Allegheny County
Department of Human Services
One Smithfield Street
Pittsburgh, PA 15222

Phone: 412. 350. 5701
Fax: 412.350.4004
www.alleghenycounty.us/dhs

# THE ROLE OF RACE IN CHILD WELFARE SYSTEM INVOLVEMENT IN ALLEGHENY COUNTY

Mary E. Rauktis, Ph.D. and Julie McCrae, Ph.D

# Allegheny County Department of Human Services

The Allegheny County Department of Human Services (DHS) is dedicated to meeting the human services needs of county residents, particularly the county's most vulnerable populations, through an extensive range of prevention, early intervention, crises management and after-care services.

This report was prepared by the Office of Data Analysis, Research and Evaluation (DARE), an office within DHS. DARE supports and publishes research related to the activities of DHS offices including: Aging; Behavioral Health; Children, Youth and Families; Community Services and Intellectual Disability.

DHS research products are available for viewing and download at the DHS Research and Evaluation webpage at www.alleghenycounty.us/dhs/research.aspx.



Published 2010 by Allegheny County DHS

Allegheny County
Department of Human Services
One Smithfield Street
Pittsburgh, PA 15222
Phone: 412. 350. 5701
Fax: 412.350.4004

# Contents

# Figures and Tables

## FIGURES



## TABLES

# Glossary

| | |
|---|---|
| DHS | Department of Human Services |
| ChildLine | Pennsylvania ChildLine and Abuse Registry |
| C2P2 | Culturally Competent Professional Practice Project |
| CPS | Child Protective Services |
| CYF | Office of Children, Youth and Families |
| FGDM | Family Group Decision Making |
| GPS | General Protective Services |
| IRB | Institutional Review Board |
| TANF | Temporary Assistance for Needy Families |
| WPIC | Western Psychiatric Institute and Clinic |

# Contributors

The Allegheny County Department of Human Services (DHS) and the University of Pittsburgh's School of Social Work Child Welfare Education and Research Programs joined together to support this project. Project partners graciously provided data, analysis, programmatic and other support to the initiative. Critical funding for this project was provided by the University of Pittsburgh Center on Race and Social Problems.

The following individuals contributed their time, knowledge and talent for the completion of this report:

- Michael Cunningham, M.S. – University of Pittsburgh School of Public Health
- Gary Marsh, Ph.D. – University of Pittsburgh School of Public Health
- Cynthia Bradley-King, Ph.D. – University of Pittsburgh School of Social Work
- Tammy Thomas, M.S.W., M.P.H. – University of Pittsburgh School of Public Health
- Debbie Swerdlow, M.S.W. – University of Pittsburgh School of Social Work

We would also like to thank Erin Dalton, Lisa Caldwell, Dr. Marcia Sturdivant and all of the Children, Youth and Family (CYF) administrators in the five Allegheny County offices for their assistance in reviewing this report and obtaining data.

# Executive Summary

## OVERVIEW

This study aimed to document the service paths of African-American and white children following referral to Allegheny County child welfare services, and to identify local decision-making points, case characteristics, organization and community factors that may contribute to service disparities. The study questions were:

- What is the extent of racial disproportionality at referral, investigation and service provision?
- Other things being equal, is a child's race related to the likelihood that he or she will be investigated and accepted for service?
- What do child welfare professionals identify as the causes for disproportionality?

## STUDY METHOD

The study took place between January and November 2008 and used a mixed methods design. Administrative and field data on a stratified random sample of 460 children, ages 0 to 17, were used in the bivariate and multivariate analyses. The sample includes children who had at least one referral to the DHS Office of Children, Youth and Families (CYF) between January 1, 2006 and December 31, 2006. Qualitative interviews were also conducted with 11 CYF caseworkers, supervisors and regional directors about their perceptions of how they obtain information to make decisions and the role that race plays in their decisions.

## FINDINGS

Referrals and investigations at CYF in 2006 show the most notable disparity concerning the rate at which African-American and biracial children are referred to CYF. African-American children are referred at three times the rate of white children, with little evidence to suggest that their level of risk or need for services is substantially different than that of white children. This is evidenced by no significant difference in overall risk ratings at referral and investigation between African-American and white families and few significant differences in ratings of particular types of risks, such as caregiver substance abuse and amount of family support. The only significant characteristics of African-American families according to these data are more frequent contact with CYF, referrals involving more children and slightly higher rates of children having received public assistance.

Biracial children are referred at four times the rate compared with white children, and had significant difference in risk ratings at referral in terms of caregiver capacity (physical, emotional and intellectual) and parenting skills and knowledge. Multivariate analyses found that child race significantly predicted case investigation, with African-American children less likely to be investigated than white children. Biracial children were twice as likely to be the subject of an investigation compared with white children.

There was no evidence in these data of a funneling effect for African-American children, where disproportionality increases at each decision point (Vandergrift, 2006). Rather, disproportionality in Allegheny County for African-American children, who represented 68 percent of children in foster care in 2008 (Pennsylvania Partnerships for Children, 2009), appears related to disparate rates of referrals and more frequent re-referrals that involve more children compared with other families.

## CONCLUSIONS AND RECOMMENDATIONS

While the individuals interviewed for this study (caseworkers, supervisors and directors) acknowledged that African-Americans are disproportionately involved in child protective services, they identified system bias as a major cause and felt that their decisions were based on safety and not race. The interviewees indicated that circumstances that are often experienced by African-American families, such as having a low income, living in an unsafe neighborhood, single parenting, lacking an education or using substances or having a serious mental illness were likely factors that make these families more vulnerable, increasing their visibility to systems such as child welfare. All of the interviewees felt that being poor and black were so intertwined that it was impossible to unravel them in order to determine which one caused African-American families to be disproportionately involved in the child welfare system.

Recommendations are to focus interventions on points in the system where disparities seem to occur. Interventions should draw from multiple explanatory theories for referral disproportionality. Based on the theory suggested by these data that poverty, system bias and community factors results in referral disproportionality, Allegheny County could utilize evidence-based and evidence-supported practices that focus on reducing disparities at the front end of the child welfare system pathway.

# Background

## WHY DO CHILDREN ENTER THE CHILD WELFARE SYSTEM?

Children and youth enter and exit child welfare services through a well-defined path with multiple decision points. Barth (2005) writes that for children in the community, entry into the child welfare system begins with a report of maltreatment. A decision is made by someone in the community that a child is being abused or neglected (or is at risk for abuse and neglect) and they make a referral to child protective services. In Allegheny County, referrals can come through the state's "ChildLine" (CPS), which are primarily referrals for abuse, or through General Protective Services (GPS), which are primarily referrals for neglect. The next step is that the referral is either investigated or a decision is made to not investigate. For CPS referrals, decisions are made about whether the maltreatment occurred ("substantiated") and whether to provide services ("accepted"). For GPS referrals, there is no process of substantiation, only a decision about whether to provide services. Services may be provided to families while the child remains at home, or the child may be placed in out-of-home care, such as in foster care or kinship foster care (placed with relatives). Goals for children placed into out-of-home care typically include: reunification with their family, adoption or another long-term permanent living situation such as legal guardianship (Barth, 2005).

### Referent Bias

Despite research supporting that child maltreatment is unrelated to race or ethnicity (Sedlak & Schulz, 2001a; Sedlak & Schulz, 2005), African-American families are over-represented in their referral to child protective services (Fluke, Yuan, Hedderson & Curtis, 2003; Lemon, Andrade & Austin, 2005). This pattern has been called "referent bias." Research suggests that there is an association between referral, type of referring agency and child and family race. Medical personnel are more likely to report African-American children to child welfare services compared with other children (Ards & Harrel, 1993; Hampton & Newberger, 1988; Hines et al., 2002), whereas schools are more likely to refer Latino/Hispanic families (Hines et al., 2002). A study of emergency room physicians found that African-American parents were more likely to be reported for abuse, even after controlling for the likelihood of abusive injury (Lane, Rubin, Monteith, & Christian, 2002). Although both white and African-American women use drugs during pregnancy at similar rates, African-American women were reported for child maltreatment upon delivery at approximately 10 times the rate for white women (Chasnoff, Landress & Barrett, 1990; Karp, 2001).

# Background

**Decisions to Investigate**

Once a referral is made to child protective services, a key decision is whether to investigate. Are African-American families investigated at a greater rate? This question was examined using data from the National Incidence Study (NIS-3; Sedlak & Schulz, 2001b; Sedlak & Schulz, 2005). African-American children who experienced emotional maltreatment, physical neglect or fatal or serious injury had caregivers with substance abuse problems, and those whose cases were reported by professionals were more likely to be investigated than white children with the same characteristics. An analysis of the 2000 NCANDS data from five states revealed that African-Americans were twice as likely to be investigated as whites (Fluke, Yuan, Hedderson & Curtis, 2003).

Most unequivocal are findings that African-American children are overrepresented among children in foster care. Every state in 2000 showed disproportionate rates of African-American children entering foster care, with rates that range from 1.58 to over 65 times the rate of white children (Vandergrift, 2006). Vandergrift refers to a "funneling effect," meaning that the percentage of minority representation increases at every step of child welfare involvement. The only stage where there are no racial differences is in rates of children's reentry into the child welfare system (Hill, 2006).

There are theories as to why African-Americans and other minorities are referred and investigated at greater rates than white families. One theory at the referral stage is that individuals have biases and inconsistencies in their decision-making processes that result in a greater number of referrals of African-Americans to child welfare services. Called "reporting bias" (Drake & Zuravin, 1998), it was empirically established in 1980 in the National Incidence Study NIS-1 (Ards & Harrell, 1993), which found that families with suspected maltreatment and higher family income had a lesser chance of having a formal report made. However, this finding was not supported when the NIS Wave 1 data were re-analyzed, due to possible selection bias in the first analysis (Ards, Chung, Myers, 1998). Zellman (1992) used vignettes to survey 1,196 mandated reporters and found some evidence of "labeling bias" or the tendency to look for and find maltreatment among certain groups. However, this finding has not been replicated in other studies and in the last 20 years, no studies have supported the presence of labeling bias in child protective services (Drake & Zuravin, 1998).

# Background

**Case Management**

If labeling isn't the reason for why children enter the child welfare system, it may be predictive of where children end up in the service pathway. In an early study of how case managers make decisions about children in state custody, Martin, Peters and Glisson (1998) found that case managers' placement and service recommendations were guided less by structured assessments and more on the labels given to children and how they entered into state care. Research on decision-making in child welfare suggests that caseworkers lack the prerequisite competencies needed for effective assessments, thereby relying on their own beliefs and culture in making assessments (Rycas & Hughes, 2003). The research emerging from the behavioral decision making field from other professions such as medicine, law, nursing and occupational therapy add to our understanding of how mandated reporters and others use cognitive shortcuts or heuristics to make decisions to report or not report, to investigate or move to substantiation and if these decisions are creating disproportionality. Finally, the use of consensus-based rather than actuarial risk assessments in making decisions may be contributing to disproportionality by inaccurately classifying cases to risk levels (Baird & Rycus, 2005; English, Aubin, Fine & Pecora, 1993).

**Poverty**

Another theory is that disproportionality has less to do with the race of the residents and more to do with the disadvantaged characteristics of families and economic deprivation of the communities in which they live. There is a link between poverty and the likelihood of child abuse (Sedlak and Broadhurst, 1996). Neighborhood poverty is positively associated with maltreatment and, in particular, with child neglect (Drake & Pandey, 1996). For example, Korbin et al. (1998), in a study of black and white neighborhoods in Cuyahoga County, found that maltreatment rates were lower for African-American families, and concluded that child maltreatment was determined more by poverty than race. The combination of impoverished neighborhoods with high crime, access to illegal substances and limited access to jobs, social services, and safe and affordable housing may create high levels of need that result in children being referred to child protective services (Dettlaff & Rycraft, 2008; Garbarino & Eckenrode, 1997).

**Child Welfare Organizational Climate**

Finally, the climate of child welfare organizations is thought to contribute to disproportionality. Organizational climate studies suggest that positive environments characterized by low conflict personalization and collaboration are predictive of positive service outcomes as well as quality (Glisson & Hemmelgarn, 1998; Glisson, 2009). Yet few would characterize the current climate of public child welfare agencies as positive. Child welfare organizational climates are often characterized by fear of liability or punitive consequences (Dettlaff & Rycraft, 2008 p. 53). In a series of focus groups with different stakeholders focusing on the reasons for disproportionality, Dettlaff and Rycraft (2008) summarized that in order to practice effectively, workers need to feel supported by the agency, and improvements made to the investigative and risk assessment processes to reduce the likelihood of ill-informed decisions (p. 53).

If national research supports that decision making in child welfare is related to disproportionality, what does Allegheny County look like? Research on referral patterns for neglect in Allegheny County between 1986 and 1989 found that although African-American families constituted 31 percent of families with children under age 18 in Pittsburgh, they were 45 percent of the referrals to CYF (Nelson, Saunders & Landsman, 1993). What do the current proportions look like compared to what was observed 20 years ago, and what are the differences at the various decision points? Based on the perspective of child welfare workers, what factors may account for why differences exist and what are possible solutions, if disproportionality exists? The objectives for the current investigation are to examine the extent of racial disproportionality and the degree to which race is related to likelihood of investigation and service provision. A second objective is to explore the perceptions of those working with families about the extent of and reasons for disproportionality.

