

In a national study of the incidence and prevalence of child abuse and neglect, the U.S. Department of Health and Human Services reported that neglect cases outnumbered abuse cases by over two to one. In 2000, 59.8 percent of cases involved neglect, while 19.3 percent of cases involved physical abuse (U.S. Department of Health and Human Services, 2002).

Many cases of child neglect are caused by or related to parental substance abuse. Since the early 1990s, the most rapidly growing segment of children in foster care has been infants with prenatal exposure to street drugs and young children with parents who are addicted to drugs or alcohol (Feig, 1990, Weston, 1989, cited in Lewis, 1997). These children stay in care for long periods of time, or return to care after brief periods of reunification.

Studies of addicted mothers demonstrate that they are more likely to have feelings of inadequacy as parents and are more likely to use a threatening approach to discipline. Higher rates of abuse and neglect among the children of drug-using mothers also spring from the high rate of childhood trauma that these women have experienced themselves (Nair, 1997, citing Amaro et al., 1990; Chasnolt, 1988, Colten, 1980, Finnegan, 1982, Ladwig & Anderson, 1989; Regan, et al., 1987; Stein, et al., 1993, van Baar, 1990; and Davis, 1990).

Use of and abuse of alcohol and other drugs (AOD) clearly affects both parenting abilities for the substance abusing parent (see, e.g., Lewis, 1997, Nair, 1997, Young & Gardner, 1998) and the physical health and developmental progress of infants exposed to drugs or alcohol abuse prenatally (see, e.g., Phibbs, 1991, Mirmiran & DeBoer, 1988).

The response to child neglect caused by substance abuse often involves several different actions. The involvement of a professional with specialized substance abuse training is often necessary. This may include a professional from outside the public child protective services agency. Ideally, a specially trained substance abuse resource person may be available within the agency itself, or even the services of a specialized unit to address substance abuse and its effects on infants, children, youth, and caregivers, and to help link children and their families with treatment resources.

This guideline is intended to address both prenatal substance abuse issues, and neglect and abuse with minor injury of children due to parental substance abuse.

For the child protective service worker who has no specialized training in recognizing and responding to AOD clients, a very careful screening process should be followed if substance abuse may be an issue for a family. While we have included an internet reference for a simple substance abuse screening tool within this guideline, professional substance abuse screening is preferred if available. A basic child protective services response should include:

- Safety assessment - determining the degree of immediate danger of abuse or neglect of the child.
- Risk assessment - determining the likelihood of future abuse or neglect.
- Psychosocial & family assessment - evaluating the long-term risks to the child and supporting the development of a case plan for appropriate services and interventions with the child and family based on their strengths and needs.

(The checklist material above is adapted from Young, N. et al.)

This guideline is intended to guide an immediate case practice response by the child protection worker, as well as to help the worker determine what long-term interventions and aftercare with family members may be needed. Immediate needs in cases of neglect and physical abuse with minor injury involving substance abuse may include critical issues of safety and risk to all children in the family or in the care of the specific caregiver and these issues should be evaluated carefully by the worker. A plan to ensure child safety and to periodically reassess safety and future risk to the children should be in place in all cases where substance abuse by the children's caregiver may be an ongoing family issue.

Planning for substance abuse relapse and aftercare services is also a critical feature of any substance abuse treatment plan for caregivers. As an initial response, studies have shown that inpatient treatment is most effective in confronting addiction issues. However, in many areas, inpatient beds may be scarce or difficult to access. Hence outpatient treatment options must be used. Strategies for intervention should acknowledge three basic assumptions:

- A true chemical dependency becomes the central organizing force around which the life of the substance abuser revolves, and that dependency affects every significant aspect of that person's functioning.
- The abuse of alcohol or other drugs on the part of even one family member, particularly if that person happens to be a parent, has a profound impact on the lives of all members of that family.
- The chemically involved parent has a range of serious medical and/or psychiatric problems, some of which may predate his or her alcohol or drug use and some of which may be the

consequence of the dependency. All of these problems need to be addressed if intervention is to succeed. (Kropenske & Howard, 1994.)

Significant numbers of substance-abusing parents have histories of severe neglect, physical abuse, and/or sexual abuse during their childhood. As adults, they are more likely to become involved in unhealthy and abusive relationships, such as domestic violence. Because of the limitations of their own childhoods, these parents may be poorly equipped to provide effective parenting to their children.

Most clients, particularly those who are involuntary, will deny the extent of their substance abuse. Typically they minimize the problem, deny its impact on the family, and are resistant to treatment. Sometimes they will deny any drug or

alcohol use. This denial may be overwhelming in an adversarial setting, where fear of losing custody of their children is very real. It is important not to take this denial and resistance personally.

The important consideration in determining whether a substance abuse problem exists is the examination of adverse consequences. Adverse consequences can occur in numerous areas, including the physical, psychological, and social domains.

- Adverse physical consequences include: Blackouts, injury and trauma, or withdrawal symptoms.
- Adverse psychological consequences include: depression, anxiety, mood changes, delusions, paranoia, and psychosis.

- Adverse social consequences include: involvement in arguments and fights, loss of employment or intimate relationships or friends, and legal problems. (Winters and Zenilman, 1994.)

Parental history of deprivation, inconsistency in child rearing practices, and loss and abuse in their own childhood, makes them poorly prepared for parenthood, and predisposed to repeating similar patterns, unless interventions are provided.

Polysubstance abuse: Most substance abusers use multiple drugs or drugs, alcohol, and nicotine together. Even if they report using only one drug, their memories may have been impaired because of their drug use.

The Guidelines are a product of the Casey Outcomes and Decision Making Project. Project partners: The Annie E. Casey Foundation; Casey Family Programs; Casey Family Services; American Humane Association, Children's Services; American Bar Association, Center on Children and the Law; Institute for Human Services Management. Guidelines developed and written by Tracey Feild, M.A. and Amy Printz Winterfeld, J.D.

Step 1. Assessment: Review the Safety Factors

If any of the following conditions exist, and appear caused by or related to substance usage, caregiver's usage has interfered with parental functioning and the child is at risk. Caregiver should not be considered a "recreational" substance user. Undertake a substance abuse screen, or refer caregiver to an AOD specialist, if available, for assessment. If an AOD specialist is not available, simple screening tools, with complete instructions for use, can be obtained via the internet through

the National Clearinghouse for Alcohol and Drug Information, a service of the Substance Abuse and Mental Health Services Administration, Public Health Service, U.S. Department of Health and Human Services (www.hhs.gov).¹ *Focus on objective indicators of neglect or physical abuse with minor injury* related to substance abuse, rather than the substance abuse itself. The issue for child welfare is how the substance abuse results in problems in appropriately caring for the child.

Indicators of Caregiver Substance Abuse -

- **Was the child born positive tox?** (This indicates lack of control, concern, or judgment by caregiver, and may indicate chronic addiction.)
- **Was the child left without appropriate supervision?** (Caregiver may leave child alone in order to purchase or sell drugs or alcohol; may be prostituting or involved in other illegal activities to support habit; or may leave child without appropriate supervision in order to procure or use substances.)
- **Does the child arrive tardy or miss school frequently without apparent good reason?** (Caregiver may be unable to get children up and ready for school on time, or to school at all due to hangover, late partying, etc.)
- **Does the child miss well-child medical appointments frequently and appear unkempt when he or she shows up at appointments?** Does the child have medical conditions that are not adequately treated? (Caregiver may exhibit erratic ability to get child to appointments and care for child appropriately due to addiction.)

- **Are the child's basic needs for food, shelter, and hygiene not met?** (Caregiver may have used all of public assistance check or available monthly funds within first 7-10 days of month to buy drugs or alcohol. Utilities may be shut off. In substandard housing, caregiver may make little effort to control environment, such as protecting food from spoilage or infestation, etc.)
- **Is there a pattern of neglect where the child does not receive adequate food, medical care, or supervision?** (These three forms of neglect are most likely to result in serious injury.)
- **Was the child abused while an adult caregiver was under the influence of alcohol or drugs?** Is the child at imminent risk of harm due to substance abuse issues? (Each of the above factors may place the child at some level of risk. If substance abuse is the underlying factor causing this risk, use this guideline)

Refer also to the guidelines for Inadequate Supervision, Physical Neglect, and Medical Neglect, as applicable, for additional information.

¹Center for Substance Abuse Treatment, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse*

and Infectious Diseases, Treatment Improvement Protocol Series 11. Substance Abuse and Mental Health Services Administration, Public Health Service, USDHHS, 1994.

Step 1. Assessment: Review the Risk Factors

The presence of certain risk factors speaks to the prognosis for the family. Any of these risk factors may mean that the caregiver needs long term counseling in addition to substance abuse treatment, and the duration of agency interventions may be considerably longer than without these factors. Significant presence of these risk factors usually means removal of the child from the home, and may make Adoption and Safe Families Act (ASFA) reunification timelines difficult to achieve. The more these factors are present, the greater the emphasis should be on concurrent planning.

Substance abuse treatment typically requires 6-12 months, plus aftercare. If there is a waiting period to begin treatment, if the client is in denial about the need for treatment, or if the client is unwilling to enter treatment, the overall timeframe could be considerably longer. Given foster care timelines

imposed by the ASFA, requiring a permanency plan for the child within 12 months, a realistic examination of the likelihood for reunification should be undertaken.

Six sets of risk factors should be included in a thorough assessment for risk arising from substance abuse:

1. Caregiver History of Substance Abuse
2. Caregiver Characteristics
3. Environmental Pressures
4. Awareness of Impact of Substance Abuse on Child
5. Parenting Skills and Responsiveness to Child
6. Family Support Systems

1. Caregiver History of Substance Abuse and Treatment

- **Does the caregiver have a history of substance abuse, and prior episodes of treatment for substance abuse?** (While some relapse is expected, a long history of chronic substance abuse, treatment, and repeated relapse may mean that permanency with caregiver is not in child's best interests. Try to determine the caregiver's motivation for entering treatment; pursue that motivation as a possible strength. In evaluating compliance with the treatment program, remember that while lack of compliance can give a clue to the caregiver's level of commitment to treatment, it may also indicate the need for different or supplemental treatment approaches.)
- **Does the caregiver have prior reports of abuse or neglect for this child or other children related to substance abuse?** (Repeated reports of abuse or neglect may show lack of concern or ability to follow through on commit-

ment to treatment. Also, it is important to base decisions on long-term patterns, rather than a single incident, which may be ambiguous.)

- **Are other children in out-of-home care?** (What has been the caregiver's level of participation with those children? Does caregiver call and visit regularly? Respond appropriately? Has caregiver ever visited the children while under the influence of drugs or alcohol?)
- **Does the caregiver appear motivated to address substance abuse issue?** (If caregiver denies the problem, minimizes significantly the severity of the problem or its impact on the child, there is a greatly reduced likelihood of treatment success. You may have to require periodic toxicity screens to demonstrate the problem to the caregiver, especially to somewhat functional AOD users.) (Kropenske & Howard, 1994)



Step 1. Assessment: Review the Risk Factors

2. Caregiver Characteristics

- **Does the caregiver have mental health problems?** (Caregiver may be taking medication for mental illness, may be in counseling, may seem depressed, or may be functionally limited. All of these could affect caregiver's ability to follow through on substance abuse treatment and be an effective parent. Parents with serious mental health problems, particularly those minimally compliant with medications, pose greater risks to children. Assessment should include a history of mental health services and hospitalizations, history of medications, and may need to include a mental health evaluation.)
- **Is the caregiver functionally limited?** (This could limit caregiver's ability to deal with substance abuse and be an effective parent.)
- **Does the caregiver have a childhood history of abuse or neglect, or parental substance abuse?** (If the caregiver was abused or neglected as a child, or if the caregiver's parents were substance abusers, caregiver is more likely to exhibit these behavior patterns as a parent, resulting in greater risk to the child.)
- **Does the caregiver have health problems related to substance abuse?** (Health problems related to substance abuse can affect the caregiver's ability for self-care and care of children. The assessment process should examine the possibility of untreated medical problems or chronic illnesses. Assessment should also look for communicable diseases, such as tuberculosis and sexually transmitted diseases, including AIDS. Caregiver may need to be referred for a medical evaluation.)
- **Does the caregiver or spouse have a history of violence toward others?** (Substance abuse, psychiatric problems, and poor impulse control can be closely linked.)
- **Does the caregiver have a criminal record?** (An examination of the caregiver's criminal history can provide information on the caregiver's lifestyle and illegal activities to which the child may be exposed.) (Kropenske & Howard, 1994)



Step 1. Assessment: Review the Risk Factors

3. Environmental Pressures and Issues

- **Do others in the household have substance abuse problems?** (Accessibility of substances and pressure from others in the household will reduce the caregiver's ability to stay sober and drug-free, or to supervise the safety of children. Remember that almost one-fourth of physical abuse and more than one half of sexual abuse occurs at the hands of adults who are not the victim's parents.) (Howard, J., 2000)
- **Does the household experience regular or periodic domestic violence?** (Domestic violence often occurs as a result of substance abuse, and substance abuse can be used to escape from fear of domestic violence or low self-esteem that led to victimization. Presence of domestic violence reduces the likelihood that substance abuse treatment alone will eliminate the problem. If domestic violence is present, use this guideline in conjunction with guideline on "Domestic Violence and Abuse/Neglect").
- **Is the household involved in a "culture of drugs," where the focus of day-to-day living is on obtaining and/or selling, and using addictive or illegal substances?** (This lifestyle will greatly reduce the likelihood of successful treatment. Until lifestyle is changed, or until caregiver removes self from household and its destructive pattern, treatment may be wasted.)
- **Does extreme poverty make the culture of drugs difficult to avoid?** (If, because of extreme poverty, caregiver is unable to leave environment where drugs are readily available, relapse will be more likely. Long-term follow-up and support will be necessary.)
- **Has there been a recent family or caregiver trauma?** (Trauma, such as death, separation, divorce, arrests, illness, accidents, etc., can lead to substance misuse to address depression caused by trauma.)
- **How long has the family lived at the current address?** (Instability of residence or a history of moves may indicate greater risk to the child.)
- **Are there physical health or safety hazards in the home?** (Has the caregiver attempted to remedy these situations, or have housekeeping habits contributed to the problem?)
- **Is there food in the home? Are children appropriately clothed?** Are there supplies and equipment for newborns? (Can the caregiver adequately care for children and plan ahead, or is the focus of activity on the acquisition and abuse of substances?) (Kropenske & Howard, 1994)

4. Awareness of the Impact of Substance Abuse on the Child

Willingness to accept and acknowledge the impact of substance abuse on the safety and care of the children may indicate receptivity to needed services and interventions.

- Does the caregiver acknowledge the relationship between being under the influence and child abuse or neglect? And is the caregiver willing to make changes to avoid repeating the abuse or neglect?
- Has the caregiver provided for the children's needs during relapse periods, by leaving them with responsible, sober, drug-free adults? Or have children been put at risk?
- In cases of prenatal substance abuse, does the parent accept that any symptoms or developmental problems exist? (If denial is strong, caregiver may not seek needed services for child.) (Kropenske & Howard, 1994)

Step 1. Assessment: Review the Risk Factors

5. Parenting Skills and Responsiveness to Child

Many substance-abusing caregivers were poorly parented, and therefore, may lack healthy role models for parenting their own children. Interactions between the caregiver and child should be observed to assess the following:

- Are the caregiver's expectations for the child's behaviors higher than the child's developmental capacities?
- Are the caregivers prone to extremes in physical discipline?

- How do caregivers respond to the child's crying?
- Do caregivers and children make eye contact?
- For a hospitalized child, how frequent are parental visits?
- Is there bonding and emotional contact between the caregiver and the child?
(Kropenske & Howard, 1994)



6. Family Support Systems

- Do caregivers have extended family, friends, or neighbors who are sober and able to provide some level of support to the family?

- Are caregivers involved with a community of faith or social or neighborhood group?
- Do relatives support lifestyle changes or do they enable the caregiver's substance use or denial of substance abuse?
(Kropenske & Howard, 1994)



Step 2. Family/Cultural Issues: Special Considerations for Native American Families

Is the child from a Native American or Alaska Native family?

