



DISPROPORTIONALITIES AND DISPARITIES IN CHILD WELFARE

A Supplement to *Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals*



National Center on
Substance Abuse
and Child Welfare



Children's Bureau

An Office of the Administration for Children & Families

SAMHSA
Substance Abuse and Mental Health
Services Administration

This tool is a companion resource to the online tutorial *Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals*. The [National Center on Substance Abuse and Child Welfare \(NCSACW\)](#) offers free online tutorials to: 1) help professionals increase their knowledge and skills to work with families affected by substance use disorders (SUDs), and 2) help build cross-systems collaboration across the various agencies serving these families.

This tool, which contains five modules to align with the online tutorial for child welfare professionals, is a resource for child welfare supervisors and staff to: 1) initiate discussions to understand the link between disproportionalities, disparities, and the child welfare system; 2) recognize disproportionalities and disparities when working with families affected by SUD; and 3) implement strategies to increase engagement with families and reduce inequities.

This tool will help child welfare supervisors

- **Connect the dots** between the online tutorial and applying an equity lens to policies and practices
- **Build staff knowledge** by offering key considerations for working with families
- **Share practice tips** for staff to implement equitable practices

Following this tool is a list of [Helpful Resources](#) to ensure supervisors have the necessary information to not only have these conversations with staff, but to support practice changes that decrease disproportionalities and disparities.

BACKGROUND

SUDs are some of the most stigmatized health conditions worldwide and historically drug policies have often perpetuated negative views of individuals affected by this disease. In the 1970s drug abuse was referred to as “America’s public enemy.” This contributed to a policy approach referred to as a “War on Drugs” with increased penalties for possession and sales of drugs, disproportionately affecting low income communities and people of color—particularly the Black population. The policies had devastating effects on these families and communities lasting for generations.³ The negative views of substance use continued to steer other antidrug campaigns such as “Just Say No” in the 1980s and influenced responses to the crack cocaine epidemic that spawned increased penalties, policing, and

DISPROPORTIONALITY is defined as the “overrepresentation or underrepresentation of a racial or ethnic group compared with its percentage in the total population”.¹

DISPARITY is defined as “unequal outcomes of one racial or ethnic group compared with outcomes for another racial or ethnic group”.²

APPLYING AN EQUITY LENS involves deliberately taking actions to ensure an organization’s mission, vision, and goals incorporate an intentional focus on reducing disproportionality and disparities, providing equitable access, and improving equitable outcomes for all families.

imprisonment.⁴ Negative media portrayals were common during this time—for example, incorrectly labeling infants exposed to substances as “addicted” and referring to them as “victims”—which further perpetuated damaging stereotypes, stigma, and discrimination. Child welfare workers should understand the effects of this history and how it continues to contribute to disproportionality and disparities within their system. For more information on stigma and SUDs, please see NCSACW’s [*Disrupting Stigma: How Understanding, Empathy, and Connection Can Improve Outcomes for Families Affected by Substance Use and Mental Disorders*](#).

Child welfare data helps identify where disproportionalities and disparities exist. For example, research shows that families of color are disproportionately represented in the child welfare system compared to the general population. The Adoption and Foster Care Analysis and Reporting System (AFCARS) 2020 data indicates that American Indian/Alaska Native children make up 2% of the children in foster care—and Black children make up 23%⁵—despite the fact they represent only 1% and 14% percent of the child population in 2020, respectively.

In addition to being overrepresented in the child welfare system, children of color also face more distinctly negative outcomes (including more foster care placement, longer stays in out-of-home (OOH) care, and lower rates of reunification).^{6,7,8} Racial and ethnic minority children may experience more negative outcomes in part because of racial bias and discrimination expressed by individuals (including child welfare workers, health care providers, and other mandated reporters); structural racism (i.e., historical policies and cultural dynamics); policies and legislation that fail to meet the needs of children of diverse racial and ethnic backgrounds; limited availability and access to services; and poverty and geographic context (such as region or neighborhood).^{9,10}

Data for families affected by parental substance use indicates that Black, Indigenous, and persons of color experience disproportionate effects of substance use and mental health disorders while facing disparate access to treatment.

- The rate of opioid overdose deaths increased by 38% from 2018 to 2019 for non-Hispanic Black individuals despite stable or decreasing rates for other races and ethnicities.¹¹
- In the 2009 National Survey of Substance Abuse Treatment Services, counties that lacked access to outpatient SUD facilities had a higher percentage of residents who were Latinx, living in poverty, uninsured, and living in rural areas.¹²
- A study of SUD disparities in rural Native American communities found that stress from racism and historical trauma causes SUDs and is a barrier to recovery.¹³

Factors influencing these SUD-related racial disparities include: 1) deeply rooted institutional racial biases that structure the experience of all Americans, 2) the effect of racism-related stressors on the biopsychosocial functioning of non-White people, and 3) the conscious and unconscious biases that shape behaviors directed at people of color (including those biases among health care practitioners themselves).¹⁴

While racial and ethnic disparities exist within child welfare, treatment, and institutions, other disparities are pervasive based on gender, sexual orientation, age, disability, socioeconomic status, and geographic location. Young people who identify as lesbian, gay, bisexual, transgender, questioning, or another diverse identity (LGBTQ+), for example, are also overrepresented in the child welfare system.¹⁵ This group faces an increased risk of discrimination, harassment, and other threats to their physical and emotional well-being compared to adolescents who identify as heterosexual—placing them at greater risk for substance use and mental disorders.^{16,17}

Child welfare supervisors and their staff must identify and understand how policies and practices contribute to the disproportionate representation and disparate outcomes that may be driven by disparate access to services and supports.