# Methodology

This study used a mixed methods approach consisting of: (1) analysis of data on a random sample of 460 children referred to CYF in 2006; (2) in-depth qualitative interviews with child welfare agency caseworkers, supervisors and directors. Institutional Review Board (IRB) approval was obtained from the University of Pittsburgh IRB.

Limitations of this study include incomplete field (case record) data on 84 cases: there was no way to ascertain if these cases were different from cases that were complete. Several of the field data measures, particularly ratings of risk and maltreatment types reported, were biased in one or another category. For example, there were high numbers of "evaluation request" listed as the reason for referral. Administrative data do not have the same level of precision as data collected for research purposes. Therefore random or systematic measurement error could impact the findings. Also, while the findings on biracial children are notable, they are based on a relatively small number of children.

## QUANTITATIVE STUDY DESIGN

A random sample of children was selected from the population of children referred to CYF in 2006. Because the family is the unit of analysis for CYF, and children are nested within sib-ships, all of the children in the family referred as well as the target child were included in the population number of 19,963. Youth older than 18, those with duplicate reports, those whose report was not in Pennsylvania and those who were not the target child of the report were then eliminated, resulting in a preliminary sampling frame of 7,846 children and youth, ages 0 to 17.

In order to obtain a representative sample of the population, a stratified sampling design was chosen. Strata were defined by the gender, race, age group and type of report: Child Protective Services (CPS) or General Protective Service (GPS). Variables related to these strata were missing for 354 children, resulting in a final sampling frame of 7,495 unique children who were the target of a referral in 2006.

The required sample size of 520 was then allocated across the strata using proportional allocation, where the sample size within a stratum is assigned proportional to the stratum size. The required sample size in each stratum was rounded up to the next highest integer or if the calculated sample size for a stratum was less than two, a sample size of two was used, resulting in a final targeted sample size of 544 children. The survey select procedure in SAS version 9.1 was used to randomly sample the children (using simple random sampling without replacement) within each stratum.

# Methodology

Tabulation of the sampled records following field data collection (on risk assessments) revealed several strata with an insufficient number of observations (less than two). These strata were collapsed by age category to increase the number of sampled records. The sample weights were then calculated for each sampled child. The base weight is the total number of children per stratum divided by the required sample size per stratum, or the inverse of the child's probability of selection. The final weight, which adjusts for the number of respondents, is the total number of children per stratum divided by the number of children actually sampled per stratum. The final weight is used in subsequent analyses. In the analyses, data on the final sample size of 460 are weighted to infer to the population of 7,495. See Appendix A for population and sampling frame.

**Data Collection**

Data sources consisted of: administrative and demographic data collected at the time of the referral per a database held by the county; and referral, intake and risk assessment information collected from case files. Because the referral and intake information and risk matrices were not included in the administrative data files, the case records on the 544 children in the sample were requested and each record was examined by either the two Principal Investigators or the two research assistants. Both research assistants were supervised by the Principal Investigators in order to assure consistency in data collection. Data collection occurred between May and October 2008 at each of the CYF regional offices and at Central Intake (Lexington). Data were missing or unable to be located (primarily risk matrices or referral) in 84 records so that the total number of complete child records was 460. These data were checked for accuracy and then merged with the administrative data so that a complete data set (demographics, referral, intake and risk) was created.

The Disproportionality Index (DI) is calculated as follows:

1. A rate per 1,000 children is computed for each racial group at each service point (referral, investigation, and service). This is the number of African-American children, for example, referred to CYF divided by the total number of African-American children in the population under age 18 in Allegheny County according to the 2006 American Community Survey through the U.S. Census.
2. Rates are then compared in relation to white children. The rate for African-American children is divided by the rate for white children.

Next, children were described according to referral and risk assessment characteristics, in relation to race, likelihood of being investigated and likelihood of case opening. Descriptive, bivariate and multivariate analyses were used. Intake characteristics included child age and gender, number of adults on current referral, number of children on the referral, maltreatment type, prior CYF history, prior ChildLine reports and overall risk-rating on the referral.

The fields were taken directly from the referral form (Form 200). Risk assessment characteristics included the 15 individual and two summary items on the risk assessment matrix, Form 210.

Rates of investigation and service opening were viewed using bivariate chi-square tests of association, and multivariate, logistic regression analyses to predict the likelihood of case investigation and subsequent service receipt, given child race, and other child and family characteristics. For all analyses, sampling weights were used to infer to the total population of children who were the target of a referral to CYF in 2006. Throughout this report, we use the term "referral" to mean children who were the target of a referral, rather than children who may have been referred, but not the target child.

## QUALITATIVE STUDY DESIGN

Several methods were used to recruit workers to participate in the study. A letter describing the study and requesting volunteers was first e-mailed to caseworkers, supervisors and directors. Following this, a snowball approach was used in which interviewed participants recommended other colleagues as possible participants. In total, 16 workers responded and were contacted with 11 completing an interview. Approval for the study was obtained from the University of Pittsburgh Institutional Review Board for all study protocols and informed consent was obtained from each participant.

### Participant Selection

The participants were primarily white (73 percent or eight individuals) and female (73 percent). This was an experienced group, having an average of six years experience in their current position; two individuals had over 10 years experience in child welfare. An attempt was made to interview individuals from all parts of the service pathway. As a result, the positions held by the interviewees included regional director (2), family services supervisors (2), intake supervisor (1), caseworkers from foster care, independent living and family support services (3), intake workers (2) and family group advocate (1). Over one-half of those interviewed had a Master's Degree in Social Work, three had Bachelor's or Associate degrees and one individual held a doctorate in social work.

# Methodology

**Interviews**

All interviews were conducted in the regional CYF offices by one of the Principal Investigators (PIs) and lasted approximately 60 to 90 minutes. The interviews followed a semi-structured format of open-ended questions exploring their perceptions of how they obtained information, made decisions and what role race plays in their decisions. All interviews were recorded, reviewed by the PI and then a trained transcriptionist created verbatim transcripts of the interviews. The transcripts were read repeatedly by the PI and a doctoral student who is an experienced qualitative researcher. This approach of multiple readings was without the use of list of codes (Miles & Huberman, 1994). A descriptive coding scheme was developed using a constant comparative process in which the codes were examined for meaning, identity and similarity or dissimilarity with others. The transcripts and codes were entered into Nvivo, a qualitative analysis application to assist in organization and analysis. Dependability was established by a reflexive journal and an audit trail including relevant records, memos and documentation of the research process. Validity was examined by comparing categories with the extant literature of this subject.

## Data Analysis

### DESCRIPTION OF THE SAMPLE AND DISPROPORTIONALITY RATES AND INDICES

Disproportionality rates were viewed at children's referral to CYF, investigation and CYF service receipt (case opening). Disproportionality indices were computed for each racial group of sufficient size involved with Allegheny County CYF, which included African-American (n=163; 37 percent), white (n=237; 51 percent), and biracial (n=56; 12 percent) children. Four children were other race/ethnicities and were not included in the analyses. The racial composition of children in the County is predominantly white (77 percent), African-American (18 percent), and biracial (2 percent). Overall, the mean age of children referred was 8.8 years; 28 percent were ages 0 to 4 years, 26 percent were ages 5 to 9 years, 27 percent were ages 10 to 14 years, and 19 percent were ages 15 to 17. One-half of children referred are male (50 percent). Disparate rates of referral were observed for African-American and biracial children and youth.

Figure 1 shows the proportion of children who were the target of a CYF referral in 2006 according to child race. African-American children represented 37 percent of children referred to CYF, but just 18 percent of the total population of children in Allegheny County in 2006 (KidsCount, Profile for Allegheny County). Clearly, African-American children are disproportionately referred to CYF, at a rate that is two times their rate of representation in the child population. White children are referred at lower rates than their representation in the population. Just over half (51 percent) of children referred to CYF in 2006 were white, while their representation in the population is 77 percent. The most disproportionate rates of referrals are among biracial children, who are just two percent of Allegheny County's child population, but 12 percent of children referred to CYF.

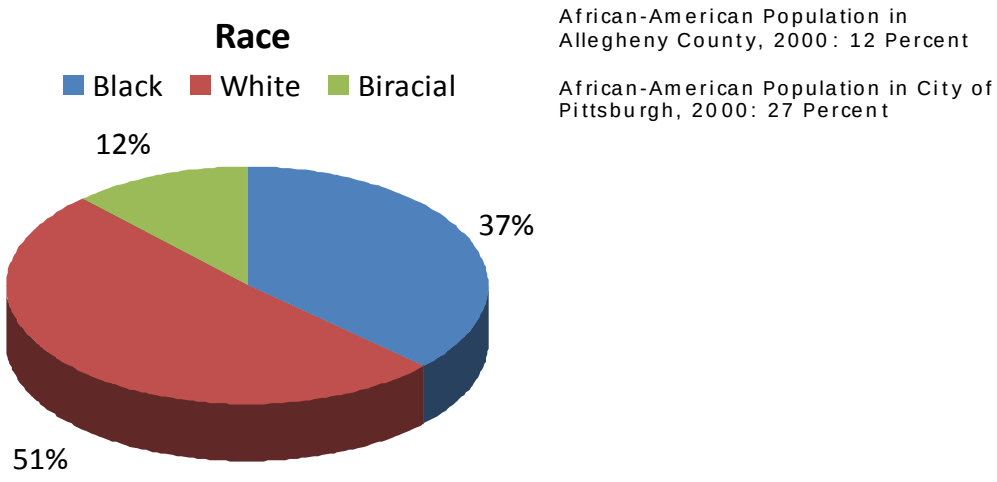


*Figure 1: CYF Referrals by Race (2006)*

## Data Analysis

Figures 2 through 4 further illustrate children's rate of referral to CYF according to population size and race and show rates of investigation and services after the referral. As shown in Figure 2, there were 46,689 African-American children in Allegheny County in 2006, of which 2,745 were referred to CYF (6 percent). Of the 2,745 referred, 1,855 were investigated (68 percent), and of these children, 1,378 were provided services (74 percent).

In comparison, 2 percent of Allegheny County's white children and 8 percent of Allegheny County's biracial children were referred to CYF in 2006. White children have similar rates of investigation (65 percent) and services (72 percent) compared with African-American children, while biracial children have the highest rates of investigation (73 percent) and lowest rates of service (61 percent).

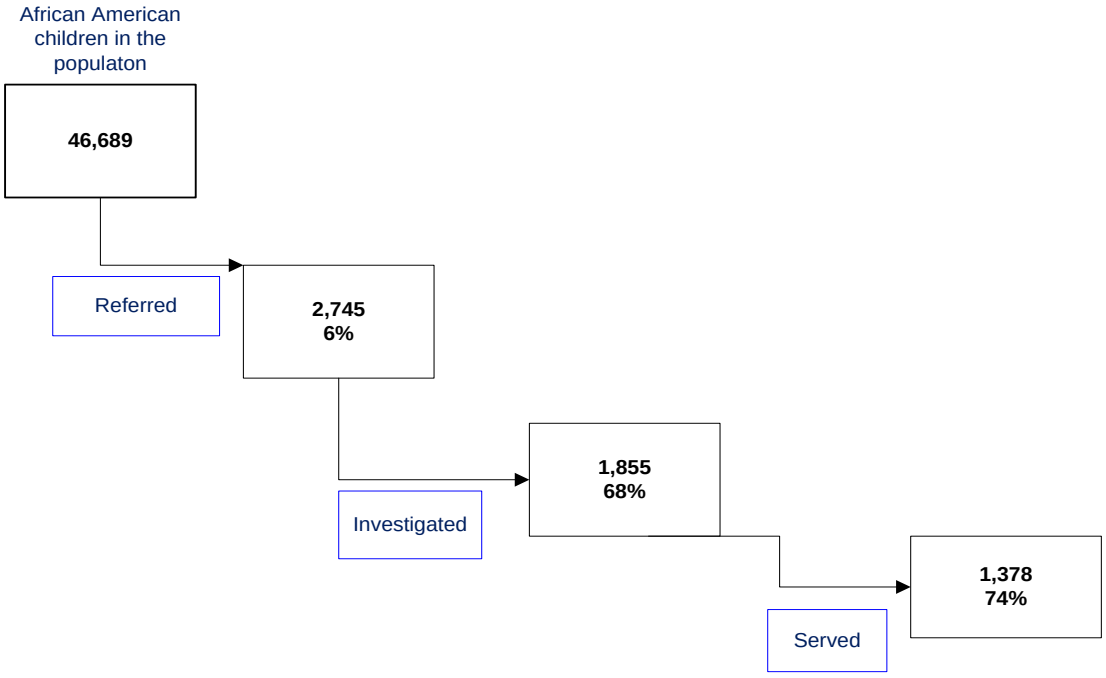


*Figure 2: Proportion of African-American Children Referred, Investigated and Served in 2006*

