CWLA Child Welfare League of America

COVID-19 and Child Welfare: Challenges and Responses

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CWLA PRESS
Washington, DC • www.cwla.org

CWLA Press is an imprint of the Child Welfare League of America. The Child Welfare League of America is the nation's oldest and largest membership-based child welfare organization. We are committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm. All proceeds from the sale of this book support CWLA's programs in behalf of children and families.

CHILD WELFARE LEAGUE OF AMERICA, INC.
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Washington, DC 20005
www.cwla.org

Cover design by Marlene Saulsbury

Edited by Rachel Adams

ISBN: 978-1-58760-212-2

Library of Congress Cataloging-in-Publication

CWLA PRESS
Washington, DC • www.cwla.org

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About this Essay Collection

The ongoing COVID-19 pandemic has exposed the strengths and weaknesses of the systems, policies, and philosophies that shape how services are organized and delivered to populations that are vulnerable. If we are to achieve the *CWLA National Blueprint for Excellence in Child Welfare* goal of a world where "all children will grow up safely in loving families and supportive communities with everything they need to flourish—and with connections to their culture, ethnicity, race, and language," we need to identify and address systemic weaknesses and preserve and build on the strengths in communities and cultures.

These essays, written by human services professionals, academics, legal experts, child welfare practitioners, and others, discuss the challenges, significant developments, and innovations resulting from the impact of the pandemic on the child welfare field—including how communities are exposing and addressing difficulties, reawakening a sense of connectedness, and taking the steps needed to advance the goals of the *National Blueprint*.

We thank all of our contributors to this timely and important collection.

Child Poverty and the Pandemic

Lenette Azzi-Lessing

The COVID-19 pandemic has intensified the hardships of children living in poverty, with school closings and reduced access to food and housing hitting these children the hardest. This essay describes these and other inequities in pandemic-related harms to children in families that are the most vulnerable. The author points out that solutions to the scourge of child poverty have been available for some time and urges readers to become active in countering the beliefs, attitudes, and policies that perpetuate aberrantly high rates of child poverty in the world's richest nation.

Like many other early assumptions, speculation that the COVID-19 pandemic would go easy on America's children has proven to be false. Yes, the number of children dying from the virus has been disproportionately low. However, school closings and the toll of being unable to spend time with friends is causing stress among children and families across the country.

The social distancing and sharp economic downturn caused by the COVID-19 outbreak has hit certain groups of children particularly hard, including the 15 million American children who are living in poverty. At nearly 20%, the U.S. child poverty rate is higher than that of most similarly developed nations (Organisation for Economic Co-operation and Development, 2019; National Center for Children in Poverty, 2018). These children, along with many of the additional 29 million children in families who are low-income, are facing grave, pandemic-related hardships in much higher numbers than those in

other countries—where a strong safety net protects children's well-being (Economic Policy Institute, 2018).

Initial announcements of school closings provoked alarm regarding the nearly 30 million children who rely on free and reduced-price breakfasts and lunches to avoid going hungry (USDA, 2019). Many of these children and their families had nowhere to turn when a number of food banks across the country also shut their doors (Dzhanova, 2020). Then there are the 1.5 million children nationally who experience homelessness in the course of a single school year, pre-pandemic (Schoolhouse Connection, 2020). Distributing meals in parking lots is helpful, but is no substitute for the food security that schools provide to children who are vulnerable.

These same children can be expected to suffer the greatest learning setbacks due to school closures and limited hours for reopening. Parents living in poverty often have inadequate educational backgrounds and many haven't been able to work from home like higher-earning parents can. This means that children who most desperately need good-quality, parent-supervised home instruction have been far less likely to receive it As a result, children who are poor are falling even further behind their peers than they were before the pandemic (Dorn et al., 2020; Esquival et al., 2020).

The pandemic has also created a perfect storm of risk for child maltreatment, especially among families already struggling with economic insecurity. Parental job loss, stress, and social isolation are potent risk factors for maltreatment (Stith et al., 2009), and fear of getting sick or being laid off can raise stress to critical levels in households that already are vulnerable. These volatile conditions have been intensifying at a time when it is more difficult than ever to identify and assess children who are in danger, with many schools closed and home visits limited to situations in which risk for harm appears to be highest (Crary, 2020).

Although it has worsened the hardships caused by COVID-19, poverty was causing hunger, homelessness, and learning problems for millions of our nation's children long before the pandemic struck. Under the guise of child neglect, it also has been pushing tens of thousands of children into our struggling foster care system every year

(U.S. Department of Health and Human Services, 2019; Pelton, 2015). Children growing up in poverty are at high risk of faring poorly in school and experience serious mental and physical health problems throughout their lives (Azzi-Lessing, 2017) As with so many facets of disadvantage, racism plays a role here too, with poverty and its grim, lasting consequences more prevalent among Black, Latinx, and Native American children (Kids Count Data Center, 2018).

Like the pandemic, child poverty is an economic disaster as well as a humanitarian one. It is costing the United States an estimated $1 trillion a year in lost productivity, as well as in taxpayers' money spent on addressing severe mental and physical illnesses, crime, and other maladies made worse when children are forced to grow up with their basic needs unmet (McLaughlin & Rank, 2018).

This is not an unsolvable problem. In 2019, the National Academies of Sciences, Engineering and Medicine issued *A Roadmap to Reducing Child Poverty*, a blueprint for reducing child poverty by half through income and employment supports for such families (National Academies of Sciences, Engineering, and Medicine, 2019). Augmenting this with improved access to health, mental health, and substance use services, along with strengths-based parenting programs, could dramatically improve the life chances of millions of American children. Such a two-pronged approach has worked in other countries. England cut its child poverty rate in half in 10 years-beginning in 1999- by providing a combination of intensive social support and stable cash assistance to families who were living in poverty (Smeeding & Waldfogel, 2010).

Thus far, the United States has lacked the political will to tackle child poverty. I believe that this is because it has been easy to ignore and because of our callous, racist, and individualistic culture that blames and shames families stuck at the bottom of our economy. Just this past May, Texas Congressman K. Michael Conaway explained his objections to expanding food stamp benefits for families struggling in the economic downturn caused by COVID-19, stating, "I don't want to create a moral hazard for people to be on welfare" (DeParle, 2020). In a study conducted around the same time, one in five mothers of young children reported that their children weren't getting enough to eat (Bauer, 2020).

My most fervent hope is these attitudes will change, now that both the pandemic and a new reckoning with racismL has brought their disastrous consequences, as well as our shared vulnerability and interdependence, into sharp focus. This will not happen, however, without persistent and effective advocacy by everyone who cares about the well-being of America's children. It will require educating lawmakers and leaders at every level of government, as well as the general public, about the consequences of child poverty and demanding policies that will bring real change. I urge you to take action by contacting your city, state, and Congressional representatives, writing opinion pieces for news outlets, and spreading the word through social media. Only through such multifaceted, collective action can we change the narrative and end the scourge of high rates of child poverty in the world's richest country.

***Lenette Azzi-Lessing**, clinical professor of social work at Boston University, is the author of* Behind from the Start: How America's War on the Poor is Harming Our Most Vulnerable Children. *She brings more than 25 years serving children and families as a clinician, agency leader, and advocate to her academic work.*

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Exploring the Potential Benefits of Virtual Child Welfare Services

Anna Davidson Abella, Flandra Ismajli, and Linda M. Callejas

This essay explores the implementation of remote services for families awaiting reunification with children placed in alternate care settings. We draw on perspectives from parents and stakeholders involved in family reunification using remote services, gathered through a rapid ethnographic assessment (REA) we conducted between March and June 2020. Based on our findings, we suggest that a hybrid model of service delivery may harness the benefits of virtual innovations in service access while also ensuring protection of parental rights and child safety. We also call for more research on the effects of remote service delivery on vulnerable families is needed.

As it emerged in March 2020, the COVID-19 pandemic derailed traditional service provision in public sector systems, shedding light on existing system inadequacies and opportunities for innovation. For child welfare, rife with structural challenges and service fragmentation, service adaptations have been especially challenging to make. Concerns for ensuring child protection complicate efforts to effectively maintain both workforce and family safety while adhering to pandemic safety guidelines.

Prior to the pandemic, most child welfare services primarily were conducted in person, including court appearances, psychoeducational training, therapy, substance use treatment, and family visitations.

However, a rapid shift to remote delivery across all services was mandated under shelter-in-place orders, significantly limiting in-person interactions between providers and families. Using results from a rapid ethnographic assessment of pandemic restrictions in Miami-Dade County, Florida (Callejas et al., in press) this essay examines the implementation of remote services for families awaiting reunification with children placed in alternate care settings.

We draw on perspectives from parents and stakeholders involved in family reunification in three key areas of remote service delivery: court processes, therapeutic and psychoeducational services, and family visitation. Ensuring continuity of services while Florida was under shelter-in-place orders was arguably one of the most significant hurdles for child welfare to overcome. While utilization of telehealth services in child welfare was an emerging practice in Miami-Dade County prior to the COVID-19 outbreak, this platform had not been developed for routine use across different services and warrants scrutiny.

After a two-week suspension of most court processes following the announcement of shelter-in-place orders, courts began conducting hearings virtually or by phone. Child welfare professionals with whom we spoke expressed deep concerns about the viability of remote court for parents with limitations in cognition, English proficiency, or phone and internet access; potential violations of parental rights and procedural safeguards; and limited empathy from judges connecting remotely. Despite these concerns, they reported increases in parent and extended family involvement in hearings.

Mothers involved in our study (Callejas et al., in press) were awaiting court hearings to determine whether they met the conditions for reunification. Some said that the long wait times, bustle of unfamiliar people, and uncertainty about how proceedings would go mirrored tensions with in-person hearings. One mother explained about her first remote hearing: "Your heart is beating fast. You don't know what's going on. You don't know who's saying what." Despite initial anxiety and confusion, parents with whom we spoke said that remote court was a positive change—particularly because it alleviated transportation and

scheduling challenges that can be significant barriers for parents trying to accommodate numerous service and employment requirements.

Parents and child welfare staff praised the use of online platforms for parenting training and individual, family, and group therapy, and said that this option should remain post-pandemic. However, one stakeholder noted that meeting the needs of families with intensive mental health or substance use issues was difficult. She said she observed parents who appeared incoherent or nodding off during telehealth sessions and seemed to be struggling with sobriety or managing serious mental illness. In these cases, reunification timelines were delayed as a result.

The transition to remote visitation was a stressful process for many parents. Some completed remote visitations without much difficulty, but one stakeholder noted in interviews that we gathered, "Before we really got the whole virtual visitation rolling…There were some parents who felt like their kids were kidnapped." Limited physical contact with their children exacerbated pre-existing feelings of paranoia and helplessness that many mothers felt about child welfare involvement. A parent advocate corroborated these feelings and explained how initial service changes exposed underlying prejudices against biological parents in services, such as a perceived lack of faith in parents' abilities to manage their family affairs during the pandemic.

As a result of our study, we suggest that a hybrid model of service delivery may harness the benefits of virtual innovations in service access while also ensuring protection of parental rights and child safety. Continuing remote services—including psychoeducation, therapy, and limited court procedures—beyond the pandemic would help to reduce persistent barriers to service engagement and might help some families engage with treatment more readily. Remote connectivity might also contribute to holistic care by allowing family members to attend proceedings to support parents during reunification. Pairing in-person visitation with virtual visits or calls might also increase communication between parents and their children. They also could engage in a greater variety of educational, employment, and social opportunities and participate in system decision-making by attending board meetings.

