

# InterSections in Practice

Aging • ATOD • Child Welfare • Children, Adolescents & Young Adults • Health  
Mental Health • Social & Economic Justice & Peace • Private Practice • School Social Work

NASW Specialty Practice Sections Annual Bulletin

VOLUME 4 • FALL 2005

## IN THIS ISSUE

The Disparity in  
Screenings for Fetal  
Alcohol Spectrum  
Disorders.....1

Addressing Disparities  
through Social Work  
Practice .....2

Social Workers Assist in  
Reducing Disparities in  
Special Education .....3

Earn 1.5 Hours of  
Continuing Education  
Credit Free .....5

Older Adults and Health  
Disparities: The Impact  
on Access to Care .....6

Eradicating Disparities:  
Iowa's Efforts to  
Eliminate Minority  
Overrepresentation in  
the Juvenile Justice,  
Child Welfare, and  
Education Systems ....9

SPS News .....13

## THE DISPARITY IN SCREENINGS FOR FETAL ALCOHOL SPECTRUM DISORDERS

Laura LaRue Gertz, LCSW, ACSW

When it comes to drinking alcohol during pregnancy, poor and minority women are more likely to be asked for a urine sample for testing than their wealthy and white counterparts. Many doctors, however, are mistaken when they bypass their wealthy, Caucasian clients and assume that a minority woman from a metropolitan city should be screened or monitored for alcohol abuse during pregnancy (Chasnoff, Landress, & Barrett, 1990).

This screening disparity in racial and socioeconomic levels is believed to result in a failure by some doctors to identify those women and their children who are in most need of assessment and intervention. Consequently, the leading cause of mental retardation—fetal alcohol spectrum disorders (FASD)—is often overlooked.

FASD is an umbrella term for the constellation of effects sometimes caused to a child whose mother consumed alcohol during pregnancy. This complex disorder can present symptoms in the form of physical and mental disabilities and impairment in behavior and learning. Many symptoms, including the facial abnormalities depicted in the sketch on this page and on page 17, have lifelong implications for functioning and quality of life. FASD is not a psychiatric disorder but may co-occur with mental illness or substance use disorders.

Despite widespread public health warnings, many people are unaware that drinking during pregnancy is unsafe to the fetus. Mixed social messages can confuse the general public into thinking it is okay. For instance, a pregnant character on the popular television show *Desperate Housewives* was portrayed intending to drink from a bottle of champagne before being distracted. Reports on other drugs, such as methamphetamine, crack cocaine, and heroin capture much of

### disparity

The condition or fact of being unequal, as in age, rank, or degree; difference.

Source: *The American Heritage® dictionary of the English language (4th ed.)*. (2000). Boston: Houghton Mifflin.

See FASD, Page 15



National Association of Social Workers  
Specialty Practice Sections

©2005 National Association of Social Workers.  
All Rights Reserved.

750 First Street, NE • Suite 700 Washington, DC 20002-4241  
202.408.8600 • www.socialworkers.org

## ADDRESSING DISPARITIES THROUGH SOCIAL WORK PRACTICE

This year's annual bulletin takes a look at the inequalities, or disparities, that exist within the health, education, aging, juvenile justice, and child welfare systems. Social workers often find themselves advocating for equal opportunities that would, ironically, prevent such disparities. This annual bulletin sheds light on some disparities and offers suggestions for how social workers can address these inequalities through practice, policy and advocacy. Did you know that:

- Suicide rates are highest among white Americans and second highest among American Indian and Native Alaskan men. Suicide rates increase with age. In 2001, more than 5,393 Americans over age 65 committed suicide. Of those, 85 percent were men and 15 percent were women (Centers for Disease Control, 2004).
- More than 4 million, or 42 percent, of men with disabilities aged 21 to 64 are employed. That compares with about 3.5 million, or 34 percent, of women with disabilities in the same age range (U.S. Census Bureau, 2005).
- More than 90 percent of white Americans aged 25 and older graduated from high school, compared with 86.8 percent of Asian Americans, 80.6 percent of African Americans and 58.4 percent of Hispanics (U.S. Census Bureau, 2004).

### References

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control (producer). Web-based Injury Statistics Query and Reporting System (WISQARS) [Online]. (2004). Retrieved from <http://www.cdc.gov/ncipc/wisqars/default.htm> on August 12, 2005.

U.S. Census Bureau. (2005, July). Facts for features: 15th anniversary of Americans with Disabilities Act [Online]. Retrieved from [http://www/releases/archives/facts\\_for\\_features\\_special\\_editions/004998.html](http://www/releases/archives/facts_for_features_special_editions/004998.html) on August 11, 2005.

U.S. Census Bureau. (2004, March). College degree nearly doubles annual earnings [Online]. Retrieved from [http://www.census.gov/Press-Release/www/releases/archives/income\\_wealth/002484.html](http://www.census.gov/Press-Release/www/releases/archives/income_wealth/002484.html) on August 11, 2005.



**InterSections in Practice  
2005 APEX Award Winner  
Newsletter Writing**

## InterSections in Practice

**NASW SPECIALTY PRACTICE SECTIONS  
ANNUAL BULLETIN**

### SPECIALTY PRACTICE SECTIONS

#### AGING

Forrest Hong, PhD, LCSW, CMC, Chair

#### ALCOHOL, TOBACCO & OTHER DRUGS

Elizabeth Pomeroy, PhD, MSW, LCSW  
Chair

#### CHILD WELFARE

Priscilla Gibson, PhD, ACSW, LICSW  
Chair

#### CHILDREN, ADOLESCENTS AND YOUNG ADULTS

Tonia Caselman, PhD, MSW, LCSW  
Chair

#### HEALTH

Lisa E. Cox, PhD, LCSW, MSW, Chair

#### MENTAL HEALTH

Gwendolyn Strong Scott, ACSW,  
LCSW, BCD, Chair

#### PRIVATE PRACTICE

Veronica Coleman, LCSW, ACSW  
Chair

#### SCHOOL SOCIAL WORK

Michelle Alvarez, EdD, MSW, LCSW  
Chair

#### SOCIAL AND ECONOMIC JUSTICE & PEACE

Mary Anne Nulty, LCSW, DAPA,  
ACSW, Chair

#### SPS STAFF

##### NASW SPS MANAGER

Nancy Bateman, LCSW-C

##### SENIOR POLICY ASSOCIATE

Melanie McCoy, LICSW, LCSW-C

##### SENIOR MARKETING ASSOCIATE

Yvette Mulkey

##### SENIOR ADMINISTRATIVE ASSISTANT

Antoniese Starks

## SOCIAL WORKERS ASSIST IN REDUCING DISPARITIES IN SPECIAL EDUCATION

Charlene Thiede, LISW, MSW

School social workers have the knowledge and skills that schools need to reduce racial and ethnic disparities in the special education system. These disparities occur when minority children are identified more frequently than their white classmates as needing special education services and then placed in more restrictive educational settings.

