communities model relies on outreach workers and volunteers to mobilize the community around shared norms for the care and empowerment of families. Goals of the initiative are to strengthen institutional and personal relationships, enhance universal services focused on wellness and early intervention, and connect child-serving organizations to improve efficiency and strengthen the coordination of care. Results after five years showed evidence of increased social support and positive parenting, as well as improvements in child safety (i.e., fewer injuries) and age-specific declines in maltreatment reports (Salazar et al., 2018; Salazar et al., 2019; Salazar et al., 2016).

Some preliminary but promising evidence indicates that paying attention to income supports such as certain kinds of earned income tax credit (EITC) programs, financial coaching, and emergency payment of key needs can reduce the risk of child maltreatment and child placement in out-of-home care (e.g., GAIN in Wisconsin, CDC studies: Klevens et al., 2017; Rostad et al., 2020). The Wisconsin GAIN study had a diverse sample in terms of race and income, but overall, the evidence base was modest. Many of these studies need to be replicated.

In addition to co-locating the services described above to reduce the burden on families (e.g., traveling to and from support providers), families may also benefit from online supports -- a form of service delivery that has greatly expanded during the pandemic. Online supports have the potential to engage more families by reducing the travel burden by extending the geographic reach of supports, and by providing supports in a way that some families may prefer (e.g., in the comfort of their own home). But additional research is needed on the effectiveness of co-locating supports in the community and providing supports online virtually.

Research Gaps in Policy and Economic Supports: Context and Rationale

Substantial research demonstrates that economic hardship is a major risk factor for child maltreatment (e.g., Berger & Waldfogel, 2011; Wilkins et al., 2014). In particular, poverty has been consistently documented to be strongly associated with child neglect (Jonson-Reid et al., 2013). Given the strong relationship between low socioeconomic status (SES) and racial/ethnic minority status in the U.S., these economic conditions have particular implications for the maltreatment of children of color (see Detlaff, 2021). For example, Jonson-Reid et al. (2013) found that Black children involved in the child welfare system resided in poorer communities, and were more commonly reported and substantiated for severe and basic needs neglect than White children. Thus, there is a need for more research to address the inequities in policies and programs that are related to child maltreatment risk.

The Centers for Disease Control (CDC, 2016a, b) has conceptualized how poverty may be related to child maltreatment. In their four-level social-ecological model of the interplay between risk and protective factors at the) individual, relationship, community, and societal levels to inform prevention programs (Fortson et al., 2016), they highlighted the importance of social benefit programs that strengthen household financial security and support basic human needs. Further, research on the social determinants of health has pointed to the role of socioeconomic factors in understanding and promoting child and family well-being (Braveman et al., 2011). These conceptual and empirical arguments have spurred action to ground prevention strategies in socioeconomic supports to families (Donkin et al., 2018). However, only very limited U.S. research addresses leveraging political and public will to provide these supports to families as a means of reducing child maltreatment.

Emerging evidence indicates that income supports are related to decreased child maltreatment. For example, it has been documented that state restrictions on access to Temporary Aid to Needy Families (TANF) are associated with significant increases in the number of child protection reports, victims of child maltreatment, and foster care placements, even after controlling for changes in incarceration and the nation's opioid epidemic (Ginther & Johnson-Motoyama, 2017). In contrast, research on participation in nutrition assistance programs (e.g., Lee & Mackey-Bilaver, 2007) and the expansion of Medicaid (e.g., Brown et al., 2019) have been associated with reducing child maltreatment as well as a range of other positive child and family outcomes. Further, housing placement and support (e.g., Farrell et al., 2019; Fowler & Schoeny, 2017) has also been found to support reduce child maltreatment.

Recently, a series of experimental and quasi-experimental studies have evaluated the effects of providing economic assistance to families with limited resources. Specifically, rigorous evaluations have demonstrated that increases in income via state-level Earned Income Tax Credit (EITC) programs reduce abusive head trauma hospitalizations (Klevens, 2017), family involvement with child protective services (Berger et al., 2017; Kovski, et al., 2021), and foster care entries (Rostad et al., , 2020). A novel ongoing study is examining the impact on child maltreatment of providing an unconditional monthly cash allowance to families with young children from birth through early childhood (e.g., Baby's First Years – see https://www.babysfirstyears.com/).

To achieve population-level reductions to child maltreatment, comprehensive national and local policy changes are necessary that address social and economic levers. However, minimal research has directly tested the provision of income supports as an explicit strategy to reduce child maltreatment. Much of the research in this arena has been correlational and focused on the evaluation of local policy implementation. It is important to consider national policy initiatives as well as under-researched areas such as universal

health care, universal basic income, paid and extended parental leave, and childcare services for younger children.

Child Protective Services and Prevention of Foster Care

Principles Underlying This Research Area

This interdisciplinary workgroup comprised experts with varying affiliations, positions, experiences,and intersecting identities. The Child Protective Services and Prevention of Foster Care workgroup identified and prioritized research areas based on empirical literature (including gapstherein), lived experience expertise, and the principles described below. We recognize that research gaps and questions sometimes cross over into the efforts of the other expert workgroups. We approached this work with four intersecting sets of principles in mind:

Research gaps should be bold and transformative. This includes consideration of innovative research methods. Bold and transformative ideas can produce research findings that can be used to break silos, knock down barriers, and reflect the participation of unconventional partnersin the research (see also next bullet point). Our ideas need to be courageous, brave, ambitious, and equitable as we deviate from and challenge the status quo. Healthy risk-taking should be celebrated. We should also focus more on the outcomes we hope to achieve and less on the specific logistics of how things will be done. Research on the transformation of child protective services (CPS) and the prevention of foster care should include rigorous standards so findings can be translated to policies and practices that support child and family well-being.

Research gaps should be addressed by research teams that meaningfully engage partnerswith lived experience in navigating the child welfare system, community members, and line staff who implement policies and programs. This resembles a community-based participatory research approach and equitable inclusiveness of key stakeholders. In a transformed system and the research that informs it, power is shared with communities, including those whohave direct experience with the child welfare system and closely related services such as behavioral health, economic assistance, housing and substance abuse treatment. Communities must be engaged to co-design practice, policy, and research -- including how findings can best be used to support communities and change the child welfare system.

Research to address gaps should prioritize diversity, equity, and inclusion (DEI). Diversity and inclusion are necessary to achieve equity. Thus, how we identify and prioritize research gaps,including how we name and address problems, should include diverse people and perspectives, particularly from groups who have been historically marginalized and systematically denied opportunities to participate in all aspects of economic, social, and civil life. This should involve power-sharing and voice to co-define and interpret issues, make decisions, and change systems. A sense of belonging should also be prioritized.

As mentioned earlier in the report, with the help of three DEI experts, DEI principles were developed and authentically included into the process of prioritizing research areas. Given recent feedback from stakeholders, we aimed to be inclusive in our listing of dimensions of family diversity. Although,

consideration of diverse identities and experiences is essential, in later deliberations, we may differentiate groups based on DEI principles. For example, groups who have historically been marginalized or who experience disproportionate representation in the child welfare system, may deserve prioritized attention. Families are diverse and complex, and child protection agencies need to adequately acknowledge and accommodate family diversity and complexity. To this end, the ***dimensions of family diversity*** we list at this stage are listed below. The dimensions of family diversity are not listed in any particular order of prioritization and may be adjusted when all the research agenda feedback has been considered.

- race and ethnicity
- socioeconomic status
- sexual orientation, gender identity and expression
- geography (rural, suburban, urban)
- native and primary household language
- household composition (one-parent, two-parent, female-headed, male-headed, multigenerational)
- age(s) of child(ren) in the home
- involvement with criminal justice systems (e.g., parent removal due to policing and/or criminal justiceinvolvement);
- military involvement
- immigration status
- disability status

Research to address gaps should focus on equitable and universal prevention, when relevant. When parents are provided with sufficient supports, services, and resources, preventive efforts are likely to be most effective. Thus, a re-envisioned child welfare system should include customizable supports and services that are accessible and culturally informed, and that meet the unique needs of families. Ideally, preventive services should be equitable and universal.

Additional Values Underlying This Research Area

In addition to the three sets of principles stated above, we believe that a re-envisioned child welfare system must consider fundamental social work values and family and community assets, as well as bring a strengths-based perspective to working with children and families. This contrasts with a sole focus on risk factors and conventional child welfare outcomes (safety, permanency, reunification). Thus, we believe prioritized research areas must be more holistic and consider family-, parent-, and child-level indicators and outcomes.

Risk and protective/resilience factors should be examined simultaneously and should include:

- Parent or caregiver substance misuse (i.e., unhealthy substance use), intimate partner violence, family violence, mental health, abilities, and physical health
- Parent or caregiver and community social supports, social capital, economic and housing instability or insecurity, and parenting-related self-efficacy
- Additional risk/protective factors to be considered based on feedback

Theoretical or Meta Considerations/Questions

Each of the research gaps outlined in this document was informed by broader questions and considerations about underlying themes and philosophies related to child welfare practice. For context, we have included some of these guiding meta-questions below:

- How do we keep outlier events from driving policy and practice? How do we overcome the excessive fear of keeping kids with their families when we know there was abuse or neglect concerns?
- Where does the evidence point: to one expanded and reimagined child welfare system or two separate systems—a larger integrated family support with a smaller more focused child protection system? Or something else?
- How do we account for the individual needs/nature of each case, when identifying outcomes, best practices, etc.?
- How do we break the system down into its component parts and look at things from the perspective of "what works for whom"?
- How do we reckon with the generally reactive approach of the current child protection system in the U.S., while thinking about reforms and moving forward to a system that works better for everyone?
- How do we promote a strengths-based shift in child welfare research and practice?
- Should a re-envisioned child welfare system focus on the well-being of children *and* their parents and families, instead of only promoting and assessing child safety? It should be noted that we believe child safety to be a key element to child well-being.

The research areas highlighted below reflect the topics that emerged as most urgent based on discussions held among the members of the interdisciplinary workgroup.

Research Gaps in Prevention of Initial and Subsequent Involvement in Child Protective Services Systems

CPS 1. What is the level of effectiveness among existing practice and policy interventions that are aimed at preventing initial and recurrent child protection services (CPS) contact and out-of-home placement?

- How does effectiveness vary by practice and policy, sub-population, maltreatment type, family structure, and by community and cultural context?
- What role does the court system play (including, but not limited to, judicial decision-making, judicial turnover, case personnel/service providers/court appointed volunteers, court procedures and policies) in shaping the effectiveness of various interventions in preventing initial and recurrent CPS contact and out-of-home placement?
- Do less adversarial models in the child welfare context result in better outcomes (fewer removals, keeping children with family, community, etc.)? Examples of less adversarial models are Indian Child Welfare Act courts (in state courts) and Healing to Wellness Courts (in tribal courts). One related question is whether early tribal involvement in a case results in better outcomes (more frequent and quicker reunification, more family placements or other preferred placements, etc.)?

- What role do child welfare workers play (including but not limited to education level, years of experience, agency turnover rate) in shaping the effectiveness of various interventions in preventing initial and recurrent CPS contact and out-of-home placement?

Context and Rationale

Preventing initial and subsequent CPS contact and entry into foster care are important goals that should engage differing aspects of community and/or child protection systems. These goals are also sensitive to state and regional policies and social contexts. Further or deeper involvement with the child welfare system may happen via different paths. For example, entry into foster care may occur immediately after a single confirmed maltreatment report, after multiple reports spanning several years, or for reasons unrelated to confirmed child maltreatment, including family "performance" or "progress" during interventions. As such, the diversity of families' experiences and paths into and through the child welfare system deserves exploration.

Further, for a variety of reasons, empirical investigations of intervention effectiveness often result in inconsistent findings. Dimensions such as demographics (e.g., rurality, income, and community resources) can vary widely and contribute to differential findings. In addition to these demographic differences, other aspects of intervention delivery (including community-level factors) and biases and abilities among those delivering interventions are important factors to consider in future research. Similarly, there is important state- and county-level variation in policies related to defining what behaviors or conditions constitute maltreatment, decisions regarding in-home service responses and alternative response options, and family court thresholds for removal (Jonson-Reid & Chiang, 2019; Rebbe, 2018; Scarcella, 2006). Current interventions typically include a suite of services including case management, home visiting programs, parent education, behavioral parent training, mental health services (for parents and/or children), substance use treatments, and attachment-based interventions. Beyond case management, these services are most commonly provided by contracted service-providing entities technically residing outside of the formal child welfare system.

Such interventions and services, and how they are delivered, also vary significantly across jurisdictions (tribal, state, county), service-providing agencies, service providers, cases, and families, in ways both intentional (i.e., by design) and unintentional. As such, variation in service delivery and policy contexts should be considered in future research. Finally, outcomes may vary by culture and community contexts in ways that cannot be foreseen or predicted by researchers without input from those with lived experience in the systems and communities to be studied. Thus, researchers should meaningfully engage with stakeholders with lived experience when designing evaluations. All of these complexities are important to consider as we look to fill research gaps in understanding the effectiveness of interventions for particular stages of CPS contact. These gaps hamper the ability to improve outcomes under the current system and restrict our ability to realistically imagine and design a 21st-century child welfare system. The following brief review is designed to provide some empirical context for the development of the research agenda.

