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FUTURE 2GEN PROGRAMMING IN INDIANA
POLICIES TO ADVANCE 2GEN PROGRAMMING

BACKGROUND

In 2016, United Way of Central Indiana (UWCI) initiated the Great Families 2020 (GF2020) program to provide financial stability to families in Indianapolis. The GF2020 service delivery model used a two-generational approach[A] (2Gen) that simultaneously addressed the needs of parents/caregivers and their children (ages 0–6). GF2020 was implemented across five neighborhoods in Indianapolis by eight subgrantees[B] and their partners.

Efforts to promote 2Gen programming rely heavily on collaboration, coordination across agencies and sectors, sharing data, and leveraging existing resources to help families achieve self-sufficiency and economic stability. Across Indiana, 2Gen programming exists in nonprofits and state agencies. However, these services are often siloed, resulting in few opportunities to collaboratively develop solutions and implement policies that address barriers to financial success. To maximize existing resources and efforts, it is important to create and implement policy solutions that more effectively elevate 2Gen services and achieve greater communication and coordination across entities. This brief highlights principles, policies, and practices for successfully promoting 2Gen programming within the state of Indiana.

2GEN APPROACH

GF2020 was based on the 2Gen model from Ascend at the Aspen Institute. The service delivery model used family coaching to direct families in need of financial services to evidence-based interventions and wraparound services. The Aspen Institute's 2Gen approach uses a whole-family perspective to mitigate negative outcomes associated with poverty by addressing the needs of parents/caregivers and their children. The model aims to develop human capital within a family and promote economic stability through job training, financial coaching, and educational services. Programs also concurrently provide services to both parents/caregivers and children, including physical and mental health services, programs that build social capital, and quality early childhood education. As a result of these core services, children experience positive academic and socioemotional development while parents improve their financial stability.

TABLE 1. Six core domains of the Aspen Institute 2Gen model

DOMAIN	EXPLANATION
Health and well-being	Mental, physical, and behavioral health, coverage and access to care, adverse childhood experiences, and toxic stress
Social capital	Peer and family networks, cohort strategies, and coaching
Early Childhood Education	Head Start Early Head Start, child care partnerships, pre-K, and home visiting
K–12 education[C]	Kindergarten readiness, third grade reading skills, parent engagement, graduation, and postsecondary preparation
Postsecondary & employment pathways	Community college, training and credentials, and workforce partnerships
Economic assets	Asset building, housing and public supports, financial capacity, and transportation

A Access the first brief and the second brief in this series for more information about the GF2020 program and its implementation.
B Subgrantees were the eight organizations that were awarded grant funding by UWCI to implement GF2020.
C The K–12 education domain was not originally incorporated into the GF2020 program as the domain was added by the Aspen Institute after GF2020 was implemented.

FIGURE 1. Aspen Institute's 2Gen model compared to ISDH social determinants of health model

ASPEN INSTITUTE'S 2GEN MODEL

ISDH SOCIAL DETERMINANTS OF HEALTH

HEALTH

HEALTH & WELL-BEING

Mental, physical, and behavioral health, coverage and access to care, adverse childhood experiences, and toxic stress

HEALTH CARE SYSTEM

Health coverage, provider availability, provider linguistics and cultural competency, quality of care

SOCIAL

SOCIAL CAPITAL

Peer and family networks, coaching, and cohort strategies

SOCIAL & COMMUNITY CONTEXT

Social integration, support systems, community engagement, addressing discrimination

EDUCATION

EARLY CHILDHOOD EDUCATION

Head Start, Early Head Start, child care partnerships, pre-K, and home visiting

K–12 EDUCATION

Kindergarten ready, 3rd grade reading skills, parent engagement, graduation and postsecondary prep

EDUCATION

Early Childhood Education, literacy, language, vocational training, higher education

WORKFORCE

POSTSECONDARY & EMPLOYMENT PATHWAYS

Community college, training and credentials, and workforce partnerships

ECONOMIC STABILITY

Employment, income, expenses, debt, medical bills, support

ECONOMY

ECONOMIC ASSETS

Asset building, housing and public supports, financial capacity, and transportation

NEIGHBORHOOD & PHYSICAL ENVIRONMENT

Housing, transportation access, neighborhood safety, parks and playgrounds, walkability

FOOD

Hunger, access to healthy options

Sources:

- The Aspen Institute, T. (2015). What is 2Gen? Retrieved from http://ascend.aspeninstitute.org/two-generation/what-is-2Gen/12.
- Indiana State Department of Health. (2018). Indiana State Assessment and Improvement Plan, May 2018-December 2021. Retrieved from https://www.in.gov/isdh/files/Indiana_State_Health_Plan_I-SHIP.pdf

POLICY EFFORTS TO ADVANCE 2GEN

Opportunities to promote 2Gen programming must consider different levels of policies when developing a comprehensive agenda. To maximize the benefit of 2Gen programming in Indiana, policy makers must incorporate relevant policy change at all levels of government while also addressing both legislative and administrative challenges. This section of the brief emphasizes policy reforms based on the intersection of the approaches for both the Center for Disease Control and Prevention's (CDC) Social Determinants of Health model and the 2Gen model. This portion focuses primarily on areas that require improvements in design, implementation, and delivery to achieve greater cross-agency and interagency collaboration. These areas include postsecondary and employment pathways, health and well-being, and Early Childhood Education.

