

**Looking Out for Georgia's Youth:
EDUCATION CAN MAKE A DIFFERENCE**

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Looking Out for Georgia's Youth: EDUCATION CAN MAKE A DIFFERENCE

We would like to thank you for educating your school community on how to protect children while also providing an enriching environment for children to learn and succeed.

A committee of individuals who work with different aspects of children's issues and present on this topic regularly designed this training. We have presented to a handful of people in a small break room and to hundreds of people in a packed cafeteria. We know that child abuse and neglect is a difficult topic to talk about and train on, and this workshop will most likely be just one of many to prepare staff for the new school year.

During this training, you have the ability to help the audience not just fulfill a legal obligation but connect what they have been trained to do professionally with child abuse reporting and prevention.

Your job is to inform and empower. You are giving these advocates for children a call to action. You can do this by making it personal. Tell them why you care about child abuse. Ask them why they do. Talk about prevention and reporting as a natural extension of their work rather than an additional duty.

You have seen evidence of the passion and sacrifice your school staff, in all positions, brings to the children and families in your community. As caring adults who see children five days (sometimes more) a week, they already help to prevent abuse. They are supporting child development in everything they do. We know that when children succeed academically it has implications that reach as far as the lives of their future children. No one in your audience wants their work undone by child abuse and neglect.

We understand you may have a short time to present the basics on mandated reporting. We have designed the presentation detailed in the next pages to be completed in 30 minutes. However, you will notice that once you've read those pages there is still a good bit more to the manual. This is designed to help you build expertise and know where to get more information as needed. We intend for the manual to support your short

presentation to the staff and assist you in answering the questions that might come up.

Good luck and thank you for your support of Georgia's children, youth and families.

Banyan Communications

Barton Child Law & Policy Center

Cobb County Schools

Georgia Center for Child Advocacy

Georgia Department of Behavioral Health & Developmental Disabilities

Georgia Department of Education

Georgia Department of Public Health

Georgia Division of Family & Children Services

Governor's Office for Children & Families

Prevent Child Abuse Georgia

PRESENTATION NOTES

Total presentation length - 30 minutes

INTRODUCTION

Time: 2 minutes

Slides 1 & 2

» *Presenter note: the following text material is to be presented to the audience.*

Good morning/afternoon, thank you for joining me today to talk about a topic that many of us wish we never had to think about at all, much less spend a significant portion of our day discussing.

Today we'll cover the predictable stuff like the:

- Types of abuse,
- The signs you should be aware of,
- How to respond to a disclosure,
- How to make a report.

In addition, we'll also talk about how to prevent child abuse and neglect. Finally, you have a packet of handouts to take with you. We only have a short time today to cover this complex and sensitive issue so taking some additional time on your own to become familiar with this information will help you to more effectively protect children.

Before we get into all of that, I have a few questions for you.

Raise your hand if you are an adult. Now I don't mean you are mature, pay your bills as soon as they come in, always eat a balanced meal and drink responsibly. Are you over the age of 18?

Great, so we're all adults here. Now drop your hands and stand up if you are now or have ever parented a child whether a biological child, foster child, adopted child, stepchild, a neighbor kid who comes over a

lot . . .

If you are not already standing up, stand up if there is a child in your life that you care for-- a niece, a nephew, a friend's child, etc. Does that get everyone out of his or her seat?

Congratulations! You all have the power to see that no child has to experience child abuse. For that reason, you have the ethical responsibility to act when you are concerned for a child. But, are you legally required to act?

CHANGES to the LAW

Time: 1 minute

Slide 3

» *Presenter note: the following text material is to be presented to the audience.*

On your handout/the slide behind me, you see a portion of the Georgia Code, the laws around child abuse and neglect that defines a mandated reporter and your obligations in that role. Some changes became official as of July 1, 2012.

The law already designated child service organization personnel as mandated reporters, but new language spells out the definition of child service organization personnel as an employee or volunteer at an organization that pretty much does anything with children.

Some roles at schools were already specified in the law, but these changes make it clear that everyone at this school is a mandated reporter, even the volunteer

who comes in on the weekend to help with landscaping school grounds, is mandated to report suspected child abuse and neglect.

You have this definition in your handouts, and the complete section of the Georgia Code is on file at the school office.

CATEGORIES of ABUSE

Time: 2 minutes

Slide 4

» *Presenter note: the following text material is to be presented to the audience.*

We will discuss four types of child abuse today- Physical Abuse, Sexual Abuse, Emotional Abuse, and Neglect

Your handouts cover much of what we talk about in more detail. Please take the time to become familiar with the information on your handouts later.

For those of you who have gotten some training on this subject before, I have a question. Of these four types of abuse, two of them are defined by patterns of behavior over time while two are considered reportable if even a single incident has happened. Tell me which is which?

That's right, for physical and sexual abuse any incidents, isolated or otherwise is reportable. Emotional abuse and neglect are about a pattern of behavior. We'll talk about this more as we explore the different types of abuse.

Which type is the most common? Also right, **Neglect.**

NEGLECT

Time: 4 minutes

Slides 5 & 6

» *Presenter note: the following text material is to be presented to the audience.*

Neglect is overwhelmingly the most common of all. 80 percent of children with substantiated allegations in the US were neglected.

Neglect is the failure of a parent, guardian, or other caregiver to provide for a child's basic needs.

So what are those basic needs – Food, shelter, clothing...

» *These your audience should be able to tell you quickly, you may have to coax the next few out of them.*

What about safety, medical care, and an education?

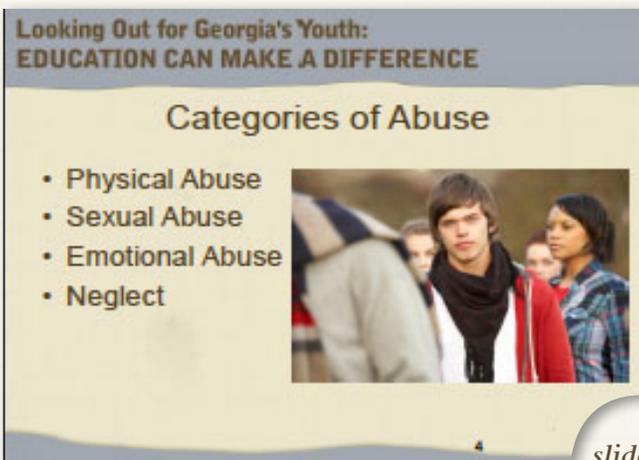
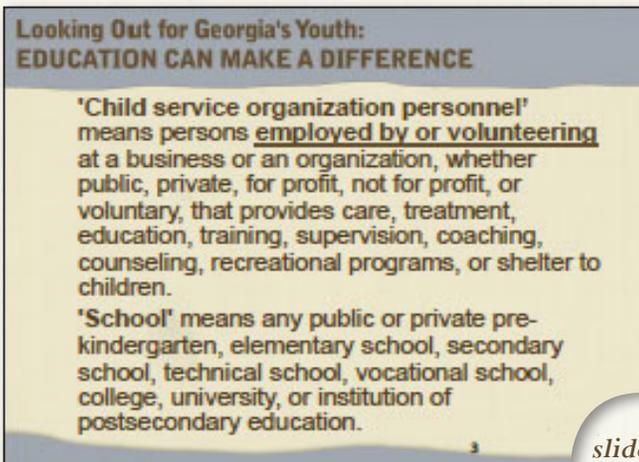
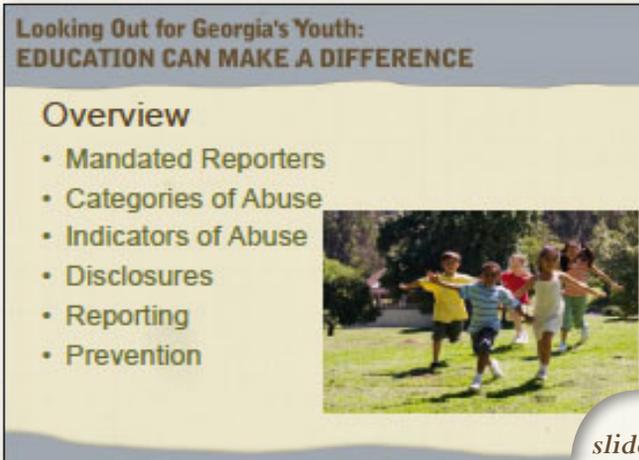
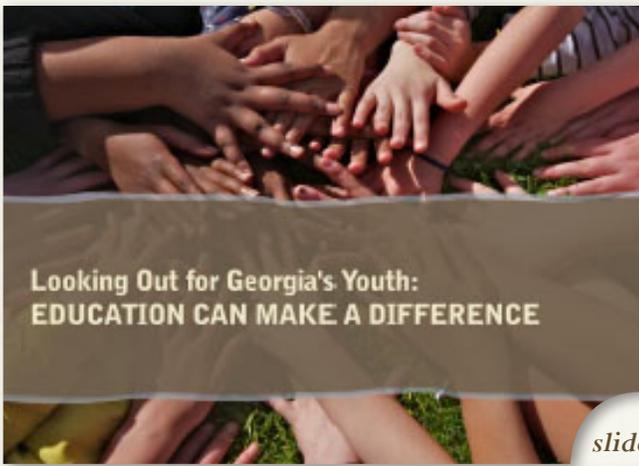
Underneath the term Neglect- you would include medical neglect, educational neglect, and physical neglect.

Physical neglect means not providing food, shelter or adequate supervision. It is also the failure to protect a child from a known risk of harm or danger. It could also mean exposing the child to environmental hazards, abandoning a child or even exposing a child prenatally to drugs and alcohol.

One basic need that children have is safety from harm, and lack of supervision is a common allegation associated with neglect in Georgia.

How young a child can a parent legally leave home alone? That's a trick question because the law doesn't spell out "adequate" supervision.

What I can tell you is that when a report of neglect due to lack supervision is made,



NEGLECT *(continued)*

there are certain guidelines that are used by the Division of Family and Children Services (DFCS) to help guide decisions about whether neglect is substantiated.

Those are:

- Children 8 and under are never to be left home alone
- Children between 9 and 12 may be left home alone for short periods of time (less than 2 hours)
- 13 and older may be left home alone longer and may babysit younger children but not more than 12 hours
- There is still a consideration of the maturity of the child. A child who is chronologically 10, but developmentally much younger might still not be "adequately" supervised if he or she is left home alone at all

What are some of the things that you might notice about a child that might make you suspect the child may be neglected?

Physical Indicators

- Needs medical or dental care, immunizations, or glasses
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or other drugs

» *Your audience will most likely come up with the physical signs very quickly and need some help on the others. Give them a chance to tell you if they already know. And then change to slide 6 to fill in the indicators that they do not share.*

Behavioral Indicators

- Is frequently absent from school
- Begg or steals food or money
- States that there is no one at home to provide care

Now, when you hear the term child abuse, what do most people think of? **Physical Abuse**

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Neglect

The failure of a parent, guardian, or other caregiver to provide for a child's basic needs. This can also include failure to protect them from a known risk of harm or danger.

slide 5

5

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Neglect

- Is frequently absent from school
- Begg or steals food or money
- Lacks needed medical or dental care, immunizations, glasses, etc.
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or drugs
- States that there is no one at home to provide care

slide 6

6

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Physical Abuse

The non-accidental physical injury of a child

slide 7

7

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Physical Abuse

- Has unexplained burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other marks noticeable after an absence from school
- Seems frightened of the parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Reports injury by a parent or another adult caregiver

slide 8

8

PHYSICAL ABUSE

Time: 4 minutes

Slide 7 & 8

» *Presenter note: the following text material is to be presented to the audience.*

It seems straightforward enough. Physical abuse is the non-accidental physical injury of a child.

But, we have a complication. In Georgia, corporal punishment is legal. So what's the difference between corporal punishment, which is protected, and physical abuse, which is not?

» *The following may be suggested as the difference. If they come up in response to the question above, make sure to point out that these are important to take into account when assessing a concern. If they do not come up here, reference them when reviewing the indicators of physical abuse.*

- The location of the injury,
- Multiple injuries of varying ages,
- Injuries that don't fit the explanation,
- If you can tell what made the injury, etc.

are all important to keep in mind because they are part of what might make you suspect that an injury is non-accidental.

The line between abuse and legal punishment is the injury. Just as we heard earlier "if you leave a mark."

» *It's rare that someone does not say, "leave a mark."*

A mark could be a bruise, a burn, a missing patch of hair, or a welt. The injury could be a broken bone. These are all Physical Indicators.

Sometimes these injuries aren't immediately visible, but there are other signs, what would they be?

» *Give your audience a chance to tell you the indicators that they already know. And then change to slide 8 to fill in the indicators that they do not share.*

These are Behavioral Indicators:

- Seems frightened and does everything he or she can to avoid going home
- Shrinks at the approach of adults

Remember that your handouts have these definitions and indicators for later reference.

» *This may be a good time to check the clock. You should be 13 minutes into the presentation. Halfway there!*

SEXUAL ABUSE

Time: 4 minutes

Slides 9 & 10

» *Presenter note: the following text material is to be presented to the audience.*

Sexual abuse can be a difficult topic to discuss. Sexual abuse is anything done with a child for the sexual gratification of an adult or older child.

It's important to remember that physical contact with the child is not required to sexually abuse a child. Direct sexual contact with a child is abuse, but it is also sexual abuse to expose a child, for a person to expose him or herself to a child, to show pornography to a child, and so on.

Raise your hand if you would know without me or anyone else telling you that a child who

- Has difficulty walking or sitting
- Is bleeding or
- Has a Sexually Transmitted Disease

Right, these are pretty obvious signs that something is wrong, and, even if you didn't associate them with sexual abuse, you would definitely act.

But, I also want to be sure to share that these physical signs are incredibly rare in cases of sexual abuse.

In cases of child sexual abuse, you are much more likely to see Behavioral Indicators. What do you think those might be?

» *Give your audience a chance to tell you the indicators that they already know. And then change to slide 10 to fill in the indicators that they do not share.*

- Suddenly refuses to change for gym or physical activities
- Has trouble sleeping or wets the bed
- Has a history of running away
- Is unduly protective of other siblings
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior.

To build on that last sign, I know that you spend a lot of time with a lot of children and your general sense of what's "normal" and what's not is very valuable, but take the time to become familiar with the characteristics of the stages of sexual development. I've included more information on your handout, but I want to encourage you to be deliberate about educating yourself.

As a general rule, obsessive behavior and interaction that involves force or coercion when more than one child is involved are big red flags.

COMMERCIAL SEXUAL EXPLOITATION of CHILDREN

Time: 1 minute

Slide 11

» *Presenter note: the following text material is to be presented to the audience.*

I know we are spending a lot of time on sexual abuse, but sexuality is not something many people feel comfortable talking about.

CSEC (continued)

It's not like *mark/no mark*. In addition to child sexual abuse that happens with a caregiver or trusted adult, there is Commercial Sexual Exploitation of Children.

It's a mouthful to say, but using this term helps to differentiate it from sexual abuse that is solely for sexual gratification the way that we've talked about before.

Someone gets sexual gratification, but often someone else is getting other kinds of compensation by facilitating the abuse.

You have a handout on this, but I want to make a few points about CSEC.

A common vulnerability to exploitation is abuse within the home.

Victims of exploitation may already feel that the authorities don't care about them; after all they weren't protected from abuse earlier. Despite recent changes to the law to try to alter the way law enforcement treats these children, CSEC victims may have good reason for feeling adversarial toward authorities. This may be part of what the exploiter has told them to keep them victims.

My final thought on child sexual abuse and commercial sexual exploitation of children is that our bodies mature well before our brains.

Just because a girl has breasts or a boy is taller than you are, it doesn't mean that they aren't still a child and vulnerable to manipulation by an adult. They are not "fast." They are not "prostitutes." They are victims. And anything you can do to educate others about this distinction will help fight this issue.

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Sexual Abuse

Anything done with a child for the sexual gratification of an adult or older child

slide 9

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Sexual Abuse

- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a sexually transmitted disease
- Runs away

slide 10

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Commercial Sexual Exploitation of Children

When individuals buy, trade, or sell sexual acts with a child

- Branding or tattooing
- Older boyfriend or male friend
- Withdrawn and uncommunicative
- Large amounts of money
- Inappropriate dress or poor hygiene
- Runaway or lack of adult supervision/support

slide 11

EMOTIONAL ABUSE

Time: 3 minutes

Slides 12 & 13

» *Presenter note: the following text material is to be presented to the audience.*

We mentioned before that Emotional Abuse (sometimes called psychological abuse) is a pattern of behavior that impairs a child's emotional development or sense of self-worth. What do you think those behaviors are? They include constant criticism, threats, rejections, even withholding love, support, or guidance. Emotional abuse is almost always a part of these other types of abuse.

Even though the abuse itself does not have a physical component, the trauma of mistreatment may have very physical consequences for the child like delayed development (physical or emotional). What else might you see?

You might see extremes in behavior such as aggression or passivity, withdrawn or demanding, inappropriately adult or inappropriately childish behavior or speech. Children may turn the aggression on themselves, even attempt suicide.

A question for the room, do you have to know whether a child is withdrawn because of emotional abuse or sexual abuse to make a report? No, you just have to be concerned that a child has been harmed or is in harm's way to make a report. This includes when the abuser is another child in the home or if you fear children may harm themselves.

» *You should be 20 minutes in.*

DISCLOSURE

Time: 1 min

Slide 14

» *Presenter note: the following text material is to be presented to the audience.*

Of course, if a child tells you that he or she has been abused or "discloses" then you have a pretty strong indicator of abuse.

Do you think the child usually says, "Last night I was physically abused by my father!" No, what do they say? "I got a whoopin'". My mommy didn't come home last night. I don't like being left alone with the babysitter."

Children may speak to the abuse indirectly; disguise their disclosure as happening to someone else or "what would you do if I told you . . ."

Finally, children make what we call Disclosures with Strings Attached. What do you think is the string or request that most disclosures include? That's right, "I want to tell you something, but you have to keep it a secret."

Can you keep it a secret? No. What can you do? You can make sure that no one who doesn't need to know is told anything – including other children, other teachers, and friends. Emphasize that the child's safety is your main concern and you will only tell the people that need to know to keep the child safe something that should be true anyway.

Everybody responds to trauma, including child abuse, differently. We know that some children go from being a victim and almost immediately become survivors. Some people remain a victim all of their lives. One factor that we know strongly influences how well a child overcomes his or her abuse is how the person they disclose it to responds.

- If you can, talk to the child in private.
- Make sure that child knows that you believe them (even if you don't) from your

words, your face and body language.

- Listen and avoid asking questions. You are there to hear what the child has to say, not to investigate.
- As soon as you can, write everything down in the exact words the child used.

REPORTING PROTOCOL

Time: 1 min

Slide 14

» *Presenter note: the following text material is to be presented to the audience. If you are not the designated reporter at that school, you may want to ask the designated reporter to be present.*

In some states, including Georgia, a designated reporter may be used to make a report.

How soon do you think you should make a report? Right, it used to be as soon as possible, but that left too much room for interpretation. Now, you should report as soon as possible, but you need to make it possible within 24 hours.

It does have to be an oral report, you can fill out a written report as well, but the call to DFCS or another reporting agency must be live-- no recordings, faxes, emails, etc. The call to make the report may be done by the designated reporter.

In your handout is a list of information that you should share if you have access to it, but please do not let it stop you making a report if you don't know everything on that list. There's always more we wish we knew, but that's why an investigation is held. Do you have to know for sure that abuse or neglect has happened?

No, you just have to suspect that a child is in harm's way and share everything you know as accurately as possible.

RIGHTS of the MANDATED REPORTER

Time: 1 min

Slide 14

» *Presenter note: the following text material is to be presented to the audience.*

Anonymity – You have the right to report anonymously, but if you are a mandated reporter and the worst case scenario happens, will you be able to prove that you fulfilled your mandate? No.

Confidentiality – You have the right to confidentiality. This means that the Division of Family and Children Services cannot reveal that you made the report.

It doesn't mean that you won't be asked to testify if it comes to a trial.

Do you think it's possible someone might guess who made the report? Yes, that's right; people figure these things out sometimes.

Is it possible that they might come fishing to confirm that? If someone asks or even tells you that they know you made the report, do you have to confirm or deny? No, you do not.

Do not engage with an angry individual and follow the same protocol that you would if parent came to you about their child's grade or what time that child gets picked up by the school bus.

Penalties – What might happen if you don't report suspected child abuse or neglect?

Yes, you could be charged with a misdemeanor.

You could lose your job, never be able to

work in your chosen profession again.

But, ultimately, the biggest consequence is that a child may suffer more harm and have more difficulty reaching his or her potential.

You wouldn't be doing this job if you didn't care, so I know that matters to you.

PROTECTIVE FACTORS

Time: 2 minutes

Slide 15

» *Presenter note: the following text material is to be presented to the audience.*

» *In a longer presentation, we might talk about risk and protective factors, but the focus on protective factors is deliberate because, as adults in the lives of children, school employees and volunteers have more opportunities to enhance protective factors than to reduce risk factors, many of which are long-term conditions and/or require clinical intervention.*

We've talked about recognizing and reporting abuse, but the truth is that as adults in the lives of children we should not wait to act until we think that a child has been abused or neglected.

Unfortunately, child abuse and neglect has been happening for a long time, and we've been able to accumulate a lot of information on children who have been abused and children who have not.

The good news is that most families do a great job of raising their children without abuse or neglect, even in tough times.

We know that these families tend to have certain factors in common. We call those Protective Factors. Just because we associate them with a lower risk for abuse, doesn't

mean that child abuse won't happen.

We've also been able to recognize families that have dealt with abuse tend to have factors in common as well. We call those Risk Factors and while they are associated with a higher risk for abuse, they do not cause abuse.

We care about these factors because we have the power to lower risk factors that families are dealing with and promote protective factors. This is a big part of prevention.

There has recently been a lot of research around childcare organizations, but I think it still applies in schools. The researchers looked at why children enrolled in high quality childcare were less likely to be abused. They found that the organizations engaged parents and promoted five protective factors.