***Community contexts*.** There are many ways of defining *community*, but a common definition may include "a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings" (MacQueen et al., 2001, p. X). Community is related to identity, culture, and lived experience, all of which may crosscut the geographic boundaries and influence the risk for CPS contact and trajectories in several ways (e.g.,

Gibbs et al., 2011; O'Leary et al., 2020). While some form of the ecological model informs a large part of child maltreatment research (Belsky, 1980; Freisthler et al., 2006), empirical attention to the broader community context is weaker, particularly with regard to CPS trajectories (Swenson & Schaeffer, 2019). Community characteristics such as unemployment rates, poverty, the number of alcohol outlets, and numerous other community-level indicators have been positively correlated with rates of child maltreatment in several communities (e.g., Farrell et al., 2017; Freisthler et al., 2006; Frioux et al., 2014; Maguire-Jack & Font, 2017; Smith et al., 2018), while availability of social services in a community appears to be protective (Ben-Arieh, 2015; Maquire-Jack & Negash, 2016).

Less attention has been paid to the association between community-level indicators and CPS trajectories (Jonson-Reid et al., 2013; Jonson-Reid et al., 2017). Moreover, other community constructs such as social cohesion and the presence or absence of a variety of specific services have received relatively little attention (e.g., Friesthler et al., 2007; McLeigh et al., 2018). There are also significant sources of variation within demographically similar communities that may affect both rates of maltreatment (Finno-Velasquez et al., 2017) and rates of substantiation or placement into foster care (Freisthler, et al., 2007). For instance, a recent study explored variation in neighborhood perception between child welfare professionals and community residents, but more work is needed to replicate and translate such findings for community-based intervention (Gross- Manos et al., 2019).

Interventions for families with CPS contact. Nationally, relatively few families receive a service response from child welfare following a referral (USDHHS, 2020), and unfortunately, most national data do not allow for isolating types of in-home services (e.g., voluntary vs. court-ordered; specific models/types of intervention) and duration. Relatively little work has been done to increase our understanding of the various impacts of services (by type and duration) on family outcomes and how that may vary by region or population (e.g., Jonson-Reid et al., 2017). One exception is an older study that found no difference in repeat CPS referrals by program intensity, controlling for program duration and other factors (Chaffin et al., 2001).

A more recent study employed a composite scoring system to rate outcomes following an open case, but it was not clear what services were included (Orsi et al., 2012). That same study suggested that programs helping families meet concrete needs were more effective than traditional programs. There is also a range of possible outcomes of services from child safety (e.g., recurrence, fatality, injury) to permanency (e.g., placement into foster care) to well-being (e.g., behavioral health, education, health). Although studies of recurrent reports are more common, a recent review found that the variety of sample composition, coding of race/ethnicity, the presence or absence of services indicators, and scarce controls for community characteristics made drawing conclusions challenging (Jonson-Reid et al., 2017). Outcomes also varied by case or system characteristics.

States differ in which behaviors are reportable as maltreatment; for example, some states consider exposure to domestic violence to be maltreatment, while others do not. Several states have moved to a privatized system (National Conference of State Legislatures, 2018; Robichau & Wang, 2018), but relatively little research has been conducted to assess child welfare outcomes under these systems with different definitions and/or approaches. For example, when Nebraska was privatized, access to needed services actually declined (Hubel et al., 2013). Other research has found that services provided to unsubstantiated cases, compared to cases that were investigated and closed, cases receiving lower-level, in-home services (but not foster care or intensive in-home services) had a lower recurrence rate

(Jonson-Reid et al., 2010). It is not clear how findings might vary in a state that gates services by substantiation. This makes drawing conclusions to inform policy decisions difficult (Jonson-Reid, 2011) and can confound testing or replication of innovations (Jonson-Reid et al., 2017).

Efficacy of case management. Most child welfare services primarily involve case management(Child Welfare Information Gateway, 2021; Jonson-Reid et al., 2017). Solution-based casework has shown some promising results, but it is unclear how it compares to other models or how it may be delivered across sites (Antle et al., 2009, 2012). The outcomes of case management mayvary by screening practices or gatekeeping of services. One study found that providing services to screened-out cases resulted in no difference in the provision of services compared to those denied due to program capacity (Conley & Duerr Berrick, 2010). Effective collaboration is likely key to effective referrals, but collaboration is affected by worker awareness of service availabilityand access (Darlington & Feeney, 2008; Stahschmidt et al., 2018).

***Parent engagement*.** We know little about how parent engagement, defined variably across studies as anything from initiating to ongoing participation in services to emotional orientations toward services (Staudt, 2007; Yatchmenoff, 2005), is related to service use (Merkel- Holguin et al., 2015) and case and family outcomes. One model that may improve outcomes is through various forms of meaningful family engagement in case planning like Family Group Conferencing (Corwin et al., 2020). Thus far, the research is mixed with regard to how this approach is associated with child welfare outcomes (Kim et al., 2016).

Over the last two decades, there have been increased demands that CPS workers meaningfully engage fathers in services (Arroyo, et al., 2019; Baum, 2017; Pruett et al., 2019). Unique to fathers, gender norms and socialization may influence the conceptualization of their role as a parent and may serve as a barrier to engaging in services (Gordon et al., 2012). In their review, Gordon and colleagues (2012) also identified barriers related to CPS, including caseworkers' preconceived ideas about fathers and lack of training in or understanding of how best to engage fathers. In response, there has been a substantial amount of scholarship about strategies to increase father involvement with CPS (e.g., Gordon et al., 2011, Maxwell et al., 2012, Scourfield et al., 2012).

In general, parents have varied emotional responses to CPS involvement. While this likely affects their engagement, we know little about how this impacts engagement or service use (Merkel-Holguin et al., 2015) or family outcomes. Studies of differential response models have generally found that parents have better emotional responses to caseworkers, but these responses were also related to their perception of the caseworker's skill and having two or more needs identified; and they are not linked to outcomes (Merkel-Hoguin et al., 2015). Finally, there may be barriers external to the system that impact engagement in services. One small study of parents mandated to services reports that most parents identified at least one barrier to accessing services, such as transportation, program eligibility, cost of services and lack of responsivity of the case manager (Estafan et al., 2012).

***Evidence-based parenting interventions*.** There are several evidence-based parenting programs that were designed originally to address child behavioral problems, which may be appropriate for child welfare-involved families; but their impact on maltreatment is less clear (Barth & Liggett-Creel, 2014; Chaffin et al., 2011; Marcynyszyn et al., 2011; Petra & Kohl, 2010). Additionally, parenting behaviors associated with disruptive child behaviors are similar to those that may be associated with maltreatment

(Price, 2006). Only a few studies have looked at such programs in relation to recurrence or placement into foster care but that literature is growing (e.g., BigFoot & Funderburk, 2011; Burnson et al 2021; Chaffin et al., 2011; Marcynyszyn et al., 2011) – with the effectiveness of Parents Anonymous, SafeCare established and studies underway for the Nurturing Families, Nurturing Parents and Positive Indian Parenting programs.

Multidimensional and multilevel factors (provider, organizational, client and logistical) affect the implementation of evidence-based interventions (Arkin et al., 2016), and these factors likely vary across organizations and jurisdictions. It is therefore necessary to conduct multisite hybrid trials (Curran et al., 2012) that study both implementation and outcomes. One barrier to large-scale uptake of evidence-based interventions is the cost associated with training and service delivery (Haskins, 2020; Jaramillo et al., 2019). Therefore, there is a need for economic analyses to examine the cost-effectiveness of more expensive evidence-based interventions as compared to inexpensive (but likely less effective) usual-care parenting interventions. Further, we need to understand the effects of other services that a caregiver may be participating in outside of the parenting intervention.

Maltreatment type. Research is mixed regarding associations between specific forms of maltreatment and outcomes (Corso et al., 2008; Hodgdon et al., 2018; Hughes & Cossar, 2016; Finkelhor et al., 2007; Strathearn et al., 2020; Warmingham et al., 2019). It is unclear whether this ambiguity is attributable to the fact that maltreatment types rarely occur in isolation (Elm et al., 2021; Herrenkohl & Herrenkohl, 2009; Negriff et al., 2017), or to the fact that our methods for sampling functionally mean that children's experiences are only captured after multiple adverse experiences accrue. We know little about which intervention models are most effective at preventing a specific type of child maltreatment (i.e., physical abuse, sexual abuse, emotional abuse; physical and emotional neglect). Sometimes this is due to lack of measurement of subtypes. For instance, the Nurse-Family Partnership has been shown to reduce risk for maltreatment reports in some studies but they do not report type (Eckenrode et al., 2017). This is a critical gap, as maltreatment subtypes represent drastically different experiences, with different etiologies and potential consequences, and therefore different needs in terms of responses and interventions to prevent recurrence or address potential consequences.

Similarly, a meta-analysis of 121 independent studies of parenting interventions as primary prevention of maltreatment or as a curative intervention following maltreatment did not address the type of maltreatment (van der Put et al., 2018). But some studies have measured the type of maltreatment. For example, a study of Parent-Child Interaction Therapy, for parents who had demonstrated physically abusive behavior, measured physical abuse as the outcome and found it to be effective in reducing those behaviors (Chaffin et al., 2011). Studies of SafeCare, which has received significant attention in relation to responding to neglect, showed that family outcomes are improved compared to traditional child welfare services (Chaffin et al., 2012; Guastaferro & Lutzker, 2019). The Period of Purple Crying effort has shown promise as an intervention to prevent physical injuries to infants in some studies but not others (Zolotor et al., 2015). There is also emerging evidence related to economic-based interventions. For example, Raissian and Bullinger (2017) found that an increase in the minimum wage resulted in fewer reports of child neglect. More research is needed to understand when interventions are type-specific and when they may have more universal impacts on maltreatment.

There are also questions about the target of a given intervention. For example, with regard to sexual abuse, most prevention programs focus on educating children about personal safety (Prevent Child

Abuse America, 2016), despite the lack of evidence that this child-level intervention is effective. Treatment of childhood sexual abuse typically focuses on the child victim, with substantial evidence supporting the effectiveness of interventions like Trauma-Focused Cognitive Behavioral Therapy (Czincz & Romano, 2013; National Child Traumatic Stress Network, 2012). Much remains unknown, however, about how best to work with parents who are not engaging in abusive or neglectful behaviors to achieve optimal outcomes, including family well-being, although there is a promising practice noted in the California Evidence-Based Clearinghouse (Berkowitz et al., 2010).

Child-level needs and services. In the search for precursors to child welfare system involvement, more attention has been given to parenting-related needs or risks, or those of the family as a whole (e.g., need for housing). Less is known about how child-level needs impact risk of CPS contact, CPS trajectories, and risk of foster care entry. The child well-being dimension in child welfare research is relatively new and often poorly measured (Jonson-Reid & Drake, 2016) although more attention to child well-being has been paid to children in foster care (e.g., Griffin et al., 2011). A few studies suggest that children's developmental or mental health concerns (measured directly or through mental health or special education service use) are associated with recurrent CPS reports (Dakil et al., 2011; Drake et al., 2006; Kahn & Schwabe, 2010; Kohl et al., 2009).

Many evidence-based parenting programs (addressed below) were designed to address child behavioral problems, but it is not known how better access to children's health care (including quality mental health and educational services) may prevent ongoing CPS contact (Ringeisen et al., 2008; Stone, 2007). One study found that children with externalizing behaviors (e.g., disruptive, aggressive, impulsive) were more likely to receive mental health services, but certain caregiver risks were associated with greater likelihood of various services and outcomes (Campbell et al., 2010). The impact of child-level needs or challenges on the risk of maltreatment may also vary by community context (Barth et al., 2006). There is a need for additional exploration of ancillary services, with more contemporary and diverse samples and with attention to community and culturally responsive interventions and context.

Culturally competent services. Across all issues addressed above, we also need to understand more about the cultural context of acceptability of various forms of services in the community and the role acceptability plays in CPS intervention and outcomes. Studies of outcomes by race/ethnicity are sometimes difficult to compare given the varying ways groups are coded or the demographic of the sample population (Jonson-Reid et al., 2017). Little is known about culturally specific adaptations of in-home services. One study of SafeCare found that outcomes varied according to client ratings of the cultural competence of their caseworker (Damashek et al., 2012), and another study documented its effectiveness with American Indian families (Chaffin et al., 2012). A third study found that increasing concrete support as part of services predicted greater perceived cultural sensitivity (Rostad et al., 2017). A small study of Latinx immigrant families suggested that engagement improved with increased cultural competency, better supervision of Spanish-speaking caseworkers, and reduced barriers to referral services (Lanesskog et al., 2019).

Court-related factors. There is a dearth of literature examining the role of court-related factors in influencing the outcomes and trajectories of children and families who become involved with CPS. These factors include, but are not limited to, judicial turnover; case personnel, including social workers, attorneys, and CASAs; training, abilities, and biases of all court and case personnel including judges;

and policies, procedures, and practices within court systems. Collectively these factors can also be viewed as components of the child welfare court system, which in turn is described in various ways (e.g., resilient, adaptive, resource-strained) (Wyman & Warner-King, 2017).
Related to this, specialized courts and innovative court models that function uniquely may be key in impacting outcomes. Some include Tribal Courts (Indian Child Welfare), Family Drug Treatment Court, and Peacemaking models (Butterwick, Connors, & Howard, 2015; Gifford, Eldred, Vernerey, & Sloan, 2014; Haight et al., 2020). Some examples of frameworks for designing and improving court systems that are described in the literature include The Court Improvement Training Academy, which provides a framework of values and principles for building a resilient child welfare court system (Wyman & Warner-King, 2017) and the Problem Solving Courts model used in drug courts (Bryan & Havens, 2008).

