Promoting Resiliency and Eliminating Disparities–Best Practices when Working with Child Welfare Involved Youth of Color

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KEYWORDS

• Child welfare • Racial disparities • Inequity • Foster care

KEY POINTS

- The US child welfare system continues to have racial disproportionality and inequities that present barriers to the best outcomes for children and families of color.
- Racial and ethnic disparities exist at the entry points into child welfare and expand at each subsequent step in the child welfare decision-making process.
- Efforts to guide best practices must consider the causative factors of disparities, which include implicit biases in caregivers and workers, systemic factors associated with poverty, and structural racism.
- Special populations, such as lesbian, gay, bisexual, transgender, queer or questioning, intersex, asexual or ally+ youth, unaccompanied children, and those in the juvenile justice system will face additional disparities in achieving optimal outcomes.

INTRODUCTION

The child welfare system in the United States is designed to ensure the safety, permanency, and well-being of the children and families it serves. Yet, the US Child Welfare System has a long history of disproportionality among children and families of color that impact outcome disparities across multiple domains, and the experiences of racial and ethnic minorities interfacing with this system of care are diverse. For the

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child psychiatrist working with these families, it is key to understand how minority populations may be impacted differently by child welfare involvement and how to advocate effectively to ensure appropriate care.

In the United States, it is not uncommon for children and families to interact with the child welfare system. In the fiscal year 2019, there were 4.4 million referrals to child protective services (CPS) involving the alleged maltreatment of 7.9 million children. Of these referrals, 2.4 million required CPS response and investigation, impacting 3.5 million children.[1] At any given moment there is just under half a million youth in state custody or foster care. The most common reason for youth to come into the foster care system is neglect followed by physical abuse, sexual abuse, and abandonment. The average age of youth in foster care is about 7 years and children spend on average 16 months in care. Youth generally have multiple placements during their time in the child welfare system. The most common out-of-home placement for youth in foster care is with a nonrelative at 46% of youth nationally, followed by kinship placement at 32%. About 10% of youth are in a congregate care placement. Trends do show increased placements with kin and decreased placements in group homes and institutions over the past decade.[2] The most common reason for exiting the child welfare system is reunification with a parent or primary caretaker, but data has shown an increased rate of adoption and guardianship as outcomes for permanency. Annually, about 26% of youth are adopted out of foster care. Despite efforts for permanency, just under 10% of youth age out of foster care annually. Most states offer support called extended foster care up until age 21 but the quality of services offered by states varies. Even with these supports, youth aging out of care face multiple challenges transitioning to adulthood and independence, and most youth will return to their family of origin in some capacity.[3]

Racial disproportionality within the child welfare system has been an identified concern for some time. The term disproportionality is used to describe the overrepresentation and under-representation of a racial or ethnic group compared with the total population while disparities are unequal outcomes between ethnic and racial groups. Black and American Indian (AI)/Native Alaskan are two groups that are overrepresented in the child welfare system. Black children make up 14% of the child population nationally and 23% of the foster care population. AI/Native Alaskans make up 1% of the child population but 2% of the foster care population.[4] The disproportionality in racial and ethnic groups varies by geographic location. Data from the National Council of Family Court Judges identify the overrepresentation of black youth in the child welfare system in 46 out of 50 states with disproportionality ratios ranging from 1.1 to 3.5.[5] Asian/Pacific Islander and Latinx children are often not highlighted in the disproportionality data when in fact these two groups have their own important experiences that need a closer look. Latinx children are less likely to encounter the child welfare system and are underrepresented in national data, but there are disparities within this population, including overrepresentation in some parts of the country and under-representation in other parts.[6] Asian/Pacific Islanders are often under-represented as well in child welfare data but this group represents 20 or more ethnic groups with individual histories, values, traditions, and languages, indicating a need to assess subgroups to understand the impact of the child welfare system on Asian/Pacific Islanders.[7]

IMPACT OF LEGISLATION AND POLICY ON RACIAL INEQUITIES IN CHILD WELFARE

The disproportionality and disparities in child welfare are perpetuated in part by structural racism that developed out of historical and cultural factors, allowing these inequities to grow. To better understand the drivers that have contributed to these

injustices, it is important to look back at the federal and state laws, programs, and policies that helped to shape our child welfare system in the United States and may have contributed to the current racial divides.

