The Journal of Sociology & Social Welfare

Volume 46
Issue 4 *December*

Article 5

2019

Structural Competency in Child Welfare: Opportunities and Applications for Addressing Disparities and Stigma

Jaclyn Chambers
jaclyn_chambers@berkeley.edu

G. Allen Ratliff
University of California, Berkeley, garatliff@berkeley.edu

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Jaclyn E. Chambers
G. Allen Ratliff
School of Social Welfare
University of California, Berkeley

Race and class disparities in the child welfare system, as well as stigma associated with child welfare involvement, have received much attention in the child welfare field. Black families living in poverty are over-represented within the child welfare system and have disparate outcomes. Additionally, scholars have highlighted how parents often experience the child welfare system as stigmatizing, particularly due to threats to their identity and loss of autonomy stemming from child welfare's focus on an individual intervention model. Child welfare agencies and researchers have employed a range of interventions to address these issues of disparities and stigma, with an emphasis on reducing bias in child welfare decision-making through practices such as cultural competency training; however, the field is beginning to shift its focus to the broader structural issues that lead to child welfare involvement and contribute to disparities. The emerging concept of structural competency could be a new framework for enacting structural responses in child welfare work. This paper examines applications of structural competency to child welfare practice and explores how it may be a promising framework to reduce disparities and stigma.

Keywords: child welfare, structural competency, racial disparities, stigma, poverty

Families from marginalized groups—including Black and Indigenous families, families experiencing poverty, and parents with disabilities—are disproportionately represented in the child welfare system and have disparate outcomes (e.g., rates of out-of-home placement, length of time in the system) (Barth, 1997; Barth, Wildfire, & Green, 2006; Berger & Waldfogel, 2004; Hill, 2006; Lee, 2016; Park, Solomon, & Mandell, 2006; Wildeman & Emanuel, 2014). These disparities reflect wider social and cultural trends of marginalization (Asad & Clair, 2018; Collins, 2017; Harnois & Ifatunji, 2011; Subramanian, Chen, Rehkopf, Waterman, & Krieger, 2005). Parents who have been the subject of child maltreatment allegations report feelings of stigma related to being labeled "bad parents" and the reduction in autonomy that results from child welfare interventions that typically prescribe services targeting parents' individual behavior (Colton et al., 1997; Dumbrill, 2006; Scholte et al., 1999; Sykes, 2011; Thrana & Fauske, 2014). While there is a large body of child welfare literature that highlights these issues of disparities and stigma, the problem remains.

Researchers and child welfare practitioners have posited various reasons for disparities and stigma within the child welfare system, with a primary discourse focused on bias in decision-making (Dettlaff et al., 2011; Rivaux et al., 2008). However, recent scholars have called for a focus on structural factors in the way we define and respond to child maltreatment (Dunkerley, 2017; Reich, 2005; Roberts, 2002). Structural forces include the policies, institutions, infrastructure, and cultural/normative beliefs within our economic, social, and political systems that interact with individuals and families in their daily lives (Bourgois, Holmes, Sue, & Quesada, 2017; Metzl & Hansen, 2014). Structural approaches to clinical practice are the center of an emerging model of structural competency in medicine and public health that promotes an understanding of how social structures impact health and behavior in order to address micro and macro disparities. Because medical practices and child welfare practices perform similar functions (e.g., assessment, treatment planning, provider/client interactions), it is logical to extend the application of structural competency to child welfare. This model could be a new framework for enacting structural responses in child welfare.

In order to motivate future practice and research in structurally competent approaches to child welfare, this paper will: (1) describe systemic disparities in the child welfare system and experiences of stigma related to existing child welfare interventions; (2) articulate structural forces impacting child welfare involvement and interventions; (3) introduce structural competency as a strategy to decrease disparities and reduce experiences of stigma; and (4) provide conceptual guidance for applying structural competency principles in child welfare.