Given the complexity of multilevel factors (e.g., individual, systems, policy), the movement of families in and out of the court system, and how these intersect with services (e.g., duration, service delivery personnel), ascertaining the role of court-related factors in the effectiveness of interventions can be difficult to examine through strict and complex quantitative research analysis alone. Thus, there are mostly descriptive studies available to provide insight into how court-related factors may contribute to the effectiveness of interventions and outcomes (e.g., Williams, Mahr, et al., 2015). Furthermore, the outcome of interest matters when evaluating court-related factors. For example, proximal and distal outcomes can be indicators of success, which can classified into a range of domains (e.g., safety, well-being, completing substance use treatment program, family preservation.)

CPS 2. What can we learn from cultural practices, best practice models, and models considered less adversarial (e.g., ICWA courts, Healing to Wellness Courts) used with sub-populations (e.g., ICWA and active efforts) that can help transform our approach to child welfare?

- How do outcomes vary when culturally responsive services and interventions are delivered by someone from that same community?

- How do outcomes vary across different jurisdictions that have variability in resources?

Context and Rationale
A number of culturally adapted or culturally specific parenting programs are mentioned in reports and literature (e.g., Positive Indian Parenting, developed by the National Indian Child Welfare Association; Family Enhancement Program for African American Families; various adaptations of Parent Child Interaction Therapy (PCIT); Ciliberti, 1997; West et al., 2020). None of these programs are listed as evidence-based, but a 1997 review indicated that flaws in research methodology at that time may have resulted in the somewhat lowered effectiveness rating of a culturally adapted or developed program (Gorman & Balter, 1997). One large-scale study of the need for cultural adaptation of best practices indicated little need for major changes to evidence-based programs but did uncover suggestions for adaptations on a case-by-case basis (Self-Brown et al., 2011). There have been some critiques of assuming that adaptations are needed because these may result from stereotypical ideas of various cultural groups (Miranda et al., 2005). Much of the recent literature focused on cultural adaptation has related to the global context, and it is unclear how the literature might inform efforts in the United States (e.g., Abdullah et al., 2020; Alampay et al., 2013).

There are anecdotal reports and theoretical discussions of effects of culturally adapted child welfare practices (Bullock, 2020; Lucero et al., 2017; O'Leary et al., 2020), but as yet, little research is available. An excellent review of the adaptation of PCIT for American Indian and Alaska Native families (Honoring Children, Making Relatives) exists but does not include outcome data (Bigfoot & Funderbunk, 2011). Relatively few family intervention programs that are considered evidence-based have been evaluated with regard to maltreatment outcomes, as most of these programs were designed to focus on disruptive child behavior (Garcia et al., 2018; Myers et al., 1992; Ramos et al., 2018).

CPS 3. What is the effectiveness of innovative and transformative programs or interventions that are currently in place but have not yet undergone a full-scale outcome evaluation and/or comparison to traditional intervention methods?

- What are the outcomes (e.g., preventing CPS involvement, preventing removal) of each program or intervention?
- Are these outcomes important to the community intended to receive each program or intervention?
- What is the program or intervention's impact (i.e., effectiveness)?
- Is there variation by sub-population and is this variation dependent on whether the group who is receiving the program or intervention participated in its development?
- Is this program or intervention an adaptation of another evidence-based program? If so, what are the adaptations?
- What does each program or intervention assume are the root causes that lead to CPS involvement and/or child maltreatment, including whether perceptions of those root causes differ along various dimensions of family diversity, in their particular jurisdiction?

Context and Rationale

There are many examples of promising approaches to prevent CPS involvement that have not been fully evaluated or have poorly understood, longer-term preventive outcomes as well as approaches that appear to result in null effects (Eckenrode et al., 2017; Green et al., 2020; Jones Harden et al., 2020; Sanders et al., 2018; Viswanathan et al., 2018). This does not mean there are no effective approaches already in existence in some jurisdictions—we simply do not know, at present. Compiling data on these novel approaches can be challenging because they may not have been formally evaluated and therefore may not show up in searches of the empirical literature or traditional avenues of evidence-based standard setting. Therefore, compiling an inventory of these promising approaches and conducting rigorous evaluations of them would help fill an important gap. A recent systematic review was only able to identify four published articles on unique community-based prevention approaches that showed promise; however, two of these focused solely on sexual abuse, and there were inconsistencies in findings by region and means of measuring maltreatment (Lo & Cho, 2021).

There is a lot of opportunity in diversion approaches that may begin with a report to CPS but are ultimately handled in a preventive or more holistic fashion. Some states screen out up to 86% of calls made to CPS. Yet there is very little research on screened-out calls because many (if not most) states simply delete details about screened-out families. What little research exists does not bring a lot of confidence that screening out correctly identifies what are generalized as "false alarms" (Putnam-

Hornstein et al., 2015). However, families reported to CPS but screened-out may be ideal candidates for voluntary preventive services (Buren & Will, 2015; Dumas et al. 2015; Loman, Shannon, Sapokaite, & Siegal, 2009; Millett, 2019).
There is only limited literature on such programs that are sometimes loosely grouped under "differential (or alternative) response" but are focused on cases that are screened out or otherwise diverted such as the Minnesota Parent Support Outreach Project (PSOP; Loman et al., 2009). The evaluation found that only about 25% of families returned to CPS with a screened-in report when services were received. In particular, among very low-income families, those that did not receive income and material needs supports fared much worse. Later, a quasi-experimental study of the same program found that compared to low-to-moderate risk differential response cases, PSOP families had fewer later reports to CPS, fewer placements into foster care, and increased access to adult mental health services (Millett, 2019).

A small study of a similar program, Marathon County (Wisconsin) Community Response Program, also showed promising results, but no multivariate controls or matching were employed (Maguire-Jack & Bowers, 2014). Importantly, there was a strong emphasis on financial support in this program. A study of Pathways to Safety in California also showed promising results in regard to subsequent substantiated reports, but the comparison group consisted of families that refused services or dropped out early, which may have affected results (Navarro et al., 2017). Another evaluation of this approach in California found no effects (Conley & Berrick, 2010). Given these mixed findings and smaller studies, there is clearly a need for more research of these models. Further, there are undoubtedly other promising or unevaluated programs that also deserve further research.

CPS 4. To what extent are risk factors commonly associated with CPS involvement (e.g., domestic violence, parental mental health, trauma histories, extreme poverty) experienced differently by families with varying ***dimensions of family diversity***?

- What do we know about service participation by families of different races and ethnicities, economic backgrounds, gender identities, and geographies (urban/rural) who are experiencing early signs of child maltreatment (i.e., before involvement in child welfare system)? Does this differ for families who are experiencing early signs of neglect?
- To what extent is the intervention different for families receiving help within or outside CPS?
- What is the relative impact of addressing those needs *alone* (e.g., risk factors associated with CPS involvement) or *together* with culturally relevant and tailored parenting interventions for reducing CPS involvement and out-of-home placement and improving parent and caregiver well-being?

Context and Rationale
The needs of families impacted by CPS are complex. Many families are simultaneously contending with varying degrees of substance misuse, mental health challenges, domestic violence, economic insecurity and poverty (Austin, 2016; Fong, 2017; Goulet et al. 2018; Yang, 2015). These families may look very different from the families included in the trials that initially established the effectiveness of various parenting interventions.

Family trauma and trauma-informed approaches. Children and parents impacted by CPS often have histories of traumatic experiences and life events (Blakey & Hatcher, 2013; Haight et al., 2007; Lucero

& Bussey, 2012; Waechter et al., 2019). Toolkits on trauma-informed systems and parenting interventions have been developed, but little is known about the effectiveness of their implementation and their impact on outcomes in child welfare (Akin et al., 2017; Johnson et al., 2018). Further, more work is needed to understand the compatibility of specific parenting interventions, particularly non-voluntary interventions, with a trauma-informed framework (Barto et al., 2018).

Interventions responding to parent-level needs and risk factors. Interventions specific to various risk factors may also be beneficial, though much less is known about their impact on child maltreatment. One small study described a promising multi-sectoral program to address substance misuse in pregnant and parenting mothers in Canada (Andrews et al., 2018). A recent systematic review (West et al., 2020) pointed out that despite the association of parental substance misuse and mental health challenges with child maltreatment, few programs have been rigorously evaluated and only one small study examined rates of foster care entry. There was, however, mention of two large rigorous projects in progress that may hold promise (i.e., Project BRIGHT and the Family- based Recovery Program).

Some evidence suggests that home visitation programs may be protective for certain families. For example, the effects of the Elmira Nurse Family Partnership model on substantiated reports of maltreatment (though it was not possible to discern type) were largely restricted to mothers reporting low to moderate domestic violence and mediated by reductions in subsequent pregnancy (Eckenrode et al., 2017). A multi-modal and flexible programming approach (somewhat like the New South Wales model), Building Healthy Children, is a model designed forteen parents that begins shortly after birth and is integrated with the “medical homes”. In a large RCT with a diverse sample, participating families were successfully engaged in preventive services and showed lower (though statistically insignificant) rates of involvement with CPS or emergency department visits for injury, and higher completion of immunizations (Paradis et al, 2013).The usual-care comparison group, however, also received case management assistance with services.

One of the dilemmas in this area of research is the lack of maltreatment type-specific informationabout both family risk as well as preventive intervention results. More research is needed to understand the benefit of economic, parenting, and other interventions (alone and in combination)with regard to early intervention to prevent specific subtypes of child maltreatment, with an eye toward neglect, specifically.

Family drug treatment court. Family drug treatment courts appear to be a useful strategy with CPS-involved parents facing substance misuse whose children enter foster or kinship care. Multiple studies have found that mothers were more likely to enter and complete substance misuse treatment and that children were more likely to be reunified following foster care placement (Burris, et al., 2011; Gifford et al., 2014; Green et al., 2007; Worcel et al., 2008). A recent meta-analysis of 17 studies supports the idea that the family drug treatment courts increase the likelihood of reunification (Zhang et al., 2019). This meta-analysis further showed a positive effect on recurrent maltreatment reports among children who entered care following the initial report. *A search of the literature shows that to date, there have been no U.S. studies to assess whether drug courts improve outcomes for families involved with CPS but not separated by foster care.* Given that the vast majority of children remain in the home versus entering foster care, this represents a large gap in the research evidence. Further, research to date has not assessed variation in outcomes by maltreatment type or across dimensions of family diversity.

Culturally specific adaptations. As was discussed for CPS 3, little is known about culturally specific adaptations of in-home services. Two meta-analyses support the idea that family preservation outcomes vary by child and family characteristics and risk factors (D'Aunno et al., 2014). As mentioned earlier, one study of SafeCare found that outcomes varied according to client ratings of the cultural competence of their caseworker (Damashek, Bard & Hecht, 2012), while another study found it was effective with American Indian families (Chaffin et al., 2012). Another study found that increasing concrete support as part of services predicted greater parent-perceived cultural sensitivity (Rostad, Rogers, & Chaffin, 2017). A small study of Latinx immigrant families involved with CPS suggested that engagement with clients would improve with cultural competency, better supervision of Spanish-speaking caseworkers, and reduction of barriers to referred services (Lanesskog, Munoz & Castillo, 2020).

There is some debate in the literature on appropriate cultural adaptation of parenting interventions related to both fidelity and effectiveness (Mejia et al., 2017). When programs have been adapted, these adaptations have often lacked rigorous evaluation (Baumann et al., 2015). A number of population-specific interventions have been developed but often without enough research to move a program beyond the indication of promise (e.g., Effective Black Parenting Program,; California Evidence-Based Clearinghouse, 2020; Walkup et al., 2009). Further, only a handful of parenting interventions have been used to either complement or prevent child welfare system involvement. But as mentioned earlier, more parent intervention studies are underway, and recent reviews have found that over 30 interventions rated by the Prevention Clearinghouse have evidence that they are effective for children and families of color (e.g., O'Brien et al., 2021; Pecora et al., 2022).

Responding to neglect specifically. Many studies indicate that neglect, whether measured by official reports or self-reports, is equally likely to result in poor outcomes when compared with abuse, and more likely to result in poor outcomes when compared to poverty alone (Ben-David, Jonson-Reid, Drake, & Kohl, 2015; Jack & Maguire-Jack, 2020; Manly, Lynch, Oshri, Herzog, & Wortel, 2013; Turner, Vanderminden, Finkelhor, & Hamby, 2019). Child neglect is also equally likely to be associated with later preventable death (Jonson-Reid, Chance, & Drake, 2007) and comprises the majority of maltreatment types associated with child maltreatment deaths nationally (US DHHS, 2020). In 2018, 72.8% of children who died from child maltreatment suffered neglect either alone or in combination with another maltreatment type. Medical neglect either alone or in combination with another maltreatment type was reported in 8.1% of fatalities. (https://www.childwelfare.gov/pubPDFs/fatality.pdf).

Incidents of child neglect—variably defined—are common not only in the U.S. but also internationally (e.g., Abdullah et al., 2020; Bullock et al., 2019). Several English-speaking countries outside the U.S. have launched large-scale initiatives specific to child neglect, although the results are unclear at present. For example, Wales announced a national plan to address neglect in 2016 that included a combination of early childhood services, parenting and job support, and a more intensive integrated service model for families with more complex needs; however, no outcome information was included in the report (Pithouse & Crowley, 2016). Some of these countries are able to build on universal early care programs (e.g., home visiting, childcare, preschool), which may make it more difficult to translate to the current policy landscape in the U.S., which does not offer universal early child care.