1. **Parental Resilience** means the adults in the family managed stress and were able to bounce back from challenges.
2. **Social Connections** – Parents who have networks of support when crisis happens weather those crises better and have opportunities to give back.
3. **Knowledge of Parenting and Child Development** – Parents who have accurate knowledge of child development have realistic expectations of their children and respond more appropriately.
4. **Concrete Support in Times of Need** – Families are aware of where and how to access services to meet their basic needs.
5. **Social and Emotional Competence of Children** – Children who learn how to regulate their emotions and effectively communicate are less stressful to parent.

Emotional Abuse

A pattern of behavior that impairs a child's emotional development or sense of self-worth

12

slide 12

Emotional Abuse

- Shows extremes in behavior
- Inappropriately adult or infantile
- Is delayed in physical or emotional development
- Has attempted suicide
- Reports a lack of attachment to the parent

13

slide 13

Mandated Reporting

- Disclosure
- Reporting
- Rights as a Mandated Reporter



14

slide 14

Protective Factors

- Parental Resilience
- Social Connections
- Knowledge of Child Development
- Concrete Support In Times of Need
- Social and Emotional Competence of the Child



15

slide 15

PREVENTION STRATEGIES

Time: 2 minutes

Slide 16

» *Presenter note: the following text material is to be presented to the audience.*

How do you promote those protective factors? Seven Supportive Strategies were identified to promote those protective factors.

1. **Value and support parents** – When you acknowledge how hard it is to raise a child to be healthy and happy, it gives them permission to struggle and recognize the value in what they do.
2. **Strengthen parenting** – There are so many ways that you strengthen parenting. When you connect with parents and help them identify a child's strengths, they feel good about the job they are doing and when we feel like we do something well, we tend to do well!
3. **Facilitate friendships and mutual support** – When you provide opportunities for parents with same-age children to meet and get to know one another; they can build those social networks that everyone needs.
4. **Respond to family crises** – When you get to know the families in your school, you hear the good and the bad. And you are then ready to link families to services and opportunities when it is most needed.
5. **Link families to services and support** – When parents hear about services from people they know and trust, it lowers stigma and makes it more likely they will actually use needed services.
6. **Further children's social and emotional development** – When you help a child get along with other's at school, this means they have skills to interact more effectively with siblings and parents at home.

PREVENTION STRATEGIES

(continued)

7. Observe and respond to early warning signs of abuse or neglect – How long abuse is allowed to continue can be a factor in how well a child recovers. You are well placed to notice those subtle signs as early as possible.

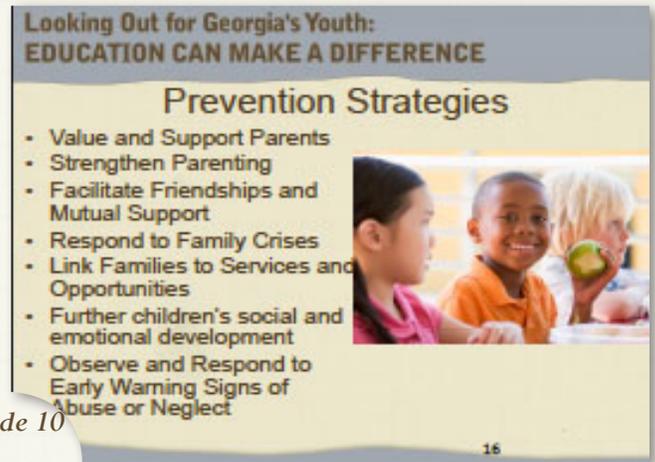
HANDOUTS & QUESTIONS

Time: 3 minutes

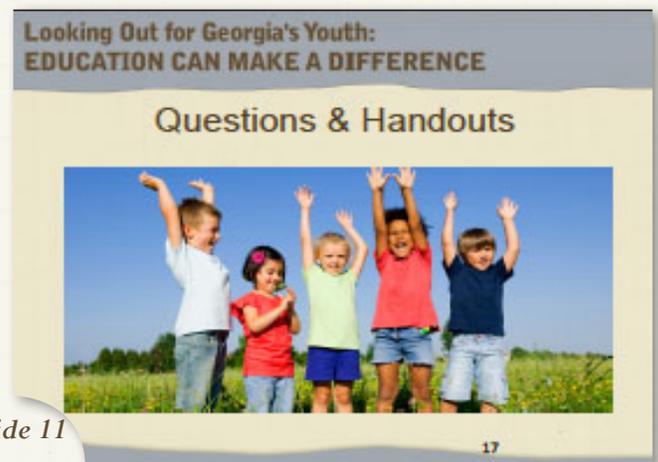
Slide 17

- » *This is a good point to wrap things up by speaking to the protocol and concerns specific to your school. Let attendees know how to contact you or the proper person with questions and concerns about child abuse and neglect.*
- » *Review the information in the handouts. Encourage attendees to become familiar with the information in the handouts. They will also need to know how to access this manual with its supplemental content on specific issues.*

end of presentation



slide 10



slide 11

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APPENDICES

**Appendix A:
Official Code of Georgia
Annotated**

O.C.G.A.

19-7-5

The underlined portions of text are new additions that became law as of July 1, 2012.

PART V
MANDATORY REPORTING OF CHILD ABUSE
SECTION 5-1.

Code Section 19-7-5 of the Official Code of Georgia Annotated, relating to reporting of child abuse, is amended by revising subsections (b), (c), (e), and (g) as follows:

"(b) As used in this Code section, the term:

(1) 'Abortion' shall have the same meaning as set forth in Code Section 15-11-111.

~~(1)~~(2) 'Abused' means subjected to child abuse.

~~(2)~~(3) 'Child' means any person under 18 years of age.

~~(3)~~(4) 'Child abuse' means:

(A) Physical injury or death inflicted upon a child by a parent or caretaker thereof by other than accidental means; provided, however, that physical forms of discipline may be used as long as there is no physical injury to the child;

(B) Neglect or exploitation of a child by a parent or caretaker thereof;

(C) Sexual abuse of a child; or

(D) Sexual exploitation of a child.

However, no child who in good faith is being treated solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered to be an 'abused' child.

(5) 'Child service organization personnel' means persons employed by or volunteering at a business or an organization, whether public, private, for profit, not for profit, or voluntary, that provides care, treatment, education, training, supervision, coaching, counseling, recreational programs, or shelter to children.

(6) 'Clergy' means ministers, priests, rabbis, imams, or similar functionaries, by whatever name called, of a bona fide religious organization.

(7) 'Pregnancy resource center' means an organization or facility that:

(A) Provides pregnancy counseling or information as its primary purpose, either for a fee or as a free service;

(B) Does not provide or refer for abortions;

(C) Does not provide or refer for FDA approved contraceptive drugs or devices;
and

(D) Is not licensed or certified by the state or federal government to provide medical or health care services and is not otherwise bound to follow federal Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, or other state or federal laws relating to patient confidentiality.

(8) 'Reproductive health care facility' means any office, clinic, or any other physical location that provides abortions, abortion counseling, abortion referrals, or gynecological care and services.

(9) 'School' means any public or private pre-kindergarten, elementary school, secondary school, technical school, vocational school, college, university, or institution of postsecondary education.

~~(3.1)~~(10) 'Sexual abuse' means a person's employing, using, persuading, inducing, enticing, or coercing any minor who is not that person's spouse to engage in any act which involves:

(A) Sexual intercourse, including genital-genital, oral-genital, anal-genital, or oral-anal, whether between persons of the same or opposite sex;

(B) Bestiality;

(C) Masturbation;

(D) Lewd exhibition of the genitals or pubic area of any person;

(E) Flagellation or torture by or upon a person who is nude;

(F) Condition of being fettered, bound, or otherwise physically restrained on the part of a person who is nude;

(G) Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area, or buttocks or with a female's clothed or unclothed breasts;

(H) Defecation or urination for the purpose of sexual stimulation; or

(I) Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.

'Sexual abuse' shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not more than five years older than the minor. This provision shall not be deemed or construed to repeal any law concerning the age or capacity to consent.

~~(4)~~(11) 'Sexual exploitation' means conduct by any person who allows, permits, encourages, or requires that child to engage in:

(A) Prostitution, as defined in Code Section 16-6-9; or

(B) Sexually explicit conduct for the purpose of producing any visual or print medium depicting such conduct, as defined in Code Section 16-12-100.

(c)(1) The following persons having reasonable cause to believe that a child has been abused shall report or cause reports of that abuse to be made as provided in this Code section:

(A) Physicians licensed to practice medicine, interns, or residents;

(B) Hospital or medical personnel;

(C) Dentists;

(D) Licensed psychologists and persons participating in internships to obtain licensing pursuant to Chapter 39 of Title 43;

(E) Podiatrists;

(F) Registered professional nurses or licensed practical nurses licensed pursuant to Chapter 24 of Title 43 or nurse's aides;

(G) Professional counselors, social workers, or marriage and family therapists licensed pursuant to Chapter 10A of Title 43;

- (H) School teachers;
- (I) School administrators;
- (J) School guidance counselors, visiting teachers, school social workers, or school psychologists certified pursuant to Chapter 2 of Title 20;
- (K) Child welfare agency personnel, as that agency is defined pursuant to Code Section 49-5-12;
- (L) Child-counseling personnel;
- (M) Child service organization personnel; ~~or~~
- (N) Law enforcement personnel; or
- (O) Reproductive health care facility or pregnancy resource center personnel and volunteers.

(2) If a person is required to report child abuse pursuant to this subsection because that person attends to a child pursuant to such person's duties as ~~a member of the staff of an employee of or volunteer at~~ a hospital, school, social agency, or similar facility, that person shall notify the person in charge of the facility, or the designated delegate thereof, and the person so notified shall report or cause a report to be made in accordance with this Code section. ~~A staff member~~ An employee or volunteer who makes a report to the person designated pursuant to this paragraph shall be deemed to have fully complied with this subsection. Under no circumstances shall any person in charge of such hospital, school, agency, or facility, or the designated delegate thereof, to whom such notification has been made exercise any control, restraint, modification, or make other change to the information provided by the reporter, although each of the aforementioned persons may be consulted prior to the making of a report and may provide any additional, relevant, and necessary information when making the report."

"(e) An oral report shall be made immediately, but in no case later than 24 hours from the time there is reasonable cause to believe a child has been abused, by telephone or otherwise and followed by a report in writing, if requested, to a child welfare agency providing protective services, as designated by the Department of Human Services, or, in the absence of such agency, to an appropriate police authority or district attorney. If a report of child abuse is made to the child welfare agency or independently discovered by the agency, and the agency has reasonable cause to believe such report is true or the report contains any allegation or evidence of child abuse, then the agency shall immediately notify the appropriate police authority or district attorney. Such reports shall contain the names and addresses of the child and the child's parents or caretakers, if known, the child's age, the nature and extent of the child's injuries, including any evidence of previous injuries, and any other information that the reporting person believes might be helpful in establishing the cause of the injuries and the identity of the perpetrator. Photographs of the child's injuries to be used as documentation in support of allegations by hospital ~~staff~~ employees or volunteers, physicians, law enforcement personnel, school officials, or ~~staff~~ employees or volunteers of legally mandated public or private child protective agencies may be taken without the

permission of the child's parent or guardian. Such ~~photograph~~ photographs shall be made available as soon as possible to the chief welfare agency providing protective services and to the appropriate police authority."

"(g) Suspected child abuse which is required to be reported by any person pursuant to this Code section shall be reported notwithstanding that the reasonable cause to believe such abuse has occurred or is occurring is based in whole or in part upon any communication to that person which is otherwise made privileged or confidential by law; provided, however, that a member of the clergy shall not be required to report child abuse reported solely within the context of confession or other similar communication required to be kept confidential under church doctrine or practice. When a clergy member receives information about child abuse from any other source, the clergy member shall comply with the reporting requirements of this Code section, even though the clergy member may have also received a report of child abuse from the confession of the perpetrator."

House Bill 1176 (AS PASSED HOUSE AND SENATE)

By: Representatives Golick of the 34th, Neal of the 1st, Willard of the 49th, Lindsey of the 54th, Oliver of the 83rd, and others

A BILL TO BE ENTITLED
AN ACT

To amend Chapter 7 of Title 5 of the Official Code of Georgia Annotated, relating to appeal or certiorari by the state in criminal cases, so as to change provisions relating to the state's right to appeal; to amend Titles 15, 16, 17, 35, and 42 of the Official Code of Georgia Annotated, relating to courts, crimes and offenses, criminal procedure, law enforcement officers and agencies, and penal institutions, respectively, so as to enact provisions recommended by the 2011 Special Council on Criminal Justice Reform for Georgians and enact other criminal justice reforms; to change provisions relating to drug and mental health court divisions; to provide for performance measures and best practices; to provide for certification; to provide for funding; to provide for oversight by the Judicial Council of Georgia; to increase the fees for pretrial intervention and diversion programs; to revise provisions relating to additional criminal penalties for purposes of drug abuse treatment and education programs; to expand the list of offenses with respect to which such additional penalties shall be imposed; to provide that funds from such penalties may be used for drug court division purposes; to substantially revise punishment provisions and the elements of the crimes of burglary, theft, shoplifting, counterfeit Universal Product Codes, forgery, deposit account fraud, controlled substances, and marijuana; to provide for and change definitions; to extend the statute of limitations for the prosecutions of the offenses of cruelty to children in the first degree, rape, aggravated sodomy, child molestation,

aggravated child molestation, enticing a child for indecent purposes, and incest; to change provisions relating to recidivist punishment; to amend Code Section 19-7-5 of the Official Code of Georgia Annotated, relating to reporting of child abuse, so as to expand mandatory reporting requirements and provide for exceptions; to change provisions relating to inspection, purging, modifying, or supplementing of criminal records; to provide for definitions; to provide for time frames within which certain actions must be taken with respect to restricting access to records or modifying, correcting, supplementing, or amending criminal records; to provide for procedure; to provide for individuals who have not been convicted to have their arrest records restricted; to provide for having the arrest records of individuals convicted of certain misdemeanor offenses restricted under certain circumstances; to provide that the Board of Corrections adopt certain rules and regulations; to change provisions relating to the administration of supervision of felony probationers; to provide for the use of graduated sanctions in disciplining probationers who violate the terms of their probation; to change provisions relating to terms and conditions of probation; to provide for a maximum stay in probation detention centers; to clarify provisions relating to probation supervision and provide for early termination of a sentence; to amend Titles 5, 15, 16, 17, 31, 36, and 42 of the Official Code of Georgia Annotated, relating to appeal and error, courts, crimes and offenses, criminal procedure, health, local government, and penal institutions, respectively, so as to conform provisions and correct cross-references; to provide for related matters; to provide for effective dates and applicability; to repeal conflicting laws; and for other purposes.

Appendix B:

Healthy Sexual Development in Children

Healthy Sexual Development in Children

The first step toward preventing the sexual abuse of children is to ensure they develop in healthy ways themselves. Professionals working with children and families have a unique opportunity to observe the formative behaviors in children and create environments that support healthy development.

As we grow and change, what is considered healthy or normal changes. The following stages of development are described in general terms, and each child will reach his or her developmental milestones at different times.

Stage of Sexual Development	Characteristics of Sexual Development	Adult Behaviors that Support Healthy Development
Infancy: 0-2 years of age	<ul style="list-style-type: none"> Sensory Learning Natural to touch genitals Developing trust and capacity for pleasure Gender and gender role development Physical reflex responses 	<ul style="list-style-type: none"> Help baby recognize correct names for body parts, including genitals Affirm child's capacity to experience pleasure from touch Help child differentiate between male and female Provide opportunities for social interaction with same age peers
Toddlers: 2-5 years of age	<ul style="list-style-type: none"> More curiosity about their own bodies and those of others Self-soothing touches to genitals increase Imitate behavior associated with gender Toilet training "Playing Doctor" and "Playing House" Cross gender behavior 	<ul style="list-style-type: none"> Be supportive not punitive in toilet training Use inappropriate behavior as opportunity to teach appropriate behavior Try not to shame self-soothing behavior or punish it Help child understand human reproduction with simple but accurate descriptions
School Age: 6-9 years of age	<ul style="list-style-type: none"> Socialization Gender Identity and gender consistency Interest in reproduction Sex play goes underground 	<ul style="list-style-type: none"> Give accurate information about reproduction Prepare child for oncoming changes of puberty Teach norms as far as

	Understanding of Orientation	sexuality, including privacy and nudity Reinforce boundaries and body safety.
Puberty: 10-15 years of age	Accelerated growth More adult appearance Preoccupation with physical appearance Hairy, sweaty, stinky and pimply Establishing sexual identity/orientation More focus on pleasure in masturbation	Make child aware of changes that will occur Emphasize changes in hygiene Media Literacy skills Discuss rights and responsibilities Educate yourself and them on STDs Clarify terms

We recommend Toni Cavanagh Johnson's guide "Understanding Children's Sexual Behaviors: What's Natural and Healthy" as resource for more information on sex and sexuality in children.

You can order a copy from Prevent Child Abuse Georgia. For more information, contact the Director, Carol Neal Rossi, at 404-413-1419 or cnealrossi@gsu.edu.

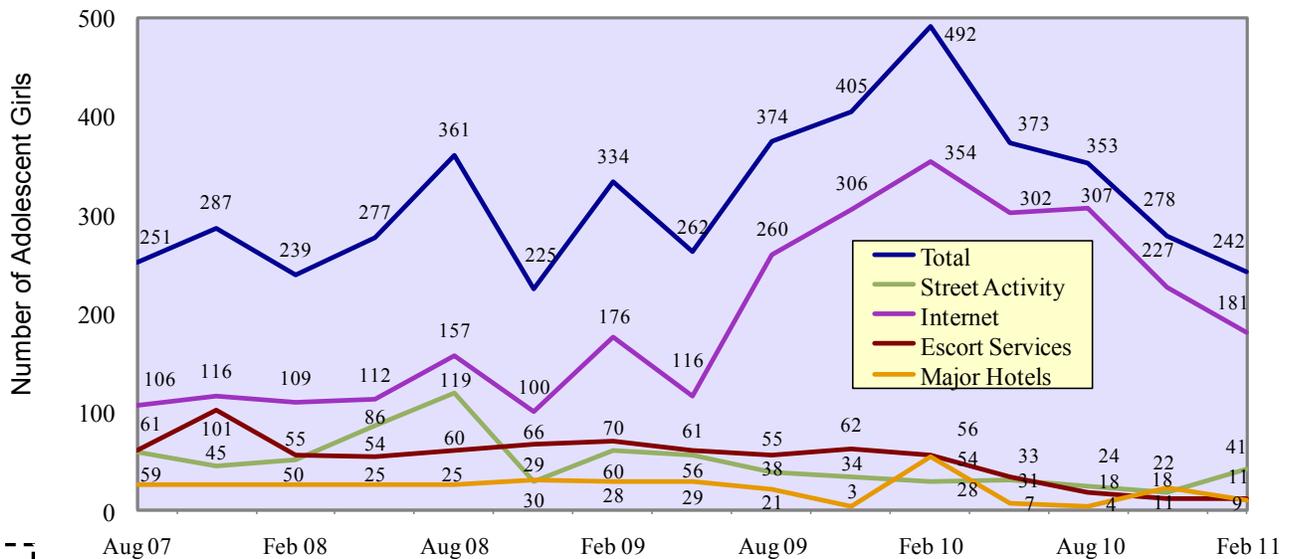
**Appendix C:
Commercial Sexual
Exploitation of Children**



Georgia's Sex Trade Problem

Recently the FBI named Atlanta as one of 14 cities in the nation with the highest incidence of children used in prostitution. Each month, approximately two to five hundred girls are commercially sexually exploited throughout Georgia and research has indicated that the average age of entry is between 12 and 14 years old.¹ Exploited girls do not self-identify as victims, and deny victimization due to fear of the physical and psychological abuse inflicted by the trafficker/pimp, as well as trauma bonds developed through the victimization process.

Adolescent Girls in Georgia's Sex Trade ²



RESEARCH

- Victims of sex trafficking are proportionately younger than other trafficking victims, with 31% of the identified sex trafficking victims being under 18 years old.³
- Experiencing early sexual or physical abuse puts youth at a greater risk for being sexually exploited.⁴
- The estimated cost of child sexual abuse in the United States is \$23 billion annually.⁵

A Statewide System to Protect Georgia's Children

Recognizing this as a serious problem in Georgia, the Governor's Office for Children and Families (GOCF) created *the nation's first statewide response* to identify child sex trafficking victims and address their needs.

Who is a child sex trafficking victim?

A child who has received food, drugs, money or shelter in exchange for sex

¹Smith, L.A., Vardaman, S.H., & Snow, M.A. (2009). *The National Report on Domestic Minor Trafficking: America's Prostituted Children*. Vancouver, WA: Shared Hope International.

²Schapiro Group, T. (2010) *Adolescent Girls in Georgia's Sex Trade: Tracking Study Results*. Atlanta, GA: The Shapiro Group.

³Farrel, A., McDevitt, J., & Fahy, S. (2008). *Understanding and Improving Law Enforcement Responses to Human Trafficking: Executive Summary*. Boston, MA.

⁴Tyler, K. and K. A. Johnson (2006). "Trading Sex: Voluntary or Coerced? The Experiences of Homeless Youth." *The Journal of Sex Research* 43(3): 208-216.

⁵The National Coalition to Prevent Child Sexual Exploitation (2008). *The National Plan to Prevent the Sexual Exploitation of Children*. Alexandria, VA.



Georgia Care Connection

Georgia is the only state in the nation with a statewide response to end sexual exploitation of children and the only state with the system of care response for victims. The Georgia Care Connection Office (GCCO) provides independent care coordination for victims of child sex trafficking. It connects these children with services and sets them on a new direction for their lives. GCCO is the single point of contact for anyone seeking help for a sex-trafficked child. The Care Connection staff acknowledges that the commercially sexually exploited child is a victim of a severe form of human trafficking and is in need of services. GCCO services include:

- “Connecting the dots” of the child’s actions and find the best opportunity for intervention.
- Leading dialogue among a multi-disciplinary team made up of family, child, and involved agencies as well as providers with the goal of developing a single, comprehensive care plan.
- Locating appropriate services.

GCCO began linking victims of commercial sexual exploitation to services in June 2009, in their first year of existence, GCCO received 101 referrals. Of these referrals:

- 100% were female
- the average child age when *referred* was 15.1
- the majority (65%) lived in Fulton and DeKalb counties
- of the 101 girls referred to GCCO, 72 became part of the tracking and monitoring system, 78% were confirmed victims and 22% were considered “At-Risk” for becoming exploited
- majority referred were African-American
- majority referred were being raised by a single parent or in DFCS custody

As compared to “At-Risk” girls, CSEC girls had higher rates of truancy, survival sex, sexual and/or physical abuse, homelessness, gang involvement, foster care, running away, delinquency, juvenile detention, drug/alcohol abuse as well as receiving psychiatric treatment.

