



California Common Core Curricula for Child Welfare Workers

Trainee's Guide

Child Maltreatment Identification Part 1: Neglect, Emotional Abuse and Physical Abuse

Version 1.25 | January 2009



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Acknowledgments

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Along the way, many other people provided their insight and hard work, attending pilots of the trainings, reviewing sections of curricula, or providing other assistance.

California's child welfare system greatly benefits from this collaborative endeavor, which helps our workforce meet the needs of the state's children and families.

The curriculum is developed with public funds and is intended for public use. For information on use and citation of the curriculum, please refer to:

http://calswec.berkeley.edu/CalSWEC/Citation_Guidelines.doc



FOR MORE INFORMATION on California's Core Curricula, as well as the latest version of this curriculum, please visit the California Social Work Education Center (CalSWEC) website: <http://calswec.berkeley.edu>

Child Maltreatment Identification
Part 1: Neglect, Emotional Abuse and Physical Abuse

Trainee's Guide

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Child Maltreatment Identification

Part 1: Neglect, Emotional Abuse and Physical Abuse

COMPETENCIES and LEARNING OBJECTIVES

CORE COMPETENCIES

The trainee will accurately identify factors that constitute abuse and/or neglect as defined by the Welfare & Institutions Code Section 300 (a) - (j) and recognize parenting behaviors that promote child safety and family well-being outcomes.

The trainee will distinguish scenarios of child maltreatment from those that are not child maltreatment based on a constellation of factors such as physical injuries and behavioral indicators, within a cultural context.

The trainee will value the importance of diversity as it relates to child maltreatment.

LEARNING OBJECTIVES

Knowledge:

- K1.** The trainee will be able to identify indicators of physical abuse.
- K2.** The trainee will be able to identify indicators of neglect.
- K3.** The trainee will be able to identify indicators of emotional abuse.
- K4.** The trainee will understand the legal basis of identifying abuse and neglect in California, and understands the associated sections of the Welfare & Institutions Code Section 300 (a) - (j).
- K5.** The trainee will be able to identify strength-based information gathering strategies (that include exploration of family strengths, resources, and risk and safety factors) necessary for working with children, families, and others in the context of making a child maltreatment determination.
- K6.** The trainee will be able to identify physical, emotional, and behavioral characteristics of children who have been maltreated, while attending to the cultural and ethnic context of the children.
- K7.** The trainee will be able to identify three cultural practices that may be mistaken for child maltreatment.

Skills:

- S1.** Given a case scenario, the trainee can identify child maltreatment.
- S2.** Given a case scenario, the trainee will be able to distinguish child maltreatment from benign cultural factors.

Values:

- V1.** The trainee will be aware of their personal values related to abuse and neglect as they relate to the legal definitions described in the Penal Code and the Welfare & Institutions Code Section 300 (a) - (j).
- V2.** The trainee will make decisions consistent with the legal definition as described in the Penal Code and Welfare & Institutions Code Section 300 (a) - (j).
- V3.** The trainee will value the benefit of acquiring and utilizing up-to-date information about cultural differences to identify child maltreatment.
- V4.** The trainee will value the importance of working with families and communities utilizing a strength-based model of practice.

RELATED TITLE IV-E CURRICULUM COMPETENCIES

- CF 5.a.** Demonstrate, through assessment, intervention and evaluation practices, a working understanding of the role and function of historical, social, political, and economic factors as the underlying causes and mechanisms of oppression and discrimination.
- CF 7.a.** Demonstrate beginning ability to apply conceptual behavioral frameworks to social environments involved in assessment, intervention and evaluation.
- CA 7.1.** Integrate knowledge and theory of human behavior and the social environment from diverse perspectives to conduct reliable and valid assessments, comprehensive service plans, effective interventions, and meaningful evaluations in child welfare.
- CP 7.1.** In evaluation of child welfare practice (engagement, assessment, planning, intervention, and evaluation), demonstrate the ability knowledgeably to apply information about human behavior and the social environment from diverse perspectives.
- CF 7.b.** Demonstrate beginning ability to gather and interpret behavioral knowledge in perceiving person and environment.

Child Maltreatment Identification

Part 1: Neglect, Emotional Abuse and Physical Abuse

AGENDA

Day 1

Segment 1: Welcome and Review of Agenda

- a. Welcome, Overview, Introductions
- b. Child Maltreatment Statistics

Segment 2: What is child abuse and what is child neglect?

Segment 3: Child Maltreatment in a Cultural Context

BREAK

Segment 4: Introduction to Neglect

- a. Introduction to Neglect
- b. Poverty & Neglect
- c. Indicators of Child Neglect

Segment 5: Challenges and Dilemmas

Segment 6: Challenges in Identifying Emotional Abuse

LUNCH

Segment 7: Introduction to Physical Abuse and Physical Abuse in a Cultural Context

- a. Defining Physical Abuse
- b. Values Clarification Activity

Segment 8: Information Gathering and Physical Abuse

Segment 9: Introduction to Types of Injuries, Part 1: Bruises, Bites, and Cultural Practices that may be construed as Abuse

BREAK

Segment 10: Empathy exercise

Segment 11: Introduction to Types of Injuries, Part 2 &

3

- a. Part 2 : Fractures and Burns
- b. Part 3 : Injuries to Face, Ears, Mouth, and Neck

Segment 12: Wrap up and Closure of Day 1/ Hints for Day 2

Child Maltreatment Identification Part 1: Neglect, Emotional Abuse and Physical Abuse

AGENDA

Day 2

Segment 13: Welcome back, Questions, and Brief Review of Day 2 Agenda

Segment 14: Continued Introduction to Types of Injuries, Part 4 & 5

- a. Part 4 : Abusive Head Trauma
- b. Part 5 : Chest Injuries and Abusive Abdominal Trauma

BREAK

Segment 15: Skill Practice/ Embedded Evaluation: Introduce, Administer Test, and Process with Class

Segment 16: Wrap up and Closure

Child Maltreatment Identification

Part 1: Neglect, Emotional Abuse, & Physical Abuse

TRAINEE'S GUIDE

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Introduction

This trainee content contains icons indicating content related to California's themes of practice:



Fairness & Equity



Family & Youth Engagement



Strength-based Practice



Outcomes-informed Practice



Evidence-based Practice

These themes are interwoven throughout the Common Core Curricula in California. Trainees are encouraged to pay special attention to the themes and make efforts to incorporate the concepts in their daily practice.

The curriculum contains content related to the two types of formal assessment in use in California: Structured Decision Making (SDM) and Comprehensive Assessment (CAT). Content specific to a particular assessment system is designated using the icons below.

SDM

Indicates content for those supervisors using the Structured Decision Making assessment tools.

CAT

Indicates content for those supervisors using the Comprehensive Assessment Tools.

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Child Maltreatment Statistics

National Statistics (2005)

- ❑ 62.8% of victims experience neglect
- ❑ 16.6% physical abuse
- ❑ 9.3% sexual abuse
- ❑ 7.1% emotional or psychological abuse
- ❑ 2.0% medical neglect
- ❑ 14.3% other types maltreatment (e.g., abandonment, threats of harm to child, congenital drug addiction)

- ❑ In 2005, approximately 899,000 children were determined to be victims of child maltreatment.
- ❑ For 2005, nationally estimated 1460 children died of abuse or neglect—a rate of 1.96 children per 100,000 of the national population.

From the US Department of Health and Human Services, Administration of Children, Youth, & Families, 2005:

<http://www.acf.hhs.gov/programs/cb/pubs/cm05/chapterthree.htm#types> or
www.childwelfare.gov

California Statistics

- ❑ As of July 1, 2006, 78,278 children were in California's child welfare-supervised foster care system.
- ❑ Between July 1, 2005, and June 30, 2006, children entered child welfare-supervised foster care:
 - ➔ 39.3% with neglect (includes both general and severe) as the removal reason
 - ➔ 17.8% with physical abuse as the removal reason
 - ➔ 11.4% with “substantial risk” as the removal reason
 - ➔ 11.0% with “at risk, sibling abused” as the removal reason
 - ➔ 8.5% with emotional abuse as the removal reason
 - ➔ 8.1% with sexual abuse as the removal reason
 - ➔ 3.8% with caretaker absence/incapacity as the removal reason
 - ➔ .1% with exploitation as the removal reason

From the Center for Social Services Research, Berkeley, CA, at

<http://cssr.berkeley.edu/CWSCMSreports/>

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California Welfare & Institutions Code, Section 300 (A-J) (from <http://www.leginfo.ca.gov>)

The California Welfare and Institutions Code (W&I Code)

Section 300 of the California W&I Code defines when the child protective services agency may intervene in cases of child abuse or neglect. It forms the basis for petitions in Juvenile Court, and determines when a child may be considered a Dependent of the court. Child welfare workers must have a working knowledge of the W&I Code in order to know when they can legally intervene with a family.

In some instances, the W & I Code refers to the California Penal code. The primary purpose of the Penal Code in CWS is to provide definitions that support the W&I Code.

For example, section 300 (d) of the W & I Code refers to section 11165.1 of the Penal Code to define the term “sexual abuse”. The text of the sections related to child welfare practice follow, and the full text of the codes can be found at:

<http://www.leginfo.ca.gov>.

Section 300 (A-J) of the W&I Code

300. Any child who comes within any of the following descriptions is within the jurisdiction of the juvenile court which may adjudge that person to be a dependent child of the court:

- (a) The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm inflicted non-accidentally upon the child by the child's parent or guardian.
For the purposes of this subdivision, a court may find there is a substantial risk of serious future injury based on the manner in which a less serious injury was inflicted, a history of repeated inflictions of injuries on the child or the child's siblings, or a combination of these and other actions by the parent or guardian which indicate the child is at risk of serious physical harm. For purposes of this subdivision, "serious physical harm" does not include reasonable and age-appropriate spanking to the buttocks where there is no evidence of serious physical injury.
- (b) The child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness, as a result of the failure or inability of his or her parent or guardian to adequately supervise or protect the child, or the willful or negligent failure of the child's parent or guardian to adequately supervise or protect the child from the conduct of the custodian with whom the child has been left, or by the willful or negligent failure of the parent or guardian to provide

the child with adequate food, clothing, shelter, or medical treatment, or by the inability of the parent or guardian to provide regular care for the child due to the parent's or guardian's mental illness, developmental disability, or substance abuse. No child shall be found to be a person described by this subdivision solely due to the lack of an emergency shelter for the family. Whenever it is alleged that a child comes within the jurisdiction of the court on the basis of the parent's or guardian's willful failure to provide adequate medical treatment or specific decision to provide spiritual treatment through prayer, the court shall give deference to the parent's or guardian's medical treatment, nontreatment, or spiritual treatment through prayer alone in accordance with the tenets and practices of a recognized church or religious denomination, by an accredited practitioner thereof, and shall not assume jurisdiction unless necessary to protect the child from suffering serious physical harm or illness. In making its determination, the court shall consider (1) the nature of the treatment proposed by the parent or guardian, (2) the risks to the child posed by the course of treatment or nontreatment proposed by the parent or guardian, (3) the risk, if any, of the course of treatment being proposed by the petitioning agency, and (4) the likely success of the courses of treatment or nontreatment proposed by the parent or guardian and agency. The child shall continue to be a dependent child pursuant to this subdivision only so long as is necessary to protect the child from risk of suffering serious physical harm or illness.

- (c) The child is suffering serious emotional damage, or is at substantial risk of suffering serious emotional damage, evidenced by severe anxiety, depression, withdrawal, or untoward aggressive behavior toward self or others, as a result of the conduct of the parent or guardian or who has no parent or guardian capable of providing appropriate care. No child shall be found to be a person described by this subdivision if the willful failure of the parent or guardian to provide adequate mental health treatment is based on a sincerely held religious belief and if a less intrusive judicial intervention is available.
- (d) The child has been sexually abused, or there is a substantial risk that the child will be sexually abused, as defined in Section 11165.1 of the Penal Code, by his or her parent or guardian or a member of his or her household, or the parent or guardian has failed to adequately protect the child from sexual abuse when the parent or guardian knew or reasonably should have known that the child was in danger of sexual abuse.
- (e) The child is under the age of five and has suffered severe physical abuse by a parent, or by any person known by the parent, if the parent knew or reasonably should have known that the person was physically abusing the child. For the purposes of this subdivision, "severe physical abuse" means any of the following: any single act of abuse which causes physical trauma of sufficient severity that, if

left untreated, would cause permanent physical disfigurement, permanent physical disability, or death; any single act of sexual abuse which causes significant bleeding, deep bruising, or significant external or internal swelling; or more than one act of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, bone fracture, or unconsciousness; or the willful, prolonged failure to provide adequate food. A child may not be removed from the physical custody of his or her parent or guardian on the basis of a finding of severe physical abuse unless the social worker has made an allegation of severe physical abuse pursuant to Section 332.

- (f) The child's parent or guardian caused the death of another child through abuse or neglect.
- (g) The child has been left without any provision for support; physical custody of the child has been voluntarily surrendered pursuant to Section 1255.7 of the Health and Safety Code and the child has not been reclaimed within the 14-day period specified in subdivision (e) of that section; the child's parent has been incarcerated or institutionalized and cannot arrange for the care of the child; or a relative or other adult custodian with whom the child resides or has been left is unwilling or unable to provide care or support for the child, the whereabouts of the parent are unknown, and reasonable efforts to locate the parent have been unsuccessful.
- (h) The child has been freed for adoption by one or both parents for 12 months by either relinquishment or termination of parental rights or an adoption petition has not been granted.
- (i) The child has been subjected to an act or acts of cruelty by the parent or guardian or a member of his or her household, or the parent or guardian has failed to adequately protect the child from an act or acts of cruelty when the parent or guardian knew or reasonably should have known that the child was in danger of being subjected to an act or acts of cruelty.
- (j) The child's sibling has been abused or neglected, as defined in subdivision (a), (b), (d), (e), or (i), and there is a substantial risk that the child will be abused or neglected, as defined in those subdivisions. The court shall consider the circumstances surrounding the abuse or neglect of the sibling, the age and gender of each child, the nature of the abuse or neglect of the sibling, the mental condition of the parent or guardian, and any other factors the court considers probative in determining whether there is a substantial risk to the child.

It is the intent of the Legislature that nothing in this section disrupt the family unnecessarily or intrude inappropriately into family life, prohibit the use of

reasonable methods of parental discipline, or prescribe a particular method of parenting. Further, nothing in this section is intended to limit the offering of voluntary services to those families in need of assistance but who do not come within the descriptions of this section. To the extent that savings accrue to the state from child welfare services funding obtained as a result of the enactment of the act that enacted this section, those savings shall be used to promote services which support family maintenance and family reunification plans, such as client transportation, out-of-home respite care, parenting training, and the provision of temporary or emergency in-home caregivers and persons teaching and demonstrating homemaking skills. The Legislature further declares that a physical disability, such as blindness or deafness, is no bar to the raising of happy and well-adjusted children and that a court's determination pursuant to this section shall center upon whether a parent's disability prevents him or her from exercising care and control.

As used in this section "guardian" means the legal guardian of the child.

California Penal Code, Sections 11164-11165 (from <http://www.leginfo.ca.gov>)

Sections 11164 and 11165 of the California Penal Code provide definitions of neglect, physical abuse, emotional abuse, and sexual abuse. The primary purpose of the Penal Code in CWS is to provide definitions that support the W&I Code.

The Penal Code relates to criminal proceedings, and defines when laws have been broken that could be prosecuted. It also defines who is mandated to report child abuse. It is important for child welfare workers to know the definitions of abuse and neglect in the Penal Code, particularly as this defines what is abuse punishable by law, and what is not. This is helpful in working with law enforcement personnel, as well as in helping to explain the law to parents and caregivers.

11164.

- (a) This article shall be known and may be cited as the Child Abuse and Neglect Reporting Act.
- (b) The intent and purpose of this article is to protect children from abuse and neglect. In any investigation of suspected child abuse or neglect, all persons participating in the investigation of the case shall consider the needs of the child victim and shall do whatever is necessary to prevent psychological harm to the child victim.

11165.

As used in this article "child" means a person under the age of 18 years.

11165.1. (Note: Sexual Abuse Identification will be covered in CMI, Part 2)

As used in this article, "sexual abuse" means sexual assault or sexual exploitation as defined by the following:

- (a) "Sexual assault" means conduct in violation of one or more of the following sections: Section 261 (rape), subdivision (d) of Section 261.5 (statutory rape), 264.1 (rape in concert), 285 (incest), 286 (sodomy), subdivision (a) or (b), or paragraph (1) of subdivision (c) of Section 288 (lewd or lascivious acts upon a child), 288a (oral copulation), 289 (sexual penetration), or 647.6 (child molestation).
- (b) Conduct described as "sexual assault" includes, but is not limited to, all of the following:

- (1) Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, whether or not there is the emission of semen.
 - (2) Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person.
 - (3) Any intrusion by one person into the genitals or anal opening of another person, including the use of any object for this purpose, except that, it does not include acts performed for a valid medical purpose.
 - (4) The intentional touching of the genitals or intimate parts (including the breasts, genital area, groin, inner thighs, and buttocks) or the clothing covering them, of a child, or of the perpetrator by a child, for purposes of sexual arousal or gratification, except that, it does not include acts which may reasonably be construed to be normal caregiver responsibilities; interactions with, or demonstrations of affection for, the child; or acts performed for a valid medical purpose.
 - (5) The intentional masturbation of the perpetrator's genitals in the presence of a child.
- (c) "Sexual exploitation" refers to any of the following:
- (1) Conduct involving matter depicting a minor engaged in obscene acts in violation of Section 311.2 (preparing, selling, or distributing obscene matter) or subdivision (a) of Section 311.4 (employment of minor to perform obscene acts).
 - (2) Any person who knowingly promotes, aids, or assists, employs, uses, persuades, induces, or coerces a child, or any person responsible for a child's welfare, who knowingly permits or encourages a child to engage in, or assist others to engage in, prostitution or a live performance involving obscene sexual conduct, or to either pose or model alone or with others for purposes of preparing a film, photograph, negative, slide, drawing, painting, or other pictorial depiction, involving obscene sexual conduct. For the purpose of this section, "person responsible for a child's welfare" means a parent, guardian, foster parent, or a licensed administrator or employee of a public or private residential home, residential school, or other residential institution.
 - (3) Any person who depicts a child in, or who knowingly develops, duplicates, prints, or exchanges, any film, photograph, video tape, negative, or slide in which a child is engaged in an act of obscene sexual conduct, except for those activities by law enforcement and prosecution agencies and other persons described in subdivisions (c) and (e) of Section 311.3.

11165.2.

As used in this article, “neglect” means the negligent treatment or the maltreatment of a child by a person responsible for the child’s welfare under circumstances indicating harm or threatened harm to the child’s health or welfare. The term includes both acts and omissions on the part of the responsible person.

- (a) “*Severe neglect*” means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. “Severe neglect” also means those situations of neglect where any person having the care or custody of a child willfully causes or permits the person or health of the child to be placed in a situation such that his or her person or health is endangered, as proscribed by Section 11165.3, including the intentional failure to provide adequate food, clothing, shelter, or medical care.
- (b) “*General neglect*” means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred.

For the purposes of this chapter, a child receiving treatment by spiritual means as provided in Section 16509.1 of the Welfare and Institutions Code or not receiving specified medical treatment for religious reasons, shall not for that reason alone be considered a neglected child. An informed and appropriate medical decision made by parent or guardian after consultations with a physician or physicians who have examined the minor does not constitute neglect.

11165.3.

As used in this article, “the willful harming or injuring of a child or the endangering of the person or health of a child,” means a situation in which any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering, or having the care or custody of any child, willfully causes or permits the person or health of the child to be placed in a situation in which his or her person or health is endangered.

11165.4.

As used in this article, “unlawful corporal punishment or injury” means a situation where any person willfully inflicts upon any child any cruel or inhuman corporal punishment or injury resulting in a traumatic condition. It does not include an amount of force that is reasonable and necessary for a person employed by or engaged in a public school to quell a disturbance threatening physical injury to person or damage to property, for purposes of self-defense, or to obtain possession of weapons or other dangerous objects within the control of the pupil, as authorized by Section 49001 of the Education Code. It also does not include the exercise of the degree of physical control authorized by Section 44807 of the Education Code. It

also does not include an injury caused by reasonable and necessary force used by a peace officer acting within the course and scope of his or her employment as a peace officer.

11165.5.

As used in this article, the term "abuse or neglect in out-of-home care" includes physical injury inflicted upon a child by another person by other than accidental means, sexual abuse as defined in Section 11165.1, neglect as defined in Section 11165.2, unlawful corporal punishment or injury as defined in Section 11165.4, or the willful harming or injuring of a child or the endangering of the person or health of a child, as defined in Section 11165.3, where the person responsible for the child's welfare is a licensee, administrator, or employee of any facility licensed to care for children, or an administrator or employee of a public or private school or other institution or agency. "Abuse or neglect in out-of-home care" does not include an injury caused by reasonable and necessary force used by a peace officer acting within the course and scope of his or her employment as a peace officer.

11165.6.

As used in this article, the term "child abuse or neglect" includes physical injury inflicted by other than accidental means upon a child by another person, sexual abuse as defined in Section 11165.1, neglect as defined in Section 11165.2, the willful harming or injuring of a child or the endangering of the person or health of a child, as defined in Section 11165.3, and unlawful corporal punishment or injury as defined in Section 11165.4. "Child abuse or neglect" does not include a mutual affray between minors. "Child abuse or neglect" does not include an injury caused by reasonable and necessary force used by a peace officer acting within the course and scope of his or her employment as a peace officer.

California Health & Safety Code, Section 1255.7 (from <http://www.leginfo.ca.gov>)

Section 1255.7 of the California Health & Safety Code pertains to the “safe surrender” of infants.

Section 1255.7

(a)

(1) For purposes of this section, "safe-surrender site" means either of the following:

(A) A location designated by the board of supervisors of a county to be responsible for accepting physical custody of a minor child who is 72 hours old or younger from a parent or individual who has lawful custody of the child and who surrenders the child pursuant to Section 271.5 of the Penal Code.

(B) A location within a public or private hospital that is designated by that hospital to be responsible for accepting physical custody of a minor child who is 72 hours old or younger from a parent or individual who has lawful custody of the child and who surrenders the child pursuant to Section 271.5 of the Penal Code.

(2) For purposes of this section, "parent" means a birth parent of a minor child who is 72 hours old or younger.

(3) For purposes of this section, "personnel" means any person who is an officer or employee of a safe-surrender site or who has staff privileges at the site.

(4) A hospital and any safe-surrender site designated by the county board of supervisors shall post a sign utilizing a statewide logo that has been adopted by the State Department of Social Services that notifies the public of the location where a minor child 72 hours old or younger may be safely surrendered pursuant to this section.

(b) Any personnel on duty at a safe-surrender site shall accept physical custody of a minor child 72 hours old or younger pursuant to this section if a parent or other individual having lawful custody of the child voluntarily surrenders physical custody of the child to personnel who are on duty at the safe-surrender site. Safe-surrender site personnel shall ensure that a qualified person does all of the following:

(1) Places a coded, confidential ankle bracelet on the child.

(2) Provides, or makes a good faith effort to provide, to the parent or other individual surrendering the child a copy of a unique, coded, confidential ankle bracelet identification in order to facilitate reclaiming the child pursuant to subdivision (f). However, possession of the ankle bracelet identification, in and of itself, does not establish parentage or a right to custody of the child.

(3) Provides, or makes a good faith effort to provide, to the parent or other individual surrendering the child a medical information questionnaire, which may be

declined, voluntarily filled out and returned at the time the child is surrendered, or later filled out and mailed in the envelope provided for this purpose. This medical information questionnaire shall not require any identifying information about the child or the parent or individual surrendering the child, other than the identification code provided in the ankle bracelet placed on the child. Every questionnaire provided pursuant to this section shall begin with the following notice in no less than 12-point type:

NOTICE: THE BABY YOU HAVE BROUGHT IN TODAY MAY HAVE SERIOUS MEDICAL NEEDS IN THE FUTURE THAT WE DON'T KNOW ABOUT TODAY. SOME ILLNESSES, INCLUDING CANCER, ARE BEST TREATED WHEN WE KNOW ABOUT FAMILY MEDICAL HISTORIES. IN ADDITION, SOMETIMES RELATIVES ARE NEEDED FOR LIFE-SAVING TREATMENTS. TO MAKE SURE THIS BABY WILL HAVE A HEALTHY FUTURE, YOUR ASSISTANCE IN COMPLETING THIS QUESTIONNAIRE FULLY IS ESSENTIAL. THANK YOU.

(c) Personnel of a safe-surrender site that has physical custody of a minor child pursuant to this section shall ensure that a medical screening examination and any necessary medical care is provided to the minor child. Notwithstanding any other provision of law, the consent of the parent or other relative shall not be required to provide that care to the minor child.

(d)

(1) As soon as possible, but in no event later than 48 hours after the physical custody of a child has been accepted pursuant to this section, personnel of the safe-surrender site that has physical custody of the child shall notify child protective services or a county agency providing child welfare services pursuant to Section 16501 of the Welfare and Institutions Code, that the safe-surrender site has physical custody of the child pursuant to this section. In addition, any medical information pertinent to the child's health, including, but not limited to, information obtained pursuant to the medical information questionnaire described in paragraph (3) of subdivision (b) that has been received by or is in the possession of the safe-surrender site shall be provided to that child protective services or county agency.

(2) Any personal identifying information that pertains to a parent or individual who surrenders a child that is obtained pursuant to the medical information questionnaire is confidential and shall be exempt from disclosure by the child protective services or county agency under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Any personal identifying information that pertains to a parent or individual who surrenders a child shall be redacted from any medical

information provided to child protective services or the county agency providing child welfare services.

