How Can We Reduce Racial Disparities in Child-Serving Systems of Care?

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My Background

- MSW Education / Training (2001-03)
- Post MSW experience (2003-06)
  - WA state DCFS – Child Protective Services
- Doctoral education (2006-2010)
  - University of Washington School of Social Work
- Post-doc research (2010-2011)
  - CASRC – MH/CW services research
- Assistant Professor at SP2 (Fall 2012-Current)
Agenda

1. Understand dynamics of racial disproportionality and disparity
2. Gain better awareness of outcomes among system-involved youth of color
3. Understand why outcomes remain abysmal
4. Identify recent promising efforts to promote implementation of effective interventions
5. Identify ways you can make a difference in addressing disparities in child-serving systems of care
National Child Welfare Statistics

- 3.6 million reports involving 6.6 million kids
- Every 10 seconds a report is made
- Substantiated: 702,000 (9.2 per 1000 kids or 10 football stadiums)
  a) Neglect: 75%
  b) Physical abuse: 17%
  c) Sexual abuse: 8.3%
  d) Psychological abuse: 6.0%
- 27% of victims are younger than 3 years
- 1,580 died due to abuse in 2014 (4-5 per day)
  a) Over 70% of those who die are under age 3
  b) One of the worst among industrialized nations
Long-Term Outcomes

- 9 times more likely to become involved in crime
- 14% of men and 36% of women in prison abused as children
- 25% more likely to experience teen pregnancy
- Increased risk of smoking, early age drinking, suicidal ideation, inter-personal violence & sexual risk-taking
- About 30% will later abuse their own kids
- 80% of 21 year olds meet criteria for at least one MH disorder
- Only 1/3 receive mental health services
- Lifetime cost: $124 billion in 2008
“State disruption of families is one symptom of...institutionalized discrimination. It reflects the persistent gulf between the material welfare of Black and White children in America. The racial disparity in the child welfare system—even if related directly to economic inequality, ultimately results from racial injustice”.

Dorothy Roberts (2002)
Key Definitions

• **Disproportionality**: a situation in which a particular racial/ethnic group of children is represented in foster care at a higher or lower percentage than other racial/ethnic groups (a skewed representation).

• **Disparity**: a *comparative difference* in outcomes across subgroups of the population (e.g., AA and Latino youth in foster care experience greater challenges accessing behavioral health services compared to Caucasian youth).
# Race and Child Welfare Outcomes

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<th>2013</th>
<th>Children in Foster Care</th>
<th>General population</th>
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<tr>
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<td>N=402,378</td>
<td>N=86,693,808</td>
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<tr>
<td></td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>White</td>
<td>42%</td>
<td>53%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>22%</td>
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</tr>
<tr>
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<tr>
<td>Total</td>
<td>401,617</td>
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</table>
The 5 Dimensions of Environment (Garcia, 2009)

- **Physical**: displacement from built environment; profound grief; undermines MH
- **Individual-social**: family values; roles, beliefs, and parenting practices + neighborhood/community
- **Institutional**: role of how organizations with which clients have direct contact with impact well-being
- **Socio-political**: Policies that govern, shape, restrict and reinforce equity, access, and fairness (e.g., ASFA)
- **Subjective**: The lived experiences
ACEs and Foster Care

• Original ACEs:
• Broadened array of ACEs for current study
• NSCAW data used to examine
  a) most prevalent ACES among national sample of 1730 youth referred to CWS
  b) impact of ACES on SEB outcomes

Garcia et al. (Under Review)
Results of ACEs in CWS

MOST PREVALENT

• Being hospitalized (33.5%)
• Negligent treatment (30.3%)
• Community violence exposure (26.9%)
• Exposure to domestic violence (26.7%)

PREDICTORS OF POOR SEB OUTCOMES

- Caregiver mental illness
- Being hospitalized
- Sexual abuse
- Mental health service use did not buffer against poor SEB outcomes! What are practice implications?
Foster Care & Risk for Delinquency

• Youth included those between the ages of 12-17 in the NSCAW-II cohort at Wave 2.
• Placement instability associated with a higher number of delinquent acts.
• Positive relationship between SEB outcomes and delinquent acts detected.
• For African-Americans, engagement in delinquent acts significantly reduced when they received mental health services!

Garcia et al. (2015)
Educational Outcomes among CW-JJ Involved Youth

- 90% of students who experience juvenile justice placement do not complete a high school education (Neild & Balfanz, 2006).
- 70% of students who experience abuse do not graduate high school (Neild & Balfanz, 2006).
Philadelphia Context

- Does single and/or multiple system involvement predict whether students in the 9th grade dropped out of high school?
- Systems: CW, JJ, special education, behavioral services, homeless shelters
- 51,687 students enrolled in 7th, 8th, & 9th during the 04-05 school year.
- 34.0% of services systems users dropped out
- The odds of school dropout increased by nearly 50% for all “multiple” system users

Garcia et al. (Under Review)
Racism and Service Utilization

• 40% of children reported to CPS do not receive MH services who need them.