This disparity, also known as *disproportionality in special education*, is the inappropriate over- or underrepresentation of students from diverse backgrounds in various disability groups, in more restrictive educational placements, and among students who are suspended or expelled from school.

The United States Congress recognized disproportionality as a serious problem nationwide and discussed possible solutions during public hearings for the reauthorization in 2004 of the Individuals with Disabilities Education Act (IDEA), the law that entitles students with disabilities to a free, appropriate public education. As a result of that debate, IDEA 2004 requires states to collect data and monitor school districts on the reduction of disproportionality.

Since 1975, IDEA has prohibited the classification of students for special education based solely on problems that are primarily the result of environmental “disadvantage” or of ethnic, linguistic, or racial differences (Coutinho & Oswald, 2004). Nonetheless, for more than three decades, minority students have consistently been over-identified for special education services and, once identified, they are more likely to be placed in restrictive settings (Westat, 2003).

The problem is caused by unequal opportunities in general education for students from racially, ethnically, or linguistically diverse backgrounds and by inadequate procedures for referral, assessment, and identification for special education (Coutinho & Oswald, 2004).

Poverty and other environmental influences place many students from diverse backgrounds at greater risk for disabilities. However, these variables alone do not account for the observed differences among groups. For example, these factors do not explain the dramatic differences in disability rates between African-American and Hispanic students, despite similar levels of environmental stress, or among students from various subgroups from state to state (Losen & Orfield, 2002).

Despite the many causes of disproportionality in special education, school social workers have the knowledge and skills that schools need to reduce these racial and ethnic disparities. Social workers can support equitable outcomes through their work in assessment with individual students and families and in schoolwide reform.

### Culturally Competent Assessment

School social workers participate on multidisciplinary special education teams that conduct assessments, classify students, and develop Individualized Education Programs (IEPs). Using a variety of formats, social workers gather data from multiple sources, including the student’s family. Social workers are trained in an ecological perspective that focuses on the interface between an individual’s coping skills and the demands of the environment (Germain,

*See Disparities, Page 4*

1982). This ecological perspective prepares social workers to assess the appropriateness of the demands of the school environment for students from diverse cultural, racial, ethnic, and linguistic backgrounds. The consideration of these factors is often missing from special education assessments when social workers are excluded from the process (Klingner, Sturges, & Moore, 2002).

Social workers have relationship-building skills that enable them to engage the families of children who are referred. Schools have traditionally had difficulty involving families from diverse racial, ethnic, and linguistic groups (Railsback & Brewster, 2003). Using culturally competent professional practices, social workers engage these families in the assessment process. They bring the family's information to the attention of the school team and help the family understand the school's concerns.

When social workers are members of special education assessment teams, they often are responsible for applying exclusionary criteria related to environmental deprivation and ethnic, racial, or linguistic diversity. Although their knowledge and skills are respected, social workers face pressure from teachers and administrators to classify the students who are referred to them (Klingner, Sturges, & Moore, 2002).

### **Culturally Competent Intervention**

Special education assessment practices account for only a small part of the problem. Students would not be referred if they were succeeding in school or if other resources were available to meet their needs. To reduce achievement gaps, schools need a quality curriculum and state-of-the-art instruction.

Additionally, a growing body of research documents the importance of noninstructional variables. The beliefs students hold about themselves, the role their families play in their education, and the beliefs of teachers about their ability to learn are powerful predictors of school success (Broussard, 2003). This research expands the potential contribution social workers can make in schools.

Traditional social work practice skills and modern language therapies, such as solution-focused and narrative therapy, can affect student, teacher, and family perceptions in ways that lead to behavioral change. But this requires a change in the focus of school social work practice, from responding to identified deficits to targeting variables associated with achievement.

At the macro level, social work practitioners can help schools develop a climate that respects individual differences, embraces diversity, and maintains high expectations for all students. Culturally responsive educational environments increase the likelihood that minority students will become successful learners (National Alliance of Black School Educators, 2002).

### **Iowa Practitioners Target Diversity**

The school social workers at the Mississippi Bend Area Education Agency in Bettendorf, Iowa, made diversity a departmental priority. They aggressively recruited minority applicants for staff positions, increasing the number of minority social work practitioners to 30 percent, a higher proportion than is found in the agency's student population. The agency found that school social workers from diverse backgrounds not only provide positive role models for minority students, they also bring new perspectives and energy to the social work department.

The social work department developed a series of training sessions for educators to address poverty, cultural competence, resiliency, and differentiated instruction. These sessions are part of the agency's essential foundations for school improvement planning.

## Recommendations

School social workers can address diversity at the micro, mezzo, and macro levels of practice. However, to be successful, social workers must continue to develop their own cultural competence. They must be willing to depart from tradition and use their practice skills to address the nonacademic variables most strongly associated with improved achievement.

**Charlene Thiede is a consultant for school social work and interagency collaboration at the Iowa Department of Education. She is a member of the Midwest School Social Work Conference, NASW's School Social Work Section, and the School Social Work Association of America. She represents the State of Iowa in a nine-state partnership with the National Center for Culturally Responsive Educational Systems to develop an evidence base for culturally responsive educational practices. She can be reached at [Charlene.Thiede@iowa.gov](mailto:Charlene.Thiede@iowa.gov)**

## References

- Broussard, A. (2003, October). Facilitating home-school partnerships for multiethnic families: School social workers collaborating for success. *Children & Schools, 25* (4), 211–222.
- Coutinho, M., & Oswald, D. (2004). Disproportionate representation of culturally and linguistically diverse students in special education: Measuring the problem [Online]. National Center for Culturally Responsive Educational Systems. Retrieved from [www.nccresst.org/Briefs/students\\_in\\_SPED\\_Brief.pdf](http://www.nccresst.org/Briefs/students_in_SPED_Brief.pdf) on June 21, 2005.
- Germain, C. (1982). An ecological perspective on social work in the schools. In R. Constable and J. Flynn (Eds.), *School social work: Practice and research perspectives*. Homewood, IL: The Dorsey Press.
- Klingner, H., Sturges, K., & Moore, R. (2002). Of rocks and soft places: Using qualitative methods to investigate disproportionality. In *Racial inequity in special education* (pp. 71–92). Cambridge, MA: Harvard Education Press.
- Losen, D., & Orfield, G. (2002). Introduction. In D. Losen and G. Orfield (Eds.), *Racial inequity in special education* (pp. xv–xxxvii). Cambridge, MA: Harvard Education Press.
- National Alliance of Black School Educators. (2002). *Addressing over-representation of African-American students in special education*. Washington, DC: Council for Exceptional Children.
- National Association of Social Workers. (2001). *NASW standards for cultural competence in social work practice*. Washington, DC: NASW Press. Available at <http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf>
- National Association of Social Workers. (2002). *NASW standards for school social work services*. Washington, DC: NASW Press. Available at [http://www.socialworkers.org/sections/credentials/school\\_social.asp](http://www.socialworkers.org/sections/credentials/school_social.asp)
- Railsback, J., & Brewster, C. (2003). Building trust with schools and diverse families [Online]. Northwest Regional Education Laboratory. Retrieved from [www.nwrel.org/request/2003dec/textonly.html](http://www.nwrel.org/request/2003dec/textonly.html) on June 21, 2005.
- Westat. (2003). *Special populations study final report*. Rockville, MD: Author.

