NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

# North Carolina Department of Health and Human Services
# CPS Assessment in Child Welfare Track Training

## Participant's Workbook
## Day Five

## September 2025

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This curriculum was developed by the North Carolina Department of Health and Human Services, Division of Social Services, and revised by Public Knowledge® in 2025.

# Table of Contents

## Instructions

This course was designed to guide child welfare professionals through the knowledge, skills, and behaviors needed to engage with families in need of child protection services. The workbook is structured to help you engage in the lesson through reflection and analysis throughout each week of training. Have this workbook readily available as you go through each session to create a long-lasting resource you can reference in the future.

If you are using this workbook electronically: Workbook pages have text boxes for you to add notes and reflections. Due to formatting, if you are typing in these boxes, blank lines will be “pushed” forward onto the next page. To correct this when you are done typing in the text box, you may use delete to remove extra lines.

## Course Themes

The central themes of the CPS Assessment Track Training are divided across several course topics.

- Purpose and Legal Basis for Child Protection Services in North Carolina
- Essential Function: Communicating
- Diversity, Equity, Inclusion, and Belonging
- Trauma-Informed Care
- Family-Centered Practice
- Essential Function: Engaging
- Safety Focused
- Essential Function: Assessing
- Interviewing Learning Lab
- The Role of Observation in Assessing for Safety
- Structured Decision-Making: Safety Assessment
- Assessment Learning Lab
- Safety Planning
- Safety Planning Learning Lab
- Trauma-Informed Practice
- Considerations for Cases Involving Special Circumstances
- Social Worker Safety
- Engaging the Family in Child Protection Services
- Risk Assessment
- Crucial Conversations
- Quality Contacts
- Assessing Family Strengths and Needs
- Secondary Traumatic Stress and Vicarious Traumatization
- Ongoing Assessment
- Family Engagement and Ongoing Assessment Learning Lab
- Documentation
- Well-Being as an Outcome
- Reasonable Efforts and Removals

- Reasonable Efforts and Removals Learning Lab
- Decision-Making
- Decision-Making and Case Closure Learning Lab

## Training Overview

Training begins at 9:00 a.m. and ends at 4:00 p.m. If a holiday falls on the Monday of training, the training will begin on Tuesday at 9:00 a.m. This schedule is subject to change if a holiday falls during the training week or other circumstances occur. The time for ending training on Fridays may vary and trainees need to be prepared to stay the entire day.

Attendance is mandatory. If there is an emergency, the trainee must contact the classroom trainer and their supervisor as soon as they realize they will not be able to attend training or if they will be late to training. If a trainee must miss training time in the classroom, it is the trainee's responsibility to develop a plan to make up missed material.

### Pre-Work Online e-Learning Modules

There is required pre-work for the CPS Assessment Track Training in the form of online e-Learning modules. Completion of the e-Learnings is required prior to attendance at the classroom-based training. The following are the online e-Learning modules:

1. North Carolina Worker Practice Standards
2. Safety Organized Practice
3. Understanding and Assessing Safety and Risk
4. Understanding and Screening for Trauma

### Transfer of Learning

The CPS Assessment Track Training Transfer of Learning (ToL) tool is a comprehensive and collaborative activity for workers and supervisors to work together in identifying worker goals, knowledge gain, and priorities for further development throughout the training process. In four distinct steps, the worker and supervisor will highlight their goals and action plan related to participating in training, reflect on lessons and outstanding questions, and create an action plan to support worker growth. The tool should be started prior to beginning the CPS Assessment Track Training and re-visited on an ongoing basis to assess growth and re-prioritize actions for development.

- Part A: Training Preparation: Prior to completing any eLearning and in-person Track Training sessions, the worker and supervisor should meet to complete Part A: Training Preparation. In this step, the worker and supervisor will discuss their goals for participation in training and develop a plan to meet those goals through pre-work, other opportunities for learning, and support for addressing anticipated barriers.
- Part B: Worker Reflections During Training: The worker will document their thoughts, top takeaways, and outstanding questions regarding each section. This level of reflection serves two purposes. First, the practice of distilling down a full section of training into three takeaways and three remaining questions requires

the worker to actively engage with the material, subsequently forming cognitive cues related to the information for future use in case practice. Second, prioritizing takeaways and questions by section allows workers to continually review information to determine if questions are answered in future sessions and supports the development of an action plan by requiring workers to highlight the questions they find most important.