CSEC girls referred to GCCO reported:

- being in “the life” on average *one year and three months* before being referred
- primarily exploited by a pimp

How Can You Help?

In order for these efforts to continue to succeed, support from the local community is necessary. As a community, we can help identify possible victims and get them into care.

POSSIBLE WARNING SIGNS:

- **Branding or tattooing:** victims branded by their pimp with tattoos that include a male name or initials, street name, gang or money symbols; these are often found on legs, neck, chest, hands or arms (*this is one of the ways that pimps maintain physical and psychological control over emotionally vulnerable girls*)
- **An older boyfriend or male friend or relative**
- **Withdrawn and uncommunicative**
- **Possession of large amounts of money** (*girls turn money over to the pimp*)
- **Poor personal hygiene and/or inappropriate dress**
- **Runaway or lack of adult supervision/support**

If you suspect a child is a victim of commercial sexual exploitation, please contact the Georgia Care Connection Office at 404-602-0068.

Calling the GCCO links the family to supportive services but does not fulfill mandatory reporting of child sexual exploitation as required by Senate Bill 69.

Commercial Sexual Exploitation of Children: A Fact Sheet

What is the **Commercial Sexual Exploitation of Children**?

The **commercial sexual exploitation of children** is a global problem that could be happening right in your neighborhood. The commercial sex industry victimizes girls, boys, and transgendered youth.

Commercial sexual exploitation of children occurs when individuals buy, trade, or sell sexual acts with a child. **Sex trafficking** is “the recruitment, harboring, transportation, provision, or obtaining of a person for the purposes of a commercial sex act.”¹ Children who are involved in the commercial sex industry are viewed as victims of **severe forms of trafficking in persons**, which is sex trafficking “in which a commercial sex act is induced by force, fraud, or coercion, **or** in which the person induced to perform such an act has not attained 18 years of age.”² A **commercial sex act** is “any sex act on account of which anything of value is given to or received by any person.”³

How does a **child** become a **victim**?

Pimps and traffickers target vulnerable children and lure them into prostitution and other forms of sexual exploitation using psychological manipulation, drugs, and/or violence. Any child may be vulnerable to such a person who promises to meet his or her emotional and physical needs. A trafficker/pimp’s main purpose is to exploit the child for monetary gain. Often traffickers/pimps will create a seemingly loving and caring relationship with their victim in order to establish trust and allegiance. This manipulative relationship tries to ensure the youth will remain loyal to the exploiter even in the face of severe victimization. These relationships may begin online before progressing to a real-life encounter.

Victims are

Targeted – Pimps are predators who seek out vulnerable victims, particularly runaways or children experiencing trouble at home. They know these children have emotional and physical needs they perceive are not being met and use this to their advantage. Pimps find victims at a variety of venues such as in social-networking websites, shopping malls, and schools; on local streets; or at bus stations. While pimps often target children outside of their family, a family member may also prostitute a child.

Tricked – Pimps are willing to invest a great deal of time and effort in their victim to break down a victim’s natural resistance and suspicion – buying them gifts, providing a place to stay, promising a loving relationship – before revealing their true intent. Frequently victims do not realize the deceptive nature of their trafficker’s interest in them, viewing their pimp as a caretaker and/or boyfriend.

Traumatized – A pimp’s use of psychological manipulation (causing the child to truly believe the pimp loves and cares for his or her well-being) coupled with physical control (threats, violence, or drug addiction) can make a victim feel trapped and powerless. This “trauma bond” is difficult to break and long-term treatment and counseling for victims is required.

Despite the seriousness of the problem, the incidence of commercial child sexual exploitation is difficult to measure. Empirical research has not conclusively defined the scope of the problem today. Below, however, are some significant findings from past studies.

Statistics

- Pimps prey on victims as young as 12 to 14 years old.⁴
- One study estimates as many as 325,000 children in the U.S., Canada, and Mexico are at risk each year for becoming victims of sexual exploitation.⁵
- A history of physical and sexual abuse is often common among victims.⁶
- One study estimates 30% of shelter youth and 70% of street youth are victims of commercial sexual exploitation. They may engage or be coerced into prostitution for “survival sex” to meet daily needs for food, shelter, or drugs.⁷

¹*Victims of Trafficking and Violence Protection Act of 2000* [United States of America]. Public Law 106-386 [H.R. 3244]. 28 October 2000. Section 103(9).

²*Ibid.*, Section 103(8).

³*Ibid.*, Section 103(3).

⁴*National Report on Domestic Minor Sex Trafficking: America’s Prostituted Children*. Washington, D.C.: Shared Hope International, 2009, page 30.

⁵R. Estes and N. Weiner. *Commercial Sexual Exploitation of Children in the U.S., Canada, and Mexico*. University of Pennsylvania, 2001, page 144.

⁶*National Report on Domestic Minor Sex Trafficking*, op. cit., n 4., page 31.

⁷*Commercial Sexual Exploitation of Children in the U.S., Canada, and Mexico*, op. cit., n. 4, page 131. See also J. Greene, S. Ennett, and C. Ringwalt. (1999) “Prevalence and correlates of survival sex among runaway and homeless youth.” *American Journal of Public Health*. 89(9) page 1406.

Barriers for victims

- **Psychology of Victimization** – Pimps may use force, fraud, or coercion to virtually enslave their victims. Juvenile victims have been controlled by threats of violence to their family; pornographic images taken and used for blackmail or stigmatization; physical, verbal, and sexual abuse. Child victims may be gang-raped to desensitize them to sexual activity prior to victimizing them in prostitution. Victims are taught to not trust law enforcement and may have experienced negative encounters with law-enforcement officers. Victims often remain with pimps out of fear of being physically harmed, having another victim endure physical harm, or a threat to their family members. Pimps have been convicted of plotting to murder cooperative victim witnesses and for the homicide of victims, further instilling fear.
- **“Trauma Bonding”** – This is also common among child victims exploited for commercial sex. The child experiences a strong link to the pimp/exploiter based in what the child perceives as an incredibly intense or important relationship, but one in which there has been an exploitation of trust or power. Emotional bonding is a learned tactic for survival and can be common between exploited children and the exploiter. Advocacy groups working directly with this population note reframing the trauma bond with a pimp/exploiter can take months of therapy and/or residential treatment for the child. Post Traumatic Stress Disorder (PTSD) is very common among children exposed to sex trafficking and commercial sexual exploitation and may be characterized by such symptoms as anxiety, depression, insomnia, irritability, flashbacks, emotional numbing, and hyper-alertness.⁶ Victims of commercial child sexual exploitation often have unique needs given the frequent nature of multiple acts of sexual exploitation or violence, by multiple offenders, over potentially a sustained period of time.

More Statistics

- Sex trafficking need not involve actual movement of the victim.⁷
- Pimps may earn hundreds of thousands of dollars every year from selling minors.⁸
- 75% of child victims engaged in prostitution are under the control of a pimp.⁹

What are potential indicators of trafficking and exploitation?

- History of emotional, sexual, or other physical abuse
- Signs of current physical abuse and/or sexually transmitted diseases
- History of running away or current status as a runaway
- Inexplicable appearance of expensive gifts, clothing, or other costly items
- Presence of an older boy-/girlfriend
- Drug addiction
- Withdrawal or lack of interest in previous activities
- Gang involvement

⁶M. Farley. “Bad for the Body, Bad for the Heart: Prostitution Harms Women Even if Legalized or Decriminalized.” *Violence Against Women*. 2004(10), page 1104.

⁷*Fact Sheet: Distinctions Between Human Smuggling and Human Trafficking*. Washington D.C.: U.S. Department of State, Human Smuggling and Trafficking Center. January 2005, page 4.

⁸D. Hughes. *The Demand for Victims of Sex Trafficking*. Washington, D.C.: U.S. Department of State. 2005, page 20. Hughes notes the Polaris Project, a Washington, D.C.-based nonprofit organization working with victims of human trafficking conducted an informal analysis in 2005 of a pimp’s wages, based on client’s direct accounts. One teenage girl was forced to meet quotas of \$500 a night, seven days a week and gave the money to her trafficker each night. This particular pimp controlled three other women. Based on these numbers, Polaris Project estimates the pimp made \$632,000 in one year from four young women and girls.

⁹*Commercial Sexual Exploitation of Children in the U.S., Canada, and Mexico*, op. cit., n. 5, page 60.

If you suspect a case of commercial child sexual exploitation or sex trafficking of children, contact the **National Center for Missing & Exploited Children®** at **1-800-843-5678** or visit www.cybertipline.com

or

the **National Human Trafficking Resource Center (NHTRC)** at **1-888-373-7888**.

For additional information and resources about Commercial Sexual Exploitation of Children and Human Trafficking, please visit the **Innocence Lost National Initiative** at <http://www.fbi.gov/innolost/innolost.htm>.

Appendix D: Bullying

PREVENT BULLYING BEFORE IT STARTS

Bullying can occur in schools and anywhere children interact. Bullying is *aggressive behavior that is intended to cause harm or distress and occurs repeatedly over time*. When the victim of bullying is a child, bullying is child abuse, regardless of the age or role of the bully. Cyberbullying is the same behavior carried over into online environments and aided by new technologies. Bullying takes multiple forms:

- **Physical:** hitting, kicking, spitting, pushing, taking personal belongings, etc.
- **Verbal:** taunting, malicious teasing, name-calling, making threats, posting negative information on the internet, etc.
- **Psychological:** spreading rumors, manipulating relationships, extortion, intimidation, etc.
- **Sexual:** unwanted physical contact, abusive comments about physical development, etc.

Steps to Bullying Prevention

Build a Solid and Supportive Relationship With A Child

Warm, supportive relationships with adults cannot be overvalued as positive influences in a child's life. Being aware of changes in a child's life, celebrating successes and helping a child through tough times all contribute to a child's overall well-being.

Model and Teach Empathy to the Children in Your Life

Empathy is the ability to put yourself in another's place and understand what that person is feeling. For younger children, you can teach through your actions that demonstrate empathy. You can join in children's play and identify emotions that come out as they play. Even when a child's play is aggressive, identify and describe the emotions. "Those monsters are very angry with one another." Get down on the child's level and join in the game. As this becomes more comfortable, you can introduce more positive characters into action like a bystander who helps victims of the monster. Older children will be more capable of discussing what is happening and what they are imitating. They can also benefit from opportunities to nurture others, particularly younger children. We can ask about what a child thinks another is feeling. Be careful not to judge the child and demand change. This is not modeling empathy.

Be Aware of Media Influence

All media is not equal, and what happens on-screen does make a big difference. Children imitate the behaviors they see on television. When a child sees a cartoon where a superhero, for instance, solves a problem with violence, the child will imitate that in his or her play. Educational shows with mutual cooperation and helping others also influence children's actions. This effect can be increased if television viewing is paired with role-playing and discussion about the show afterward.

Prepare for and Value Academic Achievement

When children do not do well in school, it is easy for them to become disconnected and act out. When children are prepared to do well and their accomplishments are celebrated, they will continue to do well in school and are less likely to find unhealthy ways of getting attention.

Encourage Healthy Friendships

Kids with a strong network of friends are less vulnerable to bullying.

Responding to Bullying

Bullying can occur in schools and anywhere children interact. According to Georgia Code, bullying is:

- (1) Any willful attempt or threat to inflict injury on another person, when accompanied by an apparent present ability to do so; or
- (2) Any intentional display of force such as would give the victim reason to fear or expect immediate bodily harm.

No one should have to put up with feeling threatened or being harmed. According to Georgia law, schools are required to adopt policies to prohibit bullying and apply penalties against those who bully. If your child is being bullied, you can take the following steps to protect your child.

HELP YOUR CHILD DEAL WITH BULLYING

Let Your Child Know It is OK To Tell

Both adults and children need to feel safe and secure to seek help and talk about what is happening. Let your child know that you are glad they told you and that it is not his or her fault. Let your child know that he or she is not alone and that you will deal with this together.

Document and Report the Bullying to the School

If the bullying happened at school, do not confront the child or the child's parents directly. Write down the facts – dates, times, people involved, and the specifics of what happened. Bring this to your school's personnel's attention. Focus on the common goal that you and the school personnel have- to get your child the education he or she deserves. This cannot happen when the child is being bullied.

Focus on Behaviors

Think about the words that you use to describe people and situations. Labeling someone is returning the attack verbally. Labels also tend to limit our sense that the situation can change. The bully is just "bad" or "mean." More neutral terms like

“irrational” and specific discussions of actions and consequences will further a discussion of events more effectively. Encourage your child to try to think of the behavior in this way as well.

One statement and walk away

Do not tell your child to fight back or ignore the bullying. Those seem to be natural responses, but they tend to be ineffective. Instead, one firm statement that says, in essence, “no” to the bully can be said by the victim or a bystander, whether adult or child. These statements can be prepared and rehearsed ahead of time. Practice with your child what he or she might say to someone who is rude or abusive. Remember not to label the bully. Examples are:

- I can't play with you if you are bullying. Stop it so we can play together.
- I don't listen to bully talk because it's not rational.
- I don't do this to you. You should really think about that.

Once a statement is made, the victim should move to a place of safety, and an adult should be told.

Appendix E: Suicide

The Role of Teachers in Preventing Suicide

If you are thinking of hurting yourself, or if you are concerned that someone else may be suicidal, call the [National Suicide Prevention Lifeline](https://www.nimh.nih.gov/health/topics/suicidal-thoughts-and-actions/index.shtml) at **1-800-273-TALK (8255)**.

Marianne is a middle school teacher. One of her students, David, began the year as a quiet, subdued, and passive young man. He did his work, but he did not participate in class or interact with the other students. Recently, David has undergone what, to Marianne, seems like a dramatic change in personality: He can barely stay in his seat, is uncooperative, has lost interest in his work, and gets angry easily. Last week, Marianne saw him punch a locker.

Marianne decided to speak with some of David's other teachers. She discovered that they had noticed similar problems, along with a decline in the quality of his school work.

Marianne spoke to the school counselor, who suggested that David come in for an appointment. Marianne told David that she was concerned about him and that she thought he might benefit from talking to someone. She walked him to the counseling office while he made an appointment, and she called the counselor later to make sure that he kept it.

Did Marianne prevent a suicide? There is a good possibility that neither she, nor the school counselor, nor her student, David, can ever really be sure. But Marianne noticed a student with problems and took effective action. In doing so, she demonstrated concern and assisted a troubled student in getting help. And she may have saved a life.

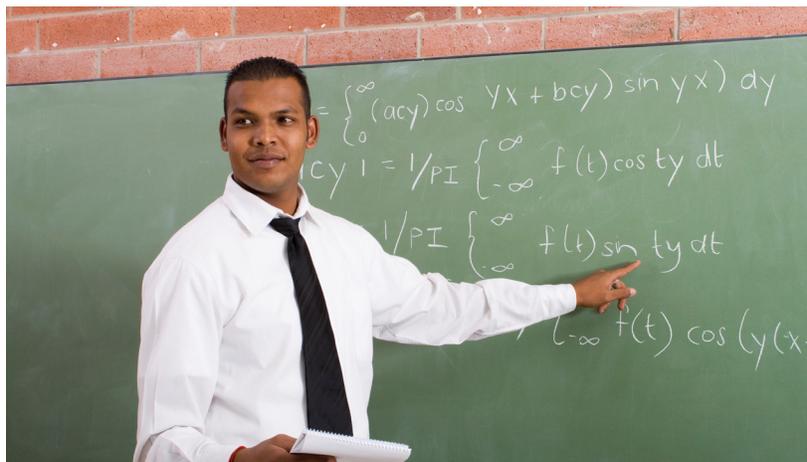


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Introduction

Suicide is the third leading cause of death among children, teens, and young adults ages 10 to 24. About 4,300 young people in this age range die by suicide each year (CDC, 2007). But this is only the tip of the iceberg. Every year, approximately 118,000 young people ages 15-24 are brought to emergency rooms to receive treatment for self-inflicted injuries (CDC, 2009a). A recent national survey (CDC, 2009b) revealed that in the 12 months preceding the survey:

- almost 13.8 percent of high school students had seriously considered attempting suicide
- 10.9 percent of high school students had made a plan for how they would attempt suicide
- 6.3 percent of high school students had attempted suicide one or more times



Very few of these suicides, or suicide attempts, take place in schools. But many young people who are at risk of suicide attend school and exhibit warning signs that, if recognized and acted on, could prevent death or injury and reduce emotional suffering.

As a teacher, you have day-to-day contact with many young people, some of whom have problems that could result in serious injury or even death by their own hand. You are therefore well-positioned to observe students' behavior and to act when you suspect that a student may be at risk of self-harm. There are specific steps you can take to identify and help young people at risk, especially if your school has created a structure that can support your personal efforts to safeguard the health and safety of its students.

Recognizing the Warning Signs

Suicide and other self-destructive behaviors rarely occur without some warning signs. You, perhaps even more than parents of teens, can assess what is “normal” adolescent behavior and what may be an indication that something is wrong.

Here are some signs that a young person may be at risk for suicide:

- **A suddenly deteriorating academic performance.** Teens who were typically conscientious about their school work and who are now neglecting assignments, cutting classes, or missing school altogether may be experiencing problems that can affect their academic success, behavior, and health and put them at risk of suicide.
- **Self-mutilation.** Some young people resort to cutting their arms or legs with razor blades and other sharp objects to cope with emotional pain. Self-mutilation of this type is an unmistakable sign that something is wrong.
- **A fixation with death or violence.** Teens may express this fixation through poetry, essays, doodling, or other artwork. They may be preoccupied with violent movies, video games, and music, or fascinated with weapons.
- **Unhealthy peer relationships.** Teens whose circle of friends dramatically changes for no apparent reason, who don't have friends, or who begin associating with other young people known for substance abuse or other risk behaviors may signal a change in their emotional lives. Their destructive behaviors may discourage more stable friends from associating with them, or they themselves may reject former friends who “don't understand [them] anymore.”

- **Volatile mood swings or a sudden change in personality.** Students who become sullen, silent, and withdrawn, or angry and acting out, may have problems that can lead to suicide.
- **Indications that the student is in an unhealthy, destructive, or abusive relationship.** This can include abusive relationships with peers or family members. Signs of an abusive relationship include unexplained bruises, a swollen face, or other injuries, particularly if the student refuses to discuss them.
- **Risk-taking behaviors.** Risk-taking behaviors often co-occur and are symptomatic of underlying emotional or social problems. Such behaviors as unprotected or promiscuous sex, alcohol or other drug use, driving recklessly or without a license, petty theft, or vandalism, especially by young people who formerly did not engage in these activities, can be an indication that something is wrong.
- **Signs of an eating disorder.** An eating disorder is an unmistakable sign that a student needs help. A dramatic change in weight that is not associated with a medically supervised diet may also indicate that something is wrong.
- **Difficulty in adjusting to gender identity.** Gay, lesbian, bisexual, and transgender teens have higher suicide attempt rates than their heterosexual peers. While coming to terms with gender identity can be challenging for many young people, gay and lesbian youth face social pressures that can make this adjustment especially difficult.
- **Bullying.** Children and adolescents who are bullied, as well as those who bully, are at increased risk of depression and suicidal ideation (Kaltiala-Heino, Rimpela, Marttunen, Rimpela, & Rantanen, 1999).
- **Depression.** Although most people who are clinically depressed do not attempt suicide, depression significantly increases the risk of suicide or suicide attempts. Symptoms of depression include the following:
 - A sudden worsening in academic performance
 - Withdrawal from friends and extracurricular activities
 - Expressions of sadness and hopelessness, or anger and rage
 - A sudden decline in enthusiasm and energy
 - Overreaction to criticism
 - Lowered self-esteem, or feelings of guilt
 - Indecision, lack of concentration, and forgetfulness
 - Restlessness and agitation
 - Changes in eating or sleeping patterns
 - Unprovoked episodes of crying
 - Sudden neglect of appearance and hygiene
 - Fatigue
 - The abuse of alcohol or other drugs as young people try to “self-medicate” their emotional pain



The Role of Teachers in Preventing Suicide

The following warning signs may mean someone is at high risk for suicide. The risk is greater if a behavior is new or has increased and if it seems related to a painful event, loss, or change.

- Talking about wanting to die or kill oneself
- Looking for a way to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having no reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

These signs are especially critical if the individual has attempted suicide in the past or has a history of or current problem with depression, alcohol, or post-traumatic stress disorder (PTSD).

Responding to the Warning Signs

It takes time and courage to reach out to students on a personal level, but your interest can be a lifeline to a child in crisis. Young people, especially those with emotional or family troubles, need support, and school can be a vital part of that support. School may be the last positive social connection for young people from dysfunctional families or who are isolated from their peers.

When you observe behavior that indicates that there is a problem—whether the student is acting out, withdrawing, committing destructive or aggressive acts toward himself or herself or others, or exhibiting a fixation with death or morbid themes—take note and take action. Consult with your school counselor, principal, or nurse to ensure appropriate and quick assessment and treatment.

Many of the same signs that a student is at risk of suicide can also indicate that the student is at risk of (or is already experiencing) other problems, including emotional distress, mental illness (such as depression or bipolar disorder), violence, domestic violence or child abuse, academic failure, running away from home, or the abuse of alcohol or other drugs. You cannot always tell exactly what may be troubling a student and what the outcomes of these troubles may be. But you can be aware of when something is wrong and take steps to get the student the type of help he or she needs. Below are some of the steps you can take to help students who may be at risk of suicide or of other problems that threaten their well-being.



The Role of Teachers in Preventing Suicide

Ask the Tough Questions

Do not be afraid to ask a student if he or she has considered suicide or other self-destructive acts. Research has shown that asking someone if he or she has contemplated self-harm or suicide will not increase that person's risk. Rather, studies have shown that a person in mental distress is often relieved that someone cares enough to inquire about the person's well-being. Your concern can counter the person's sense of hopelessness and helplessness. However, you need to be prepared to ask some very specific and difficult questions in a manner that doesn't judge or threaten the young person you are attempting to help. For example:



- I've noticed that you are going through some rough times. Do you ever wish you could go to sleep and never wake up?
- Sometimes when people feel sad, they have thoughts of harming or killing themselves. Have you had such thoughts?
- Are you thinking about killing yourself?