The Jim Crow laws that enforced a separate but equal society greatly impacted the care of orphaned Black children who were not permitted to be cared for by white-only institutions. This created a dual-track system of care for close to 100 years that unfairly benefited white children who were orphaned. The Jim Crow laws also penetrated the early child welfare policies and created a system of inequity that greatly discriminated against Black families. Early child welfare legislation, such as the Social Security Act of 1935, created programs that provided aid to families who were in "suitable homes," often excluding Black families from these aid programs. A more formalized federal child welfare system developed with the Child Abuse Prevention Treatment Act of 1974, which created a funding source for child welfare services but also created practices that were fraught with avenues for biases and discrimination leading to disparities in outcomes of maltreatment reporting. Rates of all youth coming into the child welfare system continued to rise into the mid-1980s that were driven also in part by economic instability, the War on Drugs, and high rates of female incarcerations, all of which disproportionately impacted Black families.[8] The Adoption and Safe Families Act (ASFA) of 1997 sought to establish permeance for children in foster care by requiring states to proceed with the termination of parental rights (TPR) when youth have been in care for 15 months. This disproportionately impacted children of color and families with diverse ethnic backgrounds because families often did not have access to the services they needed to help with reunification. The ASFA ignored the unique needs of children of color and has been criticized for fueling racial disproportionality, especially for Black children.[4]

The Multi-Ethnic Placement Act (MEPA) enacted in 1994 (Public Law 103–382) sought to address the disparities related to adoption rates between white and minority children by prohibiting states from delaying or denying adoption and foster care placements based on race or ethnicity. MEPA also required states to recruit prospective adoptive and foster care families from different racial and ethnic backgrounds to reflect the diversity of children needing placement. Assessments of the impact of MEPA note an increase in the number of white and Hispanic adoptions but for Black youth, the only permanency increase seen was exiting foster care to guardianship.[9]

The historical experiences of AI and Native Alaskan children and families with the federal government and the US child welfare system are troubling and important for providers working with these families to acknowledge. Tribal communities were subject to an Indian Boarding School policy for over 100 years that removed thousands of children from their families, impacting multiple generations, and decimating their cultures, which finally ended in the 1960s.[10] The Congress passed the Indian Child Welfare Act (ICWA) in 1978 in response to the disproportionate rates that AI and Native Alaskan children were being removed and placed into foster care. The investigation that prompted this legislation highlighted the devastating impact the removal of children from homes has had on the Indian tribes and their culture. Upward of 35% of all AI children were in out-of-home placements at the time. The ICWA outlines that all states must provide "active efforts" to prevent the break-up of families to address the shockingly high rates of out-of-home placements. This "active effort" clause is still key as rates of AI and Native Alaskan removal remain disproportionate.[11]

Family First Prevention Services Act of 2018 offers the promise of increasing family unity by allowing for redirection of federal funds to pay for services that can keep children from being placed into foster care, but requirements for the Western-style evidence studies may overlook traditional Native AI programs. Native Americans have

noted they were not involved in the development of guidelines and note it is difficult to meet costly standards developed by non-Native American infrastructure. So far, one program "Family Spirit" has been rated as promising, but many other programs may not be accepted by the Clearing House. Guidelines on cultural adaptations are needed to approve prevention programs targeting Native Americans.[12]

Historical policies have also impacted child welfare involvement for minority groups that are under-represented, as seen in Asian American/Pacific Islander populations. The Chinese Exclusion Act of 1882, which limited the immigration of Chinese persons, was not fully overturned until the Civil Rights Movement in 1965. Our country also has a challenging history of forcibly removing men, women, and children of Japanese descent from their communities and placing them in internment camps during World War II. Racist governmental policies have in part made it challenging for Asian minority subgroups to trust and accept government service and likely factor into the disproportionality seen in national child welfare data, among other factors.[7]