Our study documented emerging child welfare system responses to the early stages of the pandemic in Miami-Dade County. In the months since, most child welfare services continue to be conducted remotely. System leaders have implemented additional adaptations, like establishing a committee that includes service providers and a parent advocate to identify cases for in-person visitations, and partnering with public libraries to provide families with internet access for court proceedings and other remote services. The ongoing use of remote services prompts further research into its effects on families who are vulnerable, from the effectiveness of services provided to increased risk of abuse. For instance, several stakeholders noted an increase in reports of physical abuse of children by foster parents, who may be ill-equipped to adequately care for children without routine supports from schools and structured programs.

Researchers also should critically examine whether predicted spikes in child maltreatment yield verifiable findings or reflect prejudices against parents. It is also important to study how we can maximize possible gains from remote service. Reducing unnecessary barriers to services is important and may lead to greater engagement by families and lowered stress among workers. All of this rests, however, on minimizing digital inequality, which has left a quarter of the Miami-Dade County population without a reliable internet connection (Conduent Healthy Communities Institute, 2020).

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Communicating During A Crisis: Making Challenges an Opportunity

Megan Branham and Allison North Jones

The protective factors we advocate for in families, including social connections, are the same protective factors that will keep child welfare organizations surviving and thriving despite a global pandemic. Maintaining or enhancing robust communications and advocacy efforts ensures that organizations are communicating and educating policy-makers and other decision-makers about critical services being provided—and the impacts an organization is having despite the COVID-19 crisis.

The field of child welfare is no stranger to struggle and challenges. The entire foster care system is built on intervening when families are in crisis. Organizations serving children or youth in foster care are accustomed to having to piece together funding to provide critical services and programs. It shouldn't be like this, but it is. And these challenges become even greater during times of unpredictable, unprecedented crisis like a global pandemic.

The COVID-19 pandemic has brought a new set of challenges to foster care organizations. Organizational budgets already are lean, but reduced revenue from canceled fundraising events or delayed grants has made it even tougher to make ends meet. For residential care providers, around-the-clock care has always been necessary, but with youth out of school and not attending regular summer activities, there are even more hours in the day that require staffing meals and social or educational activities. Child welfare practitioners have needed to incorporate

additional sanitization measures and have worked to make available affordable virtual training options.

During spring school closures and nationwide "shelter at home" orders in place, many experts anticipated an impending surge of calls to states' child abuse hotlines as schools reopen this fall puts child welfare organizations in an even more precarious situation (Ingram, 2020). With reduced budgets, a smaller workforce, and the now even greater demands on the physical and mental health needs of children and youth in care, child welfare organizations are needing to innovate and communicate in new, unprecedented ways or risk having to close their doors permanently. But there is hope.

Across the country, we are seeing organizations innovate and adapt in different ways. Child welfare organizations and even state agencies have pivoted from canceled conferences and created ongoing training for their workforce. Sharing new and innovative practices, including engaging youth voices with virtual events, or organizing socially distanced home-visits, has encouraged other organizations to think differently about how to provide their traditional services. Allowing colleagues to connect and exchange ideas and new solutions, even if through a computer screen, has energized the field. The Florida Coalition for Children restructured their annual conference and hosted virtual conference sessions as part of their new and growing "Learning Community." A total of ten virtual training sessions provided CEU credits on various topics—including "The Value of the Youth Voice in Placement Stability" and "Examining the Relationship Between Childhood Trauma and Symptoms of ADHD", were held over the course of three months with more than 520 attendees participating. Despite mandated stay-at-home orders or restricted hours of operations, community members have found ways to rally and provide much needed resources and support. Restaurants that typically have sponsored major events are instead donating meals to foster families and residential care staff. Community partners at Carolina Youth Development Center in Charleston, South Carolina purchased pizza and wings from local restaurants while residents and staff during a local "stay at home" order. Corporate sponsors hosted "drive-through" back-to-school events to provide families

with the usual necessary supplies like book bags and pencils with new additions of hand sanitizer and face masks. Sunshine Health in Florida hosted a Family Fit & Fun Day which included a drive through community event for hundreds of students in the Fort Lauderdale area.

Residential or group home leadership has made contact with local legislators virtually, allowing them a chance to still "come on campus" virtually where they can see firsthand how some of these facilities have adapted and developed innovative programs to help prevent the academic "slide" that can happen during the summer and/or the school closures resulting from the mandatory quarantines earlier this year. During these virtual visits, lawmakers had the chance to hear the needs of youth firsthand.

Members of the media have also been engaged for virtual campus tours and feature stories of staff on the front lines. In need of "good news" stories, local reporters have jumped at the opportunity to feature child welfare organizations who have created care packages for their foster families and coordinated front porch drop-offs.

What can we learn from the past several months? For one, we've been reminded of the resiliency of our communities and how many helpers we have in our communities who are willing to engage and support various critical areas of need and populations that are at particular risk during periods of crisis. This time also is a reminder of how strong communities, like children and youth in foster care, can surprise us with their creativity and adaptability—which is also why we must share these stories of help and resilience, loudly and consistently.

As advocates, we know that in tight times, the first funding cuts to be made by organizations or the projects that are put on hold are often communications or advocacy efforts. However, this is the opposite of what is needed. Now more than ever, it is time for organizations to rely on their strong partners, both in the public and private sectors, to show just how valuable and indispensable they are when it comes to ensuring that youth receive the care they need and help them achieve permanency.

This difficult time also presents the opportunity for shared responsibility and leadership. The protective factors we advocate for in families,

including social connections, are the same protective factors that will keep child welfare organizations surviving and thriving despite a global pandemic. When organizations come together alongside business leaders, community partners, and key decision-makers, critical needs are realized and steps are taken to find a solution. Maintaining robust communications and advocacy efforts can ensure that organizations continue to collaborate and educate about the services they provide and the impacts they are making.

The reality is that during a crisis—especially one that impacts each individual, business, economy and government, like the coronavirus pandemic has—it is critically important for organizations, businesses and individuals to have a seat at the table where critical decisions are being made.

> *"When the world is silent, even one voice becomes powerful."*
>
> *—Malala Yousafzai*

> *"When I was a boy and would see scary things in the news, my mother would say to me, 'Look for the helpers. You will always find people who are helping."*
>
> *—Fred (Mr.) Rogers*

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***Allison North Jones**, founder and CEO of North Public Relations, has spent more than two decades as a communicator—first as a journalist, then as strategic communications consultant. Specializing in strategic, grassroots communications and crisis communications, Allison has spent the last decade carefully crafting highly effective communications campaigns for community initiatives that specifically help*

traditionally underserved populations throughout the Southeast have a more powerful, engaging presence in the political process.

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The Moment to Transform Child Protective Courts

Elizabeth Clement and Vivek Sankaran

This article explores lessons child protective courts learned from the COVID-19 pandemic and how they can use these lessons to build a more equitable system moving forward. The article highlights specific opportunities for innovation to increase access to justice within the child protective system, including efforts courts can lead to encourage stakeholders to resolve issues outside the court system.

For months, the children's mother refused to attend court hearings in her child protective case. She knew that if she set foot in the courthouse, the deputies would arrest her because of a warrant issued after she missed a court hearing in an unrelated criminal case. That warrant also prevented her from accessing substance abuse treatment, which she needed to help her overcome her longstanding addiction to heroin. Though she desperately wanted to get better and regain custody of her children, she feared going to jail. The fear of incarceration forced her to stay away from all public systems.

Then COVID-19 shut down many courts. In other courts, in-person hearings were limited to emergencies. But then courts got creative and started holding hearings on virtual platforms like Zoom. Some judges allowed litigants to resolve certain issues—like bench warrants—virtually. And they witnessed something remarkable. Individuals—like the mother above—started to engage with the courts on virtual platforms. Without the fear of being arrested, she attended a hearing

in her criminal case to resolve the bench warrant. With the warrant resolved, she started participating in drug treatment. For the first time in months, she saw the judge in her child protective case. And now, for the first time in over a year, she is making progress to reunify with her children. If the pandemic had not hit, who knows when this mother would have engaged with the courts.

Soon after the U.S. outbreak of COVID-19 in March 2020, Bridget McCormack, Chief Justice of the Michigan Supreme Court, remarked, "This crisis might not have been the disruption we wanted, but it's the disruption we needed" (Legal Services Corporation, 2020). Before the pandemic, families in child welfare proceedings often feared going to court. Despite the efforts of many judges, attending court hearings still created fear, stress, and anxiety for families. In part, these feelings were invoked by what courts symbolized to them: Courts were the places you went before you were locked up. Or lost your home. Or had your kids taken from you. Why would anyone possibly want to go somewhere where they could face those consequences? Additionally, attending court hearings meant taking a day off of work, missing a day of school, trying to find transportation or paying for parking, and maybe getting a ticket if your court hearing went long.

Nevertheless, many courts adhered to a system that made the courtroom the central hub of all activity. Professionals went to court to meet with others to discuss and try to resolve issues. Attorneys went to court to meet with their clients right before hearings. Everyone went to court to obtain orders. The courtroom was the prime—and maybe only—location in which stuff was accomplished.

The pandemic forced us to reexamine the traditional belief that courts serve families by simply existing as a physical space in which a judge makes a decision. Instead, it has forced courts to think of themselves as justice dispensers, entities that offer a variety of tools to families and stakeholders, only one of which is the courtroom. In this reimagining, child protective courts can play a leading role in partnering with communities to keep children safely with families.

And this partnership is sorely needed. In addition to revealing access to justice issues, the pandemic also has exposed and exacerbated

systemic disparities created by racial and cultural injustice, poverty, and other factors. Families already on the margins have been pushed further to the fringe. Without a different approach—a more proactive mindset—courts could unintentionally contribute to the effects of these disparities. While local courts have been innovating for years, a unified mindset—centered on working with partners to keep children safe with their families—is needed.

Consider, for example, Michigan's Rapid Permanency project (Michigan Courts, 2020)in which courts—after most in-person hearings were shut down—partnered with the child welfare agencies and lawyers to safely expedite the reunification of hundreds of children in foster care with their parents. The Michigan Department of Health and Human Services identified children who already were having unsupervised visits with their parents, then worked with lawyers representing children, parents, and agencies to overcome any barriers to reunification and to draft stipulated orders to allow children to return home. Courts either entered those orders without a hearing or held virtual hearings to make that happen. And all of this happened without an in-person hearing. Importantly, the courts and DHHS, with the help of lawyers, proactively worked together to get kids out of foster care.

This type of innovation is just an example of what might be possible when courts reimagine their role to facilitate and support work outside the courthouse. For example, courts could:

- *Fund multidisciplinary legal advocacy teams* to represent parents both before and after the filing of a petition to prevent the need for children to enter foster care and to reduce children's time in care.
- *Convene and lead meetings in the community* to make sure the appropriate services are available to at-risk families to prevent the need for out of home care.
- *Support mediation, family group decision-making and peacemaking programs* that give families the opportunity to resolve issues without the need for judicial intervention.