INTERSECTION BETWEEN 2GEN AND SOCIAL DETERMINANTS OF HEALTH

The key to unifying 2Gen programming across Indiana is through understanding different approaches and principles regarding its implementation and service delivery. According to the CDC, social determinants of health (SDOH) are the conditions and environments that contribute to a person's quality of life and outcomes.[1] The CDC has grouped these conditions into five domains (Table 2). Locally, state agencies such as the Indiana State Department of Health (ISDH) and the Indiana Family and Social Services Administration (FSSA) have further adopted this model, splitting the SDOH into six domains (Figure 1). The local implementation of SDOH overlaps considerably with the Aspen Institute's 2Gen model. Specifically, FSSA has incorporated SDOH guidelines to conceptualize the social, emotional, and physical supports provided to families. Like 2Gen, this service delivery model considers the whole person within their social, physical, economic, and environmental ecosystems. Moreover, both frameworks aim to achieve equitable outcomes for individuals and families—which requires removing and addressing barriers to economic stability—including poverty, lack of education and employment opportunities, accessible and affordable health care, transportation, and housing.

Though characterized differently, finding the commonalities in how these services are delivered can help nonprofits and state agencies better coordinate and collaborate by leveraging existing resources to build capacity. For instance, the FSSA already constructs their work and measurement of outcomes using the SDOH model. As such, the elements of the 2Gen model that fall under each of the six domains should be used to further inform this work and improve outcomes. Policies at the state and local levels that target social determinants of health can incorporate and help advance 2Gen efforts.

TABLE 2. Five core domains of the CDC's social determinants of health

DOMAIN	EXPLANATION
Health care access & quality	Mental health, trauma informed care, and health care access
Social & community context	Peer networks, family coaching, and mentoring
Education access & quality	Early Childhood Education, third grade literacy, certifications, and trainings
Economic stability	Workforce partnerships, job readiness, financial coaching, and asset building
Neighborhood & built environment	Providing housing, access to transportation, food access, environmental quality, recreational facilities, and neighborhood safety

WORKFORCE DEVELOPMENT

Increasing access to meaningful employment and postsecondary education are priority areas for 2Gen. As such, GF2020 provided individualized employment coaching, including job readiness, training, job placement, skill development, and adult educational services for program participants. Key policies to expand workforce development include reforms to the Indiana Manpower Placement and Comprehensive Training Program (IMPACT), Temporary Assistance for Needy Families (TANF), and transportation.

Policy landscape

Indiana Manpower Placement and Comprehensive Training (IMPACT). IMPACT was created in 1992 by the Division of Family Resources under the FSSA to help families reduce dependence on public assistance and become self-sufficient. Specifically, IMPACT targets recipients of Supplemental Nutrition Assistance Program (SNAP)[D] and Temporary Assistance for Needy Families (TANF),[E] and

provides a variety of services, such as education, job training, job search, and job placement. These core services aim to remove barriers preventing individuals from gaining and maintaining employment. A major component of IMPACT is the emphasis on "Work First," which requires participants to accept a job once it is secured.[2]

Scholarly research[3] and findings from the GF2020 evaluation indicated that child care was a major challenge to employment and ultimately, financial stability. A key strategy to ensuring that families obtain and maintain employment is providing families with quality and affordable child care.[3] Parents/caregivers without access to child care subsidies and other alternatives often forego employment to take care of their children.

IMPACT can more sustainably achieve its goals by considering the child care needs of low-income families. For instance, they can offer support to program participants to apply for Head Start, On My Way Pre-K, and/or the Child Care Development Fund (CCDF). These are federal and/or state programs that provide financial assistance to low-income families to access child care so parents/caregivers can work, attend job training, or attend educational programs. Through a robust and coordinated referral system, IMPACT can direct families with children to child care subsidy programs as part of enrolling in their workforce development efforts. By doing so, families can actively seek employment or enroll in educational services without worrying about their child care needs. Moreover, this presents a more coordinated approach to addressing whole family needs based on the intersection of the SDOH and 2Gen model approaches.

Temporary Assistance for Needy Families (TANF) reforms. TANF is a program that provides temporary cash assistance and support services to help families with children ages 0–17 take care of their basic needs. It is also designed to help low-income families achieve self-sufficiency and reduce dependency on public benefits. Like IMPACT, TANF is administered by the Division of Family Services under the FSSA, and eligibility is determined by specific nonfinancial criteria and family income levels.[4]

The Center on Budget and Policy Priorities (2020) found that TANF benefits have decreased substantially in many states over time due to inflation. Indiana is one of the 18 states with benefits levels at or below 20% of the poverty line, which amounts to $362 a month or less. In fact, in 2020, Indiana's benefit levels were set at 16%. This means that the income of a family must be less than 16% of the federal poverty level to be eligible for TANF. This makes Indiana one of the states with the lowest eligibility percentages in the country.[5]

Reduced TANF benefits can have major implications for low-income families, in which resources and opportunities are already scarce. In recent years, many states have increased their TANF benefits. Thirteen states—including neighboring states Ohio and Illinois—increased benefit levels between July 2019 and July 2020.[5] Although these increases were minimal and incremental, it indicates an upward trend in states allocating additional resources to help families meet their basic needs.

