

Introduction to a Phased Abolition and Reform Approach

The “family policing system,” often referring to traditional child protective services (CPS) models, has been criticized for its punitive, surveillance-oriented approach that disproportionately targets low-income and marginalized families—particularly Black and Indigenous ones—leading to unnecessary family separations rather than support. Advocates for abolition argue that this system conflates poverty with neglect, perpetuates racial inequities, and fails to address root causes of family stress, such as economic instability or lack of resources. Instead, a more effective child welfare approach would prioritize prevention, community empowerment, and family preservation while phasing out coercive interventions.

A phased abolition involves gradually dismantling investigative and removal powers while simultaneously building supportive alternatives to ensure child safety isn’t compromised during transition. This requires a multitiered strategy: short-term reforms to reduce harm, medium-term pilots of new models, and long-term systemic shifts toward non-punitive supports. Priorities should draw from abolitionist frameworks like those from the upEND Movement and scholars such as Dorothy Roberts, balanced with evidence from differential response systems and public health models. Below, I outline key models and policies as priorities, substantiated by research and ongoing initiatives.

Priority Models for a Supportive Child Welfare Approach

These models shift from adversarial investigations to collaborative, strengths-based supports that empower families and communities. They can be implemented in phases: starting with pilots in high-need areas, scaling based on evaluations, and eventually replacing CPS functions.

1. Community-Based Prevention and Support Networks:

- **Description:** Establish local, voluntary hubs where families can access resources like food, housing assistance, mental health counseling, and parenting education without fear of reporting or removal. These could be run by community organizations, mutual aid groups, or non-profits, emphasizing cultural competence and peer support from those with lived experience.
- **Why a Priority:** Current systems often intervene after crises; prevention addresses root causes like poverty, reducing “neglect” reports by up to 50% in some pilots. This aligns with abolition by building “care webs” that replace policing with solidarity.
- **Phased Implementation:** Begin by funding community-led “warmlines” (non-emergency helplines) as alternatives to CPS hotlines, then expand to neighborhood resource centers. Evidence from programs like New York’s Family Enrichment Centers shows improved family stability without increased risk to children.

2. Differential or Alternative Response Systems:

- **Description:** For non-severe reports, use a non-investigative track focused on family needs assessment and voluntary services, rather than substantiation of abuse/neglect. High-risk cases (e.g., physical harm) could still involve limited intervention, but with family input and appeals.
- **Why a Priority:** Traditional CPS is coercive and stigmatizing; alternative responses have reduced re-reports and removals while maintaining safety, with studies showing better family outcomes in states like Minnesota and Ohio. This model bridges reform and abolition by de-emphasizing policing.
- **Phased Implementation:** Roll out in waves, starting with low-risk cases (e.g., poverty-related neglect), monitoring via independent evaluations to ensure no safety gaps. Integrate with public health frameworks that treat child well-being as a community issue, not a family fault.

3. Restorative and Family-Centered Mediation Models:

- **Description:** Use trauma-informed mediation for conflicts, including domestic violence or custody disputes, prioritizing healing over punishment. This includes supervised visitation, co-parenting education, and restorative circles involving extended family or community elders.
- **Why a Priority:** Adversarial courts exacerbate trauma; restorative approaches reduce recidivism and promote equity, especially for families of color over-policed by CPS. They also address critiques that abolition ignores real harm by focusing on accountability without separation.
- **Phased Implementation:** Pilot in family courts with presumptive joint custody (except in proven abuse cases), expanding to include incentives for foster care alternatives like kinship placements.

Priority Policies to Enable Transition and Effectiveness

Policies should focus on upstream prevention, equity, and accountability, with built-in safeguards like data transparency and family involvement in oversight.

1. Economic and Material Supports to Combat Poverty-Driven Interventions:

- **Description:** Expand universal basic income pilots, housing vouchers, child tax credits, and food/security programs targeted at at-risk families. Tie these to child welfare by redirecting CPS budgets (e.g., from investigations to cash transfers).
- **Why a Priority:** Poverty is mislabeled as neglect in 70-80% of cases; direct aid reduces reports and separations, as seen in pandemic-era experiments where reduced surveillance didn't increase harm. This is core to abolition, shrinking the system's reach.

- **Phased Implementation:** Start with federal reforms like reauthorizing Title IV-B for prevention, then state-level mandates to assess economic needs before any intervention.