Recent discriminatory policies by the federal government still impact our most vulnerable families, as seen in the Trump-era policies that targeted the Latinx communities. In 2018, the Trump administration's "zero tolerance" policy at the border led to the creation of the family separation policy, where children were forcibly removed from their adult caregivers at the US border. This caused significant trauma and harm to those families directly impacted, but also caused distrust within the Latinx communities of government services, likely further contributing to the disproportionalities seen in Latinx child welfare data as being an under-represented population along with perpetuating racism against the Latinx communities.[13]

FACTORS THAT CONTRIBUTE TO DISPARITIES IN CHILD WELFARE DECISION-MAKING

Child welfare systems have procedures and policies they follow to meet their mission of protecting children and families. These procedures lead to successive steps in how a child and family engage these systems. Providers and stakeholders may recognize and report child abuse or unhealthy neglectful environments. These reports are triaged and screened to determine the imminence of risk and danger to a child. If a report is accepted, then case workers engage in a period of investigation and monitoring. If sufficient risk is present, then a child may be removed and placed in a safe living situation. This can include other family members, fictive kin, or directly into foster homes, and is called out-of-home care (OOHC). Next, there may be a phase of case planning where parents may work on a case plan detailing needed steps for reunification. There are guidelines for how long this period lasts, and courts are often involved in evaluating ongoing parental capacity for safe parenting. A decision ultimately is made to reunify the child with the family or seek permanency in the form of adoption or independent living for older youth. It is all too common for many children to wait years for adoption and so some children transition out of the child welfare system as they turn 18, a term referred to as "aging out."

Each of these steps moving through the child welfare system requires evaluation of the individual family and child to decide the permanency goal. When working with child welfare-involved youth and families, providers should understand where disparities enter the child welfare decision-making process. Evidence suggests bias exists at each stage of child welfare decision-making[14] and increasing disparity along racial lines occurs at each successive decision point whether reporting for abuse/neglect, referral for investigation, reunification services, out-of-home placement, and TPR or transitions out of the child welfare system. At each decision point, race is a significant factor.[15]

Although racial/ethnic disproportionality has been seen at the front end of child welfare by evidence of altered rates of referral and investigation/substantiation/placement into care, it is also seen that children of color have long OOHC time, receive fewer services, and are less likely to reunify than white children.[16]

Theories have been developed to explain these disparities and to guide interventions to reach equity. There may be implicit biases in providers and personnel that influence decisions to report suspected abuse, accept cases for investigation, and determine risks for safety. Systemic factors and racism built into the infrastructure of child welfare systems may limit the availability of prevention or reunification services. Around it all, multiple children and family risk factors are present that affect race disproportionately, such as poverty and access to care.[16] For example, child maltreatment and removals are highly correlated with poverty, which is disproportionately represented among Black and Native American children.[17]

Substance use problems, including the opioid epidemic, have ravaged many states, leading to overdoses and deaths, and it is a driving force in many children under the age of 5 entering foster care. The national prevalence of parental substance use disorders (SUD) in the child welfare system has been estimated to be as high as 26% and regional/state estimates may be higher.[18] The SUD epidemic interacts with social vulnerabilities, including adverse childhood experiences (ACEs) and racism, such that those with more risk factors are more at risk.[19] SUD is considered a brain disease that can respond to medical and psychosocial treatment.[20] But like most health conditions, racial and socioeconomic disparities act to mediate and amplify risk factors at each stage of involvement. Since the 1980s and the War on Drugs, the criminalization of SUD has led to unequal application of justice along racial and ethnic lines.[21] The numbers and proportion of children entering the foster care system have increased dramatically from 14.5% in 2000 to 36.3% in 2017 and with regional variations.[22] Currently, states having criminally focused SUD policies have more disparate outcomes in referrals, removals, and lack of reunifications.[23]

PROTECTIVE CONCERNS: ABUSE REPORTING OR "FILING"

There are disparities in the demographics of victimization. For Federal Fiscal Year (FFY) 2020, the overall victim rate was 8.4 victims per 1000 children, with children younger than 1-year-old having the highest rates of victimization. AI or Alaska Native (AN) children have the highest rate of victimization at 15.5 per 1000 children of the same race or ethnicity, and Black children have the second highest rate at 13.2 per 1000 children of the same race or ethnicity. For nearly all race categories there was a decrease of victims in the last 6 months of FFY 2020 except victims of AI/AN descent had an increase of 1.4% for FFY 2020.[24] Disparities are also reported for Asian and Pacific Islander children, but rates vary by country of maternal origin, indicating the need to look closer at subgroups within this category of racial identification.[25]