Some evaluations indicate a significant reduction in substantiated cases of foster care entries with a similar program targeting children age 8 years or younger in New South Wales, emphasizing universal

home visiting for first-time mothers, a commitment to expanding availability of evidence-based practices (like Triple P), and better services integration. Churchill and Fawcett (2016) pointed out, however, that there were gaps in services and significant attrition (particularly for indigenous families and those with complex needs), along with major implementation issues related to investment in professional development of those serving families, and both availability and accessibility of needed services.

In the U.S., SafeCare has received the most attention for responding to neglect with indications that outcomes are improved over those associated with usual care (Chaffin et al., 2012). Strong interagency collaboration, however, has been found to be key to sustaining SafeCare efforts (Green et al., 2016). Another evidence-based parenting program (Parent Child Interaction Therapy) has shown efficacy with physical abuse but not with neglect (Chaffin et al., 2004). Home visiting programs have also been suggested as important in preventing maltreatment generally, though the findings are mixed across studies and they are rarely type-specific (Kaye et al., 2018).

The results regarding usual-care child welfare early intervention and child neglect are difficult to assess because relatively few families receive intervention through child welfare after an initial report. Findings regarding the effect of in-home service interventions with families reported for child neglect are mixed, and they are complicated by the varying policy contexts in the states where studies have been completed (Jonson-Reid et al., 2019). Some studies have found small protective benefits of providing services to families at lower risk through alternative response models (Fluke et al., 2019), but findings have been mixed with significant differences in how such programs are implemented (Hughes et al., 2013). One promising approach has been examined in Minnesota where families at high risk of maltreatment that did not meet criteria for a screen-in response were diverted to needed community services as well as some direct services such as immediate material needs (Millett, 2019). Controlling for baseline differences, the program was found to reduce subsequent CPS involvement compared to families who were low risk but screened in and received differential response. However, it was not possible to assess whether families were at particular risk of neglect.

Material needs and socioeconomic interventions also show promise related to neglect. A slow roll-out of universal childcare in Germany provided a natural experiment. Sandner and Thomsen (2018) found a reduction of 0.24 cases per 1,000 children if a county increased childcare slots above the median across years of implementation. Raissian and Bullinger (2017) found that an increase in the minimum wage resulted in fewer reports of neglect.

To achieve more optimal outcomes, it is necessary to develop a better understanding of which parenting or risk-specific interventions work for which parents and under which conditions, including maltreatment type and other family-level risk and protective factors. Further, much more research is needed to understand the effects of culturally adapted versions of evidence-based parenting interventions (e.g., Baumann et al., 2015; Bigfoot & Schmidt, 2010).

Research Gaps in Community-Based Helplines and CPS Hotlines

CPS 5. Are helplines more effective than hotlines at reducing CPS involvement, reducing out-of-home placement, and improving parent and caregiver well-being?

- What are the program-, jurisdiction- or community-level elements that make helplines effective?

- How does helpline effectiveness vary along dimensions of family diversity, maltreatment types, and family-level needs/risks/strengths?
- Are helplines widely available, accessible, and culturally relevant?
- Are there virtual elements or improvements, including texting, that can be implemented to enhance helpline effectiveness?
- If helplines are effective in a particular community/context, how can they be replicated across varying jurisdictions?

Context and Rationale

Helplines offer a proactive pathway for families and community members to access critical supports without reaching a point of crisis or requiring a CPS hotline referral. Within our current system, children and families come to the attention of CPS through allegations of child maltreatment made via hotline calls. While all states have reporting laws that include major categories of abuse and neglect as per Child Abuse Prevention and Treatment Act (CAPTA) (Child Welfare Gateway, 2019), the actions or inactions included within these categories—and the addition of categories related to emotional abuse, substance abuse, and domestic violence exposure—varies (https://www.childwelfare.gov/topics/systemwide/laws-policies/state/; Reebe, 2018). Hypothetically, this variance may alter the population reported, screened in, and potentially provided services and supports. Given that most states screen out a sizable portion of hotline calls, a helpline approach may provide an opportunity to assist families in accessing services they need to prevent CPS involvement.

However, research is needed to examine the effectiveness of helplines in preventing maltreatment. This should include efforts to differentiate from the national 211-style helpline. On the other hand, as pointed out in a prior question, some jurisdictions have found ways to effectively use the CPS hotline to serve diverted cases. It is therefore somewhat unclear whether a separate system is warranted or whether a repurposing of the existing structure could accomplish this goal. Further, some studies of preventive programs for cases that are low risk or screened out find positive results only when services are received (Loman et al., 2009).

In order for a helpline approach to have the intended results, community resources must also be available and accessible. For example, a multistate examination of the 211 system found that the capacity to meet certain social needs requests related to housing and financial support was less than 65% and, in some areas, as low as 15% (Kreuter et al., 2020). Other research on helplines has tended to focus on the provision of counseling or advice. A recent global review of child helplines found a significant increase in use during COVID, but it is not possible to understand whether such use had preventive effects (Petrowski et al., 2020). It should be noted that many helplines described in the literature are staffed by individuals trained to provide information or counseling, while 211 or CPS lines are designed solely to link callers to services or determine a fit for CPS response (Bloch & Leydon, 2019; Ingram et al., 2008).

Workforce training is a relevant piece of the helpline debate if helplines are to provide direct service instead of triage and referral. Positive engagement or interaction between workers and parents is associated with more positive child welfare outcomes (Gladstone et al., 2012). This highlights the need for a workforce that has the skills necessary to engage with parents, including those who may be

struggling with emotional dysregulation due to complex trauma histories (Banyard et al., 2003; Lavi et al., 2019; Noll et al., 2011; Ryan et al., 2006; Smith et al., 2014). University–child welfare partnerships such as the National Child Welfare Workforce Institute provide an opportunity to better prepare a diverse child welfare workforce (Bertram, Collins, & Elsen, 2020; Cross et al., 2015).

An important next step in understanding the benefits of these and other training initiatives is to assess their impact on case-level decision-making and client engagement. This includes understanding how changes in parent engagement and decision-making can be tied to cultural competency training. While there generally is consensus on the importance of cultural competency in the workforce and a variety of suggested approaches to build that competency, little is known about the impact of cultural competency (and associated trainings) on the actions of child welfare workers and on client outcomes. Much of the evaluation has focused on post-test assessment of caseworker attitudes (Johnson, Antle, & Barbee, 2009). This issue is not limited to child welfare: a synthesis of knowledge on models for training mental health professionals found that only nine out of 109 models included evaluation, only three included quantitative outcomes, and only one showed change (Bhui et al., 2007).

Research Gap in Alleviating Poverty and Increasing Economic Mobility

CPS 6. To what extent do income supports (e.g., universal basic income, antipoverty programs, paid family leave, tax credits) prevent CPS involvement and out-of-home placement?

- What is the impact of these programs alone and in combination with other family- preservation services for reducing CPS involvement and out-of-home placement and improving parent and caregiver well-being?
- How does effectiveness vary by practice and policy, subpopulation, maltreatment type, family structure, and by community and cultural context?

Context and Rationale

The association between child maltreatment and poverty has been established (Conrad-Hiebner, 2018; Pelton, 2015), but the role of poverty in decision-making and outcomes is less well understood (Kedell, 2014).

Material needs interventions. One recent review suggests that cash and in-kind transfers improve engagement and reduce further system involvement (Conrad et al., 2020). There is a small but growing body of literature on the effect of changes in income or material needs and maltreatment as measured by CPS system involvement. Cancian et al. (2013) found that modest changes in maternal income related to child support was associated with about a 10% decrease in maltreatment. Yang et al. (2019) also found a decrease in maltreatment related to childcare subsidy. Berger et al. (2017) and Klevins et al. (2017) found between a 3% and 10% reduction in maltreatment related to the Earned Income Tax Credit. Rostad et al. (2017) found that clients receiving material support were about 17% less likely to recidivate.

Looking at it from a different perspective, McLaughlin (2017, 2018) found that increased cost related to gas and cigarette taxes was associated with more maltreatment referrals at an aggregate level. Other studies have found associations with increased access to health care and maltreatment (Brown et al. 2019). Material needs and socioeconomic interventions also show promise related to neglect. As was mentioned above, a slow roll-out of universal childcare in Germany provided a natural experiment.

Sandner and Thomsen (2018) found a reduction of 0.24 cases per 1,000 children if a county increased childcare slots above the median across years of implementation. Raissian and Bullinger (2017) found that an increase in the minimum wage resulted in fewer reports for neglect.

While poverty is undoubtedly a strong factor in the risk for CPS involvement, we have much to learn about the strength of effects of various attempts to address material needs and income either alone or with other social services. While effect sizes have been modest, most studies have examined the effects of a single benefit or economic stressor rather than combined effects. To our knowledge, the combined effects of economic or material need services with other forms of intervention are also untested outside of impact on engagement, which might relate to response to other referrals (Conrad et al., 2020).

Research Gap in Collaboration

CPS 7. How are partnerships between child welfare agencies formed with various entities including researchers and community and institutional partners (e.g., public health, schools, legal advocates, courts, faith-based organizations, parents, foster care alumni/ parents) to reduce CPS involvement and out-of-home placement and improve parent and caregiver well-being?

- How is the effectiveness of the partnership measured?

Context and Rationale

Collaborative arrangements between providers as well as partnering between providers and families to increase engagement is a common strategy for intervening with high-risk and child welfare involved families in the U.S. and globally (see next sections). Agreed-upon core values, common goals, and strategic plans; promotion of interagency collaboration within and between organizations; open communications; and an evaluation process that includes a feedback loop have all been identified as important elements of community collaborations (De Carolis, Southern, & Blake, 2007). But we do not yet know which of these elements is most essential, what other characteristics may be important drivers of effective collaboratives, or how these efforts affect engagement in services and outcomes.

Community-driven, bottom-up approaches that involve members of the community (vs. providers only) are another important strategy to consider. This approach may lead to greater service usage and increased system effectiveness (Wessells, 2015). Theoretically, the inclusion of parents with lived experience as part of community initiatives could reduce their distrust of the system and increase engagement with prevention efforts, as well as with CPS workers (when warranted). However, we need to test these premises.

Out-Of-Home Care Research Gaps

Values Underlying This Research Area

Each of the workgroups operated with three core values in mind:

1. ***Gaps should be bold and transformative.***
2. ***Gaps should be filled by engaging individuals with lived experience.***[42] In a transformed system, power is shared with communities, including those with lived experience as recipients of child welfare and closely related services, such as behavioral health, economic assistance, housing, or substance abuse treatment. As described above, communities must be engaged to co-design practice, policy, and research, including how findings can best be used to support communities.
3. ***Gaps should address diversity, equity, and inclusion.*** More information is available on the DEI framework from the project website and any of the sponsoring foundations for this project.

For the out-of-home care topic area, the following additional values guided the work to identify research gaps:

4. ***We believe all children deserve to grow up in a resilient and loving family.***
    - Principle: Children have a right to be raised by their family. Families have a right to raise their children. Children should be raised by families and not institutions. In instances where this is not possible, children should be placed with relatives. The system of care strives to place children with relatives and to achieve safe, stable, and timely reunification with their families if the child cannot be placed with relatives in the first place.
    - Principle: Transformative out-of-home care policies and practices need to fulfill all the key mandates of the child welfare system—safety, stability, and permanency—to ensure uptake and lasting system change.
5. ***We believe the voices of children, youth, and families provide a road map for transforming the child welfare system into a child well-being system.***
    - Principle: The lived experience of alumni of care and their families are critical to system transformation. They must have a voice in defining key research constructs, such as wellness, neglect, safety, stability, family, kin, and reunification, as they are meaningful to their history, culture, and community.
    - Principle: Alumni of care and their families and resource parents must have a voice in making meaning of all data collected.

[42] People with lived experience are those individuals or families who have been reported for child maltreatment, subject to a child protective services investigation or received a child welfare or closely related service.

6. ***Research is most valuable when equitable evidence-building is translated into actionable implementation strategies to transform child welfare practice in the real world.***

   - Principle: Transformation of child welfare practice will include technology innovations that improve workforce training and coaching; put youth, caregiver, and frontline practitioners' perspectives at the center of inquiry; and embed meaningful data collection into real-time child welfare practice.

Research Gaps That Center System Transformation Around People with Out-of-Home Care Experience

OOHC 1. What child welfare and related policies and practices contribute to the most successful outcomes for children and youth placed in out-of-home care? This includes children and youth of all identities, acknowledging that there are certain groups that the data tell us are more vulnerable to experiencing inequities in services and outcomes, such as American Indian/Alaska Native, Black, Latinx, and GLBTQQ children.

- How can policies and practices address any inequities in services or outcomes for children and families in these groups?
- How can policies and practices address any inequities in services or outcomes for children and families in these groups?

OOHC 2. Does the involvement and consultation of alumni of care, youth who are currently in care, parents, kinship parents, and other caregivers help improve the quality and safety of out-of-home care?[43]

- What services currently in place in out-of-home care are effective and who are they effective for?
- To what extent might the outcomes be better for children and families if they had an integral role in their care plan?
- To what extent would having access to support 24 hours a day and seven days a week better help parents and families?
- Does dual case management improve child outcomes? (I.e., Does a dual service provider approach or a multi-agency dual case manager approach result in better outcomes for children who are in foster care and their parents?
- What dimensions of care constitute a successful out-of-home placement based on the lived experiences of youth with individual and intersecting identities based on (1) ethnicity or race; (2) sexual orientation/gender identity, and expression; (3) disability status; (4)

[43] Selecting which youth in care and foster care alumni to interview must be done carefully. It is important to involve alumni who have recently left care in any research effort. Systems do evolve in certain ways, and 30-year-old alumni may have experienced practices or been affected by policies that no longer exist. However, system change can be informed by alumni of all ages because the foster care system has not evolved as much as it needs to in many areas, and because with age comes wisdom and insights that younger alumni may not have.

immigration status; (5) parenting status; (6) juvenile justice status; and/or (7) family incarceration status?

