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Center for the
Study of
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Ideas into Action

CULTURE IS HEALING

*Removing the Barriers
Facing Providers of
Culturally Responsive
Services*

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ABOUT CSSP

CSSP is a national, non-profit policy organization that connects community action, public system reform, and policy change. We work to achieve a racially, economically, and socially just society in which all children and families thrive. To do this, we translate ideas into action, promote public policies grounded in equity, support strong and inclusive communities, and advocate with and for all children and families marginalized by public policies and institutional practices.

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INTRODUCTION

For all children and their families to thrive, they need to be safe and healthy, together in their communities. For all parents, raising healthy children requires not only ensuring their material security and physical wellness, but also helping them to understand the family and community they belong to and to define and develop their own positive identities, including around their race, language, culture, and history.

Though being a parent is immensely rewarding, even in the best of times raising children brings myriad everyday stressors—the sleepless nights, the spells of illness, the sudden childcare cancellations—that mean parents need support from immediate family members or friends, and also the broader community. In times of crisis, this support is particularly critical. When families face eviction or cannot put food on the table, or when they face racist discrimination, these stressors exacerbate and create other problems, such as mental health struggles or family conflict, that require organized and sustained resources to stabilize. Yet to truly be supportive of children and their families, these resources should not simply be “provided.” They must reflect families’ actual needs, as they define them; support their existing strengths; and respect the diversity of families in the community. In practice, these principles mean recognizing that for families of color, who navigate the stressors of historical and ongoing racism, services grounded in race and culture are more than just elements of healthy development, but can also serve as key protective buffers against racism’s harms, while those that ignore cultural context can exacerbate harm.¹ Unfortunately, due to racism, colonialism, and xenophobia, our public policies and systems have not been designed to truly support families, least of all Black,

Indigenous, Latine/x, and other families of color.² Instead, child protective services, behavioral health, the youth and adult criminal legal systems, and others have developed to surveil, pathologize, and separate families, denying them the opportunity to thrive together and decide their own futures.³

Ensuring child and family well-being requires a radically different, anti-racist response of supports that center the voices of diverse children and families of color, are dignified and strengths-based, and that are offered in spaces they trust. As this brief highlights, community-based organizations across the country are striving to answer that call. Yet these community organizations face numerous barriers, including state and federal funders that do not recognize the true value of services developed for or by the community being served, restrictive evidence criteria that limit the availability of effective programs responsive to communities of color—even as those communities are the most harmed by the status quo—, and burdensome bureaucracy that makes it harder for providers to operate and to serve children and their families. This brief lifts up the voices of those community providers, with the goal of highlighting and addressing the barriers that stand in the way of all families having the support they need.



DESPITE RECENT CHANGES, CHILD WELFARE POLICIES CONTINUE TO OBSTRUCT CRITICAL RESOURCES FOR FAMILIES

It is widely understood that children do best when they are with their families in their homes and communities and are able to access the resources and opportunities they need to thrive. Nevertheless, almost 207,000 children were removed from their families into state custody in 2021, even when they could have been safe at home if they'd had the resources they needed, delivered in a manner that was responsive to their needs.⁴

Yet these families lacked the concrete supports—such as cash, food, and housing assistance—and therapeutic services that could have helped.⁵ In most cases (63 percent), the circumstances related to the removal concerned neglect, primarily due to poverty. A little over a third of removals (36 percent) were related to parental substance use, and another 14 percent were related to caretaker physical or mental health.⁶ These removals traumatize children, taking them away from their families and communities, often from the only parents they know, and also alienating them from their siblings and other family members. This destabilization can lead to unresolved grief, anxiety, post-traumatic stress disorder, and other adverse psychological and biological consequences.⁷ In addition to the trauma of removal, children are also harmed directly by the experience of foster care, which often fails to provide them with safe and caring environments, or to prepare them to transition to adulthood. These harms fall heaviest on the Black, Native American, and other children of color who are overrepresented⁸ in state custody due to longstanding anti-Black racism, anti-Indigenous colonialism, and white supremacy in economic policy, health care, and in the child welfare system and other public systems.⁹ Even without child removals, child welfare's intrusive investigations and extensive surveillance apparatus cause harm. Families living in highly surveilled communities live in fear of a knock on the door from CPS due to even just missing a child's medical appointment or a child missing too many days of school over the course of the year.¹⁰ These unwelcome "visits" alone can cause trauma and they erode community trust, as doctors and teachers serve as mandatory reporters to CPS and neighbors at times weaponize CPS against each other.¹¹

Inflicting the harm of family separation on children, their families, and communities is a policy choice. Though many of the conditions used to justify child removals are preventable and many children can be kept safely at home while their families receive support, historically little attention has been

paid to keeping families together by connecting them to the resources they need before a crisis. Often, any assistance a family does receive from child welfare comes only *after* a removal.¹² The passage of the Family First Prevention Services Act (FFPSA) in 2018, however, indicates growing attention on prevention. FFPSA was designed and passed with a goal of supporting children and families in their community by reimbursing states with federal Title IV-E dollars for prevention services offered to children considered to be at risk of removal. FFPSA, if implemented well and in ways that are anti-racist and affirming of family identities, better aligns child welfare financing toward preventing child removals for families who become known to the child welfare system and are at risk of separation.

