Rethinking Child Welfare to Keep Families Safe and Together:

Effective Housing-Based Supports to Reduce Child Trauma, Maltreatment Recidivism, and Re-Entry to Foster Care

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Large numbers of children who are placed in child protective custody have parents with a substance use disorder. This placement occurs despite evidence that the trauma of removal is associated with poor long-term child outcomes. This article describes a collaborative model of a continuum of housing-based clinical and support services for the whole family that has safely reduced foster care placement. An external evaluation of this pilot in Jackson County, Oregon, found significant differences in subsequent maltreatment, foster care re-entry, and family permanency outcomes favoring the treatment group. After initial external grant funds, this program is continuing and expanding across Oregon due to state legislation, and funding and can be a model for other states.

In pursuit of the protection and best interests of children, the state has a right to intervene in the private affairs of families by removing from their home children who are neglected or abused and placing them into protective custody, often in a foster care placement. This initial intervention can be critical to ensure the child's safety, but historically child welfare agencies have not been structured in a way that focused sufficiently on the longer-term well-being outcomes for children. Households in which parents abuse substances have an increased likelihood of providing chaotic environments for children. Rife with conflict, poor supervision, and insufficient emotional attention, the home lives created by parents with substance use disorders pose risks and safety factors too often requiring protective placements for children (Donahue, Romero, & Hill, 2006).

Child welfare policies have historically aimed to reduce these risks and increase safety by removing children from homes with parents who have a substance use disorder. For decades, the short-term gains of these child welfare policies may have been offset by long-term consequences of trauma associated with removal of children and placement in out-of-home care. This trauma can be avoided with appropriate resources to ensure that the children can safely remain with their parents while the family addresses the myriad problems they may be experiencing. Due to a lack of resources and other practice and policy concerns, child welfare agencies and substance abuse treatment communities have worked separately to assist a shared population that experience co-occurring problems. This recognition was made in our county in the late 1980s and resources began to be allocated to programs for the provision of integrated services.

Improved policies and systems change across the nation have contributed in part to the decline in the number of children in foster care: between 2004 and 2013 the number decreased by more than 22 percent (Child Welfare Information Gateway, 2015). Despite this drop large numbers of children continue to be removed from their families and placed into foster care, over 250,000 annually between 2009 and 2013, and many removals are for maltreatment secondary to parental substance use disorders (Child Welfare Information Gateway, 2015; Department of Health and Human Services [DHHS], 2014). This article presents the evaluation of a pilot project—a

family-focused, housing-based, drug treatment program with wraparound services provided through a collaboration involving child protection and substance abuse treatment—that reduced reliance on out-of-home care and the trauma associated with the child's removal. An underlying premise of the program is that reducing intergenerational transmission of substance use disorders and child maltreatment requires efforts to improve the parents' ability to parent while safely keeping families together or reunifying them as quickly as possible. This program model is offered to other jurisdictions to effect the systems change needed to treat parental substance abuse problems associated with child maltreatment.

Literature Review

Parental substance use is a significant risk factor for children and increases the likelihood of both child maltreatment and child welfare system involvement. Data documenting the existence of parental substance use disorders in child welfare cases is not consistently collected. However, a prospective longitudinal study identified maternal substance use as one of five key factors that increased the odds of a report to child protection services (Dubowitz et al., 2011). Higher rates of child neglect or abuse are likely consequences of parents who are impaired and prioritize their substance use (seeking, using, and recovering from intoxication) over the needs of their children. Parents with a substance use disorder parent ineffectively when their addiction contributes to a chaotic home life with few positive role models, poverty, and many moves.

Parental substance use disorders also impact decision-making processes within the child welfare system. Wulczyn (2009) found that 79% of maltreatment reports involving parents with a substance use disorder were substantiated, while only 18% of maltreatment reports not involving substance abuse were substantiated. This study also found that reports involving parental substance abuse were twice as likely as those without substance abuse to result in foster care placement. As a result, substance abuse by a parent was a reason for the removal of nearly 31 to upwards of 60 percent of children placed in out-of-home care in 2012, and child placements for maltreatment secondary to substance abuse by parents have increased

in recent years (Child Welfare Information Gateway, 2014; Correia, 2013). Although parents who abuse substances are more likely to come into and remain in contact with child protection agencies, these agencies face challenges treating the parental substance abuse problems underlying the neglect and/or abuse of children (Marsh, Smith, & Bruni, 2011).

