

Protecting Children: Highlights of Best Practice

Insights Forum

University of Maryland School of Social Work

October 4, 2000



Faculty

- **Caroline L. Burry, Ph.D., MSW**
- **Diane DePanfilis, Ph.D., MSW**
- **Howard Dubowitz, MD, MS**
- **Prasanna Nair, MD**
- **Charles I. Shubin, MD**
- **Ronald Zuskin, MSW**

Purpose

- **This forum brings together faculty from the School of Social Work and Department of Pediatrics, School of Medicine to highlight best practice approaches for identifying child maltreatment, engaging clients, assessing needs and strengths, and targeting treatment outcomes.**

Agenda

- **Introductions**
- **Definitions**
- **Engagement**
- **Assessment**
 - **Care of children with health problems**
 - **Preventive health care**
 - **Separation & visitation issues**
 - **Family Strengths**
- **Targeting risk related outcomes**

Neglect: Definition, Assessment, Management

Howard Dubowitz, MD, MS

Professor of Pediatrics

University of Maryland

School of Medicine

Co-Director, Center for Families

“The tragedy is not what we don’t know. It’s how we ignore what we do know.”

Uri Bronfenbrenner, PhD

Maryland's Definition of Neglect

“Neglect” means the leaving of a child unattended or other failure to give proper care and attention to a child **by any parent or other person who has permanent or temporary care or custody or responsibility for supervision of the child** that the child's health or welfare is harmed or placed at **substantial risk of harm.**

Why do we want to define child neglect?

**To protect children
& improve their well-being**

NOT

to blame parents

Child neglect: Proposed definition

- **Child neglect** occurs when a child's basic need is not adequately met
- **Basic needs** include: adequate food, clothing, health care, supervision, protection, education, nurturance, and a home

Advantages of a Child-focused, Broad Definition

- **Fosters a comprehensive view of causes of neglect**
- **Encourages consideration of a broad array of interventions**
- **Fits with our broad interest in the health & well-being of children**

Are we interested in:

- Potential harm? YES
- Psychological harm? YES
- Educational harm?YES
- Long term harm? YES

Picking our Battles

- Focus on issues that we know harm children
- How do we know?
 - epidemiological data (eg, bike helmets)
 - individual child (eg, history of bad asthma)
 - common sense (eg, hunger, homelessness)