Be Persistent

A student may feel threatened by your concern. The student may become upset or deny that he or she is having problems. Be consistent and firm, and make sure that the student gets the help that he or she may need.

Be Prepared to Act

You need to know what to do if you believe that a student is in danger of harming him- or herself. Many schools have procedures for this situation. If your school has such procedures, explain them to the student.

Do Not Leave a Student at Imminent Risk of Suicide Alone

If you have any reason to suspect that a student may attempt suicide or otherwise engage in self-harm, you need to remain with the student (or see that the student is in a secure environment, supervised by caring adults) until professional help can be obtained. The student's well-being supercedes any promises of confidentiality you may have made to the student. Let the student know that you care, that he or she is not alone, and that you are there to help.

Get Help When Needed

If you believe that the student is in imminent danger, you, or another member of the school staff, should call 911 or (800) 273-TALK (8255). Tell the dispatcher that you are concerned that the person with you "is a danger to [himself or herself]" or "cannot take care of [himself or herself]." These key phrases will alert the dispatcher to locate immediate care for this person with the help of police. Do not hesitate to make this call if you suspect that someone may be a danger to himself or herself. It could save that person's life.

Use Your School's Support System

School districts typically have crisis policies for working with suicidal or violent students, students who are at risk of suicide or violence, or other youngsters who are not in this acute state of crisis but still need support to stay in school and stay healthy. Familiarize yourself with these policies and programs and use them when appropriate. If your school does not have such a policy in place, see "Create a comprehensive school crisis plan," below.



The Role of Teachers in Preventing Suicide

Connect with Parents or Guardians

If a troubled student opens up to you about self-destructive thoughts or actions, contact that student's parents or legal guardian. Do not promise confidentiality to a child when it comes to issues regarding the child's safety-but always talk privately with a student before letting others know of your concerns for the student's safety. If you believe that contacting the parents or guardians may further endanger the child (if, for example, you suspect physical or sexual abuse), contact the proper authorities. In most states, teachers are "mandated reporters" and are required to report suspected child abuse.

Postvention

The suicide, or violent or unexpected death, of a student, teacher, or even a celebrity can result in an increased risk of suicide for vulnerable young people. Although rare, a suicide in the community (or even a remote suicide that receives substantial press coverage) can also contribute to an increased risk of suicide. Therefore, responding appropriately to a tragedy that may put students at risk for suicide is an essential part of any crisis or suicide prevention plan.

Postvention describes the prevention measures implemented after a crisis or traumatic event to reduce the risk for suicide to those who have witnessed or been affected by the tragedy. These measures include:

- Grief counseling for students and staff
- Identification of students who may be put at risk by a traumatic incident
- Support for students at risk
- Support for families
- Communication with the media to ensure that news coverage of such an event does not lead to additional suicides or emotional trauma

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School-Based Suicide Prevention Programs and Materials

Columbia University TeenScreen Program

(<http://www.teenscreen.org/>). TeenScreen helps schools and communities implement screening programs to identify at-risk teens and pre-teens. It uses simple screening tools that can detect depression, the risk of suicide, and other mental disorders in teens to help schools identify and arrange treatment for youth who are suffering from depression and other undiagnosed mental illness and those who are at risk of suicide.

Guidelines for School-based Suicide Prevention Programs

(http://www.sprc.org/library/aasguide_school.pdf). This 14-page report, written by the Prevention Division of the American Association of Suicidology in 1999, examines the bases of and requirements for school-based prevention programs in general, as well as for three variations of school-based suicide prevention programs: those for all students, those for groups of at-risk students as identified by research (i.e., incoming high school freshmen), and those for individual students identified through screening. It explores the essential components of and a sample curriculum for a comprehensive school-based suicide prevention program. The report also provides recommendations to ensure the longevity of programs once they are implemented.

Jason Foundation, Inc.

(<http://www.jasonfoundation.com>). The Jason Foundation, Inc., educates young people, parents, teachers, and others who work with young people about youth suicide. The foundation offers programs, seminars, and support materials on suicide awareness and prevention.

SOS Signs of Suicide Program

(<http://www.mentalhealthscreening.org/highschool/>). The SOS Signs of Suicide program provides school health professionals with the educational materials necessary to replicate this program, which teaches high school students to recognize the signs and symptoms of suicide and depression in themselves and others and to follow specific action steps to respond to those signs. The program can be incorporated into an existing health curriculum or can be used as a stand-alone program. The program includes educational materials, a training video, and an implementation manual, and can be completed in one or two class periods.

Yellow Ribbon International Suicide Prevention Program

(<http://www.yellowribbon.org/>). This organization provides training and resources for school- and community-based suicide prevention programs (including gatekeeping). Chapters in a number of states can provide suicide prevention speakers, materials, and training to schools and other organizations.

Youth Suicide Prevention. Intervention, and Postvention Guidelines: A Resource For School Personnel (<http://www.maine.gov/suicide/docs/Guidelines%2010-2009--w%20discl.pdf>). These guidelines were developed by the Maine Youth Suicide Prevention Program and designed for schools to use within existing protocols to assist at-risk students and to intervene appropriately in a suicide-related crisis.

Youth Suicide Prevention School-Based Guide (<http://theguide.fmhi.usf.edu/>). This online resource was developed by the Florida Mental Health Institute at the University of South Florida. It provides a framework for schools to assess their existing or proposed suicide prevention efforts (through a series of checklists) and provides resources and information that school administrators can use to enhance or add to their existing program. Information is offered in a series of issue briefs corresponding to a specific checklist. Each brief offers a rationale for the importance of the specific topic together with a brief overview of the key points. The briefs also offer specific strategies that have proven to work in reducing the incidence of suicide, with references that schools can use to explore these issues in greater detail.

Suicide Prevention Gatekeeping Programs

Livingworks Education, Inc. (<http://www.livingworks.net/>). Livingworks provides training and support for the Applied Suicide Intervention Skills Training (ASIST) program, a suicide gatekeeping program. Livingworks also offers shorter presentations on suicide awareness and prevention.

Preventing Youth Suicide Through Gatekeeper Training: A Resource Book for Gatekeepers (<http://www.maine.gov/suicide/docs/gkeepbook.pdf>). This book was designed for use in youth suicide prevention gatekeeper trainings and to provide basic information about suicide prevention, crisis intervention, support for survivors of suicide, and suicide prevention resources. The book was created for the Maine Youth Suicide Prevention Program.

QPR Institute (<http://www.qprinstitute.com>). The QPR Institute offers gatekeeper training programs to the general public and to professionals, including firefighters, clergy, and teachers.

Crisis Response and Postvention

Lerner, M., Volpe, J., & Lindell, B. (2003). A practical guide for crisis response in our schools (5th ed.). Commack, NY: American Academy of Experts in Traumatic Stress. A guide to preparing for and managing crises in schools. This book covers traumatic stress management, responding to suicidal or violent students, grief counseling, and other issues. Of special interest to teachers will be the section titled “Teacher Guidelines for Crisis Response.”

Bullying Prevention Websites

Cyberbully.org (<http://www.cyberbully.org/>) provides information about “cyberbullying”-the use of the Internet by children and adolescents to harass, intimidate, and socially exclude their peers. Resources on this website include the Educator’s Guide to Cyberbullying and the Cyberbullying Needs Assessment Survey.

Stop Bullying Now Campaign (<http://www.stopbullying.gov/>), sponsored by the U.S. Department of Health and Human Services, offers educational materials for parents, educators, and health professionals.

For national organizations and federal agencies with general resources on suicide prevention, go to <http://www.sprc.org/basics/national-organizations>.

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<http://www.sprc.org/sites/sprc.org/files/Teachers.pdf>

STATE AND NATIONAL RESOURCES FOR SUICIDE PREVENTION

CRISIS INTERVENTION

Georgia Crisis and Access Line 1-800-715-4225 www.mygcal.com

The Georgia Crisis & Access Line is staffed with professional social workers and counselors 24 hours per day, every day, to assist those with urgent and emergency needs. Those callers who need more routine services are directly connected with the agency of their choice and given a scheduled appointment.

National Suicide Prevention Lifeline 1-800-273-TALK (8255) www.suicidepreventionlifeline.org

A free, 24-hour hotline available to anyone in suicidal crisis or emotional distress. Your call will be routed to the nearest crisis center to you.

FOR YOUTH

To Write Love On Her Arms www.twloha.com

To Write Love on Her Arms is a non-profit movement dedicated to presenting hope and finding help for people struggling with depression, addiction, self-injury and suicide. TWLOHA exists to encourage, inform, inspire and also to invest directly into treatment and recovery.

Reach Out www.reachout.com

Comprehensive resources and support is offered through the media youth use. With this support, lives can be saved and young people's mental health and well-being can be improved. The Reach Out website was founded in 1998 in response to the escalating rates of youth suicide.

FOR PARENTS

The Society for the Prevention of Teen Suicide (SPTS) <http://www.sptsnj.org/parents/>

Georgia Parent Support Network (www.gpsn.org)

Dedicated to providing support, education, and advocacy for children and their families with mental illness, emotional disturbances, and behavioral differences.

ParentsMedGuide.org- <http://www.parentsmedguide.org/index.htm>

A website that contains information for parents and physicians on the use of medication in treating childhood and adolescent depression, including information on the FDA "black-box" warnings.

LESBIAN, GAY, BISEXUAL AND TRANSGENDER RESOURCES

The Trevor Project www.thetrevorproject.org

The Trevor Project is determined to end suicide among LGBTQ youth by providing life-saving and life-affirming resources including our nationwide, 24/7 crisis intervention lifeline, digital community and advocacy/educational programs that create a safe, supportive and positive environment for everyone.

It Gets Better www.ItGetsBetterProject.com

A place where young people who are gay, lesbian, bi, or trans can see with their own eyes how love and happiness can be a reality in their future. It's a place where LGBT adults can share the stories of their lives, and straight allies can add their names in solidarity and help spread our message of hope.

GENERAL AWARENESS AND EDUCATION

The Link National Resource Center for Suicide Prevention and Aftercare http://www.thelink.org/national_resource_center.htm

The Link's NRC is a leading resource in the country for suicide prevention and aftercare. It is dedicated to reaching out to those whose lives have been impacted by suicide and connecting them to available resources.

The Suicide Prevention Resource Center (SPRC) (www.sprc.org)

Funded by the Substance Abuse, Mental Health Services Administration (SAMHSA), supports suicide prevention using the best of science, skills and practice. The Center provides prevention support, training, and informational materials to strengthen suicide prevention networks and advance the National Strategy for Suicide Prevention. The site has links to many additional resources for suicide and suicide prevention.

Suicide Prevention Action Network www.spanusa.org

American Foundation for Suicide Prevention (AFSP) www.afsp.org

The leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide.

American Association of Suicidology (AAS) www.suicidology.org

Through better research, education, prevention programs, and treatment the American Association of Suicidology has pledged itself to a mission of understanding and preventing suicide as a means of promoting human well-being.

CDC Recommendations for a Community Plan for the Prevention and Containment of Suicide Clusters

<http://wonder.cdc.gov/wonder/prevguid/p0000214/p0000214.asp>

LOCAL SUICIDE PREVENTION INFORMATION

Georgia Department of Behavioral Health and Developmental Disabilities, Division of Mental Health, Suicide Prevention Program

<http://dbhdd.georgia.gov/portal/site/DBHDD/menuitem.890e8533f215bcb59da1df8dda1010a0/?vgnextoid=b0ee2ad627eb6210VgnVCM100000bf01010aRCRD>

Georgia Suicide Prevention Information Network www.gspin.org: GSPIN

Your community web site for suicide prevention, intervention and aftercare information. This web site has been created to address the specific problems of lack of centralized information, communication, sharing of resources, and need for support for regional/local coalition building, creating a linked network of resources and activities.

The Suicide Prevention Coalition of Georgia (SPCGA) www.spcgeorgia.org

A cooperative and representative group of non-profit organizations, businesses, state agency representatives, advocacy groups, survivors, faith and community based organizations. The group's mission is to address the problem of suicide in Georgia through collaborative efforts that promote, support, and increase awareness, prevention, intervention and aftercare. They meet monthly at the Link's National Resource Center for Suicide Prevention. Membership is open to all interested persons. Contact Marti Vogt, 678-405-2277.

Suicide Prevention Action Network – Georgia www.span-ga.org

A 501C(3) organization created in 2003 to reduce completed and attempted suicide in Georgia. Its focus is on creating public awareness and public/political will to provide resources to implement the Georgia State Suicide Prevention Plan. SPAN-GA empowers survivors of completed suicides, attempters of suicide, and supporters of suicide prevention to become actively involved in educating private and public citizens to the emotional and financial costs of suicide in Georgia.

Local Suicide Prevention Coalitions <http://www.gspin.org/index.php?module=Content&func=view&pid=28>

There are Suicide Prevention Coalitions that are continuing to be established around the state. Feel free to contact the coalitions in your area and become active in these efforts. If you do not see a coalition in your area, and would like to begin one, contact info@gspin.org.

POSTVENTION AND SURVIVOR SERVICES

Services for Families Who Have Survived a Suicide Loss <http://www.gspin.org/index.php?module=Content&func=view&pid=62>

Peer led Survivors of Suicide (SOS) groups are available in many areas throughout Georgia. Survivors of Suicide group meetings are open to anyone who has lost a loved one through suicide or who is helping someone who has lost a loved one. SOS groups are often organized by survivors and held in donated spaces. Before attending a meeting please call the facilitator to confirm the details.

Frameworks Youth Suicide Prevention Project: Postvention Community Response to Suicide

<http://www.helppromotehope.com/documents/CommunityResponsetoSuicideNAMI.pdf> Frameworks is a copy written project by NAMI New Hampshire that provides a framework of specific steps to be taken in response to a youth suicide event by specific stakeholders. It is a collaborative approach between multiple systems. The document is 110 pages in total. There is a section regarding cultural competence with excellent, easy to review guidelines on this topic on pp. 14-19. The rest of the document is organized by specific protocol recommendation by community stakeholder group. They include:

- Law Enforcement
- Medical Examiner
- Gatekeepers
- Immediate Family
- Student/Teen/Young Adult
- Clergy
- Funeral Directors
- Mental Health/Substance Abuse Provider
- Mental Health/Substance Abuse Private Provider
- Education
- Social Service Agency/Youth Program
- Community Coordinator

SCHOOL/COLLEGE RESOURCES

The Youth Suicide Prevention School-Based Guide <http://theguide.fmhi.usf.edu/>

Designed to provide accurate, user-friendly information. The Guide is not a program but a tool that provides a framework for schools to assess their existing or proposed suicide prevention efforts (through a series of checklists) and provides resources and information that school administrators can use to enhance or add to their existing program. First, checklists can be completed to help evaluate the adequacy of the schools' suicide prevention programs. Second, information is offered in a series of issue briefs corresponding to a specific checklist. Each brief offers a rationale for the importance of the specific topic together with a brief overview of the key points. The briefs also offer specific strategies that have proven to work in reducing the incidence of suicide, with references that schools may then explore in greater detail. A resource section with helpful links is also included. The Guide will help to provide information to schools to assist them in the development of a framework to work in partnership with community resources and families.

Cobb County Schools Protocol For Addressing Suicidal/Homicidal Ideations Or Attempts

<http://www.cobbk12.org/preventionintervention/forms/Suicidal-HomicidalIdeationsProtocol%2009.pdf>

This protocol is designed for the protection of students in crisis and the school employees who serve them.

Cobb County Schools Emergency Procedures and Checklist for the death of a student or staff member including sample letter to parents <http://www.cobbk12.org/preventionintervention/forms/EMERGENCY%20PROCEDURES%20AND%20CHECK%20LIST.doc>

Cobb County Schools Crisis Response Resource Manual

<http://www.cobbk12.org/preventionintervention/forms/CRISIS%20RESPONSE%20RESOURCE%20MANUAL.doc>

This manual was developed to assist schools in both planning ahead for a crisis, and responding during a crisis. It can assist in providing a consistent framework for responding to the emotional needs of children and faculty at schools to complement physical safety protocols.

Lifeline Manual for Managing Social Media Post-suicide <http://library.sprc.org/item.php?id=807&catid=40>

The recommendations in this manual detail how to safely memorialize someone who has died by suicide. These guidelines can be applied to online memorials and online messages about the deceased.

Jed Foundation – www.jedfoundation.org - Over the last ten years, The Jed Foundation has emerged as the leader in protecting the emotional health of America's 18 million college students. Our proven model **and** award-winning programs are changing the way campuses, communities and families promote mental health and prevent suicide.

SCREENING AND RISK ASSESSMENT

Columbia Suicide Severity Rating Scale - C-SSRS -The C-SSRS is used extensively across primary care, clinical practice, surveillance, research, and institutional settings. It is available in **103 languages**, and is part of a national and international public health initiative involving the assessment of suicidality, including general medical and psychiatric emergency departments, hospital systems, managed care organizations, behavioral health organizations, medical homes, community mental health agencies, primary care, clergy, hospices, schools, college campuses, US Army, National Guard, VAs, Navy and Air Force settings, frontline responders (police, fire department, EMTs), substance abuse treatment centers, prisons, jails, juvenile justice systems, and judges to reduce unnecessary hospitalizations. - http://www.cssrs.columbia.edu/about_cssrs.html

Collaborative Approach to Managing Suicide (CAMS) – Jobes, D. A. (2006). *Managing Suicidal Risk: A Collaborative Approach*. New York: The Guilford Press

TeenScreen – www.teenscreen.org - The TeenScreen National Center is a non-profit health initiative affiliated with the Columbia University Division of Child and Adolescent Psychiatry. Our program grew out of research conducted by Columbia in the 1990s which found that screening is effective in accurately identifying signs of possible mental illness and risk of suicide in youth. TeenScreen was first implemented in schools and communities.

AFSP Interactive Screening Program - http://www.afsp.org/index.cfm?page_id=05967029-BC0C-603D-5A32D68043B9D7A8

CULTURAL COMPETENCY

Culturally and Linguistically Diverse Populations <http://theguide.fmhi.usf.edu/pdf/CL-9.pdf> A checklist from the Florida School Based Youth Suicide Prevention Manual

Pace University - Multicultural Competence Suicide Prevention Kit Manual - a Multicultural Understanding in Preventing Suicide Kit that will facilitate effective crisis and suicide intervention with students from diverse cultural, identity, and ability backgrounds. <http://www.pace.edu/counseling-center/nyc-counseling-center-grants/samsha-grant-project-open>

Preventing Suicide: a resource series

http://www.who.int/mental_health/resources/preventingsuicide/en/index.html

World Health Organization website with multiple language translations of many documents on suicide prevention for many different audience groups.

Cultural Competency: A Practical Guide for Mental Health Service Providers

http://www.hogg.utexas.edu/uploads/documents/cultural_competency_guide.pdf

National Organization for People of Color Against Suicide (NOPCAS) <http://www.nopcas.com/articles/defining-a-culturally-competent-program.php>

Defining A Culturally Competent Program

PROGRAM EVALUATION

SPRC Evaluation Resource List <http://library.sprc.org/item.php?id=181&catid=39>

A list of resources related to program evaluation. The list includes book titles, online courses, toolkits, and online evaluator locators

Suicide Prevention: Prevention Effectiveness and Evaluation <http://library.sprc.org/item.php?id=5&catid=39>

A booklet by the Suicide Prevention Action Network (SPAN) that explains important prevention and evaluation concepts in the context of suicide prevention.

Measuring and Assessing Prevention Efforts Factsheet

<http://www.cobbk12.org/preventionintervention/forms/Measuringprevention.doc> Prepared by the Cobb County Schools Prevention and Intervention Center.

FAITH COMMUNITIES

Evangelical Lutheran Church in America <http://www.elca.org/Our-Faith-In-Action/Life-Transitions/Youth-Issues/Youth-Violence-and-Suicide.aspx>

After a Suicide: Recommendations for Religious Services and Other Public Memorial Observances

<http://library.sprc.org/item.php?id=187&catid=40>

This publication is a guide to help community and faith leaders who plan memorial observances and provide support for individuals after the loss of a loved one to suicide.

- [Capacity Building](#)
- [Curricula and Training Materials](#)
- [United States](#)

PRIMARY CARE

Suicide Prevention Toolkit for Rural Primary Care <http://www.sprc.org/pctoolkit/index.asp> Web-based Toolkit contains information and tools to implement state of the art suicide prevention practices and overcome the significant hurdles this life-saving work faces in primary care practices. The Toolkit offers the support necessary to establish the primary care provider as one member of a team, fully equipped to reduce suicide risk among their patients. For instance, the tools will help you engage your patients and those around them in managing their own suicide risk. You'll find tools for developing partnerships with mental health providers—regardless of how far away they may be—and a guide to developing telemental health services, a promising solution for many rural areas. There are also posters for display in your office, schools, and churches, and wallet cards listing warning signs for suicide and the number of the national crisis line.

LETHAL MEANS RESTRICTION

Means Matter www.hsph.harvard.edu/means-matter

The mission of the Means Matter Campaign is to increase the proportion of suicide prevention groups who promote activities that reduce a suicidal person's access to lethal means of suicide

National Strategy for Suicide Prevention (NSSP): Goal 5 <http://store.samhsa.gov/product/SMA01-3517>

Goal 5 in the NSSP discusses means restriction in-depth on pages 71-77 (73-80 of the PDF). The definition of means and means restriction can be found in the NSSP glossary (page 201 of the PDF). Example ideas for means restriction are provided throughout the objectives section.

Lethal Means Restriction: Its value and its problems

http://www.sprc.org/featured_resources/trainingandevents/conferences/co/pdf/lethalmeans.pdf

A paper presented at the SPRC Regions 7 and 8 Conference on 28-30 October 2003. The paper reviews different types of means restriction, discussing such topics as policy and legislation (e.g., changes in gun laws), and presents examples and effects of unrestricted and restricted access to lethal means (e.g., safety barriers on bridges, incorporation of questions related to guns in the home into physician intake).

Recent firearms research <http://www.hsph.harvard.edu/research/hicrc/firearms-research/guns-and-death/index.html>

Listing of current research on firearms with a section on guns and death which includes research on firearms and suicide. Contains citations as well as major findings.

