Assessing and Supporting Parenting in Families Affected by Substance Abuse and HIV

2007
OVERVIEW

Since 1991, the National Abandoned Infants Assistance (AIA) Program, under the aegis of the Children’s Bureau of the U.S. Department of Health and Human Services, has funded projects to address the needs of families with young children affected by substance abuse and/or HIV/AIDS. Although the projects have varied considerably in their approaches and orientation, they have shared the common goal of helping parents to provide a safe and stable environment for their children. Over the last 16 years, several core services have emerged, and the projects have learned many lessons and developed significant expertise in providing these services. To capture and disseminate this knowledge to the many others working with these populations, the National AIA Resource Center (NAIARC) is developing a set of program guides on core AIA services and program components.

The first of these guides focuses on parenting and related child safety issues among families affected by parental substance abuse and HIV/AIDS. Whereas families served by AIA projects face a complex host of challenges, parenting and child safety are essential issues in all cases. Emerging research on brain development underscores the importance of this work, documenting the impact of healthy caregiver-child relationships on child development and the future of children.

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Focus and Principles of AIA Projects

I really kind of needed a mommy and a daddy to help me out, and ... these [AIA] programs served this purpose.

— AN AIA PROJECT GRADUATE

Reflecting the Children’s Bureau’s philosophy, AIA projects are explicitly designed to promote the safety, permanency and well-being of children. The projects have found that the most effective way to do this is to focus on the family as a whole. AIA work is guided by the belief that, whenever possible, it is in a child’s best interest to be maintained safely with his/her biological parent(s). Thus, providing parental guidance and helping to strengthen parent-child relationships is central to the work of AIA projects.

Virtually all of the families served by AIA projects are affected by parental substance abuse and/or HIV/AIDS. These families are predominately headed by indigent, single women with limited education, a high incidence of domestic violence, and a host of other challenges. Unlike many family support programs, AIA projects operate with a fundamental belief that many individuals affected by HIV/AIDS and substance abuse can and want to be good parents. In efforts to help parents realize this potential and strengthen relationships with their children, AIA projects intervene in the following ways to stabilize and support families:

- establish relationships with families based on trust and acceptance;
- provide developmentally informed parental guidance;
- offer individual family treatment;
- strengthen familial and community relationships;
- address concrete basic needs, teach tangible skills, and develop linkages to community resources; and
- provide education, advocacy, and assistance in systems navigation.

Purpose and Parameters of this Guidebook

The primary purpose of this guidebook is to provide practitioners and administrators with guidance in assessing, supporting and strengthening parenting skills and parent-child relationships among families affected by substance abuse and/or HIV/AIDS. Specifically, it identifies some of the parenting-related challenges facing this population. It provides tips on building relationships with clients, assessing parenting skills and parent-child relationships, and implementing parenting intervention and safety planning strategies. The guidebook also addresses staffing for home-based, supportive interventions, and strategies for working with child protective services. Throughout the document, parent quotes and program examples illustrate many of the key points. Finally, an annotated list of assessment tools and parenting curricula used by AIA projects is included. The key ideas and majority of the information contained in this guidebook came out of intensive meetings of AIA project and National Resource Center representatives (see Appendix A for a complete list of technical expert group members).

In the interest of containing the size of this document, it focuses specifically on relationships between birth parents and their young children—the dominant population targeted by the AIA program. Further, because the parents that come to the attention of AIA projects are predominately, though certainly not solely, mothers, parents often are referred to as “she” throughout the document. This is not intended to exclude fathers or to discount the many fathers who are involved in their children’s lives or even raising their children alone. In fact, section 5 discusses specific strategies employed by AIA projects to engage and work with fathers and father figures.
SECTION 2
PARENTING-RELATED CHALLENGES
PARENTING-RELATED CHALLENGES

The universal stresses of parenting are sometimes overwhelming for even the most privileged and well-supported families. These stresses are compounded by challenges related to poverty, substance abuse and HIV/AIDS, which must be understood in order to support healthy parent-child relationships. The following are some of the issues that make basic parental duties and interactions challenging for many individuals affected by substance abuse and/or HIV/AIDS.

Need for “Re-parenting”

Many AIA clients experienced traumatic childhoods themselves, and suffer from a history of neglect and abuse that makes it difficult for them to accurately recognize and respond to their children’s emotions and needs. The last thing a fish is likely to notice is water, and the last thing a parent who was raised in an abusive environment is likely to notice is abuse. Those who were abused or neglected in childhood may have particularly strong responses of anxiety, anger, and frustration when confronted with the neediness and dependency of their small children. Before you can address practical childrearing skills and tasks with these parents, you need to assist them to recognize the important role that they, as parents, play in their child’s development. Some parents may have been deprived of positive parenting experiences when they were children and may need to be nurtured themselves before they can nurture others.

Integrating the Past

Similarly, parents often face the challenge of integrating the most painful parts of their own life experiences before they can be emotionally and physically present for their children. Without acknowledging and processing feelings related to their own past traumas, some parents may not be able to respond to their child’s behaviors and needs. Further, parents who are unable to incorporate their own childhood pain into their current sense of self, may be haunted by these disassociated memories—what Selma Fraiberg labeled “ghosts in the nursery”—and unconsciously recreate this trauma with their own children (Fraiberg, Adelson, & Shapiro, 1975).

Even clients who have worked on resolving their childhood issues may continue to struggle with the ways in which the events of their adult lives impact their parenting. For instance, women who have experienced sexual abuse or violence from an intimate partner may have difficulties being physical with their children or find that unsolicited touch from a child triggers an emotional shut-down. Likewise, women who have supported their drug addiction through sex work may have difficulties with any kind of physical intimacy. These past experiences may impact their ability to nurture and comfort their children.

PARENTS SPEAK

I could tell my daughter I loved her, I could hug her when I wanted to hug her, but if she came to me for any tenderness, I would really freak out, and say, “Don’t, now go sit down!”

… the teacher was talking about loving and nurturing your child, and she said, “So how do you feel when your child touches you?” I said, “I don’t like it.” [My daughter] was always touchy-touchy, feely-feely, squeezing me, “Can I sleep with you tonight?” I realized I had a problem: drugs, prostitution, it shuts off every emotion, because you have to get in your mind that this is for money, and that’s just it.
Mental Health Issues

Mothers who abuse drugs have a high rate of co-existing mental health disorders, particularly depression, anxiety, and post-traumatic stress disorder (PTSD). It may be difficult for these women to tolerate the conflicting emotions that are inherent in both sobriety and parenting (Suchman, Pajulo, DeCoste, & Mayes, 2006). Parents with HIV/AIDS, many of whom also have histories of substance abuse, may face additional mental health issues related to their illness. For instance, concerns about their health and disclosure, periods of sickness, and stigma related to HIV/AIDS, along with the challenge of permanency planning, guilt over past behavior, and concern about their children, compound pre-existing mental health problems (Davies, Bachanas, & McDaniel, 2002).

If these mental health issues are not recognized and dealt with, it is unrealistic to expect a parent to remain sober, adequately care for her children, or, in the case of individuals with HIV/AIDS, complete a permanent plan for her child(ren). Additionally, women who are depressed and/or isolated can have a harder time promoting emotional independence in their children and may have an inappropriate expectation that their children will provide them with nurturing and emotional support.

Challenging Child Behaviors

Some children prenatally exposed to drugs have special needs and present behavioral challenges that call for specific coping mechanisms. For instance, soothing an infant prenatally exposed to certain drugs may demand a greater degree of patience and flexibility than soothing an unexposed infant. At the same time, research suggests that the post-natal environment is even more important than the prenatal environment, and that the quality of care a child receives in the first five years of life can mitigate many potential developmental delays resulting from substance exposure (Carta, Atwater, Greenwood, McConnell, McEvoy, & Williams, 2001; Hulse et al., 1998; Bauer & Barnett, 2001). Whereas this means that strengthening the parent-child relationship is a particularly critical task, it is likely that both parents and infants will need guidance in developing emotional regulation and learning effective coping strategies.

Additionally, children who grow up with an addicted parent may share aspects of the behavior—such as impulsivity or inconsistency—even if they do not become addicts themselves. Parents may need assistance in understanding and dealing with these behaviors.

Parents Speak

Another challenge from my using is that my children, my two oldest, live my addictive life. They picked up all my addiction ways. Neither of them use, but they live and they react, and their lives and their raising of their children are that of a parent that’s used drugs and alcohol. That’s what they learned. We get so involved in getting sober but when we get sober, it’s our addictive ways we have to deal with. We put things off on them that are not really their fault… How you dealt with people has become their way of life.

Children with HIV/AIDS face additional challenges. For instance, they are at high risk of language and cognitive delays due to the impact of the virus on a child’s developing nervous system and, as they get older, they must deal with their own issues of disclosure (Davies et al., 2002). Additionally, even if they are not infected, children of parents with HIV/AIDS face numerous emotional challenges related to their parents’ illness and possible death, along with issues of secrecy and stigma associated with HIV/AIDS. It is important to help parents recognize and understand these challenges in order to effectively support their children.
Emotional Issues

Parents in recovery struggle with a range of emotions toward their children such as guilt, shame, and regret for past actions. These emotions can be valuable catalysts for change, but can also inspire mistrust toward social service agencies, which the client may perceive as stigmatizing and punitive. Some parents experience anger toward the child whose birth and identification as a substance-exposed newborn brought the parent to the attention of the legal system. Your task as a caseworker is to help your client to acknowledge and accept these emotions as the first step in moving beyond them.

Transitions

Families served by AIA projects deal with many issues related to separation and abandonment. Children who have lived with a drug-addicted parent may have experienced their parents as not emotionally or physically present—even when the parent is in the home. Families may deal with separation due to Child Protective Services (CPS) involvement, or, in the case of HIV-positive parents, due to extended hospitalization.

Additionally, when parents stop using drugs, they expect that their recovery will be greeted with enthusiasm by their children. However, this is seldom the case; it is not uncommon for children to be angry when a parent gets clean and begins to reclaim parental authority. The years of uncertainty and confusion that often characterize substance affected families make it difficult for children to accept and trust the parent’s changed behavior. Children who have been forced to be more independent may be reluctant to relinquish their parentified role and may be unwilling to accept the parent’s attempts to reclaim authority. In addition, parents often struggle with insecurity and a sense of guilt, which may result in their see-sawing between imposing little...

Lack of Safe Supports

Many AIA clients are either socially isolated or lack positive social supports. Drug dependency is frequently intertwined with other forms of dependency and harmful interpersonal relationships. To become capable parents, clients often need encouragement and support to gain self-confidence and a sense of self-efficacy, learn how to say “no,” and simultaneously develop healthy social connections.

PARENTS SPEAK

You have to look at yourself and realize what you’re capable of, because you don’t have the support system any more… When you become dependent on drugs, you become dependent on everything and everybody. So when you decide that you’re no longer going to use, that means you have to deal with dependence in general. I used to think it was a bad thing when I got cut off from my family, but now I take it as a positive thing, because it made me have to rely on myself and to make the right decisions for myself and my children.

Saying “no” felt like a death sentence to me because if I said “no,” even if you were mistreating me, you weren’t going to come anymore. So I would rather agree to whatever abuse you were giving me than to say “no.” I felt I would lose a lot if I said “no,” but I gained a wealth by saying it.

PARENTS SPEAK

1 Different states use different terminology in referring to child welfare agencies. For the sake of simplicity, we have chosen to use the term Child Protective Services (CPS), as opposed to DFS or DCFS, for example, throughout this document.
structure to overcompensating for past neglect with excessive limit-setting. Parents in recovery may experience a loss of competency as they give up the subculture they have been so skilled at navigating. Re-learning the mores of the dominant culture, developing new ways of coping, and new ways of managing stress are all demanding tasks that lead to inevitable moments of frustration, which can affect their parenting.

**Systemic Limitations**

AIA clients are frequently enmeshed with larger systems (e.g., child welfare, medical, or criminal justice) that are not necessarily sensitive to the specific needs of these families. Lack of knowledge of substance abuse and HIV/AIDS can affect child welfare workers’ attitudes and assumptions regarding child safety. The threat of incarceration for drug-related convictions is very real for many of these families, and they often distrust those who purport to help them. In addition, the Adoption and Safe Families Act (ASFA) timelines (requiring permanency planning for any child who has been in out-of-home care for 15 of the previous 22 months) do not correlate with the realities of recovery and treatment. Community-based drug treatment programs and other systems and agencies, that often work collaboratively with AIA projects, are seldom holistic enough in their approach to meet the needs of these families. Most drug treatment programs focus solely on issues of recovery, without addressing either the extensive social needs of their clients, or the integration of their parental roles and responsibilities.