- What cultural differences in parenting practices affect assessment of family functioning? How can we build evidence for culturally grounded parenting practices?

Context and Rationale

The gaps reflect a growing values stance that youth and parents have a right to help shape what services are provided to them and how those services are delivered. Many public and voluntary child welfare agencies are making earnest efforts to involve community stakeholders and people with lived experience in planning as well as in service delivery. One diagram that describes this approach was recently developed by a child welfare researcher and some constituent consultants. (See Figure 3.)

Figure 3. Constituent Engagement Around Research

Source: George G., Long, T., & Phipps, T.. (2020). *Early and Enough? Partnering with Consumers in Evaluation Processes.* Presentation for the KEMPE Center national conference, October 6, 2020. Washington, DC: WESTAT.

Research Gaps in Ethnic-Racial Patterns of Placement

The goal is to eliminate differences in care and outcomes that specifically disadvantage youth of color in terms of safety, permanency, and well-being. Note that families' lack of access to effective children's mental health services — and racial and economic inequities in access to those services — may contribute to inequities in adolescents' entry to foster care and racial inequities in entry to the juvenile justice system. Factors such as explicit and implicit racism in child welfare practices and policies, poverty, race, ethnicity, and youth characteristics may be operating.

OOHC 3. What are the ethnic-racial patterns of out-of-home care (e.g., type, quality, restrictiveness)? What factors drive these patterns, and how do they affect child well-being?

- How does disparity in upstream systems (e.g., housing, TANF) lead to disproportionality in the child welfare system?
- How might contemporary child welfare-related policies and practices, structural racism, and other forms of discrimination contribute to—and be changed to eliminate—these differences (e.g., decision-making groups that do not consider race and ethnicity)?
- How do patterns of placement characteristics vary in terms of type, quality, restrictiveness, time in care, and rates of termination of parental rights across various jurisdictions (e.g., counties, states)? How might explicit and/or implicit ethnic-racial bias on the part of workers, judges, lawyers, court-appointed special advocates (CASAs), and other decision-makers contribute to these differences? If or where bias may exist, how can it be measured empirically (e.g., actual decisions, placement data)?
- If or where bias exists, are there evidence-based practices to reduce biased behaviors among child welfare or other allied professionals?
- To what extent, if at all, do we need to adapt evidence-based practices to meet the needs of specific groups of youth and families?

Context and Rationale

One of the goals in this area is to eliminate differences in care and outcomes that specifically disadvantage youth of color in terms of safety, permanency, and well-being. Note that families' lack of access to effective children's mental health services — and racial and economic inequities in access to those services — likely contribute to inequities in adolescents' entry to foster care and racial inequities in entry to the juvenile justice system. Factors such as explicit and implicit racism in child welfare practices and policies, poverty, race, ethnicity, and individual youth characteristics need to be considered.

Ethnic-racial minority groups, particularly Black and Native American/Alaska Native children, are overrepresented in the child welfare population generally, and particularly among children in out-of-home care (Wildeman & Emanuel, 2014). However, the existence and reasons for disproportionality remain the subject of considerable controversy centered on the expression of population differences in rates and severity of child maltreatment versus the operation of systemic ethnic-racial bias (Cooper, 2013; Hill, 2004; Myers et al., 2018). Ongoing debate regarding the existence of ethnic-racial disproportionality in child welfare speaks to the need for well-designed investigations to ascertain ethnic-racial differences in out-of-home care and elucidate their root causes. Although ethnic-racial differences in rates of child welfare service referral and substantiation are best left to the consideration of the CPS and Foster Care Prevention workgroup, there is a pressing need for innovative research studies to examine the existence, etiology, and impact of ethnic-racial differences in the form, quality, and restrictiveness of out-of-home care decisions.

There has been very little research on whether and why children from different ethnic-racial groups may experience different out-of-home settings with regard to form, quality, or

restrictiveness, beyond well-established evidence that Black children are more likely to be placed in kinship care (both informal and formal) than children from all other ethnic-racial groups (Harris & Skyles, 2008). Compared to other ethnic-racial groups, Black (male) youth are also more likely to experience a congregate care setting (Wulczyn et al., 2015). Some data suggest that Latinx children also experience longer durations of out-of-home care, with lower rates of family reunification (Church II, Gross, & Baldwin, 2005), and similar patterns characterize the foster care experiences of Native American/Alaska Native children, though evidence suggests that the reasons for these patterns may vary meaningfully across ethnic-racial groups (Lawler, LaPlante, Giger, & Norris, 2012).

Importantly, ethnic-racial differences in patterns of out-of-home care are likely to have significant implications for child adjustment outcomes. On one hand, kin care has been associated with more limited access to mental health services (Leslie, Hurlburt, Landsverk, Barth, & Slymen, 2004), poorer reading achievement (Font, 2014), and longer stays in out-of-home care with lower rates of family reunification (Harris & Skyles, 2008). But studies have also shown that children placed with relatives have fewer placement changes and better behavioral and mental health functioning than children in foster care, as well as higher rates of permanency and less time in care (Ching-Hsuan, 2014; Winokur et al., 2014). Because the research findings are mixed, we need to better understand what resources are needed to support kin families.

Research Gaps in Reunification, Adoption, and Legal Guardianship

OOHC 4. What child welfare services are effective in promoting safe, stable, and timely reunification, adoption, and legal guardianship? Reunification services include intervention models and strategies that are based on a set of shared values concerning the centrality of family in practice.

- What are effective strategies to recruit non-kin resource parents who can work in partnership with biological parents toward safe and stable/sustained reunifications?[44]
- What explains disproportionalities in who gets reunified in terms of race/ethnicity; sexual orientation, gender identity and expression; age; disability status; parent-worker racial concordance; or other sociodemographic factors, and what can be done to reduce these differences? We need to look beyond the attainment of reunification to understand what factors promote successful reunifications. What specific judicial, attorney (family defense, guardian ad litem, prosecutor), and/or caseworker practices, strategies, and services promote stable family reunification, adoption and legal guardianship?[45] Do families have the supports and services they need to maintain their children at home? What supports do parents and youth say are needed to support reunification?
- What are permanency outcomes over several years? Do reunifications, adoptions, and guardianships endure for two years? Five years? Until the age of majority? Are lifelong

[44]Some non-relative resource parents end up wanting to adopt children; this desire poses a huge challenge for collaboration with birth parents. How can resource parents be committed to children's well-being and support birth parents?

[45] One consideration is who defines *stable family reunification*? Can people with child welfare system experience — the families the system is supposed to serve — help create this definition, as well as the definition of *permanency*? (Personal communication, Robyn Robbins, February 12, 2021).

familial connections strong for young adults with foster care histories in terms of birth families or other families that they live with?[46]

- Do youth, particularly sexual and gender minority youth, have a supportive home environment that will allow them to maintain a safe and stable home life?
- How might explicit or implicit bias on the part of caseworkers, judges, attorneys, or CASAs be a barrier to family reunification?
- How does use of a CASA and an attorney impact child outcomes? What percentage of children have this representation? Does it differ by race or age?
- What service or combination of services can claim an evidence base for promoting family reunification, timely adoption, and legal guardianship (i.e., what type, dose, and intensity of services, along with what kind of curricula was used to train staff)?
- More research is needed on the factors beyond child welfare systems that affect reunification. What roles do legal advocacy and court leadership play? How do child welfare workers and judges make their decisions on reunifications? Which evidence-based services best match the needs of families with different characteristics (e.g., parents with substance abuse, mental health, or domestic violence problems)? How, if at all, are these evidence-based services culturally and linguistically responsive? Are policies that encourage automatic (or virtually automatic) removal of babies who are drug-positive at birth a contributing factor to the disproportionate removal rates in certain states?
- To what extent does a sustained relationship between parent(s) and child after removal impact outcomes post-reunification?
- Does the amount of time that biological parents spend with the child each week have an impact on reunification? How does the nature of the visit impact reunification outcomes?
- Is there evidence that the relationship between foster parents and parents of children in foster care have an impact on reunification outcomes?

Context and Rationale

Helping a child achieve emotional and legal permanency is one of the three core goals of child welfare. How we achieve that and what factors impede or facilitate permanency is an important area of research. Despite the many studies that have been completed, there are knowledge gaps that need to be filled.[47]

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[46] Included in this decision-making is equitable power distribution/sharing in decision-making. For example, lawyers and judges — who often have spent the least amount of time with families — have higher power status than caseworkers and families making decisions about those families (Personal communication, Matthew Claps, March 2, 2021).

[47] See for example:

- Berrick, J. D., & Hernandez, J. (2016). Developing consistent and transparent kinship care policy and practice: State mandated, mediated, and independent care. *Children and Youth Services Review*, 68, 24–33.
- Casanueva, C., Burfiend, C., & Tueller, S. (2016). *Patterns of foster care placement and family reunification following child maltreatment investigations.* U.S. Department of Health and Human Services, ASPE.
- Hines, A. M., Lee, P. A., Osterling, K. L., & Drabble, L. (2007). Factors predicting family reunification for African American, Latino, Asian and White families in the child welfare system. *Journal of Child and Family Studies*, *16*(2), 275–289.

Research Gaps in Preventing Re-entry into Out-of-Home Care

OOHC 5. What are effective strategies to reduce re-entry to care for different age groups, such as infants or teens in out-of-home care? How might the provision of post-reunification services (e.g., timely in-home crisis intervention services or other services) promote stable reunification and prevent re-entry into out-of-home care?[48]

- Are there benefits to continuous involvement with some kind of service following reunification, adoption, or guardianship?
- To what extent would continuous involvement in a child's case after reunification of a certain length, type, and dosage level have a positive impact on children and families in terms of functioning and rates of re-entry into out-of-home care?
- What circumstances arise—and what specific supports are needed—for aging caregivers to prevent disruptions in legal guardianship and adoption?
- What does re-entry look like beyond two years post-reunification? How does it differ by race, ethnicity, and age of the child?[49]

Context and Rationale

Foster care re-entry is becoming more well recognized as a challenge for the field (e.g., Goering & Shaw, 2017; Koh & Testa, 2011; Parolini et al., 2018; Roberts et al., 2017). For example, a recent study of data from 20 states found that of all children who exited their first spell to reunification, 27% re-entered care by 2018 and of all children who exited their first spell of foster care to live with a guardian, 17% re-entered care by 2018 (Wulczyn et al., 2020).

Research Gaps in Marginalized Groups

OOHC 6. How do youth in foster care who identify with one or more marginalized identities experience out-of-home care? In what ways are their experiences similar or dissimilar to their majority-group peers?

- Spieker, S.J., Oxford, M.L., & Fleming, C.B. (2014). Permanency outcomes for toddlers in child welfare two years after a randomized trial of a parenting intervention. *Children and Youth Services Review*, 44, 201–206.
- Winokur, M., Holtan, A., Batchelder, K. E. (2014). Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment. *Cochrane Database of Systematic Reviews*, 1. Art. No.: CD006546. doi: 10.1002/14651858.CD006546.pub3

[48] For children not reunified and placed with kin, we should also be focusing on post- permanency services for them to ensure these placements remain stable.

[49] Note that we already have some research in this area. See for example:

- Parolini A, Shlonsky A, Magruder J, Eastman AL, Wulczyn F, & Webster D. (2018). Age and other risk factors related to reentry to care from kin guardian homes. *Child Abuse and Ne*glect, May;79:315-324. doi: 10.1016/j.chiabu.2018.02.024. Epub 2018 Mar 20. PMID: 29510346
- Wulczyn, F. & Parolini, A. & Schmits, F., Magruder, J. & Webster, D. (2020). Returning to foster care: Age and other risk factors, *Children and Youth Services Review*. 116(C). DOI: https://www.sciencedirect.com/science/article/pii/S0190740920305168?via%3Dihub

- How can we adapt evidence-based practices to meet the unique needs of youth and families who identify with one or more marginalized groups?
- What factors promote positive identity development, particularly ethnic-racial and/or sexual orientation/gender identity development, among youth from under-represented groups in out-of-home care?[50]
- How can we support youth who identify with one or more marginalized identities to identify and negotiate their unique experiences and fears (e.g., fear of ridicule, violence, rejection)?
- In what ways, if at all, does matching based on ethnicity/race, sexual orientation, and other dimensions of workers, resource parents, CASAs, etc., promote positive outcomes for marginalized youth in foster care?

OOHC 7. ***MEPA Issues and Impact:*** How do workers (including foster and adoptive parent licensing workers) experience the implementation of the Multiethnic Placement Act (MEPA) of 1994, as amended by the Interethnic Placement Act (IEPA) of 1996?

- Does MEPA benefit or impose burdens or restrictions to practice? How, if at all, do MEPA and IEPA affect racial disproportionality and disparity?
- Despite the difficulty in changing major federal law, are changes needed?

Context and Rationale

Each of these gaps could be addressed with respect to individual and intersecting identities based on (1) ethnicity or race; (2) sexual orientation, gender identity and expression; (3) disability status; (4) immigration status; (5) parenting status; (6) juvenile justice status; and (7) family incarceration status. Children and youth who identify with one or more marginalized identities may experience out-of-home care differently based upon the county or state where they reside and how and why they entered care.

