

# NAPCWA

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National Association of Public  
Child Welfare Administrators

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an affiliate of the American Public Human Services Association

## **Disproportionate Representation in the Child Welfare System: *Emerging Promising Practices Survey***

***March 2006***

National Association of Public Child Welfare Administrators  
*an affiliate of the American Public Human Services Association*

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## Acknowledgments

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## Executive Summary

Disproportionate representation, sometimes called overrepresentation or racial disparity, is evident in child welfare agencies across the nation. Minority children and families are overrepresented, relative to White children and families, at key decision points in child welfare agencies. While the problem has received much attention, the solutions are harder to come by.

Many child welfare agencies are addressing the issue head on, while others are in the early stages of tackling the issues in their own jurisdiction. The National Association of Public Child Welfare Administrators (NAPCWA) believed it important to have some sense of the work that is already being done, whether or not it is specifically being done to mitigate disproportionate representation. This survey requested information about a state's use of over 40 practices that have been deemed "promising practices" by various groups and researchers.

The practices were divided into societal, system, and individual levels, and the system level was subdivided into practice and policy areas. Child welfare agencies have various spheres of influence and generally have the most dramatic impact on and involvement with the system level, but all are important to reducing racial disparities within the system.

In Fall 2005, child welfare directors in all 50 states and the District of Columbia were sent surveys asking which of the practices they had in place; 31 responded (61%). They were asked how widespread the practices were (statewide, multi-jurisdiction, or limited) and how supported the practices were with regard to staff levels, funding, and other issues (comprehensively, moderately, or minimally).

The relative rate index<sup>1</sup> was calculated for each ethnic group identified by the 2000 Census in each state for the children in care. The states were divided into quartiles for each ethnic group, with those having the lowest relative rate indexes in Quartile 1, and those with the highest in Quartile 4. Using the Black relative rate index as an example, the state where Black children were least likely to be in care—a relative rate index of 1.58, meaning a Black child is 1.58 times more likely to be in care than a White child—is a Quartile 1 state. In Quartile 4, a Black child is at least 6.09 times more likely to be in care than a White child.

The survey responses were compared to the quartiles to produce a general picture of efforts to mitigate disproportionality. This descriptive data does not demonstrate that particular practices are effective in reducing disproportionality. Most often, the information referred to is for state quartile rankings related to Black children as they are the most affected ethnic minority group.

### Key Observations

- States with higher relative rate indices for Black children were more likely to have more of the practices in place. Of the five respondent states from Quartile 4, four of them had 39 or 40 practices out of 42 listed practices; no other states had 40 practices.

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<sup>1</sup> The relative rate is the ratio of the proportion of a particular ethnic group in the general population to the proportion of the ethnic group at a particular decision point.

- States with the highest relative rate indices for both Black and Hispanic children are more likely to have satellite offices.
- Nearly all respondents report having “regular race-based data collection,” the foundation for any intervention program.
- States with the lowest rates of disproportionate representation for both Black and Hispanic children are more likely to have dependency drug courts. Quartile 1 and 2 states are also more likely to have focused or limited programs, while three Quartile 3 and 4 states have statewide dependency drug courts.
- Seven of nine Quartile 4 states relative to Black children have subsidized guardianship, while only one of six Quartile 1 states have the program.
- States with a lower relative rate index for Black children had less widespread practices.
- The states with the lowest relative rate indices are more likely to have cultural competence training.

## **Recommendations**

The results of this survey demonstrate that there is promising work being done around the country to address disproportionate representation in the system. As described in more detail in the “Conclusions and Recommendations” section of the survey, there is still more work to be done. A thoughtful, comprehensive strategy developed by using sound data analysis and a diagnosis of specific problem areas and strengths, and implemented by strong leaders in an effective organization will produce the best outcomes.

The strategy should address specific decision points in the system, and not just consist of an assortment of “promising practices.” While the goal is to improve outcomes for children and families immediately affected by the practices of a particular jurisdiction, it is also important to use evaluation methods that will contribute to the child welfare field more broadly.

Future research should include evaluations of specific or combinations of practices, the role of strong leadership and effective organizations in using specific practices, and the effect of certain practices for different ethnic minority groups. Both innovative and evidence based practices should be considered when developing plans to address this issue.

# Survey Results

## Impetus for Conducting Survey

The disproportionate representation of minority children in the child welfare system is a widely accepted problem. Though the issue has received the attention of state and local child welfare directors, the federal government, foundations, and child advocacy organizations, the focus has primarily been on the scope of the problem. What is less clear is which practices produce positive outcomes for minority children and families.

There are ample existing studies and analysis of data to indicate the existence of disproportionate representation across the key decision points of the child welfare system. In many systems, there is a “funneling effect,” which means that the percentage of minority representation increases at every step—from referrals, to removal, to exiting the system. The problem is particularly acute for Black children nationwide, though Hispanic and Alaskan Native/American Indian populations experience high rates of disproportionate representation in some jurisdictions.

Six months prior to this survey, we conducted an initial inquiry into what strategies states had implemented to address disproportionality in their state. A number of states responded, and they overwhelmingly acknowledged that they were exploring ways of dealing with the issue but had not implemented a specific strategy.

States were interested in knowing what other states were doing and in implementing best practices, as they are available and known. Based on what the field believes to be emerging practices, we knew that many states had implemented some of these practices for reasons other than addressing disproportionality.

It became clear that gathering baseline data about which emerging practices are in use across the nation could be helpful. This survey is not intended to prove or disprove the use of any particular practice as a strategy or a piece of a strategy to address disproportionality. Rather, it is an overview of what states are doing with regard to practices that have been suggested as possible ways to improve the disproportionate representation of minority children in the child welfare system.

## Assumptions and Survey Development

The primary assumption in conducting this survey was that states are concerned about disproportionality, and though they may not be addressing strategically and systematically, they may still be contributing to reducing it. There are exceptions, of course. Some states and localities have a clear strategy to address disproportionate representation in their system and may, in the future, be able to clearly demonstrate positive results.

The survey is based on practices referred to as “promising” or “emerging” from various sources. As defined by the Guide for Child Welfare Administrators on Evidence Based Practice (Appendix A), most of the practices can be considered at least “promising and acceptable;” we did not include practices that are “concerning.” The list of over 40 practices (Appendix B) includes many programs familiar to child welfare practitioners: from strengths-based assessments to diversity committees to dependency drug courts. However, no matter how widely practiced and accepted, most of these practices have not specifically been studied to determine their effect on disproportionate representation.

The practices listed in the survey were culled from sources, including:

- *Racial Disproportionality in the U.S. Child Welfare System* (AECF Working Paper, 2002)
- *Practices that Mitigate the Effects of Racial/Ethnic Disproportionality in the Child Welfare System* (Casey Family Programs, 2003)
- *Reducing Disproportionality and Disparate Outcomes for Children and Families of Color in the Child Welfare System* (Casey Family Programs, 2005)
- *Crossing the Divide: Asian American Families and the Child Welfare System* (The Coalition for Asian American Children and Families, 2001)
- *Promising Practices: Addressing Racial Disproportionality in the Child Welfare System* (Child Welfare League of America, 2003)
- *Children of Color in the Child Welfare System: Perspectives from the Child Welfare Community* (Department of Health and Human Services, Children's Bureau, Administration for Children and Families, 2003).

Additional recommendations for emerging practices came from child welfare directors, state staff, advocacy group staff, and additional literature reviews.

