Child Abuse and Developmental Disabilities

Don Barriere, Ph.D., is an eloquent speaker. When he speaks, he talks of the pain. Born in 1930 of Lesban parents, Barriere knew the pain of poverty, malnutrition, and racial discrimination. But these were minor problems. Barriere was born with a hairless nose, no upper lip, and a large hole in the top of his mouth. In 1938 in rural North Dakota, no one offered anything to the Indian baby but a very crusty report (of the clinic's plate). Barriere could not talk.

When he was 9, the superintendent assured the boy's attendance. Here he was taught to call names like 'Donald Duck,' and lessons. Other children hit him, kicked him, and spat at him. Once a group of children tied him and beat him bloody. When he arrived home, his father was incensed and attacked him also, as punishment for being a victim. Everyone told him he could not live. Things stayed this way for many years. Barriere became a "juvenile delinquent," in trouble with the law.

Things only changed because of the love and intervention of one person, "the white woman" who took Barriere in, taught him to eat, taught him to talk, and arranged for his education. Barriere entered high school as the validation, obtained a bachelor's degree, became a master's in social work, and a Ph.D. in counseling. His accomplishments and awards and service took up to this.

In response to this need, NCPCA in partnership with Ronald McDonald Children's Charities (RMCC) has launched a model national child abuse prevention program. The program, HEALTHY FAMILIES AMERICA, is a replicable, a successful home visitor program operating in several states, which provides voluntary home visitation by a paraprofessional to all new parents, to the child's fifth birthday. RMCC has committed $1 million over three years, to help NCPCA reach as many families as possible to build a network of people and organizations who are willing to establish home visitor programs. Virginia will be participating in this effort to enhance support to parents. HEALTHY FAMILIES VIRGINIA is already off to a good start. In Fairfax County there is a Healthy Start program under way working with Hispanic mothers and their children and in Hampton, Va., there will be a pilot program starting this summer. Funding for the Hampton program will come from the General Assembly which appropriated $300,000 over two years as a result of a budget amendment sponsored by Senator Joseph V. Garfield Jr. VCAP looks forward to following the progress of this essential prevention program.

Spotlight: Seattle Rape Relief

Seattle Rape Relief’s Project Action provides assistance to victim/survivors with disabilities. Started in 1977, the project is one of the oldest efforts of its type. The project was funded by a federal grant until 1987. One focus of the project in 1979 was to create a curriculum on sexual assault prevention. This was one of the first sexual abuse prevention efforts developed for children with disabilities. It was piloted and tested extensively in King County, then disseminated. The project also trained teachers in over 35 school districts across the country. The project was discontinued for several years because of lack of funding. It was restored in 1990. Carolyn Paige, M.Ed., who is the current project coordinator, conducted the focus of the project. “We have expanded to serve a wider range of people with disabilities, while focusing primarily on people with cognitive disabilities and people who do not communicate verbally. We have also shifted the focus of our materials to reflect current best-teaching practices for children with cognitive disabilities,” she stated. “The children learned skills in an isolated, specific context, but did not practice the skills in a community context. In 1990, we are focusing on teaching skills in a variety of natural environments. We have reorganized and revised the entire curriculum and have made significant changes.”

The current project divides time between education and professional training and direct service. This year, we are planning to train therapists who already work with children with disabilities. We will train them about how to address the issues of sexual assault and provide appropriate counseling,” states Paige. “She notes that this approach were more effective than trying to train those who work with sexual assault survivors about children with disabilities. Paige comments, “It is not appropriate to refer a child with a disability to a sexual assault therapist who has no experience working with children with disabilities. They already know how a disability impacts a child’s life and how to individualize their counseling methods.”

The project also provides direct service through case coordination, assisting with investigations, crisis and short-term counseling, and medical and legal advocacy. Seattle Rape Relief is not a clinical facility and does not perform assessments or offer long-term counseling. The mission of professional training and case coordination is to provide legal and non-clinical staff. They are hoping to train institutional staff. Paige notes that a government-appointed task force is currently reviewing institutional abuse. The emphasis is on Washington State is to accomplish demonstration.

For more information, contact Seattle Rape Relief, PO Box 55383, Seattle, WA 98155. For information contact: Neta Baidenko.
Child Abuse and Disabilities
continued from page 1

of those who have remained in their own home. Thus, accurate statistics describing the prevalence of maltreatment of children with developmental disabilities do not exist (Richards, et al., 1989; Tharpeing, et al., 1990; Zippoli, 1986).

Disabilities in Abused Populations

Many studies of abused children report high rates of developmental disabilities in the child victims (Schilling, et al., 1986; Sullivan, et al., 1991). In 1977, GIS identified 29 percent of a group of 6,000 abused children as having developmental disabilities (Pacer Staff, 1985). Sandground, et al. (1974) found 23 percent of a sample of 60 abused children to be functioning in the retarded range. Another early study (Johnson & Morse, 1968) found an incredible 70 percent of 101 Denver cases to have physical or developmental deviations. Kline (1977) reported that abused and neglected children were three times more likely to require special education and related services than children not identified as abused or neglected (cited in Valentine, 1990).

In contrast to studies on clinical populations, national statistics do not reflect higher than expected percentages of developmental disabilities. Analyzing reports submitted by all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands, the National Center on Child Abuse and Neglect reported that 2.3 percent of abused children were mentally retarded, 1.9 percent had a physical handicap, and 1.8 percent were chronically ill (cited in Schilling, et al., 1986).

Why are percentages of children with disabilities so much lower in national data on found abused and neglected cases than in samples obtained for clinical research? One explanation for the low percentage of children with disabilities in national data is that they are not receiving the attention they need from child protective services (CPS) (Schilling, et al., 1986). Children with special needs would appear to need and deserve special attention from those responsible for protecting children. Yet, until recently, scant attention has been paid to the overlap between disabilities and abuse (Schilling, et al., 1986; Sullivan, et al., 1991).

Cammblin (1982) in a study of 50 states and the District of Columbia found that nearly two-thirds of the states do not provide information about "special characteristics" of child abuse victims. The remaining states varied in data collected and forms used for reporting, making it impossible to compare data from one state to another. Major studies by the American Humane Association, examining data from all states, have no reference to children with disabilities (Schilling, et al., 1986).

Many states separate child welfare services and services to children with developmental disabilities by housing responsibilities in different agencies. As a result of bureaucratic separation, CPS workers may regard remediation of children with special needs as the responsibility of mental health agencies (Schilling, et al., 1991).

Another roadblock to effective identification of abused or neglected children with disabilities is the education and training typically associated with CPS work. Few social workers, even those with graduate degrees, have taken formal coursework on developmental disabilities (Schilling, et al., 1991).

Why are Children With Disabilities at Greater Risk for Abuse or Neglect?

Garbarino, et al. (1987) have identified five broad categories of factors which increase risk of maltreatment. These are 1) characteristics that render the child untenable or difficult to care for; 2) stress, 3) parent vulnerabilities or a lack of personal resources to function as parents, 4) a master status relationship between adult and child that includes a devaluing pattern of interaction, and 5) a culture that fosters attitudes or actions conducive to maltreatment.