- Part C: Planning for Post-Training Debrief with Supervisor: The worker considers the takeaways and questions they identified in each section and creates a framework to transfer those takeaways and questions into an action plan.
- Part D: Post-Training Debrief with Supervisor: Provides an opportunity for the supervisor and worker to determine a specific plan of action to answer outstanding questions and to further support worker training.

While this ToL is specific to the Track Training in North Carolina, workers and supervisors can review the takeaways and questions highlighted by the worker in each section of training on an ongoing basis, revising action steps when prior actions are completed, and celebrating worker growth and success along the way.

**Training Evaluations**

At the conclusion of each training, learners will complete a training evaluation tool to measure satisfaction with training content and methods. The training evaluation tool is required to complete the training course. Training evaluations will be evaluated and assessed to determine the need for revisions to the training curriculum.

**All matters as stated above are subject to change due to unforeseen circumstances and with approval.**

# Learning Objectives

**Day Five**

| Engaging the Family in Child Protection Services |
|---|
| • Learners will be able to explain how the needs of children and youth in diverse populations impact assessment decisions. |
| • Learners will be able to identify appropriate resources specific for families of children and youth in diverse populations. |
| • Learners will be able to describe strategies to identify and locate non-resident parents. |
| • Learners will be able to identify strategies to engage and involve fathers, estranged parents, or incarcerated parents. |
| **Risk Assessment** |
| • Learners will be able to describe the purpose of SDM tools used to support assessments. |
| • Learners will be able to identify risk factors in child welfare cases and discuss how they relate to concerns of future maltreatment. |
| • Learners will be able to define protective factors. |
| • Learners will be able to distinguish protective capacities from protective factors. |
| • Learners will be able to identify protective factors in case scenarios and discuss how they mitigate risk. |
| • Learners will be able to describe how and when to complete the North Carolina Risk Assessment. |
| • Learners will be able to apply the definitions of risk factors to case examples. |
| **Crucial Conversations** |
| • Learners will be able to outline different approaches in preparing for courageous conversations. |
| • Learners will be able to discuss how their own biases may impact courageous conversations. |
| • Learners will be able to identify points of conflict and various strategies to help children and families resolve conflict. |

| Quality Contacts |
| --- |
| • Learners will be able to explain the importance of quality contacts. |
| • Learners will be able to outline NC policy related to quality contacts. |
| • Learners will be able to describe the use of quality contacts to assess and monitor child safety. |
| • Learners will be able to conduct contact interviews while maintaining child and family confidentiality. |
| **Assessing Family Strengths and Needs** |
| • Learners will be able to describe the purpose of SDM tools used to support assessments. |
| • Learners will be able to describe the skills needed to engage all family members in identifying strengths and needs in the assessment process. |
| • Learners will be able to describe the importance of using the Family Assessment of Strengths and Needs Tool in case planning. |
| • Learners will be able to outline the requirements in the assessment policy. |
| • Learners will be able to explain how to use the NC Family Strengths and Needs Assessment in case planning activities. |
| **Social Worker Safety** |
| • Learners will share and discuss examples of vicarious traumatization and STS. |
| • Learners will be able to identify at least three risk factors associated with STS. |
| • Learners will be able to identify the impacts of STS on the emotional, physical, and psychological health and decision-making of child welfare professionals and themselves. |
| • Learners will be able to recognize and discuss burnout and compassion fatigue. |