- *Convene weekly or monthly virtual hearings on Zoom or other platforms* to supplement in-person hearings. Expedited hearings could create the sense of urgency that is often lacking in child protective court and could get kids in foster care home more quickly. Virtual hearings might also be a more effective way to connect with youth in foster care, many of whom are often apprehensive about attending in-person court hearings.
- *Create streamlined, electronic processes* for parties to get the court to enter agreed-upon orders, schedule a new date, or raise issues needing immediate attention. For example, when parties agree that a child should come home, courts could establish online systems in which that can happen immediately, rather than at the next scheduled court hearing.

The jolt to our system created by the COVID-19 pandemic gives child protective courts an opportunity to strengthen their commitment to justice, and to create systems that address the needs of families, rather than force families to accommodate to the needs of the system. The opportunity for transformation is within our grasp and we already have seen tremendous collaboration between courts, DHHS, lawyers, parents, and support agencies. It is now incumbent on us to take what we have learned during this pandemic and continue to strive toward systemic change in the child protection system.

Justice Elizabeth T. Clement *joined the Michigan Supreme Court on November 17, 2017, becoming the 113th Justice and the 11th woman to serve on the bench. Clement serves as the Court's co-liaison to the State Court Administrative Office Department of Child Welfare Services. This department provides assistance to juvenile courts on child welfare matters, including child protective proceedings, foster care, adoption, termination of parental rights, permanency outcomes, and data collection and analysis.*

Vivek Sankaran *directs the Child Advocacy Law Clinic at the University of Michigan Law School. As part of this work, he represents children, parents, and other parties in both trial and appellate child protective proceedings.*

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Addressing the Digital Divide for Youth in Foster Care

Serita Cox

COVID-19's first impact on youth in foster care came on March 11, 2020. The Los Rios Community College District—which serves the greater Sacramento, California area—sounded the alarm with an SOS email: School was closing. Many students who were in foster care did not have computers or access to the Internet. iFoster, a nonprofit based in Truckee, California, set a scalable plan in place to ensure that every eligible youth currently or formerly in care, between the ages of 5 to 26, would have access to the technology they needed. We have proven with the following combination that bridging the digital divide for youth in foster care is a solvable problem—and one that can be replicated as distance learning continues this fall and into the foreseeable future: (1) the right technology solution(s); (2) accurately identifying eligible recipients; (3) implementing an efficient distribution process; and (4) accessing funds.

The first indication of how dramatically COVID-19 was going to impact youth in foster care came on March 11th from Los Rios Community College District, the second-largest community college district in California with over 75,000 students. The District sent an emergency email stating that they would be closing their four colleges and six educational centers and moving to online classes for the rest of the semester. They feared that many students, particularly

youth in foster care, did not have the technology (computer and Internet access) to make this change and risked failing their semester.

Responding to a Need

This lack of technology is not new. Since iFoster's inception in 2010, technology access has been the number one need by youth in foster care nationwide. In 2016, iFoster commissioned a University of Southern California study that found that 95% of rural youth in foster care and 79% of urban youth in care did not have access to a computer and the Internet where they live (Goldbach, 2016).

March 11 changed that. Los Rios' email brought into stark focus that the relatively few youth in foster care who made it to college were at risk of failing and dropping out because they lacked the tools they needed. With only 8% of youth in foster care ever achieving a college degree (Chapin Hall at the University of Chicago, 2016), losing even one due to our failure to adequately provide for them is a travesty. We had to act.

By the end of the day on March 11, a plan had been formed by to identify college youth in foster care who were in need of technology and to scale existing programs to supply them with smartphone hotspots and laptops. By March 12, organizations such as the Walter S. Johnson Foundation, Foster Care Counts, the California Wellness Foundation, and John Burton Advocates for Youth had pledged to help, and the California Community Colleges Chancellor's Office informed their 115 colleges that their youth in foster care would get the technology they needed. By March 13, initial forecasts started pouring in from colleges across the state, solution testing was completed (smartphones with unlimited data, paired with Chromebooks to access all college platforms), and referral and distribution processes were locked down. On March 16, the first requests came in identifying individual students in foster care. Before the first schools closed, laptops and smartphones for youth in foster care began arriving to Guardian Scholars (students who have been part of the foster care system) and foster youth services on college campuses for distribution prior to stay-at-home orders being announced.

In the months since we learned that education would be conducted remotely, more than 15,590 young people across 53 California counties, plus youth in care who are studying out-of-state, received the technology they need for distance learning. And this collaboration continues to grow, with government funding adding to existing philanthropic funding. Since the outset of the pandemic, iFoster has helped provide technology to more than 6,300 college students, more than 7,500 high school students, more than 1,250 K-8 students, and more than 300 students through our loaner program.

Bridging the Gap

The emergency is obvious. Making 44,000 youth in foster care in California stay at home during COVID-19 without the tools they need to stay connected to schools and support networks finally required acknowledging and prioritizing the issue.

Collaboration was less abrupt. Key foster care organizations in California have been sharing resources and partnering on programs for years across child welfare, K-12 education, and college. It was this foundation that was able to immediately react and invite new partners to the table to implement a plan. It takes a village, and in this case it took 686 organizations all pulling together to identify and fulfill these needs. But if this can be done during stay-at-home orders in the country's most populous state, it can be done in any state, county, or locality.

Preparation had been occurring over years of implementing tech access solutions. iFoster had provided Internet access was a more difficult issue to solve at scale specifically for youth in foster care who moved frequently. In the fall of 2019, just prior to the pandemic, iFoster launched a pilot program with the California Public Utilities Commission to provide all youth in foster care aged 13–26 with a smartphone that included unlimited voice, text, and data that operates as an Internet hotspot.

It was this combination of having an existing collaboration, as well as scalable iFoster laptop and Internet programs, that allowed California to respond so quickly to the connectivity needs of youth in foster care

when the pandemic hit. We have proven that bridging the digital divide for youth in foster care is a solvable problem, and one that can be replicated, as distance learning continues.

Fixing the Digital Divide: A How-To Manual

We believe that the digital divide can be solved for all youth in foster care with a combination of:

1. The right technology solution(s),
2. Accurately identifying eligible recipients,
3. Implementing an efficient distribution process, and
4. Accessing funds.

iFoster would be happy to share our How-To Guide to replicating what has been accomplished in California, or answer any questions about how we can support expanded efforts to bridge the digital divide nationwide on an ongoing basis. Learn more at www.ifoster.org. Contact Reid Cox at reid@ifoster.org if you would like a copy of our How-To Guide.

Serita Cox *brings to bear her personal experience with foster care, devoted commitment to several youth development initiatives, and over a decade of experience in executive-level management Fortune 100 companies, corporate strategy consulting, and nonprofit strategy consulting. For her work with iFoster, Serita has been recognized as a White House Office of Social Innovation Citizen Innovator, an Echoing Green Fellow, and an American Leader of Change.*

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Collaboration During COVID-19: The Role of Faith Communities and Technology

Jacob G. Holland and Audrey Deckinga

This essay examines the impact of the COVID-19 pandemic on child welfare agencies' ability to serve children and families. It proposes that the collaboration between child-serving agencies and local churches is essential to providing effective care for children and families who are vulnerable. To spur this collaboration between stakeholders, this article issues simultaneous calls to action: first, for the child welfare system, from policy-makers to caseworkers, to view and intentionally include the local faith community as a critical partner in the work to protect and serve children and families; and second, for the local faith community, from pastors and ministry leaders to lay people, to proactively come alongside child welfare agencies and social workers to serve those in need. This essay highlights CarePortal, a technology platform that connects the needs of children and families to people who want to help, as an effective opportunity for collaboration between the child welfare system and faith community.

According to the Children's Bureau of the U.S. Administration for Children and Families, neglect is one of the leading reasons for a family's initial involvement in the child welfare system and removal of children from their homes (Children's Bureau, 2020).

In fact, neglect was a contributing cause for removal among 63% of children removed from their homes in 2019 (Children's Bureau, 2020). These families are often isolated from the resources and relationships needed to ensure their children's safety, stability and well-being and their ability to remain intact. During the COVID-19 pandemic, physical isolation has been prescribed as a key solution to staying safe and reducing the spread of coronavirus. Certainly, it is important to follow public health guidelines such as wearing a mask, maintaining social distance, and proper handwashing. However, for children and families already living in vulnerable situations, or children experiencing abuse or neglect, the additional isolation created through stay-at-home orders and school closures has exacerbated existing crises, resulting in a peak level of physical, emotional, economic and relational needs waiting to be met. Prior to COVID-19, social workers already were overwhelmed by unmanageable caseloads, with too many children to effectively care for and too many families to support (Casey Family Programs, 2017); now, with risk factors for mental health challenges, loss of employment, housing instability and food insecurity due to COVID-19, the burden of caring for children and families in need is quite simply too much for the child welfare system to shoulder alone. In light of COVID-19, collaboration among child-serving stakeholders is the key to combatting child and youth isolation.

At the Global Orphan Project, based in Kansas City, Missouri, we believe the local faith community must come alongside the child welfare system to be part of a collaborative solution to care for children and families in crisis, and we believe technology can connect the church and state to serve together for collective impact. As the COVID-19 pandemic has continued, we have seen these themes rise to the surface in our organization. CarePortal is a technology platform of The Global Orphan Project that facilitates real-time, meaningful connections between local children and families in crisis and local churches offering resources and relationships at the point of need. Approved caseworkers identify the needs of children, often before they are in foster care. CarePortal shares these vetted needs with local churches, organizations, and individuals, giving them a real-time opportunity to

respond and care for children and families in their own communities. Since 2015, the platform has served more than 70,000 children and generated more than $24 million in economic impact in partnership with more than 2,400 local churches across 21 states and one Canadian province (CarePortal, 2020). Every request met supports families and their children who are vulnerable in critical ways, from preventing the need for foster care to achieving timely permanency to supported transition to adulthood.

At the onset of the COVID-19 pandemic, we knew the risks for acute emergencies and prolonged crises among families in need would be great. With nationwide stay-at-home orders and recommendations to avoid in-person gatherings, we wondered if the capacity of local churches to respond to CarePortal requests from social workers would be hindered. Almost ten months later, it is clear that we were right on the first account but wrong on the second. As the new school year has included options ranging from fully in-person to fully virtual and everything in between, the needs of children and families remain at the forefront. However, we are greatly encouraged by the response of local churches to care for children and families in their communities as the pandemic rages on. In fact, CarePortal's network of local churches have responded more often and served more children and families through the platform during the past several months than ever before. For example, in April 2020 alone, at the height of stay-at-home orders across the country, local churches served 3,437 children, the second-highest highest monthly total in CarePortal's history; the only month with more was September 2020, with CarePortal churches serving 4,207 children as school got underway across the country; from April through June, churches met 85% of all requests submitted by caseworkers—nearly 20% more than normal (CarePortal, 2020).

With the reality of limited resources and budget cuts emerging as a result of the country's economic downturn, the local faith community is committed to partnering with other child-serving stakeholders, including child welfare agencies, school districts, and local nonprofits, to meet the needs of children and families in vulnerable situations. It is our belief that true collaboration between compassionate stakeholders can

produce a far greater impact than any single agency or organization can ever do on its own. In our experience, we have seen that child-serving stakeholders recognize the need for collaboration to ensure that children and families receive the best possible care; what these stakeholders need is a connection point to spark effective collaboration. CarePortal is that connection point. With the far-reaching consequences of COVID-19, collaboration for the care of children and families has never been more urgent. This pandemic has forced our society to rely heavily on technology. We submit CarePortal as an example of how technology can accelerate collaboration among child serving entities in their own communities. We have seen this happen time and again between local churches and child serving agencies across the country during the COVID-19 pandemic.

