# Primary, Secondary, and Tertiary Prevention Strategies in Social Services

In 1962, pediatrician C. Henry Kempe and colleagues published "The Battered-Child Syndrome" in the *Journal of the American Medical Association*, which recognized the prevalence and clinical manifestations of child abuse and called on physicians to report such findings to legal authorities.[1170] The report is widely credited with changing both medical and public views on child maltreatment, which was previously thought to be uncommon and not a significant medical or societal concern. The result was the recognition of child abuse as a public health concern and the transformation of medical and social service response.

The advancement of clinical recognition and response to child abuse prompted novel policy strategies for prevention and intervention. In 1974, the United States (US) Congress passed the Child Abuse Prevention and Treatment Act, which authorized federal funds for the development of Child Protective Services and hotlines for the prevention, identification, and treatment of child abuse and neglect and established the National Center on Child Abuse. Today, the child welfare system encompasses a broad array of interconnected systems and services that oversee four primary domains: child protection, family-centered support, foster care, and adoption.

Child abuse and neglect—also termed child maltreatment—constitute five of the 10 categories of Adverse Childhood Experiences (ACEs) included in the original ACE Study (physical, sexual, and emotional abuse, and physical and emotional neglect).[3-5] Estimates of substantiated child abuse or neglect (i.e., confirmed after child welfare investigation) demonstrate that child maltreatment will be confirmed for 1 in 8 (12.5%) US children by 18 years of age.[1171] The child welfare system has primary responsibility for identifying, investigating, and intervening to protect children who are referred to their agencies for abuse and/or neglect. The annual rates of reported allegations (i.e., referrals) of abuse and neglect have been relatively steady over the last decade in California, whereas the rates of substantiated incidents have decreased from 11.2 per 1,000 children in 2007 to 7.7 per 1,000 in 2019 (**Figure 17**).[1172] This represents nearly 70,000 California children

Figure 17 - Child abuse and neglect allegations and substantiations, California 2007-2019
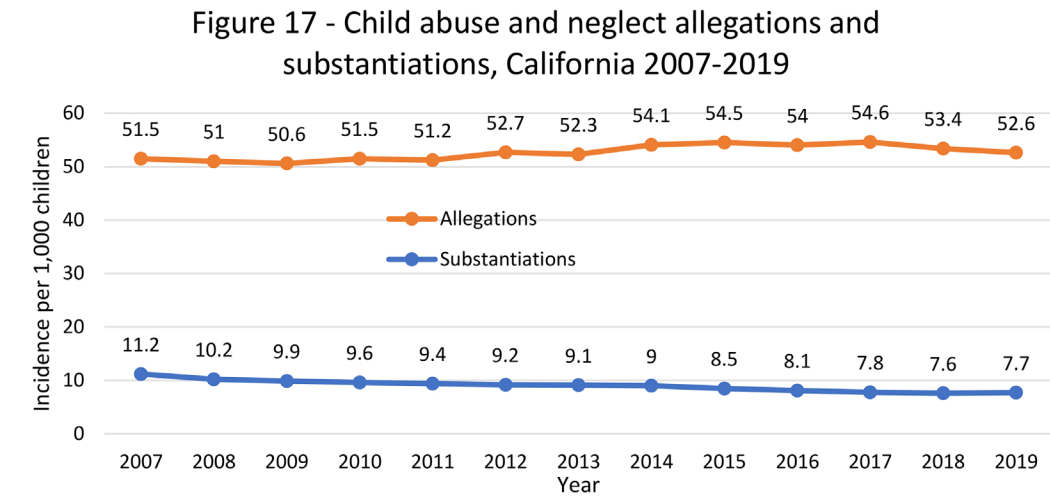
Figure 17. *California Child Welfare Indicators Project. Reproduced with permission.*[1172]

substantiated as abused and/or neglected in 2019, over three-quarters of which were for neglect. However, However, these rates probably dramatically understate the real children who are maltreated.[1171] National surveys have found that for the last two decades, approximately three times as many children are maltreated each year as are actually recorded by Child Protective Services (CPS) agencies.[1173]

Young children are the most likely to experience substantiated abuse and/ or neglect.[1174] In California, nearly half (45%) of children who have experienced substantiated child abuse or neglect were five years of age or younger, and most of these (62%) were two years or younger.[1172] Between 70% and 80% of the 148 children officially determined to have died due to abuse in California in 2018 were under five.[1175]

