Module One
WELCOME AND OVERVIEW OF TRAINING

PURPOSE:

Case Managers will understand the vision, mission and structure of the Department of Human Resources and the Department of Family and Children Services.

LEARNING OBJECTIVES:

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

- Engage effectively with fellow participants
- Demonstrate understanding of attendance requirements and training expectations
- Explain the purpose and design of the training series, and how the training series relates to the certification process
- Explain DHR and DFCS Mission and Vision Statements
- Describe the relevance of DHR and DFCS Mission and Vision to their practice as case managers
- Recall the concept of State-supervised, County-administrated Child Welfare Services
- Explain the programs of Child Protective Services, Foster Care Services, and Adoption Services in the Division of Family and Children Services.
- Point out the differences in the program areas as well as how they interrelate

August 23, 2006

EDUCATION AND TRAINING SERVICES SECTION

DIVISION OF FAMILY AND CHILDREN SERVICES TRAINING PROGRAMS

CLASSROOM STANDARDS, EXPECTATIONS AND ATTENDANCE POLICY

As professional employees with the Department of Human Resources (DHR), Division of Family and Children Services (DFCS), all participants in any DFCS training programs must abide by the DHR Standards of Conduct, which set forth acceptable and unacceptable conduct toward peers, supervisors, managers, and clients. Trainees are encouraged to review the DHR Standards of Conduct found at:

http://www2.state.ga.us/departments/dhr/ohrmd/Policies/1201.pdf

The standards and expectations for the professional behavior of trainees in the classroom are as follows:

When Division employees are in training, their conduct must reflect their commitment and service to DHR and DFCS. Time spent in the classroom and in field practice is a normal workday.

Trainers serve in a supervisory role in the classroom. Responding to the trainer in accordance with the DHR Standards of Conduct is standard operating procedure.

Trainees are expected to complete written tests that cover material presented in class.

Trainees are expected to behave in a respectful manner. Examples of behaviors that are unacceptable and will not be tolerated include the following:

- inattentiveness during classroom time as exhibited by holding side conversations, conducting personal business, reading outside material or sleeping
- personal attacks, use of offensive language, argumentativeness, or excessive talking
- use of the Internet for reasons other than classroom activity
- eating food while in the computer lab
- use of cell phones, radios or beepers during class. All such devices must be turned off during class and replies to calls must be made during official breaks.

Engaging in these behaviors or in any behavior deemed disruptive or inappropriate by the trainer may result in an immediate conference with the trainer, notification to the trainee's immediate supervisor, administrator or director, or expulsion from class. The trainer will confer with the appropriate authority prior to expelling a trainee from class.

Trainees are expected to dress in accordance with Personal Appearance During Work Hours per section IV of the DHR Employee Handbook as follows:

> *While the Department does not specify a Department-wide dress code, employees are expected to be clean and neat in appearance during work hours. As representatives of the State, employees should present a business-like professional image. Dress code policies may be established by DHR organizational units. In certain types of jobs, employees may be required to wear uniforms.*
>
> *DHR organizations units may designate specific days as "casual days". Dress on casual days may be less formal, but should always be clean, neat and suitable for the work place.*
>
> *If lettered or illustrated clothing is worn, it should not promote a particular political, moral, religious, personal or other opinion. Clothing which is obscene, vulgar, offensive or inflammatory is prohibited. Employees may be required to change inappropriate dress or instructed not to wear the same or similar clothing in the future. Employees who do not comply with established dress code standards may be subject to disciplinary action up to and including separation.*

Trainees are encouraged to review the DHR Employees Handbook at:

http://www2.state.ga.us/departments/dhr/ohrmd/Publications/index.html

In addition to adhering to the Classroom Standards and Expectations, the following attendance policies apply to all staff while engaged in any training:

Trainees are expected to arrive on time and adhere to the time allotted for breaks and lunch. If an emergency arises that warrants arriving late or leaving early, the trainee must address the emergency with the trainer in concert with approval from the supervisor.

Annual leave should not be requested and cannot be approved during training. Any exceptions must be discussed with the appropriate authority prior to training. The only acceptable excuses for being absent from classroom training are the following:

Sick leave (e.g. emergency illness or medical appointments for acute illnesses). In the case of sick leave, trainees must notify their immediate supervisor in the county office as soon as possible to report their absence from classroom training.

OR

Court leave (e.g. subpoena to court, unexcused jury duty). In the case of court leave, trainees must obtain prior approval from their immediate supervisor in the county office as soon as possible in order to be absent from classroom training.

The county supervisor or administrator is the only employee who can approve a trainee's leave request. For Centralized Hire trainees, the administrative supervisor is the only employee authorized to approve a trainee's leave request. The trainer/facilitator **will NOT** approve any leave.

The county supervisor must notify the appropriate authority as soon as possible that a trainee will be absent from class due to sick or court leave. The appropriate authority will notify the trainer of the absence.

Trainees absent from class due to approved sick or court leave may be required to make up all or part of the course depending on the length of the absence and the length of the course. This may affect time frames for their completion of training. The appropriate authority will determine with the trainer whether a trainee will continue a course, after consultation with the trainee's supervisor.

For the purposes of determining expulsion from a class, notification regarding leave or continuation in a class, the appropriate contact via an e-mail is:

- For attendance at any Office of Financial Independence training e-mail: OFItraining@dhr.state.ga.us

- For attendance at any Social Services training e-mail: SStraining@dhr.state.ga.us

I ________________________________ have read and understand the Classroom Standards, Expectations and Attendance Policy for DFCS training programs.

Signature _____________________________________ Date ___________________

Overview of New Social Services Case Manager Training, Certification and Follow Up Training

Training and certification for new Social Services Case Managers is a sequenced combination of online training, field practice activities, and classroom instruction. Certification activities are interspersed at key points. The chronological training sequence is as follows:

Keys to Child Welfare Practice Series

Week 1 **Field Practice**
Tablet PC Training (regionally)

Week 2 **Keys classroom training**

Week 3 **Field Practice**
Online Training:

- Computer Concepts
- Roadmap to Successful Online Training
- Introduction to Child Welfare Services
- CPS Intake

Week 4 **Keys classroom training**

Week 5 **Field Practice**
Online Training: CPS Investigations

Week 6 **Keys classroom training**
Keys Knowledge Assessment (score of 70% or higher)

Note: Trainees who are waived from classroom training must take the Keys Knowledge Assessment and answer at least 70% of the questions correctly in order to achieve provisional certification. The knowledge assessment for such trainees will be administered at their regional training center. Supervisors may make an appointment for testing by emailing ssregistrar@dhr.state.ga.us .

Revised August 1, 2006

Provisional Certification

County Directors have an option to provisionally certify trainees once they successfully complete the 6-week "Keys" training sequence. This decision is based on trainee performance over the first 6 weeks. For the purposes of training, the provisionally certified new case manager may provide closely supervised case management for up to seven (7) low risk cases; the case manager should not have full responsibility for these cases. This assignment gives the trainee an opportunity to apply the knowledge and skills learned in Keys Training, and it facilitates the transfer of learning to actual practice.

County Directors *should consider* the following in granting provisional certification:

- **Satisfactory completion of online training: CPS Intake and Investigations**
- **Satisfactory completion of Keys Field Practice Activities**
- **Satisfactory completion of Keys classroom training**
- **Satisfactory assessment on the Keys Trainer Feedback Form**
- **A Score of 70% or greater on the Keys Classroom Knowledge Assessment**

  (A passing score is not required, but is highly recommended for provisional certification.)

Note: *Trainees who are waived from classroom training must take the Keys Knowledge Assessment and answer at least 70% of the questions correctly in order to achieve provisional certification.* Supervisors may make an appointment for testing by emailing ssregistrar@dhr.state.ga.us .
Provisional certification may be in effect up to 90 days following the provisional certification decision. The expectation is that an initial certification decision will be made by the end of this 90-day period.

Child Protective Services Track

5 days	**Online Training**: CPS Ongoing **Field Practice**
5 days	**Child Protective Services: Process, Practice and Policy (classroom training)** CPS Knowledge Assessment (in class) A score of 70% or higher is required.
5 days (may vary)	**Field Practice**, Certification Field Based Observation, Certification Record Review Certification decision

Initial Certification as a Case Manager in Child Protective Services

In making the certification decision, County Directors should consider trainee performance over the entire training period, the assessment results, and feedback from the Field Program Specialist, Supervisor/Training Coordinator, Field Practice Advisor and Trainer. When the decision is made, the supervisor completes the ***New Case Manager Certification Process Checklist*** and emails it to: caunit@dhr.state.ga.us. A copy of the New Case Manager Certification Process Checklist should be maintained in the new case manager's personnel file, along with verification that each component has been completed. **Initial certification is required** before the new case manager assumes full responsibility for a caseload.

Foster Care Services Track

10-15 days (may vary)	**Online training:** Foster Care Policy **Field Practice**
5 days	**Foster Care Services: Process, Practice and Policy (classroom training)** Foster Care Knowledge Assessment (in class) A score of 70% or higher is required.
5 days (may vary)	**Field Practice,** Certification Field Based Observation, Certification Record Review Certification decision

Initial Certification as a Case Manager in Foster Care Services

In making the certification decision, County Directors should consider trainee performance over the entire training period, the assessment results, and feedback from the Field Program Specialist, Supervisor/Training Coordinator, Field Practice Advisor and Trainer. When the decision is made, the supervisor completes the ***New Case Manager Certification Process Checklist*** and emails it to: caunit@dhr.state.ga.us. A copy of the New Case Manager Certification Process Checklist should be maintained in the new case manager's personnel file, along with verification that each component has been completed. **Initial certification is required** before the new case manager assumes full responsibility for a caseload.

Adoption Track
* Must complete Foster Care Track and FC certification as a pre-requisite

5 days Adoption **Field Practice**

4 days **Child Assessment and Preparation Classroom Training**
Adoption Knowledge assessment (in class)
A score of 70% or higher is required; certification decision

Initial Certification as a Case Manager in Adoption

In making the certification decision, County Directors should consider trainee performance over the entire training period, the assessment results, and feedback from the Field Program Specialist, Supervisor/Training Coordinator, Field Practice Advisor and Trainer. When the decision is made, the supervisor completes the ***New Case Manager Certification Process Checklist*** and emails it to: caunit@dhr.state.ga.us. A copy of the New Case Manager Certification Process Checklist should be maintained in the new case manager's personnel file, along with verification of completion of each component. **Initial certification is required** before the new case manager assumes full responsibility for a caseload.

Resource Development Track

The Resource development worker will be certified via the Foster Care Case Manager Track, as we currently do not have a Resource Development certification process.

*Complete Foster Care Track and FC certification as pre-requisite

5 days IMPACT Classroom Training

TBD **IMPACT Application Online Course** (under development)

Ongoing Certification in Case Management

After the case manager is certified, the following activities are required over the next 6 months.

- The case manager's supervisor reviews the certified case manager's case records on a regular basis (2 records per month).
- The supervisor provides ongoing coaching and mentoring.
- The supervisor completes an Interim PMP within 6 months of certification.
- The case manager completes follow up training

Follow Up Training

If it is at all possible, we recommend that new case managers take these courses in the order in which they are listed. Supervisors are responsible for registering case managers for these courses.

Required Courses for New Case Managers within 6 months of Initial Certification

CPS Case Managers	Foster Care Case Managers	Adoption Case Managers	Resource Development Case Managers	Additional Requirements for FTM Facilitators
Documentation: 12 hours Legal: 12 hours Family Violence: TBD	Documentation: 12 hours Legal: 12 hours Family Violence: TBD IV-E classroom: 12 hours	Documentation: 12 hours Legal: 12 hours Family Violence: TBD IV-E classroom: 12 hours Adoption Assistance: 6 hours	ASAP: 30 hours Documentation: 12 hours Legal: 12 hours	FTM Overview: 12 hours FTM Skills Building: 12 hours Follow up Practice Activities required to be an Approved FTM Facilitator
Total: 30 hours	**Total: 42 hours**	**Total: 48 hours**	**Total: 54 hours**	

Required courses for New Case Managers within 6-12 months of Initial Certification

CPS Case Managers	Foster Care Case Managers	Adoption Case Managers	Resource Development Case Managers	Additional Requirements for FTM Facilitators
Substance Abuse: 18 hours Emotional Survival: 5 hours *Fiscal Policy: TBD IV-E Overview Online: 4 hours	Substance Abuse: 18 hours Emotional Survival: 5 hours *Fiscal Policy: TBD IMPACT Overview: 12 hours	ASAP: 30 hours Substance Abuse: 18 hours	Substance Abuse: 18 hours IV-E Overview Online: 4 hours Adoption Assistance: 6 hours Family Violence: TBD	None at present
***Total: 27+ hours**	**Total: 35+ hours**	**Total: 48 hours**	**Total: 34 hours**	

*Denotes that course will be available after 7-1-06

Required Courses for New Case Managers within 12-18 months of Initial Certification

CPS Case Managers	Foster Care Case Managers	Adoption Case Managers	Resource Development Case Managers	Additional Requirements for FTM Facilitators
FTM Overview: 12 hours IMPACT Overview: 12 hours Advanced Legal: 6 hours **Total: 30 hours**	FTM Overview: 12 hours Adoption Assistance: 6 hours Advanced Legal: 6 hours **Total: 24 hours**	IMPACT Overview: 12 hours Emotional Survival: 5 hours *Fiscal Policy: TBD FTM Overview: 12 hours **Total: 29+ hours**	Emotional Survival: 5 hours FTM Overview: 12 hours *Fiscal Policy: TBD **Total: 17+ hours**	None at present

*Denotes that course will be available after 7-1-06

Ongoing Professional Development for Case Managers and Supervisors

Professional Excellence Courses

After follow up training, ongoing professional development continues for all certified case managers and supervisors. Professional Excellence courses are posted on the Registration and Transcript System and will apply toward the 20 hours annual professional development mandated by the Division for continued certification. Supervisors are responsible for registering case managers for these classes.

Awareness Questions

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?

- Things we hold to be true
- Susceptible to change

- Something we hold dear
- Something that is very important
- Usually long-standing
- Takes a long time to change
- Deeply-held beliefs that are more important to us than other beliefs

- ✓ A truth that is a foundation for other truths
- ✓ A rule of action or conduct
- ✓ Statements that guide our actions

Everything we do stem from:

Principles for which we stand

The beliefs that we hold dear

The ideals we value

Values & Beliefs

1. **Families can work to make their emotional and physical environments safe for their children.**

2. **Families should only use government-sponsored financial support on a short-term temporary basis.**

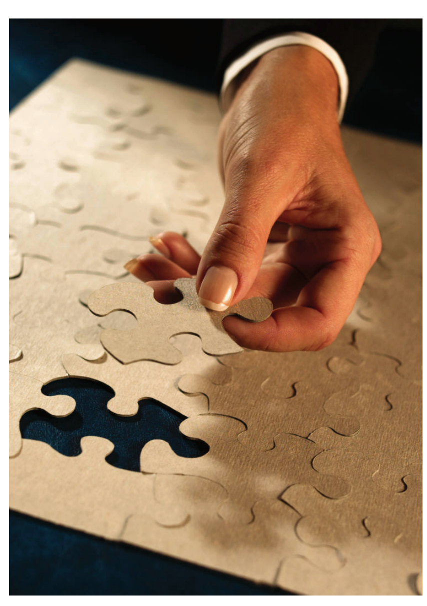
3. **A child's well-being is everybody's responsibility.**

4. **We should intervene in other people's families the same way we would want government to intervene in our families.**

5. **Families have strengths that can be the basis of creating greater safety and decreasing future risks**

6. **One of the greatest services we can give to families is to tell them, and ourselves, the whole truth as we see it, about their strengths and challenges.**

7. **We can, when prepared, supervised, and supported, help to create safety for children and their families.**



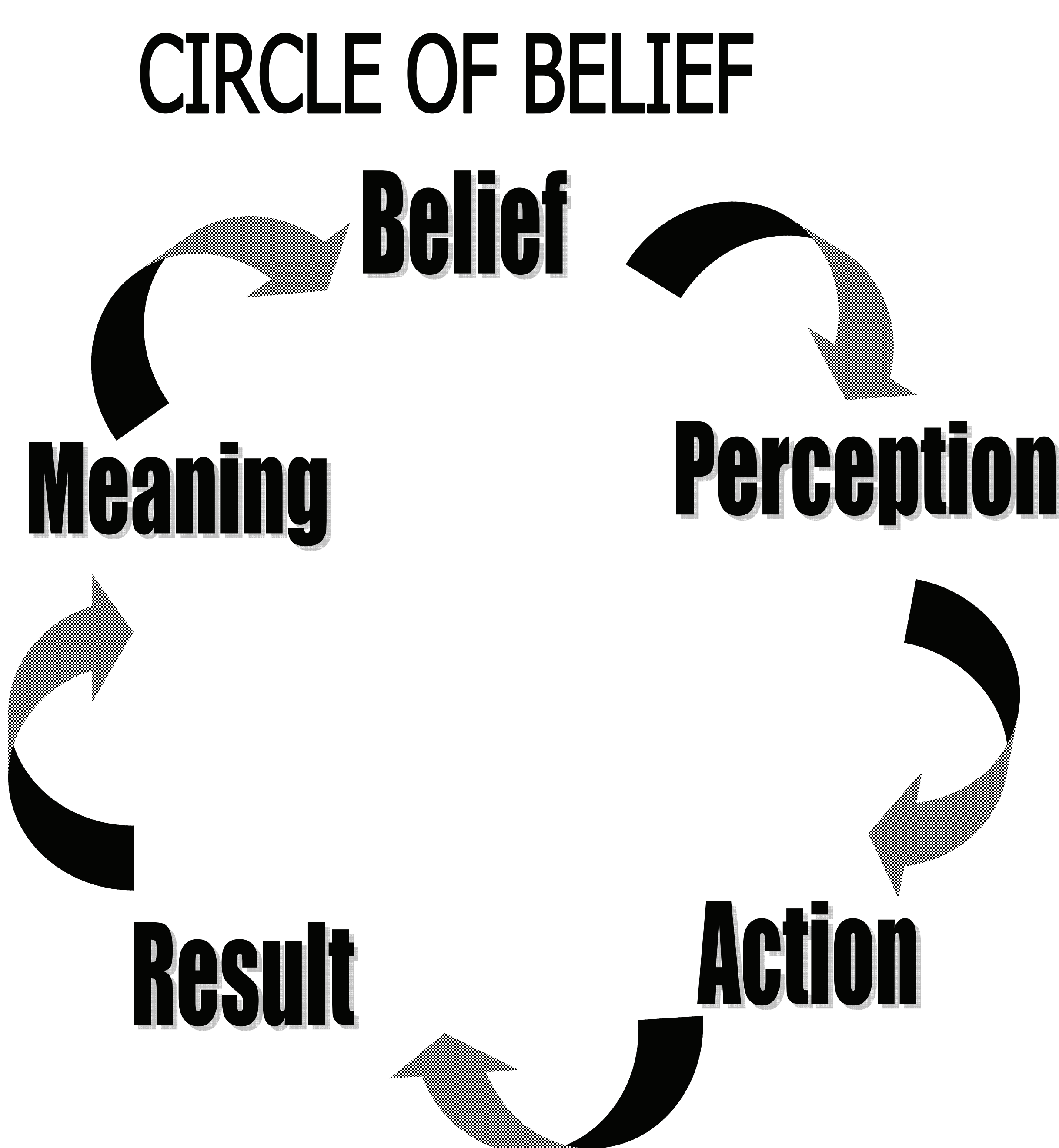
The Right Work, the Right Way

The *Right Work, the Right Way* is complete, continuous, and accurate assessment of safety, risk, strengths and needs of the family, leading to effective, comprehensive case planning and service provision that, in turn, results in safer families.

ACTIVITY
Doing the Right Work the Right Way

Scenario #

Values and Beliefs # ___
Values and Beliefs # ___
Values and Beliefs # ___
Values and Beliefs # ___
Values and Beliefs # ___

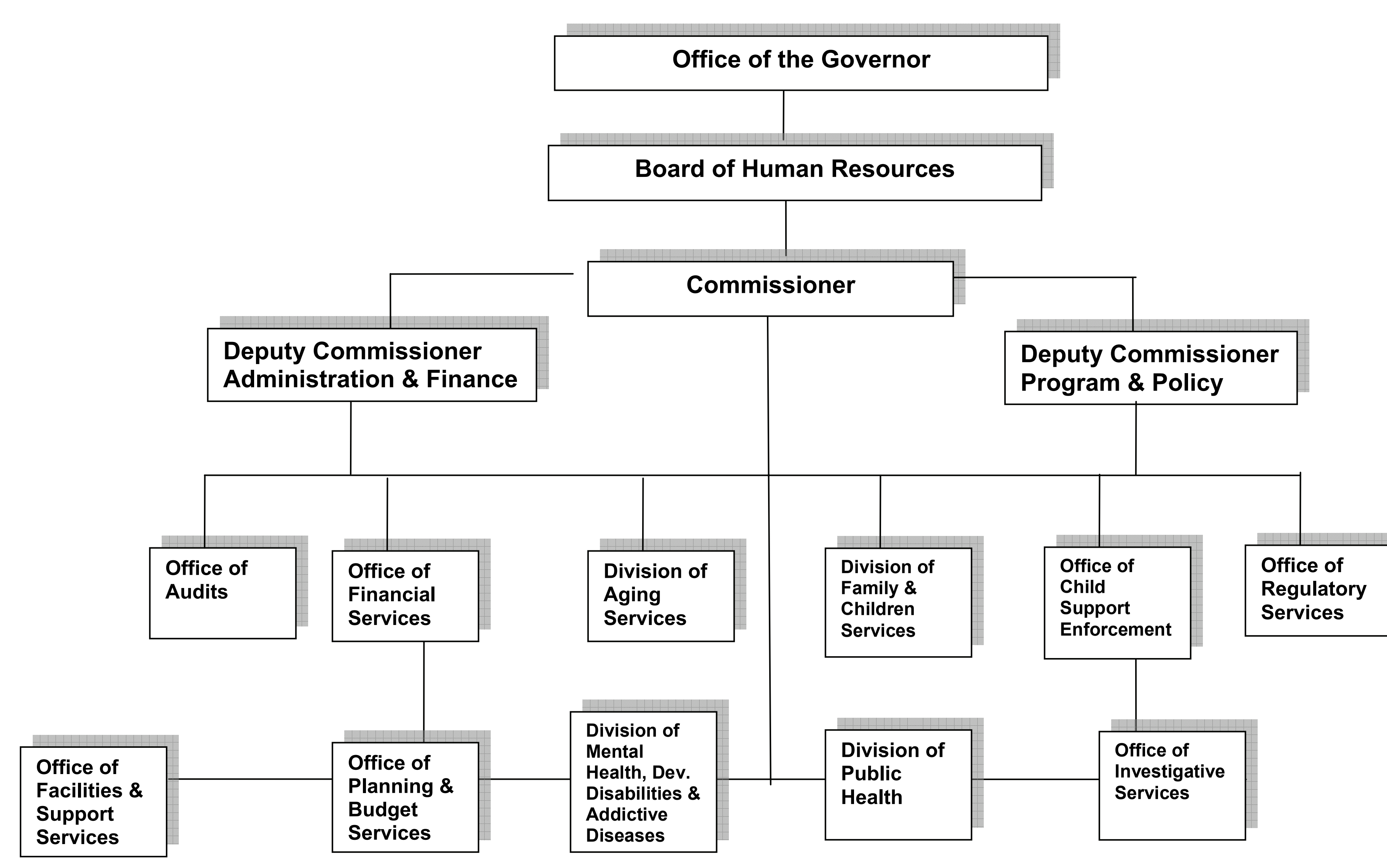

CIRCLE OF BELIEF
Belief
Perception
Action
Result
Meaning

I Believe…

Supervisor's Vision: <u>To have a unit of competent case managers</u>

Belief
Belief leads to Perception
Perception leads to Action
Action leads to Results
Results lead to Meaning
Meaning leads to Belief

Georgia Department of Human Resources
Organizational Chart



DHR Vision for the Future

Georgians living safe, healthy, and self-reliant lives.

DHR Mission

The Georgia Department of Human Resources, in partnership with others, will effectively deliver compassionate, innovative, and accountable services to individuals, families, and communities.

DFCS Mission

DFCS will be the provider of choice for a continuum of services which promotes the well-being of children and families, economic self-sufficiency for all Georgians, and communities able to provide opportunities and support to their members.

State Supervised, County Administered System

There are several ways this type of system affects the day-to day operation of a county agency.

- The responsibility for actual service program delivery is at the county department level. Policy development, monitoring, and evaluation are conducted from the state level.

- Counties are required to follow state law, administrative rules, and policy regarding service delivery.

- Within the context of law, rule, and policy, counties are given the authority to make case decisions and recommendations to the court.

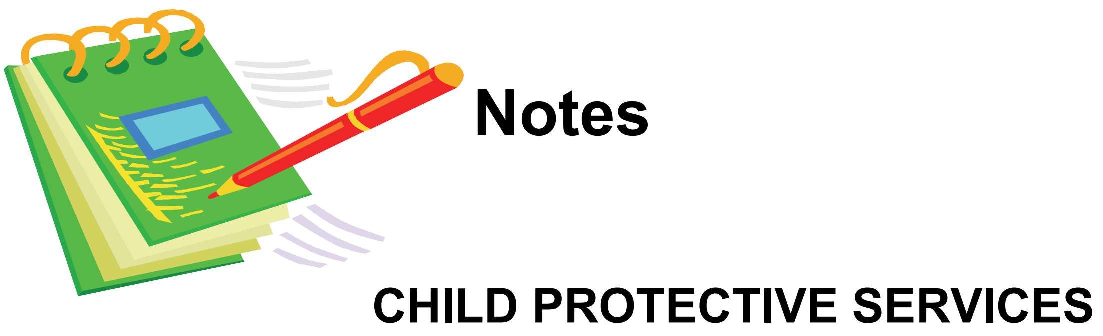
- Counties call work units different things and organize themselves differently. However, they must offer the services that are mandated by law (for example, CPS).

- There are State pay scales; however, depending on the levels of county funding, and optional programs, some counties pay an additional supplement.

- The state provides a yearly Grant-in-Aid budget allocation to each county department from which to operate for a fiscal year.

ASK MY SUPERVISOR

CHILD WELFARE CASE PROCESS CONTINUUM



CHILD PROTECTIVE SERVICES

INTAKE:

INVESTIGATION:

SAFETY ASSESSMENT/SAFETY PLAN:

RISK ASSESSMENT:

FAMILY PLAN:

CASE MANAGEMENT:

CLOSURE:

FOSTER CARE SERVICES

ENTRY INTO FOSTER CARE:

COMPREHENSIVE ASSESSMENT:

CASE PLAN:

CASE MANAGEMENT:

CLOSURE:

ADOPTION SERVICES

PRE-ADOPTIVE PLACEMENT:

ADOPTIVE PLACEMENT:

POST-ADOPTIVE PLACEMENT:

ADOPTION FINALIZATION/CLOSURE:

Module Two
TABLET TRAINING

Module Three

HISTORICAL AND LEGAL BASIS FOR CHILD WELFARE PRACTICE

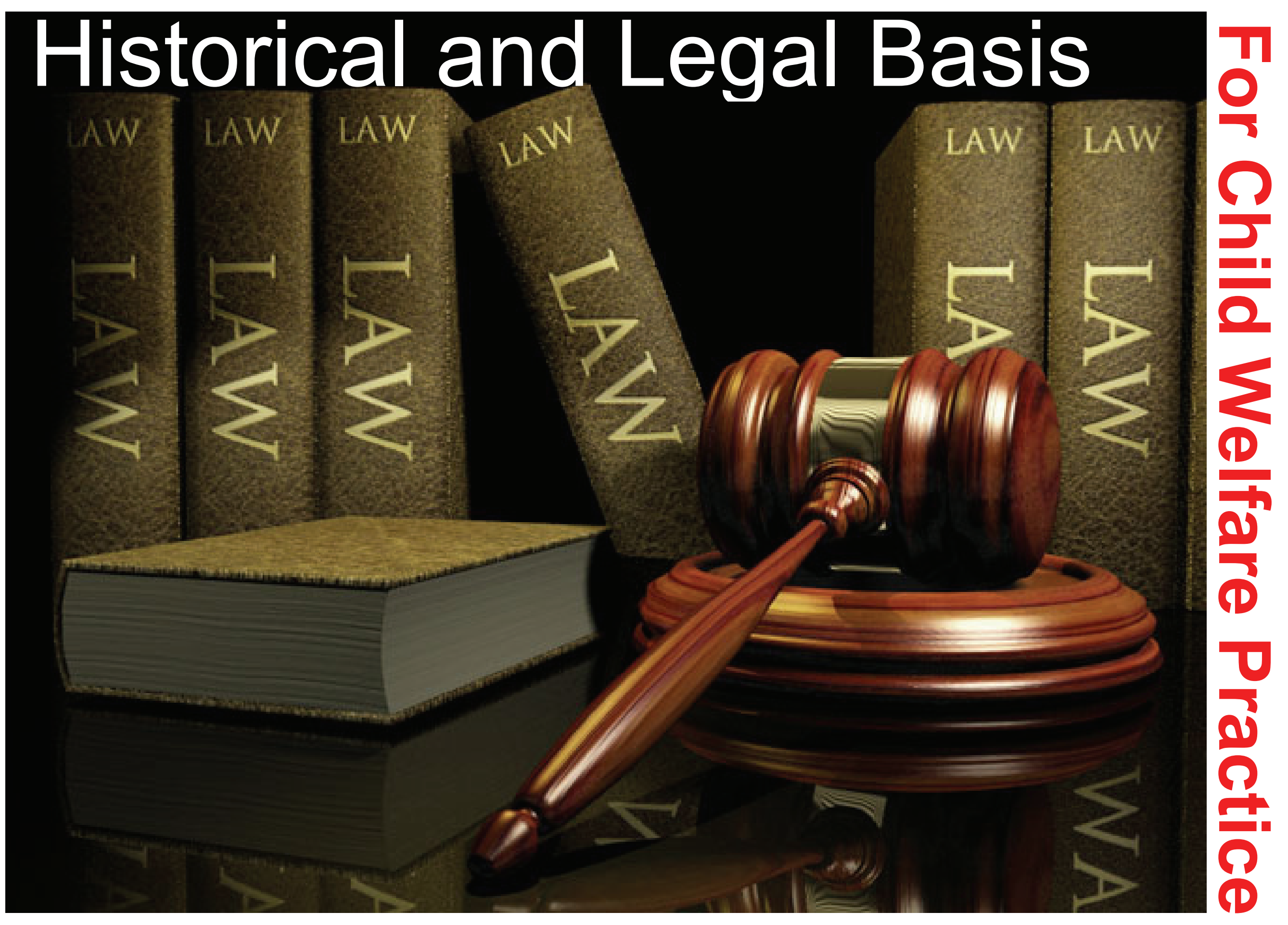
PURPOSE:

The Case Manager understands the historical and philosophical basis of child welfare practice, including the range of the Agency's responsibilities.

LEARNING OBJECTIVES:

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

- Summarize the development and historical events that have shaped the Federal and Georgia child welfare systems
- Interpret and locate federal and Georgia laws that impact child welfare and what this means for practice
- Understand how DHR and DFCS are organized, including state supervised- county administered system, and the impact on their work
- Compare the continuum of services – Child Protective Services, Foster Care Services, and Adoption Services in Georgia, pointing out the differences and interrelationships of the programs


Historical and Legal Basis
LAW
LAW
LAW
LAW
LAW
LAW
LAW
LAW
LAW
LAW
LAW
For Child Welfare Practice

United States Historical Outline of Child Welfare

1874	Maryellen – New York Prevention of Cruelty to Animals
1875	Formation of New York Society for the Prevention of Cruelty to Children
Late 1800's	First child care institutions founded/Orphanages continued until the late 1940's
1912	U.S. Children's Bureau was established
1950's	Concept of Foster family home replaces orphanages with rescue still being the goal of child welfare
1959	Study by Mass and Engler, entitled Children in Need of Parents identified the serious developmental and emotional problems of child who grow up in foster care
Early 1960's	Dr. C. Henry Kempe and associates identified Battered Child Syndrome
Late 1960's/ Early 1970's	Early 1970's Foster Care Drift identified
Early 1970's	Permanency Planning movement initiated
1970's	Legislation passed that mandated the reporting of suspected child maltreatment by both citizens and professionals
1979	Passage of the Indian Child Welfare Act (ICWA)
1980	Public Law 96-272 Adoption Assistance and Child Welfare Act- Established "reasonable efforts"
1990's/ Current	Placement prevention/ preservation of families movement
1994	P.L. 103-382, Multiethnic placement Act (MEPA)
1997	P.L. 105-89 – Adoption and Safe Families Act of 1997
2001	Promoting Safe and Stable Families Amendment

The Historical, Philosophical and Legal Bases of Child Welfare

Historically, societies have not always recognized that children have their own rights and interests separate from the rights of their parents or families, nor have most societies afforded children legal protection against maltreatment by their parents.

The Hammurabi Code, written in approximately 2150 BC in Babylonia, is the first known compilation of civil law. In the code sections regarding parent-child relationships, *children owed a duty of respect to their parents*, and if children fulfilled this duty, they were entitled to receive minimum care and treatment from their parents. If the child's duty was violated, the parent owed the child nothing, and the child's status reverted to that of a slave, (property) or a non-family member. In addition, until the father formally accepted the child as his own, the child had no status as an individual.

The code defined the parent-child relationship as *proprietary interest*. This concept has persisted in legal codes for more than 3000 years. The child, in simple terms, was viewed as an economic unit and could be sold or exchanged at the discretion of the parent.

Without inherent rights, protections and state interference, children could suffer abuse. Infanticide of unwanted children or children with birth defects, and punishment of children by dismemberment were accepted practices.

The Hebrew code, dating from around 800 BC, fully supported the concepts of the Hammurabi Code, including the parent's proprietary interest in the child and the child's absolute duty of respect to his parents. These tenets of the parent-child relationship did not end when the child reached adulthood; they remained in force *until the father died*.

Greek laws, in some respects, were unique for early civilizations. While these statutes were repressive and cruel in some respects, the treatment of children was more benevolent, particularly in later Greek civilizations. For example, the law evolved to restrict the father from unilaterally having the right to take his child's life. Instead, he was given the right to physically "chastise" the child. Eventually, the child was viewed as a distinct person from his father and could acquire and own property.

Roman law, dating from approximately 1253 BC, was more similar to the Hammurabi Code in its treatment of parent-child relationships. The doctrine of *patria potestas* established the unilateral and almost unlimited right of the father. The "father" in this society was the oldest male family member. He was the head of the family and the undisputed leader, and he retained this role and status until he died. However, in later Roman society the father's right to put a child to death was specifically outlawed, as was the right to sell a child.

A most interesting aspect of Roman society was that *despite legal prohibitions*, the practice of infanticide, the sale, mutilation, or killing of children, and the view of children as property persisted in Roman culture. The power of the *paterfamilias*, or male head of the family, was not controllable by law. This is an early expression of a pervasive cultural value of parents' rights superseding the rights of children.

The Visigothic kingdom existed in Europe between about 476 to 711 A.D. Formed with Roman, Germanic, and newly emerging Christian influences, this society was unusual in its humane treatment of children. The primary difference from earlier statutes was that the Visigothic Code stressed the *duties rather than the power of the parent*. Children could be punished or disinherited, but they could not be put to death or mutilated. The sale of children was forbidden. Parents were given authority to use reasonable physical discipline, but were not permitted to exceed what was considered reasonable. Children could also inherit property from the parents. The law upheld concepts that children had statutory rights to life and to other legal protections.

Early English law was strongly influenced by Roman law in that it permitted infanticide, the sale of children in times of poverty, and upheld the parent's right to fully control his children. However, there were differences; children were emancipated at majority, and the child had the right to own property. Children had some legal rights. The "guardian-ad-litem" or court appointed "next friend" was established during this period, although the rights of the child to independent representation were not always assured.

Later English law included the doctrine of *parens patriae*, literally the "father of his country." This doctrine evolved from case law over a period of hundreds of years. The doctrine defined the relationship between the parent and the child as a trust. The right of the parent was endowed by the "crown" (the state) because it was assumed that the parent would faithfully discharge his duties on behalf of the child. As described by Fraser,

> *"If the trust were not faithfully discharged, it would be incumbent upon the crown to intervene and to protect the child's interest. …*The State would act as a guarantor of the trust. What originally began as discretionary authority by the court to intervene in disputes involving property grew to become an affirmative duty to intervene when a child's rights were jeopardized. However, the court did not guarantee the child the right of independent representation." (Fraser, p. 322)

Early American law grew out of English law. Initially, little formal protection was offered to children. As an example, the "Stubborn Child Act" enacted in Massachusetts in 1628 held that a stubborn or rebellious son, old enough to understand, and who would not obey his parents, could be put to death.

In contrast to these general practices, there were societies in which the community's social norms and practices assured that children were cared for, even without formal legal protections. For example, in many African and Native American groups, children were historically viewed as the responsibility of the entire community, and if children were orphaned or needed care, extended family and community members assumed responsibility for their well-being. Since indigent children were fully
assimilated into the community, a separate legal or social system to assure their care was not deemed necessary.

Similarly, in most, if not all, societies, people have intervened to assure that indigent or homeless children were protected and cared for. Relatives have frequently cared for orphaned or abandoned children. Early “child advocates” also arranged shelter and physical care for many indigent children. Although these early “child advocates” were well meaning in their intent, these children were typically housed in alms or poor housed with adults who were mentally ill, mentally retarded, sick, aged, or who had committed crimes. Living conditions in these facilities were often deplorable. Yet, the work of these early advocates was important in setting a precedent for societal intervention when families or local communities did not care for children.

In the United States, governmental and legal efforts to intervene on behalf of children are marked by several significant events. The first major movement in the United Sates to protect children began in 1874 with the well-known case of Maryellen. In this case, the court acted in a manner that recognized that children did have a right to be treated humanely.

Mrs. Wheeler, a volunteer church caseworker, was visiting an elderly woman in the tenements of New York City when she learned about an 8-year-old girl named Maryellen, who had been indentured at the age of 18 months. Maryellen was thought to be frequently beaten, and her cries for help were often heard throughout the neighborhood. Authorities told Mrs. Wheeler they could not intervene because there were no laws protecting children. Mrs. Wheeler went to Henry Birgh of the New York Society for the Prevention of Cruelty to Animals for help. The *case was taken to court under laws protecting animals*; the child’s guardian was sentenced to one year in jail. Maryellen was placed with Mrs. Wheeler.

“I saw a child brought in…at the sight of which men wept aloud, and I heard the story of little Mary Ellen told…that stirred the soul of a city and roused the conscience of a world that had forgotten, and as I looked, I knew I was where the first chapter of children’s rights was being written” – Jacob Rijs, reporter, photojournalist

In 1875, Henry Birgh helped to found the New York Society for the Prevention of Cruelty to Children, because so many maltreated children were being brought to the attention of the Society for the Prevention of Cruelty of Animals. One of Birgh’s initiatives was to move New York “street kids” to small towns and farms in the Midwest with people who were of “good repute and moral character.” These children were transported on “orphan trains” to their new homes in Ohio, Michigan, Indiana, and further west.

In the late 1800’s, the first *child care institutions* were founded to provide safe shelter for children so they could be “rescued” from the deplorable conditions of the poor houses and mental institutions. The orphanage, later called the “children’s home,” remained a primary child welfare institution well into the 1940’s.

Child welfare services were first addressed by public policy in the early 1900’s. In 1912 the U.S. Children’s Bureau was established to create a federal agency that could represent the interests of children. As a result of this legislation, many public and private child welfare agencies were established and funded.

In the 1950's, professionals began to recognize that the needs of children could be better met in family settings than in institutions, and *the foster family home* began to replace the orphanage as the primary child placement resource. Rescue, however, was still the goal of care.

In the early 1960's, Dr. C. Henry Kempe and his associates identified the *battered child syndrome* and published their research findings. The research described the scope of the problem of child abuse. The report shocked many medical and social service professionals. Even so, Kempe and his associates had seriously underestimated the incidence of child abuse in the United States.

In 1959, a landmark study by Mass and Engler, entitled Children in Need of Parents, described the serious developmental and emotional problems of children who had grown up in foster care. Research during the 1960's and early 1970's identified a phenomenon called *foster care drift*, which referred to placement of children in a series of temporary foster homes with no expedient plan for a permanent family placement. A disturbingly large percentage of foster children exhibited *serious developmental and psychological problems*, apparently as a result of changing and temporary placements.

As a result of long term and impermanent foster care, many foster children lost all contact with their families and were emancipated from agency care with no permanent family ties. After living in chronic instability, they were unable to enter into or maintain healthy interpersonal relationships. Many foster children displayed identity disorders, personality disorders, and other serious emotional problems. It was becoming evident that the "cure" was often as damaging to children as the "problem" it was designed to remedy.

In the early 1970's, the "permanency planning" movement was initiated to correct the problem of foster care drift. Permanency planning referred to comprehensive case planning designed to achieve permanence for children. Initially, permanency planning was directed specifically to foster children who had been removed from their families and placed in substitute care. However, it was soon recognized that the best way to achieve permanence for any child was to prevent separation at all. The concept of permanence was thus adopted as a primary child welfare goal, and permanency-planning activities were provided to all children served by the child welfare system.

The permanency movement also generated significant changes in adoption policy and practice. Many children with special needs, who had been previously considered unadoptable because of their age, or developmental or emotional problems, became the focus of permanency planning efforts.

During the 1970's, legislation was passed that mandated the reporting of suspected child maltreatment by both citizens and professional. This led to dramatic increases in the number of investigations/assessments and in the number of children and families served in the child welfare system.

Funding changes, combined with the influx of cases to be served, created an inevitable system *overload* in the child welfare field. This situation persists today.

In 1979, The U.S. Congress passed the Indian Child Welfare Act (ICWA). Congress passed this law when it became evident that supposedly helpful interventions in Native American communities were actually eroding Indian families. Child welfare services for Native American children had been assigned to private contractors, most often churches, whose missionaries felt compelled to convert the children to Christianity and educate them to "American" ways of life. They were often removed from their families and placed in boarding schools far from home.

The Indian Child Welfare Act of 1979 assigned sole responsibility to tribal governments for child welfare and adoption decisions for children of Native American descent. This assured that child welfare interventions remained consistent with the Native American concept that the tribal community is responsible for the care of its own children. The Indian Child Welfare Act takes precedence over state and federal laws (Including the Adoption and Safe Families Act and MEPA/IEPA) and mandates that child welfare agencies notify the Bureau of Indian Affairs in Washington, D.C. if a child is identified by the family as being of Native American decent.

In 1980, Public Law (P.L.) 96-272, the Adoption Assistance and Child Welfare Act, was passed by the federal government to assure permanent homes for children and to strengthen the capability of families to care for their own children. This legislation forms the foundation of current child welfare practice.

Under this law, case managers were required to demonstrate that *"reasonable efforts "*had been made to prevent placing a child in substitute care. The concept of reasonable efforts means that every possible effort had been made by the child welfare agency to provide carefully planned, individualized, supportive and therapeutic services to strengthen families and enable them to retain care of their children. With such services, it was believed that the safety of most children could be assured in their own homes.

PL 96-272 mandates the completion of an assessment and the development of case plans for all children in substitute care. When reasonable efforts cannot prevent placement, the law requires that the child be placed in the "least restrictive, most home-like environment" possible. The agency must then engage in activities toward prompt reunification of children with their families, or provide a timely permanent alternative home for children who cannot be returned to their families.

Recently, as the child welfare field has begun to fully understand the importance of placement prevention, service intervention has increasingly placed an emphasis on the preservation of families. Agencies have developed intensive in-home family service programs that provide supportive and therapeutic services to families and children, thereby preventing the need for placement of the children outside of the home. The focus is placed on strengthening the ability of families to care for and protect their own children.

Family-centered services require that a balanced assessment of the strengths, capabilities, and needs of each family, and an individualized case plan that includes services that benefit the family as a unit, not just the child. While the mission of the child welfare field remains to protect children from maltreatment, the goals of intervention have shifted dramatically from the "rescue"

of children from their abusing or neglecting families to the protection of children in their own homes by *strengthening and preserving the family as a unit.*

In addition, our conception of who should be included in a family has been broadened to acknowledge that children may have significant emotional attachments to persons other than their biological parents and siblings. These people may include extended family members, adoptive parents, and other persons who may or may not be related to the child biologically or legally. The term "primary family" is often used instead of the more narrow term "biological family."

In family-centered practice, the family is the primary unit of intervention. This requires that case managers first determine who is included in a child's family, taking care to consider all persons, particularly primary caregivers, with whom the child has strong emotional attachments.

In October 1994, Congress passed P.L. 103-382, the "Multiethnic Placement Act" (MEPA). The Act was amended in 1996, and it is now called "The Inter-Ethnic Placement Act (IEPA). The purpose of this act and its amendment was to promote permanence for the tens of thousands of children in foster care waiting to be placed in appropriate foster or adoptive homes. The provisions of this act were intended to do the following: 1) decrease the length of time children must wait before they are adopted; 2) prevent discrimination in child placement on the basis of race, color, or national origin; and, 3) facilitate identification and recruitment of foster and adoptive families that can meet the special needs of the children in care.

Specifically, the provisions of MEPA/IEPA prohibit agencies or entities that receive Federal assistance and are involved in adoption or foster care from:

1) Denying to any person the opportunity to become an adoptive or a foster parent on the basis of race, color, or national origin of the adoptive or foster parent of the child involved; or

2) Delay or deny the placement of a child for adoption or into foster care, or otherwise discriminate in making a placement decision, on the basis of the race, color, or national origin of the adoptive or foster parent, or the child involved.

Agencies or entities may, however, consider the total needs of the child, including the needs associated with safety, social development, or identity formation and /or cultural continuity. The best interests of the child must be paramount. States and agencies should target recruitment efforts to identify adoptive and foster families from the cultural backgrounds of the children who need homes. The impetus for the act and its amendment was the adherence, in some states and agencies, to policies that discouraged cross-racial placements or that sanctioned lengthy searches for same-race families before authorizing cross-racial placements. In some cases, families were informally discouraged from applying to foster or adopt children from a different race or ethnicity. These policies contributed to placement delays, and in some cases, prevented appropriate placement or adoption for many children, since the number of potential available families for the child was reduced (U.S. Department of Health and Human Services, Internet, 1995).

On November 19, 1997, the President signed into law the Adoption and Safe Families Act of 1997 (P.L. 105-89), designed to promote adoption and support families. The thrust of child welfare legislation continues to be the placement of children in permanent, safe homes, preferably with parents or relatives. However, if such cannot be achieved, agencies and courts must move more quickly to arrange adoptive homes for children.

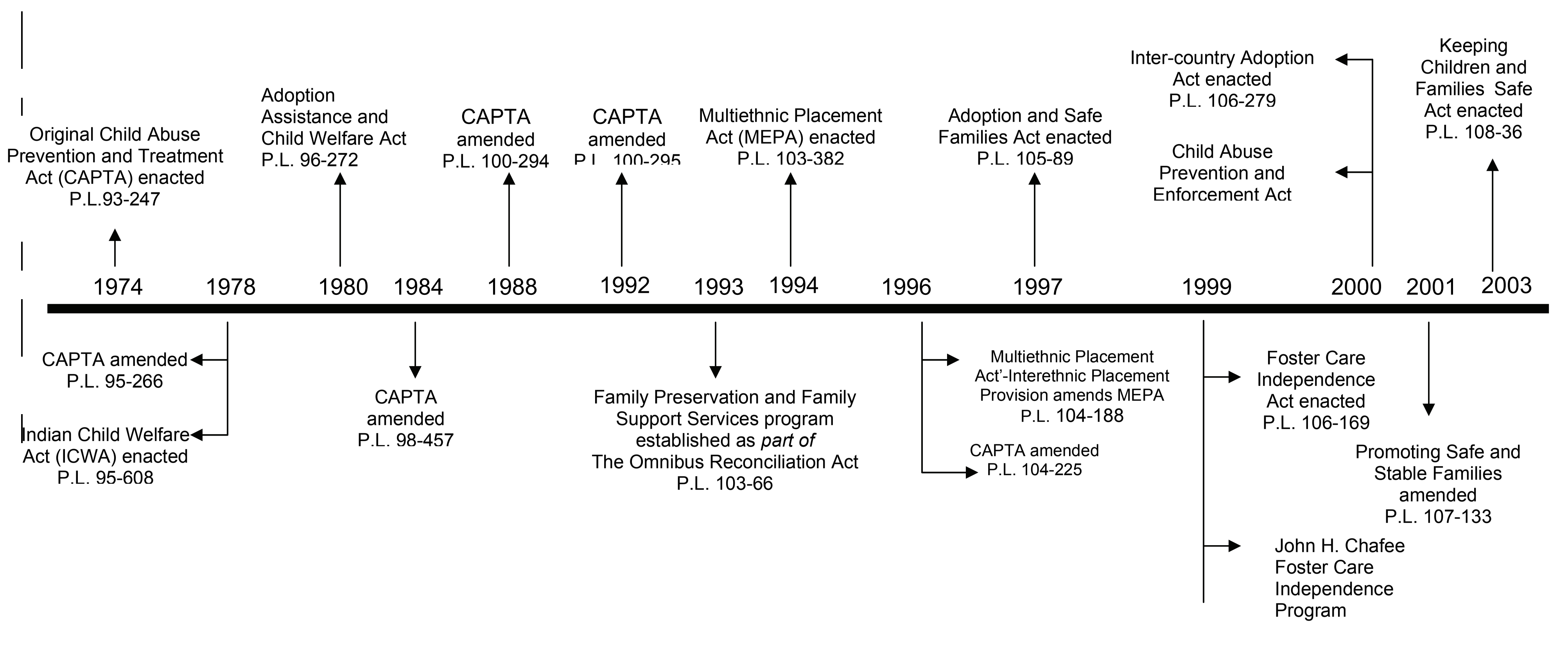
It is evident that the values and focus of the child welfare field have undergone significant changes during the past 150 years. The needs of families and children are complex, and the child welfare field has been given considerable responsibility by society for addressing the many social and environmental problems that contribute to the maltreatment of children. The field continues to be challenged by new problems, including an increase in drug use and abuse, children and parents with HIV infection (AIDS), an increasing number of delinquent youth, widespread family violence, and a growing population of youth whose backgrounds include abuse, neglect, and sexual abuse.

Understanding the history of the child welfare system enables one to understand the changing role of the caseworker and the system. It also helps us recognize that many of the stresses we experience are the result of the enormous complexity of the tasks at hand, and the often limited resources and system supports available to us.

Child welfare practice requires a high level of skill and professionalism. Despite obstacles and challenges, the skilled interventions of professional child welfare staff help many thousands of children and families annually in this country. The higher our level of skill, the better we will be able to perform despite constraints, and the more able we will be to advocate for change in our field.

Adapted from Family-Centered Child Protective Services (Core 101),
The Ohio Child Welfare Training Program 6/99.

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



Major Legislation

<table>
<tr>
<td>Child Abuse Prevention and Treatment Act (CAPTA) of 1974
P.L. 93-247

Amended 1978,1984,1988
,
1992,1996,
2003</td>
<td>Reasons Bill Initiated
• Medical recognition of Battered Child Syndrome in 1961, as well as findings from medical reports, brought public attention to the problem of child abuse.
• One of every ten children brought to hospital emergency rooms were victims of physical abuse.
• A large majority of these cases went unreported.
• Federal government was urged to take interest in the welfare of abused and neglected children.
• States had developed reporting laws and responses to reports without much uniformity.
Objectives/Goals
• To increase identification, reporting, and investigation of child maltreatment, thereby protecting children from harm.
• To monitor research, and compile and publish materials, for persons working in the field.
Services Provided/Measures Taken
• Provided assistance to States to develop child abuse and neglect identification and prevention programs.
• Placed moral weight of Federal government behind professional intervention with troubled families.
• Enhanced the Federal government’s role to be proactive in detection, prevention, and treatment of child abuse.
• Authorized limited government research into child abuse prevention and treatment.
• Created the National Center on Child Abuse and Neglect (NCCAN) within the Department of Health and Human Services to:
  ▪ Administer grant programs.
  ▪ Identify issues and areas needing special focus for new research and demonstration project activities.
  ▪ Serve as the focal point for the collection of information, improvement of programs, dissemination of materials, and information on best practices to States and localities.
• Created the National Clearinghouse on Child Abuse and Neglect Information.
• Established Basic State Grants and Demonstration Grants for training of personnel and to support innovative programs aimed at preventing and treating child maltreatment.</td>
</tr>
</table>

Major Legislation

Indian Child Welfare Act (ICWA) of 1978 P.L. 95-608	**Reason Bill Initiated** • Advocates called attention to the fact that State courts were removing a high proportion of Indian children from their families and tribes and placing them in non-Indian environment. • In some States, as many as 25%-35% of Indian children were being placed in foster care; 85% of those children were placed in non-Indian homes. • There was a growing concern that these children were losing their Indian culture and heritage. • The State court systems did not take into consideration the tribal relations of Indian people and the cultural and social standards of Indian communities. Objectives/Goals • To protect the best interests of Indian children and families. • To promote the stability and security of Indian families. • To establish minimum Federal standards for the removal of Indian children from their homes and for the placement of Indian children in homes that reflect the values of Indian culture. • To raise the standards for termination of parental rights of Indian parents. • To recognize and strengthen the role of Tribal governments in determining child custody issues. Services Provided/Measures Taken • Established minimum Federal standards for the removal of Indian children from their families. • Required Indian children to be placed in foster or adoptive homes that reflect Indian culture. • Provided for assistance to tribes in the operation of child and family service programs. • Created exclusive tribal jurisdiction over all Indian child custody proceedings, when requested by tribe, parent, or Indian "custodian." • Granted preference to Indian family environments in adoptive or foster care placement. • Provided funds to tribes or non-profit off-reservation Indian organizations or multi-service centers for purpose of improving child welfare services to Indian children and families. • Required State and Federal courts to give full faith and credit to tribal court decrees. • Set a “beyond a reasonable doubt” standard of proof for terminating Indian parents' parental rights.

