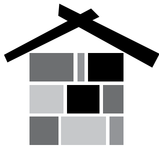

Child Welfare Information Gateway

PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

Child Neglect Demonstration Projects

Synthesis of lessons learned

July 2004

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

Child Welfare Information Gateway
Children's Bureau/ACYF
1250 Maryland Avenue, SW
Eighth Floor
Washington, DC 20024
703.385.7565 or 800.394.3366
Email: info@childwelfare.gov
www.childwelfare.gov

This synthesis was made possible by the Children's Bureau, Administration for Children, Youth and Families, Administration for Children and Families, U.S. Department of Health and Human Services. The conclusions discussed here are solely the responsibility of the authors and do not represent the official views or policies of the funding agency. Publication does not in any way constitute an endorsement by the U.S. Department of Health and Human Services. Suggested citation: U.S. Department of Health and Human Services. (2004). *Child neglect demonstration projects: Synthesis of lessons learned.* Washington, DC: Child Welfare Information Gateway.

More children suffer from neglect in the United States than any other form of maltreatment. Investigators determined approximately 61 percent of children who were victims of maltreatment in 2002 experienced neglect.[1] Research has shown neglected children are at risk for a number of behavioral, social, academic, and medical problems. The profile and risk factors for neglected children and their families are likely to vary significantly across types of neglect (e.g., physical, supervisory, emotional, educational).[2] Because neglect is often an act of omission, it is difficult to identify, prevent, and treat.[3]

In 1996 and 1997, the Children's Bureau funded 10 demonstration projects to address the prevention, intervention, and treatment needs of neglected children and their families. These projects implemented and evaluated a wide variety of service strategies with large numbers of children and families. Programs varied considerably in terms of theoretical model (psychosocial or ecological), target population, location (in-home or out-of-home), duration, and intensity. Specific project and contact information is provided in the appendix for readers interested in learning more about individual projects.

Despite their many differences, grantees experienced a number of similar challenges. The strategies they used to overcome them may help future programs avoid these common pitfalls. In addition, the shared lessons these grantees learned about staffing, service delivery, and collaboration with community partners can inform future efforts and improve outcomes for families at risk for neglect and for neglected children.

Overview of Services and Outcomes

Because there is no standard definition of neglect, each grantee established its own eligibility criteria for inclusion in the program.[4] Families were referred by child protective services (CPS) and medical or social service organizations, or were self-referred. In many cases, families were referred after neglect had been substantiated by CPS. In most instances, participation was voluntary. Most of the families lived in high-risk urban settings and were considered to be at very high risk for neglect.

The projects provided a great variety of services, and referred children and families to many other resources or services in the community.[5] The direct services most commonly provided (followed by the number of programs that provided each service) were:

- Parent education (9)
- Home visits (9)
- Referrals or links to community resources (8)
- Parent support (8)

[1] U.S. Department of Health and Human Services. (2004). *Child maltreatment 2002*. Washington, DC: Government Printing Office.

[2] U.S. Department of Health and Human Services. (1987). *Study of national incidence and prevalence of child abuse and neglect*. Washington, DC: Government Printing Office.

[3] U.S. Department of Health and Human Services. (2001). *Acts of omission: An overview of child neglect*. Washington, DC: Child Welfare Information Gateway. [Online.] Available: www.childwelfare.gov/pubs/focus/acts/index.cfm.

[4] Zuravin, S. J. (1999). Child neglect: A review of definitions and measurement research. In Dubowitz, H. (Ed.), *Neglected children: Research, practice and policy*. Thousand Oaks, CA: Sage Publications.

[5] For specific service types provided by each program, see Appendix B.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

- Mental health services (6)
- Concrete assistance (6)
- Crisis intervention (6)

The projects reported accomplishing all or most of their objectives, and all reported positive outcomes for children and families. In the case of six programs, these findings are supported by evaluation designs that included a comparison group, pre/post use of standardized instruments, and statistical analysis of data.[6] Outcomes reported by one or more of these six programs included:

Reductions in:

- Child behavior problems.
- Parent/caregiver depressive symptoms, drug use, life stress, parenting stress, perception of child behavior problems, emotional problems, and social isolation.
- Foster care placement and CPS reports.