• The gap between need for and access to services is even wider for children of color in the CWS (Garcia & Courtney, 2011; Garcia et al., 2013).

• Limited research & advocacy for Latinos (acculturation, assimilation, cultural values) (Garcia, 2009).

• Cultural factors (e.g., immigration, acculturation, assimilation, documentation status) in the CWS not considered (Garcia, 2009).
Racism & Behavioral Health Services

- NSCAW (ages 12-17)
- Cohort I (n=1005) and Cohort II (n=727)=1732
- 45.8% of Cohort I needed MH services; 25% received services
- 36.5% of Cohort II received MH services; 27% received services
- Compared to Caucasians, African Americans less likely to receive services
- After controlling for urbanicity and organizational factors, the disparity was no longer detected.
- Youth nested within disengaged organizational climates were less likely to receive services.
- Thus, inequities within the larger context are driving disparities in child welfare.
The Legacy of Racism

1. Added stress of parenting children with unmet mental health needs + parents of color underutilizing services = disproportionate representation of Latino and African American youth in the child welfare system.

2. AAs & Latinos more likely to be uninsured.

3. AAs have higher rates of illicit drug use.

4. Latinos are younger than whites; in age groups that experience higher rates of mental illness.

5. African Americans & Latinos live in areas where access to care is limited.

6. Providers biases lead to racial micro-aggressions/discrimination

7. Legacy of racist policies (harm due to detention, involuntary commitment, youth of color often placed in restrictive settings) are implemented.
Persistence and Severity

Pathways by which perceived discrimination influences health outcomes. Solid lines indicate analyzed pathways; dashed lines represent pathways hypothesized by past research.
Why Are Symptoms Severe & Persistent?

• Personal experience of discrimination and institutional racism (Pascoe & Richman, 2009)
• 1/5 Blacks have emotional symptoms due to perceived racism (Andersen, 2012)
• Micro-aggressions: displacement & colonization
• “How Racism Is Bad For Our Bodies” (Silverstein, *The Atlantic*, 3/12/13)
Prior Efforts

• Prior efforts to promote safety & inequity
  1. Caseload limitations
  2. Hiring of more staff/caseworkers
  3. More training to identify and investigate fatalities
  4. Stabilize placements
  5. Referral to parenting programs and services that have little to no evidence for effectiveness or applicability
  6. Child fatality review teams

• But, not effective
  1. Over 700,000 substantiated cases of abuse
  2. Over 1,700 child fatalities
Recent Responses to Address Trauma

- There exist numerous forms of evidence-based practice (EBP)
  1. Screening and assessment tools such as the Child Abuse Potential Inventory and Child Behavior Checklist
  2. Foster parent-mediated approaches like Multidimensional Treatment Foster Care
  3. Child abuse prevention interventions like Project SafeCare and Triple-P

- These practices improve access to needed mental health services, improve parenting, reduce rates of child problem behaviors and out-of-home placements
National Response: CWS-EBPs

- Title IV-E waiver demonstration project granted by the U.S. DHHS
  - Parent-Child Interaction Therapy: PA, WA, Northern CA
  - Functional Family Therapy: PA, WA
  - Positive Parenting Program (Triple-P): PA, WA
  - Homebuilders: WA, CA, OR
  - Incredible Years: WA, CA
  - Safe Care: WA, OK
  - Multidimensional Treatment Foster Care (MTFC): NY, CA, OH, OR
  - Multi-systemic Therapy (MST): NY, OR, CA
  - TF-CBT: Southern California, NY

- No attention to legacy of racism
Contemporary Challenges and Barriers

- These evidence-based practices are not being implemented.
- 90% of publicly-funded child welfare, mental health and juvenile justice systems do not use evidence-based practices.
- Why are their barriers to implementation of EBPs?
Barriers to Treatment

- Engagement is a significant barrier due to structural inequalities in access to care and negative organizational/agency conditions
- **Concrete obstacles:** time, competing priorities, transportation, child care
- **Perceptual obstacles:** attitudes about mental health, stigma, prior negative experiences of micro-aggressions, parents’ own stress and needs
- Youth and families of color experience these barriers more often and to a larger extent than Caucasian families. (Garcia et al., 2013; Garcia et al., 2012).
Establish research-practice partnerships to improve dissemination, implementation, and continuous improvement of evidence-based mental health services

Implementation science, defined as systemic processes, activities, and resources that are used to integrate evidence supported interventions into practice (Rabin et al., 2008), is an evolving field.
Race and implementation science

(1) Most efforts have been devoted to implementing evidence-based practices (EBPs) for psychiatric disorders in usual care mental health settings (Aarons & Palinkas, 2007).