 CONNECT THE DOTS

Module 1 provides foundational information regarding substance use, including the long-term effects of substances on the brain, the effects of SUDs on parenting, how substance use affects a family, and what recovery from SUD looks like.

Substance use often stems from trauma; many parents with SUDs and child welfare involvement, as well as their families, have experienced traumatic events. Substance use sometimes serves as a coping mechanism to escape anxiety, hopelessness, and the effects of historical, intrapersonal, and complex trauma.

There are many situations, including poverty, housing insecurity, domestic and sexual violence, and discrimination that are traumatic in nature. Child welfare workers must recognize and understand the environmental context in which families live to assess and build protective capacity—particularly to support people and communities who have experienced complex trauma (e.g., racial discrimination, community violence, and limited access to services—including substance use or mental disorder treatment).

PROTECTIVE CAPACITY

Child welfare workers must assess a family's protective capacity along with child risk and safety. Protective factors include individual, family, community, and societal characteristics that reduce the risk of child abuse and neglect while promoting child and family well-being.¹⁸ Identifying protective factors in collaboration with parents and family members can empower them to build on their strengths and engage in the recovery process. For more information on protective factors please see [Module 6 of NCSACW's Building Collaborative Capacity Series](#).

 BUILD STAFF KNOWLEDGE

Ensure staff are familiar with Adverse Childhood Experiences (ACEs): The Centers for Disease Control and Prevention (CDC) defines ACEs as potentially traumatic events that occur in childhood, and the conditions in a child's environment that undermine their sense of safety, stability, and bonding.¹⁹ The [Adverse Childhood Experiences \(ACE\) study](#), conducted by Kaiser Permanente and the CDC, is one of the largest studies involving the effects of childhood trauma on adult health and well-being. ACEs are categorized into three groups: abuse (emotional, physical, and sexual), neglect (emotional and physical), and household factors (domestic violence against mothers, mental disorders, SUDs, divorce, and incarcerated family members). Findings show the more ACEs a child experiences, the more likely they will have health issues, poor academic achievement, and SUDs later in life.

Discuss how racism and discrimination are part of ACEs: Research shows certain groups carry a greater risk of experiencing ACEs; these groups include people of color, individuals with less than a high school education, those who make less than \$15,000 per year (or are unemployed/unable to work), and the LGBTQ+ population.²⁰ An individual's exposure to racism and discrimination increases the risk of developing toxic stress and ACE-associated health conditions, such as SUDs.²¹ ACEs can accumulate and have lasting effects throughout a person's life—increasing the risk for poor social outcomes, disease, and death.²²

Introduce implicit bias and discuss why it matters for reducing disparities and disproportionality: Bias stems from the brain forming automatic associations to understand the world more effectively and efficiently.²³ Bias can be based on race, gender, socioeconomic status, sexual orientation, or other factors. While bias can be positive or negative, there are ways to reduce its effects on an individual's behavior. To do this, it is important to understand different types of bias:

Explicit bias includes "overt acts of discrimination, racism, and prejudice" while *implicit bias* includes "unconscious attitudes and beliefs" [that can produce discriminatory behaviors].²⁴ Explicit bias is easier to recognize, while implicit bias often goes unnoticed. Implicit bias is not intentional and typically occurs without conscious thought although no less harmful; it's therefore equally important to identify and determine how it affects actions.

Implicit bias may significantly alter how child welfare workers treat parents and families in the child welfare system (e.g., how a child welfare worker assesses a father who is upset or angry at a court hearing). If workers have not examined their biases, they may think a parent is "out of control" or "noncompliant" and may fear the parent's anger. However, if a worker understands their own implicit biases, they may understand the parent is reacting to trauma and needs support.

SHARE PRACTICE TIPS

- Discuss how a parent's childhood experience should always be a component of any family assessment.
- Discuss how everyone has implicit biases and the ways to reduce their effect on behavior and decision-making. Some strategies to mitigate bias include²⁵
 - Awareness of your own biases
 - Empathy
 - Self-reflection with supervisors or co-workers
- Share information about SUD treatment services in the community—including the populations they serve.
- Recommend verbally screening all parents for substance use with a standardized and validated screening tool; this step can reduce the likelihood of implicit biases influencing decisions on whom to screen. This will help determine the presence of substance use and equitably identify the need for a further clinical SUD assessment across all families.

NCSACW RESOURCES FOR CHILD WELFARE WORKERS

[Understanding Substance Use Disorders—What Child Welfare Staff Need to Know](#) spotlights five quick tips for child welfare professionals to use in their practice with families affected by SUDs.

[Understanding Screening and Assessment of Substance Use Disorders—Child Welfare Practice Tips](#) helps child welfare workers access information about identifying and assisting parents involved with child welfare services who may have a SUD. The resource includes details on signs and symptoms, validated screening tools, practices, and referral for assessment.

 CONNECT THE DOTS

Module 2 discusses the importance of early identification and the crucial role child welfare workers play in helping parents enter and complete SUD treatment. The module also identifies specific strategies for engaging parents at different stages of treatment and recovery.