Improvements in:

- Child health, developmental adaptation, and well-being.
- Parenting skills, including parent/caregiver stimulation of children, physical care of children, psychological care of children, parental teaching, caregiver skills to meet children's psycho-emotional needs, appropriate discipline, social support, knowledge of child development, and positive behavior management.
- Family housing, healthcare, support, and resources.

[6] For specific outcomes reported by each program, see Appendix B.

For more information about the projects' service populations, services, service duration, staffing, evaluation models, and reported outcomes, see Appendix B.

Common Challenges/ Successful Strategies

Despite the many differences in program design, services, and target population, grantees experienced a number of common challenges associated with addressing families' needs, engaging families, employing qualified staff, and sustaining the programs themselves. Details of these challenges and the strategies programs used or recommended to overcome them follow.

Addressing Families' Needs

The causes of child neglect are multiple and complex.[7] Families at risk for neglect face serious challenges. Most live in poverty with few resources available to them. Many neglectful families experience frequent crises, such as eviction, job loss, domestic and neighborhood violence, physical and mental illness, substance abuse, and involvement with the child welfare and legal systems. Children who are neglected often experience negative long-term consequences, including developmental and neurological deficits; poor health; and social, emotional, and academic problems. At the same time, each family is unique. Neglect may be chronic or a single occurrence, severe or mild. Personal and environmental factors

[7] Gaudin, J. M. (1993). *Child neglect: A guide for intervention. (The User Manual Series)*. Washington, DC: U.S. Department of Health and Human Services, National Center on Child Abuse and Neglect.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

vary widely and affect the types of services and supports each family needs. Strategies to address these serious challenges included the following:

- **Assess needs.** Conduct a thorough initial assessment of the child, parent/caregiver, family, and community/environment to determine strengths and needs. One program conducted screenings and assessments during parent support groups when children were in child care. Reassess and review often, and then revise service plans as needs change. Some programs found an interval of every 10 to 12 weeks to be effective.
- **Address crises.** If the need is urgent, make initial telephone contact within 24 hours of referral in order to prevent or reduce the severity of a crisis. Some programs provided a 24-hour help/advice line to afford stabilization during crises, which often occur after regular business hours.
- **Customize services and be flexible.** Develop individual service plans that combine prevention, intervention, and treatment as needed. Grantees suggested flexibility as to time, place (including home- and center-based services), content, length, and intensity of services, always based on each family's needs. In parenting education and support groups, be flexible with the curriculum. Address the most urgent needs first (e.g., domestic violence, postpartum depression, welfare-to-work issues), while presenting information and developing skills as opportunities arise.
- **Focus on poverty issues.** Some programs provided education, job training, employment, child care, and transportation to interviews to help families work their way out of poverty. Others suggested working with community members to advocate for systemic change to address financial issues that lead some families to be at greater risk for neglect.
- **Offer or refer to a broad array of services.** Offer multiple core components (e.g., assessment, emergency services, case management, parenting education, and support groups). Make referrals to and provide assistance accessing other resources and supports in the community (e.g., cash assistance and other concrete resources, mental health and substance abuse treatment, transportation, and child and respite care). One program effectively addressed potentially overwhelming problems by having the core (parent education) program integrated physically and programmatically in a medical center with strong links to government agencies and the foster care system. Another program used an automated and continually updated resource directory to ensure high-quality referrals. Use of case management and documentation was recommended to keep all disciplines and multiple providers working with each family aware of the same information.
- **Address children's needs.** One program reported good results using a center-based preschool (10 months, 5 full days per week) and psychosocial model combined with bimonthly home visits and multiple family groups. Another program found children did better when parents received professional behavior management training and the children and their families received intensive psychotherapeutic services.
- **Offer services for older youth.** Neglected older children and youth may carry a lot of

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

anger and "act out" in response to feelings of abandonment, loss of control, and identity confusion. Provide youth with positive cultural exposure such as chaperoned travel; recreational, educational, and mentoring activities; workshops on life-planning; and individual counseling. Working with the whole family to improve communication and understanding was found to be especially helpful for older youth who had been neglected.