Further, racial disparities occur throughout the full child welfare continuum of services, from reports of allegations through substantiations and removal from the home. For example, Black and Native American children in California have substantially higher rates of allegations and substantiations than other racial/ ethnic groups (**Table 7**). Black children, who represent only 6% of California's child population, encompass 14% of children with abuse and neglect substantiations. Similarly, Native American children comprise less than 0.5% of the child population, but account for nearly 1% of the children with substantiated cases.[1172]

The other broad category of adversity in the original ACE Study is household challenges (household member mental illness, intimate partner violence, substance use, incarceration, and parental separation or divorce). Not only can these five ACEs activate the toxic stress response directly, but they are also risk factors

Race/Ethnicity	Allegations per 1,000 children	Substantiations per 1,000 children
Asian	16	1.9
Black	116	19.4
Latinx	50	8.3
Native American	96	16.3
White	42	6.1
Overall	53	7.7

Table 7. *Rates of child abuse and neglect allegations and substantiations in California, by race/ethnicity.*[1172]

for the other five ACEs: their presence can contribute to child abuse (physical, emotional, or sexual) and/or neglect (physical or emotional). For example, unaddressed mental health challenges of caregivers and active substance use can increase parental stress and reduce coping skills, and can be major drivers for a child's entry into the child welfare system. In fact, co-occurring mental health and substance use disorders are common among parents of children entering the child welfare system. In national figures, the percentage of children entering foster care for whom parent drug abuse was reported as a reason for removal increased from 30.7% in 2012 to 37.7% in 2017.[1176,1177] The most recent estimates of infants estimated to be prenatally exposed to alcohol and illicit drugs range from 8.7% to 11% for alcohol and from 5% to 6% for illicit drugs.[1178-1180] Parental incarceration as a reason for removal has also increased nearly 6% during this same period.[1176]

The intergenerational cycle of ACEs and toxic stress is demonstrable when analyzing these and other risk factors for entry into the child welfare system. Parents with substance use disorders often themselves have a history of trauma themselves, with 60%–90% of treatment participants experiencing one or more traumatic events.[1177,1180] In addition to the original ACEs, there are multiple other life stressors that can also reduce a caregiver's capacity to cope effectively with the typical day-to-day stresses of raising children. These include financial and social stressors, such as poverty or financial insecurity, unemployment, housing insecurity or homelessness, and community violence. Without sufficient buffering supports, these challenges can also lead to ACEs for their children through increasing child abuse, neglect, and/or household challenges, as well as potentially serving as additional risk factors for directly activating the toxic stress response.[1181,1182] The coronavirus disease 2019 (COVID-19) pandemic is a prime example of an acute stressor that is increasing ACEs and toxic stress (see COVID-19 AND SOCIAL SERVICES).

Children placed in foster care as a result of substantiated abuse or neglect represent a population at high risk for experiencing toxic stress and the neuro-endocrine-immune-metabolic dysregulation it produces. Together with the emotional, physical, and social disruptions that foster care can entail, the toxic stress response can take a heavy toll on the health and well-being of foster children throughout their lifetimes. Consistent with many other studies, the California Youth Transitions to Adulthood Study (CalYOUTH), which followed a cohort of foster youth during their transition to adulthood, found they were "faring poorly compared to their age peers across many measures of well-being, including their educational attainment, employment, economic self-sufficiency, physical and mental health, and involvement with the criminal justice system."[1183] For example, less than half of the participants rated their health as excellent or very good. In the second follow-up wave of the study, with 19-year-old adolescents, "More than 50% of CalYOUTH participants were found to have a positive diagnosis for one or more current mental and behavioral health disorders."[1184] Young people in the study were significantly more likely than those in a similar longitudinal study of a nationally representative cohort of adolescents (the National Longitudinal Study of Adolescent Health, or Add Health) to have received psychological or emotional counseling (22.0% vs. 7.9%, $F = 44.0$, $p < 0.001$) and treatment for a drug or substance abuse problem (6.5% vs. 3.2%, $F = 4.4$, $p < 0.05$) in the past year.[1183] Further, the foster youth were over three times as likely as youth in the Add Health study to have a health condition or disability that limited their daily activities—almost one-fifth of them did.[1183] CalYOUTH respondents were more likely than Add Health adolescents to have ever been diagnosed with ACE-Associated

