Center for the Study of Social Policy

Positive Outcomes for All:

Using An Institutional Analysis to Identify and Address African American Children's Low Reunification Rates and Long-Term Stays in Fresno County's Foster Care System

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Washington, DC 20005

October 2010

ACKNOWLEDGEMENTS

The Center for the Study of Social Policy thanks Catherine Huerta, Director of Fresno County Department of Social Services, and her leadership team in Fresno County for their willingness to participate in this intensive examination process. We also thank Fresno County's workers, supervisors, community partners, the courts, parents, foster parents and youth who provided us with insights during the course of the Institutional Analysis. In particular, we wish to thank Wendy Osikafo, Quality Assurance Supervisor, and her team for providing data, setting up more than 100 interviews and coordinating the Institutional Analysis.

The Institutional Analysis would not have been possible without the funding and in-kind support of the Annie E. Casey Foundation (AECF) and Casey Family Programs. Kate Welty, the AECF technical assistance coordinator for Fresno County, provided invaluable assistance throughout this process. Additionally, the Institutional Analysis team was enriched by support from Dr. Ellen Pence, and Dr. Carol Spigner.

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The Annie E. Casey Foundation
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Casey Family Programs
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This report is a product of CSSP. We thank the Annie E. Casey Foundation (AECF) and Casey Family Programs for their support but acknowledge that the findings and conclusions present in this report are those of the authors alone and do not necessarily reflect the opinions of the foundations.

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EXECUTIVE SUMMARY

Nationally, significantly greater proportions of African American children enter and remain in foster care than children of other races. Forty-six states have disproportionate representations of African American children in their child welfare systems. In seven states, including California, the proportion of African American children in foster care is considered "extreme." That means the number of African American children involved in the child welfare system is four times their percentage of the child population in those states.[1] This overrepresentation is known as disproportionality.

African American children and their families are more likely to be reported to child protection agencies for maltreatment and have investigations of abuse and neglect opened.[2] Once involved with the child welfare system, African American children are more likely to be removed from their homes and spend longer periods of time in foster care. Often, their families have less access to helpful social services. These trends clearly illustrate racial disparity and inequity for African American children and their families.

In Fresno County, like many other places, African American families have been disproportionately represented in the child welfare system for decades. In 2000, black families comprised five to six percent of the county's general population while nearly a quarter of youth in care were black.[3] Fresno worked to rectify this problem, and by 2009, black youth comprised 17 percent of youth in care.

Despite that progress, agency leaders still were concerned by the slow reunification of black children with their parents and their long stays in foster care. As part of efforts to address these concerns, in 2006, Fresno County Department of Social Services (DSS)[4] reached out to the broader community and asked for assistance. The Department publicly committed to understanding the root causes of these inequities and to working in partnership with the community to find solutions.

In 2009, Fresno County DSS volunteered to participate in a study known as the Institutional Analysis, which seeks to understand and address organizational and structural contributors to poor outcomes for children and families involved in the child welfare, juvenile justice and other systems. Fresno County DSS agreed to this study because it believed the efforts to improve outcomes for African American families would, in turn, benefit *all* families it served. Fresno County DSS welcomed the recommendations from the Institutional Analysis to continue to advance its efforts to reduce inequities for children and families involved in the child welfare system.

Fresno County is not alone in its willingness to tackle the difficult issue of racial disparity. CSSP also has worked with two counties in Michigan and Fairfax County in Virginia on similar Institutional Analysis studies and continues to collect and analyze data about the experiences of African American families and the way child welfare systems work with them.

Fresno County DSS already has made efforts to remedy many of the findings identified in the Institutional Analysis and has outlined a clear action plan, which is included at the end of this report. CSSP will continue to work with Fresno County as it improves outcomes for children.

Findings

The Institutional Analysis in Fresno focused on two questions:

1. *What organizational factors contribute to the fact that African American children, who have been removed from their parents due to abuse or neglect, experience low reunification rates with their parents?*

2. *How are the needs for stability and nurturance being addressed for African American youth who are not reunified with their parents?*

Overall, the Institutional Analysis found a gap between the county's intent to move African American children out of foster care to their biological families or other permanent options and the actual outcomes experienced by these children and families. A broad theme identified in this study was that, through its policies and practice, Fresno County DSS did not act with a sense of urgency to safely return African American children to their families or to find other safe, permanent and loving options. Fresno County DSS did not understand the unique strengths and problems faced by African American families. Many African American families entered the child welfare system with complex challenges in their lives. Some of their problems were economic—poverty, homelessness and unemployment—while others included child maltreatment, domestic violence, mental illness and substance abuse. The Institutional Analysis found that Fresno County DSS intervened with a family through universal, rather than individualized, assessments and service plans. For example, assessments focused exclusively on substance abuse, mental health or domestic violence issues rather than comprehensively looking at a family's specific needs and assets.

Service plans for families routinely consisted of parenting classes, drug testing, domestic violence classes, individual therapy and supervised visitation with little connection to the needs identified in assessments and case notes. These services tended to be centrally located in Fresno rather than in the communities where African American parents lived, and the operating hours of service providers were inconvenient for working parents. Further, there is minimal evidence that Fresno County DSS helped support parents in achieving economic stability by linking them with other available services, such as housing programs and benefits for teen parents.

The study also found that the child welfare system was not organized in a way that supported youth in finding permanent, nurturing connections. Specifically, Fresno County DSS does not direct workers to proactively and consistently find permanent families for older youth. As a result, youth over the age of 10 were uniformly considered by workers to be unadoptable.

Recommendations

CSSP offers the following recommendations to support the safe and timely reunification of African American families and promote permanent family connections for older African American youth in foster care in Fresno County.

1. Expand expectations and opportunities for frequent and timely visits among family members. Requirements for supervised visitation should be revaluated frequently, and permission for unsupervised visits should be provided as family circumstances change. Families that do require supervised visitation should have venues for visitation close to where they live or where their children attend school, and hours for scheduling such visits should be flexible and expanded beyond the traditional work day.

2. Ensure that all family and child assessments are accurate, current, culturally relevant and dynamic in order to enhance understanding of families. As circumstances change, families should be reassessed so that opportunities to recognize positive change and promote reunification are acted upon with urgency.

3. Engage families in services relevant to their needs. Services such as parenting classes and drug testing should not be used uniformly or punitively. Services should be accessible to parents at accessible locations close to the neighborhoods where they live and at hours that allow them to continue to work. Services should include connections to economic supports.

4. Provide meaningful legal advocacy for parents and youth. Caseloads of court-appointed attorneys need to be drastically reduced. Parents need to be provided with legal advocacy to support reunification, and youth need legal help to maximize their chance for a permanent home when reunification fails.

5. Ensure that youth in foster care have comprehensive and current case plans that accurately reflect the existing strengths and needs of youth and their parents. As part of Fresno's case practice model development, ensure that youth are active participants in their case planning.

6. Consistently pursue permanency options for older youth. Outreach to find adoptive homes should continue for youth regardless of age, not stopped at an arbitrary age of 10 on the assumption that older children are not adoptable.

7. Find family connections for older youth while also helping develop skills to support their independence. Opportunities to visit family members should be encouraged even while youth are learning to live on their own.

8. Work closely with the state to take full advantage of the federal provisions in the Fostering Connections legislation to provide increased supports to youth while they are in foster care.

Fresno County Child Welfare Action Plan

A Changed Agency

For many years, Fresno County DSS has been committed to understanding the root causes of inequities within its system and working with the community to find solutions. From the beginning of the Institutional Analysis, the Department's leadership was committed to designing and implementing strategies based on the recommendations this report. After the conclusion of the Institutional Analysis and prior to the finalization of the report, Fresno County DSS took several immediate actions to begin addressing CSSP's preliminary findings. Fresno hopes its intensive review will help other jurisdictions grappling with the same problems and guide larger reforms nationally.

The Institutional Analysis findings have helped further focus, refine and motivate the overall work of Fresno County DSS. At the study's conclusion in December 2009, the Department, ignited by the experience, applied its deepened awareness and lessons learned to the efforts to address the disparities in the child welfare system.

First Steps - In the months following the analysis, Fresno County DSS worked to:

- Reframe the social worker's job description and function to emphasize advocacy for children and families and provide heightened supervisor support when issues hinder finding permanent families for children.
- Reassess agency structure and policies to encourage maximum family engagement, including changing visitation hours so they are feasible for children attending school and working parents.
- Improve services for families by enhancing links between improvement efforts and service provision, such as coordinated case planning that will connect families to supports (economic as well as more traditional child welfare services) that promote reunification and stability.
- Provide racial awareness and bias training to the agency's entire workforce of more than 300 employees to increase understanding of each individual's opportunity to mitigate bias.

Agency Goals - Fresno County DSS also established five high-priority goals and has made substantial progress toward achieving them:

- Establish a Quality Supervision approach that supports supervisors in modeling, coaching and guiding social workers to continuously develop and enhance their case review, engagement and teaming skills with families.

- Implement a Joint Community Response practice with community partners to more successfully engage African American families and conduct a more accurate up-front assessment of an individual family's needs.

- Improve front-end Team Decision-Making (TDM) practice to ensure authentic family, youth and community engagement is occurring.

- Increase legal and relational permanency, including timely reunification, for African American children and youth through Quality Engagement and Teaming practice.

- Increase the accessibility and quality of services for African American families and youth by clarifying protocols for visitation and drug testing services, as well as creating a community partnership network to better access community-based services for African American families and to advocate for filling identified gaps. Fresno County has modified contracts to expand supervised visitation hours to 9 a.m. to 8 p.m., Monday through Saturday and holidays. Providers will also be responsible for providing supervised visits in three of the communities where the majority of African American families live.

The Road Ahead

Despite this significant progress, Fresno County DSS realizes it has more work ahead. In the next several months, it will work with a Disproportionality Advisory Committee (DAC) to integrate the study's formal recommendations with the agency's current improvement priorities, and over the next year, Fresno County DSS will continue to implement these improvement priorities. The DAC, composed of youth, parents, care providers, community partners, service providers, and agency staff will continue to hold the agency and broader community accountable for implementing the recommendation of the Institutional Analysis.

Fresno County DSS believes this review is just the first of many steps that the Department will take to fully understand and address the needs of the diverse community it serves. It hopes its work will inspire other public agencies to make a similar commitment to understanding the causes of inequities and expanding partnerships to improve opportunities and experiences for all of Fresno County's children, youth and families.

In furtherance of this work, on October 1, 2010, the state of California was awarded one of six federal grants to reduce long-term foster care stays for youth. As part of this grant, California will focus efforts on reducing racial disparities in four counties, one of which is Fresno. During

the planning phase, the other three counties will use a modified Institutional Analysis based on the findings in Fresno to craft action plans to address racial disparities and reduce long-term foster care stays for youth.

INTRODUCTION

Child protection systems across the country have the critical responsibility of intervening in families' lives where children are reported to be maltreated by their parents or caregivers. Once it intervenes with families, the child protection system—whether administered by state or county governments—must ensure children are safe with their families or other permanent families and must promote each child's overall health and well-being. Further, child protection systems and the courts should ensure the best results for each child and family with whom they intervene, regardless of race.

National data show, however, that African American and Native American children and their families have different outcomes when child protection services intervene. African American and Native American children and their families are more frequently reported for child maltreatment to child protection agencies,[5] have higher rates of assignment of alleged reports for investigation by child protection agencies,[6] and have higher rates of out-of-home placement than Caucasian children and their families.[7] While it is believed that data may undercount the rate of Latino children in the child protection system, Latino children are also disproportionally present in several jurisdictions across the country.[8] Once involved with these systems, children of color experience disparities in outcomes and services: specifically, they spend longer periods of time in out-of-home care and are less likely to reunify with their families, and oftentimes both children and their parents have less access to relevant and helpful social services.[9] Outcomes regarding reunification, time spent in foster care, and number of placements for children and youth of color are, for the most part, alarmingly worse than they are for their Caucasian counterparts.[10] Long-term life outcomes for children who remain involved in the child protection system as they mature tend to be bleak, with high rates of juvenile and adult incarceration, as well as bouts of homelessness, substance abuse, mental health issues and income insecurity. [11] Improving outcomes for all children involved in the child welfare system is not possible without resolving these disparities.[12] This requires an understanding of how agency policies and practices might contribute to or exacerbate poor outcomes experienced by families of color.

The Institutional Analysis (IA) process acknowledges that there are complex challenges faced by some African American families that also contribute to the racial disparities in the child welfare system. Poverty, lack of quality education, lack of well-paying jobs, proliferation of drugs and alcohol in poor communities, lack of decent and affordable housing and medical care and violence in homes and communities are real challenges that some African American families face and that can impact the care of their children. The IA acknowledges the impact of these factors and that the child welfare system alone cannot address the larger social inequities that influence individual lives; at the same time, the ways in which a system intervenes in the lives of families should not exacerbate racial inequities. *The purpose of the IA is to examine how system interventions currently contribute to negative outcomes for African American children and families.*

In examining the issues of disparities in services and outcomes, the IA specifically focuses on the experiences of African American children and families. The IA first uses quantitative data to determine where within a system disproportionality and disparity exist, and once priorities are determined, qualitative methods are implemented to identify problematic features of the child welfare system.[13] This report describes the problematic practice identified by the IA in Fresno County, California. Institutional features (policies, practices, protocols, education and training, etc.) contributing to the poor outcomes for African American children and families identified in this report are both local to Fresno County and may have implications for work at the state and national levels.

During and after the IA study, the leadership of Fresno County DSS exemplified diligent commitment to self-examination, correction and ensuring equitable services and supports for all families. Fresno County leaders decided to tackle what is a difficult national problem. DSS provided extensive assistance in organizing the IA and devoting staff time to the process. Workers, supervisors, attorneys, community partners, parents, youth, and foster parents all willingly participated in the process and committed to improve DSS so that African American children and families are safe and strengthened by child welfare interventions.

FRESNO COUNTY

County Information

Fresno County is located in the Central Valley of California and mainly known for its agricultural industry. The county has a population of almost one million people, with approximately 500,000-600,000 people living in the city of Fresno. Despite its rich agricultural resources, a 2005 study found that Fresno County had the highest concentration of poverty in the nation.[14] As of December 2009, 30 percent of Fresno County children lived in poverty and 58 percent were in low-income households.[15] Additionally, Fresno County's residents struggle with high rates of joblessness and low levels of educational achievement. In 2009, the unemployment rate in Fresno County was 17 percent and the high school dropout rate was 24 percent.[16]

Department of Children and Family Services

The Fresno County Department of Social Services (DSS) is responsible for providing children's mental health services, early intervention and prevention services, child protection services, licensing and support of foster parents and adoption services.[17] At the time of the review, the Department was configured to have 643 employees, 484 of whom worked in child welfare. Depending on their specialty, caseworkers are outstationed in one of five local offices, each dedicated to a different aspect of work, such as adoptions or emergency response. Depending on practitioner educational and field experience, social work caseload maximums are as follows:

- 1 reunification practitioner to 30 children
- 1 adoption practitioner to 35 children
- 1 permanency practitioner to 50 (or more) children
- 1 supervisor to 7 practitioners

The agency opened an average of 60 cases per month in 2009. On October 1, 2009, there were 2,414 children and youth in court-ordered out-of-home DSS custody and an additional 202 in court-ordered family maintenance (cases where children remain at home but with supervision by the courts).

The vision and mission statements of Fresno County DSS follow:

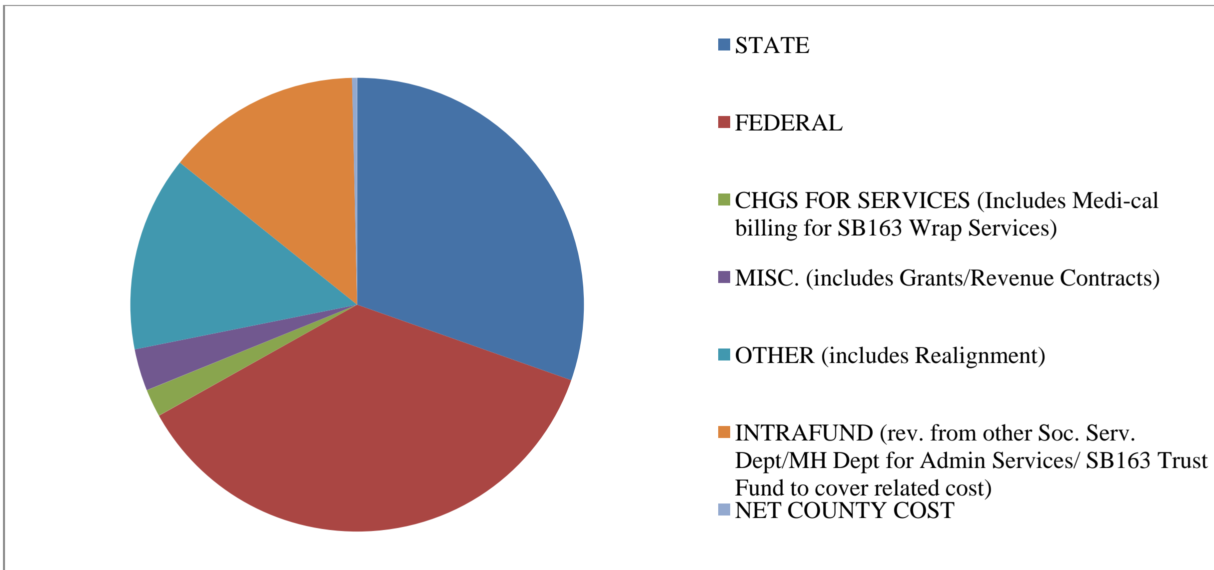
> **Vision:** *To lead an integrated network of community partners that supports, protects and strengthens children and families.*
>
> **Mission:** *To promote a system of best practice in partnership with the community, committed to prevention and early intervention, that ensures child safety, permanence and stability, family well-being, that is proactive, strategic, outcomes-based and fiscally responsible to the children and families served. To fulfill this mission, County of Fresno employees and community partners provide assessment, intervention, prevention, placement and mental health treatment services for infants, children, youth and families of Fresno County.*

Child Welfare Financing

DSS has a long history of operating within fiscal constraints. In interviews conducted for the Institutional Analysis (IA), community and DSS leaders repeatedly stressed the lack of sufficient resources in Fresno County for all families.

The majority of funding to DSS comes from federal and state allocations. DSS also receives funding from Fresno County and foundation support.[18] In addition, DSS receives reimbursement for placement and services through Social Security Income for some children and youth in care, child support payments and fees for service paid by families involved with DSS. See Figure 1 below for more information on funding sources for child welfare services.

Figure 1: Percentage of DSS FY 2009/2010 Budget by Funding Source



Source: Fresno County Department of Social Services

Like other counties in California, Fresno County's DSS has been affected by cutbacks in the state budget. For example, Medicaid no longer covers adult mental health services, which has affected the agency's ability to offer family therapy. More specific to Fresno is the limited state support received as a result of a formula linked to each county's historical designated expenditures per full time employee (FTE).[19] Fresno County's FTE reimbursement rate is much lower than comparable counties', and such low levels of state funding have reportedly made it difficult for DSS to provide families with the adequate level of resources.

Juvenile Dependency Court

The Juvenile Dependency Court in Fresno County is responsible for the legal oversight of child welfare cases. There is one Judge and one Commissioner in this unit. Children, parents and DSS workers each have legal representation. The Court reviews cases and issues orders on matters

involving the placement of children, visitation among family members, medication of children and various treatment programs for children and parents. The Court remains involved in a family's case from the very first decision to remove a child until the child is sent home, enters into a legal guardianship, is adopted or emancipates from the system. In Fresno County, some legal guardianships continue with court oversight through a review hearing every six months (these arrangements are known as "guardianships with dependency").

At the time of the IA, children were generally represented by the attorneys at the District Attorney's office, where five attorneys represent about 1,900 children and youth in care.[20] Parents are usually provided an attorney from the Public Defender's Office where four full-time attorneys and one supervisor represent approximately 950 parents. Families may be represented by private attorneys if they choose (and can afford one), and in the event of a conflict of interest, the courts will provide access to other attorneys. DSS is represented by County Counsel at dependency hearings.

Fresno County's Work to End Racial Disproportionality and Disparities

The disproportionate representation of African American families in the Fresno County DSS is not new. In 2000, African American families comprised five to six percent of the general population but 24 percent of youth in foster care. Since then, Fresno has taken a series of steps to address racial disproportionality and disparity experienced by African American children. After the implementation of these actions, Fresno County saw a decline of African American children in foster care: by 2009, African Americans represented 17 percent of youth in care. Some of the innovative steps DSS has taken include:

- In 2001, the county Board of Supervisors appointed an oversight committee made up of stakeholders from various community-based organizations, agencies and foundations. The mission of the Foster Care Standards and Oversight Committee is to "provide oversight for and promote communication between the Board of Supervisors, the Department of Children and Family Services and its related agencies and the community, with emphasis on providing information and recommendations that make the system more effective and efficient." [21] This committee meets monthly and provides annual reports that include specific recommendations to the Board. They have a consultative role around community issues such as mental health, education and foster care resources. This group has also been involved in Fresno County's efforts around reducing racial disproportionality in child welfare.

- In 2003, Fresno County began implementing *Family to Family*, a national initiative developed by the Annie E. Casey Foundation. *Family to Family* focuses on meeting the individual needs of children by making decisions inclusive of families and their informal supports and promoting practices to support placement with kin or in their own communities for children removed from their homes. As part of this work, Fresno County has worked closely with community partners and community members to help DSS staff understand neighborhood mores, values and practices.[22]

- Since 2003, DSS has closely tracked data by race and now has a webpage dedicated to analyzing and distributing this information to the public. This includes information on placement, time in care and exits from care.[23]

- Starting in 2006, staff participated in *Undoing Racism™* training,[24] a workshop delivered by the People's Institute for Survival and Beyond. The training emphasizes a genuine understanding of racism, including its history and present day implications. Ongoing training on institutionalized racism and oppression continues.

- Staff participate in brown bag lunches on equity issues.

- Since 2004, DSS has partnered with a group of community members who work as advocates with families of color to help bridge cultural gaps that may exist between the families and the agency. These individuals are called "Cultural Brokers."

- Fresno County DSS is currently participating in the California Disproportionality Breakthrough Series Collaborative. Casey Family Programs is sponsoring 14 teams from around the country to focus on reducing disproportionality and disparities for children and families of color in child welfare. The sites are learning labs for new ideas and share findings. Fresno's team is focused on reducing disparity in educational outcomes for African American children and youth involved with DSS.

These efforts have helped DSS and some of its partners increase understanding of racial disproportionality and disparities within the child welfare system and may have contributed to a decline in the racial disproportionality at entrance to care. The agency is to be commended for this accomplishment. However, prior to the IA, DSS recognized significant disparities in outcomes persisted, specifically:

- Delays in, and declining rates of, reunification
- Longer placement episodes for African American children than other groups of children

Reunification

An analysis of the Fresno County administrative data indicates that, once removed from their homes, African American children (identified as Black in Fresno's data) are less likely than any other racial or ethnic group to reunify with their parent(s). Table 1 provides a snapshot of the available data. This table displays reunification rates for children entering foster care in the years between 2002 and 2007 for three ethnic groups: Black, White, and Hispanic. For the most part, data show consistently smaller percentages of Black children exiting to reunification compared to White and Hispanic children.

- Of the White children who entered foster care sometime in the first half of 2002, about 38 percent were reunified with their families within 12 months. In contrast, 27 percent of the Hispanic children and about 12 percent of Black children were reunified with their families within a year. The percent of Hispanic children in the 2002 cohort who reunified within 24 months exceeded the percent of White children reunified within the

same time period while the percent of Black children reunified continued to be significantly lower (about 20 percent). The percent of Black children reunified within 36 months continued to be less than half the percentage of White and Hispanic children reunified within the same timeframe.

- Although an increasing percentage of Black children were reunified in the cohorts of children who entered in 2003 and 2004, the pattern among the three ethnic/racial groups remained similar to the disparate distribution of the 2002 entry cohort.

- The 2005 entry cohort appeared as if it would break the pattern established by previous cohorts. Among the Black children who entered in the first half of 2005, about 23 percent exited to their parents within 12 months compared to 11 percent of Hispanic and 18 percent of White children. However, over the next 12 to 24 months, the picture changed dramatically. While the percent of Black children reunified remained the same, the percent of White and Hispanic children reunified within 24 or 36 months grew significantly.

- The pattern identified in earlier entry cohorts resumed with children entering foster care in 2006 and 2007.

