

CHILD WELFARE TRAINING CONSORTIUM

**Curriculum Overview  
and Learning  
Expectations Guide For  
Supervisors  
Appendix B**

2012



**CWtC**

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## **Job Aids for use with the Guide for Supervisors**

### **Strategies and Techniques for PI/Case Manager Field and Office Safety**

**At the time of intake and referral**, try to find answers to the following questions:

- Does anyone in the family have a history of violent behavior?
- Does anyone in the family possess and use weapons to threaten others?
- What is the caller's assessment of the safety of this situation?
- Is there another person in the household who might become upset and violent, such as a paramour?
- Does the family possess a pet which could become vicious?
- Is there known use of drugs and alcohol in the family?

**You should be concerned** when you receive the following types of intakes:

- Safety issues raised in questions for #1 are unknowns.
- The family lives in a high-crime area.
- The intake involves violent behavior.

#### **Home Visits:**

- Always let a co-worker in the office know where you are going and when you plan to return.
- Note exits and stay near one of them. Do not let any adult family members come between you and the door.
- When meeting alone and violent behavior seems a possibility, if the individual leaves the room, go outside rather than follow the person into another room, or wait for the person to return.
- Face a hostile family member at all times. Do not turn your back on this person.
- Never touch an adult family member unless adequate rapport and a sound relationship have been developed between you and this person.
- If you feel in danger, leave immediately and seek assistance.
- Take a co-worker along if you have reason to believe that going alone may be dangerous and you believe that another worker will give you more command influence.

- With a co-worker, establish a code system to signal each other if danger seems possible and you need to leave immediately.
- Take a co-worker with you when:
  - The visit is after hours, especially when the family is unknown
  - Drugs and alcohol are involved
  - The location of the family is rural and isolated and rapport with the family has not yet been established
  - The family is part of a sub-cultural group
  - A child has just been removed
- If you believe that official influence is required to ensure your safety, request that a law enforcement officer accompany you. Below are guidelines for determining when to request official assurance:
  - When someone in the family is mentally ill.
  - When weapons are known to be present.
  - When there is a history of violence and reason to believe that this individual is hostile or resistant at the present time.
  - When your supervisor believes that immediate removal is highly possible.
  - When you intuitively feel your safety is at risk.

### **Office Safety**

- Facilities/Environment. Each office should examine the physical arrangement of doors, windows, offices, furniture, and other objects to determine how to make the environment as safe as possible. Consideration should be given to the following:
  - Can a barrier be placed between the receptionist and entering individuals?
  - Can individuals be observed BEFORE they enter the office through windows or doors?
  - Are there two or more exits from the reception and office area?
  - Are the conference or interview rooms clear of any small moveable objects that could be used as weapons?
  - Is there a special room that could be used when you believe an individual might become combative? It should have only two or three chairs and maybe a table and two exits.
  - Is there lighting adequate in the parking area, corridors, etc, for counselors who must leave the office at night?
  - Are family members prevented from having easy access to employee break rooms?
- Personnel
  - PI/Case Managers should alert receptionist to the possibility of individuals coming in

who may be or become hostile.

- An office safety plan should be established.
- This should be a signaling system for indicating the presence of a hostile individual and/or worker in need of assistance. Such a system would allow a receptionist to forewarn a PI/CM, and it would also allow a PI/CM to summon assistance as required.
- Such a signaling system can consist of using colors, e.g., a PI/CM who has a hostile client in her office calls another PI/CM or the receptionist, saying: “Mr. Blaugh is here, and we need to see the blue folder.” The blue folder could indicate that another PI/CM should immediately come into the room to help defuse the hostility.

## Worker's Safety Plan

Adapted from Domestic Violence Protocol, Massachusetts Department of Social Services

- Learning to identify dangerous behavior that elicits the need for safety planning is crucial when working in many situations, especially domestic violence.
- Listed below are some general indicators of an abusive personality. You must use extreme caution when intervening in a family.
- Remember, your involvement may threaten the batterer's control of the situation and may increase the risk to the family and to you.