The practices were divided into areas based on three primary spheres of influence: individual, system, and society. The system sphere was further divided into "Agency Policy and Organization-Wide Issues" and "Direct Practice." The "individual" level refers to the personal experiences and bias that all staff at all levels bring to the workplace and can be addressed through strategies such as cultural competence training. The "system" level refers to the policies and practices that the child welfare system has in place, or is closely involved with, such as dependency drug courts or concurrent planning. The "society" level includes larger societal institutions—e.g., all levels and functions of government, schools, faith-based communities, banking that child welfare may not directly control but in which it should play a role through economic development programs, legislative action, or other strategies.

Child welfare directors have the most control over the system response to disproportionate representation, and often exert the most influence in this area. Addressing the issue, however, will require an expansion of the role of the system to the societal and individual levels. Particular areas of influence will be likely to include activities to address economic needs and access to services, such as quality education and housing, in communities with high referral rates.

Respondents were asked to rate the scope and level of implementation for each practice. The choices for scope were statewide, multi-jurisdiction, limited, unknown, and not applicable. The choices for level of implementation were comprehensive, moderate, minimal, or not applicable. The instructions for completing the survey included the following definitions:

**Scope**

- *Statewide:* Available in most or all jurisdictions.
- *Multi-jurisdiction:* Available in many jurisdictions; may be geographically limited, but serves a majority of families due to location in high-population area.
- *Limited:* Available to a minority of families; pilot program; extent of program unknown due to local variables.

### **Level of Implementation**

- *Comprehensive:* Adequate funding, staffing, technology, and other resources; supportive leadership; staff, community and political support; program is known in the community; caseworkers are aware of the program and use it when appropriate; families and children can have access to it as necessary.
- *Moderate:* Modest funding, staffing, technology, and other resources; varying enthusiasm for program among leadership; caseworkers/supervisors have uneven access to the program, perhaps dependent on personal experience or knowledge; opposition from some sectors or individuals may contrast with enthusiastic support from others.
- *Minimal:* Limited funding, staffing, technology, and other resources; not relevant to population; lack of leadership; difficult to gain access; caseworkers/supervisors unaware of program; waiting lists make it impractical for some participants; staff, community, or political opposition.

### **Methodology and Response Rate**

The survey was created electronically online at <http://www.surveymonkey.com>. This method was chosen because of its expected ease of use, its ability to gather results quickly, and because it would eliminate the added time and expense for copying and mailing.

Prior to sending the survey, child welfare directors in all 50 states and the District of Columbia received a notice about the approaching survey. They were asked to provide an alternate contact if there was someone else in their state who would be completing the survey. Approximately two weeks later, the survey was sent electronically to the designated recipients. The respondents included child welfare directors, staff directly assigned to disproportionality issues, researchers, and other state-level staff.

Respondents were asked questions about 42 different promising practices, divided by categories noted previously: society, system, and individual. They were asked to consider both the scope and the level of implementation of each practice. They were also invited to add comments about their activities after each section.

A total of 31 of 51 surveys were returned, which is a 61% response rate. There does not seem to be a consistent explanation for those states that did not complete the survey. The states that completed the survey are regionally diverse, distributed across the disproportionality rate quartiles, and are no more likely to have outgoing child welfare directors.

The states were divided into relative rate index quartiles, described in detail below. There were six Quartile 1 respondents, eight Quartile 2 respondents, eight Quartile 3 respondents, and nine Quartile 4 respondents.

In calculating descriptive statistics all “unknowns” and “not applicables” were labeled as “system missing.” Otherwise, each practice was assigned to one of the following categories:

- statewide/comprehensive
- statewide/moderate
- statewide/minimal

- multi-jurisdiction/comprehensive
- multi-jurisdiction/moderate
- multi-jurisdiction/minimal
- limited/comprehensive
- limited/moderate
- limited/minimal

### **Description of Quartile Rankings**

The relative rate index for children in custody was calculated for each state, based on the methodology used by the National Resource Center for Child Welfare Data and Technology. The relative rate is defined as the ratio of the proportion of a particular ethnic group in the general population to the proportion of the ethnic group at a particular decision point. The number calculated for a particular jurisdiction results in a number that describes how many times more likely a child of a particular ethnicity is to be in care than a White child. For example, if the state is given a 2.5 for Black children that means a Black child is 2.5 times more likely to be in care than a White child.

Though the rates of disproportionality may differ in various jurisdictions across a state, for this survey the focus is on a statewide rate, and only for children in custody at a point in time (last day of FFY 2000). This does not address the number of referrals, the number of cases substantiated, the likelihood of entering foster care, the likelihood of terminating parental rights, or other key decision points in which disproportionality may be observed.

All states have over a rate of 1 for Black children, meaning that Black children are more likely to be in state custody than White children in every state and the District of Columbia. As disproportionate representation is a more profound and widespread problem for Black children, the quartiles referred to in most of the survey discussion are those related to Black children.

When the discussion is focused on Hispanic or American Indian/Alaskan Native children, it will be so noted. It is also important to note that in some jurisdictions the rates of disproportionate representation for other ethnic groups surpasses Black children, but not with the consistency of rates for Black children.

Using the calculated rates, states were divided into quartiles and assigned a number of 1 to 4. Quartiles were assigned to all but one state, whether or not they completed the survey. States in Quartile 1 are those where a minority child is less likely to be in care compared to a minority child in Quartile 2, 3, or 4 states.

Quartiles were calculated for each Census Bureau-identified minority group, so each state could belong to a different quartile for each minority group. For example, a state with a low relative rate index for a Black child could be in Quartile 1 for Black children, but could have a very high relative rate index for a Hispanic child and be in Quartile 4 for Hispanic children.

Quartile 1 for rates of disproportionate representation for Black children range from 1.58 to 2.65, meaning that even in the best performing state, Black children are 1.58 times more likely to be in care than White children (Table 1). Considering all 50 states, data show that a Black child was up to 65.95 times and at least 1.58 times more likely to be in foster care than a White child. For American Indian/Native Alaskan the top rate was 12.33, for Native Hawaiians or Pacific Islanders the top rate was 5.3, and for Hispanic children the top rate was 4.63.

For Black children, the distribution of rates is as follows:

	Lower Rate	Upper Rate
Quartile 1	1.58	2.65
Quartile 2	2.73	4.08
Quartile 3	4.12	5.90
Quartile 4	6.09	65.95

**Table 1: Relative Rate Index Quartile Distributions for Black Children**

For Hispanic children, the top two quartiles are below 1 (Table 2), meaning they are less likely than White children to be in state custody. The rates are as follows:

	Lower Rate	Upper Rate
Quartile 1	0.26	0.66
Quartile 2	0.70	0.99
Quartile 3	1.08	1.63
Quartile 4	1.75	6.85

**Table 2: Relative Rate Index Quartile Distributions for Hispanic Children**

## Limitations

There are a number of limitations to the survey. First and foremost, the Census Bureau and AFCARS data from which the relative rate indices were calculated is from the year 2000. As the survey is being answered based on 2005 practices, it is quite possible that states have implemented practices post-2000 that may have changed their ranking relative to other states. The indices are also subject to all other AFCARS limitations (e.g., some states combine child welfare and juvenile justice data, while others do not).

The rate of disproportionate representation was calculated at a state level. This type of calculation does not provide a full picture of the situation for minority children in the state. Where minority children are concentrated in a particular jurisdiction, the more diluted state rates do not accurately reflect the rates for those children. For example, if Hispanic children are concentrated in a particular area they may be vastly over-represented in that area, but under-represented in other areas of the state, resulting in an overall low relative rate of representation. This may be particularly relevant for Alaskan Native and American Indian children, as this survey was not able to capture any significant information related to this population.