Given the importance of TANF benefits in helping low-income families stay afloat, Indiana should consider investing additional resources in TANF. This includes increasing benefit levels, which would expand the eligibility criteria and subsequently, the number of Hoosiers who can access the program. Recent legislation (Senate Bill 233) was introduced during the 2021 session of the Indiana General Assembly to help modify the existing TANF infrastructure in Indiana. SB 233 proposes an increase in the income eligibility requirements for TANF from 16% to 35% in two years, and from 35% to 50% in three years. In addition, SB 233 would increase the monetary benefit amount by 60%.[6,7] This bill successfully passed through the Senate and has moved to the House of Representatives for consideration.

In addition, the Senate Family and Children Services committee recently passed HB 1009. This bill exempts the earned income of an individual in a household pursuing a post-secondary degree, apprenticeship, and other work-based opportunities from impacting their family's eligibility

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D The supplemental Nutrition Assistance Program (SNAP) is a program offered by the U.S. Department of Agriculture, which provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move towards self-sufficiency.

E The Temporary Assistance for Needy Families (TANF) program provides grant funds to states and territories to provide families with financial assistance and related support services. State-administered programs may include child care assistance, job preparation, and work assistance.

for the TANF program. Enacting HB 1009 would ensure that students can take advantage of opportunities to gain relevant work experience without putting their families over the eligibility threshold to receive assistance. This type of legislation—SB 233, HB 1009, or similar future bills—would have considerable impact on families' abilities to access much-needed resources.

Transportation needs in Central Indiana. The Indiana Senate recently passed SB 141 with a vote of 32–17. The bill was held for consideration by the House Roads and Transportation Committee but will not be granted additional hearings.[8] The bill had implications for the transportation needs of workers in Central Indiana. This bill required that IndyGo[F] privately raise 10% of the funds required by a 2014 law, without counting grant funding from the federal government.[9] If IndyGo was unable to meet this fundraising burden, 10% of local income tax revenue allocated for public transportation would be withheld. IndyGo stated that this penalty could cause a loss in federal funding, which could subsequently endanger the construction progress of two forthcoming rapid transit line projects, the Purple and Blue Lines.[9] While SB 141 failed to advance this legislative session, similar provisions could be incorporated into future bills. For example, a similar Indiana transit bill (HB 1279) passed through the Senate but was not voted on in the House in 2020. Transportation is an essential part of 2Gen workforce development, and a decrease in central Indiana's public transportation could affect low-income families. Mass transit is an important service for low-income families in accessing workforce development opportunities. Further, the cost of car ownership is high and having to buy a car for longer commutes can discourage low-income workers from taking more lucrative jobs. In devising policies to promote 2Gen, policy makers should consider the important impact of public transportation in facilitating access to workforce development opportunities.

WELL-BEING & MENTAL HEALTH

A fundamental component for 2Gen programming is providing mental health and wellness services to entire families. During its implementation, GF2020 participants were connected with a family coach who initiated warm referrals[G] to health providers—primarily mental health providers—with community-based family services. Findings from the GF2020 evaluation revealed that stigma associated with seeking and receiving mental health therapy often keeps participants from participating in mental health services.

Program & service delivery

Addressing stigma. Both public stigma[H] and self-stigma[I] can serve as pervasive barriers to mental health service utilization.[10] Perceptions of public stigma may contribute to those with mental illness concealing their mental health problems and willingness to seek treatment.[11] Structurally, stigmatizing attitudes may lead to a higher risk of incarceration, as well as discrimination against people with mental illness in the workplace, education, health care, and housing.[10]

Education, face-to-face contact, and political activism are three common strategies to combat mental illness stigma and discrimination. Educational approaches utilize multiple instructional resources (e.g., books, film, videos) to counter misinformation and stereotypes about individuals with mental illness. The second strategy—face-to-face contact—aims to challenge stigma through interpersonal relationships and interactions either in-person or through video. Lastly, political or social activism highlights systemic injustices and discrimination experienced by individuals with mental illness through grassroots activism and advocacy at the policy level.[12] For example, in 2008, the U.S. Congress amended the Americans with Disabilities Act to include protections for people with mental illness, partly as a result of the efforts of mental health advocates.[13]

Studies have found that education and face-to-face contact are both effective intervention strategies for reducing stigma for adults and children.[12] Education was more effective among children. Face-to-face approaches had a greater impact in improving adults' attitudes and behavioral intentions toward those with mental illness. However, in-person contact was more effective than video. In addition, research has found that anti-stigma education

F IndyGo is the Indianapolis Public Transporation Corporation, a corporation of the City of Indianapolis.
G A warm referral is the process of meaningfully guiding a family to a service provider or other agency after making a referral instead of having the parent/caregiver handle all arrangements.
H Public stigma encompasses stereotypes, prejudice, and discrimination by the general public.
I Self-stigma is internalized negative social beliefs, public attitudes, and shame.

can also facilitate acceptance and commitment to therapy, as well as reduce self-stigma amongst individuals living with a mental illness.[13] Programs seeking to provide mental health services must take into consideration how to address this stigma to engage participants more meaningfully.

