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CHAPTER 2: Fairness and Multicultural Competence in the Child Welfare System
CHAPTER TWO

FAIRNESS AND MULTICULTURAL COMPETENCE IN THE CHILD WELFARE SYSTEM

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OVERVIEW

This chapter addresses how race, culture, language, life experiences, and power status shape our understanding of fairness as a value in child welfare practice. One’s own beliefs about fairness influence social work practice. These beliefs have been developed...
and transmitted by our families of origin, the communities in which we live, and by our status in society. They have been shaped further by personal life experiences.

As social workers it is important to understand and to be respectful of different groups’ views about fairness. To have this awareness in child welfare practice, the decision-making process must be thoroughly understood in order to anticipate when fairness could be an issue, to help other child welfare professional team members understand those issues, and to advocate for remedies to unfair allocation of resources for families.

This chapter offers a social exchange/distributive justice framework for examining the concept of fairness and describes how different groups conceptualize fairness in different ways. Using examples from recent research about the overrepresentation of children of color in the child welfare system, divergent ideas about fairness are illustrated by examining the decision points in the course of a child welfare case. Using the decision points as a framework, strategies are outlined for preventing or significantly reducing inequities of treatment and intervention that produce and perpetuate system overrepresentation. Finally, knowledge, values, and skills required for ethical, culturally competent social work in the child welfare context are described.

INTRODUCTION

This chapter will address how race, culture, language, life experiences, and power status shape our understanding of fairness as a value in child welfare practice. We raise the issue of fairness in a book on multicultural child welfare practice because persons from different cultural and racial groups hold different conceptions about what constitutes fair treatment. Consequently these competing views often clash or create misunderstandings in a diverse society. There is evidence that families and children of color are treated unfairly throughout the child welfare system.

One's own beliefs about fairness influence social work practice. These beliefs have been developed by our families of origin, the communities in which we live, and by our status in society. They have been reinforced by our life experiences. As social workers it is important for us to understand and to be respectful of different groups' views about fairness. To have this awareness in child welfare practice, we need to know enough about the decision-making process to anticipate when fairness could be an issue in child welfare, to help other child welfare professional team members understand those issues, and to advocate for remedies to unfair allocation of resources for families.

The consideration of fairness affects individual social worker relationships with clients, organizations, and communities. Fairness enters the public policy arena when decisions are made as to how and when to distribute resources to families to help them provide safe and healthy environments for their children. Inevitably, social work practice is influenced by the concepts of fairness embedded in public policy. Organizational rules about service eligibility or appropriate levels of service affect fairness. Organizational rules interact and may even conflict with views of fairness held by individual social work practitioners. Even though public policy makers may
FAIRNESS AND MULTICULTURAL COMPETENCE

strive to create systems that treat persons fairly overall, fair and equitable outcomes for individual families may not always result. When social workers work with families, we make decisions about distributing resources according to our assessment of the need and the availability of resources. As with organizational rules, our own informal personal rules influence social work practice with colleagues and families.

CASE STUDY 1  THE DECISION TO PLACE A CHILD IN OUT-OF-HOME CARE

Tina, a child protective services worker, has been called to take a report on Charles, an 8-year-old boy, who came to school with extensive bruises on his arms and legs. Charles lives with his parents in a very poor part of town which is also a high-crime neighborhood. Tina decides to place Charles in foster care. She calls her office from the school to find out where there are foster home vacancies. She finds three vacancies, two of which are in Charles’ neighborhood, but Tina decides that neighborhood is too dangerous and places Charles in the third foster home on the other side of town. She then calls Charles’ mother.

Discussion Question: Under what circumstances should a social worker make the decision to remove and place a child in foster care before talking to the family?

This chapter will address how fairness and child welfare practice interact. First we will present a framework for examining the concept of fairness and its many meanings. The framework will then be applied to examples of multicultural child welfare social work practice. Using examples from recent research about the overrepresentation of children of color in the child welfare system, we will discuss how fairness affects the course of a child welfare case at different decision points.

It is extremely important to remember that at each decision point, child safety, risk of reabuse, and the protective capacity of the parents must be fairly assessed, using appropriate assessment tools (see Figure 2.1). It is the fairness of the assessments that we focus on in this chapter.

After examining the decision points, we will outline strategies for preventing or significantly reducing the inequities that result from such overrepresentation. Finally, we will describe the knowledge, values, and skills necessary for practicing in the field of child welfare in the context of ethical standards for culturally competent social work.

THREE RELATED FRAMEWORKS FOR FAIRNESS

Social Exchange

Social work practice focuses on the interaction between a client and his or her environment. When a family is referred or voluntarily comes to a social agency for help, the social worker and the agency he or she represents become important aspects of the family’s environment, and the family, worker, and agency interact to affect each other.
Social exchange theory focuses on the interaction itself, not necessarily on the actors. From varying perspectives, other psychosocial theories tend to address the following question: “Does the individual influence the group or does the group influence the individual?” Social exchange, by focusing on the interaction, conceives of influence as a two-way, reciprocal process, with the individual and the group influencing each other. The extent to which each has the power to influence the other affects the value of the social exchange.

The main propositions of social exchange theory are

1. Social behavior is an exchange of material and nonmaterial goods.
2. People behave purposively in ways that cause beneficial exchanges to happen and will repeat this behavior if it is rewarding. Cultural background may influence what is held materially and symbolically valuable for groups and individuals.
3. Benefits received in an exchange are contingent on benefits perceived as given, and people try to maximize their gains in any exchange. There is a satiation factor when maximum utility is achieved.
With its concepts of costs and rewards, social exchange is similar to an economic exchange. However, unlike an economic exchange, which can be a one-time occurrence, a social exchange depends on an ongoing relationship (Emerson in Rosenberg and Turner, 1981). Fairness comes into social exchange when one takes into account the value of the items or resources exchanged.

**CASE STUDY 1  Continued**

Tina’s telephone call to Charles’ mother, Sylvia Brown, did not go well. It started off all right; in fact, Mrs. Brown sounded relieved that Charles was safe. She said the bruises had been inflicted by her striking Charles with a belt, but she was only trying to keep him from hanging out with “the bad kids down the block.” Mrs. Brown was deferential and polite to Tina. She repeatedly, but respectfully, asked when she could see Charles. But when Tina told Mrs. Brown that Charles was placed in a foster home across town, Mrs. Brown got angry. Mrs. Brown wondered why Charles’ grandmother or the neighbor on the next block who is a foster mother was not contacted. “It would be much easier for me to visit him there and he has stayed there before. I have to take three buses to get to and from work and now you are making me take three in the opposite direction to see my son! What about his school? That isn’t fair!” She was very upset and demanded to see Charles “now.” Discussion question: In the example above what happened to change Mrs. Brown’s approach to Tina? Who holds the power in this exchange? As long as Mrs. Brown felt she could see Charles easily, she was polite but she seemed to come to the end of her rope. Why? When did the exchange stop being mutual?

The sociologist, George Homans, developed the theory of social behavior as social exchange. He noted that social equilibrium among individuals is primarily concerned with the relationship between reward and cost. When reward and cost are balanced, he called this relationship “equity.” However in comparing the behavior of cooperative subgroups in a society toward each other, their objective “should tend toward equality. The less-advantaged group will at least try to attain greater equality” (Homans, 1958, p. 604). He called this tendency to move toward equality among comparable groups “distributive justice.” Distributive justice has been conceptualized in several different ways involving the achievement of equilibrium among groups of people in a society.

When the usual or normative expectations for resource allocation are not met and a condition of injustice or inequality is identified, the result is pressure to change the distribution system. Different justice norms are preferred under different conditions. Within society in the United States, apparent tolerance for different norms of justice can be explained by differential consideration of the social, political, and economic realms of life. For example, there is little support in our society for a ceiling principle limiting the amount of money one person can make or for the redistribution of wealth, especially in the economic domain (Hochschild, 1981). However, there is support for the principle of equality in the political domain (one person, one vote).
Distributive Justice

Distributive justice is often used in the macrocontext of group social exchange, but it applies to individual exchanges as well. In individual relationships (social exchanges), microdistributive justice principles apply. Examples are need, equity, merit, contribution, desert, entitlement, retribution, and rank inequality (Rescher, 1966). Need is a principle of subjective equality, defined by a person. Need appears to be a straightforward principle, but depending on who is defining the need, it can be controversial. For example in health care, a doctor defines “medical need” for certain treatments, while a patient may feel quite differently. The opinion of a managed care company representative may differ from the doctor’s definition.

Equity can be defined as relative equality or a two-way transfer of resources for mutual benefit (Adams, 1965; Cook and Hegvedt, 1983). Merit, contribution, entitlement, and desert are related to equity in that they represent a type of equality that depends on an individual’s relative input into a social exchange. They are all relative equality principles: A person gets what he or she deserves or merits by measuring the extent of his or her contribution. The difficult part is the equation of value, which is subjective. Rank inequality results from the assumption that some persons require unequal rewards according to their relative rank or class. An example is reserved parking places close to building entrances for the disabled and assessing fines on those who use them illegally.

A form of social exchange theory closely related to rank inequality is called “status value theory” (Berger et al., 1972). Status refers to a person’s standing in a group, community, or society. Status value theory can be used to explain why new immigrants have less social power than those who have been in a country long enough to establish group membership and political influence. Within different ethnic groups, high status may be conferred on one who has lived in this country for 20 years and can speak English and low status may be conferred on one who has recently immigrated and does not speak English. Similarly, the value of an exchange with a person of high status is greater than the value of an exchange with a person of low status. In child welfare, an example could be that while both a child and a prospective foster family may be Hispanic, placing a child of a new immigrant with a family who are second-generation Hispanic may create a power imbalance and thus an uncomfortable situation for both families.
On a macrolevel, social exchange creates obligations among members of different groups. Members of one group will benefit from exchanges with other groups, but when exchanges are unequal, people incur obligations to one another. In some communities, the custom of giving dowry to a bridegroom’s family provides an example of this type of exchange. Social interaction is often considered the glue that holds societies together. Public policy derived from the principles governing social interaction is distributive justice (Homans, 1958).