Our first call to action is for the child welfare system to look beyond CarePortal to see the local faith community as a critical partner in its work to protect and care for our country's children and families during COVID-19 and beyond. Our second call to action is for local faith leaders and churches to proactively stand alongside the child welfare system in a spirit of mutual collaboration. When this happens, the lives of children and families who are vulnerable will be positively impacted as their physical needs are met and they receive the relational wraparound support that is critical to achieving the CWLA *National Blueprint* goal that "all children will grow up safely, in loving families and supportive communities, with everything they need to flourish—and with connections to their culture, ethnicity, race, and language" (CWLA, 2013).

Jacob Holland *is passionate about loving kids from hard places. As a licensed foster and adoptive dad, his life has been turned upside down by children who need family. Whenever possible, he advocates for local churches to wrap around children and families in need. He currently serves as the Development Manager for the Global Orphan Project.*

Audrey Deckinga*, LMSW, stepped into the child welfare space as a foster parent in 1978 and has been involved with child welfare in various capacities since that time. She worked in the Texas public child welfare agency for 26 years, beginning as a caseworker and retiring from her state career as the child welfare Assistant Commissioner.*

She currently consults with various agencies and nonprofits, including with the Global Orphan Project in its implementation of CarePortal.

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The Impact of COVID-19 on Latinx Immigrant Children & Families: A Call to Action

Jesse Ramirez and Kristina Lovato

This essay examines how the coronavirus (COVID-19) pandemic has exposed systemic inequities in the U.S. health care system and economy, disproportionately impacting Latinx immigrant children and families. Qualitative findings from interviews conducted with Los Angeles-based social service providers (n = 25) show that practitioners adapted to new demands during shelter-in-place orders by providing remote therapies and bilingual information to dispel myths and fears regarding COVID-19. Collaborations were formed with immigrant advocacy-based agencies to mobilize online services such as ESL classes, legal clinics, and trainings to empower immigrant communities. A call to action is issued to address macro- and mezzo-level systemic weaknesses, and to preserve and build on the strengths of Latinx immigrant families.

The coronavirus (COVID-19) pandemic has drastically exposed systemic inequities in the U.S. health care system and economy, disproportionately impacting communities of color and Latinx immigrant communities (Substance Abuse and Mental Health Services Administration Office of Behavioral Health Equity, 2020). Latinos, who make up 18.5% percent of the U.S. population (U.S. Census Bureau, 2020), account for 31% of COVID-19 cases as of August 2020 (Centers

for Disease Control and Prevention, 2020). Latinx individuals are at an increased rate of serious illness if they contract COVID-19 due to higher rates of underlying health conditions such as diabetes, respiratory and heart disease, obesity, liver disease, cancer, and stroke than non-Latinx individuals (U.S. Department of Health and Human Services Office of Minority Health, 2019). Further, Latinx individuals are more likely to be uninsured and to lack a primary care provider (U.S. Department of Health and Human Services Office of Minority Health, 2019), which may impede accessing COVID-19 testing or treatment services. Due to economic necessity, Latinx individuals are more likely to be at risk of contracting COVID-19 due to high rates of employment as essential workers in service industries such as restaurants, retail, hospitality and jobs that are not amenable to teleworking (U.S. Bureau of Labor Statistics, 2015; Gould & Shierholz, 2020). Latinx families also are more likely to live in housing that may include multigenerational families in dense neighborhoods, making it challenging to maintain social distancing (Mejia & Cha, 2020; Ariga et al., 2020; Benfer & Wiley, 2020).

Of the nation's 41 million Latinx adults, roughly half are immigrants and about another 23% are the U.S.-born children of immigrant parents (Gonzalez-Barrera & Lopez, 2020). Due to the Trump administration's anti-immigrant policies, many undocumented Latinx individuals have been dually at risk of experiencing immigration enforcement and contracting COVID-19, which places Latinx children and families at great risk of family separation and in suffering negative health and psychosocial outcomes. Many Latinx families are reluctant to get tested or seek treatment for COVID-19 due to fear of deportation; many also experience language barriers and limited access to health care and health information.

Since the global outbreak of COVID-19 in March 2020, social service workers have been on the front lines of preventative and treatment services to ensure the health and well-being of Latinx communities. In a qualitative study conducted by Lovato and Ramirez (2020), 25 social service practitioners were interviewed across health, mental health, school-based, child welfare, and faith-based institutions in Los Angeles, home to over 4.9 million Latinx individuals (Pew Research Center, 2020). The interviews examined the best practices utilized by social service providers who have been serving Latinx immigrant families during

the pandemic. Findings show that of the participants interviewed, all bilingual Spanish speaking workers utilized innovative approaches to ensure that their Latinx immigrant clients remained connected to treatment despite agency shutdowns during Shelter-in-Place. Workers provided remote individual therapy and assisted their clients in combating social isolation through attending social support groups. Practitioners quickly became familiar with telehealth and other online tools to ensure that their monolingual clients could also navigate these new technological systems to receive treatment (Lovato & Ramirez, 2020).

Social service workers have adjusted their workloads and shifted duties to meet the basic economic needs of their clients by distributing provisions and by providing bilingual information to dispel myths and fears regarding COVID-19. A network of local immigrant-based agencies in Los Angeles County also mobilized online services such as ESL classes, legal clinics, fundraising and advocacy trainings to empower individuals at risk of deportation. Findings also show that many agencies and faith-based organizations have assisted with ensuring inclusive planning efforts and have advocated to governments for increased financial support and recognition as essential service providers so they can continue in-person services when necessary. In addition to these localized efforts, a well-supported, appropriately equipped, empowered, and protected social service workforce is essential to mitigating the damaging effects of the COVID-19 pandemic on Latinx immigrant communities that are vulnerable.

A Call to Action

Given the magnitude of both the public health and economic crises, along with current restrictive immigration policy, undocumented Latinx immigrants and their families are more vulnerable than ever before. At the macro policy level, we recommend that:

- Federal, state, and local efforts increase COVID-19 testing in densely populated communities of color.
- Social service providers and government institutions create and distribute multilingual and culturally sensitive health

information via internet and social media platforms for increased accessibility.
- Courts and legal officials should not be accomplices in contributing to the hurt of undocumented families. Rather, a collaborative partnership needs be enforced to halt further child maltreatment.

At the mezzo level, social service agencies should continue to make considerable efforts in engaging and informing immigrant families via innovative approaches by:

- Promoting collaborations with faith-based leaders and multidisciplinary institutions that have been vetted and trusted by the community.
- Identifying trusted community first responders such as pastors, community clinics, and community leaders who can share information and resources about COVID-19 and immigration enforcement.
- Utilizing peer health navigators, or *promotoras de salud*, and thereby employing those directly affected by these stressors. Peer health navigators can play a vital role in promoting micro-, mezzo-, and macro-level efforts to link the community to much-needed health and behavioral health resources.

At the micro level, practitioners should continue to commit to high-quality service delivery and should be provided with the training, tools, resources and support necessary to perform their roles effectively. Recommended best practices include:

- Integrating telehealth approaches in providing bilingual, culturally competent services via accessible telehealth platforms. Consider telephone calls as many Latinx individuals may not have regular access to the internet. Also consider situations when telehealth is not appropriate, such as working with people experiencing homelessness (PEH), people experiencing intimate partner violence (IPV), sex workers, members of the LGBTQ+, community and other individuals who are economically vulnerable.

- Offering stress management for health care providers serving undocumented Latinx populations to avoid burnout and secondary trauma—as noted in CWLA's *National Blueprint for Excellence in Child Welfare* (CWLA, 2013).

Latinx immigrants who are undocumented continue to experience negative health and psychosocial outcomes due to COVID-19. We urge local, state, and federal leaders to examine how systemic racism and implicit biases have resulted in discriminatory and anti-immigrant policies that place Latinx children and families who are undocumented at a disproportionate risk from COVID-19. We urge leaders in all positions of power to strengthen protections for these families and endorse an empathetic, logical shift to immediately activate and incorporate holistic best practices to mitigate the compounding issues affecting Latinx undocumented families. Ultimately, we hope the community at large can advance positive outcomes for children and youth in order for them to live in safe, loving, and stable families and communities.

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COVID-19's Economic Impact: Threatening a Decade of Progress in U.S. Food Security

Emma Langley and Shannon Strother

As the United States struggles to mitigate and contain the spread of the novel coronavirus disease (COVID-19), the nation has faced shocks to household-level income and employment not seen since the Great Depression. As key determinants of food security, these secondary effects of the pandemic challenge working families' ability to access adequate nutritious food. Public policy measures, including the roll out of Pandemic EBT and adaptations to SNAP and school-based meals, aim to alleviate skyrocketing food insecurity; however, the unsustainable strain on charitable food organizations to meet demand for private assistance suggests that public benefits are insufficient to meet this need.

In response to the novel coronavirus outbreak (COVID-19), Texas Governor Greg Abbott declared a state of disaster on March 13, 2020. The following week schools, bars, dine-in restaurants, and gyms were closed to strengthen community-wide containment measures, and from March 31 to April 30 the governor enacted a statewide stay-at-home order (Office of the Texas Governor Greg Abbott, 2020).

As Texas and other states now struggle to reopen amidst a continued rise in COIVD-19 cases, the United States is facing an economic fallout not seen since the Great Depression. Unemployment in the Houston area has reached 13.9% while more than 2.7 million Texans have filed

for unemployment relief since mid-March (Novak & Ferman, 2020; U.S. Bureau of Labor Statistics, 2020). While hundreds of thousands of Houston area workers are unemployed, many more have been furloughed or seen their work hours reduced (Sanchez-Soto, 2020). Data from the COVID-19 Registry conducted by the Kinder Institute for Urban Research suggests that over 40% of Houston area households have lost income as a result of the pandemic (Olin, 2020).

Household-level income and employment status are key drivers of food insecurity. While the pandemic's long-term effects on the economy are uncertain, the immediate financial impact challenges many working families' ability to access nutritious food. Texas and the Houston region already faced above-average rates of food insecurity when the economy was doing well; in 2017, an estimated one out of every seven Texans and 16.3% of Houstonians had limited or uncertain access to adequate food to sustain a healthy lifestyle (Houston Health Department, 2019).

Feeding America, a nationwide network of food banks, estimates that food insecurity across the state may increase to over 20% for 2020 due to rising unemployment and poverty, erasing more than a decade of progress following the 2008 recession (Hake et al., 2020). Results from the COVID Impact Survey, conducted by NORC at the University of Chicago, indicate that as many as 26.8% of Texans were food insecure between April and May (Schanzenbach & Pitts, 2020).

Impact on Families and Communities that are Vulnerable

Populations already at increased risk for food insecurity, such as families who are low-income and immigrants, have been hardest hit by the economic effects of COVID-19. Compounding the impact of lost income, school closures have restricted access to school-based meal programs, which protect children in struggling families from going hungry (Chan & Taylor, 2020). Nearly half of all respondents with children in the COVID Impact Survey said they were worried about food running out, with food insecurity rates rising as income decreased (Schanzenbach & Pitts, 2020).