# Day Five Agenda

## CPS Assessment Track Training

Welcome

### Engaging the Family in Child Protection Services

Engaging the Non-Resident Parent

Cultural Consideration in Engaging Families

### Risk Assessment

Identifying and Understanding Risk Factors

Protective Factors

Risk Assessment Tool

### Crucial Conversations

Crucial Conversations and Managing Conflict

### Quality Contacts

Quality Contacts

### Assessing Family Strengths and Needs

Strengths-Based Approach to Assessment

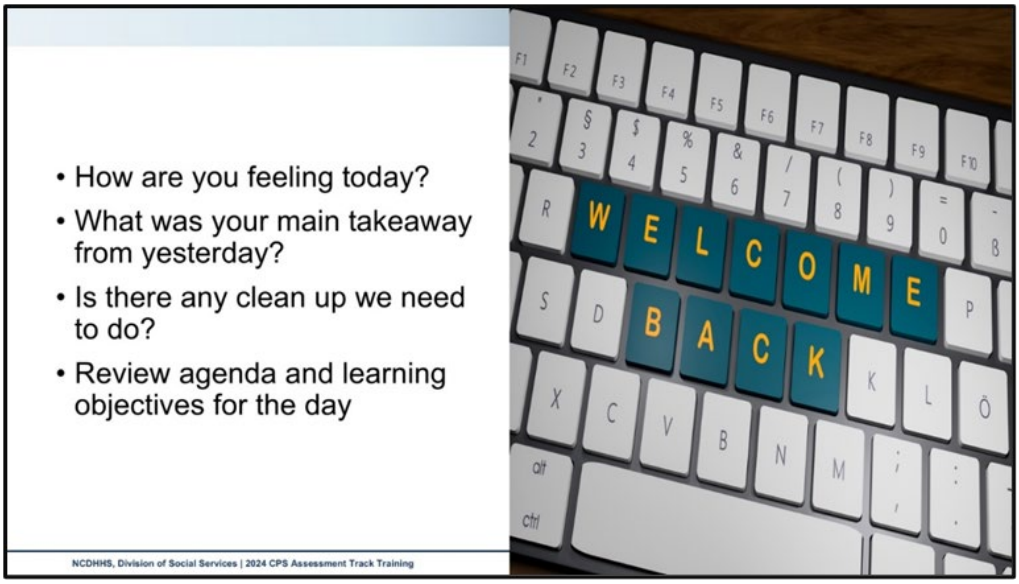
Family Strengths and Needs Assessment

### Social Worker Safety

Secondary Traumatic Stress and Vicarious Traumatization

### End-of-Day Values Reflection

# Welcome

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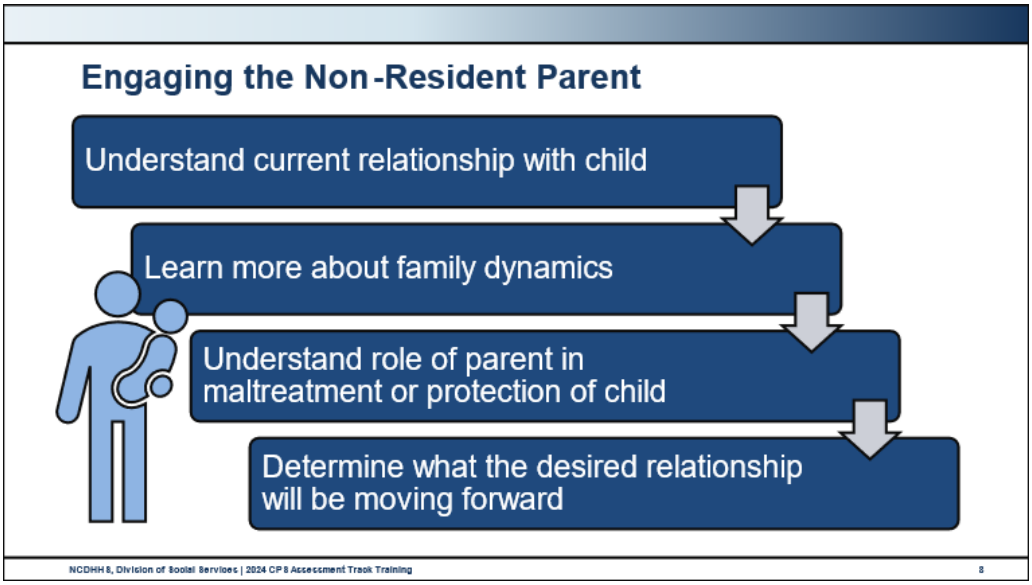
# Engaging the Family in Child Protection Services