Minority children and Black children have higher rates of reporting and substantiation of abuse. Minority children at least 12 months old with accidental injuries were three times more likely than their white counterparts to be reported for suspected abuse.[26] Also, cases of abuse and neglect for Black children are reported and substantiated at about twice the rate for white children.[27]

There may be bias in how providers respond to allegations or concerns of abuse. Medical providers are more likely to test peripartum urine drug screen for Black, Indigenous, and People of Color patients than for white patients. It has been proposed that there exists an implicit bias in reporting among medical providers and workers within child-serving systems.[28] However, Drake has proposed racial bias in reporting is not a

large factor to explain the disparate demographics in reporting, and substantiation is due to underlying risk factors that are much more common and disproportionate in Black families and those of color. For example, evidence for racial disproportionality in reporting was seen after controlling for poverty.[27,29] Reducing disproportionality in underlying risk factors affecting Black families is a needed public health approach.

Latinx children and families are less likely to encounter the US child welfare system despite significant socioeconomic risk and slightly higher rates of child maltreatment compared to whites. The reason for this paradox is complex but one key factor is linked to disparities in maltreatment reporting. Latinx children experience pervasive disparities in accessing health care across the continuum of health care services from having access to health insurance to completing subspecialty appointments.[30,31] These challenges in accessing health care likely contribute to the differences in identification and subsequent reporting of maltreatment to CPS. Research also shows that Latinx children are more likely to be reported by the educational system but less likely to be reported by social services workers, parents, friends, or neighbors.[32]

OPEN CASES/REFERRALS FOR INVESTIGATIONS

Reported cases may be investigated and substantiated for concerns of risk to the child. Racial and ethnic disparities are found here as well. Administrative data shows a disproportionate number of referrals accepted for investigation among Black and Native American children.[14] And in Canada, Black children were more likely than white children to be investigated but not more likely to substantiate, transfer to ongoing services, or place out of the home.[33]

It has been shown that AN/AI children in Alaska have higher rates of contact with CPS, higher rates of substantiated maltreatment, higher rates of child removal, and placement into OOHC.[34] This study found CPS contact before age 5 years was higher for AN/AI children compared with non-Native children (40.1% vs 15.8%) and greater CPS contact was seen in each age interval for AN/AI children. Possible explanations for the increased rate include institutional bias, detection bias, poverty, SUD, and intergenerational and collective trauma. For the 20% of AN/AI children that had continuous CPS contact, maternal substance use was the largest individual risk factor.

Latinx children have lower rates of substantiated maltreatment reports by CPS when compared with the national average and similar rates to white children.[32,35]

HOME REMOVALS/YOUTH IN CUSTODY

Race, risk, and income predict decisions to remove children from their biological homes.[36] Not surprisingly, such data has led to concerns of bias among families served by child welfare systems. A focus group study reveals a fear of cultural bias in caseworkers and the court system by respondents.[37] Multiple studies have shown African American children are removed from homes and placed in foster care at 2 to 3 times the rate of white children. Six themes involving poverty, trauma, and other family and child factors were identified by African American parents along with suggestions to improve cultural and trauma-informed competence of the child welfare service functions.[17]

The influence of parental drug use on removals is striking. From 2008 to 2017 the rate of parental drug use increased by 71% in the general population and across all racial/ethnic groups. Opioid overdose deaths have increased by 143% in non-Hispanic whites and Native Americans. Native American children had the highest and fastest growth rate of parental drug use entries into child welfare systems and had the highest disproportionality in foster care entries.[38] In fact, consuming drugs

during pregnancy as evidenced by a positive urine drug screen is considered child abuse in at least 19 states in the United States, and women can lose custody of newborns even without confirmation.[39]

