Children with disabilities in the child welfare system:

A resource guide to enhance service delivery

By Perla Almonte Nucico
Contents

Acknowledgments ......................................................................................................................... 4
Summary ........................................................................................................................................ 5
Introduction .................................................................................................................................. 6

Part 1: Intersectionality of child disability and child welfare systems ........................................... 8
  Background .................................................................................................................................. 9
  Disability in Washington State .................................................................................................... 9
  Child disability in Washington State’s child welfare system ....................................................... 10

Models of disability in child welfare practice ............................................................................. 11
  Moral model ............................................................................................................................... 12
  Medical model ........................................................................................................................... 12
  Inspirational model ................................................................................................................... 12
  Social model ............................................................................................................................... 12

Prevalence of child maltreatment among children with disabilities ............................................. 13
Susceptibility and risk factors ...................................................................................................... 13
Maltreatment type by disability .................................................................................................... 14
Disability characteristics associated with child maltreatment .................................................... 15

Environmental risk factors ......................................................................................................... 16
  Poverty ....................................................................................................................................... 17
  Substance abuse ......................................................................................................................... 18
  Parents’ mental health ................................................................................................................ 18
  Parents’ history of childhood abuse ............................................................................................. 18
  Domestic violence ....................................................................................................................... 18

Trauma among child victims with disabilities ............................................................................. 19
Placement permanency of youth with disabilities ........................................................................ 20
Categories of disability ............................................................................................................... 20
  Orthopedic/mobility impairments ............................................................................................. 21
  Hearing impairments/speech impairments ............................................................................... 22
  Learning Disabilities ................................................................................................................ 22
  Developmental Disabilities ....................................................................................................... 23
  Mental Health/Psychiatric Disorders ......................................................................................... 23

Part 2: Information to recognize abuse and neglect of children with disabilities ........................... 24
  Recognizing abuse and neglect among children with disabilities .............................................. 25
  Possible indicators of physical abuse ......................................................................................... 26
  Possible Indicators of Emotional Abuse .................................................................................... 27
Possible Indicators of Sexual Abuse

Part 3: Case scenarios and recommendations for interviewing children with disabilities

Case study one: “Charlie”

Case study two: "Sofia"

Recommendations for interviewing children with disabilities in child welfare

Part 4: Washington State child welfare policies relevant to children with disabilities and special health care needs

Addressing disability in child welfare policies

Washington State Department of Children Youth and Families practices and procedures

Part 5: Implications and recommendations for practice, research, and policy

Implications for practice, research, and policy

Recommendations for practice

Recommendations for research

Recommendations for policy

Note: This resource guide was developed by Perla Almonte Nucico during her tenure at Partners for Our Children. While the guide may evolve further, we are excited to share this iteration of the work, as part of our continuing policy and research efforts at POC.
Acknowledgments

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I also want to acknowledge the strengths and resilience of people with disabilities and their caregiving families. As helping professionals, it is essential to remember the importance of empowering communities by understanding the conditions that result in social inequity and working collaboratively to create informed systems that can fit the needs of diverse families.

Sincerely,

Perla Almonte Nucico
Summary

Parents of children with disabilities are challenged with a wide range of needs that can be difficult to meet when multiple systems of care around them are disconnected, and those systems deprioritize the needs of children with disabilities. Ultimately, children may even become victims of the unresponsiveness of these systems. Children with disabilities are at increased risk for maltreatment and often experience delays in permanency as compared to other children in out-of-home care. While the causes of child maltreatment among children with disabilities vary, it is crucial that child welfare professionals are prepared to provide quality services that respond to the safety and well-being needs of children with disabilities. Partners for Our Children, together with the Department of Children, Youth, and Families and the Alliance for Child Welfare Excellence, advance social justice for the safety and well-being of all children, but especially for those most vulnerable and those whose lives intersect with the child welfare system.

The purpose of this guide is to support Washington’s child welfare professionals in serving children with disabilities and their families. Methods include a review of social work practice literature and stakeholder interviews with social work scholars and practitioners with extensive knowledge in disabilities and child welfare. Comprehensive knowledge of the intersection of child disability and child welfare is crucial to addressing maltreatment of children with disabilities and improving their safety, permanency, and well-being outcomes. This resource guide for child welfare professionals provides:

1. Background on the intersectionality of child disability and child welfare systems
2. Information to recognize abuse and neglect of children with disabilities
3. Case scenarios and recommendations for interviewing children with disabilities
4. Washington State child welfare policies relevant to children with disabilities and special health care needs
5. Implications and recommendations for practice, research, and policy

Overall, this resource guide aims to create awareness regarding the maltreatment of children with disabilities and to strengthen child welfare services to ensure the best outcomes possible for children with disabilities and their families.
**Introduction**

In general, “disability” refers to “a physical or mental impairment that substantially limits one or more major life activities.” However, disabilities are complex, and understanding disability requires distinguishing between social disablements and physiological impairments. Social disablements are everything that makes a person “disabled” based on social ideologies and attitudes such as prejudice, ableism, inaccessibility, and discrimination while physiological impairments are the features of a disability that limit a person’s ability to function according to social standards. Although significant progress has occurred throughout the past decades, much remains to be done to address the conditions that make people with disabilities more susceptible to social injustice. Understanding child disability as it relates to safety and well-being requires addressing the limitations that exist in data collection and research of child disability in child welfare.

**Limitations in data collection and research**

Because the meaning of disability has a broad range of implications that impact self-perception of disability identity and the social distribution of disability assistance benefits, the definition of disability is subjective across many contexts, making it difficult to create a uniform definition for research studies regarding the life conditions and outcomes of people with disabilities.

For instance, because disability identity is subjective and voluntary, research sampling depends on whether or not participants identify as disabled. Some people with disabilities may base their disability identity on their level of impairment, while others may base their identity on their lived experience. A key consideration to note is that the experiences often shape the identities of people with disabilities in society, such as experiences with stigma, bullying, and employment discrimination.

Legal definitions are set to determine eligibility for benefits and support from the state and the federal government. For this purpose, disability is defined based on whether or not an individual is considered “disabled enough” to benefit from social assistance benefits. People with

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disabilities are often undercounted in prevalence study efforts because many may not fit within the legal definitions of disability or have multiple disabilities but are counted under a specific category.

Variations in definitions, therefore, can affect data collection and result in uncertain prevalence rates of disability and disability life conditions, altering outcomes in research, policies, and practice.

