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COVID-19 Special Issue:
Challenges and Opportunities Associated
with Serving Children and Families
During the Pandemic





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The COVID-19 pandemic has brought new challenges to assuring the well-being of children, adding to enduring concerns about the inadequacy of child welfare services and a deterioration of the child welfare workforce. This article summarizes remarks from an expert panel, which was convened for the 2020 Fedele F. and Iris M. Fauri Memorial Conference at the University of Michigan School of Social Work. This online conference was titled “Child Welfare and the COVID-19 Pandemic.” Panelists explained how child welfare systems have been impacted by the COVID-19 pandemic and what these systems have done to respond to increasing and changing demands brought about by shifts in child welfare policies and practices. Panelists also commented on how insights from the pandemic can help to lessen the risk of child abuse and neglect in the future

page 20 [Bracing for Impact: Lessons Learned from the COVID-19 Pandemic and the Response to Child Abuse and Neglect](#) | *Andrea Repine, Jennifer Macaulay, Stephanie Anne Deutsch*

Extreme caregiver stress, economic uncertainty, housing and food insecurities, and social isolation coupled with limited access to mental health, substance use treatment, and other community supports have historically rendered children more vulnerable to abuse victimization. Similar pandemic-related societal circumstances have sparked concern for an inevitable, co-occurring epidemic of child abuse wreaking further havoc during an already disastrous COVID-19 pandemic. While early data demonstrating abuse and neglect victimization trends have provided mixed results, what is clear is that the pandemic has notably compelled “lessons learned” across the multidisciplinary team (MDT) of professionals responding to child maltreatment concerns. Besides the emergence of innovative, technologic adaptations; a focus on COVID-19 as the latest adverse childhood experience; and lessons learned about protective family-level factors and experiences, the pandemic suggests an urgent need for a paradigm shift within child welfare toward increased upstream family supports, emotional connectedness, and resiliency as more effective strategies to prevent abuse and neglect.

page 26 [Early Stage of the COVID-19 Pandemic and Investigations of Child Maltreatment: An Empirical Study of Administrative Data](#) | *Hui Huang, Abigail Williams-Butler, Keunhye Park, Joseph P. Ryan*

After the outbreak of the COVID-19 pandemic in March 2020, the child welfare system has experienced its unprecedented impacts. This study examined the impact of the early pandemic on the number of investigations of child maltreatment, demographics of children and perpetrators involved in these investigations, allegation types, and substantiation. This study compared administrative data from the state of Michigan between March 15, 2019 and April 14, 2019 (i.e., before the outbreak of the COVID-19 pandemic) and between March 15, 2020 and April 14, 2020 (i.e., early stage of the outbreak of the COVID-19 pandemic). The results from bivariate analysis showed a substantial decrease in the number of investigations of child maltreatment, younger age among child victims, and greater percentage of concluding dispositions within 30 days after a maltreatment report. The racial and gender composition of children and the gender composition of perpetrators involved in maltreatment allegations did not statistically significantly differ prior to and after the outbreak of the COVID-19 pandemic. The results from logistic regression showed that the rate of substantiation increased after the outbreak. Practice and research implications are provided.

page 36 [Parenting Support for Families Impacted by Opioid Use Disorder during the COVID-19 Pandemic: Insights from Pennsylvania Home Visiting Pilot Programs](#) | *Deanna Marshall, Katherine Kellom, Meredith Matone, Peter F. Cronholm*

The 2018 Pennsylvania state budget directed funds toward maternal and child home visiting as a promising mechanism to support families impacted by the opioid epidemic, funding 20 pilots across the state. Pilot sites used the funding to adapt services to fit community needs. An addendum to the final survey of an ongoing mixed-methods implementation evaluation of these pilots assessed the impact of the COVID-19 pandemic on home visiting programs serving families impacted by opioid use disorders, as perceived by pilot-engaged staff. Data from this addendum suggest that shifting services to virtual removed barriers to group participation, like transportation and childcare, but presented technological challenges and increased the difficulty of trust-building. Site respondents reported that grandparent-caregivers struggled with suspended parental visitations and childcare during the pandemic.

page 45 [Practitioner and Military Family Perspectives of Child Maltreatment Risk and Protective Factors During COVID-19: A Multimethod Approach](#) | *Miranda P. Kaye, Amanda M. Ferrara, Daniel F. Perkins*

Active duty military families face unique challenges (e.g., frequent deployments and geographic relocations) that may serve to exacerbate or diminish risk and protective factors for child maltreatment. However, active duty military families' risk and protective factors for child maltreatment in the context of the COVID-19 pandemic is largely unexplored. To this end, we used a convergent parallel mixed methods design to explore practitioner- and parent-reported risk and protective factors for child maltreatment during the COVID-19 pandemic. Through a qualitative analysis, Army New Parent Support Program practitioners reported mental health, stress, support, family relationships, and resilience as risk and protective factors for child maltreatment in Army families. In convergence with these findings, quantitative analyses revealed that parent-reported psychological distress, relationship discord, uncontrolled anger, and isolation were associated with increased risk for child maltreatment. Divergence in results was also examined, and implications for practices are discussed.

page 59 [Families at the Intersection of Racial Injustice, COVID-19, and Child Welfare](#) | *Jemour A. Maddux, Charles F. Boyer, Pantea Yazdian Maddux, Paulett Diah, Tyshawn Thompson*

Considering the disruption caused by COVID-19 and the racial unrest of 2020 and 2021, professionals helping children affected by child maltreatment are seeking ways to better serve Black, Indigenous, and People of Color (BIPOC) communities at the intersection of the pandemic, racial injustice, and child welfare involvement. From a multidisciplinary perspective, this commentary provides a glimpse into the injustices experienced by BIPOC communities, which have been exacerbated by COVID-19. We briefly point out initial steps for professionals to take to strive towards equity in their service to children affected by child maltreatment during the pandemic. We also call upon professionals to oppose decisions that may promote systemic racism in our field and to give voice to BIPOC communities based on how these groups may experience child maltreatment policies and initiatives that have been created without their input by those that have amassed power.

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Uncovering the Hidden Cost of the Pandemic on Child Safety and Well-Being: Introduction to the COVID-19 Special Issue

Lisa Schelbe, PhD, MSW
Carlo Panlilio, PhD

Many of us continue to grapple with the heartache, crises, and chaos brought about by events of the last couple of years, particularly spawned by the onset of the COVID-19 pandemic. Even now, as we write this editorial, the number of deaths in the United States from COVID-19 have reached more than 565,000 and the number of cases continue to rise as we approach 32 million. For children and families in low-resourced communities, these devastating figures are even higher and expose the preexisting inequities that are exacerbated by the pandemic. It has been more than a year since the pandemic became a reality for many of us and these problems persist, even more so now as we attempt to return to “normal” (whatever that means). Yet for many children and families, the aftermath of this pandemic will persist, and our child-serving systems need to be prepared to respond.

As professionals concerned with the well-being and safety of children, many of us have already been concerned about such a response and the impact this pandemic has brought upon vulnerable children and families. As a means to engage our community of professionals and understand this issue further, we immediately created a call, in the summer of 2020, for papers on a special issue related to the topic of COVID-19 and child maltreatment. This special issue sought to include an interdisciplinary perspective related to practice, policy, and research, with articles focused on 1) the pandemic’s impact on various child-serving systems and their responses; 2) specific

child maltreatment risk and protective factors due to the pandemic; and 3) the pandemic’s exposing and amplifying inequities for vulnerable children and families. Having assumed our new positions as the editorial team of the *Advisor* in this unprecedented time, we felt compelled to pull together a collection of papers focusing on how to prepare our APSAC members’ responses. It is therefore our hope that these papers hold important insights and implications that will help our APSAC members when they are working with children and families during the pandemic and beyond.

We are fortunate to have Ortega and colleagues’ invited paper (written proceedings from the University of Michigan School of Social Work Fedele F. and Iris M. Fauri 2020 Memorial Lecture) in our special issue, which begins with a commentary about the impact of COVID-19 on children and families. This is followed by three panelists’ descriptions of how child welfare systems have been impacted by the pandemic and how these systems can be responsive to such changes. Panelist Rodriguez describes the combination of risk factors related to the pandemic that could contribute to elevated risk of experiencing child maltreatment. Using data from a prospective longitudinal study, Rodriguez described findings of mothers’ self-reports, which included more than a third of the respondents reporting increased yelling and conflict. Additionally, the study found households had financial losses related to the pandemic. The study concluded that such risk factors increased the likelihood of abuse during the pandemic.

Johnson-Motoyama, the second panelist, examines policy implications for child maltreatment prevention in light of the pandemic and economic recession. Integrating theory and research, Johnson-Motoyama presents the importance of a strong safety net for families—especially in times of crisis—and failure to support families will disproportionately impact Black, Indigenous, and people of color (BIPOC) families and communities in particular. She offers implications for policy to address such disproportionalities.

The final panelist, Merkel-Holguin, explores the impact of COVID-19 on the child welfare system. Specifically, she outlines some of the innovations and adjustments that the system has made in response to the pandemic, which have the potential to redistribute power and decision making. There are opportunities that the pandemic has offered, Ortega and colleagues conclude, including rethinking child protection. The lessons learned from circumstances that the pandemic brought about family well-being and prevention can ground future system reform and ultimately strengthen these systems' ability to support families. In "Behind Closed Doors: The Unintended Impact of COVID-19 on Child Safety," Repine and colleagues explore how the stress and isolation brought by the pandemic can increase risk of child maltreatment. School and workplace closures to promote social distancing decrease the spread of COVID-19, yet children and families become more isolated. The authors lay out a strategy for maltreatment prevention in these times, starting with reducing the stigma of caregivers asking for help. Furthermore, Repine et al. discuss how technology such as telehealth platforms can promote connections and mitigate the risks brought about by the pandemic.

Huang and colleagues use administrative data to explore changes in the numbers of investigations of child maltreatment before the pandemic and in the early stages thereafter. In the paper titled, "Early Stage of the COVID-19 Pandemic and Investigations of Child Maltreatment: An Empirical Study of Administrative Data," the authors found that despite a decrease in the number of investigations, the rate of substantiation increased disproportionately. Variability in the reporting and investigation of types and timing of maltreatment were also present. Specifically, the authors found a general decrease in the reporting

and investigation of physical or medical neglect, failure to protect, and threatened harms, particularly for younger children. The authors suggest that these changes may be attributable to school closures and detail practice implications.

The paper, "Parenting Support for Families Impacted by Opioid Use Disorder during the COVID-19 Pandemic: Insights from Pennsylvania Home Visiting Pilot Programs," by Marshall and colleagues is an evaluation of a home visiting program for families experiencing substance use. The authors argue that families for whom there is a high prevalence of opioid use are especially at risk for being adversely impacted by COVID-19. The paper details lessons learned in 20 sites across Pennsylvania during the process of shifting to a virtual setting due to the pandemic. Specifically, the authors describe innovations and practical considerations for home visiting programs. According to the authors, despite the reduced barriers (e.g., childcare and transportation) for service access, the programs still noted increased isolation, unemployment, and client relapse.

Kaye and colleagues explore practitioners' and parents' reports of perceived risk for maltreatment as it pertains to the unique needs and strengths of Army families during the pandemic. Their article, "Practitioner and Military Family Perspectives of Child Maltreatment Risk and Protective Factors During COVID-19: A Multimethod Approach," details the experiences of military families who are expecting a child or have a child under the age of three and who are eligible for the Army New Parent Support Program. The authors found that the pandemic increased military families' isolation, as well as increased mental health issues and stress. To address these pandemic-related challenges, the authors outline specific support structures needed by families, along with the emphasis that resilience and adaptability of military families should be considered as protective factors as well.

In the *Advisor's* section dedicated to racial equity commentary, Maddux and colleagues share insights about the intersection of racial injustice, child welfare, and COVID-19. Written by a team of experts from different disciplines, the article explores the crises and inequities from legal, psychological, health, and faith-

based perspectives. It concludes with a call for change and demands policies and programs that seek to end poverty and trauma rather than exacerbate them. Together, all of these articles have implications for our policy and practice when serving children and families. They inform our ways of thinking and our commitment to supporting children and families in these trying times. In line with the special issue's focus, we need to acknowledge that the aftermath of COVID-19, particularly when combined with preexisting inequities, will persist. Therefore, we must take advantage of the current opportunities to make significant and meaningful changes in society to ensure equity and justice. Furthermore, we need to continually recognize the pandemic's impact on various child-serving systems and how these systems adapt their responses, how the pandemic affords unique child maltreatment risk and protective factors in children and families, and how the pandemic has exposed and amplified inequities for our vulnerable children and families.

As we conclude this editorial, over 86 million people in the United States are fully vaccinated, which equates to more than 26% of the population. Over 40% of the population has received at least one dose. Clearly, the pandemic is far from over; yet as the pandemic continues so does our learning and work to serve children and families.

Lisa Schelbe, Editor-in-Chief
Carlo Panlilio, Associate Editor

About the Editor-in-Chief

Lisa Schelbe, PhD, MSW, is Associate Professor at Florida State University College of Social Work and a Faculty Affiliate at the Florida Institute for Child Welfare. She serves as a Co-Editor-in-Chief of the Child and Adolescent Social Work Journal. Her research focuses on young people transitioning out of foster care and services to assist with their transition out of care. She is a qualitative methodologist with experience working on interdisciplinary teams. She has published over 30 referred journal articles and co-authored a book titled Intergenerational Transmission of Child Maltreatment (Springer, 2017). Dr. Schelbe received her doctorate in social work from University of Pittsburgh, where she was a Doris Duke Fellow for the Promotion of Child Well-being.

About the Associate Editor

Carlo Panlilio, PhD, is Assistant Professor in the Department of Educational Psychology, Counseling, and Special Education, and a faculty member with the Child Maltreatment Solutions Network at the Pennsylvania State University. He received his PhD in Human Development from the University of Maryland, College Park, with a specialization in Developmental Science and a Certificate in Education Measurement, Statistics, and Evaluation. He was a former Doris Duke Fellow for the Promotion of Child Well-being. His program of research focuses on the dynamic interplay between maltreatment, context, and development and how these processes influence individual differences in learning across the lifespan. His research is guided by an interdisciplinary approach to examine the multisystemic influences of early adversity on self-regulatory processes that explain variability in the academic outcomes of children with a history of maltreatment. He has published several journal articles and chapters and was editor of Trauma-Informed Schools: Integrating Child Maltreatment Prevention, Detection, and Intervention. Dr. Panlilio previously worked as a licensed clinical marriage and family therapist in private practice, community agencies, treatment foster care, and a residential treatment facility for adolescents.

Fedele F. and Iris M. Fauri 2020 Memorial Lecture: Child Welfare and the COVID-19 Pandemic

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Keywords: University of Michigan School of Social Work, Fauri Memorial Conference, COVID-19 pandemic, child welfare, child welfare workforce, child maltreatment prevention

Introduction

Over the past decade, state child welfare systems in the United States have been pressed to do more to support and assist vulnerable families by offering more prevention and early intervention services (Herrenkohl et al., 2020). The U.S. Family First Prevention Services Act (FFPSA) was signed into law in 2018 and has been heralded as a plan to move state child welfare systems from those based predominantly on risk mitigation to ones centered on family supports, early intervention, and diversion from out-of-home placements. While there is considerable work ahead, some efforts underway to address core impediments to healthy and productive families (such as housing instability, food insecurity, and parenting stress) are promising and show a desire, if not intent, to move services “upstream” and away from the punitive, often stigmatizing approach that has existed within child welfare systems for decades. Additionally,

focused activities intended to lessen implicit bias toward families of color that implicate their overrepresentation in child protection investigations and in the use of out-of-home placements are also underway in some jurisdictions, although experts remain alarmed by data showing clear evidence of sustained racial disparities in services and outcomes associated with child welfare involvement (Dettlaff et al., 2020). Better training and the inclusion of input from families in some jurisdictions has also begun to offer hope that change is possible.

Still, the persistence of the COVID-19 pandemic has brought new challenges to assuring the welfare of children and preservation of families. Emerging risks to children and families became evident early in the pandemic due to increased social isolation, rising unemployment, domestic violence, and food insecurity (Herrenkohl et al., 2020). Child protection saw a rapid decrease in reports of child abuse and neglect, raising suspicion that children were placed in harm’s way without being discovered or reported. These concerns were raised because while reports

were declining, families were experiencing sharp increases in risk factors for child maltreatment. For many families, the pandemic included economic instability due to work stoppages, reduced hours, or job closures. Economic instability jeopardized basic health care coverage, housing stability, and home safety. Changes to the social safety net to protect families from economic disruption were slow to arrive and were also minor in scope. Many families were unable to access unemployment benefits, and stimulus funding was insufficient to overcome lost wages. At the same time, increased social distancing and schools relying more on virtual learning led to disrupted social connections and restricted the social outlets for children and their families. Changes in family dynamics because of prolonged time spent together without respite resulted in diminished work-family life balance, challenged personal space boundaries within the home, and increased parenting conflicts. Instability also led to mental health distress, loneliness, exposure to interpersonal violence, and other risks such as drug and alcohol use—factors highly associated with child abuse and neglect.

During the pandemic, we have witnessed changes to child welfare accountability, as well as investigative and child welfare case worker practices. For example, reports of suspected cases of abuse and neglect, especially from mandated reporters such as teachers, have been reduced so there are less available data to reliably ascertain child protection demands and needs (Jonson-Reid et al., 2020). If a determination of risk leads to a decision about preserving the family or a child's removal during the COVID-19 pandemic, options for safely housing the child are uncertain, as the current challenges add to an ever-increasing risk to safety, stability, and the promotion of a child's well-being within a complex and challenging home environment.

The long-running concerns about child and family well-being and the inadequacy of child welfare services available to children and families were clearly revealed, and a history of systemic, policy, and practice shortcomings are now even more pronounced (Herrenkohl et al., 2020; Herrenkohl et al., 2019; Lonne et al., 2019). These criticisms are compounded by the long-standing and troubling deterioration of

the child welfare workforce due to burnout (Lonne et al., 2019). Sadly, there had been little movement before or during the pandemic to address enduring concerns about workforce stress, although the problem will inevitably have to be addressed. Efforts to support vulnerable children remaining in the home now rely on greater worker precautions to safeguard against exposure to COVID-19. When cases are opened, service delivery must weigh permissible options such as, for example, virtual contact as opposed to in-person contact in situations assessed as low risk. Working remotely presents its own challenges because, although it assures safety from exposure to COVID-19, it may mask conditions that more holistically indicate higher risks in face-to-face encounters than what can be ascertained when interacting with families through a computer monitor, iPhone, or other methods that allow a worker to virtually interact with at-risk children and their families.

University of Michigan School of Social Work Held Its Annual Fedele F. and Iris M. Fauri Memorial Conference

In October 2020, the University of Michigan School of Social Work held its annual Fedele F. and Iris M. Fauri Memorial Conference. The Fauri conference is presented each year in recognition of the former University of Michigan Dean and Vice President Fedele F. Fauri and his wife. Dean Fauri's leadership and accomplishments in the field of child welfare spanned nearly 50 years. This year's conference featured an online panel of distinguished speakers who discussed how current circumstances are serving to expose and heighten enduring concerns about gaps in child welfare services brought to light during the COVID-19 pandemic as it impacts the vast majority of families.

This article summarizes the presentations of the panel titled "Child Welfare and the COVID-19 Pandemic." In their remarks, speakers focused on the ways child welfare systems have been impacted by the pandemic and how these systems have responded to increasing and changing demands brought about by shifts in child welfare policies and practices. Additionally,

speakers provided insights on the immediate and long-term impacts of the pandemic on child welfare service models and lessons learned during this crisis that may help to lessen the risk to children and families in the future. The following sections summarize their remarks. A brief conclusion and implications section follows.

Child Abuse Risk Rise in the Pandemic? Empirical Clues

Christina M. Rodriguez, PhD

Early on, a number of warning signs signaled that the COVID-19 pandemic would herald a period of elevated risk for child maltreatment. The incidence of maltreatment rises after natural disasters (Seddighi et al., 2019) and follows times of economic upheaval like the Great Recession (Brooks-Gunn et al., 2013). But the pandemic wove together a number of risks simultaneously for American families that could increase child maltreatment.

A number of longitudinal studies link unemployment to higher rates of child maltreatment (Slack et al., 2011). Unemployment can lead to economic hardship, which can in turn lead to food insecurity and stress on the family (Yang, 2015), as well as higher risk of psychological and physical aggression toward children (Helton et al., 2019). The COVID-19 pandemic initiated historic levels of unemployment, with over 40 million Americans filing for unemployment within weeks of the pandemic's announcement (Lambert, 2020). Economic relief from the government allocated \$500 per child, compared to \$1000 per adult, which translated to less financial support for some of the most vulnerable single-parent families raising multiple children.

The pandemic also introduced unprecedented requirements to “stay at home” and socially distance—resulting in an increased likelihood of social isolation. Research has shown that lower social support is associated with increased risk for physical abuse (Rodriguez & Tucker, 2015) and neglect (Freisthler et al., 2014). Thus, this important resource was taken away from families at the very time it was needed

most. During COVID-19, parents are spending more time at home with their children, which may result in more family conflict. During summer school breaks, non-accidental fractures at hospitals tend to rise (Leaman et al., 2017), and reports to child protective services usually decline (Jonson-Reid et al., 2020). During the pandemic, many typical mandated reporters to child protective services do not have the same oversight of children, leading to fewer official reports to child welfare (Jonson-Reid et al., 2020).

Thus, a combination of risks ushered in by the pandemic could translate into elevated maltreatment risk. In our study, mothers enrolled in a longitudinal study participated in a pandemic wave of data collection in which we assessed: (1) whether mothers perceived changes in their pandemic parenting and whether adverse changes corresponded with established measures of child abuse risk; (2) whether employment loss/reduction, food insecurity, or loneliness significantly related to current child abuse risk and mothers' reports of pandemic-related increases in conflict and neglect; and (3) whether physical and psychological child abuse risk during the pandemic increased from mothers' pre-pandemic levels.