Major Legislation

Adoption Assistance and Child Welfare Act of 1980
P.L. 96-272
 	
Amended Titles IV-B and XX of the Social Security Act
 	
Established Title IV-E of the Social Security Act
	Reasons Bill Initiated
	• Initiated in response to discontent with public child welfare system.
	• Problem of *Foster Care Drift*: the sense of impermanence in foster homes and concerns about children placed in multiple foster placements over an extended period of time.
	Objectives/Goals
	• To prevent unnecessary separation of children from families.
	• To protect the autonomy of the family.
	• To shift support of Federal government away from foster care alone, and towards placement prevention and reunification.
	• To promote the return of children to their families, when feasible.
	• To encourage adoption when it is in the child's best interests.
	• To improve the quality of care and services.
	• To reduce the number of children in foster care.
	• To reduce the duration of a child's stay in foster care.
	Services Provided/Measures Taken
	• Required states to make adoption assistance payments, which take into account the circumstances of the adopting parents and the child, to parents who adopt a child who is AFDC-eligible and is a child with special needs.
	• Defined a child with special needs as a child who:
	  ▪ Cannot be returned to the parent's home.
	  ▪ Has a special condition such that the child cannot be placed without providing assistance.
	  ▪ Has not been able to be placed without assistance.
	• Required, as a condition of receiving Federal foster care matching funds, that States make "reasonable efforts" to prevent removal of the child from the home, and return those who have been removed as soon as possible.
	• Required participating states to establish reunification and preventive programs for all in foster care.
	• Required the state to place a child in the least restrictive setting and, if to the child's benefit, one that is close to the parent's home.
	• Required that the court or agency review the status of a child in any non-permanent setting every 6 months to determine what is in the best interest of the child. Most emphasis is placed on returning the child home, as soon as possible.
	• Required that the court or administrative body determine the child's future status, whether it is return to parents, adoption, or continued foster care, within 18 months after initial placement into foster care.

Major Legislation

Adoption Assistance and Child Welfare Act of 1980 (continued) P.L. 96-272	**TITLE IV-E** – enacted by Congress to facilitate the timely achievement of permanent living arrangements for children in foster care**.** When originally enacted, Title IV-E established, among others, the following requirements: • A child must be determined eligible for Title IV-E foster care based on established criteria related to the Aid to Families with Dependent Children (AFDC) program that must be met during the six months prior to the child entering foster care. • States must make reasonable efforts to prevent a child from entering foster care and make reasonable efforts to reunify a child with her/his family when a child must be placed in foster care. • There must be written case plan for all children in foster care and their families. The case plan must include, among other requirements, the permanency goal for the child, the reasons the child is in foster care, and the services that will be provided or offered to the child and family to resolve the problems that caused the need for foster care. • There must be periodic reviews of the progress toward achieving permanency for a child conducted by an independent third party (i.e., someone who is not in the same administrative unit as is the person providing services to the child and family).
Family Preservation and Support Services Program Enacted as part of the Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66) Title XIII, Chapter 2, Subchapter C, Part 1 This program amended Title IV-B of the Social Security Act.	**Reasons Bill Initiated** • The number of reported and substantiated abuse and neglect cases was rising. • The focus of services needed to be changed from crisis to prevention. • Services often did not fit the real needs of families. • Child welfare services create a safe, stable, nurturing home. **Objectives/Goals** • To promote the safety and well being of all family members. • To enhance parental ability to create a safe, stable, nurturing home. • To assist families in resolving crises and connect them with services that would enable children to remain safely at home. • To prevent the need for out-of-home placement. • To help children already in placement return home or enter another permanent living arrangement • To promote family strength and stability.

Major Legislation

<table>
<tr><td>Family Preservation and Support Services Program
(continued)</td><td>Services Provided/Measures Taken
• Encouraged states to use funds to create a continuum of family-focused services for “at risk” children and families.
• Required states to engage in a comprehensive planning process to develop more responsive family support and preservation strategies.
• The focus of services needed to be changed from crisis to support.
• Encouraged states to: 1) use funds to integrate preventive services into treatment-oriented child welfare systems, 2) improve service coordination within and across State service agencies, and 3) engage broad segments of the community in program planning at State and local levels.
• Broadened the definition of “family” to include people needing services regardless of family configuration: biological, adoptive, foster, extended, or self-defined.
• Defined services to be provided by the States:
▪ Preservation: activities designed to assist families in crisis, often where the child is at risk of being placed in out-of-home care because of abuse and/or neglect.
Support: preventive activities, typically provided by community-based organizations, designed to improve nurturing of children, and strengthen and enhance stability of families.</td></tr>
<tr><td>Multiethnic Placement Act (MEPA) of 1994
P.L. 103-382: Title V, Part E</td><td>Reasons Bill Initiated
• A growing number of children in foster care were waiting for adoptive homes for excessive periods of time.
• Minority children were over-represented in out-of-home care.

Objectives/Goals
• To decrease the time children wait to be adopted.
• To prevent discrimination on the basis of race, color, and/or national origin, when making foster care and adoptive placements.
• To facilitate identification and recruitment of foster and adoptive families that can meet children’s needs.

Services Provided/Measures Taken
• Prohibited state agencies and other entities that receive Federal funding and were involved in foster care or adoption placements from delaying, denying, or otherwise discriminating when making a foster care or adoption placement decision on the basis of the parent or child’s race, color, or national origin.</td></tr>
</table>

Major Legislation

Multiethnic Placement Act (MEPA) of 1994 (continued)	• Prohibited State agencies and other entities that received Federal funds and were involved in foster care or adoption placements from categorically denying any person the opportunity to become a foster or adoptive parent solely on the basis of race, color, or national origin of the parent or the child. • Required states to develop plans for recruitment of foster and adoptive families that reflect the ethnic and racial diversity of children in the State for whom families are needed. • Allowed an agency or entity to consider the cultural, ethnic, or racial background of a child, and the capacity of an adoptive or foster parent to meet the needs of a child with that background when making a placement. ▪ Had no effect on the provisions of the Indian Child Welfare Act of 1978. ▪ Made failure to comply with MEPA a violation of Title VI of the Civil Rights Act.
Adoption and Safe Families Act (ASFA) of 1997 P.L. 105-89	**Reasons Bill Initiated** • Many children in foster care were waiting several years for permanent placement. • The focus on "reasonable efforts" to reunify children with their families had led to some placement decisions that were not in the best interests of the child and not adequately focused on child safety. • In order to move children into permanent homes in a more timely manner, states needed stricter guidelines for placement and reunification of children within their families. • To accelerate permanent placements of children. • To increase accountability of the child welfare system. **Objectives/Goals** • To promote permanency for children in foster care. ▪ To ensure safety for abused and neglected children ▪ Added "safety of the child" to every step of the case plan and review process. ▪ Required criminal record checks for foster/adoptive parents who receive Federal funds on behalf of a child, unless a State opted out. • Accelerated permanent placement: ▪ Required states to initiate court proceedings to free a child for adoption once that child had been waiting in foster care for at least 15 of the most recent 22 months, unless there is an exception. ▪ Allowed children to be freed for adoption more quickly in extreme cases.

Major Legislation

Adoption and Safe Families Act (ASFA) of 1997 (Continued)	**Services Provided/Measures Taken**
	• Reauthorized the Family Preservation and Support Services Program:
	  ▪ Renamed it the Safe and Stable Families Program
	  ▪ Extended categories of services to include time-limited reunification services, and adoption promotion and support services.
	• Ensured safety for abused and neglected children:
	  ▪ Ensured health and safety concerns are addressed when a State determines placement for abused and neglected children.
	• Required HHS to report on the scope of substance abuse in the child welfare population, and the outcomes of services provided to substance abusing families.
	• Promoted adoptions:
	  ▪ Rewarded states that increased adoptions with incentive funds.
	  ▪ Required states to use “reasonable efforts” to move eligible foster care children towards permanent placements.
	  ▪ Promoted adoptions of all special needs children and ensured health coverage for adopted special needs children.
	  ▪ Prohibited states from delaying/denying placements of children based on the geographic location of the prospective adoptive families.
	  ▪ Required states to document and report child-specific adoption efforts.
	• Increased accountability:
	  ▪ Required HHS to establish new outcome measures to monitor and improve State performance.
	  ▪ Required states to document child-specific effort to move children into adoptive homes.
	• Clarified “reasonable efforts”:
	  ▪ Emphasized children’s health and safety.
	  ▪ Required states to specify situations when services to prevent foster care placement and reunification of families are not required.
	• Implemented shorter time limits for making decisions about permanent placements:
	  ▪ Permanency hearings to be held no later than 12 months after entering foster care.
	  ▪ States must initiate termination of parental rights proceedings after the child has been in foster care 15 of the previous 22 months, except if not in the best interests of the child, or if the child is in the care of a relative.

Major Legislation

Promoting Safe and Stable Families Amendments of 2001 P.L. 107-133	**Reasons Bill Initiated** • Ongoing need to protect children and strengthen families. • Rapid increase in numbers of adoptions created a need for post-adoption services. • Concern for the rise in the number of children with incarcerated parents and the negative outcomes for some of these children. • Youth who aged out of foster care lag behind other youth in educational attainment. **Objectives/Goals** • To encourage and enable 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. • To reduce the risk behavior by children with incarcerated parents by providing one-on-one relationships with adult mentors. • To continue improvements in State court systems, as required by ASFA. • To provide educational opportunities for youth aging out of foster care. **Services Provided/Measures Taken** • Amended Title IV-B, subpart 2 of the Social Security Act • Added findings to illustrate the need for programs addressing families at risk for abuse and neglect, and those adopting children from foster care. • Definition of family preservation services amended to include infant safe haven programs. • Added strengthening parental relationships and promoting healthy marriages to list of allowable activities. • Added new focus to the research, evaluation, and technical assistance activities. • Allowed reallocation of unused funds in Title IV-B, subpart 2. • Created a matching grant program to support mentoring networks for children of prisoners. • Reauthorized funds for the Court Improvement Program. • Authorized a voucher program as part of the John H. Chafee Foster Care Independence Program.

Goal of the Child Protective Services Program

To ensure the protection and safety of children who are victims of abuse and neglect

Preservation of Reasonable Parenting

Child and Family Services Review Outcomes

Safety

Permanency

Child and Family Well-Being

Reference: Children Receive Adequate Services to Meet Their Physical and Mental Health Needs. Federal Register, Vol. 65 No. 16, January 25, 2000)

Georgia Statutes

Legal basis for Child Welfare:

- Children and Youth Act, O.C.G.A. 49-5-1
- Juvenile Court Code of Georgia, O.C.G.A, 49-5-40
- Interstate Compact on the Placement of Children, Chapter 39-4, O.C.G.A., annotated as amended
- Adoption: Title 19, Chapter 8
- Child Protection: Title 19, Chapter 5, articles 2 & 8; Chapter 14 & 15; э 19-7-5
- Child Welfare: Title 15, Chapter 11, article 2; Title 19, Chapter 5
- 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
- Local child abuse protocol committee, O.C.G.A. 19-15-2
- Child abuse fatality sub-committee, O.C.G.A. 19-15-3

Internet site for Statutes
Http://www.legis.state.ga.us/legis/GaCode/index.htm

Regulation/Policy: Department of Human Services

Social Services Manual, Child Protection Chapter
http://www.childwelfare.net/DHR/policies/CPS/

Foster Care Manual
http://www.childwelfare.net/DHR/policies/Foster/

B. J. Walker,

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.

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, the use 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

Department of Human Resources • Division of Family and Children Services • Mary Dean Harvey, Division Director • 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: Mary Dean Harvey, 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 **Social Services County Letter No. 2006-01**
February 3, 2006
Page Two

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 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

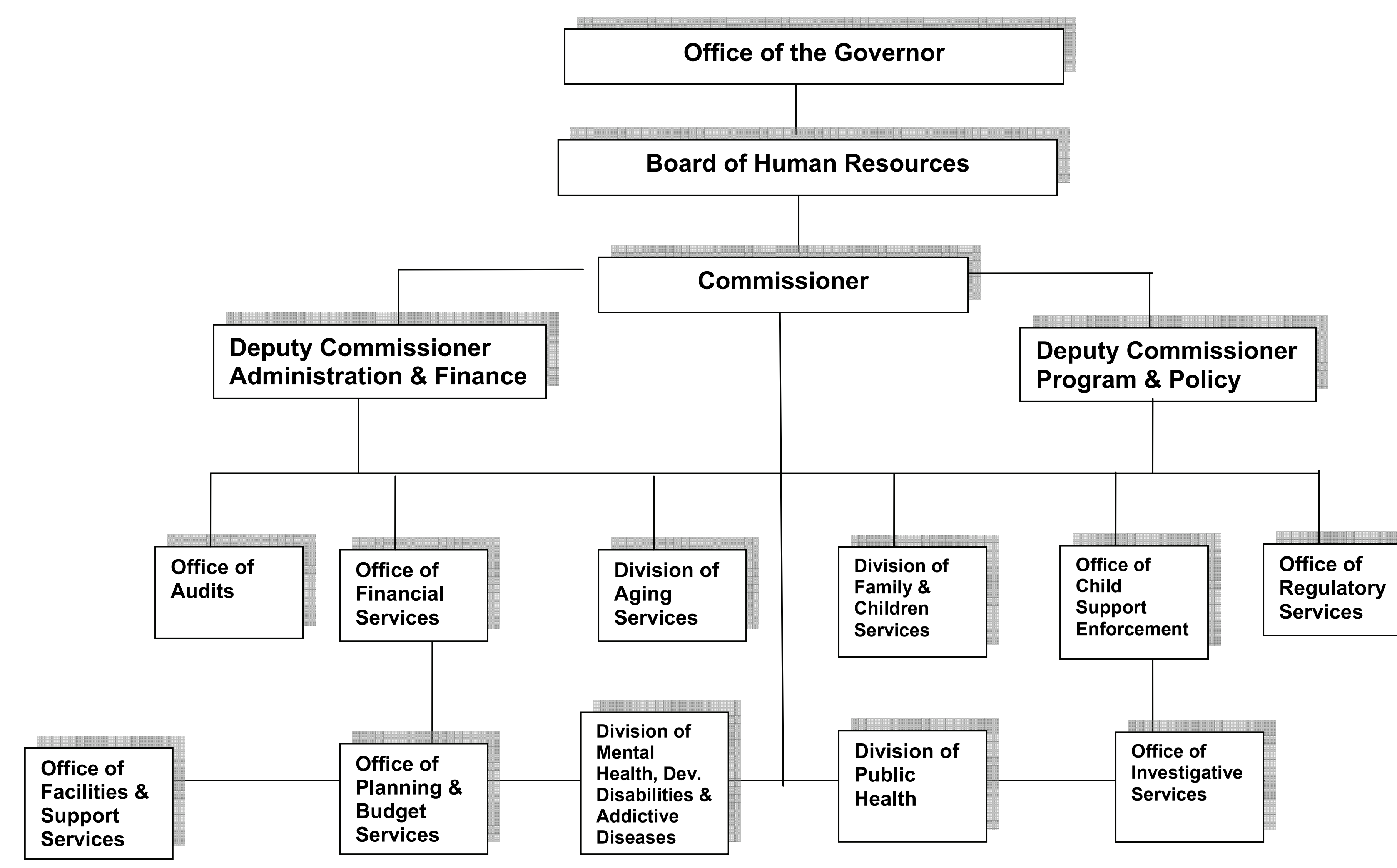
This county letter is effective upon receipt and is obsolete upon receipt of revised Chapter 60 and revised CPS policy 2104.33.

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

Georgia Department of Human Resources
Organizational Chart



DHR Vision for the Future

Georgians living safe, healthy, and self-reliant lives.

DHR Mission

The mission of the Georgia Department of Human Resources is to strengthen Georgia's families – supporting their self sufficiency and helping them protect their vulnerable children and adults by being a resource to their families, not a substitute.

DFCS Mission

DFCS will be the provider of choice for a continuum of services which promotes the well-being of children and families, economic self-sufficiency for all Georgians, and communities able to provide opportunities and support to their members.

State Supervised, County Administered System

There are several ways this type of system affects the day-to day operation of a county agency.

- The responsibility for actual service program delivery is at the county department level. Policy development, monitoring, and evaluation are conducted from the state level.
- Counties are required to follow state law, administrative rules, and policy regarding service delivery.
- Within the context of law, rule, and policy, counties are given the authority to make case decisions and recommendations to the court.
- Counties call work units different things and organize themselves differently. However, they must offer the services that are mandated by law (for example, CPS).
- There are State pay scales; however, depending on the levels of county funding, and optional programs, some counties pay an additional supplement.
- The state provides a yearly Grant-in-Aid budget allocation to each county department from which to operate for a fiscal year.

ASK MY SUPERVISOR

CHILD WELFARE CASE PROCESS CONTINUUM

Notes

CHILD PROTECTIVE SERVICES

INTAKE:

INVESTIGATION:

SAFETY ASSESSMENT/SAFETY PLAN:

RISK ASSESSMENT:

FAMILY PLAN:

CASE MANAGEMENT:

CLOSURE:

FOSTER CARE SERVICES

ENTRY INTO FOSTER CARE:

COMPREHENSIVE ASSESSMENT:

CASE PLAN:

CASE MANAGEMENT:

CLOSURE:

ADOPTION SERVICES

PRE-ADOPTIVE PLACEMENT:

ADOPTIVE PLACEMENT:

POST-ADOPTIVE PLACEMENT:

ADOPTION FINALIZATION/CLOSURE:

Module Four
FAMILY-CENTERED PRACTICE AND CULTURAL INFLUENCES

PURPOSE:

Case Managers will understand the values and characteristics of Family-Centered Practice. Case Managers will also know how social work values and principles apply to Child Welfare Practice, including respecting the family's dignity, uniqueness, culture, and right to self-determination.

LEARNING OBJECTIVES:

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

- Describe the values of family support and family-centered child welfare practice, including the preservation of parent and child rights, and apply those values in social work practice.
- Summarize the philosophy, values, and characteristics of family-centered child welfare.
- Describe how effective family-centered services can prevent the removal of children from their homes.
- Understand how strengthening families can foster positive change.
- Use family-centered casework methods to promote family preservation and permanence for children.
- Articulate the concept that child protection is a community responsibility.

- Stress the importance of a collaborative approach in working with agencies and resources to serve children and families.
- Utilize the Ethnographic Interview to discover another's culture, values and beliefs.

DEFINITIONS OF FAMILY

- A fundamental social group in society consisting of a man and woman and their offspring
- A group of persons sharing a common ancestry
- Distinguished lineage
- A group of like things
- All the members of a household under one roof

Family-Centered Practice

Family-Centered Practice is, simply, the provision of family specific services that strengthen and enable families to find ways to meet their needs and to provide safe care to their children, in their own homes and communities, and in ways that are consistent with their cultures.

Family-Centered Services vs. Traditional Social Services

FAMILY-CENTERED SERVICES	TRADITIONAL SOCIAL SERVICES
Focus on family strengths	Focus on problems and weaknesses
Focus on symptoms for safety; focus on underlying causes or change	Concentrate on immediate symptom
Focus on family system	Focus on individual
Family seen in context of many forces, some of which are outside their control	Family seen as being able to control forces in their lives and fail by choice
Individual and family interview with focus on family interviews	Individual interview
Help family solve own problems	Solve problem for family
Problem part of complex system	Problem seen in isolation
Worker and family together determine problems/needs	Worker defines problem
Worker offers strategies to include family ideas; family selects solutions	Worker defines solutions
Use crisis as a teachable moment	No special use of crises
Informal family network and community resources used more often	Services and supports are usually formal or state resources
Joining, networking, referral, teaching, and coaching	Concrete or referral services only. Worker serves as broker or manager
Visitation in home, foster home, or other comfortable location, unless safety prohibits	Visitation in the office
Length of visit determined by need or purpose	Short visits, usually less than an hour
Visits scheduled with flexibility for emergencies	Visits unannounced, monthly at convenience of worker
Assessment is an ongoing process with intervention being flexible	Assessment and intervention occurs once

Values & Beliefs

8. Families can work to make their emotional and physical environments safe for their children.

9. Families should only use government-sponsored financial support on a short-term temporary basis.

10. A child's well-being is everybody's responsibility.

11. We should intervene in other people's families the same way we would want government to intervene in our families.

12. Families have strengths that can be the basis of creating greater safety and decreasing future risks

13. One of the greatest services we can give to families is to tell them, and ourselves, the whole truth as we see it, about their strengths and challenges.

14. We can, when prepared, supervised, and supported, help to create safety for children and their families.

Family-Centered Values and Beliefs

1. Safety of the child is always the agency's first concern.
2. Family of origin is the best place to grow and develop because no other family shares the same ancestry, genetic endowment, or experiences of conception or birth.
3. Families have unique strengths, and are the experts in defining the needs.
4. Parents should be supported and have access to services in their efforts to care for their children.
5. Families are diverse and have the right to be respected for their special cultural, racial, ethnic, and religious traditions; children can flourish in different types of families.
6. Families are capable of and responsible or making change happen.
7. Productive partnerships empower families to take charge of their lives.
8. It is our job to instill hope in families who seem hopeless that they can grow and change.

Family-Centered Practice Principles

1. Protection and permanency for children is the case manager's primary responsibility.
2. It is important to engage, empower and collaborate with families. Families should be active participants in their case planning.
3. Case managers will balance the best interests of children with the rights of the parents.
4. It is important to support the family's self-determination by assisting with services and resources.
5. Case managers should be open and honest about the Agency's role as required by law.
6. Case managers should be open and honest about the facts of the family's situation and answer questions posed by the family.
7. Families should be kept informed about the progress in their case.
8. The Agency's response must be non-punitive, non-critical, and conducted in the least intrusive manner possible.

Benefits of a Family-Centered Approach to Practice

- The model exemplifies a belief that most families are capable and skilled enough to contribute to their own growth and to make meaningful change.

- The model asserts that most families do not want to hurt their children and, if given the opportunity to resolve problems and develop parenting ability, are capable of properly caring for their children.

- The family is on its "own turf." By becoming a partner in planning the change process, family members retain a measure of control over their own lives. The parent role is not usurped. This empowers and motivates families, and can reduce resistance.

- The caseworker, working with a family in their home, has a much better opportunity to assess the complex interaction of factors that contribute to maltreatment of the children. Close observation will also enable the caseworker to better identify the family's strengths and understand their culture. This opportunity to identify the unique qualities of the family and their environment will facilitate service planning.

- The Family-Centered Practice model makes extensive use of "naturally occurring resources," including extended family, neighbors, friends, and community support networks. This can help provide services in a manner consistent with the family's culture and values, **and** can also help encourage the maintenance of positive changes after the Agency is no longer involved.

- The caseworker's ongoing relationship with the family, and direct involvement in problem solving, helps to establish trust and reduces the negative effects of the case manager's authority.

- The presence of in-home services and supports can stabilize even very disrupted and chaotic family situations. Providing a family with temporary "respite" from crisis or chaos can help energize them to find more permanent solutions to their problems.

- Working with the family as a group can strengthen their unity and identity as a family. The family can learn better coping and problem solving skills, and practice these techniques in a supportive and safe environment.

Culture is:

Write your definition:

Guiding Principles for Social Services Case Managers

- Every person is unique and deserving of consideration and respect.
- A person or family is usually the best source of information about him/herself or itself, strengths and needs, and the solutions or resources needed.
- **Human beings need to express their feelings, but have a need for privacy and formality.**
- **People have their own needs/issues; expressing yours may make them feel they need to concentrate on yours.**
- **Human beings have a right to be accepted as they are.**
- **As a helping professional, a non- judgmental attitude is expected; your challenge is to record what you hear, not what you feel.**
- **People have a right to self-determination; the decisions they make or the way they approach their problems may be different than what you'd do. Remember, it's only different, not wrong.**
- **Information you obtain is confidential, except in life-threatening situations and/or as prescribed by law.**

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**

- **Ask friendly questions first**

- **Express interest**

- **Express cultural ignorance**

- **Ask descriptive questions**

- **Repeat questions, but ask them in a different way**

- **Restate client's answers in your questions**

  - **Summarize for clarity**

Ethnographic Interview

DESCRIPTIVE QUESTIONS

- **Describes the client's experiences, their daily activities, and objectives and people in their lives.**
  - **What is a typical day?"(Grand tour)**
  - **What is a typical mealtime?" (Mini-tour)**
- **Describes the client's perception of their cultural views.**
  - **What do they pass from generation to generation?**
  - **What are their traditions?**
- **How the client relates to the cultural views**
  - **What is their place in the culture?**
  - **What do parents value?**

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**

Ethnographic Interview Worksheet

Determine how your coworker's family defined:

- **Work**
- **Education**
- **Poverty**

Male and Female Roles

Module Five
CHILD DEVELOPMENT

PURPOSE:

Case managers will be able to identify "normative" principles of the human development process across life stages and understand the implications of developmental issues for children and parents receiving services. The case manager will be able to apply knowledge of human development to child welfare practice and regard an individual's developmental needs as significant.

LEARNING OBJECTIVES:

At the completion of this module, participants will be able to:

- Identify age appropriate behavior for children from birth through adolescence.
- Name behavioral signs of attachment and lack of attachment in children.
- Use child development knowledge to assist in the assessment of safety and risk, and decision-making.
- Recognize child development issues for children with special needs.

Four Steps of Assessment

Gathering Information

Information Analysis

Drawing Conclusions

Making Decisions

Piaget's Stages of Cognitive Development

Sensorimotor 0-2	Preoperational 2-6 or 7	Concrete or Operational 7-11	Formal 11+
• Process information through senses • Develop responses that are purposeful • Development of mental imaging of people and objects • Object permanence • Assimilation • Accommodation	• Use language and communicate through symbols • Intuitive, impulsive, irrational • Logic begins to develop • Egocentric • Object permanence	• Attains concept of conservation and transformation • Concepts, categories and principles • Logical thinking solidifies • Perform mental transformations • Visualize sequences of operations • Ability to reverse thoughts/operations	• Abstract principles • Hypothetical possibilities • Intellect improves based on accumulation of knowledge and experiences

Sensorimotor stage (0-2) – Learning to coordinate one's own movements with the information being processed through the senses.

Preoperational stage (2-6 or 7) – The ability to deal with the environment through symbols and internal representations

Concrete or operational stage (7-11) – Absorption of information related to functioning in the world.

Formal operations stage (11+) – Attainment of full intelligence potential and the integration of bodily maturation with mental/cognitive maturation.

ERIKSON'S PSYCHOSOCIAL STAGES OF DEVELOPMENT

Ages	Stages/Basic Conflict	Important Event	Summary
Birth to 12 to 18 months	Trust vs. Mistrust	Feeding	The infant must form a first loving, trusting relationship with the caregiver, or develop a sense of mistrust.
18 months to 3 years	Autonomy vs. Shame/Doubt	Toilet training	The child's energies are directed toward the development of physical skills, including walking, grasping, and rectal sphincter control. The child learns control but may develop shame and doubt if not handled well.
3 to 6 years	Initiative vs. Guilt	Independence	The child continues to become more assertive and to take more initiative, but may be too forceful, leading to guilt feelings.
6 to 12 years	Industry vs. Inferiority	School	The child must deal with demands to learn new skills or risk a sense of inferiority, failure and incompetence.
12-18 years	Identity vs. Role Confusion	Peer relationships	The teenager must achieve a sense of identity in occupation, sex roles, politics, and religion
19 to 40 years	Intimacy vs. Isolation	Love relationships	The young adult must develop intimate relationships or suffer feelings of isolation.

Freud's Psychosexual Stages of Development

Personality formation is influenced by a series of psychosexual stages in which each area serves as a source of **pleasure**, **frustration**, and **self-expression**. The Concept of Fixation may occur depending on frustrations. The child may become fixated or stuck in a particular stage.

Oral stage- 0-18 months

Infant experiences world initially through the mouth; oral "traits" created by levels of pleasure/frustration and self-expression that may become fixated.

Oral needs: Dependency on attention, approval, etc.

Anal stage- Toddler 18 months-3 years

Focused on process of control over elimination

Results in traits related to control: obstinate, stingy, orderly, controlling vs. disorderly, destructive, messy, cruel, and out of control

Phallic/Genital Stage 3-6 years

Focus is on sexual differences between males and

Understanding of one's gender

Latency stage: 6-10 years

Interruption in psychosexual development

Focused on learning process and acquisition of knowledge and not bodily sensations

Puberty Stage:

Upsurge of sexual energies and physical changes

Emotional turmoil

A report from the Carnegie Foundation revealed the following:

- Brain development before age one is *rapid* and *extensive*.
- Brain development if *vulnerable to environmental influence*, with the environment able to affect the number and pattern of connections between brain cells
- The influence of early environment on the brain is *long lasting*
- Early *child maltreatment* is being linked to a *negative impact* on brain development.

It is also known that:

1. The brain develops in a sequential fashion – from the most primitive (brain stem) to the most complex (cortex). The early, basic information provides a foundation for later, more complex functioning. Therefore, if the brainstem and mid-brain develop in a less than optimal fashion, all other brain development will be impacted.

2. Normal development of the neuronal systems and the functions they mediate requires specific patterns of activity – specific signals – at specific times during development. In a normal developmental process, specific signals (brain waves) develop at specific times, creating a neuronal system that mediates functioning.

3. There are critical periods, or windows of vulnerability during which the organizing systems are most sensitive to environmental input.

4. The brain remains sensitive (plastic) to experience throughout life – but different parts of the brain are more plastic (cortex) and others are relatively less plastic (brainstem).

Experience can change the mature brain – but experience during the critical periods of early childhood organizes brain systems!

Areas of Human Development

Physical (Motor) Development

- Changes in size, shape and physical maturity of the body
- Physical abilities
- Coordination

Intellectual (Cognitive) Development

- Learning and use of language
- Ability to reason, problem solve and organize ideas
- Related to the physical growth of the brain

Emotional/Social (Psychological) Development

- Feelings and emotional responses to events
- Changes in understanding one's own feelings
- Develop appropriate forms of expressing feelings
- Process of gaining the knowledge and skills needed to interact successfully with others

Sexual Development

- Discovery and responses to one's sexuality

Moral development.

- Understanding of right and wrong and change in behavior caused by that understanding
- Development of a conscious

Is This Normal?

Directions: Underline the correct answer to each question.

Remember that variations due to culture and context must always be considered when assessing individual children and families.

Infant and Toddler (0- 35 months)

Description of Child

1. 4-month-old shows no signs of stranger anxiety. **Yes** **No**

2. 12-month-old has vocabulary of 2 words: "ma" & "da". **Yes** **No**

3. 23-month-old can sit in a time out chair for 10 minutes without her parent having to remind her to stay still. **Yes** **No**

4. 18-month-old enjoys playing nearby a 4-year-old neighbor child, but becomes frustrated when the 4-year-old tries to play with his toys. **Yes** **No**

5. 1-year-old can distinguish bird toys from airplane toys, even though the shapes are very similar. **Yes** **No**

Preschool (3-5 yrs. old)

Description of Child

6. 4-year-old has recently begun nursery school for 6 hours a day. Child has become more clingy with parent and begun to have toileting accidents. **Yes** **No**

7. 3-year-old is unable to assemble a jigsaw puzzle consisting of 12 large pieces. **Yes** **No**

8. 5-year-old girl sits with her legs open in such a way that her crotch is exposed. **Yes** **No**

9. 4-year-old cannot describe the "plot" of his/her favorite cartoon movie even though she/he has seen it repeatedly. **Yes** **No**

10. 3-year-old boy enjoys wearing his mother's shoes and fingernail polish. **Yes** **No**

School Age (6-11 yrs. old)

Description of Child

11.	7-year-old has concrete grasp of spatiality and temporarily organizes time around events (meals, school, TV). Can accurately use spatial prepositions (over/under, in/out) except similar word pairs (beside/beneath).	**Yes**	**No**
12.	9-year-old can accurately apply the terms “I don’t know” and “I don’t remember,”	**Yes**	**No**
13.	10-year-old can demonstrate meta-cognition (i.e. thinking about “thinking”).	**Yes**	**No**
14.	11-year-old can understand metaphors (“Give yourself a pat on the back”).	**Yes**	**No**
15.	10-year-old boy uses sex words and scatological words (words referring to bodily functions - “fart”, “burp”) in conversation with other boys.	**Yes**	**No**

Early Adolescence (12-14 yrs. old)

Description of Child

16.	12-year-old group of same sex students call each other frequently and wear similar or matching clothing every day at school.	**Yes**	**No**
17.	12-year-old same gender pair engages in mutual sexual exploration and genital touching.	**Yes**	**No**
18.	13-year-old will “fight to the death” to protect a smaller peer.	**Yes**	**No**
19.	14-year-old has a variety of summer jobs and is making money for a stereo.	**Yes**	**No**
20.	13-year-old’s grades drop. He/she is experiencing sleep disruption and nausea, even though physician can find nothing wrong after physical exam.	**Yes**	**No**

Late Adolescence (15-18 yrs. old)

Description of Child

21.	15-year-old defines “self” based on group identity and role	**Yes**	**No**
22.	17-year-old “falling in love” with a 12-year-old.	**Yes**	**No**
23.	16-year-old who cannot describe both sides of an argument (e.g., pros and cons of summer employment).	**Yes**	**No**
24.	18-year-old that manipulates his/her environment and people by trying to figure out the rules of the game, and then beating others at their own game.	**Yes**	**No**
25.	17-year-old is fired from his/her job, is angry as a result, and says, “I’ll get you for this!” to his employer.	**Yes**	**No**

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.

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

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 pf 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

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*	• 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

Age Range	Cognitive (Intellectual)	Emotional/ Social	Sexual	Moral	Physical
	as adults • *Names common pictures and things*				
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,	• 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,	• 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

	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	with attention paid to detail, time, and space • Plays dress-up			• Spreads soft butter with knife • Buttons and unbuttons large buttons • Washes hands independently • Blows nose when reminded • Uses toilet independently
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	• 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	• 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

	opposites like "big/little' • Asks questions for information ▪ *Distinguishes left from right*	• Engages in cooperative play with other children involving group decisions, role assignments, fair play			
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

CASA-GAL Volunteer Manual Chapter 6

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.

Consequences of Abuse and Neglect

Infants and Toddlers

Physical

- Chronic malnutrition of infants and toddlers results in growth retardation, brain damage, and potentially, mental retardation (Failure to thrive).
- Head injury can result in severe brain damage, including brain stem compression and herniation, blindness, deafness, mental retardation, epilepsy, cerebral palsy, skull fracture, paralysis, and coma or death.
- 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. 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, and spinal cord injuries with subsequent paralysis.
- Internal injuries can lead to permanent physical disability or death.
- 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.
- Neglected infants and toddlers have poor muscle tone, poor motor control, exhibit delays in gross and fine motor development and coordination, fail to develop and perfect basic motor skills.
- Absence of stimulation interferes with the growth and development of the brain. Generalized cognitive delay or mental retardation can result.

Cognitive

- 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, which 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.

Social/Emotional

- 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. A 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.
- 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.
- Abused and neglected infants often fail to develop basic trust, which can 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.
- Abused toddlers may feel that they are "bad children." This has a pervasive effect on the development of self-esteem.
- Punishment (abuse) in response to normal exploratory or autonomous behavior can interfere with the development of a 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.

Moral

- Due to the lack of attachment, maltreated Infants may not respond to parent’s response of “No.”
- *Abused toddlers may fail to understand the difference between right and wrong, making discipline difficult.*
- Abused and neglected toddlers may not respond to rewards

Preschool Children

Physical

- They may be small in stature, and show delayed physical growth.
- They may be sickly, and susceptible to frequent illness -- particularly upper respiratory illness (i.e., colds, flu) and digestive upset.
- They may have poor muscle tone, poor motor coordination, gross and fine motor clumsiness, awkward gait, and lack of muscle strength.
- Their gross motor 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, or incorrect use of words.
- Cognitive skills may be at the 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/Emotional

- The child may demonstrate insecure or absent attachment; attachments may be indiscriminate, superficial, or clingy. 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 overly aggressive, bossy, and competitive with peers.
- The child may prefer solitary or 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.
- 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 often must be drawn into activities; may emotionally withdraw 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 thumb sucking.

Moral

- The child may show signs of not being able to follow simple rules.
- Child may not be consistent in knowing right from wrong and therefore not be able to make consistent choices.
- Child may exhibit negative reactions in relation to what belongs to him/her.

School-Age 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.

Adolescents

Physical

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

Cognitive

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

Social/Emotional

- The youth 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.
- The youth is 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.

- Youth may display limited concern for other people, may not conform to socially acceptable norms, and may otherwise demonstrate delayed moral development.
- Maltreated youth may not be able to engage in appropriate social or vocational roles. They may have difficulty conforming to social rules.
- Maltreated youth may display a variety of emotional and behavioral problems, including anxiety, depression, withdrawal, aggression, impulsive behavior, antisocial behavior, and conduct disorders.
- Maltreated adolescents may lack the internal coping abilities to deal with intense emotions, and may be excessively labile, with frequent and sometimes volatile mood swings.
- Abused and neglected youth 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.
- The youth 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

- Abused and neglected youth 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.
- The youth may believe that he is different from others in a negative sense, and is isolated and alone.
- Maltreated youths 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.
- Abused and neglected youth 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.

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
    - poor social relationships
    - difficulty in learning
    - withdrawal
    - poor impulse control
    - 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

Bonding

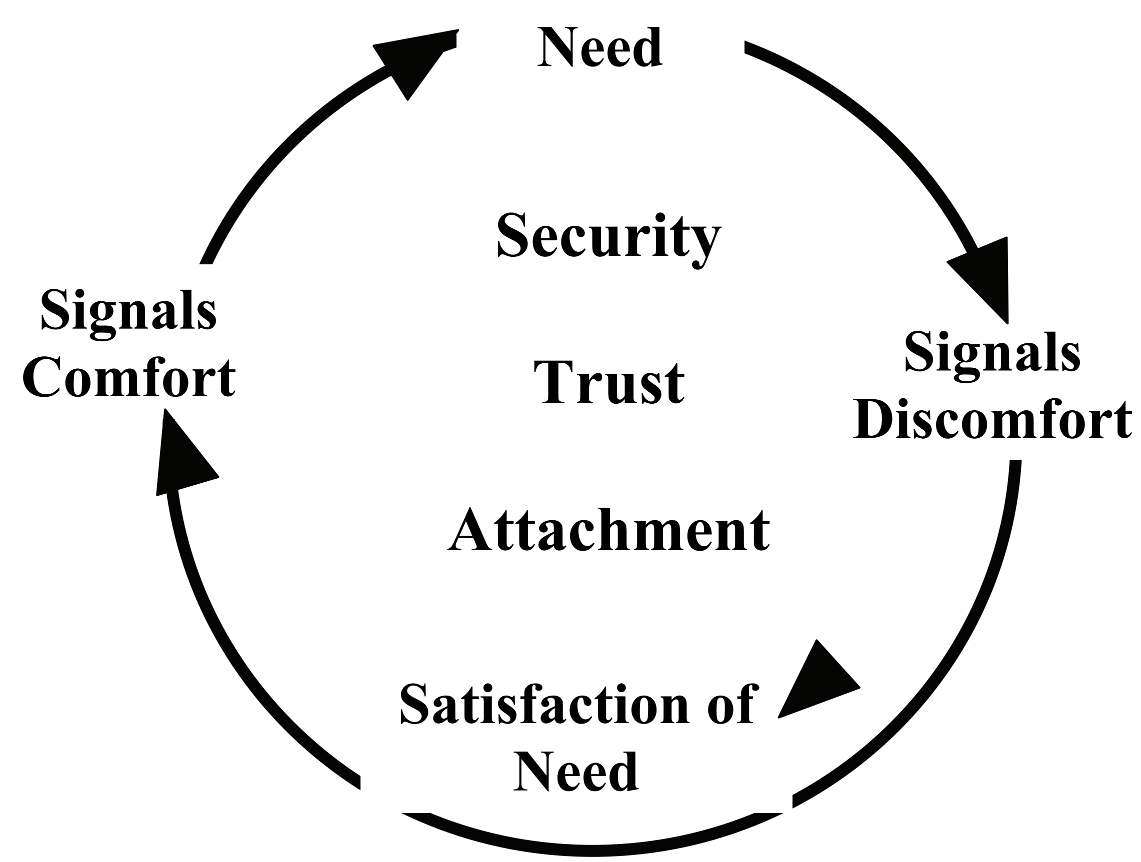
The formation of mutual emotional and psychological closeness between parents (or primary caregiver) and their newborn child. Babies usually bond with their parents in minutes, hours, or days following birth.

Attachment

Refers to a relationship that emerges over time from a history of caregiver-infant interactions. Attachment is generally formed within the context of a family, providing the child with the necessary feelings of safety and nurturing at a time when the infant is growing and developing. This relationship between the infant and the caregiver serves as a model for all future relationships.

Encyclopedia of Children's Health: www.healthofchildren.com

The
of Attachment


Need
Security
Signals
Comfort
Trust
Signals
Discomfort
Attachment
Satisfaction of
Need

Areas of a Child's Development Influenced and Enhanced by Healthy Attachment

Language

Trust and a positive "World View"

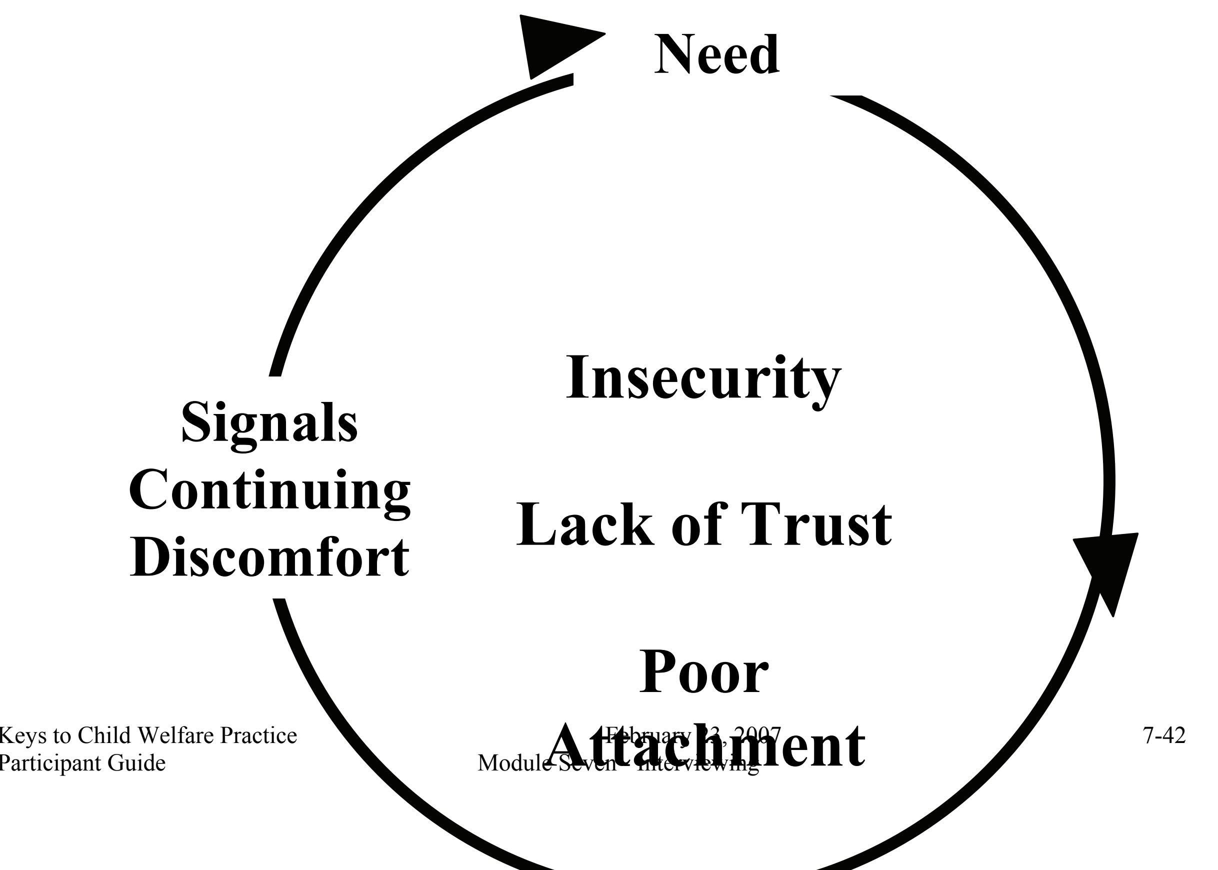
Self-esteem

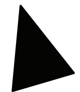
Anxiety Reduction and a Sense of Security

Learning through Social Interactions

Self-reliance

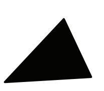
Inadequate Completion of





Signals Discomfort

Little or No Satisfaction of Need



ATTACHMENT OBSERVATION CHECKLIST	
BIRTH TO ONE YEAR	
Does the child...	***Does the parent...***

ATTACHMENT OBSERVATION CHECKLIST	
appear alert? respond to people? show interest in the human face? track with his/her eyes? vocalize frequently? exhibit expected motor development? enjoy close physical contact? signal discomfort? appear to be easily comforted? exhibit normal or excessive fussiness? appear outgoing or is he/she passive and withdrawn? have good muscle tone?	**respond to the infant's vocalizations?** change voice tone when talking to or about the baby? engage in face-to-face contact with the infant? exhibit interest in and encourage age-appropriate development? respond to the child's cues? demonstrate the ability to comfort the infant? enjoy close physical contact with the baby? initiate positive interactions with the infant? identify positive qualities in the child?

ATTACHMENT OBSERVATION CHECKLIST	
Toddlers	
Does the child...	***Does the parent...***
explore his/her surroundings?	use disciplinary measures appropriate for the child's age?

respond positively to parents?	
keep him/herself occupied?	respond to the child's overtures?
show signs of reciprocity?	initiate affection?
seem relaxed and happy?	provide effective comforting?
look at people when communicating?	initiate positive interactions with the child?
show emotions in a recognizable manner?	accept expressions of autonomy?
react to pain and pleasure?	see the child as positively "taking after" a family member?
engage in age appropriate activities?	seem aware of child's cues?
use speech appropriately?	enjoy reciprocal interactions with the child?
respond to parental limit setting?	respond to child's affection?
demonstrate normal fears?	set age appropriate limits?
react positively to physical closeness?	respond supportively when the child shows fear?
show a response to separation?	
note the parent's return?	exhibit signs of pride and joy? empathy? shame,?

ATTACHMENT OBSERVATION CHECKLIST

School Age

Does the child…	***Does the child…***

behave as though he/she likes him/herself? show pride in accomplishments? share with others? accept adult imposed limits? verbalize likes and dislikes? try new tasks? acknowledge his/her mistakes? express a wide range of emotions? establish eye contact? exhibit confidence in his/her own abilities? appear to be developing a conscience? move in a relaxed way/manner? smile easily? look comfortable when speaking with adults? react positively to parent being physically close? have positive interactions with siblings and/or peers?	show interest in child's school performance? accept expression of negative feelings? respond to child's overtures? provide opportunities for child to be with peers? handle problems between siblings with fairness? initiate affectionate overtures? use disciplinary measures appropriate for child's age? assign the child age appropriate responsibilities? seem to enjoy this child? know the child's likes and dislikes? give clear messages about behaviors that are approved or disapproved of? comment on positive behaviors as well as negative?

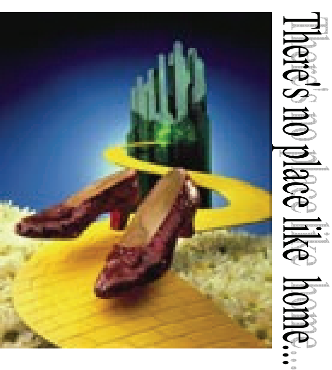
ATTACHMENT OBSERVATION CHECKLIST

Adolescents

Is the adolescent...	*Does the parent...*
aware of personal strengths?	set appropriate limits?
aware of personal weaknesses?	encourage self-control?
comfortable with his/her sexuality?	trust the adolescent?
engaging in positive peer interactions?	show interest in and acceptance of adolescent's friends?
performing satisfactorily in school?	display an interest in the teen's school performance
exhibiting signs of conscience development?	exhibit interest in teen's activities?
free from severe problems with the law?	have reasonable expectations regarding chores and household responsibilities?
aware of his/her parents' values?	stand by the adolescent if he/she gets in trouble?
keeping him/herself occupied in appropriate ways?	show affection?
accepting of adult imposed limits?	think this child will "turn out" okay?
involved in interests outside the home?	
developing goals for the future?	
emotionally close to parents?	

Adapted from Fahlberg, Vera. *A Child's Journey Through Placement*, 1991, Perspectives Press, Indianapolis, IN.

Ruby Red Shoes



There's no place like home...

Who Is Involved:

Lisa Davis, child 33 months

Ashley Davis, child 18 months

Kyla Davis, mother 24 years old

Wayne Davis, father 25 years old

Sally Todd, foster mother

Background Information:

Lisa and Ashley Davis have been in foster care for two weeks for neglect. Both girls are thin and underweight. Lisa needed to be hospitalized for pneumonia when first brought into care. She spent three days in the hospital, and is still on antibiotics. Both girls were anemic. The following is a description of an office visit. Mr. and Mrs. Davis are visiting with their children and foster mother, Mrs. Todd.

Office Visit With Children:

Mrs. Todd brought the girls to the office for their visit. They were scheduled for one-hour weekly visits with their parents. The parents arrived 20 minutes late without explanation.

When Mr. and Mrs. Davis came in, Lisa was playing with a dollhouse and Ashley was sitting in Mrs. Todd's lap. Neither child made an attempt to go to their parents.

Mr. Davis sat on the floor and began to play dolls with Lisa. Mrs. Davis took a chair near the foster mother. Mrs. Todd and Mrs. Davis began to talk about the weather, and Mrs. Davis began to tell Mrs. Todd about her week of looking for a job as a waitress.

Mrs. Todd asked Mrs. Davis if she would like to hold Ashley. She said she was tired and would hold her later.

The parents brought donuts, and asked the girls if they would like one. Mrs. Davis asked Mrs. Todd how Lisa was doing, and what the doctor said about her pneumonia. Mrs. Todd spent a few minutes telling the parents about Lisa's improvement. Both listened, but did not question or comment.

Lisa asked her mother to take her to the bathroom, and she did. At the same time, Ashley got out of Mrs. Todd's lap and went over to see her father. He picked her up and kissed her. Mrs. Todd again asked Mrs. Davis if she would like to hold Ashley and she said "No."

Mrs. Davis then got up and went over to the dollhouse to see Lisa. Lisa handed her mother a doll and said, "You be the baby." The mother seemed uncertain how to play dolls with Lisa, and soon got up and went back to her seat.

Mrs. Todd checked Ashley's diaper and determined it needed changing. She waited for either parent to offer, but neither did. Finally, she announced someone needed to change Ashley. Mrs. Davis said, "Oh well, I guess I get to do it like always." She then proceeded to change the diaper, but did not talk to Ashley nor look in her face.

Ashley went over to the doll house and Lisa said, "Go away, Assie, it's mine!" She then pushed her sister and Ashley began to cry. Mr. Davis became furious and yelled at Lisa, "Don't you dare talk to your sister like that or hit her. You want a good spanking?"

Lisa ran to her mother to be comforted, but her mother did not attempt to hold her or comfort her in any way. Ashley ran to her foster mother and climbed in her lap.

Mrs. Davis said, "They are both such brats. I can hardly stand it sometimes."

When it was time to leave, Mr. Davis picked up both children and gave them hugs. He handed each to his wife who patted both girls, but did not hug or kiss them. She quickly put them down. The girls waved good-bye without tears and left with their foster mother.

RUBY RED SHOES ATTACHMENT WORKSHEET

What behaviors indicate attachment to:

Lisa?

Ashley?

Parents?

Foster Parents?

RUBY RED SHOES LACK OF ATTACHMENT WORKSHEET

What behaviors indicate a lack of attachment or weak/insecure attachment to:

Lisa?

Ashley?

Parents?

Foster Parents

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.

Separation and Attachment Issues

- Separation may cause numerous long-term negative effects on a child's development. The more traumatic the separation, the more likely there will be significant negative developmental consequences.

- Children who have suffered traumatic separations from their parents may also display low self-esteem, a general distrust of others, mood disorders, inadequate social skills, and cognitive and language delays

- Separations interfere with the development of healthy attachments, and the child's ability and willingness to enter into intimate relationships in the future.

- When children are removed from their families, the normal attachment to their parents is disrupted; therefore, it is important that children be maintained in their homes as long as their safety is not compromised.

- When children must be removed from their families, their relationship with their parents should be maintained until they can be safely returned home. If reunification is not possible, children should be placed in a stable, permanent home as soon as possible to enable the formation and maintenance of healthy attachments with other caregiving adults.

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

Stages of Grief

Kubler-Ross

DENIAL

ANGER

BARGAINING

DEPRESSION/SADNESS

ACCEPTANCE/ADJUSTMENT

PARENTAL GRIEF AND LOSS

Parents of abused and neglected children are often vulnerable to crisis. They may have chronic stress in their daily lives. They may have few supports or resources, and may not have developed very healthy coping skills. Negative life experiences may also contribute to their general perception of hopelessness when their children are removed.

In addition to the loss of their child, parents may also experience additional losses, which include:

- **Control/privacy**-Case managers and other professionals become involved in the family's private affairs.

- **Employment**-Their employment may be jeopardized due to time missed at work because of court or Agency requirements.

- **Family's financial security and/or housing**-For families whose primary source of income is some type of assistance (e.g., TANF, SSI, child support), or whose home is tied to household eligibility requirements (e.g., public or subsidized housing), the removal of the children may result in the loss of income or housing eligibility.

- **Self-esteem**-Parents' sense of adequacy and identity as parents may be threatened by the removal of their child.

- **Pride-**Parents may experience embarrassment or shame from their community, extended family, or friends knowing that their children have been removed from their home.

- **Role as a parent-**Parents may have a sense of loss about their role as a parent. The children's separation from the family may affect the family's sense of identify

- **Support systems**-Parents may lose established support systems, either positive or negative (e.g., family members, friends, "drug buddies".

Often, parents' reactions to separation and loss are very similar to what children experience, and can also be assessed using the expressions of grief as a framework.

STAGE 1: Denial

When the loss of my child hit me, I went into shock. I cried, felt shaky, and it was hard to hear what people were saying to me. I couldn't think of anything except my child that had been put into someone else's home. I went to work like a sleepwalker, without really knowing what I was doing. I wondered what my child was doing in his new house. I would drive by the foster home, just to make sure that the home was really there. I wondered if the foster parents were taking good care of my child and doing everything the way he was used to. I would walk by his room and could hear him, and sometimes even thought that I saw him. I remembered all the good times, even if there weren't very many. I tried to keep busy and not think at all, but I kept thinking about the last glimpse of my child. I was in this shock for about 2 weeks. Other people were trying to comfort me, but I felt distant to and "outside" the rest of the world.