In addition to the trauma caused by child maltreatment, children also experience trauma when they are removed from their familiar home life and placed in substitute care. Children may also be re-traumatized when they are returned to the care of their biological parent after developing attachments to one or more foster families (Gauthier, Fortin, & Jeliu, 2004). Child protection agencies are protecting children from imminent risk and safety factors by removing them from parents who are neglectful or abusive. However, they may have been slow to learn from trauma research to address the traumatic stress that children experience when removed from their families. A parenting fact sheet developed by a Temple University collaborative suggested that the trauma of removal experienced by children may be equivalent to the trauma of being abused by a parent and may be experienced by the child as greater than the trauma resulting from the parental neglect. This trauma was likened to that associated with divorce, which has been included in the study and classification of adverse childhood experience (ACE) ("Removal From the Home," n.d.; Felitti et al., 1998). Child placement in protective custody may be as traumatic to children as divorce resulting in toxic stress and changes in neurodevelopment similar to impacts demonstrated by other ACEs.

Just as ACEs have been associated with a host of negative outcomes through disrupted neurodevelopment, placement in out-of-home care has been linked to poor short- and long-term behavioral, physical, and mental health outcomes. Neurobiological consequences result from the toxic stress associated with removal and disrupted attachment and may place children at-risk for social, emotional, and cognitive impairment with lifelong consequences (Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005). Stress and negative emotions associated with removal have been documented. One study of children placed in foster care found that in the year prior to data collection, more than half of them experienced depression,

anxiety, drug dependence, or posttraumatic stress disorder (PTSD) and nearly 20% experienced multiple problems (Casey Family Programs, 2005, as cited in Bruskas, 2008). Children who are removed from parents and placed in out-of-home care frequently suffer from a volatile mix of negative neurophysiological, emotional, and environmental influences while in foster care. Specifically, researchers found that children who are placed into foster care experience negative outcomes that compound one another, including chronic mental health problems, poor academic achievement, increased high school dropout rates, substance abuse, unintended pregnancies, un/underemployment, reliance on welfare, homelessness, or criminal and other antisocial behaviors (Doyle, 2007; Racusin et al., 2005).

Considering the trauma caused by removal and the negative outcomes linked to foster care, removal should be the option of last resort for children who are neglected associated with parental substance use disorders. Doyle (2007) suggested that children who are not in imminent danger of physical abuse enjoy better outcomes when family preservation is prioritized over removal. Children who are neglected by a parent with a substance use disorder will potentially fare better by remaining in their parents' care as part of a family-focused drug treatment program than by being removed from the family. Avoiding removal can reduce iatrogenic trauma, produce cost savings, and result in better short- and long-term outcomes for children and families (Manion, 2009 as cited in "Removal From the Home," n.d.). However, policy and systems changes are required to reduce reliance on foster care for children who come to the attention of child protection agencies as a result of neglect associated with parental substance use disorders. This group of children is a prime population for systems change to promote better and more cost-effective child and family outcomes.

Program Description

The poor outcomes for children and the costs that are associated with foster care placement led to concern about the increasing number of children in our county who are removed from their families for neglect associated with parental substance abuse (Doyle, 2007). Through a partnership

involving OnTrack (Substance Abuse Treatment), the Oregon Department of Human Services Child Welfare Jackson County Office, the court, Court Appointed Special Advocates (CASAs), the local crisis relief nursery, Jackson County Public Defender, the District Attorney, and the Jackson County Foster Parent Association, this project aimed to reduce the number of children who are removed from their families and to change the experience for those children who needed to be temporarily removed. This work was initiated as a demonstration project, supported with multiyear grants awarded by the U.S. Administration for Children and Families' Children's Bureau for two similar populations: children who are removed and children who are at risk for removal.[1]

First, a front-end model was designed to avoid removal whenever possible. Trained and certified treatment providers (peer assisters), who have personal child welfare experience and are in recovery from a substance use disorder go with child welfare case workers on investigations involving substance use allegations. The normal fear and defensiveness that frequently occurs when child welfare workers knock on a family's door is drastically reduced when someone who can say they have "been there," does not judge them, and does not have the capacity to take their children, begins the conversation with "You don't have to lose your children." The family, along with the child welfare caseworker and the peer assister, develops a services plan that usually involves immediate entry into emergency housing where the families are supervised 24/7 by on-site case managers and other treatment provider staff. This plan is shared with the judge, who usually accepts it.