- **Provide intensive, long-term services.** Assign small caseloads to facilitate intense interventions. Intensive services for 6 months to 1 year (longer if necessary) were found to be more effective in engaging families and effecting change at individual and family levels.[8] The lack of a specific time limit on services was found to reduce pressure on workers and families and allow families to pace themselves, working on issues as they arose, as time and energy permitted, with time out for crises.
- **Deliver aftercare services.** Follow-up services provided after the intensive service component were found to help monitor progress, maintain improved child and family well-being, and support implementation of a long-term plan to develop self-reliance.

Engaging Families

Most of the programs struggled to recruit, enroll, and retain participants. Programs reported that many families had transient living arrangements, reported frequent scheduling conflicts, and were difficult to contact (e.g., no telephones). Many families had a long history of unsuccessful involvement with service agencies, usually lasting too short a time for meaningful change to occur. Thus, it was found to be necessary to build intensive, ongoing recruitment and retention activities into the program. Strategies for engaging families included the following:

- **Do not rely solely on CPS for referrals.** Reports of child neglect are least likely to meet the threshold for CPS investigation or intervention, so relying solely on CPS for referrals could result in failure to meet the needs of many families.[9] Programs sought additional referrals from the medical provider community, a help/advice line, other clients, and through positive local media coverage of the program and its participants. Voluntary participation is often a key to success, so establish a system in which there are no adverse consequences for refusing services.
- **Invest in intensive, strategic outreach to new referrals.** Engage families at times and in places that are most convenient for them. One program experienced a high degree of success with a strategy to initiate two home visits, two school visits, one intervention meeting, and three phone contacts during the first month.
- **Develop relationships with families.** Focus on developing relationships with the family during initial intake, assessment, and screening. Many families prefer to start out individually rather than as part of a group. One program had success by having home visitors connect with families prenatally.

[8] For service duration reported by each program, see Appendix B.

[9] U.S. Department of Health and Human Services. (2001). *Acts of omission: An overview of child neglect*. Washington, DC: Child Welfare Information Gateway. [Online.] Available: www.childwelfare.gov/pubs/focus/acts/index.cfm.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

Maintain long-term partnerships with families (e.g., semi-annual family gatherings for all former and current families). Work with the whole family, including intensive efforts to engage fathers. Grantees also found certain staffing strategies had an impact on family engagement; these are described below, in "Hiring and Retaining Qualified Staff" and "Lessons Learned."

- **Start with concrete services.** Program design needs to provide early access to concrete services, such as financial benefits assistance, housing assistance, food banks, and transportation. Most clients are more likely to follow up on referrals for life-sustaining services than on services requiring them to engage in a change process.
- **Be culturally competent.** Employ service providers who "look like" the families they serve and who have knowledge of the community. In several programs where most of the families served were African American, direct service staff, mentors, and advisory board members were also African American. A program serving a largely Latino population hired two bilingual staff. A relationship-focused treatment model used by another program proved to be culturally appropriate and successful for the African American families it served.
- **Meet in a safe place.** In one high-risk urban area, group meetings were held in the police athletic league community center. A safe place with classroom and playgroup areas, the center also provided educational and social resources for participants.
- **Offer transportation.** Most programs found that providing transportation is essential for participation in group events. An alternative to providing transportation is to hold meetings in locations accessible by public transportation.
- **Make child care available during group meetings.** Offer child care in an adequate play space that is safe and comfortable for children and infants. Due to difficulties related to reliability of volunteer child care providers, one program recommended recruiting paid child care staff.
- **Provide incentives for group meetings.** Incentives are often concrete, such as meals at every session and subsidies for public transportation. Incentives also may be social. One program held Friday evening meetings that included a social component. Recruitment was never difficult, and there was almost always a waiting list. Program graduation ceremonies were found to be important opportunities to reward participants, validate their efforts, and reinforce their gains.
- **Vary the content of group sessions.** Utilize client leadership and input, interactive group sessions, role-playing activities, videos, games, outside speakers, rap sessions on pressing issues, and discussions.