Engaging individuals in treatment is challenging across all populations. The challenge worsens when staff ignore or misunderstand an individual's cultural context and even lack respect for the individual.²⁶ It is important to understand stigma's role as an engagement barrier, particularly for people of color and other underserved groups. Stigma can increase the trauma these individuals have faced and create fears that prevent engagement. Many parents, for example, fear their children will be placed in OOH care if they admit to having a SUD. This fear is intensified for people of color who have disproportionately experienced surveillance and criminal justice and child welfare involvement.^{27,28}

Respecting and responding to the cultural identities and needs of families are important ways to improve engagement to services. Child welfare workers can: 1) reduce stigma, and 2) build strong trusting relationships with families that promote engagement by acknowledging and respecting the cultural influences of race, ethnicity, religion, geography, and customs.

 BUILD STAFF KNOWLEDGE**Examine cultural competence, humility, responsiveness, and the implications for child welfare practice:**

Cultural competence is a set of values, principles, behaviors, attitudes, policies, and structures that enable a system, organization, or individual to work effectively across cultures.²⁹ Given the evolving and dynamic nature of individuals and cultures, staff should think of cultural competence work as ongoing—beginning with cultural awareness and a commitment to understanding the role culture plays in service provision and an individual's treatment and recovery.



Cultural humility goes beyond cultural competence as it includes a commitment to practice ongoing self-reflection, awareness, and accountability to increase the quality of engagement with diverse groups.³⁰

Cultural responsiveness means valuing individuals from all backgrounds and requires the ability to recognize potential bias, understand, and overcome cultural differences to work effectively with families.³¹ It also calls on staff to respect individuals of all cultures, socioeconomic classes, races, disabilities, religions, genders, sexual orientations, as well as other groups. Strengthening cultural responsiveness helps ensure engagement with families.

Talk about why language matters: Our language has a profound effect on our attitudes and beliefs; words can either perpetuate or prevent stigma.³² The specific words we choose to describe SUD can influence not only the likelihood that someone will engage in treatment, but also the quality of treatment they receive.³³ Using person-first, strength-based language helps reduce stigma associated with SUDs, increases engagement with families, and works to ensure successful referrals to SUD treatment.

SHARE PRACTICE TIPS

- Encourage child welfare workers to speak openly to families about their strengths and needs. Families are the ultimate experts on their own lives and experiences.
- Share ways to assess a provider's cultural responsiveness:
 - Do they offer evidence-based practices, and if so, are they designed to meet the needs of the specific population being referred?
 - Do they offer services in different languages, and if so, what languages are available?
 - What trauma-informed practices do they use? Do these practices consider racism (inter-personal and structural) and discrimination as trauma?
 - Do they have practices in place to assure supportive clinician-client matching?
- Discuss how the path to recovery looks different for each individual and how it's important to match service referrals to needs. Child welfare workers should partner with parents to determine the best treatment approach; this may include complementary, alternative, or holistic approaches different cultures may embrace.
- Discuss how language matters and provide examples of person-first terms:
 - Use "parent with a SUD" instead of "addict" or "drug abuser."
 - Use "parent in recovery" instead of "former addict."
 - Use "infant with prenatal substance exposure" instead of "addicted baby."
- Offer strategies for speaking to families in ways that are strengths-based and demonstrate staff are open to learning:
 - Ask open-ended questions about traditions, values, and beliefs to build rapport and increase understanding.
 - Avoid making assumptions about the family's culture, race, ethnicity, and community.

NCSACW RESOURCES FOR CHILD WELFARE WORKERS

[Understanding Engagement of Families Affected by Substance Use Disorders—Child Welfare Practice Tips](#)

Practice Tips provides practical tips to engage families affected by SUDs in the child welfare system.

 CONNECT THE DOTS

Module 3 describes SUD treatment while offering information on the types, settings, approaches, and key elements of treatment for parents. It also highlights the unique considerations of women and men with SUDs as well as any co-occurring issues they may face.

Effective SUD treatment and other services must fit an individual's cultural beliefs and practices, gender-specific needs, and preferred language; it must also be respectful of racial and ethnic identity and sexual orientation. By providing culturally responsive services, providers improve relationships with their clients, encourage engagement in services, increase chances of treatment completion, and decrease disparities in mental health and substance use.³⁴ Child welfare workers must understand how treatment providers tailor services to be culturally competent and responsive.

 BUILD STAFF KNOWLEDGE

- **Discuss what culturally competent and responsive SUD treatment looks like:** Learn the [Substance Abuse and Mental Health Services Administration \(SAMHSA\) Recovery Model](#), which outlines four dimensions that support recovery, and stresses the importance of connectedness and social support. The model can provide a basis for identifying local, culturally responsive SUD treatment programs and supports. Culturally competent SUD treatment should occur at all levels of the organization—including counselors and staff, programs and interventions, and administrative efforts—thereby reinforcing the value of diversity, flexibility, and responsiveness regarding the current and changing needs of families.³⁵
- **Provide information about peer support services and how peers are a critical part of the recovery process:** Peers provide a range of non-clinical supportive services to facilitate the process of recovery and holistic wellness. They use their experience in recovery to provide understanding, encouragement, hope, assistance, and guidance to help individuals obtain and maintain their own recovery. Like other aspects of SUD treatment and support services, peers should be culturally competent and responsive. Ideally, peers represent and reflect the families they serve to best achieve shared understanding, respect, and mutual empowerment.

