EDUCATION & TRAINING
Services Section

GEORGIA DEPARTMENT OF HUMAN RESOURCES
DIVISION OF FAMILY & CHILDREN SERVICES

FAMILY AND CHILDREN TRAINING SEQUENCE (FACTS)

KEYS TO CHILD WELFARE PRACTICE

DHR

ELECTRONIC PARTICIPANT GUIDE

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

Acknowledgements

The GA DFCS Education and Training Section would like to thank all who have contributed to the development and testing of this curriculum.

Deepest appreciation is expressed to the following for sharing best practice resources and knowledge, both of which proved to be invaluable. Your dedication to families and children has made it possible for us to develop this curriculum.

Department of Children and Families New Jersey Child Welfare Training Academy, Pre-Service Training Curriculum

California Common Core Curricula for Child Welfare Workers

Institute for Human Services, Columbus, Ohio

State of Florida, Department of Children and Families, Child Welfare Pre-Service Training

North Carolina Division of Social Services, Child Welfare in North Carolina

Pennsylvania Child Welfare Training Program, University of Pittsburgh School of Social Work

Texas Department of Family and Protective Services, CPS BSD Specialty Track Training November 2005

Minnesota Department of Human Services, Family Centered Child Protective Services, Core 100, Minnesota Child Welfare Training System, May 2005

National Center on Substance Abuse and Child Welfare, Online Tutorials and Training, Understanding Substance Use Disorders, Treatment and Family Recovery: A Guide for Child Welfare Professionals, 2007

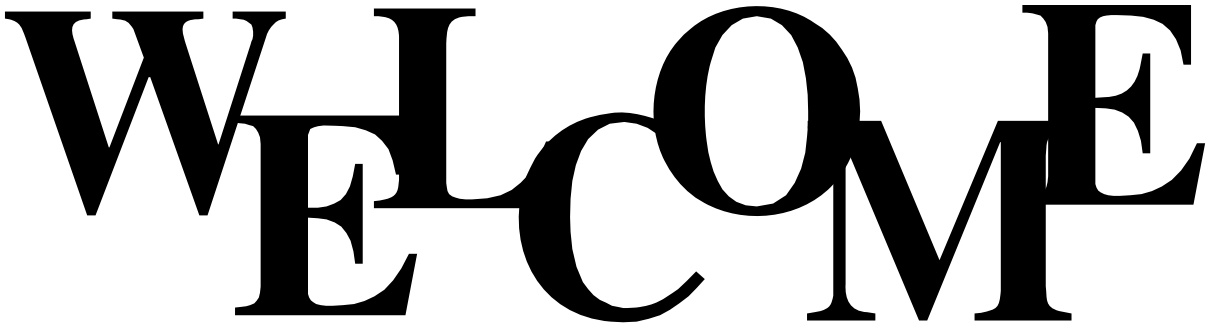
The National Children's Advocacy Center, Online Courses, Child Development 101, Allison DeFelice, PhD

Action for Child Protection, Inc. Differences Between Risk and Safety. 2002

The GA DFCS Education and Training Section, Training Unit, for participating in the Pilot.

Case Managers across the state who participated in the Pilot

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES



To Pre-Service Training

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

Rationale:

Case managers will begin to develop a relationship with other case managers. It is important for case managers to understand the history and how child welfare attitudes toward children and families progressed over the years in the United States. Case managers will identify the Federal, Sate and local laws which govern child welfare. Case Managers will understand the importance of referring to the Policy Manual

CFSR:

S1: Children are, first and foremost protected from abuse and neglect

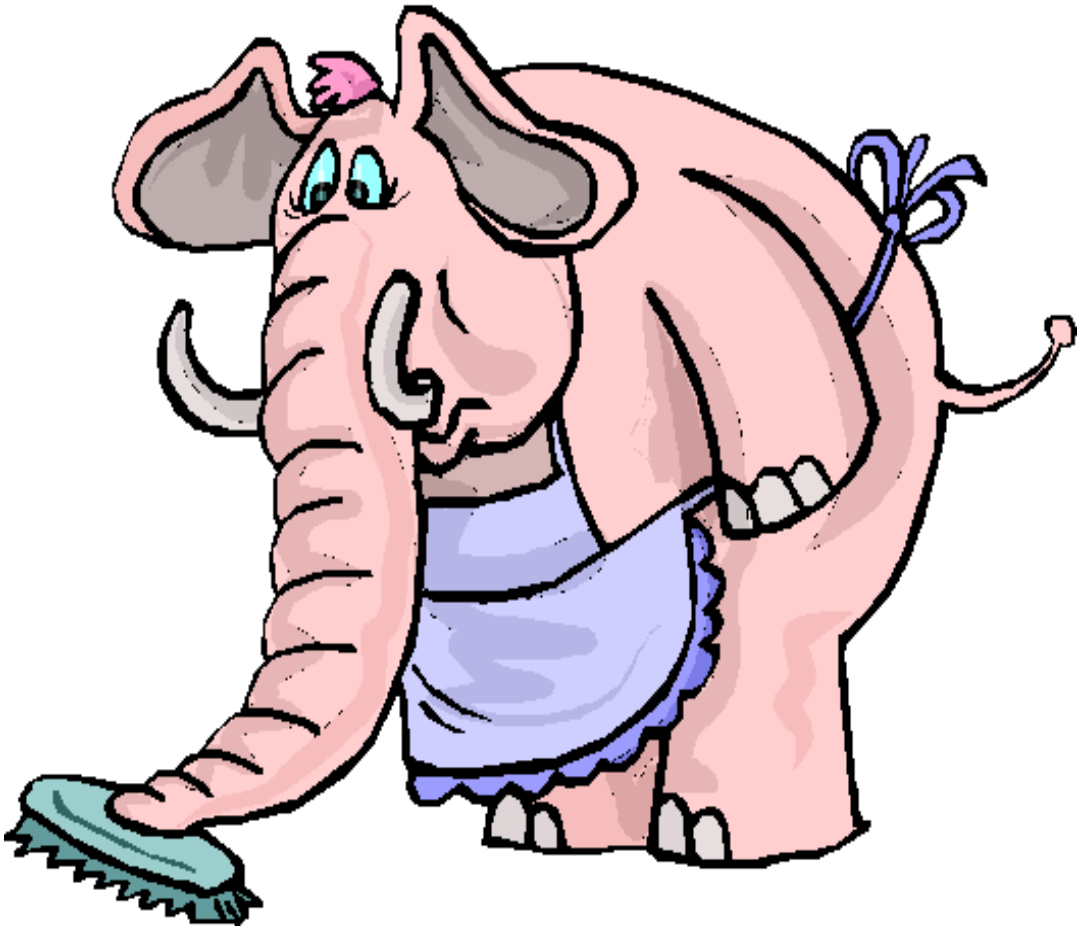
Learning Objectives:

After completion of this module, participants will be able to:

- Know the instructor
- Know general housekeeping issues
- Engage effectively with fellow participants
- Explain the attendance requirements and training expectations
- Construct an overview of how child welfare developed and historical events that have shaped the Georgia child welfare system.
- Locate and explain both Federal and Georgia laws that impact child welfare
- Identify the impact of these laws on the design of Georgia policy and child welfare practice.
- Explain how Child Protective Services, Foster Care Services, and Adoption Services in the Division of Family and Children Services are related
- Demonstrate the differences in the program areas as well as how they interrelate

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

Housekeeping



MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

Department of Family and Children Services Training
Trainer Feedback Form

Course Name:
Trainer's Name:
Trainer's Name:
Participant's Name:

Dates of Training:
Training Location:
County:
Supervisor's Name:

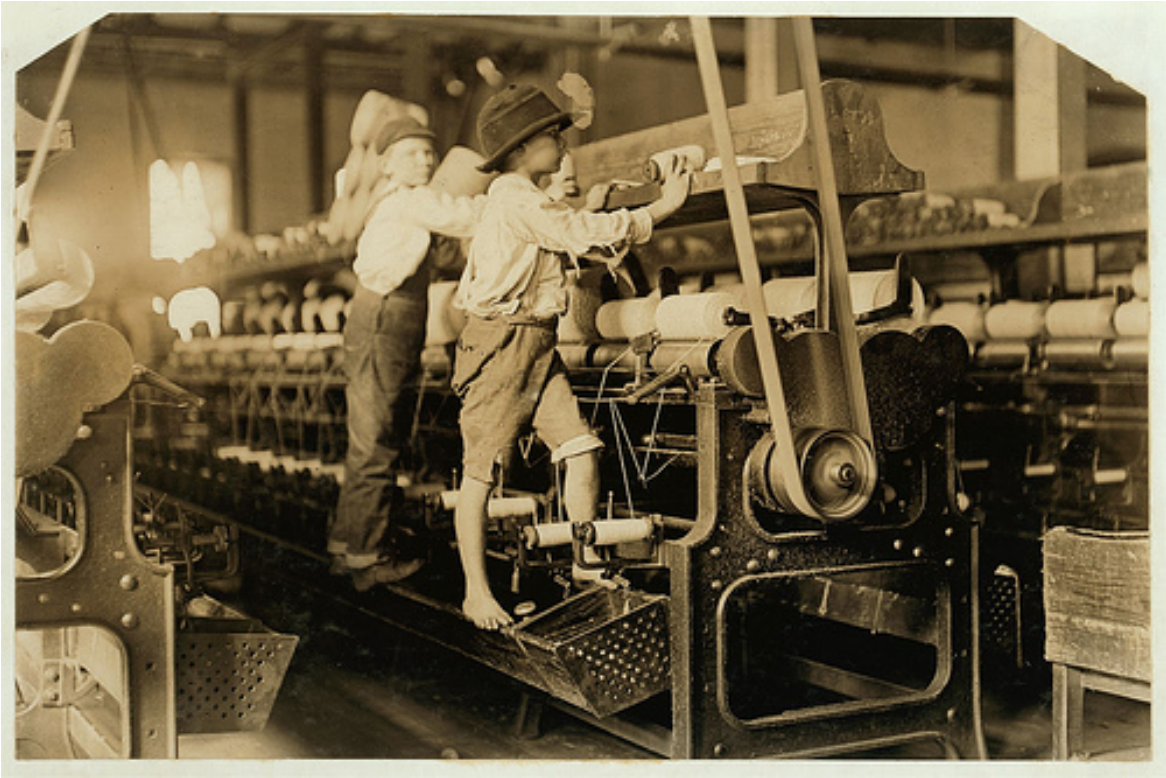
Mark the box that indicates to what extent you agree with the statement. Please respond to <u>all items.</u>

The Trainee:	Agree Strongly	Agree	Disagree	Disagree Strongly	Comments
Arrived to class on time	☐	☐	☐	☐	
Brought required manual/materials to class	☐	☐	☐	☐	
Maintained focus and attention in class	☐	☐	☐	☐	
Was courteous and non-disruptive	☐	☐	☐	☐	
Participated in group/class discussions	☐	☐	☐	☐	
Worked productively with others	☐	☐	☐	☐	
Completed classroom activities and assignments	☐	☐	☐	☐	
Demonstrated openness to new information/ideas	☐	☐	☐	☐	
Demonstrated basic ability to use and correctly complete forms for this subject	☐	☐	☐	☐	

COMMENTS (Strengths/Areas for Improvement):

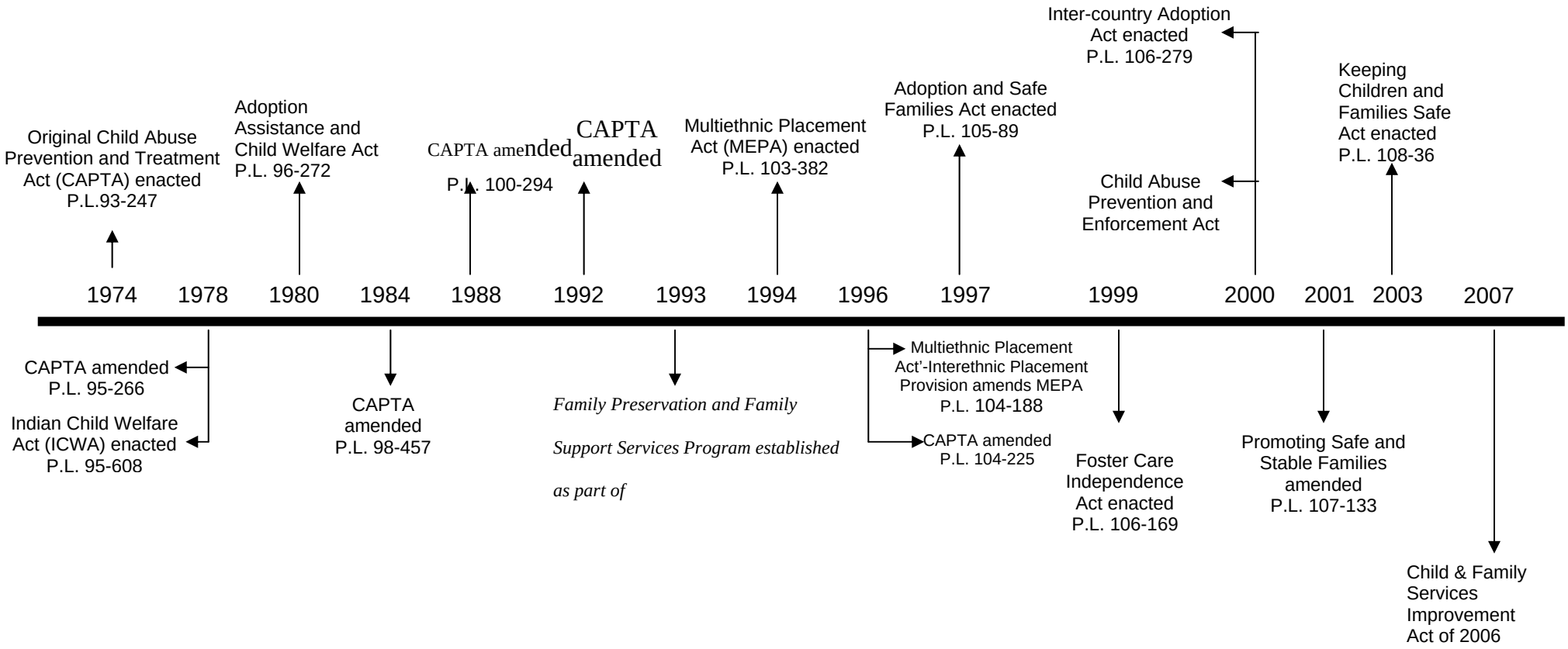
MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

History and Law



MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

Timeline of Major Federal Legislation Concerned with Child Protection, Child Welfare, and Adoption



MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

Federal Laws

Federal laws and regulations are linked with federal funds to provide services, and Georgia must comply with these laws as a prerequisite to receiving funds.

CPS Federal

- Social Security Act of 1935 as amended, and implemented in the CFR (Code of Federal Regulations). Part 200 - Title XX;
- Child Abuse Prevention and Treatment Act of 1996 as amended, and implemented by 45 CFR 1340;
- Adoption Assistance and Child Welfare Act of 1980 (P.L. 96-272);
- Adoption and Safe Families Act of 1997 (P.L. 105-89);
- Child Abuse Prevention, Adoption, and Family Services Act of 1988 (P.L. 100-294);
- Family Preservation and Family Support Services, Omnibus Budget Reconciliation Act of 1993; P.L. 103-66.

Foster Care Federal

- Social Security Act, Title XX, Social Services Block Grant;
- Social Security Act, Titles IV-B and IV-E;
  - Adoption Assistance and Child Welfare Act of 1980 (PL 96-272)
  - Adoption and Safe Families Act of 1997 (PL 105-89)
- Indian Child Welfare Act of 1978 (PL 95-608); and
- The Multiethnic Placement Act of 1994 (MEPA) of PL 103-382 as amended by the Removal of Barriers to Interethnic Adoption Act of 1996 of PL 104-188.

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

FEDERAL LAWS GOVERNING CHILD WELFARE PRACTICE

Child Abuse Prevention & Treatment Act (CAPTA) of 1974

REASONS:

- 1 of every 10 children brought to emergency rooms were victims of physical abuse
- Cases went unreported
- States had developed reporting laws but there was no uniformity

OBJECTIVES/GOALS:

- Increase identification, reporting, and investigation of child maltreatment
- Monitor research

SERVICES:

- Provide assistance to States to develop identification and prevention programs
- Created the National Center on Child Abuse & Neglect
- Created the National Clearinghouse on Child Abuse and Neglect Information
- Established Basic State Grants and Demonstration Grants

Indian Child Welfare Act (ICWA) of 1978

REASONS:

- 25-35% of Indian children were being placed in foster care with 85% of those placed in non-Indian homes
- Concern that the children were losing their Indian culture and heritage
- Court systems did not recognize the tribal relations of Indian people

OBJECTIVES/GOALS

- Protect best interest, stability, and security of Indian families
- Establish minimum Federal standards for the removal and placement of Indian children
- Recognize and strengthen the role of Tribal government in determining child custody issues

SERVICES

- Required foster/adoptive homes to reflect Indian culture
- Assistance to tribes for child and family service programs
- Created Tribal jurisdiction, when requested
- Provided funds for the purpose of improving services to Indian children and families
- Required State and Federal courts to recognize Tribal court decrees

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

FEDERAL LAWS GOVERNING CHILD WELFARE PRACTICE

Adoption Assistance and Child Welfare Act of 1980

REASON

- Foster Care drift
- Public discontent with child welfare system

OBJECTIVES/GOALS

- Prevent unnecessary separation of children and families
- Shift Federal government away from foster care to placement prevention and reunification
- Encourage adoption
- Reduce the number of children and time spent in foster care

SERVICES

- Adoption Assistance for children who are AFDC eligible and have special needs
- Defined child with special needs
- "Reasonable Efforts" to prevent removal
- Required reviews every 6 months to determine what is in the best interest of the child
- Court determine future status within 18 months after initial placement into foster care
- Established Title IV-E
  - Eligibility for IV-E
  - Reasonable efforts
  - Written case plan
  - Periodic reviews of progress toward permanency

Family Preservation and Support Services Program

REASON

- Reported and substantiated cases rising
- Focus needed to be on prevention instead of crisis
- Create a safe, stable, and nurturing home

OBJECTIVES/GOALS

- Promote safety and well being of all family members
- Assist families in resolving crises and connecting to supports
- Prevent out of home placement
- Help children return home or locate a permanent living arrangement

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

FEDERAL LAWS GOVERNING CHILD WELFARE PRACTICE

Family Preservation and Support Services Program (Continued)

SERVICES

- Required states to have a comprehensive planning process
- Improved service coordination
- Brought community in to the planning and services
- Broadened the definition of family
- Defined preservation and support services

Multiethnic Placement Act (MEPA) of 1994

REASON

- Children in Foster Care waiting too long
- Minority children over-represented in Foster Care

OBJECTIVES/GOALS

- Decrease time waiting to be adopted
- Prevent discrimination
- Identify and recruit foster/adoptive parents that meet the child's needs

SERVICES

- Prevents federal funding where discrimination is present
- States must develop plans for foster/adoptive families that reflect ethnic and racial diversity
- No effect on ICWA
- Failure to comply is in violation of Title VI of the Civil Rights Act

Adoption and Safe Families Act (ASFA) of 1997

REASON

- Children waiting several years for permanent placement
- Needed to establish stricter guidelines for placement and reunification
- Accelerate permanent placements
- Increase the accountability of the system

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

FEDERAL LAWS GOVERNING CHILD WELFARE PRACTICE

Adoption and Safe Families Act (ASFA) of 1997 (Continued)

OBJECTIVES/GOALS

- Promote permanency
- Add "Safety of the child" to every step of the case plan and review process
- Required criminal record checks for foster/adoptive parents
- Required States to initiate court proceedings to free a child for adoption once child as been in Foster Care for at least 15 of the most recent 22 months
- Promoted adoptions
- Increased accountability
- Clarified "reasonable efforts"
- Permanency hearings to be held no later than 12 months after entering foster care
- TPR after child in Foster Care 15 of the previous 22 months, unless it is not in the best interest of the child or if the child is in care of a relative

SERVICES

- Reauthorized the Family Preservation and Support Services Program and renamed it the Safe and Stable Families Program
- Ensured safety
- Report on the scope and outcome of services provided for substance abuse in the child welfare population

Promoting Safe and Stable Families Amendments of 2001

REASON

- Ongoing need to protect children and strengthen families
- Rapid increase in numbers of adoptions created need for post adoption services
- Concern for rise in number of children with incarcerated parents
- Youth who aged out of foster care behind other youth in educational attainment

OBJECTIVES/GOALS

- Encourages and enables states to develop or expand programs of family preservation services, community-based family support services, adoption promotion and support services, and time-limited family reunification services.
- Reduces risk behaviors by children with incarcerated parents by providing one-on-one relationships with adult mentors.
- Continue improvements in State court systems, as required by ASFA.

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

FEDERAL LAWS GOVERNING CHILD WELFARE PRACTICE

Promoting Safe and Stable Families Amendments of 2001 (Continued)

- Provides educational opportunities for youth aging out of foster care.

SERVICES

- Amended Title IV-B, subpart 2 of SSA

Child and Family Services Improvement Act of 2007

REASON

- Children were not being seen frequently enough by case managers to ensure safety

OBJECTIVES/GOALS

- Establish standards for the content and frequency of case manager visits for children who are in foster care
- At a minimum, standards must ensure that children are visited on a monthly basis
- Reports will be sent to the Administration for Children and Families

SERVICES

- Monthly visits are to be well-planned and focused on issues pertinent to case planning and service delivery
- At least one visit each month in a majority of the months over the year are to occur in the residence of the child (Biological or Foster Care)
- Ensure safety, permanency, and well-being of children
- All states must meet the visitation mandate by 90% in 2011.

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

Georgia Laws

The State legal bases for Child Welfare are:

CPS State*

- "Children and Youth Act", O.C.G.A. 49-5-1;
- Parent and Child Additional Identification and Reporting Procedures for Abused Children, O.C.G.A. 19-7-5;
- Confidentiality of Records Concerning Reports of Child Abuse and Neglect, O.C.G.A. 49-5-40;
- Juvenile Court Code of Georgia, O.C.G.A. 15-11-1;
- Local child abuse protocol committee, O.C.G.A. 19-15-2;
- Child abuse fatality sub-committee, O.C.G.A. 19-15-3.

Foster Care State

- Children and Youth Act, Chapter 49-5-1, O.C.G.A;
- Juvenile Proceedings Code, Chapter 15-11, O.C.G.A.
- Interstate Compact on the Placement of Children, Chapter 39-4, O.C.G.A.

*Internet site for Georgia laws: www.legis.state.ga.us

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

http://www.**odis**.dhr.state.**ga**.us

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

Department of Human Resources • Division of Family and Children Services • Steven E. Love, Acting, Division Director • Two Peachtree Street, NW • Suite 19-472 • Atlanta, Georgia 30303-3142 • Phone: 404-651-8409 • Fax: 404-657-5105

June 15, 2005

SOCIAL SERVICES MANUAL TRANSMITTAL NO. 05-09

TO: County Departments of Family and Children Services
OCP Managers of Field Operation
Regional Field Program Specialist
State Staff

FROM: Steven E. Love, Acting Division Director

RE: **Child Protective Services: 2102.4a Reasonable Diligent Search, 2103.23 Form 590 (Internal Data System), 2104.10 Meeting Response Times, 2104.21 Collateral Contacts Gathering and Verifying All Available Evidence, 2104.31 Additional Reports, 2104.35a Abbreviated investigations, 2105.5 Collaterals, 2106 Special Investigations, 2108 Administrative Case Review.**

PURPOSE

The purpose of this manual transmittal is to incorporate changes to existing policies, to incorporate the implementation steps for the Reasonable Diligent Search policy and to incorporate policy and procedures for the Abbreviated Investigations.

DISCUSSION

Changes to a reasonably diligent search incorporated the policy and procedures for conducting and documenting search efforts. Changes to Primary Client in CPS cases required clarification due to change
In the IDS system. Current revisions require that in special investigations such as daycare centers, group homes and RYDCS, the primary client will be the parent/caretakers who still has custody. In special investigations of facilities caring for children in the custody of DFCS, the primary client will be the parent/caretaker from whom custody was removed. In the case of a teen parent living in the home with their own parent, the primary client will be the parent of the at-risk child. If the at-risk child is the teen parent, the primary client is the teen's mother. If the at-risk child is the child of the teen parent, the primary client is the teen parent.

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

In order to maintain consistency, changes were made in the Meeting Response time policy regarding the ages of children as discussed under the reason for assigned 24-hour response time.

To ease the requirement for gathering collateral contacts, these of emails and written documents may be used with professionals as a means for gathering collateral contacts in investigations and ongoing cases.
In an effort to alleviate duplicate 431 reports, the Additional Reports policy has been revised.

The use of the Abbreviated Investigations in unsubstantiated cases is made permanent policy.

Revisions were needed in the Special Investigations policy to incorporate the changes made with the disbandment of the Special Investigative Unit, the formation of the Regional Field Program Specialist, to comply with HB 1580 "Foster Parent Bill of Rights."

Further changes were made to the Administrative Case Review Policy to incorporate changes resulting from the Division's restructuring.

IMPLEMENTATION:

This manual material is effective upon receipt and obsoletes previous Social Services County Letters 2004-06 and 2005-01; and the Abbreviated Investigations Memorandum dated March 29, 2005.

INSTRUCTIONS FOR POLICY MANUAL MAINTENANCE

Section II (Juvenile Court – Placement Issues
Remove pp. 37a-and replace with revised pp. 37a-37g

Section 111 (Intake)
Remove p. 75 and replace with revised p. 75

Section IV (Investigation)
Remove p. 112 and replace with revised p. 112
Remove pp. 128-131a and replace with revised pp. 128-131a
Remove pp. 128-136 and replace with revised 135-136
Strike through 2104.36 Contact for Cases Transferred for Ongoing Services at the bottom of p. 138 and the top of p. 139. Replace with revised pp. 137a and 138. **Do not strike through 2104.37 Substantiated Cases for Community Resources.**

Section V (Case Management)
Remove pp. 149-151 and replace with revised 149, 149a-151

Section VI (Special Investigations)
Remove chapter VI in its entirety and replace with the attached revised manual section

Section VIII(Administrative Case Review)
Remove chapter VIII in its entirety and replace with the attached revised manual section

Enter this transmittal on the Record of Transmittal Form

MODULE ONE
INTRODUCTION TO CHILD WELFARE SERVICES

Department of Human Resources • Division of Family and Children Services • Two Peachtree Street, NW • Suite 19-472 • Atlanta, Georgia 30303-3142 • Phone: 404-651-8409 • Fax: 404-657-5105

Social Services County Letter No. 2006-01

To: County Departments of Family and Children Services
DFCS Field Operation Directors
DFCS Regional Directors
State Office Staff
DFCS Social Services Field Staff

From: Division Director
Division of Family and Children Services

RE: TCM Billing for Safety Resources

Date: February 3, 2006

PURPOSE

The purpose of this Social Services County Letter is to explain TCM billing for Safety Resource cases. The Division has worked diligently with SMI to resolve the billing issues regarding TCM billing for Safety Resource cases. As a result, I am instructing that counties begin billing for those cases in which services have been provided, beginning the month of February 2006.

DISCUSSION

As per the forthcoming instructions in Chapter 60, if the safety resource case is entered during the time the CPS case is in investigative status, counties **cannot** bill TCM, because CPS cases in investigative status are not billable. On the tear sheet, the Safety Resource will appear with the service date pre-filled along with the case action open date from the Form 590 (like a CPS case) and an asterisk to indicate the case is in Intake/Investigative status. The Safety Resource case will not appear on the CPS past due report. Only cases with a Primary service code 3 appear on the report.

When the CPS case is transferred from investigation to ongoing, the CPS case manager will contact the Safety Resource case manager to let them know the CPS case is now in ongoing status. The asterisk is removed. When the CPS case transfers to ongoing, the safety resource case manager is to begin claiming TCM for the contact in the safety resource's home, **if the Guarantor resides in the home.** When CPS is provided across county lines and the children are served by more than one county department, only the county where the guarantor resides may bill TCM for the separate services rendered. The county that is

Social Services County Letter No. 2006-01

February 3, 2006

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serving the CPS parent will not have a guarantor in their home so billing is not possible. They should select "Non-eligible placement" as a do not bill reason on the tear sheet. If the children are residing in

different homes within the **same** county, the county will continue billing under the single Guarantor (youngest Medicaid eligible child at-risk) for that family unit.

A revised Chapter 60 will be forthcoming to further clarify Safety Resource TCM billing and other issues.

EFFECTIVE DATE

This county letter is effective upon receipt and is obsolete upon receipt of revised Chapter 60 and revised CPS policy 2104.33.

WHO TO CALL WITH QUESTIONS

If you have any policy-related questions regarding Safety Resources, please contact Annie D. Wright at adwright1@dhr.state.ga.us or at 404-463-2232. For IDS system-related questions, please contact Carroll Pearson at ccpearson@dhr.state.ga.us or at 404-656-2055.

MDH/adw

Performance of Job Responsibilities

In performing job responsibilities, Case Managers must always remember and act in accordance with the following principles and requirements of law:

- A child's health and safety must always be the paramount concern.
- A child's safety, permanency, and well being are the three desired outcomes.
- A child placed in foster care for safety reasons should be in a safe, permanent home (i.e., permanency is achieved) no later than 24 months from the date the child entered foster care.
- The case manager must make reasonable efforts to prevent a child's placement in foster care. However, if a child must be placed in foster care for safety reasons, the case manager must make reasonable efforts to reunify a child with her/his family. Federal law requires that termination of parental rights must be sought for any child in foster care 15 of the most recent 22 months, unless there is a compelling reason not to.
- The case manager must make reasonable efforts to find, as soon as possible, an adoptive home for a child whose parent(s) had rights to the child terminated.
- Placement decisions require a case-by-case approach. Race, culture, or national origins are not to be considered routinely when placing a child. The Department or placing agency must ensure that decisions rest on a child's particular and documented needs.
- The case manager must comply with the requirements established by Federal and State law, court consent decrees, and Division policies when delivering services to children and families. The case manager must ensure that all possible financial benefits are claimed.
- The case manager must have thorough documentation of the facts of the case which the case manager used as a basis for decision-making, including: with whom they spoke, who was present during the conversation, what the individual(s) told them, and what they saw, heard, and (if appropriate) smelled.

MODULE TWO
BELIEFS AND VALUES

Values and Culture

MODULE TWO
BELIEFS AND VALUES

Objectives:

Upon completion of this module case managers will be able to:

- Analyze the alignment of personal goals and expectations with realities and requirements of the job.
- Analyze how personal values influence perceptions and decisions
- Articulate, through class activities and discussion, an understanding that personal values and ethics will differ between individuals and cultures.
- Demonstrates knowledge and understanding of key cultural diversity concepts and terms.
- Demonstrates multicultural awareness -- is aware that cultural differences exist and may affect how different people think and behave.
- Demonstrate an awareness and understanding of how words can be used to create either a favorable or unfavorable impression of a person, especially with regard to cultural differences
- Demonstrate multicultural sensitivity -- appreciates a variety of cultural perspectives and values diversity.
- Utilize the Ethnographic Interview to discover another's cultural values

MODULE TWO
BELIEFS AND VALUES

Pertain to beliefs and attitudes that provide direction to everyday living

Corey, Corey and Callanan (1998)

Values can also be defined as:

- **A belief system**
- **Preferences or ideas of right or wrong, good or bad** **Zastrow, 2004**

MODULE TWO
BELIEFS AND VALUES

DFCS CORE PRINCIPLE:

"Doing the Right Work the Right Way"

DFCS Case Practice Model Values

- Children need and deserve to grow-up safe, free, and protected from abuse and neglect.
- Children do best when they have strong families, preferably their own and when that is not possible, a stable relative, foster or adoptive family.
- All families need community support and genuine connections to people and resources.
- Families have the capacity to change with the support of individualized service responses.
- Government cannot do the job alone; community partnerships are essential to ensure child safety and build strong families.
- No family who needs and wants help to keep their children safe will be left without the help it needs.
- No child in our care will leave us without a caring, committed, permanent family
- Every child we come into contact with will get the help (s)he needs to be healthy and achieve his/her full educational and developmental potential
- No child we come in to contact with will be left to struggle alone with abuse or neglect

MODULE TWO
BELIEFS AND VALUES

In your groups, discuss the following questions:

Why did you choose this job?

What do you bring to the job: (i.e., skills, life experiences, empathy)?

What do you hope to accomplish for children and families through this job? What is your vision?

Where do you see yourself, professionally, in 3-5 years?

MODULE TWO
BELIEFS AND VALUES

How might values play a role in the caseworker's interactions with the individuals in the following examples?

Example: A single mother with three children who does not work and receives public assistance

1. A substance-abusing parent

2. A teenage parent without a high school education

3. Homosexual adults seeking adoption

4. A single father trying to take care of a teen and a 5 year old

MODULE TWO
BELIEFS AND VALUES

Ethics relate to what people consider the right thing to do.

According to McGowan (1995), ethics are:

"Guidelines about how members of the profession can translate their values into action. In other words, they provide direction and how people ought to act."

Ethics relate to behavior that is considered appropriate, or the right thing to do. They help us answer the question, "Should I, or should I not."

MODULE TWO
BELIEFS AND VALUES
Ethical Responsibilities to Clients:

Commitment
Promote the well-being of the families and children assigned to you. Adhere to legal mandates.

Self-Determination
Respect the client's right to self-determination, unless the client's actions pose a serious risk to the child. Identify and clarify case goals with the client.

Informed Consent
Use clear, understandable language to inform clients of the purpose of the services, risks, limits, right to refuse or withdraw consent and the potential consequences of the refusal, and the time frames covered by the consent. Always allow clients to ask questions.

Competence
Attend and participate in appropriate training. Always consult with your supervisor. Ask questions to ensure you are using correct procedures.

Cultural Competence
Learn about your client's culture and its strengths. The information will be useful when choosing relevant services for parents and children.

Conflict of Interest
Do not take unfair advantage of any professional relationships or exploit others to further your own personal, religious, political, or business interests. There can be no personal, social, or business relationships with clients.

Confidentiality
Respect a client's right to privacy. Share information on a need to know basis, and when information is necessary to provide the best care possible for the child.

Sexual Relationships
Under no circumstances are you to engage in sexual activities or any type of sexual contact with current or former clients. Do not engage in sexual activities or contact with a client's relative or other individuals with whom the client maintains a close personal relationship when there is risk of exploitation or potential harm to the client. Do not provide services to individuals with whom you have had a prior sexual relationship. It may be difficult to maintain appropriate professional boundaries. Notify your supervisor and ask to have the case reassigned.

Physical Contact
Do not engage in physical contact with a client (cradling, caressing). There is the possibility of psychological harm or misinterpretation of the action.

Sexual Harassment
Do not sexually harass clients. Sexual harassment includes unwanted sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Derogatory Language
Do not use derogatory language in written or verbal communication to or about clients. Always use respectful and accurate language in all communication.

MODULE TWO
BELIEFS AND VALUES
Ethical Responsibilities as a Professional

Competence
Strive to become and remain proficient in professional practice and performance. Regularly review agency policies and procedures. Consult with supervisor for procedures or clarification. Base your work on casework ethics and the policies, procedures, and mission of DFCS.

Discrimination
Do not practice, condone, facilitate or collaborate with any form of discrimination on the basis of race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, or mental or physical disability.

Dishonesty, Fraud, Deception
Do not participate in, condone, or be associated with dishonesty, fraud or deception.

Impairment
Do not allow your personal problems, psychological distress, legal problems, substance abuse, or mental health problems to interfere with your professional judgment or performance.

Misrepresentation
Make clear distinctions between statements you make and actions you engage in as a private individual, and as a representative of DFCS. Accurately represent the official and authorized position of DFCS when speaking on behalf of DFCS. Ensure that representations of your credentials, education, competence, affiliations, services to be provided or results to be achieved are accurate. Claim only those relevant professional credentials you actually possess and take steps to correct any inaccuracies or misrepresentations by others.

Solicitation
Do not solicit testimonial endorsements from current clients or others who are vulnerable to influence.

MODULE TWO
BELIEFS AND VALUES
Ethical Responsibilities to Colleagues

Respect

Treat your colleagues with respect. Avoid unwarranted negative criticism of colleagues in communication with clients or other professionals. Cooperate with colleagues and other professionals.

Confidentiality

Respect confidential information shared by colleagues in the course of professional relationships and transactions.

Consultation

Seek advice and counsel of colleagues with demonstrated knowledge, expertise, and competence when it is in the best interest of clients.

Referral for Services

Refer clients to other professionals when specialized knowledge or expertise is needed. Disclose the client‘s consent when necessary and all pertinent information to the service provider.

Sexual Relationships

Avoid engaging in sexual relationships with colleagues when there is a potential for conflict of interest. If you become involved in, or anticipate becoming involved in a sexual relationship with a colleague, you have a duty to transfer professional responsibilities, when necessary, to avoid conflict of interest.

Sexual Harassment

Do not sexually harass colleagues, supervisees, trainees, or students. Sexual harassment includes unwanted sexual advances, sexual solicitation, requests for sexual favors, and other verbal or physical conduct of a sexual nature.

Ethical Responsibilities in the Work Setting

Client Records

Take all reasonable steps to ensure that documentation in case records is accurate and reflects the services provided the case plan, and the case goal. Include sufficient and timely documentation in case records to facilitate the delivery of services and to ensure continuity of services provided to clients in the future. Include only information that is directly relevant to the delivery of services, the case plan, and the goal.

Commitment to Employer

Adhere to the commitment you made to DFCS. Work to improve the agency‘s policies, procedures, and the efficiency and effectiveness of services.

MODULE TWO
BELIEFS AND VALUES

The shared values, traditions, norms, customs, arts, folklore, and institutions of a group of people, passed on from one generation to the next.

- ✓ Culture encompasses a people's history, values, beliefs, worldview, norms, communication style, patterns of thinking, and social structures.
- ✓ Culture provides a sense of identity, belonging, purpose and structure in life.
- ✓ Norms are influenced by the group's values and beliefs to determine how people within the group should behave.
- ✓ Culture is connected to symbols such as language, land, and traditions.
- ✓ It is very difficult to separate different aspects of culture such as values, beliefs, or norms since they influence one another and are integrated.
- ✓ Cultures are constantly changing at different paces.
- ✓ Individuals who are not members of the dominant society are often forced to fluctuate between two very different cultures: that of the majority and their own.

MODULE TWO
BELIEFS AND VALUES

Multicultural Terms and Definitions

Match the definitions of these multicultural words together. Write the letter of the word (in the right column) in the blank next its definition (left column).

___	1. To be open to learning about and accepting of different cultural groups.	A. Cultural Sensitivity
___	2. A belief that racial differences make one race better than another race.	B. Culture
___	3. The idea that characteristics of a cultural group are true for everyone in that group.	C. Discrimination
___	4. Treating someone differently from how you treat others because of something like race or culture instead of what they are like as a person.	D. Ethnicity
___	5. The recognition that there exist many cultures based around ethnicity, sexual orientation, geography, religion, gender, and class.	E. Multiculturalism
___	6. An attitude, opinion, or feeling formed without adequate prior knowledge, thought, or reason.	F. Prejudice
___	7. The belief that one sex (gender) is better than the other is and can be in control.	G. Race
___	8. A set of learned beliefs, traditions, principles, and guides for behavior that are shared among members of a particular group.	H. Racism
___	9. In biology, groups of people based on a set of genetically transmitted characteristics.	I. Sexism
___	10. Sharing a strong sense of identity with a particular religious, racial, or national group.	J. Stereotype

Adapted from Cultural Sensitivity Training, Texas Commission on Alcohol and Drug Abuse.

MODULE TWO
BELIEFS AND VALUES

MODULE TWO
BELIEFS AND VALUES

Cultural Differences in Communication Styles

Here are some examples of cultural differences in the ways people communicate with each other:

Animation/emotion:

- In some cultures, communication is often passionate and animated. When it is more passive or neutral, it may seem less believable and the listener may even question the speaker's motives. The assumption is that if you believe something, you will advocate for it. Truth is established by arguing for what you believe in.
- In other cultures people do not often express their emotions and may even worry that emotional communication could lead to a loss of self-control. People are more concerned with acting nice or friendly, even when they have strong differences of opinion. People may also assume that if they feel or think a certain way about something, others feel or think much as they do.
- In some cultures, it is considered OK to show a great deal of emotion when talking to people of the same culture, but not when around people of a different culture.

Eye Contact:

- In some cultures, the speaker usually looks into the listener's eyes for short moments while the listener looks steadily at the speaker. Children are taught to look at the person who is speaking to them. Direct eye contact is believed to be a sign of honesty and sincerity.
- In other cultures, direct eye contact is often viewed as disrespectful. When a person is being spoken to, he or she may look away or down as a sign of respect to the person speaking, especially if that person is older than the listener is or is in a position of authority over them.
- In other cultures, eye contact may be quite direct and held as long as the person is speaking, less so when listening. The overall amount of eye contact may not be different, but when the eye contact occurs might be different.

Gestures:

- In some cultures, people use gestures often and sometimes use large gestures. Very expressive communication is considered best, and if the gestures increase expressiveness, they are seen as helping communication to be effective.
- In other cultures, fewer gestures are used in normal conversation, but storytellers or elders may often use gestures, which are larger and more frequent than those in usual conversations are.
- In other cultures, gestures are usually kept close to the body and are not used very often. They may even be considered rude. The use of gestures often is related to the amount of emotion people typically show in their communication.

Turn taking and pause time:

- In some cultures, the speaker looking directly at the listener and becoming quiet signals taking turns.
- In cultures, pause time between speakers is very short; in fact, there may not be any pause time at all because often people speak on the end of the first speaker's last sentence.
- In some cultures, taking turns happens whenever a speaker is moved to speak. The right to continue speaking depends on how well the speaker's idea is being accepted. Responses from others are usually made at the end of each of the speaker's points, and this is not felt to be an interruption of the speaker.
- In some cultures any kind of interrupting another speaker, even just speaking responding to the points being made or beginning to speak on the end of the other speaker's last sentence, is considered unbearable rudeness, especially if the person interrupted is an elder.

Space:

- In some cultures, people tend to stand 2-3 feet apart ("arm's length"). Standing closer than that can be considered invasive or rude, depending on the relationship of those involved.
- In other cultures, keeping an arm's length apart is seen as cold, unfriendly, or a way to show superiority. Although different expectations for "normal" social distances are different, since they are unconscious, sometimes a person used to a closer social distance can actually back a person across the room.
- In some cultures, a side-by-side arrangement is more comfortable than face-to-face, especially in two-person conversations.
- Psychological space can be maintained by silence. This might be used if the listener is asked a question he or she feels is invasive or too personal.

Time:

- In some cultures, time is seen as moving in a straight line, it is seen as something everyone is short of, and the assumption is that everything should happen at a specific time. Time is seen as having a past, present, and future, and is often thought of as a real object, "which should be saved and not wasted."
- In some cultures, many activities may be going on at once, and priority is given to the peoples' immediate needs even if that means interrupting some other activity, especially those involved in one's collateral network. Time is a fluid and malleable concept.
- Some cultures are very relaxed about time, feeling the "right time" for something is when everything and everyone comes together. People might be puzzled if being late makes someone angry. "I am here now; let us get started" is a common response to this kind of situation. Time is felt to be more a matter of season, general time of day, or when the person is internally ready for a particular activity. The imposition of "clock time" by members of other cultures may be seen as arrogant, uncaring, or oppressive.

- In some cultures, time is seen as cyclical and ever returning. Some cultures are masters of waiting until "the time is right." They excel in long-term planning and maintaining long-term relationships. They may not understand why some people talk quickly and may see them as impatient.

Touch:

- In some cultures people touch each other quite frequently when talking, especially friends and children. They may even use touch as a means of communication without talking.
- In some cultures, hugging is a frequent form of greeting, even between strangers, and does not carry any sexual connotation whether between members of the same sex or the opposite sex.
- Other cultures use very little touching in public, with the exception of a handshake. Lack of touching may be related to cultural values of objectivity, efficiency, and autonomy.
- In some cultures handshakes are firm and extended, where in others the handshake is very light and fleeting, to avoid imposing energy on the other person or receiving energy one does not want.

Voice:

- Some cultures use a wide range of both volume and pitch when they speak. The voice can range from a very quiet, deep sound to very loud and high-pitched, and all may be considered appropriate.
- Other cultures tend to have a fixed, relatively narrow range of expected volume and pitch, especially in business conversation. Some people can experience those with more range in pitch and volume as "yelling at me." Adult, mature communication in public is believed to be objective, rational, and relatively non-emotional. Talking quickly, loudly, or showing emotion in the voice may be seen as inappropriate or rude.

Directness/Indirectness:

- In some cultures directness in stating the point, purpose, or conclusion of a communication is not the preferred style. In some cultures, communication is like an arrow that makes sharp turns before getting to its destination. The journey is part of the valued experience.
- Other cultures may gradually come to the point in a style that is more like a spiral with each successive piece of discussion or explanation getting closer to the central issue. They may see direct communication as abrupt or inappropriate.
- Some cultures focus on more direct and linear forms of communication and may see other styles as disorganized or intellectually weak. They may even assume non-direct speakers are being evasive or intentionally difficult. Their general form of communication tends to rely heavily on logic and technical information rather than allusion, metaphor, or other more creative or emotional styles of persuasion.

MODULE TWO
BELIEFS AND VALUES

My Communication Style

1. What is your communication style? Check the boxes to describe your own communication style when working with someone in a work setting.

Your Communication Style at Work

Communication Style	Almost Never	Little	Medium	A Lot	Almost Always
Animation/Emotion					
Eye Contact					
Gestures					
Turn Taking and Pause Time					
Space					
Time					
Touch					
Voice					
Directness/Indirectness					

2. Think about your communication style at home. Check the boxes to summarize your own communication style at home.

Your Communication Style at Home

Communication Style	Almost Never	Little	Medium	A Lot	Almost Always
Animation/Emotion					
Eye Contact					
Gestures					
Turn Taking and Pause Time					
Space					
Time					
Touch					
Voice					
Directness/Indirectness					

3. Compare your answers with those of a fellow case manager. How different are your answers from each other's? Which of you has more difference between your work and home answers? How different is your style from other members of your family? How are your two families different from each other?

MODULE TWO
BELIEFS AND VALUES

Reaching Cultural Understanding

- Are comfortable describing how their own cultural heritage influences their attitudes, beliefs, and feelings
- Identify and incorporate helping practices and help-giving networks intrinsic to clients into service plans
- Are able to explain the meaning of the diverse cultural practices of clients on their caseloads
- Are conversant with how class, gender, oppression, racism, discrimination, and stereotyping affect them and their clients
- Seek to overcome institutional barriers that may prevent various cultural groups from using community-helping services.
- Recognize how cultural differences influence their assessment and planning with various groups (ethnic, racial, religious, sexual orientation).
- Are open to learning experiences to enrich their understanding of and effectiveness in working with culturally different populations
- Can identify cultural strengths in families
- Can utilize cultural strengths to affect positive change with families
- Are able to identify factors of difference in their relationships, how these are affecting the casework process, and manage those in ways that facilitate change.

MODULE TWO
BELIEFS AND VALUES
Information to be Gathered and Explored

Cultural norms

Regarding family structure, including who comprises family, role of extended family, childcare and rearing, adolescent roles, mate selection, marital roles, care and roles of the elderly.

Personal habits and behaviors These might include practices related to health, hygiene, dress, foods, personal space, living quarters, handling finances.

Distinguishing between different subgroups Groups differ in many ways. It is best not to over-generalize about groups, because this may not explain the behaviors of individual families.

Degree of acculturation Families who consider themselves part of a minority group are also relating to the dominant culture as well as their own. It is important to look at family members'relationships with the dominant culture; realizing acculturation is a dynamic process, viewed over time and between family members.

Fluency with language Family members who do not speak English well need time to process and understand communication. In these situations, methods to overcome language barriers should be considered, including using a translator or speaking more simply and slowly. Workers should remember that many nonverbal behaviors transcend language.

Problem definition Different cultures define problems in different ways. Behaviors that seem typical in one culture may seem strange to another. Workers should pay attention to how families define their own problems and avoid imposing cultural biases or perceptions upon families.

Problem solving methods Approaches to problem solving also vary by culture. Some groups rely heavily on their own values to cope with problems; a distorted or limited understanding of a culture's underlying values may create a barrier for the worker attempting to work with a family to change and meet their needs.

Cultural resources Cultural resources within the community can provide valuable information for understanding the values and norms of different groups. It is important that workers know how to locate these resources and work with them to be culturally sensitive.

Attitudes toward external help Some groups reject any kind of outside help. In addition, negative experiences within the dominant culture can create skepticism about receiving help from human service agencies. Experiences from country of origin may create mistrust of any outside help. It is critical that workers be aware of pre-immigration conditions of the family.

Family Systems Characteristics How does the family define itself? Who are its members? What are the roles, rules, power structure, subsystems, boundaries that are culturally influenced?

Ethnographic Interview

- Your client is your cultural guide
- Provides you with two perspectives
  - The client's culture
  - The client's place in his/her culture

MODULE TWO
BELIEFS AND VALUES

• Ethnographic Interview

Descriptive Questions

Question Type	Example
Grand Tour: Elicit information about broad experiences.	- Tell me about a typical day for you (your child).
Mini Tour: Describe a specific activity or event.	- Tell me about a typical mealtime with Paul. - Tell me about a typical storytelling session.
Example: Take an experience and ask for an example.	- Give me an example of what Paul does when he cannot make himself understood. - Sarah, give me an example of overtaxing yourself.
Experience: Ask about experience in a particular setting.	- Tell me about your experience with Paul's teacher. - Tell me about your experience with student services.
Native Language: Seek an understanding of how a person uses terms and phrases.	- What would I see when you say, 'Paul hurts himself'?" - What is another way you would describe being overtaxed?

Ethnographic Interview

STRUCTURAL QUESTIONS

- Define Cover Terms
  - Explore further frequently used words or terms used by the client
  - Ask descriptive questions to help define the cover terms
- Explore Motives and Feelings
  - Ask questions that help the client define what motivates them
  - Solution focused questions work well in these situations
- Normative Scripts
  - Determine what the client believes is the "norm"
  - What he/she believes is the way things should be

MODULE TWO
BELIEFS AND VALUES
Ethnographic Interview

Social Dimensions

Social Dimension	Examples of What to Explore
People involved	Who are the members of the family? Does the family include just the parents and children, or are grandparents, aunts, uncles, cousins, and close friends all considered part of the immediate family? What are the roles of the persons who are involved with the child? Who is the caregiver? Who is the socializer? Who is the play partner? Who is the disciplinarian?
Physical places	Where does the client/family live—in a small apartment in the city, a spacious home in the suburbs, or a farm in a rural area? What places are used for different activities—where do people eat, sleep, work, play? What places does the family frequent besides their own home?
Acts	Single behaviors such as walking, singing
Activities/routines	Series of related acts, such as playing, therapy exercises, working, getting dressed
Events	What events are important for the client/family—birthday celebrations, naming ceremonies, weddings, holidays? How does the disability affect the client's/family's participation in events?
Objects	What objects are important/necessary for the client/family—medications, hearing aids, walkers, ventilator, toys, books?
Time	How is time viewed? Are schedules important? When are acts/activities/ events done?
Goals	What is the client/family trying to accomplish? What do they do to reach the goals?
Feelings	What are the client's/family's feelings about, people, places, objects, acts, activities, events, time, and goals?

Stages of the Ethnographic Interview

1. Ask friendly questions first

2. Engage the client

3. Express Interest

4. Express cultural Ignorance

5. Ask descriptive

6. Repeat questions, but ask them in a different way

7. Restate client's answers in your questions

8. Summarize for clarity

MODULE TWO
BELIEFS AND VALUES

Ethnographic Interviewing Worksheet

Determine how your coworker's family defined:

Work

Education

Poverty

Male and Female Roles

MODULE THREE
ASSESSING FAMILIES

Assessing Families Decision Making in Child Welfare

MODULE THREE
ASSESSING FAMILIES

Learning Objectives:

The Case Manager will be able to:

- Define assessment and identify the key decision points in assessing families
- Examine the underlying conditions leading to or sustaining behavior when performing an assessment
- Identify aspects of critical thinking and the importance for providing quality case management services
- Recognize the need to monitor the safety of the child by initial and ongoing assessment of risk
- Delineate the difference between safety and risk
- Define family violence and identify indicators and signs of family violence
- Direct clients to resources for family violence

MODULE THREE
ASSESSING FAMILIES

Child Abuse/Neglect Situational Exercise

Task:
The following is a list of situations which have been observed by case managers while on the job when making home visits. Rank them according to those situations which you feel involve the highest risk. (Which ones would you act on first? Are they the same?) On a scale of 1 through 10, one equals the most risk and ten equals the least risk.

A. _____ A 5-year-old has been locked in his room every day after school for 6 weeks as a punishment for bad behavior.

B. _____ A 4-year-old child often has bruises and welts as a result of discipline by his mother for lying and behaving just like his "no-good father."

C. _____The parents of two youngsters, ages 4 and 5, both spend most of their time out of the house due to job responsibilities and often don't return home until 7 or 8 p.m. The children are able to let themselves into the apartment and a neighbor "keeps an eye" on them.

D. _____ Parents give Valium to a 2-year-old to keep him quiet in the evening because he tends to run around and pester them at night.

E. _____ A child of 4 is not allowed to eat with the rest of the family and is rarely spoken to by his parents.

F. _____ A 5 year-old child has told her teacher that her daddy takes her on "special walks" in the woods and they "play with their private parts."

G. _____ Three children ages 7, 5, and 3 are seen running around a swimming pool while the parents sleep on the couch in the apartment. Parents have a known history of cocaine use.

H. _____ A 3 week-old baby, who was born with a positive toxicology screen for opiates, is otherwise healthy. The mother has a history of codeine abuse but refuses treatment.

I. _____ A father strikes his 4-year-old for knocking over a glass of milk. The child sustained a serious eye injury from the heavy ring the father was wearing. The injuries have been medically treated, and the child has just returned to school.

J. _____ The parents fight frequently due to financial problems. The father is in the habit of hitting the mother in front of the three children who hide and cry.

Source: U.S. Department of Health, Education and Welfare Office of Human Development Services, Administration for Children, Youth and Families, Children's Bureau, National Center on Child Abuse and Neglect, April, 1979, We can help: A curriculum on child abuse and neglect: Leader's manual, Washington, DC revised June 1991

MODULE THREE
ASSESSING FAMILIES

Assessment Is….