Heterogeneity of Neglect

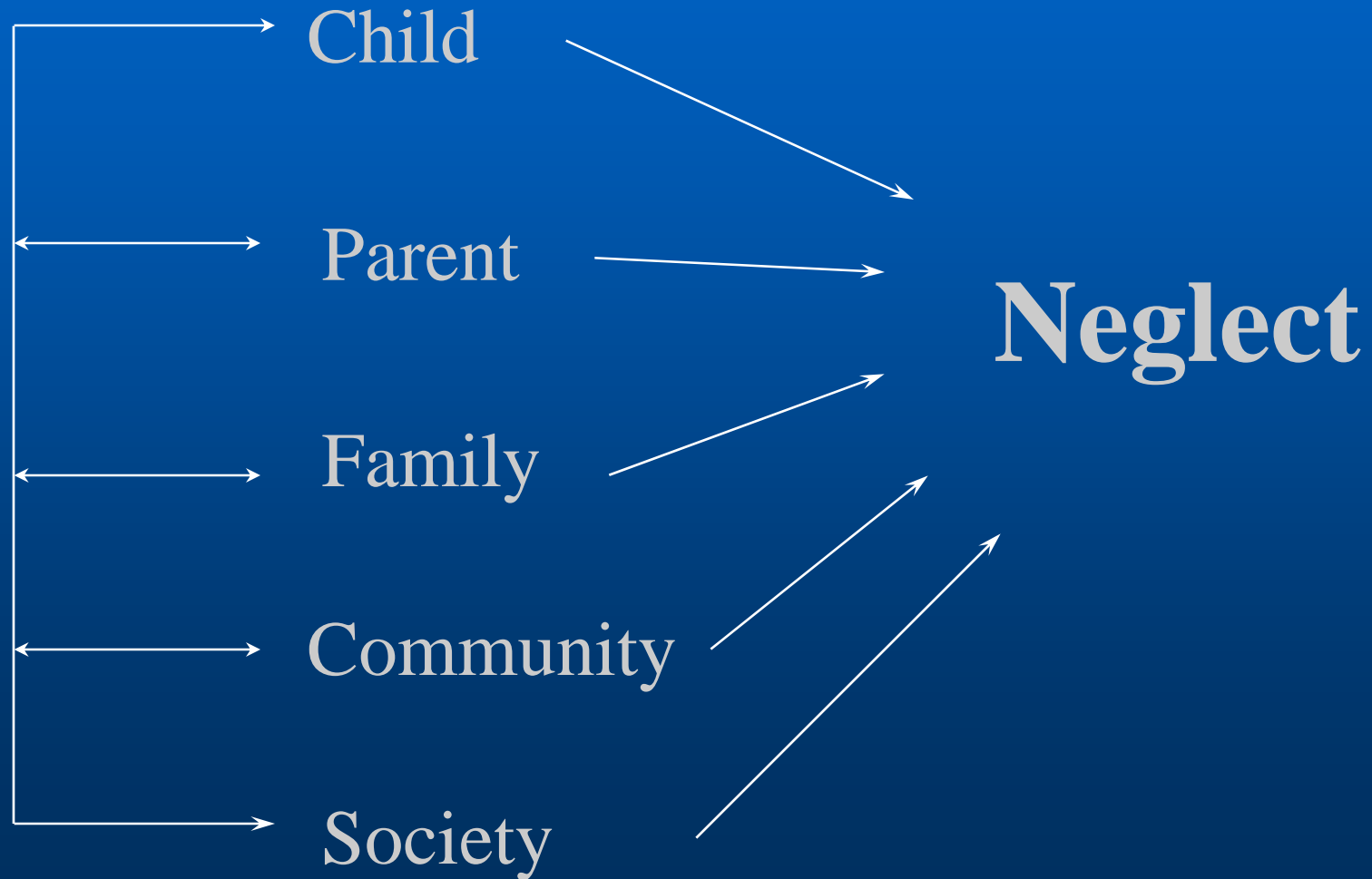
- Inadequate food, hunger, Failure to Thrive - FTT
- homelessness
- inadequate clothing
- inadequate supervision
- inadequate education
- exposure to hazards - in & out the home
- inadequate medical, dental, mental health care
- inadequate nurturing, affection, love

A clear understanding of the contributors to neglect is key to any intervention,

SO

a comprehensive assessment is needed

Etiology of Neglect



Seldom is there a single cause of neglect

Usually, there are multiple AND
interacting factors
(Ecological Theory)

Risk Factors for Neglect

- **Child: disability, prematurity, many kids**
- **Parent: depression, alcohol & other drugs, low IQ, limited nurturing**
- **Family: DV, “upper class”?**
- **Community: social isolation**
- **Society: poverty, lack of health insurance**

Protective Factors

- **Child: temperament, intelligence**
 - **Parent: caring, intelligence, resourceful**
 - **Family: supportive, father involved**
 - **Community: good resources, safe, playgrounds**
 - **Society: WIC, Headstart, health insurance**
- Let's not forget the strengths!*

A Lesson from Research

- Advantage of multiple sources of info.
 - Parents, pediatrician, teacher, others & children
- Example of child sexual abuse
- We must learn how to interview children, & to interpret their information

Observation (“red flags”)

Child: affect, development,
behavior, repeated injuries,
hygiene, clothing, hunger, growth

Parent: affect, high, not concerned

Parent - child interaction: rapport,
communication, problem solving

Home environment: safety,

organization

Core Principles for Management

- **Address contributors to the problem**
 - consider priorities, “concrete” issues
 - not always essential to address all contributors
- **Consider parents’ and **childrens’** needs**
- **Children’s protection vs. family preservation**

Core Principles for Management

- **Begin with least intrusive approach**
- **Work with the family's strengths**
- **Consider informal supports**
- **Home & community based services**

Core Principles for Management

- **Many families need long term support**
- **Extra support & monitoring**
- **Continuity & coordination of care**

When to report to CPS ?

- **When actual or potential harm is serious**
- or
- **When less intrusive efforts have failed & actual or potential harm persists**

Thinking “outside the box”

Health care provider
support/counseling

Mental health services

SWACOS

House of Ruth

The Family Tree

Community Nursing

Head Start



Family Connections

WIC

Infants & Toddlers

How Do I Successfully Engage Families as Partners?

Ronald Zuskin, LCSW-C

Director of Training

University of Maryland

School of Social Work

How Do I Successfully Engage Families as Partners?

