

Module 6: Understanding Child Maltreatment



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Unit 6.1: Maltreatment: Overview

Maltreatment Overview

Maltreatment is parenting behavior that is harmful and destructive to a child's cognitive, social, emotional, and/or physical development. For the purposes of the Maltreatment Index, "maltreatment" is the resulting harm that occurs as the result of harmful parenting behavior.

Danger Threats are specific family situations or behaviors, emotions, motives, perceptions or capacities of a family member that are out-of-control, imminent and likely to have severe effects on a vulnerable child.

Florida Administrative Code 65C-30.001(81) defines maltreatment as "a specific type of injury or harm which... as incorporated by the (Child Maltreatment Index), is the term used as an inclusive description for all forms of abuse and neglect." The reporter's statement to the Hotline of a suspected specific harm/threatened harm is referenced in the report as a maltreatment, and it must be by a parent/legal custodian or caregiver (except in human trafficking cases).

The Child Maltreatment Index

The Child Maltreatment Index incorporates the mandates of state law, administrative rules, operating procedures and recognized best practices, allowing each specific type of abuse and neglect to be clearly defined and assessed consistently throughout the state.

The objective is to improve the consistency and accuracy of findings made by child welfare professionals when dealing with similar allegations of harm or threatened harm. Improved consistency and accuracy help to ensure families are treated with fairness throughout the reporting and investigative process.

Sections of the Child Maltreatment Index:

- Definition
- Examples of Maltreatment
- Factors to Consider in Assessment of Maltreatment
- Assessing for Frequently Associated Maltreatments
- Excluding Factors
- Information Necessary to Support a Verified Finding

Child Maltreatment Index

CFOP 175-28, June 1, 2010

CF OPERATING PROCEDURE
NO. 175-28

STATE OF FLORIDA
DEPARTMENT OF
CHILDREN AND FAMILIES
TALLAHASSEE, June 1, 2010

Family Safety

CHILD MALTREATMENT INDEX

1. Purpose. The purpose of the Child Maltreatment Index is to guide Florida Abuse Hotline (Hotline) counselors and field investigation staff in determining the Department's (DCF) or designated Sheriff's Office response to Hotline calls and the assessments by investigators. The standards include a description of the evidence needed to reach a finding for each of the specific maltreatments.
2. Scope. The index applies to all calls received at the Hotline and all child protective investigations conducted under Chapter 39, Florida Statutes.
3. Definitions. For the purposes of this operating procedure, the following definitions shall apply:
 - a. Allegation. A statement by a reporter to the Hotline that a specific harm or threatened harm to a child has occurred or is suspected.
 - b. Maltreatment. A specific type of harm. The index contains 20 defined maltreatments that are inclusive of all forms of child abuse, abandonment or neglect.
 - c. Finding. The determination, after a thorough investigation, as to whether there is credible evidence supporting the reported harm or threat of harm for each alleged maltreatment.
4. Objective. The Child Maltreatment Index incorporates the mandates of state law, administrative rules, operating procedures and recognized best practices with respect to reports of child abuse, abandonment, or neglect. The allegation-based system allows each specific type of abuse and neglect to be clearly defined and treated consistently throughout the state. The objective is to improve the consistency and accuracy of judgments made by both Hotline counselors and investigators when dealing with similar allegations of harm or threatened harm. Improved consistency and accuracy helps to ensure individuals are treated with fairness throughout the reporting and investigative process. Clear definitions also reduce confusion and allow for greater confidence when making determination decisions.

5. Utilization. The index is a tool to be used by both Hotline counselors and child protective investigators to guide consistent and accurate decision making.

a. The index supports standard descriptions of specific types of injury or harm to use in determining whether the reported information meets the criteria for acceptance of a report.

b. The utilization of the index enables staff to make knowledgeable decisions about the most crucial steps in the investigation process, which are:

(1) Assessing the nature and severity of reported harm;

(2) Assessing whether immediate injury or harm exists;

(3) Assessing the probability of further harm; and,

(4) Determining if the necessary documentation and evidence are present to support a finding of abuse, abandonment, or neglect.

6. Findings.

a. The findings based upon the index relate to the evidence found during the investigation. The types of documentation that support making an accurate finding are noted in each of the specific maltreatments. The findings are only one set of considerations in determining the safety of the child and the family's capacity to provide care.

b. Upon completion of the investigation, investigators will reach a determination regarding each of the alleged maltreatments. This determination will be based upon whether information gathered from interviews, records reviews, and observations during the investigation constitute credible evidence that indicators of child abuse, abandonment, or neglect are present. The findings for each maltreatment are entered into the Florida Safe Families Network (FSFN) as follows:

(1) VERIFIED. This finding is used when a preponderance of the credible evidence results in a determination that the specific harm or threat of harm was the result of abuse, abandonment or neglect.

(2) NOT SUBSTANTIATED. This finding is used when there is credible evidence, which does not meet the standard of being a preponderance, to support that the specific harm was the result of abuse, abandonment, or neglect.

(3) NO INDICATORS. This finding is used when there is no credible evidence to support the allegations of abuse, abandonment, or neglect.

c. "Preponderance" means the greater weight of the evidence, or more likely than not to have occurred.

d. Investigators must also add additional maltreatments that they become aware of during the course of an investigation. No call to the Hotline is necessary to add maltreatments in the field, except for "Death."

e. Although the Hotline uses the maltreatment “Threatened Harm” only for narrowly defined situations, investigators may add this maltreatment to any investigation where they are unable to document existing harm, but the documentation gathered yields a preponderance of evidence that the child is at risk of harm.

7. Maltreatments. There are 20 separate maltreatments that can be assigned to an abuse report; each report of abuse, abandonment, or neglect must contain at least one of the following maltreatments. There is no limit to the number of maltreatments that may be included on a report, as long as each maltreatment is justified in the allegation narrative.

Abandonment	Human Trafficking
Asphyxiation	Inadequate Supervision
Bizarre Punishment	Internal Injuries
Bone Fracture	Malnutrition/Dehydration
Burns	Medical Neglect
Death	Mental Injury
Environmental Hazards	Physical Injury
Failure to Protect	Sexual Abuse
Failure to Thrive	Substance Misuse
Family Violence Threatens Child	Threatened Harm

** If there are no injuries for a report involving maltreatment, but the circumstances indicate the child is at risk of injury, the child protective investigator may add “Threatened Harm” to the open investigation.

8. Special Conditions Referrals. There are certain special conditions that are called into the Hotline that do not constitute allegations of abuse, abandonment, or neglect, but require a response by DCF to assess the need for services. The four categories of these calls are defined below. Directions on the processing of these call types are included at the end of the index.

a. Caregiver(s) Unavailable. Situations in which the parent(s) or caregiver(s) has been incarcerated, hospitalized, or died and immediate plans must be made for the children’s care. This referral type also includes situations where children are unable or unwilling to provide information about their caregiver(s) or custodian.

b. Child on Child Sexual Abuse. Calls alleging sexual behavior between children, when the aggressor child is 12 years or younger, which occurs without consent, without equality, or as a result of coercion, as defined in section 39.01, Florida Statutes.

c. Foster Care Referral. Calls to the Hotline regarding concerns about the care provided in a licensed foster home, group home or emergency shelter that do not meet the criteria for acceptance of a report of abuse, abandonment, or neglect.

d. Parent Needs Assistance. Situations that do not statutorily meet the criteria for an abuse, abandonment, or neglect report but the family may need services. The intent is to prevent future maltreatment by helping families or individuals through a family and/or community-centered approach before maltreatment occurs.

BY DIRECTION OF THE SECRETARY:

(Signed original copy on file)

DAVID L. FAIRBANKS
Assistant Secretary for
Programs

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ABANDONMENT

DEFINITION

Abandonment is a situation in which the parent(s) or legal custodian(s) of a child or, in the absence of a parent or legal custodian, the caregiver(s), while being able, makes no provision for the child's support and has failed to establish or maintain a substantial and positive relationship with the child. "Establish or maintain a substantial and positive relationship" includes, but is not limited to, frequent and regular contact with the child through frequent and regular visitation or frequent and regular communication to or with the child, and through the exercise of parental rights and responsibilities.

**This definition does not automatically apply to a non-custodial parent that does not have knowledge of or was unaware of the abandonment situation.

ASSESSING "ABANDONMENT" AS MALTREATMENT

- When was the parent's most recent contact with the child?
- What are the circumstances surrounding the parent's broken contact with the child?
- How frequently have the parent(s) contacted the child and the nature of these contacts?
- Did parent(s) make appropriate arrangements for the care and needs of the child?
- Is there any reason to believe that the parent(s) think the arrangements made were temporary and appropriate?
- Can the other parent be located and is this other parent aware of the current situation being reported?
- Are the child's needs currently being met, and to what extent?
- What is the parent's age, mental and emotional development as it impacts their ability to comprehend parental responsibilities?

ASSESSING FOR OTHER MALTREATMENT

- Consider for "Inadequate Supervision" when one parent leaves the child with another parent and there is a court order that limits or prohibits that second parent from unsupervised contact with the child.
- All situations of "surrendered newborn infants" (see the excluding factors section below) must be assessed for other maltreatments. If the criteria for other maltreatments are present, accept a report and do not refer to a child placement agency. For example, the infant has physical injuries that appear to be inflicted, or the infant tested positive for drugs or alcohol.

EXCLUDING FACTORS

- One parent leaving their child with another parent does not constitute “Abandonment.”
 - Parent(s) late to pick up their children at day care or school does not constitute “Abandonment.” Short-term lateness is an issue that should be resolved between the parent(s) and the providers. Consider a referral to law enforcement.
 - A foster parent dropping off a disruptive child at a DCF or a Community Based Care office does not constitute “Abandonment.”
 - Surrendered newborn infants as outlined under section 383.50, Florida Statutes does not constitute “Abandonment.” Surrendered newborn infants are children who are believed to be seven (7) days old or younger at the time they are left at a hospital, emergency medical services station or fire station.
- ** If the mother gives birth in the hospital and expresses the intent to leave the newborn and not return, the Hotline counselor should refer the caller to the nearest child placement agency in that county.
- A “child in need of services” or a “family in need of services” as outlined in Chapter 984, F.S. does not constitute “Abandonment.” These are children for whom there is no pending child protective investigation or referral alleging the child is delinquent; or no current supervision by DCF or Department of Juvenile Justice (DJJ) for adjudication of dependency or delinquency. The child must also be found by the court to have persistently run away, be habitually truant from school, or have persistently disobeyed the reasonable and lawful demands of the parent(s) or legal custodian(s), and to be beyond their control.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Reports obtained from law enforcement related to the incident.
- Interview with the person(s) caring for the child in the parent’s absence. This includes information on the arrangements agreed upon between the caregiver(s) and parent(s).
- Documentation of the last contact the parent(s) has had with their child and the number and frequency of previous contacts.
- Documentation on attempts to locate the absent parent(s) both by the investigator and others in the community.
- Interview with the parent(s) (if able to locate) to obtain their explanation of the reported incident.
- Documentation from collateral contacts which may include teachers, neighbors, and/or relatives.
- Prior history and documentation on the parent(s) related to abandonment or inappropriate supervision.

ASPHYXIATION

DEFINITION

Asphyxiation is the alteration in consciousness by a willful act of the caregiver(s) that may include suffocation and strangulation.

Suffocation: To impede breathing by smothering, immersing in water or other liquid, or other willful means.

Strangulation: Impairment of blood/oxygen flow to the brain by compression of the neck.

**This maltreatment includes the drowning of a child by a willful act.

ASSESSING “ASPHYXIATION” AS MALTREATMENT

- Was a child choked regardless of impairment or injury?
- Was the child’s breathing impaired due to the actions of a caregiver(s)?
- What was the caregiver(s)’s physical condition and mental state at the time of the incident?
- Were there physical injuries to the child?

ASSESSING FOR OTHER MALTREATMENT

- Assess for “Inadequate Supervision” and/or “Environmental Hazards” if a child asphyxiated, suffocated, or drowned due to neglect.

EXCLUDING FACTORS

- Do not add “Internal Injuries” as maltreatment in situations where a child has brain damage from asphyxiation, suffocation, or strangulation. The “Asphyxiation” maltreatment covers any injuries resulting from these acts.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team (CPT).

**A mandatory referral to CPT is required if the allegations include injuries to the head or neck on a child of any age.

- Obtain and consider any reports and interviews from law enforcement.
- Obtain photographic evidence (if any) of the injuries that appear to be related to the incident.
- Determine what the circumstances were that led to the caregiver(s)’s actions.
- Documentation of the caregiver(s)’s demeanor following the incident. What were their actions or reactions to the incident?
- Documentation from the Medical Examiner if the child died.

BIZARRE PUNISHMENT

DEFINITION

Bizarre punishment is caused by a willful act of a caregiver(s) that includes inflicting or subjecting a child to intense physical or mental pain, suffering, or agony that is repetitive, increased, prolonged, or severe. Bizarre punishment also includes confinement, torture, and inappropriate/excessive use of restraints or isolation.

Confinement: Unreasonable restriction of the child’s mobility, actions, or physical functioning; forcing a child to remain in a closely confined area that restricts movement, and/or doesn’t allow a child free access to a restroom, food, or water for a longer time than is reasonable, based on the age and developmental abilities of the child.

**Care should be taken to distinguish between brief, supervised confinements such as “time-outs” and more long-term and damaging confinements.

Inappropriate/Excessive Use of Restraints (Facility Only): Unreasonable restraint by an employee of a public or private facility (including volunteers and interns) which severely impact the child’s mobility or physical functioning.

Inappropriate/Excessive Use of Isolation (Facility Only): Use of isolation by an employee of a public or private facility (including volunteers and interns) which causes or threatens physical or mental harm to a child.

ASSESSING “BIZARRE PUNISHMENT” AS MALTREATMENT

- Was the punishment inflicted cruel, sadistic, or meant to torture the child?
- What is child’s age, medical condition, behavioral, mental, or emotional problems, developmental disabilities, and/or physical handicaps?
- What are the adverse effects to the child, both physically and/or emotionally?.
- What was the behavior of the parent(s), caregiver(s), or facility employee(s) at the time of the incident?
- For confinement, consider the environment; what was the size of the space; did the child have access to assistance if needed; was there sufficient heat or ventilation, was there presence or absence of lighting?
- For restraints, consider any injuries; were the injuries self-inflicted; were the restraints properly used?
- Did the employee’s actions violate facility policy?
- Was the facility “takedown” considered excessive and/or caused physical injury?
- What were the circumstances of the facility “takedown”?

ASSESSING FOR OTHER MALTREATMENT

If mental or physical injury is also suspected to have occurred, select those other maltreatments too.

EXCLUDING FACTORS

A child at a facility that sustains injury due to the actions of the child and there is no reason to believe that staff could have prevented the injury does not constitute “Bizarre Punishment.”

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Professional opinion from a physician, psychiatrist, or other mental health professional if the caregiver(s) or facility employee contends that confinement or physical restraint was recommended by a medical professional. This opinion must take into account whether the extent of the action was within the limits of the recommendation.
- Obtain and consider any document from the Child Protection Team.
- Documentation obtained from a multi-disciplinary staffing if there are complex needs of the child or it is determined a multi-disciplinary staffing is necessary based upon the facts of the situation.
- Photographic evidence (if any) of the injuries or environment that appear to be related to the incident.
- Statements from witnesses that may have been present at the time of the incident.
- Documentation from any reports and interviews from law enforcement.
- Documentation from any facility incident reports.
- Information as to whether the staff’s action was consistent with facility policy (consider state standards and licensing requirements).
- Obtain facility policy and determine how the action (restraints or isolation) is addressed. (Note: Facility policy SHOULD be consistent with state and federal standards, but, should not be the only source to determine what the state/federal/licensing rules are regarding use.)
- Consultation information, if applicable, with local Agency for Healthcare Administration (AHCA) and/or the Department’s Substance Abuse and Mental Health (SAMH) program office regarding the seclusion and restraint licensing standards to determine if the use was within the scope of what is required and allowed.

BONE FRACTURES

DEFINITION

A bone fracture is any broken bone in a child that is caused by the willful action of a caregiver(s). Types of fractures include:

Simple: The bone is broken, no other complications.

Compound: The bone is broken, and there is an external wound leading down to the sight of the fracture and fragments of the bone protrude through the skin.

Complicated: More than a simple fracture (e.g. has multiple branching fractures).

Spiral: Twisting causes the line of the fracture to encircle the long bone in the form of a spiral.

Transverse: The break is straight across a long bone.

Greenstick: An incomplete fracture from bending.

Compression: The bone is jammed onto itself.

Skull Fracture: A broken bone in the skull.

**Any fracture on a child that is suspected of being inflicted by a caregiver(s) shall be accepted as a report by the Hotline.

ASSESSING "BONE FRACTURES" AS MALTREATMENT

- What was the explanation given as to the injury?
- Is the explanation for the fracture consistent with the injury?
- Are there conflicting explanations for the fracture or does the child refuse to say how the fracture occurred?
- Is there a pattern of similar incidents involving the child, siblings, or other children associated with the caregiver(s)?
- What was the reaction and demeanor of the caregiver(s) after the incident?

ASSESSING FOR OTHER MALTREATMENT

- If the bone fracture is sustained as a result of neglect, the maltreatment will be "Inadequate Supervision."
- For injuries involving broken teeth, assess for "Physical Injury."

EXCLUDING FACTORS

Accidental bone fractures that are not alleged to be inflicted and there are no supervision issues suspected do not constitute "Bone Fractures" as maltreatment.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team.

**A mandatory referral to CPT is required for all fractures on a child of any age.

- Documentation of the child's medical conditions and any statements that a child has brittle bones or is prone to fractures verified by a qualified physician.
- Radiologic imaging (CT scans, bone/skeletal survey, MRI, and/or other studies).
- Obtain and consider any reports and interviews from law enforcement.
- Interviews from witnesses who may have observed the incident or have first-hand information.
- Consider the location of the fracture when assessing whether the injury was non-accidental.
- Documentation of the environment in which the injury occurred, to include photographic evidence.

BURNS

DEFINITION

A burn is injury resulting in damage to the skin through the willful action of the caregiver(s). The types of burns include:

Superficial (First Degree): Burns or damage limited to the outer layers of the skin (e.g. sunburn without blisters).

Partial Thickness (Second Degree): Burns or damage that extends through the outer layer of the skin into the inner layer. Blistering will generally be present within 24 hours.

Full Thickness (Third Degree): Burns in which the skin is destroyed, with damage extending into underlying tissues, which may be charred or coagulated.

**Any burn on a child that is suspected of being inflicted by the caregiver(s) shall be accepted as a report by the Hotline.

ASSESSING "BURNS" AS MALTREATMENT

- What is the location and description of the burn?
- What was the explanation given as to how the injury occurred?
- Is the explanation for the burn consistent with the injury?
- Is the burn of an unknown origin and appears to have been inflicted?
- Are there conflicting explanations for the burn
- Does the child refuse to say how the burn occurred?

- Is there a pattern of similar incidents involving the child, siblings, or other children associated with the caregiver(s)?
- What was reaction and demeanor of the caregiver(s) after the incident?

ASSESSING FOR OTHER MALTREATMENT

- If the burn is sustained as a result of neglect, the maltreatment will be “Inadequate Supervision.”
- Assess for “Inadequate Supervision” for sunburns that require professional medical treatment.
- Assess for “Physical Injury” for rug, rope or abrasion burns.

EXCLUDING FACTORS

Accidental burns that were not alleged to be inflicted and no supervision issues are suspected does not constitute “Burns” as maltreatment.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team.

**A mandatory referral to CPT is required for all burns on a child of any age.

- Obtain and consider any reports and interviews from law enforcement.
- Obtain photographic evidence of the injuries and/or environment that appear to be related to the incident.
- Documentation of physical objects that fit the burn pattern (to include photographs).
- Interviews from witnesses who may have observed the incident or have first-hand information.

DEATH

DEFINITION

Death is the permanent cessation of all vital functions, including the respiratory system, the cerebral function, and the circulatory system, accompanied by the cessation of heartbeat and respiration.

** Use this maltreatment when a child has allegedly died as a result of a direct willful act of the caregiver(s) or when the caregiver(s) failed to provide or make reasonable efforts to provide essential care or supervision for the child.

The investigation report alleging “Death” must also include the underlying maltreatment(s) which caused or contributed to the death; “Death” cannot be a stand-alone maltreatment. For reports of death by neglect the Hotline will also use the “Inadequate Supervision” maltreatment.

The child's death must have occurred in Florida for the maltreatment of "Death" to be added to a report.

ASSESSING "DEATH" AS MALTREATMENT

- Has the child been declared dead?
- Is the death suspected to have been a direct result of abuse or neglect by a caregiver(s)?
- What is the most appropriate secondary maltreatment?
- Has another child in the family died prior to this child's death?
- What was the caregiver(s)'s demeanor at the time of the child's death?
- Was there a delay in seeking medical treatment for the child?

ASSESSING FOR OTHER MALTREATMENT

- When a child under the age of five is found deceased and there is no information that the child had been treated for a medical problem that could have caused the death and no clear reason for trauma (such as being the victim of a car accident), the Hotline will accept an intake of "Death," with a secondary maltreatment of "Inadequate Supervision."
- Assess if there are any surviving children that are at risk; if so, use "Threatened Harm."
- If the only allegation is that the caregiver(s) had another child die due to abuse/neglect in another state, assess for "Threatened Harm" to the surviving children.
- Assess for a special conditions Parent Needs Assistance referral if it is determined the family may benefit from services to help with their grieving and no other report has been accepted for response and assessment.

EXCLUDING FACTORS

- Situations where a reporter is providing a documented cause of death that is not related to abuse or neglect (for example, a hospital calling in a child who died of leukemia just because their policy is to call in all child deaths) does not constitute "Death" as maltreatment.
- A situation where a reporter indicates that the child death has been previously reported and investigated and a Hotline record search locates the prior report in FSFN does not constitute a new "Death" maltreatment.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team.

**A mandatory referral to CPT is required on any family in which one or more children have been pronounced dead on arrival at a hospital or other health care facility, or have been injured and later

died as a result of suspected abuse, abandonment, or neglect when any sibling or other child remains in the home.

- Documentation from the Medical Examiner that includes physical findings and the cause and manner of the death.
- Information obtained from medical records for the child prior to the incident that led to the death.
- Obtain and consider any reports and interviews from law enforcement that may include 911 dispatch tapes.
- Documentation or photographic evidence of injuries that appear to be related to the death.
- Photographic evidence of the physical environment that appears to be related to the death.
- Information obtained from Emergency Medical Services or other first responders.
- Drug screen results if there is a possible correlation between substance use and the incident surrounding the death.
- Interviews from all persons who had access to or custody of the child during the time in which injury or injuries allegedly occurred that led to the death.
- Interviews from witnesses who may have observed the incident or have first-hand information.
- A detailed timeline of events tied to the caregiver(s)'s activities preceding the death, at the time of the death, and after the child's death.

ENVIRONMENTAL HAZARDS

DEFINITION

Environmental hazards are situations where a child is permitted to live in an environment that causes or creates a significant risk of impairment of the child's physical, mental, or emotional health due to the actions or non-actions of the caregiver. The environmental hazards maltreatment includes hazardous conditions and inadequate shelter, clothing or food.

Hazardous Conditions: The child's person, clothing, or living conditions are unsanitary or dangerous to the point that his/her well-being is or may be impaired as the result of the caregiver(s)'s failure to take action to correct the conditions.

Inadequate Shelter: Failure to seek or provide a physical or structural shelter which is safe, healthy, and sanitary and which protects the child from the elements (weather conditions) or other risk situations.

Inadequate Clothing: The periodic or continuing failure to provide adequate clothing for the health and well-being of the child, although reasonably financially able to do so. Inadequate clothing means that the person(s) responsible for the child is, or has been depriving the child of necessary clothing. The caregiver(s) have the means or are provided with the means to provide adequate clothing, but fail to do so. This maltreatment is not a measure of style, fashion, or quantity, but is meant to ensure that a child has sufficient clothing for his/her health and well-being.

Inadequate Food: The caregiver(s) have failed to provide or have available adequate amounts of food. If extended over time, inadequate food can lead to malnutrition or failure to thrive.

**Environmental hazards generally are a symptom of deeper underlying problems with caregiver(s) neglect and lack of stimulation. Further evaluation of the caregiver(s) is warranted to determine underlying causes.

ASSESSING “ENVIRONMENTAL HAZARDS” AS MALTREATMENT

- What is the child’s age, medical condition, behavioral, mental, or emotional problems, developmental disabilities, and/or physical handicaps?
- Has there been recent weight loss or a deterioration in appearance observed?
- Has prolonged poor personal hygiene led to health problems?
- What is the caregiver(s)’s age, mental and emotional development level?
- When did the reporter last see the child or environment?
- What is the severity, frequency, and/or duration of the conditions?
- Is there a pattern of similar incidents involving the child, siblings, or other children associated with the caregiver(s)?
- Are there weather conditions that may exacerbate the situation such as extreme heat or cold?
- Is it suspected a child is living in a home where drugs are being manufactured or distributed?
- What other safety issues exist in the home?

ASSESSING FOR OTHER MALTREATMENT

- Assess for acceptance as a special conditions Parent Needs Assistance referral if the reporter has not recently observed the child or environment and there are no current risks identified.
- Accept a Parent Needs Assistance referral for situations where it has been reported that a family is homeless.

EXCLUDING FACTORS

An allegation of homelessness by itself is not a sufficient reason to accept a report of “Environmental Hazards.” The information obtained from the reporter must be thoroughly assessed by the Hotline counselor to make this determination.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Investigator’s observations of child and environment.
- Documentation of the environment to include photographic evidence.

- Obtain and consider any reports and interviews from law enforcement.
- Determine how much control the parent(s) have over the conditions (for example, is the landlord trying to control infestations or get repairs made?).
- Information obtained from relevant collateral contacts that may include school teachers, neighbors, and the landlord.
- Documentation of a pattern of similar reports involving environmental hazards related to the caregiver(s).

FAILURE TO PROTECT

DEFINITION

Failure to protect is the failure of the caregiver(s) or other person(s) responsible for a child’s welfare to intervene to protect a child from inflicted physical, mental, or sexual injuries caused by the acts of another, or from neglect by a caregiver(s).

ASSESSING “FAILURE TO PROTECT” AS MALTREATMENT

- Did the caregiver(s) have the ability to intervene and prevent the harm but did not do so?
- If the caregiver(s) was unable to prevent the injury or neglect, did they fail to report the injury once it was discovered and was safe to do so?
- Is the caregiver(s) continually allowing a paramour or other person access to the child and/or household and the person’s presence is creating risk to the child?
- Has the child been sexually abused in the past and the caregiver(s) is allowing the abuser to have contact with the child?
- What knowledge did the caregiver(s) have of prior incidents of abuse or neglect of their child or of other children by the alleged perpetrator?
- Where was the caregiver(s) during the maltreatment events?
- Is there a pattern of similar incidents involving this child, siblings, or caregiver(s)?

ASSESSING FOR OTHER MALTREATMENT

If there are other types of abuse or neglect that were allegedly inflicted by a caregiver(s), select those maltreatments in addition to “Failure to Protect.”

EXCLUDING FACTORS

Hotline counselors should not add the “Failure to Protect” maltreatment to intakes involving allegations of domestic violence. When domestic violence is alleged, assess for the “Family Violence Threatens Child” maltreatment.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Obtain and consider any reports and interviews from law enforcement and/or the State Attorney's Office.
- Documentation of past arrests or law enforcement involvement with the family including call-outs to residence.
- Psychological reports on the caregiver(s) or other professional reports or specialized interviews, preferably from the Child Protection Team.
- Documentation from interviewing the alleged victim to include statements about whether the caregiver(s) were informed of the child's fear of the alleged perpetrator.
- Documentation from interviewing the caregiver(s) and other children in the home focusing on whether the caregiver(s) have reasonable cause to suspect the child might be at risk.
- Documentation from interviewing witnesses to the incident or persons who know of past abuse with focus on discussion about risks associated with the alleged perpetrator.
- The child protective investigator may add the "Failure to Protect" maltreatment on reports also verified for "Family Violence Threatens Child" that has resulted in harm to the child only after collaborating with Children's Legal Services for appropriateness.

FAILURE TO THRIVE

DEFINITION

Failure to thrive is a serious diagnosed medical condition that is most often seen in young children. The child's weight for height, corrected for gestational age, falls significantly short of the average weight of normal children of that age. Height, head circumference, and motor development may also be affected by Failure to Thrive, but weight for height is the primary measure.

**For a report to be accepted as "Failure to Thrive" the allegation must come from medical personnel or from a reporter with medical documentation.

ASSESSING "FAILURE TO THRIVE" AS MALTREATMENT

Is the reporter a medical person or from a reporter with medical documentation with suspicion of "Failure to Thrive"?

ASSESSING FOR OTHER MALTREATMENT

Assess for "Environmental Hazards" or "Malnutrition" if the reporter is not a medical person or does not have the proper medical documentation.

EXCLUDING FACTORS

Do not accept a report for "Failure to Thrive" when the reporter is not a medical person or is a reporter without medical documentation. Assess for "Environmental Hazards" or "Malnutrition."

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team.
- **A mandatory referral to CPT is required on all “Failure to Thrive” allegations.
- Review and documentation of the child’s medical records to assess for prior medical issues involving this child.
- Review and documentation of any psychological examinations of the caregiver(s) if available.

FAMILY VIOLENCE THREATENS CHILD

DEFINITION

Family violence threatens child means an adult who is a family or household member commits any violent criminal behavior, such as assault or battery, on another adult who is a family or household member, that demonstrates a wanton disregard for a child and could reasonably result in injury to the child.

- “Family or household member” means spouses, former spouses, intimate partners, persons related by blood or marriage, persons who are presently residing together as if a family or who resided together in the past as if a family, and persons who are parents of a child in common regardless of whether they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit.
- When the alleged perpetrator of the violent criminal behavior is a minor who is a parent, s/he can only be an alleged perpetrator of this maltreatment for his/her own child, not for other children in the home.

The criminal definition for “domestic violence” is contained in Chapter 741, Florida Statutes, which states that domestic violence is any assault, aggravated assault, battery, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another who was residing in the same single dwelling unit. (section 741.28, F.S.,). This definition is provided for information only. It includes behaviors which do not meet the criteria for this maltreatment (such as stalking).

**For a report of “Family Violence Threatens Child” to be accepted, the incident must have occurred between two adults who meet the above definition for “family” or “household members,” or between a minor who is a parent and the other parent or an adult who is a family or household member.

**If the "primary aggressor" is not clearly identified by the reporter at the Hotline, the intake should be conceded as, caregiver responsible, perpetrator unknown and the CPI will determine the identity of the perpetrator during the investigation on "family violence threatens child" maltreatments. Only one caregiver should be identified as the domestic violence perpetrator. This person can best be determined by the protective investigator during the investigation.

ASSESSING “FAMILY VIOLENCE THREATENS CHILD” AS MALTREATMENT

- Was law enforcement called related to the incident and/or was an arrest made?
- Are there current or past protective orders or injunctions?
- Were there elements of control present such as financial or isolation?
- Where were the children during the incident?
- Were the children injured as a result of the incident?
- Were weapons used or present during the incident?
- Is there a history or pattern of domestic violence?

ASSESSING FOR OTHER MALTREATMENT

- If a weapon was used during the violent episode and the child was injured with the weapon, also assess for “Physical Injury.”
- If the allegation is verbal abuse without threats of physical violence assess for “Mental Injury” to the child.
- The only time the alleged perpetrator for this maltreatment can be under 18 is when that minor child is the parent. If the child is attacking an adult in the home, assess for a special conditions “Parent Needs Assistance” referral.

EXCLUDING FACTORS

Caregiver(s) who are a participant in violent behavior with someone other than an adult who is a family or household member or intimate partner does not constitute “Family Violence Threatens Child.” If the child was injured use the appropriate maltreatment and assess for other maltreatments such as “Mental Injury.”

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Obtain and consider any reports and interviews from law enforcement that include 911 call history to the residence.
- Documentation and communication from the State Attorney’s Office.
- Review and documentation of psychological examinations.
- Documentation from interviewing the children in the home about current and past incidents.
- Documentation of the effects on the children’s daily routines, functioning, development, education and medical.
- Documentation from interviewing and observing the caregiver(s) and other participants in the incident (if any). Focus should be on their interaction and reasons for the incident and the extent of the violence.

- Documentation of coercive control behaviors as disclosed by the adult victim and/or child whether current and/or past behaviors.
- Documentation from interviewing witnesses to the incident or person who know the family well.
- Documentation for collateral contacts that may include neighbors or the family's landlord.
- Documentation of a pattern of domestic violence related incidents.
- Documentation of the lethality of the situation (choking, escalating incidents, threats to kill, etc.).

HUMAN TRAFFICKING

DEFINITION

Human trafficking of a child is the recruitment, harboring, transportation, provision or obtaining of a child for labor or services through the use of force, fraud, or coercion. Sex trafficking is a commercial sex act which includes prostitution, pornography, and exotic dancing.

