MidSOUTH Training Academy

Extra Help

Participant Manual

Day 1

UA LITTLE ROCK
COLLEGE OF BUSINESS, HEALTH AND HUMAN SERVICES
UNIVERSITY OF ARKANSAS AT LITTLE ROCK

Professional Development Series | Division of Children and Family Services | Developed and Presented by MidSOUTH

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COMPETENCIES LIST

101-3	The worker understands the dual roles of the family service worker to protect children from maltreatment, empower families, and provide services that preserve safe and stable families.
101-7	The worker knows what data must be gathered from collateral contacts, case records, and other sources to thoroughly assess health, safety, abuse, or neglect, family strengths and risk to children, and knows how to use this data to plan and provide relevant protective and supportive services.
101-8	The worker can identify the factors that must be evaluated when assessing the level of risk for an abused or neglected child in the family and the family strengths and safety factors that can mitigate and reduce risk.
101-10	The worker knows the broad range of responsibilities of the child welfare agency and family service worker, including assessing allegations of maltreatment, providing services to strengthen and support families, arranging temporary out-of-home placements and reunification, and providing permanent homes for children who cannot go home.
102-2	The worker understands the importance of effective case assessment, planning, and concurrent planning as the foundation of casework intervention.
102-4	The worker understands the factors that must be addressed in the family strengths and needs assessment, including the contributing factors to abuse or neglect, the functioning of the family as a unit, the cognitive, behavioral, social, and emotional strengths and limitations of each family member, and resources available to the family.
102-5	The worker knows strategies to engage family members into constructive and collaborative casework relationships that empower families and promote joint case assessment, planning, and service provision.
102-6	The worker understands the dynamics of resistance and knows how casework methods can defuse family member's hostility, fear, and anger.

102-7	The worker knows how to integrate casework methods with authority, when necessary, to simultaneously engage and empower families and assure protection of the children.
102-12	The worker knows strategies to conduct effective casework interviews. This includes communicating the purpose of the interview; controlling the process and direction of the interview while encouraging family members to participate; using a variety of interview methods, including open and closed-ended questions, clarification, support, summarization, and confrontation; and helping families communicate feelings as well as facts.
104-13	The worker knows the necessity of regular and frequent visits to maintain family members' relationships with the child in out-of-home placement and can use casework strategies that enable families to participate in planning and attending visits.
205-2	The worker understands legal issues that affect child welfare practice and knows how to implement legal requirements into practice. This includes confidentiality, family service worker liability, reasonable efforts, and other requirements.
312-3	The worker knows how to recognize indicators of potential danger and knows strategies to reduce risk of personal harm or injury when making home visits or interviewing hostile or violent clients.
314-1	The worker can identify pertinent data for inclusion in case records and reports; knows how to organize information in a clear, concise manner; and is able to record summarized case assessment, case plan, and other supporting data into the family case record and reports.

***Division of Children and Family Services**
FSW Competency List

WHO ARE WE?

Ask your partner(s) the following questions about themselves. Be prepared at the end of the exercise to introduce your partner(s) to the large group.

1. What is your name?

2. Where (what county) will you be working?

3. How did you decide to work for DCFS?

4. List 3 things you would like the group to know about you or 3 strengths you bring to the job.

5. What job duties have you already performed?

6. What do you think will be involved in this job?

7. What do you think will be the most **important** thing you will be doing?

8. What is one skill or area of knowledge that you think you need to perform this job?

DCFS

Mission Statement

Our mission is to keep children safe and help families. DCFS will respectfully engage families and youth and use community-based services and supports to assist parents in successfully caring for their children. We will focus on the **safety, permanency**, and **well-being** for all children and youth.

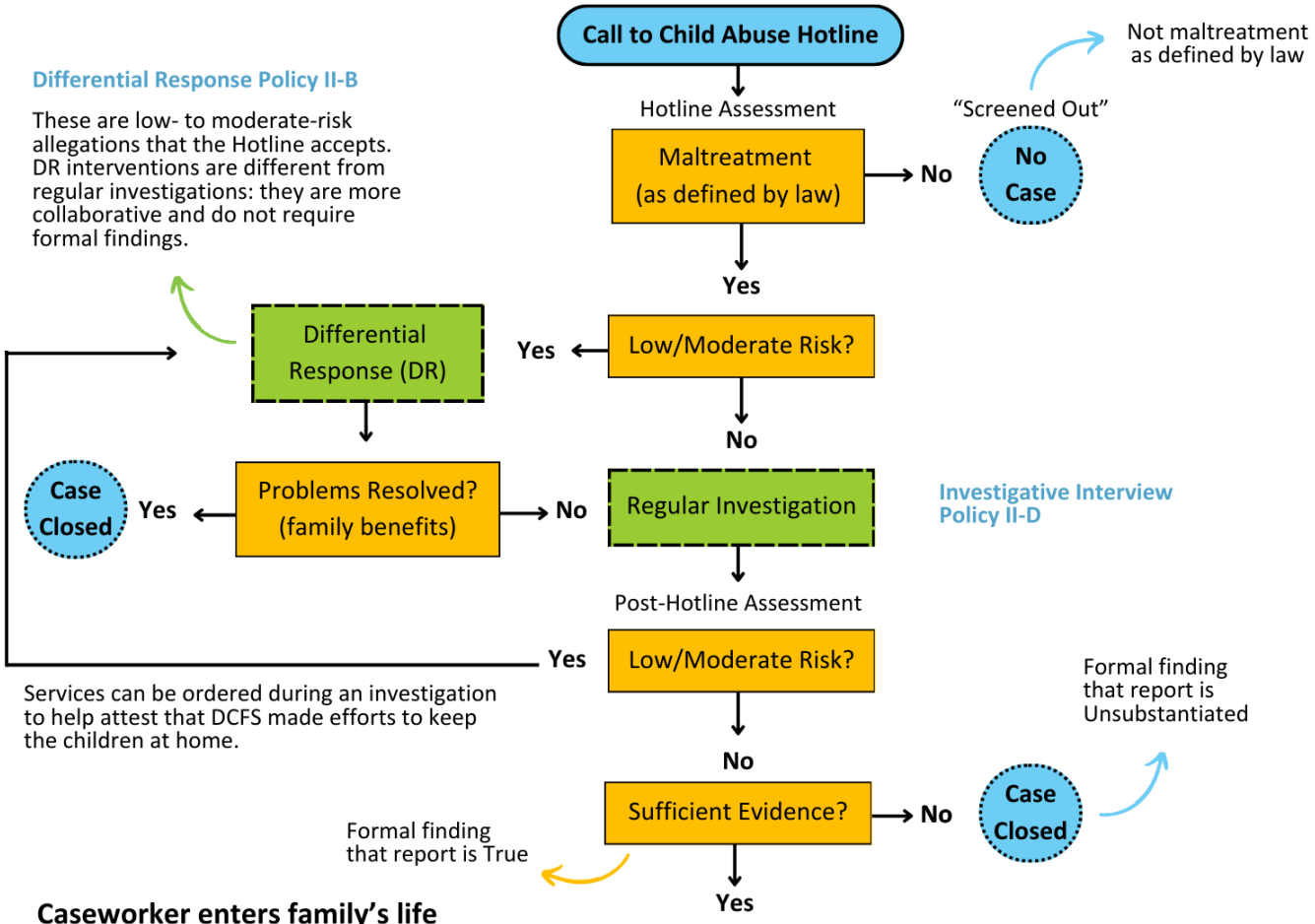
At One Table

Arkansas Practice Model
DCFS Values

1. Relationships with children, youth, and families are the foundation.
2. Collaborative partnerships with resource families.
3. Helping children and youth achieve their full potential and develop lifelong relationships.
4. Shared responsibility with community partners.
5. A strong working relationship with the legal system.
6. A workplace culture characterized by reflection, appreciation, and ongoing learning.

Our vision is that every child deserves a safe and stable family every day.

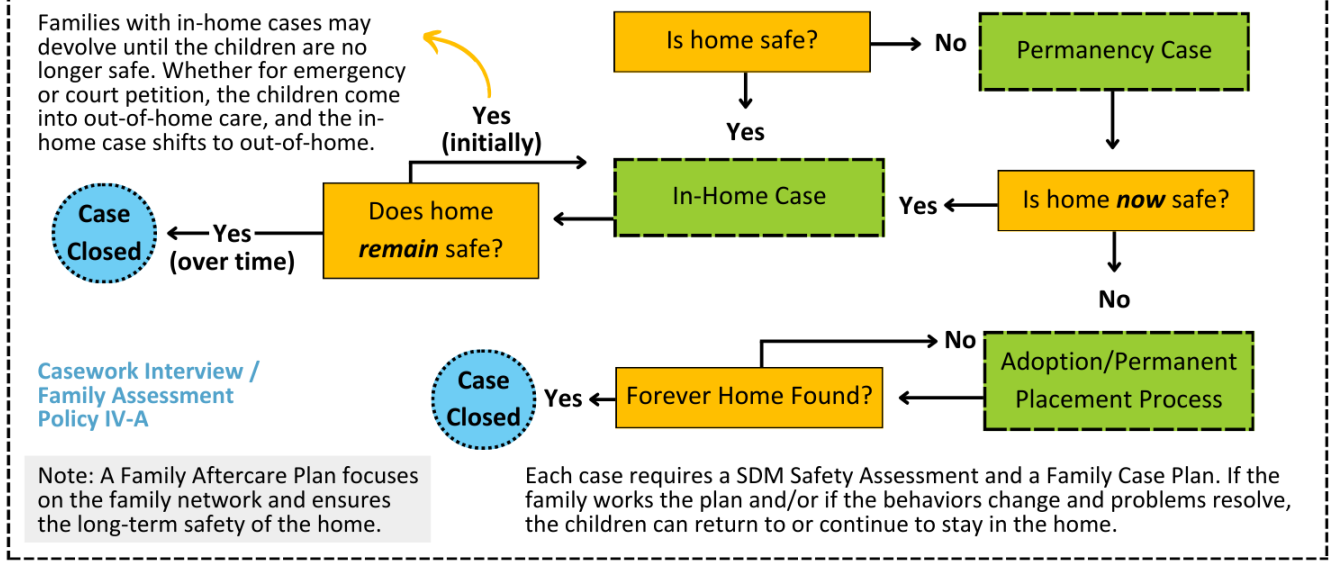
The Life of a Case



Differential Response Policy II-B

These are low- to moderate-risk allegations that the Hotline accepts. DR interventions are different from regular investigations: they are more collaborative and do not require formal findings.

Caseworker enters family's life



Note: A Family Aftercare Plan focuses on the family network and ensures the long-term safety of the home.

Each case requires a SDM Safety Assessment and a Family Case Plan. If the family works the plan and/or if the behaviors change and problems resolve, the children can return to or continue to stay in the home.

The Life of a Case - LAW

Child Maltreatment Act

- Report and investigate alleged maltreatment.
- Defines maltreatment.
- Protect and place maltreated children into a safe environment.
- Track maltreatment victims and offenders (Central Registry).
- Allow administrative review of True findings— known as Fair Hearings— to guarantee the rights of the alleged offender.

§9-28-111 - Case Plan

This is the section of the code that goes into detail about things that must be addressed and included in the family case plan. It sets out the criteria for a family case plan on an In-Home Services (Protective Services) case and then sets out the additional criteria for the family case plans on Permanency cases. Remember, some of the federal laws require these elements in family case plans in order for the state to get money to operate the program.

Arkansas Juvenile Code

- Emergency removal and placement of children into DHS custody.
- Ongoing placement in DHS custody.
- Ordering services for children and families.
- Ensuring permanency for children who cannot be safely reunited with their families.
- §9-27-801 authorizes a circuit court to establish a family treatment specialty court program for families involved in dependency-neglect proceedings. Known as Arkansas Family Treatment Specialty Treatment Court Act.

Four conditions that must be met in order to establish initial eligibility for the Title IV-E of the Social Security Act foster care maintenance funds:

- The child has been removed from the home.
- DCFS made reasonable efforts to prevent removal from the home.
- Remaining in the home is contrary to the welfare of the child.
- The child is deprived. This refers to the income of the family from which the child was removed and is one of the reasons it is important to determine the family's income.

Notes:

The Life of a Case - POLICY

Initiating Differential Response (DR) (Policy II-B)
Face-to-face contact with the victim child(ren) and at least one (1) parent/caregiver involved in a Differential Response report must take place in the victim child(ren)'s home within 72 hours of the receipt of the initial Hotline report.

All other household members must be seen face-to-face within five days of receipt of the initial Hotline report. For more information on this policy, please refer to the Master Policy Manual - Policy II-B.

Initiating an Investigation (Policy II-D)
Interviewing the child outside the presence of the alleged offender or laying eyes on the child if too young to interview.