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**PARENTS SPEAK**

The only thing I didn’t like about the system was, they returned my children but I still had a lot of unanswered issues.

I went into this congregation and that changed my life, but … I still had all these other issues. You hear people talk about God, but there’s still a reality side out there, and my reality was that I still had issues. I didn’t know what it took to be a parent.
BUILDING RELATIONSHIPS WITH CLIENTS

Relationship building is the foundation of any successful parenting intervention. Trust and acceptance are the keys to developing an alliance with the client that is an essential element of treatment. Earning your client’s trust is a process that takes time and demands persistence. Successful workers recognize that it is their responsibility to engage the client, not the client’s responsibility to drop all defenses and welcome a stranger into the home. Many clients have been referred to an AIA project due to their child having been born substance-exposed, and they may well be defensive, suspicious, or resentful over the unsought intrusion into their lives—not to mention fearful that their child will be removed from the home. Your client may have had repeated unsatisfactory encounters with social service agencies; may have been expelled from substance-abuse treatment programs; or may have been labeled as “non-compliant” or “resistant” by previous providers. The bottom line is that you will not be able to build an effective relationship unless you can overcome this backlog of mistrust by proving your worth and the value of your services. The following are some lessons learned in working through this process.

Take the Time to Engage

Be yourself, and don’t pretend you can “identify” with the client and her situation if you cannot. Doing this type of intensive family preservation work requires workers to cultivate their own self-awareness and to be clear about their own values. It is not necessary to agree with everything the client says or support everything she does, but it is essential to approach clients with a nonjudgmental, accepting attitude. This will go a long way to letting clients know that they are seen as individuals with their own feelings, beliefs, and culture, rather than as a “case.” Client readiness is a factor, as well. You may be seeing mandated clients or visiting clients who flat out refuse to let you in their home week after week. You will need persistence, a high tolerance for rejection, and the ability to not take the client’s lack of buy-in personally. It may be that you are planting a seed of motivation or interest that won’t sprout until months later.

PARENTS SPEAK

I let [my worker] come for a while, and then I locked her out, but I thank God today, she didn’t give up; she was persistent. She began to put these little sticky notes on my mailbox, and on my car…

We don’t think there are people concerned about us, not really. Then I met these [AIA] people, and if they said they were going to come, they came; if they couldn’t make it, they called ahead of time. So they showed me that they had stability, and because of their stability it made me kind of believe in myself and the system.

When the program came to me, I was pretty much ready. I was at that sick-and-tired place, I had mulled it over in my head, and mulled it over, and I didn’t know how I was going to escape this, I had got myself dug in so deep. … I was seeking some guidance.
PUTTING IT INTO PRACTICE

AIA project workers understand that families can’t address long-term goals when they have immediate pressing practical needs. One of the first steps many projects take is to provide needed supplies, e.g., diapers, infant formula, or baby equipment. For example, Best Beginnings Plus in New York City outfits new mothers with a thermometer, crib, car seat, and smoke detector. CRADLES in Austin, Texas, presents clients with a baby sling upon their child’s birth. When Vulnerable Infants Program (VIP) of Rhode Island enrolls a parent in the program, they supply a welcome package with a yearly calendar, paper, pens, and business cards of their workers. If parents enter residential treatment, VIP supplies a gift bag filled with personal care products. Additionally, VIP clients who participate in the Family Treatment Drug Court receive concrete incentives, based on the needs of the family, as they progress through the program. Examples include cameras, gift cards, bus tickets, developmental toys, and diapers.

Provide Concrete Resources

One of the most effective ways to prove your commitment to alleviating your client’s stress is to provide concrete resources that address the family’s immediate needs. A worker carrying a clipboard is less likely to be welcomed into the house than a worker carrying a box of diapers. By proving that you recognize the realities of a parent’s life and can respond to concrete problems, you can begin to prove your trustworthiness. If you demonstrate your willingness to help solve simple problems right away, you are a step closer to overcoming your client’s distrust of social service professionals.

Show Respect

Acknowledge your client’s autonomy in all your interactions. Enter their home with a respectful attitude and follow through with basic courtesies, such as asking where you can sit and how the client prefers to be addressed. Try to avoid approaching the assessment process with an attitude of entitlement; it is an important first step in learning about the client, her family, and her history. Simply prefacing your questions with an affirmation of the client’s perspective and preferences such as, “You don’t have to tell me how this happened, but …” can make all the difference. Once you have asked the question, be sure to truly listen to the answer.

Partner with your client around setting goals for herself and her family. Treat your client as the best expert on her children, and encourage her to educate...
you about the child’s personality and behaviors. Provide opportunities to explore areas where they would like more support or information. Be sure to ask what interventions or services haven’t worked in the past, and why; this is valuable information that can steer you away from repeating past mistakes. Let the parent’s priorities guide you in helping to establish goals and identify solutions. For instance, a mother’s priority may be getting school clothes for her children, not learning new ways to nurture or provide positive discipline. Often by meeting parents where they’re at, you are able to work with the client long enough to help get them to those less concrete goals. Once the relationship is established, the service plan can be updated with more specific goals related to parenting. Be patient if your client is willing to accept services, but slow to set goals. It may be that she has never in her life had a positive experience with making plans and fears setting herself up for disappointment, or that she’s just not ready. Acknowledge the barriers she faces, and provide consistent support and praise for acquiring new skills.

To build a relationship, you must be willing to deal honestly and openly with situations as they occur. Although relapse is an expected part of recovery, clients need to understand that their behavior can impact the safety of their children and place them at risk. If you can communicate honestly about difficult issues, you will be modeling a relationship in which positive regard can be combined with appropriate limit-setting—just the type of relationship your client needs to cultivate with her child.

An honest relationship also requires you to explain from the outset that you are a mandated reporter, and that you are legally required to report any issues that you witness or that the client communicates to you that suggest that the child is at imminent risk. If a situation arises that requires you to make a CPS report, you may experience understandable guilt or anxiety, especially if you have grown close with your client or identify with her. Keep in mind that clients may feel relieved to be open about the reality of their situation and to get their cards on the table. Some AIA projects even have a policy of encouraging the parent’s participation in making the call to CPS, so that the entire process is completely transparent and the parent is allowed to have input on the case. After all, it’s not as though you are going to make a report and then turn your back on the client and walk away. You will be able to support her through the process.

Advocate and Empower

Advocating for your clients requires accepting them as they are and recognizing their unique strengths as well as their vulnerabilities. Even the most challenging behaviors or attitudes offer valuable clues to your client’s skills and motivation. A parent with a history of substance abuse has probably demonstrated a high degree of resourcefulness, not to mention networking abilities. Acknowledge these skills, and help the parent to identify and positively channel these attributes. Focusing on your client’s strengths is part of the core AIA philosophy of acceptance; when you approach your client as an individual, rather than defining her in terms of her substance abuse or HIV/AIDS status, your relationship has the potential to be transformative.

Parents Speak

You know, you sit around this table and you make up all the rules, and you give them to me, but you never came to see about me. No one asked me what I thought about what you all came up with?

Be Honest

Provide accurate information, and don’t sugarcoat the truth. Be sure to inform your client of whatever bureaucratic processes she is required to complete at the outset of your relationship, and communicate clearly about the ramifications of her decisions. In taking a transparent approach, you are modeling good communication and distinguishing your relationship style from that of many child welfare workers, who don’t necessarily have the time and energy to walk clients through the details.
You may be the first professional your clients have encountered who focuses on their capabilities and affirms their competence as parents. Too often, the approach to at-risk families is to identify the negative behaviors that must be stopped, rather than the positive behaviors that can be cultivated. Yet, research suggests that promoting protective factors—such as parental resilience or an understanding of child development—is a more effective way to promote child safety with at-risk families. Protective factors strengthen all families, have no stigma attached, and are often skills that parents see the value in building (Child Welfare Information Gateway, 2007).

Your role is to work with, not for, your client, and an important aspect of this role is helping the client to identify—or, if necessary, to create—her own support network. Positive social connections can alleviate the isolation and stress experienced by many parents. Furthermore, AIA clients need a host of concrete parenting supports—such as childcare, transportation, and health care. It is the worker’s responsibility to introduce the client to community resources, and then to encourage the client to access these resources on her own. For instance, staff at Mission Inn in Grand Rapids, MI, go into the community with their clients to attend support groups, play groups or appointments. Then together they process what the experience was like for the client and what might inhibit the client from going back.

**PARENTS SPEAK**

Most addicts are very resourceful. We know how to strategize, we know how to get what we want, we know how to work around it, we know how to network. It’s just a matter of where we are concentrating that energy. And my worker just knew that I was a resourceful person because of that. She said, I’m just going to guide you in the right direction and hope you concentrate your energies in the proper manner.
fathers or father figures whenever possible. Your client may suffer from social isolation, or she may be enmeshed in unhealthy social networks characterized by conflict or dependency. In fact, almost two-thirds of parents served by AIA projects reportedly have been or are still in violent relationships (Fuger, Abel, & Stephens, 2007). For these women, it is important to acknowledge the ambivalence that they might feel toward an abusive partner, and the complexity of the situation. It may be helpful to explore with her what she gains from the partner, what it would take for her to leave him, and what she gains and loses by staying or leaving. Although an in-depth discussion about domestic violence and its impact on children is beyond the scope of this document, it is important to recognize that children exposed to violence in their own homes cannot be expected to benefit from treatment until some modicum of safety is achieved.

PARENTS SPEAK

Out of the whole team that was working with us, my [AIA] worker was the one person that would always ask my fiancé, “Well, what do you have to put in on this? How do you feel about this; do you think this is a doable thing?” And everybody else just acted like he was a little statue sitting there, or something. She was really good about doing that.

WHAT ARE THE EMOTIONAL DYNAMICS?

Many clients were never adequately parented themselves and don’t have a frame of reference for providing the unconditional love and attention their children need. You may find that clients are jealous of your focus on their child, and you will need to balance your attention. Your task is to strengthen the parent-child relationship, which means it is best to approach the parent(s) and child as a unit, rather than concentrating only on the child. Or, there may be older children in the family who are presenting more of a problem for your client than the infant who is the identified “index” child. Any successful intervention will need to address resources for all the children in the family, such as linking them to after-school care, tutoring, counseling, and collaborating with different service providers.

WHEN THE FAMILY IS NOT A SUPPORT

Clients often suffer a lack of familial support. Perhaps they are estranged from their extended family, either due to their own substance abuse, HIV/AIDS, and/or intergenerational substance abuse. They may or may not be partnered, and their partners may or may not be the fathers of their children. AIA projects work to repair family relationships, when this is appropriate, and to encourage the participation of fathers or father figures whenever possible. Your client may suffer from social isolation, or she may be enmeshed in unhealthy social networks characterized by conflict or dependency. In fact, almost two-thirds of parents served by AIA projects reportedly have been or are still in violent relationships (Fuger, Abel, & Stephens, 2007). For these women, it is important to acknowledge the ambivalence that they might feel toward an abusive partner, and the complexity of the situation. It may be helpful to explore with her what she gains from the partner, what it would take for her to leave him, and what she gains and loses by staying or leaving. Although an in-depth discussion about domestic violence and its impact on children is beyond the scope of this document, it is important to recognize that children exposed to violence in their own homes cannot be expected to benefit from treatment until some modicum of safety is achieved.

PARENTS SPEAK

I was in an abusive relationship for fifteen years. The man broke both my arms—did I say “no”? When they let me out of the hospital, the lady said, ”Don’t go back to him,” but I couldn’t say “no.” I went back again, he hurt me again, eventually I left, but “no” was just too much for me to say. … People say, just kick him out, or just leave, but there’s a lot of other issues in there. He talked for me, he did everything for me, I had to think what he wanted me to think, move when he wanted me to move, so it was really like there was two of him and none of me. When it’s like that, you could tell someone all day long, “put him out,” but it’s not that easy, because in all reality, she has become him.
stance abuse is involved, it is relevant to identify what safety threats are directly related to substance abuse; how these can be controlled; and what level of effort is required to ensure an effective safety plan in the home (see section 5 for more information). It is also important to evaluate what the National Resource Center for CPS refers to as “caregiver protective capacities.” These are three crucial categories of characteristics—cognitive, emotional, and behavioral—that are directly associated with a parent’s ability to protect their children. In other words, how a parent thinks, feels, or acts toward their child should all be assessed, and may need to be addressed separately.