However, FFPSA comes with certain undeniable disadvantages that keep federal Title IV-E prevention dollars from truly supporting children and families, particularly Black and Indigenous children and families, in their communities and outside of the surveillance of the child welfare system. First, the funds are still tied to the child welfare system, a system that causes great harm to the families it touches even without removing children, especially to communities of color. Parents can still be forced into participating in services by the threat of child removal if they don't comply. Youth and their families have been clear that they do not trust child welfare and would instead prefer resources provided *outside* of surveilling and separating systems.¹³ Second, under FFPSA funding is only available to reimburse state child welfare agencies for programs that address parenting, mental health, and substance use. Nothing is available to address the root causes of poverty or to meet the concrete needs of families that fuel child removals. Third, FFPSA restricts reimbursement to only specific evidence-based programs (EBPs) that are approved by the Title IV-E Clearinghouse (Clearinghouse). Yet the Clearinghouse's "one-size-fits-all" evidentiary criteria creates substantial barriers to approval for culturally responsive and culturally

adapted programs that could most benefit families of color (see below).¹⁴ The Clearinghouse only considers quantitative evidence of effectiveness derived from randomized control trials or quasi-experimental designs, as documented in peer-reviewed studies. This narrow definition of evidence reflects a Eurocentric worldview that prioritizes empirically derived, quantitative data and scientific expertise over more diverse worldviews, which may emphasize community-defined evidence rooted in historical community practice, qualitative data, and community expertise about what works.¹⁵ In utilizing this restrictive and narrow definition of evidence, the Clearinghouse devalues research about the importance of identity and connection to community as healing. Further, despite the heavy emphasis on empirical evidence, the Clearinghouse does *not* require approved programs to show evidence of effectiveness for families of color, who are the ones most threatened by child removal and for whom programs should be the most effective. Consequently, the Clearinghouse criteria not only hampers the availability of services that can meet the specific needs of families of color while approving services that may be less effective, ineffective, or even detrimental for families of color but also prevents and excludes programs that could lead to the greatest benefit. Considering that these services are

intended to keep families from being separated by CPS, the criteria ultimately harms families by placing greater weight on preventing deviations from flawed evidence standards than on employing all available tools to promote families staying together and prevent the trauma of child removals.

There is a clear disconnect between what children and families want and need and what services states are allowed to provide under FFPSA.²⁰ States and community organizations also report a significant problem that comes from this strict definition of “evidence-based” where providers have community-defined evidence to support the effectiveness of their programs, but the evidence is deemed insufficient by states. There is an additional disconnect between what community-based organizations that contract with state child welfare agencies need to develop and build evidence on culturally responsive programs (e.g., capacity to collect and analyze data), and the support that state agencies can actually provide. As a result, very few states have chosen to implement any culturally responsive programs, and therefore, there are significant gaps in the ability of states to truly meet the needs of children and families of color—furthering the harm caused to these families and communities.

CULTURALLY RESPONSIVE AND CULTURALLY ADAPTED PROGRAMS

Culturally responsive programs are those that are designed for a specific population and grounded in that group’s needs, values, and perspectives. For example, a parenting program that was initially developed for White American families will reflect common White American norms around parenting, family structure, problem-solving, and communication that may conflict with or not fully resonate for groups with different cultural contexts. EBPs are not always described as targeted toward any particular racial or ethnic group, but as most prevention services are originally developed for and tested on White participants, EBPs are more likely to be culturally responsive to White participants than for participants of color.¹⁶

To improve their effectiveness for people of color, programs developed for White people may be *culturally adapted*, meaning that some program elements, such as language or example scenarios, are modified to better meet participants’ cultural norms and values. According to a systematic review of 35 studies of culturally adapted EBPs used in behavioral health and child welfare contexts, 27 studies reported adapted programs led to improved outcomes, including higher participant satisfaction, increased retention or completion of services, better mental health, and other positive impacts.¹⁷ Not only can cultural adaptations be more effective than non-adapted programs but providing a non-adapted program that was tested on an advantaged group to a marginalized group can be harmful and increase health disparities.¹⁸ However, because adaptations are often limited to maintain the core elements of the original program, they may still reflect underlying norms that are not culturally appropriate and may not be as responsive to family needs as programs that are grounded in cultural values.¹⁹

METHODOLOGY

To help fill this gap for services tailored to families of color, CSSP first conducted an environmental scan to identify organizations across the country that are providing culturally grounded services. To learn more about these organizations' experiences providing these services and the challenges they face, CSSP also conducted interviews with 24 organizations in nine states: Arizona, California, Florida, Hawai'i, Montana, New York, North Carolina, Oregon, and Washington.