Hiring and Retaining Qualified Staff

Hiring and retaining qualified staff was an ongoing challenge for most of the projects. Reasons included low salaries, the stress of helping families who were dealing with complicated and serious problems, and safety issues. Unfortunately, programs found that high staff turnover often led to lower-quality service, families leaving the program prematurely, and burnout of remaining staff. Strategies for retaining staff included:

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

- **Start with good people.** Many programs cited personal qualities of the staff they hired (using descriptions such as *highly qualified, creative, resourceful, persistent, warm, nonjudgmental*, and *caring*) as critical to their success. Additional attributes of direct service staff found to be desirable included maturity, professionalism, commitment, the ability to connect, living in the community, having personal experience with the system, and child care experience (e.g., veteran parents).
- **Offer realistic job previews.** Allow prospective hires to "shadow" an experienced staff person during a home visit.
- **Adjust caseloads.** One program created a system to weight various levels of service. They then adjusted workers' caseloads according to service intensity, rather than assigning a set number of cases.
- **Make sure staff feel supported.** In one program, staff felt more supported when the program office was moved from an off-site location to the organization's headquarters. Another program supported staff by holding weekly individual supervision meetings between direct staff and the director to address complex problems. Other similar strategies included weekly clinical staff meetings, review of taped therapy sessions, and bimonthly case presentations.
- **Address staff safety concerns.** One program in a particularly high-risk area addressed home visitors' safety concerns by scheduling daytime visits only, contracting with a car service with a driver who waited outside, providing cell phones, and sending two staff into the home together.
- **Share program evaluation results with staff.** One program reported staff benefited from and felt motivated by the evaluation feedback. This may have balanced the feeling that the evaluation was sometimes getting in the way of providing services.
- **Make promotions to encourage tenure.** One way programs improved retention was by rewarding staff competence and success with promotions in level or title.
- **Engage families with the entire program.** When families feel a connection to the entire program, not just their regular contact person, staffing changes are not as disruptive.
- **Conduct exit interviews.** Both positive and negative responses were found to be instructive.

Sustaining Funding

Securing sustainable funding to continue those services that have been found effective after the demonstration grant ends is a perennial and critical challenge. Strategies included the following:

- **Start with a larger-than-required cash match.** One program found securing this initial investment from the agency and community built early commitment and made the transition to non-Federal funding less daunting.
- **Demonstrate effectiveness.** One program developed ongoing financial support from the Department of Social Services (DSS) when the program demonstrated it was reducing DSS intake workload. Another program worked early on to produce convincing service- and cost-effectiveness data. As a result, DSS provided a liaison

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

worker and awarded a contract to expand the program. They also secured a 3-year contract from the State to continue the program and had applications to several local foundations pending at the time of their final report.

- **Incorporate new program components into ongoing services.** It may be easier to sustain a modification to an existing program than to fund a new stand-alone program. In one project, an experimental condition (12 months of aftercare) became the program standard, replacing the previous 3-month limit.
- **Know your community resources and make yourself marketable.** One program sustained its neglect services by approaching county agencies that administer State drug, alcohol, crime, and delinquency funds and securing purchase-of-service contracts with them.

Lessons Learned

In addition to strategies that address the specific challenges described above, several characteristics were seen by many of the programs to be crucial to their overall success. Their recommendations are summarized below.

Use a Family Empowerment Approach

Several programs reported outcomes were better when families were empowered to be active participants rather than passive service recipients. Grantees suggested using a strengths-based, family-centered approach to guide participants toward self-reliance. One program used the Personal Goal Achievement Measure as a successful strategy for encouraging families to set their own goals and focusing the intervention on what is important to each individual parent or family.[10] Staff then helped families identify a list of steps needed to accomplish each goal and sought to provide opportunities for success in areas that mattered most to each family.

Focus on the Relationship Between Staff and Caregivers

Caregivers respond most effectively to staff persons they believe are committed to their well-being. Staff must have the ability to establish trusting therapeutic relationships, so it is important to hire the right people and provide the support they need to do their jobs well. Many grantees cited the ability to vary staff caseloads according to families' needs. Others found maintaining open lines of communication among all service providers and family members to be important.