Mothers in this study were drawn from those enrolled in the Following First Families study, a prospective longitudinal investigation carried out in the Southeast United States that oversampled for families with one or more sociodemographic risk. The study began the last trimester of mothers' pregnancy and continued until their children were age 4 ($n = 119$ mothers). Early in the pandemic (late April–May), when their children were between 5-6 ½ years old, 106 mothers reported on their pandemic parenting and abuse risk.

Only 3% of mothers reported they were hitting their children more often, but 33.3% reported more yelling, 34.9% reported more conflict, and 11.9% reported speaking with their children more harshly. Further, 7.5% reported leaving their children alone more often, 1.8% reported more difficulty feeding their children, and 1.8% reported showing less love toward their children since the pandemic began. Mothers who reported increased spanking/hitting their children, more yelling, and more neglect during the pandemic

also had the highest child abuse risk scores on established measures.

Over 38% of mothers reported their household experienced pandemic-related employment financial loss (either laid off/furloughed or reduced work hours). Those who experienced employment loss obtained higher child abuse risk scores. Without a resolution of the pandemic and the concomitant economic pressures, parents' abuse risk may be exacerbated. In addition, mothers who reported their children had received meals at school before the pandemic (24.5%) indicated they were experiencing more difficulty feeding their children, higher conflict with their children, and marginally more child abuse risk and spanking. Access to school meals indeed appears to a needed resource for parents to decrease their risk for maltreatment.

Interestingly, mothers who indicated they were experiencing loneliness during the pandemic did not obtain higher child abuse risk scores on established measures during the pandemic. Instead, mothers' greater loneliness was associated with their reports of engaging in more spanking, yelling, conflict, and neglect of their children. These results indicate that parents' perceptions of social isolation are associated with their *perceptions* of harsher and more neglectful parenting during the pandemic.

Compared to scores from data collected from mothers in the previous wave of the longitudinal study, mothers were at higher risk for abusing their children during the pandemic and used more psychological aggression. However, it appeared that mothers did not use more physical aggression, according to their self-reports (for additional details, see Rodriguez et al., 2021).

Overall, the COVID-19 pandemic has revealed gaps in the social safety net that is ill-equipped to meet the needs of many vulnerable children and families. The child protection system has been founded on sentinels like educational and health professionals as sources of mandated reports of maltreatment—a foundation that crumbled during this crisis. Because the current welfare system is a reactive system that responds to the most serious cases of maltreatment, a more proactive, public health approach is required (Higgins

et al., 2019). Shifting from reactive to proactive, prevention-oriented service models will help child welfare agencies better prepare and respond to families that are directly impacted by crises like the current pandemic.

The Covid-19 Pandemic and Economic Recession: Policy Implications for Child Maltreatment Prevention

Michelle Johnson-Motoyama, PhD, MSW

Questions and concerns abound regarding the effects of the COVID-19 pandemic on child maltreatment. Prior to the pandemic, roughly 4.3 million referrals to child maltreatment received an investigation or an alternative response from child protective services (CPS) each year (USDHHS, 2020). However, media coverage and reports from state child abuse and neglect hotlines suggest referrals to CPS fell dramatically during the pandemic's first wave. Observers largely attributed the decrease in referrals to reduced contact of children with mandated reporters, particularly teachers, resulting from stay-at-home orders. Simultaneously, the media began documenting a rise in child abuse hospitalizations, intimate partner violence, and calls to sexual abuse hotlines, suggesting an increase in severe types of maltreatment. Yet systematic and timely data that might shed light on these dynamics is unfortunately limited, making it difficult to determine how best to prevent and intervene in maltreatment cases during these unprecedented times. However, theory and research on the effects of natural disasters and economic recessions on child maltreatment offer useful insights that hold implications for policy.

Natural Disasters, Economic Recessions, and Child Maltreatment

The COVID-19 pandemic presents risks that are both unique and shared between natural disasters and economic recessions. According to Rezqian (2013), natural disasters forge a pathway to interpersonal violence through personal threats to life, loved ones, and property; the interruption and failure of

social systems and services; the collapse of social cohesion and harmony; and massive destruction and population displacement. These phenomena create mental distress, which can be exacerbated when basic provisions are scarce, law enforcement fails to fulfill its duties, governments fail to fulfill promises to help victims, and individuals perceive and experience powerlessness. In Rezqueian's (2013) model, certain groups may be more vulnerable to violence, including children, women, the elderly, those with low social support, and those with prior exposure to trauma. As a society, we have witnessed several features of Rezqueian's model during the COVID-19 pandemic. In addition to the personal threat to life of a highly contagious and deadly disease, efforts to contain the disease have spurred job losses and high rates of unemployment, creating recessionary conditions and economic stress for millions of families. A crisis of social unrest related to racial injustice has occurred simultaneously, while natural disasters such as wildfires and hurricanes have ravaged parts of the country, creating mass destruction and displacing thousands.

Decades of research on the family stress model (FSM) provide insight into how COVID-19's economic recession may affect family processes (Conger, Conger, & Martin, 2010). Economic stress affects a family's ability to care for their child's basic needs; it places strain on romantic relationships, which may contribute to divorce and single parent households; and it leads to caregiver distress, such as depression, and difficulties in parent-child relationships. Moreover, a lack of adequate nutrition and proper care for children can contribute to child behavior problems, placing children at greater risk for maltreatment (Masarik & Conger, 2017).

In the context of these theoretical models, what have we learned from research about natural disasters, economic recessions, and child maltreatment? A small number of published studies have found associations between natural disasters and child maltreatment. For example, child abuse reports were elevated in the months following Hurricane Hugo and the Loma Prieta Earthquake (Curtis et al., 2000), and elevated risks of child traumatic brain injury followed Hurricane Floyd (Keenan et al., 2004). However,

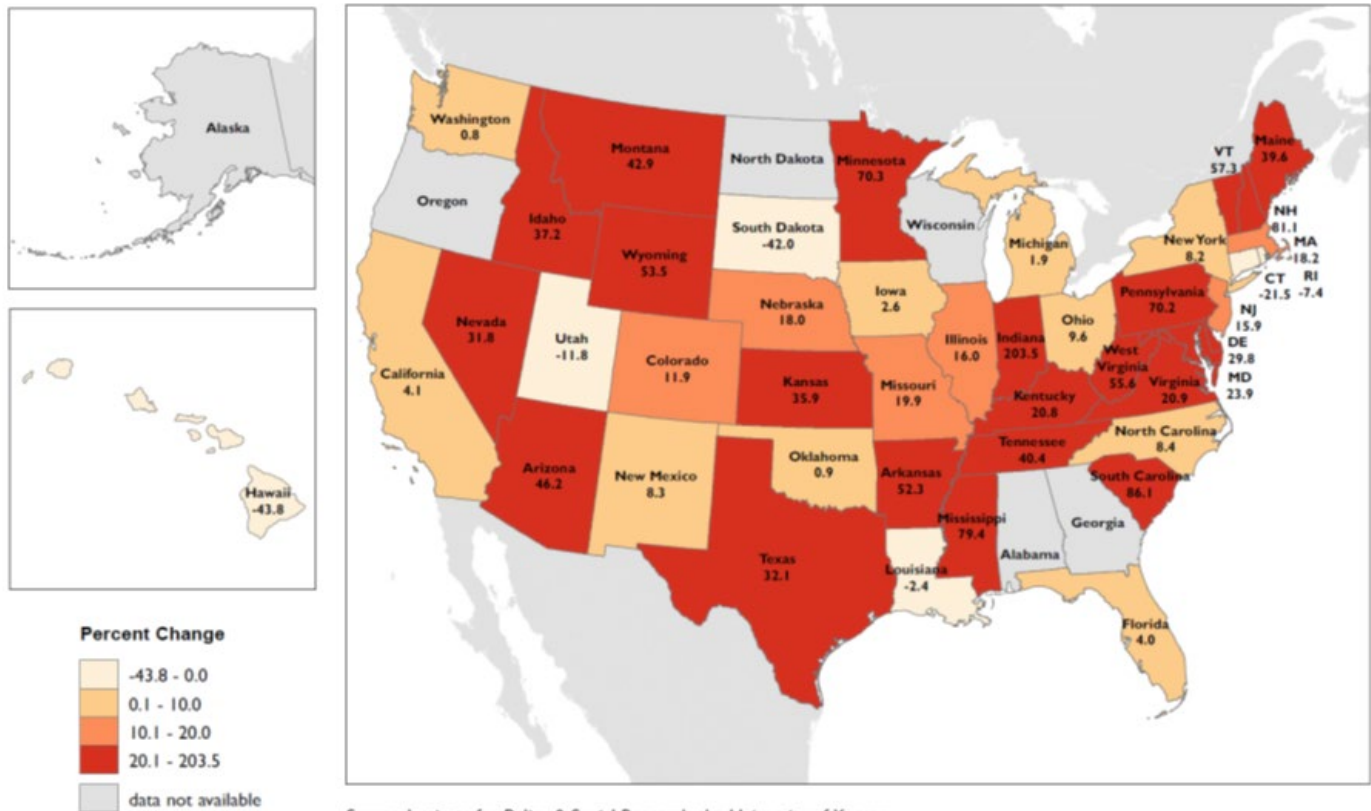
it is important to note that not all studies have found conclusive relationships, suggesting a role for protective factors in prevention (Cerna-Ternoff et al., 2019).

In our own research, we have been examining child maltreatment during the Great Recession, which began at the end of 2006 and continued to ripple through the U.S. economy as late as 2013. We examined child maltreatment trends for the nation from 1990 to 2016 and found that while rates of neglect remained somewhat constant during the recession, physical abuse and sexual abuse declined (Finkelhor, Saito, & Jones, 2018). However, upon closer examination of state level data we found wide variation in child maltreatment rates over time, with some states experiencing dramatic increases in child maltreatment (up to 204%) while others saw little change or even declines (see Figure 1). We hypothesized that state social safety net programs played at least a partial role in these trends through policies that buffered families from economic stress in some states and exacerbated risk in others. Accounting for a broad range of state-level factors associated with maltreatment, we found state-level policy changes made in Temporary Assistance to Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), and refundable Earned Income Tax Credit (EITC) policies played significant roles in preventing child maltreatment and foster care entries (Johnson-Motoyama & Ginther, 2019). We also found alternative response/differential response (AR/DR) programs, which are often responsive to needs for concrete services, to have preventive effects across states over time (Johnson-Motoyama et al., 2020). These findings build on a body of past research that has found social safety net programs to be associated with child maltreatment prevention (Maguire-Jack, Johnson-Motoyama, & Parmenter, under review). A key takeaway is that even small amounts of money appear to matter.

Implications for Policy

To date, the U.S. Congress has passed a number of coronavirus-related legislative actions to enhance unemployment insurance, increase federal funding for Medicaid, and increase food security spending. For example, the 2020 CARES Act made direct payments to taxpayers and introduced economic support for

Figure 1. Percent Change in Number of Child Maltreatment Investigations by State, 2005–2016



Source: Institute for Policy & Social Research, the University of Kansas; data from National Data Archive on Child Abuse & Neglect, NCANDS Child File.

small businesses, and the Centers for Disease Control and Prevention (CDC) passed an eviction moratorium to protect 43 million renters nationwide, which the Biden Administration extended through March 2021. However, recent reports suggest existing measures have not been sufficient to stave off food insecurity or bolster resources for household spending, rent, or mortgages. Additional federal investments are necessary to stabilize income, and concrete supports must be a priority. In the meantime, past research suggests the actions that states and localities take now to support families in need matter for prevention. Policies that increase access to the social safety net and improve the generosity of benefits are likely to have a positive impact. For example, despite legislative efforts, states have not received any additional TANF funds during COVID-19. However, the federal government has encouraged states to waive work requirements and to use funding flexibly to assist families. In turn, some states and localities have creatively developed their own pandemic emergency assistance programs through TANF. As policymakers and practitioners consider available funding arrays in their states and localities, concrete supports for vulnerable families

to address basic needs should be among the top priorities. Notably, the impacts of the pandemic and its economic fallout, while widespread, are disproportionately affecting Black, Latinx, Indigenous, and immigrant children and families. Some of these groups have historically have been more likely to come to the attention of CPS, reflecting longstanding systemic inequities that the current crisis is exacerbating. Equitable access to available services will be critical in mitigating the disproportionate impact of the pandemic on society’s most vulnerable children and families.

Some Potential Impacts of COVID-19 on Child Welfare

Lisa Merkel-Holguin, MSW

By most historical accounts, the current day United States child protection system emanates from the work of Dr. C. Henry Kempe, a tenacious researcher and relentless advocate at the University of Colorado School of Medicine. Dr. Kempe and his colleagues

were the first to recognize and identify child abuse and neglect in their defining paper, “The Battered Child Syndrome” (1962). This paper was regarded as the single most significant event in creating awareness and exposing the reality of child abuse. A decade later, the Kempe Center was born, and for almost the next 50 years, the child maltreatment field consisting of multidisciplinary professionals has been instrumental to establishing policies, laws, research, and training systems to better protect children.

Undoubtedly, the Kempe Center, along with other national, state and local government, nonprofit, and community organizations, has worked tirelessly to protect children and support families, and these groups have numerous positive outcomes to show for their efforts. Yet, there is an awakening across the world that child welfare systems need to be transformed (Casey Family Programs, 2020) or perhaps even abolished (Dettlaff et al., 2020). This reckoning emerges with a growing awareness that child welfare systems disproportionately harm people of color, exclude family systems, marginalize the poor, create an economic underclass, and produce abysmal outcomes for far too many. In addition, there is a culture of oppression that permeates many of the child welfare structures, policies, and protocols, impacting not only the children and families but also the workforce (Yang & Ortega, 2016).

New York Times opinion columnist David Brooks presented to the Weave community of the Aspen Institute in April 2020. He suggested—from studying pandemics historically—that we create a redemptive narrative to improve society. He encouraged everyday citizens to innovate their work and use the pandemic as a motivator for change. At the Kempe Center, we took his challenge seriously and asked, “How can we use our organizational position and privilege to stimulate critical thinking and inspire change in the field of child welfare?” From that question, we set out to build and convene an international community of practice to address issues of justice, social inequality, race equity, family leadership, and oppression in the child welfare and allied systems and began to discuss, debate, and solution build on how systems, communities, and individuals can begin the process of fundamentally changing the structure of these systems.

The COVID-19 pandemic, coupled with the racial awakening in spring 2020, has energized a broad swath of stakeholders to reimagine the child welfare system as one that centers on child and family well-being. Discussed below are a few ideas driving that vision.

Child Maltreatment Reporting

Since COVID-19, child maltreatment referrals have decreased, but of accepted referrals, there is an increase in the proportion of referrals involving domestic violence. A number of media reports indicate that child protection teams are seeing an increase in children with serious injuries. The competing narratives that have emerged during COVID-19 are different, yet likely shape and frame the CPS response and public opinion. For example, media reports suggest, without evidence, that low levels of reporting signify that thousands of children are being abused, and professionals and systems need to find and rescue them. For some parents in communities with the highest level of CPS surveillance, this decrease is a welcome relief from the trauma they experience at the hands of CPS (Hurley, 2020). Another narrative suggests that CPS reporting and investigative practices are intended for the most egregious cases, yet the vast majority of reports are neglect related. Thus, the decrease in reporting under COVID-19 could be acting like a natural filter, with only the most egregious cases being identified for CPS response and service. The larger issue that has emerged—independent of the narrative—is how mandated reporter policies and child abuse hotlines are shaping our response to child maltreatment, resulting in calls for reform (Raz, 2020; Worley & Melton, 2013).

A Surveillance Orientation

The CPS system is surveillance oriented, saturated in risk, and driven by procedures that deliver unequal outcomes and contribute to inequities (Roberts, 2020). In a provocative law review journal, Burrell (2019) compared stop and frisk policing policies to child maltreatment investigations. Burrell found parallels between these approaches, including the tendency to rely on a low burden of proof; the disproportionate effects on people of color in low-income communities; the overall negative impacts on the community; and worker behaviors (e.g., similarities between rogue police officers and rogue caseworkers). The review also

revealed similarities in media portrayals of crime and abuse. While there are divergent views as to whether child welfare is a helping system or a family regulation system intended to perpetuate forcible family separation (Roberts, 2020), there is likely agreement that families' perspectives of child welfare being a punishing system need to be heeded.

Economic Relief

It has been widely documented that the majority of families served by child welfare are poor and have a multiplicity of needs to address including food security, mental health, basic needs, economic relief, substance abuse, and housing stability. A number of approaches are being implemented and showing promise. The first, interdisciplinary parent representation, incorporates an interdisciplinary law office approach in which families are served by a social work staff member, parent advocate, and salaried staff attorney. By serving families holistically and by meeting families' needs, there is some evidence of such promising outcomes as timelier reunification and less time in foster care (Gerber et al., 2019). The second reform strategy that has been implemented in approximately in 30 states is differential response, also known as family assessment response or alternative response. As a widely studied experiment, differential response replaces the child abuse investigation and substantiation decision with a family assessment that focuses on identifying and meeting family needs and connecting families with services (Merkel-Holguin & Bross, 2015).

The Opportunities of Virtual Working

During COVID-19, child welfare agencies, out of necessity and with additional freedom to innovate, have revamped their ways of working with families. For example, family meetings are a standard practice that are now being conducted using virtual platforms, and anecdotal reports from family meeting facilitators are reporting an increased attendance of family members as the needs for transportation, child care, and requesting time off of work are removed. In addition, facilitators of these meetings report that the virtual space equalizes power dynamics and decreases intimidation that families can experience.

Other child welfare practice and system adjustments

include the addition of virtual support groups, increased frequency of video parenting and virtual visits, sharing parenting responsibilities, and virtual court hearings. Even after the pandemic has ended, there may be virtual practices and processes worth sustaining, as they appear to normalize shared parenting, support kin, and more equally distribute power and decision making among those involved.

In conclusion, COVID-19 has demonstrated that from this crisis, systems can innovate and possibly improve the types and range of services they offer. Child welfare agencies are well positioned to challenge institutionally racist practices and policies that prevent advancement toward a child and family well-being system. We can individually and collectively rise to the challenge posed by David Brooks—to leverage the pandemic and create a redemptive narrative for child welfare.

Conclusions and Implications

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The presentations offered during this panel discussion emphasize both the challenges and opportunities presented to child welfare systems during this truly unprecedented time. Speakers touched on critical gaps in child welfare responses and enduring challenges due to the lack of a social safety net for the most vulnerable children and families. All speakers agreed that the system, as currently configured, lacks the proactive response necessary to provide for the needs of families before and during the COVID-19 pandemic. At the same time, there was agreement that the current crisis presents opportunities to rethink child protection, advance a public health approach, invest in primary prevention, and restructure the safety net and tax system to improve the financial well-being of families.

While differences in perspective exist about why reports of abuse and neglect are down during the pandemic, there was general agreement among

our speakers that the system must assume more responsibility for the care and well-being of families, including those at lower risk for child removal. Preventing the deterioration of family functioning should be a priority, not a secondary goal. Additionally, there was agreement about the need for community systems of care that connect and embolden collaborative, cross-sector models that provide a continuum of services to those families in need, as well as those who are system-involved.

Importantly, Dr. Johnson-Motoyama and her colleagues' work contributes to a small but growing body of research that demonstrates the critical role of programs including TANF basic assistance, SNAP, and refundable EITC programs in preventing child maltreatment and foster care entry. A key takeaway from this scholarship is that even small amounts of income support matter for prevention among families with limited resources. Therefore, concrete supports to address basic needs such as housing, food, and utilities should be among the top priorities at the federal, state, and local levels to prevent child maltreatment and other forms of violence. The COVID-19 pandemic and national reckoning on racial justice also illuminate the historic dynamics of poverty and inequality in this country and present us with the opportunity to examine how we might better address the fundamental needs of children and families. For example, universal basic income and guaranteed income programs, now piloting in parts of Canada and the United States, are designed to alleviate poverty and replace means-tested programs that are stigmatizing and costly to administer. To the extent that income and child maltreatment are related, these and other innovations may hold promise for population-level reductions in child abuse and neglect.

In closing, we reiterate that creative, proactive strategies are indeed needed to better prepare and respond to the needs of families before the next national crisis appears. These strategies should build from what we have learned throughout the pandemic and capitalize on the best available evidence about what works to prevent child maltreatment. It is critical to learn from users of the child welfare system—lending voice to the many children and families who have been served, some inadequately. Additionally,

advances must be inclusive of communities of color who have been disproportionately impacted by the COVID-19 pandemic, as well as a child welfare system ill-equipped to represent their needs. While we call out the need for change, we also echo our speakers' messages of hope that crisis brings opportunity. We call on the field to consider the various ways in which hardship and suffering from pandemic can be used to motivate much needed structural changes that will benefit families of all racial groups and socioeconomic backgrounds, particularly those with few resources and limited access to desperately needed services. Indeed, there is opportunity in crisis, but only if there is intent to change and the political will do so.