STAGE 2: Anger

As I came out of the numbness of shock, I experienced sadness, anger, and felt sick. Sometimes, I couldn't eat and other times, I found myself eating constantly. I had trouble falling asleep. I started using sleeping pills, and having a few more drinks each night. I started smoking more, too. I found myself becoming tearful "over nothing." I was really concerned about what others thought of me. I was angry with perfect strangers on the street because I was going through this and not them. I was very angry with God. I didn't want my child put in foster care. I was furious with DFCS, the court, and everybody who took my child away. I became really mad at myself, and went over and over and over in my mind about what happened and what I could have done to make it different. I wasn't able to come up with anything, but I also couldn't stop thinking about it either.

Since, I couldn't figure out anything that I did wrong, I got really angry at my child and felt that he was difficult on purpose. I told myself that I was glad my child was gone and never wanted him back. I thought about how nice it was around the house without him. Above all, I resented my child for making me go through all this pain.

I got scared at how angry I was. I felt guilty about the anger and started avoiding my child and work. Everybody told me that it was normal to feel angry when things don't go the way you want. The anger sometimes helped me act to change things. Finally, when the anger didn't help, I gave up being angry and tried something else to get what I wanted.

STAGE 3: Bargaining

I went to the case manager and promised her that I would never let what I did happen again. I promised her that I would do what ever she wanted me to do. At this point I would have made any deal with the case manager. I felt that if she believed what I was saying, she would let me have my child back.

STAGE 4: Depression/Sadness

When the anger wore off and the bargaining didn't work, I went into the blues. I didn't care about anybody or anything. It wasn't worth getting up each day and nothing interested me. I felt worthless and no good. There were times when I even thought about suicide. I made myself sick with worry. I felt desperately lonely. I wasn't sure who I was without my child to care for. I didn't know what to do with no one in the house with me. The world seemed cold and silent and I felt empty and hollow. Sometimes, I would feel guilty because there was less stress with my child out of the home. I felt that I might be able to survive without my child, but I felt really bad because I had these thoughts.

STAGE 5: Acceptance/Adjustment

One day, things just seemed to be better. I began eating and sleeping well again. I missed my child, but was more realistic about his being in foster care. I started paying attention to the house and work. I started going out with friends more. I started getting interested in keeping my agreements about visiting my child and making my appointments with the case manager. I began to realize I actually had more time with my child now and felt better when I was with him than I did before he was placed in foster care. I realized that I was trying to handle too much on my own. I began to see that both my child and I needed relationships with others to deal with the loneliness and now I have some energy for that.

Expressions of Grief in the Biological Parent

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

Denial/Shock

Behavioral Expressions in Parents

Parents may:

- Deny the abuse/neglect allegations or deny that the Agency can take the children
- Appear stunned or robot-like
- Avoid contact with the case manager
- Initially comply, but with little expressed emotion

Interventions Case Managers Can Use with Parents

- Gently present the facts of the situation (refer to reports or court testimony, for example)
- Acknowledge the denial with, "I can understand why it would be difficult to believe."

Anger

Behavioral Expressions in Parents

Parents may:

- Threaten legal action
- Be uncooperative/hostile (e.g., may refuse to participate in the development of case plan or may refuse to allow case manager to visit the home)
- Be demanding; sometimes making irrational demands on the case manager or Agency

- Blame the agency, case manager, court, system, or others for the problem
- Physically or verbally threaten the case manager

Interventions Case Managers Can Use with Parents

- Acknowledge and validate feelings
- Allow time for venting, but with limits
- Attempt to problem-solve with parent

Bargaining

Behavioral Expressions in Parents

Parents may:

- Become semi-responsive to and/or more compliant to the caseworker
- Make broad promises (e.g. “It will never happen again,” “I’ll ask my boyfriend to leave,” If I go to all my parenting classes, will I get my children back?”)
- Attempt to make a deal with the case manager

Interventions Case Managers Can Use with Parents

- Parent may be trying to use bargaining in an effort to regain control over the loss (remember they often feel powerless and helpless). Point out and clarify areas in which they have some control.
- Help the parent maintain a focus on the case plan
- Negotiate, when appropriate.

Sadness/Depression

Behavioral Expressions in Parents

Parents may:

- “Forget” or miss appointments or scheduled visits

- Exhibit little follow-through/initiative in case plan activities
- Display futility and loss of hope
- Resort to old ways of coping/problem solving (e.g., relapsing on drugs or alcohol after a period of sobriety)

Interventions Case Managers Can Use with Parents

- Point out successes and progress the parent has made
- Gently insist that the parent make small efforts/ steps (i.e., take one step or action in the case plan at a time)
- Identify and help parent build support systems
- Provide support and assistance to the parent. *Example of an empathic statement: "It must be hard, but I need you to make the phone call while I'm here."*
- Be mindful of the parent's emotional state. Make referral to mental health assessments and counseling, when indicated.

Acceptance/Adjustment

Behavioral Expressions in Parents

Parents may:

- Accept responsibility for the situation
- See gains that have resulted from the Department's intervention

Interventions Case Managers Can Use with Parents

- Celebrate/acknowledge successes
- Give encouragement and support

- Strive to increase parent's involvement in making decisions about child and providing some caretaking responsibilities (e.g., during visits styling child's hair, checking child's homework, sharing information with foster parents)

What Case Managers Need to Understand About Separation, Loss, and the Grief Process in Children

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/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.

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.

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.
  ⇒ 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.

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.

Questions

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. How would you help Ben, if he were on your case load?

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.

Questions

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. How would you help Mary if she were on your case load?

Learning Disabilities

Inability to acquire, retain, or broadly use specific skills or information, resulting from deficiencies in attention, memory, or reasoning, and affecting academic performance.

Below, you will find a list of possible indicators of specific learning disabilities. Children with learning disabilities are typically of average to above-average intelligence; they simply process information differently. Keep in mind that the earlier a child is diagnosed, the better his/her chances are to enjoy and succeed in school and life!

EARLY WARNING SIGNS	
Pre-School	**Grades K–4**
✓ Late talking ✓ Slow vocabulary growth ✓ Inability to find the right word ✓ Trouble learning numbers, alphabet, days of the week ✓ Extremely restless ✓ Poor ability to follow directions ✓ Trouble interacting with peers	✓ Slow to learn connections between letters and sounds ✓ Confuses basic words (run, eat, want) ✓ Makes consistent reading and spelling errors, including letter reversal (b/d) ✓ Transposes number sequences and confuses arithmetic signs ✓ Slow recall of facts ✓ Slow to learn new skills, relies heavily on memorization ✓ Impulsiveness, lack of planning ✓ Unstable pencil grip ✓ Trouble learning about time

What Causes Learning Disabilities (LD)?

Many types of learning disabilities exist, and no single cause accounts for them. However, the basis of all learning disabilities is believed to be abnormal brain function. An estimated three to fifteen percent of school children in the United States may need special educational services to compensate for learning disabilities. Boys with learning disabilities outnumber girls five to one.

What Are the Symptoms of Learning Disabilities?

A child suffering from a learning disability may:

- ✓ Have problems coordinating vision with movement;
- ✓ Be clumsy at physical tasks (cutting, coloring, buttoning, tying shoes, running);
- ✓ Have problems with visual perception;
- ✓ Have problems with phonologic processing (recognizing sequences or patterns and distinguishing among sounds);
- ✓ Have problems with memory, speech, reasoning, and listening;
- ✓ Have problems with reading, arithmetic, or writing (most learning disabilities are complex, with deficiencies in more than one area);
- ✓ Be slow to learn the names of colors or letters, assign words to familiar objects, count, and progress in other early learning skills;
- ✓ Exhibit delayed learning to read and write;
- ✓ Have a short attention and memory spans;
- ✓ Have difficulty with printing and copying (activities that require fine motor coordination);
- ✓ Have difficulty communicating and controlling impulses;
- ✓ Have discipline problems; and/or
- ✓ Be easily distracted, hyperactive, withdrawn, shy, or aggressive.

How Is a Learning Disability Diagnosed & Treated?

A doctor examines the child for any physical disorders. The child then takes a series of intelligence tests, both verbal and nonverbal, including testing for reading, writing, and arithmetic skills. Psychological testing is the final step of evaluation. No drug treatment has much effect on academic achievement, intelligence, and general learning ability. However, certain drugs, such as methylphenidate, may improve attention and concentration. The most useful treatment for a learning disability is an education that is carefully tailored to the individual child.

Attention-Deficit/Hyperactivity Disorder

> *Excessive, long-term, and pervasive behaviors, including*
> *distractibility (poor sustained attention to tasks),*
> *impulsivity (impaired impulse control and delay of gratification),*
> *or hyperactivity (excessive activity and physical restlessness).*

Many children have specific learning disabilities/challenges, as described in the previous section. For some children these may be paired with other disorders such as attention-deficit/hyperactivity disorder (AD/HD)—previously called attention-deficit disorder (ADD) and attention-deficit hyperactivity disorder (ADHD). This disorder may also be present in children without learning disabilities. The main characteristics of children with AD/HD include hyperactivity, a short attention span, distractibility, an impulsive nature, and constant motion. This disorder is more common in boys than girls, and the symptoms are typically present before the age of seven. Several diagnostic criteria must be met before a child can be diagnosed with AD/HD, including that the behaviors must occur in more than one setting and over a period of time.

The best news about AD/HD is that it is a treatable disorder. Through the use of medication, special education programs, counseling, and parent training, children's behavior can be greatly improved, and they can become better able to concentrate. This results in better relationships with peers, teachers, and family members.

What Causes Attention-Deficit/Hyperactivity Disorder (AD/HD)?

AD/HD is not caused by poor parenting, family problems, poor teachers or schools, too much TV, food allergies, or excess sugar. AD/HD is very likely caused by biological factors that influence neurotransmitter activity in certain parts of the brain and have a strong genetic basis. Approximately four to six percent of the U.S. population has AD/HD; however, if one person in a family is diagnosed with AD/HD, there is a twenty-five to thirty-five percent probability that another family member also has AD/HD.

What Are the Signs of AD/HD?

The American Psychiatric Association's *Diagnostic and Statistical Manual* recently renamed the disorders formerly known as ADD and ADHD to be AD/HD.

AD/HD includes three subtypes:

1. A predominantly inattentive subtype (formerly ADD). Signs include:
   - Easily distracted by irrelevant sights and sounds;
   - Failing to pay attention to details and making careless mistakes;
   - Rarely following instructions carefully and completely; and
   - Losing or forgetting things like toys, pencils, books, and tools needed for a task.

2. A predominantly hyperactive-impulsive subtype (formerly ADHD). Signs include:
   - Feeling restless;
   - Fidgeting and squirming;
   - Running, climbing, leaving a seat in situations where sitting or quiet behavior is expected;
   - Blurting out answers before hearing the entire question; and
   - Having difficulty waiting in line or for a turn.
3. A combined subtype, which is the most common of the three.

AD/HD refers to all types of attention-deficit disorders, both with and without hyperactivity. To be considered for a diagnosis of AD/HD, these behaviors must appear before age seven and last for at least six months. The level of disturbance must occur more frequently, and in a more severely pronounced manner, than among other children in the same age group. And, above all, these behaviors must create a real handicap in at least two areas of a child's life, such as school, home, or a social setting.

What Treatments Are Available?

Clinical experience has shown that the most effective treatment for AD/HD is a combination of medication and therapy or counseling to learn coping skills and adaptive behaviors. The most well known treatments of AD/HD are psycho-stimulants, such as Ritalin and Dexedrine, and some antidepressants that affect the levels of dopamine, noradrenaline, and serotonin in the central nervous system. Taken in normal doses, stimulants can result in decreased appetite, stomach aches, agitation, irritability, and insomnia for some children. The long-term effects of taking these drugs are not yet known.

Medications can result in an improvement in core symptoms, such as impulsive behavior and inattention, as well as improved school and social performances. For that reason, treatment for AD/HD is more effective when regular use of drugs is combined with behavior treatment. Reward systems for appropriate behavior or performance, teaching parents child-management skills, and therapy that instructs parents and teachers in improved contingency management skills can help most children. Children who regularly take their medication and practice behavior techniques routinely do better than those who rely on stimulants alone.

When Should a Person Seek Help?

Since many children exhibit occasional inappropriate or hyperactive behaviors, widespread confusion has arisen about the diagnosis and treatment of AD/HD. Due to those uncertainties, parents and guardians should not attempt to diagnose their children. Children who are responding to stressful family situations, are bored in the classroom, or are passing through certain stages of development may appear inattentive, hyperactive, or impulsive—yet they do not have AD/HD.

To determine whether a child needs to be examined by a physician, psychologist, or other medical specialist, you should consider several critical questions:

- ✓ Are the child's troublesome behaviors excessive, long-term, and pervasive?
- ✓ Do they occur more often than in his/her peers?
- ✓ Are his/her behaviors a continuous problem, and not just a response to a temporary situation?
- ✓ Do his/her behaviors occur in several settings, or only in one specific place, such as the playground or school?

You should talk to the child's teacher to get a clearer reading on the child's daily behaviors. You should also seek a consultation with a health professional to rule out other possible psychological problems, such as depression or a learning disorder.

Special Education of Children

After a child is diagnosed with special learning needs, you may hear the term "Individualized Education Program (IEP)." The IEP is a written document that guides both teachers and parents in the appropriate education of the child for a period of one year. There is a required meeting, at least once each year, for review of this document. Teachers, case managers, parents, foster parents, CASA/GAL volunteers, and other people who interact with the child should be invited to this meeting, where they discuss what type of services the child needs and the frequency with which the child should receive these services.

The Individuals with Disabilities Education Act:

What Is the Individuals with Disabilities Education Act (IDEA)?

The **Individuals with Disabilities Education Act** (IDEA), a federal law originally passed in 1975 as PL 94-142 and amended in 1984, 1990, and 1997, mandates that all eligible children receive a free, appropriate public education, regardless of the level or severity of their disability. It provides funds to assist states in the education of students with disabilities, and requires that states make sure that these students receive an individualized education program, based on their unique needs, and in the least restrictive environment appropriate. IDEA also provides guidelines for determining what related services are necessary, and outlines a "due process" procedure to make sure needed services are provided.

Who Is Eligible for Services Under IDEA?

Children, ages three through twenty-one, who need special education and related services because of a disabling condition are eligible. Eligibility for services is determined through "nondiscriminatory evaluation." This requires that school districts use testing materials free from racial or cultural discrimination, and presented in the child's native language or means of communicating. Tests must be chosen that assess the child's actual abilities, if sensory, motor, or language impairments are present. Evaluations cannot be based solely on one general test, such as an intelligence test, and the child is to be assessed across all areas related to the disability by a "multidisciplinary team."

An appropriate education may include an out-of-district or private school placement, if the school district cannot provide appropriate services in the district. The courts have also ruled, however, that an "appropriate" education is not always the same as the "best" education, as long as the education services adequately meet the child's needs.

What Is an IEP?

An IEP refers to the Individualized Education Program. This is a written, legal document that describes the specialized educational plan and related services to be provided to the student. It is developed in a team meeting, in which all members of the IEP team decide what constitutes an appropriate education for the child who needs services. The main goal of the IEP meeting is to discuss the educational needs of the student, and write a program that identifies goals and objectives and related services needed for the year.

What Is the School's Responsibility in Developing an IEP?

The local education agency is responsible for:

- ✓ Contacting parents about the need for an IEP;
- ✓ Setting a date, time, and location to meet, that is convenient for everyone on the team, including the parent(s) or family member(s);
- ✓ Designating an official from the school district to be involved in and to conduct the meeting, and ensure the team decisions are implemented;
- ✓ Inviting all members of the IEP team;
- ✓ Ensuring that the meeting is held, the IEP written, and placement decisions made;
- ✓ Making sure that the IEP is reviewed at least annually, and revised if necessary.

What Is the Parent's Role in Developing the IEP?

In IDEA, the term "parent" refers to the child's biological parent, a guardian, a person acting as the parent of a child (such as the grandparents), or a surrogate parent appointed, if the child is a ward of the state or the parent is unavailable.

IDEA ensures that parents are equal partners in the IEP process. School personnel and parents must work toward the common goal of developing an effective education program for the child.

Parents should prepare for the meeting by reviewing their child's past education records. IDEA ensures that parents are permitted to inspect and review records in a timely manner. Parents should also have in mind goals or objectives based on what they see as needed, and they may want to talk with their child's teacher before the meeting. The IEP should describe the student's educational goals and objectives, related services needed, and the school placement decision. If parents are dissatisfied with any aspect of the IEP, and are unable to resolve the problem, they may request mediation and, if necessary, pursue due process hearing options guaranteed by the law. Parents may obtain assistance in preparing for and/or attending IEP meetings from the local organizations, such as PEPAC (Parents Educating Parents and Children), for parents of children who have a disability. Many communities also have advocacy organizations specifically serving the disabled. Every state also has a protection and advocacy (P and A) agency.

Who Should Be Involved in IEP Meetings?

IDEA requires that every IEP meeting, whether it is the initial meeting or a review, include:

- ✓ A person from the school district, other than the student's teacher, who is qualified in special education or special education supervision;
- ✓ The student's teacher;
- ✓ One or both of the student's parents, family members, or guardians;
- ✓ The student, when appropriate;
- ✓ Someone qualified to interpret the instructional implications of evaluation (this may be one of the school personnel above);
- ✓ Other people who are involved in the education of the student as identified by the school or the parent.

A meeting may be held without a parent attending, if the parent is unable or unwilling to do so. The district must, however, invite the parents and document attempts to set a time and place where all persons can attend. Parental absence from the meeting is not necessarily construed as reflecting dissatisfaction or disagreement, and IEP decisions, including school placement, will be made by the school in their absence.

What Is Included in an IEP?

IDEA requires that the following items be included in the IEP:

- ✓ A statement of the student's present levels of educational performance;
- ✓ A statement of the yearly goals, and the instructional objectives that need to be met to achieve these goals;
- ✓ A statement of the special education and related services that will be provided to the student, as well as how much the student will participate in regular educational programs;
- ✓ The dates these services will begin and how long they will last;
- ✓ For each student, age sixteen and over, transition services that will be provided;
- ✓ What the school must do to enable the student to meet the objectives, how this is to be measured, and, annually, whether the objectives from the previous year's IEP have been met.

When Is It Appropriate for the Student to Participate?

Students need to participate in the IEP process as much as they can (some older children with mental handicaps may not have the intellectual ability to understand this process). Their opinions, preferences, and choices need to be part of the decision-making process. The chance to choose areas of instruction, based on their preferences, will help them develop skills that lead to independence and self-determination. Of course, there are several factors that limit how much students participate, including their age and their ability to make adequate decisions. However, almost all students can participate, in some way, in their IEP process.

What Is to Be Reviewed at IEP Meetings?

Each student's progress related to his/her Individualized Education Program must be reviewed yearly to determine current progress and future needs. The review needs to consider the general progress of the student, staff and parental concerns about the student's progress, whether objectives are reached according to the measures described in the IEP, and what changes need to be made to meet the student's needs.

Any significant changes in the student's program, after the initial or annual IEP meeting necessitates, another IEP meeting. IDEA requires that parents receive written notice whenever the district proposes a change, or refuses to initiate anything related to the child's identification, evaluation, program, or placement.
Additionally, parents and educators should ensure that goals are functional and chronologically age appropriate, and that they prepare students for adulthood.

What Is Meant by Placement in the Least Restrictive Educational Environment?

The decision to place a student with a disability in a particular education program must be based on the factors specified during the IEP process. This decision must be reviewed at least annually, and placement may change if the child's education program or needs change.

IDEA requires that students with disabilities be educated with students who do not have disabilities, to the greatest extent appropriate. The law states that, "unless a child's individualized education program requires some other arrangement, the child is (to be) educated in the school which he/she would attend if not disabled" [Section 121a.522(c)]. It requires that removal of the child from the regular classroom occur only when education in regular classes "with the use of supplementary aids and services cannot be achieved satisfactorily" [Section 121a.550(2)].

Organizations interpret "least restrictive" as representing instruction in the regular classroom, to the greatest extent possible or appropriate. Families need, through the IEP process, to ensure that adequate accommodation and support are provided before alternative placement is considered, and that time spent outside of the regular classroom is based upon functional considerations, such as community integration and instruction. Many organizations are opposed to student placement in segregated facilities, as they do not provide opportunities for learning from non-disabled role models, although the law and many other parents and professional organizations support a full continuum of placements being available.

Adapted from materials created by the Exceptional Children's Assistance Center, 1998-99.

Other Issues That Affect Children

The children with whom you will be working may exhibit symptoms or behaviors that require professional assessment. A specific behavior may be a warning sign of a particular problem, but may also be attributable to a variety of other causes. ***It is critical that the case manager not try to diagnose.*** A referral to a competent mental health professional is the best course of action, if you learn about or observe red flags as you complete your initial investigation and as you continue to monitor the child's situation.

Below are some of the possible diagnoses that may apply to the children with whom you work.

Grief & Depression

Many of the children in care experience a tremendous amount of sadness after being removed from their homes. Despite their strong emotions, often children, cannot verbally express their persistent feelings of sadness and emptiness. At earlier developmental stages, abstract thinking and vocabulary do not exist. Children may not know why they feel sad; they simply do. Some key behaviors to look for are loss of appetite and change in sleeping patterns. Listed below, you will find several characteristics of grief and depression:

- Sudden drop in school performance;
- Loss of appetite;
- Suicidal thoughts;
- Expressions of fear or anxiety;
- Aggression, refusal to cooperate, antisocial behavior;
- Use of alcohol or drugs;
- Outbursts of shouting, complaining, unexplained irritability, or crying;
- Withdrawal;
- Change in sleep patterns.

If these characteristics are present in a child with whom you are working, request that an assessment be completed by a qualified mental health professional who can diagnose and treat childhood depression. The local child protection agency will need to make the referral for this assessment.

Childhood Depression

A feeling of intense sadness beyond an appropriate length of time.

What Causes Childhood Depression?

Children who develop major depression are likely to have a family history of the disorder, often a parent who experienced depression at an early age. Depression in children can be triggered by events or problems, such as the death of a parent, a friend moving away, difficulty in adjusting to school, difficulty making friends, or drug or alcohol abuse. However, some children become depressed without profoundly unhappy experiences.

What Are the Symptoms of Childhood Depression?

The defining features of depression in children are the same as they are for adults. However, recognition and diagnosis of the disorder are more difficult in youth because expression of the symptoms varies with youth's developmental stage, and children may have difficulty properly identifying and describing their internal emotional or mood states. Therefore, symptoms of depression may manifest in children as the following:

- ✓ Frequent vague, nonspecific physical complaints, such as headaches, muscle aches, stomach aches, or tiredness;
- ✓ Frequent absences from school or poor performance in school;
- ✓ Talk of or efforts to run away from home;
- ✓ Outbursts of shouting, complaining, unexplained irritability, or crying;
- ✓ Being bored;
- ✓ Lack of interest in playing with friends;
- ✓ Among older youth, alcohol or substance abuse;
- ✓ Social isolation, poor communication;
- ✓ Fear of death;
- ✓ Extreme sensitivity to rejection or failure;
- ✓ Increased irritability, anger, or hostility;
- ✓ Reckless behavior;
- ✓ Difficulty with relationships

Five or more of these symptoms must persist for two or more weeks before diagnosis of depression is indicated.

What Treatments Are Available?

Treatment often combines short-term psychotherapy, medication, and targeted interventions involving the home or school environment. In order to prevent the recurrence of depression, it is recommended that treatment be continued for at least six months after the remission of symptoms.

Conduct Disorder

> *A repetitive and persistent pattern of behavior in which children or adolescents violate the rights of others or violate norms and rules appropriate to their age.*

Children with conduct disorder show a chronic disregard for the norms and rules of society. Oftentimes, this disorder is ignored and the child is simply labeled a juvenile delinquent. However, children with conduct disorder have underlying emotional problems that need to be dealt with in a therapeutic setting. Below, you will find a list of common conduct disorder behaviors. A child needs an assessment if he/she displays several of these behaviors within a six-month time frame:

- Starting fights;
- Skipping school;
- Constantly lying;
- Forcing sexual activity;
- Breaking into homes, cars, or offices;
- Setting fires;
- Cruelty to animals or humans.

Through counseling, children can begin to appreciate the effect their behavior has on others and learn new ways to get their needs met without harming others.

What Causes Conduct Disorder?

Researchers have not yet discovered what causes conduct disorders, but they continue to investigate several psychological, sociological, and biological theories. Psychological and psychoanalytical theories suggest that aggressive, antisocial behavior is a defense against anxiety, an attempt to recapture the mother-infant relationship, the result of maternal deprivation, or a failure to internalize controls. Sociological theories suggest that conduct disorders result from a child's attempt to cope with a hostile environment, to get material goods that come with living in an affluent society, or to gain social status among friends. Other sociologists say inconsistent parenting contributes to the development of the disorders. Finally, biological theories point to a number of studies that indicate children could inherit a vulnerability to the disorders. Children of criminal or antisocial parents tend to develop the same problem. Other biologists believe that male hormones or problems in the central nervous system could contribute to the erratic and antisocial behavior. None of these theories can fully explain why conduct disorders develop. Most likely, an inherited predisposition and environmental and parenting influences all play a part in the illness.

What Are the Signs of Conduct Disorder?

Children who have demonstrated at least three of the following behaviors over six months should be evaluated for possible conduct disorder:

- ✓ Steals, without confrontation (e.g., forgery) and/or by using physical force (e.g., muggings, armed robbery, purse-snatching, or extortion);
- ✓ Consistently lies (other than to avoid physical or sexual abuse);
- ✓ Deliberately sets fires;
- ✓ Is often truant from school or absent from work;
- ✓ Has broken into someone's home, office, or car;

- ✓ Deliberately destroys the property of others;
- ✓ Has been physically cruel to animals and/or to humans;
- ✓ Has forced someone into sexual activity with him/her;
- ✓ Has used a weapon in more than one fight;
- ✓ Often starts fights.

What Treatments Are Available?

Treatments, including behavior therapy and psychotherapy (either individual or group sessions), are aimed at helping young people realize and understand the effect their behavior has on others. Some children also suffer from depression or attention-deficit/hyperactivity disorder; use of medications as well as psychotherapy has helped lessen their symptoms of conduct disorder. Moralizing and threatening do not work. Often the most successful treatment is to separate the child from a damaging environment and to administer strict discipline.

Post-Traumatic Stress Disorder

> *Re-experiencing a very distressing event that has overwhelmed a child's coping mechanism and has created intense feelings of fear and helplessness.*

Post-traumatic stress disorder, otherwise known as PTSD, develops as a reaction to a terrifying event or series of events, such as severe child abuse or witnessing domestic violence. PTSD typically appears within six months of the event and can last for many years. Symptoms of PTSD are placed into three categories.

Intrusion (re-experiencing the trauma)	**Avoidance/Numbing** (avoidance of things that remind one of the trauma)	**Hyperarousal** (increased tenseness and heightened awareness)
• Flashbacks and/or nightmares in which the person experiences the same feelings of distress that took place during the initial event.	• Avoids close emotional ties. • Supersensitive to activities or situations that remind one of the trauma. • Feelings of numbness.	• Exaggerated startled response (jumpy and easily startled). • Irritable and explosive. • Hypervigilance (always being watchful of potential danger).

Therapy or a combination of therapy and medication can relieve some of these symptoms and provide temporary relief from the trauma of this disorder. Ideally, both the memories of the trauma and the symptoms will fade after a period of therapy and/or medication. As with any other childhood disorder, it is critical to have a competent professional assess the child. Post-traumatic stress disorder, reactive attachment disorder, separation anxiety disorder, and simple anxiety are often misdiagnosed as attention-deficit/hyperactivity disorder. Currently, there is great controversy about the possible over-diagnosis—and overmedication—of children with AD/HD. Obtaining a second opinion is good practice. The more relevant information the case manager gathers, the more likely he/she is to understand the needs of the child and to make appropriate recommendations to the court.

What Causes Post-Traumatic Stress Disorder (PTSD)?

A child who experiences a catastrophic event may develop PTSD. A stressful or traumatic event involves a situation where someone's life has been threatened or severe injury has occurred, such as experiencing or witnessing one of the following:

- ✓ Physical or sexual assault or abuse;
- ✓ Family and community violence;
- ✓ Severe accidents;
- ✓ Life-threatening illnesses;
- ✓ Natural disasters (flood, fire, earthquakes).

A child's risk of developing PTSD is related to the seriousness of the trauma, whether the trauma is repeated, the child's proximity to the trauma, and his/her relationship to the victim(s).

What Are the Signs of PTSD?

PTSD affects how a child feels and acts. Signs of stress may include the following:

1. A child may re-experience the trauma by:
   - Talking about the trauma over and over again;
   - Including trauma-related events in play;
   - Dreaming about the trauma;
   - Feeling like the trauma is happening all over again;
   - Becoming very distressed when reminded of the trauma.
2. A child might withdraw from the trauma experience by:
   - Avoiding thoughts or feelings about the trauma;
   - Avoiding activities associated with the trauma;
   - Forgetting parts of the trauma;
   - Losing skills, such as toilet training or language skills;
   - Wanting to be alone more than usual;
   - Becoming less affectionate toward others;
   - Feeling like there is nothing to look forward to in the future.
3. A child may experience restlessness and agitation, such as:
   - Having difficulty falling asleep or staying asleep;
   - Becoming easily angered, irritable, or jumpy;
   - Having concentration problems;
   - Expressing fear (fear of being left alone or sleeping alone);
   - Becoming overly watchful and easily startled;
   - Reporting physical complaints when reminded of the trauma.

What Treatments Are Available?

Treatment of PTSD in children generally involves "talking therapies" (such as cognitive behavioral therapy, family therapy, or brief psychotherapy), and may include the prescription of medication by a psychiatrist.

Fetal Alcohol Syndrome

> *A combination of particular facial features, growth deficiency, and central nervous system damage resulting from alcohol exposure during pregnancy.*

Fetal alcohol syndrome, better known as FAS, is described as a set of particular facial features, growth deficiencies, and central nervous system damage resulting from alcohol exposure during pregnancy. Mothers who do not receive prenatal care and who regularly consume alcohol during pregnancy have an increased risk of delivering a child who has FAS. Some physical characteristics at birth include a poor sucking reflex, small eyes, thin upper lip, cleft palate, heart defects, and possible joint deformities.

What Causes Fetal Alcohol Syndrome (FAS)?

A fetus exposed to any amount of alcohol may suffer from fetal alcohol syndrome. Alcohol causes physical damage to the central nervous system. The risk of severe birth defects increases with the amount of alcohol consumption. However, even small amounts of alcohol can be harmful; therefore, women are recommended to avoid alcohol during the entire pregnancy.

What Are the Symptoms of FAS?

A child with this condition will have one or more of these effects:

- ✓ Poor sucking ability;
- ✓ Poor sleeping habits;
- ✓ Irritability from alcohol withdrawal;
- ✓ Unusually small body, head, eyes, or jaw;
- ✓ Cleft palate;
- ✓ Heart defects;
- ✓ Hip dislocation and other joint deformities;
- ✓ Mental retardation;
- ✓ Learning disabilities;
- ✓ Speech and language difficulties;
- ✓ Hyperactivity;
- ✓ Inappropriate emotional responses;
- ✓ Problems with fine and gross motor skills;
- ✓ Memory deficit or "quirky memory";
- ✓ Inability to generalize from one situation to another;
- ✓ Easily stimulated or distracted;
- ✓ Difficulty with cause and effect;
- ✓ Seeming lack of remorse;
- ✓ Lack of boundaries;
- ✓ Overly affectionate;
- ✓ Hyper/under sensitivity to touch, sound, light, and textures;
- ✓ Hygiene problems.

What Treatments Are Available?

There is no cure for fetal alcohol syndrome. However, children with FAS can be helped. The treatment involves recognizing the symptoms and addressing the problems by providing medical and dental care or placing them in special school programs.

Psychological Assessment of Children

During a case, recommendations may be made for children to undergo psychological assessment. Assessment is a process, not just a series of tests. The reasons why assessment is recommended, the particular instruments (tests) used, the individual conducting and evaluating the instruments, the timing of the assessment in the context of the child's life, and the intended uses of the assessment are all important parts of this process. Following is a brief overview of reasons that children are referred for assessment.

Reasons for Assessment

Children are referred for psychological assessment for many reasons, including:

1. **Dysfunctional and negative behavior**, such as tantrums, a demanding personality, excessive crying and whining, delinquency, defiance of rules and limits.
2. **Developmental concerns**, such as perceptual and motor problems, speech and learning problems, delayed development, school readiness determination.
3. **Educational problems**, such as inadequate performance and progress, aggressive behavior, dislike, or disinterest in school.
4. **Sleeping and eating problems**, such as infant feeding and nursing problems, excessive crying, bulimia, anorexia nervosa, over- and under-eating, and any suspected nutritional deficiencies that may be contributing to learning problems, sleep and behavior problems, fatigue.
5. **Toilet training problems**, including any manifestations of encopresis (soiling), enuresis (bedwetting), or excessive fear of going into the bathroom.
6. **Behavioral issues**, such as poor self-control, lack of motivation, irresponsibility, lying, stealing, dependence/independence conflict, setting fires, "mean" behavior toward animals and others, self-inflicted injuries, sexuality issues.
7. **Family problems**, such as sibling conflict, dysfunctional communication, inadequate support system in social relationships and skills, attachment and separation problems, aggressiveness, and abuse. Problems of change prompted by divorce, custody issues, separation, adoption, termination of parental rights, moving, visitation issues, grieving and death issues. Problems related to how the child learns and processes information that the family presents (the belief system within the family leading to attitude, temperament). Parents' negative feelings for the child, poor relationship indicators, conflict over discipline, family arguing.
8. **Medical considerations**, such as psycho-physiological reactions to stress, adjustment to illness of a child or family member, terminal illness of the child or family member, physical or sexual abuse, neglect, drug and alcohol abuse by child or other family member.
9. **Psychiatric manifestations**, including personality disorder, cyclothymic mood disturbance (alternate periods of elation and depression), disassociation and psychic numbing (emotional shutting down and flat affect), excessive fears, harming others, and psychotic behavior such as hallucinations and thought disorder.

Tools for Assessment

The selection of instruments (tests) to be administered to a child must be appropriate for the purpose of the evaluation, and must take into consideration the child's age and any special handicaps such as sensory deficits, physical or motor impairments, or speech disorders. Tests should also be culturally appropriate or at least be free of cultural bias.

Other factors of importance in selecting tests for individual examination are determined by the attributes of the tests. Among those to be considered in choosing one test in preference to another are:

- **Validity**
  How well does the test measure what it is said to measure?
- **Reliability**
  How consistently are the test results reproduced when the same individual is re-tested? When the test is broken up, via the split-half method and compared with itself, is it internally consistent?
- **Standardization**
  The test norms should be derived from a representative sample of the population to whom the test is to be applied.
- **Objectivity**
  An objective test involves specific responses to specific requests or situations. A standard set of directions is followed for administering and scoring the test. Any departures from these prescribed procedures must be reported.

(Note: No single test score is conclusive; professionals look for several sources of data to support conclusions they draw from the tests.)

Brief Descriptions of Some Commonly Used Assessment Tools

The following list of assessment tools is in no way intended to be complete. It does, however, give some examples of the types of instruments that may be used. The case manger is not expected to have an expert's knowledge of the use of assessment instruments. However, some familiarity with the types of instruments being used may help guide research and further discovery on behalf of the child.

Developmental Scales

Gesell Developmental Schedules *(2 ½ years–6 years)*

Thirteen tests assessing wide range of developmental factors in preschoolers. Assesses behavior and emotional and physical development. Used for screening, early intervention, or diagnosis.

Bayley Scales of Infant Development *(2 months–30 months)*

Two-scale test for infant mental and motor development and a behavior rating. Assesses early mental and psychomotor development. Used in the diagnosis of normal versus retarded development.

Intelligence Tests

Wechsler Intelligence Scale for Children–Revised (WISC-III) *(5 years–15 years)*
Twelve subtests divided into two major divisions yielding a verbal IQ, performance IQ, and full scale IQ for children tested individually. Provides verbal and nonverbal scales.

Wechsler Preschool & Primary Scale of Intelligence (WPPSI-II) *(2 years–6 ½ years)*
Ten standardized subtests divided into verbal and nonverbal scales to assess cognitive and reasoning abilities. Scores converted to deviation quotient comparing subject to age peers.

Stanford-Binet Intelligence Scale (SB-IV) *(2 years–Adult)*
Measures overall cognitive abilities. Emphasis at lower ages on sensorimotor performance; at school age and above, highly dependent on verbal skills. Verbal and nonverbal tests assess verbal reasoning, abstract/visual reasoning, quantitative comprehension, and short-term memory. Can be used to substantiate scores from group tests, to provide more comprehensive assessment, and when a subject has physical, language, or personality disorders that prevent group testing. Results can help identify subjects who would benefit from specialized learning environments.

Leiter International Performance Scale *(2 years–18 years)*
Multiple-item nonverbal task assessment of intelligence. Individual performance scale. Covers range of functions, non-timed, nonverbal, assumed to be culture-free. Useful for children with speech or language difficulties.

Wechsler Adult Intelligence Scale–Revised (WAIS-R) *(16 years–Adult)*
Eleven subtests yielding verbal IQ, performance IQ, and full scale IQ. Verbal and nonverbal scales. Popular and well-standardized test but considered not useful for exceedingly superior or for retarded.

Vocabulary

PPVT
Point to response nonverbal multiple-choice selection of picture associated to word spoken by examiner. Measures receptive vocabulary for Standard American English, estimates verbal ability, and assesses academic aptitude. Also used with English as a Second Language (ESL) students, mentally retarded, and gifted students. Vulnerable to deficit in visual/perceptual functions. Scores converted to mental ages, deviation IQ.

Full Range PVT
Similar to Peabody. Assesses individual intelligence when scores are converted to mental age and tables are available for comparable Wechsler Verbal IQ. May be used in testing special populations such as physically handicapped, uncooperative, aphasic, or very young subjects.

Perceptual- or Visual-Motor Integration Tests

Bender Visual-Motor Gestalt Test *(3 years–Adult)*
A paper-pencil test, untimed. Assesses visual-motor functions. Evaluates developmental problems in children, learning disabilities, retardation, psychosis, and organic brain disorders. Visual-perception, visual-motor integration, motor skill, and organizational ability are tapped by copying figures. Also used as projective test.

Illinois Test of Psycholinguistic Abilities (ITPA) *(2 years–10 years)*

Ten subtests evaluate child's cognitive and perceptual abilities in communication, auditory, psycholinguistic process of visual reception, levels of organization, sequential memory, association of symbols, ordering recall, discrimination and conceptualization of similarity, and closure.

Frostig Developmental Test of Visual Perception *(pre-kindergarten)*

Forty-one-item paper-pencil test assessing eye-motor coordination, figure-ground, form constancy, discrimination of position in space, and reproduction of spatial relationships. Evaluates children referred for learning difficulties or neurological handicaps.

Goodenough-Harris Drawing Test *(3 years–15 years)*

Assesses mental ability through nonverbal technique and drawing tasks. Revisualization, ability to reproduce representation of human figures. Developmental age scores. Also used as projective device.

Benton Revised Visual Retention Test *(8 years–Adult)*

Measures visual memory. Utilizes ten cards depicting one or more geometric forms exposed ten seconds. Assesses revisualization, spatial perception, and perceptual-motor reproductions. Scored for number correct and number of errors. Used as supplement to visual mental examinations.

Memory for Designs (Graham-Kendall) Test *(8 ½ years–Adult)*

Assesses revisualization and visual-motor coordination. Fifteen cards with simple geometric figures, each exposed five seconds, to be reproduced. Used to differentiate between functional behavior disorders and those associated with brain injury.

Auditory Processing Tests

Illinois Test of Psycholinguistic Abilities (ITPA) *(2 years–10 years)*

Assesses specific psycholinguistic abilities and disabilities in children. Facilitates assessment of child's abilities for remediation. Ten subtests of auditory-reception, association, sequential recall, grammatic closure, sound-blending, and verbal expressiveness. Assess decoding, ordering, memory, ability to analyze and synthesize parts-to-whole.

Goldman-Friscoe-Woodcock Test of Auditory Discrimination *(4 years–Adult)*

Diagnoses an individual's ability to hear clearly under increasingly difficult listening conditions. Twelve subtests measure auditory election, attention, discrimination, memory, and sound-symbol skills. Intersensory integration is involved in multiple-choice response to pictures associated with recorded words. Used for instructional planning.

Kinesthesia & Tactile Perception

Southern California Sensory Integration Tests *(4 years–10 years)*
Measures an individual's ability to see, touch, and move in a coordinated manner. Seventeen-item paper-pencil and task assessment tests measuring visual, tactile, and kinesthetic perception, and different types of motor development. Used to identify the degree and type of disorder often associated with learning and emotional programs, minimal brain dysfunction, and cerebral palsy.

Reitan-Indiana Neuropsychological Battery for Children *(5 years–Adult)*
Assesses brain-behavior functioning in children. Includes subtests of sensory perception, intersensory manual form perception, tactile localization, tactile-kinesthetic perception, learning, and recall. Used for clinical evaluations.

Motor Tests

Southern California Sensory Integration Test *(4 years–10 years)*
Five of six subtests require imitation of patterned movements, body positions, or response to verbal requests.

Southern California Motor Accuracy Tests *(4 years–8 years)*
Measures degree of accuracy in drawing a pencil line over a printed line. Used in diagnosis of perceptual-motor dysfunction in atypical children. Used in clinical evaluations.

Lincoln Oseretsky Motor Development Scale *(6 years–14 years)*
Measures motor development. Tests fine and gross motor skills. Used to supplement information obtained from other techniques concerning intellectual, social, emotional, and physical development.

Purdue Perceptional Motor Survey *(6 years–10 years)*
Range of postural, motor, body image, and form perception measures.

Frostig Developmental Test of Visual Perception *(3 years–10 years)*
Eye-motor coordination subtests measure skill of visually guided movements.

Bayley Scales of Infant Development, Motor Scale *(2 months–30 months)*
Assesses developmental levels of motor patterns, including prehension and locomotion.

Academic Skills & School Achievement

Standardized Tests Given By Schools:

All measure reading, math, and writing skills.

- **Iowa Test of Basic Skills (ITBS)**
- **Washington Assessment of Student Learning (WASL)**

Tests Given By Specialists:

Woodcock-Johnson Psycho-educational Battery (W-JPEB)

Twenty-seven-test battery. Evaluates individual cognitive ability, scholastic achievement, and interest level. Used to diagnose learning disabilities for instructional planning, vocational rehabilitation, and counseling.

Wide-Range Achievement Test–Revised (WRAT-R)

Three paper-pencil subtests, which measure basic educational skills of word recognition, spelling, and arithmetic. Identifies individual learning difficulties. Used for educational placement, measuring school achievement, vocational assessment, and job placement and training.

Peabody Individual Achievement Test (PIAT)

Four-hundred-item test of mathematics, reading, comprehension, and general information. Provides an overview of individual scholastic attainment. Used to screen for areas of weakness requiring more detailed diagnostic testing.

Adaptive Behavior Scales

Vineland Social Maturity Scale–Revised

One-hundred-seventeen-item interview covering eight categories of self-help in general, eating, dressing, communication, self-direction, socialization, and locomotion. Measures successive stages of social competence and adaptive behavior. Used to measure individual differences, which may be significant in cases of mental deficiencies and emotional disturbances, in order to plan therapy or individual education.

Woodcock-Johnson Scales of Independent Behavior (SIB) *(2 years–Adult)*

Assesses functional behavior, self-help skills, and communication skills. Usually used with developmentally delayed individuals.

A.A.M.D. Adaptive Behavior Scale *(3 years–6 years)*

Assesses social and daily living skills of children whose adaptive behavior indicates possible mental retardation, emotional disturbance, or other learning handicaps. Used for screening and instructional planning.

Personality & Social/Emotional Functioning

A variety of tests can be used to examine various personality or emotional hypotheses about children. These tests include the following:

The Achenbach Child Behavior Checklist (CBCL) *(2 years–16 years)*

Assesses behavioral problems and competencies of children and adolescents. Evaluates child behavioral problems from subject's perspective with Youth Self-Report (for ages 8–11 years), from parent's point of view with Child Behavior Checklist, and from teacher's perspective on classroom behavior with Teacher Report Form. Direct Observation Form used by experienced observer to rate on basis of a series of at least six ten-minute observation periods.

Behavioral Assessment Scale for Children (BASC) *(2 ½ years–18 years)*

Assesses the range of behavior for typically developing children in order to look for areas of psychological damage.

Minnesota Multiphasic Personality Inventory–Adolescent Version (MMPI-A) *(Adolescents–Adults)*

One-hundred-fifty-item true/false test of ten clinical variables or factors. Assesses individual personality. Used for clinical diagnosis and research on psychopathology.

Children's Depression Inventory *(8 years–13 years)*

Twenty-seven-item pencil-paper inventory measuring overt symptoms of child depression such as sadness, anhedonia, suicidal ideation, and sleep and appetite disturbance. Assesses severity of depression in children and adolescents. Also used to measure progress during treatment.

Various Projective Tests

TAT, CAT, Robert's Apperception Test for Children, Piers-Harris Children's Self-Concept Scale, Sentence Completion Test

Used with caution, as they are not standardized. They can be helpful when used with other sources and by a trained clinician.

Adapted from *Tests: A Comprehensive Reference for Assessments in Psychology, Education and Business*, second edition, Richard C. Sweetland, Ph.D., and Daniel J. Keyser, Ph.D., general editors. Kansas City, MO: Test Corporation of America, 1986. Updated for NCASAA by Peggy Tribble, Ph.D., May 2000.

DEVELOPMENTAL DELAY

Refers to a child's development in a particular domain, when an expected behavior or trait fails to emerge, or is not mastered within the normal timeframe.

DEVELOPMENTAL DISABILITY

Refers to some permanent condition that results in physical or mental impairment.

Common Developmental Disabilities

Mental Retardation

Description:	A disability, with early onset, resulting in substantial limitations in the present functioning
Characteristics:	The three requirements for mental retardation are: Intellectual Functioning 70 to 75 or below Related limitations in two or more adaptive skill areas Onset at age 18 or earlier
Secondary Conditions:	Hearing Loss Premature death Alzheimer's disease, Down's Syndrome
Physical Signs:	May be none Down's Syndrome has small stature, slant eyes, weak musculature May have difficulty with speech and language Difficulty communicating in expressive or symbolic language
Social/Emotional Signs:	Difficulty with self-care Difficulty learning appropriate social norms Difficulty with self-direction
Causes:	Down's Syndrome is due to a defective chromosome.

Cerebral Palsy

Description: A non-progressive disorder of movement that is caused by a malfunctioning of or damage to the brain

Characteristics: A group of disorders having the following traits:

- Aberrant control of movement or posture
- Early onset
- No recognized underlying pathology
- Two major physiological categories (names arise from the part of the brain affected):
  1. Pyramidal: Spasticity is the key sign, meaning jerky movements
  2. Extrapyramidal: Athetosis (slow, irregular twisting movements) is the principal sign. Snakelike movements

Secondary Conditions: Disorders of speech, such as:

- dysarthria which is slurred speech due to muscle tightness, weakness or lack of coordination
- Aphasia: impairment in the ability to communicate through speech and writing
- Hearing loss

Physical Signs:

Large or small head size
Unusual eye movement
Low muscle tone (hyotonia)

Signs in babies and small children/young children:

Problems with feeding, sucking, and swallowing
Use of one hand only
Baby is floppy
Asymmetrical crawl

Causes:

Multiple, include prenatal and post natal abuse and neglect, heredity, rubella injections, anoxia at birth (lack of oxygen), Rh-incompatibility, traumatic brain injury, metabolic disorders, brain hemorrhage or clot, and brain tumors

Muscular Dystrophy

Description: A neuromuscular disorder with early onset

Characteristics: There are many types. The common characteristic is the progressive and irreversible wasting of muscle tissue.

Onset usually by 5 years of age

Physical Signs:
Difficulty climbing stairs and rising to a standing position
Waddling gait
Frequent falls
Wasting of muscles beginning in lower trunk and calves, moves upward
Enlarged calf muscles, as muscle is replaced by fat

Social/Emotional Signs:
Difficulty concentrating
Anxiety about survival

Causes: Not known. It is passed genetically.

Population Affected: Some forms of MD are sex-linked to males

Spina Bifida

Description: The most frequently occurring permanent disabling birth defect. A failure of the spine to close properly during the first month of pregnancy.

Characteristics: Child is born with abnormal spinal cord, may even protrude through the child's back.

Secondary Conditions:
Hydrocephalus, accumulation of fluid in the brain
Latex allergy
Tendonitis
Obesity
Skin breakdown
Gastrointestinal disorders

Physical Signs:
Possible paralysis
Bowel and bladder complications

Social/Emotional Signs:
May have learning problems, including: difficulty paying attention, difficulty expressing or understanding language, and difficulty organizing, sequencing, and grasping reading and math
May experience low self esteem due to disability
Depression

Causes:
Not known, but there is a relationship between low folic acid status before conception and during the first few weeks of pregnancy and the disorder

Cystic Fibrosis

Description: The most frequent lethal genetic disease of childhood. It is a hereditary disorder of the lungs and digestive system.

Characteristics: Disease interferes with the proper functioning of the exocrine glands

Secondary Conditions{ Poor health of women makes pregnancy difficult
98% of males are infertile
Median survival is 30.1 years

Physical Signs: Difficulty breathing (due to heavy mucus production)
Persistent cough, wheezing
Salty skin
Incomplete digestion and absorption of food
Excessive appetite, with poor weight gain
Bulky, foul-smelling stools

Causes: Lack of a certain protein causes improper regulation of chloride in the organs of the body. It is passed on genetically.

Population Affected: More common among Caucasians

Activities to Support Families of Children with Disabilities

- Health and Medical Services
- Special School Programs
- Recreation Programs
- Physical Education Opportunities
- Programs to Develop Self-esteem
- Speech Therapy

Case Manager Responsibilities for Children with Disabilities

- Assess Safety and Risk
- Understand the Disability
- Advocate for the Family
- Understand and Know Community Resources

	RISK FACTORS	PROTECTIVE FACTORS
Psychological Risk & Protective Factors...	**Early Development** ▪ Premature birth or complications ▪ Fetal drug/alcohol effects ▪ "Difficult" temperament ▪ Long-term absence of caregiver in infancy ▪ Poor infant attachment to mother ▪ Shy temperament ▪ Siblings within two years of child ▪ Developmental delays **Childhood Disorders** ▪ Repeated aggression ▪ Delinquency ▪ Substance abuse ▪ Chronic medical disorder ▪ Behavioral or emotional problem ▪ Neurological impairment ▪ Low IQ (less than 80) **Family Stress** ▪ Family on public assistance or living in poverty ▪ Separation/divorce/single parent ▪ Large family, five or more children ▪ Frequent family moves **Parental Disorders** ▪ Parent(s) with substance abuse problem ▪ Parent(s) with mental disorder(s) ▪ Parent(s) with criminality **Experiential** ▪ Witness to extreme conflict, violence ▪ Removal of child from home ▪ Substantiated neglect ▪ Physical abuse ▪ Sexual abuse ▪ Negative relationship with parent(s) **Social Drift** ▪ Academic failure or drop-out ▪ Negative peer group ▪ Teen pregnancy, if female	**Early Development** ▪ "Easy" temperament ▪ Positive attachment to mother ▪ First born ▪ Independence as a toddler **Family** ▪ Lives at home ▪ Parent(s) consistently employed ▪ Parent(s) with high school education or better ▪ Other adult or older children help with child care ▪ Regular involvement in church ▪ Regular rules, routines, chores in home household ▪ Family discipline with discussion and fairness ▪ Positive relationship with parent(s) ▪ Perception of parental warmth ▪ Parental knowledge of child's activities **Child Competencies** ▪ Reasoning and problem-solving skills ▪ Good student ▪ Good reader ▪ Child perception of competencies ▪ Extracurricular activities or hobbies ▪ IQ higher than 100 **Child Social Skills** ▪ Gets along with other children ▪ Gets along with adults ▪ "Likeable" child ▪ Sense of humor ▪ Empathy **Extra-Familial Social Support** ▪ Adult mentor outside family ▪ Support for child at school ▪ Support for child at church ▪ Support for child from faith, spirituality ▪ Support for child from peers ▪ Adult support and supervision in community **Outlooks & Attitudes** ▪ Internal focus of control as teen ▪ Positive and realistic expectations of future ▪ Plans for future ▪ Independent minded, if female teen

Resiliency: The 40 Developmental Assets

The Search Institute's Framework for Looking at Protective Factors

In an effort to identify the elements of a strengths-based approach to healthy development, Search Institute developed the framework of developmental assets. This framework identifies forty critical factors for young people's growth and development. When drawn together, the assets offer a set of benchmarks for positive child and adolescent development. The assets clearly show important roles that families, schools, congregations, neighborhoods, youth organizations, and others in communities play in shaping young people's lives.

External Assets

SUPPORT:

1. **Family support:** Family life provides high levels of love and support.
2. **Positive family communication:** Young person and his/her parent(s) communicate positively and young person is willing to seek advice and counsel from parent(s).
3. **Other adult relationships:** Young person receives support from three or more non-parent adults.
4. **Caring neighborhood:** Young person experiences caring neighbors.
5. **Caring school climate:** School provides a caring, encouraging environment.
6. **Parent involvement in schooling:** Parent(s) are actively involved in helping young person succeed in school.

EMPOWERMENT:

7. **Community values youth:** Young person perceives that adults in the community value youth.
8. **Youth as resources:** Young people are given useful roles in the community.
9. **Service to others:** Young person serves in the community one hour or more per week.
10. **Safety:** Young person feels safe at home, school, and in the neighborhood.

BOUNDARIES & EXPECTATIONS:

11. **Family boundaries:** Family has clear rules and consequences, and monitors the young person's whereabouts.
12. **School boundaries:** School provides clear rules and consequences.
13. **Neighborhood boundaries:** Neighbors take responsibility for monitoring young people's behavior.

14. **Adult role models:** Parent(s) and other adults model positive, responsible behavior.
15. **Positive peer influence:** Young person's best friends model responsible behavior.
16. **High expectations:** Both parent(s) and teachers encourage the young person to do well.