- Priority I (Begin investigation within 24 hours of Hotline report).
- Priority II (Begin investigation within 72 hours of Hotline report, except for Garrett's Law cases for which the investigation must commence within 24 hours).

DCFS and CACD will assess Priority I and Priority II referrals as outlined in the "Agreement Between the Department of Human Services and the Arkansas State Police."

Initiation occurs when all victim children are interviewed or observed (if too young for an interview) within the designated time frames. This investigation can be open for 30 days. For more information on this policy, please refer to the Master Policy Manual - Policy II-D.

Immediate Protective Custody (72-hour Hold)
Immediate Protective Custody is also known as a 72-hour-hold.

Immediately notify OCC and request an ex parte emergency order from the court when:

- Circumstances present an immediate danger to the child's health or physical well-being as defined in the Safety Threat section of the SDM Safety and Risk Manual.
- Child is neglected under Garrett's Law and FSW determines that the child and any other children—including siblings—are at substantial risk of serious harm as defined in the Safety Threat section of the SDM Safety and Risk Manual.
- Child is dependent.

Required Investigation Interviews

- Alleged victim.
- Parents (custodial and non-custodial).
- Alleged offender (if not parent).
- Current or past healthcare providers (if allegation reported by a healthcare provider).
- Relevant collaterals (includes siblings and other children under care of alleged offender).

Notes:

The Life of a Case - COURT

Maltreatment Investigation

Order of Investigation:
Used when you cannot get into a home, a school, or other places to initiate or complete an investigation or if you need a drug screen on a child under 13 years old and parents refuse to give consent for the test.

- OCC files petition.
- Requires an affidavit.

If you think that the child's health and safety is in immediate danger, contact local law enforcement and ask for assistance. Keep your supervisor in the loop.

NOTE: Keep in mind that an order of investigation is not necessary each time someone refuses to be interviewed or refuses a drug test, This should be used only if DCFS believes the child is in danger or at substantial risk of harm if the interviews do not occur.

Order of Protection:
Petition is filed by family member or household member. If the situation is such that children's and family members' safety requires an Order of Protection, there must be an immediate safety plan in place if the children remain in the home.

Order of Less than Custody:
Used when the Division does not want to seek custody but when a child's health and well-being may be in danger.

- OCC files petition.
- Requires an affidavit.
- Notify supervisor.

72-Hour Hold (Protective Custody):

- Notify OCC immediately.
- A TDM must be conducted on all removals or considered removals. The TDM must be completed prior to filing the affidavit.
- Requires an affidavit. Must be amended if new facts emerge in the investigation.
- OCC must petition court for DCFS to keep child more than 72 hours.
- Emergency hearing (ex parte order—i.e., only one side was present).
- Probable cause hearing in 5 working days.
- Adjudication hearing within 30 days.

Notes:

The Life of a Case - COURT

Maltreatment Investigation

Prepare an affidavit (CFS-411 form) for the following:

- Emergency custody on new cases.
- Change of custody in open cases.
- 30-day petitions.
- Petitions for Order of Less than Custody.
- Petitions for Order of Investigation.
- Protection Orders.

There are three Types of Juvenile Court Cases:

- Dependency/Dependency-Neglect.
- Family in Need of Services (FINS).
- Delinquency.

NOTE: ACT 168 known as "Samantha's Law" allows the court to consider the preference of juveniles if of a sufficient age and capacity to reason, regardless of chronological age, in dependency-neglect hearings and when juveniles are taken into state custody regarding supervised/unsupervised family time, foster placement, and custodial placement.

Notes:

The Life of a Case - COURT

In-Home Case

30-Day Petition:
Used to ensure compliance with a family case plan. This petition is to be used if the child's safety is at risk if services provided are not completed.

- OCC files petition.
- Requires an affidavit.
- Risk that court may decide that removal is indicated even if that is not what the Division recommends.

Filing an Immediate Safety Plan with the Court:
Used if an assessment of an Immediate Safety Plan shows there is still a substantial risk of harm.

- OCC files.
- Requires an affidavit.
- Risk that court may decide that removal is indicated even if that is not what the Division recommends.

Order of Less than Custody:
The family can file. Occasionally needed in an In-Home case. Used when the Division does not want to seek custody but when a child's health and well-being may be in danger.

- OCC files petition.
- Requires an affidavit.

Notes:

Permanency Cases

Adjudication/Disposition Hearing:
Decision made that children remain in care of Division. Affidavit prepared by investigator is key. All reasonable efforts to prevent removal (past and present) should be documented.

- Investigator usually takes lead. Caseworker may testify if services were offered during the case and the caseworker (not investigator) was the one who arranged them. Caseworker may also testify if they assisted in locating kin for placement resources.
- Initial permanency goal established.
- The initial family case plan is required to be filed with the court by the adjudication hearing.

Review Hearings:
Held to report on the family's progress on meeting the permanency goal and/or concurrent goal. All reasonable efforts to reunify and/or reasonable efforts to achieve permanency (concurrent planning) should be documented.

- Usually, every 90 days in Arkansas but can be up to 6 months.

Permanency Planning Hearing (PPH):
Hearing to finalize the permanency plan.

- Requires special court report.
- No later than 12 months after the child enters care.
- Documentation of reasonable efforts for reunification or to justify a recommendation for other permanent living arrangement.

Termination of Parental Rights (TPR):
Can happen at any stage in the life of an Out-of-Home case, but usually occurs after PPH.

EXPECTATIONS OF EXTRA HELP STAFF

- Assigned as secondary on out-of-home care and protective services cases.

- Conduct home visits to children in out-of-home care and protective services cases.
    - The primary FSW should provide details about the specifics of the case. Remember to review the affidavit, recent case contacts, and most recent court orders to get additional information about the family and what you may need to be aware of when supervising family time.

- Monitor supervised family time between caregivers and their children.

- Assess safety on an ongoing basis, looking for:
    1. Current safety threats that place a child(ren) in immediate danger.
    2. Risk of future harm (that would result in the family's reinvolvement with the agency).

Note: Assessing child safety includes children in the home ***and*** in out-of-home placement.

- *Immediately* notify the primary FSW and supervisor if any safety threats are present.

Note: If you identify a safety threat, you cannot leave the child until you have spoken with the assigned/on-call supervisor and determine the next steps for either an Immediate Safety Plan or a removal.

- Maintain ongoing contact with the primary FSW to discuss progress and concerns, and to coordinate responsibilities.

INTRODUCING SAFETY ORGANIZED PRACTICE (SOP)

Overarching Objectives

- **Development of Good Working Relationships:** Using a spirit of curiosity, practices of family engagement, and a shared language for important child welfare concepts to help create good working relationships among all the key stakeholders involved with a family.
- **Use of Critical Thinking and Decision-Support Tools:** Helping all stakeholders use the best of their experience and the best of state-of-the-art child welfare research to jointly assess family situations and arrive at clear statements of both the danger to the children and the goals for a child welfare intervention.
- **Building Collaborative Plans to Enhance Daily Child Safety:** Creating jointly developed, understandable, achievable, and behavior-based plans that include all stakeholders and clearly show how the protection of children will be enhanced on an ongoing basis.

Primary Tools

- **Three Questions:** Safety Organized Practice and many other formal assessments can be boiled down to the following three questions:
    1. What are we worried about?
    2. What is working well?
    3. What needs to happen?

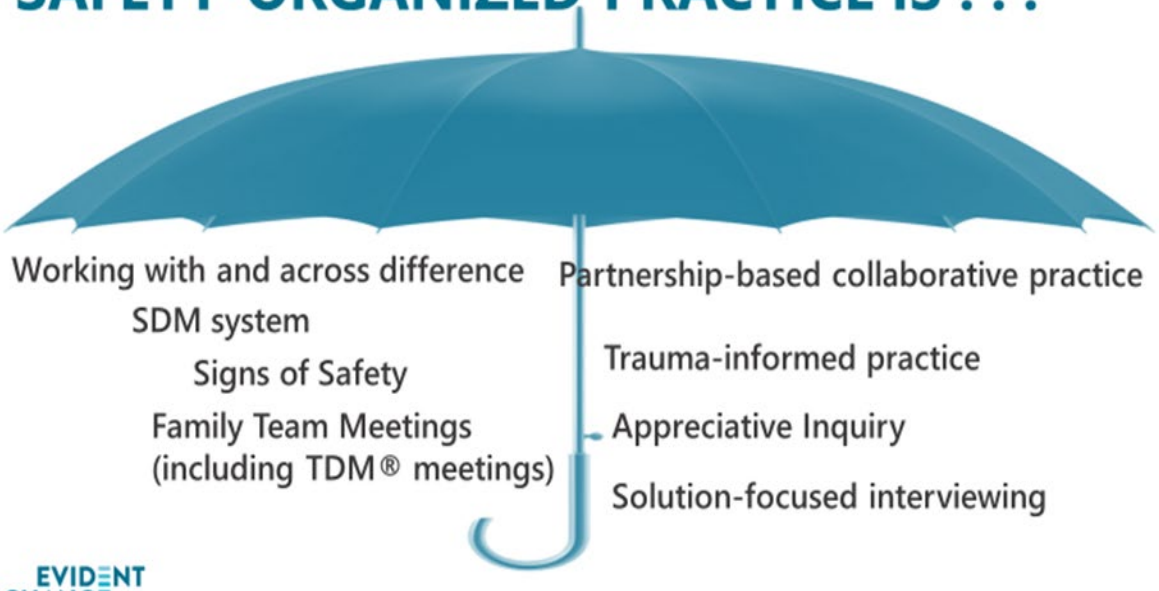
- **Three Column Mapping:** Three Column Mapping starts with the Three Questions as the primary way of organizing the map. Note that while it may seem very simple, this can be a powerful way to begin organizing your thinking. The family's input through this process is essential as they are the "experts" regarding knowledge of their personal life experiences.
- **Three Houses:** The Three Houses is a tool designed to assist children with identifying their thoughts, feelings, and opinions regarding their home situation. The Three Houses focuses on family rather than being open-ended, transitions from good things to worries to dreams, and gets at information about what is "real" in homes.
- **Circles of Safety & Support:** The Circles of Safety is a visual tool to help identify people for the child's safety network and to help professionals and family members have conversations about safety networks, the role of the safety network, and assessing who can be part of the safety network.

WHAT IS SAFETY-ORGANIZED PRACTICE?

- Development of good working relationships
- Use of critical thinking and decision-support tools
- Building collaborative plans to enhance daily child safety

EVIDENT CHANGE

SAFETY-ORGANIZED PRACTICE IS . . .



EVIDENT CHANGE

THREE COLUMN MAPPING

WHAT ARE WE WORRIED ABOUT?	WHAT IS WORKING WELL?	WHAT NEEDS TO HAPPEN?
Questions of genuine curiosity Assumptions of good intentions Behavioral detail Impact on the child Voice of the child **Externalizing the problem:** • *When did the violence first come into your life?* • *Who/what/where/when?* • *How often, how much?* • *First, last, most recent?* **Position questions:** • *Is this how you want things to be? Why or why not?* **Relationship questions:** • *Who else is worried?* **Networks:** • *Who else knows?* **Scaling questions:** • *Safety/danger, progress* • *What is keeping the number from being higher?* **Future unchanged:** • *What will happen if things keep going the way they are going?*	Questions of genuine curiosity Assumptions that good intentions are not always enough Behavioral detail Impact on the child Voice of the child **Exception questions:** • *Has there ever been a time when, before you got high, you were able to find a safe adult to watch your child?* • *Who/what/where/when?* • *How often? How much?* • *First, last, most recent?* **Coping:** • *How have you made it this far?* • *How have you accomplished what you have?* **Position questions:** • *Is it important to you that you have taken these steps?* • *Why?* **Relationship questions:** • *Who would be most pleased that you have taken these steps?* **Network:** • *Who helps?* **Scaling questions:** • *Safety/danger, progress* • *What is keeping the number as high as it is?*	Questions of genuine curiosity Assumptions that best-made plans do not always work out as they should Behavioral detail Impact on the child Voice of the child **Preferred future questions:** • *How would you like things to be instead?* • *If we meet up in a year and things are better, what will they look like?* **Position questions:** • *What kind of difference would it make for you to take this step?* **Scaling questions:** • *What does up by one look like? Up by two?* • *Willingness, confidence, capacity* **Relationship questions:** • *What do other people hope will happen?* • *What can they do to help?* • *What kind of difference would it make to your children to take these steps?* **Monitoring questions:** • *How will we know this is working?* • *Who will have to see what?*

THE THREE HOUSES

CASE EXAMPLE

Emma, age 8

HOUSE OF WORRIES

- Mom yells at me.
- I don't like getting beaten by Mom.
- I don't like seeing my brother and sister getting hurt by Mom.
- Mom slapped Kate really hard on the leg.
- Mom kicked Jacob on his bottom.
- I don't like how Mom hits Jacob and Kate in front of my friends, and then my friends don't want to play with me at my house.
- I'm worried that after Grandpa is gone, Mom will keep hitting me.
- Mom drinks bourbon with David.