MEDIA GUIDELINES AND SAFE MESSAGING

At-A-Glance: Safe Reporting on Suicide http://www.sprc.org/library/at_a_glance.pdf

SPRC's two page summary of the 2001 publication "Reporting on Suicide: Recommendations for the Media," by the Centers for Disease Control and Prevention, National Institute of Mental Health, Office of the Surgeon General, Substance Abuse and Mental Health Services Administration, American Foundation for Suicide Prevention, American Association of Suicidology and Annenberg Public Policy Center.

Safe and effective messaging for suicide prevention <http://library.sprc.org/item.php?id=257&catid=4>

A 2-page document that offers evidence-based recommendations for creating safe and effective messages to raise public awareness that suicide is a serious and preventable public health problem is now available. Contains Do's and Don'ts for creating public messages for suicide prevention.

OTHER LOCAL AND NATIONAL RESOURCES

Question, Persuade and Refer (QPR) www.qprinstitute.com

The QPR Institute is a multidisciplinary training organization whose primary goal is to provide suicide prevention educational services and materials to professionals and the general public. We offer state-of-the-art programs to institutions that want to increase their standard of care and reduce the suicide rate.

Sources of Strength (SOS) www.sourcesofstrength.com:

Sources of Strength is a comprehensive wellness program that works to use peer leaders to change norms around codes of silence and help seeking. The program is designed to increase help seeking behaviors and connections between peers and caring adults. Sources of Strength has a true preventative aim in building multiple sources of support around individuals so that when times get hard they have strengths to rely on.

Mental Health America of Georgia <http://ciclt.net/sn/adm/editpage.aspx?ClientCode=nmhag&FileName=default2> (formerly known as the National Mental Health Association of Georgia)

Georgia's leading nonprofit dedicated to helping all Georgians live mentally healthier lives. With our state-wide affiliates, we represent a growing movement of Americans who promote mental wellness for the health and well-being of everyone in our state, emphasizing mental health as a critical component of a healthy lifestyle.

National Alliance on Mental Illness (NAMI) www.namiga.org

The nation's largest grassroots mental health organization dedicated to improving the lives of persons living with serious mental illness and their families. Founded in 1979, NAMI has become the nation's voice on mental illness, a national organization including NAMI organizations in every state and in over 1100 local communities across the country who join together to meet the NAMI mission through support, education, and advocacy.

Georgia Mental Health Consumer Network, Inc. www.gmhcn.org

Our mission is to promote recovery through advocacy, education, employment, empowerment, peer support and self help, and to unite as one voice to support the priorities set each year at the annual convention.

Paginas En Español

Red Nacional de Prevención del Suicidio 1-888-628-9454:

Cuando usted llama al número 1-888-628-9454, su llamada se dirige al centro de ayuda de nuestra red disponible más cercano. Tenemos actualmente 132 centros en la red y usted hablará probablemente con uno situado en su zona. Cada centro funciona en forma independiente y tiene su propio personal calificado.

Centro de Información Nacional de la Salud Mental de SAMHSA

Several featured publications – all at no charge – in Spanish
<http://nmhicstore.samhsa.gov/espanol/default.aspx>

ParentsMedGuide.org- Spanish Language Version

<http://www.parentsmedguide.org/indexespanol.htm>

A website that contains information for parents and physicians on the use of medication in treating childhood and adolescent depression, including information on the FDA "black-box" warnings. The English version of the website is at:
<http://www.parentsmedguide.org/index.htm>

NIMH Publications in Spanish

<http://www.nimh.nih.gov/health/publications/spanish/index-publication-all-es.shtml> A variety of Spanish-language brochures, fact sheets, and booklets on mental health issues such as depression and anxiety.

AAS suicide fact sheets: Spanish Fact Sheets

<http://www.suicidology.org/web/guest/stats-and-tools/fact-sheets>

A collection of fact sheets in Spanish on: warning signs; understanding and helping the suicidal person; major sources of help for suicidal people; depression and suicide; and surviving after suicide.

Hacia La Recuperación Después del Suicidio de Mi Hijo

Toward Healing After My Child's Suicide

http://www.heartbeatsurvivorsaftersuicide.org/docs/toward_healing_translation.doc

Para el sobreviviente de un suicidio reciente

To the Newly Bereaved After Suicide

http://www.heartbeatsurvivorsaftersuicide.org/docs/to_the_newly_bereaved_after_suicide_translation.doc

Cuando alguien se quita la vida

When Someone Takes His Own Life

http://www.heartbeatsurvivorsaftersuicide.org/docs/when_someone_takes_his_own_life_translation.doc

Si, los hombres lloran

Yes Men Do Cry; http://www.heartbeatsurvivorsaftersuicide.org/docs/mencry_translation.doc

Suicidio :Cuidandose a si mismo y a su familia despues de un intento :Una guía familiar para su pariente en la sala de emergencias

Suicide: Taking care of yourself & your family after an attempt: Family guide for your relative in the emergency department

<http://library.sprc.org/item.php?id=280> Brochure intended as a guide for families of suicide attempt survivors on what to expect in the emergency department and after release from the hospital.

Entiendo y Ayudando al individuo suicida: Este atento a las sintomes

Understanding and helping the suicidal individual: Be aware of the warning signs

http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-87.pdf

Common warning signs of suicide, along with recommendations for action are given.

Ninos sobrevivientes al suicide: Una guia para aquellos y los cuidan

Child Survivors of Suicide: A Guidebook for Those Who Care for Them

http://www.afsp.org/index.cfm?fuseaction=shop.productDetails&product_id=B157BA8B-E4F7-BBE9-EA7A81D1FA6268D4

By Rebecca Parkin, M.P.H., Ph.D., and Karen Dunne-Maxim, M.S., R.N.

This paperback guide offers guidance for family members, educators and others who interact with young survivors.

Appendix F:

Abuse of Children with Disabilities

Abuse of Children With Intellectual Disabilities

By Leigh Ann Davis, M.S.S.W., M.P.A.



What Is The Arc's Position?

People (including children) with intellectual disabilities must be free from abuse, neglect, or any kind of mistreatment. Read the full Position Statement at <http://www.thearc.org/page.aspx?pid=2357>

For More Information:

Child Welfare Information Gateway
1-800-FYI-3366
www.childwelfare.gov

Prevent Child Abuse America
1-800-244-5373
www.preventchildabuse.org

The Arc

1660 L Street, NW
Suite 301
Washington, D. C. 20036
Phone: 202.534.3700
Toll free: 800.433.5255
Fax: 202.534.3731
www.thearc.org

Are Children With Disabilities at a Higher Risk of Being Abused?

Children with disabilities of any kind are not identified in crime statistic systems in the U.S., making it difficult to determine their risk for abuse (Sullivan, 2003). A number of weak and small-scale studies found that children with all types of disabilities are abused more often than children without disabilities. Studies show that rates of abuse among children with disabilities are variable, ranging from a low of 22 percent to a high of 70 percent (National Research Council, 2001). Although the studies found a wide range of abuse prevalence, when taken as a whole, they provide consistent evidence that there is a link between children with disabilities and abuse (Sobsey, 1994).

One in three children with an identified disability for which they receive special education services are victims of some type of maltreatment (i.e., either neglect, physical abuse, or sexual abuse) whereas one in 10 nondisabled children experience abuse. Children with any type of disability are 3.44 times more likely to be a victim of some type of abuse compared to children without disabilities. (Sullivan & Knutson, 2000).

Looking specifically at individuals with intellectual disabilities, they are 4 to 10 more times as likely to be victims of crime than others without disabilities (Sobsey, et al., 1995). One study found that children with intellectual disabilities were at twice the risk of physical and sexual abuse compared to children without disabilities (Crosse et. al., 1993).

Why Are These Children More Likely to Be Abused?

According to researchers, disability can act to increase vulnerability to abuse (often indirectly as a function of society's response to disability rather than the disability in itself being the cause of abuse). For example, adults may decide against making any formal reports of abuse because of the child's disability status, making the abuse of those with disabilities easier for the abuser (Sullivan, 2003). Parents fear if they report abuse occurring in the group home, they may be forced to take their child out of the home with few options for other safe living arrangements. Often the abusers are parents or other close caregivers who keep the abuse secret and do not report out of fear of legal

and other ramifications.

Children may not report abuse because they don't understand what abuse is or what acts are abusive. Communication problems that are inherent in many disabilities also make it difficult for children to understand and or verbalize episodes of abuse (Knutson & Sullivan, 1993). Those with limited speaking abilities have had no way to talk about or report abuse. Only recently have pictures demonstrating acts of abuse and sexual anatomy been added to communication boards to help non-communicative children and adults (or those with limited communication) report acts of abuse.

Are Children with Different Types of Disabilities More at Risk for Being Abused?

A number of studies have found that different types of disabilities have differing degrees of risk for exposure to violence. For example, Sullivan (2003) reported that those with behavior disorders face greater risk of physical abuse, whereas those with speech/language disorders are at risk for neglect.

Sullivan & Knutson (1998) also found that out of all the types of disability, children with behavior disorders and children with intellectual disabilities were both at increased risk for all three forms of abuse (neglect, physical abuse and

sexual abuse) compared to those children with other types of disabilities (speech/language disorders, hearing impairments, learning disabilities, health impairments and Attention Deficit Disorder).

There are no differences in which form of child maltreatment occurs the most often between disabled and nondisabled children. For both groups, neglect is the most prevalent, followed by physical abuse, sexual abuse and emotional abuse (Sullivan & Knutson, 2000).

How Can I Tell if a Child with Disabilities is Being Abused?

Children with and without disabilities share similar indicators of abuse. Along with physical signs (bruises, broken bones, head injuries, or other outward marks) two primary indicators are reports from the child that abuse has occurred and changes in the child's behavior. Children with disabilities face greater risk of abuse going unnoticed if their behavior change can be attributed to their disability instead of the abuse. Also, children with intellectual disabilities may be viewed as easily suggestible or untrustworthy, especially when the report involves abuse that seems improbable. Any time abuse is suspected, it is the adult's responsibility to carefully monitor the child's behavior, ask the child about his or her safety and follow

through by reporting any suspected abuse. State laws vary regarding who is considered a mandated reporter, although usually professionals who have regular contact with children are included, such as teachers, physicians, dentists, speech pathologists, etc. (see "To report abuse" in the box on the back page for more information).

What Are the Consequences of Being Abused?

Consequences of abuse may be physical in nature, such as damage to the central nervous system, fractures, injury to internal organs of the abdomen, burns, malnutrition, and trauma to the head (such as in the case of Shaken Baby Syndrome). Other consequences reap havoc on the heart and in the mind of a child, with abuse resulting in long-term emotional trauma and behavioral problems.

Another possible consequence of being abused is to become disabled. Some children who never had a disability before become disabled due to abuse. For example, a one-year study of children with firearm injuries identified an 11.7% mortality rate and a 10% permanent disability rate. (Dowd, et.al., 1994).

How Can I Help Prevent Abuse of Children with Intellectual Disabilities?

Encourage training and continu-

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ing education about violence against children with disabilities for those with disabilities themselves, their families, legal professionals, judges, prosecutors, victim advocacy agencies, Guardians ad Litem, public defenders and police officers. Children with disabilities need early education about the risks of abuse and how to avoid it in a way that they can understand.

Parents can get to know all persons working with their child and observe interactions closely for any signs of abuse. Parents and other caregivers may be the abusers, so other adults in the child's life should also be able to identify possible abuse and know how to go about reporting the abuse.

Parents of children with disabilities and the organizations they are a part of (such as local chapters of The Arc or state Developmental Disability Councils) can form relationships with local victim assistance or child abuse agencies, share each other's expertise and partner together in serving children with disabilities in their local communities.

Obtaining (or advocating for the funding of) family support programs, such as respite care, that have a direct impact on families with disabilities can help prevent abuse by giving families breaks from day-to-day caregiver responsibilities that can seem overwhelming.

What Legislation Exists to Help Children with Disabilities?

Although there is no single public policy initiative that addresses abuse of children with disabilities, there have been some attempts to address the issue.

The Crime Victims with Disabilities Awareness Act of 1998 mandated the inclusion of disability status in the U.S. National Crime Victim Survey. It also mandated that research be conducted to address crimes against individuals with disabilities, including children. See the report at <http://www.nap.edu/catalog/10042.html>.

The Child Abuse Prevention and Treatment Act (CAPTA) is a law that helps prevent children from being abused, including those with disabilities. Since 1974, this law has been part of the federal government's effort to help states and communities improve their practices in preventing and treating child abuse and neglect. CAPTA provides grants to states to support child protective services (CPS) and community-based preventive services, as well as research, training, data collection, and program evaluation. (see <http://www.cwla.org/advocacy/2003legagenda09.htm> for more information).

How Can I Report Abuse?

Contact your local child protection or law enforcement agency. State laws

vary regarding who is a mandated reporter. If you need assistance with reporting or have questions about reporting abuse, contact ChildHelp USA's 24-hour hotline at 1-800-4-A-CHILD.

References:

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Appendix G: Division of Family and Children Services Information:

- **Mandated Reporting Letter**
- **Statewide Interim Differential
Response Protocol**
 - **Policy on Supervision**
- **Reports of Abuse and Neglect in
Public and Private Non-Residential
Schools**
 - **Definitions**



Date: XXXX XX, 2012

XXX Street
XXXX, Georgia XXXX

RE: XXX

Dear: XXXX

This notice acknowledges your report of possible abuse or neglect, received by this office on XXX. Thank you for your concern regarding the children of Georgia and your compliance with O.C.G.A. 19-7-5. We will not reveal your name to the subject of this report; however, if court action is necessary to protect the child, you may be subpoenaed to appear at the hearing. A reporter is protected from civil or criminal liability from any report made in good faith.

As a mandated reporter, at your request you may receive the Intake report disposition (Screen Out, Screen Out Refer to Early Intervention, Investigation, Family Support) and if the intake was assigned, the response time assigned and information concerning the case disposition.

Your report was processed as indicated below. If you have any questions, please contact the XXX County Department of Family and Children Services at XXX.

Sincerely,

Social Services Supervisor

Intake Disposition:

- Screen Out
- Screen Out Refer to Early Intervention
- Family Support
Response Time: Within 5 business days
- Investigation
Response Time: Immediate to 24 hours



Nathan Deal, Governor

Clyde L. Reese, III, Esq., Commissioner

Georgia Department of Human Services • Family & Children Services • Ron Scroggy, Director
Two Peachtree Street, NW • Suite 19-490 • Atlanta, GA 30303 • 404-651-8409 • 404-657-5105

July 2, 2012

Social Services County Letter No. 2011-09-UPDATED

To: County Departments of Family and Children's Services
DFCS Regional Offices
State Office Staff

From: Ron Scroggy, Division Director

Re: Statewide Interim Differential Response Protocol

Purpose

The purpose of this memorandum is to update the intake section of the statewide Differential Response Protocol.

Discussion

The statewide Differential Response Protocol was implemented on April 1, 2012. It is important to continually evaluate and assess our work during the transition and adjust practices in order to achieve outcomes related to working with families. The Differential Response Experts and Implementation team have evaluated feedback received from county staff.

Based upon the feedback, clarifications to the intake process in section A. **Guidelines 1. Intake** are being implemented in this update.

Implementation

Revisions to the Intake section of the protocol is effective upon receipt of this updated county letter.

Questions should be directed to the regional Differential Response Expert. Regional staff may direct questions to Angela Mock at almock@dhr.state.ga.us

Statewide Family Support Protocol

Aging Services | Child Support Services | Family & Children Services | Residential Child Care

An Equal Opportunity Employer

A. Guidelines

1. Intake

The intake stage is the first and may be the sole contact with the reporter. Since the assessment begins at the time of report, having information about the family functioning assists the department in making the proper track assignment and lays a foundation for the investigation/family support assessment. During this initial engagement the Intake Worker (IW) must obtain detailed and specific information on caregiver capacity, child vulnerability and family functioning to make an appropriate intake decision and ensure child safety.

A. Engage, Gather and Actively Explore the Reporter's concerns

In order to make the most appropriate intake decision the intake worker must conduct a diligent interview exploring the six family functioning components based upon the reporter's familiarity and knowledge of the children and family. After sufficiently engaging the reporter, apply the pertinent information to the six (6) family functioning assessment components to determine whether the agency needs to intervene or the reporter's concern meets department's threshold for intervention. The six (6) family functioning assessment components are the following:

1. The extent of the maltreatment
2. The circumstances surrounding the maltreatment
3. The child's day to day functioning
4. Parental and life skills management
5. Determining how caregivers parent generally
6. Determining how caregivers discipline the children

Note: It is not appropriate to ask the reporter the six (6) family functioning assessment components as questions or deliver verbatim. The IW must engage with the reporter probing their knowledge of the family to obtain information on the components.

B. Decision Making

After engaging with the reporter to gather all pertinent information of which they have knowledge, the IW must obtain other historical information about the family prior to making an intake decision to screen in or screen out the report. The IW must:

1. Conduct CPS Screenings and review findings as outlined in intake policy 2.3 Screening Case Participants.
2. Analyze all pertinent information obtained (reporter's concerns, CPS history and any additional relevant information) to determine if there is an allegation of maltreatment as defined by CPS Intake policy and Georgia statutes.

NOTE: Allegations of maltreatment are not always reflective of an incident that is occurring or has occurred. It may manifest itself in a threat of maltreatment which may or may not yet have occurred. (e.g.

a child born medically fragile and mom lacks capacity to care for the child). An allegation of maltreatment often is the result of a caregiver's inability or unwillingness to meet the basic needs of a child or to protect a child.

3. If an allegation of maltreatment is not identified, either Screen Out or Screen Out-Refer to Early Intervention/Prevention;
4. If an allegation of maltreatment is identified, apply pertinent information to the Safety Threat questions to determine track assignment (See attachment);
5. Assign the report to the Family Support track if an allegation of maltreatment is identified and no Safety Threat is indicated (there are no YES answers to any safety threat questions).
 - a. Prior to assigning the report for Family Support Services, the Intake Supervisor must review the report to verify that an allegation of maltreatment exists and there are no indications that a safety threat exists;
 - b. Reports assigned for Family Support Services will be a response time of up to five (5) work days. Response time is met when face-to-face contact is made with the primary caregiver, all household members and the present danger assessment is completed.
6. Assign the report to the Investigations track if an allegation of maltreatment **is** identified **and** there is an indication that a safety threat exists (the IW has answered YES to one or more safety threat questions).

NOTE: The Intake Worker is to assess for insufficient caregiver protective capacity, child vulnerability, and determine if a safety threat is indicated. The current location of a child should not be a sole factor in determining child safety. (e.g. a child being a patient in a hospital does not ensure safety nor can hospital staff be utilized as a strategy to ensure child safety)

Threat of Danger?
+
Vulnerable Child
-
Caregiver Protective Capacity
=
Unsafe

2. Family Support Case Assignments

The Family Support track is utilized when there is an allegation of maltreatment but the reporter does not allege that the child is in an unsafe situation. Families in this track demonstrate the ability to keep their child safe, therefore family participation in this track is voluntary. Family Support assessors must make every effort to engage the family to support them in identifying any areas where they may benefit from services to strengthen their caregiver capacity or support/enhance child well being. DFCS will encourage the caregivers to voluntarily engage in services.

- a. Home visits are required and contact must be made with all household members. Actively engaging with all household members is paramount to successful case management.
- b. All families who agree to receive Family Support Services must be assessed for present danger and safety threats during the initial home visit and throughout the life of the family support assessment process. A present danger assessment will be utilized as the initial safety assessment tool at the first face-to-face contact with the family.

NOTE: A present danger assessment is replacing our current safety assessment tool and will be distributed and explained at the regional supervisors meetings. It will be available in SHINES in June 2012. Please complete the present danger assessment tool in hard copy and upload in SHINES until such time it is available.

- c. A risk assessment will be completed on families who decline to participate in the family support track, any time prior to the completion of the present danger assessment at the initial home visit, to determine if the case must be looped to the investigation track.

NOTE: A newly developed risk assessment will be distributed and explained at the regional supervisors meetings. It will be available in SHINES in June 2012. Please complete the new risk assessment tool in hard copy and upload in SHINES until such time it is available.

- d. If the child is assessed as unsafe (identification of present or impending danger) at any point during the Family Support assessment process an in home or out of home safety plan must be immediately initiated to ensure child safety. The existing safety plan will be used to document the actions required to assure safety. The Family Support case will be immediately reassigned for Investigation.
- e. Family Support case management activities must reflect continuous, comprehensive assessment of safety and family functioning which must be documented using the guided narrative.
- f. Family Support case management activities must include pertinent and purposeful collateral contacts that can provide meaningful information about the family's functioning.

- g. Family Support case management will focus on identifying and evaluating the families' strengths (including caregiver protective capacity), support systems and their ability to identify and access needed services.
- h. DFCS must provide the caregiver with information and linkage to resources/providers within five (5) calendar days of the caregiver identifying areas where they could benefit from services to strengthen their parental capacity or child well being.
- i. The family assessment must be completed within 45 calendar days from the receipt of intake. The agency may maintain involvement with the family for an additional 15 days to ensure the family is linked with recommended services. DFCS should assist the family in identifying and removing barriers to service delivery. Family Support cases should be closed within 60 days from receipt of the intake report.
- j. All work conducted in Family Support cases, including service referrals and updates on the families progress, must be documented or uploaded in SHINES.

Reports That Must Be Investigated

Reports where maltreatment is alleged and the information presented by the reporter would leave a reasonable person to believe the child is safe are assigned for Family Support Services. While the new SRS is being implemented and staff gain greater competency around this approach, additional safeguards must be implemented to support sound decision making. Therefore, until further notice the following reports must be assigned for investigation:

1. Domestic Violence/Intimate Partner Violence (DV/IPV)
 - a. Reports that result in any of the following:
 - i. Injury to the caregiver, other adult or child;
 - ii. Child is present and unsafe; or
 - iii. Direct exposure of the child to the family violence or when the child attempts to intervene.
 - b. Caregiver is unwilling or unable to protect the child,
 - c. Weapons are used or their use is threatened, or
 - d. The reporter indicates the incidents of DV/IPV are frequent or severe in nature.

NOTE: The safety of the adult victim must be taken into account when investigating or assessing domestic violence cases therefore; the adult victim must be interviewed separately from the abuser.