### Indicators of an Abusive Personality

- blaming everyone but self
- obsessive behavior - jealous, accusatory
- threatening suicide, violence, kidnapping, harming those who try to help
- stalking
- presenting as if he/she is the victim
- vengeful - may file for an injunction against the victim or sue for custody of the children
- powerful - may report having friends in positions of power (i.e., police, organized crime, wealthy individuals)
- paranoid/hypersensitive
- criminal record of violent offenses - check FDLE for offenses like assault/battery on police
- belligerent toward authority figures - including representatives of the agency
- current alcohol and drug abuse
- access to weapons or training in martial arts or boxing

### Safety Guidelines

- If the person exhibits the characteristics listed above, do not go to the home until you have carefully considered the following:
  - Consult your supervisor and domestic violence specialist (if available) and discuss your concerns. Begin safety planning.
  - Consider taking a co-worker or police officer to the home.
  - Never meet with a person who is under the influence.

- ☐ When conducting an assessment or interviews with the family, always be aware of triggers which may cause this individual to respond in a violent way:
  - ☐ Mom is preparing to leave - i.e., shelter, injunction, separation, or divorce.
  - ☐ Children are going to be removed - before, during, or after a hearing.
  - ☐ Batterer has just been released from jail or is facing serious criminal charges or possible incarceration.
  - ☐ Allegations have been made directly about him regarding child maltreatment or domestic violence (or both).
  - ☐ He is asking for information about the family's location if there has been a separation.
  - ☐ Permanency plan goal changes to adoption.

### **When Working in High Risk Situations**

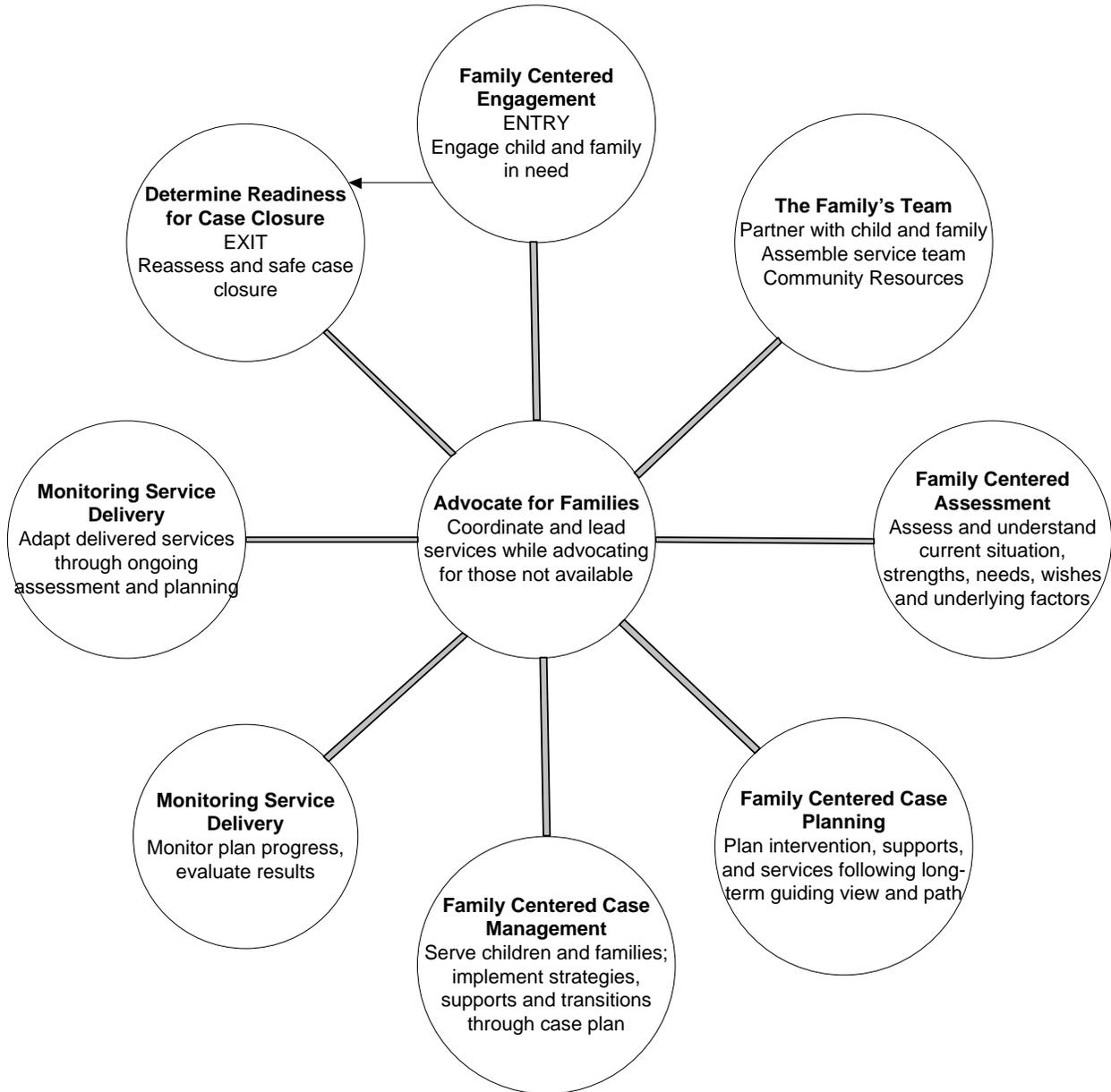
- Never meet with the batterer alone. If possible, plan the visit at the local office, or take a colleague with you.
- Exercise caution when leaving the office or the visit. Park in a safe place.
- Contact law enforcement if FDLE shows a criminal record of violent offenses.
- Notify colleagues that a potentially dangerous client is coming in to meet with you. Tell them when and where you will meet.
- Whenever possible, use a meeting room with multiple exits, in case you need to leave quickly.
- If possible, have security nearby.
- Know the procedures used in your unit for emergencies.