CONSTRUCTIVE USE OF TIME:

17. **Creative activities:** Young person spends three or more hours per week in lessons or practice in music, theater, or the arts.
18. **Youth programs:** Young person spends three or more hours per week in sports, clubs, or organizations at school and/or in community organizations.
19. **Religious community:** Young person spends one or more hours per week in activities in a religious institution.
20. **Time at home:** Young person is out with friends, "with nothing special to do," two or fewer nights per week.

Internal Assets

COMMITMENT TO LEARNING:

21. **Achievement motivation:** Young person is motivated to do well in school.
22. **School engagement:** Young person is actively engaged in learning.
23. **Homework:** Young person reports doing at least one hour of homework every school day.
24. **Bonding to school:** Young person cares about his/her school.
25. **Reading for pleasure:** Young person reads for pleasure three or more hours per week.

POSITIVE VALUES:

26. **Caring:** Young person places high value on helping other people.
27. **Equality and social justice:** Young person places high value on promoting equality and reducing hunger and poverty.
28. **Integrity:** Young person acts on convictions and stands up for his/her beliefs.
29. **Honesty:** Young person "tells the truth even when it is not easy."
30. **Responsibility:** Young person accepts and takes personal responsibility.

31. **Restraint:** Young person believes it is important not to be sexually active or to use alcohol or other drugs.

SOCIAL COMPETENCIES:

32. **Planning & decision-making:** Young person knows how to plan ahead and make choices.
33. **Interpersonal competence:** Young person has empathy, sensitivity, and friendship skills.
34. **Cultural competence:** Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
35. **Resistance skills:** Young person can resist negative peer pressure and dangerous situations.
36. **Peaceful conflict resolution:** Young person seeks to resolve conflict nonviolently.

POSITIVE IDENTITY:

37. **Personal power:** Young person feels he/she has control over "things that happen to me."
38. **Self-esteem:** Young person reports having high self-esteem.
39. **Sense of purpose:** Young person reports that "my life has a purpose."
40. **Positive view of personal future:** Young person is optimistic about his/her personal future.

Created by the Search Institute, www.search-institute.org/assets. Used with permission.

WEBSITES

Child Trauma Academy Web Site
http://www.ChildTrauma.org

Child Trauma Academy's Web site has copies of articles written by Dr. Bruce Perry as well as others in child trauma. The Web site provides up-to date alerts on child trauma and information on research and conferences. Articles are written for professionals, caretakers, and families.

National Clearinghouse for Child Abuse and Neglect (NCCAN)
http://nccanch.acf.hhs.gov/

The National Clearing house on Child Abuse and Neglect Information is a national resource for professionals seeking information on the prevention, identification, and treatment of child abuse and neglect, and related child welfare issues. The clearing house also has over 30,000 summaries of articles on child maltreatment to search.

Pre vent Child Abuse, America
www.preventchildabuse.org

Prevent Child Abuse (PCA) has a nationwide network of chapters and their local affiliates in hundreds of communities. PCA seeks to equip professionals with the latest prevention approaches through training and technical assistance.

Child Welfare League of America
http://www.cwla.org

CWLA is an association of more than 1,000 public and private nonprofit agencies that assist over 2.5 million a bused and neglected children and their families each year with a wide range of services. CWLA provides advocacy information and data on child maltreatment. It also covers all areas of child welfare from day care to institutional care. They have many resources for families and professionals working with traumatized children.

American Professional Society on the Abuse of Children
http://www.apsac.org

APSAC's mission is to ensure that everyone affected by child maltreatment receives the best possible professional response. This organization has many useful scholarly and clinical materials focused primarily at the professional audience. Caregivers working with abused or maltreated children may find this a useful resource, nonetheless.

The National Center for PTSD
http://www.ncptsd.va.govb

The National Center for PTSD is a program of the U.S. Department of Veterans Affairs and carries out a broad range of activities in research, training, and public information. The primary focus of the Center has been combat veterans and their families. Over the last few years, however, this focus has been expanded. There are may useful programs, activities and resources for anyone interested in the effects of traumatic stressors.

http://www.ncptsd.va.gov/publications/pilots/index.html
The PILOTS data base is an electronic index to the worldwide literature on PTSD and other mental-health issues of exposure to traumatic events. It is available to Internet users through the courtesy of Dartmouth College, whose computer facilities serve as host to the database. No account or password is required, and there is no charge of using the PILOTS database.

International Society for Traumatic Stress Study
http://www.istss.org

The International Society for Traumatic Stress Studies (ISTSS), founded in 1985, provides a forum for the sharing of research, clinical strategies, public policy concerns,

Module Six
CHILD MALTREATMENT

PURPOSE:

The Case Manager will be able identify indicators of maltreatment in accordance with State legal definitions of emotional abuse, physical abuse, sexual abuse, and neglect.

LEARNING OBJECTIVES:

After completion of this module, participants 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

Child Protective Services Policy Manual 2101.5

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.

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 2004

Total Reported: 101,563   Screened Out: 16,001

Assigned for Investigation	Cases 85,562	Incidents 144,741
Substantiated	30,951	53,918
Unsubstantiated	54,611	90,823

Prevalence of Maltreatment		
Substantiated Incidents	**53,918**	
Neglect	**43,888**	**81%**
Physical Abuse	**5,599**	**10%**
Sexual Abuse	**2,411**	**4.5%**
Emotional Abuse	**1,370**	**2.5%**
Other	**650**	**1%**

Red Flags

Read the following statements and identify 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.

11. A 7-year-old told her teacher that her baby sitter's boyfriend kisses her on the mouth.

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

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

- Inadequate supervision
- Inadequate food, clothing, and shelter
- Inadequate health/medical care
- Malnourishment/Failure to Thrive
- Emotional/Psychological Neglect
- Educational/Cognitive Neglect
- Abandonment/Rejection

2104.4 Lack of Supervision

Use the following guidelines for determining the level of neglect that exists when children are alone without adult supervision.

- Children eight years or younger should not be left alone;
- Children between the ages of nine years and twelve years, based on level of maturity, may be left alone for brief (less than two hours) periods of time; and,
- Children thirteen years and older, who are at an adequate level of maturity, may be left alone and may perform the role of babysitter, as authorized by the parent, for up to twelve hours.

These guidelines pertain only to children who are not in the department's custody. Situations involving children for whom the department has placement responsibility are governed by foster care requirements.

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

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

SCENARIO 1

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.

Worksheet

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

SCENARIO 2

Cherese

Let's meet Cherese, age 7, who is Jamal's first cousin. She lives with her mother in the same housing project as Jamal. Cherese is a skinny, little girl who always wears clothes that are too big and not suitable for the weather.

Cherese's mother, La Tonya, age 23, is in a job training program through Manpower. Cherese's father has left the area and his whereabouts are unknown. He has never supported her or had much contact. La Tonya likes to party and go out with friends. She has said to friends and family on more than one occasion that Cherese is a burden and she wished she had had an abortion.

Cherese is not doing well in school. Her teacher believes she may be Attention Deficit Disorder and has asked her mother to come in for a conference to discuss the situation.
La Tonya has missed three appointments. Meanwhile, Cherese's ability to sit still and concentrate has worsened.

Today, Cherese told her teacher she was hungry and didn't feel good. When questioned about when she last ate, Cherese said that she does not eat breakfast or supper at home because there is no food in the house. She couldn't remember when she last ate a meal at home. She said that her mama knows she's hungry but says she needs to eat more at school.

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 quickly 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 tracheostomy tube has been inserted. The most common reason for using a tracheostomy 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.

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

Tiffany and Tyler

Let's meet Tiffany, age 4, and her baby brother, Tyler, age 6 months. They live with their mother, Diane, age 21, and her live-in boyfriend, Keith, who works day labor. Keith is not the father of either child.

Diane was the youngest of four children. Her father was in and out of the home. Her mother worked and had little time to care for the children. Diane went to live with her aunt at age 10 and was often left to provide for herself. Diane dropped out of school at age 16 and began working at several fast food restaurants. Occasionally, she would connect with friends and then disappear from her aunt's home for weeks at a time. At age 17 she became pregnant with Tiffany. The relationship with Tiffany's father was abusive. Diane moved back with her aunt until she became pregnant with Tyler. Then she met Keith and moved in with him.

Their apartment consists of one bedroom, a living room, bath and kitchen. The children sleep in the living room at nights. The apartment is unkempt as Diane spends her days watching soap operas. When Keith arrives home from work in the evenings, Diane cooks for and spends her time with him.

Tiffany is a tiny blond with a head full of curls. She suffers from cystic fibrosis and should be followed by a pediatrician regularly. Tiffany is supposed to have breathing treatments several times a day but her mother doesn't like to do them because Tiffany cries.

Tiffany is supposed to be on a special diet but doesn't like some of the foods and besides it's expensive and time-consuming to go to all that trouble.

Diane gets mad at the doctors when she goes to them because they make her feel like she is not taking good care of her child. What do they know anyway! Tiffany may just have a lot of colds and allergies that she'll grow out of. Why make such a big deal out of everything!

It's the same with Tyler. He is a very fair, blue-eyed baby who weighed 5 lbs. 5 ounces at birth. He now weighs 10 lbs.

Secretly, Diane thinks he's ugly. He looks like a wrinkled-up old man with a big belly. The only thing wrong with Tyler is that he's such a picky eater. It takes forever for him to feed and who has time to sit and hold a baby for an hour! After a while Diane gives up and just puts him in his crib. He would rather be there anyway.

Tyler doesn't make eye contact with anyone or act like he wants to be held. When you try to hold him he gets all stiff and irritable. This makes Diane feel like Tyler doesn't like her. He in some strange way reminds her of his father, who deserted her when she was pregnant. One of these days Tyler will get hungry enough to eat and then maybe he will start acting like other babies.

Worksheet

What are the child indicators for Tiffany?

Worksheet

What are the child indicators for Tyler?
What are the parent/caretaker indicators for Diane?
What are the environmental indicators?

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

Emotional Maltreatment

- Emotional harm can be associated with physical abuse or neglect, or it can be a separate psychological phenomena.

- The dynamics of emotional harm can be extremely complicated and destructive.

- *Emotional harm that occurs without concurrent physical abuse or neglect is often beyond the legal and practical scope of child welfare intervention.* This is unfortunate because, in a very real sense, the only lasting consequence to any form of child abuse, other than permanent physical injury, are its negative emotional consequences. The literature and research consistently suggest that *many of the most serious adult psychological and behavioral dysfunctions have their roots in the emotional harm resulting from child abuse and neglect.*

- While the dynamics in an individual case may be very complicated, there are factors that suggest emotional abuse, and that increase the risk to the child. These factors are: unpredictability of parental responses, belittling and verbal denigration of a child's personal worth, and parental indifference.

Types of Emotional (Psychological)Deprivation

Rejecting

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

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

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

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

Terrorizing

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

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

School-Age Child <u>General</u>: Places children in "double binds" or places inconsistent or frightening demands on children.
<u>Behaviors</u>: 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 <u>General</u>: Threatens to or actually subjects the child to public humiliation.
<u>Behaviors</u>: Threatens to reveal embarrassing facts to the child's friends, forces the child into degrading punishments.

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.

SCENARIO 1

Tameka

Tameka Brown, 13, and her five siblings live with their mother. The family has been involved with DFCS in the past for confirmed neglect.

Today, Dr. Tim Wells called DFCS in regard to Tameka. He is a pediatric oncologist who has seen the child twice over the last two months. Tameka has been diagnosed with leukemia.

The school was the first to notice her drastic weight loss and exhaustion and encouraged her mother to take her to the health department. The health department referred her to a pediatrician and on to Dr. Wells.

Along the way, the mother had missed ten scheduled visits with the doctors for such reasons as "something came up." Dr. Wells is very concerned as he has not been able to finish her testing and begin treatment. He stated that without aggressive treatment, Tameka will not survive. He went on to say that Tameka's mother came to his office "reeking of alcohol" on one occasion. She never cancels appointments and the office must call her to reschedule. When questioned further by the intake worker, Dr. Wells stated that he had personally explained Tameka's condition to her mother and had told her that the leukemia was in an advanced stage before it was detected and that time is critical. He believes Ms. Brown understands the seriousness of the situation.

Worksheet

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

SCENARIO 2

Cameron

Cameron Williams is 10 months old. He was born almost three months premature and weighed 1 lb. 9 ozs. Cameron had all the problems of very premature babies such as respiratory problems and poor eye sight. He spent two months on a ventilator.

Cameron's mother and father are in their early twenties. The father is a mechanic for a small garage. The mother completed the tenth grade in special education and does not work outside the home. They reside in a one bedroom apartment and have one car. Both were very traumatized by Cameron's medical condition and did not seem to understand what was going on much of the time.

When Cameron was well enough to be held, both parents appeared terrified of him because he was so small. The fetal monitor also intimidated them.

From the beginning, the couple missed doctor appointments due to a lack of transportation. Cameron now weighs 9 lbs. 3 ozs. He has very thin limbs, is wrinkled and has an odd way of staring with a wide-eyed expression for long periods of time.

His mother thinks maybe he is blind although the doctors said he can see. She believes the best way to handle him is to leave him alone. Lately he has started to bang his head on the crib and rock back and forth. Cameron spits up so much when he is fed that both parents only give him an ounce or two at a time thinking this will help.

Worksheet

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

SCENARIO 3

Ian and Brett

Doris and Steve Maddox are upper-middle class professionals who work together in their own accounting firm. Their sons, Ian, age 12, and Brett, age 11, are gifted students. They both are in accelerated classes, take guitar lessons, play soccer on top level teams and study Japanese on Saturday afternoons.

Failures are not allowed in this family, nor are mistakes tolerated. Steve Maddox berates the boys and calls them "losers" if they make below an A on any test or have an off-game of soccer.

Recently at a guitar recital, Ian became so nervous he lost his concentration and made several mistakes in his performance. Mr. Maddox was so enraged that he got up and left. Mrs. Maddox told Ian she was terribly disappointed in him and he should apologize to his father.

Both boys have problems sleeping, are very anxious, and appear depressed. Brett's teacher called the Maddoxes recently to express concern about Brett's fear of not being perfect. She noticed he stutters if asked to speak in class. This is a new development.

Worksheet

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

SCENARIO 4

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.

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.

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

With excessive spanking, the bruises spare the anal canal. The darkness of normal pigmentation around the anus should not be confused with bruising. 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).

American Academy of Pediatric

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.

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 P[illegible]s, 1989

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	

Accidental or Non-accidental?	
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

Accident ... or not?

EXAMPLE 1: A young mother rushed her four year-old child to the emergency room. The little girl had second-degree water burns on her back and first-degree burns on the backs of her thighs. The mother told the intake nurse the teenager next door turned a garden hose that had been sitting out in the hot sun toward the child, who tried to run away but was burned.

Does the mother's story make sense based on the injury?

EXAMPLE 2: Another young mother rushed her two-year-old child to the emergency room. The little boy had second-degree burns on his buttocks and the insides of his thighs with no doughnut pattern. He had no other burns. The mother explained that she had placed the little boy in his car seat and that he began to scream. Since she had gone back inside the house before he screamed, it took a few moments for her to get him out of the car seat.

Does the mother's story make sense based on the injury?

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

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

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?

Shaken Baby (Infant) Syndrome

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.

What is it?

A condition in which a child, usually less than two years of age, has been seriously abused (usually by shaking) resulting in intracranial and intraocular bleeding, often with little or no external trauma or history of injury.

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.

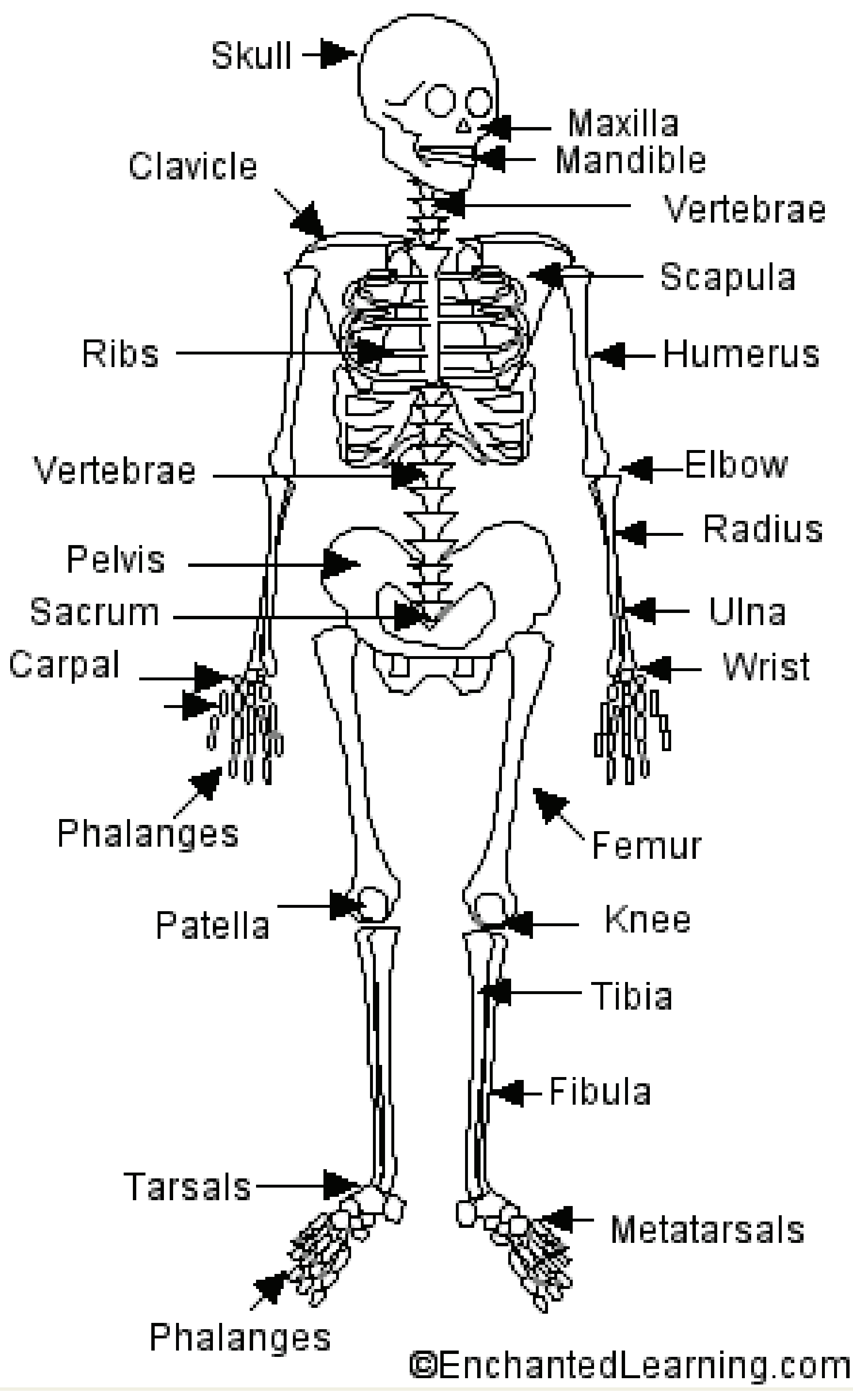
What are its effects on children?

- 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



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 aren't 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.

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.

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

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 which 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.

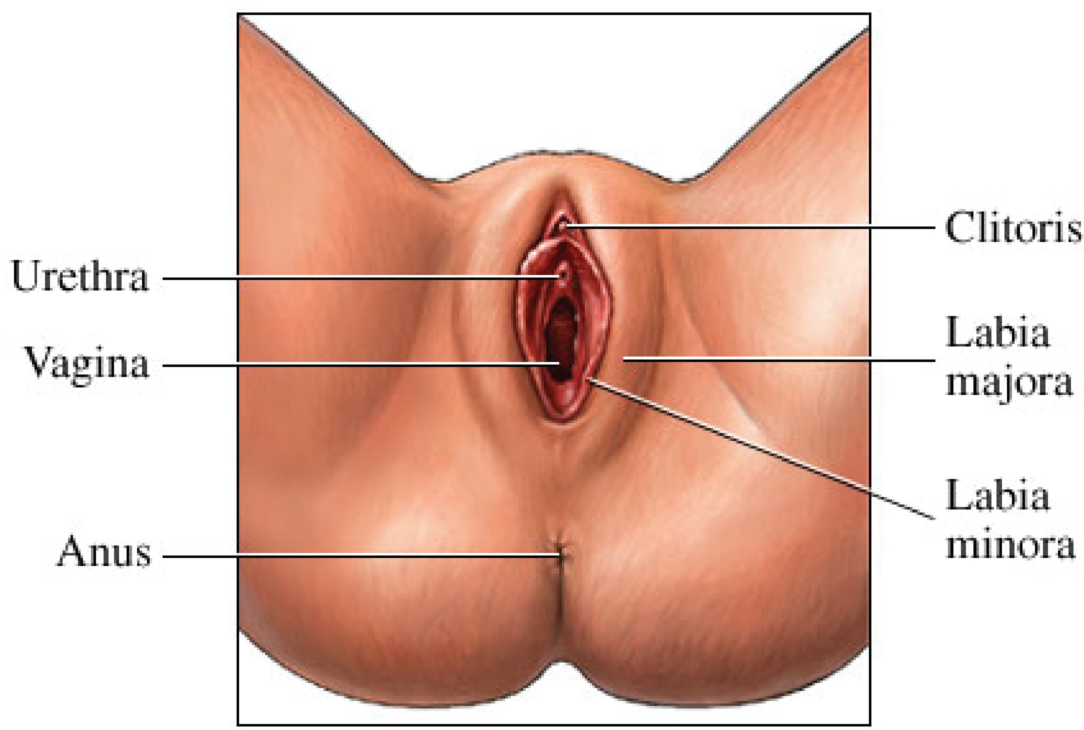
VESTIBULE
A cavity, chamber or channel that serves as an approach to another cavity. The vestibules of the vagina is the space between the labia minora and contains the openings to the vagina and the urethra.

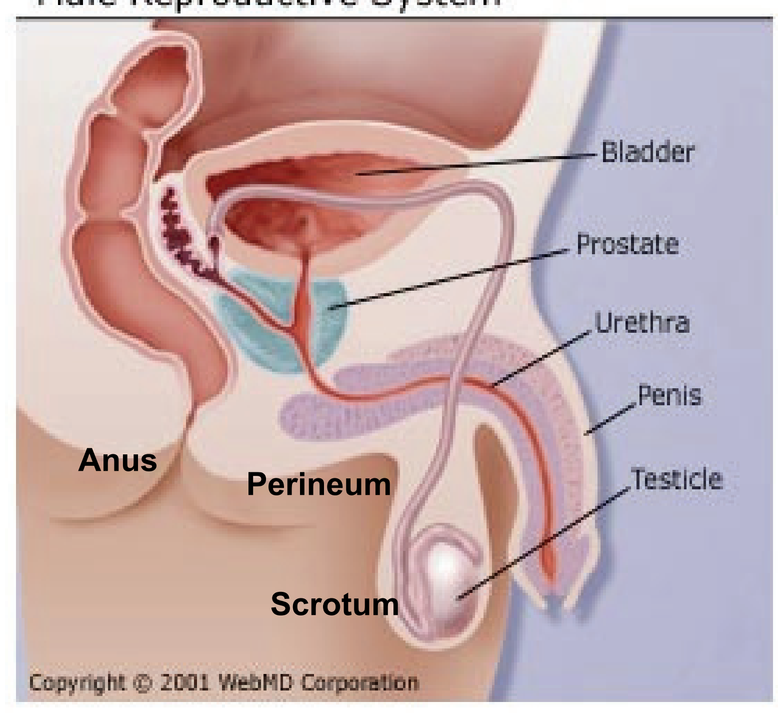
VULVA
The external female genital organs, composed of the mons pubis, the labia majora and minora, the vestibule of the vagina and its glands and the openings of the urethra and the vagina.

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





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 Ause	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

The Developing Child: What's Normal?

(Content provided by the Georgia Council on Child Abuse)

Infancy (birth to 1 year)	
Developmental Stage	<u>Trust vs. Mistrust</u> 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

The Developing Child: What's Normal?

(continued)

Toddler (2-5 years)	
Developmental Stage	<u>Autonomy vs. Shame and Doubt</u> Following sexual abuse, self-doubt and doubt of others may later appear <u>Initiative vs. Guilt</u> 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	<u>Anal Stage:</u> Toilet training Handling their own genitals Kissing parents and others Cuddling Beginning awareness of genital differences <u>Phallic stage:</u> 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

The Developing Child: What's Normal?

(continued)

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

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.

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.

WORKSHEET

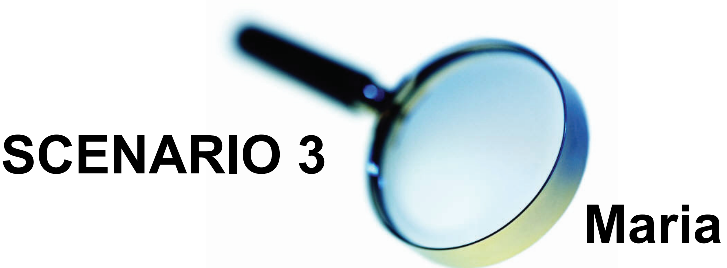
Identifying Indicators of Sexual Abuse: Scenario 2, Alphonzo

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 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 <u>her</u> 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.

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.

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 Seven

INTERVIEWING

PURPOSE:

The case manager can verbalize strategies for conducting effective casework interviews using a variety of interview methods, including open and closed-ended questions, reflections, summarization and moving families towards concreteness. Case managers will be able to deal effectively with anger and resistance. Case managers will become familiar with ethnographic interviewing.

LEARNING OBJECTIVES:

After completing this topic, the case manager should be able to:

- Demonstrate skills for interviewing children and families
- Identify the correlations between the interviewing skills and the relationship the case manager builds with a family
- Identify ways to handle anger and resistance encountered in an interviewing situation
- Identify skills for interviewing children

Purpose of the Interview

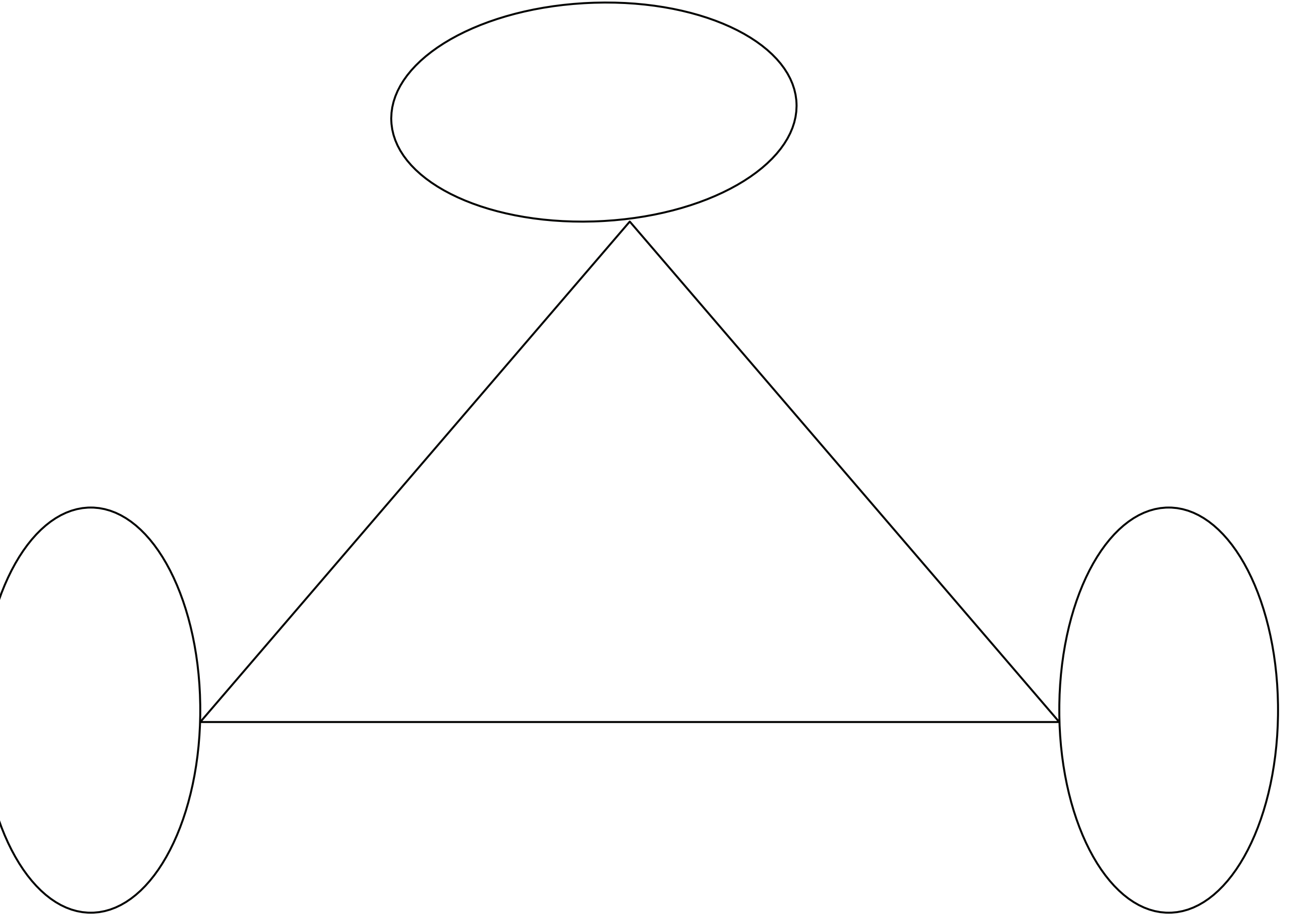
To gather and share information

Assess the family's strengths and needs

Reach a common understanding

Motivate and facilitate change

Interpersonal Helping Skills



RESPECT

GENUINENESS

EMPATHY

EMPATHY OR SYMPATHY??

- ☐ **You seem pleased with the progress you have made so far.**

- ☐ **I'd feel the same way you do if I were in your shoes.**

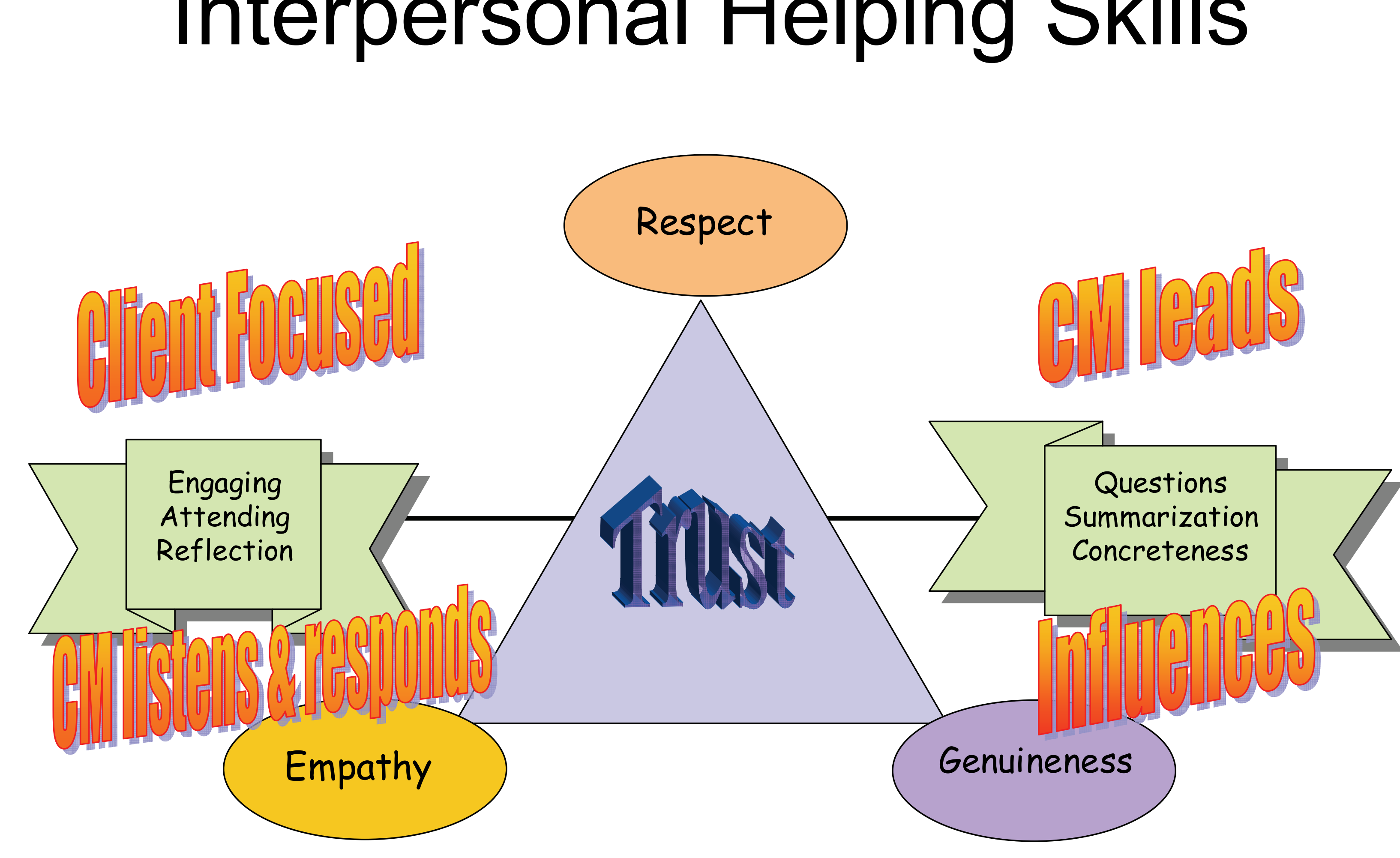
- ☐ **I'm sure you are grief-stricken because your father died.**

- ☐ **I'm so sad that you are experiencing this separation.**

- ☐ **I sense you are really frustrated with this situation.**

- ☐ **I feel awful that this has happened to you.**

Interpersonal Helping Skills



Top Ten Ways To Engage

1.______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

9. ______________________________

10. ____________________________

Five types of listening

NON-LISTENING

PRETEND LISTENING

SELECTIVE LISTENING

SELF-FOCUSED LISTENING

EMPATHIC LISTENING

Communication Skills in Helping Relationships, Vonda Olson Long

Attending is…

communicating respect and acceptance, by actively listening on a physical and psychological level.

Physical Attending

Use of Environment	Use of Body
☺ Minimize barriers	☺ Gestures
☺ Minimize distractions	☺ Eye contact
☺ Comfortable environment	☺ Facial expressions
	☺ Body posture

Psychological Attending

Observing
Client’s congruence
Client’s use of voice
Client’s nonverbal behavior

Say What???

Pleasant States	Unpleasant States
Peaceful	Fearful
Joyful	Sad
Patient	Impatient
Meek	Hostile
Intrigued	Confused
Happy	Worried
Surprised	Dismayed
Content	Jealous
Meditative	Anxious
Hopeful	Frustrated
Euphoric	Disappointed
Satisfied	Hopeless
Relieved	Guilty
Stoned	Suspicious

MINIMAL ENCOURAGERS

"I see"
Neutral – assures individual you are paying attention

"Uh huh" or "Hmmm"
Indicates that you understand the individual's meaning

"Yes," "Okay," "Of course"
Suggests approval of what individual is saying

"Go on," "And?" "but," "then what?"
Obligates the individual to continue

Head Nodding
Indicates interest; a nonverbal reinforcer to keep the interviewee talking

The best time to use a minimal encourager is when the individual should continue his or her train of thought, without interference from the Case Manager, yet the case manager wants to communicate interest in what is being said.

ACCENT REPONSES

Repeating a word or short phrase, from the individual's statement, in a questioning tone of voice.

The repeated word determines the direction of the interview.

Repetition promotes elaboration.

EXAMPLE:

Individual: "My husband keeps after me about my drinking."

Caseworker: "Drinking?"

Repeating: "Your husband?" or "keeps after you?" would determine next focus of discussion.

Please continue…

Scenario One

Ms. Martin has admitted leaving bruises on Lucy's buttocks (age 9) following being called to the school. Lucy has been suspended from school for stealing another child's dollar. Lucy has been caught stealing on three other occasions. Ms. Martin is overwhelmed and at her "wit's end" with Lucy.

Scenario Two

Tawanda Oluyda is the neighbor to Ms. Martin, and has been contacted as part of the investigation. The neighbor is reluctant to talk, but clearly has some concerns.

Scenario Three

Morgan Wilson is the maternal grandparent of 3 days old, Tami. Tami's mother (Tina) is 19 years old and addicted to "Methamphetamine." Tina checked out of the hospital and has not made contact with the Agency or her family. Morgan Wilson has been asked to provide background information.

Please Continue…
Observation Worksheet

Nonverbal

Facial ____

Gestures____

Body language ____________________________________

Para-verbal

Tone of voice _____________________________________

Rate of speech ____________________________________

Inflection ____

Minimal Encouragers

Verbal ____

Gesture ____

Accent Responses

____

____

Level 1 ~Response Styles

Fix-it ~ **EXAMPLE:** "I think you should…," "If I were you, I'd…," "You really ought to…," and "There's a great book about…"

Explain it away ~ **EXAMPLE:** "I would have called but…," "She only said that because you…," and "But I didn't mean to…"

Correct if ~ **EXAMPLE**: "You need to…," "The best way is…," and "I want you to..."

Console ~ **EXAMPLE**: "It wasn't your fault…," "You did the best you could…," and "You can't blame yourself…."

Tell a story ~ **EXAMPLE**: "That reminds me of the time…," and "I know how you feel. That happened to me too when I…."

Shut down ~ EXAMPLE: "Cheer up. You'll feel better tomorrow," "Quit feeling sorry for yourself," or "It's not as bad as you think."

Commiserate ~ EXAMPLE: "Man, I can't believe what they did to you! I'd be mad too if they did that to me!"

Interrogate ~ **EXAMPLE:** "When did this happen?" "What did you do?" "What did he say?" "What did you say back?"

Evaluate ~ EXAMPLE: "You're just too unrealistic…," "If you weren't so defensive…," or "If you would just count to ten before…"

One-up ~ EXAMPLE: "That's nothing. I …."

Level 2 ~Response Styles

REFLECTION OF CONTENT: "What I hear you saying is that the kids are making a mess instead of starting their homework."

OR

REFLECTION OF FEELING: "It seems to me that you are angry about all that you have to do?"

Level 3 ~Response Styles

REFLECTION OF CONTENT AND FEELING: "I sense you are feeling angry and frustrated that the children are not being responsible for doing what you have asked them to do.

Level 4 ~Response Styles

REFLECTION OF IMPLIED FEELINGS/CONTENT: "What I hear you saying is that you are feeling overwhelmed with the responsibilities at work and at home, and need the children to help you out more."

Using Reflection to Demonstrate Empathy

Listen to verbal message

Pay close attention to nonverbal and Para-verbal communication

Convey understanding of feelings and content

Include essence of nonverbal and Para-verbal communication

Lead Ins…

"If I get you right…"

"It seems to me…."

"What I hear you saying is…"

"In other words…"

"As I understand…"

"I gather that…."

"I sense you're feeling…"

"The message I am getting is…"

"Could it be…"

"I'm wondering if…"

Your response please….

STATEMENT: "I thought marriage would solve all my problems. I was so happy for a while, but now everything is going wrong."

LEVEL 1:

____

____

____

LEVEL 2:

____

____

____

LEVEL 3:

____

____

____

LEVEL 4:

____

____

____

Open-ended Questions

Open-ended questions typically cannot be answered with a “Yes” or “No” or other short answer. Open-ended questions encourage narrative and free response.

BENEFITS

- Focuses on the individual’s:
  - Thoughts
  - Feelings
  - Experiences
- Encourages individual to reveal areas of greatest concern
- Allows individual to determine the content and direction of the interview
- Provides insight into the individual’s feelings and intensity of feelings
- Implies case manager is interested in and respects individual
- Provides an “Open invitation to talk”

CAUTIONS

- Can be threatening to an individual who has little experience with this type of question, if asked too many
- May be time-consuming
- May further alienate individuals who feel resistant

EXAMPLES:

“What progress have you made in finding a job?”

“Would you tell me more about that?”

“How do you feel about that?”

Closed-ended Questions

Closed-ended questions have a specific short answer – most closed-ended questions can be answered in one word.

BENEFITS

- ❖ Provides direction when family member is stalled or confused
- ❖ Provides greater clarity and focus
- ❖ Helps narrow the focus of the interview
- ❖ Gives case manager greater control of the interview
- ❖ Gives the case manager a way to introduce a topic the individual may be reluctant to bring up.

CAUTIONS

- ❖ Can side-track the interview, if too many closed-ended questions are asked
- ❖ Limits disclosure of information
- ❖ Influences the individual to be a passive supplier of answers
- ❖ Limits disclosure of feelings or intensity of feelings
- ❖ Discourages mutuality of purpose between the case manager and the individual

EXAMPLES:

Did they come back?

When did you work last?

Where will you go?

Will your mother loan you the money?

Is that the last of the bills?

Indirect Questions

Indirect Questions are statements that imply a question, but are not punctuated with a question mark.

BENEFITS

- ❖ Breaks the sense of interrogation and monotony
- ❖ More passive position of interviewer

EXAMPLES:

I've been wondering about your family.

I need your social security number.

I need to know what happened next.

I've been wondering what happened after your last visit.

I've been wondering about your family.

Use of Questions in the Interview

Ask open-ended questions to start the interview. Then move to more closed-ended questions to fill-in information. Once the information is supplied, ask more open-ended questions. The process of moving from open-ended to closed-ended questioning repeats throughout the interview.

The following is an example illustrating the flow from open-ended to closed-ended questions:

Open-ended

What would you like to talk about today?

Tell me about your situation.

How do you think the Agency can help?

What seems to be bothering you about the situation?

What seems to be bothering you about Jimmy's behavior?

What do you do when _______ happens?

What was your response the last time ________ happened?

Do you get angry when __________ happens?

Closed-ended

Let me ask you…

Caregiver: You know I don't know what to do about the daycare situation. Jennifer screams every morning when I leave her there. Some mornings I feel just awful all the way to work. Makes me want to just quit my job and go back on assistance.

Reflection: ____________________________________

____

Open-ended question: ___________________________

____

Close-ended question: ___________________________

____

Accent response: _______________________________

____

Indirect question: ______________________________

____

Foster Parent: Since Penny was placed here last week, she's been so stubborn. I can't get her to do anything. And, you know, my kids are watching her – it won't be long before all of 'em refuse to do their chores.

Reflection: ______________________________________

____

Open-ended question: _____________________________

____

Close-ended question: _____________________________

____

Accent response: _________________________________

____

Indirect question: _________________________________

____

Coping Questions

Parent: "I give up! These kids get into everything and will not listen to anything I tell them. Just look at this place! I had it clean yesterday, but you would never believe it to look at it today. I just can't do this any more. I work a nine hour shift and then I have to come home to this!"

Case manager: "I hear you saying these children are a real handful. I'm sure they keep you on your toes. How did you get the place clean yesterday?"

Parent: "I made each kid clean a different room. They acted like I was killing them. If I didn't stay on them, they would stop cleaning. But, look at it now!"

Case manager: "That was a really good idea to have each child clean a different room. How did it feel to go to bed with the house clean?"

Parent: "It felt good. I actually slept last night."

Relationship Questions

BENEFITS

- ❖ Asks for the client's perception
- ❖ Heightens self awareness of how others are impacted
- ❖ Assess themselves by their own measuring stick

Example: What would your best friend say about how she could tell that you are more confident about yourself?

Example: How does your mother think parenting classes will be helpful for you?

Example: What would your daughter say about how seeing your smile helps her?

Exception Questions

BENEFITS

- Tries to identify periods when the problem did not occur and the context in which it happens
- All situations have a negative and positive side
- Pays attention to the positive

Example: When are you able to help Johnny with his homework, without becoming frustrated and calling him names?

Example: When are you able to ignore the loud behavior, and not whip them with a belt?

Example: How were you able to stay sober for a week?

Scaling Questions

Case manager: Now I want to ask you a different kind of question. On a scale of 1 to 10, where 10 stands for how confident any parent can be in making sure that his child is safe and 1 stands for you are not sure at all, that is, you feel very shaky about your child's safety, where would you put yourself between 1 and 10 right now?

Parent: I am really trying to be a good father, you know, just like my old man was for me. He didn't always do right, but he tried his best. Look at me, I turned out okay, I guess (smiles). I don't know how confident I am. I guess on the higher part.

Case manager: So, what number would you put your confidence at, between 1 and 10?

Parent: I would say around 5 or 6 and moving closer to a definite 6 because I realize that I could have really hurt him. Of course, I don't want to hurt him, but he is such a difficult child.

Case manager: 5 or 6? That's pretty high. What tells you that you are at 5 or 6?

Parent: This time I learned my lesson and now I know what could go wrong if I am not careful and it really scares me. I guess sometimes I don't know my own strength and forget that he is still a small child. I also realized how much I love my kid.

Adapted from Building Solutions in Child Protective Services by Insoo Kim Berg and Susan Kelly

Miracle Questions

Case manager: Now I am going to ask you a rather strange question (pause here). After we finish talking, obviously I am going to go back to my office and you will do your routine – whatever you need to do the rest of the day, such as feeding Jamal, looking over his homework, watching TV, or whatever. And, of course, it will be time to go to bed. When all of your family members are sleeping, and the house is very quiet (pause), in the middle of the night, a miracle happens (pause), and the miracle is that the problems that you might have with your child, or that other people think you have (use client's exact words here to describe problems) – so people like me will no longer meddle in your life. Poof! Gone! But because all this happens when you and your family are sleeping, nobody knows that the problems are all solved (pause). So, when you are slowly coming out of your sleep, what difference will you notice that will make you wonder if there was a miracle overnight and the problem is all solved?

Parent: I will have a different child, head to toe. He will wake up feeling good instead of being so grumpy and messing up everybody's day.

Case manager: So, how will he be different when his problem is all solved because of this miracle?

Parent: As I said, he will be a different child-like he used to be when he was a baby. He will wake up smiling, in a good mood, ready to face the day and do his best. He will behave himself in school all day. If he can do this once in a while, I would say that's a miracle.

Case manager: So, let's just suppose he does. What do you suppose he would say about how you will be different tomorrow morning?

Parent: I suppose I will be so surprised and maybe even talk to him nice, like we used to. Yah, that's what will happen, I will feel like talking to him in a calm voice instead of screaming at him like I do now.

Case manager: So, suppose you do talk to him in a soft, calm voice, what would he say about how that is helpful to him?

Parent: I know what he will say. He will say he likes to be my baby. We were very close until I got so involved with Tom, and I guess I lost a grip on my life and got swept away with Tom, and neglected my kid. I know what I have to do: I have to put my son first. You know, he really needs me because he doesn't see his father and I am sure he worries that I am going to be like his dad.

Adapted from Building Solutions in Child Protective Services by Insoo Kim Berg and Susan Kelly

Mismatch

I'm sure there are days when you feel like running away from it all. What stops you?	Relational Questions
On a scale of one being terrible and 10 being great, how would you describe what kind of day you are having today?	Miracle Questions
What do you suppose your children would say they like best about your being sober?	Exception Questions
If you woke up in the morning and a miracle had taken place over night resolving, the family problems, what differences would you notice?	Coping Questions
When were you able to not hit your child when he gave you an "evil eye?"	Scaling Questions

Questions to Avoid!!

Leading or Suggestive Questions

Leading or suggestive questions lead the individual to provide a specific or particular answer desired by the case manager. Often a "tag" question, such as "…did you?" or "…don't you?" is added to a leading statement.

Examples to Avoid:

- "As a concerned mother, do you think its right to ignore Timmy's behavior?"
- "I understand why you get angry, but you realize hitting him doesn't help, don't you?"
- "If you really care about your kids, would you continue to drink?"
- "You don't want to cause any more trouble, do you?"
- "When he asked you to go, you knew you shouldn't, right?"

Multiple Questions

Multiple questions are two or more questions asked as one. Responses to multiple questions can be confusing, because it is unclear which question is being answered.

Examples to Avoid:

- "Were you upset about the way she answered you or about the answer she gave?
- Do you and your boyfriend share expenses or do you keep your money in separate accounts?"
- "How do you and your husband feel about getting into a support group?"
- "How was it when you brought the baby home, did you feel unsure about taking care of him?"

Why Questions

Why questions imply "BLAME" and individuals may feel the need to justify and defend responses. Replace "Why" questions with clarifying questions, such as, "Help me to understand…" or "I don't understand what you meant when you said…" or "Tell me about…"

The question is…Scenario

Ten year-old Funke, was seen at school following a referral that she had bruises on her arm. Funke stated that her mother had grabbed her by the arm and held her while she was being spanked. There were no bruises on the buttocks. Funke admits that she gets into a lot of trouble. The case manager makes a home visit and finds mother. The mother is angry that the case manager is there and indicates that Funke is the problem. Mother spanked Funke because she was hitting her younger brother and would not stop when told. Funke used the "B" word at mother. Mother admits to grabbing Funke by the arm to get her attention and spanking Funke after Funke called her that word.

The question is…Planning Worksheet

Open-ended question ________________________________

____

Close-ended question ________________________________

____

Indirect question ____________________________________

____

Coping question ____________________________________

____

Relationship question ________________________________

____

Exception-seeking question ___________________________

____

Scaling question ____________________________________

____

Miracle question ____________________________________

____

The question is …Observation Worksheet

Nonverbal

Facial ____

Gestures______________________________________

Body language _________________________________

Para-verbal

Tone of voice __________________________________

Rate of speech _________________________________

Inflection _____________________________________

Minimal Encouragers

Verbal ____

Gesture _______________________________________

Accent Responses

____

____

The question is …
Observation Worksheet

Open-ended question ________________________________

____

Close-ended question ________________________________

____

Indirect question ___________________________________

____

Coping question ____________________________________

____

Relationship question ________________________________

____

Exception-seeking question ___________________________

____

Scaling question ____________________________________

____

Miracle question ____________________________________

____

OPPORTUNITIES FOR GROWTH

Asked leading question ______________________________

____

Asked multiple questions______________________________

____

Asked why question __________________________________

Purposes of Summarization

FOCUS STRUCTURE AND MAKE CONNECTIONS

Example: "Yesterday you were in a good mood and were talking about ______. Today you are distracted and seem distant. Tell me what has happened since we met."

FOR CLARITY AND TO FOCUS DISCUSSION

Example: "Mrs. Deen, you have said so much about your relationship with the teacher, how you help Don with his homework, and attend his baseball games. Let's talk again about arranging the parent-teacher conference that is due this month and how we can assure your attendance."

TO MAKE A TRANISITION

Example: Mrs. Stilt, we have talked about a lot of concerns you have as a foster parent: the lack of financial resources, the demands of your work that keep you from being involved in the school activities, and the stress of taking the girls shopping since each wants to shop at different stores. You also mentioned that some of these concerns would be over in the next month or so. Tell me more about what will be changing.

Purposes of Summarization

REVIEW AND "NEXT STEP"

Example: Ms. Smith, this meeting has been very productive. You have told me about John's progress in school, how he is getting along with the other children in the house, and about the visit with his birth parents. I need to talk to his school psychologist, and then I will get back with you. You should expect to hear from me by next Tuesday."

HIGHLIGHT CONTRADICTIONS

Example: "I'm puzzled,"" I hope you can help me to understand," or "I'm a little confused"

GUIDELINES FOR SUMMARIZATION

- Brief and to the point
- Natural pause
- Accurate
- Clarification, if needed

Using Summarizations

Julie Thomas, 16, is to be placed with the Parker family. Her father died recently and her mother has resorted to drinking heavily to cope. Because she has been unable to stay sober, she is unable to help Julie with her grief and loss. The Parkers have handled grieving kids in the past, and have had remarkable success with most children. The following conversation, part of planning for placement, takes place between Julie and the case manager.

Julie: I don't want to leave my home. All my stuff is here and if I stay, she won't have to go to that hospital. I could make sure she doesn't drink.

Case Manager: This is difficult for you. You hate to leave home and you are worried about your mom.

Julie: Nobody else is worried about her…What's going to happen?

Case Manager: While she's in the rehab hospital, she will be counseled and given a lot of support. She will be given help in dealing with her grief and loss. She will also gain strategies to help her with remaining sober. It is hoped that she will get the help she needs so that the two of you can get back together.

The conversation continues to discuss what Julie may and may not take with her. Julie makes the decision to leave her cat with her friend Tanya. (Mrs. Parker is allergic to cats.) Julie is concerned about the house and who will look after things while she is gone.

SUMMARIZE:

Ways to Avoid Concreteness

- ❖ Deletion
- ❖ Distortions
- ❖ Generalizations

Ways to Promote Concreteness

- ❖ Check out perceptions
- ❖ Clarify vague and unfamiliar terms
- ❖ Explore the basics for client conclusions
- ❖ Assist client to personalize statements
- ❖ Elicit specific information
- ❖ Experience, interactions, behaviors, and feelings
- ❖ Focus on the here and now
- ❖ Be concrete in response to clients

or

Instructions: Read each of the following statements. Place a "**C**" by each statement that is concrete and a "**V**" by each statement that is vague or lacks concreteness.

____ 1. I don't know. Things just get me down sometimes and I can't get moving again.

____ 2. There aren't any jobs around.

____ 3. I enjoy playing with children and helping them learn. I also really like to talk with kids. I like to hear their view of things.

____ 4. I don't like my math teacher.

____ 5. Ms. Brown is a great foster parent. She keeps me posted on how Jane is doing, encourages Jane's mother to visit, and does a lot of extra things to make Jane feel a part of the family.

____ 6. People don't love adopted kids the way they love their own kids.

____ 7. I feel so depressed.

____ 8. I want a nice home for my kids.

____ 9. I always have trouble following through on things.

Interviewing Strategy Checklist

ENGAGEMENT:

- Build rapport
- Handle anxiety

ATTENDING:

- Verbal
- Nonverbal Communication
- Para-verbal Communication
- Minimal Encouragers
- Accent Responses

REFLECTION:

- Listen to verbal message
- Pay attention to nonverbal and para-verbal cues
- Conveys understanding of feelings
- Conveys understanding of content
- Check yourself: do not interpret or add information

QUESTIONING:

- Open-ended questions
- Closed-ended questions
- Indirect questions
- Solution focused questions

SUMMARIZATION:

- Pull information together and make connections
- Get clarity and focus discussion
- Transition from one topic to another
- Review progress of interview
- Present "next steps"
- Highlight contradictions

CONCRETENESS:

- Elicit details
- Assist talker to personalize statements
- Explores basis for conclusions
- Clarifies vague or unfamiliar terms

Interviewing Pitfalls

LEADING QUESTIONS

- ❖ Legal Liability
- ❖ The interviewee may try to please the interviewer by giving the answer he/she thinks we want to hear rather than the truth.
- ❖ The interviewee may become angry that the worker is trying to pressure them into disclosing something they don't want to disclose.
- ❖ Trust between the worker and interviewee may be broken if the interviewee feels pressured.