Providers CSSP interviewed included both those whose participants were not known to be connected to the child welfare system and those whose participants were referred directly from child welfare agencies and family courts. Of the organizations interviewed, only three are implementing programs that are included in the Title IV-E Clearinghouse.²¹ Most other providers are offering original programs that they developed and that are not considered evidence-based, either by the Clearinghouse or by other federal or state agencies. However, each provider offers programs that they have demonstrated improve outcomes in the areas FFPSA prioritizes: parenting, mental health, and substance use. Some providers also assisted with accessing concrete supports, as those they serve often struggle with poverty, food and housing insecurity, unemployment, lack of transportation, and other economic barriers. Of the services discussed, six primarily served Native Americans, six primarily served Black people, three served a multi-ethnic population, and another three focused on the Latine/x community. Two programs were explicitly serving Indigenous peoples originating from Mexico, though they also included participants from the larger Latine/x community.²² Lastly, two programs served Hawaiians of differing ethnicities, with a particular focus on Native Hawaiians, one targeted Asian Americans, Native Hawaiians, and Pacific Islanders, and a final program specifically served the Cambodian community.

CSSP selected organizations offering services which were either designed by and with the communities of color they serve, and/or that are delivered in a manner that is consistent with the values, customs, and self-identified needs of participants. To guide the development, selection, and delivery of their programs, community-based organizations (CBOs) commonly employed community advisory boards, focus groups, or feedback from participants to identify unaddressed needs. Of the organizations interviewed, most are offering programs that were created for communities of color, including 16 that developed their own programs for their specific local community.²³ Two providers offer

programs that were not created for communities of color but that they culturally adapted. Finally, one CBO is implementing a program that was neither developed nor adapted for communities of color.

CSSP developed an interview protocol to understand how providers see their programs as helping address the challenges facing their communities, and the current barriers organizations experience in building evidence for culturally responsive programs, contracting with state agencies and securing federal funding. This brief highlights the lessons learned from those interviews and presents recommendations for how state and federal partners can better support investments in programming that meets the expressed needs of communities of color.



Finding: Communities Need Culturally Rooted Services Because They Face Intergenerational Trauma from Racism, Cultural Stigma, and Systemic Neglect



“The community has been through so much in our county. I mean, aside from the original genocide and displacement, there has just been like a lack of prioritization. In the Native communities...there’s a lot of system mistrust for very good reasons.”

—A provider of mental health services for Native Americans

For all people, a key component of holistic well-being is a strong sense of cultural identity and belonging, which can be bolstered through cultural events, language, preparing and sharing traditional foods, and artistic expression. While fostering a positive identity and sense of community is always important, these interviews underscored that families also specifically need culturally responsive services that can address the particular challenges facing people of color living in a racist society. First, providers repeatedly identified historical and ongoing trauma as a contributor to community members’ mental health challenges, which they were trying to address through positive cultural messaging. For example, the providers serving Native American families explicitly cited intergenerational trauma and cultural disconnection stemming from policies of colonization and genocide, including forced boarding school attendance and relocation, as the primary threats to community well-being. In addition, several providers shared that community members also struggle with pervasive and demoralizing racist stereotypes. As one provider serving Black youth expressed, they are bombarded by “lies that [they] are a mistake, that [they] are not worthy...the lies of White supremacy and Black inferiority.” In the words of another provider, “many of the depictions of American Indians have been very stereotypical...they’re not the articulate ones. They’re not the ones who are seen as having great opportunity or anything like that...it really debilitates our young people.” Providers stressed that this



“[Many young people] don’t have anybody who is knowledgeable about culture or in a position to teach them. Or maybe there’s even emotions around it like shame or, you know, all of the symptoms of that historical trauma.... And so having an opportunity to be taught or to be connected in a way that they weren’t able to access in their own family. That’s a theme that comes up a lot. Just being able to learn how to gather or how to weave or, you know, is like, really powerful for the youth. That comes up over and over again.”

—A counselor for Native American youth

trauma has very sobering consequences. One organization serving Native Americans estimated that 40 percent of the community’s young women had considered suicide by the age of 25. Another provider noted that, according to the Center for Disease Control and Prevention, almost 23 percent of Latina teens attending high school in her city had seriously considered attempting suicide.²⁴ As racism is such a central challenge facing these communities, supportive services therefore need to be able to recognize the reality of living as a person of color in a white supremacist society, as well as to avoid replicating the same racism families already struggle with.