- **Understand the impact of authority on the relationship**
 - “Authority” as an act of imagination; a perception
 - Sources of “Power”
 - Force
 - Reward Power
 - Coercive Power
 - Legitimate Power
 - Referent Power
 - Expert Power
 - Authority relations in every day life - roots of reactance

How Do I Successfully Engage Families as Partners?

- **Understand that the services we deliver may not be desired by the recipients**
 - **The “Voluntary” Client**
 - **The “Involuntary” Client**
 - The “nonvoluntary” client
 - Formal Pressure
 - Informal Pressure
 - **The Mandated Client**
 - Court Orders
 - Legislation

How Do I Successfully Engage Families as Partners?

- **Understand the reaction of involuntary clients to becoming our “partner.”**
- **Reactance Theory - Ronald Rooney, 1992**
A normal response to the threat of loss of valued freedoms:
 - Recover what is threatened
 - Incite others to restore freedom
 - Find the loophole
 - Hostility and aggression towards source of threat

How Do I Successfully Engage Families as Partners?

- **Reactance Theory (*cond.*)**
 - Intensity varies when
 - Valuable freedom is unexpectedly lost
 - Other freedoms threatened by implication
 - Threatened freedoms are valuable/significant

How Do I Successfully Engage Families as Partners?

- **Start Where the Client is, *if you can begin there***
 - “I don’t see the problem or feel the need to change.”
 - **Expect Reactance as normal**
 - **Directly help or contract to restore freedom**
 - **Emphasize specific, not global, changes**
 - **Don’t overemphasize change**
 - **Attribute behavior to the situation**

How Do I Successfully Engage Families as Partners?

- **Start Where the Client is, *if you can begin there (cond.)***
 - Avoid Labeling
 - Clearly identify areas of constrained choice and re-examining freedoms
 - Suggest multiple alternatives and support choices
 - Small, feasible steps to build early success

How Do I Successfully Engage Families as Partners?

- **Start Where the Client is, *if you can begin there (cond.)***
 - Use assessment and feedback to highlight strengths as well as problems, and to recognize/reward effort and progress
 - “Maybe there is a problem, and maybe I need to change.”

How Do I Successfully Engage Families as Partners?

Carefully manage escalation in face-to-face contact

The Arc of a Crisis	Warning Signs	Careful Management
Escalation	Mounting Anxiety	Empathize
	Pacing	Active Listen
	Shaking	Assess Responsiveness
	Stammering	Facilitate Expression
	No Eye Contact	Clarify Role/Use of Space

How Do I Successfully Engage Families as Partners?

Carefully manage escalation in face-to-face contact

The Arc of a Crisis	Warning Signs	Careful Management
Agitated Defensiveness	Belligerence	Provide Structure
	Yelling	Provide focus
	Intimidation	Set Reasonable Limits
	Pressured Speech	Self-Control
	Staring	Both Stay Seated

How Do I Successfully Engage Families as Partners?

Carefully manage escalation in face-to-face contact

**The Arc of a
Crisis**

Warning Signs

**Careful
Management**

Acting Out

Verbal Threats

Follow through with
limits

Rapid Movements

Standing

Indicate
Consequences

Approach

Use barriers

Assault

Terminate
session/Get help

How Do I Successfully Engage Families as Partners?

Carefully manage escalation in face-to-face contact

The Arc of a Crisis	Warning Signs	Careful Management
Tension Reduction	Crying	Reconnect
	Blushing	Active Listen
	Avoidance	Acknowledge regaining control
	Fear	
	Remorse	Restate mutual goals

How Do I Assess the Care of Children with Major Health Problems?

Prassana Nair, MD

Professor of Pediatrics

University Maryland School of Medicine

How Do I Assess the Care of Children with Major Health Problems?

- **All children with chronic problems must have an identified source of primary medical care**
- **To assess if care provided is optimal the worker must first be aware of the needs of these children**

How Do I Assess the Care of Children with Major Health Problems?

- The premature and/or low birth weight infant:
 - Born before 37 weeks of gestation
 - Weighs 2500 grams (5 lbs 8 oz) or less and are considered low birth weight, and may be appropriate for gestational age (AGA) or small for gestational age (SGA)
 - Records from the nursery should indicate which category the baby falls into.

How Do I Assess the Care of Children with Major Health Problems?

- **Very Low Birth Weight**
 - **Infants below 1500 grams are classified as “Very Low Birth Weight”**
 - **These are mostly infants who are born prematurely and are likely to have more problems related to growth and development than larger infants**

How Do I Assess the Care of Children with Major Health Problems?