**Data regarding the maltreatment of children with disabilities and child welfare service delivery**

Child maltreatment data in the United States have improved since the implementation of the Child Abuse Prevention and Treatment Act (CAPTA) in 1974 and its reauthorization in 2010. However, data regarding maltreatment of children with disabilities regarding their outcomes in child welfare are limited.

Addressing this gap in research is essential to improving service delivery for children with disabilities who come into contact with the child welfare system. Children with disabilities are at significantly high risk of child maltreatment, and therefore, it is crucial that professionals are aware of the implications that disability has on the lives of children and their families.

Even though the roles of child welfare professionals may vary, ensuring the safety and well-being of all children is a top priority of the child welfare system. A well-informed system that provides the workforce with effective tools to identify and prevent maltreatment of children with disabilities aligns with the overall mission and goals of assuring safety and well-being, preserving families, supporting family reunification, and permanency of children.

Effective child welfare practice must be reflected in a workforce that can conduct comprehensive investigations and assessments, interview effectively, make informed decisions, and be aware of the safety and well-being risks and needs of children with disabilities. We hope this guide enhances child welfare service delivery and improves the outcomes of children with disabilities by providing core knowledge and competency-based skills.

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Part 1: Intersectionality of child disability and child welfare systems
Background
People with disabilities of all ages are marginalized in many aspects of society. Stigma and social exclusion have silenced their life experiences and affected how society understands and responds to their needs. Safety and well-being are among some of the many issues affecting people with disabilities, including children. Demographic and social characteristics such as stigma, age, race, ethnicity, language, gender, and poverty are associated with high risk of maltreatment of children with disabilities. This high prevalence warrants the need to expand on the knowledge of child victims with disabilities and on the challenges that affect caregiving families.

Disability in Washington State
- People with disabilities made up 12.9% of the Washington State population in 2015
- Approximately 7% of those with disabilities were under 18 years of age (2015)
- The population of people with disabilities increased faster than the state’s general population, from 5.2% to 8.2%, irrespective of age (2011-2015)
- In 2015, people with disabilities made up 26% of the 636,654 Washingtonians living in poverty
- Poverty rates for people with disabilities is 19.5%, twice the rate of those without disabilities

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Child disability in Washington State’s child welfare system

In 2009, Partners for Our Children conducted a survey of parents served by Washington’s child welfare agency to understand family needs and service experiences. The study found the following:

- One-third of the 809 Washington parent participants had children with one or more special needs
- The most commonly reported special need was a mental health disability, with a rate of 59%

The same study analyzed parental risk factors associated with child maltreatment including domestic violence, childhood trauma, mental health disorders, and substance abuse and dependency. The results showed:

- 35% of parent participants reported experience with domestic violence
- 55% indicated childhood trauma
- 56% reported mental health disorders
- 29% reported substance abuse/dependency

Models of disability in child welfare practice

Models of disability are frameworks that affect society’s attitudes and approaches toward disabilities. They might change over time within families and depending on the context. Models of disability and how they are used in child welfare practice impact the interactions between child welfare professionals and the families of children with disabilities with whom they work, as well as how they understand the families’ experiences. Figure 1 provides a brief description and examples of four disability models.

Figure 1: Models of disability in the family context

<table>
<thead>
<tr>
<th>Disability Model:</th>
<th>Moral</th>
<th>Medical</th>
<th>Inspirational</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Underlying premises</strong></td>
<td>A historical model that associated disability with religious belief, sin, and shame</td>
<td>Perceives disability as an individual’s physical, mental, or health condition that needs to be treated or cured</td>
<td>Associates disability with inspiration for individuals who witness people with disabilities doing daily life activities or achieving accomplishments</td>
<td>Views disability as a physical or mental impairment that is not “standard.” Instead, disability is perceived as part of diversity and social identity</td>
</tr>
<tr>
<td><strong>Actions/attitudes associated with disability models</strong></td>
<td>Families would abandon, institutionalize, or hide their family members</td>
<td>Physicians have authority over the disabled person</td>
<td>Often used to motivate non-disabled individuals by using accomplishments of people with disabilities as inspiration with statements such as “if he can do it, so can you” or “what is your excuse?”</td>
<td>Addresses the environmental and social structures that limit a person’s ability to fully participate in society</td>
</tr>
<tr>
<td><strong>Examples of outcomes for children with disabilities</strong></td>
<td>Families would not seek adequate services for their family members as they would believe that they needed to accept “punishment” for their sins</td>
<td>Leads to classification and labeling of people based on their condition</td>
<td>Reinforces barriers that limit inclusion and equity</td>
<td>Parents and children understand disability as a social construct rather than a “personal issue” and might feel less shame and guilt</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Excessive compliments from parents/family members might put pressure on the person with a disability and limit normalization</td>
<td>Parents and children are able to identify social barriers and become self-advocates</td>
</tr>
</tbody>
</table>
Moral model
A moral model attributes disability to sin and other religious or moral punishments. 11 Although the moral model is cited less frequently in contemporary literature, individuals from older generations and other cultures can continue to carry beliefs that fit into this model. This model was formative in earlier practice and policies.

Medical model
The medical model typically views disability as something that needs a cure or medical intervention. Although some disabilities might have medical implications that require intervention, not all of them do. Many individuals with disabilities do not require health care specific to their disability. It is essential to understand this, as people with disabilities often suffer from lack of disability normalization in society. Lack of normalization is among the many barriers to full inclusion in the community. Disability is not monolithic, and people with disabilities have different needs and preferences just as everyone else does. 12

Inspirational model
The inspirational model associates disability with inspiration for non-disabled individuals who witness individuals with disabilities doing daily life activities or achieving accomplishments. Parents who overpraise their disabled children for accomplishing regular tasks might fit into this category. Disability advocates have noted the inspiration model as having adverse effects for disability communities because it prevents normalization and full inclusion of people with disabilities. This model is often used by people without disabilities to motivate themselves. 13

Social model
The social model challenges the medical model and views disabilities in terms of social and environmental barriers rather than a person’s impairment, because the implications of “disability” often create disadvantages such as restriction to normalization, full participation, or acceptance. Disability justice advocates widely use this model. 14

Reflection questions
What experiences have shaped your perception of disability? Can you recognize any of these models in your perception of disability? How can these perceptions affect the service you provide to children with disabilities and their families?