Background

The issues of disparities and stigma within the child welfare system have been covered substantially in the literature and there are existing interventions that aim to reduce these problems, yet these initiatives have not focused on structural forces that impact both parents and child welfare workers. An examination of these structural forces reveals an opportunity to apply the framework of structural competency as a potential avenue to address disparities and stigma.

Disparities and Stigma in Child Welfare

Disparities. There are numerous differences in rates of involvement, intervention strategies, and case resolutions for families in the child welfare system depending on the family's social position. Racial and class disparities in child welfare have been studied the most widely, although there are intersecting disparities that deserve equal attention. A review of the child welfare literature found that Black families are more likely than White families to: (1) be screened in for investigation; (2) have substantiated allegations; and (3) have a child removed from the home (Hill, 2006). In their nationally representative analysis of risks for foster care placement, Wildeman and Emanuel (2014)found that Black children had 2.26 times greater relative risk of foster care placement between birth and age 18 compared to White children ($p < .001$), and Indigenous children had 3.18 times greater relative risk ($p < .001$). Studies consistently find disparities in the length of foster care placements, with White children exiting to permanency much more quickly than Black children (Barth, 1997; Wulczyn, 2003). Noonan and Burke (2005) found that Black children

in foster care have a significantly lower risk of termination of parental rights compared to non-Black children (hazard ratio = 0.87), but they are also less likely to be reunified with their parents (hazard ratio = 0.93), suggesting Black children are less likely than their peers to achieve speedy permanency.

Socioeconomic status (SES) is also strongly associated with child welfare involvement. A recent national study found that children from families with lower SES had 5.8 times greater relative risk of maltreatment compared with children from higher SES families (Sedlak et al., 2010). Children from low-income families are more likely to be removed from home compared to families with higher incomes, with the likelihood of placement decreasing as family income increases (Berger & Waldfogel, 2004). Further exploring the relationship between poverty, race, and child welfare involvement, a recent study examined national maltreatment data and census data and found that the differences in official maltreatment reports between Black and White children are largely a result of racial differences in poverty rates (Kim & Drake, 2018).

While race and class have appropriately been a primary focus in the child welfare literature on disparities in system involvement, there are known disparities among other marginalized groups. For example, the prevalence of child welfare cases that involve parents with a disability are five to ten times higher than the prevalence rates of parents with disabilities in the population generally (Callow & Jacob, 2014). Parents with a serious mental illness or with developmental disabilities are more likely to have their children removed from their care than parents without these diagnoses (Booth & Booth, 2005; Llewellyn, McConnell, & Ferronato, 2003; Park et al., 2006). Intersectional disparities between marginalized identities and child welfare involvement remains an area for further exploration in the literature.

Stigma. Experiences of stigma arise when parents feel disempowerment, shame, or disgrace related to their child welfare involvement. Child welfare research, practice, and policy have overwhelmingly conceptualized child welfare involvement as a parental behavior issue. In this paradigm, children are brought to the attention of child protective services because their parents are engaging in harmful, dangerous, or otherwise unacceptable parenting practices, and they remain in the system because their parents are unable or unwilling to change. This

narrow focus on individual behavior can cause parents to experience child welfare intervention as stigmatizing, particularly due to perceptions of being labeled as a "bad parent" and the loss of power over their own decision-making about their families (Dumbrill, 2006; Sykes, 2011; Thrana & Fauske, 2014).

Intervention paradigms within the child welfare system suggest "the first line of intervention within the child welfare context is to modify parenting behavior" (Landers et al., 2018, p. 546). When the problem is viewed as a parental behavior issue, the remedy has been to require parents to comply with individual services to change their behaviors (Daro & Dodge, 2009; Daro & Donnelly, 2002), and there is an extensive literature devoted to service planning and engagement for parents (e.g., Gladstone et al., 2012; Kemp, Marcenko, Hoagwood, & Vesneski, 2009; Lalayants, 2012; Yatchmenoff, 2005).