2. Racial Equity and Anti-Discrimination Reforms:

- **Description:** Mandate bias training, data collection on disparities, and community oversight boards with veto power over removals. Repeal or narrow mandatory reporting laws that lead to over-surveillance of marginalized groups.
- **Why a Priority:** Black children are removed at rates 2-3 times higher than white peers; equity-focused policies reduce this while building trust. Critics note that without these, abolition risks uneven application.
- **Phased Implementation:** Immediate audits of current cases for bias, followed by legislative changes like California's equity assessments, scaling nationally.

3. Investment in Mental Health and Holistic Family Supports:

- **Description:** Fund integrated care models (e.g., wraparound services for mental health, addiction, and domestic violence) and incentives for schools/community programs to reduce expulsions and build resilience.
- **Why a Priority:** Trauma and unmet needs drive many interventions; holistic supports improve outcomes without coercion, as in models like Integrated Care for Kids.
- **Phased Implementation:** Redirect 15-20% of CPS budgets annually to these services, with evaluations tracking safety metrics.

Considerations for Phased Abolition

To avoid risks, phase out coercive elements (e.g., mandatory removals) only after alternatives are robust: Year 1-2 for pilots and training; Year 3-5 for scaling and budget reallocation; ongoing for evaluation. Diverse stakeholders—including survivors, parents, and child advocates—must co-design to represent all views, acknowledging that while abolition is aspirational, interim protections for severe abuse (e.g., via specialized courts) are essential. This approach, if well-substantiated, can create safer, more equitable outcomes for children and families.

Changing the Child and Family Well-being Paradigm to a Human Health Perspective, not Family Policing Function

Integration of child and family well-being into the health system as a cooperative, non-adversarial alternative could be significantly better than relying on police and courts in a scaled abolition of the legacy family policing system. This shift aligns with growing calls from abolitionists, public health experts, and reformers to reframe child welfare as a public health issue rather than a punitive or prosecutorial one, emphasizing prevention, family empowerment, and community supports over investigations, civil prosecutions, and parental rights terminations. However, this approach isn't without challenges, such as ensuring robust responses to acute harm and avoiding the medicalization of social problems. Below, I'll outline why this could be preferable, drawing on evidence from reform efforts, while addressing potential drawbacks and implementation strategies in a phased context.

Why a Public Health-Integrated Approach Could Be Better

The legacy system's ties to courts and police often exacerbate family trauma through mandatory reporting, coercive interventions, and disproportionate impacts on marginalized communities, leading to unnecessary separations in cases driven by poverty rather than malice. By contrast, embedding child well-being in the health system—through primary care, behavioral health services, and population-level prevention—promotes a cooperative model that treats family challenges as health determinants, similar to how public health addresses issues like substance use or mental health crises. This could reduce the “benevolent terror” of surveillance, where families avoid seeking help for fear of losing children, and instead foster voluntary engagement with resources like parenting support, economic aid, and trauma-informed care.

Key advantages include:

- **Prevention Over Reaction:** Public health models use data-driven, upstream interventions (e.g., universal screenings in pediatric visits or community health worker programs) to identify and address risks early, potentially preventing 70-80% of cases tied to neglect from escalating to removals. For instance, initiatives like those from Casey Family Programs integrate child welfare with health systems to allocate resources equitably, showing improved family stability without increased child harm.
- **Holistic and Family-Centered:** Health systems can wrap around families with integrated services (e.g., Medicaid-funded behavioral health or home visiting programs), addressing interconnected issues like housing instability or parental mental health, which courts often overlook in favor of adversarial proceedings. Studies comparing foster care to family preservation demonstrate better long-term outcomes for children kept at home with supports, including lower rates of delinquency and higher educational attainment.
- **Equity and Reduced Stigma:** Shifting away from policing logic disrupts racial biases inherent in court-based systems, where Black and Indigenous families face higher removal rates. A health-oriented approach, as advocated in abolitionist frameworks like upEND, builds trust through

community-led mutual aid and voluntary services, potentially shrinking the system's footprint by redirecting funds from investigations to concrete resources.

- **Cost-Effectiveness and Scalability:** Evidence from pilots integrating child welfare with Medicaid or primary care shows reduced recidivism and system involvement, freeing up resources for broader well-being investments. This fits scaled abolition by phasing out court mandates while scaling health-based alternatives, as seen in recent state reforms emphasizing prevention over prosecution.

