A WINDOW OF OPPORTUNITY

Creating a 21st Century Legacy Toward Thriving Families: A Conversation with Tracy Wareing Evans and Michael Fraser

States grappling to ensure continuity of services amid the COVID-19 pandemic highlight a stark reality: the welfare of our nation's children falls short of our collective aim to eradicate structural inequities among communities of color and low-income families. Swift action from public health and human services leaders to advance a collective vision that encompasses a prevention-focused child welfare model is a critical opportunity for collaboration between public health and human services partnerships.

This column is part of a new grant project launched between the American Public Human Services Association (APHSA) and the Association of State and Territorial Health Officials (ASTHO), with support from Casey Family Programs.

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The window of opportunity toward shifting the public discourse and understanding to a collective vision rests on building a foundational roadmap for family well-being based on known protective factors, strength-based approaches, and necessary universal supports for all families. Last month, APHSA and ASTHO colleagues gathered (virtually) with Tracy Wareing Evans, President and CEO of APHSA, and Michael Fraser, CEO of ASTHO, to discuss the human services and public health perspectives of transforming child welfare. Their conversation follows:

Public health has always emphasized primary prevention for child health and well-being. From your perspective, can you share your thoughts about why public health and child welfare haven't worked together more closely in the past?

Wareing Evans: Public health has so many synergies with human services, especially in promoting the well-being of families with young children. Yet the way the system is set up, it naturally creates silos, separating public health from child welfare services. From my time leading Arizona's human services agency, I know I didn't fully appreciate the ways in which systems and social constructs are intertwined, shape a community, and impact the ability of people who live there to be healthy and well. Community context matters—it must be more relevant in the way we approach complex social issues like preventing child maltreatment and keeping families at the center of the system. For so long, child welfare programs focused the bulk of their resources in individual intervention while public health targeted services at a population-health level—an approach that child welfare, with new federal funding, is now eagerly embracing.

Fraser: The individual disciplines of public health and child welfare are about improving child and family well-being, but often don't work together despite sharing the same goals. We have worked on programs—like home visiting and supporting mothers and babies—aimed at helping families and outcomes for children. What we're talking about now is having both public health and child welfare create a new way of doing "business as usual" by placing a stronger emphasis on investing in upstream approaches.

Public health and child welfare do share similar approaches to improve health in children and families. Child welfare drives population-level campaigns to reduce trauma and ACES; public health supports individual care and support services for families in need of support. Many public health programs are also funded by federal dollars for very specific outcomes related to a disease or a condition. This creates silos of thinking that are hard to change without leadership support and support from funders.

APHSA and ASTHO are now in partnership to support transformation of the child welfare system through a prevention-first model. In many ways, this will be transformational for how public health and child welfare agencies will work together. What are some of the ways APHSA and ASTHO work with their members to develop transformational leaders?

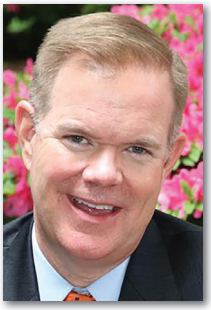
Wareing-Evans: Moving our systems upstream to help prevent issues before they happen is one of APHSA's core focus areas, along with advancing social and economic mobility for families and building the capacity of public-sector agencies to optimize their data and support their workforce.

We recognize that to achieve this desired state, we must evolve our health and human services system from a traditional model rooted in regulatory compliance and programmatic outputs to what we refer to through the Human Services Value Curve, as a "generative approach," which works seamlessly across sectors and engages whole communities in addressing the multidimensional socioeconomic issues faced by individuals and families. Our network includes cabinet-level heads of human services agencies at both state and local levels as well as directors of child welfare agencies. We partner across sectors, including academia/research, private industry, philanthropy, and community-based organizations, as well as across systems, including public health, education, housing, justice, and transportation. We use our platforms and network to provide opportunities for peer exchange and for shared learning. And, through our Organizational Effectiveness Consulting practice, we partner with our members at all levels, to close the gap between their vision and desired results and where they are today.