HOUSE OF GOOD THINGS

- I will feel safe if the court decides that I can live with Dad because he doesn't use drugs, and I won't get hurt at his place.
- I can see my grandpa and my uncle and his girlfriend when I go to Grandma's house.
- I like that I get fit when I'm with Dad and don't eat junk food.

HOUSE OF DREAMS

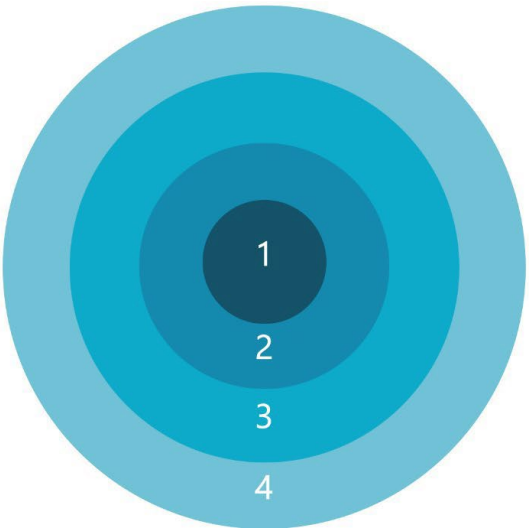
- I wish I could live with Mom and Dad together.
- I wish Mom wouldn't yell at me.
- I wish I lived in a better house than Mom's.
- I wish I could swim anywhere.
- I wish Grandpa would always stay with me.
- I wish Mom would wake up in a better mood.
- I wish I could live with Dad.
- I wish I could see Mom every second weekend so that she wouldn't yell at me so much.

(Used with permission from Nicki Weld)

CIRCLES OF SAFETY & SUPPORT

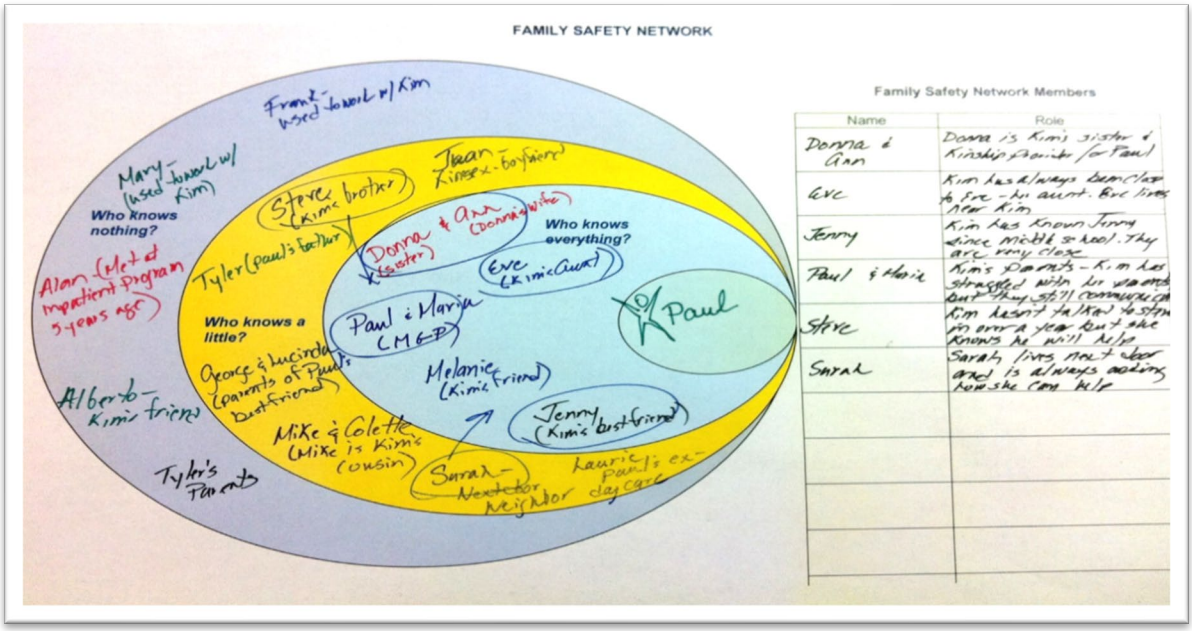
The Circles of Safety is a visual tool to help identify people for the family's safety and support network and to help professionals and family members talk about the network's role and who can be part of it.

It is typical to use the tool on the first visit with a family, when the worker is talking about the importance of the network. People in the network will work together to help the caregivers build and follow a safety plan to ensure the children will always be safe.



1. Name/photo/picture of child/children
2. Who already knows everything that has happened?
3. Who knows a little about what has happened?
4. Who knows nothing about what has happened?

Example:



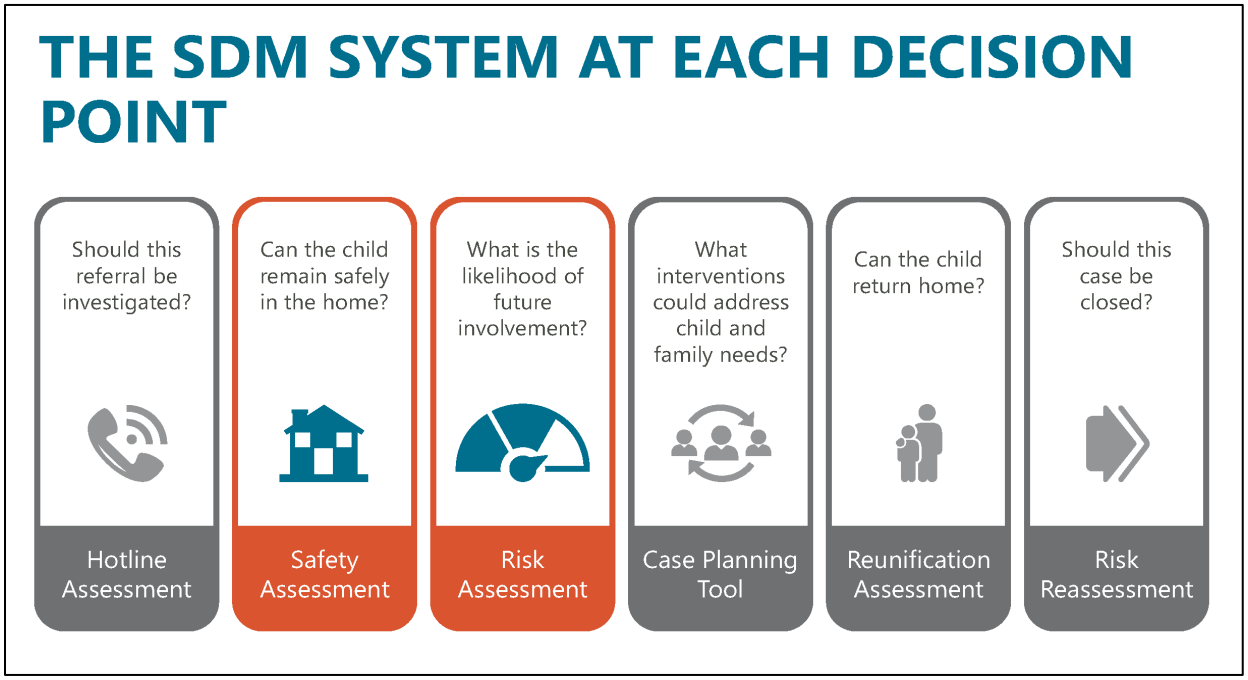
STRUCTURED DECISION-MAKING SYSTEM OVERVIEW GOALS, OBJECTIVES, AND CHARACTERISTICS

SDM® System Goals

- Reduce subsequent child maltreatment and child protective system involvement, including the following.
  - Investigations
  - Validated investigations
  - Injuries
  - Placements
- Expedite permanency for children.

SDM® System Objectives

- Identify critical decision points.
- Increase reliability of decisions.
- Increase validity of decisions.
- Target resources to families at highest risk.
- Use case-level data to inform decisions throughout the agency.



VALUING CONFIDENTIALITY

Points to remember:

- Many laws that impact child welfare services have civil and criminal penalties for violation of client confidentiality.
- It is a violation of the conduct standards set out in the Administrative Procedure Manual for the Division of Human Services to release confidential or sensitive material to unauthorized persons or entities. See DHS Policy 1006 Ethical Standards for DHS Employees and Policy 1084: DHS Employee Discipline Policy: Conduct/Performance and the DCFS Policy on Confidentiality. Administrative Procedure can be accessed through the DHS SharePoint website.

There are many "good practice" reasons to maintain client confidentiality. Three reasons to maintain confidentiality:

-
-
-

There are also several ways to maintain confidentiality. Three ways to maintain confidentiality:

-
-
-

There are limits on confidentiality. What are three examples of limitations?

-
-
-

WHEN IN DOUBT: Ask your supervisor!

IF BOTH OF YOU ARE IN DOUBT: Consider asking OCC!

ROLE CLARIFICATION FOR EXTRA HELP FSWs

Instructions: Make a quick list of job duties that seem more legalistic (or enforcement) oriented, and a list of job duties that seem more help oriented. Refer to the outlined job expectations as needed.

Legalistic	Helper

Question for Reflection: Which role do you feel more comfortable with – helping or enforcing? Why?

The dual nature of the child welfare worker's role is unavoidable.

CASE EXAMPLE – DEBBIE BRASWELL

You have been assigned as the secondary worker for Debbie Braswell and her children. A protective services case was opened on this family after a substantiated complaint of environmental neglect (lack of supervision, lack of proper food, and clothing inadequate for the weather). From your review of the case record, there was a FAST and a Family Case Plan done when the case first opened. The current primary worker is the 3rd worker, and she has made one home visit.

Debbie Braswell is a 26-year-old single parent living in a low-income housing area with her children, ages 8 years, 5 years, 4 years, and 12 months. She has never received TEA payments or SNAP benefits (formerly food stamps.) Each child has a different father, and she does not receive support from the children's fathers. None of the men were married to Debbie and none of their names are on the birth certificates.

Debbie has a high school diploma and she's maintained several minimum-wage jobs in the past. Each time she's had to quit her job due to pregnancy, lack of affordable childcare, or missing work due to "problems with the children." She is currently unemployed and does not have a significant other. She also does not have reliable transportation and there is no bus service in the town that she lives in.

Debbie Braswell began prostituting about 6 months ago to supplement her income. Neighbors suspect she is also "doing drugs." She often leaves her home for several hours at a time but always manages to get home by early evening. In the past she has asked several neighbors to keep an eye on the children while she is gone. Recently, she seems to just assume someone will supervise them and does not always bother to make care arrangements for the children. Several of the neighbors have taken it upon themselves to watch the children, often taking them into their homes and making sure they have food. However, one of her neighbors became increasingly disturbed by the mother's "careless" behavior and decided to initiate a complaint to DCFS.

Guiding Questions:

1. What would you say when meeting this client for the first time?

2. How would you prepare for this introduction?

3. What words would you use to describe/explain your roles as an Extra Help FSW?

COMMUNICATION VIDEO(S) NOTES

Instructions: Note your thoughts as you watch the videos presented about communication. Along with the following pages, use your ideas to aid your discussion on Communication with the rest of the group.

"WHAT IS COMMUNICATION?"

Information

Sender
What affects the information being given by the sender?