## Engaging the Non-Resident Parent

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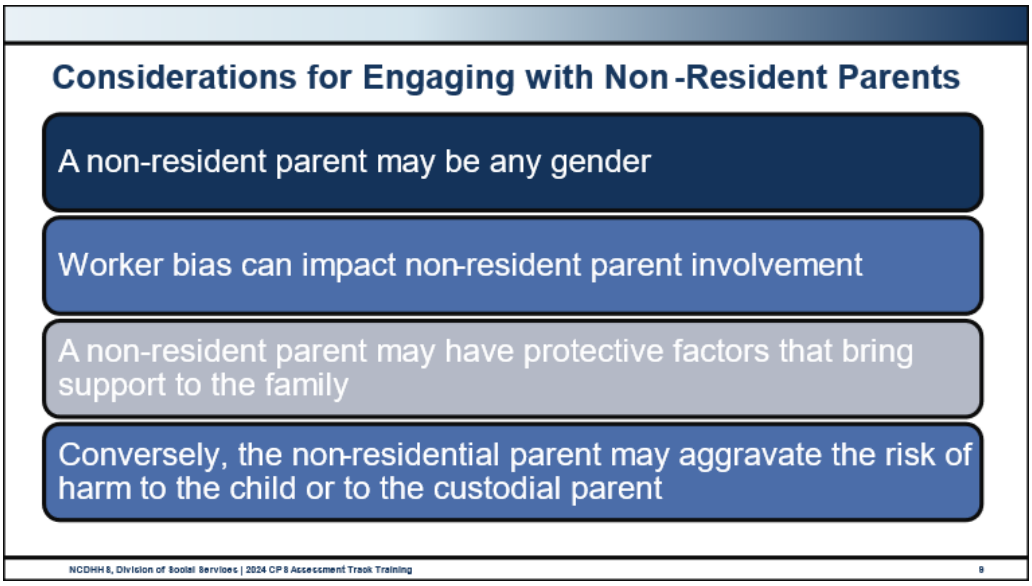


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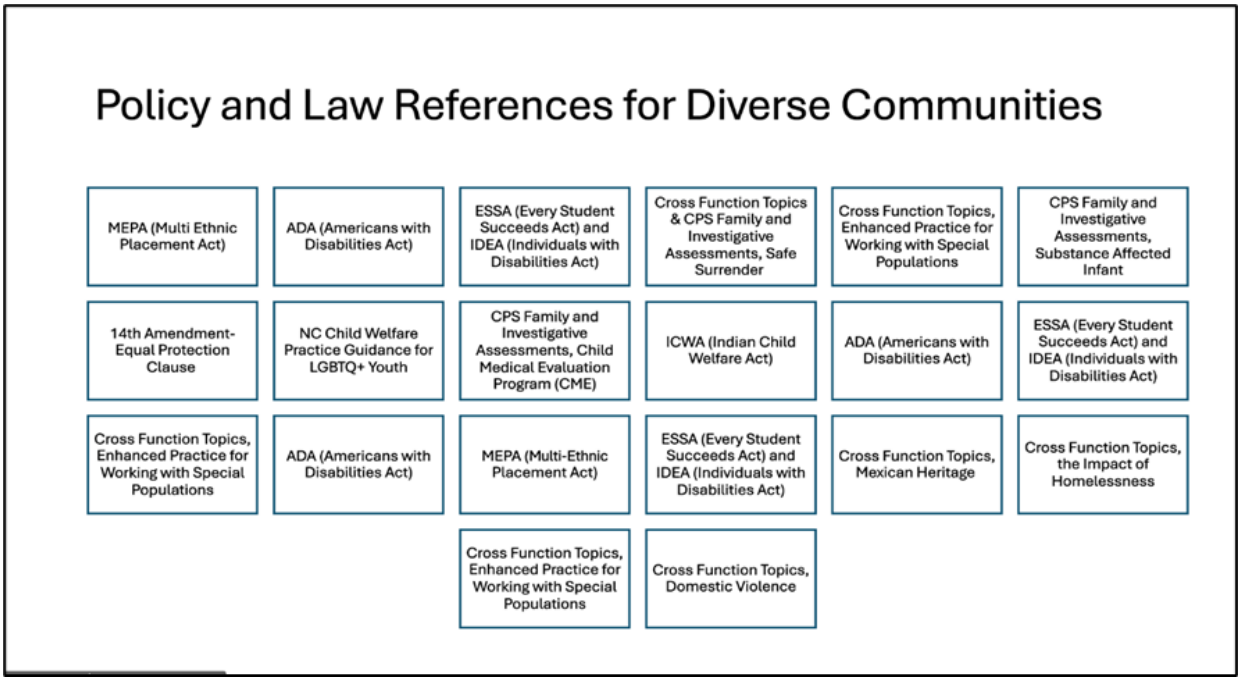
## Cultural Considerations in Engaging Families