Fraser: ASTHO works directly with the chief health officials in all 59 states and territories to support them in formulating sound public health policy and ensuring excellence in state-based public health practice. All that takes strong and consistent leadership, which is one of ASTHO's strategic goals.

ASTHO has been working with members for several years on Boundary Spanning Leadership, a model framework to develop strong cross-sectoral alliances for change. We emphasize in this training, developed by the Center for Creative Leadership, that working across sectors may take time and involve elements of compromise to achieve a shared vision.

Tracy Wareing Evans is the President and CEO of the American Public Human Services Association.



Michael Fraser is the CEO of the Association of State and Territorial Health Officials.

The evidence is clear that primary prevention will help create stronger families and reduce child trauma. How are some ways APHSA and ASTHO can work together to create a national conversation that mobilizes state and local partnerships to address upstream approaches? What is the role of family voice and communities in this work?

Wareing Evans: Together, through our network, we can help activate a prevention mindset by:

- Providing a shared learning agenda—bringing together what we know about child development and adverse child experiences (ACEs), neuroscience, trauma-informed practice, family-to-family engagement, maternal and paternal health, and population health approaches. We can bring leaders from both systems together through common language and frameworks that help translate across public health and child welfare.
- Developing and sharing practice models that link universal population-health models with effective family-led models.
- Helping build and share practical tools to align, link, and leverage funding streams and services across public health, child welfare, and the broader human and social services.
- Showcasing what is already working in communities and lifting up promising practices.

Fraser: First, we must approach our work together with a strong emphasis on achieving equity and engaging communities. We must both strive to ensure that families, and especially Black and Brown families, are assessed using a new equity lens, free from bias, bigotry, and suppositions. Structural and systemic policy practices regarding how to assess neglect must be addressed to ensure that children are safe, but not unnecessarily removed from their families.

Engagement in partnerships and families with lived experience, combined with a financial investment, will lead to structural and programmatic changes. ASTHO and APHSA have committed to a partnership, and while that makes a strong foundation, we also need to find ways to more fully engage families with lived experience to ensure our front-line leaders have clear and thoughtful direction.

As we know, primary prevention decreases ACEs. On the financial side, what does a commitment to investment in prevention services cost in the long term?

Fraser: The monetary cost of ACEs is growing. We can study specific economic costs but are now grasping the generational impact that trauma has on a person's life course. Generational poverty, poor housing, and the resulting stress in families contribute to ACEs and their outcome. We should work harder to quantify the return on investment gained from addressing the social determinants of health and long-standing inequities in relation to ACEs. This information is invaluable to policymakers with concerns about rising health care costs.

Wareing Evans: Population-level prevention programs cost, on average, five times less than individual interventions. The earlier interventions are made, the more we can save by decreasing the frequency and duration of future necessary services and interventions. Starting and maintaining prevention programs is an investment in community health 20 years down the line—it might take a little while to see the financial benefits of investing in prevention programs but the impact to child and family well-being can be felt immediately.

What are the barriers or challenges that would hinder transformation efforts? What should our members (our change agents) be considering when working toward this joint goal?

Fraser: Top-down assertions of the need for change have not been enough or translated to improvement. We recognize now that engaging our members and finding new ways to improve must happen continually. Our thinking, programs, information, and evaluation must be cross-functional, cross-funded, and cross-integrated. Changing the culture and getting buy-in across multiple stakeholders will be a crucial starting point.

Wareing Evans: Cross-system work requires both understanding the long arc of social change and the need to stay in the game together. It requires leaders of those systems dedicating time to really getting to know each other, building relationships at all levels of our respective systems, exercising humility and vulnerability in leadership to let go of deeply embedded ways of approaching the work, and acknowledging the ways in which all of us tend to default to the systems we know. I am confident we can make real progress together.

We are in a unique situation now with the COVID-19 pandemic. What opportunities do you see arise with COVID-19 response efforts? Why do you think this is the right time to restructure and transform a system? Can we afford to continue with the current model now?