(2) Those efforts, by and large, have been disappointing (McHugh & Barlow, 2010), and

(3) The question of whether and under what conditions minority youth and families in child welfare access and utilize EBPs compared to their Caucasian counterparts remains unknown (Baumann et al., 2015; Garcia et al., 2015).
EPIS Framework

**EXPLORE**
- **Outer Context**
  - Sociopolitical Context
  - Funding
  - Client Advocacy
  - Interorganization Networks
- **Inner Context**
  - Organizational char. (culture, climate, leadership)
  - Individual char. (attitudes, goals)

**PREPARE**
- **Outer Context**
  - Sociopolitical Context
  - Funding
  - Client advocacy
  - Interorganization Networks
- **Inner Context**
  - Organizational Char.
  - Leadership

**IMPLEMENT**
- **Outer Context**
  - Sociopolitical Context
  - Funding Networks
  - Intervention Developers
  - Leadership
- **Inner Context**
  - Org Char.
  - Innovation-values fit Individual adopter characteristics

**SUSTAIN**
- **Outer Context**
  - Sociopolitical Context
  - Funding
  - Public academic Collab
- **Inner Context**
  - Org char.
  - Fidelity Staffing

(Aarons, Hurlburt & Horwitz, 2011)
QUALITATIVE INQUIRY ABOUT SERVICE DELIVERY
Methods

• Search Criteria
  – Ranked as well-supported by research evidence and “high” or “medium” relevance to the child welfare context by CEBC
  – 25% of sample children or families of color

• EBPs selected
  – PCIT
  – MST
  – TF-CBT
  – Triple-P

• Conducted 30 minute semi-structured interviews
  – EBP developers and investigators who evaluated EBPs in child welfare settings

• Notes were taken of each interview

• Content Analysis: Inductive category development
Inner Context: Individual Factors

- **Stigma** → address therapist as “coach” or “trainer”
- **Illiteracy** → administer assessments orally as standard procedure to avoid stigmatizing those who can’t read
- **Poverty** → create toys using household items, such as pots and pans; and provide info on where to purchase toys at garage sales/thrift stores
- **Concrete obstacles** → provide bus fare, mileage reimbursement, offer evening appointments and on-site child care; and re-configure to deliver EBPs in home settings
- **Taxing child welfare case plans** → reduce number of sessions required; avoid kicking youth/families out of program if miss a couple weeks.
Inner Context: Individual Factors

Lack of initial buy-in → Before the 1st session, therapists call caregivers to complete the following:

1. Clarify the need for mental health treatment.
2. Establish a foundation for a working relationship.
3. Address misconceptions or attitudes towards help-seeking that may impact therapeutic process.
4. Identify concrete barriers and provide immediate resources to overcome those obstacles.
Inner Context: Individual Factors

Lack of adherence/retention

a. Provide a motivational enhancement to counteract the mandated nature of involvement in the child welfare system
b. Call caregiver to remind/check-in about homework activities & future appts.
c. Focus on family strengths and religious beliefs about parenting and mental health

-Modify case exemplars!
Inner Context: Organizations

• Inadequate training → train staff on how to engage and retain caregivers

• Lack of caseworker awareness → increase face-to-face time in the agency to keep intervention “on the radar” and enroll families; provide agency staff with quarterly newsletters

• Lack of caseworker knowledge → provide training on child development/effective practice strategies
Outer Context: Intra-Organizational Networks

• Lack of collaboration/communication →
  1. Assess whether county/state directors are committed to using their authority to support implementation
  2. Work closely with them to identify solutions as barriers emerge

• Negative organizational functioning →
  1. Learn the organizational structure of child serving agencies and their respective climate and culture
  2. Devote ample time to planning phase
  3. Develop research-practice partnerships across systems
Outer Context: Community

• Lack of community awareness of EBPs →
  1. Deliver talks at local community centers and libraries
  2. Create partnerships with other child and family serving agencies such as child advocacy centers, police departments, rape crisis centers, head start centers, family resource centers, and children’s hospitals.

• Lack of access → Implement EBPs at community resource centers where social workers on staff provide ongoing case management needs.
The Philly Mandate

Conduct research on the impact of agency and provider resources and strategies to support the implementation of EBPs

1. PCIT (2-7)
2. Triple-P (0-16 but focus is on 11-16)
3. Functional Family Therapy (11-18)

Does implementation reduce disproportionality and racial inequity?
Specific Aims

1. Identify factors that facilitate access and fidelity.
2. Develop and implement innovative strategies to support caseworkers: weekly consultation with providers, one day booster trainings, replacement trainings, and program champions, and opportunities to engage in cultural exchanges about research evidence.
3. Determine whether innovative strategies promote access, fidelity, safety, permanency, and well-being.
4. Determine whether implementation of an EBP reduces racial disproportionality and inequity in service delivery.