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Bracing for Impact: Lessons Learned from the COVID-19 Pandemic and the Response to Child Abuse and Neglect

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The onset of the COVID-19 pandemic in early 2020 felt nothing short of apocalyptic. Tense with uncertainty about the future, communities across the globe quickly faced medical equipment shortages, widespread morbidity and mortality, and economic and social disruption; for many, life seemed at a standstill, with traditional activities like school, work, and play indefinitely halted. Not surprisingly, as societal fear and panic peaked in those early months, traditionally vulnerable segments of society—the elderly, the homeless, the chronically ill, and impoverished children—experienced disproportionate burdens as critical access to mental health, substance use disorder treatment, and community-based resources like food and housing support inevitably decreased in efforts to limit infectious spread. As social isolation, job loss, food and housing insecurity, and the juggle of multiple work-life demands pervaded common experience, fear spread regarding the potential for a second wave of contagion—that of a new epidemic of child abuse and neglect (Agrawal & Kelley, 2020; Woodall, 2020). Many experts foretold of potential unprecedented spikes in child maltreatment rates among those vulnerable youngsters isolated behind closed doors with stressed caregivers, citing historical data suggestive that children have not fared well under such distressed or disastrous conditions, experiencing high rates of physical abuse, abusive head trauma,

and neglect victimization (U.S. Department of Health and Human Services [USDHHS], 2021; Agrawal & Kelley, 2020; Frioux et al., 2014; Brooks-Gunn et al., 2013, Wood et al., 2012; Berger et al., 2011; Woodall, 2020). It seemed inevitable that parenting would be easily overwhelmed, that dynamics of interminably disrupted routine and consistency, coupled with burdens of additional responsibilities to simultaneously educate children while performing work duties, would facilitate frustration, distraction, emotional dysregulation, and increased physical force as discipline. Concerns flared over loss of children’s traditional social safety net—limited support from or access to teachers and educational personnel, those key mandated reporters historically accounting for approximately one fifth of child protection hotline reports (USDHHS, 2021). A crisis of child abuse seemed nothing but inevitable.

What really followed after those early bleak months remains largely unknown, and while federal *National Child Abuse and Neglect Data System* statistics may shed some light two or so years down the road as data is compiled, the true prevalence of abuse victimization experienced during COVID-19 may remain elusive for generations to come. Early data suggests mixed findings; while jurisdictional child abuse hotlines across the nation experienced plummeting volume, sources like *Childhelp* national child abuse and sexual assault hotlines reported unprecedented call volume including from child and teen victims themselves, in contrast to mandated

reporters, endorsing concerns about isolation at home with abusers (Schmidt & Natanson, 2020). Many families opted to stay home rather than visit emergency department settings for traditional non-urgent chief complaints; published data suggests the proportion of hospitalizations directly related to abuse increased, with some data suggesting hospitalized children sustained more severe injuries (Swedo et al., 2020; Schmidt & Natanson, 2020; Kaiser et al., 2020; Lawson et al., 2020; Woodall, 2020). Noted trends sparked interesting dialogue; many experts speculated initial hotline volume declines may have actually reflected prior overreporting practices of “lower level” concerns not necessarily warranting child welfare involvement or response. Others opined about a previous inappropriate overreliance on professionals as mandated reporting sources, potentially representative of systemic flaws in the traditional approach to child welfare and safety issues (Swedo et al., 2020; Herrenkohl et al., 2021; Brown, 2021). A traditionally reactionary system remained poised to respond, waiting for the surge as experts wondered: Would things really become as dismal as predicted? (Woodall, 2020).

Fast forward to over a year later, and pandemic-related conditions largely persist, with acute stressors having become chronic and many families continuing to navigate “new normal” life. Answers to the questions above—what is really happening out there, behind closed doors—remain largely unknown. Yet, despite this, what is known with certainty is COVID-19 has indelibly impacted the multidisciplinary team (MDT) response to child abuse and neglect, having forced both unprecedented adaptations and innovations in approach but also having spotlighted several glaring deficits in our existing cross-systems response. These deficits suggest an urgent need for a paradigm shift. Never before has it been so apparent that supporting families before they are in crisis, a shift from a reactionary response to purposeful prevention, is truly necessary to keep children safe and thriving. There have been multiple lessons learned throughout COVID-19; a few key insights presented below lay foundation for change in our approach to the issue of child abuse and neglect and suggest advocacy opportunities to compel a true paradigm shift.

Lesson 1: Harness the Power of Technologic Innovation

Perhaps one of the most profound adaptations that has permeated society during the COVID-19 pandemic was the shift from in-person interactions to that of electronic, virtual platforms to continue essential societal functions. Many jurisdictional child welfare agencies and MDTs across the nation were early adopters of a shift to utilizing technology, rapidly modifying methods used to engage families and professional colleagues to mitigate disruptions in responses to child safety issues in the face of infectious spread (Font, 2021). Whereas previously conducting a visit with a family via a virtual platform was atypical, often requiring family-MDT coordination to ensure a home was accessible, the transition to secure virtual platforms improved access for many family-MDT units during high-crisis times, permitting use of a smart phone device from a parent’s car or while on their lunch break without losing working hours during a period defined by extreme economic uncertainty. Many children’s advocacy centers shifted to virtual forensic interview participation, whereas other jurisdictions permitted virtual court testimony to prevent unnecessary delays in the adjudication or prosecution process; virtual platforms were also utilized to permit ongoing contact of children in foster care placement with biological families in lieu of in-person visits (Font, 2021).

While clearly the use of technology as a communication tool within child welfare was a tremendous success, its utilization also startlingly uncovered apparent disparities in technological access among families with limited resources, lacking access to home internet or devices powerful enough to support video-based technologies (Stelitano et al., 2020). A shift in reliance on technologies also exposed significant dangers for children and teens, as rates of internet-related sexual exploitation, social media pressures, hateful content, and bullying skyrocketed (Babvey et al., 2020).

Healthcare organizations and medical professionals serving child abuse and neglect victims also monumentally shifted practice, with early data suggesting a 1,110% increase in utilization of telehealth platforms for medical assessments during the early

phase of the pandemic (Drees, 2020; Mehrotra et al., 2020). While permitting mostly continuous access for children to healthcare professionals, the shift to telehealth particularly among pediatric healthcare professionals highlighted the critically important role played by the medical community in offering caregiver support, anticipatory guidance and parenting advice to promote safety in the home (such as dialogue around medication lock boxes, gun safes, safety gates, cribs, and pack 'n plays), destressing resources, and tips on restoring structure/routine for children and caregivers struggling at home (Jenco, 2020). The shift to virtual platforms, however, also sparked concerns around a need for healthcare professionals to remain vigilant for signs of abuse and neglect, suggested variability in knowledge around abuse recognition and mandatory reporting practices, and suggested a need for broader sweeping educational efforts across adult and pediatric medical specialties. Efforts to close that gap by healthcare professionals and medical and public health-based organizations included publication of educational materials and virtual learning on the warning signs of abuse or neglect and recognition of environmental or psychosocial risk factors that may impact child safety in the home (Repine et al., 2021).

Lesson 2: Embrace the Larger Community Safety Net

MDT members across the nation recognized early on in the pandemic that school closures were likely to be monumentally impactful for children, primarily out of concerns that children would no longer have critical and liberal access to school-based professionals, the largest mandated reporter source nationally. (USDHHS, 2021). If the safety net was gone, questions of who would report abuse or neglect concerns predominated many expert conversations; pandemic circumstances revealed a perhaps inappropriate overreliance on traditional mandated reporter professionals—teachers, daycare providers, healthcare professionals—to advocate for the safety of children, as well as a clear need for efforts to educate the larger layperson community who have continuous, nonprofessional contact with children (such as grocery store employees, pharmacy staff, family members) on child abuse/neglect recognition and reporting (Brown, 2021; The Alliance for Child Protection, 2020). Effective strategies that emerged included use

of television ads, community public service/health announcements, local news articles, and even social media campaigns produced by public health agencies, school districts, jurisdictional child welfare agencies, and nonprofit organizations serving vulnerable children. The concern about a potential child abuse surge related to truncated contact with the traditional societal “safety net” of mandated reporters both underscored a need for broader scale reform of current educational efforts within layperson communities and suggested a need for exploration of other data sources to inform prevalence of abuse victimization besides hotline volume, incorporating hospital and other cross-systems data.

Lesson 3: Focus on Earlier, Upstream Family Supports and Prevention

Much of the early pandemic focus had been on presumed adversarial parent-child relationships precipitating spikes in child abuse perpetration, a notion perhaps inappropriately and naively suggestive of “perfect” pre-pandemic family and societal functioning, overemphasizing the role of the pandemic on crisis precipitation. To the contrary, the pandemic may have merely revealed a tipping point, suggesting the depth of insufficiency of current family-supporting systems not so obviously apparent during pre-pandemic conditions (Brown, 2021). For example, data suggests pandemic-related vulnerabilities may have led to spikes in domestic violence (DV) victimization among adults nationally and internationally (Boserup et al., 2020; Chandan et al., 2020). A well-established, pervasive risk factor frequently co-occurring with suspected physical abuse victimization among children in the home, DV mitigation has historically lacked attention, precision in epidemiology and statistics related to variable screening practices, non-uniform intervention, and supportive services funding across jurisdictions (Boserup et al., 2020). The Substance Abuse and Mental Health Services Administration and National Domestic Violence Hotline were swift to produce public safety messaging in response to rising rates of DV and risk of co-occurring child maltreatment, but additional and ongoing primary, secondary, and tertiary prevention efforts are urgently and fundamentally needed to effectively address the roots of family violence at both a national and international level (Chandan et al., 2020).

Pandemic-related societal conditions spotlighted the need for earlier, upstream preventative interventions by child welfare and community-based organizations to specifically impact family-level psychosocial adversities like poverty, untreated mental illness, and substance abuse before child welfare involvement, abuse victimization, and violence occur (Brown, 2021). How best to accomplish this remains elusive and likely expensive, necessitating prioritization on the federal policy and fiscal radars. At the local level, robust, relentless advocacy by MDT partners to lobby for coordinated access to, and availability of, cross-sector supports like stable housing, legal services, domestic violence support, child care subsidies, extended financial remediation for pandemic-related employment disruptions, or initiatives like local medico-legal partnerships and health insurance-based care coordination services to address the needs of families traditionally reported to child protective services will likely also be impactful (albeit challenging). In the absence of tireless work and vocal, committed advocacy to remediate these systems-level service issues, a paradigm shift is impossible.

Lesson 4: Don't Underestimate Family Strength, the Role of Emotional Connectedness, and Resiliency to Keep Children Safe and Thriving

Relationship-building and resiliency provide opportunities for families to intimately connect and grow together. While initial concerns were raised early during the pandemic regarding the potential negative impact of social distancing and isolation measures on the health and stability of the family unit, such measures may have actually been both beneficial and protective for many previously strained families. Some utilized the stay-at-home order to forge stronger relationships, participating in simple tasks like preparing or sharing meals together, reconnecting with faith, participating in virtual holiday celebrations with extended family networks, and, of utmost importance, offering support and camaraderie during a time defined by uncertainty and extra-familial separation (Prime et al., 2020). These experiences may actually have enhanced protective factors within

the family unit, increasing opportunity for direct, positive interactions between children and caregivers and permitting caregivers to more equitably share otherwise stress-provoking caregiving and family responsibilities, thereby reducing caregiver frustration, fatigue, and risk for abuse perpetration. Shifting this perspective long-term, to one in which family dynamics are seen as protective and not adversarial, and child welfare intervention as supportive and non-punitive, necessitates commitment by MDTs to utilize a strengths-based framework focused on enhancing family relationships, strengthening core skills and resiliency promotion well after the pandemic's conclusion (Center on the Developing Child, 2021).

Conclusion

So, what then do we do from here? COVID-19 has undoubtedly taught us a great deal, even beyond these initial lessons. Of paramount importance is the fundamental lesson that while the pandemic may be the newest adverse childhood experience (ACE) at the individual level, likely to endure in neurologic, neuroendocrine, behavioral, and epigenetic changes across generations, from a systems perspective the pandemic may be the most important, positive catalyst for change to ever impact how we approach child abuse and neglect across the globe. Highlighting the need for a paradigm shift towards prevention and intentional upstream intervention, towards viewing families and family safety through an entirely different lens, we remain hopeful that the hard lessons taught by the pandemic this past year will have a positive and lasting impact for endless years to come.

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Early Stage of the COVID-19 Pandemic and Investigations of Child Maltreatment: An Empirical Study of Administrative Data

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Keywords: early stage of the COVID-19 pandemic, child maltreatment investigation, substantiation, administrative data

Introduction

The first case of novel coronavirus 2019 (COVID-19) was confirmed in the United States on January 20, 2019 in Washington state, and shortly after the World Health Organization (WHO) declared a public health emergency of international concern (Taylor, 2021). To combat the spread of COVID-19, nearly all schools in the United States cancelled in-person classes and transitioned to remote instruction, substantially decreasing the amount of time that children had in person with teachers and other school personnel (Baron et al., 2020). Social distancing measures may have helped reduce community-based transmission of the disease (Cluver et al., 2020). However, the stay-at-home orders, in combination with increased economic instability (i.e., job loss, future job uncertainty) and family pressure (i.e., parents having to homeschool children while juggling work and other stressors), may increase the likelihood of child abuse and neglect for vulnerable children and their families (Cohen & Bosk, 2020).

Recent reports suggest an increase in rates of domestic violence (Bullinger et al., 2020a; Campbell, 2020) and

substance use (Czeisler et al., 2020) since the onset of the pandemic. Other research has found that stay-at-home orders have also led to increased parental stress related to harsh parenting (Keong et al., 2020) and parental burnout (Griffith, 2020). However, states in the United States have reported dramatic declines in allegations related to child abuse and neglect (Jonson-Reid et al., 2020). For example, Baron et al. (2020) found that in Florida the number of reported allegations were 27% lower than expected, which was largely driven by school closures. Rapoport et al. (2020) reported that in New York City the number of reported allegations from March to May of 2020 were 28.8% to 51.5% lower than expected and showed a decrease in child maltreatment reporting across all types of reporters (mandated reporters, nonmandated reporters). The authors also reported that the number of child protective services (CPS) investigations warranting preventive services were 43.5% lower than expected in March of 2020. Bullinger et al. (2020b) reported that following the emergency declaration in Georgia, the number of maltreatment allegations plummeted by close to 55% relative to 2018 and 2019 trends during the same time period.

However, we are unaware of emerging studies that are examining whether the demographics of child victims and perpetrators of child maltreatment, as

well as types of maltreatment allegations, changed as the number of investigations of child maltreatment decreased after the onset of the COVID-19 pandemic. Moreover, no studies examined the impacts of COVID-19 on substantiation of child maltreatment. The purpose of this study is to address these knowledge gaps. To our knowledge, this is the first empirical study to explore the immediate impact of COVID-19 on child maltreatment investigations and substantiation using administrative data within the child welfare system. The current study seeks to describe the following changes after the outbreak of the COVID-19 pandemic:

1. Number of investigations of child maltreatment
2. Number of children and perpetrators involved in each investigation and their ages
3. Distribution of race and gender in the children and perpetrators
4. Distribution of the types of maltreatment allegations
5. Changes in the rate of concluding dispositions within 30 days of referrals
6. Changes in the rate of substantiation

Methods

This study used administrative data from state of Michigan, which has a state-run child welfare system. Data includes investigations of child maltreatment allegations screened-in, disposition findings (i.e., substantiated or not), and individual demographics. The authors extracted data from the same 30-day period of two years: March 15, 2019 until April 14, 2019 (i.e., before the outbreak of the COVID-19 pandemic) and March 15, 2020 until April 14, 2020 (i.e., early stage of the outbreak of the pandemic). The purpose of choosing the same 30-day period is to limit the effects of seasonality.

We followed each investigation of the two periods for 30 days to examine its disposition outcomes. The timeframe of 30 days was chosen for two reasons. First, setting a fixed timeframe ensured an equal follow-up observation period of each maltreatment report. Second, we only had access to administrative data updated until May 14, 2020, and therefore for maltreatment reported on April 14, 2020 (i.e., the end of the period representing the early stage of the

outbreak of the pandemic), we only had access to the 30 days of follow-up observation.

Analyzing investigation-level data, we used t-tests and chi-square tests to test for differences before and after the outbreak of the pandemic and their corresponding effect size estimates (Cohen's d and Cramer's V , respectively). The effect sizes were interpreted using Cohen's guidelines, where for interpreting Cohen's d , .20 is a small effect, .50 is a medium effect, and .80 is a large effect; for interpreting Cramer's V , .10 is a small effect, .30 is a medium effect, and .50 is a large effect (Cohen, 1992). We also used logistic regression to regress substantiation on the timing of a maltreatment referral (before or after the outbreak of the pandemic) in two models: the first model includes no covariates, and the second model includes other study variables.

Data were missing at a rate of 3.4% for perpetrators' gender and less than .05% for children's age and race and perpetrators' age. Based on the very low incidence of missing data, we did not make any corrections for missing values and used listwise deletion for all analyses.

Results

Table 1 (see following pages) presents the tests on changes in investigations of child maltreatment before and during the early stage of the outbreak. We observed a 54% decrease in the overall number of child maltreatment investigations (8,128 vs. 3,771). We observed no statistically significant changes in the average number of children involved in each investigation. We observed a small change in the age of the youngest child in each investigation (6.84 vs. 5.66, $p < .001$), although the effect size suggests there is small difference (Cohen's $d = .22$). We observed no statistically significant changes in the compositions by race and gender of children involved in the investigations. We observed small changes in the average number of perpetrators involved in each investigation (1.44 vs. 1.40, $p < .001$) and the age of the youngest perpetrator in each investigation (34.52 vs. 32.94, $p < .001$), although the effect sizes suggest there are minimal practical differences (Cohen's $d = .07$ for both). We observed no statistically significant changes in the gender of perpetrators involved in the investigations.

Table 1. Maltreatment Investigation Counts, Socio-demographic, Allegation Type, and Disposition Differences Before and During Early COVID-19

	1Pre-COVID Sta- tistic	2 Early COVID Statistic	Difference, % of Change (for numeri- cal variables only)	Difference Test Statistic
State total number of maltreatment investigations	8,128	3,771	-4,357, 53%	
Average number of children involved in each investigation (SD)	1.68 (SD=1.10)	1.64 (SD=1.06)	-0.04, 2%	t (df = 11897) = 1.85, p=.07, d = .04
Age of youngest child involved in each investigation (SD)	6.84 (SD=5.36)	5.66 (SD=5.51)	-1.18, 17%	t (df = 11882) = 11.10, p<.001, d = .22
Children's race				
White	4561 (56.3%)	2076 (55.6%)		$\chi^2(df=6) = 6.40,$ $p=.38, V=.02$
Black/African American	2101 (25.9%)	996 (26.7%)		
Latino	478 (5.9%)	203 (5.4%)		
American Indian	21 (0.3%)	15 (0.4%)		
Asian/Pacific Island- er	34 (0.4%)	10 (0.3%)		
Multiracial	583 (7.2%)	292 (7.8%)		
Multiple races	320 (4.0%)	144 (3.9%)		
Children's gender				
Female only	3094 (38.1%)	1453 (38.5%)		$\chi^2(df=2) = 1.30,$ $p=.52, V=.01$
Male only	3092 (38.0%)	1453 (38.5%)		
Both female and male	1942 (23.9%)	865 (22.9%)		
Average number of perpetrators involved in each investigation (SD)	1.44 (SD=.61)	1.40 (SD=.58)	-0.04, 3%	t (df = 7769.56) = 3.68, p<.001, d = .07
Age of youngest perpetrator involved in each investigation (SD)	34.52 (SD=23.53)	32.94 (SD=9.29)	1.58, 5%	t (df = 11270.57) = 5.134, p<.001, d = .07
Perpetrators' gender				
Female only	3390 (43.1%)	1635 (45.0%)		$\chi^2(df=2) = 5.60,$ $p=.06, V=.02$
Male only	1890 (24.0%)	881 (24.3%)		
Both female and male	2581 (32.8%)	1115 (30.7%)		
Allegation Type ³				

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Failure to protect	299 (3.7%)	112 (3.0%)		$\chi^2(df=1) = 3.88,$ $p<.05, V=.02$
Improper supervision	5208 (64.1%)	2479 (65.7%)		$\chi^2(df=1) = 3.12,$ $p=.08, V=.02$
Physical abuse	3087 (38.0%)	1444 (38.3%)		$\chi^2(df=1) = .11,$ $p=.74, V<.01$
Physical or medical neglect	2478 (30.5%)	852 (22.6%)		$\chi^2(df=1) = 79.64,$ $p<.001, V=.08$
Sexual abuse	511 (6.3%)	210 (5.6%)		$\chi^2(df=1) = 2.33,$ $p=.13, V=.01$
Threatened harm	635 (7.8%)	197 (5.2%)		$\chi^2(df=1) = 26.54,$ $p<.001, V=.05$
Other	389 (4.8%)	187 (5.0%)		$\chi^2(df=1) = .17,$ $p=.68, V<.01$
Dispositions concluded within 30 days after maltreatment referral	6498 (79.9%)	3583 (95.0%)		$\chi^2(df=1) = 451.86,$ $p<.001, V=.20$

Note: ¹March 15, 2019 until April 14, 2019. ²March 15, 2020 until April 14, 2020. SD = standard deviation. ³Other allegation type includes birth match (i.e. allegation triggered by newborns of parents with history of parental rights termination), child death, and mental injury. Allegation types do not sum to 100% because a single maltreatment investigation can have multiple allegations.

Three types of maltreatment decreased from 2019 to 2020: failure to protect (3.7% vs. 3.0%), physical or medical neglect (30.5% vs. 22.6%), and threatened harm (7.8% vs. 5.2%), although the effects of all three decreases were very small (Cramer’s Vs are .02, .08, .05 respectively). In Michigan, failure to protect refers to knowingly allowing another person to abuse and/or neglect a child without taking appropriate measures to stop the abuse and/or neglect or to prevent it from recurring when the person is able to do so and has, or should have had, knowledge of the abuse and/or neglect. Physical neglect refers to negligent treatment, including but not limited to failure to provide, or attempt to provide, the child with food, clothing, or shelter necessary to sustain the life or health of the child, excluding those situations solely attributable to poverty. Medical neglect refers to failure to seek, obtain, or follow through with medical care for the child, with the failure resulting in or presenting a risk of death, disfigurement, or bodily harm or with the failure resulting in an observable and material impairment to the growth, development, or functioning of the child. Threatened harm means putting a child into a situation in which harm is likely to occur based on a current or historical circumstance. For example, a known perpetrator of a crime against a child moving into the

home is considered threatened harm.

The percentage of dispositions concluding within 30 days increased significantly after the outbreak of the COVID-19 pandemic, from 79.9% to 95.0% ($p < .001$), and the effect size of the change (Cramer’s $V = .20$) is between small and medium.