WHEN TO MAKE A REPORT

It can be unclear when (or whether) changing circumstances require you to make a CPS report. This often is a grey area that requires supervisory guidance. If new risk factors emerge (e.g., you learn about domestic violence), or if risk factors reemerge (a parent relapses), you do not necessarily need to make a new CPS report. If the family has an open CPS case, you will probably find it more effective to communicate with the client’s CPS worker to share information and to collaborate around modifying the client’s treatment plan. However, if a circumstance arises that is a trigger for mandated reporting—for instance, a child being repeatedly left without supervision—you are required by law to make a new CPS report, rather than simply notifying the client’s CPS worker. If the family has an open case when you make the report, you can let the hotline screener know, “this is an open case, and this is who the caseworker is.”

PARENTING ASSESSMENTS

Who says that I’m not a parent? How can you decide if I’m a good parent or not? I felt like nobody even tried to find out why was I using drugs, what even took me to the point of being this parent that everybody said I was.

— AN AIA PROJECT GRADUATE

The first step in addressing parenting skills and relationships with a family is to learn about the family’s immediate needs and concerns. Approximately one-quarter of AIA clients are referred from CPS, and almost two-thirds have an active CPS case (Fuger et al., 2007). With these families, it is important to read the full CPS report to understand the identified risks and safety concerns, and follow-up with the case worker to clarify why the referral has been made and the rationale for the treatment plan (see section 5 for more information about working with CPS). It is equally important to conduct your own assessment of each family, and gain their perspective on their situation.

Assessing Risk

Assessing risk is considerably more complicated than completing a checklist. It requires making observations and compiling data over time in order to measure progress and monitor any changes in the level of risk. In situations where there is evidence of present danger—such as an unexplained injury to a child, or a marked deficit in your client’s cognitive processing—this is a safety issue that will need to be reported to CPS. However, risk factors are seldom so clear cut and your job as a community-based worker is to design a risk management plan with your client, and to monitor and modify it as necessary throughout your time together.

It is fundamental to the AIA approach that parents affected by substance abuse are not by definition labeled ‘bad’ parents or incapable of maintaining a safe home. In assessing risk and safety when sub-
As illustrated in Appendix C, AIA projects employ numerous tools in the on-going assessment process. Many AIA projects have found structured observations—either directly, or through videos—to be a particularly effective means of learning about parents’ skills and the nature of their interactions with their children.

It is worth noting that assessments are not expected to be completed during your first meeting with a family. Many assessment instruments can be completed over time and, in fact, may be more likely to be completed accurately when you have established a trusting relationship with your client. It often is very instructive to compare the information received initially with the information provided once an alliance is formed and the work is moving forward. The assessment process itself can be used to educate parents in a supportive, nonjudgmental way by identifying and celebrating strengths and providing information about ways to improve areas of vulnerability that the parent has identified.

**PARENT’S HISTORY**

Most AIA case workers take a detailed biopsychosocial history on each new client, communicating, as one worker puts it, that “we care about you and where you come from.” Of course, it may well be that your client provides bare-bones information at the time of your initial assessment and only reveals deeper issues after a trusting relationship has developed between you. However, the process of collecting information can help in establishing a relationship and provide critical information about the family and their capacity to appropriately care for their children.

**OTHER ASSESSMENT DOMAINS**

In order to develop appropriate parenting interventions, it is important to learn about parents’ strengths and supports; their values and knowledge about parenting; and their own life experiences (e.g., how they were parented). The more you know about a family, the better prepared you are to help them address their needs. At the same time, it is critical to carefully select only those instruments that fit your projects’ goals, staffing and clientele, and that will generate information that you will use in case planning and service delivery and/or project evaluation. Whereas evaluation is critical to monitor program success, inform programmatic changes, and leverage funding, data collection must serve a clinical purpose as well.

**RED FLAGS**

The following list of universal safety threats was developed by the National Resource Center for Child Protective Services, a service of the Children’s Bureau operated by Action for Child Protection, Inc.

- nobody to supervise
- violence
- lack of impulse control
- no motivation
- insufficient knowledge or skill
- distorted view of a child
- deprivation of essential resources
- serious threats
- intention to seriously harm
- hiding child; refusing access
- unmet exceptional needs
- dangerous environments
- serious injuries
- provocative or self-destructive child behavior
- fear as an expression of threats or terror
- unexplained injuries
PARENT’S STRESSORS AND SUPPORTS

A key piece of the assessment process is to assist parents in identifying their primary stressors and supports. This involves working with parents to evaluate their mental health status; parental capabilities; social supports; knowledge of infant/child development; and community needs. It also involves helping parents to identify any factors that place their children at risk of removal from their care. It is important to determine the nature of the relationship, if any, the parent has with the child’s father and/or her partner. A partner who provides drugs, but no economic or emotional support with parenting, is a particular source of stress that can impact the mother’s caregiving capacities on multiple levels.

Evaluating interpersonal stressors and supports with the client reveals the challenges inherent in AIA’s family focus. Different family members may have competing needs, and family relationships are likely to be contentious or laden with tension. Yet, because the child’s well-being is dependent on the family’s well-being, it is essential that the caseworker attempt to promote the welfare of the entire family unit, with the overarching goal of supporting parents in their role as caregivers.

CHILD DEVELOPMENT

A key to effective parenting is understanding and meeting your child’s developmental needs. Children affected by substance abuse and/or HIV/AIDS are likely to be at increased risk for developmental or behavioral problems. Caseworkers should help parents to understand the strengths and needs of their children, and assist them to gain the parenting skills that will enable them to respond to these needs appropriately. Keep in mind that, although you may be very knowledgeable about child development, parents should be recognized as experts on their own children. Involving parents in assessing their child’s development can help parents form realistic expectations and goals for their child.
PARENTING KNOWLEDGE & SKILLS

Effective parents are knowledgeable about basic age-appropriate child care, child health, and nutrition. Simple assessments can help to determine whether or not the child is being adequately cared for and the extent to which the parent is aware of what is appropriate. For instance, you may look to see if there are diapers; if the child gets to bed at a reasonable hour; if the family has routines and rules and if the rules are enforced consistently; if good behavior is rewarded; if the children have been to their well-baby/child check-ups and are up to date on their vaccines; and if there is appropriate food for the children. Various tools (e.g., Annie E. Casey Life Skills Parenting Supplement described in Appendix C) are designed to assess these areas; however, it is important to be sensitive to cultural differences when conducting these assessments. Cultural standards, for instance, may affect the type and quantity of food children are given and whether a doctor is called for a child’s illness. While these practices may differ from your ideal, they do not necessarily put the child at risk. If, however, you determine that a parent is not adequately caring for her child, the next step is to learn why. Do they lack the resources or the knowledge, or is there some other obstacle, e.g., depression, fear of the health system? It is difficult to develop an appropriate service plan until these questions have been answered.

PARENTING INTERACTION

The quality of early parenting is a pivotal and persistent factor in children’s learning and social interactions (Belsky et al., 2007). In their development of the Keys to Interactive Parenting Scale (KIPS) (see Appendix C), Comfort, Gordon, & Unger (2006) drew from child development research studies to identify the following twelve parenting behaviors that are key to parent-child interaction:
- sensitivity of responses
- response to emotions
- encouragement
- promotes exploration and curiosity
- involvement in child activities
- language experiences
- touch and physical interaction
- limits and consequences
- open to child’s agenda
- reasonable expectations
- adapts strategies to child
- supportive directions

Staff can use these key parenting behaviors on the KIPS tool to guide observations of parent-child interactions and open a dialogue with parents about their individual strengths and needs in nurturing their children. Rather than labeling interactions as “good” or “bad” parenting, these specific behaviors offer parents and staff strength-based areas for assessment, reflection and discussion. They also provide a focus for reflective supervision to enhance parent-child interactions.

Monitor Your Own Values

Throughout the entire assessment process, it is crucial to be aware of how cultural standards might color your judgment. In some instances, the assessment tools that are used to evaluate family functioning are value-laden and may contain culturally-mediated questions such “Does that family have dinner together every night?” or “How many books are there in the house?” Similarly, a worker might not believe that co-sleeping with one’s infants is appropriate, despite its universal acceptance in some cultures. Instead of passing judgment, the worker should gain knowledge and understanding about safe ways to co-sleep, and educate the parent so that they can co-sleep safely.

A family that might appear “at-risk” by your own cultural standards may be functioning at a level that is positive in this family. Caseworkers are expected to be non-judgmental and accepting of cultural, linguistic and ethnic differences. From the child’s point-of-view, any disruption of his ties to his primary caregiver presents a psychological risk that must not be taken lightly. Recommendations must never be based upon the values of those ostensibly working on behalf of the child and family.
I
At Philadelphia’s Family Centered Home Visitiation Program, assessments are spread out over three months of weekly visits. The worker starts with a biopsychosocial assessment of the client, reviewing her childhood environment as well as current stressors and supports. After building the initial rapport, the worker moves on to administer a depression screen, health & safety checklist, nutrition screen, the ASQ, the KIPS parenting scale, and the Life Skills Progression Scale (see Appendix C).

I
Family Options in Chicago, Illinois, serves families at risk due to HIV/AIDS. Workers do a family genogram at their first visit, as well as completing a state-developed acuity scale, which assesses the client’s need for services.

PUTTING IT INTO PRACTICE

AIA caseworkers and parent educators prioritize creating rapport with clients as the first and most important task of the assessment process. Getting to know clients and developing a working alliance takes time.

I
In New York City’s Best Beginnings Plus, peer workers from the community do outreach to at-risk Dominican families. In the first interview, mothers are asked to describe their own childhood environment, including how their parents disciplined them. At the second interview, the worker reviews the philosophy of the program, emphasizing that participation is voluntary, and that the goal is to create a healthy relationship for the mother, her baby, and her community. One worker described her message as, “We’re not here to judge you or make you be a ‘better parent,’ but we’ve got information and resources that, if you choose to use, could make things better for your children.”

I
The parenting educator with Shared Family Care in Concord, California, and therapists in Michigan’s Mission Inn, go through the Ages and Stages Questionnaire (ASQ) and the ASQ: Social Emotional with clients at the very beginning of the assessment process. This process “puts moms in the driver’s seat,” as the mother serves as the expert who lets the worker know what her child can and can’t do. It also provides an opportunity to talk with the parent about daily routines in the home, how the family shows affection to one another, and how behavior challenges are handled.
INTERVENTIONS

All parenting interventions should respect and encourage parents’ expertise, reinforce their strengths, and allow them to identify what they want to get out of the intervention. If the worker can communicate, “I will ally with you to help your children,” this is far more effective than communicating, “I will tell you what to do to be a good parent.” This section highlights lessons learned in the following areas of parenting intervention:

- safety planning,
- partnering with CPS,
- parenting classes,
- promoting emotional attunement and realistic expectations,
- discipline,
- learning appropriate touch and play,
- recreation,
- life skills, and
- working with fathers.

Safety Planning

A safety plan, developed with the parents, is a primary tool for managing child safety. This should be a comprehensive plan identifying the actions the client will take to assure the safety of their children if situations arise that threaten them. While you can provide information about emergency and crisis resources, your client is the one who knows what situations are actually likely to arise in her home. A good safety plan is co-constructed with your client and with the involvement of any other responsible adults in the home. Developing the plan allows you to walk through a range of scenarios—possible relapse, suicidal ideation, violence towards children—and encourage your client to identify who she would call, how she would ensure the safety of her child(ren), and how she would cope with any of these scenarios. If CPS is involved and has identified safety threats, it is their responsibility to develop the safety plan; in these cases, the community provider can be an integral part of the plan and help the family to carry it out, but should not create a separate plan. Even if CPS is not involved, make sure that there is one overarching plan that is consistent with other plans that may have been constructed with a drug treatment counselor or other service provider. Bring a respectful approach and realistic expectations to working out a safety plan, and your client will be empowered by the process of taking responsibility for her family’s well-being. Also, be sure to view any safety plan as a fluid document that should be routinely revisited and updated as needed to incorporate situational changes and new risk factors.

HEALTH AND SAFETY

Any safety plan should include a review of basic environmental safety. Environmental hazards, such as open windows without guards or uncovered electrical outlets, are not only hazardous to children, but can generate stress and anger in parents who grow frustrated with trying to keep children out of harms’ way.

If drugs are present in the home, like household cleaners and chemicals, the drugs should be kept locked up and out of reach of all children. If the parent continues to use drugs, the safety plan should include who will care for the child while the parent is intoxicated and while she is coming down from her high. Safety plans should include more than simply using while the kids are asleep or using in the bathroom with the door closed.