REUNIFICATION

Racial and ethnic disparities lead to disproportionate data in reunifications as well. Many reports have documented that Black children and their families are less likely to receive alternative services like in-home services and less likely to reunify with their families.[40] In addition to cumulative ACE exposure, a child's race was significantly associated with a probability of reunification, as nonwhite children were 21% less likely to reunify than white children and race did not predict substantiation but was influenced by caseworker perceived risk.[41] Native American children and families also are less likely to obtain reunification. Data from the 2017 Adoption and Foster Care Analysis and Reporting System (AFCARS) showed Native American children aged 0 to 5 had lower odds of reunification than white children (AOR = 0.87, $P < .001$), while Hispanic children had higher odds of reunification (AOR = 1.08, $P < .001$).[42]

Children removed due to SUD are less likely to reunify than older children,[43] and engagement in substance use treatment is less common in Black, Hispanic, and Native American persons.[44] Foster care infants who live in states with criminal justice-related prenatal substance abuse policies have a lower chance of reunification with a parent, specifically non-Hispanic Black children have an OR = 0.87 chance of reunification compared to non-Hispanic white children in a state without such policies.[23]

OUT-OF-HOME PLACEMENTS AND TERMINATION OF PARENTAL RIGHTS

Close to one-third of all children in the foster care system are waiting on adoption as a permanency goal.[24] These children are in OOHC and reside in foster homes, residential treatment facilities (congregate care), hospitals, and so forth. It has been shown that Black children are more likely to disrupt foster home placements and enter group homes.[45] Also, Black children historically are less likely to be adopted than white children meaning longer time in the child welfare system.[46]

Sattler and Font demonstrated that over 2% of adoptive placements and 7% of guardianship placements were dissolved. Compared with white and Hispanic children, Black children had a higher risk of guardianship, but not adoption, or dissolution.[47] AFCARS evaluates the prevalence of TPR and finds that nearly 3.0% of AI/NA and 1.5% of AA children will experience TPR, nationally about 1% of children in the United States will have TPR. There are large variations between states and racial/ethnic variables are important.[48] Parental incarceration may represent a tipping point for TPR as parental incarceration has similar breakdowns by racial risk. Once an investigation has begun AI/NA children are more likely to have TPR than white or Black children.[48]

Tribal child welfare agency leaders feel foster care programs should be managed by the tribes to keep children in their families and/or communities and maintain connections to tribal culture. Such inputs could lead to longer reunification time frames before TPR.[49] In two states, Kentucky and Arizona, parental rights may be terminated by exposure of infants to opioids at the time of birth unless the birth mother is involved in a substance abuse treatment program.[50]

ADOPTION FROM THE CHILD WELFARE SYSTEM

When children in foster care are legally adopted, parental rights have first been terminated, and custody is transferred from the state to the adoptive parents, creating a permanent home in which to facilitate a sense of security and stability.[51,52] Of the children exiting foster care in the United States in 2020, 25% were adopted. The average age of children adopted was 6.5 years, while the average age of children waiting for adoption was 7.9 years. The majority (54%) of children were adopted by a foster parent, while 35% were adopted by a relative.[24] Most of the children who are adopted remain with their adoptive families,[51] but some children may have more difficulty with adjusting to their new environments, such as older children or children with previous exposure to trauma or current externalizing behavioral difficulties.[52] Thus, adoptive families may need additional support to provide for their adopted children, both at the time of adoption and beyond, into adolescent years for example.[51,53]

TRANSRACIAL ADOPTION

Transracial adoption remains a controversial topic in adoption care. The primary concern about transracial adoption is whether the adopted parents can help the children to build their racial identity. It is not uncommon to see in transracial adoption that adopted parents often struggle with teaching their children about the birth culture, tradition, and history and creating the necessary skills children require to survive in this racially unequal world.

