Strong Communities for Children
A Community-wide Approach to Prevention of Child Abuse and Neglect

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In 1990, the US Advisory Board on Child Abuse and Neglect declared the child protection system to be in a state of national emergency. After nearly 2 decades of astronomical growth in the numbers of child maltreatment cases, increased complexity in the issues presented, and dwindling resources for help, the Board found that the child protection system was nothing short of a disaster in all of its parts. The system could do little to prevent child abuse and neglect or to provide services to strengthen the ability of parents to care for their children, and the knowledge-base needed for careful response was largely lacking. In many cases, the system exacerbated problems. The failure of the child protection system to “keep kids safe” prompted the Board to call for a new system of child protection—a universal system grounded in the creation of communities where families, friends, and neighbors are actively involved in ensuring the safety of children.

By the mid-1990s, reform efforts were in full swing. The enactment of the Family Preservation and Family Support Act of 1993 signaled a shift in public child welfare policy toward an emphasis on the importance of families. As a result, many local child welfare systems and advocates were quick to embrace the idea—if not necessarily the practice—of community-based child protection. However, these early efforts were hampered by a narrow conceptualization of the community’s role in child protection and the families to be served. Most agencies emphasized screening of high-risk families and provided a...
limited range of services, typically educational or counseling services for the mother. In addition, even as reform seemed inevitable, some still drew a distinction between family preservation and child protection, as if they were opposing goals.5

This article reviews (a) the Board’s rationale for declaring a national emergency, (b) the limitation of early efforts to reform child protection, and (c) the approach of Strong Communities for Children. This issue of *Family and Community Health* discusses Strong Communities, which is an unprecedented initiative—consistent with the US Advisory Board’s proposed national strategy2,3—to undertake a comprehensive community-wide approach to the primary prevention of child abuse and neglect.

**THE NEED FOR A UNIVERSAL APPROACH TO PREVENTION OF CHILD ABUSE AND NEGLECT**

A problem of design

In calling for a new, universal approach to the prevention of child abuse and neglect, the Board concluded that the child protection system, as originally conceived, was inherently flawed.1–3 In language widely quoted by the media, the Board emphasized that:

The most serious shortcoming of the nation’s system of intervention on behalf of children is that it depends upon a reporting and response system that has punitive connotations and requires massive resources dedicated to the investigation of allegations. State and County child welfare professionals have not been designed to get immediate help to families based on voluntary requests for assistance. As a result, it has become far easier to pick up the telephone to report one’s neighbor for child abuse than it is for that neighbor to pick up the telephone to request and receive help before abuse happens. If the nation ultimately is to reduce the dollars and personnel needed for investigating reports, more resources must be allocated to establishing voluntary, non-punitive access to help.1(p80)

The Board based its conclusions on several factors, including (a) the finding of emergency conditions throughout the child protection system, (b) the assertion that such “critical and chronic multiple organ failure”4(p2) represented a “moral disaster” violating principles of human rights law,1(p3) and (c) the finding that these conditions are the inherent result of errors in the design of the system.1–3 Indeed, the Board went so far as to argue that nothing less than a cultural change would ensure children’s safety:

…The Nation must strive diligently to overcome the isolation created by the demands of modern life and exacerbated by the ravages of poverty. We must tear down the walls that divide us by race, class, and age, and we must create caring communities that support the families and shelter the children within them. We must take the time to see the need and lend a hand.3(p82)

**A system in crisis**

The Board’s dramatic conclusion that the nation’s child protection system warranted the declaration of a national emergency was the result in part of the sheer volume of child maltreatment reports by the early 1990s. In 1974, about 60,000 cases of suspected maltreatment were reported; by the late 1980s, the number of cases had risen to 2.4 million2—a number that continued for some years to rise.9 Although unprecedented growth in cases had occurred, resources for the child protection system had not expanded to meet the need. The crisis was exacerbated by the increased complexity in the cases.1–3 Dramatic changes in family and community life, including changes in the economic status of families, in family structure, and in the range of institutions caring for children, created new challenges for the child protection system. Cases increasingly reflected the larger problems within society: poverty, neighborhood decline, mental health problems, substance abuse, and disabilities. These problems were worsened by a greater sense of social isolation combined with deteriorating or diminishing community and individual supports.