### Activity: Considerations for Diverse Communities




**Family Member Name**

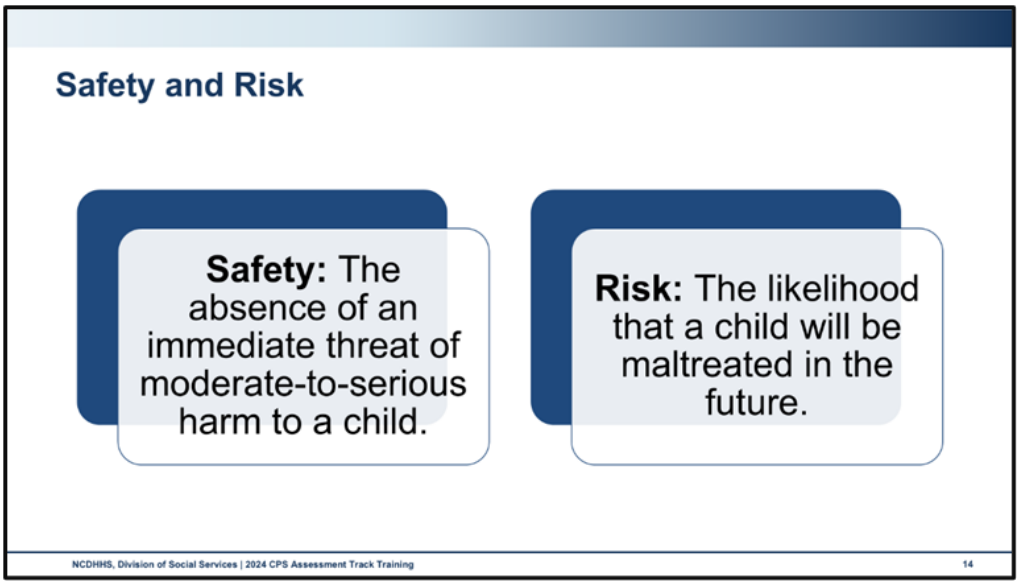
**Key Points about Family Member**

**Applicable Laws and Policy to Consider**

**Additional Considerations**

# Risk Assessment

## Identifying and Understanding Risk Factors