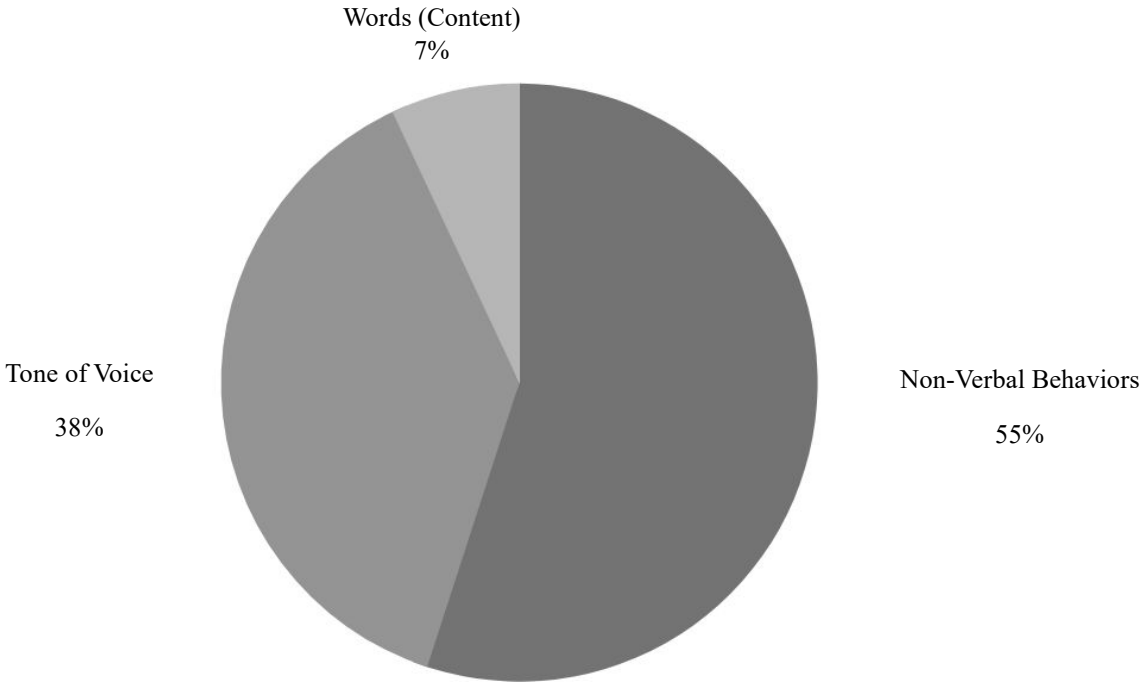
Receiver
What conditions affect the receiver's perceptions?

Information

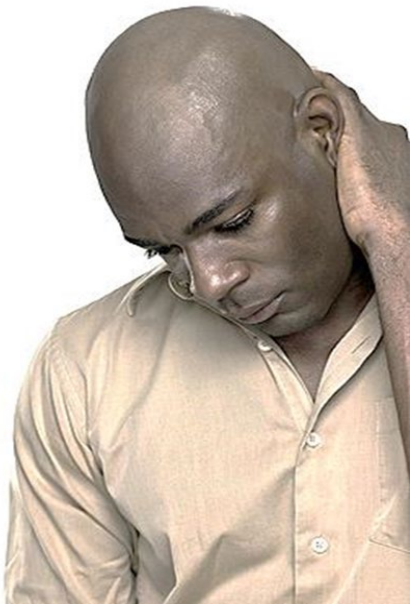
Sender → **Receiver**

How is communication affected by information sent back from receiver to sender?

Elements of Communication



FACTORS INFLUENCING EFFECTIVE COMMUNICATION



Perceptions

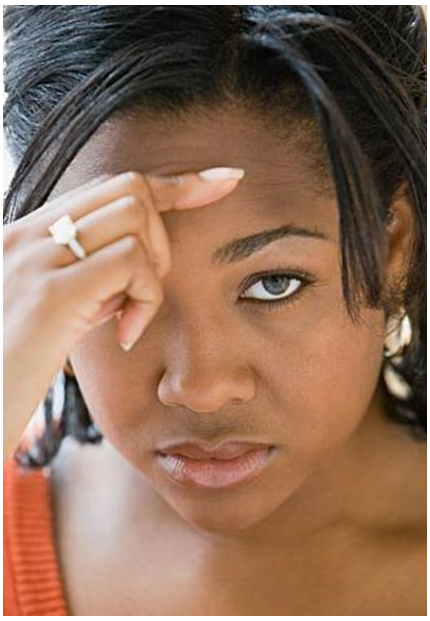
Event

Values

Perceptions

Assumptions

Communication Styles



PHYSICAL ATTENDING SKILLS

(Non-Verbal Behaviors that Facilitate Effective Communication)

- Direct eye contact (cultural caution)
- Warmth and concern reflected in facial expressions
- Eyes on the same level as the client's eyes
- Varied and animated facial expressions
- Arms and hands moderately expressive, appropriate gestures
- Body leaning slightly forward, attentive but relaxed
- Clear and voice audible but not loud
- Warmth in the tone of voice
- Voice changes to reflect the emotional tone of the client's messages
- Moderate rate of speech
- Absence of distracting behaviors (fidgeting, looking at watch, yawning, gazing)

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*Adapted from Hepworth, D. and Larsen, J.A. Direct Social Work Practice. California: Brooks/Cole Publishing Co.

BARRIERS TO COMMUNICATION

VERBAL BARRIERS

Responses that may have an immediate negative effect:

- Moralizing, Sermonizing
- Advising prematurely, or offering premature solutions
- Arguing, Lecturing, Instructing, Intellectualizing, Persuading
- Judging, Criticizing, Blaming
- Analyzing, Diagnosing, Interpreting, Labeling
- Reassuring, Sympathizing, Excusing, Consoling
- Sarcasm or distracting humor, Making light of other's concerns
- Threatening, Counterattacking, Warning
- Using excessive close-ended questions
- Stacking questions, Asking leading questions

NON-VERBAL BARRIERS

Be aware of cultural differences as you consider these barriers:

- Lack of direct eye contact
- Lack of warmth and concern reflected in facial expressions
- Inappropriately varied and animated facial expressions
- Arms and hands not expressive or overly so
- Body stiff and rigid or leaning far away from others
- Voice loud or too soft to hear
- Lack of warmth in tone of voice
- Voice without expression of emotion
- Rapid speech
- Distractive behaviors such as fidgeting, yawning, gazing, looking at watch

ENVIRONMENTAL BARRIERS

- Number of people in the home
- State of both the client and the worker
- Conditions of the physical environment

Developed from Hepworth and Larsen, Direct Social Work Practice

TRIGGER WORDS

Exercise provided by Merle Smith

Original Source Unknown

It is important to identify TRIGGER WORDS, so they do not trip us up in case work relationships. Only **you** can identify your personal triggers.

The following categories are provided to help you in that process. Write words in the right column that evoke a strong response in you (regarding the word in the left column).

Words Regarding	**Specific "Triggers for Me"**
• Gender	
• Ethnic background	
• Religion	
• Sexual orientation	
• Physical appearance	
• Body parts	
• Physical limitations	
• Mental limitations	
• Social class	
• Where you come from or where you live	
• Level of education	
• Others _____	

Other topic areas arouse strong responses and tap into our beliefs. Some of these include:

- Relative influence of environment vs. heredity
- Equal employment opportunity/affirmative action
- Mandating that public schools teach only in English
- The Equal Rights Amendment
- The death penalty
- Politics
- Religion
- Abortion
- LGBTQIA+ rights

APPLY
List one useful strategy to maintain your professionalism when someone uses a trigger word:

ENGAGEMENT

1. **Define Engagement:**

2. **Identify client behaviors that hinder engagement:**

3. **Identify worker behaviors that hinder engagement:**

4. **Identify some things that you as a worker can do to help create a respectful working relationship with your clients:**

ENGAGING FAMILIES

ENGAGEMENT:

Being fully present

OR

Creating an environment of warmth, empathy, and genuineness,

OR

Creating a positive environment to effect change.

KEY ELEMENTS OF FAMILY ENGAGEMENT:

- Consistency, Reliability, and Honesty.
- Demonstrate respect and empathy for all family members (as defined by the family).
- Active listening.
- Develop and maintain an understanding and awareness of families' past experiences, current situations, concerns, strengths, and potentials.
- Respond to families' concrete needs quickly (e.g., lack of food, housing, childcare, and transportation).
- Define roles and expectations for workers and family members.
- Develop an awareness of one's own biases and prejudices.
- Validate the participatory role of families in planning and making decisions for their own children.
- Honor the cultural, racial, ethnic, linguistic, and religious/spiritual backgrounds and experiences of children, youth, and families and respect differences in sexual orientation.
- Engage and involve fathers and paternal family members.
- Engage kinship families.
- Reinforce and honor families' rights to self-determination and autonomy.
- Review, track, and **acknowledge** progress regularly.
- Provide family members with choices whenever possible.

TIPS TO INVOLVE FAMILY MEMBERS IN FAMILY TEAM MEETINGS, STAFFINGS, OR FAMILY CASE PLAN MEETINGS:

- Be mindful of the family members' other obligations, such as employment or other mandatory meetings.
- Don't share pertinent information regarding the case in a meeting that has not been previously shared with the client ahead of time (i.e., family case plan change).
- Prepare the family by discussing agenda items, expectations, roles, and goals for the meeting.
- Discuss behavioral or health-related issues that may impede family participation (i.e., mental health, use of drugs or alcohol).

The ability to successfully join with clients involved in the child welfare systems has been viewed as the "most critical component for achieving positive outcomes".

Further information and helpful resources on Family Engagement can be obtained from the Child Welfare Information Gateway: https://www.childwelfare.gov/topics/famcentered/engaging/

SAFETY ISSUES IN CHILD WELFARE

1. **Before a home visit, the Extra Help FSW should:**

- Ask workers to check case records for worker safety concerns associated with the family (e.g., threats previously made to a worker by someone in the home, etc.).
- Notify the supervisor of the visit (and complete the required safety form).
- Travel with a cell phone and a full tank of gas.
- Have safety equipment for their car: protective gloves, disinfectant wipes, plastic trash bags, clean towels, and one change of personal clothes.

2. **During the home visit, the Extra Help FSW should:**

- Park in the street- not the driveway. Have your vehicle facing away from the residence; lock your car.
- Take a cell phone (speed dial 911) but no personal items into the residence.
- Observe sights, sounds, and smells indicative of danger.
- Stand to the side of the door when knocking and do not enter the home if adults are not present – immediately contact law enforcement to ensure the safety of children.
- Conduct interviews near an exit.
- Leave residence if it feels unsafe and contact your supervisor.

3. **When leaving the home visit, the Extra Help FSW should:**

- Observe any activity close to the front door and quickly check activity by and inside the vehicle.
- Have keys in hand when walking to parked car and lock doors immediately after entering vehicle quickly.
- Leave the neighborhood immediately and do not linger to make phone calls or take notes.

Other safety suggestions:

“Think safety – act safely!”

ONGOING ASSESSMENT

- To assess for safety
- To continue to identify factors within the family that contribute to child maltreatment
- To determine if the child is in danger
- To identify progress (or lack of) that family has made
- To inform the Family Case Planning process

Stages of the Interview		
Preparation		
Purpose of the interview	Case review	Cultural considerations
Logistics	Child/youth considerations	Collaterals, law, previous FSW
SOP/SDM tools	Supervisor consult	
Introduction and Engagement		
Identify yourself	Identify your agency	Clarify your role
Build trust, credibility	Be honest, direct	Avoid jargon, acronyms
Join with family in mutual problem-solving effort	Acknowledge family's feelings	Acknowledge your own feelings
Information Gathering and Sharing		
What is working well?	**What are we worried about?**	**What needs to happen?**
Who	What	When
Where	How	Take notes
Closure		
Wrap up	Move from personal to impersonal	Review the work you have done
Prepare for next steps	Who will do what, when, how	Ask for feedback, concerns
Thank them	Leave your contact information	
Documentation		
As soon as possible	Refer to your notes	Document SOP/SDM tools within contacts

PEARLS, NUGGETS, AND AH HA'S

(Thoughts, feelings, images)

MANDATED REPORTERS & LEGAL DEFINITIONS

WHAT is a Mandated Reporter?

According to the Merriam-Webster.com Legal Dictionary, a **mandated reporter** is "an individual who holds a professional position (as of social worker, physician, teacher, or counselor) that requires [them] to report to the appropriate state agency cases of child abuse that [they have] reasonable cause to suspect."

Note: As per ACT 727, Arkansas now recognizes a mandated reporter as "Any adult who witnesses abuse, sexual abuse, or sexual exploitation is also a mandated reporter. (Victims of violence, threats of violence, or sexual offenses by the same offender would be exempt from prosecution of failure to notify by a mandated reporter in the first and second degrees if, at a later time, the juvenile victim or victim who at the time was a juvenile accused them of not reporting the maltreatment.)"

WHO is a Mandated Reporter?

As an Extra Help FSW, by virtue of the agency that employs you, **YOU** are considered a mandated reporter. You can access the full list of Arkansas Mandated Reporters on the Arkansas State Legislature website (www.arkleg.state.ar.us). The code for this list is **A.C.A. § 12-18-402**.

HOW do I report suspected maltreatment?

You can report suspected child maltreatment to the Child Abuse Hotline at 1-800-482-5964 OR via the new **secure online portal at** mandatedreporter.arkansas.gov. Reports may also be made directly to DCFS county offices.

What information is required for a report?

In order to report suspected child maltreatment, you must have:

- A circumstance that, if true, would meet the legal definition of maltreatment.
- Identifying information on the victim/family – enough to locate the alleged victim.
- As much detail as you know about the alleged maltreatment and the circumstances surrounding it.