The nature of the allegations had also changed. Unlike the early years of mandated
reporting, by the 1990s the vast majority of reported cases involved a primary complaint of neglect or emotional maltreatment rather than physical abuse.3,9,10 This shift did not suggest a diminished need for services, however. Because victims of neglect often experience ongoing threats to their personal security, neglect can be even more insidious to the health and well-being of children than physical abuse.11

These challenges completely overwhelmed the child protection system, which was not equipped to deal with the constellation of demands on it.1–3 The volume of cases in which services were needed and the range of services needed to address increasingly complex issues demanded a system that was more preventive and comprehensive in its response. Unfortunately, however, the child protection system was designed to receive reports and conduct investigations, not to prevent harm.12 Consequently, in the early 1990s, nearly half the families, in which child maltreatment was substantiated, did not receive even the pretense of services other than an investigation.3,9

A “moral disaster” that hurts children

Although child protection is often thought to be solely in the domain of child protective services (CPS), the Board distinguished between CPS, the specialty child welfare agency that is charged with investigation of alleged child maltreatment, and the child protection system, which consists of all sectors of society that are or should be involved in the study, prevention, investigation, adjudication, or treatment of child abuse and neglect. The Board concluded that the entire system was failing, not just CPS.

The Board further concluded that this systemic failure has had huge economic and social costs. Billions of dollars are spent each year on law enforcement, juvenile and criminal courts, foster care, residential treatment programs, and counseling of adults who were maltreated as children. Billions more are spent on efforts to prevent substance abuse, eating disorders, adolescent pregnancy, suicide, juvenile delinquency, and violent crime. All of these problems have considerable roots in childhood abuse and neglect, the Board argued.

In the end, however, the Board based its concern not on the economic and social costs but instead on respect for the dignity of children as human beings.1 The Board elaborated that the “protection of children from harm is not just an ethical duty; it is a matter of national survival.”4(p4) The Board asserted that it is “simply immoral that the nation permits assaults on the integrity of children as persons... Such negligence also threatens the integrity of a nation that shares a sense of community, that regards individuals as worthy of respect, that reveres family life, and that is competent in economic competition.”4(p4)

What went wrong?

Although the Board was concerned about the problems discussed previously (problems that remain prevalent today), it ultimately concluded that these problems were not at the root of the emergency. Rather, the Board argued that the system was fundamentally flawed—that its failures could be found in its origins.1,5 When Kempe and his colleagues first published their classic article on the battered child syndrome in 1962 and then successfully advocated in the next 3 years for new child protection laws throughout the United States, the problem of child maltreatment was thought to affect only a few hundred children,13 not the millions of referrals that are received each year.9,10 Thus, it seemed reasonable to think that if these few cases could be identified and a response generated, then children would be safer.

The adoption of the Child Abuse Prevention and Treatment Act in 1974 reinforced this belief by conditioning receipt of federal child protection funds on states’ enactment of laws (which they in fact already had) to require reports and then investigations of suspected maltreatment, not to provide prevention and treatment.14 As a result, over time,
child protection became synonymous with initiating an investigation rather than looking at what government and other societal and neighborhood institutions can do to prevent or ameliorate harm to children. Moreover, as the Board lamented, the belief became widespread that child protection was the exclusive responsibility of CPS. The system was not designed to build a community safety net for the protection of children.

A NEIGHBORHOOD-BASED CHILD PROTECTION STRATEGY

On the basis of the current state of knowledge about the nature of child maltreatment and the societal response to it, the Board argued that only a universal system of family support, grounded in the creation of caring communities, could provide an effective foundation for assurance of children’s safety. In proposing a neighborhood-based child protection strategy, the Board made clear that its conceptualization of neighborhood-based was both geographic and psychological:

[The Board] used the term neighborhood-based to refer to strategies that are focused at the level of urban and suburban neighborhoods and rural communities. It is concerned not only with development of social and economic supports for troubled families and children at the neighborhood level (where neighborhood is defined by geographic boundaries) but also with the provision of both formal and informal services (e.g., self-help programs) that are based on the principle of neighbor helping neighbor, regardless of whether access to services is determined by specific place of residence.

The Board presented multiple arguments for movement to a neighborhood-based system. First, the Board noted the significance of neighborhood factors in child well-being. As neighborhoods deteriorate, child maltreatment is part of a set of problems that escalate. Neighborhoods that residents consider dangerous or scary have higher rates of maltreatment than neighborhoods that residents regard more positively, even when the neighborhoods have equivalent income levels and similar ethnic composition.