 SHARE PRACTICE TIPS

- Offer specific questions to ask families about their treatment needs:
 - What is your understanding of SUDs?
 - Would you prefer to receive services from a clinician of your own racial, ethnic, or cultural group? Are there other characteristics such as gender or age that might help you connect with a clinician?
 - Is there a faith- or community-based service you prefer?
 - Do you prefer a specific community or neighborhood? Where would you be most comfortable going for treatment? Are there areas where you would not be comfortable going?
 - Do you have any concerns about seeking treatment? What questions do you have about what to expect from treatment?
- Discuss the value of peer support services. Encourage child welfare workers to ask SUD providers if they offer these services. If not, determine if there are local peer organizations that can help.
- Invite individuals with lived experience with the child welfare system and recovery to share their experiences to further build knowledge.



CONNECT THE DOTS

This module provides information on the effects of pre and postnatal substance exposure on children, and the key roles child welfare workers play in identifying and meeting their needs.

Research has established significant disparities across key health and SUD treatment outcomes for mothers and infants. Racial biases may contribute to families of color receiving insufficient prenatal care and SUD treatment services.^{36,37} Pregnant women with SUDs, particularly women of color and those with low socioeconomic status, may be subject to increased surveillance and may experience a higher likelihood of criminal justice and child welfare involvement.³⁸

Studies have shown that women of color, particularly Black and Native American women, encounter screenings for drug use in healthcare settings at a disproportionate rate. For example, one study of illicit drug testing procedures among postpartum women indicated that Black women and their newborns were 1.5 times more likely to be tested for illicit drugs as compared to non-Black women, despite there being no significant difference in positivity rates among the women.³⁹

Postnatally, children of color are more likely to experience removal and longer placement in OOH care, and less likely to reunify with their parents. This is due to several compounding factors, such as individual biases, increased surveillance, limited resources in the community, and an overall correlation between poverty and maltreatment.⁴⁰ Child welfare workers must recognize how disparities in multiple systems affect both the family environment and a child's development—and how to improve access to needed services.



BUILD STAFF KNOWLEDGE

- **Share facts about effective treatment for pregnant and parenting women, and the disparities that exist in access and engagement (e.g., access to medication-assisted treatment (MAT)).** The American College of Obstetricians and Gynecologists (ACOG) and SAMHSA have both designated MAT as the gold standard for pregnant and parenting women.^{41,42} While MAT is the most effective treatment for opioid use disorders (OUDs), its service utilization does not match the need. In fact, only about 50% of pregnant women with an OUD receive MAT.⁴³ Further, racial and ethnic disparities in the use of MAT have been documented, including greater prescription rates and more timely receipt of treatment for White individuals compared to Black individuals.^{44,45}
- **Discuss how stigma associated with a parent's SUD can affect children:** Children are uniquely affected by their parent or caregiver's SUD. They may experience unmet developmental needs, impaired attachment, and emotional distress.⁴⁶ They may be overwhelmed with fear, anger, and confusion which can affect their behavior. Children of parents with SUDs may lash out, shut down, or isolate themselves from others.⁴⁷ Child welfare workers should have age-appropriate conversations with children about what is happening with their parents. Connecting them to culturally responsive services in the community can create a safe space for children to ask questions, raise concerns, and express their feelings.

- **Discuss reasonable and active efforts, and the importance of applying an equity lens to policies and practices:**

There is no federal definition of “reasonable efforts,” but some states have created language clarifying the term in their child welfare statutes. The Child Welfare Information Gateway (CWIG) refers to reasonable efforts as “accessible, available, and culturally appropriate services that are designed to improve the capacity of families to provide safe and stable homes for their children.”⁴⁸ Active efforts are defined as “the affirmative, active, thorough, and timely efforts intended primarily to maintain or reunite an Indian child with his or her family.”⁴⁹ The Indian Child Welfare Act (ICWA) mandates states to make active efforts in every ICWA case in two areas:

- Provide services to the family to prevent removal of an Indian child from his or her parent or Indian custodian
- Reunify an Indian child with his or her parent or Indian custodian after removal

Active efforts are different from *reasonable* efforts in that reasonable efforts might consist only of a referral for services, while active efforts would involve: 1) identifying the most culturally competent and responsive services; 2) helping families overcome engagement barriers to those services; and 3) following up with the family on how they feel about the services, if the services are a good fit, or if services need to be changed.⁵⁰



SHARE PRACTICE TIPS

- Ensure all children affected by parental substance use have access to culturally competent and responsive services, such as developmental and therapeutic treatment.
- Collaborate closely with providers working with the child and family. Monitor appointment schedules, family strengths and needs, and potential resources to ensure the family receives comprehensive and coordinated care across systems. Explore cultural barriers if families are not engaging in services.
- Consider how a parent’s SUD has affected the children. Have appropriate conversations with children to understand their feelings related to their parent’s substance use, and provide culturally responsive treatment referrals (e.g., play therapy, social skills training, early intervention) when appropriate.
- Coordinate with early childhood educators, teachers, and other school staff to help children access school-based services, after-school care, and tutoring.
- Help parents advocate for their children if specialized testing or services are needed.



CONNECT THE DOTS

Module 5 provides partnership and case management strategies to enhance coordination and collaboration between SUD treatment and child welfare workers. Child welfare workers should know the characteristics of successful collaboration between professionals, and how they partner with SUD treatment programs to prepare parents for treatment.