No →

Go to **Page 10**

Yes ↓

When dealing with substance abuse in a Native American or Alaska Native family, you should be aware of the following issues:

- Among Native Americans, more than one-third of all deaths are to persons under age 45. This is three times the rate of the general population. This is experienced as an unending sense of loss and grief for Native Americans. Within tribes, the emotional impact of this loss and grief is increased by their blood relationships and long-term ties to members of the tribe. A family member's substance abuse or the removal of a child from the family will be experienced as loss and grief as well. Frequent loss can dull one's coping resources, resulting in irrational actions, such as physical aggressiveness, flight, or the appearance of indifference or passivity, when the real emotion may be one of hopelessness and despair toward another loss.
- Most Native Americans experience racism and discrimination on a daily basis, reinforcing the message that Indian culture, traditions, and the people themselves are not valued, and are inferior. The manifestations of this attitude can be seen in negative reactions to authority figures, such as child protective services workers.
- Past experiences with the Bureau of Indian Affairs and Indian boarding schools make Indian parents extremely wary and fearful of government agencies that have the power to take their children away. Furthermore, there is the belief that once children are removed, they will never return home. Parents typically view child protective services agencies as "...powerful, arbitrary, and beyond their

influence. To cope, the parent reacts by trying to escape or with simple submission." (Horejsi, et.al., p. 8)

- Alcohol has had a devastating effect on Indian families. Many alcoholics are the children of one or more generations of alcoholics. Indian caregivers may be active drinkers themselves or be involved in co-dependent relationships. "...Most [families coming to attention of child protective services agency] grew up in dysfunctional homes where they learned to make heavy use of denial, avoidance, and blaming others as primary methods of coping." (Horejsi, et.al., p. 9.)
- "The extended family structure and its many members can be a tremendous source of support and it can compensate for inadequacies in a bio-parent's ability as a parent. It is one of the greatest strengths and assets of Indian people. However, it is possible for an entire extended family to be dysfunctional, especially if many of its members are alcoholic. In such cases, the power and solidarity of the extended family then becomes a barrier..." (Horejsi, et.al., 1991, p. 9)
- All of the above facts help explain "...why some Native American parents involved with a child protective services agency react and behave in ways that get them labeled as 'uncooperative' and 'resistant'. These descriptions also help to explain why some parents become so frightened and intimidated that they 'give up' and seemingly abandon their children." (Horejsi, et.al., 1991, p. 12) (Horejsi, et.al., 1991)

Step 2. Family/Cultural Issues: Special Considerations for Native American Families

You should be aware that Fetal Alcohol Syndrome (FAS) is 33 times more prevalent among Native Americans than in Caucasians. FAS, and the less serious Fetal Alcohol Effect (FAE), have been estimated to affect one in four Native Americans. The following are characteristics of FAS:

- Difficulty structuring work time.
- Impaired rates of learning.
- Poor memory.
- Trouble generalizing behaviors and information.
- Impulsiveness.
- Reduced attention span or easily distractible.
- Fearlessness and unresponsiveness to verbal cautions.
- Poor social judgment.
- Inability to handle money as appropriate for age.
- Trouble internalizing modeled behaviors.
- Differences in sensory awareness.
- Language production higher than comprehension.
- Poor problem solving strategies.

(American Eagle Indian Lodge, 1998)

If you suspect that FAS or FAE may be affecting the child, consider a developmental evaluation.

Also try to remember when interviewing Native American families:

- Expect the client may not make eye contact. Directness and assertiveness may be offensive to Native Americans.
- Expect several family members may attend, with communication through a single spokesperson only.
- Expect that punctuality and time may be important only to you. Don't rush the interview process. Pauses and silences can be important.
- Expect that family members may deny that alcohol is a problem, yet feel a sense of shame about it.

(National Indian Child Welfare Association, 1996)

All of the factors noted above should influence how you work with Native American families. You should look for every possible family alternative before placing a child in foster care, and, if foster care is necessary, make active efforts to place the child with Native American foster parents, preferably within the same tribe.

Consider the effects of loss and grief, racism and discrimination, and the history of the Native American population with government agencies when working with Native American families. Do not expect the caregiver's response to your intervention to mirror the response of other populations. Take special care to take into account the above factors as you plan your actions, and as you assess the family's response to your actions.

Step 2. Family/Cultural Issues: Assess Community, Family, and Cultural Issues

Assess community and cultural factors and your familiarity with them.

- Is it possible that community, cultural, or ethnic beliefs or practices that you are not familiar with are a factor in the caregiver's behavior? *Even if they are, remember that child safety is your first concern.*
- Issues around immigration and assimilation, racism, loneliness, culture shock, and language problems may have led to the substance abuse.

No →

Go to **Next Page**

Yes ↓

- Find someone in your agency knowledgeable about the family's culture before proceeding. Develop your understanding of how the family's beliefs, values, interests, and concerns may differ from your own and affect their behavior before you assess needs or begin planning services. When you understand how your cultural views and the family's culture and beliefs affect your assessment of the family's issues and needs, it may also affect how you plan to remediate them.
- If no one is available within your agency to help you understand the family's culture and belief system, identify community or neighborhood representatives (e.g., community leaders, community-based organizations, religious leaders, etc.) who could assist you in assessing needs and planning for families within this culture and in understanding the values and beliefs of this cultural group.

- Are there community and cultural beliefs that can be reinforced to encourage positive parenting practices?
- Are there specific formal community or cultural programs, supports, or services that can be accessed to address the issues in this case?
- Does the family have informal community or cultural ties or resources, such as an extended kinship network or membership in a community of faith, which can be accessed to support positive family functioning?

Step 2. Family/Cultural Issues: Assess Community, Family, and Cultural Issues

Review family's assessment of reasons behind the substance abuse and neglect or minor physical abuse.

- Are there factors or issues identified by the family that were not identified by you?
- Is it possible that issues raised in the family's assessment of the situation could be partially responsible for the neglect or physical abuse?
- Do they have any specific ideas about how to resolve the issues?
- Do any of their ideas seem reasonable?

- Can family members (including extended family) help implement any of the ideas?
- Can you help implement any of their ideas, either through development of the case plan goals, provision of services, or flexible funding?
- To the extent that you can reasonably include any of the family's (including extended family) ideas in developing the case plan goals, services, and interventions, you should do so as a high priority. **Remember family members know each other better than you do.**

Identify and review family (including extended family) strengths:

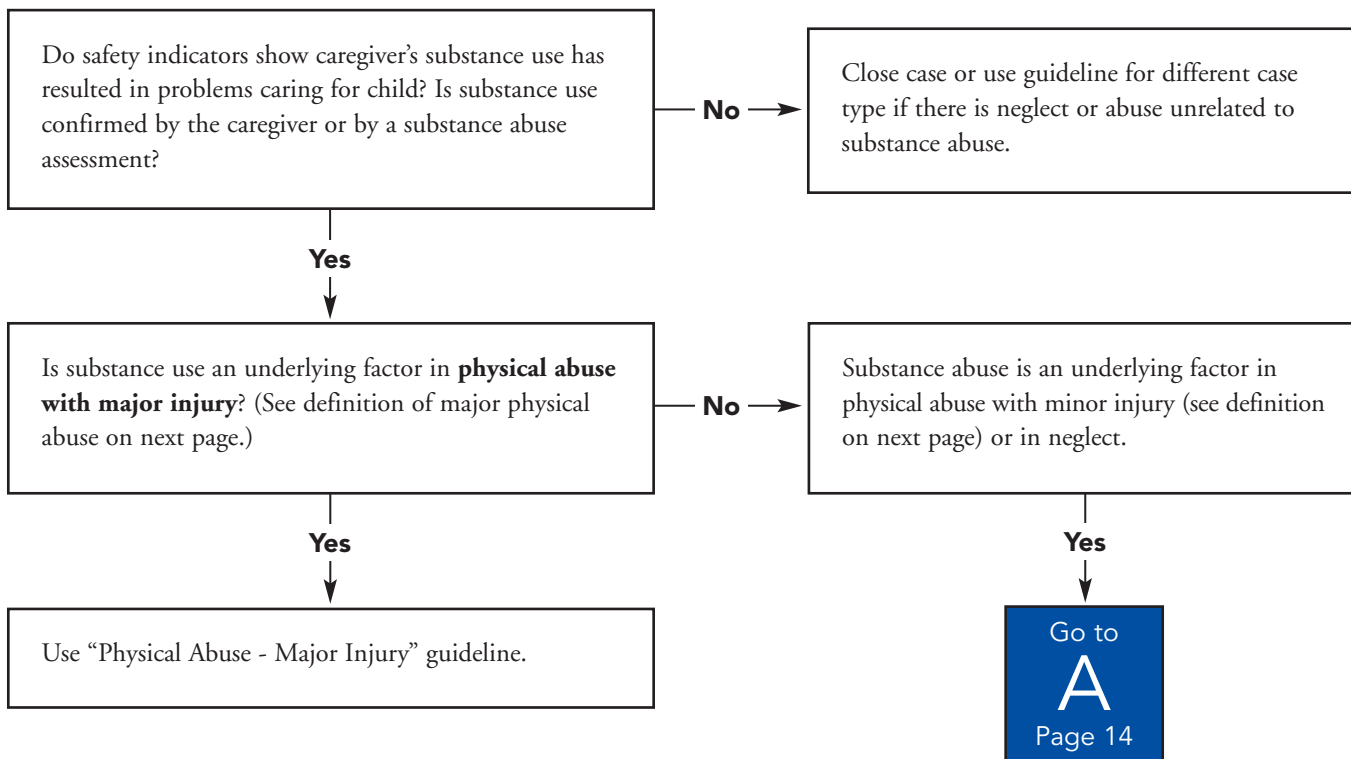
- Identify the strengths that will help this family become independent from the child welfare system. (Include relationships, employment, education, personalities, skills, support systems, etc.)
- If the family's issues and needs overwhelm their strengths, identify extended family members who could help support this family emotionally or with other resources.

- Identify extended family strengths that could help this family become independent from the child welfare system.
- Consider **all** of the strengths identified, both of the family involved in the substance abuse and of the extended family, in developing the case plan goals, services, and interventions. Plan specific steps to bolster family strengths. **Rely on family strengths whenever possible to address issues. Remember the strengths that you successfully reinforce will remain with this family after the case is closed.**

Step 3. Case Direction: Determine Case Direction

In substance abuse cases, severity of safety and risk factors will shape the permanency plan, especially the potential for reunification where children have been removed. Substance abuse treatment for the caregiver is essential to planning for child

safety and permanency. Children should not remain in the home with current adult household members if safety and risk factors suggest that the child will be at moderate or high risk.



Step 3. Case Direction: Determine Case Direction

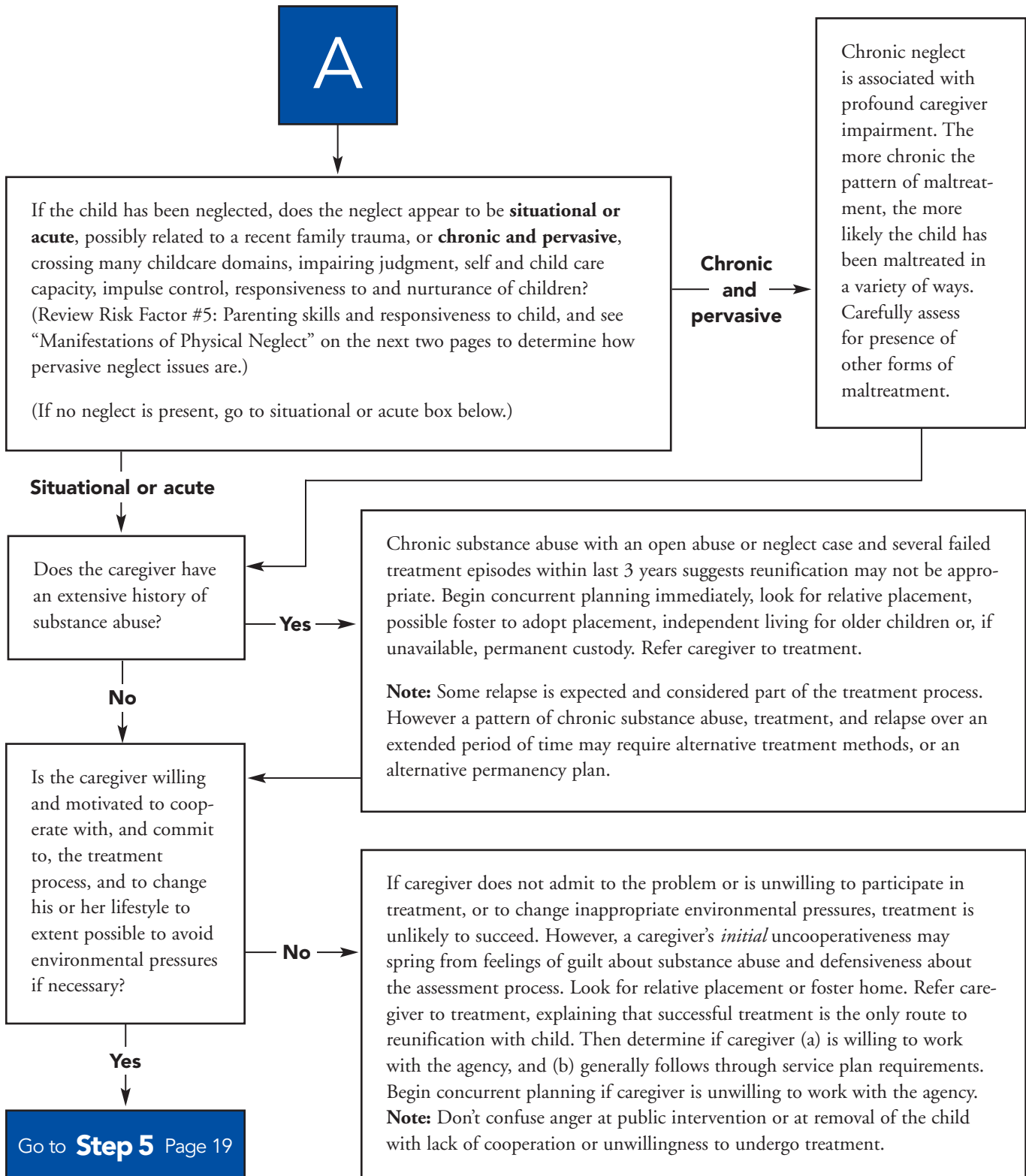
Examples of Physical Abuse with Major Injury:

- An escalating cycle of injuries beginning with minor injuries to relatively invulnerable areas of the body, and proceeding to injuries to the head, neck, stomach, genitals, and/or other soft tissue injuries.
- Life threatening injury.
- Permanent injury or risk of permanent injury.
- Dangerous acts that could have resulted in serious injury (e.g., deliberate electrical shocks, holding child's head underwater).
- Cruel and inhumane treatment (e.g., submerging toddler's head in toilet filled with feces).
- Loss of use of body parts.
- Disfigurement.
- Injury to the head.
- Injury requiring hospital care.
- Failure to provide treatment for injuries needing treatment.
- A sustained physical injury (e.g., a lost tooth, a broken bone, etc.).
- Multiple bruises or marks.
- Large burns, deep or serious burns, or multiple small burns.
- Minor injury, but child seems overly upset about or obsessed with the injury.
- Any suspicious injury with an inadequate explanation.

Examples of Physical Abuse with Minor Injury:

- No medical treatment needed.
- May need medical treatment, but immediate release afterwards.
- Injuries to areas not considered sensitive:
 - head, torso, except buttocks=sensitive;
 - limbs, buttocks=less sensitive.
- Minor injuries to children old enough to protect themselves.
- A single bruise or mark to a limb, or single small, superficial burn.

Step 3. Case Direction: Determine Case Direction



Step 3. Case Direction: Determine Case Direction

Manifestations of Physical Neglect: 1. Inadequate Child Care:

Is the caregiver unable or unwilling to provide adequate child care?