- (e) Child protective services or the county agency providing child welfare services pursuant to Section 16501 of the Welfare and Institutions Code shall assume temporary custody of the child pursuant to Section 300 of the Welfare and Institutions Code immediately upon receipt of notice under subdivision (d). Child protective services or the county agency providing child welfare services pursuant to Section 16501 of the Welfare and Institutions Code shall immediately investigate the circumstances of the case and file a petition pursuant to Section 311 of the Welfare and Institutions Code. Child protective services or the county agency providing child welfare services pursuant to Section 16501 of the Welfare and Institutions Code shall immediately notify the State Department of Social Services of each child to whom this subdivision applies upon taking temporary custody of the child pursuant to Section 300 of the Welfare and Institutions Code. As soon as possible, but no later than 24 hours after temporary custody is assumed, child protective services or the county agency providing child welfare services pursuant to Section 16501 of the Welfare and Institutions Code shall report all known identifying information concerning the child, except personal identifying information pertaining to the parent or individual who surrendered the child, to the California Missing Children Clearinghouse and to the National Crime Information Center.
- (f) If, prior to the filing of a petition under subdivision (e), a parent or individual who has voluntarily surrendered a child pursuant to this section requests that the safe-surrender site that has physical custody of the child pursuant to this section return the child and the safe-surrender site still has custody of the child, personnel of the safe-surrender site shall either return the child to the parent or individual or contact a child protective agency if any personnel at the safe-surrender site knows or reasonably suspects that the child has been the victim of child abuse or neglect. The voluntary surrender of a child pursuant to this section is not in and of itself a sufficient basis for reporting child abuse or neglect. The terms "child abuse," "child protective agency," "mandated reporter," "neglect," and "reasonably suspects" shall be given the same meanings as in Article 2.5 (commencing with Section 11164) of Title 1 of Part 4 of the Penal Code.
- (g) Subsequent to the filing of a petition under subdivision (e), if within 14 days of the voluntary surrender described in this section, the parent or individual who surrendered custody returns to claim physical custody of the child, the child welfare agency shall verify the identity of the parent or individual, conduct an assessment of his or her circumstances and ability to parent, and request that the juvenile court dismiss the petition for dependency and order the release of the child, if the child welfare agency determines that none of the conditions

described in subdivisions (a) to (d), inclusive, of Section 319 of the Welfare and Institutions Code currently exist.

- (h) A safe-surrender site, or personnel of the safe-surrender site, that accepts custody of a surrendered child pursuant to this section shall not be subject to civil, criminal, or administrative liability for accepting the child and caring for the child in the good faith belief that action is required or authorized by this section, including, but not limited to, instances where the child is older than 72 hours or the parent or individual surrendering the child did not have lawful physical custody of the child. This subdivision does not confer immunity from liability for personal injury or wrongful death, including, but not limited to, injury resulting from medical malpractice.
- (i)
 - (1) In order to encourage assistance to persons who voluntarily surrender physical custody of a child pursuant to this section or Section 271.5 of the Penal Code, no person who, without compensation and in good faith, provides assistance for the purpose of effecting the safe surrender of a minor 72 hours old or younger shall be civilly liable for injury to or death of the minor child as a result of any of his or her acts or omissions. This immunity does not apply to any act or omission constituting gross negligence, recklessness, or willful misconduct.
 - (2) For purposes of this section, "assistance" means transporting the minor child to the safe-surrender site as a person with lawful custody, or transporting or accompanying the parent or person with lawful custody at the request of that parent or person to effect the safe surrender, or performing any other act in good faith for the purpose of effecting the safe surrender of the minor.
- (j) For purposes of this section, "lawful custody" means physical custody of a minor 72 hours old or younger accepted by a person from a parent of the minor, who the person believes in good faith is the parent of the minor, with the specific intent and promise of effecting the safe surrender of the minor.
- (k) Any identifying information that pertains to a parent or individual who surrenders a child pursuant to this section, that is obtained as a result of the questionnaire described in paragraph (3) of subdivision (b) or in any other manner, is confidential, shall be exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), and shall not be disclosed by any personnel of a safe-surrender site that accepts custody of a child pursuant to this section.

Guide to California Welfare & Institutions Code (Section 300 A-J) and California Penal Code (Sections 11164 and 11165)

As Pertains to Neglect

W&I Code Section 300, subsections: (b), (e), (f), and (j)

Penal Code Sections 11165.2 (and 11165.5, 11165.6)

As Pertains to Physical Abuse

W&I Code Section 300, subsections: (a), (e), (f), (i), and (j)

Penal Code Sections 11165.3, 11165.4 (and 11165.5, 11165.6)

As Pertains to Emotional Abuse

W&I Code Section 300, subsections: (c) and (i)

Penal Code Sections: 11165.3 (and 11165.5, 11165.6)

As Pertains to Sexual Abuse

(Note: Sexual Abuse Identification will be covered at length in CMI, Part 2)

W&I Code Section 300, subsections: (d), (e), (i), and (j)

Penal Code Sections 11165.1 (and 11165.5, 11165.6)

As Pertains to Abandonment or Relinquishment

W&I Code Section 300, subsections: (g) and (h)

As Pertains to “Safe Surrender” of Infants

Health & Safety Code Section 1255.7

Instructions for accessing California W&I Code, Penal Code, and Health & Safety Code

- ❑ Go to: <http://www.leginfo.ca.gov/>
- ❑ Click on “California Law” Box (you will be redirected to a list of sections of CA law)
- ❑ Click on box to the left of “Penal Code” or “Welfare and Institutions Code” or “Health and Safety Code”
- ❑ Then click on “Search”
- ❑ Then click on the number of the section of code you want to see (e.g., if you want to see W&I Code Section 300, click on “300 – 304.7” on the web page, and you will be re-directed to the specific section).

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Risk Factors and Determinants of Child Maltreatment

Risk Factors

1. Psychological disturbance and psychopathology among parents
2. Mother's early age
3. Lack of education
4. History of child maltreatment
5. Caregiver substance abuse
6. Domestic Violence
7. Lack of social support
8. Unemployment
9. Crises in family life
10. Single parent families
11. Families with more children
12. Premature birth
13. Temperament of the child
14. Retardation, emotional disturbance and physical handicap
15. Immigration status (Fontes, 2005)

Sidebotham, Golding, & the ALSPAC Study Team (2001); Sidebotham, Heron, Golding, & the ALSPAC Study Team (2002); and Sidebotham, Heron & the ALSPAC Study Team (2006).

Interplay between Risk Factors

As was mentioned earlier, child maltreatment is the result of a complex process, perhaps even several processes, of interplays and influences of various risk factors, across the dimensions described.

Several questions come to mind and demand very careful consideration:

- ❑ First, what is the specific weight or contribution of each factor at a given time, in the process of turning a potential scenario into actual child maltreatment?
- ❑ Second, it is thought today that the potential for child maltreatment increases when there is an accumulation of risk factors (the dose theory). Are there specific combinations of risk factors within one dimension or across the four dimensions discussed above that should alert us?
- ❑ Third, we need to ask whether there are unique and differential combinations of risk factors which are linked to, and perhaps predictive of, the different forms of child maltreatment.

- ❑ Fourth, we also have to consider whether an existing risk factor is a transient and short-term stress, or if it is of a long-term, chronic nature. What does this mean in terms of the potential for child maltreatment?
- ❑ Fifth, our assessment of a specific family in a given situation should not be focused only on risk factors. Rather, we need to look for strengths, resiliency and existing support, which may serve as a balance, and even as a buffer, against abuse.
- ❑ Lastly, we need to focus on our assessments and means of prevention and intervention with high risk families.

In order to deepen and refine our appreciation of the complex processes by which the various risk factors interrelate, we need an ongoing exchange of ideas and observations across professional disciplines. Professional trainings of various disciplines focus and emphasize different viewpoints. Furthermore, the goals and the structures of the settings where we practice may often limit the scope of our understanding of the problem.

(Cohen, 1999)

Child Maltreatment in a Cultural Context

The definition of child abuse has changed over time and varies according to the values and beliefs of a culture, community, or group. Thus child maltreatment can be viewed in a cultural context as a reflection of the time and place in which one lives. It may be defined differently in various countries or in different regions within the United States. The legal definition may vary from State to State. (Child Abuse and Neglect State Statutes Series; <http://www.redwoodsgroup.com/ymca-articles-14.asp>)

Child rearing standards in a cultural context

Child rearing standards in general also may be viewed in a cultural context. What defines good parenting today differs significantly from one hundred years ago. What is considered to be optimal parenting also varies with the culture, time, and place in which one lives. What is appropriate and desirable parenting is a dynamic, rather than a static, condition which is culturally defined. (McGehee, Charles L., “Responses To Child Abuse In World Perspective,” paper presented at the Third International Institute on Victimology, Lisbon, 1984, pp. 3-4; <http://www.cwu.edu/~chasm/socialr.htm>) (Lawrence & Irvine, 2004, p. 2).

Child welfare workers working with a family of a different cultural background may be faced with unfamiliar family structures, sex roles, extended family situations, or discipline issues. In addition, workers may also be forced to address language barriers, culturally different communication styles, and social, economic, and political factors that affect child rearing (Lum, 1992).

How can child welfare workers account for cultural differences while they are investigating and providing ongoing services? One of the first steps is to better understand one’s own cultural heritage. This includes a self-examination of racial and cultural attitudes and values (Davis & Proctor, 1989). Often, personal biases run deep – stereotypic beliefs are subtle forces on our thinking. Many of the western values on which practice theories are based may conflict with the values of minority group clients. Workers can better relate to families if they are aware of their own racial or cultural stereotypes (Davis & Proctor, 1989).

Environmental Factors Influencing Child Maltreatment

The precipitation of an abusive event is often related to excessive stress or family crisis. Kagan and Schlosberg (1989) give a revealing look at what they call “families in perpetual crisis,” which aptly describes abusive families:

Living in a crisis-oriented family is like riding a roller coaster 24 hours a day: terrifying, energizing, and addicting. Families in crisis manage to flirt with disaster and avoid feelings of emptiness and despair. If you have grown up feeling cold, worthless, powerless, and depressed, crisis makes you feel alive. Growing up in a crisis-filled family means knowing no other way of life. With the threat of the collapse or dissolution of your family hovering over you, any diversion, however dangerous, provides some relief.

So child maltreatment may not be a premeditated occurrence. Rather, it often occurs as a result of:

- ❑ Stress, crisis of the moment
- ❑ Social isolation/lack of support system/resources
- ❑ Poor impulse control
- ❑ Poor parenting skills
- ❑ Situational stressors

It is not necessary for someone to intend to hurt a child for it to be considered child maltreatment or abuse. Rather, it is the condition of the child that determines if abuse has occurred.

Social and Cultural Context

Discussion of risk factors and determinants of child maltreatment focus on abuse and neglect within the family. However, we have to consider to what extent a particular child-rearing behavior is acceptable or deviant within one group, and common or different between groups. Furthermore, we have to relate to parental behavior against the backdrop of the general social and cultural context.

1. Social attitude toward children
2. Social attitude toward family
3. Social attitude toward violent behavior

Related Sections of the NASW Code of Ethics, Revised 1999

From <http://www.naswdc.org/pubs/code/code.asp>

1.05 Cultural Competence and Social Diversity

- (a) Social workers should understand culture and its function in human behavior and society, recognizing the strengths that exist in all cultures.
- (b) Social workers should have a knowledge base of their clients' cultures and be able to demonstrate competence in the provision of services that are sensitive to clients' cultures and to differences among people and cultural groups.
- (c) Social workers should obtain education about and seek to understand the nature of social diversity and oppression with respect to race, ethnicity, national origin, color, sex, sexual orientation, age, marital status, political belief, religion, and mental or physical disability.

Value: *Dignity and Worth of the Person*

Ethical Principle: *Social workers respect the inherent dignity and worth of the person.*

Social workers treat each person in a caring and respectful fashion, mindful of individual differences and cultural and ethnic diversity. Social workers promote clients' socially responsible self-determination. Social workers seek to enhance clients' capacity and opportunity to change and to address their own needs. Social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

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Partners in Identifying and Assessing Child Maltreatment

The Family

In a child abuse investigation, family members will be interviewed as part of the investigation. For example, depending on your county policy, the family may be brought in early as part of a Team Decision-Making meeting. **Note to trainees: The family does not participate in the decision as to whether or not the allegation under investigation is substantiated, indicated, or unfounded.**

In the past, families (including fictive kin, extended family members, close family friends) involved in the Child Welfare System were often excluded from the decision-making process that affected the care and custody of their children. More and more, in California and beyond, families are being included in collaborative efforts to reach decisions. It has been recognized that by doing so, more effective outcomes occur and families “own” decisions when they have been a part of making them.

The Community

The society in which we live sets the moral tone, culture, and standards of the community. Communities support children being cared for properly. Children are best raised in families. Communities have resources and supports to help families better care for their children.

Child Welfare Workers/Child Welfare System

Child welfare workers make the home calls and act as “eyes and ears for the court.” They interpret the W&I Code and offer crisis intervention, counseling, and resources to families in which maltreatment has occurred or who have been reported as having possibly been at risk for the occurrence of maltreatment. They utilize a professional body of ethics, knowledge of family dynamics, human and child development, social work, risk assessment, child maltreatment, assessment and case planning skills, and case management to protect children, strengthen families, and provide a child welfare related spectrum of services.

Medical System

The medical system offers the scientific explanation for abuse versus accidents, but cannot do it in isolation. An accurate history and assessment of family functioning and interaction is vital to the process of accurate diagnosis of child abuse and child welfare workers can assist in obtaining that information. Medical assessment and evidence is critical in making accurate determinations if maltreatment has occurred,

which the child welfare system cannot accomplish without the involvement of child abuse experts and the medical profession.

Mental Health System/Victim Witness Advocates:

Depending on the facts of the case, these individuals can also add their expertise or knowledge to the collaborative process.

Law Enforcement

Law enforcement is charged with enforcing the laws which have been passed by Federal, State, and local governing bodies, such as the California Penal Code. Law enforcement is responsible for investigating all allegations of child abuse and severe neglect, to determine, through investigation, if a violation of criminal law has occurred, to collect evidence, interview victims and potential witnesses, apprehend the offender/s, and file appropriate criminal charges. In child maltreatment cases, the preferred method for accomplishing these tasks is through coordination with multidisciplinary child abuse investigation teams.

Legislative/Legal/Judicial System

Legislators make the laws; they interpret the changing societal/cultural norms and mores. Laws give child welfare workers and law enforcement the legal basis for their authority to intervene in the lives of children and their families. Law enforcement prosecutes crimes, versus the child welfare system that protects children, but the two systems work together. Law enforcement investigates child maltreatment. Child welfare assesses if children need protection and if families need services to better care for their children.

Courts oversee and carry out the protective and prosecution aspects of child welfare cases and ensure the rights of both children and parents are protected.

Some thoughts about defining Child Neglect

We want to define child neglect in order to protect children and improve their well-being, not to blame the parent or caregivers. With a more constructive, less blaming approach, there is more of a possibility to effectively engage the parent(s)/caregiver(s) using strengths-based models.

By using a child-focused, broad definition we can move beyond the narrow focus on the parent(s) to also include for consideration other contributors. It also allows us to consider a broader array of services and a wider range of responses.

A broader definition of contributors to neglect includes child factors, parental/caregiver factors and issues, extended family factors and issues, as well as community and societal factors and issues. Including these factors in the definition allows child welfare workers to have an expanded focus on potential strengths and supports to help the family in addressing their problems and maintaining the child(ren) in the home and/or within their community.

This is congruent with our interest in the health, safety, and well-being of children.

General Definition

How we, as a society, define neglect shapes our response to the problem of neglect. In general, neglect is defined as:

- ❑ An act of omission or commission which results in minimal sufficient standards of care of minor(s) not being met.
- ❑ Child neglect is the failure of caregivers to provide adequate emotional and physical care for a child.

“Adequate emotional and physical care for a child” encompasses basic needs such as adequate food, clothing, health care, supervision, protection, education, nurturance, love and a home (Dubowitz, 2006). These basic needs are based on scientific evidence, such as epidemiological data, e.g., using infant car seats enhances child safety while riding in vehicles; research data, e.g., lack of normal brain development in neglected infants; community standards and values (to be discussed at greater length later in curriculum); experience, e.g., a child with a history of severe asthma needs to reduce exposure to irritants and/or use specific dosages of prescribed medications; and common sense, e.g., one feeds a child nutritious food at regular intervals.

With additional research comes knowledge of new hazards to children, such as second hand cigarette smoke, inadequate treatment for HIV/AIDS, failure to use vehicle restraint seats, leaving weapons accessible to children (such as firearms), exposure to intimate partner violence (domestic violence), lack of touch and expressed affection, and possibly unsupervised Internet access. (Dubowitz, 2006)

Fatalities

Kempe coined the phrase “battered child syndrome” in 1962 to describe severely and fatally beaten children, which raised the awareness of this issue (Kempe, et al., 1962). Obviously, this is the worst possible outcome and what trainings of this nature seek to avoid. The child welfare system is involved in fatalities of children when there are siblings who may need protection or when the child dies in foster or out-of-home care and is under the jurisdiction of the child welfare agency. Maltreatment deaths were more associated with neglect (35.5%) than any other type of abuse. Fatalities resulting from multiple maltreatment types account for another 30.2%.

An autopsy may reveal other old fractures, rib fractures, and other injuries previously undiagnosed. Discussion of stomach contents may help determine the time of injury/death. This may help identify the perpetrator.

Fatality Review Teams are multidisciplinary teams comprised of the medical examiner or coroner, law enforcement, medical experts, child welfare, district attorneys, county counsel, and other relevant professionals who work with child maltreatment issues. They systematically review and examine child deaths from a systems perspective, and suggest policy and training issues which may come to light.

Poverty & Child Neglect

A few words about Poverty and Neglect:

Douglas Besharov discusses poverty as a contributing factor to neglect (Besharov, 1990). Quoting Besharov, “about 30% of abused children live in single parent households and are on public assistance; the comparable figure for neglected children is about 45%” (American Humane Association, 1984). Besharov goes on to say, however, “Lest all poor families be stigmatized, though, it is important to remember that most poor families do not abuse or neglect their children. In any one year, fewer than one in five families on welfare are reported for suspected abuse or neglect, and an even smaller percentage of such reports are substantiated.”

Danziger and Danziger (1993) suggest “many parents who must deal with poverty live in stressful situations... The lack of time, inability to pay attention to and address their child’s needs, absorption with other family crises, etc., may compromise their children’s development” (p. 73). There is no doubt that poverty is stressful; such stress may increase one’s propensity to anger, hopelessness/indifference, violence, and substance abuse.

It should be stressed, however, that poverty itself does **not** constitute neglect. The following may also be present in families where neglect occurs:

- ❑ Chaos
- ❑ Lack of interpersonal and job skills
- ❑ Disorganization
- ❑ Apathy
- ❑ Drug addiction

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Further Elements of Child Neglect: Possible Behavioral Indicators

Practice Tip for Child Welfare Workers:

Behavioral indicators may raise suspicion that a child is being neglected or abused. However, certain behaviors that may indicate neglect or abuse may, in fact, NOT be due to neglect or abuse. Red flags in terms of behavior should be checked out with collaterals such as teachers, relatives, etc. as well as by observation and interview when investigating the received report.

Children who are neglected may manifest some of the following behavioral indicators:

- ❑ A large percentage of neglected children are developmentally delayed in all developmental domains. One can determine the degree of delay by comparing the child's developmental level with expected developmental achievement for the child's chronological age. Neglected children may display mild to serious delays in physical/motor development, cognitive ability, school achievement, social skills, interpersonal relationships, and emotional development. Severely neglected children may develop mental retardation as a result.
- ❑ Neglected children are often described as unresponsive, placid, apathetic, dull, lacking in curiosity, and uninterested in their surroundings.
- ❑ Neglected children may not actively approach other people, nor do they exhibit a normal degree of interest or exuberance in interpersonal interactions. They may not play, or they may play half-heartedly. In cases of serious neglect, the child may exhibit signs of depression.
- ❑ The child may appear to be hungry or always tired, such as falling asleep in school. Some older children who are inadequately fed use their own resources by scrounging for or stealing food.
- ❑ Some neglected children may be out of control as a result of not having the chance to learn limits of behavior from adult caregivers. They may exhibit a variety of behavior problems, anxiety, and other signs of emotional distress. At times the children can exhibit a false bravado, compensating for their fear by appearing invincible.
- ❑ School failure may be an indicator of neglect, particularly when it is combined with an inability to concentrate, falling asleep in class, and a lack of interest in the school environment. School failure by itself cannot be considered the result of neglect but can support a diagnosis of neglect when other indicators are also present.

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Possible Indicators of Child Neglect

- ❑ Children unattended, left alone, lack of supervision, playing with matches, house fires
- ❑ Child sleepy, dirty, hungry, poorly clothed for weather (often question of degree, chronicity)
- ❑ Lice, scabies, chronic poor hygiene
- ❑ Child depressed/withdrawn/fearful
- ❑ Child rocks, self-comforts, clingy
- ❑ Child antisocial, destructive, acts out (may also indicate physical abuse)
- ❑ Child uses drugs, gang membership
- ❑ Child is frequently injured (can also be abuse)
- ❑ Child hit by car, found wandering in street
- ❑ Child left in car, especially risky in hot weather
- ❑ Filthy home
- ❑ Unsafe home, hazards
- ❑ No/Insufficient food in home
- ❑ Failure to obtain medical/psychological treatment which results in pain/detriment
- ❑ Chronic truancy/tardiness
- ❑ “Bottle rot”, dental neglect
- ❑ Flat back of head
- ❑ Child thin, begging for food, dehydrated, malnourished
- ❑ Non-organic failure to thrive
- ❑ Child drowning (or near-drowning) in pool, tub, pond, etc.
- ❑ Child tests positive for drugs, legal or illegal
 - Positive toxicology screen at birth
 - Older child ingests drugs left out

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Possible Manifestations of Neglect

Neglect may manifest in some of the following ways:

Absence

Children who have been abandoned by their parents. This includes children who have been left by their parents with other people, including strangers, for extended periods of time without parental contact or support.

Dental Neglect

- ❑ “Bottle rot” - decayed teeth caused by giving child bottle at night or having bottle of sugary liquid in baby’s mouth over time. Sugar pools in mouth and teeth may turn black over time from decay.
- ❑ Western culture weans babies earlier than some other cultures. If you believe children should be “off the bottle” and using a cup at age 1, you should be alert to your own bias in this area.
- ❑ It is a task for children to learn to sleep through the night. As a child welfare worker you can offer suggestions on this process or have a Public Health Nurse visit with the parents to discuss. Parents can often get their children to sleep by soothing or cuddling them as opposed to offering a bottle.

“Dirty home”, by CWS standards

A dirty home is of concern if it presents a health hazard. The child welfare worker should guard against their personal bias related to what constitutes a clean home. This includes consideration of the cultural context or socio-economic status of the family.

The following may be an indicator of a problem:

- ❑ Mental illness
- ❑ Depression
- ❑ DV
- ❑ Overwhelmed
- ❑ Substance Abuse

When documenting, be descriptive (reflect in the report your use of all senses, i.e., the floor felt sticky, the odor of urine was strong, etc.), be clear, and be concise. Take pictures of the home as documentation.

Drowning/near drowning

A drowning or near drowning is considered neglect if a parent/caregiver did not supervise a child or allowed the child access to the pool, pond, or area where the situation occurred.

Drug exposed infants

Positive toxicology screen at birth is not the only indicator for impact of mother's drug use during pregnancy. The mother may not have drugs in her system at the birth, but may have used drugs throughout her pregnancy (hence the term "drug exposed infant"). This term is more inclusive and describes the possible impacts of this drug use on the infant/child long term (Villareal & Hansen, 2003).

- ❑ Alcohol exposure can result in Fetal Alcohol Syndrome, a cluster of conditions which represent lifelong issues for the child.
- ❑ Cocaine and other drugs, and subsequent withdrawal, may result in conditions in the baby such as jitteriness, hypertonicity of muscles (stiffness), hypersensitivity to light, feeding problems, etc.

Assess, as much as possible, the severity/longevity of the mother's substance abuse issue.

Failure to Thrive

Normal growth charts for infants measure three indices:

- ❑ Height
- ❑ Weight
- ❑ Head Circumference

A diagnosis of Failure to Thrive (FTT) may be life threatening without medical intervention. In the interview of the parent, it may be that the premature/medically fragile infant spent additional time in the hospital after birth and missed out on some early attachment with the parent/caregiver. It is important to have the parent not only describe how they feed the baby, but to ask the parent to demonstrate mixing formula, produce actual food, etc.

It is not always immediately apparent that an infant is FTT. The infant's face may appear normal. When undressed, the infant's body may show more apparent symptoms such as loose skin, little fatty tissue and a "wasted away" appearance (Giardino, Christian, & Giardino, p. 177; Monteleone, pp. 248-250).

Food in the Home (Lack of)

A child welfare worker in the parent or guardian's home should check the house, and should ask about and check re: food in the cupboards and the refrigerator. It is important to do this check in a low-key and respectful way. Child welfare workers can ask parents/guardians to show you what food they have in the home.

Child welfare workers should also ask when the parent/guardian shops for food. As a cultural practice, some women shop every day for fresh foods and do not keep a stock of foodstuffs in the home. In these situations, mere absence of food may not indicate the failure to adequately feed the children.

Lice/Scabies (Chronic)

Lice are crawling creatures about the size of a pencil point dot and live on the hair follicles. Lice are transmitted from one person to another or via sharing of hats, contact with untreated clothing, bedding, upholstery, and furniture. Scabies are a contagious skin disease caused by a parasitic mite (*Sarcoptes scabiei*) and is characterized by intense itching. Chronicity of lice and/or scabies may be indicative of neglect, indicating the caregiver's failure to treat the lice and/or scabies infestation.

Medical Neglect

Medical neglect may be present if a minor's condition warrants medical treatment and the parent or guardian's failure to provide such medical treatment results in unnecessary pain, permanent injury, or death. This may include failure to administer prescribed medications or administration of recommended medications in a manner or schedule that impairs appropriate care.

There may be a cultural issue present in that some cultures are not trusting of Western medicine and rely on their own "folk" remedies. The child welfare worker should approach these families in a respectful way given that research has shown that several of these folk remedies are quite effective (AAP, 1994).