- **Monitor:**
 - **Weight gain:** use appropriate growth charts, check if infant is getting the appropriate amount of calories, vitamins, iron and fluoride
 - **Development:** Check if infant is receiving regular assessment of development and hearing

How Do I Assess the Care of Children with Major Health Problems?

- **Drug Exposed Infants**

- Babies exposed to narcotics (e.g. heroin, methadone *in utero*) can have withdrawal symptoms, which can be mild to severe, lasting from a few days to several months (Neonatal Abstinence Syndrome, NAS).
- Mild symptoms can be managed without medications, by providing a quiet environment, dim lighting in the room, swaddling, and frequent small feedings if infant has vomiting.

How Do I Assess the Care of Children with Major Health Problems?

- Neonatal Abstinence score (NAS)
 - Neonatal abstinence score is a scale used to measure the severity of withdrawal.
 - If medication is needed, infant must be followed closely by the pediatrician/ primary physician, till infant is weaned off medication
 - Weight gain should be checked at least weekly until infant shows an adequate weight gain.
 - Parenting ability and mother/infant bonding must be assessed and mother should be referred to drug treatment program.

How Do I Assess the Care of Children with Major Health Problems?

- **Fetal Alcohol Syndrome**

- Infants are usually small for gestational age, may have facial abnormalities, cardiac defects, development delay and mental deficiency varying from borderline to severe
- Growth and development must be monitored and appropriate referrals made early to infant stimulation programs

How Do I Assess the Care of Children with Major Health Problems?

- **Infants born to HIV Positive Women:**
 - Ensure that infant is receiving primary care in program that is up to date with current recommendations for diagnosis and treatment of HIV infection
 - Check if the infant is getting AZT every 6 hours during the first 6 weeks of life
 - Check if mother has a reliable source of care for herself

How Do I Assess the Care of Children with Major Health Problems?

- **HIV Exposed Infant**

- After 6 weeks infant should receive **Bactrim™** for PCP prophylaxis, three days per week, till discontinued by Pediatrician.
- Infant's HIV and immune status must be closely monitored with tests for HIV infection (RNA- viral load, DNA PCR, HIV co-cultures, P24 antigen), and T cell (CD 4) counts

How Do I Assess the Care of Children with Major Health Problems?

- **Chronic Illness: Asthma**

- A common chronic lung disease
- Airways become inflamed, i.e. linings are swollen
- Airways are hyper responsive i.e. very sensitive & react to different stimuli/ triggers.
- Airways become narrow and breathing becomes difficult.
- There is often a family history of asthma or allergies.

How Do I Assess the Care of Children with Major Health Problems?

- **Asthma Education**

- Parents and older children must understand what is meant by “asthma”
- They must know:
 - Environmental controls
 - Triggers for their child
 - How different medicines work
 - How to use home peak flow monitoring:
Proper use of peak flowmeters will help them identify early stages of airway obstruction and see if treatment is working.

How Do I Assess the Care of Children with Major Health Problems?

- **Asthma Education (*cond.*)**
 - Good health care is crucial for a child with asthma
 - Even though usually easily treated it can be severe and life threatening
 - Make sure family is referred to an appropriate asthma education program
 - Poorly treated asthma is one of the most common reasons for preventable hospitalizations.

How Do I Assess the Care of Children with Major Health Problems?

- **Chronic Diseases: Cerebral Palsy (CP)**
 - Cerebral palsy is a nonprogressive condition of posture and movement
 - Often associated with abnormalities of speech, vision, and intellect
 - Resulting from a defect or lesion of the developing brain”

How Do I Assess the Care of Children with Major Health Problems?

- **Children with CP need a comprehensive interdisciplinary team approach to care including:**
 - **Physical and occupational therapists**
 - **Developmental psychologists and educators**
 - **Speech pathologists**
 - **Social Workers**
 - **Primary Health Care Providers**

How Do I Assess the Care of Children with Major Health Problems?

- **Cerebral Palsy is a nonprogressive central nervous system disorder of posture and movement**
- **Early physical and occupational therapy is crucial to limit the effects of abnormal muscle tone and to prevent development of contractures**
- **Appropriate educational management is a priority**

What Preventive Care Should Children and Youth Receive?

Charles I. Shubin, MD

Director, Children's Health Center

Mercy Family Care

Baltimore, MD

What Preventive Care Should Children and Youth Receive?

