

1440 - ENHANCED PRACTICE FOR WORKING WITH SPECIAL POPULATIONS

CHANGE # 01-2007

January 2007

I. INTRODUCTION

The effective **child** protective services social worker must approach every situation with sensitivity to those physical, emotional, cultural, or environmental factors that make children more vulnerable to abuse or less able to communicate their fears. For the purposes of this section, the term "special populations" refers to children and families who are at greater risk because of these factors.

The social worker has an ethical and professional responsibility to recognize his or her own attitudes and prejudices regarding mental and physical disability, race, culture, sexual orientation, religious beliefs, economic status, homelessness, marital status, and other highly charged beliefs. It is impossible to grow up in a culture without such beliefs. Failure to recognize one's own perspective can lead to inaccuracy in perception and, thus, to incorrect assessments.

It is not the intent of this section to provide exhaustive information about each group named, nor to suggest that the identified populations are an all-inclusive listing. This section is designed to refresh the knowledge of veteran staff, to increase the awareness of newer social workers, and to provide direction for further study.

Effective interviewing strategies and techniques shall be used which are appropriate to the child's developmental level. Documentation, including observations of the child, shall explain any inability to interview the child.

When a child is alleged to have a medical condition, disease, or illness relevant to the allegation, the agency shall consult the medical provider treating the condition. This consultation shall be focused on determining the family's assertions about that medical condition, or there shall be justification for why this was not done. Medical and psychological resources, such as the [Child Medical Evaluation Program/Child/Family Evaluation Program](#) shall be utilized, as appropriate, in the assessment of alleged victims of neglect and/or physical, sexual, or emotional abuse. The CMEP/CFEP ([DSS-5143](#)) should be considered if the social worker has questions about any of the following issues (This list is not intended to be all inclusive. There may be other instances in which a CMEP/CFEP may be considered appropriate as part of the family assessment):

- Significant delay in the child's developmental skills.
- Significant delay in the child's physical development.
- Unusual and unexplained lethargy or irritability.
- Untreated or inadequately treated medical conditions which have significant impact on the child's overall health or physical development.

- Children affected when one caregiver is violent with or uses another form of abuse with the other.
- Child-on-child sexual contact initiated as CPS for parental supervision issues.
- A child has received a non-serious injury from an unknown perpetrator.

II. THE IMPACT OF DEVELOPMENTAL DISABILITY¹

Developmental disabilities are physical or mental conditions that become apparent before the age of twenty two, continue throughout the individual's lifetime, and cause significant impairment in daily functioning. This term includes conditions such as mental retardation, motor dysfunction, vision/hearing impairments, learning disabilities, communication problems, severe emotional disturbance, neurological impairments, and chronic illnesses.

A. Accessibility and Abuse

When evaluating the accessibility risk to a child **with a developmental disability**, the **CPS social worker** should not only **complete the standard Structured Decision Making tools**, but also should consider the following questions:

1. Does the disability require increased physical contact, such as assistance with toileting or bathing?
2. Does the child have sufficient information about inappropriate or abusive touch to know to report maltreatment?
3. Is the child physically able to defend him/herself if necessary?
4. Does the child have access to friends or responsible adults to whom he/she could report maltreatment?

B. Stress Factors in Parents/Caregivers of Developmentally Disabled Children

While some disabled children may be at reduced risk for maltreatment despite the need for more nurturance, surveillance, and resources, most authors agree that the presence of a child with developmental disabilities increases the stress within the family unit.

Considerations for the CPS social worker should include:

¹ Joann Grayson, PhD., "Child Abuse and Developmental Disabilities," Virginia Child Protection Newsletter, Volume 37, Fall, 1992.