- Did the caregiver leave a young child alone in the home unsupervised?
- Does the caregiver fail to provide children with clean, adequate, seasonally-appropriate clothing that fits reasonably well?
- Did the caregiver inappropriately leave a young child in the care of another child too young for that level of responsibility?
- Did the caregiver leave the child with someone who was an inappropriate caregiver?
- Do children younger than 10 have to get meals for themselves, or are meals regularly skipped or usually nutritionally unbalanced?
- Are meals irregular or not prepared at all, with often just one meal per day?
- Is only nutritionally poor food available, or do children have to find meals themselves?
- Is there almost no food in the house, or are children too young to feed themselves?
- Are children so hungry they eat spoiled or rotten food that may make them sick with food poisoning?
- Are children malnourished or dehydrated?
- Has caregiver failed to address child's preventive health needs, immunizations, dental care, or failed to adequately address the child's medical conditions?

Manifestations of Physical Neglect: 2. Poor Household Sanitation:

Is the caregiver unable or unwilling to provide an adequate level of sanitation in the home?

- Are floors or carpet layered with dirt, food, or animal waste?
- Do dust or grease coat everything?
- Does the home smell of urine, feces, or spoiled food?
- Are there overflowing trash bins, rotting food, or dirty diapers laying around, or lots of flies?
- Is it difficult finding a place you would be willing to sit?
- Are there intolerable odors in the home?
- Are dishes left unwashed or do they have spoiled food left on them? Or does the family eat off dirty dishes?
- Do children sleep on dirty mattresses without linens, or on badly soiled linens?
- Is the home infested with rodents, roaches, or other vermin?

Step 3. Case Direction: Determine Case Direction

Manifestations of Physical Neglect: 3. Physical Hazards in the Home:

Is the caregiver unable or unwilling to provide an adequate level of physical safety in the home?

- Are utilities off or frequently off, or inadequate (e.g., heating insufficient, only on for part of the day, burst pipes, no running water)?
- Are kitchen or bathroom facilities inoperable or frequently inoperable?
- Is there peeling lead paint, exposed wiring, leaking gas, hot water or steam coming from radiators, or a lack of heat?
- Are there other serious repair or maintenance problems that appear dangerous to children, such as rotting floors

and walls, missing steps, broken glass in play areas, or broken or missing windows within children's reach?

- Is there dangerous junk, dangerous substances, or rusting metal within children's reach?
- Are there sharp tools, knives, weapons, or matches within children's reach?
- Is there no furniture or broken furniture in the home?
- Are there grossly insufficient linens, towels, blankets, dishes, utensils, pots, and pans?
- Are children of the opposite sex over age 9 sharing the same bed?
- Are dangerous pets kept within the children's reach?
- Is security so poor that others can easily enter the home at night?

Manifestations of Physical Neglect: 4. Inadequate Children's Hygiene:

Is the caregiver unable or unwilling to provide an adequate level of hygiene for the children?

- Do children appear not to bathe regularly or wash even when dirty?

- Is children's hair visibly dirty?
- Do children have mouth or body odors?
- Are clothes noticeably soiled or stained beyond cleaning?
- Do others complain about the children's hygiene?
- Are children's teeth encrusted with food particles and plaque?

Manifestations of Physical Neglect: 5. Housing Instability:

Is the caregiver unable to provide stable housing for the children?

- Is the family homeless?
- Does the family move frequently (more than once every 6 months)?

- Do the children change schools frequently, or miss school frequently because they haven't enrolled in a new school?
- Do children miss medical check-ups frequently due to changes in housing?

Step 4. Permanency Planning: For Native American Children, Keep ICWA Requirements in Mind as You Begin Planning

Determine the child's Native American heritage — Is this child a member of a federally recognized Indian tribe, a child of a tribe member, or eligible for tribal membership?

No →

Go to **Next Page**

Yes ↓

Notify the tribal court that the child is the subject of an open child welfare case. Keep in mind that the Adoption and Safe Families Act (ASFA) requirements for timely

permanency do not supersede the requirements of the Indian Child Welfare Act (ICWA).

Regarding reasonable efforts:

ICWA requires that active efforts must be made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family. Such efforts should “involve and use the available resources of the extended family, the tribe, Indian social services agencies, and individual Indian caregivers.” This requirement is for

Native Americans living both on and off of reservations. ASFA provides for efforts to prevent family breakup on a case-by-case basis. Your agency should consider ICWA legal standards for placement with extended family, other members of the child's tribe, and other Indian families, before suspending active efforts to aid the family and before considering termination of parental rights (TPR).

Regarding termination of parental rights for American Indian children:

Parental rights may be terminated only where there is evidence beyond a reasonable doubt, including testimony of expert witnesses, that the continued custody of the child by the parent (or Indian custodian) is likely to result in serious emotional or physical damage to the child. Active

efforts to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family must have been made before a termination of parental rights may be sought. Remember that failure to adequately utilize appropriate tribal, extended family, and community resources could trigger the “failure to provide services” exception in the TPR filing requirement.

Make sure your agency attorney reviews ICWA before filing any actions with the court regarding permanency for this child. Remember that any permanency plan developed for a Native American child which provides for an out-of-home

placement, including an adoptive placement, would be subject to the placement preferences in ICWA (which include placement with extended family, other members of the child's tribe, and other Indian families).

Step 4. Permanency Planning: Keep in Mind ASFA Safety and Permanency Goals and Required Timelines as You Begin Planning

For healthy development, children need consistent care and a feeling of belonging in a safe, permanent home. To help ensure permanency for children, the federal Adoption and Safe Families Act (ASFA), requires an initial focus on child safety, then development of a permanency plan for each child within 12 months.

- Can immediate child safety be assured only by placing the child outside the home?

No →

Go to next step for identifying case goals and services. Ensure that the plan includes supports for child safety at home. Include monitoring for child safety in plan.

Yes ↓

Begin permanency planning efforts immediately.

Develop a permanency goal and permanency plan for the child, in collaboration with the child's parent(s).

- Involve the child's parents, the child (generally if the child is 14 or older, and/or able to understand the situation), other relatives, or persons important to the child in the planning process.
- Do "concurrent" planning, that is, plan at the same time for the possibility of reunification of child and parent or finding an alternate permanent home for the child with relatives, through guardianship, or by adoption.
- Focus on child safety as the paramount goal, but make reasonable efforts to return the child home, unless the

parent has assaulted, seriously injured, or killed a child or another child of the parent or there are "aggravated circumstances" such that the child's safety would be endangered by reunification. "Aggravated circumstances" not requiring reunification efforts include any listed in your state's law and the following as defined by federal ASFA law: abandonment, torture, chronic abuse, or sexual abuse.

- Ensure that the child's permanency plan includes: protection of the child's health and safety, type and appropriateness of the child's placement (see the Placement Level of Care guideline), any services to be provided to the child and the reason, services to be provided to the child's biological parents, foster parents, or identified permanency family.

Under the ASFA, federal law requires compliance with the following timelines to ensure permanency for children in the custody of state child welfare agencies. State law timelines may be more restrictive.

- If reasonable efforts to return a child home are not being made due to aggravated circumstances, a court permanency hearing must be held within 30 days of placement.
- For every child in an out-of-home placement (including placement with relatives), a court permanency hearing must be held within 12 months of the date of the child's first placement out of the home to determine the child's permanency plan.

- If a child has been in placement for 15 out of the last 22 months, a court petition to terminate parental rights must be filed, unless:
 1. A relative is caring for the child.
 2. There is a documented compelling reason that termination of parental rights is not in the child's best interests.
 3. The state failed to provide the family with services, unless reasonable efforts to reunify the family were not required for the reasons listed above.

Step 5. Goals and Services: Identify Goals and Services

Service interventions should address the following issues:

1. Protect the child.
2. Treat addiction and underlying causes of addiction.
3. Treat child care and functioning issues resulting from neglect (if needed).
4. Improve parenting (if needed).
5. Address basic needs (if needed).
6. Achieve permanency and family stability.

Goal 1 Protect the child.

- Is there a sober, drug-free adult relative, who does not currently live in the household, willing to care for the child 24 hours a day, 7 days a week in the caregiver's or own home while caregiver undergoes treatment? Or
- Is there a treatment program available that will accept both caregiver and child? Or
- If treatment is not immediately available, and risk factors seem relatively low, and caregiver is relatively functional, can you develop a safety plan with the caregiver that addresses how children will be cared for and by whom during relapse, and how and when caregiver will implement the plan?

No →

Refer child to relative placement or foster care.

Yes ↓

Place children in care of relative, in foster care, or develop safety plan with caregiver. (Although many professionals believe that children shouldn't remain with substance abusing caregivers, substance abusing caregivers often far outnumber available treatment slots. A shortage of treatment slots means that removal of all children of substance abusers may not be feasible. The alternative is to develop safety plans with cooperative, relatively functional, substance abusing caregivers whose children are at lower risk.

See box at right.

Developing a Child Safety Plan for Children Remaining in Their Own Homes with Substance Abusing Caregivers

- Find out children's daily schedule, health status.
- Find out caregiver's daily and weekly activities, involvement with other agencies.
- Find out role of other adult household members in child care, attitudes toward children, history of problematic behaviors toward children.
- Help caregiver to develop a schedule, prioritize responsibilities and tasks, and identify supportive help. (Relapse or escalation of drug use is likely if caregiver senses failure or experiences frustration.)
- Work with caregiver to identify triggers or signs of relapse in her- or himself.

Develop a step-by-step plan for how to protect the children before relapse occurs. This would include who the caregiver will call, how the children will be cared for, and by whom, when relapse occurs.

Step 5. Goals and Services: Identify Goals and Services

Goal 2

Treat addiction and underlying causes of addiction.

Caregiver should be referred to appropriate treatment program with aftercare components. Intensity and duration of active aftercare, including counseling, and regular drug testing, should mirror intensity and duration of addiction. Intensity of risk factors should be considered in addressing

intensity and duration of services. Minimum period for recovery is 6 months, more common is 9-12 months. All addicts will require long-term aftercare. (West, 2000)

The key to successful recovery is to make sure the caregiver is not overwhelmed with too many tasks and responsibilities at one time. Steps toward achievement of case plan

goals may have to occur sequentially, rather than simultaneously. Of course, in reunification cases, court timelines must also be considered.

Remember:

- Substance abusers who abuse or neglect their children have a chronic and often progressive disease that cannot be cured, but can be treated.
- Addiction is not the result of irresponsible choices.
- Treatment is a process; that process includes relapse.
- Relapse is most likely to occur within the first 3 months after treatment.

- Relapse, when recognized and addressed, can be a phase in the recovery process.
- Preventing relapse involves creating and strengthening skills to cope with the anxiety that is often linked to relapse, and developing safety plans for children.
- Aftercare should address the stresses of parenting, and should include support groups where possible. (NCASA, Columbia University, 1999)

Step 5. Goals and Services: Identify Goals and Services

Behavioral Signals of Imminent Risk of Relapse

- Increasing self pity,
- Increasing depression,
- Setting expectations that are too numerous or unrealistic,
- Feelings of being “all-powerful” or not needing support, and
- Distancing from friends who are clean and sober. (Kropenske & Howard, 1994)



Effect of Substance Abuse on the User’s Affect:

Substance use produces dopamines in the brain, which provide for and allow the brain to experience happiness or euphoria. Addiction causes the body to reduce its natural production of dopamines, thus creating the need for alternative ways to provide those dopamines (through substance abuse). The process of addiction leads to the body requiring increasing levels of dopamines, which the body no longer produces naturally, to achieve the same level of happiness. Early recovery is characterized by a lack of affect, caused by the loss of dopamines produced naturally by the body or through those produced by substance use. It takes the body 6-9 months to begin producing dopamines once recovery has begun.

- Don’t be surprised, during your visits with the caregiver, or at caregiver visits with children, if the caregiver seems lacking in affect. This is not reflective of feelings toward the child, but of the body’s failure to produce dopamines, and the lack of dopamines produced through the use of addictive substances.
- With medical authorization, encourage the caregiver to undertake physical exercise, which speeds up the body’s natural production of dopamines.
- Substance abuse treatment should be combined with counseling to address depression and self-image. (West, 2000)

Step 5. Goals and Services: Identify Goals and Services

Goal 3

Treat child care and functioning issues resulting from abuse/neglect (if needed).

- All children under age 6 should receive a full developmental screen. Assure that well-child check-ups, immunizations, and other health care needs are current.
- Assure enrollment of children in an appropriate educational setting, if school age. Depending on the duration of the substance abuse, special educational testing or early intervention services may be warranted. Refer young children to Head Start or community child care if appropriate.
- Assure that children's basic needs for food, clothing, and shelter are met.
- Assess mental health needs. If neglect has occurred over a substantial portion of the child's life, particularly look for bonding and attachment issues. If physical abuse with minor injury has been an issue, an evaluation should be undertaken and therapeutic services should be provided. If other specific needs are identified or suspected, refer to appropriate services or specialized assessment.

Goal 4

Treat abusive parenting behaviors (if needed).

- In cases of substance abuse resulting in physical abuse with minor injury of the child, address substance abuse issues first, while assuring that the child is adequately protected. Once substance abuse issues are under control, begin to address abusive behaviors through therapy. You should not address both simultaneously so as not to overwhelm the caregiver.
- The motivation of the abuser should be carefully assessed in determining the therapeutic interventions that should be provided, and the long-term risk to the child. The four abuser types below are typical motivations of child abusers, with types 2 and 3 being most prevalent. In cases of physical abuse with minor injury, these motivations may not be as clear, but review each of the case types to look for signals as to what is motivating the abuse. This will help you determine how much intervention is needed and the long-term risk to the child in this household.

1. Negative Affect Toward the Child:

- Has strong negative feelings about the child, child may be scapegoated.
 - Negative feelings toward a spouse, partner, self, or other may be displaced onto the child.
 - The child may be blamed for being dependent and immature and not nurturing the parent.
 - If the parent is incapable of ambivalent feelings, he or she may exaggerate the negative feelings toward the child.
- Treatment success is possible if the abuser can be made to see who he or she is really angry at, or if abuser can become more confident in managing the child. Parenting classes may help only if abuser has a real problem managing the child. Therapy for the parent is recommended. (Salter, Richardson & Martin, 1985)

Step 5. Goals and Services: Identify Goals and Services

2. World View that Rationalized the Abuse:

- The caregiver feels that the child deserves to be abused because of his or her behavior.
- Minor infractions may be blown out of proportion and described as personal affronts toward the caregiver.
- The abuse is seen as the only way to control the child for as long as possible, because once the child has grown, the child may try to control the caregiver.
- The caregiver may not see any reason to control his or her impulses when provoked by a child who cannot fight back.

- The caregiver sees the world as a tough place to live, with others out to do him or her in, so he or she has the right to abuse this child.
- The caregiver makes no attempt to control his or her impulses because he or she perceives the actions to be reasonable.

These caregivers are resistant to change, and manipulative. Treatment success is possible *only* if abuser can begin to understand and face the fact that he or she really thinks that hurting a child is justifiable. Parenting classes or anger management classes *will have little impact* on changing this behavior. Abuser needs therapy. (Salter, Richardson & Martin, 1985)

3. Inability to Control Impulses:

- The caregiver becomes overwhelmed by his or her impulses and cannot weigh pros and cons accurately.
- The caregiver may express guilt or confusion about impulsive behavior and promise to “do better.”

Treatment success is linked to the abuser’s belief in external controls, since the abuser cannot rely on internal controls

to control his or her impulses. External controls may not always work, if the abuser sees only minor consequences to his or her impulsive behaviors. Abusers who are highly motivated to eliminate abusive behaviors may be able to develop and rely on internal controls to abusive behaviors. Anger management classes may help, but *therapy should be provided as well*. (Salter, Richardson & Martin, 1985)

4. Payoff:

- The abusive act may relieve the caregiver of emotions that are unpleasant (e.g., warding off depression through anger, discharging impulses rather than tolerating them).
- The abusive act may distract a caregiver from interpersonal or other problems.
- The abusive act actually may make the caregiver feel better, by relieving stress or tension.