Qualitative studies have explored how the child welfare system can stigmatize and disempower families. A qualitative study of child welfare workers and mothers with open, substantiated neglect cases found the child welfare workers indicated a preference for working with mothers who were deferential and compliant with services; thus many mothers felt forced to "play nice" with caseworkers in order to keep their families together, even if they questioned the legitimacy of child welfare's findings of neglect against them (Sykes, 2011). Dumbrill (2006) found that *how* child welfare workers wield their power is a key determinant of parents' perceptions of the child welfare system: parents who experienced a child welfare worker's power as supportive rather than punitive tended to feel less stigmatized and be more engaged with services. As families move deeper into the child welfare system, their perceptions of stigma grow: foster care and out-of-home services are seen as most negative, while in-home, preventive services are the least negative (Colton et al., 1997; Scholte et al., 1999). Furthermore, the experience of child welfare stigma is likely to be more pronounced for families from marginalized groups that are disproportionately represented at every step in the system.

Child welfare initiatives to reduce disparities and stigma. Understanding and addressing the causes of racial and class disparities and associated stigma in the child welfare system requires an understanding of the causal forces at play and the paradigms of intervention. Chibnall and colleagues (2003) describe three

main theories in the child welfare literature about the causes of racial disparities: (1) racial disparities arise from bias in reporting and addressing child abuse; (2) racial disparities reflect real differences in level of need and child maltreatment rates; and (3) racial disparities are a result of the compounding interaction of real risk and implicit bias. Expanding on these theories, a more recent framework conceptualized by Boyd (2014) broadens the possible causes of child welfare disproportionality and disparities into five explanatory pathways: (1) disproportionate need; (2) human decision-making; (3) agency-system factors; (4) placement dynamics; and (5) policy impact. Boyd's framework expands upon previous theories by capturing structural-level contributors to disparities, such as agency-system factors (e.g., agency infrastructure, institutional racism) and policy impact (e.g., federal legislation, funding).

Interventions that aim to address disparities and stigma have mainly focused on individual biases in decision-making, with cultural competency training as one of the more prevalent practice initiatives (Osterling, D'Andrade, & Austin, 2008). Cultural competency was originally an attempt to address the interpersonal dissonance between White healthcare providers and their patients of color and included a variety of approaches to train providers on how to engage with diverse patients (Metzl & Hansen, 2014; Metzl & Roberts, 2014). Cultural competency training in child welfare aims to address potential worker bias and has been a focal point in the field for at least two decades (Pierce & Pierce, 1996). Although cultural competency promotes an important need for providers to engage respectfully and authentically with diverse clients, the model fails to incorporate an understanding of how the structural forces at play affect the lives of clients beyond simple interpersonal dynamics. Cultural competency training has been shown to improve workers' awareness and skills related to working with culturally diverse families (De Jesús, Hogan, Martinez, Adams, & Hawkins Lacy, 2016; Lawrence, Zuckerman, Smith, & Liu, 2012) but there is little evidence of its impact on overall disparities and stigma.

Scholars have noted that strategies to reduce disparities are in urgent need of further exploration (Hill, 2006), and a review of major child welfare policy and practice shifts in the past few decades identifies disparities related to race and SES as major areas that need to be addressed by researchers (Petersen et

al., 2014). Child welfare workers have also expressed a desire to address disparities, but they do not have sufficient evidence to guide their practice toward this end (Chibnall et al., 2003). Drake and Jonson-Reid (2011) call for addressing root causes of poverty; Roberts (2002) implores the field to examine how child welfare policies and practices are impacting communities of color at large; and Reich (2005) examines the child welfare system itself as a structure of social control and challenges the unequal power dynamics in state/parent interactions. These scholars have decidedly taken a structural lens, yet these ideas have not been translated into practice strategies and evaluated for their impact on disparities and stigma. A few recent child welfare initiatives have emphasized structural racism and structural barriers to accessing support and have begun training workers to better understand these issues (James, Green, Rodriguez, & Fong, 2008; Johnson, Antle, & Barbee, 2009), but these approaches appear to be relatively rare.