The program requires families to participate in intensive day treatment 20 hours per week as well as utilizing support services such as: case management and bonding and attachment services (learning the importance of facial expressions, body language, touch, and of tone of voice, pacing, timing, and intensity of verbal communication). Families are provided with emergency housing where there is 24/7 supervision and move to

[1] The projects described were made possible by two grants awarded by U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau: the Regional Partnership Grant (grant number HHS-2007-ACF-ACYF-CU-002-) from 2007 until 2011, and the Family Connections initiative (FC grant number HHS-2009-ACFF_OF-) from 2009 to 2011.

transitional, then permanent, housing as threats are removed. Other support services include transportation, relationship education, couples and family therapy, and medical education and care. This participation involves a minimum of 20 hours per week. At the same time, their children are provided with therapeutic child care and developmental services to address assessed deficiencies. Family compliance is promoted by having parents who are committed to treatment enter housing together. When parents are required to initially participate in separate treatment programs because of clinical indicators such as dissimilar commitment to recovery, parents focusing more on one another than on their children or recovery, or existing no-contact orders, children may need to reside with only one parent initially. possible, child care is shared and the goal is to reunite the parents as quickly as possible.

A family who enters emergency housing has a petition filed with the court giving temporary custody to the Oregon Department of Human Services, Child Welfare, and the child is placed with the parents. A continuum of housing options keeps families safely together while safety threats to children are resolved. Housing options include gender-specific residential treatment for moms and dads with their children, as well as emergency, transitional, and permanent housing where families live safely together under supervision. Along with housing, programs are offered that are family-centric, evidence-based, and gender-specific. Treatment for the substance use disorder is trauma-informed and provided along with family-strengthening services including bonding and attachment therapy, family and couples therapy, relationship education, yoga, and music with children.

Child Welfare staff and the judges gain confidence in a family's ability to safely parent their children through progress reports from treatment providers and observations of family visits. As confidence in the family grows, the treatment team makes a recommendation for the family to move to less intensely supervised housing. As they do, the focus shifts to the maintenance of recovery, continued improved parenting, strengthening family and couples' relationships, building life skills, and moving toward system independence. Families typically stay in the program for 18 to 24 months; about four months are spent in emergency

or residential treatment, followed by four months spent in transitional housing. The families are supported through their transition to permanent housing for a minimum of four months and a maximum of a year or more.

After active treatment is completed, many families move into permanent affordable housing, with drug- and alcohol-free leases offered by the treatment provider. All residents of the program are required to comply fully with their individual services and support plans. While living in the treatment provider's permanent housing, families are provided with continuing supportive services, and their sobriety is monitored through random urinalysis as appropriate. To minimize the risk of relapse due to lack of appropriate housing, the treatment provider supplies families with desirable, affordable, substance-free, permanent housing. In this housing environment, families learn how to be good tenants; after a year of good tenancy and completion of service plans, they earn a rental reference that opens housing options for them. Case managers assist families in locating mainstream housing when they are ready to move.

Because we want to ensure that biological parents are kept substantively involved in the lives of their children when they must be temporarily removed, foster parents are recruited who are willing to mentor families through our "Partners in Parenting" program. For example, biological parents can meet the foster parent at school in the mornings to hug their children and wish them a good day, or attend doctor's appointments, school conferences, and other important appointments with the children. Under this model, foster parents act as safety providers when parents interact with children, and also teach the parents skills of daily living and parenting practices so that children have consistent parenting when they return to their biological parents. Foster parents then stay involved with the family after the children are returned so that the children do not suffer another relationship interruption. Additionally, biological parents and children maintain a relationship with the foster parent to provide ongoing support to them as a collective family by choice. Ludy-Dobson and Perry (2010) suggest that this type of parental coaching can minimize stress and reduce the trauma of removal.

Methods

Data for this project were originally collected for federal grant reporting requirements under the two grant programs that funded the pilot project. Both grants served parents who were involved with the child welfare system, had abused substances, and had opted into substance abuse treatment, but focused on different populations that had goals of either keeping their families together or achieving speedy reunification with children. Child welfare outcomes were evaluated using a quasi-experimental design involving a non-equivalent, retrospective comparison group of families involved with child welfare.

