Strengthening Families and Communities to Prevent Child Abuse and Neglect: Lessons From the Los Angeles Prevention Initiative Demonstration Project

Abstract: The Prevention Initiative Demonstration Project funded by the Los Angeles County Department of Children and Family Services is a community-specific strategy delivered through eight regional networks designed to address the full spectrum of community-based prevention. This article summarizes a strong and meaningful pattern of improvements found in the second year evaluation for three groups of families – those living in high-risk communities but not involved with DCFS, those being investigated by DCFS for possible child maltreatment, and those with open DCFS cases.
INTRODUCTION

Leaders in public child welfare agencies across the country recognize that prevention can be an important supplement to traditional protective services and foster care, but few have invested resources or created the partnerships necessary to develop community-based public-private initiatives at a scale that could make a measurable difference in preventing or decreasing child abuse and neglect. This article reports on an extraordinary countywide effort by the Los Angeles County Department of Children and Family Services (DCFS) to fund eight regional community-based prevention networks designed to address the full spectrum of child abuse and neglect prevention.

Begun in February 2008 as a demonstration project that was designed to provide guidance for redesign of a number of the department’s existing community-based contracts, the Prevention Initiative Demonstration Project (PIDP) is a community-specific strategy delivered through eight PIDP networks that work closely with the 18 local DCFS regional offices that serve the same eight Service Planning Areas (SPAs). Working in partnership with DCFS and local universities, Casey Family Programs funded and co-led the descriptive evaluation of PIDP’s first program year 2008-09 (McCroskey et al 2009) and empirical assessment of second-year (2009-10) outcomes for three groups of families – those living in high-risk communities but not involved with DCFS, those being investigated by DCFS Emergency Response (ER) workers, and those whose children have open DCFS Family Maintenance (FM) or Family Reunification (FR) cases. This article provides an overview of the theories and strategies guiding PIDP, a brief description of the first two years, and summarizes the results for families after two years. These findings are particularly noteworthy because they show a strong and meaningful pattern of improvements for families, including families who were not involved with DCFS as well as those with various levels of system involvement.

PROGRAM THEORIES AND STRATEGIES

Underlying Theories and Research

The child welfare field has long recognized that prevention is the “third vital leg of the child welfare tripod” that must be combined with child protection and foster care to keep children safe (Citizens Committee for Children of New York City, 2010: 4). In practice, however, the pathways to child maltreatment are varied and difficult to predict, there are never enough resources for intervention with those already identified as “at risk”, and so without special efforts, the dream of preventing abuse tends to lose ground to the realities of crisis response and protective services (Daro, Budde, Baker, Smith & Harden, 2005; Spielberger, Haywood, Schuerman, Michels & Richman, 2005). Unfortunately this means that the goals of child safety, permanence and well-being are compromised because prevention really is a vital element in strengthening families and communities.

The National Research Council and Institute of Medicine’s 2009 report, Preventing Mental, Emotional, and Behavioral Disorders Among Young People, advanced a broader conceptualization of prevention based on findings from emerging prevention science. The report places various services and other strategies along a continuum of health promotion, universal, selected, and indicated prevention programs (National Research Council and
Institute of Medicine, 2009). *Promotion* refers to strategies designed to encourage or nurture good health. *Universal* is the term applied when a prevention program is helping all populations. *Selective* is the term applied when focusing on only vulnerable or high-risk populations. *Indicated* is the term used when prevention programs focus on working with individuals with early symptoms or a problem of illness.

Incorporating this broad definition of prevention into child welfare is challenging for many reasons, not least of which is the fact that it requires efforts that extend well beyond the usual purview of the public child protective services system, developing on-going collaboration between public agencies and community-based networks that include a broad array of community groups which support and strengthen families at the local level.

“Prevention of child abuse and neglect is not the sole responsibility of any single agency or professional group; rather it is a shared community concern. Effective strategies require multiple actions at the individual, family and community levels to reduce risk factors and strengthen protective factors.” (Schorr & Marchand, 2007: ii).

**Prevention Strategies**

There have been numerous collaborative efforts designed to improve outcomes for children and families in LA over the last two decades; the network of relationships created through these iterative efforts has provided essential building blocks for substantive improvements in many areas (McCroskey 2006). The fact that LA had not invested in preventing child abuse emerged as a concern in 2003-04. After key leaders developed consensus among interest groups to guide planning for practical prevention strategies (see Note 1), the Commission on Children and Families (an oversight group appointed by the County Board of Supervisors) and DCFS agreed to develop a demonstration project that could test emerging ideas. Detailed planning for PIDP began with a workgroup convened by the Commission and DCFS that set out broad-brush principles for the plan that DCFS used to test the potential of enhanced community partnerships relying on networks led by the most experienced community-based organizations working in LA County’s eight Service Planning Areas (SPAs).