Second, the Board noted that children’s well-being is highly related to the level of social capital in a neighborhood. Accordingly, child protection activities should include a focus on strengthening relationships and enhancing parents’ sense of personal and collective efficacy. Trying to establish a new norm of neighborliness, the Board envisioned an ethic of mutual assistance so that parents who receive help also give—the cornerstone concept in a universal system of family support.

Third, the Board argued that experience has shown that services embedded in neighborhoods are typically most effective. The Board cited research on exemplary community programs for family support as an example of the types of settings in which parents can come together, get to know each other, share resources, and support one another.

A core concept in the Board’s vision was the necessity of making child protection part of everyday life:

The protection of children goes beyond the social service office, the police station, the courtroom, and the foster home. Child protection should become a part of everyday life so that every place where children are is a safe haven.

Everyone must agree ... that children have a right, at a minimum, to protection of their personal security. That premise implies building a society in which the social and physical environments are so safe that they “demand” the protection of children.

The Board’s vision was a society that “cares enough about children as people to permit childhood.” To that end, the Board challenged “all American adults to resolve to be good neighbors—to know, watch, and support their neighbors’ children and to offer help when needed to their neighbors’ families.”

THE LIMITS OF REFORM

Driven by the consensus that the child welfare system, as then designed, often was both inefficient and ineffective, numerous efforts
to reform children’s services, including CPS, emerged in the mid- to late-1990s.\textsuperscript{5-7,16} For the most part, these efforts, especially those that were federally supported, emphasized service integration, collaboration, or coordination as a way of improving financing structures, quality of services, and organization of services. The nascent family support movement aimed to move the locus of administration and casework “away from individual agencies running their programs with their funding sources and toward communities configuring their resources to achieve certain goals for children and families; away from investigating, substantiating, and closing and toward assessing and providing services to strengthen families to prevent additional maltreatment.”\textsuperscript{5(p395)}

The implementation of community-based child protection that emerged was almost always narrower than the Board’s vision in several key respects. First, these efforts tended to define community as the human service agencies within the community. The use of informal helpers was approached cautiously, particularly in high-need communities where the perception was that there were few supports that could be drawn upon. To the extent that informal helpers were engaged, their role was dependent on the specific needs of the family, and, therefore, driven by the formal system.

Second, in contrast to the Board’s universal approach to prevention of child abuse, these early efforts still emphasized services to families that had been referred to CPS. In the new paradigm, CPS, with its limited resources, would focus its efforts on serving high-risk families while shifting primary responsibility for low-risk families to community-based agencies.\textsuperscript{6}

Third, the motivation for reform differed. These early efforts were aimed primarily at deploying scarce resources more effectively by narrowing the focus of CPS and involving community agencies. Most reformers saw the problem as primarily one of money and administrative competence. Unlike the Board, they did not perceive the system as fundamentally flawed in design. Few desired to move the central responsibility for children’s safety from CPS.

Fourth, if the substance of the system changed, the early reform initiatives emphasized the development of new services or programs (eg, home visitation, therapy for child victims, family support, etc) to fill perceived gaps in service. Few fully embraced or perhaps even understood the Board’s focus on creation of caring communities.

THE STRONG COMMUNITIES APPROACH

The uniqueness of Strong Communities

Strong Communities for Children is a comprehensive community-based initiative to prevent child abuse and neglect by building systems of support for families of young children. Starting from the US Advisory Board’s premise that child protection should be a part of everyday life,\textsuperscript{5} the vision of Strong Communities is for every child and every parent to be confident that someone will notice and someone will care whenever they have reason to celebrate, worry, or grieve.

The first effort to implement fully the Board’s neighborhood-based strategy for child protection, Strong Communities is located in part of 2 counties in northwestern South Carolina. With fewer than 150,000 residents living in an area that is approximately 30 miles wide in each direction, the participating communities are diverse in population density, wealth, ethnicity, and residential stability. The initiative is administered by the Institute on Family and Neighborhood Life of Clemson University, with primary bases in 2 family resource centers.

Strong Communities is distinctive for its use of a full-blown public health approach to child maltreatment. In contrast to the early reform efforts that emphasized treatment of the individual, Strong Communities takes an approach that applies research about the causes and correlates of child abuse and neglect to the design and implementation of a universal, community-level approach to primary prevention. Focusing on primary community
institutions—the places where families work, study, play, and worship, and the various community servants whom Mr. Rogers counted among “the people in your neighborhood”—Strong Communities is striving to build a norm of inclusion and mutual assistance for all families with young children. It is a movement intended to build community itself, not merely an administrative reform to facilitate coordination of human service providers.