The evaluation was designed to answer three research questions:

1. Do children in the treatment group experience lower rates of subsequent maltreatment reports than comparison group children?
2. Do children in the treatment group experience lower rates of subsequent maltreatment removals than comparison group children?
3. Do children in the treatment group enjoy more favorable permanency outcomes (i.e., reunification) relative to the comparison group?

Treatment and Comparison Groups

The target population for the treatment group was children who were in, or at risk for, an out-of-home placement due to the methamphetamine or another substance use disorder of a parent or caretaker. The treatment group consisted of 196 children who were admitted to either grant-funded program between January 2008 and September 2011and for whom a minimum of 18 months follow-up data were available. The comparison group was a retrospective group of children who were reunified with their parent following the most recent removal as a result of child maltreatment. Since the outcomes of interest were child welfare recidivism and re-entry, comparison cases were selected only if reunification occurred

and there was an equivalent follow-up time period of 18 months in which to examine reoccurrence of maltreatment or re-entry to foster care. To be considered retrospective, the child maltreatment report must have occurred in the county in calendar years 2005, 2006, or 2007. The comparison group was used to compare child welfare outcomes in the county prior to the implementation of enhanced services provided as part of the treatment.

Eligibility criteria for the comparison group were specified with the goal of identifying a retrospective group of children whose characteristics matched the characteristics of children in the treatment group. The comparison group included 54 children (a sub-population of the original retrospective comparison group) who experienced an out-of-home foster care placement and excluded cases in which the safety plan involved removal of the children from one parent and placement with the other parent. In addition, the parent of the children who were removed due to substantiated maltreatment must have had data on alcohol and/or drug abuse noted in their child welfare record as a family stress indicator. Each family selected for inclusion in the comparison group had to have at least one child aged 5 or younger. Since the comparison group only included children who were reunified with their parent, the size of the resulting comparison group for these analyses was reduced considerably from the group for whom child welfare data was originally collected. Examining only children who were reunified with their parent put the comparison group at an advantage when making comparisons to the treatment group; that is, only the safest most successful families in the comparison group were used to compare subsequent maltreatment reports and subsequent removals with the treatment group.

Definitions and Measures

For the treatment group, subsequent maltreatment report or removal refers to a substantiated maltreatment report or removal made on any date after the program entry date. For the comparison group, a subsequent report or a subsequent removal was one that occurred on any date after the child was physically reunified with their parent following the

most recent removal. Subsequent maltreatment and subsequent removal were operationalized this way because of the interest in examining safety of the children versus reoccurrence of maltreatment or re-entry to foster care while in the care of their biological parents, rather than in substitute care. Child welfare outcomes for children in the treatment group (with 18 months of follow-up data) were examined regardless of whether or not the children and their families successfully completed the treatment program. The follow-up period for examining subsequent substantiated maltreatment reports and removals was 18 months for both the comparison and treatment groups.

Data Collection and Analysis

The Oregon Department of Human Services, Child Welfare Jackson County Office (DHS) provided child welfare data for the treatment group outcomes and the state Oregon Department of Human Services (state DHS) Child Welfare Office provided data for the comparison group outcomes. Data provided by the county DHS and state DHS offices came from the National Child Abuse and Neglect Data System (NCANDS) and the Adoption and Foster Care Analysis and Reporting System (AFCARS) databases. Oregon adopted a new data management system during the study period that led the state to recommend avoiding some of the data for evaluation purposes (DHHS, 2011). As a result, the county DHHS office collected by hand the remaining data that were needed to complete the evaluation. The data required considerable cleaning and recoding prior to analysis.

Continuous data on the number of subsequent maltreatment reports and number of subsequent removals were recoded into dichotomous categorical variables with the attributes yes and no. The data were analyzed at the level of the unique child using SPSS 22. Cross-tabulation and bivariate chi-square analyses were used to evaluate the categorical outcomes of subsequent maltreatment report, subsequent removal, and final family permanency outcome (reunified or not) to determine whether significant differences existed between the treatment and comparison group.

Results

Similar results were found when using children as the units of analysis and when using families as the unit of analysis. Results presented here are based on analyses using individual children as the unit of analysis and all children in the families of both the treatment and comparison groups were included in analyses.

Child Demographics

Children in the treatment and comparison groups did not differ significantly in terms of their sex, race/ethnicity, or average age at entry (see Table 1). In the comparison group, over half of the children were male and in the treatment group slightly less than half were male. The majority of children were Caucasian (71% and 67%) and the average age was approximately three years. Children under the age of six made up roughly three quarters of each group.