- **Pediatric Preventive Care**

- Well child visits scheduled at 1,2,4,6,9,12 and 18 months and 2,3,4,5,6,8,10,12,14,16 and 18 years to include the following:

- Health history - initial and interval, personal, family and social
- Developmental screenings to detect children at risk for or already showing developmental delays (Denver Developmental Screening Test)

What Preventive Care Should Children and Youth Receive?

- **Pediatric Preventive Care**

- **Well child visits (*cond.*)**

- **Mental health screening to detect behavioral or psychosocial difficulties or both, including school problems and family violence, involving children or adults or both**
- **Comprehensive physical examination from “head to toe,” includes screening for evidence of abuse, neglect or both and for growth**
- **Vision and hearing screening**

What Preventive Care Should Children and Youth Receive?

- **Pediatric Preventive Care**
 - **Laboratory and other tests**
 - **Hereditary diseases (“PKU” [phenylketonuria]) at birth and repeated as needed**
 - **Lead and anemia at 9-12 months and yearly as needed according to behavior, exam findings and environment from 2-6 years - more often as results dictate**
 - **Cholesterol screening as indicated by family history**

What Preventive Care Should Children and Youth Receive?

- **Laboratory and Other Tests** (*cond.*)
 - **Tuberculosis by needle test only (“Mantoux test”) and not multipuncture test (“Tine test”) if high risk by history of exposure to active tuberculosis or other risk factors (e.g., HIV positive)**
 - **Sexually transmitted diseases if sexually active or 16 years or older**

What Preventive Care Should Children and Youth Receive?

- **Immunizations as recommended by the American Academy of Pediatrics Committee on Infectious Diseases and the U.S. Public Health Service Advisory Committee on Immunization Practices. This schedule changes periodically**

What Preventive Care Should Children and Youth Receive?

- **Health education and anticipatory guidance:** Health education focuses on specific problems (e.g., asthma). Anticipatory guidance involves age-appropriate advice and counseling concerning anticipated concerns and health and developmental issues, including discipline (e.g., discussing the increasing mobility and curiosity of toddlers and how best to manage them).

What Preventive Care Should Children and Youth Receive?

- **Dental Preventive Care**

- Regular Dental visits every 6 months starting at age 3 or earlier if there are problems. Dental preventive care includes the following:

- Oral screening examinations searching for cavities, malocclusion (need for orthodontics), and other abnormalities
 - Fluoride and sealant applications as recommended

What Preventive Care Should Children and Youth Receive?

- **Dental Preventive Care**
 - **Oral Health Education (*cond.*)**
 - Advice on brushing and flossing
 - Diet education, especially dietary fluoride; not letting babies sleep with bottles of milk or juice
 - Dental injury prevention education, especially use of mouth guards

How Do I Assess Child Behavior Related to Separation and Visitation?

Caroline L. Burry, Ph.D, MSW

Assistant Professor

University of Maryland

School of Social Work

How Do I Assess Children's Behavior Related to Separation and Visitation?

- **Introduction**

- Visitation is a core service for children in out-of-home care
- Many children present challenging behaviors around visitation; it is important to assess these.

How Do I Assess Children's Behavior Related to Separation and Visitation?

- **Topics of Discussion**

- Typical behaviors around visitation and underlying feelings and issues to explore
- Strategies to use in assessing these behaviors and issues

How Do I Assess Children's Behavior Related to Separation and Visitation?

- **Typical Behaviors/Possible Related Issues**
 - Sleep problems/regression; “being bad” in hopes of being returned; post-traumatic stress
 - Clinginess/grieving losses; regression
 - Verbal and physical hostility/expressing anger or sadness; “being bad” in hopes of being returned; post-traumatic stress
 - Inconsistent behaviors/uncertainty about the future; confusion; lack of trust

How Do I Assess Children's Behavior Related to Separation and Visitation?

- **Typical Behaviors/Possible Related Issues**
(cont.)
 - Lying and stealing/"being bad" in hopes of being returned; anger; lack of trust; low self-esteem
 - Overly affectionate/regression; wanting to be seen positively
 - Pseudomaturity/assertion of some control; fear of emotional closeness with foster parents; rejecting need for birth parents; reenacting former roles

How Do I Assess Children's Behavior Related to Separation and Visitation?