Despite the high need for mental health support, providers reported that their communities also struggle with cultural stigma around mental health. The provider of a suicide prevention program noted that the organization’s community needs assessments revealed strong resistance to discussing



“The system is not kind to a lot of people, yeah. Right, and that has been a huge thing, so there’s distrust, also, of the system. So, working through engagement strategies that help us address those very real systemic and outside influences becomes a really huge part of what we do.”

— A provider of a family-based treatment program for Latine/x teens

mental health in the Latine/x community. The program manager of another Latine/x-serving organization remarked that her participants were more comfortable describing their physical symptoms of stress than they were speaking directly about mental health. In interviews with two different organizations serving Asian Americans, staff members highlighted that their community members often did not have the language to explicitly discuss depression or anxiety, with one provider noting that her clients preferred to use the language of sleep quality as a code for depression. These examples demonstrate the need for community-based supports that recognize and understand these nuances.

Providers also underscored how their communities are underserved and ill-treated by the public systems that are supposed to help. In many cases, providers noted that their families had access to few prevention services generally and a dearth of culturally appropriate services specifically,

and some organizations were the only providers of culturally responsive services in their area. Providers further reported that when their participants did interact with the public behavioral health system, they faced discriminatory treatment, lack of language access, and an imposition of Eurocentric health norms that made them feel pathologized and that did not reflect their values. These experiences have created persistent mistrust of official systems and underscore the need for culturally responsive services that draw upon the specific values and strengths of the communities they serve and are offered in spaces community members trust.



“We held these focus groups, and we got people from behavioral health to come and attend. And what they heard was Black people basically denouncing the system. You know, by saying that...some of them had actually tried to avail themselves of the services, but felt like they were treated, you know, in such a disrespectful way that they never wanted to go back.”

—A provider of mental health services for Black children and adults

Finding: Providers Regard Attentiveness to Culture as Important for Program Success

Though providers offering culturally responsive or adapted services all pay attention to cultural needs, they differed in their views regarding the relationship between culture and program goals. Some organizations viewed incorporating culture as a path to improve program delivery. For example, one organization implements a parenting curriculum that was initially developed solely with White participants. Yet as this provider serves a multi-ethnic population who do not always relate to the examples used in the curriculum, the provider regularly modifies the content to make it more culturally relevant with the aim of more effectively meeting other program outcomes. However, for other CBOs fostering cultural resilience and connection is a distinct goal that is central to the value they provide participants. The director of a mental health program for children and families directly framed the organization’s embrace of ceremonial song and dance, language revival, and sharing traditional meals as the opposite of the typically available services that either explicitly marginalize people of color or overlook the importance of diverse cultural norms and values, especially

in a White-dominated society. The provider of a parenting curriculum in Hawai’i draws on Native Hawaiian family values with the express aim of helping participants reconnect to traditional family norms that were disregarded and devalued under colonization. For these organizations, cultural resilience is the foundation that helps the community heal from intergenerational trauma. Overall, whether providers incorporate culture as a means to an end or center and build on culture as critical to well-being, providers regard explicit attention to specific cultural needs as critical to program success, a perspective that was echoed in most other interviews. This importance placed on cultural specificity echoes research that when services are created without attention to culture and identity, they can be less effective at best and outright harmful at worst.²⁵ In contrast, programs that do pay attention to cultural needs, especially those developed by and for the communities they serve, can be more effective than supportive services that pay no attention to cultural specificity.²⁶



Finding: Providers Struggle to Navigate Restrictive Evidence-Based Requirements



“What does ‘evidence-based’ look like for kids of color or for communities of color?... A lot of that research either doesn’t exist or it’s very scarce.”

—The CEO of a non-profit providing afterschool counseling

Subfinding 1: Restrictive criteria exclude programs designed by and for communities of color because of limited definitions of “evidence.”

The interviews also demonstrated how FFPSA, and other prevention funding sources that privilege narrowly defined evidence-based programs, disadvantage programs and services that could be effective for communities of color without consulting the people for whom these services are intended. For example, providers reported that participants experienced improved outcomes aligned with the Clearinghouse’s target domains of child well-being and adult well-being, including reduced suicide risk and depression, improved family communication and relationships, and deepened community connections. Yet when asked what they considered evidence of program effectiveness, providers pointed to sustained attendance, participants referring other community members, high demand for services leading to waitlists, alignment of services with traditional practices, positive qualitative feedback from participants, and positive outcomes noted in pre and post surveys.²⁷ These forms of evidence reflect Indigenous and diverse ways of knowing and are examples of community-defined evidence, which focuses on what practices are supported by tradition, beliefs, or personal experience, even if they are not empirically validated. However, these types of evidence do not meet FFPSA’s and many other federal and state funding stream’s narrower definition of evidence, which requires quantitative data validated through controlled trials, even if that data has not been validated by any communities of color, never mind the specific community that will participate in the program.²⁸ Limiting funding streams to “evidence-based practices” and privileging some forms of evidence over others can therefore disadvantage culturally responsive approaches while leaving families with only unresponsive interventions.