Process of gathering information about a family and a child to gain an understanding of the strengths, needs and problems that need to be addressed

Product when enough information is gathered to make a statement about the child and family's situation

Four Steps in Decision Making (Assessment)

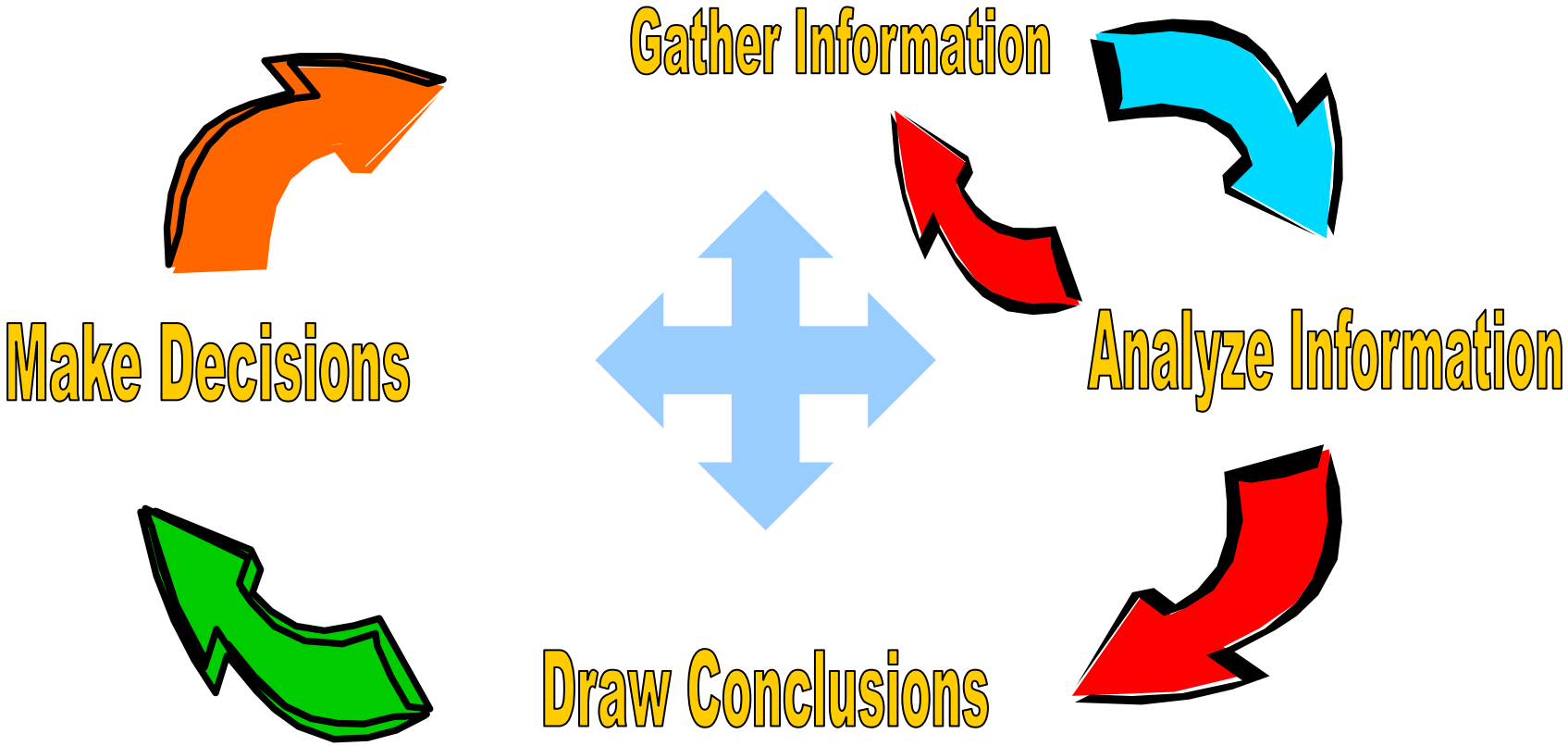
Step 1: Information Gathering

Step 2: Analyzing the Information

Step 3: Drawing Conclusions

Step 4: Making Decisions

Assessment Process



MODULE THREE
ASSESSING FAMILIES

Assessment Process

I= Information Gathering; A=Analyze Information; C=Drawing Conclusions; D=Making Decisions

_____ 1. Case Manger Sams looked in a child development resource to compare Tony's behavior with other 4-year-olds.

_____ 2. When Mrs. Autry and her boyfriend admitted he left the bruises on Allison when he used a hairbrush to spank her, the Case Manager was relieved they were honest and thanked them for their truthfulness. He accepted their promise to use non-physical discipline methods.

_____ 3. Mr. Johnson's speech was slurred during the home visit and he had trouble staying awake. He told the Case Manger his doctor had prescribed medication for an injury at work two days ago.

_____ 4. Sally's foster mother says Sally, age 11, can only attend to homework for 10-15 minutes before becoming frustrated. Her teacher states she is working below grade level and has trouble following directions. The Case Manager arranges for an educational evaluation.

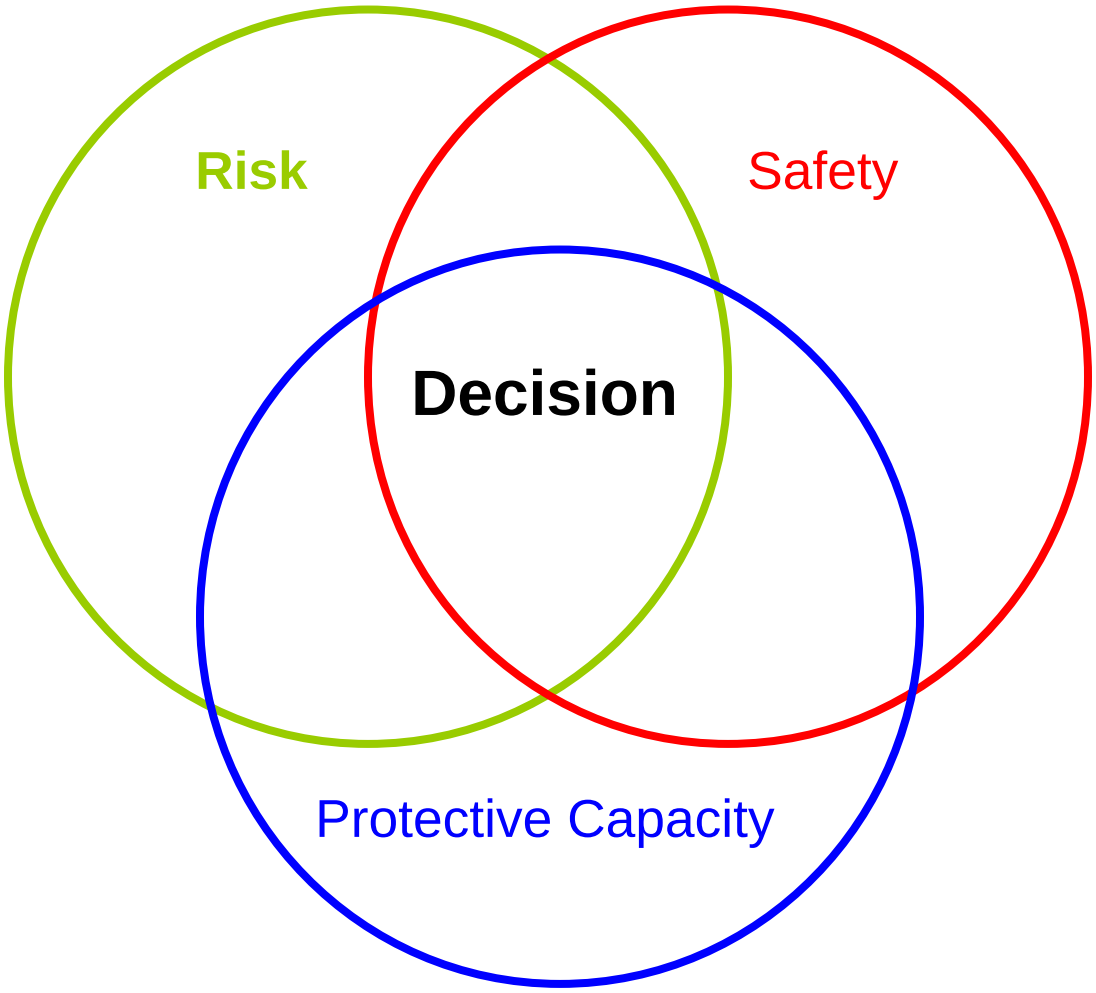
_____ 5. Audrey, age 9 was left to care for her two younger siblings, ages 3 and 6, while her mother went to work. A neighbor stated this occurs often and Audrey sometimes stays home from school to care for the 3 year old. The case manager determines this is a problem of supervision

_____ 6. Case Manager Sams told his supervisor he believed David was adjusting to his foster placement because his nightmares have decreased to once a week, his appetite has improved, and he likes to play with Timmy, the foster parent's son.

_____ 7. Mrs. George did not comply with her case plan and missed two appointments at the substance abuse treatment program. Mrs. George received a DUI over the weekend. Case Manager Morris told Mrs. George the children would have to stay with someone else until she completed the case plan.

_____ 8. The Villavong family recently moved to the community. Based on a referral from the school, the Case Manager made a home visit. She found only straw mats for sitting and sleeping. She went to the library to learn more about the Vietnamese Culture.

Three Elements of Assessment



Safety Assessment

Process used to determine the current threat of harm to the child.

Is the child currently safe?

If not, what needs to happen to ensure safety?

Danger loaded influences include but are not limited to:

- Severe Harm
- Premeditated maltreatment
- Young children being left alone
- Parents are unable and/or unwilling to perform “parental duties”
- Violence propensity
- Parent’s emotion state
- Danger to the child’s life or health
- Impairment to his or her mental well-being (including emotional abuse)
- Disfigurement
- Severe developmental impairment
- Dangerous housing
- Negative perception of the child

A safety assessment is not the same thing as a risk assessment.

Differences between Risk and Safety

SAFETY is concerned with…	RISK is concerned with…
Current dangerous family conditions	The likelihood of future maltreatment
Severe forms of dangerous family conditions and sever maltreatment only	Maltreatment on a continuum from mil to severe
Those family conditions that meet the danger threshold	Family functioning
Specific threats to a child's safety only	General child well-being
Decision making based on the present to the immediate near future (next few days)	Decision making based on an unlimited time frame (any time in the future)
A judgment about the certainty of severe effects	A judgment about any negative effects from future maltreatment
Family situations and behaviors that are currently out-of-control only	All family situations and behaviors from onset progressing into seriously troubled
Evaluating family situations and behaviors that must be managed and controlled	Evaluating family situations and behaviors that may need to be treated
A limited number of safety factors only	All aspects of family life relevant to understanding the likelihood of maltreatment

Action for Child Protection (2004)

MODULE THREE
ASSESSING FAMILIES
Activity
Application of Scenarios to Highlight Safety, Risk and Protective Factors

Directions: Look at variables below and develop a scenario that highlights an immediate safety, a risk or protective capacity that mitigates the safety and/or risk. Examples of the variable and suggested answers are listed below.

	Elevates to immediate safety concern	**Demonstrates risk**	**Mitigating protective capacity**
Example: An alcoholic parent	*The alcoholic parent leaves a baby alone while he/she goes out to the bar.*	*The alcoholic parent has driven in the past with the baby while under the influence of alcohol*	*The alcoholic parent leaves the baby with a relative while going out to the bar.*
Scenario 1: A mother who remains with a partner that hits her.			
Scenario 2: A family that is homeless			
Scenario 3: A father with limited cognitive capacity			
Scenario 4: A child that has bruises on the legs and arms			

What is Critical Thinking?

- More than a step by step problem-solving process
- Applies reflective skills to concrete situations - can only be learnt and refined through practice - through doing and reflecting on what we have done and why we did it that way
- Involves creative and lateral thinking as well as analytical thinking
- Allows for shades of grey, strives for depth, acknowledges ambiguity, complexity vs. black & white
- Focus is on process vs. content
- Encourages an holistic/ integrated perspective rather than simple undisciplinary/ linear approaches
- Values original/ insightful thought vs. 'second hand' thinking
- Suspends closure/neat and packaged solutions rather than strives for closure
- Exploring/probing vs. dogmatic/avoiding
- Fair-minded vs. ego or sociocentric
- Collaborative/ communal vs. authoritative

"I can put myself in others' shoes, try to think from their perspective, consider why people see things as they do and aim to understand where they are coming from."

MODULE THREE
ASSESSING FAMILIES
Activity: Attributes of Critical Thinking

Instructions: Review the attributes of a critical thinker. How many of these do you consistently adhere to?

A critical thinker:

- ☐ Asks pertinent questions
- ☐ Has a sense of curiosity
- ☐ Listens carefully to others and is able to give feedback
- ☐ Is interested in finding new solutions
- ☐ Is flexible and open minded
- ☐ Is able to admit a lack of understanding or information
- ☐ Has a habit of using plans and suppressing impulsive behavior
- ☐ Has a willingness to abandon non-productive action plans
- ☐ Has the willingness to engage in and persist at a complex task
- ☐ Is concerned more with finding the truth than being right
- ☐ Is able to consider the possibilities
- ☐ Is aware of one's own prejudices and biases and does not allow them to sway one's judgment
- ☐ Relies on reason rather than emotion
- ☐ Suspends judgment until all facts have been gathered and considered
- ☐ Is able to clearly define a set of criteria for analyzing ideas/problems
- ☐ Looks for evidence to support assumptions and beliefs
- ☐ Is able to follow evidence where it leads and adjust solutions when new facts are found
- ☐ Examines problems closely
- ☐ Is willing to examine beliefs, assumptions, and opinions and weigh them against facts
- ☐ Assesses statements and arguments for contradictions
- ☐ Is able to consider a variety of possible viewpoints and explanations
- ☐ Is able to reject information that is incorrect or irrelevant
- ☐ Attempts to ensure that the model of understanding is understandable to others
- ☐ Sees that critical thinking is a lifelong process of self-assessment

Resource: Ferrett, S. *Peak Performance* (1997).

Family System

Relationships, roles, rules, beliefs, boundaries, and communication patterns that exist and evolve among the interdependent members comprising the family.

- Families are the primary influence in our lives
- History tends to repeat itself
- Families move through time on a horizontal as well as vertical continuum
- Each member must maintain both separateness from and connectedness to the family

MODULE THREE
ASSESSING FAMILIES

Chief Enabler	*Family Hero*
Provides responsibility: can be counted on **Traits and behaviors:** • **Self-righteous** • **Super-responsible** • **Sarcastic** • **Passive** • **Physically sick**	**Provides self-worth to the family; someone to be proud of** **Traits and behaviors:** • **Good kid** • **High Achiever** • **Follows rules** • **Seeks approval** • **Very responsible**
Scapegoat	***Lost Child***
Removes blame from substance abuser; provides distraction **Traits and behaviors:** • **Hostile** • **Defiant** • **Rule-breaker** • **Troublemaker** • **Withdrawn**	**Relief; one child not to worry about** **Traits and behaviors:** • **Shy** • **Quiet** • **Solitary** • **Daydreamer** • **Attaches to things**
Mascot	***Additional Points About Family Roles***
Comic relief, fun and humor **Traits and behaviors:** • **Immature** • **Fragile** • **Cute** • **Hyperactive** • **Anything for a laugh**	• **Family members may have one role consistently or there may be periods of changing roles** • **The family hero and the scapegoat** may periodically **swap roles** • **Some family members may have dual roles** • **Children frequently take role into foster placements. This produces added challenges to working with children in placement.**

MODULE THREE
ASSESSING FAMILIES

Family Rules

It's not okay to talk about problems
What It Means This is the don't talk rule. Caregivers may say, "What happens in this house is no one else's business, so keep your mouth shut." Children may learn this rule by watching caregivers who don't talk about problems. **How It Affects the Family** Family members tend to avoid problems or to deny there are any problems
It's not okay to talk about or express feelings openly
What It Means This unspoken rule is don't express feelings, don't show feelings around anyone else, don't explore feelings or talk about them. **How It Affects the Family** By denying or stifling feelings, family members come to believe it's better to deny feelings than to risk letting others see who they really are.
Don't address issues or relationships directly
What It Means Family members learn to communicate indirectly, with one person acting as a messenger to others. Caregivers draw the children or some other third party into the middle of their conflict to avoid facing each other. **How It Affects the Family** This kind of communication produces confusion and guilt for all.
Always be strong, good and perfect
What It Means Family members begin to believe there is one right way to do things. Families create an ideal about what is good and right and best, but even perfect is never good enough. **How It Affects the Family** The ideal is so fare removed from what is possible and realistic that family members end up punishing themselves and others because expectations are not met.

MODULE THREE
ASSESSING FAMILIES

Family Rules

Don't be selfish
What It Means Family members learn to view themselves as wrong for placing their needs before the needs of others **How It Affects the Family** It this rule is applied rigidly to every situation, feelings of guilt and shame are certain to emerge. Because they believe their own needs are wrong, family members are never able to ask directly for those needs to be met. Consequently, they try to get personal needs met through manipulation or by taking care of others.
Do as I say and not as I do
What It Means Children are told by their caregivers to be honest but see their caregivers being dishonest **How It Affects the Family** If children see their caregivers day-in and day-out living without self-restraint or self-discipline, then they will come to believe this is the way to live.
It's not okay to play
What It Means The rule is real, serious people don't play. Having fun is not productive, so having fun is not okay. **How It Affects the Family** Life is seen as difficult and almost always painful.
Don't rock the boat
What It Means In families where there are unresolved issues such as substance abuse, the family system seeks to maintain a kind of balance, but the balance it seeks to maintain is unhealthy. **How It Affects the Family** The flaw in this rule is the family system doesn't allow for healthy change. This rule locks family members into a set of unhealthy rules.

Contributing Factors That Relate to Maltreatment

Age of Caregiver

Number of Children in Family

Number of Adults in Family

Characteristics of Caregiver

Relationships of Caregiver

Substance Use/Abuse

Financial Status

Parenting Education

Caregiver Abuse History

History of Domestic Violence

Disabled Children in the Home

Family Violence is…

A pattern of behavior used to establish power and control over another person through fear and intimidation, often including the threat or us of violence.

- ***Family Violence impacts a significant number of the families we work with.***

- According to Georgia Law, O.C.G.A 19-13-1, the term "family violence" means the occurrence of one or more of the following acts between: past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household.

- The law also states in O.C. G. A. 6-5-70 under the offense of cruelty to children, "such person, who is the primary aggressor, intentionally allows a child under the age of 18 to witness the commission of a forcible felony, battery, or family violence battery; or such person, who is the primary aggressor, having knowledge that a child under the age of 18 is present and sees or hears the act, commits a forcible felony, battery or family violence battery.

Significant Statistics

According to the Georgia Bureau of Investigations in 2007:

- 61,464 cases of family violence investigated.
- 19,654 persons were arrested for family violence
- 16,311victims were the current spouse of the offender;
- 46 female and 7 male fatalities
- Domestic violence is the leading cause of injury to women in the United States - more than car accidents, muggings, and rapes combined.
- 75% of domestic violence homicides occur after separation.
- Over three million children are at risk of exposure to parental violence each year.
- Sixty-three percent of young men between the ages of 11 and 20 who are serving time for homicide have killed their mother's abuser.
- Approximately one in four pregnant women has experienced domestic violence while pregnant. Pregnancy is often a time of initiation and/or escalation of physical abuse.

The Cycle Theory of Battering

Phase I -- Tension Phase

- Stress builds
- Communication breaks down
- Victim snses growing danger and tries to avoid abuse
- “Minor” violence/abuse occurs
- Incidents occur more often
- Intensity increases
- Batterer denies, minimizes, or blames external factors
- Victim hopes things will change “somehow”

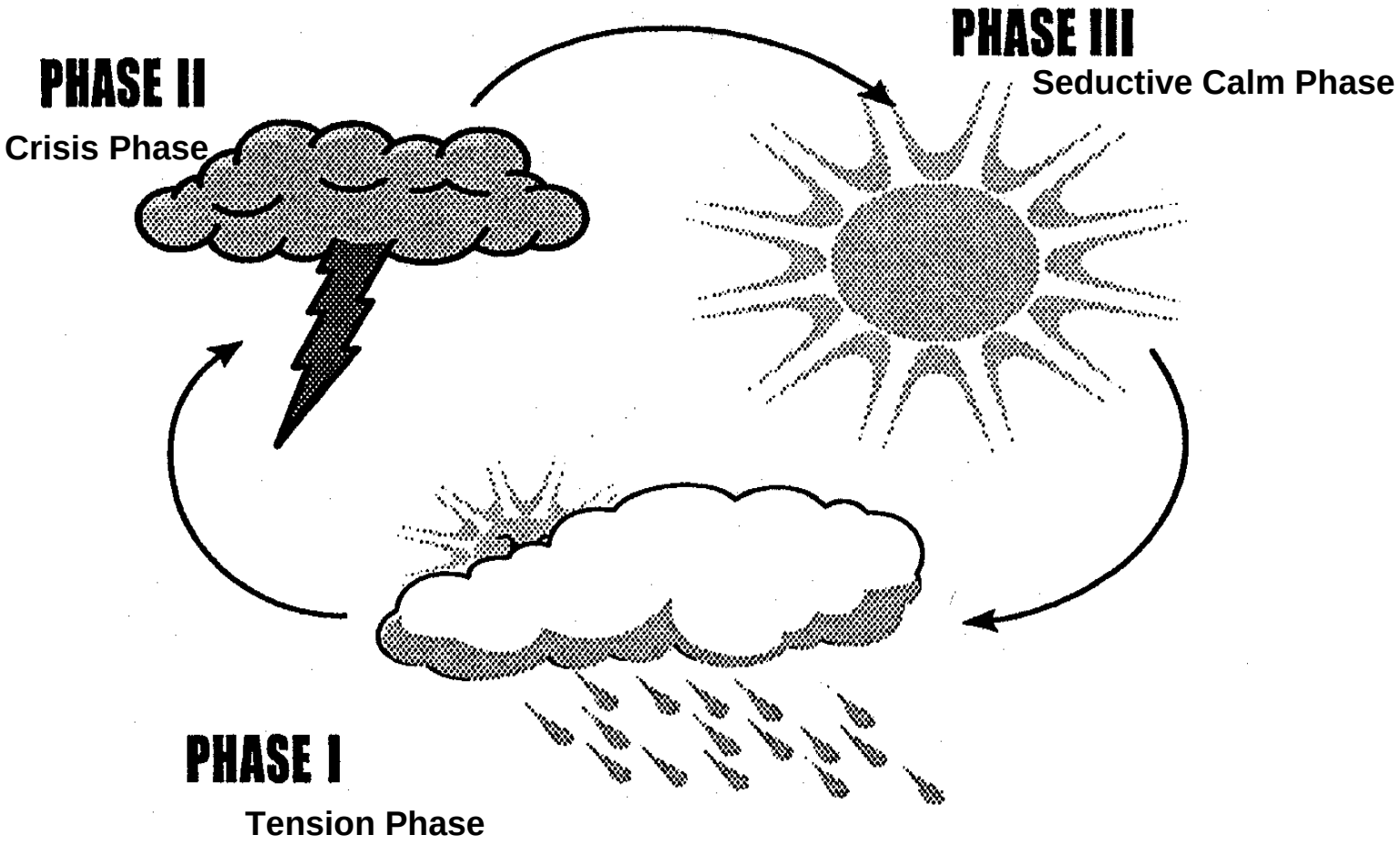
Phase II – Crisis Phase

- Anxiety is extremely high
- Major, controlled violence occurs
- Batterer is explosive, acute, and unpredictable
- Serious injuries or death may occur
- Abuse blames victim
- Victim adapts in order to survive
- Victim may escape only to return when crisis is over
- Abuser may isolate victim physically and emotionally

Phase III – Seductive Calm Phase

- The whole family is in shock at first
- Abuser may be remorseful, seeking forgiveness
- Abuse temporarily stops
- All are relieved that the crisis has passed
- Victim is worn down and accepts promises if offered
- Children become caretakers to survive or keep the peace
- Victim wants to believe violence won’t reoccur
- Abuser’s positive qualities are most evident

MODULE THREE
ASSESSING FAMILIES



The Progression of Family Violence

At first, she stays because:

- She loves him.
- She **believes** he'll grow up or change.
- She believes she can control the beatings by doing as he says: cleaning the house, keeping the children quiet, having dinner on time, etc.
- She believes she can convince him that she loves him and thereby end his jealousy.
- She believes it is her duty to make the relationship work.
- She believes him when he says he's sorry and won't do it again.
- She's afraid of what will happen if the police get involved.

Later, she stays because:

- She loves him, though less.
- She believes he loves and needs her.
- She believes she can't support herself.
- She's under pressure from family or friends to stay.
- She **hopes** he'll change or get help.
- She is increasingly afraid of her partner's violence.

Finally, she stays because:

- She believes no one can love her.
- She believes she can't survive alone.
- She believes she has no control over her own life.
- She feels **hopeless** and **helpless,** having no options
- She has developed serious emotional and physical problems.
- She becomes depressed and immobile; decisions are difficult, sometimes impossible.
- She becomes suicidal or homicidal
- He has become tremendously powerful in her eyes, and she is afraid.
- He threatens to kill her, the children, or her family.

MODULE THREE
ASSESSING FAMILIES

Barriers to Leaving a Violent Relationship

Lack of resources:

- Most women have at least one dependent child
- Many women are not employed outside of the home.
- Many women have no property that is solely theirs.
- Some women lack access to cash or bank accounts.
- Women fear being charged with desertion and losing children or joint assets.
- A woman may face a decline in living standards for herself and her children.

Institutional responses:

- Some clergy and secular counselors are trained only to see the goal of "saving" the marriage at all costs rather than the goal of stopping the violence.
- Some police officers do not provide support to women. They treat violence as a domestic "dispute" instead of a crime.
- Some police officers may try to dissuade women from filing charges.
- Some prosecutors are reluctant to prosecute case. Some judges rarely levy the maximum sentence upon convicted abusers. Probation or a fine is much more common.
- Despite a restraining order, little prevents a released abuser from returning and repeating the assault. There are not enough shelters to keep women safe.

Traditional Ideology:

- Many women do not believe divorce is a viable alternative.
- Many women believe that a single-parent family is unacceptable and that even a violent father is better than no father at all.
- Many women are taught by family, religious leaders or cultural norms to believe that they are responsible for making their marriages work. Failure to maintain the marriage equals failure as a woman.
- Many women become isolated from friends and families, contributing to a sense that there is nowhere to turn.
- Many women rationalize their abusers' behaviors by blaming stress, alcohol, problems at work, unemployment, or other factors.
- Many women are taught that their identity and worth are contingent upon getting and keeping a man.
- During non-violent phases, he may fulfill the woman's dream of romantic love. She believes he is basically a "good man." The abuser rarely beats the woman all of the time.
- The battering may occur over a relatively short period of time. He may tell her – and she may believe – that this battering was the last. Generally, the less severe and less frequent the incidents, the more likely she is to stay.

Adapted from National coalition Against Domestic Violence Web site, www.nadv.org

MODULE THREE
ASSESSING FAMILIES

Relationship Between Family Violence and Child Abuse

- Children are often the forgotten victims of family violence.
- Children who are raised in a violent home learn to obtain what they want through aggression by age 6.
- Child abuse is 15 times more likely to occur where battering is present.
- Seeing someone battered is considered a form of emotional abuse.
- Children who grow up in violent homes often become violent themselves,
- **Batterer's traumatize children in the process of battering their victim**

MODULE THREE
ASSESSING FAMILIES

In the Words of Their Mothers...

Annette

The kids were carrying a dreadful secret. If they talked, they would lose their dad, and they would be responsible for "breaking up" the family. If they didn't talk, they felt like they were taking part in my abuse. The kids were torn to pieces by the time we left him. And even that didn't end it. Every time he had visitation, he'd grill them about me, and he was always trying to make them choose between him and me. He'd coach them on things he wanted them to say to me and then they'd have to decide: "Should I say it or not?" He tried to turn them into weapons in his war on me.

Jocelyn

One morning after my husband left for work, my sons were in their room and as I cleaned the kitchen, I realized that they were role-playing one of our fights. My youngest called his brother a "rotten *#@*" and I wanted to die. Over the years the imitation continued. The older one wanted to beat up his dad for me and tried on a few occasions. But the younger one walked around the house calling me a fat pig. Eventually he started to hit me. That was too much. It opened my eyes. I wouldn't tolerate this behavior from an eight-year-old, so why was I tolerating it from my husband? I realized that my kids were growing up with a totally distorted image of what a family is, what a normal mom is, what a normal dad is, what love is. They'd already learned to disrespect women—to disrespect me.

Cheryl

One day my husband laid into me because I was delayed at the church and I wasn't home with dinner on the table when he came in from work. He cursed me out and carried on, and afterwards my son said to me, "I'd be mad too if I came home and my wife wasn't there." He was only nine years old. I hated the way he thought about women and the way he talked to me, and I realized that if we stayed there he was going to wind up thinking and acting just like his father.

Children from Violent Homes Learn to Believe:

It's acceptable for men to hit women

Violence is the way to get what you want

Big people have power they misuse

Men are bullies who push women and children around

Expression of feelings signifies weakness

They shouldn't talk about violence

They shouldn't trust

They shouldn't feel

Adapted from Western Australia Gov. web page at www.helath.wa.gov.au/publications/dvpk_eoc.html

MODULE THREE
ASSESSING FAMILIES
Effects of Abuse on Children

Emotional

- Feelings of guilt for the abuse and for not stopping it
- Grieving for family and personal losses
- Confusion or conflicting feelings toward parents
- Fear of abandonment, of expressing emotions, of the unknown, and of personal injury
- Anger about violence and chaos in their lives
- Feelings of depression, helplessness, powerlessness
- Embarrassment from the effects of abuse and the dynamics at home

Cognitive

- Blaming others for their own behavior
- Belief that it is acceptable to hit people they care for in order to get what they want, to express their anger, to feel powerful, or to get others to meet their needs
- Low self-concept originating from a sense of family powerlessness
- Tendency not to ask for what they need, let alone what they want
- Lack of trust
- Belief that feeling angry is bad because people get hurt
- Development of rigid stereotypes: To be a boy means…to be a girl means…to be a man, woman, husband, or wife means…

Behavioral

- Acting out or withdrawal
- Overachiever or underachiever
- Refusing to go to school
- Caretaking and being more concerned for others than self; parental substitute
- Aggressive or passive
- Rigid defenses (aloof, sarcastic, defensive, “black and white” thinking)
- Excessive attention seeking, often by using extreme behaviors
- Bedwetting and nightmares
- Out-of-control behavior; inability to set own limits and follow directions
- Aggression toward victim

Social

- Isolation from friends and relatives
- Frequently stormy relationships that start intensely and end abruptly
- Difficulty in trusting, especially adults
- Poor anger management and problem-solving skills Excessive social involvement (to avoid home life)
- May be passive with peers or bully peers
- Engagement in exploitative relationships, either as perpetrator or victim
- Play with peers becoming exceedingly rough

Physiological

- Somatic complaints (headaches, stomachaches)
- Nervous, anxious, and short attention span (frequently misdiagnosed as having Attention Deficit Hyperactive Disorder)
- Tired, lethargic
- Frequently ill
- Poor personal hygiene
- Regression in development (bedwetting, thumb sucking, etc. depending on age)
- Desensitization to pain
- High-risk play and activities
- Self-abuse

Ways Batterers Use or Harm Children and the Effects by Age Group

Newborn to 1 year

Ways Batterers Use or Harm Children to Control Adult Victim:

- Being violent in front of children
- Waking children up with the sound of the violence
- Exposing child to assaults against their mother or property
- Threats of or use of violence against child
- Taking child hostage to get the mother to return to batterer

Effects of This Abuse on Children:

- Physical injury or death
- Excessive crying
- Not being responsive or cuddly
- Fear
- Sleep disturbances
- Insecurity for being cared for by a traumatized mother
- Nervousness, jumpiness
- Traumatized
- Premature birth
- Failure to thrive
- Eating disturbances
- Colic or sickness

Age 2 to 4 years

Ways Batterers Use or Harm Children to Control Adult Victim:

- All of the ways listed for ages newborn to 1 above
- Hurting child when the child intervenes to prevent the mother from being injured
- Using children as a physical weapon against the victim
- Interrogating children about mother's activities
- Forcing child to watch assaults against mother or to participate in the abuse

Effects of This Abuse on Children:

- All affects listed for ages 0-1
- Withdrawal
- Insecurity
- Problems relating to other children
- Acting out violently
- Delayed toileting
- Depression

Age 5-12 years

Ways Batterers Use or Harm Children to Control Adult Victim:

- Being violent physically or sexually towards the mother in front of the children
- Hurting child when the child intervenes o stop violence against mother
- Using child as a spy against mother
- Forcing child to participate in attack on mother
- Physically or sexually abusing child
- Interrogating child about mother's activities

Effects of This Abuse on Children:

- Physical injury or death
- Early interest in alcohol or drugs
- Insecurity, low self-esteem
- Becoming an overachiever
- Depression
- Becoming embarrassed about family
- Becoming caretaker of adults
- Developing problems to divert parents from fighting
- Fear
- School Problems
- Withdrawal
- Bed-wetting
- Sexual activity
- Becoming violent
- Running away

Teen Years

Ways Batterers Use or Harm Children to Control Adult Victim:

- Physically or sexually abusing teen
- Coercing teen to be abusive to mother
- Being violent physically or sexually towards mother in front of teens
- Hurting teen when the teen intervenes to stop violence against mother
- Using teen as a spy against mother
- Forcing teen to participate in attack on mother

Effects of This Abuse on Teenagers:

- Confusion about gender roles
- Becoming super achiever at school
- Truancy
- Shame and embarrassment about family
- Suicide
- Tendency to get serious in relationships to early in order to escape home
- School problems
- Social problems
- Becoming abusive
- Depression
- Alcohol or drug abuse
- Sexual activity

MODULE THREE
ASSESSING FAMILIES

The State of Georgia defines Family Violence as (§OCGA 19-13-1):

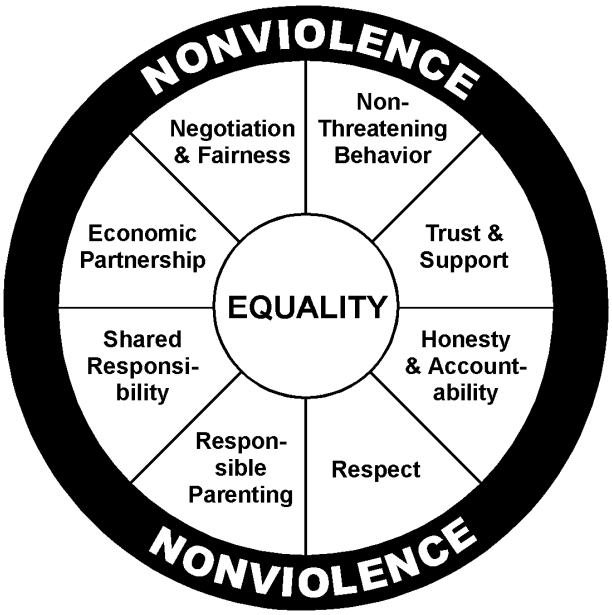
"... the occurrence of one or more of the following acts between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household:

(1) Any felony; or

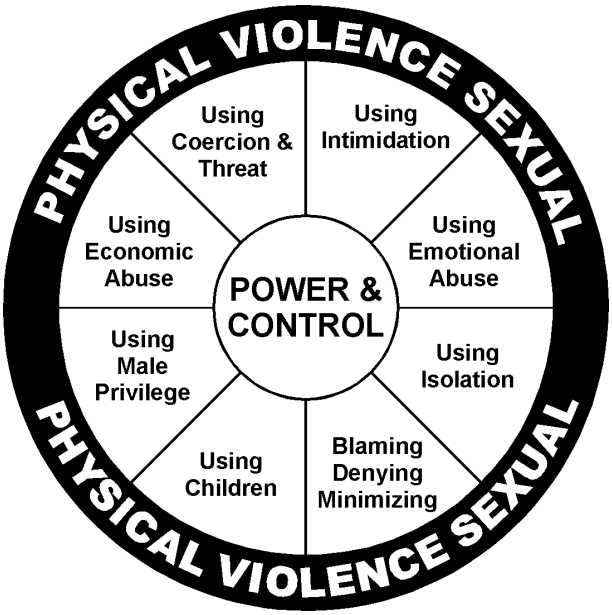
(2) Commission of offenses of battery, simple battery, simple assault, assault, stalking, criminal damage to property, unlawful restraint, or criminal trespass."

UNDERSTANDING FAMILY VIOLENCE

The Equality Wheel



Power and Control Wheel



MODULE THREE
ASSESSING FAMILIES

Information on Shelter Care Services

24 hour Crisis Line/Crisis Intervention

Staff or volunteers who have completed the required training answer the crisis line. An answering machine will never answer. An answering service is acceptable but victim will be contacted within 30 minutes. Crisis intervention might include safety planning, emotional support, validating the victim's experience and feelings, information/referrals regarding services, exploring options, discussion of effects of violence on adults and children.

The shelter phone number or the statewide toll-free 24 hour crisis line **1-800-33-HAVEN (1-800-334-2836)** which will automatically connect you to the nearest family violence agency

Safe Confidential Shelter

Safe, confidential shelter for clients on a 24 hour a day, 7 day a week basis. The shelter should provide 24-hour coverage with staff or volunteers who have completed the required training.

Linkage with Community Agencies

The shelter will maintain linkages with community agencies/individuals for the provision of required services and train community agencies/individuals to further the aim of creating an environment that is sensitive and responsive to the needs of family violence victims and their children.

Children's Services

Children's Services including counseling and support are offered.

Emotional Support

Emotional support shall be available to clients and referrals made as appropriate.

- Individual counseling and support is provided when requested or deemed advisable by staff.
- Support groups are structured and facilitated services offered in a safe and accessible location at least twice monthly.

Community Education Services

Family violence education and prevention programs and information is provided to the community

Legal and Social Services Advocacy

Legal and social services advocacy to clients is provided

Household Establishment Assistance

When requested, assistance will be provided to victims in establishing new permanent residences.

Follow up Services

Follow up services will be offered to each adult client as a part of the exit procedure. At minimum a safety plan will be created.

Parenting Support and Education

Parenting support and education will be provided as needed for parents.

All services are free and confidential. Client does not need to reside in shelter to receive services.

MODULE THREE
ASSESSING FAMILIES
STATE OF GEORGIA 1-800 NUMBER FOR FAMILY VIOLENCE VICTIMS

1-800 33 HAVEN (1-800-334-2836)

- This number automatically connects the caller to the nearest family violence shelter. The caller does not have to go through a third party to reach a shelter.
- The number is operational 24 hours per day, every day of the year and is answered by a trained individual working in the local family violence shelter.
- The caller can remain anonymous if she/he chooses
- The shelter will explain resources available to the caller including coming for emergency shelter and safety; legal options; counseling offered by shelter for both adults and victims, resources for assistance with housing needs, other community resources that may be needed by the individual.
- All information is confidential (with exception, of course, of reporting child abuse/neglect).
- A record will be kept so that the caller will not have to give their story with each call.
- The caller will be offered shelter but if shelter is not needed or wanted at this time all other services are explained. Arrangements would be made to provide requested services to caller regardless of shelter residency.
- If needed and requested emergency transportation to reach the shelter will be arranged for the caller.
- This number will also provide information to friends or family members of victim.
- The 1-800 number is an excellent resource to you as a DFCS worker if you do not have the local shelter number available. The agency will be glad to discuss with you their services and if needed will help you evaluate how best to serve a victim.

MODULE FOUR
CHILD MALTREATMENT

Child Maltreatment

MODULE FOUR
CHILD MALTREATMENT

LEARNING OBJECTIVES:

After completion of this module, case managers will be able to:

- Accurately describe and identify physical, emotional, and behavioral indicators of abuse and neglect in child victims and their families
- Recognize physical and behavioral indicators of child physical abuse, sexual abuse, emotional abuse, and neglect
- Explain how indicators are used to identify maltreatment
- Differentiate between inflicted injuries, and those caused by accidents, natural disorders, or cultural healing practices

MODULE FOUR
CHILD MALTREATMENT

Child Protective Services Policy Manual Transmittal

Maltreatment

This refers to one or more forms of neglect, abuse or exploitation. It may be used as a general term or in reference to a specific category such as neglect, physical abuse, emotional neglect, medical neglect, emotional abuse, sexual abuse, exploitation or exposure to family violence.

Neglect

This is a condition in which a parent or caretaker, responsible for a child under the age of eighteen years, either deliberately or by disregard, permits the child to experience avoidable present suffering and/or fails to provide one or more of the components generally deemed essential for developing a person's physical, intellectual, social and emotional capacities.

Physical Abuse

This is physical injury or death inflicted upon a child by a parent or caretaker by other than accidental means (O.C.G.A. 19-7-5). It often occurs in the name of discipline or punishment and may range from the use of the hand to the use of objects.

Sexual Abuse

This is a form of child abuse in which any of nine specific behaviors occur between a child under the age of eighteen years and the parent or caretaker and during which the child is being used for the sexual stimulation of that adult or another person. Sexual abuse shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not more than three years older than the minor. However, sexual abuse may be committed by a person under the age of eighteen years when that person is either significantly older than the victim or when the abuser is in a position of power or control over another child. Alleged sexual abuse by an extra-familial perpetrator must be evaluated on the basis of parental approval or the lack of parental supervision (O.C.G.A. 19-15-1).

The nine specific behaviors (O.C.G.A. 19-7-5) are:

(1) Sexual intercourse, including genital-genital, oral-genital, anal-genital or oral-anal, whether between persons of the same or opposite sex;

(2) Bestiality;

(3) Masturbation;

(4) Lewd exhibition of the genitals or pubic area of any person;

(5) Flagellation or torture by or upon a person who is nude;

(6) Condition of being fettered, bound or otherwise physically restrained on the part of a person who is nude;

(7) Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area or buttocks or with a female's clothed or unclothed breasts;

(8) Defecation or urination for the purpose of sexual stimulation; or

(9) Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.

Sexual Exploitation (O.C.G.A. 19-7-5)

This is a form of maltreatment in which a child's parent or caretaker allows, permits, encourages or requires a child under the age of eighteen years to engage in sexual acts for the stimulation and/or gratification of adults or in prostitution as defined by law (O.C.G.A. 16-6-9), or allows, permits, encourages or requires a child to engage in sexually explicit conduct for the purpose of producing any visual or print medium (O.C.G.A. 16-12-100).

Maltreatment Reports
Georgia 2006

Total Reported: 92,952
Screened Out: 14,657 (16%)
Diverted: 22,833 (25%)
Accepted for services: 55,462 (60%)
Substantiated: 22,779 (41%)
Accepted for services, entered into data system: 12,595 (23%)
Investigated, substantiated, and closed: 10,184 (45% of substantiated cases)

Neglect: 73.9%
Physical Abuse: 10.8%
Sexual Abuse: 4.6%
Emotional and Other Maltreatment: 22.3%

MODULE FOUR
CHILD MALTREATMENT

More Policy Definitions

Caretaker

This is a parent, guardian, foster parent, employee of public or private residential home or facility or a day care facility, personnel of public and private schools or any other person often found in the same household or caretaking unit for a child (e.g. boyfriend/girlfriend, stepparent, adoptive parent).

- **Primary** caretaker: The adult (typically the parent) living in the household who assumes the most responsibility for child care.
- **Secondary** caretaker: An adult living in or often in the household who has routine responsibility for child care, but less responsibility than the primary caretaker. A significant other may be a secondary caretaker even though this person has minimal child care responsibility.

Child

This is any person from birth to eighteen years of age.

Child Abuse means (O.C.G.A. 19-7-5):

- Physical injury or death inflicted upon a child by a parent or caretaker by other than accidental means; provided however, physical forms of discipline may be used as long as there is no physical injury to the child;
- Neglect or exploitation of a child by a parent or caretaker;
- Sexual abuse of a child; or
- Sexual exploitation of a child.
- However, no child who in good faith is being treated solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered to be an "abused" child.

Categories of Indicators

Child Indicators

- Physical Development
- Emotional Development
- Cognitive Development
- Social Development

Parent Indicators

- Interaction with child
- Support system
- Relationships with other adults
- Parenting skills

Environmental Indicators

- Provisions for child needs
- Safety conditions
- Physical environment

MODULE FOUR
CHILD MALTREATMENT

Red Flags

Read the following statements. Using Ink Annotation, highlight what causes you concern in each situation.

1. A 9-year-old has welt marks all over her buttocks. She says her mother spanked her for leaving her homework assignment at school.

2. A 4-month-old has a bald flattened spot on the back of her skull. The baby also looks extremely underweight. Neighbors report that the baby is heard crying constantly.

3. A 7-year-old girl, one of four siblings, is constantly berated by her parents. She is more severely punished than her brothers and sisters and she is not allowed to play outside after school or have friends over. The school makes a report after she stabs herself in the wrist with a pencil.

4. A 12-year-old goes to school in cold weather frequently missing key items of clothing: socks, under garments, hat, sweater or coat.

5. An infant is born with a positive toxicology for drugs.

6. Two children ages 4 and 7 have been found left alone in their apartment for several days.

7. A neighbor reports that the mother of three young children has been lying on the living room floor unable to move for hours while her children are left to fend for themselves.

8. The father of a 17-year old swings a bat directly at the teen. The teen ducks and fortunately is not hit.

9. An 11-year-old attempting to protect Mom during an argument with Dad has bruises on his face and cuts on his hands and arms.

10. A 10-year-old says her stepfather examines her between her legs while bathing her, to make sure she is clean. She said it doesn't bother her.

MODULE FOUR
CHILD MALTREATMENT

How would you feel?

You are the single parent of two children, ages 3 and 4. You work 40 hours a week; you earn $200/week. Your elderly aunt cares for the children while you work, but she is not in good health and is very susceptible to illness. Your youngest child has been sick with a cold, fever, and nasty cough for 5 days. She is lethargic and doesn't appear to be getting over it. This week your rent is due; you also need to buy food, and must use cash, since your food stamps ran out several days ago. You also must put gas in your car to get to work every day next week. But, you're worried about leaving the children with your aunt, because the last time she got sick she got pneumonia. However, if you miss work, you also lose pay. Finally, your child should go to the doctor. But, you will need to take a whole day off work and sit at the clinic if Medicaid is going to pay; or, you'll need to pay the doctor up the street, who will see you in an hour.

Put yourself in this parent's situation. How would feel if you were faced with this situation? Of the following four options which would you select and why?

1. Leave the children with your aunt and hope she doesn't get sick, and go to work all 5 days; you'll have money for food and rent. Medical care for your child will have to wait.

2. Get your 9-year-old niece to stay with the children, and to call you at work if anything happens. Your niece will have to stay home from school to do this.

3. Stay home from work and care for your children yourself in order to prevent your aunt from getting sick; go to the clinic and let Medicaid pay the bill, lose several days of income; either food or rent will have to wait.

4. Take your child to the doctor and pay the cost; and worry about the rent next month, hoping your landlord doesn't put you out as he has threatened to do when you don't pay the rent.

Distinguishing Poverty From Neglect

When attempting to distinguish between poverty and neglect it is important to assess and document the following factors.

Families who live with poverty do **NOT** exhibit these factors, while neglectful parents may exhibit one or more of these factors.

1. Absence of healthy attachment.
2. Failure to feed child when food is available.
3. Chronic failure to supervise.
4. Lack of appropriate limit setting
5. Lack of developmental stimulation.
6. Lack of emotional nurturance and guidance.
7. Failure to take a child to the doctor, because of lack of judgment or motivation, when care and transportation are available.
8. Failure to regularly send child to school.

Dr. H. Cantwell and Dr. D. Rosenberg, *Child Neglect.* 1990.

Causes of Neglect

Substance Abuse

Depression and/or mental illness

Poor social skills

Generational Patterns

Mental Retardation

Areas of Child Neglect

Indicators of Inadequate Supervision

Child Indicators:

- Child is below 8 years of age
- Child between the ages of 9 and 12 is left for more than 2 hours
- Child younger than 13 years of age is left to care for other children
- Child is left frequently

Conditions to consider:

- Child knows how to contact the parent
- Child knows an emergency procedure
- Child has the mental capacity and maturity level to deal with the situation
- Child has the physical capacity to meet his/her own basic needs
- Child is emotionally secure

Parent/Caretaker Indicators:

- Parent does not prepare the child with an emergency procedure
- Parent puts own needs above those of the child
- Parent leaves the child for his/her own personal pleasure
- Parent is depressed or withdrawn
- Parent does not return home within a reasonable time frame
- Parent does not recognize the uneasiness and discomfort of the child
- Parent often leaves child in the care of others
- Parent expects oldest child to care for younger children

Environmental Indicators:

- Provisions arranged for the child
- Danger level of neighborhood
- Availability of friends or neighbors in an emergency
- Condition of the physical environment:
  - Temperature
  - Adequate shelter from weather
  - Cleanliness
  - Accessibility to noxious substances (cleaners, chemicals, drugs, alcohol)

If a child has been denied access to the home or is abandoned Determine:

- What actions were taken by the caretaker that indicate a desire to give up responsibility and obligations for the child
- What are the reasons for these actions
- Did the caretaker fail to return or communicate despite an ability to do so

MODULE FOUR
CHILD MALTREATMENT

Indicators of Inadequate Food Clothing and Shelter

Child Indicators:

Inadequate Nutrition:

- Steals or hoards food
- Poor quality foods dominate the diet - sweets, candy
- Appears malnourished
- Appears anemic (Children who are anemic as a result of lack of iron in the diet may appear drowsy and pale.)
- Appears skinny
- Has protruding abdomen
- Has “pinched” face
- Has prominent ribs
- Has wrinkled buttocks with obvious lack of fatty tissue
- Generally appears undernourished or emaciated
- Appears ashen
- Does not vocalize
- Is developmentally delayed
- Does not make or maintain eye contact
- Refuses to eat
- Has diarrhea
- Has nausea
- Child is/has been vomiting

Inadequate Clothing/Hygiene

- Clothing is too small or too large
- Dirty, torn clothing
- Inappropriate for protection from weather
- Lack of essentials like shoes, underwear, jacket
- Siblings are dressed better
- Long, untrimmed fingernails
- Residue of feces in genital area
- Crusty eyes, nose, mouth
- Dirty residue or rashes in folds of skin
- Severe diaper rash
- Impetigo or other skin diseases

Indicators of Inadequate Food Clothing and Shelter
(Continued)

Parent/Caretaker Indicators

- Alcohol/drug use
- Continuous friction in the home
- Depressed parent
- Immature parent
- Mentally ill parent
- Mental retardation of the parent
- Multiple sexual partners
- Consistently putting own needs ahead of the needs of the child
- Unrealistic expectations of the child
- Failure to individualize children and their needs
- Failure to use discipline for the child's development
- Overly severe control and discipline
- History of neglect as a child

Environmental Indicators

- Neighborhood is dangerous
- Emergency caretakers are non-existent
- Food is insufficient
  - Food is not available in the house
  - Child does not have access to food that is available in the house
  - Perishable foods kept in a refrigerator that is not working properly
  - Rotten, moldy or insect-infested food that is accessible to the child
- Home is dangerous
  - Broken glass; broken or missing doors
  - Bug or rodent infestation
  - Child does not have a safe, designated place to sleep or eat
  - Drugs or alcohol easily accessible to the child
  - Exposed electrical wires
  - Gas leaks
  - Lead paint
  - Open wells
  - Poisons or cleaning products are easily accessible to the child
  - Unprotected stairways

MODULE FOUR
CHILD MALTREATMENT

SCENARIO 1

JAMAL

Jamal is five years old. He is a lot like most five year olds; he loves pizza, ice cream and the cowboy boots his “Grandma Ruby” gave him for his birthday. Jamal considers himself to be a big boy. He can dress himself and knows to put on clean clothes when they are available. He can make peanut butter and jelly sandwiches and cereal with milk but lots of times there is no food in the house and Jamal is hungry.

Jamal lives with his mother, Angelique, age 20. She is the love of his life and he tries hard to please her. It makes him sad when she calls him a baby but he doesn’t like to be left by himself. He gets scared when she goes off at night and he is sure there are monsters in the closet and under his bed. He has even seen them peeking at him when he tries to sleep. Mama got real mad because she came home and found him asleep with all the lights on. She talked about not having the money to pay the light bill.

Sometimes Mama goes off during the day and Jamal goes to the park by himself to play with his truck. He has to cross a busy street to get there but he is a big boy. Today, Mama left early to go see friends and told Jamal to stay in the house. He got bored and decided to take his truck and go to the park. When he went to cross the street, he forgot to look both ways and ran out in front of a car. The lady wasn’t going very fast but it knocked Jamal unconscious for a minute and broke his left arm. When he became conscious, he cried and cried for his mama but the police could not locate her. Neighbors in the apartment complex told the police that Mama left Jamal alone “all the time.” At the emergency room, a nice lady came with the policeman to talk to him. She asked him a lot of questions about his mama and his grand-mama. He tried to remember the names of Mama’s friends and his grand-mama’s last name and address but he couldn’t. He was so scared and upset. He just wanted to go home.

MODULE FOUR
CHILD MALTREATMENT

Worksheet

What are the child indicators?
What are the parent/caretaker indicators?
What are the environmental indicators?

Indicators of Inadequate Health and Medical Care

Child Indicators

- Suffers chronic illness and lacks essential medial care
- Lacks dental care and dental hygiene
- Fails to receive necessary prosthetics including eyeglasses, hearing aids, etc.
- Fails to receive follow-up care for a diagnosed problem
- Receives no preventive medical care

Parent/Caretaker Indicators

- Fails to initiate care for an acute serious medical problem
- Non-compliance with medical recommendations for care and treatment of the child
- Disregards child's need for preventive medical care
- Disregards child's need for dental care

Environmental Indicators

- Environmental allergenic conditions
- Physical conditions
- Provisions for child's needs

Medical Neglect Defined

Absence or omission of essential medical care or services that seriously harms or threatens harm to the physical or emotional health of the child

This includes withholding treatment for infants with life threatening conditions.

Caretakers must:

- Seek medical care
- Allow medical care in acute serious illnesses
- Comply with medical recommendations for home treatment
- Seek treatment for disabling or handicapping chronic conditions
- Provide adequate preventive care
- Provide timely visits to health professionals including dentists

Deprived Child means (O.C.G.A. 15-11-2)**: (CPS Manual 2101.5)**

- Without proper parental care or control, subsistence or education as required by law, or without other care or control necessary for the child's physical, mental or emotional health or morals;
- Placed for care or for adoption in violation of law;
- Abandoned by parents or other legal custodian;
- Is without a parent, guardian or custodian; and,
- No child who in good faith is being treated solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered a "deprived child."

Indicators of Failure to Thrive

Child Indicators:

- Appears emaciated, pale, and weak: have little subcutaneous fat and decreased muscle mass.
- Infants are often below their birth weight
- Listless, apathetic, and motionless and at times irritable.
- Unresponsive or resistant to social involvement. Others become actively distressed when approached. Many show a preference for inanimate objects.
- Sleep for longer periods than appropriate
- Display immature posturing
- Self-stimulatory rocking, head-banging, or rumination (vomiting and swallowing)
- Primary delays in gross motor and social domains

Parent/Caretaker Indicators

- Be depressed, socially isolated, withdrawn and anxious
- May have a history of abuse and neglect
- Fail to interact warmly with their infants
- Show little ability to empathize
- May create an unpleasant or painful feeding situation for the infant
- Appear not to know how to engage in meaningful activity with their infant
- Not realize the child is failing to grow
- Not be able to report accurate feeding times, schedules, or the quantity of formula the infant has taken.

Intervention Strategies for Failure to Thrive

Failure to Thrive Evaluation

- Complete Medical History
- Complete Physical
- Behavioral/Interaction Assessment

- Immediate hospitalization of the infant is necessary, with a treatment program that provides caloric intake far in excess of that needed for maintenance under normal conditions. This typically leads to rapid weight gain, called "catch-up growth," in children who are undernourished from under feeding. Some infants achieve age-appropriate weight within a couple of weeks.
- Rapid "catch-up growth" during hospitalization is diagnostically significant for this syndrome, particularly when the child is fed in the hospital with the same formula used at home.
- Some secondary physical conditions affecting the infant as well as apathy and depression, appear to be resolved as a result of intensive feeding programs.
- Parents should be directly involved in all aspects of the treatment program. Supportive counseling and education by a caring, nurturing professional can help parents feel less guilty, anxious, and depressed, and can teach and reinforce proper feeding methods and improve parent-child interactions. This treatment program should begin in the hospital. If the parents are not involved in the treatment, the child can be expected to regress when returned to the home.
- The parents' problems are not simply the result of a lack of parenting knowledge. Therefore, Kempe and Goldbloom warn that parents cannot be "treated" with a few educational sessions on proper feeding techniques. They state:

  > "The immaturity, neediness, and feelings of helplessness of the neglectful mother are not transformed into empathic nurturing by one or two lectures. She herself must experience from someone the empathy and nurturing she is expected to give her baby, and she must be able to depend on this support while she learns how to be a more sensitive parent for the infant's benefit."