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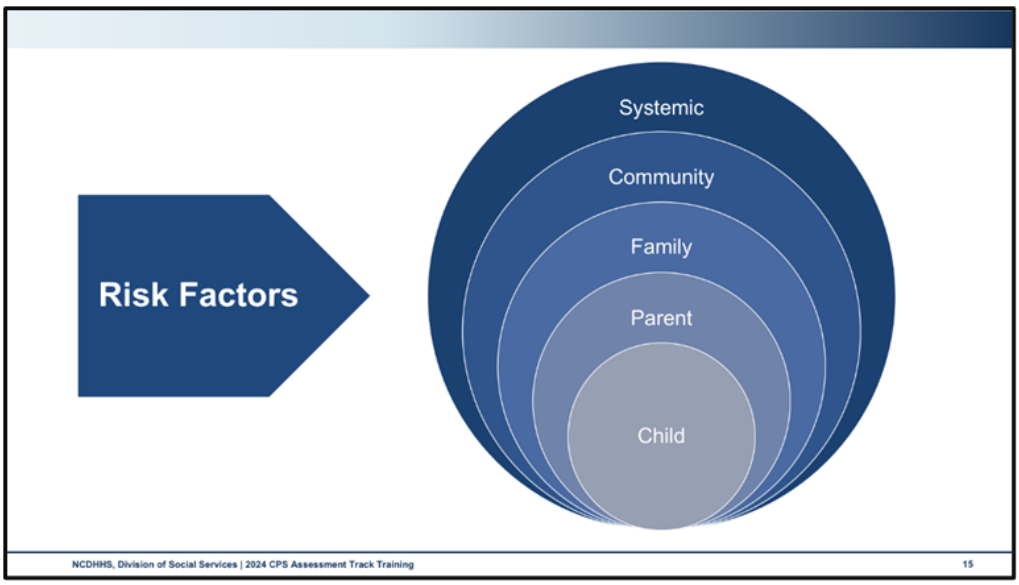


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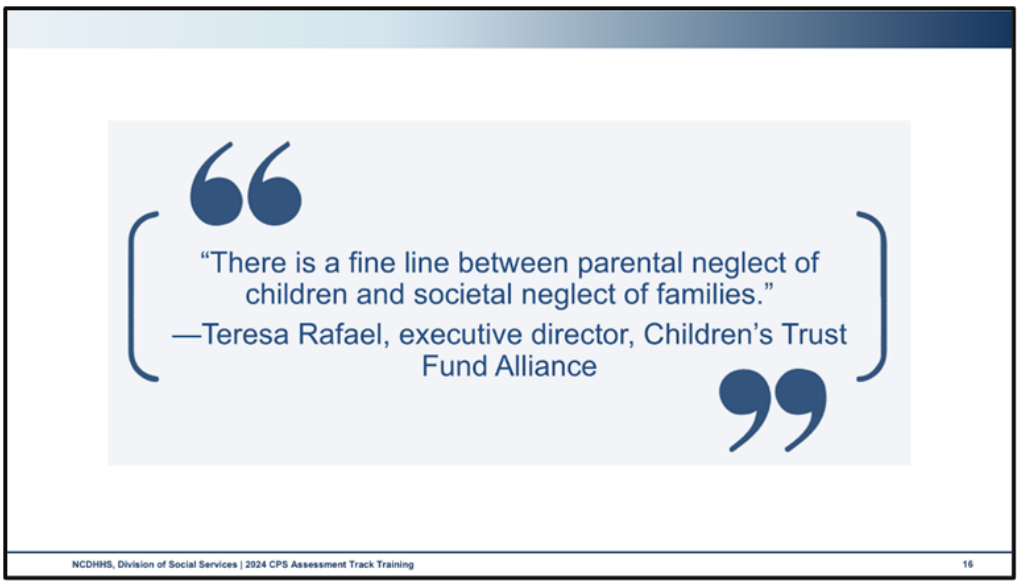


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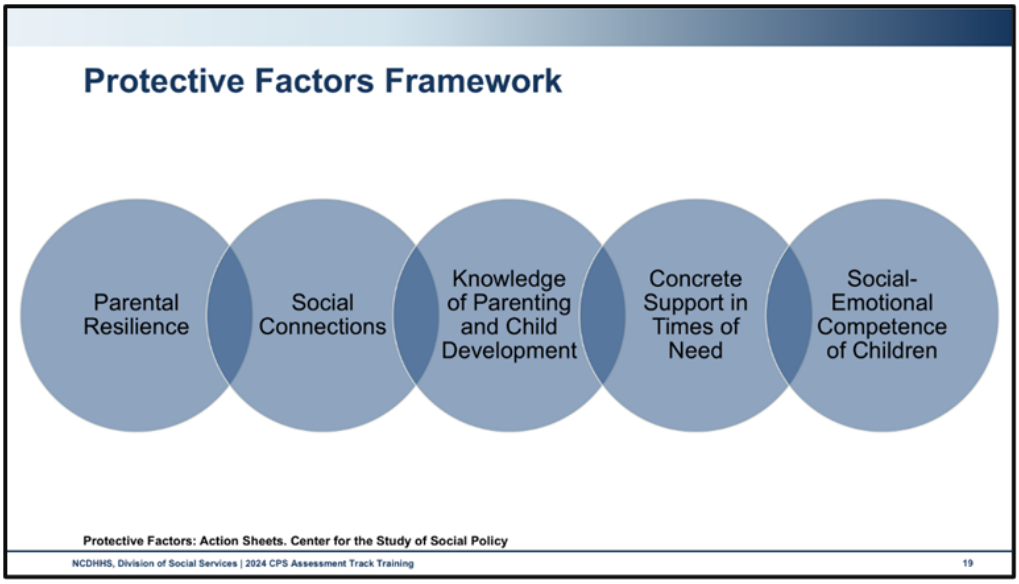
## Protective Factors