See *Disparities*, Page 6



EARN  
1.5 HOURS  
OF CONTINUING  
EDUCATION  
CREDIT FREE

Here's how:

- Read the *InterSections in Practice*
- Afterward, take the *InterSections* test online ([www.socialworkers.org/sections](http://www.socialworkers.org/sections))
- Print your certificate

## Resources

Elementary and Middle Schools Technical Assistance Center. Available at: <http://www.emstac.org/registered/topics/disproportionality/intro.htm>

Harvard Civil Rights Project. Available at: <http://www.law.harvard.edu/civilrights>

National Association of Social Workers. (2001). NASW standards for cultural competence in social work practice [Online]. Available at: <http://www.socialworkers.org/practice/standards/NASWCulturalStandards.pdf>

National Association of Social Workers. (2002). NASW standards for school social work services [Online]. Available at: [http://www.socialworkers.org/sections/credentials/school\\_social.asp](http://www.socialworkers.org/sections/credentials/school_social.asp)

National Center for Culturally Responsive Educational Systems. Available at: <http://www.nccrest.org/events.html>

# OLDER ADULTS AND HEALTH DISPARITIES: THE IMPACT ON ACCESS TO CARE

Lisa Yagoda, LICSW, ACSW

Disparities can be associated with a complex array of factors, such as age, gender, race, ethnicity, socioeconomic status, education, and occupation, as well as social and environmental factors. While the term *disparity* covers a broad range of issues, this article focuses on disparities that influence access to health care and services for older Americans. Health is a major determinant of quality of life and longevity. Understanding the nature and underlying causes of disparities is critical for developing psychosocial and public policy interventions that will reduce the impact of illness and increase the overall quality of life for older individuals and the older population in general.

## Demographics

Both the life expectancy and the overall health of Americans have improved greatly over the past century. The life expectancy at birth in the United States has increased from less than 50 years to more than 76 years (National Institute on Aging, 2005). According to data compiled

by the Federal Interagency Forum on Aging-Related Statistics (2004), by 2030 there will be roughly 70 million Americans age 65 years or older—more than double the population over 65 years in 2000. Within that time frame, the number of people 85 or older is expected to double, while the number of those 100 or older is expected to triple.

Not only is the United States population aging, but its racial, ethnic, and gender makeup is also changing. The Agency for Healthcare Research and Quality reports that older women outnumber older men 20.8 million to 14.8 million (DHHS, 2005). Currently, minority Americans comprise 14 percent of the nation's older population and are projected to be 26.4 percent of that population by 2030.

The demographic changes that are anticipated over the coming decade and beyond magnify the importance of addressing disparities in the health status of older persons. These disparities result from complex interactions

among physical and environmental factors, specific health behaviors, and differences in quality of health care. The number of people in groups that currently experience poor health is expected to increase dramatically, creating challenges and opportunities at all levels of social work practice, particularly for those in the health care arena.

### Access to Care

Health disparities are due, at least in part, to problems in accessing and using health care services. Older adults may experience the effects of health disparities more dramatically than any other population group, and because they are more likely to have chronic illnesses, make frequent visits to medical facilities, and live in poverty, their access to care becomes even more challenging. In designing programs and services, the following factors should be considered regarding access to care:

- Approximately 26 percent of older Americans have only Medicare coverage for health care, compared with about 16 percent of Americans under the age of 65 years who have no health insurance coverage.
- In 1998, only 5 percent of older and disabled Hispanic women in all age groups reported having Medicare coverage.
- In general, elderly members of racial and ethnic minorities covered by Medicare suffer from more illnesses and are more apt to live in poverty. They face greater problems with access and the financial burdens related to health care.
- Preventive health screening rates are low for all Americans, and the lowest rates are found among racial and ethnic minorities, low-income Americans, and the elderly.
- Older persons with chronic or disabling conditions represent a large and growing sector of the population, and one that needs

access to health care services. However, many people with disabilities do not seek or obtain health care. Often care facilities are not accessible or do not have the necessary equipment to serve people with disabilities.

- Health care providers and programs that exemplify cultural competence are lacking. Difficulties abound in areas such as language and communication, feelings of isolation, and encounters with providers who lack knowledge of clients' cultures and challenges.
- Health literacy refers to a set of skills needed to read, understand, and act on basic health care information. Low health literacy affects older adults in disproportionate numbers. Low health literacy has a direct effect on access to health care services and is a risk factor for poor health outcomes in older adults.

Careful planning is needed to address the challenge of access to health care services for older persons in this country. Policies are needed that consider the growing aging population, increases among older minorities and those with chronic and disabling conditions, and the ability of the health care system to meet their unique needs.

### Clinical Research Trials

Research shows that older adults are markedly underrepresented in clinical trials. Historically, clinical trials have focused on relatively young participants; as a result, the treatment decisions for older persons are based on knowledge gleaned from a younger cohort. For example, an article in the *Journal of the American Medical Association* (Mitka, 2003) noted that older adults make up 63 percent of cancer patients in the United States but only 25 percent of participants in clinical trials.

See *Older Adults*, Page 8

There may be several reasons for the smaller number of older adults in clinical trials. One of the most frequently reported challenges involves traveling to the research site. Transportation availability, complexity of directions, and the time and cost involved in getting to the research site are all possible deterrents to participation. Study criteria that eliminate older adults as research participants are another challenge. Also, clinical research protocols are often quite rigid, calling for participants with specific health profiles and stable conditions. And older people consume the majority of prescription medications, so the issue of polypharmacy is a common reason for excluding older subjects from trials. Insurance reimbursement is also a contributing factor—Medicare and many insurance companies will not pay for experimental treatments.

Most of the diseases affecting the older population have been studied in primarily white male populations. Despite the projected growth in minority and female elders, there is little information on clinical issues that specifically affect these groups. Research on health conditions in various unique populations of older persons is limited because these people have traditionally been excluded from major research studies in this country (American Geriatrics Society, 2001).

The problem is not a new one. Despite the fact that the imbalance in study participants has been recognized for years, the disproportionate lack of older persons participating in clinical trials still exists. The trend, however, finally appears to be shifting, as both the research community and policy groups begin to emphasize the inclusion of older adults in clinical trials.

## Conclusion

Millions of Americans are leading healthier lives, in part thanks to discoveries about age-related health care; but disparities still exist. In delivering services, we cannot assume that what works for younger adults will work for the older population. Similarly, programs and services designed for members of the majority group of older persons will not automatically apply to minority elders.