Subfinding 2: Becoming an evidence-based program is resource-intensive and not well funded.

Building the sort of quantitative evidence required to be considered evidence-based is expensive and time-

consuming, which means funding that require EBPs often excludes less-resourced organizations.²⁹ This resource barrier applies even to those adapting approved EBPs, as even modest cultural adaptations must undergo new evaluations and require capacity and evaluation infrastructure that are not attainable for small programs without additional resources and support. Currently, of the organizations CSSP interviewed, less than half of all providers (11) have partnered with external researchers to build their evidence base. Seven of those organizations are providers funded through the California Reducing Disparities Project (CRDP), an initiative created specifically to help develop and evaluate culturally relevant practices according to community-defined criteria. Even CRDP support may not lead to programs being regarded as “evidence-based” by FFPSA or other federal or state standards because the evaluations do not require control groups.³⁰ The remaining organizations (13) were largely relying on pre and post surveys and other data outlined above. When asked if providers had plans to generate more quantitative data through controlled trials, responses varied. Some organizations were already doing the most that they could, with one program coordinator remarking that “a lot of small, medium-sized nonprofits—and maybe some of the bigger ones—[we] don’t have the capacity to do that.” Another person noted that her organization was trying to build evidence by conducting their own research, though they had no dedicated funding to do so. Considering that by some estimates it can take well over a decade to move from the development of an EBP to full implementation, and that funding to support this work is hard to access, many of these community providers may never achieve the “evidence-based” label.³¹ Yet others who had secured funding that either did not require EBPs or that supported promising practices saw no value in building the intensive evidence



“[Regarding the] evaluation, you could always get a university partner for that, and it wouldn’t necessarily have to be super expensive. But, yeah, that can take a while, so that would be more difficult. And then you got to get it published, and then you got to get it reviewed...by the archive and you know they say it takes 10 years to go from the academic perspective to being evidence-based and implemented. So that is a barrier for sure.”

—The research director of an organization serving multi-ethnic rural families

that FFPSA requires. Two other providers mentioned that they could not justify creating a control group that does not receive responsive services when there is so much need yet so few options for their community to receive culturally competent care.

Subfinding 3: Inconsistent definitions of what qualifies as an EBP makes it difficult for providers to access funding. Finally, inconsistency in the acceptance of EBPs poses yet another barrier to funding. As different funders and research clearinghouses define “evidence-based” differently, even those providers who are implementing services designated as evidence-based may find that some grants do not recognize that specific EBP. For example, one CBO faced challenges qualifying for a grant from the Center for Disease Control and Prevention, which did not recognize the curriculum the provider offered as “evidence-based”, even though the curriculum is recognized by the California Evidence-Based Clearinghouse for Child Welfare, the Substance Abuse and Mental Health Services Administration, and the Department of Justice.³² Several other providers CSSP interviewed are offering services that qualify as EBPs in some clearinghouses but that are not approved by the Title IV-E Clearinghouse. Consequently, even as evidence builds for culturally responsive services, they might still not be funded, hampering efforts to provide them to families who could benefit.

Finding: Evaluators Who are Unfamiliar with the Community Can Lead to Culturally Inappropriate Evaluations

While partnering with external evaluators can be helpful, evaluations can be limited when evaluators do not understand the cultural context of the intervention or if evaluation criteria are inappropriate. For example, one provider described how an external program evaluator wanted to collect data from participants about their mental health, sexual orientation, and gender identity. Not only did the questions use terms that did not translate properly, but they were also deemed disrespectful to ask of the elders participating. The program coordinator at another nonprofit recalled that their experience with evaluation was challenging because their evaluator, who was similarly not attuned to what questions were inappropriate, was nevertheless asking questions required by their funder.

Finding: Excessive State Requirements and Bureaucracy Harms Providers’ Ability to Offer Services

Beyond the challenges posed by evidence criteria, community-based providers also struggle to navigate the cumbersome rules, bureaucracy, and other barriers of government contracts. Moving from applying for a grant to receiving funding for services rendered is often a long and arduous process full of confusion, stress, and uncompensated labor. It can take hundreds of pages of documentation just to respond to an RFP, with still hundreds of pages of further supporting documents once a provider is approved. Then, CBOs spend much of their time trying to comply with even more paperwork to track data program outcomes once they begin providing the contracted services. For providers who have multiple funding sources, the immense reporting requirements are even more challenging because they must comply with various statutory requirements for different agencies. One provider, recalling their experience submitting data reports to their city, county, and state funders, outlined how challenging it was to comply with each funding source’s different reporting standards, as well as different portals and IT requirements. All the documentation takes time away from serving the community and increases the workload for the staff, which can lead to burnout.