DISCLOSING PERSONAL INFORMATION

- ❖ The discussion becomes about you, rather than the client.
- ❖ The case manager can lose his/her objectivity about the issue at hand.
- ❖ The client may believe that the worker has more problems than him/herself and the worker loses his effectiveness with the client.

MAKING PROMISES YOU CAN'T KEEP

- ❖ Lose trust, lose credibility.

HANDLING HOSTILE OR ACCUSATORY STATEMENTS

- ❖ Case managers should not be offended by comments made to them or about them.
- ❖ Look for underlying feelings.

GIVING SOLUTIONS

- ❖ Becomes case manager's responsibility.

Round	Choice	Score
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Expressions of Anger Worksheet

ASSERTIVE – Expresses feelings and thoughts honestly and directly without violating the rights of others

AGGRESSIVE – Stands up for self at cost to others

MODIFIED ANGER – Does not express feelings (mild irritation)

INDIRECT ANGER – Passive-aggressive: sarcasm, ignoring, plays role of martyr

HIDDEN ANGER – Silent resistance: foot tapping, nervous laugh

DEPRESSION – Anger turned inward; blames self

VIOLENCE – Loss of impulse control; may act physically or verbally

DISPLACEMENT – Directs anger towards a perceived weaker object

Five Steps of Anger Management

1. **Admit** that you are angry, to yourself and/or to someone else

2. **Believe** you can control your anger. Tell yourself that you can!

3. **Calm** down. Control your emotions. Take some time for yourself, breathe deeply, count to ten, cry…do whatever works for you.

4. **Decide** how to solve the problem. This step only works once you are calm. Figure out what you need, and what's fair.

5. **Express** yourself assertively. Ask for what you need. Speak calmly, without yelling, and people will listen to you.

Source

Masters, K. (1992). The angry child: Paper tiger or sleeping giant? Santa Monica, CA: Psychiatric Hospital Division of National Medical Enterprises, Inc.

Anger Reduction Techniques

GET IN TOUCH WITH OWN FEELINGS

- ❖ Control your breathing
- ❖ Use positive self-talk
- ❖ Do not take the anger personally

GIVE SPACE

- ❖ Use non-threatening, non-confrontational body language
- ❖ Avoid touching the angry person
- ❖ Position yourself to the side of the person, not squarely facing them
- ❖ Do not stand between them and the might you want to position yourself to exit, however, if threatened
- ❖ Avoid extensive eye contact and physical closeness

LISTEN AND RESPOND

- ❖ Use less inflammatory words
- ❖ Use reflections, open-ended questions, and active listening
- ❖ Avoid humor - in the haze of anger it is easily misinterpreted
- ❖ Allow the expression of feelings and needs

STAY GOAL FOCUSED

- ❖ Re-focus attention from emotions to thinking
- ❖ Listen and respond, then re-focus on the goals

SET LIMIT

- ❖ Defines the parameters of the conversation
- ❖ Provide a way to end the conversation (talking later, a cooling off period, moving the place and/or time of the appointment, etc.)

MOVE

Fourteen year-old Nedra Lloyd has been in foster care for three months due to physical abuse by her mother. She wants to go home and is very angry with her mother, foster parents, and the case manager for not letting her go. Her mother has said that she does not want Nedra back at this time. The foster mother has brought Nedra to the office to meet with the case manager and talk about the situation. Nedra sits in a corner of the case manager's office with her arms folded tightly across her body and a sullen look on her face.

Foster Mom: "Nedra and I had an argument this morning before school about her visit tomorrow with her mother. She isn't sure about talking to her mother right now. Says she may not come in for the visit."

Nedra: "Mom really pissed me off the last time I talked to her. She said she wasn't sure when I could come home! She acts like this is all my fault. She takes a belt and beats the crap out of me and makes it my fault!"

Case Manager: "Sounds like you are angry and perhaps a little hurt by what your mother said. Let's talk about how you are feeling a little more."

Nedra: What's there to talk about? I want to go home and you should make Mom let me come." (Nedra's voice cracks and her face becomes flushed.)

Foster Mom: "We know this is upsetting to you and we want to see you go home as soon as possible. But, no one can do that until your mother feels ready to talk about what happened and help think of ways for the two of you to get along better in the future."

Case Manager: "Your foster mom is right, Nedra. This must be very hard for you, but the more you visit with your mom the better chance we all have of working this out. Can you visit with your mom tomorrow without getting too angry?"

Nedra: (Voice softer and face no longer flushed) "Okay, I'll try but it might be better if one of you were there to help me out. She makes me so mad sometimes!"

Case Manager: "That sounds like a good idea. Let's talk about who should sit in on the visit."

WORKSHEET

Dealing with Anger Scenario 1

How is anger being expressed?

What behavior indicates anger?

What do the foster mom and case manager do to handle the anger?

Dealing with Anger

SCENARIO 2

The mother [illegible]ghter who alleges abuse by her father comes to the office to meet with the case manager. She does not believe the daughter and is angry that DFCS has intervened.

Case Manager: Thank you for coming in today Ms. Waganer. I would like to talk with you about what Tasha has told me regarding her father.

Mother: (Face getting flushed.) We have nothing to talk about. It should be obvious to any intelligent adult that Tasha is lying. Her father would never do the things she is saying.

Case Manager: This must be a very difficult time for you. Your daughter is saying one thing and your husband another. That must be confusing and frightening.

Mother: Actually, it's neither. I believe my husband and see no reason for this to go any further. Just send my child home and get out of our lives!

Case Manager: I can understand your desire to have DFCS out of your life but I cannot do that until we are able to sort this situation out and make sure your daughter is safe.

Mother: (Face very red and voice shaking, stands up and points to case manager.) Listen lady! I'm not going to sit here and discuss this with you! Got that?

WORKSHEET

Dealing with Anger Scenario 2

How is anger being expressed?

What behavior indicates anger?

What does the case manager do to handle the anger?

Types of Resistance

Avoiding
Uses words or actions to confuse or change the subject
Consistently verbalizes a lack of understanding
Focus is on minute and unimportant details
Denies or minimizes the situation

Example:

Passive
Displays little energy and gives evidence of low self esteem
Appears and verbalizes feelings of being overwhelmed and unable to cope
Complains about what others have done
Portrays himself or herself as the victim and helpless
Agreeable but consistently does not follow through

Example:

Hostile
Verbally attacks and blames others
Uses finger pointing and pounding on the table
Defensive and sometimes unreasonable
Vents feelings about one thing and then relates many other incidences
Raises voice and often uses offensive language

Example:

Signs of Resistance

- "I need to know more." And more still...
- "Let me tell you about this, and this, and this, and this..."
- "It just won't work for us. You don't understand. This is a different situation."
- "There's no xx#!! way I'm going to do that. Who the **!!* do you think you are?"
- "Okay, tell me this again. I don't understand. What do you mean?"
- "I'm not getting this. Let's do this again..."
- "I have nothing to say."
- "Just tell me what to do. Let's get on with it."
- "Sure, sure. Okay. Yeah, I'll do that."
- "Listen, I can't come down; my neighbor had an emergency..."

Techniques for Working Through Resistance

❖ Watch for cues

❖ Bring It Up

❖ Listen to the response

TIPS FOR SEXUAL ABUSE ASSESSMENTS

Follow county protocol-

- Find out what the protocol is in your county prior to "stumbling into" one of these investigations.
- Don't wait for a training "down the road" to find out what you need to do.

Interview the child alone-

- **Ask** to interview the child alone.
- School staff or non-offending parents will influence the interview without realizing their impact. It is very difficult for responsible adults to not react to a disclosure. The child will perceive this and react as well.
- Don't allow a well-intentioned adult to have the child sit in his/her lap to disclose.
- Having a second case manager present is acceptable if visit is purposefully planned.

Interview the alleged victim child first-

- If the child has gone home for the evening, delay intervention until the next day if by doing so you can see the child away from the adults.
- It is difficult to delay intervention when you are not certain of the outcome: however, you will not be able to protect the child if there is molestation occurring and you are unable to prove it.
- Conduct the interview in a neutral setting instead of where the abuse reportedly occurred or in the home of the alleged perpetrator.

Interview all siblings separately-

- Be aware that molesters will often target other accessible children. The siblings may not have disclosed that they are being similarly abused. Do not interview children together with their siblings.
- Older children often realize the impact of disclosure and will sabotage the younger ones reporting abuse to protect the family.

Do not use dolls and/or formatted drawings to help the child explain the molestation UNLESS YOU HAVE BEEN TRAINED to do so-

- Similarly, do not video or audiotape an interview unless trained in forensic interviewing.
- You must be able to prove a level of expertise to use these tools.
- It is acceptable to allow a child to draw pictures to explain what they can't do so in words. You are not trained to interpret those drawings but can report what the child said about them.

Be aware of the time:

- Do not start sexual abuse interviews late in the afternoon, right before the child is to get on a school bus to go home, or 10 minutes before they are due to go to lunch.
- These interviews take a lot of patience and should not be rushed. You do not want the child to begin disclosure and then have to leave in the middle.

Gather enough information to determine if the child can safely go home, or with another caretaker, today.

- If you have a lengthy interview with the child and get every detail of the molestation, he/she will still have to retell the complete story to a police officer or psychologist.
- The best disclosure is the first one. Protect the evidence by being sure that you have enough to substantiate the concerns and then follow your county protocol as to what steps are taken next.

Be sure you **REMEMBER EVERY WORD** the child tells you.

- Do not take notes during a disclosure but scribble key phrases so you can recreate the conversation verbatim.
- This is another reason not to have the child tell you too much. Their words are in your head and not on a police report or a video/audio tape.

Remember **children will recant-**

- When they are disclosing, you continue to follow protocol steps until complete. Once the disclosure begins, do not interrupt or delay until a more convenient day.
- Expect this case will need your attention after work hours and plan accordingly.

- Techniques to establish child's cognitive functioning
- Rules established for the interview
- Type of questions asked
- How the child was engaged
- Attending behaviors demonstrated by the interview

Note when the interviewer established enough information to determine maltreatment occurred without pushing for details.

Module Eight
INTRODUCTION TO DOCUMENTATION

PURPOSE:

The case manager will learn and demonstrate knowledge of documentation standards.

LEARNING OBJECTIVES:

After completion of this module, the participant will be able to:

- Understand the purpose of documentation and identify the documentation standards
- Recognize the importance of effective, timely documentation
- Apply Social Services Policy Manual Chapter 80 documentation standards
- Formulate strategies for maintaining current documentation

Georgia Department of Human Resources

CONTACT SHEET

PAGE NO. _____

CASE NAME: _____ CASE ID NO.: _____

Date **Staff Member** **Type Contact/Activity**	***Individual(s) Contacted, Purpose, Content, and/or Results of Contact***

Case File Organization

Three-ring binders, as available, with notated index dividers, will be used to maintain all active cases. The services worker is responsible for purging the oldest material from each section, if it is not applicable to current case activity, when the folder is full. The purged material will be retained in order, as in the binders, in file folders complete with dividers. The filing in the binders and folders will be in chronological sequence in each section.

CPS complaints may be set up in file folders initially. CPS complaints may be transferred to binders only if the complaint is validated and a case is opened for ongoing services/treatment.

Case files will be organized as outlined below. (Chapter 70 Social Services Policy Manual)

Face Sheet

Form 450 - Basic Information Worksheet

Reporting

Form 431 - Child Abuse and Neglect Report
Form 451 – Targeted Case Management
Form 590 – Internal Data System Forms

Service Documentation

Form 452 – Contact Sheet
Form 453 – Intake Worksheet
Form 454 – Investigative Conclusion
Form 455 – Safety Plan
Form 457 – Risk Scale
Form 458 – Strength and Need
Form 387 – Case Plan Goals
Form 388 – Case Plan Steps
Form 460 – Re-Assessment Scale
Form 458 – Strength and Need Re-Assessment
Case Record Review Guide

Health

Physical Exam Reports
Dental Records/Reports
Psychological Reports/Psychiatric Evaluations
Health Appraisal Reports
Immunization Report/Records
Legal Documents

Petitions

Emergency Placement Order
Juvenile Court Complaint
Subpoena – Witness List
Birth Certificate
J.J./Notification to Client Assess to Records
Police Reports
Form 5459- Authorization Release of Information

Correspondence

General Letters-Incoming / Outgoing
Acknowledgment to Mandated Reporter
Form 713

PUP/HS/PA

Form P100 – PUP/Homestead/Parent Aide Authorization
Form 101 – PUP/Homestead/Parent Aide Cumulative Record
Related Invoices

Family Service Worker

Form 562 – Referral for Family Service Worker
Form 502 – Family Service Worker Activity Plan
Form 452 – Contact sheet used by Family Service Worker

Financial

Representative Payee Documentation
Expense Payment Authorization

Miscellaneous

Parenting Class Documents
Volunteer Services Documents
School Reports/Records
Child Death Report Form
Miscellaneous Referrals (Clothing, Food, Utilities, Subsidized Child Care)

Pictures

Diagrams/Drawings
Snapshots/Photos (Use manila envelope)

Case File Organization

Three-ring binders, as available, with notated index dividers, will be used to maintain all active cases. The services worker is responsible for maintaining the material according to foster care policy (1011.18) on retention of records. The filing in the binders and folders will be in chronological sequence in each section.

Case files will be organized as outlined below. (Chapter 70 social Services Policy Manual)

Basic Information

Form 450 - Basic Information Worksheet
Form 451 - Targeted Case Management
Form 590 - Internal Data System Forms
Initial AFCARS form

Legal

Court Orders
Deprivation Petition(s)
Juvenile Court Complaint(s)
Subpoenas
Form 3 – Voluntary Agreement to Place Child in Foster Care (Adoptive Planning)
Form 5 – Voluntary Agreement to Place Child in Foster Care
Form 518 – Termination of Voluntary Agreement to Place Child in Foster Care
Form 7 – Consent to Remain in Care
Form 9 – Consent to Drive a Motorized Vehicle
Form 11 – Acknowledgement of DFCS Driving Policy for Youth
Form 510 – Legal Services Request Report
Form 572 – Surrender of Rights/Final Release for Adoption (Biological Father)
Form 573 – Surrender of Rights/Final Release for Adoption (Parent)
Form 576 – Acknowledgement by Grandparents and /or Guardian
Form 577 – Acknowledgement of Surrender of Rights
Form 578 – Mother's Affidavit
Form 579 – Adoptive Mother's Affidavit
Form 580 – Disclaimer, Denial and Surrender of Rights
Form 581 – Withdrawal of Surrender
Death Certificate
Social Security Card

Case Plan

Family Assessment

Permanency Time Line
Family Strengths and resources: Prospect for Early Reunification
Permanency Prognostic Indicators
Form 419 – Background Information (Family Medical Info.)
CPRS – Case Plan Reporting System
Form 391 – Written Transitional Living Plan (if applicable)
Form 392 – Judicial Review Report (if applicable)
Case Review Notification Letters (if applicable)
J.J./Parental Notification of Access to Records

Placement Documentation

Form 6 – Family Foster home placement Agreement Between County DFCS
Form 40 – Agreement Supplement
Form 448 – Institutional Placement Agreement
Form 469 – Foster Child Information Sheet
Form 419 – background Information
Long Term Foster Care Agreement
Notification Form for Change in Case Plan/Services
Home Evaluation
Form 96 – (ICPC- 100B) Interstate Compact Reports on Placement Status/Child
Form 97 – (ICPC-100A) Interstate Compact Application Request to Place Child
Form 749 – Application for admission to Residential Child Care Agency
Level of Care Application
MATCH Application
MATCH treatment plan
MATCH utilization review guides

Financial

Request for Special Board Rate
Form 122 – Foster Care Referral Form
Form 123 – Interagency/Interoffice Update and Follow up
Form 526 – Foster Care Invoice Form 527 - Initial authorization of Foster Care
Form 529 – Authorization of Foster care Change/Termination
Vital Statistics

Birth Certificate
Death Certificate
Social Security Card

Correspondence

Form 713 – interagency/Interoffice Referral/Follow up
Form 5459 – Authorization Release of Information
Authorization Release of Information

General Letters
Incoming/Outgoing
Permission to Travel

School Records

Report Cards
Test/Examination Reports
Evaluation Reports
Other Educational Related Documents

Health

Form 535 – Authorization and Claim for Psychological, Psychiatric or Speech Therapy Services
Physical/Psychological/Psychiatric/Speech/Dental Records
Immunization Records

Family Services Worker

Form 562- Referral for Family Service Worker/chore Services
Form 502 – Family Service Worker Services,
Form 452 – Contact Sheet used by Family Service Worker (if applicable)
Accountability Form (if applicable)
EBT Family Services Worker/Recipient Receipt (if Applicable)
Handicapped Parking DRS 29 (if applicable)

Service Documentation

Form 452 – Contact Sheet
Case Record Review Guide

Pictures

Drawings/Diagrams
Snapshots/Photos (use manila envelope)

Social Services Documentation Requirements

CHAPTER 80

DOCUMENTATION

TABLE OF CONTENTS

SECTION	HEADING	PAGE
80.0	Introduction	10-10
80.1	Case Recording Content	10-10
80.2	Case Recording After the Development of the Safety Plan and Case Plan	10-13
80.3	Time Frames for Documentation	10-14
80.4	Use of Abbreviations	10-14
80.5	Formats	10-15
80.6	Documenting Decisions	10-17
80.7	Names, Courtesy and Professional Titles	10-18
80.8	Page Numbering	10-19
80.9	Corrections/Changes/Inserting Information in Case Recording/ Falsification of Records	10-21

APPENDICES

Appendix A **Subjective, Vague, and Judgmental Terms**
Appendix B **Glossary of Abbreviations**

CHAPTER 80

DOCUMENTATION

80.0 INTRODUCTION

The case record is the official comprehensive account of activities relating to a specific client or family unit. Two primary components of the record are:

(1) The case narrative, which is the written documentation of case contacts by case managers, supervisors and other agency personnel and

(2) Required forms, formal assessments (such as family assessments, psychological test, case plans) and information related to medical, psychological, legal and financial aspects of the case.

The case record serves as an administrative tool used to provide information concerning the case to state and county administrators. It is also a vital resource for the agency in providing continuity of service to the family and as a resource if the case requires court action. The case record may also be seen by auditors, the legal community and, in some instances, the media. Therefore, accurate, timely documentation significantly impacts the credibility of the worker as a professional and the agency as a responsible institution.

80.1 CASE RECORDING CONTENT

REQUIREMENT

Documentation shall include the following types of information:

- Facts
- Observations
- Interpretations
- Decisions

80.1 PROCEDURES

1. Documentation of facts, observations, interpretations and decisions in case recording:

10-10

Facts are client activities, agency actions or information from official records or documents. In addition, facts may be straightforward descriptions of circumstances.

Example: Mrs. White called the office today and asked for childcare services for her children while she is in substance abuse treatment.

Observations are recorded notes about the client, condition of the home, physical injury and/or behavior seen by the case manager or seen and reported to the worker by others. When recording observations, the source of the information must be clear.
Example: The case manager observed Mrs. Lee crying and clenching her fist.
Example: Ms. June Allen, aunt, reported seeing Jack playing in the street at 5 P.M.

Interpretations are the case manager's opinions or conclusions, based on facts and observations. When recording an opinion, document clearly that this is an opinion and supply ample evidence to support it.

Example: The client reported she frequently has to leave work to return home to see about her children because her husband leaves them alone. It is the opinion of the case manager that Mrs. Christian needs childcare, as she has no one to care for her children while she is at work.

Decisions in cases are based on program policy and good practice principles. They are supported by documented facts, observations and interpretations. It is also important to document supervisory consultation and approval, staffings, and other consultation received in making a decision. The four-step assessment process of 1) gathering information 2) analyzing information 3) drawing conclusions and 4) making decisions would be applied in this process. These decisions provide the basis for actions in a case.

2. All narratives shall include:

- Month, day and year of contact
- Case Manager's full name on each page (or for each entry if more than one person documents on a page of Form 452)

- Type of activity (telephone contact, home visit, visit to school, etc.) and where it occurred. Use words to indicate who initiated the contact, such as "to", "from", "received", "sent"
- Who was contacted (see 80.7)
- Purpose of contact
- Significant information or observations **10-11**

3. It is not necessary to repeat what has been said in previous entries or is recorded on intake or assessment forms. The documentation may refer to previous entries or to a form for information not included on the Form 452.

   Example: "The condition of the home as observed on 01/10/02 (page 9) remains the same."

   Example: "Case Manager met with Ms. Jones on this date as planned to complete the CPS Investigation. We discussed (and then list the items). See Form 454 for additional information obtained."

4. When documenting **dates,** enter the month, day and year.
   Example: "by 9/01/01", not "by next week."

5. Subjective or vague terms are not to be used in isolation. If used, vague or subjective terms must be clarified by clear descriptions.
   Example of using descriptive terms rather than a vague word: Instead of recording, "Mrs. Jones will obtain adequate housing", record, " Ms. Jones will obtain adequate housing that at a minimum has running water, electricity, two bedrooms, bathroom and kitchen."
   See Appendix A for a list of vague terms.

6. Judgmental terms shall not be used in case recording. **Exception:** Judgmental terms may be used ONLY when quoting someone.

   Example of Avoiding Judgmental Terms: Instead of saying, "The family is dysfunctional", say, "I observed Mr. and Mrs. Guy and children, Lauren, Jason, and Mark yelling and screaming at each other."

   See Appendix A for a list of judgmental terms.

7. Avoid words/phrases such as "appeared", "seems to be", "apparently", which may indicate observations are uncertain. These words may infer confusion or uncertainty later or in court.

8. Labels such as "alcoholic", "schizophrenic" and "mentally retarded" shall be used **ONLY** when a certified or licensed professional has made such a diagnosis or when quoting someone.

Example: Instead of saying, "Mrs. Rush is an alcoholic", it is better to say, “CM observed that Mrs. Rush staggered when she walked, her speech was slurred and difficult to understand, her breath smelled of alcohol and her eyes were red.” **Example:** "Julie's grandmother said, 'It is embarrassing to have a mentally retarded grandchild.' "

80.1 PRACTICE ISSUES

1. Black ink shall be used for forms and case recording.

2. Entries must be legible, including signatures. If the case manager's signature is not legible, the name must be printed under it. When the name of the recorder is typed, it is to be initialed by that person.

3. Case records are professional documents subject to subpoena. Documentation in the case record shall be done in a professional manner by adhering to program policy and Chapters 70 and 80. Recording shall be as brief as possible, but as detailed as necessary, to achieve the purpose of the documentation.

4. Notes written on Post-its or other pieces of paper and notes glued or taped in the record are not permanent forms of case recording. **Exception:** Notes written by others may be affixed to a blank Form 452 or sheet of paper and included in the appropriate section of the record.
   Examples: Notes from a child’s teacher, a physician’s instructions or comments written on a prescription sheet.

   Note: It may be necessary for the case manager to add explanatory comments to the page on which such notes are attached. These should be cross -referenced on the 452 by date.

80.2 CASE RECORDING AFTER THE DEVELOPMENT OF SAFETY PLAN AND CASE PLAN

REQUIREMENT

Documentation entries must reflect the individual and/or family’s progress in following the safety plan and achieving the case plan goals. Should there be changes or an amendment to the case plan, this must be documented. In court-ordered case plans, the necessary steps to obtain the court’s approval of such changes must be documented as well.

10-13

80.2 PROCEDURES

All mandated face-to-face monthly contacts with the family should include:

- Month, day and year of contact
- Worker's full name on each page (or for each entry if more than one person documents on a page of Form 452)

- Type of activity (telephone contact, home visit, visit to school, etc.) and where it occurred. Use words to indicate who initiated the contact, such as "to", "from", "received", "sent".
- Who was contacted (see 80.7)
- Purpose of the contact
- Significant information or observations
- Assessment of the progress on case plan goals
- Safety issues/effectiveness of protection plan
- The result of the contact and when applicable, the plan for the next contact
- Specific program policy requirements for case documentation

80.3 TIME FRAMES FOR DOCUMENTATION

REQUIREMENT

All case events must be recorded on appropriate forms within a maximum of 30 days of occurrence. Exception: **All documentation of a CPS investigation shall be completed within the 30-day investigation period (See CPS Manual 2104.39).**

80.3 PRACTICE ISSUES

The following special circumstances may effect time frames for completion of documentation:

- **Waivers for completion of a CPS Investigation (see CPS Manual 2104.28)**
- Child death or serious injury (see CPS Manual 2108.4)
- Requests to inspect records under the Open Records Act (see CPS Manual 2109.4)

80.4 USE OF ABBREVIATIONS

REQUIREMENT

The use of abbreviations in case recording is optional. Any abbreviation used shall be from the official Glossary of Abbreviations (see **Appendix B**) and/or from a local list developed by the county. **(The county list must not conflict with the Appendix B list).**

10-14

80.5 FORMATS

REQUIREMENT

The following formats are approved for case record documentation and may be used unless program requirements dictate otherwise:

- Process
- Summary
- Combination

80.5 PROCEDURES

1. Process Format

Process is a specific narrative of facts, observations, interpretations, and/or decisions written in chronological order. The documentation includes who, what, when, where, how and why. The sequence of events and timing are important in this format. The question/answer investigative style (such as that used by law enforcement) is a form of Process Format.

Examples of occasions when Process Format may be used:

- Initial interview with a child or disabled adult alleged to be a victim of abuse or neglect.
- Interview with parents when assessing whether the safety plan is controlling high-risk situations.
- Presentation of a child to a potential adoptive resource

2. Summary Format

Summary is an organization of facts, observations, interpretations, and/or decisions collected from one or more contacts. The documentation includes who, what, where, when, how and why. However, rather than giving a chronological account (as in Process Format), Summary pulls together multiple contacts in one narrative entry or organizes material from one or more contacts under written topics.

Examples of occasions when Summary Format may be used:

- Family Assessment
- Child(ren) Study
- Series of activities necessary to accomplish a task, such as completion of a referral to home health
- OTI or other home evaluation **10-15**
- The same information was obtained from two or more people, such as from collaterals.
- Multiple contacts with the same individual
- Several individuals reporting the same information
- Multiple contacts with different people and different content, organized under topics.

3. Combination Format

Combination is utilizing summary and process formats together.

Examples of occasions when Combination Format may be used:

- Initial assessments in CPS and APS
- When needing to verify that a series of tasks were carried out in a timely manner even though the results were not accomplished, e.g., a referral was in time for the client to make necessary arrangements, yet she still did not keep the appointment.

80.5 PRACTICE ISSUES

Issues to Consider When Determining The Format To Use:

- How the information will be used now and over the life of the case
- Fulfillment of policy and statutory requirements
- Whether the source of the information, how the information was requested/obtained, and the sequencing and time frames would affect the actual meaning of the content.
  Example: In a sexual abuse investigation, a chronological record (Process Format) of the sequence of events can be crucial in preparing for court testimony.
- The experience and skill level of the staff person completing the documentation. Supervisors must determine if the case manager has the necessary knowledge and skills to use Summary Format. New workers, especially, should use this format only when their process dictation demonstrates accuracy: 1) in recording information; 2) in drawing conclusions based on information obtained and recorded and 3) in making sound decisions consistent with the information and conclusions recorded.

80.6 DOCUMENTING DECISIONS

REQUIREMENT

1. Case decisions, directives and/or recommendations made by the supervisor or designee, consultants, multi-disciplinary teams and/or panels **shall be** documented in the case record.

2. Differences of opinions in case decisions, directives and/or recommendations from the supervisor or designee, multi-disciplinary teams and/or panels **shall not** be included in the case record.

80.6 PROCEDURES

If there is a disagreement with other professionals regarding a case decision, the case manager should discuss with the supervisor professional ways to document this and the appropriate place for this documentation.

80.7 NAMES, COURTESY AND PROFESSIONAL TITLES

REQUIREMENT

1. Adults' names shall be documented in case narratives as follows:

   - By first and last name **at least once in each entry**

     Example: Ms. Sue Smith

     Example: Dr. John Jones

- Thereafter, courtesy title and last name may be used unless another individual in the household or interview could be confused for that person.

  Example: Ms. Smith

  Example: Dr. Jones

- Relationship titles such as “mother”, “grandmother”, “father”, “grandfather”, “aunt”, “uncle”, etc. may also be used after stating the first and last name at least once in each entry.

10-17

- Documentation shall **not** refer to an adult by first name only, unless this is the only information available.

Exception: The first name may be used for children who remain in foster care after age 18.

2. First names may be used to document names of children in case narratives. The term “child” may also be used to refer to a child in case recording, unless to do so would make the narrative unclear.

3. When known to the worker, professional titles shall be used in the case recording.

   Example: Professor John Landers

80.7 PROCEDURES

1. When using relationship terms, the case manager must clearly state to whom the party is related.

2. When there is only one individual in the case or in the interview, it is acceptable to use “client” or “customer” to refer to that individual.

3. Nicknames shall not be used in case recording unless quoting someone. Nicknames shall be noted on the Form 450, next to the legal name, for reference.

4. Use of the first person pronoun “I”, “case manager (CM)”, “worker”, and “family service worker (FSW)”, are acceptable ways to refer to the writer in the case recording.

10-18

80.8 PAGE NUMBERING

REQUIREMENT

All pages of Form 452 must be numbered and in chronological order in the case record.

80.8 PROCEDURES

1. Each time the case is opened the numbering on the Form 452 shall begin with "1" and continue consecutively until closed.

2. In already existing cases, the next time documentation is done, note the date the numbering system is beginning on Form 452 and begin with number “1”.

3. When the case record is in more than one binder/folder, each binder/folder must be labeled on the outside cover with dates of coverage for that binder.

Example: Volume 1: 2/17/01–8/10/01, Volume 2: 8/11/01–7/20/02, etc.

The numbering of Form 452 in each volume shall begin with “1”.

4. When documenting on the reverse side of the Form 452, both front and back pages are numbered consecutively.

5. If additional pages of Form 452 need to be added to the already existing case recording use the same page number where the information is to be inserted along with a letter of the alphabet (beginning with the letter “a”).

Example: If three additional pages were inserted after page 52, the numbering would be "52a, 52b, and 52c".

10-19

80.9 MAKING CORRECTIONS / CHANGES / INSERTING INFORMATION IN CASE RECORDING; FALSIFICATION OF RECORDS

REQUIREMENT

Administrative Services County Letter 94-12 states, "If any employee shall, outside established regulations, steal, alter, corrupt, falsify, forge, remove or destroy any record, document, correspondence, contract, conveyance, minutes, books, sound recordings, processing records of or belonging to the Department of Human Resources, or if any employee shall cause to be committed or procure the commission of any of these offenses, he shall be subject to disciplinary action up to and including immediate dismissal by the Department in addition to any civil actions which may be brought against such employee for such acts. Penalty for falsification of any record where the falsification presents the potential for endangerment of safety or security of a client or any person shall be immediate dismissal."

80.9 PROCEDURES

1. When correcting or making changes in the case record the following shall be done: Draw a single line through the original entry so it can still be read, and make the correction above the case recording. In the margin, where the correction starts, initial and enter the date the change is made. **NEVER USE WHITE-OUT/COLOR OUT WHEN MAKING CORRECTIONS.**

2. When inserting additional information or out-of-place entries onto a Form 452, write the entry in the next available space on the 452. Cross-reference this out-of-place entry and the place on the 452 in which it should have been recorded by noting in the margin by each, "misplaced entry".

10-20

APPENDICES

APPENDIX A

SUBJECTIVE, VAGUE AND JUDGMENTAL TERMS

The following lists give examples of subjective, vague terms and judgmental terms (these are not all inclusive lists). Subjective, vague terms are not to be used in isolation. If used, clarify by using descriptive words. Judgmental terms are used ONLY when quoting someone.

SUBJECTIVE, VAGUE TERMS

Abusive	Messy
Acting Out	Neat
Adequate	Neglectful
Angry	Nervous
Apparently	Nurturing
Appeared	Obviously
Appropriate	Offensive
As soon as possible	Physical
Clean/dirty	Proper
Cluttered	Quality
Good/poor/housekeeping	Regular
Good/poor/parenting skills	Seems to be
Happy/sad	Suitable
Healthy	Stable
Hostile	Unmotivated
Hyper	Upset

Hysterical	Verbal
Immediately	Tidy
Loud	Well cared for

JUDGMENTAL TERMS

Dysfunctional
Filthy
Junky
Lazy/Sorry
Nasty
Obnoxious
Promiscuous
Provocative
Slob
Ugly
Druggie/Doper
Crackhead

APPENDIX B

GLOSSARY OF ABBREVIATIONS

FAMILY RELATIONSHIPS

AMo	Adoptive Mother
AFa	Adoptive Father
BFa	Birth Father
BMo	Birth Mother
BP	Birth Parent
Fa	Father
FFA	Foster Father
FMo	Foster Mother
Leg/Fa	Legal Father
Leg/Mo	Legal Mother
Mo	Mother
PFa	Putative Father
SFa	Step-Father
SMo	Step-Mother
Dgt	Daughter
Bro	Brother
Sib	Sibling(s)
Sis	Sister
MGFa	Maternal Grandfather
MGMo	Maternal Grandmother
MGPs	Maternal Grandparents
PGFa	Paternal Grandfather
PGMo	Paternal Grandmother
PGPs	Paternal Grandparents
M/A	Maternal Aunt
M/U	Maternal Uncle
P/A	Paternal Aunt
P/U	Paternal Uncle
Fa/L	Father-in-Law
Mo/L	Mother-in-Law
Dgt/L	Daughter-in-Law
Son/L	Son-in-Law

Bro/L	Brother-in-Law
Sis/L	Sister-in-Law

GENERAL TERMS

Adop/Asst	Adoption Assistance
ADL	Activities of Daily Living
AFCARS	Adoptive and Foster Care Analysis Reporting System
AH	Adoptive Home
A.K.A.	Also known as
AL	Annual Leave
ALJ	Administrative Law Judge
ANE	Abuse, Neglect, Exploitation
AHV	Announced Home Visit
AOD	Alcohol and other Drugs
Appt.	Appointment
APS	Adult Protective Services
ASAP	As soon as possible (requires a date)
Assm.	Assessment
Asst.	Assistance
@	At
Attn.	Attention
Atty.	Attorney
Auth.	Authorized/Authorization
BC	Birth Certificate
BSW	Bachelor of Social Work
CAN	Child Abuse and Neglect
CAPS	Child Care and Parent Services
CASA	Court Appointed Special Advocate
CC	Child Care
Ch	Child
Chn	Children
Cl	Client
COB	Close of Business
Col/C	Collateral Contact
Cont.	Continued
corr.	Correspondence
CP	Case Plan
CPR	Citizen Panel Review
CPS	Child Protective Services
CR/A	Case Review – Administrative
CR/J	Case Review – Judicial

CM	Case manager
CS	Child Support
CSEU	Child Support Enforcement Unit
CG	Caregiver
CT	Caretaker
Cust	Customer
DFCS	Division of Family and Children Services
DHR	Department of Human Resources
DJJ	Department of Juvenile Justice
DMA	Department of Medical Assistance
DOAS	Department of Administrative Services
DOB	Date of Birth
DOD	Date of Death
DOL	Department of Labor
EA	Emotional Abuse
EAP	Emergency Assistance Program
EEA	Emergency Energy Assistance
EMRG/A	Emergency Assistance
EMRG/PLC	Emergency Placement
EOM	End of Month
EPSDT	Early Periodic Screening Diagnosis and Treatment
ESC	Emergency Shelter Care
FBI	Federal Bureau Investigation
FC	Foster Care
ESC	Emergency Shelter Care
FFC	Family Foster Care
IFC	Institutional Foster Care
REL	Relative Foster Care
REL/H	Relative Home
RFC	Regular Foster Care
FH	Foster Home
FHFV	Foster Home Field Visit
TFC	Therapeutic Foster Care
FLSA	Fair Labor Standards Act
FP	Foster Parent
FS	Food Stamp
FSW	Family Service Worker
FV	Field Visit
GA	General Assistance
GBI	Georgia Bureau Investigation
GCIC	Georgia Crime Information Center
GSP	Georgia State Patrol
HB	House Bill (should be followed by a number)
H/Eval	Home Evaluation
Hm St	Home Study
HV	Home Visit
Hx	History
IA	Independent Adoption

ICF	Intermediate Care Facility
ICPC	Interstate Compact Placement of Children
IDS	Internal Data System
IEP	Individualized Education Plan
IL	Independent Living
ILC	Independent Living Coordinator
ILP	Independent Living Program
INS	Immigration and Naturalization Services
INV	Investigation
JJ	J.J. vs. Ledbetter
JL/JR	DFCS policy/procedure on the admission, treatment, and release of children from state operated psychiatric hospitals
Juv Ct	Juvenile Court
LCC	Local Coordinating Council
LCSW	Licensed Clinical Social Worker
LOC	Level of Care
LTC	Long Term Care
LTFC	Long Term Foster Care
LWOP	Leaving Without Pay
Maltx	Maltreater/Maltreatment
MAPP	Model Approach to Partnership in Parenting
GPS	Group Preparation and Selection
DT	Deciding Together
MATCH	Multi-Agency Team for Children
MH/MR/SA	Mental Health-Mental Retardation-Substance Abuse
Misc	Miscellaneous
MOU	Memorandum of Understanding
MSW	Masters of Social Work
Negl	Neglect
N/AP	Not Applicable
N/AV	Not Available (Needs to be followed by efforts made or plan to obtain information)
NCIC	National Crime Investigation Clearinghouse
NET	Non-Emergency Transportation
NH	Nursing Home
NHV	Nursing Home Visit
O.C.G.A.	Official Code of Georgia Annotated
OSAH	Office of State Administrative Hearings
OFA	Office of Fraud and Abuse
OJT	On the Job Training
Ong	Ongoing
ORS	Office of Regulatory Services
OTI	Out of Town Inquiry
OV	Office Visit
PA	Physical Abuse
PCR	Panel Case Review
PCH	Personal Care Home

PIC	Private Industry Council
PIP	Preventing Inappropriate Placements
PL	Public Law (needs to be followed by a number)
PLA	Placement of adults
PLC	Placement (includes Foster Care, Adoptions, etc.)
PMF	Performance Management Form
PMP	Performance Management Process
POB	Place of Birth
PPST	Psychological, Psychiatric or Speech Therapy
Pre-K	Pre-Kindergarten
PRV	Preventive
PSDS	Protective Services Data System
Psy	Psychological
PUP	Prevention of Unnecessary Placement
Rec'd	Received
Ref/s	Referral Source
Rep.P	Representative Payee
RD	Resource Development
RDS	Random Drug Screen
RIF	Reduction In Force
RMSS	Random Moment Sample Study
ROI	Release of Information
RSDI	Retired Survivors Disability Insurance
RSM	Right from the Start Medicaid
SA	Sexual Abuse
SAAG	Special Assistant to the Attorney General
SB	Senate Bill (should be followed by a number)
Sched	Schedule
SV	School Visit
SL	Sick Leave
Soc St	Social Study
SP	Safety Plan
SSA	Social Security Administration
SSBG	Social Services Block Grant
SSI	Supplemental Security Income
SSCL	Social Services County Letter
SSMT	Social Services Manual Transmittal
SSN	Social Security Number
Sub A	Substance Abuse
Supv	Supervisor
SW	Social Worker (non-DFCS)
TANF	Temporary Assistance for Needy Families
TC	Telephone call/contact
TCM	Targeted Case Management
Title VI	Part of the Civil Rights Act of 1964
TPR	Termination of Parental Rights
Tx	Treatment
UHV	Unannounced Home Visit

VA	Veterans Administration
VR	Vocational Rehabilitation Services
W/	With
W/O	Without
WIC	Women, Infant, and Children
WRTI	Without Regard to Income
WTLP	Written Transitional Living Plan
Yrs.	Year(s) old
IV-B	Title IV-B (State Funding Source-Some Federal)
IV-D	Title IV-D (State Child Support Program)
IV-E	Title IV-E (a Federal Funding Source)

MEDICAL

ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
AIDS	Acquired Immune Deficiency Syndrome
AMA	Against Medical Advice
ARBD	Alcohol Related Birth Defect
C/Dep.	Chemical Dependence
CNA	Certified Nursing Assistant
CVA	Cardiovascular Accident (stroke)
FAS	Fetal Alcohol Syndrome
FDP	Factious Disorder by Proxy
FTT	Failure to Thrive
FX	Fracture
HBP	High Blood Pressure
HD	Health Department
HHN	Home Health Nurse
HIV	Human Immunodeficiency Virus
Med	Medical
Meds/Rx	Medication
MI	Myocardial Infarction
MSP	Munchausen Syndrome by Proxy
PHN	Public Health Nurse
RN	Registered Nurse
Rx	Prescription
SIDS	Sudden Infant Death Syndrome
SUID	Sudden Unexplained Infant Death Syndrome
SNF	Skilled Nursing Facility

Tips for Case Recording

- **Include Necessary Documentation:**

1. Descriptive information - dates, names, levels of functioning, facts, details, environmental factors, content of the interview.

2. Transactive information- agreements/plans, interactions with others, process of interview.

3. Analytic information- worker's impressions, worker's assessment, worker's hypothesis based on the facts of the case.

- **Avoid Unnecessary Documentation:**

  1. Avoid information incriminating others

  2. Avoid evaluating comments

  3. Avoid unsubstantiated judgments

  4. Avoid incriminating remarks

  5. Exclude trivial, unnecessary, or "gossipy" information

  6. Avoid labeling and diagnosing

  7. Avoid information regarding conflicts with other professionals.

Is This Too Much Information?

1. I visited Mrs. Thelma Jones, mother of Susie Jones. She suspects housing manager (Mr. Smith) of theft. Says that several neighbors believe Mr. Smith enters their apartments when they are away. She has reported her theft to the police.

2. Mr. John Brown's clothing was soiled and dirty; there was a strong odor of urine in the apartment. Two windowpanes, kitchen and bathroom, were missing. The apartment was very cold. Mr. Brown stated that he was cold and hungry. There was no food in the house.

3. I visited the Simms family in their apartment to begin a CPS investigation. There were beer cans everywhere. Mr. Jay Simms has a problem with drinking. I believe he may be an alcoholic.

4. Ms. Allan told me about her sister's upcoming divorce. The brother-in-law has been having an affair with Ms. Watson (one of our clients).

5. Ms. Jessie James reported that she has been giving her TANF check to her boyfriend, Mr. Sam Kent, who is now sharing the apartment.

6. I visited Mr. Alan Young at his home. Mr. Young was acting a little crazy today.

7. Mr. Pete Owens, maternal uncle of Pat Owens, is still carrying junk into the apartment. I don't think he cares or wants to change.

8. Mrs. Lois Lane (foster mother) called at the last minute to say she could not transport Timmy Smith to the office for his visit. She has done this before and I am tired of putting up with her. Because of her, the visit will start late and I will be stuck here after 5:00

9. Mr. Chris Davis mentioned his neighbor; Ms. Tiny Thomas (one of our clients) is babysitting and not reporting the income.

10. CM attended a meeting at the school today (4-12-05) with school counselor, Patsy Evans, and foster parent, Harvey Antler, regarding foster child, Anna Moore. Ms. Evans stated that Anna needed to be tested again. Mr. Antler reported Anna was doing fine in the foster home and I think Ms. Evans is wrong about Anna's need for testing.

11. Mary Lamb is a spoiled child and nothing can be done with her.

12. Mrs. Priscilla Clifton was disoriented. She did not remember me and then insisted I was her sister. The apartment was littered with broken dishes and refuse.

Judy Smith Scenario

You are the case manager for this on-going CPS case and you have just returned from an unannounced home visit to Judy Smith on this date. You are about to document the visit. The visit was prompted by a call you received this morning from the Parenting Class instructor, Cindy Vaughn, stating that Ms. Smith did not attend the scheduled class yesterday. The visit went like this:

Ms. Smith met you at the door and said she was not having a good day but that you could come in if you wanted to. A man you did not know was stretched out on the couch in the living room watching cartoons with Ms. Smith's 3 year old daughter Janet. Ms. Smith made no attempt to introduce him and he did not look up from the TV. Janet smelled of urine and was dressed only in underpants. She did have her hair neatly braided with pink bows on each of her many braids. Janet was holding a cat and from the other smells in the house you decided the cat must be staying inside and in need of a litter box. The man and the cat were new additions since your last visit 2 weeks ago. The living room was uncluttered and the floor was clean.

Ms. Smith walked into the kitchen without comment and you followed her. You attempted to engage her in conversation but she did not respond. The kitchen sink was full of dishes with the overflow stacked on the counter. The dishes contained dried food that appeared several days old. Ms. Smith began to remove the dishes from the sink and prepared to wash them. You observed several roaches on the counter. The floor was sticky to walk on but looked as if it had been swept recently. You noticed empty cereal bowls on the table that appeared to have been used this morning. You decided to just wait and waited for a few minutes in silence. Finally, Ms. Smith began to talk. She told you that she and Janet had been to visit her sick mother in a town four hours away and just returned late last night. The man in the living room was her brother and he brought them home. He will be returning to his home later today. She said the trip was not planned as her mother had emergency surgery. She did not have time to clean up before they left and she stated she had been very upset the three days before they left due to worry over her mother's illness and her lack of transportation to go see her mother. Ms. Smith has not been willing to discuss her family at all on previous visits and you have no identifying information about them.

This CPS case had been substantiated for neglect three months ago. Ms. Smith had been depressed and was sleeping all day. Janet had been taking care of herself by eating dry cereal and sitting in front of the TV all day. Since services were initiated, Ms. Smith has been seeing a therapist and taking medication for her depression, attending parenting classes, working with an In-Home Parent Educator weekly to improve parenting skills and meeting with a Parent Aid each month to work on housekeeping, nutrition and organizational skills. She had been doing so well that you were about to staff the case with your supervisor to discuss closure.

Prior to the visit today, the entire home had been clean on each contact and Janet had been clean and supervised. You learned Ms. Smith missed her Parenting Class yesterday due to her trip. She stated that she notified the In-Home Parent Educator and the Parent Aid of the need to re-schedule and the Parent Aid is coming this afternoon. She did not have a number to contact the Parenting Class instructor. She finished the dishes before you left and was about to give Janet a bath. She stated that she has remained on her medication.

Georgia Department of Human Resources

CONTACT SHEET

PAGE NO. _____

CASE NAME: _____ CASE ID NO.: _____

Date **Staff Member** **Type Contact/Activity**	***Individual(s) Contacted, Purpose, Content, and/or Results of Contact***

Documentation Strategies

- Keep a notebook with a section divider for each case. Jot down notes as soon as the contact occurs. List dates and important information as well as telephone contacts related to the case and then refer to the notebook when using your tablet to document.

- Take a copy of the familyh plan on home visits. Use the plan to guide your discussion while updating the family progress on the plan. Use the notes you make to prompt your documentation.

- Some counties develop a form for foster parents to complete and submit each month with their invoices. The form may have a place to list any medical or counseling appointments, progress in school, reaction to visit, behavioral challenges that may have occurred during that month. This form can be filed in the Correspondence section of the record and referenced on the Form 452. This in no way takes the place of case manager visits to the foster home but can provide assistance in keeping up with the many documentation demands of a busy caseload.

- Because the tablets are so portable, many workers find that they can document while waiting for court or other meetings.

- Flextime is another helpful hint. You can arrange with your supervisor to come in early or stay late when the phones are not ringing to do documentation and then flex that time out within the week. Remember, any change from your regular schedule must be cleared with your supervisor.

- Some workers find that protected or quiet time is helpful in keeping documentation current. During this time, messages are taken and returned at intervals or when the protected hours are over.

- Talk to the workers in your county as well as your supervisor for additional suggestions.

- Don't get behind – As you fill out your mileage every month, document those visits so you will have a lot done timely.

Module Nine
FAMILY DYNAMICS IN CHILD MALTREATMENT

PURPOSE:

The Case Manager will be able to identify parent, individual, family and environmental factors, which contribute to child maltreatment.

LEARNING OBJECTIVES:

After completion of this module participants should be able to:

- Identify and evaluate stressors in family systems, and understand the contributing dynamics to child maltreatment in families.
- Identify different substances that are abused and, recognize the dynamics of a substance abusing family and know how to work with children affected by substance abuse.
- Identify domestic violence and demonstrate an understanding of DFCS policy regarding family violence.

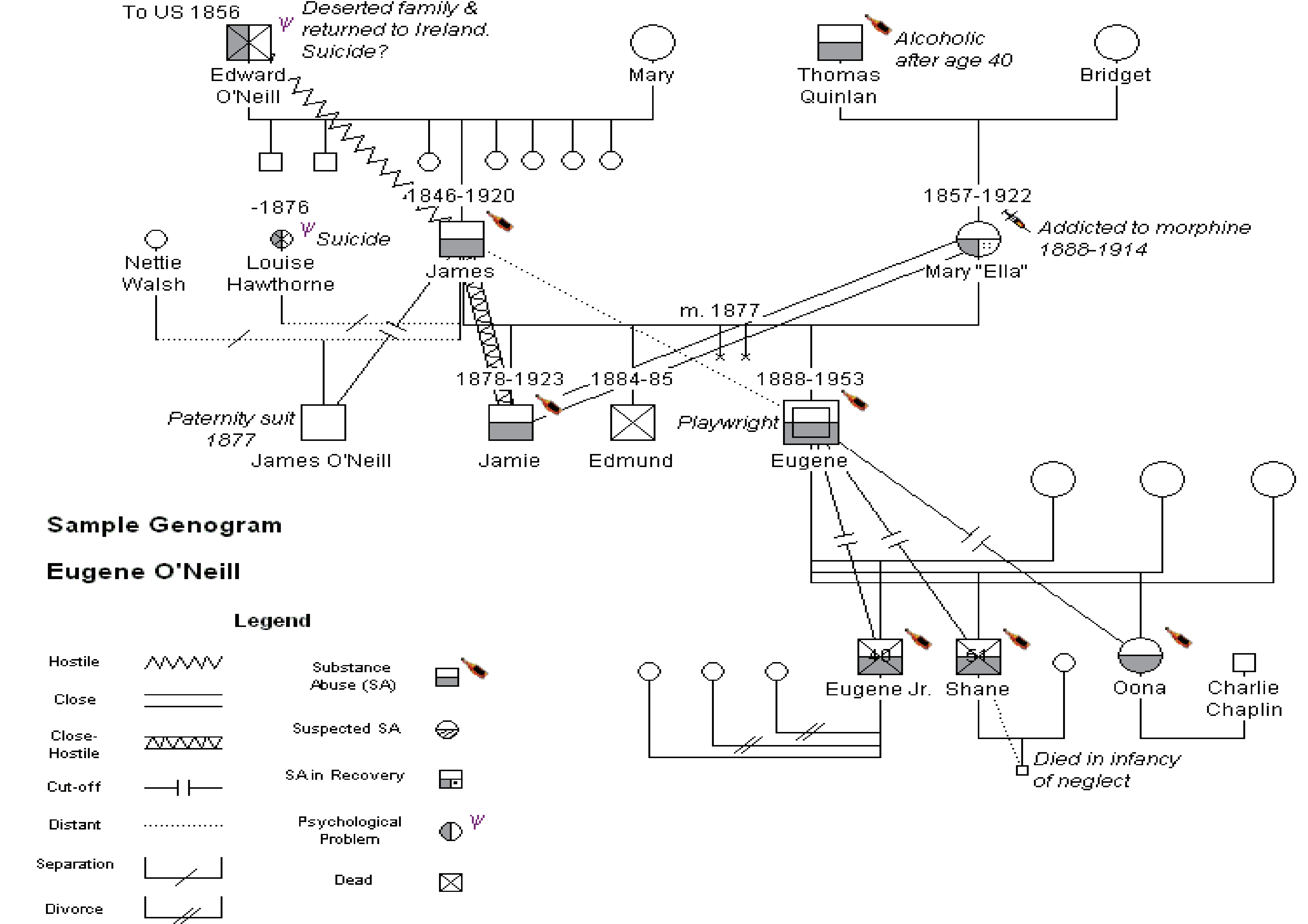
Four Essentials of Family Systems

1. Families are the primary influence of our lives.

2. History tends to repeat itself

3. Families move through time on a horizontal as well as a vertical continuum

4. Each member must maintain both separateness from and connectedness to the family.



To US 1856
Deserted family & returned to Ireland. Suicide?
Edward O'Neill
Mary
Thomas Quinlan
Alcoholic after age 40
Bridget
1846-1920
James
-1876
Suicide
Louise Hawthorne
Nettie Walsh
1857-1922
Addicted to morphine 1888-1914
Mary "Ella"
m. 1877
1878-1923
1884-85
1888-1953
Paternity suit 1877
James O'Neill
Jamie
Edmund
Playwright
Eugene
Sample Genogram
Eugene O'Neill
Legend
Hostile
Close
Close-Hostile
Cut-off
Distant
Separation
Divorce
Substance Abuse (SA)
Suspected SA
SA in Recovery
Psychological Problem
Dead
40
Eugene Jr.
54
Shane
Oona
Charlie Chaplin
Died in infancy of neglect

Standard Symbols for Genograms

Male | Female | Gay/Lesbian/Bisexual | Transgender People | Pet

Man to woman | Woman to man

Birth Date
'41-
written on left above of symbol

Age
'82-
23
written inside symbol

Death
1943-2002
59
an X through Symbol
Age at death in box
Death date on right above symbol

Location & Annual Income
Boston
$100,000
'72-
written above birth & death date

Significant Institutional Connection

AA
Therapist
m 1970
Therapist

Marriage
m 1970

Living Together or Affair
LT '95
LT = Living Together

Lesbian Couple
LT '90

Arranged Marriage
ar.*m '75

knew each other 2 years
Love marriage 04
2 yrs lo.*m '04

Marital Separation
met '88, LT '89, m '90 s '95

Divorce
m '90 s '95 d '97

Getting back Together after Separation or Divorce
s 95-96, s 96, d '97 remar '00

Children: List in birth order beginning with the oldest on left

'82- 13 Biological Child

'94- LW 98-99 11 Foster Child

'95- IA '97 10 Adopted Child

'97-'97 Stillbirth

'99 Miscarriage

'01 Abortion

'03- '03- Twins

'04- '04- Identical Twins

'05- Pregnancy

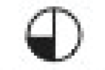
Symbols Denoting Addiction, and Physical or Mental Illness

Drug or Alcohol Abuse

Suspected Abuse

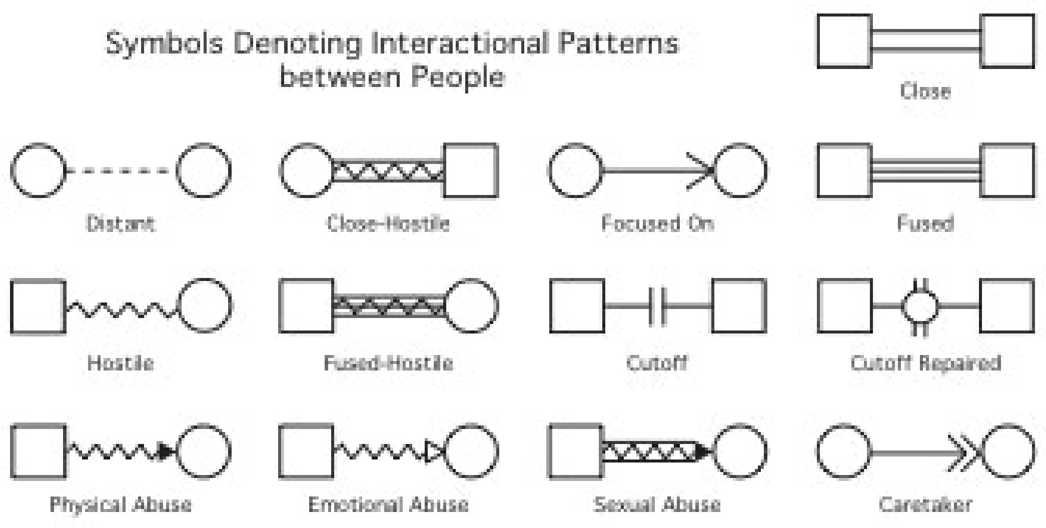
In Recovery from Drug or Alcohol Abuse

Serious mental or Physical problems


Recovery from Serious mental or Physical problems

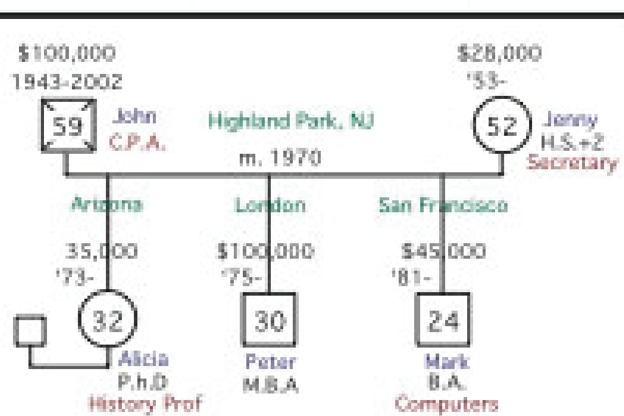
Serious mental and Physical problems

Recovery from Substance abuse and mental or Physical problems



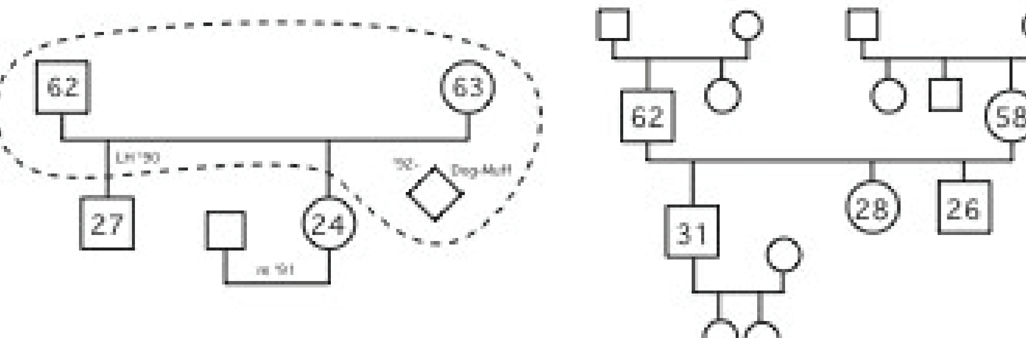
Annual income is written just above the birth & death date.