2. Child death, serious injury or near fatality (CD/SI/NF) (policy 2104.3) where maltreatment of the deceased child is alleged. Reports must be assigned for investigation when maltreatment is alleged even if there are no surviving children.
3. Serious or life threatening medical neglect where the caregiver is the maltreater.

4. Sexual abuse when the alleged perpetrator has access to the alleged victim, access to the child is uncertain or the non-offending caregiver does not believe or protect the child.
5. Reports alleging Munchausen Syndrome By Proxy. Such reports cannot be assigned for Family Support Services without the county director or designee first consulting with the Collaborative Partners Section and obtaining approval for Family Support assessment.
6. New reports of maltreatment when the family has an active Family Support, Family Preservation or Permanency Case.

Reports Concerning Children in Foster Care/Open Foster Care Cases

No intake report involving the alleged maltreatment of a child in DFCS custody can be assigned to Family Support Services.

1. CPS reports alleging the birth of an infant to a mother who has a child currently in foster care must continue to be investigated per CPS Policy 2103.10.
2. CPS reports alleging the birth of an infant to a child in DFCS custody that contain allegations of safety threats must be assigned for investigation. Reports that do not contain allegations of safety threats are screened out and reported to the assigned Permanency SSCM for follow-up.
3. CPS reports alleging maltreatment of a foster child should be investigated as outlined in CPS Policy 2106 and therefore, are not appropriate for a Family Support response.
4. CPS reports received on a foster child that do not contain an allegation of maltreatment, but contain an allegation of possible violation of the DFCS foster child safety agreement or foster care policy violation should be assessed per FC Policy 1015.20 to 1015.35.

Worker Assignment

County directors, in consultation with their Regional Directors, must determine the SSCM skill level needed to assure appropriate family and community engagement in Family Support cases. Select the most appropriate SSCM staff to be assigned to complete Family Support cases.

B. Quality Reviews

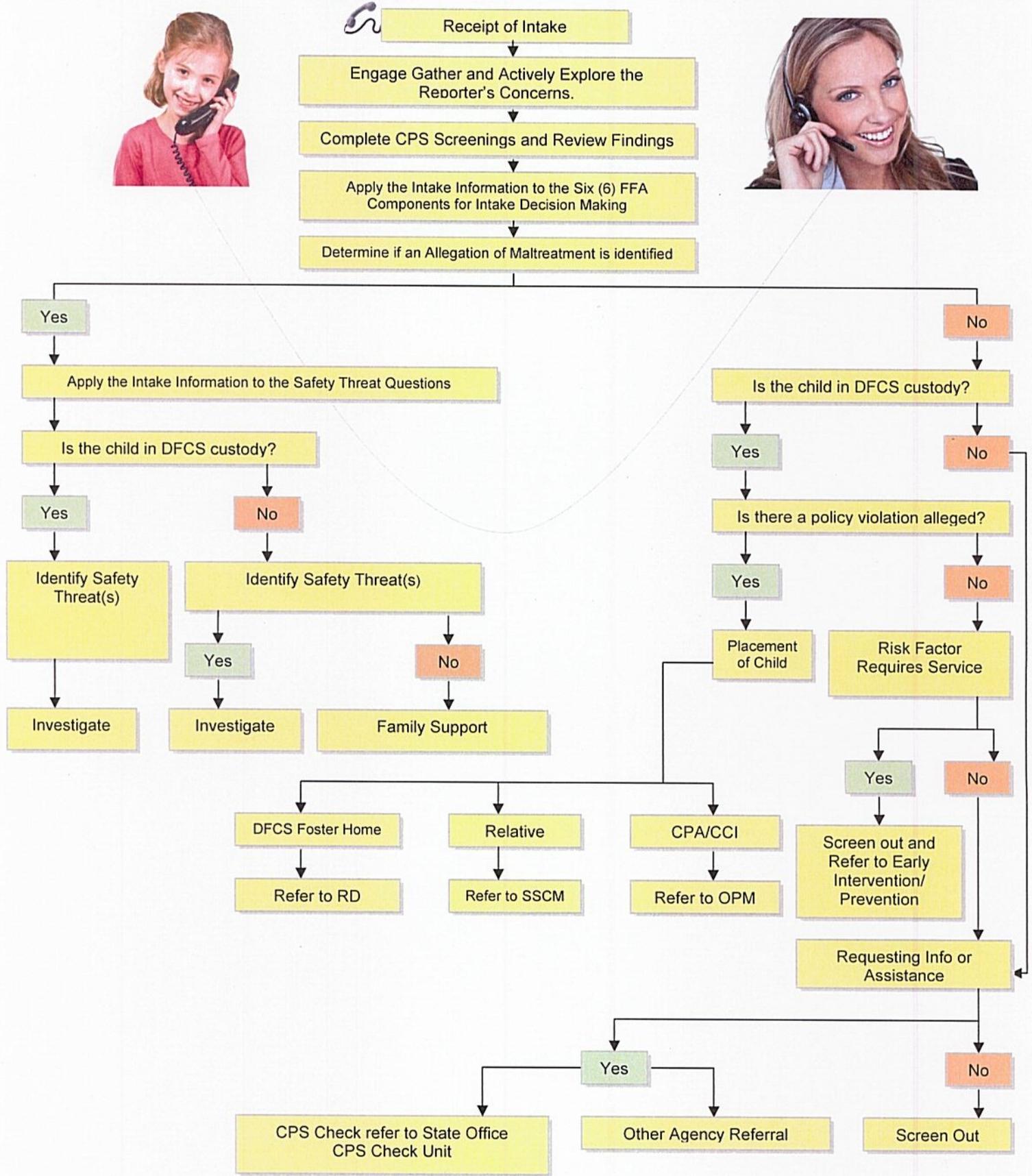
Random state reviews will be conducted to assess the decision-making process in the following areas:

1. Disposition of CPS Report
2. Allegation Coding of CPS Report
3. Assessment of Safety
4. Management of Safety Plans
5. Assessment of Needs of Family
6. Access to Services Verified

Policy questions should be directed to your Regional DR expert for follow up with the Practice and Policy Unit at PPDUnit@dhr.state.ga.us.

Attachments:
Making An Intake Decision Tree
Safety Threat Questions and Instructions

Making an Intake Decision



Revised June 19, 2012

Instructions for Use of Georgia Safety Threat Questions

1. The Intake CM will obtain sufficient information during the intake process then use the information to answer the Safety Threat Questions and the six (6) Family Functioning components. Do not ask the reporter the questions verbatim.
2. The Safety Threat Questions and the six (6) Family Functioning Assessment components will be utilized by the Intake CM after the conclusion of the contact with the reporter and if applicable in consultation with a supervisor.
3. Any **YES** response must meet the definition requirements.
4. Any **YES** responses to the Safety Threat Questions will be used in conjunction with the following FFA components to determine if safety threats may exist which will determine whether to assign the referral to Investigations or Family Support:
 - a. What is the extent of the maltreatment?
 - b. What are the circumstances surrounding the maltreatment?
 - c. What is the child's day to day functioning (e.g. routine, general behavior, physical capacity, temperament)?
 - d. What are the parental life management skills (e.g. feel, think, act on a daily basis related to coping skills, social skills, decision-making, problem solving, employment, self care, mental health, physical health)?
 - e. How does the caregiver parent generally?
 - f. How does the caregiver discipline the child (ren)?
5. Document a **summary** of the responses to the Safety Threat Questions and the six (6) FFA components that support the track assignment in the **Additional Comments** section of the Intake. **Do not** upload these questions in Shines external documentation.
6. The supervisor will review all information including the **Additional Comments** section of the intake to approve the track assignment.

Georgia Safety Threat Questions

1. Is the child extremely fearful of the home situation or people within the home?
2. Are one or both caregivers violent or dangerous?
3. Are one or both caregivers out of control (Caregivers mental/physical health, disability or lack of protective factors adversely effects their ability to provide for the safety and well being of their child; also includes caregivers that are currently or have a history of parenting when intoxicated or while under the influence of alcohol, prescription or illegal drugs)?
4. Are one or both caregivers in the home unable or unwilling to perform their parental duties or responsibilities?
5. Do one or both caregivers have; extremely unrealistic expectations (given the child's age or level of development), extremely negative perceptions of the child or is their viewpoint of the child bizarre?
6. Do one or both caregivers fear they will maltreat the child or are they requesting the child be placed out of home?
7. Is the child's living conditions life threatening? Are the child's physical living conditions hazardous, does the living environment present a situation of substantial or imminent harm to the child?
8. Is the caregiver unable or unwilling to meet the child's immediate need for food, clothing, shelter or medical care where the absence of these necessities is creating substantial or imminent threat of harm?
9. Are one or both caregivers unable or unwilling to explain the child's injuries and/or condition?
10. Has the child sustained a serious injury due to the action or inaction of one or more caregiver?
11. Has the child been left unsupervised for extended periods of time (Caregiver has not, will not or cannot provide sufficient supervision to protect the child form substantial or imminent threat of harm)?
12. Do we believe the family will flee/hide child?
13. Do one or both caregivers lack parenting knowledge, skills or motivation essential to protect the child?
14. Does the child have exceptional needs which the caregivers cannot or will not meet?
15. Is the caregiver impaired due to victimization from domestic violence/intimate partner violence; caregiver lacks the capacity to protect the child and is without supports?
16. Has the death of a sibling or other child in the household occurred due to abuse/neglect or uncertain circumstances?

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2104.4 Lack of Supervision

Discussion

Use the following guidelines for determining the level of neglect that exists when children are alone without adult supervision.

- Children eight years or younger should not be left alone;
- Children between the ages of nine years and twelve years, based on level of maturity, may be left alone for brief (less than two hours) periods of time; and,
- Children thirteen years and older, who are at an adequate level of maturity, may be left alone and may perform the role of babysitter, as authorized by the parent, for up to twelve hours.

These guidelines pertain only to children who are not in the department's custody. Situations involving children for whom the department has placement responsibility are governed by foster care requirements.

Procedures/Practice Issues

There are sometimes circumstances where an unsupervised older child is at risk or where a younger child has the maturity level to be left alone or to care for other children. Some examples are:

- It may not be advisable to leave an older child who has a special condition or disability alone. Discuss individual case situations with the supervisor.
- Consideration may be given to a child younger than 13 years, who exhibits strong maturity skills and has participated in a course on babysitting, to be alone or to care for other children. Verify that the child participated in the skills class and discuss with the supervisor to determine if a neglectful situation exists. Suggested questions to ask are:
 - Does the child know the emergency plan for the family?
 - Does the child know the parent's phone numbers (work and home)?
 - Can the child demonstrate the plan and recite the numbers?
 - What is the availability of the parent during this time?

X Are there environmental factors that add further risk to the situation?

Child Protective Services: Investigation

X Are there factors that reduce risk, i.e. supportive/available neighbors?

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Reports of Abuse and Neglect in Public and Private Non-Residential Schools

2106.29 Introduction

DFCS has the authority and responsibility for accepting reports of suspected abuse and neglect of children by school personnel in public and private non-residential schools. There is a fundamental difference between public and private schools in the State of Georgia:

- **Public non-residential schools** are under the oversight of the Department of Education (DOE), but are administered by area, county, or independent boards of education.

All area, county, and independent boards of education are authorized by law to adopt written policies which authorize school principals and teachers employed by such boards to use corporal punishment, in the exercise of their sound discretion, on a pupil in order to maintain proper control and discipline. (See [O.C.G.A. 20-2-731](#))

The authorization to use corporal punishment is subject to the following requirements:

- Corporal punishment shall not be excessive or unduly severe; (See [O.C.G.A. 20-2-731\(1\)](#).)
- Corporal punishment shall never be used as the first line of punishment for misbehavior unless the pupil was informed beforehand that specific misbehavior will result in its use; however, corporal punishment may be employed as a first line of punishment for those acts of misconduct which are so "antisocial or disruptive in nature as to shock the conscience;" (See [O.C.G.A. 20-2-731\(2\)](#).)
- Corporal punishment must be administered in the presence of a principal, assistant principal, or their designee employed by the board of education authorizing the punishment and another principal, assistant principal, or their designee must be informed beforehand and in the presence of the pupil of the reason for the punishment; (See [O.C.G.A. 20-2-731\(3\)](#).)

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- The principal or teacher administering the corporal punishment must provide the child's parent, upon request, a written explanation of the reasons for the punishment and the name of the principal, assistant principal, or their designee who was present; however, that explanation shall not be used as evidence in any subsequent civil action brought as a result of the corporal punishment; (See O.C.G.A. 20-2-731(4).) and
- Corporal punishment shall not be administered to a child whose parent or legal guardian has, upon the day of enrollment of the pupil, filed with the principal a statement from a licensed medical doctor in Georgia stating that it is detrimental to the child's mental or emotional stability. (See O.C.G.A. 20-3-731(5).)

If the parent/legal guardian/legal custodian believes that corporal punishment was administered to their child outside established policies, the parent should seek recourse through the school principal and ultimately the school board.

See [Appendix F](#) for excerpts of [O.C.G.A. 20-2-730](#), [O.C.G.A. 20-2-731](#), and "Punishment not excessive as matter of law" [Maddox v. Boutwell, 176 Ga.App. 492, 336 S.E.2d 599 (1985)].

- **Private non-residential schools** are not licensed, regulated or certified by any public agency and do not have to meet the same state standards or laws governing public non-residential schools. Private non-residential school administrators set internal policies and discipline methods for private schools. When parents entrust the care of their child to a private non-residential school, they grant those administrators the same rights to discipline their child as the child's parent has.

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2101.5 Definitions

Abandonment

This occurs when a parent, stepparent, guardian, custodian or other person in control of or having responsibility for a child leaves a child unattended or in someone's care with no intention to return to assume care and responsibility for

the child. Examples of abandonment includes leaving a baby with a stranger, leaving a baby in a garbage can, leaving a child with no apparent intention to return or refusing to cooperate with the department to have a child returned to one's care.

Assessment

The process of assessment includes all activities and documentation, which focuses not only on the incident and risk of maltreatment, a family's strengths, and needs and the conditions or behaviors that need to change. The focus is to ensure protection and safety to children and to understand the risk to a child. Once safety is ensured, it is necessary to examine the origin and the extent of the maltreatment and to determine the family's ability to make changes that will eliminate or significantly reduce future risk of repeated maltreatment.

Battered Child:

A child upon whom multiple, continuing, often serious non-accidental injuries have been inflicted.

Berube, M. (2002) The American Heritage Stedman's Medical Dictionary, Boston, New York: Houghton Mifflin Co.

Battered Child Syndrome

A combination of continuing, often serious physical injuries, such as bruises, scratches, hematomas, burns, or malnutrition, inflicted on a child through gross abuse usually by parents, guardians, or other individuals.

Berube, M. (2002) The American Heritage Stedman's Medical Dictionary, Boston, New York: Houghton Mifflin Co.

Caretaker

This is a parent, guardian, foster parent, employee of a public or private residential home or facility or a day care facility, personnel of public and private schools or any other person often found in the same household or caretaking unit for a child (e.g. boyfriend/girlfriend, stepparent, adoptive parent).

- **Primary** caretaker: The adult (typically the parent) living in the household who assumes the most responsibility for childcare.
- **Secondary** caretaker: An adult living in or often in the household who has routine responsibility for childcare, but less responsibility than the primary caretaker. A significant other may be a secondary caretaker even though this person has minimal childcare responsibility.

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Case Determination

This is the finding upon the completion of a CPS investigation of either substantiated or unsubstantiated.

Child

This is any person from birth through seventeen years old.

Child Abuse means (O.C.G.A.19-7-5):

- Physical injury or death inflicted upon a child by a parent or caretaker by other than accidental means; provided however, physical forms of discipline may be used as long as there is no physical injury to the child;
- Neglect or exploitation of a child by a parent or caretaker;
- Sexual abuse of a child; or
- Sexual exploitation of a child.
- However, no child who in good faith is being treated solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered to be an "abused" child.

Contributing Factors

These include, but are not limited to, such issues as substance abuse, domestic violence, mental illness and unemployment. Contributing factors may also exist within the community and include inadequate housing, poor access to resources, crime, and other factors.

Control

The ability to manage immediate safety threats, which place a child in danger of serious harm.

Corporal Punishment

This is any physical punishment of a child to inflict pain as a deterrent to wrong doing. It may produce transitory pain and potential bruising. If pain and bruising are not excessive or unduly severe and result only in short-term discomfort, this is not considered maltreatment.

Credible Information

A safety assessment standard used to help evaluate the presence of safety factors based on known facts (present or history) and/or reasonable belief.

Critical Thinking

A disciplined process of actively and skillfully conceptualizing, applying, analyzing, synthesizing and/or evaluating information gathered from or generated by, observation, experience, reflection, reasoning, or communication as a guide to belief and actions.

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Deprived Child means (O.C.G.A. 15-11-2):

- Without proper parental care or control, subsistence or education as required by law, or without other care or control necessary for the child's physical, mental or emotional health or morals;
- Placed for care or for adoption in violation of the law;
- Abandoned by parents or other legal custodian;
- Is without a parent, guardian or custodian; and,
- No child who in good faith is being treated solely by spiritual means through prayer in accordance with the tenets and practices of a recognized church or religious denomination by a duly accredited practitioner thereof shall, for that reason alone, be considered a "deprived child."

Discipline

By design it is to help children control and change their behavior. The purpose is to encourage moral, physical and intellectual development and a sense of responsibility in children. Through appropriate discipline children learn to rely on their own resources, gaining self-confidence and a positive self-image.

Early Intervention Services

This is a voluntary family support program available to screened out CPS referrals, unsubstantiated closed CPS cases and substantiated risk controlled and closed CPS cases. It provides preventive services to families in need of brief intervention before they need CPS services, and to alleviate risk factors. Intervention services may also be provided to families whose CPS case is being closed to assist them with the transition from involvement with the department to functioning on their own.

Emotional (Psychological) Deprivation

This is a form of deprivation to a child under the age of eighteen years that may result in impaired psychological growth and development. It frequently occurs as verbal abuse or excessive demands on a child's performance and results in the child having a negative self image and disturbed behavior. It is usually a persistent and chronic pattern of behavior toward a child; not a one-time, isolated incident. It may occur with or without other forms of abuse or neglect. The Juvenile Court (O.C.G.A. 15-11-2) recognizes that parental care or control is necessary for a child's mental or emotional health. The Crimes Against Family Members Act of 1999 (O.C.G.A. 16-5-70) provides for the offense of cruelty to children when a person intentionally allows a child under eighteen years to witness family violence by seeing or hearing the act.

Factitious Disorder by Proxy (FDP)

The essential feature is the deliberate production or feigning of physical or psychological signs or symptoms in another person who is under the individual's care. Typically, the victim is a young child and the perpetrator is the child's mother. The motivation for the perpetrator's behavior is presumed to be a psychological need to assume the sick role by proxy. Life stressors, such as

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chronic family dysfunction, may be present. They are often unresponsive to their children when they are unaware of being observed.

American Psychiatric Association. (2000) Diagnostic and Statistical Manual of Mental Disorders, (4th ed., text revision). Arlington, VA.

Family Plan

This is a written agreement that defines those actions that will allow a family to achieve a level of functioning, ensures protection and safety of children and eliminates, or significantly decreases, the risk of maltreatment. It includes developing measurable and specific outcomes directly related to the maltreatment and to risk reduction. Outcomes/goals are broken down into specific steps with time frames for accomplishment and review.

Family Plan Goals

These are behaviorally stated actions that a person agrees to perform to reach the anticipated case plan outcome. Goals are specific, behavioral, positively stated, **measurable** and written in clear and simple language.

Family Plan Steps

These are the specific activities necessary to meet case plan goals. They outline who will do what, when, how often and where.

Family Violence

This is the occurrence of any felony, battery, assault, stalking, criminal damage to property, unlawful restraint or criminal trespass between past or present spouses, persons who are parents of the same child, parents and children, stepparents and stepchildren, foster parents and foster children, or other persons living or formerly living in the same household. The term "family violence" shall not be deemed to include reasonable discipline administered by a parent to a child in the form of corporal punishment, restraint or detention (O.C.G.A. 19-13-1).

Failure to Thrive Syndrome

Failure to thrive is a description applied to children whose current weight or rate of weight gain is significantly below that of other children of similar age and sex. Infants or children that fail to thrive seem to be dramatically smaller or shorter than other children the same age. Teenagers may have short stature or appear to lack the usual changes that occur at puberty.

U.S. National Library of Medicine, National Institutes of Health, U.S. Department of Health and Human Services (2008) Medline Plus, Bethesda, MD. See <http://www.nlm.nih.gov/medlineplus/ency/article/000991.htm>

Fetal Alcohol Syndrome

A complex of birth defects including cardiac, cranial, facial, or neural abnormalities and physical and mental growth retardation, occurring in an infant due to excess alcohol consumption by the mother during pregnancy.

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Berube, M. (2002) The American Heritage Stedman's Medical Dictionary, Boston, New York: Houghton Mifflin Co.

Foreseeable Future

Reasonable anticipation or expectation of an event or occurrence to come.

Homestead Services

This is the department's most intensive family preservation service. It is a contracted service. It is a family focused, crisis-oriented, short-term (180 day), intensive in-home counseling program for families with children at risk of foster care placement. Homestead services may also be provided to families who are ready for reunification.

Immediate

Not separated in time, acting or happening at once, next in order.

Information and Referral (I & R)

This is a disposition to a request for information. It is not a report of abuse/neglect. Information is provided or a referral is made to available resources. Internal Data System and Child Abuse/Neglect Worksheet are not completed.

Judgment

Opinions based on facts and the case mangers interpretation of the facts.

Lack of Supervision

This occurs when a parent fails to provide needed supervision or temporarily leaves a child alone or in the care of others who themselves are incapable of providing care. This situation is qualified by the age and capability of the child and the circumstances in which the child is left.

Maltreatment

This refers to one or more forms of neglect, abuse or exploitation. It may be used as a general term or in reference to a specific category such as neglect, physical abuse, emotional neglect, medical neglect, emotional abuse, sexual abuse, exploitation or exposure to family violence.