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Prevalence of child maltreatment among children with disabilities
Most parents of children with disabilities provide safe and nurturing care for their children. Nonetheless, research suggests that children with disabilities are three to four times more likely to be victims of abuse or neglect than children without disabilities, and up to one-quarter of disabled children will experience some form of violence during their lifetime.\(^{15}\)

The National Child Abuse and Neglect Data System (NCANDS) is a voluntary data collection system that gathers information regarding abuse and neglect trends in all states. In 2013, the annual report on abuse and neglect data from the 2012 NCANDS data pointed to child disability as a significant risk factor for abuse and maltreatment.\(^{16}\) Rates of child abuse and neglect from 50 states, the District of Columbia, and the Commonwealth of Puerto Rico collected for the 2012 NCANDS report also indicated that 13.3% of abuse and neglect victims had a disability, and 4.3% of victims had a medical condition that was not classified by NCANDS. The report noted that some victims had multiple disabilities but were counted in only one disability category. Additionally, the report indicated that 3.2% of victims had behavioral problems, and 2.5% had an emotional disturbance. These findings are important for a variety of child welfare efforts aiming to understand risk factors leading to maltreatment of children with disabilities, work toward prevention, and improve child welfare services.

Several risks factors intersect and result in higher susceptibility of abuse and neglect of children with disabilities. This section highlights critical risk factors of child maltreatment.

Susceptibility and risk factors
Children with disabilities experience higher vulnerability for abuse and neglect due to characteristics of disability that can affect their mobility or ability to communicate, recall information, and/or understand maltreatment. Different types of disabilities can be associated with different types of maltreatment and potential for ongoing victimization. Environmental risk factors associated with the child’s family and community around them, such as poverty, substance abuse in the family, parents’ mental health, parents’ history of childhood abuse, and domestic violence, are also associated with increased susceptibility. Some risk factors leading to the maltreatment of children with disabilities are similar to those affecting children in the general population, including parental stress. However, families of children with disabilities face unique challenges that may cause additional stress. This section highlights the common risk factors that influence abuse and neglect. By becoming aware of the susceptibility for abuse and neglect among children with disabilities, child welfare professionals can expand their critical thinking.


skills to conduct practical assessments to ensure safety and well-being. Please be aware that many of these risk factors often co-occur and interrelate.

**Maltreatment type by disability**

While children with disabilities generally experience increased rates of all types of maltreatment, certain characteristics of disability impact the type of maltreatment a child will experience. Nonetheless, neglect is the most common type of maltreatment among children with and without disabilities.\(^{17}\) Data from the 2017 NCANDS report found that 74.9% of all child maltreatment cases were related to neglect.\(^{18}\) Failure to provide adequate medical care can result in serious harm for children with special health care needs. Therefore, it is important to consider that children with disabilities that require ongoing medical treatment and follow-ups, especially young children and those with lower levels of functioning, may be at higher risk of being neglected.

Disabilities that manifest in difficult behaviors such as aggression, difficulty learning, inadequate social skills, low academic performance, hyperactivity, and excessive anxiety might have profound effects in the bonding relationship between parent and child. Parents may become stressed and respond to these types of behavioral patterns by using abusive forms of discipline.\(^{19}\) These behaviors are often severe and frequent throughout the developmental stages of a child. Children with disabilities who exhibit challenging behaviors may face unique challenges being understood. These behaviors may include Attention-Deficit/Hyperactivity Disorder (ADHD) or other learning and emotional disabilities. Parents, teachers, and child care providers may treat these children as willfully misbehaving and administer punishment or consequences.

Children with developmental disabilities (DD) and intellectual disabilities (ID) are more likely to become victims of sexual abuse. In general, sexual abuse rates are seven times higher among people with DD and ID than those without disabilities because perpetrators use their power to manipulate and take advantage, and believe that victims might not be able to testify against them.\(^{20}\) When working with children and youth with DD and ID, it is crucial to consider and watch for signs of this type of abuse, as they are likely more vulnerable. Figure 2 shows the types of child maltreatment that are commonly associated with different types of child disability.


Disability characteristics associated with child maltreatment

Disability should not be considered a direct cause of maltreatment. However, child welfare professionals should be aware that certain individual characteristics related to a disability may increase the risk for maltreatment and difficulty in identifying maltreatment or prosecuting perpetrators. This may result in ongoing abuse and neglect of children with disabilities.  

Children with language impairments are typically assumed to have intellectual delays. This assumption leads perpetrators to believe that their victims cannot understand the abuse. Child welfare professionals might also be unsure whether or not a child can testify if they assume intellectual delays in cases where the child cannot communicate. An essential recommendation for practice is to refer to children with language impairments as children who “do not speak,” rather than referring to them as “non-verbal.” The term “non-verbal” carries severe negative implications in case investigations and limits the existing strengths of the child. For instance, a child may be considered “non-verbal” because they cannot use verbal language to express...
themselves, but he/she may have other forms of communications such as sign language or simple gestures to indicate “yes” and “no.” Some children with autism and cerebral palsy may have severe communication barriers. In the case of children with autism, communication might be especially challenging, as they are often not able to match their words and emotions in a social context. They also tend to have difficulties understanding figurative or indirect language.

Children with intellectual disabilities or other impairments can have memory difficulties that limit their ability to report abuse and neglect. While they might recall significant events such as violent incidents, they may have difficulty remembering specific places, dates, and descriptive details. These language and memory limitations can affect interview processes and disclosure of maltreatment when child welfare professionals are not informed and prepared to provide accommodations.

Children with mobility impairments and high health care needs are often dependent on others for basic daily functioning, including help with eating, bathing, and toileting. Reliance on others may also limit a child’s ability to report abuse and neglect.

**Environmental risk factors**

Environmental factors such as poverty, substance abuse, parents’ mental health, parents’ history of childhood abuse, and domestic violence are associated with increased risk of abuse and neglect. While this may also be true for parents in the general population, caring for children with disabilities often requires specialized services, higher levels of supervision and care, and navigating systems that often fail to fit the needs of families with various backgrounds and needs. A combination of factors affect the lives of parents of children with disabilities and may create adverse effects on the child-parent relationship and the caregivers’ abilities to ensure safety and well-being.
Poverty
Poverty is a community factor that has severe implications on the safety and well-being of children with disabilities; therefore, it is important to emphasize its effects on the family. A strong indicator of the co-occurrence of poverty and family economic distress is the fact that families caring for a person with a disability have a greater dependence on means-tested benefits. Low-income families of children with disabilities are more likely to experience severe stress as a result of low socioeconomic status and limited access to services for both children and parents. Poverty conditions may limit opportunities for healthy coping strategies including access to services such as family counseling, support groups for parents of children with disabilities, adequate child care, access to health care, and opportunities for family recreational activities. Absence of coping strategies may severely compromise the emotional and mental health of parents.