Whether due to child abuse or neglect, to sociodemographic factors correlated with entry into out-of-home care, or to out-of-home care itself, youth in foster care face disproportionate barriers to self-determination and agency. These barriers may be further magnified among those who identify with one more marginalized subpopulations based on sexual orientation, gender identity, gender, ethnicity-race, ability, legal status, or other factors. Self-determination means “having the power to make decisions, to direct one’s actions, to dream and take risks, and to exercise rights and responsibilities” (Powers et al., 2012, p. 2181). We must seek to ensure that all youth in foster care have this opportunity by identifying and removing structural barriers that hinder their capacity to realize their full potential.

A positive sense of self and one’s identities is central to positive adaptation for all youth but perhaps especially for youth who encounter elevated rates of discrimination and marginalization (Marcelo & Yates, 2018). For example, what positive and negative roles do resource parents play in identity development for youth who identify with a marginalized identity?

[50] Studies might also explore the impacts of youth having to conceal parts of their identities for fear of retribution (e.g., hide that they identify as LBGTQ). Does this lead to youth not getting specialized care that they need (e.g., specialized health care, mental health care, reproductive/sexual health care, hormone therapies).

Thus, efforts to identify features of the out-of-home care experience that hinder or promote positive identity development have tremendous potential for enhancing positive development among marginalized youth in foster care (White et al., 2008). As these efforts progress, we encourage sensitivity to the dynamic, rather than static, nature of how youth identify (e.g., youth reports of ethnicity-race may change over time; Schmidt et al., 2015) as well as to the multiple groups with which youth identify (e.g., multiracial youth, youth who identify with multiple marginalized communities; Grooms, 2020).

One of the research gaps listed above focuses on the Multi-Ethnic Placement Act and its successor. Since MEPA and the Adoption and Safe Families Act, adoptions increased by 22% from 2005-2007 to 2017-2019. The proportion of transracial adoptions (those in which the child is not of the same race as either adoptive parent) also increased, from 21% to 28% of all adoptions. Nevertheless, hundreds of thousands of children—more than 50% children of color—currently remain in foster care as they await permanent home placements.[51]

Research Gaps in Infants and Young Children

Note that the research gaps related to adolescents are listed in the lower priority group, and are also mentioned in some of the other research gap sub-questions.

OOHC 8. What are effective strategies to promote permanency outcomes for infants and very young children in out-of-home care (including situations in which infants and young children are in out-of-home care with their mothers)? Are there any inequities in services or outcomes for these young children and their families?

- What are the practice models for caring for and providing effective support for infants in foster care?

  What are effective strategies to promote positive parenting and successful reunification for substance-involved and intimate partner violence–affected families with very young children?[52] For example, some Title IV-E Demonstration Waiver projects found recovery

[51] Research by Mathematica Policy Research (2020) has uncovered some key racial differences in the adoption data for the United States, including:

- Adoptions of Black children in 2017–2019 were 22% lower than in 2005–2007, whereas adoptions of white and Hispanic children increased by 41% and 36%, respectively, in the same time period. The decline in adoptions of Black children was largely due to a declining number of Black children in foster care over the time period (43% less).
- A child's race is associated with the time spent in foster care before adoption. Black children adopted between 2017 and 2019 spent the longest time in foster care before adoption—an average of 33 months—compared to 27 months for white children and 28 months for Hispanic children. [Do these data imply the presence of racial bias against Black children? Note that Black children are more likely to be adopted by their relative caregiver and relative adoptions are a fast-growing trend line. It could be that the system is trying to be especially sensitive to Black families and the time they may need to come to an adoption decision.]
- Raising awareness of these trends in adoption may help federal and state policymakers focus resources, technical support and outreach strategies to states that need to improve their recruitment and retention of a diverse pool of adoptive and resource parents. (Mathematica, 2020)

[52] The effectiveness of many program strategies for substance-involved families with young children and families affected by intimate partner violence is hindered by codependency among parents. Often, reunification is unsuccessful because one parent is not willing to part ways with the parent who poses a risk to the child. In one

coaches to be an effective strategy. And in an initial CQI study, Utah found that in comparison with other families served in child welfare, families served by the whole family substance abuse treatment programs had higher rates of family reunification, and lower rates of repeat maltreatment and foster care reentry.[53]

- What are developmentally appropriate visitation practices to promote attachment security and timely reunification for infants in out-of-home care?[54] How can advances in neuroscience help inform practice in this area?
- How does time with family members and building relational permanence affect child and familial well-being and the achievement of legal permanency?[55]
- What are healthy coparenting practices for children who have been successfully adopted or placed in guardianships? (Current Children's Bureau demonstration grants only emphasize coparenting in situations eligible for reunification.)
- How can birth parents be engaged in permanency planning efforts for infants and young children when reunification isn't the goal?
- How can strategies that minimize delays in achieving permanency for infants and young children be designed to avoid compromising parent rights by minimizing the time allotted for reasonable efforts or progress to be made, or other problems?
- What are effective and culturally sensitive strategies to determine when adoption is the appropriate case plan?
- What is the role of specialized courts (e.g., Safe Babies Court Team Approach[56]) in determining best placements for infants and toddlers?

Context and Rationale

Because of their unique vulnerabilities, maltreated infants are more likely to be placed in foster care in the U.S. than children from other age groups. Infants are four times more likely to be placed in care than older children (Wulczyn et al., 2011), and they are the largest group of children entering care; in 2020, 20% of all children entering care were infants (Administration for Children and Families, 2021). About 10% of all entries include neonates under the age of 30 days (Wulczyn, 2019). Although rates of infant entries are high, they are not the same across states. From 2005 to 2014, infant entry rates rose in 22 states, with some states experiencing increases of over 90%, and in 2014, seven states placed one out of every 50 infants into foster care (Lloyd, 2019).

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study of the national Adoption and Foster Care Analysis Reporting System (AFCARS), Boyd (2019) found that while close to 17% of infant entries were due exclusively to parental substance abuse, fully one-half of entries included parental substance abuse as a contributing factor.

[53] Utah the Department of Human Services. (2021). *CQI Report: Parent Child SUD Residential*. Salt Lake City: Author.

[54] Studies in this area should pay attention to issues of codependence between partners, and strategies to promote coparenting — not just between biological parents, but also between biological parents and system providers. Research might explore video/virtual visits when in-person visits are not possible due to drug screen results or other "failure to comply" issues that do not pose a safety risk to the child but that typically cause visits to be canceled as punishment or as standard protocol.

[55] See, for example, https://www.casey.org/impact-on-legal-and-relational-permanency/

[56] See, for example, https://www.zerotothree.org/resources/services/the-safe-babies-court-team-approach

The characteristics of infants who enter foster care are different from the characteristics of older children who do so. Infants placed in foster care are more likely to be Black compared to older children, who are more likely to be White (Jones Harden, 2008). Some data suggest that excessively punitive drug sentencing policies have helped fuel some of this spike in foster care (Drug Policy Alliance, 2015; Roberts, 2012). In addition, some evidence suggests that high rates of entry to care among infants are driven to a large extent by parental substance abuse. In one study of the national Adoption and Foster Care Reporting System (AFCARS), Boyd (2019) found that almost 17% of infant entries were due exclusively to parental substance abuse, and fully one-half of entries included parental substance abuse as a contributing factor. Tonmyr et al. (2011) noted similar findings from their study in Canada. In a recent study of all births in California, of the 1.45% of infants diagnosed with prenatal substance exposure (*N*=7994), 61.2% were referred to child welfare, and about one-third (29.9%) were placed in care (Prindle et al., 2018).

Infants have unique placement patterns once they arrive in care. Placement stability for infants in care is notably better than for older children, but placement instability at any age is troubling and may have disproportionate developmental and mental health consequences for infants (Lewis et al., 2007). Infants need stable, nurturing, sensitive care to develop secure attachments and effective strategies for self-regulation (Dozier et al., 2013; Stahmer et al., 2005). Evidence from California indicates that infants experience an average of 2.58 placement changes per 1,000 days in care (Webster et al., 2020). Other evidence from the National Survey of Child and Adolescent Well-being indicates similarly troubling figures: more than 80% of infants with child welfare contact experienced at least one caregiver change over a two-year period, and about half (51%) experienced two or more caregiver changes (Casanueva et al., 2014).

Infants who arrive in care have rates of health and developmental concerns well above what might be expected in normative samples (Leslie et al., 2005; Rosenberg & Smith, 2008; Silver et al., 1999; Urquiza et al., 1994). Disruptions in sleep-wake, feeding, and self-regulation patterns present challenges for even the most adept and sensitive of resource parents. Some evidence suggests that there is a selection effect associated with the types of caregivers who are willing and able to take especially challenging children into their homes (Rubin et al., 2008). These selection effects are also evident in the case of infants. A study examining a nationally representative sample of children in care found that infants placed with relatives had fewer motor and cognitive delays and easier temperaments (Stacks & Partridge, 2011), whereas infants who were more difficult to care for were usually placed with non-kin resource parents.

Following infants' stay in care, permanency patterns are unique. Some evidence suggests that infants younger than three months at entry remain in care longer than older infants and longer than children of any other age (Stacks & Partridge, 2011; Wulczyn et al., 2011). Longer lengths of out-of-home care for very young infants may reflect higher adoption rates as compared to older infants (Barth et al., 1994), which often entail lengthy finalization processes. For several decades, infants have been viewed as more "adoptable" than older children. A seminal child welfare text from 1974 suggested that "for adoptive purposes, a child of two is 'middle-aged' and a child of five is 'old'" (Kadushin, 1974, p. 589). Although these characterizations seem antiquated in the context of contemporary child welfare practice, data on potential adoptive parent preferences

suggest that many U.S. adults prefer infants to older children in the adoption decision (Dave Thomas Foundation, 2017; Ishizawa & Kubo, 2014; Jones, 2008).

Data on adoption from foster care supports these findings, as the odds of adoption for children placed in care as infants are notably higher than they are for any other age group (Barth, 1997; Berrick et al., 1998; Snowden, 2008). Research evidence has also found that children who exit foster care through adoption or guardianship prior to the age of 5 years are less likely to re-enter foster care. Innovative approaches exist to help infants achieve legal permanency. For example, Baby Courts help ensure that specialized assessment and careful decision-making are applied. The Illinois Birth through Three (IB3) IV-E Waiver Demonstration focused explicitly on infants and saw significant increases in family reunification in the intervention group, relative to the comparison group (Illinois Department of Children and Family Services, 2018).

For children placed in care as infants, the odds of returning home through reunification are low (Connell et al., 2006; Courtney & Wong, 1996; WESTAT, 2001), and the infants who return home have a higher-than-average likelihood of returning to care. Although the re-entry rate for elementary school-age children is approximately 16.3% (Barth et al., 2008), rates for infants are typically closer to one-third (Frame et al., 2001; Wulczyn et al., 2011).

Efforts to identify evidence-based strategies to promote stable reunifications for infants have been limited. Although early studies indicated that frequent visitation was associated with reunification, more recent work to *require* frequent visits in Australia raises doubt about forced visitation as a key to success (Humphreys & Kiraly, 2011). That is, parents who frequently visit with their children without the coercion of the state may be those most likely to reunify anyway. Other efforts to promote reunification and permanency more broadly have been more successful. Coaching interventions for birth parents and intentional, intensive parenting interventions targeting both biological and resource parents have been shown to promote permanency for very young children (Bernard et al., 2013; Fisher et al., 2005; Spieker et al., 2014). Likewise, efforts to promote secure attachment relationships between parents and young children seem especially effective (Dozier et al., 2006).

In many jurisdictions, the large majority of infants and toddlers entering care have parents who are substance-involved (Ghertner, 2018). While intentional efforts to promote reunification for substance-involved families have suggested positive effects, the benefits are very modest (Ryan et al., 2006). New efforts to identify robust evidence-based strategies to interrupt parental drug involvement and the behaviors associated with drug involvement that thwart sensitive caregiving are urgently needed. Culturally and racially appropriate robust evidenced-based strategies are needed, including whether accessible and effective pre-natal programs for pregnant women at risk of all ages and ethnic group affiliation reduce rates of removal.

Research Gaps in Resource Parent Recruitment and Retention

OOHC 9. How can we develop evidence-based recruitment, screening, and matching practices to engage highly effective resource parents for children in out-of-home care? (“Highly effective” would be defined in the RFP but might include such dimensions as the ability of the resource

parents to support the overall case plan, coordinate with birth parents, and support child development and well-being.)

- What are effective strategies for recruiting and training highly effective resource parents, particularly from ethnic minority communities? How often are BIPOC staff, veteran resource parents, and community stakeholders meaningfully involved in the recruitment and retention process?
- What are some effective evidence-based strategies for recruiting families to foster and adopt children in rural communities? For recruiting families from underrepresented groups in rural communities?
- Is there equity in the recruitment of resource families? Has the use of agencies based in communities of color been an effective strategy to promote the recruitment of American Indian, Black, and Latinx families?
- How would child-parent matching practices be different if they were based on the experiences and recommendations of alumni of care and youth in care? What barriers do would-be resource parents encounter in the approval process (e.g., lack of timely communication, unacceptably complicated or slow screening procedures, licensing strategies that reflect the institutional racism often encountered by American Indian/Alaska Native, Black, and Latinx families)?[57]
- To what degree do licensing requirements (e.g., number of beds/bedrooms, lack of expungement or disregard of previous unrelated criminal offenses) prevent kinship placements when there are no safety concerns? How can the approval process be informed by the experiences of families of color? What efficiencies have been or can be developed to support ethnic minority applicants and streamline the process?[58]
- How can resource parents serve the entire family (not only the children) through shared parenting and other strategies? (Note that this is not about resource parents serving as ambassadors from the system to "fix" the biological family.)[59]
- What are effective practices for targeted recruitment of resource parents in LGBTQ communities, given that a disproportionate number of youth in care are LBGTQ?