The onerous paperwork can then lead to reimbursement delays, due to both the time needed for contract monitors to review the submitted material and any missing data or misunderstandings. Multiple providers described late payments ranging from a month to two years after services have already been provided. Even without delayed payments, reimbursement provisions fundamentally create substantial hardship for smaller and less resourced nonprofits, especially those led by people of color, as they are less likely than larger, predominantly White-led organizations to have sufficient cash reserves or private donors to help them meet upfront financial requirements. With late reimbursements, this harm is further compounded. In a particularly egregious example, months-long reimbursement delays forced the executive director of one nonprofit to take out a loan just to pay their staff, which the organization is still paying off years later. Nor was the organization ever able to receive the full funds they were owed to pay down the debt, as eventually enough time passed that the fiscal year ended, and the state funds were no longer available. These constant roadblocks have led some to conclude that government administrators do

not act as partners working to help organizations provide badly needed services, but rather as distrustful gatekeepers who act like providers are “taking money from them” and that “their primary objective is not to get the services to the people [but instead to] audit the expenditures.”



“I’m sure we’re submitting well over 1,000 pages today of the records...and you know that they’re going to look for one page off, yeah. In the meantime, they put us on hold until they have a chance to review everything, and so, you know, they make it difficult to survive. Basically, I contribute 100% of my salary back to the organization and I live on my Social Security, but you know, even with that, I’m at the point now behind the state agencies where I’m barely making it.”

—The president of an organization serving Black youth

Furthermore, the funding that is available is not always sufficient or sustainable. Though some providers noted that their grants were flexible and could be used for general operating support, others received grants that were restricted to program delivery and specific billable services,

which is also how FFPSA reimbursement operates. Without unrestricted funds, providers struggle to absorb funding delays or to pay staff for the significant effort of navigating bureaucratic barriers. Several providers noted that funding was not enough to pay staff competitive salaries or to provide health care benefits, which is particularly troubling as there is a shortage of qualified staff to hire, especially in rural areas that are already underserved. The limited pay also made it harder for providers to meet the high demand for services in communities that have great need. Several providers noted that once community members began to trust the services they offered, their caseloads grew substantially, leading to overloaded staff and long waitlists. Additionally, some funders do not recognize the significant time invested in building trust with the community or in ensuring that services are culturally appropriate, time that staff put in separately from program implementation. Short-term grants, that only last one to three years, also make it difficult for organizations who are constantly applying and reapplying for grants, trying to retain staff, and trying to ensure that trust built with children and families is not eroded by staff departures or programs ending.



RECOMMENDATIONS TO BETTER SERVE COMMUNITIES OF COLOR THROUGH CULTURALLY RESPONSIVE PROGRAMS

The organizations that CSSP interviewed are committed to meeting their communities' needs and to helping children, youth, and families heal and thrive. Yet they are operating in a funding environment that does not consistently value the importance of and evidence behind programs grounded in cultural values and prioritizes services that are not tailored for their community members' needs and that can often be experienced as harmful. These organizations, which are often led by people of color, are also struggling with a government contracting process that disadvantages organizations like theirs and makes it harder for them to serve their communities as needed. The following recommendations are actions that federal, state, and local agencies can take to better support culturally responsive services and the organizations that provide them.

Steps that policymakers can take to invest in the development and evaluation of culturally responsive services:

- **Modifying federal Clearinghouse criteria to be more inclusive of culturally responsive programs by expanding allowable evaluation methods, supporting cultural adaptations, and incorporating community-defined evidence standards.**³³ Health and Human Services (HHS) should revise Clearinghouse criteria to: require states evaluating programs funded with Title IV-E dollars to meaningfully partner with community members with lived experience with the child welfare and other public systems to co-design evaluations of where services could be adapted to better meet the needs of the children and families in their community,³⁴ and allowing them to adjust program implementation as part of a robust continuous quality improvement process without risking the loss of reimbursement, including when adjustments require adding new content to existing EBPs.³⁵ HHS should also incorporate research around culturally appropriate and equitable evaluation criteria when assessing new programs to approve³⁶ and pair disaggregated analysis with qualitative data to understand what aspects of programs work (or don't work) for which communities and why. Additionally, Clearinghouse criteria for promising practices should not require randomized control trials.³⁷ Furthermore, HHS should modify Clearinghouse criteria by accepting more inclusive types of community-defined evidence of effectiveness that CBOs can most readily produce, much of which they already submit to state funders, such as pre and post surveys, qualitative feedback, and data concerning sustained attendance and community referrals. When recognized as a complement to empirical evidence, community-defined evidence standards can better identify beneficial practices that have been validated by community acceptance and utilization.³⁸
- **Engaging community members to define and identify promising practices using community-defined evidence.** One approach that agencies can learn from is the California Reducing Disparities Project (CRDP), which used focus groups, town halls, and surveys focused on distinct communities of color to identify population-specific behavioral health needs, service gaps, and promising practices supported by community-defined evidence.³⁹ The multi-year initiative then funded organizations offering services aligned with the findings of the needs assessments, and funded evaluations to support building quantitative and qualitative evidence. Other states should follow this example by working with community members, providers, and researchers to identify what kinds of practices are beneficial, as well as what practices are harmful. Agencies, policymakers, and researchers running clearinghouses should also work with these stakeholders to identify what communities consider to be evidence of effectiveness.