- If the parents appear unable to improve their care of the infant under controlled hospital conditions, substitute care placement should be considered.
- Children, who are hospitalized for malnutrition and returned home, without appropriate follow-up services and a demonstrated change in the quality of parental care, are at very high risk of harm, including death (Kempe & Goldbloom, 1987).

Medically Fragile Infants

Medically Fragile Infant:

An infant who has had and is expected to continue to have a need for more medical care than usual.

Medically Fragile Birth Weight:

Low birth weight is 5 lb, 8 oz or less. Very low birth weight is 3 lb, 5 oz or less. Very low birth weight infants are 90 times more likely to die at birth or during the first year of life. They suffer from the most serious complications. Of those who survive, a large percentage will be left with medical, neurological or developmental problems.

Medically Fragile Conditions:

Breathing problems: Many low and very low birth weight infants suffer from respiratory distress syndrome (RDS), an inability to get enough oxygen. Some require placement on a ventilator with oxygen to avoid respiratory failure and cardiopulmonary arrest.

Some infants require ventilator assistance for only a few days of life; others become ventilator dependent for weeks and even months. Long-time dependency on the ventilator is an indicator of a medically fragile child who will need careful attention once sent home.

Infants with breathing problems are highly susceptible to viral infection and pneumonia. Re-hospitalization in the first year is common. Before taking the infant home, the caretaker needs to be taught warning signs of infections, about special medications and more.

Once the infant can manage without oxygen and is gaining weight and is eating well, he or she will be discharged from the hospital.

Tracheotomy: An incision into the trachea (windpipe) into which a tube called a tracheotomy tube has been inserted. The most common reason for using a tracheotomy tube in a preterm infant is related to prolonged ventilator support.

The greatest danger is that the tube might fall out or become obstructed. Before taking the infant home the caretaker must be taught how to suction the tube, how to perform infant CPR and how to access emergency aid when needed.

Apnea: Apnea is defined as a “cessation of breathing for 15 to 20 seconds or less.” The most common type is “apnea of pre-maturity.” This appears to be caused by the inability of the infant’s immature brain to trigger the act of breathing. If the infant continues to have apnea periods at or near the time of hospital discharge or the results of a pneumocardiogram indicate the continued presence of apnea, the infant will be sent home on an apnea monitor. The monitor will give out a warning signal if there is a cessation of breathing, at which point the caretaker may need to give the infant CPR.

Medically Fragile Infants (Continued)

Brain Damage: One of the most serious complications of low birth weight and pre-maturity is intraventricular hemorrhage (IVH), or bleeding in the brain. The severity of the bleeding in the brain is reported in grades. Grade 1 and Grade 2 IVH are rarely related to poor outcomes. However, Grades 3 and 4 IVH indicate serious hemorrhage and are frequently associated with mental retardation and cerebral palsy.

Hydrocephaly: A neurological abnormality that may be present at birth or become evident soon after. It is sometimes a complication following an intraventricular hemorrhage and is another complication of pre-maturity.

Hydrocephaly is an abnormal collection of cerebral spinal fluid in the cavities of the brain. The buildup of fluid in the brain can be very damaging. Treatment often requires a surgical intervention called shunting. A plastic tube is inserted in the skull through which the fluid is drained off from the brain into the body and finally excreted.

Once the infant goes home, there is potential for the shunt to block. The caretaker needs to be taught to recognize symptoms such as bulging forehead, vomiting, high pitched cry, etc. These infants must remain under the care of a pediatric neurologist and be monitored frequently.

When hydrocephalic infants are discharged from the hospital, there should be a visiting nurse referral. The caretaker will need reinforcement of the training received in the hospital. The infant should be monitored closely for a period of time.

Retinopathy of pre-maturity: Retinopathy means disease of the retina of the eye. The severity of visual problems increases among very low birth-weight and very premature infants who have required extended periods of oxygen during the neonatal period. While most cases will resolve spontaneously, blindness does result in a reported 5% to 11% of very low birth-weight infants. Because of the risk of such serious eye damage, all infants diagnosed with retinopathy of prematurely at birth should receive close follow up after hospital discharge.

Hearing loss: The premature infant is at risk for a hearing loss. The incidence has been reported to be about 1% to 3%. Several factors contribute - lack of oxygen at birth, environmental noise levels in the hospital if the infant remained for an extended time, congenital infections or middle ear disease.

A hearing screening test for hearing loss is recommended to be done by 6 months of age. Early identification of deafness or severe hearing loss is extremely important so immediate measures can be taken to teach the developing infant alternative communication skills. Hearing impaired infants must participate in a specialized language development program.

Medically Fragile Infants (Continued)

Congenital heart disease: About 8 out of every 1,000 babies are born with a congenital heart defect. There are 35 different types. A major heart defect can cause death shortly after birth. Other conditions require careful medical management by a pediatric cardiologist.

Caregivers of these infants will need to learn special care needs, such as administering medications, watching for signs of cardiopulmonary distress and administering infant CPR. These infants require an environment that guarantees they will consistently be given their medications promptly and correctly, and all their follow-up visits to the cardiologist will be kept. The sicker infants exhaust themselves when eating and often need frequent small feedings. Those who are at risk for congestive heart failure are clearly medically frail infants.

Serious infections transmitted from the mother. During pregnancy, both viral and bacterial infections can cause hazard to the developing fetus. Sexually transmitted disease (or STD) is the term used now instead of VD (venereal disease).

Cytomegalovirus: If a mother has cytomegalovirus (CMV) before or during pregnancy, the fetus is at risk for preterm birth, low birth-weight, microcephaly (or small brain), mental retardation and visceral and skeletal malformations. As of now, there is no specific treatment for the infection. At birth, some complications will be immediately apparent. Infants diagnosed with CMV infection need to be followed carefully during the first year of life.

Syphilis: Infants born of mothers with untreated syphilis are born infected. If the mother is treated in the second trimester (4th through 6th months), the fetal syphilis can be cured. By law, every infant is tested for syphilis at birth if the mother has had any evidence of syphilis. The test is called VDRL or RPR. If an infant tests VDRL+ (positive), it means that syphilis might have been transmitted from the infected mother to the infant. At birth, an untreated infant may seem well, but if not treated will go on to develop serious symptoms and complications. These infants must receive a course of penicillin treatment at birth before being discharged. These infants must have periodic follow up during the first year of life.

Human Immunodeficiency Virus (HIV). HIV, the virus that causes acquired immunodeficiency syndrome (or AIDS), can be transmitted from the infected mother to her infant. Not all infants born of infected mothers will go on to develop AIDS. Currently, it is estimated that only about 25% of infants born of HIV-positive mothers will develop symptomatic HIV infection (also known as pediatric AIDS) although all infants born to infected mothers will test positive at birth. Perinatal (from mother to child during pregnancy, labor or delivery) HIV transmission can be reduced by as much as two-thirds if the mother takes the drug AZT. HIV can also be transmitted from mother to baby by breastfeeding, so HIV+ mothers should feed their babies with formula.

MODULE FOUR
CHILD MALTREATMENT

Medically Fragile Infants: Indicators of Neglect

Child Indicators:

- A medically fragile infant who is not getting proper medical care
- Birth weight is less than 5 lbs.
- Suffers from respiratory distress syndrome
- Has had to have a tracheotomy tube to breath
- Experiences apnea (breathing cessation)
- Experiences bleeding in the brain
- Has abnormal collection of cerebral spinal fluid in the brain cavity
- Disease of retina of the eye due to premature birth
- Hearing loss
- Congenital heart disease
- Viral and bacterial infections
- Complication due to cytomegalovirus (CMV) infection
- Syphilis
- HIV infection
- Cocaine or crack exposure
- Fetal alcohol effects and/or syndrome

Parent/Caretaker Indicators

- Irresponsible
- Has other young children at home with no support from family or friends
- Intellectually disabled
- Angry, hostile toward medical staff
- Depressed
- Was neglected or abused as a child
- Offered to give baby up for adoption, then changed mind
- Wanted an abortion but waited too late or was convinced not to
- Refused or did not seek prenatal care
- Has abused or neglected another child
- Is addicted to a substance
- Makes negative statements about the infant
- Makes negative remarks about learning techniques or skills required to care for the infant
- Unwilling to learn new techniques or skills required to care for the infant
- Avoids spending time with the infant in the hospital, even when transportation/child care is available
- Mother does not have support from baby's father
- Refuses to touch or look at infant

Medically Fragile Infants: Indicators of Neglect
(Continued)

Environmental Indicators

- Home cannot be heated or cooled adequately
- No preparation has been made for the infant
- Lack of consistent electric service (hasn't paid bills), especially if child needs a monitor or other electric apparatus
- Unsanitary conditions
- Pest infestation
- Living with substance abusers
- Home has a history of substance involvement
- Other household members express negative attitudes toward infant

Indicators of Emotional Abuse/Neglect

Child Indicators:

- Sleeping problems
- Eating problems
- Impaired ability to think or reason
- Impaired ability to form relationships
- Anxiety with new situations
- Developmental lags
- Easily distracted
- Depressed/sad
- Runs away as coping method
- Suicidal
- Destroys property
- Grades do not reflect intellectual ability
- Low self-esteem

Parent/Caretaker Indicators

- Labels child
- Criticizes child
- Humiliates child
- Places child in “double binds”
- Makes unusual and inconsistent demands of child
- Fails to nurture child
- Shows no interest in child’s activities
- Isolates child from family, friends and social contacts
- Controls child by verbal threats and punishment
- Low self-esteem
- Fails to respond to child’s request

Types of Emotional (Psychological)Deprivation

Rejecting

Infant General: Refuses to accept child's primary attachment.
Behaviors: Refuses to return smiles, punishes child for vocalizations, abandons baby.

Toddler General: Actively excludes child from family activities.
Behaviors: Refuses to allow child to hug caregiver, treats the child differently from siblings, pushes child away.

School-Age Child General: Consistently communicates to children that they are inferior or bad.
Behaviors: Uses labels such as "bad child," "dummy" and always tells children they are responsible for family problems.

Adolescent General: Refuses to acknowledge the changes in children as they grow up, attacking children's self-esteem.
Behaviors: Treats an adolescent like a young child, excessive criticism, and verbal humiliation.

Terrorizing

Infant General: Consistently violates child's ability to handle new situations and uncertainty.
Behaviors: Teases, scares infants by throwing them up in the air, reacts in unpredictable ways to infant's cries.

Toddler General: Uses extreme measures to threaten or punish the child.
Behaviors: Verbal threats of mysterious harm such as attacks by monsters, leaving the child in the dark, alternates rage with warmth.

School-Age Child General: Places children in "double binds" or places inconsistent or frightening demands on children
Behaviors: Sets up unrealistic expectations and criticizes the child for not meeting them, forces children to choose between parents, teases the child, plays cruel games.

Adolescent General: Threatens to or actually subjects the child to public humiliation.
Behaviors: Threatens to reveal embarrassing facts to the child's friends, forces the child into degrading punishments.

MODULE FOUR
CHILD MALTREATMENT
Types of Emotional (Psychological)Deprivation (continued)

Ignoring

Infant General: Fails to respond to infant's social behaviors, which form the basis for attachment.

Behaviors: Mechanical care-giving with no affection, failing to make eye contact with infant.

Toddler General: Pattern of apathetic treatment and lack of awareness of child's needs.

Behaviors: Refuses to speak with the child at mealtimes, leaves the child alone for significant periods, and fails to respond to child's requests for help.

School-Age Child General: Fails to protect the child from threats when caregiver is aware of the child's need for help

Behaviors: Fails to protect the child from assault by other family members, shows no interest in child's education or life outside the home.

Adolescent General: Gives up parenting role and shows no interest in the child.

Behaviors: Says, “This child is hopeless, I give up” and means it. Refuses to listen to children’s discussion of their lives and activities and focuses on other relationships to the exclusion of the children.

Isolating

Infant General: Denies the child social interactions with others.

Behaviors: Refuses to allow relatives and friends to visit the infant, leaves the infant unsupervised for long periods of time.

Toddler General: Teaches the child to avoid social contact beyond the caregiver-child interaction.

Behaviors: Punishes children for making social overtures to other children, rewards the child for withdrawing from social contacts.

School-Age Child General: Attempts to remove the child from social relationships with peers.

Behaviors: Refuses to allow other children to visit the home, keeps the child from engaging in after-school activities.

Adolescent General: Over-controls the child's social interactions, restricts the child's freedom to an extreme degree.

Behaviors: punishes children for engaging in normal social activities (such as dating), accuses the child of lying/doing drugs, etc. whenever the child leaves the home, refuses to allow children to engage in social activities.

Types of Emotional (Psychological)Deprivation (continued)

Corrupting	
Infant	General: Reinforces bizarre habits or creates addictions. Behaviors: Creates drug dependencies, reinforces sexual behaviors.
Toddler	General: Gives inappropriate reinforcement for antisocial behaviors. Behaviors: Rewards children for aggressive acts toward animals or other children, "brain washes" child into racism
School Age Child	General: Rewards child for antisocial or illegal acts; exposes child to poor role models Behaviors: Exposes the child to pornography, rewards the child for stealing.
Adolescent	General: Continues to involve child in illegal or immoral behavior, encourages child to be part of this lifestyle at the expense of healthier behaviors. Behaviors: Involves the child in prostitution, encourages the child to hit or verbally abuse siblings, encourages drug use.

MODULE FOUR
CHILD MALTREATMENT

SCENARIO

Curtis

Curtis Latham, 12, was placed in foster care due to physical abuse by his mother's boyfriend. He has been in foster care three months in the home of Hattie Mason. Curtis is hungry most of the time.

His foster mother buys only one gallon of skim milk a week and often Curtis puts water on his cereal. She keeps a lock on the refrigerator and the children are not allowed access to the refrigerator or the cupboards. There are no snack foods, fruit, or drinks in the home ever. Sometimes when Curtis wakes up in the morning he can smell bacon frying but Ms. Mason tells the children she cannot afford to feed them bacon.

Portions at dinner are so small that Curtis could easily eat twice the amount of food he is served. All the children in the home have complained about being hungry. Ms. Mason gets mad and tells them they don't have to eat like "pigs."

Curtis had just started a growth spurt when he came into care and his shoes are too small. He has told his foster mother that his shoes hurt his feet and the soles are coming off, but she told him he would just have to make do. She stated there is no money for "luxuries."

Today his foster care caseworker came by the school to see him. Curtis told her he is tired of being hungry and not having a decent pair of shoes. She seemed surprised and told him she would look into the situation.

MODULE FOUR
CHILD MALTREATMENT

Worksheet

What are the child indicators?
What are the parent/caretaker indicators?
What are the environmental indicators?

Definitions of Physical Abuse

Policy Definition:

Physical Abuse:
A form of child abuse which results in physical injury or death inflicted upon a child by a parent or caretaker by other than accidental means. Physical abuse often occurs in the name of discipline or punishment and may range from the use of the hand to the use of objects. (O.G.C.A. 19-7-5)

Physical injury
Bodily harm or hurt such as bruises, welts, fractures, burns, cuts or internal injuries but excluding mental distress, fright or emotional disturbance.

Legal Definition from the Criminal Code of GA, 1990

16-5-70 Cruelty to Children

(a) A parent, guardian, or other person supervising the welfare of or having immediate charge or custody of a child under the age of 18 commits the offense of cruelty to children when he willfully deprives the child of necessary sustenance to the extent that the child's health or well-being is jeopardized.

(b) Any person commits the offense of cruelty to children when he maliciously causes a child under the age of eighteen cruel or excessive physical or mental pain.

(c) A person convicted of the offense of cruelty to children as provided in this Code section shall be punished by imprisonment for not less than one year or more than 20 years.

Indicators of Physical Abuse

Child Indicators	Adult Indicators
The child may: • tell you he is being hit or burned, or other treatment • be wary of physical contact with adults • seem afraid of parent or other person • be frightened in the face of adult disapproval • be apprehensive when others cry • show extremes of behavior (e.g., aggressiveness/ withdrawal) • be overanxious to please • not discriminate about approaches to adults **Physical signs might include:** • bruises and welts • bruises in specific shapes • loop marks • hanger marks • bite marks • burns • lacerations and abrasions • dislocation of shoulders, • hips, etc • head injuries • bald spots • internal injuries	**The adult may:** • be angry, impatient, loses or almost loses control often • appear unconcerned about child's condition • view child as bad or as the cause of life's problems • resist discussion of child's condition or family situation, view questions with suspicion • use discipline inappropriate to child's age, condition and situation • offer illogical, contradictory, unconvincing or no explanation of injuries • show poor understanding of normal child development (e.g., may expect adult-like mature behavior from a young child)

Bruises, Bites, & Lacerations

What are they?

- Bruises are injuries to the underlying soft tissue without breaking the skin, often characterized by ruptured blood vessels and discolorations.
- Bites are skin wounds or punctures produced by an animal's or human's teeth or mouthparts
- Lacerations are breaks in the skin of varying depth that may be linear (regular) or stellate (irregular) and are caused by forceful impact with a sharp object.

How prevalent is it?

- Bruises, bites and lacerations comprise a common group of abusive injuries caused by hitting the child with the hand or an object.

What are its effects on children?

- In child abuse situations children may have multiple bruises in various stages of healing
- Bruises on the cheeks, abdomen, back, buttocks and inner thigh should raise suspicion of abuse
- Patterns of bruises and welts are suggestive of objects used (e.g. hand, wire, hanger, rope, belt buckle, human bite marks, pinch marks)

Battered Child Syndrome

DESCRIPTION:

"This is often a child **less than three years of age** who has been very seriously abused with both new and old injuries in different stages of healing, frequently involving both skull, long bone or hip injuries and less serious bruising, indicating a repeated pattern of abuse with marked discrepancies between medical findings and the parent's explanation. It is also described as 'unrecognized trauma'". *CPS Manual 2101.5*

INDICATORS:

The indicators of this syndrome include:

- **Unsuspected fractures** "accidentally" discovered in the course of an examination, sometimes a routine examination.
- **Injuries out of proportion** with the history provided or with the child's age.
- **Multiple fractures,** often symmetrical. This means the fractures may appear on both arms or both sides of the body. Any fractures in non-walking babies are suspicious.
- **Multiple injuries** in various stages of healing.
- **Skeletal trauma** combined with other types of injuries, such as burns.
- **Subdural hematoma.**
- **Failure-to-thrive**- the child may appear malnourished, underweight or have unhealthy-looking skin.

MODULE FOUR
CHILD MALTREATMENT

Accidental or Non-accidental?	
BRUISES	
Is it accidental?	Non-intentional falls
Steps to confirm	Check for location of bruises; bruises on knees, shins, forehead or elbows are usually not-intentional. Check for bruises on the forehead; bruises to the forehead will often drain through soft tissues to give appearance of black eyes 24-72 hours afterwards, usually confirmed with history and bruise is not tender. Check if bruises are on single surface or clustered; usually one bruise on a single surface is caused nonintentionally. Correlate nonintentional incident with developmental age and motor skills of child. Check for discrepancies between the bruise and the history provided by the caregiver.
Is it a medical condition?	Hemophilia Leukemia Idiopathic thrombocytopenic purpua Mongolian spots Maculae cerulae Salmon patches Hemangiomas (“strawberry patches”)
Steps to confirm	Medical tests to check bleeding function: prothrombin (PT), partial prothrombin (PTT), bleeding time, platelet count, and complete blood count (CBC) Histopathologic examination by physician,. Find out if spots were present at birth Spots are flat, non-tender but more blue/green than bruises. Check history; 90% detected within the first month of life.

Bruising from Physical Abuse

Dating bruises can be difficult. Descriptions of color changes vary between examiners. The rate of healing of bruises depends on:

The location of the bruise: Bruises on the face or genitals often heal faster than bruises on other parts of the body because of the excellent blood supply in those areas. Bruises on the shins are slow to heal because of comparatively poor blood supply.

The depth of the bruise: Deep tissue bruises in areas such as the thighs or hips may take longer to become apparent and longer to heal.

The amount of bleeding in the tissues: Bruises resulting from large amounts of blood in the tissues take longer to heal.

The circulatory status of the bruised area: Bruises will appear and resolve more slowly if circulation is impaired.

Generally, bruises progress through a series of color changes as the acute inflammation subsides, the red blood cells break down, and the hemoglobin breaks down. Colors change from red to blue, green, yellow, and brown before clearing. Since there is so much variability in the speed of this progression, it probably is safest to describe bruises as either "new" (red, purple, or blue) or "old" (green, yellow, or brown).

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Accidental or Non-accidental?	
BITE MARKS	
Is it accidental?	Bitten by animal Bitten by toddler
Steps to confirm	Check if flesh is torn or just compressed; torn flesh is usually a dog bite, compressed flesh is usually a human bite. Measure the distance between the center of the canine teeth, the third tooth on each side; if it is greater than 3 cm, the bite is most likely from an adult. Check for discrepancies between the injury and the history provided by the caregiver.

MODULE FOUR
CHILD MALTREATMENT

CHILD PROTECTICE SERVICES
INVESTIGATION

2104.11 Contact With Children

Requirement

- Interview and observe separately each allegedly maltreated child within the assigned response time (see 2104.12 and 2104.13). Make every attempt to make the interview setting a private location where the child can be interviewed alone;

- Interview and observe every child alleged to be maltreated and all other children living in the household with the alleged maltreater;

- Observe all reported injuries, and, whenever possible, photograph all observed injuries;

- Determine whether a child found to have **any** injury has any additional injuries that are not immediately apparent (e.g. injuries hidden under long sleeves, pants; torso injuries);

  ✓ **Undress infants under age one year to determine whether there are any physical signs of child maltreatment.**

  ✓ Undress children four years and under, who are the subjects of physical abuse allegations, to identify any physical signs of child maltreatment.

- Interview other children who have come under the alleged maltreater's direct care.

- Contact all significant parties (i.e. mother, father, other guardian) who were not seen within the initial response time as soon thereafter as possible.

- Interview other children who have been under the direct care of the alleged maltreater; biological children; step-children; foster children; day care children; children in the home to visit a non-custodial parent. Request that other counties or states interview children not accessible to the investigator. An exception to interviewing all children in the direct care of the maltreater may occur for school or day care settings (See 2106.3c).

- Document (including photographic evidence) that at-risk children have been seen within the response time in the CPS case record (see Documentation Chapter 80.1). This may be a copy of the police report in counties where protocol provides for law enforcement to meet this response.

Social Services Manual
October 2003

Cultural Practices and Child Abuse or Neglect

Some cultural practices lead to referrals of abuse and neglect. You need to be aware of the most common of these practices in order to work effectively. This list is not complete. For example, many people in addition to Christian Scientists believe in prayer rather than medical care and are opposed to blood transfusions. You may encounter religious, spiritual or cultural practices not on this list. Carefully assess whether the child is in need of medical care.

Remember that not all members of the culture listed below engage in these practices.

PRACTICE	CULTURE	DESCRIPTION	COMMENTS
Leaving children in the care of a child under 12	Mexico	Some Mexican caregivers believe that the oldest daughter should be responsible for caring for younger siblings even when the daughter is as young as eight or nine. This sometimes leads to a referral for inadequate supervision.	May be inadequate supervision when the responsible child is incapable of caring for herself or the children. Assess the safety of the children and the presence of other adults who informally supervise.
Cupping	Mexico	Alcohol is ignited in a cup. After the alcohol is poured out, the hot cup is inverted and placed over a part of the child's body that is hurt. This produces redness and circular burns.	Used instead of medical care, so may lead to intervention to provide medical care. Normally not considered physical abuse by legal authorities.
Name unknown	Vietnam	As a remedy for colds, an adult places heated liquid into a baby bottle and places this many times on the child's back. This causes first degree burns and scarring	Used instead of medical care, so may lead to intervention to provide medical care. Cases in Georgia have not lead to charges of physical abuse.
Coining	Vietnam Cambodia	As a remedy for fever, chills and headaches, the adult massages the child's skin with oils and strokes the skin with a coin until marks appear. These marks may look like strap marks on the back. Or the coin may be rolled up and down the child's arms leaving lines	Not considered physical abuse by legal authorities. This process is not painful to the child and does not create scarring. Used instead of medical care, so may lead to intervention to provide medical care.

Cultural Practicies and Child Abuse or Neglect (continued)

PRACTICE	CULTURE	DESCRIPTION	COMMENTS
Hot and Cold Treatment	Latin America	When a child twists or sprains a wrist of ankle, this practice is used to treat it. An adult places an analgesic balm such as "Icy Hot" on the child's skin and then runs cold water over the skin, resulting in second and third-degree burns	The clear lines between burned and unburned skin make this condition appear abusive. Because this leads to serious burns, supporting the family in changing this practice is necessary.
Burning string	Southeast Asia	When a child has abdominal pain or fever, the adult lowers pieces of burning string onto the child's lower rib cage or navel.	Appears to be abusive but is not usually considered physical abuse by legal authorities. Used instead of medical care, so may lead to intervention to provide medical care.
Use of curanderos	Mexico	Curanderos are spiritual healers who may counsel the family when a child is ill or when the family needs advice. These healers are often consulted instead of mental health practitioners.	When this practice is used with a child who requires mental health services, intervention may be needed to ensure the child receives appropriate services. Normally, this practice does not lead to a charge of neglect.
Use of "rubbing doctor"	Mexico	When children or adults twist, sprain or break limbs, they often seek the help of a "rubbing doctor", who is similar in some ways to a chiropractor. The doctor places poultices on the affected limb and later massages the limb.	Not considered physical abuse by legal authorities. This process is not painful to the child and does not create scarring. Used instead of medical care, so may lead to intervention to provide medical care.
Use of Christian Science practitioner	Christian Science	Christian Science, a religion founded in Boston in 1879, includes the tenet that members refrain from seeking medical care for themselves and their children.	Christian Scientists normally take their children to a dentist and can obtain care during childbirth. Other forms of medical care are not allowed.
Caida de Mollera- "Fallen fontanel"	Mexico	This practice is based on the belief that the normal soft spot on an infant's head (the fontanelle) means the baby's head has fallen and can be retrieved by shaking or sucking the depression out. This practice sometimes leads to subdural hematomas, retinal hemorrhages and, occasionally, the child's death	Appears to be abusive but is not usually considered physical abuse by legal authorities. Used instead of medical care, so may lead to intervention to provide medical care.

Sources:

Smith, J., Benton, R., Moore, J and Runyan, D. *Understanding the Medical Diagnosis of Child Maltreatment*. Denver: American Human Association, 1989
Atkinson D, Morton G and Wing Sue D. *Counseling American Minorities, A Cross-Cultural Perspective,* Third Edition. Dubuque, Iowa: William C. Brown Publishers, 1989

Burns

What is it?

An injury caused by fire, heat, radiation, electricity or a caustic agent.

How prevalent is it?

- Most common of severe injuries
- Fourth most frequent cause of death of children under five years old.

What are the effects on children?

- In children younger than 3 years old, scald burns from hot liquids or hot water are the most common cause of burns, accidental and non-accidental
- Smoke inhalation, scald burns, contact and electrical burns are especially likely to affect children younger than age 4.
- Children and elderly are the most commonly burned compared to other age groups due to less mobility
- Many die from shock of the burns to their systems
- Treatment is painful; recovery is slow.
- Types of burns seen in abuse include:
    - Cigarette or cigar burns
    - Rope burns on the wrist or ankles from being bound
    - Burns in the shapes of household utensils or appliances (e.g. iron, heated forks or spoons)
    - Glove or stocking like burns with no splash marks caused by immersion in scalding water.

Severity of Burns

There are three factors in assessing the severity of burns:

1. **Degree of burn**
2. **Percentage of body burned**
3. **Age of the person**

First-degree Burn

Appearance at time of injury	A superficial burn of minimal depth Characterized by erythema (redness), hypermia (redness that disappears under pressure), tenderness and swelling. Can be serious if covering a large percentage of body area – for example, sunburn
Appearance 2 weeks later	No scar

Second-degree Burn

Appearance at time of injury	Burn extending through the epidermis (the outer layer of sk and into the dermis (the next layer). Usually not severe enough to interfere with skin after injury, so no scar tissue develops. Characterized by vesicles (weeping blisters) on the skin's surface, with increased sensitivity to touch.
Appearance 2 weeks later	If no infection occurs, no scar remains. If infection occurs, may require surgery.

Third-degree Burn

Appearance at time of injury	Entire thickness of skin is burned (epidermis and dermis). including the hair follicles. Area looks white or charred and is not sensitive to touch or a pin prick. These injuries require hospitalization and often require skin grafting.
Appearance 2 weeks later	These burns heal with scarring, creating a change in color and a "parchment" type of skin.

Relationship of Water Temperature to Third Degree Burns

Temperature	Time Required for Third Degree Burns
120 °F	10 minutes
125 °F	2 minutes
130 °F	30 seconds
140 °F	5 seconds
150 °F	2 seconds
160 °F	1 second

Types of Burns

Burns by Objects:

- Objects include irons, stove burners, heater grates, radiators, electric hot plates and hair dryers
- Objects such as combs, keys, knives or cigarette lighters heated and "branded" into the skin
- During summer months, second-and third-degree burns caused by vinyl upholstery, seat belts, infant backpack carriers or seatbelt buckles

Chemical Burns:

- Household items such as acidic cleaners
- Burning process continues as long as the substance is in contact with the skin

Cigarette Burns:

- Measure about 1 cm in diameter
- Often found on the trunk, external genitalia and extremities, such as the palms of the hands and the soles of the feet
- Presentation ranges from blisters to deep wounds

Electrical Burns:

- Occur from the conduction of current through the saliva of a child.
- Child may be sucking or mouthing a plug or biting a live electric cord
- Burns at the corners of the mouth are common

Immersion Burns:

Produced by immersing child into high temperature water.

Forms of immersion burns include:

- Stocking or glove
- Doughnut hole
- Parallel lines
- Flexion burns

Splash Burns

- Occur from hot liquid either thrown or poured
- Less severe than immersion burns; liquid runs off the skin before it has a chance to incur deep damage
- Deepest burn is usually the area in contact with the main mass of fluid
- Often burn pattern is an "arrowhead" configuration

Accidental or Non-accidental?	
SPLASH BURNS	
Is it accidental?	Spilling a hot liquid
Steps to confirm	Check location of splash burn; nonintentional burns are most likely to occur on the front of the head, neck, trunk and arms. It is usually possible to estimate the direction from which the liquid came and the position of the body. Check for discrepancies between the burn and the history provided by the caregiver.
CIGARETTE BURNS	
Is it accidental?	Brushing against a cigarette
Steps to confirm	Check location of burns; usually nonintentional if found on child's face, arms or trunk. Check shape of burn; usually nonintentional if burn is more elongated than round with a higher degree of intensity on one side. Check for discrepancies between the burn and the history provided by the caregiver.
Is it a medical condition?	Impetigo Insect bites
Steps to confirm	Suspicious blisters will generally be cultured by a physician for streptococcal infections that may be found with impetigo and treated with antibiotics.

IMMERSION BURNS	
Is it accidental?	Falling into a hot bathtub
Steps to confirm	Check for clear lines of demarcation; nonintentional burns have no clear line demarcating the burned and unburned skin. Check deepness of burn; nonintentional burns will not be as deep as forced burns because an unrestrained child will rarely be unable to remove himself from the burning environment. Check if perineum and feet are burned, but not the hands; it is imipossible for a child to nonintentionally fall into a tub in this position. Check for doughnut hole, parallel lines and flexion burns; these burns may be indicative of abuse. Check for discrepancies between the burn and the history provided by the caregiver.
Is it a medical condition?	Staph Scalded Skin Syndrome (SSSS) Toxic Epidermal Necrolysis (TEN)
Steps to confirm	Ask about symptoms of fever, malaise and sore throat. Check for mouth and nose crusting. Ask about onset of medical condition.

Accidental or Non-accidental?	
BURNS BY OBJECTS	
Is it accidental?	Coming into contact with a burning object
Steps to confirm	Check location of burn; some areas of the body are clearly more difficult for a child to self-inflict a burn. Check pattern of burn; an irregular burn will be left by young children who move away from a burning object reflexively. Check deepness of burn; nonintentional burns are usually deep on one edge of the burn. Check margins of burn; nonintentional burns usually do not have crisp overall margins. Check for discrepancies between the burn and the history provided by the caregiver.
Is it a medical condition?	Varicella (chickenpox) Poison oak, ivy or other contact dermatitis
Steps to confirm	Check history Consult with physician

Head and Face Injuries

What is it?
An injury that occurs to the eye, nose, mouth, ear and skull due to blunt or penetrating trauma.

How prevalent is it?

- Head injury is the leading cause of death from child abuse
- Head injury occurs as a result of vigorous shaking (Shaken Baby Syndrome) and pressure on the carotid arteries in the neck during shaking, which results in decreased oxygenation of the brain and swelling

What are its effects on children?

- Most victims of head injury are younger than 2 years of age
- The amount of blood loss from a scalp wound may be enough to produce shock in children
- Children having a head injury may show these symptoms: nausea, vomiting, abnormal behaviors, altered mental state, seizures, dilation of one pupil or of both pupils, which are unresponsive to light
- Children with skull injuries may have these symptoms:
    - Contusions, lacerations, hematoma to the scalp
    - Deformity to the skull
    - Blood or cerebrospinal fluid leakage from the ears or nose
    - Bruising around the eyes (racoon eyes)
    - Bruising behind the ears

MODULE FOUR
CHILD MALTREATMENT

Guide to Physical Injuries

A <u>medical</u> <u>examination</u> is necessary to determine the nature and extent of injuries.

HEAD AND NERVOUS SYSTEM:

Injuries	Possible results of Injuries
Injury to the head	Loss of consciousness Seizures Increased drowsiness; however, it must be remembered that an unconscious child may be suffering from the effects of medication or poison
Subdural Hematoma (result of being shaken)	Irritability Lethargy Breathing difficulty Convulsions Vomiting Retinal hemorrhages
Hair pulling	Bald patches on the head interspersed with normal hair
Trauma to Spinal cord	Paralysis of muscles: legs or arms or legs

FACE:

Injuries	Possible Results of Injuries
Blunt trauma to the eye	Hemorrhage Dislocation of the lens Detachment of the retina
Direct blow to the nose	Bleeding Swelling Deviation of the nasal septum
Blows to the mouth	Swelling, loose or missing teeth
Abuse related injuries to the ear	Swelling of the external ear Perforation of the eardrum Bruises & hemorrhage Eardrum ruptures

Guide to Physical Injuries

(Continued)

INTERNAL:

Injuries	Possible Results of Injuries
Blows to abdomen	Bowel separation Recurrent vomiting Swelling Tenderness Injury to other organs such as the spleen, liver or kidney

SKELETAL:

Injuries	Possible Results of Injuries
Twisting or jerking of legs or arms	Swelling at points where two bones join Tenderness at the ankles, wrists or other joints Dislocation of bone Sprained ankles or wrists
Shaking a child	Whiplash Subdural hematoma Retinal hemorrhaging Periosteal elevations Metaphyseal fractures Nursemaid elbow
Tossing a child up in the air to play "catch"	Whiplash Nursemaid elbow Bruising

Guide to Physical Injuries

(Continued)

SKIN:

Injuries	Possible Results of Injuries
Lacerations or other disfigurements	Strap marks Belt buckle marks Looped cord marks Strap marks Choke marks on the neck Bruises from gags Rope burns Blisters (expecially around the wrist or ankles) Welts (raised ridges on the skin, often seen in the lower back area and are usually left by a slash or blow) Human bite marks (distinctive crescent shaped lines of tooth imprints)
First-degree burns	Redness
Second-degree burns	Blistering
Third-degree burns	Destruction of the skin tissue Loss of sensation
Laxative poisoning	Severe dehydration Bloody stools
Abuse related injuries to genitals, inner thighs	Pinch marks Cuts Abrasions
Tying up	Circle-shaped tie marks
	Friction burns appearing as large blisters that circle the entire extremity

Assessing Head Injuries

- When reviewing a child's medical record, find the type of injury in the bold row of this table.
- Then find the additional injury or information from the interview with the family in the first column.
- Refer to the second column to see whether this child can be presumed abused or whether the injury is suspicious but not conclusive for abuse.

If Child Has Skull Fracture With or Without Epidural Hematoma

And…	Then…
Child has unexplained long-bone fractures or old fractures	The child is presumed abused
There is no history of trauma.	The child is presumed abused
There is history of trivial trauma (a fall of less than 3 feet) and history is developmentally incompatible.	The child is presumed abused

If Child Has Multiple or Basilar Skull Fracture

And…	Then…
Child has unexplained long-bone fractures or old fractures	The child is presumed abused
There is no history of trauma	The child is presumed abused
There is a history of trivial trauma and history is developmentally incompatible.	The child is presumed abused

Assessing Head Injuries

(Continued)

If Child Has Craniofacial Blunt Trauma (swelling, bruising)

And	Then
Child has unexplained long-bone fractures or old fractures.	The child is presumed abused
There is no history of trauma	The child may have been abused
There is a history of trivial truma and history is developmentally incompatible	The child may have been abused

If Child Has Subdural, Subarachnoid or Intracerebral Hematoma

And	**Then**
Child has unexplained long-bone fractures	The child is presumed abused
There is no history of trauma.	The child is presumed abused
There is no history of trauma and clinical or radiographic findings show focal impact	The child is presumed abused
There is a history of trivial trauma and history is developmentally incompatible.	The child is presumed abused

Expected Injuries from Falls

Refer to this table when comparing a child's injuries to the history provided by the caregiver. Although there are exceptions to the information below, this should give you guidance in determining whether an injury could have resulted from the fall described by the caregiver.

Falls From Less Than 4 Feet

Injuries Seen Commonly…

Concussion/soft tissue injury
Linear fracture
Epidural hematoma

Injuries Possible But Not Common..

Depressed fracture

Falls From More Than 4 feet

Injuries Seen Commonly…

Concussion/soft tissue injury
Linear fracture
Epidural hematome
Depressed fracture
Multiple fractures
Subarachnoid hemorrhage
Contusion

Injuries Possible But Not Common…

Subdural hematoma

MODULE FOUR
CHILD MALTREATMENT

Accidental or Non-accidental?

HEAD INJURIES

Is it accidental?	Birth trauma causing effusion, cephlohematoma, diffuse cerebral edema, infraction, cerebral contusions, posttraumatic hypopituitarism Insect bite on head (usually forehead)
Steps to confirm	Check onset of injury; injuries from birth trauma should become apparent shortly after birth. Check for discrepancies between the injury and the history provided by the caregiver; subdural hematomas found in an infant or toddler without adequate explanation of trauma may be indicative of abuse.
Is it a medical condition?	Infectious meningitis
Steps to confirm	Check compatibility between the history and physical findings. Consider child's developmetnal maturity.

EYE INJURIES

Is it accidental?	Chemical burns Nonintenional foreign body to eye (e.g., sticks, sand or paper edge)
Steps to confirm	Check for discrepancies between the injury and the history provided by the caregiver.
Is it a medical condition?	Conjunctival hemorrhaging during birth Allergic conditions ("allergic shiners")
Steps to confirm	Conjunctival hemorrhaging during birth usually disappears by 1 month of age Check history

Accidental or Non-accidental?

EAR INJURIES	
Is it accidental?	Injury from inserting cotton swab
Steps to confirm	Check if laceration is of the external auditory meatur; this injury can occur only by inserting a pointed object into the ear. Check for discrepancies between the injury and the history provided by the caregiver.

NASAL INJURIES	
Is it accidental?	Injury from inserting foreign bodies into the nose
Steps to confirm	Check if foreign bodies are found in more than one site; if just found in nose, this is common in the normally developing child. Check for discrepancies between the injury and the history provided by the caregiver.

TOOTH INJURIES	
Is it accidental?	Non-intentional falls Striking the mouth with a hard instrument
Steps to confirm	Check if any teeth are loosened; any loosening of the teeth should be immediately examined by a dentist to determine the severity. Check for discrepancies beteen the injury and the history provided by the caregiver.

Accidental or Non-accidental?

HAIR LOSS	
Is it a Medical Condition?	Trichotillomania Tinea capitis (ringworm) Idiopathic (e.g. alopecia areata) Nutritional deficiencies
Steps to confirm	Check whether loss of hair is in a localized spot. Varying bald spots may be indicative of abuse. Localized spot usually on back of head. A child will be at least 3 years of age for this condition to occur. Check for scaly skin. Fungal culture of scalp by physician. Check history.
POISONING	
Is it accidental?	Toxic doses of vitamins and minerals to cure illness Feeding a baby improperly diluted formula Non-intentional ingesting of medicines, household cleaners, etc.
Steps to confirm	Check with the parent about cause of poisoning; Non-intentional poisoning may be a form of neglect in terms of lack of supervision that may be treated with education and support.

MODULE FOUR
CHILD MALTREATMENT

Shaken Baby (Infant) Syndrome

What is it?

How prevalent is it?

- Retinal hemorrhages are common in abused children. In shaken babies, the incidence is 50 to 80%. These are bilateral (two-sides) in at least 60-90% of cases of Shaken Baby Syndrome.
- The true incidence is not known but estimates range from an annual figure as low as 600 cases per year to as high as 1400 in the United States.
- Shaken Baby Syndrome is recognized as the most common cause of mortality and accounts for the most long-term disability in infants and young children due to physical child abuse.

What are its effects on children?

- Some common presenting complaints or history of Shaken Baby Syndrome include:
    - Extreme irritability
    - Decreased appetite or feeding problems
    - Poor sucking or swallowing
    - Vomiting
    - Lethargy/poor muscle tone
    - Inability to follow movements
    - No smiling or vocalization
    - Rigidity/seizures/convulsions
    - Difficulty breathing
    - Comatose
- Some medical indicators of Shaken Baby Syndrome include:
    - Retinal hemorrhage (usually bilateral)
    - Subdural hemorrhage
    - Cerebral edema (brain swelling)
    - Subarachnoid hemorrhage
    - Fractures (ribs or long bones)
    - Grasp bruises around ribs, neck, or head
    - Cerebral infraction
- Some common consequences to a SBS baby may include:
    - Partial or total blindness
    - Developmental delays
    - Seizures
    - Cerebral palsy
    - Paralysis
    - Hearing loss
    - Speech and learning difficulties

Internal Injuries

What is it?

Bodily harm, wounds or injuries that occur inside the body, particularly in the chest and abdominal areas.

How prevalent is it?

- Abdominal injuries are the second leading cause of death from child abuse
- The abdomen is a more common site of injury in children than in adults
- Blunt trauma is the most common type of abdomnimal trauma in children, usually the result of a punch or kick to the abdomen

What are its effects on children?

- Because the child's abdominal wall is elastic and absorbs much of the force, only mild bruising may be seen or there may be no external signs of injury
- A child may experience abdominal tenderness, vomiting and or signs of shock with abdominal injuries
- In children the spleen is the most commonly injured abdominal organ, followed by the liver
- Injury to the liver is the most common abdominal injury that leads to death
- Indicators of possible internal injuries include:
    - Pain in the stomach, chest or internal area
    - Visible bruising of the chest and abdomen
    - Distended, swollen abdomen
    - Tense abdominal muscles
    - Labored breathing
    - Severe, pinching pain in the chest while breathing
    - Nausea or vomiting

Fractures

What is it?

An injury caused by a break, rupture or crack, expecially in bone or cartilage.

How prevalent is it?

- Fractures account for about 20% of abusive injuries
- Children between the ages of 1 and 5 can easily get spiral fractures from twisting their own legs or ankles.
- Young children with growing, soft bones are more likely to have spiral fractures from falls than are adults.
- Children have elastic chest walls and soft, pliable ribs. Because ribs tend to bend rather than break, rib fractures are less common in infants and young children than adults.

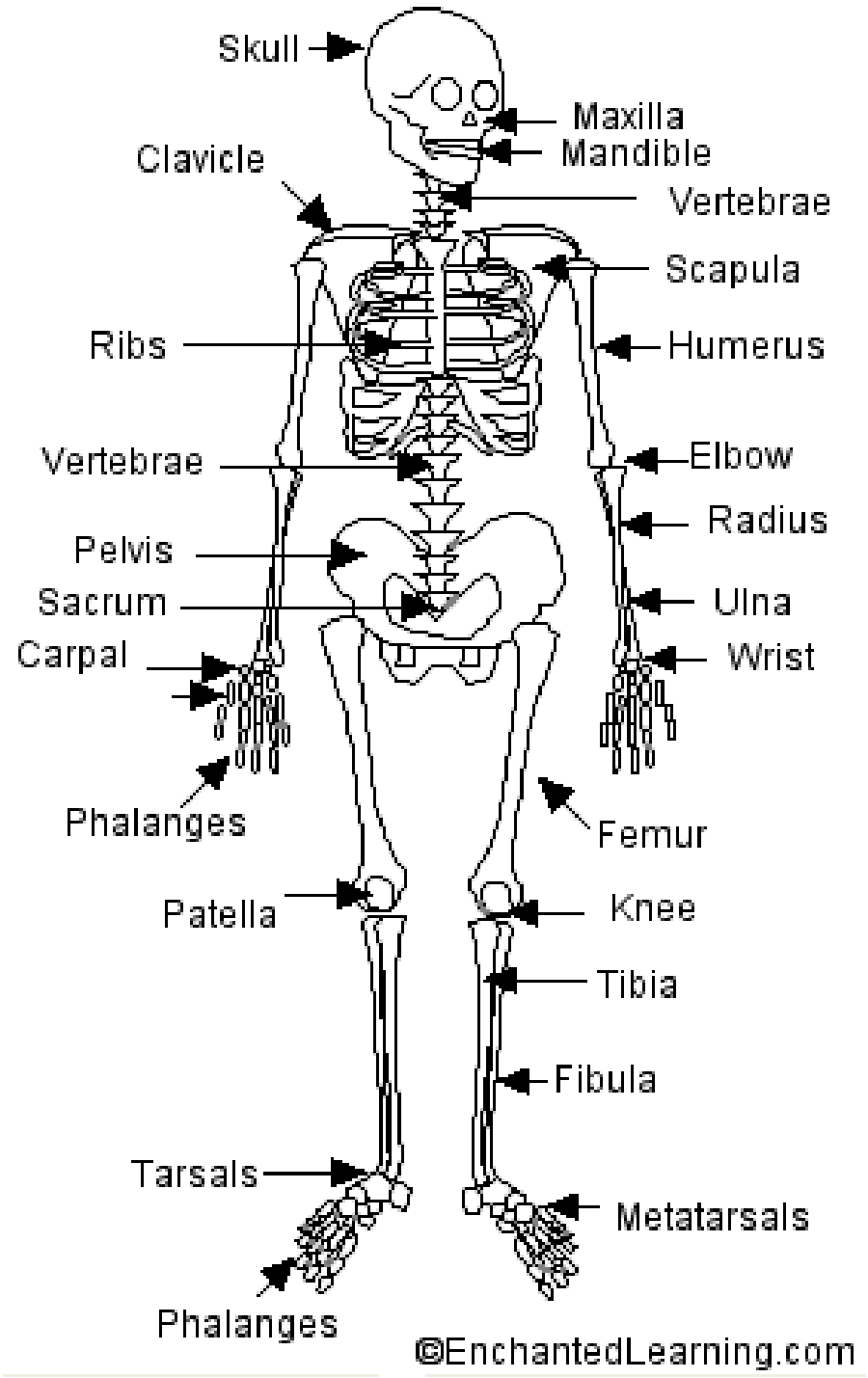
What are its effects on children?

- Metaphysical fractures in children can only occur from a jerking force and should be considered as suspect for abuse
- Children who suffer breathing or coughing problems should have x-rays to rule out rib fractures.
- Because of the flexibility of the chest wall and ribs, significant injury may occur to underlying organs and vessels without an external sign of injury

Identifying Types of Fractures

Type of Fracture	Description
Closed	A fracture of the bone with no skin wound
Comminuted	A fracture in which the bone is broken or crushed into more than two separate fragments
Complicated	A fracture in which the broken bone has injured some internal organ
Compound	A fracture in which the bone is broken and protruding from the skin
Compression	Collapse of bone along the direction of force
Dislocation	A fracture near a joint that is dislocated.
Epiphyseal	A fracture at the very end of a growing bone: often not visible on x-ray
Green Stick	A fracture in which the bone is partially bent and partially broken, as when a green stick breaks; these occur in children, especially those with rickets.
Hairline	A minor fracture in which all portions of the bones are in perfect alignment
Impacted	A fracture in which the bone is broken and one end is wedged into the interior of the other end.
Metaphyseal	A chip of the growing end of a long bone pulled off by a ligament; this fracture usually comes from shaking
Pathologic	Fracture of a diseased or weakened bone, produced by a force that would not have fractured a healthy bone
Periosteal elevation	A separation of the periosteum (new tissue that forms a sheath over the bones of infants) from the hard bone beneath
Spiral	A slanting, diagonal fracture
Torus	A bone buckling and bending rather than breaking
Transverse	A fracture in which the fracture line is at right angles to the long axis of the bone

Human Skeleton



DEFINITION OF CORPORAL PUNISHMENT CPS POLICY 2101.5

Corporal punishment is any physical punishment of a child to inflict pain as a deterrent to wrongdoing. It may produce **transitory pain** and **potential bruising**. If pain and bruising are not excessive or unduly severe and result only in short-term discomfort, this is not considered maltreatment.

MODULE FOUR
CHILD MALTREATMENT

Discipline vs. Excessive Physical and Emotional Punishment

DISCIPLINE

- Designed to teach children to control themselves by focusing on preventing mistakes.
- Effective caregivers set and communicate expectations for their children's behavior and expect children to exercise some self-control.
- The word discipline means to teach.

Caregivers:

- Praise the child for desirable behavior.
- Set expectations that are reasonable for the child's developmental age.

Children:

- Learn to be in control of themselves, but are not asked to meet impossible standards.
- Live in a home where rules are fair, consistent and clear and learn to trust their caregivers.
- Develop a sense of security and self-worth.
- May include the use of warnings or countdowns to remind the children of the rules. Caregivers expect their children to make a deliberate choice about whether to obey rules.
- Well-disciplined children know when they have broken rules and learn to expect consistent consequences.
- Bases rules on what is best for the child and the caregivers.
- Tends to increase the child's maturity and responsibility over time.
- Teaches children to be responsible, caring adults.
- Taught by example.
- Self-disciplined caregivers establish standards for their own behavior and children learn from this example.

EXCESSIVE PHYSICAL AND EMOTIONAL PUNISHMENT

Caregivers:

- May not set reasonable limits with their children.
- Believe physical punishment is the only way to control children. When spankings don't work, they see hitting the child as the only option for controlling the child.
- Often expect far too much for the child's age.

Children:

- "Do not learn self-control and may become increasingly aggressive.
- Are often demeaned, and feel guilty and ashamed.
- When punished for meeting unrealistic expectations, will begin to feel they are bad and will feel hopelessly unable to avoid painful punishment.
- Are believed by caretakers to be willfully disobeying and may be punished severely before the child knows what he did wrong
- Have no chance to make choices about their behavior because they don't know what they are expected to do.
- May base rules on what is annoying to caregivers, regardless of whether these actions are developmentally appropriate for the child.
- Are taught that the angriest, meanest person in the room has all the power.
- Taught by example.
- Are taught to over react and to use anger and force to get what they want

Guidelines for Constructive Discipline

Role of discipline is to help children:

- Develop self-control
- Express emotions appropriately
- Respect others' rights
- Build self-esteem
- Become self-reliant
- Develop orderliness

Effective Strategies for Preventing Unwanted Behavior:

- **Establish a routine.** Set consistent schedules for eating, going to bed, etc.
- **Establish consistent tasks** the child should accomplish, such as always brushing her teeth and washing her face before bedtime.
- **Show love** and caring to the child.
- **Try to understand** your child. Learn about normal child development to help put your child's behavior into perspective. Think about why your child may be acting out. Work with your child.
- **Set and maintain realistic limits** for children. For example, teach your children not to leave the yard when they are playing. Explain why you've set this limit. Most importantly, remind children of the limits until they remember them. Enforce the limits every time children test them.
- **Encourage children to be self-reliant**. Encourage them to think problems through and generate solutions. Allow children to be part of decision-making when possible. For example, give a young child a choice of two outfits to pick between to wear to school on a particular day.
- **Encourage children to express feelings**. Let children know it is okay to say, "That makes me mad" or "you hurt my feelings." Even when the child's feelings won't change a situation, listen to the feelings. For example, your child may not like a chore you've asked him to do. Even though he still has to do the chore, he should be able to say he doesn't like it.
- **Encourage responsibility**. When you ask your child to complete a task, set realistic time limits and standards, and make sure these have been met.
- **Change the situation** instead of trying to change the child. For example, if you don't want your child to eat cookies you've made for a social gathering, cover the cookies with foil. Don't expect too much self-control from a small child.

- **Set examples for your child.** Teach your child to share by sharing with others. Be organized and responsible yourself, and your children will learn to follow your examples.
- **Make sure the child knows you love her, but don't like her behavior.** Don't say, "You're a bad girl," say instead, "What you did made me angry."
- **Enforce rules immediately**, fairly and consistently. Don't expect your partner to discipline the child several hours after the misbehavior when your partner comes home. The child probably won't remember what she did wrong by that time.
- **Make consequences appropriate** for the misbehavior. For example, if a child damages something that belongs to a neighbor, ask the child to apologize and help pay for repairs or a replacement. This is a logical consequence. Spanking a child for hitting a sibling is inappropriate because this sends mixed messages to the child about hitting.
- **Don't make empty threats**. If you threaten to do something, do it.
- **Give the child warnings.** Many parents use a counting approach to remind the child of the rule and allow the child time to stop misbehaving.
- **Avoid physical punishment whenever possible.** If you must use it, spank a child on the buttocks with your bare hand only. Never slap a child in the face or with an object. A better way to be physical with a child is to simply use your proximity and body size to stop misbehavior. Walk up to the child and place your hand on his shoulder.
- **Timeout may be effective**, especially when a child is having a temper tantrum or is in some way out of control. But remember that time passes very slowly for a small child two or three minutes in timeout is usually enough.
- **Stay in control of yourself.** Calmly enforcing rules will encourage your child to respect you and will increase your chances of being effective with your child.

Case Scenario 1
Daniel

Daniel was brought to the emergency room by his mother and a neighbor who heard him crying hysterically. The neighbor had knocked on the door of Daniel's home and found his mother, Adella, home. Adella explained to the neighbor that Daniel, age 3, pulled the ironing board over and was hit by the falling, hot iron. The neighbor offered to drive Adella and Daniel to the hospital.

Daniel was very dizzy, sleepy, and he appeared confused. The nurse lifted Daniel's shirt and saw the clear imprint of an iron on Daniel's upper back. The skin was red and blistered, and the burn had not been treated in any way. The physician who examined Daniel was concerned and talked with Adella. Adella said Daniel wandered into the living room while Adella was changing clothes to go to work. She said she heard the ironing board fall over, but did not become concerned because Daniel was "always into something." Adella said she thought he was crying because he was "having a tantrum" and she ignored him. Adella said she had a lot of trouble getting Daniel to settle down for his nap when she was getting ready to leave for work.

The physician admitted Daniel because he continued to be sleepy and was increasingly unresponsive. Further examination showed that Daniel had a small bruise on his forehead. Adella said Daniel rolled off the couch when he was watching television last night.

Case Scenario 1
Daniel

1. What are the physical indicators of abuse?

2. How likely is it that he pulled the ironing board over on his back?

3. Could he have sustained a concussion from falling off the couch? Why?

4. Could he have sustained a subdural hematoma from falling off the couch?

5. Is Daniel's burn abusive? What about his head injury?

Case Scenario 2
Melanie

Melanie, age 2, was brought to the local walk-in clinic by her father, Lenny, and his girlfriend, Renee, because Melanie had a sore ear. The doctor examined Melanie and found she had otitis media – a common ear inner ear infection in young children. In Melanie's case the disease had progressed so far that she was in extreme pain and the doctor found her fussy and uncooperative during the examination.