Families affected by SUDs often have needs beyond the scope of the SUD treatment providers; it is unlikely that any single agency has the full range of services required to fulfill the diverse needs of the families they serve. Thus, relationships with other community providers (e.g., housing, employment services, education services, transportation, physical and mental health care, childcare) are crucial to support long-term recovery in a manner that aligns with the beliefs, traditions, and values of families served.

Child welfare workers should partner with providers and organizations that the family identifies as important to their recovery and well-being, including cultural leaders, community representatives, cultural centers, and faith-based organizations.

NCSACW RESOURCES FOR CHILD WELFARE WORKERS

NCSACW developed the seven-part *Building Collaborative Capacity Series* to provide states and communities with strategies to create cross-systems collaborative teams, communication protocols, and practice innovations. These strategies aim to improve screening, assessment, and engagement to best serve families affected by SUDs and child welfare service involvement.

Module 7—Frontline Collaborative Efforts: Developing and Monitoring Joint Case Plans and Promoting Treatment Retention and Positive Family Outcomes describes how cross-systems collaboratives can jointly develop and monitor family case plans that are culturally responsive, mutually supportive, and considerate of the needs and requirements placed on the family by each involved system. It also offers strategies to promote family engagement into treatment and case plans, treatment completion, and positive family outcomes.

BUILD STAFF KNOWLEDGE

- **Help child welfare workers broaden their view of community support service providers that can help families in their recovery:** Identify providers in the community that serve families with diverse racial and cultural backgrounds. Reach out to those providers to discuss their service array and the populations they serve. Being aware of formal and informal networks of providers will help ensure families receive a holistic and comprehensive case plan.

- **Share strategies for cross-systems communication:** Strategies to support cross-systems collaboration include identifying a point of contact at each agency, establishing the frequency of updates/communication, defining expectations, and understanding the type of services available. Child welfare workers need to feel safe sharing communication challenges with supervisors and leadership so they can develop protocols and tools to improve communication.

SHARE PRACTICE TIPS

- Understand the values and mission of community organizations that serve families with diverse cultural backgrounds.
- When communicating with providers from outside organizations, avoid using uncommon terminology and acronyms to support cross-agency communication.
- Ask how community partners address bias in their agencies.
- Use “warm hand off” and “closed loop” referrals to increase the likelihood that parents will connect with services.
- Share information pertaining to a parent’s SUD history with the SUD treatment provider before the assessment.
- Ensure or develop a method for SUD treatment providers to report back to the child welfare worker on a parent’s progress.
- Schedule time to meet with community partners to discuss what is and isn’t working as it pertains to referral and information exchange procedures.

CONCLUSION

As a supervisor, having these conversations with your staff may prove challenging, and at times, uncomfortable. Remember: Lead with empathy and openness when educating others about the inequities that exist within child welfare. To help inform your conversations, NCSACW provides the following resources organized under each of the modules in the online tutorial.

For more information, please visit NCSACW’s [*Spotlight on Disproportionality and Disparities among Families in Child Welfare and Substance Use Treatment*](#) page.



HELPFUL RESOURCES

MODULE 1

- [What are ACEs? and How Do They Relate to Toxic Stress?](#): This infographic, created by Harvard's Center on the Developing Child, outlines the relationship between ACEs, toxic stress, racism, and community violence, with tips on how to counteract and prevent lasting harm.
- [The prevalence of adverse childhood experiences, nationally, by state, and by race/ethnicity](#): This brief uses data from the 2016 National Survey of Children's Health (NSCH) to describe the prevalence of one or more ACEs among children from birth through age 17, as reported by a parent or guardian. Children of different races and ethnicities do not experience ACEs equally.
- [Systemic Racism and Substance Use Disorders](#): This article reviews evidence of racial disparities in SUDs, discusses the historical and legal foundations of systemic racism and disparities, and offers recommendations for providing care in a more racially equitable manner.
- [inSIGHT: A Workshop on Implicit Racial Bias for Child Protection Workers](#): This online course includes insights on how our minds operate and helps explain the origins of implicit associations. It uncovers personal biases and suggests strategies for overcoming them.
- [Child Welfare Practice to Address Racial Disproportionality and Disparity](#): This CWIG resource offers child welfare caseworkers, administrators, program managers, and policymakers strategies to mitigate racial disproportionality and disparity along the child welfare continuum.

MODULE 2

- [Cultural Humility Practice Principles](#): This one-page resource, created by the National Child Welfare Workforce Institute, outlines the definition and practice principles associated with cultural humility.
- [Moving Toward Cultural Competence: A Bridge Worth Building](#): This National Resource Center for Diligent Recruitment document covers key areas to explore and questions to consider when moving toward cultural competence regardless of the population involved.
- [Cultural and Structural Competence to Improve Treatment Engagement for Substance Use Disorders](#): This guide, created by Advancing Drug and Opioid Treatment (ADOPT) at the University of California San Francisco, explores opportunities to improve cultural and structural competency among health care providers who treat patients with SUDs.
- [Treatment Access Barriers and Disparities Among Individuals with Co-occurring Mental Health and Substance Use Disorders: An Integrative Literature Review](#): This Journal of Substance Abuse Treatment article examines literature pertaining to barriers to substance abuse and mental health treatment for persons with co-occurring substance use and mental health disorders (COD).