Potential Drawbacks and Mitigations

While promising, this integration isn't a panacea and must be balanced against criticisms. One concern is that health systems might not adequately handle severe abuse or violence, where some form of accountability is needed beyond voluntary supports, however, the criminal investigation and prosecution of abuse would be addressed separately as it is now by police and prosecutors. Critics also warn of over-medicalizing family issues, turning social determinants like poverty into "disorders" that pathologize parents rather than addressing systemic inequities. Additionally, fragmented systems could hinder integration, with silos between health, child welfare, and community services causing families to "fall through cracks."

To mitigate these in a phased abolition:

- **Hybrid Safeguards:** Retain limited, trauma-informed judicial oversight for egregious cases (e.g., via specialized health-court hybrids) while prioritizing health-led assessments, ensuring no safety gaps during transition.
- **Community Oversight and Lived Experience:** Involve parents with system experience in designing health integrations, as in federal capacity-building efforts, to avoid biases and emphasize cultural competence.
- **Evaluation and Collaboration:** Use pilots like those preventing system involvement through primary care to monitor outcomes, with cross-agency partnerships (e.g., health and behavioral services) to build seamless supports.

In summary, a health system-integrated approach offers a more humane, effective path forward in abolishing family policing, substantiated by reform evidence showing superior child and family outcomes when coercion is minimized. This doesn't eliminate all risks but represents a paradigm shift toward true well-being, provided it's implemented thoughtfully with diverse stakeholder input.

Analysis of Individual Agency Impact on Child Maltreatment Fatalities

Yes, it is likely that no individual child welfare agency—such as a state or local Child Protective Services (CPS) entity—can reasonably reduce the annual number of child maltreatment deaths (approximately 1,900–2,000 in recent years) in a substantial or sustained way on its own. This is because maltreatment fatalities are influenced by multifaceted factors beyond the scope of any single agency’s investigative or intervention powers, including underreporting, inconsistent definitions across states, and root causes like poverty, substance abuse, and mental health issues that often precede agency involvement. National trends show that while overall child victimization rates (e.g., substantiated abuse and neglect) have declined modestly since the 1990s, fatality rates have remained relatively stable at around 2.2–2.7 per 100,000 children, suggesting limited agency-driven progress despite increased reporting and interventions.

Individual agencies face structural limitations: Many fatalities (up to 50% in some estimates) occur in families unknown to CPS prior to the incident, limiting preventive reach. Even among known cases, evidence on CPS effectiveness is mixed; while targeted programs like home visiting or abusive head trauma prevention can avert some deaths, broader agency efforts often fail to lower rates significantly due to resource constraints, high caseloads, and reactive rather than proactive models.

Studies testing CPS involvement’s impact on fatality risk among at-risk children show no clear preventive effect, and methodological challenges in using homicide rates as proxies for agency success highlight that isolated reforms (e.g., better training or reviews) yield only marginal reductions without systemic support. Publicized fatalities can temporarily increase removals but don’t sustain lower death rates, underscoring that agencies alone can’t address upstream determinants.

Potential of a Population Health Approach Focused on Economic Hardship and Inequalities

Yes, it is more likely that replacing the legacy child welfare system with a population health approach—emphasizing upstream prevention through reducing economic hardship and inequalities—would improve child safety and well-being more effectively than relying on individual agencies’ punitive or investigative models. This framework treats child maltreatment as a public health issue, using data-driven, community-wide strategies to address social determinants like poverty, which drive 70–80% of neglect cases (the leading maltreatment type linked to fatalities). By integrating economic supports (e.g., cash transfers, child tax credits, housing subsidies) with health services, early education, and norm-changing initiatives, this approach has shown greater potential to lower maltreatment rates, including fatalities, compared to the legacy system’s focus on post-incident responses.

Evidence supports this shift: Economic supports like the Earned Income Tax Credit (EITC), Temporary Assistance for Needy Families (TANF), and childcare subsidies have been linked to 10–20% reductions in maltreatment reports and CPS involvement, with effects strongest in low-income

families. For instance, modest increases in child support income (\$100/year) decrease screened-in reports, while negative economic shocks (e.g., earnings drops) raise CPS likelihood by 18%. Neighborhood poverty correlates with higher maltreatment risks, but interventions like family resource centers yield cost savings (\$1.8 billion annually nationally) through reduced abuse. Population health models, such as CDC's framework or initiatives like Thriving Families, Safer Children, incorporate these by aligning stakeholders (health departments, communities) to prevent involvement altogether, showing declines in victimization where implemented. This contrasts with legacy systems, where even enhanced CPS efforts struggle against inequalities, and could avert the \$80–124 billion annual economic burden of maltreatment.