In some cases, environmental safety is out of the control of clients who live in sub-standard housing. The best support you may be able to provide your client is to help her advocate with her landlord for safe, legal living conditions, or help her find housing in other safer areas.

In discussing safety with your client, try to avoid talking down or promoting a feeling of inadequacy. Ask the client, “What’s your idea of safety?”—then follow up with positive examples that are already in the home, whether this is food in the refrigerator, a smoke detector, a crib, a lock on the front door, or other childproofing strategies. Start by talking about what is working, then lead up to areas for improvement. Rather than assuming the same words mean the same thing to each of you, it is important to continually check what each of you thinks the other means.
Cultural issues also come into play in addressing health and safety issues. You may well be requiring your client to satisfy safety guidelines that didn’t apply in her own childhood. As one AIA worker notes, there is no Spanish word for “childproof,” and parents of all ethnicities are likely being held to a higher standard of childproofing than applied when they were growing up.

PARENTS SPEAK

What if I don’t know that my child is at risk? I raised my child the way I was raised. Then a CPS worker came in and told me there was something wrong, and I felt like, gee lady, I’ve been living like this all my life. It would be good to be taught about safety without making me feel inadequate. If someone tells me that being safe means that my kids have food, a place to sleep every night, and no strangers coming through the apartment—I think I would be insulted. A lot of these things, I would look at as my responsibility for taking care of my child, not a safety precaution.

PUTTING IT INTO PRACTICE

AIA projects use a variety of techniques to reinforce household safety.

- Workers with Best Beginnings Plus show their clients a video created in collaboration with the local hospital’s pediatric department that depicts children in a variety of easily preventable dangerous situations (such as leaning out of an open window) and discusses the lessons learned.

- Other workers review Health and Safety checklists with clients at the first visit and review it periodically. See Appendix E for a sample Health & Safety Checklist used by the Family Centered Home Visitation Program in Philadelphia.

PHYSICAL AND EMOTIONAL SAFETY

Constructing a safety plan involves helping your client understand and acknowledge the triggers that may provoke a relapse, a violent outburst, or depression. Rather than placing a judgment on these possibilities or pretending they won’t occur, you can empower your client by encouraging her to strategize realistically about what she can do to protect herself and her children from harm. It is essential to be specific in your questions and in creating a plan. Ask: “If you feel the urge to use, who will you call? What will you do? How will you do it?” Make sure that your client has identified a safe caregiver for her children, should she need one. Similarly, you will want to ask, “If you feel yourself wanting to harm your baby, what can you do? Who can you call?”

It may be that another adult who either lives in the house or has access to the house presents a safety threat. Perhaps your client is in a relationship...
PUTTING IT INTO PRACTICE

• Many AIA projects have staff available on a 24/7 basis to assist families should a crisis occur. Additionally, Best Beginnings Plus gives each family a card with the phone number of an on-call general practitioner who can be contacted 24/7. Families are trained on how to make the call, navigate the voice mail, enter their child’s medical record number, and wait for the call-back.

• The Coordinated Intervention for Women and Infants (CIWI) Project in New Haven, Connecticut, provides recycled cell phones to mothers affected by domestic violence. They also instruct these mothers to be prepared by keeping a baggie with ID and cash in their baby’s diaper bag, identifying who they will call if they don’t feel safe calling the police, and where they will go if they have to leave the home immediately.

• One CRADLES client with developmental disabilities was having trouble keeping an abusive partner out of the house, posing considerable risk to her seven children. Her case worker spent an afternoon role playing a variety of scenarios in which the partner might try to enter the home and drilled her on calling 911 until she—and her worker—were confident that she had mastered this skill.

• Mission Inn uses a client crisis/safety planning form with clients to help identify potential crises and ways to prevent or manage them. This crisis planning form includes local help numbers as well as open space where clients can personalize the plan with their own supports (e.g., “I can call ___”) and add their own coping strategies. This is a duplicate form, which the worker fills out with the client, so that each can keep a copy. (See Appendix F for a sample of this form).

PARENTS SPEAK

We did something in treatment where we had a journal process group. They would put some subject on the board, and the one that stuck out in my mind was when they said, “Describe a safe place.” And what they were referring to was what you want as far as your family home environment to be. And just to sit and write things down and mull them over in your head and rehearse it—that helps you to get so much closer to where you want to be, allows you to practice it in a way.

involving domestic violence, or her partner or close relative is drug addicted. It is important that the safety plan provide for situations involving these individuals. If there are older children in the home, they should know the details of the safety plan. It is very useful to hold a family meeting with everyone in the family present to talk over the plan to be certain that everyone is aware of the details. Older children need to understand that it is okay to leave their home if a threatening adult enters the home, to identify a safe place to hide, and to identify other trusted adults in their lives, such as teachers, who can provide support and security.
Changes in welfare reform and the passage of ASFA have shortened the timelines for clients to achieve financial stability and for workers to complete permanency planning. AIA projects are designed to maintain children with their biological families and prevent their placement in out-of-home care. Due to the uncertainty of state funding, child welfare departments won’t be motivated to work with projects unless they are viewed as successful in reducing the need for placement while ensuring the safety and permanence of children referred for intervention.

**CLARIFY ROLES AND RESPONSIBILITIES**

You will build greater trust if you are proactive in affirming professional differences, both philosophical and practical. While you and the CPS worker both share the goal of safety and permanence for the child, you each play different roles and have different perspectives on the family as a whole. Whereas AIA workers are involved in supporting, advocating for, and skill-building with parents and caregivers, CPS workers can act as investigators who have the power to remove children from their parents.

Let CPS workers know that their opinions are valuable and that you don’t view them as the “bad guys.” Given their case loads and systemic pressures, it is impossible for CPS workers to have all the information about client families that you have. At the same time, you need to be clear about the limits of your role. Remember, you can help mediate a non-adversarial working relationship between the client and CPS, but you do not carry the same responsibilities as a CPS worker, and you want the client to recognize that you are there to provide different types of services. When CPS has identified safety threats, they must establish a safety plan. The AIA worker can then be brought in as a key service provider to carry out that safety plan, but it does not relieve CPS of its duty to oversee that safety plan. AIA can be the eyes and ears in the home,

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2 Differential Response is a front-end alternative to the traditional child welfare approach. It is characterized by the following general components: screening based on risk, voluntary provision of services, respectful engagement of families, increased community involvement, and a focus on prevention.
partner with CPS to alert them to any increasingly volatile circumstances, and work with family members to make the safety plan successful. To maintain the trust of your clients, be sure to let them know if you are going to provide information to CPS, and always go to your supervisor when you have questions about conveying information that the client has shared with you.

OUTREACH

The same persistence required to establish a successful relationship with clients is required with CPS. AIA projects need to keep in continuous contact with all levels of their local CPS agency, talking together, holding joint meetings, and making regular presentations at each unit to explain what the project does and how it can benefit clients on the CPS caseload. Due to high turnover, it is important to return at regular intervals and orient CPS staff on an ongoing basis. Keeping in regular contact with clients’ caseworkers will also further trust, collaborative treatment planning, and positive referrals to other caseworkers.

During presentations, keep the emphasis on how the AIA project can provide support in meeting the needs of children and serve as a valuable resource in risk management. Take the opportunity to educate CPS workers as to the range of clients you can assist. To get buy-in from current staff, it is essential to reassure them that you are providing a means to lighten their work load, not creating more work.

Mailings also can be a useful form of outreach. Mission Inn sends regular mailings describing their services, with referral forms enclosed, to all local CPS units, foster care agencies, and other service providers who work with their identified population.

EDUCATE

One of the most valuable roles an AIA worker can play is to educate clients about what is involved in working with CPS. Workers can provide information on the court process and accompany clients to court to offer support. For instance, workers with the TIES Program in Kansas City, MO, prepare their pregnant clients (who have been referred to the program due to substance abuse) for what they can expect from the newborn crisis intervention assessment that will usually result when their child is born with a positive toxicology test.

PARENTS SPEAK

My CPS worker felt like a blank slate to me. She showed up at court, at meetings, at my house once a month. It was just like having a chalkboard sitting there, with a piece of chalk scribbling down notes. It’s not that I didn’t like her—you could just tell that she was overwhelmed. She just wanted to get it done. When my [AIA] worker came, it eased up the burden for me, helped me to kind of sort things out. We sat down and prioritized what needed to be done. She said, it’s in the best interests of the children to stay with you, and if we can make that happen, we’ll make that happen. She just eased it all up for me. As the relationship developed, I learned to have my voice and talk to my CPS worker about things that I was concerned about. The [AIA] worker really helped me get over my fear and get a handle on what was going to happen with CPS.
AIA workers can also educate CPS workers and the courts (e.g., attorneys and judges). This may take the form of providing education about general matters: for example, clarifying the disease course of HIV/AIDS and helping workers to understand that children can stay in the home safely with HIV-positive parents. Similarly, by educating these systems about the role of relapse in the recovery process, AIA workers can advocate for women who have substance abuse histories and are competent parents. Education also may take the form of providing insight into specific matters: for example, if a client is not complying with a treatment plan of attending therapy simply because she doesn’t like the therapist, the AIA worker may be able to help her advocate for a different therapist. AIA workers can also advocate for increased visitation and reunification for those children placed out of the home.

PUTTING IT INTO PRACTICE

AIA projects have developed a variety of ways of collaborating with CPS that allow workers to support and advocate for the specific needs of their client families.

- The Oklahoma Infants Assistance Program (OIAP) in Oklahoma City works with families whose infants and young children have had prenatal drug exposure; most of their clients enter the program to fulfill the requirements of a child welfare treatment plan. OIAP works in close collaboration with CPS, which has created a separate unit servicing only OIAP clients. One benefit of this relationship is that OIAP gets access to statewide database reports, facilitating their research on outcome measures.

- Best Beginnings Plus has a Memo of Understanding (MOU) with CPS, authorizing them to provide preventive services—on a voluntary basis—to CPS clients.

- In-home workers from Coordinated Intervention for Women and Infants, most of whose cases are referred from child welfare, meet bi-weekly with workers in the protective services unit at CPS to review cases, exchange relevant information, and coordinate treatment planning.

- CPS workers in Rhode Island review the cases of children in care every six months. Care coordinators with the Vulnerable Infants Program 2 attend these administrative rounds to provide updates on behalf of their client families.

- Shared Family Care is an innovative child welfare model that places at-risk families in the homes of community mentors while the parent gains the skills needed to transition to independent living. Case managers attend their clients’ monthly meetings with CPS workers to provide support and to corroborate the progress clients are making.

- TIES Family Support Specialists advocate on behalf of the child and for services to the parent(s) and/or caregiver; maintain frequent contact with Children’s Division workers; and participate in weekly or monthly Family Drug Court staffings.

Child Protective Services is only one of many systems and agencies that AIA projects collaborate with in order to enhance parents’ capacity to adequately care for and ensure the safety of their children. No single worker or agency can effectively address the multiple, interwoven challenges facing families affected by substance abuse and/or HIV/AIDS. Creating and sustaining mutually cooperative relationships with community organizations, child welfare agencies, medical and mental health institutions, substance abuse treatment agencies, child development specialists, schools, courts, and housing authorities is an ongoing task for all AIA projects. The same strategies that are key to relationship building with clients—establishing rapport, giving honest assessments, co-creating goals, and providing concrete services—are essential to the success of interagency collaborations.
The Good, Bad, and Ugly of Parenting Classes

If you are working with a client who has had involvement with the child welfare system, chances are good that she has taken a parenting education class. There are an estimated 50,000 parenting programs nationwide, the majority of which are designed to prevent child maltreatment (Center for the Study of Social Policy (CSSP), 2004). These short-term didactic classes, which focus on child development milestones and recommended skills for managing child behavior, have notable limitations; yet, they continue to be routinely prescribed as a requirement for family reunification. While some studies suggest that didactic classes can improve parents’ attitudes toward and perceptions of their children, by and large they have not been found to effect changes in parents’ actual behaviors. These classes may allow for information-sharing, but they don’t create a context within which to practice skills, nor to receive corrective feedback (Price & Schmidbauer, 2003).