Our final analyses examined the influence of our study variables on substantiation of child maltreatment. As presented in table 2, the results of Model 1 show that maltreatment investigations after the outbreak of the COVID-19 pandemic were 1.27 times more likely to be substantiated in comparison to pre-COVID. In Model 2, where covariates were added, the results showed a similar effect of timing: Maltreatment investigations after the outbreak of the COVID-19 pandemic were 1.25 times more likely to be substantiated in comparison to pre-COVID. Greater odds of substantiation was also associated with children who were younger (OR = .98) and Black (OR =1.16) and perpetrators who were younger (OR = .99), male only (OR = 1.81), or involve both female and male perpetrators (OR = 1.53). As compared with physical abuse, allegation types of failure to protect, improper supervision, and threaten harm were associated with increased odds

Table 2. Factors Associated with Substantiation of Child Maltreatment using Logistic Regression

	Model 1	Model 2		
	Odds Ratio	95% CI	Odds Ratio	95% CI
<i>Maltreatment report year (ref: 2019)</i>				
2020	1.27	(1.15, 1.40)	1.25	(1.12, 1.38)
Number of children involved in an investigation				
1.03				
(.97, 1.10)				
Age of youngest child involved in an investigation			.98	(.97, <1.00)
<i>Children's race (ref: White children)</i>				
Black/African American			1.16	(1.02, 1.31)
Latino			1.21	(.98, 1.50)
American Indian			.88	(.35, 2.19)
Asian/Pacific Islander			.26	(.06, 1.10)
Multiracial			1.14	(.94, 1.38)
Multiple races			1.10	(.85, 1.40)
<i>Children's gender (ref: female only)</i>				
Male only			.99	(.88, 1.11)
Both female and male			1.09	(.93, 1.29)
Number of perpetrators involved in an investigation				
1.06				
(.93, 1.21)				
Age of youngest perpetrator involved in an investigation			.99	(.99, 1.00)
<i>Perpetrators' gender (ref: female only)</i>				
Male only			1.81	(1.59, 2.07)
Both female and male			1.53	(1.28, 1.83)
<i>Allegation type (ref: physical abuse)</i>				
Failure to protect			1.90	(1.47, 2.45)

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Improper supervision			1.89	(1.67, 2.14)
Physical or medical neglect			.76	(.67, .86)
Sexual abuse			.72	(.56, .94)
Threatened harm			3.23	(2.71, 3.84)
Other			.82	(.64, 1.05)
Constant			.13	

Note: ref = reference group. CI = Confidence Interval. Odds ratios in bold are statistically significant based on a 95% CI that does not bound the zero. 1Other allegations include birth match, child death, and mental injury.

that child maltreatment would be substantiated (OR = 1.90, 1.89, and 3.23, respectively), while physical or medical neglect and sexual abuse were associated with decreased odds that a referral would be substantiated (OR = .76 and .72, respectively). We chose to use physical abuse as the reference group, because physical abuse is a maltreatment category commonly used across jurisdictions and it, therefore, enhances the generalizability of our findings.

Discussion

This study showed a decrease in maltreatment investigations after the outbreak of the COVID-19 pandemic using Michigan state administrative data from the same 30-day period in 2019 and 2020. The decrease may be associated with the closing of schools, which could have resulted in decreased surveillance on child maltreatment. In Michigan, schools were ordered to close on March 16, 2020 and remained closed until the end of school year. When schools were closed, school-age children had less in-person interactions with their teachers and other school personnel, and therefore signs of child maltreatment were less likely to be noticed by school personnel. This is especially important considering that school personnel are the largest source of reports of child maltreatment. In 2018, 20.5% of maltreatment reports in United States were submitted by educational personnel (Children’s Bureau, 2020). The effect of school closings on the decrease in maltreatment reports has been shown in previous statistics on seasonal fluctuation in child maltreatment reports (Hines & Brown, 2012; Jonson-Reid et al., 2020). During summer months, when children have less interactions with school personnel, the number of maltreatment reports is fewer than during the months when children are in

school. It should also be noted that there was a new procedure for handling reports involving domestic violence enacted in late 2019 in Michigan, which might have contributed in part to the decrease in child maltreatment investigations. According to this new procedure, the presence of domestic violence itself is not a sufficient basis for assigning an investigation. Only if domestic violence has resulted in actual abuse, neglect, or threatened harm to a child would an investigation be assigned. To examine the impact of the new procedure on the number of maltreatment allegations, we compared the number of maltreatment allegations between February 2019 (new procedure not in place) and February 2020 (new procedure in place). We found a 20% decrease in the overall number of child maltreatment investigations (7,360 vs. 5,922), which is a smaller scale of decrease than the 54% decrease found in the same 30-day period before and during the early stage of the outbreak. Thus, the new procedure for handling reports involving domestic violence explained only a portion of the decrease in child maltreatment investigations.

This study also found that the ages of the youngest child and youngest perpetrator in maltreatment investigations that took place during the early stage of the pandemic were younger than those in the pre-COVID maltreatment investigations. The decrease in the age of the youngest child in each maltreatment investigation could be related to how changes in maltreatment surveillance varied between age groups. As mentioned above, when schools were closed after the outbreak of the pandemic it is likely that fewer cases of suspected abuse against school-age children were being reported than prior to the pandemic. This effect of school closures would not have impacted the

maltreatment surveillance on children younger than school age. As a result, the age of the youngest child in each maltreatment investigation tended to be lower after the outbreak of the pandemic. Furthermore, the decrease in the age of the youngest perpetrator in each maltreatment investigation could be related to the decrease in the age of the youngest child in each maltreatment investigation, since younger children may be more likely to have younger parents.

An important finding is that the race and gender of children and the gender of perpetrators involved in maltreatment allegations did not change after the outbreak of the pandemic. This finding indicates that as the number of maltreatment allegations decreased after the outbreak of the pandemic, the decrease proportionately occurred to children of all races and genders, and therefore, the disposition of race and gender of children did not change. In other words, the early pandemic had equal impact on the number of investigations of child maltreatment across racial and gender groups.

This study also found that three types of maltreatment decreased from 2019 to 2020: failure to protect, physical or medical neglect, and threatened harm. The decrease is especially pronounced for physical or medical neglect. Both types of neglect are observable to caregivers who have frequent contact with children, such as teachers. For example, teachers might notice that a student often comes to school hungry and poorly groomed, which can be a sign of physical neglect. Similarly, teachers might notice that a student is exhibiting poor health, which can be a sign of medical neglect. As schools closed after the outbreak of the pandemic, teachers would have had fewer opportunities to identify signs of physical or medical neglect.

Another important finding of this is that after the outbreak of the pandemic, higher percentages of dispositions were concluded within 30 days of maltreatment referrals. Moreover, this study found that maltreatment referrals reported after the outbreak had greater odds of being substantiated. Both changes might be related to the substantial decrease in the number of maltreatment investigations after the outbreak. As the number of maltreatment referrals

decreased, child protective investigators may have experienced reduced caseloads, which could have helped them complete investigations in a timely manner. In addition, the reduced caseload could have enabled investigators to devote more time to each case, thereby increasing the likelihood they would identify evidence of child maltreatment. Another possible explanation is that the difficulties families have faced after the outbreak of the pandemic have caused increased concern among investigators for families' well-being. Such concern could have made them more likely to substantiate child maltreatment, since substantiated cases are more likely to receive services (Jonson-Reid et al., 2017).

Practice and Research Implications

As the number of COVID-19 infections has continued to rise in the United States, many families have experienced health and finance related stress. Incidence of substance use and domestic violence, two risk factors of child maltreatment, have been on the rise. At the same time, with the closing of schools, children have been left under the care of their families, which can significantly increase parental stress. However, the number of investigations of child maltreatment dropped substantially after the outbreak of the COVID-19 pandemic. The closing of schools and reduced in-person contact between school personnel and children might have contributed to this change. Therefore, it is important to engage other community members and mandatory reporters in child protection. This could involve raising public awareness of the signs and consequences of child maltreatment and of services available through the child welfare system. Other mandatory reporters, especially law enforcement and providers of substance use and domestic violence treatment, need to assess the safety of children at home and make reports when necessary.

Meanwhile, the decrease in the number of investigations of child maltreatment after the outbreak of the COVID-19 pandemic suggest that less families had contact with the child welfare system. Therefore, it is likely that less families received services through the child welfare system. It is important to provide families in need with access to services and resources through other channels. For example, families in need

can benefit from publicly funded childcare, which can reduce parenting stress, and in turn, can reduce the risk of child maltreatment. Another example is to advocate for families in need to receive cash assistance and flexible funds to reduce the risk of poverty related child neglect (Feely et al., 2020).

This study examined the impacts of the outbreak of the COVID-19 pandemic on investigations of child maltreatment and dispositions, which are at the front end of child welfare services. Future research needs to examine its impact on the later stages of child welfare services, such as in-home service, out of home placement, therapeutic services, and discharge services. Studies of these latter stages can further expand our understanding of how the child welfare system responded to the pandemic.

Limitations

This study has two limitations. First, the generalizability of our findings is limited. This study used administrative data from Michigan. The findings are generalizable to states and jurisdictions that have similar sociodemographic and state-run child welfare systems. Second, this study examined only the impacts of the early pandemic on the investigation part of child welfare services. We did not examine the impacts of the early pandemic on other parts of child welfare services, such as in home services, out of home services, and independent living services.

Conclusion

This study found that during the early stage of the outbreak of the COVID-19 pandemic, Michigan had fewer investigations of child maltreatment than during the same 30-day period prior to the pandemic. Other changes include younger age among child victims and perpetrators, higher percentages of dispositions

concluded within 30 days after maltreatment referrals, and greater odds of cases being substantiated. The racial and gender composition of children and the gender composition of perpetrators involved in maltreatment allegations did not statistically significantly differ prior to and after the outbreak of the COVID-19 pandemic. The decreased number of investigations could be related to changes in surveillance resulting from school closures. As many families have experienced health and finance related stress during the pandemic, it is important to provide them access to services and resources via the child welfare system and other channels.

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Parenting Support for Families Impacted by Opioid Use Disorder during the COVID-19 Pandemic: Insights from Pennsylvania Home Visiting Pilot Programs

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Background

Investing in Home Visiting in Response to the Opioid Epidemic

The opioid crisis in the United States has had a disproportionate impact on adults of childbearing age. Young families have experienced wide-ranging loss, familial disruption, and adverse health and well-being. State and local governments have begun to enact systems-level public health responses targeting the needs of families. Evidence-based home visiting (EBHV) programming serves pregnant families and those with young children, often in under-resourced communities, and operates as one of the predominant public investments in maternal and child health.

EBHV programs, by design, rely on robust referral networks within their communities to support clients' unique needs (Health Services and Resources Administration, 2020). These programs have served young families impacted by opioid use disorders (OUD), though most often not through targeted enrollment. Frequently, home visiting adaptations for

special populations, including those with substance use concerns, are limited to additional staff trainings or curricular adaptations. Though training is an important first step, current home visiting adaptations have proven limited in addressing these needs, as home visitors often remain hesitant to engage around these difficult topics (Duggan et al., 2004; Tandon et al., 2005; Dauber et al., 2017).

The Intersection of the COVID-19 Pandemic, Prevention Services, and Individuals Impacted by OUD

Prevention-focused programming, like home visiting, is a critical tool for preserving family stability and well-being in the midst of crisis and/or sustained hardship. Yet economic or public health crises create risk for the stability of prevention programming within communities, which often operates with inadequate funding and tenuous political will for its prioritization. During the COVID-19 pandemic, these challenges were further exacerbated by the need for physical distancing policies that altered service operations. Widespread service disruptions across child welfare, public health, and community-based social services impacted many families.

The COVID-19 pandemic presents several challenges specific to individuals and families impacted by OUD. Beginning with clinical risk, individuals with OUD are at higher risk for complications from COVID-19 due to occurrences of respiratory sedation and compromised pulmonary function and lung capacity (Valkow, 2020). From an exposure lens, the co-occurrence of substance use disorders (SUD) with housing instability, homelessness, or incarceration exacerbates the risk of contracting COVID-19 as congregate settings (including shelters) have been sources of spreading events (Valkow, 2020). Beyond disproportionate risks of COVID-19 illness, the pandemic has been associated with other health and social risks for individuals and families experiencing OUD. Increases in overdoses and overdose fatalities have been observed during periods of mandated stay-at-home orders throughout the country (Rosenbaum et al., 2021; Mason et al., 2021). Similarly, increased severity of domestic violence has been reported in correspondence with shelter-in-place policies, the frequent comorbidity of domestic violence and SUD present a concern for high acuity needs for some families (Leslie & Wilson, 2020; Cafferky et al., 2018). Currently, the specific impacts of the pandemic on mothers and caregivers of young children with OUD are not fully articulated. Among the broader community, emerging data have shown that challenges accessing health care, childcare, housing, food, transportation, jobs, and mental health treatment have been exacerbated by the pandemic (U.S. Census Bureau, 2020).

Pennsylvania OUD Pilot Programs: Incorporating COVID-19 Into an Ongoing Evaluation of Implementation

In 2018, in response to the opioid crisis's acute impact in Pennsylvania, the Governor's Office invested in EBHV as a promising mechanism to support families in communities with a high burden of OUD. In Pennsylvania, six evidence-based models are supported by state dollars to support families experiencing economic or social disadvantage. Twenty EBHV pilot sites were selected for funding based on the varied strategies proposed to serve families impacted by SUD in a diversity of geographic

settings and EBHV models. These pilots presented an opportunity for sites to take a more systems-based approach to addressing OUD with clients by expanding capacity to screen and refer and partnering with external organizations for consulting and collaboration.

The intention of these pilots was not to provide treatment or recovery services, but rather to provide parenting support and resources for home visiting-eligible families impacted by OUD. Most pilot programs aimed to recruit families impacted by the opioid epidemic in Pennsylvania, but some broadened their reach to clients impacted by additional types of substance use. In this article, all pilots are referred to as OUD pilots for simplicity, but context for additional SUD is provided when appropriate.

To evaluate the implementation of these pilots, a research-policy partnership conducted a one-year implementation evaluation to describe the varied systems-level approaches taken by each pilot site. Given the high degree of variation across pilot sites and the lack of existing evidence for how to adapt EBHV to serve families impacted by OUD, an evaluation design that focused on implementation factors instead of client outcomes was employed. Role-specific interviews, structured using the Consolidated Framework for Implementation Research domains, explored pilot goals, community setting, local infrastructure, and the implementation process. The evaluation included survey assessments at three time periods, the last of which coincided with the early months of the COVID-19 pandemic, June 2020.

This ongoing evaluation provided an opportunity to understand the implementation of prevention programming during two public health crises—the ongoing opioid epidemic and the COVID-19 pandemic. Pilots began in early 2019, with the final months coinciding with the start of the COVID-19 pandemic. Between March 17 and June 5, 2020, per state mandate, all home visiting agencies in Pennsylvania shifted to virtual visits. This altered the traditional setting in which EBHV occurs, resulting in sudden shifts to the delivery of pilot components and additional challenges faced by pilot-engaged families.

To capture the impacts of the pandemic on home visiting programs and clients, the final survey was adapted to include a COVID-19 addendum. This addendum assessed the impact of the pandemic on home visiting pilot programs supporting families impacted by OUD. This paper focuses on data resulting from the COVID-19 addendum, providing standalone survey data from program staff that address shifts in service provision and perceived client needs and program engagement.

Methods

Context

A research-policy partnership used a mixed-methods approach to evaluate the implementation of pilot programs designed to address substance use in EBHV in Pennsylvania. OUD pilot sites were based out of EBHV local implementing agencies spread across the commonwealth, half in urban and half in rural settings.

As part of a larger, ongoing implementation evaluation, this paper describes the results of an addendum to the final survey administered in June 2019, added to address changes to pilot implementation and client engagement due to the COVID-19 pandemic.

For the broader implementation evaluation, the research team developed a longitudinal survey to measure concepts of implementation across the sites at three time points—before launching the pilot (baseline), mid-implementation (8 months post), and at the end of the first year of implementation. The research team gave surveys to pilot-engaged staff, including home visitors, partner agencies, and a site-selected “champion” of the

pilot work at each site. At the implementation midpoint, the study team visited 10 sites purposively sampled for geography, pilot components, and EBHV model and conducted 36 in-depth semi-structured interviews with 52 individuals, most of whom also completed the surveys.

The methods described in the following sections are intended to provide a broader context for the COVID-19 addendum survey sample and results provided in this paper.

Overall Study Design and Procedures

A set of longitudinal surveys was developed to include several existing scales and frameworks to assess context and relevant implementation concepts, such as local service coordination. The baseline pilot survey provided information on each site’s goals for the pilot programming, intended pilot components, and partnerships. Most survey questions were specific to the pilot work, while some were included to gather important contextual information about the site that may shape implementation efforts. The baseline and 12-month surveys included questions on hiring and staffing needs for implementation. The 8- and 12-month surveys had additional questions about planning, coordination, and barriers and facilitators to implementation developed from the findings from the baseline survey and qualitative interview data.

The three surveys were completed by the main contact identified by each site to represent their agencies’ perspectives about the pilot (i.e., Pilot Champion) and two to four pilot-engaged staff members.

Survey	Participant(s)	Baseline	8 months	12 months
Baseline Pilot Survey	Pilot Champion	X		
Community Collaboration Assessment	Pilot Champion and two to four additional key staff	X	X	X
Organizational Readiness for Implementing Change (ORIC)	Pilot Champion	X	X	X
Pilot Program Staff Training	Pilot Champion	X		X
COVID Addendum	Pilot Champion			X

The five survey components were administered as follows: The second- and third-round surveys were intended to be administered exactly 6 and 12 months after the baseline survey. The second survey's distribution was delayed to 8 months after baseline due to funding delays and associated staffing issues experienced at many sites. Dissemination of the third and last round of surveys was intended for March 2020. Due to the COVID-19 outbreak and stay-at-home order, the third surveys were delayed until early June.

COVID Addendum Design and Procedures

The final survey in June 2020 was amended to include a supplemental panel of COVID-19 contextual questions to document 1) any pandemic-related changes to pilot activities and 2) pandemic-related changes to client families and the community for each local home visiting agency. Prior to the start of the pandemic, sites varied in pilot activities, but almost all offered some in-home or one-on-one services (n = 17) and some center-based group component (n = 17). Alternative settings included drug and alcohol treatment facilities (n = 4) and prisons (n = 2). Clients ranged from those in active addiction to those in long-term recovery to grandparents or other kinship caregivers. This addendum was administered to pilot champions at each of the sites implementing these pilots (n = 20). Results from this addendum include data from the open response and categorical survey questions listed below.

COVID-19 Addendum Questions

- How has the COVID-19 stay-at-home order impacted families in treatment or recovery in your pilot? (open response)
- Please identify the particular issues that have been negatively impacted by COVID-19. (categorical response)
- How has the COVID-19 stay-at-home order impacted grandparents raising grandchildren or others present in multi-generational households in your pilot? (open response)
- How have pilot-enrolled families' needs changed since the stay-at-home order began in PA? (open response)
- As stay-at-home is lifted, what challenges do

anticipate will persist for families in treatment or recovery in your community? How do you plan to address any of these challenges in your programming? (open response)

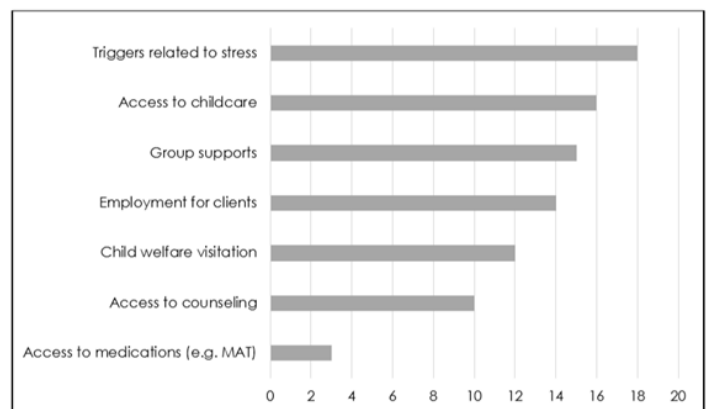
Analysis

Categorical survey responses related to COVID-19 along with open-ended responses were imported into NVivo 12 as a dataset. For close-ended questions related to the impact of COVID-19, frequency counts were calculated from categorical responses across pilot sites. A content analysis was performed to analyze responses to open-ended survey questions. Participant responses were reviewed independently by two team members and, after discussing these data, a final list of codes was established and applied systematically to the data. The themes emerging from across participant responses are described below.

Results

The COVID-19 addendum survey was conducted as part of the third survey of pilot champions. Data discussed in this paper reflects the responses of the pilot champion at each site (n = 20). When asked to indicate whether particular issues were negatively impacted by COVID-19, the majority of pilot champions endorsed that the pandemic worsened clients' experience with triggers related to stress, access to childcare and group support, and employment. About half of the 20 sites reported that child welfare visitation and access to counseling were complicated by COVID-19. Only a few sites indicated that clients' access to medications were negatively impacted by the pandemic. Figure 1 illustrates perceived issues for OUD pilot-engaged clients that have been negatively

Figure 1: Pilot Champion Perceptions of Client Needs Impacted by COVID-19



impacted by COVID-19, as reported by pilot champions.

The following themes are the result of a content analysis applied to open-ended survey items related to COVID-19.

Shifting to Virtual Settings

Almost all of the sites made changes to their pilot programming in the final months related to the COVID-19 stay-at-home order. The most common changes were to parenting groups and recruitment strategies, as these in-person activities had to abruptly shift to virtual approaches in March 2020.