Typically you would include the person's occupation and education near the name and the person's whereabouts at the top of the line connecting to the symbol.



Household shown by encircling members living together (Couple living with their dog after launching Children)

Siblings of Primary Genogram Members are written smaller and higher. Spouses are written smaller and lower:



Eco-Map

Curtis Family

Health Care

Employment

Foster Parent Support Group

Religion

School

Social Welfare

Community

Friends

Local CMH

Neighborhood

Other Members Of the Family Network

Household Members

Aunt Beverly

Uncle Henry

Jon & Linda

Kentucky family

Carl

Ron

Mark & Joan

Strong Connection ______

Tenuous Connection -----------

Stressful Connection ///////

Flow of Resources ←→

CHARACTERISTICS OF FAMILY ROLES

	ENABLER	FAMILY HERO	SCAPEGOAT	LOST CHILD	MASCOT
CHARACTERISTIC AGES		Oldest child	May be second child	May be third child	May be youngest child
SCHOOL CHARACTERISTICS		Makes good grades	Fails in school	Quiet, shy, often goes unnoticed	Class “cut up”; class clown
OUTER CHARACTERISTICS	• Assumes responsibility for sheltering and shielding the impaired person from harmful consequences • Controller/Sufferer • Works hard keeping the troubled person looking good • Denies that the troubled person has a problem • Excuses the negative behaviors • Outsiders become enemies of the family • Becomes the cause of the other person’s negative behavior • Helps to mask the problem	• A leader • Lots of activities • Admired • Goes from accomplishment to accomplishment • Teachers brag about • Serious, seldom plays • Adult-like, extra mature • Seems to: “have it made”; “Have it all together” • Relatives dote on • Helpful at home\ • Successful away from home	• Rebellious • A “screw up” • Angry • May try to compete with the hero but loses out • Stops trying to please family, may withdraw • Compared to older brother or sister • Puts on “tough act” • Early chemical use • Girl may get pregnant • Runs with peers who are like him	Loner Ill at ease with others May read, listen to music or look at TV a lot Tries not to be a bother Strong attachment to animals No close friends	Happy-go-lucky Disruptive Hyper-energetic Family regards as fragile – in need of protection Keeps focus on self
INSIDE CHARACTERISTICS	• Realizes that there is a problem but will not accept the problem. • Feels weak to solve • Losses self respect	• Inadequate – never good enough • Scared, guilty, lonely	• Feels left out in family • Feels like misfit • Needs attention but can’t ask for it • Lonely, guilty, hurt	Feels different Feels like an outsider Low self worth Feels forgotten	Fearful-anxious (sees something is wrong but no one acknowledges it) Confused – in the dark May feel crazy

Enabling

How Enabling Works

- The enabler begins with a reaction of "What is wrong with me that they continue to use or act this way?" Stemming from feelings of inadequacy, the enabler begins to change his/her behavior to be "better" for the user or impaired person.
- Next, the enabler tries to change the immediate environment and balance it to appease the user or impaired person.
- Next, the enabler feels the urge to take on the whole world, to cover up and to protect the user or impaired person from the natural consequences of his/her continued use or behavior.
- To do all of this is to compromise one's self. Thus, the enabler begins to devalue himself and build a wall to separate him/herself from others.
- The next stage is to withdraw emotionally. One may participate in activities and verbalize feelings well, but withhold emotionally. Gray days are normal, and shame is pervasive.
- The pain becomes increasingly stronger and the Enabler wants to die emotionally. His/her moods, feelings, behavior, etc. are dependent and predicated upon the moods, feelings and behavior of the user or impaired person. The enabler is in a mode of constant reaction to unpredictability.
- At this point the enabler is starving for affection and attention, and will do almost anything to get affection.
- Frequently, the enabler plans to eliminate the use or behavior as a way out of his predicament. The enabler fantasizes about his/ her death, etc. but the enabler continues to manipulate and minimize the user's or impaired person's world just so the user will like him.

Don’t Talk

Don’t express feelings

Don’t address issues or relationships directly

Always be strong and perfect

Don’t be selfish

Do as I say and not as I do

It’s not okay to play

Don’t rock the boat

Mental Illness

- Diagnosed based on the nature and severity of an individual's symptoms
- Meets the criteria of DSM
- Dual Diagnosis

Indicators of Mental Illness

- ➢ Social Withdrawal
- ➢ Depression
- ➢ Thought Disorders
- ➢ Expressions of Feelings
- ➢ Behavior

Defintion of Substance Abuse

Substance Abuse is...

Excessive use of mind-altering substances, especially alcohol and/or illegal drugs, including prescription medication.

Use vs. Abuse vs. Addiction

Use…

Partaking of alcohol or drugs

Abuse…

The excessive use of mind-altering substances

Addiction…

The use of alcohol or drugs compulsively or habitually

THE DISEASE MODEL

- A brain disease
- Addiction results from a combination of factors
- Addiction is approached as a medical disease just like other medical conditions.
- Addiction is not caused by a failure of will or by deliberate misconduct.
- Addicted individuals cannot control their alcohol or drug use.
- The disease is chronic, relapsing, and fatal if not arrested.
- Abstinence is the only means for arresting the progression of the disease.

Denial is a defense mechanism (a usually unconscious mental device that an individual may use to protect their ego from shame, anxiety, or other unacceptable feelings or thoughts)

Actions That Demonstrate Denial

Denial causes substance abusers not to see the connection between using alcohol or other drugs and negative consequences

- **Rationalizing.** "I work better when I'm high."
- **Minimizing.** "The cop only gave me a warning and drove me home. If I was drunk I would have gotten a DUI."
- **Projecting.** "My husband thinks I shouldn't take any pills at all, give me a break!"
- **Diverting.** "I'll do something about my smoking when you do something about your weight."
- **Hostility.** "What gives you the right to judge me?"
- **Blaming**. "It wasn't my idea to go to that bar."

The Relapse Process

RELAPSE occurs when a person who has stopped using a substance begins to use it again.

- To stop using means being actively engaged in a recovery process, not a temporary period of sobriety

Triggers

↓

Relapse Mode

↓

Full Relapse

TRIGGERS

- External stressors
- Negative emotions
- Unpleasant physical states

THE RELAPSE MODE

- Withdrawing
- Not attending support meetings
- Failing to practice and use new skills
- Returning to denial
- Believing alcohol or other drug use is the only way to have fun or fix the problem.

FULL RELAPSE

- Can occur in varying degrees from single instance of use to an extended period of binging

Important Points To Remember When Dealing With Relapse:

- Expect relapse. Don't be shocked or angry.

- Help the person stay away from triggers.

- Realize the changes you are asking the person to make -- start over, move to new housing, and give up friends or family.

- Be alert; don't be drawn into denial and manipulation.

- Stay in touch with treatment resource.

Family System Rules
Pertaining to Substance Abuse

Use of the substance is the most important thing in the family's life.

Substances are not the cause of the family's problems.

Substance abuser is not responsible for their abuse.

Family maintains status quo by enabling.

No discussion of substance abuse among family or outsiders.

No one may express feelings.

Substances

Substance: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Intoxication Effects*/Potential Health Consequences
Cannabinoids			*euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination*/cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety; panic attacks; tolerance, addiction
hashish	boom, chronic, gangster, hash, hash oil, hemp	I swallowed, smoked	
marijuana	blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I swallowed, smoked	
Depressants			*reduced anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration*/fatigue; confusion; impaired coordination, memory, judgment; addiction; respiratory depression and arrest, death *Also, for barbiturates—sedation, drowsiness*/depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness, life-threatening withdrawal. *for benzodiazepines—sedation, drowsiness*/dizziness *for flunitrazepam*—visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects *for GHB*—drowsiness, nausea/vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death *for methaqualone—euphoria*/depression, poor reflexes, slurred speech, coma
barbiturates	*Amytal, Nembutal, Seconal, Phenobarbital;* barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V injected, swallowed	
benzodiazepines (other than flunitrazepam)	*Ativan, Halcion, Librium, Valium, Xanax;* candy, downers, sleeping pills, tranks	IV swallowed, injected	
flunitrazepam***	*Rohypnol;* forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV swallowed, snorted	
GHB***	*gamma-hydroxybutyrate;* G, Georgia home boy, grievous bodily harm, liquid ecstasy	I swallowed	

methaqualone	*Quaalude, Sopor, Parest;* ludes, mandrex, quad, quay	injected, swallowed	
Dissociative Anesthetics			*increased heart rate and blood pressure, impaired motor function*/memory loss; numbness; nausea/vomiting *Also, for ketamine—at high doses, delirium, depression, respiratory depression and arrest* *for PCP and analogs—possible decrease in blood pressure and heart rate, panic, aggression, violence*/loss of appetite, depression
ketamine	*Ketalar SV;* cat Valiums, K, Special K, vitamin K	III injected, snorted, smoked	
PCP and analogs	*phencyclidine;* angel dust, boat, hog, love boat, peace pill	I, II injected, swallowed, smoked	
Hallucinogens			*altered states of perception and feeling; nausea;* persisting perception disorder (flashbacks) *Also, for LSD and mescaline—increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors* *for LSD —persistent mental disorders* *for psilocybin—nervousness, paranoia*
LSD	*lysergic acid diethylamide;* acid, blotter, boomers, cubes, microdot, yellow sunshines	I swallowed, absorbed through mouth tissues	
mescaline	buttons, cactus, mesc, peyote	I swallowed, smoked	
psilocybin	magic mushroom, purple passion, shrooms	I swallowed	
Opioids and Morphine Derivatives			*pain relief, euphoria, drowsiness*/nausea, constipation, confusion, sedation, respiratory depression and arrest, tolerance, addiction, unconsciousness, coma, death *Also, for codeine—less analgesia, sedation, and respiratory depression than morphine* *for heroin—staggering gait*
codeine	*Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine;* Captain Cody, Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV injected, swallowed	
fentanyl and fentanyl analogs	*Actiq, Duragesic, Sublimaze;* Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	I, II injected, smoked, snorted	
heroin	*diacetylmorphine;* brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I injected, smoked, snorted	

morphine	*Roxanol, Duramorph;* M, Miss Emma, monkey, white stuff	II, III injected, swallowed, smoked	
opium	*laudanum, paregoric;* big O, black stuff, block, gum, hop	II, III, V swallowed, smoked	
oxycodone HCL	*Oxycontin;* Oxy, O.C., killer	II swallowed, snorted, injected	
hydrocodone bitartrate, acetaminophen	*Vicodin;* vike, Watson-387	II swallowed	
Stimulants			*increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness*/rapid or irregular heart beat; reduced appetite, weight loss, heart failure, nervousness, insomnia *Also, for amphetamine—rapid breathing*/ tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction, psychosis *for cocaine—increased temperature*/chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition, panic attacks *for MDMA—mild hallucinogenic effects, increased tactile sensitivity, empathic feelings*/impaired memory and learning, hyperthermia, cardiac toxicity, renal failure, liver toxicity
amphetamine	*Biphetamine, Dexedrine;* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II injected, swallowed, smoked, snorted	
cocaine	*Cocaine hydrochloride;* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II injected, smoked, snorted	
MDMA (methylenedioxy-methamphetamine)	Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I swallowed	
methamphetamine	*Desoxyn;* chalk, crank, crystal, fire, glass, go fast, ice, meth, speed	II injected, swallowed, smoked, snorted	
methylphenidate (safe and effective for treatment of ADHD)	*Ritalin;* JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II injected, swallowed, snorted	

nicotine	cigarettes, cigars, smokeless tobacco, snuff, spit tobacco, bidis, chew	not scheduled smoked, snorted, taken in snuff and spit tobacco	*for methamphetamine—aggression, violence, psychotic behavior*/memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction *for nicotine—*additional effects attributable to tobacco exposure, adverse pregnancy outcomes, chronic lung disease, cardiovascular disease, stroke, cancer, tolerance, addiction
Other Compounds			
anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise;* roids, juice	III injected, swallowed, applied to skin	*no intoxication effects*/hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; in adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics
inhalants	*Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl);* laughing gas, poppers, snappers, whippets	not scheduled inhaled through nose or mouth	*stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing*/unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death

*Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Most Schedule V drugs are available over the counter.

**Taking drugs by injection can increase the risk of infection through needle contamination with staphyloco hepatitis, and other organisms.

***Associated with sexual assaults.

Meth Messages to the Brain

- More Dopamine

- Hours later cell receptors turn off the flow of dopamine

- Brain cell releases enzyme to knock out extra dopamine

- With repeated use, the enzymes kill the dopamine cell

- Leads to a chemical change in the way the brain works

History of Methamphetamines

Early 1900's	**Known as Benzedrine - Used in nasal decongestants and bronchial inhalers; treatment of depression, narcolepsy, schizophrenia, alcoholism and obesity**
1940's	**Hitler took Benzedrine and mixed with other chemicals to create Methamphetamine. His army had the ability to fight for days without food or sleep. Japanese Kamikaze pilots took Meth to numb fears prior to diving their planes into American ships**
1960's	**Became available through prescriptions and a booming black market.**
1970's	**Use waned as many people overdosed and died**
Early 1980's	**Reappeared being used casually to heighten energy and lose weight quickly**
Present	**More pure and potent than in the past, drug is more dangerous and fatal.**

Signs of a Meth Lab

Although not in and of themselves conclusive evidence, the following could signal the presence of a meth lab.

- Unusual, strong odors (like cat urine, ether, ammonia, acetone, or other chemicals) coming from sheds, outbuildings, other structures, fields, orchards, campsites, or especially vehicles (older model cars, vans) etc.

- Possession of unusual materials such as large amounts of over-the counter allergy/cold/diet medications (containing ephedrine or pseudoephedrine), or large quantities of solvents such as Acetone, Coleman Fuel, Toluene, etc.

- Discarded items such as ephedrine bottles, coffee filters with oddly colored stains, lithium batteries, antifreeze containers, lantern fuel cans, and propane tanks.

- The mixing of unusual chemicals in a house, garage, or barn, or the possession of chemical glassware by person not involved in the chemical industry

- Heavy traffic during late night hours.

- Residences with operating fans in windows in cold weather, or blacked-out windows.

- Renters who pay their landlords in cash.

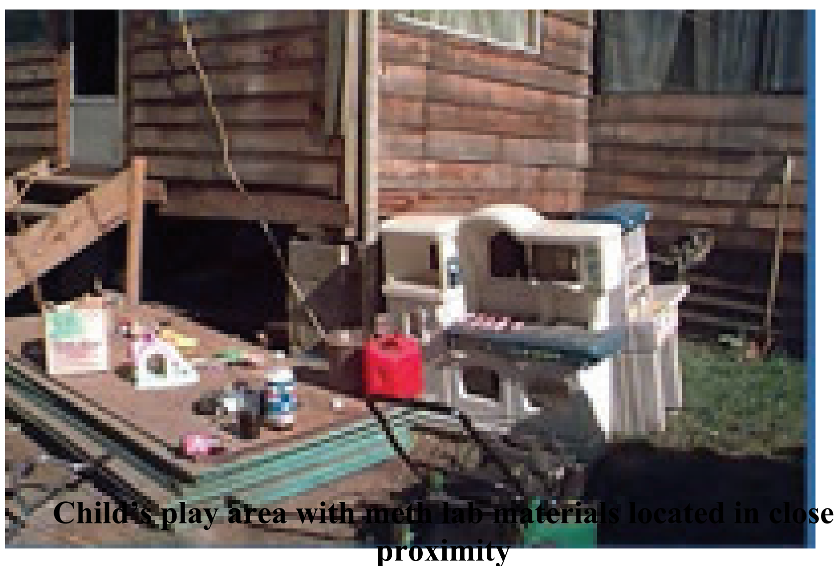
If You Suspect a Meth Lab

Seventy five percent of meth labs found in Georgia have been "stumbled upon". If you suspect a meth lab take these steps:

- Remain calm. Give yourself time to think.
- Do NOT approach the suspects.
- Do NOT enter the lab area.
- If you are in the lab already, find an excuse to leave immediately.
- Keep a safe distance.
- Follow all policies regarding meth labs.

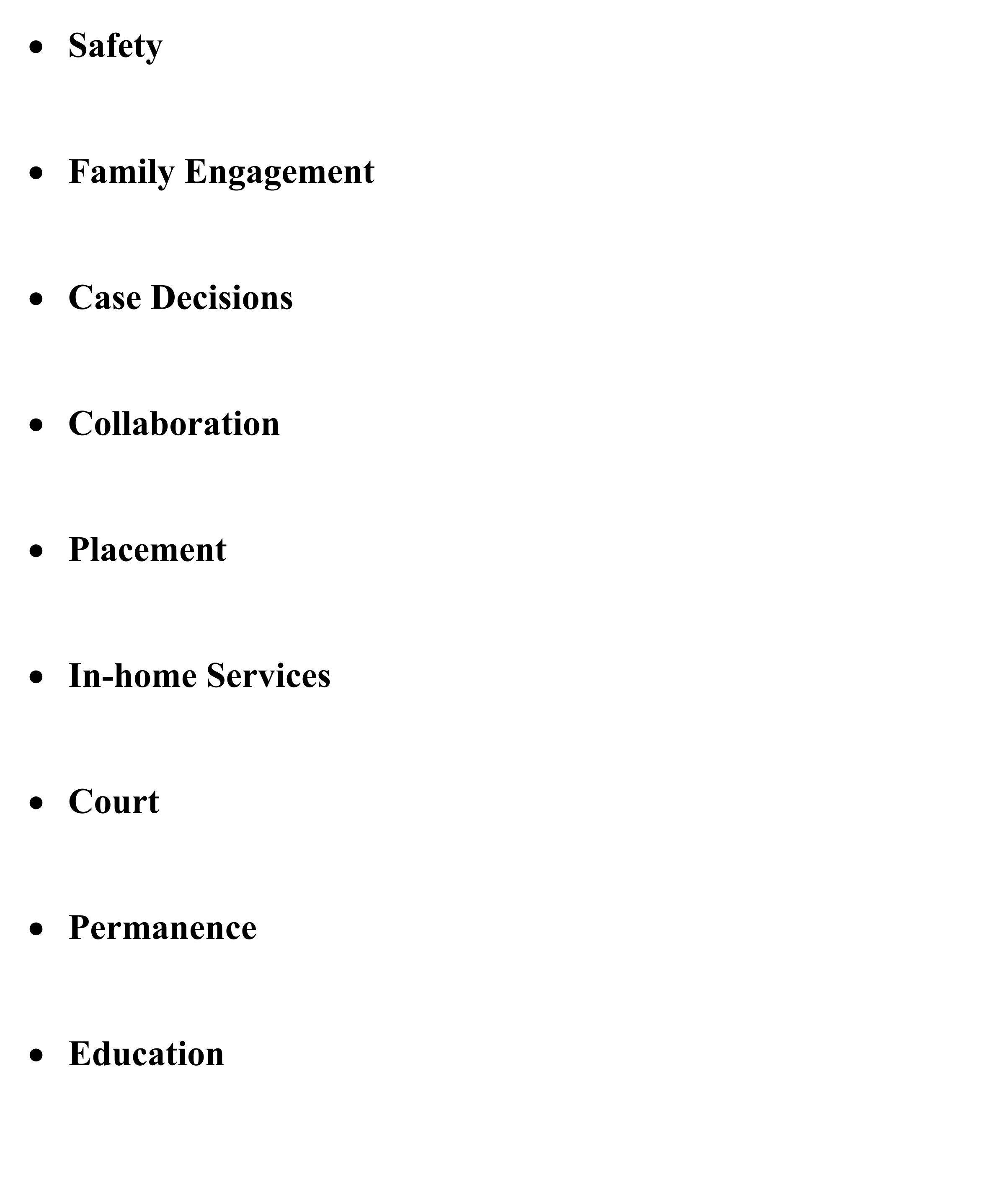
Dangers to Children Living in the Presence of Meth Labs

- Chemical contamination
- Fires and explosions
- Abuse and Neglect
- Hazardous Lifestyle
- Social Problems
- Other Risks



Child's play area with meth lab materials located in close proximity

Suggestions for Child Welfare Practice



The Effects of Substance Abuse on Parenting

It is important to remember that when a parent is involved with drugs or alcohol to a degree that interferes with his/her ability to parent effectively, a child may suffer in a number of ways:

- Parent may be emotionally and physically unavailable to the child.
- Parent's ability to provide protection may be seriously impaired.
- Parent may "disappear" for hours or days.
- A parent may spend the family's income on alcohol and/or other drugs
- Parent lacks resources.
- Parent may jeopardize child's health and safety by being involved in criminal activity.
- A child may be placed at increased risk for sexual abuse with the parent's substance-abusing friends coming in and out of the home.
- Parent may become incarcerated, depriving child of parental care.
- Exposure to substance abuse may contribute to the child's own substance abuse.

WHAT THE CHILD EXPERIENCES

- ✓ Broken Promises
- ✓ Inconsistency & Unpredictability
- ✓ Shame & Humiliation
- ✓ Tension & Fear
- ✓ Paralyzing Guilt & an Unwarranted Sense of Responsibility
- ✓ Anger & Hurt
- ✓ Loneliness & Isolation
- ✓ Lying as a Way of Life
- ✓ Feeling Responsible
- ✓ Feeling Obliged

Mrs. Glover

Key points

Family out of balance

Approach substance abuse in the same manner as other risks

Develop contingency plans

Consider non-substance abusing family members as the primary concern

Treatment begins with total abstinence

Substance abusers don't have to ask for help

Recovery means new friends, skills and values

Family members need to learn new behaviors

Family members need to hear it's not their fault

Helpful Services

- ✓ Substance Abuse treatment services
- ✓ Home-based services to build family skills
- ✓ Relocation out of an environment where drug or alcohol use is pervasive
- ✓ Financial Assistance and child care while in treatment
- ✓ SSI, TANF, Food Stamps, Child Support
- ✓ Frequent visitation
- ✓ Assistance with family violence issues

Family Violence is...

A pattern of assaultive and coercive behaviors, including physical, sexual, and psychological attacks, as well as economic coercion that adults or adolescents use to control their relationship with other persons living or formerly living in the same household.

- ***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

- Between January and August of 2003, there were 96 reported fatalities from acts of domestic violence in Georgia. In 2001 66 fatalities resulted from acts of domestic violence.
- The Georgia Department of Human Resources (DHR) reported that domestic violence crisis lines received 72,042 calls in 2002.   In 2001 DHR reported that domestic violence crisis lines received 62,801 calls
- According to the Georgia Crime Reporting Information Center a total of 49,946 cases were reported to Georgia law enforcement in 2001.
- 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 have experienced domestic violence while pregnant. Pregnancy is often a time of initiation and/or escalation of physical abuse.

Statements about Family Violence	*Why Society Supports* the Statement	Facts
Family violence does not occur in middle and upper social and economic classes.	Family violence is seldom recognized or acknowledged in middle and upper social and economic class families. Family violence in middle- or upper class families is usually met with polite silence.	Family violence occurs on all social and economic levels, in all educational, racial and age groups.
Family violence is a private matter. No one has the right to interfere in family affairs.	Society maintains polite silence in response to family violence. Battered persons may not be referred to treatment resources or for legal advice.	Family violence is not a private affair -- it is a tragic community problem and a major health problem facing this country.
If victims of family violence wanted to leave the relationship, they would and could at any time.	Some people insist victims get out of abusive relationships, with little or no understanding of how trapped the victims are either financially or physically.	Victims leave *when* they are able, based on resolving emotional and economic dependence, availability of resources and support. Women are at greatest risk of being killed when they try to leave a batterer.
Men are inherently more aggressive and violent than women.	'Boys will be boys" and similar stereotypical thinking reinforces that it is acceptable for men to be physical, even violent. Men or boys who are not physical or aggressive in their behavior are considered "sissy." Male victims of abuse are often disbelieved.	Battering is learned. Men who use violence to solve conflict and/or express frustration have learned that it is permissible to do so. Women also batter.
Alcohol causes family violence.	Stereotypical thinking and media portrayal of batterers often blames alcohol as the cause. “He was just drunk when he did it" is a thought many people use to excuse or deny the reality of family violence.	Studies show that 25% of battering cases involve alcohol. Drinking batterers may feel they can avoid responsibility for their behavior. Alcohol doesn't cause or excuse battering.

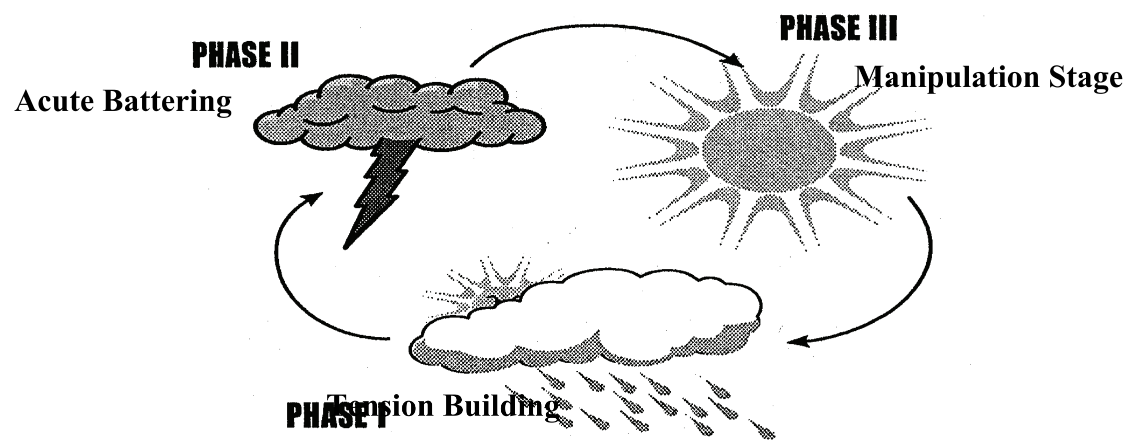
The Cycle Theory of Battering

Phase I -- Tension Building

Phase II -- Acute Battering

Phase III – Manipulation Stage

Additional Cycles -- Ongoing Repetition of Phases I, II, and III



Barriers to Leaving

- Fear
- Lack of shelter
- Protection
- Support
- Lack of employment
- Lack of legal assistance
- Immobilized by psychological and physical trauma
- Cultural/ religious/ family values
- Continuing to hope that the perpetrator will change
- Being told by others that the violence is the victim's fault

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,
- **Batterers traumatize children in the process of battering their victim**

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.

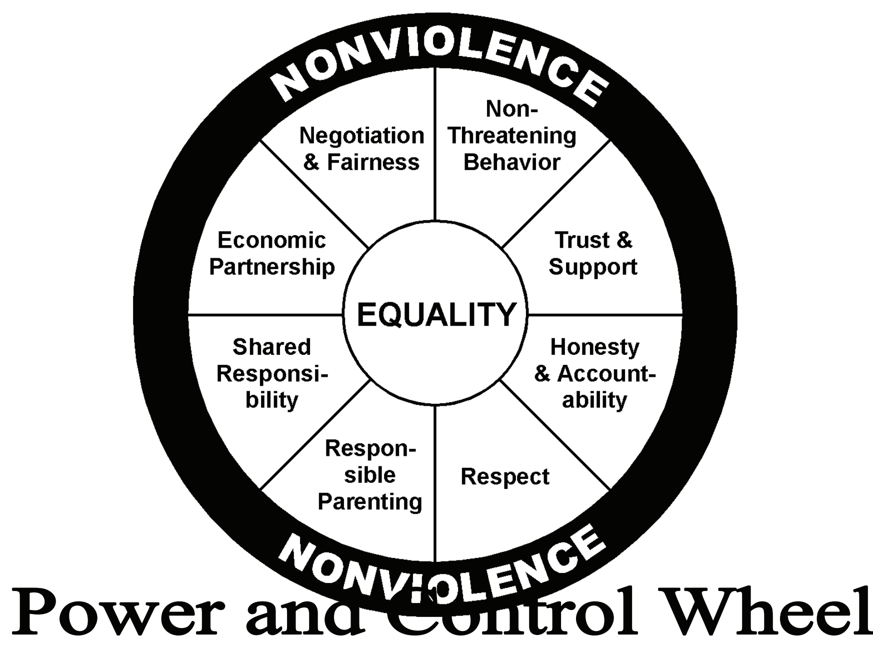
Jocelyn

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.

UNDERSTANDING FAMILY VIOLENCE

The Equality Wheel



Power and Control Wheel

Signs and Indicators of Family Violence that the Battered May Exhibit

Visible Signs of Abuse

- Bruises or injuries to the face, chest and arms, especially in various stages of healing.
- A batterer is frequently careful about where he injures the victim and may aim for the back, stomach or other body areas that are not visible when the victim is dressed.
- Victims often give very unlikely explanations for these injuries. If they do admit to being abused, they may minimize the violent incidents. Their partner may always be present when you meet with the victim.

Other Signs of Abuse

- Low self-esteem, which can manifest itself in many ways
- Victims may make derogatory statements about themselves and their abilities. They may have no confidence.
- They may be shy, timid, embarrassed.
- Victims may comment or complain of a jealous, possessive male partner. They may express fear of their partner's temper.
- Expressed problems with anxiety, insomnia or violent nightmares may be symptoms of abuse.
- Changes in appointment patterns -- for example, in a health clinic, either increasing appointments for vague complaints or frequently missing appointments for vague, questionable reasons.
- Victims may exhibit economic dependence on their mates -- they may defer questions about financial matters to them. They may have to ask their partners for permission to purchase or pay for something.
- The partner may try to answer all questions directed to the victim.
- Victims may express their distress in body language -- sighing, dropped shoulders, depressed appearance.
- Victims may be emotional -- they may cry easily or may be angry and defensive.
- They may ask questions or make comments about a friend who is abused.
- Victim's attempted suicide or self-directed abuse
- Once they have disclosed, victims may blame themselves, may express that they have no place and no one to turn to, they may deny or minimize the violence, or they may even defend their partner's behavior.

Signs and Indicators of Family Violence that Batterers May Exhibit

- Have an explosive temper;
- Criticize, denigrate or frequently “put-down” their mates;
- Want complete control over their mates, especially in a health care environment -- they may show up unexpectedly; may try to always be with their mate or may get extremely upset if their mate returns home later than expected.
- Be jealous and suspicious;
- Be impulsive, demanding and impatient;
- Be defensive, especially about inquiries regarding their mates;
- Have low-self esteem;
- May lament over unachieved goals; may express disappointment in their achievements or career, even if they are successful by other’s standards;
- Suffer from stress disorders.

Information on Shelter Core 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.

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 Ten
ASSESSING SAFETY AND RISK

PURPOSE: Introduce the roles and responsibilities of Child Protective Services case managers in keeping children safe.

LEARNING OBJECTIVES:

After completion of this module, the participant will be able to:

- Identify the broad range of responsibilities in Child Protective Services
- Understand the dual roles of the case manager regarding the authority to intervene to protect children from maltreatment and providing services that preserve and empower families
- List facts that must be evaluated when assessing the level of risk for a child, family strengths and safety factors that mitigate risk
- Identify strategies for a child's immediate safety and long-term risk reduction
- Articulate the basis of decision making in Georgia's child welfare services utilizing the Concept-Guided Risk Assessment process
- Utilize critical thinking skills to practice assessing allegations of substance or sexual abuse
- Identify best-practice standards of transitioning a family from receiving Investigative to Ongoing Services

SELF-EVALUATION: DEALING WITH YOUR AUTHORITY

The following statements relate in some way to your ability as a child protective services worker to deal with your authority as a representative of child protective services.

Read each statement selecting the word to fill in the blank that most closely describes what you do or feel in the particular situation.

Upon completion, add up your score. Be sure to answer honestly – your answer will not be shared with others. This is your self-evaluation. Each of the responses below is preceded with the following statements:

When conducting investigations…

1. I ___________ avoid stating to the parents why I'm there.

5 ___________	4 ___________	3 ___________	2 ___________	1 ___________
Always	More Often Than Not	Sometime	Seldom	Never

2. It is ________ easier for me to get an idea what is going on in a family if I avoid focusing on the alleged abuse or neglect.

5 ___________	4 ___________	3 ___________	2 ___________	1 ___________
Always	More Often Than Not	Sometime	Seldom	Never

3. I __________ hesitate to confront the parents if something they say is inconsistent or contradictory.

5 ___________	4 ___________	3 ___________	2 ___________	1 ___________
Always	More Often Than Not	Sometime	Seldom	Never

4. I am ________ apologetic during the interview. I may use statements such as, "I hate to keep asking you these questions, but its part of my job."

5 ___________	4 ___________	3 ___________	2 ___________	1 ___________
Always	More Often Than Not	Sometime	Seldom	Never

5. I __________ avoid asking questions which the parents would view as inflammatory.

5 ___________	4 ___________	3 ___________	2 ___________	1 ___________
Always	More Often Than Not	Sometime	Seldom	Never

6. I ___________ avoid being firm or confrontational with parents because I feel that it inhibits developing a therapeutic relationship.

5 ___________	4 ___________	3 ___________	2 ___________	1 ___________
Always	More Often Than	Sometime	Seldom	Never

Not

7. I ___________ avoid telling the parents what may result from the investigation, for example, submitting their names to the central registry.

5 ____________	4 ____________	3 ____________	2 ___________	1 ________
Always	More Often Than Not	Sometime	Seldom	Never

8. I ___________ feel personally attacked when the parents are hostile toward me or when they reject my offer for help.

5 ____________	4 ____________	3 ____________	2 ___________	1 ________
Always	More Often Than Not	Sometime	Seldom	Never

9. When the parents are hostile or uncooperative, I ________ feel I need to assert whatever power I can to control the situation.

5 ____________	4 ____________	3 _________	2 ___________	1 ________
Always	More Often Than Not	Sometime	Seldom	Never

10. Even if I know that the family is going to be resistant, I ________ find it difficult to know how to be more assertive and convincing.

5 ____________	4 ____________	3 ____________	2 ___________	1 ________
Always	More Often Than Not	Sometime	Seldom	Never

11. When I have to pressure the parents, I ________________ feel as though I have personally failed.

5 ____________	4 ____________	3 __________	2 ___________	1 ________
Always	More Often Than Not	Sometime	Seldom	Never

12. I ___________ find myself putting off conducting investigations (or seeing clients) who are uncooperative and/or resistant.

5 ____________	4 ____________	3 __________	2 ___________	1 ________
Always	More Often Than Not	Sometime	Seldom	Never

13. I __________ dread going out on investigations.

5 ____________	4 ____________	3 __________	2 ___________	1 ________
Always	More Often Than Not	Sometime	Seldom	Never

14. I ___________ feel unsure about what I can or cannot legally do during an investigation, particularly if someone challenges me.

5 ____________	4 ____________	3 __________	2 ___________	1 ________
Always	More Often Than Not	Sometime	Seldom	Never

15. I ____________feel as though I don't have enough information to make a decision as to whether abuse or neglect exists.

5 ____________	4 ____________	3 __________	2 ___________	1 ________
Always	More Often Than Not	Sometime	Seldom	Never

16. I _________ put off making a decision to remove a child, feeling as though I need more information.

5 ____________	4 ____________	3 __________	2 ___________	1 ________
Always	More Often Than Not	Sometime	Seldom	Never

17. The parents' story ______________ tends to convince me that they were not responsible for their child's condition, although I later find it to be untrue.

5 ______	4 ______	3 ______	2 ______	1 ______
Always	More Often Than Not	Sometime	Seldom	Never

18. I ________ feel my decision is disputable.

5 ______	4 ______	3 ______	2 ______	1 ______
Always	More Often Than Not	Sometime	Seldom	Never

19. I _________ prefer to provide ongoing services rather that investigate.

5 ______	4 ______	3 ______	2 ______	1 ______
Always	More Often Than Not	Sometime	Seldom	Never

20. When conducting investigations with police officers, I ______________ feel that they should be in charge.

5 ______	4 ______	3 ______	2 ______	1 ______
Always	More Often Than Not	Sometime	Seldom	Never

This activity was adapted from: Creative Associates Incorporated. (1981) Child Protective Services Supervisor's Guide. Washington, D.C.

TRAINER'S GUIDE: DEALING WITH YOUR AUTHORITY

Directions: Add up your score after completing the worksheet and determine what the scores mean based on the following scale:

The scale:

100 – 80	**You are not ready to be conducting investigations. Discuss your discomfort with your supervisor. Ask to accompany more experienced workers as they conduct investigations.**
80 – 60	**You are too uncomfortable with your authority. It has a definite effect on your effectiveness and job satisfaction. Your response sheet might indicate a pattern regarding the area of greatest discomfort. Ask your supervisor for assistance in overcoming these problems.**
60 – 40	**Your discomfort reflects an ambivalence toward your role and responsibilities. As a result, the effectiveness of your investigations is unpredictable and too dependent on your feelings at the moment. Work with your supervisor to resolve this ambivalence before you burn out.**
40 – 20	**You have a good understanding of your role and responsibilities. Any discomfort you feel is within the normal and acceptable range and probably does not interfere with the effectiveness of most of your investigations.**
20 - 0	**Did you answer honestly? If yes, bask in the satisfaction that very few workers ever achieve this level of self-assurance.**

Tips for Intake Case Managers

Listen carefully for subtle statements (for example): "She would be able to take care of her kids except for that good for nothing…never mind…" (referencing a boyfriend that we may not know about).

- Challenge report discrepancies at the end of the call. If you attempt to do so earlier, you will stop reporter from wanting to share.
- Don't just write down information; challenge yourself to understand it. Use your assessment skills.
- Always use Family-Centered practice. Keep in mind what will help the family, not just "gotcha" facts.
- Probe for family strengths as well as deficiencies to help identify supports for change. Remember you are the professional; the caller probably has not routinely made this report or similar calls before. Your job is to *probe* for more information than the caller *even knows they know* about the family.
- Look for ways to educate the public as to what they can do to keep children safe, in addition to what DFCS and other service organizations provide.
- The skills practiced here today can be used in any interview. All case managers, in all programs, should probe for additional information.

Definition of Critical Thinking

"Critical thinking is a *disciplined process* of actively and skillfully conceptualizing, applying, analyzing, synthesizing and/or evaluating information gathered from, or generated by, observation, experience, reflection, reasoning, or communication as a guide to belief and actions."

8 Characteristics of Critical Thinking

1. Ask questions
2. Define a problem
3. Examine evidence
4. Analyze assumptions and biases
5. Avoid emotional reasoning
6. Avoid oversimplification
7. Consider other interpretations
8. Tolerate ambiguity

Critical Thinking in CPS

When the worker…

- **Recognizes relevant information**
- Determines what it means
- Makes decision to protect child
- Clearly communicates the process

Errors in Critical Thinking

Errors in Critical Thinking	Case Example	How to Avoid Error
1. Staff based assessments of risk on a narrow range of evidence.		
2. Judgments were biased toward information readily available to them.		
3. Judgments were biased toward evidence that was vivid, concrete, arousing emotion and either the first or the last communication received.		
4. Evidence was often faulty due to biased or dishonest reporting or errors in communication.		
5. Professionals were slow to revise their judgments despite a mounting body of evidence against them.		

1999, Eileen Munro

Risk and Safety Decision Worksheet

DIRECTIONS: Read your assigned scenario and Decide either:

- What decisions/actions would you make/take to assure the child is safe tonight?

- What decisions/actions would you make/take to assure the child is not at risk of harm in the future?

Scenario #1: A mother passes out frequently from substance abuse and is unable to care for her 6-month-old child.

Scenario #2: A father spanked his 2-year-old daughter with a belt and left bruises on her back and buttocks. This was the third incident within the past two months. The mother was working during each incident.

Scenario #3: A 12-year-old boy reports to school at least once a week with bruises. He has also come with a black eye on several occasions. The child reports that his mother allows his older siblings (16, 19) to beat him when he misbehaves. The father is remarried with another child but still lives in the area.

Scenario #4: A mother leaves her 2, 4 and 7 year old children alone when she goes out with friends. The neighbors have witnessed this occurring on several occasions and it appears to be happening more frequently.

Case Process Continuum

CPS	**PLC**	*Adoption*
Intake	Entry into FC	***Pre-Adoptive PLC***
Investigation	CCFA	***Adoptive PLC***
Safety Assessment/Plan	Case Plan	***Post-Adoptive PLC***
Risk Assessment	Case Management	***Finalization/Closure***
Family Plan	Closure	
Case Management		
Closure		

Form 453
Intake Worksheet

County: *

Report Date: 6/13/2005 Time: 1:23 PM

Reporter Information

Mandated Reporter: ○ Yes ⦿ No

Last Name: First Name: Middle:

Reporter Code

Reporter County

Address

Telephone Numbers:

Type: Select...

Add a phone number

City:

State: Zip:

Confidentiality Explained: ○ Yes ○ No

Date Mandated Reporter Letter Sent:

Case Information

Primary Client

Existing Case Number (if applicable):

Last Name: First Name Middle Name

Address:

Telephone Numbers:

Type: Select...

Add a phone number

City

State: Zip:

Directions to Home:

Family Information

Primary Caretaker

Last Name: * First Name: Middle Name:

Birth Date: Sex: ○ M ○ F

Age: SSN: Alleged Maltreater: ☐

Relationship:

Race: ☐ White

Children

Last Name: * First Name: Middle Name:

Birth Date: Sex: ○ M ○ F

Age: SSN:

Race:
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Unable to determine

Hispanic/ Latino Ethnicity:

AM:

Add Allegation

Location: *

Add Child

Other Household Members

Last Name: First Name: Middle Name:

Hispanic/Latino Ethnicity: DOB:

Sex: ○ M ○ F SSN: Relationship:

Race:
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaskan Native
- ☐ Native Hawaiian/Other Pacific Islander

Reporter's Allegations

Alleged Maltreater

Last Name : Last Name : Middle Name :

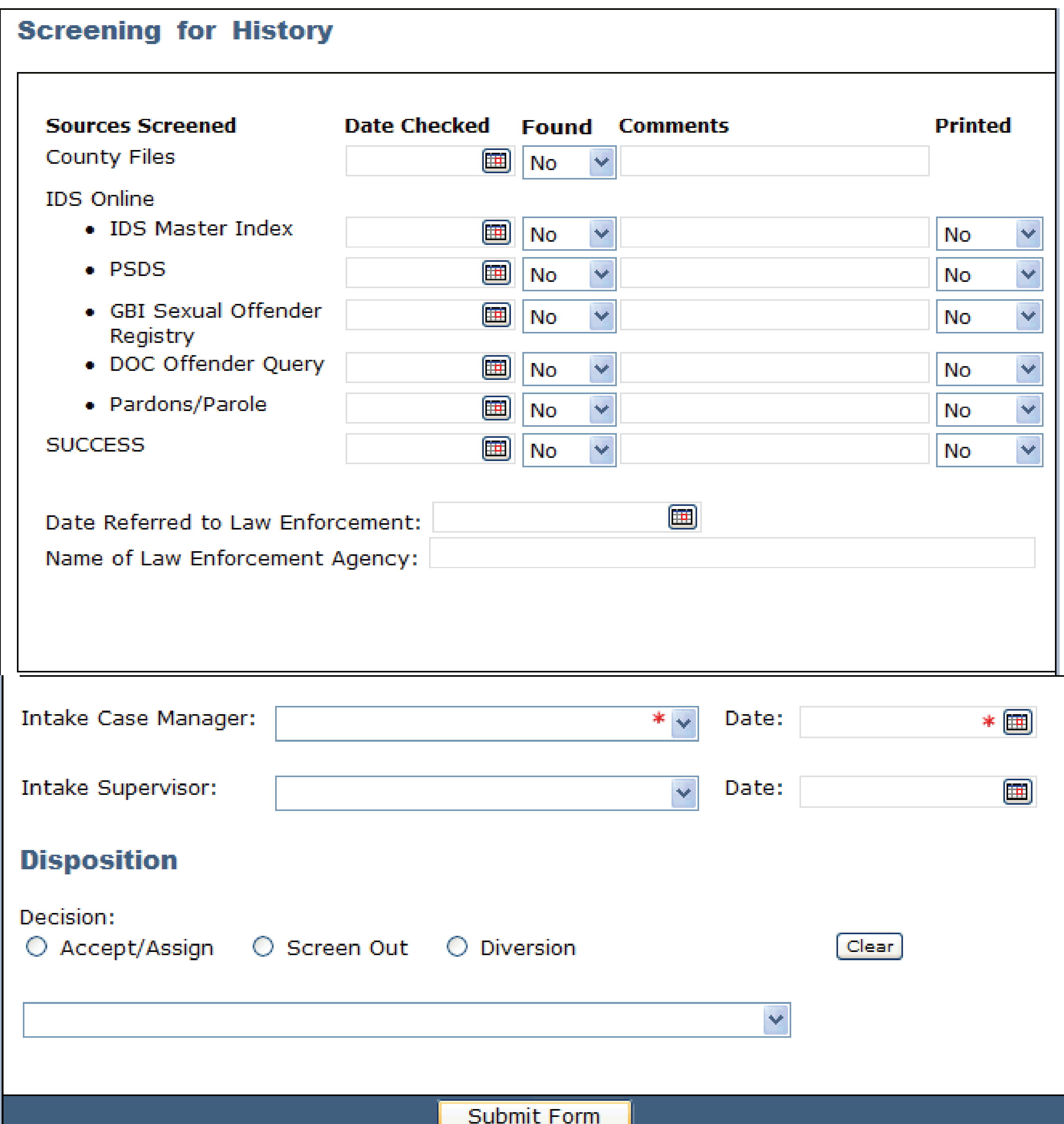
Sex: ○ M ○ F

Relationship to Victims:

Address :

City: State: ZIP:

Telephone Numbers:



Screening for History

Sources Screened	Date Checked	Found	Comments	Printed
County Files		No		
IDS Online				
• IDS Master Index		No		No
• PSDS		No		No
• GBI Sexual Offender Registry		No		No
• DOC Offender Query		No		No
• Pardons/Parole		No		No
SUCCESS		No		No

Date Referred to Law Enforcement:

Name of Law Enforcement Agency:

Intake Case Manager: * Date: *

Intake Supervisor: Date:

Disposition

Decision:

◯ Accept/Assign ◯ Screen Out ◯ Diversion Clear

Submit Form

Basic Information Worksheet

Case Information

Case Number: * County: *

Case Worker : Supervisor:

Adult(s)

Primary Client

Last Name: * First Name: Middle Name:

Sex ○M ○F

Address:

Telephone Numbers:

Type: Select...

Insert item

City:

State: Zip:

Hispanic/Latino Ethnicity: DOB:

SSN: Medicaid No:

Education: Relationship:

Race:

- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ American Indian/Alaskan Native
- ☐ Unable to determine

Current Employment Of Primary Caretaker

Name of Employer:

Address: Telephone Numbers:

Type: Select...

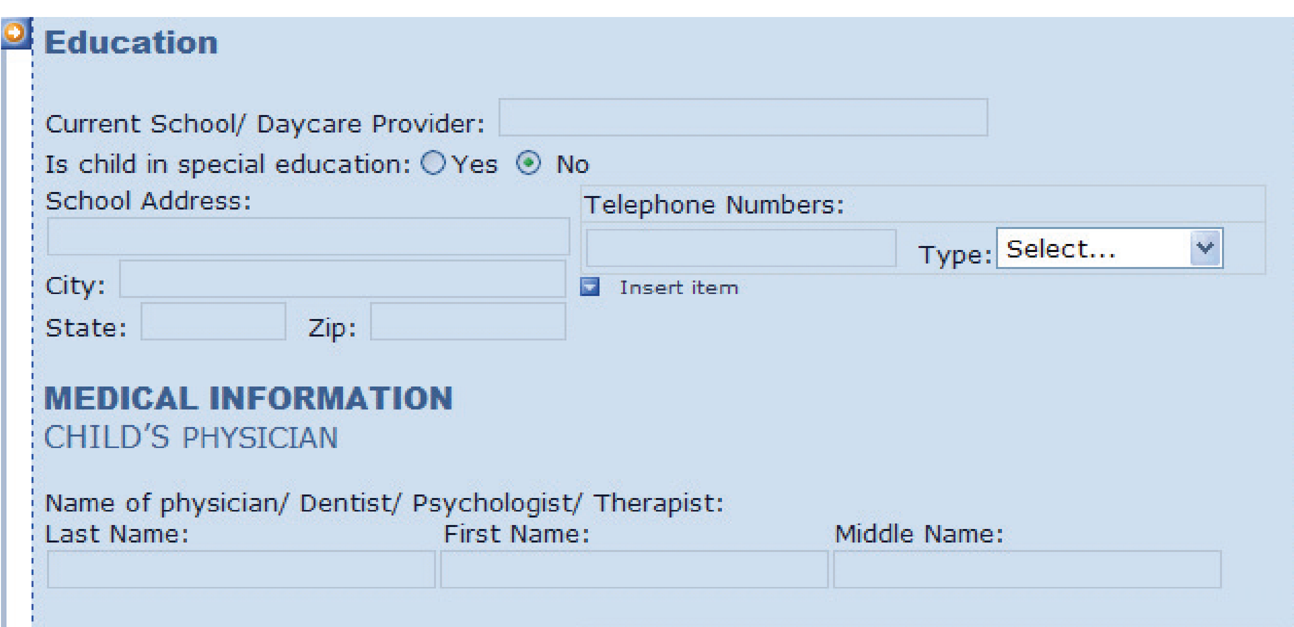
Secondary Caretaker

Last Name: First Name: Middle Name:

Sex ○M ○F

Telephone Numbers:

Type: Select...



Education

Current School/ Daycare Provider:

Is child in special education: ◯ Yes ◉ No

School Address:

City:

State: Zip:

Telephone Numbers:

Type: Select...