Note: Anonymous reporting is now prohibited under ACT 727.

Where can I access the legal definitions of child maltreatment?

You can access the full list of child maltreatment legal definitions on the Arkansas State Legislature website (www.arkleg.state.ar.us). The code for this list is **A.C.A. § 12-18-103**.

*Merriam-Webster.com Legal Dictionary, s.v. "mandated reporter," accessed January 19, 2022. https://www.merriamwebster.com/legal/mandated%20reporter.

SHOULD IT BE REPORTED?

1. A 13-year-old child comes to you with 13 belt marks spread over his lower back, buttocks, and upper thighs. He says the punishment was administered by his father because he (the boy) had lied about doing his homework.

2. Your neighbor is a single mother of three children ages nine years, seven years, and six months. She leaves the children alone from 5:30 p.m. to 9:30 p.m., while she attends night classes at college. The children have strict instructions not to let anyone in the house. The oldest child knows how to dial 911.

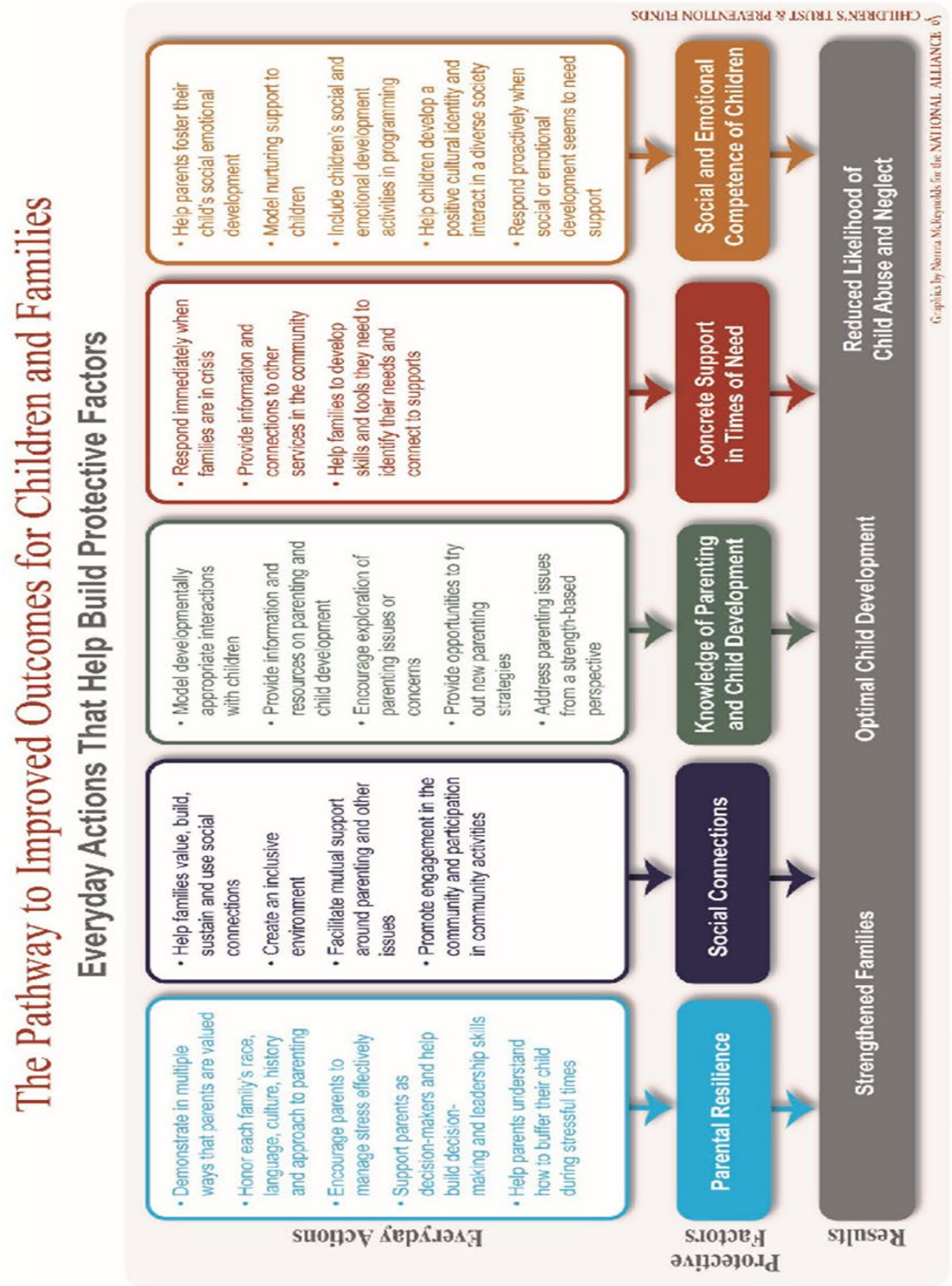
3. You witness your neighbor lose her temper with her five-month-old daughter. She shakes the child violently and slams her down into the crib because the child will not stop crying.

4. A toddler is notorious for biting. His teacher at daycare bites him back to punish the biting behavior. The next day, the child has two visible bruises on his arm in the shape of teeth marks.

5. A single father has four children ranging in age from 6 to 12 years old. The 12-year-old daughter has many childcare responsibilities after school. All the children wear old, ill-fitting clothes. The clothes are clean but are not always appropriate for the weather.

6. A 22-month-old has two cigarette burns. One burn is on the back of the hand and one is on the right cheek. The caregiver tells you that the child accidentally ran into a lit cigarette while toddling around the house.

7. You notice four small circular bruises on the arm of a one-month-old infant. When questioned, the mother says she has no idea how the child got these marks.


The Pathway to Improved Outcomes for Children and Families
Everyday Actions That Help Build Protective Factors
Everyday Actions
Protective Factors
Results
• Demonstrate in multiple ways that parents are valued
• Honor each family's race, language, culture, history and approach to parenting
• Encourage parents to manage stress effectively
• Support parents as decision-makers and help build decision-making and leadership skills
• Help parents understand how to buffer their child during stressful times
Parental Resilience
• Help families value, build, sustain and use social connections
• Create an inclusive environment
• Facilitate mutual support around parenting and other issues
• Promote engagement in the community and participation in community activities
Social Connections
• Model developmentally appropriate interactions with children
• Provide information and resources on parenting and child development
• Encourage exploration of parenting issues or concerns
• Provide opportunities to try out new parenting strategies
• Address parenting issues from a strength-based perspective
Knowledge of Parenting and Child Development
• Respond immediately when families are in crisis
• Provide information and connections to other services in the community
• Help families to develop skills and tools they need to identify their needs and connect to supports
Concrete Support in Times of Need
• Help parents foster their child's social emotional development
• Model nurturing support to children
• Include children's social and emotional development activities in programming
• Help children develop a positive cultural identity and interact in a diverse society
• Respond proactively when social or emotional development seems to need support
Social and Emotional Competence of Children
Strengthened Families
Optimal Child Development
Reduced Likelihood of Child Abuse and Neglect
Graphics by Nurtira McReynolds for the NATIONAL ALLIANCE of CHILDREN'S TRUST & PREVENTION FUNDS

PHYSICAL AND BEHAVIORAL INDICATORS OF CHILD ABUSE AND NEGLECT

Type of Child Abuse/Neglect	Physical Indicators	Behavioral Indicators
Physical Abuse	**Unexplained bruises and welts:** • On face, lips, mouth • Torso, back, buttocks, thighs • Clustered, forming regular patterns • Reflecting shape of article used to inflict (electric cord, belt buckle) • On several different surface areas • Regularly appear after absence, weekend, or vacation • Human bite marks • Bald spots	• Wary of adult contacts • Overly compliant - low profile • Apprehensive when other children cry **Behavioral extremes:** • Aggressiveness • Withdrawal • Overly compliant • Lags in development • Afraid to go home
	Unexplained burns: • Cigar, cigarette burns, especially on soles, palms, back or buttocks • Immersion burns (sock-like, glove-like, doughnut-shaped on buttock or genitalia) • Patterned like electric burner, iron, etc. • Rope burns on arms, legs, neck, or torso **Unexplained fractures:** • To skull, nose, facial structure • In various stages of healing • Multiple or spiral fractures **Unexplained lacerations or abrasions:** • To mouth, lips, gums, eyes • To external genitalia	• Report injury by parents or caregivers • Exhibits anxiety about normal activities, e.g., napping • Complains of soreness and moves awkwardly • Destructive to self and others • Early to school or stays late as if afraid to go home • Accident prone • Wears clothing that covers body when not appropriate • Chronic runaway (especially adolescents) • Cannot tolerate physical contact or touch

*From Cynthia Crosson Tower, *Child Abuse and Neglect: A Teacher's Handbook for Detection, Reporting, and Classroom Management,* pp. 82-83. Copyright 1984 by the National Education Association of the United States. Reproduced with permission.

PHYSICAL AND BEHAVIORAL INDICATORS OF NEGLECT

Neglect involves inattention to the basic needs of a child. While physical abuse tends to be episodic, neglect tends to be chronic. Neglect is more difficult to separate from poverty and/or cultural issues. It is useful to assess whether most of the children in a given community display these indicators, or only a few.

Physical Indicators Behavioral Indicators	Behavioral Indicators
• Constant hunger • Poor hygiene • Clothing inappropriate for the weather • Consistent lack of supervision • Constant fatigue • Listlessness • Unattended physical or medical problems • Lice (untreated) • Failure-to-Thrive (non-organic)	• Begging or stealing food • Constantly falling asleep in class • Poor school attendance • Coming to school early/staying late • Addiction to alcohol/drugs • Delinquent acts • Stating there is no one to look after them • Destructive • School dropout (adolescents)

CHARACTERISTICS OF NEGLECTFUL CAREGIVERS

Neglectful caregivers may:

- Have a chaotic home life
- Live in unsafe conditions
- Abuse alcohol/drugs
- Have intellectual limitations
- Have psychiatric conditions
- Be impulsive; lack ability to delay gratification
- Be unable to afford childcare
- Be emotionally needy
- Have low self-esteem
- Be passive
- Need help developing skills to make changes

POVERTY V. NEGLECT

Vignettes

1. The house consists of two rooms with a front and back porch. The porches and many of the open windows are covered with torn screens. There is a cool morning breeze blowing through the house, and flies are abundant on the porches and in the house. The three children, ages 1, 3, and 4 are asleep on the two old sofas in the larger room on a pallet in the middle of the floor. In addition to the sofas, there is an old end table with a lamp. This second room appears to be a kitchen (of sorts) with a few free-standing cabinets, two mismatched chairs, a pump, and a wood-burning stove. The floor of the house is bare plank boarding. The bathroom facilities consist of an old outhouse adjacent to the house and the house has no electricity.

2. A family of five; mom, dad, and three kids, have traveled from the state of Washington to Arkansas in a car. The trip took over a month and they left Washington because they were looking for employment. They have been sleeping in the car at roadside parks. The family arrived in Arkansas one week ago and has been sleeping in the car, under a bridge in downtown Little Rock. The parents attempted to enroll the children in school so the children could eat at least two meals per day. The children are dirty, have a strong body odor, and all have head lice. The family has informed the school officials that they have applied to stay at the Salvation Army.

3. Mom (23 years old) and Dad (24 years old), live with their five children in an old, abandoned trailer. There are utilities, but they are frequently cut off due to non-payment. When the water is cut off, the family uses the outdoors as their restroom. The yard and trailer have a strong odor, and both are swarming with flies and roaches. Neither Mom nor Dad graduated from high school. Mom has never been employed, and Dad has worked for a wrecker company and as a truck driver. Dad is currently unemployed. The children are regularly sent to school but are just as often sent back home due to head lice and poor hygiene. The two-bedroom trailer has been home to this family for two years. There is no air conditioning and no heat. The windows are uncovered in the summertime and covered with cardboard in the winter.

Answer the questions below:

a) Is this situation neglect or poverty? Why?
b) What actions should be taken? What resources are needed to make the situation better?

Remember: Poverty in and of itself is not neglect. If a family has a lack or need, services should be offered. If services have been offered and refused, then the situation becomes one of neglect.