Family-centered perspective. A report by the Substance Abuse and Mental Health Services Administration (2007) provides implementation strategies for mental health services to reach families in need. A key recommendation is approaching service delivery from a family-centered perspective instead of an individualized treatment plan between a mental health professional and patient.[14] A family-centered delivery model considers the needs of family members, significant relationships, and other caregivers. For example, addressing socioeconomic and family factors such as poverty, parent mental illness, or parental marital discord that may impact a child's psychological development. Through a collaborative process, families and professionals can work together to promote healthy emotional and behavioral development. Programs seeking to provide mental health services should consider providing both individual- and family-centered services to better address mental health needs of the family.

Policy landscape

Parity in mental health. Parity in insurance coverage means that mental health services will receive the same level of treatment and benefits as physical health conditions.[15] Treating mental illnesses like other health conditions can increase the likelihood of diagnosis, as well as reduce stigma associated with seeking and receiving services.[15,16]

Federally, the Mental Health Parity Act (MHPA) of 1996 (Public Law 104-204) offered limited parity by prohibiting large group health plans that chose to offer mental health benefits from imposing less favorable limitations and restrictions than for other medical or surgical treatments.[17] In 2008, the MHPA was replaced by the Mental Health Parity and Addiction Equity Act (MHPAEA)—also known as the Federal Parity Law—to add new protections, including extending parity to substance use disorders.[17] The MHPAE applies to most health plans including, Medicaid Managed Care Organizations (MCOs), State Children's Health Insurance Programs, and individual health plans sold in the Health Insurance Marketplace through the Affordable Care Act (ACA).[18] In 2010, the ACA expanded the scope and applicability of the MHPAEA by increasing coverage for young adults with mental health conditions. It also increased mental health benefits in individual and small-group market plans as a result of the Essential Health Benefit mandate.[17,19]

State agencies are primarily responsible for overseeing and facilitating the implementation of the 2008 Federal Parity Law. Types of benefits provided, diagnoses/illnesses included, and eligible programs and populations can vary by state.[18] Research has found that state parity laws can significantly reduce the financial burden on families with children who have mental health care needs while not driving up total health care costs. This underscores the statute's importance in combating discrimination for treatment of mental illnesses and addictions.[20] However, research also indicates that state parity laws have minimal or no effect on mental health treatment utilization and access.[20] As a result, further policy considerations should aim to increase usage rates of mental health treatment for families. Limited in-network options, for example, can result in higher costs for out-of-network care. In 2017, 20% of in-network admissions for mental health or substance abuse led to out-of-network charges even for Hoosiers with large employer coverage.[21] Shortages in mental health care professionals and providers, particularly in rural areas, also impact access to mental health care and substance use treatment.[21]

A 2018 report by The Kennedy Forum found that despite the passage of the Federal Parity Law, challenges in enforcing parity at the state level remain. Indiana is among 31 states that received a failing grade on enforcement of parity statutes.[22] The Kennedy Institute (2018) provided three fundamental recommendations on how Indiana could improve its parity statute. Those recommendations included considering how mental health and addiction conditions are defined, how they are covered, and how compliance with parity law is monitored and enforced.[22] In 2020, Indiana enacted House Bill 1092 which requires state authorities to amend state Medicaid plans to include reimbursement for the treatment of outpatient mental health and substance abuse treatment services and develop annual reports demonstrating compliance with Federal Parity Law.[23] However, in 2021, the proposed House Bill 1153—which would have expanded mental health coverage by prohibiting insurance programs from using an

individual's incarceration, hospitalization, or temporary cessation in substance use to determine eligibility—has failed to advance in the Indiana General Assembly.[24] In the future, the Indiana General Assembly should expand and promote equitable mental health insurance coverage by enacting legislation similar to 2021's HB 1153.

Mental health care access and investment. The Indiana Division of Mental Health and Addiction (DMHA) within the FSSA administers public mental health and substance use disorder services across Indiana. The state has a biennial budget that determines funding for various state activities and programs for two fiscal years, including appropriations for Medicaid and other mental health-related services. Initially, the budget plan for fiscal year 2021–2023 (HB 1001) was set to cut more than $26 million from the DMHA, including $10 million from the Recovery Works program and $8 million from addiction services.[25] It is unclear at this time if those provisions will make it into later versions of the budget plan. However, given that more people need DMHA services than are receiving them,[26] budget reductions can impact the ability for service providers to meet increasing demand. In fact, between 2018 and 2019, 69% of Hoosier adults with a mild mental illness, 60% with a moderate mental illness, and 31% with a serious mental illness did not receive treatment.[21]

In addition, there are racial, ethnic, and gender disparities in access to treatment. According to the National Institute of Mental Health, there were an estimated 52 million adults in the United States living with a mental, behavioral, or emotional disorder in 2019. However, only 45% of them received mental health services.[27] Of that 45%, the percentage of adults who received mental health services was highest among white adults (50%) and lower among Hispanic (34%), Black (33%), and Asian (23%) adults.[27] Further studies have shown that compared to their white counterparts, non-white racial and ethnic groups are significantly more likely to delay, neglect, or withdraw early from needed mental health care.[11] In 2019, more women (50%) than men (37%) were receiving treatment.[27]

Additionally, 37% of adults in Indiana reported symptoms of anxiety and/or depressive disorder during the COVID-19 pandemic. Of this group, 22% were recommended to receive counseling or therapy but did not receive services.[22] Given the ongoing nature of the pandemic and potential post-pandemic challenges, it is crucial for Hoosiers to have access to mental health care services. Therefore, the state should prioritize legislation that address these unmet needs.