Table 1:
Fresno County Foster Care Entry Cohort Data:
Percentage of Children Exiting to Reunification
Entry Cohorts Represent Children Entering Foster Care in the first six months (January 1 – June 30) each year from 2002-2007

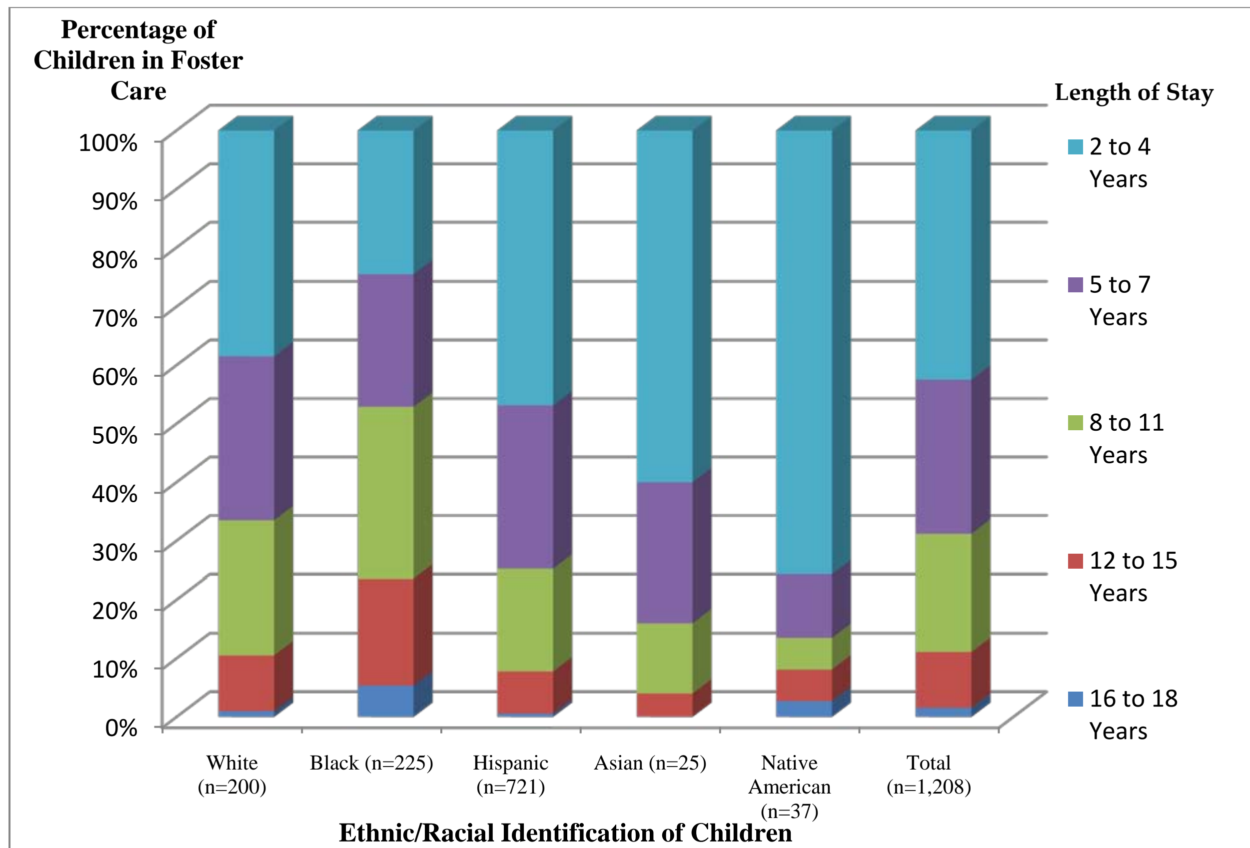
Ethnic Group	12 months %	24 months %	36 months %
2002			
Black	12.1	19.7	19.7
White	38.1	38.1	45.2
Hispanic	26.5	44.5	47
2003			
Black	13.8	20.7	27.6
White	27	34.9	38.1
Hispanic	29.2	39	48.1
2004			
Black	16.7	28.6	31
White	30.5	42.4	44.1
Hispanic	21.8	39.3	42.7
2005			
Black	23.1	23.1	23.1
White	18.2	42.4	42.4
Hispanic	11.4	40.3	44.3
2006			
Black	0	0	0
White	29.2	50	50
Hispanic	11.5	41	41
2007			
Black	14.3	19	N/A
White	19.1	34	N/A
Hispanic	20	48.6	N/A

Source: Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Cuccaro-Alamin, S., Williams, D., Zimmerman, K., Simon, V., Hamilton, D., Putnam-Hornstein, E., Frerer, K., Lou, C., Peng, C. & Moore, M. (2010). *Child Welfare Services Reports for California*. Retrieved 4/19/2010, from University of California at Berkeley Center for Social Services Research website. URL: <http://cssr.berkeley.edu/ucb_childwelfare>

Duration of Placement

As of June 30, 2008, Fresno County's African American children stayed in care significantly longer than other ethnic/racial groups. On June 30, 2008, 1,208 children had been in foster care two years or more. As reflected in Figure 2, the largest proportion of these children, 43 percent, had been in care two to four years and 2 percent had been in care 16 to 18 years. Among all children, about 31 percent had been in care eight or more years. However, 53 percent of the Black children in custody had been in care eight or more years. By comparison, 34 percent of the White children; 25 percent of the Hispanic children; 16 percent of the Asian children and 13 percent of the Native American children had been in care eight or more years.

Figure 2:
Fresno County Children in Foster Care Entry two or more years
Distribution by Ethnic/Racial Identification and Length of Stay
June 30, 2008



Source: Children's Research Center SafeMeasures® Data. Fresno County, CFSR Measure C3.1 07/01/2008 and 6/30/2009. Retrieved July 27, 2009 from Children's Research Center website. URL: https://www.safemeasures.org/ca/

FOCUS OF INQUIRY

The Center for the Study of Social Policy (CSSP) identified the focus of inquiry based on the data previously discussed and in consultation with the Fresno County IA Advisory Committee, which consisted of DSS representatives, legal advocates and DSS community partners. The data show disparate outcomes for African American children and families; thus the focus of inquiry is on the experience of this population. In particular, the IA posed on the following questions:

What organizational factors contribute to the fact that African American children, who have been removed from their parents due to abuse or neglect, experience low reunification rates with their parents?

After establishing that African American children spend significantly more time in out-of-home care than other racial or ethnic groups, a member of the study team reviewed individual cases involving African American families in Fresno. This case review uncovered an interesting phenomenon. While African American children were experiencing long stays in out-of-home care, some were in one stable placement for many years, often with a relative. This suggested they may be achieving "relational" permanency (strong, but informal bonds with caring adults) in the absence of a legally designated permanent placement. To better understand this phenomenon, a second question was developed:

How are the needs for stability and nurturance being addressed for African American youth who are not reunified with their parents?

This question explores the experience of African American youth involved in the child protection system and the institutional features that support these youth in obtaining permanent, stable, loving families.

METHODOLOGY/APPROACH TO THE STUDY

The IA is an approach that combines quantitative and qualitative methodologies to explore questions such as those of concern to Fresno County. It employs methods of data collection and analyses traditionally used in case studies, organizational assessments and managerial audits combined with the concepts and assumptions of institutional ethnography.[25] Using multiple data collection strategies and sources, the IA explores how child welfare work in Fresno County, as it is institutionally organized, contributes to poor outcomes for African American children in the child welfare system. The focus of the IA is not on identifying the shortcomings or failures of individual caseworkers, judges, lawyers or police. Instead, the IA seeks to identify and examine problematic institutional assumptions, logic, policies and protocols that organize practitioner action.

As a managerial assessment, the IA is intended to make visible problematic policies, practices, programs and other structures that may be impacting racial disparities, so that institutional remedies (policies, programs, administrative protocols, etc.) can be crafted. Further, as a case study, the IA is valuable in pointing to possible new directions for research and hypothesis testing in the field at large.[26]

The remainder of this section provides a basic overview of the IA methodology as applied in Fresno County, including the analytical assumptions and framework, data collection and analysis, and study limitations. (For a more detailed description of the methodology, please see Appendix A).

Analytical Assumptions

The inquiry of the IA is grounded in the viewpoint of family members, children, fathers, mothers and other primary caregivers. It seeks to discover how the ways in which institutions organize their workers to describe, document and act on cases can inadvertently contribute to poor outcomes for family members. It is grounded in the notion that there is often a gap between what family members need to be successful in reunification or establishing a permanent home where children thrive and how the workers acting on cases have been coordinated and organized to intervene.

The IA is guided by several assumptions related to how institutions work, the inquiry process and institutional racism.[27]

Assumptions about how institutions work:

- *Institutions are designed to ensure consistency among staff and to limit the influence of individual worker behavior.*[28]

Institutions generally seek to have workers treat similarly situated cases similarly. Regardless of the idiosyncratic beliefs of an individual worker, institutions seek to coordinate and organize individual practitioner actions by employing certain standard practice to produce institutionally authorized results or outcomes. In other words, staff members are guided to do their jobs within

the context of the forms, policies, philosophy and routine work practices of the institution in which they work. Therefore, when case management practices produce consistently poor results for an identified group of children and parents, a part of the problem must lie in the way workers are organized to process or manage the cases. The analytical framework that follows elaborates more on the methods by which institutions direct workers to think about and interact with families.

- *The institutional view of clients can be biased.*[29]

The same institutional rules, policies, forms and manuals that are designed to establish consistency and neutralize individual worker bias can still produce a biased picture of clients. To effectively process large numbers of clients, institutions necessarily rely on segmenting them into cases and then further segmenting them into categories of cases from which interactions follow. Individual information – strengths, needs, fears, aspirations – is filtered through the categories, forms and rules employed by the institution which may produce institutional bias.

- *The diverse experiences of members of any community must be accounted for in the design of institutional interventions.*

Public institutions serve communities with different identities and histories. While the service entry point is the same for all, each entrant brings his or her own cultural assets and problems. Yet, the institutional response is more likely to deny the differences in an effort to be consistent, unbiased and/or "color blind." In order to serve all children and families well, consideration of the diverse experiences and needs of all recipients of services must be incorporated. If not, the unique aspects of individuals disappear and well-intentioned interventions may be misguided.[30]

Assumptions about the inquiry process:

- *Population specific studies produce valid insights.*

Population specific studies have become commonly accepted in the field of public health in trying to understand how and why different portions of the population have different health outcomes. [31] As a result of population specific studies, greater understanding has been gained about the contributors to the outcomes achieved. Valid studies are not limited to large, statistically valid research methodologies. Often, qualitative case studies of small, non-randomly selected populations "triggered by a curious observer can lead to new hypotheses for exploration."[32]

- *Institutional changes can improve outcomes for children and families.*

The fields of management and financial auditing and program evaluation have established that analyses of institutional features identify areas for improved performance across a wide range of organizations and settings. As described by one author, "The management audit…focuses on results, evaluating the effectiveness and suitability of controls by challenging underlying rules, procedures and methods…they are potentially the most useful of the evaluation methods, because they result in change."[33]

Assumptions about the effects of institutional racism on African American families:

- *Institutional racism has meant that African American families are subjected to systemic and structural disadvantages in terms of income, education, housing and other such opportunities and resources that contribute to stability and advancement.*

This historical disadvantage comes into play in all aspects of family life and government or state intervention into family life. It must be taken into account and addressed when working with African American families.

- *African Americans have experienced historical and current obstacles when interacting with public systems, including schools, courts, health care and others.*[34]

African Americans as a group have had many negative experiences over the centuries of state involvement in family life that has produced a low level of trust that public systems will work toward their benefit. Thus, child welfare system must acknowledge and account for this in their individual interactions with African American families.

- *African American communities are often viewed as "troubled" within environments that are not conducive to producing good outcomes.*

African American communities are complex with a range of challenges and resources. Strategies need to recognize and capitalize on the strengths of the communities, employing both formal and informal supports assisting families.

The Analytic Framework

Core standardizing methods for organizing how workers think about and interact with families

- *Mission statements, job descriptions, job functions.*
- *Externally established laws, regulations and other governmental requirements such as the Adoption and Safe Families Act of 1997.*
- *Internal administrative policies, protocols and procedures such as team-decision making meeting protocols, decision-making panels, formats for case plans and court reports and case recording.*
- *Accountability structures and practices that dictate who is accountable to whom and for what are they accountable.*
- *Procedures and communication for linkages (passing along critical information about families) among service providers.*
- *Professional development, training requirements and opportunities provided for knowledge and skill building.*
- *Concepts, theories and language of interventions used.*
- *Resources—time and money—available to workers when performing their jobs and families.*

The analytic framework for the IA, which drives the selection of data sources and collection methods, identifies problematic features and produces recommendations, is depicted in Figure 3. The graphic is designed to illustrate how various institutional features of the child welfare system can influence the outcomes African American children and families experience when they become involved with the system. In this framework, the child welfare system encompasses not only the child protection agency but the courts and community partners as well.

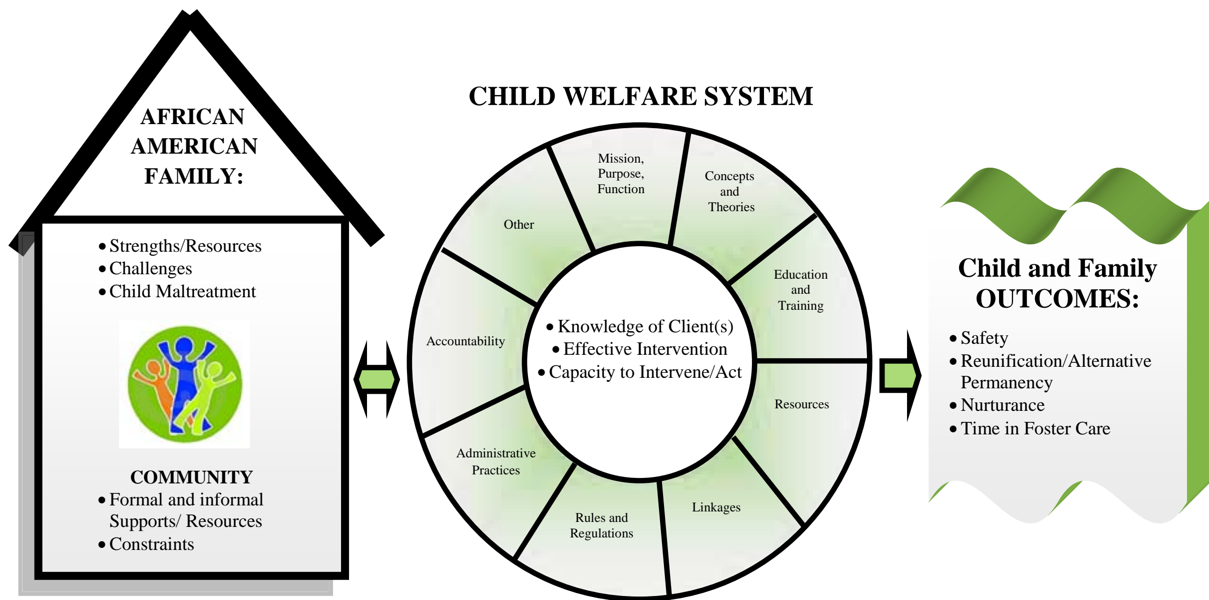
When the system is functioning well, the expected *outcomes* are that children will be safe and nurtured while in foster care, will be reunified with their families as quickly as possible or will be connected to another permanent family to limit the amount of time children spend in foster care. When these outcomes are not achieved or there is a disparate pattern of achievement, then there is a system problem to be identified, assessed and remedied. In the work with Fresno County, the starting point for the IA was based on several years of data indicating outcome disparities for African American children.

The body of work supporting the IA suggests there are at least eight primary or *core standardizing methods*[35] that institutions use to organize how workers know families, work with them and have the have the capacity to act in a way that supports reunification and nurturance.[36] These methods are listed in the sidebar on the left as well as in the *Child Welfare Systems* wheel in Figure 3. (Each of these methods is described in more detail in Appendix A.) Any one or combination of these methods can be problematic to achieving the desired outcomes more equitably.

The analytical framework applies a very specific lens to the child welfare system. It is designed to capture and consider the interaction of *African American families* with the child welfare system as experienced by those families in the context of their lives and community. That is, the framework acknowledges that African Americans experience pervasive and continuing disadvantages in many life outcomes including in the areas of education, health and wealth. It assumes that patterns of racism exist and that these patterns are present in institutional practice. The patterns are often subtle and so embedded in daily practice that they are not fully visible to the observer, hence the need for an intentional assessment.

The analytic framework of the IA therefore scrutinizes these eight core methods for their effect on African American families.

Figure 3: The Institutional Analysis (IA) Framework



Institutional Analysis Team

A team of 24 people, including staff and consultants from CSSP, Praxis International, the Annie E. Casey Foundation, and Casey Family Programs, conducted Fresno's IA. The collective experience of team members represents decades of experience at all levels of child welfare from frontline practice to state agency leadership. In addition, most members had a variety of experiences providing technical assistance to jurisdictions throughout the country on child welfare issues. Team members were trained in August 2009 on the IA core standardizing methods, interviewing and other data collection skills. A team of Fresno DSS staff were assigned to assist the IA team in obtaining files, verifying agency policies and procedures and coordinating meetings and travel.

Data Collection Tools and Activities

Data collection began with an examination of quantitative data provided regarding the outcomes experienced by African American children in Fresno County. Data were analyzed by decision points in case processing and over time to identify areas of racial disparity. The IA proceeded using a variety of qualitative methods as indicated in Table 2 and described in greater detail in Appendix A—Methodology.

Table 2: Summary of IA Data Collection Activities

Activity and Timing	Purpose
June-November 2009: Big Picture Interviews With **13** Individuals	Interviews with Department leadership, Community Partners, Technical Assistance Providers gave a better understanding of issues such as funding streams, local political structure, court and DSS structure, local data, missions and directives of the child protection agency and its partners.
November 2009: Case-Based Analysis of **6** cases, including interviews with **49** individuals	Using a specific protocol, case-based analysis obtained an in-depth examination of the effectiveness and quality of human services interventions with children and their families. [37] (Appendix B provides a summary of each assessment item in the protocol and further describes the case-based analysis process in the IA process). The 6 cases involved children of all ages who were identified as African American and the children had been in custody over two years.
December 2009: Individual Interviews with **60** agency social work staff, private providers, community partners	The interviews were designed to understand the everyday case processing and managing routines of child welfare practitioners and their partners. Interview participants were selected to gain perspectives from the provider community, clients (parents and youth), system partners (court officers, attorneys, child advocates), agency practice initiatives and staff who were currently processing cases as frontline workers and who were considered by the agency to be competent workers.
December 2009: **18** Observations of: juvenile court, parenting classes Team Decision Making meetings, Child Focus Team meetings, No Family Reunification Panel and frontline workers	Observations provided the opportunity to see practitioners of different experience and skill level performing the tasks and duties and responsibilities discussed in the work practice interviews. Observations served to flesh out the interviews by identifying when and why practitioners may deviate from stated work practices and to provide a better understanding of the work conditions, time pressures, interactions among interveners (i.e. judges, family members, workers, attorneys, etc.) and availability of resources to get the job done.
December 2009: **3** Group Interviews with groups of parents and youth	These group sessions were designed to seek a range of perspectives on how the system worked for "clients" and to gain understanding about what was happening in their lives as they proceeded through various points of case processing.
December 2009: **9** Group Interviews with groups of guardians, attorneys for parents and children, frontline family reunification and permanency workers and Cultural Brokers	These groups were composed of individuals who perform the same function or are involved in the same process and were designed to obtain their reflections and observations of their work and to prompt exchanges about the intent of the process, the institutional organization of the process, the relationship of various players in managing a case through that specific part of an overall process and the eight core standardizing methods (regulations; resource allocation; administrative tools; lines of accountability; training; linkages to each other and others; institutional assumptions, concepts and operating theories, etc.)
December 2009: Guided Review of **32** Paper Case Files	Data collection from case files was intended to learn how the case workers come to know the family, what forms are used, how interaction with families and service providers are documented and what knowledge is gained about the family.

Data Analysis and Safeguards to Bias

Data analysis occurred concurrent with data collection. Each new insight or piece of information was considered in light of previous information gathered, starting with the original analysis of Fresno's quantitative data on reunification rates by race and ethnicity. The on-site data collection team debriefed as a whole at the end of each day, and representatives of the IA Advisory Committee and Fresno County Quality Assurance staff and leadership joined in the discussions. The team met with Fresno County child welfare leadership at the end of the on-site work and provided an overview of the preliminary findings, asking for feedback and clarification. Each finding that is included in this report had to be supported by multiple data sources to be considered valid. Observations that did not meet the multiple source test were rejected. A draft of the report was shared with Fresno County to obtain further feedback on findings. Although specific case examples are used to illustrate particular findings, the data presented are common occurrences, not rare events.

Limitations of the IA

Led by the data and the concern of Fresno county leadership, this IA focused only on the experience of African American families and findings are based on the experience of a limited number of African American children and families. As a result, this study should be considered a beginning point of the analysis, not an exhaustive investigation. It was not intended to identify the root causes of disparity but to point out problematic institutional features that contribute to disparities so that these can be remedied.

This is uncharted territory for the child welfare field as little attention has been devoted to unpacking the interaction between organizational dynamics and family experience, particularly for the African American family. Each application of the IA identifies new lessons and opportunities for refinement and strengthening of the next application of the IA.

CSSP and Fresno County recognize that other racial and ethnic groups experience disparate treatment and outcomes. The institutional features identified in this study may also affect other populations of children and families. Finally, some of the institutional features discussed in this report may also impede quality service delivery to all children and families in Fresno County.

PROBLEMATIC INSTITUTIONAL FEATURES CONTRIBUTING TO POOR OUTCOMES FOR AFRICAN AMERICAN FAMILIES

This report describes in detail some of the most prominent problematic institutional features contributing to slow or low reunification rates for African American children and that also contribute to the lack of nurturance and legal permanency for African American children who have been in foster care for long periods of time. The discussion provides examples from the data collected, but again each example represents common, not aberrant, practice. The information presented was verified by multiple data sources and multiple examples. The report's findings are organized under each of the IA's two focus questions. At the beginning of each question is a case story that illustrates the overlapping nature of the findings described in the report.

Research Question 1: ***What organizational factors contribute to the fact that African American children, who have been removed from their parents due to abuse or neglect, experience low reunification rates with their parents?***

*CASE STORY—WALTER**

Walter and his wife, Janice, were married and had four children when they became involved with the child protection system (CPS). Walter and Janice struggled financially and Janice had a long history of crack cocaine addiction. The four children had lived with their parents or extended family members since infancy. Concerned family members called CPS several times to report the parents for child neglect. In 1998, CPS removed all four children based on both parents' substance abuse issues and inadequate provision of food and supervision for the children. Both Walter and Janice initially did not participate in the services offered by DSS and, after the children had been in care 18 months, Walter and Janice voluntarily agreed to a legal guardianship with Walter's brother, the children's uncle. Two years later, this uncle passed away and all four children came back into care. In the two years his brother cared for his children, Walter remained active in the children's lives and saw them regularly. Walter also paid for and completed a six-month inpatient drug treatment program and a three-month outpatient treatment program. After the death of his brother, the children were placed with Walter's relatives. However, these relatives struggled financially to take care of the four children and repeatedly asked DSS for help in accessing health insurance, mental health services and clothing for the children. After struggling for nearly a year to access services and financial assistance, the relatives asked DSS to take the children. DSS placed the children in separate foster homes and because of mental health concerns, the older girls were initially placed in separate specialized foster homes. Upon the children's reentry into foster care, Walter asked to have his children returned to him. However, having failed to reunify with the children two years previously, DSS did not provide any reunification services. DSS did provide Walter and Janice with weekly supervised visits and Walter, but not Janice, consistently visited with the children. Soon after their placement in foster care, Walter, without assistance from DSS, completed classes that addressed domestic violence and parenting, and he began participating in random drug testing. Walter, thus, completed all requirements of his original reunification case plan. He provided documentation that he had completed all services required by DSS. Two years into their time in foster care, Walter asked to be and was reassessed for placement of his children. He shortly thereafter tested positive for marijuana (that he claimed was medical marijuana for a documented medical condition). DSS denied reunification services and continued supervised visits and drug testing for Walter. He tested clean for five additional years and during this time repeatedly urged his lawyer and caseworker to return the children to his care. He was never reassessed during those five years. Finally after much urging by Walter, his lawyer successfully brought a motion to change the goal of his oldest three children to reunification. At the time of the review, Walter had safely reunified with two children and was pursing reunification with his other children.

*Names and some other identifying information in the case stories and case examples have been changed to protect the privacy of the individuals who participated in the IA study.

1. DSS lacks sufficient policies, protocols and supervisory practices to prevent negative assumptions of African American families from impacting worker-client interactions.