Multiple sites reported either cancelling group components entirely or figuring out new ways to hold groups via web meeting platforms. One site described adapting their recruitment strategy to fit within the new stay-at-home orders: “Our recruitment strategy has changed a bit since the stay-at home order. We are no longer able to go to other social service agencies and speak about our program or share flyers about our program. We have now adjusted to our recruitment via email and virtually to continue to share information about our program with possible clients. We have an electronic copy of our referral form that we shared with multiple social service agencies we felt could benefit from having our agency’s information.” Another site reported shifts to practice within the new guidelines: “We made changes to how we had to do class and in-home visits. We changed to have all our classes and in-home visits through Zoom calls, which worked out very well for us.”

In some instances, curricula were not set up to easily go virtual, so groups were cancelled until staff could update their strategies. This was especially true for group curricula like Parent Cafés that depend on in-person facilitation and interpersonal interaction. The sites that paused were waiting to be trained on any content or facilitation adaptations in order to offer the curricula virtually.

Maintaining Client Engagement

Pilot champions and home visitors reported varying impacts of COVID-19 on group program attendance and engagement. Some pilot champions described service interruptions and cancelations attributed

to because families going into “crisis mode”: “Our attendance has been affected in the beginning of the stay-at home order due to many families being in crisis mode. After a few weeks it seems families began to adjust and maintain some order in their lives where we then were able to get back on track with attendance. We feel then [sic] needed that added support in the beginning, and still to this day during this stay-at home order. I feel being able to give that added support has helped us maintain our attendance throughout this pandemic.” They reported that, for the most part, this trend subsided as families and home visitors adjusted to this new normal. Others reported having more families engaged in virtual groups by eliminating common barriers to participation, including child care and transportation. As one site shared: “We had a huge turnout for class which was very surprising to us. We thought that it would be hard to get people to attend but we actually found it to be the opposite.”

As sites shifted to virtual home visits during the stay-at-home order, they reported difficulties engaging pilot families who did not have access to technology: “During the COVID-19 time we have not been able to see the families. We had to learn quickly how to do this virtually with the families. Many families did not have access to technology so that has also been a problem.” Lack of technology access did not fall along geographic lines, with both urban and rural areas reporting similar challenges.

Additionally, some home visitors shared that clients seemed reticent to participate in virtual groups because it was an uncomfortable and less secure way to discuss sensitive topics. As one champion shared: “The families I serve that are in treatment or recovery do not feel that it is a comfortable or safe way of communicating. The virtual connection has seemed to make some feel uncomfortable with what they are willing to say or talk about.”

Along the same lines, sites expressed that it was harder for families to build relationships and group connections virtually: “Many agencies are only completing services via the phone or virtually and to some of our families speaking with new people via the phone or virtually causes them great anxiety.” Pilot

champions reported that relationships with clients are built on trust, and those relationships have been disrupted by COVID-19 because their families are less trusting of virtual communications.

External Stressors Among Clients with OUD

During the stay-at-home order, sites reported an increase in external stressors for clients enrolled in the pilot, including unemployment, lack of child care, and suspension of parental visitation rights, which contributed greatly to already heightened levels of stress and anxiety.

A few sites reported that families experienced relapses during this time of increased stress, loss of routine, isolation, and uncertainty, made more difficult by fewer available recovery meetings in the community. For these reasons, many champions anticipated an increase in client relapses during and after the pandemic: “For those who were struggling still with the choice to get sober there were many struggles. No access to face-to-face meetings or support groups, unemployment, isolation and boredom, which has always been used as a trigger to use. Getting clean is a huge decision in life, having to make that and try and remain during such an uncertain time has been an immense undertaking and takes more effort than it already did in a normal setting.”

Many champions also feared that families would experience homelessness due to unemployment and associated financial hardship. They reported that many were already unable to pay rent, which could possibly lead to evictions and homelessness. As one champion described: “Due to lack of employment for some families they are now dealing with the inability to pay their rent or utilities. Many are getting unemployment, which is helping, but many lack the skills needed to budget the money appropriately. That seems to be a reoccurring challenge within the community. Also, many families were dealing with homelessness right before the stay-at-home order was put into place. So they do not have access to many apartments due to them not showing individuals due to the COVID-19.”

Further, champions reported that pilot-enrolled families who were involved in the child welfare system

saw a sudden stop or shift to visitation rights for their children in out-of-home care. Others saw courts close and custody hearings postponed indefinitely, delaying reunification with their children. Sites shared that custody issues like these caused additional strain and uncertainty for their families struggling with substance use disorder, because “[m]any of the families did not have full custody of their children at the time of the stay-at-home order. Therefore, visitations were at zero for the entirety of the order and only some were granted video visitations.”

Grandparents Parenting Grandchildren

Grandparents with custody of grandchildren were hit particularly hard by the COVID-19 stay-at-home order, according to pilot sites. Over half of the sites had some grandparent clients enrolled in the pilot. Champions described grandparents who were serving as primary caregivers to their grandchildren as struggling with a sudden shift in parental visitation rights intertwined with the personal health risks of COVID-19 for older adults: “Grandparents in kinship care situations had to make decisions to not let the parents visit with children to eliminate risk to child and themselves being a high-risk population.”

Further, sites described how grandparents who relied on others to supervise children while they worked were suddenly without childcare or school supervision. This left many to care for grandchildren all day long and coordinate online schoolwork and activities. One champion shared that “grandparents are dealing with several issues with child care for grandchildren who are normally in the schools at daycare. Child care has been difficult as well because their normal daycare / babysitters are reluctant to watch the children because of the pandemic and they also have their own children at home.” Another site’s champion described how “[s]ome grandparents aren’t as in tune with technology and accessing online schoolwork was difficult for them.”

Anticipating Post-COVID Challenges

When asked what challenges pilot champions anticipated once the pandemic subsides and restrictions are lifted, responses ranged from increased client stressors to difficulties implementing typical

home visiting programming.

Multiple champions described fears of clients' economic situations as a result of the pandemic. One described how uncertain regaining employment was for their clients and how they aimed to address it: "Many may not be called back to work or may be laid off for an extended period... We will offer parenting support and resources for mental health, employment, etc." Another described possible client housing challenges: "I fear that homelessness among our clients could possibly increase due to them getting caught up on their rent or having the ability to continue to pay the rent if they have lost their job."

Another common concern was around client engagement when reverting back to in-person services: "Definitely we going to have some challenges because visits will performed virtual or telecommunication with [sic] are not the same as face to face." Another champion noted that families might need time to be willing to attend group gatherings again and planned for how to continue to keep families connected: "I anticipate that individuals will be less likely to come to a group setting right away. I plan to just continue to keep in contact with them and continue to let them know the services are available."

Lastly, many champions discussed anticipating challenges with home visitor and client safety as isolation guidelines are lifted and people begin to engage in person again. As one noted: "We feel very unsure when staff and patients will feel comfortable with home visiting. We will need to make sure we feel safe and have safe protective equipment available to us." Another champion imagined various responses from clients and possible implications for health: "I think families will respond in a myriad of ways. Some will be so glad social distancing/stay at home restrictions have been lifted that they will ignore possible health risks. They will seek opportunities to socialize with some people that will increase the likelihood of relapse. Some will be fearful of exposure and continue to isolate themselves and children."

Discussion

This study describes a perceived significant impact of mandated shelter-in-place orders issued during the

COVID-19 pandemic on the delivery of evidence-based home visiting (EBHV) to families impacted by OUD. Safety measures imposed for the health and well-being of families and home visitors uprooted the traditional home visiting practice of meeting face-to-face in families' homes, with downstream effects. While all home visiting clients were impacted, caregivers with OUD were uniquely affected by the new normal imposed by the pandemic.

The primary concerns raised by home visiting programs were caregiver stressors related to isolation and loss of routines, difficulty accessing services, loss of employment, and increased caregiving burdens. Home visiting agencies described instances of relapse that they attributed to these stressors and a fear of continued increases in relapse for caregivers in recovery during and after the pandemic. Grandparents raising grandchildren in the context of parental OUD were identified by home visitors as having layered challenges, with acute issues around childcare closures and technology access and proficiency.

For families with caregivers in treatment and recovery, service connectivity and coordination are essential functions of EBHV, as reported by home visitors and program administrators in this pilot evaluation. Prior to the pandemic, many pilot home visitors adapted their roles to assist with navigation of services and systems, including the child welfare system, drug court, incarceration, medication assisted treatment, and other therapies.

Implications

Supporting families with re-engagement in these systems and services following extended pandemic-related interruptions is likely to be a role home visiting programs are called upon to fill. Home visitors are among the few prevention professionals with roles embedded in communities that extend into homes with longitudinal family relationships and are uniquely positioned to understand the pulse of the changing needs of families with young children during crises. Importantly, these programs are also some of the very few to target and meaningfully engage grandparent caregivers.

Across a large network of programs operating across

a geographically diverse state, home visiting programs voiced a preparedness to find ways to address high acuity client needs that have been exacerbated by the pandemic. Needed adaptations moving forward may include expanded collaboration with external partners across social service and health sectors, targeted staffing roles for individuals with content expertise in SUD treatment and recovery, and/or additional training. Further, these results demonstrated sustained family efforts to engage in services during this time of elevated need, indicating the perceived value of this prevention service during a crisis period. The new flexibility of virtual or hybrid program delivery may expand home visiting's reach to higher acuity clients beyond the pandemic, shaping the standard of care moving forward.

Limitations

These data are representative of a specific population of service providers from a subset of home visiting agencies in Pennsylvania. The methods used in this evaluation were not designed to be generalizable but may be useful in providing a snapshot of COVID-19's impact on families of young children impacted by opioid and substance use.

Conclusion

Family-focused prevention programming is critically important to preserving family well-being and stability during what is likely to be an extended period of increased hardship, loss, and stress stemming from the pandemic. Shifts to virtual implementation methods have presented both challenges to adhering to evidence-based models and unanticipated benefits of increased engagement due to certain barriers being reduced. The pandemic has likely also intensified the needs of high acuity families, including those struggling with OUD. As we exit the pandemic, continued focus on these programs and their service delivery needs will be critical to promoting family well-being.

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Practitioner and Military Family Perspectives of Child Maltreatment Risk and Protective Factors During COVID-19: A Multimethod Approach

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Physical distancing efforts due to the coronavirus (COVID-19) pandemic have isolated families and may result in a number of unintended consequences, including increased parental loneliness, anger, anxiety, depression, and stress; increased parental substance abuse; paranoia about leaving the home; and decreased support from family and friends (Humphreys et al., 2020; Wang et al., 2020; Zhou et al., 2020). As parents' stress increases and their mental health decreases, they are less likely to engage in positive parenting and instead engage in negative parenting behaviors such as harsh, permissive, or neglectful parenting (Beckerman et al., 2017; Ciciolla et al., 2013). In fact, recent reports suggest the COVID-19 pandemic has elevated parental stress, resulting in increased risk of harsh parenting (Chung et al., 2020) and child maltreatment (Brown et al., 2020). In addition, parent stress and mental health may be affected by limited family relationships and social support during this time; for example, relationship issues during COVID-19 lockdowns have been related to mental health concerns (Pieh et al., 2020). Conversely, positive family relationships, including intimate-partner relationships and social support, may buffer stress and act as a protective

factor for child maltreatment (Brown et al., 2020). These increased risks and decreased protections place families at increased risk for child maltreatment (i.e., physical, sexual, or emotional abuse or neglect) during COVID-19 (Humphreys et al., 2020; Riegler et al., 2020). In particular, active duty military families often have unique experiences that can affect their parent stress and mental health as well as social support and family relationships, which in turn can affect their risk for child maltreatment.

Active Duty Military Families' Risk and Protective Factors for Child Maltreatment

Active duty military families face challenges unique to military life, including frequent geographic relocations, deployments and post-deployment reintegration, combat-related physical and mental health injuries, and living in geographically isolated areas. These unique challenges can serve to exacerbate or diminish risk and protective factors for child maltreatment that both military and civilian families possess (Palmer, 2008). Risk factors are characteristics families possess that heighten the probability of child maltreatment in the future, while protective factors are characteristics families possess that are correlated

with positive outcomes over time (Masten & Wright, 1998). Although prior research has identified other risk and protective factors for child maltreatment in active duty military families (e.g., Smith Slep et al., 2014), the current study focused on parent stress and mental health as well as social support and family relationships for two reasons. First, these risk and protective factors are malleable (i.e., as opposed to fixed factors such as race/ethnicity that do not change over time), meaning they are likely to change in the context of COVID-19 and they can be addressed via telehealth services in this unprecedented time. Second, prior research has found that these risk and protective factors are related to the unique experiences of military families as discussed next.

Increased stress and decreased mental health have been well-documented as risk factors for child maltreatment in active duty military families (e.g., Cozza et al., 2019; Lorber et al., 2017; Kaye et al., 2019). According to Palmer's (2008) theory of risk and protective factors and supported by research suggesting maternal stressors impact military children through mothers' mental health and parenting (Gewitz et al., 2018), military-specific challenges affect parents' mental health and stress, which in turn affects their interactions with their children. Military-specific challenges include stress associated with deployment (Creech et al., 2014; Gibbs et al., 2007), post-deployment reintegration (Taylor et al., 2016), military-related job stressors (Stander et al., 2011), and combat-related physical and mental health injuries (Hisle-Gorman et al., 2015; Morris et al., 2019). In addition, mental health challenges are not atypical among service members (Kehle et al., 2011) or their partners (Renshaw et al., 2008). Similarly, parenting distress, harsh parenting, and other problematic parenting practices are common in active duty military families, particularly before and after deployments (Creech et al., 2014; Willerton et al., 2011). Distress, particularly when related to parenting, has also been associated with child maltreatment in active duty military families (Schaeffer et al., 2005). In contrast, decreased stress and increased mental health can serve as a protective factor for child maltreatment in active duty military families, resulting in positive child outcomes (De Pedro et al., 2011). Services addressing both stress and mental health are

available and sometimes required for military parents (Rentz et al., 2006), and these services are often highly coordinated (Chamberlain et al., 2003).

Poor social support and challenging family relationships have been studied as both risk and protective factors for child maltreatment in active duty military families. In active duty military families, poor social support may be compounded by social isolation due to geographic relocations (Cozza et al., 2019) or deployed family members (Dichter et al., 2015; Rabenhorst et al., 2015). Active duty military families also face unique parenting challenges with changing parenting roles accompanying parental separations and reintegration and associated parental well-being (DeVoe et al., 2020). Similarly, interpersonal problems occur due to frequent separations, family role changes, high levels of stress and worry, and mental health challenges (Dekel & Monson, 2010; Sayers, 2011) and have been associated with child maltreatment (Cozza et al., 2019; Kaye et al., 2019; Schaeffer et al., 2005). For mothers, low marital satisfaction, low social support, and low family cohesion have been related to child maltreatment perpetration (Schaeffer et al., 2005). In contrast, increased social support and high family cohesion are protective factors for child maltreatment in active duty military families (Stith et al., 2009).

While increased stress, decreased mental health, poor social support, and challenging family relationships are risk factors that civilian families are also likely to experience during physical distancing due to the COVID-19 pandemic, investigating these risk factors as they relate specifically to active duty military families is essential given the unique circumstances they face. As aforementioned, these families face compounding challenges such as deployment, geographic relocations, living in remote locations, and dealing with combat-related injuries. Physical distancing, awareness of one's exposure to the virus, and dealing with the consequences of getting the virus during the pandemic may exacerbate their feelings of stress and social isolation. For example, for a family who already feels socially isolated, quarantining at home may further cut them off from community resources, increasing stress and mental health problems. On the other hand, active duty military families may be protected from many of the risk

factors related to the pandemic due to the specialized support services they receive. In fact, prior research has found that many active duty military families are adaptable, cope well, and are resilient (Meadows et al., 2017; National Academies of Sciences, Engineering, and Medicine [NASEM], 2019).

Military Parent Support

In efforts to promote resilient families, healthy parenting attitudes, and skills to prevent child maltreatment within the military, the Army provides prevention and intervention efforts at no cost to families. One such program is the New Parent Support Program (NPSP), a secondary prevention (i.e., for families at high risk of child maltreatment) home visitation program that delivers parenting education and support for military connected expectant parents and parents with children from birth to age 3. Supporting military-connected parents of young children is particularly important, as more than half of the cases of child maltreatment across the military occur with children under the age of 5 (U.S. Department of Defense, 2020). NPSP helps parents at high risk for family violence learn to cope with stress, isolation, military transitions, and the everyday demands of parenting. With nearly all families reporting that their lives have changed (Pew Research Center, 2020) and their stress has increased during the COVID-19 pandemic (Brown et al., 2020; Chung et al., 2020), NPSP practitioners are in a unique position to observe changes in the military families they serve.

In light of the evidence linking increased parental mental health and stress, relationship issues, and poor social support with child maltreatment in the independent contexts of the military and the COVID-19 pandemic, understanding the combined effects of a military context and the pandemic on factors for child maltreatment is particularly important. The purpose of this study was to examine self- and practitioner-reported child maltreatment factors of Army parents enrolled in NPSP services during the COVID-19 pandemic. By using these two data sources, the present study can compare and contrast across different perspectives as well as modes of inquiry. The present study was guided by the following research questions:

1. What risk and protective factors do practitioners perceive as family needs during the COVID-19 pandemic?
2. What parent-reported risk and protective factors are associated with child abuse potential during the COVID-19 pandemic?
3. To what extent do practitioner-identified risk and protective factors converge with parent-reported risk and protective factors are associated with child abuse potential?

Method

A convergent parallel mixed methods design was used, in which qualitative and quantitative data were collected in parallel, analyzed separately, and then merged. Convergent designs obtain different but complementary data on the same topic, allowing for a comparison of results to establish convergence or divergence (Creswell & Plano Clark, 2018). The research team collected this data from Army NPSP practitioners and the families they serve across 10 Army installations.

Practitioner focus groups

The focus group protocol was developed for a larger examination of NPSP services during COVID-19 (see Ferrara et al., in press). The protocol was based on emerging literature detailing practices of switching in-person health services to telehealth services and family violence risks during COVID-19. Next, research team members independently reviewed and revised the questions. In the final protocol, practitioners were asked to respond to a series of open-ended questions. The final protocol received IRB approval and all practitioners provided informed consent prior to participation. The data examined in the present study pertains to practitioners' perceptions of the family needs they have been addressing most during the COVID-19 pandemic between March 2020 and June 2020.

Practitioner participants and procedures.

Army NPSP practitioners were drawn from 8 of the 10 installations ($N = 30$). All consenting practitioners

were female; 20 were registered nurses, nine were licensed social workers, and one was a licensed marriage and family life therapist. Practitioners participated in nine virtual focus groups lasting between 23 and 68 minutes ($M = 51.62$; $SD = 13.96$ minutes), which took place between May 2020 and June 2020 as part of a larger examination of Army NPSP services during COVID-19 (Ferrara et al., 2021). The audio-recorded virtual focus groups were led by an experienced moderator and supported by a similarly experienced assistant moderator, transcribed verbatim using Amazon Transcription (AWS), and corrected by the research team.

Qualitative data analysis

The research team collected and analyzed practitioner data in three phases (i.e., open coding, axial coding, selective coding; Charmaz, 2017) as part of a larger study (see Ferrara et al., in press). Data within the identified subtheme of family well-being were re-examined by the first author with particular attention to family violence risk and protective factors, reapplying selective coding—developing themes that expressed the content of each of the groups.

Parent participants and procedures

Following IRB approval, families stationed at 10 installations across the United States enrolled in Army NPSP services between September 2018 and September 2020 were offered the opportunity to participate in an evaluation of NPSP services. Consenting parents receiving NPSP services during the COVID-19 pandemic ($N = 292$) participated in an online survey between March 15, 2020 and September 30, 2020. Participants were predominately female (93.5%; 4.8% male; 1.7% other or unknown), White/Caucasian (59.2%; 21.6% Hispanic; 20.2% Black/African American; 4.1% Asian/Pacific Islander; 3.4% American Indian; 2.1% other), spouses of service members (77.1%; 18.8% Active Duty service member; 2.1% retired military; 2.1% other or unknown), and married (93.5%; 5.2% single or separated; 1.4% unknown), with an average age of 27.236 ($SD = 5.237$) years. Parents reported having zero (i.e., they or their partner were pregnant) to six children living in their home ($M = 1.458$; $SD = 1.141$). Parents completed two quantitative measures assessing child abuse potential and risk and protective factors.

Child abuse potential

The Brief Child Abuse Potential Inventory (BCAP; Ondersma et al., 2005) identifies parents at risk for the perpetration of child maltreatment through their indication of *agreement* (1) or *disagreement* (0) with 24 items assessing child abuse potential. This measure has been shown to have high sensitivity for detecting instances of child maltreatment (Milner & Wimberley, 1980; Ondersma et al., 2005). Positively worded items on BCAP (e.g., “My life is good”) were reverse coded such that higher responses indicated more risk for child maltreatment. Responses for the BCAP risk abuse subscale were then summed (Cronbach’s $\alpha = .856$).

Risk and protective factors

The Army uses the 59-item Family Needs Screener (FNS; Kantor & Straus, 1999) to screen families for NPSP services and identify areas of need to assist in service delivery. Recent work identified 37 items representing five factors (i.e., relationship discord, support, psychological distress, violence approval, and family of origin violence and neglect) and nine covariates that predicted family violence (Kaye et al., 2019). The current study considered malleable factors—the 9-item psychological distress (i.e., a combination of depression, suicide ideation, stress, and poor self-esteem), 4-item relationship discord (i.e., intimate-partner relationship perception), and 6-item social support (i.e., a combination of emotional and instrumental social support) subscales—along with the single-item covariates assessing uncontrolled anger and isolation (see Figure 1 for sample items). Participants rated items on a 4-point Likert-type scale ranging from 1 (*strongly disagree*) to 4 (*strongly agree*). Responses for the FNS psychological distress, relationship discord, and social support subscales were summed. These factor subscales were scored such that a higher value indicates that the factor is a risk for child maltreatment, while a lower score indicates that the factor is a family strength. These factors were part of a five-factor model that demonstrated adequate fit and predictive validity for family violence in past research (Kaye et al., 2019), and the internal consistency reliabilities for the psychological distress, relationship discord, and social support factors in the present study were .888, .777, and .669, respectively.