### **If You Find Yourself in a Violent Situation**

- Trust your instincts. If you feel afraid, you are probably unsafe!
- Stay calm. The batterer will try to test your limits. It is important not to engage in a confrontation.
- If you feel anger directed at you, try to calm him. Explain that his anger is misplaced and you are there to help. End the visit.
- When you are aware of escalation in his anger, always notify the adult victim of the risk to her and the children!

# Core Practice Functions

## Core Practice Functions



## Abuse or Not?

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

<b>Hair Loss</b>	
Is it Non-intentional?	Steps to Confirm
None	None
Is it a Medical Condition?	Steps to Confirm
Trichotillomania Tinea capitis (ringworm) Idiopathic (e.g., alopecia areata) Nutritional deficiencies	<input type="checkbox"/> Check to see if loss of hair is in a localized spot. <input type="checkbox"/> Varying bald spots may be indicative of abuse. <input type="checkbox"/> Localized spot is usually on back of the head. <input type="checkbox"/> A child will be at least 3 years old for this condition to occur. <input type="checkbox"/> Check for scaly skin. <input type="checkbox"/> Fungal culture of scalp by physician. <input type="checkbox"/> Check history.
<b>Burns</b>	
Is it Non-intentional?	Steps to Confirm
Spilling of a hot liquid	<input type="checkbox"/> Check location of splash burns; non-intentional burns are most likely to occur on the front of the head, neck, trunk, and arms. It is usually possible to estimate the direction from which the liquid came and the position of the body. <input type="checkbox"/> Check for discrepancies between the burn and the history provided by the caregiver.
Is it a Medical Condition?	Steps to confirm
None	None
Brushing against a cigarette	<input type="checkbox"/> Check location of burns; usually non-intentional if found on child's face, arms or trunk. <input type="checkbox"/> Check shape of burn; usually non-intentional if burn is more elongated than round, with a higher degree of intensity on one side. <input type="checkbox"/> Check for discrepancies between the burn and the history provided by the caregiver.
Is it a Medical Condition?	Steps to confirm.
Impetigo Insect Bites	<input type="checkbox"/> Suspicious blisters are generally cultured by a physician for streptococcal infections that may be found with impetigo and treated with antibiotics. <input type="checkbox"/> Examine lesions: impetigo lesions have various shapes and sizes, cigarette burns are symmetrical.
Is it Non-intentional?	Steps to Confirm