1. What is the parent's response to the disability? Parents may react with guilt, anger, ambivalence, and/or sorrow. Have the parents received support and guidance in dealing with these feelings? Is the parental relationship suffering due to the stress of caring for a disabled child?
2. Are adequate resources available to the family? Does the family have sufficient time and money to access these resources? Is the family willing to use these resources?
3. What is the impact on the non-disabled siblings? Is there inappropriate assignment of responsibilities to or lack of nurturing for the other children?
4. Do the parents/caregivers have realistic expectations of each child? Children with lesser degrees of impairment are thought to be at higher risk for unrealistic expectations. Mildly impaired children may not be identified as disabled and their behavior may be attributed to "willfulness."

C. Parental Vulnerabilities

Parents of developmentally disabled children are likely to be at higher risk to maltreat their children if their abilities to cope are impacted by factors such as mental retardation, mental illness, substance abuse, poverty, unemployment, inadequate knowledge of or experience with child-rearing practices, and/or immaturity.

CPS social workers should weigh these factors in the overall assessment of the child's safety and risk of harm and the need for services and resource development with the family.

It is known that child abuse and neglect can **cause** a full range of disabilities, ranging from mild to severe. In a 1981 study, Nora Baladerian concluded that twenty-five per cent of all disabilities were caused by physical abuse or neglect. In 1991, this same researcher estimated that between 32,000 and 80,000 children become disabled each year as a result of abuse or neglect. Two limited but independent studies in 1971 indicated that eye disorders were present in forty percent of hospital samples of battered children, suggesting strongly that **abuse can result in** many children **with visual disabilities** or blindness. Whenever a disability could have been caused by maltreatment, the social worker should consider medical evaluations **for** the alleged victim child.

D. Deteriorating Relationships

Prolonged hospitalizations, institutionalization, frequent care giving by others, and early separations can interfere with parent-child bonding. Problems do not end after bonding. While most children outgrow their helpless and dependent behaviors,

some developmentally disabled children will either be delayed in becoming capable of self-care or will never become independent.

E. Cultural Attitudes that Allow or Encourage Maltreatment

Historically, our society has treated disabled children as if their disability desensitized them to physical or emotional pain. A significant portion of our institutionalized population consists of individuals with disabilities, suggesting a societal attitude that these individuals are not harmed by institutionalization.

F. Barriers to Identification of children who are disabled that are subjected to abuse, neglect and/or dependency are:

1. Children with disabilities are more likely to be seen as unreliable reporters of abuse or neglect.
2. The client may not be able to communicate the facts in detail.
3. Symptoms of the disability may mask maltreatment; e.g.:
 - The child may be self-abusive.
 - The child may be prone to accidental injury.
 - The child may have poor judgment or impulse control and may act out inappropriately.
4. The disability may require increased touching for routine care, making identification of inappropriate touch difficult.
5. The child may be more vulnerable to attention from the perpetrator due to cognitive impairments or emotional deprivation.
6. The child may be socially isolated and may not know whom to tell.
7. The child may not have received appropriate training in sex education or prevention and may not be aware that a problem exists.

III. ISSUES RELATED TO MENTAL RETARDATION

A mentally retarded child will be delayed in the mental and emotional maturation process. Depending on the level of retardation, the child may have difficulty communicating about maltreatment. The social worker will need to use interviewing techniques appropriate to the mental age of the child and his/her interests. The skilled use of anatomically correct dolls, drawings, and other techniques that do not require verbal skills may be useful in the assessment process. **The interviewer must exercise extreme caution not to suggest that any particular "answer" is sought in response to a**

question. The interviewer should be aware of assumptions he or she may make based on the physical age of the mentally retarded child. A physically mature, mentally delayed child may have normal sexual responses combined with the judgment and insight of a much younger child.

A mentally retarded caregiver/parent cannot be assumed to be incapable of offering minimally sufficient care. The assessment of maltreatment must be based on the action or inaction of the caregiver/parent, as it is in any other situation.