EARLY CHILDHOOD EDUCATION (ECE)

ECE was an essential aspect of GF2020. Findings from the GF2020 evaluation indicated that the largest gap in ECE services was the cost of programming while maintaining employment. Both subgrantee staff and participants revealed that lack of access to affordable child care was a key barrier to finding and maintaining employment.

Currently in Indiana, there is vast unmet need in child care. In 2020, the average annual cost to send an infant and a 4-year-old to a child care center in Indiana was $22,000.[28] This accounts for 65% of income for a family of four with an income at 127% of federal poverty level.[28] The Indiana Early Learning Commission (ELAC) estimated that only 35% of children with working parents are enrolled in known child care in 2020.[28] Racial disparities seen in access and utilization across ECE service providers also remain a concern. Children of color are more likely to live in poverty and more likely to need child care funding.[29]

Financial and spatial equity[J] are also a concern in the Indiana ECE infrastructure. Children's access to high-quality ECE[K] varies widely by location in Indiana, with a large degree of variation within Marion County alone. In April 2019, 37% of children in Grant County received care from a high-quality ECE provider, while four Indiana counties did not have any high-quality ECE.[28] Ensuring equity in ECE service provision for lower-income families should be a priority for anyone seeking to advance 2Gen efforts. It is important to note that while increasing quality is a major priority, providers that transition to higher accreditation also increase the cost of their services, resulting in additional challenges for families.

J Spatial equity refers to addressing challenges to lack of equitable access to resources and services based on geography.

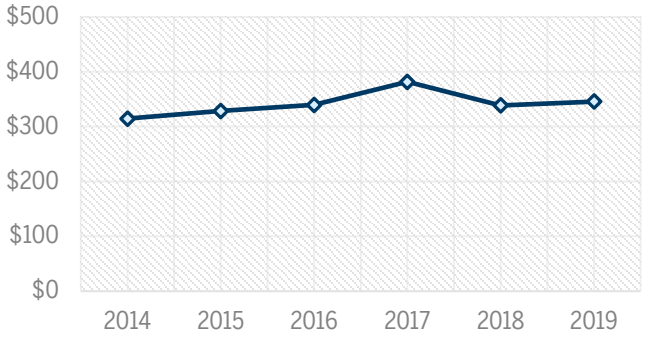
K Paths to Quality (PTQ) is an accreditation program for ECE providers. High-quality ECE refers to PTQ level 3 and 4. PTQ 3 indicates a planned curriculum for ECE and PTQ 4 indicates national accreditation.

Further, personnel shortages also affect the inadequate supply of ECE care. ELAC estimated there was a deficit of about 8,000 ECE workers in Indiana in 2020, with Marion County accounting for 1,500 of those unfilled positions.[28] The lack of sufficient ECE workers is largely a result of high turnover rates due to lower compensation and excessive stress. A 2017 survey of Nebraska ECE workers[L] found that child care workers had an annual 26% turnover rate.[30] More than half of ECE administrators (58%) attributed salary as the main reason for ECE personnel leaving their jobs.[30] Qualitative studies of ECE worker well-being indicate that the profession is high-stress and perceived as low prestige.[31] These factors likely contribute to higher rates of turnover and hinder ECE service capacity.

Policy landscape

Increase ECE access and investment. A large number of child care funding sources are available in Indiana, both from federal and state-level sources. The two largest programs covering the cost of child care for working families in Indiana are Child Care Development Fund (CCDF) and Head Start, which comprise 27% and 39% of total Indiana child care funds, respectively.[28] These programs rely mostly on federal funding, with accompanying funds from the states. CCDF enrollment in 2019 comprised 27,000 children in Indiana, with Head Start and Early Head Start enrollment comprising 15,000.[28] Other child care funding sources include On My Way Pre-K (OMWPK), TANF, Title I Funds, Special Education funds, among other sources.[28] Despite this array of funding sources, there is not nearly enough funding to cover the cost of child care.

FIGURE 2. Total child care funding in Indiana in millions (2014–2019)[28]



In 2019, ELAC estimated that Indiana needed $1.1 billion to cover the funding for all children in poverty, leaving a funding shortfall of about $680 million.[32] Despite increases in the Child Care and Development Block Grant (CCDBG) in the 2020 fiscal year budget and funding increases from the CARES Act, there is still vast unmet need in Indiana child care funding.[33] At the national level, policy makers should consider increasing funds allocated to Head Start, as well as the CCDBG, particularly to account for the increases in compensation necessary to fund a high-quality ECE workforce. This gap could be one of the many factors that contribute to the several thousand children on waiting lists for CCDF vouchers in Indiana.[M]