- **Creating a federal and/or state grant program to develop culturally responsive programs and to build evidence through appropriate evaluations.** When the community engagement process identifies promising (and harmful) practices and community-defined evidence standards, state and federal agencies should rewrite their grants to direct funding toward the development and implementation of aligned services and evaluation strategies and away from culturally harmful practices. For example, the California Department of Health Care Services built on CRDP's work by allocating \$429 million in grants to organizations seeking to implement, expand, or scale aligned EBPs and/or community-defined evidence practices.⁴⁰ Similarly, state child welfare agencies should work collaboratively with other state partners to identify dedicated funds for this work. For example, as agencies draw down Title IV-E dollars for services that were previously funded through state dollars or more flexible child welfare financing streams, such as the Social Security Block Grant or Community-Based Child Abuse Prevention funds, they should redirect the newly freed state and flexible federal dollars to support the development of responsive services. These grants should help organizations build evidence for aligned programs that reflect both community-defined evidence criteria and Clearinghouse criteria. Grants should also specify that services should be evaluated according to principles for culturally appropriate evaluation, which include ensuring the evaluation team includes people with relevant lived experience and those from the community, developing an advisory board of community stakeholders who are paid for their contributions, and asking questions that are relevant to the stakeholders.⁴¹ Without a culturally appropriate approach to evaluation, evaluators will be unable to properly understand program effectiveness and risk doing harm. If agencies are not able to fund evaluations directly, they can also provide technical assistance to organizations and help them partner with external evaluators who are trained in culturally competent evaluations.
- **Revising contracting criteria to include EBPs from different clearinghouses and community-defined responsive practices.** The CBOs CSSP interviewed already face barriers to building the evidence required to be considered "evidence-based," which requires significant investments in time and organizational resources. Inconsistency in what qualifies as an EBP increases the risk that these efforts will be wasted. States should eliminate confusion stemming from inconsistent definitions of "evidence-based" and make it clear that contracts that require EBPs will accept programs that are included in any of the various databases. Contracts should also allow for cultural adaptations of programs that have been designated as evidence-based, even if the adapted version does not itself have that designation. For programs that are not included in any of the clearinghouses, such as many culturally responsive programs, states should engage community boards and experts in prevention services to develop community-defined evidence criteria to assess the evidence of program effectiveness and include these criteria in requests for proposals and contracts language.

Actions that policymakers can take to increase support for culturally responsive service and improve partnerships with providers include:

- **Providing longer-term flexible funding for general operating support.** Short-term grants that only last one or two years keep providers chasing grants and make it difficult for them to plan for longer-term needs. State contracts should provide funds for at least three years to allow CBOs to be more sustainable. Providers also often receive funding that is restricted to programmatic expenses, even when the funding amount does not reflect the true cost to provide services. General operating support allows organizations to account for the upfront costs of community engagement, administrative paperwork, and funding delays. General support also provides stability that allows for more consistent staffing and programming, which is critical for mental health and substance abuse services that rely heavily on building trust and relationships. Additionally, flexible funding would help providers support participants more holistically, especially for those whose financial circumstances pose barriers to participating in prevention services, such as when participants cannot put gas in the car or cannot afford child care.