**GIFT-GIVING AS SOCIAL EXCHANGE**

In preindustrial societies, the gift incurred reciprocal obligations. Some societies are known for holding ceremonies in which the rich and powerful give food, beverages, and other gifts in exchange for loyalty. The Northwest Coast American Indians held potlatch ceremonies (Boas, 1967) in which goods would be given away or destroyed. The intent was that valuable gifts, such as elaborately carved art and canoes, eventually would be returned for in-kind value as loyalty to the chief of the tribe. Gift-giving also had mystical meanings and was intended to remind people of their ancestral heritage and past obligations to each other.

In German the word *Gift* means both gift and poison: The *Rhinegold* extracts a very high price from the person who dares to take it from its natural state in the river bed and forge it into a ring of power.

In medieval Europe the poor were often seen as sacred or favored by God and to be revered. It was the obligation of those more fortunate in this world to give to the poor who were seen as giving up their claim on this world for the next.

Examples of macrosocial exchange or macrodistributive justice are the principles of *Equality, equal opportunity, and equal results.* The microprinciples of *equity, need, and desert* are the individual-level precursors to the macroprinciples. For example, one person’s *need* may be seen as representative of the needs of others in the same group and as a call for *equality* for all the individuals in the group. In 1955, Rosa Parks’ refusal to give up her seat on the bus, which led to the boycott of Montgomery Alabama buses by the African American community, is a good example.

In the child welfare context, if some children receive in-home family preservation services as the first choice of intervention, why are not all children entitled to equal consideration under the same conditions?

**CASE STUDY 2  THE DECISION TO PROVIDE IN-HOME SERVICES**

Connie, a child protective services worker assigned to work with the local hospitals, is called to take a referral on Jae-Sung Kim who was born 4 weeks prematurely and who shows signs of being an “irritable baby.” He currently is in the neonatal intensive care nursery. His mother, who went home 48 hours after the birth, is a young, unmarried Korean woman who only visits him late at night and some of the nurses think she is “high” (continued)
While social exchange considers the value of the resource exchanged, it, unlike an economic exchange, does not end after one transaction. Because the relationship or interaction is not complete after one instance, each actor in the exchange incurs certain obligations toward the other. Such obligations create differences in status between people: Conventionally, creditors (those who are owed) hold power over those who owe. Those who owe are dependent on those who have resources to distribute. However, the person who is owed may in reality depend on the power to reciprocate and may rely further on the continuance of the relationship for his livelihood. Hence, social exchange is a “theory of mutual interdependence” (Thibaut and Kelley, 1959).

Discussion Question: What happened? How should Connie handle this?

While social exchange considers the value of the resource exchanged, it, unlike an economic exchange, does not end after one transaction. Because the relationship or interaction is not complete after one instance, each actor in the exchange incurs certain obligations toward the other. Such obligations create differences in status between people: Conventionally, creditors (those who are owed) hold power over those who owe. Those who owe are dependent on those who have resources to distribute. However, the person who is owed may in reality depend on the power to reciprocate and may rely further on the continuance of the relationship for his livelihood. Hence, social exchange is a “theory of mutual interdependence” (Thibaut and Kelley, 1959).

One person’s reliance on another person is a potential source of power. Social exchange creates a power-and-dependence relationship. For example, a child welfare worker may be more powerful than parents because he or she can remove their child from them with the state’s authority.

CASE STUDY 1 Continued

Tina’s perception of Charles’ neighborhood as dangerous affects her decision-making about first making a foster care placement, and then where that placement should be. She is satisfied that Charles is safe for now and is baffled by Mrs. Brown’s response to her decision.

Most parents in this situation feel powerless; parents with low status may feel even more powerless relative to most parents. Once the child has been removed, the social
Procedural Justice: How Is Fairness Decided?

The decision making does not end when the principles of fairness are determined. How the decisions are made is another consideration. This is called “procedural justice.”

Political philosopher John Rawls (1971) devised a “thought experiment” as a way to illuminate a society’s decision making about resource distribution. This experiment’s primary condition was that no one person knew his or her status as decisions were being about how to distribute resources in a new society. The idea was that by not knowing one’s own status (how each would wind up), each decider would be more likely to apply fair procedures.

In the United States the avowed purpose of public social policy is to “limit arbitrary distinction among individuals or groups” (Purtilo and Cassel, 1981). However, achieving a fair distribution of society’s benefits or the right to such distribution does not mean that individuals will be treated fairly (procedural justice). For many impoverished children, for example, the right to a public education does not guarantee their receiving the same quality of education as their more affluent neighbors. Procedural justice is the set of rules for the application of distributive justice principles. By isolating certain groups of persons who are not perceived as part of the social majority, the society as a whole may not apply majority-group fairness standards to these individuals.

These three constructs—social exchange, distributive justice, and procedural justice—are perhaps the most frequently noted when theories of fairness are discussed. What the theories do not tell us is how people decide how to attribute value to an exchange. Nor do they tell us the extent to which different groups value different things. As ethical social work practitioners, however, it is our job to learn how different people value different things, especially regarding the family. It is essential to keep in mind that most cultures regard their children as their most important and valuable contribution to the society.

The social exchange/distributive justice framework gives us tools with which to analyze decision making within the child welfare system. There is compelling evidence that even when cultural considerations are not taken into account, the child welfare system has operated unfairly with regard to families of color and has created inequitable situations for those families. The next section of this chapter will be
devoted to applying principles of social exchange and distributive justice in the context of the child welfare system and looking at how children and families of color are disadvantaged. As a further application of this framework, we will then examine the roles and tasks of child welfare social workers and the development of competencies to foster equitable practice.

CHILDREN OF COLOR ARE OVERREPRESENTED IN THE CHILD WELFARE SERVICES SYSTEM

Children in the United States

How do we know there is a problem? According to the 2003 updates to the 2000 census, the United States had an estimated total population of 290,809,777 persons. There were an estimated 70.6 million children under the age of 18 who make up 24.3 percent of the total population. Of these children, 27 percent have low income, defined as below 200 percent of the federal poverty level. To what extent does the child welfare system reflect these numbers?

Children in the Child Welfare System

According to reports from Child Trends Databank and the Adoption and Foster Care Analysis Reporting System (AFCARS) in 2001, African American and American Indian/Alaska Native children were overrepresented in the foster care system nationwide based on their proportion in the U.S. general child population. In other words, more African American and Native American children appeared in the child welfare service population than we would have predicted, given their numbers in the general population of children.

Among the children in the child welfare system, there are also disparities among different groups with respect to the proportions in out-of-home care. Because federal funding for children in the child welfare system is derived primarily from Title IV-E of the Social Security Act, which pays for out-of-home care, we might expect that most children in the child welfare system would be in out-of-home care rather than other parts of the child welfare system, such as in family maintenance, emergency response or early intervention. However, among children in out-of-home care, there are higher proportions of children of color.

There were 542,000 children in foster care nationwide during the 2000–2001 federal fiscal year that ended on September 30, 2001. Table 2.1 shows the percentages of children who entered and left foster care during fiscal year 2001 and compares these percentages to the estimates of the population of children by race or ethnic group.

According to Table 2.1, among children in out-of-home care, 2 percent were American Indian/Alaskan Native children, compared to 1 percent American Indian/Alaskan Native children in the population. Further, 38 percent of the children in out-of-home care were black, non-Hispanic, as compared to the 15 percent of the general child population occupied by this subgroup in 2001.
Children in Poverty

Demographic information compiled from the Census Bureau by the National Center for Children in Poverty shows the proportion of children of color who live in poverty. The federal poverty level is $18,400 annual income for a family of four. Low-income families have less than $36,800 per year of income or are below 200 percent of the poverty level. In 2001,

- 62 percent of Hispanic children lived in low-income families
- 29 percent of white children lived in low-income families
- 58 percent of black children lived in low-income families.

Research shows that family structure is associated with family poverty. Children living in families with single mothers tend to be poorer than those who live with two parents or with grandparents. Again, information from the National Center for Children in Poverty shows that

- 54 percent (6,633,961) of low-income families are headed by a single parent.
- 18 percent (4,571,058) of all other families are headed by a single parent.

<p>| TABLE 2.1 Race/Ethnicity of the United States Foster Care Population as of September 30, 2001, Compared to Estimated Population of Children under 18 |
|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|--------------------------------------------------|</p>
<table>
<thead>
<tr>
<th>PERCENTAGE OF RACE/ETHNICITY OF CHILDREN IN FOSTER CARE (NUMBER)</th>
<th>PERCENTAGE OF RACE/ETHNICITY OF CHILDREN WHO ENTERED FOSTER CARE (NUMBER)</th>
<th>PERCENTAGE OF RACE/ETHNICITY OF CHILDREN WHO LEFT FOSTER CARE (NUMBER)</th>
<th>PERCENTAGE OF ESTIMATED UNITED STATES POPULATION OF CHILDREN UNDER 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian/Alaskan Native</td>
<td>2% (10,106)</td>
<td>3% (7,364)</td>
<td>2% (6,544)</td>
</tr>
<tr>
<td>Asian/Hawaiian/Pacific Islander/non-Hispanic</td>
<td>1% (5,200)</td>
<td>1.4% (4050)</td>
<td>1.4% (3,735)</td>
</tr>
<tr>
<td>Black non-Hispanic</td>
<td>38% (204,973)</td>
<td>28% (81,118)</td>
<td>30% (79,308)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>17% (89,785)</td>
<td>16% (46,574)</td>
<td>15% (40,346)</td>
</tr>
<tr>
<td>White non-Hispanic</td>
<td>37% (203,222)</td>
<td>46% (134,773)</td>
<td>45% (117,377)</td>
</tr>
<tr>
<td>Unknown/unable to determine</td>
<td>3% (17,235)</td>
<td>3% (9,079)</td>
<td>4% (9,602)</td>
</tr>
<tr>
<td>Two or more races/non-Hispanic</td>
<td>2% (11,479)</td>
<td>2% (7,042)</td>
<td>2% (6,087)</td>
</tr>
<tr>
<td>Total</td>
<td>100% (542,000)</td>
<td>99.4% (290,000)</td>
<td>99.4% (262,999)</td>
</tr>
</tbody>
</table>

CHAPTER TWO

The proportion of children of color who live in families where poverty co-occurs is greater than the proportion of children with white parents. It may be that poverty and family structure interact with race and ethnicity to bring children of color into the child welfare system at greater rates than their white counterparts. However, it is important to note here that the presence of poverty, although a factor among single-parent families and a contributor to the lack of available resources in communities, does not explain why the child welfare system treats families of color differently than majority families (Roberts, 2002).