Improving access to health services and programs for older Americans has been an important public policy objective for decades. Many policy initiatives—such as Healthy People 2010 and Medicare reform—call for eliminating disparities in health care to foster better quality of life for current and future older Americans.

Additional research is needed to understand all the factors that affect health disparities and develop new ways to apply existing knowledge. It is also important for direct service providers to acknowledge the significance of culture in all approaches to practice. As social work professionals strive to attain these goals, they should consider innovative strategies to improve the health status of vulnerable populations.

**Lisa Yagoda, LICSW, ACSW, is the senior policy associate for aging for the National Association of Social Workers. She can be contacted at LYagoda@naswdc.org**

## References

- American Geriatrics Society. (2001). Position statement on ethnogeriatrics [Online]. Retrieved from <http://americangeriatrics.org> on June 3, 2005.
- Federal Interagency Forum on Aging-Related Statistics. (2004). *Older Americans 2004: Key indicators of well-being*. Washington, DC: U.S. Government Printing Office.
- National Institute on Aging. (2005). Strategic plan to address health disparities FY 2000–2005 [Online]. Retrieved from [www.nia.nih.gov/AboutNIA/StrategicPlan](http://www.nia.nih.gov/AboutNIA/StrategicPlan) on February 17, 2005.

Mitka, M. (2003). Too few older patients in cancer trials. *Journal of the American Medical Association*, 290 (1), 27–28.

U.S. Department of Health and Human Services (DHHS), Agency for Healthcare Research and Quality. (2005). *2004 national healthcare disparities report* (Publication No. 05-0014). Washington, DC: U.S. Government Printing Office.

## **ERADICATING DISPARITIES IOWA WORKS TO ELIMINATE MINORITY OVERREPRESENTATION IN THE JUVENILE JUSTICE, CHILD WELFARE, AND EDUCATION SYSTEMS**

Brad Richardson, PhD, and Nancy McFall Jean, MSW

For more than a decade, minorities have been overrepresented in the juvenile justice and child welfare systems in Iowa. Now, based on educational data, administrators in the public schools are facing the overrepresentation of children of color in school suspensions and finding ways to eliminate the “achievement gap.” In this article we consider the work of the Disproportionate Minority Contact (DMC) Resource Center at the University of Iowa’s School of Social Work to reduce minority overrepresentation in the juvenile justice child welfare, and educational systems, and offer recommendations for social workers who serve these populations.

### **The Child Welfare System**

In Iowa, children of color comprise 12 percent of the population and more than 20 percent of those in the child welfare system (DHHS, 2001). This overrepresentation of minority children has been documented as a national trend; children of color represent nearly half of the foster care population nationwide, although they are only 20 percent of the nation’s children (National Data Analysis System, 2005).

Although data suggest that they are not at greater risk for abuse or neglect, minority children are clearly overrepresented in the child welfare system. From administrative data, we also know that children of color experience a

higher number of out-of-home placements and are less likely to be reunified with their birth parents. According to a Casey Family Programs Fact Sheet (n.d.), children of color with the same characteristics as their Caucasian counterparts receive different treatment at every point in the child welfare decision-making process, including the decision to place them out of the home, the number of out-of-home placements, and the rate of reunification with birth families.

The DMC Resource Center aims to reduce the overrepresentation of children of color in the child welfare system through the Minority Youth and Families Initiative. This initiative was funded by the Iowa Department of Human Services (DHS) and has pilot projects in Des Moines and Sioux City.

In Des Moines, the project is implemented by PACE Juvenile Justice Center, a local inner-city nonprofit that provides case management and family support services to African-American households referred by DHS when there has been a maltreatment report to DHS and other children in the home may be at risk. The project uses *embedded workers*, social workers who live in the community in which they work. These social workers are culturally sensitive

*See Iowa, Page 10*

and employ a strengths-based and family-centered approach. The project has been able to prevent re-abuse, prevent the abuse of other children in the families, and avoid the need for foster or group-home care. To date, no subsequent maltreatment reports have been filed on any of the families that have participated in the program. Twelve families, including 22 children, have been served by two embedded social workers since January 2005.

In Sioux City, where Native American children and youths are significantly overrepresented in the child welfare and juvenile justice systems, the pilot project created a Specialized Native American Unit within DHS. The unit's goals include earlier identification of relatives as placement options, recruitment and retention of Native American foster parents, and use of family team meetings. Since January 2005, 10 workers have accepted assignment to the unit and approximately 30 families and 120 children have been served. Eight families were diverted to tribal jurisdiction, and another 15 families participated in preventive services. No maltreatment reports have been recorded among these families.

In both communities, a local planning committee was organized to develop a plan for the project. As a result of the successes seen with the families served, the state has continued the pilot projects for another year.

### **The Juvenile Justice System**

Much like the child welfare system, the juvenile justice system is finding ways to grapple with the overrepresentation of minority youths. Minorities make up only 9 percent of Iowa's youth population, but a third of youths held in juvenile detention facilities are minorities. The DMC Resource Center works in counties where minorities are significantly overrepresented in

secure confinement and assists local efforts to address related issues.

The DMC Resource Center provides technical assistance in support of county-based coalitions that have identified overrepresentation as a priority problem. It analyzes local data, provides training as needed and defined by the communities, attends meetings, and provides information, research, evaluation, and assistance in obtaining federal technical support. The DMC Resource Center uses a strengths-based, solution-focused, family-centered orientation to community social work and direct practice.

The DMC Resource Center heightens awareness by hosting an annual statewide DMC conference, bringing together social workers, attorneys, police officers, educators, and other professionals and community members for two days to discuss solutions to reduce the overrepresentation of minorities in the juvenile justice system. Conference participants learn about cultural competency and diversity issues and acquire tools for developing effective strategies to reduce overrepresentation. Last year, the conference drew 300 participants from 14 states.

### **The Education System**

Minorities are also overrepresented in the number of suspensions from Des Moines Public Schools (DMPS), which correlates with their overrepresented involvement in the child welfare and juvenile justice systems. For example, African-American students are arrested at rates that far exceed their proportion of the population at Des Moines high schools. The *Des Moines Register* (Deering, Alex, & Blake; 2003, June 17) examined arrest data and found that "Black students, who constitute 15 percent of

Des Moines' high school student body, accounted for 33 percent of the 556 arrests" (§ 1).

Who are the students most at risk for suspension? According to the schools, many of the characteristics listed are the same ones included in the profile of students who drop out of school: African-American males with academic difficulties who are enrolled in special education programs (DMPS, 2005). Data collected at the county detention center and reviewed by the Polk County Diversion Project's detention review team show that youths who appear at the detention center and are confined have an average of 11 school suspensions.

In 2005, the DMPS requested training for its social workers and psychologists in strengths-based, culturally competent group facilitation. The DMC Resource Center provided the training and worked with DMPS to process information obtained through a series of focus groups conducted with African-American and Latino students who had been suspended and a parallel set of focus groups with their parents.