Another major challenge is the lack of child care providers participating in CCDF. As a 2017 report notes, despite a minor increase in overall child care capacity due to more CCDF slots, there was a national net loss of 356,000 CCDF-funded child care providers from 2005 to 2017.[34] The large losses seen in CCDF providers overall were largely due to losses in family care providers, which comprised 173,000 of the providers lost during that period.[34] More study is needed to establish reasons behind a lack of participation from ECE providers in CCDF in Indiana. However, it is clear that the loss of CCDF-participating family care providers decreases child care accessibility for low-income families, worsens spatial inequities in child care, and limits child care options for parents who work nontraditional hours.[34]

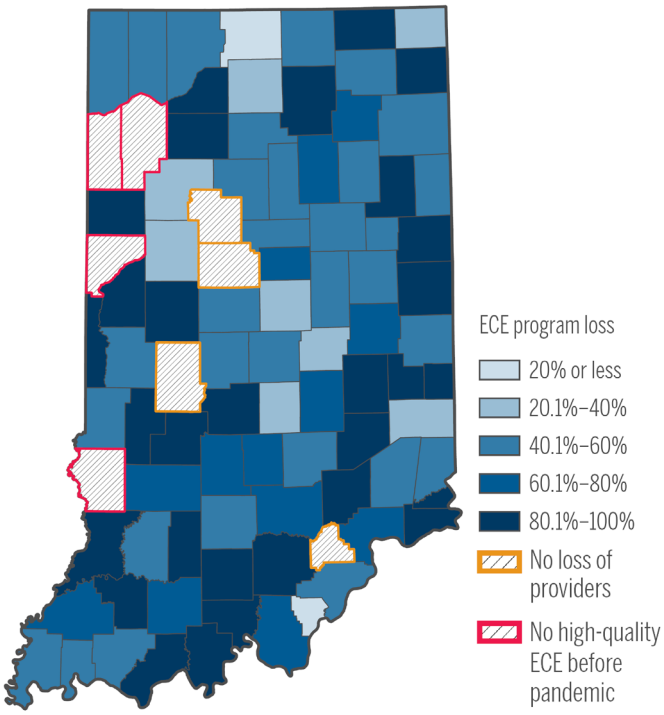
The COVID-19 pandemic has compounded these challenges and had a detrimental effect on ECE in Indiana. In an April 2020 survey, two-thirds of the state's more than 1,000 ECE programs indicated that one or more families had removed their children from child care.[35] Three in five programs surveyed stated they expect a long-term reduction in enrollment, posing a major challenge to organizations.[35] As seen in Figure 3, most counties lost between 50%–100% of high-quality ECE providers at the onset of the COVID-19 pandemic. Counties highlighted in yellow did not lose providers during this time, while those in red had no high-quality ECE providers prior to COVID-19. The decline in ECE enrollment seen due to the pandemic has caused a large decrease in ECE workers nationally. The Bureau of Labor

L Sample included pre-K teachers (N=281), early elementary (grades K-3) teachers (N=175), and child care workers at child care centers (N=166).

M The Indiana ELAC reports an annual count of unduplicated children on the CCDF waitlist during the course of a year, whereas the Indiana FSSA reports a point-in-time count. As of February 2021, there were 3,726 of children on the CCDF waiting list. It is unclear if the total on the CCDF waiting list for 2021 will exceed previous CCDF waiting list yearly totals.

Statistics estimates that the national number of child care workers dropped from more than 1 million in February 2020 to an estimated 876,000 workers in February 2021.[36] Cost increases have complicated ECE for both parents and providers. The Center for American Progress estimates that the true cost of ECE in the midst of COVID-19 has increased 47%, with the cost burdens being particularly high for children 3 and older and children enrolled in family child care.[37] Additionally, issues with spatial equity worsened during the COVID-19 pandemic, as 29 Indiana counties had no high-quality ECE options, up from four counties in early 2020 (Figure 3).[35]

FIGURE 3. Percentage of high-quality ECE programs lost (April 20, 2020–June 30, 2020)[35]



Despite these barriers and COVID-19 related challenges, policy makers have many options at the federal and local level to improve child care for families, both in CCDF-related policy and other programs. At the state level, Indiana policy makers should adopt a more lenient criteria during eligibility and redetermination to ensure that working families' CCDF vouchers are not terminated due to pay fluctuation and increasing subsidy stability.[38] At the national level, policy makers should contemplate a CCDF model that works similarly to the Military Child Care Act of 1989, where copays are determined on a sliding scale based on income.[39] This would expand CCDF benefits and avoid creating a benefits cliff for working families with incomes slightly above 85% of median state income. However, it is essential to note that a more expansive eligibility criteria would first require a larger allocation of funds, a greater number of CCDF slots, and a larger number of CCDF-participating providers.

Local policy developments, such as On My Way Pre-K (OMWPK), have more potential to successfully integrate 2Gen principles into ECE expansions. OMWPK began as a a state-funded pre-kindergarten program in 2014. The first five counties to pilot the program included Allen, Jackson, Lake, Marion, and Vanderburgh counties.[40] OMWPK designates vouchers to high-quality ECE centers, facilitating child progression into K–12 schooling. OMWPK replaced the Early Education Matching Grant, and later expanded statewide in 2019, eventually absorbing the Indianapolis Preschool Scholarship Program in 2020. OMWPK has more broad eligibility criteria than many Indiana social services, as families with a 4-year-old child and an income 127% of federal poverty level eligible.[40] Additionally, in 2019, families with an income between 127% and 185% of the federal poverty level became eligible for a limited number of OMWPK vouchers.[41] The guaranteed voucher structure of OMWPK after enrollment allows for flexible workforce development activities for parents; however, at eligibility, OMWPK has similar work eligibility requirements to CCDF, which can pose a barrier in accessing child care for parents who are unemployed or have barriers in accessing employment.[41] Policy makers should consider changing work eligibility requirements to provide greater flexibility to parents.