CASE STUDY 1  Continued

When Tina talks to Charles' mother, she only has time to tell her about the placement, ask that she come to the office, tentatively ask about what happened, and to gather basic information about the immediate family. She finds the mother overwhelmed with work and caring for Charles' two younger sisters. Mr. Brown has moved out of town to try to find work and will be gone for at least 6 months. Tina does not find out that Mr. Brown's married sister lives nearby and may be a resource for the family. Tina does not ask about any other relatives.

For his part, Charles says he misses his family. This week he will miss a field trip to the natural history museum because he is not at home and his foster parents cannot find transportation to take him across town to school. The foster parent reports that after his mother visits, Charles becomes weepy and will not eat.

Discussion Question: Tina does not ask about other relatives because she believes that "the apple doesn't fall very far from the tree." How does this affect her decision making from now on, since Charles is already in foster care?

CHILD WELFARE SYSTEM DECISION POINTS

To improve child welfare services, we need to examine where key decisions are made in existing systems to determine whether practice reflects the values of fairness and equal opportunity. We need to do this on a local, community basis and resist relying on aggregate national or even statewide data. Recent studies have examined the role of a host of independent variables in child abuse incidence, looking for possible factors in bias. These include child's race, type of abuse and type of reporter, substantiation rate, victimization determination, parental characteristics, abuser characteristics, and child welfare system differences. In this section, we will systematically look at the decision points in a child welfare case and review what research shows about each area. We will also introduce skills and knowledge necessary for fair child welfare practice, and we will present strategies for avoiding unfair or potentially unfair results.

Prevention and Early Intervention

In some communities, formal agency resources are available to help families prevent problems. Specific examples of formal programs for families and children are
Public health nursing visits for first-time mothers
- Early Head Start programs for very young disadvantaged children
- Health insurance through the state children’s health insurance program
- Early Periodic Screening Detection and Treatment (EPSDT) through Medicaid to detect preventable learning and health conditions and to direct children and their families to treatment and after-school programs.

In addition, school social workers or counselors may offer referral and other counseling services to students. Informal services also act as supports and prevention agents to families in many communities. Examples of informal services include

- Family members unofficially caring for children while parent is working away from home, in prison or under residential treatment, or otherwise unavailable
- Neighbors providing informal supervision after school
- Church or other faith-based organization members offering food or voluntary childcare services. Some church communities keep up-to-date lists of formal and informal local resources for parents who need help with specific problems, such as childcare availability.

One important service gateway for poor families is through the Temporary Assistance for Needy Families (TANF) public program that replaced Aid to Families with Dependent Children (AFDC) in 1996 under the rubric of welfare reform. Workers in this program used to be called “eligibility workers” because they primarily determined whether families were eligible for cash assistance, according to federal policies. Now these workers can be called “employment counselors” or “intake workers.” This program is designed to support poor families with cash grants as long as the parent (usually a single mother) is willing to look for work or to get training for work. The focus of the TANF program has been employment development, but several counties and states, El Paso County in Colorado, for example, have assigned workers to the TANF program to provide services to address the needs of families with working parents (Berns and Drake, 1999). The county director in El Paso County has conceptualized the poverty program to be the primary prevention program for child welfare services (Berns, 2001). Not only this is done in order to support the work effort and help the parent succeed in becoming economically self-sufficient, but it also serves the purpose of assessing a family for potential problems and offers preventive services.

Although these formal and informal supports exist in many communities, all community members, particularly those who are impoverished and socially isolated, do not have equal access. Children of color, in particular, do not always have equal opportunity to access culturally competent prevention and early intervention services (see Johnson, 1965). Additionally, children whose families speak English as a second language, or who do not speak English at all, are disadvantaged by the lack of proficient, culturally knowledgeable service providers. The culturally specific strengths and customs of some families may be misinterpreted by child welfare workers unfamiliar with the culture in question, sometimes with serious detrimental results.
Strategies

At the prevention and early intervention stages, strategies for addressing fairness concerns can include public services in ethnic communities such as child abuse prevention and new parent education, early childhood health screening, and child safety outreach campaigns. Child welfare agencies can collaborate to develop minority-defined and minority-based models of early intervention and family preservation. Policies can be developed that expand the definition of “relative” care to include nonmajority-based definitions of who is part of the family. The community of service providers can be encouraged to participate in intercultural communication training. The various professionals who constitute the multidisciplinary response team could benefit from the same, as well as training on how to work effectively as a team. Child welfare services agency staff could be located or outstationed in the community they serve with other members of the multidisciplinary team; for example, the TANF workers, mental health practitioners, domestic violence counselors, substance abuse counselors, and public health nurses.

In addition, new options for service could be offered at the paraprofessional level such as teaching homemakers, substance abuse aides, and community home visitors. Through focused, on-the-job training, social workers and other decision makers could develop greater expertise in engaging, assessing, and motivating parents. Communities could develop their own child safety plans with support from community and public agencies. Poverty-targeted intervention and support programs could be codeveloped by the agency and community members. To heighten effectiveness and a sense of “ownership,” agencies could assign certain community resource development tasks to specific social workers.

CREATIVE FIELD PLACEMENT

A student who had been a former county employee who had returned to school to obtain her Master's degree in social work wanted to do “something different” for her second-year internship. Working with the field instructor and the school, she developed as a special project a community-based center for grandmothers who were taking care of their grandchildren with child welfare system involvement. The center was such a success that upon graduation, the county not only continued the project, but made her the project manager. Her goal was to expand services to grandmothers who were informally taking care of their grandchildren as a prevention service.

Reporting Suspected Child Abuse and Neglect—Bias at the Beginning?

A report of suspected child abuse is obviously the result of a decision-making process on the part of the reporter. In that moment of decision, bias may play a role. Many professionals are mandated reporters of suspected child abuse and neglect. Every state has laws about mandated child abuse and neglect reporting. These can be social workers, teachers, domestic violence counselors, police officers, doctors, and public health nurses. When a mandated reporter or other concerned person calls to make a report of suspected child
abuse or neglect, the first point of contact is generally the Hotline or Emergency Response line. Once that occurs, the recipient of the call (who may be a social worker, a social work aide, or a clerk) gives the information to a decision maker about the risk to the child or children based on the caller’s information. Sometimes there is very little information available. Based on the caller information about the child’s or children’s safety or risk of harm, the Hotline worker’s decision options are (1) to offer referrals to community services, (2) to refer to the emergency response workers, or (3) to do nothing.

There is some research to support the assertion that reporting may be biased from the first point of contact. The timing and act of reporting is one of several points in the child welfare process in which biased judgment may enter. Bias may indirectly enter the equation in several contexts such as:

- **Service availability:** In affluent areas, there may be fewer calls to the Hotline because of a higher awareness of prevention services and the greater presence and greater accessibility of services in such areas.
- **Screening practices:** County public hospitals may routinely screen every newborn for drugs, but private suburban hospitals may only screen teenaged parents. In most communities, teenaged parents are more likely to be persons of color and/or poor.

Looking at state level data on investigation and victimization, Fluke et al. (2003) found that African American children were overrepresented and white children consistently underrepresented at the “decision to investigate” stage in a five-state study. At the point of victimization determination, little disproportionality was found statewide, but differences remained from county to county. This may mean that the disproportionality occurs when African American children are initially referred to the child welfare agency (Fluke et al., 2003). In addition, it may mean that aggregated state information may mask certain types of disproportionality.

If the call is referred to the emergency response worker, once that worker has assessed the situation for safety and risk, he or she must make a decision about whether to offer child welfare services. In one study done in California, 80 percent of the calls to the Hotline resulted in no services. Only 8 percent were opened in the child welfare system. Of those 8 percent, however, 40 percent of the cases opened had an additional report made in the next year (De Panfilis, 2002).

Based on the social worker’s knowledge of the community, the first decision may be to substantiate child abuse and/or neglect, and the first intervention may be to remove the child from the home and place him or her in out-of-home care. Judgments are made by social workers and the court legal dependency system about viable alternatives to out-of-home care, such as the fitness of relatives, the location of the relatives’ neighborhoods, and the character of the community. In the flow of a child welfare case, does the family have community or other resources on which to rely? The greater the availability of community ties and resources, the less often crisis will occur and the less likely government intervention becomes. However, what if a family doesn’t have any or doesn’t know of any resources, and they are poor? What if they are new to this country? What if there is no source of relative care nearby? In a more perfect world, a family’s dependence on public resources has many alternatives and is only necessary as a last resort.
Increasingly, as more multicultural data become available from child welfare agencies required to demonstrate the efficacy of their services, the discrepancy between outcomes for the children of culturally diverse families and outcomes for white children grows. Minority children are more likely than white children to be removed from their homes for child abuse and neglect, receive fewer services within the child welfare system, remain in foster care for longer periods, and are more likely to come back into foster care again after they return to their families (Courtney et al., 1996). As we examine various aspects of the child welfare process, we can see elements of this disturbing pattern as it takes shape.

Substantiation and Victimization Rates

Substantiation is the point at which an investigator or a social worker determines that child abuse or neglect has occurred and can be substantiated with facts. There is some evidence to indicate that cases involving children of color are substantiated more frequently than those involving white children. However, the victimization rate, the rate at which children of various backgrounds are harmed or injured, does not show the same discrepancies. In an earlier study, the authors reached the conclusion that African American children are not at greater risk for abuse and neglect than white children, but they are reported and investigated more often (Ards and Harrell, 1993; Ards et al., 1998).