Note: It is recommended by Dr. Howard Dubowitz that the child welfare worker use the term "non-adherence" rather than "non-compliance" when the parent/caregiver does not follow medical advice or directives, as the former term is less pejorative. There may be a number of reasons (cultural, economic, spiritual, lack of understanding of the instructions, etc.) why a parent/caregiver may not access medical care or follow medical directives.

Psychological Neglect

Psychological neglect may be present in some situations where a minor is a danger to him/herself or others. Psychological neglect may also be present in some situations where a minor has a condition of sufficient severity so as to warrant treatment, and the parent or guardian is not addressing this issue or the minor's behavior (or treatment is the precipitating factor).

Supervision (Lack of)

Children who are not old enough to care for themselves and are left unattended, or who are supervised by someone who is not competent to meet their needs are at risk of injury or death.

This may include leaving a child unattended in a car. If the outside temperature is high, this may put the child at serious risk of harm. Even with windows cracked, the temperature can rise substantially in short amount of time.

In an effort to help prevent future tragedies like this, Jan Null, Certified Consulting Meteorologist, is using a Davis Weather Station to determine just how hot (and how quickly) the temperature becomes inside vehicles compared to the ambient temperature.

"The numbers I am getting are quite an eye opener," says Jan. "For example, on May 24th, another 86 degree day, the shaded temperature inside my car rose from 84 to 109 in just ten minutes, then up to 119 after 20 minutes. It stabilized between 125 and 130 after 30 minutes. The temperature in direct sunlight in the car rose to 141 degrees after 10 minutes, 148 after 20 minutes, and topped out at 153 at 30 minutes" (*About Davis*, 2002).

Truancy/Tardiness (Chronic)

SARB (School Attendance Review Board) handles most truancy and tardiness problems. Chronic truancy/tardiness may indicate a "problem" at home.

Failure to Thrive

Definition

“Failure to thrive” is a description applied to children whose current weight or rate of weight gain is significantly below that of other children of similar age and sex.

It is important to determine whether the failure to thrive results from medical problems with the child (organic), or from psychosocial factors in the environment such as abuse or neglect (non-organic).

Assessment

Most children with failure to thrive (FTT) can be assessed by a general pediatrician with the help of professionals in other disciplines. The clinical evaluation for FTT should include a comprehensive history, physical examination including developmental assessment, feeding observation, and a home visit by an appropriate health professional. A growth chart including all growth parameters and trends since birth is plotted.

Medical Causes

There are multiple medical causes of failure to thrive that may disturb the body’s metabolism enough to result in delayed growth. These include:

- ❑ Chromosome abnormalities such as Down syndrome and Turner syndrome
- ❑ Defects in major organ systems
- ❑ Abnormalities of the endocrine system
- ❑ Damage to the brain or central nervous system, which may cause feeding difficulties in an infant that result in delayed growth
- ❑ Abnormalities in the cardiac and respiratory systems, which can disrupt delivery of oxygen and nutrients to the body
- ❑ Anemia or other blood disorders
- ❑ Abnormalities in the gastrointestinal system
- ❑ Some diseases such as cerebral palsy, chronic gastroenteritis, and gastroesophageal reflux

Psychological and Social Causes

- ❑ Emotional deprivation as a result of parental withdrawal, rejection or hostility
- ❑ Economic factors can affect nutrition, living conditions, and parental attitudes
- ❑ Environmental factors may include exposure to infections, parasites, or toxins
- ❑ Many times the cause cannot be determined

Recognition of FTT Secondary to Neglect or Abuse Risk Factors

- ❑ Underlying undiagnosed diseases
- ❑ Parental depression, stress, marital strife, divorce
- ❑ Parental history of abuse as a child
- ❑ Mental retardation and psychological abnormalities in the parent(s)
- ❑ Young and single mothers without social supports
- ❑ Domestic violence
- ❑ Alcohol or other substance abuse
- ❑ Previous child abuse in the family
- ❑ Social isolation and/or poverty
- ❑ Parents with inadequate adaptive and social skills
- ❑ Parents who are overly focused on career and/or activities away from home
- ❑ Failure to adhere to medical regimens
- ❑ Lack of knowledge of normal growth and development
- ❑ Infant with low birth rate or prolonged hospitalization
- ❑ Negative emotional environments
- ❑ Crowded or unsanitary living conditions

Symptoms

- ❑ Height, weight, and head circumference in an infant or young child do not progress normally according to standard growth charts – weight less than 3rd percentile, weight 20% below ideal weight for height, or a falloff from a previously established growth curve.
- ❑ Physical skills such as rolling over, sitting, standing, and walking are slow to develop
- ❑ Mental and social skills are delayed
- ❑ Development of secondary sexual characteristics are delayed in adolescents

Treatment

The treatment depends on the cause of the delayed growth and development. The child welfare worker should have a medical expert assess the child and determine if the cause is organic. Intervention may be necessary if the cause is determined to be non-organic.

Note: The information provided herein should not be used during any medical emergency or for the diagnosis or treatment of any medical condition. A licensed physician should be consulted for diagnosis and treatment of any and all medical conditions. Call 911 for all medical emergencies.

From <http://www.drkoop.com> and
http://www.guideline.gov/summary/summary.aspx?view_id=1&doc_id=8451

Positive Toxicology

Newborn urine is tested. An initial test is done, and then a confirmation test of the same sample is completed.

A “positive” screen indicates that the mother of the newborn has ingested drugs within 72 hours prior to giving birth (generally). An exception is marijuana, which shows up in the body’s system for longer periods of time.

Assess:

- ☐ Support system?
- ☐ Other parent/caregiver in home also drug-involved?
- ☐ Prior children removed?
- ☐ Prior services successful?
- ☐ Prenatal care?
- ☐ Preparations for baby?
- ☐ Discussed adoption/abortion/not wanting baby?
- ☐ Condition of home?
- ☐ Condition of siblings in home?
- ☐ Any deceased siblings?
- ☐ Admission of substance abuse, minimizing?
- ☐ Severity/longevity of substance abuse?

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Perceptions and Dilemmas in Identifying and Intervening in Neglect

Perceptions of Neglect

Rose and Meezan's (1996) study revealed differences in the perceptions of the seriousness of neglect held by different groups. Comparisons revealed that various groups perceive the dimensions of neglect differently in terms of their potential harm to the child.

- ❑ Members of minority groups perceive some types of child neglect as more serious than do their Caucasian counterparts (a finding that is contrary to popular opinion).
- ❑ Investigative workers see most types of child neglect as more serious than do service workers.
- ❑ Workers see all types of child neglect as less serious than do the mothers.

Dilemmas in Identifying Neglect

It is not difficult to identify children who are seriously neglected and at risk. However, the child welfare worker will encounter many family situations in which an accurate determination of neglect and of risk to the child are difficult. These situations may create difficult dilemmas for the child welfare worker. These include:

1. *Differences in values, norms, and standards of acceptable child rearing to different cultural groups.* A failure to understand these differences might lead a worker to misinterpret the parents' behavior as neglectful. Examples might include: the age at which parents expect their children to become more self-sufficient and care for themselves or younger children; the age at which parents allow their children to remain at home unsupervised; differences in dietary practices and food choices; values about formal education in public schools, or home schooling; different medical interventions, including reliance on traditional healing instead of western medicine; and standards of housekeeping and cleanliness.

Cultural norms concerning neglectful behavior vary from society to society. Within a given society, cultural norms change over time. In Laotian, Cambodian, and many other societies, leaving an infant in the daylong care of 7-or 8-year-old siblings would be expected rather than be considered neglect (Korbin & Spilsbury, 1999). In modern American culture, the infant and the siblings would be judged as neglected.

2. *Marginal child rearing in which there is a potential for permanent detrimental outcomes for long-term exposure to marginal care.* Whether and how to intervene in such cases is a difficult decision because the risk is not always immediate, but the damage is cumulative in nature.

Dilemmas in Intervening in Neglect Situations

Intervening in an effective manner in cases of chronic neglect is difficult in that, in many situations, the causes have more to do with environmental factors outside of the child welfare worker's and the family's control. However, there are steps you can take to address factors contributing to the neglect (Nelson & Landsman, 1995):

- ❑ In addition to family therapy, day care, household management, family planning, and parenting skills training, the family may be greatly helped by referrals for job training or education.
- ❑ Foster a sense of partnership and respect between yourself and the family. Show faith in their ability to make choices by involving them in decisions.
- ❑ Emphasize the family's existing strengths.
- ❑ Provide intensive contact and outreach in the first months; follow this with less intensive contact.
- ❑ Serve these families in their own homes in order to influence their surrounding environment.

Child Emotional Abuse

General Definition

"This form of child abuse and neglect includes acts of omissions by the parents or other person responsible for the child's care that have caused, or could cause, serious behavioral, cognitive, emotional, or mental disorders" (National Center on Child Abuse and Neglect, as cited in Winton & Mara, 2001, p. 88).

Emotional abuse often occurs along with other forms of child abuse and neglect. James Garbarino, Edna Guttman, and Janis Seeley (1986) define emotional abuse as a "concerted attack by an adult on a child's development of self and social competence, as a pattern of psychically destructive behavior".

Legal Definitions

In California, child emotional abuse neglect is legally defined in two areas of the law: Section 11165.3 of the Penal Code, and Section 300 (c) and (i) of the Welfare and Institutions Code.

Challenges in identifying and assessing emotional abuse

- ❑ Difficult to define and to evaluate
- ❑ Difficult to file a petition on
- ❑ Exists along a continuum and often in conjunction with neglect, sexual molest, or physical abuse
- ❑ Best way to prove emotional abuse exists in a family is to have a psychological evaluation of the victim which describes it and states minor is suffering detriment and requires protection. (Generally, that is obtained after filing a petition on something else.)

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Indicators of Emotional Abuse

This destructive behavior includes, but is not limited to:

Assaults (Verbal)

The adult engages in (including, but is not limited to):

- ❑ Name calling of the child
- ❑ Profanity about the child
- ❑ Threatens the child
- ❑ Belittles the child

Cinderella Syndrome or Scapegoat

The adult singles out one child to criticize, punish, and/or do work.

Confusion

The adult confuses the child's sexual identity by dressing the child as the opposite gender and not allowing normal gender identity to develop.

Corruption

The adult "mis-socializes" the child by:

- ❑ Stimulating the child to engage in destructive antisocial behavior,
- ❑ Reinforcing that deviance, and
- ❑ Making the child unfit for constructive social experience.

Domestic Violence (Exposure to)

Children exposed to violence are likely to suffer emotional damage (National Clearinghouse on Child Abuse and Neglect, 2000).

"Double Binds"

The adult puts the child in a "no win" situation: whatever the child does or chooses is going to be "wrong."

Humiliation

The adult performs acts that result in extreme embarrassment and feelings of humiliation for the child.

Ignoring and/or Depriving

The adult deprives the child of essential stimulation and responsiveness, stifling emotional growth and intellectual development. This may include depriving the child of books or toys, which also impacts emotional and intellectual growth, and results in psychic pain.

Isolation

The adult:

- ❑ Cuts the child off from constructive experiences
- ❑ Prevents the child from forming friendships
- ❑ Makes the child believe he or she is alone in the world

Rejection

The adult:

- ❑ Refuses to acknowledge the child's worth
- ❑ Refuses to acknowledge the legitimacy of the child's needs
- ❑ Shows overt rejection (pushes the child away)
- ❑ Dismisses the child's comments, ideas, or needs.

Terrorizing

The adult:

- ❑ Verbally assaults the child
- ❑ Creates a climate of fear for the child
- ❑ Bullies or frightens the child
- ❑ Makes the child believe that the world is capricious and hostile.

Unpredictability (Parental)

Most situations, even when unjust and painful, are easier to deal with if their occurrence is logical and predictable. However, when emotional or physical trauma is capricious and unpredictable, a constant and extreme degree of anxiety and apprehension can exist.

Unrealistic Expectations

The adult is scolding, yelling, and demeaning when the child displays developmentally appropriate behavior. Alternatively, the adult scolds, yells, or demeans the child, based on behavior the child is not yet capable of.

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Child Physical Abuse

Legal Definitions

In California, child physical abuse is legally defined in two areas of the law: Sections 11165.3, 11165.4 (and 11165.5, 11165.6) of the Penal Code, and Section 300 (a), (e), (f), (i), and (j) of the Welfare and Institutions Code.

A Few Words about Poverty and Abuse

While research of Douglas Besharov shows poverty to be a contributing factor to *neglect*, Finkelhor (1994) found socio-economic status **not** to be a defining variable for *abuse*. In fact, Finkelhor found (as have others) that abuse in middle- and upper-class families is underreported.

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Values Clarification: Personal Definitions of Abuse and Neglect

Most people have a highly emotional reaction to observing or being exposed to child abuse and neglect. Child welfare workers are no exception. One reason that legal definitions of abuse and neglect are so important is the variable reaction to different behaviors by different people. What one child welfare worker may consider personally to be neglectful, for example, another may see as a minor oversight in parenting.

For this reason, it is vital that workers know the law, and reflect on their own definition of what constitutes abuse and neglect. The law attempts to precisely define abuse and neglect, but can be interpreted differently depending on who is reading it. If a worker is unsure of whether a child has been abused or neglected under the law, it is vital that he or she consult with a supervisor to determine the best course of action and to prevent acting on one's personal bias in this area.

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Values Clarification Exercise, Groups 1-6

Values Clarification Exercise Group 1

TRAINER: Distribute a copy of this page to a group in the training. There are six separate sets of questions (1 for each group for a total of 6 groups).

INSTRUCTIONS TO TRAINEES:

- ❑ As a group, please discuss one question at a time.
- ❑ Each member should respond to each question by describing how the issue was addressed in their own culture and family.
- ❑ Compare each other's answers, consider differences in attitudes and values, and identify ways in which failure to recognize cultural differences could lead to misunderstandings or misjudgments about one another.

QUESTIONS FOR GROUP # 1:

- ❑ *At what age were you left alone to care for yourself?*
- ❑ *Under what circumstances?*
- ❑ *Whom were you told to contact in an emergency?*
- ❑ *At what age were children in your family given responsibility to care for other kids in the family?*
- ❑ *At what age were you allowed to babysit when your parents weren't at home?*

Values Clarification Exercise

Group 2

TRAINER: Distribute a copy of this page to a group in the training. There are six separate sets of questions (1 for each group for a total of 6 groups).

INSTRUCTIONS TO TRAINEES:

- ❑ As a group, please discuss one question at a time.
- ❑ Each member should respond to each question by describing how the issue was addressed in their own culture and family.
- ❑ Compare each other's answers, consider differences in attitudes and values, and identify ways in which failure to recognize cultural differences could lead to misunderstandings or misjudgments about one another.

QUESTIONS FOR GROUP # 2:

- ❑ *What form of discipline or punishment did your family use most often*
- ❑ *Did this form of discipline affect how you felt about your parents?*
- ❑ *How so?*
- ❑ *Were there any kinds of discipline or punishment that your parents wouldn't use because they felt it would be harmful to you?*
- ❑ *Did your friends receive the same type of discipline from their parents?*

Values Clarification Exercise

Group 3

TRAINER: Distribute a copy of this page to a group in the training. There are six separate sets of questions (1 for each group for a total of 6 groups).

INSTRUCTIONS TO TRAINEES:

- ❑ As a group, please discuss one question at a time.
- ❑ Each member should respond to each question by describing how the issue was addressed in their own culture and family.
- ❑ Compare each other's answers, consider differences in attitudes and values, and identify ways in which failure to recognize cultural differences could lead to misunderstandings or misjudgments about one another.

QUESTIONS FOR GROUP # 3:

- ❑ *Did you ever have injuries as a child?*
- ❑ *How did your parents find out?*
- ❑ *What did they do and how soon after discovery of the injury did they act?*
- ❑ *What was done, if anything, to reduce the risk of future injury?*

Values Clarification Exercise

Group 4

TRAINER: Distribute a copy of this page to a group in the training. There are six separate sets of questions (1 for each group for a total of 6 groups).

INSTRUCTIONS TO TRAINEES:

- ❑ As a group, please discuss one question at a time.
- ❑ Each member should respond to each question by describing how the issue was addressed in their own culture and family.
- ❑ Compare each other's answers, consider differences in attitudes and values, and identify ways in which failure to recognize cultural differences could lead to misunderstandings or misjudgments about one another.

QUESTIONS FOR GROUP # 4:

- ❑ *At what age did your family toilet train?*
- ❑ *Was the same expected for both boys and girls?*
- ❑ *What methods were used for toilet training?*
- ❑ *What happened when there was an "accident"?*

Values Clarification Exercise

Group 5

TRAINER: Distribute a copy of this page to a group in the training. There are six separate sets of questions (1 for each group for a total of 6 groups).

INSTRUCTIONS TO TRAINEES:

- ❑ As a group, please discuss one question at a time.
- ❑ Each member should respond to each question by describing how the issue was addressed in their own culture and family.
- ❑ Compare each other's answers, consider differences in attitudes and values, and identify ways in which failure to recognize cultural differences could lead to misunderstandings or misjudgments about one another.

QUESTIONS FOR GROUP # 5:

- ❑ *How did your family respond to babies crying?*
- ❑ *Were boys and girls treated the same way when they were crying?*
- ❑ *At what age was it expected that children would not cry?*

Values Clarification Exercise

Group 6

TRAINER: Distribute a copy of this page to a group in the training. There are six separate sets of questions (1 for each group for a total of 6 groups).

INSTRUCTIONS TO TRAINEES:

- ❑ As a group, please discuss one question at a time.
- ❑ Each member should respond to each question by describing how the issue was addressed in their own culture and family.
- ❑ Compare each other's answers, consider differences in attitudes and values, and identify ways in which failure to recognize cultural differences could lead to misunderstandings or misjudgments about one another.

QUESTIONS FOR GROUP # 6:

- ❑ *How were tantrums handled in your family?*
- ❑ *Who was expected to deal with the acting-out child?*
- ❑ *Was the response different if the tantrum happened in public?*
- ❑ *At what age was a child considered too old to have tantrums?*

Elements to Consider in Identifying Physical Abuse (Short Version)

In order to carry out effective child abuse assessments and investigations, the following framework will assist child welfare workers. By carefully considering each element, child welfare workers will be much more capable of reaching the determination of whether child maltreatment has occurred. The elements to consider in evaluating physical abuse are:

- ❑ *Location/Scene of Incident*
- ❑ *Location of Injury on the Body*
- ❑ *Type(s) of Injury*
- ❑ *Severity/Extent of Current Injury/Injuries*
- ❑ *Frequency of Injuries over Time*
- ❑ *Explanation of Injury*
- ❑ *Child's Overall Appearance*
- ❑ *Chronological Age of Child*
- ❑ *Developmental Abilities of Child*
- ❑ *History of Unreported Maltreatment of these children by any caregivers, or history of unreported maltreatment by these caregivers toward any children*
- ❑ *History of CWS Involvement – with these children or with these caregivers*
- ❑ *Parent's/Caregiver's Own History of Maltreatment*
- ❑ *Parent/Caregiver Substance Abuse*

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Elements to Consider in Identifying Physical Abuse (Extended Version)

NOTE to Trainees: Always check your county's protocols for investigating allegations of physical abuse. Depending on your particular county's protocols, some of the following elements may not be part of the child welfare worker's tasks.

Location/Scene of Incident:

❑ Measure

It is very important to observe the scene or location where the incident occurred and to measure if justified by the offered explanation, such as a fall. If, for example, the story indicates that the child fell or rolled off the bed, it is important to measure the distance of the fall and to photograph the measurement.

❑ Photos! Photos! Photos!

It is important to photograph both the injury and the scene of the incident where the injury occurred.

❑ Envision how it occurred, but **do not suggest**.

Imagine how scenarios occur and what injuries one would expect to see as a result. Elicit from the parent/caregiver what occurred with as much detail as possible, taking accurate notes, and then bring that information to consult with the child abuse expert and law enforcement as appropriate.

Location of Injury on the Body

Injuries to some areas of the body may be more suspicious for abuse because it is less likely that injuries would be sustained to those areas in an accidental way. Some areas of the body present higher risk to a child if they are injured there, so these are also cause for concern:

- ❑ Face and head—Obviously there is concern about injury to the brain, eyes, face. Injuries may be accidental or non-accidental to this area.
- ❑ Typical accidental areas for bruising involve forehead, chin, knee, shins, or elbow.
- ❑ Genitals—Injuries to this area may be suspicious for maltreatment, including physical or sexual abuse.
- ❑ Soft tissue areas, such as the abdomen, liver, etc., are of concern as there are no bones to protect those organs. There may be internal injuries which can be serious as a result of trauma.

- ❑ Location is important because we will have more concern about a bruise to the eye versus bruise to the shin, in terms of severity of the injury.
- ❑ The most common non-accidental fractures in children of all age groups involve the skull, the long bones, and the ribs (King, Diefendorf, Apthorp, Negrete, Carlson, 1988; Merten, Radlowski, & Leonidas, 1983).
- ❑ In infants, the most common fractures are in the skull, ribs, and metaphyses (APA # 5, 2003).
 - ➔ If child is age 5 and under, check for bruises. (if your county policy allows)
 - ➔ If child is over 5, check for injuries if physical abuse alleged OR if child discloses it (if your county policy allows).

Types of injuries

There are several types of injury, from bruises to bites, fractures, internal injuries, head trauma, fatalities, and burns. These types of injuries are covered in depth at a later point in this curriculum.

Severity/Extent of Current Injury/Injuries

Bruises versus broken bones? In terms of abuse, bruises are less serious than broken bones (e.g., fractures). Significant concern should arise around traumas to the head, soft tissues, and internal organs. In addition, severe burns are a significant concern.

Frequency of Injuries over Time

Frequency of injuries is also a concern. Repeated injuries are more serious than isolated incidents, unless it can be proven to be a series of accidental injuries. Multiple non-accidental injuries of different ages indicate increased risk because the abuse is ongoing.

If bone fracture(s) arise as a concern, CWS workers will likely need to request and wait for the results of a full skeletal survey from medical practitioners before making a determination of child maltreatment, as a skeletal survey can identify bone breaks over time for a given child. (See also content on fractures for more detail about this in segment entitled “Types of Injuries: Accidental and Non-Accidental, Part 2.”)

Explanation of Injury (*further detailed description in next handout*)

- ❑ Interview Victim
- ❑ Interview Parent/Caregiver
- ❑ Interview Victim’s Siblings

- ❑ Obtain Medical Opinion (see content labeled “Information Gathering and the Identification of Physical Abuse: Obtaining Medical Opinions” Extended Version)
- ❑ Interview Other Witnesses
- ❑ Accidental vs. Non-accidental
- ❑ Discipline vs. Abuse and Discipline vs. Punishment
 - ➔ In all cases, ask child how discipline happens at home and if there are any marks as a result.
 - ➔ Do injuries match the story?

Child’s Overall Appearance

Observe the overall appearance/hygiene/attire of the child:

- ❑ Does the child appear well cared for?
- ❑ Check with pediatrician if possible to see if overall health and weight is appropriate to the child’s developmental age. Also, ask pediatrician if child is up to date on immunizations.

Chronological Age of Child

The younger the child, the higher the risk, in terms of child maltreatment.

There is the greatest concern about the youngest children (infants and children under age 5) when it comes to child abuse, as they are least able to protect themselves or ask for help (e.g., Can the child “run, yell, tell”?). Children ages 5 and under are also least likely to be in other settings, such as school where there are other eyes to watch out for them and report possible maltreatment. Infants and children under age 2 are most often victims of fatal child abuse and have the highest rates of skeletal injury and abusive head trauma (Administration for Children & Families, Children’s Bureau, Child Maltreatment Figures, 2003).

Developmental Abilities of Child

If a child is not old enough to walk, then they are not going to fall down and be injured. For example, in the case of a 3-week-old infant with a fractured femur where no explanation is given to describe how the injury occurred, this situation is highly suspicious for child abuse.

- ❑ *Look at the developmental functioning of the child:*

One of the questions to ask during an assessment is, “Is the child on track developmentally for their chronological age?” Use knowledge of child development and see if the injury is consistent with the child’s level of functioning, if the injury could have occurred in an accidental way. If, for example, the story is that the infant rolled off the bed, consider if the infant is capable of rolling yet?

Consider the information you have on child development from the class on “Child & Youth Development” to assist you in this area of your assessment.

Children with developmental delays or premature births have an increased risk of being maltreated. Child maltreatment may result in the development of disabilities, which in turn can precipitate further abuse (American Academy of Pediatrics, 2001).

❑ *Babies*

Babies are non-mobile until around 9 months to 1 year. Any fracture on an infant (under 1) is considered suspicious, unless it can be explained by major trauma, such as a car accident, for example (Giardino, Christian, & Giardino, p. 105). Note: The bones of infants are pliable and tend to bend rather than break.

Eighty percent (80%) of inflicted fractures are found in infants younger than 18 months. Only 2% of accidental fractures are found in children of this age (Worlock, Stower, Barbor, 1986).

❑ *Toddlers*

Toddlers have lots of accidental injuries. They are learning to walk and “toddle”; they are up and down and unsteady on their feet. They may have lots of accidental marks, but again mostly on front, including the face and shins.

History of Unreported Maltreatment

- ❑ **Of these children by any caregivers, or**
- ❑ **By these caregivers toward any children**

For families that both are and are not involved with CWS, there may be a history of unreported maltreatment of the children or a history of unreported maltreatment by the parents/caregivers of any children (in or out of the household). CWS workers should assess for possible unreported maltreatment history, not only to complete a comprehensive picture in the identification process of child maltreatment, but also because 1) these are important factors in the assessment of safety, risk, and protective capacity, 2) these are important pieces of information to consider in the development of case planning services for children, youth, and families involved with CWS, and 3) these factors may affect the eventual placement of the child(ren) with extended family, friends, or non-relative foster caregivers.

A prior history of abuse in the family indicates an increased risk for further maltreatment. Talk with relatives, neighbors, and school personnel to discern if there has been prior maltreatment in the family, even if it was not reported to CWS.