Falling into a hot bath	<ul style="list-style-type: none"> <li><input type="checkbox"/> Check for clear lines of demarcation; non-intentional burns have no clear line separating burned and unburned skin.</li> <li><input type="checkbox"/> Check deepness of burn; non-intentional burns are not as deep as forced burns because an unrestrained child will rarely be unable to remove himself or herself from the burning environment.</li> <li><input type="checkbox"/> Check to see if perineum and feet are burned, but not the hands; it is impossible for a child to non-intentionally fall into a tub without hands going into water.</li> <li><input type="checkbox"/> Check for doughnut hole, parallel lines, and flexion burns; these burns may be indicative of abuse.</li> <li><input type="checkbox"/> Check for discrepancies between the burn and the history provided by the caregiver.</li> </ul>
Is it a Medical Condition?	Steps to Confirm
<input type="checkbox"/> Staph Scalded Skin Syndrome (SSSS) <input type="checkbox"/> Toxic Epidermal Necrolysis (TEN)	<ul style="list-style-type: none"> <li><input type="checkbox"/> Ask about symptoms of fever, malaise, and sore throat.</li> <li><input type="checkbox"/> Check for mouth and nose crusting.</li> <li><input type="checkbox"/> Ask about onset of medical condition.</li> </ul>
Coming into contact with a burning object	<ul style="list-style-type: none"> <li><input type="checkbox"/> Check location of burn; some areas of the body are clearly more difficult for a child to self-inflict burn.</li> <li><input type="checkbox"/> Check pattern of burn; an irregular burn will be left when a young child who moves away from a burning object reflexively.</li> <li><input type="checkbox"/> Check deepness of burn; non-intentional burns are usually deep on one edge of the burn.</li> <li><input type="checkbox"/> Check margins of burn; non-intentional burns usually do not have crisp overall margins.</li> <li><input type="checkbox"/> Check for discrepancies between the burn and the history provided by the caregiver.</li> </ul>
Is it a Medical Condition?	Steps to Confirm
Varicella (chickenpox)	<ul style="list-style-type: none"> <li><input type="checkbox"/> Check history.</li> <li><input type="checkbox"/> Consult with physician.</li> </ul>
<b>Fracture</b>	
Is It Non-intentional	Steps to Confirm
Birthing trauma (fractured clavicles most common) Little league elbow Nurse-maid elbow Fractures from passive exercises for therapeutic reasons	<ul style="list-style-type: none"> <li><input type="checkbox"/> Consult with physician to decide cause of fracture.</li> <li><input type="checkbox"/> (Refer to Types of Fractures in the MAL PG for a description of the different types of fractures.)</li> <li><input type="checkbox"/> Check for discrepancies between the fracture and the history provided by the caregiver.</li> </ul>

Is it a Medical Condition?	Steps to Confirm
Congenital syphilis Infantile cortical hyperostosis (Caffey's disease) Leukemia Menkes' kinky hair syndrome Osteogenesis imperfecta Osteomyelitis Rickets Scurvy	<input type="checkbox"/> A physician can use radiology to decide if a fracture exists and also to gain insight into how it was produced. <input type="checkbox"/> Obtain pediatric radiologist if possible. <input type="checkbox"/> It is critical to tell radiologist that child abuse is suspected. <input type="checkbox"/> X ray is fine for screening. <input type="checkbox"/> A bone scan can be used to reveal old, healed fractures caused by suspected abuse.
<b>Head Injury</b>	
Is It Non-Intentional	Steps to Confirm
Birth trauma causing effusion, cephalohematoma, diffuse cerebral edema, infarction, cerebral contusions, posttraumatic hypopituitarism Insect bite on head (usually forehead)	<input type="checkbox"/> Check onset of injury; injuries from birth traumas should become apparent shortly after birth. <input type="checkbox"/> Check for discrepancies between the injury and the history provided by the caregiver; subdural hematomas found in an infant or toddler without adequate explanation of trauma may be indicative of abuse.
Is it a Medical Condition?	Steps to Confirm
Infectious meningitis	<input type="checkbox"/> Check compatibility between the history and physical findings. <input type="checkbox"/> Consider child's developmental maturity.
<b>Eye Injury</b>	
Is it Non-Intentional	Steps to Confirm
Chemical burns Non intentional foreign body to the eye (e.g., sticks, sand, or paper edge)	<input type="checkbox"/> Check for discrepancies between the injury and the history provided by the caregiver.
Is it a Medical Condition	Steps to Confirm
Conjunctival hemorrhaging during birth Allergic conditions ("allergic shiners").	<input type="checkbox"/> Conjunctival hemorrhaging during birth usually disappears by one month. <input type="checkbox"/> Check history