Treatment success is linked to the abuser finding alternative ways to achieve the same payoff, or to interfere with the ability of the abuse to generate a payoff. Anger management and therapy are recommended. Parenting classes are not likely to help. (Salter, Richardson & Martin, 1985)

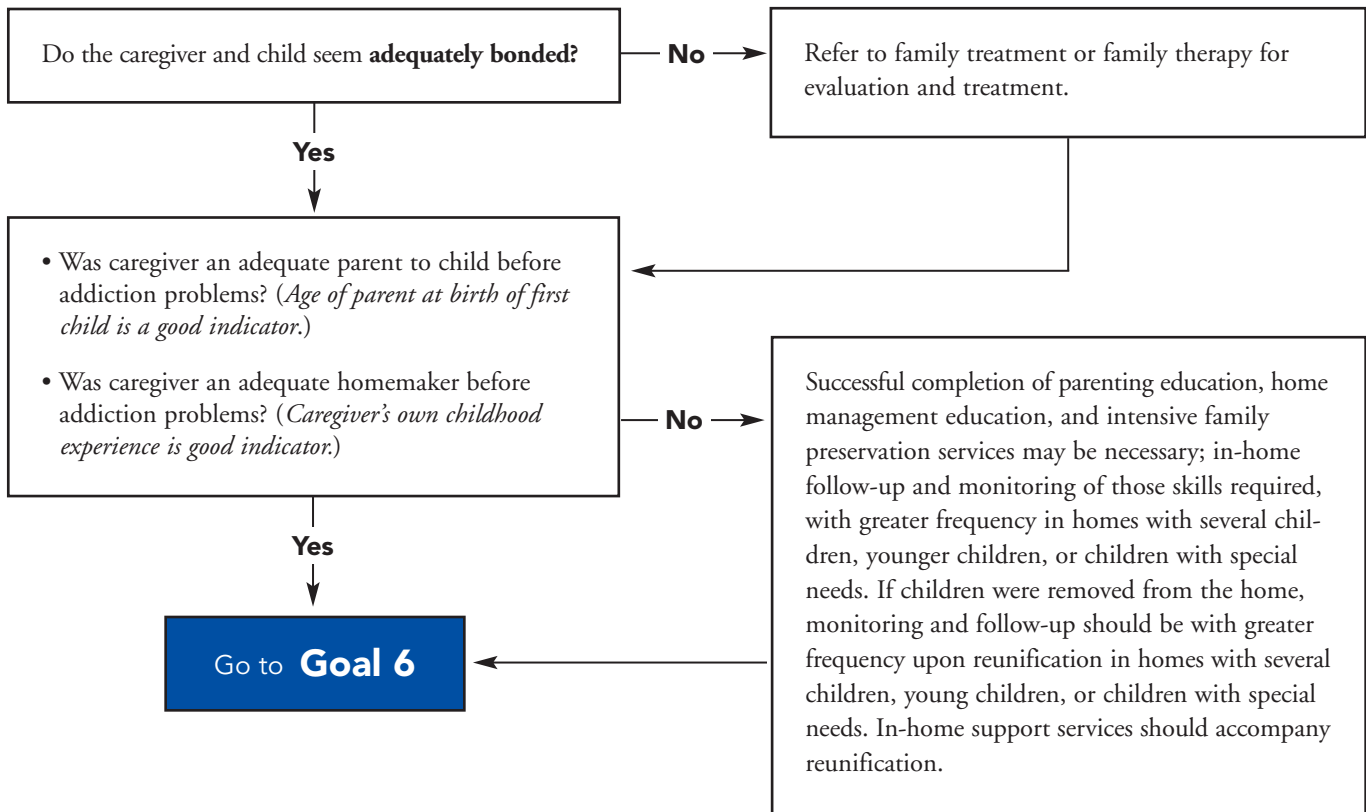
Step 5. Goals and Services: Identify Goals and Services

Each of the abuser categories listed above requires therapeutic treatment to address the abusive behaviors, and to prevent these behaviors from escalating. Important to the

treatment process is the *recognition by the abuser that abuse has occurred, and the motivation of the abuser to eliminate the abusive behavior.*

Goal 5

Improve parenting (if needed in neglect cases, and if warranted in abuse cases).



Step 5. Goals and Services: Identify Goals and Services

Goal 6

Address basic needs.

- Does caregiver have minimally adequate housing?
- Does caregiver have a job, income, or public assistance that will support minimum needs?
- Does caregiver have a minimally adequate plan for food, medical care, and childcare and schooling for child?

No →

Refer to housing, TANF agency, public health, food banks, childcare referral services, etc. Assure caregiver has transportation to services, ongoing counseling. Oversee process through case management support.

Yes

Step 6. Achieve Permanency: Assure Permanency and Family Stability

Review family strengths

- Does caregiver have a plan, resources, and motivation to avoid or minimize environmental pressures and other risk factors that led to substance abuse and child abuse or neglect?
- Are other adults in the household willing and motivated to participate in treatment, counseling, and in reducing risk factors?
- Are there family members who will continue to support this household after the case is closed?
- Does the caregiver have sufficient interpersonal skills to plan for the family's needs?
- Does the caregiver have the ability to deal effectively with stress and crisis?
- Do family members have a positive sense of family and cultural identity?
- Does the parent have sufficient parenting skills and knowledge to support appropriate child development?
- Does the parent have a positive attitude toward the child?

No →

Link to support groups, continued counseling, family counseling, case management. Use these services to determine when family is ready for reunification and/or case closure.

When caregiver:

1. Has completed treatment, and has remained sober and drug free for 3 months (measured through random drug testing),
2. Has a viable child safety plan,
3. (For abuse cases) has progressed in therapy and has been cooperative with treatment process,
4. Has a viable plan for meeting basic needs,
5. Can show improvement in and substantial active pursuit of improving parenting skills (if needed), and

When child functioning issues have been addressed or child has made adequate progress in treatment, family may be reunified.

Step 6. Achieve Permanency: Assure Permanency and Family Stability

Assess family strengths to assure stability:

- Does caregiver have sober and drug-free friends or relatives to call on for support and assistance?
- Is caregiver linked with alcohol or drug support groups and other community organizations for relapse prevention?
- Is caregiver motivated to participate in drug testing for a period of 6 months to 1 year after last AOD usage depending on the duration of the substance abuse and presence of risk factors?
Note: Some relapse can be anticipated.
- Is caregiver motivated to have agency continue monitoring the family and care of the child?

Yes

Due to the special needs of the child or the number and ages of children, are additional support services needed? If yes, consider child care, respite, homemaker, or other support services to reduce stress on caregiver. Continue services until caregiver is substance free for 3-12 months based on duration of addiction. Phase out services over time.

Monitor case for 6-12 months after treatment without new reports.

No

- Link caregiver to other community support services (e.g., community centers, faith organizations of which caregiver is a member, etc.) for ongoing and crisis situations.
- With caregiver, create plan for how caregiver will deal with crisis.
- Periodically contact designated relatives or others regarding contact with caregiver to make sure they are still supporting caregiver.
- Monitor drug screens with frequency and duration of monitoring based on duration of addiction, risk factors, and relapses.
- Monitor care of children regularly, with greater frequency during first 6 months. This includes monitoring supervision, school attendance, health care, basic needs.
- Prepare to re-assess child safety issues, particularly if relapse occurs.

Notes

Notes

Notes

References

- The Adoption and Safe Families Act of 1997. (Public Law 105-89).
- American Eagle Indian Lodge, website at <http://members.tripod.com/AIHC1998/FAS.html>
- Baker, D. R. (1999). *Iowa child welfare law: A manual for social workers (1999 Update)* (2d ed.). Washington, DC: American Bar Association.
- Bowdry, C. (1990). "Toward a treatment-relevant typology of child abuse families," *Child Welfare*, Volume LXIX (4), July/August, pp.333-340.
- Center for Substance Abuse Treatment. (1994). *Simple screening instruments for outreach for alcohol and other drug abuse and infectious diseases*. Treatment Improvement Protocol Series #11, Washington DC: U.S. Department of Health and Human Services, Public Health Service, Substance Abuse and Mental Health Services Administration, DHHS Publication No. (CMA) 94-2094.
- Feig, L. (1990). *Drug exposed infants and children: Service needs and policy questions*. Washington, DC: U.S. Department of Health and Human Services.
- Filip, J., McDaniel, N., & Schene, P. (1992). *Helping in child protective services: A competency-based casework handbook*. Englewood, CO: American Humane Association.
- Gelles, R. (2000). "Treatment resistant families," in *Treatment of child abuse*, Edited by Robert M. Reece. Baltimore, MD: Johns Hopkins University Press.
- Horejsi, C., Craig, B.H.R., and Pablo, J. (1991). *Reactions by Native American parents to child protection agencies: A look at cultural and community factors*, Missoula, MT: Unpublished, University of Montana, prepared through Grant #08CT0074/01 for the Office of Human Development, U.S. Department of Health and Human Services.
- Howard, J. (2000). *Substance abuse treatment for persons with child abuse and neglect issues*. Washington, DC: U.S. Department of Health and Human Services, Center for Substance Abuse Treatment, Treatment Improvement Protocol Series 36.
- The Indian Child Welfare Act of 1978. (Public Law 95-608).
- Jaudes, P., & Mitchel, L. (1992). *Physical child abuse* (second edition). Chicago, IL: National Committee for Prevention of Child Abuse.
- Kropenske, V. and Howard, J., et. al. (1994). *Protecting children in substance-abusing families*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.
- Lewis, M. et. al. (1997). "Two-year placement outcomes of children removed at birth from drug-using and non-drug-using mothers in Los Angeles." *Social Work Research*, 21(2), pp. 81-90.
- Mirmiran, M., & DeBoer, S. (1988). Long term effects of chemicals on the developing brain and behavior. In V.K. Myers (Ed.), *Teratogens: Chemicals, which cause birth defects*. Amsterdam: Elsevier, pp. 271-314.
- Nair, P. et al. (1997). "Risk factors for disruption in primary caregiving among infants of substance abusing women." *Child Abuse & Neglect*, 21(11), pp. 1039-1051.
- National Indian Child Welfare Association, (1996). *Cross-cultural skills in Indian child welfare*, Portland, OR: Author.
- Pantell, R.H., Fries, J., & Vickery, D. (1990). *Taking care of your child: A parent's guide to medical care*. 3rd Edition. Reading, MA: Addison-Wesley Publishing Company.
- Phibbs et al. (1991). The neonatal costs of maternal cocaine use. *Journal of the American Medical Association*, 266(11), pp. 1521-1526.
- Salter, A., Richardson, C., and Kairys, S. (1985). "Caring for abused preschoolers," *Child Welfare*, Volume LXIV (4), July-August, pp. 343-356.
- Salter, A., Richardson, C., and Martin, P. (1985). "Treating abusive parents," *Child Welfare*, Volume LXIV (4), July-August, pp. 327-342.
- Sigurdson, E. and Reid, G. (1996). *The Manitoba risk estimation system reference manual* (Version 4.2). Winnepeg, Manitoba, Canada: Sigurdson, Reid and Associates, Ltd.
- Smith, J. et al. (1997). *Understanding the medical diagnosis of child maltreatment: A guide for nonmedical professionals* (revised, 2nd edition). Englewood, CO: American Humane Association.

The National Center on Addiction and Substance Abuse at Columbia University. (1999). *No safe haven: Children of substance-abusing parents*. New York: Columbia University.

U.S. Department of Health and Human Services, Administration for Children and Families. (1998). *Principles for implementing the Adoption and Safe Families Act of 1997*. Washington, DC (unpublished flyer).

U.S. Department of Health and Human Services. (2002). *Child maltreatment 2000: 11 years of reporting*. Washington, DC: U.S. Government Printing Office.

West, K. (2000). “*Substance abusing families and meeting ASFA timelines*.” Presentation at Second National Roundtable on Implementing the Adoption and Safe Families Act, Philadelphia, PA: American Humane Association, May 2000.

Weston, D.R., et al. (1989). Drug exposed babies: Research and clinical issues. *Zero to Three*, 9(5), pp. 1-31.

Winterfeld, A. (1998) An overview of the major provisions of the Adoption and Safe Families Act of 1997. *Protecting Children*, Volume 14 (3), pp. 4-8.

Young, N., & Gardner, S. (1998, Winter). Children at the crossroads. *Public Welfare*, pp. 3-10.

Participation in Focus Group to Develop Guideline:

Louis Kaszas, Supervisor, Cuyahoga County (OH)
Department of Children and Family Services

Tina Willauer, Supervisor, Cuyahoga County (OH)
Department of Children and Family Services

“Failure to thrive (FTT) is a nonspecific term applied to infants and young children who are failing to grow in a normal fashion.” (Smith, 1997). Most often, failure to thrive involves children under age 3 because they normally grow rapidly and must depend upon their parents to meet their needs for food. A diagnosis of failure to thrive is not based on a single measurement of a child’s weight and height, but is based on a pattern or trend of growth that is consistently less than expected for a particular child. *Infants can be in significant, even life-threatening, danger if their nutritional needs are not met.* Potential failure to thrive in infants must therefore be assessed promptly, including a medical examination.

Failure to thrive can be organic; that is, it can be caused by an underlying physical disease. It can also be nonorganic; that is, the cause can be psychosocial and not the result of an underlying medical condition. The cause of failure to thrive can also be mixed; that is, it can be caused both by an underlying disease and by a problem in parent-child interaction or in the home environment (Smith, 1997). There should be both a social evaluation (including evaluation in the home environment) and a medical evaluation and diagnosis prior to the conclusion that nonorganic failure to thrive is occurring.

Concern about failure to thrive arises when there is:

- Less than expected growth; and
- The child’s weight falls below the 5th percentile for her age, height is under

the 5th percentile for his or her age, or weight and height are under the 10th percentile for his or her age; and

- There is a poor growth trend such that the child’s growth descends across two lines on a standard growth chart.

(Note: Clinical growth charts can be found for reference at the web site of the National Center for Health Statistics at: http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/clinical_charts.htm.)

But many factors affect growth, and should be considered before a child is labeled failure to thrive. For example, the child may be normally thin or short; some children are normally in the 5th percentile for height and weight and continue on a normal growth pattern in that percentile. Children who were born prematurely will normally be somewhat smaller than others of the same age during the first year of life. The mother may also have medical issues that can interfere with lactation and therefore with providing sufficient nutrition for the child. Certain medical conditions (e.g., Down’s syndrome) can also affect growth (Dubowitz, 1998).

Even when failure to thrive is diagnosed, it is important to realize that although it may reflect inadequate nutrition or a problem in the parent-child relationship, it may not. If failure to thrive is identified as nonorganic (psychosocial) in origin, it should be because there has been a problem identified in the home environment, not solely because of the apparent absence of a medical cause (Dubowitz, 1998).

The crux of failure to thrive is caloric intake. “Either the calories are not being offered to the child, the child is not taking the offered calories, the child is using calories at an increased rate, or the calories are not being absorbed into the body from the gastrointestinal system.” (Smith, 1997). To clarify the pattern for each child, a comprehensive medical evaluation should occur and psychological evaluations may be needed.

To supplement the medical evaluation, four main areas should be assessed by social workers to clarify the reasons for nonorganic or mixed failure to thrive (Dubowitz, 1998):

- Child factors;
- Parental factors;
- Family factors; and
- Community and cultural factors.

Each of these factors is discussed in more depth in the chart that follows, with suggestions for assessment and effective response strategies.

A child’s feeding history should always be assessed, as well as whether there is adequate food in the home. Workers will need to ask what the child is fed, when (how often), where the child is fed, who feeds the child, and who eats with the child. Observe a feeding in the home, if possible. For infants, assess the positioning of the infant (i.e., how the child is held and whether it is a comfortable position for feeding), general interaction between parent and child, and feeding interaction (e.g., does the parent make eye contact with infant while feeding). Observe whether the

child appears to have motor issues that interfere with feeding, the child's behavior during feedings and the parent's response, and whether the child is capable of feeding himself.