A Minnesota study comparing substantiation rates among American Indian and African American children revealed that the children of color were not treated the same way as white children. Researchers Ards and colleagues examined data from counties with large minority populations (“study counties”) and compared this data with data from nonstudy counties and with statewide aggregated data (Ards et al., 2003). Ards and colleagues found that disparities in the treatment of children of color “could not be explained fully by characteristics of victims, offenders, counties, reporters, and the types of alleged maltreatment.” When the Minnesota group could not explain the variance between groups after accounting for all variables noted above, they concluded that the differences resulted from discrimination.

Safety and Risk Assessment

Safety assessment occurs at the initial referral for the first time and subsequently along the case planning and treatment process. Risk assessment often happens when a child has been referred to out-of-home care and the risk of going home to his or her family must be calculated. Researchers who have developed actuarial tools for assessing risk in child abuse and neglect report that bias exists in risk assessment screening when clinical judgment is used (Baird et al., 1999), as opposed to seemingly more objective risk assessment tools. Child welfare researchers, practitioners, and policy makers continue to debate the potential for predicting abuse using clinical judgment versus actuarially developed risk assessment tools. On their side of the debate, actuarial tool designers are able to present research evidence of fair decision making in rerisk assessment. These actuarial tools, however, assess risk in situations where abuse and neglect have already occurred; consequently these instruments assess the possibility of reabuse rather than initial abuse or neglect (Baird et al., 1999).
On the other side of the coin, risk assessment is an area in which clinical judgment and the effort to be fair have resulted in some incorrect assessments. In an effort to attend to cultural issues (and to be fair) some safety considerations may be missed, especially in an effort to be fair to families who present with different values than those held by the social worker (Baird et al., 1999). Baird found this to be true for social workers who were trying to be culturally aware, but who did not really understand the culture of the family with whom they were working. The social workers were often reluctant to act when a situation was neglectful because they did not want to appear to single out the parent because of his or her cultural values. One strategy to address this potential problem is to ensure that professionals are able to interpret and correctly assess abuse and neglect in terms of both more universal child development stages, and a “prudent parent” standard that exists for families in a given community.

CASE STUDY 1  Continued

Tina is writing a court report to request that Charles remain in foster care for now. Her supervisor asks her what her reasons are for continuing to keep Charles in foster care. Tina states that the community is unsafe and therefore it is likely that Charles will be abused again if he goes home.

Discussion Question: If you were the supervisor what would you ask Tina now?

Foster Care

As noted previously, significantly more children of color are placed in foster care than their numbers in the child population would indicate. Several factors appear to combine to create this situation. At a stage when placement might be prevented, African American families are offered access to family preservation services at lower rates than other families (Denby et al., 1998). Children of color tend to be offered out-of-home care in lieu of in-home services at the front end of service provision more often than majority children. Thus they enter foster care at higher rates than white children, although their characteristics may be the same or similar. Their families are offered fewer services to keep families together before the option to place a child in out-of-home care is used (Denby et al., 1998); consequently they are found in out-of-home care more often than other children and in greater proportions.

The fact that placement is used, an action that must be supported by legal intervention, may prejudice the type of service subsequently provided. By the time the situation is such that the child gets to court, there are few other alternatives or resources available. This makes the court very powerful. It is generally understood

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\*Some states have legal definitions of prudent parent. The concept refers to parental liability due to negligence. A prudent parent is one who exercises good judgment and common sense in matters affecting the well-being of his or her child.
that the child welfare legal dependency system overrelies on out-of-home care as the intervention of choice because of the way child welfare services are funded by public policy (Pew Report, 2004).

Personal and residential characteristics of families may conflict with those of the social worker or court officer, resulting in stereotyped thinking and decision-maker bias toward using out-of-home care, rather than in-home services. Stereotyping may occur on the basis of ethnicity, neighborhood, economic level, culture, age, substance abuse history, sexual orientation, or single-parent status. The worker may regard kin or the neighborhood of kin as unsafe. There may also be a bias against using kin because of fear of collusion with family members or outmoded thinking: “the apple doesn’t fall far from the tree.” The child may be placed out of the neighborhood because the worker may be afraid to go into the neighborhood. The worker may not speak the family’s language and translators may be unavailable. Choosing placement may be not so much an assessment decision. Rather, it may reflect a lack of confidence in one’s assessment tools and skills or a way to avoid making the wrong decision. These biases are not limited to social workers. There may be a local judicial culture biased in favor of out-of-home care and against teenaged single parents, for example. Judges and court systems, court-appointed clinicians, police, and school personnel often exhibit the same or similar conflicts and issues with regard to family characteristics as social workers. In its efforts to rebuild foster care and establish broad community support for local foster care networks, the Annie E. Casey Foundation’s (2001) Family to Family Program is attempting to ameliorate this situation.

Through removing children to a safer neighborhood, with more financially secure parents or with a two-parent family, or by placing children in culturally different neighborhoods, social workers and other professionals often intend to improve the child’s life chances. Despite being well-intended in many cases, these decisions may create unfair and even emotionally destructive situations for families and children. Perhaps the most prominent and extreme example of such placement was the forced separation of thousands of Native American children from their parents in the nineteenth century to attend “Indian Schools” far from home (Lomawaima, 1994; Trennert, 1988). As noted in a recent study, foster care placement itself can have a traumatic effect on children, giving children a sense of loss, fear, abandonment, isolation, helplessness, and confusion (Finkelstein et al., 2002). Not surprisingly, it appears that a combination of preplacement and placement trauma leads to negative effects on both academic performance and school behavior in foster children (Geroski and Knauss, 2000).

Nevertheless, when the decision maker is an individual social worker with many cases, or a law enforcement officer responding to an emergency call, there is a greater possibility that the error will be in favor of out-of-home placement as the more conservative choice for the child’s safety. If, as it appears, families of color are offered in-home services less often than white families, then this practice creates further unfairness in the system. What are some of the factors that result in unfair distribution of resources? Do workers intend to be unfair? This is not likely. Moreover, the placement system is constrained by legal time limits, for example, that call for permanency planning for children who have spent 15 of the
last 22 months in out-of-home care. Sometimes the most convenient placement is made instead of the best one. The initial decision to place based on child safety may wind up being more permanent even in light of new information. Placing a child across town with a foster family may seem to be less complicated and expensive when compared to placing him or her with an aunt who lives 2000 miles away.

**The Timing of Family Reunification**

In some child welfare systems, there is now an option of differential response to child abuse and neglect. In differential response systems, it is readily acknowledged that one service does not fit all families. However, at the point of determining which response to take to a family, placement, or in-home services, are there some assessments biased by who is more cooperative and who is more resistant, rather than safety and risk? Do those groups of persons who are seen as more resistant wind up going to court more often than those who are seen as cooperative and who can generate a case plan without going to court? The social worker must have skills in assessing, engaging, and motivating parents to participate in the child protection and service planning processes. Further, it may be the social worker’s role to motivate other team members to do the same. Unfairness in the child welfare decision-making process results when service availability determines decisions rather than needs. To compound the problem, needs are often decided without parental input, especially when workers have difficulty communicating with families. This kind of unilateral process does not encourage social exchange and cooperation.

Harris and Courtney (2003) report finding a significant interaction between race, ethnicity, and family structure with respect to family reunification. Specifically, they found that being a single-parent family and being African American put a family at a disadvantage for reunification. In two-parent families, being Hispanic conferred a reunification advantage on both African American and Caucasian families. A child of an African American single parent, however, is more likely to experience longer periods of foster care than the children of other single parents. Once children of an African American single parent have been placed in out-of-home care, they are reunified at a slower rate than two-parent Hispanic or white children.

The researchers also found that child health problems slowed reunification, as did being in out-of-home care with kin. Children who were removed because of neglect were reunified more slowly. Neglect may be a sign of poverty or of the presence of substance abuse in the family. Hence, it could be argued that substance use by parents is another factor in slower reunification, but this study did not indicate the presence of substance abuse among the population of families.

Once African American and Native American children are in the child welfare system, they tend to stay longer. Biases not only come into play at the time of the decision to place a child in out-of-home care, but they also affect the offering and provision of family reunification services when the time comes to decide where the

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2See the *Adoptions and Safe Families Act of 1997* (Public Law 105–87).
child should live after out-of-home care. Reunification may depend on equal access to services for different groups. Availability of services in one’s neighborhood can influence reunification rates positively.

When services are not available, children’s legal rights may not be equally enforced. In case planning, a core issue is that needed services are unavailable or are limited in poor neighborhoods.

CASE STUDY 1  Continued

Tina has developed a treatment plan for Charles and his family which has been approved by the juvenile court judge. This plan indicates the mother's need for improving her parenting skills and managing her anger. Mrs. Brown has to take three buses to the family services agency across town after work because there are no anger management classes during the day nearby in her neighborhood. As a result, she misses every other class because her childcare is unreliable. Her missing classes are characterized as resistance or noncooperation to the juvenile court judge, and reunification is delayed. What would a better strategy have been? A better strategy might have been to explore the single-parent self-help group that has been developed by the pastor of the church in Mrs. Brown's neighborhood. Although she is not single, since Mr. Brown has been out of town for so long, the pastor feels Mrs. Brown could benefit from participating in this group. This arrangement would permit the mother to participate in the services and also make it easier for her to carry out the treatment plan without having to take three buses.

Mental Health Service Use among Children in Foster Care

Multiple variables affect mental health services use: Older, male children who are not in kinship care, who have been sexually or physically abused, and those with greater emotional and behavioral problems receive more mental health services than other children. In a study of foster youth, however, even when controlling for the level of need, one report showed that a court referred Caucasian youth more often than African American and Latino youth, 71 percent, 46 percent, and 61 percent respectively (Garland et al., 2003).