While challenges like ensuring accountability for severe cases persist, the evidence indicates this holistic, equity-focused replacement would yield better outcomes by addressing root causes at scale, rather than isolated agency fixes.

the concept of child and family well-being is best considered within the context of the nation's health system rather than treating neglect as a civil offense that relies on courts to separate parents from their parental rights. This perspective is supported by a growing body of public health research, policy frameworks, and expert analyses that emphasize prevention, equity, and holistic support over punitive measures, which often exacerbate family trauma and systemic inequalities without significantly improving outcomes. Reframing neglect—frequently tied to poverty, mental health challenges, or resource shortages—as a public health issue allows for upstream interventions that address root causes, promote family stability, and reduce long-term societal costs, while still incorporating safeguards for severe cases. Below, I outline the key reasons for this preference, drawing on evidence from health organizations and studies, while addressing potential counterpoints for balance.

Advantages of a Health System Context for Child and Family Well-Being

1. Emphasis on Prevention and Upstream Interventions:

- Traditional court-based approaches are reactive, intervening after harm occurs through investigations, civil proceedings, and potential parental rights terminations, which can lead to unnecessary family separations in up to 70-80% of neglect cases driven by socioeconomic factors rather than intentional abuse. In contrast, a public health model treats maltreatment as preventable through community-wide strategies, such as strengthening economic supports (e.g., housing subsidies or child tax credits), providing universal access to mental health services, and implementing home visiting programs that build parental resilience before crises escalate. For example, the CDC's public health strategy for child abuse and neglect focuses on data-driven prevention, including norms-changing campaigns and family treatment to mitigate health consequences, which has shown promise in reducing recurrence and long-term impacts like chronic diseases or criminal involvement.

2. Promotion of Equity and Reduction of Systemic Bias:

- Court systems disproportionately affect families of color and low-income households, with neglect often conflated with poverty, leading to stigmatization and higher rates of removal without addressing underlying issues. A health-oriented framework integrates social determinants of health, such as economic insecurity or access to care, through clinician training and equitable reporting practices that prioritize support over punishment. This approach aligns with global health standards, where maltreatment is viewed as having broad economic and social costs (e.g., hospitalization and lost productivity), and prevention yields better outcomes for marginalized communities.

3. Holistic Support and Long-Term Outcomes:

- Health systems facilitate integrated care, including trauma-informed treatments for children and families, which can halve the risk of future maltreatment and improve educational, behavioral, and physical health trajectories. Unlike adversarial court processes that may deepen emotional scars, public health models encourage voluntary engagement, reducing the “hidden foster care” pitfalls and fostering family preservation. Research indicates that maltreatment doubles crime risks later in life, but preventive health interventions can break this cycle more effectively than legal sanctions.

Potential Concerns and Balanced Considerations

While the evidence leans toward a health system approach, some critiques highlight challenges in implementation. For instance, siloed systems between health, child welfare, and courts can hinder coordination, potentially delaying responses to acute risks like severe abuse. Critics also argue that without judicial oversight, accountability for egregious neglect might weaken, as health models may overlook the need for “justice” in protecting children from ongoing harm. Additionally, task-shifting mental health services to non-specialists in child welfare contexts has faced scrutiny for inconsistent outcomes, though this is more about execution than the model itself.

These concerns can be mitigated through hybrid models that retain limited court involvement for high-risk cases while prioritizing health-led assessments and community oversight. Overall, the current child welfare system’s failures—such as ignoring prevention and perpetuating racial inequities—underscore the need for a paradigm shift to public health, as advocated by organizations like the CDC and WHO, to achieve true well-being for children and families.

adopting a standard foundational view of human health and child well-being—one that emphasizes reducing economic and social inequality—would likely improve coordination and implementation across remaining siloed systems. This unified framework would promote cross-sector integration, shared accountability, and data-driven strategies to address root causes like poverty and disparities, ultimately enhancing efficiency and outcomes in areas such as child welfare, public health,

education, and social services. Evidence from public health models, policy analyses, and cross-sector initiatives supports this, showing that such approaches break down barriers, foster equitable resource allocation, and yield better long-term results for families and communities, though success depends on robust implementation mechanisms like shared leadership and funding reforms.

Below, I outline the key reasons, supported by evidence, while noting potential challenges for a balanced view.