**A report for this maltreatment may be accepted even if the alleged perpetrator is not a caregiver.

ASSESSING "HUMAN TRAFFICKING" AS MALTREATMENT

- Is the caller a professional reporter who works with human trafficking cases and suspects human trafficking?
- What is the alleged perpetrator's legal relationship to the child?
- Is food being withheld from the child?
- Is the child being physically confined?
- Are there threats being made to the child or the child's parents or siblings?
- Is the child being threatened with deportation?
- Was the child given false promises of reunification with family, citizenship, education, or eventual independence?
- Is the child isolated – not attending school, no access to telephones or friends, etc.?
- Is drug and/or alcohol dependency being used by the perpetrator to control the child?
- Is a child being induced to commit commercial sex acts (including prostitution)?
- Can the adults responsible for the child produce documentation legitimizing their role as caregiver(s) (such as birth certificate, visa, divorce papers, school records, etc.)?
- If the adult caregiver(s) alleges that the child was placed in their custody through a "family arrangement," does the victim have ongoing contact with their biological parents?
- Can the child identify or describe specific familial connections (such as names of relatives, how family members are related, etc.)?

- Can the child describe traditional familial interactions with the caregiver(s) in the past (such as birthday parties, holiday celebrations, etc.)?
- Did the caregiver(s) flee when the child was reported or taken into custody?

ASSESSING FOR OTHER MALTREATMENT

This maltreatment will almost always be accompanied by other allegations of abuse, neglect, or abandonment and should be assessed as such.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Documentation from any reports and interviews from law enforcement.
- Information obtained from the Department’s Refugee Services.
- Information obtained from the Department of Health and Human Services.
- Legal documentation such as birth certificates, visas, divorce papers, school records, etc.
- Documentation that the child has engaged in prostitution or commercial sex acts.
- Documentation from interview and/or observing the caregivers and other children in the home with the caregiver(s).
- Documentation from interviewing and observing the child.
- Documentation from interviewing witnesses to the incident or persons who know the child or caregiver(s) well.

INADEQUATE SUPERVISION

DEFINITION

Inadequate supervision is leaving a child without adult supervision or arrangement appropriate for the child’s age or mental or physical condition, so that the child is unable to care for his/her own needs or another’s basic needs or is unable to exercise sufficient judgment in responding to any physical or emotional crisis. This includes situations where a child has been placed in a situation or circumstances which are likely to require judgment or actions greater than the child’s level of maturity, physical condition, or mental abilities reasonably dictate, and a potential threat of harm to the child is present.

**There is no age stated in Florida Statute after which a child can be left unattended or alone. There are also no established time frames for how long a child of any given age can be left alone. Each situation must be assessed focusing on the specific child, caregiver(s), and incident factors.

ASSESSING “INADEQUATE SUPERVISION” AS MALTREATMENT

- What is the age, maturity and developmental stage of the child particularly related to the ability to make sound judgments?
- What is the frequency and duration of the occurrence?

- What is the time of day or night when the incident occurred?
- Are the caregiver(s) accessible by telephone and the child mature enough to know when and how to use the telephone to contact the caregiver(s)?
- How accessible are the caregiver(s) to the child? Can the caregiver(s) see and/or hear the child?
- What is the proximity to the child of other responsible persons?
- Has sufficient food and provisions been left for the child?
- Are the caregiver(s) out of direct supervision of the child and there are factors that create risk based on the age, developmental level, or disabilities of the child (for example, riding a bicycle in the street after dark)?
- Has a child been left alone when s/he has a condition that requires close supervision, such as a medical condition, behavioral, mental or emotional problems, developmental disabilities, or physical disabilities?
- Has a child been left at home alone or unattended in a place which is unsafe?
- Is the child on medication that cannot or should not be self-administered by a child?
- Have the caregiver(s) arranged for secondary caregiver(s) deemed inappropriate or inadequate due to a known history of violence, substance abuse, emotional instability, immaturity, age, or other limitation which affect the ability to care for the child?
- Is there substance misuse issues related to the incident?

ASSESSING FOR OTHER MALTREATMENT

When there is an allegation of inadequate supervision due to alcohol or substance abuse assess for the “Substance Misuse” maltreatment.

EXCLUDING FACTORS

A situation where the only allegation is that the caregiver(s) are late picking up the child does not constitute “Inadequate Supervision.” Refer these calls to law enforcement.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Investigator’s observations of the child and environment.
- Documentation from any reports and interviews from law enforcement that includes 911 call out history.
- Documentation of harm that occurred or was likely to occur based upon the circumstances.
- Information from drug screen results if applicable.
- Documentation from interviewing the child and assessment of developmental, physical, and mental abilities relevant to incident.
- Documentation from interviewing the caregivers related to the incident.

- Documentation from interviewing witnesses to the incident or persons who know the family or situation well (for example, neighbors, family members, or landlord).
- Documentation of the environment to include photographic evidence.
- Consider patterns of similar reports involving inadequate supervision involving the caregiver(s).

INTERNAL INJURIES

DEFINITION

An internal injury is an injury to the organs occupying the thoracic (chest) or abdominal cavities that is not visible from the outside. Internal injuries may be accompanied by other external injuries. A person so injured may be pale, cold, perspiring freely, have an anxious expression, seem semi-comatose, or exhibit other symptoms such as lethargy, disorientation, blood in bowel movements or urine, and/or loss of consciousness.

ASSESSING “INTERNAL INJURIES” AS MALTREATMENT

- Is the allegation of internal injury being reported by a physician or someone reporting on behalf of a physician? If not, see the “assessing for other maltreatment” section.
- Is the caller alleging that the internal injury occurred accidentally or by an intentional act?

ASSESSING FOR OTHER MALTREATMENT

- Use the “Internal Injuries” maltreatment only when the allegation is made by a physician or someone reporting on behalf of a physician. When other reporters are making this allegation without medical documentation, assess for “Physical Injury” as the maltreatment.
- If the child had symptoms that should have caused a reasonable person to seek medical care and treatment was not sought, assess for “Medical Neglect.”

EXCLUDING FACTORS

The “Internal Injuries” maltreatment will not be coded on the report if the reporter is someone other than a physician or reporting on behalf of the physician. See the “assessing for other maltreatment” section.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team.
- Information obtained from Emergency Medical Services or other first responders.
- Documentation obtained from radiologic imaging that identify other injuries either healed or in some stage of healing.

- Documentation of the child’s medical conditions and any statements that a child is prone to internal injuries verified by a qualified physician, preferably the Child Protection Team.
- Obtain and consider any reports and interviews from law enforcement.
- Documentation related to when the symptoms first appeared and what action was taken by the caregivers.
- Interviews from witnesses who may have observed the incident or have first-hand information.

MALNUTRITION/DEHYDRATION

DEFINITION

Malnutrition is a lack of necessary or proper nutrition or liquids in the body caused by lack of access to food, inadequate food, lack of food or liquids, or insufficient amounts of protein, minerals, or vitamins.

**If a medical professional is making an allegation of malnourishment it shall be accepted by the Hotline as a report.

ASSESSING “MALNUTRITION/DEHYDRATION” AS MALTREATMENT

- Is the child not growing or has lost weight, and the reporter believes this is due to the child being fed insufficient amounts of food?
- Has there been a decrease in the child’s lean body mass or fat?
- Has there been a change in the child’s general appearance such as thinning hair, paleness, aged skin and/or bulging abdomen?
- Has there been a change in the child’s behavior (e.g. decreased school performance, alteration in consciousness, lack of interest to external stimuli)?
- Is the child frequently and repeatedly deprived of meals or is frequently and repeatedly fed insufficient amounts of food to sustain health?
- Does the child frequently and repeatedly asks neighbors for food or steals food, and other information indicates that the child does not receive enough food at home to sustain health?

EXCLUDING FACTORS

Frequently feeding a child fast food does not constitute “Malnutrition” unless the child has a medical condition requiring a special diet and the fast food is dangerous to his/her health.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team and the child’s Primary Care Physician.

**A mandatory referral to CPT is required for all reports alleging “Malnutrition.”

- Documentation from interviewing and/or observing the caregivers and other children in the home, focusing on the nutrition that was provided to the alleged victim.
- Reviews and documentation from prior history of similar maltreatment or child medical problems in the family or by the perpetrator.

MEDICAL NEGLECT

DEFINITION

Medical neglect is when caregiver(s) have failed to provide dental, medical or psychiatric treatment for a health problem or condition which, if left untreated, could become severe enough to constitute serious or long-term harm to the child. This includes lack of follow through on a prescribed treatment plan for a condition which could constitute serious or long-term harm to the child.

**Inadequate financial ability alone is not medical neglect.

** Caregiver(s) who by reason of legitimate practice of religious beliefs do not provide specified medical treatment for a child may not be considered abusive or neglectful for that reason alone. However, this exception does not eliminate the requirement that such a report be made to the Hotline nor does it prevent the Department from conducting an investigation to determine harm.

** In situations where caregiver(s) refuse to allow a newborn to be tested for HIV and the mother has been diagnosed HIV positive, a report shall be accepted by the Hotline only when called in by medical professionals.

ASSESSING “MEDICAL NEGLECT” AS MALTREATMENT

- What are the child’s physical conditions and the seriousness of the current health problem?
- What is the probable outcome if the current health problem is not treated?
- What are the reasons offered for not getting treatment for the child?
- Has appropriate nutrition, hydration, medication, or other medically indicated treatment been withheld from newborn infants?
- Is a diaper rash being reported that has open or bleeding lesions that require professional medical attention and no such attention has been provided?
- Caregiver(s) failed to use a medical device that is prescribed by a physician when this results in reasonable cause to suspect the child is threatened with harm?

EXCLUDING FACTORS

- A lack of immunizations under current law or many minor conditions which under usual conditions have no potential for serious or long-term harm (such as head lice) does not constitute “Medical Neglect.”

- Not providing medication for a child diagnosed with ADHD or ADD does not constitute “Medical Neglect.”

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team and the child’s Primary Care Physician.
- **A mandatory referral to CPT is required for all reports alleging “Medical Neglect.”
- Review and documentation of the child’s prior medical history and how/if follow-up was completed by the caregiver.
- Documentation of the proper administration of prescribed medications to include what the medication is prescribed for, what happens if the child does not take the medication, what is the potential harm, and pill count.
- Documentation of the family’s financial ability to obtain treatment.
- Documentation on the long-term potential harm due to the non-treatment.
- Documentation from interviewing the caregivers, focusing on their ability to understand the child’s health needs and to respond to those needs.

MENTAL INJURY

DEFINITION

Mental injury is an injury to the intellectual or psychological capacity of a child as evidenced by a discernible and substantial impairment in the ability to function within the normal range of performance and behavior. The impairment may be in the emotional, affective, cognitive, physical, or behavioral functioning of the child. Damage can be present and observable, or can be forecast as highly probable for the near future.

ASSESSING “MENTAL INJURY” AS MALTREATMENT

- Is there observable or probable impairment of the child’s ability to function as s/he normally functions?
- Has there been a noticeable change to the child’s behavior based upon action of the caregiver(s)?
- Does the caregiver(s)’s actions inappropriately restrict the child’s autonomy or independent learning?
- Have there been statements heard by the child that reflect unrealistic expectations of the child and which are inappropriate to the child’s developmental level?
- Is there a pattern of acts or verbal mistreatment directed at the child by the caregiver(s)?
- Are there willful violent acts directed toward a child’s pet, possessions, or environment?

- Is the child exposed to repeated violent, brutal, or intimidating acts or statements among household members?
- Is the child demonstrating self-mutilating behaviors or suicidal ideations that appear to be caused by the caregiver(s)'s statements or actions?

ASSESSING FOR OTHER MALTREATMENT

If there are other types of abuse or neglect that were allegedly inflicted by the caregiver(s), select those maltreatments in addition to "Mental Injury."

EXCLUDING FACTORS

Temporary unhappiness or a distress reaction alone due to the caregiver(s)'s statements or actions does not constitute "Mental Injury."

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team.
- **A mandatory referral to CPT is required for all symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.
- Supportive documentation from other licensed professionals that may include physicians, psychiatrists, psychologists, or other licensed mental health professionals.
 - Review and documentation of the child's prior mental health history and how/if they were treated.
 - Obtain and consider any reports and interviews from law enforcement that include call outs.
 - Documentation on whether the child's ability to function has been adversely affected, comparing prior functioning level to the child's current level.
 - Documentation from interviewing the child, siblings, caregiver(s), and other relevant sources familiar with the family's situation.

PHYSICAL INJURY

DEFINITION

Physical injury includes any physical maltreatment of a child which is not covered by other abuse maltreatments that result in permanent or temporary disfigurement, permanent or temporary loss or impairment of a bodily part or function, or is a willful act or threatened act which causes or is likely to cause the child's physical health to be impaired.

Definitions of maltreatments associated with "Physical Injury" are as follows:

Bite: A wound, bruise, cut, or indentation in the skin caused by seizing, piercing, or cutting skin with teeth.

Brain or Spinal Cord Damage: Injury to the nerve tissue contained within the cranium/skull or spinal cord.

Bruise: An injury resulting from bleeding within the skin where the skin is discolored but not broken.

Cut: An opening, incision, or break in the skin made by some external agent.

Dislocation: Displacement of any body part, especially the temporary displacement of a bone from its normal position in a joint.

Intra-Cranial Hemorrhage: An abnormal collection of blood within the skull including subdural, subarachnoid, or epidural hematoma and intra-cerebral hemorrhage.

Munchausen's Syndrome by Proxy: a form of child abuse in which a parent induces real or apparent symptoms of a disease in a child

Oral Injury: Injuries to the mouth to include broken teeth.

Puncture: An opening in the skin which is relatively small as compared to the depth as produced by a narrow pointed object.

Shaken Baby Syndrome (Abusive Head Trauma): Injuries, particularly to the head, caused by violently shaking an infant.

Welt: An elevation on the skin that can be produced by a lash or blow. The skin is not broken and the mark is reversible.

ASSESSING "PHYSICAL INJURY" AS MALTREATMENT

- Is the injury on a high risk body area such as the head, neck, stomach, genitals, or chest?
- Are there multiple injuries that appear to have been inflicted at various time intervals?
- Does the injury appear to be non-accidental?
- Is the explanation of the injury consistent with the injury?
- Does the child have a medical condition, disability, behavioral, emotional problem, or other issue that increases the child's vulnerability?

- Were the actions by the caregiver(s) severe that may have resulted in significant impairment regardless of injuries?
- Does the child have a significant injury suspected to be caused by abuse regardless of the child's willingness to say how the injury occurred?
- Did the injury require medical treatment?
- Was an instrument used during the incident?
- Are there patterns of similar incidents with this child or other children that the caregiver(s) have been responsible for?

ASSESSING FOR OTHER MALTREATMENT

- Use "Inadequate Supervision" for physical injury due to neglect.
- If a child is bitten by another child or animal assess for "Inadequate Supervision."
- For situations where a deadly weapon was left in a place accessible to a child assess for "Inadequate Supervision."
- If a caregiver(s) threatens to use a deadly weapon against a child but does not have the weapon at the time of the threat assess for "Mental Injury."

EXCLUDING FACTORS

Do not use this maltreatment for allegations other than abuse; this maltreatment is only used for injuries or threatened injuries due to abuse. Assess for other maltreatment or service needs.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team.

**A mandatory referral to CPT is required for bruises anywhere on a child 5 years of age or under and/or injuries to the head on a child of any age.

- Obtain and consider any reports and interviews from law enforcement that include call outs.
- Documentation of current or past injuries.
- Documentation of the typology of the injury to include location and description.
- Photographic evidence of the injuries.
- Identification and possible etiology (hand, belt, electrical cord, etc.) based upon observation, interviews and medical input.
- Documentation from interviewing witnesses to the incident or persons who know the family well.

SEXUAL ABUSE

DEFINITION

Sexual abuse is sexual conduct with a child for arousal or gratification of the sexual needs or desires of the caregiver(s). This maltreatment includes both allegations of sexual abuse and the threat of harm by sexual abuse. Three types of sexual conduct are included in this maltreatment:

Sexual Molestation: Sexual conduct with a child when contact, touching, or interaction is used for arousal or gratification of the sexual needs or desires of the caregiver(s), including, but not limited to:

- The intentional touching of the genitals or intimate body parts, including the breasts, genital area, groin, inner thighs, penis, and buttocks, or the clothing covering them.
- Encouraging, forcing, or permitting the child to inappropriately touch the same parts of the caregiver's body.

Sexual Battery: Sexual conduct involving the oral, anal, or vaginal penetration by, or union with, the sexual organ of a child; the forcing or allowing a child to perform oral, anal, or vaginal penetration on another person; or the anal or vaginal penetration of another person by any object. This includes digital penetration, oral sex (cunnilingus, fellatio), coitus, and copulation.

Sexual Exploitation: Sexual use of a child for sexual arousal, gratification, advantage, or profit. This includes, but is not limited to:

- Indecent solicitation of a child or explicit verbal enticement.
- Allowing a child to participate in pornography.
- Exposing sexual organs to a child for the purpose of sexual arousal or gratification, aggression, degradation, or similar purposes.
- Intentionally perpetrating a sexual act in the presence of a child for the purpose of sexual arousal, gratification, aggression, degradation, or similar purposes.
- Intentional masturbation of the caregiver's genitals in the child's presence.

**Use this maltreatment when a child has been sexually abused or is at threatened harm of sexual abuse due to the actions or non-actions of the caregiver(s). The caregiver(s) is alleged to have sexually exploited the child not only if s/he engages in the behaviors or activities listed under "Sexual Exploitation," but also if s/he condones or does not stop another non-caregiver(s) from exposing the child to these behaviors or activities.

**If the alleged perpetrator has current access to the child, this must be an immediate response.

**When an allegation of "Sexual Abuse" is made due to threatened harm from sexual abuse, at times a CPI is able to determine that a child has not been sexually abused but is at serious risk of sexual abuse

because of the evidence obtained. In such situations, the CPI should add the allegation of “Threatened Harm” to their investigation and determine findings accordingly.

ASSESSING “SEXUAL ABUSE” AS MALTREATMENT

- Is the child being used for sexual arousal, advantage, or profit?
- How did the reporter obtain their information (eye witness, child statement, third party, etc.)?
- Does the child have a sexually transmitted disease?
- Did the caregiver(s) expose their sexual organs to a child that is inappropriate or appears to be for sexual gratification?
- Has one child in the home been sexually abused by the caregiver(s) and are there siblings in the home who may also be victims as well?
- Did the caregiver(s) sexually abuse a child and also have other children living in their household who are the same sex and similar age to the child victim?
- What is the extent of the primary caregiver’s knowledge of the situation to include if they were present?
- Is there prior sexual abuse history involving the child or the caregiver(s)?
- Does the child have a disability or medical condition that increases their vulnerability?
- Is there a threat that the child is being sexually abused, for example a child is exhibiting sexual acting-out behaviors beyond their developmental level that is so severe it is expected that someone may have sexually abused them?

ASSESSING FOR OTHER MALTREATMENT

- Allegations of child prostitution should also be assessed for “Human Trafficking.”
- When a child has been sexually abused in the past and the caregiver(s) allow the abuser to have contact, the child may be at risk. Also assess for “Failure to Protect.”

EXCLUDING FACTORS

- A situation involving touching that can be reasonably construed to be normal caregiver(s) responsibility such as wiping a child who is not able to do so without assistance does not constitute “Sexual Abuse.”
- Normal caregiver(s) interaction with affection does not constitute “Sexual Abuse.”
- Touching that is intended for valid medical purposes does not constitute “Sexual Abuse.”

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team and the child’s Primary Care Physician.

****A mandatory referral to CPT is required for any report alleging sexual abuse of a child or any sexually transmitted disease in a prepubescent child.**

- Documentation from any reports and interviews from law enforcement.
- Documentation of an arrest being made related to the sexual abuse incident.
- Documentation of physical evidence observed by the CPI, law enforcement, medical professionals, or the Child Protection Team.
- Results of any psychological exams of the child and/or the caregiver(s).
- Documentation of the statement given by the child (preferably through a forensic interview by a CPT professional), caregiver(s) and siblings to include an assessment of credibility.
- Documentation from interviewing witnesses to the incident or persons who know the family well.
- Documentation from prior history of sexual abuse in this family or by the caregiver(s) with different child victims including prior allegations of sexual abuse made by the child.

SUBSTANCE MISUSE

DEFINITION

Substance misuse covers three areas: the caregiver(s) inappropriately using drugs or alcohol, a child inappropriately consuming or being given drugs or alcohol and poisoning due to caregiver(s) actions or neglect.

****Drugs or substances include: cannabis (marijuana); hallucinogens (LSD, mushrooms); stimulants (including cocaine), sedatives (including alcohol and valium), narcotics (pain relievers), inhalants, or any over-the-counter or prescribed drugs.**

Caregiver(s) using drugs or alcohol: Exposure of a child to drugs or alcohol is established by –

- A test administered at birth which indicates that the child’s blood, urine, or meconium contained any amount of drugs, alcohol or a controlled substance or metabolites of such substances, the presence of which was not the result of medical treatment administered to the mother or the newborn infant.
- Evidence of extensive, abusive, and chronic use of drugs or alcohol by the caregiver(s) when the child is demonstrably affected by such usage.
- Breastfeeding a child while frequently consuming drugs or alcohol, or by using an excessive amount of drugs or alcohol.

Child has consumed drugs or alcohol due to the caregiver(s) actions or neglect: A child has consumed drugs or alcohol that substantially affects the child’s behavior, motor coordination or judgment, or that results in sickness or internal injury.

When a child is consuming drugs or alcohol to the point of being affected, it must be determined that they are doing so with the consent, encouragement, insistence, or neglect of the parent.

Substance misuse also occurs when the caregiver(s) exceed the proper dosage for drugs when the drug substantially affects the child's behavior, motor coordination, or judgment, or when the child sustains an internal injury from the drug.

Poisoning: Any substance, other than controlled substances or alcohol, taken into the body by ingestion, inhalation, injection, or absorption that substantially affects the child's behavior, motor coordination, or judgment that results in sickness or internal injury. Virtually any substance can be poisonous if consumed in sufficient quantity; therefore, the term "poison" often implies an excessive degree of dosage rather than a specific group of substances. This includes noxious substances that, when taken into the body, would be harmful or injurious.

ASSESSING "SUBSTANCE MISUSE" AS MALTREATMENT

Caregiver(s) using drugs or alcohol:

- Has an infant tested "positive" for alcohol or drugs at birth?
- Does a newborn have withdrawal symptoms, is physically affected, or is diagnosed with fetal alcohol syndrome?
- Did the mother test positive for alcohol or drugs when the child was born?
- What is the frequency and extent of the caregivers drug or alcohol use?
- What is the harm that has resulted or is threatened by the caregiver's substance misuse?
- Where is the child when the caregiver(s) uses drugs or alcohol?
- What is the degree of behavioral dysfunction or physical impairment linked to the caregiver(s)'s drug or alcohol use?
- Is the caregiver(s) using crack cocaine, methamphetamines, or heroin regardless of specific effects on the child?
- Has the caregiver(s)'s drug or alcohol use resulted in inadequate food, clothing, shelter, medical care, or supervision for a child?
- Did the caregiver(s) admitted or observed history of drug and/or alcohol use cause concern about the caregiver(s)'s current ability to provide safe care for children under their supervision?
- Is the reporter providing specific adverse effects to the child as a result of the drug or alcohol use?
- Is law enforcement reporting that the caregiver(s) were intoxicated while driving with a child in their vehicle?

Child has consumed drugs or alcohol due to the caregiver(s) actions or neglect:

- What substances were consumed by the child and in what quantity?
- Did the caregiver(s) make any attempt to stop the child from using the drugs or alcohol including whether the caregiver(s) had the ability to stop the child?
- What actions did the caregiver(s) take upon discovering the child had consumed drugs or alcohol?
- If the consumed substances were hidden, were there any reasons to believe that the caregiver(s) should have taken additional precautions?
- Where were the caregiver(s) when the usage occurred?
- Did the caregiver(s) encourage the child's drug or alcohol use?
- Why were the drugs or alcohol provided to the child? Were they for a religious ceremony or holiday tradition?

Poisoning:

- Did the caregiver(s) give or cause a harmful substance to be given to the child?
- Were the actions of the caregiver(s) intentional?

ASSESSING FOR OTHER MALTREATMENT

- "Substance Misuse" impacts other areas of maltreatment. Consider issues resulting from a caregiver(s) or child's "Substance Misuse" to assess for other maltreatment.
- Assess for "Inadequate Supervision" if the lack of supervision or omission caused a child to be *poisoned*. Do not use "Substance Misuse" in these situations.

EXCLUDING FACTORS

Do not use "Substance Misuse" if the lack of supervision or omission caused a child to be *poisoned*, assess for "Inadequate Supervision."

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team.
- Documentation from the child's counselor or therapist that identifies the effects of the caregivers' drug or alcohol use on the child.
- Documentation of toxicology results and drug screens results for the child, caregiver(s), or both.

- Documentation, if any, of meconium drug testing results of newborns potentially exposed to drugs utero.
- Documentation of the effects on the child related to a caregivers' substance misuse such as excessive school tardiness or absence, unsanitary living conditions, missing meals, etc.
- Documentation of inappropriate use/dose of prescribed medications to include a pill count, date of prescription, and directions for dosage.
- Documentation that the caregiver(s) were responsible for the child at the time of the drug or alcohol usage.
- Documentation from interviewing and/or observing the caregiver(s), children and household members related to the extent of the caregivers' drug or alcohol use focusing on the frequency and level of the usage and the effects on the child.
- Documentation of prior history of maltreatment linked to substance misuse in the family.
- Documentation of drug related criminal history.
- Documentation that the child has consumed damaging substances from witnesses and interviews or from medical results.

THREATENED HARM

DEFINITION

Threatened harm is a behavior that is not accidental and which is likely to result in harm to the child. The Hotline is limited to only two situations for selecting this maltreatment:

- The preventable death of one child provides reason to suspect that another child is at risk, or
- The caregiver's children are currently in out-of-home care or parental rights have been terminated.

**If the caregiver(s) have children currently in out-of-home care or parental rights have been terminated and they currently have a child under age five in their home and there are no other allegations of maltreatment except a report for "Threatened Harm." Out-of-home care means the placement of a child in licensed and non-licensed settings arranged and supervised by the Department or a contracted service provider.

**Child Protective Investigators may add "Threatened Harm" to an open investigation if there are no injuries involving maltreatment, but the circumstances indicate the child is at risk of injury.

ASSESSING "THREATENED HARM" AS MALTREATMENT

- What is the severity of the harm that is likely to occur?
- What is the connection of the actual incident to the likelihood of injury or future injury to each specific child?
- Is the child death being referenced documented in FSFN?

- Is there prior documented child welfare history in FSN?
- Where did the reporter get their information?

ASSESSING FOR OTHER MALTREATMENT

In most situations involving risk of abuse or neglect to a child, the maltreatment used will be the abuse or neglect maltreatment code that describes the type of harm that is threatened. For instance, when the child is threatened with physical abuse the maltreatment code selected should be the appropriate abuse code such as “Physical Injury” or “Burns.”

EXCLUDING FACTORS

- A situation where there is no risk to surviving children of a child that died as a result of a preventable death and there are no other allegations related to these children, does not constitute “Threatened Harm.”
- If the reporter is the **Case Manager** of a child where the mother has other children in out-of-home care and there are no allegations of abuse, abandonment, or neglect, do not accept a report of “Threatened Harm.” Refer the caller to Florida Administrative Code 65C-30.016 for instructions on staffing with Children’s Legal Services.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Documentation from prior risk and safety assessments in addition to any prior child death reviews or reports.
- Obtain and consider any reports and interviews from law enforcement.
- Documentation from interviewing prior or current case managers or staff within the Department or a Community Based Care agency who has knowledge of the family’s circumstance and prior child welfare history.
- Results of any psychological exams related to the caregiver(s).
- Information obtained from all medical records and professionals to include the Child Protection Team.
- Documentation obtained from interviews with the child, household members, and collateral contacts with knowledge of the family (teachers, neighbors, extended family members, etc.).

SPECIAL CONDITION REFERRALS

The following pages contain information regarding the four special condition referrals. They are structured differently, since no investigation is required.

Special condition referrals are requests brought to the attention of the Department that require a response by the Department or the investigating Sheriff. These requests do not constitute willful abuse, abandonment, or neglect, but they may result in additional allegations of maltreatment and/or the need to shelter a child upon response.

If a child protective responder conducting the assessment of a special conditions referral discovers information that constitutes reasonable cause to suspect that a child has been abused, abandoned, or neglected, a call must be made to the Hotline.

Special condition referrals are considered intakes and applicable background checks should be completed on all participants listed and added onto the intake as outlined in Children and Families Operating Procedure 175-94.

The four special condition referral types are listed on the following pages.

CAREGIVER(S) UNAVAILABLE

DEFINITION

Caregiver(s) unavailable is a situation, in which a child is in need of supervision and care, but there is no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care, and there are no allegations that meet the criteria for a report of abuse, abandonment, or neglect.

ASSESSING “CAREGIVER(S) UNAVAILABLE” FOR REFERRAL

- Are the caregiver(s) available to make acceptable temporary living arrangements for the child?
- Is law enforcement refusing to release the child to anyone until a Department person makes contact?
- How long is the parent/caregiver(s) expected to be unavailable to care for the child?
- Are the caregiver(s) about to be incarcerated and plans must be made for the child’s immediate care?
- Are the caregiver(s) about to be hospitalized and plans must be made for the child’s immediate care?
- Have the caregiver(s) died and plans must be made for the child’s immediate care?

ASSESSING FOR OTHER MALTREATMENT

Assess for the “Human Trafficking” maltreatment if the adults responsible for the child cannot produce documentation legitimizing their role as caregiver(s) (such as birth certificate, visa, divorce papers, school records, etc.)?

EXCLUDING FACTORS

- Situations where the counselor identifies allegations of abuse, abandonment or neglect during the call that may or may not be related to the reason that the caregiver(s) are unavailable. Instead, an abuse report will be accepted for response and assessment.
- A situation where a relative has been caring for a child for some time and is seeking custody. If the current needs of the child are being met, the counselor should not accept a “Caregiver(s) Unavailable,” but refer the caller to the clerk of court and Chapter 751, F.S., “Temporary Custody of Minor Children by Extended Family.”

FIELD GUIDANCE

Individuals identified to care for the child in the absence of their parent or primary caregiver(s) should be added to the caregiver(s) unavailable referral and subject to the same background checks as outlined in CFOP 175-94. While an official home study is not required, a home visit and assessment of suitability shall be completed on the identified caregiver.

CHILD-ON-CHILD SEXUAL ABUSE

DEFINITION

Child-on-child sexual abuse refers to any sexual behavior between children twelve years or younger, which occurs without consent, without equality, or as a result of coercion. The statutory definitions for consent, equality and coercion are provided below:

Consent: An agreement, including all of the following

- Understanding what is proposed based on age, maturity, developmental level, functioning, and experience.
- Knowledge of societal standards for what is being proposed.
- Awareness of potential consequences and alternatives.
- Assumption that agreement or disagreement will be accepted equally.
- Voluntary competence.
- Mental competence.

Equality: Two participants operating with the same level of power in a relationship, neither being controlled nor coerced by the other.

Coercion: The exploitation of authority or the use of bribes, threats of force, or intimidation to gain cooperation or compliance.

ASSESSING “CHILD-ON-CHILD SEXUAL ABUSE” FOR REFERRAL

- Is the alleged offender 12 years of age or younger at the time of the call?
- Assess the specific behaviors of the alleged offender and the victim.
- Did the alleged event occur without consent, without equality, or as a result of coercion?
- Consider the difference in age between the alleged offender and the victim.

ASSESSING FOR OTHER MALTREATMENT

- Fully assess for other maltreatment such as “Inadequate Supervision.” A child-on-child sexual abuse referral may be accepted for response and assessment even when other maltreatments are accepted for investigation too.
- Assess for a parent needs assistance referral if the information is not accepted as a child on child sexual abuse referral and there are no other maltreatments identified.

EXCLUDING FACTORS

Regardless of the decision to accept a child-on-child referral for Department response, the counselor shall refer the caller to the local sheriff's agency to report the allegations.

FIELD GUIDANCE

For additional information on response and assessment related to child-on-child special condition referrals, refer to section 39.307, F.S., and 65C-29.007, F.A.C..

FOSTER CARE REFERRAL

DEFINITION

A foster care referral is a situation involving concerns about the care being provided in a licensed foster home, group home, or emergency shelter that does not meet the criteria for acceptance as a report of abuse, neglect, or abandonment.

An example would be the use of corporal punishment on a foster child that does not result in harm.

ASSESSING "FOSTER CARE" FOR REFERRAL

- Is the home licensed?
- Does the information being reported appear to be a licensing violation?
- Is there information that corporal punishment was used on a foster child?

ASSESSING FOR OTHER MALTREATMENT

Foster parents allegedly using corporal punishment on a biological child does not constitute acceptance as a foster care referral. However, the counselor should assess for the physical injury maltreatment.

EXCLUDING FACTORS

This referral should only be used if there are no allegations that meet the criteria for any maltreatment; it is not necessary to use both a maltreatment code and a foster care referral.

FIELD GUIDANCE

Refer to 65C-29.006 and 65C-13.034, F.A.C. for guidance related to the response and assessment of foster care referrals.