Lenny commented to the doctor that Melanie was "damn hard to control" and was "always whining about something." As the doctor continued her examination, she noticed bruises around Melanie's mouth with no injury to her teeth or frenulum of the mouth. She also found old, healing burns encircling Melanie's wrists. As she turned Melanie's left wrist over to examine it further, Melanie cried out in pain. The doctor ordered x-rays of Melanie's arm, which showed a compression fracture. Lenny said he did not know of any reason why Melanie should have a fracture, and said he was not aware of any fall or accident she'd had recently. Lenny said the bruises on Melanie's mouth and wrists were due to a "skin disease."

MODULE FOUR
CHILD MALTREATMENT

Case Scenario 2
Melanie

1. What are the physical indicators of abuse?

2. What do her bruises indicate?

3. Could skin disease have caused Melanie's bruises?

4. What could have caused her compression fracture and what more should be done about it?

Sexual Abuse

This is a form of child abuse in which any of nine specific behaviors occur between a child under the age of eighteen years and the parent or caretaker and during which the child is being used for the sexual stimulation of that adult or another person. Sexual abuse shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not more than three years older than the minor. However, sexual abuse may be committed by a person under the age of eighteen years when that person is either significantly older than the victim or when the abuser is in a position of power or control over another child. Alleged sexual abuse by an extra-familial perpetrator must be evaluated on the basis of parental approval or the lack of parental supervision (O.C.G.A. 19-15-1).

The nine specific behaviors (O.C.G.A. 19-7-5) are:

(10) Sexual intercourse, including genital-genital, oral-genital, anal-genital or oral-anal, whether between persons of the same or opposite sex;

(11) Bestiality;

(12) Masturbation;

(13) Lewd exhibition of the genitals or pubic area of any person;

(14) Flagellation or torture by or upon a person who is nude;

(15) Condition of being fettered, bound or otherwise physically restrained on the part of a person who is nude;

(16) Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area or buttocks or with a female's clothed or unclothed breasts;

(17) Defecation or urination for the purpose of sexual stimulation; or

(18) Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.

Sexual Exploitation (O.C.G.A. 19-7-5)

This is a form of maltreatment in which a child's parent or caretaker allows, permits, encourages or requires a child under the age of eighteen years to engage in sexual acts for the stimulation and/or gratification of adults or in prostitution as defined by law (O.C.G.A. 16-6-9), or allows, permits, encourages or requires a child to engage in sexually explicit conduct for the purpose of producing any visual or print medium (O.C.G.A. 16-12-100).

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Legal Definitions
(Criminal Code of Georgia, 12/30/01)

16-6-22. Incest
A person commits the offense of incest when he engages in sexual intercourse with a person to whom he knows he is related either by blood or by marriage as follows: father and daughter or stepdaughter; mother and son or stepson; brother and sister of the whole blood or of the half blood; grandparent and grandchild; aunt and nephew; uncle and niece.

16-6-2. Sodomy; aggravated sodomy
A person commits the offense of sodomy when he performs or submits to any sexual act involving the sex organs of one person and the mouth or anus of another. A person commits the offense of aggravated sodomy when he or she commits sodomy with force and against the will of the other person, or when he or she commits sodomy with a person who is less than ten years of age.

16-6-1. Rape
A person commits the offense of rape when he has carnal knowledge of a female forcibly and against her will or of a female who is less than ten years of age. Carnal knowledge in rape occurs when there is any penetration of the female sex organ by the male sex organ.

16-6-22.1. Sexual battery
A person commits the offense of sexual battery when he intentionally makes physical contact with the intimate parts of the body of another person without the consent of that person.

16-6-22.2. Aggravated sexual battery
A person commits the offense of aggravated sexual battery when he intentionally penetrates with a foreign object the sexual organ or anus of another person without the consent of that person.

16-6-3. Statutory rape
A person commits the offense of statutory rape when he or she engages in sexual intercourse with any person under the age of 16 years and not his or her spouse, provided that no conviction shall be had for this offense on the unsupported testimony of the victim.

Reducing the Shock

Jessica

Three-year-old Jessica is the daughter of Robert and Sara Bault. Robert is a lawyer and Sara is Public Relations Director for a large corporation. Jessica is a beautiful child, with her long, black hair in an intricate braid. She's dressed in a crisp, pink sundress and spotless, white tennis shoes. You've had a chance to put her at ease and now must continue the interview about sexual abuse by her father (CW = Caseworker).

CW: Can you tell me what happened?

Jessica: We were playing a secret game. My teeter feel funny.

CW: And where is your teeter?

Jessica: (Points to her vagina)

CW: Why did your teeter feel funny?

Jessica: He touch it.

CW: Was this part of the secret game? (Jessica nods yes) What did he touch your teeter with?

Jessica: Finger.

CW: OK, did Daddy put his finger under your panties?

Jessica: (Confused) I don't know. He touch my teeter.

CW: That's OK. Can you tell me anything else about the secret game?

Jessica: He take out his peepee.

CW: Where is his peepee?

Jessica: Where he peepees and he take it out of his pants.

CW: When Daddy peepees, he takes his peepee out of his pants?

Jessica: Yes.

CW: OK, I see, so Daddy had his peepee out of his pants when you were playing the game. (Jessica nods yes.) Did he do anything else?

Jessica: He made the white stuff come out.

CW: He made the white stuff come out of his peepee? How?

Jessica: He said to wick it.

CW: He told you to lick his peepee?

Jessica: Yes, an' the white stuff tas-tes bad.

CW: Oh, I see, he told you to lick his peepee and the white stuff came out? (Jessica nods yes)

Jessica: It tas-tes bad.

CW: Is there anything else about the secret game you want to tell me?

Jessica: Not to tell Mommy or she will go away.

CW: Who told you not to tell Mommy?

Jessica: Daddy. It's secret.

Reducing the Shock

ANGELO

Seven-year-old Angelo lives with his mother, Theresa Valez, and her boyfriend, Mark. Theresa works as a waitress at night and leaves Angelo with her unemployed boyfriend while she works. Angelo is a bright child with dark brown eyes, dressed in torn jeans, a Power Rangers t-shirt and scuffed-up tennis shoes. You've had a chance to put him at ease and now must continue the interview about sexual abuse from his mother's boyfriend (CW = Caseworker).

CW: So you drank some beer with Mark and looked at some pictures with naked people in them? Is that right? (Angelo nods yes) What happened next?

Angelo: I was feelin' bad and Mark tole me it was time to go to bed. He was going to take a bath with me because I felt bad.

CW: And did you and Mark take a bath together? (Angelo nods yes) What happened next?

Angelo: Mark made me sit in front of him and he washed my back.

CW: Did he do anything else?

Angelo: He kept pushin' his thingee on me.

CW: And where is his thingee?

Angelo: Between his legs and stickin' out of the water.

CW: So Mark was pushing his thingee on you and washing your back? Did he do anything else?

Angelo: He pulled me up in his lap and was washing my thingee. I was feelin' sick.

CW: Where was Mark's thingee while he was washing your thingee?

Angelo: He was pushin' it in my butt and trying to stick it in my pooter.

CW: Mark was trying to stick his thingee in your pooter? (Angelo nods yes)

CW: Where is your pooter?

Angelo: (Embarrassed) Here. (Points to his buttocks)

CW: OK, I see. Did he stick his thingee in your pooter?

Angelo: He did it a lot. His thingee was hurting my pooter and I threw up.

CW: What did Mark do when you threw up?

Angelo: He took his thingee out and washed me off.

CW: What happened next?

Angelo: He said to go to bed and he would sleep with me or I might get sick again.

CW: And did Mark sleep with you? (Angelo nods yes) Did Mark put his thingee in your pooter while he was sleeping with you?

Angelo: Yes.

CW: Did he do anything else?

Angelo: He told me I couldn't tell Mama.

MODULE FOUR
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Reducing the Shock

TIFFANY

Sixteen-year-old Tiffany lives with her mother and stepfather, Yvette and Harley Nelson. Tiffany is a streetwise teenager who openly admits that she has sex with her boyfriend, 16-year-old Jake. You've had a chance to put her at ease and now must continue the interview about sexual abuse from her stepfather (CW = Caseworker).

CW: Tell me what happened when you came home from your date.

Tiffany: He was waiting up, like he always does, and started calling me slut and whore and asking if I was givin' it to Jake. He said if I was givin' it away I could give him some too. And he starts grabbin' my tits and pulling me down in the basement where his workshop is – saying cunts like me don't care where they get it, as long as they get it.

CW: So, he called you names and grabbed your tits and forced you into the basement?

Tiffany: Yeah, so Yvette wouldn't hear. He's such an asshole, always trying to cop a feel.

CW: What happened when he took you down to the basement?

Tiffany: The son of a bitch pushed me down the stairs and slammed my head against the wall. He said he'd kill me if I didn't shut up and slammed my head again. I shut up after that. So now the motherfucker has me where he wants me.

CW: What did he do after that?

Tiffany: He fucked me every way he could think of.

CW: What did he do, specifically?

Tiffany: He made me suck his dick. Then he did me the regular old way and then in the butt. If he could have thought of anything else he would have done that too.

CW: OK, I see. Is there anything else you'd like to tell me about this?

Tiffany: No.

Ways Emotions Can Impact Your Job

- ☹ Prevent you from building rapport with the child
- ☹ Block your ability to hear the child
- ☹ Prevent you from responding genuinely
- ☹ May affect your decision making
- ☹ May add significantly to your stress level

Ways to Control Emotions

- ☺ Recognize strong feelings
- ☺ Analyze your feelings often
- ☺ Recognize that others find dealing with sexual abuse difficult
- ☺ Learn facts about sexual abuse
- ☺ Use your emotions to help you do your job
- ☺ Use your supervisor as a support system

Child Indicators of Sexual Abuse

Physical Indicators	Behavioral Indicators	Emotional Indicators
• Enlarged vaginal opening. • Frequent sore throats • Blood in underclothing • Pain or itching of genital area or during urination • Difficulty walking or sitting • Bruises, bleeding or swelling of genital, rectal or anal areas • Vaginal odor or discharge • Frequent urinary tract or yeast infections • Sexually transmitted diseases. • Presence of semen • Pregnancy • Foreign bodies in the vagina, urethra or rectum • Somatic problems, particularly stomach and head aches, with no apparent medical cause	• Poor peer relationships or lack of social skills • Overly compliant behavior • Sudden drop in school performance • Delinquency, skips school or running away • Use of illegal drugs or alcohol • Parentification • Sexual knowledge or behavior that is unusual for the child's age • Change in eating, sleeping or any unexplained change in behavior • Excessive masturbation • Regressive behavior • Tries to look or act older, "pseudo-maturity" • Sexual details in art and drawings • Victimizes others • Seductiveness	• Fantasizes often • Cries often • Extreme sensitivity to feelings of others • High level of irritability • Mood swings • Poor self-esteem • Depression • Internalized guilt • Extremely fearful (darkness, being left alone, etc.) • Hypervigilance (extreme watchfulness) • Shows few feelings or emotions • Appears numb • Feelings of shame or worry; overly serious • New fear of day care, sitter or a particular person or place • Fear of baths • Withdrawal • Suicidal feelings or suicide attempts • Fear of injury, pregnancy • Disassociation

MODULE FOUR
CHILD MALTREATMENT

Glossary of Medical Terms

ANUS

Opening to the rectum

AUTOINOCULATION

A type of nonsexual transmission of a sexually transmitted disease in which the person transmits the disease to his or her own genitals by touching. For example, a person who has warts on her hand may give herself genital warts by touching her genitals with that hand. This type of transmission is uncommon.

CANDIDIASIS

Infection with, or a disease caused by a yeast like fungi. Sometimes results from a disturbance in the normal balance of the bacterial flora of the body. Can be a variety of infections of the skin, mouth and throat (commonly called thrush), intestinal tract and vagina.

CERVICAL EROSION

Irritation on the exterior of the cervix uteri caused by trauma or infection

CERVICITIS

Infection /inflammation of the cervix uteri

CERVIX

Any neck-shaped anatomical structure, such as the narrow outer end of the uterus

CHLAMYDIA TRACHOMATIS

Various strains of this organism cause trachoma, a chronic disease of the eye; conjunctivitis, urethritis; and proctitis, an inflammation of the mucous membrane of the rectum.

CLITORIS

A small erectile organ at the upper end of the vulva, homologous to the penis

COITUS

Sexual intercourse

CONDYLOMA ACCUMINATUM

Genital or venereal wart. Wart-like growth or raised spot on the genitalia.

CONDYLOMA LATURM

A broad, flat, syphilitic growth occurring on the folds of moist skin, especially the genitals and anus

CUNNILINGUS

Oral stimulation of the female genitalia

DYSURIA

Difficult or painful urination

ENCOPRESIS

The inability to hold one's feces. Other terms used are incontinence of stool or fecal soiling. This is usually a psychological symptom and has been described as a presenting complaint in incest or other emotional disorders.

EPIDIDYMIS

Tube passing from the testes to the vas deferens

ENURESIS

Involuntary discharge of urine; usually refers to involuntary discharge while sleeping; bed-wetting.

FALLOPIAN TUBE

Either of a pair of slender tubes connecting the uterus to the region of each of the ovules in the female reproductive system (uterine tubes).

FELLATIO

Oral sucking or manipulation of the penis

FOURCHETTE

External tissue extending from the hymen toward the anus, contained within the labia majora.

FOSSA NAVICULAR

Concavity in fourchette at the 6 o'clock position

GENITAL HERPES

Viral disease transmitted sexually and, in rare instances, by autoinoculation.

GENITALIA

The external reproductive organs

GONORRHEA

A venereal disease caused by Neisseria gonorrheoae. Contagious inflammation of the genital mucuous membrane.

HEMATOCHEZIA

The passage of bloody stools, a symptom of many causes that the physician needs to consider

HEMATURIA

The passage of bloody urine

HERPES

A common viral disease marked by the formation of small vesicles in clusters. Herpes labialis is of the lip (a cold sore); herpes simplex is of the mouth or genitals. Herpes zoster (shingles) is not sexually transmitted.

HYMEN

The membranous fold partially covers the external orifice of the vagina

INGUINAL

Of, relating to, or located in the groin.

INTROITUS

The general term for the entrance to a space, such as the vaginal opening

LABIA MAJORA

Outer lips to vagina. Covered by pubic hair after menarche (the onset of menstruation at puberty).

LABIA MINORA

Inner lips to vagina

LACTOBACILLUS

Normal vaginal bacteria after menarche.

LEUKORRHEA

A normal, whitish mucoid vaginal discharge. Due to estrogen changes associated with puberty.

MEATUS

A general term for an opening in the body, e.g., urethra meatus, either male or female.

MIDLINE COMMISSURE

Synonymous with midline raphe

MIDLINE RAPHE

Midline fusion external from the fourchette toward the anus – not a scar

MONILLASIS

Also moniliosis. Infection with any species of Monilia, a large group of molds or fungi commonly known as fruit molds. The closely related pathogenic organisms are now called Candida.

ORCHITIS

Infection of the testes

PELVIC INFLAMMATORY DISEASE (PID)

Infection of the fallopian tubes and/or ovaries. Commonly called PID.

POSTERIOR FORNIX

Vaginal cavity located beneath the cervix.

PREPUCE

The foreskin or covering of the clitoris or glands of the penis

PROCTITIS

Inflammation or infection of the rectum

PROSTATE

Gland that produces semen

PROSTATITIS

Prostatic infection

RECTUM

Terminal aspect of the colon

SALPINGITIS

Infection of or inflammation of the fallopian tube

SCROTUM

Sac containing the testes

SEMEN

The penile ejaculate containing spermatozoa in, a nutrient plasma of secretions from the prostate, seminal vesicles and other glands (spermatic fluid).

SMEGMA

A normal, whitish secretion that collects under the foreskin of the penis or in the labial folds. It is composed chiefly of dead epithelial cells.

TESTES

Male sex organs that produce spermatozoa

TRICHOMONAS

A parasitic flagellate protozoa producing urogenital disease in humans

URETHRA

Opening to the bladder

URETHRITIS

Inflammation of the urethra.

UTERUS

Reproductive organ composed of a cervix, corpus mid fundus.

VAGINA

A canal in the female from the vulva to the cervix

VAGINITIS

Vaginal infection

VESTIBULE

A cavity, chamber or channel that serves as an approach to another cavity. The vestibules of the vagina is the space between the labia minora and contains the openings to the vagina and the urethra.

VULVA

The external female genital organs, composed of the mons pubis, the labia majora and minora, the vestibule of the vagina and its glands and the openings of the urethra and the vagina.

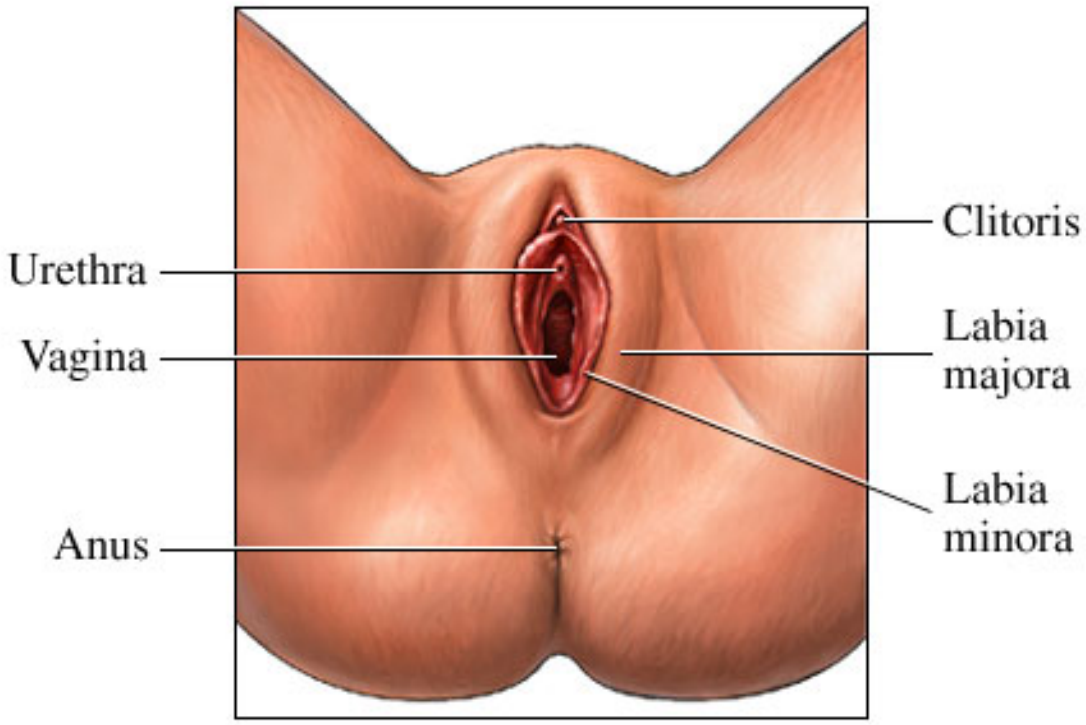
VULVITIS

Inflammation of the vulva. Usually occurs as a concurrent infection of the vagina, vulvovaginitis

VULVOVAGINITIS

Inflammation of the vulva and the vagina at the same time.

Female Genitalia



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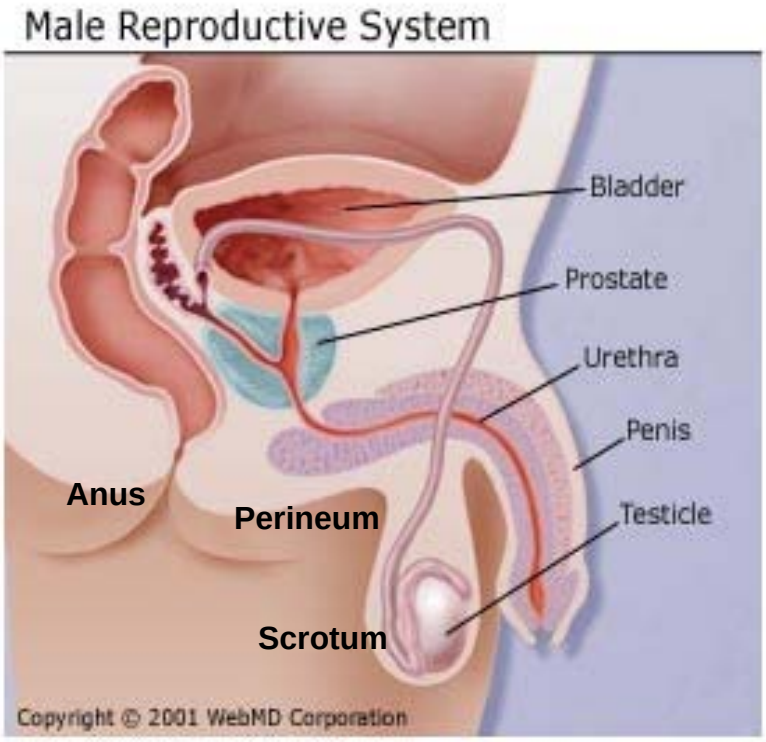

Physical Indicators Identified in a Medical Examination

Female

Chafing, abrasions or bruising of inner thighs and genitalia
Scarring, tears or distortion of the hymen
A decreased amount of or absent hymenal tissue
Scarring of the navicular fossa
Injury to or scarring of the fourchette
Scarring or tears of the labia minora
Enlargement of the hymenal opening

Male

Bruises, scars, chafing of the thighs, penis, scrotum
Bite marks
Penile discharge

Both Sexes - Anal

Bruises around the anus, scars, anal tears that extend into surrounding perianal skin
Anal dilation
Sphincter laxity

Source: Dr. Jane L. Wilkov, M.D., F.A.A.P.

Evidence of Sexual Abuse?

Sexually Transmitted Diseases

Neisseria gonorrhea

Evidence of Sexual Abuse	Certain **(except for sexually active adolescence)**
Epidemiology	Infected female to male (single exposure) - 20% Infected male to female (unknown exposure) - 90% Sexual contact Perinatally acquired causes eye infection No evidence to support persistent birth-acquired, asymptomatic, anogenital beyond neonatal period Must have culture - not rapid detection kit
Incubation	Adults: 3-7 days
Symptoms/ Consequences	Includes vaginitis in pre-pubescent children, discharge, swelling, painful urination and redness, although patients may also be asymptomatic Adolescents have upper tract symptoms - pelvic inflammatory disease (PID)

Syphilis

Evidence of Sexual Abuse	Certain **(except for sexually active adolescence)**
Epidemiology	Acquired by sexual contact Congenital - transplacental or perinatal transmission
Incubation	10-90 days after exposure - average 3 weeks
Symptoms/ Consequences	Primary: chancre (painless red ulcer) Secondary: 4-6 weeks later - rash, malaise, fever Tertiary: 60% of untreated patients develop - involves aorta and central nervous system

Chlamydia trachomatis

Evidence of Sexual Abuse	Probable
Epidemiology	Can occur as baby is born through the birth canal of infected mother (perinatal), can have prolonged carrier at least up to 2 years of age (causes conjunctivitis, pneumonia in infants) Rare to see in anogenital tract without sexual transmission Must be culture proven (not rapid screen test)
Incubation	1-2 weeks
Symptoms/ Consequences	Vaginitis - most asymptomatic

Evidence of Sexual Abuse? (continued)

Human papilloma virus (HPV)

(sometimes referred to as genital or venereal warts)

Evidence of Sexual Abuse	Probable
Epidemiology	Occurs during direct contact with infected skin or mucosa Perinatal or sexual By nonsexual direct contact (diapering), not proven
Incubation	Maternal transmission - can become obvious any time up to at least 20 months
Symptoms/ Consequences	Genital bleeding, pain, discharge or asymptomatic Different types give different appearance - most common type 6 and 11 Fleshy cauliflower projections called condyloma acuminata

Trichomonas vaginalis ("Trich")

Evidence of Sexual Abuse	Probable
Epidemiology	Almost always sexually transmitted Neonatal period - can cause vaginitis or nasal discharge persistent for 3-6 weeks No documented cases of transmission through fomites
Incubation	4-20 days - average 1 week
Symptoms/ Consequences	Vaginitis or asymptomatic Adolescents: malodorous discharge, itching

Human Immunodeficiency Virus (HIV)

Evidence of Sexual Abuse	Probable if no other risk
Epidemiology	Sexual - contact with semen/vaginal secretion or blood Shared needles of drug users and through contaminated blood products used in blood transfusions Transplacental or intrapartum exposure through infected mother's breast milk
Incubation	3-6 months. If acquired perinatally must have symptoms by 2 years
Symptoms/ Consequences	The virus break down the body's immune system, or its ability to fight disease.

Evidence of Sexual Abuse? (continued)

Herpes simplex virus

Evidence of Sexual Abuse	Type I: possible Type II: probable
Epidemiology	Close contact with person shedding virus Asymptomatic shedding is possible Perinatal transmission causes neonatal disease in first 4-6 weeks of life Autoinoculation occurs (for example, Type I oral-genital area)
Incubation	2-20 days, average 2-7 days
Symptoms/ Consequences	Genital herpes: itching, swelling, vesicles, ulcer - painful Primary outbreak - systemic symptoms Recurrences usually milder

Molluscum contagiosum

Evidence of Sexual Abuse	Unlikely but possible
Epidemiology	Direct contact with infected skin or towels
Incubation	1 week-6 months
Symptoms/ Consequences	Formation of pox-like sores on the skin, fleshy umbilicated papules, sometimes itches Genital lesions may be from sexual abuse

Bacterial vaginosis (syndrome associated with overgrowth of organisms including Gardnerella vaginitis)

Evidence of Sexual Abuse	Uncertain, probably unlikely
Epidemiology	Common in sexually active adults and adolescents Uncertain if acquired at birth - present in children with no history of sexual abuse
Incubation	Unknown
Symptoms/ Consequences	Odorous discharge

Candida albicans (yeast)

Evidence of Sexual Abuse	Unlikely
Epidemiology	Not sexual, Organism present in intestinal tract, vagina, mucous membranes of healthy people
Incubation	Unknown
Symptoms/ Consequences	Itching, cheesy white discharge Not likely in unestrogenized (prepubertal) female

MODULE FOUR
CHILD MALTREATMENT

The Developing Child: What's Normal?

(Content provided by the Georgia Council on Child Abuse)

Infancy (birth to 1 year)	
Developmental Stage	Trust vs. Mistrust Infant needs to experience caregivers as responsive to meeting his or her needs When caregiver sexually abuses an infant, it may lay groundwork for lack of trust
Normal Developmental Process	Little control of body, rapid change Learns to trust No sense of right and wrong Must be touched and held to thrive Discovers own body parts, explores genitals, fingers, toes Touching genitals or rubbing against crib or toy
Normal Sexual Development	Pair Bonding: Oral stage of development Sucking, body contact, cuddling, rocking movements, clinging, and touching Genital touching may occur Genital play: Self-touching May thrust pelvis when being cuddled or falling asleep Identification of gender or sex role: Identification with same-sex parent and with socially approved sex-role behaviors
Development Interrupted by Sexual Abuse	Displacing fear and anxiety through excessive crying and fretful behavior Vomiting, bowel disturbances Eating problems and sleep disturbances Failure to thrive

MODULE FOUR
CHILD MALTREATMENT

The Developing Child: What's Normal?

Toddler (2-5 years)	
Developmental Stage	Autonomy vs. Shame and Doubt Following sexual abuse, self-doubt and doubt of others may later appear Initiative vs. Guilt Feelings of wanting one parent to exclusion of the other, typically leads to guilt in the child
Normal Developmental Process	Gains some control, coordination of body Moves about independently Begins to communicate through speech Relates to more adults and other children Often overwhelmed by intense feelings Struggles with feelings of doubt and shame Curious about body parts and differences between boys and girls Plays “house” or “doctor” Touches own or others’ genitals
Normal Sexual Development	Anal Stage: Toilet training Handling their own genitals Kissing parents and others Cuddling Beginning awareness of genital differences Phallic stage: May show increased curiosity about sex May purposely display genitals to peers Often fascinated by excretion Develops need for increased privacy, especially in bathroom Masturbation
Development Interrupted by Sexual Abuse	5 year olds: Desperate need for love Difficulties in communication and in trusting adults May not feel guilt about sexual abuse, but feels worthless Does not understand what sexual abuse is about Uses denial to repress feelings Uses a lot of sexualized play to communicate feelings Wetting, soiling may indicate a cut off from body sensations Fear of a particular person or place Victimization of others

MODULE FOUR
CHILD MALTREATMENT

The Developing Child: What is Normal?

Latency (6-12 years)	
Developmental Stage	Industry vs. Inferiority Normal development in gaining skills and becoming productive Sexual abuse in this stage produces a far-reaching sense of inadequacy Develops good physical coordination
Normal Developmental Process	Thinks about causes and effects Concerned with fairness and rules Conforms to expectations of others Develops self-esteem through accomplishments and positive relationships with adults Curiosity about bodies may lead to “peeping” or looking at pictures Experiments with “dirty words”
Normal Sexual Development	Increased awareness of and interest in anatomical differences between the sexes May ask practical questions about sex, such as how a baby comes out of the mother’s stomach Thinks of marrying someone of the opposite sex Often discreet about their bodies and more anxious about being touched May talk and joke about boyfriends and girlfriends Occasional masturbation common Intense or frequent masturbation may signal anxiety, distress or sexual abuse Displays increased secretive behavior among peers Increased interest in socializing
Development Interrupted by Sexual Abuse	Nightmares and other sleep disturbances Fear that the attacks will recur Phobias concerning specific school or community activities Withdrawal from family and friends Regression to earlier behaviors Eating disturbances Physical ailments e.g. abdominal pain or urinary difficulties Negative feelings about his or her own body Feels/says he or she is “different” Has difficulties with other children Feels ashamed Believes the only way to get attention is by allowing adults to use their bodies Sexually over-stimulated May disconnect from body sensation or feel revulsion

MODULE FOUR
CHILD MALTREATMENT
Identifying Indicators of Sexual Abuse

SCENARIO 1 — Angela

Angela, age 7, was placed in a newly approved foster home 8 months ago because her father sexually abused her. The abuse had been going on for 3 years before Angela disclosed the abuse to a friend, who, in turn, reported it to a teacher. Angela was quiet and withdrawn during the early weeks of placement. A month after placement, the foster mother reported observing Angela in her room re-enacting what appeared to be intercourse with a doll. The foster mother also reported she had found Angela masturbating at least six times during the last 2 weeks, and Angela continued to masturbate even when her foster mother walked into the room.

The caseworker visited the home to assure the foster parents that Angela's behavior was typical for a child who had been sexually abused. During this visit, the worker noticed Angela seemed extremely friendly with her foster father. The child followed him all over the house and when he sat down, she tried to get into his lap. For the most part, Angela ignored the foster mother and responded in a hostile tone when the foster mother addressed her.

The caseworker contacted Angela's school and learned that Angela does not get along well with other children. Although she is bright, her grades are slipping. Angela's teacher said that Angela's one great love is swimming, and that she is part of a group of children who stayed after school to swim in the high school swimming pool instead of going to day care. The teacher reported that lately Angela had "become bashful" about putting on her bathing suit and sometimes cried for several minutes before changing.

Soon after Angela learned her father was convicted of sexual molestation, she accused her foster father of sexually molesting her. She gave details about how her foster father would help her get ready for bed and tuck her in each night with a forceful kiss on her mouth. Angela also stated that he liked lots of "bear hugs" and would pat her bottom. When asked if she ever told the foster mother, Angela stated her foster mother was "mean and would never believe me."

Angela was removed immediately from the home and a child welfare investigation began. The foster father denied all allegations.

Angela was given a medical exam, which revealed that she had a thick discharge and vaginal irritation.

MODULE FOUR
CHILD MALTREATMENT

WORKSHEET

Identifying Indicators of Sexual Abuse: Scenario 1, Angela

What are the physical indicators of abuse?

What are the emotional indicators of abuse?

What are the behavioral indicators of abuse?

Identifying Indicators of Sexual Abuse

SCENARIO 2 Alphonzo

Mrs. Walker is concerned about her youngest child, Alphonzo, who is 4. Alphonzo has started having nightmares at night and has been taking long naps during the day. Alphonzo sleeps so deeply during these naps that he doesn't wake up, even when she shakes him.

Mrs. Walker is very proud of Alphonzo because he is becoming very independent lately. For example, he wants to make his own cereal in the morning and he won't let Mrs. Walker walk with him into his preschool classroom anymore. Lately, he wants to give himself his bath and won't let Mrs. Walker in the bathroom at all. Mrs. Walker says that she has been monitoring Alphonzo's bowel movements since he had severe diarrhea 3 months ago. Lately, he complains of diarrhea and hurries into the bathroom but when she checks, his bowel movements appear normal.

Mrs. Walker is concerned because sometimes when she reaches out to hug Alphonzo, he pulls away from her. Mrs. Walker doesn't know whether this is normal or not. Alphonzo seems to be talking less and less. For example, this morning Mrs. Walker noticed Alphonzo playing with his trucks. She said, “I like the red truck, Alphonzo. Which one is your favorite?” Alphonzo yelled, “Truck, bang, bang, buszsch.” Alphonzo has always been such a serious little boy, but lately he just won't talk to anyone. He must be going through a shy stage.

Still, Mrs. Walker feels there is something very wrong with Alphonzo.

MODULE FOUR
CHILD MALTREATMENT

Worksheet Alphonzo
Identifying Indicators of Sexual Abuse:

What are the physical indicators of abuse?

What are the emotional indicators of abuse?

What are the behavioral indicators of abuse?

MODULE FOUR
CHILD MALTREATMENT

Identifying Indicators of Sexual Abuse

SCENARIO 3 Maria

Maria, 10 years old, told her best friend that her mother's boyfriend, Marcello, repeatedly forced her to fondle him when her mother was babysitting the next-door neighbor. Maria encourages her mother to babysit because it gives her money to take Maria out for dinner at McDonald's.

Maria is a very articulate child. She tells her friend she's "coping fine with the situation" and that "adults often have problems relating to children." Maria is very worried about her mother because she is working so many hours and Marcello won't help at all. Maria does the family's laundry, cleans and even writes out checks for the monthly bills for her mother to sign. Maria microwaves frozen dinners for Marcello unless he orders pizza. She also runs her mother's bath for her late at night when her mother returns home from work.

Maria's teachers think Maria is a very polite. She is well behaved and shows no signs of aggression. Her teachers do think Maria is overly sexual. She wears tight clothes and make-up, and seems to be flirting with boys her own age as well as teachers.

This morning a bad thing happened to Maria: She suddenly became very dizzy in school. The school nurse called to ask Maria's mother to take her to the doctor for a complete examination. The doctor found that Maria has a gonococcal infection of the throat. Maria's mother told the doctor Maria was taking antibiotics for a middle ear infection. The doctor also said Maria's dizziness is the result of not having eaten for almost 24 hours. Maria forgot to eat breakfast or lunch and didn't realize how hungry she was. The doctor also commented on some old and new scratches on Maria's stomach and thighs. Maria said a dog jumped up on her and scratched her.

Now it is 5:00 and Maria is scared because she felt like the doctor was staring at her. She decided to talk to her friend. But after she told her friend what happened, her friend said she was going to tell her mother. Maria told her that she was just joking she just saw a T.V. movie about a kid who had that happen to her. What Maria doesn't know is that her friend's mother wouldn't have believed the story. Many of the mothers in Maria's neighborhood don't like their daughters hanging around with Maria because she is so flirtatious. Maria's friend's mother commented just the other day that Maria was "looking to get pregnant." If Maria's friend had told her mother what Maria said, her mother would have responded that Maria clearly asked for it.

MODULE FOUR
CHILD MALTREATMENT

WORKSHEET

Identifying Indicators of Sexual Abuse: Scenario 3, Maria

What are the physical indicators of abuse?

What are the emotional indicators of abuse?

What are the behavioral indicators of abuse?

Child Sexual Abuse Accommodation Syndrome

Stage 1: Secrecy

Offender engages the child, gets the child's compliance, abuses the child and convinces him or her to keep silent. The child is usually terrified by the fact that this act has to be kept secret. Often the offender threatens the child with terrible consequences if she tells about the abuse.

Stage 2: Helplessness

The child feels helpless to stop the continued abuse. The child may feel that since she did not tell the first time the abuse happened, she can never tell. Many offenders wake children up to abuse them – children are then in a very vulnerable position and will not fight back.

Behavioral and emotional signs appear most often in the first two stages.

Stage 3: Accommodation

Child begins to work out her anger about the abuse, tries to accept it by believing the offender's rationalizations. The child may start to dissociate – turn off feelings. She may even develop multiple personality disorder to "escape" while the abuse is occurring. The child will emotionally adjust to the continued abuse in the best way she can.

Stage 4: Disclosure

Child discloses, often years after the abuse began. The disclosure may be unconvincing and confusing.

Stage 5: Recantation

Not all children recant, but some do. After disclosure, the family is in crisis and the child may be under considerable pressure to retract the claims of abuse. The child may say the abuse didn't really happen, that she dreamed it or that it actually happened to someone else.

MODULE FOUR
CHILD MALTREATMENT

Environmental Factors

Closed Home

Isolation

- The family has few friends.
- Few people come into or leave the home.
- Few people have access to the home, so no one knows what is going on with the children.

Secretiveness

- The family has many secrets, and no one is allowed to tell these secrets.

Lack of connections with the community, neighborhood or outside world

- The family shares no information with the outside world.
- The family has little to no involvement with the community, neighborhood, and outside world in general.

Open Home

Crowded with strangers and acquaintances coming and going

- Strangers and acquaintances have access to the home at all hours of the day.
- A lot of people, not known to the family, come into and out of the home.

Inadequate supervision

- Offending parent or caretaker has easy access to child on a regular basis.
- Child is alone unsupervised, or with surrogate caretakers on a regular basis.
- The parents establish no boundaries in the home.
- The parents have no structure in the home.

Poor choice of surrogate caretakers or baby-sitters

- Strangers or sitters, that are too young and inexperienced, may supervise the child.

Inappropriate sleeping arrangements

- Sleeping with opposite sex siblings, or other relatives, especially when there is a significant age difference.
- Note: Sleeping arrangements may be completely appropriate based on the family's culture.
- In some cultures, families live in one room, and abuse never occurs.
- It is critical to observe environmental dynamics, within the context of the family's culture.

Offender has access to the child

- Due to the lack of boundaries, structure, and supervision, the offending caretaker has easy access to the child on a regular basis.
- Sometimes, strong ties between the offender and someone else may complicate the situation, and may make it difficult for the other person to protect the child.

To A Safer Place

Child Indicators -Linda
Child Indicators -Shirley
Child Indicators -Wilford

To A Safer Place

Child Indicators -Larry
Parent Indicators -Mother
Environmental Indicators

MODULE FOUR
CHILD MALTREATMENT

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Impact of Maltreatment On Child Development

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

Objectives:
After completion of this module case managers will be able to:

- Determine why a thorough knowledge of child development is essential for effective Child Welfare practice.
- Identify age appropriate behavior stages, processes and milestones of normal physical, cognitive, social and emotional development of children from birth through adolescence
- Identify potential negative outcomes of abuse and neglect on the physical, cognitive, social, and emotional development.
- Identify why infants and toddlers are at particularly high risk of abuse and neglect, with potentially severe consequences
- Recognize strategies to provide services to promote healthy development
- Explain the process and dynamics of normal, reciprocal attachments of children with their families and other significant caregivers
- Explain the impact of foster care placement on a traumatized child's attachments
- Identify methods to help the child develop connections and enhance attachments while in care
- Describe the potentially traumatic outcomes of the separation and placement experience for children and their families, including precipitation of psychological crisis, serious disruption of family relationships, and disturbances in the child's cognitive, emotional, social, and physical development
- List the stages of grief, and understand how grief manifests in children.
- Comprehend the serious negative effects on children of changing and inconsistent living arrangements

REMINDER NOTES FOR USING CHILD DEVELOPMENT CHARTS

- ✓ There is a wide range of typical behavior, and at any particular age twenty-five percent of children will not have reached the behavior or skill, fifty percent will be showing it and twenty-five percent will already have mastered it

- ✓ Some behaviors may be typical – in the sense of predictable – responses to trauma, including the trauma of separation as well as abuse and neglect

- ✓ Prenatal and postnatal influences may alter development

- ✓ Other factors, including culture, current trends, and values, also influence what is defined as typical

- ✓ A Case Manager needs to become aware of his/her own values, attitudes and perceptions about what is typical in order to be more objective and culturally sensitive when assessing a child's needs.

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

CHILD DEVELOPMENT…					
Age Range	**Cognitive (Intellectual)**	**Emotional/ Social**	**Sexual**	**Moral**	**Physical**
Birth – 18 months	**PRIMARY TASK:** Focus is on developing trust – Accomplishment of this is highly dependent on the parents or other caregivers providing care. The child's self-concept as a lovable and worthwhile person has its roots in this age period since trust is a major building block for all relationships; every area of development is likely to be affected by the events of this stage.				
0-6 months	• Recognition of mother • No concept of past and future • Reaches for familiar people or toys	• Attachment to mother/caretaker • Totally dependent • Totally trusting • Learns intimacy	• Erections possible • Both sexes can be stimulated	• None	• Sucking • Hands clenched/grip • Neck muscles develop • Pulls at clothing • Laughs/coos
6-12 months	• Objects can be held in memory • Learns through routines and rewards • Recognizes name • Says two to three words besides "mama" and "dada" • Imitates familiar words	• Separation from mother • Begins to develop a sense of self • Learns to get needs met • Trusts adults • Stretches arms to be picked up • Likes to look at self in mirror	• Generalized genital play	• None	• Rolls over • Stands with support • Creeps/crawls • Walks with help • Rolls a ball imitation of adult • Pulls self to standing position and stands unaided • Transfers object from one hand to the other • Drops and picks up toy • Feeds self cracker • Hold cup with two hands • Drinks with assistance • Hold out arms and legs while being dressed

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

CHILD DEVELOPMENT…					
Age Range	**Cognitive (Intellectual)**	**Emotional/ Social**	**Sexual**	**Moral**	**Physical**
12-18 months	• Experiments with physical environment • Understands the word ”no” • Comes when called to • Recognizes words as symbols for objects (cat – meow) • Uses 10 to 20 words, including names • Combines two words such as “daddy bye-bye” • Waves good-bye and plays pat-a-cake • Makes the sounds of familiar animals • Gives a toy when asked • Uses words such as “more” to make wants known • Points to his/her toes, eyes, and nose • Brings objects from another room when asked	• Early social development • Egocentric • Accepts limits • Develops self-esteem (love from family) • Plays by self	• Continued generalized genital play	• Fear of authority figures	• Creeps up stairs • Gets to standing position alone • Walks alone • Walks backward • Picks up toys form floor without falling • Pulls and pushes toys • Seats self in child-size chair • Moves to music • Turns pages two or three at a time • Scribbles • Turns knobs • Paints with whole arm movement • Shifts hands • Makes strokes • Uses spoon with little spilling • Drinks from cup with one hand unassisted • Chews food • Unzips large zipper • Indicates toilet needs • Removes shoes socks, pants, sweater

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

CHILD DEVELOPMENT…					
Age Range	**Cognitive (Intellectual)**	**Emotional/ Social**	**Sexual**	**Moral**	**Physical**
18 months-3 years	**PRIMARY TASK:** To establish a distinct self, separate from parent figures. ▪ The primary needs are increased control over feeding and toilet habits, without experiencing rejection or harm from too much independence. ▪ The child begins to learn about limits ▪ Child angers easily; likes to assert himself, and his favorite word is "NO!" This period is especially connected to physical growth, especially the capacity to walk, run, climb, and control elimination.				
18 months-3 years	• Can conduct experiments inside head but limited to experience • Rapid language growth • Copies adult chores in play • Carries on conversation with self and dolls • Asks "What's that?" and Where's my…?" • Has 450 word vocabulary • Gives first name • Hold up fingers to tell age • Combines nouns and verbs "mommy go" • Refers to self as "me" rather than by name • Tries to get adult attention , exclaiming "watch me" • Likes to hear same story repeated • May say "no" when means "yes' • talks to other children as well as adults •Names common pictures and things	• Autonomy struggles • Learns system of meeting needs • Social development increases • Points to things he/she wants • Joins in play with other children • Shares toys • Takes turns with assistance	• Continued generalized genital play • Early sex-role development	• Knowledge of preferences of authority figures	• Can run, throw ball, kick ball, jump • goes up stairs with one hand held by adult • Turns single pages • Snips with scissors • Holds crayon with thumb and fingers (not fist) • Uses one hand consistently in most activities • Rolls, pounds squeezes and pulls clay • Uses spoon with little spilling • Gets drink from fountain or faucet independently • Opens door by turning handle • Takes off and puts on coat with assistance • Washes and dries hands with assistance

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

CHILD DEVELOPMENT…					
Age Range	**Cognitive (Intellectual)**	**Emotional/ Social**	**Sexual**	**Moral**	**Physical**
3 - 5 years	**PRIMARY TASK:** To develop a sense of reality that is distinct from fantasy. ▪ Primary concern of the child is sex differences, and it includes interest in pregnancy and birth ▪ Period of high creativity • Strong needs to make distinctions between what is real and what is imagined.				
3 - 5 years	• Can conduct experiments inside head • Cannot sequence • Capacity to use language expands • Understands some abstract concepts: colors, numbers, shapes, time (hours, days, before/after_ • Understands family relations (baby/parent) • Can tell a story • Has a sentence length of 4 to 5 words • Has a vocabulary of nearly 1000 words • Names at least one color • Understands "tonight," "summer," "lunchtime," "yesterday" • Begins to obey requests like "put the block under the chair" • Knows his/her last name, name of street on which he/she lives and several nursery rhymes • Uses past tense correctly • Can speak of imaginary conditions "I hope" • Identifies shapes	• Can cooperate • Self-perceptions develop • Cannot separate fantasy from reality • Has nightmares • Models on same-sexed parent • Experiences and copes with feelings (sad, jealous, embarrassed) • Plays and interacts with other children • Dramatic play is closer to reality, with attention paid to detail, time, and space • Plays dress-up	• Generalized genital play in males • Masturbation to orgasm in females is possible • Early experimentation • Gender identity established • to urinate standing up • Bathroom slang and name calling '"pooh face" • Plays "nurse-doctor-patient" game with peers	▪ Self-esteem dependent on authority figures ▪ Negotiates to get needs met	• Swings/climbs • Uses small scissors, • Jumps in place • Walks on tiptoes • Balances on one foot • Rides a tricycle • Begins to skip, • Runs well • Bathes and dresses • Runs around obstacles • Walks on a line • Pushes, pulls, steers wheeled toys • Uses slide independently • Throws ball overhead • Catches a bounced ball • Drives nails and pegs • Skates, • Jumps rope • Pastes and glues appropriately • Skips on alternating feet • Pours well from small pitcher • Spreads soft butter with knife • Buttons and unbuttons large buttons • Washes hands independently • Blows nose when reminded • Uses toilet independently

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

CHILD DEVELOPMENT…					
Age Range	**Cognitive (Intellectual)**	**Emotional/ Social**	**Sexual**	**Moral**	**Physical**
6-9 years	**PRIMARY TASK**: To develop a sense of values to guide decision-making and interests as well as capabilities that lay the foundation for future decisions. • Needs of the child revolve around tasks, hobbies, and skill-oriented activities • Friendship with peers, especially of the same sex, is important • Competition is heightened, as is preoccupation with performance				
6-9 years	• Can think using symbols • Can recognize differences • Makes comparisons • Can take another's perspective • Defines objects by their use • Knows spatial relationships like "on top," "behind," "far," and "near" • Knows address • Identifies penny, nickel, dime • Knows common opposites like "big/little' • Asks questions for information ▪ Distinguishes left from right	• Early close peer relationships • Presence of well-developed defenses • Develops identity outside family (school, friends) • Has likes and dislikes (food, friends, games) • Chooses own friends • Plays simple table games • Plays competitive games • Engages in cooperative play with other children involving group decisions, role assignments, fair play	• Defenses reduce experimentation but some continues	▪ Has a conscience ▪ Refinements in moral development	▪ Is increasing small muscle motor skills ▪ Cuts foods with a knife ▪ Laces shoes ▪ Dresses self completely ▪ Ties bow ▪ Brushes independently ▪ Crosses streets safely

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

CHILD DEVELOPMENT…					
Age Range	**Cognitive (Intellectual)**	**Emotional/ Social**	**Sexual**	**Moral**	**Physical/Motor**
10-15 years	**PRIMARY TASK:** To create a personal identity based on the integration of values and a sense of self. The adolescent must establish an identity in relation to society, the opposite sex, ideas, the future, possible vocations and the universe.				
10-15 years	• Can engage in inductive and deductive logic • Neurons are present • Understands hypothetical situations • Conflicts with parents increase	• Increased autonomy struggles • Increased focus on identity • Focus on peer relationships • Rebellious • Often moody • Romantic feelings • Struggle with sense of identity • Feels awkward or strange about he/her body • Worries about being normal • Frequently changing relationships	• Puberty • Sex organs mature • Males ejaculate and have wet dreams • Both sexes able to masturbate to orgasm with fantasies • Girls develop physically sooner than boys • May display shyness, blushing and modesty	• Moral development is legalistic • Recognition of principles (e.g. justice) • Selection of role models	• Greater body competence (e.g. physical coordination) • Manual dexterity • Growth patterns vary
16 to 21 years	PRIMARY TASK: The establishment of independence. This can create tension with the family over limits, values, responsibilities, friends, and plans for the future.				
16-21 years	• Uses formal logic (e.g. opposes racism) • Debates and can change sides of debate • Understands probabilities • Uses more flexible abstract thinking • Examination of inner experiences • Conflicts with parents begin to decrease	• Interest in relationships • Solidifies personal identity • Becomes goal directed • Sometimes rebellious • Increased concern for others • Increased concern for future • Places more importance on his/her role in life	• Feelings of love and passion • Development of more serious relationships • Sense of sexual identity established • Increased capacity for tender and sensual love	• Identifies with moral principles, rules, and limit testing • Experimentation with sex and drugs • Examination of inner experiences	• Heightened physical power, strength, coordination

Chart compiled by Katie Thompson, Elon College student intern, NC Guardian ad Litem Program. Sources include: "Infant and Toddler Development," Dr. Maureen Vandermaas-Peeler, Elon College; "Child Development," Ray Newnam, Ph.D.; "LD In Depth," LD OnLine, www.ldonline.org; "Growing Up," Pasternak and Kroth; "Your Child's Growth: Developmental Milestones," American Academy of Pediatrics, www.aap.org; and "Normal Adolescent Development," American Academy of Child and Adolescent Psychiatry, www.aacap.org.

Case Manager's Role in Child Development

1. Case Managers must be able to recognize the negative effects on a child's development of abuse and neglect.

2. Case Managers should know age-appropriate behavioral expectations and be able to educate and counsel parents regarding proper child care practices and discipline strategies

3. Case Managers should be able to assist parents and foster caregivers to access services and activities to meet children's special needs and to enhance development.

4. Case Managers should be able to identify early warning signs of developmental disability and begin early intervention services.

5. Case Manager's knowledge of child development is necessary to prevent crisis for the child during placement into substitute care.

6. Case Managers should have essential knowledge and skill related to development.

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

IMPACT OF CHILD MALTREATMENT ON INFANTS AND TODDLERS

Characteristics of infants and toddlers that place them at high risk of maltreatment from parents who are predisposed to maltreat.

- Infants are demanding. They require constant attention and a great commitment of time. Infants often do not respect the parent's schedule. Sleep is frequently interrupted, and new parents are chronically tired. This is inherently stressful to even the most competent parent.
- A crying (screaming) infant can be extremely distressing to a parent, particularly if the parent is unable to quiet the infant.
- Newborns are often not very pretty. They are red, wrinkled, and may appear deformed to an uneducated parent. Their appearance may frighten a parent, or may stimulate a parent's feelings of poor self-esteem.
- Newborns are not very social for the first three or four months. They demand a lot and give little back. The parent must derive any pleasure from providing care, rather than expecting expressions of gratitude or recognition from the infant.
- Infants who are premature, sickly, have medical conditions, are irritable, colicky, or otherwise require special care are most susceptible to abuse. Separations as a result of hospitalization or illness may prevent early attachment. Sickly or premature infants are more demanding in their care needs than healthy infants.
- The toddler is developing autonomy. "Me do it!" and "NO!" characterize the behaviors of this stage, which often include stubbornness, rebelliousness, tantrums, angry outbursts, aggressiveness, obstinacy, and oppositional behavior. Struggles for power and control may develop. Oppositional behaviors can try the patience of even the most knowledgeable and understanding parent.
- Toilet training can be one of the most stressful developmental tasks for both children and parents. Trying to toilet train a child before he is ready can lead to extreme frustration and feelings of failure on the parent's part. The child experiences criticism, and often punishment, for reasons he does not understand. Toilet training can become a battleground between a parent who wants social compliance and a child whose major developmental task is to remain in control of his own body and his environment.

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

Characteristics of infants and toddlers that make them especially susceptible to serious outcomes from maltreatment.

- Infants and toddlers cannot protect themselves. They can't run, scream, or go for help. They are dependent and vulnerable. They will die if they are not properly cared for.
- Very rapid brain and body growth during the first two years makes the infant extremely susceptible to the effects of malnutrition. Mental retardation and growth deficiencies can result.
- The infant's soft skull and unprotected body are very susceptible to injury. Head injuries easily lead to severe brain damage. The soft bones of the skull are more likely to fracture from a blow.
- Muscles are not developed adequately to protect the trunk and abdomen, and blows to this part of the body will cause serious internal injuries.
- Head and neck muscles are not strong enough to with-stand even a mild shaking without potential brain and spinal cord injury.
- Infants are more susceptible to infection; they have not yet developed immunity to many environmental agents.
- Infants and toddlers use their bodies to explore their environments, to manipulate objects, to solve problems, and to master many tasks. Physical injury, therefore, can have serious implications for cognitive development as well as physical development.
- Infants and toddlers are particularly vulnerable to the emotional effects of abuse and neglect. They likely experience abuse and neglect as raw, diffuse, pervasive and incomprehensible pain. Abuse and neglect create barriers to attachment and the subsequent development of trust. This can permanently impair the child's relation-ship ability and create serious personality problems.
- Chronic malnutrition of infants and toddlers results in growth retardation, brain damage, and potentially, mental retardation.
- Head injury can result in severe brain damage or death. Direct blows to the head can create swelling of brain tissue and subdural hematomas (pools of blood in the brain), which destroys brain tissue and can result in brain stem compression and herniation, blindness, deafness, mental retardation, epilepsy, cerebral palsy, skull fracture, paralysis, and coma.
- Injury to the hypothalamus and pituitary glands in the brain can result in growth impairment and inadequate sexual development.
- Less severe but repeated blows to the head can also result in equally serious brain damage. When injured, the infant's soft brain tissue swells. Pressure inside the skull leads to a decrease in oxygen supply to the brain, and involved nerve cells die. This type of injury may be detectable only with a CT scan, and, in the absence of obvious signs of external trauma, may go unnoticed.
- Blows or slaps to the side of the head over the ear can injure the inner ear mechanism and cause partial or complete hearing loss.
- Shaking can result in brain injury equal to that caused by a direct blow to the head. Additionally, bones in the neck and spine can be injured, resulting in a collapse of the vertebrae. Spinal cord injury can result in paralysis.
- Internal injuries can lead to permanent physical disability or death. 0
- Medical neglect, as in withholding treatment for treatable conditions, can lead to permanent physical disability, such as hearing loss from untreated ear infections, vision problems from untreated strabismus (crossing of the eyes), respiratory damage from pneumonia or chronic bronchitis, etc.