What are the effects of these attributes of the child on the likelihood of abuse? (Friedrich & Birmaher, 1976; Frolo, 1981; Hether, 1973; Sandground, et al., 1974). There are several factors associated with developmental disabilities which serve to increase the risk of victimization. The disability may increase physical contact with violent toileting, flossing and bathing (Cole, 1984/85). Condoned physical interactions can escalate into abuse.

The child with a disability is physically less able to defend himself (Garbarino, et al., 1987, Pacer, 1985) and may not understand that the care provider is doing something wrong (Cole, 1984/85; Pacer, 1985). Lack of knowledge is compounded in the case of sexual abuse, since children with disabilities often receive no or inadequate education about sexuality and are frequently excluded from programs designed to teach

abuse prevention skills (Sean, 1988; Sullivan, et al., 1991; Tharpeing, et al., 1990). Some are very compliant due to a need to be valued (Tharpeing, et al., 1990). Abuse can lead to a sense of social powerlessness (Cole, 1984/85; Sean, 1988). Life-long dependency can render a child more trusting and less likely to question (PACER, 1985; Sean, 1988; Tharpeing, et al., 1990).

Certain behaviors may elicit an abusive response from caregivers. For example, children with neurological dysfunction can be characterized by "high-pitched, disagreeable screaming" (Nichtsmin, 1973, as cited in Frolo, 1981). Excessive crying has been cited as a trigger for abuse in numerous studies (Murray, 1979; Weston, 1968 cited in Frolo, 1980). Frolo and her colleagues (1981) have demonstrated empirically that cries of premature infants (who are more likely to have a developmental disability) are especially aversive. Additionally, children with developmental disabilities may lack behaviors that normal children use to attract caregiving and attention. (Frolo, 1980; 1981; 1985; Valentine, 1990; Garbarino, et al., 1987). Because of impaired levels of functioning, these children may not respond to ordinary expressions of affection (Lewis, 1983). One of the rewards of childrearing is to witness the child's growth through developmental stages. The child with disabilities, in contrast, can be "forever vulnerable" and never capable of self-care.

Caution is noted in interpreting these studies. Garbarino points out that the child's disability plays some process role in maltreatment that has yet to be addressed empirically (Sullivan, et al., 1991). Additional research is needed that deals with the special needs. Most authors agree that the presence of a child with developmental problems is a family stressor. Parents are described as reactively angry, guilt-ridden, and denial of the birth of a child with a disability (Murphy, 1982). The special needs of this child are likely to require considerable expenditure of time and money with variable rates of progress. In short order, the family must learn about the child's disability and develop ways to cope. Services are not always available. Says Carol Burnham, a social worker who has adopted a child with disabilities, "We naively thought that the future would secure and easy, free from the trauma of the past." Burnham was "reduced

continued on page 4
to begging for services." In the past, access to services, such as health care, has been limited for this group due to their stigmatization.

The current focus is on understanding the intersection of mental health and other social determinants of health, such as poverty. The paper highlights the importance of addressing these issues in a comprehensive manner to improve outcomes for children and families. It suggests that through collaboration between different stakeholders, including mental health professionals, educators, and policymakers, we can work towards creating a more supportive and inclusive environment for children with mental health challenges. The document emphasizes the need for continued research and policy actions to address the barriers that prevent children from accessing the care they need.
The Respite Resource Project

The Respite Resource Project was established in 1988 to foster the development of respite services among families with children with developmental disabilities and chronic illnesses. Project activities have included the development of model respite programs, respite resource development, dissemination, and technical assistance.

Two model programs were developed and successfully replicated from 1988 through 1991. The Project's goal was to increase awareness of school-age siblings to determine whether such educational programs may be developed and implemented at the school level. The Respite Resource Project has received a three-year grant from 1991 through 1993. The project is continuing to support the development of respite care services through competitive grants, technical support for respite programs, dissemination of information, and state and local advocacy.

Several local programs are currently receiving grants to address a range of respite needs. The Virginia Beach Community Services Board is developing respite services for families of medically fragile children. A respite voucher system is being piloted by the ABC/Early Virginia. Theinning program, which matches families with trained volunteers, is provided through the Virginia Head Injury Foundation (VHID).

Department for Rights of Virginians with Disabilities
101 North 14th Street
17th Floor
Richmond, Virginia 23219
(804) 225-2842 (Voice and TDD)

The Management and Advocacy of the rights of persons with disabilities, through a community-based approach, which includes the development of policies and programs to improve public attitudes towards persons with disabilities. Services are provided at no charge.

First Steps
1-800-234-1464
A free service which answers questions about infant and toddler development. Provided by the Virginia Department of Health and the Virginia Department of Mental Health. Information on Substance Abuse.

Virginia Head Injury Foundation
3212 College Avenue, Suite 315
Richmond, Virginia 23220
(804) 374-VHIF

Head injury in children is a leading cause of death and disability in the United States. For families under the age of 14, over two million head injuries occur each year. Of these, over 100,000 result in serious and physical impairments which preclude them from respite care services. The Project is currently exploring the potential for developing a respite program for families of children with head injuries.
Child Abuse and Disabilities

continued from page 3

Starr, et. al., 1984). Various explanations for this finding have been offered. It may be that the seriously impaired child is identified as such and services are offered immediately, lowering risk of abuse. Another explanation is that parental expectations for mildly impaired children may be high because no disability or reason for poor performance is apparent.

In contrast, a study of institutionalized children with mental retardation found a greater degree of impairment in victims of abuse. In comparison to non-abused residents, abused residents exhibited more aggressive and self-injurious behaviors, were younger, had lower verbal quotients, less verbal ability and had more ambulation ability (Rusch, Hadd & Griffin, 1986).

In a similar study (Zartica, et. al., 1987), 182 abused and non-abused clients from five residential facilities were compared. Abused subjects were rated as "frequently violent" twice as often as non-abused subjects. The abused clients were also significantly more likely to be disruptive, rebellious, and hyperactive. Abused clients were most often in the "severe" range and were less likely to be profoundly, mildly, or moderately impaired. The researchers suggested that since abuse is an interaction, profoundly retarded may be at lesser risk due to decreased interaction. Those in the mild to moderate range may be in greater control of disruptive behaviors than those labeled "severe".

The Problem of Cause and Effect

"The maltreatment literature has generally not applied rigorous criteria to establish firmly whether abuse or neglect preceded or succeeded any identified disability" (White, et. al., 1987, p. 97). Oakes and his colleagues (1987) note that 60 percent of handicaps occur after birth.

It is known that child abuse and neglect can cause a full range of disabilities (Baldrian, 1991; Dey, et. al, 1984; Neelis & Karagiannis, 1982; South, no date). Impairments due to abuse range from mild to severe. It is possible that the high percentage of abuse and neglect in populations of developmentally disabled is because the maltreatment has caused the disabling condition. This point is of more than theoretical interest. The child who is damaged because of abuse needs a different intervention plan than a child born with disabilities who is abused due to parental stress.