Quantitative data analysis

Descriptive statistics and correlations were computed for all variables. BCAP risk was used as a dependent variable in a multiple regression with the three malleable FNS subscales (i.e., psychological distress, relationship discord, and social support) and two malleable covariates (i.e., uncontrolled anger and isolation) as predictor variables.

Results

Practitioner-identified factors

Practitioners reported that “the pandemic was on the forefront” for their clients. As one practitioner described, “The content of our conversation changed immediately. My clients’ initial reaction to the pandemic was on the forefront. We talked a lot about the pandemic, their anxieties due to it, and how they just need to see a way forward as it related to not leaving their homes.”

Within this context of the families’ focus on the pandemic and their changing needs, five themes associated with changing family needs during the pandemic were identified: (1) isolation with one subtheme, decreased mental health, and two categories, anxiety and depression; (2) challenging family relationships; (3) limited support; (4) increased stress; and (5) family resilience.

Isolation

Practitioners in six focus groups discussed the risks active duty military families were facing were due to the isolation of the pandemic: “The isolation has, maybe, exacerbated some of their [high risk] symptoms, and with limiting resources for childcare or even therapy being limited, I think that has contributed to some of the decompensating we’ve seen with some of our families.”

Decreased mental health

Practitioners across eight focus groups indicated families were facing increased mental health issues. Consequently, they were conducting increased mental health checks: “[I] keep reminding myself to check in with that mental health component.” In particular, they expressed concerns over parents’ anxiety and

depression as it related to the isolation created by the pandemic.

Anxiety

Practitioners in four groups discussed parental anxiety compounded by COVID-19: “Folks are still very isolated. And for those individuals...who are at risk for depression or have a history of depression or anxiety, this just puts them at further risk.” This was particularly emphasized for clients with existing mental health conditions, pregnant parents, and those with family members and friends who contracted COVID-19 or died from the virus.

Depression

Practitioners in four focus groups also discussed the impact of pandemic-related isolation on parental depression: “This isolation has really upped that depression for [clients who are prone to depression].” Depression was specifically linked to the risk for child maltreatment: “It’s just anybody who’s at risk for depression, if they’re isolated, that’s an environment in which they are more likely to withdraw even further and same thing with the anxiety...which therefore makes their children at greater risk for becoming victim.”

Challenging Family Relationships

Six groups discussed challenges in relationships with both children and partners: “With this pandemic, things get out of balance, relationships get out of balance.” One practitioner noted, “A lot of them have already some shaky relationships with their partner, and that partner’s in their home all the time. And so, the mom doesn’t get much relief from her immediate situation because she has nowhere to go.” Others discussed challenges with parenting during the pandemic: “I think we’re having to address parents having more frustration with kiddos. They don’t understand that this is a new lifestyle for their kids. And they don’t understand why kids are acting up more than usual.” Conversations included parents’ need for managing anger and frustration due to challenging family relationships, and practitioners discussed their concerns that family violence might go undetected during the pandemic.

Limited Support

In six focus groups, both social and concrete support were identified as needs families were experiencing. Limited social support was compounded due to COVID-19, with many practitioners reporting parents' feelings of loneliness: "They're socially isolated in ways, and they are limited. They don't have anybody else for support." Practitioners also discussed parents' limited concrete support, such as little access to daycare due to COVID-19, limited ability to obtain groceries, and a lack of information about hospital practices for delivery during COVID-19, "But, specifically, basic needs has come up... When this first started, we were addressing things like toilet paper that we hadn't had to deal with before."

Increased Stress

Practitioners in three groups discussed stress that families were experiencing due to the pandemic: "Almost all of my clients are mentioning stress being one of the things going on now. You have this mom stuck in the house with little kids, and that's actually compounding the stress too." Clients were experiencing, "Stress. Stress of the unknown, stress of COVID, lately, the stress of Mr. Floyd's death, and stress of being pregnant, not knowing what's going to happen when they get to labor and delivery... So, they all have worries, they're stressed."

Family Resilience

Family resilience during COVID-19 was identified in two groups with remarks that active duty military families may be protected from some of the challenges of the pandemic due to their resiliency and adaptability: "They're used to the military lifestyle and the changes." Family resiliency conversations centered

on coming together as a family, getting both parents involved in services, and establishing routines; for example, one practitioner stated, "I think that they're pretty resilient, so they're seeing it as an opportunity... to kind of get some work done. I've had some families who have used this time to focus on potty-training or napping routines and utilizing both parents to participate."

Parent Results

Descriptive statistics and correlations are presented in Table 1. On average, parents reported low-to-moderate levels of psychological distress, relationship discord, social support, uncontrolled anger, and isolation. All included variables were significantly correlated with risk for child maltreatment. Multiple regression results indicated that parent-reported risk and protective factors explained nearly half of the variance in child abuse potential, $F(5, 286) = 46.419, p < .001, R^2 = 44.8\%$, adjusted $R^2 = 43.8\%$. In particular, increased psychological distress, relationship discord, and isolation were related to increased risk for child abuse (see Table 2). For example, every one-point increase in isolation corresponded to an approximately one-point increase in child abuse potential.

Merged Results

Practitioners' descriptions of active duty military families' risk and protective factors for child maltreatment converged with parent-reported risk and protective factors that were associated with risk for child abuse in four main ways (see Figure 1). First, the quantitative finding that parent-reported psychological distress was significantly related to risk for child maltreatment converged with practitioners' qualitative reports of mental health and stress functioning as

Table 1. Pearson Correlations Between FNS and BCAP and Descriptive Statistics

Factor	1	2	3	4	5	M	SD	Min.	Max.
1. BCAP Risk for abuse						4.017	4.235	0	23
2. FNS Psychological distress	.572**					15.140	4.617	9	31
3. FNS Relationship discord	.474**	.366**				6.938	2.507	4	16
4. FNS Social support	.405**	.563**	.348**			12.414	3.212	6	23
5. Uncontrolled anger	.317**	.342**	.298**	.172**		1.623	0.757	1	4
6. Isolation	.524**	.591**	.352**	.581**	.203**	2.120	0.921	1	4

Note. * $p < .05$ ** $p < .01$

Table 1. Pearson Correlations Between FNS and BCAP and Descriptive Statistics

Variable	B	SEB	Beta
Constant	-6.229***	.843	
FNS Psychological distress	0.291***	.054	.318***
FNS Relationship discord	0.427***	.084	.253***
FNS Social support	-.020	.076	-.015
Uncontrolled anger	.491†	.268	.088†
Isolation	1.095***	.272	.238***

Note. † $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$; B

increased risk factors during the pandemic. Second, the quantitative finding that relationship discord was significantly related to risk for child abuse converged with the qualitative finding that practitioners viewed challenges in family relationships as a risk factor. Third, the quantitative finding that uncontrolled anger was marginally related to risk for child maltreatment converged with practitioners’ qualitative reports that families were experiencing increased anger and frustration in their family relationships. Finally, the quantitative finding that isolation was related to risk for child abuse converged with practitioners’ qualitative descriptions of families’ isolation— isolation due to COVID-19 impacted other risk factors such as poor mental health, increased stress, decreased support, and challenging family relationships.

Practitioners’ descriptions of active duty military families’ risk and protective factors for child maltreatment also diverged with parent-reported risk and protective factors in two ways. First, practitioners described how poor social support functioned as a risk factor for families; however, in the quantitative results, a lack of social support was not associated with risk for child abuse. Second, in the qualitative results, reduced concrete support and family resilience were uniquely identified as a risk and protective factor, respectively.

Discussion

Active duty military families face unique challenges that may serve to exacerbate or diminish risk and protective factors for child maltreatment during the COVID-19 pandemic. As pandemic-related risks are likely to impact families for the foreseeable future, a more comprehensive understanding of the

factors associated with child maltreatment during COVID-19 is warranted. Thus, the research team compared qualitative Army NPSP practitioner responses and quantitative military family self-reports of factors for child maltreatment during the COVID-19 pandemic. Through the qualitative analysis, Army NPSP practitioners reported that, across their experiences with families during the pandemic, poor mental health, increased stress, lack of social and concrete support, and challenges in family relationships were risk factors for child maltreatment in Army families during the pandemic. While these factors may not be unique to military families, in practitioners’ descriptions, these factors were at the forefront of families’ needs and have been exacerbated due to the ongoing pandemic. Unique to military families, practitioners reported that Army families demonstrated resilience throughout this time, and they saw this as a protective factor. Then, through quantitative analysis, parent-reported psychological distress, relationship discord, uncontrolled anger, and isolation were associated with child abuse potential. In addition, through comparing and synthesizing both qualitative and quantitative data about Army families, Army NPSP practitioners’ identification of families’ risk and protective factors during COVID-19 demonstrated both convergence and divergence with parent-reported risk and protective factors associated with child maltreatment risk.

Convergence

Practitioner-identified risk factors and parent-reported risks associated with child maltreatment potential converged around mental health, stress, and psychological distress. Practitioners cited mental health issues, including depression, anxiety, and stress as increased risk factors for the families they

Figure 1. Joint Display of Qualitative and Quantitative Results



Note. Significant variables in the multiple linear regression are indicated by † $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

served during the pandemic. This converged with the finding that parent-reported psychological distress was significantly related to risk for child maltreatment. While parents reported low-to-moderate levels of psychological distress, mental health issues are not atypical among active duty military families (Institute of Medicine of the National Academies, 2014). In addition, Army NPSP practitioner reports that pandemic-related isolation exacerbated mental health issues and stress for families reflect emerging research about COVID-19 lockdowns, which has indicated that mental health issues in the general population, including anger, anxiety, depression, and stress, intensified as a result of quarantining (Serafini et al., 2020). Research has also associated higher anxiety and depressive symptoms with parental stress and child abuse potential during COVID-19 (Brown et al., 2020). The current findings extend these prior studies by providing practitioner observations of mental health issues and stress during the pandemic, along with an association between parent-reported psychological distress and anger and risk for child abuse.

Similarly, practitioners viewed challenges in family relationships as an increased risk factor during the pandemic. This converged with the finding that parent-reported relationship discord and uncontrolled anger were related to risk for child maltreatment. Parents again reported low-to-moderate levels of these risks; however, relationship problems are common in active duty military families due to frequent separations, family role changes, high levels of stress and worry, and mental health challenges (Dekel & Monson, 2010; Sayers, 2011). With findings that relationship discord was associated with substantiated child maltreatment in Army families (Kaye et al., 2019) and relationship issues during the pandemic also related to mental health concerns (Pieh et al., 2020), our findings highlight the need for practitioners to support relationships between partners through regular check-ins and providing evidence-informed stress-reduction strategies.

The quantitative finding that isolation was associated with child maltreatment potential converged with several areas practitioners identified as risk factors, including poor mental health, increased risk, limited

support, and challenging family relationships. Army families may be particularly at risk for experiencing social isolation during the pandemic, as they continue to experience deployments and military-related relocations. Military installations are often located in geographically isolated areas, and families living in private housing (as opposed to installation housing) are more likely to report feeling socially isolated and disconnected (National Academies of Sciences, Engineering, and Medicine, 2019). In past research, isolation predicted substantiated child maltreatment in Army families (Kaye et al., 2019). Practitioner observations of increased family isolation during the pandemic, as well as the quantitative finding that isolation is associated with risk for child maltreatment, are troubling, as family life is unlikely to return to normal in the near future. Thus, practitioners supporting families should consider implementing strategies to reduce isolation through virtual events for parents.

Divergence

Practitioner and parent reports of risk and protective factors diverged around two areas: support and resilience. Practitioners indicated families experienced increased risks associated both concrete and social support, yet parent-reported lack of social support was not associated with risk for child maltreatment. One possibility for this divergence is that the risk around social support that practitioners reported was related more to feelings of isolation compared to the quantitative measure which assessed a combination of emotional and instrumental support. Perhaps active duty military families were better equipped to deal with low instrumental social support during the pandemic, as they frequently face challenges in this area. For example, active duty military families are unlikely to have family geographically nearby to provide help with childcare and household tasks. This divergence could also stem, in part, from the lack of opportunity parents had to report on concrete support (e.g., food, shelter, basic needs). While active duty military families do not experience the same income-related risks as civilian families, many of them struggle financially (Hosek & Wadsworth, 2013), and one in seven active duty military families reported experiencing food insecurity (Wax & Stankorb, 2016). Nevertheless, practitioners should not overlook risks

associated with concrete and social support in military populations.

On the other hand, practitioners recognized that many families demonstrated resilience in the face of the pandemic. Many active duty military families are adaptable, cope well, and are resilient (Meadows et al., 2017; NASEM, 2019). In fact, these families, who are connected to NPSP services because they screened as high risk for child maltreatment, reported low-to-moderate levels of risk during the early shutdowns of the COVID-19 pandemic. While the isolation associated with the pandemic exacerbated existing challenges for many families, others may show resilience in the face of the challenges associated with the COVID-19 pandemic. More in-depth research is needed to increase understanding of the protective nature of resilience during the pandemic.

Implications and Recommendations for Practice

As information related to risk and protective factors for child maltreatment during COVID-19 continues to evolve, these findings provide a starting point for practitioners supporting active duty military families during the pandemic. Considering how Army NPSP practitioners' observations of families' increased isolation, poor mental health, increased stress, limited support, and challenges with family relationships converged with the relationship between parent-reported risk factors (i.e., isolation, relationship discord, and psychological distress) and child abuse potential, addressing these risks is essential in preventing child maltreatment during the ongoing pandemic. Programming to provide emotional support, decreasing isolation, and improving family relationships is needed. Numerous evidence-based programs that address these risks exist, including Attachment and Biobehavioral Catch-up (ABC) Intervention, Incredible Years Parent Training Program, Parents as Teachers, and Strength at Home – Couple's Program. In addition, strategies to promote family resilience may include compassion- and mindfulness-based interventions (Cousineau et al., 2019; Gliske et al., 2019) and teaching coping skills or relaxation techniques, such as arousal regulation, cognitive restructuring, goal setting, and self-talk (Forbes & Fikretoglu, 2018). Implementing telehealth

services to continue to serve families while physical distancing measures are in effect may be particularly important to enhance social connections and decrease isolation as would providing virtual gathering opportunities for parents.

Practitioners should conduct increased psychological assessments and monitoring during the pandemic. Army NPSP practitioners in the study reported conducting mental health check-ins with families each meeting. These check-ins should include assessments of pandemic-related stressors (e.g., feelings of isolation and anger), family relationships (e.g., partner/spouse, children), direct effects of COVID-19 (e.g., infected family members, grief due to the loss of loved ones; Ferrara et al., in press), and pre-existing psychological conditions (e.g., depression, anxiety; Pfefferbaum & North, 2020). Moreover, practitioners are encouraged to connect families with community resources to diminish feelings of isolation, especially for families who may be new to the area or live off-post.

Limitations

The present study is limited by its design in a few ways. Parent-reported risk factors and child maltreatment potential may be underrepresented in the present study due to social desirability (Bradshaw et al., 2011). In addition, child maltreatment potential, as measured by the BCAP, provides an indication of physical abuse, leaving neglect unexamined. Nor are there direct measures of the unique experiences that may affect military parents' stress and mental health (e.g., deployment, geographic relocations, parental injury). Research is needed to better understand how military families' service experiences have directly and indirectly affected their functioning during the COVID-19 pandemic. It is also important to recognize that the present study is a snapshot of practitioner observations and family experiences during the COVID-19 pandemic; it does not control for the services families have already received via Army NPSP. As such, the present results should be interpreted cautiously; they may not be representative of changes families experience over the course of the pandemic. In addition, the findings reported are limited to active duty Army families with children birth to age 3. Families with older children, in other branches of the military, serving as reserves or in the National Guard,

or civilians may present different experiences and needs in the context of COVID-19.

Conclusions

This study is part of an important emerging body of literature examining the impacts of COVID-19 and physical distancing prevention measures on family well-being. The present study provides both qualitative and quantitative results from two different sources to develop a more complete understanding of active duty military family risk factors for child maltreatment in the context of the COVID-19 pandemic. The vast majority of these results converged, suggesting that support for malleable risk and protective factors such as mental health and stress, family relationships, support, resilience, and most importantly isolation, are even more critical to preventing child maltreatment in this uncertain time. Efforts to prevent family violence and promote family well-being during the pandemic must continue, and practitioners should be prepared to identify and address risk and protective factors.

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Families at the Intersection of Racial Injustice, COVID-19, and Child Welfare

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Keywords: Racial justice, COVID-19, child maltreatment, health disparities, psychology, courts

Introduction

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The arrival of COVID-19 in the United States changed the nation. On March 19, 2020, California was the first state to issue a stay-at-home order due to the pandemic (Exec. Order No. N-33-20, 2020). Six days prior, on March 13, 2020, Breonna Taylor was fatally shot by police in her apartment. By May 31, 2020, 42 states and territories enacted mandatory stay-at-home orders (Moreland et al., 2020). Six days prior, on May 25, 2020, George Floyd was killed during an arrest by Minneapolis Police Officer, Derek Chauvin, who knelt on Mr. Floyd's neck for approximately 9 minutes. Earlier during the same month, video surfaced of Ahmaud Arbery being fatally shot after he was confronted while out on a jog.

While COVID-19 brought so much to a standstill, racial injustice appeared to proceed undeterred, which catalyzed national and international demonstrations against racism and police brutality. Businesses, media companies, professional associations, and other groups published statements about their plans to tackle systemic racism in their respective industries. Child welfare agencies and professional societies followed

suit and likely encountered, or re-encountered, our profession's longstanding tension between strengthening families and protecting children, which cannot be treated as mutually exclusive (Sugrue, 2019).

The following provides faith-based, medical, psychological, and legal perspectives regarding the families at the intersection of child welfare involvement, racial injustice, and COVID-19. After reviewing a variety of concerns regarding the experiences of these families, we conclude with final thoughts for faith-based leaders, medical practitioners, mental health specialists, and lawyers/advocates involved in Child Protective Services (CPS) cases.

A Faith-Based Perspective on CPS, COVID-19, and Race

Charles F. Boyer, DMin

The pandemic has caused more children to be at home. This reality is extremely challenging for all families, but far more so for Black families. They face additional stress, childcare issues, cramped living conditions, and financial strains. Black children are already overrepresented in the child welfare system. When environmental stressors are exacerbated, increased disparity will inevitably occur (Brown et al., 2020). The prophetic role of Black faith leaders ("prophetic" meaning here to see the inevitable, challenge

oppressive systems, and imagine new realities) is sorely needed at the intersection of suspected child maltreatment, racial injustice, COVID-19, and CPS involvement.

Black children are 23% of those represented in the child welfare system (KIDS COUNT Data Center, 2020). Research shows race plays a role in the disproportionality (Rivaux et al., 2008). The insidious cyclical nature of systemic racism breeds poverty, implicit bias, unjust criminal and youth legal systems, the school-to-prison pipeline, limited quality healthcare, and apartheid-like housing and educational segregation. The dual pandemics of systemic racism and COVID-19 leave the most vulnerable in our society, Black children, at major risk.

We cannot understand the struggle of many Black parents to adequately care for children without understanding poverty. Economic strains lead to poor housing, nutrition, and health. Single mothers and poor families are often faced with impossible choices due to a lack of resources. Wealthier parents have access to childcare, while poor parents have to choose between work or childcare, often necessitating older siblings caring for their younger brothers or sisters. Also, poor Black parents struggling with substance use have less options than wealthier White parents.

Poverty is also the major factor in the way COVID-19 has disproportionately hit Black communities (Henry, 2020). Many people of color are service and labor workers, doing everything from food service delivery to home health aide jobs. Many do not have the privilege of working remotely. These essential workers encounter obstacles to social distancing and sheltering in place, and they have more human contact. It is the risk taken by service workers that allows the wealthy to stay safe. Also, many economically disadvantaged people live in multigenerational living spaces (Pew Research Center, 2011). These factors ensure increased community spread.

Ever since the inception of the United States, generationally persistent racial injustice has been inextricably linked to public policy and government institutions. Implicit bias is also present and operative in the child welfare system. Even when factors such

as poverty are controlled for, research shows implicit bias plays a major role (Dettlaff, 2011). Starting from the very beginning of the spectrum, Black mothers are under an unwarranted level of scrutiny (Ellsworth et al., 2010; Kunins et al., 2007). Black children are more likely to be removed from the home than White children, and race has been identified as a significant factor in these decisions (Rivaux et al., 2008; Pryce et al., 2019). The very growth of the child welfare system tracks the growth of one of the nation's most racialized institutions: the criminal justice system.

Fifty years ago, President Richard Nixon declared a drug war that targeted Black people in response to accomplishments of the civil rights movement (LoBianco, 2016). As a result, Black people are more than three times more likely to be arrested, convicted, and incarcerated for substance use, possession, and distribution despite the fact that rates of drug usage among Black people are similar and, in many cases, less than those of Whites (Carson & Sabol, 2012). The prison population drastically increased from 1970 to present day, making the United States the world's greatest incarcerator (Lee, 2015). As incarceration rates rose, the number of children in foster care rose dramatically (O'Neill Murray & Gesiriech, 2004). Women have been incarcerated at increasingly higher rates and their children removed as a result (Rippey, 2020).

The stressors of poverty and structural racism under normal conditions are enough to be deemed a socio-spiritual crisis. Now with the pandemic, the crushing weight of this crucible is exacerbated, and the factors cited for intervention have been magnified. Substance use and overdose, food insecurity, and domestic violence have dramatically increased (Welch & Haskins, 2020). On top of all of this, these same factors have led to higher COVID-19 death rates of Black people (Centers for Disease Control and Prevention [CDC], 2021c).