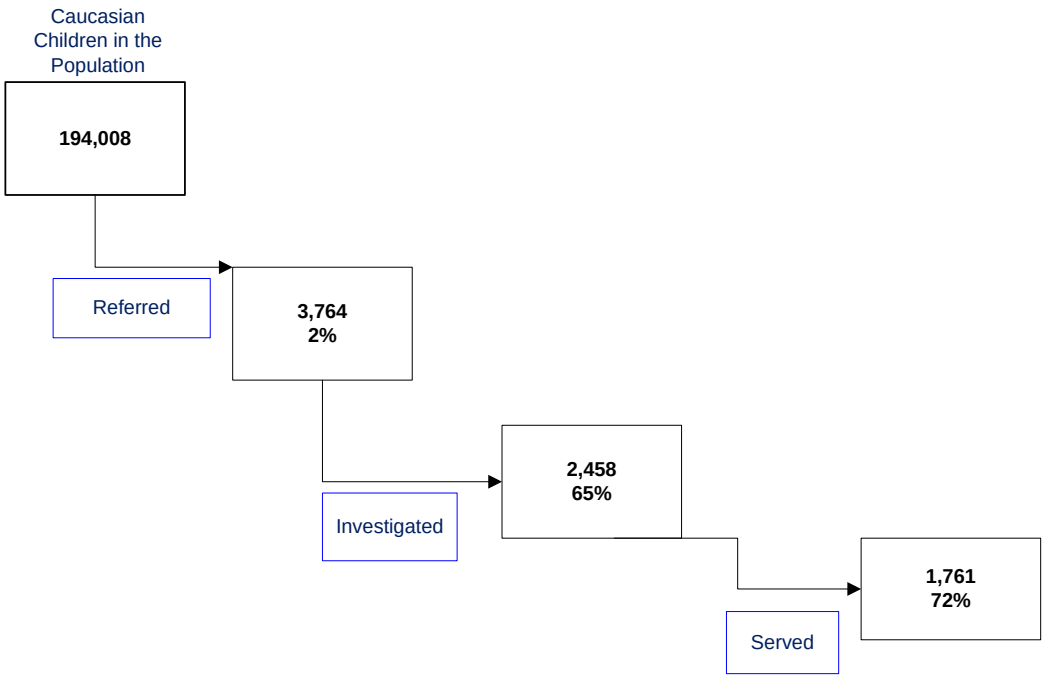


*Figure 3: Proportion of White Children Referred, Investigated and Served in 2006*

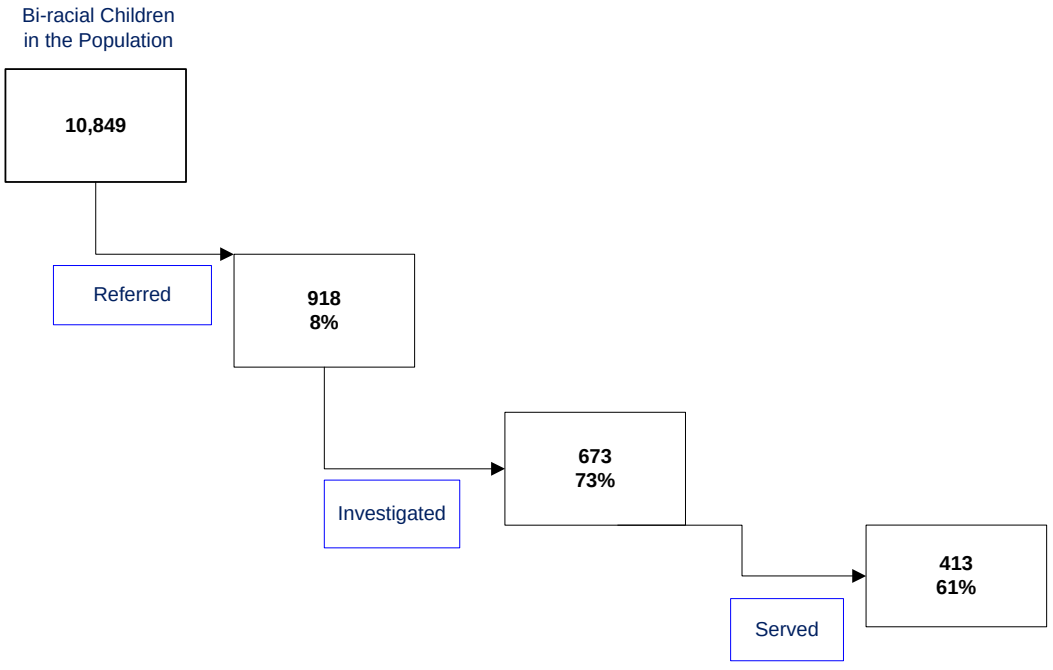


*Figure 4: Proportion of Biracial Children Referred, Investigated and Served in 2006*

## Data Analysis

A disproportionality index was computed for African-American and biracial children compared with white children at each stage (Table A). First, referral, investigation and service rates per 1,000 children were computed for each racial group. This is the number of children referred over the total number of children in the population * 1,000. For African-American children, this is (2,746/46,689) * 1000 = 58.79. (46,689 is the child census for Allegheny County, 2006). The referral rates for white and biracial children, respectively, using this same formula are 19.40 and 84.62. Next, rates for African-American and biracial children were compared to white children. This is the rate for African-American (or biracial) children divided by the rate for white children. For African-American children at referral, this is 58.79/19.40 = 3.03. The indices were also computed for rates of investigation and services, using weighted data.

| Child Race | Rate Compared to White Children | | |
|---|---|---|---|
| | African-American | White | Biracial |
| Referred | 3.03 | 1.00 | 4.36 |
| Investigated | 1.03 | 1.00 | 1.12 |
| Served | 1.04 | 1.00 | 0.86 |

*Table A: Disproportionality Index*

### DO REFERRAL AND RISK ASSESSMENT CHARACTERISTICS VARY ACCORDING TO A CHILD'S RACE?

We wanted to know whether African-American, white and biracial children differ according to their characteristics at CYF referral and case investigation (risk assessment), since decisions to refer a family to CYF or provide services may hinge on differing needs of families according to race. At referral, according to data from "Form 200" that is taken during the call to CYF, families were significantly different ($p \leq .05$) according to race by child age, caregiver age, number of children listed at referral, and prior reports to CYF. Assessed risk also differed by race, with African-American families deemed at risk due to prior maltreatment reports and biracial children at risk due to caregiver factors.

When a call is received, a reason for referral is assigned by the call screener. The proportions by category were 57 percent evaluation request; 19 percent other; 14 percent neglect; 10 percent physical or sexual abuse. When the "evaluation request" was further investigated (see Appendix B for Description Evaluation Types), 40 percent of the reasons for reporting to CYF were substance abuse related or due to physical neglect (33 percent) and supervisory neglect (24 percent). As shown in Figure 5, biracial children are significantly younger at the time of the referral compared with other children. Well over one-third of biracial children (38 percent) are younger than age five, compared with 24 percent of African-American children and 28 percent of white children.

## Data Analysis

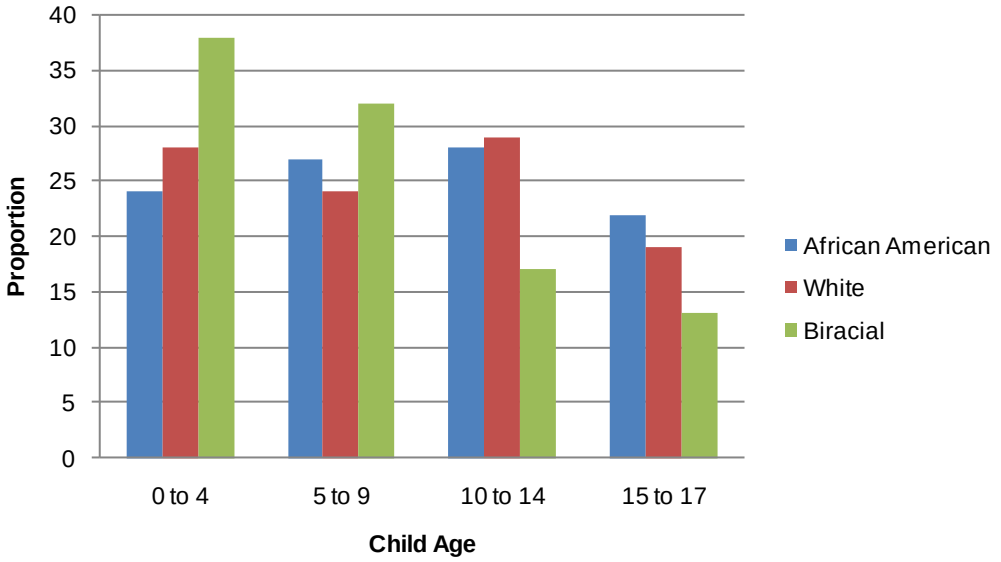


*Figure 5: Age of Children at CYF Referral According to Child Race/Ethnicity*

Figure 6 illustrates that African-American children are referred to CYF with a significantly greater number of other children listed at intake compared with white and biracial children. Over one-third of African-American children are referred to CYF with four or more other children (39 percent) compared with 20 percent of white children and 25 percent of biracial children. Biracial children have the highest rates of having a teenage parent (11 percent), while African-American families have the highest rates of previous referrals to CYF (69 percent) compared with 58 percent of white children and 49 percent of biracial children. No other referral characteristics varied significantly according to child race, including gender, number of adults at intake, child public assistance history, maltreatment type, ChildLine referral and risk rating.

## Data Analysis

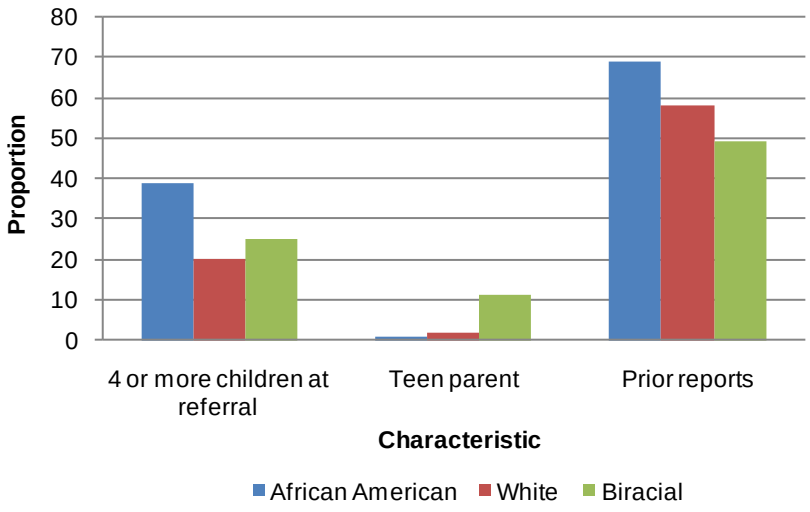


*Figure 6: Significant Differences in Referral Characteristics by Child Race*

At the stage of investigation a risk assessment is done (Appendix C). The risk assessment used by Pennsylvania is a consensus-based measure of risk in which the worker assigns a ranking score of low, moderate or high risk to the following factors: child factors, caregiver factors and family factors. A score is also assigned to the overall severity and overall risk. Within each factor are sub-factors which are rated. For example, child factors include vulnerability, severity and recency of abuse/neglect, prior abuse or neglect, and emotional harm. The vulnerability factor includes the child's ability to care for him/herself. Younger age increases vulnerability, although certain conditions such as developmental delays or serious chronic illnesses would increase vulnerability risk at any age (Appendix C). Workers are trained in risk assessment using a standard curriculum and must receive a passing score in using it to assess risk in a video vignette. Workers who do not achieve a passing score receive remedial training.

Taken as a group (n=454), a relatively small proportion of the cases were rated as high risk (2 percent), compared to moderate (54 percent) and low (44 percent). It is unclear whether this is a true representation of the risks of the population, or whether it is due to differences in raters or agency culture that impacts how workers use the risk assessment. It may be the result of a measurement problem with the risk assessment. In the subsequent analyses, moderate and high-risk ratings were combined. As seen in Table B, the most frequently rated moderate-to-high risk factors for all children were child vulnerability (65 percent), caregiver impairment (43 percent) and access to children (37 percent). The least common moderate-to-high risk factors were emotional harm (4 percent), home condition (8 percent) and family supports (10 percent). Child vulnerability is highly correlated with child age, suggesting that this risk is primarily an indicator of younger child age.

## Data Analysis

Table B also shows the proportion of children rated with moderate or high risk for each risk assessment item by race. A significantly higher proportion of biracial children (64 percent) are rated as having moderate to high risk with reference to caregiver factors of age, physical, intellectual and emotional status, compared with African-American (44 percent) and white children (37 percent). Parents of biracial children had the highest rates of moderate to high-risk parenting skills and knowledge (36 percent) compared with 22 percent of African-American and 15 percent of white children. African-American children have the highest rates of moderate to high-risk ratings regarding previous abuse or neglect (33 percent) compared with 13 percent of white children, and 20 percent of biracial children. No other risk assessment characteristics varied significantly by child race.

| Risk Assessment Domain | % Moderate or High Risk | | | |
|---|---|---|---|---|
| **Child factors** | African American (n=98) | White (n=142) | Biracial (n=38) | Total (n=278) |
| Vulnerability | 61 | 68 | 74 | 65 |
| Severity/recency of abuse or neglect | 11 | 12 | 9 | 11 |
| Prior abuse or neglect | 16 | 11 | 12 | 13 |
| Emotional harm | 3 | 6 | 0 | 4 |
| **Caregiver factors** | | | | |
| Age, physical, intellectual or emotional status[a] | 44 | 37 | 64 | 43 |
| Cooperation | 15 | 19 | 9 | 16 |
| Parenting skills/knowledge[a] | 22 | 15 | 36 | 20 |
| Substance abuse | 16 | 20 | 32 | 20 |
| Access to children | 43 | 34 | 38 | 37 |
| Prior abuse or neglect[a] | 33 | 13 | 20 | 20 |
| Relationship with child | 14 | 8 | 15 | 12 |
| **Family** | | | | |
| Family violence | 22 | 25 | 28 | 24 |
| Home condition | 10 | 7 | 3 | 8 |
| Family supports | 9 | 12 | 10 | 10 |
| Stress | 39 | 29 | 34 | 33 |
| Overall severity | 12 | 15 | 24 | 15 |
| Overall risk | 33 | 31 | 40 | 33 |

*Table B: Proportion of Children with Moderate or High Ratings on Risk Assessment Domains by Child Race*

*Note:* Analyses are weighted. The total sample n is 460, which represents 7,495 children. Of the 460 children referred, 309 were investigated. 31 children were missing risk assessments. [a]Significantly related to child race/ethnicity in bivariate analyses ($p \leq .05$).