History of CWS Involvement

- ❑ **With these children, and/or**
- ❑ **With these caregivers**

Prior CWS involvement indicates there is a higher risk of maltreatment. Review prior records carefully to see if there is a pattern and to gain a thorough understanding of the case history.

- ❑ Juvenile Court involvement previously indicates increased risk of maltreatment. This indicates there were family issues and problems that required a high level of intervention. It indicates a history of maltreatment to the child or a sibling of the child.
- ❑ Children freed for adoption/never reunified indicates high risk. These include children who were made dependents of the court for some type of maltreatment; the parents were offered services for their return and did not substantially comply with their reunification plan. This indicates a risk for other children living with those parents based on the history.
- ❑ If parents have other children who are not living with them, make sure to include this information on the face sheet. It is a risk factor. Make sure to inquire if the parents have had any other children who do not live with them now.
- ❑ If parents have deceased children, make sure to include this information as well. Inquire about and note the date, cause, and location of death. This can also be a risk indicator.

Parent's/Current Caregiver's Own History of Childhood Maltreatment

Parents who were abused as children have an increased risk of maltreatment to their own children (Wells and Sirotnak, 2004). If one was never nurtured, it may be difficult to know how to nurture someone else. Humans learn from what they are taught; it may be difficult to discipline appropriately if one has neither experienced nor learned appropriate discipline. Parents who grew up in homes with substance abuse or maltreatment may not have experienced appropriate boundaries, structure, and routines that children need. Therefore, they may have trouble establishing boundaries, structure, and routines for their own children.

However, a basic premise of social work is that people have the capacity for change. An educational, strengths-based approach may help in working with families to learn new approaches to parenting.

Parent/Current Caregiver Substance Abuse

A significant number of children in this country are being raised by parents with addictions. With more than one million children confirmed each year as victims of child abuse and neglect by state child protective service agencies, state welfare records have indicated that substance abuse is one of the top two problems exhibited by families in 81% of the reported cases (National Association for Children of Alcoholics, 1998).

- ❑ Substance abuse interferes with normal functioning, even absent other issues and challenges with which these parents may be dealing. Substance abuse does not mix well with parenting.
- ❑ Children may suffer from neglect by parents who are under the influence, out looking for drugs, passed out, coming down off of drugs, or who leave children unattended when under the influence. The inebriated or high parent may leave children in the care of inappropriate caregivers who may subject them to physical abuse, sexual abuse, or neglect. Parents who are under the influence have compromised judgment and compromised ability to provide appropriate nurturing, care, and supervision to children.
- ❑ Loss of impulse control by parents/caregivers under the influence can lead to violence and abuse. There may be an overlap with domestic violence and substance abuse.
- ❑ People may lie/minimize while under the influence of drugs or alcohol. They may be involved in criminal activity and have the children present in a “meth lab,” a dangerous environment where there are weapons, drugs, and drug paraphernalia. They may also be involved in a high-speed chase, burglary, or other crime with the children present.

Information Gathering and the Identification of Physical Abuse: Explanation of Injuries

It is important to obtain explanations from the child/adolescent victim, the parent(s) and/or caregiver(s), siblings, other witnesses, and medical staff to assess if child maltreatment has occurred. *Before you interview any children, become familiar with your particular county's procedures and policies on checking children for injuries, as protocols may vary from county to county.*

FIRST: Interview Victim (when possible, when verbal)

The reported victim should be interviewed individually by the child welfare worker, not with parents/caregivers or siblings present.

- ❑ The child should be interviewed in a neutral setting, such as school, when possible, rather than in the home. If interviewed in the home, it should be in a private room or area where his/her answers won't be overheard.
- ❑ The alleged victim should be checked for injuries:*
 - ➔ If the child is under age 5 on all referrals of possible maltreatment (if that is consistent with your county's policy).
 - ➔ On physical abuse referrals, no matter what the age of the child (if that is consistent with your county's policy).
 - ➔ A welfare check should be completed on all children during all investigations of possible maltreatment referrals. This means that all children being interviewed should be asked the following types of questions:
 - *What happens in your house if you do something wrong?*
 - *If the answer is spanking/hitting, there should be follow-up questions:*
 - *Ask them if they are spanked or hit, by whom?*
 - *Ask them with what (are they spanked/hit with)?*
 - *Ask them if that type of spanking or hitting ever leaves marks?*
 - *Ask them if they have marks now? (If they answer yes, they should be checked for marks/injuries.)*

*After interviewing children, do a matter-of-fact check for marks in the least intrusive manner possible. The child welfare worker may elicit the parent's or child's help in doing so. **Do not strip children; rather, pull up shirts, pull down pants, etc.** For babies, have the parent change the baby's diaper; at the same time, the child welfare worker can observe the parent's ability to clean the child and care for the child's needs. If the child to be interviewed is an older child of a different gender than the interviewer, the child welfare worker should enlist the help of school personnel, a

police officer, or another child welfare worker of the same gender to ask the child if there is a need to check for injuries.

Interview Parent(s)/Caregiver(s)

Parents/Caregivers should be interviewed about their version of events during which the reported injury occurred, as well as about their relationship with their child, their own functioning, and their family's functioning. It is important to keep in mind the following information when conducting a child abuse investigation and assessment:

People may lie to child welfare workers and police officers during child abuse investigations. They may fabricate a story about how the injury occurred rather than disclose what really happened. In child abuse cases, explanations of falling a very short distance from a couch, bed, or table are common explanations given for serious injuries.

There are three ways a person lies: omission, commission, and mixed. With lies of omission, an individual *leaves out* information in their narrative. With lies of commission, an individual *adds untruthful information in their narrative*. In mixed lies, there is a *combination of omitting and fabricating information*.

Some reasons people might lie to child welfare workers in a child abuse/neglect investigation are:

- ❑ Didn't mean to do it (intent)
- ❑ Fear of consequences
- ❑ Arrest
- ❑ Children being taken away
- ❑ Loss of job
- ❑ Loss of TANF/welfare funds
- ❑ Family repercussions
- ❑ Deportation
- ❑ Shame (may be cultural issues here)
- ❑ Substance abuse issues
- ❑ Distrust of authority figures (may be cultural issues here)
- ❑ Resentment about intrusion (may be cultural issues here)

Additionally:

- ❑ *People do take their children to Emergency Rooms (ERs) after abuse has occurred (in most cases). Therefore do not assume that if they brought the child for treatment, they could not have caused the injury. They may be fearful of the consequences, and so will change the story of how the injury actually happened.*
- ❑ *People can love their kids and abuse them. As already stated, child abuse is not generally a premeditated situation. It is generally more about loss of control and inappropriate methods of parenting and discipline. It may include severe abuse*

and very violent behavior, but often it happens quickly and the parents either regret it or are afraid of telling what actually happened, but they want the child to receive medical treatment.

- ❑ *People may take the truth and change it a little.* They may recount a situation which actually occurred, but did not cause the injury. Then, when questioned if such an incident occurred, the child may concur, but it is not that particular incident that caused the injury. In child abuse cases, explanations of falling a very short distance from a couch, bed, or table are common.
- ❑ *Changing stories are very suspicious* (Wells and Sirotnak, 2004). For example, the parent/caregiver tells the nurse their explanation. Then the parent/caregiver is questioned again by one or more doctors or other medical personnel. Then the child welfare worker appears to re-question them, saying there are concerns about possible maltreatment. After that, perhaps a detective or police officer comes to re-question them. The parent/caregiver may change the story each time or embellish it to try to improve the credibility of the explanation. **Therefore it is very important to take accurate notes!**

The parent/caregiver may be changing the story with each subsequent interviewer because they feel they were unable to persuade the prior interviewer. They may try to say that the prior interviewer did not obtain the right information from them, or that they remembered something else since then. Each interviewer must be clear as to what was said, so that disparities in the explanation can be discovered.

- ❑ *The absence of an explanation is also suspicious* (AAP #1, 2003; Wells and Sirotnak, 2004). If the parents/caregivers are present, and the child has an injury, the child would have cried out or made some indication they were injured in most cases, even if the injury was accidental. Therefore, if the child has a suspicious injury and the parents/caregivers claim that they were present and that they have no idea how the injury occurred, that is suspicious unless another reasonable explanation can be found.
- ❑ *An unknown perpetrator is considered high risk.* In situations where there is an insufficient explanation about how an injury occurred, and there are multiple possible perpetrators of the abuse, the child should not be placed back in the home if there was a serious non-accidental injury, since it is unclear who to protect the child from. Even if the other party or parties did not cause the injury, they may have failed to act protectively to prevent the abuse to the child.
- ❑ *Blaming siblings for abuse is also suspicious* (AAP # 2, 2003). If a child has a suspicious or serious injury and the parent/caregiver attributes the injury to a sibling of that child, particularly a sibling who is a young child, this explanation is

suspicious. The sibling should of course be interviewed as well as a consultation with a pediatrician, medical person, or child abuse expert to see if a child has the strength to inflict the injury on the victim.

- ❑ *Saying the child “bruises easily” or has “brittle bone disease” is suspicious. Don’t accept the parent’s explanation of what would be attributed to a legitimate medical condition. A medical opinion is required to determine:*
 - ➔ If the child has a medical condition which accounts for excessive bruising with normal activity, or
 - ➔ If the child has a bone abnormality or medical condition which accounts for the existence of fractures that are not the result of maltreatment.

Interview Siblings

Siblings should also be interviewed individually and in a neutral setting when possible. Siblings should not be interviewed as a group as they may influence each other. Sometimes, one or more siblings may be protective of the parent or influence the other children not to talk. Some siblings may be more fearful, whereas others may be willing to describe abuse. Interviewing siblings separately is also a way of corroborating information; it makes a case much more credible if children independently describe abusive acts to the child welfare worker and the stories are similar. Siblings may turn out to be some of the most credible witnesses if the cases go to court. Siblings should also be checked for marks/injuries if warranted by the referral information and case situation.

Interview Other Witnesses

Other witnesses who are important to talk with in conducting a child abuse investigation include the following:

- ❑ *Relatives* can tell a great deal about the family and their functioning and history. They also may be, or know of, alternative caregivers if a child must be removed from the home.
- ❑ *Neighbors* can give information about the ongoing atmosphere in the home, who comes in and out, any concerns they have had for the children’s safety, any problems, such as ongoing domestic violence or substance abuse issues, as well as details about the specific incident being investigated. Neighbors also must be assessed as to their own credibility and relationship to the family.
- ❑ *Teachers* can give information about whether the child appears generally well cared for, as well as any concerns they have had about the child, especially in terms of possible maltreatment. They can also give information about how the child behaves and performs at school, both academically and socially.

- ❑ *Family pediatricians* can be contacted for information about whether the child has received regular well-child care checks and if they are caught up on their immunizations, as well as any history of serious or suspicious injuries. They can be asked if they have ever had any concerns for the child's welfare or if they have ever suspected possible maltreatment.

Accidental versus non-accidental

Children can be hurt severely, accidentally. Doctors and medical personnel are trained to respond and treat medical conditions. They may have limited information as they see the child and family in the hospital, clinic, or medical office. Despite training and increased awareness about child maltreatment, there are situations in which the medical personnel are unsure, incorrect, or lack sufficient information to know if child maltreatment has occurred (Rubsam, 2001).

Social workers in the field of child protection are in the unique position of seeing children and families in their homes and in their communities. They can assist the medical professionals by providing them with the background setting of where the injury occurred. This, along with the law enforcement report, helps determine the accidental or non-accidental nature of the injury.

Discipline vs. Abuse & Discipline vs. Punishment

Discipline (to teach or instruct) refers to the system of teaching and nurturing that prepares children to achieve competence, self-control, self-direction, and caring for others. Punishment is defined as the application of a negative stimulus to reduce or eliminate a behavior. There are two types typically used with children: verbal reprimands and disapproval and punishment involving physical pain (American Academy of Pediatrics, 1998).

- ❑ Many parents base their parenting behaviors on the ways that they were raised and the methods used by their caregivers growing up. If a parent was raised in an environment lacking in nurture, proper care, or in which they were maltreated, that parent may be less equipped to provide nurturing and appropriate parenting techniques to their own children (Knutson, DeGarmo, Koeppi, & Reid, 2005; Regalado, 2004).
- ❑ Child welfare workers should develop empathy for these at-risk parents who may in fact have good goals in terms of wanting to set limits on their children's behaviors, but who may lack the necessary knowledge and skills to carry out those goals with effective methods.

- ❑ A strengths-based approach leads child welfare workers towards joining with the parent in the goals they may have and helping them acquire appropriate, safe, and nurturing discipline techniques to more effectively reach those goals (Horn, 2004).
- ❑ Another factor to consider is the cultural context of the discipline. There may be practices in a family's country of origin that are different from those of Western culture. The parent may be utilizing these techniques with no intent to abuse. A child welfare worker sensitive to the family's cultural context can tease out those practices from abuse and assist in educating the family to other options of discipline (Maiter, Alaggia, & Trocme, 2004).

Information Gathering and the Identification of Physical Abuse: Obtaining Medical Opinions

After gathering the information from the alleged victim, the siblings, the parent/caregiver, any other relevant witnesses to the incident, and those who have information about the child and family, the child welfare worker should talk with the doctor or child abuse medical expert about the child's injury and the explanations given in order to determine if abuse has occurred. The following questions are important ones to ask medical provider(s) as part of the determination of whether or not the abuse occurred:

- ❑ *What is the nature of the injury?*
- ❑ *What does that mean? (So that you can explain it to the court and everyone else who needs to know, ask the medical expert to explain the injury in layman's terms.)*
- ❑ *How do you spell it?*
- ❑ *Is the explanation given (by the parent) consistent with the injury?*
- ❑ *If not, what is the mechanism that caused this injury?*
- ❑ *Is it a non-accidental injury?*
- ❑ *Can you put that in writing?*
- ❑ *What would the child's reaction to the injury be?*
(Would the child have cried out? Would the child have obviously been in pain?)
- ❑ *Can you give me the age of the injury?*
(This may help identify perpetrator in some cases, as it gives a window of time when the injury occurred. This time frame may be matched up with the timeframes of who was caring for the child when, and narrow down who was caring for the child at the time the injury occurred.)
- ❑ *Are there any other reasonable or likely causes for the injury or findings that may be caused by something other than abuse or neglect? What are they and can you rule them out with a high degree of certainty?*

Practice Tip: Know Your Experts!

When assessing injuries, the worker must remember that they are a child welfare worker, not a medical professional. If there is a question about whether trauma was inflicted or accidental, a thorough medical examination can usually assist in the assessment. When a doctor, nurse, or other professional renders an opinion on whether an injury was accidental or not, or was consistent with a parent's description of the cause of the injury, it is vital that the medical professional's opinion is documented very carefully. Asking the physician to give their diagnosis in writing will often provide for better documentation, and will encourage the physician to clarify why they feel an injury was accidental or non-accidental.

Supplemental Scenarios for Age/Injury Activity

Instructions:

- Read description of injury aloud,
- Elicit input from class on possible causes, and
- Provide real outcome after discussion.

Example 1: Possible Physical Abuse

Female, 4 years old. Child was brought to the emergency department at 8:00 pm with a large bump on head above right eye.

Cause: Child was bouncing on living room couch, slipped, and hit her head on the edge of the coffee table. Parents verified and the child told doctor what had happened outside the presence of her parents.

Example 2: Possible Supervisory Neglect

Female, 1 year old. Drowning, EMT called to the home.

Cause: Father was asleep. The 1-year-old got out through sliding glass door and fell into the pool. The 13-year-old sibling was at home at the time as well.

Example 3: Possible Supervisory Neglect

Male, 7 years old. Died in an apartment fire

Cause: Mother left child alone in apartment for 5 hours while she went to work. Blaze started in child's bedroom, possibly by cigarette lighter.

Example 4: Physical Injury

Male, 3 months old. Presenting in Emergency Room, with seizures. Grandmother states her son, Terry, 43 years old, brought the baby to her saying the baby had spit up after taking a bottle and was shaking like he was cold.

Cause: Baby had old and new subdural hematomas and a fractured skull. Father finally admitted to shaking the baby twice. He was charged with criminal attempted homicide, simple assault, aggravated assault.

Example 5: Physical Injury

Female, age 9 years. Fractured elbow, presenting at the Emergency Room at 8:30 pm.

Cause: Went down metal slide standing up in socks. At bottom of slide, child's feet went out from under her and her right elbow slammed against the edge of slide. Child did not disclose injury to parent for 9 hours because she had disobeyed mother's injunction to "play safely" on the swing set.

Example 6: Possible Medical Neglect

Female, 18 months. Infant diagnosed with meningitis. Infant died.

Cause: Parents said they believed child only had a cold or the flu and did not seek medical attention because they believe strongly in faith healing and chose to pray for the child. Parents charged for manslaughter and willful cruelty to a child.

Types of Injuries: Accidental and Non-Accidental, Part 1 (Bruises, Bites, and Cultural Practices that may be Construed As Abuse)

Bruises/Pettichiae/Abrasions

Bruises are a result of bleeding under the skin when there is some type of impact made and when there is an underlying bony prominence. Accidental bruising is common in toddlers, especially on the shins, elbows, forehead, knees, and chin.

Our bones protect us. The organs that have no bones underneath may sustain trauma but have no visible external bruising, despite serious injuries to these internal organs. This may also result in a delay in medical treatment if a child has sustained significant non-accidental trauma but an accurate history is not given when the child is seen for medical treatment.

Current literature indicates that bruises of identical age and cause on the same child may not appear as the same color and may not disappear at the same rate (Langlois & Gresham, 1991). In contrast to prior practice, current literature does not support attempting to age bruising (Schwartz & Ricci, 1996). (This is an example of how information in the field of child abuse is always evolving and that there are ongoing discoveries and controversies in the field of social welfare, as there are in other professions.) Characteristics of the bruise depend on:

- ❑ Force applied
 - ❑ Location where force is applied
 - ❑ Size of the blood vessels damages
 - ❑ Type of tissue injured
 - ❑ Child's ability to clot
 - ❑ Color of skin
- Kuelbs, C., 2005 "Abuse Through the Life Cycle"

Bruises may take on the pattern of an object and indicate how and with what a child was hit:

- ❑ *Grab marks:* Have a characteristic oval shape and are most commonly located on the upper arm, shoulder, and extremities. The characteristic pattern for these is one or two thumb prints on one side of the body, with up to eight finger marks on the other side.

- ❑ *Handcuffing/Tying up:* Leaves a pattern although it may be subtle. Circumferential marks are injuries which may be around the wrists, neck, and ankles as a result of restraint. These are abrasions or scars which encircle the extremity involved. In cases of strangulation, pettichiae are present, which are pinpoint types of hemorrhages.
- ❑ *Handprints:* May leave abrasions from ring marks which may cut the skin. The full or partial handprint may be visible. Slap marks are characterized by linear, parallel bruises.
- ❑ *Linear marks:* Are a line and result from being hit with straight objects such as a belt, switch, or ruler.
- ❑ *Loop/horseshoe shape:* Injuries are from an electric cord. (Loops with braiding are the same shape but from a rope.)
- ❑ *Pettichiae:* Are broken capillaries, pinpoint hemorrhages consistent with strangulation.
- ❑ *Pinch marks:* Are opposing oval shapes, typically on the arm or leg.
- ❑ *Rope marks:* Also leave a pattern.
- ❑ *Scars:* Indicate old abrasions and injuries, and therefore are indicative of increased risk if there are also newer injuries.
- ❑ *Shin marks/bruises:* Normal shin bruises on toddlers are circular and may be numerous, but only on the front of the legs.
- ❑ *Slate gray or Mongolian Spot:* A Slate Gray spot is a birth mark which can closely resemble a bruise in shape and color. It appears to shrink as a child ages, but actually stays the same size as a child grows. Slate gray spots often fade by the time a child is four years old, but may remain into adulthood. They are more common on children of color, including Native American, Hispanic, Asian and African American children. They may be green or purplish in color, but can be colored like and look like a bruise. They are not sensitive to touch. They are often on lower back or upper buttocks, but can be anywhere, including the face or ankles.

Bites

There are three elements to a human bite mark:

- ❑ Horseshoe, oval shape
- ❑ Discoloration inside the oval from suction

- ❑ May be round reddened area in interior due to tongue thrust (Pediatrics, 1999)

When children have human bite marks, the injury should be viewed, measured, and photographed as soon as possible, as the injury will change size and shape as it heals due to the elasticity of skin. The victim should be seen by a forensic dentist as soon as possible. Dental impressions can be taken and can match up bite patterns with the perpetrator. The perpetrator may have limited mental capacity or be mentally ill. This injury is indicative of a high risk situation for the child.

Dog bites appear distinctly different than human bites. The shape is different and there are generally accompanying scratch marks. If a parent or caregiver states that a bite mark is the result of an animal bite, a dental expert will be able to discern a human bite mark from an animal bite mark.

- ❑ Adult human bites are a primitive form of expressing anger. Adults who bite a child out of anger present a significant risk to the child (AAP #1, 2003).
- ❑ Bites may be associated with sexual molestation.
- ❑ Sometimes children bite other children. An adult bite will differ in size and characteristics from a child bite, which may be identified if seen quickly by an expert and depending on the nature of the injury pattern.
- ❑ Some parents may bite their children to teach them not to bite other children. While this may not be the most desirable approach in teaching a child not to bite, it presents a significantly different risk level than an adult who bites out of anger. In such cases, the child welfare worker can take an educational approach towards working with the parent on other ways to teach their child not to bite. Also, children in these instances would probably not need to be removed from their homes of origin if no other risk factors exist.

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Folk Medicine Practices

Remember to observe certain cautions

Avoid stereotyping; the behaviors discussed below, while more common in some groups, are found among all cultures. Only some members of a group will show these behaviors; members of different cultural groups display culturally congruent behaviors to varying degrees.

Source

Tom McIntyre & Patricia Silva (1992). Culturally diverse childrearing practices: Abusive or just different? *Beyond Behavior*, Volume 4, Issue 1, pp 8-12.

The ways in which various cultures treat family members who have fallen ill can also bring about reports of abuse. There are time-honored folk medicine practices which may be viewed as irrational, ineffective, and insupportable by western medical standards. However, many folk medicine practices are central spiritual and/or cultural practices, and are integral to the functioning and belief systems of a particular group of people.

For example:

- ❑ A teacher calls a Latino student to her side upon seeing his reddened and crusty eye margins. Upon inquiry, the student tells how his mother places petroleum jelly on her children's eye areas when they have difficulty sleeping. This practice is believed to promote slumber. The teacher, explaining and criticizing this practice to colleagues in the school lounge, is informed by a Latino peer that this is a common home remedy in some Latin cultures.
- ❑ A teacher is concerned about a ring-shaped burn on the body of one of his students. In response to his report of suspected abuse, the caseworker in charge calls back to inform the instructor that this resulted from a folk medicine healing practice known as "cupping." This practice is common in some East Asian (Wei, 1983) and Eastern European countries. Cupping involves lowering a ceramic cup, turned upside down with a candle underneath, down to the skin of the afflicted area of the body. A suctioning effect results, which is believed to draw out aggravating substances. A variation of this practice involves igniting alcohol-soaked cotton which surrounds a piece of broken glass in a cup. The cup is then turned over onto the skin, perhaps leaving a burn and/or a puncture wound.
- ❑ An Asian American teacher, aware of the limited knowledge base among her non-Asian colleagues regarding some Asian folk medicine treatments, presents a short

informational session at a staff meeting. She describes how pinching, scraping, or “coining” (i.e., rubbing a coin into an afflicted area) can leave marks and skin abrasions that might be mistaken for evidence of abuse.

- ❑ A student reports to her teacher that her brother is extremely ill, and that he is experiencing nausea with wrenching pain and extreme tenderness in the lower right abdomen. She also says that her Christian Scientist parents are praying for a cure rather than taking him to the hospital, even though they suspect appendicitis. Although they are aware that they are required by state law to report this practice when they engage in it, they are failing to make this disclosure.
- ❑ A preschool teacher in a low-income African American community notices that one of her pupils is ill and has a severe rash. Upon inquiry, she discovers that the student’s family has already attempted to treat him with folk remedies often found in African American homes (Stack, 1974). Lye or detergent was added to the youth’s bath water to treat his rash. For his stomach pains, he drank “persnickety,” a pungent brew made from tobacco added to the child’s milk.
- ❑ A novice teacher, newly assigned to a school in a low-income Latino area, is perplexed by the odd smell emanating from a lethargic student. He is told by his team leader to read a book on Santeria. Santeria, a blend of Catholicism, African spirit worship, and folk medicine practices, is common in Latino and Afro-Caribbean communities (Canino, Velez & Stoltberg, 1987; Gonzalez-Wippler, 1989). Depending on the individual’s country of origin, it might also be known as Lucumi, Macumba, Candomble or Shango. For ill children, animal sacrifices, or the wearing of certain colors, beads, or potions may be prescribed by a priest known as a “Centro” or “Santero” (Canino, Velez, & Stoltberg, 1987; Gonzalez-Wippler, 1989).

Origins and Types of Folk Remedies

Some folk remedies leave marks, bruises, or other injuries. Folk remedies are a cultural expression of love and healing. However, jurisdictions have developed different policies regarding the response to folk remedies.