In order for social work to be most effective, the agency should create a climate in which a worker and a family can develop mutually trusting relationships.[38] Considering the sensitive nature of this work, trust does not often come naturally. Historically, families of color have had negative experiences at the hands of public institutions and people in powerful roles. These past experiences can create barriers to trust on the part of families and the agency. In addition, some African American families have multiple stressors (economic pressures related to housing and employment, single parent households, neighborhoods connected to struggling schools, etc.) that impact the quality of their parenting. Their needs may be different and their comfort level in expressing those needs to representatives of public systems may differ as well. It is critical for child welfare policies and practices to recognize these dynamics and organize the work of their staff in ways that support the building of relationships with families that can promote change.

DSS uses Cultural Brokers who serve as advocates for African American families as one strategy to counter these problems. Cultural Brokers are "community members that have received extensive training on the child welfare system [and] the *Family to Family* Initiative...Ideally (but not always) the Brokers will be of the same culture as the family and/or have an extensive knowledge base of the family's culture."[39] DSS policy directs the caseworkers to collaborate with Brokers "so that better outcomes are achieved for the family." The role of a Cultural Broker is to ensure that families understand decisions made by DSS and the court, participate in decision-making processes whenever possible, and provide a fuller understanding to DSS and its partners of the family's strengths and needs. Cultural Brokers are an example of policy that recognizes the sensitive nature of this work and the needs of different populations of families. While this appears to be a promising strategy, there are a limited number of Cultural Brokers, so not all families have access to this resource and most are on their own to negotiate relationships with DSS.

- ***DSS has insufficient mechanisms to prevent negative stereotyping of African American families.***

Interviews with parents, youth, workers, attorneys and other providers demonstrated that negative assumptions about African American families and communities exist and can directly influence interventions with a family. DSS has not sufficiently addressed the pervasive negative attitudes and beliefs of many staff about West Fresno. During a focus group one worker lamented "A new [DSS] office is being opened in West Fresno. How close do we need to be? We don't need to be in the neighborhood of the people." Similarly, a provider expressed frustration about working with African American children. This provider talked of trying to expose youth to a "different value system," but then these youth "go right back to these same environments [West Fresno] with the same high risk factors."

Several workers and providers talked about African American youth being different from other youth. A caseworker described most African American children as being "more drug-exposed" and that she believed the exposure impacted their ability to function because "there is something that just doesn't connect in their brains." A service provider attributed poor outcomes for

African American youth to their desire to be "the new 'Puffy' and the new 'LeBron.'" Many workers commented that African American youth, particularly youth with dredlocks, paid too much attention to their hair. Workers discussed the difficulty in dealing with foster parents around the hair care needs of youth and how youth themselves spend an enormous amount of time "twisting" or otherwise caring for their hair to the annoyance of school personnel, foster parents and other adults. Workers are not directed by the child welfare system to examine hair care as a part of a cultural dynamic in African American communities. In fact, some research suggests that building a sense of pride in a youth's racial/ethnic identity, which can be expressed in part through hair, can serve as a buffer to mental health problems, particularly depression,[40] and thus it is important to support the development of such identity in youth.

- ***DSS has insufficient supervision, policies and protocols to promote workers using a strength-based approach with families.***

As a DSS caseworker stated, "there is no clear agency directive that states that workers are to be engaging and hopeful toward the children and parents they serve." Parents expressed the desire for less judgment and condescension from workers and providers. One parent talked about having "no hope. You feel like everyone is out to get you." Other parents talked about feeling negatively labeled by DSS and stated, "We even have to enter the building through the side door; we're not good enough to walk through the front door."[41]

From the review of case files, it is readily apparent that youth were told their problematic behaviors were part of what might slow down reunification. *Walter's oldest girl, a 17-year-old high school student, regularly skipped classes while he was attempting to reunify. Both Walter and her caseworker told her that in order to be sent home she must behave and do well in school. As a result, to this day the girl believes that her behavior directly contributed to the slow reunification she experienced and believed that she was to blame for the fact it took seven years to achieve reunification with her father.*

One strategy to eliminate or at least neutralize negative assumptions of African American families is for workers, lawyers, judges and other providers to identify and genuinely understand a family's strengths and needs. A number of DSS documents such as the quarterly assessment form and forms that guide Team Decision Making meetings require workers to list family strengths. However, in examining foster family agency reports to DSS of youths' progress, the same strengths ("likes to dance," "loves her sister," "has good hygiene") were listed on quarterly reports repeatedly despite the growth and development of the child and other changes in circumstances. Furthermore, despite being routinely listed, there was little evidence that the strengths were built upon in the case plan for this child. The case plan focused on attending school, behaving appropriately in the group home and attending her therapy appointments. DSS through administrative mechanisms has not yet consistently challenged all staff to identify, understand and incorporate family and community strengths into case practice and planning.

2. Administrative practices and tools used by workers often result in DSS and the courts making decisions about families without fully understanding the strengths and challenges of each family and the community in which they live.

- ***Instruments, such as drug, domestic violence and mental health assessments, and experts' evaluations of parenting capacities are conducted at one or two points in time and are not effectively integrated into an evolving understanding of the family.***

At the beginning of a case, multiple formal assessments are conducted by DSS to determine the needs of a parent and services and activities. For example, drug abuse assessments and psychological evaluations are frequently ordered by the court and must be completed by parents. The expectation is that these assessments will help the caseworker gain an understanding of a family and create a case plan that is tailored to their needs and will therefore facilitate safe and speedy reunification. For example, in one case reviewed, the mother had a history of domestic violence with the father of her two younger children. She underwent a domestic violence assessment when she had a voluntary family maintenance (preventive services) case and then again when her children were removed. The first assessment found that her risk for domestic violence was high given childhood exposure to domestic violence between her parents and her ongoing love for and continued involvement with the father of her children. Recommendations included that mother stay away from the father and attend individual therapy. The second assessment did not include information about her childhood history and the father was incarcerated, so she scored low on the domestic violence risk assessment. Her children were placed with paternal relatives (an aunt and cousin), and the case plan did not account for the mother's or children's safety or provide any support to the mother about ways to co-parent with the father once he was released from prison. In part because of the failure of assessments to gain a full understanding of the family and use it to shape interventions, this family was ill-prepared to deal with the father when he was released from prison. In this case, upon his release, the father broke down the door of the relatives' home and acted in a threatening manner toward the relatives and his children. The relatives did not report this incident to DSS, but the worker discovered this incident from a police report. Subsequently, the relatives were confronted by DSS about why they did not report the interaction with the father and the children were removed from the relatives' home.

Using one, short study to determine parent-child bond

Bonding studies are used to evaluate parent-child relationships in order to determine if reunification efforts should continue, parental rights should be terminated, or to compare the bonding of a child with their parents versus prospective adoptive parents. The clinician observes the parent or caregiver interacting with the child through activities such as applying lotion to the child's body, feeding the child, having the adult put together a block figure and having the child copy, applying a band aid to the child, or combing each other's hair. The parent chooses a task from a series of cards and follows directions for carrying out that task. The clinician, who is often meeting this family for the first time, explains each activity to the parent. Reportedly, parents sometimes cry during the study for fear of not performing well. Through observation the clinician determines how well the parent/caregiver does in each category and generates a report about the level of bond in the family. Attorneys and caseworkers reported that this short (2-4 hours) study is weighted heavily in the court's decision making about the termination of parental rights.

In Walter's case, he received a drug abuse assessment at the beginning of his case but was never reassessed. He participated in random drug tests for seven years, but there was no further assessment of his potential to maintain sobriety and adequately parent his children. Further, the worker assigned to support reunification still talked about the father as having a problem with drugs even when he had been testing clean consistently for five years. These are not isolated incidents, but examples of how DSS policies and practices do not organize workers to reassess and incorporate new information into an evolving understanding of African American families. Parents reported that the lack of clarity and accurate reassessment was defeating and that their efforts and changes were not recognized as steps towards reunification.

Conflicts in the findings of various required assessments also led to parental confusion about the direction the agency was taking regarding reunification. An African American mother was working to get her children back by participating actively in a domestic violence victims group. The staff at this center regularly documented that she was making good progress in her treatment and was ready and able to reunify with her children. However, a point-in-time mental health assessment was much less favorable. The clinician determined that the mother had a "fixed and enduring personality problem and is too damaged" to get her children back. Despite the mother's compliance with the case plan, that assessment trumped her actions and other assessments. The mother's visits were ultimately discontinued and the children's goal was no longer reunification, leaving both mother and children confused and hurt regarding the process and the outcome.

- ***The service recommendations are generic and not tied to case plans.***

Most parents are ordered to complete virtually the same service plan: parenting classes, psychological evaluations, individual therapy, drug assessment and treatment and domestic violence assessment and treatment. Some of the forms DSS and the courts use are pre-populated with these generic services. Supervisors and leadership stated in interviews that DSS assumes each parent needs all of these services, unless the need is specifically ruled-out through an assessment. Assessments themselves regularly identify services with which parents should comply but do not identify the specific behavior change that is required. Some parents complete all required services and others do not; parental compliance with services is tracked and reported to court. The focus is on parental compliance with the case plan, which may or may not result in the desired behavior change. In some cases, parents are able to get their children back upon completion of services, but in other cases parents who also completed services are not reunified. Throughout the IA, it was clear that parents were unaware of what they needed to do to get their children back, especially if they had completed all of the ordered services. In a focus group with African American parents with children in care, one parent asked, "Why are my children still in foster care if I did what I needed to do? They [DSS] didn't understand the extent to which I had changed." Walter, when interviewed about his experience with DSS, threw his arms up in the air and said, "I give up, just tell me what to do and I'll do whatever you say."

- ***Documentation in case files and court reports are often incomplete, inaccurate or outdated and these deficiencies were not corrected by supervisors or the courts*.**

As a result of fragmented case management, each family involved with DSS comes into contact with many workers (see Figure 4), who are expected to collect and document information from and about the family. This documentation is heavily relied upon to convey relevant information about a family to successive workers, lawyers, judicial officers and decision-making groups. The agency's reliance on specialized workers and specialized decision-making bodies makes accurate documentation vitally important. In order to make the best decisions that ensure the safety and stability of placement and permanency for children and youth, the information needs to be complete and to reach all the necessary parties. Case record reviews and the case-based analysis found that documentation was often incomplete and/or inaccurate, and many errors were left uncorrected.

In one case examined, a mother had her two young children removed from her care based in part on her substance abuse issues. This family was assigned three case managers over a two-year period. Court reports were incomplete; specifically, they did not include full information about drug testing results or the fact that the mother's subsequent pregnancy might account for a gap in her drug testing and her full participation in other services. These reports did not contain details about the full length of the substance abuse treatment program she attended nor did they appear to be supported with written progress reports from providers. Furthermore, the information provided to the court did not reflect the healthy development of her children before they entered foster care. Some of information, such as drug testing results and participation in substance abuse treatment services, was documented in the case file, but administrative forms and supervision of workers did not require that this information be presented to court. Other pieces of information, such as why the mother missed drug tests while in her first trimester of pregnancy and if such drug testing could be accomplished in the prenatal care appointments she was attending, appear to have been lost or not explored. Both the mother and the kinship care provider for her children believed that her case remained open longer than necessary because the court was not fully informed of the progress she had made.

Case files include multiple reports where information appeared to be copied verbatim from past reports but never updated or even mistakenly contained information from other unrelated cases. For example, one case file reviewed contained several handwritten letters from a mother expressing strong desire to have bi-monthly visits with her 17-year-old son in his foster care placement. However, the file consistently read, "[mother] has not made the effort to contact DSS to start the visitation process." In all of these cases, the pace of reunification was negatively affected by the quality of information maintained in files and presented at court.

Information from the parents was often limited or missing at the critical decision points. One critical decision is whether to offer parents reunification services. In California, there are 15 statutory reasons that a parent may be denied reunification services when a child is removed from his/her care and custody.[42] In order to determine whether reunification services should in fact be denied when a parent appears to meet at least one of these criteria, the No Family Reunification Panel, or No FR Panel, meets to discuss the case. The panel is composed of two Family Reunification Supervisors, the caseworker, the Court Report Writer and the Assessment (permanency planning) Supervisor. The individuals participating in the panel vary. Through

interviews, the IA team learned that decisions by the No FR Panel can be predicted by the individuals in the room and that frequently there was little discussion of whether services could be helpful to the family even if they met one of the 15 criteria. Parents' only means of communicating with this panel is the submission of a form stating why they should reunify with their child. However, in the last quarter of 2009, DSS reported obtaining no parental statements for the No FR Panel. There is a question about the extent to which parents understand the nature and importance of this review for the future of their relationship with their children. Further, the premise of denying reunification services for this group of parents was problematic in and of itself given research finding that a significant percentage (more than one-third) of parents who do meet one of the 15 criteria but still receive reunification services are successful in reunifying with their children.[43]

3. Generally, the child welfare system does not support caseworkers to act as advocates to help families obtain services and supports. Multiple reasons for this lack of advocacy include:

- ***Tools for advocacy are not sufficiently built into workers' tasks and relationships.***

According to the social work code of ethics, "the primary mission of the social work profession is to enhance human well being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed and living in poverty."[44] In fulfilling this code, social workers are to act, when necessary, as advocates for families. Advocacy is not purely the domain of lawyers. In order to advocate with, or sometimes for a client, a worker must know his/her client and have an understanding of his/her goals. Advocacy can involve articulating why a particular course of action makes the most sense for a client and negotiating within DSS, with the courts and with other systems regarding the needs of a client. In Fresno County, workers often do not have the knowledge, skills, tools or supervision to advocate for parents and families.

For example, a case record reviewed revealed the experience, over the course of 10 years, of an African American mother with several young children. She had a long history of good parenting with episodic moments of compromised parenting due to significant mental health issues. Her family regularly intervened to provide stable and loving care for the children when the mother experienced deterioration in her mental health. On one occasion, however, the family failed to intervene quickly enough during the mother's mental health breakdown. The mother, in an actively psychotic state and potentially self-medicated with marijuana, drove into a police car while her children were with her and was arrested. The criminal justice and child protection systems were not organized in a manner to jointly assess and treat this mother, and the worker was not directed by DSS to advocate for the mother in order to support timely reunification. The DSS worker's notes reflect that she understood the significant mental health needs of the mother but provided no advocacy to assist her in entering a mental health facility. Further, no protocols exist that facilitate or enforce communication between the DSS worker and probation officer, so the worker had very little information on the status of the mother's criminal case.[45] As a result of insufficient advocacy, the mother was in jail for more than a year awaiting treatment and the disposition of her criminal case. Soon after the mother received adequate medication and mental

health treatment, DSS and the courts allowed her to resume her parenting responsibilities. The lack of advocacy by the worker, as well as by the mother's lawyers, significantly delayed her reunification with her children.

- ***High caseloads affect workers' ability to build relationships with families that can foster change.***

DSS employs caseworkers with a varying level of education and experience.[46] New caseworkers start as a Social Worker I and must hold at least a Bachelor's degree in a social science field, such as social work, psychology and criminology. As caseworkers gain experience at DSS, they have the opportunity to be promoted to Social Workers II and III. The agency also hires a limited number of Master Practitioners. These workers have Master's degrees in social work and extensive casework experience. DSS leadership asked workers for input in setting reasonable caseload caps and ranges. Based on worker feedback, reunification Social Workers III and Master Practitioners, who can have the highest caseloads, now range in case size from 27 to 30 children; Social Workers I and Social Workers II have smaller caseloads. This range is in sharp contrast to the Child Welfare League of America Standards that recommend that a social worker should carry between 12-15 children on their ongoing caseloads.[47] The caseload size for these reunification social workers is too high to adequately work with families.

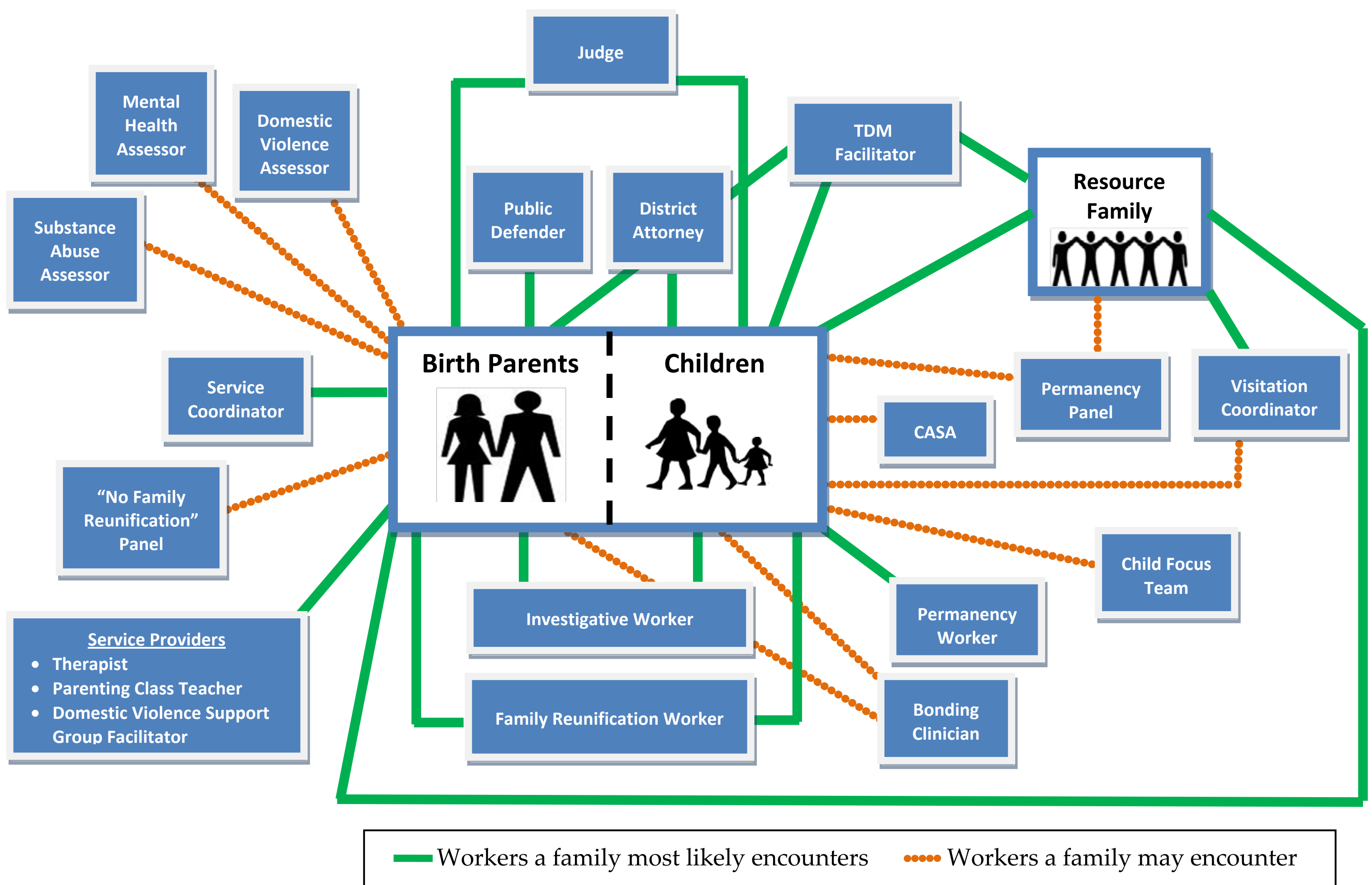
All caseworkers interviewed stated that they did not have adequate time to interact with families. They reported that the majority of their time is spent on completing required paperwork and attending required visits with children. One supervisor reflected that often the agency seems to most value workers who get all their paperwork done on time. As stated previously, accurate documentation is important to conveying critical information about the family, services delivered and efforts of the Department to work with the family. However, documentation is not the only, or primary, role of a caseworker. In observing workers in the field, the practice of prioritizing paperwork over family engagement was evident. In one case shadowed by an IA reviewer, the worker spent the initial time sorting through Medicaid and other paperwork for placement with the foster parent and private agency worker and talking *about* the youth while the youth sat listening. Toward the end of the visit, only after the paperwork was completed, the worker focused her full attention on the youth and engaged the youth in a more natural conversation about how she was doing and what her placement concerns might be. This systemic impediment of high caseloads and an overall lack of an emphasis on family engagement negatively affect workers' ability to build a constructive working relationship with clients.

- ***Frequent rotation of workers reduces the development of expertise that specialization was designed to produce.***

In every case reviewed by the IA team, children and families had multiple workers during the time their cases were open. Different workers are assigned particular tasks such as investigation of an allegation, providing service referrals for children and parents, facilitating a Team Decision Making meeting or visiting children in their placements. In Fresno County, a family will typically have an investigative worker, service coordinator, Family Reunification worker, Permanency worker and perhaps school-based caseworker. In addition to the multiple workers, there are different attorneys representing parents, youth and the agency. Other individuals that a

family may or may not interact with include: a Court Officer; Team Decision Making meeting participants; assessors for treatment related to domestic violence, substance abuse and mental health; Social Work Aides supervising visitation; a Permanency Panel and clinician assessing bonding between parent and child. Beyond the task specialization, worker turnover, worker reassignment to a different unit and case reassignment makes the building of relationships and transfer of information enormously challenging. Workers described the need for a "permanency plan for staff" and noted that the instability of roles reduced their willingness to invest in clients because they did not know how long the clients would be with them. The frequent rotation and interruption of worker/client relationships also reduces the development of expertise that specialization was designed to produce. Thus, the DSS structure undermines the stated purpose behind the creation of this multi-layered, specialized approach to case management.

Figure 4: Child Welfare Workers Intervening in a Family's Life in Fresno County



Agencies typically move toward job specialization as part of an effort to work more effectively and efficiently. However, the IA identified several pitfalls of such specializations in Fresno, including that information gained from one worker may not be adequately conveyed to another

worker, that roles can become so fragmented that no single worker feels they have the power or responsibility to advocate for the family or make decisions about the case and that parents and youth feel unable to build a trusting and working relationship with any worker.

At the beginning of a case, when they are experiencing the trauma of separation and trying to understand child protection interventions, parents and youth encounter a large number of workers. Parents described the number of different workers as confusing, especially since they interacted with some workers only one or two times. For example, parents interact with an investigator when a decision is being made to remove a child. If his/her child is removed, a parent attends a Team Decision Making (TDM) meeting facilitated by another DSS worker. At that meeting, some decisions may be made about services the parent needs. The parent then is directed to see a different DSS work, a Service Coordinator, who refers him/her to services identified at the TDM. Then parents attend the detention hearing where they meet their lawyer, the judge and a different DSS worker, a DSS court liaison. Additional services, not previously identified at the TDM or by the service coordinator, may be ordered at that time. If reunification is offered, the parents will be assigned a new reunification caseworker.

The IA team observed multiple challenges for parents in accessing services related to their case goals and plans because of the rotation of workers. Families can also experience up to a three-week delay in contact with a worker when a case is transferred from an Investigative worker to a Family Reunification worker. The delay is important because service access is a critical factor to ensuring speedy and safe reunification. *In Walter's case, the court-ordered reunification services reinstated but the case was not transferred to a Family Reunification worker for two months. Walter struggled with paying a security deposit on a Section 8 house, adjusting to raising teenage girls as a single parent and advocating for these girls at their school. He received no support from DSS during this delay in the case transfer, and subsequently, the only case service he received from DSS was payment for continued drug testing after five years of sobriety.*

- ***The large array of providers and decision-makers do not support workers in advocating for the services and supports needed by children and families.***

Fresno has taken some innovative steps to improve practice for specific populations of children. However, some of the reforms have resulted in adding more professionals to an individual case, but not supporting workers in an advocacy role for these specific populations of children.

For example, Child Focus Teams have been developed to assess and provide recommendations to case plans for children ages zero to five who are placed by DSS. The largest number of children coming into care in Fresno County is children in this age group,[48] and the need for targeted interventions with these children and their parents is widely recognized.[49] The Child Focus Team is designed to bring a multi-disciplinary lens to understanding and supporting the needs of these children and their families. Teams consist of a social worker, home visitor to the child, public health nurse, education liaison for pre-school and child mental health specialist. Within the first 30 days, a home visitor is expected to meet the child and caregiver, who is not usually the parent, to collect additional information and provide advice and support to the caregiver. The team reportedly updates its recommendations for subsequent hearings. However,

the IA team observed that the Child Focus Team was making its initial decisions about services by reading the information from court reports and other investigative documentation, rather than directly gathering information from the family or others that may be involved with the child. The Child Focus Team also appeared to function as another body that controlled access to resources through bureaucratic action, rather than as an entity charged with assessing and advocating for resources necessary to support a particular child and family. Workers are supposed to follow the recommendations of this consultative team. In practice and by design, no one is designated clearly as an advocate for the specialized needs of children in this age range.