## Data Analysis

**Summary of Referral and Risk Assessment Characteristics by Child Race**

We wanted to know whether African-American, white and biracial children differ according to their characteristics at CYF referral and assessed risk. At referral, according to data from the "Form 200," families were significantly different ($p \leq .05$) according to race by child age, caregiver age, number of children listed at referral and prior reports to CYF. Assessed risk also differed by race, with African-American families deemed at risk due to prior maltreatment reports and biracial children at risk due to caregiver factors.

### WHAT CHARACTERISTICS PREDICT INVESTIGATION AND SERVICES?

Data obtained from the referral (Form 200) was further used in a set of bivariate analyses on intake characteristics, investigation, and services (Table C). The total sample (n) is 460 which represent the population of 7,495 children. Of the 460 sample children, 309 were investigated (67 percent), of which 220 were subsequently opened for services (71 percent of those investigated). Younger child age, two adults listed at intake, low income (as measured by the child's history of public assistance) and a moderate or high risk score on the current referral were significantly related to investigation ($p \leq .05$). Prior reports to CYF were significantly related to services ($p \leq .05$).

Multivariate analyses of predictors of investigation using logistic regression found that referrals on children younger than age four were approximately three times more likely to be investigated (OR=3.544, $p \leq .05$). Child race significantly predicted case investigation, with African-American children less likely to be investigated compared with white children (OR=.70, $p \leq .05$). Biracial children were twice as likely to be investigated compared with white children (OR=2.27, $p \leq .05$). Children referred to CYF along with four or more other children were more likely to be investigated (OR=3.13; $p \leq .05$), as were children with two adults listed at referral (OR=4.66, $p \leq .001$). Children living in poverty, measured by the child having a history of receiving Temporary Assistance for Needy Families (TANF), were twice as likely to be investigated compared with children who did not have a history of public assistance (OR=1.99, $p \leq .05$). Finally, compared with referral allegations of "other," children whose allegation was "evaluation request" were significantly less likely to be investigated. In relation to service receipt, results show that children with moderate to high overall risk were over twice as likely to receive services compared with children with no or low overall risk (OR=2.68, $p \leq .05$).

| Characteristic | Total % (n=460) | % Investigated (n=460) | % Served (n=309) |
|---|---|---|---|
| Child age[a] | | | |
| 0 to 4 years | 28 | 72 | 66 |
| 5 to 9 years | 26 | 62 | 71 |
| 10 to 14 years | 27 | 67 | 75 |
| 15 to 17 years | 19 | 66 | 76 |
| Child gender | | | |
| Female | 50 | 68 | 71 |
| Male | 50 | 66 | 72 |
| Child race/ethnicity | | | |
| Black | 37 | 68 | 74 |
| White | 51 | 65 | 72 |
| Biracial | 12 | 73 | 61 |
| No. of children at intake | | | |
| 1 | 20 | 61 | 62 |
| 2 to 3 | 52 | 65 | 75 |
| 4 or more | 28 | 75 | 70 |
| No. of adults at intake[a] | | | |
| 1 | 5 | 48 | 81 |
| 2 | 67 | 82 | 69 |
| 3 or more | 28 | 33 | 80 |
| Caregiver age | | | |
| <20 years | 3 | 54 | 77 |
| 20 to 29 | 33 | 69 | 65 |
| 30 to 39 | 43 | 68 | 74 |
| 40 and older | 22 | 69 | 75 |
| Child Public Assistance (since 7/2002)[a] | | | |
| No | 56 | 62 | 69 |
| Yes | 44 | 72 | 74 |
| Report risk rating[a] | | | |
| No or Low | 44 | 27 | 80 |
| Moderate or High | 56 | 98 | 70 |
| Maltreatment type[ab] | | | |
| Physical or Sexual abuse | 10 | 84 | 52 |
| Neglect | 14 | 78 | 71 |
| Evaluation request | 57 | 53 | 68 |
| Other | 19 | 84 | 84 |
| Prior reports or CYF[b] | | | |
| No | 40 | 62 | 66 |
| Yes | 60 | 69 | 76 |
| Regional office[ab] | | | |
| Lexington | 48 | 43 | 60 |
| Not Lexington | 52 | 88 | 76 |
| Referral Type | | | |
| Not ChildLine | 91 | 66 | 70 |
| ChildLine | 9 | 76 | 83 |
| Total | 100 | 67 | 71 |

*Table C: Proportion of Children Investigated and Served According to Characteristics of the Referral and Results of Bivariate Analyses*

*Notes.* Analyses are weighted. The total sample n is 460, which represents 7,495 children. Of the 460 children referred, 309 were investigated, of which 220 were served. Maltreatment type was analyzed for children with one type reported only (n=378). [a]Significantly related to investigation $p \leq .05$ [b]Significantly related to services $p \leq .05$

## Data Analysis

Maltreatment type listed on the referral was significantly related to both investigation and services. Physical and sexual abuse and "other" maltreatment types were associated with investigation. Neglect and other maltreatment types were associated with service. It is important to note that in the maltreatment category on the referral, "evaluation request" was used in more than one-half of the referrals in the sampled records. Subsequent re-analysis of this category found that "evaluation request" included a myriad of reasons for referral (see Appendix B for the additional categories). Since it is neither mutually exclusive nor exhaustive, the "evaluation request" category is not a good predictor of investigation or service. Finally, the location of the office (not Lexington) was associated with both investigation and service.

| Item | Proportion of Children Opened for Services According to Each Item | |
|---|---|---|
| **Child factors** | **No or Low Risk** | **Moderate or High Risk** |
| Vulnerability[a] | 79 | 67 |
| Severity/recency of abuse or neglect | 70 | 77 |
| Prior abuse or neglect[a] | 69 | 88 |
| Emotional harm | 70 | 91 |
| **Caregiver factors** | | |
| Age, physical, intellectual or emotional status | 68 | 76 |
| Cooperation[a] | 67 | 89 |
| Parenting skills/knowledge[a] | 67 | 86 |
| Substance abuse[a] | 68 | 82 |
| Access to children | 72 | 68 |
| Prior abuse or neglect | 69 | 78 |
| Relationship with child[a] | 68 | 94 |
| **Family** | | |
| Family violence | 72 | 67 |
| Home condition | 71 | 72 |
| Family supports | 69 | 82 |
| Stress[a] | 65 | 83 |
| Overall severity | 69 | 78 |
| Overall risk[a] | 61 | 89 |

*Table D: Results of Bivariate Analyses of the Proportion of Children Opened for Services According to Risk Assessment Ratings on Each Individual Item and Overall Severity and Risk*

## Data Analysis

Table D presents the results of bivariate analysis of risk assessment characteristics and the proportion of children opened for services. You would expect to see that being rated at high or moderate risk on a child, caregiver or family factor would associate with being opened for services from CYF. Indeed, a significant finding did develop for cases rated as moderate or high overall risk, 89 percent were opened for service, compared with 61 percent of cases rated no or low risk ($p \leq .05$). However, overall severity was not significantly related to case opening in bivariate analyses. Also significantly associated with case opening were moderate to high risk-ratings of: prior abuse or neglect, caregiver cooperativeness, parenting skills and knowledge, substance abuse, relationship with child and family stress. No- or low-risk rating on child vulnerability was significantly associated with a case opening.

**Predictors of Investigation (Multivariate Analysis)**

The bivariate analyses give some indication of what may be predictors of investigation and services. In logistic regression, odds ratios estimate the probability of a given outcome for different groups while controlling for other potential predictors. For example, if males and females are being compared on an outcome and the odds ratio is greater than one for females, then females are more likely to have the outcome than the males. If the odds ratio is less than one, then the outcome is less likely for females. Table E displays the results of logistic regression analyses predicting case investigation according to intake (referral) characteristics.

| Independent variable *(reference group)* | Odds of Investigation | β | SE(β) |
|---|---|---|---|
| Child Age (15 to 17 years) | | | |
| 0 to 4 years | 3.44* | .64 | 0.3 |
| 5 to 9 years | 1.59 | -0.13 | 0.23 |
| 10 to 14 years | 1.99 | .09 | 0.25 |
| Child Gender (Female) | | | |
| Male | 1.12 | .06 | 0.14 |
| Child Race/ethnicity (White) | | | |
| Black | .70* | -0.51 | 0.23 |
| Biracial | 2.27* | 0.67 | 0.3 |
| No of children at intake (One) | | | |
| Two to three | 1.84 | 0.03 | 0.19 |
| Four or more | 3.13* | 0.56 | 0.24 |
| No of adults at intake (One) | | | |
| Two | 4.66*** | 1.36 | 0.25 |
| Three or more | 0.36*** | -1.19 | 0.28 |
| Child TANF since 7/02 (No) | | | |
| Yes | 1.99* | 0.34 | 0.15 |
| Referral reason (Other) | | | |
| Physical or Sexual abuse | 0.58 | 0.46 | 0.44 |
| Neglect | 0.28 | -0.28 | 0.39 |
| Evaluation request | 0.11*** | -1.19 | 0.25 |
| Prior reports or CYF (No) | | | |
| Yes | 1.40 | 0.17 | 0.16 |
| Referral Type (Not ChildLine) | | | |
| ChildLine | 2.00 | 0.35 | 0.19 |

*Table E: Results of Logistic Regression Analyses Predicting Case Investigation*

*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

## Data Analysis

Results show that referrals on children younger than age four were approximately three times more likely to be investigated (OR=3.544, $p \leq .05$). Child race significantly predicted case investigation, with African-American children less likely to be investigated compared with white children (OR=.70, $p \leq .05$). Biracial children were twice as likely to be investigated compared with white children (OR=2.27, $p \leq .05$). Children referred to CYF along with four or more other children were more likely to be investigated (OR=3.13; $p \leq .05$), as were children with two adults listed at referral (OR=4.66, $p \leq .001$). When there were three or more adults in the household, the case was less likely to be investigated. Children living in poverty, measured by the child having a history of receiving TANF, were twice as likely to be investigated compared with children who did not have a history of public assistance (OR=1.99, $p \leq .05$). Finally, compared with referral allegations of "other," children whose allegation was "evaluation request" were significantly less likely to be investigated (OR=.11, $p \leq .001$). Allegations of "other" were the most likely to be investigated, when all factors are considered. These include acting out or youth with mental health problems, truancy, positive maternal substance use, emotional maltreatment, and homelessness. In this analysis, the type of referral, GPS or ChildLine, was not a significant predictor.

**Predictors of Service (Multivariate Analysis)**

Characteristics that were significantly related to services in bivariate tests were further used in logistic regression analyses predicting services, considering all other factors. Correlational analyses showed that many of the risk assessment items are highly correlated with each other; for example, caregivers rated with substance abuse problems were also frequently rated with parenting skills problems. This means that including them in the same predictive model is not advised. To remedy this, a variable was created to measure the total number of risk items that were rated as "moderate to high risk" for each child ("cumulative risk"). Table F illustrates the proportion of children with differing levels of cumulative risk. Bivariate, chi-square analyses showed that children did not vary significantly according to the numbers of risk factors rated as moderate or high according to their race. In total, 16 percent of children did not have any risk assessment items rated moderate or high, 38 percent had one to two items rated moderate or high, 36 percent had three to five items rated moderate or high, and 10 percent had six or more items rated moderate or high.

## Data Analysis

| Number of Risk Items Rated Moderate or High Risk | Child Race/Ethnicity | | | Total |
|---|---|---|---|---|
| | African-American (n=100) | White (n=143) | Biracial (n=37) | (n=280) |
| None | 15 | 18 | 13 | 16 |
| 1 to 2 | 33 | 43 | 29 | 38 |
| 3 to 5 | 40 | 31 | 46 | 36 |
| 6 or more | 11 | 8 | 12 | 10 |

*Table F: Cumulative Risk at the Time of the Investigation by Child Race/Ethnicity*

*Note.* The first risk assessment item, child vulnerability, is excluded from the cumulative risk variable, since it is nearly synonymous with child age.