Child Maltreatment and Health Disparities During COVID-19

Paulett Diah, MD, FAAP

Racism, a system of advantage and disadvantage based upon race and not purely on prejudicial

beliefs (Heard-Garris et al., 2018), which structures opportunity and assigns value based on how one looks (Jones et al., 2008), is a core social determinant of health (Trent et al., 2019). Defined by the World Health Organization (WHO) as, “The conditions in which people are born, grow, live, work, and age,” social determinants of health are influenced by economic, political, and social factors, which are heavily linked to health inequities, independent of genetics or behavioral choices (Trent et al., 2019). Healthcare access and quality, education access and quality, economic stability, social environment and community, and neighborhood environment affect a wide range of health risks and outcomes (CDC, 2021a). According to Sondik et al. (2010), health inequities among racial minorities are pronounced, persistent, and pervasive.

Further, racism is a driver of, and may be a cause of, health inequities. It is associated with low birthweight, mental health issues, and increased poor health outcomes (Trent et al., 2019). Paradies et al. (2015) conducted a meta-analysis that corroborated prior studies showing the magnitude of associations between racism and mental health. Gee and Ford (2011) revealed that individuals who reported experiencing racism had greater rates of illnesses than those who did not. Chronic stress results in prolonged exposure to stress hormones, such as cortisol, leading to chronic inflammatory reactions, which predispose individuals to chronic disease (e.g., heart disease and diabetes mellitus). Also, racism, as a stressor, can be experienced vicariously by children (Heard-Garris et al., 2018). While this body of research has been invaluable in advancing knowledge on health inequities, it still locates the experiences of racism at the individual level. Yet the health of social groups is likely most strongly affected by structural, rather than individual, phenomena (Gee & Ford, 2011).

In addition to the above, in 2020, we witnessed the development of the healthcare emergency, the COVID-19 pandemic. Kyeremateng et al. (2021) stated that the COVID-19 pandemic was a children’s rights crisis, and Bryant et al. (2020) stated that adverse childhood experiences (ACEs) had potential to worsen during the COVID-19 pandemic. Pre-existing difficulties with access to healthcare and health

equality were challenges system wide.

The CDC reported 30.1% of pediatric COVID-19 cases between ages 0 and 4 were Hispanic/Latino, and 27.1% between ages 5 and 17 were Hispanic/Latino (CDC, 2021b). In a sample of 576 children under age 18 from 14 states that were hospitalized with COVID-19 between March 1, 2020 and July 25, 2020, Black non-Hispanic children and Hispanic/Latino children had hospitalization rates of 10.5 and 16.4 per 100,000, respectively; the hospitalization rate for White children was 2.1 per 100,000 (Kim et al., 2020). Data concerning underlying medical conditions was available for 222 of these 576 children, and researchers found 37.8% of the children had obesity, 18.0% had chronic lung disease, and 15.4% had prematurity. Notably, a higher prevalence of chronic disease was seen in the Hispanic and Black children (45.7% and 29.8%, respectively) compared with White children (14.9%). The presence of underlying medical conditions, which predispose children to COVID-19 associated hospitalizations, appear to have a racially disparate impact.

Since the health crisis, general pediatric and pediatric subspecialties witnessed a sharp decline in healthcare services. Statewide lockdowns dramatically limited foot traffic to pediatric services, and reports to various State CPS agencies rapidly fell. In March 2019, the New Jersey child abuse hotline received 7,501 reports. In March 2021, after Governor Murphy issued a stay-at-home order, the SCR received 5,117, a reduction of 32% (Napoliello, 2020). Kaiser et al. (2021) conducted a retrospective study of data from 52 children’s hospitals regarding emergency department and inpatient encounters in children ages 5 and under from January 1 to August 31, 2020. When compared to prior years, they found a sharp decline in pediatric volume and a significant decline in child physical abuse volume for a particular week. Voddi et al. (2021) also reported a decline in physical abuse and sexual abuse examinations by 72% and 63%, respectively, during COVID-19. Similarly, Cho et al. (2021) reported a reduction in incoming consultation to a child abuse program during March 2020. Notably, these findings point to a decrease in child maltreatment reports, but they do not establish an actual decline in child maltreatment during the pandemic.

Psychological Perspectives (COVID-19, Maltreatment, Injustice)

Tyshawn Thompson, MA

Black, Indigenous, and people of color (BIPOC) communities in particular have been disproportionately impacted by the COVID-19 pandemic. This is concerning given the many pre-pandemic issues marginalized communities faced, such as the healthcare disparities previously discussed. According to Fors (2018), BIPOC children are disadvantaged in terms of healthcare discrimination. She reported that modern healthcare is blemished by racial inequity and that quality healthcare is contingent upon social status, which systemically puts BIPOC communities at a disadvantage. These realities further decrease social status and healthcare opportunities for already disadvantaged groups. This vicious cycle can be incredibly distressing, especially to families requiring assistance to meet their children's needs during a pandemic.

As mental health providers working with children in a child maltreatment context, it is important to understand the child's family system to treat them—that is why we consider the effects of COVID-19 on caregivers and parenting stress. Brown et al. (2020) found that during COVID-19, caregivers have experienced mood changes, increased stress, and increased depression and anxiety symptoms. In Brown et al.'s study, Latinx parents reported the highest levels of COVID-19 associated stress among the ethnic groups studied. Decreased family support, social distancing, stay-at-home orders, financial strain, and the inability to adequately socially distance due to living in public housing were among the most notable stressors identified by these caregivers. Brown et al. (2020) also found that caregivers who experienced greater stress in the form of financial decline, as well as those who endorsed higher symptoms of depression and anxiety, had a higher potential for child abuse. Conversely, parents who felt supported—that is, they received financial support and social support and felt somewhat in control during the pandemic—were noted to have a lower potential for child abuse (Brown et al., 2020). This finding elucidates that a potential

protective factor against child maltreatment is parental support and strengthening families.

Research suggests that individuals from various marginalized or non-privileged groups are at higher risk for ACEs (Mersky et al., 2013; Merrick et al., 2018). ACEs include child maltreatment, separation from a parent, having household members with mental illness, and other potentially traumatic events, which may result in subsequent health issues and functional impairment. Making things worse, upon seeking healthcare services for these issues, non-privileged groups are likely to face additional inequities (Fors, 2018).

While individuals from marginalized groups are at higher risk for ACEs (Mersky et al., 2013; Merrick et al., 2018), it is worth reiterating that reports of child maltreatment have not increased since the beginning of the pandemic. Baron et al. (2020) explored this finding by reviewing the effects of COVID-19 stay-at-home orders on students. They indicated the shift to online instruction put children at an increased risk for undetected abuse because school personnel are key reporters of child maltreatment. If undetected maltreatment has indeed increased due to remote learning and the strain of the pandemic on families, then it is reasonable to be concerned about the safety and welfare of children in families with pre-pandemic poverty, inequities, and systemic disadvantage working against them (Brown et al., 2020). As a solution, the impulse to reopen schools is understandable. However, it is important to underscore that strengthening these at-risk families, and striving to remedy the injustices against them, does not have to wait for schools to reopen and would surpass what increased surveillance could accomplish by itself.

The Courts During COVID-19 and Structural Racism

Pantea Yazdian Maddux, JD

The courts play an integral role in child maltreatment cases. They act as the fact finders responsible for determining whether a child has been abused or neglected, and they determine the child's need for protection by the state. Through hearings, conferences,

and trials, the courts must also ensure that parents are receiving the services they need to improve their ability to care for their children. Child maltreatment cases are handled in various courts; juvenile, family, and some trial courts have jurisdiction over these cases. In addition, local courts are bound by their states' civil laws and procedures, which differ by jurisdiction across the nation. However, they share in the essential role of ensuring the safety, permanency, and well-being of children.

Starting in March 2020, COVID-19 resulted in prolonged shutdowns of non-essential businesses. Although courthouses were among the buildings to shut their doors, the judiciary was still under pressure to provide essential child welfare operations. However, during an unprecedented shutdown, courts began to roll out remote technology-based access to judicial proceedings. However, this sudden and significant change in judicial procedure caused delays, adjournments for non-urgent matters, and difficulty accessing the courts. Given that African Americans and families of Indigenous ancestry are disproportionately represented in the child welfare system (Berget & Slack, 2021), it stands to reason that these judicial closures and delays will have a racially disproportionate impact.

During the pandemic, some courts developed their own approaches to move the judicial process forward. For example, a Los Angeles juvenile court suspended all court-ordered family visitation, while other localities encouraged in-person family visits (Kelly et al., 2020). Courts implemented virtual conferences, hearings, and trials (American Bar Association, n.d.). Non-urgent cases would have to be adjourned to accommodate for urgent virtual hearings (Judicial Council of California, 2020). Surely, some families lacked the electronic capabilities to access the virtual judiciary. In addition, previously ordered in-person services, such as psychological evaluations and psychotherapy, were suspended, delayed, or became inaccessible as providers went fully remote.

In response to these concerns, the federal government provided guidance through the Children's Bureau (CB), a federal agency organized under the United States Department of Health and Human Services'

Administration of Children and Families. In a March 27, 2020 letter to legal and judicial leaders across the nation, the CB made clear that despite the public health crisis, courts were expected to continue judicial proceedings, family visits where possible, and services and efforts towards reunification (Milner, 2020). The bureau emphasized that "prolonged or indefinite delays in delivering services and postponements of judicial oversight place children's safety and well-being in jeopardy..." (p. 2).

Further, the CB strongly discouraged the blanket orders limiting family visits, finding it "contrary to the well-being and best interest of children..." They also offered specific guidance for courts, lawyers, and agencies to continue serving the best interests of children. The fallout of what the CB endeavored to address is yet to be fully known. However, given the disproportionate representation of African Americans and families of Indigenous ancestry in the child welfare system, it is reasonable to conclude that these concerns have had a racially disproportionate impact.

From a legal perspective, the effects of COVID-19 on parents involved in the child welfare system is not limited to judicial process. Previous writers have discussed in detail the increased risk of illness from COVID-19 for African Americans, those of Indigenous ancestry, and low-income families (Raifman & Raifman, 2020). It appears that this increased risk exists largely due to structural racism in employment, housing, and healthcare laws (Yearby & Mohapatra, 2020).

Structural Racism in Employment Laws

Racial and ethnic minorities are disproportionately exposed to COVID-19 because of their employment in "essential" jobs that cannot be performed remotely from home. Communities of color make up a disproportionate number of frontline workers (Hawkins, 2020). In addition, the majority of agricultural workers and home healthcare workers are made up of ethnic minorities and women of color, respectively. However, we lack employment laws to ensure that "essential workers" are protected while at work and that access to equal pay, paid sick leave, and unemployment insurance benefits are made available

to them. One writer suggests that Jim Crow-era employment laws continue to create disparities today (Yearby & Mohapatra, 2020). Without remedying these concerns, families are left vulnerable to stress, job loss, and financial decline, which can increase child maltreatment risk.

Structural Racism in Housing Laws

We lack federal housing laws to address health-related housing hazards that leave low-income racial minorities more susceptible to COVID-19 infections. As Yearby and Mohapatra write, “African American and Latinx households are almost twice as likely to lack complete plumbing than White households, and Native American households are 19 times more likely to lack complete plumbing” (2020, p. 8). These authors also stated that living in housing with health violations, such as challenges in accessing clean and safe water, increases the susceptibility of these families to COVID-19 and presumably to investigation by CPS for environmental neglect. However, they explain, the only federal housing law addressing a health hazard pertains to lead paint, even though research points to other health hazards plaguing racial minorities and low-income families living in hazardous conditions.

Structural Racism in Healthcare Laws

The rates of hospital closures in African American neighborhoods often leave racial minorities with limited access to local healthcare (Yearby & Mohapatra, 2020). Also, as previously indicated, research has also shown that African Americans receive poorer medical care than their White counterparts (Ayanian et al., 1999). In addition, those without health insurance often do not receive the healthcare they need for themselves and their children, which may increase the risk for medical neglect. While the Coronavirus Aid, Relief, and Economic Security (CARES) Act does provide Medicaid coverage for COVID-19 testing and treatment, the healthcare provisions of the act must be expanded to provide protection to all without healthcare benefits. The absence of certain laws perpetuates disparities that place families of color at greater risk of poverty, contracting COVID-19, and involvement in the child welfare system.

Final Thoughts

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Faith leaders have a moral imperative to address these inequities. Prophetic and priestly voices must be heard calling for cultural, theological, and political reimagining. We must change the rhetorical framing of these issues from bad parents to racially traumatized caregivers who need resources that prioritize their children *and* the family. We must have community-led and informed solutions that are funded by reallocating resources from a system that is racially flawed to one that affirms humanity and intervenes prior to desperation (Samuels, 2020). This kind of advocacy from faith leaders can help build strong and safe families and fairer systems. Additionally, houses of worship can work collaboratively for block vaccinations and equity focused policies that provide quality low- and no-cost healthcare. Finally, the prophetic voice needs to be heard to abolish the drug war and any predatory aspects of the child welfare system. As a community, we need to demand policies and programs that mitigate poverty and trauma rather than exacerbate it.

Pediatric medical providers have an opportunity to address the conditions that lead to the poor outcomes illuminated by COVID-19 on BIPOC communities due to preexisting healthcare disparities. In 2016, the American Academy of Pediatrics (AAP) developed strategies to address health disparities in pediatrics (Trent et al., 2019). The AAP wrote its equity agenda through the development of a Task Force on Diversity and Inclusion and the release of Policy Statements, including *The Impact of Racism on Child and Adolescent Health* (Trent et al., 2019) and *Truth, Reconciliation, and Transformation: Continuing on the Path to Equity* (AAP Board of Directors, 2020).

The agenda aims to achieve health equity for BIPOC children by focusing on changes to the following five domains: 1) An internal processes through fostering an organizational culture aimed to eliminate racism

and promotes equity, diversity, and inclusion; 2) Education to equip AAP members with knowledge and skills to address equity, diversity, and inclusion; 3) Workforce and leadership to strengthen and diversify the pipeline to pediatrics and AAP leadership; 4) Clinical Practice to equip members with the knowledge, skills, and capacity to advance health equity and combat racism through clinical practice -- To provide linguistically and culturally effective care, specifically addressing bias and discrimination; and 5) Policy and advocacy to advance the AAP Equity Agenda through advocacy and policy development (AAP, 2021). Through adoption of the agenda at the community level, pediatricians will be better equipped to address healthcare disparities with many BIPOC communities.

Given the above, the role of mental health providers is challenging yet crucial. It is incumbent upon mental health providers to be aware of implicit biases and psychology's history in institutional oppression (Loeb et al., 2020), and to acknowledge race and ethnicity as salient variables in treatment that come with unique disadvantages. People from BIPOC communities experience inequality exacerbated by mental health stigma, limited access to treatment and insurance, as well as culturally insensitive providers and practices (Loeb et al., 2020). With greater awareness and responsibility, mental health providers can practice fairly and promote racial justice in their work, especially during this COVID-19 era where injustice is so apparent. The APA's *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (2017) is suggested reading as a starting point in the journey to provide culturally sensitive care and to combat injustice in communities with an extensive history of oppression.

Also, legal professionals have a responsibility to assess the needs of the children and families they come across and to advocate for the safeguarding of their rights. They must identify novel issues as they arise and pursue improvements. Also, attorneys for CPS-involved clients during this public health crisis have a unique duty to make sure the judicial process moves forward despite the impact of the pandemic on the courts.

Call to Action

Most lawyers, healthcare specialists, social workers, and other practitioners will not have the opportunity to lead in developing child maltreatment policies, guidelines, and initiatives for their workplace or profession. However, as frontline professionals and the end users of these products, we all can stand in the gap between BIPOC communities and policies that inadvertently risk contributing to systemic racism.

Therefore, in conclusion, we offer a call to action for self-policing within our disciplines by challenging workplace and national policies, guidelines, and initiatives that may promote inequity or worsen existing disparities (APA, 2019). These unintended outcomes may result when those in positions of authority multiply and hoard power and force conformity on less powerful communities who are not meaningfully heard or permitted to persuade during the deliberation of system changes that will affect them. These problems are particularly ripe to occur when professionals in power operate from either of these flawed perspectives: 1. That all races will be equally impacted by systemic change; 2. That families from certain racial groups require saving or developing, regardless of the collateral damage to their families and communities (Blum, 2015); and 3. That these families have no wisdom to contribute for meaningfully addressing the issues at hand (Kendi, 2019). Therefore, practitioners are encouraged to give voice to BIPOC communities based on how these communities perceive or may experience certain policies (Annie E. Casey Foundation, 2006). By calling for the retraction or revision to policies, practice decisions, and other initiatives when appropriate, we can collectively bend the arc towards racial justice in child welfare practices.

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Call For Consulting Editors Of The *APSAC Advisor*

The APSAC *Advisor* currently is seeking Consulting Editors in the following areas:

- Early Childhood Education
- Child Welfare
- Equity & Social Justice
- Prevention
- Public Health

The primary responsibility of a Consulting Editor is to assist in the identification of reviewers for the *Advisor* within their area of expertise. The Editorial Team will contact the Consulting Editors as manuscripts are submitted to assist in the process of identifying appropriate reviewers. It is estimated that this will be one or two emails a month. Consulting Editors occasionally may be asked to review a manuscript that is directly in their area. When there is a disagreement among reviewers, Consulting Editors may also be asked to provide guidance to the Editorial Team. Additionally, the Consulting Editors may be asked to provide feedback and generate ideas for special issues and potential guest editors. They may also be asked to contribute to commentary providing a perspective from their area of expertise. Serving as a Consulting Editor is an unpaid volunteer position with a two-year term. Consulting Editors will be recognized in each issue of the *Advisor*.

People interested in serving as a Consulting Editor should submit 1) a letter describing their interest, qualifications, and description about their ability to contribute the [APSAC's commitment to eliminate systemic racism and implicit bias in the child maltreatment field](#) and indicating if they are a APSAC member or willing to join APSAC if selected as a Consulting Editor 2) their resume/curriculum vitae to the APSAC *Advisor* Editorial Team at info@apsac.org. Materials are due by August 1, 2021. Please send materials and any questions to info@apsac.org.

News of the Organization

Janet Rosenzweig, MS, PhD, MPA, Executive Director

APSAC Is Working for You!

When COVID-19 dramatically changed the way almost everyone conducted business last year, APSAC changed with the times and in doing so increased our reach by more than tenfold. Participants experienced APSAC educational programs more than 9,000 times, APSAC [educational videos on YouTube](#) had more than 8,000 views, and APSAC Forensic Interviewing Clinics were redesigned for the virtual environment and ran at capacity. While so many aspects of life seemed to stop, the need to keep children safe remained a priority. APSAC, our members, and our colleagues have risen to the challenge and will continue to redouble our efforts in 2021. Stay in touch with APSAC at www.apsac.org and see how APSAC's expanded education and training offerings can benefit you, your practice, and your community.

Register Now! The APSAC Virtual Colloquium Has an Outstanding Lineup!

July 12 - 15, 2021

This year's program features more than 70 virtual workshops, as well as plenary sessions from Dr. Jessica Pryce, Dr Sharon Cooper and forensic interviewing experts Julie Kenniston and Dr. Tom Lyon!

APSAC's first Virtual Colloquium received rave reviews; the special brand of bringing experts and practitioners together will be evident once again as we work to meet our mission of 'strengthening practice through knowledge.'

[Registration is open now!](#) Join your friends and colleagues and some of the best minds in the field!

APSAC Welcomes New Members to the Board of Directors

Dr. Debangshu Roygardner

Debangshu Roygardner, PhD, is the Assistant Director of Mental Health Services and the Assistant Director of the Vincent J. Fontana Center for Child Protection at New York Foundling. He is also an Adjunct Assistant Professor in the Department of Psychology through the School of Professional Studies at the City University of New York. Dr. Roygardner earned his PhD in Psychology from the Graduate Center at the City University of New York in 2017 along with a Doctoral Certificate in Africana Studies. He co-edited the book "See You at the Crossroads: Hip Hop Scholarship at the Intersections," which was awarded the 2016 Critic's Choice Award through the American Education Studies Association.

In his previous life, Dr. Roygardner was a hip-hop artist who performed nationally and internationally and whose work appeared on major media including CNN, NBC, Fox, RapGenius, and Huffington Post.

Love the APSAC Advisor? Members Can Access the Entire Catalog!

A wonderful benefit of membership is access to the APSAC library. There you will find issues of the *APSAC Advisor* dating back to 1990 along with issues of the *Alert* dating back to 2010, Guidelines, Position Papers, and Research to Practice Briefs. And everything is searchable by topic and author! Access the library here!

Update: The APSAC Center for Child Policy



The Center for Child Policy is an initiative created through partnership among APSAC, the Institute for Human Services, and the New York Foundling. The center's mission is to translate research into usable resources that promote evidence-informed policymaking and best practices for all professions involved in the field of child maltreatment. The work of the Policy Center is targeted to help policymakers make evidence-informed policy decisions and to help professionals in the field apply research to best benefit their practice and the children and families they serve. Current issues include mandatory reporting, differential response, abusive head trauma, immigrant children and family's psychological maltreatment, and intrafamilial child torture (ICT). Policy Center staffer [Pamela J Miller, JD, MSW, LISW-S](#) presented a highly regarded webinar on ICT, [a recording of which can be found here](#).

For more information on the Policy Center, visit its website: CenterforChildPolicy.org

Get the Latest from the Experts in the APSAC & Foundling Webinar Series



APSAC and the Vincent J. Fontana Center for Child Protection of the New York Foundling are proud to present the APSAC & Foundling Educational Webinar Series. Join us for in-depth conversations with leading experts in the field of child maltreatment. See the

full schedule of 2021 webinars below. See here for information on Continuing Education Credit for the APSAC & Foundling Webinar Series. For more information or questions about registration, contact the Fontana Center.

Upcoming webinars:

- [“Investigation and Prosecution of Child Abuse and Neglect”](#) presented by Victor Vieth, JD, MA | July 20 from 2-3 pm ET
- [“What do Red States and Blue States Tell us About Religion, Parenting, and Corporal Punishment in America?”](#) presented by Darrell Armstrong, DDIV, MDIV, EdS-MFT | October 6 from 2-3 pm ET
- [“Moving Beyond Mandatory Reporting from Recognizing, Reacting to Reporting to Resolving Child Maltreatment”](#) presented by Stacie LeBlanc, JD, MEd | November 9 from 2-3 pm ET

APSAC Can Support Your Conferences and Training

APSAC makes a great partner for a statewide organization planning a conference. [Contact Dr. Jim Campbell](#) if you'd like us to bring our national resources to your state or community. APSAC is now certified to offer CEUs in certain disciplines, further adding value to your event. We now also offer back-end support including online registration and credit card processing.