Another notable limitation is that some states are locally administered. Those states may be less likely to know the extent of the programs and practices in individual jurisdictions. Time limits and workload issues made it impossible to seek input from individual counties.

Practice descriptions were not provided, so every attempt was made to make the short name of each practice as descriptive as possible. All requests for clarification were granted, although some of the comments indicated confusion about the names of some of the practices. It is possible that states defined practices differently.

The survey gathered information about the scope and level of implementation, but a variety of issues were not addressed. These issues include: whether or not specific jurisdictions were targeted for services, how long practices had been in place, the variations in service delivery from jurisdiction to jurisdiction, funding and leadership changes, and the extent to which the practice was part of a larger strategic plan.

## Observations

As previously noted, the observations from this survey are not findings and do not intend to prove whether or not particular practices are effective. The descriptive statistics noted here provide us with an overview in what is happening across the nation, at a particular point in time.

Respondents with a particular practice were asked to describe the scope and level of implementation. To evaluate the scope, number one was assigned to statewide practices, number two was assigned to multi-jurisdiction practices, and number three was assigned to limited practices.

States with the lowest rates of disproportionate representation for Black children, those in Quartile 1, seem to have less widespread practices. When the average scope for all practices was calculated the range was 1.1 to 2.25. All Quartile 1 states were 1.789 or above (Table 3). Of the states with the most widespread scope, three of the top four were Quartile 4 states, and there were no Quartile 1 states in the top 14, meaning the Quartile 1 states had less widespread practices (Table 4).

Scope	
Quartile	Average
1	1.789
1	1.829
1	1.833
1	1.852
1	1.923
1	2.154
~	
4	1.100
4	1.205
4	1.235
4	1.595
4	1.725
4	1.889
4	2.000
4	2.000
4	2.250

**Table 3. Q1 and Q4 (for Black Children) Average Practice Scope**

Scope	
Quartile	Average
4	1.100
3	1.108
4	1.205
4	1.235
2	1.342
2	1.462
3	1.542
4	1.595
3	1.645
2	1.684
2	1.697
4	1.725
~	
4	2.000
4	2.000
2	2.036
3	2.094
1	2.154
4	2.250

**Table 4. Most and Least Widespread Practice Scope (Quartiles for Black Children)**

Quartile 3 and 4 states were more likely to have both the lowest and highest overall number of practices (Table 5). The lowest number of practices, 18, was a Quartile 4 state, and the next two states, 24 practices each, were both Quartile 3 states. On the high end, there were seven states that reported having 39 or 40 practices, including four Quartile 4 states, one Quartile 3, one Quartile 2, and one Quartile 1. Taken together, these may suggest that states with the lowest rates of disproportionate representation have more targeted programs. Quartile 1 states tend to have a mid-range number of programs, with less of a statewide scope. These states may have more targeted efforts underway, or allow more local decision-making.

Quartile	Number of Practices
4	18
3	24
3	24
~	
1	39
2	39
3	39
4	39
4	39
4	40
4	40

**Table 5.**  
**Highest and**  
**Lowest**  
**Number of**  
**Practices**  
**(Quartiles for**  
**Black**  
**Children)**

***Society: Community-Level Practices***

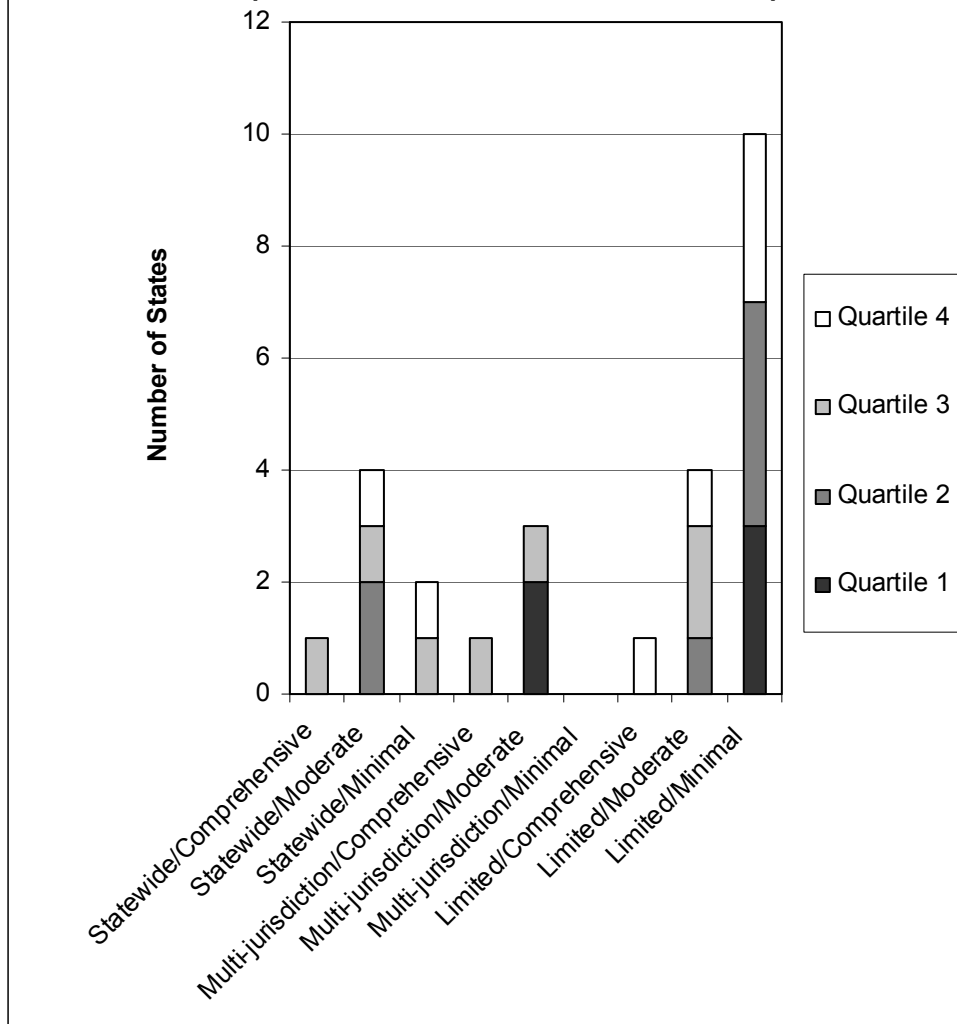
The first section of the survey includes five community-level practices. There were no practices associated with higher or lower rates of disproportionate representation, for either Black or Hispanic children.

While most states had targeted community partnerships (30), community-wide parenting programs (31), culturally diverse foster care recruitment (32), and substance abuse facilities for parents and children (26), the degree of scope and level of implementation varied greatly.

Though 26 states reported having “substance abuse facilities for parents and children,” the scope and level of implementation are skewed toward the lower ranges of each (Figure 1). Just one state reported having a statewide/comprehensive facility, while ten reported having limited/minimal access to this service. The likelihood of having access to such a facility does not seem to be related to the disproportionate representation rate for either Black or Hispanic children.

Other community-level practices and issues mentioned in the comments section include an effort to pool resources among agencies, a distinction between rural and urban areas, focus groups within communities, participation in the Casey Family Breakthrough Series, multidisciplinary efforts to reduce child abuse, partnerships with local Native American advocacy organizations, and public hearings with open invitations to stakeholders and the public.