As a result of these routinely mandated classes, you may encounter a certain understandable resistance when you approach a client with the goal of providing parenting education. Be patient, and keep in mind that parenting is about a relationship, so not surprisingly, the relationship the parent has with you is a major factor in the success of training. Furthermore, training that is experiential and integrated into daily life is far more likely to change behavior than training in a classroom setting. For instance, Pro-Kids Plus, a former AIA project in Hartford, CT, uses “parenting intervention on the go,” in which the child’s needs and the parenting interaction are addressed during every encounter with the family. Workers use the technique of “pivoting the caregiver’s consciousness to the child so that the needs of the child and relationship are not lost in the myriad other seemingly more pressing needs” (McLaren, 2003).

Further, research suggests that parenting programs that include an individualized component and that offer home visiting or training in a combination of office and home settings are most successful (Lundahl, Nimer, & Parsons, 2006). Reflecting this, many AIA projects offer customized parenting groups accompanied by individual work. This approach can help parents who, for instance, lacked support in their own childhood and need to work through their own history and come to a point of empathy for the child they were before they can feel empathy toward their children. This emotional work needs to occur before the basics of child rearing can be effectively addressed. Because some parents with traumatic histories would have difficulty discussing this in a group setting, AIA projects offer an opportunity to work on these issues one-on-one and assist parents to develop individual coping strategies to handle their own uncomfortable emotions. This work cannot be done easily in a large group.

WORKERS SPEAK

The women in our residential drug treatment program get comprehensive hands-on parenting education, but what we are finding is that they also need individual time, assessment, and intervention depending on what their primary issues with parenting may be. Themes include defining safety, as they are at high risk of abusing their children based on the parenting they received; how they can help their child to attach when they do not know how; learning to not leave their children or push their children off on others; and how to create a healthy structure in the home.

Other factors associated with strong parenting programs include
- long-term availability;
- connecting parents to additional support services;
- creating support groups of parents staffed by peer facilitators;
- respect for individual and cultural differences;
- a focus on parents’ strengths; and
- recognition that learning is affected by the quality of interpersonal relationships (Center for the Study of Social Policy, 2004)
CHARACTERISTICS OF GOOD PARENTING EDUCATION CLASSES

While individualized intervention is imperative, parenting classes also serve a purpose if they are conducted well. Members of the AIA Technical Expert Group, whose ideas and experience informed this document, identified the following characteristics of a good parenting education class:

- Leaders don’t take for granted what attendees will know or understand about child development, child rearing, or creating a safe home environment.

- Topics for discussion acknowledge the parent as an individual with a range of concerns, not just as a parent.

- Leaders avoid a cookie-cutter approach and are flexible enough to set aside standard topics such as developmental milestones in order to address other critical issues.

- Parents are encouraged to explore how their own personal experiences—as a child and as an adult—affect their relationship with and approach to their children. Similarly, they are encouraged to try to understand how their interactions make their children feel, rather than focusing solely on child behaviors and milestones.

- Parents are taught a variety of specific strategies they can use with their children to improve their relationship and increase positive behaviors of their children.

- Parents get explanations about the expectations of the child welfare system and are supported in strategizing how to ally with child welfare workers.

PARENTS SPEAK

Through my parenting group, I learned to make “I” statements, to consider my children, to take responsibility, that it’s a give and a take, that I can be wrong sometimes, that they can make their own opinions. It helped me realize that when I make decisions, I have to make them around my children; I have to include what could happen to my children. I had to learn to look at the bottom line—did I make a decision for me, or were my children included?—and 99% of the time I found that each decision I made, I made selfishly—it was about me.

Promote Emotional Attunement

Perhaps the most crucial intervention with at-risk parents is to strengthen their emotional attunement to their children. A parent who is not sensitive to a child’s emotional needs may be able to learn behavior management skills, but will be unable to provide the emotional nurturance essential to the child’s attachment. The capacity for emotional attunement is dependent on what is sometimes referred to as “mentalization,” the ability to perceive and understand the mind of someone else. If a parent is not capable of acknowledging her own mental and emotional states, she will not be able to create a healthy parent-child relationship. Therefore, the first step in promoting emotional attunement often involves working with clients on identifying their own feelings and increasing their comfort level with learning to talk about their feelings and express them appropriately. It is particularly important for the client to gain comfort in identifying and managing painful emotions, as this is the basis for her being able to handle and appropriately respond to her child’s emotional distress; in turn, it is the basis for the child learning emotional regulation.
Emotional attunement is particularly relevant with substance-abusing mothers, given that substance abuse can be seen as a way of compensating for difficulties with emotional regulation. Building on studies of brain pathways, some researchers hypothesize that “as a mother’s capacity to contain and regulate her own and her child’s painful affect increases, her desire to return to drug use as a source of emotional comfort may also diminish…. New treatment models that help parents invest in their children, rather than substances, may therefore ‘reset’ the focus of the reward system” (Suchman, Pajulo, DeCoste, & Mayes, 2006, p. 220). In other words, rather than waiting for a mother to complete recovery as a precondition of involvement in her child’s life, working on a healthy parent-child relationship has the potential to support the recovery process. Structured play time is one example of an intervention that can increase the intrinsic rewards of this relationship. Ultimately, the goal is to help the parent see the child as another individual, understand the child’s strengths and developmental needs, and become psychologically free enough to respond to the child not as an extension and recapitulation of herself, but as someone who is dependent upon her, loves her, and can give her pleasure. The parent can, in fact, gain a sense of competency, efficacy and accomplishment through the act of parenting.

Promote Realistic Expectations

A basic understanding of child development will enhance parents’ capacity to form realistic expectations of their children’s behavior. Providing parents with accurate information about a child’s capabilities and concerns at different ages and stages allows them to have more appropriate expectations, increased patience, and a greater understanding of sometimes challenging behaviors, reducing the likelihood of inappropriate response and ineffective disciplinary practices.

PUTTING IT INTO PRACTICE

Mission Inn caseworkers provide parents with teaching tools called the Baby Stages Wheel and the Preschool Stages Wheel, which were created by the Michigan Association for Infant Mental Health. These wheels outline what healthy social, emotional development for infants, toddlers, and preschoolers typically looks like and the appropriate caregiver responses to promote social and emotional development at each stage. Caseworkers give this to parents as they work with them to complete the ASQ:SE for their children. Other AIA projects, such as Shared Family Care, also use the ASQ:SE as a teaching opportunity.

PARENTS SPEAK

We had this icebreaker in our parenting group where the leader said, “Brag on your children.” There were ten of us sitting there, and she gave us fifteen minutes, then she went up to the board and said, “Okay, what did you all come up with?” Not one of us had anything good to say about our children. There was no connection; we had no connection with our children. We had it in other areas, where everything was wrong. The leader said that didn’t make us bad parents, it’s just that we centered our energy on what the children did wrong instead of helping them, praising and encouraging them. But when she gave us that exercise again a year later, we all came up with something!

3 Baby Stages and Preschool Stages Wheels can be ordered for $1 per wheel for Michigan orders and $2 per wheel for out-of-state orders. For more information, go to www.mi-aimh.msu.edu.
Encourage Effective Discipline Techniques

Parenting interventions often involve teaching effective, nonviolent disciplinary techniques. As a caseworker, you can encourage the use of positive reinforcement, especially since this is as relevant a motivational technique with parents as with children. Some AIA projects do not encourage parents to use time-outs because they have found it to be an ineffective tool for families where there has not been a sufficient amount of “time-in” with children. Instead, they focus on proactively setting up a child-safe environment, fair and consistent limit-setting, distraction, and redirection to help young children learn appropriate behaviors. They encourage parents to let their children experience, learn to identify, and appropriately express their emotions, even if these are negative, rather than rush to shut them down.

Other AIA projects have had found time-outs to be effective when used appropriately with children who are preschool through elementary aged. These projects help parents to use brief time-outs constructively to provide a sense of containment and security following out-of-control behaviors. However, this technique is not recommended for very young children, and it is critical to ensure that a strong parent-child relationship is in place prior to implementing it. For instance, the Oklahoma Infants Assistance Program first focuses on building up the parent-child relationship through special play time, and then they teach parents how to use time-outs as one of many techniques including redirection. When used correctly, they have found this technique can help to raise a parent’s confidence and self-efficacy and result in a positive response from the children. Regardless of the specific technique, parents should be encouraged to allow children to make their own decisions when it is safe, and select from choices provided by parents so they learn how to manage their own behavior.

Some parents may be hesitant to consider alternative strategies because they know only one way, saying: “this is how I was raised”. Workers can pose questions to parents individually or in support groups to help them explore their experiences and alternatives for their children. “How did you feel about the way you were raised and what would you have changed if you could? How did you feel and what did you do when someone disciplined you when you were a child? How did you learn the “right” behavior in that situation so you didn’t get into trouble the next time? Think of a time when you disciplined your child. What happened? How did your child respond when you disciplined him? How do you think he felt? What can you do to help your child learn how to act the next time in this situation? How can you help him manage his behavior in other situations in your home, and also in the community with other children and adults when you aren’t there?” Whereas these questions can be helpful in exploring alternative patterns and behaviors with clients, some parents may need to just “vent” and feel like they are heard before they are willing or able to look at their own behaviors.

PARENTS SPEAK

The leader of our parenting group said, “I want to hear all the things you were told when you were coming up as a child, you know, like don’t walk under a ladder.” After we were done, she said, “Now tell me, which one of these things ever proved useful?” We found out that we had lived for years on myths that were not true, and we had passed them on. So she was able to open the door and go back inside and say, “Now that you know this, what would you do differently?” I had to realize that because of my own problems, I was overbearing, I was overprotective; because of all the things that had messed me up, I was afraid to allow my children to live their lives. I was afraid they’d get caught up in my life. We put challenges and burdens on ourselves and try to live up to these expectations, so if I’m putting it on me, would I not be putting it on my child?
Workers also must be sensitive to cultural differences in accepted discipline techniques and not necessarily hold families to predominantly white, middle-class standards of appropriate parenting. Forehand & Kotchick (2002) note that "aspects of parent training may need to be modified to match parenting beliefs and expectations. For example, in our work with African American families, we encountered substantial resistance to the notion of reinforcing or rewarding children for compliance with parental demands. We dealt with this issue by changing our language—instead of referring to reinforcement as rewarding good behavior, we referred to the practice of overtly showing or verbalizing appreciation for child compliance as 'showing your child that you love her' and as a step to building stronger parent-child relationships."

Similarly, completing a legal care plan for one's children may be considered a sign of giving up, particularly to a person who is deeply religious. A worker may not realize the role that religion plays in a person's concept of death related to planning. One way to help a parent recognize the importance of making a legal care plan and disassociating it with religious concepts of death is by normalizing the process as something that every parent should do whether or not they are currently healthy.

It is also important to recognize that culture is not just about race or religion. For instance, an African-American client in her forties noted that "They sent this young white girl to my house to talk to me about being a parent, you know, making this living will... I was offended because she was young." So, while the fact that the case worker was white may have caused the client some discomfort, the worker's age seems to have been more problematic for her.

Learning How to Touch

A very popular intervention technique among many AIA projects is teaching infant massage, either one-on-one or in groups. Infant massage is a valuable concrete interaction that frees the parent to focus on what she or he is doing with the baby. By interacting with their child in a clearly nurturing, pleasurable way, parents can reduce their own feelings of guilt or shame. Infant massage also helps parents, who may be uncomfortable with any physical intimacy due to their own histories of physical or sexual abuse, to become more at ease with appropriate touch with their baby. Additionally, infant massage can directly benefit the baby by increasing alertness, relaxing stiff muscles, building muscle tone, enhancing immune function, stimulating circulatory and gastrointestinal systems, and reducing pain and colic symptoms (International Association of Infant Massage, 2000).

Learning How to Play

Most AIA projects encourage parents to play with their children. For many parents, it is a revelation that playfully relating to their child is "good parenting." Thus, parents frequently need guidance in how to enjoy child-centered play. Techniques include promoting "floor time," or what the Best Beginnings Plus project calls "dance with your baby" time, which focuses on showing mothers how to interact with and pay attention to their babies. Some parents need particular encouragement to get past cultural barriers around getting down on the "dirty" floor. To respect this belief, staff often lay a blanket on the floor for the family to play on.

A key aspect of play-based interventions is to help parents learn to be good observers. You can assist this process by "wondering" with the parent: for example, "I wonder what he's trying to tell us ... I wonder what she would do if we tried this..." Wondering aloud promotes curiosity, along with receptivity to learning from the child. It encourages interest in identifying the thoughts, wishes, and feelings underlying the child’s behaviors, which is particularly valuable to cultivate during stressful interactions. Promoting play can be done one-on-one, or in groups. Some AIA projects hold center-based parent-child playgroups, which may revolve around a given theme (e.g., "look at your child's emotions"). Parents are free to play, while staffers float around the group, offering encouragement and suggestions for optimal approaches. This kind of structured child-centered play allows parents the time and space to make discoveries and have insights about their children’s motivation. It also allows workers a low-pressure way to guide parents in exploring the strengths and limitations of their interactions.
Many projects also encourage parents to engage in language building with their children. This can take the form of reading stories aloud. If you work with parents who either aren’t literate or have limited literacy, encourage them to pick up picture books and tell a story based on the picture. Let them know that simply talking to their child is a way of building language skills.