PARENT NEEDS ASSISTANCE

DEFINITION

Parent needs assistance referrals are calls to the Hotline that do not meet the statutory criteria for an abuse, abandonment, or neglect investigation but the Hotline counselor identifies the family may be in need of services.

ASSESSING “PARENT NEEDS ASSISTANCE” FOR REFERRAL

- Does it sound like a situation that could get worse if they do not get assistance?
- Does the situation sound like there is a potential for abuse, abandonment or neglect if the situation goes unresolved?
- Would the family benefit from services offered in the local community?

ASSESSING FOR OTHER MALTREATMENT

Fully assess each call to determine whether there are any allegations that meet the criteria for a report of abuse, abandonment or neglect.

EXCLUDING FACTORS

If a report is being accepted for any of the twenty maltreatments, it is not necessary to also use parent needs assistance.

FIELD GUIDANCE

Field staff should utilize the parent needs assistance job aid developed by the Family Safety Program Office for minimal guidance on the response and handling of these referrals.

Activity: Child Maltreatment Index

Read the scenarios and identify which maltreatment applies.

Scenario 1:

The children, ages 4 and 6, are suspected to be endangered on those occasions when their mother leaves them in the care of her mother, Mildred. Mildred is an amputee who is dependent on a wheel-chair. She currently has a broken arm and is described as being unable to provide safe and adequate supervision for her grandchildren. The children are aware that they can leave the residence and wander anywhere in the neighborhood that they choose, without being found and returned because of their grandmother's physical limitations. The mother and grandmother have been cautioned previously but continue with this arrangement.

Maltreatment:

Scenario 2:

Mary tested positive for cocaine at the time of delivery today. The drug screen on the baby is pending. The baby is doing fine. APGARS were 5 and 9, and she was delivered by C-section. The mother received prenatal care through the clinic and also a private physician.

Maltreatment:

Scenario 3:

The single mother, Lorine, passed away last night. There are no known family members willing or able to take custody of Lorine's children.

Special Condition Referral:

Scenario 4:

The mother and her children live in a condemned apartment building, apartment 3. No one else actually lives in the building. The mother is said to have no visible means of income. The children cannot stay awake during the day and are obviously not getting sufficient sleep at night. The older son has to urinate frequently and has a history of pus coming from his penis. The mother has failed to get him medically checked. The younger son is showing some of the same signs and smells strongly of urine. The children are not clean. Michelle has ringworm on her face, and the mother put shoe polish on it to try to cover it up, instead of obtaining medical treatment.

Maltreatments:

Scenario 5:

The parents advise that their 14-year-old child refuses to go to school or to abide by the parents' rules. They are unable to control his behavior and are worried that he will get harmed when he is "running the streets" instead of going to school. They want help in getting him to listen and to behave.

Maltreatment:

Scenario 6:

It is alleged that a young girl, approximately 9 years of age, is residing with the Gutierrez family. She is forced to live in the garage and does not attend school. Allegedly, this girl "works" for the family and is forced to clean, and do wash for 16 hours per day.

Maltreatment:

Abandonment

Abandonment: a situation in which the parent(s) or legal custodian(s) of a child or, in the absence of a parent or legal custodian, the caregiver(s), while being able, makes no provision for the child's support and has failed to establish or maintain a substantial and positive relationship with the child. "Establish or maintain a substantial and positive relationship" includes, but is not limited to, frequent and regular contact with the child through frequent and regular visitation or frequent and regular communication to or with the child, and through the exercise of parental rights and responsibilities.

Section 827.10, F.S. Unlawful Desertion of a Child.

Threatened Harm

Threatened Harm: a behavior that is not accidental and which is likely to result in harm to the child.

The Hotline is limited to only two situations for selecting this maltreatment:

- The preventable death of one child provides reason to suspect that another child is at risk, or
- The caregiver's children are currently in out-of-home care or parental rights have been terminated.

Assessing Warning Signs to determine if a Child is Unsafe

- There are "warning signs" or "symptoms" of maltreatment that should be assessed on an ongoing basis.
- Certain family factors might influence the occurrence of maltreatment, while behaviors exhibited by parents may serve as a clue that abuse is already occurring.
- These warning signs are not the causes and conditions that led the child to be unsafe, but rather are the indicators that they are unsafe.
- It is impossible for the child welfare professional to have a list they just check off that tells them s child is unsafe.
- The effective and sufficient collection of information from the six domains, as well as the critical assessment and analysis of this information, enable the child welfare professional to determine if the child is safe or unsafe.

Human Trafficking

Section 787.06(2)(d), Florida Statutes, defines “human trafficking” as “transporting, soliciting, recruiting, harboring, providing, enticing, maintaining, or obtaining another person for the purpose of exploitation of that person.”

There are 4 forms of sex trafficking:

Renegade/Survival Sex: There is no third party. No pimp. The victim may “broker” exchanges for a sexual act independently. There may be an exchange of a sexual act for money, food, housing, clothing, etc. Any exchange of a sexual act for any tangible thing, or the promise of a tangible thing, is human trafficking.

Pimp Trafficking: There is a third party who is “brokering” the exchanges of the sexual act for a tangible item, typically money. Pimps can be any age, any gender, and come from all types of backgrounds.

Familial Trafficking: A family member is involved in the trafficking of the child. There may be an exchange for money, for drugs, for rent, etc.

Gang Trafficking: The trafficking is a source of generating money for the gang, and the gang member is involved in the trafficking of the victim. This might be a local, state, national, or transnational gang. A gang is defined as “An association of three or more individuals whose purpose, in part, is to engage in criminal activity.”

USING THE CHARTS BELOW: For Labor Trafficking, there is a process + a way or means + a goal to support a finding of human trafficking. For Sex Trafficking, if the victim is under the age of 18, there is a process + a goal – a finding of human trafficking **does not require** a ways or means.

Labor Trafficking

Process	+	Way/Means	+	Goal
<i>Recruitment</i>	A	<i>Threat</i>	A	<i>Prostitution</i>
<i>or</i>	N	<i>or</i>	N	<i>or</i>
<i>Transportation</i>	D	<i>Coercion</i>	D	<i>Pornography</i>
<i>or</i>		<i>or</i>		<i>or</i>
<i>Transferring</i>		<i>Abduction</i>		<i>Violence/Sexual Exploitation</i>
<i>or</i>		<i>or</i>		<i>or</i>
<i>Harboring</i>		<i>Fraud</i>		<i>Forced Labor</i>
<i>or</i>		<i>or</i>		<i>or</i>
<i>Receiving</i>		<i>Deceit</i>		<i>Involuntary Servitude</i>
		<i>or</i>		<i>or</i>
		<i>Deception</i>		<i>Debt Bondage (with unfair wages)</i>
		<i>or</i>		<i>or</i>
		<i>Abuse of Power</i>		<i>Slavery/Similar practices</i>

Sex Trafficking (victim under age 18)

Process	+	Goal
<i>Recruitment</i>	A	<i>Prostitution</i>
<i>or</i>	N	<i>or</i>
<i>Transportation</i>	D	<i>Pornography</i>
<i>or</i>		<i>or</i>
<i>Transferring</i>		<i>Violence/Sexual Exploitation</i>
<i>or</i>		<i>or</i>
<i>Harboring</i>		<i>Forced Labor</i>
<i>or</i>		<i>or</i>
<i>Receiving</i>		<i>Involuntary Servitude</i>
		<i>or</i>
		<i>Debt Bondage (with unfair wages)</i>
		<i>or</i>
		<i>Slavery/Similar practices</i>

Unit 6.2: Neglect

Neglect Overview

The most severe consequence of neglect is death. In 2012, neglect was reported to be a primary component in 70% of US child maltreatment deaths (Children’s Bureau, 2013).

The Florida Child Abuse Death Review (CADR)

The Florida Child Abuse Death Review is a statewide multidisciplinary, multiagency child abuse death assessment and prevention system that consists of state and local review committees. The requirements and expectations are outlined in section 383.402, Florida Statutes.

Florida Child Abuse Death Review Committee:

- established by statute in 1999
- administered by the Florida Department of Health
- utilizes state and locally developed multidisciplinary committees to conduct detailed reviews of the facts and circumstances surrounding child abuse and neglect deaths.

Section 383.402, Florida Statutes

- The purpose of the child abuse death review process is to:
- Develop a community-based approach to address child abuse deaths and contributing factors.
- Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse or neglect.
- Identify gaps, deficiencies or problems in the delivery of services by public and private agencies to children and their families. The services may be related to child abuse deaths.
- Develop and implement data-driven recommendations for reducing child abuse and neglect deaths.

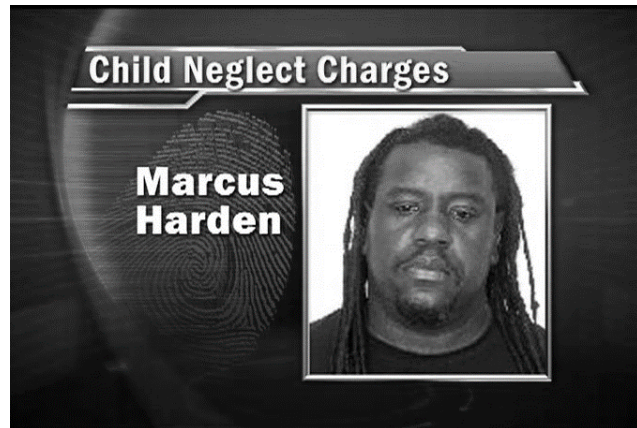
Father of murdered infant charged with child neglect

Marcus Harden, 38, was arrested and charged with child neglect on Wednesday.

TAMPA --

The father of an infant police said was murdered by her mother is facing child neglect charges.

Marcus Harden, 38, was arrested and charged with child neglect on Wednesday. Police said Harden left 4-month-old Markala Thompson alone with her mother, Eboni Shameeca Thompson, 31, who was not allowed to be unsupervised with the child.



Detectives said they learned Eboni Thompson was living in the home with the child despite a court order barring her from doing so.

Investigators said Harden left the baby in Thompson's care for 15 minutes on Dec. 14, even though he was aware she was not supposed to be with the children.

While Harden was away from the home, Thompson choked the crying infant until she stopped breathing, police said.

The medical examiner said the little girl had also suffered multiple broken ribs and a broken arm.

Thompson was arrested on Dec. 17 and charged with first-degree murder and two counts



of aggravated child abuse. Police said she admitted to abusing the baby several times over the past four months. Tampa police also said an autopsy found the baby, 4-month-old Markala Thompson, had three broken ribs and a broken arm from a previous injury. Thompson also is charged with two counts of aggravated child abuse.

Four other children who were living with Harden - three girls, ages 17, 6 and 4, and a 21-month-old boy - are in the custody of the Department of Families and Children.

Child Fatality Prevention Website

- Created to raise public awareness about child fatalities throughout the state
- Assists communities with identifying where additional resources or efforts are needed to assist struggling families
- Includes information regarding all child fatalities called into the Florida Abuse Hotline alleged to be a result of abuse or neglect
- Data can be sorted and viewed by county, child's age, causal factor and prior involvement.
- Cases listed as verified indicate that enough evidence exists to determine that the child's death was caused by abuse, abandonment or neglect.
- Prior involvement indicates that the deceased child or the family of the deceased child had contact with Florida's child welfare system. This could have been through a child protective investigation conducted by DCF or one of six sheriff's offices and/or foster care or family support services provided by one of Florida's Community-Based Care lead agencies.
- Also includes information about DCF's prevention campaigns relating to the leading causes of child fatality in Florida—unsafe sleep, drowning and inflicted trauma.
- Child Fatality Prevention Website: www.myflfamilies.com/childfatality/

Pool Safety

- Florida leads the nation for children ages 1-4 who drown in pools; 79 children ages 0-5 drowned in 2012.
- The 10 Florida counties with the highest rates of childhood drowning between the ages of 1 and 4 were:
 - Brevard
 - Broward
 - Charlotte
 - Hillsborough
 - Miami-Dade
 - Orange
 - Osceola
 - Palm Beach
 - Pinellas
 - Polk.
- An alarming number of pool drowning's occur annually despite CADR recommendations:
 - Pool alarms
 - Fences
 - Locked gates
 - Other protective barriers.

- Many investigations have revealed that the caregivers were distracted, using the Internet or other computer-related activities, and/or were impaired by substance abuse.
- Bath tubs are the second most common bodies of water to claim children by drowning and can occur with very little standing water.

High Temperatures and Hot Cars

In just 10 minutes, the temperature of a parked vehicle can rise 20 degrees.

- The crack of a window, even by inches, is no match to combat the rising heat.
- This heat can be deadly, especially for children whose body temperatures rise five times faster than adults.

Children can easily be left behind in the car when parents are distracted, rushing and multi-tasking, or have a change in routine.

- This is especially true during the summer months when kids are out of school and may have a different caretaker or driver.

In the state of Florida, it is a criminal offense (see F.S. 316.6135) to leave a child unattended in a vehicle.

- Anyone who sees a young child, vulnerable adult or animal left unattended in a vehicle should call 9-1-1 immediately.
- Leaving a child younger than 6 years of age unattended or unsupervised in a car for longer than 15 minutes is a second degree misdemeanor.

Safe Sleeping

Some characteristics of a safe sleeping environment:

- Baby sleeps alone
 - No secondhand smoke
 - No pillows, stuffed animals, toys or bumper pad
 - If using a blanket, it must be tucked in and only as high as the baby's chest
 - No heavy or loose blankets
 - Crib sheets fit tightly over mattress
 - On a firm mattress
 - In a safe, infant bed
 - Not too hot
 - On his/her back
 - "Feet to foot" (Position the baby so his feet are near the foot of the crib.)
-
- Sudden Unexpected Infant Death (SUID): the sudden and unexpected death of an infant under 1 year of age, which remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene and review of the clinical history
 - There has been a significant decrease in the numbers of infant deaths certified as SUIDS in Florida and nationally in recent years since it has been recognized that unsafe sleeping conditions put infants at a greater risk for sudden death.
 - There are factors related to infant sleeping positions and sleeping environments that increase the risk of infant death from asphyxia due to suffocation or overlay. These factors include:
 - prone sleeping position
 - bed-sharing (co-sleeping, particularly with individuals who are under the influence of drugs and/or alcohol, those who are obese or who are exhausted)
 - soft bedding.

When is it NOT Neglect?

As defined in section 39.01, F.S., it is NOT neglect when:

- Caused primarily by financial inability, unless actual services have been offered and rejected.

OR

- The parent/legal guardian is legitimately practicing his religious beliefs under a recognized church or religious organization and thereby does not provide specific medical treatment for a child. For that reason alone a parent must be considered a negligent parent or legal custodian.

What can the Court do?

The court can order that services be provided when the health of the child requires:

- Medical Services from a licensed physician, dentist, optometrist, podiatrist or other qualified health care provider; or
- Treatment by an accredited practitioner who relies solely on spiritual means for healing under the tenants and practices of a well-organized church or religious organization.

Child Maltreatment Index

ENVIRONMENTAL HAZARDS

DEFINITION

Environmental hazards are situations where a child is permitted to live in an environment that causes or creates a significant risk of impairment of the child's physical, mental, or emotional health due to the actions or non-actions of the caregiver. The environmental hazards maltreatment includes hazardous conditions and inadequate shelter, clothing or food.

Hazardous Conditions: The child's person, clothing, or living conditions are unsanitary or dangerous to the point that his/her well-being is or may be impaired as the result of the caregiver(s)'s failure to take action to correct the conditions.

Inadequate Shelter: Failure to seek or provide a physical or structural shelter which is safe, healthy, and sanitary and which protects the child from the elements (weather conditions) or other risk situations.

Inadequate Clothing: The periodic or continuing failure to provide adequate clothing for the health and well-being of the child, although reasonably financially able to do so. Inadequate clothing means that the person(s) responsible for the child is, or has been depriving the child of necessary clothing. The caregiver(s) have the means or are provided with the means to provide adequate clothing, but fail to do so. This maltreatment is not a measure of style, fashion, or quantity, but is meant to ensure that a child has sufficient clothing for his/her health and well-being.

Inadequate Food: The caregiver(s) have failed to provide or have available adequate amounts of food. If extended over time, inadequate food can lead to malnutrition or failure to thrive.

**Environmental hazards generally are a symptom of deeper underlying problems with caregiver(s) neglect and lack of stimulation. Further evaluation of the caregiver(s) is warranted to determine underlying causes.

ASSESSING "ENVIRONMENTAL HAZARDS" AS MALTREATMENT

- What is the child's age, medical condition, behavioral, mental, or emotional problems, developmental disabilities, and/or physical handicaps?
- Has there been recent weight loss or a deterioration in appearance observed?
- Has prolonged poor personal hygiene led to health problems?
- What is the caregiver(s)'s age, mental and emotional development level?
- When did the reporter last see the child or environment?

- What is the severity, frequency, and/or duration of the conditions?
- Is there a pattern of similar incidents involving the child, siblings, or other children associated with the caregiver(s)?
- Are there weather conditions that may exacerbate the situation such as extreme heat or cold?
- Is it suspected a child is living in a home where drugs are being manufactured or distributed?
- What other safety issues exist in the home?

ASSESSING FOR OTHER MALTREATMENT

- Assess for acceptance as a special conditions Parent Needs Assistance referral if the reporter has not recently observed the child or environment and there are no current risks identified.
- Accept a Parent Needs Assistance referral for situations where it has been reported that a family is homeless.

EXCLUDING FACTORS

An allegation of homelessness by itself is not a sufficient reason to accept a report of “Environmental Hazards.” The information obtained from the reporter must be thoroughly assessed by the Hotline counselor to make this determination.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Investigator’s observations of child and environment.
- Documentation of the environment to include photographic evidence.
- Obtain and consider any reports and interviews from law enforcement.
- Determine how much control the parent(s) have over the conditions (for example, is the landlord trying to control infestations or get repairs made?).
- Information obtained from relevant collateral contacts that may include school teachers, neighbors, and the landlord.
- Documentation of a pattern of similar reports involving environmental hazards related to the caregiver(s).

INADEQUATE SUPERVISION

DEFINITION

Inadequate supervision is leaving a child without adult supervision or arrangement appropriate for the child's age or mental or physical condition, so that the child is unable to care for his/her own needs or another's basic needs or is unable to exercise sufficient judgment in responding to any physical or emotional crisis. This includes situations where a child has been placed in a situation or circumstances which are likely to require judgment or actions greater than the child's level of maturity, physical condition, or mental abilities reasonably dictate, and a potential threat of harm to the child is present.

**There is no age stated in Florida Statute after which a child can be left unattended or alone. There are also no established time frames for how long a child of any given age can be left alone. Each situation must be assessed focusing on the specific child, caregiver(s), and incident factors.

ASSESSING "INADEQUATE SUPERVISION" AS MALTREATMENT

- What is the age, maturity and developmental stage of the child particularly related to the ability to make sound judgments?
- What is the frequency and duration of the occurrence?
- What is the time of day or night when the incident occurred?
- Are the caregiver(s) accessible by telephone and the child mature enough to know when and how to use the telephone to contact the caregiver(s)?
- How accessible are the caregiver(s) to the child? Can the caregiver(s) see and/or hear the child?
- What is the proximity to the child of other responsible persons?
- Has sufficient food and provisions been left for the child?
- Are the caregiver(s) out of direct supervision of the child and there are factors that create risk based on the age, developmental level, or disabilities of the child (for example, riding a bicycle in the street after dark)?
- Has a child been left alone when s/he has a condition that requires close supervision, such as a medical condition, behavioral, mental or emotional problems, developmental disabilities, or physical disabilities?
- Has a child been left at home alone or unattended in a place which is unsafe?
- Is the child on medication that cannot or should not be self-administered by a child?

- Have the caregiver(s) arranged for secondary caregiver(s) deemed inappropriate or inadequate due to a known history of violence, substance abuse, emotional instability, immaturity, age, or other limitation which affect the ability to care for the child?
- Is there substance misuse issues related to the incident?

ASSESSING FOR OTHER MALTREATMENT

When there is an allegation of inadequate supervision due to alcohol or substance abuse assess for the “Substance Misuse” maltreatment.

EXCLUDING FACTORS

A situation where the only allegation is that the caregiver(s) are late picking up the child does not constitute “Inadequate Supervision.” Refer these calls to law enforcement.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Investigator’s observations of the child and environment.
- Documentation from any reports and interviews from law enforcement that includes 911 call out history.
- Documentation of harm that occurred or was likely to occur based upon the circumstances.
- Information from drug screen results if applicable.
- Documentation from interviewing the child and assessment of developmental, physical, and mental abilities relevant to incident.
- Documentation from interviewing the caregivers related to the incident.
- Documentation from interviewing witnesses to the incident or persons who know the family or situation well (for example, neighbors, family members, or landlord).
- Documentation of the environment to include photographic evidence.
- Consider patterns of similar reports involving inadequate supervision involving the caregiver(s).

Failure to Thrive (FTT)

Failure-to-thrive is a medical term used to diagnose infants who are underweight and malnourished.

Doctors compare the infant's weight and height to a chart of standard height/weight measurements for infants.

- Weight or height is below the 5th percentile of the population on a standard weight/height curve (some experts recommend 3rd percentile)
- Actual weight is 20% or more below the ideal weight for height
- Weight gain is significantly slower than normal
- Triceps skin-fold thickness (total body fat measurement) is below 15th percentile for the population
- Children at risk often come from families in which the mother has experienced maltreatment in her own childhood.
- This type of caregiver often has difficulty relating to others, may be chronically depressed, and often has feelings of being overwhelmed and inadequate.
- One study (Haynes, Cutler, Gray, O'Keefe and Kempe, 1983) found that caregivers of FTT infants tended to:
 - blame their babies for not gaining weight
 - interpreted the meaning of their babies' crying in negative ways
 - had difficulty bonding with their infants because they prioritized their own needs as more important.

Failure to thrive is not always a result of maltreatment. FTT can occur due to organic or non-organic reasons.

- Organic FTT results from congenital or genetic causes.
- Non-organic FTT results from action or non-action on the part of the caregiver.

Child Maltreatment Index

FAILURE TO THRIVE

DEFINITION

Failure to thrive is a serious diagnosed medical condition that is most often seen in young children. The child's weight for height, corrected for gestational age, falls significantly short of the average weight of typical children of that age. Height, head circumference, and motor development may also be affected by Failure to Thrive, but weight for height is the primary measure.

**For a report to be accepted as "Failure to Thrive" the allegation must come from medical personnel or from a reporter with medical documentation.

ASSESSING "FAILURE TO THRIVE" AS MALTREATMENT

Is the reporter a medical person or from a reporter with medical documentation with suspicion of "Failure to Thrive"?

ASSESSING FOR OTHER MALTREATMENT

Assess for "Environmental Hazards" or "Malnutrition" if the reporter is not a medical person or does not have the proper medical documentation.

EXCLUDING FACTORS

Do not accept a report for "Failure to Thrive" when the reporter is not a medical person or is a reporter without medical documentation. Assess for "Environmental Hazards" or "Malnutrition."

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team.

**A mandatory referral to CPT is required on all "Failure to Thrive" allegations.

- Review and documentation of the child's medical records to assess for prior medical issues involving this child.
- Review and documentation of any psychological examinations of the caregiver(s) if available.

Malnutrition/Dehydration

Child Maltreatment Index MALNUTRITION/DEHYDRATION

DEFINITION

Malnutrition is a lack of necessary or proper nutrition or liquids in the body caused by lack of access to food, inadequate food, lack of food or liquids, or insufficient amounts of protein, minerals, or vitamins.

**If a medical professional is making an allegation of malnourishment it shall be accepted by the Hotline as a report.

ASSESSING “MALNUTRITION/DEHYDRATION” AS MALTREATMENT

- Is the child not growing or has lost weight, and the reporter believes this is due to the child being fed insufficient amounts of food?
- Has there been a decrease in the child’s lean body mass or fat?
- Has there been a change in the child’s general appearance such as thinning hair, paleness, aged skin and/or bulging abdomen?
- Has there been a change in the child’s behavior (e.g. decreased school performance, alteration in consciousness, lack of interest to external stimuli)?
- Is the child frequently and repeatedly deprived of meals or is frequently and repeatedly fed insufficient amounts of food to sustain health?
- Does the child frequently and repeatedly asks neighbors for food or steals food, and other information indicates that the child does not receive enough food at home to sustain health?

EXCLUDING FACTORS

Frequently feeding a child fast food does not constitute “Malnutrition” unless the child has a medical condition requiring a special diet and the fast food is dangerous to his/her health.

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team and the child’s Primary Care Physician.

**A mandatory referral to CPT is required for all reports alleging “Malnutrition.”

- Documentation from interviewing and/or observing the caregivers and other children in the home, focusing on the nutrition that was provided to the alleged victim.
- Reviews and documentation from prior history of similar maltreatment or child medical problems in the family or by the perpetrator.

MEDICAL NEGLECT

DEFINITION

Medical neglect is when caregiver(s) have failed to provide dental, medical or psychiatric treatment for a health problem or condition which, if left untreated, could become severe enough to constitute serious or long-term harm to the child. This includes lack of follow through on a prescribed treatment plan for a condition which could constitute serious or long-term harm to the child.

**Inadequate financial ability alone is not medical neglect.

** Caregiver(s) who by reason of legitimate practice of religious beliefs do not provide specified medical treatment for a child may not be considered abusive or neglectful for that reason alone. However, this exception does not eliminate the requirement that such a report be made to the Hotline nor does it prevent the Department from conducting an investigation to determine harm.

** In situations where caregiver(s) refuse to allow a newborn to be tested for HIV and the mother has been diagnosed HIV positive, a report shall be accepted by the Hotline only when called in by medical professionals.

ASSESSING “MEDICAL NEGLECT” AS MALTREATMENT

- What are the child’s physical conditions and the seriousness of the current health problem?
- What is the probable outcome if the current health problem is not treated?
- What are the reasons offered for not getting treatment for the child?
- Has appropriate nutrition, hydration, medication, or other medically indicated treatment been withheld from newborn infants?
- Is a diaper rash being reported that has open or bleeding lesions that require professional medical attention and no such attention has been provided?
- Caregiver(s) failed to use a medical device that is prescribed by a physician when this results in reasonable cause to suspect the child is threatened with harm?

EXCLUDING FACTORS

- A lack of immunizations under current law or many minor conditions which under usual conditions have no potential for serious or long-term harm (such as head lice) does not constitute “Medical Neglect.”

- Not providing medication for a child diagnosed with ADHD or ADD does not constitute “Medical Neglect.”

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team and the child’s Primary Care Physician.

**A mandatory referral to CPT is required for all reports alleging “Medical Neglect.”

- Review and documentation of the child’s prior medical history and how/if follow-up was completed by the caregiver.
- Documentation of the proper administration of prescribed medications to include what the medication is prescribed for, what happens if the child does not take the medication, what is the potential harm, and pill count.
- Documentation of the family’s financial ability to obtain treatment.
- Documentation on the long-term potential harm due to the non-treatment.
- Documentation from interviewing the caregivers, focusing on their ability to understand the child’s health needs and to respond to those needs.

The Gavin Family

Gavin Scenario

The Gavin family is not new to the agency. On this occasion, a call was received, alleging that the children were begging for food. The Gavin family home is unkempt and dirty. The sagging couch was piled high with mixed loads of dirty and clean, unfolded laundry. The front window has a large piece of cardboard covering the broken-out pane. The greasy kitchen table holds remnants of food: an open loaf of bread, soggy cereal in bowls, and an opened can of potted meat that looks rancid.

Ms. Gavin is a divorced woman in her mid-30's and the mother of seven children. She is obese, weighing close to 300 pounds, and by her own admission, she seldom leaves the sofa. From her position on the couch, she talks on the telephone (mostly fending off bill collectors) and yells at the children when they cross her path. Ms. Gavin was the first-born child of a 16-year-old mother who ultimately had four children.

At about the age of 5, Ms. Gavin was placed in care after having been given up by her mother. She stayed institutionalized until the age of 10, when she was placed in a number of successive foster care homes. At the age of 16, she returned home to her mother for one year until she became pregnant with her oldest daughter, Joy, and moved out on her own. Joy is currently being raised by Ms. Gavin's mother, and Ms. Gavin has had no contact with either Joy or her mother in over two years. At the age of 18, Ms. Gavin began working in a poultry processing plant where she met "John," whom she had a relationship with for 12 years but never married because "he had a wife someplace else."

John is the father of the other six children, but seldom comes around anymore, according to Ms. Gavin.

Ms. Gavin expects the 11-year-old daughter, Jennie, to take care of all of the other children. Jennie is older and larger than any of the other fourth-graders in her school and is frequently absent. Her mother allows this and expects Jennie to cook and clean when Ms. Gavin is not present. Lately, Jennie has been leaving the house pretending to go to school and has been found wandering the city on two occasions.

The 7-year-old, Jimmy, also often stays home from school, but Ms. Gavin says she does not mind because he is her "little man around the house." However, she also says that she is concerned because he is failing in school and has no friends. Both Jennie and Jimmy have a speech impairment that makes it difficult to understand them and for which they are receiving special services at school.

The four preschoolers spend most of their day watching TV and squabbling. They seldom go outside. The children all bear the scars of a woman who cannot communicate joy, interest, or love. Yet, she clings to them tightly and says, "They are my whole life."