Table G presents the results of two logistic regression analyses predicting services. Both analyses include predictor variables of child demographic characteristics, maltreatment type and prior reports. Model 1 includes cumulative risk, while Model 2 includes overall risk, as rated by caseworkers in the last item on Form 210.

| Case Characteristic *(reference group)* | Model 1 (n=210) | | | Model 2 (n=217) | | |
|---|---|---|---|---|---|---|
| | Odds of case opening | Beta | SE | Odds of case opening | Beta | SE |
| Child age *(15 to 17 years)* | | | | | | |
| 0 to 4 years | .54 | -.18 | .26 | .56 | -.19 | .27 |
| 5 to 9 years | .64 | -.01 | .30 | .66 | -.03 | .29 |
| 10 to 14 years | .51 | -.24 | .29 | .58 | -.17 | .29 |
| Child gender *(Female)* | | | | | | |
| Male | 1.11 | .05 | .17 | .97 | -.01 | .16 |
| Child race/ethnicity *(White)* | | | | | | |
| Black | 1.00 | .14 | .25 | 1.06 | .18 | .25 |
| Biracial | .65 | -.29 | .29 | .65 | -.31 | .30 |
| Prior reports to CYF *(No)* | | | | | | |
| Yes | 1.70 | .27 | .17 | 1.79 | .29 | .17 |
| Referral reason *(Other)* | | | | | | |
| Physical or Sexual abuse | .25* | -.72 | .35 | .30* | -.68 | .34 |
| Neglect | .54 | .05 | .32 | .66 | .10 | .32 |
| Evaluation request | .52 | .00 | .23 | .63 | .06 | .23 |
| No. of risk items rated moderate to high *(None)* | | | | --- | | |
| 1 to 2 (Low cumulative risk) | .52* | -.71 | .28 | | | |
| 3 to 5 (Moderate) | 1.33 | .23 | .29 | | | |
| 6 or more (High) | 1.79 | .53 | .55 | | | |
| Moderate to high overall risk | -- | -- | -- | 2.68* | .49 | .19 |

*Table G: Results of Logistic Regression Analyses Predicting CYF Services*

*$p \leq .05$. **$p \leq .01$. ***$p \leq .001$.

Results show that children with moderate to high overall risk were over twice as likely to receive services compared with children with no or low overall risk (OR=2.68, $p \leq .05$). Children referred for physical or sexual abuse were significantly less likely to receive services compared with children referred for "other" maltreatment types (OR=.25 and OR=.30, $p \leq .05$). In Model 1, children with lower levels of cumulative risk (1 to 2 items rated moderate or high) were significantly less likely to receive services compared with children with no items rated moderate or high risk (OR=.52, $p \leq .05$). Younger age, which was a statistically significant predictor of investigation, was not found to be a predictor of service receipt. However, the overall risk factor score includes vulnerability, which takes into account child age.

In summary, the multivariate results give a picture of the factors that predict who is opened for investigation and served. Younger age, biracial children, households with more children, lower income and two adults living in the home are more likely to be investigated. There were fewer significant predictors of which families receive services, although receiving a moderate to high risk assessment score increased the odds of the family being opened for services.

## SYNTHESIS OF QUALITATIVE AND QUANTITATIVE FINDINGS

**What is the extent of racial disproportionality at referral, investigation and service provision?**

African-American families in Allegheny County are referred in greater numbers and at a rate disproportionate to their proportion in the population. Biracial families were referred at higher rates than either African-American or white families.

The finding of referral disparity was for African-American families supported by the qualitative findings. Those interviewed gave many examples of other systems over-referring to CYF and the potential reasons for this pattern. In this example, a supervisor talks about a case in which the evidence of abuse substantiation was inconclusive but she felt that racial bias was a factor in the decision made by the judge. One theme that emerged was that of over-referral occurring due to bias in other systems.

- *And I swear if it was a black family, this kid would not have been returned. I don't know why I feel like that, but I do …And I will never forget, I had this judge say to me, these children don't look dependent. What does that mean? So I always think of when I have cases like that.*

Similarly:

- *We had a white male baby who was allegedly left somewhere. I believe the father -- the father's family came. The child was handed over to him. That's it. That's it. Take him home. That's it.*

Community professionals may also over-refer due to misunderstanding the role of CYF in providing community safety:

- *I'll never forget the one I got…So I finally got a hold of this kid's therapist and I'm like what's going on here. Why is this kid even -- why can't this kid go home when he's supposed to be with his mom? …You know, this kid can go home. And the therapist, no lie, said it's a bad environment for the kid. You know, community violence in the neighborhood. You know, what are you guys going to do to help this kid out. You know, you got to help this mother move. And I told her this kid's going to have to learn to duck and drop like the rest of the kids in this neighborhood.*

Community members may also contribute to over-representation at referral due to over-reporting within the community as a way of managing conflict.

- *Part of it is a lot of them know our system, meaning that if I (tick) you off, I'm going to call CYF because I know you have a kid and I know they'll come out and investigate it ….That's my little revenge against you.*

Another related reason for reporting bias may be due to how other systems interact with poor families. Individuals working in other systems such as education, law enforcement and medicine may attribute parental behaviors to be due to personal rather than situational causes. This is called an error of attribution and is illustrated in the following example in which a supervisor describes why the family of a child with a serious chronic illness is repeatedly re-referred to CYF by the hospital.

- *And she misses appointments, so the clinic would call and she'd go, she'd make them up, she's got Alliance for Infants, she's got support stability and dietician and other things that go with the stuff …So we closed it and the clinic called and said, well they missed this appointment and they missed this, and this is really serious and we think this little child is at risk……And in some ways, I don't know if they're necessarily picking on this family, but it's just kind of unfair to this family. I said, ok they have (transportation) , so they can get to their appointments, can you schedule them earlier, we don't always have those, well maybe you should make allowances given that's when this young mother can get the child there if that's what you want. Meanwhile, we encourage her, don't miss your appointments, and she says, well I always make them up. Do you see the importance? People are going to keep calling us (CYF) if you miss appointments. So we're going to close it out, but I'm sure if she misses another appointment or two, it'll come back up. And that's what happens. It just doesn't go away because the families that we have always do have these deficits, whether it's a health problem or the other things we talked about before. There's a lot going on, certainly poverty among them, it's a pretty common thread in anything here, even more common than race.*

Similarly, another supervisor observes:

- *I think we have to look at what's socially acceptable from that family's perspective. They may not have the resources to pay for a babysitter. The kids might get home at 3:00 and mom doesn't get home until 4:30. We're not going to penalize them because they don't have resources, but do they have a plan in place to make sure the kids are safe.*

As illustrated in the above examples, poverty and class are intertwined, and everyone interviewed discussed how difficult it is for other systems to tease out racial bias from class bias and how class impacts what you can access and how you are treated.

- *But, you know, those doctors are more, I think, they're more apt. I'm going to say they're more apt to call it in on low economic families than they are higher class families.*

- *That family I was talking about, with the Cystic Fibrosis was not an African-American family, but because of poverty, because of those things, they trust systems less, because that's who tend to turn around and find their most negative stuff and turn them in, so they tend to trust folks less. I think that's true with a lot of medicine, with a lot of doctors too. I've even felt that way when I've called on behalf of other people and I'm like, I'm sorry, do you talk to Mrs. Jones like this when she calls? And they're like, what are you talking about? And I'm just asking you a simple question and it doesn't sound like you have the time. But that's me of course, I tell my workers, don't do this! Why would you do that? I realize we all have tough days, but it leads to the problems. So you tend not to trust people, you tend to seek less care.*

All of the interviewees were consistent in the belief that being poor results in having fewer financial resources and less social capital on which to draw. This puts families at a disadvantage in dealing with systems as demonstrated in this comment about the causes of disproportionality:

- *Because they're poor, poverty plays a major role in everything. That example that I gave you of that young man, he just didn't have any money. If he had money, he would have been in a different situation…People have a hard time assisting people financially. That's why you have so many kids in placement. If you'd assist the families with those issues surrounding poverty, you wouldn't have to put their kids in placement.*

In answer to the question about the causes of disproportionality, an administrator noted:

- *Racism is a factor. I think poverty is a factor. I think drug addiction is a factor. Those are probably the three reasons why it's disproportionate.*

In addition to class and poverty, other factors identified as contributing to disproportionality at referral, include drugs, alcohol, mental health problems and limited knowledge of or access to treatment services.

- *Just anecdotally my feeling is access to resources and the other factors in terms of class and poverty and -- you know, class and poverty. When you look at the risk factors…would be, you know, the drug and alcohol issues, the mental health factors.*

- *What might also bring kids, both black and white children into child welfare is also their mothers primarily being mentally ill.*

- *Every time her mom comes back into the picture, my child, well, it's mom, so I don't take that away from her, but mom is very ill. There are some drug and alcohol issues and mental health issues going on as well as a long criminal history and makes really poor, impulsive decisions.*

- *If you have a family who is just not aware of the resources or doesn't know how to plug in to make more, you plug them in, they'll be fine. Like I said, you put the D&A component or mental health component, you can't force no one to get mental health treatment. I mean if they want to go and get the treatment and work on mental health issues, cool. Stabilize. Cool. If not, we may have to, you know, moderate or supervise. Make sure that that kid's going to be safe.*

Sometimes poverty, race and mental health substance abuse all together create situations so that it isn't clear if it one or all of these factors contribute to disproportionality. A mental health bias may be operating but the illness has the potential for noncompliance and relapse leading to a high-risk situation. In this example a caseworker describes a case in which a young, single, biracial mother with co-occurring bipolar illness and substance abuse was in danger of losing her parental rights.

- *Well, I think they just kind of looked at her as if she was unfit based on family history of mental health. Yes. And she was struggling so much for validation. Yes. They punished her. How are you going to take care of a kid? …The judge said this is not a case for SPLC nor adoption. Mother is somewhat being punished for mental health. Because she was in Western Psychiatric Institute and Clinic (WPIC) for three months, satisfying her goal of mental health. Unfortunately, she's in there. We did make arrangements for her daughter -- her three-year old daughter to go there and visit with her. I knew when I was making the recommendation that it was a risk. It's a risk. It's going to be long term, but she's still going to have her rights.*

Another example about race, class and disability and bias:

- *And it depends on the way the -- you know, it depends on the income and the status of the family because sometimes, you know, these kids, a lot of them may be coming from a drug addicted home…That they are really coming from that and, you know, that there is no support and the family really can't afford it. And sometimes the parent is nowhere to be found. They're not even there the day of the hearing. Or if they do come, you know, they haven't got representation so the hearing is continued. You know, following directions and being consistent with whatever it is. So that's a lot of time is the majority of the case, but then there -- it's just that they're already labeled sometimes before they even start.*

## Data Analysis

In response to questions about how race may impact their decisions, those interviewed consistently said that race was not a factor in their decisions; safety and risk were paramount. This comment is illustrative of this theme:

- *If the child has a burn, the child has a burn. Race doesn't matter. So if there is a burn that is indicative of abuse, it doesn't matter how much support this family has or how much money they have, if the story isn't consistent with the injury, we have to make sure that kid's safe…We're looking at is there physical abuse, is there sexual abuse, is there neglect that places that child in immediate danger? So we really can't go solely off of where this family comes from or how much money they have.*

And similar responses from two different intake workers:

- *But it really -- it doesn't really factor in. And the bottom line is, it's risk and safety.*

- *But personally as for decision making, it's kind of -- I don't see it. You know what I mean? If Mom's got a drug or alcohol problem and she's black, white, orange, yellow, I don't care. She's doing a drug and alcohol evaluation.*

Although the individuals who were interviewed did not feel that their decisions were based on race, they believed that a "funneling" effect was operating in that disproportionality increases at each decision point. A supervisor in family services said:

- *I think it'd be interesting to look at who comes in the front door and who comes out the other end towards us. But I would say that the majority of our clients are African-American much more than our community as a whole…I have 5 caseworkers and they each have 16-17 cases on their caseloads and I would say they only have about three to four white families at a time.*

Qualitative findings also supported younger age as a significant factor in predicting an investigation after referral. Age is a "Dominance Rule" because it dominates other facts when making a decision about safety and risk. This was due to the vulnerability of a smaller child as illustrated by this comment by an intake worker:

- *Small child can't fend for itself. Can't pick up a phone. Can't call nobody. Small child doesn't know to go to a neighbor or go to extended family. Small child, everything hinges on mom.*

- *Suppose you got kids, you know, seven, eight, nine, they know how to pick up a phone. They know extended family. They know next-door-neighbor. You got an infant, a couple months old, year old, maybe two, better safe than sorry.*

Although everyone believed that race did not play a role in their decisions, at least one person did acknowledge that while her decisions were based on safety and risk, there may be other unconscious factors that influence decision making:

- *But I wonder how often. I think about that a lot, how often we make those decisions when we aren't even conscious of it, because of the way they look or where they live.*

In summary, while the caseworkers, supervisors and directors interviewed for this study acknowledged that African-Americans are disproportionately involved in child protective services, they identified system bias as a major cause and felt that their decisions were based on safety and risk rather than race. The interviewees indicated that circumstances that are often experienced by African-American families, such as having a low income, living in an unsafe neighborhood, single parenting, lacking an education, using substances or having a serious mental illness were likely factors that make these families more vulnerable, increasing their visibility to systems such as child welfare. All of the interviewees felt that being poor and black were so intertwined that it was impossible to unravel them in order to determine which one caused black families to be disproportionately involved in the child welfare system.