Immigrant communities are overrepresented in many of the industries most effected by social distancing guidelines, including jobs in entertainment and recreation, hospitality, and food service (Gelatt, 2020). Nearly eight out of 10 working adults in these industries in the Houston region have reported being negatively impacted by COVID-19 (Sanchez-Soto, 2020). Further, immigrants in these sectors tend to have lower incomes than their U.S.-born peers and less access to social safety net programs such as unemployment insurance and Medicaid (Gelatt, 2020). For example, an estimated 2.4 million Texans were denied federal stimulus check payments due to immigration status—including 940,000 U.S. citizens and green card holders in mixed-status households (Wermund, 2020).

Public Policy Responses to Food Insecurity

News outlets across the country have documented the dramatic rise in food insecurity as emergency food distributions are met with long lines of desperate families. These and other crisis response efforts have been supported through the Families First Coronavirus Response Act (U.S. Department of Labor, 2020). This massive relief package bolstered federal nutrition programs including the Supplemental Nutrition Assistance Program (SNAP)—an essential first-line defense against food insecurity. This legislation allowed Texas to waive renewal requirements and automatically extending benefits to SNAP recipients, suspend interview requirements for new applicants, and provide emergency benefits up to the maximum monthly benefit amount (Food Research and Action Center, 2020).

Through the relief package, Texas also is participating in a new USDA program called the Pandemic Electronic Benefits Transfer (P-EBT) which provides low-income families with a debit card or credit to their Lonestar Card to reimburse the value of free meals their child normally receives at school (Dwyer, 2020). P-EBT has been made available to families regardless of immigration status and will not affect a family member's eligibility for a green card or other benefits (Dwyer, 2020). In addition to P-EBT, the Texas Department of Agriculture has received

a federal waiver to allow school districts to distribute curbside "grab and go" meals (Dwyer, 2020).

Burdens on the Emergency Food System

Texas received 417,468 new SNAP applications in April—more than triple the number received in the same month in 2019 (Fernandez, 2020). As record numbers of households apply for state and federal aid, millions of Americans have also turned to charitable food assistance programs. Data from the COVID-19 Impact Survey show a stunning one in 10 respondents had interacted with food banks and pantries within the past week. Among households with 2019 income below $20,000, 22% reported receiving assistance from a food pantry (Schanzenbach & Pitts, 2020).

Alongside this surge in demand for services, food banks and pantries face declines in volunteer staffing and food donations. To help alleviate shortages, the USDA allocated billions to purchase fresh produce, dairy, and meat products to be distributed through food banks, community groups, and faith-based organizations (Medica, 2020).

Catholic Charities has provided food assistance and other services to address the most pressing needs of families in southeast Texas for 75 years. Now, more than ever, the experience and expertise of local hunger relief agencies is needed. However, the strain put on charitable organizations to address food insecurity is unsustainable. As such, it is imperative that the USDA and the Texas Health and Human Services Commission resist partisan debates about SNAP expansion and continue to support efforts that maximize access.

The need has never been greater for public and private partners in hunger relief to come together to protect children, families, and the most vulnerable. As the COVID-19 pandemic increases in severity during the upcoming winter months, community and faith-based organizations must play a vital role in helping those in need access nutritious food. Supporting these efforts, while continuing to deliver state and federal aid, will be essential to protect millions of Americans from the devastating physical and psychological consequences of food insecurity.

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Creativity Across Borders: Supporting Transnational Families during a Pandemic

Elaine Weisman

A child's right to a loving family and connection to their culture, ethnicity, race, and language is a cornerstone of CWLA's *National Blueprint for Excellence in Child Welfare*. For thousands of children, these connections span international borders. Modifying assessment tools, empowering local professionals, and reimagining service delivery models can increase our ability to connect families in the midst of the COVID-19 pandemic—particularly in communities that have been hit the hardest.

Although children appear to be at lower risk for health complications related to the coronavirus, the consequences of travel restrictions, limited access to schools and services, and extended family separation can be long lasting. The implications for transnational families are significant and require creativity and innovation to protect the welfare of children whose connection to family requires cross-border collaboration. International Social Service, USA (ISS-USA), based in Baltimore, Maryland, has been working with child welfare systems and professionals around the world for nearly 100 years, growing and adapting to meet the changing needs of children and families crossing borders.

Children in the process of reunifying with family need social work assessments and follow-up services that cannot be put on hold.

Home studies remain a critical component of determining the suitability and safety of placement of a child in a new home. Meanwhile, considerations about the availability of, and access to, community resources to support a child's placement now also must take into account pandemic-related closures and service changes. ISS-USA has modified internal templates and created guidelines for virtual assessments to be used by U.S. and international partners and is developing a training for dissemination in early 2021. Remote assessments, which are followed up by an in-person home safety assessment, allow interviews and permanency planning to proceed while limiting the time social workers spend physically in a family's home. Despite the modality shift, the underlying practice that all assessments be completed by local child welfare professionals in that country or jurisdiction, remains central. This approach is grounded in the belief that local professionals, community stakeholders, and family support systems are the best resources to support children as they transition to their new environments.

Supporting families reunify in some settings has required additional creativity. Since 2018, ISS-USA has been working with partners in Guatemala and Honduras to support immigrant children returning to family care after a voluntary return to home country or deportation. Through this program, families have received food and basic supplies, help with school enrollment, connections to medical and mental health care, and social-emotional support from a social work case manager. The pandemic has resulted in curfews and travel restrictions, severely limiting families' access to basic services. Needing to adapt in real time, social work case managers in both countries have been communicating with clients through regular phone and video calls; liaised with schools and public services; coordinated grocery delivery to families in remote communities; and conducted support groups and counseling through virtual chat rooms on topics of migration, disease prevention, and family relationship building. In Honduras, realizing that in-person visits would not be possible for an extended period of time, ISS-USA partner Familias Solidarias began making direct cash transfers to families, who in turn used the funds to buy food and basic supplies, pay rent on their homes, and invest in their businesses. Making direct payments

to families—a radical departure from how we traditionally offer support, particularly in countries that are low-income—represents a major innovation in funding allocations that restores dignity to, and trust in, families.

The coronavirus disproportionately has affected communities of color and immigrant communities in the United States, as well as in countries whose medical and economic infrastructures are more vulnerable. Child welfare services must concentrate on how to adapt and deliver services in these communities. Child welfare is not a field that is easily carried out from home, but the pandemic has constrained many of us to working remotely and with limited contact with families in need of services. This change has encouraged us to rethink policies and practices, return to basic questions of physical and emotional needs, and reconnect with fundamental principles of social work that teach us to respect the inherent dignity of people.

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COVID-19 and the Importance of Addressing Prenatal Care in Pre-Birth Planning Conferences

Anna Caroline Straughan

The CSA #14 policy was issued in New York City as a protocol for child welfare agencies to determine the placement of a baby of an expectant mother whose older children are custody of child protective services. Pre-Birth Planning Conferences were established as part of the protocol to assess for risks. Expectant women are at a heightened risk for infection with COVID-19, which can cause complications during pregnancy. This article examines the potential of Pre-Birth Planning Conference to support the health of expectant mothers and discusses the rationale for prioritizing prenatal care during COVID-19.

COVID-19 has been a challenging time for expectant women. The nascent virus has raised fears among doctors and mothers about the possible risks of pregnancy during the pandemic. Little research has been published about pregnancy and birth during the time of COVID-19, but what is understood is that prenatal health must be taken very seriously. Expectant women involved with the child welfare system are particularly vulnerable during this time. Reports, journals, and testimonies have found that this population is at a higher risk of receiving inadequate prenatal care while experiencing high levels of stress and anxiety related to fear of child removal. Inadequate

prenatal care can lead to complications during the pregnancy and at the time of delivery.

Expectant women involved with the child welfare system and their unborn child are further marginalized in their ability to receive adequate prenatal care. Statistically, mothers involved with the child welfare system are more likely to be of low socioeconomic status and from communities that are underserved (Berger et al., 2013; Drake et al., 2009; Pac et al., 2017). Child welfare agencies should focus on the health of the mother and her unborn baby and utilize established protocols as a space to discuss prenatal health care and pregnancy concerns. In New York City, the Child Safety Alert #14 Pre-Birth Planning Conference protocol has the potential to be a space for the agency to support the expectant mother and her baby's health and fetal development by ensuring that she has access to prenatal care and is able to stay safe during COVID-19.

The CSA #14 is a policy that puts into place the steps for determining the fate of an expectant child. In New York City, Child Safety Alert #14 was issued specifically to determine if an expected baby must be apprehended into custody upon birth. In the Summer of 2008, Commissioner John B. Mattingly issued a revision to the Child Safety Alert #14 that further clarified the policy regarding safety planning for expectant mothers involved with the child welfare system and the expectant baby (Mattingly, 2008). Commissioner Mattingly's memorandum outlined a protocol for the moment when an agency learns about a mother's pregnancy. The policy clearly states that the intention of the protocol is to assess the immediate and imminent risks within the parents' household to determine if foster care placement can be avoided (Mattingly, 2008). The protocol delineates that a Pre-Birth Conferences must occur prior to determining the custody of the baby. The conference is meant to assess the circumstances surrounding the birth, the safest and most stable placement for the child, the necessary services that must be completed, and ways to collaborate and develop a safety plan for the baby. Pre-Birth Conferences are vital to the possibility of preserving family integrity. While Pre-Birth Conferences are held to address caregiver protective capacities and risks within the home, they also

could provide a space to discuss the prenatal care usage among expectant mothers who have had prior children removed by CPS—and to address barriers that may affect prenatal care access during the time of COVID-19.

Studies have shown that expectant women are highly at risk of contracting COVID-19 due to their weakened immune systems (Phoswa & Kahliq, 2020). Much other information surrounding COVID-19 and pregnancy remains unknown. While studies have reported on pregnancies in the third or late-second trimester, information is still yet to be known about the effects of COVID-19 in the first trimester (Rasmussen & Jamieson, 2020). Some reports show that newborns delivered from mothers with COVID-19 were born premature or with a low birth weight (Rasmussen & Jamieson, 2020). Given the risks associated with COVID-19, maternal health and prenatal care is especially important in reducing complications during fetal development and during the time of delivery. Adequate prenatal care has been shown to be correlated with decreased risks of complications that can lead to long-term developmental issues for the child (Heaman et al., 2008). However, expectant women involved with the child welfare system are a population that statistically has a history of receiving inadequate to no prenatal care (Putnum-Hornstein & Needell, 2011; Wall-Wieler et al., 2018). The presence of COVID-19 may further exacerbate existing barriers that bar mothers from receiving prenatal care. Child welfare agencies should communicate with expectant mothers about their barriers to prenatal care access and provide assistance. Agencies that assist expectant mothers with their prenatal health needs may be providing vital support for the long-term health of both the mother and her baby.