**Outreach**

The strategies used in Strong Communities to change the environment include a continuum of activities that are designed to redirect existing community resources in support to individual families, to build or strengthen relationships among members of the community, to engage primary community institutions in such activities, and to mobilize the community in creation of new norms and structures for expressions of neighborly concern. Strong Communities uses 2 primary strategies for accomplishing these objectives: (a) outreach for the purpose of building community and changing norms and (b) coalescence of existing community physical and human resources in direct support to families with young children.

The essence of building safe communities for children is in creating environments that promote citizen engagement and a perception that, if citizens do reach out, they can make a difference. In Strong Communities, community outreach workers are primarily responsible for increasing the collective commitment of citizens and institutions to watch out for (watch over) children and their families, building the capacity of the community to work together, and applying the assets in primary community institutions to support and nurture families.

Roughly speaking, each outreach worker is assigned to a single community, although the geographic areas covered vary substantially, and the populations covered vary from about 5000 to about 50,000. Our impression is that the optimal community size for coverage by a single worker is 10,000 or fewer—obviously a lower ceiling than we have been able to achieve.

All of the outreach staff have extensive paid or volunteer experience in community work, but none had worked as organizers before joining Strong Communities. Specific professional backgrounds are highly diverse—for example, a nurse, a minister, a school administrator.

Eight principles guide the outreach workers in their efforts. First, the specific activities that outreach workers use to engage the community should be logically related to the ultimate outcome of reducing child abuse and neglect. In other words, an activity “fits” if it naturally brings people together so that connections among families are enhanced and isolation is reduced. Some activities, such as reading to children, have value but they do not necessarily facilitate the goals of Strong Communities. Outreach workers are encouraged to stimulate activities that strengthen relationships, create a “buzz” about the necessity of supporting families, and build a sense of efficacy among volunteers and parents.

For example, one Strong Communities outreach worker has stimulated the development of a family-friendly playground. The fact that the playground will increase recreational opportunities for children is a worthy goal in and of itself. For Strong Communities, however, the importance of the playground lies in the fact that it is designed to facilitate relationships between parents while their children are playing.

Second, outreach strategies should be directed toward the transformation of community norms and structures so that residents “naturally” notice and respond to the needs of children and their parents. The setting should be organized in such a way that support of families is almost demanded. In other words, structures should be organized to facilitate family support. For example, pediatric well-child care traditionally has been organized around a schedule that is front-loaded after the birth of a child and gradually tapers off. The visit is between physician and parents and is often quite limited in time. In Strong
Communities, the staff are working with pediatricians to incorporate a periodic group visit of new parents that would replace a scheduled individual visit. If each individual visit is ordinarily scheduled for 10 minutes, the pediatrician can bring in 6 families for a group visit that lasts an hour and not expend time beyond what would have been spent in individual visits. The added benefit: parents have an opportunity to socialize and form a social network of other parents with newborns while the pediatrician spends a few minutes with each parent and newborn for a brief examination. Structuring well-child care in this way is consistent with the American Academy of Pediatrics’ (AAP’s) view that pediatricians should promote supportive environments for families that will contribute to the health and well-being of children.17

Third, outreach activities should continuously “push the envelope.” The objective is not necessarily the implementation of discrete programs but instead the continuous creation of settings in which Strong Communities’ core message is heard and applied. So the Strong Communities management team is less concerned when outreach workers do not complete a project than when they are not frequently starting new activities. (If the activity works, the community should be encouraged to take over the primary responsibility; if it does not work, it should be jettisoned.) In this case, more is better.

Fourth, outreach is directed toward volunteer recruitment, mobilization, and retention. Volunteerism is extremely important in Strong Communities because the very act of volunteering builds community. When parents who are challenged by their everyday situation or who are simply running out of energy see others who are willing to help, it is encouraging and energizing to them—a sense of efficacy that is likely to extend to family life. Often those helped become the helpers. In doing so, they gain an increased sense of competence. Thus, the engagement of volunteers helps sustain the initiative over the long term and creates a sense of responsibility among residents toward others in the community.