Does the mandate/funding re-allocation matter for youth/families of color?
Methods

How am I evaluating impact?

a. Surveys to case managers to examine implementation and organizational processes
b. Clients complete measures on perceived impact of Triple-P on child clinical outcomes/well-being
c. De-identified administrative data on safety and permanency outcomes
d. Interviews with agency providers
e. Focus groups with parents and teens

What is your role in the research/evaluation process?

a. Gather valid data from your clients.
b. Track data and make it accessible to researchers.
c. Participate in data collection
Ideological Reframing

• Deconstruct the way in which foster care is framed and how services are delivered
  - Emphasis on not blaming the caseworker or individual youth and families
• Rely on the valid, culturally applicable research evidence to guide child welfare policy decision-making and implementation
• Recognize the importance of integrating the micro, mezzo, and macro contexts to implement EBPs and reduce racial disparities
Effective Service Delivery Drivers

Hypothesized Pathways to Effective Mental Health Service Delivery among Youth and Families Served by the Child Welfare System

**MACRO: EXTERNAL CONTEXT**
- Dissemination of effective practice strategies
- Proximity to appropriate services
- Development of effective practice strategies
- Funding

**MESO: TRANSITIONS**
- Awareness of effective practice strategies
- Job support
  - Implementation of effective training strategies
  - Interagency Collaboration

**MICRO: ENGAGEMENT**
- Implementation of effective practice strategies
- Cultural Competency
- Stigma
- Insider Work
Policy Recommendations

- Implement EBPs to promote safety & healthy development & prevent child abuse
- Title IV-E Waiver Demonstration Project: discretionary funding to support EBP implementation
- Allocate funding to better support caseworkers so children are properly protected:
  1. restructure organizational practice (leadership, innovation, job/staff support, retention of educated workforce, inter and intra-agency communication and collaboration)
  2. provide caseworker training and support to build knowledge, confidence, and self-efficacy
  3. Promote cultural exchanges to achieving intended outcomes

making a difference
How can you make a difference?

Start by asking yourself…

- **Assessment/Case Planning**: How do you illuminate the experiences of people of color?
- **Intervention**: How would you address need? What first comes to mind when you hear “evidence-based practice”?
- **Effectiveness**: How do we know if what we implement is effective AND applicable for our clients/target population? Will efforts reduce racial inequity?
Assessment (Garcia et al., 2009)

- **Physical**: displacement from built environment; profound grief undermines health/mental health
- **Individual-social**: family values; roles, beliefs, and parenting practices intersect with neighborhood and community conditions
- **Institutional**: role of how organizations impact engagement and well-being indicators
- **Socio-political**: policies and reform that govern, shape, restrict and reinforce equity, access, and fairness
- **Subjective**: The lived experiences
Intervention: Evidence-Based Practice as a Process

- Integration of best research evidence with clinical expertise and client values” (Sacket, et al, 2000)
- Utilize research to inform and improve practice for clients/target population
- Requires ecologically-grounded interventions
- Engagement is critical!
  a. Meet client where they are at
  b. No assumptions – understand their journey
  c. Explain what your role is and be transparent
Rely on the 5-step EBP process as a tool to inform intervention and evaluation of effectiveness:

1. Formulate a question to answer practice needs
2. Search for evidence to answer question
3. Critically appraise evidence for validity, impact & applicability
4. Select & implement intervention. Assess for feasibility!
5. Client monitoring, evaluation & feedback

How much change do we need to observe for success?

(Gambrill & Gibbs, 2009; Wodarski & Hopson, 2012)
A Note on Searching for Evidence

• Search process
• Use a variety of sources and search engines
• Where to go if do not have access to search engines?
  1) NREPP: SAMHSAs national registry of EBPs (reviews of 385 interventions)
  2) CA Evidence-Based Practice Clearinghouse(CEBC)
     a. Scientific Rating: Scale from 1-5, with 1 being “well-supported” and 5 being “concerning”
     b. CWS relevance level: high(1), medium(2), low(3)
Final Thoughts

• Engage in ecological assessment
• Implement EBP process with a critical lens – know your target population!
• Know who you are – reflexivity!
• Believe in resiliency: “The capacity of both individuals and their environments to interact in ways that optimize developmental processes” (Ungar, 2014, p. 256).
• Implementation science is evolving.
• What impact might all these efforts have on the impact of racial disparities in the CWS?