Baldrian (1991), in a review of 18 studies, concluded that 25 percent of all disabilities were caused by physical abuse or neglect. The range in the studies was 3 percent to 50 percent. An article not reviewed by Baldrian was written by Donna Zadnik, supervisor of children's services at Columbia Lighthouse for the Blind. She noted that two studies (Frenzi, 1971 and Jensen, 1971) found eye disorders present in 40 percent of hospital samples of burned children. This, coupled with her clinical experience, led her to conclude: "many children may be visually handicapped or blind because of child abuse, but this fact is almost totally overlooked" ... (1984).

Baldrian (1991) estimates that 32,000 in 80,000 children per year become disabled due to abuse and/or neglect. This is a much more conservative estimate than that of Brandwein (1973) who estimated that 170,000 children become mentally retarded each year due to abuse or neglect.

Detection and Reporting

Maltreatment of the handicapped is thought to be significantly underreported compared to the general population (Sean, 1986; Seattle R ape Relief, no date; Sullivan, et. al., 1987; Thairinger, et. al., 1990).

There are many roadblocks to detection of abuse in the exceptional population. Perhaps the most obvious problem is communication difficulties (PACER, 1985; Sullivan, et. al., 1991). "Cases of abuse of people with limited verbal skills currently will not come to light if medical symptoms of sexual abuse (e.g., pregnancy, venereal disease) are present and diagnosed, if the abuse is witnessed (by another client or worker) and reported, or if the individual is somehow able to indicate that the abuse has occurred ..." (Sean, 1988, p. 7). Indeed, some authors maintain that the best chance found in medical reports (Zadnik, 1973).

A second problem is that one cannot rely upon behaviors, indicators. Some symptoms of child abuse are similar to behaviors of non-victimized children with developmental disabilities (Davis, et. al., in Sean, 1988; Sullivan, et. al., 1991). Children with disabilities may experience abstractions and confusions due to accidental falls or due to self-abuse (Ammann, et. al., 1989). Medications may have side effects, changing mood so that emotional indicators may be absent. For example, an adolescent who is disabled may disclose abuse in graphic detail in front of a group of people while showing little emotion (Sean, 1988). Emotional retraction of those denied personal integrity by being institutionalized may be similar to reactions to sexual abuse (Cole, 1986, as cited in Sean, 1988).

Given this overlap between symptoms of child abuse and symptoms due to the disability, cases of abuse can easily be overlooked. Gay Carolyn Page, director for Seattle Rape Relief, "signs and symptoms are confused with the disability rather than to the abuse." Still, some researchers have documented changes in behavior occurring in those with disabilities following assault (Cherniak, 1985; PACER, 1986). "Look for sudden changes in behavior or difficulty in sexual acting out," states Non Baldarian, Ph.D., of the Disability, Abuse and Personal Rights Project.

A third roadblock to detection is confidentiality (PACER, 1985). This can be a host against believing the disabled, even though there is no evidence that children with disabilities are any less reliable in disclosure than anyone else, although research is lacking (Sean, 1988).

Finally, some authors suggest that abused children with disabilities are reluctant to report abuse by caregivers due to fear of losing someone who depends upon for basic care (Cole, 1984-95; PACER, 1985). Others feel that the children fear retribution or it may be simply that the child with disabilities has few people to confide in (Cole, 1984-95).

Assessment and Investigation

Even skilled professionals may feel over whelmed when the victim is a child with a

Barriers to Identification

- Children with disabilities are seen as unreliable reporters
- Child may not be able to communicate facts in detail
- Symptoms of disability may mask abuse
- Child may engage in self-abusive behaviors
- Child may be prone to accidental injury
- Child may act out sexually due to poor judgment or poor impulse control
- Touching may be required to assist the child, making it possible to use new or inadequate techniques
- Child may be more vulnerable to insensitive due to cognitive impairments or emotional deprivation
- Child may be more socially isolated — may not know who to talk to
- Child is less likely to receive sexuality education or recreation training — may be ignorant of the problem
Prevention programs should be offered to students as well as the general population. In Virginia this it accomplished through The Family Life Education Program. It is not known, however, how many schools have access to prevention programs designed for children with special needs.

An outside advocate should interview each institutionalized child several times a year to determine if that child is experiencing abuse or neglect or sexual abuse. Ideally, the advocate should be assigned the same children so she can get to know them over a period of time.

Child abuse detection training should be aimed at child protection teams who do the special education evaluation. Since each special education student has a full evaluation every three years part of that evaluation should be determining if the child is experiencing abuse, neglect, or sexual abuse. A checklist could be developed to assist the psychologist on the team in making a determination.

Special education teachers should be required to have training in the detection and reporting of child abuse prior to licensing.

Institutions that serve only children with developmental disabilities should be required to have a contract with a specialist in child abuse and neglect. This person or consultant could arrange for staff training, prevention training for the children, and offer specialized treatment services to those children already known to be victimized. Since high percentages of children in institutions for mentally retarded, deaf, or blind are known to be victims of abuse, neglect, or sexual abuse, this service should be considered as mandatory. Children suffering from effects of underdetection and/or untreated victimization are unlikely to receive maximum benefits from other remedial programs. Thus, treatment for vicimization will likely be cost-effective by enhancing progress in other areas.

Disability and abuse are experienced by rights of the disabled need to be addressed by rights of children with disabilities to be free from abuse in the same way that all children, jobs, and education is certainly important. Many organizations may not be aware of the abuse that is being committed but are not addressing these issues in any effective way. The same advocacy skills are needed to address a child's right to be free of abuse.

Virginia is to be commended for what has been accomplished in starting to address the needs of developmentally disabled children who are also victims of abuse and neglect. For instance, one does not have to look far to realize that there are many facilities that are not providing the necessary services. This is particularly true for mental health facilities which have a higher percentage of abuse and neglect in their populations.

Still, links between those who focus on the needs of children with disabilities and those who work to prevent child abuse, child neglect, and sexual abuse are important. The information that is shared must be done to benefit and help a group of very vulnerable children.
The Healthy Start Program

A great deal of enthusiasm has been generated for a child abuse prevention program which faced its start in Hawaii in 1975. The program is the Healthy Start Program, and it has found its way to Virginia. Healthy Start is a community-based, multidisciplinary program designed to prevent child abuse and neglect, enhance parent functioning and enhance child development in a multi-ethnic cultural environment. The program includes the following components:

- Early identification of families at risk, made possible by the review of hospital records by using a list of risk indicators. Those families meeting specific criteria are assessed using the Family Stress Checklist created by the E. Henry Kempe Center. Families deemed to be at risk are encouraged to accept visiting support services on a voluntary basis. Only five percent of Hawaii families identified as "at risk" refuse services.

- Home-based intervention services are offered where family support workers provide emotional support to parents and model effective skills in coping with everyday problems. Workers use the Nursing Child Assessment Satellite Training (NCAST) to identify problem areas and develop interventions. The frequency of home visits is based on the family's needs.