The use of services of volunteers is important for another reason. Although many citizens become involved to “give back,” a significant number of the volunteers in Strong Communities are individuals who have a specific professional role (usually not a human service professional, however) but who go beyond the expectations of their job to help the community. These individuals and work settings that change their general mode of doing things to fit Strong Communities are what we call neighborly volunteers.18

For example, firefighters have mentored children on a daily basis, provided help to pregnant teens, gathered resources for families in need, and organized their neighborhoods. Their visibility in the community in a helping role beyond what is expected encourages others to participate and sends the message that families are important.

Fifth, outreach activities should be directed toward the establishment or strengthening of relationships among families or between families and community institutions. Relationship building is always a feature of Strong Communities. Therefore, one function of outreach workers is to build connections between various networks in the community.

Sixth, outreach activities include a focus on the development of widely available, easily accessible, and nonstigmatizing social and material support for families of young children. This principle has been summarized in 5 words: “People shouldn’t have to ask.” Help is most effective and most accepted when it is “built in”—an expectable part of the routines of the setting.

Seventh, although the ultimate goal is the protection of children, outreach activities are directed toward parents, and they are undertaken in a way that enhances parent leadership and community engagement. Children are safer when their parents are better supported in their parenting role, so activities focus on strengthening relationships among parents. Activities also focus on engaging parents in their community and on facilitating reciprocity of help whenever possible. When parents are engaged in their community, they are
more likely to feel efficacy in their parenting responsibilities. Moreover, when parents who under ordinary circumstances would be viewed as clients can help others, they develop a sense of efficacy in their parenting skills that often does not occur in venues such as parenting classes.

Eighth, outreach activities should be designed so that they build or rely on the assets (leadership, networks, facilities, and culture) in and among the primary institutions in the community. As vividly illustrated in the article in this issue by Murphy-Berman et al., the operationalization of Strong Communities' principles is heavily influenced by local culture, resources, and issues. Even the same strategy (“special events”) is manifest in quite different ways in communities with different bases from which to work. Whatever the particular context, however, we begin by considering the assets that may be leveraged in community action.

**Strong Families**

*The role of the healthcare sector*

Strong Communities also systematizes the communities' expressions of caring for families with young children. Much of our outreach work is now focused on the mobilization of community resources of time, expertise, and facilities in a system that we ultimately intend to be universally available to families with young children in our service area. We call these direct service components *Strong Families*. Consistent with our effort to build social capital to normalize the experience of giving and receiving help, community gatekeepers are encouraged to enroll (not refer) families with children younger than 6, who in so doing join.

The cornerstone of the recruitment effort is primary healthcare, especially pediatrics. (We also seek to engage obstetric and family practices as partners in Strong Families.) Two points are relevant here. First, as a practical matter, given that almost all young children receive at least some well care, primary healthcare is the best means of universal access to young families, even if that process is somewhat fragmented and uneven. Second, in substance, Strong Families’ emphasis on building supportive environments for families as a way of promoting the health, safety, and well-being of children complements and integrates healthcare providers' own efforts. The design of Strong Families is thus consistent with the AAP's position that pediatricians should “nurture and advocate for neighborhood structures that support healthy families capable of promoting optimal health, safety, and development in their children.”

In Strong Families, health system involvement is coordinated by a nurse who is employed by Strong Communities (Clemson University). The health system coordinator initially focused her efforts on recruiting pediatricians to enroll families in Strong Families. Through 2007, she recruited 16 private community pediatric healthcare practices and the Center for Pediatric Medicine and the pediatric residency program at Greenville Hospital System University Medical Center to enroll families in services.

After 1 year of enrollment, 2,479 families had joined Strong Families; of those, 64.6% were enrolled through the healthcare system. Many more had participated in Strong Families activities but had not joined. This gap relates to the fact that activities are commonly organized by volunteers, who may not make the relevant individual paperwork a priority but who do count the people present.

In addition to recruitment of families, healthcare professionals are encouraged to alter their well-child care to increase family support. Besides giving information about Strong Families, some practices have expanded their anticipatory guidance related to child safety, community resources, and parent well-being.
Still others have actually broadened the array of support services (eg, group well-child care) directly or indirectly available through the practice itself. Greenville Hospital System University Medical Center also provides training on family support through its pediatric residency program.

Strong Families has developed a pediatric healthcare handbook that is used to recruit practices and to assist practices in enhancing their parent support activities. The handbook includes fact sheets for the physician and handouts for parents that are related to keeping children safe. Besides providing information about children’s growth and development and about affirmative steps that parents can take to enhance their family’s safety, the fact sheets emphasize parents’ self-care and their engagement in the community.

