Risk management in schools

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Disclosure

- The presenters have no financial relationship to this program.

Objectives

Participants will learn to:

- Identify and assess for child abuse.
- Determine when a CYFD/CPS referral needs to be made.
- Inform families that a report is being made.
- Assess risk related to nonsuicidal self-injury and suicidality.

School Policy

- Ask about your school’s policy on suspected child abuse and neglect reporting
  - Imminent danger protocol vs. ability to make the call in collaboration with the family
  - Difference of settings (schools vs. clinical settings)
- When suspected cases arise seek consultation
- When a report is made:
  - Find out the relevant paperwork and documentation for your school.

New Mexico Law

- In 2015 New Mexico Supreme Court ruled that all residents are required by law to report suspected child abuse and neglect.

- The ruling reverses a 2013 decision by the state Court of Appeals that limited who was required to report such allegations.

New Mexico mandated reporting law 32A-4-3 2016

Every person, including a licensed physician; a resident or an intern examining, attending or treating a child; a law enforcement officer; a judge presiding during a proceeding; a registered nurse; a visiting nurse; a schoolteacher; a school official; a social worker acting in an official capacity; or a member of the clergy who has information that is not privileged as a matter of law, who knows or has a reasonable suspicion that a child is an abused or a neglected child shall report the matter immediately to:

(1) a local law enforcement agency;

(2) the department; or

(3) a tribal law enforcement or social services agency for any Indian child residing in Indian country.

http://law.justia.com/codes/new-mexico/2016/chapter-32a/article-4/section-32a-4-3/

Call your local law enforcement agency or

Text **#SAFE (#7233)** from a cell phone or

Call **1-855-333-SAFE (7233)** from a land line

You may report suspected child abuse 24 hours a day, seven days a week.

* Our job is not to figure out whether the abuse occurred or not. However, if abuse is suspected, it is our job to report it.

Child Abuse Definition:

B. "abused child" means a child:

(1) who has suffered or who is at risk of suffering serious harm because of the action or inaction of the child's parent, guardian or custodian;

(2) who has suffered physical abuse, emotional abuse or psychological abuse inflicted or caused by the child's parent, guardian or custodian;

(3) who has suffered sexual abuse or sexual exploitation inflicted by the child's parent, guardian or custodian;

(4) whose parent, guardian or custodian has knowingly, intentionally or negligently placed the child in a situation that may endanger the child's life or health; or

(5) whose parent, guardian or custodian has knowingly or intentionally tortured, cruelly confined or cruelly punished the child;

2016 New Mexico Statutes Chapter 32A - Children's Code Article 4 - Child Abuse and Neglect Section 32A-4-2 - Definitions

Examples of Child Maltreatment:

Physical abuse (CPA)	Sexual abuse (CSA)	Neglect
· *Hit with closed fist or belt buckle* · *Contact that leaves a bruise, burn, lacerations, skeletal injury or tissue swelling.* · *Use of excessive or unusual corporal punishment.* · *Prolonged shaking*	• *Indecent exposure/exhibitionism* • *Exposing children to pornographic material* • *Making a child touch an adult's sexual organs or child molestation* • *Penetration* • *Comercial sexual exploitation*	• *Child abandonment* • *Abusing alcohol and/or drugs that put child in way of harm* • *a parent knowing about abuse and not doing anything to protect the child* • *lack of proper parental care, food, shelter, education or medical care*

RED FLAGS

- Red Flag = any statement/indication made by the child that indicates potential child maltreatment and warrants further assessment

  e.g.: *“My dad smacks me when he’s mad”*

  “My mom stays in bed all day”

- You will learn how to assess these RED FLAGS when they arise
  - **If a red flag arises, start with open ended questions and assess for safety concerns**

<u>When</u> should you assess?

If there are any red flags/concerns

<u>Who</u> should you assess?

Every child you work with. Just because a child “doesn’t seem” like s/he has experienced abuse or maltreatment is **not** an excuse not to ask.

Key points of introducing **Limits of Confidentiality**

- Confidentiality is broken when:
    1. you suspect the child is, *or is in danger of*, being hurt
    2. you suspect the child might hurt themselves
    3. you suspect the child might hurt somebody else
- It's our **job** to disclose these things (this is *not* a personal choice)
- Remember: you will discuss disclosure to the child first
- ** DO NOT PROMISE to keep any secrets for the child**

- When assessing potential abuse/maltreatment (RED FLAGS), you will likely feel *nervous*. This is normal; however, it is important to appear calm.
    - Remember to **breathe & take your time**
    - You want the child to *believe you can handle* what s/he might tell you.
- Use <u>open-ended</u> questions or prompts (e.g. Tell me more)
- *If* the child is struggling to answer questions, you can provide a **range** of options (e.g., for frequency questions).
    - Q: How often does your dad hit you? *A: I don't know*
    - Q: Would you say it happens every day, a few times a week, once a week, once a month, or once this school year? *A: I guess once a month.*

For all types of abuse, assess for:

- Duration → first time, last time, dates (if known)
- Frequency of abuse → how often it occured
- Severity of the abuse (injury)
- Perpetrator(s)
- Others involved → witnesses, other victims
- Previous recipients of the disclosure → who else knows

Start with “Before when I asked you _____, you said _____. Tell me more about that.”