MODULE 3

- [Why Develop a Culturally Sensitive Approach to Social Work with African American Clients?](#): This article in *The New Social Worker* asks current and future therapists to examine and confront their views regarding racism and discrimination.

- [Developing Culturally Responsive Approaches to Serving Diverse Populations: A Resource Guide for Community-Based Organizations](#): This guide, from the National Research Center on Hispanic Children and Families, helps community-based organizations (CBOs) serve the needs of their diverse populations. Child welfare workers can use this tool to assess whether the CBO they refer to is culturally competent.
- [Peer Recovery Staff's Role in Engaging Families and Supporting Their Recovery Journey](#): In this four-part video series, Peer Recovery Support staff from the Quality Improvement Center from Collaborative Court Team demonstration sites discuss their personal journeys from program participants to program staff and court team members—and how they support families in their own recovery journey. The videos help professionals from child welfare, courts, SUD treatment, and other family-serving agencies better understand how Peer Recovery Support staff can strengthen services and supports for children and families.
- [Meeting the Needs of Lesbian, Gay, and Bisexual Clients in Substance Abuse Treatment](#): This study in Counselor found that additional screening, training, outreach, and integration of health care services are warranted to meet the needs of lesbian, gay, and bisexual individuals in SUD treatment.
- [Access For Everyone: A Toolkit for Addressing Health Equity and Racial Justice within Integrated Care Settings](#): The Center of Excellence for Integrated Health Solutions offers this toolkit to help professionals and organizations in mitigating racial inequities and the associated stigmas that lead to mental health and SUD treatment disparities, while offering tools to support clients and organizations.
- [The Office of Minority Health](#): This organization offers free and accredited e-learning programs to improve cultural competency, along with information on the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS Standards) framework. There's also a toolkit to guide organizations' efforts in evaluating their implementation of the CLAS standards.

MODULE 4

- [Advancing Racial and Ethnic Equity in Head Start](#): This webinar series promotes anti-bias and anti-racist strategies Head Start and Early Head Start programs can use in their practices, services, and systems. Topics for the four-part series include:
 - Exploring terminology and engaging in challenging conversations about racism
 - Discussing children's understanding of race and identity development
 - Developing anti-bias teaching practices
 - Examining principles and policies for human resource systems that honor diversity, equity, and inclusion
 - Exploring intersections of health and racial equity to support the wellness of children, families, and staff
- [Tribal Family Wellness Plan Learning Modules](#): This four-part series provided by the Quality Improvement Center for Collaborative Community Court Teams, in collaboration with the Tribal Law and Policy Institute, guides tribally driven collaboratives seeking to: 1) reduce the impact of SUDs on pregnant and parenting women and their families, and 2) improve systems and services to reduce prenatal substance exposure, prevent the separation of families, and support infant and family wellness.
- [Strategies for Reducing Disproportionality](#): This CWIG webpage provides state and local examples of mitigating disproportionality and disparity and moving toward equity within child welfare systems.
- [Increasing Equity in Early Intervention](#): This brief from the Education Trust offers several strategies states can use to mitigate systemic racial inequities in the health and education systems where early intervention services take place. The report identifies the strengths of state approaches and opportunities for increasing equity in providing early intervention services.

MODULE 5

- [**Race and Poverty Bias in the Child Welfare System: Strategies for Child Welfare Practitioners**](#): This American Bar Association article examines the overrepresentation of children and families of color in juvenile courts and recommends careful consideration and reform of the policies and practices that drive bias and structural racism.
- [**MythBusters: Implicit Bias Edition**](#): This guide from the Kirwan Institute for the Study of Race and Ethnicity provides the definition and effects of “implicit bias.”

CONTACT US

FOR ADDITIONAL INFORMATION: ncsacw@cffutures.org

For our newsletter to get the first look at resources, education, grant opportunities, and training developed by the NCSACW: <http://wwwcffutures.org/subscribe/email>

TOLL-FREE: 1-866-493-2758

VISIT OUR WEBSITE: <https://ncsacw.acf.hhs.gov/>

Acknowledgments: This resource is supported by contract number HHSS270201700001C from the Substance Abuse and Mental Health Services Administration (SAMHSA), co-funded by Children’s Bureau (CB), Administration on Children, Youth and Families (ACYF). The views, opinions, and content of this resources are those of the authors and do not necessarily reflect the views, opinions, or policies of SAMHSA, ACYF or the U.S. Department of Health and Human Services (HHS).



National Center on
Substance Abuse
and Child Welfare



ENDNOTES

- 1 Child Welfare Information Gateway. (2021). *Child welfare practice to address racial disproportionality and disparity*. U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau. <https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/>
- 2 Child Welfare Information Gateway. (2021). *Child welfare practice to address racial disproportionality and disparity*. U.S. Department of Health and Human Services, Administration for Children and Families, Children’s Bureau. <https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/>
- 3 Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African American Population: An Urgent Issue*. Publication No. PEP20-05-02-001. U.S. Department of Health and Human Services, Office of Behavioral Health Equity. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf
- 4 Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African American Population: An Urgent Issue*. Publication No. PEP20-05-02-001. U.S. Department of Health and Human Services, Office of Behavioral Health Equity. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf
- 5 Adoption and Foster Care Analysis and Reporting System (AFCARS). (2020). *The AFCARS report*. Administration for Children, Youth and Families, Children’s Bureau. <https://www.acf.hhs.gov/sites/default/files/documents/cb/afcarsreport28.pdf>