Expectant mothers face barriers that are structural as well as personal. The latter is often related to the mother's fear that her child will be removed from her care upon birth. In the magazine *Rise*, written for and by parents who have been involved with the child welfare system, often features articles about the fear expectant mothers have of child removal. One recent article specifically focuses on the questions that expectant mothers have regarding the possibility of removal, highlighting that this fear created a personal barrier to seeking supports

and prenatal care (Farmer et al., 2020). The Bronx Defenders attorneys and parent advocates noticed the effects that this fear had on expectant mothers who were clients at the Bronx Family Court; women who became pregnant while involved child welfare system would often disappear completely. It was found that "many women did not seek prenatal health care or medical treatment during their pregnancy; they stopped attending their court appearances and services like mental health or substance abuse treatment programs; and they often…stopped visiting their older children in foster care" (Ketteringham et al., 2016). The staff of Bronx Defenders began to notice that the fear of child removal was compromising their clients' prenatal health. This phenomenon has been corroborated by years of research that has shown that fear of being reported to CPS is associated with inadequate prenatal appointments

In 2020, several reports have found that while social distancing measures have been greatly effective in reducing the spread of COVID-19, expectant mothers have become increasingly fearful of attending prenatal appointments (Chen et al., 2020). Foregoing prenatal care can be far more harmful because complications such as gestational diabetes, hypertension, and preeclampsia may not be caught early on and can put both mother and baby at risk (Schwartz & Graham, 2020). Therefore, child welfare agencies should discuss the very real concerns that expectant mothers have regarding their prenatal appointments. Child welfare agency staff may be able to play a vital facilitation role between maternal care institutions and clients by ensuring that expectant mothers have access to health information regarding COVID-19 and pregnancy.

Structural barriers to prenatal care remained consistent prior to COVID-19. In 1990, a New York City-focused study examined barriers to prenatal care among Black and Hispanic mothers who were low-income (Kalmuss & Fennelly, 1990). According to the study, financial obstacles posed the largest structural barrier and lacking health insurance deterred women from initiating prenatal care in a timely manner. A New Jersey study (2000) found that administrative issues such as ineligibility for publicly funded care, access to transportation and distance to providers

were major structural barriers that affect expectant mothers' ability to seek prenatal care. In large urban area, such as New York City, access to transportation is complicated by COVID-19. Although research has shown that there is little evidence that depicts that mass transits puts passengers at risk, the percentage of commuters who take the train has dropped 92% since the start of COVID-19 (Joselow, 2020). Expectant mothers who rely on public transport may avoid going to their prenatal care offices due to the suspected risk of contracting COVID-19. Child welfare agencies should provide a safe space for expectant women to voice their concerns with public transit. It may be in the best interest of the agency to support the mother by providing an alternative mode of transport to her appointments if necessary.

During Pre-Birth Planning Conferences, the services plans that are developed which include parenting classes, anger management, and domestic violence classes may not fully address the very essential health care needs of the mother and her expectant child, especially in the time of COVID-19. In fact, it is possible that the added services may further impact the mother's ability to focus on taking care of her body and impede upon her ability to maintain or obtain prenatal health and may even put her at heightened risk for COVID-19 if she may attend services in-person. While services such as parenting, anger management, and domestic violence classes may offer valuable skills necessary for strengthening protective caregiver capacities, they typically pertain to the risks that were present when the older children were remanded into custody of the state. In doing so, the Pre-Birth Conference and subsequent service plan may fail to address the personal and barriers that pose immediate and imminent risk to maternal health and fetal development of the child. The looming threat of child remand by CPS, compounded by additional stress caused by the service plan and COVID-19, may exacerbate preexisting mental health concerns of the mother such as depression or anxiety and may result in more harm to both the mother and the expectant child. Ensuring that an expectant mother has been routine prenatal care and has access to her doctor is the safest way to treat gestational hypertension and preeclampsia and promote a healthy

pregnancy and delivery. Therefore, establishing collaborative relationship between the child welfare agencies and the expectant mother may reduce maternal stress and allow the mother to voice her needs and identify her concerns. A collaborative relationship during the Pre-Birth Conference may also allow for more open discussion about the need to protect the health of the mother and her expectant child.

The Healthy Mothers, Healthy Babies initiative at Bronx Defenders emphasis the need to bring collaboration into Pre-Birth Conferences and ensure that the mother has reproductive autonomy to make decisions regarding her pregnancy. Ensuring that Pre-Birth Conferences allow space for expectant mothers to voice their concerns about their pregnancy is imperative to long-term safety of the expectant child during COVID-19. Agency workers should be prepared to communicate the importance of prenatal care and assist with allocating prenatal resources and affordable care. Instead of threatening removal of the expectant child, it would be in the best interest of the mother, baby, and agency to support the expectant mother's decision to go through with the pregnancy (if she so chooses), ensure that the service plan is directly pertaining to the health and safety of the expectant child, and not solely address the original safety risks that lead to the removal of the older child. In doing so, the agency should also support the expectant mother's well-being, given that high levels of psychosocial stress can negatively impact pregnancy. Overall, in the time of COVID-19 Pre-Birth Conferences have the potential to be a collaborative space where the expectant mother and the agency can have an open conversation about the prenatal care of the expectant child.

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The National Family Preservation Network: Analyzing Remote Child Welfare Services During COVID-19

Michelle Reines

The COVID-19 pandemic has had a significant impact on family-serving agencies and their clients. The National Family Preservation Network sought to assemble guidance for service delivery by collecting information about how agencies adapted during the pandemic. Fortunately, remote services do not seem to adversely affect the number of families served or their outcomes. Agencies have been innovative in developing strategies for serving families remotely and technology has played a big part in this. The lessons learned from this experience can be applied to other scenarios when remote services may be necessary or preferable.

Since March 2020, the COVID-19 pandemic has had a significant impact on child- and family-serving agencies and their clients. The National Family Preservation Network, headquartered in Asheville, North Carolina, conducted a survey about how agencies adapted during the quarantine, which seven agencies completed. The participating agencies provide family preservation and/or family reunification services in Georgia, Mississippi, North Carolina, Tennessee, Indiana, and Florida. The following is a compilation of their responses.

How Did You Modify Agency Procedures During the Pandemic?

All agencies transitioned to virtual services, either partially or fully. In cases where in-person contact was chosen or necessary, guidelines from the Centers for Disease Control and Prevention were implemented, including use of face coverings, social distancing, hand sanitizer, and increased cleaning of facilities.

Some agencies already had a remote workforce. Those that did not were able to set up virtual files, and some workers were provided with internet hotspots. Workers mostly continued to receive pre-quarantine levels of supervision, including weekly individual and group meetings.

Virtual services were mostly provided using Zoom and FaceTime. Several agencies needed to develop protocols and train staff on using this technology. There was concern with HIPAA compliance, which must be addressed if agencies continue to provide remote services. Emails were used in lieu of signatures and several agencies began utilizing DocuSign. In programs where flex funds are provided to families, most of the needed items were purchased online and shipped directly to families.

Which Program Modifications Worked Well?

One agency recommended that staff and families have mutual input about how and where services would be performed. Giving staff this choice raised their morale during a difficult period. Many families said they have never had any influence on service delivery before this. Intensive programs often require 8–10 hours of service per week, which was challenging. To achieve this, agencies provided daily contact or shorter sessions (1–3 hours) more often (4–6 times/week). Workers also encouraged families to bring their technology into situations so they could give immediate feedback to parents.

For younger children and/or children with attention deficits, many workers found games, videos and music to play during sessions. An agency that largely serves teens with self-harming behaviors stressed the

importance of ensuring that clients remain on-screen. These approaches allowed for status checks and helped with engagement during sessions.

What Were the Challenges and How Were They Addressed?

The most widely reported issue with remote services was lack of technological devices and/or limited access to internet services. This included slow internet speeds and inadequate minutes on cell phone plans.

Several agencies were able to purchase computer tablets and laptops for families so that they could have access to video sessions. The families who did not have video technology received services via telephone, and sometimes Tracfones and phone cards were purchased for them. An agency that was unable to provide video technology to all families prioritized those with younger children who might have more difficulty talking on the phone.

There were families who were hesitant and even uncooperative about using virtual services. It seemed that they had difficulties building rapport and feeling safe with therapists in this format. Some families had problems navigating videoconferencing. Workers assisted them with this, but it did not always resolve issues such as forgetting appointments.

How Many Families Did You Serve Remotely? Have Referrals Decreased?

Most agencies reported that their numbers had remained the same or only slightly decreased. Some cases began in-person pre-quarantine and were completed virtually. Others were virtual during the entire course of services. A few families refused virtual services or withdrew during this period, but these numbers do not appear to be higher than they would with in-person services.

In situations where referrals had decreased, this seemed to be due to children's lack of interaction with people who would report signs of abuse or neglect. Crisis Stabilization Units also saw a decrease in

clients, which affected referrals. Agencies worked to maintain/increase referrals through marketing outreach, networking, trainings, and frequent communication with referral sources.

How Did Outcomes for Families Served Remotely Compare to Those from Before the Pandemic?

The consensus among respondents is that there was no significant change in outcomes for remote services compared to in-person services prior to the quarantine. In areas where outcomes were minimally affected, there were various explanations for this.

Withdrawal from services might have been prevented if workers had been able to maintain in-person contact, such as dropping by the home. Some agencies indicated that reunifications were adversely affected due to the lack of home visits. Programs that measure school attendance noted a slight decrease in this metric due to the transition to online classes.

Will You Permanently Alter Your Services to Include Remote Components?

Funding sources will mostly dictate modes of service delivery and some of them seem to support a combination of in-person and remote programming. Survey respondents expressed an interest in continuing to provide remote services in some form.

There are families who have time barriers, so connecting remotely has been helpful. Families who live in remote/rural areas can get services that do not exist in their communities. Remote services also could be provided during extreme weather situations.

How Will You Return to Safely Providing Services in Families' Homes?

Some state reopening plans are not allowing agencies to start seeing families in-person yet. One agency is only going into families' homes on

an emergency basis, while advocating for their families to be considered "emergency cases." Others are developing phase-in plans for in-person services.

Safety procedures include asking screening questions (via telephone) prior to entering homes. Sometimes face coverings are being provided for clients who do not have their own. Some staff are provided with hand sanitizer and thermometers for themselves and their clients. Outdoor sessions are encouraged whenever possible.

Conclusion

Nobody knows when the COVID-19 pandemic will end. Child- and family-serving agencies may continue to provide remote services in some form for months or years to come. Fortunately, according to the agencies with whom we spoke, remote services do not seem to adversely affect the number of families served or their outcomes. The lessons learned can be applied to other scenarios when remote services may be necessary or preferable.

Michelle Reines *earned her MSW degree from Florida International University and served the Palm Beach County Children's Services Council. She later transitioned to the North Carolina Division of Social Services as family preservation and reunification consultant. In July 2019, Michelle became executive director of the National Family Preservation Network.*

Shifting to a Remote Children and Family Services Workforce: The Illinois Department of Children and Family Services

Marc D. Smith

When the COVID-19 pandemic struck and it became clear that one of the best options to help curb and prevent the spread of the virus was social distancing, the Illinois Department of Children and Family Services moved quickly to ensure that its child abuse hotline remained staffed 24 hours a day. This meant securing equipment and training employees—and had the added benefit of improving morale and reducing the number of callbacks.

For some, working from home during the pandemic has been as easy as using a laptop and cellphone. Transitioning a large call center, which staffs a 24-hour hotline for reports of abuse neglect, to remote-only work poses a more difficult challenge. When the COVID-19 pandemic struck in March 2020, the Illinois Department of Children and Family Services (DCFS) moved quickly to ensure this important service was not interrupted—and also saw increased efficiency and improved worker morale.