- ***Input from family members is not present in many decision-making meetings.***

Team Decision Making meetings are held at the beginning of cases or upon placement change for children in foster care. Policy requires the involvement of parents and youth. However, many other decision-making meetings occur that directly impact families where workers are not similarly directed by policy or supervision to involve the family. This lack of involvement negatively impacts the ability of the family to access the services they want or need. *In Walter's case, once the court changed the goal to reunification for his oldest children, DSS told him that he must come to their offices for a case staffing about reunification. The oldest children, all teenagers, were not invited to this meeting. Walter reported and the worker confirmed that the purpose of the meeting was to inform him of what services he needed to do to successfully reunify. These services consisted only of continued random drug testing. When interviewed by members of the IA team, Walter and the oldest girls talked about how it would have been helpful to be supported in their transition to living together as a family again and be supported in obtaining academic support for the girls.*

4. Policies about and resources to support visitation between parents and children, a critical element to facilitating reunification, do not support relationships within African American families.

Fresno County policy states that it "is essential to Family Reunification that children and parents visit often during the Family Reunification process. The only exceptions are if the court orders no visits, the therapist recommends no visits, or an older child requests not to visit their parents."[50] The importance of regular visitation between parents and children is well supported with research. According to several studies, regular and meaningful visits between children and their parents greatly increases the likelihood of reunification, shorter stays in foster care and improved well-being.[51] Fresno policy further states that "Visits between children and parents should progress from supervised, to unsupervised, to liberal to extended."[52] Visit location is not restricted to a specific place. All types of parent-child visits are considered a departmental service to the family.

- ***There are insufficient administrative triggers to move families toward unsupervised visitation when safety concerns have been addressed.***

DSS policy suggests that all case circumstances initially require supervised visits but the Department has the flexibility to "request that the court order a third party be allowed to supervise visits. This could be a relative or friend." Although workers are supposed to assess

the necessity of supervised visits, a court order is necessary to progress from the most restrictive to least restrictive visit arrangements; see Appendix C for a description the rungs and criteria for movement on what could be called a visitation ladder policy. This policy assumes that a period of supervised visits is necessary to ensure safety and to provide opportunities for assessment of family strengths and interactions. The IA found that nearly all families began with supervised visits regardless of the reason for entry into care or the specific safety threats to children.

In several instances, it appeared that the criteria for supervised visits were inconsistently applied, confusing and/or clearly outdated given the elapsed time and changed family circumstances since the requirement for supervised visits was first established. That is, if child safety was the initial reason for supervised visits and even when the changed circumstances of child and parent clearly reduced the safety concerns, the supervised visit requirement remained frozen in time.

For example, in one of the cases that was part of the IA case-based analysis, the mother had visits with three of her children supervised by a relative. However, this mother had a fourth child after the removal of her older three children, who remained in her care and custody. The older children questioned why they needed supervised visits any longer since the mother was safely caring for a now three-year-old sibling.

In yet another example, the Department petitioned the court to move children from a placement with a paternal cousin, with whom they had been living for over six months, to a more restrictive placement because the "relative has failed to protect the children by allowing their mother to have unauthorized contact with them." The contact consisted of the mother being in the relative's home preparing meals for the children, bathing the children and putting the children to bed. The paternal cousin also allowed the mother to go shopping at the grocery store with her and the children. In this case, the cousin was not authorized to supervise visits even though she had provided informal care to these children and support to the mother for years. DSS and the court's structure of visitation did not support an already existing family dynamic, which created difficulty and further trauma for the family.

As a final example, a mother experienced inconsistent access to her daughter when the girl changed placements. When her daughter was placed with her father (the child's maternal grandfather), the mother could visit as often as she wanted, as the grandfather was designated as the third party and allowed to supervise visits. However, when the child was removed from the grandfather and placed with another relative who was hostile to the mother, the mother lost visitation flexibility, both in scheduling and location. At the time of the review, her visits were supervised by a visit specialist twice a month in a therapeutic setting. In contrast, her weekly visits with her 14-year-old son were unsupervised, while her 4-year-old son lived with her. There were no identified protective concerns for the daughter. The specialist who supervised the visits believed that the mother and daughter have productive, nurturing visits. Yet, this assessment by the specialist, formed from multiple observation opportunities, did not appear in the family story that was presented to the court. Other professionals with less information believed that the mother and daughter had limited attachment. Not only was this experience of different types of supervised visits stressful to the mother-child relationship, but also the full information about the nature of the mother and child relationships was not presented to court.

All of this information suggests a lack of effective institutional triggers to remind workers and lawyers to regularly and proactively seek modification of court orders concerning visitation and to move to expand visitation when there are no legitimate reasons to restrict it.

- ***Reliance on a centralized location—the DSS building in downtown Fresno—is a barrier for family visits.***

The central downtown office accommodates most supervised visits. However, transportation to and from the downtown location was an often cited as a challenge for African American parents. Case files reviewed regularly show parents calling because of delays in getting to the Central Visitation Center. If parents are late, visits may be cancelled. In addition, the Central Visitation Center offers limited hours for family interaction; it is open until 5 p.m. on weekdays, with no weekend hours. This means that parents who work traditional 9-to-5 jobs ask for time off to attend appointments. The hours are also a problem for children even if the parents have flexibility. For children in school, workers stated that they frequently had to be taken out of school early to get to visits on time. Furthermore, caseworkers believed there was insufficient capacity at the visitation center to ensure regular visiting between children and parents. One case manager commented, "Visits kill me. The visitation center at the agency is booked for months. The community agencies never have any spots." Although DSS has contracts with other supervised visitation centers that have more accommodating hours, their visitation spots were few and quickly filled, especially in afternoons and on weekends.

One of the case records reviewed described initial visits shortly after the children were removed as "going well," and when they did occur, "the mother and stepfather are very appropriate with the minors and the minors follow direction very well." However, after four visits, the process began to break down because the foster parents found it increasingly difficult to transport children from school to the central visitation location. The fifth family visit "included only two of the children. The parents were upset that the two other children did not show up for the visit. The visits have been scheduled for one hour, twice a week…however for the last month, the current foster parents, along with the visitation center staff have had problems getting all parties to attend the visits as scheduled. [The parents] have been frustrated that at times not all the children are showing up to visits at the same time…the undersigned addressed with the foster parents the significance of the visits and making sure that the current visitation schedule is maintained." Unfortunately, the children continued to miss visits and after several months the parents began to miss visits too.

5. Resources within the agency or county are under-utilized by DSS, and those few provided to African American parents are often not relevant to addressing the problems that were preventing them from reunifying with their children.

- ***Existing resources that prioritize families involved with DSS are underutilized.***

Fresno County is struggling economically to meet the needs of all its citizens. Interviews with community and DSS leaders as part of the IA stressed the lack of sufficient resources in Fresno County for all families, and the IA found a lack of resources in critical areas, such as adult mental health treatment). However, an unexpected finding was that there were essential public

resources that exist to support families involved with the child welfare system that were underused in African American families. For example, safe and affordable housing was an urgent need for families with many cases reviewed. Fresno County has transitional housing available for homeless families; for those involved with DSS, there is a 30-day waiting period, while it is three to six months for non-DSS families. Families stay in this housing for approximately two months, allowing them to save money. The program puts 75 percent of their CalWORKs (welfare) payment into savings for the family and 25 percent is available to them for expenses. According to the housing program administrators, DSS staff do not make many referrals to this program and there is availability for additional DSS-involved families. Access to this type of housing support could have accelerated reunification in several of the cases reviewed. *For example, Walter had been living with his mother in a one-bedroom apartment and was told that in order to reunify he had to secure bigger housing. Through the caseworker, he requested DSS assistance in obtaining a security deposit for a Section 8 home. His request was denied twice by DSS according to the worker because there were no funds. Meanwhile, he had liberal visits with his older three children and all would stay in his one bedroom apartment. After several months, Walter scraped together the security deposit from family, friends and his SSI benefits.*

DSS uses a Central Desk to approve requests for financial supports for families. The Central Desk approves expenses for transportation assistance, furniture, rental deposit, orthodontia and drug and alcohol treatment. However, in cases examined involving African American families, many had significant financial needs that were not addressed. While resources in Fresno County are limited, Central Desk staff reported that workers do not regularly ask for services. Specifically, the Central Desk staff reported that, despite misconceptions among social work staff, "there are no limits on the number of rehab placements or treatment services [for parents with substance abuse issues]. There also is no limit on how much money can be used for housing needs, and there isn't a limit on how many times it can be accessed by the same family." Several case files, including Walter's, revealed that housing was a barrier to reunification. Interviews with providers also revealed that they believe there is a DSS policy of only one rehabilitation placement (inpatient substance abuse treatment) per family. DSS internal structures do not effectively relay accurate information to workers and providers about service and resource availability.

Finally, DSS leadership reports that in 50 percent of open DSS cases parents are receiving cash assistance, though 78 percent of families are eligible for this assistance. However, insufficient internal policy exists to help DSS-involved parents connect with the financial support for which they were eligible. Linkages is a statewide innovation focusing on providing coordinated welfare and child welfare services to families.[53] In Fresno, CalWORKs (welfare) job specialists attend Team Decision Making meetings. If a family is eligible for and/or receiving cash assistance and is involved with DSS through a family maintenance case, Linkages will work with them. Families receiving Linkages services have one service plan created so they do not have to comply with a both CPS plan and CalWORKs plan. Linkages funded services include mental health services, parenting classes, in-home parenting programs, substance abuse treatment, child care and transportation, immediate access to food stamps and Medi-Cal.[54] Job specialists at Linkages believe that the program is significantly underutilized and that is not getting referrals despite outreach to DSS.

The IA found that despite protocols supporting collaboration between DSS and essential services, workers did not know about or understand how to adequately access these services for families. Again, this suggests that DSS has insufficient administrative directives and supervision to support workers in accessing these resources for their clients.

- ***Mental health services, supervised visitation and drug testing are used for extended periods of time without sufficient directives when these services can cease.***

While services that support economic stability appeared to be underutilized, mental health and drug abuse assessments, drug testing, therapy and supervised visitation appeared to be highly used and can go on for years. In several cases examined, parents were testing for drug use for many, many years. There was no institutional standard that allowed after a certain time period of proven sobriety for a parent to end drug testing. Some attorneys for parents even suggested that continued drug testing is helpful to their clients because it creates a record of sobriety. However, as parents pointed out, the drug testing protocol requires parents to call every day to determine if they must go to the Center and provide a sample. Drug testing, rather than a service, is used as a surveillance tool that after many years becomes a burden to families. *In Walter's case, the continued drug testing often interfered with his ability to work. Walter had a degenerative health problem, but was able to work on a part-time basis. However, Walter reported that employers were not sympathetic to his need to come late to work because he had to provide a sample at the drug testing center. Walter's health condition also prevented him from driving. He therefore needed to rely on a slow public transportation system to get to the drug testing center and then on to work.*

Such an extended use of services, with strong punitive consequences for noncompliance, does not recognize of the complexity of daily life for the families served. For example, a single mother directed to take domestic violence classes for batterers, even though she was the victim, was only allowed three absences in 52 weeks of classes. If the parent misses more than three classes, s/he must drop out and is considered to have failed the course. When asking if she could miss a class to attend a funeral, the class instructor, directed by policy, told her to consider whether the funeral of a close family member was more important than the class.

- ***There are limited contracts with community-based providers specializing in services to African American families living in West Fresno.***

A limited number of providers regularly bid on contracts offered by DSS. According to several DSS fiscal and contract staff, these are typically larger agencies with sufficient infrastructure to write strong proposals. DSS contracts with only a few smaller community-based agencies based in African American neighborhoods. It was noted that DSS previously procured services through sole-source solicitations in order to target diverse providers or providers located in the minority community. However, that practice has been discontinued and DSS does not conduct outreach to smaller, community-based providers to encourage responses to requests for proposals.

DSS began addressing the issue of limited community-based service providers in part by outstationing staff in a multi-service building based in West Fresno in Spring 2010. However, due to limited funding, effective interventions geared toward African American families are minimal.

Further, most resources are located in downtown Fresno, not in communities where African American families live. For example, the primary supervised visitation center is the DSS downtown Fresno office. Similarly, the primary agency for drug testing is located downtown. Case notes, information from parents, workers, caregivers and providers all support the difficulty African American families have in accessing these centralized services. In addition, concern was expressed by DSS leadership that the new competitive contracting process could significantly alter the Cultural Broker program because of the limited grant writing capabilities of the current group of Brokers.

6. DSS tools and administrative practices fail to identify and address a parent's personal history of trauma. Further, DSS does not account for the trauma of protective intervention on the lives of families and children. As a result, service planning and provision miss important factors than can positively influence change.

For children, the experience of abuse and neglect and subsequent removal from their families is traumatic. The long-term effect of these traumatic events is well documented. However, parents often have their own histories of trauma that affect their caregiving capacities.[55] In addition, the separation of the family can evoke in parents "the feelings of grief, hopelessness and rage about the forced separation from their children."[56] Further, the unresolved grief "may leave [a parent] with little energy to actively engage in services that could strengthen her abilities to parent now and in the future."[57]

Fresno County policy guidance acknowledges that removal and placement can cause a child to have feelings of separation and loss and that children need an opportunity to grieve. [58] However, policy is silent with regard to the loss and grief parents may be experiencing or to their own traumatic histories. During placement transitions, caseworkers are instructed to "ask the care provider what other support they may need to provide care and support to the children,…observe the comfort level between out-of-home caregiver and placed child…reassure the child"[59] and provide child and care provider with contact information. This language focuses on the child and is silent on the needs of parents who are also experiencing loss.

A mother's unresolved grief and trauma may manifest itself as intense anger and hostility towards the child welfare system, making it very difficult, uncomfortable and ineffective for workers to provide essential reunification services to families.

Making Visits Better: The Perspectives of Parents, Foster Parents, and Child Welfare Workers, University of Illinois, Children and Family Research Center.

In each case examined, the effect of trauma was apparent. However, missing from the system intervention was recognition of the trauma and how to support the healing process to promote successful reunification. Administrative forms, case notes and other documentation did not reflect any assessment of parental history of trauma. If trauma was identified in psychological evaluations, such information was not routinely incorporated into case plans with parents. In one of the case-based analyses, the mother entered an inpatient drug treatment program after opting to receive voluntary family maintenance services through DSS. The day after she started this program her daughter died of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death Syndrome. She stated that the only effort anyone made to address her grief and loss was a workbook on dealing with grief given to her during her time in drug treatment. She was expected to read the book and complete exercises on her own. She did not receive individual therapy and believes she could have benefited from having her grief, loss and other issues "talked about…with someone." She has continued to struggle with addiction, and her other children have been in and out of foster care. Now she has reunified with several of her children. To this day, she still experiences pain and sorrow from the loss of her daughter.

In another case-based analysis, documentation of the mother's first visit with her children in the week after their removal in 2007 indicates that she cried when she saw them. The visitation observer documented that she reminded the mother she had signed an agreement that she was not to cry. She explained to the mother that her crying might upset the children. There was no documentation or valuing that the mother's crying was a sign of attachment to her children. Yet in later visits, the mother as a result of the earlier warnings appeared to lack emotion when interacting with her children and this lack of emotion was interpreted negatively by subsequent visitation observers. This mother's sadness about the removal of her children was seen as something to censure, rather than value and address.

Research supports a number of strategies for better trauma identification and response. These include gaining an understanding of the parental history and context of their lives and providing opportunities for "mothers…to share their feelings of grief and to gain perspective with a supportive, empathic person, knowledgeable about the child welfare system, for example…parent advocate or member of the clergy."[60] Using parents who have previously been involved with DSS and successfully reunified with their children , called parent advocates or parent partners, appears as a promising way to fill this role. One African American parent involved with DSS reported, "If parent partners were involved earlier, there would be a better understanding of what the parents were going through and show them some light at the end of the tunnel." Currently, DSS has few administrative protocols (forms, evaluations, case plans, or court reports) that direct workers to account for a parent's trauma in planning and assessing progress.

7. **While there are laws and policies that organize DSS and the courts to expedite ending reunification services and terminating parental rights, there are insufficient laws and policies that expedite reunification when indicated.**

DSS practice requires that a parent complete nearly all services in a case plan before children can return home. However, no policy requires this practice. Further, no policies prevent a caseworker from returning to court in three or four months to change case goals when a child can

safely return to his/her family, yet workers regularly report that they wait until the next six-month court hearing to request such a change.

The Adoption and Safe Families Act (ASFA) "reaffirm(ed) the focus on child safety in case decision-making to ensure that children did not languish and grow up in foster care but instead were connected with permanent families."[61] As a result, state child welfare agencies have mandated timelines for decision-making regarding termination of parental rights and incentives for increasing adoptions. California responded to the mandates with its own statutes and regulations intended to accelerate the path to termination of parental rights. Under California Welfare and Institutions code 361.5(b), there are 15 reasons to bypass reunification services, or deny reunification services upon an initial removal of a child. This code section says that "reunification services need not be provided to a parent or guardian...when the court finds, by clear and convincing evidence" any one of the 15 reasons is present. Some of these reasons are parental abandonment, the parent has caused the death of another child, a finding of severe sexual abuse, a finding of the infliction of severe physical harm, the parent has had a previous termination of their rights to another child and has not addressed the problems that led to the previous removal or the parent has a history of extensive, chronic use of drugs or alcohol and resisted prior court-ordered treatment.

Further, California's Welfare and Institutions code accelerates the termination of reunification services and parental rights for young children. Section 361.5 allows for six months of reunification services to parents of children age three or younger; parents will be granted another six months of services if they are making substantial progress toward reunification. Some workers and supervisors also believe that California state statute allows workers to go back into court after four months of services and request the termination of services if the parent is not making moderate to significant progress. However, no such statutory requirement exists. This misunderstanding reflects the imbedded concept that the child welfare system must quickly determine if a parent can reunify or find other placements for children who will not go home. However, as discussed later in this report, there is no parallel imbedded urgency to find permanent, legal homes for children who do not reunify.

The data show that parents and youth experience pervasive delays in reunification because no overall structure exists to promote timely and safe reunification. In one case reviewed, an African American mother making significant progress on all of her services reported growing frustration with the pace of her case. A year into the case, the mother wanted her children returned before the next six-month court hearing. The caseworker documented that the mother said to her, "You sure are making it hard on me to get my kids back." A few months before the court hearing, the caseworker documented that the mother sounded defeated when she stated that she had "done so much and has come so far and that maybe the children would be better off not being with her" as she feared that there would be further delay in getting her children returned. Although the children were returned to her at the court hearing (20 months after placement), the mother believed that reunification was delayed because her progress had not been adequately recognized, she was unable to return to court early, and the Department gave her little help in finding an apartment. The pace of decision-making did not reflect an urgency to safely reunite children and parents.

8. **DSS and its partners do not intervene with families in ways that support kinship placements with African American extended families or the development of new support networks for parents and youth when family is unavailable.**

Currently, the child protection system is organized to provide services to children and their legal parents. Over time, child protection systems have recognized the importance and value of kinship relationships and have promoted placement with relatives, including relatives who are not blood-related, such as godparents or others considered to be family. The federal Fostering Connections legislation passed in 2008 provides new support for relatives caring for foster children, including a state option for federal reimbursement under Title IV-E for guardianship assistance payments; requirements for states to provide relatives with notice of the placement of a related child in foster care; codification of existing federal guidance permitting flexibility in foster care licensing for relatives; requirements for states to make reasonable efforts to keep siblings together in foster care and grants to support family connections.[62] In addition, California has been implementing a Kin GAP program since 2000. Provided that permanent placement in the relative's home is in the best interests of the child, this payment program provides relative caregivers who are unable or unwilling to adopt a child in foster care with another option. Supporting placement with kin is important in that it keeps children connected to those they love and who love them, keeps them with their community, and often allows them to have a relationship with their parents even if their parents are never able to assume parenting responsibilities for them. This strategy has directly supported African American children and families.[63] However, placing a child with relatives is not the full extent of support needed for families, and often system interventions undermine family relationships rather than preserve them.

- ***DSS does not guide work of staff to address or minimize conflict in extended families.***

Relationships among parents and relatives who are caring for their children can be difficult and stressful. DSS policies and expectations do not organize workers to find ways to address or minimize this conflict. For example, in one case reviewed, a young African American mother, explaining how she became involved in prostitution, shared with the caseworker that she was raped by her uncle a few years earlier when she was a teenager. Without consulting the mother, the worker reported the rape to the police, and during the police investigation, the mother recanted. As a result of this action, the mother's relationship with her extended family, some of whom were caring for her children, became very strained. This example illustrated that the worker did not have the knowledge, skills and supervision to figure out how to intervene productively with the mother and her family about this allegation. The case file also revealed that the mother did not receive any support services to deal with this trauma.

Children living with relatives were also not supported in negotiating the dynamics of their extended families. In a case reviewed, a 9-year-old girl, spent nearly her entire childhood living with different maternal relatives. These relatives were white and had negative views of African Americans. The child's paternal family is African American. The caseworker noted the negative views of these family members but DSS did not provide the tools or directives to help her intervene. Further, this child's family regularly vilified the mother. Caseworkers and therapists noted that the child would try to please her relatives by criticizing her mother while at

the same time enjoying visits with her mother. However, the worker was not directed through policies and practices to address the negative behaviors of the extended family members that impacted the child, comprised visits and slowed reunification.

- ***DSS directs parents to find new peers and support in order to reunify with their children but does not assist them in developing these new relationships.***

Workers are not organized to support families in the context of their communities or in helping parents develop new supports. Information collected showed that parents often were socially isolated before and after DSS involvement. One African American mother interviewed explained feeling alone and disconnected from others and as a result she continued to use drugs as a way of maintaining a connection to her partner. Parents in a focus group stated and case record reviews found that DSS frequently required parents to leave their spouses/partners as a condition for having their children returned to them. *In Walter's case, DSS informed him that he would not successfully reunify with his children if he remained involved with his wife. He subsequently left her and moved in with his mother. His children, especially the girls, continue to talk with their mother on the phone. The family as a whole reported struggling to find ways to stay connected to the mother but not jeopardize reunification.*

In another case, DSS allowed continued reunification services and recommended family maintenance only after the mother acknowledged that she would not allow "uncleared" people into her home, even if they were not to have contact with her children. In a February 2009 court report, the mother "states that she understands that any person who she allows into her home will need to be cleared first." This mother reports having few, if any, visitors because of her concern about clearance.

While parents may have needed to separate from their partners or peers in order to assure their children's safety, DSS was not organized to help these same parents find new networks of support, and the agency's actions, in some cases, undermined their ability to find new supports. Case file reviews and interviews found few examples of parents being assisted in connecting with positive social networks, a factor in preventing child maltreatment.[64]

Research Question 2: ***How are the needs for stability and nurturance being addressed for African American youth who are not reunified with their parents?***

On June 30, 2008, there were 225 African American youth who had been in foster care for at least two years. Nearly 50 percent (119) had been in care for eight years or longer, with nearly 20 percent (53 youth) in care 12 years or more. Some of these African American children are in long-term living arrangements with caring adults, but others are not. This section of the report describes the findings about how DSS policies and practices account for the nurturance and stability of these children and youth.

CASE STORY—Shawna

Shawna, age 17, and her sister Danielle, 15, are the oldest of four children. For several years, their mother was involved in a violent relationship with their stepfather. When they were 9 and 7, their mother was arrested after stabbing their stepfather in the wrist with a pen, causing a minor wound. The stepfather had been drinking and hitting their mother before she stabbed him. The police and DSS intervened after this incident. The family had been living in a motel and the girls were not regularly attending school because of transportation problems. The court ordered supervised visits between the girls and their mother at the time of removal. The mother did not complete reunification services and so services were terminated. At various times while in foster care, the girls lived with their cousin, their grandmother, in agency foster homes ,and group homes. While in foster care, Shawna and her sister ran away from placement several times. The case goal for both girls is long-term foster care.

The mother and girls maintained regular phone and in-person contact, despite the current court order that states that contact must be supervised. In 2009, at age 17, Shawna had a baby girl. Shawna secretly attended prenatal care appointments with her mother. When the caseworker heard about this, she warned her that such contact was not allowed because of the court order. After Shawna delivered her baby, her mother came to the hospital to visit. A DSS caseworker, at the hospital to investigate the father of the baby and her parenting abilities, told Shawna's mother she was violating the order requiring supervised visits so the mother ended her visit with her daughter and grandchild.

When Shawna and her baby were discharged from the hospital, they were not initially placed together because Shawna was considered a "run" risk. Two Department caseworkers arrived at the hospital; one took the infant, while the other talked with Shawna to let her know that she and her child were not going to be placed together. This action was taken despite the fact that Shawna's primary caseworker, who was on vacation at the time, had told her that the baby would be placed with her. After a week, DSS did find a placement for Shawna and her baby. Court orders were never amended to allow for more liberal visits between the mother and Shawna and her new baby.