2GEN NEEDS AND COALITION BUILDING

Needs assessment of barriers in Indiana

Pathways to helping Hoosier families attain financial stability and self-sufficiency can look differently across Indiana. Different communities face unique needs and set of challenges. For example, employment and transportation initiatives might require different types of assistance or strategies in an urban area, such as Indianapolis, compared to a rural area in Indiana. Other key demographics—such as age, race, ethnic, and cultural composition—may also play a role in community needs. Therefore, it is important for policy makers looking to pass overarching legislation to conduct needs assessments to identify how certain programs and initiatives need to be tailored to the challenges faced by different communities in Indiana.

These types of assessments could also help public and nonprofit agencies identify ways to streamline their services, such as simplifying an application process or working with other agencies to integrate their services. Legislation pursued in Indiana should ultimately be informed by families, organizations, and agencies that work directly with the current services available to gain an accurate picture of the barriers beyond administrative control. In addition to gaining a first-hand understanding of barriers, families must also inform what would work as effective incentives for program involvement and retention. The Indiana State Health Assessment and Improvement Plan is an excellent example of a robust needs assessment commissioned by the Indiana State Department of Health to identify key issues faced by communities in Indiana. Delving deeper into how these issues vary by sociodemographic factors can help develop more effective programs and policies that target needs of communities.

Creation of 2Gen commission in Indiana

Maryland and Washington, D.C., created a commission to advance 2Gen policies, principles, and practices at the highest level of government. In Maryland, a 2Gen commission was formed by HB 1363.[42] Maryland's Two Generation Family Economic Security Commission is charged with the following:

1. Identify services and policies within state programs that can be coordinated to support a multigenerational approach.
2. Identify program and service gaps and inconsistencies among federal, state, and local policies.
3. Identify, test, and recommend best practices at federal, state, and local levels by implementing pilot programs in partnerships with relevant local jurisdictions, agencies, and departments.
4. Solicit input and guidance regarding 2Gen approach practices and policies from external sources with direct knowledge and experience in the field of multigenerational poverty including, but not limited to, 2Gen approach practicing states, federal and Maryland agencies, private foundations, community-action partnerships, and welfare-advocacy organizations.

Adopting a similar approach in Indiana could help restructure and facilitate more effective coordination of 2Gen programming. Specifically, a 2Gen commission that integrates the perspectives of multiple stakeholders, including public and private entities. The commission can help to inform the work of 2Gen in a strategic and sustainable way—such as evaluating the effectiveness of programming, learning about barriers to success, and sharing best practices with the broader community to better adapt to ongoing needs. This should also include service recipients as stakeholders in the decision-making process to better understand and incorporate their experiences. For example, the Governor's Workforce Cabinet can execute similar responsibilities as the Maryland 2Gen commission. This cabinet leverages cross-sectional partnerships to address the employment and educational needs of both individuals and employers while also building a productive and engaged workforce. Building on these foundational structures can help address whole family's needs and elevate 2Gen efforts.[43]

ADMINISTRATIVE CHANGES TO ENHANCE 2GEN PROGRAMMING

CO-LOCATION AND INTEGRATION OF SERVICES

Co-location is when several services are administered or housed in a single location or facility. A co-location of service model can involve a shared physical space and resources, as well as partnerships with other health and human service agencies. Co-location of services can improve access to care, streamline referral processes, and improve interagency communication and collaboration, especially for programs with multiple shared goals for family and child outcomes.[44] In addition to patient-related barriers (e.g., a lack of health care insurance), studies have shown that service fragmentation is a fundamental institutional barrier to care and a contributing factor to underutilization.[45] Service fragmentation happens when services are offered at separate locations or departments and/or have different application processes.[44] In Central Indiana, for example, to qualify for CCDF funding for On My Way Pre-K and other child care assistance, parents must be working, going to school, or have a referral from the Department of Child Services (DCS) or a TANF/IMPACT caseworker.[46] Utilizing a co-location service model can help parents looking for work while also providing a direct pipeline to enroll their child in pre-K.