CHECKLIST FOR MAKING OBSERVATIONS IN THE HOME

FOR REPORTS OF NEGLECT*

The following conditions are present, and caregivers exhibit no concern/interest in remedying them:

- Bare electrical wire, frayed cords, overloaded sockets or open sockets
- Exposed heating elements or fan blades
- Gas leaks
- No railings on stairs
- Broken, jagged, or sharp objects
- Unprotected windows, e.g., upper story windows which are uncovered yet accessible to a small child
- Medicines, cleaning compounds, and hot liquids within child's reach
- Loose boards, holes in walls

Sanitation

- Overrun with vermin
- Urine-soaked mattresses
- Eating utensils reused over and over again, without washing
- Human or animal feces on floors and walls
- Encrusted or multi-layered dirt throughout
- Toilets being used, but not in working order
- Garbage left to rot inside house

Furnishings

- Inadequate number of beds for number of persons residing in the home
- Stove not working
- Refrigerator not working
- Cupboards barren of food

Utilities

- Heating inoperable
- Electricity inoperable
- No water

Space

- Inadequate space and privacy relative to the number, and ages, of residents of the home

Structure

- Repairs needed to make the home habitable

*Adapted from "Child Neglect Severity Scale," developed by Aileen Edington and Marilyn Hall, Dallas Children and Youth Project, Southwestern Medical School, University of Texas, Health Science Center, June 1980.

EFFECTS OF NEGLECT

Long-term effects of neglect include:

- May interact less with peers
- Passive behavior and helplessness under stress
- May have developmental delays, especially language delays
- May have increased criminal behavior
- High levels of anxious attachment
- May have a significantly negative impact on brain development

Brain Development*

• The brain develops from the bottom up and is the only organ that is underdeveloped at birth.

• At birth many of the neurons a person will have for life are present, but neural pathways and connections have not developed.

• Environment and experience influence the quantity and quality of the neural pathways.

• Experiences at very early ages have more impact on brain development than experiences at later stages (due to the rapid maturation of the brain in the first 6 months).

• Optimal brain development of the somatosensory cortex requires that the infant be physically touched in a consistent, soothing, and comforting manner.

• The ability to form attachments (and the subsequent ability to care about others) depends on the development of the somatosensory cortex in the brain.

• Caregivers with impaired attachment do not feel an emotional pull to respond to their children.

**Adapted from "Experience, Brain Development and the Next Generation" Lecture transcript by Bruce Perry, M.D., Ph.D. at Arkansas Children's Hospital on November 10, 1998.*

Check out this article from the American Psychological Association: http://www.apa.org/monitor/2014/06/neglect.aspx (retrieved October 12, 2016)

FAILURE-TO-THRIVE

Failure-to-thrive is a term applied to children under three years of age who are not growing at the rate expected for their age and sex. Children whose weight persistently falls below the established growth curve or whose weight when plotted on the growth chart crosses two major percentile lines over time are considered failure-to-thrive. Many of these children have delayed developmental skills. If the weight is decreased enough there may also be an abnormal head circumference and body length.

Causes of Failure-To-Thrive

Organic: These children have medical conditions that explain their failure to thrive. These may be problems with their gastrointestinal, neurological, respiratory-pulmonary, cardiovascular, or endocrine systems. Cases of failure-to-thrive with purely organic causes will not be on the DCFS caseload.

Inorganic: Failure to thrive in these children cannot be explained by medical problems. Causal factors are environmental, instead of biological.

Mixed Interaction: These cases have a mixture of causal factors, including medical problems and environmental conditions.

Many theorists and clinicians are moving away from the organic/inorganic classification. In most cases, multiple features of the child, family, and the environment interact and result in failure-to-thrive.

Factors in Inorganic FTT:

- **Poverty –** unemployment; unstable housing; lapse in financial assistance, may "water down" formula to save money.
- **Family Conflict And/or Dysfunction –** marital problems; domestic violence; crisis-oriented; caring for several small children.
- **Isolation –** parental abuse or inconsistency; lack of support systems (formal or informal); lack of social relationships.
- **Maternal Characteristics –** childhood experience of loss, separation, abuse/neglect; absent, ill, or abusive maternal caregiver; absent father; depression; often perceive baby negatively ("greedy," "bad," "hyper"); low self-esteem; chronic anger; chronically ill or fatigued; anxious; feelings of inadequacy and being overwhelmed.
- **Substance Abuse By Caregiver –** keeps caregivers from responding to child's needs; takes family's money for food.
- **Poor Information –** caregivers do not have adequate knowledge of child development and nutrition.
- **Child's Characteristics –** difficult feeders, temperament, appearance, and personality.

FAILURE-TO-THRIVE: WHAT TO WATCH FOR

Maternal Characteristics

- Depressed, apathetic
- States child as "bad," "greedy," "hyper"
- Views child who never cries or wants attention as a "good baby"
- Waters down formula
- Has inadequate or incorrect knowledge about child development or nutrition
- Has childhood history of loss, deprivation, abuse

Child Characteristics

- Undernourished appearance; seems small for age
- Apathy, irritability, and sadness
- Less responsive and vocal than other children of same age
- Gaze abnormalities – either stares or refuses to make eye contact
- Less smiling
- Decreased cuddliness – may appear "stiff"
- Decreased interest in toys
- Diarrhea or vomiting

Behaviors Related to Eating

- Caregiver doesn't take cues from child; she decides when the child has "had enough"; may terminate meal arbitrarily
- Caregiver spends less time looking at infant while feeding; may prop the bottle up for the infant instead of holding child
- Caregiver has difficulty pacing the meal; may feed quickly to "get it over with"
- Caregiver allows child to "graze"; child does not sit at the table, but instead moves around the house, eating little bits of food throughout the day; child eats less regular, skimpier meals
- Child is less enthusiastic about eating; may resist eating
- Child allowed to eat "junk food" to the exclusion of other, more nutritious foods
- Infant started on cereal and solid foods too early; drinks juice, water, and soda, instead of milk or formula

Developmental Milestones

Developmental milestones are different for every individual child. However, healthy children should achieve these milestones at approximately the same ages.

Use the following link (https://www.cdc.gov/ncbddd/actearly/milestones/index.html) to access the CDC's information page on developmental milestones, which includes links to both the printable milestone checklist and the handy Milestone Tracker App. These can be very helpful tools in your direct work with families.

EMOTIONAL MALTREATMENT (MENTAL INJURY)

EMOTIONAL MALTREATMENT is injury to a juvenile's intellectual, emotional, or psychological development as evidenced by observable and substantial impairment of the juvenile's ability to function within the juvenile's normal range of performance and behavior.

- Common, everyday occurrence
- A systematic belittling of character
- Consistent indifference to the need for attention, praise, or affection
- A consistent attack on the fulfillment of needs

Emotional Maltreatment includes:

- Rejection: refusal to touch, show affection, or acknowledge accomplishments
- Ignoring: preoccupation with self to the point that it is impossible to respond to the needs of others
- Isolating: preventing the experiencing of normal social relationships
- Corrupting: reinforcing antisocial or deviant behavior, especially aggression or deviant sexual activity
- Terrorizing: repeated threats, both verbal and physical

PHYSICAL AND BEHAVIORAL INDICATORS OF EMOTIONAL MALTREATMENT

Type of Child Abuse/Neglect	Physical Indicators	Behavioral Indicators
Emotional Maltreatment	• Speech disorder • Lags in physical development • Failure to thrive (especially in infants) • Asthma, severe allergies, or ulcers • Substance abuse	• Habit disorders (sucking, biting, rocking, etc.) • Conduct disorders (anti-social, destructive, etc.) • Sleep disorders • Inhibition of play **Behavioral extremes:** • Compliant, passive • Aggressive, demanding **Overly adaptive behavior:** • Inappropriately adult • Inappropriately infantile • Developmental lags (mental, emotional) • Delinquent behavior (especially adolescents) • Self-mutilation

*From Cynthia Crosson Tower, *Child Abuse and Neglect: A Teacher's Handbook for Detection, Reporting, and Classroom Management,* pp. 82-83. Copyright 1984 by the National Education Association of the United States. Reproduced with permission.

IDENTIFYING EMOTIONAL MALTREATMENT

CAREGIVER	CHILD
Does the caregiver:	Is the child:
— Describe the child as "bad" or "different" — Continually berate / belittle the child in the presence of the child or others — Humiliate the child publicly — Seem unable to accept the child as they are – limitations and potential — Demand excessive academic, athletic, or social performance — Withhold physical and verbal contact — Blame the child for the family's problems — Use the child as a vehicle for marital fighting — Use gestures, tone of voice, or statements to intimidate — Destroy child's possessions — Force the child to watch violence — Place the child in chaotic circumstances	— Disruptive, hyper-aggressive, or overly demanding — Timid, withdrawn, overly compliant — Exhibiting unaccountable learning difficulties — Manipulative — Exhibiting a sudden behavior change — Fearful of caregiver — Depressed / suicidal — Failure-to-thrive — Indifferent to caregiver — Experiencing eating disorders, sleep disorders — Experiencing intrusive memories, hyper-arousal, general inability to focus — Willfully injuring animals — Fire setting

PHYSICAL AND BEHAVIORAL INDICATORS OF SEXUAL ABUSE

Type of Child Abuse/ Neglect	Physical Indicators	Behavioral Indicators
Sexual Abuse	• Difficulty in walking or sitting • Torn, stained or bloody underclothing • Pain or itching in genital area • Bruises or bleeding in external genitalia, vaginal or anal areas • Venereal disease • Frequent urinary or yeast infections • Frequent unexplained sore throats • Pregnancy	• Unwilling to participate in certain physical activities • Sudden drop in school performance • Withdrawal, fantasy, or unusually infantile behavior • Crying with no provocation • Bizarre, sophisticated, or unusual sexual behavior or knowledge • Anorexia (especially adolescents) • Sexually provocative • Poor peer relationship • Reports sexual assault by caretaker • Fear of or seductiveness toward males • Suicide attempts (especially adolescents) • Chronic runaway

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BEHAVIORAL INDICATORS

Read the following scenarios. Evaluate the situations and determine if there are any behavioral indicators of sexual abuse.

1. You have been contacted by a worker at Kiddie Kat Day Care who works in the three-year-old room. She is concerned about possible sexual abuse of J, a three-year-old in her class. J's mother has recently remarried, and J's stepfather has been picking her up from the daycare. The teacher knows that there are approximately two hours between the time J is picked up and the time her mother gets home. J is somewhat reluctant to go with her stepfather at times, although lately she has been acting happy to see him when he gets there. The teacher has noticed that J frequently masturbates at naptime by rubbing against a soft toy. When questioned, J says she touches herself "because it feels good." J recently told her teacher that "Daddies and boys have wienies."

2. You have been contacted by a school counselor about eight-year-old K. The counselor is concerned about possible sexual abuse of K. K seems very quiet and reserved. This behavior is different from last year when K was seen as outgoing and sociable. K has been seen hanging around the playground after school is out, but she always leaves if someone asks what she is doing. K is performing poorly in class, after having been an "A" student. She frequently seems sleepy or preoccupied. The counselor has talked to K. K was fearful and anxious, but finally told the counselor she didn't like "him touching me like that. It's a dirty touch." The counselor called the Hotline at that point.

TABLE 1
Behaviors Related to Sex and Sexuality in Preschool Children

NATURAL AND EXPECTED	*OF CONCERN*	*SEEK PROFESSIONAL HELP*
Touches/rubs own genitals when diapers are being changed; when going to sleep; when tense, excited, or afraid.	Continues to touch/rub genitals in public after being told many times not to do this.	Touches/rubs self in public, or in private, to the exclusion of normal childhood activities.
Explores differences between males and females, boys and girls.	Continues questions about genital differences after all questions have been answered.	Plays other gender roles in an angry, sad, or aggressive manner. Hates own/other sex.
Touches the genitals or breasts of familiar adults and children.	Touches the genitals or breasts of adults not in the family. Asks to be touched themselves.	Sneakily touches adults. Makes others allow touching, demands touching of self.
Takes advantage of opportunity to look at nude persons.	Stares at nude persons, even after having seen many persons nude.	Asks people to take off their clothes. Tries forcibly to undress people.
Asks about the genitals, breasts, intercourse, and babies.	Keeps asking people even after caregiver has answered questions at age-appropriate level.	Asks strangers after caregiver has answered. Sexual knowledge too great for age.
Erections	Continuous erections	Painful erections
Likes to be nude. May show others their own genitals.	Wants to be nude in public after the caregivers say "No."	Refuses to put on clothes. Secretly shows self in public, after many scoldings.
Interested in watching people doing bathroom functions.	Interest in watching bathroom functions does not wane in days/weeks.	Refuses to leave people alone in bathroom, forces way into bathroom.
Interested in having/birthing a baby.	Boy's interest does not wane after several days/weeks of play about babies.	Displays fear or anger about babies, birthing, or intercourse.
Uses "dirty" words for bathroom and sexual functions.	Continues to use "dirty" words at home after caregiver says "No."	Uses "dirty" words in public, and at home, after many scoldings.
Interested in own feces.	Smears feces on walls or floor more than one time.	Repeatedly plays or smears feces after scolding.
Plays doctor, inspecting others' bodies.	Frequently plays doctor after being told "No."	Forces other child to play doctor, to take off clothes.
Puts something in the genitals or rectum of self or other *due to curiosity or exploration.*	Puts something in genitals or rectum of self or other child after being told "No."	Uses coercion or force in putting something in genitals or rectum of other child.
Plays house, acts out roles of Mommy and Daddy.	Humps other children, with clothes on.	Simulated or real intercourse without clothes, oral sex.