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

Consequences of Abuse and Neglect on Cognitive Development

- Absence of stimulation interferes with the growth and development of the brain. Generalized cognitive delay or mental retardation can result.
- Brain damage from injury or malnutrition can lead to mental retardation.
- Abused and neglected toddlers typically exhibit language and speech delays. They fail to use language to communicate with others, and some do not talk at all. This represents a cognitive delay that can also affect social development, including the development of peer relationships.
- Maltreated infants are often apathetic and listless, placid, or immobile. They often do not manipulate objects, or do so in repetitive, primitive ways. They are often inactive, lack curiosity, and do not explore their environments. This lack of interactive experience often restricts the opportunities for learning. Maltreated infants may not master even basic concepts such as object permanence, and may not develop basic problem-solving skills.

Consequences of Abuse and Neglect on Social Development

- Maltreated infants may fail to form attachments to primary caregivers.
- Maltreated infants often do not appear to notice separation from the parent and may not develop separation or stranger anxiety. Infants and toddlers may willingly "go to anyone," and show equal pleasure in the presence of strangers and close family. This lack of discrimination of significant people is one of the most striking characteristics of abused and neglected children.
- Maltreated infants are often passive, apathetic, and unresponsive to others. They may not maintain eye contact with others, may not become excited when talked to or approached, and often, cannot be engaged into vocalizing (cooing or babbling) with an adult. These infants may not develop nonverbal communications that attract and hold an adult's attention.
- Abused or neglected toddlers may not develop play skills, and often, cannot be engaged into reciprocal, interactive play. Their play skills may be very immature and primitive. This can affect their relationships with other children.

Consequences of Abuse and Neglect on Emotional Development

- Abused and neglected infants often fail to develop basic trust. This will impair the development of healthy relationships. • Maltreated infants are often withdrawn, listless, apathetic, depressed, and unresponsive to the environment.
- Abused infants often exhibit a state of "frozen watchfulness," that is, remaining passive and immobile, but intently observant of the environment. This appears to be a protective strategy in response to a fear of attack. It is as if the child were "on guard."
- Abused toddlers may feel that they are "bad children." This affects the development of self-esteem.
- Punishment (abuse) in response to normal exploratory or autonomous behavior can interfere with the development of healthy personality. Children may become chronically dependent, subversive, or openly rebellious.
- Abused and neglected toddlers may be fearful and anxious, or depressed and withdrawn. They may also become aggressive and hurt others.

Reference: The Pennsylvania Child Welfare Training Program CORE 103 The Effects of Abuse and Neglect on Child Development

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

IMPACT OF CHILD MALTREATMEN ON PRESCHOOL CHILDREN

Physical

- They may be small in stature, and show evidence of delayed physical growth.
- They may be sickly, and susceptible to frequent illness; particularly upper respiratory illness (colds, flu) and digestive upset.
- They may have poor muscle tone, poor motor coordination, gross and fine motor clumsiness, an awkward gait, lack of muscle strength. • Gross motor play skills may be delayed or absent.

Cognitive

- Speech may be absent, delayed, or hard to understand. The preschooler whose receptive language far exceeds expressive language may have speech delays. Some children do not talk, even though they are able.
- The child may have poor articulation and pronunciation, incomplete formation of sentences, incorrect use of words.
- Cognitive skills may be at a level of a younger child.
- The child may have an unusually short attention span, a lack of interest in objects, and an inability to concentrate.

Social

- The child may demonstrate insecure or absent attachment; attachments may be indiscriminate, superficial, or clingy. The child may show little distress, or may overreact, when separated from caregivers.
- The child may appear emotionally detached, isolated, and withdrawn from both adults and peers.
- The child may demonstrate social immaturity in peer relationships; may be unable to enter into reciprocal play relationships; may be unable to take turns, share, or negotiate with peers; may be too aggressive, bossy, and competitive with peers.
- The child may prefer solitary of parallel play, or may lack age appropriate play skills with objects and materials. Imaginative and fantasy play may be absent. The child may demonstrate an absence of normal interest and curiosity, and may not actively explore and experiment.

Emotional

- The child may be excessively fearful, easily traumatized, may have night terrors, and may seem to expect danger.
- The child may show signs of poor self-esteem and a lack of confidence.
- The child may lack impulse control and have little ability to delay gratification. The child may react to frustration with tantrums, aggression.
- The child may have bland, flat affect and be emotionally passive and detached.
- The child may show an absence of healthy initiative, and must often be drawn into activities; may withdraw emotionally and avoid activities.
- The child may show signs of emotional disturbance, including anxiety, depression, emotional volatility, self-stimulating behaviors such as rocking, or head banging, enuresis or encopresis, or thumb sucking.

Reference: The Pennsylvania Child Welfare Training Program CORE 103 The Effects of Abuse and Neglect on Child Development

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

IMPACT OF CHILD MALTREATMEN ON SCHOOL-AGED CHILDREN

Physical

- The child may show generalized physical developmental delays; may lack the skills and coordination for activities that require perceptual-motor coordination. The child may be sickly or chronically ill.

Cognitive

- The child may display thinking patterns that are typical of a younger child, including egocentric perspectives, lack of problem-solving ability, and inability to organize and structure thoughts.
- Speech and language may be delayed or inappropriate.
- The child may be unable to concentrate on schoolwork, and may not be able to conform to the structure of a school setting. The child may not have developed basic problem-solving and may have considerable difficulty in academics.

Social/Emotional

- The child may be suspicious and mistrustful of adults or overly solicitous, agreeable, and manipulative, and may not turn to adults for comfort and help when in need.
- The child may talk in unrealistically glowing terms about her family; may exhibit "role reversal" and assume a "parenting" role with the parent.
- The child may not respond to positive praise and attention or may excessively seek adult approval and attention.
- The child may feel inferior, incapable, and unworthy around other children; may have difficulty making friends, feel overwhelmed by peer expectations for performance, may withdraw from social contact, and may become a scapegoat for peers.
- The child may experience damage to self-esteem from denigrating or punitive messages from an abusive parent or lack of positive attention in a neglectful environment.
- The child may behave impulsively, have frequent emotional outbursts, and be unable to delay gratification.
- The child may not develop coping strategies to effectively manage stressful situations and master the environment.
- The child may exhibit generalized anxiety, depression, and behavioral signs of emotional distress; may act out feelings of helplessness and lack of control by being bossy, aggressive, destructive, or by trying to control or manipulate other people.

Moral

- The child may not have respect for others' belongings and, therefore, might misuse or take them.
- The child may not be able to develop positive values and might exhibit unacceptable behaviors.

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

IMPACT OF CHILD MALTREATMEN ON ADOLESCENCE

Physical

- May be sickly or have chronic illnesses.
- Sensory, motor, perceptual motor skills may be delayed, and coordination may be poor.
- Onset of puberty may be affected by malnutrition and other consequences of serious neglect.

Cognitive

- May not develop formal operational thinking; may show deficiencies in the ability to think hypothetically or logically and to systematically problem solve.
- Thinking processes may be typical of much younger children; the youth may lack insight and the ability to understand other people's perspectives.
- May be academically delayed and may have significant problems keeping up with the demands of school. School performance may be poor.

Social/Emotional

- May have difficulty maintaining relationships with peers; they may withdraw from social interactions, display a generalized dependency on peers, adopt group norms or behaviors in order to gain acceptance, or demonstrate ambivalence about relationships.
- Likely to mistrust adults and may avoid entering into relationships with adults.
- Maltreated youth, particularly those who have been sexually abused, often have considerable difficulty in sexual relationships. Intense guilt, shame, poor body image, lack of self-esteem, and a lack of trust can pose serious barriers to a youth's ability to enter into mutually satisfying and intimate sexual relationships.
- May display limited concern for other people, may not conform to socially acceptable norms, and may otherwise demonstrate delayed moral development.
- May not be able to engage in appropriate social or vocational roles. They may have difficulty conforming to social rules.
- May display a variety of emotional and behavioral problems, including anxiety, depression, withdrawal, aggression, impulsive behavior, antisocial behavior, and conduct disorders.
- May lack the internal coping abilities to deal with intense emotions, and may be excessively labile, with frequent and sometimes volatile mood swings.
- May demonstrate considerable problems in formulating a positive identity. Identity confusion and poor self-image are common. The youth may appear to be without direction and immobilized.
- May have no trust in the future and may fail to plan for the future. The youth may verbalize grandiose and unrealistic goals for himself, but may not be able to identify the steps necessary to achieve the goals. These youth often expect failure.

Moral

- May develop a negative view of the universe with values that reflect this--values that have little meaningful faith or trust in life and provide little security or stability; little trust or valuing of self to others.
- May believe that he is different from others in a negative sense, and is isolated and alone.
- Often do not develop a sense of oneness with others, with nature, with the world, or the universe. They have an inability to feel at peace.
- Often have an inability to see, appreciate, and share caring and beauty. They need immediate gratification and display compulsive behaviors rather than positive choices.

Difficult Phases of Normal Development

Ages Zero to Three Months

Colic

- Fussy, intractable crying
- 20 minutes to two hours at a time
- One or more times per day, in the absence of hunger of physical symptoms such as ear infection.

Associated injuries:

- Violent shaking (resulting in subdural hematomas or retinal hemorrhages)
- Grab marks on shoulders and upper arms with underlying fractures often result form parental inability to deal with colic
- Ribs may be fractured from over-tight holding
- Mouth injuries may result from rough covering with the hand or forcing bottles or pacifiers
- Injuries inflicted during colic are highly associated with fatal abuse.

Ages Four Months Plus

Night crying/awakening

- Continues after infant has given up middle of the night feeding
- Also occur following an acute illness that has involved nighttime contact with parents

Associated injuries:

- Similar to those seen in colicky babies, with the exception of mouth injuries.
- Adults who are exhausted by interrupted sleep are likely to lose control

Ages Six Months to Two and One-Half Years **Separation anxiety**

- Manifested by crying, clinginess, and fearfulness, when the mother is not present (e.g., when left with a baby-sitter).
- For 6 to- 12-month babies, this can also happen when the mother is out of the child's visual field.

Associated injuries:

- Marks from spanking and slapping
- Parents often perceive the child as spoiled and punish harshly to "train" the child.

Ages Nine Months to Two and One-half Years

Exploratory behavior

- Child's gets into everything repeatedly
- Come out of normal, healthy curiosity
- Interest in the environment can be physically dangerous for the child as well as frustrating to parents when valued possessions are touched (e.g., VCR or television)

Associated injuries:

- Grab marks and spank marks
- In a home, which has not been "child-proofed," poisoning, burns, choking, and/or injury from falling are serious risks.

Ages One and One-Half to Three Years

Negativism

- Normal phase in which children delight in refusing most adult requests or suggestions
- Generally argumentative
- Child's "no" is a healthy sign of developing self-identity and independence.

Associated injuries:

- Slap-marks to mouth or cheek.
- Facial injuries carry the risk of eye or eardrum damage.

Poor appetite

- Normal at this age because growth rate has slowed
- Forced feedings and power struggles around the amount and types of food to be eaten will further diminish appetite

Associated injuries:

- Slap-marks on the cheeks and/or pinch-marks on the face
- Parents may squeeze the nostrils to force the child to open his mouth to breathe
- Aspiration of food into the lungs is a danger
- Forced spoon-feeding may also cause mouth injuries.

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

Ages One and One-Half to Five Years

Toilet training

- Process by which a child learns to be independent in using the toilet to urinate and defecate
- Initial (but often not full) signs of readiness for daytime training are usually seen by 24 months
- Nighttime bladder control may not be achieved for several years
- Girls are often ready before boys

Associated injuries:

- Often are seen when parental demands are too harsh or exceed the child's maturational level.
- Child may wet or soil himself during the day beyond the usual age level at which control is expected.
- Genital bruises
- Genital burns or dunking burns to a wider area of the buttocks, lower back, and stomach
- Highly associated with serious and even fatal abuse.

Ages Six to 11 Years

Lack of compliance with parents' expectations

- Common, and is often due to self-assertion, control conflicts, or simply lack of attention or forgetfulness by the child.
- School-aged child's apparent capacity for self-care may result in parents' not providing necessary supervision and attention.
- As with younger children, the school-aged child's dependence on caretakers, confusion about normative behavior, vulnerability, and strong desire to protect caretakers may make him hesitant to report maltreatment and, thus, more likely to be victimized repeatedly.

Associated Injuries:

- Associated with hitting (e.g., bruising) or lack of parental supervision (e.g., scalding).
- Behavioral indicators of maltreatment may be most evident in school
  - poor concentration
  - difficulty in learning
  - poor impulse control
  - poor social relationships
  - withdrawal
  - poor problem solving
  - abnormal anxiety about acceptance and performance
  - withdrawal.

Ages 12 to 18 Years

Confrontation

Acting out

- Confrontations with caretakers that result in physical or emotional abuse.
- Adolescent's capacity for self-care (coupled with the child's desire for making his/her own decisions and the tendency to avoid responsibility) may lead to a lack of parental supervision.
- Adolescent's emerging sexuality may make him/her particularly vulnerable to sexual abuse, especially if there has been previous sexual abuse.
- Acting-out behaviors tend to worsen. For example, maltreated children may steal from and hit playmates, while adolescents may burglarize and use weapons in fights

Associated Injuries:

- Commonly result from hitting (bruised, welts)
- injuries due to recklessness
- drug use
- self-destructiveness
- lack of self-care

BEN

Ben is 13 years old. He is short, not quite 5 feet tall, and is still growing. He is chubby, and weighs about 135 pounds.

As a young child, Ben lived with his grandmother after the death of his mother. An uncle living in the home sexually abused him. Ben's mother died when he was 3, and he and his father went to live with the paternal grandmother. Ben's father is currently in jail for a robbery.

Name-calling was a frequent problem in his family of origin. He makes friends well, but tends to choose kids who are younger, mostly boys. He is protective of his younger friends and plays well, not being too rough with them.

Ben likes computer games and riding his bike. He has dreams of being a pro-football player. Ben hates school and is a C-D student. He can be argumentative, and is often a "poor loser" and sometimes has tantrums. He fights with any peers who show him some aggression, including girls.

Ben

1. Identify the trauma that Ben has experienced and how this has affected his development.

2. What behaviors are on target for Ben's age?

3. What behaviors are not on target for Ben's age?

4. What would you include in the case plan?

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

MARY

Mary is 3 years old. Her mom is rumored to be an active cocaine user, and involved with the sale of other drugs to support her habit. Mary was recently placed in foster care after being found alone in a car. Mary has been in her foster home for two weeks; her mom has not been heard from.

Mary is wetting the bed every night, but does not wet during the day. She frequently asks for a bottle at bedtime. She plays well with the older children in the foster home, but lays on the floor crying and sucking her thumb when she is reprimanded, or when the older children don't want to play with her. Mary is aggressive with the younger children.

Mary enjoys playing outside. She especially likes active games that include running or jumping. Mary has not asked for her mother, but has become very attached to her foster mother.

Mary

1. Identify the traumas that Mary has experienced and how this has affected her development.

2. What behaviors are on target for Mary's age?

3. What behaviors are not on target for Mary's age?

4. What would you include in the case plan?

Attachment and Bonding

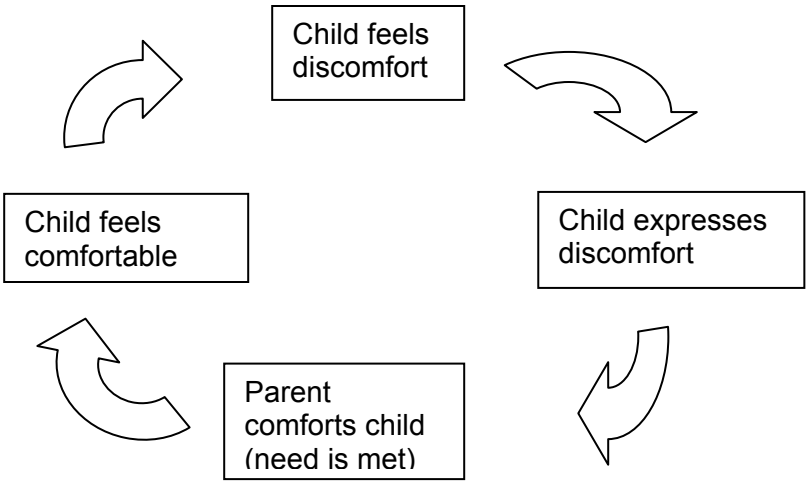
Attachment Defined

The organization of behaviors in the child that are designed to achieve physical proximity to a preferred caregiver at times when the child seeks comfort, support, nurturance or protections. (AACP, 2005)

Secure attachment: an exclusive attachment made between children and their contingent, sensitive caregivers, who provide nurture, comfort, buffering, shared exploration, and help. Parents represent a secure base for exploration.

Bonds: Close relationships which tend to be formed with teachers, friends, and others who have shared experiences and emotions. (Gray, 2007)

Arousal Relaxation Cycle



A The second method of developing attachment is for the parent to initiate a positive interaction with the child and the child then responds positively. This builds the self-worth and self-esteem. Example: A parent smiles and offers a child a favorite toy. The child laughs and takes the toy. Building a history of having positive interactions will strengthen attachment and help the relationship survive when a crisis occurs.

The third method is when a parent "claims" a child. "She looks just like my mother." "He acts like his father." This includes the process of sharing family history to enable the child to understand the family he is a member of.

Children do NOT learn to attach by being told to not love another person. Similarly having attachments broken by multiple placements does cause trauma and may lead the child having difficulties attaching in the future.

Examples of bonding activities that lead to attachment are:

- Responding to Arousal/Relaxation Cycle
  - Providing daily care for the child
  - Using child's tantrum to encourage attachment
  - Responding to child when he is physically ill
  - Helping child express and cope with feelings
  - Share child's excitement about her achievement

- Initiating Positive Interaction
  - Making affectionate overtures; hugs, kisses, physical closeness
  - Reading and playing games with the child
  - Helping child with homework
  - Going to fun events together
  - Saying, "I love you"
  - Teaching the child about extended family and culture

- Claiming Behaviors
  - Encouraging the child to call parents "mom" and "dad"
  - Hanging pictures of child in the house
  - Including child in family rituals
  - Buying clothes
  - Involving in religious or rite of passage events

.

Jennifer's Story

My name is Jennifer. I am sixteen years old. I went into foster care when I was a baby and then went back home when I was 5. In second grade my mom sent me to live with my grandmother. My grandmother died the next year and I went back to my mom. At age 9 I returned to foster care. I lived with two families and then an adoptive family. But the adoptive family decided they didn't want me. I lived with several families after that. They put me in a group home six months ago. I'm getting out of here and can you believe this? They're looking for another family for me. I'm thinking it might have made more sense if somebody had done more when I was a little kid.

I don't know when I realized that I was different from other kids. It feels like something I always knew. Like I was born with it. That there was something bad about me. I don't hate my parents but I don't think they should have been parents. One of my foster moms told me I was a drug baby. This may be true. I know they put me in foster care because no one was taking care of me and I wasn't growing. I can't remember a lot. But I felt an emptiness or a hurt for many years. I couldn't be filled up. I needed my mom. I needed for the confusion to end. I needed to feel like someone cared about me. When I was little and would see my mom I didn't know what to do. I don't remember a lot about my foster parents. All of that is sort of a blur. What did I need? I needed for the hurt deep inside of me to go away. That's all I could think about.

Worksheet: Jennifer's Needs

Statement	What does this indicate about what Jennifer may have needed to support positive attachment?
I don't know when I realized I was different from other kids. It feels like something I always knew. Like I was born different.	
That there was something bad about me.	
Told me I was a drug baby.	
They put me in foster care because no one was taking care of me and I wasn't growing.	
I needed my mom.	
When I was little and would see my Mom, I didn't know what to do.	
I don't remember a lot about my parents.	
I needed for the hurt deep inside of me to go away. That's all I could think about.	

Source: Adapted from Foster PRIDE/Adopt PRIDE Training Program. CWLA, Washington, D.C., 2003.

Attachment Timeline

How long does it take a normal child to develop an attachment by age of child?

Birth to 2 years Several days.
Therefore, if the parent has only one hour of contact with the child each week, the child begins to attach to the available caregiver.

2-5 year olds One week to two months

6-10 year olds Two months to six months

10-14 year olds Six months to a year

Separation Anxiety Disorder

- ✓ Recurrent excessive distress when separation from home or caretakers occurs or is anticipated;
- ✓ Persistent and chronic worry about losing a caretaker or that person being hurt;
- ✓ Persistent worrying that an event will lead to separation from a caretaker (e.g., getting lost or being kidnapped);
- ✓ Reluctance or refusal to go to school because of the fear of separation;
- ✓ Excessive fear of being alone at home or elsewhere without a caretaker;
- ✓ Reluctance or refusal to go to sleep without being near a caretaker or when away from home;
- ✓ Nightmares involving separation; and/or
- ✓ Complains of physical symptoms (i.e., headaches, stomach aches, nausea, vomiting) when separation from a caretaker takes place or is anticipated.

Stages of Grief

Kubler-Ross

DENIAL

- AVOIDANCE
- CONFUSION
- FEAR
- NUMBNESS
- BLAME

ANGER

- FRUSTRATION
- ANXIETY
- IRRITATION
- EMBARRASSMENT
- SHAME

DEPRESSION/SADNESS

- OVERWHELMED
- BLAHS
- LACK OF ENERGY
- HELPLESSNESS

BARGAINING

- REACHING OUT TO OTHERS
- DESIRE TO TELL ONE'S STORY
- STRUGGLE TO FIND MEANING FOR WHAT HAS HAPPENED

ACCEPTANCE/ADJUSTMENT

- EXPLORING OPTIONS
- A NEW PLAN IN PLACE

MODULE FIVE
IMPACT OF MALTREATMENT ON CHILD DEVELOPMENT

Isaiah Worksheet

1. What expressions of Grief did you identify in each individual and what made you decide:
   - Isaiah?

   - Adoptive Father?

   - Adoptive Mother?

   - Sister?

   - Case Manager?

   - Biological Mother?

2. How would a case manager know if Isaiah reached the acceptance/adjustment stage?

4. How is a permanency plan of reunification impacted by the acceptance/adjustment stage?

What Case Managers Need to Understand About the Grief Process

Expressions of Grief

D – Denial /Shock; **A** – Anger; **B** – Bargaining; **D** – Sadness/Depression;

A – Acceptance/Adjustment

Denial/Shock

Behavioral Expressions in Children

- Child may not show any emotional reaction to the move (i.e., the move is "taken in stride") (Example: "She waved good-bye to me at the door when I left; she was all smiles, and went off to play with the children and all the new toys")
- Child may deny the event happened and/or deny any negative feelings about the event (Example: "I'm not staying here. My mommy will be back for me soon" or "I'm just here for a little while, then I'm going home.")
- Child may appear to make a good adjustment to the placement for a period of time. Referred to as the "honeymoon period."
- Child may be emotionally numb. The child may seem quiet, compliant, or easy to please. In contrast with his normal behavior, this behavior appears passive and emotionally detached
- Child's behavior may appear robot-like. Child may go through the motions of daily activity, but there is a lack of commitment or conviction to the activities

What Case Managers Need to Understand About Denial/Shock

- A common error made by caseworkers, foster parents, and parents is to misinterpret the child's compliant and unemotional behavior, and judge the placement as "an easy move, he did fine."
- When a child is thought to have handled a move without distress, behavioral signs that emerge later may not be recognized as part of the grieving process. The child may be punished for the behaviors or the behaviors may be ignored or attributed to emotional or behavioral problems. This may intensify the child's distress and deprive him of needed support and help.
- Children who have not developed strong attachments to their caretakers may not react at all when moved. This lack of response may indicate that the child's ability to form relationships has been damaged. Absence of an emotional response, which extends beyond the first few weeks of out-of-home placement, should be of considerable concern to the caseworker and foster parent.

What Case Managers Need to Understand About the Grief Process

Anger

Behavioral Expressions in Children

- The child may be **oppositional and hypersensitive**. He may act out his feelings through angry outbursts; tantrums in response to minor events; blaming others, and verbal and physical aggression.
- In younger children, physical symptoms and emotional outbursts are common. In older children the anger may be directed into destructive and aggressive behaviors. Behaviors may include:
  - Tantrum behaviors and emotional, **angry outbursts**, which are easily precipitated and which seem excessive for the situation.
  - **Withdrawing, sulking, or pouting**; self-imposed isolation with refusal to participate in social interactions.
  - **Crabby and grouchy, hard to satisfy**.
  - **Aggressive or rough behavior with other children**; may bully or physically hurt other children.
  - Breaking toys or objects, lying, stealing, and other **anti-social behaviors**.
  - **Refusing to comply with requests**, rebellious and oppositional.
  - Teenagers may **run away or engage in other self-endangering behaviors**, such as substance abuse, self-mutilation, fighting.
  - **Toileting problems**—enuresis, encopresis may occur—as well as smearing of feces.
  - **May not talk, eat, or sleep**

What Case Managers Need to Understand About Anger

- The child's oppositional behavior may be disruptive to the foster family. Confrontations between the caretakers and the child may promote a struggle for control. Case managers should not be surprised or offended by phone calls from frustrated foster parents or schools who want you to "do something" about the child.
- There may be a tendency to want to punish the child for misbehavior. If the child's behavior is properly identified as an expression of normal grieving, caretakers are generally more able to provide support and give the child opportunities for appropriate expressions of angry feelings, while gently setting firm limits for the child's behavior.

What Case Managers Need to Understand About the Grief Process

Bargaining

Behavioral Expressions in Children

- The child may become "good as gold," eager to please, and **promise to do better**.
- The child may **try to undo what she feels she has done** to precipitate the placement. A child who believes she was "sent away" because she didn't eat her dinner will try hard to eat everything put in front of her.
- The child may **try to negotiate agreements with the caregiver or caseworker,** and will agree to do certain things in exchange for a promise that he will be allowed to return home. ("I'll go to counseling and get better grades, then can I can go home?")

What Case Managers Need to Understand About Bargaining

The child's willingness to be "good" may represent a desperate attempt to control the environment and to defend against feelings of emotional turmoil. In reality, there is little chance of the child's behaviors producing the desired results of reunification. Case managers should not allow themselves to be fooled by these surface behaviors. Maintaining realistic expectations about the child's behaviors will put case managers in a better position to provide the support needed when the child realizes the ineffectiveness of the bargaining strategy and begins to experience the full emotional impact of his loss.

Sadness/Depression

Behavioral Expressions in Children

- Adolescents may have suicidal ideation or actual suicide attempts. There may be an increase in substance use or abuse.
- Older children, responsible for their own care, may demonstrate a decline in self-care, hygiene, and general appearance.
- The child appears to have lost hope, and experiences the full emotional impact of the loss. The child/youth may exhibit the following:
  - Social and **emotional withdrawal** and failure to respond to other people. The young child may cling to adults, but the clinging is remote, forlorn, and detached. Older children may isolate themselves and avoid interaction.
  - The child may be generally "out of sorts," **touchy, vulnerable to minor stresses, easily hurt.** He may cry with little or no provocation.
  - The child may be **extremely anxious, easily frightened, frustrated, and overwhelmed** by minor events and stresses.
  - The child is **without direction or energy**, listless. He appears distracted and lost.

What Case Managers Need to Understand About the Grief Process

- The child may play sporadically, but his activities are mechanical without investment or interest. There is little goal-directed activity--the child drifts from one thing to another with a **short attention span**. The child is **unable to concentrate,** which often results in school problems or failure.
- The child may demonstrate **regressive behaviors**, such as thumb sucking, toilet accidents, or baby talk.
- **General emotional distress** is often seen in younger children, including whimpering, crying, head banging, rocking, refusal to eat, excessive sleeping, vomiting and other stomach upsets, and susceptibility to colds, flu, and illness.

What Case Managers Need to Understand About Sadness/Depression

There may be a considerable lapse of time between the original separation and the onset of depressive behavior in the child. Case managers should be aware of this, so that they don't attribute the child's behavior to a more recent cause, when it actually could be their demonstration of depression over the earlier separation.

Acceptance//Adjustment

Behavioral Expressions in Children

- Demonstrates an increased energy level
- Child becomes receptive to making emotional connections
- The child demonstrates a healthy sense of attachment to the substitute caregivers, including developing a sense of security in the new environment
- The intensity of emotional distress decreases, and the child begins to experience **pleasure in normal childhood play and activities**
- The child who is punished for autonomous behavior may learn that self-assertion is dangerous and may assume a more dependent posture. He may exhibit few options, show no strong likes or dislikes, may not be engaged into productive, goal-directed activity. The child may lack initiative, give up quickly, and withdraw from challenge.
- The child is able to engage in **goal directed activities** again

What Case Managers Need to Understand About Acceptance/Adjustment

Behaviors in the child that suggest the child is adjusting are generally positive signs, as they indicate that the child is coping with the separation appropriately; **however**, it is critical to keep the Permanency goal in mind! If permanent separation is not part of the case plan, then significant adaptive behavior by the child is not desired. It is inappropriate for a child to totally resolve the loss of his family, if the permanency plan is reunification

MODULE SIX
EDUCATION FOR CHILDREN IN CARE

Education for Children in Care

MODULE SIX
EDUCATION FOR CHILDREN IN CARE

Learning Objectives:

Upon completion of this module Case Managers will be able to:

- Articulate the importance of educational success for children and youth
- Identify educational services, laws and supports for children and youth
- Identify the supports that schools can provide to case managers and youth in care
- Identify Educational Outcomes from the CFSR
- Determine information be documented in the case record

Statistics about Foster Youth and Education

Endless Dreams Video Training Fact Sheet **Treehouse** (2000):

Foster youth are 50 – 100 percent more likely to fail a grade

Approximately 50% of youth in foster care are enrolled special education programs

60% of youth in foster care do not graduate from high school

25% of youth in foster care are homeless in the 12-18 months after leaving foster care at the age of 18.

- 34% end up on welfare
- 25% of males are imprisoned
- 20% of females give birth

Many students in foster care have high rates of absenteeism, tardiness and discipline problems

MODULE SIX
EDUCATION FOR CHILDREN IN CARE

EDUCATION GOALS FOR YOUTH IN OUT-OF-HOME CARE

Goal 1: Youth Are Entitled to Remain in Their Same School When Feasible

Goal 2: Youth Are Guaranteed Seamless Transitions Between Schools and School Districts When School Moves Occur

Goal 3: Young Children Enter School Ready to Learn

Goal 4: Youth Have the Opportunity and Support to Fully Participate in All Aspects of the School Experience

Goal 5: Youth Have Supports to Prevent School Dropout, Truancy, and Disciplinary Actions

Goal 6: Youth Are Involved and Engaged in All Aspects of Their Education and Educational Planning and Are Empowered to Be Advocates for Their Education Needs and Pursuits

Goal 7: Youth Have An Adult Who Is Invested in His or Her Education During and After His or Her Time in Out-Of-Home Care

Goal 8: Youth Have Supports to Enter into, and Complete, Postsecondary Education

MODULE SIX
EDUCATION FOR CHILDREN IN CARE

Laws Regarding School Services

Individuals with Disabilities Education Improvement Act of 2004

Section 504 of the Rehabilitation Act

Americans with Disabilities Act 1990

No Child Left Behind Act (NCLB), Public Law 107-110

McKinney-Vento Homeless Education Assistance Act

MODULE SIX
EDUCATION FOR CHILDREN IN CARE

Endless Dreams Worksheet

INSTRUCTIONS: Complete the following worksheet as you view the video.

1. Most children in foster care or out-of-home care have never had a _____.

2. Researchers have found that children _____ academically _____ with every school move.

3. Often when children are moved they _____ the cause of the move and feel like it is their fault.

4. Schools expect children to sit down, focus, and get to their schoolwork. This is often difficult for children in foster care who have so many emotional issues and familial problems on their minds**.**

   True or False

5. In some cases, children might choose _____ to hide the trauma they have been in.

6. _____ among all the adults that work with the child is vital.

7. The following are techniques or tactics suggested or discussed in the video to help children or youth in foster care succeed in school:
   - ✓ Use a track sheet to facilitate communication between _____ and _____.
   - ✓ Build a _____ with the child.
   - ✓ Provide the child with an opportunity to _____ appropriate behaviors.
   - ✓ Provide the child with _____, order, and safety.
   - ✓ Help the child or youth with _____ skills, study skills, and note taking skills.
   - ✓ Maintain _____ among all adults involved with the child.

MODULE SIX
EDUCATION FOR CHILDREN IN CARE

Issues to Address in Order to Improve Performance on WB2 Outcome

- Failure to provide appropriate educational services
- Multiple school changes as a result of changes in foster placement
- Educational records missing from case file or not provided to foster parents
- Inadequate educational advocacy
- Issues with school/agency relationships, communication or cooperation
- Failure to address educational needs in case plans
- Failure to address school absenteeism, tardiness and truancy
- Although the educational needs of foster children often are neglected; state child welfare agencies appear to pay even less attention to the educational needs of children who remain at home.
- Foster parents often are more involved than are case managers in advocating with schools for educational services
- Both foster parents and case managers need training in school policies, special education programs and development of individualized education plans

MODULE SIX
EDUCATION FOR CHILDREN IN CARE

Ideas to meet Educational Needs:

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EDUCATION FOR CHILDREN IN CARE

Types of Assistance/Services Available from the School

- Provide information and referrals to DFCS staff regarding educational services for children
- Assist in case planning to identify specific educational needs and services through individual case staffing and attending agency meetings as needed
- Assist CPS/FC staff in reviewing and interpreting IEPs and 504s
- Provide technical assistance to case managers to ensure that individual children receive appropriate education services
- Assist case managers to ensure that the appropriate documentation is included in the education record
- Assist case managers with referrals to the Pre-Kindergarten Program
- Provide Special Education Services
- Reasonable accommodations for disabilities under Section 504
- Provide bilingual education
- Assist case managers with referrals to Gifted and talented education programs
- Assist case managers with guidance about career and technology education programs
- G.E.D. programs (Should be considered only as a last resort)
- Free and Reduced Lunch (all children in State custody are eligible for free and reduced lunch)
- Head Start (all children in State custody age 3-5 are eligible)
- Private Tutoring (regional funds may be available for private tutoring for children needing extra assistance)
- After School Programs
- College tuition/HOPE grant (assistance for eligible children)

MODULE SIX
EDUCATION FOR CHILDREN IN CARE

Questions to Ask When Identifying Child's Educational Needs

- What are his/her strengths in school?
- What are his/her weaknesses in school?
- Are there gaps in the child's education?
- Is he/she failing classes?
- Has he/she ever been retained or held back?
- Does he/she need tutoring?
- Did he/she master the objectives on the ITBS/CRCT test?
- Did he/she receive any special services at his/her previous school (i.e. speech, occupational, physical therapy, content mastery, resource classes, behavior intervention class, modified assignments or tests, bi-lingual classes, gifted and talented classes, Advanced Placement (AP) classes, etc.)?
- Does he/she have behavior problems at school that affect his/her learning?
- Does he/she have attention problems at school that make it difficult to learn? Has he/she been diagnosed with ADD/ADHD?
- Has he/she received special education services or other accommodations in the past?
- Has he/she been diagnosed with or is he/she suspected to have any of the following disabilities that might affect his/her education:
    - Autism, Auditory Impairment, Visual Impairment, Deaf/Blind, Speech Impairment, Traumatic Brain Injury, Orthopedic Impairment, Mental Retardation, Learning Disability, Emotional Disturbance, or Multiple Disabilities? (If yes, may be eligible for special education)

For children age 3-4:

- Would he/she benefit from a preschool program to help prepare him/her for kindergarten?
- Did he/she receive Babies Can't Wait services up until age 3, and would he/she benefit from similar services continued through the school district?

For grades 9-12:

- How many credits do they currently have? How many do they need to graduate?
- Does he/she need assistance in preparing for the Graduation Exam?
- Does he/she plan to attend post-secondary training or education, and is he/she on the right track to fulfill all prerequisites for acceptance?
- Was he/she previously involved in or have an interest in participating in school programs (i.e. athletics, band, ROTC, clubs, student council)?

Information to Include in the Case Record

- ✓ Report Card (Current School Year)
- ✓ Progress Reports
- ✓ Placement Authorization Forms
- ✓ List of any medications taken during the school day (Give a copy to the school nurse)
- ✓ Awards/Letters of Achievement
- ✓ Standardized testing scores
- ✓ Correspondence to and from school (letters from Teachers/Principles, Discipline Referrals, Other)
- ✓ School photographs, Class Group Photos, Team Photos

Secondary (9-12) Students only

- ✓ Class Schedules (Secondary 9-12 students only)
- ✓ Graduation Test Scores (Secondary 9-12 students only)
- ✓ College Entrance Exams (PSAT, SAT, ACT)

Children served via Special Education also should have:

- ✓ Referrals for specific education services
- ✓ Meeting notices for current school year
- ✓ Initial and current assessments and evaluations from the school system
- ✓ IEP (Individualized Education Program) updated annually
- ✓ IEP Progress Reports
- ✓ Section 504 Plans
- ✓ Current Individual Family Service Plan (IFSP) if receiving services from Early Childhood Intervention.

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Examples of Information to be Included in the Case Plan

The child's current school placement (School Name, Address, Phone Number, Principal's Name, Teacher's Name), educational needs, any limitations in the child's English-speaking proficiency and adjustment to school, including strengths.

Example: Johnny is in the 1st grade at Lee Elementary School 202 First Street, Fayetteville. . The principle is Mr. Neal Brown and his teacher is Sharon Flanders. Johnny is at risk of failing math and is in need of tutoring. The foster parent made arrangements with his teacher and the foster parent agreed to take Johnny early for morning tutoring. Johnny's first language is Spanish, but he speaks English well enough to succeed in the regular classroom. Johnny's favorite subject is Music.

Example: Annie is in the 3rd grade at the Sussex Elementary, 24 North Avenue, Hapeville. The principle is Marvin Jones and her teacher is Evelyn Moore. This school is the closest to the foster home. Annie's removal was the week prior to the ITBS test, and because her scores were low on the ITBS test, Annie is at risk of being retained in the 3rd grade. Annie will need to attend summer school to take the test again and attempt to pass it so she can be promoted to the 4th grade. Annie has been referred for a special education evaluation. She enjoys learning, but is having difficulty due to her family situation.

Any special education or remedial assistance the child may be receiving. If child has had an IEP or 504 Plan, include information regarding dates and issues.

Example: Steven was evaluated for special education services this school year, but the testing suggested that he did not qualify."

Example: Tonya is receiving special education services. She is in a resource classroom for math, and receives special assistance in the mainstream classroom for all other subjects. Her last IEP Meeting was on April 15th, and the IEP committee meeting summary is included in the case file."

Always include the current school and grade

Enter enrollment/withdraw dates and grades each time the child changes schools during the school year.

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Resources for Case Managers, Families and Foster Families

Georgia Board of Education
Director of Special Education
Nancy O'Hara
Director, Special Education Services
1870 Twin Towers East
205 Jesse Hill Jr. Drive SE
Atlanta, GA 30334
(404) 656-3963
(404) 651-6457
nohara@doe.k12.ga.us

Kim Hartsell
Director, Special Education Supports
1870 Twin Towers East
205 Jesse Hill Jr. Drive SE
Atlanta, GA 30334
(404) 656-3963
(404) 651-6457
khartsel@doe.k12.ga.us
Department of Public Instruction

Office of Civil Rights Region IV - Atlanta
Roosevelt Freeman, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Atlanta Federal Center, Suite 3B70
61 Forsyth Street, S.W.
Atlanta, GA 30303-8909
Voice Phone (404)562-7886
FAX (404)562-7881
TDD (404)331-2867

National Center for Learning Disabilities
1401 New York Avenue, NW, Suite 900
Washington, D.C. 20005
Voice: (202) 879-5773 Fax: (202) 879-5773

National Association of State Directors of Special Education (NASDSE)
1800 Diagonal Road, Suite 320
Alexandria, VA 22314
Voice: (703) 519-7008 TDD: (703) 519-7008

National Association of Developmental Disabilities Councils
1234 Massachusetts Avenue, NW, Suite 103
Washington, D.C. 20005
Voice: (202) 347-1234 E-mail: naddc@igc.apc.org
Website: www.naddc.org
National Parent Network on Disabilities (NPND)
1727 King Street, Suite 305
Alexandria, VA 22314
Voice: (703) 684-6763 E-mail: npnd@cs.com

Government Agencies

Administration on Developmental Disabilities
U.S. Department of Health and Human Services
Hubert Humphrey Building, Room 329D
200 Independence Avenue, SW
Washington, D.C. 20201
Voice: (202) 690-6590 TTY: (202) 690-6415

Clearinghouse on Disability Information
Office of Special Education and Rehabilitative Services
U.S. Department of Education
Switzer Building, Room 3132
330 C Street, SW
Washington, D.C. 20202-2524
Voice: (202) 205-8241

National Library Service for the Blind and Physically Handicapped
Library of Congress
1291 Taylor Street, NW
Washington, D.C. 20542
Voice: (202) 707-5100 TTY: (202) 707-0744

Office of Special Education Programs
U.S. Department of Education
MES Building, Room 3086
600 Independence Avenue, SW
Washington, D.C. 20202-4611
Voice: (202) 205-5507

Eric Clearinghouse on Disabilities and Gifted Education
Council for Exceptional Children
1920 Association Drive
Reston, VA 20191-1589
Voice: (800) LET-ERIC or (703) 264-9475
E-mail: ericec@cec.sped.org Website: http://ericec.org

National Parent to Parent Support and Information System

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EDUCATION FOR CHILDREN IN CARE

C/O Kathleen Judd
P.O. Box 907
Blue Ridge, VA 30513
(800) 651-1151
E-mail: judd103w@wonder.em.cdc.gov

Law
Legal information, links and resources about state laws, federal laws and statutes, lawyers and attorneys. www.alllaw.com

Information Lines/Hotlines
Americans with Disabilities (ADA) Information Line
(800) 514-0301

U.S. Department of Education Information Resource Center
(800) USA-LEARN

U.S. Department of Justice ADA Information Line
(800) 515-0301

Exceptional Children's Assistance Center (ECAC)
(800) 962-6817

Internet Sites

IDEA Parent Guide http://www.ncld.org/content/view/900/456084/

Special Education Resources on the Web http://www.seriweb.com/

Our Kids (Parenting resource site) www.our-kids.org

Parents Place www.parentsplace.com/index.htm

Including Your Child (NPIN Virtual Library) http://npin.org/library/1998/n00006/index.html

Foster Parent Community www.fosterparents.com

Foster Parent Resources www.fostercare.org/FPHP

Parent Soup http://parentsoup.com

Positive Parenting http://positiveparenting.com

About Website – page on Special Needs www.specialchildren.about.com

Center for Children with Special Needs www.cshcn.org

Children's Disabilities www.childrensdisabilities.info

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Federation for Children with Special Needs www.fcsn.org

ICanOnline (a great website about disability) www.icanonline.net

Our-Kids www.our-kids.org

Special Child www.specialchild.com

Special Needs Resources www.fostercare.org/FPHP/fpspecl.htm

Educational Surrogate Program Q & A
www.dese.state.mo.us/divspeced/Compliance/edSurrogate/surrogatebrochure.htm

Casey www.casey.org www.casey.org/cnc/support_retention/nav_education.htm

North American Council on Adoptable Children www.nacac.org

National Foster Parent Association www.NFPAinc.org

PATH www.pathinc.org

Foster Care Support Network www.fostercaresupport.net

Connect for Kids www.connectforkids.org

Children's Advocacy Institute www.caichildlaw.org

Pacer Center Inc. www.fape.org/pubs/FAPE-25%20Planning%20Your%20Childs%20IEP.pdf

Oregon Parent Training and Information Center www.open.org/-orpti

Special Education in Plain Language www.cesa7.k12.wi.us/sped/Parents/plglossary.htm

National Center for Homeless Education (located in Greensboro, N.C.)
www.asbj.com/current/coverstaory.html

ED.gov www.ed.gov/offices/OSERS/IDEA/the_law.html

Special Ed Connection Splash Page www.lrp.com/ed

FAPE Publications (helping parents and advocates improve educational results for children with disabilities) www.fape.org/pubs/index.htm

NLD on the web – Your child's IEP www.nldontheweb.org/wright-3.htm

Planning your child's Individualized Education Program www.fape.org
Child Law Practice (ABA) www.abanet.org/child

Children's Advocacy Institute Web www.caichildlaw.org

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Schwab Learning (for parents and children with learning disabilities) www.schwablearning.org
(parents) www.sparktop.org (children)

http://www.hottolearn.com (learning styles)

http://www.SparkTop.org (8-12 year olds learning & attention problems)

http://www.ideallives.com (articles)

http://www.post-gazette.com/regionstate/20020228foster4.asp

http://www.bridges4kids.org

http://www.teacherstoolkit.com/classroom4.htm

http://www.connectforkids.org/cnlib/pub/print_article.htm?url

http://www.ideallives.com/resource_kits.html

http://www.nichcy.org/reauth/goodman.htm

http://www.cesa7.k12.wi.us/sped/parents/plglossary.htm (glossary of Special Ed)

http://www.advocate_tools@sendfree.com (free kit)

http://www.iser.com/CAadvocacy.html

http://www.nldontheweb.org/wright-3.htm (IEP's)

http://www.adhd-add.info/ (wonderful site)

http://www.ldonline.org (learning disabilities)

Suggested Books

From Emotions to Advocacy (The Special Education Survival Guide)
By Pam & Pete Wright

Guidebook for Raising Foster Children
By Susan McNair Blatt, M.D.

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EDUCATION FOR CHILDREN IN CARE

Suggested Articles

IDEA Parent Guide http://www.ncld.org/content/view/900/456084/

Readers Talk Back
October 2002 (Connect For Kids Website)

Parent Involvement in Schools
October 2002 (Connect For Kids Site)

More Than A's and B's
By Julee Newberger (Connect For Kids Site)

Help for Foster Parents by Nancy Duncan (Connect For Kids Site)

Education Advocacy in Child Welfare Cases: Key Issues and Roles
By Kathleen McNaught (Child Law Practice (ABA) website- November 2002)

Education Law Primer for Child Welfare Professional – Part I & II
By Kathleen McNaught (Child Law Practice (ABA) website- March 2003)

IEP Secrets Revealed
By Dani and Gene Feirstein (www.nfpainc.org – National Advocate, Fall 2003)

Advocating in School for the Children in Your Care
By Casey Family Program (www.nfpainc.org – National Advocate,Fall 2003)

Individualized Education Program: Is It Really Worth the Effort of the Foster Parent to Participate?
By Carl Christman (www.nfpainc.org –National Advocate , Fall 2003)

Training Foster Parents to Help Children with Special Education Need
By Paulette Meier (www.nfpainc.org – National Advocate, Fall 2003)

Foster Parents and IEPs/Advocating for Your Child's Education
By Jan Kjelland (September 2003, Impact Publications, Inc., Foster Care Support Network)

Are We Ignoring Foster Youth with Disabilities?
By Dr. Sarah Geenen (Fostering Futures Project, Spring 2003)

School and Foster Children
By Susan McNair Blatt, M.D. (www.nfpainc.org – National Advocate, Fall 2003)

The IEP Notebook
By Sue Thompson (www.nldontheweb.org/thompson-3.htm - for individual use only)

Your Child's IEP: Practical and Legal Guidance for Parents
By Pamela and Pete Wright (www.nldontheweb.org/wright-3.htm)

MODULE SEVEN
PLACEMENT AUTHORITY AND COURT

Placement Authority and Court

MODULE SEVEN
PLACEMENT AUTHORITY AND COURT

LEARNING OBJECTIVES:

Upon completion of this module case managers will be able to:

- Describe how a case enters the court system.
- Identify the perspectives and roles of the various participants in a child abuse /neglect court case.
- Summarize the juvenile court process.
- Gain a general overview of placement authorities, be able to identify various court hearings, define how a case enters the court system, and summarize the juvenile court process.
- Describe proper court appearance
- Be prepared to appear in court.

MODULE SEVEN
PLACEMENT AUTHORITY AND COURT

TYPES OF PLACEMENT AUTHORITY

Short-Term Emergency Care

- Custodian unable to provide care because of an immediate emergency or illness
- Child not in imminent risk of abuse or neglect (other than the potential risk from being without a caretaker)
- Maximum of 7 calendar days

Superior Court Order

- DFCS ordered to provide placement services
- Divorce proceedings/ custody battles

Consent to Remain in Care

- Youth age 18-21
- Complete educational goals

Voluntary Agreement to Place Child In Foster Care

- Families experiencing short-term crisis
- 90 days with possibility of one 90-day extension
- No indication of abuse or neglect

Voluntary Surrender of Parental Rights

- Parents willingly want to surrender rights to a child
- Parent places child with Agency for adoption
- Final after 10 days, if not withdrawn
- DFCS obligated to place child with appropriate adoptive resources

Termination of Parental Rights

- Reunification efforts were made, but failed, and the child cannot be safely returned home
- Reunification efforts were not appropriate because of specific circumstances
- Required after child has been in care 15 out of 22 months, unless a compelling reason exists
- Method of achieving permanency through adoption

Temporary Custody Order

- Granted by Juvenile Court
- Child determined to be deprived
- Limited to 12 months from date child removed from the home
- DFCS becomes child's legal custodian

MODULE SEVEN
PLACEMENT AUTHORITY AND COURT

JUVENILE COURT PROCESS FC Policy 1002.2		
ACTION	**HOW ACCOMPLISHED (PROCESS)**	**OUTCOME**
Child removed from home for his safety and protection and is placed in care **(Emergency Pick-up order or Shelter Care order)**	• DFCS files a deprivation complaint or petition; or • Court issues an ex parte order or other such order granting authority; or • Law enforcement or officer of the court removes and obtains approval from the court authorizing DFCS to take placement responsibility; or A verbal order is issued by a juvenile court judge (only if followed by a written order which is obtained the first work day after the issuance of a verbal order).	Child considered in protective custody until an informal detention hearing within 72 hours is held. A written order signed by the judge (or designated court personnel) should be obtained for the case record as the documented legal authority to hold a child.
72-Hour Hearing (Detention Hearing)	• Scheduled as a result of the filing of a deprivation complaint or petition. • Purpose is to allow the court to determine whether there is probable cause to believe that the allegations of the complaint are true.	If the judge finds probable cause, then the child remains in shelter care. A petition must be presented to the court within five calendar days of the 72-hour hearing.
Adjudicatory (10-Day) Hearing	• Held within ten calendar days (unless continued by the court) of filing the deprivation petition. • Purpose is to determine whether the allegations in the petition are true and if the child is "deprived" for purposes of the Juvenile Court Code. • A dispositional hearing may be held immediately following the adjudicatory hearing or continued until another date.	After hearing the evidence, the court will make and file findings regarding the child's deprivation, including whether such deprivation is found as a result of alcohol or other drug abuse. Such findings become the basis of the Case Plan for Reunification. Judicial determination may be made at this time (or in a later order) as to whether DFCS is making **"*reasonable efforts to preserve and reunify families*."**
Dispositional Hearing	• Purpose is to determine what actions and recommendations are in the best interest of the child now that he/she has been found "deprived." • If available, DFCS should share the results of the Comprehensive Assessment with the court to assist decision-making re: the placement and needed service activities.	The possible dispositional alternatives are: • Permit the child to remain with parent or other custodian, possibly with supervision;

MODULE SEVEN
PLACEMENT AUTHORITY AND COURT

JUVENILE COURT PROCESS FC Policy 1002.2		
ACTION	**HOW ACCOMPLISHED (PROCESS)**	**OUTCOME**
	• The Initial Case Plan may be incorporated into the dispositional order of the court (or in a later supplemental order).	• Transfer temporary legal custody to DFCS, another agency or any individual (including a putative father) who has been studied and approved for the care of the child.
Motion Hearing (Extension of Custody)	• Held within 12 months from the date the child is removed from the home for purposes of extending custody. • It is recommended that DFCS file for a motion hearing within 90 to 120 days of the expiration of the temporary custody order. A permanency hearing may be held at the time of the extension hearing.	If granted, this single extension of custody is for a period not to exceed 12 months.
(Case Plan) Review Hearing	• Held if the parent disagrees with Case Plan and exercises his/her right to request a hearing before the court within 5 days of receipt of the Plan.	Upon reviewing the Case Plan and hearing evidence, the court may issue a supplemental order to incorporate any. changes/revisions.
Permanency Hearing	• Held whenever a Non-Reunification Case Plan is submitted to the court, then a hearing shall be scheduled 30 days from the filing of the Plan; or held within 12 months of removal of the child to determine the permanency plan and set the future course of the case (whichever comes first). • Thereafter, held every 12 months as long as the child remains in care. (Can be held in conjunction with the Motion Hearing to extend custody.)	A permanency plan finding is made. Other findings, if applicable, are made with respect to the child in out-of-state placement or for the youth age 14 and over. An order is entered (usually within 30 days of the permanency hearing) documenting the court's findings.
Review Hearings	• May be held at any time by the court to determine the continued appropriateness of the Case Plan goals /services and the progress to date; overall case outcome for permanency is the focus.	At the time of every review, DFCS will be expected to indicate whether when the Agency intends to file a petition for TPR. A supplemental order may be entered if there are Case Plan revisions.

MODULE SEVEN
PLACEMENT AUTHORITY AND COURT

Professional Dress Guidelines

- A neutral colored suit in navy or another dark color with a skirt. (Check with your Agency to see if pants are allowed in court.)
- Skirt length should be a little below the knee and never shorter than above the knee
- Blouses should be cotton or silk (White of light pastel color)
- Panty hose should be flawless (no runs) and conservative in color. (You may want to bring an extra pair with you.)
- Basic pumps with 1”-2” heel (No strappy sandals or platforms)
- Simple accessories. No visible body piercings (now rings, eyebrow rings, etc.) No visible tattoos.
- Make-up should be minimal and in conservative tones
- Minimal cologne or perfume
- Light briefcase

Professional Dress Guidelines

- A two piece suite in navy or another dark color
- A tie in a simple pattern that matches the colors of your suit
- Button down dress shirt (white or pastel)
- Polished dress shoes in a dark color
- No earrings! If you normally ear one, take it out
- Hair should be clean and neat.
- Clean trimmed fingernails
- Minimal Cologne
- Light briefcase

Demeanor in Court

- Do not bring food or drinks into the courtroom.
- Do not chew gum or have anything in your mouth that will need to be spit out.
- Do not smoke in the courthouse.
- Do not use your cellular phone or even have it turned on when you are in the courtroom.
- Do not have your pager turned on while you are in the courtroom (unless it is a silent pager).
- Turn off your watch alarm.
- Do not talk when the Judge is speaking. If necessary, take conversations outside the courtroom.
- Address the Judge as "Your Honor."
- Remember, someone is always watching you.

MODULE SEVEN
PLACEMENT AUTHORITY AND COURT

TIPS FOR CASEWORKERS ON TESTIFYING IN COURT

WHAT TO EXPECT

You'll answer questions from attorneys and the judge or magistrate.

During you testimony, attorneys may make "objections."

If the objection is overruled, answer the question.

If the objection is sustained, do not answer.

The judge decides whether your testimony is credible and persuasive.

DIRECT EXAMINATION

The attorney cannot ask "leading questions" during direct examination.

When testifying about your first-hand knowledge, state the facts only.

Offer opinions based on your area of expertise.

Answer all questions truthfully to the extent of your knowledge.

Preferred statement: "I don't remember."

General answers may be enough if you don't recall details.

After cross-examination, the agency attorney may ask more questions.

MODULE SEVEN
PLACEMENT AUTHORITY AND COURT

CROSS-EXAMINATION

Maintain a professional demeanor at all times and answer each question truthfully to the best of your ability.

The cross-examining attorney may ask you about your qualifications.

The questions often require you to only give brief answers.

Do not dodge cross-examination questions.

Always answer the question that is asked, not the question that you would have preferred had been asked.

Be wary of “trick question.”

The cross-examining attorney may be hostile to put you on the defensive.

The agency attorney will protect you from improper attorney behavior.

PREPARATION

- Learn the legal requirements for the hearing so you know what the judge wants to know.
- Review the case record and highlight all key information.
- Meet with your supervisor and previous social workers, if possible, to go over the case.
- Talk with the agency attorney about what areas should be covered at the hearing.