- **Typical Behaviors (*cond.*)**
 - Running/depression; feeling overwhelmed; asserting control
 - Withdrawal/hopelessness; depression; post-traumatic stress

How Do I Assess Children's Behavior Related to Separation and Visitation?

- **Some Factors to consider in Assessing Behaviors/Issues**
 - The child's age and developmental stage
 - The child's placement history
 - The child's loss and grief experiences

How Do I Assess Children's Behavior Related to Separation and Visitation?

- **Some Strategies for Working with Children Around Visitation Behaviors and Issues**
 - Give them permission to have and express feelings
 - Help them express feelings in safe ways
 - use tools (Life Book, play therapy, art, journals, etc.)

How Do I Assess Family Strengths and Target Intervention Outcomes?

Diane DePanfilis, PhD., MSW

Associate Professor

University of Maryland

School of Social Work

Co-Director, Center for Families

Assessing Family Strengths

- **Extremely important in area such as child maltreatment**
- **Increases the likelihood of successful engagement**
- **Can be maximized when developing intervention outcomes and goals**

Principles of the Strengths Perspective

- **Emphasize personal and environmental strengths**
- **Understand from the client's point of view**
- **Promote mutual agreement between client and helper**
- **Use empathy**
- **Avoid blame and blaming**
- **Emphasize positives, not negatives**

Defining Family Strengths

- **“Family strengths are the competencies and capabilities of both various individual family members and the family unit that are used in response to crises and stress, to meet needs, and to promote, enhance, and strengthen the functioning of the family system” (Trivette, et. al., 1990).**

Understanding the Nature of Family Strengths

- **“Strengths are not isolated variables, but form clusters and constellations which are dynamic, fluid, interrelated, and interacting” (Otto, 1962, p. 80).**
- **“Competent families appear to be the result of the presence and interrelationship of a number of variables” (Lewis, 1976, p. 205).**

Dimensions of Family Strengths

- **Commitment to promote the well-being of individual members and family as a whole.**
- **Appreciation for the small and large things that individual family members do well.**
- **Effort to spend time together.**
- **A sense of purpose that helps the family “stick together” in times of stress.**

Dimensions of Family Strengths

- **Common agreement among members to invest in meeting needs of one another.**
- **Ability to communicate in ways that emphasize positive interactions.**
- **A clear set of family rules, values, and beliefs that establish expectations about acceptable and desired behavior.**
- **A varied repertoire of coping strategies that promote positive functioning in dealing with stressful life events.**

Dimensions of Family Strengths

- **Ability to engage in problem-solving to evaluate options for meeting needs and obtaining resources.**
- **Ability to be positive and to see the positive aspects of their lives.**
- **Flexibility and adaptability.**
- **A balance between the use of internal and external family resources for coping and adapting to life events and planning for the future.**

Why target outcomes?

- If we don't know where we are going, how will we know when we get there?



Levels of Outcomes*

- Community
- Service System
- Agency
- Program
- Family
- Individual
- Scorecards
- Accountable for what?
- Achievement of mission.
- What is success?
- Family success?
- Individual success?

*McCroskey (1997).

Definition – Program Outcome

- **A condition of well-being for children, families, or communities.**
- **Examples:**
 - **Child safety**
 - **Child well-being**
 - **Family well-being**
 - **Permanency**

Definition – Client Outcome

- **Positive results for individuals and families that indicate that both risks and effects of maltreatment have been reduced.**
- **Examples:**
 - Behavioral control
 - Social skills
 - Child management skills
 - Communication skills
 - Social support

Principles*

- **Outcomes need to be measured differently at different levels.**
- **At all levels, outcomes and indicators should be practical, results-oriented, clearly important to the well-being of children and families, and stated in understandable terms.**

*Adapted from McCroskey (1997).

Process of using outcomes

- **Assess key strengths, needs, risks, problems**
- **Define key outcomes**
- **Consider alternative measures as indicators of outcomes**
- **Select assessment measures**
- **Apply measures at beginning, intervals, and at closure**

Example-match risks to outcomes

Risks

- Inappropriate harsh parenting, inappropriate expectations of children
- Fear of expressing feelings, verbally abusive, doesn't recognize feelings of others

Outcomes

- Parenting knowledge & skills
 - knowledge, emotional control, discipline
- Communication skills
 - verbal expression, verbal responses, empathy