DCFS took on this challenge at about the same time that the California State Department of Social Services commissioned Schorr and Marchand to test their Pathway Mapping Initiative in developing statewide consensus about “pathways” that could help to prevent child abuse and neglect. The six goals described in their 2007 report provided a broad road map that mirrored the consensus developing among key players in LA: 1) Children and youth are nurtured, safe and engaged; 2) Families are strong and concerned; 3) Identified families access services and supports; 4) Families are free from substance abuse and mental illness; 5) Communities are caring and responsive; 6) Vulnerable communities have capacity to respond.

Planners also worked to integrate a developing community-level change model from LA into planning for PIDP. This model is based on a familiar ecological series of concentric
circles at the center of which are children and families. Rather than moving outward to service delivery systems, however, the community-level change model focuses on relationships, social networks and the role of relationship-based community organizing in connecting people, strengthening families and communities (McCroskey et al., 2009). The ideas advanced by the National Research Council and Institute of Medicine fit comfortably with this community-level change model. The processes of conceptualizing and planning for PIDP are described in more detail in PIDP evaluation reports from years one and two (McCroskey et al, 2009; McCroskey et al, 2009a; McCroskey et al, 2010).

The Strengthening Families principles developed by the Center for the Study of Social Policy also made an important contribution to plans for PIDP. This framework highlights the need to go beyond risk assessment to strengthening families by focusing on the protective factors that have been shown to prevent child abuse and neglect -- parental resilience, social connections, knowledge of parenting and child development, concrete support in times of need, and children’s social and emotional development. These principles are based on best practices and evidence from research that links improvements in family protective factors to reductions in substantiated reports of child abuse and neglect (Center for the Study of Social Policy 2009; Reynolds & Robertson, 2003; Reynolds, Mathieson & Topitzes 2009).

Ultimately the PIDP planning team agreed on three core values that guided development of the initiative: (1) investing in building the capacity of communities; (2) integration and alignment of existing services; and (3) collaboration across the multiple LA County government departments that serve families and children. They also identified three strategies that were essential to strengthen families, improve community safety nets and prevent child maltreatment: (1) decreasing social isolation; (2) increasing economic stability; and (3) integrating the community-based spectrum of services and supports.

PIDP was designed to address the full spectrum of child abuse prevention including promotion and universal (primary) prevention approaches directed to the whole community, as well as selective (secondary) and indicated (tertiary) approaches directed to families already referred to or engaged with DCFS. Each of the eight PIDP networks was asked to devote at least half of their resources to primary prevention, supporting and engaging families and strengthening social networks so that child abuse/neglect did not occur. They were also asked to address secondary prevention, involving parents with unfounded and inconclusive ER referrals as decision-makers in promoting their children’s development, learning and well-being, and addressing potential risk factors so that re-referrals for child maltreatment were reduced. And they should devote about 20% of PIDP resources to strengthening the capacity of parents whose children had open DCFS cases to care for and protect their children.

PIDP networks seek to strengthen and support families throughout the region/SPA they serve with a special emphasis on families living in the most impoverished neighborhoods where DCFS referrals are most likely to originate. The initiative is based on the hypothesis that child abuse and neglect can be reduced and children can remain safely in their homes without abuse or neglect if:
• Families are less isolated and able to access the support they need;
• Families are economically stable and can support themselves financially;
• Activities and resources are integrated in communities and accessible to families.

IMPLEMENTATION

Year One Funding
PIDP required a relatively modest expenditure of $10 million over the first two years (an annual amount of $5 million per year in LA is quite modest when compared with the annual DCFS budget of over $1.5 billion). A total of four years of “demonstration” is planned with step-down funding in each of the last two years; the idea is to incorporate lessons learned from the four-year demonstration project into contracting processes for Promoting Safe and Stable Families/Child Abuse Prevention and Intensive Treatment (PSSF-CAPIT) and other regular funding streams. The initial investment of $10 million included $3.76 million from the County’s Title IV-E Waiver capped reinvestment funds and “savings” that had been set-aside from a previous community services plan. PIDP was designed as a demonstration project to make strategic use of these funds.