Structural considerations in child welfare. Before examining the structural factors impacting child welfare involvement, it is important to further clarify what is meant by the term "structural." Drawing on previous scholars' definitions of structure, structural forces are hierarchical economic, social, and political systems that interact with people in their daily lives, including the policies, institutions, infrastructure, and cultural beliefs that comprise these systems (Bourgois et al., 2017; Metzl & Hansen, 2014). That these structural forces impact people on an individual level is not a new concept to child welfare, or to social work more broadly, as the profession has long utilized a biopsychosocial model focused on how environmental factors impact clients (Cornell, 2006; Norton, 2012; Pardeck, 1988).

The interaction of structural forces and child welfare disparities implicates the need to highlight structural vulnerability as it relates to child welfare. Structural vulnerability describes the particular risk of adverse outcomes for certain groups due to the systemic factors working against them and illustrates how some groups are especially vulnerable to poor outcomes given their social position in a hierarchical society (Quesada, Hart, & Bourgois, 2011).

There are known structural factors that make certain groups more vulnerable to child welfare intervention. Poverty has been

consistently associated with child welfare removals, and there is a significant association between low SES and higher rates of child removals (Berger & Waldfogel, 2004; McGowan, 2005; Myers, 2008). Children living in poverty are more likely to experience maltreatment, with national estimates showing an incidence rate 26.5 times higher in families making less than $15,000 per year, compared to families making above $30,000 per year (Chibnall et al., 2003). The economic position of families experiencing poverty makes them particularly susceptible to child welfare intervention, because the majority of child welfare cases (78%) stem from allegations of neglect (U.S. Department of Health & Human Services, 2013), and poverty can be difficult to distinguish from neglect, as inadequate shelter, malnutrition, inadequate clothing, and similar resource deprivation are all considered criteria for child neglect (Tang, 2008). Finally, researchers have also noted a strong correlation between poverty and mechanisms that may contribute to child maltreatment (e.g., parental stress), making families living in poverty more vulnerable to these risk factors (Chaudry & Wimer, 2016).

The intersection of race and SES situates families of color in a particularly structurally vulnerable position. Families of color in poverty are disproportionately represented in the child welfare system and experience higher rates of related negative outcomes. Racial disparities and SES disparities are enmeshed, as families of color are much more likely to be living in poverty than White families (Chibnall et al., 2003; Drake et al., 2011).Recent U.S. census data show the racial disproportionality in poverty rates: about 77% of the population identifies as White and the poverty rate for this group is 8.8%, while 13.4% of the population identifies as Black and the poverty rate for this group is 22% (Semega, Fontenot, & Kollar, 2017; U.S. Census Bureau, 2017). Kim and Drake (2018) examined national maltreatment and census data to better understand the relationship between race, poverty, and maltreatment and found that maltreatment risks did not differ between Black and White children after controlling for county-level poverty rates. Their analysis suggests the disproportional poverty rate between Black families and White families is a primary driver of racial disparities in maltreatment reports, implicating economic structural factors as determinants of child welfare involvement for families of color experiencing poverty.

In addition to economic systems, scholars have noted the importance of place-based social systems, such as neighborhoods, in understanding child welfare involvement. Coulton, Korbin, Su, and Chow (1995) found neighborhood conditions were significantly related to rates of child maltreatment reports. Child maltreatment rates have been linked housing insecurity (Warren & Font, 2015), unemployment (Freisthler, Merritt, & LaScala, 2006), social disorder and lack of social integration (Freisthler & Maguire-Jack, 2015; Garbarino & Sherman, 1980) and community violence (Lynch & Cicchetti, 1998).