- Language is medical facility for well-baby visits. Developmental screening using the revised Denver Developmental Admission Questionnaire is introduced as necessary.

- Referral and coordination with other community agencies is an integral part of this program.

According to project organizers and researchers, the model in its entirety is what produces the desired outcome. Anything less will not get the results, and the results are impressive! The project goal of no abuse or neglect for 95 percent of targeted children after one year of service has been exceeded in every year. An evaluation of 1,204 high-risk families served during 1987-1989 revealed only one case of abuse (a 99.95 percent non-abuse rate) and six cases of neglect (a 99.95 percent non-neglect rate). One of Virginia's Healthy Start programs is implemented by Northern Virginia Family Services and services families in Fairfax County. It is funded by a five year child abuse prevention grant awarded to the Fairfax County Department of Human Development from the National Center for Child Abuse and Neglect.

Developed very closely after the Hawaii project, Healthy Start of Fairfax County accepted its first referral in February 24, 1992. Its primary referral source is the Maternity Clinic of Fairfax Hospital which refers families from designated high risk areas to project staff consisting of Linda Dumpy, Project Coordinator, and four trained paraprofessionals who are bilingual and bicultural. "Our project differs slightly from the Hawaii model in that our first year specifically targets indigent families and we begin services personally," Dumpy explains. "Otherwise, we followed the model very closely."

Once a family is referred, the Early Identification Specialist appoints the Family Stress Clinician. Any family found to meet the at-risk criteria established by this instrument is offered services. Of those families offered services, 95 percent have accepted." Dumpy states. "This is higher than our expected goal of 90 percent. We are pleased that so many families desire services."

Regular home-based visits focus upon fostering positive parent-child interaction, ensuring safety of the child and internal teaching of child rearing skills. Periodic developmental screenings help detect delays. Dumpy hopes to use the HOME Inventory to assess changes in parent-child interaction, as is done in Hawaii.

A unique feature of the Hawaii model is its level system. Healthy Start is conducted weekly for a minimum of two months. Upon review of specific criteria, the families may at the point move to level 2 which includes semi-monthly visits. Eventually, they progress to level 3 with monthly visits, and finally, level 4 which involves quarterly visits. According to Dumpy, the level system allows a family to receive services according to their needs and fosters a sense of progress, deter donor burn-out, and allows more families to enter the program. Each worker is expected to serve no more than 25 families at one time.

This project is being evaluated by an independent evaluator and there are very specific project outcomes to meet including: 80-95 percent of served children will not experience abuse or neglect, have no developmental delays, and will be up-to-date on immunizations. Gains are also expected in parenting skills and parent-child bonding. Dumpy feels certain these goals will be met.

There is another Healthy Start program which is located in Hampton. It is one of three programs offered by the newly formed Hampton Family Resource Project.

"We are excited about having the opportunity to replicate the Hawaii model," explains Debbie Ruslaw, Resource Development Supervisor for the Hampton Department of Social Services. "The highly acclaimed Hawaii program was selected because it has demonstrated through repeated evaluations that it is effective in reducing the incidence of child abuse and neglect."

Two other aspects of the program appealed to Ruslaw and the Citizens Services Task Force, who spent months researching several different prevention strategies. First, it provides individualized, comprehensive home-based family support services. Second, the program focuses on the needs of the entire family for as long as the family needs the support. Many home visiting programs work with the family for six months to two years. Healthy Start provides services until the child enters school in age five.

Healthy Start of Hampton recently hired its first family support worker, a family support worker, one early identification worker, one clerical worker, a supervisor, all of whom began Aug. 3, 1992. The second team will be hired in January.

A second component of the Hampton Family Resource Project is "Healthy Family," a home visitation program serving several parent effectiveness services. Including nurseries, programs, parent support groups, pay groups, an informative newsletter timed to or sent to all parents of children ages 1,
PROJECT SPECIALCARE

SpecialCare is a program of Child Development Resources (CDR). CDR is a 25 year old private, nonprofit agency providing services for young children and their families and training for the professionals who serve them. SpecialCare is designed to expand child care options for families of young children with disabilities. The project provides training, technical assistance, and specializes staff development for caregivers in 5 counties of Virginia, including the Eastern Shore. Training from the project builds on caregivers' existing skills and helps them enhance their skill and comfort in caring for children with disabilities.

SpecialCare is a three-year model demonstration project funded by the U.S. Department of Education, Early Education Program for Children with Disabilities. The project is in its third year. They have completed five trainings and have trained over 90 providers. The project keeps a list of providers who have completed the training. Parents wishing to hire a child care provider can consult the list. Patricia Kasten, coordinator, did not know how many parents of developmentally disabled had used the service.

For more information contact Barbara Kiev or Sheryl Osborne, Co-Coordinator, CDR SpecialCare, 1900 Government Road, Williamsburg, VA 23185, (804) 898-0171.

Human Services which will allow for the expansion and evaluation of the program.

Funds for the Hampton Family Resource Project come from a variety of sources. Grants have been awarded by the Virginia General Assembly, the City of Hampton and the Virginia Family Violence Prevention Program. Some activities, such as the family life education program, are totally supported by the efforts of the Department of Social Services staff and community volunteers.

"We are excited about the possibilities these services offer the families in Hampton," Russell explains. "The cost and severity of today's problems require a new strategy, one that is based on prevention. The services offered by the center seek to reinforce and support, rather than replace, the family."

Nurturing Programs

Another exciting prevention program has recently been found in Virginia. Nurturing Programs is an outgrowth of a 1980 award by the National Institute of Mental Health to Family Development Resources, Inc. in Eau Claire, Wis. This project measured the impact of dysfunctional parenting practices on children. Project staff began to develop an effective prevention program in order to meet the concerns and needs raised, resulting in the first of the Nurturing Program: The Nurturing Program for Parents and Children 4-12 Years. Since that time several more programs have been developed: Parents and Children Birth to 5 Years; Parents and Adolescents 12 to 18 Years; Teenage Parents and Their Children Birth to Five Years Foster and Adoptive Families and Their Children; Parents With Special Learning Needs and Their Children. A tool to measure high-risk parenting attitudes — the Adult Adolescent Parenting Inventory (see review, VCWN, volume 30) — was developed as well.

Two of the programs — Nurturing Programs for Parents and Children Birth to 5 Years, and 4 to 12 years — are available in Spanish.

The programs are designed to promote the development of the building blocks of effective parenting. These component parts include:

- building a bond with the child in the earliest stage possible, hopefully within 24 hours after birth;
- empathy for the needs of the child and an ability to act on the child's behalf;
- parental awareness of one's own needs, as it is difficult to meet the needs of children if parents cannot identify, understand and meet their own needs;
- gentle, calm, nurturant touch;
- setting limits by establishing boundaries, creating rules, and providing appropriate consequences, all of which help children develop self-control and responsible character;
- providing unconditional love, being

benevolent in communications, and treating children with respect and dignity;
- acquiring adequate knowledge of child development.