In most respects, the data from the qualitative interviews support the finding of over-representation of African-Americans in referrals by other systems to CYF and investigation of families with younger children. What is most surprising, and absent from the analysis of the qualitative data is the quantitative finding of disproportionate referral and investigation of biracial families to CYF. This was mentioned only twice: once in describing a parent as biracial and a general comment describing the families in the McKeesport area. It was never mentioned as a factor in disparate referrals to CYF. While the assumption may be that these are "black families", in fact, they do not seem to be assessed at the same level of risk as black families, and they are more likely to be referred to CYF and investigated. The other notable discrepancy was that while some of the interviewees felt that a funneling effect was occurring, this was not observed in the quantitative findings.

## Conclusions & Recommendations

### DISPARITY IN CYF REFERRALS

Data from referrals and investigations at Allegheny County CYF in 2006 show a notable disparity concerning the rate at which African-American children are referred to CYF, rather than the rate at which children are investigated or served. African-American children are referred to CYF at three times the rate of white children, with little evidence to suggest that their level of risk or need for services is substantially different. This is evidenced by no significant difference in overall risk ratings at referral and investigation between African-American and white families, and few significant differences in ratings of particular types of risks, such as caregiver substance abuse and amount of family support. The only significant characteristics of African-American families according to these data are more frequent referrals to CYF, referrals involving more children and slightly higher rates of children having received public assistance, an indicator of poverty. Data also identified a disparity in that biracial children are referred to CYF at four times the rate of white children. Their risk assessments suggest higher risk due to caregiver factors, yet they are served at a slightly lower rate. Recommendations are directed to services and coordination that target factors contributing to disproportionality at the decision junctures at the start of the service pathway.

Biracial families also show notable disparity concerning the rate at which they are referred to CYF. In 2006, they were referred at four times the rate as white children, and the logistic regression analyses suggest that they are more likely to be investigated, even when controlling for other factors. Additional research using the population is needed in order to confirm and explore this finding in greater detail. Biracial families show unique needs compared with other families. They have the highest rates of young (teen) mothers, higher-risk parenting skills and caregiver impairments such as physical, emotional, and cognitive difficulties. An important question is whether biracial caregivers and families are uniquely at risk, or if this is a perception based on bias and stereotyping.

## Conclusions & Recommendations

There was no evidence in these data of a funneling effect for African-American children, where disproportionality increases at each decision point (Vandergrift, 2006). Rather, disproportionality for African-American children in Allegheny County, who represented 68 percent of children in foster care in 2008 (Pennsylvania Partnerships for Children, 2009), appears to be related to disparate rates of referral and more frequent re-referrals that involve more children compared with other families. This suggests a number of possibilities: (1) that foster care service decisions result in greater numbers of white children remaining at home compared with African-American children, (2) other services provided to African-American families are inadequate to resolve family difficulties and prevent children from entering foster care, and (3) that referral sources over-refer.

### COMMUNITY FACTORS AND REFERRAL DISPROPORTIONALITY

A thorough understanding of where disparities exist in the decision-making junctures is important to identify possible strategies to address it. It is clear that this is a complex problem, and that the response needs to be multi-faceted. However, Lemon, Andrade and Austin (2005) suggest that an agency maximize their resources by focusing their interventions on where the disparities seem to be occurring, and use several interventions that draw from different explanatory theories (p. 45). Based on the theory suggested by these data that poverty, system bias and community factors result in referral disproportionality, Allegheny County could use several interventions to target these problems (Figure 7). Interventions could be selected from each theory area targeting that decision point (Lemon, Andrade & Austin, 2005).

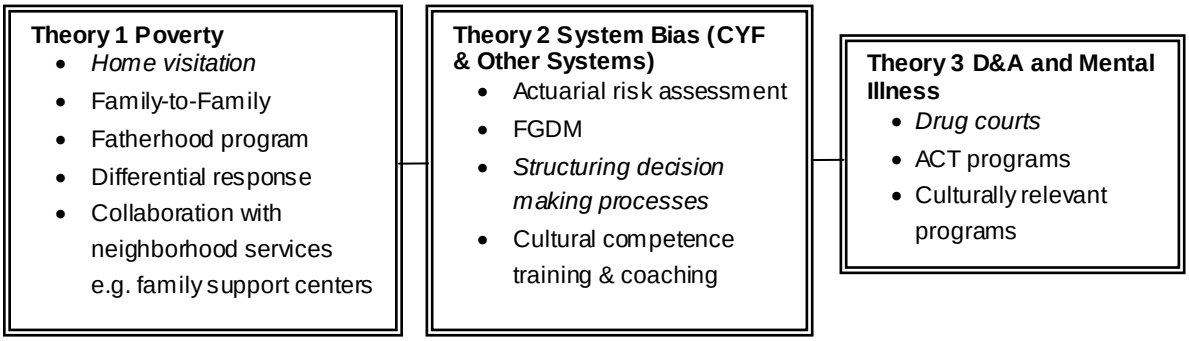


*Figure 7: Targeting Referral Disproportionality in Allegheny County (Lemon, Andrade & Austin, 2005)*

## Conclusions & Recommendations

**Poverty**

A recent study of poverty in Allegheny County found the poverty rates of African-Americans to be four times those for white residents of the county (Davis, Bangs, Wallace & Crawley, 2007). In addressing the poverty factors that contribute to referral, the agency could select from evidence-based or evidence-supported interventions that strengthen families with young children such as Nurse Home Visitation. This intervention addresses maltreatment by improving the maternal life course through targeting and reducing welfare dependence, substance use and multiple unplanned pregnancies (Olds, Henderson, Kitzman, Eckenrode, Cole & Tatelbaum, 1999). Another possible strategy that could address both poverty and systems factors such as neighborhood support networks are Family-to-Family, an initiative of the Annie E. Casey Foundation. One of the core strategies of Family-to-Family is building community partnerships, through building relationships with a wide range of community organizations and leaders in neighborhoods in which child protection referral rates are high, and collaborating to create an environment that supports families involved with the child welfare system. (http://www.aecf.org/MajorInitiatives/Family%20to%20Family/CoreStrategies.aspx).

**Fatherhood Initiatives**

Although the evidence is still emerging on the effectiveness, fatherhood initiatives may help to keep fathers engaged financially as well as emotionally with families. Increasing the involvement of non-custodial fathers in prevention services may help to stabilize the family so that child welfare involvement is limited or short-term (Lemon, Andrade & Austin, 2005).

**Differential Response**

Differential response (also known as alternative response) is a new paradigm characterized by greater respect for families, increased community involvement and voluntary provision of services (Waldfogel, 1998). In this model, child protective services (CPS) would focus on families at high risk, while concurrently an alternative services system serves families at low to moderate risk. CPS retains the authoritative protective role while community providers would take on the responsibility of family support. Differential response has been identified as a promising strategy for reducing disproportionality at the early juncture of the service pathway (Lemon, Andrade & Austin, 2005). In summary, these are just a few of the strategies with some empirical basis that can be considered as part of an overall plan to reduce poverty that is contributing to disproportional referral to child protective services.

## ADDRESSING SYSTEM BIAS

System bias was believed to be a factor in the referral disparities in Allegheny County according to those interviewed. Less discussed by some of the workers is the possibility of their own biases. Skilled, culturally competent workers should screen out inappropriately referred cases, resulting in lower rates of investigation for African-American and biracial children. Child race significantly predicted case investigation, with African-American children less likely to be investigated compared with white children (OR=.70, $p \leq .05$) and biracial children twice as likely to be investigated compared with white children (OR=2.27, $p \leq .05$). This, coupled with no significant difference in referral risk-ratings by race, suggests that biased decision-making exists at this decision-making juncture. Combined with biased referrals into the child welfare system, this could potentially be an important factor in disproportionality.

### Actuarial Risk Assessments

One approach for addressing this problem is by accurately assessing risk and removing bias. Actuarial risk assessments are those in which risk factors are identified based on empirical evidence of factors statistically associated with future maltreatment (Baird & Wagner, 2000). There is some evidence that suggests that actuarial assessments are more accurate than consensus-based assessments, such as the Risk Assessment Matrix used in Pennsylvania (Baird & Wagner, 2000). The lack of variance seen in the sampled risk assessments suggests that the risk measure currently used by Pennsylvania does not help to support and structure decision making.

### Family Group Decision Making

Family Group Decision Making (FGDM) may reduce system bias by making decision making collaborative and transparent. Although it has not been used specifically to address disproportionality at the referral and intake decision making junctures, family group has been identified as a strategy for reducing disproportionality further down in the pathway (e.g. placement) (Crampton & Jackson, 2007).

### Restructure Referral Forms

The interviews with the workers also identified instances in which workers used short cuts in thinking. These intrinsic processes, referred to as cognitive heuristics, help workers to manage the volume and complexity of often incomplete and conflicting information in order to keep “information processing demands within bounds” (Abelson & Levi, 1985, p 255), but may also allow biases and stereotypical views or “mental models” to impact decisions contributing to racial disparities in child protective services (Azar & Goff, 2007).

## Conclusions & Recommendations

One of the most frequently mentioned short cuts by those interviewed was the tendency to "make decisions based on paper" which essentially means that the worker makes a decision about a family based on what they read on the referral form or what they have in the record before ever seeing the family. The referral form used by the call screeners could be restructured to reduce the risk that early information "anchors" the perception of the workers. Some suggested changes to the form include:

- Revise the reasons for referral to be a checklist (rather than text box) in which neutral descriptors are used with associated definitions to describe reasons for referral e.g. "Hygiene concerns" rather than "children are filthy"; "supervision neglect" rather than "lets children run the street". Keep the information on the referral relevant: irrelevant or biased language that can lead to a particular mental model should be avoided.

- In addition, most supervisors and regional directors review incoming referrals with workers. In reviewing cases prior to investigation supervisors can frame this with the worker by asking them some key questions prior to going out: What are the objectives? What do we know? What are the sources of uncertainty? What don't we know about? How can we reduce uncertainty?

**Discussion Groups**

Although decisions are rarely made in isolation, many of those interviewed reported how helpful it was, long before a formal decision was made, to "talk it out" and "kick it around." In the East Regional Office, groups meet frequently to informally discuss families and obtain varying points of view. This process seems to "open up" thinking and everyone interviewed who had participated in them, reported it to be a very helpful process. One supervisor said that it was particularly helpful to have a diverse group of individuals who are not part of the team.

- *I do appreciate it when we have more people to really discuss them out. We've been a pretty stable office for a while and I know what E is going to say, or J is going to say. I never know what C is going to say, but that's why I like having her there. And we have such a wide range of experience and points of view. I do think it's nice to hash it out.*

## Conclusions & Recommendations

Diverse groups consider a broader range of perspectives and are less likely to make extreme decisions because diversity promotes testing assumptions and exploring new strategies (Isenberg, 1986; Schulz-Hardt et al., 2002). Similarly, these groups could be enhanced by organizing the discussion around a few questions:

1. What are the objectives?
2. Are the right people here in this group?
3. What do we know? What may be the cause(s)? What are the sources of uncertainty? What don't we know about? How can we reduce uncertainty?
4. What information do we need to get?
5. Do we have discrepant information or information that challenges our preferred positions?
6. What are the options? Are there dominance rules that assign "weight" to certain pieces of information or to certain options? What are the consequences to the options and what could go wrong?
7. What would a "good decision" look like?

This group discussion process is based on a process model used for crisis decision making in public health emergencies (Parker et al., 2009). The medical profession is also using a similar process with doctors and nurses, particularly as it relates to diagnostic decisions.

In summary, human decision-making processes are, by nature, flawed. We need to use shortcuts to manage the information but there are risks that the decision may be biased or lead to a decision resulting in a negative outcome. Policies, by their nature, are limited in scope, and cannot guide every decision. Therefore, other processes such as empirically-based decision tools and structured and supportive groups may help to open up thinking and decrease decisions that may unconsciously be based on biasing heuristics. However, this is an area that could benefit from basic research on how caseworkers think and what strategies are most effective.

**Cultural Competency Training**

Training in cultural competence and the role of CYF is another strategy for addressing system bias. In the case of Allegheny County, this could also include outreach to other systems and awareness of what CYF can legally do in protecting children and what alternative services can be used by other systems in preventing maltreatment. Caseworkers cannot remove children because of unsafe neighborhoods, interpersonal disputes or custody disagreements. However, CYF can be a resource for information to other systems that are interacting with families in need of support. The research supports that infrequent and one-time trainings are insufficient to promote real cultural understanding of front-line workers (Green, 1999). The State of Washington has undertaken a comprehensive approach to increasing the competence of their workers through the Culturally Competent Professional Practice Project (C2P2). C2P2 includes training workers in using African-American cultural norms to build positive relationships with family members. As one of the individuals in the interview observed about her role as an African-American working in CYF and acting as a translator "*See, we don't have to learn about the culture of Caucasians, because we've had to…but Caucasians have never had to learn our culture, ever. So that's basically the bottom line. And we don't take into consideration culture."* Training along with coaching and mentoring may be another strategy for reducing system bias when used in conjunction with other approaches.