TABLE 2

Behaviors Related to Sex and Sexuality in Kindergarten Through Fourth-Grade Children

NATURAL AND EXPECTED	*OF CONCERN*	*SEEK PROFESSIONAL HELP*
Asks about the genitals, breasts, intercourse, and babies.	Shows fear or anxiety about sexual topics.	Endless questions about sex. Sexual knowledge too great for age.
Interested in watching/peeking at people doing bathroom functions.	Keeps getting caught watching/peeking at others doing bathroom functions.	Refuses to leave people alone in the bathroom.
Uses "dirty" words for bathroom functions, genitals, and sex.	Continues to use "dirty" words with adults after caregiver says "No" and punishes child.	Continues use of "dirty" words, even after exclusion from school and activities.
Plays doctor, inspecting other's bodies.	Frequently plays doctor, and gets caught, after being told "No."	Forces other child to play doctor, to take off clothes.
Boys and girls show interest in having/birthing a baby.	Boy keeps making believe he is having a baby after months.	Displays fear or anger about babies or intercourse.
Shows others their own genitals.	Wants to be nude in public after the caregiver says "No" and punishes child.	Refuses to put on clothes. Exposes self in public after many scoldings.
Interested in urination and defecation.	Plays with feces. Purposefully urinates outside of toilet bowl.	Repeatedly plays with, or smears, feces. Purposefully urinates on furniture.
Touches/rubs own genitals when going to sleep; when tense, excited, or afraid.	Continues to touch/rub genitals in public after being told "No." Masturbates on furniture, or with objects.	Touches/rubs self in public, or in private, to the exclusion of normal childhood activities. Masturbates on people.
Plays house, may simulate all roles of Mommy and Daddy.	Humps other children, with clothes on. Imitates sexual behavior with dolls/stuffed toys.	Humps naked. Intercourse with another child. Forcing sex on other child.
Thinks other-sex children are "gross" or have "cooties." Chases them.	Uses "dirty" language when other children *really* complain.	Uses bad language about other child's family. Hurts other-sex children.
Talks about sex with friends. Talks about having a girl/boyfriend.	Sex talk gets child in trouble. Romanticizes all relationships.	Talks about sex and sexual acts a lot. Repeatedly in trouble, with regard to sexual behavior.
Wants privacy when in bathroom, or changing clothes.	Becomes very upset when observed changing clothes.	Aggressive or tearful in demand for privacy.
Likes to hear, and tell, "dirty" jokes.	Keeps getting caught telling "dirty" jokes. Makes sexual sounds, e.g., moans.	Still tells "dirty" jokes, even after exclusion from school and activities.
Looks at nude pictures.	Continuous fascination with nude pictures.	Wants to masturbate to nude pictures, or display them.

TABLE 2 *(Continued)*

NATURAL AND EXPECTED	OF CONCERN	SEEK PROFESSIONAL HELP
Plays games related to sex and sexuality with same-aged children.	Wants to play games related to sex and sexuality with much younger/older children.	Forces others to play sexual games. A group of children forces child(ren) to play.
Draws genitals on human figures.	Draws genitals on one figure and not another. Genitals' size disproportionate to body.	Genitals stand out as most prominent features. Drawings of intercourse, group sex.
Explores differences between males and females, boys and girls.	Confused about male/female differences after all questions have been answered.	Play other gender roles in a sad, angry, or aggressive manner. Hates own/other sex.
Takes advantage of opportunity to look at nude child or adult.	Stares/sneaks to stare at nude persons, even after having seen many persons nude.	Asks people to take off their clothes. Tries forcibly to undress people.
Pretends to be the opposite sex.	Wants to be the opposite sex.	Hates being own sex. Hates own genitals.
Wants to compare genitals with those of peer-aged friends.	Wants to compare genitals with those of much older, or much younger, children or adults.	Demands to see the genitals, breasts, or buttocks of children or adults.
Interested in touching genitals, breasts, or buttocks of other same-age children, or have other children touch their own.	Continuously wants to touch genitals, breasts, or buttocks of other child(ren). Tries to engage in oral, anal, or vaginal sex.	Manipulates or forces other children to allow touching of genitals, breasts, or buttocks. Forced or mutual oral, anal, or vaginal sex.
Kisses familiar adults and children. Allows kisses by familiar adults and children.	French kisses. Talks in sexualized manner with others. Fearful of hugs and kisses by adults. Gets upset with public displays of affection.	Overly familiar with strangers. Talks/acts in a sexualized manner with unknown adults. Physical contact with adults causes extreme agitation.
Looks at the genitals, buttocks, or breasts of adults.	Touches/stares at the genitals, breasts, or buttocks of adults. Asks adult to touch them on genitals.	Sneakily or forcibly touches genitals, breasts, or buttocks of adults. Tries to manipulate adult into touching them.
Erections.	Continuous Erections.	Painful Erections.
Puts something in own genitals/rectum *out of curiosity and exploration.*	Puts something in own genitals/rectum when it feels uncomfortable. Puts something in the genitals/rectum of other child.	Uses coercion or force in putting something in genitals/rectum of other child. Anal, vaginal intercourse. Causing harm to own/others' genitals/rectum.
Interest in breeding behavior of animals.	Touching genitals of animals.	Sexual behaviors with animals.

INCEST STAGES

Intra-familial sexual abuse frequently passes through the following stages:

- Engagement
- Sexual Interaction
- Disclosure
- Recanting/Suppression

Some professionals list secrecy as an incest stage. However, for purposes of our discussion secrecy is assumed to be a dynamic that permeates all stages.

Engaging – Key Issues • Building Trust • Favoritism • Alienation • Boundary Violations	**Disclosure** • Accidental vs. Purposeful • Crisis
Sexual Interaction • Progression • Place • Time • Bribes, threats, punishment, guilt – to maintain the secret	**Recanting/Suppression** • System mobilizes to maintain status quo • Overt/covert pressure • Victimized by "helping" systems

PROGRESSION OF SEXUAL ACTS

- Least Intrusive
- Nudity
- Disrobing
- Genital Exposure
- Observation of the Child (Intimate Activities)
- Kissing – Lingering, Intimate
- Fondling
- Masturbation
- Fellatio
- Cunnilingus
- Digital Penetration of Anus or Vagina
- Dry Intercourse
- Vaginal or Anal Intercourse
- Most Intrusive

SEXUAL ABUSE EXAMINATIONS

WHAT IS THE PURPOSE OF A MEDICAL EXAM?

- The physician can detect, diagnose, and treat any physical injuries.
- The physician can diagnose and treat any sexually transmitted diseases.
- The physician can arrange for any needed follow-up treatment.
- The physician can collect medical/legal evidence.
- The physician or treatment team can meet the immediate psychosocial needs of the family and offer crisis intervention services.
- The physician or treatment team can assure the child that their body is all right, or if the child has been injured, that they will heal.

WHAT IS MEDICAL EVIDENCE? WHAT ARE SIGNIFICANT FINDINGS?

- Scars, lacerations, notches
- Thickening or wearing away of the hymen
- Lax anal tone
- Hemorrhoids, fissures, anal dilation

WHAT FINDINGS ARE MOST SIGNIFICANT?

- Sexually transmitted diseases, specifically syphilis, gonorrhea, and chlamydia
- Sperm
- Pregnancy

POEM WRITTEN BY A TWELVE-YEAR-OLD GIRL, WHO IS AN INCEST SURVIVOR.

Do you know what it's like when your sisters hate you?
-and your brother calls you a liar?

Do you know what it's like to be the one everyone blames for the trouble…?
When all you wanted was some help?

I asked you for help, and you told me you would,
If I told you the things my Dad did to me.

I asked you for privacy and you told me to trust you,
Then you made me tell my story to fourteen strangers.
And you sent two policemen to my school, who said in front of everyone,
"Let's go downtown for a talk,"
Like I was the one being busted.

I asked you to believe me, and you said that you would…
Then you connected me to a lie detector test,
Like you really didn't.

I asked you for help and you gave me a doctor
Who spread my legs and stared
Just like my Father…
Who said it wouldn't hurt – just like my Father…
Who said, "Relax – it will be over soon" –
Just like my Father.

I asked you for protection, and you gave me a social worker that grinned and called me Honey…

Then you sent me to live with strangers in another place,
With another school –
While he went home on bail.

Do you know what it's like to live where there's a lock on the refrigerator?
-Where you have to ask permission to use the shampoo,
And where you're not allowed to call your friends.

I asked you to put an end to the abuse;
You're putting an end to my whole family.
So, it's my word against his now;
I'm twelve years old-
And he's the manager of a bank.

You say you believe me –
Who cares?
If nobody else does.

Your questions got me confused;
My confusion got you suspicious.
I can't help it if I can't remember dates,
Or explain why I couldn't tell my Mom.

I asked you for help.
I asked you to believe me.
I asked you for protection.
You told me to trust you.

ASSESSMENT

What is assessment?

Assessment is an *ongoing* evaluation process of a family's functioning that begins from the moment a worker receives the case.

As the worker works *with* the family, they will be assessed for both **safety threats** and **risk** of potential harm or future agency reinvolvement (noting any **complicated factors**). Strengths and ***protective factors** will be assessed as well**.**

***Information compiled from www.childwelfare.gov and Evident Change's Structured Decision Making©**

Remember to "Maintain a focus on safety."

> *"The focus of child protection work is always to increase safety. Maintain this orientation in thinking about the agency and the worker's role as well as specific details and activities of the casework." (Turnell, A., & Edwards, S. (1999). Signs of safety: A solution and safety-oriented approach to child protection casework. New York: Norton.)*

SAFETY V. RISK

Instructions: Fill in the blanks with the definition buzz words that the trainer gives you from their guide.

A. SAFETY THREAT

- There is_____danger.
- There are_____and_____behaviors, observations, or conditions.
- The behavior or situation is out of_____.
- The end result of the behavior or situation is likely to be _____.
- A safety threat is something that is occurring_____or something that_____ that is putting the child in danger _____.

B. RISK

- Risk is the _____ that something will occur in the _____.
- Risk is categorized in the Division Information Management System as _____,_____,_____, or _____ .
- There can be a_____level of risk of future maltreatment, but that _____ means that there is immediate danger.

C. PROTECTIVE FACTORS

- Protective factors are the _____, _____, _____ and_____, that indicate one of the_____ in the child's environment can bring _____ to an otherwise dangerous situation.

The ultimate goal of child welfare is_____.

IV-E WINDOW OF OPPORTUNITY

CONTRARY to the WELFARE

The Department of Health and Human Services must ensure that all other conditions are fulfilled for children who would be **income-eligible for IV-E (deprivation)**.

There is a window of opportunity for establishing this eligibility.

Once a child's income eligibility (deprivation) is established, they may or may not be eligible for IV-E maintenance payments, depending on a number of factors.

However, if the window of opportunity is not realized, the child will be ineligible for IV-E payments for the entire stay in out-of-home care.

In addition, it may affect whether the child will qualify for subsidized adoption, if adoption is the eventual permanency option.

- The child must have been **removed** from their primary caregiver.
- **"Contrary to the Welfare"** language must be included in the ***first*** order that removes the child from parental custody.
- The Court must make a ruling on whether the agency made **reasonable efforts to prevent removal** (60 days).
- Deprivation (Eligibility Unit DCFS)

DEPRIVATION

REASONABLE EFFORTS

REMOVAL

CANS and FAST ASSESSMENT INSTRUMENTS

During the first *30 days of the assessment process, the worker must complete the appropriate assessment, which documents information the worker has obtained about the family during the assessment process. Assessments must be updated every 3 months after that time.

The **CANS**, which is used for any child in **an out-of-home placement**, is divided into two forms:

- CANS 0-4
- CANS 5+
    - (If a child is almost 5 years old, the worker has the discretion to choose to use the CANS 5+ form. The child must turn 5 before the next CANS update is due, which is every 3 months.)

For the purposes of the CANS, the caregiver is defined as any potential **permanency planning** caregiver. For example:

- If the mother's boyfriend lives with her and he is a potential caregiver and will potentially need services, he will be rated on the CANS.
- If a child's parental rights have been terminated and there in no identified potential permanency caregiver, there will be no caregiver to rate.

The **FAST** is used for any **in-home protective services case**. This can be both court-involved and non-court involved. If the children remain in the home, a **FAST** is required.