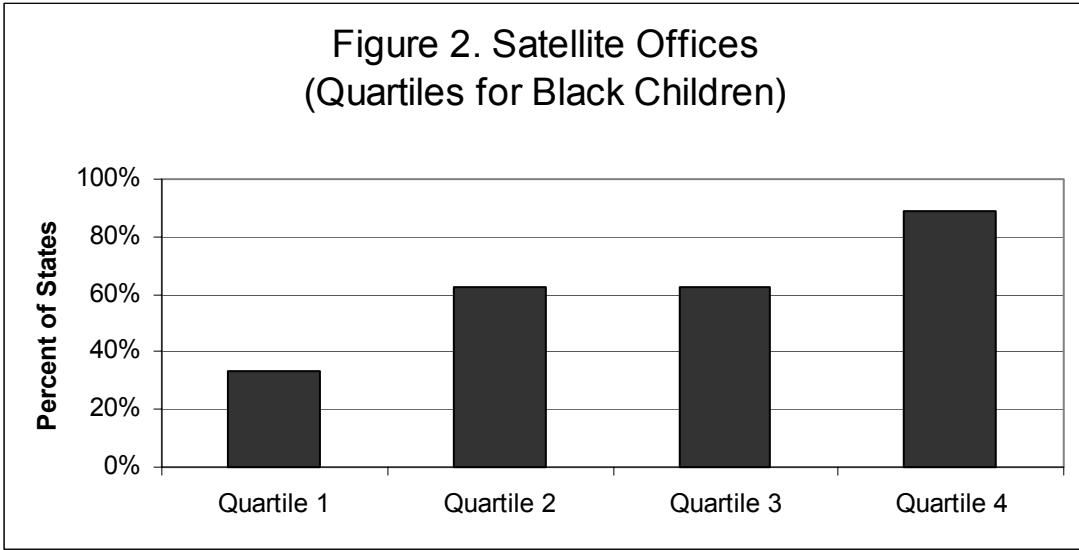
**Figure 1. Substance Abuse Facilities for Parents and Children (Quartiles for Black Children)**



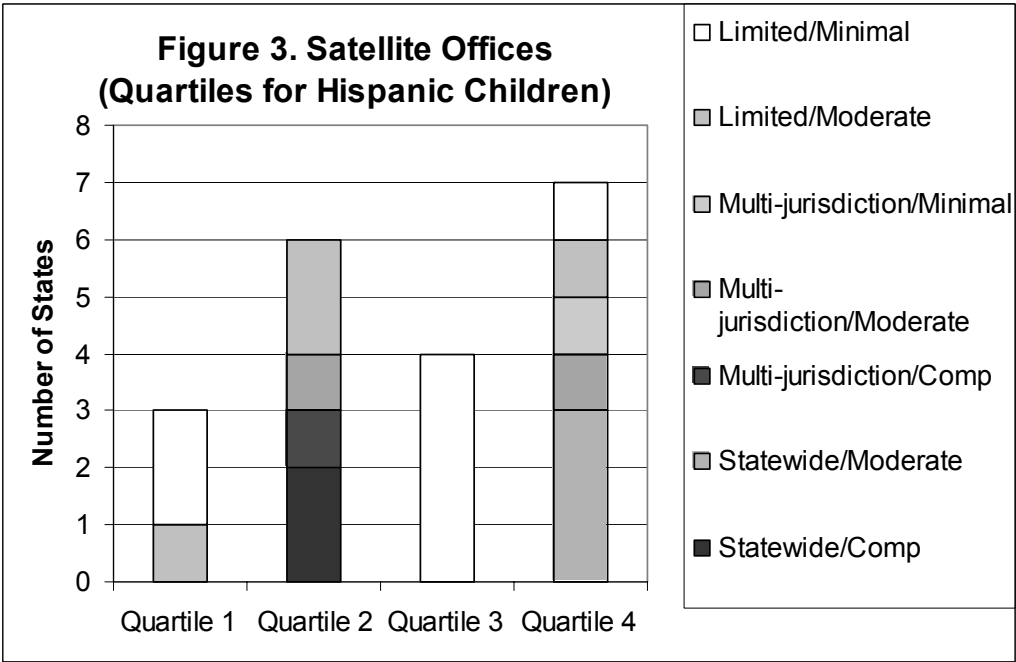
**System: Agency Policy and Organization-Wide Issues**

There were 13 practices listed on this section of the survey, including items such as values-based hiring practices, satellite offices/immersion, diversity committees, and race-based data collection.

States with the highest rates of disproportionality were more likely to have satellite offices/immersion programs (Figure 2). Eight out of nine states in the fourth quartile had at least some satellite offices. Three described this practice as being statewide, three as multi-jurisdiction, and two as limited. In contrast, only two out of six states in the first quartile had satellite offices. First quartile states also had far more limited programs, with one state describing their satellite offices as limited/moderate, and one as limited/minimal.

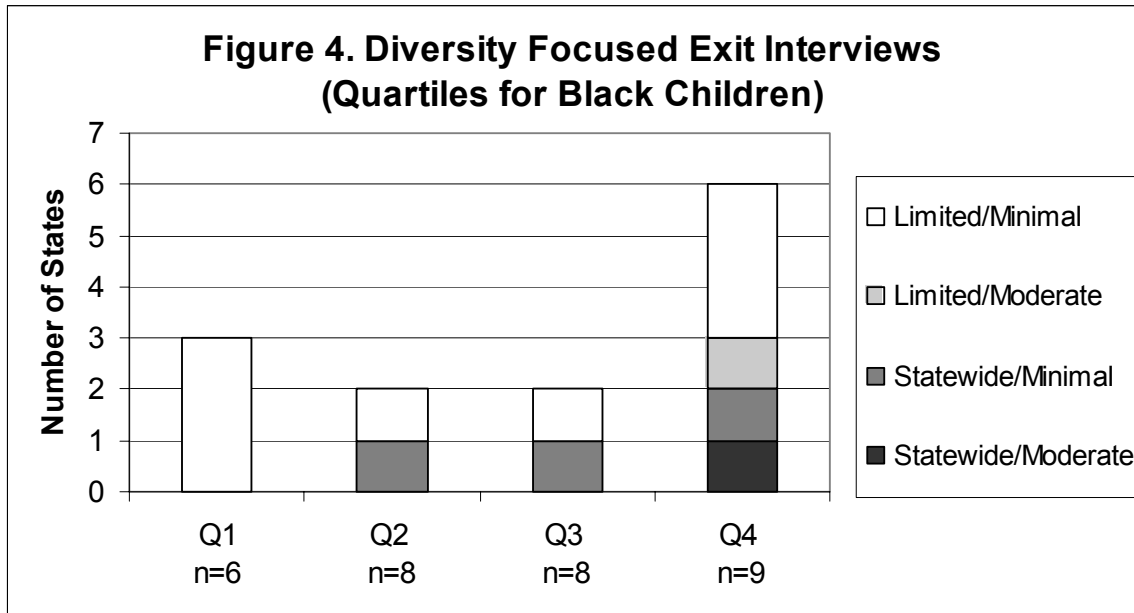


States with the highest disproportionate representation rates for Hispanic children are also more likely to have satellite offices (Figure 3). Of the 20 states reporting the presence of satellite offices in their states, the three with statewide/comprehensive programs are among the states with the most disproportionality.