A particular stressor linked to low economic status among parents is the potential inability to hold employment or further their education. The effects of economic stress among mothers might be more profound than the effects on fathers because mothers tend to take on more caregiving responsibilities. Intense caregiving responsibilities plus multiple barriers to employment, including limited access to proper child care, might increase parental stress among mothers of children with disabilities.

Child welfare professionals should also be aware of the prevalence of disability among Native American children and consider that they may be more vulnerable to being isolated from access to services, especially children who live on reservations. An important fact to consider: Data from 2017-2018 found that the rates for children served under the Individuals with Disabilities Education Act (IDEA) were the highest among Native American children, with 18% out of all children served.

**Substance abuse**

Substance abuse among parents of children with disabilities is also linked to maltreatment of children with disabilities, especially of boys. Disabilities and other health conditions such as Fetal Alcohol Syndrome and low birthweight are strongly associated with substance use and exposure during pregnancy. Infants who are born with a disability or health conditions from mothers with substance use disorders are particularly more likely to experience child neglect.\(^{27}\)

**Parents’ mental health**

It is important to emphasize that stress as a result of parenting children with disabilities is commonly associated with increased risk for child maltreatment. However, existing mental health conditions might also create significant limitations in a parent’s ability to provide safe nurturing care for their child(ren). A recent study exploring child protection decisions involving parents with mental illness and substance abuse concerns found that parents with serious mental health disorders are more likely to have their children placed in out-of-home care. The study identified three main safety threat concerns that can lead to placing children out-of-home: Caretaking impairment due to emotional stability, developmental status, or cognitive deficiency; failure to meet a child’s immediate needs; and threats of harm. \(^{28}\)

**Parents’ history of childhood abuse**

While not all parents who experience childhood maltreatment become perpetrators, parental experiences of family abuse increase a child’s risk of being maltreated. Specific factors such as substance abuse, stress, anxiety, and depression can influence abusive behavior in parents with an existing history of childhood abuse. \(^{29}\)

**Domestic violence**

Domestic violence is also a common indicator of child abuse and neglect. Parents who experience intimate partner violence are more likely to use physical punishments as a form of discipline.


Parent victims might also be isolated, which makes domestic violence and child maltreatment more challenging to identify and report.30

**Trauma among child victims with disabilities**

Child welfare professionals should be aware of the trauma effects of maltreatment among children with disabilities. Because children with disabilities are more likely to experience ongoing abuse and neglect, the consequences of trauma can have severe adverse effects on the child’s development. Complex trauma can affect brain development, especially among young children, and can result in severe behavioral, emotional, and mental disorders.31 These effects can further affect a child’s ability to function, including their ability to understand maltreatment and process trauma. Child welfare professionals should also be aware that children with disabilities tend to be socialized to be compliant with authority figures and may not want to report maltreatment due to fear of repercussions.32

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Placement permanency of youth with disabilities

It is important, then, that child welfare professionals not only ensure the safety of children with disabilities, but work to create sustainable well-being. An essential aspect of well-being for children with disabilities in child welfare is placement stability. Youth with disabilities in out-of-home care face more challenges to permanency than all other children in the child welfare system. These challenges include longer stays in placement, lower likelihood to be reunified with their families, higher rates of adoption disruption, and a higher risk of being placed in out-of-home care, such as in a group home or an institution. Placement stability of youth with disabilities is crucial to ensuring a successful transition to adult life. However, collaboration among multiple systems of care is required to improve placement outcomes. Below is a list of recommendations for child welfare professionals to help improve permanency outcomes for youth with disabilities:

- Provide disability training for prospective adoptive parents
- Increase efforts to maintain natural support systems for children through extended family (as potential placements or support systems)
- Shift perspective on prospective parents from willingness to “fit” based on their capacity to care for a child with special needs
- Strengthen planning efforts for youth with disabilities by creating and implementing coordinated plans that include full disclosure of child’s disability and needs, post-adoption support, and planning for transition to adulthood
- Advocate for increased access to disability-competent mental health services
- Advocate for increased access to adoption and ensure respite care for adoptive families
- Provide access to training for parents on disability education that fits each family’s unique needs
- Provide access to social support groups for adoptive parents and youth

Categories of disability

The following section provides an overview of the different categories of disabilities with the purpose of expanding on the child welfare professional’s ability to identity disabilities and assess potential risks to safety and well-being. Please be aware that disabilities are complex and that a child might have multiple disabilities. Please also note that only certified medical or clinical professionals can diagnose disability.

**Orthopedic/mobility impairments**
Orthopedic/mobility impairments are physical disabilities that result from congenital disabilities, accidents, or progressive diseases that can have physical effects on the child’s body.  

<table>
<thead>
<tr>
<th>Types of disabilities</th>
<th>Safety and well-being risk factors to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cerebral palsy</td>
<td>Depending on the disability, children with orthopedic/mobility impairments might require intense levels of care from parents/caregivers. Children might be at higher risk of falling or physically hurting themselves. Children might need help taking medication or using specialized equipment. Meeting these needs would then be considered critical for the child’s safety and well-being.</td>
</tr>
<tr>
<td>• Spina bifida</td>
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<tr>
<td>• Spinal cord injury</td>
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<tr>
<td>• Post-polio syndrome</td>
<td></td>
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<tr>
<td>• Muscular dystrophy</td>
<td></td>
</tr>
<tr>
<td>• Multiple sclerosis</td>
<td></td>
</tr>
<tr>
<td>• Limb amputations</td>
<td></td>
</tr>
</tbody>
</table>

**Children might experience:**

- Physical pain
- Lack of coordination
- Lack of ability to stand, walk, and/or use limbs
- Need for help bathing, using the bathroom, feeding, and dressing
- Need for crutches, canes, braces, walkers, or wheelchairs
- Need for car seat even if the child is over the legal age or might require other specialized equipment
- Need for physical therapy

**Blindness/visual impairments**
Blindness or severe vision impairments that are not correctable might cause daily life limitations for children.  

<table>
<thead>
<tr>
<th>Types of disabilities</th>
<th>Safety and well-being risks factors to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Total blindness</td>
<td>Legally blind or partially blind children might be at higher risk of being physically injured, especially younger children. The dangers to consider might include, but are not limited to:</td>
</tr>
<tr>
<td>• Partial blindness</td>
<td></td>
</tr>
<tr>
<td>• Childhood blindness</td>
<td></td>
</tr>
<tr>
<td>(commonly caused by optic-nerve hypoplasia)</td>
<td></td>
</tr>
<tr>
<td>• Deaf-blindness</td>
<td></td>
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</tbody>
</table>

- Fire/burn injuries
- Tripping
- Injuries from running into the sharp-edged furniture
- Need for school accommodations and need for particular skill development training programs

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### Hearing impairments/speech impairments

Hearing loss affects the child’s ability to develop speech and social skills. Hearing loss might also affect speech development, but not all speech disorders are related to hearing loss.