Responding to failure to thrive often requires a comprehensive, multidisciplinary team approach. Often the social work agency comes into a case after a medical diagnosis of failure to thrive

and the social worker's job is to address psychosocial factors and ensure that medical recommendations are followed. Although the goal is to address all contributing factors, begin with the least intrusive approach. For example, if formula is not being prepared properly, demonstrate how to prepare the proper formula concentration. Consider what interventions have been tried in the

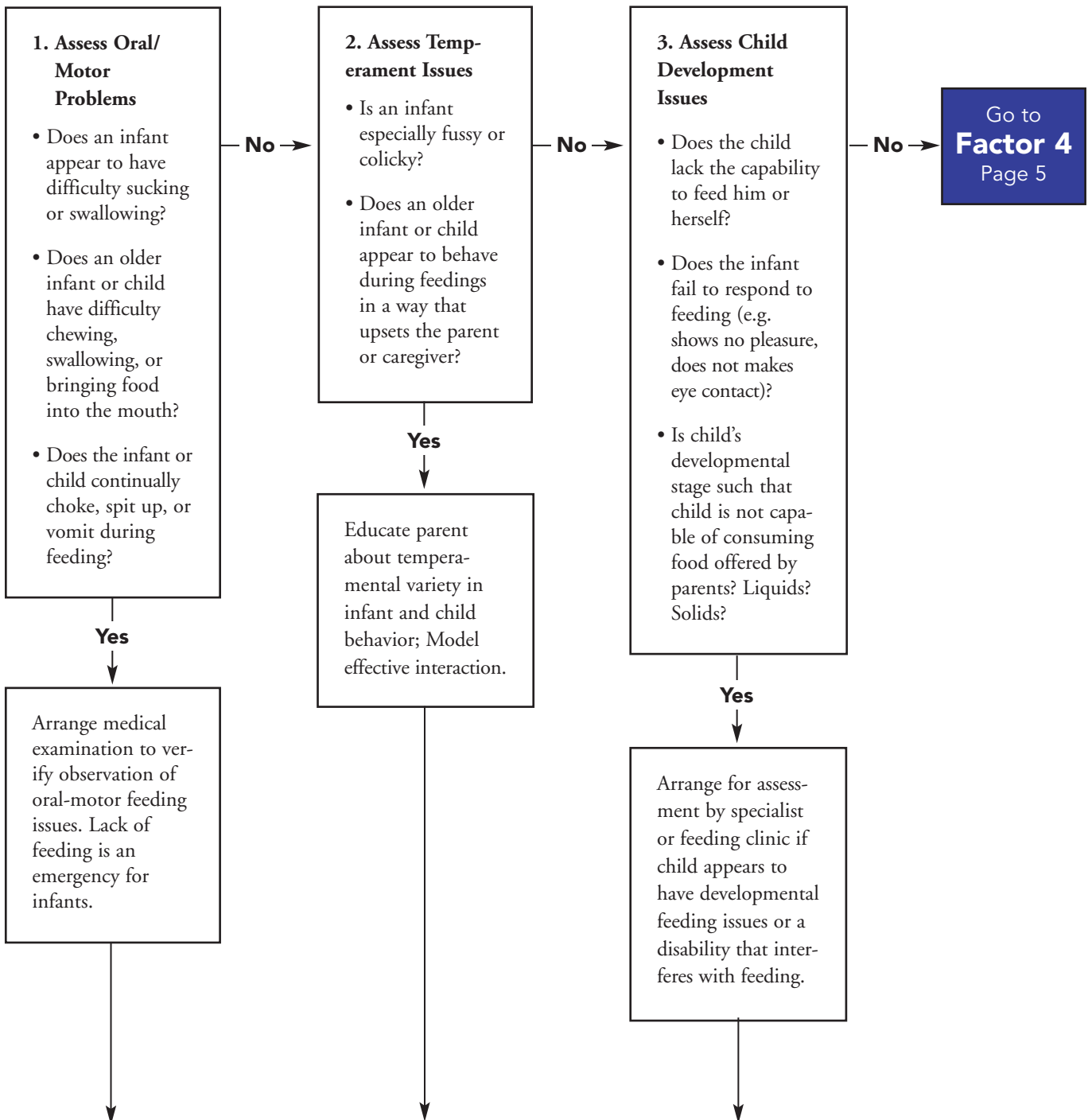
past, results of those interventions, and changes that may be needed to address all contributing factors. *Tailor your approach to a family's strengths and needs; and be sure that there is adequate medical follow-up to monitor the child's health — especially for infants — for whom feeding issues can quickly become a life-threatening emergency.*

The Guidelines are a product of the Casey Outcomes and Decision Making Project. Project partners: The Annie E. Casey Foundation; Casey Family Programs; Casey Family Services; American Humane Association, Children's Services; American Bar Association, Center on Children and the Law; Institute for Human Services Management. Guidelines developed and written by Tracey Feild, M.A. and Amy Printz Winterfeld, J.D.

Step 1. Assessment: Assess the Child Factors

The first step in assessing the possible causes of failure to thrive is to observe a feeding in the home in order to assess the parent-child interaction during feeding and the various

physical, environmental, or psychosocial factors that may be contributing to the failure to thrive. Observe the child during the feeding for the following factors:



Step 1. Assessment: Assess the Child Factors

Manage through occupational therapy and/or medical treatment. Follow-up regularly with medical provider.

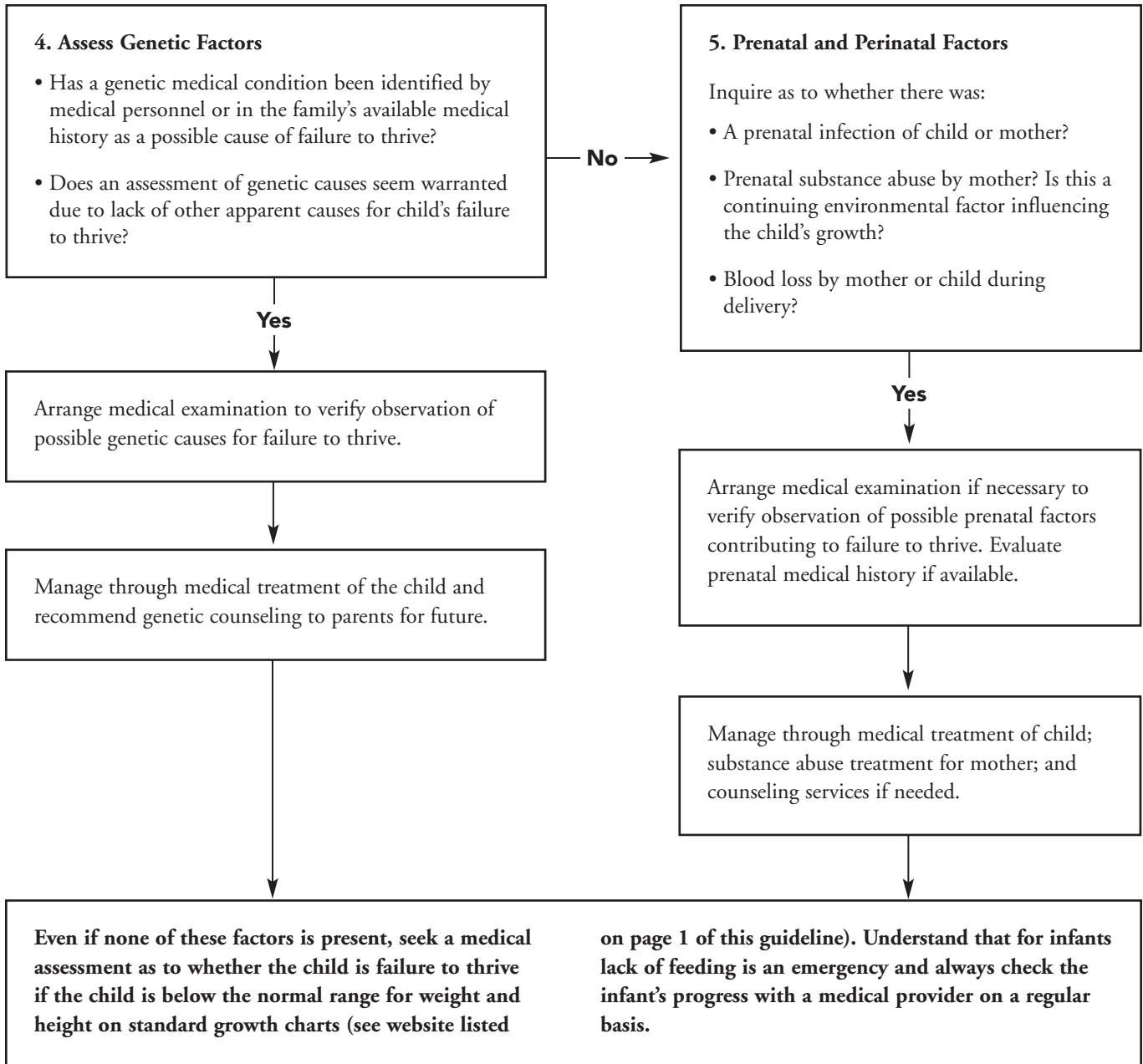
Manage through continued home visits, Arrange counseling services if needed.

Educate parent about normal child development and appropriate foods for infants and children of different ages

Understand that for infants lack of feeding is an emergency and always check the infant's progress with a

medical provider on a regular basis.

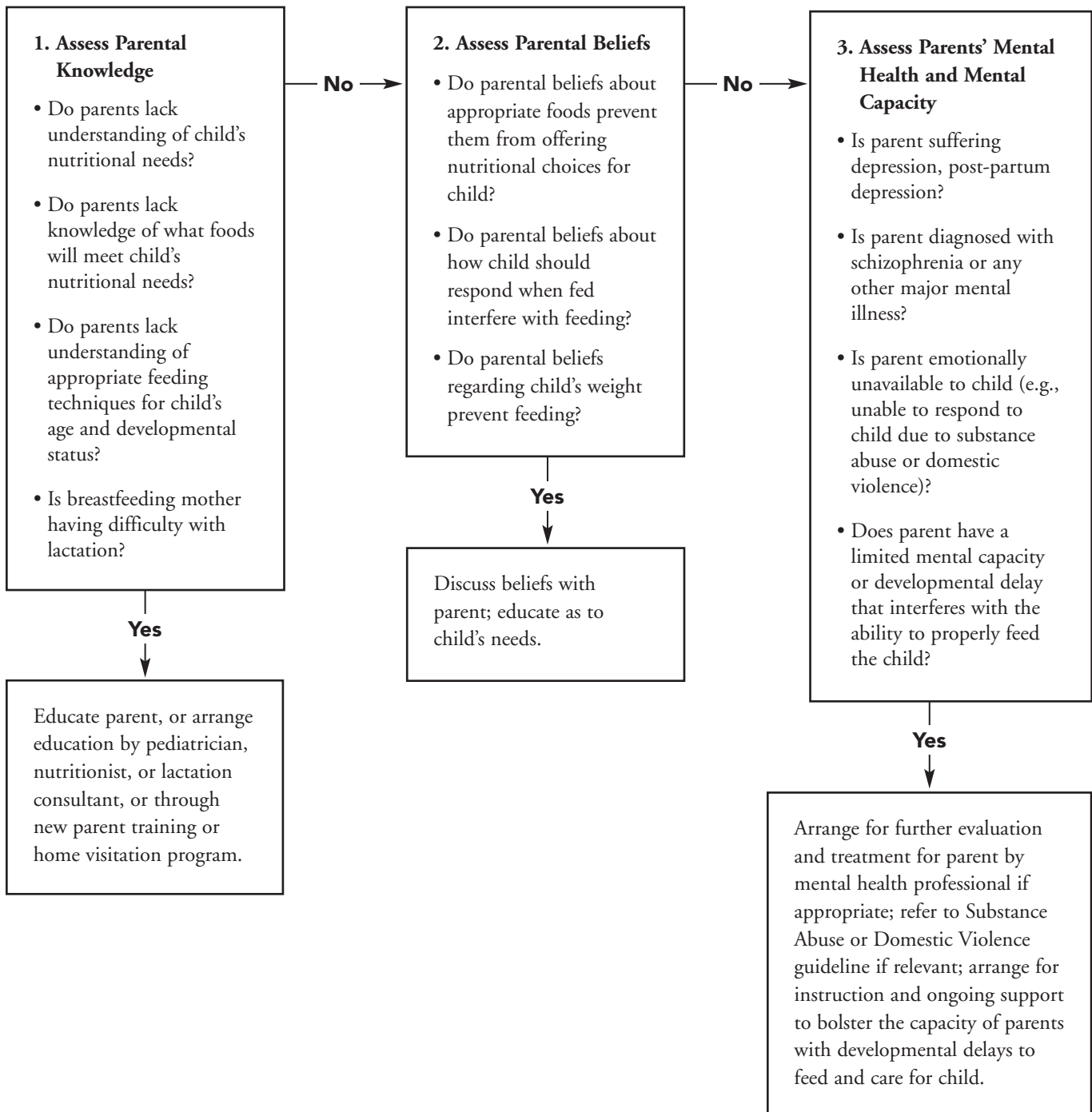
Step 1. Assessment: Assess the Child Factors



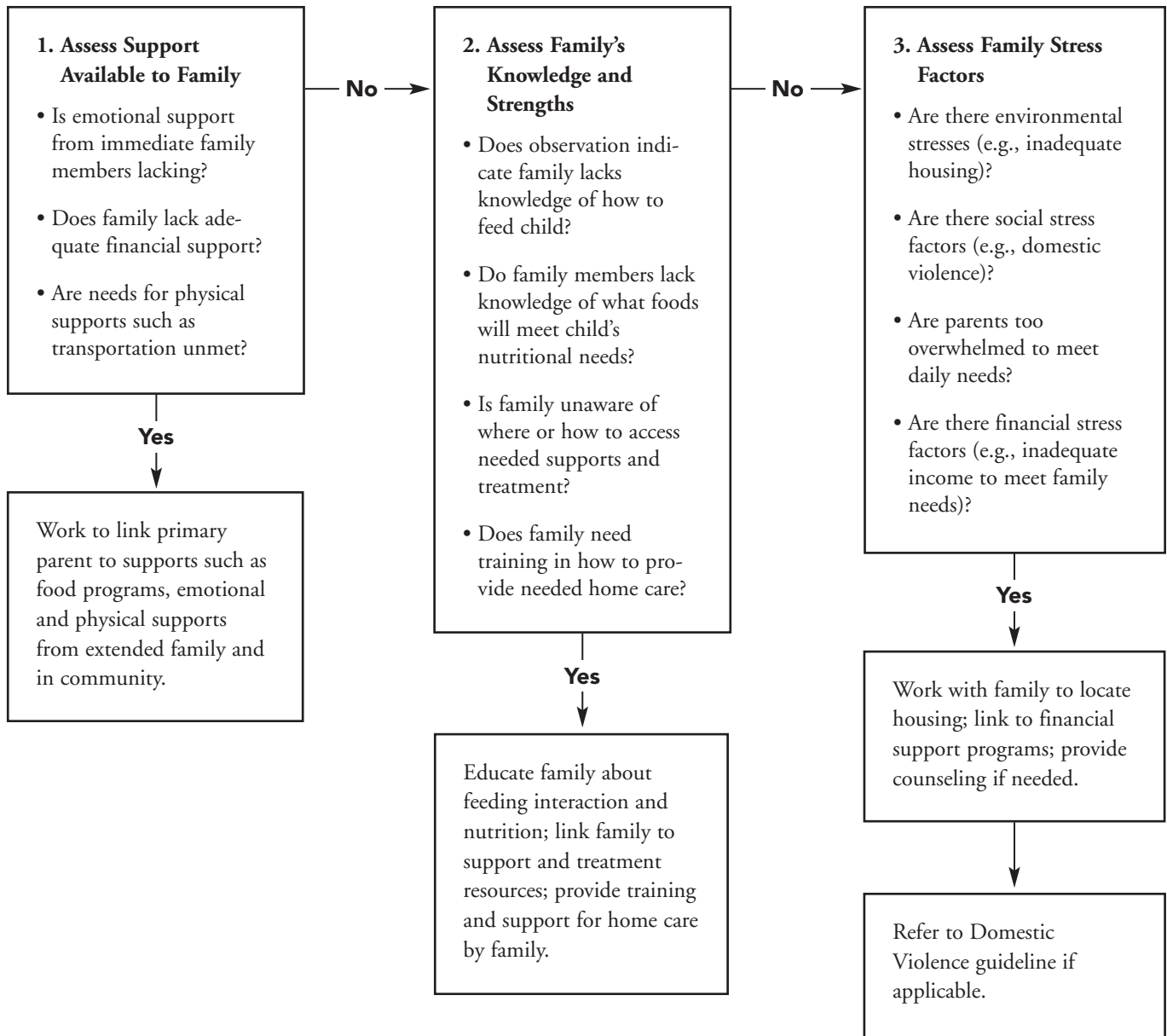
Step 1. Assessment: Assess the Parental Factors