CPA versus Corporal Punishment:

Corporal Punishment:

- Legally acceptable use of physical force to punish a child
- It is within a parent's right to use corporal punishment
- E.g., spanking

Child Physical Abuse:

- Use of physical punishment that crosses a threshold (i.e., leaving a mark)
- Excessive or unusual physical punishment
- Physical force used on a child outside the context of discipline

Child sexual abuse (CSA):

- *Has anyone ever touched you in your private parts? What happened?*

(Taken from K-SADS-PL Trauma Screener)

Examples of sexual abuse:

- Indecent exposure
- Exposure to pornographic material
- Masturbation in front of children
- Touching
- Penetration
- Commercial sexual expolitation

Neglect:

Think frequency, duration, & severity (safety risks)

and monitoring over time

·In New Mexico in 2010, 86.5% of the victims of child maltreatment were neglected.

Examples of Neglect:

- Lack of clothing, food, shelter, education
- Failing to provide medical care or supervision
- Abandoning child
- Abusing alcohol or drugs that put child in way of harm

*Assessing for Neglect is different than those for CPA/CSA.

Neglect Assessment

- Neglect is different from CPA or CSA in that it is the absence of care/intervention rather than inflicting abuse
- Child coming in dirty clothes
- Child complaining of constant hunger
- Parents coming in intoxicated
- Child describing parent as being intoxicated or on drugs
- Parent describing another adult in the home as violent or potentially dangerous
- Child riding in car with intoxicated parent
- Child is suicidal and parent is not getting child mental health care

KEEP THE CHILD IN MIND:

If child discloses abuse/maltreatment, praise him/her for sharing with you, "*you are very brave for sharing this with me.*" At any point, you can remind child that it is your job to help ensure that the child is safe.

Seeking Supervision/Consultation:

- Refer back to your school or place of employment's policy
- Consult with other professionals
- If someone tells you they think X is not reportable, but you feel it rises to the level of suspicion you are still obligated ethically and legally to report

If you feel a child is in imminent danger, do no let them leave school and alert the appropriate authorities right away

***If you think alerting the family may cause further bodily harm to the child or will result in other negative consequences you may choose not to alert the family to your report ***

SPIKES Protocol (Baile et al., 2000)

SPIKES originally used in oncology as a helpful framework for breaking bad news

- **Setting**- private place, consider who should be present
- **Perception**-ask for caregiver's perception of what happened
- **Invitation**-invite them to be a part of the call
- **Knowledge**-what is the basis of the call, explain possible outcomes of the call
- **Emotions**- encourage the caregiver's expression of emotion, validate, and demonstrate empathy

Pause to allow the parent digest the information. Do your best to present a calm demeanor by taking your time (belly breathing!), to help the family feel less anxiety during this difficult time.

Encourage the family to ask questions.

Inform the parent:

“If they take the case, I want you to know that someone will come to interview your family within the next 5 days.”

Overview of ALL steps taken after a child reports a “red flag” of maltreatment:

1. Conduct thorough follow-up assessment (*Intensity, frequency, duration*)
2. Consult with a supervisor/colleague
3. Talk to the child *alone* about disclosing to the parent and making the call
4. Talk with the parent and child about making the call
5. Make the call
6. Fill out required paperwork
7. Debrief with the family

Making the Call

The idea of calling in a report can be *anxiety-provoking*

- Make sure to remain calm (**breathe**!)

<u>Things to know/consider:</u>

- Be prepared to give the person answering:

→ your name & affiliation → demographic information about the family/child and alleged perpetrator (address, names, ages, siblings)

→ all of the information gathered about the abuse (extent of the injuries)

- Stay calm & answer all of their questions as fully as possible, but do NOT make judgments (present only the facts)

Making the Call

Provide **only the information you have been told and what you have observed. It is important **not** to give your opinion or make judgments. The report should contain **only the facts**. It is *okay* to tell the Child Protective Specialist you don't know something or do not have the information to answer a question.**

Remember: we are not conducting forensic evaluations. You are **not** expected to look for any current injuries on the child that are not readily visible

AFTER the call/report is made:

- CYFD may take a child into protective custody if it is necessary for the protection from further abuse or maltreatment (rare result). Based upon an assessment of the circumstances, CYFD may offer the family appropriate services. The CYFD caseworker has the obligation and authority to petition the Family Court to mandate services when they are necessary for the care and protection of a child.

- CYFD has 60 days (most reports are expected to be resolved in 30) after receiving the report to determine whether the report is "indicated" or "unfounded."

OF NOTE:

*It is extremely rare that a child is removed from the home.

*Services may be offered even in “unfounded” cases.

Assessing Suicide

- Risk Factors
- Protective Factors
- Suicidal Ideation and Non-suicidal self-injury
- School/Clinic Procedures
- Resources

Triaging suicidality

Seek professional mental health care support/guidance

- Suicidal Ideation – passive: thoughts of death/dying; active: thoughts of killing self (high risk)
- NSSI
- Intent – would you do it?