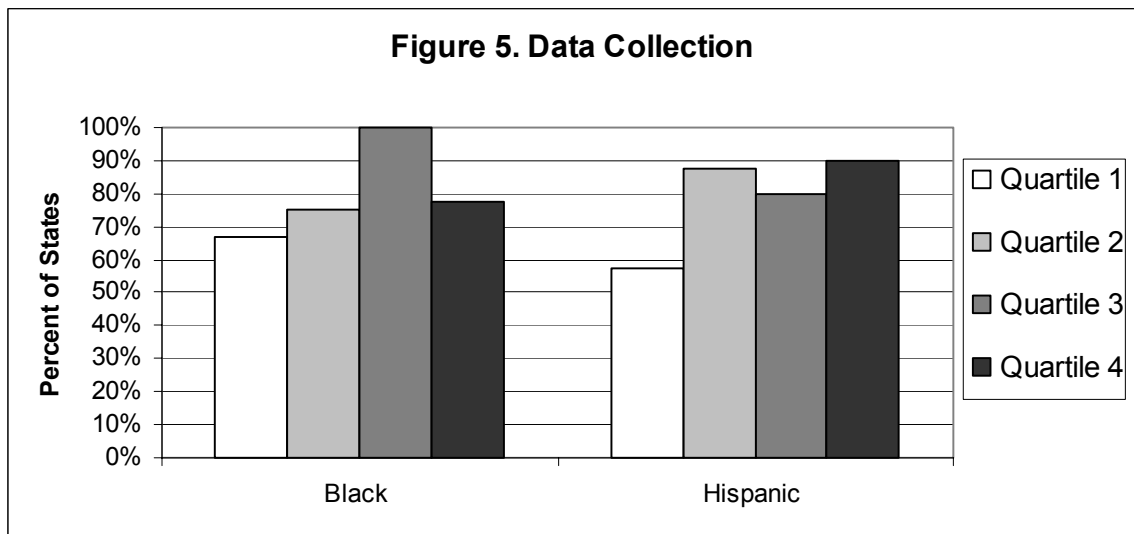


This could be due to a recognized need for satellite offices in the states with higher rates of disproportionality, for both Black and Hispanic. There are many possible explanations for this association, including the possibility that they aren't effective in reducing disproportionality, they haven't been in place long enough to change their rates, or their presence is raising the rates of disproportionality by identifying more children in need of care.

Similar to the presence of satellite offices in states with higher rates of disproportionality, states in Quartile 4 were also more likely to have “diversity-focused exit interviews.” Three of six states in Quartile 1 had limited/minimal programs, while four of nine states in Quartile 4 had implemented this practice. This does not appear to be a widespread practice.



Most states report having “regular race-based data collection” in place (Figure 5). One state reports having multi-jurisdiction/moderate, and all others are either statewide or limited. Collecting data is the first step to identifying the problem, and will provide a baseline for evaluation of future work.



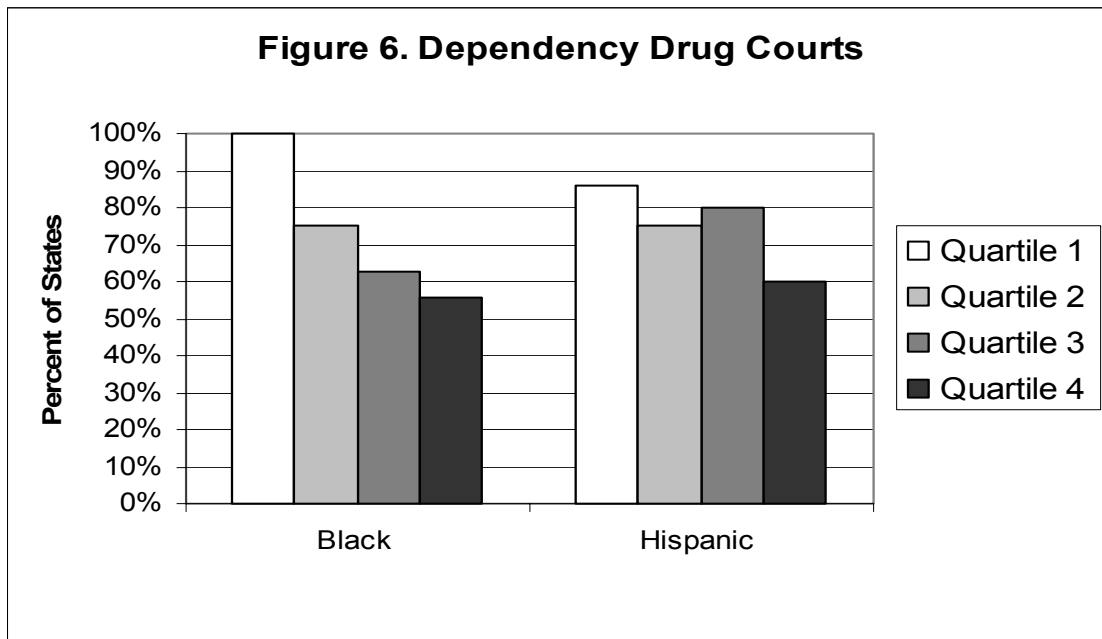
Additional comments and suggestions in this section included regional training and core curriculum expanded to include ethnicity, race and disproportionality, creation of a division specifically intended to deal with multicultural issues, participation in same-

state organizations dealing with disproportionate representation in other programs (e.g., dental, mental health, and substance abuse services), Tribal/State collaborations, minority specific committees, minority staff recruitment, Indian Child Welfare Act (ICWA) compliance review, and an increased level of focus on contracting with women and minority-owned businesses.

**System: Direct Practice**

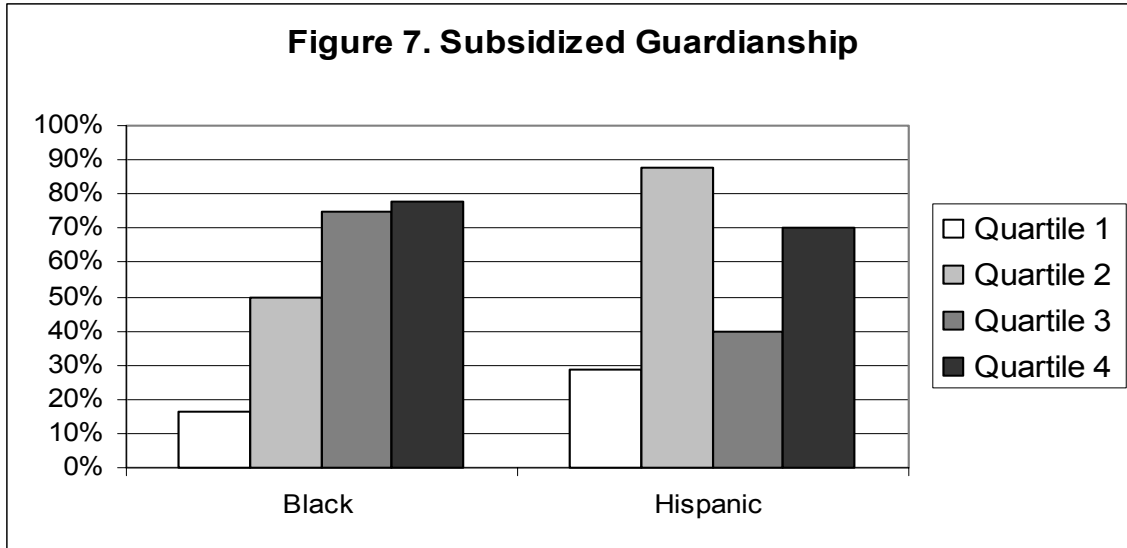
This section of the survey was the longest, with 19 identified practices. Direct practice at the system level is the area where child welfare systems often have the most influence. Many of the practices, such as dependency drug courts, certainly require community support, and change may not be led by the system; however, they are included in this section because they directly affect both how protective service workers execute their job and how a family experiences the system.