Chronic vs. Situational Neglect

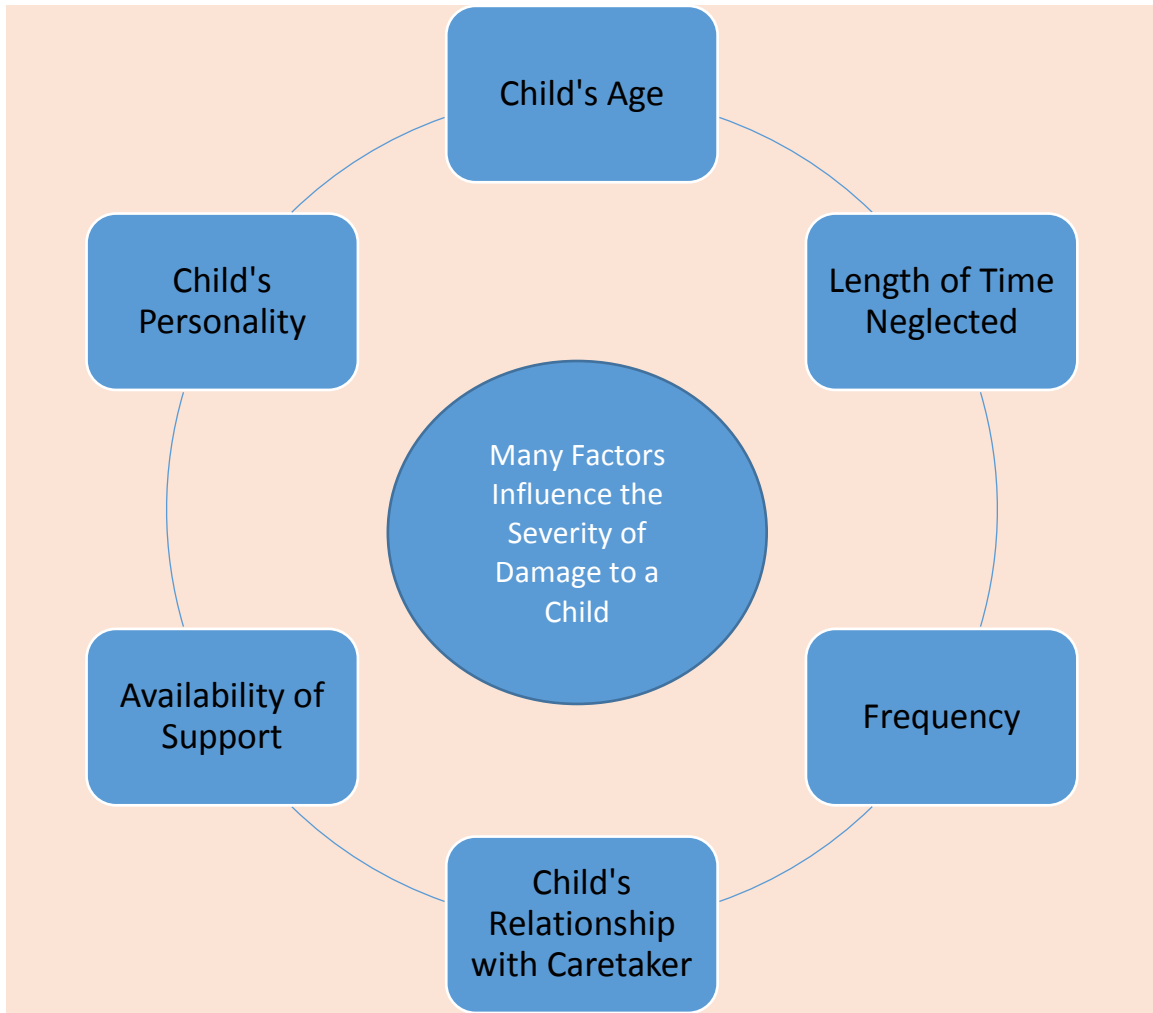
Crisis/Situational

- Parents fundamentally able to cope but temporarily overwhelmed
- Major crisis, or series of crises
- History of adequate child care
- Regular employment
- Sufficient income and skills
- Emotional support from friends and relatives
- Average problem-solving abilities
- Generally good physical health, minimal use of illegal substances, and essentially no illegal activity
- Adequate education and housing that allow for individual space and organization of belongings
- Intimacy is non-sexualized
- Acceptance of differences in opinion
- Understanding and acceptance of their respective roles
- Generally good mental health
- Likely to be cooperative with genuinely supportive child protection personnel
- Likely to regain ability to solve problems themselves when crisis has passed

Chronic

- Parents with continual and serious child-rearing difficulties
- Constantly in stressful situation or crisis
- Little parenting knowledge
- Limited education/vocational opportunities and skills
- Generational poverty
- Extreme social isolation
- Little support from relatives or friends
- Poor problem-solving skills; blame others
- Ill health, substance abuse, drug-dealing, legal problems, physical/developmental disability
- Overcrowded or run-down housing
- Prostitution
- Abuse between adults
- Untreated mental illness
- Parental history involves neglect as a child
- Distrustful of professional helpers
- New crises constantly arise even as old crises are resolved

Factors that Impact Neglect of a Child



Common Effects of Child Neglect

Infants

The effects of neglect in infancy are likely to result in failure to thrive, which can lead to death of the child. Other effects:

- lack of attachment to mother
- impaired brain, motor and physical development
- malnutrition, significant health problems
- development of anxious, insecure attachments in other relationships
- insecurity limits ability to explore environment
- development of feelings of incompetence

Toddlers

- extremely withdrawn and passive
- engage in random, undisciplined activity
- impaired brain, motor and physical development
- deficits in coping skills - displays frustration, anger and noncompliance
- attention/affection need sought indiscriminately from adults
- malnutrition, significant health problems

Kindergarten/School-aged Children

- lack of attachment
- significant health problems
- delayed or impaired speech
- developmental delays
- violent acts
- severely withdrawn
- inability to concentrate
- serious learning deficits and delays
- low self-esteem
- curiosity blunted, almost nonexistent

Adolescents

- low self-esteem
- poor school attendance
- work and learn below average levels
- high risk for delinquent behavior
- high risk for “ungovernable” behavior (e.g., truancy, running away, substance use/abuse)

Behavioral and Emotional Effects of Neglect

- **Developmental delays:** A large percentage of neglected children are developmentally delayed in all domains. The degree of delay is determined by comparing the child's developmental level with expected developmental achievements for the child's chronological age. Neglected children may display from mild to serious delays in physical/motor development, cognitive ability and school achievement, social skill and interpersonal relationships, and emotional development. Severely neglected children may become mentally challenged as a result.
- **Unresponsiveness:** Neglected children are often characterized as unresponsive, placid, apathetic, dull, lacking curiosity and uninterested in their surroundings. They do not approach other people, or exhibit a normal degree of exuberance in their interactions. They may not play, or they may play half-heartedly. In cases of serious neglect, the child may exhibit signs of depression.
- **Hunger/Fatigue:** Some older children who are inadequately fed use their own resources by scrounging for, or stealing and hoarding food.
- **Out-of-Control Behavior:** The child may be "out of control" due to an absence of limits from adult caretakers. The child exhibits a variety of behavior problems, anxiety, and other signs of emotional distress. A false bravado may be seen.
- **School Failure:** School failure may be an indicator of neglect, particularly when 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 present.
- **Physical Signs of Stress and Anxiety:** The child may show physical signs of stress and anxiety, including physical illness and regressive behaviors.
- **Aggression:** The child may be aggressive with other children, have temper tantrums, may be "touchy."
- **School-age child shows many of the same characteristics as the pre-school child:** The child's problems in relationships and developmental delays are more pronounced the longer he/she has been maltreated.
- **The child assumes the "adult" role in his/her relationship with the parent:** The child is often a "little helper," who cares for the parent, demonstrates excessive concern when the parent is distressed, is unusually compliant.
- **Difficulty in Relating:** The child has difficulty relating to other children and to adults. He may be manipulative, or withdrawn and distant. He may have angry, aggressive outbursts and temper tantrums.
- **Chronic Anxiety:** The child may appear to be "hyperactive," including having an unusually short attention span, an inability to concentrate. The child often does not do well in school and may appear to be "preoccupied."
- **Fear of the parents:** The child may demonstrate a fear of the parents or, in some cases, an absence of fear or concern in the face of parental or adult authority.

Behavioral and Effects on the Gavin Family

Check the box and briefly explain					
	Mr. Gavin	Ms. Gavin	Jennie	Jimmy	4 Children
Developmental delays					
Unresponsiveness					
Hunger/Fatigue					
Out-of-Control Behavior					
School Failure					
Physical Signs of Stress and Anxiety					
Aggression					
School-age same as the pre-school child					
The child assumes the "adult" role					
Difficulty in Relating					
Symptoms of Chronic Anxiety					
Fear of the parents					

Unit 6.3: Physical Abuse

Maltreatment Index and Physical Abuse

- Most of the time, you will not see the maltreatment occur.
- It will be the hotline counselor's responsibility to gain as much descriptive evidence of what the reporter has seen or heard in order to make a determination that an investigation of whether maltreatment has or is likely to occur is warranted. It will be the responsibility of the child protective investigator to make a true determination as to whether or not maltreatment has occurred or is likely to occur.

Florida Statutes 39.01(2): Abuse

- "...any willful act or threatened act that results in any physical, mental, or sexual abuse, injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions..."

Child Maltreatment Index Categories

- Asphyxiation
- Bone Fracture
- Burns
- Internal Injuries
- Physical Injury
 - Cuts, Punctures and Bites
 - Bruises, Welts
 - Dislocation
 - Skull Fracture, Brain or Spinal Cord Damage
 - Intra-Cranial Hemorrhage
- Physical Injury
 - Other, including:
 - Munchausen Syndrome by Proxy
 - Abrasions and Blinding/Eye Damage
 - Injury to Teeth and Jaws, Mouth and Lips
 - Damage to Ears/Hearing, Hair Pulling
- Excessive Corporal Punishment: Beatings
 - Battered Child Syndrome
- Poisoning
- Bizarre Punishment
- Malnourishment/Dehydration

Florida Maltreatment Index Definitions

Asphyxiation

“...the alteration in consciousness by a willful act of the caregiver(s) that may include suffocation and strangulation.”

Bone Fractures

“...any broken bone in a child that is caused by the willful action of a caregiver(s).”

Burns

“Injury resulting in damage to the skin through the willful action of the caregiver(s).”

Internal Injuries

“...an injury to the organs occupying the thoracic (chest) or abdominal cavities that is not visible from the outside. Internal injuries may be accompanied by other external injuries. A person so injured may be pale, cold, perspiring freely, have an anxious expression, seem semi-comatose, or exhibit other symptoms, such as lethargy, disorientation, blood in bowel movements or urine, and/or loss of consciousness.”

Physical Injury

“Physical injury includes any physical maltreatment of a child that is not covered by other abuse maltreatment that results in permanent or temporary disfigurement, permanent or temporary loss or impairment of a bodily part or function, or is a willful act or threatened act that causes or is likely to cause the child’s physical health to be impaired.”

Bizarre Punishment

“Bizarre punishment is caused by a willful act of a caregiver(s) that includes inflicting or subjecting a child to intense physical or mental pain, suffering or agony that is repetitive, increased, prolonged, or severe. Bizarre punishment also includes confinement, torture, and inappropriate/excessive use of restraints or isolation.”

Malnutrition/Dehydration

“A lack of necessary or proper nutrition or liquids in the body caused by lack of access to food, inadequate food, lack of food or liquids, or insufficient amounts of protein, minerals or vitamins.”

- If a medical professional is making an allegation of malnourishment, it must be accepted by the Hotline as a report.

Most Life Threatening Physical Abuse

Any abuse resulting in head injuries, particularly:

Head injuries

- Subdural hematomas
- Abusive Head Trauma: serious, often fatal injuries caused by violent shaking of a very young child.
 - Shaken infants - do not often show visible signs of external trauma.
 - Generally seen in children 2 years of age or younger- most common in children less than 6 months of age.
 - Three main signs: 1) subdural hematoma; 2) retinal hemorrhage; 3) metaphyseal lesions.

Other forms of life-threatening physical abuse

- Battered Child Syndrome
- Internal injuries
- Burns, both non-intentional and abusive. One of the most common causes of death in children. Most commonly burned in the bathroom, and are at risk during toilet training.
- Weapon injury
- Poisoning: about 17% of children who are poisoned die.

Child Abuse Critical Indicators

When considering whether or not the child has been physically abused, section 39.01(30)(a), F.S., states that when the child appears to have had physical abuse inflicted on him or her, it is important that the child be evaluated for physical, mental or emotional injury. The factors to be considered include:

- The age of the child.
- Any prior history of injuries to the child.
- The location of the injury on the body of the child.
- The multiplicity of the injury.
- The type of trauma inflicted.

The Child Protection Team Section 39.303, F.S.

- In every district in Florida, there are Child Protection Teams (CPT) of professionals to help child welfare professionals in their work with families.
- The Child Protection Team program is a medically directed, multidisciplinary program that works with local Sheriff's offices and DCF in cases of child abuse and neglect to supplement investigation activities.
- CPTs provide expertise in evaluating alleged child abuse and neglect, assessing risk and protective factors, and providing recommendations for interventions to protect children and enhance a caregiver's capacity to provide a safer environment when possible.
- If child abuse or neglect is reported to the Florida Abuse Hotline and accepted for investigation, the case is automatically eligible for CPT assessment. And many types of abuse or neglect must be referred for CPT assessment. (s. 39.303(2)(a)-(h), F.S.)
- Any sexually transmitted disease in a prepubescent child must be referred to the CPT in the geographic area in which the child is located.
- Other child abuse, abandonment and neglect reports to the Hotline that also must be referred to CPT include cases involving:
 - Injuries to the head, bruises to the neck or head, burns, or fractures in a child of any age.
 - Bruises anywhere on a child five 5 of age or younger.
 - Any report alleging sexual abuse of a child.
 - Reported malnutrition or failure of a child to thrive.
 - Reported medical neglect of a child.
 - Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.
 - A sibling or other child remaining in a home where one or more children have been pronounced dead on arrival at a hospital or have been injured and later died as a result of suspected abuse, abandonment or neglect.
- Once a referral from DCF or law enforcement has been accepted, the CPT may provide one or more of the following services:
 - Medical diagnosis and evaluation
 - Nursing assessments
 - Child and family assessments
 - Multidisciplinary staffing's
 - Psychological and psychiatric evaluations
 - Specialized and forensic interviews
 - Expert court testimony
- Child Protection Team staff also provide training services, including:
 - Training for child protection investigators and other community providers of child welfare services.
 - Training for emergency room staff and other medical providers in the community

Activity: Assessing Situations for Physical Abuse

Directions:

- Read the scenario.
- Identify and list the kinds of physical evidence in the scenario.
- Review *Is it Physical Abuse or Not?* and *Child Physical Abuse Critical Indicators* and identify which questions and actions might be useful to utilize in that particular scenario, being prepared to explain why they would be useful. For scenario 1, identify the questions and actions by checking box #1. For scenario 2, check box #2, and for scenario 3, check box #3.
- For scenarios 1 and 2, you will brainstorm these with the entire class. For scenario 3, participants will brainstorm in small groups, and then debrief as a class.

Activity Notes:

Is It Physical Abuse, or Not?¹

Fracture	
Is It Non-intentional?	Steps to Confirm
<ul style="list-style-type: none"> • Birthing trauma (fractured clavicles most common) • Little league elbow • Nurse-maid elbow • Fractures from passive exercises for therapeutic reasons 	<ul style="list-style-type: none"> • Consult with physician to decide cause of fracture. • <i>(Refer to Types of Fractures for a description of the different types of fractures.)</i> • Check for discrepancies between the fracture and the history provided by the caregiver.
Is it a Medical Condition?	Steps to Confirm
<ul style="list-style-type: none"> • Congenital syphilis • Infantile cortical hyperostosis (Caffey disease) • Leukemia • Menkes kinky hair disease • Osteogenesis imperfecta • Osteomyelitis • Rickets • Scurvy 	<ul style="list-style-type: none"> • A physician can use radiology to decide if a fracture exists and also to gain insight into how it was produced. • Request pediatric radiologist if possible. • It is critical to tell radiologist that child abuse is suspected. • X ray is fine for screening. • A bone scan can be used to reveal old, healed fractures caused by suspected abuse.
Burns	
Is it Non-intentional?	Steps to Confirm
<ul style="list-style-type: none"> • Spilling of a hot liquid 	<ul style="list-style-type: none"> • Check location of splash burns; non-intentional burns are most likely to occur on the front of the head, neck, trunk, and arms. It is usually possible to estimate the direction from which the liquid came and the position of the body. • Check for discrepancies between the appearance of the burn and the history provided by the caregiver.
Is it a Medical Condition?	Steps to confirm
<ul style="list-style-type: none"> • Brushing against a cigarette 	<ul style="list-style-type: none"> • Check location of burns; often non-intentional if found on child's face, arms or trunk. • Check shape of burn; usually non-intentional if burn is more elongated than round, with a higher degree of intensity on one side. • Check for discrepancies between the appearance of the burn and the history provided by the caregiver.

¹ Adapted from Smith, J.C., Benton, R., Moore, J.K., and Runyan, D. (1989). *Understanding the Medical Diagnosis of Child Maltreatment*, Denver: American Humane Association.

Is it a Medical Condition?	Steps to confirm.
<ul style="list-style-type: none"> • Impetigo • Insect Bites 	<ul style="list-style-type: none"> • Suspicious blisters are generally cultured by a physician to test for streptococcal infections that may be found with impetigo and treated with antibiotics. • Examine lesions: Impetigo lesions have various shapes and sizes; cigarette burns are symmetrical.
Is it Non-intentional?	Steps to Confirm
<ul style="list-style-type: none"> • Falling into a hot bath 	<ul style="list-style-type: none"> • Check for clear lines of demarcation; non-intentional burns have no clear line separating burned and unburned skin. • Check deepness of burn; non-intentional burns typically are not as deep as forced burns because an unrestrained child will rarely be unable to remove himself or herself from the burning environment. • Check to see if perineum and feet are burned, but not the hands; it is impossible for a child to non-intentionally fall into a tub without hands going into water. • Check for doughnut hole, parallel lines, and flexion burns; these burns may be indicative of abuse. • Check for discrepancies between the appearance of the burn and the history provided by the caregiver.
Is it a Medical Condition?	Steps to Confirm
<ul style="list-style-type: none"> • Staph Scalded Skin Syndrome (SSSS) • Toxic Epidermal Necrolysis (TEN) 	<ul style="list-style-type: none"> • Ask about symptoms of fever, malaise, and sore throat. • Check for mouth and nose crusting. • Ask about onset of medical condition.
<ul style="list-style-type: none"> • Coming into contact with a burning object 	<ul style="list-style-type: none"> • Check location of burn; some areas of the body are clearly more difficult for a child to self-inflict burn. • Check pattern of burn; an irregular burn will be left when a young child moves away from a burning object reflexively. • Check deepness of burn; non-intentional burns are usually deep on one edge of the burn. • Check margins of burn; non-intentional burns usually do not have crisp overall margins. • Check for discrepancies between the appearance of the burn and the history provided by the caregiver.
Is it a Medical Condition?	Steps to Confirm
<ul style="list-style-type: none"> • Varicella (chickenpox) 	<ul style="list-style-type: none"> • Check history. • Consult with physician.

Bruise	
Is it Non-intentional?	Steps to Confirm
<ul style="list-style-type: none"> • Non-intentional Falls 	<ul style="list-style-type: none"> • Check for location of bruises; bruises on knees, shins, forehead, or elbows are often non-intentional. • Check for bruises on the forehead; bruises to the forehead often drain through soft tissues to give appearance of black eyes 24-72 hours afterward, usually confirmed with history and when/if bruise is not tender. • Check to see if bruises are on a single surface or clustered; one bruise on a single surface is caused accidentally. • Correlate non-intentional incident with developmental age and motor skills of child. • Check for discrepancies between the appearance of the bruise and the history provided by the caregiver.
Is it a Medical Condition?	Steps to Confirm
<ul style="list-style-type: none"> • Hemophilia • Leukemia • Idiopathic thrombocytopenic purpura • Mongolian spots • Maculae ceruleae • Salmon patches • Hemangiomas (“strawberry marks”) 	<ul style="list-style-type: none"> • Have medical tests done to check bleeding function: prothrombin time (PT), partial prothrombin time (PTT), bleeding time, platelet count, and complete blood count (CBC). • Have histopathologic examination by physician. • Find out if spots were present at birth. • Check history; 90% of skin medical conditions are detected within the first month of life.
Bite Marks	
Is it Non-intentional?	<ul style="list-style-type: none"> • Check to see if flesh is torn or just compressed; torn flesh is commonly from a dog bite, and compressed flesh is commonly from a human bite. • Measure the distance between the center of the canine teeth, typically the third tooth on each side; if it is greater than 3 centimeters, the bite is most likely from an adult. • Check for discrepancies between the appearance of the injury and the history provided by the caregiver.

Head Injury	
Is it Non-intentional?	Steps to Confirm
<ul style="list-style-type: none"> • Birth trauma causing effusion, cephalohematoma, diffuse cerebral edema, infarction, cerebral contusions, post-traumatic hypopituitarism • Insect bite on head (usually forehead) 	<ul style="list-style-type: none"> • Check onset of injury; injuries from birth traumas should become apparent shortly after birth. • Check for discrepancies between the appearance of the injury and the history provided by the caregiver; subdural hematomas found in an infant or toddler without adequate explanation of trauma may be indicative of abuse.
Is it a Medical Condition?	Steps to Confirm
Infectious meningitis	<ul style="list-style-type: none"> • Check compatibility between the history and physical findings. • Consider child’s developmental maturity.
Hair Loss	
Is it a Medical Condition?	Steps to Confirm
<ul style="list-style-type: none"> • Trichotillomania • Tinea capitis (ringworm of the scalp) • Idiopathic of unknown cause (e.g., alopecia areata) • Nutritional deficiencies 	<ul style="list-style-type: none"> • Check to see if loss of hair is in a localized spot. • Varying bald spots may be indicative of abuse. • Localized spot is usually on back of the head. • A child will be at least 3 years-old for this condition to occur. • Check for scaly skin. • Fungal culture of scalp by physician. • Check history.
Eye Injury	
Is it Non-intentional?	Steps to Confirm
<ul style="list-style-type: none"> • Chemical burns • Non-intentional foreign body to the eye (e.g., sticks, sand, or paper edge) 	<ul style="list-style-type: none"> • Check for discrepancies between the appearance of the injury and the history provided by the caregiver.
Is it a Medical Condition	Steps to Confirm
<ul style="list-style-type: none"> • Sub-conjunctival hemorrhaging during birth • Allergy conditions (“allergic shiners”) 	<ul style="list-style-type: none"> • Sub-conjunctival hemorrhaging during birth usually disappears by one month. • Check history

Ear Injury	
Is it Non-intentional?	Steps to Confirm
<ul style="list-style-type: none"> Injury from inserting cotton swab 	<ul style="list-style-type: none"> Check if laceration is of the ear canal; this injury can occur only by inserting a pointed object into the ear. Check for discrepancies between the type of or appearance of the injury and the history provided by the caregiver.
Nasal Injury	
Is it Non-intentional?	Steps to Confirm
<ul style="list-style-type: none"> Injury from inserting foreign bodies into the nose 	<ul style="list-style-type: none"> Check to see if foreign bodies are found in more than one site; if found only in nose, this is common in the developing child. Check for discrepancies between the appearance of the injury and the history provided by the caregiver.

Child Physical Abuse Critical Indicators

Behavioral and Emotional Indicators of Physical Abuse

There are many variables that affect the child’s response to maltreatment and the effects of maltreatment on the child’s development.

1	2
<input type="checkbox"/>	<input type="checkbox"/> The age of the child when the maltreatment begins <ul style="list-style-type: none"> • The younger the child when first abused, the more likely the child will have serious developmental problems from the maltreatment.
<input type="checkbox"/>	<input type="checkbox"/> The length of time the child is maltreated <ul style="list-style-type: none"> • The greater the period of time the child is maltreated, the more severe the developmental outcomes will be.
<input type="checkbox"/>	<input type="checkbox"/> The frequency of the maltreatment <ul style="list-style-type: none"> • The more often the child is abused, the more pervasive the effects will be.
<input type="checkbox"/>	<input type="checkbox"/> The nature of the child’s relationship with the abuser <ul style="list-style-type: none"> • The closer the relationship of the abuser to the child, the more likely the child will be negatively affected. Abuse by a parent has significant, long-lasting consequences.
<input type="checkbox"/>	<input type="checkbox"/> The type of maltreatment <ul style="list-style-type: none"> • The more severe the pain and the greater the injury inflicted on the child, the more negative the psychological, as well as the physical, outcomes will be.
<input type="checkbox"/>	<input type="checkbox"/> The availability to the child of support <ul style="list-style-type: none"> • The presence of other, non-abusing adults who can provide proper care and nurturance, either in the home or easily available to the child, can help to mediate the negative effects of abuse.
<input type="checkbox"/>	<input type="checkbox"/> Constitutional factors <ul style="list-style-type: none"> • The child’s basic personality and temperament can affect the outcomes of abusive treatment. • Some children are more resilient than others and have unusual coping strengths. Other children are more vulnerable.
<input type="checkbox"/>	<input type="checkbox"/> Young children who have been abused severely and at an early age <ul style="list-style-type: none"> • May display pervasive indicators of developmental delay and typical developmental patterns.
<input type="checkbox"/>	<input type="checkbox"/> The child may be remote, withdrawn, lacking in curiosity, compliant, and detached; the child may not relate to other people.
<input type="checkbox"/>	<input type="checkbox"/> The child may whine, whimper, or cry, with no expectation of being comforted. <ul style="list-style-type: none"> • The child may not look to adults for help.

1	2
<input type="checkbox"/>	<input type="checkbox"/> A state of 'frozen watchfulness' has been noted in severely abused children <ul style="list-style-type: none"> • They remain emotionally withdrawn and uninvolved, but watch carefully what is going on around them.
<input type="checkbox"/>	<input type="checkbox"/> They may exhibit discomfort with or fear of physical contact
<input type="checkbox"/>	<input type="checkbox"/> Severely abused children may appear to be autistic <ul style="list-style-type: none"> • Many do not relate in typical ways to the people and objects in their environment. • Most seriously abused infants show serious delays in all areas of development.
<input type="checkbox"/>	<input type="checkbox"/> The child may display a forlorn, clinging dependency, but may be lacking in healthy attachment to any adult, and may appear unable to attach in healthy ways.
<input type="checkbox"/>	<input type="checkbox"/> The child may appear depressed, or display flat affect and lack of emotion. He/she may not: <ul style="list-style-type: none"> • Cry or respond when in pain or when injured • Show any enjoyment. • Smile or play.
<input type="checkbox"/>	<input type="checkbox"/> Pre-school-aged children who have been abused may display the following characteristics. They may: <ul style="list-style-type: none"> • Be timid, easily frightened. • Duck, cringe, flinch, withdraw, attempt to get out of the way, or otherwise exhibit fear of the parent.
<input type="checkbox"/>	<input type="checkbox"/> The child may be very eager to please, may crave affection, and may show indiscriminate attachment by becoming affectionate with anyone, including strangers.
<input type="checkbox"/>	<input type="checkbox"/> Early signs of role reversal may be present. The child may: <ul style="list-style-type: none"> • Try hard to meet the parent's needs. • Demonstrate a clingy attachment and verbalize love for the abusing parent.
<input type="checkbox"/>	<input type="checkbox"/> The abused adolescent may show behavior problems: <ul style="list-style-type: none"> • Lying, stealing, acting out, and other aggressive behaviors. • Use of alcohol or drugs. • Truancy, including repeatedly running away and refusing to go home. • Generalized difficulty in entering into and sustaining interpersonal relationships.

Injuries and Evidence

1	2
	Does the child experience frequent injuries?
	Does the child have multiple bruises and injuries?
	Are the child's bruises and injuries in inaccessible places?
	Are the child's injuries at different stages of healing?
	Are the child's injuries inconsistent with the adult's explanation?

Physical Clues: How to Check the Injury

1	2
	Refer to the Child Maltreatment Index.
	Consider the location of the injury on the child's body.
	Look at the skin, which may be the first identifiable location for abuse and the most accessible location for non-health professionals to inspect for trauma.
	Check other areas of the child's body, not just the area of the injury.
	Consider the shape and appearance of the marks or other injuries.

Child Vulnerability

1	2	3
		Is the child 5-years-old or younger?
		Have there been prior intakes/investigations?
		Has there been limited access to or contact with the child by the outside world?

Target Child Factors

1	2
	Is there no observable sign of bonding with the target child?
	Does the child have flat or depressed affect?
	Does the child lack peer relationships?
	Has the child been subjected to unusual forms of discipline?
	Is the only type of discipline used physical?
	Does the child exhibit behaviors indicative of abuse and neglect?
	Is the child secretive about his or her injuries?

Parent/Caretaker Characteristics

Does the parent/caregiver:

1	2
	Portray a sociopathic personality (overly charming, extremely cooperative), externalizing role in abuse or other problems (“not my fault,” smooth talker)?
	Appear to make extreme progress (always pleasing, complete/appear to complete assignments quickly, give the right answers all the time)?
	Tell you what you want to hear?
	Display violent and aggressive behavior (domestic violence reports, other police reports, charges involving violence, etc.)?
	Have unrealistic expectations of the child?
	Appear to be alienated from the family with no family support network?
	Appear to be isolated, lacking in social contacts, such as friends or having activities?

Child/Caregiver Behaviors

Interview parents separately and look for the following behaviors:

1	2
	Shows inappropriate concern given the nature and severity of the child's condition or injury.
	Is extremely compliant/cooperative (This behavior might be an indicator of abuse when considered along with other factors. "If I say what they want to hear, they'll go away.")
	Exhibits explosive or threatening behavior when discussing possible maltreatment.
	Accuses the other parent or a child in the household.
	Contradicts the story of the other parent.
	Describes a minor accident, yet major injuries have occurred.
	Dates the injury differently from the clinical dating.
	Describes behavior impossible for the child's development.
	Explains the injury by being evasive or vague.

Parent/Caretaker History

Does the parent/caregiver's history indicate or portray:

1	2
	Maltreatment as a child?
	Alcohol or other substance abuse?
	Mental illness?
	Frequent moves?
	Job instability?
	Criminal history?

Parent/Caretaker Relationship(s)

Do the parent/caregiver's relationship(s) characteristics include:

1	2
	Boyfriends/girlfriends drifting in and out of the home?
	A relationship that takes precedence over the child's needs (e.g., the adult's needs come first)?
	An imbalance of power?
	Domestic violence?
	No clear identification of roles?
	Open hostility and/or negative perceptions?

Adult Behaviors Indicative of Child Abuse

Does the adult:

1	2
	Call a child by offensive names or chronically ridicule the child?
	Perform willfully malicious/violent acts directed toward a child's possessions, pets, or environment?
	Use crude, brutal, or severely misguided actions in the attempt to gain submission or enforce maximum control to modify a child's behavior?
	Have unrealistic expectations that are inappropriate to the child's developmental level?
	Have a need to always be in charge, or always be critical?
	Totally reject a child or have obvious preference for one child over another?
	Have distant, shallow, or superficial relationships with family members, or arise isolated from society?
	Act extremely disappointed regarding the baby's gender?
	Demonstrate a failure to bond with his/her infant?
	Suffer from acute tension, encounter chronic crises, or appear to be easily frustrated?
	Demonstrate poor impulse control?
	Often blame the child for problems?
	Provide inaccurate, illogical, or conflicting explanations for a child's injury?
	Expose a child to a hostile or dangerous situation?
	Fail to protect a child from inflicted injury?
	Abuse substances to the degree that he/she is unable to provide adequate care?

	Beat or corporally punish a child so that it leaves or it is likely to leave an injury?
	Kick, scratch, or punch a child?
	Hit or slap an infant?
	Pull a child's hair?
	Over-medicate or poison a child?
	Tie a child's limbs together or to an object?

Physical Environment

Does the physical environment portray any of the following?

1	2
	An environment that poses a safety risk (such as electrical or fire hazards, weapons)
	A sleeping area for the child that is inappropriate
	A child who is removed from others during common activities, such as eating, sleeping, etc.
	A home that is physically isolated, such as being far away from other homes/people
	An unsecured swimming pool (since drowning is the leading cause of neglect deaths [inadequate supervision] annually in Florida) ***You must be aware of drowning risk factors when there are bodies of water or a pool on the premises or close by the home, and you must include these factors in any safety plans, etc. that are developed with the family.*** (See questions below on Drowning/Inadequate Supervision.)

Factors to Consider on Drowning/Inadequate Supervision

1	2
	Was the pool in safe condition? Was the pool water murky or unkempt?
	Were there layers of protection, such as locks on doors that are out of reach of the child, pool alarm, pool fence, etc.?
	How did the child get access to the pool?
	Were the locks/layers of safety being used?
	Was this the child's residence or relative's, friend's, vacationing home, etc.?
	Was the caregiver under the influence of drugs (prescribed or otherwise)/alcohol?
	Is there a criminal history or DCF history of drugs/alcohol?
	Is there evidence of alcohol or drug paraphernalia observed?

	Has the child gotten into the pool area alone before?
	Does the parent have a developmental impairment?
	Does the child have any delays or impairment, such as autism?
	Are there priors of inadequate supervision and/or substance misuse?
	Collateral contacts of neighbors on supervision issues in past – unreported?
	If the parent was sleeping, had he/she been diagnosed as depressed and taking medication, past or present?
	Who was designated to watch the child? If a child, what is the relationship and how old is the child?
	Has code enforcement been involved?
	Did caretaker know how to swim?
	Did the child know how to swim?
	Did the caretaker know CPR?

Factors to Consider on Intentional Physical Abuse Cases

Questions to consider with intentional physical abuse:

	Who called 911?
	Was it delayed? Did alleged perpetrator call someone else before calling 911?
	Check cell phone and text records.
	Did the caregiver/alleged perpetrator drive to the hospital? If yes, what is the distance – how long would it take for EMS to arrive?
	Initial statement, child stopped breathing, found unresponsive, sick, accidentally dropped or fell on child?
	Where was mom and dad? If at work, what type of work does mom/dad do?
	Was alleged perpetrator employed, or was he/she full-time caretaker?
	Were they working in shifts?
	Were finances for day care an issue?
	How long had mom/dad known alleged perpetrator?
	What was motivating factor – crying, toilet-training, illness?
	What was the activity of the alleged perpetrator right before the crying started?
	Did alleged perpetrator have a DV history, criminal history?
	Was alleged perpetrator on probation, past or current?
	Was alleged perpetrator on probation, past or current?
	Was mom/dad aware of abuse or suspect?
	Has he/she seen any previous bruises while in alleged perpetrator's care, or child fearful?
	What was her/his reason for alleged perpetrator watching child (no day care, cannot afford, work schedule)?
	Has she/he been a victim of domestic violence in this situation or in the past?

Investigative Techniques for Physical Abuse

When assessing for physical abuse, use the following techniques:

<input type="checkbox"/>	Always investigate, even if the explanation seems plausible.
<input type="checkbox"/>	Check other areas of the child's body, not just the area of the injury.
<input type="checkbox"/>	Interview all subjects of the intake individually.
<input type="checkbox"/>	Check for and analyze all prior case histories and intakes.
<input type="checkbox"/>	Refer the child to CPT.
<input type="checkbox"/>	Notify Law Enforcement/SAO within mandated timeframes.
<input type="checkbox"/>	Interview all persons in the environment who may have information.
<input type="checkbox"/>	Gather information from school personnel and family physicians.
<input type="checkbox"/>	Get the child's version of what happened.
<input type="checkbox"/>	Always probe deeper with each piece of information you gather.
<input type="checkbox"/>	Each answer you receive is only one piece of the puzzle; it should spark another question or clue to investigate.
<input type="checkbox"/>	Always ask to see the physical source of the injury: iron, stove, burner, rope, etc.
<input type="checkbox"/>	Visit the site of the "accident."
<input type="checkbox"/>	Consider whether if physical environment and explanation for how the injury occurred match.
<input type="checkbox"/>	Visit and observe entire home environment for clues, especially child's bedroom.
<input type="checkbox"/>	Take photographs.

Activity – Assessing for Physical Abuse

1. **Scenario 1-** “Daniel”: We will read and solve this one together.
2. **Scenario 2-** “Matti”: We will read and solve this one together.
3. **Scenario 3-** “Melanie”: Each group will read through this and analyze the situation. We will then debrief as a class.

Scenario One: “Daniel”

Daniel was taken to the emergency room by his mother and a neighbor who heard him crying hysterically. The neighbor had knocked on the door of the home and found his mother, Adella, home, and little Daniel walking around without a shirt on. The neighbor said she saw the imprint of a burn on his back that was in the shape of an iron. While she was in the home, Daniel continued to cry hysterically.