MODULE SEVEN
PLACEMENT AUTHORITY AND COURT

TESTIFYING ON REASONABLE EFFORTS

When you testify, be ready to answer these questions:

Case Plan

- What family problems endanger the child?
- How did you involve the parents in developing the service plan?
- What is the service plan for all family members?

Service History: For each service offered, before or after the child was removed:

- What is the service and the goal?
- Who is the service provider?
- When was the service offered to the family?
- Did the family agree to participate?
- How long was the service provided?
- How often was the service provided?
- How did you make the service accessible to the family?
- Did the family complete the service?
- What was the impact of the service on family problems?
- If preventative or reunification services were not offered, why not?

Visitation History: If the child has been removed before the hearing:

- How often was the parent scheduled to visit the child?
- How often did the parent visit?
- How did you make visiting accessible to the parent?
- Was visitation supervised? Who supervises? Why?
- Was visitation restricted? When? How? Why?
- Was visitation suspended? When? Why?
- How was the quality of parent-child interaction during visits?

Your Contacts with Child and Family

- How often did you see or talk to the child? Where?
- How often did you contact each parent?
- If contact was suspended, why?

For contested hearings, meet with the agency attorney in advance.
Lay out all the key information in the case, good and bad. The attorney will tell you what questions will be asked in direct examination. Discuss potential cross-examination questions. Ask any legal questions you have.

Excerpted from: *Iowa Child Welfare Law: A Manual for Social Workers,* 2d ed., 105: by Debra Ratterman Baker (ABA Center on Children and the Law, 1998)

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE

Focusing on Strengths and Change

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE

Learning Objectives:

Upon completion of this module Case Managers will be able to:

- Identify the six principles of strength based Practice
- Identify the four factors critical for positive change behavior
- Identify family strengths and the impact of the use of case manager authority
- Define the circles of strength and supports found within families and work with families to identify and promote these resources and strengths.
- Use positive, strength based language when working with families.
- Practice positive and strength based ways to give directions, advice or suggest a change of behavior
- Use family strengths as benchmarks to assess the status of a family over the course of time
- Define characteristics of each stage of change in the Prochaska/DiClemente model of Trans-Theoretical Change
- **E**mpathize with families feelings of the intrusion into their lives from DFCS involvement**.**
- Experience empathy for the feelings and behaviors of resistance in families and learn strategies to engage the families and reduce the levels of resistance.
- Identify and use methods for engaging cooperation with the family.
- Identify and use strategies that help clients move toward change
- Recognize the stages of change and be able to motivate the client at each stage.
- Recognize that sometimes clients use traps, lies and deception and apply skills to deter these behaviors.
- Define family team meeting and how it is used to promote strengths and build relationships with the family
- Define the structural overview of family team meetings.
- Recognize and apply the benefits of family team meetings to case management practice.

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE

What Do We Mean by Strength-Based?

Strength defined:

"capacity for exertion or endurance; a strong attribute or inherent asset" (Moore et al, 2002)

Family strengths:

- Are developed from a set of supportive relationships.
- Are processes that support and protect families and family members, especially during times of adversity and change.
- Help to maintain family cohesion while also supporting the development and well-being of individual family members.

The absence of strengths can be as problematic for children as the presence of deficits.

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE

SIX PRINCIPLES OF STRENGTH BASED PRACTICE

Accountability

Action

Believing

Brief

Cooperation and Competence

Advantages

QUESTIONS TO DETERMINE ACTION

- Asking the family member about any changes already taken since the child welfare agency first intervened (change question)

- Asking about how the family member's behavior was different at times when the problem did not occur (exception question)

- Asking the family member to imagine that a miracle has happened and the problems have been solved. Then ask for a description of what would be different in his/her life. (miracle question)

- Asking the family member to specify on a scale of 1 to 10 progress made towards solving a particular problem. This is done by establishing a baseline the first time this question is asked, and subsequently referring to the baseline to measure continued progress. (scaling question)

Four Critical Factors for Positive Change

Client Factors (40%)

The client's preexisting assets and challenges

Relationship Factors (30%)

The connection between client and case manager

Hope and Expectancy (15%)

The client's expectation that work will lead to positive change

Model/Technique (15%)

Case Manager procedures, techniques and beliefs

Clark 2001

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE
POSITIVE FAMILY PROCESSES

Positive family processes help us feel "normal" and are essential, especially in tough times/times of crisis. The following is a general list of processes.

- Positive mental health of parents
- Household routines
- Time use
- Consistent mealtime gatherings
- Communication and praise
- Monitoring, supervising and involvement
- Parent-child warmth and supportiveness
- Valuing elders of the family
- Employment / consistent income
- Cultural and religious rituals and celebration practices
- Other family processes that are not mentioned here that could also be considered *strengths* in a family

What about YOUR family? (Your birth family or the family you have created for yourself)

Tip:
These are some of the specific processes you can discuss with families when inviting them to identify their strengths.

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE
Based on a True Story

Once upon a time there was an African American Twelve-Year-Old Girl who lived with her family. Her mother and father were devoutly religious and attended a Baptist Church where they were very connected. One day her father found out that the Twelve-Year-Old Girl had lied. He wanted to teach her not to lie. So, he punished her by hitting her on the arm with a belt, leaving bruises. Several days later the Twelve-Year-Old Girl's school teacher saw the bruises. When the girl told the teacher that her father had punished her for lying, the teacher called CPS.

A CPS Assessor went to the home of the Twelve-Year-Old Girl. The CPS Assessor talked with the girl, with the mother, and with the father. The CPS Assessor then decided that the girl was in danger of being harmed, and she proceeded to tell the parents that she was going to remove the Twelve-Year-Old Girl from their home and put her in a foster home. The mother asked the CPS Assessor to contact their Pastor, who is the father's cousin, to help resolve the situation. The CPS Assessor said she didn't have time to talk to the Pastor, as that wouldn't change the outcome today and she needed to work on removing the Twelve-Year-Old Girl.

They argued. The father told the CPS Assessor that he had never hit the girl before. He told the CPS Assessor that he loved his daughter very much and that he wanted her to learn to respect her parents and not to lie to them. The CPS Assessor said that he had shown very bad parenting skills and that she was going to take him to court so that the court would order him to take parenting courses in order to learn to be a better parent. This made the father very angry. Or maybe it was just the attitude of the worker. Or maybe it was that it was late in the afternoon and everyone was tired and hungry. Nobody knows. But the father got very mad. He was angrier than he had ever been before.

Everyone was yelling. The Twelve-Year-Old Girl was crying. The CPS Assessor said that she was going to call the police to assist her with the removal. Then the girl would be safe. She would be away from her mother and father in a foster home.

When the CPS Assessor said this, the father became so mad that he yelled to the CPS Assessor, "Okay then, take her!" And he packed her bags. He gave the CPS Assessor the bags. He shoved the girl into the arms of the CPS Assessor. By this time, the Girl was sobbing, pleading and pulling on her father's arms. The Girl had never seen a CPS Assessor before. She was afraid of going to a foster home. She had never seen her father so angry. She had never seen her father cry. She was very, very scared.

So, the CPS Assessor took the Twelve-Year-Old Girl, still crying, out the front door, and while still standing in the front yard, she called the police from her cell phone.

Now it was very late in the day, about 5:00 p.m. The CPS Assessor had to leave because she had her own daughter to pick up at school. She called her office for another worker to come and finish the task of removing the Twelve-Year-Old Girl from her home. By the time the On-Call Case Manager arrived, the CPS Assessor was standing in front of the house, with the police *and* the Twelve-Year-Old Girl. The CPS Assessor and the police were discussing the situation, saying that the father was out of control, that the father was dangerous, that he had harmed the Twelve-Year-Old Girl and that he would hurt her again. The CPS Assessor said she knew this because he was very strict and very mean. The On Call Case Manager could hear what they were saying all the way from his car. He could hear them because they were speaking in very loud voices. The On Call Case Manager knew that the Twelve-Year-Old Girl could hear them too, because she was standing nearby.

The On Call Case Manager called the girl aside. They sat down and discussed the situation. The On Call Case Manager asked the girl how often her father hit her to punish her. She said that he had never hit her before, that this was the first time. The On Call Case Manager asked her if she was afraid of her father. She said, "No." She said that he was strict and that he never let her eat junk food, but that he never had hit her before. The On Call Case Manager asked the Twelve-Year-Old Girl what she thought about all the stuff that was going on. She said that she was scared. She said that she had never seen her father so mad at anyone ever before. She didn't understand why the police were there. She said the police scared her. She didn't like knowing that her neighbors were watching and listening to what was happening in their front yard. She also said that she needed to use the rest room, but didn't know where to go.

When the CPS Assessor left, the On Call Case Manager went into the home and sat down to talk with the father and mother again. The father's cousin, a Pastor from their church was also at the home to offer support to the family. This time the Twelve-Year-Old Girl was in her own room, out of earshot, eating a snack and watching TV. After talking together for a while, the On Call Case Manager made a decision. Because this was a one-time incident, (there were no previous reports of any abuse), because the Girl showed no signs of being afraid of her father, because the father said that he now understood that it is against the law to hit his daughter, that the family was connected in their community and had support, and because he promised not to hit his daughter again, the On Call Case Manager decided it would be safe after all for the Girl to stay in her own home, at least for this night. The On Call Case Manager instructed the parents that there would be CPS follow-up with their family. The parents agreed to cooperate by following a Safety Plan.

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE

That night, the Twelve-Year-Old Girl slept in her own bed. She was happy to be home with her parents who loved her, rather than in the home of strangers (who knows where?).

However, the Twelve-Year-Old Girl will never forget the experience of seeing her father get so mad. She will never forget her father shoving her away from him into the arms of a stranger. She will never forget standing outside her house with the police and a social worker while all her neighbors watched through their windows, wondering what horrible things her parents had done to her.

……

The moral of the story: Having the authority to investigate the occurrence of child abuse does not give you the right to disrupt a family and cause further harm to the child or the family.

Be careful. Be respectful. Be cautious.

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE
Managing Authority Tips

"In child welfare, relationships are influenced by how the worker manages and conveys his or her authority."

- Recognize that the client may have had prior experiences with the Department either directly or as a member of someone else's extended network and ask him or her to share feelings and concerns based on this past. Listen without becoming defensive.
- Accept that the client may have many negative feelings or experiences. Let the client know that you hope for a new relationship, based not on whatever has happened in his or her past but on what you and he or she are able to accomplish in the present.
- Convey your belief that good things can be accomplished by communicating clearly with each other and working together. h
- Explain your specific role with this family and check for mutual understanding.
- Emphasize your concern for the well-being of the person and the family as often as possible, even when you must undertake an action such as removing a child as a safety intervention or advocating for continued agency involvement through the Court.
- Listen patiently while the client learns how to relate to you.

  "I'm not accusing you nor am I blaming you…I'm asking you to work with me, and I want to hear your thoughts and feelings about this".
- Convey explicit messages about your intended uses and the limits of your authority.

  "Sometimes children are in such danger that I don't feel I can leave them in the situation. When that happens, the child welfare agency must intervene to promote their safety, sometimes through out-of-home placement…but I want to stress that this is a temporary solution, and I want to work with you to get them home safely as quickly as possible".

  "Also, I don't have ultimate decision-making power over what happens here - you, the Judge, my supervisor, the CASA, and your attorney [if you have one] all have a voice, too".
- Treat the person with respect, even while challenging his or her behavior.

  "I am sorry that you feel this way. I am not trying to create more problems. I just want to help you understand the reality of this situation…that if you continue to [leave the baby unsupervised, not provide the toddler with his asthma medication, place the children in a dangerous environment, etc.] certain things will happen. I don't want them to be a surprise to you".

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE
Managing Authority Tips

- Convey desire to understand

  "I can understand that you may be afraid to tell me how it happened, but I really need to understand in order to be helpful".

- Acknowledge that it might be difficult for the client to trust you

  "I know you don't know me very well, and I understand why you might not trust me".

- Offer feedback in a way that is neutral and objective

  "Here are the options, what do you think?"

- Ensure that you and the client *really* understand the situation in the same way

  "Here's what I think I hear you saying: [paraphrase client's interpretation]; this is what I think: [explain your understanding]. Do I understand you? What do you hear me saying?"

- Offer assistance that is supportive and helpful

  "Let me describe some ideas I have. There are services the department could help you obtain that could really make it easier for you to provide a safe, permanent home for your kids"

- Whenever possible, to respect the authority of the parents elicit their input into decisions related to achieving child welfare outcomes.

- Promote responsibility for completing necessary activities by checking in with the client in a supportive and consistent manner

  "You planned to visit Raul on Thursday. Did you go? What did you do when you got there?"

- Build on strengths

  "I see that you're working hard to give Jon the care and structure he needs by attending the counseling sessions and implementing the strategies you and the counselor agree can help Jon succeed in school."

- Discuss the future in terms that include the client's decision to continue (or not) to work with you as well as potential consequences

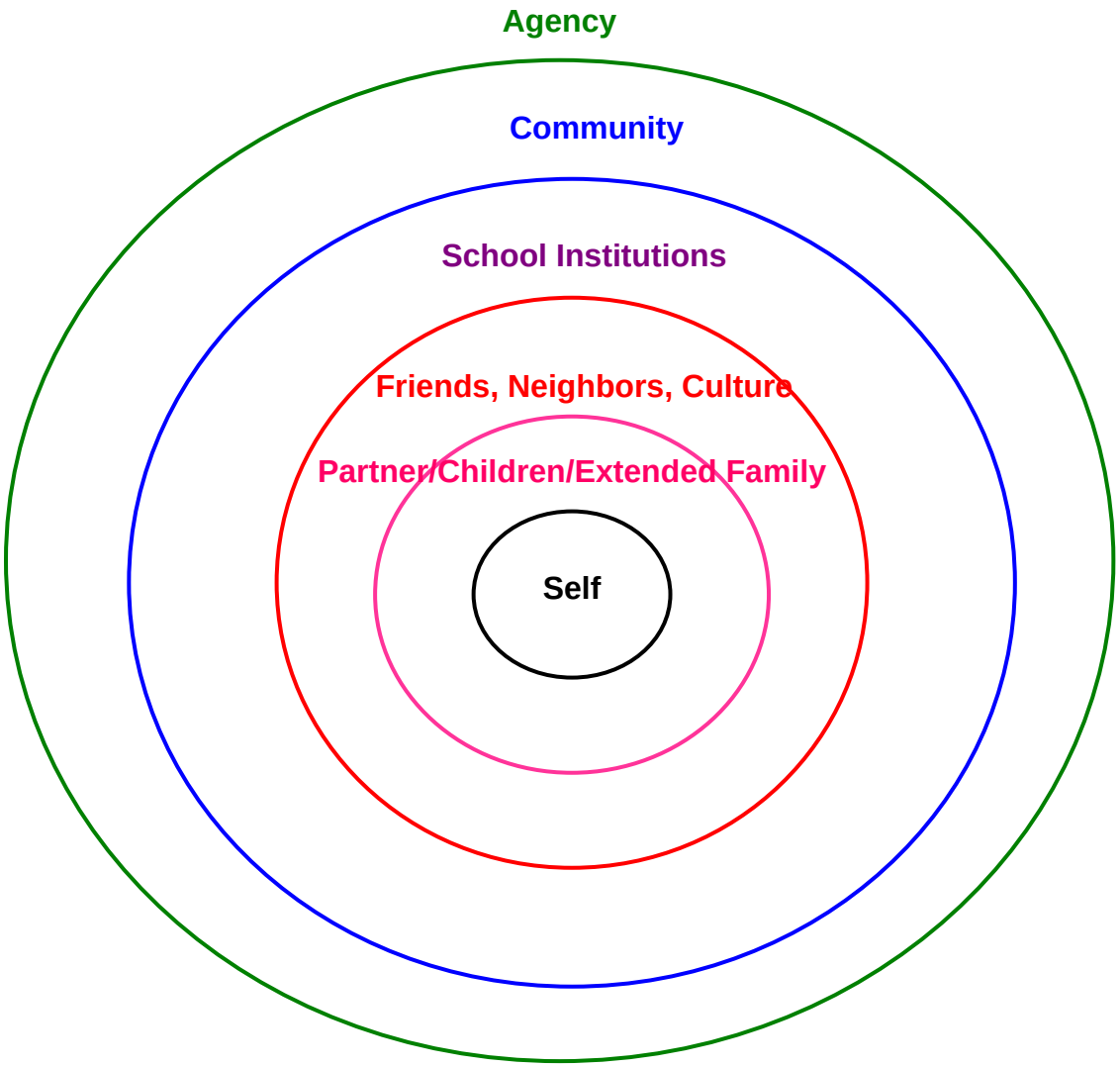
  "We've accomplished some but not all the things that we agreed were necessary in order for Jodie to come home…and we're coming up to the time for a permanency review. What are your thoughts and feelings about the future?"

- Be honest about the challenges you have faced together

  "It has not been easy for us to work together. I wasn't sure you were ready to really make the changes necessary to keep Bart and Jane home…and I think you weren't sure I could help you with anything. But here we are. Now, I would really like to hear what you think about continuing to work with me and my department".

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE
Circles of Strength and Support

Families/individuals receive support, resources and strengths from many sources. The more support structures available to a family the more likely they are able to handle life problems with minimal negative impacts. No person/family is immune from life problems; what matters are the skills and support each person has to handle problems when they occur. The circle of support includes many rings.



Priorities: #1 Family/Friends #2 Community #3 Agency

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE

What We Say Makes a Difference

Common Expressions:	Strength-based Reframe:
Referring to children as “placements.”	**Example:** Consider using terms like children, or youth, or referring to them by name.
Labeling children as “hard to place.”	**Example:** Consider instead that families may be hard to find.
Referring to children as damaged (as in cars or furniture).	**Example:** Consider the terms “fragile” or “challenging” or “lacking in resiliency.”
Referring to “removing” children from a placement (as one might remove garbage or snow).	
Referring to “natural parents” (as if foster and adoptive families are not “natural”).	
Referring to children “blowing out” of foster care as if they were a tire – or a candle.	
Referring to foster parents or foster families as “homes” or “beds” and asking, “How many ‘placements’ can you take?”	
Using the phrase: “We are putting the child up for adoption” (like the auction block or theatre stages during the orphan train decades in the 1800s).	
Referring to making “home visits” to foster parents. They are not clients.	
Referring to staff in residential facilities as “caretakers” (as in a mortuary).	
Screening out or weeding out prospective foster or adoptive parents (a screen is what is used to keep out bugs; we weed the garden by yanking out and throwing away unwanted matter).	
Referring to a relative as being “too old to chase after a toddler.”	
Referring to “those people who live in the projects.”	

MODULE EIGHT
FOCUSING ON STRENGTHS AND CHANGE

Strength-Based Language

- Focuses on what is strong, not just what is wrong
- Encourages families to do their personal best within the framework of their cultures
- Reframes deficits as opportunities for growth
- Acknowledges and builds on successes
- Presumes a desire for and the possibility of a positive outcome
- Holds the belief that families can and do change, with support and resources
- Includes feelings and words that match
- Models empathy and offers support

If you were "in the system," which of these would <u>you</u> hope your child welfare worker was committed to practicing?

The Other Side of the Desk

Have you ever thought just a wee little bit,
Of how it would seem to be a misfit,
And how you would feel if you had to sit
On the other side of the desk?

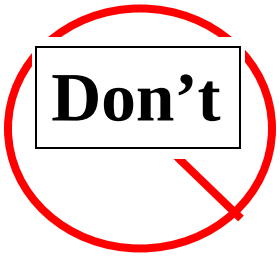
Have you looked at the man who seemed a bum
As he sat before you, nervous … dumb,
And thought of the courage it took to come
To the other side of the desk?

Have you thought to yourself, "It could be I
If the good things in life had passed me by,
And maybe I'd bluster and maybe I'd lie
From the other side of the desk?"

Did you make him feel he was full of greed?
Make him ashamed of his race or creed?
Or did you reach out to him in his need
To the other side of the desk?

May we all have wisdom and lots of it
And much compassion and plenty of grit,
So that we may be kinder to those who sit
On the other side of the desk.

The Importance of Phrasing

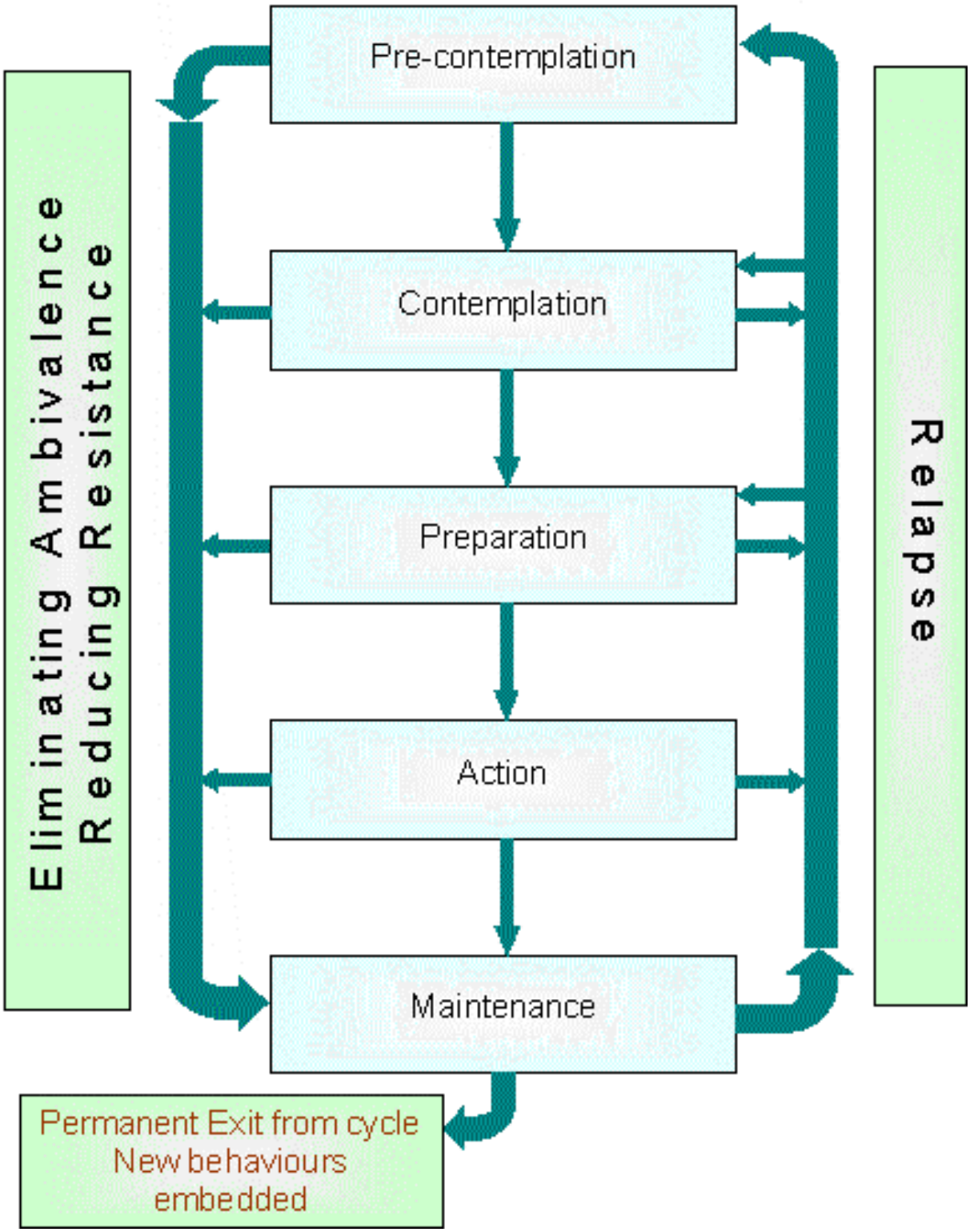
"You  Say!"

WHAT NOT TO SAY	PHRASING FOR A BETTER OUTCOME
1. Don't forget to follow through with your case plan activities.	1. You'll be more ready to reunify with your children <u>when</u> you follow through with your case plan activities.
2. Don't hang out with the same people who got you into trouble in the first place.	2. You'll be more able to provide a safe home for your children <u>when</u> you hang out with positive, supportive, people who stay within the law.
3. Don't hit your child.	3. Your child will stay safe and be more responsive to you <u>when</u> you use appropriate, non-harming discipline techniques, like the ones you are learning in your parenting class.
4. Don't keep turning up with a dirty Urine Analysis. You'll never get your child back if you keep using.	4. The judge will be more inclined to reunify you with your children <u>when</u> we can report that you have been turning in clean Urine Analysis tests.
5. Don't skip your court-ordered parenting classes.	5.
6. Don't shut down on the possibility that some of your other family members might be of help, even if you are fighting with them right now.	6.

7. Don't forget to respond to my phone calls and letters.	7.
8. Don't be late to your visitation appointments.	8.
9. Don't drink or use drugs.	9.
10. Don't stop taking your prescription medication.	10.
11. Don't forget that the next time we go to court, the attorney and the judge will be noticing whether you have been following your case plan or not.	11.

MODULE EIGHT
BUILDING HELPING RELATIONSHIPS

CIRCLE OF CHANGE



MODULE EIGHT
BUILDING HELPING RELATIONSHIPS

Personal Questions

1.

2.

3.

4.

5.

6.

MODULE EIGHT
BUILDING HELPING RELATIONSHIPS

Role Clarification

Modeling Social Work values and reinforcement

Collaboration and Problem Solving

Empathizing

Humor

Optimism/Strength Based

Self Disclosure

MODULE EIGHT
BUILDING HELPING RELATIONSHIPS

Prochaska and DiClemente's Stages of Change Model

Stage of Change	Characteristics	Techniques
Pre-contemplation	**"Nothing Needs to Change"** • **Not considering change** • **Either avoids thinking about change or has decided that benefits of current behavior outweigh costs** • **May appear as denial or rationalization**	• **Build rapport and trust** • **Validate lack of readiness** • **Provide information and feedback to raise problem awareness and possibility of change** • **Raise doubt to increase the client's perception of risks and problems with current behavior** • **Help them do a self-assessment** • **Identify relationships that help rather than enable** • **Create awareness of defenses**
Contemplation	**"I am considering change."** • **Thinks there may be a problem, but has not decided what to do about it.** • **May appear as ambivalence or mixed feelings**	• **Acknowledge ambivalence (mixed feelings) about change** • **Explore discrepancy between present behavior and personal values or goals** • **Discuss pros and cons of behavior change** • **Talk about ways to "experiment" with change**
Preparation	**"I am figuring out how to change."** • **Preparing to change by making small initial steps** • **Attitude may improve with a plan of action** • **May begin to ask questions about planning or how others have done it.**	• **Build confidence** • **Talk about timing of change** • **Present information, options, and advice** • **Identify and assist in problem solving re: obstacles** • **Help client identify social supports** • **Verify that client has underlying skills for behavior change** • **Encourage small initial steps** • **Resist the urge to push**

MODULE EIGHT
BUILDING HELPING RELATIONSHIPS

Stage of Change	Characteristics	Techniques
Action	**"I'm working on reaching my goals."** • **Actively making changes** • **May have found ways to manage urges or triggers that would lead back into problem behavior(S)**	• **Cheering on** • **Supporting and encourage efforts to change** • **Develop reachable goals and monitor progress** • **Help develop plans to maintain behavior over time**
Maintenance	**I've made my changes. Now I have to keep it up."** • **Maintaining changes over time** • **Developing ways to manage problems and stressors** • **Momentary slips are followed by remorse and renewed efforts**	• **Plan for follow-up support** • **Help identify and use strategies to prevent relapse** • **Reinforce internal rewards** • **Discuss coping with relapse**
Relapse	**"I've fallen back. Now all is lost."** • **Has a slip and revisits the problem behavior** • **May appear as anger, demoralization, or denial of the behavior. Most reenter an earlier stage having learned something from the relapse.**	• **Address relapse, but do not add to feelings of shame** • **Assess and discuss what went wrong** • **Raise importance or confidence for another attempt** • **Use relapse as an opportunity to grow- "Don't give up"**

MODULE EIGHT
BUILDING HELPING RELATIONSHIPS

Defense Mechanisms

Denial and Minimization

Rationalization

Projection and Displacement

Internalization

WHAT MOTIVATES PEOPLE TO TAKE ACTION TO CHANGE?

Giving **Advice**

Removing **Barriers**

Providing **Choices**

Decreasing **Desirability**

Practicing **Empathy**

Providing **Feedback**

What Doesn't Motivate Clients to Take Action

External Pressure

Client Distress

Low Self-Esteem

Breaking Denial

Label Acceptance

Problem Recognition

MODULE EIGHT
BUILDING HELPING RELATIONSHIPS

Trap	What Not to Say	What To Say
Playing the Expert	You don't have a job because you're not putting in enough applications	What ideas do you have as to how you might get a job?
Arguing the Positive Side	You need to stop making excuses and find a job	How would things be better for you if you found a job?
Giving Unsolicited Advice	You need to get up first thing in the morning, get a cup of coffee, and go in to fill out that application	If you decided you wanted to put in a job application, how would you go about that?
Premature Focus on Change	We've been talking a lot about how important it is to get a job, and this week I'd like you to submit five job applications	Ultimately you're the one who has to decide whether you want to put in the hard work to finding a job. What do you think is a reasonable number of applications to put in this week?
Asking Backward-Focused Questions	Why did you go to that party when you know it was going to get you in trouble? Why haven't you been able to get a job?	It sounds like that situation really got you in trouble What can you do this week to move this thing forward?

Deception & Lying

- A person will lie to save face.
- A person will lie to save face for someone he or she cares about.
- A person will lie to prevent a perceived loss of freedom or resources.
- A person will reinterpret information so that it fits with his basic assumptions about his goodness or competency.
- A person will bend information in response to who is asking the question and how the question is phrased.

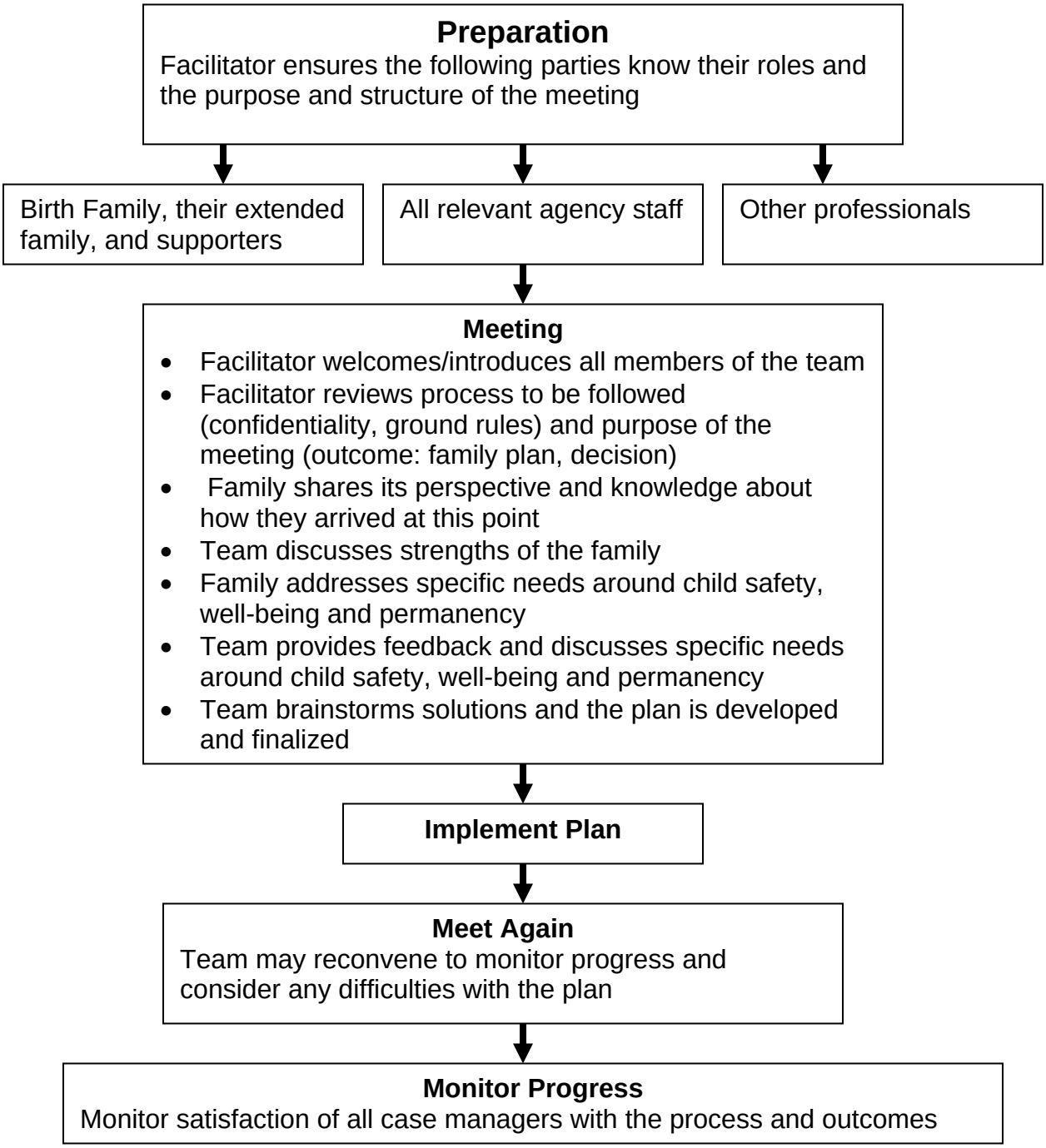
MODULE EIGHT
BUILDING HELPING RELATIONSHIPS

Family Team Meetings

A task oriented, facilitated, structured meeting which exists to build on the wisdom and resources of the Team members, both formal and informal, and to either develop a formal family plan or make a formal decision (e.g., permanency or placement decision).

MODULE EIGHT
BUILDING HELPING RELATIONSHIPS

Structural Overview of a Family Team Meeting



MODULE EIGHT
BUILDING HELPING RELATIONSHIPS

Family Team Meetings

Benefits to Families

The identified benefits to families include:

- Get to the basic issues faster
- Positive, respectful process that supports the family
- Case plan are individualized
- Team holds the system accountable for meeting the family needs
- Meeting is the family's meeting
- Models functional problem solving skills

Benefits to Case Managers

The identified benefits to workers include:

- Improved assessment of families; gets at causes not just symptoms; the team shares an honest view of the family's strengths and needs and previously undisclosed information comes out at the meeting; "you get to know the family much better," "family members are less likely to exaggerate the faults of other members when they are in attendance."
- Families are more involved and invested**;** families problem solve their own issues without DHS confrontation
- Communication is enhanced; family meetings save time on communication with the parties to the case
- Collaboration at meetings improves planning
- Team holds the family accountable
- Whole team understands information about the family
- Get to the basic issues faster
- Impacts the relationship between the worker and the family in a positive way
- Best use of time
- Support for the family is volunteered and more readily available [visits, transportation, etc.]
- Case managers feel the team is truly making the decisions for the child and the weight of protection is not solely on their shoulders
- Length of services has decreased as families are able to meet their treatment goals more quickly
- Fewer crisis; less time messing with a case

MODULE NINE
INTRODUCTION TO INTERVIEWING

Introduction to Interviewing

MODULE NINE
INTRODUCTION TO INTERVIEWING

Objectives:
Upon completion of this module case managers will

- Define respect.
- Distinguish behaviors that communicate respect.
- Define empathy.
- Differentiate empathy from sympathy.
- Define facilitative genuineness.
- Demonstrate the behavioral characteristics of the core helping conditions.
- Explain the role of interpersonal helping skills in the development of effective helping relationships.
- Explain barriers to effective communication, including difficulties in encoding and decoding.
- Explain the functions and characteristics of effective attending behaviors.
- Describe the elements of non-verbal communication.
- Demonstrate effective attending behaviors.
- Demonstrate congruence between verbal and non-verbal expression
- Describe the purpose for and construction of open, closed, indirect, circular, solution-based, and scaling questions.
- Explain the difference between effective and ineffective questions.
- Demonstrate purposeful use of questions.
- Identify the main components of human feelings.
- Define the components of reflecting.
- Distinguish between effective and ineffective reflections.
- Explain how the application of interpersonal helping skills supports effective communication with children.
- Describe communication strategies that can enhance child welfare work with children.
- Obtain or convey important information about child welfare issues to children and youth.
- Explain steps involved in conducting an information gathering interview.
- Identify strategies of casework interviewing.
- Demonstrate skills in interviewing methods.
- Demonstrate the capacity to employ the core conditions and the interpersonal helping skills (attending, reflection, effective questions, concreteness, and summarization) to engage and reach mutual understanding with an interviewee.

Respect is…

Valuing another person because he/she is a human being

Respect implies that being human has value itself

When we show people respect, we encourage self-respect.

Possible Responses to DFCS Involvement

Shock and Denial

Shame and Guilt

Anger and Defensiveness

Common Denominator

SELF-RESPECT
SELF-RESPECT
SELF-RESPECT

MODULE NINE
INTRODUCTION TO INTERVIEWING

Respecting Respect
Attitudes and Values Underlying Respect

Human beings are worthy of respect

Strategies for incorporating this value:

Remember the maxim: "There's a little bit of bad in the best of us and a little bit of good in the worst of us."

Behaviors demonstrating this value:

- Convey respect from the first moment of the relationship.
- Do not suggest that respect is being withheld until more information is gained.
- Do not suggest that judgments have been made about the client that must be disproved.

Each person is unique

Strategies for incorporating this value:

Remind yourself of the Native American wise saying: "You cannot understand another man until you've walked a mile in his moccasins."

Behaviors demonstrating this value:

- From the beginning convey openness to varied ways of viewing situations and solving problems.
- Effectively ask questions and actively listen in order to learn about the uniqueness of the client and his or her situation.
- Refrain from the easy strategy of categorizing all seemingly similar situations and then treating them alike.
- Refrain from stereotyping all seemingly similar groups of people and assuming that you, therefore, understand their characteristics.
- Actively look for the unique strengths and needs of each individual.
- Remember the uniqueness of each situation and each individual in order to understand different circumstances and different ways of solving problems.
- Acknowledge that you know very little about a client initially with only a brief case record and that the best source of information for the unique details of the situation and possible solutions will come from the client.
- Explicitly ask clients if they feel they are being treated with respect and why or why not, looking for examples of behaviors which that individual client perceives as respectful and disrespectful.

MODULE NINE
INTRODUCTION TO INTERVIEWING

People have the right to make their own choices

Strategies for incorporating this value: Remember the maxim "If you give a man a fish, he will eat for a day; if you teach him to fish, he will eat for a lifetime."

Behaviors demonstrating this value:

- Recognize that clients have the right to make their own decisions and the responsibility to accept the consequences for the choices they make.
- Acknowledge that parents usually want to do what is best for their children and may be prevented from doing so from lack of information, skills, or resources.
- Convey that your primary role is as a guide and resource for clients in identifying and implementing their own choices for achieving the best welfare for their child within their definition of family.
- Clarify from the beginning that your role is not to exert control over clients' lives but to assist them in taking charge of their own lives.
- Develop a list with clients of areas they have control over and choices they actually can make. While this is a first step in developing a list of client goals, it also reinforces for clients a sense of control over their lives.
- Encourage clients to make decisions, help them with the decision-making process, support them in their decisions, and help them understand the consequences of their decisions.

People can change

Strategies for incorporating this value:

"Expectations about a person's ability to do something are as important as their actual ability to do it – and maybe even more important."

Behaviors demonstrating this value:

- Refrain from assuming that past behavior is an absolute predictor of future behavior.
- Discover clients'strengths and suggest ways in which they can be used to change old patterns of behavior.
- Ask clients about areas and behaviors they would like to change, and how you might help them do so.
- Acknowledge and support small steps clients take toward change.
- Convey the attitude and expectation that clients can do what's expected of them and can make changes in their lives.

Communicating Respect

Show commitment

Definition: Commitment involves an interest in and an agreement to work with the client in a helpful way.

Behaviors that communicate commitment:

Develop empathy

Definition: Empathy embodies attempting to see the world through the eyes of another and communicating understanding of and compassion for the other‘s experience; empathy operationalizes the value that all people are unique.

Behaviors that communicate empathy:

Communicate warmth

Definition: Warmth includes all those verbal and nonverbal behaviors that express understanding and caring. Warmth is a unique communicative strategy that is dependent upon developing the prior skill of empathy. Without some understanding of another, it is almost impossible to incorporate or display any feelings of warmth.

Behaviors that communicate warmth:

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Communicating Respect

Suspend critical judgment

Definition: Critical judgment encompasses the processes of evaluating something and deciding on its value or rightness.

Behaviors that communicate suspending critical judgment:

Reinforce client strengths

Definition: Client strengths include any and all of the things that people do well, positive steps they have taken, their own potential to take charge of their lives, and unexplored resources that are available to them.

Behaviors that reinforce client strengths:

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Process of tuning (feeling) into another person's feelings, developing a sense of what the situation means to and feel like for that individual, and communicating understanding and compassion to that person.

"Putting oneself in another's shoes"

Key steps to effective empathy

1. Recognizing presence of strong feeling in the social work setting (i.e., fear, anger, grief, disappointment)
2. Pausing to imagine how the client might be feeling
3. Stating our perception of the client's feeling (i.e., "I can imagine that must be ..." or "It sounds like you're upset about ...")
4. Legitimizing that feeling
5. Respecting the client's effort to cope with the predicament
6. Offering support and partnership (i.e., "I'm committed to work with you to ..." or "Let's see what we can do together to ...").

Platt FW. Empathy: can it be taught? Ann Intern Med 1992 Oct 15; 117(8):700; author reply 701.

Statements that Facilitate Empathy

Statements that facilitate empathy have been categorized as queries, clarifications, and responses.[21] Examples of each are as follows:

- **Queries**
  "Can you tell me more about that?"
  "What has this been like for you?"
  "How has all of this made you feel?"
- **Clarifications**
  "Let me see if I've gotten this right ..."
  "Tell me more about ..."
  "I want to make sure I understand what you've said ..."
- **Responses**
  "Sounds like you are ..."
  "I imagine that must be ..."
  "I can understand that must make you feel ..."

Hypothesis-Test-Feedback Loop

Client: I am sick and tired of not being able to pay my bills. No one has been able to help me, and nothing I am doing is working.

Case Manager (stating the hypothesis): I can see that you are frustrated by not being able to earn enough money to pay your bills

Client (giving feedback): Yeah, but I'm really more worried that my kids don't have everything they need. My kids are depending on me.

Case Manager (correcting the hypothesis): So, it sounds like you're really more concerned about making sure your kids are okay and have what they need.

Client (closing the empathy loop): Yes, exactly.

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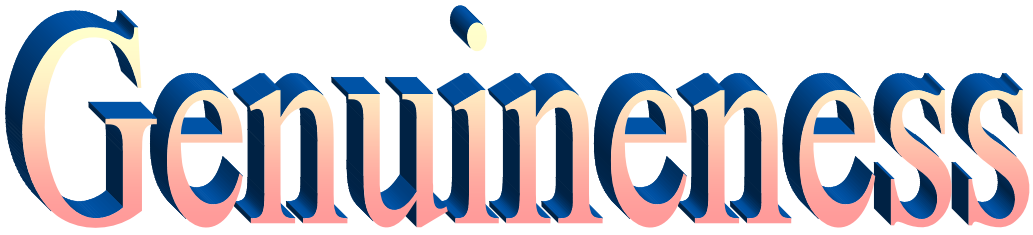
Empathizing

Identify a specific situation in which you were aware of feeling empathy toward a child or parent (e.g., a child in the news, someone from your class or neighborhood or family).

Whom did you feel empathic towards?

What was the person feeling?

How did you convey the empathy you experienced? (If you didn‘t have an opportunity to actually convey empathy, what are some things you could have done or would like to have done?)



Being aware of one's own feelings and making a conscious choice about how to respond to the other person, based on what will be most helpful in facilitating communication and developing a good relationship

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Take Two

Setting: Housing Project

Child welfare worker is meeting in kitchen with new client. Broken window over sink is covered by cardboard patch. Unwashed dishes, pots and pans, ashtrays, and cups litter the kitchen, dinette, and living room. A garbage bag is overflowing with trash, used disposable diapers, and food wrappers. The client, Miss A., is a 19-year-old mother of two who left her infant daughter and 3-year-old son alone three nights ago (she says they were asleep at the time) to go bar hopping. The little boy heard a noise, got scared, and was found wandering in the street. Both children were placed in protective custody when the mother could not be found.

Take One:

Child welfare worker: Miss Rammbo

Client: Miss Andrews

Miss R. enters the apartment and glances around, taking in the mess. She grimaces.

Miss R: (cool and professional) Hello, I'm Miss Rambo from the Department of Social Services. Pleased to meet you.

Miss A: Yeah, come in. (Miss A. leans back against her stove and stares at Miss R. The worker returns her gaze.)

Miss R: (forced cheeriness) Well, there's no time like the present. Let's get started, shall we?

Miss A: (anxiously) What's going to happen?

Miss R: We have a great deal to talk about, Miss Andrews. But first, I need to find a place to sit. Is there anywhere *clean* I can sit?

Miss A: Oh! Yeah, there. (Points to chair.) Miss R. remains standing.

Finally, Miss A. picks up the papers and moves them out of the way a little.)

Miss R: (Sits on dinette chair, distaste written on her face. Tone is exaggerated.) Thank you so much! Miss A. shoves some stuff out of the way and sits down too. She leans back in her chair, looking wary. She first wraps her arms tightly around herself, then lights a cigarette, blowing smoke at Miss R.

Miss A: Do you mind if I smoke?

Miss R: (makes a face, waves smoke away) Oh, no. It's fine.

Miss R: (flat tone of voice): I'm here to investigate what happened the other night when your children were unsupervised, what steps my department has to take, and to see what help you need.

Miss A: (defensive). What happened the other night was a big screw-up and not my fault. My boyfriend was 'sposed' to watch the kids. Why aren't you going after him? **I** don't need your kind of help!

Miss R: (icily) You sound upset, Miss Andrews, but y*ou're* the parent and you're responsible for your children! *You* have to make sure that any babysitting arrangements you make are actually going to work out.

Take Two:

Case Manager: Ms. Calhoun

Same setting, same client

Child welfare worker:

Miss Calhoun Miss C. enters the apartment and glances around, taking in the mess. She nods and smiles slightly at Miss A. and extends her hand.

Miss C: Hello, I'm Miss Calhoun from the Department of Social Services.

Miss A: Yeah, come in. (Miss A. reluctantly shakes hands, and then leans back against her stove, staring at Miss C. The worker returns her gaze mildly for a moment. She notices that Miss A.'s face is ashen and she looks as if she hasn't slept in days.)

Miss C: (warmly) I'm pleased to meet with you today.

Miss A: (anxiously) What's going to happen now?

Miss C: (softly, quietly) We very much need to talk about that, Miss Andrews.

Miss A: Cherie, My name is Cherie

Miss C: I really prefer to show you respect by addressing you as Miss Andrews, if that is okay?

Miss A: That will be fine, whatever you are comfortable.

(Pause, uncomfortable silence.) Miss C notices that Cherie is extremely nervous and doesn't seem to know how to proceed; decides to take charge. May I move these papers off this chair and sit here?

Miss A: Oh! Yeah, whatever you want. (shrugs)

Miss C: (moves papers, sits on dinette chair). There, that's good. Let's get started, okay?

Miss A. shoves some stuff out of the way and sits down, too. She leans back in her chair, looking wary. She wraps her arms tightly around herself, and lights up a cigarette.

Miss A.: Mind if I smoke?

Miss C: You know, it does make me sneeze. Could you crack your window a bit?

Miss A: I guess.

Miss C: (softly) Thanks. It's often a little hard to begin. We don't know each other at all and here I am, needing to talk about your kids, what happened the other night, and things that are very important and personal to you.

Miss A: (relaxes her arms a little, leans forward) My kids! Where are they? When do I get them back?

Miss C: (leans forward to same degree as Miss A.) Those are great questions. This is exactly what I hoped we would talk about, too…

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Components of Genuineness

► Be yourself

► Match your verbal and non-verbal behaviors

► Use non-verbal behavior to reach out

► Be spontaneous

► Stay non-defensive

► Use Self-disclosure

Communicating genuineness reduces the emotional distance between workers and clients by establishing that workers are not there to judge and criticize, but are human beings, too.

Using Self-Disclosure

Only share personal feelings and experiences if it seems that this will help the family think about new possibilities or talk more freely about the things *they* need to talk about.

MODULE NINE
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Facts About Feedback

Conditions for Effective Feedback:

- Give feedback in an open climate: Set the stage for giving feedback. Do not "dump" information or criticism and then leave the receiver to interpret it on his or her own.
- Feedback is best received when it is linked to clear expectations. Be sure that when you provide any type of feedback, it is related to clear expectations of performance.
- Feedback is best received when there is a trusting relationship. This doesn't mean that you have to be best friends with the person. It does mean that professional respect and trust exist in the relationship, so that the person receiving the feedback can hear the information and use it to improve his or her performance.
- Feedback needs to come from a credible source. Be sure of the facts, since there are often two sides to every story.
- Feedback should be structured appropriately. Providing feedback in a timely manner and giving it in a private moment allows the receiver to hear the information without distraction.
- When feedback is received, the person should be able to use it. Once again the timing of feedback is often very important and relates to whether the receiver can use the new information in changing or improving his or her behavior.

Qualities of Effective Feedback:

- Feedback must be **useful**. Feedback is useful if the receiver can use the information to change or alter her/his behavior. It needs to be clear enough to help the receiver know that he or she has done something correctly or incorrectly.
- Feedback needs to be **specific**. Feedback is specific when it isolates the behavior or practice that has to be changed or affirmed. Each opportunity to reinforce specific behavior helps the receiver understand how to apply it to his or her own work in the field.

- Feedback must be **frequent** enough to sustain positive behavior and to allow the receiver to use it in a timely way to alter behavior, if needed. Research has shown that giving repeated positive feedback makes a greater impact on performance than waiting until negative feedback is necessary.
- Feedback needs to be **well-timed**. Feedback following close upon performance is more effective than that given later. Feedback also needs to be matched to the emotional readiness both of the person receiving it and the person giving it. Giving feedback when you are angry may distort the message and defeat the purpose of the feedback. It may also result in an outcome different than you wanted. Being aware of the receiver‘s emotional state is also important. This does not mean you should not give the critical feedback, but consider whether the person can hear it at the time you plan to give it.
- Feedback is **direct.** Make sure the feedback is direct and related to performance or to a behavioral issue. When a person is uncomfortable with direct feedback, he or she often will provide some general praise and then say, “but…” What does this do? It reduces the effectiveness of positive praise and reinforces negative behavior. It also gives the receiver a mixed message. It is important to raise a specific concern rather than conduct a fishing expedition with the person. Each opportunity you use to give direct feedback provides the receiver with a model for how to conduct him- or herself with others.
- **Helpful** feedback means that the receiver perceives the motives of the giver as constructive. If the feedback is tied to helping the receiver improve performance and is related to already established expectations, the person will be better prepared to accept the information.
- Feedback needs to be **behavioral.** Feedback that focuses on observable behaviors directs the discussion to changing behavior, not to the person‘s belief system or personal values.
- Feedback needs to be **clear.** This means you must be sure that your feedback is understood by the receiver. When we are providing feedback about changing behaviors or performance, it is always important to check with the receiver to evaluate whether he or she understands what we have said about his or her performance.

Conditions for Effective Feedback

Effective feedback is given:

► In an open climate

► Relative to expectations

► In the context of a trusting relationship

► By a credible source

► Privately

► Received when it is able to be used

Qualities of Effective Feedback

Effective feedback is:

► Useful

► Specific

► Frequently given

► Well-timed

► Direct

► Helpful

►Behavioral

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Types of Feedback

Positive

Negative

Developmental

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Four Case Vignettes: Child Welfare Worker-Client First-time Interviews

#1
You are a 10-year-old who had been living in a homeless shelter with your mother and brothers. Recently, your mother's boyfriend beat her so badly she had to be hospitalized. It's unclear when she will be released, although she is expected to survive. You and your younger brothers were turned over to the child welfare authorities. You are now staying in a respite care home with your brothers. You are about to meet a new child welfare worker, since the worker who put you in this home just had a baby of her own and has gone on maternity leave.

#2
You are the 25-year-old mother of three: a 6-year-old daughter with severe cerebral palsy, a hyperactive 4-year-old son, and a colicky new infant daughter. You were called into the State Central Register because you beat your son, fracturing his arm, after you caught him dumping a whole can of baby powder into the baby's face. Your husband is so angry he won't speak to you. You were allowed to bring your son home with a safety plan in place which included, among other provisions, part-time day care for your son, and that you are currently not allowed to be with the children unsupervised. You continue to feel guilty, worthless, and overwhelmed. You are meeting with a new child welfare worker assigned to help you.

#3
You are a 16-year-old girl whose grandmother threw you out of her house after she caught you stealing money from her purse. You justified taking the money (to yourself; no one else believes you were right) because your grandmother was a certified kinship placement and she actually got a foster care allotment for you from the Department of Social Services…but she never wanted to give you any of it. Before you moved in with her, you had been living with your dad and step-mom, but you think your step-mom hated you because you look so much like your mother. You lived with your mother up until four years ago, when she married a guy who sexually abused you. They're still married and your mother claims you made the whole abuse story up. Now a child welfare worker wants to put you in a new place, something called a "therapeutic foster home" where they supposedly know how to deal with kids like you.

#4
You are a 30-year-old father. While your wife was working, you scalded your 3-year-old daughter when giving her a bath after she had a toileting accident. At the time, you didn't believe it was an accident: it seems like she does this for attention or because she's a spoiled brat. You feel guilty because you suspected the water was too hot and you didn't mean to really hurt her. Your daughter's home from the hospital, and she seems to have forgiven you, although you are extremely careful around her now. You have to keep meeting with the Department of Social Services because they want to be sure nothing like that ever happens again. You're about to meet a new worker, as your case has been transferred.

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Feedback: Respect, Empathy, Genuineness

Indicate yes or no for the following items

Did the "child Case manager" in your role-play show respect by:

_____ demonstrating commitment?

_____ communicating warmth?

_____ reinforcing strengths?

_____ suspending critical judgment?

Example;

Did the "child case manager" demonstrate genuineness by:

_____ being him-or herself?

_____ exhibiting congruent verbal and nonverbal behaviors?

_____ being spontaneous and non-defensive?

_____ using self-disclosure?

Example:

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Did the “child case manager” convey empathy by:

_____ developing accurate perception?

_____ tuning in to feelings?

_____ recognizing nonverbal cues?

_____ reaching for the client’s experience?

_____ showing his/her desire to comprehend?

_____ discussing what is important to the client?

_____ referring to the client’s feelings?

_____ reflecting implicit messages?

Example:

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Communication

Effective Communication

The receiver understands the message as the sender intended it to be understood.

Pathways of Communication

The Elements of Communication are:

Message: The content of the communication.

Sender: Source of the message.

Receiver: Interpreter of the message.

Stimulation: The internal or external spark necessary to initiate communication.

Motivation: The benefits/lack of benefits the communicator anticipates from sending/not sending a message.

Code: The symbols used to carry the message.

- Nonverbal: eyes, mouth, facial expression, body movement, arms, legs, etc.
- Language: words
- Paralanguage: tone and level of voice, fluency in speech

Encoding: The process of putting a message into the form in which it is to be communicated.

Decoding: The process the receiver goes through to interpret the exact meaning of a message.

Channel: The medium selected to carry the message, e.g., face-to-face dialogue, telephone contact, television, letter.

Frame of Reference: Background and experience of sender and receiver, including education, cultural and class orientation, language, race, gender, likes, dislikes, values, current needs, developmental status, personality, experience, etc.