**Help Families with Mental Illness, Substance Abuse and Disability**

*Pittsburgh's Racial Demographics: Differences and Disparities* (Davis, Bangs, Wallace & Crawley, 2007) reports that African-Americans in Allegheny County have higher rates of serious mental illness than whites (p.64) and have higher rates than that of the nation. One of the frequently mentioned causes of disproportionate referrals was the presence of serious mental illness or substance abuse of a parent, particularly a mother. The bivariate analyses support that moderate to high risk-ratings of substance abuse associate with opening a family for services. One of the most difficult aspects of both mental illness and substance use is the nature of the illness. Both conditions require time for the individual to become motivated to get help and both have the future probability of relapse. As one caseworker noted in assessing when to intervene with a family:

- *"Mental health is confusing. Very confusing".*

Another observed that time is needed to fully understand the course that it is taking:

- *"How many times do people relapse? You have to be clean before you can address the mental health needs that are going on. You need at least 3-6 months of clean time without using any type of minor mood altering substance just to begin to even dialogue about what else is going on."*

Allegheny County has led the nation in the use of alternative sentencing strategies though the Drug Court and more recently, Mental Health Court. Capacity and experience exists for CYF to work with these programs when parents, particularly caregiving mothers, have active substance abuse or untreated mental illness that results in incarceration. Allegheny County also has Assertive Case Management Teams in the community. In other words, there is the expertise and capacity to help young families who are struggling with addiction and mental illness. Culturally relevant programming that is located in neighborhoods may be another way of engaging parents in services. Ethnic-specific services are defined as those that primarily serve clients of one ethnic group and attempt to respond to the cultural needs of the clients (Lemon, Andrade and Austin, 2005, p. 32). Situating ethnic-specific services in neighborhoods where clients reside may also help to eliminate some of the cultural and transportation barriers.

## CONCLUSIONS AND RECOMMENDATIONS

Allegheny County has many of these promising practices already in place. Alternative sentencing strategies and FGDM are well-established practices. Culturally relevant programming is offered through Family Resources and other service providers. Gender and race-relevant programming for drug and alcohol addiction is available through established providers. Given the relative wealth of services that exist, the research question becomes what individual and community factors prevent parents from accessing services?

In summary, the problem of racial disproportionality in the child welfare system is well known and was found here in rates of CYF referral and in other reports of disproportionality among Allegheny County's foster care population. African-American children are referred at greater rates than white children but less frequently investigated, despite similar levels of risk rated by intake workers during the referral. Biracial children are referred at even greater rates and have unique service needs, yet have the lowest rates of service. Few characteristics predict CYF services in this study and the lack of variance in reports of risk, with just 2 percent to 3 percent of children rated with high risk at referral and investigation suggests the need for further research about how tools such as the referral and risk assessment are used by workers to aid decision making.

## Conclusions & Recommendations

The primary points of disparity are at referral and foster care, where poverty, caregiver substance abuse, and mental health play a role. Nurse home visiting, differential response, and Family-to-Family are interventions that may help reduce the need for child welfare involvement by circumventing families' need for CYF to begin with by strengthening outcomes for high-risk mothers, or by engaging the community in decisions and supports for families. Family Group Decision Making (FGDM) is another avenue for group decision making but has not shown strong outcomes beyond families' satisfaction (Berzin, 2006; Weigensberg, Barth, & Guo, 2008), so ought to be supplemented with assurance that families receive necessary services and that the family plan is followed through with.

Structured decision-making, group reflective processes involving supervisors and teams, training with mentoring and coaching, and restructuring forms and discussions to reduce cognitive biases are examples of system changes that could improve the consistency of assessments and case decisions about which children need services. Finally, court initiatives such as Drug Courts and Family Finding are promising strategies to increase the possibility that all children have the option of living with kin while remaining close with primary caregivers in the event that out-of-home placement is unavoidable.

## CONTACT INFORMATION

Mary Beth Rauktis Ph.D.
Research Assistant Professor
University of Pittsburgh, School of Social Work
Child Welfare Training and Research Program
2326 Cathedral of Learning
Pittsburgh, PA 15260
412 648 1225
Mar104@pitt.edu

Julie S. McCrae, Ph.D., MSW
Research Assistant Professor
University of Delaware, Graduate School of Social Work
Butler Institute for Families
2148 S. High Street
Denver, CO 80208
303-871-4533
Julie.McCrae@du.edu

## BIBLIOGRAPHY/FURTHER READING

Abelson, R. P., & Levi, A. (1985). Decision making and decision theory. In Gardner Lindzey and Elliot Aronson, Eds. The Handbook of Social Psychology (vol. 1, 3rd Ed., pp. 231-309). New York: Random House.

Ards, S. D., & Harrell, A. (1993). Reporting of child maltreatment: A secondary analysis of the national incidence surveys. *Child Abuse and Neglect, 17,* 337-344.

Ards, S. D., Chung, C., & Myers, S. L. (1998). The effects of sample selection bias on racial differences in child abuse reporting. *Child Abuse & Neglect, 22,* 103-115.

Azar, S. T., & Goff, P. A. (2007). Can science help Solomon? Child maltreatment cases and the potential for racial and ethnic bias in decision making. *St. John's Law Review, 81,* 533-573.

Baird, C., & Rycus, J. S. (2005). *APSAC Advisor*, *16*, 2005.

Baird, C., & Wagner, D. (2000). The relative validity of actuarial and consensus based risk assessment systems. *Children and Youth Services Review, 22*(11/12), 839-871.

Barth, R. P. (2005). Child welfare and Race: Models of Disproportionality. In D. M. Derezotes, J. Poerter & M. Testa (Eds.*), Race Matters: The Over representation of African American Children in the System*. (pp-25-46). Washington, DC: Child Welfare League of America.

Berzin, S. C. (2006). Using sibling data to understand the impact of family group decision-making on child welfare outcomes. *Children and Youth Services Review*, *28*, 1449–1458.

Chasnoff, I. J., Landress, H. J., & Barrett, M. E. (1990). The prevalence of illicit drug or alcohol use during pregnancies and discrepancies in mandatory reporting in Pinellas County, Florida. *The New England Journal of Medicine, 322,* 1202-1206.

Crampton, D., & Jackson, W. (2007). Family group decision making and disproportionality in foster care: A case study. *Child Welfare, 86*(3), 51-69.

Davis, L., Bangs, R., Wallace, J., & Crawley, D. C. (2007). Pittsburgh's racial demographics: differences and disparities. Pittsburgh, PA: Center on Race and Social Problems, School of Social Work, University of Pittsburgh.

# Resources


Dettlaff, A. J., & Rycraft, J. R. (2008). Deconstruction disproportionality: Views from multiple community stakeholders. *Child Welfare, 87*(2), 37-58.

Drake, B., & Pandey, S. (1996). Understanding the relationship between neighborhood poverty and specific types of child maltreatment. *Child Abuse & Neglect, 20*(11), 1003-1018.

Drake, B., & Zuravin, S. (1998). Bias in child maltreatment reporting: revisiting the myth of classlessness. *American Journal of Orthopsychiatry, 68*(2), 295-304.

English, D., Aubin, S., Fine, D., & Pecora, P. (1993*). Improving the accuracy and cultural sensitivity of risk assessment in child abuse and neglect cases*. Seattle WA: Risk Assessment Project.

Fluke, J., Yuan, Y., Hedderson, J., & Curtis, P. (2003). Disproportionate representation of race and ethnicity in child maltreatment investigation and victimization. *Children and Youth Services Review, 25*(5/6), 359-373.

Garbarino, J., & Eckenrode, J. (1997). *Understanding Abusive Families—An Ecological Approach to Theory and Practice.* San Francisco, CA: Bossey-Bass.

Glisson, C., & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect, 22*(5), 401-421.

Glisson, C. (2009). Organizational climate and service outcomes in child welfare systems. In M. Webb, K. Dowd, B. Jones-Harden, J. Landsverk, & M. Testa (Eds.), *Child welfare and child well-being: New perspectives from the National Survey of Child and Adolescent Well-being* (pp. 208-235). New York: Oxford University Press.

Green, J. W. (1999). *Cultural awareness in the human services: A multi-ethnic approach.* Boston: Allyn and Bacon.

Hampton, R. L., & Newberger, E. H. (1988). Child abuse incidence and reporting by hospitals: Significance of severity, class and race. In Hotaling, G. T., Finkelor, D., (Eds.). *Coping with family violence: Research and policy perspectives* (pp. 212-221). Thousand Oaks, CA: Sage Publications.

Hines, A. M., Lee, P. A., Drabble, L., Snowden, L. R., & Lemon, K. (2002). An Evaluation of Factors Related to the Disproportionate Representation of Children of Color in Santa Clara County's Child Welfare System: Phase 2 Final Report. Online, retrieved from: http://www2.sjsu.edu/depts/socialwork/cwrt/

Isenberg, D. J. (1986). Group polarization: A critical review and meta analysis. *Journal of Personality and Social Psychology, 50*, 1141-1151.

Karp, S. (2001, February). "Crack Babies": Black children defy stereotypes, face bias—the tragedy of crack babies. *The Chicago Reporter.* http://findarticles.com/p/articles/mi_m0JAS/is_21_30/ai_73039563?tag=content;col1

KidsCount. *Pennsylvania Partnerships for Children* retrieved on 11/12/2008. http://www.kidscount.org/cgi-bin/clicks.cgi

Korbin, J., Coulton, C., Chard, S., Platt-Houston, C., & Su, M. (1998). Impoverishment and child maltreatment in African American and European American neighborhoods. *Development and Psychopathology, 10*, 215-233.

Lane, W. G., Rubin, D. M., Monteith, R., & Christian, C. W. (2002). Racial differences in the evaluation of pediatric fractures for physical abuse. *Journal of the American Medical Association 288*, 1603-1609.

# Resources


Lemon, K., Andrade, A. D., & Austin, M. J. (2005). *Understanding and Addressing Disproportionality in the Front End of the Child Welfare System*. The Center for Social Services Research, University of California at Berkley.

Martin, L.M., Peters, C. L., & Glisson, C. (1998). Factors affecting case management recommendations for children entering state custody. *Social Service Review, December,* 521-544.

Miles, M.B., & Huberman, A. M. (1994). Qualitative Data Analysis: An expanded sourcebook. Thousand Oaks, CA: Sage.

Nelson, K. E., Saunders, E. J., & Landsman, M. (1993). *Social Work, 38*(6), 661-671.

Olds, D. L., Henderson, C. R., Kitzman, H. J., Eckenrode, J. J., Cole, R. E., & Tatelbaum, R. C. (1999). Prenatal and infancy home visitation by nurses: Recent findings. *The Future of Children*, *9*(1), 44-65.

Parker, A., Nelson, C., Shelton, S. R., Dausey, D. J., Lewis, M. W., Pomeroy, A., & Leuschner, K. J. (2009). Measuring Crisis Decision Making for Public Health Emergencies. Prepared for the U.S. Department of Health and Human Services Office of the Assistant Secretary for Preparedness and Response. RAND WR-577-DHHS.

Rycus, J. S., & Hughes, R. C. (2003). *Issues in Risk Assessment in Child Protective Services. Policy White Paper.* Columbus, Ohio: North American Resource Center for Child Welfare, Center for Child Welfare Policy.

Schulz-Hardt, S., Jochims, M., & Frey, D. (2002). Productive conflict in group decision making: Genuine and contrived dissent as strategies to counteract biased information seeking. *Organizational Behavior and Human Decision Processes, 88*, 563-586.

Sedlack, A. J., & Broadhurst, D. D. (1996). Third Incidence Study of Child Abuse and Neglect: Final Report. Washington, DC: U.S. Department of Health and Human Services.

Sedlack, A. J., & Schultz, D. (2001a). *Race differences in risk of maltreatment in the general child population.* Paper presented at the Race Matters Forum, January, 9-10, Chevy Chase, Maryland.

Sedlack, A. J., & Schultz, D. (2001b). *Race differences in child protective investigations of abused and neglected children.* Paper presented at the Race Matters Forum, January, 9-10, Chevy Chase, Maryland.

Sedlack, A. J., & Schultz, D. (2005). Race differences in risk of maltreatment in the general child population. In D. M. Derezotes, J. Poerter & M. Testa (Eds.*), Race Matters: The Over representation of African American Children in the System*. (pp-97-117). Washington, DC: Child Welfare League of America.

Vandergrift, K. F. (2006). Disproportionate representation in the child welfare system: Emerging promising practices survey. Retrieved May 6, 2009, from http://www.napcwa.org/Home/docs/Disproportionate-Representation.

Waldfogel, J. (1998). The future of child protection: How to break the cycle of abuse and neglect. Cambridge: Harvard University Press.

Weigensberg, E. C., Barth, R. P., & Guo, S. (2008). Family group decision making: A propensity score analysis to evaluate child and family services at baseline and after 36-months. *Children and Youth Services Review, 31*, 383-390.

Zellman, G. (1992). The impact of case characteristics on child abuse reporting decisions. *Child Abuse and Neglect, 16*, 57-74.

# Appendix A

## POPULATION AND SAMPLING FRAME

| **Total Number of Children (# of children) Involved in CYF as a Result of a CPS or GPS Report in 2006*** | **19,963** |
|---|---|
| Missing or – value for child age | -622 |
| ≥ 18 years old | -1,950 |
| Total # of children, ages 0 to 17 | **17,391** |
| # of children with >1 report (duplicates) | -3,426 |
| # of children who were not the target child | -5,983 |
| # of children whose report was not in PA | -133 |
| # of unique target children reported, ages 0-17 | **7,849** |
| Missing race, gender, or both | -354 |
| Final population of children to sample from | **7,495** |
| Target Sample size for statistical estimates: | 544 |
| Field data incomplete | - 84 |
| Final n | **460** |

* Since the family is the unit of analysis for CYF, this number includes all children in the family and not just the target child who is the object of the report.