System level factors may interact with family/cultural factors to complicate the study of racial/ethnic bias in mental health services use. For example, Latino youth are referred to mental health services less often than Caucasian youth, and numerous studies have shown that Latino families have been found to use formal mental health services less often than others and to rely more on traditional healers. Caseworkers may make assumptions about family preferences, culturally appropriate services availability, or the efficacy of such services, and not refer to formal mental health services. When this kind of biased thinking occurs, families are not given the opportunity to choose whether they want traditional healing or are willing to try Western medicine or both.
In addition, families may feel more comfortable when the service treatment planning process includes them and community traditional healers who can provide support and connection to their community (Jackson, 2003).

**Strategies for Addressing Fairness at the Point of Foster Care Entrance**

As a standard matter of assessment, identifying Native American children and complying with the Indian Child Welfare Act (ICWA) (P.L. 95–608) is essential at the start of intervention and prior to a foster placement decision. Signed into law in 1978, the ICWA was drafted to prevent the breakdown of Indian families and tribes. As a federal statute, the ICWA takes precedence over state laws and reaffirms tribal jurisdiction in custody cases involving Native American children. In terms of supporting individual child welfare worker’s efforts to employ fairness, collaborative supervision to identify and address individual assumptions is crucial. For supervision, the expectation that families are to be included in case planning is a must, in order to put the treatment in the context of the family’s values. A team approach to case planning should include more than one professional in addition to the family. Although usually seen as a more mesotask or macrotask, the individual worker can also work with community leaders to identify resources that may be needed by many families, thus including the community in the solution to child abuse and neglect. Most urban planning and architecture schools know how to design buildings to be family friendly and these professionals can help to design or to renovate existing buildings to make them more “welcoming” and approachable to the community.

Developing standardized safety assessment tools with community members and applying them fairly can be an important strategy for staying in touch with the community and for supporting social workers. Since safety is not an one-time activity, safety guidelines may have to be reestablished at many decision points along the way. Parents will have to understand the components of safety assessment and should be helped to develop plans for when situations become unsafe. If local resources are not available, then the community and agency can develop them together. This is another area in which local community resources that are nearby and culturally consonant with the families are very important.

Training should be multidisciplinary whenever possible to ensure that professionals, paraprofessionals, and community members understand their common goals—as well as their different focus and language. Learning something new together is an important social exchange activity that can level the power playing field and encourage team communication. Training, when agency-based and inclusive of the community, can also serve as a venue for clarifying shared and individual responsibilities within an agency environment and a community. Training that includes mandated reporters of child abuse and neglect can help in a number of ways. First, it can address the community’s assumptions about child abuse and neglect and the expectations of the child welfare agency and the community.
In terms of the organization and the system, neighborhood-based services or family resource centers located in communities encourage cross communication and accessibility. Co-locating different professionals in one community-based office creates team membership and encourages the community to approach and participate in helping families and children.

Adoption

Children of color who are legally available for adoption remain in the child welfare system longer than white children (Needell et al., 2003). Some are not placed at all. According to the AFCARS Report using 2001 data, 22 percent (116,653) of children in foster care have the case goal of adoption, up from 19 percent in 1999. Among the 126,000 children who are waiting to be adopted, including children not in foster care, 45 percent (56,306) are African American children, up from 42 percent (53,340) in 1999, 2 percent (2,146) are American Indian/Alaskan Native children waiting to be adopted. Among the 50,000 children who were adopted in 2001, 35 percent were African American (17,500); 1 percent (715) were American Indian/Alaskan Native (U.S.H. & H.S., 2002, 2003).

The Adoption and Safe Families Act (1997) and the Safe and Stable Families Act (2000) call for concurrent planning when children go into foster care. This means that the child welfare worker must plan for two contingencies at the same time: safety and permanency. If after a certain amount of time in the child welfare system the conclusion is that a child cannot be made safe within his or her own family, then alternative permanent arrangements are supposed to be implemented. The preliminary work and the investigation of these permanent arrangements are required to be done at the outset.

As part of the California Long Range Adoption Study (C.L.A.S.), researchers found about one-third of prospective white adoptive parents willing to adopt African American children reported being discouraged from doing so by their social workers. Among those prospective parents who actualized their adoption, only 12 percent of those who were willing to adopt an African American child actually adopted one. The same study also showed that among those prospective parents who were not willing to adopt African American children, very few of them could be convinced to change their minds (Brooks and James, 2003).

To conduct concurrent planning calls for special kinds of foster parents: those who might be willing to adopt children as well as temporarily foster them. To identify such parents, special local agency efforts can be made to recruit in local communities, and special training can be provided.

Older children, children of color, and children with behavior or anger problems are less likely to be seen as adoptable by their workers, as well as more likely to be perceived as costly to care for by prospective adoptive parents. These factors may lead to serious disadvantages for these children in the permanency decision-making process.

Waiting children are children who have a goal of adoption and/or whose parental rights have been terminated. Those children who are 16 or older and who have “emancipation” as their goal have been excluded from this figure.
In addition, there are financial disincentives for families to leave the child welfare system, through either adoption or other means. Strategies to encourage the adoption of children of color include support of kin adoption and nonrelative legal guardianship or guardianship within extended families. The concept of “extended family” needs to be broadened to more closely reflect the definition held by the local community. Many families of color have a broader definition of “family” than do majority families, but laws may not support this broader definition.

**Strategies for Encouraging Permanency**

Again training is an important strategy to address permanency issues. Workers need to be aware of their biases regarding the adoptability of all children: older children, children of color, and special needs children. They also must be taught about out-of-state adoptions and placements with single/working/gay/lesbian parents. In some states, placement with gay or lesbian parents is discouraged or not supported. Multicultural training consisting of racial awareness, multicultural planning (directed at a family’s shaping their status as multicultural family), and survival skills (for the child to cope with institutional racism) is helpful for parents considering transracial adoption (Vonk, 2001).

We also know about the factors that lead to adoption disruption. One factor is having some negative feelings about the adopted child. Social workers need to carefully assess prospective adoptive parents’ attitudes toward child characteristics such as race and ethnicity. Those parents who are willing to consider adopting children with special needs are more likely to adopt African American children (Brooks and James, 2003).

**SIDEBAR**

The adoptive parent of eight special needs children told me, “Once you’ve been through the home study process you think you’re supposed to be perfect. When problems surface with the child, you don’t want to talk about it, because you’re supposed to be perfect. It must be your fault!” *Postadoption wraparound services* have been developed and can assist adoptive families in adjusting to their new circumstances and avoid adoption disruption.

**Teenagers in the Child Welfare System and Beyond**

Another point in the course of a child welfare case is occupied by foster youth. Too often the way out of the child welfare system for foster youth, especially adolescent boys of color, is through the juvenile justice system. In fact, some have theorized that the child welfare system is the cause of many youth going into the juvenile justice system (Finkelstein et al., 2002; Lowenthal, 1999). Many services available to children in the child welfare system are not available to youth in the juvenile justice system. Strategies for addressing these issues are collaboration with juvenile justice probation officers and others (e.g., substance abuse treatment personnel), and training for social workers and foster parents to help youth avoid being expelled from or “blowing” placements.
CHAPTER TWO

Independent Living Programs and resources for former foster youth after the age of 18 such as the John Chafee Foster Care Services Program (created by the Foster Care Independence Act of 1999, P.L. 106–169) offer resources for independent living to all former foster youth between the ages of 18 and 21. The Foster Care Independence Act also enabled the states to offer Medicaid to former foster youth.

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Although he was speaking about what it would take to remedy institutional racism on a societal scale, President Johnson's words apply to foster children who "age out" of the child welfare system:

But freedom is not enough. You do not wipe away the scars of centuries by saying: “Now you are free to go where you want, and do as you desire, and choose the leaders you please.” You do not take a person who, for years, has been hobbled by chains and liberate him, bring him up to the starting line of a race and then say, “you are free to compete with all the others,” and still justly believe that you have been completely fair. Thus it is not enough just to open the gates of opportunity. All our citizens must have the ability to walk through those gates.

This is the next and the more profound stage of the battle for civil rights. We seek not just freedom but opportunity. We seek not just legal equity but human ability, not just equality as a right and a theory but equality as a fact and equality as a result . . . . To this end equal opportunity is essential, but not enough, not enough. Men and women of all races are born with the same range of abilities. But ability is not just the product of birth. Ability is stretched or stunted by the family that you live with, and the neighborhood you live in—by the school you go to and the poverty or the richness of your surroundings. It is the product of a hundred unseen forces playing upon the little infant, the child, and finally the man. (Lyndon Baines Johnson, Howard University commencement address, June 4, 1965)

The Voting Rights Act of 1965 was approved by the president on August 6, 1965.

PREPARATION AND SUPPORT FOR THE WORKFORCE

Given the very substantial multicultural challenges faced by child welfare service workers at each point along the service continuum, an effective and thorough system of education and training is essential for us to reach the goals of equity and fair treatment for all families. The culturally effective child welfare organization would be one that promotes a learning environment in which assumptions can be questioned and treatment models can be examined for fairness. In this environment, outcomes would be examined, not to sanction but to identify and remedy unsuccessful models and to develop better workers and best practices. This requires an organizational environment that sees fair treatment as a parallel process from client to worker to supervisor, program manager, and administrators.

If families have difficulties establishing relationships with helpers, especially helpers whose ethnic and cultural backgrounds differ from their own, hiring workers whose ethnicities reflect those vulnerable populations might positively affect the
entries and lengths of stay of children in the child welfare system. The research on counselor–client racial matching is somewhat equivocal about these empirical outcomes. Perhaps more importantly, however, a more culturally diverse workforce is likely to affect positively the experience of the child or family in dealing with a helping agency, the experience of potentially being heard and understood and appreciated on one's own terms.

Seeing cultural diversity as a source of strength, both for the clients themselves and for the agencies that serve them, is an important step. Using a strengths-based practice approach with regard to clients requires the capacity to perceive the strengths of clients and families—and this capacity is nurtured by hiring individuals who reflect the client base and also by staff development programs that encourage greater understanding of different cultures and world views. The workforce needs support for ongoing education and training, good supervision by culturally aware and diverse supervisors, and supportive work environments, which themselves model ways that diverse individuals can work cooperatively and effectively together.