Type of Injury	Description of Folk Remedy Injury	Method of Treatment	Cultural Group	Belief
Bruises	Cao Gio (coining): Light bruising with pettichiae usually between ribs on front and back of body that may resemble strap marks. Also may be seen on neck, both sides of spine, or along inner arms.	Menthol oil or ointment is applied to symptomatic area. Edge of coin is rubbed over the area with firm, downward strokes.	Mien, Vietnamese, Ethnic Chinese, and rarely, Lao and Cambodian	Pains, colds, heat exhaustion, vomiting, headache. Coining forces the “bad wind” or noxious substance from the body.
	Tzowsa (spooning): Light bruising, pettichiae, or abrasion on both sides of the spine, behind both knees, bend of both arms, and on chest from just above nipple to clavicle.	Similar method as coining but a spoon is used. If raised area appears, cupping treatment is applied.	H’mong	Exudes pain
	Bat Gio (pinching): Intense, isolated nonsymmetrical areas anywhere on the body. Found between eyes on forehead, along trachea, necklace pattern around base of neck, upper chest both sides, upper arms,	Pinching Tiger Balm, a mentholated ointment may be massaged into the area before pinching.	All Southeast Asian groups	Exudes the bad wind for localized pain, no appetite, heat exhaustion, dizziness, fainting, blurred vision, any minor illness, cough, or fever. Very

Type of Injury	Description of Folk Remedy Injury	Method of Treatment	Cultural Group	Belief
	along the spine or along side of spine.			commonly used.
Burns	Poula (burning: ¼ inch diameter, asymmetrical superficial burns. Appear as single burn in center of forehead or two nearly symmetrical vertical rows of burns down the front or back of the body, including the neck.	Tall weed-like grass is dried and the end dipped in heated, melted pork lard. Tip is ignited and applied to the treatment area.	Mien, rarely Cambodian	Exudes noxious element for pain, cough, or diarrhea. Also used for failure to thrive.
	Ventouse (cupping): Two-inch circular bruise and burn marks painful to the touch. Usually appears in symmetrical, vertical rows of 2-4 cups on both sides of chest, abdomen, or back, or singly on forehead.	Vacuum is created in a special cup by burning alcohol-soaked cotton inside the cup. When the flame extinguishes, the cup is immediately applied to the skin. Suction is created and the skin is sucked up into the cup. The cup remains on for 15-20 minutes until suction is easily released.	H'Mong, Mien, Vietnamese, Ethnic Chinese and rarely, by Lao and Cambodian	Suction exudes the noxious element used especially for pain, body ache, or headache
Retinal hemorrhages	Caida de Mollera (fallen fontanelle)	Baby is held upside down	Hispanics	Treatment for diarrhea or vomiting in which the

Type of Injury	Description of Folk Remedy Injury	Method of Treatment	Cultural Group	Belief
				anterior fontanelle may have sunken from dehydration

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Types of Injuries: Accidental and Non-Accidental, Part 2

Fractures and Burns

Fractures/Broken Bones

Fracture patterns often provide important information about the mechanism of injury (Feldman, 1997). The femur is the biggest bone in the body. It is hard to break and requires a lot of force to do so. In children younger than age two, the most common inflicted fractures are in the femur, humerus, tibia, and ribs (AAP # 2, 2003).

Fractures in children less than a year old are suspicious. Age is the single most important risk factor in skeletal trauma: 55% to 70% of all skeletal inflicted traumas occur in infants younger than 1 year (Merten, Radlowski, and Leonidas, 1983; Gross & Stranger, 1983).

A skeletal survey is a series of body X-ray views and should be considered on children under two who have a serious injury, to check for other/older fractures. Skeletal surveys identify the location of the injuries, and often a specific mechanism of injury can be inferred from the fracture pattern. Further, one can estimate the age of an injury with a skeletal survey (Kleinman, 1987). Skeletal surveys are indicated in children under the age of 3 who have evidence of physical abuse (AAP # 5, 2003).

Seek Medical Attention

- ❑ If a child is limping, medical attention should be sought. There may be an undiagnosed fracture or other injury.
- ❑ In 1946, Caffey stated that if a child had one serious injury, one should check for other injuries. While this seems like common sense to us now, this was really the beginning of modern child maltreatment assessment on a medical level.

Indicators of Fractures

- ❑ *Callus*: When bones break, they lay down new bone material to heal. That material is called callus. Callus can be seen in x-rays. The degree of callus formation can help a doctor approximate the age of a given fracture. (Pediatric radiologists read X-rays.)
- ❑ *Diaphysis*: The diaphysis is the shaft part of bone. Diaphyseal fractures are four times more common than metaphyseal fractures. However, diaphyseal fractures are more likely to be accidental than are metaphyseal fractures.
- ❑ *Metaphysis*: The growing end of the bone is called the metaphysis. When laying down new bone, this occurs at the metaphysis, at the joints. Fractures in these

areas are called metaphaseal fractures. Metaphaseal fractures are more suspicious of abuse.

Types of Fractures

- ❑ *Elbow Fractures:* Are common in older children, but suspicious in children under the age of 3. Certain fractures of the shoulder, a common accidental injury in older children, may be associated with shaking and pulling on the arm in younger children.
- ❑ *Hand/Feet Fractures:* Are unusual areas for both accidental and non-accidental injuries. Fractures of the fingers and toes are suspicious for abuse and may be the result of bending or blows.
- ❑ *Multiple Fractures:* Multiple fractures, especially bilateral fractures, are suspicious for abuse. Fractures in various stages of healing and repetitive fractures are also suspicious (AAP #5, 2003).
- ❑ *Osteogenesis Imperfecta (OI):* Is a disorder of the bones which results in increased fragility and susceptibility to fractures as a result of minor trauma (Feldman, 1997). OI (and other conditions which could result in bones breaking without significant force) should be verified by a doctor.
- ❑ *Other Fractures:* Other unusual fractures include pelvic fractures, which can result from being kicked. Fractures to the sternum result from direct blows. Fractured vertebrae may be a result of shaking (Feldman, 1997).
- ❑ *Rib Fractures:* Rib fractures are often not the presenting problem. They may be found at autopsy. They may be symptomatic of shaken baby syndrome, as they are a result of forceful squeezing, often in conjunction with shaking. It requires considerable force to fracture ribs. Rib fractures may be painful if left untreated, resulting in the child being fussy; the fussy child may then be subjected to even further abuse. The result can be a severely battered child, with a child brought to the attention of medical personnel or child welfare for subsequent injuries (who has multiple injuries of different ages and in different locations).

Rib fractures constitute nearly a quarter of all fractures seen in abuse, and are a sign of serious physical abuse to a young child. Ninety percent (90%) of non-accidental rib fractures are seen in infants younger than age 2. Posterior rib fractures are frequently multiple and bilateral (Merten, Radlowski, Leonidas, 1983; Kleinman, 1998).

- ❑ *Spiral Fractures:* Are a twisting, forceful break. In the past, these were thought to be highly suspicious for abuse. However, spiral fractures can occur by accidental means, in toddlers or older children when there is a twisting (accidental) incident.

Examples include falling through a jungle gym when the foot is caught, or running in a field and the foot becomes caught in hole and the child keeps running. In both of these scenarios, there is a twisting occurring with enough force to cause an accidental fracture.

Falls

Falls of all kinds represent an important cause of child injury and death. Fractures are frequently caused by falls, but inflicted fracture injuries are also blamed on falls. Where the child is old enough, he or she can be asked how the injury occurred (see information gathering segment). The falls described as causing inflicted injuries are usually minor in nature and the severity of the injury is most often inconsistent with the degree of the fall. (Pediatric Trauma Center Data, 01/2000-03/2006)

Burns

Burns are very painful, even when accidentally inflicted. It is important to discuss burns, to sort out some of the ways we can determine if burns are accidental or non-accidental. Child welfare workers need to consult with a medical professional for a medical opinion of the injury. The information on burns will assist you in your investigatory interview, to determine reasonable explanations. That, along with your collateral interviews and the medical consultation, will ensure the most accurate course to take.

Burns may be inflicted on a child via contact with a hot object, immersion in or pouring over scalding water or hot liquid, exposure to flame, being forced to drink caustic chemicals, or exposure to electrical appliances. Pain precedes burning- the body recoils from uncomfortable heat sources as soon as it can.

Burns were traditionally classified as first-, second-, or third-degree, increasing in severity from first to third:

- ❑ First-degree involves reddening of the skin, such as involved with a sunburn or minor contact burn.
- ❑ Second-degree burns involve blistering.
- ❑ Third-degree burns are the most serious and can be life threatening and require skin grafts.

The currently used designations are:

- ❑ Superficial- involves reddening of the skin, such as involved with a sunburn or minor contact burn.
- ❑ Partial thickness- burns involve blistering
- ❑ Full thickness- burns are the most serious and can be life threatening and require skin grafts.

The severity of a burn depends upon several factors:

- ❑ The amount of time the skin is exposed to the heat source;
 - The longer the skin is exposed to the heat source, the more severe and potentially damaging the burn will be.
- ❑ The temperature of the heat source;
 - The higher the temperature of the heat source, the shorter the time of exposure to it before there will be a burn.
- ❑ The thickness of the skin;
 - Tests on which burn exposure times have been calculated were on adult male forearms. Therefore, the times relating to children's skin are approximated from this data. Additionally, there are areas of the body where skin is thicker than others, i.e., the skin of the inner thigh is thinner than the skin on the soles of the feet. The thinner the skin, the shorter the exposure time to the heat source before a burn is produced.
- ❑ The type of exposure
 - Heat content/specific heat source
 - Heat conductivity within the source
 - Heat emission from surface to source
 - Coupling media between the heat source and the skin

Contact Burns

When the skin comes into contact with a hot object, this may cause a contact burn to the skin. The burn pattern will often indicate what the source of the burn was. Examples include heater grates, irons, car cigarette lighters, curling irons, hot plates, stovetop burners, and radiators. In investigating burns, it is important to get a good description of the incident, to obtain photos of the injury from the hospital, if already bandaged, or by taking photographs, and also observing and photographing the scene. A child abuse burn expert should be available to help assess the injury and the explanation when all of the information has been collected. Generally a non-accidental burn will have less demarcation, depth, and uniformity than an inflicted one (AAP #1, 2003).

Cigarette Burns

Cigarette burns may be accidental if the child walked or brushed by an adult holding a cigarette, but not if there are multiple burns. A non-accidental cigarette burn would be a deeper, more uniform burn but it may take an expert to tell the difference. Non-accidental cigarette burns may be seen in clusters on the hands and feet (AAP #1, 2003).

It is even more difficult to differentiate cigarette burns from other types of conditions as it heals, since it can resemble other conditions, and vice versa. Some of the other injuries/conditions that can resemble cigarette burns, especially when healing, include:

- ❑ Flea bites

- ❑ Impetigo, ringworm, and other skin infections
- ❑ Chicken pox
- ❑ Scabies
- ❑ Poison ivy

Flame

Children may be exposed to non-accidental burns by such mechanisms as holding their hand over a flame. Intentional burning to punish in such a way indicates a high risk situation for the child.

Immersion

The most common type of burn in child abuse is the classic immersion in scalding water.

Clearly demarcated lines are suspicious in burns. The key to figuring out immersion burns is if there are splash marks. If placed in uncomfortably hot water, one wants to get away, get out, scramble. In such a case, if stepping into a tub, there would be splash marks and a much less linear type of injury. It is more suspicious if two feet are involved rather than one.

Thus when we see a line, it indicates the child was held in some way in the hot water, unable to withdraw or escape. If the child is held in water, there is less splash and the injury is more sharply demarcated, more linear (AAP #1, 2003). Immersion burns are often linked to potty training problems, and non-accidental scalding water burns predominantly involve toddlers. Parents may have unrealistic expectations about potty training, trying to institute it before the child is ready developmentally. When putting a child in a tub, parents feel the water with their hand first. Even failing to do this, when placing a young child in a tub, the caregiver will have an idea of the heat of the water when initially doing so.

Leaving a baby or young child in a tub unsupervised is dangerous, especially with the water still running. (*Neglect may be an issue if abuse is disproved.*)

Sometimes the water temperature is affected by other water being turned on or used, such as during toilet flushing. If the water is running in the tub and the child is already in it, the water temperature would heat up and the child would make an attempt to climb out if developmentally able to do so. Law enforcement can be called upon to measure the water temperature and test if there is a fluctuation in water temperature as described in the given explanation. In serious scald burns, porcelain may spare the buttocks/feet in tub where there is contact, and there may be a circular donut pattern to the buttocks where the sparing occurred. Folded up legs may also spare inner touching skin on the backs of legs.

A “glove burn” is the same concept, in which a hand is held in scalding water and there is a clearly demarcated line to the burn and very little splash. A “stocking burn”

is the same concept but the foot held is held in water. In serious immersion burns like these, photograph scene and injuries, or obtain copies of the photographs of the injuries from the hospital, and obtain a history of what reportedly occurred. Law enforcement may be involved as well to assist in the investigation.

Questions which should be asked where there are immersion burns include:

- ❑ What was holding the hot water? Some container compositions may keep the water hotter than others.
- ❑ How deep was the water in the container?
- ❑ What was the child's exact positioning in the water when the burn occurred?
- ❑ What was the estimated temperature of the water?

Liquid

If a child pulls a pot of very hot water or liquid onto the head, this may be a supervision issue. Clothing may affect the pattern of the burn as it will hold the heat in longer. Non-accidental liquid will tend to come to a point. If a child is held in place and hot liquid poured over the body or part of the body, an injury will appear to be more linear, and less "coming to a point" in the pattern. The literature refers to it as an "inverse tree appearance", which is an apt description (AAP # 1, 2003).

Burns caused by hot oil can be more severe because oil can get hotter than water and is more viscous. It holds heat longer than water.

With splash burns, questions which should be asked include:

- ❑ How far did the liquid travel in the air from object to child? Liquid loses heat the further away from the heat source it is.
- ❑ What was the estimated volume of liquid (cupful, pot, coffee pot full)?
- ❑ What was the position of the child when it occurred: sitting, standing, laying?

Burns are very painful, whether accidental or not; they happen quickly. It is preferable to consult an MD who is a burn expert, as burns are difficult for doctors also to discern if non-accidental. Letter from doctor is key in pursuing these cases, as the child may need to be placed out of the home due to risk.

There are a number of factors which raise the suspicion index for inflicted burns:

- ❑ Blaming a sibling, particularly a minimally verbal pre-schooler;
- ❑ An unrelated adult seeking medical attention for the child in lieu of the parent or caregiver;
- ❑ Changing or differing histories provided over time;
- ❑ Treatment delay of over 24 hours post exposure to heat source;
- ❑ History of other injuries to the child;
- ❑ Inappropriate affect for either the parent or child;
- ❑ History incompatible with either the injury or the developmental abilities of the child

- ❑ Mirror image burns;
- ❑ Burns localized to the perineum, genitalia, or buttocks;
- ❑ Burns older than history provided by parent/caregiver (or child);
- ❑ Multiple similar burns on the body
- ❑ Other current or healing injuries

Cultural/folk medicines/healing

Folk medicines and cultural practices for home healing are often effective. Some others may not be. Some cultural practices may be mistaken for maltreatment due to their appearance. Some cultural or folk practices result in patterns on skin that look like burns, and so are covered in this section:

- ❑ *Coining/Cao-Gio*—This cultural practice is of Southeast Asian origin. In order to rid the body of toxins, fever, or congestion, the practice is to rub a heated coin up and down on the torso in warm oil. Coining can leave red streaks which appear to be burns or bruises on the back or the chest. It reportedly does not hurt and is very effective in treating chest congestion.
- ❑ *Cupping*—This cultural practice is of Mexican and Asian origin. The practice involves placing a heated cup on the torso on different areas. It can leave circular marks and suction marks inside, creating a burn or bruise as well.
- ❑ *Moxibustion*—This is the practice of burning herbs or string on abdomen, for the same purpose and with similar results, leaving marks which appear to be burns on the torso.

Understanding the cultural perspective does not in itself define if it is abuse or not; rather it is a way of understanding the behavior. However, within each culture there is a range of behaviors along a continuum; there are subcultures which may be abusive within an overall culture.

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Types of Injuries: Accidental and Non-Accidental, Part 3

Injuries to the Face, Ears, Mouth, and Neck

Injuries to the Face, Ears, Mouth, and Neck

Any injuries to the head are potentially serious. The severity of the presenting inflicted injury, while perhaps minor in nature, may be indicative of on-going or escalating maltreatment. A blow hard enough to bruise the face or surrounding areas of a young child must be taken very seriously. There is no legitimate excuse or reason for striking a young child in the face and this type of injury represents very high risk to the child. The force necessary for non-severe bruising or cuts may be only a fraction of a degree from one which would cause serious or fatal injury.

Frenulum tears: Are injuries to the connecting tissue between the tongue and the floor of the mouth and between the lips and the gums. These may be caused by a direct blow to the face or from jamming a spoon or bottle into a resistant child's mouth (Wells and Sirotnak, 2004).

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Types of Injuries: Accidental and Non-Accidental, Part 4

Abusive Head Trauma

Head Trauma

If there are severe injuries to the face/head, there should be concern about possible internal head injuries.

In non-accidental head trauma cases, there is often either a lack of an explanation, or there is a story of a minor fall offered as an explanation (such as a fall from a couch). Children can be injured in short falls but if a skull fracture results, it tends to be a simple rather than complex fracture with less severity of symptoms, such as intracranial bleeding or brain injury. In cases of severe head trauma with no plausible explanation (such as a car accident), child maltreatment should be suspected (Feldman, 1997). Almost a third of skull fractures in children under age 3 are non-accidental (Leventhal, Thomas, Rosenfield, Markowitz, 1993; Meservy, Towbin, McLaurin, Myers, Ball, 1987). Abusive head trauma is the primary cause of death in infants in child abuse cases (DOJ, 2002).

- ❑ *Bilateral Head Injury*: When an injury is described as “bilateral,” it means there are injuries to both sides, which is more suspicious for non-accidental injury than having just one injury site.
- ❑ *Shaken Baby Syndrome* (Boos, 2003)
 - ➔ Takes a significant amount of force
 - ➔ Affects children generally under one, but can be up to age 5
 - ➔ Retinal hemorrhages are symptomatic
 - ➔ May be fatal or may result in permanent brain damage
 - ➔ Whiplash injury inside skull involves acceleration/deceleration injury. The brain is traveling back and forth and smashing into the skull.
 - ➔ The head of a young child is larger than that of an adult in proportion to body, which results in more whiplash trauma. Also, the brain of a child is softer than that of an adult.
 - ➔ Coup-Contrecoup - During impact trauma, there is a primary impact site when hit by an object and secondary impact site as the brain slams into the opposing side of the skull. This is also an acceleration/deceleration type of injury.
 - ➔ Shaken Baby Syndrome can also be Shaken Baby with Impact as in some instances the types of injuries indicate the head was struck against something instead of or in addition to being solely shaken.

- ❑ *Skull Fractures:* Are not predictive of brain injury. It is possible to have a skull fracture with no internal injury to the brain, or to have significant brain injury with no skull fracture. Bruises may be visible externally in cases of head trauma, or there may be internal bruising that is not visible externally. Lacerations and abrasions may also be present externally (AAP #3, 2003).
- ❑ *Subdural Hematoma:* Is a medical term for a brain bruise, “sub” meaning “under” the skull (dura). Hematoma is a medical term for a bruise.
- ❑ *Symptoms:* In cases of head injury, symptoms may include loss of consciousness or an altered conscious state, seizures, vomiting, lethargy, or irritability. In cases of severe head trauma, there is a predictable time courses of medical conditions seen with head injuries which occur in the four to six hours following the event. Knowledge of these conditions, such as brain swelling, may help time the injury, which may help pinpoint the perpetrator of the event (as to who had access to the child at what times during the hours preceding medical treatment).

Types of Injuries: Accidental and Non-Accidental, Part 5

Chest Injuries & Abusive Abdominal Trauma

Internal Injuries

Bones protect our organs. However, areas of the body that are not protected by bones are vulnerable to internal injuries—such as the abdomen, liver, etc. While bruising (which occurs as the result of force between bones, internal bodily surfaces, and external objects) helps in the ready identification of injury, it can be difficult to immediately identify injury without bruising. There can be significant internal injuries to the parts of the body that cover the abdomen and yet not have visible external injuries.

When children are brought into the ER after known severe trauma such as a car accident, there is an automatic and rapid check for internal injuries, which can be life-saving. When children are brought into the ER after being subjected to severe abusive trauma but an inaccurate history is given, the child may suffer internal bleeding and damage due to a delay in treatment as the severity of trauma is not yet known and treatment cannot be initiated. There is an approximately 50% mortality rate, mostly due to delay in seeking care or misleading histories at presentation, thus delaying appropriate diagnosis (Kaplan, Rich, 2006 “Abusive Abdominal Trauma” Presentation at American Professional Society on the Abuse of Children Colloquium, Nashville, TN).

Trokel, et al., “*Blunt abdominal injury in the young pediatric patient: child abuse and patient outcomes.*” (Child Maltreatment, February, 2004):

The 3 most common mechanisms of this type of trauma are:

- ❑ Motor vehicle accidents- 61%
- ❑ Abuse- 16%
- ❑ Falls- 13.5%

Mortality is 6 times greater in abdominal injuries resulting from abuse than from abdominal trauma resulting from falls.

Incidence and Prevalence

- ❑ Abdominal trauma from any cause is uncommon in children;
- ❑ Inflicted trauma accounts for 4-15% of abdominal trauma;
- ❑ Abdominal injuries are the second leading cause of mortality in child abuse cases.
- ❑ Abdominal trauma/injuries account for 6 to 8% of all physical abuse (Brown, Canty, Canty, 1998; Cooper, Floyd, Arlow, 1988; Ledbetter, Hatch, Feldman, Fligner, Fligner, Tapper, 1988).

- ❑ Internal organ injuries are “second only to head trauma as the most common causes of death in child abuse cases” (DOJ, 2002).

Ledbetter, Hatch, Felman, Fligner, and Tapper (1988) compared abdominal injuries in children which were accidental versus those which were non-accidental as part of their study (N=156 patients >13 years old). Some of their findings follow:

- ❑ Abusive injuries were more common in younger children than in older children. The median age of the abused group was 2.6 versus 7.8 years for the accidental group.
- ❑ Abused children had vague histories accounting for their injuries. 70% of the injuries in the accidental group were due to motor vehicle accidents. 20% were due to falls from great heights.
- ❑ The abused group had delayed medical care with inaccurate histories whereas the accidental group did not.
- ❑ The abused group had more injuries to the hollow viscera organs (esophagus, stomach, duodenum, jejunum, small intestine, large intestine, hypopharynx) whereas the accidental group had more injuries to the solid organs (liver, pancreas, kidneys, spleen).
- ❑ The abused group had a higher mortality rate (53%) versus the accidental group (24%).
- ❑ Boys outnumbered girls 2:1 as victims of this form of abuse.

However, a more recent study indicated that the liver is the most often injured organ in abdominal child abuse fatalities, with a lacerated liver being involved in 52% of the cases (Price, Rush, Perper, Bell, 2000).

General Features of Abusive Abdominal Injury

- ❑ Usually the result of a punch, kick, or deceleration
- ❑ Toddlers and young children are particularly at risk
- ❑ Due to their age or the severity of injuries, the victims are often unable to verbalize complaints
- ❑ Children do not expect the blow or kick that injures them and are unable to protect themselves
- ❑ There are often no external signs of injury (including bruising)
- ❑ Parent(s) don't provide an accurate history (if they were not responsible for the injury or were not present when the child was injured, they may not know)
- ❑ The child may not have immediate symptoms
- ❑ If there is also abusive head trauma, abdominal injury might be overlooked

CHILD MALTREATMENT IDENTIFICATION PART 1

Version 1.25 (Updated October 2013)

TRAINER:

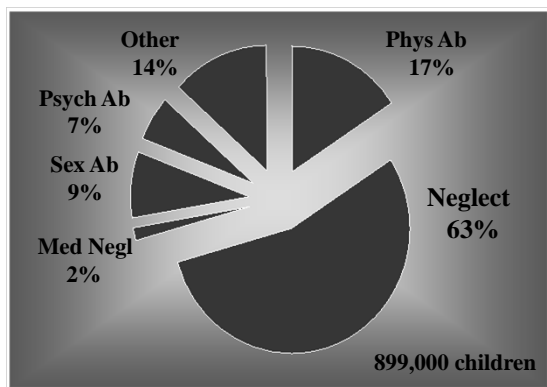
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Welcome

Learning Objectives and Competencies

2

Types of Maltreatment Identified by CPS in 2005



National numbers.....

- In 2005, 899,000 children were victims of abuse or neglect
- For 2005, a nationally estimated 1460 children died of abuse or neglect – a rate of 1.96 children per 100,000 in the national population

(US DHHS, Adm. Of Children, Youth & Families, 2005)

4

What is Child Abuse?

- Legal definitions:
 - W&I Code (a-j) – used for determining juvenile court jurisdiction
 - Penal Code (11164 & 11165) – used for determining if abuse or neglect occurred
 - Health and Safety Code

5

Exercise

- W & I Code
- Code of Ethics

6

Context for Child Maltreatment

- Cultural context
- Child rearing standards
- Environmental factors

7

COLLABORATION

- WHO IS ON YOUR TEAM?



8

CHILD NEGLECT



9

Why Child Neglect is Important

- It's common in child welfare
- Morbidity
- Mortality
- Our opportunity to intervene
- Our responsibility to intervene
- The law

10

Child neglect affects

- Emotional health
- Social development
- Cognitive development
- Physical health

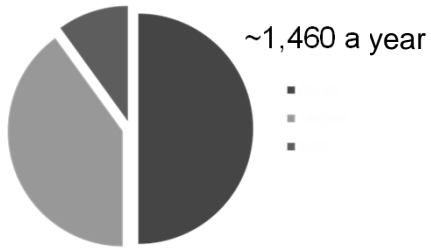
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Neglect is # 1

- 62.8% of victims experience neglect.
If we add medical neglect, this number goes up to 64.8%!
(U.S. DHHS, Adm. Of Children, Youth & Families, 2005)
- Child neglect continues to be the largest single category of child maltreatment representing over 58% of the 2.97 million reports of child maltreatment nationwide.
(Chalk, Gibbons, & Scarupa, 2002)

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Fatalities due to Child Maltreatment



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- Maltreatment deaths were more associated with neglect (42.2%) than with any other type of abuse.
- Fatalities resulting from multiple maltreatment types account for another 27.3%
- Children under age 4 account for 76.6% of all child abuse deaths
- Children under 1 account for 42% of all child abuse fatalities

(U.S. DHHS, Adm. Of Children, Youth & Families. 2005)

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How we define child neglect

Shapes our response to the problem

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What is it?

Act of omission or commission which results in minimal sufficient standards of care of minor(s) not being met.

Basic needs include: adequate food, clothing, health care, supervision, protection, education, nurturance, love, & a home.