1. **DSS is not structured to make aggressive or expeditious efforts to support permanent legal connections for African American children. As a result, African American children languish in care, many times without legal or relational connections to caring, committed adults.**

- ***There is no clear policy or protocol about when and at what pace workers should move toward ensuring youth are in a legal guardianship or adoptive home.***

Federal and state laws clearly establish timelines for decisions related to reunification or alternative permanency. After the decision is made to end reunification services for parents and, in many cases, to terminate their parental rights, there are no further decision-making timelines. Federal law requires that reasonable efforts be made to secure a permanent family arrangement for children who cannot go home. In Fresno, the court reviews cases on a regular basis every six months until the case is closed. DSS policy and practice reflect a lack of clarity about what is expected in cases involving children who are unable to return to their parents. Because of a lack of policy and practice guidance, some children and youth remained in foster care or kinship care with little efforts to transform that relationship into a legally binding permanency option. The reviews of case records indicated that very young children often had a permanency goal of "long-term foster care." For example, a social work case note from May 2009 regarding three African American brothers, all under the age of five, read:

> "Social worker asked Mrs. M if she has given any thought to adoption and Mrs. M. said that she has not, and that she thought the previous social worker had advised her to remain in a plan of long-term foster care."

The No Family Reunification Panel is used to make timely decisions about whether DSS should recommend to court that a parent receive reunification services. However, similar urgency to find permanent families for those children where reunification has been ruled out is lacking. In one case reviewed, the child entered foster care as an infant. A No-Family Reunification Panel determined that the parents should not receive reunification services. The African American infant girl was placed with relatives and parental rights were not terminated. Over the next seven years, this girl had 10 different placements with relatives, none of whom expressed an interest in permanent, legal custody and all of whom actively undermined the girl's developing relationship with her mother. At the time of the review, the caseworker believed that as this young girl gets older, she will eventually return to her mother since the relatives demonstrate little

> "*Getting African American kids adopted is hard. Lots of people only want Caucasian kids. There is not as much of a push to get them adopted. When I had two Caucasian kids on my caseload that hadn't been adopted, people kept asking me why. I have plenty of African American kids on my caseload that haven't been adopted. No one asks why...I just don't think we try as hard as we should."*—DSS Caseworker

commitment to this young girl and believe she is troubled. This case illustrates that despite quick institutional movement to end reunification services, no similarly speedy institutional action occurs to identify permanent families for very young children during this critical developmental period.

DSS has permanency panels designed to fully inform caregivers of legal permanency options for the children in their care. Workers must appear before the permanency panel prior to a family proceeds to court to establish a permanent legal arrangement. The worker, parent, or youth must declare that they are ready to move to a more permanent arrangement. This panel is an opportunity to promote timely legal permanency in a manner that is the best fit for the child and caregiver. However, observation of this panel found little engagement and interaction among the caregivers, caseworker and other professionals during the meeting. The discussion of permanency options occurred in a manner that was highly technical and full of DSS jargon (for example, "juris," "ASQ evaluation" and "will mother contest placement"). When asked if she was the "maternal aunt," the caregiver hesitated. When the question was rephrased and she was asked if she was on "mom's side of the family?" the caregiver answered, "Yes." Though there was a great opportunity to build relationships at this meeting, bureaucratic assessment and decision-making was prioritized over this critical family engagement. Further, the practice is also entirely dependent on the worker proactively bringing the case to the panel. Over the last several months the number of cases brought to this panel has declined, which interviewees attributed to new workers and supervisors. Regardless of the reason, without an institutional requirement and accountability structures to track movement toward permanency, a large number of African American youth are not finding legal permanency.

- ***In practice, permanent families are not sought out for older youth who have goals of "long-term foster care."***

For children over the age of ten, interviews, case notes, and observations all confirmed that DSS and the court do not actively push for legal permanency. Data show that emancipation is the third highest type of exit from foster care in Fresno County. Table 3 below shows that all of the 778 children exiting from foster care between October 2007 and September 2008, 295 (38%) exited through reunification, 180 (23%) exited through adoption, and 176 (23%) exited through emancipation. For African American children exiting care, the highest percentage of exits was through emancipation (44% of African American youth).

Table 3: Fresno County Children Exiting From Foster Care from October 1, 2007 to September 30, 2008 by Exit Type

Exit Type	Ethnic Group					
	Black	White	Hispanic	Asian	Native American	Total
Count	n	n	n	n	n	n
Reunified	14	43	203	20	15	295
Adopted	17	34	115	7	7	180
Kin-Gap	2	5	21	0	6	34
Other Guardianship	3	3	11	4	4	25
Emancipated	39	35	87	9	6	176
Other	13	13	39	0	3	68
Total	88	133	476	40	41	778
Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Glasser, T., Williams, D., Zimmerman, K., Simon, V., Putnam-Hornstein, E., Frerer, K., Ataie, Y., Winn, A., & Cuccaro-Alamin, S. (2008). Child Welfare Services Reports for California. Retrieved April 1, 2008, from University of California at Berkeley Center for Social Services Research website. URL: <http://cssr.berkeley.edu/CWSCMSreports/>						
Data Source: CWS/CMS 2008 Quarter 3 Extract.						
In Care 8 Days or More						

Case goals for older youth are far too frequently "long-term foster care" and "independent living." One group home administrator lamented that his agency was "expected to just be a holding place for them [youth] until they turn 18 or go home since there's nothing else to do with them." A youth in a focus group said, "A friend's mom thought about adopting me—that didn't work out but that was the only time I was considered for adoption." Those writing and approving court reports for youth in long-term foster care or independent living made little to no mention of proactive activities undertaken to find permanent legal homes or other caring adults who would be a life-long connection for a youth. In case files reviewed, relatives who stepped forward were assessed for placement, but there was little evidence of inquiry made in cases where no relatives or other caring adults volunteer to care for a child.

Further, some children in Fresno County were labeled by workers as "unadoptable." In conversations with workers and providers, children considered to be unadoptable were for the most part older children or children with disabilities. Court reports and case records also described children as unadoptable despite the fact that many youth want to be adopted. As one youth said, "When you're adopted, you're like their child. You're their son, their daughter." Yet the agency's permanency activities appeared for the most part to be sporadic and reactive, rather than consistent and proactive, especially in cases with older youth.

- ***Little attention to permanency for older youth is organized into the work of their advocates.***

As a result of training and court expectations, Court Appointed Special Advocates (CASAs) and District Attorneys responsible for representing children paid keen attention to the safety and the stability of children on their caseloads. Although stability was not always achieved for their clients, most lawyers and CASAs believed that placement stability and compliance with expectations at school and in treatment were critical aspects to children's well-being. Unfortunately, attention to stability often negated any urgency to find a permanent, legal family for children. That is, in many cases, youth lived in stable placements with relatives or foster parents for many years. Youth reported that no one, including their lawyers, asked them about returning to their parents or in pursuing a permanent legal relationship with their current caregiver or other caring adult.

Lawyers who represent children have extraordinarily high caseloads and frankly admit that they must triage cases. Cases where youth had behavioral problems and were not faring well in school got more attention than youth who seemed to be doing well in their current living situation. CASA volunteers have a very small number of cases and visit with children at least two times a month. CASAs were not directed to investigate and advocate for permanent connections to family for children. When working on a case, the areas of focus for CASA workers are education, medical care, mental health needs and placement stability. Little focus on permanent legal connections is organized into their work.

- ***Kinship caregivers often remain court supervised placements in order to have ready access to resources.***

For some kinship placements, the need to receive ongoing assistance to support children is the sole reason for continued DSS involvement. In interviews, relative caregivers talked about their need for assistance with living expenses, access to mental health services for children, and support for any other needs that might arise. Some relatives felt secure in knowing that they could call a caseworker and be able to access services. Workers and others reported the lack of ready access to these supports once a case is closed.

"Guardianship with dependency" allows relatives to care for children while the court maintains oversight and DSS remains involved. Guardians talked about feeling comfortable knowing they could reach out to DSS to obtain referrals, payment for mental health services or other supports a child in their care may need. Interviews with workers and guardians found that caregivers do not have confidence that other community-based supports are available or will respond as quickly as DSS.

The absence of post-placement—post-adoption and post-guardianship—services reinforces the need for continued dependency. DSS must have adequate community partnerships to ensure that these families are meaningfully connected to ongoing supports.

2. DSS policies do not support African American youth in maintaining or attaining connections with their biological parents or extended family.

- ***Supervised visitation policies instituted many years ago remain unchanged without reevaluating the age, needs and safety of youth.***

African American youth who have been in foster care placements for long periods of time often seek nurturance from their families of origin. Many youth find or reconnect with their families without any support or assistance from DSS or other providers. Older youth reported and case reviews documented that many youth had frequent, ongoing contact with their parents although such contact was not necessarily approved by or known to DSS or the courts. As previously noted, the IA team found court orders requiring supervised visits at one point in time that had never been reassessed or updated to reflect the passage of time and changed circumstances. One youth could not attend his grandmother's funeral because his mother would be present. There was no assessment about whether his mother would constitute a threat to his safety or well-being; the denial was based on an old court order that required supervised visits. Youth and parents expressed frustration and confusion over the rules of contact. In many instances, parents were caring for younger siblings and were in contact with their extended family. In other instances, parents were not able to care for these youth but the relationship was important in both parents' and children's lives. Visitation as currently structured is used to control contact long after the need for supervision was established, rather than being used to support the kinds of relationships that can contribute to reunification or other permanent living arrangements.

An illustration of the use of visitation to control contact past its possible utility is the case of Shawna. *When Shawna came into care, her mother and stepfather consistently visited her and her siblings during the first few months of placement. But, the parents were not allowed to move beyond supervised visits because they had not "ameliorated the circumstances"—domestic violence, homelessness, scant provision of nutritional meals, substance abuse and educational neglect—that brought the children into care. Over time, the parents stopped the formal visiting, they separated, and the children remained in care. However, Shawna and her mother found ways to remain in contact. When Shawna and her sister ran from placement, they often ran to their mother. Yet eight years after the original visitation court order, Shawna's mother is prevented from visiting with her now 17-year-old daughter in the hospital and meeting her first grandchild.* The changing circumstances brought about through the passage of time were not considered. Further, if ensuring safety is the reason for supervised visits, the investigator could have provided supervision. If the purpose is an assessment opportunity, the opportunity was lost. This is not only an example of visit practice being out of sync with a family's reality; it is also an example of how caseworkers are organized to place the immediate task—ensuring compliance with court order and determining the teen's parenting capacity—over the evolving needs of the family.

- ***Youth are deterred from interacting with extended family members because of insufficient guidance to caseworkers about when, how and for whom to seek criminal background checks.***

Children must be safe in their foster home placements and be safe upon return to their parents or other permanent living arrangement. In an effort to ensure safety of children while in a foster care placement, criminal background checks are conducted, and a criminal record found for persons living in the home can affect the child's placement. California Welfare and Institutions Code section 341.3(a)(5) directs the Family Court judge to look at good moral character of relatives and any other adults living in the home to see if there is a prior history of violent criminal acts, child abuse or child neglect. Older youth expressed confusion about why family members were unable to care for them. As one youth said about trying to be with his family, "Youth gotta do too much stuff to see your family." Youth who had been living with or visiting extended family members before they entered foster care were suddenly limited in their contact with these relatives due to their criminal backgrounds. If a person has a criminal history, that is not violent or against children, DSS can obtain an exemption for placement.[65] Without an exemption for a past criminal conviction, a relative cannot be cleared for placement.

Caseworkers perceived that criminal charges unrelated to child safety or many years old (for example, shoplifting, driving under the influence when the relative was a young adult but is now a grandparent) were a barrier for placement with relatives and other household members. In practice, much depends on the individual advocacy of the worker to get an exemption, rather than any institutional standard governing whether exemptions are appropriate and in the best interest of the child. In one of the cases reviewed, a girl in foster care for eight years experienced ten different relative placements in part due to caregivers failing to get clearances for family members who sometimes stay in the household. The agency needs to develop guidelines for the assessment of criminal records and a clear policy on who must be subjected to clearances when a child is in the home of a relative.

The need to clear people who are involved with children in foster care can limit the ability of youth to participate in activities with their family, peers and other adults. Youth in foster care and group home administrators reported that the requirement to clear adults prevented youth from going on sleepovers or field trips. For example, sisters placed in separate foster homes could not initially spend the night together. The case note read: "B. would like to spend the night with her sister, but is unable to do so due as D. [sister] is living with foster parents of a different FFA [Foster Family Agency]." In this case, each foster care agency required new clearances of any adults not previously cleared by their own agency, regardless of the fact that each sister was living with approved foster parents. The notes reflected that nearly six months later, a supervisor intervened and gave approval for the sisters to spend the night together.

Many youth are a part of extended families where members have criminal histories. These convictions can range from misdemeanor property crimes to violent offenses. They may be recent or from a much earlier period. The review found little guidance to workers on how to assess these histories in the context of a child's need for safety and relationship. Most youth were interested in having relationships with these family members, but these policies act to control contact rather than assist in developing safe, caring relationships. Data show and youth

report that upon emancipating from the foster care system, some youth live with the very adults with whom DSS previously had not allowed them to have contact.

3. DSS administrative practices and tools do not regularly acknowledge, explore or treat the trauma, depression and anger that characterizes the emotional life of many youth involved in the foster care system. Unaddressed trauma can contribute to behavioral problems and ultimately reduce opportunities for permanence.

Children and youth in the foster care system have experienced traumatic events ranging from physical and sexual abuse to loss, neglect and removal from their homes. Research says that "traumatic events in childhood increase risk for a host of social (e.g., teenage pregnancy, adolescent drug abuse, school failure, victimization, anti-social behavior), neuropsychiatric (e.g., post-traumatic stress disorder, dissociative disorders, conduct disorders), and other medical problems (e.g., heart disease, asthma)."[66] The way a child responds to trauma varies significantly depending on the individual. If the root cause of the trauma is not understood, a child's trauma reaction may be misinterpreted as an anger-management issue or even overlooked entirely.

One teenager in care reported that he had not been attending his high school classes recently and was in jeopardy of not graduating. He lamented, "I let people get to me and I shouldn't let people keep me from going to school. A lot of things are on me. I'm going to be at school worried thinking, is my mom okay? Are my sisters okay?"

IA team members observed a court trial about repeated and sometimes violent sexual abuse of a young girl by her stepfather over a five-year period. A family friend who also was a foster parent to this girl's younger siblings told the team members that this girl was "totally traumatized." However, both this girl's caseworker and lawyer thought the girl was doing "great." This girl was pregnant by her boyfriend and wanted the baby, was doing well in school and had no behavioral problems in her foster home. This difference between how the worker and attorney evaluated how this young girl was doing and how the family friend felt she was coping may have significant ramifications for long-term outcomes for her. Further, this girl's younger teenage brother was present during the entire court hearing listening to testimony about the duration and nature of the abuse of his sister. Both he and his mother became distraught during the hearing. However, no effort was made to stop the hearing or comfort either person. At the end of the court hearing, the young boy jumped up from his seat and went to embrace his mother.

African American youth in a focus group expressed difficulty in talking about their anger and other feelings, especially in therapy, a usual referral for youth. Youth said:

"I need to open up, but it's [therapy] not working because I'm not telling my feelings to a stranger."
"I don't trust people like that [therapists]. I tried to trust somebody but it didn't work, so I write it down."
"Now that I don't do counseling, I don't really talk to anyone."
"I just be quiet most of the time."

IA team members also reviewed a case of a 16-year-old who was involuntarily hospitalized by police because she had made suicidal threats.[67] This youth had been in care since age nine and experienced 12 placements in seven years. She was living with a relative who was interested in guardianship or adoption. On the day of the incident, the caregiver reported that the youth refused to do her homework and chores and ran away from the home. The caregiver contacted the police, and the youth returned home before they arrived. When she got home, she sat on a chair, rocking back and forth, and threatened to hurt herself. Once the caseworker learned of this incident, she assumed that the placement was not stable and the youth needed to be moved. However, the caregiver had learned that the girl's mother had called her multiple times that day asking for money for drugs. The caregiver insisted that she was committed to this young girl. After seven years in placement, the stress of her family situation still had emotional and behavioral implications for the girl. Review of the case file found that case plans and services did not address her history of trauma and ongoing stress of dealing with her mother.

Nothing in DSS paperwork for children and youth-in-care requires an assessment of trauma. Court reports require information in regarding mental health and emotional status, and nothing prevents the worker from using these domains to report on the youth's trauma or on efforts to address their experiences of abuse or neglect. However, case files reflect that DSS does not direct workers to assess and work with children and others to heal the effects of trauma.

4. **The separation of teen services (Independent Living Skills) from foster care services results in an overemphasis on preparing youth for independence at the expense of long-term nurturing relationships critical to healthy youth development.**

- ***While prioritizing the life skills and logistics associated with transitioning from foster care, DSS misses the opportunity to help young people find and maintain permanent connections.***

While the legal age of adulthood in the United States is 18, experience and research suggest that the need for parenting continues far beyond this artificial cut-off. Many young people continue to receive emotional and financial support from their parents or other family members well past age 18. Approximately 14 percent of men and 17 percent of women between 18 and 24 years old live at home with their parents or grandparents.[68] However, most child welfare systems have historically focused on providing support and services for youth in care until age 18 and then ceasing to "parent." In 1999, with the passage of the Foster Care Independence Act, states received special funding dedicated to supporting young people exiting foster care with their transition to adulthood. It was an important step to acknowledging that while these young people need basic skills to become successful adults, what is too often missing is the support in building relationships. National data show that young people transitioning from care need permanent connections most of all. Youth with family permanence experience better outcomes in the areas of housing, health insurance and personal and community engagement.[69]

"My social worker told me that no one is going to pay for me after 18 so we need to dismiss you." —youth in foster care, almost 18

In Fresno, DSS works to connect youth aging out of the foster care system with independent living services but does not help them live

interdependently in the community. Youth talked about receiving assistance with starting a bank account, signing up with independent living services, and acquiring transitional living housing but not receiving assistance to reconnect with family or to build relationships with other caring adults.

Both courts and agencies prematurely delegated tasks to youth without providing them with the support to develop the skills to succeed. During a hearing, the study team observed in court a Commissioner encouraging a youth to enroll herself in school and talk with her lawyer or caseworker about getting some additional services she required even though she did not have contact information for either the lawyer or the caseworker. While seemingly helpful, the message youth receive is that once they reach the age of 18 they will be completely on their own. Further, for many youth still struggling with self-advocacy skills, such delegation of responsibility sets them up for failure.

"We, as an agency, sometimes forget how important this permanent connection can be, and when they become 18 and this hasn't been addressed, it's too late."—Independent Living Supervisor

DSS policy mandates that, "At the age of 17, 17½, and 30 days prior to dependency being dismissed, all youth eligible for the Independent Living Program (ILP) will be offered individual conferences designed to help them develop an Emancipation Plan to ensure post-emancipation stability and that aftercare needs will be met."[70] This Emancipation Plan is guided by a form that prompts workers to fill out information in six domains: housing, education, employment, medical/mental health/ dental, other and resources. Nowhere in this form or in the policy guiding emancipation conferences is there any emphasis on permanency or relationships that will support the youth in their transition to adulthood.

- ***The agency is not structured to provide continuous case management relationships with older African American youth that are focused on permanency and that provide structure, emotional support, problem solving help and advocacy services***.

For some youth, group home providers and caseworkers are the only consistent presence in their life. They form relationships and bonds. However, these workers are guided to focus on the importance of "boundaries" rather than on building permanent relationships for and with the youth on their caseloads. Caseworkers talked about the need to sever contact with youth when they reach 18 and their cases are closed. Workers worried about becoming too attached to youth and becoming the only resource, or "crutch," for youth. DSS staff also talked about the reluctance to develop close relationships with youth because of their concern that the constant changes in staff reassignment would be disruptive to the relationship and damage the youth.

"[Group home counselors] try not to maintain contact with the kids after they leave because a lot of times the boundaries get crossed; the kids will try to take advantage of the situation and they need to really start doing things on their own."
—group home administrator

- ***African American youth transitioning out of care are not always connected to services available through other funding streams.***

Providers and caseworkers identified the need for youth transitioning out of foster care to have access to employment, educational supports and opportunities, mental health services, child care and parenting support for those youth who have children. Many of these exact services were available for pregnant and parenting teens, regardless of their involvement with DSS. Two programs, CaLearn and the Adolescent Family Life Program (AFLP), provide services for pregnant and parenting teens. Both programs work to help youth achieve a High School education (diploma or GED), good health, delayed second pregnancy and self-sufficiency. AFLP is voluntary and for teens not eligible for CalWorks (public assistance, also known as TANF). CaLearn is a mandatory program for youth who are pregnant or parenting, on public assistance, younger than 19 and without a diploma or GED. Both programs are available to whoever is the custodial parent. CaLearn provides cash assistance, transportation, child care (if not available at the school), clothing vouchers, assistance with books and school supplies, testing fees and any expense that the teen and child may need to achieve the goals of the program. If the teen is maintaining at least a 2.0 grade point average or making progress towards a GED they receive a $100 bonus per quarter and a $500 bonus at the time of graduation. AFLP does not have supportive services or flexible funding. Both programs provide a caseworker to assist the youth with navigating systems, obtaining services and removing barriers to success. The workers will make referrals for services through Medi-Cal for mental health or substance abuse treatment and can pay if the youth is not eligible for Medi-Cal. According to program administrators, both the AFLP and CaLearn program are under-utilized by pregnant and parenting teens who are in foster care and there is little to no cross-team coordination of cases for this population of foster youth. Workers in AFLP and CaLearn expressed a desire to be included in team meetings of older foster youth and to become more integrated with foster care services. Thus, the opportunities exist for youth to be connected to flexible services and for cross-division collaboration, but the child welfare system is not organized to ensure these opportunities are realized.

RECOMMENDATIONS

Fresno County's child welfare agency and its partners have been working to improve its child welfare practice and results for several years. This study was commissioned to provide additional information to direct Fresno's work to reduce racial disparities and improve outcomes for all children and families. Based on the preliminary study findings, Fresno County DSS implemented several activities almost immediately after the IA took place. Specifically, Fresno County DSS reframed expectations of social workers to encourage them to act as advocates for children and families, reorganized its child welfare services to be better integrated and more accessible to families, and trained its workforce to understand ingrained racial biases.

The recommendations that follow are specific to the findings of the IA and complement the noteworthy initial steps Fresno County DSS has already undertaken. While these recommendations are primarily focused on DSS, other public agencies and community partners are necessary actors in improving results for children and families.

The recommendations themselves must be viewed within the larger context of the mission and responsibilities of the Fresno DSS – to emphasize the safety of all children, to ensure that the child welfare system acts to address the developmental needs of children in its care and to act with urgency and intensity to safely reunify children with their families whenever possible.

The IA's findings and recommendations focus on improving safe and timely reunification for African American families and increasing family connections and supports to youth who have been in care for an extended period of time. In order to achieve these goals, an overarching recommendation is that Fresno County DSS develop an *integrated case practice model* that focuses on engaging families in assessment, planning, and services, a recommendation on which Fresno DSS has already begun to take action. In developing Fresno's case practice model, we recommend that DSS assess how the current specialization of workers impacts the desired goals of improved family engagement and its relationship to positive outcomes for families.

In order to support the safe and timely reunification of African American families, CSSP recommends that Fresno County:

1. **Expand expectations and opportunities for frequent and timely visits among family members.**

   Expand expectations and opportunities for frequent and timely visits among family members. Requirements for supervised visitation should be revaluated frequently, and permission for unsupervised visits should be provided as family circumstances change. Families that do require supervised visitation should have venues for visitation close to where they live or where their children attend school, and hours for scheduling such visits should be flexible and expanded beyond the traditional work day.

2. **Ensure that all assessments are accurate, current, culturally relevant and dynamic.**

   To enhance understanding of families, assessments should be accurate and account for the cultural context of parents and children. It is critically important that Fresno County DSS and its partners reassess families on an ongoing basis and make current, accurate judgments about risk, safety and child and family needs. As circumstances change, families should be reassessed so that opportunities to recognize positive change and promote reunification are acted upon with urgency. Overtime, the multiple formal and informal assessments that families experience should be integrated into a consistent and evolving understanding of a family's strengths and needs. All relevant and current assessments should inform case plans and services. Assessments should also account for and address trauma experienced by parents and children.

3. **Engage families in services relevant to their needs.**

   Most families that are involved with Fresno DSS require meaningful economic supports in addition to social services to improve their ability to safely care for their children. In order to effectively link families to housing, food and other concrete supports, cross-division connections need to improve so that currently available resources in multiple divisions are made readily accessible to families. Coercive requirements, such as drug testing for extended timeframes after a person is no longer abusing drugs, should be evaluated for relevance and its impact on a parent's ability to hold a job, participate in services and successfully reunify with their child. Cultural Brokers, or other similarly individualized supportive and culturally relevant services for parents, need to be expanded. Families need to know that, when they engage in services and supports as part of a DSS case plan, these interventions will benefit them and their children. Decisions about the distribution and location of services in the county and the identification and development of new services should be guided by geomapping and feedback from consumers who use these services.