<table>
<thead>
<tr>
<th>Types of disabilities</th>
<th>Safety and well-being risks factors to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Total deafness</td>
<td>Children with hearing impairments might experience:</td>
</tr>
<tr>
<td>• Sensorineural hearing impairment (most common)</td>
<td>• Difficulty developing skills and social skills</td>
</tr>
<tr>
<td>• Deaf-blindness</td>
<td>• Higher risk of becoming victims of sexual abuse due to factors such as difficulty communicating with professionals</td>
</tr>
<tr>
<td>• Language disorder/language delay/developmental dysphasia</td>
<td></td>
</tr>
</tbody>
</table>

### Learning Disabilities

Learning disabilities are disorders that affect a person’s ability to learn in different areas. Some learning difficulties include, but are not limited to: trouble processing thoughts, understanding abstract ideas, math, reading comprehension, paying attention, etc.

<table>
<thead>
<tr>
<th>Types of disabilities</th>
<th>Safety and well-being risks factors to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Dyslexia (difficulty reading)</td>
<td>• Higher risk for becoming victims of sexual abuse</td>
</tr>
<tr>
<td>• Dyscalculia (difficulty with math)</td>
<td>• Higher risk of physical abuse as a form of discipline (especially for children with behavioral problems)</td>
</tr>
<tr>
<td>• Dysgraphia (difficulty writing)</td>
<td>• Higher risk of emotional abuse</td>
</tr>
<tr>
<td>• Central auditory processing disorder</td>
<td>• Increased risk of severe injuries</td>
</tr>
<tr>
<td>• Nonverbal learning disorders</td>
<td></td>
</tr>
<tr>
<td>• Fragile X syndrome (FXS)</td>
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Developmental Disabilities

Developmental disabilities are conditions that affect physical, mental or both types of development. This can include intellectual disabilities and other physical disabilities.\(^47\)

<table>
<thead>
<tr>
<th>Types of disabilities</th>
<th>Safety and well-being risks factors to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Down syndrome</td>
<td>Higher risk of abuse and neglect, especially among younger children with behavioral problems or when other ecological factors exist such as low socio-economic status and parental stress</td>
</tr>
<tr>
<td>• Autism spectrum disorder</td>
<td></td>
</tr>
<tr>
<td>• Cerebral palsy</td>
<td></td>
</tr>
<tr>
<td>• Fetal alcohol spectrum disorders</td>
<td></td>
</tr>
<tr>
<td>• Hearing loss, blindness, and speech disorders</td>
<td></td>
</tr>
<tr>
<td>• Muscular dystrophy (^48)</td>
<td>• Depending on the specific type of disability, a child might require medical treatment and specialized services</td>
</tr>
</tbody>
</table>

Mental Health/Psychiatric Disorders

Mental health disorders severely affect the child’s ability to learn, behave, and handle emotions.\(^49\)

<table>
<thead>
<tr>
<th>Types of disorders</th>
<th>Safety and well-being risks factors to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anxiety</td>
<td>As children who come into contact with the child welfare system, it is essential to consider several trauma effects that might relate to the child’s mental health conditions. Some abuse and neglect risk factors to consider include:</td>
</tr>
<tr>
<td>• Depression</td>
<td></td>
</tr>
<tr>
<td>• Oppositional defiant disorder (ODD)</td>
<td>• Behavioral problems related to mental health might increase the child’s risk for abuse</td>
</tr>
<tr>
<td>• Conduct disorder (CD)</td>
<td>• ADHD, behavioral issues, anxiety, and depression are the most common mental health disorders among children in the U.S. (^50)</td>
</tr>
<tr>
<td>• Attention-deficit/hyperactivity disorder (ADHD)</td>
<td></td>
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<tr>
<td>• Tourette syndrome</td>
<td></td>
</tr>
<tr>
<td>• Obsessive-compulsive disorder (OCD)</td>
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</tr>
<tr>
<td>• Post-traumatic stress disorder (PTSD)</td>
<td></td>
</tr>
</tbody>
</table>

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Part 2: Information to recognize abuse and neglect of children with disabilities
Recognizing abuse and neglect among children with disabilities

This section is intended to provide child welfare frontline workers with signs and considerations to help them recognize maltreatment of children with disabilities. The following section includes possible indicators of maltreatment.

Please consider the following:

- The signs of maltreatment among children with disabilities are the same as those for children in the general population
- Abuse and neglect often co-exist in children with and without disabilities
- Not all parents/families of children with disabilities abuse or/and neglect their children
- Other signs of abuse and neglect may exist
- Signs can, and often do, overlap with various types of abuse and neglect
- Disability makes children more vulnerable to becoming victims of abuse and neglect

This guide should not be used to replace medical consultation, supervisory decision-making, or a comprehensive child safety assessment.
### Possible indicators of physical abuse

<table>
<thead>
<tr>
<th>Physical signs in child/youth</th>
<th>Behavioral signs in child/youth</th>
<th>Behavioral signs in parents/caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Bruises or welts in unusual parts of the body or unusual patterns</td>
<td>□ Cannot explain or recall how injuries occurred</td>
<td>□ Domestic violence</td>
</tr>
<tr>
<td>□ Bruises in various stages of healing</td>
<td>□ Frequently complains of headache or stomachache</td>
<td>□ Substance abuse</td>
</tr>
<tr>
<td>□ Bruises in specific shapes such as handprints or belt marks</td>
<td>□ Is violent to animals or other children</td>
<td>□ Childhood trauma</td>
</tr>
<tr>
<td>□ Unexplained or multiple broken bones</td>
<td>□ Is dressed inappropriately to hide bruises or other injuries</td>
<td>□ Denies the existence of problems/ concerns with child</td>
</tr>
<tr>
<td>□ Unexplained burns</td>
<td>□ Dislikes or shrinks from physical contact</td>
<td>□ Shows little concern.</td>
</tr>
<tr>
<td>□ Unexplained bite marks</td>
<td>□ Cries or complains about not wanting to go home</td>
<td>□ Perceives child as a burden, problem, or as bad</td>
</tr>
<tr>
<td>□ High sensitivity to pain or complains of soreness</td>
<td>□ Seems withdrawn or depressed</td>
<td>□ Doesn’t respect boundaries or listen when the child says “no”</td>
</tr>
<tr>
<td>□ Bald spots from hair pulling</td>
<td>□ Seem afraid of certain people.</td>
<td>□ Demands a level of physical or academic performance the child cannot achieve</td>
</tr>
<tr>
<td>□ Head injuries</td>
<td>□ Frequent missed medical appointments or has not received medical care brought to the parents/caregivers’ attention</td>
<td>□ Look primarily to the child for care, attention, and satisfaction of their own emotional needs</td>
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<tr>
<td></td>
<td></td>
<td>□ Uses harsh physical discipline with the child</td>
</tr>
</tbody>
</table>
### Possible Indicators of Emotional Abuse