Each program comes with a multipurpose material — curricula, children's books, workbooks, prototypes, assessment tools, and audiovisual materials — to meet the goals. Implementation can be in groups or in the home. However, the program should include all members of the family.

Funds from the Virginia Family Violence Prevention Program and from the federal challenge grant monies awarded to the Virginia Department of Social Services have made it possible for Virginia's Child Abuse Prevention to hire a project coordinator and buy 30 sets of the six adaptations of the Nurturing Program. "So far we have been able to train staff in 22 agencies statewide," explains Sheryl Herber, Project Coordinator. In order to make the program an agency must be willing to hire volunteer, and staff complete a two day training program; 2) adhere to policies and procedures developed for effective program implementation; and 3) provide statistics about the families being served. If an agency is willing to comply, it can borrow one of the six adaptations to begin a program. Once they have used it and decide they want to continue the program, the agency raises small funds to buy the materials and retells the one borrower. "One agency borrowed our program for children ages 4-12 years," Herber remarks. "It was so successful they found the funds to buy their own materials, returned ours, and borrowed the 0-5 adaptation so they could expand their services." It is the kind of use we hope to continue to see."

For more information readers may contact Herber's successor, Karen Schrader, at Viburg's Parent Child Abuse Prevention, 224 E. Broad Street, Suite 302, Richmond, VA 23219, (804) 775-1777.
Child Abuse and Disabilities

and initiative even the usual referral, it is important to realize that many cases can be handled remotely.

In order to document, Vanderlaan stresses the need for videotape or at least audiotape, the interviews. Documentation allows the clinician to establish what the child can produce in terms of credible history.

The medical exam is a crucial component for children with developmental disabilities. Vanderlaan noted that a review of records of 20 cases in 1985 indicated that half of the children with disabilities showed significant medical indicators. "The expense of a medical evaluation is always worthwhile with this population," explains Vanderlaan. "A medical evaluation, can run out study, pregnancy, and STDs. Children worry that their bodies are damaged in some way, a medical exam can reassure them that they are "OK."

Physical findings that indicate injury or infection in children who have not been able to give complete histories on interview would remain unknown and untreated without a medical evaluation.

Conflicts With No Easy Answers

Even if a case of possible abuse or neglect is identified, referred, and properly investigated, some unique problems remain in interpreting and labeling the results.

If a family fails to follow prescribed treatments suggested by professionals, if a family lacks the time or inclination to carry out a treatment program, the CPS worker may be caught in a dilemma. Support groups and parent advocates may encourage a parent to define their limitations. Write a letter," the problem with Laura having multiple disabilities is that the attention she needs can be overwhelming... We are constantly giving advice to teachers, doctors, therapists... We are already running out of time and realizing we can't do everything... We need to strike a balance in our lives or we'll have deep-seated frustrations forever." (National Family's Newsletter, Winter, 1992, p. 4).

If too much pressure to ignore treatment directives, has our society then adopted a "lower standard of care" for the disabled? Can the state force a parent and family into extraordinary incursions of time and finances because they happen to have given birth to a child with disabilities? Can we define the parent as negligent if they fail to meet the challenge? Since foster homes are increasingly scarce, since few foster parents have had training, and since the incidence of abuse of disabled in residents, case is so high, can we state who removes a child for neglect or abuse or sexual abuse offer the child an abuse-free environment? If the problem is lack of report or services and if these are not available, does labeling the problem "abuse" or "neglect" help?

Interpreting cases of possible sexual abuse may contain some dilemmas. Emphasis on sexual exploitation may, in some cases, be directed to efforts to allow disabled individuals the right to sexual activity (Thangratier, et al., 1990).

Sears (1988) writes about "sexual neglect," where persons with developmental disability are deprived of their sexual rights. In the next paragraph Sears describes sexual abuse of residents by other residents. How is one to determine the difference in all cases? When can persons with mental retardation consent to sexual activity? Many non-handicapped teens have chosen to become intimate sexually, ten later decided that the activity or the relationship was not in their best interest. If the disabled teen or young adult engages in sexual activity and later is dissatisfied or decides that they regret the activity, is their partner automatically a sexual abuser? Laws are places forbid sexual activity with mentally retarded or mentally ill persons, and would, thus, define the partner as abusive regardless of consent (Thangratier, et al., 1990). If a person with much freedom are we willing to give teenagers and young adults with disabilities to make the same choices (and, perhaps the same mistakes) in their non-handicapped peers? Questions about sexual abuse and consent are not easily addressed or answered; nor are there consensus among professionals (West, 1987). What is asked of the legal system is both protection of a legal right to engage in sexual relationships while at the same time providing protection from exploitation due to a disability (Thangratier, et al., 1990).

Treatment Considerations

There are few published reports of the effects of abuse on children with developmental disabilities (Sears, 1988). Indeed, there is little or nothing in the literature on emotional, psychological and, personality development of children with disabilities (Thangratier, et al., 1990). Persons with developmental disabilities, especially those with mental retardation, have typically been regarded as unsuitable candidates for psychotherapy, thus, little attention has been paid to therapy needs for emotional difficulties in this population. The authors who address this question of effects of abuse on the child with disabilities feel that the effects are likely to be more severe (Thangratier, et al., 1990, Varley, 1984, cited in Sears) than for a non-handicapped population.

There is some optimism, that care providers such as schools and medical personnel tend to witness services and support following a referral in CPS (Zaidman, 1973). This can occur if socials or medical personnel are uncomfortable working with abuse or if they perceive CPS as now "in control" of the case. Zaidman notes that this conclusion is based evaluate if those providers who know them best. The need for social workers and child care providers to continue services, in some instances, and then to find the materials available to assist the therapists.

Prevention

Prevention ideas are numerous and there is little agreement about how to spend limited prevention dollars.

There are some critical issues of preventing disabilities. Efforts on this front include adequate prenatal care and prevention of teenage pregnancy.

Other stress preventing abuse which can cause disabilities. Baldwin remarks, "At least 25 percent of all disabilities are caused by abuse, with each disabled child costing taxpayers about $400,000 in their life time. The dollars become significant when you realize that 1,000,000 to 60,000 children each year are disabled due to abuse. Prevention of disability caused by abuse should be a national priority." Those who agree with Baldwin are enthusiastic about programs that identify parents at high risk for abuse and offer them intensive assistance prior to abuse occurring (Sears, et al., 1994). Typically, these programs are identified by one of three approaches. Some programs target groups such as young parents, those who give birth to a low birth weight baby, first time parents or mothers abusing alcohol or other substances. While not all parents in the group are high-risk, the group is generally over represented among those who abuse. A second approach is to select participants by virtue of a checklist of characteristics or indicators typical of families who abuse (Fuchs) on a discussion about preventing child abuse and disabilities. .

continued on page 12
Organizations

National Resource Institute on Children and Youth with Handicaps
University of Washington
Seattle, WA 98195
(206) 543-2213
NRCH works to provide training and consultation to agencies so they may work together to protect vulnerable children. They also publish Special Issues, which are four page information capsules on issues such as children with disabilities within the child welfare system.