**Ethnic and Cultural Diversity among Workers and Supervisors**

Working sensitively with diverse persons both as clients and as coworkers will enhance the worker–supervisor system and help us achieve deeper understanding of different groups (and probably ourselves), but these relationships may also be a source of misunderstanding and tension. Even the routine training of social workers in the postindustrial West may prove a stumbling block, when the students are from another culture. In a study of Arab social workers who attended Western universities, researchers discovered that the students experienced discomfort, conflict, and other undesirable reactions when their own cultural values came into conflict with the values they encountered while performing their field work (Haj-Yahia, 1997).

A key factor in establishing a meaningful cross-cultural exchange in the relationships between client and worker, supervisor and supervisee, and between coworkers appears to be a willingness and openness to discussing cultural variables, at all levels. For example, although wide acceptance and support appears to exist for bringing multiculturalism into the supervisory relationship, in practice these discussions may be very limited, possibly due to the discomfort of the individuals involved, lack of knowledge, or even lack of time.

A recent article examining cultural variables in supervision revealed that when discussions of cultural issues did take place between counseling supervisors and supervisees, those supervised reported greater satisfaction with their supervision and the ability to forge a stronger working alliance (Gatmon et al., 2001). Further, the researchers found that a supervisor’s being able to provide an atmosphere of safety, depth of dialogue, and frequent opportunities to discuss cultural variables contributed significantly to working alliances and to satisfaction with supervision. These findings suggest that more training may be needed to increase supervisor competence in discussing cultural issues. The researchers concluded that it is not entirely the cultural match between the supervisor and the supervisee that is important, but rather the existence and the quality of the discussions that take place regarding cultural difference and similarity.
Inadequate access to supervisors and mentors who have had multicultural training or who are from culturally diverse backgrounds continues to be a problem among counselors and therapists, as is the gap of understanding between more recently trained staff who have had some form of multicultural education and supervisors who lack such training (Tummal-Narra, 2004). Undoubtedly the same challenges exist in social work. An additional, important reason to impart cross-cultural competencies and communication skills to supervisors is to ensure they are able to model these capacities for their supervisees (Garrett et al., 2001). When multicultural perspectives and education are not woven into every aspect of practice, especially supervision, the resulting divisiveness, alienation, and power imbalances are likely to impair agency–staff and worker–client relationships and prevent the agency from serving families effectively.

Education and training that strengthen the capacity of individuals and helping institutions to work respectfully and fairly with diverse families and staff members are essential if the goal of equal treatment is ever to be met. It is just as clear that equity goals must pervade all levels of an institution or agency, from administrators to clerical staff. Yet a mere recitation of the need for fairness, sensitivity, and understanding is not enough. The mechanics of inequality are far too long-standing and far too subtle and far-reaching to disassemble so easily, even when the force of law has repeatedly been applied. The challenge for the field of child welfare and all other human services fields is to understand what equal practice really should look like, and to devise ways of achieving it, in very practical terms. In the next sections, we will examine some historical and legal context, and begin looking at ways to fashion the kind of child welfare system we need to create for the future, one in which all children and families have equal access to the resources they require.

REACHING THE GOAL OF EQUAL PRACTICE

Translating the intent to render fair and equitable treatment into the attitudes and practice that result in such treatment is a complex and challenging task. Since the passage of the Civil Rights Act of 1964, many systems within the society have struggled both to define the meaning of fairness and to make fair treatment a reality. These systems include not only the field of child welfare, but also several major components of society’s infrastructure: education, the election system, medicine, the labor and housing markets, and the fields of civil and criminal justice. Possibly the most telling lesson in how far the society has come and also how far it has yet to go is the famous court decision in Brown v. Board of Education, which reached its 50th anniversary in 2004. Although many of the most blatant trappings of racial discrimination have faded since Brown, educational and other forms of equity have not been achieved in most communities of the country. Specific instances and policies that constitute discrimination, or at least inequity, have become more subtle and difficult to examine, confounded as they often are with economic factors and unacknowledged forms of unequal treatment.

As discussed earlier in the chapter, the kind of continuing racial and ethnic placement, overrepresentation, and service disproportionalities we have seen in child

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welfare cannot be the result of chance; some more insidious process must be at work to reproduce or sustain mechanisms of injustice. Even when prescribed conduct and policies have changed, significant numbers of individuals may be so enmeshed in their own cultures and long-held beliefs that they continue to discriminate, some intentionally and some when they are not fully aware of the discriminatory and potentially harmful character of their behavior towards others.

Despite the best efforts of many individuals seeking to create fair policies over the 40 years since the Civil Rights Act, unequal treatment and inequities similar to those cited earlier in the chapter continue to pervade many aspects of life. We still have a substantial gap between the level of equal treatment shown in daily child welfare practice and the multicultural understanding required to bring about true equity in the major systems of society. Although “diversity” and “multicultural” terminology have entered the mainstream, and most acknowledge the need to better serve multicultural human services clients, for many the dominant European white culture remains the standard and the “other” cultures the exceptions (see Hird et al., 2001).

As noted earlier, we must be clear about what we mean by “equity” in terms of treatment by agencies and individuals. Equity in operational terms does not mean the same treatment for all, or even the same treatment accorded to the members of the majority. This principle should be especially clear in the case of a society like this one in which constitutional provisions are expressly intended to prevent the majority from dominating the rights of the individual. Rather, equity requires treatment as an equal, which is the right, as legal philosopher Ronald Dworkin framed it, not to receive the same distribution of a burden or benefit, but to be treated with the same respect and concern as anyone else (Dworkin, 1978).

Regarding the US Supreme Court case of DeFunis, a reverse discrimination action in which a white law school applicant challenged a school’s affirmative admissions policy, Ronald Dworkin observed:

> We must try to define the central concept on which [the plaintiff’s claim] turns, which is the concept of an individual right to equality made a constitutional right by the Equal Protection Clause. What rights to equality do citizens have as individuals which might defeat programs aimed at important economic and social policies, including the social policy of improving equality overall? There are two different sorts of rights they might be said to have. The first is the right to equal treatment, which is the right to an equal distribution of some opportunity or resource or burden . . . The second is the right to treatment as an equal, which is the right, not to receive the same distribution of some burden or benefit, but to be treated with the same respect or concern as anyone else. If I have two children, and one is dying of a disease that is making the other one uncomfortable, I do not show equal concern if I flip a coin to decide which should have the remaining dose of a drug.


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SETTING STANDARDS FOR PRACTICE

To bring practice more in line with aspiration and insure that all are served fairly by society’s institutions, many professions have created frameworks and standards of conduct for their practitioners. Increasingly, as many job descriptions become more service oriented, flexible, and multidimensional, many human services, medical, educational, and corporate entities are using competency frameworks to establish and maintain practice standards within their organizations (McLagan, 1997). These frameworks attempt to analyze even complex occupations and break them down into units, not only into the individual tasks and behaviors that make up the job, but also into the internal attributes, the value, and orientation important to a good performance.

Although competencies and the values in which they are embedded may be specific to a given field of work, typically, the framework includes the knowledge, skills, and attitudes considered desirable for effective work. If the goal is equitable practice in a given profession, it is clear that all three are essential. Knowledge of cultural differences is important, as are the skills to put this knowledge into practice. But these two attributes alone will not make an effective practitioner, if the attitudes and values needed to practice well in a multicultural environment are absent. Although attitudes and values are harder to observe and to measure than objective knowledge and demonstrable skills, these make up an important part of any competency framework. It could easily be argued that values and attitudes are central, because in most human services frameworks they underlie the kind of openness of mind, even-handedness, sensitivity, and flexibility necessary to understand another person’s culture and another person’s world. In child welfare services, family members outside of the dominant, mainstream culture are doubly vulnerable; not only may they face allegations of abuse or neglect, but they are also likely to be unfamiliar with the culture of the person investigating such allegations.

CULTURALLY APPROPRIATE SERVICES: HEALTH CARE

Before moving to a discussion of social work competency frameworks, it may be valuable to do a little cross-cultural comparison by examining the development of competencies from another professional culture: health care. Especially in the public health field, health care has several common features with social work: it must deal with a highly diverse population; it must often render an important service to a vulnerable, sometimes unwilling or reluctant group of clients; and it must prepare its professional staff to bridge communications gaps between cultures. Just as failures of understanding and communication in child welfare may place children at risk of harm, in medicine, the failure to communicate well with patients of other cultures may lead to the failure to diagnose and treat disorders successfully.

Health care, though grounded in science, has many elements of a counseling relationship. Trust, open communication, and understanding between care provider
and patient is important, even essential, to successful treatment. When these elements are lacking, recovery may not be as rapid or treatment may fail completely. As in child welfare when cross-cultural communication is impaired, many problems can arise—the diagnosis may be wrong for lack of adequate information exchanged by doctor and patient or patient’s family; the patient may not follow the treatment regimen because he did not understand the doctor or nurse or pharmacist; the patient may not receive his or her medication because a family member preferred to use folk remedies—and some of these problems are due to barriers between cultures.

Possibly the most compelling account of this kind of cross-cultural misunderstanding is Anne Fadiman’s (1997) report of the course of treatment of a young Hmong child in Merced, California, who eventually was diagnosed with severe epilepsy. In this harrowing example, the child’s parents, members of a Hmong family from Laos, struggle both to heal their daughter through traditional remedies and to comprehend treatment offered by Western doctors, and the doctors struggle equally hard to communicate with the family and to insure their own regimen is followed. In the middle of the struggles were social workers, nurses, and other hospital staff, few of whom were able to successfully open and sustain a channel of communication. Though one social worker valiantly grew close to the family and learned much about their culture, she was unable to bridge the gap between the parents and the medical staff. When the child lost her life, it was a sorrow borne by people on both sides of the cultural rift, each of whom arguably did their best to protect and save the child.