What we have heard from these focus groups is that students want to succeed in school and their parents want them to succeed. Students realize that sometimes parents must work extra hours to make enough money to support the family, which reduces the amount of time parents can be at home. Many students want mentors and teachers who understand and support them. The DMC Resource Center and DMPS are currently reviewing the findings and developing intervention strategies to reduce minority overrepresentation in suspensions.

### **Why Do These Disparities Exist?**

Efforts to reduce disparities across systems—child welfare, juvenile justice, education, housing, and labor—require consideration of

the factors that lead to these disparities. Many experts say that the root causes are poverty (Rozie-Battle, 2002); the presence of racism or lack of cultural competence among professionals working with youths of color; and the lack of services and resources that would help these youths make informed decisions (Villarruel, et al., 2002).

Poverty exposes families to multiple stress factors that may compromise their ability to manage day-to-day activities. Because minority families in this country, particularly African-American families, are more likely than non-minority families to be poor, they are also more vulnerable to social problems, including child abuse and neglect, domestic violence, and substance abuse (Children's Bureau, 2003).

Despite their need for services, poor families are more likely to live in resource-poor communities, many of which also are geographically isolated from other communities that might offer support and services (Children's Bureau, 2003). As a result, families that live in poverty are the least likely to have resources available to them, leaving them even further compromised. The more compromised a family is, the more likely that it will eventually come into contact with child welfare or some other social system.

### **Implications for Social Workers**

The disproportionate rate of children of color in the child welfare and juvenile justice systems, and in school suspensions, is of serious concern to social workers. When disparities in outcomes by race or ethnicity occur, agencies must employ strategies to mitigate these disparities and improve outcomes for all children (NASW, 2001). These strategies include the following:

*See Iowa, Page 12*

- Recruiting multiethnic staff and including cultural competence requirements in job descriptions and performance promotion criteria.
- Reviewing current and emergent demographic trends for the geographic area served by the agency to determine service needs, including interpretation and translation services.
- Encouraging the participation of families as major stakeholders in the development of service delivery systems.
- Maintaining awareness of the effect of social policies and programs on diverse client populations and advocating for and with families whenever possible.
- Requiring staff to participate in educational and training programs to expand their cultural competence.

### Recommendations

Social workers in the child welfare system can help reduce the overrepresentation of children of color in the system by considering the following strategies:

- Use family group decision-making processes (Casey Family Programs, 2003), which allow the family to participate in a broad range of decisions about the child's well-being. Involving the child and family in decision making and giving families an opportunity to contribute their ideas about cultural issues should be a valued part of the casework process.
- Use strengths-based asset models to determine whether reunification with the birth family is a viable option. Studies have shown that African-American children in out-of-home care are more likely to be reunited with their birth families if parents received services; had a high school education, job skills, and jobs; and did not have substance

abuse problems (Westat & Chapin Hall Center for Children, 2001).

- Screen for and treat substance abuse disorders. It is estimated that 80 percent of children in out-of-home placements are there as a result of parental substance abuse problems (DHHS, 2000).
- Locate kin and other persons who can provide support and a sense of permanency for the child, if reunification with the birth family is not an option. In recruitment efforts for out-of-home care, social workers should seek families that reflect the ethnic and racial background of the children for whom the homes are needed, and situations that are in compliance with the Multiethnic Placement Act of 1994 (P.L. 103-382), the Interethnic Adoption Provisions of the Small Business Job Protection Act of 1996 (P.L. 104-188), and the Indian Child Welfare Act (P.L. 95-608) (NASW, 2005).

For instance, when a Native American child requires out-of-home care, social workers must include tribes in decision making and for assistance in locating an appropriate placement. Social workers should also consider the particular needs of children who have English as a second language. If children are placed with families of a different race, ethnicity, or culture, the families should receive diversity training, when appropriate.

Social workers in the juvenile justice system can help reduce the overrepresentation of children of color in the system by considering the following strategies:

- Advocate for decreasing the disproportionate incarceration of youths of color and for the construction of appropriate residential programs (Villarruel et al., 2002).

- Identify the resources that are available to juveniles, including alternative programs, group homes, mentors, after-school programs, and therapeutic services. School dropout prevention programs are becoming more numerous and varied. These programs include violence and bullying prevention, after-school recreation, mentoring and academic improvement programs, and social competence curricula to encourage students to refrain from violent behaviors (NASW, 2003).
- Analyze client data by race and ethnicity to detect disparate treatment; use objective screening instruments to eliminate subjectivity from decision making; coordinate with police to better control who comes in the door of the juvenile justice system; change hiring practices to make staff more representative of youths in the system; hold staff accountable for placement decisions; develop culturally competent programming; and employ mechanisms to divert youths of color from secure confinement (Hoyt, n.d.).

## SPS NEWS

- Coming Winter 2005, the SPS program will launch the eConnection, a yearly electronic update for its members.
- In October 2005, the SPS Program introduced a new Specialty Practice Section: Children, Adolescents, and Young Adults (CAYA).
- The Poverty and Social Justice Section has a new name, Social and Economic Justice & Peace Section.

In the education system, disparities in school suspensions can lead to minority children being “tracked” into the juvenile justice system. We know from the Des Moines Public School experience that children of color are more likely than Caucasian children to receive suspensions. Some analysts contend that zero-tolerance laws—enacted by state legislatures and then, in 1994, by Congress—are to blame. Over the past decade, some experts have observed that disciplinary policies originally intended for “dangerous” students and mandating severe punishments (suspension, expulsion, or referral to law enforcement) have been expanded in many districts to cover a broad range of student behaviors, from possession of weapons and drugs to threats, truancy, and tardiness.

The Youth Transition Funders Group (n.d.) found that, “Zero tolerance policies prematurely push struggling students out of schools and into the juvenile justice system, dramatically increasing racial disparities. Some jurisdictions report that almost half of all their referrals to juvenile court originate from schools.”

## Conclusion

While there are many disparities in the child welfare, juvenile justice, and education systems, the DMC Resource Center’s efforts to eliminate disparities in these systems have shown that measurable results can be achieved through a combination of systems change and direct practice.

Poverty and racism may be contributing factors to minority overrepresentation in the child welfare and juvenile justice systems and in school suspensions. However, we do not have a clear understanding of why the disparities exist,

*See Iowa, Page 14*

particularly with regard to African-American youths. We do know that the overreliance on current practices of excessive suspensions, confinement, and out-of-home placements has not been effective in preventing or eliminating disparities.

Social workers must continue to demand better jobs and services for low-income families through advocacy at the state and national levels; and staff in all systems need better training in cultural competency and in using strengths-based, solution-focused, and family-centered services.