Adella told the neighbor that Daniel, age 3, pulled the ironing board over and was hit by the falling, hot iron. The neighbor offered to drive Adella and Daniel to the hospital. Daniel was very dizzy, sleepy, and appeared confused.

At the hospital, the nurse looked at Daniel’s unclothed back and saw the clear imprint of an iron on Daniel’s upper back. The skin was red and blistered, and the burn had not been treated in any way. The physician who examined Daniel was concerned and talked with Adella.

During their conversation, Adella said Daniel wandered into the living room while she was changing clothes to go to work. She said she heard the ironing board fall over, but did not become concerned, because Daniel was “always into something.” Adella said she thought he was crying, because he was “having a tantrum,” and she ignored him as she continued to get ready for work. The neighbor knocked on the door just before she was going to leave for work.

The physician admitted Daniel, because the extent and depth of the burn required extensive hospital treatment. Further examination showed that Daniel had a small bruise on his forehead. Adella said Daniel rolled off the couch when he was watching television last night.

What was the physical evidence you identified?

Which items did you use to assist in your thinking process?

What was the extent of the maltreatment? (Write relevant bullet point notes under each item.)

<input type="checkbox"/> Type of maltreatment	<input type="checkbox"/> Description of emotional & physical symptoms
<input type="checkbox"/> Severity of maltreatment	<input type="checkbox"/> Identification of the child & maltreating caregiver
<input type="checkbox"/> Description of specific events	<input type="checkbox"/> Condition of the child

What were the circumstances surrounding the maltreatment?

Circumstances Surrounding Maltreatment	Your Notes
<input type="checkbox"/> The duration of the maltreatment	
<input type="checkbox"/> History of maltreatment	
<input type="checkbox"/> Patterns of functioning leading to or explaining the maltreatment	
<input type="checkbox"/> Parent/legal guardian or caregiver intent concerning the maltreatment	
<input type="checkbox"/> Parent/legal guardian or caregiver explanation for the maltreatment and family conditions	
<input type="checkbox"/> Unique aspects of the maltreatment, such as whether weapons were involved	

<input type="checkbox"/> Caregiver acknowledgement and attitude about the maltreatment	
<input type="checkbox"/> Other problems occurring in association with the maltreatment	

What other professionals must be notified to verify the abuse or accidental injury?

Scenario Two: "Matti"

EMS took in 4-month-old Matti to the hospital after her mother came home from work and found her daughter in the crib having seizures when she looked in on her after getting home. She asked her boyfriend what happened to the baby, and he said he did not know. He reported that he fed her, but she wouldn't stop crying for a long time. So he decided to just put her in her crib anyway, because he could not get her to stop crying.

At the hospital, the doctors did a number of diagnostics and discovered a subdural hematoma (bruising under the scalp area) and a number of areas of bleeding in the brain. The baby was diagnosed with inflicted head trauma. There were no other options or diagnosis to explain the child's internal brain injuries. At the hospital, due to the internal brain swelling, the baby required a shunt to release fluid, and there were concerns of possible long-term damage that may not be known for some time. There are possibilities of full recovery or equally of long-or short-term difficulties with sight, neurological impairments for short-or long-term, possible speech impairments or other consequences. Baby was admitted to ICU and placed in a medical coma while further testing and efforts were made to decrease swelling that would potentially cause future and further damage.

What was the physical evidence you identified?

Which items did you use to assist in your thinking process?

What was the extent of the maltreatment? (Write relevant bullet point notes under each item.)

<input type="checkbox"/> Type of maltreatment	<input type="checkbox"/> Description of emotional & physical symptoms
<input type="checkbox"/> Severity of maltreatment	<input type="checkbox"/> Identification of the child & maltreating caregiver
<input type="checkbox"/> Description of specific events	<input type="checkbox"/> Condition of the child

What are the circumstances surrounding the maltreatment?

Circumstances Surrounding Maltreatment	Your Notes
<input type="checkbox"/> The duration of the maltreatment	
<input type="checkbox"/> History of maltreatment	
<input type="checkbox"/> Patterns of functioning leading to or explaining the maltreatment	
<input type="checkbox"/> Parent/legal guardian or caregiver intent concerning the maltreatment	
<input type="checkbox"/> Parent/legal guardian or caregiver explanation for the maltreatment and family conditions	
<input type="checkbox"/> Unique aspects of the maltreatment, such as whether weapons were involved	
<input type="checkbox"/> Caregiver acknowledgement and attitude about the maltreatment	
<input type="checkbox"/> Other problems occurring in association with the maltreatment	

What other professionals must be notified to verify the abuse or accidental injury?

Scenario Three: “Melanie”

Melanie, age 7, was taken to the local walk-in clinic by her father, Lenny, and his girlfriend, Renee, because Melanie had a sore ear. The doctor examined Melanie and found she had otitis media — a common ear infection in young children.

She was in a lot of pain, and the doctor found her fussy and uncooperative during the examination. Lenny told the doctor that Melanie was “damn hard to control” and was “always whining about something.”

The doctor continued her examination, and she noticed some marks and what seemed like old scarring on Melanie’s shins, thighs and belly. Upon questioning and further examination, another was noted on Melanie’s upper back, but it was more acute and oozing with liquid. Melanie said it was ‘itchy’.

The doctor diagnosed that the old scars were from impetigo, as was the more acute lesion on her upper back.

What was the physical evidence you identified?

Which items did you use to assist in your thinking process?

What was the extent of the maltreatment? (Write relevant bullet point notes under each item.)

<input type="checkbox"/> Type of maltreatment	<input type="checkbox"/> Description of emotional & physical symptoms
<input type="checkbox"/> Severity of maltreatment	<input type="checkbox"/> Identification of the child & maltreating caregiver
<input type="checkbox"/> Description of specific events	<input type="checkbox"/> Condition of the child

What were the circumstances surrounding the maltreatment?

Circumstances Surrounding Maltreatment	Your Notes
<input type="checkbox"/> The duration of the maltreatment	
<input type="checkbox"/> History of maltreatment	
<input type="checkbox"/> Patterns of functioning leading to or explaining the maltreatment	
<input type="checkbox"/> Parent/legal guardian or caregiver intent concerning the maltreatment	
<input type="checkbox"/> Parent/legal guardian or caregiver explanation for the maltreatment and	

family conditions	
<input type="checkbox"/> Unique aspects of the maltreatment, such as whether weapons were involved	
<input type="checkbox"/> Caregiver acknowledgement and attitude about the maltreatment	
<input type="checkbox"/> Other problems occurring in association with the maltreatment	

What other professionals must be notified to verify the abuse or accidental injury?

Conclusion

As is the case with any maltreatment, physical abuse leaves lasting scars. For these maltreatments, there also are psychological and emotional scars.

In the beginning, the scars from physical abuse are the pain and other problems stemming from the actual physical harm. Emotional and behavioral problems can arise quickly, including anger, hostility, fear, anxiety, humiliation, aggression toward others, self-destructive behavior, hyperactivity and other manifestations in the child.

Long-term, the consequences of child physical abuse may include the following:

- Long-term physical disabilities (for example, brain damage or eye damage).
- Disordered interpersonal relationships (for example, difficulty trusting others within adult relationships or violent relationships).
- A predisposition to emotional disturbance.
- Feelings of low self-esteem.
- Depression.
- An increased potential for child abuse as a parent.
- Drug or alcohol abuse.

Source: https://www.childwelfare.gov/pubs/factsheets/long_term_consequences.cfm

Unit 6.4: Sexual Abuse

Florida Maltreatment Index

SEXUAL ABUSE

DEFINITION

Sexual abuse is sexual conduct with a child for arousal or gratification of the sexual needs or desires of the caregiver(s). This maltreatment includes both allegations of sexual abuse and the threat of harm by sexual abuse. Three types of sexual conduct are included in this maltreatment:

1. Sexual Molestation: Sexual conduct with a child when contact, touching, or interaction is used for arousal or gratification of the sexual needs or desires of the caregiver(s), including, but not limited to:

The intentional touching of the genitals or intimate body parts, including the breasts, genital area, groin, inner thighs, penis, and buttocks, or the clothing covering them.

Encouraging, forcing, or permitting the child to inappropriately touch the same parts of the caregiver's body.

2. Sexual Battery: Sexual conduct involving the oral, anal, or vaginal penetration by, or union with, the sexual organ of a child; the forcing or allowing a child to perform oral, anal, or vaginal penetration on another person; or the anal or vaginal penetration of another person by any object. This includes digital penetration, oral sex (cunnilingus, fellatio), coitus, and copulation.

3. Sexual Exploitation: Sexual use of a child for sexual arousal, gratification, advantage, or profit. This includes, but is not limited to:

- Indecent solicitation of a child or explicit verbal enticement.
- Allowing a child to participate in pornography.
- Exposing sexual organs to a child for the purpose of sexual arousal or gratification, aggression, degradation, or similar purposes.
- Intentionally perpetrating a sexual act in the presence of a child for the purpose of sexual arousal, gratification, aggression, degradation, or similar purposes.
- Intentional masturbation of the caregiver's genitals in the child's presence.

**Use this maltreatment when a child has been sexually abused or is at threatened

harm of sexual abuse due to the actions or non-actions of the caregiver(s). The caregiver(s) is alleged to have sexually exploited the child not only if he/she engages in the behaviors or activities listed under “Sexual Exploitation,” but also if s/he condones or does not stop another non-caregiver(s) from exposing the child to these behaviors or activities.

**If the alleged perpetrator has current access to the child, this must be an immediate response.

**When an allegation of “Sexual Abuse” is made due to threatened harm from sexual abuse, at times a CPI is able to determine that a child has not been sexually abused but is at serious risk of sexual abuse because of the evidence obtained. In such situations, the CPI should add the allegation of “Threatened Harm” to the investigation and determine findings accordingly.

ASSESSING “SEXUAL ABUSE” AS MALTREATMENT

- Is the child being used for sexual arousal, advantage, or profit?
- How did the reporter obtain their information (eye witness, child statement, third party, etc.)?
- Does the child have a sexually transmitted disease?
- Did the caregiver(s) expose their sexual organs to a child in a manner that is inappropriate or appears to be for sexual gratification?
- Has one child in the home been sexually abused by the caregiver(s) and are there siblings in the home who may also be victims as well?
- Did the caregiver(s) sexually abuse a child and also have other children living in their household who are the same sex and similar age to the child victim?
- What is the extent of the primary caregiver’s knowledge of the situation to include if they were present?
- Is there prior sexual abuse history involving the child or the caregiver(s)?
- Does the child have a disability or medical condition that increases his/her vulnerability?
- Is there a threat that the child is being sexually abused, for example a child is exhibiting sexual acting-out behaviors beyond his/her developmental level that is so severe it is expected that someone may have sexually abused the child?

ASSESSING FOR OTHER MALTREATMENT

- Allegations of child prostitution should also be assessed for “Human Trafficking.”
- When a child has been sexually abused in the past and the caregiver(s) allows the abuser to have contact, the child may be at risk. Also assess for “Failure to Protect.”

EXCLUDING FACTORS

- A situation involving touching that can be reasonably construed to be normal caregiver(s) responsibility, such as wiping a child who is not able to do so without

assistance, does not constitute “Sexual Abuse.”

- Normal caregiver(s) interaction with affection does not constitute “Sexual Abuse.”
- Touching that is intended for valid medical purposes does not constitute “Sexual Abuse.”

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Information obtained from all medical records and professionals to include the Child Protection Team and the child’s Primary Care Physician.
 - **A mandatory referral to CPT is required for any report alleging sexual abuse of a child or any sexually transmitted disease in a prepubescent child.
- Documentation from any reports and interviews from law enforcement.
- Documentation of an arrest being made related to the sexual abuse incident.
- Documentation of physical evidence observed by the CPI, law enforcement, medical professionals, or the Child Protection Team.
- Results of any psychological exams of the child and/or the caregiver(s).
- Documentation of the statement given by the child (preferably through a forensic interview by a CPT professional), caregiver(s) and siblings to include an assessment of credibility.
- Documentation from interviewing witnesses to the incident or persons who know the family well.
- Documentation from prior history of sexual abuse in this family or by the caregiver(s) with different child victims, including prior allegations of sexual abuse made by the child.

Sexual Maltreatment—Florida Statutes

Sexual Abuse: s. 39.01(69), F.S.

“Sexual abuse of a child” means one or more of the following acts:

- Any penetration, however slight, of the vagina or anal opening of one person by the penis of another person, with or without semen emission.
- Any sexual contact between the genitals or anal opening of one person and the mouth or tongue of another person.
- 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 any act intended for a valid medical purpose.
- 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 either the child or the perpetrator, except that this does not include any act:
 - which may reasonably be construed to be a normal caregiver responsibility, any interaction with, or affection for a child; or
 - intended for a valid medical purpose.
- The intentional masturbation of the perpetrator’s genitals in the presence of a child.
- The intentional exposure of the perpetrator’s genitals in the presence of a child, or any other sexual act intentionally perpetrated in the presence of a child, if such exposure or sexual act is for the purpose of sexual arousal or gratification, aggression, degradation, or other similar purpose.
- The sexual exploitation of a child, which includes allowing, encouraging, or forcing a child to:
 - solicit for or engage in prostitution; or
 - engage in a sexual performance, as defined by chapter 827.
 - participate in the trade of human trafficking as provided in s. 787.06(d)(g), F.S.

Other Statutes and Operating Procedures Related to Sexual Abuse

- s. 39.302, F.S. -- Institutional Child Abuse, Abandonment, Neglect

- s. 39.303, F.S. -- Child Protection Team

- s. 39.3035, F.S. -- Child Advocacy Centers

- s. 39.304, F.S. -- Photos, Medical Exams, X-rays
- s. 39.307, F.S. – Reports of Child-on-Child Sexual Abuse
- s. 39.806(1), F.S. -- Child Sexual Abuse-Grounds for Termination of Parental Rights
- 65C-28.004(10), F.A.C. -- Placement of Children Who are Victims of Sexual Abuse
- 65C-28.004(6), F.A.C – Placement of Alleged Abuser
- CFOP 175-20 -- CPT and Sexual Abuse Treatment Programs

Five Sexual Abuse Phases

- Engagement – Initial stage when child is “groomed” by the abuser. The abuser:
 - is usually in child’s family
 - has power and authority over child
 - has opportunity.
- Sexual Interactions – Over time, the abuser will engage the child in sexual activity. It likely will begin with a behavior such as inappropriate touching and progress to a more serious behavior, such as intercourse.
- Secrecy – The primary task for the abuser is to ensure the child keeps the activity secret.
 - Essential and enables repetition
 - Encouraged with rewards
 - Enforced with threats
 - Secrecy phase often lasts for months or years.
- Disclosure – Disclosure can be accidental or initiated by one of the participants and, therefore, purposeful. How this happens and how others respond are critical to the impact on the child.
- Suppression – In most cases, there is a period of suppression following disclosure.
 - Family may try to suppress publicity, information and intervention.
 - Perpetrator may exploit power position and pressure the child and family.

Activity: Sexual Abuse - Does it Meet the Legal Definition?

Directions:

Working in your group, read through each brief scenario and determine the following:

- Does it represent an aspect of sexual abuse as defined by Florida Statutes or is it not sexual abuse?
- If it does represent sexual abuse, identify the specific section in the statutes cited on pages 146-147 that it represents.
- After you complete all of these, you will debrief as a class.

Practice Scenarios

Scenario 1: The father of a 13-year-old girl has been touching his daughter’s breasts over her clothes. The 13- year-old tells her best girlfriend, who tells her mother, who calls the Hotline.

Is this sexual abuse based on Florida Statutes? If it is, explain what type it is and where it is in the Florida Statutes.

Scenario 2: An 8-year-old girl discloses to her teacher that her grandfather has put his finger in her “hoo-hoo” many times (as she pointed to her vaginal area) – whenever they are alone together. She called this the “Sweet Secret Game,” but she doesn’t like it.

Is this sexual abuse based on Florida Statutes? If it is, explain what type it is and where it is in the Florida Statutes.

Scenario 3: An anonymous caller reports that an 11-year-old boy is watching his 25-year-old aunt undress and masturbate herself. She lives in the home and leaves the door of her bedroom open when his parents are away and encourages him to watch.

Is this sexual abuse based on Florida Statutes? If it is, explain what type it is and where it is in the Florida Statutes.

Scenario 4: A mother is reported for taking her 2-year-old daughter’s temperature anally when she is feverish. The mother explained that her daughter was so fussy that she could not put the thermometer in her mouth to get her temperature orally.

Is this sexual abuse based in Florida Statutes? If it is, explain what type it is and where it is in the Florida Statutes.

Scenario 5: A 4-year-old girl made a comment in her pre-school that her 12-year-old cousin licked her “cootchie” between her legs when they play of the “Lollipop Game.” When the girl was interviewed, she confirmed the “Lollipop Game” and identified her cousin.

Is this sexual abuse based on Florida Statutes? If it is, explain what type it is and where it is in the Florida Statutes.

Scenario 6: Everyone just got back from the beach, and Dad and his 6-year-old son are trying to get ready to go out with the family for dinner. Dad and his son are taking a shower together.

Is this sexual abuse based on Florida Statutes? If it is, explain what type it is and where it is in the Florida Statutes.

Sexual Maltreatment—Indicators of Sexual Abuse

Physical Indicators

The indicators of sexual abuse vary in children of different ages.

- Sexual abuse includes a wide range of behaviors and activities, some of which have no physical signs. These can include:
 - Kissing
 - Fondling
 - Genital exposure
 - Observation of adult sexual activity by a child.
- When a child has been physically involved in sexual activity, there may be physical indicators or injury. These may be validated through a medical examination by a physician trained in sexual abuse.
- These are several physical indicators common in sexually abused young children.
- Depending upon how recent and how extensive the sexual activity, there may be no clear physical evidence.

Physical Injury to the Genitals

- Injuries include bruising, cuts or lacerations, bite marks, stretched rectum or vagina, fissures in the rectum, or swelling and redness of genital tissues.
- These injuries may have been caused by penetration of the vagina or rectum with fingers, an adult penis, or other objects.
- Injuries to the genitals in older infants and toddlers may be the result of physical punishment for toileting accidents.

Sexually Transmitted Diseases

- The presence of sexually transmitted diseases, including herpes on the genitals, gonorrhea, syphilis, venereal warts, or Chlamydia, strongly suggests sexual exposure.
- The presence of monilia (yeast infection) in a female child or adolescent may not necessarily be the result of sexual abuse.
- Yeast infections may occur from having taken systemic antibiotics, or from excessive douching.
- A yeast infection in a preadolescent child, particularly, warrants a medical examination and further investigation.

Suspicious Stains, Blood or Semen on the Child's Underwear, Clothing or Body

- The presence of blood or semen strongly suggests sexual exposure, and all evidence must be collected by law enforcement.

Bladder or Urinary Tract Infection

- This includes pain when urinating, blood and pus in the urine, and high frequency urination.

- Urinary tract infections can be common in sexually active women.
- They are uncommon in children, unless the child has a physical abnormality of the urinary system, such as children with spina bifida who often have chronic urinary tract infections as a result of neurological dysfunction.
- Any urinary tract infection in a child must be medically evaluated for the possibility of sexual abuse.

Painful Bowel Movements or Retention of Feces

- Might indicate that the rectum has been penetrated. Chronic constipation may also cause painful bowel movements and retention of feces by a child.

Early, Unexplained Pregnancy

- Particularly in a child whose history and behavior does not suggest sexual activity with peers.

Behavioral Indicators

Verbal Disclosure

- When a child discloses sexual involvement, or that an adult has done "bad things" to him/her, this disclosure must always be taken seriously.
- If a child's disclosure is handled improperly, the child may be unwilling to talk about the abuse again.
- The child is often hesitant to disclose due to threatened consequences imposed by the perpetrator.
- Disclosure may only be hinted at (e.g., "I don't want to go home," or "I don't like my dad anymore.")

Precocious Sexual Knowledge and Inappropriate Sexual Behavior

You must have a basic knowledge of appropriate sexual knowledge/behavior in children of different ages in order to recognize when a child possesses sexual knowledge or engages in sexual behavior that is not typical for his or her age.

- Behaviors that often indicate unusual sexual involvement include:
 - Seductive behavior toward adults of the opposite sex (generally, female children toward adult men)
 - Sexual acting out in pre-adolescent and adolescent children, including promiscuity or blatantly provocative dress
 - Excessive masturbation (again, beyond what is age appropriate)
 - Enticing other children into sexual play (beyond normal curiosity and visual or tactile exploration, such as the "doctor" games and mutual disrobing often engaged in by younger children)
 - Involving other children, either of the same or opposite sex, in more extensive

sexual behavior. Adolescent male perpetrators are themselves very often victims of sexual abuse.

- Creating and playing out sexual scenarios with toys or dolls
- The "child" doll presses her face into the "daddy" doll's groin and says "he likes this;" or the "daddy" doll puts his hand under the "child" doll's skirt and rubs her.
- Specific fears of males or females
- Adolescent fear of sex (beyond normal adolescent ambivalence and anxiety)
- Some children wear extra layers of clothing, or clothing that is inappropriate for the weather:
 - An apparent symbolic attempt to hide, or to protect their bodies.
 - The child may hide clothing that is stained, bloodied, or otherwise soiled as a result of sexual activity.
- A sexually abused child may have difficulty with, or appear to lack interest in participating in regular physical activities.
- Indicators: difficulty sitting in a chair, sitting awkwardly, or squirming, having difficulty walking, staying seated and choosing not to become involved in games or sports. Indicators may be the result of pain or discomfort in the genital area.

Generalized Indicators of Emotional Distress are Prevalent

NOTE: These indicators are also prevalent in other maltreated children and are not direct indicators of sexual abuse:

- Fears and phobias (of the dark, of school, of going out, of going home, of being left alone, or free-floating anxiety).
- Aggressive behaviors, tantrums, acting out, running away from home, fighting.
- Withdrawal from social relationships, secrecy, isolation, and a prevailing lack of trust in relationships. This is often mistaken for independent activity.
- Low self-esteem, poor body image, perceives oneself in a negative way with a distorted sense of one's own body.
- Regression in young children: enuresis, encopresis, thumb-sucking, baby talk, clinging behaviors.

Sexual Maltreatment, Sexual Development and Behavior Ages 2-12

Key Points:

The National Center on the Sexual Behavior of Youth (NCSBY) states that research on sexual behavior of children ages 2 to 12 has documented that:

- Sexual responses are present from birth.
- A wide range of sexual behaviors for this age range are normal and non-problematic.
- Increasing numbers of school-age children are being identified with inappropriate or aggressive sexual behavior. It is not clear if this increase reflects an increase in the actual number of cases of sexual abuse or an increase in identification and reporting.

Typical sexual knowledge of children ages 2-to 6-years-old includes:

- Understanding that boys and girls have different private parts.
- Knowing labels for sexual body parts, but using slang words such as “weenie” for “penis.”
- Having limited information about pregnancy and childbirth.

Typical sexual knowledge of children ages 7-to 12-years-old:

- Learn the correct names for the genitals but use slang terms.
- Have increased knowledge about masturbation, intercourse and pregnancy.
- Understand the physical aspects of puberty by age 10.

It can be hard to tell the difference between “normal” sexual behaviors and behaviors that are signs that a child may be developing a problem. Sexual play that is more typical or expected in children will more often have the following traits:

- The sexual play is between children who have an ongoing, mutually enjoyable play and/or school friendship.
- The sexual play is between children of similar size, age, and social and emotional development.
- It is lighthearted and spontaneous. The children may be giggling and having fun when you discover them.
- When adults set limits (for example, children keep their clothes on at day care), children are able to follow the rules.

Preschool age (0 to 5 years)

Common:

- Will have questions and express knowledge relating to:
 - differences in gender, private body parts
 - hygiene and toileting

- pregnancy and birth
- Will explore genitals and can experience pleasure
- Showing and looking at private body parts

Uncommon:

- Having knowledge of specific sexual acts or explicit sexual language
- Engaging in adult-like sexual contact with other children

School-age (6-8 years)

Common:

- Will need knowledge and have questions about
 - physical development, relationships, sexual behavior
 - menstruation and pregnancy
 - personal values
- Experiment with same-age and same-gender children, often during games or role-playing
- Self-stimulation in private is expected to continue.

Uncommon:

- Adult-like sexual interactions
- Having knowledge of specific sexual acts
- Behaving sexually in a public place or through the use of phone or Internet technology

School-age (9-12 years)

Hormonal changes and external influences, such as peers, media and Internet, will increase sexual awareness, feelings and interest at the onset of puberty.

Common:

- Will need knowledge and have questions about
 - Sexual materials and information
 - Relationships and sexual behavior
 - Using sexual words and discussing sexual acts and personal values, particularly with peers
- Increased experimentation with sexual behaviors and romantic relationships
- Self-stimulation in private is expected to continue

Uncommon:

- Regularly occurring adult-like sexual behavior
- Behaving sexually in a public place

Adolescence (13-16 years)

Common:

- Will need information and have questions about
 - Decision-making
 - Social relationships and sexual customs
 - Personal values and consequences of sexual behavior
- Self-stimulation in private is expected to continue.
- Girls will begin menstruation; boys will begin to produce sperm.
- Sexual experimentation between adolescents of the same age and gender is common.
- Voyeuristic behaviors are common in this age group.
- First sexual intercourse will occur for approximately one-third of teens.

Uncommon:

- Masturbation in a public place
- Sexual interest directed toward much younger children

See (below): *Sexual Maltreatment, Sexual Development and Behavior in Ages 2-12*

Sexual Maltreatment, Sexual Development and Behavior in Ages 2-12

NCSBY² Fact Sheet

This Fact Sheet provides basic information about sexual development and problematic sexual behavior in children ages 2-12. This information is important for parents and professionals who work with or provide services to children, such as teachers, physicians, child welfare personnel, daycare providers, and mental health professionals. Understanding children's typical sexual development, knowledge, and behavior is necessary to accurately identify sexual behavior problems in children. Guidelines to distinguish typical sexual behaviors from problematic sexual behaviors are described below.

Research on sexual behavior of children ages 2 to 12 has documented that:

- sexual responses are present from birth;
- a wide range of sexual behaviors for this age range are normal and non-problematic;
- increasing numbers of school age children are being identified with inappropriate or aggressive sexual behavior; it is not clear if this increase reflects an increase in the actual number of cases or an increase in identification and reporting;
- several treatment interventions have been found to be effective in reducing problematic sexual behavior in children, such as cognitive behavioral group treatment; and
- sexual development and behavior are influenced by social, familial, and cultural factors, as well as genetics and biology.

Typical sexual knowledge of children age 2 to 6 years old:

- understand that boys and girls have different private parts;
- know labels for sexual body parts, but use slang words such as weenie for penis; and
- have limited information about pregnancy and childbirth.

Typical sexual knowledge of children ages 7 to 12 years old:

- learn the correct names for the genitals but use slang terms;
- have increased knowledge about masturbation, intercourse, and pregnancy; and
- understand the physical aspects of puberty by age 10.

Common vs. Infrequent Sexual Behaviors in Children

In the last decade, research has described typical sexual behaviors in boys and girls ages 2-12. The table below lists sexual behaviors that are commonly observed or reported by parents of pre-school and school-age children.

² NCSBY: National Center on the Sexual Behavior of Youth

Common Sexual Behavior

AGES 2-6	AGES 7-12
<ul style="list-style-type: none">-Do not have a strong sense of modesty, enjoy own nudity-Use elimination words with peers-May explore body differences between girls and boys-Curious about sexual and genital parts-Touch their private parts, even in public-Exhibit sex play with peers and siblings; playing “doctor”-Experience pleasure from touching their genitals	<ul style="list-style-type: none">-Sexual play with children they know, such as playing “doctor”-Interested in sexual content in media (TV, movies, radio)-Touch own genitals at home, in private-Look at nude pictures-Interested in the opposite sex-Shy about undressing-Shy around strange men

Infrequent Sexual Behaviors (Ages 2-12)

<ul style="list-style-type: none">-Puts mouth on sex parts-Puts objects in rectum or vagina-Masturbates with objects-Touches others’ sex parts after being told not to-Touches adults’ sex parts	<ul style="list-style-type: none">-Asks to engage in sex acts-Imitates intercourse-Undresses other people-Asks to watch sexually explicit television-Makes sexual sounds
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Research has also described infrequent and uncommon sexual behaviors in boys and girls ages 2-12. Sexual behaviors reported by parents of pre-school and school age children to be infrequent or highly unusual follow.

Sexual Play vs. Problematic Sexual Behavior

Professionals in the field have developed a continuum of sexual behaviors that range from common sexual play to problematic sexual behavior. These are described below.

Sexual play

- is exploratory and spontaneous;
- occurs intermittently and by mutual agreement;
- occurs with children of similar age, size, or developmental level, such as siblings, cousins, or peers;
- is not associated with high levels of fear, anger, or anxiety;
- decreases when told by caregivers to stop; and

- can be controlled by increased supervision.

Problematic Sexual Behavior:

- is a frequent, repeated behavior, such as compulsive masturbation.
Example: A six-year-old repeatedly masturbates at school or in other public places.
- occurs between children who do not know each other well.
Example: An eight-year-old girl shows her private parts to a new child during an after school program.
- occurs with high frequency and interferes with normal childhood activities.
Example: A seven-year-old girl has been removed from the soccer team because she continues to touch other children’s private parts.
- is between children of different ages, size, and development level.
Example: An eleven-year-old boy is “playing doctor” with a three-year-old girl.
- is aggressive, forced, or coerced.
Example: A ten-year-old threatens his six-year-old cousin and makes him touch his penis.
- does not decrease after the child is told to stop the behavior;
Example: A nine-year-old child continues to engage other children in mutual touching after being told the behavior is not allowed and having consequences, such as being grounded.
- causes harm to the child or others.
Example: A child causes physical injury, such as bruising, redness, or abrasions on themselves or another child, or causes another child to be highly upset or fearful.

Children with Sexual Behavior Problems

Children with sexual behavior problems (SBPs) are children 12 years and under who demonstrate developmentally inappropriate or aggressive sexual behavior.

This definition includes self-focused sexual behavior, such as frequent public masturbation, and intrusive or aggressive sexual behavior towards others that may include coercion or force. Although the term “sexual” is used, the children’s intentions and motivations for these behaviors may be unrelated to sexual gratification.

Some children who have been sexually abused have inappropriate sexual behaviors and others have aggressive or highly problematic sexual behavior. However, it should be noted that the majority of children who have been sexually abused do not have subsequent inappropriate or aggressive sexual behaviors.

Although only a small number of children develop problematic sexual behavior, professionals and parents may have concerns about (1) whether the behavior is problematic, (2) whether a

child should be referred for mental health services, and (3) when an incident should be reported to the proper authorities.

Additional information about adolescent sex offenders and children with sexual behavior problems is available from the **National Center on Sexual Behavior of Youth**, www.ncsby.org

This Fact Sheet was prepared through the National Center on Sexual Behavior of Youth at the Center on Child Abuse and Neglect, University of Oklahoma Health Sciences Center and was authored by Jane F. Silovsky, PhD and Barbara L. Bonner, PhD. This project is funded by grant number 01-JR-BX-K002 from the Office of Juvenile Justice and Delinquency Prevention (OJJDP), US Department of Justice.

For more information on behaviors related to see also:

Children's Sexual Behaviors: A Parent's Guide. Updated and expanded by the Provincial Child Sexual Abuse Advisory Committee 2013, Prince Edward Island, Canada.

http://www.gov.pe.ca/photos/original/CSA_Healthy.pdf

Johnson, T. C., Ph.D. Behaviors Related to Sex and Sexuality in Children, "The Pennsylvania Child Welfare Training Program, Module 2: Identifying Child Abuse and Neglect, **Handout #26**, page 1-7."

http://www.pacwrc.pitt.edu/curriculum/ctc/mod2/hndts/ho26_bhvrsltdtosxandsxltyinchldrn.pdf

Activity: What are the Indicators?

Directions:

1. Read scenario 1. Using *Sexual Maltreatment—Indicators of Sexual Abuse* as the focus, work through the questions together.
2. In your groups, review the next scenario and determine what the indicators are related to the scenario, and whether the scenario describes sexual abuse, according to Florida statute. Discuss as a class, as well as responding to the discussion questions.
3. You may use all jobs aids and information that have been reviewed in this unit.
4. Someone from the group should record the group's answers and be prepared to report to the class.

Scenario 1 - Billy: Seven-year-old Billy has been playing aggressively with other younger children in the neighborhood. One of the smaller children complained that the 7-year-old is mean and pushes her down and lays on top of her and “pushes” against her with his “pee-pee part.” Billy lives with his mother and her new boyfriend in a small apartment. He has also starting using language that seems much more mature for his age and words no one has ever heard him use before.

Discussion Questions:

- What could be the cause of this child's behavior?
- Why do you think he is doing sexual things to younger children?
- Is what he is doing a “typical” behavior for his age or not?

Scenario 2 - LaShonda: Five-year-old LaShonda at kindergarten is very shy about toileting in front of other girls and won't ask for help with her clothes from the teacher, when she needs it. When she did get help one time, the teacher noticed that the child had on three pairs of underwear. She is often scratching her genital area and constantly adjusting her pants or dresses around herself when she sits with other children. She is quiet and keeps to herself a bit more than other children her age. Once, when she was playing by herself with some dolls, one of the teachers saw her lift the doll's skirt and poke a pencil in and out between the doll's legs.