COVID-19 AND SOCIAL SERVICES

Since the beginning of the coronavirus disease 2019 (COVID-19) pandemic, child and family-facing service agencies have become concerned about the potential increased risk for child abuse and neglect during this time of crisis, grief, economic insecurity, and social isolation. With many school buildings shuttered and medical visits declined, children's lives have become more hidden behind closed doors. Reports to child abuse hotlines across the nation, including in California, have declined by as much as 50% during the pandemic. The drop began soon after California began its stay-at-home orders to prevent the spread of the coronavirus.[1211] On the other hand, child self-reports to the Childhelp National Child Abuse Hotline have increased; there were 31% more calls and messages in March 2020 than in March 2019.[1212]

When children are alone with caregivers for longer and more challenging times, including potentially being home-schooled, they are also more distant from non-family adults

COVID-19 AND SOCIAL SERVICES

in settings like daycare, schools, after-school programs, places of worship, and other public areas, where their safety and well-being can be assessed externally. There is a need for alternate ways to assess the safety and well-being of children and families during shelter-in-place. For example, Sacramento County has developed a tip sheet, "Supporting Safety and Well-Being of Children and Families during COVID-19," with guidance for teachers, social workers, counselors, day care providers, and others who work with children virtually.[1213] There is also a statewide guide, "Recognizing Child Abuse and Neglect through Distance Learning Recommendations for California's Educators."[1214] Both offer concrete suggestions for how to ask engaging, solutions-oriented questions that can help identify whether support is needed or a safety concern may be present.

However, although there are increased risks for children during the COVID-19 pandemic, it is important to avoid placing certain groups, such as families of color or low-income families, under heightened scrutiny and potential for child removal.[1215] Many families are dealing with growing food insecurity, lack of housing stability, inadequate income, and social isolation. The pandemic is also straining the availability of childcare. Poor families are becoming more impoverished. Families and communities of color are especially suffering in multiple ways,

including disproportionate rates of the illness and death from COVID-19. As pointed out above, the majority of substantiated child maltreatment cases are for neglect, not physical abuse or exploitation, and neglect and the challenges related to poverty are strongly associated.

In April, 2020, Governor Gavin Newsom announced $42 million in funding for children who are at greater risk for abuse or neglect during the pandemic, including roughly $7 million for social worker overtime and additional outreach. "Without the structure and safety of school, children—who are already vulnerable to abuse and neglect at home—face a greater threat," said Newsom. "Similarly, we recognize that many parents who have lost jobs and income due to the COVID-19 pandemic may be feeling overwhelmed and strained." Funding for more resources and support for parents can reduce financial stress on parents, which will also reduce the chances of abuse.[1211]

From a trauma-informed perspective, all families have strengths and resiliency worthy of investment and care. The current crisis is an opportunity for the child welfare system to collaborate with and engage communities in efforts link families and children with needed supports and resources, including easing social isolation.

Health Conditions (AAHCs), including high blood pressure (10.3% vs 6.4%, F=5.3, p < 0.05), high cholesterol or high lipids (6.9% vs 3.7%, F=6.4, p < 0.05), diabetes or high blood sugar (4.8% vs 0.4%, F=40.8, p < 0.001), and asthma or reactive airways disease (26.6% vs 16.0%, F=19.7, p < 0.001).[1183]

In addition, CalYOUTH respondents were more likely than Add Health participants to have been hospitalized within in the prior three months (males 30.3% versus 3.1%; females 28.9% versus 15.4%). CalYOUTH participants were more likely to report they were hospitalized due to illness (males 30.2% versus 15.1%; females 30.9% versus 13.3%) or a substance abuse or mental health problem (males 36.7% versus 7.0%; females 11.7% versus 1.2%).[1183]

Child welfare involvement has also been consistently associated with poorer educational outcomes. Among 4,000 youth involved with California's foster care system enrolled in high school between 2002 and 2007, less than half (45%) had completed high school by 2010, compared to 79% of the general student population.[1185] Numerous studies have also documented former foster youth to have lower earnings and greater risk of unemployment, as well as greater risk of involvement in the criminal justice system.[1186-1192]