Recommendation for transracial adoption:

1. Encouraging families to have a conversation about race with the children at an earlier age. The conversation should be developmentally appropriate.
2. Adoptive parents need to acknowledge that the cultural identity and racial identity might differ in transracial adoptees.
3. Adoptive parents need to develop cultural competency. According to Vonk, parents need to understand three aspects of cultural competency: racial awareness, survival skills, and multicultural family planning (**Box 1**).[54]

TRANSITIONS TO PERMANENCY

Legal permanency is defined through family reunification, adoption, guardianship, or other planned permanent living arrangement. In 2018, about 7.5% of youth "aged out" without permanency and this group features more Black and Hispanic individuals. These youth are at higher risk for homelessness, have poor health care access, lack of education, early pregnancy, physical and mental health issues, low employment, and criminal justice involvement.[56,57] Machine learning methods were used to identify youth at higher risk of not exiting to permanency by age 18. Black youth and those with missing race information had the highest rate of exiting without permanency. Youth at risk of exiting without permanency had patterns associated with poorer outcomes. These findings may allow proactive interventions to augment support specific to the youth's cultural background.[57] Garcia and colleagues studied how well child-serving systems of care prepare racially diverse youth in foster care to do well in adulthood. These results can guide efforts to improve functioning in these youth as they leave the foster care system. Placement stability, having youth live with a family at the time of exit, having access to mental health services, preparation to leave care, and satisfaction with a foster family was among the factors predicting better outcomes.[58]

Box 1
In transracial adoption, parents should be encouraged to learn self-awareness[55]

Self-Awareness	Survival Skills	Multiracial Family Planning
• Understanding the impact of race, ethnicity, and culture in people beliefs and values • Be aware of "our own feelings of cultural superiority" • Acknowledging within the family that racial prejudice, biases, and discrimination do exist and the "white benefits" might not extend to the minority adopted children	• Acknowledge and understand the needs of preparing the children to fight against racism • Encouraged discussion about race and racism within family members • Prepare children with answer for racially insensitive comment and teach them not to tolerate racially biased remarks • Not to ignore or minimize racial difference among child and family	• It is important to understand that if transracial adoptees are only surrounded by the parent's racial group, they find it hard to identify or develop pride in their own race or culture of birth. • Making opportunities to learn about their birth culture • Encouraging to learn about other cultures and tradition along with their own racial culture • For a religious family, parents should have open communication and conversation about religion in the family. • Taking the children to a place of worship where they might find people from their ethnicity which will give them the opportunity to know the people from their culture, find a mentor.

SPECIAL POPULATIONS

LGBTQ + Youth

Lesbian, gay, bisexual, transgender, queer or questioning (LGBTQ) youth are overrepresented in the foster care system.[59] Their overall reason for presenting to foster care may not differ much from those in the general, but familial rejection due to the child's identity or expression of identity may further lead the child to enter foster care or placements outside of the home.[59,60] Further, the foster care system is not properly equipped to meet all of the needs of LGBTQ youth, thus exposing them to further discrimination in foster care placements.[60] In fact, LGBTQ youth are more likely to experience homelessness, placement in group homes rather than residential homes, and movement to new placements than non-LGBTQ youth.[61,62] As a result of unstable placements, they experience higher emotional distress, poorer school functioning, and more concerns related to substance abuse and mental health.[59,63]

LGBTQ youth would clearly benefit from legislation to protect them from further discrimination when entering the foster care system. In regard to related legislation, however, there are no national laws in effect that dictate what is or is not discrimination for LGBTQ in the foster care system. State legislation varies widely, in that some states have laws in place to protect youth in foster care from discrimination based on sexual orientation and gender identity, other states have laws in place just related to sexual

orientation, and the remaining states have no legislation to protect LGBTQ youth in foster care.[60]

UNACCOMPANIED CHILDREN

In the United States, unaccompanied children are often presented from Mexico or Central America, at times fleeing violence or unsafe living environments. Unaccompanied children are often processed by US Customs and Border Protection but then transferred to the Office of Refugee Resettlement in Health and Human Services. Children could be immediately deported, qualify for various forms of relief (such as asylum or visas), or enter into legal proceedings, but without a government-appointed lawyer.[64] Unfortunately, there is no distinction between adults and children in immigration legal proceedings, leaving children to defend their need to remain in the United States.[65]

When children flee their original country, they encounter trauma from separation, the passage to the United States, and potential harms along the way; further, they are at risk for re-traumatization by the government processes that they subsequently encounter. Given the large number of unaccompanied minors presenting to the United States and facing decisions on their future, a human rights crisis has formed.[66] As many as 35% of unaccompanied children are ultimately placed in long-term foster care placements. They face difficulties with acculturation in a new country and coping with the uncertainty of their legal status. Furthermore, they need culturally competent placements, as well as trauma-informed treatment for prior trauma and mental health concerns, both during their placements and beyond.[67]