VIDEO TAPING

Many AIA projects use videotaping to observe parents playing with their children. This can be an extremely effective tool to allow parents to witness their interactions with children and to identify areas of strength and improvement. Several projects follow the Interaction Guidance Model of videotaping parent-child play sessions for immediate review with parents. In accordance with this model, workers first listen to the parents’ comments and reactions to the video before making their own observations. Workers highlight moments when the client exhibits the most sensitivity and nurturing behavior toward the child, and point out the pleasure and gratification the child derives from the interaction. These positive moments are jumping off points for further discussion, including discussion of problems and areas of concern as identified by the parent. The Interaction Guidance Model has been found to be especially useful for depressed, cognitively limited, and/or young mothers, as it is an accessible way to encourage a new perspective on both the child’s behavior and the parent’s reactions (McDonough, 2006).

Encourage Recreation

Families affected by substance abuse and/or HIV/AIDS can be especially well served by programs that enable them to identify healthy recreational opportunities. Many AIA projects organize community events as a way of helping clients build social networks and learn how to engage in shared activities with their children. For example, Best Beginnings Plus sponsors a Father’s Day event at a baseball game. CRADLES organizes visits to the local Children’s Museum. Families affected by HIV/AIDS also benefit from events that are designed to create positive memories. The parent organization of Family Options in Chicago, Illinois, sponsors two weekend-long camps each year for the children of HIV-positive clients, as well as back-to-school parties and visits to the zoo.

PARENTS SPEAK

Family camp helps the kids a lot. What they really like is that the families who come are either infected or affected by the [HIV] virus, and that whole weekend the kids can talk about it and do whatever it is they need to do. My daughter told me one time that when she gets to camp, “I can unzip my coat. It’s like I’m wearing a coat when we’re at home, but I can unzip my coat and take it off. Then on Sunday, when it’s time to go back, I have to step back in it and zip it back up.” They’re carrying all this excess baggage.

Provide Life Skills Training

The parenting education provided by AIA projects includes training in basic life skills that many of these families never received. These projects have learned that an effective way to help parents create healthy community connections and learn to advocate for themselves and their families is by modeling how it is done. For instance, clients with the Shared Family Care project live with mentors who model how to grocery shop within a budget, as well as how to prepare nutritious meals for themselves and their children. Shared Family Care clients also receive a date book when they start the program, “I can unzip my coat. It’s like I’m wearing a coat when we’re at home, but I can unzip my coat and take it off. Then on Sunday, when it’s time to go back, I have to step back in it and zip it back up.” They’re carrying all this excess baggage.
Working with Fathers and Father Figures

AIA projects are child-focused and family-centered. Although the vast majority of parents served by AIA projects are women, some families present as two-parent households; in other families, women have partners, who may or may not be the father of one or more of the women’s children. Some families may be headed by biological fathers who may or may not be currently involved with the children’s mothers. An increasing number of AIA projects are making efforts to engage fathers or father figures, recognizing the important role they play in their children’s lives.

Most AIA projects make special efforts to engage fathers and partners in the intervention. For instance, Family Options in Chicago, strives to treat fathers the same as mothers, inviting them to participate in the various activities offered through the program and provide whatever social work support they need. When working with a mother who is estranged from the father of her children, Family Options staff reviews laws about fathers’ rights and emphasizes the importance of putting differences aside and having open conversations with fathers about future custody planning. Typically this is only encouraged when a father knows the HIV status of the mother and when a father is actively involved in parenting their children. Family Options also holds mediation meetings between parents if both parents are open to this offer.

A few programs have found that a male case worker can be particularly helpful in engaging fathers and male partners. Recognizing that a father’s continued use of drugs can be harmful to the family, the Vulnerable Infants Program requests that CPS conduct a substance abuse assessment of all fathers and intervene when indicated.

A few AIA projects have gone a step further by providing separate services specifically designed for fathers and partners. These separate programs or services typically emerge from the following concerns as articulated by the Oklahoma Infants Assistance Project (OAIP) director:

PUTTING IT INTO PRACTICE

A peer consultant at Mission Inn developed and implemented her own program called The Lies that Bind—The Legacy of the Locks. This program is a cognitive restructuring and resocialization program based on the work of several experts in the fields of neuroscience and psychology. A cross-disciplinary, holistic approach, the program introduces participants to their unconscious beliefs that have been making decisions for them without their conscious awareness. One of the main tools of the program is a comprehensive assessment that exposes the negative, self-defeating programming that the participants received during their formative years. After extracting the unconscious beliefs, participants are given a variety of tools to assist them in reprogramming their unconscious thought process. Tools include belief system cards, groups targeting specific beliefs and fears, field trips, lifestyle comparison speakers, principle analogy movies, and topic panels. The program also offers practical instruction on transitioning from a subculture environment into the dominant culture. The program uses trained peer instructors and co-instructors who can “speak the language” of the group participants, as well as licensed MSW therapists.
Special Circumstances

Whereas most of the information in this document assumes that the parent and child are together and have a goal of remaining together, this is not true for all families. Following are some lessons learned in addressing future care and custody planning with HIV+ parents, and working with parents who are physically separated from their children or in the process of reunifying with them.

FUTURE CARE AND CUSTODY PLANNING

Developing a future care and custody plan for one’s child is an important parental responsibility, but one that few parents—sick or healthy—actually complete. When working with parents with HIV/AIDS who may be terminally ill, it is important to normalize this process and identify the benefits of it. Addressing custody and care planning empowers parents with the ability to determine who will care for their child(ren) in the event of their passing, and it can help to alleviate stress. One parent explains that coming up with a future care plan for her child made her a better parent because it put the reality of her HIV status in focus. It made her reflect on how she wanted to parent her child, which led her to take better care of herself and her daughter. It was a very freeing experience for her and was a great relief to know who would be caring for her child if she was not able to. This response may not be true for all parents. Thus workers should never force any parent to develop a care plan; rather they should be there to help the parent(s) work through the process if and when they are ready.

PARENTING CHILDREN PLACED OUT-OF-HOME

When children are removed from the home by CPS, working on parenting issues in more than just a superficial manner becomes a significant challenge. Although “parenting” typically is on the court ordered treatment plan, some parents may only receive a one-hour visit with their child(ren) once per month. Particularly with infants, this compromises the attachment process and the parenting role, with
many parents expressing concern that their babies don’t know or remember them. Separation may delay the identification of emotional issues mothers may have in parenting their children, and the practice and implementation of new parenting skills may not occur in any systematic way until the mother receives longer and more frequent visitation or is reunified with her children.

However, there are things that can be done to foster parenting skills and parent-child relationships while waiting for the family to be reunified. First and foremost is to always conceptualize the parent as a parent and help her to maintain that role. From the beginning, encourage parents to consistently consider their child and their child’s needs in making decisions. Reinforce that these are their children and that they have a powerful and unique role in their children’s lives, even if they do not currently have much contact. Utilizing role play and modeling to teach parenting skills can bolster confidence in parenting abilities, allay fears about reunification, and meet the CPS treatment plan requirement.

Parents can practice these new skills with other children they are involved with and during visitation with their own children. To provide increased opportunities for parent-child interaction, Great Starts, an AIA program in Knoxville, Tennessee, has mothers play with and care for infants in the therapeutic nursery—even though the parents are not related to these children. Parents can also interact with nieces and nephews, cousins, or children in their neighborhood. In addition to providing the parents with a chance to practice new skills, this interaction can help to identify potential emotional responses the parent may have to sober parenting.

Some AIA projects have found a pattern of increased visitations, including overnight visits, occurring prior to the final return of the children helpful. This allows the child and parent time to get accustomed to each other and the living situation while also allowing children time to transfer away from their foster parents. Encouraging the parent to talk with the foster parent to determine routines, favorite foods, sleep and nap patterns, calming and soothing techniques the child responds to, and other child specific facts can help smooth the transition. This can be difficult for parents to do as it acknowledges someone else knows their child better than they do; but having and using this knowledge can significantly impact their child’s adjustment. It is also helpful to assist the parent in anticipating behaviors that are common in children when initially reunified. Often children seek close physical proximity and a high level of attention. In young children this may take the form of wanting to be held. Rather than identifying the child as having been “spoiled” by the foster parents, it is helpful to think about the child needing reassurance and comforting and that the clinginess is likely short-term. Often children may react negatively to seemingly innocuous behavior such as a parent going into the bathroom. If, however, the parent had a previous pattern of getting high in the bathroom, the child’s reaction makes sense. Helping the parent look at the situation through the eyes of the child will help the parent better identify the child’s needs and respond appropriately.

Other practical suggestions to help with reunification include having a doctor selected ahead of time, identifying the school or choosing a daycare, and making sure all paperwork from CPS documenting parental custody and any medical records and/or birth certificates are turned over at the time of reunification to the parent. This helps the parent enroll the child in school, sign up for government aid, and obtain medical treatment.

Once reunification occurs, there are several important issues to address with both children and parents. As parents become sober and learn new skills and ways of interacting, children also develop and learn new skills. By the time reunification occurs, children and parents may be very different than when they were first separated from each other. While an exciting and happy time, resuming living together and especially beginning to live together, are not without their challenges.
Parents may feel that children should automatically recognize all the hard work and changes the parent has made and immediately trust that the changes are permanent. Children who have lived with a parent with a significant addiction, particularly one who had achieved sobriety in the past and then relapsed or had made and broken multiple promises, will likely need some proof before accepting these changes as legitimate. As such, one of the main issues children often experience is regaining trust in their parent. This may take the form of fearing a parental relapse, having difficulty relinquishing a parentified role, or simply not believing the parent will do what she says she will do. Another issue for older children can involve anger and upset that their parent is becoming sober for a younger child but was not able or willing to do so for them. Other issues include upset at having to change schools and move into different neighborhoods with a resulting loss of friends and, if part of a sibling group, confusion if siblings return home at different times, as can be the case if CPS is concerned about overloading the parent.

It is important for parents to recognize the fears and concerns of their children as legitimate and respond to them in a way that is validating and helpful to the child. Helping parents face their past behavior and acknowledge the impact this behavior may have had on their children is essential in helping them empathize with their children and identify how best to address the various issues that may arise. This will be difficult if the shame and guilt around their using behaviors have not been acknowledged and processed.
A positive climate supports staff to feel safe sharing and expressing themselves; feel a connection and shared commitment to the goals of the project; and participate actively in the process of program development. An essential component of a positive work environment is a strong peer support network. Staff members maintain a programmatic focus on improving child safety and parenting skills, while working with others in the community who may have different priorities. Building the necessary collaborations requires skill, commitment, and a reliable support network through effective supervision, teamwork, and training.

AIA projects have found that quality supervision enables staff members to reflect on their work, learn from their experiences, remain faithful to the treatment goals, and find the support they need to continue performing the work with positive regard for the families they serve. One of the key elements of reflective supervision—a technique employed by several AIA projects—is to have a regularly scheduled, protected time to discuss and process feelings, challenges and successes related to this kind of work. The supervisor must be consistent and available to the staff person on an as needed basis in addition to the scheduled supervision sessions. The clinician sets the agenda for what they need to talk about during each session, and the supervisor creates a safe, respectful, nurturing environment. The reflective supervisor becomes a partner to the clinician in working through difficult feelings and experiences. This provides an opportunity for clinicians to explore issues of transference and counter transference; to become more aware of how their own values and experiences shape the way they interact with clients; to deepen their knowledge base; and to put into words the feelings that this work brings up. In a parallel process, this type of supervision creates the same safe, nurturing place for sharing and working through difficult issues that staff provide for their clients.
PUTTING IT INTO PRACTICE

Arbor Circle (parent agency of Mission Inn) developed a home visiting safety training module that focuses on a 4-step guideline: (1) remain calm; (2) trust instincts; (3) evaluate options; and (4) seek supervision. All of these are incorporated into a variety of scenarios, including aggressive behaviors, substance abuse problems, boundaries, car problems, infectious diseases, and children left home alone.