Offer Staff Ongoing Training

Programs recommended additional staff training on subjects such as child welfare reform's impact on case management, behavioral health availability, case management across agencies, best practices in meeting child care needs, maternal depression, parenting stress, community resources, and general principles for good practice (e.g., community outreach, empowerment approaches, strengths perspective, cultural competence, developmental appropriateness, outcome-driven service plans).

[10] This tool was developed by the Parent Empowerment Program, Montefiore Medical Center, 3314 Steuben Avenue, Bronx, NY 10467.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

Use Multidisciplinary Teams in Working with Families

Many programs found support to families could be provided most effectively by multidisciplinary teams.[11] These teams were composed of various combinations of professionals, paraprofessionals, and volunteers. (How programs defined "professional staff" and assigned roles varied widely.) In one program, parenting skills were taught by professional staff. Another program used master's-level social workers and certified preschool teachers. Having professional staff with experience dealing with serious mental health issues and multiproblem neglectful families was found to be beneficial. In one program, staff nurses who were highly committed and possessed clinical experience in many areas made home visits. In addition to professional support, peer support and positive role models were often provided by teams of mentors or through group mentoring. One program recommended using extended family members or friends as mentors rather than recent program graduates. Recent graduates often experienced problems too overwhelming to allow them the flexibility they needed to take care of others.

Build Collaboration with Other Community Partners

Grantees agreed neglect is too complex for any one organization or agency to address successfully on its own; collaboration with a broad range of key community resources and partners at every level was seen as critical. Productive partnerships with other service providers, medical centers, and CPS were often reported. One program found building a partnership with the Department of Health, which also had a home visiting program, strengthened both programs. Another found developing partnerships with kinship-serving agencies and obtaining additional funding helped them target appropriate services to relative caregivers. Collaboration with CPS was seen as beneficial, but since many families distrust child welfare agencies, partnerships with other community-based organizations provided additional referral sources and supported a multitrack response system.

Offer a Combination of Out-of-Home and In-Home Services

Parent support groups were found to be effective tools for engaging families, providing peer support, educating parents, building and maintaining skills, and increasing self-esteem. Most programs found in-home services improved engagement, recruitment, and retention by avoiding the transportation, child care, and physical disability issues presented by out-of-home services. One program found engaging families affected by substance abuse or mental health issues through in-home family therapy led to fewer missed appointments for the family members' out-of-home treatment services. Another program found making two home visits per week was better for high-risk families and produced better gains than weekly visits.

Form an Advisory Committee that Engages all Stakeholders

Advisory committees need to include local leaders, program participants, and members of key community organizations. These committee members can assist with planning to create a program that is sensitive to the target

[11] For specific staffing information for each program, see Appendix B.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

population and community, and ensure a strong collaborative network.

Conclusion

Though the target populations and approaches to neglect vary from community to community, programs faced similar challenges in serving families, recruiting and retaining participants and staff, and finding resources to sustain services. In addressing these challenges, grantees felt certain strategies were key to their success. A family empowerment approach, with an emphasis on fostering positive relationships between staff and caregivers, was found to be key. Programs emphasized the need for care in hiring as well as ongoing training. Due to the complexity of the issues faced by the families served, programs recommended the use of multidisciplinary teams and collaboration with multiple community partners. Because both methods of service delivery were found to have unique strengths and drawbacks, a combination of out-of-home and in-home services was suggested. Finally, an advisory committee composed and representative of the community served was found to strengthen planning for effective programs. Organizations wishing to build or refine neglect programs may find these lessons learned helpful in their own efforts to address the needs of this complex population.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

Appendix A: Children's Bureau Child Neglect Demonstration Projects

Family Intervention Program
Valley Youth House Committee, Inc.
531 Main Street, 2nd Floor
Bethlehem, PA 18018
Anne Adams
610.954.9561 extension 24

Family Network Project
Joan A. Male Family Support Center
(formerly Parents Anonymous of Buffalo
and Erie County)
60 Dingens Street
Buffalo, NY 14206
Joan A. Male
716.822.0919

Family Preservation Services for African American Families at Risk of Neglect
Portland State University
P.O. Box 751
Portland, OR 97207-0751
Kristine Nelson, D.S.W.
503.725.5012