<b>Ear Injury</b>	
Is it Non-intentional	Is it a Medical Condition?
Injury from inserting cotton swab	<input type="checkbox"/> Check if laceration is of the external auditory meatus; this injury can occur only by inserting a pointed object into the ear. <input type="checkbox"/> Check for discrepancies between the injury and the history provided by the caregiver.
Is it a Medical Condition?	Steps to Confirm
None	None
<b>Nasal Injury</b>	
Is it Non-intentional?	Steps to Confirm
Injury from inserting foreign bodies into the nose	<input type="checkbox"/> Check to see if foreign bodies are found in more than site; if found only in nose, this is common in the normally developing child. <input type="checkbox"/> Check for discrepancies between the injury and the history provided by the caregiver.
Is it a Medical Condition?	Steps to Confirm
None	None
<b>Tooth Injury</b>	
Is it Non-intentional?	Steps to Confirm
Non-intentional falls. Striking the mouth with a hard instrument.	<input type="checkbox"/> Check to see if any teeth are loosened; any loosening of the teeth must be immediately examined by a dentist to decide severity.
Is it a Medical Condition?	Steps to Confirm
None	None
<b>Poisoning</b>	
Is it Non-intentional?	Steps to Confirm
Giving toxic doses of vitamins and minerals to cure illness Feeding a baby improperly diluted formula Non-intentional ingesting of medicines, household cleaners, etc.	<input type="checkbox"/> Check with parent about cause of poisoning; non-intentional poisoning may be a form of neglect that can be treated with education and support.
Is it a Medical Condition?	Steps to Confirm
Endocrine	<input type="checkbox"/> Consult with physician.

## Burns: Severity and Types

Degree	Appearance at Time of Injury	Appearance 2 Weeks Later
First-Degree Burn	<ul style="list-style-type: none"> <li><input type="checkbox"/> A superficial burn of minimal depth.</li> <li><input type="checkbox"/> Characterized by redness, hyperemia (redness which disappears under pressure), tenderness and swelling.</li> <li><input type="checkbox"/> Can be serious if it covers a large percentage of body area - for example, sunburn</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> No scar</li> </ul>
Second-degree burn	<ul style="list-style-type: none"> <li><input type="checkbox"/> Burn extending through the outermost layer of skin and into the next layer.</li> <li><input type="checkbox"/> Usually not severe enough to interfere with skin after injury, so no scar tissue develops.</li> <li><input type="checkbox"/> Characterized by weeping blisters on the skin's surface, with increased sensitivity to touch.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> If no infection occurs, no scar remains.</li> <li><input type="checkbox"/> If infection occurs, surgery may be required.</li> </ul>
Third-degree burn	<ul style="list-style-type: none"> <li><input type="checkbox"/> Entire thickness of the skin is burned, including the hair follicles.</li> <li><input type="checkbox"/> Area looks white or charred and is not sensitive to touch or a pin prick.</li> <li><input type="checkbox"/> These injuries require hospitalization and often require skin grafting.</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> These burns heal with scarring, creating a change in color and a "parchment" type of skin.</li> </ul>
Rule of Nines	Percentage of Body Burned	Age
<p>Burns are considered severe when they cover the following percentages of the body in correlation with certain age groups. Physicians use the "Rule of Nines" to indicate the body surface covered by the burn. They explain the amount of surface area burned in percentages, rather than measuring the exact size of the burn. First-degree burns are not included in this measurement. Note that a burn that may cover only a small area of an adult could cover an appreciably larger area of an infant's body.</p>	<input type="checkbox"/> Over 10 %	<input type="checkbox"/> Under two years of age
	<input type="checkbox"/> Over 15%	<input type="checkbox"/> Between two and twelve years of age
	<input type="checkbox"/> Over 20%	<input type="checkbox"/> Any Age
	<input type="checkbox"/> Over 65%	<input type="checkbox"/> Any age, sometimes fatal, even when only first degree
	<input type="checkbox"/> Any portion of the face hand or genitalia.	<input type="checkbox"/> Any age
Type of Burn	Description	