How a Unified Framework Improves Coordination

1. Fosters Cross-Sector Partnerships and Shared Goals:

- A standardized view centered on human health and child well-being encourages partnerships across traditionally siloed sectors (e.g., health care, child welfare, housing, and education) by aligning them under a common theory of change, such as the Life Course Health Development (LCHD) framework. This shifts from reactive interventions to proactive, preventive strategies that address social determinants like economic inequality, improving multidirectional communication and service alignment. For example, initiatives like the Accountable Health Communities Model and All Children Thrive networks integrate services to tackle childhood adversity, resulting in better resource referrals and a ~20% reduction in hospital bed-days for marginalized children in pilots.
- By embedding equity principles—such as targeting vulnerable groups (e.g., low-income or Indigenous families)—these frameworks reduce disparities while enhancing coordination through shared leadership and trust-building relational structures.

2. Enhances Data Sharing and Policy Integration:

- Silos often arise from fragmented data and mismatched priorities; a unified framework promotes linked data platforms, indicator sets, and child impact assessments (CIAs) to create a shared evidence base, making inequalities visible and enabling coordinated responses. In OECD countries with integrated child well-being plans (e.g., Australia, Finland), this has led to better policy coherence, with tools like disaggregated indicators highlighting socio-economic gaps and guiding resource allocation across sectors. Similarly, U.S. efforts under Public Health 3.0 and state health-housing initiatives have broken data silos through interoperability, improving service delivery for families facing economic hardship.

3. Supports Innovative Funding and Implementation:

- Emphasizing inequality reduction allows for alternative funding models, such as braided streams or shared savings, to overcome “wrong-pocket” issues where one sector invests but another benefits. Primary prevention approaches, like those redirecting child welfare funds to community supports, have shown high ROI (e.g., \$25 saved per \$1 invested) by coordinating early interventions that address economic stressors, reducing the need for siloed crisis responses. Global frameworks, such

as WHO's well-being implementation guide, advocate for equitable social protection systems that integrate across silos to prevent poverty and promote health equity.

Evidence of Effectiveness

- In practice, frameworks like OECD's integrated child policy plans (adopted by 21 of 34 countries) have improved coordination by focusing on cross-cutting issues like mental health and maltreatment, with evidence from evaluations showing reduced inequalities through targeted vulnerable group support.
- U.S. examples, including the Family First Prevention Services Act and cross-state health-housing collaborations, demonstrate that addressing social determinants via unified views leads to better outcomes, such as decreased family separations and improved access for low-income groups.
- Broader public health models, like those dismantling silos in adversity response, highlight benefits including cost savings and enhanced equity, with integrated care reducing barriers for marginalized families.

Potential Challenges and Mitigations

While promising, challenges include resistance to change, resource constraints, and ensuring inclusive stakeholder involvement (e.g., families with lived experience). Mitigations involve phased implementation with evaluations, as in OECD recommendations for streamlining coordination entities and prioritizing key issues, to build buy-in and sustain progress. Overall, this approach represents a substantive step toward more effective, equitable systems.

Yes, addressing the well-understood failures of the DSM-based mental health system would indeed be a critical component of an all-of-government approach to replacing failed legacy systems like child welfare and DSM-reliant mental health frameworks with a human rights-based model, akin to the World Health Organization's (WHO) recent guidance on five modules for mental health policy reform. This integration is essential because both systems perpetuate similar harms—such as over-medicalization, racial and socioeconomic biases, and coercive interventions that violate rights—while ignoring upstream social determinants like inequality and poverty. A unified, rights-centered paradigm, as advocated by the United Nations (UN) and WHO, could foster cross-sector coordination, preventive supports, and equity, but only if DSM critiques are explicitly confronted to avoid replicating pathologizing logics in new structures. Below, I break this down with evidence from reform calls, system failures, and implementation pathways.