IV. ISSUES RELATED TO MOTOR IMPAIRMENTS

Any disability which necessitates increased physical contact, which limits the child's ability to defend him/herself, which limits a child's social contact outside the living situation, and/or which increases the child's dependency on the caregiver for survival is a disability that increases the child's risk for maltreatment. Reports involving children whose physical disabilities limit self-mobility must be investigated with these aspects in mind. If routine care requires touching of the genitals, the child may have difficulty differentiating between acceptable and non-acceptable touch.

If a child's physical disability is perceived to be the result of action or inaction by the parent/caregiver, that child may be a painful reminder to that parent or caregiver of their feelings of guilt. Intervention plans should include consideration of the parent/caregiver's acceptance of the child and his/her disability.

V. ISSUES RELATED TO SENSORY DISABILITY

A hearing-impaired child or family member may require a **licensed** interpreter and or visual aids to communicate about the maltreatment. The interpreter, if used **for court**, should be acceptable to the court and must be able to interpret effectively, accurately, and impartially. **The North Carolina Interpreter and Transliterater Licensure Act (N.C.G.S. § 90D) requires that the interpreter provided must be licensed to interpret.** If a child is not able to communicate due to unfamiliarity with standard sign language, the regional office for the hearing impaired will have a list of individuals who are familiar with local "home signs" and who can assist with interpretation. **For information about obtaining interpreter services, contact Calotta Dixon with the Division of Social Services at 919-733-9461 or Carlotta.Dixon@ncmail.net.**

A vision-impaired child may not be able to relay information that relies on visual cues. Appropriate interview techniques will take the child's perceptual abilities into consideration.

VI. ISSUES RELATED TO LEARNING DISABILITIES

Children with learning disabilities frequently display a variety of problems that **parents/caregivers** may interpret as willfulness, disobedience, **or** laziness. Such children may be more likely to be subjected to over discipline.

Children with learning disabilities or attention deficit disorder frequently have at least normal intellectual ability. Parents and caregivers may have difficulty resolving their awareness of the child's abilities and his or her poor performance.

If a child has been diagnosed with learning disabilities, it is important for the social worker to assess the parent/caregiver's understanding of and response to the disability. Often a parent or caregiver can use effective means of helping the child by reinforcing methods used in the classroom.

In assessing the strengths of the family, it is important for the social worker to determine the areas in which the child is successful by his/her own standards. In these areas, the child may provide information regarding interests and learning abilities that can be tapped for constructive planning. **This can be done by reviewing the child's Individualized Education Plan (IEP), talking with the child's therapist, teacher and other school staff who may have knowledge about the child's learning abilities.**

VII. ISSUES RELATED TO SEVERE EMOTIONAL DISTURBANCE AND MENTAL ILLNESS

Emotional disturbance frequently results from maltreatment, but some disturbances are early manifestations of genetically transmitted or drug-enhanced mental illness.

Children who are classified as developmentally disabled as a result of emotional disturbance or mental illness have usually displayed behavior that is well beyond acceptable norms. Atypical emotional or behavioral conditions likely to be included in this category would be:

- Delay or abnormality in achieving expected emotional milestones, such as pleasurable interest in adults and peers, ability to communicate emotional needs, and ability to tolerate frustration;
- Persistent failure to initiate or respond to most social interactions;
- Fearfulness or other distress that does not respond to comforting by caregivers;
- Indiscriminate social interactions; and
- Self-injurious or excessively aggressive behaviors.

Emotionally and mentally disturbed children are at higher risk of maltreatment because of the unpredictability of their responses to the environment. This may increase the frustration of the caregiver or parent and may lead to abuse or neglect.