Mandated Reporter

This is a person required to report known or suspected child abuse, neglect or exploitation under penalty of law for failure to report. Mandated reporters include physicians, osteopathic physicians, interns, residents and other hospital personnel, dentists, psychologists, podiatrists, nursing personnel, social work personnel (including all DFCS professional staff), school teachers and administrators, school guidance counselors, child care personnel, day care personnel, law enforcement personnel, child counseling and child service organization personnel. (O.C.G.A. 19-7-5)

Medical Neglect

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This is a form of neglect involving the absence or omission of essential medical care or services, causing harm or seriously threatening harm to the physical or emotional health of a child younger than eighteen years. It includes the withholding of medically indicated treatment for disabled infants with life-threatening conditions.

Munchausen Syndrome

A psychological disorder characterized by the repeated fabrication of disease symptoms for the purpose of gaining medical attention.

Berube, M. (2002) The American Heritage Stedman's Medical Dictionary, Boston, New York: Houghton Mifflin Co.

Monitoring

The active evaluation of safety threats and protective capacities to assure that a child is not in present danger.

Neglect

Failure of a parent/caretaker to provide adequate food, clothing, shelter, medical care, supervision or emotional care for child to whom they are responsible. Physical injury to a child may occur when appropriate actions by a parent/caretaker are not taken.

Parent Aide Services

These are para-professionals contracted by the department to work as team members with case managers to provide support services to families. Any family referred to social services is eligible for Parent Aide services. Parent aides assist with parenting skills, discipline, home management, budgeting, food and nutrition education and meal preparation. Families with active social services cases may receive up to twelve months of parent aide services. Families screened out for CPS or whose cases are closed by the department may receive short-term preventive services.

Physical Abuse

This is physical injury or death inflicted or permitted to be inflicted, upon a child, by a parent/caretaker by other than accidental means (O.C.G.A. 19-7-5). It is the willful infliction of physical injury or suffering which often occurs in the name of discipline or punishment and may range from the use of the hand to the use of objects.

Physical Injury

This is bodily harm or hurt such as bruises, welts, fractures, burns, cuts or internal injuries but excluding mental distress, fright or emotional disturbance. When corporal punishment is involved, the severity of injuries will determine whether the situation is deemed physical abuse.

Preponderance of Evidence

Based on the evidence, it is more probable than not that an event occurred. Considering all available evidence, the evidence that an event occurred is of

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greater weight or is more convincing than the evidence provided that the event did not occur.

Present Danger

The likelihood of immediate and serious harm to a vulnerable child precipitated by one or more safety threats and/or missing or insufficient protective capacities.

Prevention of Unnecessary Placement Services (PUP)

This is a resource for the purchase of support services for families with children at **imminent** risk of placement or with children ready for reunification from foster care. By purchasing services such as emergency housing, food, clothing and therapy in combination with social services support, families can frequently be kept intact with children safely remaining in the home. As a result, both the trauma and the expense surrounding placement is often avoided. Provision of these services may be necessary as part of the reasonable efforts required to avoid placement of children. (See 2107 for eligibility criteria)

Protective Capacities

Family strengths or resources that reduce control and/or prevent threats of serious harm from arising or having an unsafe impact on a child and enable a caregiver to meet the child's basic needs.

Protective Services Data System (PSDS)

This is the state's system for identifying and locating prior reports of child abuse and for meeting both state and Federal reporting requirements on all cases investigated for alleged maltreatment of children.

Prospective Safety

The extent to which safety threats have been resolved or diminished to a level that accessible family protective capacities assure the future safety of a child.

Reasonable Cause

There is a suspicion founded upon circumstances sufficiently strong to warrant a reasonable person to believe that something is true.

Response Time

This refers to the time frame between receipt of a report of maltreatment and the first contact with children alleged to be maltreated. Depending on the severity of the report, response time is immediate to twenty-four (24) hours or five (5) working days.

Risk Assessment

This refers to the process used to identify the elements of individual and family functioning to determine whether a reasonable likelihood exists that children in the home will be abused or neglected in the foreseeable future

Risk

This is the reasonable likelihood that future maltreatment will occur.

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Safe

There are no imminent threats of serious harm stemming from caretakers' actions or inactions or the accessible protective capacities of the family are able to prevent these actions or inactions.

Safety

This is the absence of immediate risk of harm to a child, based on current conditions.

Safety Assessment

A decision-making and documentation process conducted in response to a child abuse and/or neglect report or any other instances in which safety needs to be assessed throughout the life of the case to help evaluate safety threats, present danger, child vulnerability, family protective capacities, and to determine the safety response.

Safety Factors

These are the major problems in need of immediate control to ensure that a child is protected and safe.

Safety Threat

Acts of conditions that have the capacity to seriously harm any child.

Safety Plan

This is a plan which identifies responses that are necessary to ensure a child's protection and safety. It is completed during investigation.

Safety Response

An intervention designed to control a safety threat or supplement missing or insufficient protective capacities required when the protective capacities of the family cannot manage immediate and serious threats of harm to any child.

Safety Plan Review

A structured review to support and document decisions to modify, maintain or discontinue an existing safety plan, including a review of changes in protective capacities and child vulnerability, and progress towards resolving safety threats.

Safety Steps

These are the specific activities that address the identified safety factors. They outline who will do what, when, how often and where, for the purpose of meeting each identified safety factor. There may be several safety steps for each identified factor.

Screened-Out Referral

This is a report to CPS that does not contain the components of a CPS report (See 2103.18). The report is logged, documented on Child Abuse/Neglect Worksheet) and an IDS form (Internal Data System) is completed. A referral to available resources may be made.

Serious Injury

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This is an injury such as bodily injury that involves substantial risk of death, extreme physical pain, disfigurement or protracted loss or impairment of the function of a body part, organ or mental capability. Examples include head trauma, blunt trauma, internal bleeding, multiple bruising and contusions, laceration of organs and amputation.

Sexual Abuse

This is a form of child abuse in which any of nine specific behaviors occur between a child under the age of eighteen years and the parent or caretaker and during which the child is being used for the sexual stimulation of that adult or another person. Sexual abuse shall not include consensual sex acts involving persons of the opposite sex when the sex acts are between minors or between a minor and an adult who is not more than three years older than the minor. However, sexual abuse may be committed by a person under the age of eighteen years when that person is either significantly older than the victim or when the abuser is in a position of power or control over another child. Alleged sexual abuse by an extra-familial perpetrator must be evaluated on the basis of parental approval or the lack of parental supervision (O.C.G.A. 19-15-1).

The nine specific behaviors (O.C.G.A. 19-7-5) are:

- (1) Sexual intercourse, including genital-genital, oral-genital, anal-genital or oral-anal, whether between persons of the same or opposite sex;
- (2) Bestiality;
- (3) Masturbation;
- (4) Lewd exhibition of the genitals or pubic area of any person;
- (5) Flagellation or torture by or upon a person who is nude;
- (6) Condition of being fettered, bound or otherwise physically restrained on the part of a person who is nude;
- (7) Physical contact in an act of apparent sexual stimulation or gratification with any person's clothed or unclothed genitals, pubic area or buttocks or with a female's clothed or unclothed breasts;
- (8) Defecation or urination for the purpose of sexual stimulation; or
- (9) Penetration of the vagina or rectum by any object except when done as part of a recognized medical procedure.

Sexual Exploitation (O.C.G.A. 19-7-5)

This is a form of maltreatment in which a child's parent or caretaker allows, permits, encourages or requires a child under the age of eighteen years to engage in sexual acts for the stimulation and/or gratification of adults or in prostitution as defined by law (O.C.G.A. 16-6-9), or allows, permits, encourages or requires a child to engage in sexually explicit conduct for the purpose of producing any visual or print medium (O.C.G.A. 16-12-100).

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Shaken Baby Syndrome

A syndrome in infants in which brain injury is caused by shaking of such violence that the child's brain rebounds against the skull, resulting in bruising, swelling, and bleeding of the brain and often leading to permanent, severe brain damage or death.

Berube, M. (2002) The American Heritage Stedman's Medical Dictionary, Boston, New York: Houghton Mifflin Co

Signs of Danger

Observable indicators of danger.

Substance Abuse

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

1. recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home;
2. recurrent substance use in situations in which it is physically hazardous;
3. recurrent substance-related legal problems;
4. continued substance use despite persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance.

American Psychiatric Association. (2000) Diagnostic and Statistical Manual of Mental Disorders, (4th ed., text revision). Arlington, VA.

Substantiated

An investigation disposition by a CPS investigator concludes, based on a preponderance of evidence collected, that the allegation of maltreatment as defined by state law and CPS procedure requirements is true.

Sudden Infant Death Syndrome (SIDS)

A fatal syndrome affecting apparently healthy sleeping infants under a year old and that is characterized by a sudden cessation of breathing.

Berube, M. (2002) The American Heritage Stedman's Medical Dictionary, Boston, New York: Houghton Mifflin Co.

Supplementation

The addition of additional protective capacities to the family system without removal of the child.

Third Party

This is someone outside the home that is not in a caretaker role with a child (See 2103.18).

Underlying Conditions

Underlying conditions refer to the needs of individual family members, perceptions, beliefs, values, feelings, cultural practices, and or previous life

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experiences (including learned behavior) that influence the maltreatment dynamic within a family system.

Unsafe

Caretaker's actions or inactions present imminent threats of serious harm to a vulnerable child and the family's accessible protective capacities are insufficient to prevent these actions or inactions.

Unsubstantiated

An investigation disposition by an abuse investigator concludes that, under state law and CPS procedure requirements, there is either no evidence or the allegation of maltreatment was not supported by a preponderance of evidence.

Vulnerability

The degree to which a child cannot avoid, negate or modify the impact of safety threats or missing or insufficient protective capacities.

Vulnerability Reduction

Alterations to a child's behavior or condition that lessen the likelihood of a child being a target of maltreatment.

Appendix H: Resource List

Concrete Support in Times of Need Resource List

Housing

The **Georgia Department of Community Affairs (DCA)** is the main government agency that addresses housing issues. State budget changes may impact availability of these services. You may want to check in with **Voices for Georgia's Children** to see if any relevant budget items or legislation has passed after each legislative session.

www.dca.state.ga.us www.georgiavoices.org

The **Housing Choice Voucher Program**, also known as Section 8, is rental assistance for low-income individuals and families. The DCA has a link to check the status of waiting lists in your area. In order to keep this housing “decent, safe, and sanitary” there may be serious consequences for illegal activities that individuals should be aware of. Tenants are responsible for any activities in their homes even of guests.

Participants in the Voucher Program must maintain a high level of communication with DCA. For instance, participants are also required to notify DCA and the landlord if the head of household will not be in the unit for more than 14 days. They must be told in writing within 30 days about the birth, adoption or custody of a child. They must be notified of any household members are no longer in the home or if there are any changes to family composition or income. Adult occupants must be approved before taking up residence. Residence is considered established if someone is there more than 50% of the time or uses the mailing address in any way. Individuals not comfortable with these and many other requirements of this subsidized housing should keep that in mind before applying. www.dca.state.ga.us/housing/RentalAssistance/programs/hcvp_program.asp

The **Georgia Dream Home Ownership Program** is primarily for first time home buyers, although those who have not owned a home in the past three years and in targeted areas (your chance of being in a targeted area increases the further south and west you are) also qualify. There are income and home price limits, but they are fairly inclusive. Income requirements are a bit higher in counties near metropolitan Atlanta at the income limit of \$71,000 for a one or two persons and \$82,000 for three or more persons. The Atlanta Metro maximum sales price is \$250,000. The Metro Atlanta area is defined roughly by Dawson in the north, Heard in the west, Lamar in the south, and Barrow in the east. For everywhere else, it's \$61,000 for one to two people and \$70,000 for three or more. The maximum home sales price is \$200,000. There are also multiple down payment assistance options. Like just about any assistance with home ownership, home buyer education is required.

<http://www.dca.state.ga.us/housing/Homeownership/programs/GeorgiaDream.asp>

For the other end of the spectrum, you may be trying to help a family with basic shelter. DCA has a **Homeless Assistance Directory**. It can become familiar with options in your area before you need to refer someone. Cultivating a contact at the organization that seems most relevant to the population you serve would be ideal.

<http://www.dca.state.ga.us/housing/SpecialNeeds/index.asp>

HomeSafe Georgia, previously titled the Georgia Hardest Hit Fund, is for homeowners who have experienced job loss or a substantial decrease in income. It is a lengthy process, but there are some shortcuts if you are already in foreclosure. It is also a process that can be done almost exclusively online or over the phone if transportation is an issue. www.homesafegeorgia.com

Concrete Support in Times of Need Resource List

The **Georgia Initiative for Community Housing** (“Initiative” or “GICH”) offers communities a three-year program of collaboration and technical assistance related to housing and community development. The objective of the Initiative is to help communities create and launch a locally based plan to meet their housing needs.

<http://www.fcs.uga.edu/hace/hdrc/gich>

Cynthia Harrison
Community Initiatives Coordinator
Office of Special Housing Initiatives
(404)502-6176
(404)679-0669 fax

Transportation

The **Clean Air Campaign** website has a commute calculator to help individuals weigh their options. It also offers financial incentives for changing the way you get to work. It has information on employers who support alternatives like flex hours and carpooling, how to educate employers, and tax benefits. It does not just apply to the Metro Atlanta area. The Clean Air Campaign is now working with government agencies, employers, schools and residents in Athens-Clarke County, Central Savannah River Area (CSRA), Chattahoochee Valley, Northwest Georgia, and Middle Georgia. Commuters who carpool, vanpool, bike, or use transit and are unable to catch their normal ride home due to unexpected events (illness, unscheduled overtime, etc.) can receive a free Guaranteed Ride Home from The Clean Air Campaign or RideSmart. www.cleanaircampaign.org
ridesmart.myridesmart.com

Thanks to the proliferation of the internet, it is much easier to find the critical mass for **carpooling**. Ridesmart and eRideShare.com are listed on the resource sheet in your handouts. It is still easier to do in larger cities, particularly near Atlanta, but if you can find a way to access lots of people in your area, your facility could help to create cooperative options for transportation. ridesmart.myridesmart.com eRideShare.com

Zipcar is a car sharing service available in Atlanta and Columbus. You become a member and reserve a car when you need a vehicle paying by hour or day. You pick up the car from a reserved spot and return it there when you are done. www.zipcar.com

Park and Ride Lots are another tool to aid in the carpooling or vanpooling options. There are lots in 63 counties around the state.
www.dot.state.ga.us/travelingingeorgia/Pages/ParkRide1.aspx

Food

Georgia’s **Women, Infants and Children (WIC) program** is the fifth largest in the country. It provides nutrition, education, and supplemental foods to low income families. Women, infants, and children in families with income at or below 185 percent of the federal poverty level are eligible. That would be at or below \$41,351.20 for a family of four. The benefits are for women who are pregnant, postpartum, or breastfeeding. Children under the age of 5 are also eligible. wic.ga.gov

Concrete Support in Times of Need Resource List

Child nutrition programs provide free and low-cost food to adult and child care organizations, shelters, “at risk” afterschool programs, preschool and schools. School lunch and breakfast in particular are working to improve the nutritional content. The income requirements vary. For reduced price meals income must be below 185% FPL, but for free meals it must be below 130%.
www.fns.usda.gov/cnd/care/CACFP/aboutcacfp.htm

Food stamps help to pay for the cost of food. The program also strives to help low-income households make healthier eating and lifestyle choices. It has a more complicated formula for eligibility than some of the other assistance programs in this list. There is an income requirement, 130% of the FPL, but your rent or mortgage, utilities, medical care, child care, and child support payments are considered in your eligibility. Also, any assets like bank accounts and your vehicle may disqualify you from benefits. compass.ga.gov

Food banks collect, inventory, and evaluate donated food. Then it is distributed through partner agencies. Partner organizations include: food pantries, youth programs, senior centers, community kitchens, day care centers, night shelters and rehabilitation centers. The Georgia Food Bank Association is part of the Feeding America national network of food banks and through its members feed an impressive one in eight Georgians in 2010. This resource is on your handout. It's a great way to find identify local food banks. georgiafoodbank.com

According to the United States Department of Agriculture (USDA), “[t]he number of **farmers markets** has more than tripled in the past 15 years and there are now more than 6,100 around the country.” Local and regional markets help farmers get a higher return on their produce. The markets also provide some variety, particularly fresh produce, where the access may be limited. Many local farmers’ markets have the capacity to accept EBT food stamps, and some even have bonus incentives to attract those customers. www.usda.gov/wps/portal/usda/usdahome?navid=KYF_MISSION

Childcare

The **Childcare and Parent Services (CAPS)** program subsidizes childcare costs for low income families. The program is for children up to the age of 13, but some special needs children may qualify up to age 18. Eligible families may choose where their child receives child care, including center or home-based care.

Quality Care for Children is a great resource for parents to find quality care by calling their help line, 877-ALL-GA-KIDS. Parents using informal child care, for whatever reason, should be given tools to be educated about what makes a safe and nurturing environment for his or her child. Qualitycareforchildren.org has a great Family, Friend, and Neighbor checklist. Check out their website for that and other great handouts for your parents. Qualitycareforchildren.org

Bright from the Start: Georgia Department of Early Care and Learning (Bright from the Start) is the government entity that oversees licensing, professional standards, multi-agency collaborations, federal aid to programs, and technical assistance to organizations that provide for the early child care and early education need of children in Georgia. dec.al.ga.gov

Concrete Support in Times of Need Resource List

The National Association for the Education of Young Children (NAEYC) is a membership organization for professionals serving the needs of children birth through 8 years of age. NAEYC provides accreditation that ensures high quality care that supports optimal development and safety. Naeyc.org

The **Georgia Association on Young Children (GAYC)** is an important resource for those seeking NAEYC accreditation and other support for quality care. Their mission is to increase public awareness of the importance of early childhood education and to improve the quality of programs for young children through learning opportunities for early childhood educators. Gayconline.org

Healthcare

PeachCare for Kids™ is comprehensive healthcare coverage for children in families where the income is less than 235% of the Federal Poverty Level (currently around \$43,546 a year for a family of three or \$52,523 for a family of 4). It is free for children under the age of 6. The cost per month for an older child's coverage is \$10 to \$35 and a maximum of \$70 for two or more children living in the same household. PeachCare covers everything a good insurance plan would cover including preventative services, primary care, dental, vision, drugs and mental health. You can apply for PeachCare for Kids™ online. They give a number, but it's clear that they prefer you use the website as much as possible. www.peachcare.org

Planning for Healthy Babies (P4HB) is a program to address the growing issue of low birth weight and very low birth weight (VLBW) babies. This program is particularly interested in helping mothers make healthier choices including spacing births further apart. Participants receive primary care and family planning services. Between pregnancies, women who have given birth to low birthweight babies can get other services like substance abuse treatment, limited dental services, and prescription drugs for the treatment of chronic diseases.

dch.georgia.gov/00/channel_title/0,2094,31446711_165928655,00.html

Medicaid is defined on the Department of Community Health website as simply “a medical assistance program that helps many people who can't afford medical care pay for some or all of their medical bills” (Accessed July 21, 2011). However, if your only qualification is low income, you must have very little income (\$424 per month for a family of three). For instance, someone living on unemployment would most likely be well over the limit. However, if you are a child, teenager, adult over 65, blind, disabled, or need nursing home care; Medicaid is an excellent option. It also can be a requirement for other programs to be in Medicaid. Pregnant women can even get same-day service when applying so that prenatal care for mother and baby can start right away. There are two notable exceptions. If you are coming off of Temporary Assistance for Needy Families or if you have significant medical debt, you may qualify for assistance through Medicaid. dch.georgia.gov/00/channel_title/0,2094,31446711_166523306,00.html

The **Georgia Volunteer Health Care Program** supports free clinics and healthcare providers around the state. You can find a list of these clinics by city on the Georgia Department of Community Health website. One concern is that you are far more likely to find a free clinic in higher density, urban areas of the state, and there are only two in the southwest part of Georgia.

dch.georgia.gov/00/channel_title/0,2094,31446711_84265607,00.html

Concrete Support in Times of Need Resource List

The **Rx Outreach Program** helps individuals get generic medications. This program is for all ages, uninsured, underinsured, and those having limited prescription drug coverage. The income limit is \$50,000 for a family of four. They ship your medications to you and charge a \$20-30 administrative fee.

dch.georgia.gov/00/article/0,2086,31446711_32383141_60764354,00.html

For people who aren't comfortable on the internet, a good healthcare referral and information resource is the **Healthy Mothers, Healthy Babies Powerline**. They are available during regular business hours, Monday through Friday from 8:00am to 6:00pm. They do have Spanish speaking staff and use a Language Line for other languages. They will give referrals and do not provide any direct services.

www.hmhbga.org 1-800-300-9003

Finance & Assets

The **Path2College 529 Plan** is offered by the state of Georgia and provides tax advantages to parents and others who set aside money for a child's future education expenses. These savings are tax-free, and participants have seven investment options to choose from. www.path2college529.com

Individual Development Accounts (IDAs) are a special savings account for specific purposes. In some states, TANF funds are set aside to match these funds much like an employer might match retirement savings. Georgia is not one of those states. However, IDAs may be a useful way for a low-income family to put aside money. Since Georgia does not have a statewide IDA program, you can look up the closest local organization on the IDA network page. That website is in your handouts. www.idanetwork.com

Financial literacy is defined as "the ability in making informed judgments and effective decisions on the use and management of money" (Gavigan 2010). Many financial literacy programs are geared toward children and college students, but adult classes might also benefit the community. Information about credit and credit scores would be particularly beneficial. More specific courses may be related to getting home buying assistance in the form of Home Buyer education.