Failures of the DSM-Based System and Their Parallels to Child Welfare

The DSM (Diagnostic and Statistical Manual of Mental Disorders), now in its fifth edition (DSM-5), has been widely criticized for its biomedical dominance, which reduces complex human experiences

to categorical diagnoses often detached from social, cultural, or environmental contexts. Key failures include:

- **False Positives and Over-Diagnosis:** The DSM's expansive criteria contribute to pathologizing normal variations in behavior, leading to unnecessary labeling and treatment. For instance, critiques highlight how it inflates prevalence rates (e.g., ADHD or depression) without improving outcomes, creating a "false positives problem" that burdens individuals with stigma and ineffective interventions. This mirrors child welfare's tendency to conflate poverty with neglect, resulting in disproportionate family separations rather than support.
- **Biases and Power Imbalances:** The system embeds cultural, racial, and gender biases, disproportionately affecting marginalized groups by framing structural issues (e.g., trauma from racism or economic stress) as individual disorders. Similarly, child welfare systems exhibit racial disparities in removals, treating family challenges as personal failings.
- **Neglect of Social Determinants:** By prioritizing biological explanations, the DSM ignores root causes like inequality, leading to coercive treatments (e.g., involuntary hospitalization) that violate autonomy and fail to address recovery holistically. This parallels child welfare's punitive focus, where economic hardship is mislabeled as parental inadequacy.

These shortcomings have prompted UN and WHO calls for radical reform or even abolition of coercive psychiatric models, emphasizing a "revolution" away from biomedical dominance toward rights-respecting, community-based care. Ignoring them in broader reforms risks entrenching similar flaws in successor systems.

Role in an All-of-Government Human Rights-Based Approach

An all-of-government strategy—involving coordinated federal, state, and local efforts across health, justice, education, and social services—would benefit from centering DSM critiques to build a cohesive, preventive framework. This aligns with UN/WHO advocacy for human rights-based approaches that prioritize dignity, non-discrimination, participation, and accountability, shifting from coercion to empowerment.

- **Integration with Child Welfare Reform:** Both systems intersect in cases involving parental mental health or child trauma; addressing DSM flaws could prevent misdiagnoses that fuel unnecessary removals, instead promoting family preservation through rights-respecting supports like peer-led recovery and economic aid.
- **Alignment with WHO's Five Modules:** The WHO's 2025 guidance on mental health policy and strategic action plans outlines five modules to guide rights-based transformations: (1) Introduction and purpose, emphasizing human rights alignment; (2) Context analysis for evidence-based planning; (3) Policy development with stakeholder involvement; (4) Strategic action plans for implementation; and (5) Monitoring and evaluation for accountability. Extending this to child

welfare could involve adapting modules for integrated reforms, such as assessing social determinants in policy (Module 2) and evaluating equity in outcomes (Module 5), while critiquing DSM to ensure non-pathologizing assessments.

Challenges and Pathways Forward

While critical, this component requires safeguards against resistance from entrenched biomedical interests or incomplete implementation, which could recreate silos or biases. Pathways include phased pilots (e.g., community-led programs blending mental health and child supports), federal funding reallocations, and training in rights-based practices, as seen in successful HRBA initiatives.

Ultimately, this holistic shift could yield more effective, dignified outcomes, substantiating UN/WHO visions for systemic change

Implications for Criminal Prosecution of Child Abuse Offences after Abolition of the Legacy Child Welfare System

Abolishing the punitive, surveillance-heavy legacy child welfare system (including CPS investigations and family courts for non-criminal matters) would not compromise responses to physical and sexual abuse, as these are already—and would continue to be—handled via criminal investigations and prosecutions. This aligns with abolitionist frameworks, such as those from the upEND Movement, which argue for dismantling coercive elements while preserving (and reforming) criminal accountability for intentional harm. Key considerations include:

- **Continuation and Enhancement of Criminal Functions:** Police and criminal courts would retain jurisdiction over abuse cases, potentially with improved protocols (e.g., trauma-informed investigations and multidisciplinary teams involving health professionals) to reduce re-traumatization. Fatalities linked to abuse could trigger homicide charges, ensuring deterrence without relying on CPS for prevention.
- **Shift for Majority Neglect Cases:** With neglect comprising 74–76% of reports, abolition would redirect these to non-punitive, public health-oriented supports (e.g., economic aid, mental health services, and community resources) to prevent escalation, as discussed in prior responses. This could reduce overall system involvement and fatalities by addressing root causes like poverty, without conflating them with criminality.
- **Safeguards and Equity:** To avoid gaps, phased abolition should include clear thresholds for criminal referrals (e.g., evidence of intent or injury), bias training for law enforcement, and independent oversight to mitigate disparities in prosecutions (e.g., over-policing of marginalized families). Evidence suggests this hybrid model—criminal for harm, supportive for needs—could lower recidivism and improve well-being more effectively than the current dual system.

In essence, retaining criminal pathways for the minority of severe cases enables a safer, more equitable transition to abolition, focusing resources on prevention rather than policing families.