Specific dollar amounts were designated for each of the eight SPAs based on the population of families and children and relative number of child abuse referrals coming from each region. DCFS staff designed a Request for Qualifications (RFQ) process to identify the most experienced lead agencies willing to lead PIDP networks, and encouraged local providers to work together to designate a lead who would pull various stakeholders together. It should be noted that this RFQ process required a significant departure from usual contracting practices (which often rely on RFPs that do not give much credit for experience or performance) that would not have been possible without leadership from elected officials, two successive DCFS Directors, and buy-in from public sector and community leaders who participated in four years of consensus building.

Network Design
Given LA’s history of using network approaches, several agencies had experience leading DCFS-funded Family Support or Family Preservation networks and similar networks sponsored by other funders. As was hoped, only one proposal from an experienced lead agency (representing a group of agencies) was received from five of the eight SPAs. DCFS staff worked with providers in the other SPAs to coordinate and consolidate applications. In the end, DCFS staff identified 12 lead agencies that would spearhead development of the eight PIDP networks. In two SPAs, three agencies were designated to-co-lead PIDP networks; in two SPAs, agencies that had less experience working with DCFS were asked to work with “mentors” that were lead agencies in nearby areas. The array of experience among the lead community-based organizations (CBOs) also led to a relatively quick start-up period. As it turned out, diversity of expertise among the PIDP lead agencies was also a real strength, since the group meets regularly to share information and ideas.

Although PIDP was not the only prevention and early intervention initiative underway in LA during this time, it was significant for three reasons: 1) the RFQ process called for
experienced and capable lead agencies, thus ensuring that PIDP built on existing community capacity developed over the last decade or more; 2) PIDP was designed to fill gaps in local family service systems by focusing on social connections and economic opportunities for families, and encouraging partnerships with existing services to increase access to community services and resources; and 3) DCFS encouraged leaders of their 18 local regional offices to build relationships with these community-based networks, planning and problem-solving together to fill gaps in services and sustaining communication through the four-year implementation period.

Evaluation Partners

The evaluation team included researchers from Claremont Graduate School, USC, UCLA and the University of Washington -- selected and funded by DCFS and Casey Family Programs, which provided extensive technical assistance to DCFS. DCFS staff worked closely with the team to support the evaluation, including facilitating monthly meetings, providing access to data, collecting additional data and analyzing local child welfare data. The expanded evaluation advisory committee included at least one liaison from each of the eight PIDP networks, with representatives from DCFS regional offices and departments (see Note 2). Evaluation instruments and summaries of research findings were reviewed by the advisory committee as well as community residents, parents, foster parents and young adults with experience as child welfare services consumers.

Year One Findings

Overall, descriptive findings from the first year evaluation highlighted network adherence to the three core prevention strategies; reports also described the broad range of partnerships and activities that were used in different regions to integrate or braid together the key strategies. During the first program year (which was as long as 18 months for some networks depending on start-up dates), the eight PIDP networks got off to a running start. Eighty-nine CBOs and local groups participated in the eight PIDP networks; taken together these networks served nearly 20,000 people (not an unduplicated count). Network membership reflected a core concept suggested by the National Research Council and Institute of Medicine (2009) that coordinated community-level systems need to be multi-disciplinary, including the multiple public systems (public health, mental health, health care, education) that support the development of children, working in collaboration with community agencies such as housing programs, employment services, civic and faith-based groups in touch with local conditions and resources.

The Network Collaboration Survey, based in part on the Wilder Collaboration Factors Inventory, was developed to assess indicators of effective inter-agency collaboration. Even in the first year, functioning of the PIDP networks was as good as or better than most other social delivery networks in other parts of the country. Survey findings showed that the agencies involved in the PIDP networks had long histories of working in their respective communities; most (87%) had been working for more than 10 years, with 53% working in the community for more than 25 years. PIDP networks demonstrated creativity in blending funding from several sources; the first year report includes “maps” of funding provided to network members through various contracts, as well as funding
network agencies received from First 5 LA (which provides help to children under age five and their families through a tobacco tax authorized by a California ballot proposition) (McCroskey et al, 2009a). Evaluation findings also supported the expectation that existing program infrastructure and cross-agency collaboration would facilitate identification of additional resources for individual families. A number of networks included funded members as well as unfunded members who contributed free services and resources for needy families.