Table 1. Demographics of Children in the Treatment and Comparison Groups

		Treatment	Comparison	Difference test[a]
Sex				1.07
	Male	49.2%	57.8%	
	Female	50.8%	42.2%	
Race/ethnicity				.27
	Minority	28.6%	32.6%	
	Caucasian	71.4%	67.4%	
Age of child (mean in years)		3.58	3.62	.07
Age of child (categorical)				1.37
	< 1	24.6%	20.0%	
	1 to 5	48.7%	58.0%	
	6 or older	26.7%	22.0%	

[a] *t statistic for tests of continuous variables and* $\chi 2$ *for tests of categorical variables*

Table 2. Subsequent Maltreatment Reports

	Treatment Group		Comparison Group		Total	
No subsequent maltreatment report	177	90.3%	42	77.8%	219	87.6%
Subsequent maltreatment report	19	9.7%	12	22.2%	31	12.4%
Total	196	100.0%	54	100.0%	250	100.0%

X^2 *(1, N = 250) = 6.12, p < .05*

Subsequent Reports of Maltreatment

Subsequent substantiated maltreatment reports for the treatment and comparison groups were examined. Whereas only 10% of children in the treatment group experienced subsequent maltreatment evidenced by a substantiated report within 18 months, 22% of children in the comparison group did. The rate of subsequent maltreatments in the treatment and comparison groups differed significantly, X^2 (1, N = 250) = 6.12, $p < .05$ (see Table 2). With a Cramer's V of .156, the relationship between treatment group membership and a lower likelihood of subsequent maltreatment is moderate. The answer to the first research question is yes, children in the treatment group experienced significantly lower rates of subsequent maltreatment reports than comparison group children.

Subsequent Removals

Rates of removal due to maltreatment subsequent to program entry (out-of-home care re-entry) for the treatment group and subsequent to reunification for the comparison group were analyzed. Over 18 months, 5% of children in the treatment group experienced re-entry (a subsequent removal) and seventeen percent of children in the comparison group experienced re-entry. The rate of subsequent removals in the treatment and comparison groups differed significantly, X^2 (1, N = 250) = 8.06, $p < .05$ (see Table 3). With a Cramer's V of .180, the relationship between treatment group membership and a lower likelihood of subsequent

removal is moderate. The answer to the second research question is yes, children in the treatment group experienced significantly lower rates of subsequent maltreatment removals than children in the comparison group.

Table 3. Subsequent Maltreatment Reports

	Treatment Group		Comparison Group		Total	
No subsequent removal	186	94.9%	45	83.3%	231	92.4%
Subsequent removal	10	5.1%	12	16.7%	19	7.6%
Total	196	100.0%	54	100.0%	250	100.0%

$\chi^2 (1, N = 250) = 8.06, p < .05$

Family Permanency

Evaluating family permanency outcomes involved recoding the foster care discharge reason for children who experienced a removal into a dichotomous categorical variable with reunified and not reunified as attributes. Reunification rates for the treatment and comparison groups were then examined. While over 92% of children in the treatment group experienced reunification as their family permanency outcome, just over half of the children in the comparison group (52%) were reunified with their parent. The reunification rate in the treatment and comparison groups differed significantly, $\chi 2$ (1, N = 162) = 33.694, p = .000 (see Table 4). With a Cramer's V of .456, the relationship between treatment group membership and a higher likelihood of reunification is strong. The answer to the third research question is yes, children in the treatment enjoyed significantly more favorable permanency outcomes (i.e., reunification) relative to the comparison group. The size of the treatment group was smaller in this analysis, as it was limited to children in the treatment group who had been discharged from their most recent foster care episode.

Table 4. Reunification Outcomes

	Treatment Group		Comparison Group		Total	
Not reunited	9	8.3%	26	48.1%	35	21.6%
Reunited	99	91.7%	28	51.9%	127	78.4%
Total	108	100.0%	54	100.0%	162	100.0%

X^2 *(1, N = 162) = 33.694, p = .000*

Discussion

Three outcomes (subsequent maltreatment; subsequent removal, i.e., out-of-home care re-entry; and final family permanency outcome), were examined to assess child safety in both the treatment and comparison groups. Children in the treatment program had better outcomes, evidenced by experiencing fewer subsequent reports and removals and higher rates of reunification.