**Brad Richardson, PhD, is coordinator of the DMC Resource Center and associate director at the University of Iowa's School of Social Work National Resource Center for Family Centered Practice. He can be contacted at bradrichardson@uiowa.edu**

**Nancy McFall Jean, MSW, is the senior policy associate for children and families for the National Association of Social Workers. She can be contacted at NMcFallJean@naswdc.org**

## References

- Casey Family Programs. (n.d.). *Fact sheet: Statistics illustrating major trends and issues in the child welfare system* [Online]. Retrieved from [www.casey.org/MediaCenter/MediaKit/FactSheet.htm](http://www.casey.org/MediaCenter/MediaKit/FactSheet.htm) on July 14, 2005.
- Casey Family Programs. (2003). *Practices that mitigate the effects of racial/ethnic disproportionality in the child welfare system* [Online]. Retrieved from [www.casey.org/NR/rdonlyres/F2CF350A-1A46-RE02-80EA-3746F2A70F20/132/casey\\_mitigating\\_disproportionality.pdf](http://www.casey.org/NR/rdonlyres/F2CF350A-1A46-RE02-80EA-3746F2A70F20/132/casey_mitigating_disproportionality.pdf) on July 18, 2005.
- Children's Bureau. (2003). *Children of color in the child welfare system: Perspectives from the child welfare community* [Online]. Retrieved from <http://nccanch.acf.hhs.gov> on June 10, 2005.
- Deering, T., Alex, T., & Blake, B. (2003, June 17). One in three school arrests involved blacks. *Des Moines Register* [Online]. Retrieved from <http://www.dmregister.com> on July 17, 2005.
- Des Moines Public Schools. (2005). *Plan for progress, minority achievement plan, and minority suspension* [Online]. Retrieved from [www.dmps.k12.ia.us/whatsnes/05Plan\\_for\\_Progress\\_Minority\\_Suspension.pdf](http://www.dmps.k12.ia.us/whatsnes/05Plan_for_Progress_Minority_Suspension.pdf) on July 14, 2005.
- Hoyt, E. H. (n.d.). *Pathways to juvenile detention reform and reducing racial disparities in juvenile detention* [Online]. Annie E. Casey Foundation. Retrieved from [www.buildingblocksfor youth.org](http://www.buildingblocksfor youth.org) on July 15, 2005.
- National Association of Social Workers. (2001). *Standards for cultural competence in social work practice*. Washington, DC: NASW Press.
- National Association of Social Workers. (2003). *Poverty and Social Justice SPS Update: The juvenile justice system and youths of color: A look at disparities in confinement*. Washington, DC: NASW Press.
- National Association of Social Workers. (2005). *NASW standards for social work practice in child welfare*. Washington, DC: NASW Press.
- National Data Analysis System. (2005). *Children of color in the child welfare system* [Online]. Retrieved from [http://ndas.cwla.org/research\\_info/minority\\_child](http://ndas.cwla.org/research_info/minority_child) on June 17, 2005.
- Rozie-Battle, J. L. (2002). *African-American teens and the neo-juvenile justice system*. *Journal of Health & Social Policy*, 15 (2), 69-79.
- U.S. Department of Health and Human Services. (2000). *Rethinking child welfare under the Adoption and Safe Families Act of 1997: A resource guide* [Online]. Retrieved from [www.cwresource.org](http://www.cwresource.org) on June 2, 2005.
- U.S. Department of Health and Human Services. (2001). *Child welfare outcomes 2001: Annual report to Congress* [Online]. Retrieved from [www.acf.hhs.gov/programs/cb/publications/cwo01/cwo01.pdf](http://www.acf.hhs.gov/programs/cb/publications/cwo01/cwo01.pdf) on July 14, 2005.
- Villarruel, F. A., Walker, N. E., Minifee, P., Rivera-Vazquez, O., Peterson, S. and Perry, K. (2002). *Donde esta justicia? A call to action on behalf of Latino and Latina youth in the justice system* [Online]. Retrieved from [http://www.buildingblocksfor youth.org/latino\\_rpt/index.html](http://www.buildingblocksfor youth.org/latino_rpt/index.html) on June 11, 2005.
- Westat, Inc., & Chapin Hall Center for Children. (2001). *The role of race in parental reunification. In Assessing the context of permanency and reunification in the foster care system* [Online]. U.S. Department of Health and Human Services. Retrieved from [www.hhs.gov](http://www.hhs.gov) on June 10, 2005.
- Youth Transition Funders Group. (n.d.) *A blueprint for juvenile justice reform* [Online]. Retrieved from <http://www.ytfg.org> on June 10, 2005.

the nation's attention. Yet, alcohol causes more damage to a fetus than any other drug, licit or illicit.

Social workers have a unique opportunity to affect change among both pregnant women and children who were exposed to alcohol in utero. Social work skills such as engagement, family-based assessment, and linkage to services are an integral part of the treatment needed to reach this vulnerable population.

Researchers have long known that alcohol can have negative effects during pregnancy. Evidence for the earliest suspicion of teratogenic effects of alcohol was first reported in a scientific journal in 1899. Another report in 1900 indicated that the placenta was not a barrier to alcohol; thus, alcohol ingested by the mother passed to the unborn child (Randall, 2001).

In 2005, the surgeon general of the United States issued a statement that no amount of alcohol is safe during pregnancy. Yet, rates of drinking among women of childbearing age are increasing (SAMHSA, 2005). In a 2005 study by Chasnoff and other researchers, half of all women who were using alcohol before they knew they were pregnant continued to drink after learning of their pregnancy.

Even with light drinking (defined as drinking less than one day per week), studies indicate substantial risk for the child. Moreover, women who drink lightly are most often missed in routine prenatal care and screening (Chasnoff et al., 2005). In its 1996 Report to Congress, the Institute of Medicine stated that, of all substances of abuse, alcohol produces by far the most serious neurobehavioral effects in an unborn child.

The direct costs to health care, social services, and other systems, and the indirect costs—such as loss of productivity due to morbidity, disability, and mortality—can average \$2 million in an individual's lifetime and can be as high as \$4.2 million for the most severely affected individuals (Lupton, Burd, & Harwood, 2004). A striking public health issue, FASD is totally preventable.

A significant form of brain damage resulting from fetal alcohol exposure is the thinning or agenesis of the corpus callosum, which connects the left and right hemispheres of the brain and allows them to communicate. This phenomenon is associated with deficits in attention, intellectual functioning, reading, learning, verbal memory, and executive and psychosocial functioning (SAMHSA, 2005). Brain damage caused by fetal alcohol exposure has lifelong effects. However, not all persons with FASD have the same level of impairment; with the right supports in place, many can improve their adaptive function and quality of life.

In addition, many children with FASD have normal intelligence and a normal appearance, but they have severe problems in development, learning, and behavior. Many of the signs and symptoms of FASD are also present in other learning disabilities.

Identification is complicated by the fact that there is not a unique list of characteristics categorically present in children with FASD. However, the following are commonly seen in persons with FASD:

- Difficulty taking in, storing, and recalling information;
- Difficulty using information appropriately in a specific situation;

*See FASD, Page 16*

- Low intelligence;
- Lower level of adaptive functioning than intelligence would suggest;
- Impaired ability in reading, spelling, and arithmetic;
- Impaired sensory integration;
- Low self-esteem and other personal issues.