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[57] Some experts believe that many agencies still recruit families who approach the child welfare system solely to adopt a child. "Many families and system representatives are still here to "rescue children." The existing system needs to be replaced, not fixed" (Personal communication, Robyn Robbins, February 12, 2021).

[58] In some states, such as Indiana, potential kin placements are disqualified for not being able to pass a drug screen for marijuana, so the child goes into foster care. How is this situation different in states where medical or recreational use of marijuana is legal? Is there evidence that the current standard/practice of denying placement with kin due to marijuana use and placing them into foster care is better for children? Also, in Indiana, disqualification is usually a "one chance" situation — for example, if an aunt or grandparent appears at the initial hearing and states that they "can't pass a drug screen for marijuana today, but give me two weeks and I can, and I'll give up marijuana to take in my nephew/grandchild," their request is often denied and the child placed into foster care. What policy revisions are needed, especially in states where recreational marijuana is legal, and many functional, healthy and responsible adults use marijuana occasionally with no known detriment to their children.

[59] The redefining of foster care as a substitute for parents into a support for families is just a small part of creating a relationship-based system of care. I have experienced both nationally and locally the success of systems built by people with lived experience focused on relationship building as the core value. (Personal communication, Robyn Robbins, February 12, 2021).

- What are effective practices that promote the licensing of kinship caregivers?[60] Do poverty and other barriers or biases prevent the necessary kinship parent supports from being provided?[61] Does a bias against kinship caregivers exist, and how do we change that so that children who need resources receive them without being penalized because they stay with a relative versus a foster family?[62] Do criminal background checks prevent kinship placements, particularly for families of color?

OOHC 10. What are effective strategies for retaining highly effective resource parents?

- What are the factors that contribute to resource parent turnover rates?
- Will providing effective support and training lead to higher rates of retention of foster parents?

Context and Rationale

One of the major reasons for a shortage of resource parents in many communities is that too many resource parents do not continue to foster after their first child—with some even requesting that the child they are caring for be moved to another home. While New Jersey and other states have implemented increased staff visitation and support of new placement situations, these and other strategies need to be tested—and scaled up if they are successful.

All too often, the traumas associated with foster care entry are compounded by ongoing threats associated with the quality of out-of-home care (Konijn et al., 2019; Rubin et al., 2007). Care quality is directly related to the supply of qualified caregivers available to support children in need, but problems of resource parent recruitment and retention are widespread. Ample evidence demonstrates that the supply of available resource parents does not meet the demand for care from children (Kelly et al., 2018); this phenomenon extends beyond the United States (Ciarrochi et al., 2012), and these resource gaps are particularly pronounced in communities of color (Marcenko et al., 2009). Although recent national studies suggest an overall increase in the number of available foster parents, 20 states still show a significant discrepancy between the

[60] The Emergency Child Care Bridge Program in California established a new statewide funding stream in the early childhood education system (ECE) directed to county child welfare departments implementing in partnership with local ECE agencies. Key elements of the program include braided funding for vouchers, essential services that promote family well-being and self-sufficiency, trauma-informed training for ECE providers and co-located navigators in child welfare offices. Taken together, these components have increased the willingness of resource parents (particularly kin) to engage and stay engaged with child welfare. Can California's approach be expanded to other states that support access to ECE for resource parents? (Personal communication, Jacquelyn McCroskey, December 30, 2020)

[61] For example, in Kentucky under Family First, there are two options for relatives to receive payment for being a foster parent. If you are a caregiver who has resources, such as bedrooms of a certain size, etc., you can receive the full foster payment amount, the same as a nonrelative licensed foster parent. However, if you can't provide the same level of accommodations, you only receive half of the foster payment. This is difficult situation for kinship families because sometimes they have no notice when a child they are related to has been removed and needs a placement, and many aren't as prepared financially as a nonrelative foster parent would be. This is a financial barrier that prevents those who most need the financial assistance from receiving it. How can a mindset shift be made to change this situation? (Personal communication, Norma Hatfield, February 24, 2021)

[62] One of the kinship parent workgroup members attended an event with child welfare leaders from more than 20 states. Most leaders stated or implied that additional services for kinship parents were not needed. One state representative said, "They love their grandkids and want to take care of them, so we don't need to offer as much as we do to get nonrelative foster families." (Personal communication, Norma Hatfield, February 24, 2021)

number of children needing care and the number of foster caregivers available to serve them (Fostering Media Connections, 2019).

Further, the most recent national study of resource parent characteristics, an indicator of match between children's needs and caregiver characteristics, was conducted more than two decades ago (U.S. Department of Health and Human Services, 1993), and the National Study of Child and Adolescent Wellbeing (NSCAW), a national study of children touched by the child welfare system, was launched more than a decade ago (Barth et al., 2008). Even with two additional study phases, those landmark studies leave many unanswered questions about how resource parents learn about foster caregiving and what draws them to participate.[63]

An examination of recruitment strategies used by a wide range of public child welfare agencies in one state revealed remarkable heterogeneity in approach and message (Berrick et al., 2011). The variation in strategies mirror those characterizing best practices within the professional community (Pasztor et al., 2005), and many have intuitive appeal, but few have been tested for effectiveness.

Once potential caregivers show an interest in care, there is limited information about who persists through the resource parent approval process and who drops out. Moreover, there is little information about when or why caregivers desist. Some sources suggest that upwards of one-quarter of U.S. adults have considered becoming resource parents (Dave Thomas Foundation for Adoption, 2017), though there is an obvious gap between reported interest and executed action. States vary in their stated criteria for foster care providers, as well as in their required training to become providers. In some cases, these criteria may block viable out-of-home care providers from obtaining approval to bring a child into their home. In other cases, bureaucratic problems (e.g., paperwork delays, inattentive workers) may pose powerful obstacles (Shlonsky & Berrick, 2001).

Which individuals are screened-in and screened-out as approved resource parents is entirely opaque. Screening is not standardized across jurisdictions, and there is a lively debate about whether standards of care should be raised to ensure greater resource parent quality (see lessons from adoptive parent recruitment in Crea et al., 2011) or adjusted to increase the pool of available homes (Colton et al., 2008). Although screening tools have been developed by researchers and others (Luke & Sebba, 2013; Orme et al., 2007; SAFE at home[64]), only a few are in widespread use, and we have no research evidence to indicate where the cut-off point should be set to ensure quality care. Whether and how these "leaks" in the pipeline affect potential caregivers, especially caregivers of color, and how those issues might be addressed is urgently needed.

With an ample supply of approved caregivers, child welfare professionals might thoughtfully engage in matching practices that connect children with adults who have the capacity to meet their unique needs. Much has been written about the purported benefits of matching the characteristics of children with their caregivers. Most studies rely on the views of workers about their beliefs, however, rather than about evidence of effects; the research on this issue is also

[63] For more information about the NSCAW studies, see https://www.acf.hhs.gov/opre/project/national-survey-child-and-adolescent-well-being-nscaw-1997-2014-and-2015-2022

[64] See SAFE home study: structured analysis family evaluation, http://www. safehomestudy.org

largely dated and notably thin (Zeijlmans et al., 2017). Methodologically rigorous studies that examine matching effects of caregiver characteristics and capacities with children and their needs would be a welcome addition to the field.

Because of the implications for children's well-being, there is a pressing need to identify barriers to securing and maintaining high-quality out-of-home placements. Although this research gap is present for both relative and non-relative foster placements, we advise separate investigations of each caregiving context given the likelihood that barriers to securing caregivers, challenges to sustaining positive care provision, and opportunities for intervention will vary meaningfully across out-of-home care contexts (Bissell, 2017). The distrust of kinship families by some child welfare systems should be assessed and, if found to be present, addressed.

In 2016, the Annie E. Casey Foundation published a comprehensive summary of extant needs and approaches to meeting many of the challenges pertinent to recruiting highly effective foster care providers (Annie E. Casey Foundation, 2016). Moving forward, there is a pressing need to evaluate, disseminate, and implement effective strategies to further understand and meet these challenges.

Research Gaps in Kinship Diversion

OOHC 11. What are the child and family experiences and outcomes associated with kinship diversion, and how do these compare to kinship foster care?[65]

- How many children are cared for under kinship diversion? Are there disproportionalities in who receives kinship diversion in terms of geography (i.e., state or county, urban or rural), race/ethnicity, gender, sexual identity, or other characteristics?
- Are there differences in the characteristics, needs and strengths, or levels of risk for children and caregiver factors and characteristics in kinship diversion compared to kinship foster care?
- What do we know about which kinship caregivers are deterred by formal processes or who opt for informal/diversion placement status (which often means less or no money, supports, etc.)?
- Which states actively promote the use of kinship diversion? Which states restrict or prohibit its use? Do states that use kinship diversion see lower rates of kinship foster care? What contributes to disparate distributions in the use of kinship foster care, KinGAP, and kinship diversion across states?
- What are biological parents' experiences of kinship diversion? To what extent do the services they are offered match their needs? Are there unique challenges of engagement

[65] Most approaches to kinship care involve placing the child with a relative, who is then licensed or not licensed by the child welfare agency. *Kinship diversion* refers to "situations in which a child welfare agency investigates a report of child abuse or neglect, determines that a child cannot remain safely with parents/guardians and helps to facilitate that child's care by a relative instead of bringing the child into state custody. For jurisdictions that use kinship diversion, policy and practice vary considerably. State and county child welfare agencies have different approaches to safety assessments of the relative's home; post-diversion agency supervision and case management; the types and duration of services provided to the family; the transfer of legal custody/guardianship; and other requirements." See Annie E. Casey Foundation. (2013). *The kinship diversion debate: Policy and practice implications for children, families and child welfare agencies.* Baltimore: Author, p. 2. Retrieved from https://www.aecf.org/resources/the-kinship-diversion-debate/

when agencies try to offer supports? What rights do biological parents have regarding contact, visitation, and/or reunification? How do agencies involve fathers (and their extended families) in kinship diversion?

- How stable and how permanent is kinship diversion? How do children experience kinship diversion? How do kinship caregivers experience it?
- What are the child and parent well-being outcomes of kinship diversion (e.g., what is the long-term impact of kinship placement on family relationships)? How do these outcomes compare to kinship foster care outcomes, in which relatives are licensed and receive financial benefits and other supports? (Gathering the perspectives of youth and young adults who grew up in care with kin caregivers in operationalizing the definition of *well-being* would be important.)
- Are there costs to engaging in kinship diversion (i.e., to the state, to caregivers)? Are these potential costs playing out in ways that reify racist practices? Are diversion families receiving adequate financial support to successfully support the children in their care? Caregivers who don't need support in the form of monthly financial cash payments may still need support in the form of services (e.g., childcare, clinical services, peer support/relationship-building resources, educational supports, respite services, transportation assistance).
- What practices or evidence-informed approaches to kinship diversion would result in the most positive outcomes for children and families?[66]

Context and Rationale

For well over three decades, U.S. child welfare policy has promoted relatives as a preferred placement setting for children who require out-of-home care. Uniform national policies with regard to payment subsidies, training, support, and permanency have been incremental as policymakers have attempted to balance the competing concerns relating to family privacy and public accountability (Berrick & Hernandez, 2016; Berrick & Needell, 1999). Increasingly, though, states and jurisdictions are turning to relatives not as children's formal resource parents, but rather as an alternative to out-of-home care altogether. This is called "kinship diversion." The practice typically occurs at the request of a child welfare agency following a child maltreatment referral, investigation, and/or family team meeting (Crampton & Jackson, 2007).

Kinship diversion, sometimes referred to as "shadow foster care," is understudied (Gupta-Kagan, 2020). Some research suggests that the number of children living in kinship diversion may be as few as 135,000 to as many as 400,000, though data to support these claims are dated (Annie E. Casey Foundation, 2013; Main et al., 2006).[67] One study from more than a decade ago indicated that in 2007 nearly 30 states actively promoted kinship diversion, yet 12 states prohibited the practice altogether (Annie E. Casey Foundation, 2013). These differences suggest sharply different perspectives in public policy.

[66] The reports and consultation from Generations United might be especially useful for addressing this research gap.

[67] An estimated 2.7 million children live with kin, the vast majority of whom are outside the foster care system (https://www.gao.gov/assets/710/708020.pdf). Of course, not all of these are kinship diversion since many of these families don't touch the child welfare system at all.

In spite of its relatively widespread use, the field knows very little about the children and families touched by kinship diversion. Kinship diversion's benefits include its family focus and community-based response, as well as the cultural continuity children typically enjoy. Some of the differences between kinship diversion and kinship foster care, however, raise questions about children's, parents', and kin caregivers' rights. Unlike in kinship foster care, for example, assessments of caregiver strengths, needs, and abilities are not typically conducted in kinship diversion. Although caregivers may be offered referrals to local community-based agencies to meet service needs, these caregivers do not receive ongoing support or supervision, nor are they eligible for funding outside of basic cash assistance (TANF) and Medicaid healthcare coverage (Annie E. Casey Foundation, 2013).