Insert item

MEDICAL INFORMATION

CHILD'S PHYSICIAN

Name of physician/ Dentist/ Psychologist/ Therapist:

Last Name: First Name: Middle Name:

Preferences:

Daily Routine (sleep or eating schedule, type formula):

Religious Preference:

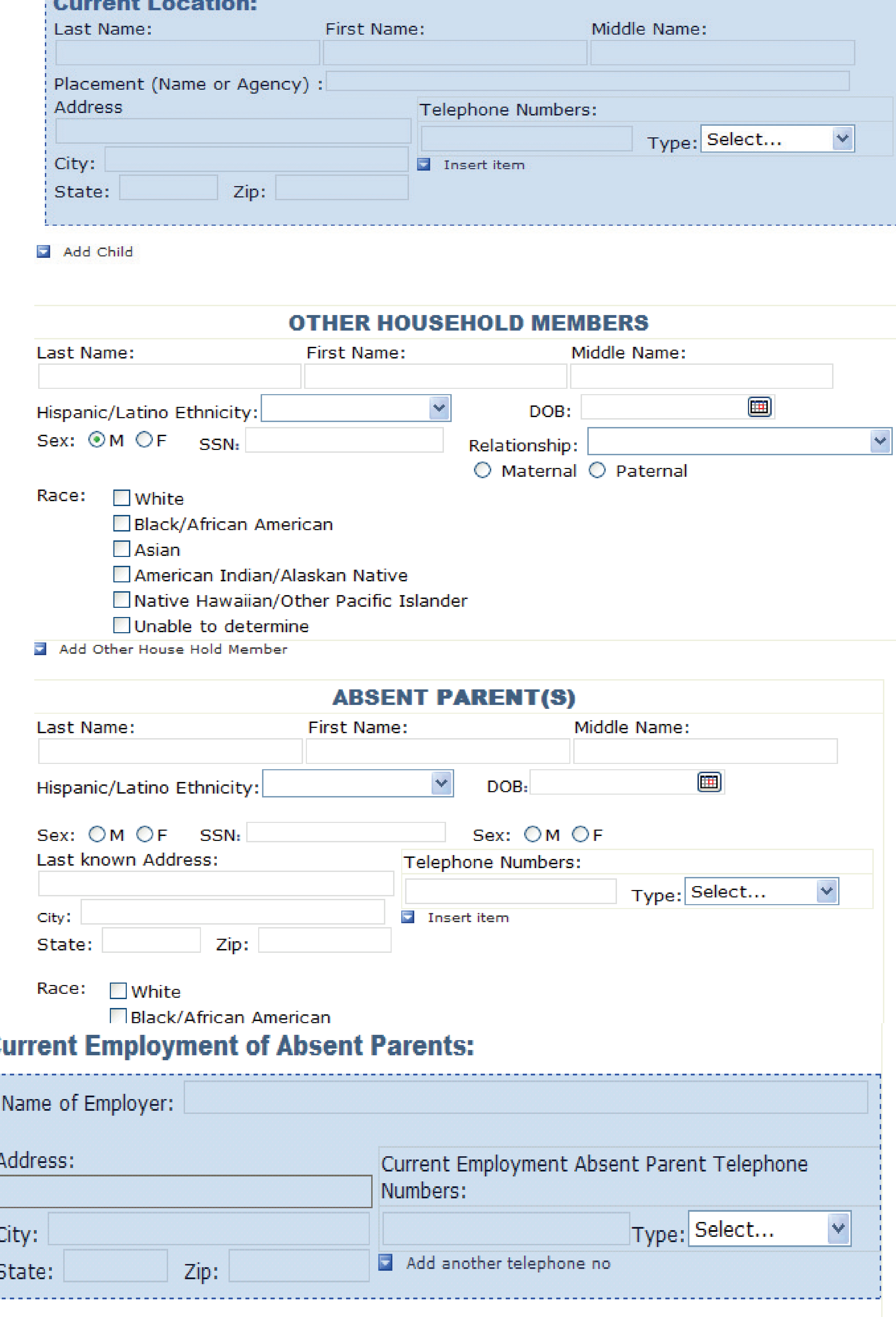
Special Skills or Achievements:

REMOVAL INFORMATION

Document Reasonable Efforts Used to Prevent Placement:

Reasonable Efforts:

- [ ] Use family resources, neighbors or individuals in the community as safe resources.
- [ ] Use community agencies or services as safety resources.



Current Location:

Last Name: First Name: Middle Name:

Placement (Name or Agency) :

Address

City:

State: Zip:

Telephone Numbers:

Type: Select...

Insert item

Add Child

OTHER HOUSEHOLD MEMBERS

Last Name: First Name: Middle Name:

Hispanic/Latino Ethnicity: DOB:

Sex: M F SSN: Relationship:

Maternal Paternal

Race:
- White
- Black/African American
- Asian
- American Indian/Alaskan Native
- Native Hawaiian/Other Pacific Islander
- Unable to determine

Add Other House Hold Member

ABSENT PARENT(S)

Last Name: First Name: Middle Name:

Hispanic/Latino Ethnicity: DOB:

Sex: M F SSN: Sex: M F

Last known Address:

City:

State: Zip:

Telephone Numbers:

Type: Select...

Insert item

Race:
- White
- Black/African American

Current Employment of Absent Parents:

Name of Employer:

Address:

City:

State: Zip:

Current Employment Absent Parent Telephone Numbers:

Type: Select...

Add another telephone no

AUTHORIZATION FOR PUP/EARLY INTERVENTION /HOMESTEAD AND PARENT AIDE SERVICES

All services have 12 month limit from date of approval

Indicate application type:
- ☐ PUP (UAS 521)
- ☐ Early Intervention (UAS 551 $500.00 limit)
- ☐ Homestead (UAS 571 $3500.00 limit)
- ☐ Parent Aide (UAS 573 $2500 limit)

Case Summary: (Specify documented service needs of the family include indicators of risk, how services will be utilized, and how the family will maintain changes after service.)

☐ PUP (UAS 521)

Authorization Amount $ (see 75% of estimated per diem cost chart for PUP)

Number months estimated for Foster Care: Select...

Active Social Service Case Type ○ CPS ○ FC ○ Adoption

☐ Early Intervention (UAS 551 $500 limit)

Case Type:
- ○ Closed-Low Risk, Substantiated Cases
- ○ Closed-Unsubstantiated Cases
- ○ Screened-Out Diversion Services
- ○ Open cases that have been reassessed as low-risk and closed

☐ Homestead UAS 571 – Maximum Amount per family $3,500

Active Social Service Case Type ○ CPS ○ FC ○ Adoption

☐ Parent Aide (UAS 573 $2500 limit)

Active Social Service Case Type ○ CPS ○ FC ○ Adoption

Case Manager's Signature : Date:

Supervisor's Signature: Date:

ENTITLEMENT CODES
PUP (UAS 521)

Date : Code:

Expenditure (Service Provider):

Amount: Cumulative total:

Add Entitlement

ENTITLEMENT CODES
Early Intervention (UAS 551 $500 limit)

Date : Code:

Expenditure (Service Provider):

Amount: Cumulative total:

Form 455A
Safety Assessment

Case Information

Complaint Date: *

County: Case Number:

Case Manager:

Primary Caretaker:

Last Name: First Name: Middle Name:

Assessment of Behaviors and Conditions

The following list of factors describes behaviors or conditions associated with a child being at risk of serious harm. Identify the presence or absence of each factor for each child by selecting "Yes" or "No" for each Question. Repeat for all Caretakers - Child combinations.

Questions

1 Does the Caretaker's history indicate violent or out of control incidents or maltreatment that is callous, deliberate or cruel?

Caretaker: *Child:* Yes No

2 Does the Caretaker describe or act toward the child in negative terms or do they have unrealistic expectations?

Caretaker: Child: Yes No

3 Has the Caretaker caused physical harm to the child or have they made plausible threats to cause physical harm? This is a critical factor for children four years and younger or for any special needs children.

Caretaker: Child: Yes No

4	Has the Caretaker previously maltreated a child and the maltreatment , or the caretakers response to the prior incident, makes the child's safety a concern?		
	Caretaker:	Child:	Yes No
5	Does the family refuse access to the child or there is reason to believe that the family is about to fle or the child's whereabouts cannot be ascertained ?		
	Caretaker:	Child:	Yes No
6	Is the Caretaker unable or unwilling to provide the supervision necessary to protect the child from harm?		
	Caretaker:	Child:	Yes No
7	Is the Caretaker unable or unwilling to meet the child's needs for food, clothing, shelter, medical, education, emotional or mental health care?		
	Caretaker:	Child:	Yes No
8	Is the explanation for the injury unconvincing or inconsistent?		
	Caretaker:	Child:	Yes No
9	Is the child fearful of the caretaker, other family members, or other people living in the home or having access to the home?		
	Caretaker:	Child:	Yes No
10	Is the child's living conditions hazardous, threatening, or unsafe?		
	Caretaker:	Child:	Yes No
11	Is child sexual abuse suspected and do circumstances suggest that the child's safety may be of immediate concern?		
	Caretaker:	Child:	Yes No
12	Does the Caretaker's drug or alchol abuse affect their ability to supervise, protect or care for the child?		
	Caretaker:	Child:	Yes No
13	Is there domestic violence/other (specify)?		
	Caretaker:	Child:	Yes No

Notes:

Reasonable Effort Checklist

For each behavior or condition identified, consider the resources available in the family and the community that might help the child safe. For each child check the response selected to protect the child. Describe in the "Evidence" section of Form 454 all safety interventions taken or immediately planned and explain how each intervention will protect the child.

1 Use family resources, neighbors or individuals in the community as safe resources.
Child: Yes No

2 Use community agencies or services as safety resources.
Child: Yes No

3 The alleged maltreater leaves the home, either voluntary or through legal action.
Child: Yes No

4 Have the non-maltreating caregiver move to a safe environment with the child.
Child: Yes No

5 Have the caregiver(s) place the child outside the home.
Child: Yes No

6 Legal action must be taken to place the child outside the home.
Child: Yes No

7 Other.
Child: Yes No

Why responses 1-5 could not be used to keep the children safe:
Child: Explanation (if necessary)

Your decision with caretakers regarding the placement:
Caretaker: Decision:

Notes

Safety Decisions

For each child listed below select your safety decision. Make each child's safety decision based on the assessment of all safety factors and any other information known about the child and case. Select "**Safe**" only if all thirteen safety factors are marked "**No**".

- **Unsafe:** The child is in immediate danger of serious harm.
- **Conditionally Safe:** Controlling safety interventions have been taken since the referral was received, and those interventions have resolved the unsafe situation for the present.
- **Safe:** The child is not likely to be in immediate danger of serious harm.

Child	Safe	Conditionally Safe	Unsafe

Supervisor Signature/ Approval of Plan:

Date:

Form 455b
Safety Plan

Case Information

Case Number:

Primary Caretaker

Last Name:	First Name:	Middle Name	County:
*			

Allegations and Safety Factors

Safety Factor:	*
Change:	

Person Responsible

To be Completed by

Description of Actions

Comments

Agreement

Agreement: ◯ Yes ◯ No

Date Discussed with Parent(s)/Guardian: *

Family Plan

Entry > Ch Vul > Car Cap > Care > Maltreat > H Envir > S Envir > Resp

* required field

Family Plan Detail

Case Name:

Last Name | First Name | Middle

Case Number:

Case Type: Ongoing

Family Plan Detail

Plan Type: Ongoing Case Plan

***Care Taker on the Plan**

Name	Relationship
☐	

Insert item

Family Plan Dates

Date Plan Completed:

Next Review Due:

Current Review Completed:

Reason for Involvement/Strengths & Resources

Reason for CPS Involvement

Insert item

Description of Family Strengths and Resources:

Additional Information:

Family Plan Item List

Risk Assessment

Identify in Risk Assessment	Area of Concern	Initial Level of Concern	Current Level of Concern	Initially Addressed
☐	Child Vulnerability		Select...	
☐	Caregiver Capability		Select...	
☐	Quality of Care		Select...	
☐	Maltreatment Pattern		Select...	

Family Plan

Entry > Ch Vul > Car Cap > Care > Maltreat > H Envir > S Envir > Resp

* required field

Family Plan Item Detail

Case Name:

Last Name	First Name	Middle

Case Number:

Case Type: Ongoing

Family Plan Item Detail

Area of Concern: Child Vulnerability

*Goals:

*Initial Level of Concern:

*Current Level of Concern: Select...

Goal Completed: ◉ Yes ○ No

Date Goal Completed:

Steps/Services

Include Beginning and Ending Dates (and/or Frequency). Include specific measurable activities that outline who will do what, when, how often and where ?

Date Created: ☐ Step Completed ☐ Court Ordered

Date Completed:

Insert item

Family Plan

Division of
FAMILY & CHILDREN SERVICES
GEORGIA DEPARTMENT OF HUMAN RESOURCES
DHR

Entry > Ch Vul > Car Cap > Care > Maltreat > H Envir > S Envir > Resp

* required field

Family Plan Item Detail

Case Name:

Last Name	First Name	Middle

Case Number:

Case Type: Ongoing

Family Plan Item Detail

Area of Concern: Caregiver Capability

*Goals:

*Initial Level of Concern:

*Current Level of Concern: Select...

Goal Completed: (•) Yes ( ) No

Date Goal Completed:

Steps/Services

Include Beginning and Ending Dates (and/or Frequency). Include specific measurable activities that outline who will do what, when, how often and where ?

Date Created: ☐ Step Completed ☐ Court Ordered

Date Completed:

Insert item

Family Plan

Division of
FAMILY & CHILDREN SERVICES
GEORGIA DEPARTMENT OF HUMAN RESOURCES
DHR

Entry > Ch Vul > Car Cap > Care > Maltreat > H Envir > S Envir > Resp

* required field

Family Plan Item Detail

Case Name:

Last Name	First Name	Middle

Family Plan

Entry > Ch Vul > Car Cap > Care > Maltreat > H Envir > S Envir > Resp

* required field

Family Plan Item Detail

Case Name:

Last Name	First Name	Middle

Case Number:

Case Type: Ongoing

Family Plan Item Detail

Area of Concern: Maltreatment Pattern

*Goals:

*Initial Level of Concern:

*Current Level of Concern: Select...

Goal Completed: (•) Yes ( ) No

Date Goal Completed:

Steps/Services

Include Beginning and Ending Dates (and/or Frequency). Include specific measurable activities that outline who will do what, when, how often and where ?

Date Created: ☐ Step Completed ☐ Court Ordered

Date Completed:

Insert item

Family Plan

Entry > Ch Vul > Car Cap > Care > Maltreat > H Envir > S Envir > Resp

* required field

Family Plan Item Detail

Case Name:

Last Name | First Name | Middle

Case Number:

Case Type: Ongoing

Family Plan Item Detail

Area of Concern: Home Environment

*Goals:

*Initial Level of Concern:

*Current Level of Concern: Select...

Goal Completed: ◉ Yes ○ No

Date Goal Completed:

Steps/Services

Include Beginning and Ending Dates (and/or Frequency). Include specific measurable activities that outline who will do what, when, how often and where ?

Date Created: ☐ Step Completed ☐ Court Ordered

Date Completed:

Insert item

Family Plan

Entry > Ch Vul > Car Cap > Care > Maltreat > H Envir > S Envir > Resp

* required field

Family Plan Item Detail

Case Name:

Last Name | First Name | Middle

Case Number:

Case Type: Ongoing

Family Plan Item Detail

Area of Concern: Social Environment

*Goals:

*Initial Level of Concern:

*Current Level of Concern: Select...

Goal Completed: ◉ Yes ○ No

Date Goal Completed:

Steps/Services

Include Beginning and Ending Dates (and/or Frequency). Include specific measurable activities that outline who will do what, when, how often and where ?

Date Created: ☐ Step Completed ☐ Court Ordered

Date Completed:

Insert item

Family Plan

Division of FAMILY & CHILDREN SERVICES
GEORGIA DEPARTMENT OF HUMAN RESOURCES DHR

Entry > Ch Vul > Car Cap > Care > Maltreat > H Envir > S Envir > Resp

* required field

Family Plan Item Detail

Case Name:

Last Name	First Name	Middle

Case Number:

Case Type: Ongoing

Family Plan Item Detail

Area of Concern: Response to Intervention

*Goals:

*Initial Level of Concern:

*Current Level of Concern: Select...

Goal Completed: ◉ Yes ○ No

Date Goal Completed:

Steps/Services

Include Beginning and Ending Dates (and/or Frequency). Include specific measurable activities that outline who will do what, when, how often and where ?

Date Created: ☐ Step Completed ☐ Court Ordered

Date Completed:

Insert item

Signature Section

Approval Status: ◉ Yes ○ No

Client can enter comments here: ☐ Client comments

Parent/Guardian Print Name: ◉ Select... ○ Other

Signature:

Risk Assessment

Division of
FAMILY & CHILDREN SERVICES
GEORGIA DEPARTMENT OF HUMAN RESOURCES DHR

Case Information

Case Number: ____________

Case Name:

Last Name: ____________ First Name: ____________ Middle Name: ____________

Assigned Response Time: ☐ 24 hours ☐ 5 days

Case Worker Name: ____________ Response Date: ____________ Response Time: ____________

Case Worker ID: ____________ Date Began: ____________

Supervisor: ____________ Law Enforcement Officer: ____________

Purpose:

☐ Investigation ☐ Risk Reassessment ☐ Case Closure

☐ Other ____________

Date Assessment Completed: ____________

FACTORS AND SCALES OF CONCERN:

Child Vulnerability: Are the Following Risk Factor Indicators Present?

Child Fragility/Protection:

?	Is any child four years old or younger or otherwise unable to protect him/herself?	☐ Yes ☐ No ☐ Unknown
?	Is any child physically impaired, mentally impaired, or in need of special care?	☐ Yes ☐ No ☐ Unknown
?	Is any caregiver unwilling or unable to protect the children?	☐ Yes ☐ No ☐ Unknown
?	Does any alleged perpetrator, child or adult, have access to any children in the family?	☐ Yes ☐ No ☐ Unknown
Child Fragility/Protection scale of concern: ☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme		

Child Behavior:

?	Is the behavior of any child hostile or aggressive or unusually disturbed, fussy, or irritable?	☐ Yes ☐ No ☐ Unknown
?	Is any child's behavior seen as provoking?	☐ Yes ☐ No ☐ Unknown
Child Behavior scale of concern: ☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme		

CHILD VULNERABILITY

OVERALL scale of concern: ☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

Justification of Finding:

Caregiver Capability: Are the Following Risk Factor Indicators Present?

Knowledge/Skills:

?	Are any caregivers significantly lacking knowledge of child development?	☐ Yes ☐ No ☐ Unknown
?	Do any caregivers have unrealistic expectations or frequently fail to understand the needs of any child, considering the child's behavior and development?	☐ Yes ☐ No ☐ Unknown
?	Does any caregiver significantly lack the parenting skills needed to meet any child's behavioral and developmental needs?	☐ Yes ☐ No ☐ Unknown

Knowledge/Skills scale of concern:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

Control:

?	Does any caregiver lack impulse control?	☐ Yes ☐ No ☐ Unknown
?	Is the discipline used disproportionately harsh compared to the misbehavior?	☐ Yes ☐ No ☐ Unknown

Control scale of concern:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

Functioning:

?	Is any caregiver unable to cope appropriately with stress?	☐ Yes ☐ No ☐ Unknown
?	Does any caregiver have a history of mental illness such as depression, attempted suicide, schizophrenia, bi-polar disorder, etc? (diagnosed or indications)	☐ Yes ☐ No ☐ Unknown
?	Does any caregiver have a significant impairment in mental capacity such as retardation, brain damage, etc? (diagnosed or indications)	☐ Yes ☐ No ☐ Unknown
?	Does any caregiver have a history of drug or alcohol abuse?	☐ Yes ☐ No ☐ Unknown
?	Were any caregivers abused or neglected as children?	☐ Yes ☐ No ☐ Unknown

Functioning scale of concern:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

CAREGIVER CAPABILITY

OVERALL scale of concern:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

Justification of Finding:

Quality of Care: Are the Following Risk Factor Indicators Present?

Emotional Care:

?	Does any caregiver lack empathy for or show lack of attachment to any child?	☐ Yes ☐ No ☐ Unknown
?	Is any caregiver so self-centered or needy that his/her own needs are placed above the needs of any child?	☐ Yes ☐ No ☐ Unknown
?	Is any child unwanted, disliked, or seen as a burden by any caregiver?	☐ Yes ☐ No ☐ Unknown
?	Is any child scapegoated, rejected, humiliated, or treated differently by any caregiver?	☐ Yes ☐ No ☐ Unknown
?	Has any child experienced a significant separation from the primary caregiver?	☐ Yes ☐ No ☐ Unknown
Emotional Care scale of concern: ☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme		

Physical Care:

?	Has any child been inadequately supervised or left with an inappropriate caregiver?	☐ Yes ☐ No ☐ Unknown
?	Has any child been denied essential medical treatment?	☐ Yes ☐ No ☐ Unknown
?	Is there an overall lack of physical care for any child?	☐ Yes ☐ No ☐ Unknown
Physical Care scale of concern: ☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme		

QUALITY OF CARE

OVERALL scale of concern:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

Justification of Finding:

Maltreatment Pattern: Are the Following Risk Factor Indicators Present?

Current Severity:

?	Is actual or potential harm severe?	Yes No Unknown
?	Was any child addicted or exposed to drugs or alcohol?	Yes No Unknown
?	Has any child suffered physical injuries or sexual abuse?	Yes No Unknown
?	Did the abuse/neglect of any child require immediate medical care?	Yes No Unknown
?	Is the maltreatment premeditated, bizarre, or sadistic?	Yes No Unknown
Current Severity scale of concern: None Very Little Somewhat Considerable Extreme		

Chronicity:

?	Is there a history of sexual abuse of any family member as a victim or perpetrator?	Yes No Unknown
?	Has there been a recent incident, or indication, or abuse/neglect (within the last six months or so)?	Yes No Unknown
?	Has there been a prior abuse/neglect investigation regardless of finding?	Yes No Unknown
?	Has any child been removed from the home by a protective service agency?	Yes No Unknown
?	Has any prior incident resulted in a severe outcome?	Yes No Unknown
Chronicity scale of concern: None Very Little Somewhat Considerable Extreme		

Trend:

?	Are incidents escalating in severity?	Yes No Unknown
?	Are more people becoming involved, (either as a victim or as perpetrator)?	Yes No Unknown
?	Have incidents been occurring more frequently?	Yes No Unknown
?	Have more types of abuse or neglect been occurring?	Yes No Unknown
Trend scale of concern: None Very Little Somewhat Considerable Extreme		

MALTREATMENT PATTERN

OVERALL scale of concern: None Very Little Somewhat Considerable Extreme

Justification of Finding:

Home Environment: Are the Following Risk Factor Indicators Present?

Stressors:

?	Question	Response
?	Is any caregiver experiencing any recent stress about child development issues, such as toilet training, identity development, or parent-child conflict?	☐ Yes ☐ No ☐ Unknown
?	Is the family experiencing any recent significant stress?	☐ Yes ☐ No ☐ Unknown
Stressors scale of concern: ☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme		

Dangerous Exposure:

?	Question	Response
?	Is the home so crowded or chaotic that responsibility for care giving is unclear, leading no one to assume responsibility for the children?	☐ Yes ☐ No ☐ Unknown
?	Are conditions in and/or around the home hazardous or unsanitary?	☐ Yes ☐ No ☐ Unknown
?	Do behaviors of any household member expose children to dangers?	☐ Yes ☐ No ☐ Unknown
Dangerous Exposure scale of concern: ☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme		

HOME ENVIRONMENT

OVERALL scale of concern:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

Justification of Finding:

Social Environment: Are the Following Risk Factor Indicators Present?

Social Climate:

?	Is the family socially isolated or unsupported by extended family?	Yes No Unknown
?	Are the social relationships of any caregiver primarily negative?	Yes No Unknown

Social Climate scale of concern:
None Very Little Somewhat Considerable Extreme

Social Violence:

?	Has any person in the home ever been a victim of spousal abuse?	Yes No Unknown
?	Has any person in the home ever been a perpetrator of spousal abuse?	Yes No Unknown
?	Does any person in the home promote violence?	Yes No Unknown
?	Does any person in the home have a history of criminal involvement?	Yes No Unknown
?	Is there an imbalance of power between adults that affects any non-perpetrators' ability to protect a child?	Yes No Unknown

Social Violence scale of concern:
None Very Little Somewhat Considerable Extreme

SOCIAL ENVIRONMENT

OVERALL scale of concern:
None Very Little Somewhat Considerable Extreme

Justification of Finding:

Response to Intervention: Are the Following Risk Factor Indicators Present?

Attitude:

?	Question	Response
?	Does any caregiver deny, seem unaware of, or take the allegations less seriously than CPS?	Yes No Unknown
?	Is a caregiver unmotivated/unrealistic about change?	Yes No Unknown
Attitude scale of concern: None Very Little Somewhat Considerable Extreme		

Deception:

?	Question	Response
?	Is any caregiver hostile toward or refusing to cooperate with CPS?	Yes No Unknown
?	Does any caregiver offer implausible explanations, attempt to deliberately mislead CPS or refuse to disclose important information?	Yes No Unknown
Deception scale of concern: None Very Little Somewhat Considerable Extreme		

RESPONSE TO INTERVENTION

OVERALL scale of concern:
None Very Little Somewhat Considerable Extreme

Justification of Finding:

STRUCTURED NARRATIVE

(Complete All Items Unless an Exception is Given)

1. Current Allegations

Additional allegations:

2. Detailed Previous CPS Involvement/Foster Care History

Include date, allegation of "who did what to whom," disposition, risk finding, and outcome for each previous report of abuse/neglect involving any family/household member.

Date of Report:

Allegations:

Alleged Perpetrator(s):

Alleged Victims(s):

Dispositions:

Court Involvement:

Services Provided:

Serious Injury/Child Death ☐ Yes ☐ No
Explain if yes:

Date of Closure:

Narrative on History

3. Log of Contacts

Log of contacts including all collaterals. Include comments and dates of contact for each person interviewed and his/her response to what was reported.

Interview Date:

Name:

Last Name:	First Name:	Middle Initial:

Title:

Contact Type:

Contact with:

Name:

Last Name:	First Name:	Middle Name:

Organization Name:

Relation:

Title

Household Member □ Yes □ No
Collateral □ Yes □ No

Summary

* Have all children been interviewed?

4. Information about Absent Parent(s):

Include name, address, phone number, and comments/response resulting from any contact, such as information about past incidents of abuse or neglect or past risk.

Last Name:	First Name:	Middle Name:

Address:

City:

Telephone No.	Type
	Select…

State: ZIP:

Children

-

Comments:

(Please include assessment of AP's ability and willingness to care for the child(ren), any CPS history involving this child or any other minor children, criminal background, results of screenings, and any other pertinent information.)

5. Investigation Actions:

☐ Yes ☐ No ☐ N/A Gave a copy of the Parent's Guide to the parent (in the home or absent) or legal guardian?

Date completed

☐ Yes ☐ No ☐ N/A Notified parent (in the home or absent) or legal guardian of interview or examination of a child immediately after contact with child.

Date completed

6. Relatives:

Give names, addresses, and telephone numbers of relatives in and out of state.

Maternal Relatives:

Name	Address	Phone	Relation

Paternal Relatives:

Name	Address	Phone	Relation

7. Current Court and Placement Activities:

Include: CPS initiated court and placement activities. Placements made by the parents during the investigation, with dates of placements, names, and addresses of caregivers, and results of abuse/neglect background checks on caregivers. If placement is to be made, please list reasonable efforts to maintain child in home.

Document Reasonable Efforts Used to Prevent Placement:

Child: **Select…**

Reasonable Efforts:

- ☐ **Use family resources, neighbors or individuals in the community as safety resources.**
- ☐ **Use community agencies or services as safety resources.**
- ☐ **The alleged maltreater leaves the home, either voluntarily or through legal action.**
- ☐ **Have the non-maltreating caregiver move to a safe environment with the child.**
- ☐ **Have the caregiver(s) place the child outside the home.**
- ☐ **Legal action must be taken to place the child outside the home.**

☐ Other: ____________________

Reason Child(ren) Removed:

Plans for Child:

Referred to (Name of Provider):

Last Name:	First Name:	Middle Name:

Referral Date: ____________

Removal Date: ____________

CASE CONCLUSION

8. Disposition of Abuse and Neglect:

Maltreatment (Incident Based Findings)

Maltreatment Summary

Child: Select…

Maltreatment Type	Substantiated?	Evidence Description
	☐ Yes ☐ No	

*** Include codes for reported and substantiated maltreatment plus codes for any additional non-reported maltreatment discovered during the investigation.**

Evidence Summary
Include detailed description of all evidence, how it supports each type of substantiated maltreatment, and who can support that evidence if it becomes needed for court action.

9. Risk Determination:

Pre-fills overall rating from Risk Assessment form.

CHILD VULNERABILITY:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

CAREGIVER CAPABILITY:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

QUALITY OF CARE:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

MALTREATMENT PATTERN:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

HOME ENVIRONMENT:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

SOCIAL ENVIRONMENT:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

RESPONSE TO INTERVENTION:
☐ None ☐ Very Little ☐ Somewhat ☐ Considerable ☐ Extreme

10. Assessment of Family Strengths:

Please check the box below if the area is a strength.

Child Vulnerability: ☐ Yes ☐ No

☐ **Child Fragility/Protection**

☐ **Child Behavior**

Caregiver Capability: ☐ Yes ☐ No

☐ **Knowledge/Skills**

☐ **Control**

☐ **Functioning**

Quality of Care: ☐ Yes ☐ No

☐ **Emotional Care**

☐ **Physical Care**

Maltreatment Pattern: ☐ Yes ☐ No

☐ **Current Severity**

☐ **Chronicity**

☐ Trend

Home Environment: ☐ Yes ☐ No

☐ **Stressors**

☐ **Dangerous Exposure**

Social Environment: ☐ **Yes** ☐ **No**

☐ **Social Climate**

☐ **Social Violence**

Response to Intervention: ☐ **Yes** ☐ **No**

☐ Attitude

☐ **Deception**

11. Overall Risk Finding:

☐ Risk indicated—Case Open for Services ☐ Risk Indicated—Case Open for Placement

☐ Risk Factors Controlled ☐ No Significant Risk Factors ☐ RA Not Applicable

Give supporting rationale for the risk finding. Discuss actions taken to control threats to child safety. Discuss any services needed to reduce the risk at the end of the investigation and in the foreseeable future.

Date Completed: ______

Have you completed the 431 in IDS? ☐ **Yes** ☐ **No**

Case Manager's Signature:	Date Saved:

☐ **Verified the 431 was entered in IDS.**

Supervisor's Signature:	Date Submitted:

This document contains copyrighted material owned by DFPS and used with its permission.

Small Group Activity

DIRECTIONS: Look at your assigned form(s) and decide:

What information is needed to complete all the sections of this tool?

Policy 2101.5 Definitions: Likert Scale of Concern

- **Extreme:** Based upon the conditions within the family, your interactions with the family and those who know them, you have definite reasons to suspect there are circumstances that will adversely impact the well-being of the children. Without mitigating circumstances or interventions, there *is* an imminent or future risk to child safety.

- **Considerable:** Based upon the conditions within the family, your interactions with the family and those who know them, you have significant reasons to suspect there are circumstances that will adversely impact the well-being of the children. Without mitigating circumstances or interventions, imminent or future risks to child safety *appear to be probable*.

- **Somewhat:** Based upon the conditions within the family, your interactions with the family and those who know them, you have some reasons to suspect there are circumstances that will adversely impact the well-being of the children. Without mitigating circumstances or interventions, imminent or future risks to child safety *appear to be fairly likely*.

- **Very Little:** Based upon the conditions within the family, your interactions with the family and those who know them, you have a few reasons to suspect there are circumstances that will adversely impact the well-being of the children. Imminent or future risks to child safety *appear to be slight*.

- **None:** Based upon the conditions within the family, your interactions with the family and those who know them, you have no reason to suspect there are circumstances that will adversely impact the well-being of the children. Given age appropriate childhood activities and behaviors, there appear to be *no* imminent or future risks to child safety.

Risk Assessment Definitions

Child Vulnerability

Question	Definition
Child Fragility/Protection	
Is any child four years old or younger or otherwise unable to protect him/herself?	Given the child's age, mental and physical conditions, consider the likelihood that any child will be able to avoid an abusive/neglectful situation. Examples include, but are not limited to, indications that a child would be unable to recognize and flee a dangerous situation or seek outside protective resources such as telling a relative, teacher, etc.
Is any child physically impaired, mentally impaired, or in need of special care?	Child requires more than normal age-appropriate care for any reason, such as a physical disability, developmental delay or mental retardation. Examples include, but are not limited to, special medical needs, physical/emotional difficulties, attention deficit/hyperactivity, learning disability, combative or self-destructive behaviors, etc.
Is any caregiver unwilling/unable to protect the children?	Evaluate all caregivers regarding their ability and willingness to protect. Consider indications of any physical, mental, or emotional condition which might hinder the caregiver's ability to protect even if the caregiver is willing to do so. Also consider a caregiver's ability to protect even if the caregiver is willing to do so. Also consider a caregiver's unwillingness to protect by virtue of lack of caring for the child or being afraid of the perpetrator. Indications of an inability or unwillingness to protect might be repeated missed medical appointments, repeated failure to provide a protective environment, or continuing to allow access to the child to those who pose a threat to the child's safety.
Does any alleged perpetrator, child or adult, have access to any children in the family?	Consider the likelihood that any alleged perpetrator will come into contact with the child in a caregiver capacity. Consider whether absences such as incarceration, hospitalizations, or other separations will deny the AP access to the child in the foreseeable future.
Child Behavior	
Is the behavior of any child hostile or aggressive or unusually disturbed, fussy or irritable?	The child's behavior is hostile, aggressive, disturbed, fussy or irritable given ordinary circumstances. Examples include, but are not limited to, children who lash out at peers, cruelty to animals, fire setting, bed wetting beyond what is developmentally appropriate and excessively angry/ill-tempered or fussy (e.g., inconsolable) responses to routine situations.
Is any child's behavior seen as provoking?	Consider how the child's behavior is perceived by the caregivers and how that perception contributes to the caregiver's treatment of the child. Examples include, but are not limited to, a caregiver who is provoked by even normal child's behavior such as an infant's crying or who makes inappropriate sexual advances while blaming the child.

Caregiver Capability

Question	Definition
Knowledge/Skills	
Are any caregivers significantly lacking knowledge of child development?	Caregivers who do not have the knowledge to recognize when a child's behavior is age appropriate or understand the major milestones in a child's development. They see changes/developments as a challenge to their authority rather than a normal process. For instance, believing a child is crying to deliberately aggravate the parent or to challenge their authority instead of understanding that a baby cries because it wants something and has no other way to communicate. Another indication would be a caregiver assuming that a child has an understanding of language beyond the child's age.
Do any caregivers have unrealistic expectations or frequently fail to understand the needs of any child, considering the child's behavior and development?	Caregivers fail to either acknowledge any child's basic needs for food, clothing, or shelter or make assumptions that are not in accord with what the child is developmentally capable of doing/feeling. Examples include, but are not limited to, leaving children alone or assigning child-care to children who aren't capable, assigning motivations to children's behaviors that aren't developmentally appropriate, expecting young child to prepare own meals, or expecting a child with mental retardation to comply with multi-step instructions, etc.
Does any caregiver significantly lack the parenting skills needed to meet any child's behavioral and developmental needs?	here are indications that caregivers have a poor ability to manage children's behavior and/or meet children's needs, may not recognize dangers, may demonstrate poor judgment, or may lack nurturing. Caretakers may have good intentions but simply don't know how to apply these intentions in a practical manner.
Control	
Does any caregiver lack impulse control?	Caregivers act without thinking, respond impulsively to emotions, are unable to see logical consequences for spontaneous behavior, etc.
Is the discipline used disproportionately harsh compared to the misbehavior?	Overly severe discipline or giving punishment that does not relate to the act or punishment that the child can't possibly understand. Some examples include, spanking for little or no reason, excessive physical discipline, forcing the child to perform extraneous activities for extended periods, or force-feeding a child for spilling food.
Functioning	
Is any caregiver unable to cope appropriately with stress?	This question is intended to measure how well the caregivers deal with whatever amount of stress they are experiencing not the **amount** of stress. Some indications of not dealing with stress include sleeplessness, indecisiveness, abuse of drug/alcohol, inability to concentrate, depression, confusion, isolation, or lashing out physically/verbally toward others, etc.

Question	Definition
Does any caregiver have a history of mental illness such as depression, attempted suicide, schizophrenia, bi-polar disorder, etc. (diagnosed or indicated)?	This question asks for either behavioral indicators that a caregiver is suffering from a mental illness, or a history of diagnosed mental illness.
Does any caregiver have a significant impairment in mental capacity such as retardation, brain damage, etc. (diagnosed or indicated)?	This question asks for behavioral indicators that a caregiver is suffering from impairment in mental capacity or a diagnosis of mental impairment.
Does any caregiver have a history of drug or alcohol abuse?	Any history of drug/alcohol abuse is significant. This history can be based on behavioral indicators as well as client-admitted history or that confirmed by others.
Were any caregivers abused or neglected as children?	This question relates to the caregiver's perception that he/she was abused or neglected as a child or the abuse or neglect may be confirmed by prior CPS records or other reliable sources may confirm the abuse or neglect.

Quality of Care

Question	Definition
Emotional Care	
Does any caregiver lack empathy for or show lack of attachment to any child?	Lack of empathy is when the caregiver is unable to understand or participate in the child's feelings or ideas. Lack of attachment is when the caregiver is emotionally distant from the child. Some indicators are how the caregiver describes their feelings about the child or how the caregiver responds/provides attention to the child or even notices the child (e.g. appears disinterested and/or disconnected).
Is any caregiver so self-centered or needy that his/her own needs are inappropriately placed above the needs of any child?	There are indications that the caregiver thinks only of him/herself and puts own needs above the child's needs. Some examples include leaving children alone to be with friends, spending money for him/herself while children go without, or the need to please others is greater than the need to protect children.
Is any child unwanted, disliked, or seen as a burden by any caregiver?	This question asks about indications that any child is unwanted or unliked by any caregiver. This may apply to all children (as in not wanting to be in a parenting position at all) or may be centered around one specific child (as in a child that reminds the caregiver of a former relationship or incident).
Is any child scapegoated, rejected, humiliated or treated differently by any caregiver?	This question refers to indications of deliberate and intentional mistreatment of one or more children. This may be in the form of emotional insensitivity or physical disparity but serves the purpose of singling out the child in such a way that could result in significant harm. Examples include, but are not limited to, forcing a child to do activities separate from others, humiliating acts in front of others, or verbally berating the child in the presence of others. This may or may not rise to the level of meeting the statutory definition of emotional abuse.
Has any child experienced a significant separation from the primary caregiver?	This question relates to whether any child has been sent to live with others or been unable to live with their family for any reason. Consider the child's age, duration of out-of-home stays, and number of out-of-home caregivers in assessing the importance of this separation in the development of the child. Examples include but are not limited to, a newborn hospitalized for an extended period, children living elsewhere during caregiver incarceration/treatment, and the caregiver chronically living elsewhere.
Physical Care	
Has any child been inadequately supervised or left with an inappropriate caregiver?	Indications of inadequate supervision may be seen when placing a child in a situation that requires judgment or actions beyond the child's level of maturity, physical condition, or mental abilities. An inappropriate caregiver is any person who lacks the judgment necessary to keep the child safe from harm. This may or may not rise to the level of meeting the statutory definition of neglectful supervision.
Has any child been denied essential medical treatment?	Failure to seek medical treatment could result in death, disfigurement, bodily injury, or observable impairment to the growth, development and functioning of a child. May or may not rise to the level of meeting the statutory definition of medical neglect.
Is there an overall lack of physical care for any child?	This question addresses indications of a general disregard for the needs of the child that do not necessarily rise to the level of meeting the statutory definition of physical abuse. Some examples include non-essential medications/treatment not given, wearing clothes inappropriate for the weather, neglecting basic hygiene, etc.

Maltreatment Pattern

Question	Definition
Current Severity	
Is actual or potential harm severe?	In assessing the current severity, evaluate whether the actual physical harm or threat of harm resulted in, or could have resulted in, a significant physical injury. Indications of risk of harm include, but are not limited to, bruises, broken bones, burns, failure to thrive, and abandonment. Indications of risk of harm include, but are not limited to, throwing/shaking a child resulting in no injury, threatening a child with a gun without shooting, leaving children under 4 years of age without adequate supervision, without incident, etc.
Was any child born addicted or exposed to drugs or alcohol?	This includes babies who were born either addicted or exposed to drugs or alcohol. May be indicated by clinical tests, self-report by mother/others, or observable condition of the child.
Has any child suffered physical injuries or sexual abuse?	n the current investigation, are they any indications that any child suffered a physical injury or sexual abuse of any kind?
Has the abuse/neglect of any child required immediate medical care?	This includes situations in which medical attention was obtained as well as those in which a reasonable person would have expected that medical attention was required.
Is the maltreatment premeditated, bizarre, or sadistic?	In assessing this item consider indications that the maltreatment was planned or that the perpetrator derived pleasure from the maltreatment. Some examples include ritualistic abuse, abuse involving animals, cigarette burns, poisoning, Munchausen's by Proxy, bondage, placing a child in a tub of scalding water, or holding a child's hand over a flame.
Chronicity	
Is there a history of sexual abuse of any family member as a victim or perpetrator?	This includes both civil and criminal reports of sexual abuse in Georgia and other localities regardless of the disposition or the role of the principals in those past reports.
Has there been a recent incident, or indication, of abuse/neglect (within last 6 months or so)?	This question applies to any indication of abuse or neglect within the last 6 months and is not restricted to official Agency reports. It may include statements from the child, family, community, professionals or others.
Has there been a prior abuse/neglect investigation regardless of finding?	This includes any CPS involvement in Georgia or in other localities regardless of the disposition.
Has any child been removed from the home by a protective service agency?	This question applies to the court ordered removal of any child in Georgia or in other localities. This also includes serious incidents in licensed foster/adoptive homes.
Has any prior incident resulted in a severe outcome?	Indications of severe outcomes are those which require prompt medical attention; may require medical or psychiatric hospitalization; may endanger the child' life; may cause permanent functional impairment, death, or disfigurement; and, sexual intercourse or sexual acts performed with a child.

Trend	
Are incidents escalating in severity?	There are indications that the outcomes of each incident are increasing in seriousness, may be more out of control and are known to more people.
Are more people becoming involved, as either a victim or perpetrator?	There are indications that the persons involved in subsequent incidents differ or are increasing in number either as perpetrators or as victims.
Have incidents been occurring more frequently?	There are indications that the amount of time between incidents is decreasing whether or not officially reported.
Have more types of abuse or neglect been occurring?	There are indications that different types of abuse or neglect (physical abuse, neglectful supervision, etc.) are occurring in the family.

Home Environment

Question	Definition
Stressors	
Is any caregiver experiencing any recent stress about child development issues, such as, toilet training, identity development, or parent-child conflict?	Consider whether normal development milestones, stressful to any parent, are perceived as inordinately stressful to any caregiver or taken as personal affronts to their ability to parent rather than attempts by the child to work through a stage. Examples of childhood behaviors reflecting these development milestones include, but are not limited to, colicky babies, saying "No", temper-tantrums, separation/individuation, importance of peer relationships/alliances, and teenage acting-out-behaviors.
s the family experiencing any recent significant stress?	Has this family been burdened with life circumstances that strain their ability to cope or put the child at risk of abuse or neglect? Examples of stressful events include but are not limited to, care giving of a sick/elderly family member, birth or death of a family member, unemployment, loss of support network, moving/eviction, loss of transportation and legal problems. Be alert to the issues that may be worrying the family. Take into account the cultural context of the stressor and whether the cultural context makes it harder to deal with the stress. For instance, a family that has to deal with a situation they never imagined could happen to them.
Dangerous Exposure	
Is the home so crowded or chaotic that responsibility for care giving is unclear, leading no one to assume responsibility for the children?	There are indications that crowded home conditions contribute to confusion or chaos with regard to who might be responsible for young children at any given point in time. For example, the number of persons in the household makes it easy to assume that someone is watching young children when, in fact, no one is.
Are conditions in and/or around the home hazardous or unsanitary?	Conditions in or around the home are unsanitary or hazardous to the point that health considerations apply. Examples would include, but are not limited to, major infestations of roaches, lice, fleas, maggot-ridden garbage, rotten food accessible to children, or feces in the home. Hazardous living conditions include, but are not limited to, broken glass, open furnaces, exposed electrical wires, buckets of water, easy access to household chemicals, and living in a drug house or condemned home.
o behaviors of any household member expose children to danger?	Any behaviors which cause or could cause a threat to the safety of a child. Includes but is not limited to drug dealing, excessive drinking or intoxication, access to firearms, extreme rage, fights with others, domestic violence, etc.

Social Environment

Question	Definition
Social Climate	
s the family socially isolated or unsupported by extended family?	This question relates to indications that the family lacks tangible support from either the community at large or the extended biological family. For instance, isolated, unsupported families may lack avenues for learning positive parenting skills, reducing stress, and managing crisis.
Are the social relationships of any caregiver primarily negative?	Negative social relationships may tend to enable behaviors that negatively impact any individual within the family; for example, associations with persons who engage in criminal, anti-social, or other violent/abusive lifestyles. Negative relationships can also mean isolation from personal or social contacts as a means to control family secrets.
Social Violence	
Has any person in the home ever been a victim of spousal abuse?	This question asks whether any person has experienced verbal, emotional, or physical intimidation or abuse at the hands of a significant other, whether or not it was reported to law enforcement.
as any person in the home ever been a perpetrator of spousal abuse?	This question asks whether any person has been the source of verbal, emotional or physical intimidation or abuse of a significant other, whether or not it was reported to law enforcement.
Does any person in the home promote violence?	Promotion of violence is indicated when any person in the home advocates, either through verbal or physical means, violent solutions to situations.
Does any person in the home have a history of criminal involvement?	This question asks whether any caregiver has ever been either accused or convicted of any criminal act. Examples of violent criminal acts include, but are not limited to, assault, armed robbery, family violence, rape, sexual assault, stalking, malicious destruction of property, arson, drug dealing, and child pornography. Other criminal acts which may impact the child include, but are not limited to, public intoxication, writing bad checks, collection of unpaid traffic violations, etc.
is there an imbalance of power between adults that affects any non-perpetrator's ability to protect a child?	This question asks whether there are indications that one adult in the home is intimidated by another adult to the extent that any well-intentioned desire to protect a child may be ineffective if that protection requires standing up to the intimidator.

Response to Intervention

Question	Definition
Attitude	
Does any caregiver deny or seem unaware of, or take the allegations less seriously than DFCS?	Consider the caregiver's ability to acknowledge a problem when being presented with factual indications that the abuse and neglect has resulted in substantial harm or risk of harm to any child in the home.
Is a caregiver unmotivated/unrealistic about change?	Consider the caregiver's ability and desire to make changes necessary to avoid further maltreatment to any child. Also consider indications that the plans for change are realistic and achievable in view of the caregiver's circumstances.
Deception	
Is any caregiver hostile toward or refusing to cooperate with DFCS?	Consider the caregiver's reaction to the CPS intervention following the initial contact. Consider their ability to participate in the investigation process when it is in the best interest of the child. Some indications of a family's failure to cooperate are refusing to meet with the worker or making genuine threats as a means to intimidate staff.
Does any caregiver offer implausible explanations, deliberately mislead DFCS or refuse to disclose important information?	Consider the caregiver's reaction to the CPS intervention following the initial contact. Consider whether the explanation is inconsistent with the injuries/incident or contrary to known facts about the case, as well as whether the family is providing evasive responses.

Your Opinion Please

Please consider carefully each of the possible responses to the following questions. Circle the letter corresponding to your choice.

1. I prefer that people who visit in my home...

   A. Call and arrange a convenient time in advance.
   B. Let me know that they are coming on a particular day, but need not be specific about the time.
   C. Drop in unexpectedly.

2. When I have guests for a meal, I prefer...

   A. To be in the kitchen alone and to serve the meal myself.
   B. To have the guests with me in the kitchen to keep me company.
   C. To have the guests pitch in and help with the preparation and cleanup.

3. If someone drops in while I'm eating a meal, I would most likely...

   A. Ask him or her to come back later when it would be more convenient.
   B. Ask him or her to have a seat in the living room until the meal is finished.
   C. Discontinue the meal to join the guests.
   D. Add another place and insist that they join in the meal.
   E. Ask them to sit with me (us) at the table, but not ask them to join in the meal.

4. If I walked in on a guest opening a closet or bureau drawer, I probably would...

   A. React with indignation and anger.
   B. Ask if he or she were looking for something.
   C. Tell him or her that I would like to have my privacy respected.
   D. Pretend I didn't notice.

5. The compliments which mean the most to me generally come from persons....

   A. Who know me well.
   B. Who are casual acquaintances.
   C. Who are total strangers.
   D. Who are "experts" in the area about which they are commenting.

Source: Lloyd, 1989.

FACTS: Not My Problem

FACT: The parent does abuse marijuana and alcohol although cocaine usage was alleged by a person believed to be an ex-boyfriend. HE/SHE HAS NEVER ADMITTED to anyone that she uses any drugs. The participant playing the parent should NOT directly admit to usage during role-play.

The parent believes there will be dire repercussions if he/she admits to her usage: she'll go to jail; child will go to foster care. He/She adamantly tells you that substance abuse is "NOT MY PROBLEM."

The child is aware of the parent's usage, but has been told by his/her parent that if he/she tells anyone she will end up with people who don't love him/her. The participant playing the child should NOT directly admit to the parent's drug usage either.

TIPS FOR BUILDING RAPPORT WITH FAMILIES STRUGGLING WITH SUBSTANCE ABUSE ISSUES

- Build rapport with the parent ***before*** discussing substance abuse. Do not jump right in with plans/discussion to take a drug screen test.

- Emphasize that DFCS is not the police. We are not interested in "catching" illegal activity. We want to support families to make necessary changes to keep children safe.

- The parent "checks the case manager out" to see if she is worthy of her trust. For example, the case manager should demonstrate trustworthiness by suggesting services the Agency can provide IF this were a problem in this household.

- Don't force a "confession" of substance abuse. Accept the parent's language such as "I guess I'll go to one of those programs" (without ever admitting she has a drug problem).

- Interview the parent and child separately. Preferably the child first before the parent has an opportunity to alert her you are coming.

- Be careful you don't trick the child into saying something she doesn't want to. She will not trust you later if this is her perception. Encourage her to disclose in order to get help for her mother but be sure she knows what you will do with any information revealed.

- Accept ambiguity by the parent. She may continue to say she doesn't trust you won't take her child away, but then she will continue to test to see what other options you have if she decides to go get help.

- Allow parent to correct the allegations (for example: she does not abuse cocaine but instead drinks beer). This is an important distinction to some parents: it "never got as bad" as was reported. Once in treatment, the mother will be taught that all usage has similar outcomes but help her "save face" to open the door to treatment when necessary.

TIPS FOR BUILDING RAPPORT WITH FAMILIES STRUGGLING WITH SUBSTANCE ABUSE ISSUES (continued)

- Don't get in a power struggle with a parent that they can only go to inpatient treatment. Write goals/steps in family case plans that the parent will get an assessment for substance abuse treatment and follow all recommendations made by the professional.

- **DFCS should not act in the role of substance abuse counselor and identify the only treatment that will work with a particular parent.**

- Some people will start outpatient treatment and then go inpatient (or fail their way into) once they understand (and/or trust) the programs better. DFCS' role is to get parents to the door and the SA programs will help direct them to appropriate services once there.

- Even before you get a chance to attend other courses, educate yourself about drug usage. If you see a pipe, roach clip or lots of cough syrup bottles, know what that means. We are NOT advocating that you try any of these substances; educate yourself through literature instead.

- Let the parent know when you see paraphernalia during the visit (if you can do so safely), or call for a follow up office visit to discuss an important matter.

WORKSHEET: How Did I Get Here?

Running late to work, Jackie jumped on the subway car at the last moment before the conductor closed the door. Unfortunately the hood of her coat is caught in the door. Today it is 20 degrees outside and Jackie has to walk 5 blocks to work after she gets off the subway car.

- What is the **Best** that Jackie can hope happens in this situation?

- What is the **Worst** that Jackie imagines will happen in this situation?

Jeffrey steps out of his car to lock the garage door. The car door accidentally locks with both the dog and Jeffrey's 3-month-old nephew inside.

- What is the **Best** that Jeffrey can hope happens in this situation?

- What is the **Worst** that Jeffrey imagines will happen in this situation?

Ms. Shelby Filerstone just found out her beloved husband of 12 years has been having sex with their 8-year-old daughter.

- What is the **Best** that Ms. Filerstone can hope happens in this situation?

- What is the **Worst** that Ms. Filerstone imagines will happen in this situation?

ACTIVITY: What Do I Do?

For the 3 scenarios, identify 3 or 4 steps you could take BEFORE asking the child directly about the sexual abuse allegations.

Foster parent tells you during a routine monthly visit that child may have been molested prior to removal from her home, although this was not the reason she was brought into DFCS care. Before you get a chance to respond, the foster mother calls Leila in the room and says "Tell this lady what your daddy did to you".

1.

____

____

2. ____

____

3. ____

____

A child breaks down in tears at school, without apparent cause, as you try to talk to him about the whipping he received last night from his uncle. Child has no marks but is clearly afraid of his uncle, and isn't explaining why.

1. ____

____

2. ____

____

3. ____

A mother (who now trusts you as her Ongoing case manager) asks that you talk to her child about possible sexual abuse by the father. She just has a suspicion but no concrete knowledge that something inappropriate occurs when the child visits her

father. The mother doesn't want to "start a big thing" by calling the police unless others have similar suspicions.

1.

____

____

2.

____

____

3.

____

____

ACTIVITY: What Strength?

DIRECTIONS:

1. **IDENTIFY** a family strength first.

2. **REFER** to the RA Definitions in the Participant Guide to decide what category/concept that strength would fit in.

3. **DOCUMENT** on the Risk Assessment Tool ***after*** you have made your decision.

4. **REPEAT** for all the other strengths you identify in your family.

ASK a neighbor to prompt you with strengths you possess if you have trouble getting started.

MOLD the form to fit your purposes. Either complete the form based on you as a child in your family, you as a parent in your own family now, or you as a caregiver of other children (e.g., nieces, nephews, or grandchildren). Although the categories may need to be "fudged" a little to fit your family, you can still use this format to identify your strengths.

FOCUS on things you would tell a potential boss in a job interview or a potential mate you would like to get to know better.

RESPONSE TO INTERVENTION *can either be an imagined DFCS worker at your door or address how you feel about having to complete this activity.*

ACTIVITY: What Strength?