# Appendix B

## REQUEST FOR EVALUATION

| Type | # of Children | Percentage |
|---|---|---|
| Physical abuse | 36 | 17% |
| Sexual abuse | 15 | 7% |
| Physical neglect | 71 | 33% |
| Supervisory neglect | 52 | 24% |
| Substance abuse | 87 | 40% |
| Domestic violence | 23 | 8% |
| Abandonment | 10 | 5% |
| Parent/child conflict | 20 | 9% |
| Other | 34 | 16% |

**Description, Evaluation Requests (n=215)**

Text from the referral form "specific allegations" was coded by two raters based on NCANDS and NSCAW definitions and reviewed by project investigators. Figures total greater than 215 because children may have more than one type reported.

# Appendix C

## MODEL RISK ASSESSMENT FORM

The risk assessment used by Pennsylvania is a consensus-based measure. There is research supporting the superiority of actuarial risk assessment over consensus based tools in accurately predicting risk (Baird & Wagner, 2000). Pennsylvania should research the potential cost and time savings of using an actuarial measure.

**PENNSYLVANIA MODEL**
**RISK ASSESSMENT FORM**

ASSESSMENT CODES: Z - NO RISK L - LOW RISK M - MODERATE RISK H - HIGH RISK X - UNABLE TO ASSESS

| CASE NAME: | CASE # |
|---|---|

| A. CHILD FACTORS — NAME: / AGE: | | | | | | HIGHEST RISK FACTOR |
|---|---|---|---|---|---|---|
| 1. VULNERABILITY | | | | | | |
| 2. SEV/FREQ AND/OR RECENTNESS OF ABUSE/NEGLECT | | | | | | |
| 3. PRIOR ABUSE/NEGLECT | | | | | | |
| 4. EXTENT OF EMOTIONAL HARM | | | | | | |
| **B. CARETAKER, HOUSEHOLD MEMBER, PERPETRATOR** — NAME: / AGE: | | | | | | HIGHEST RISK FACTOR |
| 5. AGE, PHYSICAL, INTELLECTUAL OR EMOTIONAL STATUS | | | | | | |
| 6. COOPERATION | | | | | | |
| 7. PARENTING SKILLS /KNOWLEDGE | | | | | | |
| 8. ALCOHOL/SUBSTANCE ABUSE | | | | | | |
| 9. ACCESS TO CHILDREN | | | | | | |
| 10. PRIOR ABUSE/NEGLECT | | | | | | |
| 11. RELATIONSHIP WITH CHILDREN | | | | | | |

| C. FAMILY ENVIRONMENT | | RISK FACTOR |
|---|---|---|
| 12. FAMILY VIOLENCE | | |
| 13. CONDITION OF THE HOME | | |
| 14. FAMILY SUPPORTS | | |
| 15. STRESSORS | D. PLEASE USE BACK OF PAGE FOR NARRATIVE | |

| WORKER | DATE | OVERALL SEVERITY | |
|---|---|---|---|
| SUPERVISOR | DATE | OVERALL RISK | |

# Appendix C

## RISK/SEVERITY CONTINUUM

| NO RISK | LOW RISK | MODERATE RISK | HIGH RISK |
|---|---|---|---|
| **1. VULNERABILITY** | | | |
| Over age 18 | Cares for and can protect self with minimal assistance and has no physical or mental handicap. Typically age 12-17. | Requires adult assistance to care for and protect self or has minor limitation or has mild to moderate impaired development. Typically age 6-11. | Is unable to care for or protect self without adult assistance. Has severe physical or mental handicap or limitation. Is severely impaired developmentally. Typically age 0-5. |
| **2. SEVERITY, FREQUENCY AND/OR RECENTNESS OF ABUSE/NEGLECT** | | | |
| No injury. No discernable evidence of abuse or neglect. No discernable pattern of inappropriate punishment or discipline. Has basic medical, food and shelter needs met. Receives adequate supervision at all times. | Has minor injury as a result of abuse or neglect which requires no medical attention. May show rare incidence of inappropriate punishment or discipline. Usually has basic medical, food and shelter needs met. On occasion may experience minor distress or discomfort due to neglect or lack of supervision. | Has significant physical injury possibly requiring medical diagnosis or treatment as a result of CAN. May have an ongoing history or pattern of harsh discipline or punishment. CAN is repetitive or cumulative. Injury to torso or back. Implement used resulting in marks or bruises. Not a high risk implement. Imminent risk of above. Child is 6-11 years of age, left alone periodically or left with unsuitable caretakers. Inconsistently has basic medical, food and shelter needs met. | Has serious physical injury. Has been sexually abused. May need immediate medical treatment and/or hospitalization. Suffers severe pain o ongoing history of harsh punishment or discipline. Injury to head, face, neck or genitals internal injuries or sexual assault. High risk implement used. Imminent risk of above. Child is 0-5 years of age, left alone or with an unsuitable caretaker. Rarely has basic medical, food and shelter need met. |
| **3. PRIOR ABUSE/NEGLECT** | | | |
| No signs symptoms, credible statements or reports that suggest that prior CAN has occurred. | Isolated report or incident of inappropriate physical discipline. No conclusive or credible statement suggesting prior CAN. | Previous substantiated report of abuse and/or neglect. Observable physical signs of previous CAN. Credible statements of previous abuse or neglect not investigated. | Previous substantiated reports of serious bodily injury. Severe abuse o neglect resulting in a serious condition. Credible statements or documentation of serious bodily injury or neglect not previously investigated. Multiple reports of moderate risk issues. |
| **4. EXTENT OF EMOTIONAL HARM** | | | |
| Has no emotional harm or behavioral disturbance related to abuse and/or neglect. Is comfortable in caretakers home. | Has minor distress or impairment in role functioning, or development related to CAN. Has doubts or concerns about the caretaker's home. | Has behavioral problems that impair social relationships, development or role functioning related to CAN. Has fear of caretakers or home environment. | Has extensive emotional or behavioral impairment or serious developmental delay related to CAN Is extremely fearful about caretakers or home environment. |
| **5. AGE, PHYSICAL, INTELLECTUAL OR EMOTIONAL STATUS** | | | |
| Has no intellectual or physical limitation. Is cognitively able to understand and to provide for child's best needs. Seems mature and able to cope. | Has some physical or mental limitations but there is no evidence of any negative impact on family functioning. Parent is aware of limitations and has made adaptations, including use of appropriate resources. | Is physically/emotionally/ intellectually limited. Has past criminal/mental health record/history. Has poor impulse control. Is under 20. | Is severely handicapped; Has poor conception of reality; Has severe intellectual limitations. Is unable to control anger and impulses. Under 16. |
| **6. COOPERATION** | | | |
| Caretaker appropriately responsive to requirements of investigation. Actively involved in case planning and services. Participates in services provided to him/her and child. Acknowledges problems. Initiates contact with Caseworker to improve services and may seek additional services. | Caretaker offers minor resistance to investigation. Does not take initiative in obtaining needed services. Occasionally fails to follow through with services. Requires reminders and encouragement to follow through. Appears to make use of services by altering behavior in ways that reduce risk to the child. Willing to take some responsibility for the problem. | Caretaker is hostile or cooperates reluctantly with investigation only with direct instructions. Fails to follow through with case plan despite repeated reminders. Passively undermines interventions by canceling appointments, failing to attend meetings or follow up with referrals. Although expressing compliance, makes no effort to alter behavior lowering risk to the child. Fails to accept responsibility for the problem or their own behavior. | Caretaker actively resists any agency contact or involvement. Will not permit investigation to occur. Is very hostile or will only cooperate with police involvement, may threaten worker or service provider with physical harm. Refuses to take child for treatment or assessment and is disruptive to the point that makes services impossible to deliver. Completely denies problems and has no motivation to change behavior affecting the risk to the child. |
| **7. PARENTING SKILL/KNOWLEDGE** | | | |
| Exhibits appropriate parenting skills and knowledge pertaining to child rearing techniques or responsibilities. Understands child's developmental needs. Does not use implements or physical means to discipline. | Exhibits minimal deficits in parenting skill and knowledge pertaining to child rearing techniques or responsibilities and/or in understanding child's developmental needs. Does not use high risk implements to discipline. | Is inconsistent or has moderate deficits in necessary parenting skills/knowledge required to provide a minimum level of care. Frequently uses physical means to discipline. Implement used, not a high risk implement. | Is unwilling/unable to provide the minimal level of care needed for normal development. Usually resorts to physical means of discipline. High risk implement(s) used. |

## Appendix C

| NO RISK | LOW RISK | MODERATE RISK | HIGH RISK |
|---|---|---|---|
| **8. ALCOHOL/SUBSTANCE ABUSE** | | | |
| No past or present abuse. | History of abuse with no current problem; Use without inappropriate consequences. | Reduced effectiveness due to abuse or addiction; Regular use results in problem behavior and/or incapacity. | Substantial incapacity due to abuse. |
| **9. ACCESS TO CHILDREN** | | | |
| Responsible caretaker is available or perpetrator has no access. | Supervised access or shared responsibility for care of child. | Perpetrator has limited unsupervised access or child being cared for in non-supportive or neglectful environment. | Immediate, unlimited access or full responsibility for care of child. |
| **10. PRIOR ABUSE/NEGLECT** | | | |
| Not neglected or abused as a child. No information or indication of caretaker as perpetrator of abuse or neglect. | No history of abuse or neglect as a victim or perpetrator. Isolated instances of inappropriate discipline as a victim and/or a perpetrator. Inconclusive statements of CAN history by subjects or collaterals. | Prior indicated or substantiated incident of abuse/neglect as a victim or a perpetrator. Admission to prior instances of abuse or neglect (perp. or victim) not yet investigated. Credible statements of above. | History of chronic and/or severe abuse/neglect; or abuse causing serious bodily injury as a perpetrator. Two indicated reports of CAN. Credible statements suggesting history of severe abusive or neglectful incidents towards children. |
| **11. RELATIONSHIP WITH CHILDREN** | | | |
| Caretaker/child interaction is frequent and pleasurable to both. Mutual affection is prominent and appropriate. Child is aware of and consistently responds to verbal cues of caretaker. | Caretaker anger regarding child's behavior is rarely directed toward the child inappropriately. Anger is generally controlled. Child occasionally does not respond to verbal cues. Attachments of caretaker and child are obvious and extensive. No indication of role blurring (scapegoating or parentification). | Caretaker anger is occasionally extreme. Child's behavior regularly serves to provoke negative response; Displays of affection are intermittent or irregular; Child is occasionally scapegoated or parentified. | Caretaker anger is usually extreme and results in physical abuse, verbal abuse or extreme criticism. No appropriate affection shown to child. Child is consistently scapegoated or parentified; Role blurring occurs frequently. There is a complete lack of attachment or positive interaction between caretaker and child; Or conversely child is inappropriately dependent upon or clinging to caretaker. Child's behavior quite provocative. |
| **12. FAMILY VIOLENCE** | | | |
| No use of or threats of violence to resolve conflicts. No history of violence in adult relationships or between adults in family of origin | Indirect or implied verbal threats only in adult relationships or in family or origin: Some success with problem solving techniques. | Direct physical and/or verbal threats; Use of violence between adults; History of physical threats and injury in family of origin: Other methods of dealing with issues rarely used. | Physical violence between adults resulting in injury. Physical violence primary method of conflict resolution. History of physical violence in family of origin; History of protection orders or criminal charge. |
| **13. CONDITION OF THE HOME** | | | |
| No health or safety concerns on property. | Minor health or safety concerns on property. Some minor problems posing no immediate threat and easily correctable. | Serious substantiated health or safety hazards, i.e. overcrowding, inoperative or unsafe water and utility hazards; other health and sanitation concerns. | Substantiated life threatening health or safety hazards, i.e., living in condemned and/or structurally unsound residence; exposed wiring and/or other potential fire/safety hazards. |
| **14. FAMILY SUPPORTS** | | | |
| Frequent supportive contacts with family/friends. Involved with community resources as needed; Child monitored by two or more outside adults. | Occasional contact with supportive family/friends; Effective use of community resources, but could benefit from a larger variety of resources; Child monitored by one outside adult. | Sporadic supportive contact; under-use of community resources; Child is inconsistently monitored by outside adults. | Caretaker geographically or emotionally isolated; Community resources not available or not used. Child has minimal or no contact with outside adults. |
| **15. STRESSORS** | | | |
| No recent losses or disruption to family routine. Stable housing history. Coping skills are varied and adequate. One child living in the household. | Family circumstances have led to anxiety and/or irritation or minor depression. Caretaker appears to have the ability to care for the children in the household. Housing is stable. Coping skills are functional. Two to three children living in the household. | household. Family has difficulty maintaining stable housing. Coping skills are limited. Four to five children living in the household. | household. |
| | Family crises, losses or circumstances have led to intense anxiety or major depression. Caretaker has difficultly caring for the children in the | Family crises, losses or circumstances have led to serious psychiatric or emotional problems. Caretaker unable to adequately provide for the number of children in the household. Family has a pattern of frequent moves and homelessness. Coping skills are severely limited. Six or more children living in the | |