Sibling Information Network
The A. J. PappenKau Center
991 Main Street
East Hartford, CT 06108
(203) 287-7705
The Sibling Information Network, founded in 1981, was established to assist individuals interested in the unique needs of families of persons with disabilities. The Network has information about audiovisual materials, resources for sibling programs, sibling group information, and bibliographies. The quarterly newsletter is a major project and contains SIBPAGE, an insert for children 5 to 15. Sample copies are available upon request.

National Father’s Network
National Father’s Network
The Merrywood School
16130 N.E. Eighth Street
Bellevue, Washington 98005
(206) 747-4004
Too often, dads are the neglected parent in the family and in service delivery to children with special needs. The National Father’s Network was created to promote and advocate for the needs and concerns of men, to enhance their abilities to be competent, caring fathers. Over the past six years, the Network has developed more than 43 support programs for fathers in 32 states and Canada. A quarterly newsletter is available free of charge. Several monographs and videos are available for sale. The Network does a limited number of outreach trainings each year.

National Coalition on Abuse and Children
American Foundation for the Blind
15 W. 16th Street
New York, NY 10011
(212) 202-2043/2067 (TOO)
Contact Christine F. Pawlowski, Ed.D., Chair
The National Coalition is an informal group of individuals who first pooled together in November 1990. Their purpose is to increase the impact of their work related to abuse and disability issues. The Coalition meets at various national conferences, and communicates through periodic newsletters and computer bulletin boards. There are no membership fees.

Children of Alcoholics Foundation, Inc.
P.O. Box 4168
Grand Central Station
New York, NY 10163-4168
(212) 154-0006
(1-800) 359-CODA
Contact Ms. Lucie Robinson, Director of Public Information
The Children of Alcoholics Foundation, Inc., a non-profit voluntary organization, develops programs in child advocacy, public policy, and public education to stop, heal, and offer hope to the nation’s 28 million children of alcoholics (7 million under the age of 18). The Foundation’s primary goals are:
• to educate the public and professionals about children of alcoholics;
• to promote research and new data;
• to develop programs and materials for prevention of future alcohol-related problems.

The Foundation’s report “Children of Alcoholics in the Medical System: Hidden Costs,” is the country’s first large-scale study to document health care patterns and use rates of children of alcoholics. Among its many findings, the study reports that health care costs for children with FAS (Fetal Alcohol Syndrome) is estimated at $327 million.

Spectrum Institute
Disability, Abuse and Personal Rights Project
P.O. Box T
Covina, CA 91725-0090
(626) 459-2245 (EXT. 333)
Interested readers can obtain a list of publications from the Disability, Abuse and Personal Rights Project. Included are one on interviewing skills for those investigating abuse of disabled adults. Also available are over 50 publications by Nora J. Balesier. Ph.D. Included is a survivor’s manual for people with developmental disabilities who are new to reading skills, articles on prevention, tapes of conference presentations, articles for prosecutors, materials for parents of disabled children, and bibliographies.

The Council for Exceptional Children
1920 Association Drive
Reston, VA 22091
(703) 260-3600
FAX: (703) 246-9404
From modest beginnings in 1922, the CEC has grown to an organization of 5,500 members with 975 local chapters, 3 state or provincial branches, 54 federations, and 17 divisions. The purpose of the organization is to improve the conditions of exceptional children and youth — both those who are gifted and those with disabilities. They publish two journals, Exceptional Children and Teaching of Exceptional Children. They also host an annual convention, CLEARhouse On Handicapped and Gifted Children, and the CEC-ECRS. CEC-ECRS supports literature and unpublished literature which is exchanged and distributed throughout the country. They also maintain a CEC-ECRS listserv and network with agencies that share similar interests. They analyze and synthesize literature into research reviews and similar documents. ERCS offers free reference and referral services to the general public. For more information about the CEC-ECRS system, call (1-800) USE-ERIC. For specific information about disabilities, call (703) 284-9474.

Commonwealth of Virginia,
Department of Social Services
VCFP is copyrighted but may be reproduced or reprinted with permission. Write for “Request to Republish” forms. Requests or inquiries are addressed to: Jessica Greaves, Ph.D.
Department of Psychology
James Madison University
Harrisonburg, VA 22807
FAX: (540) 581-1622
FAX: (540) 581-1622
Child Abuse and Disabilities continued from page 10
risk, see VCPN volume 10). A third approach is more informal, identifying at-risk parents by referral from practitioners. To avoid the stigma of labeling, some programs offer intensive intervention to all new parents regardless of risk.
An example of a program that targets risk groups is the Hand-to-Hand program in Harrisonburg, Virginia. This program matches trained volunteer mentors with pregnant teenagers.
Murphy (1982) describes a program that uses a psychosocial risk inventory to determine risk. Several other instruments are also available (see VCPN, volumes 10 and 30). The Healthy Start Program (see Spotlight, this issue) is an example of this approach being tried in two Virginia locations.
A program relying on the more informal referral method with no fixed criteria for defining "at-risk" is the Nurturing Program (see Spotlight, this issue and VCPN, volume 30).
A third group of preventive ideas is based on reducing stress for families of children with disabilities and troubled families in anticipating problems. These approaches attempt to lower stress through the use of support groups, respite care, parent training and support (Davis & May, 1991; West, et al., 1988). Several such programs are described elsewhere in this issue.
A fourth set of prevention strategies recommends teaching abuse prevention skills and/or human sexuality education for children with disabilities (Cole, 1986/87; Paige, et al., 1991; Scher, 1987; Sear, 1988; Sullivan, et al., 1987; Zastal-Wiener, 1987). Only a few curricula specifically to developmentally disabled are available. Those that can be located are reviewed in the resource reviews. Prevention efforts do appear promising. Part (1986, as reported in Sear, 1988) has convincingly demonstrated the utility of a prevention education approach for those with developmental disabilities. All of the disabled, women without sex education interviewed had been sexually victimized while only 12 percent of those with prevention education had been.
A fifth initiative seeks to institute reform in institutions, residential centers and schools. Most substantial reforms (such as not allowing staff to be alone with a child or not allowing a child to be transported or accompanied by only one staff person) would be expensive. Usual funding and staff ratios are considerably improved, opportunity to be done with a child will continue in new settings.
Another institutional reform is to improve hiring practices by using criminal records checks and more thorough background searches (Sear, 1987; Zirpali, et al., 1987). Hiring practices will continue to be hampered, however, by a low level of pay, thus attracting less qualified applicants. Better quality of staff can facilitate another reform, that of eliminating dangerous practices such as use of aversive like shock rods (Maurer, 1973). In order to manage difficult behavior without overuse of aversives or isolation requires skill, patience and good relationship skills.
Staff training has also been suggested (Sullivan, et al., 1987; Zirpali, et al., 1987). Although 7 sensitive issue, there appears to be no research to determine the effectiveness of staff training in preventing abuse (Musick, 1984). One negative effect noted is that after training, some staff may become aware of touching children at all and try to adhere to a "no touch" policy (Sear, 1988). Carolyn Paige of Seattle Rape Relief comments that some staff providers commonly express is that they will become guardian and reticent to show affection for a child. We need to keep in mind that staff are service providers, if not friends. If we want to keep children safe, it is in our best interests to set clear guidelines with the way we show affection while encouraging positive relationships within a child's peer group.
The choice does not appear to be a simple one, however. Bartlett, in his autobiographical talk, speaks over and over about how important it was for "the white woman" to touch him. Affectionate touch may be essential to survival for very young babies. Service providers may be the only "friends" an abused child with disabilities has. If foster parents or residential staff do not offer affection as well as physical necessities, the child may be further damaged.
A final preventive strategy is trying to detect abuse early. With this goal in mind, various authors have suggested educating doctors in abuse detection (Elvás, et al., 1990), training special education teachers to spot abuse (Therian, et al., 1990; Zastal-Wiener, 1987; Zirpali, 1986), encouraging evaluators and case managers to report and carefully examine medical data on all new referrals (Zudan, 1973), asking children themselves (Sear, 1988), and designating at least two non-family adults for a child to contact if they are abused (Paige, et al., 1991).