If they say no - what stops you?

If they say yes- high risk- seek help

Plan

Suicidality Risk Factors

- Previous attempts
- Self-Harm: cutting, scratching (needle, knife, nails, etc.), burning, drug abuse
- Level of suicide risk based on client’s desire, capability, and intent

Suicide Assessment Guide

DIRECTIONS: This form is intended to be used as a general guide for organizing relevant information regarding suicide risk. It is not intended to result in a specific "score" that corresponds to a particular risk level. There is always significant clinical judgment involved in the suicide assessment process.

CONSULT WITH YOUR SUPERVISOR IMMEDIATELY IF YOU ARE USING THIS FORM

Demographic Indicators:

__ Male (H) __ Female (L)
__ White (H) __ Native American (H) __ Non-white (L)
__ Single, Divorced, Widowed (H) __ (Married (L)
__ Age 45-54 (H) __ Age 85+ (H) __ Age 15-24 (M) __ Other ages (less prevalent rates of suicide)
__ Sexual Minority (M to H)

Historical-Situational Indicators:	**LOW**	**MODERATE**	**HIGH**
Prior suicidal ideation/attempts	__ None	__ One to few, mild/moderate lethality	__ Multiple attempts, high lethality
Prior self-harm behavior	__ None	__ One to few attempts	__ Significant history, multiple acts
Family history of suicide	__ None	__ Parasuicide acts	__ Suicide within family
History of trauma or abuse	__ None		__ Yes
Psychiatric history	__ None	__ Prior treatment	__ Uncooperative in tx, hospitalization
Life circumstances	__ Stable	__ Some changes/mobility	__ Unstable, frequent mobility
Violent behaviors	__ None		__ Violent acts toward others
Impulsive/reckless behaviors	__ None	__ Some impulsive acts	__ Frequently impulsive/reckless
Medical history	__ Healthy	__ Mild problems, some health concerns	__ Chronic or terminal illness
Daily functioning	__ Good	__ Moderately good, some problems	__ Impaired in many activities
Short-Term Clinical Indicators:	**LOW**	**MODERATE**	**HIGH**
Recent losses (exposure to suicide)	__ None	__ Within last weeks/month	__ Within days of loss
Depression/anxiety	__ Mild	__ Moderate	__ Severe
Substance abuse (alcohol/drug)	__ None/little	__ Frequent to excessive	__ Chronic abuse or hx of treatment
Personality Disorders (Cluster B esp.)	__ None	__ Features of disorders	__ Confirmed diagnosis or presence
Medical disorders	__ None	__ Mild problems, some health concerns	__ Functional difficulties, chronic pain
Traumatic Brain Injury (TBI)	__ None	__ Mild (one)	__ Mild (multiple), moderate, severe
Self-esteem	__ High	__ Moderate	__ Low, high self-hate and hopeless
Family acceptance (sexual orientation)	__ High	__ Moderate	__ Low, none
Smoking	__ None	__ Little to infrequently	__ Frequent, daily
Suicidal plan			
Method	__ Undecided	__ Decided	__ Decided, taking actions to create
Availability	__ No	__ Yes	__ Yes
Time-place	__ Not specific	__ Unsure, some specifics	__ Specific
Lethality	__ Low	__ Moderate	__ High
Final arrangements	__ None	__ Some planning	__ Witten note, wills, forfeit objects

Protective Factors:

__ In therapy __ Easy access to therapy, including transportation __ Family, community, social support __ Healthy romantic rlshp
__ Cultural and religious beliefs discouraging suicide __ Hopefulness, reasons for living __ Employment

References: American Foundation for Suicide Prevention. (2015). Facts and figures. Accessed online at https://www.afsp.org/understanding_suicide/facts and figures • Centers for Disease Control (CDC). (2014). Injury prevention & control: Division of violence prevention. Accessed online at http://www.cdc.gov/ViolencePrevention/suicide/ • McIntosh, J. L., & Drapeau, C. W. (2014). U.S.A. suicide in 2011: Official final data. Washington, DC: American Association of Suicidology. • McLean, J., Maxwell, M., Platt, S., Harris, F., & Jepson, R. (2008) Risk and protective factors for suicide and suicidal behaviour: A literature review. Edinburgh, Scotland: Scottish Government Social Research.

Clinic Procedures

DON'T PANIC!

- Definition - *An emergency is a situation that any student faces in which*
  - *a) they are uncertain how to proceed, and*
  - *b) some decision needs to be made before the client leaves.*
- Procedure
  - Assessment (Determine level of risk)
  - Intervention
    - Notify and involve others: clinic staff, supervisors, family/support systems, and appropriate agencies

Helpful Resources

- American Association of Suicidology
- American Psychiatric Assn of Practice Guidelines
- American Foundation for Suicide Prevention
- National Suicide Prevention Resource Center
- SAMHSA
- Suicide Awareness Voices of Education
- Suicide Prevention International
- Suicide Prevention Resource Center
- WHO Suicide Prevention