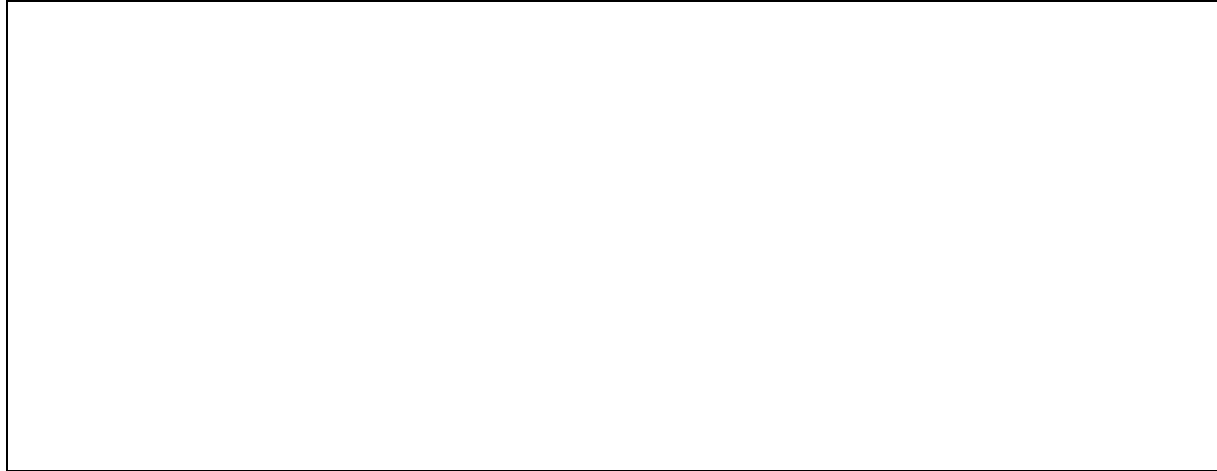
Discussion Questions:

- Why would a child wear so many pairs of underpants?
- What about her observed play with dolls? Typical or not typical?
- What could be causing her to scratch herself so much?
- What is your hypothesis of this behavior in a 5-year-old?

Scenario 3 – Charlie: Three-and a-half-year-old Charlie is boisterous and frequently touches himself in the genital area over his clothes and squeals with laughter. He has been found at his day care facility in the play-yard and in the play tunnels with a 3-year-old girl. Both children had taken their pants off and were looking at each other in the genital area.

Discussion Questions:

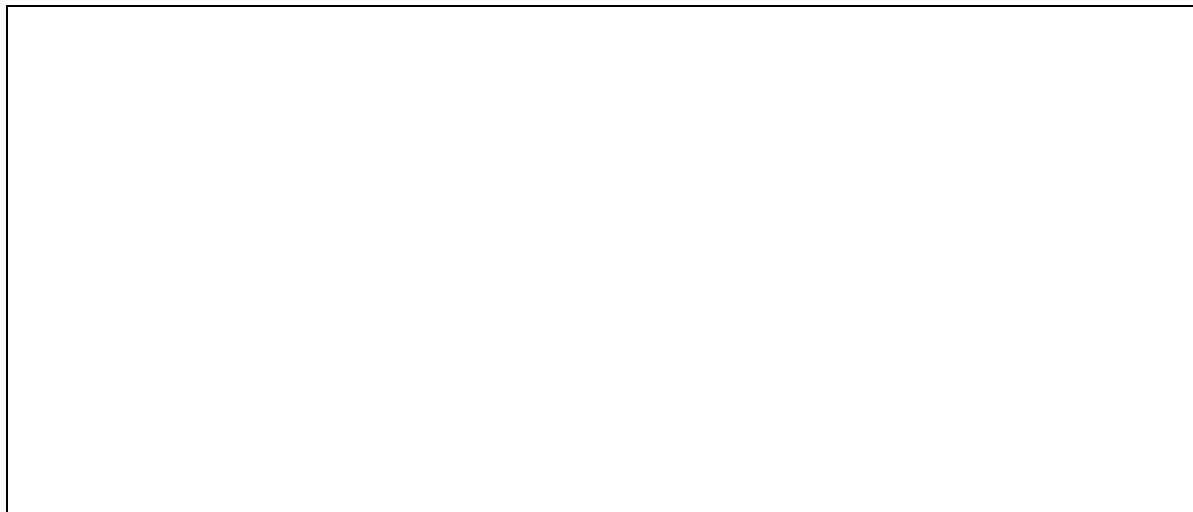
1. Is this typical behavior or not? Why?
2. Are you concerned with sexual abuse?
3. If yes, then why?
4. If not, then why?
5. What else should we know or want to know before determining whether there is concern for sexual abuse?



Scenario 4 - Amanda: Eleven-year-old Amanda is a chronic runaway. She is picked up by law enforcement and taken to the local runaway youth shelter. She seems somewhat mature for a pre-pubescent and initially will not discuss why she continues to run away from her family. The counselors note that she behaves in a very solicitous way (physically) with the male residents, as well as the male counselors.

Discussion Questions:

1. What do you think is the cause of her behavior?
2. What may have happened to her at home or maybe somewhere else?
3. What approach would be helpful to find out about her home life?
4. If she has no physical findings (after a CPT exam), is that a definitive indication of no sexual abuse?
5. Is it possible that she is a victim and will not tell anyone? Why wouldn't she tell? What would keep her willing to keep a secret?
6. If she was sexually abused, what reason would she have to be overtly sexual with others?



NCSBY suggests the following to Professionals and Parents:

- Do not overreact, as most sexual behaviors in children are within the typical or expected range.
- Inappropriate or problematic sexual behavior in children is not a clear indicator that a child has been sexually abused.
- Most children will stop the behavior if they are told the rules, mildly restricted, well-supervised, and praised for appropriate behavior.
- If the sexual behavior is problematic as defined above, referral for mental health services is recommended.
- Problematic sexual behavior in a child is significantly different from adolescent and adult sex offense.
- A report to Child Protective Services (CPS) and/or law enforcement may be required by law for certain behaviors, such as aggressive or forced sexual behavior.

Why Children Recant

There are several reasons why children recant

- Secrecy
- Denial
- Lack of support and pressure from others
- Societal attitudes
- Child and family interactions with professionals
- Intervening events over time.

For more information on research about recanting, read the article "Recantation in Child Sexual Abuse Cases" by Margaret Rieser, published in The Child Welfare League of America Journal, LLX, Number 6, November-December 1991.

Activity: Grappling with Potential Sexual Abuse Cases

Materials:

- *Sexual Maltreatment, Sexual Development and Behavior in Ages 2-12*
- Scenario 1: Destiny (Age 4)
- Scenario 2: Lee-Ann (Age 13)

Directions:

1. Read through the first scenario about Destiny.
2. We will then work together to identify what is developmentally appropriate and inappropriate sexual behavior.
3. As a group, read through the second scenario again, this time with additional information. Discuss what can be identified as developmentally appropriate and developmentally inappropriate sexual behavior. Debrief as a class.
4. Do the same thing with the third and fourth scenarios.

Activity Notes:

Destiny/ age 4

Destiny, age 4, lived with her mother and grandmother. Also in the home was the 32-year-old cousin to the mother, whom Destiny knew as “Uncle Jake.” He was new in the home and had only lived with Destiny, her mother and her grandmother for about one year.

When Mom was at work, it was either Grandma or Uncle Jake who watched over Destiny. Mom worked at Walmart and sometimes had different hours, depending on schedule issues. Destiny went to daycare in the daytime and was picked up by Grandma after daycare if Mom was not available. Uncle Jake worked the midnight shift at a local factory and would come home and sleep in the daytime when Destiny was in daycare and Mom and Grandma were at work. Grandma worked as a “lunch lady” at the local elementary school and was able to both take and pick up Destiny daily, when necessary, due to her part-time work hours.

Destiny started complaining of being “itchy” in her “potty parts” to her mother and grandmother when they would see her with her hands in her pants at night, naptimes or in the tub. Whenever she was asked about this, she told her Mom and Grandma that she was “scratching her itchies.” The Mom and Grandma did not notice any redness or irritations for

Destiny and could not figure out why she had “itchies.” She did not seem fearful of anyone in the house and was an outgoing and happy child otherwise.

Discussion Questions:

1. What could be the cause of Destiny’s “itchies.” See if you can think of at least 4-5 possibilities.
2. If you were an investigator, what would you want to ask Destiny to gain more information?
3. Do you think Destiny should get an examination, and, if so, by whom?
4. Is there someone else besides the CPI who should talk with a child of this age with this type of history (concern of possible sexual abuse due to hands in pants and “itchies”)?
5. What should be considered if Destiny does not disclose sexual abuse?

Lee-Ann/age 13

Lee-Ann moved to Florida from Kentucky with her mother, stepfather and two younger siblings. Her family had been in Florida for about 6 months when an anonymous report came in that Lee-Ann may have been a victim of sexual abuse by her stepfather.

During an interview, Lee-Ann confirmed that her stepfather had been “doing it” to her for a few years now. “It” happened in both Kentucky and in Florida. Lee-Ann presented as a pretty street-savvy child, was sarcastic and sometimes openly disrespectful when spoken to by teachers, the CPI and when interviewed at CPT. She openly acknowledged that she didn’t really care about what was happening at home and that sometimes her stepdad would give her money or gifts afterward when they had “date night.” She also casually made the comment in her interview that at least he is not “doing” her sisters.

Lee-Ann’s description of “date night” included her going to the backyard with her stepdad while her younger sisters had to stay in the house. The family lived on a large piece of property in a rural area, and the shed was far from the house. The younger siblings knew that Tuesday night was “gardening night” for Lee-Ann and their stepdad. They were allowed to stay up later and watch a scary movie or a favorite TV program, as long as they did not come outside or anywhere near the “gardening shed.” This was because their stepdad said he did not want them to get hurt around the yard tools.

Lee-Ann’s younger siblings were 7-and 8-years-old. They did not confirm knowing anything about what was happening with Lee-Ann and her stepdad and did not disclose anything happening with themselves and the stepdad. Both younger sisters describe Lee-Ann as mean, bossy with them, and always telling them what to do at home. They both gave examples where Lee-Ann would not let them go with Stepdad to the local ice cream store (or anywhere else), unless they would go together or unless she went with them.

Lee-Ann’s mom worked night shift at the local hospital and would not come home until after 11:30 pm on Tuesdays. Those evenings, Lee-Ann detailed being required to “blow” stepdad, having him “put his fingers in (her)” and her being forced to “jerk him off.” She was very descriptive and nonchalant with her descriptions, and almost seemed indifferent in her presentation of the sex acts.

School personnel (Guidance Counselors) have described Lee-Ann as a bit “wild” at school with the boys. She is apparently known for being quite sexually active and not well-liked by many of the other girls. Lee-Ann is often sent home for dressing inappropriately, she skips classes, and she uses very foul language. She seemed to get a lot of satisfaction in talking about sex acts, making sure that the boys (as well as her female peers) all know she is experienced and making no effort to hide her sexual behaviors. It was no secret that she would engage in sex acts in and around the school with almost anyone and had no real

ongoing relationships with her peers, regardless of her sexually intimate physical interactions. Some of the boys were intimidated to be around Lee-Ann because she took a lot of pride in actively shaming them verbally in front of their friends about their willingness or lack of willingness to get involved with her on a physical level. An example of this was when she called out to one of the boys in front of the other boys and called him “dinky dick.”

There were also rumors of possible drug use that includes distribution—“probably pot,” according to the guidance counselor. Lee-Ann seemed clever enough to never get caught, but it was well-known among the student population that she was a source. The kids at school referred to her as the “whore-ti-culturist,” which she seemed to self-promote when she heard it. She was so proud of this nickname that she had it written on her notebooks and the bottom of her shoes.

Because of the sexual abuse, Lee-Ann and her siblings spent some time in foster care. Lee-Ann never reunited with her mother and aged out of foster care due to her mother’s rejection of Lee-Ann. The stepfather was eventually convicted and went to prison. Even during trials and time in shelter care, Lee-Ann frequently recanted the very specific history of her molestation and would beg the CPI to let her and her sisters return home. However, during the investigation, the sisters *unknowingly* supported the history by Lee-Ann about times and dates in which Lee-Ann’s stepfather would take her out into the yard, and they would spend time in the shed “gardening.”

Debriefing Questions:

1. Why would Lee-Ann, who is a victim of sexual abuse for many years, want to be sexual with her peers?

2. What value do you think Lee-Ann places on her own sexuality?

3. Where does that value come from?

4. Lee-Ann's behavior is not often likeable by adult authority figures. What is it about Lee-Ann that presents a challenge to adults in her life?

5. Why would her mother not want to believe Lee-Ann? What motivation may a mother have for not believing her own child?

6. What was Lee-Ann's attitude toward her sisters?

7. Assuming that Lee-Ann's siblings and Lee-Ann went into foster care because of the abuse but the mother did not believe Lee-Ann, what attitudes do you think her siblings would have with Lee-Ann if they also did not believe her?

8. What type of concerns or traumatic issues could Lee-Ann face when she becomes an adult?

9. What might her relationships be like? What about trust? What about her value of herself and her relationships with men? With other women?

10. What are some factors you consider when you think of the possibility of working with a "Lee-Ann" at some point in your child welfare career?

Unit 6.5: Mental Injury

Mental Injury Defined

s. 39.01(42), F.S., defines mental injury as:

- Mental Injury: an injury to the intellectual or psychological capacity of a child as evidenced by a discernible and substantial impairment in the ability to function within the normal range of performance and behavior.

The Maltreatment Index adds: The impairment may be in the emotional, affective, cognitive, physical, or behavioral functioning of the child. Damage can be present and observable, or can be forecast as highly probable for the near future.

Mental Injury often falls into the mandatory referral category for the Child Protection Team, specifically if there are “symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.”

Myths about Verbal Abuse

1. Sticks and stones break bones, but words don't hurt.
 - In some cases, words can hurt more than a stick or stone ever could.
 - It is often not just about the words hurled abusively but also about who is the abuser.
 - If the abuse comes from a parent whom a child needs to trust and depend on for love and support, the result can be an experience of abandonment and betrayal.
2. Verbal abuse is no big deal - it doesn't hurt.
 - Abuse leaves children doubting their own feelings.
 - Part of the reason it is most destructive is the painful and damaging way in which it threatens to invalidate the reality of the victim.
 - Verbal abuse is damaging to the victim's mental health, self-esteem and self-worth.
3. The target (victim) of the abuse deserved it.
 - Each and every adult is responsible for managing his or her own feelings.
 - Verbal abusers try to hold the victim responsible for what they feel, then they want to “get” the victim or pay the victim back for it.
 - How the verbal abuser feels is NOT the child's responsibility.
4. It is the victim's fault for disagreeing with the abuser.
 - There is nothing the victim does that warrants or justifies verbal abuse.
 - Verbal abuse is an aggression and an emotional violation.

5. The target of the abuse made the abuser mad.

- Abusers notoriously think that their poor choices and inability to take responsibility for their choices are someone else's fault.
- It is the abuser's responsibility.

6. Verbal abuse is less impactful than physical abuse.

- Verbal abuse is an element of emotional abuse.
- Verbal abuse is emotional battering.
- Verbal abuse bruises the child emotionally, in a way that hurts as much, if not more, than actual physical bruises.

7. Verbal abuse only involves name-calling or yelling.

- Verbal abuse is more than name-calling or yelling and screaming.
- It is using words to intimidate or control.
- It involves threats, put-downs and/or making fun of someone.
- Verbal abuse is any language used to demean, criticize, tear-down, make fun of, embarrass or otherwise intimidate or control another person.

8. Verbal abuse is not as bad as hitting someone.

- Verbal abuse is as painful and debilitating emotionally, if not more so, than physical abuse.
- As victims of physical abuse walk on egg shells and try not to upset the abuser, the same is true for the victim of verbal abuse.
- Many victims of both physical and verbal abuse state that the physical bruises heal significantly faster than the emotional bruises.

Mental Injury – Emotional Abuse

Emotional abuse refers to the psychological and social aspects of child abuse, and it is one of the main causes of harm to abused children.

Mental injury is a pattern of behavior attacking a child's emotional development and sense of self-worth that

Includes:

- Excessive, aggressive or unreasonable demands placing expectations on a child beyond the child's capacity
- Failure to provide psychological nurturing necessary for a child's psychological growth and development (i.e., providing no love, support or guidance).

Boys and girls are equally likely to be victims of emotional abuse by their parents. Emotional maltreatment has been reported to peak in the 6- to 8- year-old range and to remain at a similar level throughout adolescence (Kaplan and Labruna 1998).

Characteristics of Emotionally Abusive Parents

- Many parents are emotionally abusive without being violent or sexually abusive; however, emotional abuse invariably accompanies physical and sexual abuse.
- Emotionally abusive parents practice forms of child-rearing that are oriented toward fulfilling their own needs and goals, rather than those of their children.
- Their parenting style may be characterized by overt aggression toward their children, including shouting and intimidation, or they may manipulate their children using more subtle means, such as emotional blackmail.
- Parents may also emotionally abuse their children by "mis-socializing" them, which means that they may encourage their children to act in inappropriate or criminal ways with direct encouragement and/or by surrounding the child with adults for whom such behavior is normative.
- Emotional abuse does not only occur in the home. Children can be emotionally abused by teachers and other adults in a position of power over the child.
- Children can also experience emotional abuse by other children, and one of the most common experiences of child-to-child emotional abuse is "bullying."

Types of Mental Injury

After the description of each type of mental injury, a brief scenario provides examples of each.

Spurning (Hostile Rejecting/Degrading)

- Includes verbal and non-verbal caregiver acts that reject and degrade a child.
- Belittling, degrading and other nonphysical forms of overtly hostile or rejecting treatment.
- Shaming and/or ridiculing the child for showing normal emotions such as affection, grief or sorrow.
- Consistently singling out one child to criticize and punish (e.g., to perform most of the household chores, or to receive fewer rewards).
- Humiliating in public.

Scenario 1: Nathan is not allowed to eat with his family, even though his two older siblings are allowed to do so. On Fridays, Nathan gets to eat out of a dog bowl on the floor to celebrate the weekend. Nathan is also not allowed to watch TV with the other kids because, he is told by his parents, his presence disturbs them. He is also not allowed to have a bed of his own; he is forced to sleep on the wood floor outside the hallway, while his siblings sleep comfortably in their beds.

Terrorizing

Includes caregiver behaviors that threaten or are likely to physically hurt, kill, abandon, or place the child or child's loved ones/objects in recognizably dangerous situations.

- Placing a child in:
 - unpredictable or chaotic circumstances
 - recognizably dangerous situations
- Setting rigid or unrealistic expectations with threat of loss, harm or danger if they are not met.
- Threatening or perpetrating violence against:
 - the child
 - a child's loved ones or objects.

Scenario 1: Joey's dad makes Joey go to the backyard and makes him sit on a chair in the hot sun because he left some toys on the floor. He makes their trained pit bulls sit there and guard Joey until he says they can back off.

Scenario 2: Emma's parent takes her pet guinea pig, Oink-Oink, and does things like twist Oink-Oink's ears, choke him, and burn his paws in front of Emma.

Scenario 3: Jamie’s dad thinks that five-year-old Jamie needs to get tougher, and that his mom babies him. He tells Jamie he is tired that he is not swimming like he needs to swim, so he throws Jamie into the deep end and tells him to swim. Jamie – who has had two swimming lessons – is terrified that he is going to die and doesn’t believe his dad or mom will save him.

Exploiting/Corrupting

Includes caregiver acts that encourage the child to develop inappropriate behaviors (self-destructive, anti-social, criminal, deviant or other maladaptive behaviors).

- Modeling, permitting or encouraging:
 - Antisocial behavior (e.g., prostitution, performance in pornographic media, initiation of criminal activities, substance abuse, violence to or corruption of others)
 - Developmentally inappropriate behavior (e.g., parentification, infantilization, living the parent’s unfulfilled dreams)
- Encouraging or coercing abandonment of developmentally appropriate autonomy through extreme over-involvement, intrusiveness and/or dominance (e.g., allowing little/no opportunity/support for child’s views, feelings, and wishes; micromanaging child’s life)
- Restricting or interfering with cognitive development

Scenario 1: Amanda’s mom takes her to Walmart every Saturday night and teaches her how to shoplift.

Scenario 2: Henry’s dad makes Henry do sexual things for his friends when they come over to watch wrestling on TV.

Scenario 3: Bennie’s mom takes Bennie to the street corner of their low-income neighborhood and teaches him how to deal drugs in the neighborhood.

Isolating

Includes caregiver acts that consistently deny a child opportunities to meet needs for interacting/communicating with peers or adults inside/outside home.

- Confining the child or placing unreasonable limitations on the child’s freedom of movement within his/her environment
- Placing unreasonable limitations or restrictions on social interactions with peers or adults in the community

Examples: The child is locked in the bathroom overnight, or is put in the closet to remain

overnight, or is chained to a piece of furniture, or is put in a dog cage and left there.

Denying Emotional Responsiveness (Ignoring)

Includes caregiver acts that ignore the child's attempts and needs to interact (failing to express affection, caring and love for the child) and showing no emotion in interactions with the child.

- Detached and uninvolved through either incapacity or lack of motivation
- Interacting only when absolutely necessary
- Failing to express affection, caring and love for the child

Scenario 1: In this case, the parent does not respond to the child when the child talks to the parent. The parent might look beyond the child or doesn't talk to the child at dinner time. Perhaps the parent talks with everyone in the house except the child. In essence, the child is considered a non-person and treated as such.

Mental Health, Medical and Educational Neglect

Includes unwarranted caregiver acts that ignore, refuse to allow, or fail to provide the necessary treatment for the mental health, medical and educational problems or needs of the child.

- Ignoring the need for, failing or refusing to allow or provide treatment for serious:
 - emotional/ behavioral problems or needs of the child
 - physical health problems or needs of the child
 - educational problems or needs of the child

Scenario 1: The child has one or more serious mental health symptoms, such as major Attention Deficit or Head Banging, and the parent refuses to seek medical help for the child or treat the child after receiving medical advice. Instead, the parent might lock the child in the closet, might refuse medication for the child, or might just keep the child home and not allow an education at all.

Activity: Types of Mental Injury

- Create a brief role play (under one minute) that demonstrates the behavior associated with the specific type of mental injury on the paper cut-out provided.
- Use **PG: 136-138, *Types of Mental Injury*** and **PG: 140-141, *Mental Injury: Examples of Caretaker Behavior by Age of Child*** as a reference.
- Do not let other groups know your type of mental injury or hear your discussion as the class must guess which type you are demonstrating.
- Each group will have 5 minutes to produce a brief role play.

Mental Injury: Examples of Caretaker Behavior by Age of Child

The chart below portrays the different types of mental injury behaviors you would likely see a parent/caregiver inflict on a child at various ages. Portrayed here are the behaviors toward:

- Infants
- School-age children
- Adolescents

	Rejecting	Terrorizing	Ignoring	Isolating	Corrupting
INFANTS	Refuses to accept child's primary attachment	Consistently violates child's ability to handle new situations and uncertainty	Fails to respond to infant's social behavior, which form the basis for attachment	Denies the child social interactions with others	Reinforces bizarre habits or creates addictions
	Behaviors				
	Refuses to return smiles, punishes child for vocalizations, abandons baby	Teasing/scaring infants by throwing them up in the air, reacting in unpredictable ways to infant's cries	Mechanical caregiving without affection, fails to make eye contact with infant	Refuses to allow relatives and family friends to visit the infant, leaves the infant unsupervised for long periods of time	Creates drug dependencies, reinforces sexual behaviors
	Rejecting	Terrorizing	Ignoring	Isolating	Corrupting
SCHOOL AGE CHILD	Consistently communicates to child that he/she is inferior/bad	Places child in "double binds" or places inconsistent or frightening demands on child	Fails to protect the child from threats while aware of the child's need for help	Attempts to remove the child from social relationships with peers	Rewards child for anti-social or illegal acts, exposes child to poor role models
	Behaviors				
	Uses labels such as "bad child," "dummy," always tells children they are responsible for family problems	Sets up unrealistic expectations and criticizes the child for not meeting them, forces children to choose between parents, teases the child, plays cruel games	Fails to protect the child from assault by other family members, shows no interest in child's education or life outside the home	Refuses to allow other children to visit the home, keeps the child from engaging in after-school activities	Exposes the child to pornography, rewards the child for stealing

ADOLESCENTS	Rejecting	Terrorizing	Ignoring	Isolating	Corrupting
	Refuses to acknowledge the changes in child as the child grows up, attacks child's self-esteem	Threatens to or actually subjects child to public humiliation	Gives up parenting role and shows no interest in the child	Over-controlling the child's social interactions, restricting the child's freedom to an extreme degree	Involves child in illegal or immoral behavior, encourages child to be part of this lifestyle at the expense of the child
	Behaviors				
Treats an adolescent like a young child, excessive criticism, verbal humiliation	Threatens to reveal embarrassing facts to the child's friends, forces the child into degrading punishments	Says "This child is hopeless, I give up" and means it, refuses to listen to child's discussion of his/her life and activities, focuses on other relationships at the exclusion of children	Punishes child for engaging in typical social activities (dating); accuses child of lying/doing drugs, etc., whenever they leave home; refuses to allow engagement in social activities	Involves child in prostitution, encourages child to hit or verbally abuse siblings, encourages drug use	

Legal Requirements to Prove Mental Injury

- The law requires a direct cause-and-effect relationship between parental behavior and harm to the child.
- Courts make rulings based on expert testimony about the child's mental and emotional well-being.
- Harm to the child must be demonstrated in the form of significant impairment in the child's functioning.
- Professional evaluation must be obtained to prove significant impairment.
- The suffering causes, or will cause, continuing difficulties in the child's ability to think, reason, and relate to others, and has sufficient indicators and substantial, observable symptoms.
- There must be identifiable parental behavior that could cause harm. This parental behavior must be established through substantial, observable action or lack of action on the part of the caregiver.
- A causal link between the parental behavior and the harm to the child must be established.
- A direct link must be shown.

Indicators of Mental Injury

General Behavioral Indicators	General Physical Indicators
<ul style="list-style-type: none"> • Habit disorders, such as poor eye contact, sucking, biting, rocking, enuresis, or eating and other food- related disorders • Conduct disorders, including withdrawal and anti-social behavior • Neurotic traits, such as sleeping disorders, inhibition of play, compulsiveness, hysteria, obsession, phobias and hypochondria • Suspicious, untrusting, pessimistic, depressed, anxious, preoccupied behavior • Inappropriate adult behavior or inappropriate infantile behavior • Developmental lags in mental and emotional growth • Suicide attempts • Poor self-image • Running away • Adaptive behavior in an attempt to respond to family's inconsistent interactions or expectations • Nervous tic, persistent stuttering, or speech disorder • Subservient role in the home • Developmental lag in decision-making • Hesitant to participate in discussions • Overriding worry about pleasing authority figure • Anger/hostility when not feeling in control 	<ul style="list-style-type: none"> • Hair missing because of pulling • Nails bitten • Body posture/facial expressions are withdrawn • Hives • Nervous tics • Overweight • Depression - low self-worth, low self-esteem • Thoughts and/or acts of suicide • Rebelliousness • Self-inflicted injuries

Caregiver Behaviors

- Have a need to always be in charge; can never let go, always critical
- Practice the abuse daily, ongoing and continuous
- Have distant, shallow or superficial relationship with family members
- Deny themselves fulfillment of emotional needs
- Are usually isolated from society
- Totally reject the child
- Make any positive interaction between the child and themselves inconsistent and unpredictable
- Program the child for failure
- Impose unrealistic expectations on the child
- Refuse to make allowances for the child's individuality

Activity: Margaret

Directions:

- Read the scenario about Margaret.
- After you read it, take 7-8 minutes to discuss the provided questions with your group, using *Indicators of Mental Injury*, the *Maltreatment Index* and anything else you have learned to answer these questions.
- Be prepared to discuss this in class.

Margaret

Margaret was reported by a family friend to be a victim of mental injury, because the friend felt Margaret is being “abused.”

The friend reported that Margaret, who is 11-years-old, is treated differently from her three siblings. She is not allowed to eat with the family, nor is she included in family social outings. She is also not permitted to participate in any social activities outside the home. You interviewed Margaret, and her descriptions of her treatment agreed with the allegations.

Margaret said she deserved this treatment because, “I’m a trouble-maker. I can’t control myself. They have to watch me all the time, or I’ll go crazy and hurt someone.”

Margaret’s teacher said Margaret is a good student but has few friends. The teacher also said Margaret is sensitive and cries when she makes mistakes.

You conduct a family interview. Margaret’s parents describe Margaret as “a problem child, one of those kids you have to watch all the time.” Neither parent spoke to Margaret or made eye contact with her throughout the interview. Even Margaret’s youngest sibling, a 5-year-old girl, described Margaret as “bad.”

Unit 6.6: The Dynamics of Substance Abuse

Misuse: Maltreatment Index

Substance misuse is used in the Maltreatment Index, but "abuse" is really how we talk about it. When a caregiver(s) is using drugs or alcohol, exposure of a child to drugs or alcohol is established by –

- A test administered at birth which indicates that the child's blood, urine, or meconium contained any amount of drugs, alcohol or a controlled substance or metabolites of such substances, the presence of which was not the result of medical treatment administered to the mother or the newborn infant.
- Evidence of extensive, abusive and chronic use of drugs or alcohol by the caregiver(s) when the child is demonstrably affected by such usage.
- Breastfeeding a child while frequently consuming drugs or alcohol, or by using an excessive amount of drugs or alcohol.

Substance Abuse and the Maltreatment Index

- The Maltreatment Index divides substance misuse into three areas:
 - The caregiver(s) inappropriately using drugs or alcohol
 - A child inappropriately consuming or being given drugs or alcohol and
 - Poisoning due to caregiver(s) actions or neglect.

Why People Use Alcohol and Other Drugs

- **To feel good.** Most abused drugs produce intense feelings of pleasure. This initial sensation of euphoria is followed by other effects, which differ with the type of drug used. For example, with stimulants such as cocaine, the "high" is followed by feelings of power, self-confidence and increased energy. In contrast, the euphoria caused by opiates such as heroin is followed by feelings of relaxation and satisfaction.
- **To feel better.** Some people who suffer from social anxiety, stress-related disorders and depression begin abusing drugs in an attempt to lessen feelings of distress. Stress can play a major role in beginning drug use, continuing drug abuse, or relapse in patients recovering from addiction.

- **To do better.** Some people feel pressure to chemically enhance or improve their cognitive or athletic performance, which can play a role in initial experimentation and continued abuse of drugs such as prescription stimulants or anabolic/androgenic steroids.
- **Curiosity and "because others are doing it."** In this respect, adolescents are particularly vulnerable because of the strong influence of peer pressure. Teens are more likely than adults to engage in risky or daring behaviors to impress their friends and express their independence from parental and social rules.

Source: <http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction>

Risk and Protective Factors

Risk Factors	Domain	Protective Factors
Early Aggressive Behavior	Individual	Self-Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Anti-drug Use Policies
Poverty	Community	Strong Neighborhood Attachment

- People who enter substance abuse treatment often first used drugs or alcohol in middle to late adolescence.
- Many behavioral, social and environmental factors affect whether and how a person develops a substance use disorder.
- There are biological risk and protective factors for substance abuse disorders.
- Every person has unique combinations of risk and protective factors, which form a complex interplay that affects the probability that the person will use or abuse substances.
- Children are exposed to both risk and protective factors that can either increase or decrease the likelihood of them developing substance use problems.

Spectrum of Addiction: Experiment, Use and Abuse

- People progress from substance use to abuse and addiction in different ways.
- Alcohol and other drug use exist on a continuum that starts with substance use and moves to abuse, and dependence.
- The differences between the categories are based on how many and what types of negative consequences are associated with the substance use.
- Process begins with experimental use.
 - The person experiences the positive effects of the substance – effects such as euphoria.
- As the person continues to use, he or she may begin to experience some of the negative physical or psychological consequences
 - DUI charges
 - Waking in the morning and not remembering what happened the previous night.
- Despite the negative consequences, some people continue to use, trying to capture that initial euphoria, running a risk of becoming dependent.
- Using more of the substance to get the same effect and in some cases using the substance more often, they will experience many more negative physical, psychological and social effects and less intense positive effects.
- Use continues due to physical dependence on the substance and changes in brain chemistry.

Addiction

- Addiction is a disease with its own psychopathology characterized by compulsion, loss of control, and continued use in spite of adverse consequences.
- Addiction is progressive, potentially fatal if untreated, and incurable but remissible through abstinence and recovery.
- As time passes, and drug use continues, changes in the brain result in voluntary drug use becoming compulsive drug use.