It is also crucial to recognize how the structure of the child welfare system constrains and impacts workers. Smith and Donovan (2003) found that "best practices in child welfare are compromised not only by organizational pressures, such as time limitations, but also by pressures to conform practices to the expectations of powerful institutions in the organizational environment" (p. 541). A key structural force that has been highlighted in the literature is the immense workload placed on child welfare workers. Child welfare workers are often assigned extremely high caseloads, so the amount of time they have to understand a family's needs and strengths may be limited (Kim, 2011; Yamatani, Engel, & Spjeldnes, 2009). The public cultural discourse around child welfare work can constrain workers' options for intervention. For example, child welfare workers are often blamed or subject to lawsuits when egregious child outcomes occur, such as sexual abuse or a child fatality. This socio-political atmosphere can encourage workers to increase monitoring of families and avoid any actions (or inaction) that could lead to possible negative press or litigation (see Cook, 2018; Lawlor, 2018; Winton, 2018).

Child welfare policy can produce its own structural constraints. Ayón and Aisenberg (2010) found that workers' actions are limited by organizational structural factors, such as the power structures (e.g., supervisors as decision-makers) and policies that determine decision-making within the child welfare system. One example of child welfare policy that directly impacts workers is the permanency time limits mandated by the 1997 Adoption and Safe Families Act (ASFA). Even if a worker recognizes that a longer-term intervention plan may be beneficial for a family dealing with structural barriers to housing, employment, healthcare, or other needs, ASFA constrains the

timeframe that child welfare workers and families have to implement achievable goals. There are also signals that a state's overall policy regime type affects how punitive its child welfare system is, suggesting that the political systems within a state could impact trends in child welfare practice (Edwards, 2016). Recognizing the resources, politics, and policies surrounding the child welfare system allows for a better understanding of how the structure of the child welfare system is itself constraining in worker/family interactions.

Structural Competency: An Opportunity

Recent literature in social sciences details the extensive impacts of structural factors on the health and wellbeing of individuals. Widely referred to as social determinants, social environmental factors, and social-ecological factors, these structural or non-individualistic factors are outside of an individual's control, yet play an outsized role in how they affect an individual. In response to this growing body of research and the need for healthcare professionals to address structural factors in their service provision, a new framework for pedagogy and clinical practice has emerged, known as structural competency (Metzl, 2012). Initially developed within medicine by physician-scholars who advocated for medical providers to be more aware of the structural factors that impact patients, Metzl and Hansen (2014) define structural competency as the "trained ability to discern how a host of issues" (i.e., symptoms, attitudes, behavior) represents "downstream implications" of "upstream decisions" (p. 5). This recognition of how "upstream" (i.e., policy) decisions lead to "downstream" (i.e., practical, actual effects on individuals) implications is the heart of structural competency. Structural competency has primarily focused on the development of pedagogical approaches to train healthcare providers to intentionally recognize the structural factors at play in the lives of patients (Bourgois et al., 2017; Metzl & Roberts, 2014). As a nascent practice paradigm, structural competency has yet to be supported with empirical data, but growing calls for structural awareness across social sciences highlight the need for increased attention on this framework.

Structural competency is not only a response to the wider acknowledgement of structural factors at work in the lives of individuals, but also a response to an outdated cultural competency paradigm (Metzl & Hansen, 2014). The structural competency literature has articulated the differences between structural competency and cultural competency as clinical approaches, arguing that a structural approach to patient care "must consider structural determinants of stigma and inequalities" (Conley & Malaspina, 2016, p. 194). In order to translate this focus into practice, a set of five core competencies were described by Metzl and Hansen (2014). These are: (1) recognizing the structures that shape clinical interactions; (2) developing an extra-clinical language of structure; (3) rearticulating "cultural" presentations in structural terms; (4) observing and imagining structural intervention; and (5) developing structural humility. These core competencies are intended to provide healthcare providers and educators with the tools to interrogate their own approaches to clinical practice and education.