The first item of note is that states with the lowest rates of disproportionate representation of both Black and Hispanic children are more likely to have dependency drug courts. Interestingly, Quartile 1 and 2 states, though more likely to have a program, have more focused or limited programs. There are no statewide programs in these states, compared to three statewide programs in Quartile 3 and 4 states for Black and Hispanic children. It is not possible to tell from this survey if the multi-jurisdiction and limited programs in states with the lowest rates of disproportionality were specifically targeted to areas where there was the greatest need or if there were other factors.

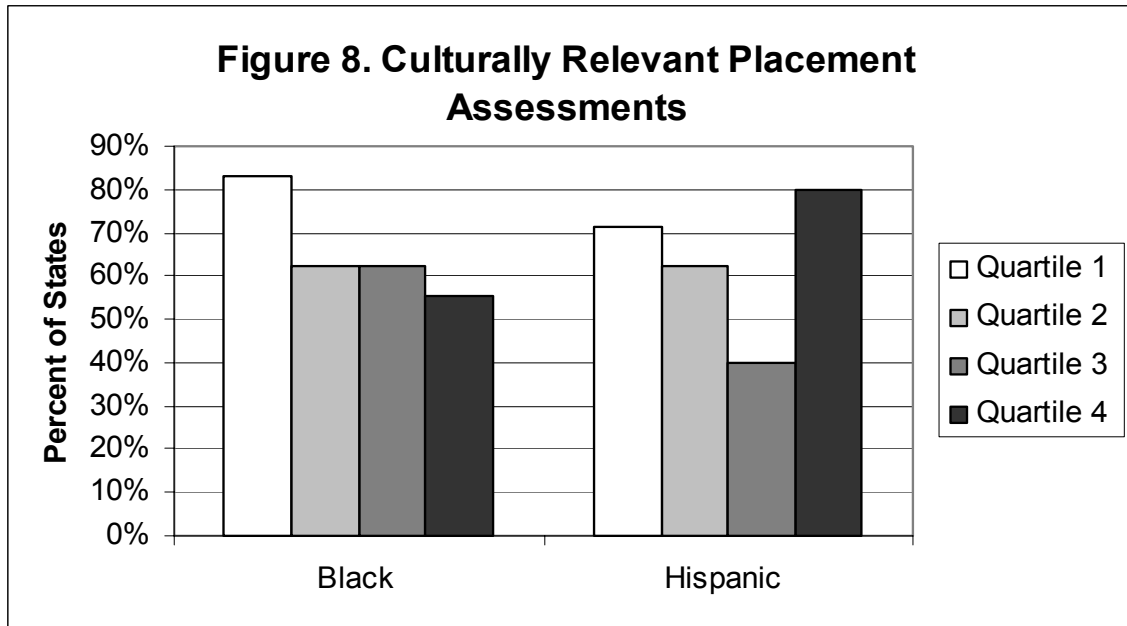


States with the highest rates of disproportionate representation for Black children are more likely to have subsidized guardianship, while only one of six states (16.7%) from Quartile 1 and seven of nine states in Quartile 4 (77.8%) reported having subsidized guardianship.

The picture is less clear for states with higher rates of disproportionality among Hispanic children. Where it existed, subsidized guardianship was likely to be statewide. For example, in Quartile 4, for both Black and Hispanic children, seven of seven states with subsidized guardianship had statewide programs (Figure 7).

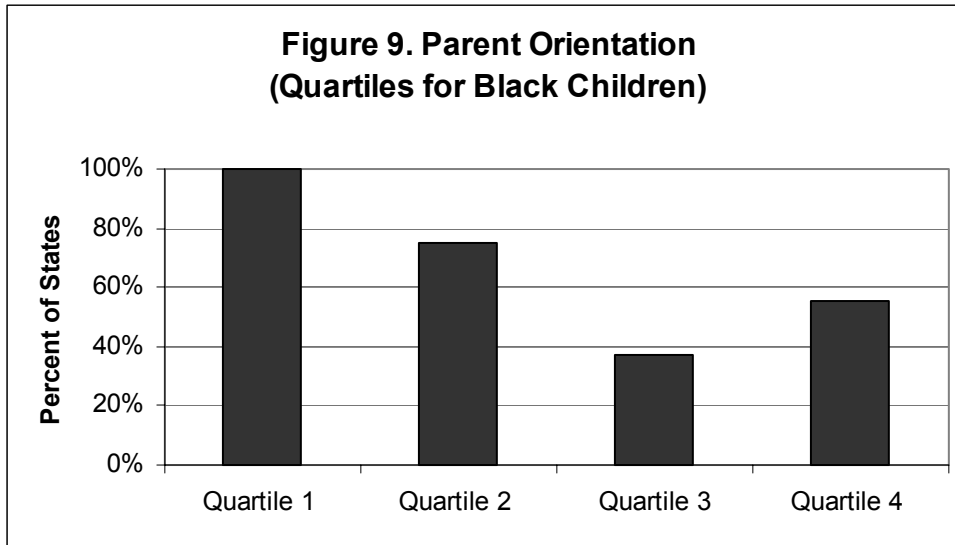


Though states with the lowest rates of disproportionate representation seem slightly more likely to have "culturally relevant placement assessments," the practice seems fairly evenly distributed across quartiles, scope, and level of implementation. Overall, 20 of 32 respondents report having culturally relevant placement assessments (Figure 8).



Of respondents, six of six (100%) of Quartile 1 states, six of eight (75%) of Quartile 2 states, three of eight (37.5%) Quartile 3 states, and five of nine (55.56%) of Quartile 4

states, report having parent orientation to child welfare (Figure 9). The numbers are similar for states with regard to Hispanic disproportionality rates.



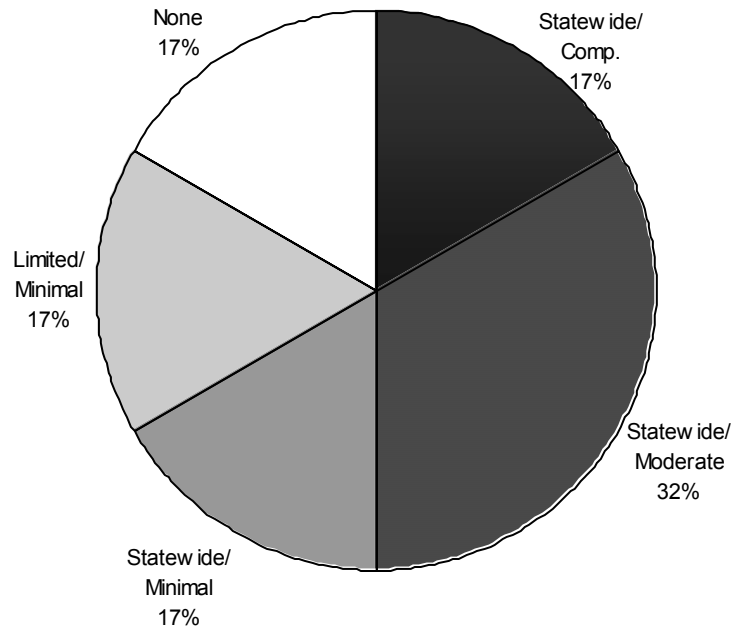
States' additional practices in this section included a unit specifically for addressing the needs of Native American children, use of a dynamic family assessment, a dual track response system, use of flexible wrap-around funds, allowing local jurisdictions to make decisions about their own needs, and ongoing collaboration with the Division of Multicultural Affairs, including training, field visits, ride-alongs, and memos.