Spotlight on Minnesota: The PACER Center

PACER (Parent Advocacy Coalition for Educational Rights) is a coalition of 19 Minnesota disability organizations. It is staffed primarily by people who are parents of children and adults with disabilities or people who have disabilities themselves. PACER offers information about laws, procedures, rights and responsibilities. Its programs help parents become informed and effective representatives for their children and young adults in educational, vocational and other service decision making.
"PACER was founded on the concept of 'parents helping parents,'" explains Deb Jones, of PACER's Let's Prevent Abuse Project. "A major way we do this is through education." PACER programs are numerous. There are parent training workshops, ranging from general information about special education to communication with schools to special topics such as siblings, sexuality or the role of grandparents. There are workshops to train trainers. There is individual assistance and support, and services designed for African-Americans, for parents of Hispanic backgrounds, those who are American Indian, Southeast Asian or cultural groups.
PACER workshops also target the child's needs developmentally. There is an early childhood family training program, transition activities for parents of secondary students, transition planning in health care, and programs in supported employment.
PACER also sponsors activities for students and teachers. "Our disability awareness project, COUNTER MEEN, reaches over 14,000 school children each year. We have 50 volunteer puppets who take the life-sized puppets to schools." The performance is designed to promote understanding of children with disabilities and help children feel at ease with disabled classmates. The puppets and scripts are available for purchase by groups wishing to conduct disability awareness programs.
PACER puppets are also used in programs to teach children about child abuse. Scripts have also been developed for children with mental retardation.
The comprehensive resource center allows parents, teachers, children, and adults with special needs to acquire hands-on experience with personal computers, adaptive devices and educational software. A software lending library is available to families.
PACER publishes four different newswletters and offers an extensive collection of resource materials and videotapes. A 12 page catalogue lists booklets, newsletters, information handouts, workshop materials, books, videotapes, and other items.
A copy of the publications catalogue and/ or further information about the PACER model is available from: PACER Center Inc., 4831 48th Ave. S.. Minneapolis, MN 55417-1096. (612) 827-2066 VOICE/TDD; FAX (612) 807-5065.

continued on page 13
Spotlight on San Diego: The Center for Child Protection

When Robin Vanderlinden, L.C.S.W., joined the staff of Children's Hospital and Health Center in 1986, she noticed that there were few referrals of sexually abused youth with developmental disabilities. Vanderlinden and Maddie Kaufhold, M.D., who had a background in work with mental retardation, began asking why. Their inquiry culminated in the addition of forensic assessment of developmentally disabled victims of sexual assault to the Center's forensic agenda.

The Center for Child Protection is a specialized service that offers assessment and treatment to child victims of sexual assault. Over 95 percent of their referrals are from law enforcement. "We have a very good relationship with law enforcement," explains Vanderlinden. "We do a videotaped interview and afterwards the child receives a complete medical examination."

The Center also offers a four-week course for children who are scheduled to testify in court. The course was developed in coop­eration with the state office of Criminal Justice Planning and the Family Protection Unit of the District Attorney's office. The "Kids in Court" class meets for four evenings and is taught by a judge, an attorney, and a social worker. "We avoid reference to the specific facts of a child's case," notes Vanderlinden, "because that could be misconstrued as 'coaching.' Instead, we instruct the children about court procedures, and we role play a trial so they can understand what each job person does."

While the children attend their course, sessions for families are also offered.

continued from page 14

A final psychotherapy effort targets early identification of disabilities by CPS (Child­

Highlighting, ed., 1986). This approach suggests that if a disability is spotted and treated, then risk of abuse or neglect will be lowered. West Virginia University is just testing this approach. To date, over 150 CPS and social workers have completed the typical training program and now refer for further evaluation. (For a description of work book materials, see Resource Reviews, this issue.) The project has concentrated upon birth to six years, since older children will likely be identified by the school system.

Virginia's Picture

Virginia's CPS data is quite different from the national statistics cited earlier. Virginia does collect data on child characteristics, although this data has been reported only on a random sample of cases. A recent, sample of 420 cases shows that 19 percent were "foundout" for abuse or neglect. Fifty-five percent of children in foundout cases were listed as having no developmental problems. In another 13

continued on page 16

In addition to support for the legal system, the center offers counseling and treatment. Approximately 1,200 children are served each year.

The Center has maintained an excellent relationship with law enforcement and the staff have extensive experience with sexual abuse investigations and treatment. Even so, getting referrals of developmentally disabled victims was difficult. "In the beginning," says Vanderlinden, "there was a real lack of experience with this population on the part of law enforcement and the bias was that a case with a mentally retarded victim couldn't be prosecuted. Consequently, the investigation of a case with a mentally retarded victim wasn't as vigorous."

Vanderlinden notes that investigations have two focuses: protection and prevention of the child. "When prosecution is not possible, vigorous investigation by law enforcement helps child protective services to protect the child," she notes.

If there is a specialization, then staff begin to gain confidence in their ability to work with difficult cases. In 1986, the Center for Child Protection made a video (see review, this issue on "Evaluating Developmentally Disabled Victims of Sexual Abuse"). In San Diego, there are seven prosecutors who work full time on child abuse cases. The chief of this unit, arranged for the child abuse detectives from law enforcement to attend a workshop and view the film. He encouraged police officers to refer the cases for screening so they could be evaluated by these prosecutors. The results have been promising.

Vanderlinden explains, "Over the last five years we have gone from no cases with developmentally disabled victims to having cases referred routinely."

At first, Vanderlinden did all the interviewing for developmentally delayed clients. She later decided that all clinicians should learn the assessment skills. Now handicapped clients are seen by the entire staff.