In partnership with local DCFS offices, PIDP networks identified high-need communities based on geographic boundaries and some focused on specific local concerns (e.g., racial disproportionality). One DCFS regional office developed detailed maps down to the block level, supporting more effective outreach to the highest need families. DCFS offices that had long-standing collaborative relationships with PIDP leads were clearly advantaged in moving expediently from planning to implementation, developing strategies to address local conditions.

Basically first year study findings showed that all eight PIDP networks worked with local DCFS regional offices to develop plans that addressed local needs, enhanced family protective factors, decreased social isolation, increased economic resources, and connected families to existing resources, activities and services; thus most of the PIDP activities remained the same during year two. Reports examining the first year start-up process and descriptive study results in detail can be found on the Casey Family Programs website (McCroskey et al 2009; McCroskey et al 2009b; Edgar 2009).

**Year One Evaluation**

During the second year, DCFS, evaluators and lead agencies continued to work together in regular team meetings and small task groups to support continuous improvement and improve data collection. For example, DCFS staff worked with a group of leaders to redesign data collection forms so they would provide unduplicated counts of people served by PIDP networks in each SPA, including separate counts of those already involved and those not known to DCFS, and data on the number of people served and activities offered under each of the three core strategies. They also modified the monthly reporting format to assure adequate information for financial and program monitoring. DCFS staff and evaluators developed a telephone survey of Regional Administrators to gather their responses to and ideas about how to improve PIDP. The evaluation team analyzed these data and worked closely with lead agencies to summarize their activities, achievements and challenges (McCroskey et al, 2010b).

One of the “notable strategies” highlighted in the first year evaluation report was the Faith-Based Parent Visitation Centers established to serve SPA 8. The second year contract required all of the PIDP networks to support development of such centers, and by the end of the second year, almost all of the PIDP Networks had been instrumental in developing local Faith-Based Family Visitation Centers.

The evaluation study design for Year Two included five components: 1) Description of network activities, including analysis of program monitoring and tracking data, interviews with DCFS staff and meetings with networks to assess local program
strategies; 2) Assessment of data on the results of various economic development strategies; 3) Collection and analysis of data on the protective factors that can strengthen families; 4) Analysis of Child Welfare Services/Case Management System (CWS/CMS, California’s State Automated Child Welfare Information System) data on child welfare outcomes; and 5) Assessment of “notable” strategies used by PIDP networks that should be continued and enhanced in years three and four. While DCFS staff took on expanded responsibility for monitoring and collecting descriptive data, the evaluation team focused on three outcome questions:

1. Did families report improvements in protective factors?
2. Were economic development and family self-sufficiency strategies effective?
3. Did families and children referred by DCFS experience changes in re-referrals, reunification or permanency?

People Served
The reach of PIDP during 2009-10 was about the same as in 2008-09. An unduplicated count of people served showed that the eight PIDP Networks served 17,965 people. Table 1 shows that 13% or 2,391 were individuals involved with DCFS – either during an ER referral or after a child abuse case had been opened. The other 87% lived in poor communities targeted by DCFS as posing enhanced risks for children and families.

<table>
<thead>
<tr>
<th>Table 1. Total Persons Served</th>
<th>DCFS Clients</th>
<th>Community Residents (Non-DCFS)</th>
<th>TOTAL</th>
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</thead>
<tbody>
<tr>
<td>SPA 1</td>
<td>147</td>
<td>467</td>
<td>614</td>
</tr>
<tr>
<td>SPA 2</td>
<td>445</td>
<td>2,173</td>
<td>2,618</td>
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<tr>
<td>SPA 3</td>
<td>281</td>
<td>491</td>
<td>772</td>
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<tr>
<td>SPA 4</td>
<td>121</td>
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<tr>
<td>SPA 5</td>
<td>51</td>
<td>74</td>
<td>125</td>
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<td>SPA 6</td>
<td>597</td>
<td>3,723</td>
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<td>SPA 7</td>
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<td>1,586</td>
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<tr>
<td>SPA 8</td>
<td>691</td>
<td>4,834</td>
<td>5,525</td>
</tr>
<tr>
<td>Count of unduplicated people served</td>
<td>2,391</td>
<td>15,574</td>
<td>17,965</td>
</tr>
</tbody>
</table>

The networks also continued to integrate the three core strategies – social networking, economic opportunities, and access to existing services and resources. The next sections summarize findings from the year two PIDP evaluation, providing answers to three outcomes questions.