<table>
<thead>
<tr>
<th>Emotional/ Behavioral signs in child/youth</th>
<th>Behavioral signs in parents/caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sudden behavior change</td>
<td>Constantly blames, belittles, or berates the child</td>
</tr>
<tr>
<td>Seems depressed or angry</td>
<td>Inconsiderate about the child’s needs and emotions, and refuses to consider offers of help for the child’s problems</td>
</tr>
<tr>
<td>Difficulty paying attention</td>
<td>Overtly rejects the child</td>
</tr>
<tr>
<td>Withdrawn</td>
<td>Expresses negative feelings about the child's disability</td>
</tr>
<tr>
<td>Anxious or agitated</td>
<td>Perceives child or child’s disability as a burden</td>
</tr>
<tr>
<td>Sleep problems</td>
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<tr>
<td>Changes in eating habits</td>
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</tr>
<tr>
<td>Self-harm</td>
<td></td>
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<tr>
<td>Thinks negatively about self or displays signs of low self-esteem</td>
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<tr>
<td>Overly-affectionate towards strangers or people they haven’t known for very long.</td>
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<tr>
<td>Lacks social skills</td>
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<tr>
<td>Has no/ few friends</td>
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<tr>
<td>Extreme outbursts/ difficulty controlling emotions</td>
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<tr>
<td>Obsessive behavior</td>
<td></td>
</tr>
</tbody>
</table>
### Possible Indicators of Sexual Abuse

<table>
<thead>
<tr>
<th>Physical signs of sexual abuse in child/youth</th>
<th>Behavioral signs in child/youth</th>
<th>Behavioral signs in parent/caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Has difficulty walking or sitting</td>
<td>□ Reports of sexual abuse by a parent or another adult caregiver</td>
<td>□ Engages in touching that a child or child’s parents/caregiver have indicated is unwanted</td>
</tr>
<tr>
<td>□ Becomes pregnant or contracts a venereal disease, particularly if under age 14</td>
<td>□ Suddenly refuses to change for gym or to participate in physical activities or refuses to remove clothes to change or bath</td>
<td>□ Tries to be a child’s friend rather than filling an adult role in the child’s life</td>
</tr>
<tr>
<td>□ Presents signs of trauma to the genital area, such as unexplained bleeding, bruising, or blood on the sheets/clothes</td>
<td>□ Reports nightmares or bedwetting</td>
<td>□ Does not seem to have age-appropriate relationships</td>
</tr>
<tr>
<td></td>
<td>□ Experiences a sudden change in appetite</td>
<td>□ Spends time alone with children outside of their role in the child’s life or makes up excuses to be alone with the child</td>
</tr>
<tr>
<td></td>
<td>□ Shows sexual behavior that is inappropriate for the child’s age</td>
<td>□ Expresses unusual interest in child’s sexual development, such as commenting on sexual characteristics or sexualizing normal behaviors</td>
</tr>
<tr>
<td></td>
<td>□ Runs away</td>
<td>□ Gives a child gifts without occasion or reason</td>
</tr>
<tr>
<td></td>
<td>□ Attaches very quickly to strangers or new adults in their environment</td>
<td>□ Spends a lot of time with your child or another child you know</td>
</tr>
<tr>
<td></td>
<td>□ Frequently complains of headache or stomachache</td>
<td></td>
</tr>
<tr>
<td></td>
<td>□ Does not want to be left alone with certain people or being afraid to be away from primary caregivers, especially if this is a new behavior</td>
<td></td>
</tr>
</tbody>
</table>
Part 3: Case scenarios and recommendations for interviewing children with disabilities
Case study one: “Charlie”
Charlie is a 12-year-old male and was reported by his teacher to CPS. His teacher decided to call CPS after witnessing that on several occasions, Charlie waited in the rain for several hours for his family to pick him up after school. While waiting, Charlie told his teacher that his mom always picks him at 3:30 p.m. outside school. When the teacher reminded Charlie that it was a half-day and asked him to come inside to call his mom, he refused and said he did not want to get in trouble. The teacher called and spoke with Charlie’s mom, who apologized and said that Charlie “has issues.” Charlie’s mom arrived several minutes later and appeared upset with Charlie. After speaking with the teacher, CPS learned the following information about Charlie:

- During the winter, Charlie often comes to school without a coat. When asked to bring a coat to school, he insists that he is not cold.
- Charlie’s clothes are often dirty or inside out.
- Charlie has come to school several times this year without his lunch and refuses to buy lunch from the cafeteria.
- Charlie’s teacher reported that Charlie had several outbursts in the cafeteria and at assemblies this year. During these outbursts, Charlie often runs away, screaming and then hides.
- Charlie is quiet in class and occasionally talks to himself under his breath.
- Charlie is teased in class and has been in two fights this year.

Discussion questions:

1. As the caseworker, what conclusions would you draw from the information above?
2. Does this sound like a case of child neglect?
3. What next steps do you think would be appropriate?

When you meet with Charlie’s mom to investigate, she explains that Charlie is on the Autism Spectrum and you learn the following information:

- Charlie’s mom is teaching Charlie how to become more independent.
- Charlie’s mom is a single parent and cannot afford therapy or respite services for Charlie. She recently started a new job and is working mornings, so Charlie has to get ready for school on his own.
- Charlie has begun to dress himself and pack his lunches, but he is still learning and making occasional mistakes like wearing dirty clothes or forgetting to bring his lunch.
- Like some people on the autism spectrum, Charlie processes sensory information differently. Charlie has a hypersensitivity to noise and is unable to filter out irrelevant sounds, which makes the loud cafeteria and assemblies an overwhelming experience.
for him. Recently Charlie started eating his packed lunch outdoors and avoiding the cafeteria altogether. However, when he forgets his lunch, he is too disturbed by the loud cafeteria to buy lunch.