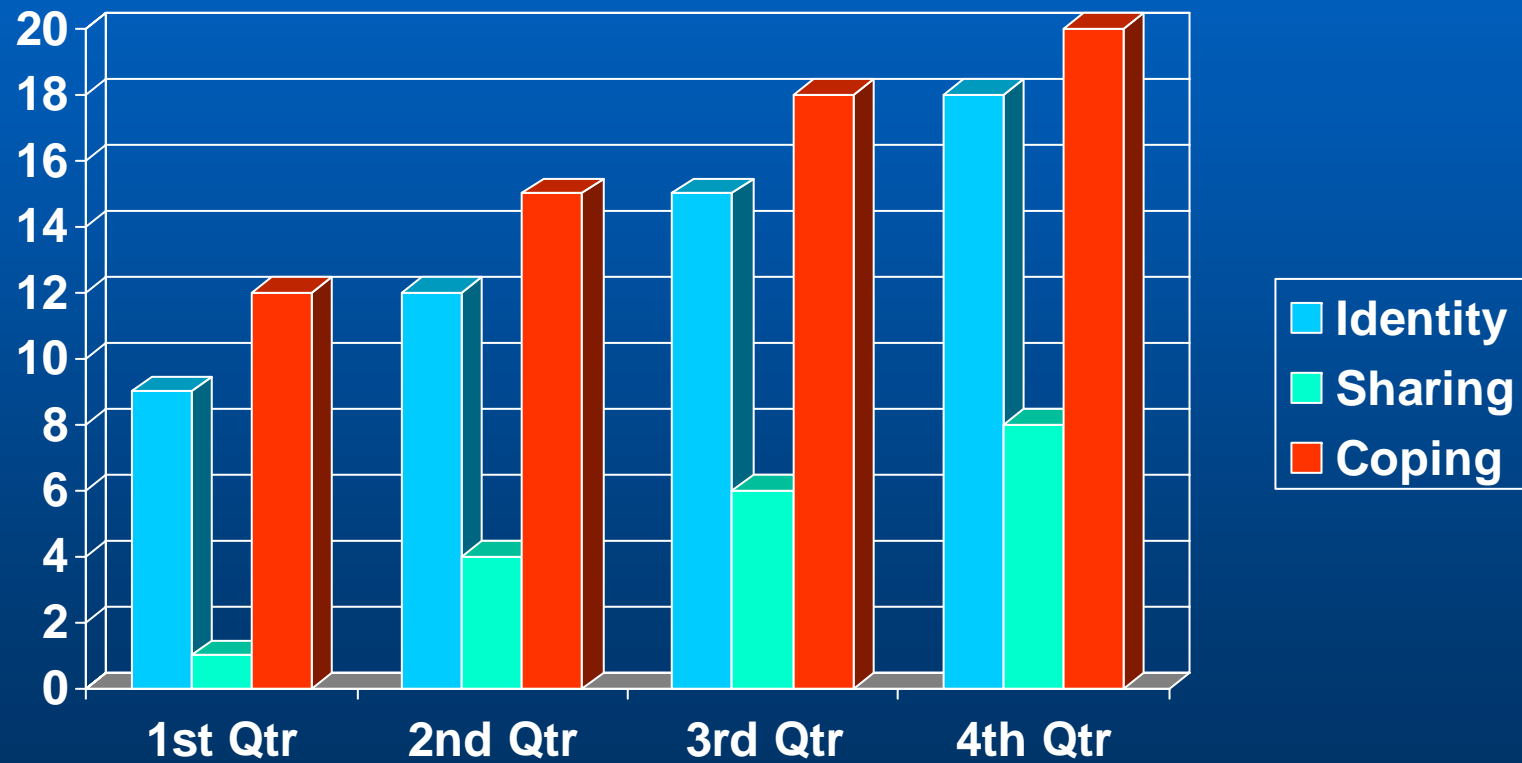
Gordon Family Functioning issues

- **Distance between couple**
- **Strain in marital relationship over miscarriage**
- **Matt is fearful of Dad**
- **Mom and Matt are close, Dad distant**
- **Role strain with Mom back at work**
- **Communication is strained**
- **Don't do anything fun as a family**

Assess Family Functioning

- Interviews/meetings with family as a system and with individuals
- Use Family Functioning Style scale - have each complete separately and then bring together for discussion
- Derive areas for work from assessment
- Use Family Functioning Style scale at periodic intervals and at closure

Measuring Change-Gordon Family



Wrap Up

- Importance of keeping up on best methods for responding to child maltreatment
- Questions & comments