**PIDP YEAR 2 OUTCOMES**

**Did families report improvements in protective factors?**
To better understand the impact of prevention efforts, an instrument designed to measure protective factors was developed by Dr. Franke in collaboration with PIDP agency staff, families, and community members who participated in Neighborhood Action Councils.
(NACs). Relationship-based organizing strategies were used in four of the eight SPAs as the keystone for developing social networks and providing access to economic supports and services; this strategy built on previous work by one of the lead agencies, the South Bay Center for Counseling (see Note 3).

The instrument, the Relationship-Based Organizing Protective Factors Survey (RBO-PFS), includes 72 items, with four factors designed to measure protective factors: Social Support, Personal Empowerment, Economic Stability/Economic Optimism, and Quality of Life and an additional a single item measuring quality of life. Also included are five factors specific to families with children: Immediate and Extended Family Support, Professional Support, Personal Non-Family Support, Successful Parenting, and Parenting Challenges.

Data collected from the survey and focus groups (mostly in December 2009 and April 2010) held in all eight SPAs highlighted the benefits that parents and youth felt they received through participation in PIDP. To estimate change in protective factors, a retrospective version of the survey was administered; respondents reported current ratings on survey items and 6-month retrospective ratings on the same set of items. In another version of the survey, which was administered to PIDP families in three SPAs, respondents reported only current ratings. Because of limited time and research capacity at some PIDP agencies, only a non-random sub-sample of respondents completed the retrospective version of the survey. Both survey versions were translated into Spanish, and each 72-item section (retrospective and current) took approximately 45 minutes to complete.

Results from the RBO-PFS were calculated for three groups: 1) 355 PIDP survey respondents who participated in NACs in four SPAs; 2) PIDP NAC participants (group one) plus an additional 183 PIDP survey respondents who participated in other social networking strategies in four other SPAs (n=538); and 3) 1,001 survey respondents participating in NACs that were sponsored by PIDP as well as other funding sources.

Parents and youth who participated in NACs (and the smaller number who participated in other kinds of social networks) reported a pattern of benefits including greater involvement in their community, more desire to engage in community activities, and feeling less lonely or isolated. More specifically, there was a significant improvement across three points in time for five factors and a quality of life item. Significant changes were found for three additional factors between two time points. The effect sizes, while statistically significant, were in the small range for all of the functioning areas.

Patterns in responses suggest that, in general, the reported impact of this prevention strategy on protective factors is most evident during the first 4-6 months of participation, and then benefits stabilize. Given the nature of the relationship-based model that serves as the framework for the NACs, it would be expected that as the groups form, become cohesive and participants develop relationships with each other, perceived improvements in the protective factors measured would be evident. Similarly, it would be expected that once the group has attained a moderate to high level of cohesion (likely to occur within
the first 6 months of group formation), changes in perceived levels of support as a result of group participation would stabilize.

This pattern of benefits reported by participating families is particularly important because such protective factors have been linked to long-term strengthening of families (Center for the Study of Social Policy, 2009) and significant reductions in substantiated reports of child maltreatment (Reynolds & Robertson 2003).

Were economic development and family self-sufficiency strategies effective?

PIDP networks were also charged with improving the economic conditions of families, weaving economic and community development strategies into their approach to preventing child maltreatment. The networks used a variety of approaches and activities ranging from employment preparation and placement, summer youth jobs and support for small business development to providing classes on financial literacy, computers and access to GED classes. The wide variety of activities reflects the fact that enhancing economic opportunities for families requires strategies that focus on creating access to capital by utilizing effective partnerships that generate revenue for residents and their neighborhoods, increasing employability, decreasing roadblocks to employment, and increasing family financial literacy.

Findings showed that the family economic empowerment strategies used by the PIDP networks produced positive results in terms of employment training, job placement and income supplements across SPAs. Some families had access to training in financial literacy, budgeting, banking and credit management; others had access to personal coaching on achieving educational goals, employment preparation and developing small businesses. For example, between 2008-10, the SPA 6 Ask, Seek, Knock (ASK) Family Resource Centers trained and placed nearly 300 local residents in the workforce, and provided pro bono legal services to over 1,000 residents. At the request of local residents, the network provided access to pro bono legal assistance in order to help parents navigate the court system, expunge criminal records, establish eligibility for reduction in convictions and/or certification of rehabilitation, all of which increase employability.