Services offered through a co-location service model depend on community needs and programmatic goals. Humbolt County, California, is an early example of the integration of health and human services. The county offers co-located care for mental health, public health, and employment training programs.[42] Part of Humbolt County's successful model implementation included integrating funding streams, shared objectives, and approaching health through a whole-person care perspective.[44]

Co-located programs can be an efficient way to connect and refer families to service providers. However, if services are operating independently, families can slip through the cracks.[46] It is also important to keep in mind that co-located care can either reduce stigma or inadvertently increase perceptions of stigma by offering multiple behavioral primary and behavioral health care services on a single location.[44] Education can be a useful tool for mitigating perceptions of stigma.[12,43]

Implementing a co-location services model can be done at the administrative level and further incentivized through legislation. A joint user agreement, for example, is a formal agreement between two government entities to share a facility for multiple services.[48] State legislation can also appropriate funds to encourage the delivery of services through an integrated and comprehensive health and human services system. If human service agencies and programs cannot adopt a co-location service model, developing strategies for seamless integration can promote service access and utilization. Although not a co-located program, the FSSA administered service Indiana 211 line is a free information source that connects Hoosiers to social service providers in their local communities.[49] The Indiana 211 line provides the basis for implementing the "No Wrong Door" policy, which is a simplified process where individuals can learn about available options for care and get connected to services to address their needs regardless of which agency they reach first.[50]

DATA SHARING

One major limitation of the Indiana FSSA is the lack of comprehensive data sharing between separate organizations within the FSSA. Despite having a vast array of programmatic data, the Indiana FSSA often lacks the holistic data sharing and integration necessary to evaluate programmatic outcomes. For example, system-level coordination between child care providers is a concern, as there are three separate organizations that collect ECE-related data for children, including the FSSA's Office of Early Childhood and Out-of-School Learning, Early Learning Indiana, and the Indiana Department of Education (IDOE).[28] The lack of data integration inhibits the Indiana ELAC from assembling a unduplicated total count of children in ECE.[28] Administrators need information to prioritize holistic solutions that address the social determinants of health in Indiana. Comprehensive, consolidated data from programming is a necessity, and policy makers should consider issues of data capacity and integration as an essential element of the 2Gen framework.

DISCUSSION

Both the social determinants of health (SDOH) and 2Gen philosophies consider the role one's environment plays in shaping access to opportunities, outcomes, and overall quality of life. Further, they recognize the importance of addressing whole-family needs. Having a keen understanding of SDOH when developing programs and policies can help policy makers create legislation that leads to more equitable outcomes and increase quality of life for all Hoosiers. Ultimately, this helps to eliminate disparities, maintain health parity, and create a healthier population, society, and workforce. Further, race, ethnic background, gender, income level, and other sociodemographic characteristics are significant predictors to access or lack thereof in services that improve quality of life. Policy efforts that advance 2Gen initiatives must be crafted to ensure both equitable resource distribution and family outcomes, as well as address the compounding impact of exclusion and discrimination in social service systems.

It is also important to leverage lessons from the implementation of other 2Gen programs. For example, families participating in the GF2020 program were assigned a coach who connected them with appropriate service providers through warm referrals. While this model is not feasible for all social services administered by public and nonprofit agencies, streamlining the steps taken to access services through a co-location service model or programmatic service integration can increase satisfaction and utilization of services.

FIGURE 4. Policies to advance 2Gen programming in Indiana

POLICY RECOMMENDATIONS

WORKFORCE

- **IMPACT:** Eliminate barriers to employment by incorporating a referral system into IMPACT services.
- **TANF reform:** Increase TANF benefit levels and applicability by enacting SB 233 and/or HB1009.
- **Transportation access:** Encourage investment in reliable public transportation and avoid future legislative efforts, such as SB 141, which seek to reduce state transportation funding.

MENTAL HEALTH

- **Parity statutes:** Strengthen enforcement of state parity statutes to reduce financial burden on families seeking treatment for mental illness and substance use.
- **Mental health funding:** Ensure that mental health and addictions services are properly funded to meet the needs of Hoosiers.
- **Insurance coverage:** Expand and promote equitable mental health insurance coverage by enacting legislation similar to HB 1153.
- **Stigma:** Address stigma through education and public outreach
- **Family-centered perspective:** Incorporate family-centered approaches to services

ECE

- **ECE funding:** Increase state and federal ECE funds to increase compensation for a high-quality ECE workforce, address child care provider shortages, and expand child care accessibility.
- **Expanding eligibility:** Adopt more lenient criteria during eligibility and redetermination to ensure that working families' CCDF vouchers are not terminated due to pay fluctuation, and increasing subsidy stability.

STREAMLINING SERVICES

1 CO-LOCATION & INTEGRATION OF SERVICES

Co-located programs can be an efficient way to streamline processes and improve interagency collaboration

2 DATA SHARING & COOPERATION

Building data capacity and integration into programmatic decision making is essential

3 EQUITY CONSIDERATIONS IN 2GEN

Policy efforts must address equitable resource distribution and family outcomes

CREATION OF 2GEN COMISSION

A 2Gen commission would build a coalition to integrate the perspectives of multiple stakeholders, including public and private entities. The commission can help inform 2Gen work in a strategic and sustainable way—such as evaluating the effectiveness of programming, learning about barriers to success, sharing best practices with the broader community, and better adapting to ongoing needs.

The bills referenced in this brief were under consideration at the time of this brief was written on April 15, 2021. The information in the brief should be interpreted with this in mind. There may be upcoming changes that are not reflected in this brief.

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PREPARED BY
Roxann Lawrence, *Director of Evaluation*
Jacob Purcell, *Research Assistant*
Rachell Peña, *Research Assistant*
Karla Camacho-Reyes, *Special Projects Coordinator*

101 W. Ohio Street, Suite 400
Indianapolis, IN 46204

Phone: (317) 278-1305
Email: iucrisp@iu.edu
go.iu.edu/CRISP

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