Relative to other studies, the subsequent maltreatment report and subsequent removal rates experienced by the treatment group are positive. In the existing literature, rates of subsequent maltreatment vary depending on the definition used and time frame examined. Rates are lower with a stricter definition of subsequent maltreatment, such as substantiated reports, and higher when a longer follow-up period is examined. Available rates of subsequent maltreatment range from 17% to 35% (when children remain with their parents) when tracked over 5 years (Fluke et al., 2005), and up to 48% when children in foster care were tracked for 3 years (Drake, Johnson-Reid, & Sapokaite, 2006). Across the United States, state foster care re-entry rates within a 12-month period following reunification ranged from 2.3% to 27.8%, with a median rate of 11.9% in 2005 (U.S. Department of Health and Human Services, 2011). Oregon's 2006 re-entry rate was 8.6% within a 12-month period (U.S. Department of Health and Human Services, 2012). The treatment group of children with parents with a substance use disorder experienced lower rates of subsequent maltreatment than

other studies of general populations not limited to parents with substance use disorders.

With regard to family permanency outcomes, the treatment group, who participated in family-focused drug treatment, performed exceptionally well. In 2003, the U.S. Government Accounting Office reported that "[c]hildren in substance abusing families remain in substitute care placements for significantly longer periods of time, and experience significantly lower rates of family reunification relative to almost every other subgroup of families in the child welfare system" (as cited in Ryan et al., 2008, p. 1073). The Adoption and Safe Families Act (ASFA) (1997), designed to shorten the time children spent in out-of-home care, has presented challenges for parents with substance use disorders, and many have had their children removed as a result of maltreatment. Researchers have found that parents who abuse substances were less likely to be reunified with their children following implementation of ASFA than they were prior to ASFA (Rockhill, Green, & Furrer, 2007). Increased rates of adoption for children of parents with substance use disorders and have had their children removed due to maltreatment are in part due to delayed treatment entry resulting from insufficient beds or space and the inability to complete treatment within the ASFA recommended timeframe.

Although the treatment group outcomes were powerfully positive, this study is not free of limitations. First, the characteristics of the comparison group may influence the generalizability of results. The subset of parents in the comparison group who were reunified with their children was smaller than the original sample and may differ from them in unknown ways. Second, using a non-equivalent comparison group design means that a selection bias could have impacted the results. Factors that affected comparability of the groups in this study favored the comparison group (only examining children in the comparison group who had been reunified and who were subjected to lower levels of DHHS supervision than the treatment group), but the treatment group that enjoyed more supportive services had better outcomes. Third, the positive outcome of a small number of subsequent maltreatment removals presented a statistical

limitation; we found very few statistically significant predictors of failure in analyses conducted for the final grant report that were not presented in this article. The final study limitations stem from the analysis of secondary child welfare data. National reports have highlighted limitations particularly of data in AFCARS (Office of the Inspector General, 2003; Testa, Koh, & Poertner, 2008).

Conclusion

These evaluation results demonstrate desirable safety and permanency outcomes among families with maltreatment reports who were kept together safely while being provided effective substance use treatment for the parents and other wraparound services for the family. This type of program, offered by a transformed system, will minimize the trauma experienced by children in out-of-home placements, reduce the child welfare caseload, and reduce expenses associated with foster care. This change in philosophy and practice can take place on a larger scale without increased safety risks to children. In fact, the program in this study will be sustained by funding from state legislation, and the model will be expanded to produce statewide systems change and improve outcomes for a larger population. As a result, the financial costs associated with the traditional response to child maltreatment of removal from the home will be reduced and can be reinvested. Reallocating resources to make it possible for more parents who have substance use disorders and are involved with the child welfare system to receive clinically proven, trauma-informed care, provided by a transformed child welfare system, could improve outcomes for these families and is a sound investment. Important considerations for future research include evaluating statewide outcomes and conducting a cost analysis. Longer-term outcomes for children as they age into adolescents and adults are also of interest, including educational achievements, involvement with or avoidance of the juvenile justice system, and entry into the child welfare system by the next generation (children of the children in the program) in order to evaluate the benefits of remaining at home. The vision of the legislation is to transform the state's child welfare system to one that is

fully trauma-informed and to improve outcomes for children and families, reducing the intergenerational transmission of child maltreatment and substance use disorders across the state.

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