Early qualitative evaluations of medical educational programs grounded in structural competency have found that structural competency training improves medical student awareness of structural factors that affect health outcomes, resulting in stronger clinical relationships with clients (Metzl & Petty, 2017; Metzl, Petty, & Olowojoba, 2018; Neff et al., 2017). An instrument called the Structural Foundations of Health Survey was created to assess understanding of structural factors of certain health conditions (e.g., diabetes). When used to evaluate the ability of medical students to identify causal factors linked to health conditions, the students who had been trained in structural competency were significantly more able to describe complex structural factors leading to disease than were students who had not been trained (Metzl & Petty, 2017).

Structural competency has emerged in medicine, yet adjacent helping professions that interact with clients facing disparities have also taken up structural competency. Structural competency emphasizes an understanding of the process by which policy decisions lead to on-the-ground implications for clients and practitioners. The opportunities for structural competency to be incorporated within helping professions are rapidly growing as new fields conceptualize these opportunities

within research, practice, and pedagogy. Although the five core tenets of structural competency have been built into medical training programs that have evolved from the structural competency movement, there are few examples of applications of the core tenets to other specific fields. An excellent example of applying the core structural competency tenets to another field is the Downey and Gómez (2018) elaboration of structural competency within reproductive healthcare, in which the authors describe each tenet of structural competency in relationship with the practices, needs, clients, and values of reproductive health practice.

Applying Structural Competency to Child Welfare

A structural competency approach in child welfare emphasizes a practical examination of how structural forces lead to child welfare involvement and contribute to a greater likelihood of entering the system (and deeper system involvement) for families of color, those living in poverty, and other marginalized groups. Each of the five core structural competencies outlined by Metzl and Hansen (2014) are described below in more detail and conceptually applied to child welfare. This conceptual application is intended to motivate a broader discourse on effective child welfare practices addressing structural forces. To incorporate these competencies into child welfare policies, practices, training, and evaluation, structural competency training could be required in addition to, or instead of, the cultural competency training that is required by many jurisdictions.

1. Recognizing the structures that shape clinical interactions. The first structural competency focuses on the cornerstone: understanding and recognizing how structures impact clinical interactions. A structural vulnerability checklist developed by Bourgois, Holmes, Sue, and Quesada (2017) for use in medical settings may be a helpful tool to consider the breadth of structural factors at play. This checklist organizes its structural assessment into the following domains: financial security (e.g., employment, income); residence/shelter (e.g., safety, stability, access); risk environments (e.g., violence, environmental risks like pollution); food access (e.g., adequate, good quality, accessible); social network/support (e.g., friends/family members); legal status (e.g., unresolved legal cases, documentation); education

(e.g., literacy, access to education); and discrimination (e.g., complications in resource access due to inequitable treatment). These domains can be easily connected with child welfare contexts—many of them are areas that are already considered in child welfare in individualized applications. Further, structural competency training can help trainees to recognize structures in these domains that impact clinical interactions. A qualitative study evaluating a structural competency training course for physicians found that physicians who had taken the course increased their attention to structural factors in assessment, diagnosis, and treatment, and also reported improved clinical relationships with patients (Neff et al., 2017). These results highlight the importance of implementing structurally-competent frameworks within child welfare, as increased attention to structural factors can address disparities, while improved relationships can reduce stigma.

2. Developing an extra-clinical language of structure. This competency describes the importance of speaking to structures in our society at large, naming how they impact families and communities, and incorporating a language of structure into the lexicon of child welfare. Metzl and Hansen (2014) suggest physicians should become familiar with interdisciplinary literature on structures from economics, sociology, history, and other fields. While a review of these literatures may not be feasible within the context of child welfare training, key structural competency topics (e.g., recognizing structural barriers, understanding structural vulnerability) could replace or augment child welfare's current training efforts focused on cultural competency. The Structural Foundations of Health Survey (Metzl & Petty, 2017) that has been previously used to evaluate structurally competent medical training programs could be adapted to fit a child welfare context and utilized as an evaluation tool for structural competency trainings for child welfare workers.