In summary, foster youth have been documented to have greater risk of the medical, behavioral, educational, and social consequences of toxic stress. These outcomes are not simply the result of foster care, but are also tied to the marginalized communities in which youth lived and their histories of trauma prior to entering care. Even when these challenging circumstances do not lead to entry into the child welfare system, children who face these types of childhood adversity are at high risk of experiencing significant short- and long-term health and social consequences.[8,23,817,1193-1197]

PRIMARY PREVENTION STRATEGIES

Historically, the national child welfare system has directed almost all its attention and resources to tertiary prevention efforts for children who have already experienced abuse and/or neglect (i.e., to prevent recurrence). In California, the Department of Social Services (CDSS) is the administrative agency that oversees the child welfare system. The Office of Child Abuse Prevention (OCAP) within CDSS has recently championed a more overt primary prevention focus (i.e., preventing abuse and neglect before they occur) by addressing the major drivers of child welfare involvement: poverty, unaddressed mental health challenges of caregivers, substance use, and a parental history of child abuse.[1198] OCAP receives the majority of its $60 million annual budget from federal sources. (These include the Child Abuse Prevention and Treatment Act; Community-Based Child Abuse Prevention;

Promoting Safe and Stable Families; and the Child Abuse Prevention, Intervention, and Treatment Act.)

OCAP's 2020–2025 Strategic Plan[1198] represents a forward-looking and strategic child welfare approach to incorporating a public health framework into its prevention efforts. With primary prevention of child abuse and neglect as a key priority, OCAP promotes not only trauma-informed services and responses, but also trauma-informed policies and systems. This requires a high level of state and local engagement and collaboration to foster safe, thriving families and communities. The overall goal is to establish an integrated statewide cross-sector system to support families and provide safe, stable, nurturing relationships and environments for all children, through training, grants, campaigns, county-level prevention, and evidence-based intervention efforts (for instance, see THE CALIFORNIA EVIDENCE-BASED CLEARINGHOUSE FOR CHILD WELFARE).[47]

Grounded in a public health framework, OCAP's primary prevention approach starts with acknowledging and addressing the foundational socioeconomic and environmental factors shaping the conditions in which families and children live their daily lives. The focus is on implementing systems of care that build community-protective factors and increase access to the resources that address the broader social determinants of health (economic supports, housing security, food security, and equity). Interventions at this level encompass cross-systems approaches to address poverty and other environmental conditions that impact child safety and wellness, and enhance equity. Key strategies include:[23,1198,1199]

- Reduce poverty and improve economic stability through increased access to safety net supports;
- Increase social connections through Family Resource Centers and community events;
- Improve neighborhood safety and play areas for children;

THE CALIFORNIA EVIDENCE-BASED CLEARINGHOUSE FOR CHILD WELFARE

The California Evidence-Based Clearinghouse for Child Welfare is an online resource for child welfare professionals, researchers, policymakers, staff of public and private organizations and academic institutions, and others working to improve outcomes for children and families. It allows user to identify, select, and implement "evidence-based child welfare practices that improve child safety, increase permanency, increase family and community stability, and promote child and family well-being."[977] The average number of visitors per month between July 2019 and March 2020 was 29,331.

- Improve access to high-quality child care to support school readiness;
- Improve access to high-quality healthcare;
- Increase family-friendly work environments (e.g., paid family leave and on-site child care); and
- Increase public awareness and support for a shared community responsibility for child well-being (i.e., investing in our future).

These strategies particularly address new parents, since children under five have the highest rates of reported and substantiated abuse and neglect. Efforts to raise the awareness of the general public, business leaders, educators, service providers, and decision-makers about the nature and scope of problems associated with abuse and neglect is also part of primary prevention.[1200,1201]

As documented above, racial inequities are evident across every part of the child welfare system impacting children and families. There are several initiatives underway in California to advance racial equity. For example, the California Strategic Growth Council supports the Capitol Collaborative on Race and Equity (CCORE), formerly the Government Alliance for Race and Equity (GARE) Capitol Cohort, which is a capacity-building program to embed racial equity approaches into institutional culture, policies, and practices for California state government entities, and a network that has been working together since 2018.[1202] As a network, CCORE is collectively elevating racial equity values, collaborating on strategies, creating leadership models for racial equity, developing customized Racial Equity Action Plans, and supporting transformational governance.