Most PIDP networks worked to expand access to Earned Income Tax Credits (EITC) by setting up local tax centers or working through established Volunteer Income Tax Assistance (VITA) sites. PIDP Networks in SPAs 2, 4, 7 and 8 joined forces, with the leadership of the South Bay Center for Counseling and the SPA 8 Children’s Council, in creating the Greater LA Economic Alliance (GLAEA). GLAEA provided free income tax preparation for individuals with a maximum gross annual income of $50,000, free workshops on EITC and childcare tax credits, small business tax preparation, preparation of Individual Taxpayer Identification Number applications, and banking services. Over $4.4 million in tax credits were received by residents in these SPAs in 2009-10. The refunds filed for totaled $4,411,599, with an average refund of $1,062. Based on survey data, families intended to use these dollars primarily to pay existing bills.

Networks that worked through VITA sites engaged an additional 4,315 individuals who
came from approximately 207 LA County zip code areas. The majority of people who took advantage of the service were Hispanic or African-American and over 55% reported earning less than $20,000 annually. Almost 77% of the respondents indicated that they were getting a refund.

**Did families and children referred by DCFS experience changes in re-referrals, reunification or permanency?**

Since both referral patterns and the array of services, supports and activities offered by PIDP networks differed, the evaluators took an individualized approach to analyzing CWS/CMS data to highlight results achieved in different areas. The team selected five communities for analysis, each of which highlighted a different aspect of PIDP; the communities also represented the five SPAs in which PIDP networks served the largest number of DCFS families. In collaboration with local DCFS and network leaders, evaluators identified the most appropriate PIDP samples and methods for establishing comparison groups using random sampling. Discussions also helped to specify the outcomes that were most relevant to local service delivery and potentially most useful for program improvement.

Evaluators worked closely with administrators in local offices to identify persons served by PIDP and to assure accurate description of the criteria used for referral, so that DCFS staff in the Bureau of Information Services could randomly select appropriate CWS/CMS records for comparison. In each of the five communities, results for PIDP families were compared with those of randomly selected comparison groups designed to match local program conditions. Statistical significance was determined using two-sample test of proportions. In all cases an alpha level at .05, one-tailed, was employed. Findings for the five communities included:

**Lancaster.** Analysis focused on re-referral rates of 40 DCFS ER families served by the SPA 1 PIDP network in comparison with a group of 70 other Lancaster families receiving DCFS ER services during the same time period. The comparison group was randomly selected and matched on referral year and disposition of allegations, but evaluators were unable to match families on their need for concrete supports, the primary reason for referral to the SPA 1 PIDP network. Analysis focused on subsequent re-referrals during the program period (between June 2008 and July 2010). While only 23% (n=9) of PIDP families were re-referred to DCFS during the study period versus 31% (n=22) of the comparison group, this difference was not statistically significant (z=1.00). For the purposes of this analysis, a "re-referral" to DCFS means any call to the hotline deemed serious enough to require an in-person CSW visit; thus, hotline calls that were "evaluated out" or eliminated from follow-up because they were not deemed to present a risk to child safety were not included.

Although the numbers were quite small, the percentage of substantiated dispositions for these subsequent allegations was higher for the PIDP group than for comparison families; 56% (n=5) of the PIDP families and 27% (n=6) of the comparison group. This difference was not statistically significant (z=2.23). This suggests that, having tried a supportive prevention-oriented approach, CSWs may have weighed subsequent allegations more strongly, received more information from the PIDP network, had additional information
on family circumstances that went well beyond the concrete needs presented by the family initially, or more challenging problems were identified through re-referral.

**Pacoima, North Hills and Van Nuys.** Analysis of CWS/CMS data in SPA 2 focused on 38 DCFS ER families served by the PIDP network; these families lived in three target zip codes (one from each area) selected by DCFS offices. Discussions with managers in the three DCFS offices in SPA 2 revealed that CSWs tended to refer both families with less serious circumstances, as well as very seriously troubled ER families, to PIDP because they trusted that the network could deal effectively with all kinds of family problems, having shown that they would go “above and beyond” to assure that families were linked to appropriate service providers. Thus, the sub-group included in this analysis was screened to exclude families with the most serious problems as judged by administrators in the DSFC offices (n=38, out of a group of 53 families referred to PIDP). These families did not have an open case with DCFS at the time of referral but had had at least one prior referral within 12 months; they did not have serious and sustained problems (e.g., histories of domestic violence, violent criminal charges) and thus might benefit from approaches that could prevent re-referral. A comparison group of 100 families, selected by thirds from each of the target zip codes, included ER families with at least one prior referral within 12 months prior to the current referral (matching the PIDP group). Findings showed no statistical difference between PIDP and comparison group families (z=.533). Both groups had similar proportions of re-referral to DCFS – 32% of PIDP families (n=12) versus 27% of the comparison group (n=27).