By providing child welfare workers training on the terms and central tenets of key literature bases, the child welfare field will be better able to recognize and describe structural barriers that differentially impact certain families. When equipped with an extra-clinical language of structure, child welfare workers working with families experiencing poverty can better understand and describe socioeconomic status as a structural construct due to policies and practices that have historically limited

wealth accumulation, employment opportunities, and intergenerational mobility for people of color living in poverty. This extra-clinical language of structure can create opportunities for parents to feel understood in their experiences and increase engagement in interventions. The use of structural language in child welfare interactions can decrease feelings of stigma by recognizing that often problems are not the sole responsibility of the parent and that devoted parents in bad structural conditions can struggle with parenting. Additionally, this language can support positive identity in parents without losing sight of the need for child safety.

3. Rearticulating "cultural" presentations in structural terms. The third tenet of structural competency calls for an expanded understanding of why families come to the attention of the child welfare system and how to intervene. The practical application of this tenet can be illustrated by a hypothetical but familiar case example: a mother who is reported to the child welfare system after leaving her 2-year old son at home in the care of her 10-year old daughter for several hours one evening while she was at work. A structurally competent response would ask what local, state, or national policies might be restricting the family's access to childcare? What economic factors have led the mother to work an evening job?

Another common example is a family whose housing poses some threat to their children's safety, perhaps due to overcrowding, exposure to hazardous materials, or problems with the physical structure of the building. A structurally competent assessment might ask what policies or physical structures are contributing to the lack of safe, affordable housing? Is there a transportation infrastructure that restricts where the parents can reasonably live and work? Is there something about the interaction of this particular family's characteristics (e.g., race, gender, income, family structure, mental and physical health, criminal history) and these policies that may lead them to have fewer housing options available? Rather than essentializing or stereotyping, structural competency calls for understanding how structures impact different families in varying ways. While child welfare cases are often much more complex than these brief hypothetical scenarios, these examples allow for an

initial exploration of how this tenet of structural competency might be applied.

4. Observing and imagining structural intervention. It is likely that in many instances child welfare workers are not overlooking these structural factors, but rather feel limited in terms of what they can do to address them. It may be difficult to talk about structural issues, and even harder to imagine how to help families, given these barriers. Dedicated child welfare workers may find the resources at their disposal miss the mark in addressing the actual underlying issues that led to a family's involvement with child welfare services. Observing and imagining structural intervention may seem like the most difficult aspect of structural competency, as structures may feel unalterable.

Structural barriers may be an area where all parties in a child welfare case—parents, workers, judges, and others—feel as though their hands are tied. It is important to recognize, as noted by Downey and Gómez (2018), that "by definition, structural issues cannot be addressed by an individual" (p. 217). Micro interventions alone will not address structural-level problems, and macro changes may indeed seem infeasible, given the current political and economic environment in which child welfare systems function. Structural competency gives workers a language to recognize these structural barriers, and it calls for interventions that fit a family given the relevant structural constraints.

Returning to the case examples above, each person involved may determine that they cannot impact the availability of evening childcare options or safe, affordable housing. While a child welfare worker likely cannot change structural barriers in any given case, they may instead highlight such issues and suggest exploring feasible alternatives given a family's structural barriers. Using the first example from above, a structurally competent response might encourage the child welfare worker to collaborate with the mother's neighbors to explore options related to communal child care, or the worker might collaborate with other providers to advocate for subsidized child care services in the area (especially if multiple families are confronting the same struggle), rather than requiring the mother to secure paid childcare or alter her work hours.

A moderate but feasible practice change might be for caseworkers to communicate structural vulnerability information

to supervisors, judges, and other decision-makers, emphasizing the structural factors that affect families, with the goal of creating a practical plan for a family facing structural barriers. Child welfare can thus recognize a risk to child safety posed by structural determinants, and help reduce stigma by helping parents feel understood and supported. In recognizing problems that lie within structures and not within the family, the system may be better positioned to make changes on a macro level.