Criteria for Substance Use Disorders

- Substance use disorders are divided into two categories: Substance Abuse and Substance Dependence. Both refer to maladaptive patterns of substance use that lead to significant impairment or distress.
- People who are dependent upon a substance may experience:
 - *Tolerance*, which refers to the need to increase amounts of the substance in order to achieve intoxication or the desired effect. A sign of tolerance is a diminished effect with continued use of the same amount of substance.
 - *Withdrawal*, which is the development of a substance-specific syndrome when substance use is stopped or decreased. The type and length of withdrawal symptoms vary depending upon the substance. A sign of withdrawal is the need to take the same or similar substance in order to avoid withdrawal symptoms.
- People who are dependent upon substances may also:
 - Take substances in a larger amount or over a longer period of time
 - Want to cut down or control substance use, but may be unable to do so
 - Spend a lot of time and effort doing whatever is necessary to obtain the substance or recovering from the negative effects of using the substance
 - Give up or reduce social, occupation, or recreational activities because of substance use
 - Continue to use the substance despite awareness of physical or psychological problems that are either caused or worsened by substance use

Source: DSM is the manual used by clinicians and researchers to diagnose and classify mental disorders. The American Psychiatric Association (APA) will publish DSM-5 in 2013, culminating a 14-year revision process. For more information, go to www.DSM5.org.

APA is a national medical specialty society whose more than 36,000 physician members specialize in the diagnosis, treatment, prevention and research of mental illnesses, including substance use disorders. Visit the APA at www.psychiatry.org and www.healthyminds.org. For more information, please contact Eve Herold at 703-907-8640 or press@psych.org.

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Implications for Child Welfare

Alcohol and Drug Use Continuum	Implications for Child Welfare and Examples of Risks to Children
Substance use—the use of alcohol or other drugs to socialize and feel their effects.	
Use may not appear abusive and may not lead to dependence; however, the circumstances under which a parent uses can put children at risk of harm.	
Substance abuse—includes at least one of these factors in the last 12 months:	
Effects have seriously interfered with health, work or social functioning Person has engaged in hazardous activity on a recurring basis, such as driving or operating machinery under the influence Person has experienced use-related legal problems Person has continued use despite ongoing or recurring problems caused or exacerbated by use—this includes a maladaptive pattern of use, such as binge drinking	
Addiction (or substance dependence)—a pattern of use that results in three or more of the following symptoms in a 12-month period:	
Tolerance—needing more of the drug or alcohol to get —high Withdrawal—physical symptoms when alcohol or drugs are not used, such as tremors, nausea, sweating, and shakiness Unable to control use—a strong craving or compulsion to use and an inability to limit use The alcohol or drug increasingly becomes the focus of the person’s life at the expense of all other areas, including family, work, social and recreational Continued use despite ongoing or recurring physical or psychological problems caused or exacerbated by the alcohol and drug use	
Sources: American Psychiatric Association, 2000; SAMHSA, 2005.	

Physical, Psychological and Parenting Effects of Substance Use

SUBSTANCE		PHYSICAL/PSYCHOLOGICAL	PARENTING EFFECTS
Alcohol	<p><i>Alcohol abuse is a pattern of problem drinking that results in health consequences, social problems or both. Alcohol dependence, or alcoholism refers to a disease that is characterized by abnormal alcohol-seeking behavior and impaired control over drinking.</i></p>	<p>Short-term effects of alcohol use include:</p> <ul style="list-style-type: none"> • Distorted vision, hearing, and coordination • Impaired judgment • Altered perceptions and emotions • Bad breath • Hangovers <p>Long-term effects of heavy alcohol use include:</p> <ul style="list-style-type: none"> • Loss of appetite, vitamin deficiencies, stomach ailments • Skin problems • Sexual impotence • Liver damage • Heart and central nervous system damage • Memory loss 	<ul style="list-style-type: none"> • A parent may forget or neglect to attend to parenting responsibilities. • A parent may stay out all night and leave children alone due to intoxication. • A parent may have rages and depressive episodes, creating an unstable environment for children.
Cocaine	<p>Cocaine is a white powder that comes from the leaves of the South American coca plant. Cocaine is either "snorted" through the nasal passages or injected intravenously. Cocaine belongs to a class of drugs known as stimulants, which tend to give a temporary illusion of limitless power and energy that leave the user feeling depressed, edgy, and craving more.</p>	<p>Physical risk-associated with using any amount of cocaine and crack:</p> <ul style="list-style-type: none"> • Increases in blood pressure, heartrate, breathing rate, and body temperature • Heart attacks, strokes, and respiratory failure • Hepatitis or AIDS through shared needles • Brain seizures • Reduction of the body's ability to resist and combat infection 	<ul style="list-style-type: none"> • A child's crying, which may be only a mild annoyance to a non-using parent, is magnified in its intensity to the parent on cocaine. • A parent may become angry or impatient with a child for any reason because of thought distortion and misperception of the child's intent. • A parent addicted to crack can leave an infant or toddler alone for hours or sometimes days at a time to pursue the drug.

Cocaine

Crack is a smokable form of cocaine that has been chemically altered. Crack cycles rapidly through the body so that a physical and psychological "high" vanishes quickly, within 5 to 15 minutes, leaving in its wake anxiety, depression, and paranoia, as well as an intense craving for a return to the euphoric state.

Crack heightens feelings of power and control over one's life, feelings that may be sorely lacking in those belonging to oppressed social groups

Cocaine and crack are highly addictive. This addiction can effect physical and mental health and can become so strong that these drugs dominate all aspects of an addict's life.

Psychological risks:

- violent erratic or paranoid behavior
- hallucinations and "coke bugs"- a sensation of imaginary insects crawling over the skin
- confusion, anxiety and depression, loss of interest in food or sex
- "cocaine psychosis"— losing touch with reality, interest in friends, family, sports, hobbies, and other activities

Some users spend hundreds or thousands of dollars on cocaine and crack each week and will do anything to support their Many turn to drug-selling, prostitution and other crimes.

Cocaine and crack use have been a contributing factor in drownings, car crashes, falls, burns and suicides.

Cocaine and crack addicts often become unable to function sexually.

Even first time users may experience seizures or heart attacks, which can be fatal.

- CPS workers frequently investigate maltreatment reports in homes barren of furniture and appliances that have been sold to purchase crack and other drugs.
- The absence of food in the refrigerator or cupboards is evidence of parental inability to attend to a child's most basic needs.
- Some parents will do whatever it takes to pursue their habit, even if it means sacrificing the health and well-being of loved ones.
- Crack can contribute to a significant increase in sexual abuse of young children in two ways:
 1. The heightened physical sensations induced by crack can lead users to seek out sexual encounters. A child who is available and unprotected by a functioning adult, as when children accompany parents to so-called crack houses, is an easy target for sexual abuse by an individual high on crack.
 2. Very young children, even babies, can be prostituted by their crack-addicted parents desperate to obtain the drug.

Methamphetamine

Methamphetamine is a stimulant drug chemically related to amphetamine but with stronger effects on the central nervous system. Amphetamines are synthetic psychoactive drugs that stimulate or increase the action of the central nervous system. Methamphetamine is a stimulant drug chemically related to amphetamine but with stronger effects on the central nervous system. Amphetamines are synthetic psychoactive drugs that stimulate or increase the action of the central nervous system. Amphetamines may be smoked, injected, inhaled or taken orally as a capsule or tablet. Street methamphetamine is referred to by such names such as speed, meth and chalk. Methamphetamine hydrochloride, clear chunky crystals resembling ice, can be inhaled by smoking and is referred to as ice, crystal and glass. Both drugs have limited medical uses, primarily in the treatment of obesity. Methamphetamine is produced in clandestine laboratories with relatively inexpensive ingredients, such as caffeine, ephedrine and phenylpropanolamine—all legal substances that are usually found in over-the-counter diet pills and decongestants, making it a drug with a high potential for abuse.

The effects of methamphetamine use include:

- euphoria
- increased heart rate and blood pressure
- increased wakefulness; insomnia
- increased physical activity
- decreased appetite; extreme anorexia
- respiratory problems
- restless, anxious and moody
- aggressive and hostile
- excited or talkative experience
- a false sense of self-confidence or superiority
- hypothermia, convulsions and cardiovascular problems, which can lead to death
- irritability, confusion, tremors
- anxiety, paranoia or violent behavior
- can cause irreversible damage to blood vessels in the brain, producing strokes
- for users who inject the drug, skin abscesses may occur

Long-term effects
Users of large amounts of amphetamines over a long period of time can develop an amphetamine psychosis, a mental disorder similar to paranoid schizophrenia. Those with amphetamine psychosis exhibit bizarre, sometimes violent, behavior. Users may experience fatigue; long, disturbed periods of sleep; irritability; intense hunger; and moderate to severe depression.

Long-term use of methamphetamines can cause users to exhibit violent behavior, confusion, and insomnia. They may also exhibit paranoia, auditory hallucinations, mood disturbances and delusions. The paranoia can result in homicidal and suicidal thoughts.

- Methamphetamine is an increasing problem among parents in the child welfare system.
- Parents may not supervise children or provide for their basic nutritional, hygienic, or medical needs.
- Violence, aggression, and paranoia may lead to serious consequences for children of meth abusers.
- Additional risks to children can be quite extreme if the drug is being "cooked" in their residence.
- These risks include fire and explosions as well as unintentional absorption of the drug from the home environment.

Methamphetamine	<p>It is a white, odorless crystal-like powder that readily dissolves in water or alcohol.</p> <p>Amphetamines have the potential to produce tolerance, which means that increased amounts of the drug are needed to achieve the desired effects.</p>	<p>Methamphetamine users have been known to forego food and sleep and indulge in binging that is called a "run." This occurs when the user continually takes the drug every 2 or 3 hours over several days until he/she either runs out of the drug or is too disorganized to continue.</p>	
SUBSTANCE	PHYSICAL/PSYCHOLOGICAL	EFFECTS	PARENTING EFFECTS
Hallucinogens	<p>Hallucinogenic drugs are substances that distort the perception of objective reality. The most well-known hallucinogens include phencyclidine, commonly known as PCP, angel dust, or love boat; lysergic acid diethylamide, commonly known as LSD or acid; mescaline and peyote; and psilocybin, or "magic" mushrooms. Under the influence of hallucinogens, the senses of direction, distance and time become disoriented. These drugs can produce unpredictable, erratic and violent behavior in users that sometimes leads to serious injuries and death. The effect of hallucinogens can last for 12 hours.</p> <p>LSD produces tolerance, so that users who take the drug repeatedly must take higher and higher doses in order to achieve the same state of intoxication.</p>	<p>Physical risks associated with using hallucinogens:</p> <ul style="list-style-type: none"> • Increased heart rate and blood pressure • Sleeplessness and tremors • Lack of muscular coordination • sparse, mangled and incoherent speech • decreased awareness of touch and pain that can result in self-inflicted injuries • convulsions • coma; heart and lung failure <p>Psychological risks associated with using hallucinogens:</p> <ul style="list-style-type: none"> • a sense of distance and estrangement • depression, anxiety and paranoia • violent behavior • confusion, suspicion and loss of control • flashbacks • behavior similar to schizophrenic psychosis • catatonic syndrome whereby the user becomes mute, lethargic, disoriented, and makes meaningless repetitive movements <p>Everyone reacts differently to hallucinogens--there's no way to predict if you can avoid a "bad trip."</p>	<ul style="list-style-type: none"> • A parent may forget or neglect to attend to parenting responsibilities. • Parents may leave children alone while seeking, obtaining, or using the drug. • A parent may become angry or impatient with a child for any reason because of thought distortion and misperception of the child's intent

SUBSTANCE PHYSICAL/PSYCHOLOGICAL EFFECTS	PHYSICAL/PSYCHOLOGICAL EFFECTS	PARENTING EFFECTS
<p style="text-align: center;">Marijuana</p> <p>Marijuana is the most widely used illicit drug in the United States and tends to be the first illegal drug teens use. It can be either smoked or swallowed.</p> <p>Marijuana blocks the messages going to your brain and alters your perceptions and emotions, vision, hearing, and coordination.</p>	<p>Short-term effects of using marijuana:</p> <ul style="list-style-type: none"> • sleepiness • difficulty keeping track of time, impaired or reduced short-term memory • reduced ability to perform tasks requiring concentration and coordination, such as driving a car • increased heart rate • potential cardiac dangers for those with preexisting heart disease • blood shot eyes • dry mouth and throat • decreased social inhibitions • paranoia, hallucinations <p>Long-term effects of using marijuana:</p> <ul style="list-style-type: none"> • enhanced cancer risk • decrease in testosterone levels for men; also lower sperm counts and difficulty having children • increase in testosterone levels for women; also increased risk of infertility • diminished or extinguished sexual pleasure • psychological dependence requiring more of the drug to get the same effect <p>The physical effects of marijuana use, particularly on developing adolescents, can be acute.</p>	<ul style="list-style-type: none"> • A parent may forget or neglect to attend to parenting responsibilities. • Parents may leave children alone while seeking, obtaining, or using the drug. • Parents may fall asleep while under the influence of depressants and be unable to supervise or protect their children.

(Dore, 1998; Gold, 1992; National Institute on Drug Abuse [NIDA], 2001; NIDA, 2003).

Substance Abuse and Child Maltreatment

Substance abuse may serve as a dis-inhibitor for the parent

- Leads to hitting the child (physical abuse)
- Leads to emotional abuse (vilifying, scape-goating)
- Leads to having fun and not supervising (neglect)
- Leads to children getting caught in the crossfire when parents are engaged in inappropriate behaviors (endangerment- threatened harm)
- Being drunk may serve as a rationalization for sexual abuse of a child

Substance abuse can lead to illegal activity to support parental addiction

- Prostitution of parent (absent caretaker)
- Prostitution of child (sexual abuse)
- Stealing, passing bad checks, etc. (corruption, mental injury)
- Buying and selling drugs (mental injury, threatened harm)
- Parent involves child in criminal activity (corruption, endangerment, mental injury)

Substance abuse can drain family resources

- No money for food, clothing (physical neglect)
- Failure to seek medical care (medical neglect)
- Homelessness (failure to provide shelter)
- Pawns household items, etc. (failure to provide basic needs)

Substance abuse may impair child-caring behaviors

- Parent doesn't cook and/or feed.
- Parent doesn't send child to school.
- Parent doesn't physically care for child.
- Parent doesn't provide adequate supervision.
- Parent uses inappropriate caretakers, who may endanger or abuse the child.

Prescription Drug Abuse – The Mayo Clinic (2011)

The use of prescription medication in a way not intended by the prescribing doctor; includes everything from taking a friend's prescription painkiller for your backache to snorting ground-up pills to get high.

Prescription Drug Abuse Fact Sheet

Source: *U.S. Drug Enforcement Administration (2009)*

- In 2009, nearly 7 million Americans abused prescription drugs – more than the numbers who are abusing cocaine, heroin, hallucinogens, Ecstasy and inhalants combined.
- Prescription pain relievers are new drug users’ drug of choice vs. marijuana or cocaine.
- Opioid painkillers now cause more drug overdose deaths than cocaine and heroin combined.
- Nearly 1 in 10 high school seniors admit to abusing powerful prescription painkillers.
- 40 percent of teens and an almost equal number of their parents think abusing prescription painkillers is safer than abusing “street” drugs.
- Hydrocodone is the most commonly abused controlled pharmaceutical in the U.S.
- 25 percent of drug-related emergency department visits are associated with abuse of prescription drugs.
- Methods of acquiring prescription drugs for abuse include “doctor-shopping,” traditional drug-dealing, theft from pharmacies or homes, illicitly acquiring prescription drugs via the Internet, and from friends or relatives.
- Doctor involvement in illegal drug activity is rare – less than one tenth of one percent of more than 750,000 doctors are the subject of DEA investigations each year – but egregious drug violations by practitioners, unfortunately, sometimes occur. DEA pursues criminal action against such practitioners.
- DEA Internet drug-trafficking initiatives over the past three years have identified and dismantled organizations based both in the U.S. and overseas, and arrested dozens of conspirators.
- Because of major investigations, tens of millions of dosage units of prescription drugs and tens of millions of dollars in assets have been seized.

Different Substances Affect Parenting Differently

- Children need parents and caregivers to perform basic functions to support their physical, social, emotional, intellectual and spiritual development.
- When a parent has a substance use disorder, it can reduce the parent’s ability to perform many parenting functions and fully meet the children’s needs. Frequently, life becomes topsy-turvy and chaotic for the children.

Fetal Alcohol Syndrome (FAS)

- Drinking alcohol during pregnancy can have serious effects on fetal development. Collectively, these defects are called Fetal Alcohol Syndrome (FAS).
- FAS is one of the most commonly known birth defects related to prenatal drug exposure.
- Children with FAS may exhibit:
 - Growth deficiencies, both prenatally and after birth
 - Problems with central nervous system functioning
 - IQs in the mild to severely disabled ranges
 - Such characteristic facial features as: flattened mid-face, epicanthal folds on the eyes, short/upturned nose, thin upper lip
 - Irritability in infancy, hyperactivity, and other emotional and behavioral disorders throughout childhood, including attention deficit disorder (ADD) or with hyperactivity (ADHD), and poor social judgment.
 - Small eye openings and poor development of the optic nerve
 - A small head and brain
 - Joint, limb, ear and head malformations.
- The use of other substances can have significant effect on the developing fetus:
 - Cocaine or marijuana use during pregnancy may result in premature birth, low birth weight, decreased head circumference or miscarriage.
 - Marijuana use has been associated with difficulties in functioning of the brain.
 - Even if there are no noticeable effects in the children at birth, the impact of prenatal substance use often can become evident later in their lives.
 - As they get older, children who were exposed to cocaine prenatally can have difficulty focusing their attention, be more irritable, and have more behavioral problems. Difficulties surface in sorting out relevant versus irrelevant stimuli, making school participation and achievement more challenging.

Substance Abuse does not occur in a bubble.

- A person's battle with addiction is usually closely tied to the personal relationships he or she has with family members.
- As child welfare professionals, we are called to look at the family conditions to determine if a child is safe or unsafe.
- It is important to ask questions about the addict's family.
- There are often family dynamics that reinforce addictive behaviors, and family members may have no idea these behaviors exist.

The Impact of Substance Abuse on Childhood Development

Disruption of the Bonding Process

When mothers or fathers abuse substances after delivery, their ability to bond with their child—so important during the early stages of life—may be weakened. In order for an attachment to form, it is necessary that caregivers pay attention to and notice their children’s attempts to communicate. Parents who use marijuana, for example, may have difficulty picking up their babies’ cues because marijuana dulls response time and alters perceptions. When parents repeatedly miss their babies’ cues, the babies eventually stop providing them. The result is disengaged parents with disengaged babies. These parents and babies then have difficulty forming a healthy, appropriate relationship.

Neglected children who are unable to form secure attachments with their primary caregivers may:

- Become more mistrustful of others and may be less willing to learn from adults
- Have difficulty understanding the emotions of others, regulating their own emotions, or forming and maintaining relationships with others
- Have a limited ability to feel remorse or empathy, which may mean they could hurt others without feeling their actions were wrong
- Demonstrate a lack of confidence or social skills that could hinder them from being successful in school, work and relationships
- Demonstrate impaired social cognition, which is awareness of oneself in relation to others as well as of others’ emotions. Impaired social cognition can lead a person to view many social interactions as stressful.

Emotional, Academic and Developmental Problems

Children who experience either prenatal or postnatal drug exposure are at risk of a range of emotional, academic and developmental problems. For example, they are more likely to:

- Experience symptoms of depression and anxiety
- Suffer from psychiatric disorders
- Exhibit behavior problems
- Score lower on school achievement tests
- Demonstrate other difficulties in school.

These children may behave in ways that are challenging for biological or foster parents to manage, which can lead to inconsistent caregiving and multiple, alternative care placements. Positive social and emotional child development generally have been linked to nurturing family settings in which caregivers are predictable, daily routines are respected, and everyone recognizes clear boundaries for acceptable behaviors.

Such circumstances often are missing in the homes of parents with substance abuse problems. As a result, extra supports and interventions are needed to help children draw upon their strengths and maximize their natural potential despite their home environments.

Protective factors, such as the involvement of other supportive adults (e.g., extended family members, mentors, clergy, teachers, neighbors), may help mitigate the impact of parental substance abuse.

Lack of Supervision

The search for drugs or alcohol, the use of scarce resources to pay for them, the time spent in illegal activities to raise money for them, or the time spent recovering from hangovers or withdrawal symptoms can leave parents with little time or energy to care properly for their children. These children frequently do not have their basic needs met and often do not receive appropriate supervision. In addition, rules about curfews and potentially dangerous activities may not be enforced or may be enforced haphazardly. As a result, substance abuse is often a factor in neglect cases.

Parentification

As children grow older, they may become increasingly aware that their parents cannot care for them. To compensate, the children become the caregivers of the family, often extending their caregiving behavior to their parents as well as younger siblings. This process is labeled “parentification.” Parentified children carry a great deal of anxiety and sometimes go to great lengths to control or to eliminate their parents’ use of drugs or alcohol. They feel responsible for running the family. These feelings are reinforced by messages from the parents that the children cause the parents’ substance abuse or are at fault in some way if the family comes to the attention of authorities. Sometimes, these children must contact medical personnel in the case of a parent’s overdose, or they may be left supervising and caring for younger children when their parents are absent while obtaining or abusing substances.

Social Stigma

Adults who abuse substances may engage in behaviors that embarrass their children and may appear disinterested in their children’s activities or school performance. Children may separate themselves from their parents by not wanting to go home after school, by not bringing friends to the house, or by not asking for help with homework. These children may feel a social stigma attached to certain aspects of their parents’ lives, such as unemployment, homelessness, an involvement with the criminal justice system, or substance abuse treatment.

Adolescent Substance Use and Delinquency

Adolescents whose parents abuse substances are more likely to abuse substances themselves. Some adolescents mimic behaviors they see in their families, including ineffective coping behaviors, such as using drugs and alcohol. Many of these children also witness or are victims of violence. It is hypothesized that substance abuse is a coping mechanism for such traumatic events. Moreover, adolescents who use substances are more likely to have poor academic performance and to be involved in criminal activities. The longer children are exposed to parental substance abuse, the more serious the negative consequences may be for their overall development and well-being. *Source: Protecting Children in Families Affected by Substance Use Disorders, ICF International 2009, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families Children’s Bureau Office on Child Abuse and Neglect.*

The Substance Abuser's Child May:

- Appear unkempt
- Be frequently sleepy
- Be late to school
- Have unexplained bruises
- Know too much about drinking
- Appear withdrawn/depressed
- Display behavior problems
- Be frequently absent
- Complain of stomachaches.

Family Disease

- Children whose parents or caretakers are alcoholics or drug users are at greater risk of developing a substance use disorder.
- Children of alcoholics are 50-60 percent more likely to develop alcohol use disorders than children whose parents are not alcoholics.
- Children of parents who abuse illicit drugs may be 45 to 79 percent more likely to do so themselves than the children whose parents do not abuse illicit drugs.
- The conflicts that happen in an addicted family all happen slowly and gradually so that the family may not realize the depth of the disease or the dysfunction in which they live.

Reassignment of Roles and Responsibilities

- Children begin to learn that they cannot rely on the substance abuser to follow through on what he/she has said.
- Family members adapt by reassigning family roles/responsibilities.
- Children may be easily overburdened with the tasks of taking care of themselves and their siblings, preparing meals, getting to school alone, caring for the substance-abusing parent, etc.
- Due to the family's secret, the child has less support for the stress of his/her increased responsibilities.

Family Roles

- **Rescuer/Enabler:** Often steps in to save the addict, bails the addict out, makes excuses or fills in for the addict. Shielding the addict from consequences of substance abuse makes it easier for the addict to continue using.
- **Hero/Caretaker:** Tries to divert attention away from the problem by being too good to be true, secretly hoping that exemplary behavior will somehow make it easier for the addict to stop using. High achievers who do everything to assure that the addict has as little responsibility as possible, minimizing the possibilities for trouble to occur.
- **Adjuster/Lost Child:** Behaves apathetically to distance self from pain; passively withdraws from upsetting situation; hurting but attempts to avoid feeling the pain by refusing to confront the addiction or its consequences.
- **Scapegoat/Rebel:** Draws attention away from the family's primary problem of dependency through delinquency or other misbehavior; reacts to feeling trapped by the situation at home by poor school performance, hostility and other behavior problems.
- **Mascot/Pleaser:** Also draws attention away from the family by trying to please, by acting in a humorous way, the clown.

Breastfeeding Death

SC woman gets 20 years in breastfeeding overdose

BY JEFFREY COLLINS

Associated Press April 4, 2014

SPARTANBURG, S.C. — A judge sentenced a South Carolina woman to 20 years in prison Friday for killing her 6-week-old daughter with what prosecutors say was an overdose of morphine delivered through her breast milk.

A prosecutor said Stephanie Greene, 39, was a nurse and knew the dangers of taking painkillers while pregnant and breast feeding, instead choosing to conceal her pregnancy from doctors so she could keep getting her prescriptions. She lost her nursing license in 2004 for trying to get drugs illegally.

The 20-year sentence was the minimum after a Spartanburg County jury found Greene guilty of homicide by child abuse Friday. She could have faced up to life behind bars. Greene will have to serve 16 years before she is eligible for parole. She said nothing in court and quietly shuffled out of the courtroom, her hands and feet shackled, after she was sentenced.

Her lawyer said she will appeal and it's likely the case will be tied up for years to come. Both the prosecutor and Greene's lawyer agree no mother has ever been prosecuted in the United States for killing her child through a substance transmitted in breast milk. Also, prosecutors didn't prove how the baby got the morphine and there is little scientific evidence that enough morphine can gather in breast milk to kill an infant.

History

Greene's fourth pregnancy in 2010 was unplanned, but she and her husband of 10 years joyously accepted the surprise. She has two children from a previous marriage. Greene's husband supported his wife and was devastated as he prepared to raise their 7-year-old son alone.

Alexis was born healthy, and her mother chose to breast feed. Forty-six days later, Greene called 911 to report her baby was unconscious in her bed. On a recording of the call, she sounds groggy and unfocused. The former nurse first tries to do CPR compressions on the baby's back and has trouble counting to keep pace. Investigators at the scene found dozens of pill bottles and painkiller patches on her nightstand where the couple's then 4-year-old son could get to them.

A toxicology report from the baby's autopsy found a level of morphine in the child's body that a pathologist testified could have been lethal for an adult.

A review of her medical records showed Greene carefully hid her pregnancy from her primary doctor. After a home pregnancy test showed she was pregnant, she told her doctor she needed to go to a gynecologist for birth control. She then got prenatal care from that doctor while not telling the doctor all of the painkillers she was taking.

Greene's nursing license suspended in South Carolina in 2004 because she was irrational at work, tried to call in a prescription illegally and refused a drug test, according to an order from the state's Nursing Board.

* * * *

Child has consumed drugs or alcohol due to the caregiver(s) action or neglect:

- A child has consumed drugs or alcohol that substantially affects the child's behavior, motor coordination or judgment, or that results in sickness or internal injury.
- When a child is consuming drugs or alcohol to the point of being affected, it must be determined that the child is doing so with the consent, encouragement, insistence or neglect of the parent.
- Substance misuse also occurs when the caregiver exceeds the proper dosage for drugs when the drug substantially affects the child's behavior, motor coordination or judgment, or when the child sustains an internal injury from the drug.

“Poisoning due to caregiver's actions or neglect”

- Poisoning is defined as any substance, other than controlled substances or alcohol, taken into the body by ingestions, inhalation, injection, or absorption that substantially affects the child's behavior, motor coordination, or judgment and results in sickness or internal injury.
- Virtually any substance can be poisonous if consumed in sufficient quantity; therefore, the term “poison” often implies an excessive degree of dosage rather than a specific group of substances.
- Includes noxious substances that, when taken into the body, would be harmful or injurious.

Substance abuse and other problems

Substance abuse often co-occurs with other problems, which makes it difficult to assess its impact on child maltreatment. Parental substance abuse is likely to co-occur with the following problems that also are associated with child maltreatment:

- Lack of knowledge about child development
- Poor problem-solving and social skills
- Low maternal affection
- Poor attachment relationships
- Poor attention to the needs of an infant
- Disinterest in spending time with one's children
- Inconsistent disciplinary practices
- Social isolation
- Mental health problems, especially depression
- Anger toward or a lack of attention to one's children
- Difficulty maintaining employment
- Engagement in criminal behavior
- Failure to provide appropriately for the needs of one's children (clothing, food, medical care, hygiene, and emotional attention).

Substance Abuse and Family Violence

- Substance abuse by itself does not cause violence.
- Alcohol facilitates or triggers, rather than causes, assault.
- Substance abuse is often used to legitimize or excuse the violence.
- The relation between alcohol and violence is affected by multiple factors, such as personality, provocation and threat, as well as learned alcohol expectancies, situational factors and biochemical factors.

Unit 6.7: The Dynamics of Domestic Violence

Definitions

Florida Coalition Against Domestic Violence: “A pattern of controlling behaviors – violence or threats of violence – that one person uses to establish power over an intimate partner in order to control that partner’s actions and activities. Domestic violence is not a disagreement, a marital spat, or an anger management problem. Domestic violence is abusive, disrespectful, and hurtful behaviors that one intimate partner chooses to use against the other partner.”

Section 741.28, Florida Statutes: “Any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.”

Florida Department of Children and Families, Family Violence Threatens Child Maltreatment: “Family violence threatens child means an adult who is a family or household member commits any violent criminal behavior, such as assault or battery, on another adult who is a family or household member, that demonstrates a wanton disregard for a child and could reasonably result in injury to the child.”

Key Points

- Domestic Violence:
 - Is a pattern of conduct, not an individual, isolated event
 - Includes *possible* use of physical force or the threat of physical harm against adult victims (or children) to establish dominance. Domestic violence perpetrators may use physical force frequently or infrequently.
 - Can still occur through financial and verbal power and control efforts, even in the absence of physical abuse.
 - Can include a wide range of assaultive and coercive behaviors. Some of these are criminal, some are not; some of these are physically damaging, some are not. It is important to note that not all DV perpetrators use all of the tactics. One domestic violence perpetrator’s pattern may include one event of physical force (e.g., shoving the adult victim against a wall) combined with repeated incidents involving non-physical tactics (e.g., threats to kill, to abduct the children, etc.). Another domestic violence perpetrator may repeatedly use physical violence against the adult victim and/or children.

- Includes pattern of assaultive and coercive behaviors in intimate relationships. Not all assaults are part of an ongoing pattern of coercive behaviors that result in gaining power and control over a partner. A domestic violence victim *may* use physical force (in self-defense or in retaliation) without engaging in a pattern of assaultive and controlling behavior against the domestic violence perpetrator.
- Is only the intimate partner relationship of spousal, live-in partners and dating relationships.
- As a child welfare professional, you will also see violence in familial relationships. Family violence typically will not have a pattern of coercive control and involves mutually combative behaviors between household members, with no manner of control involved in the incident or in their daily life.

Who is Battered?

Domestic violence victims come from all groups:

- 85% of domestic violence victims are women.
- One in every four women will experience domestic violence in her lifetime.
- There is not a typical woman who will be battered - the risk factor is being born female.
- A female's use of retaliatory violence in response to the domestic violence is not considered a campaign of power and control over another; instead, it is considered an isolated incident of violent behavior. This is not to say that there are not female perpetrators but rather to show that often times when women are arrested or labeled a perpetrator in some other way, it is the result of self-defense and/or retaliatory violence.
- Heterosexual males can be victims of domestic violence by their female partners.
- Homosexual males can be victims of domestic violence by their male partners.
- Any DV victim may minimize and deny the violence to protect the children and him/herself.
- It is important to note that, although battering is occasionally an isolated act, once it begins, it often continues and escalates in frequency and severity.

Specific Vulnerabilities of Certain Cultural Groups

Battered Immigrant and Refugee Women

In the United States, battered immigrant and refugee women face additional barriers to accessing safety due to their issues of gender, race, socioeconomic status, immigration status and language.

A battered woman who is not a legal resident or whose immigrant status depends on her partner is isolated by cultural and legal dynamics that may prevent her from leaving her husband, seeking support from local agencies that may not understand her culture or requesting assistance from an unfamiliar American legal system. Some obstacles may include a distrustful attitude toward the legal system, language and cultural barriers (that may at the least be unknown and at the worst hostile), and fear of deportation.

Individuals with Physical, Psychiatric and Cognitive Disabilities

People with disabilities experience sexual and domestic violence at higher rates than the mainstream population. They may also experience maltreatment from their caretakers, including personal assistants, paid staff, family members and parents.

Examples can include:

- The denial of medications and personal care.
- The use of psychotropic medication as a restraint.
- Daily and intimate care mistreatment and neglect.
- Inaccessible organizations, facilities and equipment
- Unavailable or disabling assistive technology devices essential for communication and movement.
- Improper use of restraints and the denial of life-sustaining medical treatment and therapies.

Older Battered Women

Domestic violence in later life is a subset of the larger issue of elder abuse. Older women are a nearly invisible, yet a tragically sizable population who are uniquely vulnerable to domestic violence. Unlike domestic violence, elder abuse may not be perpetrated by an intimate partner or include power and control dynamics. Older women are more likely to be:

- Bound by traditional and cultural ideology that prevents them from leaving an abusive spouse or from seeing themselves as a victim.
- Financially dependent on their abusive spouse without access to the financial resources they need to leave an abusive relationship.
- Isolated from their family, friends and community, due to their spouses' neglect and abuse.