Family Reclaim: A Community-based Collaborative to Strengthen Families with Substance Abuse and Neglect Issues
Family Support Services of the Bay Area
554 Grand Avenue
Oakland, CA 94610
Patricia Chambers, Ph.D.
415.861.4060 extension 3024

Family Support and Intervention for Neglected Preschool Children
University of Rochester
Mt. Hope Family Center
187 Edinburgh Street
Rochester, NY 14608
Jody Todd Manly, Ph.D.
585.275.2991

Healthy Families D.C.
Mary's Center for Maternal and Child Care, Inc.
2333 Ontario Road, NW
Washington, DC 20009
Joan Yengo
202.483.8196 extension 321

Helping Families Prevent Child Neglect
University of Maryland, Baltimore
School of Social Work
525 West Redwood Street
Baltimore, MD 21201
Diane DePanfilis, Ph.D., M.S.W.
410.706.3609

Homefriends
Temple University
Center for Intergenerational Learning
1601 North Broad Street, USB206
Philadelphia, PA 19122
Adam Bruner, Ph.D.
215.204.3196

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

Neglected Children in Intergenerational
Kinship Care
Georgia State University
College of Health and Human Sciences
University Plaza
Atlanta, GA 30303-3083
Susan J. Kelley, Ph.D.
404.651.3043

Parent Empowerment Program: Neglect Prevention Education for Pregnant and Parenting Teens
Montefiore Medical Center
Child Protection Center
3314 Steuben Avenue
Bronx, NY 10467
Karel Amaranth
718.920.6429

To order copies of any of these projects' final reports, contact Child Welfare Information Gateway at info@childwelfare.gov or 800.394.3366.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

Appendix B: Project Information

Project Name	Population Served[12]	Service Types[13]	Duration	Staffing	Reported Outcomes
Family Intervention Program	• At least one parent with a substance abuse or mental health problem • 96% of families have history of abuse or neglect • 74% of households have an adult with a history of past arrest	• Assessment • Concrete assistance • Crisis intervention • Health care • Home visits • Mental health services • Outreach • Parent education • Referral • Respite services • Substance abuse treatment • Transportation	Up to 18 months	• Professionals • Attempted peer mentoring program did not turn out to be feasible	• Substance abuse impact reduced in 50% of families where it was a problem • Decrease in caregiver emotional problems • Increase in parenting skills for 65% of parents • Improved health of children • Decreased behavior problems of children • Some reduction in social isolation of caregivers
Family Network Project	• Poor, female, socially isolated • Chronically neglecting families • 60% Caucasian	• Assessment • Concrete assistance • Crisis intervention • Day care • Home visits (biweekly) • Parent education and support • Referral • Respite	As needed	• Project director (MSW), social work/educator (BSW), parent aides (HS graduate to BSW) • Supported by student interns and volunteers	• Families maintained adequate housing • Families achieved adequate health care • Caregivers developed skills to meet children's psycho-emotional needs • Caregivers showed improvement in using appropriate discipline
Family Preservation Services	• African American or mixed race • 2/3 of primary caregivers unemployed and never married • Drugs/alcohol abuse issues	• Modified Family Enhancement Program • Advocacy • Aftercare • Concrete assistance • Crisis intervention • Day care • Home visits • Mental health services • Parent education and support • Referral	Intensive services for 4 to 8 weeks, aftercare for up to 12 months	• Project Director (MSW), professional outreach and aftercare coordinators (BA) • Extended family and friends help support caregivers • Most staff were African American residents of the community served	• Decrease in founded neglect reports and out-of-home placement • Child well-being increased from intake to the end of the intensive phase of services • Increases in family support and family resources
Family Reclaim	• Multi-stressed families with substance abuse issues • 68% African American, 5% Latino	• Concrete assistance • Crisis intervention • Mental health services • Parent education • Referral • Respite • Transportation	As needed	• Program director, social workers/family advocates, youth mentor	• Improvement in child well-being scores • Improvement in family functioning for a significant number of families • 97.5% of children at risk for removal were able to remain with their families • Improvement in children's academic performance and school attendance • Cost effective

[12] All families were at high risk for neglect. Most were poor and lived in high-risk inner-city areas.