4. **Provide meaningful legal advocacy.**

   Caseloads for attorneys representing parents or youth are extraordinarily high and minimize effective legal advocacy. Fresno County should evaluate contracting to ensure that attorneys have reasonable caseloads and are paid for their time and effort, both in court and out of court. Attorneys should be trained in national models for representing parents and children in order to improve the engagement of clients in their cases and case plans. Finally, the court, CASA workers and lawyers for children must increase efforts to ensure that children achieve timely permanency, not only through reunification but also through guardianship and adoption.

In order to support youth in foster care to maintain family connections and supports, CSSP recommends that Fresno County:

1. **Ensure that case plans are comprehensive and current.**

   Case plans need to be dynamic documents that accurately reflect the current strengths and needs of youth and their parents. Safety concerns about contact between youth and their parents must be objectively reassessed as situations change and children develop. The suitability of placements with relatives should also be revisited as youth age. Finally, case plans should account for the desires of youth. For example, if a youth continually leaves her placement and runs away to her mother, the case plan should reevaluate the safety concerns that initially made such placement unsuitable and assess the suitability of the current placement, the capacities of the parent or relative and the desire of the youth. As part of Fresno's case practice model development, ensure that youth are active participants in their case planning.

2. **Continually and consistently pursue all permanency options for older youth.**

   Aggressive outreach to identify adoptive homes should not arbitrarily end when the youth is over the age of 10. For families that have a guardianship with dependency, the ongoing need for court and DSS involvement should be regularly evaluated and terminated when it is no longer necessary.

3. **Support or find family connections for older youth while also helping them build skills necessary for living independently.**

   Fresno County should assess how the structure of services to teens in care helps those young people build skills to live independent of the foster care system and assists them in developing meaningful life-long family connections. In many instances, older youth reconnect with their family or find previously unknown family members while in foster care. To support these connections, opportunities to visit with family members should be enabled whenever possible. Workers also need to be organized to help youth negotiate and understand their sometimes complicated family dynamics. Workers need to be encouraged to pursue waivers for family members when children and youth can be safely placed with relatives.

4. **Fresno County leadership should work closely with state of California to take full advantage of provisions in the federal Fostering Connections law.**

   The federal Fostering Connections legislation provides several meaningful opportunities for states to support youth while they are in foster care. California recently passed legislation in line with Fostering Connections that provides foster care services—including transitional housing, financial aid, tutoring and other educational supports—to youth until age 21. Fresno County should work in tandem with the state to effectively implement the changes and to identify and act on additional opportunities in the law to support older youth.

FRESNO COUNTY DEPARTMENT OF SOCIAL SERVICES

Child Welfare Equity Action Plan

Our Call to Action

Over-representation of African American children in the child welfare system and the poorer outcomes that they experience is a local and national problem that we cannot ignore.

Nationally, significantly greater proportions of African American children enter and remain in foster care than children of other races and ethnicities. Forty-six states have disproportionate representations of African American children in their child welfare systems. In seven states, California among them, the proportion of African American children in foster care is considered "extreme," constituting four times what one would expect based on their occurrence in the general child population of those states.

Furthermore, once involved with these systems, African American children are more likely to be removed from their homes, spend longer periods of time in out-of-home care and often their families have less access to relevant and helpful social services.

Similar trends exist for African American children in Fresno County. In 2000, African American children represented roughly 5 percent of the county's general population and yet represented nearly a quarter of the youth in foster care. The Department began to take steps to address this problem and by 2009, 17 percent of youth in care were African American. Despite this progress, our Department remains concerned about the low reunification rates of African American children with their parents and their longer stays in care.[1]

Our Commitment

We are committed to understanding the causes of inequities for African American families and taking action that will ultimately improve outcomes for *all* children and families.

In 2006, the Fresno County Department of Social Services (DSS), determined to take a proactive approach, reached out to the broader community and asked for their assistance. DSS publicly committed to understanding the root causes of these inequities and began working in partnership with the community to find solutions.

In the last four years, Fresno County DSS has changed policies, altered practices and provided substantial education and training to staff. But even in the midst of positive changes, DSS continued to seek ways to more deeply understand the true, underlying causes these inequities in order to strategically target the right solutions.

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[1] Center for the Study of Social Policy, Positive Outcomes for All: *Using an Institutional Analysis to Identify and Address African American Children's Low Reunification Rates and Long-term Stays in Fresno County's Foster Care System,* October 2010.

In 2009, Fresno County DSS was invited by Annie E. Casey Foundation, a longtime partner of the County, to participate in an examination of its services through a process called an Institutional Analysis. Presented with this opportunity and in consideration of our commitment to the community, DSS enthusiastically volunteered to have a team of reviewers from the Center for the Study of Social Policy, Praxis International, Annie E. Casey Foundation and Casey Family Programs intensively assess Fresno's child welfare system to identify policies and practices that may contribute to poor outcomes for African American children and families. The DSS did this with the anticipation that the efforts to improve outcomes for African American families would also result in improved outcomes for all the children and families that we serve.

A Changed Agency

Fresno DSS is not the same agency it was when this work began four years ago.

DSS leadership conscientiously and effectively elevated the need for improved engagement with African American families through continuous data collection, dissemination and analysis; courageous training and dialogue on individual bias and institutional racism; assessment and modification of existing agency policies that have the potential to exacerbate inequities and engagement of critical community partners called "Cultural Brokers" in the agency's front end assessment and decision-making process, as well as ongoing case planning with families.
The Institutional Analysis helped to further focus, refine and motivate the Department's work in this area. At the conclusion of the analysis in December of 2009, the Department, ignited by the experience, was eager to apply the deepened awareness and lessons learned immediately to the efforts to address the disparities in Fresno's child welfare system. Determined to build upon the progress of the prior four years, the Fresno County DSS decided to review and implement strategies based on the preliminary findings of the Institutional Analysis pending final publication of the report. The most significant actions taken by Fresno County DSS in the months following the Institutional Analysis are included herein.

Our First Steps

In the months following the analysis, we took steps to:

☑ **Reframe the social worker's job.**

- We are encouraging staff members across the Department to improve their advocacy for children and families (this includes full safety and risk assessments) rather than focusing too heavily on process.
- We now expect staff members to elevate issues that impede service delivery to families and permanency for children to supervisors when they run into problems or obstacles that are system barriers that they can't resolve themselves, greatly empowering employees to think outside the box and resolve issues quickly.

☑ **Reassess agency structure and policies to ensure they are supportive of maximum family engagement.**

- Fresno DSS Child Welfare divisions are reorganized in their entirety to ensure the efficacy of services delivered to children and families through an integrated case management model.
- We have modified our visitation contracts to include expanded visitation hours (9 a.m. to 8 p.m., Monday through Saturday and holidays) to increase the visiting options for families with school age children. Providers will now be required to provide visitation services in three main communities in which our clients reside. These new contracts will be in effect January 2011.

☑ **Improve access to services and quality of services for families by enhancing linkages between system improvement efforts and service systems.**

- We have adopted a coordinated case planning approach that is being rolled out this month to link families involved with the child welfare system to CalWORKs services and supports that can facilitate family reunification and stability.
- We have implemented a single practice approach to integrate the concepts, theories and practices of Fresno's multiple child welfare improvement initiatives that spans the entire child welfare service continuum. The technical assistance teams for those various initiatives are now actively coordinating their efforts to support Fresno's direction.

☑ **Provide "Racial Sobriety" training to the entire child welfare workforce. The training seeks to enhance self-awareness leading to an acceptance of all people as members of the same human family, thus mitigating stereotypical biases and to increase awareness of each individual's opportunity to mitigate the impact of institutional bias.**

- In March, we provided "Racial Sobriety" training orientation to the five Program Managers.
- In April, we provided training for all agency supervisors.
- In July, we provided training for nearly all of the agency's roughly 300 workers.

Today

Today, we have made substantial progress toward achievement of the following five high-priority agency goals:

☑ **Establish a Quality Supervision approach that supports supervisors in modeling, coaching and guiding Fresno social workers to continuously develop and enhance their engagement and teaming skills with families.**

- We have developed a case review and reflective supervision process, as well as a range of tools to support the quality supervision approach (September 2010).
- We are training agency supervisors on the Quality Supervision approach (October 2010).
- We will formally implement the Quality Supervision approach (November 8, 2010).

☑ **Implement a Joint Community Response practice (strategy that involves a coordinated joint response between a social worker and a Cultural Broker and/or Parent Partner) to more successfully engage African American families and conduct a more accurate, up-front assessment of the family's needs. To accomplish this, we:**

- Have developed the Joint Community Response protocol with Emergency Response supervisors, workers and Cultural Brokers (August 2010).
- Are facilitating peer-to-peer training on effective family engagement with supervisors, workers and Cultural Brokers (October 2010).
- Are developing full implementation plan/roll-out for Joint Community Response (October 2010).

☑ **Improve front end Team Decision Making (TDM) practice to ensure authentic family, youth and community engagement is occurring. Our work involves:**

- Conducting assessment of front end TDM protocol, supervision and practice quality (July 2010).
- Modifying TDM policy and protocol based on the assessment findings (September 2010).
- Providing refresher training for agency supervisors and workers (October-November 2010).

☑ **Increase legal and relational permanency for African American children and youth, including increased and timelier reunification, through Quality Family Engagement and Teaming practice.**

- Define management roles in implementing Joint Community Response, as well as Permanency Teaming practices, which are a series of meetings that are designed to increase the engagement with families so as to better understand their needs.
- Develop a full implementation/roll-out plan, leadership structure and communications plan that leverages the child welfare reorganization to promote a one-agency approach (July 2010).
- Develop protocols for Permanency Teaming practices (September 2010).
- Train all agency supervisors and workers on Quality Supervision and Permanency Teaming practice (October-November 2010).

☑ **Increase the accessibility and quality of services for African American families and youth.**

- Conduct an assessment of the DSS structure and the use of specialized staff to identify barriers to relationship building and the effective provision of services (October 2010).
- Clarify and finalize protocols that address utilization related to visitation and drug testing services (November 2010).
- Create a community partnership network to better access community-based services for African American families and to continually assess those services and advocate to fill identified service gaps (December 2010).

- Establish and hire a Community Partnership Coordinator to work with the community to access, assess and advocate for services (December 2010).

Our Work is Not Done

Despite this significant progress, our work is not done.

In the next several months, DSS will work with our Disproportionality Advisory Committee (DAC) to integrate the formal recommendations from the Institutional Analysis with our current improvement priorities. Over the course of the next year, DSS will continue to move our action plan forward and implement our current improvement priorities. The DAC, which includes youth, parents, care providers, community partners, service providers and agency staff, will continue to hold the agency and broader community accountable for implementing the recommendations of the Institutional Analysis.

Over the next five years, the Department will work closely in partnership with state, local and non-profit agencies to reduce long-term foster care for African American and Native American youth. On October 1, 2010, the California Department of Social Services was awarded a new five-year grant from the federal Administration for Children & Families (ACF) of up to $14.5 million dollars. Fresno is one of four pilot counties that will be working to identify and overcome barriers to permanency. The grant funds and the statewide partnership allow Fresno to further institutionalize and spread the recommendations of the Institutional Analysis.

Fresno County DSS recognizes that this review is just the first of many steps that the Department will need to take to fully understand and address the needs of the diverse community that we serve in Fresno County. We hope our work will inspire other public agencies to make a similar commitment to understanding the causes of inequities. We look forward to expanding our partnerships to improve opportunities and experiences for all of Fresno County's children, youth and families.

APPENDIX A

Methodology

I. Introduction

This appendix describes the methodology employed in the Fresno study. Specifically, it describes the study team composition, Fresno County's Department of Children and Family Services (DFCS) participation, the study impetus, the application of institutional ethnography concepts and tools to frame the data collection and analysis process, the knowledge base for the study and the study limitations. [2] Throughout, it describes actual data collection and analysis in Fresno County.

II. Institutional Analysis Team

A 24-member team, including staff and consultants from the Center for the Study of Social Policy, Praxis International, the Annie E. Casey Foundation, and Casey Family Programs conducted the Institutional Analysis (IA) in Fresno County. Collectively, team members represented decades of experience at all levels of child welfare from front line practice to state agency leadership. In addition, most members had expertise providing technical assistance to jurisdictions throughout the country on child welfare issues. Team members were trained in August 2009 on the IA core standardizing methods, interviewing and other IA data collection skills. A team of Fresno DSS staff were assigned to assist the IA team during the week obtaining files and agency policies and procedures and coordinating meetings and travel during the week.

In an IA, the large team is generally organized into smaller subgroups that focus attention on different aspects of case processing. For example, one subgroup might examine court practices while another subgroup examines case worker interventions and yet a third subgroup might focus on the interventions of community-based services. In the Fresno County study, five such subgroups focused on: Reunification, Juvenile Dependency Court, Long-Term Foster Care/Older Youth, Services/Resources, and Finance/Contracts.

III. Fresno County Participation

This investigative approach is dependent on both institutional cooperation and participation of representatives from the institution to be explored. The partnership between the outside reviewers and the local workers and managers in the system accomplishes three core objectives: 1) it helps investigators understand what they are observing, reading and hearing, 2) it provides access to files, information and people otherwise not available to an investigator, and 3) it enhances the likelihood of change coming from the report as insiders discover for themselves the shortcomings of how work is being coordinated and organized within the system. Fresno County was an active partner in this study, opening its files, organizing interviews and providing invaluable insight that helped develop the findings and recommendations.

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[2] This is not an extensive discussion of the components and underpinnings of the methodology employed. Such a discussion is forthcoming from the Center for the Study of Social Policy to be published at a later date.

IV. Study Impetus

Child welfare systems are complex. They involve many different actors and agencies: child protection workers and agencies; lawyers and judges involved in juvenile dependency courts; therapists, counselors, foster parents and the private agencies that employ and supervise them; and concerned professionals and neighborhood residents alike. At the heart of these systems are the children and families who have been reported to the child protection agency. How these children and families are served is organized by laws, rules, regulations and procedures that often originate outside of the system.[3] For example, the federal government exercises oversight of state programs as well as provides significant levels of funding to underwrite the services provided to children and families. In California, the state also oversees county child protection agencies.

Families enter the child welfare system as the result of a professional, family member or neighbor having a concern about the safety or well-being of a child. Sometimes, families self-report when they are seeking help to better provide for their children. Reports are investigated or assessed and decisions are made about opening a service case based on criteria established in federal and state laws along with local agency policy and procedures. Depending on the nature of the concern and the findings of the assessment, children may remain with their caregivers – birth parents, grandparents, other relatives or guardians – or they may be removed from the custody of caregivers and placed with substitute families. Removal decisions involve local judiciary in juvenile dependency courts. The federal criteria for removal is that it is not "in the best interest of the child" or that it is "contrary to the child's well-being" to remain with the caregivers.[4] The substitute families may be strangers to the child, recruited by the local agencies or they may be relatives of the child. These substitute caretakers must meet certain criteria in order for the child to be placed in their home. In some cases, children are not placed with families but in congregate care settings. Again, the placement decisions are guided by state and local agency policy, procedures and resource availability. In some situations, placement decisions may also be influenced by federal reimbursement criteria. The delivery of services to children and families while their cases are open can vary greatly across systems within a state and across the country.

In response to the varied service approaches, lengthy foster care stays for children (the biggest driver of federal costs) and the need for children to be in safe, stable and permanent homes, the federal government established a series of national child welfare outcomes for all systems to strive toward.[5] Thus, outcome performance data is being accumulated and analyzed on a regular basis. African American and Native American children and their families are more frequently reported for child maltreatment to child protection agencies.[6] National data show that African American and Native American children and their families have different outcomes when a child protection agency intervenes in their lives. They have higher rates of assignment of alleged

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[3] http://www.cssp.org/center/about_us.html#analysis.
[4] http://www.acf.hhs.gov/programs/cb/laws_policies/policy/im/2001/im0111a1d_2007.htm#one.
[5] http://www.acf.hhs.gov/programs/cb/cwmonitoring/recruit/cfsrfactsheet.htm.
[6] Differing from past NIS reports, the most recent NIS-4 data indicates that children of color have a higher rate of maltreatment in some of the harm and endangerment standards. *Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress*, January 2010.

reports for investigation by child protection agencies[7] and higher rates of out-of-home placement than Caucasian children and their families.[8] While it is believed that data may undercount the rate of Latino children in the child protection system, Latino children are also disproportionately present in several jurisdictions across the country.[9] Once involved with these systems, children of color experience disparities in outcomes and services. Specifically, they spend longer periods of time in out-of-home care and are less likely to reunify with their families; oftentimes both children and their parents have less access to relevant and helpful social services.[10] Outcomes regarding reunification, time spent in foster care, and number of placements for children and youth of color are, for the most part, alarmingly worse than they are for their Caucasian counterparts.[11] Long-term life outcomes for children who remain involved in the child protection system as they mature tend to be bleak, with high rates of juvenile and adult incarceration as well as bouts of homelessness, substance abuse, mental health issues and income insecurity. [12]

African American families have been disproportionately represented in the population of children in the custody of Fresno County Department of Social Services (DSS) for years. In 2000, African American families comprised five to six percent of the general population while they represented 24 percent of youth in care. By taking a series of intentional steps, this disproportionality declined so that by 2008 African Americans represented 14 percent of youth in care.[13] However, prior to the IA, DSS recognized African American children were still experiencing delays in and declining rates of reunification and longer placement episodes than other groups of children.

When institutions produce results that are consistently negative for certain groups of people, the source of inequity will in some significant way rest in how the institution has conceptually and administratively organized its work. Locating its source almost always points to concrete changes that can eradicate many problematic practices.

V. Analytical Assumptions

The inquiry of the IA is grounded in the viewpoint of family members, children, fathers, mothers and other primary caregivers. It seeks to discover how the ways institutions organize their workers to describe, document and act on cases can inadvertently be a source of poor outcomes for family members. It is grounded in the notion that there is often a gap between what family members need to be successful in reunification or establishing a permanent home where children thrive and how the workers acting on cases have been coordinated and organized to intervene.

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[7] Dunbar & Barth, *Racial disproportionality, race disparity, and other race-related findings*; King, G., Trocme, N., and Thatte, N (2003). *Substantiation of a multitier process: The results of a NIS-3 analysis*.
[8] Hill, 2006. *Synthesis of research on disproportionality in child welfare: An update,* Casey-CSSP Alliance for Racial Equity in Child Welfare. Dunbar & Barth*, Racial disproportionality, race disparity, and other race-related findings*.
[9] Hill, *Synthesis of research on disproportionality*.
[10] Hill, R. *Synthesis of research on disproportionality* and Dunbar and Barth, *Racial disproportionality, race disparity, and other race-related findings*.
[11] Hill, *Synthesis of research on disproportionality.*
[12] Courtney, M et al. (2005) *Midwest Evaluation of the Adult Functioning of Former Foster Youth*, Chapin Hall Center for Children at the University of Chicago.
[13] Fresno specific data is included in the report's Introduction.

The IA is guided by several assumptions related to how institutions work, the inquiry process and institutional racism. [14]

A. <u>*Assumptions about how institutions work*</u>

1. *Institutions are designed to ensure consistency among staff and to limit the influence of individual worker behavior.*[15]

Institutions generally seek to have workers treat similarly situated cases similarly. Regardless of the idiosyncratic beliefs of an individual worker, institutions seek to coordinate and organize individual practitioner actions by employing certain standard practice to produce institutionally authorized results or outcomes. In other words, staff members are guided to do their jobs within the context of the forms, policies, philosophy and routine work practices of the institution in which they work. Therefore, when case management practices produce consistently poor results for an identified group of children and parents, a part of the problem must lie in the way workers are organized to process or manage the cases. The Analytical Framework that follows elaborates more on the methods by which institutions direct workers to think about and interact with families.

2. *The institutional view of clients can be biased.*[16]

The same institutional rules, policies, forms and manuals that are designed to establish consistency and neutralize individual worker bias can still produce a biased picture of clients. To effectively process large numbers of clients (families and children), institutions necessarily rely on segmenting them into cases and then further segmenting them into categories of cases from which interactions follow. Individual information – strengths, needs, fears, aspirations – is filtered through the categories and forms and rules employed by the institution. As a result, the unique aspects of individuals disappear and well-intentioned interventions may be misguided.[17]

3. *The diverse experiences of members of any community must be accounted for in the design of institutional interventions.*

Public institutions serve communities with different identities and histories. While the service entry point is the same for all, each entrant brings his or her own cultural assets and problems. Yet, the institutional response is more likely to deny the differences in an effort to be consistent, unbiased and/or "color blind." In order to serve all children and families well, consideration of the diverse experiences and needs of all recipients of services must be incorporated.

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[14] CSSP is developing a bibliography that cites research supporting these assumptions. We provide some examples from the bibliography in this section.
[15] Knight, J. (1992). *Institutions and Social Conflict*. (Cambridge: Cambridge University Press). Pence, E. and Sadusky, J. (2005). Safety and Accountability Audit. Praxis International, Inc. and Pence, E. (2009). (In)visible Workings. Praxis International, Inc.
[16] Knight, J. (1992). *Institutions and Social Conflict.*
[17] Campbell. M. and Gregor, F. (2002). *Mapping the Social: A primer in doing institutional ethnography* (Aurora, On: Garamond Press), pp. 37-39.

B. ***Assumptions about the inquiry process***

1. *Population specific studies produce valid insights.*

Population specific studies have become commonly accepted in the field of public health in trying to understand how and why different portions of the population experience different health outcomes. [18] As a result of population specific studies, greater understanding has been gained about the contributors to the outcomes achieved. Valid studies are not limited to large, statistically valid research methodologies. Often, qualitative case studies of small, nonrandomly selected populations "triggered by a curious observer can lead to new hypotheses for exploration."[19]

2. *Institutional changes can improve outcomes for children and families.*

The fields of management and financial auditing and program evaluation have established that analyses of institutional features identify areas for improved performance across a wide range of organizations and settings. As described by one author, *"The management audit…focuses on results, evaluating the effectiveness and suitability of controls by challenging underlying rules, procedures and methods…they are potentially the most useful of the evaluation methods, because they result in change."*[20]

C. ***Assumptions about the effects of institutional racism on African American families***

1. *Institutional racism has meant that African American families are subjected to systemic and structural disadvantages in terms of income, education, housing and other such opportunities and resources that contribute to stability and advancement.*

This historical disadvantage comes into play in all aspects of family life and government or state intervention into family life. It must be taken into account and addressed when working with African American families.

2. *African Americans have experienced historical and current obstacles when interacting with public systems, including schools, courts, health care, etc.*[21]

African Americans as a group have had many negative experiences over the centuries of state involvement in family life that has produced a low level of trust that public systems will work toward their benefit. Thus, child welfare system must acknowledge this low level of trust and account for it in their individual interactions with African American families.

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[18] Agency for Healthcare Research and Quality on the Inclusion of Priority Populations in Research, February 2003, http://grants.nih.gov/grants/guide/notice-files/not-hs-03-010.html.

[19] Mayes, N. and Pope, K. (1995) Observational methods in healthcare settings. *British Medical Journal Vol. 311*, pp. 182-184.

[20] Arter, D. R. Management Auditing: A results oriented audit can create the impetus for positive change. Retrieved from www.qualitydigest.com/april00/html/management.html.

[21] For examples, see Mays, V.M., Cochran, S.D., & Barnes, N.W. (2007) Race, Race-Based Discrimination, and Health Outcomes Among African Americans. *Annual Review of Psychology*, vol. 58.

3. *African American communities are often viewed as "troubled" within environments that are not conducive to producing good outcomes.*

African American communities are, however, complex with a range of challenges and resources. Strategies need to recognize and capitalize on the strengths of the communities, employing both formal and informal supports assisting families.

VI. Institutional Analysis as a Tool for Eliminating Racial Disparities

The IA is a method of inquiry that examines the work organization and coordination of CPS, juvenile court and related legal and human service agencies in managing child protection cases. The examination attempts to locate—within local, state and national organizational processes– the key sources of the disparate and poor outcomes for African American children drawn into these systems.

A. *The Investigator's Point of Entry*

The inquiry focuses on the lived experiences of family members, children, fathers, mothers and other primary caregivers. It seeks to discover whether the way workers have been organized by systems to talk about and act on cases can inadvertently be a source of poor outcomes for family members. It begins with the notion that there is often a gap between what family members need to be successful in reunification or establishment of a permanent home where children thrive and how the workers acting on cases have been coordinated and organized to intervene. The lens of inquiry is not on the skills, actions or even beliefs of individual social workers, therapists, judges, prosecutors or police. It is the institutional policies and practices, logic and assumptions that have organized these practitioners to act and talk about cases in very specific institutionally authorized ways. By asking how workers are *coordinated* to work on cases rather than looking at the individual actors doing the work, the IA process reveals systemic problems and points to organizational change. This change is initiated at the managerial level but ultimately alters the everyday work practices of intervening professionals.