Environment: The time, place, and physical and social surrounding in which the communicators find themselves.

Feedback: The verbal, visual, and behavioral responses to messages received, usually necessary to ensure accuracy of understanding.
Interference: Anything internal or external that interferes with effective communication, for example:

- Differences between sender and receiver: gender, status/power, culture, language, feelings, values, beliefs, age.
- Anticipation of sender‘s statement or receiver‘s response.
- Preparation of one‘s own next statement or response.
- Number and role of other persons present.
- Television set, radio, stereo.
- Preconceived notions about sender or receiver.
- Previous experience.

Effective communication: That which occurs when the receiver understands the sender‘s message as the sender intended.

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Characteristics of Effective Communication

Commonality of terms: Words and phrases have the same meaning to both sender and receiver.

Equally attentive listening: Sender and receiver each listen attentively and non-judgmentally to what is being said, or requested, and to the terms being used.

Acknowledging interference: Interference can distort meaning. Whatever is creating the "buzz" in the flow of information needs to be acknowledged so that it can be managed.

Common anticipation/flow: Sender and receiver balance message being sent and information being received.

Shared power: Senders and receivers need to share the power of information—balancing what someone wants/needs to know, with what someone wants to share. Sometimes people attempt to control conversations by not providing information or by providing too much information.

Awareness of difference: Senders and receivers need to manage their differences, including culture, authority, gender, etc., which may influence the interpretations of information both sent and received.

Congruity: The verbal, paraverbal, and nonverbal elements of communication are aligned.

Planning: It takes time to ensure mutual, common understanding. Allocate sufficient time to allow for questions and feedback.

Credibility: An important facet of communication is the credibility of the sender to send information to the receiver. Supervisors must be a credible source of information in order for staff to learn their jobs.

Concern for people: The style of communicating greatly affects the extent to which communication is effective. Zig Zigler says, "People don't care how much you know until they know how much you care!" The maintenance and/or support of self-esteem is critical to fostering the motivation to communicate.

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Attending

Attending is the conveyance of respect for, acceptance of, and interest in a person through use of the environment and one's body, through observing and listening to the person, and through verbal and no-verbal responses.

Physical Attending

Psychological Attending

Non-Verbal Behavior:

Paraverbal Communication

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Non-Verbal Modes of Communication

	INEFFECTIVE USE **Doing any of these things will probably close off or slow down the conversation**	EFFECTIVE USE **These behaviors encourage talk because they show acceptance of and respect for the other person**
Attention	Spread among activities	Given fully to talker
Space	Distant, very close	Approximately arm's length away
Movement	Away	Toward
Posture	Slouching, rigidly seated, leaning away	Relaxed, but attentive; seated leaning slightly forward
Eye Contact	Absent, defiant, jittery	Regular
Time	Slow to notice talker, in a hurry	Respond at first opportunity, share time with them
Feet & Legs (sitting)	Used to keep distance between the persons	Unobtrusive
Furniture	Used as a barrier	Used to draw persons together
Facial Expression	Does not math feelings, scowl, bland look	Matches your own or other's feelings, smile
Gestures	Compete for attention with your words	Highlight your words, unobtrusive, smooth
Mannerisms	Obvious, distracting	None or unobtrusive
Voice: Volume	Very loud or very soft	Clearly audible
Voice: Rate	Impatient or staccato, very slow or hesitant	Average or a bit slower
Energy Level	Jumpy, pushy, apathetic, sleepy	Alert; stays alert throughout a long conversation
Dress and Grooming	Sloppy, garish, provocative	Tasteful

ACT – Interpersonal Helping Skills, Resource Guide Revised 05/08/92 Source: Amity: Friendship in Action; Part 1: Basic Friendship Skills. 1980 by Richard P. Walters. Published by C.H.I., Boulder, CO.

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Decoding Non-Verbals

Behavior	Examples (Underline those you observe)	Decoding (Decide what the behavior means)
Eye Motions	Makes steady eye contact; stares at the floor, objects or persons; shifts eyes on darts, blinks rapidly; or dart; covers eyes with hands; looks down; avoids eye contact; looks defiant; has teary or watery eyes; has dilated pupils	
Feet and Legs	Keeps feet and legs comfortable and relaxed; crosses and uncrosses of legs repeatedly; taps foot; keeps legs and feet stiff and controlled; extends legs to keep distance	
Hands and Arms	Folds arms across chest; uses hands and arms to gesture inn conversation; has trembling or fidgeting hands; keeps fist clenched; rarely gestures, keeps hands and arms stiff.	
Physical Gestures and Habits	Drums, taps, scratches, bites nails, cracks knuckle; cracks neck; thumps with fingers or feet; fidgets; trembles; ;lays with buttons, clothes; rubs or strokes face or body	
Tone of Voice	Is bright, vivid, firm, confident, strong, with many changes of inflection; is flat, weak, hesitant, shaky, showing an absence of feeling; is loud, soft, modulated; whispery or inaudible	
Rate of Speech	Is rapid or slow; staccato; rushed; slurred; evenly paced	
Fluency of Speech	Exhibits stutters, hesitation, or speech errors; lisps; whines; is modulated	
Skin	Perspires; exhibits changes in skin tone, e.g. gets pale or blushes; has blotches	

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Behavior	Examples (Underline those you observe)	Decoding (Decide what the behavior means)
Posture	Seems alert, ready for activity; slouches, slumps; holds arms or legs crossed as if to protect self; is tense; rigid; loose; pliant; faces speaker; turns away; rocks back and forth; squirms; twists own hair, taps fingers; breathes more slowly or deeply, leans away	
Facial Expressions	Smiles, matches tone; appears blank; scowls; wrinkles nose; bites lip; frowns; has set look with very tight lips; lips quiver; tics; knits eyebrows	
Hand Gestures	Nods up and down; shakes head from right to left; hangs head, with jaw toward chest	
Shoulder Gestures	Shrugs, leans forward, slouches, is stooped over, turns away from other	
Touching	Touches to get attention; is affectionate; is aggressive (pokes in chest); touches with sexual overtones; condescends (pats on head); shakes hands firmly (but no too firmly)	
Space	Moves away; maintains distance; moves in close; maintains an arm's length	
Clothing	Is sloppy; garish; provocative, bold, colorful; stylish; ragged; torn; dirty; out of date; sets a specific message	
Energy Level	Appears alert, focused; jumpy; pushy; apathetic; sleepy; nervous	

Congruence: The match between verbal and non-verbal behavior

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Attending to Attending

Check the attending behaviors you observed during your peer interview.

_____ creating a comfortable environment

_____ removing physical barriers

_____ minimizing distractions

_____ making appropriate eye contact

_____ leaning slightly forward with an "open" posture

_____ using gestures to enhance the communication process

_____ using facial expressions to mirror client facial expressions

_____ monitoring voice quality so that its volume, inflection, and emphasis were appropriate

_____ noticing and trying to understand the other person's expressions, gestures, and body movements

_____ responding effectively to the other person's tone of voice

_____ seeking congruence between the person's verbal, paraverbal and nonverbal behaviors

_____ using verbal following

_____ using minimal encouragers

_____ projecting congruence him- or herself

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Here's Looking at You

What did you learn? Answer the following questions based on your observations of the partner and with who you worked to convey attending.

My Partner's posture was ☐ relaxed ☐Tense ☐other _____

My partner's facile expression conveyed:

☐ mad

☐ sad

☐ glad

☐ scared

☐ other _____

My partner exhibited ☐ congruence or ☐ incongruence among his/her verbal, paraverbal, and nonverbal behaviors, in the following ways:

My attending behaviors seemed to encourage my partner to keep talking with me:

☐ yes

☐ no

☐ I'm not sure

MODULE NINE
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The Structure of Questions
Questions, properly framed and timed, deepen understanding-both yours and the client's.

The three most used – and most useful – questions in the child welfare field are *open, closed,* and *indirect* questions.

The Open Question:

- Is an invitation to talk, such as sharing stories, thoughts, feelings, or fears.
- Usually begins with —how, —what, —could, or —would.

Examples: "How do you feel about the visitation plans?" "What happened when you used 'time-out' with Tommy?" "Could you tell me about your experiences with your mother when you were a teenager?"

The Indirect Question:
- Is more like a statement inviting a response.
- Implies, but doesn't directly ask, a question.
- Is useful for approaching sensitive topic areas, where it supports the speaker's sense of control over the pacing and depth of sharing.

Examples*:* "I'm wondering what you'll do when Glenn gets out of jail." "I've been thinking about Robert's friends and how it must be tough for you to have them right here in the same building." "The other day, I noticed how Dana seems so very grown-up for a ten-year-old."

The Closed Question:
- Focuses on very specific information, requiring one- or two-word responses.
- Usually start with words like "is","will","where","when" and "did."

Examples: "When is Bettina's appointment with the optometrist?" "Is Dan home from school today?" "Did you attend the first session of the parenting skills course last Monday night, like we planned?"

Other important questions for gathering information while keeping the interview from feeling like an interrogation are:

The Relationship Question:

- Focuses on the feedback and/or support the client hears from significant others.
- Asks the client to reveal what others are saying to him/her. —What does (_____) say about (_____)?

*Examples: "*What does your mother say about your plans to let Danielle move in with her father?" "What were your children's reactions when you told them about moving to Georgia?

The Scaling Question:

- Asks clients to rank-order or rate something, providing insight on how much significance they place upon their feelings, needs, beliefs, or experience.
- Usually begins with a description of the rating system, for example: "On a scale of one-to-ten, with ten being totally satisfied, how would you rate…"

Examples: —On a scale of one-to-ten, with "ten" being totally committed and "one" being totally opposed, where do you stand on the plan to have Chase return here when he finishes his program at Gateway?

Would you call yourself "cold," "lukewarm," or "hot" to the idea of having Millie attend the alternative school program after she has the baby?

The Solution-based/Exception Finding Question:

- Seeks descriptions of clients' past efforts to solve or avoid problems.
- Contains reference to clients'history with the situation and an invitation to share their successes or failures as they tried to solve it on their own.

Examples: "When you caught Marty sniffing glue last summer, what did you do?" "When you first noticed that Marta was losing weight, how did you handle the situation?"

The Miracle Question:

- Asks clients permission to think about an unlimited range of possibilities for change.
- Begins to move the focus away from their current and past problems and toward a more satisfying life.

Examples: "Suppose that while you are sleeping tonight and the entire house is quiet, a miracle happens. The miracle is the problem, which brought you here (or to the attention of DFCS), is solved. However, because you are sleeping, you don't know the miracle has happened. So, when you wake up tomorrow morning, what will be different that will tell you that a miracle has happened and the problem, which brought you here, has been solved?"

The Coping Question

- Asks how clients manage to keep going in spite of the adversity they face

Example:

How did you manage to get up this morning (make it to this meeting, get through yesterday, etc.)?

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Ineffective Questions

Questions that form barriers to sharing information, building or maintaining relationships, or influencing change are known as ineffective questions.

The Double Question:

- Includes two questions in the same sentence.
- Is difficult or impossible to answer.

*Examples: "*Did you attend orientation and what did you think about the instructor?" "Did you get all your questions answered or were you confused about some things?" "Do you like hot tea or iced tea?"

The Bombarding Question:

- Contains a series of questions.
- Creates an "interrogation" effect.

Examples: "Did you know your ex-husband was going to call the hotline? How was Jeremy acting when he was dropped off, anyway? Just what was going through your head?"

The Statement Question:

- Expresses the questioner's ideas or values or wishes.
- Often begins with openers like "Don't you think…" or "Wouldn't you like…"

Examples: "Don't you think it will be too hard for you to take care of your children until you complete the alcohol treatment program?" "Wouldn't you like to sign up for the new welfare-to-work jobs co-op *right now*?"

The "Why" Question:

- Implies a judgment or criticism of the other person's motives, feelings, or actions.
- Invites defensive or self-justifying responses.

Examples: "Why didn't you stop yourself before you hurt him?" "Why would you consider moving *there*?" "Why didn't you call me before things got so confusing?"

The Loaded Question:

- Contains blame or implies guilt for a negative behavior.
- By answering the question, the person would acknowledge his or her failure.

Examples: (to a person who has not admitted a drinking problem): "Have you stopping whacking your son after you've had a few too many beers?" (To a teenager who denies being sexually active): "So, did you buy condoms from the drug store or get them from the nurse at the clinic?"

MODULE NINE
INTRODUCTION TO INTERVIEWING

Susan

Client: Susan, age 19

Ben, Susan's son, age 2

"I'm Susan. I'm nineteen. I've got a kid, Ben, He's two. They took him away from me and put him in foster care six months ago after I got drunk, trashed my apartment and beat Ben up."

"At first, it was hard for me to take things seriously, you know, but in the past three months, I've turned things around. I've stopped drinking so much, been working steadily at my job, fixed up the apartment, and am getting along better with my landlord. I've visited Ben a lot, too. In the past month, he's been home on several overnights that have gone pretty good."

"You and I started talking about a plan to bring Ben home, but then I hit a snag. Things were okay, you know. Ben was sleeping through the night in his own bed, not crying out and stuff and we were good together. But…I dunno. When I took him back to Mrs. B's, he seemed glad to see her, too, maybe even more smiley. And even though she tries to be nice, I know she looks down on me. By what she asks me, you know, 'Did Ben eat?' "What did you do? Oh, you watched TV. What else?' I just got to feeling down, and it was really like I was going down the tubes, sliding faster and faster. I couldn't stop! So I just went down to the Dew Drop to be around people, and someone bought me a beer, and then another one, and before I knew it, well, it hit the fan… a big fight, chairs flying, broken glass, and the police. I spent the night in jail; I got a court date on disorderly conduct and resisting arrest. It was a mess! And I didn't even start it."

"But I can't help thinking, what's the use? What's the point? I can't get it together. I'll never get it together."

MODULE NINE
INTRODUCTION TO INTERVIEWING

ASSESSMENT QUESTION GUIDE

Questioning begins with eliciting the client's point of view.

These questions convey the sense that the worker values the client's input and perspective and promotes the engagement process. In addition, the worker can follow each question with "What else?" or "Can you tell me more about that?" in order to get more information or greater clarity.

- "Tell me what you know about the concerns raised about child's care (or injury)?"
- "How is it that someone might think that your child may have been harmed or been neglected?"
- "Who else might have had access to your child during that time?"
- "Have there been other instances where concerns have been raised about your care of the child(ren)?"
- "Have you ever felt that you might not be meeting the child's needs or not supervising or protecting them?"
- "What tells you that you are doing an adequate job taking care of your child (ren)?"

Questioning moves to more specific questions about the allegations that prompted the intervention.

If the allegations involve injury to the child, the worker may want to follow this line of questioning that attempts to draw the clearest possible picture of how the injury occurred and the context in which the injury happened. The object is to attempt to generate a kind of eyewitness account of events.

The use of specific, sequential questions is sometimes called chaining. Every question attempts to create the next logical link in the series of actions and responses that made up the injury event or events. This level of detail is important in regard to understanding what may have happened and in determining if inconsistencies or contradictions are present.

The worker begins by describing the injury or injuries that have been documented or reported. The exact questions used and their order will vary depending on the particular circumstances.

The questions below are offered as options.

- "Tell me where you were and what was going on before the incident where your child was hurt?"
- "Who else was present when the child was injured?"
- "Show me where the incident happened (if it occurred in the home and that is where the interview is taking place)."
- "So what happened next?"
- "And then what happened?"
- "What did you say or do then?"

ASSESSMENT QUESTION GUIDE

(Continued)

- "What did the other person say or do then?"
- "What did the child say or do then"
- "When did you first notice that the child had been hurt or was in distress?"
- "What did you observe that indicated the child had been hurt or was in distress?"
- "What did you do then?"
- "How did you know that was how you should respond?"
- "Has this situation with you child happened before?"
- "How did you respond then?"
- "What made the situation in which the child was hurt different?"

Exploring contradictions and inconsistencies

If the explanation given by the client contradicts or is inconsistent with the injuries or medical evidence, the worker may want to use confrontational questions in the "Colombo" style of confrontation.

- "The medical evidence or explanations given by the child or others is different than what you have presented to me. How would you explain the differences?"
- "From what I know about the kinds of injuries your child has, it's difficult for me to understand how they could have occurred given your explanation. Help me understand how that could be."
- (Example: injuries on front, back and inner thighs of child's legs and buttocks are not consistent with parent's explanation of a fall from a bicycle or fall down steps.)
- "What puzzles me is you say you didn't take the child to the hospital for two days after the injury because you didn't think it was serious and the child seemed to be OK. However, the doctor says the injury would have caused severe pain and the child would likely not have been able to walk. What do you think about that?"
- "You say that the child was running and fell and hit his head on the wall. The child says you hit him on the head with a frying pan because he wouldn't finish his breakfast. That's a very different version. What do you think about that?"

Introduction of questions to the client: Example

"Mr. and/or Mrs./Ms. Jones, I am going to ask you some questions about yourself and your family that will help me to better understand if there are any additional risks to your child that I or possibly you may not be aware of. In addition, another purpose of theses questions is to help us identify strengths and resources that you and your family have that may help to keep the child (ren) safe and healthy. Do you have any questions before I begin?"

MODULE NINE
INTRODUCTION TO INTERVIEWING

ASSESSMENT QUESTION GUIDE

(Continued)

Note: The worker should be prepared to recognize and compliment the client for any positive qualities or accomplishments or positive steps the client may have taken or is taking to keep the child safe and properly cared for.

Given specific case circumstances, the worker must decide which of the following questions are appropriate to be asked at the initial visit, which ones are best asked at a later visit, what questions should be omitted entirely and what new questions should supplement the list below.

Sample questions to parents about children:

- "Tell me about your children. How would you describe _____ (name)?"
- "What qualities do you like best about your child (ren)?"
- "What behaviors would you like to see changed in your child (ren)?"
- "What do you expect your child to do for you?"
- "What would your child say are the times that he/she feels most safe?"
- "What would your child say are the times that he/she feels most unsafe or afraid?"
- "What do you believe about how children should be taught how to behave?"
- "When a child doesn't do what a parent tells him/her to do, how do you think the parent should correct him/her?"
- "Does the child's age influence how you would correct him/her?"

Sample questions to parents about their own childhood experiences:

- "How did you learn about parenting?" "From whom?"
- "How are your ideas and parenting practices similar to or different than your parents (or the people who raised you)?"
- "When you were growing up, did you ever live away from your parents?" If Yes,
- "Tell me about that."
- "Tell me about your growing up years. What were some of the best times you remember? What were some of the worst times?"
- "Were there times when you didn't feel safe?" "Tell me about those times."
- "How did you cope with those unsafe or scary times?" "Who helped you?"
- "Looking back on your childhood and teen years, do you believe by today's standards you might have been physically, emotionally, or sexually mistreated or neglected?"

MODULE NINE
INTRODUCTION TO INTERVIEWING

ASSESSMENT QUESTION GUIDE

(Continued)

Sample questions related to parents about keeping children safe:

- "If you were harmed or mistreated, what are you doing now as a parent to help keep your children safe from that kind of harm or fear?"
- "Are there times when your child (ren) misbehaved and you felt like hitting him, even hurting him, but didn't?" "How were you able to do that, not hitting or hurting him?"

Sample questions about parents' relationships & safety:

- "How did you and your spouse/boyfriend/girlfriend meet?"
- "What qualities in the other helped you decide to be a couple or stay together?"
- "What qualities or behaviors about the other person would you like to see changed?"
- "How do the ways in which you treat each other help the children feel and be safe?"
- "Are there ways and times when you treat each other that make the child feel unsafe?"
- "What would I see and hear if I were here when you were angry at each other?" "Would I hear insults, cursing, and threats?" "Would I see anyone get pushed or hit?" "Tell me about that?"
- "What would your children, friends, or relatives say about what needs to change in your relationship to create a safer and happier home?"
- "Have you (either of you) called the police or had the police called on him/her because of a problem in this relationship or any other relationship? Tell me about that."
- "Have either of you had a Protection From Abuse order issued against you?"
- "Do you (either of you) have children from a different relationship? Where are they?"

Sample questions about arrest/criminal history:

- "Have you ever been arrested and charged with a violent crime or assault against an adult or child? Tell me about that."
- "Where you ever convicted of a violent crime or assault against an adult or child? Tell me about that."
- "Have you ever been convicted of any crime? Tell me about that."

ASSESSMENT QUESTION GUIDE

(Continued)

Sample questions about drug & alcohol use:

- "Tell me about what part alcohol plays in your daily life?"
- "Has anyone ever told you that they thought you had a problem with alcohol?"
- "Is drug or substance use a part of your life?"
- "Has anyone ever told you that they thought you had a problem with drugs, either prescription or non-prescription?"
- "Have you ever been arrested for drug use or possession?"
- "What would family members, friends, employer, or your children say about how alcohol or drugs influences your personal behavior, work behavior, parenting or behavior toward each other?"
- "Have you ever been in an alcohol or drug rehab program? What was the outcome?"

Sample questions about mental health/supports/change:

- "When you are feeling stressed or down or overwhelmed, who do you turn to for support?"
- "How often do you feel that way?"
- "Have you ever had health or mental health problems that required you going to a hospital, or made you unable to care for yourself or your children?"
- "Are there any supports that you had in the past, but don't have now?"
- "What would it take to get those supports back, or to find replacement supports?"
- "Considering all that we have talked about, what do you think needs to change in order for your children to feel and be safe, and for you to feel like and be an effective parent?"

Resource: The Pennsylvania Child Welfare Training Program 301: Effective Interviewing: Skills for Promoting Engagement & Change

MODULE NINE
INTRODUCTION TO INTERVIEWING

Reflection: The process of understanding another person's feelings, values, experiences, beliefs, needs and self-concept by listening to the words and feelings in the message, observing nonverbal cues, and then stating in the receiver's own words what the sender is communicating for verification by the sender.

MODULE NINE
INTRODUCTION TO INTERVIEWING

Do's and Don't of Reflection

DO:

- Be attentive.
- Want to listen.
- Work to see the world through the other person's eyes, since his/her emotions are as valid as yours.
- Remember that people's feelings can change from moment to moment.
- Trust the other person's ability to handle his/her feelings and find solutions to his/her problems.
- Temporarily put aside your own feelings and focus all your attention on the other person's message. If you find yourself thinking that the other person's message makes you feel anger or some other emotion, or if you want to interject your own thoughts to explain something, you are not trying to "see" through the other's eyes. Shifting focus from the sender to yourself impedes reflection.

DON'T

- Criticize or be judgmental.
- Reassure or sympathize.
- Tell the person what to do.
- Tell the person how to feel.
- Try to solve another person's problems for him/her.
- Try to convince the person to behave, think, or feel the way you think he/she should.
- Send a message related to yourself.
- Allow emotionally laden words to upset you.

What I'm Hearing Is…

1. You are interviewing Madonna, a client who was just transferred to you from a retiring child welfare worker in your agency. Madonna became a client six months ago when her 2-year-old was found to be undernourished and not always supervised adequately. Now, Madonna is frantically jiggling her new, fussy baby. Although, with the assistance of a parent aide, she has been providing nutrition and supervision for her 2-year-old, you are concerned that this new baby will overwhelm her fledgling parenting skills. "Hi," you say, soothingly. You nod toward the baby. "It's tough when they won't settle down." "I'll say!" she's exclaims. "This baby cries and cries and cries and cries. Nothing I do will make her settle down. I'm almost beside myself!"

Develop a reflection of Madonna's feelings:

2. You're the case manager responsible for youth in residential care. You have been working with 14-year-old Peter, who met his placement goals during the past year at Macgregor's Hall. Peter passed all his subjects, didn't get in trouble during home visits, and participated in the local Alateen program. The staff agrees that he has achieved his objectives, although his counselor expresses concern that Peter still has an "underdeveloped" conscience. Peter is scheduled to go back home permanently. As you meet with him to finalize plans, especially around what he will do with himself during the summer months, you notice that he is fiddling with an expensive gold chain worn around his neck.

   "Peter," you say, "what a beautiful chain. I haven't noticed it before."

   "Yeah." He smiles. "Nice, isn't it? I found it out by one of the barns."

   "Oh?" you say, "Nobody said they lost it?"

   "Nah," he says, with a deep sigh. "Besides… you snooze, you lose, that's what everybody always says. Gotta stay sharp or the sharks'll get you."

   Develop a reflective response that focuses on the content of Peter's last statement:

Competence in the skill of reflections requires continual practice, as well as valuing the worth of individuals.

MODULE NINE
INTRODUCTION TO INTERVIEWING

Communication Strategies for Working with Children and Youth Relationships:

- *Frame the event.*
- *Use an inviting opening statement.*
- *Encourage questions.*
- *Attend to emotional content.*
- *Make descriptive comments.*
- *Avoid critical statements.*
- *Give praise.*
- *Comment on specific behavior.*
- *Speak in the first person.*

Language:

- *Establish a common vocabulary.*
- *Use simple, clear words.*
- *Use simple sentences.*
- *Explain transitions.*
- *Ask for examples.*
- *Avoid abstract concepts.*
- *Avoid asking for relational judgments.*
- *Use restating.*
- *Use repetition.*
- *Be aware of children's very literal use of language*
- *Be on the alert for possible miscommunication.*

Voice:

- *Speak slowly.*
- *Use your gentlest tone of voice.*
- *Use a calm and controlled tone of voice.*

Body language:

- *Maintain eye contact.*
- *Stay tuned to attending.*

Space:

- *Find the comfortable distance.*
- *Tune in to the environment.*
- *Use touch when appropriate.*

MODULE NINE
INTRODUCTION TO INTERVIEWING

How the Unique Aspects of Adolescent Development Impact the Interview Dynamic

Cognitive Development

1. **Adolescents process questions differently from adults**.

   Adult interviewers must gauge an adolescent's ability to process language, his/her level of vocabulary, ability to abstract and other indicators of cognitive development in order to structure appropriate questions.

2. **Adolescents think more in the present and have trouble focusing on the future**.

   Interviewers have to make the connections -- between what information the interviewer is seeking and the teenager's interests -- for the teenager to see.

   The interviewer has to somehow address the teen's immediate concerns to put the interview back on track.

3. **Adolescents are fairness fanatics**.

   An interviewer must learn how to navigate around sticking points like these to put the interview back on track.

Identity Development and Social Development

1. **Egocentricity**.

   Critical to a successful interview is the ability of the interviewer to build trust so that the teenager can feel that s/he can confide in the interviewer. This includes asking questions in a non-judgmental way.

2. **Identity development**.

   Interviewers must take special care to structure questions and use a tone of voice that conveys to the young person that the interviewer is not judging the young person but is instead truly interested in who s/he is.

3. **Relationships with authority figures**.

   Rapport-building is the necessary foundation for a successful interview. Adults typically use eye contact to convey interest. A young person, however, will sometimes interpret a stranger making eye contact with him/her as a sign of aggression. Therefore, the adult must gauge the situation before deciding whether to use eye contact. Moreover, in general two adults should not interview an adolescent at the same time, because the adolescent will feel "ganged up on." With a child who the interviewer senses is overly eager to please, the interviewer should reassure the child that s/he will not be judgmental of the child's answers (i.e., "I'm going to continue to help you as your attorney no matter what you tell me about what happened that day") and simply wants to hear the child's viewpoint

4. **Competency Development (i.e., Mastering Skills).**

   Talking about what s/he (and his/her family) has done well is a way to build rapport and get the adolescent more involved in the interview.

Resource: *TALKING TO TEENS IN THE JUSTICE SYSTEM: Strategies for Interviewing Adolescent Defendants, Witnesses, and Victims*. American Bar Association Juvenile Justice Center Juvenile Law Center, Youth Law Center Lourdes M. Rosado, Editor http://www.njdc.info/pdf/maca2.pdf

MODULE NINE
INTRODUCTION TO INTERVIEWING

Caseworkers may directly interview children for several purposes:

- Establish a trusting, helping relationship.
- Gather relevant assessment information about the child and the situation.
- Explain and prepare the child for a change.
- Help the child deal with concerns or fears.
- Engage an older child or youth to participate in problem-solving.
- Provide support and assistance in a traumatic situation.
- Help an older child or youth to plan and implement changes

MODULE NINE
INTRODUCTION TO INTERVIEWING

Points to Remember When Interviewing Children

- Children may sound adult, but they do not always know what adults know.
- Children will answer what they think you mean or what.
- Children don‘t know that they have clarification rights.
- Children believe that they are supposed to have an answer.
- Prepositions are difficult and confusing for children (under, over, in, on, through, on top, underneath).
- Time concepts are difficult for children:
- Attach distant times to memorable events, such as holidays.
- Attach time of day to meal times, television programs, light or dark, day or night.
- Thinking is very concrete; do not use irony, metaphor, or analogy.
- Young children do not think logically. Their responses may be out of order, disjointed, or a combination of several incidents.
- Children‘s attention span is limited.

Techniques for Interviewing Children

- Use appropriate intonation and language, and do not lead children.
- Ask the child to give you examples.
- Be open to what children tell you.
- Think about and formulate beforehand, your opening statements, taking into consideration the child‘s age, ability level, behavior, and reasons for referral.
- Make descriptive comments, such as —I like your shirt.
- Use reflections. Give praise frequently.
- Avoid critical statements.
- Use simple questions and concrete referents:
- Ask for affect labels.
- Show pictures and ask the child to describe what is happening in the picture.
- Have the child draw a picture of a child and tell about it.
- Use story completion.
- Have the child respond to a hypothetical problem. Model the interview after a school-type situation.
- Formulate questions in the subjunctive mood (hypothetical) when necessary.
- Be tactful. Recognize children‘s discomfort.
- Use props, crayons, clay, and/or toys to help young children talk.
- Use sentence completion technique.
- Use fantasy techniques such as:
    - Three wishes
    - Desert Island: “Here‘s a pretend question. Suppose you were shipwrecked on a desert island. If you could have just one person with you, who would that person be?”

- Help children express their thoughts and feelings:
  - Use alternative techniques. For example, “Do you ever wish you could be someone else, or are you happy to be you?”
  - Give children a chance to give a positive response before asking a question that will require a negative response. “What things do you like about school?” “What things aren‘t so good?”
- Follow up with probes that provide concrete structure.
- Clarify an episode of misbehavior by recounting it.
- Clarify interview procedures for children who do not communicate.
- Understand and use silence.
- Handle resistance and anxiety by giving support and reassurance.
- Consider the child‘s age and needs in setting tempo and length of the interview.

Statements to Use When Interviewing Children

- “There are no right or wrong answers; only things that you know. I‘m not there in your life, so I don‘t know the answers to my questions. I need for you to tell me what you know.”
- “The truth is the best answer; no pretending or making things up. Only what‘s real.”
- “No guessing. ‘I don‘t know’ is a good answer, if you really don‘t know something.”
- “If a question doesn‘t make sense or you get confused, say ‘I don‘t understand’ or ‘huh‘?”
- “If you used to know something that you can‘t remember anymore, just say, ‘I forgot’.”
- “If you know the real answer but you don‘t want to tell me something, just say you don‘t want to talk about it. That‘s okay.”
- “If I get something wrong or I don‘t understand what you mean, I want you to tell me. I won‘t get mad. Sometimes I might get confused and need your help.”

MODULE NINE
INTRODUCTION TO INTERVIEWING

Scenarios for Communicating with Children

Scenario A: Matt

Matt is a 13-year-old white male from a rural background who has lived with his mother's cousin for nine months due to Matt's involvement in a string of "B & Es" (breaking and entering) involving hunting trailers and vacation homes that were closed for the season. Matt and some friends did very little damage but they fenced stolen electronic items and drank the alcohol they found in these homes. Matt has been attending Alateen and an individual counseling program and has been working 20 hours per week in a community-cleanup program in order to make full restitution for the damages he caused. He has been very compliant with the program; two visits to the county jail have helped convince him that he wants to turn his life around. The Alateen program has been extremely important in helping him face the fact that he was becoming alcohol dependent. He has made a friend in the program who shares his interest in music, video games, and camping. A friend who is positive and supportive is a new experience for Matt. He is being prepared for reunification with his mother. In the past nine months, she also attended counseling and has become more assertive and involved as a parent. She wants to have Matt returned as soon as possible because she misses him, feels she can now control his behavior, and feels that he is a burden on her cousin, although her cousin has never indicated this to anyone, and in fact enjoys having Matt in her home.

MODULE NINE
INTRODUCTION TO INTERVIEWING

Adult Role for Scenario A: Foster Care Case Manager

Concern/Issue: You want to reunify Matt with his mother as soon as possible but you worry that when Matt returns home he may revert to his self-destructive behaviors.

1. What are some strategies and skills you will use to engage Matt?

2. What setting would you choose to facilitate communication (e.g., an office in your building? a playground? a fast food restaurant?). Why do you think your choice of setting would be effective?

Scenario B: Shelly

Shelly, an 11-year-old African-American girl, has been placed with her grandmother while her mother completes a substance abuse program. She has been there for a month. Things were very scary at home as her mother descended into a crisis involving cocaine, gave birth to a premature baby (now in a specialized foster care placement), and had domestic problems with her boyfriend. However, Shelly has been having a difficult time making the transition from living at her mother's, where she had free rein to do as she pleased, to living with her "old-fashioned" grandmother who has rules about everything from how to line up the silverware in the drawer to when to go to bed to what tone of voice it is appropriate for a young lady to use in conversation with an adult. Shelly often "sasses" her grandmother back, refuses to do her chores, and dawdles so much that she is late for school. She also often wakes up screaming from nightmares, complains of headaches and stomachaches, and cries easily herself.

MODULE NINE
INTRODUCTION TO INTERVIEWING

Adult Role for Scenario B: Foster Care Case Manager

Issue/Concern: The grandmother is very stressed and frustrated by Shelly. She has asked you to help her understand —what's going on with that child and to decide whether she needs to institute new discipline strategies to cope with Shelly's sassy, —out-of-control behaviors. You are concerned that this placement could disrupt and you might have to find another home for Shelly if you can't help her and her grandmother get along better. Although Shelly's behaviors do seem disrespectful of the grandmother's wishes, you are also concerned about the meaning of the other symptoms, e.g., the nightmares, headaches, and stomachaches.

You plan to meet jointly with Shelly and her grandmother in the near future, but first you want to talk with Shelly individually to try and reach an understanding of her thoughts and feelings about her situation.

1. What are some strategies and skills you will use to engage Shelly?

2. What setting would you choose to facilitate communication (e.g., an office in your building? a playground? a fast food restaurant?). Why do you think your choice of setting would be effective?

MODULE NINE
INTRODUCTION TO INTERVIEWING

Scenario C: Lena

Lena, a 6-year-old Hispanic girl, has been living in a foster home for several months. She was placed after she and her 6-month-old brother were left unsupervised for two days by their single parent father, while he was binge drinking with a friend across town. Lena eventually dialed 911 because she was hungry, and because her brother wouldn‘t stop crying. When the police located her father, he insisted that the 6-year-old was capable of caring for herself and her brother when he wasn‘t home, and when no relatives were found who could care for the children, a protective removal was deemed necessary to promote their safety. Lena appears to be a fearful, nervous child who misses her mother a lot. The mother is divorced from the father, and he has physical custody of the children. The mother is in the advanced stages of multiple sclerosis, and is physically unable to care for the children. She lives in an apartment, and requires daily assistance from a home health aide. Lena makes her cards and includes her in her bedtime prayers. She clings to a stuffed toy (“Gee”) her mother gave her during one of her visits, much as a toddler clings to a favorite ’blankie‘. Lena is seen by the foster parents and by her teachers as an “angel—a good, compliant little girl who‘s never any trouble.” The last time the foster care worker met with the foster parents, Lena put words in Gee‘s mouth that made the worker wonder if the little girl thinks being placed in a foster home is her punishment for telling the truth about what her father did. (Lena held Gee up to the worker and said: “Gee says it‘s not nice to tell on Daddy. Gee says he‘ll never be bad again.”)

MODULE NINE
INTRODUCTION TO INTERVIEWING

Adult Role for Scenario C: Foster Care Case Manager

Concern/Issue: You want to follow-up on your concern that Lena may think what has happened in her family is her fault. You want to clarify that she didn‘t do anything wrong.

1. What are some strategies and skills you will use to engage Lena?

2. What setting would you choose to facilitate communication (e.g., an office in your building? a playground? a fast food restaurant?). Why do you think your choice of setting would be effective?

MODULE NINE
INTRODUCTION TO INTERVIEWING

Stages of the Interview Process

Preparation

Engagement

The Interview

The Closing

Documentation

MODULE NINE
INTRODUCTION TO INTERVIEWING

Preparing for the Interview

Review preparation before going into the field:

- ✓ Research files to learn of any previous DFCS involvement.
- ✓ Consult with colleagues.
- ✓ Conference with your supervisor.
- ✓ Develop a plan of action.
  - What is the purpose of the interview?
  - What are the goals?
  - What order do the interviews need to be done in?
  - What is the best location for the interviews to take place?
  - How long will be needed for each interview?
  - Is law enforcement needed?
  - Is English the primary language or is an interpreter needed?
- ✓ Determine what information can most likely be obtained in an interview and what can be elicited from another source.

Preparing yourself for the interview:

- ✓ Remember that your own values about behavior, customs, families, and child-rearing go with you as you enter a client‘s home.
- ✓ Recall discussion of use of authority vs. power and how these dynamics can affect an interview.

MODULE NINE
INTRODUCTION TO INTERVIEWING

Approaching the Family

- ✓ Remain calm.
- ✓ Address the parent/caregiver in a respectful way (Mr., Mrs., Ms.)
- ✓ Introduce yourself by name.
- ✓ Show your identification.
- ✓ Ask if you may enter the home.
- ✓ Clearly state the purpose of your visit.

  "We have a report concerning injuries your child has received (your children being left alone, etc.) Our agency is required to look into all reports such as this to make sure that the children are safe."
- ✓ Show empathy and concern for the client.
- ✓ Be non-punitive in your approach.
- ✓ Be honest.
- ✓ Avoid making promises.
- ✓ Be descriptive. For example, "On the basis of the report we have received, Johnny has injuries on his arms and legs."

MODULE NINE
INTRODUCTION TO INTERVIEWING

Strategies for Home Visits

Door-to-Door Salesperson (good for first contacts)

- A smile on your face.
- Identify yourself while showing your identification.
- Ask to enter the home pleasantly, —May I come in?
- Do not discuss the nature of your visit until entering the home.

The carrot (good for passive-resistance or to gain subsequent contact with family)

- Pleasant demeanor.
- If you are aware of client needs, such as food, diapers, or other concrete assistance, bring it with you.
- Incorporate your 'free sample' into a request to enter or speak with the client.

The stick (good for clients who have avoided you)

- Knock on the door loudly and persistently.
- Use firm, non-nonsense voice.
- Be prepared with concrete information about the client's behavior. "I was here on the fifth, the tenth, and the twelfth. There was talking and noise from the apartment, but no one answered."

Lieutenant Columbo approach

- Ask client for assistance.
- Express confusion and request clarification.
- Very low-key and non-threatening.

Power of silence

- Speak very softly
- Use short, simple statements and questions.
- Allow the client plenty of time to answer.
- Be relaxed and non-accusatory.
- You must be comfortable with silence.

Negotiation

- If it is not an emergency and the client will not allow entry, ask for a convenient time to return.
- Do not discuss the nature of the referral.
- If there is a potential issue of domestic violence, be open to negotiating a different setting for meeting.

Good guy rub-off

- If client has a positive working relationship with another social worker or colleague, ask that person to accompany you. Have the known and trusted party introduce and endorse you.

Implied intimidation rub-off (good for strong resistance or those with law enforcement connections)

- If the client is on probation or parole, ask the officer to accompany you.
- If there is a history of law enforcement involvement, request an officer to accompany you.

MODULE NINE
INTRODUCTION TO INTERVIEWING

Interview Methods

Observation: Refers to what we see when we are with the family.

The Johnson Family The Johnson family had been referred by the school principal for suspected abuse of six year old Betty. During the 30 minute interview with Betty‘s mother, the case manager noted that Betty stood quietly by her mother and patted her softly on the shoulder, knee, and back while the mother cried and told the case manager her story. Betty brought her mother a box of tissues, threw the used tissues in the trash, and asked her mother if she would like a glass of water. When the mother began to look for her cigarettes and lighter, Betty jumped to get them for her. Betty repeatedly said, “It‘s okay, Mommy. It will be okay.”

Betty‘s mother sometimes ignored Betty, and at other times rested her head against Betty‘s shoulder. Betty‘s face reflected serious concern. She did not smile or laugh. She intently watched her mother, scrutinized her mother‘s face and body language, and responded immediately when her mother seemed to want or need something. The case manager noted that Betty‘s behavior could potentially be interpreted as the “role reversal” that is typical of abused children.

MODULE NINE
INTRODUCTION TO INTERVIEWING

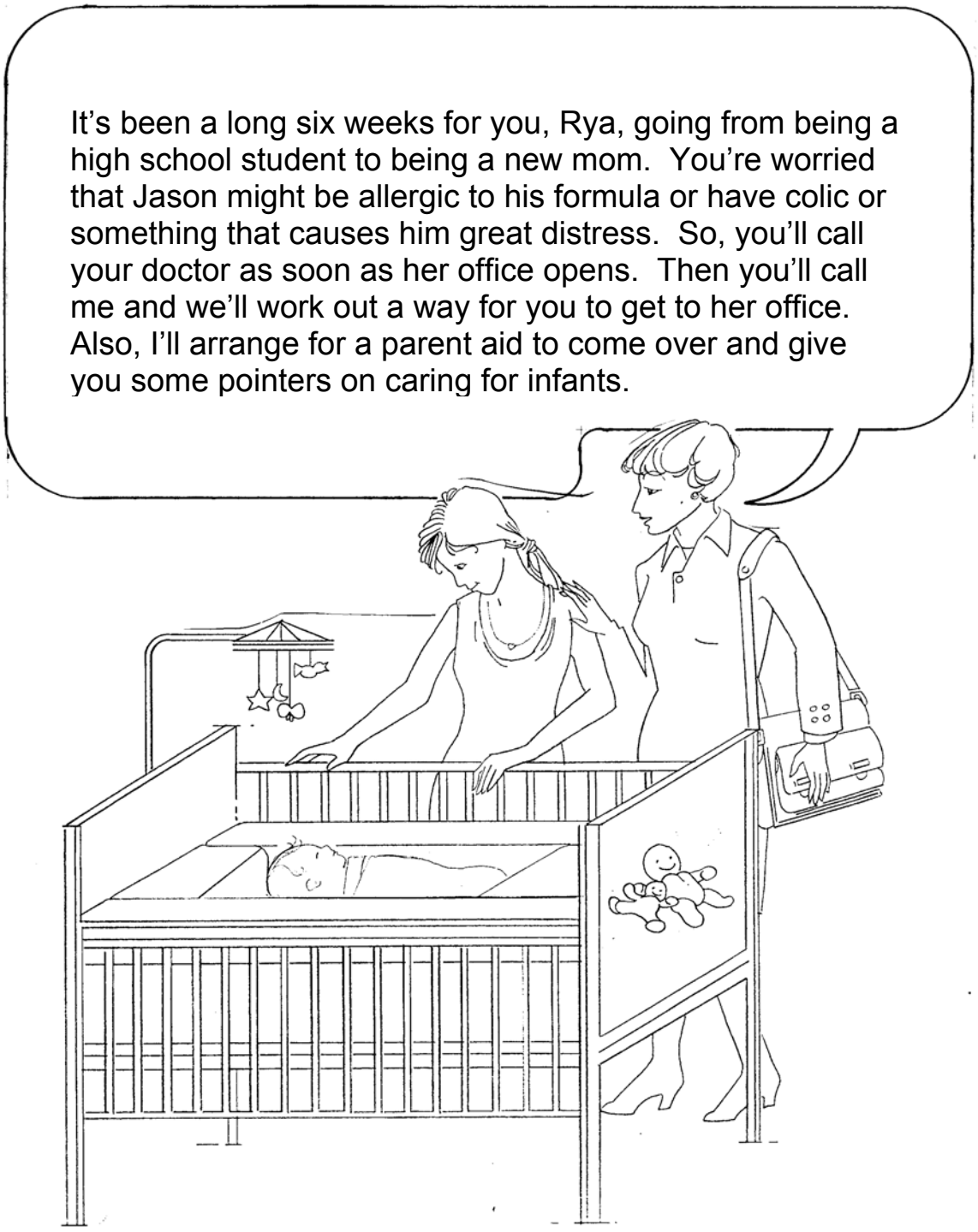
Listening: One of the most effective interviewing techniques

Focused Listening: Attempting to concentrate on a specific part of a message and to search for connections when they are not readily apparent.

Question Formulations: Purposeful questions, comments, and other interjections are used by the case manager to direct and guide the interview to achieve its purpose.

MODULE NINE
INTRODUCTION TO INTERVIEWING

Summarization



Summarizing Summarization

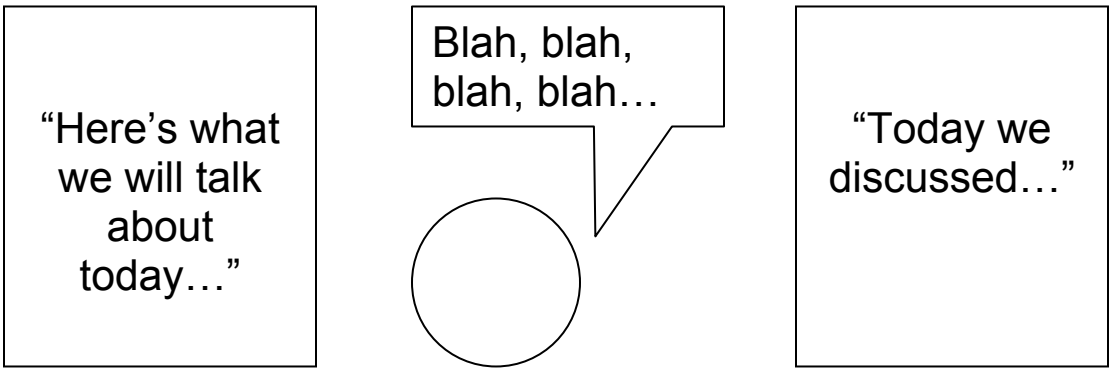
Length: Keep it brief.

Timing: Use during natural breaks in client's train of thought or when client is rambling or delivering long, hard-to-follow dialogue. Apologize in the latter case.

Tone: Convey acceptance of client's perspective and experience.

Accuracy: Check for accuracy with client,

Supportive Skills:



Order of the Interviews

1. Child Victim

2. Siblings and other children

3. Non-offending parent

4. Alleged perpetrator

5. Collateral sources

MODULE NINE
INTRODUCTION TO INTERVIEWING

The Interview Guide

General Flow

- This interview will last for about 5 to 8 minutes.
- The interviewer and the interviewee are encouraged to discuss the interview before it is conducted.
- The interview will be observed by colleagues, who will later offer verbal and written feedback.

Specific Interviewer Tasks

- Interview your partner for about 5 to 8 minutes.
- Remember that this is an initial interview; your goal is to engage and reach mutual understanding with your "client," not to resolve a problem.
- We'd like you to demonstrate the following skills:
    - Attending: nonverbal and verbal
    - questions: open and closed
    - reflection: of feeling and content
    - summarizing: to close the interview
    - core helping conditions (empathy, respect, genuineness)
- You may demonstrate any of the other skills practiced during the week.
- You will be receiving feedback; we'll also want you to give yourself feedback.
- You are encouraged to contemplate an action plan as a result of the feedback process: "Which skills do I need to focus on back at the job?"

Specific Interviewee Tasks

- To the best of your ability, try to simulate words, actions, and feelings of the role your partner has picked for you.
- You have been given a sketch outline; make up any details you wish.
- Try to attend to the impact the interviewer's words and actions are having on you.
- Try to notice behaviors, being as specific as possible, that in the role made you feel "engaged and wanting to achieve mutual understanding with this person."
- Be prepared to offer feedback.

Specific Observer Tasks

- Attend to the interview, paying particular attention to **interviewer behaviors** and **interviewee reactions**.
- After the interview, complete the worksheet, Feedback Forms.

Be prepared to explain or elaborate on your feedback if the interviewer has any questions.

MODULE NINE
INTRODUCTION TO INTERVIEWING

► Suggested Interview Topics

Instructions: The following are roles that will be assumed by the person being interviewed. If you are the interviewer, it is your choice which role you wish your partner to assume. If you and your partner want to suggest another role, you may, as long as it is related to child welfare practice. All these scenarios are in the initial phase of the relationship, seeking to join and otherwise engage your client and reach mutual understanding about his/her situation.

- You are a single parent, overwhelmed with the responsibility of caring for three young children, and hoping to arrange day care so you can continue your education.

- You are the parent of a 15-year-old adolescent who has begun staying out all night with friends whom you have never met. You have been contacted by the school because of your teen's truancy, and they share your suspicion that drugs may be involved.

- You are a 12-year-old youth who has had a lot of child care responsibilities for your younger siblings, especially since your mother started drinking again. You would like more time for yourself and to be with your friends. However, you know your mother needs you and you don't want to let her down.

- You are a new parent dealing with a fussy baby and you are exhausted. You have no help, and you haven't had more than a few hours sleep since the baby came home. Sometimes you just want to shake the baby to make the crying stop.

- You are the parent of three children, all of whom are having difficulties in school. You'd like to help more, but you can barely read and write. When you go to the school for meetings, you feel as though they talk to you like the fourth kid in the family. You want to help the kids, but you're tired of feeling embarrassed.

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Introduction to Documentation

MODULE TEN
INTRODUCTION TO DOCUMENTATION

LEARNING OBJECTIVES

Upon completion of this module case managers will be able to:

- Identify and use the CFSR guidelines for recording documentation
- Identify what information needs to be documented in case records
- Demonstrate awareness of the value of quality case documentation
- Identify strategies for meeting documentation requirements
- Use correct spelling, grammar, and sentence and paragraph structure within case documentation.
- Use terminology appropriately and consistently throughout case documentation
- Recognize how their own cultural background may affect their case documentation
- Differentiate between pertinent detail and verbosity
- Demonstrate the ability to record information in a clear, concise and efficient way
- Identify and state case facts instead of worker opinion
- Use the Tablet to take notes and complete documentation

MODULE TEN
INTRODUCTION TO DOCUMENTATION

CHILD and FAMILY SERVICES REVIEW

The qualitative review process, using the Federal Child and Family Services Review guide and ratings, focuses on the quality of case management in each program area and measures the effectiveness of the agency's involvement in each case reviewed. CFSR is looking more in depth at how families are progressing with agency involvement.

QUALITY:

- Did documentation support decisions and were contacts sufficient to provide and/or follow up w/support services?
- Were all needs identified and services provided timely to meet those needs?

CFSR is looking for case record documentation to address specifics, rather than friendly visits, in the areas listed below.

SAFETY:

- Were all risks identified/assessed and was DFCS policy followed in all program areas?
- Were screen outs and diversions appropriate and all criteria considered; did documentation support the decision?
- Was all risk thoroughly assessed and safety provided in 6investigations? (Reasonable efforts?)
- Were assessments completed and services provided to prevent further risk? WAS FOLLOW UP DOCUMENTED?
- Was risk continually assessed with each contact?
- Were placements monitored/visited adequately to meet the child's needs and assure ongoing safety?
- Was there appropriate follow up for subsequent reports of maltreatment?
- Was there supervisory involvement; conferences, approval signatures, etc.?
- Was there documentation to indicate attempts to find parents?
- Was there documentation to indicate safety plans were being monitored?
- When safety issues are identified, does documentation include how the agency plans to address those issues?

PERMANENCY:

Do children have permanency, stability and continuity in their living situation?

- How effectively and timely is the Agency moving children toward permanency?
- Are permanency goals appropriate?

- What services are being provided to assist in achievement of those goals?
- Are placements stable or are moves in child's best interest? Does documentation indicate reason for moves?
- What is the agency doing to maintain connections for child w/family, culture and community? What specific activities?
- What are barriers to permanency?
- Were attempts to find relatives documented?
- Was there agency effort to prevent unnecessary moves?
- What efforts are being made to finalize adoptions timely according to ASFA regulations?
- Does documentation indicate why child is not placed w/siblings?
- Does documentation indicate a provider's involvement? Are providers being monitored for specific progress with family?

WELL BEING:

Do families and children have adequate services to meet their needs?

- What support did the agency provide for the placement?
- Were children's, parents and foster parents' needs assessed and identified?
- Were there unidentified needs?
- What kind of assessments was completed? (CCFA, psych evaluations, etc.) Does documentation indicate FOLLOW UP?
- Were appropriate services provided to address all identified needs?
- Were visitations w/parents and siblings facilitated by agency?
- Were the child's educational, physical and mental health needs assessed when appropriate? (If relevant in CPS but mandated in PLC.)
- Did the agency provide follow up to ALL recommendations?
- Were child and family involved in development of case plan? (In placement, we are looking for involvement beginning w/age 8 if child is mentally capable of understanding. In CPS, only if child is directly involved in reason case is open such as involvement in family counseling, behavioral problems etc.)
- Were worker contacts made according to needs in CPS and Placement? Was there documentation to indicate interaction between worker and child and/or parents on home visits? Were case plan goals and progress (or lack of) addressed w/each visit?
- What is agency doing to move family toward achievement of case plan goals?
- Are case reviews updated with new information?
- How is the agency advocating for child's educational needs?
- Does documentation indicate how agency is meeting child's physical and mental health needs?
- Does documentation include specific agency support for foster parents?