JUVENILE JUSTICE

Youth in foster care who also are involved in the foster care system are known as crossover youth, creating a phenomenon known as the foster care to prison pipeline.[60,68] Estimates of crossover youth vary by study, but often span estimated ranges, such as from 7% to 24%, indicating a noticeable portion of youth in foster care who go on to become involved with the juvenile justice system.[69] At highest risk of involvement in the juvenile justice system are individuals who have been placed in congregate or groups settings, or had an older age at first involvement with the foster care system; in addition, African American males were at higher risk, noting a complex intersection and overall systemic concern.[69] Crossover youth are more likely to have a history of abuse, encounter problems in educational settings, and have more substance use and mental health concerns.[60] Further, looking beyond youth, adults who are incarcerated are more likely to have been in foster care, signaling this pipeline exists well beyond the end of a foster care placement.[70]

BEST PRACTICE INTERVENTIONS

Efforts to guide best practice interventions, including those listed later, follow factors proposed to explain disparities in outcomes for children and families of color.[16]

Training Regarding Implicit Biases in Child Welfare Personnel

Health care providers and those working with children in the child welfare system need to be vigilant in detecting their own racial biases and seeking training or experiences to address their biases. The ways clinicians and child welfare workers read various clinical and demographic factors, such as racial/ethnic identity, poverty, and addresses are inherently influenced by their own lived experiences, training, and ongoing exposures. Organizations can work to become antiracists by institutional efforts to identify

and change racist patterns.[14] These can lead to organized efforts to evaluate and understand experiences of discrimination and racial stressors in those served.

Such practices could include routine, universal, verbal screening for SUD of every pregnant patient, which is an objective approach that minimizes any provider bias as current practices for screening for substance use during pregnancy disproportionately impact women of color and need to be informed by racial equity.[28] Medical providers are encouraged to be thoughtful and consider the social context when reporting and base concerns on evidence only to be internally consistent.[40]

Child- and Family-Level Risk Factors that Affect Race Disproportionately: Poverty

The disproportionate exposure to risk factors, such as poverty faced by Black children, has been felt to explain much of the racially disparate outcomes in child welfare.[27] Efforts to improve these underlying societal factors are important to policymakers charged with improving population health outcomes. Child psychiatrists and child welfare workers must consider how social determinants of health place an inequitable burden on racial and ethnic groups leading to additional adverse exposures in childhood.

Access to substance abuse treatment for all racial/ethnic groups is needed because maternal substance abuse may be the factor with the biggest impact on the trajectory of a child's child welfare involvement.[34] States also need to evaluate punitive prenatal drug abuse policies that define drug use during pregnancy as abuse and their disparate impact on racial/ethnic groups.[38]

System Factors and Structural Racism—Availability of Prevention Services

Child welfare systems have been charged to build an antiracism framework.[71] Child welfare policies and judicial practices need to be examined in light of potential racial bias to identify and eliminate interventions that unfairly penalize children and families of color, especially those involving substance abuse issues.[42] To address these issues the Breakthrough Series Collaborative framework was developed by the Casey Family Programs to reduce disproportionality and disparate outcomes for children and families of color in the child welfare system. It addressed all three theories of cause to create more positive outcomes through the QI process of plan, do, study, and act.[46] One example of this work is the King County Coalition on Racial Disproportionality, which focused on children in care longer than 2 years and developed programs to fight disproportionality and increase awareness within the community. The program collected data on the problem, and targeted strategies for change, including collaborative teams of child welfare workers, and permanence champions. The effort has resulted in legislation requiring statewide analysis of disproportionality and increased local awareness, including more court-appointed special advocates workers of native descent.[72]

In addition, Wisconsin developed the Wisconsin ICWA as a collaborative approach to achieve better outcomes for Indian children in the state. These services address the historical disproportionality of removals of Indian children to placements outside their homes. Joint development of the program occurred with tribal representatives, with ongoing stakeholder education and advocacy. Targeted areas include improved (1) regulations, policies, and practices, (2) better working relationships between tribes and child welfare, (3) improved knowledge and sensitivity of providers and agencies, and (4) improved identification of Indian children.[73]