VIII. IMPLICATIONS OF CHRONIC ILLNESS

- A. A severe chronic illness is defined as a condition that lasts for a substantial period of time or that has effects that are debilitating for a long period of time. Typically, a chronic illness interferes with daily functioning for greater than three months a year or is likely to require hospitalization for more than one month a year. Examples include:
- Congenital heart disease;
 - Short bowel syndrome;
 - Chronic renal failure;
 - Juvenile rheumatoid arthritis;
 - Leukemia;
 - Bronchopulmonary dysplasia (BPD);
 - Acquired Immune Deficiency Syndrome (AIDS); or
 - Hepatitis.
- B. Severe chronic illness increases the stress in the family due to financial and emotional costs, de-emphasis of other issues that may impact the family, separations that interfere with family bonding and resentment. These stresses may be taken out on the child in the form of neglect, abandonment, physical, emotional, or sexual abuse.

IX. THE IMPACT OF CULTURAL DIVERSITY

The field of child protective services is being challenged to respond with knowledge and sensitivity to individuals from a wide diversity of cultural backgrounds. In North Carolina, the majority of children's services caseloads are comprised of white and African-American children. This population is enriched with significant representation from minority cultures, including Native Americans and a variety of ethnic and cultural groups from Asia, the Middle East, Central and Latin America, and Europe. Each culture brings its own values, customs, beliefs and language.

Culture refers to the total system of values, beliefs, traditions, and standards of behavior that regulate life within a particular group of people. **Values** are general principles or ideals, usually related to worth and conduct, that a culture holds to be important. Values describe strongly held beliefs regarding what life and people should be like, what is "good" and "bad" in life, what is "right" or "wrong" about behavior. Values often address similar principles across cultures, but the content and conclusions

of the values may be very different from culture to culture. For example, no major cultural or ethnic group sanctions maltreatment of children, but the specific behaviors considered to be "maltreatment" can vary widely. Some cultures condemn any corporal punishment as cruel and damaging to children; others value physical discipline as an effective means of reinforcing the difference between "right" and "wrong." In the first example, any physical punishment might be perceived as abusive; in the second, failure to physically punish may be perceived as neglectful. It is critical for the observer to understand the meaning of the behavior within the cultural context. (CWLA, Child Protective Services: A Training Curriculum, 1989, Volume 1, pp.91-93).

A. Agency Assessment: The Cultural Competence Continuum

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or profession and enable effective work in cross-cultural situations. Cultural competence can be viewed as a goal toward which agencies can strive. Along the continuum there are many points of development. Six of these points are identified as follows:

1. **Cultural destructiveness.** Extreme examples would include cultural genocide; dehumanization or sub humanization of client groups; and/or bigotry, which allows the dominant group to disenfranchise, control, exploit, or systematically destroy the minority population. Cultural destructiveness can be subtle as well as overt.
2. **Cultural incapacity.** This system or agency lacks the capacity to help minority clients or communities; the system is biased, believes in the superiority of the dominant group, and is paternalistic toward the "lesser" races. Such agencies may act as agents of oppression by enforcing racist policies and maintaining stereotypes. Characteristics of these agencies include discriminatory hiring practices, subtle messages to people of color that they are not valued or welcomed, and generally lower expectations of minority clients.
3. **Cultural blindness.** The culturally blind agency provides services with the expressed philosophy of being "unbiased." These agencies typically act as if helping approaches used by the dominant society are universally applicable. Such services tend to be useless to all but the most assimilated people of color and ignore the richness of cultural diversity. Ethnocentrism is reflected in attitude, policy, and practice despite the agency's liberal self-assessment.
4. **Cultural pre-competence.** These agencies recognize their deficiencies and make genuine efforts toward cultural competency by hiring minority staff, by recruiting minority members for boards and advisory committees; by exploring how to reach minority populations in their service area, and by initiating training for their staff in cultural sensitivity. Agencies at this point are prone to premature senses of accomplishment or failure.

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5. **Basic cultural competence.** Culturally competent agencies are characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and the provision of a variety of service models in order to better meet the needs of minority populations. This agency works to hire unbiased employees, seeks advice and consultation from the minority community, and actively decides what it is and is not capable of providing to minority clients.