In health care, language and communication barriers are common and, as noted above, can lead to patient dissatisfaction, poor comprehension, and adherence to provider instructions, as well as lower care quality (Center on an Aging Society, 2004). Just as minority families often have less access to in-home supportive child welfare services, many racial and ethnic minority individuals and their children are more likely to be uninsured and to have lower access to health care services than whites (Child Welfare League, 2000). In addition, racial and ethnic minorities have higher incidence of and mortality from chronic diseases (Center on Aging Society, 2004). The health services provided to racial and ethnic minority clients are often inferior, and the mental health care provided is often inappropriate and antagonistic to the cultural values and life experiences of populations of color (Sue, 2003).

Growing challenges in achieving equity in health care and mental health services have led to the development of the National Standards on Culturally and Linguistically Appropriate Services (CLAS)\(^6\) by the Office of Minority Health of the Department of Health and Human Services (U.S. Department of Health and Human Services, 2001). Implementation of several of the more concrete among these fourteen standards is mandatory for organizations receiving federal funds. Other standards remain at the “recommended” or “suggested” level for different kinds of educational or health care organizations (U.S. Department of Health and Human Services, 2001). Private practitioners are encouraged to adopt practices consistent with the standards.

\(^6\)CLAS is to be distinguished from the California Long-Range Adoption Study (C.L.A.S.) noted earlier in the text.
In enacting the CLAS standards, the Office of Minority Health commented as follows:

The following national standards . . . respond to the need to ensure that people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards for culturally and linguistically appropriate services (CLAS) are proposed as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers. The standards are intended to be inclusive of all cultures and not limited to any particular population group or set of groups; however, they are especially designed to address the needs of racial, ethnic, and linguistic population groups that experience unequal access to health services. Ultimately, the aim of the standards is to contribute to the elimination of racial and ethnic disparities and to improve the health of all Americans. (U.S. Department of Health and Human Services, 2001)

The standards are significant because they are national in scope and are the product of a multiyear deliberative process involving numerous health professionals within and outside of the Office of Minority Health, as well as members of the public who attended regional meetings and contributed written comments. They are truly national standards, which can be applied to any regional organization, and, unlike many human service practice frameworks, they are potentially enforceable at least among institutions receiving federal dollars.

### NATIONAL CULTURALLY AND LINGUISTICALLY APPROPRIATE STANDARDS FOR HEALTH CARE

1. **Standard 1.** Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

2. **Standard 2.** Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

3. **Standard 3.** Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

4. **Standard 4.** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/customer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. **Standard 5.** Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

6. **Standard 6.** Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretations services (except on request of the patient/consumer).

7. **Standard 7.** Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly-encountered groups and/or groups represented in the service area.

8. **Standard 8.** Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

9. **Standard 9.** Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement plans, and patient satisfaction assessments, and outcomes-based evaluations.

10. **Standard 10.** Health care organizations should ensure that data on the individual's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems and periodically updated.

11. **Standard 11.** Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as the needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

12. **Standard 12.** Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. **Standard 13.** Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

14. **Standard 14.** Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Standards 4, 5, 6, and 7 are current requirements for receiving federal funds.

The Office of Minority Health recommends Standards 1, 2, 3, 8, 9, 10, 11, 12 and 13 for adoption as mandates for Federal, State and national accrediting agencies.
These standards have the advantage of being both very comprehensive and concrete in the way they may be applied within an organization. The standards operate on several levels, each layer building on the prior standards to achieve a systematic, structural approach to integrating the principles and actions of culturally competent practice into every aspect of the organization's functioning. For these reasons, the CLAS standards may be considered a potential foundation on which to build other human service frameworks for multicultural competence.

CONSTRUCTING SOCIAL WORK COMPETENCIES FOR EQUAL PRACTICE

In tailoring competencies for multicultural practice in social work, we first need to think about what is meant by the construct of cultural competence; second, we must consider the roles and tasks a social worker will be performing and how principles of multicultural practice can be applied in those contexts. Although there exist many statements of what constitutes cultural competence, the following definition of cultural competence appears to capture the many aspects of its meaning:

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behaviors that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious, or social groups. “Competence” implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities. (See Cross et al., 1989)

International Perspective

The importance of cultural sensitivity in working with children and families from a culture other than the social worker's home culture cannot be overemphasized. This is particularly the case in child welfare, when the balance of power is heavily weighted towards the social worker, who both wields the power of the state and is also in helping relationship with a client. As Hardy-Desmond and colleagues put it, too often the prevailing view is that “culture is the icing when in fact it is the cake” (2001, p. 151). Culture is not merely “world-view”; in many ways people from distinctly contrasting cultures may reasonably be said to inhabit different worlds (Berger and Luckmann, 1966). Clearly the meanings of many seemingly sound and “universal” values and constructs blur when we take an international perspective.

As Garland and Escobar (1988) pointed out, not only do values differ across cultures, but professional social work values also vary from one country to another. In one study they cited dealing with international professional values taught in social work schools, no value or ethnic issue was stressed in as many as 50 percent of the schools studied (Yelaja, 1984). The kind of individualism, self-determination, and
rationalism that are held as desirable attributes by mainstream American culture may be unacceptable personal flaws in a culture that encourages cooperation and self-denial. In formulating competencies for cultural competence, an obvious but important first step is for the social worker to acknowledge the presence and power of one’s own cultural background, as well as its nonuniversal character. Given that this cultural limitation will hold for all or most of us equally—clients and social workers alike—flexibility and openness will serve well as multicultural tools.

Among key characteristics noted as essential building blocks of cultural competence are

1. Awareness and acceptance of difference
2. Awareness of one’s own cultural values
3. Understanding the dynamics of difference
4. Development of cultural knowledge
5. Ability to adapt practice to the cultural context of the client. (Cross et al., 1989)

In addition to knowledge, flexibility, self-awareness, and an attitude of respect and acceptance regarding other cultures, it is important to be aware of the subtleties of language and artistic expression, through which much cultural information is conveyed. This information may help a social worker understand a culture’s accepted coping mechanisms, manner of accepting help, and mutual assistance styles (Lum, 1999). All of these aspects of culture, if close attention is paid, will enhance understanding of family and group roles, and deepen the social worker’s capacity to foster child and family well-being.

Roles, Tasks, and Responsibilities of the Social Worker

As noted earlier, integrating cultural competence awareness and the behaviors that flow from this awareness is challenging for any human service activity. This challenge is especially demanding when the perceived mission and mode of operation of that service activity or organization conflict with the traditions of the people served, or when power differences exist, either real or perceived. The social worker, in keeping with social work traditions, is likely to be cast in the role of helper or facilitator, but if he or she is also working in a hospital, school, or agency setting, the social worker is charged with working within or even enforcing the rules of the organization. Inhabiting this dual role is the special challenge of the child welfare social worker, who may be called on to investigate allegations of abuse or neglect, decide whether or not to remove children from their home, and then work with the family members for reunification.

In all of these roles, however, the culturally competent social worker is responsible for mediating the mores, values, and regulations of the dominant, mainstream culture for those clients who may not be assimilated into that culture or who may be members of a distinct subgroup. By learning as much as possible about the client’s culture and by paying sensitive, respectful attention to the client and the client’s family
and associates, the social worker is then capable of interpreting the dominant culture for the client while striving to enhance client well-being. To be culturally competent is, at the very least, to be capable of serving as a useful bridge between cultures. Such a role is fully compatible with a strengths-based approach. The culturally sensitive social worker finds creative ways to establish mutual understanding and common ground with a member of another culture, while seeking out and utilizing the client’s unique strengths and those present in the social environment to accomplish service goals.

National Association of Social Workers (NASW) Standards for Practice

The preamble to the NASW Code of Ethics states that the primary mission of the social work profession is “to enhance human well being and help meet the basic human needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (National Association of Social Workers, 2000). Increasing numbers of the service population are also members of other cultures. Recognizing that cultural diversity is not limited to racial and ethnic groups, NASW has expanded its idea of multiculturalism to include cultural experiences of people of different genders, social classes, sexual orientations, ages, spiritual beliefs, and physical and mental abilities. Thus NASW’s concept of cultural competence has a very broad reach: cultural competence in social work practice implies a heightened consciousness of how clients experience their uniqueness and deal with their differences and similarities within a larger social context (NASW, 2001).

As revealed in previous sections of the chapter, especially in the section dealing with the standards for health care practice, rendering the many systems of large service organizations more culturally competent is extremely difficult. The NASW has set forth five essential components to help a system move in that direction. We have seen some of these elements in operational form in the National Standards for Culturally and Linguistically Appropriate Services CLAS in Health Care (2001):

### ESSENTIAL ELEMENTS FOR A SYSTEM TO BECOME MORE CULTURALLY COMPETENT

The system should:

1. Value Diversity
2. Have the capacity for cultural self-assessment
3. Be conscious of the dynamics inherent when cultures interact
4. Institutionalize cultural knowledge
5. Develop programs and services that reflect an understanding of diversity between and within cultures.

(NASW, 2001)
Regrettably, child welfare agencies and social work education programs do not have the resources or necessary influence within the society to make certain that the kinds of standards mandated for health care are mandated similarly for child welfare. If the mandatory CLAS Standards dealing with client primary language, bilingual staff and interpreters, written materials and notices, and signage were practiced in the daily operations of child welfare agencies nationwide, and if the recommended standards were nationally disseminated, we might be further along the road to equity. Attitudinal change regarding equitable treatment of all individuals takes place slowly, but as we have seen in the years since the Civil Rights Act and Brown v. Board, the presence of mandate can be a significant spur to change.

With a view toward establishing a generalist’s guide for culturally competent practice, NASW approved ten standards in 2001. These standards contain within them the idea that achieving cultural competence is not stagnant but an ongoing process. The presence of various cultures within the society is constantly changing and the society itself adapting; to practice effectively, the social worker must continue to grow and learn in response to this dynamic process. Also prominent in these standards is the idea of advocacy: for a more diverse professional workforce, for more culturally sensitive services and programs, for better social policies affecting multicultural clients, and for more language and linguistically appropriate services for clients. Significantly, some of these elements are mandated in the CLAS Standards, notably those dealing with signage, materials, information, and interpreters provided in the client’s language.