B. *Institutional Features to Consider*

Over a decade of experience in IA work and dozens of specific studies by its developers suggests there are certain institutional features of legal and human service institutions at play in creating the gap between what people need and what institutions do. Briefly, these features include the following:[22]

- *Fragmentation*: Institutions employ fragmented approaches to complex situations;
- *Conceptual practices*: Institutions engage in conceptual practices that organize how workers think and act;

[22] For more complete descriptions of the problematic features, see Pence, Ellen, PhD, (*In)visible Workings: A change agent's guide to closing the gap between what people need and what legal and social institutions do.* Praxis International, Inc., St. Paul, MN (2009).

- *Coordination through text*: Institutions coordinate and standardize workers' actions through texts including policies, forms, standards and guides for recording interactions with clients;
- *Limitation masking*: Institutions mask what it can and cannot accomplish and have no mechanism for acknowledging when they fail the people they are designed to serve;
- *Reliance on categories*: Institutions rely on the use of categories to process large numbers of cases;
- *Communication without dialogue*: Institutions create communication patterns that subvert opportunities for dialogue;
- *Coercion*: Institutions use coercion to gain compliance;
- *Timing*: Institutions operate on a time different from "lived time;"
- *Inadequate accountability*: Institutions maintain inadequate systems of accountability;
- *Function over need*: Institutions give priority to the institutional tasks and requirements that support the institution's functioning and preserving the institution over individual needs; and
- *One-size fits all standards*: Institutions create standards based on "fictitious universal" people and individualize social problems.

C. Institutional Methods as Investigative "Trails" of Inquiry

Case management institutions want to achieve a certain level of consistency in their practices. Most agencies want to be organized so that people will receive very similar kinds of interventions regardless of who is acting on the case at any point in time. There are methods that an agency or collection of agencies processing cases uses to promote such consistency.

The IA has identified eight common methods legal and human service agencies attempt to standardize how workers intervene in cases.[23] The IA investigator thinks of these eight methods as *trails of inquiry*. The IA is designed to uncover when and how these standardizing methods are at play in a problematic way at any given interchange.

The trails are followed as investigators focus on the study question(s) at key interchanges between a worker or organizational process and the persons whose cases are being managed. Team members are trained to always look for and document how any one of these methods of managing workers is operating at any given point of intervention. The task of the investigator is to uncover when the design of these standardizing methods might be contributing to the condition under study. In Fresno County, the condition under study was poor child welfare outcomes for African American children families.

[23] Pence, E. and Sadusky, J. (2005). *Safety and Accountability Audit*. Praxis International, Inc. These eight methods of standardizing workers practice are not meant to be an exhaustive list; they should not put a boundary around the focus of an investigation and what it uncovers but instead account for the complexity of institutional action.

Each of the eight *core standardizing methods* is briefly described below:

1. ***Mission statements, job descriptions and job functions***. Agency mission should, by definition, drive all practice in an agency and each person's assigned function when intervening should be linked back to achieving the mission. Each task the worker is assigned links to their function in the case. An IA will often expose a gap or even a conflict between an agency's stated mission and the tasks assigned a worker. When a mission statement claims the agency seeks to provide support and nurturance for children but the work it takes to do that is either not assigned to anyone or not expected of workers, then a gap occurs. Similarly, when an investigator uncovers the need for certain actions to occur and the practitioner says, "That's not my job, my job is simply to…," then again, a gap occurs. For example, in an IA of how victims of domestic violence are kept safe and served, an investigator observed a deputy who was serving a protection order to a man who was visibly shaking and very volatile at being evicted from his home. When the investigator asked the deputy, *"Do you think you should call the woman and tell her how he reacted?*" the deputy responded, *"Oh no, that's not my job. I'm like a mailman I deliver these things, that's it."* IA investigative team members gain insight about problems associated with how workers are organized to understand their function and role by examining how they spend their time, what of institutional significance they document and what kinds of tasks prioritized in an overtaxed system.

2. ***Rules and regulations laws, regulatory and administrative policies, and policy manuals*** are powerful determinants of how a worker will act on a case. The IA looks to see how regulations act to enhance or limit the worker's ability and capacity to effectively intervene. The existence of a policy and its consistent implementation are objects of inquiry in any IA. Policy itself is not a neutral object. It carries institutional assumptions, priorities, definitions and concepts. Policy may or may not be enforced within an agency, consistently applied or understood by practitioners within an institution and embraced by workers as effective.

3. ***Administrative procedures and protocols*** tell workers how they should put policy and job function into practice in everyday case processing routines. These procedures consist of screening tools, report-writing formats, matrices, assessments tools, directives, and protocols for conducting family-involved team meetings. Administrative tools are attached to every regulation. The tools act as the coordinator of the relationship between the institution (represented by the worker) and the client; as such, they can enhance the worker-client relationship or impede it.

4. ***Organized linkages*** connect a worker operating at a given point of intervention to other practitioners with prior or subsequent involvement in the case. For example, an investigative worker's actions are in part determined by information received by the hotline worker, and information required to file a petition with the Family Court (in some systems this task may be completed by another worker), the judge who receives the petition and subsequent case workers. In many instances a worker does not have a strong link with another actor in the system necessary to help a family. For example, clients involved in the child protection system who are also on probation in the juvenile or

criminal justice system have both a probation officer and a case worker. If these two actors are working closely together for the good of a family, more resources, information, understanding and perhaps leverage can be used to work with a family. When these key workers have a weak link to each other, opportunities for help are missed. Every worker in this complex system is dependent on all workers who have been involved with the case before them. Similarly how a worker at a certain point acts (meaning gathers and documents information, processes information, relates to the client, makes decisions and acts on those decisions) produces the conditions and boundaries around which subsequent workers can act. The investigative teams must explain and analyze those inter-relationships.

5. ***Resource allocation*** dictates the capacity of an agency to carry out its mission and achieve its goals. Resources are not limited to budget dollars but also include such things as interventions to improve parenting, visits from workers, health care, home care assistance, tutoring, emergency funds, child care, substance abuse evaluation and treatment and staff time (case loads). The rules and practices that determine access to resources and the types of resources made available examined as part of any IA.

6. ***Education, training, and skill development*** in the form of training for workers and supervisors, educational requirements, mentoring opportunities and participation in local, state and/or national forums shape how workers come to talk about and act on cases. Training that fails to connect workers to the realities of clients' lives and help workers skillfully interact with clients will produce problematic practices. Training is always intricately connected to concepts and theories that are institutionally authorized and hold what many call "institutional currency."

7. ***Concepts and theories*** are embedded in the assumptions and logic of the child welfare field and established in policy and administrative systems. Policies and administrative practices are connected to broader assumptions, theories, values and concepts regardless of the individual values of the practitioner who will carry them out. IA investigators are trained to look for the operative theories at any point of intervention and assumptions or concepts built into administrative tools and policies. For example a parenting assessment form, a bonding study format and a report writing directive are all administrative tools that are shaped by concepts and theories recognized and authorized by the management structure of an institution or agency. The team then must identify theories and assumptions that may contribute to producing both racial equity and racial disparity.

8. ***Systems of accountability*** are designed to hold those who intervene with a family accountable. The investigation looks for how workers are or are not organized to be accountable to the well-being and success of their clients. Additionally investigators look for accountability to other interveners and practitioners and to the overall intervention goals. Examples of accountability include supervisory approval of case plans, quality control of guardian ad litem procedures and reports, fairness and accuracy in documentation, integrity of case documents, family involvement in case planning, court review of placements and permanency plans, the use of lawsuits and grievance procedures. In the course of an investigation the analysts will often hear from every

corner of the institution complaints about how others in the system go about processing cases. It is important for an analyst to ask how these complaints get resolved. Is there a method for intra- and inter-agency accountability and problem solving?

Other factors may influence organizational behavior in a specific location. For example, in jurisdictions where a particularly egregious or fatal case of child abuse or neglect occurs, the political atmosphere may escalate the pressure on workers to remove children from their families even when risk of harm is low (rather than directing workers to provide more intensive in-home supports to families). Alternatively, a jurisdiction may be in the midst of civil litigation and the unique features of the lawsuit or settlement agreement may direct attention, interventions and resources to particular types of cases of abuse and neglect. The factors often cloud the ability to assess the strengths and needs of individuals and may erode the system's accountability to clients.

D. Data Collection Tools and Activities

Data collection started with the quantitative data provided by Fresno County regarding the outcomes experienced by African American children. It then progressed to using standard ethnographic methods of information gathering: interviews, observation and file reviews.

1. Interviews

IA teams typically conduct different types of interviews over the course of examining a particular case processing step. In an IA, interviewers are trained to conduct certain types of interviews as part of the overall attempt to document the work of case processing.

- ***Big Picture Interviews***

One type of interview is the ***big picture interview*** that is typically conducted before the team goes to a site and after the team completes data collection to help interpret what has been found. Big picture interviews are also conducted during the site visit. In these interviews the IA team is looking to gain a better understanding of the overall structural issues regarding funding streams, local political structure, court and agency structure, local data, missions and directives of the child protection agency and its partners.

In Fresno County, the Team conducted **13 big picture interviews** between June and November 2009. One of the products of these interviews was a map of case processing highlighting the major decision points as well as any directives (regulations, policy, protocol and forms) relevant to the decision points.

- ***Work Practice and Text Interviews***

Another type of typical interview in an IA is a ***work practice interview.*** Here a worker is asked to describe in detail how she or he goes about a certain task. The interviewer asks the worker to describe performing a particular task as if the interviewer was going to step in and do that job. How would she be assigned the case? What information would she receive (a file, a phone

number or a person coming to her office?) What would she do first, how would she do it and what tools (assessment tools, matrices, forms, resource lists or guides) would she use? The interviewer conducts the interview as if he will be charged with doing this task tomorrow, leaving no detail uncovered.

Work practice interviews sometimes include a ***text-based interview*** or separate text-based interviews are conducted. In text-based interviews, the interviewer and the worker walk through how a particular text is used in processing a case. A common text in these cases are risk assessment tools. The interviewer asks the worker to describe using it in a case. Then looks through several such assessments with a worker to ask about how the worker decided to document certain pieces of information or to fill in certain blanks and not others. The interviewer wants to see how this text is produced and to understand how it is used. The interviewer is also questioning the construction of the administrative form or guide that directs the worker to document. It is rare that an institutional worker ever starts with a blank sheet of paper. There is almost always a pre-existing text that must be fully examined to understand that same text filled-out regarding a real person. The text is viewed as an actor in the case. Perhaps it prioritizes, screens, helps categorize or highlights certain pieces of information. The interviewer's goal is to uncover all the important roles the text plays. At the same time the text carries within it assumptions, concepts, and theories that the worker is organized to use or at least address as she processes the case. For example, when a worker is using a bonding study form, the form itself defines the indicators of positive bonding and the worker is directed to look for and document the existence or absence of these signs, such as "parent knew how to care for the child's grooming needs." [24] The analyst first inquires about the conceptual connection between caring for a child's grooming needs and parental bonding and then asks about the experiences of the worker in filling in this piece of information in cases involving African American families and non-African American families.

In **Fresno County, the IA Team conducted 60 work practice interviews** in December 2009 designed to understand how practitioners go about doing their work in everyday case processing and managing routines. Interview participants were selected to achieve perspectives from the provider community, clients (parents and youth), system partners (court observations, attorneys and child advocates) and staff who were currently processing cases as frontline workers and were considered by the agency as competent workers. Some of these interviews included text-based questions, but no solely text-based interviews were conducted.

- ***Group Interviews***

In an IA, **group interviews** are used to obtain a broader range of information and insight than individual interviews though the possibility of exploring any particular issue in depth is diminished.

[24] This text is an example of introducing criteria for bonding that the individual worker may never have even considered. As a result, the bonding study form is an example how the worker is organized to talk about a case in institutionally authorized ways.

In **Fresno County**, group interviews were used in two very specific ways. First, they were used to explore the experiences parents and youth who had been involved in the child welfare system. Group interviews allowed the Team to gather an account of how the system worked from their perspective, to discover what was helpful and harmful for them in the reunification process and to learn what change would be required to better provide support and nurturance and reach reunification in a timelier fashion. The goal was to understand what was taking place in the lives of clients being processed at various points of case processing. This effort allowed the IA Team to gain insight in how interventions actually impact the lives of members of the public who are the objects of the state intervention. **Three groups of parents and youth** were convened in December 2009 by the IA Team.

Group interviews were also used to explore the experiences of **practitioners** involved in the same process. Here the goal was to have practitioners reflect on their work as a group and react to each other's comments and observations about the intent of the process, the institutional organization of the process, and the relationship of various actors in managing a case through that a specific part of the process. **A total of nine groups** were convened in December 2009. They were composed **of guardians, attorneys for parents and children, frontline family reunification and permanency workers and Cultural Brokers.**

2. Observations

In conducting an IA, members of the investigative team observe several different workers doing the same job whenever practical. Their fundamental aim is to see the activities described in workers' job description, mission and organizational duty, and regulations and rules.

Observations are an important source of information to the team because they allow the investigators to see the conditions in which practitioners are required to work and people, who are being processed as cases, are expected to function. Practitioners tend to provide interviewers with an official description of their daily work routines, such as "*Next, I assess for risk…*"or "*I go to court and answer questions the judge or county attorney poses about the case…*" It is only when watching the worker perform these tasks that the interviewer gains an expanded picture of job function in action. Workers are more than willing to discuss these realities of their work but they rarely raise them as problematic. This is perhaps because they seem so commonplace that workers do not thing they deserve any mention; yet, case outcomes are very much influenced by these conditions of case processing by the worker. An analyst should leave an observation well prepared for an interview with any one of the practitioners who participated in a given interchange. The observation adds depth and detail to each interview and each case file review.

In the **Fresno County study, 18 observations** were made of juvenile court proceedings, parenting classes, Team Decision Making meetings, Child Focus Team meetings, No Family Reunification Panel and worker interactions with children, parents, foster parents, kinship caregivers and substance abuse specialists.

3. *Text analysis and case file reviews*

In an IA, the Team reads case files that offer a broad representation of the kinds of cases workers are processing. The number of case files to read is determined by the scope of the investigation (resources, size of the team and the question or questions being explored). It is often the case, however, that a small number of case files may yield significant insights.

When reading the files, analysts are directed to make note of a) how the workers were organized and coordinated to know the family, what forms were used, and how interaction with families and service providers was described; b) how workers conveyed that knowledge to subsequent interveners, as well as what and how they documented information and its implications for case outcome; c) what capacity the worker has at each point of intervention and how the worker intervened and d) how workers are made accountable to act in ways that reach these goals.

Selected files for examination generally should represent:

- a typical range of case circumstances faced by clients and workers in the system.

- the work of competent workers processing the case because the objective is to better understand how cases processed competently within the system result in poor outcomes. This does not mean that the team would not review a case file where a worker inadequately completed a task or exhibited extreme bias, but the team's focus would be on how such individual failures are discovered, held to account or corrected by a system to avoid injustices linked to individual worker failures.

In the **Fresno study, 44 cases were reviewed**. First, in November 2009, a small subset of the team conducted an in-depth analysis of **six cases.** The case-based analysis included interviews with 49 individuals, each of whom were involved in one or more of the cases reviewed. The review used a specific protocol to examine the quality and effectiveness of human services interventions with children and their families. [25] The six cases involved children with a broad range of ages who were identified as African American and who had been in custody more than two years. The protocol used asks interviewers to assess the status of children and families and system performance in serving them by exploring the key areas identified in Appendix B.

In December 2009, the team as a whole reviewed another **38 Fresno case files** using text analysis.

E. Data Analysis

In an IA, data analysis is concurrent with data collection. Each new piece of information is considered in light of previous information starting with the original quantitative data that drove the focus of the inquiry. Thus, the analysis and development of findings is an iterative process as described below.

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[25] The process and its related conceptual framework influenced the design of the federal Child and Family Services Review, the evaluative methodology utilized by the Administration on Children, Youth and Families to review all 50 state child welfare programs, as well as child welfare systems of the U.S. Virgin Islands and Puerto Rico.

1. *Debriefings*

The debriefings are the bridge between data collection and data analysis. Debriefings in an IA consist of members of the team reporting on their interviews, observations and case file reviews each day, often including representatives of the system under study. The reporting process begins with this instruction: Describe who you interviewed or what you observed; what step of the process or text were you discussing or observing; name any insights you received about how the work is organized that might be relevant to our inquiry. Debriefings are a facilitated process that provide the opportunity for the team to begin identifying important themes to pursue through additional information collection and analysis as well as feedback and clarification from the agency.

For example a team member may have understood from interviews that the current policy on placement does not allow a child to be placed under the care of someone who would not be a suitable adoptive parent. If this is not actually the policy, a local representative is likely to identify and clarify the misunderstanding and produce the actual current policy. The team member must then determine if this was a practitioner's misunderstanding of policy or a widely held view of current policy. It is not uncommon for an IA to find "policy mythology," with practitioners believing a certain practice to be required by policy or law when it is not.

Individual daily debriefings are also conducted. Individuals reviewing case files debrief their reading with one of the IA leaders while another team member takes detailed notes. When debriefing a file, the readers note any places where practices may have had a significant impact on the case outcome and discussing any problematic conceptual or administrative practices that were noted. Readers also look for what was documented and how.

In Fresno County, the on-site data collection team debriefed as a whole at the end of each of the four days of on-site data collection and analysis. This meeting included representatives of Fresno County Quality Assurance Staff and leadership. In addition team members debriefed individual file reviews with Dr. Ellen Pence, Gayle Samuels and Kristen Weber.

2. *Developing Findings*

In an IA, a final debriefing is convened at the end of the intensive data collection period to formulate preliminary findings based on emerging themes in the observations. [26] This preliminary list is used as the starting point for the findings that will be enumerated in the IA final report. This process generally requires a half day. It is facilitated by a senior team member and recorded.

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[26] Some members are required to conduct follow-up interviews or last-minute observations during this time period because, during the preparation of findings, it was noted that an important step of the process was not fully examined or additional interviews are necessary.

Prior to the final debriefing, each subgroup of the team meets to compile its observations. During the final debriefing, each subgroup shares its observations. The facilitator asks for any and all insights or statements that link poor case outcomes to an organized, coordinated practice in the system. At the same time they are asked to comment on practices that seemed to produce equity rather than disparity.

The facilitators have three frames for helping to guide the discussion:[27]

- the map of the process developed after the big picture interviews, asking members to comment on each step of case processing;

- the eight trails of inquiry asking members to locate a source of a problematic practice (is it linked to the mission statement or job description, a rule or regulation, a procedure or administrative tool); and

- the problematic features of legal and human service institutions previously enumerated.

While these three frames are not systematically discussed during debriefings they do inform the facilitator's questions and lines of inquiry with reporting teams to generate the most complete list of possible findings from the week.

Each practice that is observed or uncovered as a likely contributor to a poor case outcome is first noted as a practice, then screened out if it seems to be an example of poor case work, individual practitioner error or a one-time event linked to either unusual circumstances or the idiosyncratic practice of an individual worker.[28]

Keeping the focus on the way the worker is organized rather than on his or her personal skills or work habits is not always simple or straightforward to do especially when doing an investigation with people who may be involved in training workers on best practices. Investigators are often quick to conclude: this worker should have, if well trained, done x or y or z. While such an observation may be true, the question for the team is how this practice comes about and is allowed to stand in for acceptable processing. Take, for example, case file documentation of a worker's initial interview with an 8-year old child who had just moments before arrived at a foster home:

> *The worker asked the child about what had happened that night and the child started to cry. The worker rephrased the question two more times and both times the girl cried and gave no information. The worker then notes that she concluded the interview and told the child she would return in the morning.*

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[27] This facilitation requires a person or persons who are experts in the IA process and the three frameworks as applied to legal and human service agencies. It is a directed debriefing process. By using these frameworks to ask questions of the IA team, the facilitators keep the inquiry focused on managerial systems rather than skills or failures of individual practitioners.
[28] Such an example might lead to an exploration of why an individual practitioner's mistake goes unchecked in the system, thus uplifting the question of how people in the system are held accountable to a standard of practice.

This is one of many examples of workers not engaging with children in supportive and nurturing ways when the children were obviously suffering. The worker did not document any attempt to comfort the child, only her attempt to conduct the initial post separation interview. The IA process seeks to find out *how this practice becomes acceptable*, not to point out how a well-trained worker would have comforted this child. The eight methods provide a starting point for that inquiry: *what* task or *function* is the worker asked to accomplish in this encounter? Is support and comforting part of that? If so, how is the worker held accountable to that work? Does this behavior go unchecked by supervision?

It is the repetitive nature of an observation that allows the IA team to identify it as a finding. If a practice is seen only rarely in the process it is not considered a finding of the analysis. However, if many examples are found in the files and observations of children and parents, then it rises to the level of a supported finding.

On-site, the IA facilitators and leaders take a few hours to synthesize the findings into an organized presentation for agency and community leaders. Then a large debriefing is held to discuss the preliminary findings with the agency leadership. It is up to the host agency to determine who to invite to this meeting.

The IA leaders make a presentation calling on the leaders of the subgroups to supply the details and case examples for key points or findings. Agency leaders are asked to comment on each finding in order to determine if there are explanations for practices that were not considered or if investigators misunderstood how a certain practice is organized in the agency. Detailed notes are taken. This process is very useful in indicating what follow-up information is needed before formulating final findings It also ensures that management foresees the findings of the report rather than feeling blindsided.

On the final day of the on-site work the team followed this debriefing process and met with Fresno County child welfare leadership to provide an overview of the preliminary findings and receive feedback.

F. ***Report Writing***

Once the team leaves the site, a subgroup of the data collection team is convened and lead by an experienced IA investigator. This subgroup does the final synthesis of the data and report writing. The work of the subgroup begins with all of the debriefing notes; the map of the system that contains the policies, protocols and administrative tools used at each point of case processing; tapes of debriefings and big picture interviews. The process followed in the final debriefing is repeated to find multiple examples from multiple sources to support proposed findings. Observations that do not meet the multiple source test are rejected.

For **Fresno County**, once data analysis and report writing began, the process described above was followed. Through this process a draft of the report was prepared and shared with Fresno County to obtain further feedback and validate the findings. Although specific case examples are used to illustrate particular findings, the data presented are common occurrences, not rare events.

VII. Knowledge Base

The IA approach to examining racial disparities in child welfare is grounded in several bodies of knowledge and research built over the last 20 years in different disciplines including health, mental health, organizational culture and bureaucratic reform, and sociology. For example:

- In the health field, continued disparities in health outcomes for African Americans despite technological advancements has prompted population studies of African Americans as a sub-population alone rather than comparative studies including other sub-population groups (i.e. Caucasian subgroup).[29]

- Similarly, a growing number of health and mental health studies point to chronic discrimination as a significant contributor to the poorer outcomes.[30]

- Health and mental health studies seeking to identify and understand buffers to the effects of chronic discrimination have identified strong ethnic identity and the strength of the African American community.[31]

- The "re-inventing" government movement introduced the importance of organizational climate and structure to public agency performance.[32] In human services specifically, studies have directly linked organizational culture, structure and climate to child and family outcomes.[33]
- Institutional ethnography is a branch of sociology that attempts to better understand why the observed work of an institution is the way it is. It "is method of inquiry that allows people to explore the social relations that structure people's everyday lives." [34] It was first developed by Dorothy E. Smith, PhD, and is "now being used by researchers in the social sciences, education, human services, and policy research."[35] The IA is based on the Praxis Institutional Audit, which employs the institutional ethnography approach and is a method of identifying, analyzing and correcting institutional failures to protect people drawn into legal and human service systems because of violence and poverty.[36]

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[29] Dr. Richard S. Cooper and his colleagues wrote in the March 20, 2003 in The New England Journal of Medicine, "But in the United States, there is substantial variation in health status among major population subgroups. This self-evident truth has been the driving force behind the use of racial or ethnic categories in surveillance for disease." *Race and Genomics*, p. 1168.
[30] Mays, Vickie M., Cochran, Susan D., & Barnes, Namdi, W. (2007). Race, Race-Based Discrimination, and Health Outcomes Among African Americans. *Annual Review of Psychology*. 58:201-205.
[31] Society for Research in Child Development (2009, April 29). African-American Teens' Perceptions Of Racial Discrimination. Mandara,et al. The Effects of Changes in Racial Identity and Self-Esteem on Changes in African American Adolescents' Mental Health. *Child Development*, 2009; 80 (6): 1660 DOI. McBride, Velma, et.al. Factors and Processes Associated With Physical and Psychological Health of African-American Mothers with Type 2 Diabetes: A Heuristic Model. Diabetes Spectrum. July 2003 vol. 16 no. 3 166-171.
[32] Osborne, D.,& Gaebler, T. A. (1992). *Reinventing Government*. Reading, MA: Addison-Wesley.
[33] Glisson, C., & Hemmelgarn, A.L. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse & Neglect*, 22(5), 401-41.
[34] http://faculty.maxwell.syr.edu/mdevault.
[35] Ibid, and http://faculty.maxwell.syr.edu/mdevault/Partial%20Bibliography.htm for a partial bibliography of work about and using Institutional Ethnography.
[36] See examples of audits at http://www.praxisinternational.org/praxis_safety_audits_home.aspx.