Burns by objects	<ul style="list-style-type: none"> <li>☐ Objects include irons, stove burners, heater grates, radiators, electric hot plates, and hair dryers.</li> <li>☐ Objects such as combs, keys, knives, or cigarette lighters can be heated and “branded” into the skin.</li> <li>☐ During summer months, second and third-degree burns can be caused by vinyl upholstery, seat belts, infant backpack carriers, or seatbelt buckles.</li> </ul>
Chemical burns	<ul style="list-style-type: none"> <li>☐ Household items such as acidic cleaners cause chemical burns.</li> <li>☐ Burning process continues as long as the substance is in contact with the skin.</li> </ul>
Cigarette burns	<ul style="list-style-type: none"> <li>☐ They measure about 1 cm in diameter.</li> <li>☐ They are often found on the trunk, external genitalia and extremities, such as the palms of the hands and the soles of the feet.</li> <li>☐ The presentation ranges from blisters to deep wounds.</li> </ul>
Electric burns	<ul style="list-style-type: none"> <li>☐ The conduction of current through the saliva of a child causes electric burns.</li> <li>☐ The child may be sucking or mouthing a plug or biting a live electric cord.</li> <li>☐ Burns at the corners of the mouth are common.</li> </ul>
Immersion burns	<ul style="list-style-type: none"> <li>☐ Immersing a child into high-temperature water produces immersion burns.</li> <li>☐ Forms of immersion burns include stocking or glove, doughnut hole, parallel lines, and flexion burns.</li> </ul>
Splash burns	<ul style="list-style-type: none"> <li>☐ Hot liquid either thrown or poured produces splash burns.</li> <li>☐ They are less severe than immersion burns; liquid runs off the skin before it has a chance to incur deep damage.</li> <li>☐ The deepest burn is usually the area in contact with the main mass of fluid.</li> <li>☐ Often the burn pattern is an “arrowhead” configuration.</li> </ul>

## Interview Skills Checklist

Place a check by each skill you observe.

### Core Conditions

- Genuineness/Authenticity
- Respect
- Empathy

### Exploring Skills

- Active Listening
- Attending Behaviors
- Reflecting
- Encouraging
- Allowing Silence

### Focusing Skills

- Reframing
- Clarifying
- Questioning:
  - Open-ended Questions
  - Closed-ended Questions
  - Indirect Questions
  - Solution-focused Questions
- Summarization

### Directing Skills

- Give Options or Suggestions
- Give Advice, Support, or Direction
- Provide Effective Feedback

## **Stages of the Interview**

### **Preparation**

- The purpose of the interview was considered.
- All available information was obtained and analyzed; additional information was obtained, if necessary.
- Decision as to who will be interviewed; when; and where was made.
- Necessary information needed based upon the purpose/type of interview was obtained.
- A checklist with major points to cover during the interview was developed.
- How to engage the interviewee and build rapport were considered.
- The introduction/greeting with the family was planned.
- How to document/take notes was planned.

### **Engagement**

Engaging the family and building rapport. Strategies to engage the family and build rapport are:

- Introductions (show/display ID), explanations of role/agency; purpose for the visit were completed.
- Once inside, informal conversation was initiated and something positive was pointed out.
- Rapport was built by demonstrating authenticity/genuineness, respect, empathy.
- Attempts were made to be responsive and respectful of the family's perspectives, strengths, culture.
- The family's needs were addressed.

### **The Interview**

- Information that addresses the purpose for the interview was obtained.
- All major points are covered.
- Focus was on the child's needs for safety, permanence, and well-being.
- Interviewing techniques that facilitate the interview were used. (listen, reflect, encourage, reframe, clarify, question, give options/feedback, summarize)
- Attempts were made to build a trusting relationship: demonstrate genuineness, respect, and empathy.

- Non-verbal (eye contact, facial expressions, nods, smiles, looks of concern) and paralinguistic behaviors (moderate calm speech, etc) were used and controlled.

### **Closing**

- What has been accomplished and what is left to accomplish was summarized.
- Praise was used to recognize efforts.
- Questions were invited and answered honestly.
- Assurance and support was offered; unrealistic reassurances or promises were avoided.
- The person(s) was thanked and a time and date for the next interview was set.

### **Documentation**

- Note taking as completed appropriately.
- The interview was documented in FSFN.

## Dealing with Resistant, Hostile, or Threatening Family Members

- **Reframing**

- This technique is based on the fact that the individual may be influenced by an overwhelming negative perspective about life in his or her specific circumstances.
- This technique seeks to help someone develop a new perspective about a problem or situation.
- Example: “Now that this problem is out in the open, you can find some help and relief which you deserve and get help for working on improvements. In the long run this will be better for both you and your children.”