DCFS is required by law to maintain "a single, state-wide toll-free number…which all persons, whether mandated or not mandated by law, may use to report suspected child abuse or neglect at any hour of the day or night, on any day of the week" (Illinois Abused and Neglected Child Reporting Act [ANCRA]; 325 ILCS 5). The Child

Abuse and Neglect Hotline (1-800-25-ABUSE) is available 24 hours a day, seven days a week, and is the first way in which most children who are abused or neglected come to the department's attention. Many refer to the hotline as the "front door" of the Illinois child welfare system, and as such, it serves a critical function in the department's mission of keeping children safe.

The hotline has faced criticism in recent years due to the high rate of triage message-taking and the length of time before reporters receive a callback, both of which have increased as the number of hotline calls continue to rise every year. In September 2019, DCFS engaged Illinois Central Management Services' Office of Rapid Results team to develop a plan to ensure the department would handle all calls in real time on a caller's first attempt to reach the hotline. The department also reached out to the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign to design and conduct a comprehensive review of the hotline that would include the following areas: call volume; staffing levels; staff training; business processes; and technologies and data systems.

Unbeknownst at the time, the work done to reimagine the hotline's future as a result of these two reviews would serve as the blueprint for the hotline's ability to quickly shift from staffed call centers in Springfield and Chicago to a fully remote workforce able to work safely from home when the COVID-19 pandemic hit in March.

Collaboration with several divisions within the department was crucial to ensure the hotline could continue its vital role of assessing child safety. Within days of Governor J.B. Pritzker's stay-at-home order on March 12, 2020, the department's Office of Information Technology Services and telecommunications unit secured and configure state-issued mobile phones, laptops, and headsets for each call floor worker to use remotely. Several workers volunteered to be "super users" to assist their peers by answering minor technology-related questions and troubleshooting technical difficulties rather than overwhelming the department's help desk with questions. The department continues its efforts to provide all workers with new, faster laptops and dual monitors to work even more efficiently.

In fall 2019, 20 new positions were allocated to the hotline with an additional 40 positions allocated in February 2020. When the stay-at-home order was announced, the hotline was in the midst of hiring and training for these new positions. The hotline leaders responded quickly and retooled the training to be remote and virtual. This retooled training is completed via webcam, screen sharing, and live call monitoring by trainers. Staff and trainers report the virtual training experience is comfortable and better than the in-person method of training.

DCFS now is able to conduct personnel interviews remotely, ensuring that vital staff positions do not go unfilled simply because in-person interviews cannot be conducted. Over the past year, the hotline base staffing has grown to 175 call floor workers. Today, the hotline is at approximately 80% of the base staffing compared to late fall 2019 when it was at approximately 70% base staffing with 135 positions budgeted. Additional shift patterns have been developed to provide better phone coverage, and a new satellite hub for the call center will be opened in this fiscal year. Most importantly, the pool of interested candidates increased significantly when hotline staff began working remotely and opportunities across the state opened to work for the hotline remotely rather than reporting to a brick-and-mortar site.

Call floor workers are embracing remote working. In March 2020, workers completed a survey to gauge their job satisfaction. Results showed that morale was low, workers did not feel connected to their supervisors and they did not feel communication was effective. Staff were working 12 hours of mandatory overtime a week and burnout was evident. In mid-May, staff again were surveyed—and the responses could not have been more different. Workers reported that they felt safe, they knew their families were safe, their level of communication was improved, their overtime was more manageable (now on a voluntary basis and averaging three hours a week), and they felt more focused and productive overall. Possibly most surprising, call floor workers feel more connected to their peers and supervisors than ever before.

During the COVID-19 pandemic, when children have been isolated from the teachers, coaches, friends, or other trusted adults who might otherwise detect compromise to their safety and well-being, calls to

report suspected child abuse and neglect have decreased by as much as by 57% in Illinois, according to DCFS data, compared to the same time in 2019. As schools were making plans for returning to learn, annual physicals are scheduled and other activities slowly start back up, DCFS administrators anticipated that calls to report suspected abuse and neglect would begin to rise, and that is exactly what happened. Schools across Illinois are trying several different approaches to educate kids, including home learning and in-school learning, and DCFS has made it easier for teachers and others to report allegations of abuse and neglect through its website. We have updated our reporting systems and optimized it for use through smartphones and tablets. Through thoughtful preparation, call floor workers remain ready to answer the call any time, day or night, from anywhere, and now reporters have another option (see Table 1).

While making operational challenges during a time of duress is not ideal, the groundwork we started in 2019 has played an important role in keeping our hotline staffed. We continue to look at ways to make improvements while also allowing our employees to work safely.

Table 1. *Number of Calls Requiring a Callback due to High Volumes*

Month	Number of calls triaged	Percent of calls responded to in real time
March 2020	9,182	46.1%
April 2020	1,563	83.9%
May 2020	557	90.6%
June 2020	52	95.3%
July 2020	207	94.2%
August 2020	115	96.3%

Note: Triaged calls are answered by a call floor worker, assessed for urgency and the safety of the child, and assigned for callback.

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services to families in crisis, since 2009. In that role, he collaborated with child welfare leaders, professionals, and other stakeholders to implement family-centered systems and practices that protected and supported children and families. Prior to serving with Aunt Martha's, Smith worked for more than two decades as a social worker, trainer, and leader in child welfare. From 2004 to 2009, he served as a program administrator and recovery coach at Treatment Alternatives for Safe Communities, where he managed the child welfare division. Earlier in his career, from 1993 to 2000, Smith worked as a public service administrator for the Illinois Department of Children and Family Services. Smith has served on numerous boards, committees, and work groups, helping to shape policies and inform best practices in leadership and in the field. He has also led the development of program models that have increased the likelihood of family reunification, increased adoptions, and significantly improved the ability of workers and agencies to connect people with substance abuse treatment, mental health care, and other supportive services. A licensed clinical social worker and certified trainer, the Joliet resident received his bachelor of science degree in criminal justice from Illinois State University and his MSW from the University of Illinois at Chicago.

The Challenge of Stay-at-Home Orders for Children, Youth, and Families

Rick Azzaro

COVID-19 will forever change our reality and produce many expected and unexpected consequences. In the interest of public health, our response has necessitated the need for widespread restrictions and stay-at-home orders. Stay-at-home orders required us to modify child welfare practices and, often, can add additional stressors related to our capacity to function and meet the demands of daily living. Social services that typically support and respond to family violence, substance abuse, and mental health concerns are dramatically restricted during the pandemic, resulting in decreased access, limited reporting, and isolation of those in need of support services. Families isolated at home are likely experiencing additional stress, increases in intimate partner violence (IPV), substance abuse, suicide, and child abuse. This article explores the unseen consequences of individual and family struggles that happen behind closed doors and provides recommendations for future policies and practices.

As the COVID-19 pandemic continues, so does our discourse on what is working and not working in the social services fields—and how the pandemic's possible long-term consequences (i.e., new public health practices, economic fallout, the use of technology

in the emerging new world of work) will take shape. Our learning curve will take some time to reveal the many unexpected and latent outcomes we will experience in our institutions, communities, and social worlds.

Stay-at-Home Orders and their Impact

Stay-at-home orders can have dire consequences for populations that are vulnerable. While we as a society often equate home as a safe place, for many of our families it is anything but safe. Popular culture often reinforces the myth of "home" as a warm and safe place of belonging. Home is represented as a place where we build our identity, grow, and are protected from the outer uncertain world by people who love us. Professionals in the social service arenas know this is not universally true.

The COVID-19 experience has resulted in a plethora of intense new stressors while limiting or restricting many of the resources people routinely use to cope with them. The unemployment rate is now in the tens of millions and some have lost their homes and/or businesses (Lawson et al., 2020). Families sequestered because of stay-at-home orders can experience an additional layer of stress, which may increase the risk of intimate partner violence (IPV), substance abuse, suicide, and child abuse (Campbell, 2020; Marroquin et al., 2020; Czeisler et al., 2020; Tull et al., 2020). Furthermore, disruption in daily routines and anxiety related to COVID-19 may be exacerbating preexisting problems such as mental illness or substance use. People in crisis may not have access to or may avoid hospitals and other providers due to prevailing anxiety or restrictions (Froimson et al., 2020).

Social Isolation

IPV, substance abuse, suicide, and child abuse are each unique, and often interrelated, epidemics in and of themselves. Research recognizes social isolation as a common, high-risk pre-condition for all four social concerns (Killgore et al., 2020; Nitschke, 2020; Tull et al., 2020).

Limits to social connectedness and situations disposed to secrecy place individuals in an ideal predicament for vulnerability and danger.

Children

Children are most often abused in the context of an existing relationship. It is estimated that 90% of abused children know their abuser; national data from the U.S. Department of Health and Human Services indicates that in 2018, 76% of child abuse perpetrators were a parent to their victim (Garbarino & Kostelny, 1992; U.S. Department of Health and Human Services, 2020).

Furthermore, our myth of "stranger danger" represents only a very small percentage of the violence experienced by children. The reality is that children are more typically abused by family members inside their homes (Fortson et al., 2016). The CDC indicates that at least one in seven children have experienced child abuse and/or neglect in the past year. In 2018, nearly 1,770 children died of abuse and neglect in the United States (Centers for Disease Control and Prevention, Web-based Injury Statistics Query and Reporting System [WISQARS], 2019).

Furthermore, all child protection reporting laws are predicated on social interaction between children and adult professionals who are required to report. Without direct exposure to professionals and the community at large, children are at greater risk of not being identified. Stay-at-home orders and social distancing, while necessary, have reduced our ability to interact with children and identify and respond to child abuse. During the COVID-19 crisis, child abuse reporting dramatically has decreased across the nation (Thomas et al., 2020). Does this mean that there less child abuse is occurring? No. This indicates that decreases in reporting are directly related to a reduction of community eyes and ears interacting with children—most notably, distance from teachers, who are among the largest groups of child abuse reporters (Baron et al., 2020). Given that children are most often abused by people they know, and that child abuse reporting is compromised, we can expect that a large number of children, out of view, are being abused and neglected in their homes (Pereda & Díaz-Faes, 2020).

Intimate Partner Violence

The CDC's National Intimate Partner and Sexual Violence Survey (NISVS) suggests that one in four women and nearly one in 10 men have/or will experience sexual violence, physical violence, and/or stalking by an intimate partner during their lifetime (Smith et al., 2018).

Intimate partner violence has its foundation in power, control, and social restriction. It is well understood that perpetrators seek to restrict and control all aspects of their victim's independence and social connections; social isolation and secrecy are primary tools for those who perpetrate. Consequently, the mandates of stay-at-home restrictions can serve perpetrators' aim to limit the social sphere of their victim. It is therefore expected that IPV will rise dramatically and that victims may be less likely to seek services during this extraordinary time (World Health Organization, 2020). Comprehensive data of increases in IPV cases are uncertain at this time, but several U.S. cities have indicated increases between 10% and 27%, and many providers have reported increases in crisis calls and challenges to accommodate those in IPV-focused shelters (Boserup et al., 2020; Bradbury-Jones & Isham, 2020; Bullinger et al., 2020). During COVID-19, firearm sales have increased. As we know that possession of a firearm increases intimate partner fatalities, it is possible that there may also be an increase in IPV fatalities (Bradbury-Jones & Isham, 2020; Donnelly et al., 2020; Froimson et al., 2020).

Substance Abuse

According to the National Survey on Drug Use and Health (NSDUH), 19.7 million American adults (aged 12 and older) struggled with a substance use disorder in 2017, and according to the CDC, more than 67,000 people died from drug overdoses in 2018.(Substance Abuse and Mental Health Services Administration, 2019).