- 6 Center for the Study of Social Policy & Annie E. Casey Foundation. (2011). *Disparities and disproportionality in child welfare: Analysis of the research.* https://casala.org/wp-content/uploads/2015/12/Disparities-and-Disproportionality-in-Child-Welfare_An-Analysis-of-the-Research-December-2011-1.pdf
- 7 Child Welfare Information Gateway. (2021). *Child welfare practice to address racial disproportionality and disparity.* U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. <https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/>
- 8 National Conference of State Legislatures. (2021). *Disproportionality and race equity in child welfare.* <https://www.ncsl.org/research/human-services/disproportionality-and-race-equity-in-child-welfare.aspx>
- 9 Child Welfare League of America. (2008). Statement submitted to hearing on racial disproportionality in foster care before the Subcommittee on Income Security and Family Support of the Committee on Ways and Means, U.S. House of Representatives, 110th Congress, second session, July 31, 2008. Government Printing Office.
- 10 Child Welfare Information Gateway. (2021). *Child welfare practice to address racial disproportionality and disparity.* U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. <https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/>
- 11 Larochelle, M. R., Slavova, S., Root, E. D., Feaster, D. J., Ward, P. J., Selk, S. C., Knott, C., Villani, J., & Samet, J. H. (2021). Disparities in opioid overdose death trends by race/ethnicity, 2018–2019, from the HEALing Communities Study. *American Journal of Public Health*, 111, 1851-1854. <https://doi.org/10.2105/AJPH.2021.306431>
- 12 Cummings, J. R., Wen, H., Ko, M., & Druss, B. G. (2014). Race/ethnicity and geographic access to Medicaid substance use disorder treatment facilities in the United States. *JAMA Psychiatry*, 71(2), 190-196. <https://doi.org/10.1001/jamapsychiatry.2013.3575>
- 13 Skewes, M. C., & Blume, A. W. (2019). Understanding the link between racial trauma and substance use among American Indians. *American Psychologist*, 74(1), 88–100. <https://doi.org/10.1037/amp0000331>
- 14 Farahmand, P., Arshed, A., & Bradley, M. V. (2020). Systemic racism and substance use disorders. *Psychiatric Annals*, 50(11), 494-498.
- 15 Child Welfare Information Gateway. *Working with LGBTQ+ youth and families.* <https://www.childwelfare.gov/topics/systemwide/diverse-populations/lgbtq/>
- 16 Child Welfare Information Gateway. *Working with LGBTQ+ youth and families.* <https://www.childwelfare.gov/topics/systemwide/diverse-populations/lgbtq/>
- 17 Medley, G., Lipari, R. N., Bose, J., Cribb, D. S., Kroutil, L. A., & McHenry, G. (2016, October). *Sexual orientation and estimates of adult substance use and mental health: Results from the 2015 National Survey on Drug Use and Health.* NSDUH Data Review. Retrieved from <https://www.samhsa.gov/data/>
- 18 Family Resource Information, Education, and Network Development Service National Center for Community-Based Child Abuse Prevention. *Protective factors.* <https://friendsnrc.org/prevention/protective-factors/>
- 19 Violence Prevention. *Preventing Adverse Childhood Experiences.* Center for Disease Control and Prevention. https://www.cdc.gov/violenceprevention/aces/fastfact.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fviolenceprevention%2Facesstudy%2Ffastfact.html
- 20 Injury Prevention & Control: Division of Violence Prevention. *We Can Prevent Childhood Adversity: The Science of Adverse Childhood Experiences (ACEs) Shows We Can Improve People's Lives and Help Them Thrive.* Veto Violence. <https://vetoviolence.cdc.gov/apps/aces-infographic/home>
- 21 Harris, N. B., Maybank, A., Bignall, R., & Wade, R. (2021, April 28). *Racism and discrimination as risk factors for toxic stress [Webinar].* ACEs Aware. <https://www.acesaware.org/events/racism-and-discrimination-as-risk-factors-for-toxic-stress/>
- 22 Injury Prevention & Control: Division of Violence Prevention. *We can prevent childhood adversity: The science of Adverse Childhood Experiences (ACEs) shows we can improve people's lives and help them thrive.* Veto Violence. <https://vetoviolence.cdc.gov/apps/aces-infographic/home>
- 23 Kirwan Institute for the Study of Race and Ethnicity. (n.d.) *Implicit bias 101.* Center for the Study of Social Policy. <https://kirwaninstitute.osu.edu/implicit-bias-101>
- 24 Ellis, K. (2019, December). *Race and poverty bias in the child welfare system: Strategies for child welfare practitioners.* American Bar Association. https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january---december-2019/race-and-poverty-bias-in-the-child-welfare-system---strategies-f/
- 25 National Institute for Children's Health Quality. (2019). *Implicit bias resource guide.* <https://www.nichq.org/resource/implicit-bias-resource-guide>
- 26 Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African American Population: An Urgent Issue.* Publication No. PEP20-05-02-001. U.S. Department of Health and Human Services, Office of Behavioral Health Equity. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf