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How do we know what children need?

- Scientific evidence
 - epidemiological data (e.g., infant car seats)
- Community standards, values
 - Not without question
- Experience (e.g., history of severe asthma)
- Common sense (e.g., hunger)

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New Knowledge New Forms of Neglect

- exposure to 2nd hand smoke
- inadequate treatment of HIV/AIDS
- not using car seats/belts
- access to a gun
- exposure to domestic violence
- unsupervised Internet access ?

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Why do we want to define child neglect?

To protect children
& improve their well-being

NOT

to blame parents

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Advantages of a Child-focused, Broad Definition

- Moves us beyond the narrow focus on parents to consider other contributors
- Leads us to consider a broader array of services, responses
- A more constructive, less blaming approach
- Fits with our broad interest in the health, safety & well-being of children

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General Neglect

Penal Code

300 (b) Welfare & Institutions Code

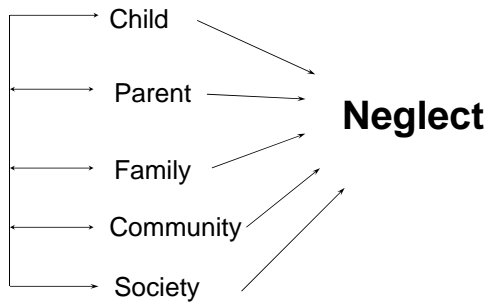
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SEVERE NEGLECT

- Withholding food/water on a prolonged, willful basis
- Severe malnutrition
- Non-organic failure to thrive
- Failure to provide medical treatment which will result in permanent and/or severe illness or death.
- Defined in PC 11165.2. (a)

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Contributors to Neglect



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Poverty & Child Neglect

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Poverty & neglect

- **3rd National Incidence Study**
- Rate of neglect **44 x** higher in families earning < \$15,000/ year

(Sedlack & Broadhurst, 1996)

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Elements of Neglect

- Poverty as an issue
- BIAS
- Poverty itself does not constitute neglect
- Other factors: chaos, lack of interpersonal or job skills, disorganization, apathy, drug addiction
- Others?

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BEHAVIORAL INDICATORS OF NEGLECT

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- Large percentage of neglected children are developmentally delayed
- May present as unresponsive, placid, dull, uninterested in their surroundings
- May appear hungry or tired
- May be out of control
- May have school/learning issues

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What does neglect look like?

- Absence
- Lack of supervision
- “dirty” home
- Dental or medical
- Psychological
- Chronic lice/scabies
- FTT
- Drug exposure (in utero and beyond)

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What can neglect look like?



Challenges & dilemmas of neglect

- Different standards, values and norms re: child rearing in different cultural groups
- Marginal child rearing issues
- Ross & Meezan study



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Intervention and Treatment Can Work!



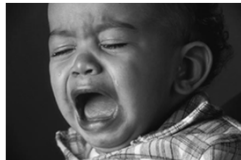
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Severe Neglect & Resilience

- At age 4, excellent catch up in growth & dev. for children who arrived < 6 months
- For those who arrived > 6 months, good catch up in development
- McCarthy General Cognitive Index = 92 (vs. 109 for UK adoptees)

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EMOTIONAL ABUSE



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DEFINITIONS OF EMOTIONAL ABUSE

- PENAL CODE
- W & I CODE

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Challenges with Emotional Abuse Investigations

- Difficult to define and evaluate
- Difficult in the Court process
- Often combined with other factors of abuse
- Often requires great effort to get documentation

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What does it look like?

- | | |
|----------------------|-----------------------------------|
| ▪ Rejection | •Setting unrealistic expectations |
| ▪ Isolation | •Verbally assaulting |
| ▪ Terrorizing | •Putting child in "double binds" |
| ▪ Ignoring/depriving | •Parental unpredictability |
| ▪ Corrupting | •Exposure to DV |
| ▪ Humiliating | |
| ▪ Confusing | |
| ▪ scapegoating | |

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Impact of Emotional Abuse on Development

- Research findings!



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PHYSICAL ABUSE



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Physical Abuse:

- Non-accidental, inflicted injury/trauma
 - WIC 300 (a) – physical abuse
 - WIC 300 (e) – severe physical abuse of a child under 5 years old
 - Injuries causing death, permanent disfigurement, significant bleeding, deep bruising, significant internal or external swelling, fractures, unconsciousness, prolonged withholding of food.
- ★ SUBSTANTIAL RISK of physical harm

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Physical Abuse in a Cultural Context

- Do our personal values, experiences and biases influence our decisions?



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Elements to consider in evaluating abuse:

- Location of injury on child's body
- Location/scene of the incident
- Type(s) of injury
- Severity/extent of current injury/injuries
- Frequency of injuries over time
- Explanation of injury/injuries
- Child's overall appearance

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Elements, cont'd

- Chronological age of child
- Developmental abilities of child
- History of unreported maltreatment of these children by anyone or by these adults of any other children
- History of CWS involvement
- Parent/caregiver's own history of abuse/neglect
- Parent/caregiver substance abuse

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Characteristics of Child Typical Triggers

- Colic; incessant crying
- Awakening at night
- Separation anxiety
- Normal exploratory behavior
- Normal negativism
- Poor appetite
- Toilet training resistance or accidents

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Information Gathering – Parent/Caretaker

- People do lie
- People do take children to ER after abuse but there may be a delay in seeking care
- People can love their kids & abuse them
- May take truth, change it a little
- Changing/contradictory stories very suspicious
- Absence of explanation suspicious

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Information Gathering, cont'd

- Blaming sibs suspicious
- Incident described not consistent with the developmental abilities of the child
- No witnesses to incident
- “Trigger Event” described
- “Unknown” perpetrator high risk

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Information Gathering- Medical Personnel

- What is the nature of the injury?
- Is injury consistent with explanation?
- What mechanism would cause this injury?
- Spell it – what does it mean?
- Put it in writing.
- How old is the injury?
- Would child be in pain?
- Cry out when injured/reaction?

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TYPES OF INJURIES



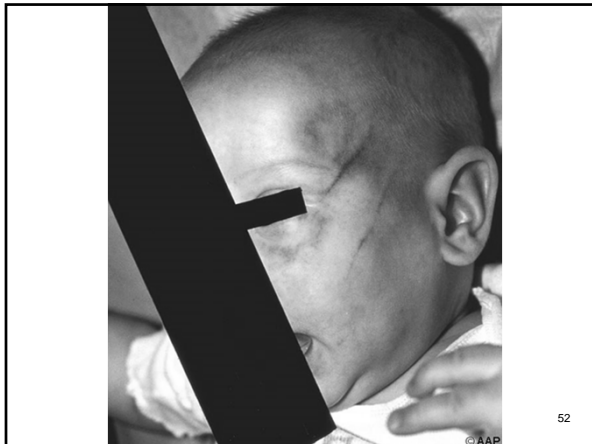
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- Bruises/ Pattern Bruising
- Broken Bones/Fractures
- Bites
- Burns
 - Contact
 - Liquid
 - Immersion
 - Flame
- Internal Injuries
- Head Injury

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Bruises

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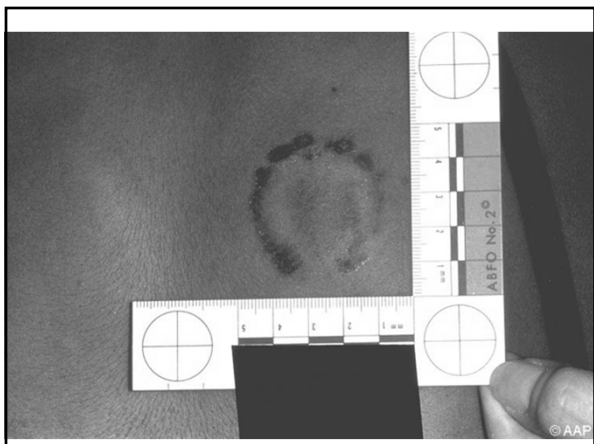












Empathy Exercise

- How would you feel...
 - Child
 - Parent
 - Social Worker
 - Medical Professional

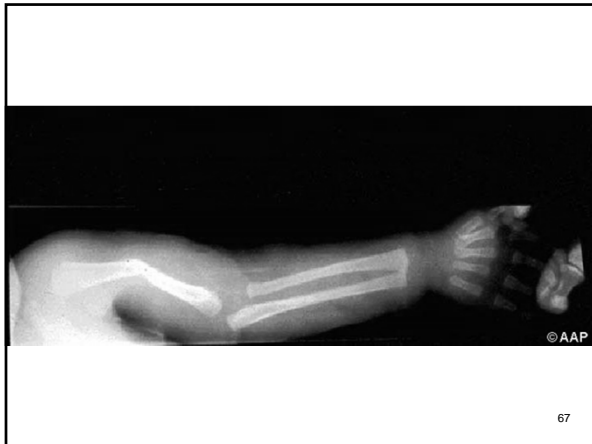
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Fractures

65

- The most common nonaccidental fractures in children of all ages involve the skull, the long bones, and the ribs.
- In infants, the most common fractures are in the skull, ribs, and metaphyses.

66





- Twenty per cent of fractures in abused children involve the femur.
- 20% of femoral fractures seen in children ages 2 to 3 are due to abuse
- 60 % of femoral fractures seen in children under 1 are due to abuse.

- There may be a delay in seeking medical treatment in cases of abuse.
- In many abuse cases, minor falls are blamed for fractures and other serious injury.

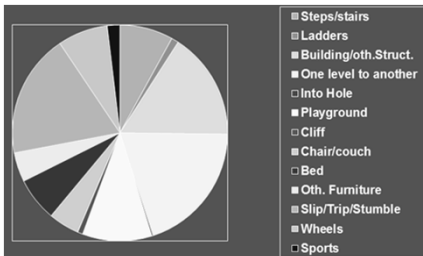
70

- Many studies have documented that minor falls do not usually produce serious injury.
- In one study of 246 children, only 3% suffered fractures, and none involved the femur.

71

Pediatric Trauma Center Data

- 01/00-03/06
- All Falls by Major E-codes
- N=2417
- By major mechanism subgroups

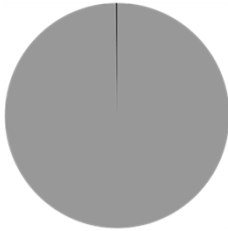


72

Pediatric Trauma Center Data

- 01/00-03/06
- All Falls

- N=2417
- By Mortality Rate
(.008% to .016%*)



*Of the four deaths, two were clearly a result of a fall from height—one from a 3rd story and one from a 2nd story. The other two deaths were complex cases and the etiology was not clear.

73



74



75

Self care

- Be prepared, burns are difficult to look at.
- Likewise, this is parallel to your need to take care of yourself as a child welfare worker
- High burnout if you don't!

76

Burn Types

- **Thermal :**
 - **Scalds**
 - ❖ Flowing/splashing/splattering liquid
 - ❖ Immersion
 - **Contact**
 - ❖ Smoldering source
 - ❖ Hot solid
 - **Flame**
 - **Radiant**

77

- Burns represent 10% of all physical abuse cases.
- The peak age of burn victims is 13 to 24 months.

78

Severity Factors

- Exposure time
- Temperature of heat source
- Thickness of skin
- Type of Exposure
 - Heat content/specific heat of source
 - Heat conductivity within source
 - Heat emission from surface of source
 - Coupling media between heat source & skin

79

Burn Profile Checklist

- | | |
|---------------------------------------------|---------------------------------------------------------------|
| ▪ Attributed to sibling | ▪ History incompatible with injury or developmental abilities |
| ▪ Unrelated adult seeking medical attention | ▪ Mirror image burns |
| ▪ Differing histories | ▪ Localized to perineum, genitalia, buttocks |
| ▪ Treatment delay >24 hr | ▪ Older than history |
| ▪ History of injuries | ▪ Other injuries |
| ▪ Inappropriate affect-parent or child | |

80



© AAP 81











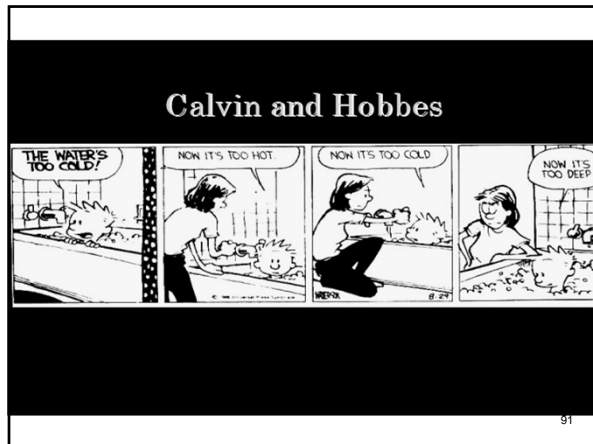
- Tap water scald burns account for 87% of inflicted burns.
- They are often associated with toilet training accidents.

89

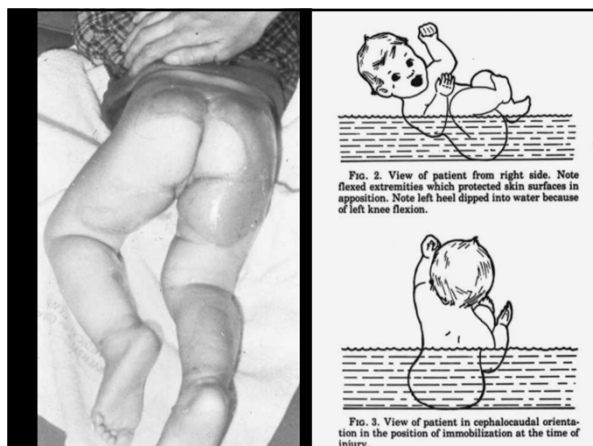
Reference Temperatures, degrees F
(pain precedes burning!)

- 101 **Comfortable Infant Bathing**
- 104-106 **Hot tub**
- 109-113 **Painful for adults**
- 113 **2nd degree burn; 6 hours**
- 120 **2nd degree burn; 10 minutes**
- 127 **2nd degree burn; 1 minute**
- 130 **2nd deg; 10 sec (child), 30 sec (adult)**
- 140 **2nd deg; 1 sec (child), 3 sec (adult)**
- 156 **3rd degree burn; 1 second child**

90









Pull down
scalds

Flowing water
runs downhill

94

170° F faucet water
Toddler left in tub.

Parents find
standing, holding
open hot water
handle.

Injury fits history,
but neglect?



Clues to Abuse: Explanation of injury

- **History**
- **Not consistent with age / ability of child**
- **Only 1 in 11 10-month-olds tested could climb into a bathtub**

(Allasio & Fischer)

96

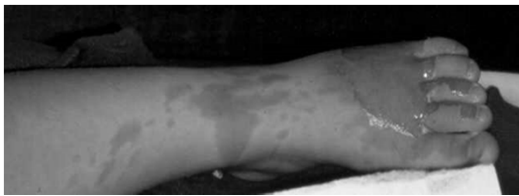


Explanation of injury:
Does it Fit?

- Heights/depths/volume
- Types handles/ease of turning
- Does water accumulate with open drain?
- How fast/hot as tub fills?
- Bathroom layout
- Other basins

97

Other hot fluids: Oil splatter
(Heat content greater than water;
fluid more viscous)



98

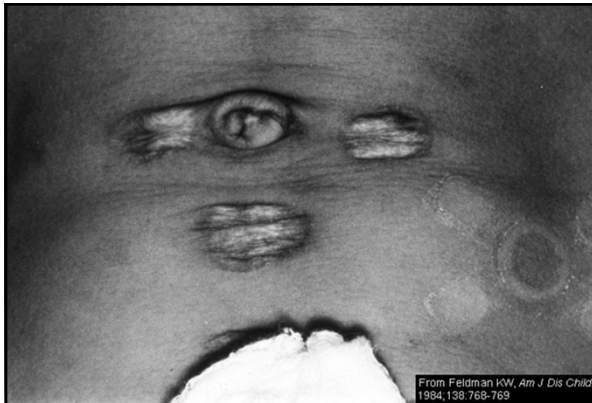


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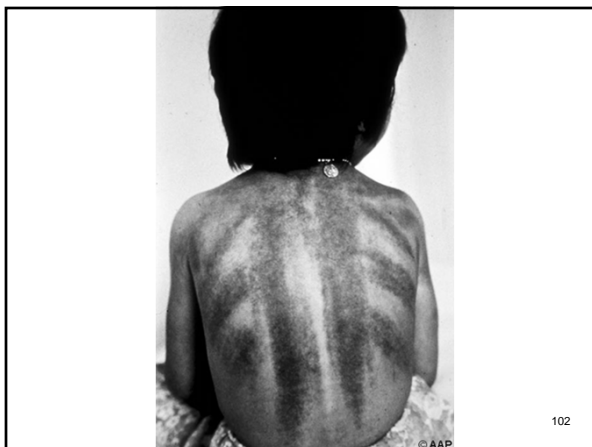
Cultural Folk Treatments

- Moxibustion – Asian medicine practice of burning herbs to the abdomen
- Cao Gio – SE Asian practice of rubbing hot coins over the back of chest to cure fever, pain, congestion
- Cupping – Mexican/S. American practice of placing warm cup over the chest to draw out illness

100

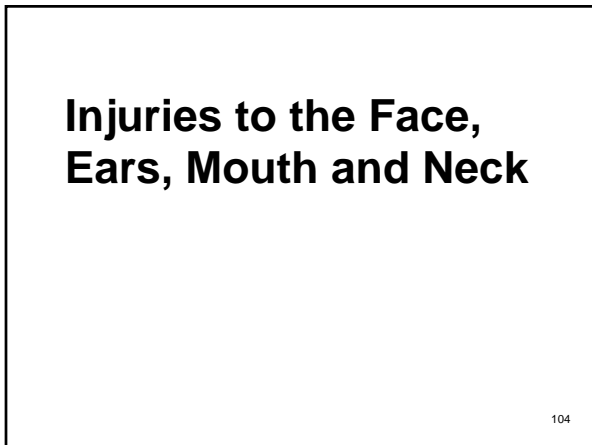


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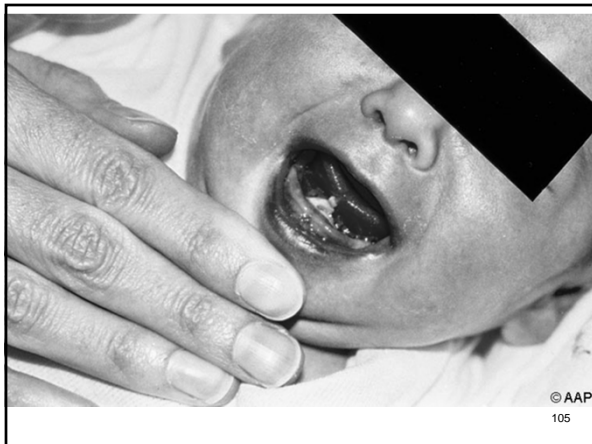
102





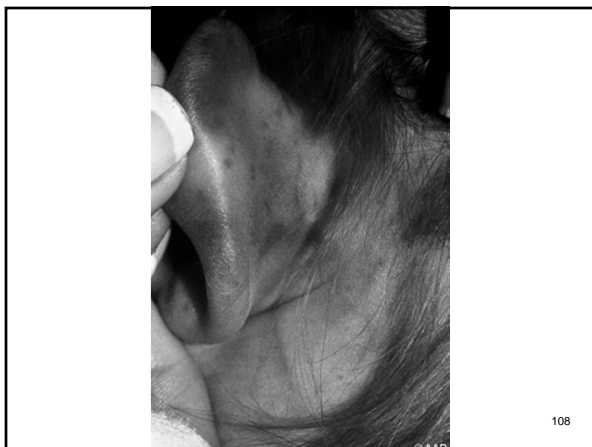
Injuries to the Face, Ears, Mouth and Neck

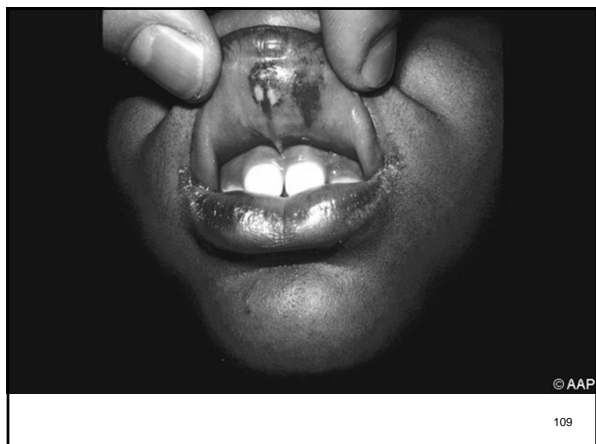
104











Day 2: WELCOME BACK

- REVIEW OF PREVIOUS DAY
- AGENDA FOR TODAY

110

Abusive Head Trauma

111

- Head injuries are the primary cause of death in infants in child abuse cases.
- Head injury is the leading cause of death in child abuse cases.

112

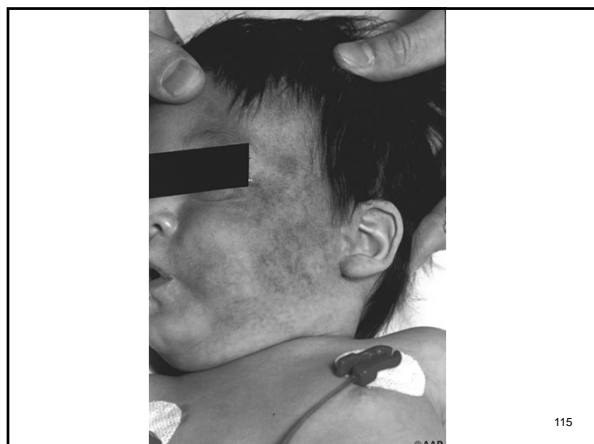
Abusive Head Trauma

- Head trauma means injury to the face, scalp, skull, meninges and/or brain as a result of mechanical force
- May be a result of direct impact, asphyxiation, or shaking

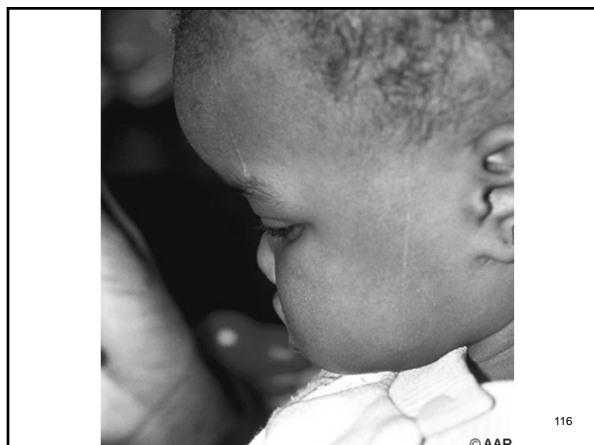
113

- *Concussion* is the most common brain injury and usually has a brief period of loss of consciousness with memory loss for the event.
- *Diffuse axonal injury* is the term for a more severe brain injury. Unconsciousness is immediate and lasts more than 6 hours.

114



115



116

- The skull of the small child is thinner than that of an adult. The larger head size and lesser muscle strength results in more acceleration-deceleration injury.
- *Skull fractures* do not predict the amount of brain injury – large fractures can be associated with minor brain injury and severe brain injury can occur without a fracture.

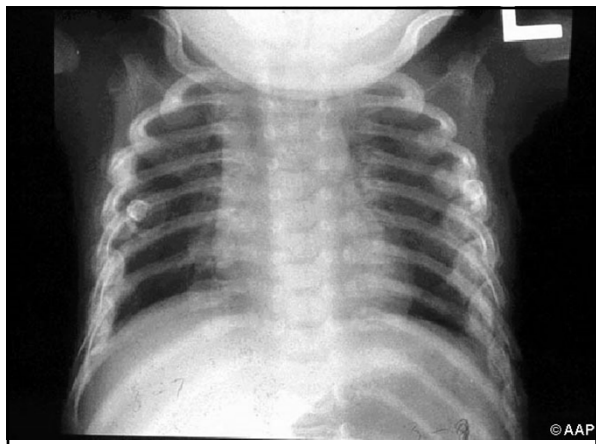
117

- Skull fractures may be simple or complex.
- Approximately 1/3 of skull fractures in children under 3 are nonaccidental.

118

Chest Injuries

119



Abusive Abdominal Trauma

- Abdominal injuries are the second leading cause of mortality in child abuse cases.
- Average age is older, approximately 2 years.
- Boys outnumbered girls 2:1 as victims of this form of abuse.
- Approximately 50% mortality rate, mostly due to delay in seeking care or misleading histories at presentation delaying appropriate diagnosis.

(Kaplan, 2006)

121

Internal Organs include:

- Liver
- Stomach
- Pancreas
- Spleen
- Kidney
- Spinal column
- Duodenum

122

Epidemiology

- 3 most common mechanisms (n=927):
 - Motor vehicle accidents 61%
 - Abuse 16%
 - Falls 13.5%
- Mortality 6X greater in abuse than falls

(Trokkel et al, 2004)

123

General Features of Abusive Abdominal Injury

- Result from punch, kick, or deceleration
- Toddlers and young children at particular risk
- Victims often unable to verbalize complaints
- Children don't expect and don't protect
- Often no external signs

124

- Parents don't provide an accurate history
- May not have immediate symptoms
- Where there is an abusive head trauma, abdominal injury may be overlooked
- **MORE FATAL THAN ACCIDENTAL INJURY!**
 - 53% to 24% in Ledbetter et al (1988) study
 - N=156 patients <13 years old with blunt abdominal injury

(Kaplan, 2006)

125

EMBEDDED EVALUATION

Time to see what you have learned so far!

126

Life and Death

- "We rarely hear about county social workers until they make a mistake..."

Unfortunately we can't pass laws demanding they make no mistakes. All we can do is demand the highest training, and impress upon child protection officials that the decisions they make are among the most critically important in our society."