### ***Individual Staff Development***

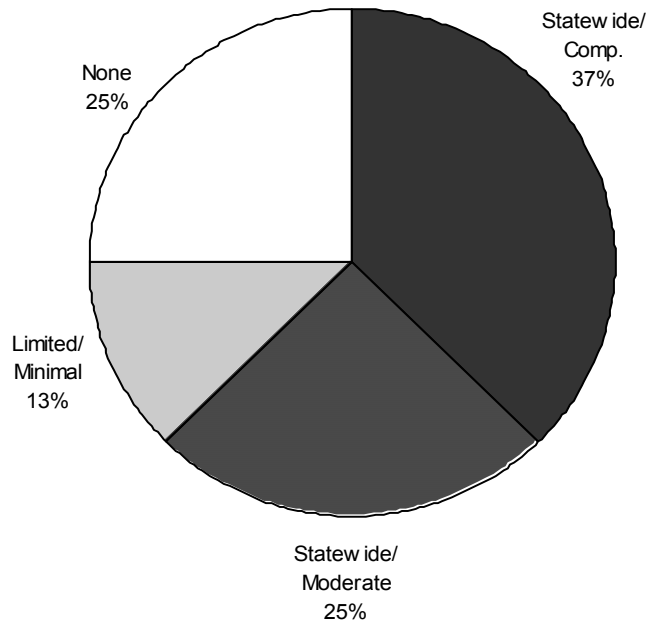
There were four practices listed in the Individual Staff Development section of the survey. All practices were occurring at varying degrees of intensity in many states: One-on-one diversity interviews (27), new employee diversity training (23), cultural competence assessment in performance evaluations (17), and cultural competence training (23).

The most noteworthy information in this section is that states with the lowest relative rate indexes for Black children are more likely to have cultural competency training. In Quartile 1, five of six states have cultural competence training, including four with some degree of statewide training (Figure 10). Of the eight states each in Quartiles 2 and 3, there are six and four states, respectively, with cultural competence training (Figures 11 and 12). In Quartile 4, five of nine states have statewide cultural competence training (Figure 13).

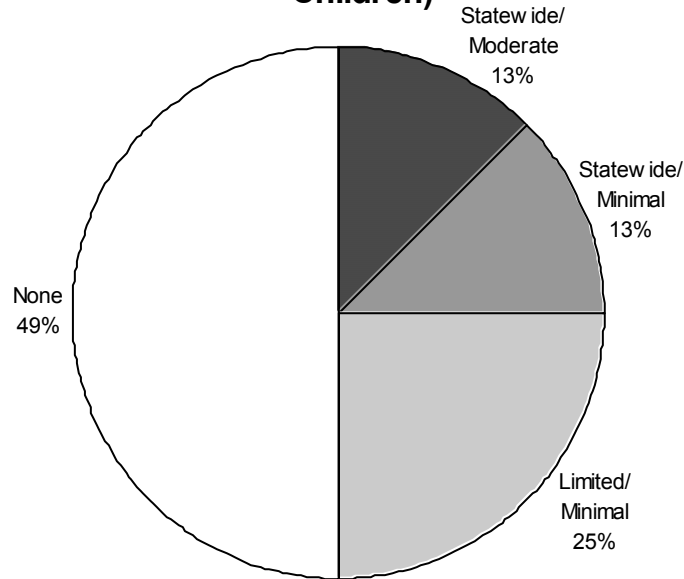
**Figure 10. Cultural Competency Training (Q1 for Black Children)**



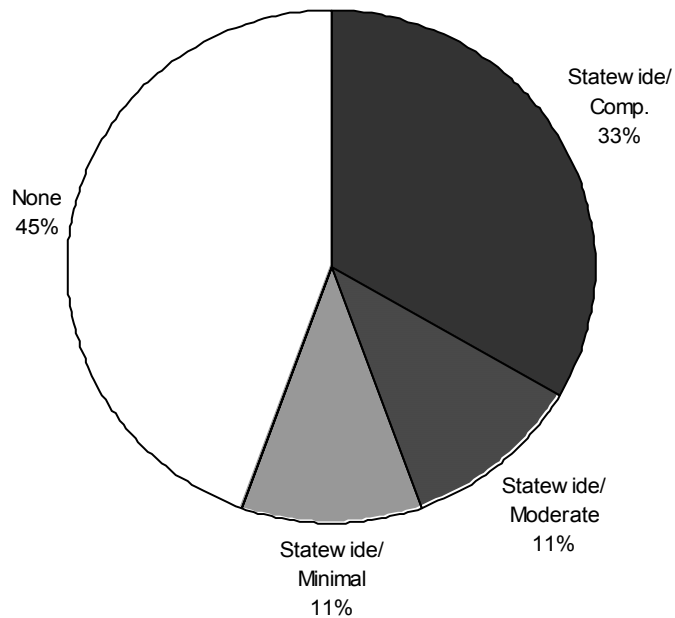
**Figure 11. Cultural Competency Training Quartile 2 (for Black Children)**



**Figure 12. Cultural Competency Training, Quartile 3 (for Black Children)**



**Figure 13. Cultural Competency Training, Quartile 4 (for Black Children)**



States also reported using intense diversity training, enhancements to core curriculum, and cultural competence training specifically for working with Latino families.

## **Conclusions and Recommendations**

This survey is intended as an initial overview of practices that have the potential to affect disproportionate representation and not as evidence of whether or not particular practices are successful or should be replicated. Though there are some overall trends, the only clear result is that we need further study on whether or not the practices assumed to improve disproportionate representation are effective.

This suggestion clearly requires baseline data, which would be best gathered at the local level. As noted before, statewide data provide a high level picture that may not accurately portray the situation for minorities in localities. County-administered states and large jurisdictions, in particular, should be surveyed separately.

When evaluating data, recognize that simply reducing the number of minority children in care is not necessarily the best approach to improving disproportionate representation. The goal is to address these underlying issues, regardless of where they occur—at the societal, system, or individual levels.

We also recommend further discussions, perhaps between states or jurisdictions with low rates of disproportionate representation who have strategic plans to address the issue, and between states or jurisdictions with higher rates of disproportionate representation who have not yet fully addressed the issue or who are interested in implementing additional strategies.

As data become available showing which of these emerging practices are most effective, it may also be helpful to compile a list of which states have implemented the practice and at what scope and level of implementation. States that already have a practice in place may be able to provide support for and insight into that practice that may not be obvious from research. In addition to ad hoc state-to-state discussions, a formal group discussion or a more complete written inquiry may be appropriate.

Without reserve we can recommend that the strategies chosen should not be a series of practices just because they are listed as “emerging” or “promising” practices—which does not mean some may not have more of an effect than others. The only way to achieve results is to implement thoughtful and sustainable plans that achieve measurable results. This requires an effective organization, including strong leadership and a thoughtful strategic plan.

As we better understand not just the extent of disproportionate representation, but the causes and the depth of it, the field will be able to address the issue in more useful ways. When states or local jurisdictions implement strategic plans with the intent to affect disproportionate representation, we expect to see programs targeted to specific jurisdictions and to learn the efficacy of specific practices.