- **Utilizing or Joining Resistance**

- This technique serves to weaken the effect of the resistance and takes away the need to resist.
- Rather than trying to break through or overpower resistance, the counselor joins in, almost promotes resistance, or even aligns with the resistor.
- Examples: “You should be upset.” “I’d be really angry, too.” “I can certainly see why you feel that way.” “What can we do to resolve this and to satisfy you?”

- **Role Replacement**

- This technique works best when it is not too structured but is very spontaneous. The purpose is to help the individual see another perspective, to put him or her in another’s shoes, and to enhance understanding of others.
- Ask the individual to assume the role of someone else and to explore how he or she feels, what that person’s motivations are, etc.
- Examples: “Why would you do if you saw someone possibly abusing her children?” “If you were (child’s name) and a grown-up did this to you, how would you feel?”

- **Selective Learning**

- This technique works best with individuals who are using obscene language, who respond abruptly, or who are defensive.
- Do not reply or acknowledge abusive or destructive statements.
- Respond only to constructive statements.

- **Broken Record (Repeat key questions)**

- This technique works well with individuals who are delusional or are hallucinating. This is a high-risk situation. It also works well with individuals who are vague or confused.
- Don’t challenge the delusion or hallucination. Avoid arguing. Listen carefully and respectfully.

- Accept the delusion or hallucination as part of the individual's reality but express that it is unreal for you.
- Patiently help the individual to refocus into the present circumstance.
- Repeat key questions, emphasizing closed questions to help focus the individual.
- **Disarming Anger**
  - This is useful with clients who use verbal threats or who refuse to follow directions.
  - This is an agreement between the counselor and the individual that the counselor will talk about the issue at hand or continue with the interview ONLY after the individual calms down and/or stops specified angry behaviors.
  - Use "I" statements to indicate reaction to behavior.
  - Remain calm.
  - Use selective ignoring and empathy.
  - Talk only about one issue.
  - Get overt agreement that the interview can continue only after the individual stops the abusive behavior.

## Child Interview Checklist

### Planning

- Analyze available information.
- Determine what information to collect.
- Schedule the interview at an appropriate time.
- Take necessary actions to prevent interruptions.
- Determine how to document the interview.
- Engagement
- Greet the child by name.
- Introduce self in friendly manner.
- Agree that PI/CM and the child will tell only the truth.
- Discuss how the child can answer questions.
- Talk to child about nonthreatening topics first.
- Avoid initiating physical contact with the child.

### The Interview

- Obtain names and relationships of family members.
- Maintain comfort in introducing abuse topic.
- Determine name of the alleged abuser.
- Determine the relationship of the alleged abuser.
- Determine the frequency of the alleged abuse.
- Determine when the last incident occurred.
- Determine if anyone witnessed the alleged abuse.
- Reflect content back to the child.
- Use neutral minimal encouragers.
- Use clarifying or probing questions.
- Avoid inappropriate, close-ended questions.
- Avoid *why* questions.
- Avoid judgmental comments or questions.

### The Closing

- Praise or thank the child for his or her efforts.
- Offer assurance and support.
- Document analysis of information gathered.

## **Documentation**

- Write up the interview immediately.
- Augment in-session note taking immediately.
- Transcribe audiotape, if used.
- Document analysis of information gathered.
- Review and evaluate the interview.
- Document your observation of events and review your documentation with your supervisor/mentor.

## **Ready for Investigative Closure**

**Review data entered into the SA and the Investigative Summary (IS) narrative to ensure:**

- Interviews and contacts made with all victims, children, and subjects or the reasons why one or more were not completed is documented in the SA and case file.
- All diligent efforts to locate the family and/or subjects are documented in the SA/IS.
- Every allegation in the investigation is addressed in the IS and has findings.
- All demographic data has been added to the Participants Tab and updated to reflect information revealed during the investigation.

**Ensure that each finding is supported by documented evidence that was gathered during the investigation.**

- Each maltreatment must have documented evidence to either refute or support the findings.
- This evidence must be supported by the investigation and consistent with the requirements of the Child Maltreatment Index.