APSAC Is a Great Partner for Grant and Contract Opportunities!

States often issue Requests for Proposals (RFPs) to add training, research, or evaluation activities to their child welfare, child health, or related services. APSAC has joined state chapters in successfully responding to state-issued RFPs. If APSAC's experience, access to national experts, and other resources can add value to your response to an RFP, please [contact Dr. Janet Rosenzweig](#).

APSAC Is Working to Make Research Findings More Accessible!

We are proud of the high-impact factor of our journal, *Child Maltreatment*, but know that not everyone has the time or inclination to read entire research articles. This problem is not specific to APSAC; national reports suggest a 20-year gap between generating clinical knowledge through research and use of that knowledge across the mental health and healthcare fields. To help meet our goal of strengthening practice through knowledge, APSAC is now publishing [Research to Practice Briefs](#) to translate research findings published in CM into plain language, with an emphasis on implications for practice and policy. All briefs contain an introduction to the issue, a summary of the

research questions, a summary of the findings, and the implications for policy and practice.

To join our team of brief writers, or explore bringing this project to a graduate class, [contact Bri Stormer, MSW](#).

A Final Note

It has been my privilege to serve as APSAC's Executive Director since 2016 and to be part of APSAC's tremendous growth and in membership and service.

This is exactly the right time to open this opportunity for someone else while I return to focus on my work in child sexual abuse prevention and public policy. If you are interested in joining APSAC's team, please contact [APSAC President Stacie LeBlanc](#), and please stay in touch with me at DrRosenzweig@SexWiseParent.com.



APSAC Welcomes Our Newest Members!

January 1 - May 15, 2021

Cassandra Acevedo
Britni Adams
Di Ai
Robin Alexander
Kate Alexander
Kay Alexander
Sumaia Hamed Abdullah
Alhamed
Elizabeth A'Neals
Giana Angotti
Julia Arroyo
Adrienne Artis
Rick Ascano
A R Ascano
Luciana Assini-Meytin
Zoe Augustine
Courtney Bachus
Haragobinda Baidya
David Ballard
Katherine Barfield-Craig
Crimson Barocca
Luis Barrios
Reina Batrony
Heather Batten
Kristen Beard
Claire Beaumont
Melissa Beaupre
Catherine Beck
Svetlana Berkemeier
Christy Bezrutzyk
Tina Bigdeli
W. Warren Binford
Kristin Bishay
Justin Bishop
Lauren Black
Allison Bloom
Margaret Bodman
Dee Bonnick
Lisa Bourgoyne
Reid Boyer
Cathy Boyle
Brittany Breaux
Rep. Denise Brewer
Adam Brinkman
Lenora Brinson
Robin Brown
Swan Brown Ronde
Leona Brown-Insley
Ana Karen Brunet
Michael Bryant
Dane Burcham
Lauren Burge
Jacqueline Burgess
Lisa Burns-Brown
Jodi Byrnes-Klaus
Ninoshka Caceres
Kristine Campbell
Anita Capillo
Gretchen Carson
Ashley Carter

Christina Casanova
Yenys Castillo
Ryan Castro
Summer Chahin
Kacie Chase
Andrea Chase
Debra Chatman-Finley
David Chayer
Hui-Ying Chu
Marie-Eve Clément
Jennifer Cleary
Judy Cohen
Sarah Coker-Robinson
Karlene Cole-Palmer
Michelle Comas
Sharon Cooper
Alandra Copeland
Molly Cousin
Letticia Craft
Mickey Curtis
Jasmine Curtis
Kathleen Curtis
Amy Daley
Maleaha Davis
Adrienne Davis
Pamela Deavours
Andrea DeBell
Hadih Deedat
Joanna DeMeyer
Emily Denne
Lisa Di Enno
Chiara Diamond
Sonya Dickerson
Karissa DiMarzio
Jeffrey Dion
Jennifer Dodson-Weihl
Christine Doller-Poligrates
Sandra Donnay
Jessica Draper
Dawn Drasher
Chiodera Drayton-Smith
S. Keya Drechsel
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Valerie Dugas
Esther East
Benjamin Eithun
Marc Elcock
Rima Ellard
Rachel Ellner
Catherine Esperanza
Yvonne Eссор
Linda Estes
Lea Fantom
Donia Ferguson
Mary Fernandez
Rachel Ferrari
Michelle Ferrer
Liza Fetterley
Jessica Fidler
Jane Flygstad

Mireia Forner Puntonet
Shirley Fox
Kie Fujii
Kathy Gallardo
Ashley Galsky
Wendy Gamble
B.D. Garber
Adina Gardner
Marguerite Garrison
Megan Gauthier
Elizabeth Germaine
William Gillespie
Penny Gindlesperger
Lisa Gitelson
Chrysilia Gkleka
Jennifer Glover-Rowland
Sara Gluzman
Claudia Gonzalez
Tina Goodman-Brown
Eric Green
Jennie Green
Whitney Greene
Catherine Griner-Hadsock
Jessica Guice-Albritton
Breyanna Guiden
Leah Gunning Francis
December Guzzo
Tanya Haase
Marisol Habrahamson
Marcie Hambrick
Kim Hamilton
Jennifer Hammel
Kelsey Harford
Jeanine Harper
Nancy Harrison
Bennette Harrison
Prajakta Harshe
Harborview Abuse &
Trauma
Brandi Hawk
Muna Heaven
Melissa Heffler
Carl Heffner
Whitney Hellyer
Cynthia Henderson
Alex Henry
Avery Herman
Johanna Hernandez
Zynovia Hetherington
Sue Hobbs
Diana Hoffman
Celia Holmes
Rachel Hopperdietzel
Shaia Hubbard
Jennifer Hubbs
Danielle Igbani
Cathy Ingalls
Yuki Irisawa
Tasha Jackson
Anita Jaffer

New Members

Rachel Jawad-Craley
 Mariah Johnson
 Christiana Jolda
 Ellen Jonsson
 Sandra Jordan
 Laura Kaehler
 Laura Kane
 Karen Kennard
 Matt Kliethermes
 Nadya Kotik
 Nick Kuehnel
 Karen Lakin
 Jennifer Laney
 Kristen Lathrop
 Brian Lavery
 Adam Levine
 Hung-Peng Lin
 Britany Link
 Jennifer Livingston
 Rose Locklear
 Cheryl Long
 Daisy Lopez
 James Loving
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 Francesca Manno
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 Tiffany Thompson
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 Tracey Childress
 Carnigee Truesdale
 Kelly Tucker
 Lisa Turman
 Robin Turner
 Erin Turner
 Miranda Tutor
 Amber Ugasco
 Ritu Ullal
 Elisa Valles
 China Walker
 Cassidy Wallis
 Rita Ware
 Doressa Warren
 Joni Weinstock
 Virginia Whalen
 Jawanna Wheeler
 Julie Whitman
 Megan Whitney
 Jennifer Williams
 Mona Williams-Hayes
 Jessica Wipperfurth
 Andrea Wohl
 Diane Womer
 Karen Wray
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 Megan Yanny
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 Wendy Zinn

Washington Update

John Sciamanna

President's American Family Plan Tackles Child Poverty

In April, President Biden unveiled his American Families Plan (along with an earlier plan on infrastructure). The plan is likely to form the basis of a future reconciliation bill that would include a number of tax and human services issues including a Child Tax Credit (CTC) designed to reduce child poverty by half, a family and medical leave plan to cover all families, and a comprehensive childcare plan to extend quality child care to families ranging from middle to lower income.

Most significant in this American Families Plan is an extension of the CTC. As part of the March COVID-19 relief package, Congress passed a one-year expansion of the CTC. The Center on Poverty and Social Policy at Columbia University estimated that the expansion could cut child poverty overall by almost 45% and reduce racial disparities in child poverty—cutting Black child poverty by 52%, Hispanic child poverty by 45%, Native American child poverty by 62%, Asian American and Pacific Islander child poverty by 37%, and White child poverty by 39%.

The current CTC expansion will begin in July 2021, and making it “refundable” will provide \$3,600 per child ages 0-5, \$3,000 per child ages 6-17. This will be distributed monthly starting in mid-July. That translates into \$300 per month for children under age 6 and \$250 per month for children aged 6-17. The benefit will be distributed through the Internal Revenue Service (IRS). This is a one-year CTC, but the Biden American Families Plan would make it permanent. Key members of Congress, including Senator Sherrod Brown (D-OH), Senator Michael Bennet (D-CO), Congresswoman Suzan DelBene (D-

WA) and Congresswoman Rosa L. DeLauro (D-CO), have had legislation in the past two congresses to make this CTC permanent.

In 2019, Congress appointed the National Academies of Sciences, Engineering, and Medicine to identify strategies to reduce the number of children in poverty in the United States by half in 10 years. In a report, *A Roadmap to Reducing Child Poverty*, the National Academies concluded: “Some children are resilient to a number of the adverse impacts of poverty, but many studies show significant associations between poverty and child maltreatment, adverse childhood experiences, increased material hardship, worse physical health, low birth weight, structural changes in brain development, mental health problems, decreased educational attainment, and increased risky behaviors, delinquency, and criminal behavior in adolescence and adulthood. As for the timing and severity of poverty, the literature documents that poverty in early childhood, prolonged poverty, and deep poverty are all associated with worse child and adult outcomes.”

Administration Releases Full Budget at the End of May

This year's budget was released on Friday, May 28, 2021. The Administration had released an April 2021 outline, what some call a “skinny budget” for new Administrations, but this document now provides specific funding levels. The President's fiscal year (FY) 2022 budget begins on October 1, 2021. This year's budget, the first for the new Biden Administration, is the first budget since the end of the 10-year budget cap law that required a “parity” in spending increases and restrictions between the defense budget and those remaining departments considered “non-defense” spending. In other words, equal spending increases for

the defense budget when compared to the rest of the budget.

Within child welfare, the budget includes some significant increases within the Child Abuse Prevention and Treatment (CAPTA) law and Title II, Community-Based Child Abuse Prevention (CB-CAP) state grants (\$49 million), a new \$100 million through Child Welfare Services to address racial inequity in child welfare, and a significant increase of \$9 million for the Family First Act Clearinghouse (up from \$2 million).

Items that will indirectly have an effect on families and children and, by extension, child welfare, include a major initiative to address the social determinants of health (SDoH) with an increase from the CDC's \$3 million to \$150 million. Building on a proposed expansion of early childhood education, the budget includes major increases for Head Start (\$1.2 billion), Child Care (\$1.4 billion) and prekindergarten state grants (\$175 million). The Administration also seeks increases of more than 15% for the Maternal and Child Health Block Grant and a more than 50% increase from prepandemic levels for the Individuals with Disabilities Education Act: Infants and Toddlers (IDEA Part C).

The Administration proposed increases for CAPTA state grants and the Community-Based Grants to Prevent Child Abuse and Neglect (CB-CAP) would increase state grants at \$120 million—an increase from FY 2021's \$90 million, and an increase for CB-CAP at \$80 million—up from \$60 million in FY 2021. CAPTA Discretionary Grants would remain at \$35 million. Both increases represent significant progress from before FY 2018 when CB-CAP was at \$39 million and CAPTA state grants were below \$30 million.

Also of significance to the issue of racial equity and child welfare, the Administration is proposing an increase for Adoption Opportunities to \$46 million up from \$44 million in FY 2021. The new \$2 million would be used to address efforts in “Diligent Recruitment Plans” to effectively focus on targeting homes and families that meet the needs and reflect the racial or cultural representation of children and young people in foster care.

A Quality Improvement Center or other national effort will use a data-driven approach to work with local sites and build on current work through regional offices and constituency groups that revealed an urgent need to meet diligent recruitment requirements under the Multiethnic Placement Act (MEPA). A recent review through the Child and Family Services Reviews (CFSRs) found 34 states falling short of the required diligent recruitment efforts required under Title IV-B state plans.

Also important is \$100 million in new funding under Title IV-B (also known as Child Welfare Services or CWS); that would fund grants for state, local, and tribal child welfare agencies to partner with other government and community stakeholders across the education, health, human services, and early childhood sectors to advance comprehensive policy and practice reforms. These reforms would focus on advancing racial equity and safely reducing the number of children entering foster care, particularly in communities overrepresented in the child welfare system.

The agencies and their partners could use the funds for a variety of purposes to make progress toward reform goals, such as recruiting parents and children with lived experience to serve as peer mentors and navigators; developing help lines to refer families to essential services; ensuring families can access emergency assistance, respite care, and other supportive services in their own communities to prevent removals; better equipping caseworkers to meet the needs of the communities they serve; implementing race-blind decision-making practices; building data systems to inform decision making on both individual cases and systemic reforms; and ensuring child welfare agencies and their partners have the tools they need to better distinguish poverty from neglect and directing services appropriately.

Funding under this proposal would be for a limited number of grantees, representing both geographic and urban/rural diversity. Strategies and reforms identified under this program would be used to inform the broader work of advancing equity and prevention across the nation's child welfare systems.

CAPTA Reauthorization

On Thursday, June 10, The Senate Health, Education, Labor and Pensions (HELP) Committee acted on their version of a CAPTA reauthorization, S 1927, CAPTA Reauthorization Act of 2021. The legislation had been drafted by Committee members in a bipartisan manner. The legislation redesigns existing statute to streamline some of the language around definitions and research and encourage states and child protection systems to examine or develop “alternate pathways” to help families. The Senate bill creates a new title III on child fatalities that would create a new federal work group through the Department of Health and Human Services (HHS) and some other departments to examine and collect data on child fatalities and to issue an annual report to Congress. In addition, it authorizes up to \$20 million a year to fund state projects to conduct some of the same work at the state and local level. The legislation also separates out the current “plans of safe care” and renames them “Family Care Plans,” a separate title.

In January, the lead Democrat (Rep. Bobby Scott) and lead Republican (Rep. Virginia Foxx) on the House committee with jurisdiction over the law reintroduced [The Stronger Child Abuse Prevention and Treatment Act](#) legislation, which reauthorizes CAPTA and includes many reforms advocated for by the National Child Abuse Coalition. This same bill passed the House during the 116th Congress, but progress stalled in the Senate. The House re-passed their legislation on March 16, 2021.

The next steps are likely to include direct conversations between both the House and Senate Committees to determine if they can compromise on a final bill. If they can do that, it is likely the Senate bill would be modified to include compromise language and would then be approved by the Senate. That version would go to the House for a final approval. At this point the CAPTA reauthorization bills include just CAPTA and the Adoption Opportunities Act. It is unclear how quickly an agreement on one final CAPTA reauthorization will take to complete.

Washington Agenda for 2021

The Congressional calendar has slowed during the spring. At one point it looked as if two separate “reconciliation” bills would be passed by the Senate, with one for infrastructure and one for the American Family Plan. It is more likely there will be only one such reconciliation. That reconciliation process allows the Senate to avoid the filibuster, but it also restricts what can be included. The one reconciliation that may be taken up is likely to focus on some of the key human service initiatives including the CTC and child care. It could include some parts of an infrastructure bill that does not get bipartisan support.

While Congress debates that process, they also must start to address FY 2022 appropriations. With a late budget release and the COVID-19 pandemic, that timetable is really late this year. It is likely that Congress will have to provide a temporary funding bill (continuing resolution or CR) to get past the start of the new fiscal year on October 1, 2021. It looks very likely Congress will be working well into the December holiday period.

About the Author

John Sciamanna, Vice President of Public Policy for the Child Welfare League of America, began working for CWLA in 2001. In his role, he oversees federal legislative policy as it affects child welfare and children's programs. This includes federal legislative and administrative action as well as the annual federal budget.

Healing Interpersonal and Racial Trauma: Integrating Racial Socialization Into Trauma-Focused Cognitive Behavioral Therapy for African American Youth

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Introduction

African American youth are disproportionately impacted by traumatic experiences relative to peers of other ethnic and racial groups, which may be attributed to the increased prevalence of racism-related stressors within this population. In recognition of the growing racial disparities in trauma exposure and the traumatic consequences of racism-related encounters, this article proposes adaptations to Trauma Focused Cognitive Behavioral Therapy (TF-CBT) through integrating racial socialization (RS), or the process of transmitting culture, attitudes, and values to prepare youth to cope with stressors and oppression. While RS has been integrated into other interventions for African American families, no enhancements exist for African American youth who have experienced interpersonal trauma and racial trauma.

Article Aims

The authors note that focusing on general coping strategies may ignore culturally specific strategies that could enhance coping and improve initiation and retention in TF-CBT treatment. Guided by the racial encounter coping appraisal and socialization theory (RECAST), the authors postulate that integrating RS into trauma-focused cognitive behavioral frameworks

holds the potential to: (1) enhance positive coping strategies among African American youth to adaptively negotiate interpersonal and race-related traumatic stressors more adaptively; (2) assist youth with managing additional race-related stress that may compound more general traumatic experiences; and (3) bolster treatment engagement to enhance positive therapeutic outcomes for African American youth.

The authors provide specific recommendations for integrating RS into pre-treatment assessment and each of the TF-CBT PRACTICE components (psychoeducation/parenting, relaxation, affective expression and modulation, cognitive coping, trauma narration and processing, in vivo mastery, conjoint sessions, and enhancing future safety and development).

Recommendations

Prior to engaging in any of these recommendations, the authors suggest that clinicians engage in self-examination to increase awareness of their own biases and the ways that these biases may influence assessment and treatment. This can be accomplished through peer consultation and/or professional development.

Pretreatment Assessment: The authors encourage clinicians to consider tailoring their assessment battery to better capture youth's symptom presentation (e.g.,

psychosomatic symptoms) and assess for youth's experiences with racism-related stressors (e.g., racial discrimination), which may heighten PTSD symptoms. Screening for parents' experiences with racism and discrimination may also be warranted, as this impacts child-rearing practices by increasing the likelihood that parents are communicating RS messages to their children. Relatedly, clinicians should assess the family's current use of RS using standardized, empirically supported measures.

PRACTICE recommendations:

PRAC: During *Psychoeducation and Parenting*, clinicians should discuss results of RS assessment and caregiver's beliefs and values around child-rearing. Clinicians should also inquire about cognitive and attitudinal barriers to treatment, including beliefs about or prior experiences with mental health to provide corrective information as needed, and introduce RS as a protective factor. When reviewing *Relaxation*, clinicians should assess youth's beliefs (e.g., African Americans have to work twice as hard to get half as much) and emphasize the importance of relaxation for recharging and healing. The authors also recommend that clinicians assess culturally relevant strategies that youth and families utilize to cope with stress (e.g., prayers, music) and potentially incorporate these into traditional relaxation techniques. As some African Americans may experience psychosomatic stress responses, explicitly stating how relaxation can alleviate these symptoms may be helpful. With regard to *Affective expression and modulation*, the authors suggest that clinicians encourage youth to accurately appraise experiences of racism and discrimination (e.g., microaggressions, witnessing police brutality in media) that lead to affective changes so they can label and communicate their feelings, including in situations where there may be heightened racial tension. During *Cognitive coping*, clinicians should consider processing and role-playing techniques that teach children how to behave in situations that mirror previous discriminatory encounters (e.g., police stops or being followed by store employees). Clinicians should ensure they do not invalidate their client's race-related traumatic experiences during cognitive coping, but rather help them to focus on adaptive thoughts. Additionally, for clients who indicate race-related

index traumas, clinicians may want to attend to racial pride messages that can reduce or repudiate negative messages about self-worth or guilt and encourage clients to generate positive self-statements related to their race or help them with instilling pride through reminders of the resilience of African Americans.

T: During *Trauma* narration and processing, clinicians should assess the child's and caregiver's understanding of cultural norms around trauma narratives (e.g., "not telling family business"), as well as cognitions about oneself, others, and the world rooted in cultural norms (e.g., being a "strong black woman") that may present barriers. When constructing the narrative, culturally relevant forms of communication such as fables with morals or creating a song, rap, or poem should be considered and clinicians could encourage youth to include a chapter describing the historical plight of their racial group and how their ancestors overcame challenges. During processing, clinicians can utilize Socratic questioning to ensure the client can externalize racist and discriminatory encounters and internalize ethnic and self-pride to counteract negative beliefs and messages about themselves and others.

ICE: During *In vivo* mastery, therapists should allow clients the opportunity to practice skills that may reduce negative cognitions, emotions, and behaviors in response to future triggering racial encounters by constructing and moving through a fear hierarchy associated with entering into situations where racism or discrimination may be present. In *Conjoint* sessions, it is important to discuss the success of RS activities throughout treatment and the impact they had on the client's racial identity, as well as provide caregivers the time and space to hear and validate children's experiences of racial trauma while supporting helpful development of strategies and thoughts/beliefs to cope with these experiences. During the *Enhancing safety* module, therapists should develop a safety plan that equips the youth with how to respond in the event of future experiences with racial discrimination and to identify warning signs of danger (e.g., police stops). These efforts can be aided through role playing new skills with the caregiver.

Future research should continue to study the ways in which RS can be integrated into child trauma

treatment. Specifically, preliminary research can determine the feasibility and acceptability of integrating RS into trauma treatment that leads to focus groups for manualizing and piloting adaptations, which would inform randomized controlled trials.

Bottom Line

Integrating cultural practices such as RS into trauma-focused interventions can help to address African American youth's increased risk of trauma exposure that may be tied to race-related stressors and ensure culturally appropriate treatment. Once clinicians have had the opportunity to examine their own biases and understanding of cultural competence, the above recommendations can aid in enhancing treatment engagement, progress, and overall outcomes in this population while simultaneously ensuring challenges facing African American clients are not overgeneralized.

Citation

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