VIII. Limitations of the IA

Led by the data and the concern of Fresno County leadership, this IA focused specifically on the experience of African American families. Furthermore, findings from the IA are based on the experience of a limited number of African American children and families. As a result, this study should be considered a beginning point, not an exhaustive investigation. It was not intended to identify the causes of disparity but to identify what in the structure of the institution itself could be contributing to disparity so that the institution can address issue. This is uncharted territory for the field of child welfare as little attention has been devoted to unpacking the interaction between organizational dynamics and family experience, particularly of the African American family. Each application of the approach identifies new learning and opportunities for refinement to strengthen the next application.

Finally, CSSP and Fresno County recognize that other groups experience disparate treatment and outcomes. The institutional features identified may also affect other populations of children and families or other institutional features may affect unique dynamics with other populations. Fresno may consider further qualitative work to understand the experiences of other populations encountering the child welfare system as the findings and recommendations may be different.

APPENDIX B

Quality Service Review

The current status of the focus child and family and the system performance are explored using the following areas of inquiry. Persons using these questions are directed to the **Quality Service Review Protocol (QSR)** for further explanation of the questions and matters to consider when applying these questions to a child and family receiving supports and services. Training on review concepts, methods and uses is recommended for anyone wishing to apply these questions to the children and caregivers in a family receiving services.

Areas of Inquiry

QUESTIONS CONCERNING THE STATUS OF THE CHILD

1. **STABILITY:** Degree to which: ● The child's daily living, learning, and work arrangements stable and free from risk of disruption. ● The child's daily settings, routines, and relationships consistent. ● Known risks being managed to achieve stability and reduce the probability of future disruption. *[Timeframe: past 12 months and next 6 months]*

2. **LIVING ARRNAGMENT:** Degree to which: ● Consistent with age and ability, the focus child is in the most appropriate/least restrictive living arrangement, consistent with the child's needs for family relationships, assistance with any special needs, social connections, education, and positive peer group affiliation. ● [If the child is in temporary out-of-home care] the living arrangement meets the child's needs to be connected to his/her language and culture, community, faith, extended family, tribe, social activities, and peer group.

3. **EMOTIONAL WELL-BEING:** Degree to which: ● Consistent with age and ability, the focus child is presenting adequate levels of emotional, cognitive, and behavioral development and adjustment, as evidenced by adequate adjustments, attachment, coping skills, and self-control. ● The focus child is achieving an adequate level of functioning in daily settings and activities, consistent with age and ability. *[For a child age two years and older]*

4. **OVERALL STATUS OF THE CHILD:** ● Based on the review findings determined for the three Stats Reviews above, how well is the child presently doing?

QUESTIONS CONCERNING THE STATUS OF THE PARENT/CAREGIVER

1.a **PARENTING CAPACITIES (Home Setting):** Degree to which: ● The parent/caregiver demonstrates adequate parenting capacities on a reliable daily basis commensurate with that required to provide the child(ren) with appropriate nurturance, guidance, protection, care and supervision. ● If the child(ren) has special medical, emotional, behavioral, and/or developmental needs, the caregiver has and uses any special knowledge, skills, and supports that may be required to meet the needs of the child(ren).

1.b **GROUP CAREGIVER SUPPORT FOR THE CHILD:** Degree to which the child's/youth's primary caregivers in the group home or facility supporting the education, development, and independence of the child/youth adequately on a consistent daily basis [as appropriate to age and need].

2. **PARENTING CHALLENGES:** Degree to which: ● Parents, with whom the child is currently residing or has a goal of reunification, present or experience a pattern of significant, ongoing challenges that limit or adversely affect the parent's capacity to function successfully as an adequate caregiver for this child. ● The family has any special life challenges that interfere with or prevent them from living together safely and functioning successfully.

4. **OVERALL PARENT/CAREGIVER STATUS:** ● Based on the review findings determined for the Parent/Caregiver Status Reviews above, how well is the parent or caregiver presently doing?

QUESTIONS CONCERNING SYSTEM PERFORMANCE INDICATORS

1a. **ENGAGING – Outreach & Relationship Building:** Degree to which: ● Interveners involved with the family use out-reach and engagement strategies, including special accommodations with any difficult-to-reach family members, to increase family engagement and participation in the service process. ● Interveners build a trust-based working relationship with the child, family and/or others to support ongoing assessment, understanding, and service decisions. ● Interveners rely on a mutually beneficial partnership with the child, family, and/others that is sustaining their interest in and commitment to a change process.

1b. **ENAGEMENT - ROLE & VOICE:** Degree to which family members with whom the child is living and/or will be reunited, are active ongoing participants (e.g., having a significant role, voice, influence) in decisions made about child/family change strategies, services, and results. [*Role and voice in recent meetings]*

2. **TEAMWORK:** TEAM FORMATION: Degree to which: (1) The people who provide support and services for this child and family form a working team to meet, talk, and plan together; and (2) The team has the skills, family knowledge, and abilities necessary to organize effective services for a child and family of this complexity and cultural background. ● TEAM FUNCTIONING: Degree to which (1) Team members collectively function as a unified team in planning for safety and reducing risk; and (2) Actions of the family team reflect effective teamwork and collaborative problem solving that benefited the child and family.

3. **ASSESSMENT & UNDERSTANDING:** Degree to which: ● There is a shared, big picture understanding of the child and family's strengths, protective capacities, hopes, needs, safety risks, and underlying issues that must change for the child to live safely and permanently with the family of origin or adoptive family without agency supervision. ● These understandings are reflected in the family change process and used for helping the

family achieve safety, permanency, and well-being (as defined in stated conditions for safe case closure). ● There is ongoing situational awareness of the child and family being maintained throughout the child and family change process.

4. **CRITICAL DISCERNMENT:** Degree to which the decision agent (i.e., individual worker or team) used critical discernment in strategic decisions (e.g., substantiation, diversion, removal, return, parent replacement, safe case closure) in the life of the case as evidence by: ● 1) EVIDENCE: Assembling a fact base and interpreting accurate, sufficient, relevant meanings to inform the strategic decision? ● 2) DECISION: Applying relevant criteria to focus and guide selection of the most appropriate near-term safety protections and most beneficial long-term outcome path for the child and family with respect to safety, risk, well-being, and permanency? ● 3) ERROR AVOIDANCE: Detecting and avoiding possible sources or error in fact or reasoning that could yield false positive and/or false negative errors at strategic decision points?

5. **PLANNING:** Degree to which a well-reasoned, strategy planning process was used for: A. SAFETY by recognizing, controlling and managing threats of harm while building and sustaining protective capacities of the parents in the home and family situation? B. PERMANENCY by 1) Reunifying the child and parent, replacing the entering parent with another, or achieving independence for an older youth; and 2) Supporting and evaluating the stability and success of the child and family in a potentially permanent home to ensure family sustainability as a condition for safe case closure.

6. **COURT INVOLVEMENT:** Degree to which: ● The family participates in the court process. ● Petitions and motions are filed in a timely manner with hearings conducted on schedule. ● The parent and child are receiving adequate legal representation. ● The judge is holding all parties accountable for following orders. ● The judge achieved a reasonable balance of flexibility and enforcing actions to permanency of children? ● Court orders are clear to all, with parties receiving copies in a timely manner.

7. **RESOURCES:** Degree to which: ● Supports, services, and resources (both formal and informal) necessary to implement change strategies are available when needed for/by the child and family. ● Any flexible supports and unique service arrangements (both formal and informal) necessary to meet individual needs in the child's plans are available for use by the child and family on a timely, adequate, and convenient local basis. ● Any unit-based and placement-based resources necessary to meet goals in the child's plans are available for use by the child and family on a timely and adequate basis.

8. **INTERVENTION ADEQUACY:** Degree to which: ● Change-related interventions, actions, and resources being provided to the child and family have sufficient power (precision, intensity, duration, fidelity, and consistency) to produce results necessary to achieve and maintain desired functional and supportive life goals and permanency outcomes set for this child and family.

9. OVERALL PRACTICE PERFORMANCE: ● Based on the review findings determined for the Service Reviews above, how well is the service system functioning for this child now?

APPENDIX C

Fresno County Policies and Procedures

"The Visitation Ladder"

- Supervised visits can be "*from one hour to several hours long*" and should generally be required less than three months before progressing to unsupervised visits. Caseworkers are required to supervise at least one visit a month so that they can observe the relationship between the parent and child and record in case notes. If supervised visits continue past three months, the caseworker is to seek supervisor consultation. Together they are to "*review the parents' progress on their reunification case plan. If parents' are actively participating in services and attending visits regularly, the social worker will consider moving to unsupervised visits."*

- When a family moves to unsupervised visits, the caseworker is to consider *"the child's school schedule, the parents' work schedule, the parents family reunification services schedule and the resource family's schedule, when arranging the visit schedule."* No suggested time frame is given for unsupervised visits, families may be moved from unsupervised to liberal visits after supervisory consultation. Again, together they are to "*review the parents' progress on their reunification case. If parents' are actively participating in services and attending unsupervised visits regularly, the social worker will consider moving to liberal visits."*

- *"Liberal visits are unsupervised, can be overnight, and last up to 14 days."* They *"should not go on for an extended period. Generally after 30-60 days…families can begin an extended visit."* Again, movement from liberal to extended visits is to be preceded by a supervisory consultation. As with other visit decisions, the caseworker "*will consider moving to extended visits"* if *"parents are actively participating in services and the family has done well during the liberal visits."*

- An extended visit becomes *"a placement after sixty (60) consecutive days."*

APPENDIX D

Key Definitions

The following terms are used with some frequency in this report. The terms are defined as follows:

- **Disparity:** " unequal treatment when comparing racial or ethnic minority to a non-minority. This can be observed in many forms including decision points, treatment, services, or resources." (Robert Hill, *Synthesis of research on disproportionality in child welfare: An update, 2006,* Casey-CSSP Alliance for Racial Equity in Child Welfare)

- **Disproportionality:** "refers to a situation in which a particular racial/ethnic group of children is represented in foster care at a higher percentage than other racial/ethnic groups. It looks across racial/ethnic groups at relative ratios of children at various points in the child welfare system to their numbers in the general population." (Race Matters Consortium: Common Definitions)

- **Institutional Racism:** "denotes those patterns, procedures, practices, and policies which operate within social institutions so as to consistently penalize, disadvantage, and exploit individuals who are members of non-white groups." (Shirley Better, *Institutional Racism: A Primer on Theory and Strategies for Social Change*, 2nd edition, 2008, Rowman & Littlefield Publishers, Inc.)

- **Family Reunification:** "typically court-ordered but can also be voluntary, provides intervention and support services for a limited time period to parents/caregivers and children who have been removed from the home (placed into a foster home, with a relative, or into a group home) to make the family environment safe for the child to return."(California Center for Research on Children and Families, *Understanding the Child Welfare System in California: A Primer for Service Providers and Policy Makers,* 2009)

- **Permanence/Stability: "**achieved with a family relationship that offers safe, stable, and committed parenting, unconditional love and life-long support, and legal family membership status. Permanence can be the result of preservation of the family, reunification with birth family; or legal guardianship or adoption by kin, fictive kin, or other caring and committed adults." (National Resource Center for Permanency and Family Connections at the Hunter School of Social Work (2004).

- **Nurturance**: "The providing of loving care and attention." (The American Heritage Dictionary of the English Language, Fourth Edition, 2000, Houghton Mifflin Company)

ENDNOTES

[1] Hill, Robert (2005). *Overrepresentation of Children of Color in Foster Care in 2000 – Revised Working Paper*.
[2] Hill, R. (2006). *Synthesis of research on disproportionality in child welfare: An update,* Casey-CSSP Alliance for Racial Equity in Child Welfare.
[3] In this report, African American and black are used interchangeable. Fresno County reports racial data as "white," "black" and "latino." Other national reports use the terminology "African American."
[4] Fresno County's child welfare services used to be a part of the Department of Children and Family Services. However, in December 2009, child welfare services were reorganized to be a part of the Department of Social Services. For the purposes of this report, we refer to the department under its new name.
[5] Differing from past NIS reports, the most recent NIS-4 data indicates that children of color have a higher rate of maltreatment in some of the harm and endangerment standards. *Fourth National Incidence Study of Child Abuse and Neglect (NIS-4): Report to Congress*, January 2010.
[6] Dunbar & Barth, *Racial disproportionality, race disparity, and other race-related findings*; King, G., Trocme, N., and Thatte, N (2003). *Substantiation of a multitier process: The results of a NIS-3 analysis*.
[7] Hill, *Synthesis of research on disproportionality* and Dunbar & Barth*, Racial disproportionality, race disparity, and other race-related findings*.
[8] Hill, *Synthesis of research on disproportionality*.
[9] Hill, R. *Synthesis of research on disproportionality* and Dunbar and Barth, *Racial disproportionality, race disparity, and other race-related findings*. For a basic set of definitions of many of the terms used in this report (e.g., disparity, nurturance), please see Appendix D.
[10] Hill, *Synthesis of research on disproportionality.*
[11] Courtney, M et al. (2005) *Midwest Evaluation of the Adult Functioning of Former Foster Youth*, Chapin Hall Center for Children at the University of Chicago.
[12] For the purposes of this report, the authors adopt the definition of racial disparities used by Robert Hill in the *Synthesis of Research on Disproportionality in Child Welfare: An Update*. "Disparity means unequal treatment when comparing racial or ethnic minority to a non-minority. This can be observed in many forms including decision points, treatment, services, or resources."
[13] This paper uses the term "child welfare systems" to encompass organizations/agencies that provide families with prevention, substance abuse, mental health, housing and other supportive social services. "Child protection system" refers to government agencies that investigate allegations of a parent/guardian neglecting or abusing a child, as well as provide protective supervision of families and protective custody to ensure children's safety.
[14] *The Enduring Challenge of Concentrated Poverty in America: Case Studies from Communities Across the U.S*. (2008). A Joint Project of the Community Affairs Offices of the Federal Reserve System and the Metropolitan Policy Program at the Brookings Institution.
[15] Fresno County Self Assessment: December 16, 2009. California- Child and Family Services Review: AB636 Outcomes and Accountability. Retrieved from http://www2.co.fresno.ca.us/0110a/Questys_Agenda/MG173237/AS173268/AS173282/AI173455/DO173621/1.PDF.
[16] California Department of Education, Educational Demographics Office, dropout rates retrieved from http://www.cde.ca.gov/ds/sd/sd/.
[17] A few weeks before beginning the on-site data collection process, the Fresno County Board of Supervisors decided to restructure Fresno County child welfare services. As of December 28, 2009, services provided by the Department of Children and Family Services went to other county departments—for example, children's mental health is now handled by the department of Behavioral Health, which formerly served adults only. Most significantly, Child Protective Services became part of the Department of Social Services, which provides services such as Employment and Temporary Assistance. While a shift like this one can present challenges and opportunities for any system, the impact on this system's ability to learn from the IA seems mostly positive. The director of DCFS became the director of the new Social Services agency. Her commitment to addressing and reducing racial disparities will help ensure the agency stays invested in the process. In addition, it is likely that the staff turnover will be kept to a minimum. This restructuring could in fact present a genuine opportunity for child welfare services to be reorganized and implemented in ways that ameliorate racial disparities. For the purposes of this report, we refer to the department under its new name.

[18] The following foundations make substantial monetary and/or in-kind donations to DSS: Hewlett Johnson, Stuart Foundation, Annie E. Casey, Casey Family Programs, First 5 and The Youth Law Center.
[19] In 2002, the state of California set allocations for each county child protection system from the general fund based on each county's designated expenditures per full time employee. At this time, the Board of Supervisors in Fresno was fiscally conservative. As a result, their rate was set at $81,000 per FTE. This is the second smallest rate in all California's counties. The average allocation is $129,000 per FTE and counties like Santa Clara ($176,000) and Sacramento ($162,000) are much higher. This rate is frozen at the 2002 levels, and the only way this rate could increase would involve reducing the rate of other counties.
[20] In 2010, the District Attorney did not win the contract to continue to represent children.
[21] See Foster Care Standards Committee home page: http://www.co.fresno.ca.us/Departments.aspx?id=666.
[22] See the *Family to Family* Strategic plan for more information on the four core strategies. Information can be retrieved from http://www.aecf.org/upload/pdffiles/familytofamily/keyelements.pdf.
[23] http://www.co.fresno.ca.us/DepartmentPage.aspx?id=22733.
[24] For more information about the People's Institute for Survival and Beyond and their curricula see http://www.pisab.org/index.cfm?fuseaction=Page.viewPage&pageId=497.
[25] The field of institutional ethnography is often attributed to the thinking and work of Dorothy Smith. See Smith, D.E. (2005). *Institutional Ethnography: Sociology for people* (Toronto: AltaMira Press).
[26] Oakes, J.M. and Kaufman, J (eds). (2006) *Methods in Social Epidemiology* (Jossey-Bass). Karleson, S. and Nazroo, J.Y. (April 2002) Relation between Racial Discrimination, Social Class, and Health Among Ethnic Minority Groups. *American Journal of Public Health*, Vol 92, No 4, p. 624-631.
[27] CSSP is developing a bibliography that cites research supporting these assumptions. We provide some examples from the bibliography in this section.
[28] Knight, J. (1992). *Institutions and Social Conflict*. (Cambridge: Cambridge University Press). Pence, E. and Sadusky, J. (2005). Safety and Accountability Audit. Praxis International, Inc. and Pence, E. (2009). (In)visible Workings. Praxis International, Inc.
[29] Knight, J. (1992). *Institutions and Social Conflict.*
[30] Campbell. M. and Gregor, F. (2002). *Mapping the Social: A primer in doing institutional ethnography* (Aurora, On: Garamond Press), pp. 37-39.
[31] Agency for Healthcare Research and Quality on the Inclusion of Priority Populations in Research, February 2003, http://grants.nih.gov/grants/guide/notice-files/not-hs-03-010.html.
[32] Mayes, N. and Pope , K. (1995) Observational methods in healthcare settings. *British Medical Journal,* Vol. 311, pp. 182-184.
[33] Arter, D. R. Management Auditing: A results oriented audit can create the impetus for positive change, Retrieved from www.qualitydigest.com/april00/html/management.html.
[34] For examples, see Mays, V.M., Cochran, S.D., & Barnes, N.W. (2007) Race, Race-Based Discrimination, and Health Outcomes Among African Americans. *Annual Review of Psychology*, vol. 58.
[35] Pence, E. and Sadusky, J. (2005). *Safety and Accountability Audit*. Praxis International, Inc.
[36] This includes the overall systems capacity to act as well as how workers were afforded the proper resources and authority to act.
[37] The process and its related conceptual framework influenced the design of the federal Child and Family Services Review, the evaluative methodology utilized by the Administration on Children, Youth and Families to review all 50 state child welfare programs and child welfare systems of the U.S. Virgin Islands and Puerto Rico.
[38] See the body of work by Charles Glisson and his colleagues regarding Organizational Climate, Structure, and Organization. One example is Glisson, C., & Hemmelgarn, A.L. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse & Neglect*, 22(5), 401-41.
[39] Department of Children and Family Services, Policy and Procedure Guide, Division 3, Chapter 4, Item 20.
[40] Society for Research in Child Development (2009). Ethnic Pride May Boost African-American Teens' Mental Health. *ScienceDaily*. Retrieved from http://www.sciencedaily.com/releases/2009/11/091113083259.htm
[41] Although the parent felt that DSS required them to enter through a side door, further inquiry found that in fact parents were supposed to enter through a front door unless there were specific safety concerns.
[42] California Welfare and Institutions Code Section 361.5(b).
[43] Berrick, J.D. (2003). *Utilizations of "Reunification Bypass" in Six California Counties,* Center for Social Services Research, University of California-Berkeley.
[44]See the Code of Ethics of the National Association of Social Works at http://www.naswdc.org/pubs/code/code.asp.

[45] Furthermore, as is the case in other states and federally, neither the criminal justice nor DSS keep accurate statistics on the population of incarcerated parents with children involved in the child protection system.
[46] For the purposes of this report, we refer to all DSS case carrying workers as "caseworkers." We consider social workers as those who have received either undergraduate or graduate training in social work.
[47]For a more detailed explanation see CWLA Standards of Excellence for Family Foster Care Services, Revised 1995 or http://www.cwla.org/newsevents/news030304cwlacaseload.htm.
[48] Needell, B., Webster, D., Armijo, M., Lee, S., Dawson, W., Magruder, J., Exel, M., Glasser, T., Williams, D., Zimmerman, K., Simon, V., Putnam-Hornstein, E., Frerer, K., Cuccaro-Alamin, S., Lou, C., Peng, C., Holmes, A. & Moore, M. (2010). *Child Welfare Services Reports for California*. Retrieved 3/17/2010, from University of California at Berkeley Center for Social Services Research website. http://cssr.berkeley.edu/ucb_childwelfare.
[49] For example, see Reynolds, A., Mathieson, L.C., Topitzes, J.W. (2009). Do Early Childhood Interventions Prevent Child Maltreatment? A Review of Research, *Child Maltreatment, 14*(2), 182-206.
[50] Department of Children and Family Services, Policy and Procedure Guide, Division 3, Chapter 6, Item No. 9, "Liberalizing Parent/Child Visits."
[51] For a summary of some of this research see New Jersey Child Advocate. (January 2010). *Protecting and Promoting Meaningful Connections: The Importance of quality family time in Parent-Child visitation*, www.childadvocate.nj.gov; Potter, C.C., & Klein-Rothschild, S. (2002) Getting Home on time: Predicting timely permanence for young children. *Child Welfare, LXXXI*(2), 123-150.
[52]Department of Children and Family Services, Policy and Procedure Guide, Division 3, Chapter 6, Item No. 9, "Liberalizing Parent/Child Visits."
[53] Launched in November 2000, the CalWORKs/Child Welfare Partnership Project has developed practices and tools to support families involved in both the welfare and child protection systems. For more information see http://www.cfpic.org/linkages/linkages_001.htm (Retrieved March 25, 2009).
[54]For families on the road to reunification, the extended, liberal visits do not allow them to access the Linkages program and resources because children must be in their parents care on a full-time basis (in liberal visits children may be in their parents care for up to 13 consecutive days, but then must go back to their foster home for at least one day before returning again to their parents' care). That is, the liberal visitation structure undermines the ability of the family to gain timely economic assistance.
[55] New Jersey Child Advocate, *Protecting and Promoting Meaningful Connections.*
[56] *Making Visits Better: The Perspectives of Parents, Foster Parents, and Child Welfare Workers* , University of Illinois, Children and Family Research Center, p. 13.
(http://www.cfrc.illinois.edu/pubs/pdf.files/visitperspectives.pdf.
[57] Ibid.
[58] Department of Children and Family Services, Policy and Procedure Guide, Division 3, Chapter 5, Item 13, "Initial Out of Home Placement and Placement Changes."
[59] Ibid.
[60] *Making Visits Better*, University of Illinois.
[61] Golden, O. and Macomber, J. (2009). Framework Paper: The Adoption and Safe Families Act, *Intentions and Results: A look back at the Adoption and Safe Families Act*, Center for the Study of Social Policy and Urban Institute.
[62] Information obtained from www.fosteringconnections.org.
[63] Government Accounting Office, (July 2007).*African American Children in Foster Care: Additional HHS Assistance Needed to Reduce the Proportion in Care*. http://www.gao.gov/new.items/d07816.pdf.
[64] See *Protective Factors Literature Review: Early care and education programs and the prevention of child abuse and neglect*, Center for the Study of Social Policy. Retrieved from http://strengtheningfamilies.net/images/uploads/pdf_uploads/LiteratureReview.pdf.
[65] The exemption is guided by California Health and Safety Code section 1522.
[66] Perry, B. MD, Ph.D. Effects of Traumatic Events in Children, *Child Trauma Academy, Vol, 199.*
[67] 5150 is a specific California Welfare and Institutions Code, which allows a professional person designated by Fresno County to take an individual to an approved psychiatric facility for involuntary 72-hour treatment and evaluation. This person could be a police officer or perhaps a crisis mental health worker.
[68] Pew Research Center (March 18, 2010). *The Return of the Multi-Generational Family Household*, http:///pewsociatrends.org.

[69] This data is based on information gathered through the Jim Casey Youth Opportunities Initiative. Specifically, the Initiative collects data through the Opportunity Passport™ Participant Survey, an Internet-based survey that captures self-reported youth indicator data as well as demographic characteristics from Opportunity Passport™ participants.
[70]Department of Children and Family Services, Policy and Procedure Guide, Division 3, Chapter 12, Item No. 5.