One study identified significant secondary disabilities in persons with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE), including the following: 94 percent had mental health issues, 79 percent had employment problems, 83 percent had experienced dependent living, 50 percent had experienced confinement in jail or a treatment facility, and 35 percent had alcohol or drug problems (Streissguth, Barr, & Kogan, 1996).

### Treatment Barriers

One of the greatest barriers to access to services for children or adults with FASD is timely and appropriate diagnosis. Many health care

providers do not have specialized training in FASD diagnosis and, therefore, may not recognize the effects of prenatal exposure to alcohol or feel comfortable assessing and diagnosing FASD. Neonatal toxicology screens do not detect alcohol, so infants at risk for FASD are often not identified at the time of birth.

The guilt and shame felt by many pregnant women who drink may prevent them from identifying themselves and their children as being in need of services. In fact, many women who use alcohol and other substances are reluctant to get prenatal care for fear of being reported to child protective services. Yet infants whose alcoholic mothers enter treatment and stop using alcohol by the third trimester have substantially improved outcomes. The value of proactive approaches with pregnant women is clear in terms of offsetting costly services for children who were exposed to alcohol in utero and preserving their quality of life (Lucas, Goldschmidt, & Day, 2003).

### FASD Terminology

There is currently no national consensus on distinguishing terminology for the diagnostic description of the effects of prenatal alcohol exposure. Following are some of the frequently used terms and their distinctions:

*Alcohol-Related Birth Defects (ARBD)*—physical anomalies only.

*Alcohol-Related Neurodevelopmental Disorder (ARND)*—neurodevelopmental abnormalities or a complex pattern of behavior or cognitive abnormalities inconsistent with the developmental level that cannot be explained by family background or environment alone.

*Fetal Alcohol Effects (FAE)*—cognitive difficulties, growth deficiencies, and knowledge of a mother who drank during pregnancy, but no facial anomalies.

*Fetal Alcohol Syndrome (FAS)*—distinct facial features, growth deficiencies, central nervous system defects, and knowledge of a mother who drank during pregnancy.

*Partial Fetal Alcohol Syndrome (pFAS)*—some of the facial features of FAS, along with evidence of growth retardation, neurodevelopmental abnormalities, or a complex pattern of behavior or cognitive abnormalities inconsistent with a developmental level that cannot be explained by family background or environment alone.

(SAMHSA, 2005)

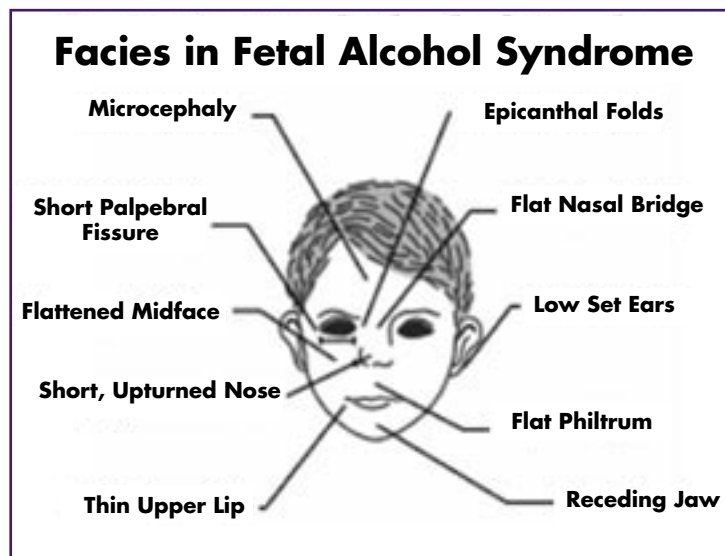
**Microcephaly:** an abnormally small head, usually signals an underdeveloped brain and possibly some degree of mental retardation.

**Short palpebral fissure:** the distance between the inner and outer corners of the eye is shorter than average.

**Flattened midface:** with the appearance of flattened cheeks.

**Short, upturned nose:** extends from the flattened nasal bridge.

**Thin upper lip:** may vary depending on race or ethnicity.



**Epicanthal folds:** extra skin folds coming down around the inner angle of the eye.

**Flat nasal bridge:** contributes to the appearance of a flattened face.

**Low set ears:** ears may appear underdeveloped.

**Flat philtrum:** no groove or crease running from the bottom of the nose to the top of the lip.

**Receding jaw:** also a small mouth with a high arched palate, small teeth with poor enamel coating.

*This chart was used with permission of the National Training Institute, Copyright 2001.*

The above chart shows FAS facies, or abnormalities, commonly seen in children with fetal alcohol syndrome. As shown in the sketch, a child exposed to alcohol prior to birth usually has a smaller-than-normal head circumference of less than 33 centimeters, while the average full-term infant's head size is 35 centimeters. Additionally, children with FAS may have malformed internal organs, such as their heart or kidneys. Many also experience vision problems and frequent ear infections or hearing loss.

The facial characteristics depicted in the chart above may not seem unusual. A trained professional, however, would be able to recognize the features as abnormal, measure the characteristics, and appropriately diagnose.

## Disparities

In a *New England Journal of Medicine* article discussing the fact that physicians select pregnant women for urine toxicology screening on the basis of race and social class by a factor of 10 to 1, the authors note that “the preconception that substance abuse, especially during pregnancy, is a problem that affects minority groups, urban populations, and lower socioeconomic groups could bias physicians in identifying substance exposure in newborn infants” (Chasnoff et al., 1990, p. 1206). In a

five-city study of universal screening of varying racial and socioeconomic compositions, the highest rates of alcohol use were in the city that also had the highest percentage of Caucasian women and the highest socioeconomic status (Chasnoff et al., 2005).

Targeted screening is a barrier to appropriate care, as urine toxicology reports do not detect alcohol or many drugs used more than 48

*See FASD, Page 18*

hours prior to testing. The reasons for disparities in screening and identification of alcohol use during pregnancy, and of persons who may have FASD, vary widely by community and by practitioner. However, the result can be failure to identify persons who are in need of assessment and intervention. The American College of Obstetrics and Gynecology Committee on Ethics issued a statement in May 2004 that physicians have an ethical obligation to learn and use techniques for universal screening.

### Social Work Intervention

Chasnoff and other researchers (2005) found that verbal screening and assessment uncovered a significantly higher rate of alcohol or illicit drug use than did clinically guided urine toxicology tests. This finding illustrates the importance of the social work role. More than a medical test is needed, and social workers can assist with verbal screening and assessment.

The *4Ps Plus* is a five-question screening that quickly identifies obstetrical patients in need of in-depth assessment or follow-up monitoring. It takes less than a minute to complete. A positive response to any of the questions is considered a positive screen. The woman is asked the following questions:

- Parents: Did either of your parents ever have a problem with alcohol or drugs?
- Partner: Does your partner have a problem with alcohol or drugs?
- Past: Have you ever drunk beer, wine, or liquor?
- Pregnancy: In the month before you knew you were pregnant, how many cigarettes did you smoke?
- Plus: In the month before you knew you were pregnant, how many beers/how much wine/how much liquor did you drink?