Because these caregivers do not have a legal relationship to their relative child, they do not hold educational, medical, or custodial rights or obligations. These limitations on access to services, resources, and supports have implications for the children. Parents may benefit, but they also may be harmed by kinship diversion. Their rights, including rights to access and visitation to the child, access to services, or access to legal representation, are unaddressed under kinship diversion. As a rapidly growing alternative to the traditional child welfare system, information on kinship diversion is urgently needed, yet little research has been conducted to date.

Research Gaps in Distributive Equity

OOHC 12. How can we promote distributive equity (i.e., the provision of comparable services to children and their parents with similar needs) in out-of-home care? What do we know about the case-planning decisions and how interventions are selected for each child or family member in response to diagnosed needs and strengths?

- What are barriers to behavioral health equity, particularly with regard to accessing high-quality, trauma-informed interventions and/or evidenced-based practices, in the context of foster care?[68] How do these challenges vary across sociodemographic groups, and how can we mitigate them? How do we explore the difference and impact between trauma that occurs for children in their home versus trauma that is caused by child welfare system involvement?
- Are there differences by race/ethnicity, sexual orientation, and/or gender identity and expression in the use of psychotropic medications for youth in foster care? What do we know about the diagnostic requirements and other assessment and treatment processes that should be implemented before prescribing psychotropic medications for children and adolescents? How extensively are various kinds of psychotropic medications prescribed, and how do those rates vary by youth characteristics and community? What do we know about the effects of these medications on children over time? [69]

[68] While FFPSA is focused on services to families at risk of out-of-home placement, given FFPSA prioritization and promotion of evidence-based and promising practices, it seems that this is an important area for study. Most notably, how is FFPSA affecting the breadth of and equitable access to available EBPs? (Personal communication, Matthew Claps, March 1, 2021)

[69] For example, Texas has reduced use of psychotropic medication use by youth in foster care by about 30%, so there are pockets of innovation to study and learn from. See: https://www.dfps.state.tx.us/Child_Protection/Medical_Services/Psychotropic_Medications.asp

- How are we addressing the needs of LGBTQIA+ youth and their unique needs as an intersectional and marginalized group?

Context and Rationale

Within foster care, an equitable service framework holds that children with similar needs should receive comparable services. To the degree that the form, frequency, and/or quality of service provision varies for reasons other than the presenting needs of the child and family, there is distributive inequity (McBeath & Meezan, 2009). There is some evidence that children of color, particularly Black and Native American children, receive inequitable treatment within the foster care system and that these inequities transcend multiple domains.

For example, Garland et al. (2003) reviewed the literature on ethnic-racial patterns of mental health usage for children in out-of-home care and documented significant disparities. Likewise, in a national study of children ages 2-14 years using NSCAW data, researchers found that children and youth scoring high on a measure of mental health need were more likely to use mental health services than children and youth with relatively low scores; however, Black school-age children were least likely to use such services (Burns et al., 2004).

Children in out-of-home care typically attend poorer performing schools compared to children receiving in-home child welfare services or low-income children (Smithgall et al., 2004), but it is unclear whether additional inequities extend across groups within out-of-home care. Documenting the extent of distributive inequities in educational, health, and intervention services for youth in foster care and elucidating the factors underlying these disparities will help service providers respond appropriately to the needs of vulnerable children.

Research Gaps in Congregate Care/Therapeutic Residential Care

OOHC 13. How can child welfare (including resource parents) and behavioral health address the emotional and behavioral health treatment and complex medical needs of children and youth so that they do not need to be placed in group homes or residential treatment centers?[70]

- Why are Black youth over-represented in the use of group/facility-based placements? What sociodemographic factors such as poverty should be explored? What practices are being employed in jurisdictions where Black youth are not over-represented in congregate care settings?[71]
- How can agencies be supported in developing effective alternatives to group placements, including for young children, older children, children of color, youth at risk of commercial sexual exploitation, and pregnant and parenting teens?[72] What barriers exist to equitably accessing behavioral health and high-quality community-based interventions?

[70] One of the concerns in the field is that group homes are not solely used to address behavioral and emotional health treatment needs of children. Group homes are often used as placements for youth who are unable to be placed with resource parents. (Personal communication, Michelle Ziko, March 3, 2021)

[71] The Black community is outraged about the overuse of group placements with so many poor outcomes. Overuse of this placement option is seen as consistent with incidents of poor policing in the Black community, and has been called out as the “child welfare to prison pipeline” (Personal Communication, Sharon McDaniel, May 6, 2021).

[72] The foster care youth and alumni policy council recommends using “expecting (pregnant)” or “expecting and parenting,” so as to include fathers.

- How do we apply what we know are the most effective practice models for group homes and residential treatment centers to maximize treatment effectiveness, shorten length of stay, and improve permanency for youth placed in these facilities?
- What are the most cost-effective ways to fund behavioral health agencies to provide high-quality therapeutic group home and residential treatment services to youth with severe behavioral health risks/conditions that need intensive treatment?

Context and Rationale

The Family First Prevention Services Act (2018) restricts eligibility for federal funding for congregate care settings to two weeks (with some exceptions). The effort is a clear signal that federal officials prefer family-based settings over group placements, and financial incentives now align with these priorities. Group placements are seen, in most states and internationally, as a "last-resort" placement setting, rather than a preferred starting point (Knorth et al., 2008).

Developmental theory indicates that—at least for younger children—families are best situated to provide the care, attachment, and stability that children need (Berrick et al., 1998; Dozier et al., 2014). For older children, the evidence about the effectiveness of congregate care is mixed. Most studies are limited methodologically, but some studies that are more robust suggest disparate findings. Some studies show modest beneficial effects compared to community-based alternatives (Breland-Noble et al., 2004, 2005); some show no effects (Barth et al., 2007; James et al., 2012); and one study evidenced more positive effects for youth in group placements compared to treatment foster care (Lee & Thompson, 2008). Beneficial effects are typically noted as short term and do not generally appear to be sustained over time (DeSwart et al., 2012).

Because there is mounting evidence that many children served in group or residential treatment settings could be served with equal effectiveness in well-supported treatment foster care homes (Chadwick Center and Chapin Hall, 2016; Chamberlain & Reid, 1991; Henggeler et al., 2003; McCurdy & McIntyre, 2004), the additional costs associated with congregate care, as well as its greater degree of restrictiveness, call into question its suitability for large numbers of children in out-of-home care (James, 2011).

AFCARS data indicate that about 10% of children and youth in out-of-home care live in congregate care—4% in group homes and 6% in institutions (U.S. Department of Health and Human Services, 2018),—and these rates declined by 57% from 2005 to 2020 (U.S. Department of Health and Human Services, AFCARS data). However, substantial state variation exists in the use of congregate care, even for young children (Annie E. Casey Foundation, 2015). On balance, some children are more likely to be served in group placements than others, including boys, older youth, Black youth (Wulczyn et al., 2015), and children with behavior problems (James et al., 2006; Trout et al., 2008). A study of older youth in care, for example, indicated that the majority had spent some time in a residential treatment facility during their total stay in care (McMillen et al., 2004). In general, children in group placements are more likely to have been removed for reasons related to child behavior problems than due to child maltreatment, though many children in group homes and residential treatment centers have a behavior profile very similar to other children in out-of-home care (Chadwick Center and Chapin Hall, 2016; U.S. Department of Health and Human Services, 2015).

We know too little about why group placements are used for some children and youth. Although common notions of group placement usage suggest that children move sequentially from less restrictive to more restrictive settings, the evidence suggests otherwise. One study examining a nationally representative sample showed that among all children placed in a congregate care setting over a three-year period, fully half were placed directly into congregate care upon removal from their homes (James et al., 2006). A more recent study of first-time foster care spells in 15 states found that 15% of youth were placed in group care as their first placement (Zhou et al., 2021). These children typically have highly variable placement patterns (James et al., 2004; Zhou et al., 2021), and they frequently do not reflect a lower-to-higher restriction pattern (Farmer et al., 2003; James et al., 2004). Therefore, efforts to impose gatekeeping measures as a strategy to reduce or eliminate the use of group placements in child welfare will need to be implemented carefully so that child placement instability is not increased (Budde et al., 2004).

There is a growing consensus in the policy and practice community that congregate care should be limited to children with specific treatment needs, using evidence-based models administered by behavioral health staff, and that the use of group placements as a child welfare placement option should be ended. However, further study is needed to understand how placement decisions are currently made, to ensure that child welfare professionals have viable alternatives to group placements, to carefully select only those children who might benefit from time-limited congregate care, and to identify models of care that are responsive to children with varying needs. In addition, in light of new federal legislation strictly limiting funding for group placements, research is needed to understand the placement trajectories and well-being outcomes of children and youth who were placed in group placements but could have been served in a home or community setting.

Research Gaps in Juvenile Justice

OOHC 14. *Crossover Youth*: What factors contribute to youth in out-of-home care entering the juvenile justice system, and how can we effectively support “crossover” and “dual jurisdiction” youth?

- What are effective strategies to support collaboration and communication between child welfare and juvenile justice systems in the service of promoting positive development for youth who experience both systems sequentially or concurrently? *We specifically encourage efficacy studies of multidisciplinary team (MDT) approaches to cross-system collaboration.*
- What evidence-based strategies reduce the probability that youth in out-of-home care will become involved with the juvenile justice system and/or the probability that youth who have transitioned from juvenile justice into out-of-home care will re-enter the juvenile justice system? How, if at all, do these education and behavioral health strategies need to be tailored in any way for youth involved in gangs? *We specifically encourage efficacy studies of Multidimensional Treatment Foster Care (MTFC), Functional Family Therapy (FFT), and Functional Family Therapy-Foster Care.*

- What accounts for the overrepresentation of American Indian/Alaska Native, Black, Latinx, and multi-racial children in the population of crossover youth? Who is reporting child welfare-involved youth to the juvenile justice system (e.g., school staff, resource parents)? How, if at all, does the path to the criminal justice system differ for youth in foster care and youth not involved with child welfare?[73] How do these factors differ from those that account for disproportionality in out-of-home care generally?
- What accounts for the overrepresentation of females among crossover youth as compared to the broader population of youth in the juvenile justice system?
- How can we harness the protective potential of foster care and treatment foster care to reduce rates of juvenile justice entry among abused and neglected children? (Note also that foster care itself is often a risk factor for juvenile justice involvement.)
- Are there any effective specialized diversion programs for nonviolent/first-time youth offenders who are also involved with the child welfare?
- Do families whose children have entered the juvenile justice system receive the information, assistance, and resources they need to support their child's achievement of positive outcomes? What is the amount of support that is currently provided to families with a child in the juvenile justice system?
- What are the successful collaborations between the juvenile justice and child welfare systems?
- How can permanency be elevated as a primary outcome when preventing involvement in juvenile justice?
- What is the impact of helping youth involved in the juvenile justice system access Medicaid-funded services?

Context and Rationale

Child welfare-involved youth are at heightened risk of becoming involved in juvenile justice (Herz, Ryan, & Bilchik, 2010), juvenile justice-involved youth often require child welfare services upon release (Cusick, Goerge, & Bell, 2008), and crossover or dual-jurisdiction youth (i.e., those with both child welfare and juvenile justice system oversight) are at significantly higher risk for negative outcomes (including adult criminality and multisystem involvement) than single-system-involved youth (Culhane et al., 2011; Herz et al., 2010; New York City Office of the Mayor, 2015).

Research has identified several indicators of child welfare-involved youth who are at elevated risk for becoming crossover youth, namely youth who reside in out-of-home care as older children, who experience multiple placements while in care, and who are placed in congregate care settings (Halemba, Siegel, Lord, & Zawacki, 2004; Ryan, Marshall, Herz, & Hernandez, 2008). Moreover, evidence suggests these correlations reflect reciprocal processes wherein youth with challenging behaviors encounter longer, more disrupted, and more restrictive out-of-home

[73] One of the foster care alumni had a foster mother who would call the police on in foster care for things that most parents (and even most other resource parents) would not call the police for. How common is that, including for youth placed in congregate care settings?

settings, which, in turn, further disrupts positive attachments and likely foments further delinquency (Ryan & Testa, 2005).

There is an ongoing need to understand how child welfare experiences can influence pathways toward and away from delinquency. For example, out-of-home care could mitigate the risk of future delinquency by preventing re-victimization, promoting a positive developmental environment, and activating other protective buffers, such as early intervention or mental health services (Jonson-Reid, 2004). At the same time, however, as noted above, out-of-home care may exacerbate the known risks of childhood abuse and neglect for later delinquency. Multidimensional Treatment Foster Care (MTFC; Chamberlain, 2003) is one of the most promising interventions that has been empirically evaluated for both child welfare and juvenile justice youth. This family-based intervention stands in marked contrast to many other contemporary congregate care treatment approaches for delinquent youth (e.g., Daly et al., 2018; James, 2011; Pecora & English, 2016). Intensive parent training for resource parents and, ultimately, for biological parents as well as reliable aftercare support services can support positive transitions from juvenile justice to family care settings and show promise for reducing the child welfare to juvenile justice pipeline (Herz et al., 2010).

Finally, delinquency is strongly associated with school failure and educational difficulties (Gallegos & White, 2013), but school bonding and attachment are associated with youth resilience (Bender, 2012). Consequently, integrative approaches to support crossover youth must incorporate insights and services from educators. Here again, we need to develop collaborative case plan procedures to ensure that youth are held in the supportive grasp of multiple systems, rather than left to fall through the gaps between them (or languish within any one of them) (Leone & Weinberg, 2012).