**Review the SA and IS to ensure that safety factors are appropriately addressed in the disposition decision and overall child safety assessment.**

- All known safety threats and protective capacities of the family such as prior intakes and investigations, services provided or offered, criminal history results, domestic violence incidents, and the ages and developmental levels of child are documented and reflect the decision-making process.
- If safety threats are identified in the assessment, there is documentation of the services offered.
- If services are refused by the family, a legal staffing to consider filing a dependency petition must be documented and relative collateral contact must be completed.
- CSA must be submitted within 45 days of receipt of intake by hotline

## **FSFN Investigative Closure Checklist**

- SAO Form
- TANF
- Releases Signed
- Notifications
- ICWA
- Initial Assessment
- Updated Assessment
- Notes
- Disposition
- Criminal Checks Done
- Prior Reviewed
- Reporter Notified
- High Risk Form
- Pool Safety Form
- HIPAA
- Rights and Responsibility Information
- Safety Plan
- CPT Referral
- Legal Packet
- ESI staffing Packet

## Child Resource Record

- Medical, dental, psychological, psychiatric, behavioral history
- Copies of all on-going documentation including:
  - Health checkups provided through Medicaid
  - Parental consent for treatment or court order
  - Copy of the Medicaid card
- Copy of the Shelter Order
- Copy of the court order or Voluntary Placement Agreement
- Copy of the Predisposition Report (PDS)
- Copy of the Case Plan
- Copy of the most recent JRSS/CPU
- School Records: Report cards, FCAT results, All Individual Educational Plans (IEPs), including meeting notes and any notes from the guidance counselor/office.
- Any psycho-educational evaluations or other evaluations to assess educational needs
- All disciplinary records
- Any consents or communications from the child's parent
- An envelope for storing pictures
- Most recent photograph available
- Copy of the child's birth certificate or birth verification
- Documentation of immigration status, including certificate of citizenship, if available
- Names and phone numbers of staff to be contacted in emergencies

## JRSSR/CPU Requirements

### F.S. 39.701(8)(a)

- Description of placement
- Safety of the child
- Continuing necessity for placement
  
- Diligent efforts to comply to case plan
  
- Fees assessed and collected
  
- Services provided addressing child's needs
  
- Statement regarding compliance
  
- Statement of foster parent/legal custodian regarding child's return to parents
  
- Statement regarding parent-child visitation and recommendation for future visitation
  
- Number of times child has been removed from home and placed elsewhere
- Number and types of placements
- Reason for changes in placement
  
- Number of times child's educational placement has changes
- Number and types of educational placement
- Reason for changes in educational placement
  
- If child is 13-17; results of pre-independent living, life skills, or independent living assessment
- Specific services needed
- Status of the delivery of the identified services
- Copies of records
  - Medical
  - Psychological
  - Education
  
- Copies of child's current records:
  - Health
  - Mental health
  - Education

## Monthly Contacts

### Prepare for the Contact

- Review the case plan.
- List the case plan tasks to be addressed during the contact.

### Conduct the Contact w/Child, Parent, and Caregiver – QPS #54, 55

- Face-to-face contact with the child, parent, and caretaker-at minimum, every 30 days; make unannounced contact every 3 months
- Observations of the children and home environment
- Interactions between child and other family members
- Continuous ongoing assessment of the safety plan
- Parent/caregiver feedback re: progress/effectiveness of case plan tasks/services (QPS #24)

### Interview/observe family members/environment to verify they are:

- carrying out tasks according to measures in the case plan
- changing behavior
- getting the skills and help they need
- overcoming barriers
- retrieving certificates for completing programs (i.e., parenting, substance abuse, treatment programs)

### Contact Service Providers - QPS #25

- Conduct ongoing communication with service providers.
- Request updates and progress reports.
- Place progress reports in file and document.
- Obtain copies of certificates of completion.
- Assess effectiveness of service to reach case plan goal.

### Document Contacts in Case Notes - F.A.C. 65C-30.007(9)

- within 48 hours of the contact or case activity (FSFN Policy)
- within 2 working days of the contact - F.A.C.
- purpose of contact
- outcomes of the contact with child, parents, caregiver
- interview/observation of child interactions w/family members/caregiver
- verification of clients' accomplished tasks and effectiveness of services
- identification of additional services needed
- outcomes of provider communication/reports