(Union Tribune July 26, 1998)

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CLOSURE

THANK YOU AND GOOD LUCK TO YOU
IN YOUR CHILD WELFARE WORK WITH
CHILDREN AND THEIR FAMILIES

128



CALIFORNIA COMMON CORE CURRICULA FOR CHILD WELFARE WORKERS



MASTER GLOSSARY

366.26

The legal process by which the court determines the most appropriate permanent living arrangement for the child, either through adoption, legal guardianship, or a planned permanent living arrangement.

387 petition

A petition filed under Welfare & Institutions Code Sec. 387, requesting a child's removal to a more restrictive placement. 387 petitions must be filed to request removal from a parent on a Family Maintenance plan, removal from a relative to foster care, and removal to a higher level of foster care.

388 petition

A petition filed under Welfare & Institutions Code Sec. 388, requesting a change of a court order. Any interested party can file a 388 petition.

AB 458

The California Foster Care Non-Discrimination Act (AB 458) went into effect in 2004 and prohibits discrimination in the California foster system on the basis of "actual or perceived race, ethnic group identification, ancestry, national origin, color, religion, sex, sexual orientation, gender identity, mental or physical disability, or HIV status." [California Welfare & Institutions Code Sec. 16013(a) and 16001.9(a)(23)]. AB 458 also mandates initial and ongoing anti-discriminatory training for group home administrators, child welfare workers, foster parents, relative caregivers and foster family agency staff.

AB 490

The Ensuring Educational Rights and Stability for Foster Youth (AB 490, Steinberg, 2003) legislation expands and stipulates authority for school records of foster, homeless, and incarcerated youth. It also establishes legislative intent that foster youth are ensured access to the same opportunities to meet academic achievement

standards to which all students are held; maintain stable school placements; be placed in the least restrictive educational placement; and have access to the same academic resources, services, and extracurricular and enrichment activities as all other children. The law makes clear that education and school placement decisions are to be dictated by the best interest of the child.

AB 636

The Child Welfare System Improvement and Accountability Act of 2001 (AB 636, Steinberg) establishes a system whereby counties identify and replicate best practices to improve child welfare service outcomes through county-level review processes. It is also referred to as the California–Child and Family Service Review (C-CFSR).

AB 3632

The Special Education Pupils Program (AB 3632) was passed in 1984 and assigns responsibility to state agencies and counties for meeting the goals of an Individualized Educational Plan (IEP). This legislation assigns schools the responsibility to educate, the state Department of Mental Health (DMH) the responsibility to provide mental health services, and the state Department of Social Services the responsibility to provide out-of-home care.

Ability to Locate

This term from the California Standardized Safety Assessment Matrix refers to the ability of the social worker to determine where the children and/or family are located. [This includes information gathered as part of the hotline information gathering process and that is essential to facilitate the ability of the responding ER social worker to locate the child. Specifics regarding hard-to-find locations should be gathered as part of this assessment.] (*#12 in the Standard Areas for Review*)

Ability to Meet Child's Needs

This term from the California Standardized Safety Assessment matrix refers to the ability of the caregiver to provide a safe, stable home and meet the basic needs of children in their care. [This includes the ability to respond to a child's age and condition by providing care in a way that supports the child's health, mental health, education, development, and physical and emotional well-being.] (*#10 in the Standard Areas for Review*)

Addiction

Dependence on a chemical substance to the extent that a physiological and/or psychological need is established. This may be manifested by any combination of the following symptoms: tolerance; preoccupation with obtaining and using a substance; use of the substance despite anticipation of probable adverse consequences;

repeated efforts to cut down or control substance use; and withdrawal symptoms when the substance is unavailable or not used.

Adoption

Occurs when the court terminates the rights of the legal parent, usually the biological parent, and orders that another person is now the legal parent of the child.

Adoption & Safe Families Act (ASFA)

The National Child Welfare Act of 1997 which set performance goals, outcomes, and indicators for social work system practice.

Alternative Dispute Resolution

Various processes by which legal disputes are settled without going to trial.

Alternative Permanency

Arrangements whereby youth for whom family restoration is not possible or appropriate establish enduring emotional ties with unrelated adult caregivers who are willing and able to offer a stable and supportive continuing relationship whether within or outside of the legal channels of adoption or guardianship.

APGAR Test

A test administered at one minute and five minutes (and may be repeated at a 10-minute interval) after birth to help health care providers assess critical aspects of a baby's health at birth.

AOD (Alcohol and Other Drugs) Abuse

A pattern of substance use that threatens one's health or impairs one's social or economic functioning.

Attention Deficit Hyperactivity Disorder (ADHD)

ADHD is characterized and diagnosed by three types of behavior: (1) inattentiveness; (2) hyperactivity or impulsivity; or (3) combined (inattentiveness and hyperactivity). ADHD typically manifests initially in childhood.

Autistic Spectrum Disorder (ASD)

A group of developmental disabilities that are related to brain function including autistic disorder, pervasive developmental disorder—not otherwise specified (PDD-NOS, including atypical autism), and Asperger's disorder. People with ASD tend to have difficulties with common culturally agreed upon social and communication skills and are likely to repeat certain behaviors and resist change in their daily activities. Many people with ASD also have unusual ways of learning, paying attention, or

reacting to different sensations. ASD begins during childhood and lasts throughout a person's life however, early intervention can be critical in improving prognosis.

Basic Needs

This term from the California Standardized Safety Assessment Matrix refers to the fundamental needs of a child and family for food, shelter, clothing, medical care, and

the child's need for supervision. (#26 in the Standard Areas for Review)

Batterer Intervention

Intervention focused on helping the batterer learn to be non-violent.

Bias-Free Written Language

Communication that makes a conscious effort to avoid perpetuating biases in language that emerge as a result of assumptions or attitudes on the basis of race, gender, religion, or nationality. This includes rephrasing for gender neutrality, use of inclusive terminology, appropriate forms of address and titles, and avoiding stereotypes. (<http://www2.state.ga.us/Courts/supreme/biasfree.htm>)

Bench Officer

Judges, Referees, or Commissioners who hear the evidence presented and make decisions about the families who come before the court.

Best Interest of the Child

One of the fundamental tenets of the dependency system for achieving the best outcomes for each individual child.

Burden of Proof

A party's responsibility to prove something in dispute.

Bottle Rot

Severe dental decay which appears as blackened baby teeth, caused by improper feeding, including allowing milk or other liquid to pool in the baby's mouth during sleep. Bottle rot can cause damage to permanent teeth and gums if not treated properly by a dentist.

Bruise

Bleeding under the skin which results in discoloration. A bruise may take on the pattern of the object which caused the injury.

California Child and Family Services Review (C-CFSR)

Authorized by the Child Welfare System Improvement and Accountability Act of 2001 (AB 636, Steinberg), this county-level review process encompasses a system of continuous quality improvement which seeks to identify and replicate best practices to improve child welfare service outcomes.

California Child Welfare Outcomes and Accountability System

California's accountability mechanism that tracks and monitors child welfare outcomes, measures performance on a county and statewide basis, and enforces

continuous quality improvement by requiring counties to set and meet improvement goals.

Caregiver

Parent(s), guardian(s), or other adult(s) fulfilling the parental role and entrusted with the responsibility to care for the child(ren).

Caregiver-Child Interaction

This term from the California Standardized Safety Assessment Matrix refers to the verbal and non-verbal communication and behavior between a caregiver and child, which reflects the quality of the relationship and the degree to which it is reciprocal. [This includes behaviors that demonstrate a caregiver's awareness of the child's emotional state, the caregiver's capacity for empathy and bonding, and the caregiver's ability to respond appropriately to the child, including responses associated with child discipline.] (#11 in the Standard Areas for Review)

Caregiver's Compliance/Progress toward Case Plan Objectives

This term from the California Standardized Safety Assessment Matrix refers to the progress of the parent(s) in achieving the objectives of the change-oriented interventions specified in the case plan. [This includes the frequency and extent of the parent's participation in case plan activities, and the degree to which the parent demonstrates that these activities have resulted in change consistent with case plan objectives. Compliance is not the sole basis for considering preservation/restoration, but is one element in assessing the parent's success in achieving the objectives of the case plan and preparation to act as a responsible parent.] (#37 in the Standard Areas for Review)

Caregiver's Personal History of Abuse

The information gathered and utilized by the social worker in the assessment process to determine whether the caregiver has ever been a victim of child abuse or neglect him/herself, and whether that history affects the caregiver's protective capacity.

Caregiver Protective Capacity

This term from the California Standardized Safety Assessment Matrix refers to the ability and willingness to utilize internal and external resources to mitigate or ameliorate the identified safety and risk concerns, and to support the ongoing safety of the child. [Such capacities include, but are not limited to, attachment to the child, parental caregiving skills, awareness of and ability to interpret the child's needs, positive motivation to nurture or meet the child's needs, willingness to seek and use help, and willingness/ability to act protectively when the child is threatened with harm. Protective capacity elements are the focus of both safety plans and case plans for change-oriented intervention. They point to the inherent capacities of the family or the resources that could be mobilized to contribute to the ongoing protection of

the child as well as to the ability or motivation of the parents to change.] (#8 in the Standard Areas for Review)

Caregiver Willingness to Change

This term from the California Standardized Safety Assessment Matrix refers to the caregiver's motivation to change those conditions that threaten child safety and/or those ineffective/inappropriate behaviors that were identified in the initial assessment. (#22 in the Standard Areas for Review)

Case Plan

The written document which is developed based on an assessment of the circumstances which required child welfare services intervention, and in which the social worker identifies a case plan goal, objectives to be achieved, specific services to be provided, and case management activities to be performed. [Div 31-002(c)(2)]

Change-Oriented Services

Child Welfare Services interventions that increase protective capacities of the caregivers by modifying conditions or ineffective/inappropriate behaviors that threaten child safety, reconciling the competing demands of urgency and the gradual nature of meaningful change processes.

Child and Family Services Review (CFSR)

Authorized by the 2000 Federal Rule pursuant to ASFA, this formal review of state child welfare programs is conducted every three years by the federal government using specific benchmarks designed to assess achievement of child safety, permanency, and well-being outcomes and to identify the state's strengths, needs, and requirements for technical assistance.

Child and Family Support Assessment (CAFSA)

The Child and Family Support Assessment is comprised of an initial face-to-face assessment of child safety, risk for maltreatment, and parental protective capacity followed by a more comprehensive child and family assessment.

Child Development

This term from the California Standardized Safety Assessment Matrix refers to the child's language, cognitive, social/emotional, sensory, and motor development. [The social worker will note any diagnosed developmental problems or apparent need for developmental testing.] (#29 in the Standard Areas for Review)

Child Neglect

Acts of omission or commission which result in minimal standards of care not being met.

Child Strengths and Vulnerability

This term from the California Standardized Safety Assessment Matrix refers to behavioral and attitudinal strengths of the child that support the child's safety, permanency, and well-being, including health, education, and social development. The child's vulnerability refers to the child's susceptibility to suffer abuse or neglect based on age, health, size, mobility, social/emotional state, and the ability of the caregiver to provide protection. [Key characteristics indicating increased child vulnerability include developmental disability, mental illness (including withdrawn, fearful, or anxious behavior), and lack of self protection skills; children with substance-abusing parents; homeless children; and children experiencing chronic neglect.] (#3 in the Standard Areas for Review)

Child Welfare High Risk Response (see also Differential Response)

Intervention in situations in which children are at moderate to high risk for continued child abuse/neglect, and actions have to be taken to protect the child with or without the family's agreement. May involve the filing of criminal charges against the adult(s) who caused harm.

Child Well-Being

Child and youth well-being is the state that occurs when children/youth are able to function at their best and are able to achieve their full developmental potential. Well-being includes the ability of a child or youth to grow, to develop their capacities, and to act with meaning and purpose in daily life.

Child's Attorney

An attorney that represents the child in court and informs the court of the child's wishes and the child's best interests.

Child's Immediate and Ongoing Needs

This term from the California Standardized Safety Assessment Matrix refers to the identified developmental, behavioral, cultural, and physical needs of a child including immediate and ongoing needs for safety and security/permanency. [This includes ensuring that children and families receive sufficient support and services when and where they need them in order to maintain all aspects of their functioning that may be compromised by risk factors associated with abuse and neglect. Immediate and ongoing safety, permanency, and well-being needs include medical, dental, mental health, and developmental needs; housing, food, clothing, education, and emotional support (i.e., healthy family and peer relationships).] (#15 in the Standard Areas for Review)

Child's Permanency Needs

This term from the California Standardized Safety Assessment Matrix refers to the maintenance and/or establishment of enduring family attachments. This includes a broad array of individualized permanency options, including Reunification, Adoption, Legal Guardianship, and alternative permanent living arrangements for all children and youth to promote their safety, permanence, and well-being. [Permanency is both a process and a result that includes involvement of the child/youth as a participant or leader (when possible) in finding a permanent connection with at least one committed adult, who provides:

- a safe, stable and secure parenting relationship,
- love,
- unconditional commitment,
- lifelong support in the context of reunification, a legal adoption, or guardianship, where possible, and in which the child/youth has the opportunity to maintain contacts with important persons, including brothers and sisters.

A broad array of individualized permanency options exist for all children and youth to promote their safety, permanence, and well-being. Reunification and adoption are two important ones among many that may be appropriate. California Permanency for Youth Task Force.] (*#20 in the Standard Areas for Review*)

Child's Relationship with Peers and Adults

This term from the California Standardized Safety Assessment Matrix refers to the quality of connectedness (defined as close and positive attachment) experienced by the child toward significant adults or peers in his or her life. [This quality is measured by the degree to which these relationships meet or enhance the child's emotional, developmental, social, mental, and/or educational needs. These significant relationships may include immediate family, friends, professionals, or extended family, and also can include anyone who has an impact on the child's life. Significant relationships are not solely measured by frequency of contact with the child.] (*#32 in the Standard Areas for Review*)

Collateral Contacts

Persons from whom pertinent information is gathered to make a decision regarding the allegations of child maltreatment and the potential risk of abuse in the future. [The child welfare worker contacts persons who may have knowledge about the family for the express purpose of obtaining pertinent information regarding the risk

and safety of the child. Applicable policies and regulations must be followed regarding the release of confidential information obtained from collateral contacts.]

Common Continuum of Alcohol and Drug Dependency & Response (see also Cycle of Addiction)

Describes the pattern of use that can lead to dependency: non-use/selective abstinence; experimental use/initial use; response use, “at risk” use; situational/crises, or binge use/abuse; unhealthy use, chronic abuse; chemical dependency/addiction; recovery and relapse; and “in recovery.”

Community Response (see also Differential Response)

A proactive response to, and assessment of, situations involving families under stress who come to the attention of the Child Welfare System but who do not present an immediate risk for child maltreatment. Provides families with access to services to address identified issues without formal entry into the system.

Component

In the CFSR review, a component comprises part of a composite.

Composite

Reflects the general domain assessed by data. In the CFSR review, each composite comprises one or more weighted components. The individual measures in a composite are weighted using a technique known as principal components analysis.

Concurrent Planning

The process of coupling aggressive efforts to restore the family with careful planning for the possibility of adoption or other permanency options should circumstances prevent the child from returning to her/his family of origin.

Confidentiality

The protection of information from release to organizations or individuals not entitled by law to such information.

Contributing Factors Requiring Intervention

This term from the California Standardized Safety Assessment Matrix refers to the circumstances that require child welfare services intervention (WIC 16501.1(f)(1). (#23 in the Standard Areas for Review)

County Counsel

An attorney that represents the child welfare agency in court. (The child welfare agency, not the individual child welfare worker, is the client.)

Court Appointed Special Advocate (CASA)

CASA is a program designated by the local presiding juvenile court judge to recruit, screen, select, train, supervise, and support lay volunteers to be appointed by the court to help define the best interest of the child. CASA volunteers visit the child regularly and write reports for the court.

Cultural and Language Considerations

This term from the California Standardized Safety Assessment Matrix refers to the consideration and exploration of the family's cultural framework in the assessment and the development of safety plans and case plans. [This includes social work intervention, services, and assessments that are culturally competent and linguistically sensitive, including the provision of services in the language of the client population served.] (#4 in the Standard Areas for Review)

Current and Previous Social Services

This term from the California Standardized Safety Assessment Matrix refers to any social services currently or previously provided by a public child welfare agency or any social services agency. [These services may include CalWORKS, mental health services, counseling services, family resource services, etc. This information is used by the social worker to determine the response type, conduct safety assessments, perform case management, and make decisions regarding service interventions, placement, permanency goals, and readiness for case closure.] (#24 in the Standard Areas for Review)

Current and Prior CWS History

This term from the California Standardized Safety Assessment Matrix refers to the information gathered by the social worker from reviews of the CWS/CMS and other available documentation to determine whether or not the child and family have current or past involvement with the public child welfare agency. (#2 in the Standard Areas for Review)

Current and Prior Maltreatment

This term from the California Standardized Safety Assessment Matrix refers to a current or prior act of omission or commission by a parent or any person who exercises care, custody, and ongoing control of a child which has resulted in, or has placed the child at risk of, developmental, physical, or psychological harm. [The child welfare worker will gather information provided by reporting parties and collateral contacts (when appropriate) about that person's knowledge of current maltreatment of a child. The child welfare worker will also gather information about any previous incidents of child maltreatment involving the child or family.] (#1 in the Standard Areas for Review)

CWS Response (see also Differential Response)

A proactive response to, and assessment of, situations involving families with low to moderate risk of child maltreatment. CWS response includes the engagement of families, voluntarily whenever possible, in the development and implementation of a service plan directed at the protection of the child.

CWS Stakeholders

More than 60 invited representatives from many sectors of the child welfare community who met monthly over the course of three years to identify and recommend changes in California's Child Welfare Services, leading to better outcomes for children and their families.

Cycle of Addiction (see also Common Continuum of Alcohol and Drug Dependency & Response)

Describes the pattern of use that can lead to dependency: non-use/selective abstinence; experimental use/initial use; response use, "at risk" use; situational/crises, or binge use/abuse; unhealthy use, chronic abuse; chemical dependency/addiction; recovery and relapse; and, "in recovery."

Decision Making Model

A general model adapted from Stein and Rzepnicki to assist new workers in the process of decision making (Miller, 2005). This general model includes the following steps:

- Step 1: Information Gathering
- Step 2: Application of Rules of Criteria
- Step 3: Discussion/Feedback
- Step 4: Decision/Professional Judgment
- Step 5: Reassessment

Defacto Parent

A person who has been found by the court to have assumed the day-to-day role of parent for a substantial period of time, fulfilling the child's physical and psychological needs for care and affection. (2009 California Rules of Court, Rule 5.502(10))

Definitions of Physical Abuse, Sexual Abuse, Emotional Abuse, Neglect and/or Exploitation

Penal Code 11165 et seq.

Delinquency Proceeding

A juvenile court hearing in which the court is asked to declare a minor a ward of the court for behavior that would be considered criminal if the minor were an adult. (Welfare and Institutions Code Sec. 602.)

Delinquent Behavior

This term from the California Standardized Safety Assessment Matrix refers to behavior by a person under the age of 18 that is persistently or habitually in conflict with the reasonable orders of his guardians and/or is in violation of any laws of this state or the United States. (Welfare & Institutions Code Sec. 601, 602) (#35 in the *Standard Areas for Review*)

Dental/Medical Care

Dental and medical care (including routine examinations, diagnoses, treatment, or hospital care under general or special supervision) are to be rendered by licensed dental and medical professionals, respectively. [This term is from the California Standardized Safety Assessment Matrix (#27 in the *Standard Areas for Review*).]

Dependency Proceeding

A juvenile court hearing in which the court makes a determination as to whether or not a minor will be declared a dependent of the court. The determination is based on establishing that child abuse or neglect has occurred, as defined by one or more of the grounds specified in Welfare and Institutions Code Sec. 300.

Detention Hearing

The first judicial proceeding in a dependency case wherein the judge decides whether the child should remain in protective custody, away from his or her parents, while an investigation into the reasons for the removal is conducted. At this hearing, the court will appoint counsel, advise parents of their rights, explain the court process, order visitation when appropriate, inquire about possible relative caregivers, inquire into the child's paternity and determine whether the Indian Child Welfare Act might apply. This hearing must be held within three days of the physical removal of the child.

Differential Response (see also Child Welfare High Risk Response, Community Response, and CWS Response)

A system for triaging referrals received by the Child Abuse Hotline/Intake that provides a broader range of responses by the Child Welfare System to assure child safety and family maintenance that includes partnerships with community based agencies and consults with families to identify community supports and strength-based solutions appropriate to their circumstances.

Differentiation

The process by which neurons become specialized in response to neurochemical and micro environmental cues. These cues tell each neuron which combination of genes to activate in expressing a “unique neurochemistry, neuroarchitecture and functional capability....Each neuron undergoes a series of ‘decisions’ to determine its final location and specialization”. [Adapted from: Perry, B.P. (2002). Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind*, 3, p. 83.]

Dismissal

The court dismisses the dependency petition indicating the termination of legal proceedings. This can happen because a child is returned home and supervision is no longer necessary, or because a child has reached the age of majority and the agency has met all the dismissal requirements in WIC Sec. 391.

Disparity

Disparity refers to inequities based on a child’s or family’s minority racial or ethnic status in access to, or the quality of, treatment, services, or resources available through involvement in the child welfare system. “Research shows that children of color in foster care and their families are treated differently from—and often not as well as—white children and their families in the system” [Hill, R.B. (2006). *Synthesis of Research on Disproportionality in Child Welfare: An Update*. Casey Family Programs, p. 3]. Decision points in case management (e.g., reporting, investigation, substantiation, foster care placement, adoption, and exit) are often used to analyze the presence of disparities.

Disposition

At this hearing, the court considers what it should do to protect and help the child and his or her family. The court decides whether to dismiss the case, order informal services for the family without making the child a dependent, appoint a guardian with the consent of the parents, declare the child a dependent of the court and leave the child in the home of the parents with family maintenance services, remove the child from the home and order reunification services for the parents, or remove the child from the home and not order reunification services for one of the reasons in WIC Sec. 361.5(b). The court also approves the case plan submitted to the court which outlines the services to be provided to the child and family. This hearing can occur at the same time as the jurisdiction hearing and must occur within 10 court days of the jurisdiction hearing for detained children and within 30 court days for a non-detained child.

Disproportionality

Disproportionality refers to the differences in the percentage of children of a certain racial or ethnic group in the population as compared to the percentage of the children of the same group in the Child Welfare System. “For example, in 2000 Black children made up 15.1% of the children in this country but 36.6% of the children in the Child Welfare System” [Hill, R.B. (2006). *Synthesis of Research on Disproportionality in Child Welfare: An Update*. Casey Family Programs, p. 3].

Division 31

The State of California’s regulations that provide policy and procedures on the delivery of child welfare services. These regulations are reflected in programs that are funded by Title IV-E federal funds. Each county develops more specific policy and procedures from these state regulations.

Domestic Violence

This term from the California Standardized Safety Assessment Matrix refers to a pattern of assaultive and coercive behaviors used against intimate partners (including physical, sexual, and psychological attacks, as well as economic coercion). [Refer to the legal definitions in Family Code Sec. 6211. Also recommend using the National Council of Juvenile and Family Court Judges’ *Effective Interventions in Domestic Violence and Child Maltreatment Cases: Guidelines for Policy and Practice* (Greenbook Project).] (#34 in the Standard Areas for Review)

Due Process

The conduct of legal proceedings according to rules and principles to protect private rights, including notice and the right to a fair hearing.

Early Reunification

Efforts directed at enhancing parental protective capacity in order to permit the child to return to his or her family within 30 to 60 days of placement.

Educational Needs

This term from the California Standardized Safety Assessment Matrix refers to the level of the child’s academic performance which takes into account the child’s age relative to assigned grade level, the child’s performance as recorded, monitored, and measured by the child’s educational institution, and any barriers that are identified that may interfere with the child’s successful academic performance. (#30 in the Standard Areas for Review)

Educational Surrogate

The responsible adult appointed to represent the rights of a child with exceptional educational needs in all educational matters related to the provision of a free

appropriate public education if the educational rights of the child's parents have been limited. (Education Code Section 56050)

Ethnographic Interviewing

A skillful and engaging method of interviewing designed to elicit comprehensive information about a person's life experience in terms of values, beliefs, customs, history, and family composition, etc., often relying on open-ended questions.

Evidence-based Practice

The application to service delivery of research evidence related to child welfare, integrated with clinical expertise and client values. The existing body of research reflects varying levels of methodological rigor and efficacy, and differences in applicability to child welfare practice. Where available, research on child welfare practice is integrated into the common core.

External Resources

The formal or informal resources outside the individual or the family, (i.e., community connections, support of friends, church, or community organizations, etc.) that strengthen their capacity to mitigate risk and to support the ongoing safety of a child. (See also Protective Capacity.)

Factitious Disorder by Proxy

Commonly referred to as Munchausen Syndrome by Proxy, this DSM IV-TR recognized disorder is manifested when a caregiver deliberately induces illness in another person (usually a child).

Failure to Thrive (FTT)

Condition that exists when a child under age 2 is below the fifth percentile on normal growth charts for height, weight, and head circumference. Organic causes should be ruled out. Non-organic failure to thrive is a result of caloric deprivation and there is often a corresponding lack of bonding between the primary caregiver and the baby.

Fairness and Equity

A principle of best practice that promotes policies, procedures, practices, and service arrays that support all children and families in obtaining similar benefit from child welfare interventions and equal opportunity to attain positive outcomes. The concept 'fairness and equity' embodies the ideals of social justice and cultural competency, and the reduction of disproportionality and disparities in the child welfare system.

Family and Household Relationships

Refers to the interactions between persons who are related by blood, marriage, or adoption, and/or who reside together in the same dwelling.

Family and Youth Engagement

Practices and strategies congruent with relevant sociocultural dynamics that effectively engage parents, youth, and extended family members in a respectful and collaborative manner in the assessment, intervention and case planning processes.

Family to Family

An initiative designed in 1992 and field tested in communities across the country that effectively incorporates a number of strategies consistent with the values and objectives of the California Child Welfare Redesign, including comprehensive assessment, family team decision-making, neighborhood placement in families, and concurrent planning to assure children permanent families in a timely manner.