Individuals who suffer with addiction are at higher risk of contracting COVID-19 and are more susceptible to advanced illness and complications than the general population. This is primarily due to

the preexisting medical illness of addiction and other social determinants of health. The complex stress inherent in the COVID experience also adds additional risk factors for individuals struggling with addiction (Zaami et al., 2020). The American Medical Association states that 40 states reported increases in opioid-related mortality in 2020 (American Medical Association, 2020). Additionally, reports collected in real time by the Washington, DC-based group ODMAP—the Overdose Detection Mapping Application Program, administered by the University of Baltimore—found a significant spike of 18% in the number of fatal overdoses compared to 2019 (Alter & Yeager, 2020).

Suicide

According to the CDC and the National Violent Death Reporting System (NVDRS), suicide is a rapidly growing public health concern. In 2018, suicide was responsible for more than 48,000 deaths, resulting in about one death every 11 minutes (Centers for Disease Control and Prevention Web-based Injury Statistics Query and Reporting System [WISQARS], 2019). Suicide prevention programs routinely focus upon securing support, building sustained social connectedness, early identification, economic support, and access to mental health services (Crosby et al., 2011), all of which have been compromised during the COVID-19 experience (Sher, 2020). Historical reports indicate increased suicide rates in the United States over the course of the 1918–1919 influenza pandemic and with the elderly in Hong Kong during the 2003 SARS epidemic (Wasserman, 1992; Cheung et al., 2008). Research indicates that subjects reported higher levels of suicidal ideation in 2020, and professionals expect, but cannot presently confirm, higher incidence of suicide globally during and following the COVID-19 epidemic (Czeisler et al., 2020; Horesh & Brown, 2020; John et al., 2020).

In *Why People Die by Suicide* (2007), Dr. Thomas Joiner identifies social isolation as one of the three key components contributing to suicide. The stress inherent in the COVID-19 experience, combined with the mandate to socially isolate, will likely result in an increased incidence of suicide. Resources for those experiencing suicidal thoughts

and inclinations, while present, have been virtually sidelined. Furthermore, mental health services and supports have been compromised, emergency rooms overwhelmed, and professional supports limited. Past research has linked suicide to unemployment and with a dramatically rising unemployment rate, we can expect increased personal lethality (Elbogen et al., 2020). Given the extreme stress inherent in the overload of the COVID-19 experience, medical professionals may be at increased risk for suicide, as well (Center for Disease Control: Web-based Injury Statistics Query and Reporting System (WISQARS), 2019).

A Call to Action

In addition to offering benefits and services to reduce hardship and suffering during COVID-19, we should scrutinize the lessons learned and develop new strategies to respond to future situations where stay-at-home orders and restrictions are required. Primary to future preparedness is the need for dedicated funding reserves to assist systems, communities, families, and individuals, and the expansion of emergency management preparedness and public benefits. We should strive to:

- ***Increase availability and access to telehealth and tele-mental health services.*** Telehealth and tele-mental health services have expanded dramatically during the COVID-19 experience and show promise as an ongoing, promising avenue for services (Gruber et al., 2020; Moreno et al., 2020; Reay et al., 2020; Zhou et al., 2020).
- ***Provide greater training for medical professionals to conduct universal biopsychosocial functioning home assessments.*** Universal assessment of biopsychosocial functioning in a client's home environment conducted by medical professionals can help to identify health/mental health concerns related to family/home dynamics. Increased medical training in this area will assist to assess global functioning and risk. (Jani & Lee, 2015).

- ***Make in-home "check-in" services available through local social service agencies.*** Dedicated funding and the establishment of in-home services to execute home "check-ins" for families who are high-risk may help to reduce family hardship and elevate service delivery and child abuse reporting.
- ***Elevate the use of media platforms (TV, print media, social media, and radio) to connect with children, families, and communities at risk.*** Media should be used to provide public psychoeducational information, supports, and resources for mental health and health services (Nitschke et al., 2020; Serlachius et al., 2020).
- ***Increase broader child abuse reporting training using a community approach: "see something, say something."*** The pandemic has revealed how compromised our child abuse reporting systems can be when stay-at-home orders are implemented (Baron et al., 2020; Thomas et al., 2020). Increasing our efforts to establish and sustain universal approaches to child abuse training and reporting for the broader community can help to identify suspected abuse outside of conventional systems (i.e., schools, mental health providers, recreational entities, etc.).

It is expected that the trauma of the COVID-19 experience will have long-term, lasting impacts on children, youth, families, and communities. As child welfare practitioners and concerned citizens, we should focus on what we cannot see, new ways of connecting with families, and our capacity to assure that our safety net is positioned for the inevitable increase of violence, mental health concerns, and substance abuse. The new landscape created by COVID-19 also will require additional resources, new strategies, and a more comprehensive community response to identifying those in need of services. As our communities and institutions mutate to respond to this difficult time, it is imperative that we broaden our efforts to enlist a greater collective of eyes and ears to identify individuals in need—and to employ new strategies for assessment and reporting.

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Videoconferencing in Child Welfare: An Appreciative Inquiry

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Videoconferencing has positively affected connections between parents and the child welfare system—though with notable limitations. Some counties have reported increased parent engagement and increased efficiencies for case and court workers. Groups that have traditionally been marginalized may particularly experience benefits, with less disruptive time schedules doing much to alleviate intimidation and burden. Where appropriate, to the exclusion of investigations and family visits, we urge child welfare practitioners and researchers to embed videoconferencing in practice models post-COVID.

Child welfare leaders and practitioners have pushed forward the use of technology to sustain child welfare practice in the face of a brutal global pandemic. For example, videoconferencing, a method previously non-approved for official contact, has unexpectedly strengthened connections between parents and the child welfare system, with some notable limitations.

Videoconferencing Accelerates Engagement

Parent engagement is key to children's safety, permanence, and well-being. Engagement is driven by parent buy-in and trust. National data

indicates that Black families as well as Indigenous and other people of color are disproportionately represented at all levels of child protection (Bartholet, 2011; Center for Juvenile Justice Reform & Chapin Hall at the University of Chicago, 2009). These groups historically have received unresponsive and biased treatment from government organizations, leading many families to distrust the child welfare system generally and interactions with workers from a different race in particular. This distrust has been made worse by the demands the system places upon families: having to navigate frustrating public transportation systems, take off from work, and arrange for child care during in-person hearings and meetings in courtrooms and government buildings. Videoconferencing levels the playing field, deemphasizing power disparities by enabling parents to engage from environments of their choosing and on less disruptive time schedules.

Videoconferencing strengthens engagement with another population as well: younger parents with younger children. The child welfare system has seen a surge in younger families, due in significant part to the persistent opioid crisis (National Academies of Sciences, Engineering, and Medicine, 2017). Younger parents rely on their smartphones for almost everything: communication, connection, and information. Ninety-six percent of 18-to-29-year-olds own a smartphone; 22% of this population is "smartphone dependent." (Pew Research Center, 2019). For these families, videoconferencing is familiar and vastly more comfortable than walking into an intimidating government building.

Videoconferencing, while still an emerging practice in child welfare, is showing promise. A North Carolina county with whom the authors have corresponded, for example, is using virtual child and family team meetings. to connect family members, community supports, social workers, and children to create safety and permanency plans. Caseworkers in the county have found that in "casual" interactions via videoconferencing, parents have shared valuable, previously unshared information. Through videoconferencing, families living in rural areas also are accessing social work supports and behavioral health services that largely were unavailable to them pre-pandemic.

Experiences from other programs offer lessons for child protection agencies. Nurse Family Partnership (NFP) in Colorado, for example, already was using virtual communication before the pandemic to connect staff and—in certain circumstances—to conduct home visits (Casey Family Programs, 2020a). The popularity of NFP's services has soared during the pandemic, with higher enrollment in March 2020 than the year before. Since 1998, Florida has leveraged telehealth to connect specialized pediatricians in urban areas to hard-to-reach, rural jurisdictions. By providing expert medical evaluations of child maltreatment allegations, this program has reduced child trauma, increased timeliness of evaluations and decreased the investigative burdens (Arnold & Esernio-Jenssen, 2013), and has been adopted by several other states. Since the onset of the pandemic, such telehealth services have expanded exponentially, including in Pennsylvania, where the Office of Mental Health and Substance Abuse Services relaxed restrictions on telehealth in response to the pandemic (Pennsylvania Department of Human Services, 2020). This led Allegheny County to add mental health and substance abuse treatment services to its telepsychiatry practice. Treatment providers, "optimistic that they may see more engagement and longer lengths of stay in outpatient treatment" (Casey Family Programs, 2020a), have seen early indications that their optimism may be justified.

Increased use of videoconferencing has benefited caseworkers and court workers, as well. Synchronous and asynchronous online direct practitioner support groups have provided child protection workers with peer support and coaching (for example, using appreciative inquiry during videoconferencing to focus on family strengths). Caseworkers have reported increased administrative flexibility, with more time to check in with children and families and prepare for court hearings (Casey Family Programs, 2020b). In an overview of conversations with stakeholders, Casey Family Programs reported that virtual court hearings yielded time and cost savings, increased family participation, facilitated greater collaboration between parties, and enabled professional development for staff attorneys and caseworkers (Casey Family Programs, 2020b).

Face-to-Face Contact Remains Crucial

Videoconferencing is not a panacea. States and localities generally have continued to conduct investigations in person, even in the face of soaring COVID-19 numbers; resumed regular monthly in-person visits within a couple of months; and acknowledged that remote family visits were a poor substitute for in-person visits. For example, California's Department of Social Services issued guidance in late March that categorized emergency response investigations as essential government functions, directing investigations to continue in-person with precautions (California Department of Social Services, 2020a). Michigan also continued in-person investigations because they addressed an "immediate child health or safety concern" while scaling back other types of in-person visits (Michigan Department of Health & Humans Services, 2020a). Michigan resumed all in-person casework requirements starting on July 1, 2020 (Michigan Department of Health & Human Services, 2020b). Similarly, social workers with the Los Angeles County Department of Children and Family Services resumed regular monthly in-person visits in July because they found speaking with a child directly, away from parents or caregivers, was still the best way to evaluate a child's safety and well-being (Los Angeles County Department of Children and Family Services, 2020). To minimize the risk of workers contracting COVID-19, some states and localities have established procedures for caseworkers to screen homes for the virus before conducting home visits (Tennessee Department of Children's Services, 2020).

At the onset of the pandemic, many states either issued blanket bans on in-person family visits or introduced restrictions (Datawrapper, 2020). California's Department of Social Services, in a notable exception, instructed counties from the start to prioritize in-person family visits for children under three years to cement "critical early bonds with their parent." (California Department of Social Services, 2020b). Biological parents and children—especially young children—overwhelmingly found videoconferencing a distressing substitute for in-person visits, even with increased frequency of contact (Ellerbeck, 2020). Most states

and localities reinstated in-person family visits, with precautions, by May 2020.

Where to Go from Here

We urge child welfare practitioners and researchers to study COVID-19-spurred innovations like videoconferencing and embed them into practice models where proven beneficial. Creative strategies to engage parents, increase access, and strengthen connections with groups that traditionally have been marginalized, when rigorously examined and considered with regard to context, can only serve to strengthen the child welfare system in the long term.

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