A practical approach could be to incorporate a structural vulnerability checklist into the child welfare safety and risk assessments that are utilized by child welfare agencies and typically focus on family-level risk and protective factors (Southern Area Consortium of Human Services [SACHS], 2012). Incorporating a structural vulnerability checklist—akin to the Bourgois and colleagues (2017) structural vulnerability checklist mentioned previously—within safety and risk assessments could help child welfare workers better name the structural factors impacting families, understand their prevalence, and begin the process for brainstorming structural intervention. While some practice changes that the child welfare field could consider have been discussed here, organized advocacy for an integrated structural competency paradigm within child welfare is necessary to effect wider shifts on disparities and stigma. The goal is for child welfare practice to incorporate changes that will better assist families in addressing their needs given structural constraints, beginning a pivot from oversight to advocacy, while ultimately striving toward larger structural changes.

5. Developing structural humility. Structural humility calls for individuals to accept that the full impact of structural barriers for any given family may never be fully understood, no matter how much training one receives. Metzl and Hansen (2014) call for structural competency practitioners to recognize that the skills they develop are "the beginning points of conversations rather than endpoints" (p. 12). This tenet makes explicit that structural competency is a process rather than an accomplishment, and addressing structural factors is an ongoing practice that has no threshold for completion.

In child welfare, this competency suggests a training and practice paradigm that emphasizes the unique and particular structural interactions for each family, decentering the notion of workers as the sole arbitrators of correct or appropriate

parenting practices. Child welfare workers adopting a structural humility perspective may be less inclined to feel frustration toward parents who do not readily and quickly respond to individual-focused interventions, possibly reducing disparities and stigma felt by parents in their interactions with workers. Structural humility is a foundational mindset for constructing effective and achievable interventions for parents and families living in hierarchical systems that marginalize them.

Conclusion

Existing paradigms in child welfare continue to frame parent behavior as the cause of child maltreatment and the target for intervention, but these approaches fail to address wider structural factors operating in the lives of vulnerable families. Structural competency challenges the traditional assumption that child welfare involvement results from parents' personal agency alone and reframes child maltreatment to include societal-structural issues, expanding the site for intervention. It can give child welfare workers language and knowledge to address structural issues they have already begun to identify in their work. While structural competency is not a silver bullet that will address all of the complexity related to disparities and stigma, it could motivate a needed shift in child welfare practice. Updating policies with a structurally competent lens may decrease disparities on a macro level, and training workers to see and speak to structural forces may reduce experiences of stigma on a micro level. Conceptual and concrete suggestions presented here for how structural competency might be implemented in child welfare are by no means exhaustive, nor are they intended to be prescriptive. Practitioners, policy makers, researchers, and families are best positioned to implement structural competency more broadly, collaborating to develop creative methods for integrating structural competency.

The literature on structural competency in the medical arena is still nascent, and further research is needed to assess methods for implementing structural competency. Additionally, while the fields of child welfare and medicine do have many parallels, they also have crucial differences. One major difference between medicine and child welfare is that families do not often voluntarily seek out child welfare intervention,

whereas people often actively seek out healthcare intervention. Another difference is that the primary clients in medicine are the patients themselves, whereas in child welfare "the primary client of services is the child, and yet the focus of much concern about cooperation and engagement is the parent" (Platt, 2012, p. 140). Therefore, what works for implementing structural competency in medicine may or may not work in child welfare, and strategies for implementing structural competency within child welfare should be subject to rigorous empirical testing in order to determine their impact.

Structural competency provides a unified language for discussing the structural issues that many in the child welfare field already recognize to some degree. Ideally, if structural factors are widely accepted as important and examined within child welfare services, there will be increased motivation and opportunity for engaging with structural issues at macro levels in policy development and advocacy. Just as Metzl and Hansen (2014) suggest medicine needs to incorporate social and political action to address structural factors that lead to disparities, so too can child welfare recognize the need for wider advocacy. Structural factors that implicate disparities and stigma in child welfare can only be shifted at structural levels, requiring an evolution in research, practice, and dialogue at local, regional, and national levels.

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