6. **Advanced cultural competence.** The most positive end of the scale is represented in the agency that holds culture in high esteem, that adds to the knowledge base of culturally competent practice through research and experimentation that seeks out staff who are specialists in culturally competent practice. (The preceding discussion was included in a pilot training program for cultural competence prepared for the People of Color Leadership Institute of the Northwest Indian Child Welfare Association, Inc. in Portland, Oregon in June, 1992.)

B. Achieving Cultural Competence

Five essential elements contribute to the process of a system, institution, or agency becoming more culturally competent. They are:

1. The agency learns to value and seek out diversity;
2. The agency conducts ongoing cultural self-assessments, recognizing the impact of culture on the system's philosophy and practice;
3. The agency understands the dynamics of cross-cultural difference, anticipating and planning for the misinterpretation and misjudgment which occurs normally in such interchanges;
4. The agency incorporates cultural knowledge into service delivery; and
5. The agency constantly adapts to diversity, helping to create a better "fit" between the needs of the community and the services available through the agency.

C. Agency Assessment of and Response to Cultural Diversity

In March of 1990, the Child Welfare League of America, through its Task Force on Cultural Competence, made recommendations identifying the best methods and practices for responding to cultural diversity. These recommendations, with some of the practical implications for social workers in child protective services, are:

1. Expanding the knowledge about the ethnic composition of the child welfare system.

Each county should take the initiative to determine the degree of ethnic diversity of the county population as well as the current caseload, in order to determine

what cultural knowledge and practice sensitivity should be developed within the agency.

2. Developing techniques for raising sensitivity to the issues of ethnicity and culture in child welfare policy and practice.

Some of the issues to be considered should include: the availability of trained interpreters for clients who are not fluent in the English language; differences in child-rearing practices which fall into the "gray area" of abuse/neglect laws; cultural practices which are not harmful to the child but which may be misinterpreted; identification of trusted leaders and culturally acceptable resources within the minority population; and the cultural acceptability of resources and assistance from the DSS. Cultural-specific knowledge should also include an understanding of community expectations of appropriate child-rearing practices, the community's view of child development and children's ability to handle responsibility, and the community's views of the roles of "family."

3. Designing mechanisms to encourage agency administrators and practitioners to improve their capacity to manage and serve culturally diverse clients.

Both staff and administrators need to attend workshops and training sessions designed to increase cultural competence, and to share the learning from such events with staff that are unable to participate.

4. Planning strategies for increasing the participation of minorities in the decision-making process within child welfare agencies.

In addition to striving for cultural diversity in hiring practices, agencies can also encourage the involvement of individuals from significantly represented populations on community child protection teams, boards of social services, the Guardian Ad Litem program, and advisory committees. The community can serve as a resource to financially strapped agencies by providing volunteer interpreters. Such interpreters require training regarding confidentiality.

D. Guidelines for Social Work Practice

If a person assumes that his or her world view is the best, right, or the "only" one, s/he is **ethnocentric**. **Ethnocentrism** prevents us from understanding others, can **cause us to** communicate disrespect, will interfere with our ability to communicate

effectively with those of differing values, and will prevent our learning from the experiences and successes of other cultures. At the other extreme, if we accept all behavior which is condoned within a culture or subculture, we may overlook maltreatment. We need to develop our abilities to assess cultural beliefs and practices based on the function of that belief or practice: cultural traits have validity if they serve a function of survival, enhance social integration and organization, and promote the individual and collective well-being of group members (CWLA, Child Protective Services: A Training Curriculum, Volume 1, p.99-109).

Abuse, neglect and dependency are still as they are legally defined but the response is one that is educational rather than accusatory. For example, though a family may feel a particular discipline is useful at home, educate the family that it is against the law and direct them to try something more appropriate.