For the purposes of a FAST, the caregiver is defined as any adult in the home who **plays a caregiver role** for the child. For example:

- If a child lives with the mother and grandmother and both assist in care, then both the mother and grandmother would be rated. If the grandmother has no role in caring for the child, then only the mother would be rated on the FAST.

The shared vision of the child-serving system is that children are safe and healthy. It is not the vision for children and families to be "in a service".

~John Lyons, Ph.D., developer of the CANS/FAST

POLICY APPLICATION

Answer the following questions based on Policy V-B and Procedure V-B1 (Family Service Worker Contacts).

1. How often will the FSW visit the child? *Explain in detail*.

2. What must take place before reducing the frequency of contact with a child in the home?

3. Where is the visit supposed to occur? What must happen if the visit does not take place in this location?

4. How is a contact defined?

During contact with the family, the worker should do the following:

Assess any changes in the caregivers' capacity to adhere to the safety plan and their willingness to continue to work with the agency.

T or F

Have a private conversation with the child to determine their level of comfort and safety while being in the home.

T or F

Discuss with the caregivers any services or support that may be needed to continue to safely maintain the child in the home.

T or F

Assist the child if they are experiencing a period of crisis in the home, school, or community.

T or F

POLICY APPLICATION (1)

Answer the following questions based on Policy VI-C (Maintaining Family Ties in Out-of-Home Placements) and Procedures VI-C1 & VI-C2 (Parent-Child Contact and Sibling Contact for Children in Out-of-Home Placements).

- How often will Family Time be scheduled?
- Can Family Time be canceled or postponed if a caregiver has a positive drug screen?
- Do siblings have to be placed together?
- What is the minimally acceptable number of scheduled Family Time between siblings if they are not placed together?
- What is the preferred location for Family Time to take place?

Answer the following questions based on Policy VII-I (Division Contact with Children in Out-of-Home Placements) and Procedure VII-I1 (Supervision of Children in Out-of-Home Placement).

How often will the FSW visit the child?

For what purposes?

1.

2.

3.

4.

5.

6.

POLICY APPLICATION (2)

- The worker should _____ the child and placement provider when home visits and Family Time will take place.
- In addition to face-to-face home visits and Family Time with the child, what are some other acceptable forms of contact that can supplement these?
- If a worker is unable to keep a scheduled visit appointment, what will they do?
- When are the requirements for an Out-of-Home Placement visit met?

Home visits should include:

- Private conversation with the child
- Documentation of the date and summary of the results of each visit.

Any change in the frequency of visits requires supervisory approval and documentation.

If there are allegations of child maltreatment in the Resource Home: First, notify your Supervisor about the allegations.

Agency policy sets out that the following must occur:

- Notify the child's caregivers, the OCC Attorney, the child's CASA, and the Attorney-Ad-Litem immediately if the child is the subject of an allegation of child maltreatment.
- Report to the Child Abuse Hotline immediately. Notify Attorneys-Ad-Litem for all other children placed in the out-of-home placement if the allegation is in connection with the resource home.

CONTACT OR VISIT?

In the field, everyone seems to use these words interchangeably. You hear of people going on a "home visit." An FSW "visits" a foster child in the resource home. Staff members supervise "visits" (now called "Family Time") between caregivers and their children who are in out-of-home care. You will document both "visits" (Family Time) and contacts (sometimes "home visits") on the contact screen in the Division Information Management System. Let's look at these more closely.

A simple rule of practice:
Contacts refer to any interaction with a client, collateral, agency staff person, Provider, Ad-Litem, CASA, OCC, etc. Contacts can be face-to-face (in various locations), by phone, by email, or by some other means of communication. This means that "home visits" are considered *contacts*.

The term "***visit***" is being phased out of child welfare work in the state of Arkansas to be replaced with "***Family Time***." Family Time is much more narrowly defined than contacts are. Family Time includes:

- Family Time between caregivers and their children in out-of-home care.
- Family Time between siblings in out-of-home care, or between siblings in out-of-home care and siblings who were not removed from the home; and/or
- Family Time between grandparents and children in out-of-home care.

1. **When a caregiver "visits" with their child in care, do you document their interaction as a contact or as a visit (Family Time)?**

2. **If you are *present* at a "visit" between a child and their caregiver, do you document *your* interaction as a contact or a visit (Family Time)?**

3. **When you meet with a child in the resource home, do you document that interaction as a contact or a visit (Family Time)?**

DIVISION INFORMATION MANAGEMENT SYSTEM CONTACT PURPOSES

QUICK REMINDER – CONTACTS AND "VISITS"

- In CHRIS, any interaction you (the worker) have with a client is called a "contact" and is documented as a contact. So, even though people talk about going on a "home visit," when you get back to your office, that "visit" is documented as a contact.
- In CHRIS, a "visit" has a very narrow focus. It is scheduled/supervised Family Time between a caregiver/sibling/grandparent and a child in out-of-home care or between siblings both in out-of-home care. These must be documented as visits to avoid any deficiencies when your out-of-home care case is reviewed.

CONTACT PURPOSES (from the CHRIS picklist)

One Challenge: These pick-list terms are not defined. So, there are times when it may be confusing about which one to use in which situation. You can pick more than one purpose.

3 Month Staffing	Foster Child – every other week	Psychological
Adoption Contact	Foster Child – monthly	Psychological
Approval Letter for Guard. Subsidy	Foster Child – weekly	Purchases
Assessment	Foster Parent Contact	Referral for Service
Case Consultation	FP Removal Request Staffing (48 Hour)	Relationship Support
Closure Staffing	Guardianship Subsidy Determine. Mtg.	Special Staffing
Drug Screen	Homemaking	Subsequent Staffing
Education	ICPC Contact	Subsidized Guardianship Agreement Review (CFS-435_G)
Family Contact – every other month	Initial Staffing	Subsidized Guardianship Denial
Family Contact – every other week	Legal	Supervisory Guardianship Consultation
Family Contact – monthly	Medical/Dental	Teaching
Family Contact – weekly	Other	Transitional Services
Family Contact waiver requested	Other Staffing	Transitional Skills Class
Family Search	Parenting	Transportation of Family Member
FINS Petition	Permanency Planning Staffing	Treatment Plan Update
FINS Review	Personal Care	
Foster Child – every other month	Placement Assessment	

Document your observations and the details of what occurred at each contact in the Comments field for the specific contact.

RULES TO REMEMBER WHEN DOCUMENTING CONTACTS

Answer the essential questions:

- Who are the people involved?
- What type of contact is it?
- When did it take place (date and time)?
- Where did it occur?
- Why did you make contact?
- How can you reconnect?

- Be objective – just the facts, please.
- Summarize all related facts.
- Document as activities occur.
- Ensure information relates to the goals of the Family Case Plan.
- Minimize personal opinions (and indicate when using them).
- Write in third person.
- Use quotes and quotation marks when appropriate.
- Record only your own activities.
- Avoid emotionally charged narrative.
- Be complete.

CHECKLIST FOR DOCUMENTATION

Documentation must address:

- — What progress has been made in addressing the actionable (or non-actionable that need to be addressed) Identified Needs or Strengths from the CANS/FAST which are grouped in the Family Case Plan?
- — What is the progress or lack of progress toward accomplishing the Family Case Plan Goal?
- — Paint an accurate picture of the event.
- — Your narrative is documented proof of the event.
- — Well-written documentation will stand up in court.
- — The tone of your narrative should display confidence in your understanding of the event.
- — Refrain from labeling or drawing conclusions.
- — Document all services offered that were appropriate to remedy the situation.
- — Document all services accepted, which were appropriate to remedy the situation, and who accepted (and any reason given for acceptance).
- — If services were offered but refused, document who refused the service and the reason given for refusal.
- — Document efforts to reunify the family in cases of out-of-home placement.
- — Document any changes in contact/Family Time schedule, why it was changed, who was notified, and when notified.
- — Document all contacts and Family Time (whether in-person, via phone, via email, etc).
- — Keep your documentation current. It is more difficult to attempt to recreate the event.
- — Documentation is accurate, concise, professional, and truthful.
- — Documentation is complete and can be shown to anyone.
- — Write in third person. (Worker went to the home…)
- — When documenting contacts, focus on safety, permanency & and well-being.
- — Use quotes and quotation marks when appropriate.

***ALWAYS* CHECK FOR CORRECT SPELLING AND GRAMMAR!**

TAKING CARE OF YOU

Although your work can be energizing and fulfilling, it can be emotionally and physically difficult. It is important to remember and understand your own limits, in order to enhance your well-being and longevity in the work you love.

Secondary traumatic stress is the experience of people who are exposed to others' traumatic stories as part of their jobs and as a result can develop their own traumatic symptoms and reactions.[1]

Whether it is called burnout, compassion fatigue, secondary traumatic stress, or vicarious stress, it can lead to problems for the worker.

SIGNS AND SYMPTOMS OF EXCESSIVE STRESS[2]

Emotional Indicators: • Unable to make decisions • Feeling anxious, tense, nervous, unable to relax • Easily irritated	• Diminished sense of humor • Getting angry over minor things • Feeling unworthy or not good enough • Depression
Behavioral Indicators: • Withdrawing from friends, family, and co-workers • Working harder but getting less done • Excessiveness (e.g. in smoking, drinking, eating, spending, etc.) • Scapegoating (blaming others, finding fault, being critical or hard to please)	• Difficulty having normal conversations with family and friends • Arriving late to work and/or to appointments, etc. • Argumentative • Deteriorating work performance • Taking increased time off for minor ailments
Physical Indicators: • Frequent headaches, colds • Digestion problems • Abdominal pain • Diarrhea or constipation • Unexplained changes in weight • Clumsiness/accident prone • Decreased interest in sex • Deterioration in personal appearance • Poor concentration	• Change in sleep habits (too much or too little sleep) • Sleep disturbances (e.g. interrupted sleep, difficulty getting to sleep, not be able to get back to sleep if awakened in the night, difficulty getting up in the morning) • Feeling tired / drowsy all day • Feeling run down most of the time

[1] Promoting Resilience and Reducing Secondary Trauma among Child Welfare Staff, The Resilience Alliance. ACS-NYU Children's Trauma Institute, September 2011.
[2] Managing Stress as a Child Welfare Caseworker, Institute of Human Services.

Tips for wellness and self-care:

- Be aware of personal stressors and your own reactions
- Care for your body with good nutrition, exercise, and sleep
- Mind your food and beverage intake
- Recognize what can be changed
- Be with people you cherish and who cherish you
- Find time for solitude and closure after each day's work
- Engage in intentional spiritual practices each day
- Buy a plant or picture to make your office space nurturing
- Use professional consultation or personal therapy for support
- Cultivate relationships with colleagues you trust and can rely on
- Balance your work time with pleasure time
- Enjoy nature
- Play

There are many helpful resources available on the internet. Remember that one of the most important resources is your Supervisor. Talk to your supervisor. They can help you strategize ways of handling work related stress.

Application:

List one way that work-related stress has affected you in the past:

_____

List a strategy for self-care that you have used or that appeals to you:

_____

HOW DO WE SAY GOODBYE? HOW DO WE BEGIN WITH THE END IN MIND?

There can be a wide range of emotions related to endings. When faced with an ending, it is important to take time to recognize it.

Workers spend time engaging the family and building trust, the worker and family have (to some extent) shared experiences. It is necessary to honor that shared experience by addressing that the contacts/visits are no longer going to happen.

The very nature of the extra help worker is temporary.

- Let your families know that your role is temporary.
- Let your families know if you are nearing the end of your time with the agency.

Take time to summarize (briefly) your work/time together. End on a positive note, if possible.

- Is there a strength (or two) that you have identified that you can share with your client's family?

Use the following list of conversation starters at the BEGINNING of your work with your families to help draw out and discover strengths. More suggestions are in the CANS/FAST Engagement Tools that are available in the Resource section of public CHRISNet (Sharepoint).

- What do you enjoy doing? (We usually enjoy what we are good at!) What do you yearn to do? (Yearnings suggest possible talents!)
- Tell me about something you do well.
- Tell me about one of the biggest challenges in your life. How did you overcome it? What do you like about yourself?
- What are some unusual skills you have? (The word 'unusual' forces them to think about what is different about themselves. Make sure to delve deeper to find the underlying strength/s)
- What are you proud of in your life?
- Tell me about your first (or most recent) achievement. (Encourage them to share even it seems boring or small now - this gives pointers to early success - and strengths)
- What do you get complimented on most? (This is a great question because it assumes they GET complimented and asks what is mentioned most FREQUENTLY)

STRENGTHS
(Practice!)

1. Identify the strengths you bring to this position.

2. Identify 1-2 strengths of each person at your table. Share.