Similarly, there was no significant difference in substantiation for the very small group of families who had subsequent allegations. One third (33%, 4 out of 12) of subsequent allegations were substantiated for the PIDP group versus 15% (4 out of 27) for the comparison group (z=1.32). DCFS opened cases on all four of the substantiated referrals from the PIDP group versus only one of the substantiated referrals in the comparison group, again suggesting that CSWs may have thought differently about the families served by PIDP. Discussions with managers in the three offices suggested that whether subsequent referrals were from mandated reporters in the PIDP network or from others who report families involved with PIDP, CSWs tended to turn to PIDP staff for further information when another allegation came in, since they trusted and relied on their information and the quality of services provided, and they knew that network agencies would continue to be involved in the family’s life. This suggests that the prevention approach taken in SPA 2 may enhance the safety of children because “another set of eyes” is available to support caseworkers dealing with troubled families in high-need areas.

**Pomona and El Monte.** Analysis of CWS/CMS data in SPA 3 focused on results in reunification and case closings for a total of 110 DCFS children whose families received PIDP services; this included 67 DCFS children who were in out-of-home placement and 43 DCFS children who received FM services while remaining at home. Statistically significant differences were found for the FR group but not for the FM group. These children and their families were served using a case management model co-developed by DCFS and the PIDP network. PIDP planners in SPA 3 were particularly concerned about
disproportionate numbers of African American and Latino families coming to their attention. The group identified specific neighborhoods in three communities with high numbers of DCFS referrals, open cases and disproportional representation of families of color. The model includes a four-person team with a case manager, a mental health clinician, a parent advocate (a life-trained paraprofessional who has successfully navigated the DCFS system), and a cultural broker (a culturally and linguistically appropriate person who assists families in navigating the protective services system). In addition, the cultural brokers were available to attend Team Decision Making meetings (TDMs) when CSWs believed they could be helpful; in 2009-10 the SPA 3 PIDP network reported that PIDP cultural brokers attended 200 TDMs in the El Monte (n=86) and Pomona (n=114) DCFS offices. The network also referred families to social networking groups provided by Parents Anonymous and a broad range of services provided by other network partners. The randomly selected comparison group from the same time frame and geographic areas included 200 cases, equally divided between FM and FR.

Findings showed that a significantly higher percent of PIDP children left the foster care system; 81% (n=54) of PIDP children left care versus 58% (n=58) of the comparison group (p<.05, Z=2.93).

While a higher percentage of PIDP children experienced positive “permanency exits” of reunification, adoption or guardianship than those in the comparison group -- 67% (n=45) of PIDP children (n=45) versus 54% of comparison cases (n=54) – this difference was not statistically significant (z=1.70). And the difference between case closures for PIDP children with FM cases (91%, n=39) versus the comparison group (80%, n=80) was not statistically significant (z=1.57).

**Compton.** Analysis in SPA 6 focused on outcomes for 180 DCFS families served by the Compton ASK Center, one of four such Centers developed by the SPA 6 PIDP network. Most of the families referred by DCFS were identified through ER (n=130), while an additional 50 families had children with open FM or FR cases. Between them, the 50 families had 120 children with open cases, including 31 FR cases where children were in out-of-home placement. The ASK Centers are open to all families regardless of income, residency or DCFS status, providing a safe place where families can work with trusted “navigators” to find resources from a data base of over 1500 local resources. ASK Centers also provide education, employment training, pro bono legal services and a wide range of social networking opportunities.

In the first analysis, the 130 ER families included 109 new referrals and 21 referrals on existing open cases. A comparison group of 150 Compton families was randomly selected to match these proportions weighted by referral year and allegation disposition. Results showed that families receiving PIDP services were significantly less likely to be re-referred to DCFS compared with the randomly-selected comparison group – 12% (n=15) of PIDP families versus 23% (n=34) of the comparison group. This difference was statistically significant (p<.05, Z=2.22).

In the second analysis, the PIDP group of 31 foster children with open FR cases whose
families took advantage of ASK Centers were compared with a randomly selected group of 50 other FR children from Compton. Findings showed no differences between the two groups in the percentage of children who exited from foster care during the study period - 52% (n=16) of the PIDP group versus 48% (n=24) of the comparison group (z=.316). However, there was a significant difference between the PIDP children and those in the comparison group -- all of the PIDP children left foster care for “permanency exits” of reunification, adoption or guardianship, compared with 83% of the comparison group (p<.05, Z=2.11).