Behavioral Health

The single point of access for the Georgia Department of Behavioral Health and Developmental Disabilities and a source of excellent referrals is the **Georgia Crisis and Access Line (GCAL)**. This is a good way to access mental health, substance abuse, crisis, and emergency services 24 hours a day. www.mygcal.com

If you call the Georgia Crisis and Access Line and your situation is assessed as needing immediate face-to-face intervention, the intake personnel may choose to send a **Mobile Crisis Team**. They will arrive at the scene of the crisis within 1 ½ hours. The Team consists at a minimum of a licensed clinical social worker, a behavior specialist, and direct support staff. Depending on the situation, other professionals may be included. The social worker will, with the team members' input, will make recommendations for interventions and referrals for additional support that should be made within 24 hours. The Mobile Crisis Team coordinates intensive in-home and out-of-home supports provided on a time-limited basis, not to exceed 7 days. dbhdd.georgia.gov

Concrete Support in Times of Need Resource List

The **Community Service Boards** are often significant resources around the state that cover all three areas under behavioral health. However, the actual services that they offer will vary from site to site. Their missions typically include giving support to individuals regardless of their ability to pay, but how that translates into exact cost may vary as well. www.gacsb.org

It is important to remember that when it comes to services that the least restrictive option be found that helps keep everyone safe. However, in some cases, group homes or residential treatment may be needed. **Group Homes** under the Georgia Department of Behavioral Health and Developmental Disabilities include residential services for all our categories. The Division of Developmental Disabilities has facilities that serve a small group of individuals, no more than four. There are facilities for adults and children over the age of 10. Children aged 5 to 9 are provided intensive in-home supports. Those with mental illness and addiction concerns may even be in the same group home. It may be difficult to know which treatment facility is best for an individual without consulting resources like the Georgia Crisis and Access Line. If you are working with family or friends of someone in treatment, let them know that visitation hours may be limited and to be aware of what is acceptable to bring to patients ahead of time.

www.mygcal.com

We all know that catching a problem early is best time to intervene. With what we know about children's development today, we can no longer wait until children enter school to assess a child's health and developmental progress. We can identify developmental problems early and with a higher probability of lessening if not eliminating impact on that child's later life. As the name of the next resource on our list says, babies can't wait. **Babies Can't Wait** (BCW) serves children up until their third birthday regardless of family income. Anyone can refer a child for an assessment, but a diagnosis of a specific mental or physical condition, including a developmental delay, is required for services beyond the assessment. The evaluation and service coordination to develop a plan are offered at no cost. The early intervention services are offered on a sliding scale. Federal mandates require that, as much as is possible and appropriate that these services be provided in the home and community settings. This helps to lessen barriers to access. health.state.ga.us/programs/bcw

Children 1st is a point of entry for public health and prevention services, including BCW. Children's 1st seeks to screen all births and children up to age 5 and provide assessment of all children and families that are identified as at risk for poor health or developmental outcomes. The Children 1st program is partnered with and links children to many organizations around the state. health.state.ga.us/programs/childrenfirst

Other

Voices for Georgia's Children provides legislative advocacy and awareness of children's issues in the state of Georgia. They support policy that helps children grow up safe, healthy, educated, connected to their family and community, and employable. Georgiavoices.org

Appendix I: Frequently Asked Questions

Georgia Center for Child Advocacy Child Abuse Prevention & Response Training for Educators

Frequently Asked Questions - What Educators Want To Know

SCHOOLS OFTEN HAVE CONCERNS AND QUESTIONS ABOUT CHILD ABUSE AND NEGLECT. SOME OF THE MOST FREQUENT QUESTIONS ARE ADDRESSED BELOW.

- **What constitutes suspicion? How much investigating should I do?**

Suspicion of abuse or neglect is based upon indicators. Indicators consist of physical indicators (e.g., questionable injuries, consistent hunger, or poor hygiene), child behavioral indicators (e.g., begging or stealing food, fear of caretaker, or highly sexualized play), a child's statements reporting abuse or neglect, or a caretaker's statements (e.g., description of abusive or neglectful behavior).

Educators do not need to prove that abuse or neglect occurred to make a report to Child Protective Services. It is appropriate, however, to inquire about suspicious injuries and to support a child who discloses. ("Can you tell me what happened?" "I'm sorry that happened to you.") Educators should not press the child for details beyond what the child is willing to share. Schools should not be conducting their own investigations.

- **Is it appropriate for teachers to view a child's body areas that are covered by clothing when there is suspicion of abuse?**

When there is suspicion of abuse based upon the indicators described above (e.g., a child's report of inflicted injury or teacher observation of questionable injuries), a cursory, non-invasive observation of the reported injured areas may be appropriate, especially if the injury is located on appendages or non-private body parts. When observing injuries, the child's need for privacy should be respected. The child's consent should be obtained in a non-coercive manner. A child's refusal to show injured areas should be respected.

When the injuries are located in private body areas, the child should be referred to the school nurse.

Children should not be needlessly subjected to physical inspections. There must be sufficient cause to suspect that viewing the child's body would reveal evidence of injury.

- **What happens after I report?**

When a report of suspected child abuse or neglect is made, the Child Protective Services worker must determine if the situation described meets the legal definition of child abuse or neglect and whether Child Protective Services has the legal authority and responsibility to respond. If the report meets these criteria, Child Protective Services will interview the child and siblings—often at school. The Child Protective Services worker will also interview the parents or caretakers, the alleged perpetrator, and others having information about suspected abuse or neglect.

The Child Protective Services worker will conduct a child present danger assessment, determine if abuse or neglect occurred or if there is risk of harm, and develop a service plan with the family when indicated.

Why don't I ever hear what happened to the child?

Georgia Code permits the Child Protective Services worker to disclose information to an educator learned during the course of a Child Protective Services response (or during the provision of Child Protective Services services to a family) without the consent of the family, provided, in the judgment of the Child Protective Services worker, the educator has a legitimate need for information and disclosure is in the best interests of the child.

Minimally, Child Protective Services workers are required by policy to notify reporters that the report was received and the intake disposition.

- **When I reported my suspicions to the school administrator, he or she didn't report. What should I do?**

Section 63.2-1509 of the Code of Georgia allows teachers and staff, in lieu of a report to Child Protective Services, to immediately notify the person in charge or his/her designee

“who shall make a report forthwith” to Child Protective Services. Liability for failure to report rests with the person in charge or designee. If the school administrator does not report to Child Protective Services, the teacher may consider making the report to Child Protective Services.

- **What if the Child Protective Services worker tells the parent that I’m the one who reported?**

Federal regulations, the Code of Georgia, and Child Protective Services policy specify that the identity of the reporter be protected and not released unless by court order where the information provided by the reporter is necessary for a full disclosure of the child’s situation.

- **Will the child be removed?**

Child Protective Services is required to try to prevent removal of the child whenever possible and to provide for the safety of the child in his or her own home.

Will there be criminal charges against the parent?

Child Protective Services is required to report all cases of suspected child abuse or neglect to law enforcement.

- **Where is the line between abuse and discipline?**

The intent of the child abuse reporting law is not to interfere with appropriate parental discipline but to respond to extreme or inappropriate parental/caretaker actions. Excessive corporal punishment can easily result in an unintended injury(ies) to a child due to the difference in size between an adult and a child, the presence of anger, and the use of force. Actions that are excessive or forceful enough to leave injuries are considered abusive.

- **If a child is abusing another child (peer or sibling) is it child abuse?**

Situations of child abuse, including sexual abuse, are reportable when the perpetrator is in a caretaking role (e.g., babysitter) or there is suspected lack of supervision by the parent/adult caretaker, enabling the activity to take place.

The following variables should be considered when assessing possible abuse, including sexual activity, between children:

- Whether the behavior is considered developmentally appropriate (e.g., fighting between same age children or sexual curiosity between same age children)
- The age difference between the victim and perpetrator
- The use of force or violence
- The nature and frequency of the abuse
- The existence of a power differential, knowledge differential, and gratification differential (sexual abuse) between perpetrator and victim

Children who perpetrate violence against other children may themselves be victims.

Sexual perpetrators who are age 12+, engage in repetitive sexually exploitive behaviors, use violence, or demonstrate other anti-social behaviors should also be referred to law enforcement for possible prosecution due to difficulties with self-control and associated risk to others.

- **What if I suspect abuse in my personal life? Am I still required to report?**

Section 19-7-5 of the Code of Georgia limits required reporting to persons acting in their professional or official capacities. Anyone, however, may report suspected child abuse or neglect.

Appendix J:

Child Protection Policy

Insert a copy of your school's
child protection policy,
protocol, or equivalent
document **here** for reference

Appendix K:

Required Handouts

Looking Out for Georgia's Youth: EDUCATION CAN MAKE A DIFFERENCE

INTRODUCTION

After attending the **Looking Out for Georgia's Youth: Education Can Make a Difference** training and reading this packet, you should be better able to:

- Understand how the mandated reporting laws affect you
- Define four types of abuse and related indicators
- Describe the process for responding to a disclosure of child abuse
- Follow the basic procedure for reporting suspected of child abuse
- Identify protective factors and strategies for preventing child abuse

DID YOU KNOW?

Nationally in 2010, reports from education personnel and law enforcement made up the largest percentages of alleged child abuse reports, at 16.4 % and 16.7% respectively.

MANDATED REPORTERS

Section 19-7-5 of the Official Code of Georgia Annotated, relating to reporting of child abuse, designated several categories of individuals as **mandated reporters**, who "having reasonable cause to believe that a child has been abused shall report or cause reports of that abuse to be made."

All child service organization personnel are mandated reporters.

(The complete section of the Georgia Code is on file at your school)

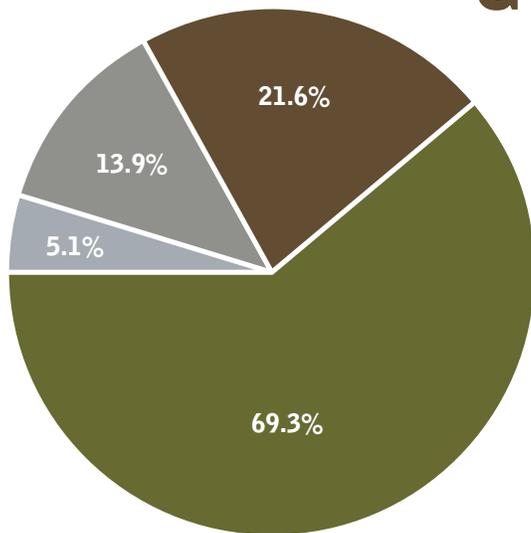
Child service organization personnel' means persons employed by or volunteering at a business or an organization, whether public, private, for profit, not for profit, or voluntary, that provides care, treatment, education, training, supervision, coaching, counseling, recreational programs, or shelter to children.

- O.C.G.A. 19-7-5(b)(5)

A report of alleged child abuse is made in Georgia every 14 minutes.*

*38,578 reports in FFY 2010

OVERVIEW OF CHILD ABUSE IN GEORGIA*



VICTIMS OF CHILD ABUSE (REPORTED)



Neglect - **69.3%**



Emotional / - **21.6%**
Psychological



Physical Abuse - **13.9%**



Sexual Abuse - **5.1%**

NEGLECT IS ABUSE?

Not only are there more reports of neglect and more substantiated cases of neglect than all the other types of abuse combined, but 430 of child fatalities in the U. S. were attributed to neglect alone.

* FFY 2010

Physical Abuse

The non-accidental physical injury of a child. Physical abuse is the most visible and widely recognized form of child abuse.

INDICATORS

- Has unexplained burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other marks noticeable after an absence from school
- Seems frightened of the parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Reports injury by a parent or another adult caregiver

In Georgia, Corporal Punishment is legal. Abuse is not.

Corporal punishment is any physical punishment of a child to inflict pain as a deterrent to wrongdoing. It may produce transitory pain and potential bruising. If pain and bruising are not excessive or unduly severe and result only in short-term discomfort, this is not considered maltreatment.

-Georgia DFCS

Neglect

The failure of a parent, guardian, or other caregiver to provide for a child's basic needs.

Neglect may be:

- The failure of a parent, guardian, or other caregiver to provide for a child's basic needs.
- Physical (e.g., failure to provide necessary food or shelter, or lack of appropriate supervision. This also includes the failure to protect a child from harm/danger.)
- Medical (e.g., failure to provide necessary medical or mental health treatment)
- Educational (e.g. failure to educate a child or attend to special education needs)
- Emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care, or permitting the child to use alcohol or other drugs)

INDICATORS

- Is frequently absent from school
- Begs or steals food or money
- Lacks needed medical or dental care, immunizations, or glasses
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or drugs
- States that there is no one at home to provide care

Child Protective Services guidelines for supervision:

- Children eight years or younger should not be left alone;
- Children between the ages of nine years and twelve years, based on level of maturity, may be left alone for brief (less than two hours) periods of time; and,
- Children thirteen years and older, who are at an adequate level of maturity, may be left alone and may perform the role of babysitter, as authorized by the parent, for up to twelve hours.

These guidelines assume that the child's age is equivalent with his or her developmental level. A child's maturity should **ALWAYS** factor into how much supervision is needed.

Sexual Abuse

The exploitation of a child for the sexual gratification of an adult or older child. Sexual abuse is most commonly perpetrated by an individual known to the victim, rarely is the offender a stranger. One-third of all sexual abuse is perpetrated by another child.

Sexual abuse includes touching offenses: fondling, sodomy, rape; and non-touching offenses: child prostitution, indecent exposure and exhibitionism, utilizing the internet as a vehicle for exploitation.

INDICATORS

- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a sexually transmitted disease
- Runs away
- Reports sexual abuse by a parent or another adult caregiver

Up to 50 percent of those who sexually abuse children are under the age of 18.

(Hunter, J.A., Figueredo, A., Malamuth, N.M., & Becker, J.V. (2003). Juvenile sex offenders: Toward the Development of a typology. Sexual Abuse: A Journal of Research and Treatment, (2003) Volume 15, No. 1).

Commercial Sexual Exploitation Of Children

The buying, selling or trading of sex acts with a child

If you suspect a child is a victim of commercial sexual exploitation, please contact the Georgia Care Connection Office at 404-602-0068.

Calling the GCCO links the family to supportive services but does not fulfill mandatory reporting of child sexual exploitation as required by Senate Bill 69.

INDICATORS

- Branding or tattooing: victims branded by their pimp with tattoos that include a male name or initials, street name, gang or money symbols; these are often found on legs, neck, chest, hands or arms (this is one of the ways that pimps maintain physical and psychological control over emotionally vulnerable girls)
- An older boyfriend or male friend or relative
- Withdrawn and uncommunicative
- Possession of large amounts of money (girls turn money over to the pimp)
- Poor personal hygiene and/or inappropriate dress
- Runaway or lack of adult supervision/support

An estimated 300 girls are commercially exploited in Georgia every month (and we are still learning how to track the boys). Atlanta has been identified by the FBI as one of the 14 cities with the highest incidence of commercial sexual exploitation of children. However, victims of exploitation come from all over the state and 45% of those referred to Georgia Care Connection lived outside of Fulton and DeKalb counties.

Emotional Abuse

A pattern of behavior that impairs a child's emotional development or sense of self-worth.

It frequently occurs as verbal abuse, but can also include the following: rejection, terrorizing, shameful forms of punishment, withholding physical and emotional contact; developmentally inappropriate expectations.

INDICATORS

- Shows extremes in behavior, such as overly compliant or demanding behavior, extreme passivity, or aggression
- Inappropriately adult (parenting other children, for example) or inappropriately infantile (frequently rocking or head-banging, for example)
- Is delayed in physical or emotional development
- Has attempted suicide
- Reports a lack of attachment to the parent

Suicide

Many of the indicators of abuse are common to multiple categories of abuse. Indicators like running away, school problems, aggression, depression, anxiety, withdrawal, excessive worries, substance abuse, self injury, and suicidal thoughts or actions could be a response to any type of abuse. Deciding why a child needs help is less important than acting on your concern that a child is in harm's way.

If the child you are concerned about has attempted suicide in the past or your concern is about the danger that the child represents to him or herself, you may want to contact the Suicide Prevention Lifeline 1-800-273-TALK (8255) to learn more. Some of the warning signs that someone is at high risk include:

- Talking about wanting to die or kill oneself
- Looking for a way to kill oneself, such as searching online or buying a gun
- Talking about feeling hopeless or having a reason to live
- Talking about feeling trapped or in unbearable pain
- Talking about being a burden to others
- Increasing the use of alcohol or drugs
- Acting anxious or agitated; behaving recklessly
- Sleeping too little or too much
- Withdrawing or feeling isolated
- Showing rage or talking about seeking revenge
- Displaying extreme mood swings

DISCLOSURES

When a child tells you that he or she has been abused, i.e. makes a disclosure, you should always take the statement seriously, regardless of how credible the child's statement seems.

1. Indirect Hints

EXAMPLES

- "My brother wouldn't let me sleep last night."
- "There was no one home to help me with my homework."
- "My babysitter keeps bothering me."
- "I don't like it when my mother leaves me alone with my uncle."

EXPLANATION

A child may talk in these terms because he or she hasn't learned more specific vocabulary, feels ashamed or embarrassed, has promised not to tell, or for a combination of those reasons.

2. Disguised Disclosure

EXAMPLES

- "I know someone who is being touched in a bad way."
- "What would happen if someone told you that he was getting hit and wanted it to stop?"

EXPLANATION

The child may be talking about someone she or he knows, but is just as likely to be talking about himself or herself. Encourage the child to tell you what he or she knows about the "other child." Then ask whether something like what is being said has ever happened to him or her.

3. Disclosures With Strings Attached

EXAMPLE

- "I have a problem, but if I tell you about it, you have to promise not to tell."

EXPLANATION

Many children believe something very negative will happen if they break the secret of abuse. The child may have been threatened by the offender to ensure his or her silence. Let the child know that there are some secrets that you just can't keep. Assure the child that your job is to protect the child and keep him/her safe. Let the child know you will keep it as confidential as possible but that you are required by law to make a report.

What to do When a Child Discloses

1. Find a private place to talk with the child

2. Reassure the child

"I believe you."

"I am glad you told me."

"It is not your fault this happened."

"(Sexual) abuse is wrong."

3. Listen openly and calmly.

Try to keep your own emotions and nonverbal cues neutral. Don't comment on the child's situation as being "good" or "bad." Let the child tell his or her own story.

4. Write down the facts and words as the child has stated them.

Leave out your own assumptions and value judgments.

5. Report the disclosure to the designated reporter in your school/system/agency or your local child protection agency or law enforcement entity.

6. Respect the child's need for confidentiality...

...by not discussing the abuse with anyone other than those required by school/agency policy and the law.

If a child does make a disclosure, *don't* try to get all the details. Listen attentively and ask him/her if he/she wants to say anything else. Believe in the child and be supportive. If she or he chooses to say nothing more, then proceed to notify DFCS or your designated reporter. Also, write down the actual words used in the disclosure and your interaction with the child. This first statement made spontaneously has forensic significance to the investigators and the exact words can be important.

Above all, MINIMIZE the number of questions you ask the child and avoid the use of leading questions (questions that suggest an answer).

MAKING A REPORT

In Georgia, you may fulfill the mandate by reporting to a **designated reporter**. However, there may be situations when you feel more comfortable making a report directly to DFCS.

During regular business hours (8 a.m. to 5 p.m.), you should call the DFCS office in the county in which the child lives. You can look that up online at <http://dfcs.dhs.georgia.gov/complete-list-all-county-offices> or contact **Georgia's Child Protective Services office** at (404) 657-3400.

Between 5 p.m. and 8 a.m., Monday through Friday and on weekends, holidays, and furlough days, you can call **1-855-GA CHILD (1-855-422-4453)**. This number is staffed 24 hours a day.

When You Suspect a Child is Being Maltreated

- Report your concerns to the designated reporter in your school or to a supervisor
- Follow up with your designated reporter to assure that a report is made to child protective services
- Remember, to make a report or cause a report to be made, mandated reporters only need to have "reasonable suspicions," not direct evidence
- School officials do have the authority to photograph injuries

To Whom Do You Report?

An oral report must be made within 24 hours by telephone or in person to the DFCS office providing protective services in the county in which the child lives.

Your program, agency or facility may have an internal child maltreatment reporting protocol. Know this protocol. It is strongly recommended that each staff person involved in the reporting process receive confirmation when a report is made. When unable to reach DFCS, a report must be made to local law enforcement or district attorney in the county in which the child lives. If the child is in immediate danger, call 911. Follow-up with your local DFCS as soon as possible to make an official report to their office.

Rights of the Mandated Reporter

Mandated reporters who report in “good faith” are protected by law, even if the report is not substantiated.

- ***Anonymity or confidentiality.***

All reports are confidential, and the reporter may remain anonymous. It is, however, most helpful to the child if the reporter provides his or her contact information. It is also impossible to prove that you fulfilled the mandate to report if you do so anonymously.

- ***Knowledge of the outcome only of a report.***

Mandated reporters who provide their name at the time of filing the child maltreatment report may request information from DFCS on the outcome of a report. Legally DFCS cannot share any information other than the outcome. Mandated reporters are supposed to receive a letter of acknowledgment, acceptance for investigation or screen-out of the case. If you have reported before and not received a letter, you may want to follow-up to get that documentation.

What are the Penalties for NOT Reporting?

Any person or official required by Georgia law to report suspected cases of child maltreatment and who knowingly and willfully fails to do so shall be guilty of a misdemeanor.

THE ROLE OF CHILD PROTECTIVE SERVICES

The Division of Family and Children Services (DFCS) provides a number of services to communities in Georgia. Child Protective Services (CPS) is a term for those services related to child abuse and neglect, but you may hear DFCS and CPS used interchangeably.

- Interview the child and parents/caregivers
- Arrange for child’s medical examination, if necessary
- Assess parents/caregivers’ abilities to care for/protect the child
- Provide support for services to parents/caregivers
- Request immediate temporary custody of child from judge in juvenile court when abuse/ neglect is substantiated
- Petition court for permanent custody when parents/ guardians (when given support) fail to demonstrate ability or willingness to care for the child

PREVENTION

PROTECTIVE FACTORS

Parental Resilience

Parents Can Bounce Back!

Social Connections

Parents Have Friends!

Knowledge of Child Development

Parents Know How Children Grow and Learn!

Concrete Support in Times of Need

Parents Know Where to Turn for Help!

Social and Emotional Competence of Children

Children Learn to Talk About and Handle Feelings!

PREVENTION STRATEGIES

- Facilitate Friendships and Mutual Support
- Value and Support Parents
- Strengthen Parenting
- Respond to Family Crises
- Link Families to Services and Opportunities
- Observe and Respond to Early Warning Signs of Abuse or Neglect
- Further Children's Social and Emotional Development

RESOURCES

Georgia Department of Human Services

Division of Family and Children Services
404-657-3400

National Parent Helpline

855-4A PARENT or 855-427-2736
nationalparenthelpline.org

Child Welfare Information Gateway

A service of the Children's Bureau/ACYF
800-394-3366
childwelfare.gov

Strengthening Families

202-371-1565
strengtheningfamilies.net