There is a community-based bimonthly review conference for mentally retarded children and adults. It is staffed by the regional center case manager, law enforcement, CPS, and the center clinicians. The case review serves as a forum where emerging concerns can be brought and the team can arrive at a consensus about how to proceed with the case. The staff can also advocate for services for the child victim.

One test of need is whether or not a service is utilized. The literature suggests that children with disabilities are at increased risk for all forms of child abuse. The Center for Child Protection has used a "follow-up" formula — offer the service and see what happens. If there is need, people will come forward. Did it work? Says Vanderlinden, "When we become visible as a place where mentally retarded victims could get help, we got lots of referrals."

The Center for Child Protection offers a variety of on-site and off-site training programs and workshops in annual conference. For more information, contact Center for Child Protection, Children's Hospital, 800, Frost Street, San Diego, CA 92123, (619) 576-8814, FAX (619) 278-2365.

Spotlight: Boy's Town

The Boys Town National Institute for Communication Disorders in Children has a dedicated Abuse Hotline that it has been operating since 1983. The Center provides evaluation and treatment for 250 to 300 abused children with communication disorders each year. The short-term residential program specifically for hearing-impaired abused children is the only program of its kind in the United States.

The Center uses a model titled TEACCH (Therapeutic Education of Aged Children Handicapped). Three families at a time can enroll in the six week program which entails the entire family living in a unit that adjoins the hospital.

"Virtually all of the children have behavioral management problems," explains Executive Director, Patrick Sullivan, Ph.D. "We use a social learning theory model. We work with the entire family because the family is the basic unit of our society."

The Center's program employs staff with disabilities who are good role models for the parents. There is also a 20 week outpatient program for those close enough to commute. They are developing protocols for police and CPS to assist them in investigations. The Center is one of five sites selected by the National Center for Child Abuse and Neglect to conduct a national research. Two students are currently underway. One is a screening of 1000 CPS cases to determine if any of the children have disabilities. The second study is mapping a data base of police data on extra-family abuse and CPS data on intra-family abuse with a data base of 50,000 children with disabilities.

More information is available from Patricia Sullivan, Ph.D., Clinical Director of the Center for Abused Handicapped Children, Boys Town National Institute for Communication Disorders in Children, 555 N. 35th St., Omaha NE 68131, (402) 445-6800 (Voice or TDD).
Let's Prevent ABUSE

Let's Prevent: A Parent's Prevention Handbook for Early Childhood Professionals, Do you know what to do if you suspect that a young child is being abused? This handbook provides ideas for those who work with children to help prevent abuse.

The handbook covers: recognizing and preventing abuse, creating a safe environment for children, and providing support for children who have experienced abuse. It is an excellent resource for childcare providers, teachers, counselors, and anyone who works with children.

Available from: PACER Center, Inc.
4500 15th St. S.
Minneapolis, MN 55417-1098
612-877-2988

This handbook is a valuable resource for anyone working with children. It offers practical guidance on how to create safe environments and provide support for children who have experienced abuse. Whether you're a childcare provider, teacher, or counselor, this handbook can help you make a positive difference in the lives of children.

This resource manual provides a comprehensive list of information about child abuse and child neglect. It includes the following: definitions, legal definitions, reporting, services and agencies, education and training, evaluation, research and statistics, and resources. This manual is designed for professionals and is available in both print and electronic formats.


This manual is designed for parents of children with disabilities and includes information on child development, special education, and support services. It is available in both print and electronic formats.


This book includes a comprehensive overview of exceptional children, including classification, causes, and interventions. It is available in both print and electronic formats.


This book includes a comprehensive overview of the effects of abuse and neglect on exceptional children, including identification, prevention, and intervention strategies. It is available in both print and electronic formats.

Publications from NCPCA


This manual is designed for parents of children with disabilities and includes information on child development, special education, and support services. It is available in both print and electronic formats.


This book includes a comprehensive overview of exceptional children, including classification, causes, and interventions. It is available in both print and electronic formats.


This book includes a comprehensive overview of the effects of abuse and neglect on exceptional children, including identification, prevention, and intervention strategies. It is available in both print and electronic formats.
Recent problems of the child were unknown. The remaining 32 percent had developmental delays or chronic medical problems. Over 2 percent had a physical disability, 1.6 percent were mentally retarded, and 9 percent had medical problems. Over 9 percent had learning disabilities, nearly 12 percent were emotionally disturbed, and 15 percent had behavioral problems. Figures for the "at-risk" category were similar. The "unsubstantiated" cases were most likely to be children with no known problems (66 percent).

Thus, it appears that Virginia's CPS workers are more likely to make a finding of abuse and neglect if a child has a handicapping condition than if he or she does not. This is in contrast to many authors in the literature who stress repeatedly that children with disabilities have a credibility problem and thus are not taken seriously by CPS.

In Virginia, CPS workers see routinely trained in child development or normal development. The Virginia Department of Social Services is concerned, however, about the overlap between child abuse and disabilities. One major effort has been coordination with the Virginia Institute for Developmental Disabilities and with the Office of Prevention in the Department of Mental Health, Mental Retardation and Substance Abuse Services. Over the last two years, several conferences, attended by 400 or more, have provided a training forum for those interested in child abuse and its prevention in children with disabilities.

Several state agencies that serve children with developmental disabilities were contacted. Although many services and programs are available to children with developmental problems, apparently none have focused on the identification of abuse, neglect and sexual abuse as a primary goal. Therapeutic services are available to children with developmental disabilities, but no service appears to have specialized therapy for the effects of abuse, neglect, or sexual abuse.

For example, the Department of Mental Health, Mental Retardation and Substance Abuse Services has funded five positions for counselors to work with deaf clients. Susan Stagnoli, LPC, is the Regional Deaf Services Coordinator with the Fairfax Falls Church Community Services Board. She has served as a liaison to CPS and has helped to start an innovative parenting skills program for deaf parents with hearing children. However, most of her counseling clients are adults. Stagnoli did not know how many deaf children were in her catchment area and noted that confidentiality guidelines often prevent her from directly identifying the children who might need her services.

VCPN is interested in locating service providers in Virginia who have developed special programs for treatment of abused, neglected, or sexually abused children with disabilities. We would also like to locate educators who are using abuse prevention programs especially designed for children with disabilities. Write and tell us about yourself!

Summary

A significant percentage of abuser, neglected, or sexually abused children fit a definition of "developmentally disabled." Awareness of the overlap between abuse and disabilities increases. CPS and service providers can begin to develop more sophisticated methods for detection, intervention, and intervention for these children who are felt to be at higher risk for maltreatment.

In order to move forward, specialists in developmental problems need to develop positive relationships with those who are experts in child abuse, child neglect, and child sexual abuse. Children suffering from the effects of trauma will not be able to achieve their potential, meeting the needs of exceptional children is likely to require persistent and innovation. Our most vulnerable children deserve this additional effort.

References Available Upon Request

James Madison University
Department of Psychology
Harrisonburg, VA 22807
Attention: J. Grayson
Address Correction Requested