Advocates have called for child welfare systems to build networks of Black foster parents and those of color to support a child's ability for skill building, role play, and

processing of racial disparities and discrimination. In some cases, children in OOHC with congruent ethnicity with the families have improved behavioral outcomes.[74]

DISPARITIES IN PSYCHOTROPIC MEDICATION

Children in foster care have complex mental health needs and so have high rates of mental health diagnoses and service utilization, including the use of psychotropic medications.[75] Rates of psychotropic medications for children in foster care are estimated to be thrice greater than for children in the general population and seems driven by child characteristics rather than mental health need.[76,77] Given the lack of evidence for efficacy and growing concerns for adverse effects it is important to consider racial and ethnic disparities in the use of psychotropic medications for children in foster care.

Studies of psychotropic medication use in children show that African-American children with Medicaid have lower rates of medication use when compared with white children.[78] Similarly, studies looking at children in the public service sector, including those in child welfare, showed less medication use in African-American and Latino children compared with white children,[79] and fewer expenditures on psychotropic medication.[80,81]

Other studies, however, show increased usage. A study of the use of psychotropic medication in children entering foster homes showed African American children were more likely (AOR = 5.4) than Latino children to have prescribed stimulants and atypical antipsychotics (AOR = 5.1).[82] Children who are Black and of other races have also been found to have higher odds of concomitant antipsychotic treatment.[83] These results indicate ethnic children may not receive standard of care treatments for some mental health disorders. Limited evidence is available, so more research is needed.

SUMMARY

As practicing child and adolescent psychiatrists, knowledge about the racial disproportionality and disparities in the child welfare system is important so that the treatment of the children and families served considers the families' identity, values, and culture. Understanding the complexities of the child welfare system process helps the provider to better advocate and inform best practices and decrease unconscious biases that so often perpetuate racism in our society. Psychiatrists can also help to advocate for state and federal legislation that is inclusive of all families from all racial identities and provides avenues for culturally appropriate, trauma-informed mental health services. Racial disparities are still a large challenge for the child welfare system. More research into the disproportionality and subsequent disparities among race and ethnicity in the child welfare system is needed for all cultural minorities, not just Black and AI/Native Alaskan populations. This research should investigate subgroups of the racial and ethnic category as well to help better understand and then subsequently address these disparities. Program development that is culturally and trauma-informed is key to serving this population. These programs need to meet the families where they are and help prevent home removals. Programs that can integrate cultural responsiveness while still addressing the impact of trauma are key for youth and families in child welfare as these two factors are often intertwined. Areas of need include specialized substance use treatment for new mothers with a focus on the infant–mother dyad relationship creating culturally informed family stabilization that understands the values of AI/Native Alaskan peoples and many more. As child psychiatrists, it is imperative to use our voices and expertise to fight against laws and policies that promote racism and discrimination.

CLINICS CARE POINTS

- Racial disproportionality within the child welfare system has been identified as an identified concern. Black and American Indian/Native Alaskan youth are two groups that are overrepresented in the child welfare system, while Asian/Pacific Islander and Latinx youth are underrepresented.
- Significant disparities impact Black and American Indian/Alaska Native youth and families at each step of the child welfare system, including higher rates of abuse reporting, substantiation, and longer lengths of stay in the system when compared with white youth.
- Each cultural and ethnic group has unique experiences with the child welfare system that need further research, particularly Asian/Pacific Islander and Latinx groups.
- Child welfare legislations, policies, and programs should be inclusive of all racial and ethnic groups and work to identify and eliminate interventions that unfairly penalize children and families of color.
- Best practices for addressing and eliminating these disparities include, but are not limited to, requiring implicit bias training for all professionals working with children's welfare involved youth and families; investigating and changing societal factors that perpetuate poverty; and fostering an antiracist culture within child welfare to combat structural racism.
- Programs to support child welfare youth and families need to address both cultural preferences as well as the impact of trauma on child development and caregiver relationships.
- Child welfare involved youth are at risk for inappropriate use of psychotropic medication, and preliminary data suggests disparities in psychotropic use for youth of color in foster care.

DISCLOSURE

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