Fraser: COVID-19 can become a catalyst for change and innovation. The pandemic continues to fracture families, decimate communities, and reveal growing racial and ethnic health disparities. At the same time, gaps in health and technology infrastructures and social systems necessitate an urgent discussion among leaders to address all the gaps that brought us to this point. All around us, national and state leaders are more aware of the fragility of systems that support housing, food distribution, employment, education, and community supports. This awareness is sparking a new commitment to work together, across sectors, to address equity and structural racism by uncovering the policies and practices that have brought us to this point. APHSA and ASTHO hear the voices of our members and carry their messages to federal agencies and lawmakers—advocating for additional resources, changes to regulations that hinder progress. These advocacy strategies also apply to changes needed in the child welfare system.

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Wareing Evans: To borrow language from our partners at ASTHO, what we do in this moment must be about bouncing forward, not just bouncing back. It is not enough to restore a present that was not where we wanted it to be. This is a time to collectively reorganize around the changing environment in new and productive ways. Bridging human services with public health creates opportunities to shift services upstream and not only prevent harm before it happens, but truly build resilient communities.

Indeed, the pandemic and related economic shocks is the sort of "disorienting dilemma" that is a catalyst for system transformation—it has already "dislodged" so many entrenched ways of doing business. If we lean in, together we can uproot traditional, historical thinking that has limited our impact in the past, especially as we work to eradicate the structural inequities and bias inherent in both systems.

One other important point is coming out of the pandemic. To support child and family well-being we cannot pit public health against the economy—they are not counter forces. We must promote health and well-being and economic mobility together.

Moving toward primary prevention in the child welfare system can especially affect children from low-income families, and families of color. How do we ensure we are working to reach those who are most at need? How do you believe creating a more transformative system will positively address systemic disparities and inequalities?

Fraser: There are many, many contributing factors disproportionally affecting low-income families and families of color. To tackle only one condition means leaving others unaddressed and still manifested in disparities. The dynamic approach must be multi-tiered and as complex as the contributing factors. It must take into account sectors in education, transportation, environment, and a host of others. We will most likely not hit the mark on our first try or even our tenth, so it is important to pull additional levers and continue to invest in families who have for too long borne the generational, racial, and financial costs of inequity.

Structural and systemic policy practices regarding how to assess neglect must be addressed to ensure that children are safe, but not unnecessarily removed from their families.

Wareing Evans: The data on social and racial disparities are indisputable and intolerable. COVID-19 laid bare the stark health disparities for Black, Latinx, American Indian, and Alaska Native individuals. Infection, hospitalization, and death rates are higher across the board.

In child welfare, we have known similar disparities along race and income lines for too long. When comparing maltreatment rates across race and ethnicity, American Indian, Alaska Natives, and Black children have the highest rates of entering foster care at 16.0 children per 1,000 for American Indian/Alaska Native and 9.1 per 1,000 children for Black and Latinx children compared to just 5.3 per 1,000 for White children based on 2018 AFCARS data. Yet, research indicates that there is no relationship between race and increased cases of maltreatment that is not explained by disparities in socioeconomic status and other systemic barriers.

The challenge before us is complex, dynamic, rooted in historical policy and practice, and bigger than any one system or sector. There is no silver bullet—no single approach. This effort must have a shared commitment to tackle what structurally gets in the way, especially for families who face the greatest adversities. The first step is asking ourselves the uncomfortable question of how we got here and how we can prevent more damage to communities of color.

Any other thoughts or advice that you would like to share as we launch this work?

Wareing Evans: I would challenge all of us committed to this partnership and this work to ask ourselves: Are we curious enough? Are we asking the right questions? How might we break open new pathways? In what ways can our cross-system work accelerate change?

We have to co-build "system resilience"—co-designing metrics that help us capture what it means for everyone to thrive in a community. We need to focus on what those thriving metrics should be—and use them as the measure. This includes metrics that tell us how families are doing. How do we know we are moving upstream and helping prevent issues before they happen? Are we enabling the conditions that meet families where they are and address root causes?

Fraser: When we put families at the center of our shared work, I think we can do amazing things that transcend silos and turf and allow staff to make connections based on needs. The more flexibility leadership grants to teams to work together and innovate, the better our solutions will be. Even amid a global pandemic, we can imagine a better future for children and families that includes both of our memberships.