CDSS participated in the first GARE Capital Cohort. Implementation activities include workforce development to make the workforce more reflective of those who are being served, provision of learning opportunities for staff, and development of a racial equity tool to apply to policy development and program implementation. CDSS has a newly formed Office of Equity, whose mission is to: expand services for people with disabilities; provide services in multiple languages; review data to better understand who CDSS serves and how they are served; learn about racial equity; enforce our civil rights laws; support the work of Tribal, Immigrant, or Refugee programs; contract with providers to increase services to underserved populations; and work to diversify the workforce and create an inclusive environment that engages and partners with community. The Office of Equity houses immigration and legal services to serve mixed-immigration status households in seeking Deferred Action for Childhood Arrivals (DACA) status, avoiding inappropriate deportations, and proving other immigration remedies.[1203] It also houses the Office of Tribal Affairs, whose vision is to cultivate informed participation and trusting relationships with and among the tribes, CDSS, and

counties to enhance the well-being of Native American children and families.[1204]

Although not totally new to the social services and child welfare field, there are currently widespread efforts to integrate trauma-informed policies and practices into all aspects of social services for families and children. Even with strengths-based approaches however, human service agencies need to understand the impact of traumatic experiences on client functioning and mitigate the potential re-traumatizing effects of their own service systems. Trauma-informed practices are both about what is being done, and how it is being done. Because implementing a trauma-informed systems approach involves considerable changes in policies and practice, agency leadership and middle management must be committed to the changes and actively engage in the process for it to be successful. As articulated by the National Child Traumatic Stress Network and others, trauma-informed policies and practices are of particular relevance in the social services sector for all levels of prevention.[1205,1206]

SECONDARY PREVENTION STRATEGIES

In the child welfare field, secondary prevention strategies are offered to populations that have one or more risk factors associated with child abuse and neglect, such as parental substance abuse, young parental age, parental mental health concerns, exposure to violence, and parent or child disabilities. These services and resources aim to strengthen protective factors to mitigate or eliminate risk based on the well-established Strengthening Families framework.[1207] Programs also seek to provide services and resources in communities with a high incidence of any or all of these risk factors. This assets-based approach supports families and communities to identify and build protective factors such as early parent–child attachment and nurturing, knowledge of parenting and child development, parental resiliency, concrete supports in times of need, social connections, and child social and emotional competence. In the child welfare sector, these secondary prevention strategies include:

- Differential response programs, as an alternative to formal CPS involvement, for families experiencing serious parental stress that use community resources to provide concrete services (e.g., crisis respite care or food and transportation assistance) and parenting guidance and education;

- Accessible Family Resource Centers that offer information, education, and referral services to meet concrete needs, as well as parenting supports to vulnerable families, such as peer mentoring and support groups, with a particular focus on teen parents, single parents, and families with young children;

- Home visiting programs that provide support and assistance to families at risk of experiencing abuse or neglect (see the next section, **Primary, Secondary, and Tertiary Prevention Strategies in Early Childhood Supports**);
- Respite care for families in crisis or with children with special needs; and
- Family-centered substance abuse treatment services.

In California, OCAP supports the implementation of these types of secondary prevention strategies by building the capacity and strengthening the sustainability of family-strengthening organizations to work effectively with diverse populations, particularly children and families in poverty, and to effectively implement evidence-informed prevention programs and practices through the dissemination of organizational best practices and workforce development opportunities.

TERTIARY PREVENTION STRATEGIES

Tertiary prevention strategies focus on families where child abuse or neglect has already occurred and seek to prevent its recurrence and reduce the negative consequences of the maltreatment. Traditional child welfare services provide supports and resources to families and children involved in the child welfare system to prevent recurrence and re-entry, including removal and foster care, traditional family reunification, and a range of wraparound support services. Specific tertiary prevention strategies include:

- Intensive family preservation services with trained mental health counselors that are available to families 24 hours per day for intensive bursts of time (e.g., six to eight weeks);
- Parent mentorship programs, with stable families providing support and acting as role models to families in crisis;
- Parent support groups that help transform harmful practices and beliefs into more positive parenting ones; and
- Healthcare services to address AAHCs in children and caregivers, support family-oriented therapeutic modalities, and strengthen resilience capacities for affected families. Some children in foster care are cared for by specialty child abuse pediatricians or a primary care clinic that specializes in the foster care community. Child welfare organizations can also connect children, youth, and families (via the online provider directory) to an ACEs Aware provider who is trained to recognize and respond to toxic stress.[153]

These services may include trauma-informed clinical interventions to regulate the stress response, like mindfulness practices, improved nutrition, sleep, exercise,

enhancing healthy relationships, access to nature, and if indicated, psychotherapy and other mental healthcare (see the earlier section, **Tertiary Prevention Strategies in Healthcare**, for more details).

Through this wide-ranging set of prevention programs at all three levels of prevention, OCAP plays a valuable and innovative role in encouraging and supporting cross-sector collaboration in statewide and community efforts to support all the children and families of California, and creating trauma-informed systems that includes primary, secondary, and tertiary prevention strategies (see EXAMPLES OF TRAUMA-INFORMED OCAP INTERVENTIONS AT ALL LEVELS OF PREVENTION).

EXAMPLES OF TRAUMA-INFORMED OCAP INTERVENTIONS AT ALL LEVELS OF PREVENTION

In 2020, the Chadwick Center for Children and Families at Rady Children's Hospital San Diego, a longtime OCAP partner, established a comprehensive, science-based professional education program to meet the needs of administrators and staff of Family Resource Centers, Child Abuse Prevention Councils, and other OCAP stakeholders in California. Curricula in multiple forms address the diverse needs of adult learners, ranging from five-minute micro-learning activities, to longer webinars or presentations, to multi-day, in-person trainings, followed by a series of consultations calls and booster sessions. Training topics include: Introduction to Trauma-Informed Care;

Reflective Supervision; Trauma and Parenting; and Using the Wellness Recovery Action Plan as a Tool to Heal Trauma.

The Advancing California's Trauma-Informed Systems (ACTS) project supports the goal of providing trauma-informed care (TIC) throughout California. Based on the best research and expertise available, ACTS has created a menu of TIC training and technical assistance for county-level child-serving child systems (welfare, local community organizations, and schools) focusing on three core domains: the organizational environment, workforce development, and trauma-informed services.[1208] County systems implement these

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EXAMPLES OF TRAUMA-INFORMED OCAP INTERVENTIONS AT ALL LEVELS OF PREVENTION

TIC improvements and continue the work of developing trauma-informed systems after training and technical assistance have ended. Counties served to date include: Calaveras, Los Angeles, Riverside, San Diego, Santa Barbara, Solano, Tehama, Tulare, and Tuolumne.

Lead4Tomorrow's Family Hui program[1209] is a peer-led parenting support group program. The Family Hui "Bloom" curriculum is trauma-informed and rooted in positive parenting principles, and includes information about ACEs, resiliency, and parenting skills. This program is intended to train parents to become leaders within communities and systems. It has had great success in reaching refugee and tribal communities, including the Afghan community. The Farsi language does not contain a word for child abuse, and the Family Hui program worked with translators to find an appropriate definition. Program materials have been translated into Farsi and Spanish, and a graphical representation has been created for those who do not read.

Celebrating Families funds a train-the-trainer model for a trauma-informed skill-building program for families with a parent with a substance addiction, through the Celebrating Families curriculum. Three organizations are being trained: SHIELDS for Families in Los Angeles; Para Los Niños in Los Angeles, and the Sherwood Valley Band of Pomo Indians in Mendocino County.

The Innovative Partnership grants provide funding for statewide regional collaborative networks between Child Abuse Prevention Councils and community stakeholders to strengthen families and prevent child abuse through increased availability of meaningful resources. Each regional and local network focuses on different strategies. Examples of innovative partnerships include outreach to families at risk of homelessness, mental health/substance abuse, those affected by fires, tribal communities, and migrant families (Lake, Mendocino), and trainings on ACEs, poverty, substance abuse, and protective factors (Amador, Fresno, Kern, Placer, Sacramento, San Francisco, San Joaquin, San Louis Obispo, Santa Barbara, Ventura and Yolo Counties).[1210]