Staff Training

Staff training is another essential component of all AIA projects. Over the years, AIA projects have evolved as the needs of the clients have changed. All of these changes, including new challenges that may arise, present important opportunities for training. Staff members should have the opportunity to identify the areas in which they want further training through direct suggestions and feedback. Some training areas that are critical for addressing parenting issues include substance abuse, worker safety, and ways to effectively deal with personal emotions that may arise when working with clients who have life-debilitating issues. It also is critical to explore one’s own values regarding parenting and understanding cultural differences in this area.

Worker Safety

Delivering services in the home provides a wealth of teachable moments. However, home-based interventions have the element of unpredictability, which makes it very important to consider personal safety and protection. Staff may feel uncomfortable or feel as if they lack a sense of control when entering a family’s home. It is important to acknowledge this discomfort and determine whether it stems from stretched personal boundaries and/or from signs of impending danger.

To maximize safety and minimize workers’ concerns, AIA projects have employed the following safety measures.

- Provide cell phones for all staff members to use in case of emergency while in the field.
- Use weekly calendars so that supervisors know of each worker’s whereabouts (including day, time, and location of each home visit).
- Use teams for home visits—either routinely or whenever a worker has any safety concerns.
- Conduct visits outside of the home when a worker does not feel safe entering the home.
- Collaborate with local police to provide safety trainings and educational presentations on client violence.
FUTURE DIRECTIONS

As evidenced throughout this document, AIA projects have amassed a tremendous wealth of experience and knowledge in working with families affected by substance abuse and/or HIV/AIDS to understand and address their parenting strengths and vulnerabilities. The ability to develop honest, trusting, and supportive relationships with families forms the core of this work. Conducting useful assessments and intervening effectively in the areas of child safety, parenting, and life skills grows out of these relationships. In order to do this difficult work, staff must have certain characteristics and be provided with a safe, supportive work environment; adequate training; and regular, professional supervision.

AIA projects also have gained an understanding of many issues common among the families they serve, e.g., domestic violence, poverty, and traumatic histories, and the impact of these challenges on parent-child relationships. In recent years, AIA projects have seen an increase in the prevalence of teen parents and undocumented immigrant parents. Both of these groups present additional challenges to the projects.
Teen Parents

Teen mothers affected by substance abuse and/or HIV/AIDS have unique developmental needs and limited education, and they typically lack emotional and financial support from their families. Further complicating the situation, some cultures consider a young woman a fully independent adult when she has a baby. Because motherhood does not automatically confer the status of emancipated minor in the United States, truancy laws still apply. Moreover, this culturally imposed premature independence makes it difficult for AIA projects to retain the teens in order to sufficiently prepare them for and support them in their parenting. Additionally, some projects have found that postpartum depression is more common among teen mothers.

Although a plethora of knowledge exists about the vulnerabilities of teen parents, AIA projects are continuing to learn about the ways in which substance abuse, HIV/AIDS, and/or cultural differences compound these vulnerabilities, and the most effective interventions to support these young families. One way that projects such as BB+ and CRADLES have addressed these complex needs is to hire workers that are culturally sensitive and representative of the community in which they reside. They work with teen mothers and extended family members to enhance the mother’s parenting skills and help the family as a whole to support the young woman through the process of becoming a parent. They also increase the level of support and the frequency of home visits.

Undocumented Immigrant Families

Similarly, AIA projects are increasingly challenged by the complexity of undocumented immigrant families. These families typically have a fear of accessing local community resources because of their real or perceived risk of being detected, detained, and, ultimately, deported with or without their child(ren). They also struggle economically. In many of these families, all the adults work day labor and other, often multiple, low paying jobs to make ends meet.

This impacts their ability to care for their children and to access services only available during traditional working hours. Additionally, undocumented immigrants are not eligible for TANF or health care. If their children are born in the United States, they can receive TANF for the child only, but this does not give them access to transitional child care, which is tied to the parent’s TANF. Further, although some states offer health insurance specifically for these children, it is not available for pregnant women, and most providers will not accept it because they don’t want to deal with the requisite paperwork.

To address some of these challenges, AIA projects in locations with significant undocumented populations hire bi-lingual and bi-cultural staff who work intensively with these families to help them access community resources. However, as noted numerous times throughout this document, none of this is possible without establishing trusting relationships with families. In order to do this, staff must be willing to work flexible hours to accommodate working families’ schedules.

In future years, as populations continue to shift and other challenges emerge, AIA projects look forward to continuing to partner with families affected by substance abuse and/or HIV/AIDS to better understand the most effective ways to support them in caring for their children.
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APPENDIX A

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APPENDIX B

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APPENDIX C

Assessment Tools

The following list provides a brief description of tools that are employed by AIA projects to assess various parenting-related issues in families affected by substance abuse and/or HIV/AIDS. AIA projects that were, to the best of our knowledge, using each tool during the time of publication, are indicated.

Ages and Stages Questionnaire (ASQ)

ASQ is a series of 19 parent-reported questionnaires, which provide initial screening of infants and young children (ages 0-5 years) for developmental delays; assess parent education and involvement; identify areas needing further assessment. Interpretation of client scores requires professionals or trained paraprofessionals.

The questionnaires and user’s guide cost $190, and a video on the use of ASQ during a home visit costs $44. For more information, refer to http://www.brookespublishing.com/store/books/bricker-asq/index.htm

RESEARCH:
A great number of studies have been conducted in U.S. and Canada, which support ASQ as an accurate, cost-effective, and parent-friendly assessment tool for screening and monitoring of preschool children. Refer to the following website for additional research on ASQ: http://agesandstages.com/research/asqstudies.html.

AIA PROJECTS:
The Vulnerable Infants Project 2 (VIP-2)

Ages and Stages Questionnaire: Social-Emotional (ASQ:SE)

ASQ:SE is a series of 8 parent-completed, child-monitoring questionnaires, which help identify children’s developmental problems through their social-emotional behaviors and determine whether further evaluation or referral for intervention is necessary. Target groups are infants and young children ages 0-5 years. The ASQ:SE can be self-administered by trained parents but should be scored by professionals or paraprofessionals.

The initial cost is $125 for the questionnaires and user’s guide. Additional information can be found at http://www.brookespublishing.com/store/books/bricker-asq/index.htm

Adult-Adolescent Parenting Inventory (AAPI-2)

The AAPI-2 is a 40-item, self-reported questionnaire used to assess the parenting attitudes and child-rearing practices of adolescents and adults. This tool is also used to identify clients at-risk of abusive parenting practices and other factors known to be attributable to child abuse and neglect. Target groups are persons ages 13 and older.

The AAPI-2 complete kit, including the handbook, test forms A and B, scoring stencil, profiles, and worksheets, costs $122 and $186 for the CD-ROM. Training workshops and assistance are also available. For more information, call 828-681-8120, send an email to fnc@nurturingparenting.com, or visit their website at http://www.nurturingparenting.com/aapi/aapi2_info.php

RESEARCH:

AIA PROJECT:
The Vulnerable Infants Project 2 (VIP-2)
Center for Epidemiologic Studies Depression Scale (CES-D)

The CES-D is a 20-item, self-administered instrument, which aims to detect major or clinical depression for persons older than 18 years. The scale is used to assess the frequency and duration of cognitive, affective, and behavioral depressive symptoms within the past week. The CES-D instrument is cost-free and no training is required.

RESEARCH:
Published by the National Institute of Mental Health, the CES-D is extensively used for research purposes to investigate levels of depression among the general population. For additional literature on CES-D, refer to the following:


AIA PROJECTS:
FCHVP, Project Milagro

Ansell Casey Life Skills Assessment (ACLSA)

ACLSA is an assessment tool that measures independent life skills acquisition among children and young adults. This tool, available in self-report and caregiver report formats, divides clients into four age-related levels: Level I (8-10 years), Level II (11-14 years), Level III (15-18 years), and Level IV (19 years and older). Depending on the ACLSA level, the measure is composed of four to six life skills domains, including daily living tasks, housing & community resources, money management, self-care, social development, and work & study habits. There are also Parenting Infants and Parenting Young Children supplements that measure domains such as child care, child growth and development, health, nurturing, nutrition, safety, and well-being.

The ACLSA is free and can be electronically completed via internet. *The Life Skills Guidebook* is designed to offer teaching curriculum and individual learning plans for youth. For more information, refer to [http://www.caseylifeskills.org/index.htm](http://www.caseylifeskills.org/index.htm).

RESEARCH:
According to *The Life Skills Guidebook*, the ACLSA is the only life skills measure developed for child welfare with established reliability and validity. For more information, refer to the guidebook at [http://www.njacyf.org/main/pdf/ansell_casey_lifebook.pdf](http://www.njacyf.org/main/pdf/ansell_casey_lifebook.pdf).

AIA PROJECT:
Shared Family Care

Child Abuse Potential Inventory (CAP)

Purpose and Target: The CAP is a parent self-report questionnaire which aims to assist in the screening of suspected physical child abuse cases in social services. It can be used to assess clients prior to treatment, or evaluate treatment progress. It has also been found effective in screening for risk of neglect.


AIA PROJECT:
Oklahoma Infants Assistance Project
**Hawaiian Early Learning Profile (HELP)**

HELP is a family-centered, curriculum-based assessment for use by professionals working with infants, toddlers, and young children (0-36 months of age). HELP is used for identifying children’s needs, tracking growth and development, and determining goals and objectives. Using play-based activities and intervention strategies, HELP covers skills in six domains: cognitive, language, gross motor, fine motor, social, and self-help.

HELP starter materials include HELP 0-3 reference manual ($60), HELP preschoolers assessment and curriculum guide ($65), HELP at Home parent handouts ($65-90), assessment booklets ($3), and HELP charts ($3). A 20-minute training video ($15), to be used in conjunction with the reference manual, is also available for professionals using HELP. For more information or to order materials, visit their website at http://www.vort.com/index.html

**RESEARCH:**


**AIA PROJECT:**
CRADLES

**Home Observation for Measurement of the Environment (HOME) Inventory**

The HOME, serving as a screening tool, is designed to measure the quality and quantity of stimulation and support available to a child in the home environment. HOME inventories are available for infants and toddlers (birth to 3 years old), early childhood (ages 3 to 6), and middle childhood (ages 6 to 10).

A Supplement to the HOME for Impoverished Families (SHIF) was developed for use with young children living in impoverished urban environments. The SHIF should be used in conjunction with HOME rather than as an independent assessment.

The cost for the comprehensive manual is $50, standard manual is $40, and child care HOME manual is $30. Other items that can be purchased separately include infant and toddler forms ($15 per pad), early childhood forms ($25 per package of 50 forms), and middle childhood forms ($12.50 per package of 25 forms). Training workshops are also offered by the authors, B. Caldwell and R. Bradley. For more information, refer to the website at http://www.ualr.edu/crtldept/home4.htm.

**AIA PROJECTS:**
FCHVP, CRADLES, Great Starts, New Start for Infants, Project SAFE

**Kempe Family Stress Inventory**

The Kempe Family Stress Inventory is designed to assess parenting difficulties and parents’ risks for child maltreatment by rating parents’ responses to a psychosocial interview. It can be used as a screening tool for at-risk families and includes a number of domains such as psychiatric and criminal history, childhood history of care, emotional functioning, perception of children, discipline of children, and level of stress in the parent’s life.

The Kempe Family Stress Inventory is cost-free. However, interviewers need to have training or experience to conduct psychosocial interviews.

**RESEARCH:**

**AIA PROJECT:**
New Start for Infants
**Keys to Interactive Parenting Scale (KIPS)**

Purpose and Target: KIPS is a structured observation tool of parent-child interaction for family service providers working with families of infants, toddlers and preschoolers. KIPS includes 20 minute observation video of a free play between a parent or other caregiver and a child. Target groups are parents and children of age 2 months through 5 years. Reviewing the video, twelve specific facets of parenting behavior within the context of the child’s needs are scored based on a 5-point scale.

Training is required to get certified and to use KIPS. Annual renewal is required. A one-day onsite training and online KIPS eLearning are available. Onsite one-day training fee is $2000; eLearning registration fee is $100 per learner; and annual recertification fee is $30. For more information and the cost of KIPS materials see www.ComfortConsults.com.

**AIA PROJECTS:**
FCHVP, CRADLES

**Life Skills Progression (LSP)**

LSP is a field-tested tool for use with at-risk families of children from birth to age three, designed to measure a variety of family competencies, track the progress of children and parents, and demonstrate the effectiveness of home visiting programs.