Some of the areas of social work practice which are particularly vulnerable to cultural insensitivity are:

1. The Development of the Casework Relationship
 - a. Many minority cultural groups do not trust "white" institutions.
 - b. Miscommunication and misinterpretation of culturally defined behavior is likely. If the client and social worker are not fluent in the same language, trained interpreters will be needed to facilitate communication. Qualified interpreters who follow agency policy regarding confidentiality are critically important to the CPS process.
 - c. Unintentional disrespect may be shown by ignorance of "social rules", such as using direct eye contact or addressing the client by his or her first name.
 - d. Casework decisions may exclude persons in traditional positions of influence.
 - e. People typically do not trust someone who is different.
2. The Assessment of Abuse/Neglect/Dependency
 - a. The social worker may misjudge the presence or degree of maltreatment if client behavior is viewed outside the cultural norms of the majority.
 - b. Assessment of safety and of risk of harm to the child must occur within the context of culture if it is to have meaning.
 - c. In cases of extreme poverty, some behaviors may be unfortunate but necessary to the survival of the family; e.g., the handling of significant responsibility by young children.

3. The Assessment of Client Skills, Strengths, and Dysfunction

Traits should be measured by their usefulness in a specific cultural context. To determine skills, strengths, and dysfunction without such consideration is to invite inaccuracy.

- a. A trait that may not appear to be a strength to a social worker may represent significant adaptation on the part of the client.
- b. A client's behavior may reflect balancing of the expectations of two cultures.
- c. A behavior that is dysfunctional in one culture may be functional in another.
- d. A client's perception of the value of a trait is defined by his or her culture.
- e. A social worker may not recognize the value of a client's behavior if it is viewed out of context.

4. Special Considerations Regarding Sexual Orientation

Several studies have indicated that gay and lesbian teens are three times more likely than heterosexual teens to attempt suicide, due to conflicts about sexual orientation. Gay and lesbian youth often face ostracism and harassment from family, peers, and social institutions if they are open about their sexual orientation. Those who choose to deny or hide their sexual preferences may experience self-hatred. Families who learn that their children are homosexual react in numerous ways, from acceptance to abandonment or abuse. Many runaway children have left home because of their sexual orientation and have become easy targets for exploitation.

It is unlikely that social workers who investigate cases of abuse, neglect, or dependency would be initially informed that a family conflict involved a child's sexual orientation. Such disclosure will require a high degree of social worker sensitivity to the possibility of the issue.

5. The Provision of Services

- a. A social worker can anticipate problems when clients are provided services that are not compatible with their values or standards. Additionally, social workers may be dealing with conflicting values within the family unit.
- b. Intervention plans should reflect culturally appropriate means of handling problems by linking clients with resources in the cultural community.
- c. A social worker can ease the distrust of agencies by referring clients to helping persons within resource agencies, rather than to the agency itself.

E. Issues in Alternate Care

1. Foster and adoptive care placements will be more stressful if the placement resource does not have understanding of cultural differences. Social workers must be knowledgeable about such issues in order to make the best use of resources and to prepare caregivers for expected behaviors.
2. Awareness of cultural representation in the client population is critical to the recruitment of culturally diverse placement resources. States are required to recruit foster homes that reflect the characteristics of children needing placement. However placement cannot be denied nor delayed simply on the basis of race or culture, but must be based on the individual strengths and needs of the child and placement provider.²
3. Cultural sensitivity in foster and adoptive families helps to break down ethnocentrism in the community.

X. THE IMPACT OF HOMELESSNESS

When a child is a member of a homeless family, the social worker is sometimes confronted with the responsibility for determining whether or not a homeless child is being abused or neglected or is dependent. In this situation, it is critical to determine whether or not a child's basic needs are being met, whether or not the parent is able to reasonably protect the child from harm, and whether or not temporary care with relatives, kin or others might help the parent to locate employment and permanent housing.