Source: (Chasnoff et al., 2005) Reprinted with permission.

Social workers can use a number of assessment and intervention strategies with pregnant women and persons with FASD. Following are a few suggestions:

- Promote clear messages, such as those in the SAMHSA (2005) materials: “If you drink, don’t get pregnant. If you’re pregnant, don’t drink.”
- Promote universal screening of women during pregnancy and of all children born to women who are known to use substances.
- Use engagement techniques and a nonjudgmental approach when screening and doing assessments. Offer clear, honest information about resources, referrals, and the consequences of choices. Provide ways for women to talk about alcohol and drug use and to get help.
- Facilitate links between agencies and providers to promote a seamless system of care for pregnant women who use alcohol and for children exposed prenatally to alcohol.
- Promote provider collaboration and communication.
- Use a family systems, strengths-based approach in assessment and intervention. A social worker may serve as family liaison or negotiator on the assessment and evaluation team (Malone, McKinsey, Thyer, & Straka, 2000), harnessing family strength and facilitating empowerment.
- Stress education before pregnancy and access to family planning, contraceptives, and substance abuse treatment. Screen for life stressors that may contribute to drinking, including stress, depression, or partners who drink.
- Continue to use engagement techniques during pregnancy and build trust; screen for life stressors, alcohol, and other substance use; and make referrals to treatment as needed.

- Facilitate early assessment and intervention after birth. Assess all children whose mothers were in substance abuse treatment or who acknowledge a history of drinking during pregnancy. Assess all children with growth or neurocognitive deficits or facial characteristics typical of FASD.

## Hope for the Future

Numerous studies have shown that educational input from prenatal care providers significantly increases the likelihood that a woman will make healthy decisions during her pregnancy. Additionally, intervention can influence a woman's behavior during future pregnancies. Social workers are uniquely prepared to perform interventions to reduce the likelihood of alcohol consumption during pregnancy and to encourage women to get treatment early.

Social workers are also an important part of the system of care needed to identify, assess, and intervene with individuals prenatally exposed to alcohol. While all persons with FASD have unique individual characteristics, many share similar strengths. Persons with FASD are often described as friendly, caring, loyal, fair, compassionate, determined, and kind to younger children and animals. With early intervention and treatment by skilled providers, many can develop coping skills that will harness their strengths and significantly enhance their quality of life.

**Laura LaRue Gertz, LCSW, ACSW, is the senior policy associate for health for the National Association of Social Workers. She can be contacted at [lgertz@naswdc.org](mailto:lgertz@naswdc.org)**

## References

- American College of Obstetricians and Gynecologists committee on ethics. (2004, May). At-risk drinking and illicit drug use: Ethical issues in obstetric and gynecologic practice [Online]. *Obstetrics & Gynecology*, 103(5), 1021-1031. Retrieved from <http://www.ncbi.nlm.nih.gov> on August 12, 2005.
- Chasnoff, I. J., Landress, H. J., & Baret, M. E. (1990). The prevalence of illicit-drug or alcohol use during pregnancy and discrepancies in mandatory reporting in Pinellas County, Florida. *New England Journal of Medicine*, 322 (17), 1202-1206.
- Chasnoff, I. J., McGourty, R. F., Bailey, G. W., Hutchins, E., Lightfoot, S. O., Pawson, L. L., Fahey, C., May, B., Brodie, P., McCulley, L., & Campbell, J. (2005). The 4 P's Plus screen for substance use in pregnancy: Clinical application and outcomes. *Journal of Perinatology*, 25, 368-374.
- Institute of Medicine. (1996). *Fetal Alcohol Syndrome: Diagnosis, epidemiology, prevention and treatment*. Report to Congress. Washington, DC: National Academy Press.
- Lucas, E. T., Goldschmidt, L., & Day, N. L. (2003). Alcohol use among pregnant African American women: Ecological considerations. *Health and Social Work*, 28(4), 273-283.
- Lupton, C., Burd, L., & Harwood, R. (2004). Cost of Fetal Alcohol Spectrum Disorder. *American Journal of Medical Genetics*, 127 C(1), 42-50.
- Malone, D. M., McKinsey, P. D., Thyer, B. A., & Straka, E. (2000). Social work early intervention for young children with developmental disabilities. *Health and Social Work*, 25(3), 169-180.
- Randall, C. L. (2001). Alcohol and pregnancy: Highlights from three decades of research. *Journal of Studies on Alcohol*, 554-561.
- Streissguth, A. P., Barr, H. M., & Kogan, J. (1996). *Final report: Understanding the occurrence of secondary disabilities in clients with Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE)*. Seattle: University of Washington Publication Services.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2005). Fetal alcohol spectrum disorders: The basics. Fetal Alcohol Spectrum Disorders Center for Excellence, SAMHSA [Online]. Retrieved from [www.fascenter.samhsa.gov/misc/FASDBASICS/FASDTheBasic.pdf](http://www.fascenter.samhsa.gov/misc/FASDBASICS/FASDTheBasic.pdf) on June 15, 2005.

## Resources

- Children's Research Triangle. Available at: <http://www.childstudy.org>
- National Center on Substance Abuse and Child Welfare (NCSACW). Available at: <http://www.ncsacw.samhsa.gov>
- National Institute on Alcohol Abuse and Alcoholism (NIAAA). Available at: <http://www.niaaa.nih.gov>
- National Organization on Fetal Alcohol Syndrome (NOFAS). Available at: <http://www.nofas.org>
- Substance Abuse and Mental Health Services Administration (SAMHSA). Fetal Alcohol Spectrum Disorders Center for Excellence. Available at: <http://www.fascenter.samhsa.gov>



National Association of Social Workers  
Specialty Practice Sections

750 First Street, NE, Suite 700  
Washington, DC 20002-4241

Non Profit Org.  
U.S. Postage  
PAID  
Washington, DC  
Permit No. 8213



**Social Workers  
Help starts here.**

National Social Work  
Public Education Campaign

**REGISTER.  
EDUCATE.**



**Licensed Social Workers:** Help make the new social work consumer Web site – [www.HelpStartsHere.org](http://www.HelpStartsHere.org) – an invaluable resource for the public.

**HERE'S WHAT YOU CAN DO:**

- 1 **REGISTER** in the National Social Worker Finder online search tool: [www.HelpPRO.com](http://www.HelpPRO.com)

Registration takes less than 20 minutes and costs just \$25.\*  
*\*Registration is free for current holders of the QCSW credential.*

- 2 **EDUCATE** the public on your area of expertise. Submit Web content for one of 30 different categories:

**Online:** [www.socialworkers.org/consumerWeb/contribute/default.asp](http://www.socialworkers.org/consumerWeb/contribute/default.asp)  
**Email:** [consumer@naswdc.org](mailto:consumer@naswdc.org)  
**Fax:** 202.336.8307