Parental knowledge of the child’s nutritional needs and appropriate feeding techniques, views on frequency of feedings, and parental mental health or medical issues such as problems

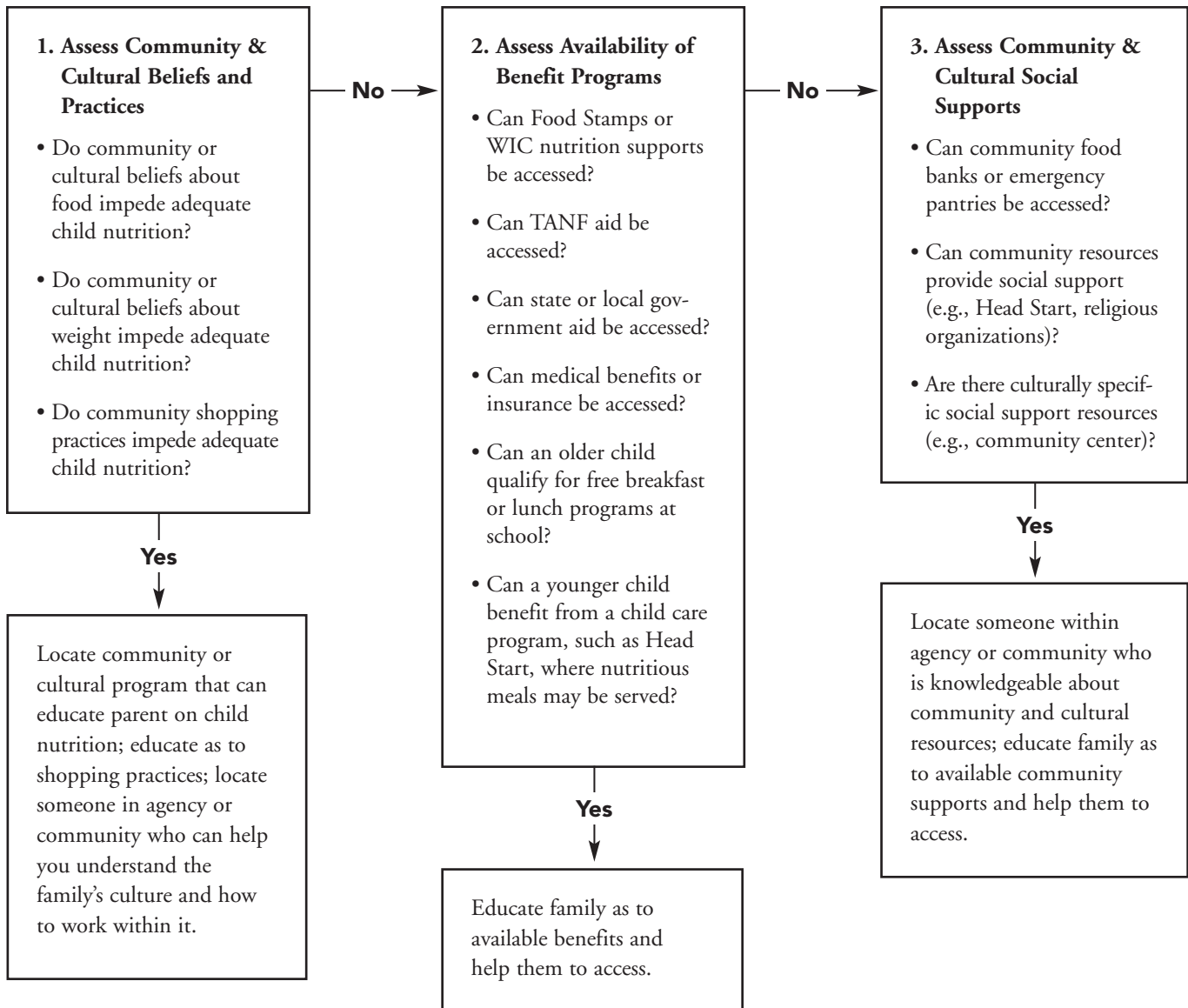
with lactation, can also contribute to failure to thrive. Observe the parents and tactfully ask them about the following factors:



Step 1. Assessment: Assess the Family Factors



Step 2. Family/ Cultural Issues: Assess Community, Family, and Cultural Factors



Step 2. Family/ Cultural Issues: Assess Community, Family, and Cultural Factors

- Is it possible that community, cultural, or ethnic beliefs or practices that you are not familiar with are a factor in the parents' behavior?

However, keep in mind that if a child is starving due to inadequate feeding, there must be a response to protect the child's safety and health. Failure to thrive should not be excused as a permitted cultural practice.

No →

Go to **Step 3** Page 10

Yes ↓

- Find someone in your agency knowledgeable about the family's culture before proceeding. Develop your understanding of how the family's beliefs, values, interests, and concerns may differ from your own and affect their behavior before you assess needs or begin planning services. When you understand how your cultural views and the family's culture and beliefs affect your assessment of the family's issues and needs, it may also affect how you plan to remediate them.

- If no one is available within your agency to help you understand the family's culture and belief system, identify community or neighborhood representatives (e.g., community leaders, community-based organizations, religious leaders, etc.) who could assist you in assessing needs and planning for families within this culture and in understanding the values and beliefs of this cultural group.

4. Assess Community & Cultural Material Supports

- Are there community-specific resources for financial support?
- Are there culturally specific material support resources?

No →

Go to **Step 3** Page 10

Yes ↓

Educate family as to availability of community or cultural material supports and help them to access resources.

Step 3. Permanency Planning: For Native American Children, Keep ICWA Requirements in Mind as You Begin Planning

Determine the child’s Native American heritage — Is this child a member of a federally recognized Indian tribe, a child of a tribe member, or eligible for tribal membership?

No →

Go to **Next Page**

Yes ↓

Notify the tribal court that the child is the subject of an open child welfare case. Keep in mind that the Adoption and Safe Families Act (ASFA) requirements for timely

permanency **do not** supersede the requirements of the Indian Child Welfare Act (ICWA).

Regarding reasonable efforts:

ICWA requires that active efforts must be made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family. Such efforts should “involve and use the available resources of the extended family, the tribe, Indian social services agencies, and individual Indian caregivers.” This requirement is for

Native Americans living both on and off of reservations. ASFA provides for efforts to prevent family breakup on a case-by-case basis. Your agency should consider ICWA legal standards for placement with extended family, other members of the child’s tribe, and other Indian families, before suspending active efforts to aid the family and before considering termination of parental rights (TPR).

Regarding termination of parental rights for American Indian children:

Parental rights may be terminated only where there is evidence beyond a reasonable doubt, including testimony of expert witnesses, that the continued custody of the child by the parent (or Indian custodian) is likely to result in serious emotional or physical damage to the child. Active

efforts to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family must have been made before a termination of parental rights may be sought. Remember that failure to adequately utilize appropriate tribal, extended family, and community resources could trigger the “failure to provide services” exception in the TPR filing requirement.

Make sure your agency attorney reviews ICWA before filing any actions with the court regarding permanency for this child. Remember that any permanency plan developed for a Native American child which provides for an out-of-

home placement, including an adoptive placement, would be subject to the placement preferences in ICWA (which include placement with extended family, other members of the child’s tribe, and other Indian families).

Step 3. Permanency Planning: Keep in Mind ASFA Safety and Permanency Goals and Required Timelines as You Begin Planning

For healthy development, children need consistent care and a feeling of belonging in a safe, permanent home. To help ensure permanency for children, the federal Adoption and Safe Families Act (ASFA), requires an initial focus on child safety, then development of a permanency plan for each child within 12 months.

- Can immediate child safety be assured only by placing the child outside the home?

No →

Go to next step for identifying case goals and services. Ensure that plan includes supports for child safety at home. Include monitoring for child safety in plan.

Yes ↓

Begin permanency planning efforts immediately.

Develop a permanency goal and permanency plan for the child, in collaboration with the child’s parent(s).

- Involve the child’s parents, the child (generally if the child is 14 or older, and/or able to understand the situation), other relatives, or persons important to the child in the planning process.
- Do “concurrent” planning, that is, plan at the same time for the possibility of reunification of child and parent or finding an alternate permanent home for the child with relatives, through guardianship, or by adoption.
- Focus on child safety as the paramount goal, but make reasonable efforts to return the child home, unless the

parent has assaulted, seriously injured, or killed a child or another child of the parent or there are “aggravated circumstances” such that the child’s safety would be endangered by reunification. “Aggravated circumstances” not requiring reunification efforts include any listed in your state’s law and the following as defined by federal ASFA law: abandonment, torture, chronic abuse, or sexual abuse.

- Ensure that the child’s permanency plan includes: protection of the child’s health and safety, type and appropriateness of the child’s placement (see the Placement Level of Care guideline), any services to be provided to the child and the reason, services to be provided to the child’s biological parents, foster parents, and identified permanency family.

Under the ASFA, federal law requires compliance with the following timelines to ensure permanency for children in the custody of state child welfare agencies. State law timelines may be more restrictive.

- If reasonable efforts to return a child home are not being made due to aggravated circumstances, a court permanency hearing must be held within 30 days of placement.
- For every child in an out-of-home placement (including placement with relatives), a court permanency hearing must be held within 12 months of the date of the child’s first placement out of the home to determine the child’s permanency plan.

- If a child has been in placement for 15 out of the last 22 months, a court petition to terminate parental rights must be filed, unless:

1. A relative is caring for the child.
2. There is a documented compelling reason that termination of parental rights is not in the child’s best interests.
3. The state failed to provide the family with services, unless reasonable efforts to reunify the family were not required for the reasons listed above.

Step 4. Goals and Services: Identify Goals and Services

Goal 1

Address medical factors for child.

Address the need for medical treatment:

If failure to thrive is suspected, a medical exam is always necessary. Child welfare staff can contribute to the physician’s understanding of the issues by presenting their observations and gathering a thorough history, if possible, of the following factors. It is the physician’s role to confirm if these apply.

- Did you observe oral or motor problems that prevent the child from feeding?

- Is there a medical condition that prevents the child from absorbing calories?
- Are there genetic factors contributing to failure to thrive?
- Did prenatal factors contribute to failure to thrive?
- Have other medical factors been identified as contributing to mixed causes of failure to thrive?

Yes

If a medical or genetic problem is identified, medical oversight and continued monitoring are always needed. Work with the physician and family to educate parents about needed medical treatment, occupational therapy, or genetic counseling. Consult, too, with your agency’s in-house medical personnel (e.g., nurses, nurse-practitioners) if they are available for this purpose.

Can parents access needed medical treatment:

- Do parents know where to go for child’s treatment?
- Can parents pay for needed medical treatment?
- Can parents transport child for medical treatment?

No

- Educate parents on treatment resources.
- Determine if there is a visiting nurse or growth, parenting, or feeding clinic that they can access.
- Locate financial resources, Medicaid options for treatment.
- Provide or arrange transportation if needed.

Yes

If there are mixed psychosocial causes for the failure to thrive, develop plans to address parental and family or cultural factors as well.

Step 4. Goals and Services: Identify Goals and Services

Goal 2

Address parental education and family interaction factors and identify how family assessment of issues and family strengths can support the safety plan and case plan.

Are parents able to feed child correctly?

- Do they lack understanding of child’s nutritional needs?
- Do they lack knowledge of the frequency with which the child should be fed (e.g., infants eat every 2-4 hours)?
- Do they lack knowledge of what to feed child (e.g., infant formula)?
- Do they lack knowledge of how to feed child (e.g., positioning infant)?
- Is parental interaction with child ineffective for feedings (e.g., punitive)?
- Are there parental mental health issues that interfere with providing nutrition for child (e.g., schizophrenia, post-partum depression)?

Any Yes

Work with parents in a relaxed, encouraging manner to:

- Praise their positive efforts to feed and nourish their child.
- Educate them on nutrition and feeding techniques or refer them to a pediatric nutritionist or clinic.
- Demonstrate effective feeding techniques, interactions.
- Obtain treatment for parental mental health issues, if needed.

Note: If feeding interaction appears physically abusive (e.g., yanking child’s head, force feeding), refer to guidelines for Physical Abuse.

Step 4. Goals and Services: Identify Goals and Services

Review family's assessment of the situation.

- Are there factors or issues identified by the family that were not identified by you?
- Is their assessment of the issues helpful in determining how to plan for child safety and nutrition?
- Do they have any specific ideas about how to plan for safety and resolve nutrition issues? Do any of their ideas seem reasonable?
- Can family members (including extended family) help implement any of the ideas?
- Can you help implement any of their ideas; either through case plan goals, services, or flexible funding? Can you reinforce the family's knowledge of nutrition and positive feeding interactions by helping them to partner with a nutritionist, feeding clinic or physician?
- To the extent you can assure child safety while reasonably including any of the family's (including extended family's) ideas in developing the case plan goals, services and interventions, you should do so. Focus on encouraging good nutrition and positive feeding interactions.



Identify and review family (including extended family) strengths.

- **Identify the strengths** that will help the adult to adequately feed the child. (Include relationships, employment, education, personality, skills, support systems, etc.)
- If the adult's issues and needs overwhelm her strengths, identify extended family members who could help support adequate nutrition for the child.
- Identify extended family strengths that could help the adult adequately feed the child.
- Bolster family strengths with support from a nutritionist, feeding clinic, or physician.
- Consider **all** of the strengths identified, both of the family involved in the failure to thrive and of the extended family, in developing the case plan goals, services, and interventions. Plan specific steps to use and bolster family strengths. **Rely on family strengths wherever possible to address issues. Remember the strengths that you are successful in reinforcing will remain with this family after the case is closed.** Utilize support from a nutritionist, feeding clinic, or physician to provide continuing assessment of child safety and to reinforce family strengths.

Step 4. Goals and Services: Identify Goals and Services

Goal 3

Provide supports to family to maintain child in home.

- Support family through education on nutrition and feeding techniques, as much as possible and realistic.
- Support family access to needed medical resources (e.g., nutritionist, physician, feeding clinic).
- Connect family to community and cultural social supports.
- Connect family to needed benefit programs.
- Address family stress factors through social supports.
- Access counseling on child development and temperament issues.



Goal 4

Assess and address community or cultural issues contributing to failure to thrive (if any), and reinforce community and cultural strengths, supports, and services.

Assess the following:

- Are there community or cultural beliefs that can be reinforced to encourage positive family interactions and parenting practices (e.g., cultural tradition of caring for one's child)?
- Are there specific formal community or cultural programs, supports, or services that can be accessed to address the issues in this case (e.g., support or treatment resources for persons from this culture)?
- Does the family have informal community or cultural ties or resources, such as an extended kinship network or membership in a community of faith, that can be accessed to support positive family functioning?

Address the following:

- Provide nutrition counseling to address cultural beliefs about food and weight.

- Provide guidance on shopping practices.

- Connect family to positive community organizations and role models.

When possible in service planning:

- Incorporate mechanisms to reinforce cultural strengths into the service plan for the child and family.
- Incorporate culturally specific supports and services into the service plan for the family.
- If treatment services are a part of the service plan, locate treatment providers that are aware of cultural factors and incorporate these factors into service provision.
- For all services that are part of the service plan, attempt to locate programs that are culturally sensitive.

Step 4. Goals and Services: Identify Goals and Services

Goal 5

Identify safety issues that must be addressed through continued monitoring or home visits.

Can you identify a process to ensure that the child receives adequate nutrition in the home and that others supervise the child's nutritional intake?

No →

Ensure child safety and develop and implement an alternate permanency plan for the child in a timely manner.

Yes

If the child can safely remain at home, with help from community support persons and extended family, develop a plan with specific timelines to monitor child's ongoing safety.

Step 5. Achieve Permanency: Assure Permanency and Family Stability

Review child’s progress:

- Has child’s growth continued in a normal fashion as periodically monitored in accordance with child’s treatment process?
- Have caregivers been able to access and follow through with any indicated medical treatments for child?
- If applicable, has parent-child feeding interaction improved (e.g., child no longer ignored in crib)?
- Are child’s nutritional needs being met?
- Has risk (particularly of malnutrition and neglect), as assessed by agency’s risk assessment instrument, abated?