**AIA PROJECT:**
FCHVP

**Parenting Stress Index (PSI)**

PSI is a clinical and research parent self-report instrument designed as a screening and diagnostic assessment tool. The purpose is to identify parent and child stress under which deviant child development or dysfunctional parenting is likely to occur. Target groups are parents of children ages 1 month to 12 years, with a primary focus on preschoolers.

The PSI Long Form Kit, which includes a manual, 12 reusable item booklets, and 25 hand-scorable answer sheet/profile forms, costs $131. The PSI Short Form costs $90 but only includes a manual and 25 hand-scorable questionnaire/profile forms. No training is required for administering and scoring the PSI, but the interpretation of scores requires someone with training in psychology, social work or other related disciplines.

PSI is published by Psychological Assessment Resources, Inc. For more information about PSI or to order materials, visit the website at http://www3.parinc.com/products/product.aspx?Productid=PSI.

**AIA PROJECTS:**
Mission Inn, VIP2, Great Starts, Project Milagro, CRADLES, New Start for Infants, Project SAFE
APPENDIX D

Parenting Curricula

The following list provides a brief description of parenting curricula used by AIA projects.

The Healthy Families San Angelo Curriculum

The Healthy Families San Angelo Curriculum promotes positive outcomes by providing information to families on healthy parent-child relationships, developmental stages, health and safety needs, brain stimulation, and building positive self-esteem. This curriculum covers the developmental milestones for children 1-5 years of age and shows activities to promote child development, which can be utilized as a compliment to the Ages and Stages Questionnaire. For more information on this curriculum, visit their website at http://www.hfsatx.com/curriculum/

AIA PROJECT:
BB+

The Incredible Years

The Incredible Years is a comprehensive set of curriculum, consisting of the Parent Training Series, the Teacher Training Series, and the Dina Dinosaur Child Training Program. The main purpose is to promote social competence and reduce regression and related conduct problems in young children, ages 2 to 8 years, and then prevent children from developing delinquency, drug abuse, and violence problems as they enter adolescence. Target groups are parents, teachers, and young children, ages 2-12.

The newly revised 2006 handbook, The Incredible Years: A troubleshooting guide for parents of children aged 2-8 years, is available for $19.95. Separate training and a four-level, hierarchical certification are required for parent, teacher and child training. Workshops are offered one to three times a year in Seattle. Registration fees for the Seattle training is about $300-$400. On-site training is possible. For more information, visit their website at www.incredibleyears.com.

RESEARCH:
Evidence of Effectiveness
http://www.incredibleyears.com/ResearchEval/effective.asp


AIA PROJECT:
OIAP

Nurturing Parenting

Nurturing Parenting programs are designed for the prevention and treatment of child abuse and neglect. Five programs are available: prenatal, birth to 5 years, school-age 5-11 years, parents and adolescents, and teen parents. One example includes the Nurturing Parenting program for parents and their infants, toddlers, and preschoolers (birth to 5 years). This program consists of 48 home-based sessions or 24 group-based sessions which aim to teach parents to recognize and understand feelings, infant and child massage, nurturing parenting routines, child development, and ways to build self-esteem in themselves and their children.

The cost for the programs can vary depending on the type of program and materials used. Individual materials include the implementation manual ($30), activities manuals ($45-$50), and parent handbooks ($225). For more information refer to http://www.nurturing-parenting.com

RESEARCH:
Nurturing Parenting programs have been reviewed for their validation in several studies. For additional information on relevant studies, visit http://www.nurturingparenting.com/research_validation/index.php

AIA PROJECT:
CRADLES
**Parent Child Interaction Therapy (PCIT)**

The PCIT is an evidenced-based treatment model with highly specified, step-by-step, live-coached sessions with both the parent/caregiver and the child. The goals of treatment are to improve the quality of the parent-child relationship, decrease child behavior problems and increase parenting skills. This model targets any parent of a child aged 2-7 with acting out behavior. It also has been used successfully with physically abusive parents and has been extended to children up to age 12.

To use this model, mental health professionals with a minimum of a master’s degree in psychology or a related field must undergo 40 hours of direct training with ongoing supervision and consultation for approximately four-to-six months. PCIT training is provided by Robin Gurwitch, Ph.D., Beverly Funderburk, Ph.D., and Melanie Nelson, Ph.D., University of Oklahoma Health Sciences Center, 405 271-8858 or Robin-Gurwitch@ouhsc.edu. For more information see www.pcit.org.

**RESEARCH:**
For additional literature on PCIT, refer to the reference list at http://pcit.phhp.ufl.edu/Literature.htm

**AIA PROJECT:**
OIAP

**Partners in Parenting Education (PIPE)**

The PIPE instructional model is a preventive intervention for parenting educators that focuses on the use of supervised parent-child activities. The goal of these activities is to help parents identify and recognize their child’s needs and emotional communications and to increase relationship building skills of parents with their infants and toddlers.

Materials for purchase include the English Curriculum Package ($450) and the Educator’s Guide ($280). PIPE’s two-day trainings are scheduled several times a year in various locations for a cost of $250. For more information, refer to www.howtoreadyourbaby.com.

**RESEARCH:**
Zero To Three, Bulletin of Zero To Three: National Center for Infants, Toddlers, and Families, August/September 1996, Volume 17, No. 1

**AIA PROJECT:**
FCHVP
# APPENDIX E

Child: ____________

## Health & Safety Checklist

Start Date: ____________

### PREGNANCY TO 8 MONTHS

---

#### BEDROOM

<table>
<thead>
<tr>
<th>To Do</th>
<th>Action</th>
<th>Date Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) 1. Move Furniture and cribs away from windows.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 2. Make sure slats on cribs/playpens are no more than 2 3/8 inches apart.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 3. Make sure mattress and sheets fit bed frame snugly.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 4. Install bumpers and pads on inside of crib for young infants, the soft kind that bends or folds when stood on.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 5. Remove soft pillows or stuffed animals from the crib</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 6. Remove mobiles over the crib once child can sit or pull to Sit.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 7. Watch infant at all times while on changing table or bed.</td>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

#### ALL ROOMS

<table>
<thead>
<tr>
<th>To Do</th>
<th>Action</th>
<th>Date Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) 1. Put electric outlet covers on all unused outlets.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 2. Put a gate across stairways top and bottom, until child can handle stairs.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 3. Keep all plants and ashtrays out of the baby’s reach.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 4. Install smoke detectors on each floor of your home, especially near sleeping areas; change the batteries each year.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 5. Cover or pad sharp corners on furniture and appliances.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 6. Remove throw rugs on tile floors.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 7. Use non-skid floor wax on wood, tile, or linoleum floors.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 8. Keep floors and low tables cleared of breakable dangerous items.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 9. Place safety locks on all windows and screeners or open windows no more than 6 inches.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 10. Everyday check the floor and other surfaces for ant tiny objects such as coins or safety pins that can cause choking.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 11. Secure lamps and other free standing objects.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 12. Watch a child at all times when in a walker.</td>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

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*(Their use is not recommended by the American Academy of Pediatrics)*

#### GENERAL SAFETY

<table>
<thead>
<tr>
<th>To Do</th>
<th>Action</th>
<th>Date Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) 1. Post emergency numbers beside the telephone.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 2. Use an infant/toddler car seat at all times while in a car.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 3. Keep baby/child safely away from even trusted pets.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 4. Practice a fire escape plan with each family member.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 5. Set hot water heater to no more than 120 degrees Fahrenheit.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 6. Attach electric lamp cords and extension cords to tables or baseboards so baby/child can’t reach them or trip.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 7. Have painted surfaces checked for lead.</td>
<td>( )</td>
<td></td>
</tr>
<tr>
<td>( ) 8. Fence off space heaters, radiators and heating grates.</td>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>
## Health & Safety Checklist (continued)

### 9 TO 36 MONTHS:

#### KITCHEN

<table>
<thead>
<tr>
<th>To Do</th>
<th>Action</th>
<th>Date Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) 1.</td>
<td>Put cleaning supplies out of the reach or in locked cabinets.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 2.</td>
<td>Install safety latches on all cabinets below waist level. You may want to keep one cabinet with pots, pans and unbreakable bowls unlocked for child exploration.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 3.</td>
<td>Turn pot handles towards back of stove when cooking.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 4.</td>
<td>Take knobs off of gas ranges when not in use.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 5.</td>
<td>Have a secure cover for the garbage can.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 6.</td>
<td>Install safety locks on drawers with knives and other sharp utensils.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 7.</td>
<td>Make sure highchairs are stable and have safety straps.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 8.</td>
<td>Remove table cloth to prevent toddlers from pulling it off.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 9.</td>
<td>Remove pet food bowls to an area inaccessible to your child.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 10.</td>
<td>Remove throw rugs from kitchen floor.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 11.</td>
<td>Keep hot liquids away from children.</td>
<td>( )</td>
</tr>
</tbody>
</table>

#### BATHROOM

<table>
<thead>
<tr>
<th>To Do</th>
<th>Action</th>
<th>Date Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) 1.</td>
<td>Put safety latches on all bathroom cabinets.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 2.</td>
<td>Remove all electrical appliances near water.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 3.</td>
<td>Keep all medicine in a locked medicine cabinet.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 4.</td>
<td>Place a non-skid mat on the bottom of the tub.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 5.</td>
<td>Buy a rubber safety cover for the bathtub water faucets and spout to prevent accidental head injuries and scalding.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 6.</td>
<td>Watch your children at all times while in the bathroom.</td>
<td>( )</td>
</tr>
</tbody>
</table>

#### BEDROOM

<table>
<thead>
<tr>
<th>To Do</th>
<th>Action</th>
<th>Date Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) 1.</td>
<td>Install a night light for nighttime trips to the bathroom.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 2.</td>
<td>Keep window blinds and cords away from baby’s crib and out of reach.</td>
<td>( )</td>
</tr>
</tbody>
</table>

#### GENERAL SAFETY

<table>
<thead>
<tr>
<th>To Do</th>
<th>Action</th>
<th>Date Done</th>
</tr>
</thead>
<tbody>
<tr>
<td>( ) 1.</td>
<td>Keep all matches, candles, plants and ash trays out of reach.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 2.</td>
<td>Keep keys to electric machines safety out of reach.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 3.</td>
<td>Keep firearms, medications and hazardous materials locked away from children at all times.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 4.</td>
<td>Keep small objects from child that he/she could swallow.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 5.</td>
<td>Use an infant/toddler car seat at all times while in car.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 6.</td>
<td>Keep cigarette smoke out of the child’s environment.</td>
<td>( )</td>
</tr>
<tr>
<td>( ) 7.</td>
<td>Supervise older siblings when around infants/toddlers.</td>
<td>( )</td>
</tr>
</tbody>
</table>
## APPENDIX F

### Arbor Circle Crisis/Safety Plan

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Case #:</th>
<th>Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Program:</th>
<th>Staff Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Potential Crisis:</th>
</tr>
</thead>
</table>

### In order to prevent a crisis, I will take these actions:

- [ ] I/my child will use the following strategies for coping:
  - ____________________________________________
  - ____________________________________________
  - ____________________________________________

- [ ] I/my child will call one or more of the following people:
  - ____________________________________________
  - ____________________________________________
  - ____________________________________________

- [ ] I will remove all weapons, medications, or other means to harm self/others to which I/my child has access.

- [ ] I will ensure the safety of my child by providing a necessary level of supervision or by ____________________________________________________________________________________________.

- [ ] I will contact my Arbor Circle worker during regular business hours by calling __________________________.

- [ ] I will contact Arbor Circle after hours by calling ____________________________ or by following the on-call procedures provided to me.

- [ ] I will go to Network 180 or contact the Network 180 Help Line at (616) 336-3535.

- [ ] I will go to: ____________________________________________________________________________________.

- [ ] If I feel my symptoms are worsening, I will: _______________________________________________________
  - ____________________________________________________________________________________________

- [ ] I will call 911 for any immediate life threatening situations.

- [ ] Other: _______________________________________________________________________________________
  - ______________________________________________________________________________________________

I agree that with the use of this Plan I can keep myself/my child safe from harm. If at any time I feel that I can no longer do so, I will immediately call for additional help.

<table>
<thead>
<tr>
<th>Client Signature</th>
<th>Date</th>
<th>Arbor Circle Staff Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent/Guardian Signature</th>
<th>Date</th>
<th>Parent/Guardian Printed Name</th>
</tr>
</thead>
</table>
National Abandoned Infants Assistance Resource Center
University of California at Berkeley
1950 Addison Center, Suite 104, #7402
Berkeley, CA 94720-7402
510-643-8390
http://aia.berkeley.edu