- 27 Child Welfare Information Gateway. (2021). *Child welfare practice to address racial disproportionality and disparity*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. <https://www.childwelfare.gov/pubs/issue-briefs/racial-disproportionality/>
- 28 Berger, L. M., Cancian, M., Cuesta, L., & Noyes, J. (2016). Families at the intersection of the criminal justice and child protective services systems. *The ANNALS of the American Academy of Political and Social Science*, 665(1), 171–194. <https://doi.org/10.1177/0002716216633058>
- 29 Child Welfare Information Gateway. *Guiding principles of systems of care: Cultural competence*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. <https://www.childwelfare.gov/topics/management/reform/soc/history/cultural/>
- 30 Project READY. (n.d.) *Module 8: Cultural competency & cultural humility*. Institute of Museum and Library Services. <https://ready.web.unc.edu/section-1-foundations/module-8/>
- 31 Child Welfare Information Gateway. (n.d.) *Cultural responsiveness*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. <https://www.childwelfare.gov/topics/systemwide/cultural/>
- 32 Kelly, J. F., & Westerhoff, C. M. (2009). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy*, 21(3), 202–207. <https://doi.org/10.1016/j.drugpo.2009.10.010>
- 33 Volkow, N. D., Gordon, J. A., & Koob, G. F. (2021). Choosing appropriate language to reduce the stigma around mental illness and substance use disorders. *Neuropsychopharmacology*, 46, 2230–2232. <https://doi.org/10.1038/s41386-021-01069-4>
- 34 Substance Abuse and Mental Health Services Administration. (2014). *Improving Cultural Competence. Treatment Improvement Protocol (TIP Series No. 59)*. HHS Publication No. (SMA) 14-4849. Rockville, MD: Substance Abuse and Mental Health Services Administration
- 35 Substance Abuse and Mental Health Services Administration. (2014). *Improving Cultural Competence. Treatment Improvement Protocol (TIP Series No. 59)*. HHS Publication No. (SMA) 14-4849. Rockville, MD: Substance Abuse and Mental Health Services Administration
- 36 Schiff, D. M., Nielsen, T., Hoeppner, B. B., et al. (2020). Assessment of racial and ethnic disparities in the use of medication to treat opioid use disorder among pregnant women in Massachusetts. *JAMA Network Open*, 3(5). <https://doi.org/10.1001/jamanetworkopen.2020.5734>
- 37 Crawford, C., Sias, S. M., & Goodwin, L. R. (2015). *Treating pregnant women with substance abuse issues in an OBGYN clinic: Barriers to treatment*. *Vistas Online*. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy>
- 38 Stone, R. (2015). Pregnant women and substance use: fear, stigma, and barriers to care. *Health and Justice*, 3, 2. <https://doi.org/10.1186/s40352-015-0015-5>
- 39 Kunins, H. V., Bellin, E., Chazotte, C., Du, E., & Arnsten, J. H. (2007). The effect of race on provider decisions to test for illicit drug use in the peripartum setting. *Journal of Women's Health*, 16(2), 245–255. <http://doi.org/10.1089/jwh.2006.0070>
- 40 National Conference of State Legislatures. (2021). *Disproportionality and race equity in child welfare*. <https://www.ncsl.org/research/human-services/disproportionality-and-race-equity-in-child-welfare.aspx>
- 41 Crawford, C., Sias, S. M., & Goodwin, L. R. (2015). *Treating pregnant women with substance abuse issues in an OBGYN clinic: Barriers to treatment*. *Vistas Online*. <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy>
- 42 Substance Abuse and Mental Health Services Administration. (2018). *Clinical Guidance for Treating Pregnant and Parenting Women with Opioid Use Disorder and Their Infants* (HHS Publication No. (SMA) 18-5054). Rockville, MD: Substance Abuse and Mental Health Services Administration
- 43 Schiff, D. M., Nielsen, T., Hoeppner, B. B., et al. (2020). Assessment of racial and ethnic disparities in the use of medication to treat opioid use disorder among pregnant women in Massachusetts. *JAMA*, 3(5). <https://doi.org/10.1001/jamanetworkopen.2020.5734>
- 44 Lagisetty, P. A., Ross, R., Bohnert, A., Clay, M., & Maust, D. T. (2019). Buprenorphine treatment divide by race/ethnicity and payment. *JAMA Psychiatry*, 76(9), 979–981. <https://doi.org/10.1001/jamapsychiatry.2019.0876>
- 45 Hadland, S. E., Bagley, S. M., Rodean, J., et al. (2018). Receipt of timely addiction treatment and association of early medication treatment with retention in care among youths with opioid use disorder. *JAMA Pediatrics*, 172(11), 1029–1037. <https://doi.org/10.1001/jamapediatrics.2018.2143>
- 46 Lander, L., Howsare, J., & Byrne, M. (2013). The impact of substance use disorders on families and children: from theory to practice. *Social Work in Public Health*, 28(3-4), 194–205. <https://doi.org/10.1080/19371918.2013.759005>
- 47 Arria, A., & Mericle, A. (2014). *Disrupting the legacy of addiction: An evaluation of the Betty Ford Children's Program*. Treatment Research Institute. <https://storage.snapages.site/hxzxb5z3kz/assets/files/TRIChildrensProgramReport2014Final.pdf>
- 48 Child Welfare Information Gateway. (2020). *Reasonable efforts to preserve or reunify families and achieve permanency for children*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.
- 49 Legal Information Institute. (2016). § 23.2 Definitions. <https://www.law.cornell.edu/cfr/text/25/23.2>
- 50 National Indian Child Welfare Association. *For families and service providers*. <https://www.nicwa.org/families-service-providers/>