The handbook also provides an anticipatory guidance checklist that physicians can use in their conversations with parents. The checklist includes points related to the family (eg, preparing for an infant; postpartum mood disorders; the spousal relationship; infant crying; shared care of the infant; parents’ support networks; caregiver fatigue; sleep problems; accident prevention) and the community (eg, community involvement; family activities; parent support groups; community resources; child care, including occasional babysitting; playgroups).

Components

In concept, Strong Families is similar to the early settlement houses that provided easily accessible and nonstigmatizing fellowship and practical assistance to neighborhood residents. Many of the settlement houses grew into substantial community centers that offered a variety of opportunities for people in the neighborhoods to socialize, relax, and learn.20 Like the settlement houses, Strong Families provides activities and services designed to build or strengthen a family’s social support network, encourage mutual support and parent leadership and, where needed, provide or arrange for professional support and direct services.

Strong Families is even more grassroots than the settlement houses were, in that most of the resources are donated. Facilities and maintenance are donated rent-free by community organizations. Most of the activities are at least partially organized and led by community volunteers, and most of the professional time and expertise (eg, financial counseling; personal problem-solving [chat with a family advocate]) are donated by individual professionals or their employers. In other instances, the Strong Families service (eg, group well-child visits) is the product of restructuring of services conventionally delivered in a less family-friendly manner.

The organization of these “free” services has required creative leveraging of resources of many organizations and considerable time of Strong Communities’ own staff. However, these services have been largely undertaken with existing resources (either no new revenue or, in a few cases, use of conventional public funding mechanisms such as a bundled Medicaid service). In that context, we are endeavoring to make Strong Families services sufficiently routine and regular that they will become part of the local culture (“just how things are done”) and are thus sustained after grant funding ends.

• Connections for Strong Families. When families “join” Strong Families, they are automatically placed on a mailing list for Connections for Strong Families (Connections). Connections is regularly mailed to families of children younger than 6 who are identified by health-care providers, real estate agents, apartment managers, church congregations, specialty business managers (eg, children’s clothing stores), teachers, public safety officials, and others in the community. The timing of the mailing conforms to the well-child visit schedule recommended by AAP. Connections consists of a LINKLetter (www.healthysteps.org) for families of children 3 years old or younger, a family activity calendar (for families of children younger than 6) and, occasionally, short and brief topical
documents (appropriate for families of children younger than 6) that discuss issues associated with Strong Communities objectives.

• **Family activity centers.** Family activity centers (FACs) are community settings (eg, schools, churches, fire stations, libraries) that are central to Strong Families’ efforts to stimulate expanded social support networks and active engagement in the community and to improve parental efficacy. Recruited by Strong Communities outreach workers, community organizations (alone or with partner organizations) donate their facilities and human resources to create FACs. Because FACs are designed to bring together and provide support to parents of young children in the community, members of the community (including young parents themselves) are integrally involved in developing the centers and planning and hosting the activities.

A calendar describing FAC activities is mailed monthly to families as part of Connections for Strong Families and posted in strategic locations throughout the community, including media outlets. All activities and services at the FACs are offered for no fee.

Comprehensive FACs regularly offer at least 5 core services.

• **Family activities and playgroups.** Both of these services have value in themselves, not only because of the importance of fun (and related positive affect) and time together in forging family cohesion but also because of the services’ symbolic value. There is potential meaning to parents—and their sense of collective efficacy—in the knowledge that their neighbors care enough about families of young children that the community makes free activities regularly available in convenient locations.

Moreover, family (parent–child) activities and playgroups are important because they offer opportunities for young parents (and perhaps for volunteers of other generations) to get to know each other. A related commercial service is the franchised delivery of exercise programs for toddlers and preschoolers. Young children themselves do not care whether they belong to an exercise club (in effect, a playgroup). However, parents (probably especially mothers) welcome the time to interact with their peers. Unfortunately, the franchising of this opportunity is a good example of the many ways that everyday assistance that once was simply part of life has become a professional commodity to buy.21

We are planning to begin regularly to advertise (through kindergartens, eg) the availability of special children’s activities that also include club-like ways for parents to spend the time (eg, cooking groups)—contrasted with meetings of parents with child care available. Community groups will take responsibility for planning and conducting children’s activities, and Strong Communities staff and parent volunteers will organize parents’ activities (or, at least part of the time, Parents’ Nights Out).