- Charlie depends on routine to make sense of the world around him. He often does not like making changes such as wearing a coat during inclement weather or telling his mom to pick him up early from school. Charlie will occasionally lie or keep information from his mom to help maintain the stability of his daily habits. This school year, Charlie started hiding the school calendar from his mom so that he does not have to go home early on half days.

**Discussion questions:**

1. How did this additional information change your perception of the case and the appropriate next steps?
2. What are priority safety and well-being issues to address?
3. What are other potential safety and well-being risks to discuss with the parent?
Case study two: "Sofia"

Sofia is a seven-year-old female who was reported to CPS investigators for potential neglect. Sofia has Down syndrome and her pediatrician called CPS after her family missed several appointments and unsuccessful attempts to contact the child’s parents. After speaking with the doctor and her parents, you learn the following information:

- Shortly after being born, Sofia had to have heart surgery.
- Nine months ago, Sofia's family was informed that she is having heart issues again. Sofia's pediatrician has referred her to a cardiologist for an urgent appointment. Since then, Sofia's family has not gone to the cardiologist and has stopped coming into their scheduled appointments with Sofia's pediatrician.
- Sofia's parents live in a rural neighborhood, have low income, and large amounts of medical debt from Sofia's health needs.
- Aside from the special education, Sofia receives at school, she and her family do not access any other disability resources.
- Sofia's mom doesn't talk to Sofia about her disability, and she claims that Sofia's health issues are "their fault."
- Sofia has several large bruises on her arms, but her parents state that she just bruises easily and probably got them on the playground at school.

When you meet with Sofia, she appears uncomfortable with answering your questions and repeatedly doesn't answer. Sofia seems scared and unsure throughout the interview. You continue to ask Sofia questions, and she eventually yells, "I don't know!" At the end of the interview, you have gained no new information.

**Discussion question:**

1. How could you have made Sofia feel safe during the interview?
2. Could you have included an adult she trusts in the interview process?
3. How do you respond to signs of abuse when the child has a limited ability to self-report or articulate their experience?
4. Medical expenses and guilt about Sofia's disability are significant causes of possible neglect. How can you help Sofia’s family better understand her disability and issues threatening Sofia’s health?
Every child with a disability is unique in how their disability influences their life. Don’t be afraid to ask questions and try to gain as much knowledge and context as possible about their disability and who they are.
Recommendations for interviewing children with disabilities in child welfare

Many children with disabilities are reluctant to disclose maltreatment for many reasons, including intimidation, dependency needs, and social isolation. As mentioned in part 1 of this resource guide, children with specific disability characteristics such as language limitations, memory difficulties, and perceived intellectual delay have a lower probability of reporting maltreatment, often resulting in unreported or non-prosecuted cases.  

When interviewing children with disabilities that affect their ability to communicate or understand complex communication, keep in mind the following considerations:

- Introduce yourself and role in an age-appropriate way.
- Use direct language: avoid the use of figurative language and leading questions.
- Simplify conversations so that the child can easily understand your questions and statements. Rephrase questions if the child doesn’t understand.
- Be patient. Allow children time to clarify, remember details, and respond.
- Do not assume intellectual delays unless you have enough facts.
- Redirect the child’s attention. Certain disability can cause obsessive behavior resulting in the child’s compulsive focus on one specific topic. Be patient and redirect the child back to the purpose of the interview as many times as necessary.
- Some disabilities might cause limitations when the child relies on routines. For instance, children with certain disabilities such as Autism might become confused when visiting places that they are not used to visit. In such cases, children might get “mentally stuck.” Redirect the child by asking them to do simple tasks like saying their names or asking them what they did after waking up.
- For children who can’t speak: gather information regarding any types of communication, including communication devices and sings. Some children might only be able to use hand gestures to indicate “yes” and “no.” In such cases, closed-ended questions might allow you to gather necessary information.
- A useful technique to interview children with closed-ended questions is first to ask them questions to rule out broader circumstances and then narrow down to more specific questions. Asking “what, how, when, and where” closed-ended questions might facilitate this task. Appropriate training on interviewing children who don’t speak through closed-ended questions is highly recommended.

Part 4: Washington State child welfare policies relevant to children with disabilities and special health care needs
Addressing disability in child welfare policies

Research has identified that there are multiple needs of children with disabilities who come into contact with the child welfare system. Achieving safety and well-being outcomes for children with disabilities in child welfare is impacted by systemic challenges that result from a lack of supportive state and federal policies for children and families with multiple additional identities. Nonetheless, child welfare professionals’ awareness of existing child welfare policies that might assist in cases involving children with disabilities and high health care needs might increase successful outcomes for children and families. This section provides a glance at a few Washington State child welfare policies that are relevant to children with disabilities and special health care needs. Please be aware that Washington’s child welfare system is complex, and there might be many other relevant policies not mentioned in this guide. The purpose of presenting the following policies is to create awareness of specific points in child welfare cases in which policies might assist address the needs of children with disabilities and health care needs. Please see section 5 for policy recommendations.

Washington State Department of Children Youth and Families practices and procedures

<table>
<thead>
<tr>
<th>Policy</th>
<th>Disability Context</th>
<th>When to use</th>
<th>Resource</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1110. Present danger</strong></td>
<td>Include disability risk factors if you can determine that child is disabled and use this to assist your immediate danger assessment</td>
<td>All programs at any time, when present danger is identified</td>
<td><a href="https://www.dcyf.wa.gov/sites/default/files/pdf/PresentDangerGuide.pdf">https://www.dcyf.wa.gov/sites/default/files/pdf/PresentDangerGuide.pdf</a></td>
</tr>
<tr>
<td><strong>1130. Safety plan</strong></td>
<td>Ensure that the safety plan identified and addressed any safety threats related to any identified child disability, special needs, and the home environment</td>
<td>When a child is identified as unsafe and either: Remains in the home; is returned home by a court order; or is returning home when the safety threats can be managed or controlled in the home</td>
<td><a href="https://www.dcyf.wa.gov/1100-child-safety/1130-safety-plan">https://www.dcyf.wa.gov/1100-child-safety/1130-safety-plan</a> <a href="https://www.dcyf.wa.gov/sites/default/files/pdf/SafetyThresholdHandout.pdf">https://www.dcyf.wa.gov/sites/default/files/pdf/SafetyThresholdHandout.pdf</a></td>
</tr>
<tr>
<td>1140. Family Assessment</td>
<td>When gathering information to gain understanding of the family’s strengths, needs, and resources that affect a child’s safety, well-being, and permanency, be sure to ask questions regarding any existing disability in the child or special needs concerns. Guiding questions are provided in part III of this guide</td>
<td>When conducting an assessment of the family</td>
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</tr>
<tr>
<td>43092. Child Health and Education Tracking (CHET)</td>
<td>The CHET program is responsible for identifying each child's long-term needs at initial out-of-home placement by evaluating his or her well-being. The results of the evaluation are used to develop an appropriate case plan and assist in placement decisions</td>
<td>Children’s Administration (CA) CHET screeners are responsible for conducting CHET assessments when the child is expected to stay 30 days or more, within the first 30 days of the child’s initial placement date</td>
<td></td>
</tr>
<tr>
<td>43105. Extended Foster Care Program <em>(For Youth with Disabilities)</em></td>
<td>When a youth is disabled, the caseworker MUST coordinate with the Developmental Disabilities Administration (DDA), the youth’s assigned Court Appointed Special Advocate (CASA)/Guardian Ad Litem (GAL), attorney and court to assist the youth with the decision to enroll in the EFC program</td>
<td>When supporting eligible youth between the ages of 18 and 21 in a successful transition to independence</td>
<td></td>
</tr>
<tr>
<td>Laws: RCW 13.34.267 RCW 13.34.268 RCW 74.13.020 RCW 74.13.031 RCW 74.13.336 RCW 74.15.020 PL 110-351</td>
<td>A list of further required procedures is listed in the website</td>
<td><a href="https://www.dcyf.wa.gov/4310-services-adolescents/43105-extended-foster-care-program">Website links</a></td>
<td></td>
</tr>
</tbody>
</table>
Part 5: Implications and recommendations for practice, research, and policy
Implications for practice, research, and policy