Family Well-Being

A primary outcome goal for California's child welfare services whereby families demonstrate self-sufficiency and the ability to adequately meet basic family needs (e.g., safety, food, clothing, housing, health care, financial, emotional, and social support) and provide age-appropriate supervision and nurturing of their children.

Fetal Alcohol Spectrum Disorders

An umbrella term referring to all disorders occurring due to an alcohol exposed fetus including Fetal Alcohol Syndrome (FAS), Fetal Alcohol Effects (FAE), Alcohol-Related Neurodevelopmental Disorders (ARND), Partial FAS and Static Encephalopathy, Alcohol Exposed.

Folk Treatments

Cultural practices and natural healing methods which are used to treat illnesses and injuries.

Fontanel

Any of the soft membranous gaps between the incompletely formed cranial bones of a fetus or an infant.

Fracture

Broken bone. Knowing the type of fracture may help to determine if it was caused accidentally or non-accidentally.

Guardian Ad Litem

A person appointed by the court after a hearing to make decisions about case strategy for an incompetent parent.

History of Child Abuse and Neglect

Refers to caregiver's identification as a perpetrator of substantiated child abuse or neglect as defined by a child protection agency.

History of Criminal Behavior

This term from the California Standardized Safety Assessment Matrix refers to a caregiver's previous or current illegal activity as defined by federal and state law that may affect the caregiver's protective capacity. [Typical sources include self-report, drug test results, and law enforcement records.] (#25 in the Standard Areas for Review)

Home Environment

This term from the California Standardized Safety Assessment Matrix refers to the physical condition of the home including safety hazards and health concerns. (#9 in the Standard Areas for Review)

Inclusive Governance

A characteristic of effective community partnerships that ensures that the diverse perspectives of the people affected by a decision, especially groups currently and historically under-represented, are taken into account in making and shaping decisions.

Independent Living Skills Program (ILSP)

A program for children age 16 through 21 that provides services to help youth become self-sufficient by the time they leave the foster care system. Dependent children who are or have been in placement after the age of 16 must be offered enrollment in this program.

Indian Child Welfare Act (ICWA)

Congress passed these laws in 1978 to protect the best interests of Indian children and to promote the stability and security of Indian tribes and families by establishing specific standards that must be met before an Indian child can be removed from his or her family and placed in an adoptive or foster care placement. Congress was concerned about the high rate of Indian children being removed from their homes and placed with non-Indian families and the negative consequences this has had on Indian children, families, and tribes. This federal law is codified in California statute and rule of court.

Individualized Educational Program (IEP)

A written document developed for each public school child who is eligible for special education services. The IEP is created by a team that includes educators, caregivers, and other child specialists (including a child welfare representative, if applicable) and is reviewed at least once a year.

Initial Safety Determination

The [California child welfare improvement] intake function, utilized to ensure the immediate safety of the child and the identification of risk factors.

Internal Resources

Resources that exist within each individual in the family and in the family as a whole (i.e., emotional and psychological strengths, etc.) that strengthen the capacity to mitigate risk and to support the ongoing safety of a child. (See *also* Protective Capacity.)

Intimate Partner Violence (IPV) (see Domestic Violence)**Jurisdiction Hearing**

At this hearing, the court takes jurisdiction of the case if it determines that the allegations in the petition filed by the child welfare agency have merit, and that the child has been abused or neglected as defined in Welfare and Institutions Code Sec. 300. Jurisdiction grants the court authority to make orders regarding disposition. The jurisdiction hearing must be held within 15 days of the detention hearing.

Juvenile Dependency

A legal system that designates children under age 18 as dependents of the court if a judicial determination of parental abuse or neglect is made. California's system simultaneously strives to preserve the family unit, while obtaining permanency for children.

Kin

Includes relatives in a nuclear or extended family, members of a child's clan or tribe, stepparents, or any other adults who share a fictive kinship bond with a child (e.g., godparents).

Kinship Care

Kinship care is the full time care, nurturing, and protection of children by relatives, members of their tribes or clans, godparents, stepparents, or any adult who has a kinship bond with a child.

Legal Guardianship

Occurs when the court suspends, but does not terminate, parental rights, and another adult is appointed to be responsible for the child.

Level of Care to Meet Child's Needs

This term from the California Standardized Safety Assessment Matrix refers to the assessment and determination of the appropriate services and placement type that best meets the child's physical and emotional needs. [This includes considerations of placing the child in the least restrictive, most family-like setting; addressing the child's personal characteristics and cultural background; maintaining the child's connections to family and siblings whenever possible; allowing the child to remain in his/her current school if possible; allowing for reasonable visitation, reunification, and permanency planning; and providing for any special needs of the child. Based on Div 31-400 in general.] (#16 in the Standard Areas for Review)

Maltreatment (see Current and Prior Maltreatment)

Measure

An actual indicator of performance.

Mediation

A discussion facilitated by a trained mediator concerning a court case that provides a problem-solving forum as an adjunct to formal court proceedings for all interested persons to develop a plan in the best interests of the child. Family preservation and family strengthening are emphasized.

Mediator

A trained professional who guides the discussion at mediation in a neutral manner with the aim of bringing the parties to consensus.

Medical/Dental Care

Medical and dental care (including routine examinations, diagnoses, treatment, or hospital care under general or special supervision) are to be rendered by licensed medical and dental professionals, respectively. [This term is from the California Standardized Safety Assessment Matrix (#27 in the Standard Areas for Review).]

Mental Health/Coping Skills

This term from the California Standardized Safety Assessment Matrix refers to emotional and psychological well-being, including the ability of an individual to use his or her cognitive and emotional capabilities to handle day-to-day life stressors and function effectively in society. (#28 in the Standard Areas for Review)

Minimum Sufficient Level of Care (MSLC)

The social standard for the minimum of caregiver behavior below which a home is inadequate for the care of a child. Factors to consider in establishing what the MSLC is for a particular child include those that relate to:

- the child's needs,
- contemporary social standards, and
- community standards.

Mongolian Spots (see Slate Gray Patches)

Multi-Disciplinary Teams

A group of professionals and paraprofessionals representing an array of disciplines (e.g., resource families, service providers, law enforcement, juvenile courts, and other community organizations) who interact and coordinate efforts with parents and families, pooling their skills to offer comprehensive, coordinated services.

Munchausen Syndrome by Proxy (see Factitious Disorder by Proxy)

Mutual Combatants

Two persons, equally involved in the commission of a crime against the other person with neither person acting in self-defense.

Neurogenesis

The process by which new nerve cells and the network of branched cells and fibers that supports the tissue of the central nervous system ("neuroglia") are generated. This "birth" of neurons occurs primarily during the second and third trimesters of pregnancy. [Adapted from: Perry, B.P. (2002). Childhood Experience and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind*, 3.]

Neuronal Migration

The process by which neurons "cluster, sort, move and settle into their final 'resting' place." Primarily guided by neuroglial cells, neurons migrate out from where they are produced in the center of the developing brain to where they will eventually settle (i.e. the brainstem, cortex, etc.). Although most neuronal migration takes place in utero and during in the perinatal period, it continues to occur throughout childhood. Environmental factors and "intrauterine and perinatal insults" can affect the migration of neurons, thus influencing the formation as well as the function of the developing neural network. [Adapted from: Perry, B.P. (2002). Childhood Experience

and the Expression of Genetic Potential: What Childhood Neglect Tells Us About Nature and Nurture. *Brain and Mind*, 3, p. 83.]

Non-Adversarial Approaches

Practices, including dependency mediation, family group conferencing, or decision-making and settlement conferences, designed to engage family members as respected participants in the search for viable solutions to issues that brought them into contact with the child welfare system.

Non- Minor Dependent Youth

As defined by the Fostering Connections to Success and Increasing Adoptions Act of 2008, a non-minor dependent youth is a current or former dependent child or ward of the juvenile court who

- has attained 18 years of age but is less than 21 years of age;
- is in foster care under the responsibility of the county welfare department, county probation department, or Indian tribe; and
- is participating in a transitional independent living case plan.

Noticing

Formal provision of the date, time, location, and purpose of the hearing.

Overrepresentation

Overrepresentation refers to the current situation in which particular racial/ethnic groups of children are represented in foster care (or in the child welfare system as a whole) at a higher or lower percentage than their representation in the general population. [Adapted from McRoy, R. (2005). *Moving from Disproportionality to Fairness and Equity*. Lecture presentation, The Symposium on Fairness and Equity in Child Welfare Training and Education, 2005.]

Outcomes-Informed Practice

Practice that supports and is informed by federal and state outcomes. All training in California supports the federal outcomes of Safety, Permanency and Well-Being. California also has developed state-specific performance measures. [For more information on the performance measures in California, refer to the website for the Child Welfare Dynamic Report System at the Center for Social Sciences Research (CSSR) at UC, Berkeley: http://cssr.berkeley.edu/ucb_childwelfare/]

Parenting Skills

This term from the California Standardized Safety Assessment Matrix refers to the skills a parent demonstrates regarding the capacity to effectively care for, guide, and discipline the child(ren) in the parent's custody. (#31 in the Standard Areas for Review)

Participatory Case Planning

A strategy encompassing several formal models and informal philosophies aimed at working together with the family and others (such as relatives, service providers and community members) to develop strength-based case plans that are tailored to meet the specific needs of the family.

Party

A participant in the case who has the right to receive notice and to present evidence to the court.

Peer Quality Case Reviews

A key component of the C-CFSR designed to enrich and deepen understanding of a county's actual practices in the field by bringing experienced peers from neighboring counties to assess and identify the subject county's strengths and areas needing improvement within the child welfare services delivery system and social work practice.

Performance Indicators

Specific, measurable data points used in combination to gauge progress in relation to established outcomes.

Permanence

A primary outcome goal for child welfare services whereby all children and youth have stable and nurturing legal relationships with adult caregivers that create a shared sense of belonging and emotional security that endures over time.

Permanency Hearing

The hearing where the court determines the most appropriate permanent plan for the child. This can occur at the disposition hearing if the court does not order reunification services under WIC Sec. 361.5(b) or at a hearing wherein the court terminates reunification services. The permanent plans in California in order of preference are: return home, adoption, legal guardianship, permanent placement with a relative, or permanent placement with an identified placement and a specific goal. If the court chooses adoption or legal guardianship, it must set a hearing under WIC 366.26 which is referred to as a .26 hearing or a selection and implementation hearing.

Perpetrator

The person who has committed the abuse against the child.

Perpetrator Access

This term from the California Standardized Safety Assessment Matrix refers to the perpetrator's relationship to the child; and the frequency and intimacy of the perpetrator's contact with the child. (*#5 in the Standard Areas for Review*)

Pediatric Radiologist

A medical expert who interprets X-rays regarding fractures and internal injuries in children.

Petechiae

Pinpoint hemorrhages often associated with suffocation.

Physical Abuse

Non-accidental, inflicted injury/trauma to a child.

Positive Toxicology Screen (pos tox)

A screening test (usually referring to a test of newborn urine) which demonstrates that a substance has been ingested by indicating positive results for a drug. Mothers who test positive for drugs upon delivery will have infants who also have ingested the same substance. Generally these results indicate usage by the mother within the past 72 hours.

Post Permanency Hearing

Review hearings after the development of a permanent plan for the child during which the court reviews the case and case plan. Must be held no less than every six months.

Posttraumatic Stress Disorder (PTSD)

As defined by the DSM IV-TR, PTSD refers to an emotional illness that develops as a result of an event involving actual or threatened death, serious injury, rape, or childhood sexual abuse and is out of the normal experience for that individual (or may be accumulative or repeated). The stressor must be extreme, not just severe, and cause intense subjective responses, such as fear, helplessness or horror. Key symptoms include:

- Re-experiencing the event
- Avoidance
- Emotional numbing
- Increased arousal

Pre-Placement Preventative Services

This term from the California Standardized Safety Assessment Matrix refers to services designed to help children remain with their families by preventing or eliminating the need for removing the child from the home. [These services are emergency response services and family maintenance services. Div 31-002 (p) (8).] (#14 in the Standard Areas for Review)

Prevention

Service delivery and family engagement processes designed to mitigate the circumstances leading to child maltreatment before it occurs.

Program Improvement Plan (PIP)

A comprehensive response to findings of the CFSR establishing specific strategies and benchmarks for upgrading performance in all areas of nonconformity with established indicators.

Protective Capacity

Refers to the ability and willingness to utilize *internal* and *external* resources to mitigate risk and to support the ongoing safety of a child.

Reasonable Efforts

A legal determination as to whether or not the child welfare agency has provided the family with adequate services, which can include visitation, referrals, and other case management. Reasonable efforts must be made to reunify the family or to finalize a permanent plan for the child.

Recovery

Recovery refers to both internal conditions experienced by persons who describe themselves as being in recovery—hope, healing, empowerment, and connection—and external conditions that facilitate recovery—implementation of the principle of human rights, a positive culture of healing, and recovery-oriented services.

<http://www.psychservices.psychiatryonline.org/cgi/content/full/52/4/482> .

Relapse

The recurrence of symptoms (usually referring to substance abuse) after a period of successful recovery. Relapse is common in recovery from addiction and not considered a treatment failure. As with other chronic illnesses, significant improvement is considered successful treatment even if complete remission or absolute cure is not achieved.

Relapse Prevention

Relapse prevention efforts in drug treatment require the development of a plan tailored to maintaining new behavior in an effort to avoid renewed substance abuse. The plan involves integrating behavior diversion activities, coping skills, and emotional support.

Resource Families

Relative caregivers, licensed foster parents, and adoptive parents who meet the needs of children who cannot safely remain at home. Resource families participate as members of the multidisciplinary team.

Restraining Order [Protection Order]

A restraining order is a court order intended to protect victims of domestic violence from being physically abused, threatened, stalked, or harassed by the person who previously perpetrated abuse.

Reunification

Occurs when the court determines there is no longer a substantial danger to the child and returns the child to the physical custody of the parent or caregiver who participated in child welfare services.

Risk

The likelihood that a child will be abused, neglected, or exploited.

Risk Assessment

The process utilized by a child welfare worker to determine the likelihood that a child will be abused, neglected, or exploited. [This could include the use of a variety of tools and/or experience, training, and professional judgment, as well as other research-based tools (including evidence-based decision-making tools) to:

- facilitate the interviewing of children, families, and community members;
- gather and evaluate information from collateral contacts;
- gather and evaluate psycho-social information regarding the parent;
- review and evaluate past history (including use of CWS/CMS data).

Risk elements are the focus of the case plan for change-oriented interventions—they indicate what has to be addressed as the child protection system works with the family to change the conditions that put the child at risk, as well as potential future safety challenges. The assessment of risk also incorporates the elements of protective capacity.]

Safety

A primary outcome for child welfare services whereby all children are, first and foremost, protected from abuse and neglect.

Safety Assessment

The process utilized by a county child welfare worker to determine if a child is currently safe from physical abuse, sexual abuse, emotional abuse, neglect, and/or exploitation. [This could include the use of a variety of tools and/or experience, training, and professional judgment, as well as other research-based tools (including evidence-based decision-making tools) to make that determination. The safety assessment is conducted as part of the initial CPS intervention and continues throughout the life of the case. *A safety assessment is not the same thing as a risk assessment.*]

Safety Interventions

This term from the California Standardized Safety Assessment Matrix refers to the actions, services, arrangements, and circumstances intended to mitigate the threat of, repeat abuse of, or maltreatment of the child. [This includes the development of a safety plan for providing services to promote the health and safety of the children in the family. The safety plan addresses what threats of severe harm exist; how they will be managed, including by whom, under what circumstances, with what specified time requirements, etc.] (*#13 in the Standard Areas for Review*)

Safety Threshold

The point when family conditions, in the form of behaviors, emotions, intent, situations, etc., are manifested in such a way that they exceed risk factors and threaten the child's safety.

School Attendance Review Board (SARB)

School Attendance Review Boards handle most attendance issues for school jurisdictions without the involvement of Child Protective Services.

Secondary Trauma

Secondary, or vicarious trauma, refers to the effect of trauma on those people who care for, or are involved with, those who have been directly traumatized.

Shaken Infant Syndrome

Severe trauma to a child under age 5, and generally under age 1, as a result of severe shaking that results in a whiplash-type of injury. Retinal hemorrhages are symptomatic. A significant amount of force is required.

Shared Family Care

Temporary placement of children and parents in the homes of trained community members who, with the support of professional teams, mentor the families to develop the necessary skills, supports, and protective capacity to care for their children independently.

Shared Responsibility

This concept encourages community residents to get involved in child protection. It offers opportunities for participation and stresses the importance of community responsibility for child safety and well being. This does not negate the ultimate accountability of the child welfare agency for child protection. Rather, it engenders a community mindset to develop capacity to protect children and to strengthen and preserve families.

Sibling Placement

This term from the California Standardized Safety Assessment Matrix refers to the efforts made in all out-of-home placements, including those with relatives, to place siblings together in order to maintain the continuity of the family unit. [Sibling is defined as a person related to the child by blood, adoption, or affinity through a common legal or biological parent. Welfare & Institutions Code Sec. 16002(a)(b)] (#19 in the Standard Areas for Review)

SIDS

Sudden Infant Death Syndrome is the unexplained, unexpected death of an otherwise healthy child up to age 1. There is an absence of an explanation of the cause of death via autopsy, and a death scene investigation should be conducted to rule out other causes of death.

Skeletal Survey

A body X-ray to determine if there are fractures or internal injuries. Usually ordered for children age 2 or under when the physician suspects abuse.

Slate Gray Patches (formerly known as Mongolian Spots)

A birth mark which resembles a bruise in appearance. May be colored brown or greenish-purple and is often located on the lower back/buttocks, although it can occur anywhere on the body. More common on children of color, this condition is often mistaken for child abuse.

Social Environment

This term from the California Standardized Safety Assessment Matrix refers to the social interactions of those living in or having significant contact in the home that support or compromise the child's health and safety. [This includes the degree to

which communications, interactions, and relational networks within the home or surrounding the child support or compromise the child's health and safety. Also included are the current and historical conditions within the home which are associated with the caregiver's capability to rely on an appropriate social network, ability to solve problems, and ability to communicate effectively. Positive aspects of the social environment may mitigate risk to the child.] (#7 in the Standard Areas for Review)

Stages of Change

The five stages of change are: pre-contemplation, contemplation, preparation, action, and maintenance.

Standardized Safety Approach

A uniform approach to the safety, risk, and protective capacity of the adult caregiver to assure basic statewide levels of protective responses and to assure that fairness and equity are embedded in criteria used for case decisions.

Status Offender Proceeding

Occurs when the court is asked to declare a minor a ward of the court based on the minor's refusal to obey reasonable orders of the minor's parents. (Welfare and Institutions Code Sec. 601.)

Status Review Hearing

At this juvenile court hearing, held every six months after disposition, the judge reviews the case and the case plan. In family maintenance cases, the judge must decide if the conditions that brought the family within the court's jurisdiction still exist or if such conditions are likely to exist if supervision is withdrawn. In family reunification cases, during the period in which reunification services are being provided, the court must return the child home unless the agency can show that return of the child to the home would create a substantial risk of detriment to the child's safety, protection, or physical or emotional well-being.

Strength-based Practice

Practice that identifies strengths in an individual, family, or system, and the formulation of service arrays and interventions that acknowledge and build on those strengths. A strength-based approach honors and respects the dignity of family members and incorporates the family's collective knowledge about the resources and strengths in their family system. Strength-based practice involves joining with the family to reach goals for improvement in family functioning. It includes:

- Using language that focuses on strengths
- Specific interviewing skills

- Specific assessment criteria
- Specific model practices
- Specific casework practices
- Engagement of the neighborhood and the community
- Agency practices with staff and the community

Subsequent Referrals

This term from the California Standardized Safety Assessment Matrix refers to reports received by the child welfare agency regarding new allegations made after the initial report of child maltreatment. (*#36 in the Standard Areas for Review*)

Substance Abuse

This term from the California Standardized Safety Assessment Matrix refers to the abuse of alcohol and other drugs (AOD) by the parent, caregiver, or the child. [Considering substance abuse in making safety assessments will include the severity and impact of the AOD use on each member of the family. Some cases will require differentiating between substance use, abuse, or dependence for the adult or adolescent family members.] (*#33 in the Standard Areas for Review*)

Substance Abuse Assessment

Screening and/or assessment to determine the presence of an AOD abuse disorder. This assessment process should: employ cultural sensitivity; use a standardized tool such as the Addiction Severity Index (ASI); use Standardized Placement Criteria such as the American Society of Addiction Medicine (ASAM) Placement Criteria; and ensure that re-assessments occur with concomitant case plan adjustment.

Substitute Care Provider

A foster parent or relative/non-relative extended family member who is responsible for a child's care during his or her placement in out-of-home care. [The non-relative extended family member may be a person who has an established familial or mentoring relationship with the child or an established familial relationship with an adult relative of the child.]

Substitute Care Provider's Strength and Willingness to Support the Child's Case Plan

This term from the California Standardized Safety Assessment Matrix refers to the active participation of the caregiver in activities that promote and support the child's safety, permanency, and well-being, including health, education, and social development. (*#18 in the Standard Areas for Review*)

Substitute Care Provider's Willingness/Ability to Provide Care, Ensure Safety

This term from the California Standardized Safety Assessment Matrix refers to the substitute care provider's ability and commitment to the care and safety of the child. [This includes the willingness to accept the child into the caregiver's home and provide for the child's daily care and maintenance.] (*#17 in the Standard Areas for Review*)

Successful Youth Transition

The desired outcome for youth who experience extended stays in foster care, achieved by the effective provision of a variety of services (e.g., health and mental health, education, employment, housing, etc.), continuing through early adulthood, while simultaneously helping youth to maintain, establish or re-establish strong and enduring ties to one or more nurturing adults.

Support System

Refers to an informal network of people, resources, and/or organizations whose assistance and encouragement strengthen an individual's or family's functioning.

System Improvement Plan (SIP)

A key component of the C-CFSR, this operational agreement between the county and the state outlines a county's strategy and actions to improve outcomes for children and families.

Uniform Practice Framework

A fully articulated approach to all aspects of child welfare practice that:

- Uses evidence-based guidelines for the start-up phase and ongoing incorporation of known "best" or "promising" practices
- Aligns with sound child and family policy
- Is responsive to unique needs of diverse California counties
- Can be integrated with a Differential Response system
- Addresses shared responsibility with the community
- Emphasizes non-adversarial engagement with caregivers
- Integrates practice work products from the Full Stakeholders Group and the Statewide Regional Workgroups.

Violence Propensity/Capability

This term from the California Standardized Safety Assessment Matrix refers to a pattern of aggressive, coercive, threatening, or potentially harmful behavior or

history on the part of a parent or household member. [The presence of family violence in the home, social isolation, and prior criminal convictions may indicate safety and/or risk concerns for the child. These include concerns about the child witnessing domestic violence.] (*#6 in the Standard Areas for Review*)

Visitation

This term from the California Standardized Safety Assessment Matrix refers to the formalized face-to-face contact between a child and a parent(s)/guardian, siblings, grandparents, or others deemed appropriate by the county or juvenile court to promote the continuity of parent-child relationships and permanency. (Div 31-002 (v)(1)(B)) [The duration, frequency, location, and supervision of the contacts will be based on the safety goals of the case plan, the child's developmental needs, and the parents' strengths and needs. Regular and frequent contacts between parent and child and/or between the child and his or her siblings help to maintain family relationships, empower parents, minimize children's separation trauma, and provide an opportunity for family members to learn and practice new skills and interactive behaviors.] (*#21 in the Standard Areas for Review*)

Voluntary Relinquishment

Process by which parents voluntarily surrender their parental rights and allow their child to be adopted.

Vulnerable Families

Families who face challenges in providing safe, nurturing environments for their children, including families demonstrating patterns of chronic neglect; families with young children (ages 0-5); families affected by alcohol and drug abuse; families experiencing poverty or homelessness; family victims of domestic violence; and family members whose mental health is compromised.

Welfare and Institutions Code

A series of laws that govern California's dependency system.

Child Maltreatment Identification

Part 1: Neglect, Emotional Abuse and Physical Abuse

REFERENCES and BIBLIOGRAPHY

ALL-COUNTY LETTERS (ACLs)

05-09: Reporting and Investigation Requirements for Child Abuse Allegations Regarding Children in Out-Of-Home Placements
<http://www.dss.cahwnet.gov/getinfo/aclo5/pdf/05-09.pdf>

ALL-COUNTY INFORMATION NOTICES (ACINs)

I-65-03: Promising Practices Guide On Child Safety
http://www.dss.cahwnet.gov/getinfo/acino3/pdf/I-65_03.pdf

I-41-02: 2001 Chaptered Legislation Affecting the Emergency Response, Family Maintenance, Family Reunification and Permanency Planning Components of Child Welfare Services and the Adoptions Program
http://www.dss.cahwnet.gov/getinfo/acino2/pdf/I-41_02.pdf

I-22-01: 2000 Chaptered Legislation Affecting the Emergency Response, Family Maintenance, Family Reunification and Permanency Planning Components of Child Welfare Services and the Adoptions Program
http://www.dss.cahwnet.gov/getinfo/acino1/pdf/I-22_01.pdf

I-47-00: 1999 Chaptered Legislation Affecting the Adoptions Program, The Office Of Child Abuse Prevention, The Child Welfare Services Program, The Foster Care Program and The Foster Care Audits Program
http://www.dss.cahwnet.gov/getinfo/acino0/pdf/I-47_00.pdf

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RESOURCE AGENCIES (to be added to by the respective RTA's):

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|---------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------|
| Asian Perinatal Advocates | http://www.apasfgh.org/ |
| Asian Pacific Islander Family Resources Network | http://www.samoancenter.org |
| Chadwick Center for Children & Families
San Diego Children's Hospital | http://www.chadwickcenter.org . |
| Female Genital Cutting Education & Networking Project | http://www.fgmnetwork.org |
| Inter-African Committee on Traditional Practices Affecting the Health of Women and Children | http://www.iac-ciaf.ch/ |