Assessment of Abuse/Neglect of Homeless Families

- Does the child have living arrangements that are reasonably safe and sanitary, or is the environment clearly injurious due to illicit activities, physical endangerment, and/or unhealthful conditions?
- Does the child have reasonable outlets for appropriate socialization with peers?
- Does the child have untreated medical problems?
- Is the school-aged child enrolled in school?
- Does the family have access to minimal sanitary facilities, including working toilets, bathing facilities, and laundry facilities?
- Is the child under age twelve supervised by a responsible adult? Are responsible adults available in the event of an emergency?
- Does the child indicate emotional or physical damage resulting directly or indirectly from homelessness?
- Are alternate, stable living arrangements readily available to the child?

² 42 U.S.C. 551 etseq, "Multiethnic Placement Act" as modified by 42 U.S.C. 671 etseq, "Interethnic Adoption Provisions."

- Could this situation meet minimum standards of care with available community resources? If so, is the parent/caregiver willing to enroll the child in these resources?
- **Could the worker and family collaborate with Work First to address the family's issues?**

XI. THE IMPACT OF DRUG AND ALCOHOL ABUSE

Prenatal Exposure

North Carolina **child** protective services laws do not address abuse or neglect of the unborn child. The definition of a juvenile includes unemancipated children from birth to eighteen years. **However, federal law requires** reports of children born **with a positive toxicology for** illegal substances **must** be accepted for CPS assessment to **develop a protection plan**. While the prenatal drug exposure does not constitute neglect per se, the DSS has a responsibility to assure that the living environment will not be injurious to the newborn. Some of the issues to be considered during the assessment, as well as during the provision of **CPS In-Home Services**, are:

- Are other children living in the home? Are siblings well cared for? Are immunizations current? Do siblings attend school on a regular basis?
- What is the infant's medical condition? Are there special care needs? How medically fragile is the child? To what extent is the child irritable or lethargic? Is there special equipment or medication needs?
- What medical follow-up is needed for the child? Does the child need to be tested for HIV?
- What is the parent's pattern and history of drug use? What drug(s) were taken? How often? Is either parent using drugs now? What is the method of use? Are other household members suspected to be involved in drug activity? Is there a history of violence within the household?
- What is the parent's history of drug treatment? Is the mother in treatment now? Is she considered to be compliant with treatment?
- Does the parent have physical, intellectual, or emotional problems that would impact his or her ability to care for the child?
- Does the parent exhibit appropriate parenting skills and seem responsive to the infant's needs? Did the mother have prenatal care? Are her expectations and perceptions realistic?
- What is the parent's age and school/work history?
- Have there been previous allegations of abuse, neglect, or dependency?
- What supports are available? Are there responsible family members or friends who can assist the parent in caring for the child? Does the parent have established supports within the community; i.e., church or community group?

- What are the environmental conditions of the home? Is the home clean? Are utilities working? Are there safety hazards? Is there evidence of preparation for the infant's arrival?

Research suggests that at least eleven percent of babies born in this country have been prenatally exposed to illegal drugs. The overall rate of drug use by pregnant women does not seem to be significantly related to social class, income, or ethnicity.

Addictive Drugs and Alcohol and the Impact on Abusive and Neglectful Behavior

The continued use of addictive drugs and alcohol by the parent places the child at increased risk for neglect, abuse, and dependency. Users may display poor judgment due to their decreased ability to evaluate the reality of their situation. They may not be conscious that they are neglecting their children's needs. They may be focused on their own desire for more drugs or alcohol while placing the needs of the child at a lower priority. Alcohol and drug use decrease self-control and frequently lead to violence in the environment. If the use of these substances results in intoxication, the child may be left without effective supervision for extended periods of time.

CPS In-Home Services

Breaking a drug addiction is difficult. Denial and relapses are common. Structure and accountability are essential. Therefore, **use the Structured Decision Making tools and the Family Services Agreements throughout the life of the case.** Be sure to address the need for medical care appointments, access and cooperation with health care resources, participation in drug treatment, routine drug screens, and visitation planning if the child is placed out of the home. **Whenever working with a child and family, address the child wellbeing issues.**