- This is especially true because older women suffer greater rates of chronic illness, which makes them dependent upon their spouses or caregivers and, thus, reluctant or unable to report abuse.

Battered Women Living in Rural Communities

Survivors in rural areas often face a lack of resources, isolation, small-town familiarity among neighbors, few (if any) support agencies, and poor or little transportation and communication systems in addition to the other barriers to safety that may be compounded by the rural lifestyle.

There may be a sense that sexist, racist, misogynistic, anti-Semitic and homophobic language and actions are often more acceptable in some rural communities, and that attitudes seem slower to change.

The patriarchal "good old boys" network, fundamentalist religious teachings, deep-rooted cultural traditions and commonly accepted sexual stereotyping can form a chorus of accusations that the battered rural woman is unfaithful in her role as a woman, wife and mother.

The act of leaving the home place, land and animals that could depend on her may be emotionally wrenching leaving the battered rural woman surrounded by walls of guilt and self-abasement.

GBTQQ Survivors

Same-sex battering is one person's use of physical, sexual or emotional violence, or the threat of violence or the fear of outing, to gain and maintain control over another. Same-sex battering can happen in any same sex relationship regardless of culture, race, occupation, income level and degree of physical or cognitive ability.

Power and Control Wheel



Major Aspects of the Power and Control Wheel

The major categories of the Power and Control Wheel include:

- Coercion and Threats
- Intimidation
- Use of Emotional Abuse
- Use of Isolation
- Minimizing, denying and blaming
- Using children against the adult victim
- Using male privilege
- Using economic abuse.

Below includes descriptions of batterer behavior for each of these categories.

Coercion and Threats

- Making and/or carrying out threats to do something to hurt her.
- Threatening to leave her, to commit suicide, to report her to child welfare.
- Making her drop charges.
- Making her do illegal things.

Intimidation

- Making her afraid by using looks, actions, gestures.
- Smashing things.
- Destroying her property.
- Abusing pets.
- Displaying weapons.

Use of Emotional Abuse

- Putting her down.
- Making her feel bad about herself.
- Calling her names.
- Making her think she's crazy.
- Playing mind games.
- Humiliating her.
- Making her feel guilty.

Use of Isolation

- Controlling what she does, who she sees and talks to, what she reads, where she goes.
- Limiting her outside involvement.
- Using jealousy to justify actions.

Minimizing, denying and blaming

- Making light of the abuse, and not taking her concerns about it seriously.
- Saying the abuse didn't happen.
- Shifting responsibility for the abusive behavior.
- Saying she caused it.

Using children against the adult victim

- Making her feel guilty about the children.
- Using the children to relay messages.
- Using visitation to harass her.
- Threatening to take the children away.
- Undermining her parenting efforts, such as putting her down in front of the children. and/or disregarding her parenting decisions in front of the children.

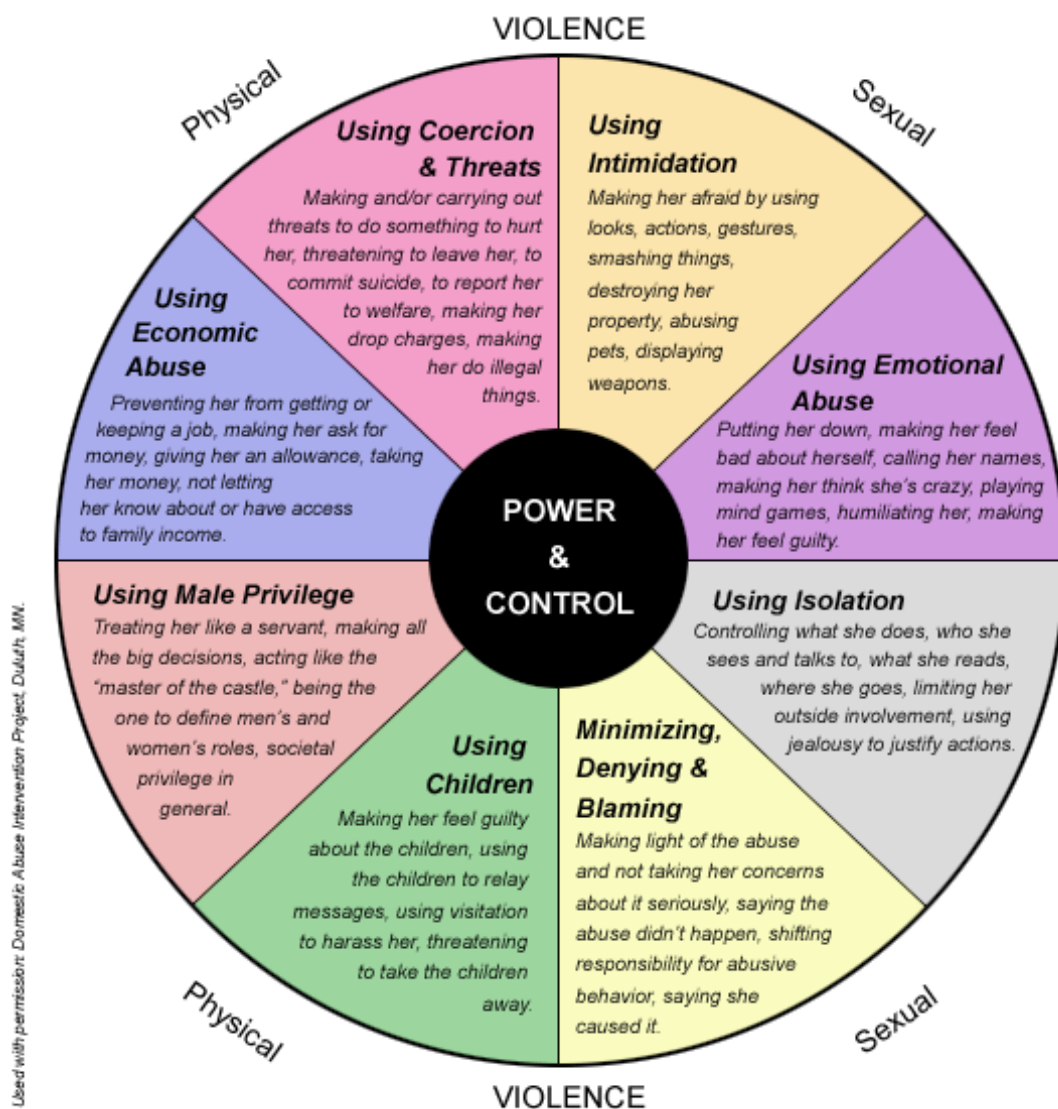
Using male privilege

- Treating her like a servant.
- Making all the big decisions.
- Acting like the “master of the castle.”
- Being the one to define men’s and women’s roles.

Economic abuse

- Preventing her from getting or keeping a job.
- Making her ask for money.
- Giving her an allowance.
- Taking her money.
- Not letting her know about or have access to family income.

Wheel of Power and Control



Links between Domestic Violence and Child Abuse

The U.S. Advisory Board on Child Abuse suggests that Family Violence may be the single major precursor to child abuse and neglect fatalities in the United States.

- Child abuse occurs in up to 70% of families who experience DV.
- The risk of child abuse is 1500% greater in homes where there is domestic violence.
- Children who are exposed to DV are at higher risk of physical abuse.
- 40-60% of men who abuse women, abuse children
- Research indicates that some child abuse begins with spouse-battering that escalates to include the children.
- Domestic violence, when pervasive in a child's life, sets a pattern and models an interactive response that can establish an expectation for children of how individuals treat each other.
- The perpetrator's behavior can directly impact the child, such as being:
 - Hit by the batterer when trying to intervene and protect the abused parent.
 - Forced to witness or participate in the beatings.
 - Threatened to be beaten if the child discloses to anyone.
 - Hit with objects by the batterer, who intended to strike the abused adult.
- A child who is exposed to a perpetrator's abuse, over time, may accept this type of behavior as acceptable or normal.
- The child may use similar behaviors with his or her peers, and be unaware that this is not acceptable in other families.
- Male children are at greater risk of becoming abusers if they witness their father abusing their mother. However, not all of these boys become perpetrators. Battering is a choice, and many men who witnessed abuse as a child do not abuse their partners.

Batterer Behaviors/Behavior Threats That Raise the Risk of Lethality

There are some behaviors or threats of behaviors that raise the risk of lethality.

If the abuser exhibits the below activities, a survivor's risk of being killed are higher:

- Used, or threatened to use, a gun, knife, or other weapon against the victim.
- Threatened to kill or injure the victim.
- Tried to strangle (choke) the victim.
- Is violently or constantly jealous.

There are also signs to look for in the abuser that indicate a high risk of lethality:

- The abuser threatens suicide or homicide. If he says he will kill himself, understand that this likely means he will kill the partner, as well.
- The abuser fantasizes of homicide or suicide. If he sees this as a "solution" to his problems, he may attempt it. Beware of the abuser threatening to kill himself. Usually, it means he plans to kill the partner first.
- The abuser has access to weapons. If the abuser owns weapons or has access to weapons, and has used them or threatened to use them in the past, there is a potential for a lethal assault. The use of guns is a strong predictor of homicide.
- Separation violence. If the abuser believes the partner will leave him, and he can't imagine life without the partner, he may try to kill the partner.

Other Important Facts

- Many homicides occur when a victim is leaving her abusive partner.
- Seventy-five percent of women are seriously injured when they leave or try to leave an abusive relationship.
- If there is escalating danger and the batterer begins to act more and more as if he has no regard for the consequences of his actions—legal or otherwise—the victim is at extremely increased risk of danger.

If the Woman Leaves...

- The most dangerous time for a battered spouse is when she leaves. So, it's very important to have a safe place to go.
- The Florida Coalition Against Domestic Violence includes a network of 42 certified domestic violence centers, serving 67 counties. These centers provide safe shelter for battered women and their children where, they can access interventions and resources, food, clothing and safety planning.
- To access the nearest domestic violence center by telephone, just dial the FCADV toll-free number, 1-800-500-1119, and you will be connected to the domestic violence center nearest to you.
- Florida Statutes establish privileged, confidential communication between domestic violence center staff and their clients.
- Information about the shelter location cannot be disclosed to ensure the safety of the clients and staff. Exceptions are law enforcement, medical and fire-fighting personnel, when they need to access the shelter.
- Domestic violence center staff are required to report suspected abuse or neglect of children; however, they are still bound to the confidentiality rules regarding their clients' privileged communication.
- The most dangerous time for a survivor of domestic violence is when they leave the batterer.
- Domestic violence advocates can only share information with other service providers with the informed, reasonably time-limited, written consent of the survivor. The release of information can only last for a short time, typically 30 days, but can be renewed by the survivor if needed. There are both state and federal laws that mandate this confidentiality standard (s .39.908, F.S, s. 90.5035, F.S., s. 90.5036, F.S., and the Federal Violence Against Women Act of 2005).

Factors Involved in a Woman's Decision to Return or Not Return

The following factors may or may not come into play regarding a woman's decision to return to her batterer or to leave permanently.

1. If the criminal justice system, such as law enforcement or the state attorney's office, has not held him accountable for his violence in the past, the woman may feel she is unsafe to leave because there will be no one there to protect her and her children.
2. The longer the abuse has been going on, the greater the chance she will choose to stay.
3. If the abuse is "not that bad" according to her perception, she has a greater chance of staying. Or, if the injuries are severe, she may have more pressure from others to leave, as well as her own fear for herself.
4. The less able the victim is to provide financially for herself and the children, the greater chance she will stay.
5. Depending on how severely the children are being affected, their presence may keep her from leaving, especially if she is financially dependent and if he has threatened to take them away if she leaves.
6. Extended family may or may not be supportive. If there is no family support, it is more likely she will stay, especially if services, such as shelter, are unavailable or scarce. This is one of the reasons why batterers isolate survivors from their survivor networks.
7. If the children are being abused, she is more likely to leave to keep them from further abuse. On the other hand, if the batterer does not abuse the children, she may be more willing to stay.
8. Depending on her culture or religious beliefs, she may be heavily criticized for leaving. On the other hand, if she is part of a society that expects her to leave the situation, she may be ashamed if she doesn't leave. She may have a very real fear of being killed. As noted, she's at the greatest risk of death when she tries to leave.

Protection Strategies for the Woman Who Remains with the Batterer

Many survivors are already implementing these safety strategies to keep themselves and their children safe. It is wise then to ask the survivor to share what she has already been doing before telling her what she should do.

She is the expert on her safety and the safety of her children. The safety strategies that are most effective are those that build on her current efforts.

1. When she feels the tension building and an episode feels imminent, she can get the children to a safer place, such as with neighbors, friends or relatives for a day or night or a short period of time, until after an incident occurs.
2. Have a safety plan that is shared with the children for when a violent incident begins suddenly. For example, if battering begins, the children know to go to their rooms and close the doors, or to the house of a neighbor, who has agreed ahead of time to provide safe haven for the children when needed.
3. Teach the children never to get in the middle of an adult fight, even if they are trying to help protect her, and never to put themselves in danger.
4. Give her children permission and encouragement to have relationships with at least one other non-violent, trusted adult they can talk to as well as someone who can be a good role model. Examples might be a teacher, a minister, a school counselor, a coach, an aunt or an uncle.
5. When the violent incident is over, assure them that they are safe and what has scared them is now in the past. Speak to them in a calm, soothing voice.
6. Encourage them to ask questions, so they can voice their fears and misunderstandings, so she can correct them. For example, children may misunderstand and think the domestic violence is their fault or is their responsibility to resolve.
7. Stick to established, daily routines, such as a bedtime ritual and meals at usual times, although it's important to note that the batterer may sabotage her efforts to do this. Routine helps children to feel the world is secure and predictable.
8. When the home is unsafe, older children should know:
 - How to call 911.
 - Names and phone numbers of trusted adults they can call for help any time of the day or night.
 - Hiding places and exits from the house.
 - To stay out of the way of the violence.

Why it Matters

- If a child witnesses abuse of a parent, he will likely grow up to be a batterer if the child is male, and the female child will likely grow up to be involved with a batterer.
- Seeing someone else being battered can be as emotionally harmful as actually being battered oneself.
- At least a third of American children have witnessed violence between their parents.
- Boys who witness domestic violence are twice as likely to abuse their own partners and children when they become adults. However, battering is a choice, and many male children exposed to domestic violence choose not to batter as an adult.
- The greater the severity and frequency of the victimization, the greater the likelihood of severe and frequent violent offending outside of the family.

Child Maltreatment Index

FAMILY VIOLENCE THREATENS CHILD

DEFINITION

Family violence threatens child means an adult who is a family or household member commits any violent criminal behavior, such as assault or battery, on another adult who is a family or household member, that demonstrates a wanton disregard for a child and could reasonably result in injury to the child.

- “Family or household member” means spouses, former spouses, intimate partners, persons related by blood or marriage, persons who are presently residing together as if a family or who resided together in the past as if a family, and persons who are parents of a child in common regardless of whether they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit.
- When the alleged perpetrator of the violent criminal behavior is a minor who is a parent, s/he can only be an alleged perpetrator of this maltreatment for his/her own child, not for other children in the home.

The criminal definition for “domestic violence” is contained in Chapter 741, Florida Statutes, which states that domestic violence is any assault, aggravated assault, battery, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another who was residing in the same single dwelling unit. (section 741.28, F.S.). This definition is provided for information only. It includes behaviors which do not meet the criteria for this maltreatment (such as stalking).

**For a report of “Family Violence Threatens Child” to be accepted, the incident must have occurred between two adults who meet the above definition for “family” or “household members,” or between a minor who is a parent and the other parent or an adult who is a family or household member.

**If the “primary aggressor” is not clearly identified by the reporter at the Hotline, the intake should be conceded as, caregiver responsible, perpetrator unknown and the CPI will determine the identity of the perpetrator during the investigation on “family violence threatens child” maltreatments. Only one caregiver should be identified as the domestic violence perpetrator. This person can best be determined by the protective investigator during the investigation.

ASSESSING “FAMILY VIOLENCE THREATENS CHILD” AS MALTREATMENT

- Was law enforcement called related to the incident and/or was an arrest made?
- Are there current or past protective orders or injunctions?
- Were there elements of control present such as financial or isolation?
- Where were the children during the incident?

- Were the children injured as a result of the incident?
- Were weapons used or present during the incident?
- Is there a history or pattern of domestic violence?

ASSESSING FOR OTHER MALTREATMENT

- If a weapon was used during the violent episode and the child was injured with the weapon, also assess for “Physical Injury.”
- If the allegation is verbal abuse without threats of physical violence assess for “Mental Injury” to the child.
- The only time the alleged perpetrator for this maltreatment can be under 18 is when that minor child is the parent. If the child is attacking an adult in the home, assess for a special conditions “Parent Needs Assistance” referral.

EXCLUDING FACTORS

Caregiver(s) who are a participant in violent behavior with someone other than an adult who is a family or household member or intimate partner does not constitute “Family Violence Threatens Child.” If the child was injured use the appropriate maltreatment and assess for other maltreatments such as “Mental Injury.”

DOCUMENTATION TO SUPPORT A FINDING OF MALTREATMENT

- Obtain and consider any reports and interviews from law enforcement that include 911 call history to the residence.
- Documentation and communication from the State Attorney’s Office.
- Review and documentation of psychological examinations.
- Documentation from interviewing the children in the home about current and past incidents.
- Documentation of the effects on the children’s daily routines, functioning, development, education and medical.
- Documentation from interviewing and observing the caregiver(s) and other participants in the incident (if any). Focus should be on their interaction and reasons for the incident and the extent of the violence.
- Documentation of coercive control behaviors as disclosed by the adult victim and/or child whether current and/or past behaviors.
- Documentation from interviewing witnesses to the incident or person who know the family well.
- Documentation for collateral contacts that may include neighbors or the family’s landlord.
- Documentation of a pattern of domestic violence related incidents.
- Documentation of the lethality of the situation (choking, escalating incidents, threats to kill, etc.).

Activity: Does it Reach the Level of Maltreatment?

Directions:

- You will be assigned to one of three groups. Each group will be assigned one of the case scenarios that follow.
- Read the case scenario and evaluate as a group whether it describes a domestic violence situation that would rise to the level of the Maltreatment Index allegation of “Family Violence Threatens Child.”
- List the reasons the group decided the scenario described maltreatment or not. What were the indicators of domestic violence, and what were the indicators of the effect on the child? Note other information and organize according to the six domains.
- Each group will present its findings. If you have time before the group results are presented, read the case scenarios the other groups were assigned.

The Parkins Family

Mother, Mary, 37, and her husband, Dale, 65, have been married for four years. They have a blended family: two children of hers, Lisa, 15, and Ken, 13. Their father is dead. When they married, Dale moved his daughter, Tammy, also 15, into their home. Tammy, prior to this, had been living with her mother in another state. Within a few months of the marriage, Dale moved the family to another state, Florida, near a military base, since he is a retired Army colonel. Prior to this, Mary and her children had lived in the same neighborhood as her family, and she had a good deal of support as a single, working mother.

The Parkins have come to the attention of DCF because of a report to the Hotline from a neighbor, alleging an incident of Domestic violence. The narrative stated that Dale was heard from outside the home yelling and screaming obscenities at the mother and the sound of breaking glass and loud thuds. Mary is also heard yelling back. Two of the children, Lisa and Ken, quickly retreated to this neighbor’s home not long after it started. The children don’t say much to the neighbor about what is happening next door, they just ask to come in and visit with her children.

The Parkins live in a nice house in an upper middle class neighborhood. Each child has his or her own room. The home is orderly and neat. Both parents are home together as Dale is retired and Mary no longer works. The children seem well-dressed and well-fed, although Lisa is underweight. Lisa and Ken have good grades and are involved in many after-school activities. Lisa, in particular, exceeds academically and in relationships with others. Tammy is an average student, but has no significant problems in school, academically or with teachers or peers.

The CPI conducts an introduction with the family and advises them of the report that the Department has received. When the family is together, the incident is downplayed, and most questions are answered by Dale, unless he prompts Mary or one of the children to agree with him. Dale admits to having a temper, but only when he is not respected or obeyed. The other family members agree. All say it doesn't happen often. When the children are with the family, Lisa and Ken are quiet and subdued, compared to their typical demeanor, which is more relaxed and animated when interviewed away from the other family members. Tammy seems comfortable either when she is with the family or alone. Dale doesn't want the others to be interviewed alone; however, he agrees to it when the CPI explains that it is standard procedure. The CPI begins the interviews with the family, interviewing each family member alone, starting with the victim children.

The children tend to fight with each other, sometimes to the point of physical injury – especially Lisa and Ken. When questioned about this, they say they've always fought, but lately it has been worse. Both Lisa and Ken say Dale is a much harsher, stricter parent than their mother is or their father was. They both say they are afraid of him when he erupts. Both also agree that it happens about two or three times a year. Both children have a standard plan to leave the home when the violence begins or before, if they can sense it coming. Both children seem to love their mother and trust her to take care of their needs, but they fear for her. Lisa says she stays at school as much as possible, just to avoid the whole thing. All three children agree that Dale picks on Lisa more than the others and is very critical. For example, when they go out to dinner, Dale insists that everyone eat everything on their plate. Lisa rarely can eat a whole adult dinner, and she is too old for the children's menu. Dale will insist on staying at a restaurant until Lisa eats everything. Sometimes, this takes hours. When she makes a "B" instead of her usual "A" on her report card, she is restricted to her room until the next report card is released. Ken and Tammy are not held to this standard, and Tammy routinely makes "C"s. They receive no punishment for this. When Tammy is interviewed, she just rolls her eyes and says, "That's just how Daddy is," and tells you that Dale and her mother used to fight like this, and that's why they divorced. She says she's learned to just stay out of the way and retreat to her room.

When Mary is interviewed, she admits that the incidents are worse than Dale says, but that she has never been physically injured, nor have the children. She says he "just calls me names, but he has never threatened to hurt me" and "if he ever touches me or my kids, I'll hit him over the head with an iron skillet, and I'll make sure he never will again." Mary says that she can sense when he's about to erupt and it happens about once a year. She says she "knows how to handle him," and she never fears that he is going to physically hurt her. During the incident in question, Dale was yelling at her and then he went into another room, away from her, and began throwing things and turning over furniture. He typically does that, however, he never does it when she or the children are in the room. She says he is a controlling husband. She is not allowed to work out of the home, because Dale wants her home with him since he is retired. This initially was a welcome relief from being a working mother, but Dale also resents any friends she wishes to see. He does not allow her to use the car unless she asks his

permission and tells him exactly where she is going. Then he checks the gas gauge and odometer before and after, as well as monitors the time, to be sure she obeys him. She has limited access to the checking account, and Dale gives her a small allowance, but most purchases require his permission.

When Mary is asked about how Dale's behavior affects the children, she says it doesn't seem to affect Tammy much, and she just goes to her room and shuts the door. Dale rarely yells at Tammy, and Mary says his relationship with his own daughter seems good.

Mary's children are more affected and, sometimes during a violent outburst, Lisa is targeted by her stepfather and is referred to as a "little bitch." He shouts and blames her for whatever issue he and Mary are fighting over. They have learned to leave the house as soon as they are aware an incident is starting. They go to a neighbor's home or that of a friend. After an incident is over, Dale takes the only car the family has and will be gone anywhere from a few hours to a day or two. He arrives back refreshed and acts as if nothing has occurred. When others in the family feel anger at any time, they know they must try to hide it or repress it, lest they "set off" Dale.

Dale is interviewed last. As mentioned, he is a retired military officer. He is very amiable and charming. He says he is trying to teach Mary's children responsibility. He thinks they are "soft" and could use some military discipline. He says he adheres to strict limits for bedtimes, curfews, etc. He continues to minimize the reported incident and denies any "out of control" behavior. Sure, he gets upset and may raise his voice, but he is just trying to be firm.

The Smith Family

Brad, 25, and Janet, 24, met in high school and married soon after graduation. They've been married 7 years and have four children: Darnell, 6; Keisha, 4; Frank, 2; and Sharrone, 6 months. Brad is a day laborer at several construction companies. Janet works at a local daycare, where she is able to take the three youngest children. They live in a three bedroom trailer in a trailer park near the outskirts of town. The boys share a room, and Keisha and the baby share a room.

DCF became involved with this family when it was reported to the Hotline that the children were seen outside on the deck of the home late at night. The oldest child, Darnell, was holding the baby, who was crying. They were dressed in their pajamas, and the temperature was in the lower 40's. Screaming adults could be heard, as well as crashing objects and loud thumps against the walls. The caller said she started to call the police, but soon the noise stopped, and Brad left the house and drove away. Then Janet brought the children in-doors, and nothing else went on. The next day the neighbor decided to call the Hotline because of the children, but did not want to leave her name.

When the CPI arrives later that day, the home is sparse but clean. The children are in front of the TV. Keisha is watching the baby, and the boys are playing on the floor. They are adequately clothed. Janet answers the door, and she has a black eye and she limps slightly with her right leg. The CPI notes that there is minimal food in the refrigerator. When asked, Janet explains that Brad didn't give her money for groceries this week. She gives him her paycheck, and then he gives her cash for the household needs. She says he'll be home soon and will let her go grocery shopping tomorrow. She says she has enough to feed the kids today. She says she has milk and bread and cheese. She plans on making grilled cheese and has a can of soup she can heat up. She explains she doesn't drive or have access to the bank account.

When Janet is interviewed and asked about the incident last night, she is reluctant to talk about it or her noted injuries. She says Brad loves her children very much. She says that Brad is just a very jealous man, and sometimes he gets mad when she is tending to the children when he wants something. "He's really just a big baby, himself. But he lets his tantrums get out of hand sometimes, and he pops me one. Especially on Friday night after he has a little too much to drink, he'll want my 'attention', you know. But, I make sure he doesn't hit the kids. I send them outside and lock the door, so they won't get hurt and he won't hear them cry. They just sit outside on the deck until I tell them it's safe. Usually, Brad will pass out or take off in the truck. Darnell, my oldest, is such a good boy. He takes care of the others just like a little man. He always knows just what to do. I swear, they never stay out very long."

Examination of the children indicates there are no physical injuries. The baby, Sharrone, is small for her age and is fussy and irritable. She seems to startle easily, and then begins to cry and fret. The older children try to calm her. Two-year-old Frank is in diapers and keeps taking away his baby sister's bottle to feed himself. Keisha is very quiet and timid. She has a doll that she clutches as the 2-year-old attempts to take it away. Janet explains that Keisha is just scared of strangers. Darnell seems old beyond his years. He is very solemn, polite and pays close

attention to everything. He is quick to stop one of the other children before they get hurt or hurt each other, or in some other way cause trouble. Janet seems to expect this from him and depends on him being her assistant.

Brad arrives and is surprised to see the CPI. The children do not interact with Brad when he arrives and “steer clear.” He pays them little, if any, attention. He refuses to discuss his family with the CPI and says, “I never laid a hand on them kids. Unless you can show me where they got hurt, or you got a warrant, you need to get out of here.” Brad sounds very threatening, and Janet seems afraid and begs the CPI to leave. The CPI explains that he/she has seen that the children aren’t physically harmed, but there are some concerns and the CPI will return, with law enforcement if necessary.

The director of the day care where Janet works and three of the children stay says that Janet is a good employee and is very good working with the children at the center. She says that Janet is as good a mother as her husband will allow. But sometimes she comes in injured, especially after a weekend, and offers some unlikely reason for her injuries. Sometimes, the injuries make it hard for her to do her job with the kids at the center and must make it hard at home. Sometimes, they also show up in the morning and it’s obvious they haven’t been fed. Janet says that Brad “forgot” to take her grocery shopping. The baby is always fussy and seems to be exhibiting some signs of delays in her development.

The director says 2-year-old Frank is especially aggressive, even for a 2-year-old, and is always fighting with the other children. He seems to regress and, though he has been potty-trained, he episodically shows up in diapers. Sometimes, he uses baby-talk and cries and demands a bottle. Four-year-old Keisha is shy and doesn’t seem to make friends with other children. She just cries a lot for her older brother, Darnell, who is in elementary school. Reports from Darnell’s teacher are that he is very mature for his age and keeps up with his studies, despite not always having his homework completed. He says he has to help with the kids at home. Other than that, he is a model student, if a little too serious.

Criminal Background Checks and Domestic Violence

- Important information to note:
 - If the batterer has been convicted of domestic violence, especially if firearms are involved.
 - If the batterer has been convicted of other violent crimes, especially if firearms are involved.
 - If the batterer has been convicted of child abuse or neglect regarding other children in other families.
 - If the batterer has any active protective orders (injunctions) in place.
 - Domestic Violence Injunctions in current and past relationships for batterer and survivor.
- A criminal background check will also tell you if there are any active protective orders (injunctions).
- This information will help you decide if you may require law enforcement backup.

The Role of Injunctions and Intervention

- An injunction is a protective order.
- Protective order for adult victim of domestic violence:

The victim may ask the state attorney to file a criminal complaint. The victim also has the right to go to court and file a petition requesting an injunction for protection from domestic violence, which may include, but need not be limited to, provisions that restrain the abuser from further acts of abuse; direct the abuser to leave the victim's household; prevent the abuser from entering the victim's residence, school, business, or place of employment; award the victim custody of his/her minor child or children; and direct the abuser to pay support to the victim and the minor children if the abuser has a legal obligation to do so. (s. 741.29, F.S.)
- Protective order for child abuse victim:

"At any time after a protective investigation has been initiated pursuant to part III of this chapter, the court, upon the request of the department, a law enforcement officer, the state attorney, or other responsible person, or upon its own motion, may, if there is reasonable cause, issue an injunction to prevent any act of child abuse. Reasonable cause for the issuance of an injunction exists if there is evidence of child abuse or if there is a reasonable likelihood of such abuse occurring based upon a recent overt act or failure to act." s. 39.504(1), F.S.
- If an injunction is already in place, it can be used to protect the adult victim, with law enforcement support, if necessary.
- As a child welfare worker, you, too, can petition the court for an injunction to protect the children in a family, if the parents seem unable to make the needed changes on their own.

- An intervention is a supportive service that strengthens and supports the safety of families. An intervention may be targeted at the adult victim, the batterer, the children, or the whole family, depending on the needs.
- Interventions used by child welfare professionals can be strengthened through collaborations with other programs in the community. Examples of services that can play a crucial role in helping to protect children include:
 - Emergency shelter and longer-term (or "transitional") housing programs for abused women and their children.
 - Legal assistance and advocacy for abused women.
 - Law enforcement or prosecution-based domestic violence programs.
 - Batterers' intervention and education programs.
 - Parenting classes for batterers that stress the impact of domestic violence on children (as opposed to programs that teach abusers how to parent despite their violence).
 - Support programs for abused women that help them to help their children recover from the effects of the domestic violence.
 - Programs to help children who have witnessed domestic violence.
- If the courts become involved, batterers can be required to participate in interventions. Experience has shown that this may be the most successful way of getting batterers to work toward change. Research also has shown that ordering the non-offending parent to counseling or other interventions is not the most effective way of aiding the victim, as it sends the message that it is somehow her "fault" for being battered.
- Interventions for survivors and their children should be determined through meaningful and private conversations with the survivor about what will help keep the children safe. It is not effective to mandate her to a lengthy course on Domestic Violence. Batterers can be mandated to attend Batters Intervention Program. However, if we mandate a survivors attendance at courses, and this is not what she identifies as something that will increase her safety, we can impede her progress. For instance, if she is mandated to take a 12-week class, she has less time to seek employment and to gain financial stability apart from the batterer. It reinforces the notion that the violence is her fault and she needs to be fixed in order for it to stop. It gives more power to the batterer and, therefore, can increase the level of danger for the survivor and her children. It is a very harmful practice that should be avoided. Voluntary referrals should be made to certified Domestic Violence centers.
- It is better to facilitate a meeting with a domestic violence advocate who is trained specifically in supporting the adult victim. A DV victim advocate will assess and help the non-offending parent by offering a range of options and interventions, allowing the adult victim to choose.

Source: <http://www.sao4th.com/how-we-can-help/how-to-file-charges/>

Domestic Violence Advocates and Child Welfare Professionals

- Same focus. DV victim advocates are concerned about both adult and child safety. It is a common misperception that they are only interested in the adult, which is not true. DV advocates do not see child safety independent from the safety of the victim parent. This is a core component of the Safe and Together Model. When we increase the survivor's safety, we increase the child's safety.
- Same focus in advocacy. Similarly, DV program staff and child welfare professionals are advocates for both the adult victim and the children. Certified DV centers have child/youth advocates as well as adult advocates, and they provide services for children, such as safety planning and counseling.
- Differences in confidentiality requirements. As with everyone, DV victim advocates are required by law to report suspected abuse of a child or a vulnerable adult. However, when cooperating with protective investigation services staff, the DV shelter staff and volunteers must protect the confidentiality of other clients at the DV center.
- Different Safety Plans. Both CPIs, case managers and DV victim advocates utilize safety plans; however, those look different and could have a different focus.

The Florida Coalition Against Domestic Violence (FCADV) provides a number of different trainings that can augment your understanding of domestic violence and your role as a child welfare professional. Included in these offerings is an eight-hour training on child welfare and Domestic Violence partnerships, which you are encouraged to take. (fcadv.org)