[13] *Concrete assistance* includes financial benefits assistance, housing assistance, legal assistance, transportation, food bank, and assistance meeting basic needs. *Parent education* includes adaptive functioning, communication skills, negotiation skills, educational support, employment/job readiness training, and money management/budgeting skills.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.

Project Name	Population Served[12]	Service Types[13]	Duration	Staffing	Reported Outcomes
Family Support and Intervention for Neglected Preschool Children	• Families identified as neglectful • 59% African American • Frequent issues with substance abuse, mental health, and domestic violence	• Assessment • Day care (therapeutic preschool) • Home visits (bimonthly) • Mental health services • Parent education and support • Transportation	10 months (longer as needed)	• Consistently professional, highly qualified (MSW) staff • Experience in dealing with serious mental health issues and multiproblem neglectful families	• 99% of children achieved at least one developmental goal • 94% of families made progress on treatment goals • Improved parenting skills and increased social support for caregivers • Increased knowledge of child development and positive behavior management • Children's developmental adaptation exceeded that of control group
Healthy Families D.C.	• First-time parents identified as overburdened • 88% single mothers • 66% Hispanic, 29% African American • 61% Spanish speaking with limited English • 57% teens	• Healthy Families model • Assessment • Home visits (weekly) • Parent support • Referral	Long term (up to 3–5 years)	• Chosen for their ability to connect with families and their educational background • Live in the community being served • Culturally competent • Extensive training	Met objectives with regard to: • Healthy birth weights • Immunizations and well-care visits • Developmental screenings • Progress toward self-sufficiency goals • No cases of child abuse or neglect
Helping Families Prevent Child Neglect	• Presence of concern for at least one subtype of neglect and presence of at least two other risk criteria • Not involved with CPS, willing to participate • 95% single parents • 85% African American	• Advocacy • Assessment • Concrete assistance • Crisis intervention • Home visits (weekly) • Outreach • Parent education and support • Service planning	3 or 9 months	• Social work interns • Mostly African American	• Reduced caregiver depressive symptoms, drug use, life stress, parenting stress • Increased appropriate parenting attitudes, satisfaction with parenting, perceived social support • Fewer CPS reports on participants following than prior to intervention • Enhanced physical and psychological care of children • Decreased caregiver perceptions of child behavior problems
Homefriends	• Children with at least one special need • Living in inadequate housing • Caregivers recovering from substance abuse • 90% African American • 90% unemployed • 83% single parents	• Modified Family Friends program • Home visits (weekly) • Parent education and support • Referral • Respite	10 months (average)	• Senior volunteers from the child's neighborhood • All direct service staff and nearly all mentors were African American	• No families in intervention group had child placed in foster care • Some improvement found in parental teaching and stimulation of children • Parents experienced an improvement in their feelings and perceptions of themselves as parents
Neglected Children in Inter-generational Kinship Care	• Grandparents who are primary caregivers (98% female) and lack the financial/ supportive resources to parent • History of abuse or neglect by birth parents • 96% African American families	• Concrete assistance • Health care • Home visits (monthly) • Mental health services • Parent education and support • Referral • Service planning • Transportation	12 months	• Full-time professional social workers and part-time registered nurses • Staff and advisory board composed primarily of African Americans	• Decreased child behavior problems • Reduced risk for child neglect • Improved caregiver health • Caregiver empowerment • Increase in caregiver social support • Decrease in caregiver stress
Parent Empowerment Program	• Socially isolated, resource-poor teen mothers (average age 20 years) • Pregnant or parenting • 97% single parents • 60% Latino, 30% African American	• After care • Assessment • Crisis intervention • Day care • Home visits • Parent education and support • Referral	6 months, with after care	• Program coordinator (MSW) and case manager (BSW) • Culturally competent clinicians (bilingual staff for Spanish-speaking clients)	• Slight increase in child well-being scores • Slight increase in knowledge of infant development • Slight downward trend in child abuse potential • Significant percentage of family-identified goals partially achieved or achieved

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. Available online at www.childwelfare.gov/pubs/candemo/index.cfm.