**Torrance and South County.** Findings for SPA 8 focused on reunification for families using the two Faith-Based Family Visitation Centers established through collaboration between DCFS and the SPA 8 PIDP network. The primary focus of PIDP in SPA 8 is on NACs as described earlier (for additional details and a case study of the combined impact of multiple NACs in one community, see McCroskey et al, 2010b). Since the SPA 8 PIDP network was also the first to anchor development of faith-based Family Visitation Centers, a model of particular interest to DCFS, analysis focused on results for these families. Records of FM cases referred by two DCFS offices were combined, yielding a total sample of 79 FR cases referred to Visitation Centers. The randomly selected comparison group of 100 FR cases was matched on geography, families having had at least one supervised visit in a DCFS office, and worker indication of need for monitored family visits.

Findings showed significant differences between children served by the Faith-Based Family Visitation Centers (n=79) and a comparison group (n=100) from the same geographic area whose workers indicated need for monitored visits and who had received at least one monitored visit in a DCFS office during the study period (there were long waiting lists for the faith-based visitation centers during this time frame). Seventy-one percent of the PIDP sample (n=56) left foster care during the study period versus 55% (n=55) of the comparison group. For the PIDP group, 69% (n=55) experienced “permanency exits”, 1% (n=1) had a less positive exit, and 29% (n=23) were still in care. For the comparison group, 50% (n=50) experienced “permanency exits”, 5% (n=5) had less positive exits, and 45% (n=45) were still in care.

PIDP children were significantly more likely to leave the foster care system (p<.05, Z=2.04) and more likely to have positive “permanency exits” (p<.05, Z=2.41). Children whose families were unable to take advantage of the Visitation Centers (there were long waiting lists during this time period) were significantly less likely to exit the foster care system (p<.05, Z=2.04)

**Study Limitations**

As mentioned above, there were some parents who did not complete the protective factors survey for a second time so there were no data on how they were functioning. In addition, while the special community analysis of CWS/CMS outcome data did rely on comparison families who were randomly chosen from a group of similar families who did not receive PIDP services, the evaluation design did not allow for random assignment of families at the start of the project to PIDP and comparison group conditions.
Conclusions

The second year PIDP evaluation found that PIDP networks were leveraging DCFS and Title IV-E Waiver funds to provide family support, economic empowerment, social networking and other services to prevent child maltreatment. Parents reported significant initial gains in family support, connections to the community, and less parenting stress after 6 months of participating in social networking groups. The CWS/CMS data findings showed that some PIDP activities helped to relieve pressure at the front end of the child protective services system by engaging families referred to DCFS in supportive services, while others helped speed timelines to permanency for children with open cases who were living in out-of-home care.

Taken together, PIDP findings show strong and significant pattern of improvements for families in terms of social support (reported by parents in all eight SPAs), decreased re-referrals (in one of the three areas tested) and more timely permanency (in all of the three areas tested). The fact that results were found across levels of prevention underlines the fact that PIDP accomplished exactly what it was designed to do in only two years. First, it pilot tested locally relevant approaches to strengthening families. Second, it demonstrated the potential for significant improvements in child safety and well being as a result of well-designed prevention services that braid three core elements to create accessible and welcoming webs of community support, activities and services for families. Although the PIDP pilot project will continue through June 2012, and additional data may shed more light on the key elements that contribute to success, the fact that the promising practices reported here are also consistent with national research on what works to strengthen families, prevent child maltreatment, and reduce out-of-home placement provides additional support for these conclusions.

The pattern of gains reported by parents in every SPA suggests that the DCFS strategy of selecting experienced network leads, building on existing local partnerships, and encouraging local DCFS offices to work collaboratively with local networks to customize local approaches paid off. Rather than specifying exactly what services should be provided how often and to whom, as is common in traditional contracting arrangements, PIDP allowed local partners to use creativity in meeting local conditions and needs.

The striking pattern of outcomes that emerged in the second year evaluation highlight results that can be achieved through a combination of flexible funding and public-private partnerships guided by the goals of assuring child safety, strengthening families, and developing community partnerships that keep all of the key stakeholders moving forward together. The results achieved to date are impressive, demonstrating the potential power of community partnerships for prevention -- even in a place as large, diverse and cantankerous as Los Angeles County.
References


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