### NASW STANDARDS FOR CULTURAL COMPETENCE IN SOCIAL WORK PRACTICE

1. **Standard 1. Ethics and Values** Social workers shall function in accordance with the values, ethics, and standards of the profession, recognizing how personal and professional values may conflict with or accommodate the needs of diverse clients.

2. **Standard 2. Self-Awareness** Social workers shall seek to develop an understanding of their own personal, cultural values and beliefs as one way of appreciating the importance of multicultural identities in the lives of people.

3. **Standard 3. Cross-Cultural Knowledge** Social workers shall have and continue to develop specialized knowledge and understanding about the history, traditions, values, family systems, and artistic expressions of major client groups that they serve.

4. **Standard 4. Cross-Cultural Skills** Social workers shall use appropriate methodological approaches, skills, and techniques that reflect the workers’ understanding of the role of culture in the helping process.

5. **Standard 5. Service Delivery** Social workers shall be knowledgeable about and skillful in the use of services available in the community and broader society and be able to make appropriate referrals for their diverse clients.

6. **Standard 6. Empowerment and Advocacy** Social workers shall be aware of the effect of social policies and programs on diverse client populations, advocating for and with clients whenever appropriate.

(continued)
CHAPTER TWO

Continued

7. **Standard 7. Diverse Workforce**  Social workers shall support and advocate for recruitment, admissions and hiring, and retention efforts in social work programs and agencies that ensure diversity within the profession.

8. **Standard 8. Professional Education**  Social workers shall advocate for and participate in educational and training programs that help advance cultural competence within the profession.

9. **Standard 9. Language Diversity**  Social workers shall seek to provide or advocate for the language appropriate to the client, which may include use of interpreters.

10. **Standard 10. Cross-Cultural Leadership**  Social workers shall be able to communicate information about diverse client groups to other professionals.

NASW Standards for Cultural Competence in Social Work Practice can be found at www.socialworkers.org/sections/credentials/culturalcomp.asp.

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**Competencies for Public Child Welfare in California**

In moving from the NASW Standards for Cultural Competence in Social Work Practice to the multicultural practice section of the Curriculum Competencies for Public Child Welfare in California, we are obviously taking our examination of competency frameworks from the general to the more specific. The California competencies are promulgated by the California Social Work Education Center (CalSWEC), a partnership among California schools of social work, public human service agencies, and professional organizations dedicated to integrating child welfare social work education and practice in the state to insure effective, culturally competent service delivery. The CalSWEC competencies, the basis of a public child welfare curriculum in California, were initially adopted in 1992 after a statewide collaborative drafting effort involving school faculty, agency personnel, and other stakeholders. The goal was to develop a competency-based curriculum to meet the needs of both graduate social work education and professional child welfare services (Clark and McCormick, 2000).

The CalSWEC competencies as a whole are revised every 4 or 5 years to reflect current practice. The most recent revision, adopted in 2002, was the culmination of an inclusive process involving human services stakeholders and educators throughout the state. In crafting the final revision, a curriculum modification workgroup strived to integrate its efforts with the educational guidelines and accreditation standards set forth by the Council on Social Work Education. The structure divides the competencies into Foundation and Advanced categories, which roughly correspond to the first and second years of the MSW program. As with the very first version, the elements are competencies that capable graduate social work specialists in child welfare are expected to know and be able to do (Clark and McCormick, 2000).
FAIRNESS AND MULTICULTURAL COMPETENCE

ETHNIC SENSITIVE AND MULTICULTURAL PRACTICE (FIRST YEAR)

A working knowledge of and sensitivity to the dynamics of ethnic and cultural differences are at the core of child welfare services. Culturally competent practice acknowledges that an individual's culture is an integral part of overall development and selfhood and strives to use concepts of culture in a manner that enhances individual and family functioning. Given the diverse service population, cultural competency and understanding of the cultural norms of major ethnic groups should be a criterion for competent performance throughout the curriculum. This section includes foundation knowledge, values, and skills for culturally competent child welfare practice.

1.1 Student demonstrates sensitivity to clients' differences in culture, ethnicity, and sexual orientation.

1.2 Student demonstrates the ability to conduct an ethnically and culturally sensitive assessment of a child and family and to develop an appropriate intervention plan.

1.3 Student understands the importance of a client's primary language and supports its use in providing child welfare assessment and intervention services.

1.4 Student understands the influence and value of traditional, culturally based childrearing practices and uses this knowledge in working with families.

1.5 Student demonstrates the ability to collaborate with individuals, groups, community-based organizations, and government agencies to advocate for equitable access to culturally sensitive resources and services.

CULTURALLY COMPETENT CHILD WELFARE PRACTICE (SECOND YEAR)

This section builds upon the skills developed towards cultural competence in the foundation. A comprehensive understanding of the cultural norms and values of California's major ethnic, cultural, and immigrant groups is critical in order to make appropriate assessments and to work effectively with members of these groups. Advanced culturally competent practice requires knowledge of the specific challenges faced by different ethnic and cultural populations and the ability to apply that knowledge in legal, social, and psychosocial contexts.

5.1 Student demonstrates knowledge of legal, socioeconomic, and psychosocial issues facing immigrants and refugees and is able to devise sensitive and appropriate interventions.

5.2 Student is able to critically evaluate the relevance of intervention models to be applied with diverse ethnic and cultural populations.

(continued)
Like the NASW standards, the CalSWEC multicultural practice competencies acknowledge the need to broaden the reach of “diversity” to embrace individuals of different sexual orientations as well as different ethnic and racial backgrounds. The importance of a client’s language, the effects of psychosocial issues and the need to advocate for equitable access to resources are also stressed. But a close comparison of the NASW and the CalSWEC formulations, which are certainly compatible if not fully congruent, reveals that the CalSWEC competencies include an emphasis on practice skills.

While it is not practical or even desirable to include an inventory of every specific skill needed for multicultural practice, the CalSWEC competencies include specific requirements for actual decision points along the child welfare service continuum, beginning with the ability to conduct an “ethnically and culturally sensitive assessment” at Competency 1.2 for the first year of study. The more advanced second-year competencies include, at numbers 5.3 and 5.4, knowledge of the requirements of placement acts regarding Native American and multi-ethnic children.

Significantly, competency 5.2 implies within its text the knowledge that not all intervention models used with families of the dominant culture have application or relevance to all kinds of families. The competency CalSWEC member schools and agencies aspire to instill in master’s level social work graduates is the capacity to “critically evaluate the relevance” of these models. This capacity is clearly an advanced skill, one requiring a depth of self-knowledge, objectivity, and analytic power possessed by few professionals. The challenge is all the greater in the present context in which we have few reliable multicultural intervention models and fewer tools to measure the efficacy of the models we do have. All the more skill, judgment, creativity, and respect for cultural differences are then required of the practitioner.

The competencies as written are not “finished” in any sense; they will be modified as needed to adapt to anticipated advances in practice and structural changes in California’s child welfare services system. Nevertheless we can see the trend toward greater specificity and application—how the policy language of multiculturalism is gradually being translated into the attitudinal and action steps a professional needs to take to accomplish the reality of culturally appropriate, equitable child welfare practice.

**SUMMARY**

Although four decades have passed since the Civil Rights Act, traces of cultural and racial bias continue to operate in American society and its institutions. Despite the legal and moral imperative to offer services fairly and to limit arbitrary distinctions among people
served, such bias is evident in current child welfare practice. Bias is revealed most clearly
by the significant overrepresentation of children of color in the child welfare system and
by the differential treatment certain groups of children and their families are likely to
receive. Without increased awareness of these cultural deficits in practice and meaningful
strategies to correct them, the child welfare system is in danger of inflicting further injury
on the children and families it is designed to protect.

In this chapter we have suggested a framework for examining the idea of fairness
and its meanings in the child welfare context. By using a construct of fairness derived
from the concepts of social exchange and of distributive and procedural justice, we are
able to analyze how the child welfare system can fail to operate fairly with multicultural
families and also how to approach and remedy many of these problems. At each decision
point in the child welfare services continuum, there is an opportunity to intervene in a
culturally appropriate way. At each of these points, beginning with the initial report and
assessment, and ending potentially with adolescent services, the social worker can learn
to respond sensitively to the family’s individual strengths and needs. Consequently we
have taken a systematic look at these stages and introduced skills, knowledge, and strate-
gies for effective practice.

Clearly more than intent is required to effect cultural change within a social insti-
tution. Over the years, we have seen intent supported by legal action and we have seen
the systems of education, health care, social work, and other human services entities
adopt policies designed to alleviate bias. Many professional fields have established a sys-
tem of multicultural “competencies” to help guide their practitioners to more sensitive
practice. In some fields, like health care, certain practices are mandatory.

It is useful for the child welfare field to compare across disciplines to examine the
cultural competencies we hold in common and those areas in which we differ. In this chap-
ter we have looked at the structure of national health care competencies, as well as those
for the NASW and for the child welfare–specific competencies of the CalSWEC. These
codified values, skills, and attitudes are valuable tools to foster the kind of equitable prac-
tice which the field as a whole must adopt. As knowledge and understanding deepen, along
with particular practice skills, we would expect further refinements in our competency
frameworks. Nevertheless, broad, comprehensive, and consistent systems of education
and training, as well as support within the workforce, are required to reach the goals of fair
treatment and equal practice. External measures and regulations will not be effective in the
absence of the kind of internal multicultural understanding that can only be achieved
through informed communication and through formal and continuing education.

STATE EXAMPLE OF DISPROPORTIONALITY

California has a more diverse population than many other states. The following table
describes the proportion of races and ethnicities of all children in California compared to
the proportion of each race among (1) children with substantiated cases of abuse and/or
neglect and (2) children under the jurisdiction of the California public child welfare
system, starting in 2001.
More than twice as many African American children are among those with cases of substantiated abuse and/or neglect and more than four times as many among those who are under the jurisdiction of the California child welfare system. There are 2.4 times more Native American/American Indian children under the jurisdiction of the child welfare system than there are in the total population of California children.