10. Assessment of Family Strengths:
Please check the box below if the area is a strength.

Child Vulnerability: ☐ **Yes** ☐ **No**

☐ **Child Fragility/Protection**

☐ **Child Behavior**

Caregiver Capability: ☐ **Yes** ☐ **No**

☐ **Knowledge/Skills**

☐ **Control**

☐ **Functioning**

Quality of Care: ☐ **Yes** ☐ **No**

☐ **Emotional Care**

☐ **Physical Care**

Maltreatment Pattern: ☐ Yes ☐ No

☐ **Current Severity**

☐ **Chronicity**

☐ **Trend**

Home Environment: ☐ Yes ☐ No

☐ **Stressors**

☐ **Dangerous Exposure**

Social Environment: ☐ Yes ☐ No

☐ **Social Climate**

☐ **Social Violence**

Response to Intervention: ☐ Yes ☐ No

☐ **Attitude**

☐ **Deception**

Module Eleven
LEGAL SYSTEM AND PERMANENCY

TIME: 3 hours, 45 minutes

PURPOSE:

Case managers will become familiar with the juvenile court process including court orders, understanding the operation of the court process, and will understand the need for permanency for children.

LEARNING OBJECTIVES:

After completion of the module case managers will be able to:

- Make placement decisions and understand court orders
- Define 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.
- Prepare for appearing in court.
- Understand a child's need for permanency and identify the resources for permanency

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

FC Policy 1002.2

JUVENILE COURT PROCESS		
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 Initial Case Plan may be incorporated into the dispositional order of the court (or	The possible dispositional alternatives are: • Permit the child to remain with parent or other custodian, possibly with supervision; • Transfer temporary legal custody to DFCS, another

JUVENILE COURT PROCESS		
	in a later supplemental order).	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 and when the Agency intends to file a petition for termination of parental rights. A supplemental order may be entered if there are Case Plan revisions.

Professional Dress Guidelines
WOMEN

DO:

- Wear solid, neutral or subdued colors
- Wear suits (with skirt or pants)
- Wear conservative dresses (especially solid colors)
- Have light/natural looking make-up
- Wear minimal jewelry (Small earrings, one necklace, two rings max.)
- Have short/medium nails
- Wear low (2 inch max) heels (closed toe or closed heel or both)
- Have overall good hygiene (a clean, polished appearance}
- Remove body piercing and cover tattoos)

DO NOT:

- Wear short skirts (more than 2" above the knee)
- Wear low cut tops
- Wear sheer blouses or shirts
- Wear crop shirts (midriff showing)
- Wear sleeveless/halter tops
- Wear party/nightclub type dresses
- Wear big/bold/excessive jewelry (especially earrings)
- Wear hats
- Wear flip-flop, platform shoes
- Wear shoes that are open on both ends (toe and heel)
- Have excessively long (especially long acrylic) nails
- Have unusual color nail polish (i.e., blue, green, black) or bright red
- Have chipped nail polish
- Wear heavy dark makeup
- Wear facial jewelry (lip, nose, eyebrow piercing)
- Show tattoos (cover if possible)
- Have hair that hangs in the face and/or has to be repeatedly fixed and/or covers eyes
- Wear hair jewelry (rhinestone barrettes, or pins)
- Have on heavy perfume
- Have chew gum or eat candy (you don't want anything in your mouth that could affect your speaking)

Professional Dress Guidelines
MEN

DO:

- Wear solid, neutral or subdued colors
- Wear suits (pants/jacket)
- Wear dark dress pants with a white or light colored shirt
- Wear dress shirts (button up shirts)
- Wear a tie (solid or subdued patterns)
- Wear dress shoes (polished)
- Wear a brown or black leather belt
- Have overall good hygiene (a clean, polished appearance, remove body piercing, cover tattoos)

DO NOT:

- Wear polo shirts
- Do not have on wrinkled or bun-ironed shirts
- Wear khaki pants (Those are dress casual, not professional dress.)
- Wear baggy and/or low-hanging pants
- Wear jewelry (For men, about the only acceptable jewelry is a conservative watch, a wedding and/or class ring)
- Have ungroomed facial hair
- Wear tennis shoes, boots, sandals, /hiking shoes
- Wear theme ties (Mickey Mouse, cartoons, etc.)
- Wear hats or caps
- Show tattoos (cover if possible)
- Wear hair that hangs in the face and /or has to be repeatedly fixed and/or covers eyes
- Wear belts with designs on them/metal details/big belt buckles
- Use heavy cologne or aftershave
- Have chew gum or eat candy (you don't want anything in your mouth that could affect your speaking)

Demeanor in Court

RESPECT

- 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.

General Rules of Testifying

- ✓ Tell the Truth!
- ✓ Be yourself!
- ✓ Be natural and use common language.
- ✓ Try to avoid work related jargon or slang.
- ✓ Your role is to testify, not to convince.
- ✓ Speak in a clear tone of voice.
- ✓ Avoid covering your mouth or resting your chin on your hand while you are speaking. Speak at a normal rate of speed so that the court reporter and the jury can hear your words.
- ✓ When asked a question, pause, think about the question and think about your answer before you start talking.
- ✓ Simple "yes" or "no" answers should be directed to the person who asked the question.
- ✓ Longer, narrative answers, however, should be directed to the judge.
- ✓ Answer the questions with a "yes" or "no," if possible, then explain. Be brief and on point if a narrative answer is requested.
- ✓ Avoid answering any question that you do not understand completely. Ask to have the question clarified.
- ✓ “I do not know” or "I do not remember" are valid answers, if appropriate.
    - "I do not know" means that you do not and never did know something.
    - "I do not remember" means that you may have known something at some previous time, but do not remember it now.
- ✓ Use terms like "approximately" when asked for measurements of time and distance.
- ✓ Avoid appearing arrogant.
- ✓ Avoid giving the answer to a question until the attorney has finished asking it.

- ✓ Avoid allowing yourself to be talked into false testimony or affirming incorrect statements.
- ✓ Listen carefully to each question, and be sure that everything in it is true before adopting it as your own. For example: "Isn't it true that..."
- ✓ If you realize that you have made an error in your testimony, immediately ask the judge for permission to correct the error.
- ✓ If your testimony is interrupted for any reason, stop talking. This is especially true when it is interrupted by a question from the judge or counsel's objection.
- ✓ Avoid being anxious to volunteer information.
- ✓ Avoid testifying, reading from or otherwise referring to your report without first asking for permission from the judge to refresh your recollection by looking at it.
- ✓ Remember that all documents taken by you to the witness stand can be examined by either attorney. (This is why it is not a good idea to take case records into the court room.)
- ✓ If you are asked to read a document out loud by an attorney or the judge, read it slowly so the court reporter can record your testimony.
- ✓ Remember that you cannot offer or volunteer your opinion unless you are testifying as a court qualified expert witness.
- ✓ Do not be intimidated by the attorneys. They are simply representing their clients. Remember to only answer the question asked of you. Do not hesitate to ask for clarification if you are uncertain about a question.
- ✓ Speak Up! Remember that everyone must hear your answers.
- ✓ Avoid answering the question with the phrase "I believe..." "I think... or "I am not sure..."
- ✓ You are to testify only as to what you saw, heard, smelled, tasted or felt, unless you are an expert witness qualified by the Court to give your opinion(s).

Permanency Plan Options

Reunification

Adoption

Guardianship

Permanent placement with a fit and willing relative

Another planned permanent living arrangement

Assumptions and Beliefs About Permanency

All children have a right and need to live and develop within safe, secure, and permanent families.

Children separated from their families for extended periods of time, are likely to experience tremendous psychological and developmental disruption.

A child's perception and experience of time are determined by the child's level of cognitive development.

The best choice for a child is the least restrictive, most family like setting available that meets the child's safety, emotional, and physical needs.

UNDERSTANDING AND HANDLING OF FEELINGS TYPICAL OF CHILDREN IN PLACEMENT

There are five emotions that most children who are in foster care seem to experience to some degree. These feelings are:

1. *Confusion*

   Because the child's initial placement is often the result of a crisis, he or she is usually unprepared for the move. Being moved to the home of strangers may cause such a shock that the child is unable to hear or comprehend explanations given to him or her. The child is likely thinking: "Where am I going? Why? Where is my mother? Will my parents find me? Where are my brothers and sisters? Are they all right? What's going to happen? Will I like these foster parents? Will they be nice to me? Why did this happen?" The child is unlikely to verbalize confusion, but we can assume he or she is experiencing it.

2. *Anger*

   When recovered from the shock of the move, the child is most likely to feel angry. The anger may be directed towards him or herself, the foster or adoptive family, the caseworker or others. Most children, especially younger children, cannot acknowledge anger towards their primary parents. Even when the child does make angry statements about his primary parents, it is important not to agree with him or her, but rather to acknowledge how the child is feeling.

3. *Ambivalence and mixed feelings*

   The mixed feelings a child experiences - rejection and attachment, love and hate, trust and mistrust - can be summarized as ambivalence. Most children have mixed feelings about their primary parents, and their foster or adoptive parents, and their caseworker too.

4. *Fantasizing and wishful thinking*

   When the truth is painful and overwhelming, it is easy to see how a child can fantasize. At times, it may seem that a child is lying about his situation, but in fact the story he or she tells may simply be

wishful thinking, or it may reflect the child's lack of understanding about the situation.

5. *Identification with birth family*

In spite of all of the feelings described above, the child will still feel a strong sense of identification with his or her family. Most children, with the exceptions of some teens, would prefer to be living with their families, even if they were abused in that setting. Children usually love their foster or their adoptive families, but it is important to remember that these feelings are separate from the love they feel for the birth family or other primary family.

Vera Fahlberg, *A Child's Journey Through Placement.* Perspective Press. 1991.

The Lifebook

What is the Lifebook?

The Lifebook is a tool for providing children in care with information about their own personal histories and with opportunities for questioning, understanding, and accepting their own past. The Lifebook is made of simple materials; usually begins with "I was born on. . ." and progresses through events in the child's life. It contains pictures, stories, photographs, report cards, school work, maps, birth certificates, and so on.

The Lifebook can be used with children of preschool age, with school age children, or with adolescents. It may be used with all children in care, regardless of whether they will ultimately return to their birth families or move out of foster care on their own.

Why Construct a Lifebook?

The Lifebook can contribute significantly to the development of a "psychological base" for the child. It helps the child understand the past, function better in the present, and prepare for the future. The ways it contributes to each of these phases of the child's life are summarized below.

The Past

1. Organizes the pieces of a child's life experiences in a tangible manner, which will help the child visualize his "history" and "roots."
2. Gives significant adults involved with the child (parents, foster parents, adoptive parents, social workers, etc.) words to phrase the life events, which are often hard to explain to children, in a way that encourages understanding and discussion of feelings.
3. Gives the child something unique that is part of him and that he/she can turn to when he/she needs reassurance or understanding.
4. Helps the child sort out the realities and fantasies of his memories. Helps the child fill in the gaps and clears up some of the confusions that may exist in his comprehension of his/her life experiences.
5. Helps give some context to the sources of the child's hurts or sensitivities.
6. Serves as an ongoing, continuous record that links changes, moves, and people in the life space of the child.
7. Provides a method by which the child can come to terms with his/her life experience and identify what has contributed to that experience.

The Present

1. The life events of a child are presented in a non-judgmental and understanding manner that helps counter-balance any feelings of self-blame or badness that the child may possess as a result of his experiences.
2. The photographs, mementos, and thoughts compiled over the months and years help to show the important uniqueness of the child's growth and development.
3. The book provides graphic evidence of being cared for and about; messages that say, "you and what you do and how you express yourself are valuable."

The Future

1. If the child returns to birth parents, the Lifebook can provide a linkage between experiences in foster placement and experiences in the birth family.
2. If a child moves into an adoptive family, it helps the child bring a sense of self-worth and value into his/her new home. The book helps him take his past experiences with him.
3. If the child remains in foster care, the Lifebook can help provide continuity to the child's life experiences in multiple placements. The book helps organize the variety of people the child has encountered.

When Should One Begin the Lifebook?

It makes the most sense to begin the process of making a child's Lifebook when the child comes to the attention of the system. Contact with and knowledge about parents is most often accessible and accurate at this point. The parents can be encouraged to provide the child with a sense of his/her family story.

Since building the Life Book is an ongoing process, changes in the development or experiences of the child, and those significant others in the child's life, can be described. The child's sense of confusion is heightened at the time of his/her placement or changes in placement. This confusion may make it difficult for the child to recall the experience later, if it is not documented in some way.

Who Contributes to the Lifebook?

All significant people in the life of a child can contribute to his book. Some possible contributions from foster parents are noted below:

1. Foster parents play a crucial role in compiling, collecting and preserving pictures, school papers or records, cards, and stories about the everyday life of the child.
2. Foster parents can read the book to smaller children.
3. Foster parents can help reinforce the value of the book with a child.

What Things Go into a Lifebook?

1. Child's birth information:
    - Copy or a certified birth certificate (Additional birth certificates can be ordered from vital records)
    - Date, time, location (city, state, hospital), weight, and length

2. Child's family tree:
    - Genogram
    - Date of parents' birth
    - Location of parents' birth
    - Physical description of parents
    - Educational/employment experiences of parents
- Special health information about parents
    - Statement of reason for placement(s) away from parents (statement made by parents, if possible and /or appropriate)
    - Number of siblings of parent
    - Number and ages of other children of parent

3. Foster homes/relative homes where the child has lived:
    - Names of foster families
    - Addresses of foster families
    - Dates of placements and moves from placement

4. Medical information of child, especially any special medical experiences

5. Names of social workers/agencies where child, and perhaps parents, received services

6. Letters, mementos from parents/relatives or significant others of child

7. Pictures of child at various ages

8. Other helpful information:

A. Pictures:
- Birth parents
- Birth parents' home
- Siblings
- Friends
- Foster families
- Pets
- Schools
- Social workers
- Special occasions (graduations, birthdays, holidays, vacations, awards, etc.)

B. Drawings by the child:
Comments by child regarding drawings or feelings

C. Achievements of child:
- School
- Church
- Athletics
- Hobbies
- Activities
- Developmental

D. Report Cards:
- Comments of teachers
- Samples of school work

E. Stories, comments from social workers

F. Anecdotes about child:
- A funny occasion
- A scary time
- An important experience in the child's growth
- Pranks or jokes

G. Friends' comments about the child (autograph book signatures or messages)

What Behaviors Might Come Up in Building the Life Book?

The foster parent may worry about the child going over past events. When there is worry about the many difficult things in a child's life experiences that need to be explained, remember, "It's not what is out in the open that causes problems – it's what is hidden or not openly talked about."

The child may renew old behaviors or act out. The child needs support and understanding.

If separated from siblings, there may be an interest in finding out about them and seeing them.

Other children in the home may want a Lifebook.

Information About the Child and Their Life Book.

The child may feel very possessive about his book.

Remember, the Lifebook belongs to the child. Share the book with others only with the child's permission.

DILIGENT SEARCH

CPS Policy 2102.3a
FC 1002.3.1

- Required by law (O.C.G.A. 15-11-55)
- Purpose is to identify individuals who may be considered a resource for placement or custody of the child.
- Case Managers must conduct a diligent search for:
  - Parent(s)

    - Relative of the child
    - Others who may have an ongoing interest in the child
- Search must be conducted within 60 days of the child's removal from home.
- Court determines if the search efforts were "reasonable diligent"

METHODS FOR CONDUCTING THE SEARCH:

- ✓ Interview child & family
- ✓ Review the Basic Information Worksheet
- ✓ Use Family Team Meeting, Family Planning meeting or Multi-Disciplinary Team meeting
- ✓ Review Family Assessment Report of the CCFA
- ✓ Check DFCS Systems
    - SUCCESS
    - IDS
    - Any other know source of information
- ✓ Contact any other person involved with the child or family who may have information
- ✓ Direct contact via telephone, mail or face-to-face to determine individual's interest

Module Twelve
PLANNING WITH FAMILIES

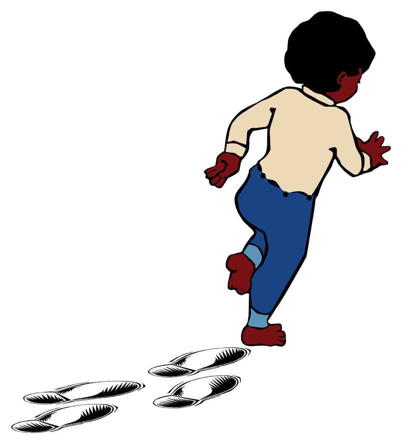
PUPROSE:

Case Managers will understand the importance of family involvement in case planning to insure child safety, and timely, high quality services to families.

OBJECTIVES:

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

- Understand the importance of case decisions and change.
- Explain the purpose of the family/case plan.
- Identify the component of the family/case plan.
- Involve families in the development of appropriate, time-limited case goals and steps.
- Formulate observable, behavioral measures of the goals and steps, and identify the most appropriate services and activities to achieve case plan steps.



Steps in Planning with Families

Information Gathering

Analyses the Family Situation: *Look for the Underlying Problem*

Drawing Conclusion*:* *Formulate Goals*

Making Decisions: *Identify Intervention Activities*

And the Answer Is?

Foster Care 1007

1. The Case Plan is the primary tool for _______________ intervention with families.
2. The Case Plan is based on having a thorough understanding of ____________________ unique to a family.
3. The ____ provide valuable information to the court, DFCS, service providers and others who are significant in planning with and for the family.
4. The case outcome for children in temporary out-of-home placement ______________________________.
5. Since permanency must be finalized within _______________ after a child enters care, it is especially critical for the initial Case Plan to be well executed.
6. The Plan must be ___________________________ and involve the input of other significant parties. The use of family conferencing strategies enhances case plan development, placement planning and decision-making.
7. Goals must address only those behaviors or conditions that must be corrected ____ returned.
8. Goals must be specific, ________________________, positively stated, measurable and written in clear and simple language.
9. The steps are those activities which outline ________________ __________________________________, when, how often and where. Steps are the "stepping stones" toward the achievement of a specific goal.
10. ______________________________ for achievement help to direct and motivate; however, the time needed by the parent to make the necessary changes must be balanced with the child's developmental needs and his/her needs for permanency.

And the Answer Is?

CPS 2105.9

1. Develop the family plan on Social Services – and ____________ :Goals/Steps.
2. Substance abuse, if identified as a need on the Strengths and Needs Assessment, becomes _________________________ to address in the initial case plan.
3. During the initial case planning, discuss all needs that must be addressed _______________________ to case closure.
4. It is difficult for a family to tackle changes relating to more than two or three needs at one time. Where there are multiple needs to address, it is advisable to deal with ________________________________ on any one case plan.
5. The Case Plan includes: Outcomes - ________________ ______________________ (CPS) or _____________________ (Placement)
6. Protection - The most common case outcome is to protect children from further _______________________ and to work with the family to change _____________________________ or circumstances that created the risk, thus assuring children's ______________________.
7. Permanency - This is most often used in the placement or foster care program. In choosing permanency, decide how permanency will be achieved by selecting one of the following five alternatives: ______________________, long term foster care, emancipation, adoption or other.
8. Goals are specific, behavioral, positively stated, ____________ and written in clear and simple language.
9. Family involvement in the development of goals is criical. Successful case plans are developed ____________ families, not _____________families.

And the Answer Is?

10. Behaviorally specific. It _________________ what behavior or circumstance needs to be learned and/or demonstrated. Changing that behavior or circumstance is ___________________________ to lowering the risk of maltreatment to the children;
11. It is realistic and within _____________ capacity to achieve;
12. It is measurable. Measurable achievement criteria indicates how the case manager and the family __________________ that the goal is achieved;
13. It is needs related. Families often have many problems. Relate goals to the numerically rated needs chosen for inclusion in the case plan. Consider whether the highest numerically rated needs are the ones ________________________________ to the identified maltreatment; and,
14. It is positively stated in terms of what _____________________ __________________the family will learn and demonstrate.
15. _______________- the specific activities that outline who will do what, when, how often and where.

Components of the Family Plan

Outcomes

Protection

Permanency

Goals to be achieved

Specific steps that must be taken in order to reach the goals

Indicators of Well Written Goals

Behaviorally specific

Realistic

Measurable

Need-related

Positively Stated

EXAMPLE GOAL:

Sarah McKenzie will have a job to meet her family's basic needs.

Questions to consider:

Identifying Goals
1. Jackie Smith will stop hitting her son Jason as the only means of discipline and will stop excessive criticism of him.
2. Mr. Russet will become and remain alcohol free by the first of May.
3. Jackie Smith will exhibit age-appropriate parenting skills toward her son, Jason
4. Mrs. Smith will attend Alcoholic Anonymous.
5. Mrs. Sherrill’s yard needs to be safe for Paul to play in.

Identifying Goals
6. Mrs. Brown will obtain and use financial resources to meet monthly basic needs of her family.
7. Mr. Smith is unable to provide Michael with the emotional nurturing that is appropriate for his age.
8. Mrs. Willis will not leave Scott home alone.
9. Ms. Morris needs to learn how to plan nutritious meals.
10. Towanda Norton will do better at paying her bills on time.

Criteria for Steps

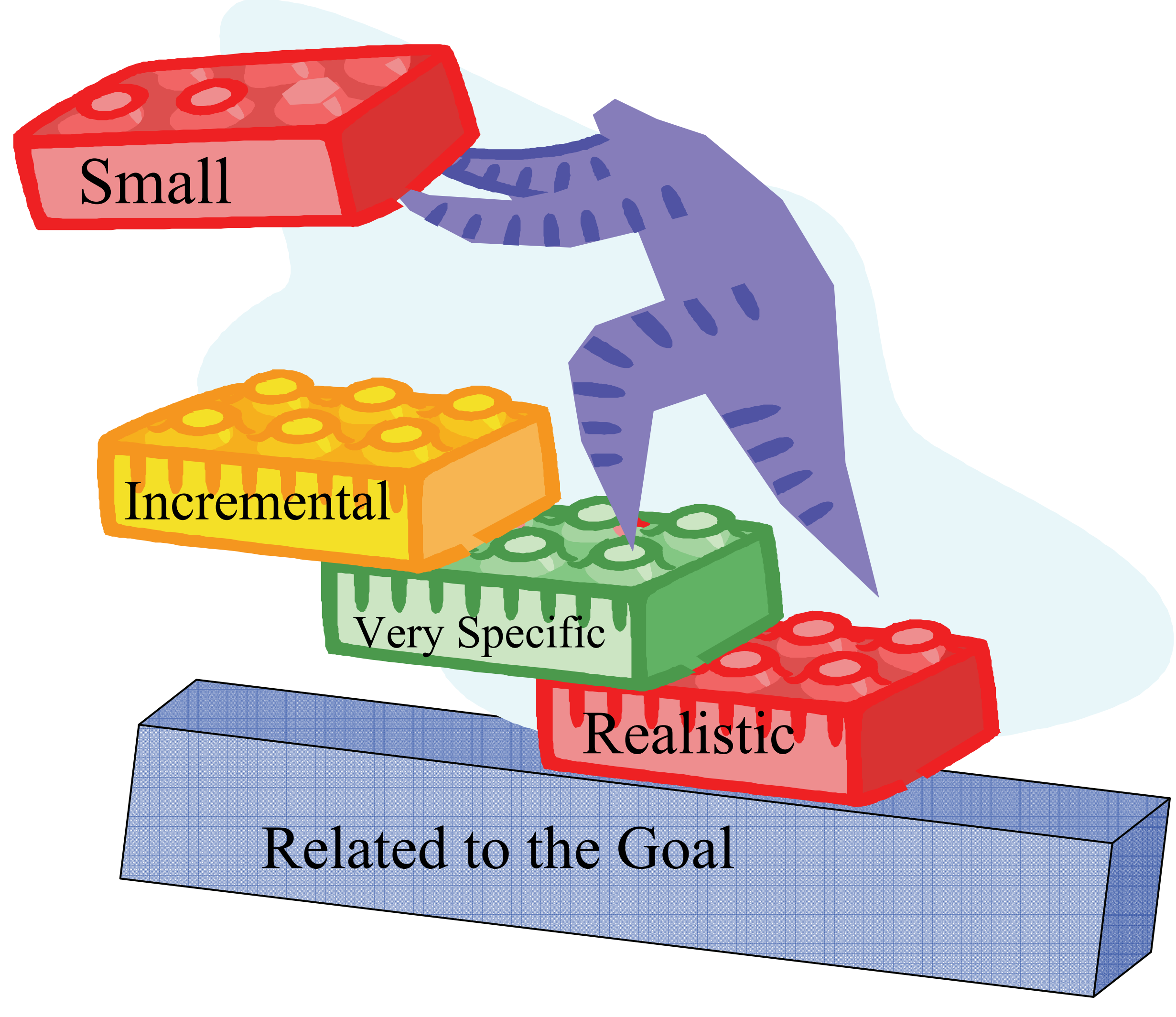
Who will do What

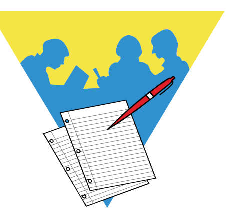
When

Where

How often

Steps Must Be:





The Family Plan

- **Guides all the agency's work with the family and child from intake through case closure and aftercare services**

- **Documents what must change in order for the parents to meet the needs of the child and provide documentation of the changes that have or have not occurred.**

The purpose of the Family Plan planning process is:

- **To clarify with the family the reasons for DFCS involvement;**
- **To focus on the safety, risk, and permanence needs of the child;**
- **To involve the family in identifying areas that need improvement;**
- **To clarify expectations for behavioral change with all persons involved; and**
- **To acknowledge the family's strengths and commitment to their child.**

The plan must address:

- **The services to be provided or arranged;**
- **The visitation plan designed to maintain links with the family;**
- **The expectations of the family, agency, placement provider and community members;**
- **The target dates; and**
- **The expected outcomes.**

The Family Plan is important because it:

- **Assures attention to critical needs in the family;**
- **Guides overall planning and service delivery for families and children;**
- **Documents objectives that parents must meet for reunification and**
- **Documents behaviorally specific activities necessary to meet objectives;**
- **Assigns responsibility for activities;**
- **Documents the level of progress of the family toward reunification; meets the requirements of Federal and State law;**
- **Provides documentation necessary to draw Federal IVE funding;**
- **Provides documentation for the court; and**
- **Documents reasonable efforts by the agency, in preparation for termination of parental rights.**

Wesley and Caroline

Wesley, 14, and Caroline, 8, were reported to DFCS by a neighbor who said several times she had seen their mother, Ms. Stanley, hit them when she was clearly drunk. Wesley was cradling the side of his face. He said it was really sore, but there were no marks, bruises, or swelling. Reporter thinks Wesley's mother may have slapped him as she has seen this happen before. She has not noticed marks or bruises before. The reporter explains that the mother "doesn't hit the kids that hard, but that she hits them often." When she asked him how it happened, he wouldn't answer. The Case Manager noted that although his face was tender there were not marks or injuries outside or inside his mouth. Caroline had no marks or injuries. Wesley said that he had been in a fight at school; however, Caroline said their mother slapped Wesley and pushed him down for fighting with Caroline. Caroline said her mother hits them with her hands but not with an object. Caroline said her mom usually hits them when she is stressed and "takes a lot of extra pills". Caroline says her mother will "cuss" at them, and tell them they are nothing but trouble, when she is stressed. Wesley refused to talk, saying he didn't want to be put in some kind of group home.

Ms. Stanley said sometimes her kids do get out of control, and she hits, slaps, or pushes them. She acknowledged striking Wesley for disobeying her, adding that she never hit her kids hard enough to "hurt" them. She said that she raises her kids the way she was raised, and she wants her kids to mind her when she needs them to do things. She says being a single parent is hell and she gets no help from anyone. She admits to currently being stressed as she has just been given an important new family at her law firm, and depending on how things go, the firm stands to make millions of dollars. She denies having a substance abuse problem, saying Caroline is overly sensitive. Her father prescribes the only medications she takes, and he is a physician. Ms. Stanley does not want or need DFCS intervention.

Step One: Identify the primary problems that make these children unsafe.

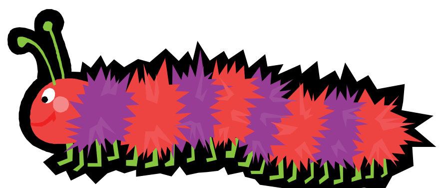
Step Two: Pick one of these problems and reframe it describing the positive behavioral outcome that the parent must do to make these children safe.

Step Three: Write steps that would build on each other to lead the parent to the desired goal. *Remember that this activity is to practice the skill of writing and does not represent Good Practice for working with the family.*

Control

VS.

Change



Tips for Establising Family Involvement

☺ Acknowledge the difficulty that the client may have working with the case manager because of the power dynamics inherent in the case manager-client relationship.

☺ Acknowledge cultural and gender differences and invite the client to ask questions and point out when the client feels that he/she may have been misunderstood.

☺ Invite the client to share how such a problem would be solved in his/her culture of origin, and integrate this method whenever possible. (This can be particularly effective when working with families that immigrated to the U.S.)

☺ Ask the client who in his/her family or cultural group can assist him/her, or whom the client would like to include in the family planning process. Integrate these people whenever possible. (Make sure that the client has signed consent to release information forms for all people with whom you discuss the case.)

☺ Explain the process of formulating the family plan carefully and invite questions by the client.

☺ Reframe clients' behaviors as strengths whenever possible.

CPS Policy Reference 2105.11

Services are activities that help achieve the steps and goals of the case plan. They are tailored to the individual and to resource availability in the community. Always relate services to the attainment of a selected step and goal. Examples of services are:

- **Family Service Workers** provide in-home help for:
  - Parenting education/modeling and child care
  - Home and financial management to assist in reducing risk to children
  - Shopping, meal planning/preparation to meet nutritional needs of families
  - Families needing support, guidance, structure, respite

- **Employment** services, based on:
  - Lack of sufficient income to provide for basic needs
  - A desire for employment

- **Individual counseling or psychotherapy** help for:
  - Unresolved individual issues that are incapacitating
  - Poorly developed interpersonal relationships
  - Other serious mental health disorders

- **Group counseling,** to help with:
  - Difficulty in social relations and those needing group supports
  - Strong character defenses such as projection
  - Need for confrontation from a number of people
  - Child development

- **Marital and family counseling,** to help with:
  - Families with destructive relationships
  - Generational conflict
  - Blended families
  - Child development
  - Role reversal, boundary issues, scapegoat

- **Educational services,** to help with:
  - A learning deficiency
  - Employment enhancement
  - Completion of school or GED

- **Parent Aide** services / **Parenting Skills** training, to help with:
  - The socially isolated
  - Those needing parenting skill development

- Parents needing to improve parenting, nurturing skills
- Parents needing to understand discipline issues
- Parents needing to learn child development

- **Day care/child development** services, to help with:
  - Observing and monitoring a child's behavior and physical condition
  - Day care for a parent's employment
  - Child needing developmental stimulation or socialization

- **Homestead** services, to help with;
  - Families in crisis with children at risk of foster care placement
  - Families in need of intensive counseling
  - Families needing support and counseling for reunification

- **Prevention of Unnecessary Placement (PUP),** to help with;
  - CPS case where a family is in crisis with children at risk of entering foster care
  - Short term, crisis-oriented services to prevent out-of-home placement
  - Immediate reunification of foster children returned to their parent or relative

- **Foster care or shelter,** if;
  - Parent is unwilling to protect and/or provide safe environment
  - Children at risk of maltreatment when in-home services do not reduce risk
  - Overwhelmed parents or families in crises, unable to cope
  - Children who provoke their parents to the extent that an unstable atmosphere prevails

Community Collaboration

Juvenile Court

- Assures the rights of parents and children are not violated. Grants legal sanction to DFCS to intervene on behalf of maltreated children.
- Terminates or limits parental rights and assigns responsibility for custody and care of the children to the child protection agency
- Routinely reviews family plans and activities for children in agency custody.
- May appoint attorneys or guardians-ad-litem to represent the parties.

Mental Health

- Identifies situations in which children are potentially being abused or neglected, and initiates a referral to the child protection agency.
- Develops and provides mental health and counseling services to children and families.
- Assumes responsibility for placement of, or community-based services to, emotionally disturbed and mentally ill children and adults.
- Participates in collaborative decision making in jointly served cases.
- Develops and provides specialized expertise to treat family and child problems contributing to or resulting from maltreatment.

Public Education

- Identifies situations in which children are potentially being abused or neglected, and initiates a referral to the child protection agency.
- Monitors children and reports suspected maltreatment on an ongoing basis.
- Collaborates with child protection agency to plan and provide remedial and supportive services to children in school.

Law Enforcement

- Investigates and intervenes when perpetrators are believed to have broken the law.
- Files criminal charges when appropriate.
- Supports and protects child welfare agency staff from the harmful acts of family members.
- Conducts arrests, files restraining orders, protects family members.
- Helps case managers remove a child from a family in an emergency or prior to the issuance of a court order.

Health Care System

- Recognizes and identifies children who are potentially maltreated; conducts thorough medical examination and refers to agency for assessment.
- Gathers medical and other evidence to substantiate presence of abuse or neglect in court proceedings.
- Provides emergency and ongoing medical treatment to abused and neglected children.
- Provides specialized services to families, begins to engage families into the service process.

Module Fourteen

CONTINUOUS ASSESSMENT, REASSESSMENT, and CLOSURE

PURPOSE: The case manager understands the importance of conducting routine and timely case reviews with families and knows how to reassess the outcomes of all case plans and service interventions and make appropriate plan modifications.

LEARNING OBJECTIVES:

After the completion of the module, participants will be able:

- To utilize the Trusting Relationship with the family to motivate and influence change
- To identify resistance to change as a normal response
- To demonstrate the importance of continuous assessment of the family's progress
- To explain the importance of the family involvement in the reassessment of the plan
- To explain the interrelationship between CPS and FC in the case outcome

Analyzing a Relapse

- What was different about this relapse?
- How did the family member(s) end the episode?
- What was learned from the episode that can be used in the future?
- What does the family member do between episodes to avoid relapses?
- When is the family member more vulnerable to relapse?
- Are there any larger system issues that cause a "ripple effect?"

Adapted from: Berg, 1. K. (1994). Family based services: A solution focused approach. New York: W. W. Norton & Company

A Story of Progress

Dr. Carl Henley is a recently-retired professor at the UNC-CH School of Social Work. Several years ago he suffered a rare spinal stroke, which left his left side paralyzed. Medical practitioners were not sure if he would ever regain use of his left side again, but, from day one, Dr. Henley was convinced that he would recover. His progress has been slow but steady, and today he is not only walking, but playing golf! We asked him what tips he had for staying motivated throughout his recovery, and these are his words of wisdom:

- Try not to have unrealistic expectations.
- Burnout comes from trying to solve the entire problem at once.
- Set small, realistic goals so you can enjoy some successes along the way
- When progress is slow, people are inclined to give up and say, "What's the use?"
- Keep up with your successes and your "failures," so you know what you do well and where you can improve.
- Celebrate your successes, however small.
- Take time to entertain yourself and do things you enjoy.
- Have a goal, something you are looking forward to, and reward yourself when you get there.
- Don't be afraid to change what you're doing if it isn't working - talk to someone about your frustrations.
- Recognize that not everything you're going to do is going to be successful, don't beat yourself up when things don't work out.

These motivational tips can be applied personally and to your clients. Remember that your motivation will directly impact your clients' motivation. In addition to teaching them motivational skills, you can set a good example for your clients by

taking care of yourself along the way, celebrating your successes, and striving to improve your own practice.

Steps of a Case Plan Review/Case Plan Update

Gather updated information.

Review the family's progress with key service providers.

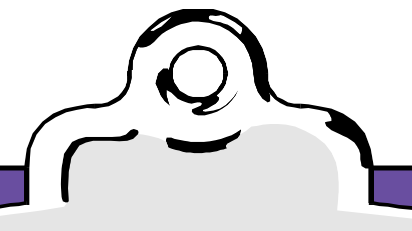
Contact other collaterals.

Review the family plan with the family.

Update the family plan.

Review the case in supervision.

If case goals and steps have been achieved or if no additional services are needed, the case should be closed.



Guidelines for Evaluating the Family Plan

- Pay attention to new information.
- Don’t assume that the client has been deliberately evasive when new information comes to light.
- Some new information is useful; some is not.
- Be flexible and willing to change your mind.
- Keep asking questions.

Strategies for Effective Case Closure

Define the nature of the relationship early in the casework process.

The case manager should explain to the client that the purpose of the casework relationship is to help the client learn to help himself/herself and that the relationship will end when that purpose has been achieved.

Include a planned period of separation prior to final termination.

The case manager should involve the family in planning for closure through the family plan discussion and review, and by setting time frames for case closure. The case manager's direct involvement should be gradually decreased during this period. The case manager should encourage and reward the family for learning to manage problems for which the family previously turned to the worker.

Acknowledge the feelings of the client, and reassure him/her that ending services does not change the case manager's feelings for the client.

The case manager should reaffirm concern and caring for the family and the case manager's belief that the family is important. The family may not express feelings of abandonment, or a belief that the worker no longer cares (or never really did care) about the family. However, this issue is often important to the family. The case manager may need to talk about the permanence of feelings despite physical separation and lack of contact.

Encourage the transfer of attachments from the case manager to other relationships within the community.

Through the relationship with the case manager, the family may have learned that other people can be trusted and will help. This may help the family to establish or strengthen relationships within the family or community. Linkage with naturally occurring support systems can provide the family with relationships that can exist over long periods. The case manager should encourage and facilitate the development of these relationships as part of the family plan. The case manager should help the family to identify potential supports and to develop skills to access them.

Spend time prior to closing reviewing the family's progress and the relationship between the family and the case manager.

When faced with a change or loss, people naturally want to commemorate what has happened and remember the progress that has been made. Structuring this discussion for the family, and offering them a chance to ask questions, allows the family to see where they have come from and accept the closure of the relationship.

Prepare to answer questions about further contact.

When a positive case manager-family relationship has developed, the family may wish to continue to have contact with the worker once the case has been closed or transferred. The case manager may also be tempted to maintain contact with the family to provide ongoing support or may feel a strong attachment to the family. In some selected circumstances (particularly in rural counties or within closely knit cultural groups), ongoing contact between the family and the case manager is inevitable. Case managers have an ethical obligation, however, to avoid dual relationships with families.

Ending the Relationship with the Child

STRATEGIES	
• Talk with the child about what is happening • Long before the actual termination date, have a conversation with the child about what will happen • Deal with both your feelings and the child's about the impending closure	
Sample Conversation	
Case Manager	**In about a month or two, it's very likely the judge will sign the paper telling us that your parents can care for you without my help.**
James, age 8	**I won't see you anymore?**
Case Manager	**I'll see you a couple more times. Today isn't the last time. I just want to let you know ahead of time. Knowing what will happen ahead of time is good because then we aren't surprised. It gives us time to get ready.**
James	**Ready for what?**
Case Manager	**Ready to say good-bye to each other.**
James	**But what if I need you? What if my Dad gets mad and hits me again?**
Case Manager	**Your Dad has worked really hard to change what he does when he gets mad. He really wants to be a good Dad. Has something happened that makes you afraid?**
James	**No, but I will miss you. Can I call you?**
Case Manager	**Of course you can. We will talk about it more.**

Module Fifteen
TAKING CARE OF YOURSELF

PURPOSE:

Case managers will learn techniques to work effectively and safely in stressful and potentially dangerous situations.

LEARNING OBJECTIVES:

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

- Plan, prioritize, and effectively monitor completion of activities and tasks, within time frames required by the Agency.
- Develop skills related to identifying, responding to, and resolving potentially dangerous situations.
- Demonstrate an understanding of the importance of self-care and stress management in the provision of quality child welfare services.

Best Practices that Lead to TIME MANAGEMENT

- ☺ Well written case/family plans
- ☺ Prompt return of phone calls
- ☺ Empowerment
- ☺ Honesty, credibility, solid assessment and case management skills
- ☺ Timely submission of court reports
- ☺ Having a good understanding of your professional role

Attitudes Toward Time Management: Myths

I haven't got time to use all that time management stuff.

The people I work with won't let me manage my time the way I want.

How I manage my time is just part of my personality.

If I use time management, my life will be too controlled.

Common Problems Managing Time

<table>
<tr><th colspan="2">Problem: Your work environment discourages you from spending time the way you want or need to.</th></tr>
<tr><td>Examples:
The smell of coffee leads to the break room.
Your office is too hot or cold.</td><td>Possible Solutions:</td></tr>
<tr><th colspan="2">Problem: You lack skill to manage time effectively.</th></tr>
<tr><td>Examples:
You aren’t able to gracefully end a conversation with someone who interrupts you.
You aren’t able to control phone conversations.
You aren’t able to say “no” when you already have too much to do.
You aren’t able to prepare a daily “to do” list and work through it.</td><td>Possible solutions:</td></tr>
<tr><th colspan="2">Problem: You are not getting enough rewards for using time well, or you are getting rewards for using it inappropriately.</th></tr>
</table>

Examples:	Possible solutions:
• Attention – Playing the martyr and telling others how hard you work • Power – Being late for meetings • Avoidance of tasks – procrastinating in the hopes that someone else will do the work or the problem will go away • Resistance to change – change is hard work • Avoidance of responsibility – blaming others for your own choice or actions • Excitement and stimulation – running breathlessly to every meeting or finishing reports with only seconds to spare	
Problem: It is difficult to manage your time because it is not clear what you should be doing.	
Examples:	**Possible solutions:**
• You are a new worker and are unsure what to do next on a case. • You are not clear about the Departmental policy.	
Problem: It is difficult to manage time because you schedule poorly.	

Examples:	Possible Solutions:
• Forgotten appointments or last-minute meetings draw you away from ongoing tasks. • You are often late for meetings because you miscalculate how much time it will take you to get there, or you get lost on the way.	

Problem: Constant interruptions prevent you from managing time.

Examples:	Possible Solutions:
• Your phone rings throughout the day. • Chatty colleagues • Urgent problems constantly arise that must be handled immediately and cause you to drop everything.	

Problem: Disorganization causes you to waste time.

<table>
<tr><td>Examples:

• You cannot locate necessary forms in a timely manner.

• You must reschedule visits and phone calls because you don’t have the proper materials or you don’t ask the right questions.

• You forget information gathered during in-person contacts and then must ask again.</td><td>Possible solutions:</td></tr>
<tr><td colspan="2">Problem: Waiting wastes too much of your time.</td></tr>
<tr><td>Examples:

You spend time:

• Waiting for court hearings

• Waiting for clients during appointments

• Waiting for IDS to come back on line when there is an error in the network.</td><td>Possible solutions:</td></tr>
</table>

Our Own Worst Enemies:

Time-Sabotaging Gremlins

Procrastination

Pre-Task Avoidance Rituals (PTAs)

Small Irritants Create Huge Obstacles

Tips for Efficiency

Barter/trade/use cooperative arrangements/delegate

- One-time arrangement
- On-going swap

Organize your work area(s)

- Have certain places dedicated to certain tasks only
- Use hints to let your brain know what you are going to do

Take advantage of professional advice from colleagues and other experts

- Ask someone who is great at time management and organization for management tips

Don't interrupt yourself; do one thing at a time

- Make note of other tasks as you think of them, but do not interrupt what you're doing to work on them

Write "next step" reminders

- When you finish one piece of the task remember to write a note to indicate where you stopped and what the next step is

Use "bits of time"

- 5 minutes – Make an appointment, revise a to-do list, correct a letter, file your nails, water plants, plan evening social event, submit a report for approval, read e-mail, schedule an extended weekend vacation
- 10 minutes – Pick out birthday card, sort through mail, boot up computer, scan an article, clean top of desk, do isometrics, review court report draft for missing information, review newly distributed policy, draft agenda for multi-disciplinary meeting.
- 30 minutes – Write thank-you notes, write sections of a court report, set up family plan meeting, balance checkbook

Plan ahead

- Set things out the night before, develop tomorrow's "Today List" at the end of the day
- Budget your time realistically. (HINT: Estimate how long it will take and then double that)
- When you schedule a large block of deskwork, take periodic breaks to improve concentration and give you some variety

Consolidate

- Return phone calls during one block of time
- Combine home visits
- Complete family plan updates at the same time that you complete the six-month review report
- Do IDS work at one time, and read e-mail only once or twice a day

Avoid Interruption

- Use a space away from your colleagues and telephone to complete tasks that require concentration
- Use call-forwarding to voice-mail to protect time
- Let your chatty colleague know you are under deadline and need not to be disturbed for the next hour or so
- Set times to be available to take phone calls each day
- Find an effective way to deal with troubling interruptions by supervisors

Make meetings, in-person contacts, and home visits productive

- Make the purpose of the meeting clear
- Establish a written agenda and set clear time limits
- State and end the meeting on time
- Be clear about your purpose for an in-person contact or home visit
- Know your family plan, goals and steps and use them to guide the meeting
- Use a "cheat sheet" or outline to keep track of assessment information and necessary documentation
- Keep meetings and in-person contacts reasonably brief

Use a traveling idea log

- Create a log for recording ideas relating to ongoing projects or tasks that "pop" into your brain

Learn how and when to say "No"

- Know your limits
- Keep your supervisor informed about your caseload and about particularly time-consuming or stressful cases

Learn to do it anyway

- Sometimes a job has to be done **now** and we don't want to do it now. The solution is to grit your teeth and do it anyway

Evaluate your time-use interventions

- Remember: No time management tactic is worth using unless it helps you achieve your goals. Once you start a new approach, use it long enough to give it a fair trial

Monday Morning

It is Monday morning, and you have the following things to complete by Wednesday. What are the most important things you need to do for the two days? Prioritize these items (Do all of them need to be done today? What can you justify not doing? What are some alternative solutions?).

1. Two court reports are due.
2. Two foster parents have called: One demanding that you move a sibling group of three as soon as possible and another to report that the child has run away.
3. A neighbor calls in a complaint on they Smith case stating that the mother poured boiling water on her 2-year-old son, and her 3-year-old daughter is running around the neighborhood with only a diaper on. This is the fifth complaint on the family in two weeks; the others were unfounded.
4. The State is coming to audit cases on Friday morning and your supervisor is reviewing all cases on Wednesday for complete family plans and contacts. Your county did not pass the last audit and it is extremely important that your county passes this time. You have not entered your contact from last week on a case being audited.
5. Mr. Sweet and his attorney have called threatening legal action if you do not arrange a supervised visit with his children this week.
6. Ms. Green called to report that she does not have any food in her house for her four children and her food stamps don’t come for another two days.
7. You need to visit two children by Tuesday afternoon to meet state compliance.
8. You have a required court appearance on Tuesday afternoon.
9. You have a foster parent appreciation meeting on Monday afternoon.

Awareness and Safety

Self Awareness

Environmental Awareness

Client Awareness

Before You Go Out into the Field, Decisions to Make

The following assessments are important in determining the level of support that may be necessary when completing a home visit and will help you to know what you should bring with you:

What is known about the neighborhood in which your contact must be made?

Is it a high crime area?

Is there drug traffic or gang activity?

Is it a rural area with poor access?

Always let someone in the office know where you are and when you expect to return. Discuss the following with a co-worker or your supervisor:

Should you wear jewelry?

Should you wear high heels?

Should you carry a purse?

Do you need to bring a cell phone?

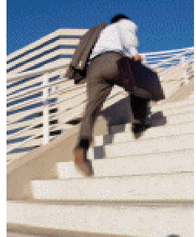
Should you go with another co-worker, or will it be safe for you to go alone?

Selecting a car to drive into the field is another important safety issue.

Know its running condition. Will it start quickly if you need to leave in a hurry?

Try to know ahead of time where you will park and if the parking place

Steps to a Personal Safety Action Plan



1. **Plan ahead:**

   - If possible, have a veteran worker go with you the first time.
   - Make a note of the purpose of the visit (so you don't forget to get information and/or forms signed).
   - Make sure your car has gas and good tires.
   - Go to the restroom before leaving the office.
   - Do you have a map or directions?
   - Put your purse/wallet in the trunk and cell phone in your pocket.
   - SIGN OUT PLEASE! It is important that someone knows where to look for you if you are not back after a reasonable time.

2. **Drive by the residence to see if things seem okay** – is there anything suspicious going on? Do not put yourself in harm's way.

3. **When pulling into the parking lot/neighborhood, look around to see who is hanging around and what the atmosphere seems to be.** Sometimes it's best to make visits to undesirable neighborhoods in the morning before a lot of activity begins.

4. **Back your car into the parking space**.

5. **Listen outside the door of the home for disturbances** such as screaming, yelling or fighting.

6. **Note at least two (if possible) exits and entrances**.

7. **When knocking on the door, stand to the side, not in front of it.**

8. **Introduce yourself clearly,** letting the family know who you are and why you are there. Show your work identification.

9. **Assess the person/persons you are talking with**. What is their demeanor? Are they intoxicated?

10. **Note the location of doors in the home**. Leave the door unlocked if possible.

11. **Scan the environment for any weapons** – guns are often kept in the bedroom, knives in the kitchen.

12. **Note any drug paraphernalia** lying about and what danger that poses to you or the children.

NOTE: DHR Employee Handbook prohibits carrying weapons of any kind (knives, firearms, explosives) unless job-related and specifically required as a condition of employment.

Trust Your Judgment

Become familiar with the following
Messengers of Intuition

- **Nagging feelings**
- **Persistent thoughts**
- **Sarcasm**
- **Wonder**
- **Anxiety**
- **Curiosity**
- **Hunches**
- **Gut Feelings**
- **Doubt**
- **Hesitation**
- **Suspicion**
- **Apprehension**
- **Fear**

Friday Afternoon

It's Friday afternoon, and you are going to see a client you have seen only once before. You know she has a substance abuse problem she is dealing with, although when not drinking she appears to be an even-tempered and coherent individual.

1. **Determine what safety decisions you would make before going to the home visit.**

When you arrive at the house, there are many cars around and several people you don't know sitting in chairs, drinking beer or soda. Your client and her family are nowhere to be seen.

You had said something about coming this afternoon, but this particular time was not specified. The curtains in the house are closed and the door is shut.

You are going away this weekend, and you have over $100 in your purse. You feel uneasy.

2. **Determine what safety actions you would put into place in this situation.**

HEALTH SAFETY NOTES

1. Wash your hands often, alcohol-based hand wipes and gel sanitizers work well when soap and water are not available. Do not use hand wipes and sanitizers in front of the client.

2. Cover your nose and mouth when sneezing and coughing. The main way that illness, like colds and flu, are spread is from person to person in respiratory droplets of coughs and sneezes.

3. Routinely clean and disinfect surfaces, such as desks and phones, to provide an extra margin of safety.

Griffin et al., 1997

STRESS!

“is the nonspecific response of the body to any demand made on it.”

Common Physiological Responses to Stress

Stress causes an increase in:		We may notice this as:
Blood sugar	→	Increased energy, fatigue when the stress is alleviated
Oxygen flow	→	Increased alertness; shortness of breath
Blood pressure & heart rate	→	Increased pulse; pounding in the chest
Stomach acid	→	Sour stomach or nausea
Temperature	→	Feeling flushed; redness in the face; sweaty palms

Online Health Poll

10,558 self selected people answered the question “What causes you the most stress?” Answers were as follows:

JOB	**42%**
FAMILY	**32%**
APPEARANCE	**14%**
HEALTH	**11%**
COMMUTE	**3%**

Signs of Unhealthy Stress

Physical Signs:

- Ulcers or chronic stomach problems
- High blood pressure
- Stress-related skin conditions, such as eczema or psoriasis
- Periods of extreme anxiety or anxiety attacks
- Weight gain or loss
- Sleeplessness or disturbed sleep patterns

Cognitive Signs:

- Inability to concentrate and stay on task
- Forgetfulness

Emotional Signs:

- Depression symptoms: hopelessness, loss of interest in activities that are usually enjoyable, sleep disturbance
- Irritability
- Uncomfortable levels of anxiety
- Reduced empathy toward clients and others around us

Behavioral Signs:

- Increased smoking
- Compulsive eating or weight loss
- Increase in nervous behaviors, such as nail-biting, teeth grinding, playing with hair, etc.
- Increased alcohol consumption

Workplace Signs

- Burnout
- Discouragement, pessimism, decline in motivation or effort
- Apathy, negativism, irritability, rigidity
- Blaming others
- Resistance to change; loss of creativity
- Becoming more emotionally affected by clients and colleagues
- Late paperwork
- Longer lunches or no lunch at all, because there is always something to “catch up” on
- More time spent in the office and less in direct client contact

Improve Your Overall Health

1. Pay attention to nutrition

2. Exercise regularly

3. Use prevention to avoid health problems

4. Relax regularly

Manage Your Environment

1. **Sight:** Pictures, paint, decorative objects and lighting can be used to brighten your environment.

2. **Sound:** Listen to music if it is permitted in your office. Relaxing music at home or in the car may also help to calm you and keep your mind clear as you go through the workday.

3. **Smell:** Plants, flowers, humidifiers, or air purifiers will fight pollution and affect your mood.

4. **Touch:** Obtain comfortable furniture, and make sure you follow ergonomic recommendations in the workplace. A supportive chair and properly placed computer monitor and keyboard are particularly important.

Develop and Strengthen Your Support Systems

Listening:

Appreciation:

Challenges to Improve:

Reality Testing:

Technical Assistance:

General Guidelines for a Successful Stress Management Plan

1. Establish clear specific goals.
2. Start small.
3. Do something now.
4. Start from where you are, not where you want to be.
5. Start with what is most important to you.
6. Make changes one at a time.
7. Plan ways to manage your stress.
8. Make it easy to manage stress.
9. Reward yourself for good work and effective stress management.
10. Pick stress management techniques likely to work for you.
11. Look for ways to control your life.
12. Do it every day.

Stress Management Plan Worksheet

Signs of Unhealthy Stress:

Examples: Burnout. Unable to fall asleep or sleep through the night; stress related skin conditions such as hives; increased smoking/drinking

1.

2.

3.

4.

Sources of Stress:

Examples: Over-commitment; unresolved interpersonal problems, case content

1.

2.

3.

4

Strategies for Stress Management:

Examples: I will walk twice a week for 15 minutes after lunch (friend optional, ; I will go to the movies once a month with a friend or my partner.

1.

2.

3.

4.

Thoughts That Cause Stress

Examples: I will never finish all that I need to do. I am so incompetent. I don't deserve to take time off for myself.

1.

2.

3.

4.

5.

Thoughts That Prevent Stress

1.

2.

3.

4.

5.