• **Financial education, career counseling, and related mentoring.** An ever-increasing challenge for young families is simply making ends meet, even when parents are college-educated. Real income for young adults has been declining, job insecurity is high, the number of uninsured has been climbing, debt load has been rising, and savings are typically small or nonexistent.22–24 The potential adverse consequences for children’s care are obvious.

Accordingly, FACs offer education, counseling, and mentoring on a variety of topics in financial planning and career development (eg, basic budgeting; obtaining a loan; reducing debt; planning for children’s expenses; starting a business; buying a home; beginning to invest). Such services are contributed both by bankers and by other volunteers who have been trained (typically by bankers) in use of curricula provided by The Federal Deposit Insurance Corporation, Fannie Mae, and other government-related financial services.

• **Parents’ Night Out.** Using trained volunteers as child care providers, Parents’ Night Out is designed to allow parents
time for themselves and a chance to “recharge their batteries.” It also directly offers an alternative for parents without a nearby friend or relative whom they trust to provide spur-of-the-moment care, whether for respite, a particular task, or an emergency.

- **Chats with a family advocate.** With time contributed by individual professionals and by human service agencies, chats with family advocates are generic social services. The “chats” are advertised as opportunities for neighborly advice, assistance in problem solving, and connections to community resources. The service is designed to provide an easily accessible, nonthreatening setting to aid parents in dealing with personal and family problems.

- **Extra Care For Caring Families.** Families enrolled in Strong Families are also eligible for Extra Care for Caring Families. Extra Care is a support service for families of children younger than 3 that is offered through participating pediatric and family practice healthcare providers. When parents express an interest in the service, the provider notifies the Strong Families health system coordinator, who will then facilitate at least 1 supportive contact (ie, a home visit, a group activity for parents, and/or a phone conversation) between “regular” office-based well-child services. If a family has more extensive needs, the family is matched with an Extra Care family advocate, who is a mental health professional who provides general family support in the home or other community settings. Like other components of Strong Families, enrollment in Extra Care entitles parents to the Connections newsletter.

- **Family partnerships.** Family advocates are also mental health professionals. However, they serve families of young children in unconventional, especially “friendly” ways. Both independently and in concert with kindergarten teachers, they do home visits before kindergarten begins or soon thereafter, and they find other times to get to know parents, whether at home, at school, or in other community venues.

Family advocates have 2 principal functions. First, they nurture parents’ engagement and leadership in the school and the community and, by so doing, seek to build parents’ confidence in their care of their children and to facilitate other adults’ support for the family. Second, in their various contacts with the parents, the family advocates seek to develop relationships so that they “naturally” learn about any special needs for family support. Besides facilitating mutual assistance among the parents whose children are enrolled in the kindergarten, they “do whatever it takes” to offer useful help (not only counseling or psychotherapy) that is responsive to the family’s situation.

**CONCLUSION: STEPS TOWARD NEIGHBORLY COMMUNITIES**

Expressing its vision for a safe society for children, the US Advisory Board on Child Abuse and Neglect articulated a strategy aimed at achievement of a culture change that would be felt in everyday life—a *neighborly society* in which families are strong and children are safe. The Board imagined a country filled with neighborhoods characterized by “friendship among neighbors, watchfulness for each other’s families, physical safety, common knowledge of community resources, visible leadership, and a sense of belonging, ownership, and collective responsibility.”

Although Strong Communities for Children is little more than midway through what is planned to be a decade-long initiative, it already has demonstrated that community residents can be mobilized to “keep kids safe” when they understand the nature of the problem and they are provided commonsense ways of responding in the settings of everyday life. Within about 5.5 years, a few outreach workers and some of the volunteers whom they recruited have enlisted thousands of volunteers and hundreds of organizations
in just part of a single metropolitan area. Collectively, they are determined to ensure that the young families among them will be noticed and cared for.

This initial infusion of vast social capital in a relatively small, although diverse, area has occurred through a 2-fold process. In one part, outreach workers have been skilled teachers and energetic catalysts for community action. In the other, the resources they have generated are being integrated in a system of volunteer-based support for families of young children. As discussed throughout this issue of *Family and Community Health*, the combination has created an inspiring movement toward communities blanketed by a social fabric woven too tightly for children to fall through. The process promises to be one that has application in widely diverse communities seeking to be healthier and safer for all.

**REFERENCES**