No →

- If child is receiving adequate nutrition continue to monitor treatment process and compliance with plan for 6 months.
- If there is inconsistent progress, continue medical evaluation and treatment — especially for infants — and monitor for ongoing risk and child safety.
- If there is no progress and child is malnourished, consider alternative permanency plan for child.

Yes ↓

Assess parent, family, and community-cultural strengths:

- Has caregiver been cooperative with own treatment process (if needed)?
- Have caregivers participated in planned services?
- Do caregivers demonstrate ability to utilize community and cultural supports?
- Have caregivers gained necessary knowledge about child nutrition and feeding techniques?
- Is the family free of other abuse or neglect issues?
- Is the family free of domestic violence or substance abuse issues?
- Are the family’s basic needs met?

No →

Refer to Substance Abuse and Domestic Violence guidelines, if appropriate, to address other issues.

Yes ↓

When:

- Child is adequately nourished at home,
- Caregiver’s issues are being addressed,
- Family shows evidence of commitment to child safety,

Child may be reunified, and case monitored for 6 months, or if child has not been removed, case monitored for 6 months, then closed.

Step 5. Achieve Permanency: Assure Child Safety

Ensure child safety:

- During the time that case remains open, regularly reassess the child's safety with agency risk assessment instrument as per agency policy.
- Monitor child safety by regular visits and if the child is being served by a physician, nutritionist, or feeding clinic, by checking with these professionals as to whether the child's nutritional needs are being met.
- If risk continues at unacceptable level, return to the beginning of Step 4 and revise the service plan to ensure child safety, adequate support for the child and family, and adequate ongoing monitoring of the child's nutritional status in accordance with applicable planning steps.

Please refer to the United States Clinical Growth Charts that can be found on the Internet at the web site of the United States Centers for Disease Control, National Center for Health Statistics at http://www.cdc.gov/nchs/about/major/nhanes/growthcharts/clinical_charts.htm as a reference for determining normal growth patterns for infants, children, and adolescents from birth to 20 years of age. Reference charts are available at this web site in English, Spanish, and French.

Notes

References

- The Adoption and Safe Families Act of 1997. (Public Law 105-89).
- Baker, D. R. (1999). *Iowa child welfare law: A manual for social workers (1999 Update)* (2d ed.). Washington, DC: American Bar Association.
- Dubowitz, H., & Black, M. (1998). *The connection between failure to thrive & child neglect. Presentation at the 12th National Conference on Child Abuse and Neglect*, Cincinnati, Ohio, November 1998.
- Filip, J., McDaniel, N., & Schene, P. (1992). *Helping in child protective services: A competency-based casework handbook*. Englewood, CO: American Humane Association.
- The Indian Child Welfare Act. (Public Law 95-608).
- Pantell, R. H., Fries, J., & Vickery, D. (1990). *Taking care of your child: A parent's guide to medical care* (3rd ed.). Reading, MA: Addison-Wesley Publishing Company.
- Smith, J. et. al. (1997). *Understanding the medical diagnosis of child maltreatment: A guide for nonmedical professionals* (revised, 2nd ed.). Englewood, CO: American Humane Association.
- U.S. Department of Health and Human Services, Administration for Children and Families. (1998). *Principles for implementing the Adoption and Safe Families Act of 1997*. Washington, DC (unpublished flyer).
- Winterfeld, A. (1998) An overview of the major provisions of the Adoption and Safe Families Act of 1997. *Protecting Children*, Volume 14, (3), pp. 4-8.
- Wissow, L. Failure to thrive and psychosocial dwarfism. (1990). In L. Wissow, *Child advocacy for the clinician*. Baltimore, MD: Williams & Wilkens.
- Significant input into this guideline was provided by Howard Dubowitz, M.D., Professor of Pediatrics, Co-Director - Center for Families, University of Maryland School of Medicine.

According to national child maltreatment data, there were 25,450 child victims of medical neglect in the United States in 2000 (U.S. Department of Health and Human Services, 2002). Although this number of victims represents just 3% of substantiated maltreatment cases, it is crucial to respond to medical neglect because not doing so can have severe consequences for the child.

By definition, medical neglect is the parents' failure or refusal to provide needed medical treatment, as a result of which the child could be seriously disabled or die. There is cause for concern not only when a child is refused medical care in an emergency, but also when a child with a treatable chronic disease or disability has frequent hospitalizations or significant deterioration because the parents ignore medical recommendations (Smith, 1997). Children with severe developmental delays or disabilities may be especially vulnerable if refused medical treatment for their condition.

If you need more information about a child's illness or assistance in evaluating the seriousness of the child's condition, you should arrange to consult a physician. Describe the child's symptoms and ask for a diagnosis or opinion as to necessary treatment. If needed, contact the agency attorney to obtain a court order for a medical evaluation of the child.

Parents may refuse medical care for their children for different reasons. Some object based upon religious beliefs. Others may simply be fearful or anxious about a medical condition or treatment that they do not understand.

Sometimes a family will not seek treatment for financial reasons. You will need to assist such families in locating low-cost medical resources. Familiarize them with state children's health insurance program (SCHIP) benefits, social security disability (SSI), or Medicaid for which they may be eligible. State-by-state information about the children's health insurance program is currently available on the internet at www.insurekidsnow.gov or by calling toll-free 1-877-543-7669 (1-877-Kids Now). Medicaid information can be found at www.hcfa.gov/medicaid/medicaid.htm.

When a misunderstanding about a child's diagnosis or treatment is the main reason for refusing medical care, the goal should be to identify the parents' specific concerns and alleviate those concerns with additional information. The child's physician can provide medical information. However, you can play an important role in facilitating communication between the medical provider and the parents, who may be more comfortable in talking to you. Both social workers and physicians should make every attempt to include parents in the treatment decision process (Smith, 1997).

If parents continue to refuse medically recommended treatment for a child who is likely to suffer disfigurement, serious disability, or death as a result, you will need to work with the physician and your agency's attorney to obtain a court order for treatment.

There are three general types of medical neglect that warrant a response from

child protective services agencies (Schmitt, 1975):

1. Serious acute illness.

Situations that are medical emergencies are in this category. For example, children with acute appendicitis for whom the parents refuse an appendectomy; a child whose parents refuse a blood transfusion needed to treat shock; or a child who is so severely dehydrated that hospitalization is needed.

When the parents refuse to consent to medical treatment in such acute emergencies, a court order for treatment is needed quickly. If necessary, you should advocate for an emergency hearing to ensure needed medical treatment.

2. Life-threatening chronic diseases.

A chronic disease is one that lasts over a long period of time, such as diabetes mellitus or asthma. When a child with such a disease does not receive needed home medical treatment for the condition, they can experience serious or life-threatening medical problems. For example, a child with chronic asthma who does not receive regular medical care or who has an acute asthma attack and does not receive needed medication, is at risk of serious or life-threatening consequences. Families who cannot adequately cope with their child's chronic illness will need support services to ensure that their child receives adequate care. Families who refuse to provide care, such that the situation becomes an emergency, will need a court order for treatment.

3. Chronic diseases that can cause disability or disfigurement.

Some diseases, if left untreated, can cause a permanent disability or disfigurement for a child. A child with

congenital cataracts or glaucoma, for example, needs surgical treatment, or blindness will result. In these cases, the parents may need to be educated about the need for treatment and the

results expected if treatment is not provided. If the parents still refuse treatment, obtaining a court order is appropriate.

The Guidelines are a product of the Casey Outcomes and Decision Making Project. Project partners: The Annie E. Casey Foundation; Casey Family Programs; Casey Family Services; American Humane Association, Children's Services; American Bar Association, Center on Children and the Law; Institute for Human Services Management. Guidelines developed and written by Tracey Feild, M.A. and Amy Printz Winterfeld, J.D.

Step 1. Assessment: Identify Case Type

For the purpose of developing a service plan, medical neglect falls into three general categories.

- The first category, *serious acute illness or injury*, requires the most immediate response as it includes cases that may be considered medical emergencies.
- The second category, *life-threatening chronic diseases*, may have elements of the first category (medical emergency), if the situation continues without treatment for a critically long period of time (e.g., diabetes mellitus) or is allowed

to become an acute episode (e.g., asthma). This category will require a timely response, and may require that you seek emergency medical services, if the situation has become acute.

- The third category, *chronic diseases that can cause disability or disfigurement*, may require parent education services as well as a non-emergency medical response.

Select the category that best fits the characteristics of the current case.

1. Serious Acute Illness or Injury

- Will the child’s condition potentially be fatal if medical treatment is not provided?
- Will the child be seriously disabled or disfigured if medical treatment is not provided?

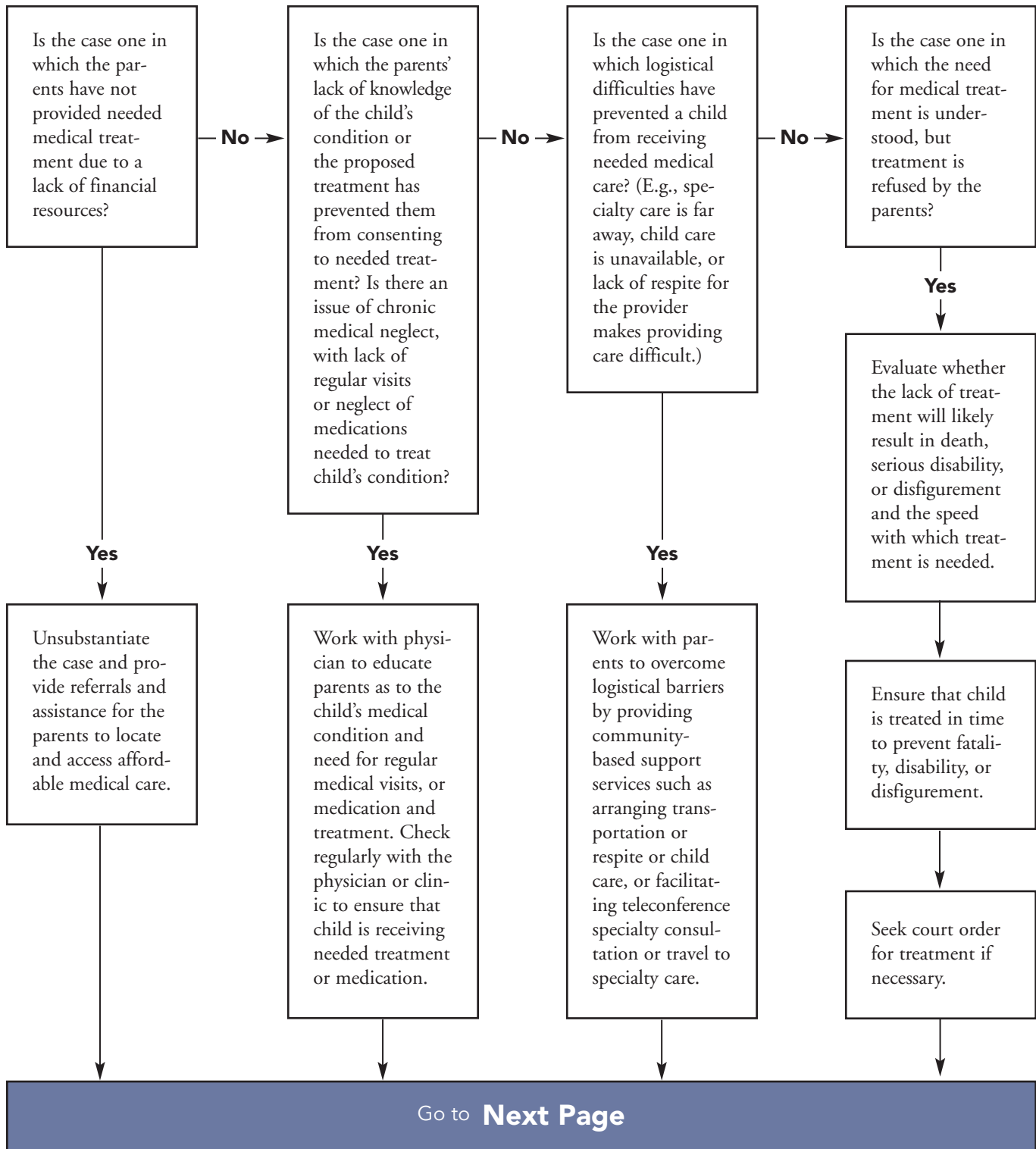
2. Life-Threatening Chronic Diseases

- Does the parent recognize that the child’s condition requires long-term home care and/or adequate care outside the home?
- Does the parent refuse to provide needed ongoing care or treatment?
- Due to lack of ongoing care or treatment, has the child’s condition deteriorated such that it may cause death or disfigurement if untreated?

3. Chronic Diseases That Can Cause Disability or Disfigurement

- Is the parent educated as to the consequences that will result if the child’s condition is left untreated?
- Does the parent refuse to provide treatment for the child’s condition knowing that it will worsen over time?
- Will the lack of medical treatment cause permanent disability or disfigurement over time?

Step 1. Assessment: Assess Factors Resulting in Neglect



Step 2. Family/Cultural Issues: Assess Community, Family, and Cultural Issues

Is it possible that community, cultural or ethnic beliefs or practices that you are not familiar with are a factor in the parents' behavior?

However, keep in mind that preventing death, disability, or disfigurement of a child by medical treatment should take priority over parents' cultural or religious beliefs.

No →

Go to **Next Page**

Yes ↓

- Find someone in your agency knowledgeable about the family's culture before proceeding. Develop your understanding of how the family's beliefs, values, interests and concerns may differ from your own and affect their behavior before you assess needs or begin planning services. When you understand how your cultural views and the family's culture and beliefs affect your assessment of the family's issues and needs, it may also affect how you plan to remediate them.

- If no one is available within your agency to help you understand the family's culture and belief system, identify community or neighborhood representatives (e.g., community leaders, community-based organizations, religious leaders, etc.) who could assist you in assessing needs and planning for families within this culture and in understanding the values and beliefs of this cultural group.

Keep in mind that if community, cultural, or religious beliefs are causing the parents to refuse medical treatment for the child, and a child fatality, disability,

or disfigurement may result, you should act, in a **timely fashion**, to prevent death, disability, or disfigurement to the child.

Step 2. Family/Cultural Issues: Assess Community, Family, and Cultural Issues

Review family’s assessment of reasons behind medical neglect:

- Are there factors or issues identified by the family that were not identified by you?
- Is it possible that their assessment of the issues could be partially responsible for the medical neglect?
- Do they have any specific ideas about how to resolve the issues?
- Do any of their ideas seem reasonable?

- Can family members (including extended family) help implement any of the ideas?
- Can you help implement any of their ideas, either through development of the case plan goals, provision of services, or flexible funding?
- To the extent, you can reasonably include any of the family’s (including extended family) ideas in developing the case plan goals, services and interventions, you should do so as a high priority. **Remember they know each other better than you do.**



Identify and review family (including extended family) strengths:

- Identify the strengths that will help this family become independent from the child welfare system. (Include relationships, employment, education, personalities, skills, support systems, etc.).
- If the family’s issues and needs overwhelm their strengths, identify extended family members who could help support this family.

- Identify extended family strengths that could help this family become independent from the child welfare system.
- Consider **all** of the strengths identified, both of the family involved in medical neglect and of the extended family, in developing the case plan goals, services, and interventions. Plan specific steps to use to bolster family strengths. Rely on family strengths whenever possible to address issues. **Remember the strengths that you are successfully reinforce will remain with this family after your case is closed.**



When possible in service planning:

- Incorporate mechanisms to reinforce cultural strengths into the service plan for the child and family.
- Incorporate culturally specific supports and services into the service plan for the family.

- If treatment services are a part of the service plan, locate treatment providers that are aware of cultural factors and incorporate these factors into service provision.
- For all services that are part of the service plan, attempt to locate programs that are culturally sensitive and where language barriers do not impede service provision.

Step 3. Permanency Planning: For Native American Children, Keep ICWA Requirements in Mind as You Begin Planning

Determine the child’s Native American heritage — Is this child a member of a federally recognized Indian tribe, a child of a tribe member, or eligible for tribal membership?