- **Establishing timeframes for reimbursement and protecting providers from financial burden due to delays.** Providers should not have to wait months to years to be paid for services, forcing them to take out loans that burden them financially. In a study of the problem of delayed funding for city nonprofits, a task force convened by the New York City Comptroller's Office recommended holding contracting agencies accountable for timely payments by establishing timeframes for payments.⁴² State contracting agencies should adopt this recommendation to help hold themselves accountable to nonprofits they fund. States should also adopt a version of New York City's Returnable Grant Fund, which offers nonprofits that are awaiting city contracts an interest-free loan against their outstanding grant to cover up to three months of expenses. One provider in New York spoke highly of this fund, which allows their organization to stay afloat as they await reimbursement. Additionally, providers who must take out private interest-bearing loans should be reimbursed for the interest paid and ultimately paid the full value of the contract for the services they provide.
- **Prioritizing investments in programs developed by and for communities of color.** When reviewing proposals from providers, states should prioritize and give additional credit for those programs that are able to demonstrate input from the community in the design of the program. States should also award points to proposals that can demonstrate the integration of core cultural values, and what elements of culture and identity they are incorporating as a healing approach.
- **Structuring contracts to recognize that communities are not limited to specific geographic areas.** A few providers mentioned that their funding limited them to serving families in specific counties or cities, which meant they had to turn away people from outside the service area who were otherwise going unserved. Additionally, research has shown that transition-aged young people define their community based on relationships, not geographical boundaries.⁴³ States should integrate this finding into how they structure service contracts. Allowing providers to serve people throughout the state and outside of specific geographic areas would help them serve those who currently need services but may be outside of the service area of an organization's contract.
- **Reviewing the contracting process to reduce areas of greatest inequity and redundancy.** The present focus on EBPs and onerous administrative requirements make it harder for less resourced organizations to access government contracts and create barriers to the proliferation of culturally responsive services. State and federal funders should partner with a diverse range of providers to review the contracting process, from initial RFPs to funding allocations and reimbursement timelines to assess where in the process organizations led by and serving communities of color are least represented, and how to best remove barriers. As a start, grant administrators should review what are the statutory requirements governing the funding and should remove documentation requirements that are duplicative and unnecessary. State funders should also streamline their reporting infrastructure and requirements so that organizations with different state grants do not have to navigate conflicting processes. In Philadelphia, the Department of Human Services has identified opportunities to restructure and reimagine which requirements they make of providers are truly necessary and which can be removed, as well as how the state can help providers meet their criteria.
- **Fostering more cooperative relationships with CBOs and reducing administrative barriers.** Exhaustive reporting requirements imposed by contracting agencies can create financial burdens and negative relationships with providers who are offering needed services yet do not feel trusted. When providers have been reliably and responsibly applying grant funds, it is a waste of time, effort, and goodwill to require them to fill out mountains of paperwork in reporting requirements. One provider in Washington mentioned that in contrast to previous antagonistic funding experiences, their funding from the United Way of King County was based on trust, required minimal reporting requirements, and created the space for the nonprofit to discuss any challenges and opportunities for programmatic growth. State contractors should similarly reduce the frequency of audits for organizations that have shown a track record of success and focus instead on how to best facilitate service provision and support providers with challenges they face.

CONCLUSION

We owe children and families of color the chance to thrive together through the ups and downs of life. Many government agencies, including child welfare agencies, now recognizing that racism within and outside of public systems has harmed families of color, have committed to reducing racial disparities and furthering racial equity. Yet many families of color still live in communities that are widely recognized to be ill-served by the current human services infrastructure and which have too few, if any, of the culturally responsive services they deserve. While increasing funding for prevention is a step in the right direction, state and federal agencies must issue an explicit commitment to supporting organizations providing services that are developed to best serve communities of color and take active efforts to remove barriers and unnecessary criteria that are in the way. Agencies must coordinate to invest in the development and provision of those culturally responsive services. This work will require affirming the value in services that are grounded in cultural values and utilize connections to identity and culture as healing, expanding their understanding of what communities themselves consider evidence that programs are serving them effectively, as well as intentionally structuring funding to enable CBOs to provide services to populations who are already underserved. Without these efforts, the benefit of prevention services will be limited, and families will continue to be subject to destructive separations that do not serve children's well-being.

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- ²⁰ CSSP provided technical assistance to states implementing Title IV-E prevention plans between 2019 and 2022.
- ²¹ Due to the Clearinghouse's strict criteria, however, an organization offering an approved program may be ineligible for reimbursement if they are implementing the wrong version. For example, the Strengthening Families Program has different curricula for children in different age groups. Though the Clearinghouse has approved the version for youth ages 10-14, the version for younger children ages 6-10 has not been approved, meaning the provider could receive reimbursement for the services they currently offer older children but not for their services to younger children.
- ²² Two of the organizations that CSSP interviewed centered their work on Indigenous migrants, including those from the Mexican states of Oaxaca, Guerrero, and Michoacán. In those interviews, staff members noted that they also serve those from the larger Latinx community as well.

- ²³ Two programs have been so substantially adapted that they are being categorized as original programs for this report. For example, one service is a pilot model that is an adaptation of another program that is itself a cultural adaptation of an original EBP.
- ²⁴ CSSP uses the term “Latina” here to reflect the terminology used in the source data. U.S. Center for Disease Control and Prevention, 2021 Youth Risk Behavior Surveillance System. Data retrieved from: <https://nccd.cdc.gov/Youthonline/App/Default.aspx>
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- ²⁷ A few programs have resulted in published studies. Two programs, the Cambodian Association of America’s Community Wellness Program and Flint Fathers and Sons, have been evaluated using quasi-experimental design, while another, MICUNAY, has been evaluated using a randomized control trial. Comunilife’s Life is Precious program, has been researched through an uncontrolled trial without a comparison group. The Weaving Healthy Families pilot that the All Nations Health Center is implementing has yielded a published. Lastly, a few other programs have been studied qualitatively.
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