# Appendices

## Appendix A

### Excerpt from *Guide for Child Welfare Administrators on Evidence Based Practice*

#### **Child Welfare Practice Classification System**

The proposed classification system uses criteria regarding a practice's theoretical soundness, clinical support, acceptance within the field, and potential for harm, documentation, and empirical support to assign a summary classification score. A lower score indicates a greater level of support for the practice protocol. The summary categories are:

1. Well-supported, efficacious practice
2. Supported and probably efficacious practice
3. Supported and acceptable practice
4. Promising and acceptable practice
5. Innovative or novel practice
6. Concerning practice

**Specific criteria for each classification system category are presented below:**

#### ***Well-Supported, Efficacious Practice***

- The practice has sound theoretical basis in generally accepted child welfare or related professional principles.
- A substantial clinical-anecdotal literature exists indicating the practice has value with children receiving services from the child welfare or related system and their parents/caregivers.
- The practice is generally accepted in clinical practice as appropriate for use with children receiving services from the child welfare or related system and their parents/caregivers.
- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, or other available writings that specifies the components of the service and describes how to administer it.
- At least two randomized, controlled outcome studies (RCT) have found the practice to be superior to an appropriate comparison practice, or different or better than an already established practice when used with children receiving services from the child welfare or related system and their parents/caregivers.
- If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.

#### ***Supported and Probably Efficacious Practice***

- The practice has a sound theoretical basis in generally accepted child welfare or related professional principles.
- A substantial clinical-anecdotal literature exists indicating the practice's value with children receiving services from the child welfare or related system and their parents/caregivers.

- The practice is generally accepted in clinical practice as appropriate for use with children receiving services from the child welfare or related system and their parents/caregivers.
- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, or other available writings that specifies the components of the practice protocol and describes how to administer it.
- At least two studies utilizing some form of control without randomization (e.g., matched wait list, untreated group, placebo group) have established the practice's efficacy over the passage of time, efficacy over placebo or found it to be comparable to or better than an already established practice.

### ***Supported and Acceptable Practice***

- The practice has a sound theoretical basis in generally accepted child welfare or related professional principles.
  - A substantial clinical-anecdotal literature exists indicating the practice's value with children receiving services from the child welfare or related system and their parents/caregivers.
  - The practice is generally accepted in clinical practices as appropriate for use with children receiving services from the child welfare or related system and their parents/caregivers.
  - There is no clinical or empirical evidence or theoretical basis indicating that practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
  - The practice has a book manual, or other available writings that specifies the components of the practice protocol and describes how to administer it.
  - At least one group study (controlled or uncontrolled), or a series of single-subject studies suggest the efficacy of the practice with children receiving services from the child welfare or related system and their parents/caregivers
- or***

A practice has demonstrated efficacy with other populations, has a sound theoretical basis for its use with children receiving services for the child welfare or related system and their parents/caregivers, but has not been tested or used extensively within the child welfare population.

- If multiple outcome studies have been conducted, the overall weight of evidence supports the efficacy of the practice.

### ***Promising and Acceptable Practice***

- The practice has a sound theoretical basis in generally accepted child welfare or of related professional principles
- A substantial clinical-anecdotal literature exists indicating the practice's value with children receiving services from the child welfare or related system and their parents/caregivers.
- The practice is generally accepted in clinical practice as appropriate for use with children receiving services from the child welfare or related system and their parents/caregivers.
- There is no clinical or empirical evidence or theoretical basis indicating that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, or other available writings that specifies the components of the practice protocol and describes how to administer it.

### ***Innovative or Novel Practice***

- The practice may have a theoretical basis that is an innovative or novel, but reasonable, application of generally accepted child welfare or related professional principles.
- A relatively small clinical literature exists to suggest the value of the practice.
- The practice is not widely used or generally accepted by practitioners working with children receiving services for the child welfare or related system and their parents/caregivers.
- There is no clinical or empirical evidence or theoretical basis suggesting that the practice constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.
- The practice has a book, manual, or other available writings that specifies the components of the practice protocol and describes how to administer it.

### ***Concerning Practice***

- The theoretical basis for the practice is unknown, a misapplication of child welfare principles, or a novel, unique, and concerning application of child welfare or related professional principles.
- Only a small and limited clinical literature exists suggesting the value of the practice.
- There is a reasonable theoretical, clinical, or empirical basis suggesting that compared to its likely benefits, the practice constitutes a risk of harm to those receiving it.
- The practice has a manual or other writings that specify the components and administration characteristics of the practice that allows for implementation.

## Appendix B

### *Emerging Promising Practices in Disproportionate Representation*

#### **Society**

- Targeted community partnerships
- Participation in economic development programs
- Community-wide parenting programs
- Culturally diverse foster care recruitment efforts
- Adequate beds available in substance-abuse facilities for parents and children

#### **System**

##### *Agency Policy and Organization-Wide Issues*

- Diverse staff recruitment practices
- Values-based hiring practices
- Employ certified diversity facilitators
- Satellite offices in ethnic geographic locations (immersion)
- Diverse client input on policies and procedures
- Diverse staff input on policies and procedures
- Diversity audit of program outcomes
- Yearly/regular collection of race-based data in child welfare decision points
- Diversity-focused exit interviews
- Diversity committees
- Multi-Ethnic Placement Act enforcement
- Indian Child Welfare Act enforcement
- TANF-Child Welfare connections

##### *Direct Practice*

- Differential/Alternate response
- Family-centered practice
- Mediation and arbitration
- Wrap-around services
- Strengths-based assessments
- Dependency drug courts
- Post-reunification services
- Tested risk assessment tool
- Training on distinction between safety and risk
- Concurrent planning
- Family Group Decision Making
- One family—one judge
- Subsidized guardianships
- Technical assistance for mandated reporters
- Family preservation services
- Culturally relevant placement assessments
- Family to Family
- Translation services
- Parent-Partner Program
- Parent Orientation to child welfare

**Individual Staff Development**

One-on-one diversity interviews

New employee diversity training

Assess cultural competence in staff performance evaluations

Cultural competence training

## Appendix C

### *Description of Spheres of Influence*

#### Spheres of Influence

**Society**—Society includes community agencies; local, state, and federal government; major institutions such as education, churches, and banking; and our culture and values. It is important to recognize that disproportionality in the child welfare system is certainly a reflection of institutional and systemic racism at the societal level. Child welfare agencies cannot expect to single-handedly overcome bias in society, but can be expected to play a role in improving circumstances for families.

Child welfare agencies can influence legislation, participate in community collaborations, raise awareness of issues, and coordinate resources to those families most at risk for services.

*Example: A representative from the child welfare agency can participate on a planning team addressing the local low-income housing crisis.*

**System**—The system level is the child welfare agency itself. Though policies and practices in child welfare are unlikely to be explicitly biased, there is still reason to examine and revisit long-standing approaches to service.

Child welfare agencies have the ability to strongly or solely influence the development and implementation of new or improved standards, policies, regulations, training, and supervision.

*Example: The agency adds culturally relevant questions, specific to a large number of minority children in their community, to their foster care placement procedures.*

**Individual**—An individual worker, supervisor, or administrator enters their role in the child welfare system with a personal outlook and approach, reflective of their family, community, and society at large. The child welfare agency's role is to reduce the impact of any potential individual bias by concentrating on enhancing and improving individual skills, knowledge, and competencies.

*Example: The agency includes a "cultural competence" section on individual performance reviews.*

#### Process

##### **Diagnostic**

A diagnostic is the tool or strategy employed to determine in which areas there are needs to be addressed. It is used to help shape and define the specific role the agency should play in any intervention, as it is used to pinpoint particular areas of deficiency and strengths.

*Example: Results from focus groups, assessments, surveys, and evaluations.*

***Intervention***

The intervention is the specific tool or strategy used to address a particular deficiency or magnify a strength. The intervention can be brief and targeted, but is more likely part of a larger change plan implemented to address an aspect of disproportionality.

*Example: The agency's change plan includes the renewal of the diversity committee and mandatory cultural competence training.*