No →

Go to **Next Page**

Yes ↓

Notify the tribal court that the child is the subject of an open child welfare case. Keep in mind that the Adoption and Safe Families Act (ASFA) requirements for timely

permanency do not supersede the requirements of the Indian Child Welfare Act (ICWA).

Regarding reasonable efforts:

ICWA requires that active efforts must be made to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family. Such efforts should “involve and use the available resources of the extended family, the tribe, Indian social services agencies, and individual Indian caregivers.” This requirement is for

Native Americans living both on and off of reservations. ASFA provides for efforts to prevent family breakup on a case-by-case basis. Your agency should consider ICWA legal standards for placement with extended family, other members of the child’s tribe, and other Indian families, before suspending active efforts to aid the family and before considering termination of parental rights (TPR).

Regarding termination of parental rights for American Indian children:

Parental rights may be terminated only where there is evidence beyond a reasonable doubt, including testimony of expert witnesses, that the continued custody of the child by the parent (or Indian custodian) is likely to result in serious emotional or physical damage to the child. Active

efforts to provide remedial services and rehabilitative programs designed to prevent the breakup of the Indian family must have been made before a termination of parental rights may be sought. Remember that failure to adequately utilize appropriate tribal, extended family, and community resources could trigger the “failure to provide services” exception in the TPR filing requirement.

Make sure your agency attorney reviews ICWA before filing any actions with the court regarding permanency for this child. Remember that any permanency plan developed for a Native American child which provides for an out-of-

home placement, including an adoptive placement, would be subject to the placement preferences in ICWA (which include placement with extended family, other members of the child’s tribe, and other Indian families).

Step 3. Permanency Planning: Keep in Mind ASFA Safety and Permanency Goals and Required Timelines as You Begin Planning

For healthy development, children need consistent care and a feeling of belonging in a safe, permanent home. To help ensure permanency for children, the federal Adoption and Safe Families Act (ASFA), requires an initial focus on child safety, then development of a permanency plan for each child within 12 months.

- Can immediate child safety be assured only by placing the child outside the home?

No →

Go to next step for identifying case goals and services. Ensure that plan includes supports for child safety at home. Include monitoring for child safety in plan.

Yes ↓

Begin permanency planning efforts immediately.

Develop a permanency goal and permanency plan for the child, in collaboration with the child’s parent(s).

- Involve the child’s parents, the child (generally if the child is 14 or older, and/or able to understand the situation), other relatives, or persons important to the child in the planning process.
- Do “concurrent” planning, that is, plan at the same time for the possibility of reunification of child and parent or finding an alternate permanent home for the child with relatives, through guardianship, or by adoption.
- Focus on child safety as the paramount goal, but make reasonable efforts to return the child home, unless the

parent has assaulted, seriously injured, or killed a child or another child of the parent or there are “aggravated circumstances” such that the child’s safety would be endangered by reunification. “Aggravated circumstances” not requiring reunification efforts include any listed in your state’s law and the following as defined by federal ASFA law: abandonment, torture, chronic abuse, or sexual abuse.

- Ensure that the child’s permanency plan includes: protection of the child’s health and safety, type and appropriateness of the child’s placement (see the Placement Level of Care guideline), any services to be provided to the child and reason, services to be provided to the child’s biological parents, foster parents, and identified permanency family.

Under the ASFA, federal law requires compliance with the following timelines to ensure permanency for children in the custody of state child welfare agencies. State law may be more restrictive.

- If reasonable efforts to return a child home are not being made due to aggravated circumstances, a court permanency hearing must be held within 30 days of placement.
- For every child in an out-of-home placement (including placement with relatives), a court permanency hearing must be held within 12 months of the date of the child’s first placement out of the home to determine the child’s permanency plan.

- If a child has been in placement for 15 out of the last 22 months, a court petition to terminate parental rights must be filed, unless:

1. A relative is caring for the child.
2. There is a documented compelling reason that termination of parental rights is not in the child’s best interests.
3. The state failed to provide the family with services, unless reasonable efforts to reunify the family were not required for the reasons listed above.

Step 4. Goals and Services: Identify Goals and Services

Case Type 1 - Serious Acute Illness or Injury

(any case where the child will die or be disabled if medical treatment is not provided immediately)

Goal 1

Ensure immediate emergency medical treatment for child.

With physician assistance, determine the immediacy of the need for treatment and the consequences if parental consent for treatment is refused. Is the consequence likely to be death or disfigurement of the child if emergency treatment is not provided?

No →

Go to
Case Type 2 or 3
Page 12

Yes ↓

Explain any needed emergency treatment to parents and the consequences of potential death, disfigurement, or disability of child if treatment is refused.



Does parent consent to emergency treatment after appropriate explanation?

No →

Work with physician and agency attorney to obtain court order for treatment.

Yes ↓

Obtain emergency treatment for child. Follow up to educate parents as to any additional treatment needs and to address cultural, financial, or logistical barriers to treatment.

Step 4. Goals and Services: Identify Goals and Services

Goal 2

Educate parents as to need for treatment.

Following emergency treatment, determine the reasons for parental refusal to consent to medical treatment for child. Is parent's refusal:

- Cultural? Or do language barriers prevent access to care?
- Financial?
- Fear as political refugees? Concern for immigration status?
- Denial of need for care?

Does it seem clear that parents can be educated as to the need for medical care and will follow through to ensure that the child receives care?

No →

Work with physician and agency attorney to obtain court order for treatment.

Yes

- Obtain further information from physician as to needed treatment and consequences if treatment is not provided, and explain this information to family.
- Respond to family's cultural concerns regarding treatment.
- If language barriers are impeding access to care or family's understanding of needed treatment, help to facilitate initial contacts with the provider or locate a provider

whose office can communicate with patients in the language needed to communicate with this family.

- Respond to family's concerns regarding political or legal ramifications of seeking treatment.
- Assist family through the treatment process.

Goal 3

Locate treatment resources and educate parents on how to access treatment.

- Locate community resources for low- or no-cost medical treatment and explain to parents how to comply and assist them to comply with requirements for access.
- Locate cultural resources for explaining needed medical care to parents and overcoming any language barriers,

and work with cultural program partners to educate parents as to needed treatment.

- Mediate with medical providers concerning parents' fear of political or immigration repercussions of seeking medical treatment for child.

Step 4. Goals and Services: Identify Goals and Services

Goal 4

Provide supports to enable family to access treatment.

- Determine if barriers such as transportation to medical facilities prevent parents from accessing care and arrange transportation services if needed.
- Determine if need for training in how to use equipment prevents parents from providing home care and arrange for training and/or home visit by medical personnel.
- Arrange for ongoing support for home care for child from other family members if possible and needed.

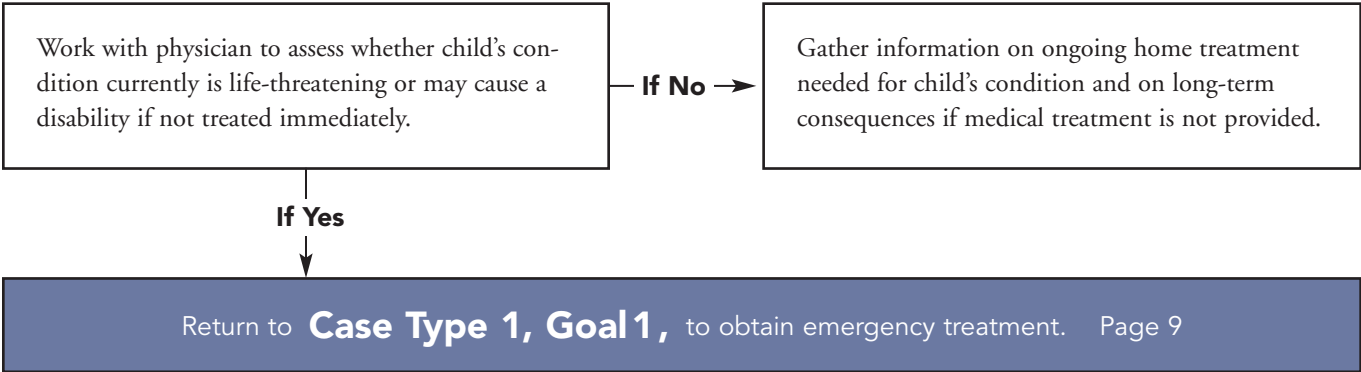
Goal 5

Ensure that child receives follow-up care if needed.

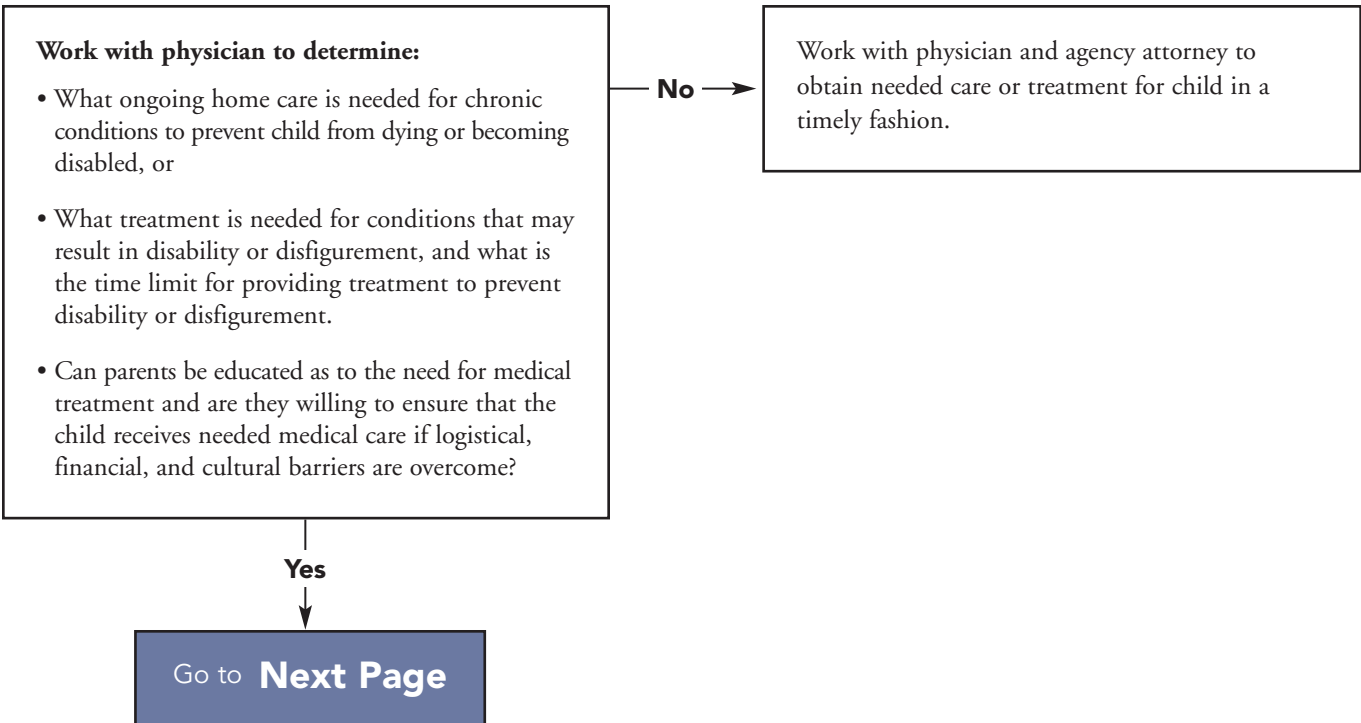
- If child is discharged with recommendations for ongoing or home care:
- Request that physician or clinic notify you if follow-up visits are not made.
 - If home care is recommended, work with family to educate on how to provide that care and monitor case for six months. Close case if care is provided.
 - If follow-up care or needed home care is not provided, return to Goal 1 to consider obtaining medical care for the child on an emergency basis by court order or placing the child out of the home to obtain needed care.

Step 4. Goals and Services: Identify Goals and Services

**Case Type 2 - Life-Threatening Chronic Diseases and
Case Type 3 - Chronic Diseases Which Can Cause
Disability or Disfigurement**



Goal 1 **Ensure that child receives needed medical treatment in a timely fashion.**



Step 4. Goals and Services: Identify Goals and Services

**Case Type 2
Life-Threatening Chronic Diseases**

Goal 2 Arrange ongoing treatment for child.

- Educate parents as to need for ongoing treatment.
- Educate parents as to how to provide home treatment.

**Case Type 3
Chronic Diseases That Can Cause Disability or Disfigurement**

Goal 2 Assure child's need for treatment is adequately addressed before disability or disfigurement occurs.

- Educate parent as to long-term, permanent consequences if medical treatment is not provided to child.

- Respond to parents' cultural or political concerns regarding treatment.
- Respond to financial barriers to treatment. (Explore eligibility for state children's health insurance program (SCHIP), Social Security disability (SSI), Medicaid,

EPSDT, and community resources for developmental disabilities if applicable.)

(See Case Type 1, Goals 2 - 5 above, for more detailed discussion of these steps.)

If parents continue to refuse to provide treatment for child, seek a court order for treatment and a permanent living arrangement for child (preferably with relatives

or kin) in which child's need for ongoing treatment will be met.

Step 5. Achieve Permanency: Assure Permanency and Family Stability

All Case Types

For all case types, assess the following:

- Are there community or cultural beliefs that can be reinforced to encourage medical treatment needed to prevent death, disability, or disfigurement (e.g., cultural tradition of caring for one's child)?
- Are there specific formal community or cultural programs, supports, or services that can be accessed to address the issues in this case (e.g., support or treatment resources for persons from this culture)?
- Does the family have informal community or cultural ties or resources, such as an extended kinship network or membership in a community of faith, that can be accessed to support the provision of necessary medical care?
- Are there community or family resources for overcoming language barriers (e.g., medical providers who speak the family's language, family members, or community service agencies who can provide interpretation or translation of medical information)?



Review Family Strengths:

- Is parent now educated, motivated, and able to provide child with emergency and ongoing medical treatment as needed?
- Are other adults in family willing and motivated to help ensure that child receives needed ongoing treatment?
- Does caregiver have friends, relatives, or community or cultural supports to call on for emergencies or problems or for surmounting language barriers?

No →

- Ensure that child receives needed medical treatment by court order if necessary.
- Seek an alternate permanent living arrangement for child with relatives willing to provide medical care.

Yes



- Assure monthly visits for six months to monitor that child receives needed medical treatment and follow-up care.
- Refer to Case Type 1 above if monitoring visits indicate that child continues to be refused medical care or child's condition is deteriorating due to insufficient care.

Notes

References

The Adoption and Safe Families Act. (Public Law 105-89).

Baker, D. R. (1999). *Iowa child welfare law: A manual for social workers (1999 Update)* (2d ed.). Washington, DC: American Bar Association.

The Indian Child Welfare Act. (Public Law 95-608).

National Endowment for Financial Education and American Humane Association. (2000). *Family money basics: Achieving financial well-being*. Denver, CO: National Endowment for Financial Education.

Pantell, R. H., Fries, J., & Vickery, D. (1990). *Taking care of your child: A parent's guide to medical care* (3rd ed.). Reading, MA: Addison-Wesley Publishing Company.

Schmitt, B., & Kempe, C. H. (1975). The pediatrician's role in child abuse and neglect. *Current Problems in Pediatrics*, 5, (3).

Smith, J. et. al. (1997). *Understanding the medical diagnosis of child maltreatment: A guide for nonmedical professionals* (revised, 2nd ed.). Englewood, CO: American Humane Association.

U.S. Department of Health and Human Services. (2002). *Child maltreatment 2000: 11 years of reporting*. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, Administration for Children and Families. (1998). *Principles for implementing the Adoption and Safe Families Act of 1997*. Washington, DC (unpublished flyer).

Winterfeld, A. (1998) An overview of the major provisions of the Adoption and Safe Families Act of 1997. *Protecting Children*, Volume 14, (3), pp. 4-8.

Participation in Focus Group to Develop Guideline

Pamela Boaz, Adams County (CO) Department of Human Services

Susie Kimble, Adams County (CO) Department of Human Services

Carrie McLoughton, Adams County (CO) Department of Human Services

Jody Perkins, Adams County (CO) Department of Human Services

Nancy Stowall, Adams County (CO) Department of Human Services

Sue Tripathi, Adams County (CO) Department of Human Services