MODULE TEN
INTRODUCTION TO DOCUMENTATION

DFCS FIELD OPERATIONS CASE REVIEW GUIDE
AUGUST 2008

Region:	Case Name:	Reviewed by: (Name and Position)
County:	Case Numbers:	Case Worker:
Case Program:	Open (removal if FC) date:	Date of Review:
Review Period:		☐ [redacted] ☐ [redacted]

CASE PROGRAM	APPLICABLE QUESTIONS
Diversion	Only the Alpha Questions for Items 1, 3, & 4 Also Question A on Items 21, 22, & 23
Family Preservation	Items 1, 2, 3, 4, 15 (alpha E only)17, 18, 19, 20, 21, 22, & 23
Intake	Item 1 (*Only* Alpha Questions; not Item 1 itself)
Investigation	Items 1, 2, 3, 4, 21A, 22A, & 23A Alpha Question B on Item 22
Placement	Items 3 - 23

MODULE TEN
INTRODUCTION TO DOCUMENTATION

SAFETY				
OUTCOME S1: Children are, first and foremost, protected from abuse and neglect.				
ITEM 1	**Of all of the investigations received on this case during the period of review, were responses to all accepted maltreatment reports initiated with face to face contact with the child(ren) *(who is/are the subject of the alleged maltreatment)* within the assigned time frame or was there documentation that concerted diligent efforts were made to locate the child(ren) within the assigned response time frame? (Timeliness of initiating reports of child maltreatment).**	☐ **Yes**	☐ **No**	☐ **N/A**

Item	Description	Yes	No	N/A
A	Does the intake clearly identify child victim, caretakers and allegations?	☐	☐	☐
B	☐ [redacted] ☐ [redacted] ☐ [redacted] ☐ [redacted] ☐ [redacted] ☐ [redacted] ☐ [redacted] ☐ [redacted] ☐ [redacted] ☐ [redacted] Were the following screens checked, reviewed and results documented:	☐	☐	☐
C	Based on information available, was the appropriate case disposition and time frame assigned?	☐	☐	☐
D	Did the supervisor approve the intake and assign it to the investigator timely?	☐	☐	☐
E	Were all the screenings and prior history reviewed and significant findings documented?	☐	☐	☐

MODULE TEN
INTRODUCTION TO DOCUMENTATION

F	Was the assigned response time met for each identified child victim?	☐	☐	☐
*G	If response time frame was not met, were there timely and concerted diligent efforts made and documented(concerted diligent efforts refer to going to extreme measures to locate the child victims)?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME S1: Children are, first and foremost, protected from abuse and neglect.				
ITEM 2	**Within the previous 6 months, has this case been <u>without</u> a substantiation of maltreatment? (Absence of recurrence of maltreatment)**	☐ **Yes**	☐ **No**	☐ **N/A**

Item	Description	Yes	No	N/A
A	If the current investigation is substantiated, did any of the prior substantiation investigations within the last 6 months involve a different perpetrator?	☐	☐	☐
B	If the current investigation is substantiated, did any of the prior substantiation investigations within the last 6 months involve a different allegation?	☐	☐	☐
C	If the family had a prior family preservation case, does documentation support that adequate services were provided to resolve risk to the family prior to case closure?	☐	☐	☐
D	Does documentation indicate that a FTM was held prior to case closure in Family Preservation cases to develop a discharge plan for the family?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME S2: Children are safely maintained in their homes whenever possible and appropriate.				
ITEM 3	**During the period under review, did the agency make concerted efforts to provide services to the family to prevent child(ren)'s entry into foster care or their re-entry after a reunification?** *For example:* *Were services appropriate?* *Safety assessed and addressed on an ongoing basis?* *Services provided to non-custodial parents?* *Risk factors such as domestic violence addressed?* *Or was the risk so great that an emergency removal was warranted?* **(Services to family to protect child(ren) in home and prevent removal or re-entry into foster care).**	Yes ☐	No ☐	N/A ☐

Item	Description	Yes	No	N/A
*A	Were needed and available services provided at a frequency and quality necessary to support the child in their own home, safety resource or foster home?	☐	☐	☐
*B	Does documentation support that reasonable efforts were provided to prevent the child from being removed form their birth home, relative home or foster home?	☐	☐	☐
C	Is there documentation that cases were staffed and services initiated timely when cases were transferred between programs/counties?	☐	☐	☐
D	If the case was closed, was the family provided with linkages to appropriate resources to address any identified needs?	☐	☐	☐
E	Does the case record contain a current valid court order/authority for placement?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME S2: Children are safely maintained in their homes whenever possible and appropriate.				
ITEM 4	**During the period under review, was there a concerted effort to assess and address risk and safety concerns to the child in their own home or in the home of a safety resource or foster home?** *For example:* *• initial assessment* *• all safety plans identify risk and appropriate services to address risk* *• allegations should have been substantiated based on the evidence in the file* *• all adult household members(age 16 and older) assessed (including all intake screening on newly identified household members)* *• ongoing assessment for safety including family engagement in services to address identified concerns* *• case closed appropriately • Foster Home Policy Infraction concerns* **(Risk assessment and safety management)**	☐ Yes	☐ No	☐ N/A

Item	Description	Yes	No	N/A
A	Is there clear documentation that a separate face to face interview was conducted with each parent/and or caregiver as well any other adult household member, including a discussion of all allegations?	☐	☐	☐
B	Is there clear documentation that a separate face to face interview was conducted with the alleged perpetrator, including a discussion of all allegations?	☐	☐	☐
*C	Is there clear documentation that each child subject to the report or foster child was observed and interviewed privately?	☐	☐	☐
D	If there were allegations of physical abuse on a child under the age of four, was the child examined for injuries per policy?	☐	☐	☐
E	If the child is under age one, regardless of allegations, is there documentation to support the child was undressed and observed for injuries?	☐	☐	☐

F	Were all other children subject to the care of the alleged perpetrator observed and interviewed during the course of the investigation/assessment?	☐	☐	☐
G	In diversion cases, was the parent/caregiver contacted and provided with an explanation of concerns?	☐	☐	☐
*H	Does documentation support that the frequency and quality of contacts with knowledgeable and credible collaterals were sufficient to assess safety and risk (regardless of placement; birth home, relative, foster home, institution, etc.)?	☐	☐	☐
*I	Does documentation support that professional providers of services who may be knowledgeable about the alleged maltreatment of the child or needs of the family preservation plan were interviewed?	☐	☐	☐
J	Was the original safety assessment appropriate?	☐	☐	☐
*K	Does the documentation support that the ongoing assessment of safety is accurate (regardless of placement type)?	☐	☐	☐
L	Is the safety plan adequate to address identified safety issues?	☐	☐	☐
M	If overnight unsupervised visitation is occurring between the child and parent, did the Court approve the visitation?	☐	☐	☐
N	If a safety resource was utilized, was the appropriate resource assessment completed within 72 hours and located in the record?	☐	☐	☐
O	Do the risk assessment or re-assessment and documentation support the assigned level of intervention/support?	☐	☐	☐

P	Was there evidence of supervisory input including case staffing documentation, supervisory approvals required by policy, approval of case closures?	☐	☐	☐
Q	For open diversion cases, foster care cases and family preservation cases, when new significant safety concerns were identified was a timely CPS referral made?	☐	☐	☐
R	Was a CPS alert issued timely and located in the case file when a family could not be located or moved during the course of an open case?	☐	☐	☐
*S	Does the risk assessment indicators show that risk of further maltreatment is sufficiently reduced and there is no evidence that the child is unsafe or unprotected prior to case closure?	☐	☐	☐
*T	If parents are non-compliant with their case plans, has the agency sought legal interventions with the court to gain compliance?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

PERMANENCY				
OUTCOME P1: Children have permanency and stability in their living situations.				
ITEM 5	**Within the past 12 months of current removal date, has this been the only episode of foster care for this child? (Foster care re-entries)**	☐ **Yes**	☐ **No**	☐ **N/A**

Item	Description	Yes	No	N/A
A	If the child had a prior episode of foster care, was there evidence of after care services being provided or a discharge plan discussed with the parents?	☐	☐	☐
B	Does documentation reflect the agency made concerted and reasonable efforts to prevent the subsequent removal?	☐	☐	☐
C	If the family had a prior foster care case, does documentation support that adequate services were provided to resolve risk to the family prior to reunification and case closure?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P1: Children have permanency and stability in their living situations.				
ITEM 6	**Does the child have a stable placement** *(not more than 1 placement)* **or if there are subsequent moves does documentation support each move to be in the best interest** *(planned, purposeful moves related to achieving the child's goal, death of foster parent, foster parents move to another state)* **of the child and consistent with achieving the child's permanency goal?** *(Does not include trial home visits, runaway, visitations, pre-placements, hospitalizations, respite care or camps). (Even if the child has a single placement, if the placement does not meet the child's needs or is not considered stable this item is not a strength and should be marked no).* ***(Stability of foster care placement)***	☐ Yes	☐ No	☐ N/A

Item	Description	Yes	No	N/A
A	If the child has had a foster home disruption, is there evidence the case manager provided resources to the caregiver to prevent the disruption?	☐	☐	☐
*B	If the child has had multiple placements moves, are the moves in the child's best interest and/or achievement of their permanency?	☐	☐	☐
C	Is there evidence of planning and pre-placement visits prior to the child's move to a new placement?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P1: Children have permanency and stability in their living situations.				
ITEM 7	**Did the agency select an appropriate permanency goal for the child in a timely manner (including the designation of a concurrent plan)?** *Things to consider are as follows:* *• permanency goal identified in the case file, case plan and court order* *• was the goal established timely (within 60 days of initially coming into care, and* *• subsequent determinations based on ASFA,* *• is the goal appropriate to meet the needs of the child and the circumstances of the case)?* **(Permanency goal for child)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
*A	Is the current identified permanency plan appropriate for the child based on the case file review?	☐	☐	☐
B	Is the identified permanency goal consistent throughout the file review (documentation, case plan, court orders, SHINES, AFCARS, etc.)?	☐	☐	☐
C	Is there a judicial determination regarding reasonable efforts within 60 days of the date the child was removed (must be child specific and meaningful)?	☐	☐	☐
D	If there is a Voluntary Placement Agreement, was the agreement signed by parent/legal guardian and an agency representative?	☐	☐	☐
E	Does the court order contain a judicial finding of Contrary to the Welfare, signed by the Judge? *The judicial determination regarding "contrary to the welfare" must be made in the first court ruling that sanctions the child's removal. The physical removal from the home must coincide with the judicial ruling of "contrary to the welfare."*	☐	☐	☐

F	If the child is removed from the home before March 27, 2000, is the Contrary to the Welfare finding stated in a court order (signed by the Judge) issued within 6 months of the child's removal? Or is there a removal petition filed within 6 months of the child's removal that results in a judicial finding of contrary to the welfare?	☐	☐	☐
G	If the child is removed from the home on or after March 27, 2000, is the Contrary to the Welfare finding stated in the removal court order and signed by the Judge?	☐	☐	☐
H	Is there a judicial finding of Reasonable Efforts to Prevent Removal or Reasonable Efforts to Reunify Child and Family in the court order signed by the Judge? *For a judicial removal, there must be a determination to the effect that the State agency made reasonable efforts to prevent the removal of the child from the home or that reasonable efforts were not necessary. If the child was removed before March 27, 2000, the requirement may be satisfied with a judicial finding that "reasonable efforts were made to reunify" the child and family after removal.*	☐	☐	☐
I	Is there a timely extension (hearing held) of custody (prior to the expiration of previous order)?	☐	☐	☐
J	Is there a judicial determination regarding reasonable efforts to finalize the permanency plan, within 12 months of the date of initial removal or within the most recent 12 month period where there is a subsequent order? (Reasonable efforts must be child specific and meaningful to one of the five Federal Permanency Plans (1) Reunification, (2) adoption, (3) guardianship, (4) live with a fit and willing relative and (5) another planned permanent living arrangement.	☐	☐	☐
K	If required by ASFA or if the case is appropriate, has the agency filed a petition for TPR *(if case is not appropriate for TPR then NA should be selected)?*	☐	☐	☐

*L	If the child has been in care 15 out of the last 22 months, has the agency documented compelling reasons for not pursuing TPR?	☐	☐	☐
M	Are the services being provided consistent with the identified permanency goal(s)?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P1: Children have permanency and stability in their living situations.				
ITEM 8	**Did the agency make concerted efforts to achieve reunification, guardianship or permanent placement with relatives in a timely manner?** *Consider the time the child has been in foster care, the identified permanency plan, etc., are there any reasons prohibiting the case from having been resolved within 12 months child on trial home visit etc.* **(Reunification, guardianship, or permanent placement with relatives)**	Yes ☐	No ☐	N/A

Item	Description	Yes	No	N/A
*A	Were identified services provided in a timely manner?	☐	☐	☐
*B	Are the services being provided consistent with reunification, guardianship or permanent placement with relatives?	☐	☐	☐
C	If the agency has identified a concurrent plan, is there documentation supporting the work toward efforts to achieve both of the goals?	☐	☐	☐
D	If the child has been in care 12 months or more and reunification remains the permanency plan, is it the appropriate plan for the child?	☐	☐	☐
E	If so, has the parent made diligent efforts to complete their case plan or are there barriers which prohibited the agency from providing a required service prior to reunification?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P1: Children have permanency and stability in their living situations.				
ITEM 9	**Did the agency make concerted efforts to achieve a finalized adoption?** ***Consider:*** ***• was adoption identified as a concurrent plan in a timely manner*** ***• concerted effort to locate absent parents at the beginning and throughout the case*** ***• was adoption achieved within 24 months from the date the child entered into foster care, or*** ***• documented ongoing efforts of the agency to locate an adoptive home for a special needs child yet no home has been located*** **(Adoption)** IF PERMANENCY HAS NOT BEEN ACHIEVED IN 24 MONTHS AND CHILD IS NOT SIGNIFICANTLY SPECIAL NEEDS THIS ITEM IS A NO. IF CHILD IS SPECIAL NEEDS AND THERE IS NOT CONCERTED EFFORTS TO RECRUIT A PERMANENT HOME, THEN THIS ITEM IS A NO.	☐ **Yes**	☐ **No**	**N/A**

Item	Description	Yes	No	N/A
A	If the child has been in care 15 out of 22 months, has the agency filed a petition on both parents for TPR?	☐	☐	☐
B	Is current TPR ruling under appeal?	☐	☐	☐
C	If siblings with TPR are placed in separate adoptive homes, do you have a waiver?	☐	☐	☐
D	Upon completion of one parent's TPR, did the agency initiate an adoption assistance application?	☐	☐	☐
E	Does documentation support the child has been prepared for adoption?	☐	☐	☐
F	Does the case plan include goals related to adoption?	☐	☐	☐

G	If the agency has identified a concurrent plan, is there documentation supporting the work toward efforts to achieve both of the goals?	☐	☐	☐
H	Was the child life history initiated timely?	☐	☐	☐
I	Have the foster parents been provided timely notice of the plan to submit TPR, the option to adopt and their rights?	☐	☐	☐
*J	For children in care with adoption as a permanency plan without an identified resource does documentation support diligent efforts to recruit an adoptive family (special needs and non-special needs children)?	☐	☐	☐
K	Did the agency make diligent efforts to overcome any delays in the legal process which were within their control?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P1: Children have permanency and stability in their living situations.				
ITEM 10	**APPLA: Did the agency make a concerted effort to ensure the child is prepared to make a transition from foster care and that the child has a commitment for a "permanent living arrangement" with their current caregiver (includes long-term care facilities)?** *There must be documented commitment via case narrative or long-term foster care agreement.* **(Another planned permanent living arrangement)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
A	If the planned goal is "Another Planned Permanent Living Arrangement", does the court order specify the plan and the compelling reasons for this option?	☐	☐	☐
B	If the agency has identified a concurrent plan, is there documentation supporting the work toward efforts to achieve both of the goals?	☐	☐	☐
*C	Is there a signed form indicating or documentation that supports the caregivers' commitment to the child until he/she is emancipated from foster care?	☐	☐	☐
*D	Is the child connected and actively involved in developing skills related to Independent Living (could come from other sources besides ILP)?	☐	☐	☐
*E	Prior to emancipation, does documentation support the agency's attempt to facilitate a connection for the child to appropriate adults and services in the community?	☐	☐	☐
F	Does documentation support the involvement of the youth in permanency planning and case planning including the WTLP?	☐	☐	☐
G	If the child has expressed a desire to not be adopted, does documentation reflect that the agency provided the child with adequate information and counseling to make an informed decision?	☐	☐	☐

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P2: The continuity of family relationships and connections is preserved for children.				
ITEM 11	**Did the agency make concerted efforts to ensure the child's foster care placement was close to the parents in order to facilitate face to face contacts between the child and parent? If the child is not placed in close proximity, is the placement based on child's needs and intended to ensure the child's case plan goals are met?** *Consider:* • *same community, county, state (less than 1 hour travel time)* *(if whereabouts of the parents are unknown was there documented diligent efforts to locate the parents)* **(Proximity of foster care placement)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
A	Is there documentation indicating the child needs specialized treatment which is not available within their community?	☐	☐	☐
B	Is the child placed with a relative who is in close proximity to their parent/sibling/community?	☐	☐	☐
C	Is the child placed in a setting designed to help achieve their case plan goal which is not in close proximity to their parent/sibling community?	☐	☐	☐
D	Does agency documentation reflect efforts to place child in close proximity to their parent/sibling/community?	☐	☐	☐
E	If child is not placed in close proximity, does documentation reflect ongoing efforts to secure a placement in close proximity to the parent?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P2: The continuity of family relationships and connections is preserved for children.				
ITEM 12	**Did the agency make concerted efforts to ensure that all siblings living in foster care were placed together unless a separation was necessary to meet the needs of one of the siblings?** *(specialized foster care, abusive to one another, different fathers and places with paternal family members, size of the sibling group i.e. five or more children and attempts are made to place them in close proximity to one another)* **(Placement with siblings)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
*A	Is there documentation indicating it would not be in a child's best interest to be placed with their sibling?	☐	☐	☐
*B	Does agency documentation reflect efforts to place siblings together and if not together, in close proximity to one another?	☐	☐	☐
*C	If siblings are separated, does documentation reflect ongoing efforts to secure a placement where all siblings can be placed together, unless treatment indicated…if so then this answer would be NA.	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P2: The continuity of family relationships and connections is preserved for children.				
ITEM 13	**Did the agency make concerted efforts to ensure that visitation between the child and mother, father and/or siblings is of sufficient frequency and quality (adequate length of time) to promote continuity in the child's relationship to these close family members** *(exceptions may consider documented information that indicates contact is not in the child's best interest)?* *If the whereabouts of the parents are unknown, there should be documentation of diligent efforts to locate the parents.* *If parents are incarcerated, did the agency promote other forms of contact including letters, telephone calls and visits when possible?* **(Visiting with parents and siblings in foster care)**	Yes ☐	No ☐	N/A

Item	Description	Yes	No	N/A
A	Does the case plan identify specific visitation between child and parents as well as siblings not placed within foster care?	☐	☐	☐
*B	Does the documentation support agency effort to encourage and assist the family to ensure the visits occur?	☐	☐	☐
*C	Does documentation support agency efforts to promote visitation between siblings not placed within the same foster home?	☐	☐	☐
D	If child is placed in a relative home, does documentation support the parent child visitation is being supervised by the caregiver in the least restrictive environment possible?	☐	☐	☐
*E	If a parent is incarcerated, is there documentation of the agency's efforts to facilitate other forms of contact between parent and child?	☐	☐	☐
F	Does documentation support the agency's effort to promote and encourage a relationship between the parent and child during visitation *(this addresses quality of the visit)*?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P2: The continuity of family relationships and connections is preserved for children.				
ITEM 14	**Did the agency make concerted efforts to maintain the child's important connections to their neighborhood, faith, community, language, extended family, tribe** *(was sufficient information obtained to determine if the child may be eligible for tribal membership)***, school and friends?** **(Preserving connections)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
A	Does documentation support the agency's effort to keep the child in the same school?	☐	☐	☐
B	Does documentation support the agency's effort for the child to maintain relationships with "fictive" family?	☐	☐	☐
C	Does documentation support the efforts of the agency to keep the child connected to their heritage?	☐	☐	☐
D	Does documentation support the agency's effort to keep the child linked to the family's religious affiliation?	☐	☐	☐
E	Does documentation support the agency efforts to continue the child within the same community (placement, Boys and Girls Club, health department, medical providers etc?)	☐	☐	☐
*F	If the child is Native American, is there documentation in the case file that the agency took appropriate steps to identify the child's Native American heritage?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P2: The continuity of family relationships and connections is preserved for children.				
ITEM 15	**Did the agency make concerted efforts to place the child with relatives** *(maternal/paternal)* **whenever possible** *(was there evidence that relatives had been considered and ruled out or were unwilling to be considered)***? Is the child currently placed in a stable relative placement** *(even if the child has a relative placement if the placement does not meet the child's needs or is not considered stable this item is not a strength and should be marked no)***? (Relative placement)**	Yes ☐	No ☐	N/A

Item	Description	Yes	No	N/A
*A	Does documentation support that a thorough diligent search was completed for maternal and paternal family members?	☐	☐	☐
B	Does documentation reflect case manager utilized information from the diligent search to develop support services for the child and family?	☐	☐	☐
C	Does documentation reflect evaluations of extended family members or family members' decisions not to be evaluated for placement of the child?	☐	☐	☐
D	Does documentation support services being provided to relative placements and safety resources?	☐	☐	☐
E	Does the case file contain 72 hour evaluations for safety resources for Family Preservation cases and/or full home evaluations/ICPC evaluations for relative placements and/or relative foster home cases?	☐	☐	☐
F	Does documentation reflect the relative caregivers' acknowledgement of their right to become a relative foster home as well as discussion and consideration of the associated requirements?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME P2: The continuity of family relationships and connections is preserved for children.				
ITEM 16	**Other than visitation, did the agency make concerted efforts to promote, support and/or maintain positive relationships between the child in foster care with his/her mother, father or caregiver from whom they were removed?** • *exceptions include cases with TPR, abandoned child in which parents can not be located, whereabouts of parents are unknown and the agency has documented diligent efforts to locate the parents, contact with the parents has been determined to not be in the best interest of the child, parents are deceased, etc*. **(Relationship of child in care with parents)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
A	Does documentation reflect parental involvement in child's school activities inclusive of IEP, extracurricular events, etc.?	☐	☐	☐
B	Does documentation support parental involvement in child's medical decisions?	☐	☐	☐
C	Does documentation support the agency encouraged the parent(s) to maintain other forms of contact with their child, family counseling, letters, phone calls etc.?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

WELL-BEING				
OUTCOME WB1: Families have enhanced capacity to provide for their children's needs.				
ITEM 17	**Did the agency make concerted efforts to assess** *(formal or informal)* **the needs of the child(ren), parents and/or foster parents/caregiver to identify the services necessary to achieve case plan goals and adequately address the issues which necessitated the agency's involvement with the family? Did the agency provide the appropriate services?** *(if either question is answered "no," then this item is no).* **(Needs and services of child, parents, foster parents)**	☐ **Yes**	☐ **No**	☐ **N/A**

Item	Description	Yes	No	N/A
A	Was an FTM conducted which clearly demonstrates the inclusion of family members, child (if developmentally and age appropriate/school age), caregivers, stakeholders and service providers (within 9 days of date of removal for foster care and 45 days of initial family preservation staffing for Family Preservation cases)?	☐	☐	☐
B	Was information obtained from, as well as shared with agency resources (OFI, CRS, etc.)? *(This information may be in the FTM or narrative).*	☐	☐	☐
C	Does documentation support the development of the case plan/family plan from information gleaned during the FTM, from assessments, deprivation findings and with the inclusion of family members?	☐	☐	☐
*D	Are the findings from assessments (substance abuse assessments, psychological, CCFA, developmental, mental health, etc.) incorporated into the case plan?	☐	☐	☐
*E	Is the agency providing services at a frequency and quality to enable the family to meet the identified case plan goals? If not, is there documentation as to why the service cannot be provided or why the recommendation cannot be followed?	☐	☐	☐

*F	Are services provided by external partners being monitored for quality and frequency?	☐	☐	☐
G	Does documentation support ongoing discussion of case plans, goals, services provided and progress toward case outcomes with parents, children, caregivers (relatives, foster parents, guardians, fictive kin) and service providers?	☐	☐	☐
H	Were subsequent FTMs held when needed (***newly identified needs, change in permanency plans etc.)?***	☐	☐	☐
*I	Were needed services initiated timely?	☐	☐	☐
*J	Prior to emancipation, does documentation support the agency's attempts to prepare the child for employment, securing housing and/or continuing education services?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME WB1: Families have enhanced capacity to provide for their children's needs.				
ITEM 18	**Did the agency make concerted efforts to involve parents and children (if developmentally appropriate) in the case planning process on an ongoing basis?** • *consulted with the child and parents* • *involved in periodic reviews* • *used terms and language a child can understand* • *is there a case plan in the file (signature alone does not indicate involvement)* **(Child and family involvement in case planning)**	☐ Yes	☐ No	☐ N/A

Item	Description	Yes	No	N/A
*A	Does documentation indicate that family members were involved in decisions regarding case planning, service delivery and frequency of services?	☐	☐	☐
B	Does documentation and case planning reflect that case plans were periodically reviewed per policy and with the inclusion of the children, parents, caregivers and service providers?	☐	☐	☐
C	Is there documentation to support that the family preservation case plan was developed immediately following the FTM? *(if no FTM occurred within at least 90 days of the receipt of the referral.)*	☐	☐	☐
D	Is there documentation to support the original foster care case plan was completed within 30 days of the child's date of removal (reviewed with parent and signature requested)?	☐	☐	☐
E	Does documentation reflect that families were provided a copy of the initial safety plan, case plan and any subsequent plans developed?	☐	☐	☐

Comments

Use the chart on the tab labeled Service Documentation to answer Items 19 & 20

OUTCOME WB1: Families have enhanced capacity to provide for their children's needs.				
ITEM 19	**Did the case manager make contact, with the child(ren), which was of sufficient frequency and quality to ensure safety, permanency and well-being of the child and promote achievement of case goals** *(must meet at least the minimum monthly policy requirement; if the child has special needs or placement is not stable, contact should be more frequent)***?** **(Caseworker visits with child)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
*A	Was the frequency and quality of the contacts between the caseworker and the child(ren) purposeful and sufficient to address issues pertaining to safety, permanency, well-being and to promote achievement of family support strategies (must at least meet minimum policy standards or standards established in the FTM)?	☐	☐	☐
*B	Did documentation reflect that private and individual contacts were made with the child(ren)?	☐	☐	☐
C	Does documentation reflect child was seen monthly in their home or place of residence?	☐	☐	☐
*D	If the child was on run-away status, did documentation support ongoing diligent attempts to locate the child?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME WB1: Families have enhanced capacity to provide for their children's needs.				
ITEM 20	**Did the case manager make contacts with mother(s) and father(s) of the children that were of sufficient frequency and quality to ensure safety, permanency and well-being of the child and promote achievement of case goals? (Caseworker visits with parents)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
*A	Was the frequency and quality of the contacts between the caseworker and the mother(s) purposeful and sufficient to address issues pertaining to safety, permanency, well-being and to promote achievement of family support strategies (must at least meet minimum policy standards)?	☐	☐	☐
*B	Was the frequency and quality of the contacts between the caseworker and the father(s) purposeful and sufficient to address issues pertaining to safety, permanency, well-being and to promote achievement of family support strategies (must at least meet minimum policy standards)?	☐	☐	☐
*C	Was the frequency and quality of the contacts between the caseworker and the original caregiver purposeful and sufficient to address issues pertaining to safety, permanency, well-being and to promote achievement of family support strategies (must at least meet minimum policy standards)?	☐	☐	☐
D	Did contacts with parents include discussions related to services being provided by providers, case progress, consequences of not completing case plan goals?	☐	☐	☐
*E	If mother(s) whereabouts were unknown, did documentation reflect an ongoing diligent effort to locate mother and/her extended family?	☐	☐	☐

*F	If father(s) whereabouts were unknown, did documentation reflect an ongoing diligent effort to locate father(s) and his/their extended family?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME WB2: Children receive appropriate services to meet their educational needs.				
ITEM 21	**If educational needs were identified in the case were they addressed appropriately?** *(This includes both placement and family preservation cases, if the child is in foster care educational needs must always be clearly assessed).* **(Educational needs of the child)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
*A	If identified or observed as a need, does documentation support that the child's educational needs were addressed *(including the action taken, caretaker input, child input, collateral input)?*	☐	☐	☐
B	Have the birth parents been engaged in the educational plan for the child(ren) as evidenced by involvement in counseling sessions, conversations with case manager regarding needs and progress?	☐	☐	☐
C	Have the foster parents been engaged in the educational plan for the child(ren) as evidenced by involvement in counseling sessions, conversations with case manager regarding needs and progress?	☐	☐	☐
D	Is purposeful contact being maintained between the school system and the agency?	☐	☐	☐
E	Is there a copy of the educational documentation in the case file ***(IEP, grades, etc.)?***	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME WB3: Children receive adequate services to meet their physical and mental health needs.				
ITEM 22	**If physical health needs were identified in the case were they addressed appropriately?** *(This includes both placement and family preservation cases) If the child is in foster care physical health needs must always be clearly assessed).* **(Physical health of the child)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
*A	If identified or observed as a need, does documentation support that the child's physical health needs including dental were addressed (including the action taken, caretaker input, child input, collateral input follow-up appointments, consideration of prescription medications and adverse affects)?	☐	☐	☐
B	Were all appropriate children, referred to Babies Can't Wait per CAPTA requirements?	☐	☐	☐
C	Have the birth parents been engaged in the health treatment plan including dental for the child as evidenced by involvement in counseling sessions, conversations with case manager regarding needs and progress?	☐	☐	☐
D	Have the foster parents been engaged in the health treatment plan including dental for the child as evidenced by involvement in counseling sessions, conversations with case manager regarding needs and progress?	☐	☐	☐
E	Is purposeful contact being maintained between the health care providers, including dental and the agency?	☐	☐	☐
F	Is there a copy of health care documentation from the providers in the case file (i.e. treatment notes, physical, dental care, etc.)?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

OUTCOME WB3: Children receive adequate services to meet their physical and mental health needs.				
ITEM 23	**If mental health or developmental needs were identified in the case were they addressed appropriately?** *(This includes both placement and family preservation cases) If the child is in foster care mental health and developmental needs must always be clearly assessed).* **(Mental/behavioral health of the child)**	☐ Yes	☐ No	N/A

Item	Description	Yes	No	N/A
*A	If identified or observed as a need, does documentation support that the child's mental health needs were addressed (including the action taken, caretaker input, child input, collateral input)?	☐	☐	☐
B	Have the birth parents been engaged in the mental health treatment plan for the child as evidenced by involvement in counseling sessions, conversations with case manager regarding needs and progress?	☐	☐	☐
C	Have the foster parents been engaged in the mental health treatment plan for the child as evidenced by involvement in counseling sessions, conversations with case manager regarding needs and progress?	☐	☐	☐
D	Is purposeful contact being maintained between the mental health provider and the agency?	☐	☐	☐
E	Is there a copy of the Mental Health Documentation in the case file?	☐	☐	☐

Comments

MODULE TEN
INTRODUCTION TO DOCUMENTATION

The following chart is to be used in responding to items 19 and 20

Service Documentation						
(track six month review period)						
Date(s) of contact/assessment with Child/children	Month	Month	Month	Month	Month	Month
Child #1						
Child #2						
Child #3						
Child #4						
Child #5						
Foster Parent/Caregiver						
Mother						
Father						
Father						
Collateral/resource provider						

Role of the Supervisor

Review of documentation provides the supervisor with information about:

- Frequency and content of case manager-client contacts
- Family's strengths, needs and risks
- Plans to assure safety; case management decisions, services or interventions to reduce risk
- Progress toward outcomes
- Any changes in the child and family's situation

MODULE TEN
INTRODUCTION TO DOCUMENTATION

http://www.odis.dhr.state.ga.us/

Unclear Writing

Sentences taken from actual letters received by a welfare department in application for financial support.

- I received a marriage certificate and six children. She had seven; one died which are baptized on a half sheet of paper.
- The baby was born two years old.
- The client cannot get sick pay. She has six children. I am not sure why.
- I am glad to report that my husband who was missing is dead!
- In answer to your letter, I have given birth to a boy weighing 10 pounds. I hope this is satisfactory.
- I am forwarding my marriage certificate and five children, one of which is a mistake as you can see.
- In accordance with your instructions, I have given birth to twins in the enclosed envelope.
- CM was informed last night that Marvin had his teeth knocked out by Supervisor Stewart.

MODULE TEN
INTRODUCTION TO DOCUMENTATION

USING PRONOUNS CLEARLY

Because a pronoun REFERS BACK to a noun or TAKES THE PLACE OF that noun, you have to use the correct pronoun so that your reader clearly understands to which noun your pronoun is referring. Therefore, pronouns should:

1. AGREE IN NUMBER

If the pronoun takes the place of a singular noun, you have to use a singular pronoun.

If a student parks a car on campus, he has to buy a parking sticker.

NOT: *If a student parks a car on campus, they have to buy a parking sticker.*

REMEMBER: The words EVERYBODY, ANYBODY, ANYONE, EACH, NEITHER, NOBODY, SOMEONE, A PERSON, etc. are singular and take singular pronouns.

Everybody ought to do his best. (NOT: *their best*)

Neither of the girls brought her umbrella. (NOT: *their umbrellas*)

2. AGREE IN PERSON

If you are writing in the “first person” (I), do not confuse your reader by switching to the “second person” (you) or “third person” (he, she, they, it, etc.). Similarly, if you are using the “second person”, do not switch to “first” or “third”.

When a person comes to class, he should have his homework ready.

NOT: *When a person comes to class, you should have your homework ready.*

3. REFER CLEARLY TO A SPECIFIC NOUN

Do not be vague or ambiguous

NOT: *Although the motorcycle hit the tree, it was not damaged.* (Is “it” the motorcycle or the tree?)

NOT: *If you put this sheet in your notebook, you can refer to it.* (What does “it” refer to, the sheet or your notebook?)

Resources:

Purdue University Online Writing Lab (OWL). http://owl.english.purdue.edu , 226 Heavilon Hall, Purdue University.

The Pennsylvania Child Welfare Training Program 315: Writing Skills for Case Documentation **Handout #4**

PRONOUN PRACTICE

Example 1

Lori called upset that her mother had told her that we did not believe her regarding the incident. She stated that we felt she made it up and now she does not know what to do next. She said that she feels like hurting herself over this. I stated that with her history, she should not believe everything she hears.

Example 2

Stephanie stated that her father does not like her boyfriend because he never finished high school.

MODULE TEN
INTRODUCTION TO DOCUMENTATION

The Apostrophe

The apostrophe has three uses: 1) to form possessives of nouns, 2) to show the omission of letter, and 3) to indicate plurals of letters, numbers, and symbols. Do not use apostrophes for possessive pronouns or for noun plurals.

1. To show possession:

To see if you have a possessive, turn the phrase around and make it an "of the…" phrase: the boy's hat = the hat of the boy

To place the apostrophe correctly to show possession:

Add **'s' t**o the singular form of the word (even if it ends in –s):

The owner's car

Add **'s'** to the plural forms that do not end in –s:

The children's game

Add **'s'** to the end of plural nouns that end in –s:

Three friends' letters

Add **'s'** to the end of compound words:

My brother-in-law's money

2. To show omission of letters

Who's = who is

He'll = he will

3. To form plurals of letter, numbers, and symbols:

There are three 5's on my license plate.

I got two A's on my report card.

NOTE: Do not use apostrophes for possessive pronouns or for noun plurals.

Wrong: his' book

Correct: his book

Resources:

Purdue University Online Writing Lab (OWL). http://owl.english.purdue.edu , 226 Heavilon Hall, Purdue University.

The Pennsylvania Child Welfare Training Program 315: Writing Skills for Case Documentation **Handout #5**

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Quotation Marks

Direct quotations are another person's exact words—either spoken or in print—incorporated into your own writing. The following are general rules to know when using quotation marks in your work.

- ☆ Use a set of quotation marks to enclose each direct quotation included in your writing.
- ☆ Use a capital letter with the first word of a direct quotation of a whole sentence. Do not use a capital letter with the first word of a direct quotation of part of a sentence.
- ☆ If the quotation is interrupted and then continues in your sentence, do not capitalize the second part of the quotation.
- ☆ Indirect quotations are not exact words but rather re-phrasings or summaries of another person's words. Do not use quotation marks for indirect quotations.
- ☆ If you leave words out of a quotation, use an ellipsis mark to indicate the omitted words. If you need to insert something within a quotation, use a pair of brackets to enclose the addition.
- ☆ Use quotation marks to indicate words used ironically, with reservations, or in some unusual way.
- ☆ Put commas and period within closing quotation marks. Put colons and semicolons outside quotation marks.

Writing Dialogue

Write each person's spoken words, however brief, as a separate paragraph. Use commas to set off dialogue tags such as "she said" or "he explained." Closely related narrative prose can be included in a paragraph with dialogue. If one person's speech goes on for more than one paragraph, use quotation marks to open the speech and at the beginning—but not the end—of each new paragraph in the speech. To close the speech, use quotation marks at the end of the final paragraph.

Purdue University Online Writing Lab (OWL). http://owl.english.purdue.edu , 226 Heavilon Hall, Purdue University.

The Pennsylvania Child Welfare Training Program 315: Writing Skills for Case Documentation **Handout #6**

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Run-on Sentences

Run-on sentences are terms describing two independent clauses that are joined together with no connecting word or punctuation to separate the clauses. The best way to avoid run on sentences that are not punctuated correctly is to use one or the other of these rules.

1) Join two independent clauses with a coordinating conjunction (and, but, for, or, not, so yet), and use a comma before the connecting word.

_____, and _____.

(He enjoys walking through the country, and he often goes backpacking on his vacations.)

2) When you do not have a connecting word or when you use a connecting word other than and, but, for, or not, so or yet between the two independent clauses, use a semicolon (;)

_____; however, _____.

(He often watched TV when there were only reruns; however, she preferred to read instead.)

Resources:

Purdue University Online Writing Lab (OWL). http://owl.english.purdue.edu , 226 Heavilon Hall, Purdue University.

The Pennsylvania Child Welfare Training Program 315: Writing Skills for Case Documentation **Handout # 7**

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Writing Numbers

Although usage varies, most people spell out numbers that can be expressed in one word or two and use figures for other numbers, such as:

Written out:

Over two pounds

Four million dollars

Thirty-one years ago

Fifty people came

Figures:

After 126 days

Only $31.50

4.78 liters

The most important thing to remember when writing numbers is clarity for the reader.

- Numbers in series should be consistent:

  Two apples, six oranges, and three bananas

  The vote was 9 in favor and 6 against

- Write out numbers beginning sentences:

  Six percent of the group failed.

- Use a combination of figures and words for numbers when such a combination will keep your writing clear:

  There were five 13-year-olds in the foster home.

Resources:

Purdue University Online Writing Lab (OWL). http://owl.english.purdue.edu , 226 Heavilon Hall, Purdue University.

The Pennsylvania Child Welfare Training Program 315: Writing Skills for Case Documentation **Handout #8**

TONE

REWRITE the narrative below changing the tone.

Mrs. Smith again was not home for our scheduled appointment. She shows no respect for me and I did not get any messages from her canceling the appointment. It is clear that she has no desire to work on trying to get her children home. This case manager left her a note informing her that again, she has wasted my time and because of that, I will not be scheduling any visits for her with her children until she meets with me.

What to Record

- ✓ **Statements made by contacts during the course of case assessment or case planning.**
- ✓ **Information that is used in the development or refinement of an assessment.**
- ✓ **Information from any contact regarding the health, safety, welfare, or situation of a child.**
- ✓ **Information relating to the success or failure to achieve or perform activities.**
- ✓ **Changes in household composition, address, or living arrangements.**
- ✓ **Information affecting eligibility for services.**
- ✓ **Marked changes in appearance or functioning.**
- ✓ **All "in-person" or phone contacts with your client. Note the date and topic. Unsuccessful attempts to make contacts should also be recorded.**
- ✓ **Phone contacts made and received about your client.**
- ✓ **Correspondence sent out about your client or received from others about your client. Note the date and purpose; refer to file.**
- ✓ **Efforts to make referrals and the results of such efforts.**
- ✓ **All legal activities.**
- ✓ **Information acquired from staffings, team meetings and other meetings concerning the client.**

Reference: "Case Documentation", SUNY Research Foundation c. 1994

CASE FACT FROM OPINION

DIRECTIONS: Rewrite those statements that are opinion in a way that makes the difference between fact and opinion clear.

1. Being unemployed is depressing Jan.

2. Alan said his mother smacked him.

3. On the last contact visit, the living room was not safe for the children.

4. The clothing in which Mrs. Smith had dressed the baby was not appropriate.

5. A family foster home is not appropriate for Ian

6. Jenny is a happy child.

Vague Terms

Assigned Term: _____

Behaviorally Descriptive Terms:

Normal stage of development	Adequate
Hyperactive	Neat
Sexually acting out	Acting out
Poor attitude	Apparently
Immature behavior	Appropriate
Poor parenting skills	Healthy
Filthy	Messy
Lazy	Abusive
Dysfunctional family	Hysterical
Pothead	Regular meal
Hostile	Angry
Unmotivated	Cluttered
Obviously	Neglectful
Tidy	Upset

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Documentation Checklist

This checklist can be used to review documentation to ensure it meets policy standards. Each county may require the inclusion of items not listed here. If so, this list will need to be changed to include county requirements.

- ☐ Month, Day and Year of contact? (80.1.2, 80.2.2)
- ☐ Location where contact took place? (80.1.2, 80.2.2)
- ☐ Purpose of contact? Is this a TCM contact? (80.1.2, 80.2.2)
- ☐ References to previous entries made for repeated information? (80.1.3)
- ☐ Vague or subjective terms clarified by clear descriptions? See Appendix A for list. (80.1.5)
- ☐ Judgmental terms not used? See Appendix A for list. (80.1.6)
- ☐ Avoided use of “appeared”, “seems to be” and “apparently”? (80.1.7)
- ☐ Avoided using labels that are not diagnosed by a certified professional? (80.1.8) (EX. alcoholic, schizophrenic and mentally retarded)
- ☐ All abbreviations used are from the official Glossary of Abbreviations or from your county list. See Appendix B. (80.4)
- ☐ First and last names of all adults are used according to policy? (80.7.1)
- ☐ Relationship titles are preceded by stating the first and last name at least once in the entry. (80.7.1)
- ☐ Professional titles are used when known? (80.1.3)
- ☐ All facts are straightforward descriptions of circumstances. (80.1.1)
- ☐ Observations are recorded notes about circumstances witnessed by the case manager or reported to the worker by others with the source of the information recorded. (80.1.1)
- ☐ Interpretations are identified as interpretations and evidence to support them is recorded.
- ☐ Decisions are based on program policy and good practice principles, supported by documented facts, observations and interpretations and supervisor’s consultation is recorded.
- ☐ Included diligent search efforts in the case record? Established paternity?
- ☐ Verified Native American heritage?
- ☐ Included copies of letters and other materials from collateral contacts in the case record? Included medical records, birth certificates, and school records in the case record?
- ☐ Collected all important case information about family background, interaction patterns, visitations, diligent searches?
- ☐ Documented missed contacts or visits that were not the family’s fault?
- ☐ Fairly and accurately documented parts of the service plan that the family is not in agreement with, but with which they are expected to comply?
- ☐ Included accurate information that supports the activities outlined in the most recent Service Plan?
- ☐ Described observations and contacts in factual and behavioral terms?
- ☐ Documented the quality of parent-child visits in behavioral terms?
- ☐ Included specific information about family strengths?
- ☐ Checked spelling, grammar and punctuation? Checked that the progress notes are written in clear, concise and understandable language? Checked that the progress notes are jargon-free?
- ☐ **Assured that someone other than yourself could pick up the case record and readily understand the decisions and progress based on the plans and progress notes for this particular case?**

Using your Tablet for Documentation

1. Use ink annotations feature to jot down observations while you wait for your appointment. (Tablet Tutorial available)

2. While on the telephone, open a word document and begin taking notes.

3. Before you go out on a visit, save a copy of the forms, you will need signed to the desktop of the computer for quick access during your visit. Use the ink annotations feature to obtain the necessary signature.

4. Use Windows Journal to take notes (Tablet Tutorial available)

5. Use the sticky note function to set reminders of phone call, appointments, home visits, staffings etc. (Tablet Tutorial available)

6. Use the Voice Recognition tool to record notes (Tablet Tutorial available)

Additional Ideas:

MODULE TEN
INTRODUCTION TO DOCUMENTATION

DOCUMENTATION TIPS FOR MANAGING YOUR TIME

- Organize your work and office.
- Do your documentation during the time of day when you have your highest energy level.
- Use a daily "To Do List" and mark off tasks as they are completed.
- Maintain and use a calendar.
- Know and adhere to deadlines for reports.
- Plan for the unexpected. Backdate deadlines. If something is due the 20th, plan to complete it by the 18th.
- Avoid Procrastination.
- Adhere to Program Policy (CPS, FC, and Adoption).
- Keep accurate records, using policy as your guide.
- Maintain a running log of all telephone calls for reference.
- Maintain essential information in contact notebook divided out by case name. In addition, include all essential forms, addresses and telephone numbers.
- Take a copy of the case plan goals and steps to use with the client during the visit.
- Allow foster parents or other professionals to document what child/client told them. (For example, what child reported or what was observed during a visit.) The case manager verifies by interviewing the child/client and documents information is consistent with that documented by (enter name of person).
- Use checklist that identifies what is to be done on cases and time frame
- Have specific guidelines regarding what and what not to include in documentation – learn to shorten narrative yet be thorough.
- Document immediately after the contact/visit. For example, park the car and do documentation of that contact (or write notes using the ink annotations function of your tablet. In doing this, you can clear your mind before making the next contact and give that contact you full attention.
- While waiting on your court case to be called, complete your documentation or update case plans.
- Develop forms to help with documentation and prevent duplication.
- File case narratives daily in the record.
- With supervisory approval work on Saturday/Holiday when there are no interruptions
- Obtain permission to leave the building in order to be free of interruptions.
- Keep your manager informed. If necessary, put it in writing.

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Case Narrative

Prissy Rich 10/12/07

Prissy was in the office this date to discuss her plan to move to another county. CM asked when she planned to move and she did not know but agreed to let CM know in advance. CM asked where she planned to move and prissy said she did not know yet but that she was sick of living in this county as everybody was against her and she wanted DFCS out of her life. CM told her we just wanted to help and Prissy said we could help if we would just go away. CM acknowledged that it must be hard to have extra people coming and going from her home. Prissy said that she actually liked Ms. Jones, the parent aide. CM asked how Ms. Jones was helpful to her and Prissy said that Ms. Jones had been teaching her things about how to care for the baby. CM asked what kind of things and Prissy said that Ms. Jones told her babies needed to be held when they took a bottle and that she had been holding the baby when she fed her. CM told her that was great and asked if she liked holding the baby to feed her. Prissy said she thought it was a waste of time but that the baby was eating better and she thought the baby was starting to gain weight. Discussion continued about childcare and Prissy moved past her complaints about DFCS. CM asked her where the baby was and she said in the car.

CM asked who was with the baby, Prissy said no one because the baby was asleep and always slept for at least an hour, and she had only been at the office for about 30 minutes. CM immediately escorted Prissy out to get the baby and instructed Prissy to bring her into the office. The baby seemed fine- but CM asked the Supervisor to join them in the CM's office. CM and Supervisor talked to Prissy about never leaving the baby alone in a car and explained all of the things that could happen. She acted like she understood but this CM is still very uncomfortable about the fact that she was allowed to leave with the baby and did not agree with the Supervisor's decision to just do a safety plan. CM thinks this child should be in foster care.

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Katie Sudds 3/2/2007

CM went to foster home to see child. CM saw child and foster parent. FP stated that things were going well. Child was dressed appropriately for the weather. FP said school going well- no problems at all. CM asked child how she was doing. Child stated that she wanted a new Barbie for her birthday. CM told her to make her mother aware of that on her next visit. Child wanted to know when she could see her mom. CM told her we have not heard from her mom this month but that maybe she would call soon and request a visit. CM told them both to call if they had any problems and that CM would see them next month.

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Murphy Broadback 4/6/2008

CM went to group home for quarterly face-to-face contact with Murphy Broadback. Murphy has been at the group home for almost a year and all reports are that he is doing well. See copy of monthly reports in CORR section of case record.

CM met with counselor at the home prior to meeting with Murphy. The counselor reported that Murphy had made much progress in his therapy group this quarter. She had reported at previous quarterly meeting that Murphy had not wanted to share any of his issues with the group and just sat there until the time was up and then left. During this quarter, he has begun to really open up about his feelings regarding his birth father and his anger that his sister is still at home with their adoptive family. The therapist began meeting with him individually a few months ago and that one-on-one has given him the encouragement to share with the group. The counselor warned CM that Murphy would want to discuss his desire to return to the adoptive family as soon as possible. Counselor reported that the adoptive family has remained very committed and that they attend all family functions even though it is a 4-hour drive for them.

CM met with Murphy alone then to discuss his progress over the last quarter. He reported that he is feeling good about everything these days and just wants to go home. He wanted to know when that could happen. CM told him it was not just a CM decision but that we would get together with a group to discuss exactly what needed to happen before that could occur. Murphy wanted to know a date and time when that meeting would happen. CM told him that she did not know and he became very angry and started acting out. The counselor came in and was able to get him to calm down without assistance. Murphy seems scary when he gets mad. CM decided to leave at that point and told counselor that CM would call about another appointment.

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Maggie Riggs 4/06/2008

Home visit to see the Riggs family for monthly contact. Saw mom and all four children. Mom had agreed to parenting classes but missed the first class due to lack of transportation. She said she would try to get there next week. I reminded her that it was in her case plan to complete the course. I do not really think she intends to go.

All of the children were dressed appropriately and appeared clean. The house was dirty. I reminded mom that keeping a clean house is also a part of her case plan. I think that is a wasted effort.

Mom stated that she was still looking for a job but did not see how she could work without childcare. She said she is dating a new man and that he had offered to move in and support her and the children. She said that would probably work out better than her getting a job without childcare.

I asked if the school age children had been attending regularly and she stated that they had not missed a day since DFCS got involved. I asked about report cards and she said they have not received them. I happened to know report cards went out last week.

I told mom I would need to walk through the house to look for safety issues. She agreed and took me to the kitchen. She had an adequate supply of food and other supplies. The electricity and water were working and she had a way to cook. I noticed she had not put the safety covers on the electrical sockets that I brought her last month.

I told mom to keep up the good work and I would see them next month.

MAIN IDEAS FROM TRAINING

- ☆ Value good case documentation. It may save you or a child that you work with.
- ☆ Take time to write correctly, you never know who will be reading your work.
- ☆ Write facts, not opinion
- ☆ Record information in a clear, concise, and sequential manner
- ☆ Write not as you speak, but as you would like to read.

MODULE TEN
INTRODUCTION TO DOCUMENTATION

DIVERSION
CFSR Documentation Checklist

Outcome S1: Children are, first and foremost, protected from abuse and neglect

Item 1

- ☐ Did the 453 clearly state that Diversion decision met protocol?
- ☐ Did the supervisor sign 453?
- ☐ Was the response time met?
- ☐ If maltreatment identified, was a CPS referral made immediately?

Item 2:

- ☐ Were all screenings and prior history reviewed and documented?

Outcome WB1: Families have enhanced capacity to provide for their children's needs

Item 17:

- ☐ Was information obtained from and shared with OFI?
- ☐ Were parents contacted and provided an explanation of concerns?
- ☐ Was the frequency and quality of contacts with the parent/caregiver purposeful?
- ☐ Were referrals made to community resources

Item 18:

- ☐ Were the frequency and quality of contacts with the children purposeful?

Outcome WB2: Children receive appropriate services to meet their educational needs

Item 21:

- ☐ How were educational needs assessed? If identified as a need were needs addressed?

Outcome WB3: Children receive adequate services to meet their physical and mental health needs

Item 22:

- ☐ How were physical and dental health assessed? If identified as a need, how is the need being addressed?

Item 23:

- ☐ How was mental health assessed? If identified as a need, how is the need being addressed?

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Investigation
CFSR Checklist

Outcome S1: Children are, first and foremost, protected from abuse and neglect

Item 1

- ☐ Was response time met? If not, why and are attempts well documented?
- ☐ Is documentation clear that separate face-to-face interviews occurred with each parent and all allegations discussed? What were the parent's responses
- ☐ Did a face-to-face interview occur with the perpetrator to discuss all allegations? What was the response?
- ☐ Were each of the children who is in the home (including those there only on weekends) observed and interviewed? Their responses?
- ☐ If physically abused or under 1, was child examined for injuries?

Item 2:

- ☐ Were all screenings and prior history reviewed and documented as part of the assessment?

Outcome S2: Children are safely maintained in their homes whenever possible and appropriate

Items 3 and 4

- ☐ Were professional collaterals interviewed? What and what was stated?
- ☐ Is Safety Assessment appropriate?
- ☐ Does Safety Plan address issues?
- ☐ What were the reasonable efforts?
- ☐ Was safety resource assessed?

Outcome WB1: Families have enhanced capacity to provide for their children's needs

Item 17:

- ☐ If professional collaterals not used, who was used as a collateral how are they related and what was stated?
- ☐ If not opened for Family Pres, were linkages made to community resources? If so, where? If not, why not?

Outcome WB2: Children receive appropriate services to meet their educational needs

Item 21:

- ☐ How were educational needs assessed? If identified as a need, how is the need being addressed?

Outcome WB3: Children receive adequate services to meet their physical and mental health needs

Item 22:

- ☐ How were physical and dental health assessed? If identified as a need, how is the need being addressed?

Item 23:

- ☐ How was mental health assessed? If identified as a need, how is the need being addressed?

MODULE TEN
INTRODUCTION TO DOCUMENTATION

CFSR Family Preservation Checklist

Outcome S1: Children are, first and foremost, protected from abuse and neglect

Item 1:

☐ Did a new referral come in on the family this month? If yes, was the investigation initiated timely?

Item 2:

☐ Was a new referral substantiated this month on this family?

Outcome S2: Children are safely maintained in their home whenever possible and appropriate

Item 3:

☐ Are the children in a safety resource? If so, was a home assessment completed?

☐ How long have the children been in the safety resource? When were visits made to the safety resource this month and what was discussed?

Item 4:

☐ Are the children safe? How did you determine this? What is the risk to the children?

Outcome P1: Children have permanency and stability in their living situations

Item 8:

☐ What is the permanency plan for the children?

Outcome WB1: Families have enhanced capacity to provide for their children's needs.

Item 17:

☐ Was a FTM held within 45 days of the initial staffing? What is the date of the documentation?

☐ What are the strengths and needs of the family?

☐ Did the risk assessment take place within 90 days? When was it and what is the date of the documentation? Was the family involved?

☐ Who were your collaterals this month and what did they state?

Item 18:

☐ Who participated in the development of the family plan (please identify adult, child)

☐ When did the parents get a copy of the plan?

☐ Are all required signatures on the plan in the file?

Item 19:

☐ What dates were visits made with the children this month? What was discussed?

Item 20:

☐ What dates were visits made with the parents this month? What was discussed?

Outcome WB2: Children receive appropriate services to meet their educational needs

☐ When were the educational needs of the child assessed?

☐ If the child has needs, are records in the file?

MODULE TEN
INTRODUCTION TO DOCUMENTATION

☐ What did the counselor state this month

Outcome WB3: Children receive adequate services to meet their physical and mental health needs
Item 22:

☐ When was the physical health of the children assessed? If needs identified, what did collaterals state?

Item 23:

☐ When was the mental health of the children assessed? If needs identified, what did collaterals state?

MODULE TEN
INTRODUCTION TO DOCUMENTATION

CFSR Placement Checklist

Outcome S1: Children are, first and foremost, protected from abuse and neglect

Item 1:

☐ Did a new referral come in on the family this month? If yes, was the investigation initiated timely?

Item 2:

☐ Was a new referral substantiated this month on this family?

Outcome S2: Children are safely maintained in their home whenever possible and appropriate

Item 3:

☐ Are the children in a safety resource? If so, was a home assessment completed?

☐ How long have the children been in the safety resource?

☐ When were visits made to the safety resource this month and what was discussed?

Item 4:

☐ Are the children safe? How did you determine this? What is the risk to the children?

Outcome P1: Children have permanency and stability in their living situations

Item 6:

☐ Did the child move this month? Why? How is in the best interest of the child?

Item 8:

☐ What is the permanency plan for the children?

Outcome P2: The Continuity of family relationships and connections is preserved for the children

Item 11:

☐ Where are the children placed? Are efforts being made to move to home county, if not, why not?

Item 12:

☐ Are the siblings placed together? If not, why not?

Item 13:

☐ When did the parent and children visit this month?

Item 14:

☐ How was the child's connection to the community maintained this month?

Item 15:

☐ Is the child in a relative placement? Is there an approved home evaluation in the record?

Item 16:

☐ Was the parent invited to medical appointments this month? Did the parent attend the child's school functions this month?

MODULE TEN
INTRODUCTION TO DOCUMENTATION

Outcome WB1: Families have enhanced capacity to provide for their children's needs.
Item 17:

- ☐ Was a FTM held ? What is the date of the documentation?
- ☐ What goals have the parent achieved?
- ☐ What goals are the parents working on?

Item 18:

- ☐ Who participated in the development of the family plan (please identify adult, child)
- ☐ When did the parents get a copy of the plan?
- ☐ Are all required signatures on the plan in the file?

Item 19:

- ☐ What dates were visits made with the children this month? What was discussed?

Item 20:

- ☐ What dates were visits made with the parents this month? What was discussed?

Outcome WB2: Children receive appropriate services to meet their educational needs

- ☐ When were the educational needs of the child assessed?
- ☐ If the child has needs, are records in the file?
- ☐ What did the counselor state this month

Outcome WB3: Children receive adequate services to meet their physical and mental health needs
Item 22:

- ☐ When was the physical health of the children assessed?
- ☐ If needs identified, what did collaterals state?

Item 23:

- ☐ When was the mental health of the children assessed? If needs identified, what did collaterals state?