Children with disabilities are at significantly increased risk for experiencing abuse and neglect and experiencing adverse conditions when they are involved with the child welfare system. However, a review of the literature suggests that not enough attention has been given to the needs of children with disabilities in the child welfare system and that there is a need to create collaborative systems and to improve efforts to ensure their safety and well-being outcomes.

Recommendations for practice

Child welfare professionals and other helping professionals, including medical providers and social service providers must use effective developmental screenings for children to assess disability as early as possible. Early identification and intervention are crucial health preventive measures. Early identification of disability can allow parents a better opportunity to find the services and resources necessary for their children. Practice must also be informed of the multiple factors that increase maltreatment risk of children with disabilities. Poverty must be considered a significant risk factor; however, parents should not be blamed for their socioeconomic status. Instead, practitioners should focus on understanding the effects of poverty on the family and on the child’s safety and well-being. Understanding poverty factors affecting the family might allow for better collaborations with families to help them find adequate services and supports. The need for cross-collaboration of systems that interact with families must be emphasized and addressed within agencies’ strategic plans. Improving cross-collaboration of service agencies can create significant advantages for families who struggle navigating disjointed systems.

Competency-based training models are crucial for strengthening child welfare professionals’ ability to provide adequate services. The Institute for Human Services (IHS) Ohio Child Welfare Training Program has a set of competencies that are specific to children with disabilities and special health care needs. Below is an overview of these competencies.

1. Ability to identify indicators of specific developmental disorders in children and adolescents:
   - Knows the characteristics and indicators of autism spectrum disorder, pervasive developmental disorder and Asperger’s syndrome, in children and youth.
   - Knows the early indicators of developmental disorders or delays in infants and very young children.
   - Understands how developmental disorders affect children’s physical, cognitive, social, and emotional development and functioning.
   - Knows how to use observation, interviewing, and developmental assessments to identify children who are developmentally delayed and to refer them for comprehensive assessment.

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2. Ability to provide case management and supportive services to families of children with developmental disorders:
   - Knows the types of services necessary to enable families to care for children with developmental disorders in their own homes.
   - Understands the cause and effect relationship between children’s developmental disorders and child maltreatment and the increased vulnerability of children with disabilities to maltreatment.
   - Understands the importance of respite care, support networks, and other supportive family services in sustaining families’ ability to care for their children at home.
   - Can monitor family situations to ensure the ongoing safety of children with developmental disorders at home or in out-of-home care.

3. Ability to identify and assess mental health problems in children and adolescents:
   - Knows the characteristics, behavioral indicators, and preferred treatments for mood disorders such as depression, bipolar disorder, and anxiety in children and adolescents.
   - Knows the characteristics, behavioral indicators, and preferred treatments for trauma and post-traumatic stress disorder (PTSD) in children and adolescents, and how children’s responses to trauma may be misdiagnosed indicators of mental illness or behavioral disorders.
   - Understands how mental health and behavioral disorders can affect the social, emotional, and cognitive development and functioning of children and adolescents.
   - Can prepare children and adolescents for psychological, psychiatric, and developmental assessments and, where appropriate, help them understand the findings.

4. Ability to provide and monitor treatment for children and youth with mental illness, emotional, or behavioral disorders:
   - Knows how mental illness or behavior problems in children and adolescents can increase their risk of maltreatment.
   - Knows the types of medications used to treat mental health problems in children and adolescents, their effectiveness, their side effects, and the risks of misuse or discontinuation.
   - Knows strategies to help parents and caregivers cope with the stresses of caring for children or adolescents with mental health and behavioral disorders.
   - Can mobilize and help access supportive community-based services, specialized out-of-home placements, financial resources, and respite care for families whose children or adolescents have mental illness or behavior problems.
Recommendations for research
Based on the observations made throughout the development of this guide, further research should expand on the implications of poverty as a factor of child maltreatment among children with disabilities. Poverty is a complex issue that can have adverse effects on the well-being of a family caring for a child with a disability. Poverty should be understood as an environmental factor that increases risk and as a family indicator of potential parental stress. More research is also needed to assess the needs of children with disabilities in tribal communities as they may be geographically isolated from services. Further research should also focus on creating tailored services for children with disabilities who have experienced trauma through maltreatment and disruptions in caregiving.

Recommendations for policy
There are several issues that must be addressed in policy in regards to children with disabilities in the child welfare system. The following are key recommendations that may warrant more attention. Policies addressing the needs of children with disabilities in child welfare should:

- Invest in prevention/early intervention to build parenting capacity and family support.
- Address the disproportional rates of child maltreatment among child victims with disabilities by strengthening child welfare investigation and creating more equitable justice processes to prosecute perpetrators of child maltreatment and prevent further victimization.
- Increase specialized services (including culturally-sensitive services) for children with disabilities and families of diverse backgrounds.
- Increase cross-systems coordination to improve communication between systems and prevent disruptions of social services for children during child welfare cases.
- Increase assistance with educational services, housing, and arrangement of health and mental services for youth with disabilities transitioning out of the system.

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