**Parental Resilience**: Managing stress and functioning well when faced with challenges, adversity, and trauma

**Social Connections**: Positive relationships that provide emotional, informational, instrumental, and spiritual support

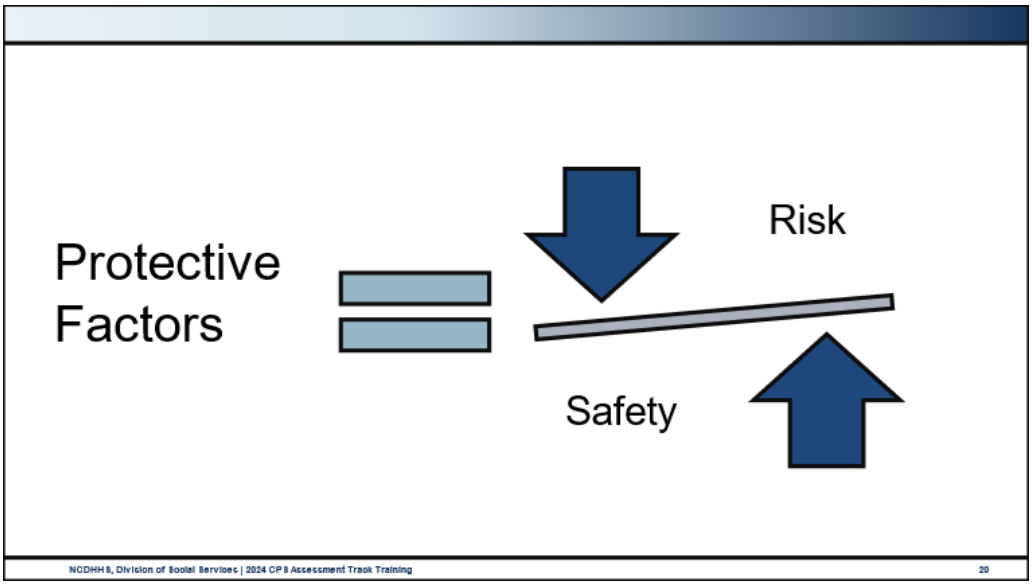
**Knowledge of Parenting and Child Development**: Understanding child development and parenting strategies that support physical, cognitive, language, social, and emotional development

**Concrete Supports in Times of Need**: Access to concrete support and services that address a family's need and help minimize stress caused by challenges

**Social and Emotional Competence of Children**: Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships

**Some strategies that can be used to mitigate risk and strengthen families include:**

- **Parental Resilience**: Encourage parents to take care of themselves, seek support from others, and develop problem-solving skills.
- **Social Connections**: Help parents build a support network, connect with other families, and participate in community activities.
- **Knowledge of Parenting and Child Development**: Provide parents with accurate information about child development, positive parenting practices, and child safety.
- **Concrete Support in Times of Need**: Connect families with resources such as housing, food, and healthcare, and help them navigate complex systems.
- **Social and Emotional Competence of Children**: Promote children's social and emotional development through positive interactions with caregivers, peers, and the community.

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## Activity: Protective Factors Exploration

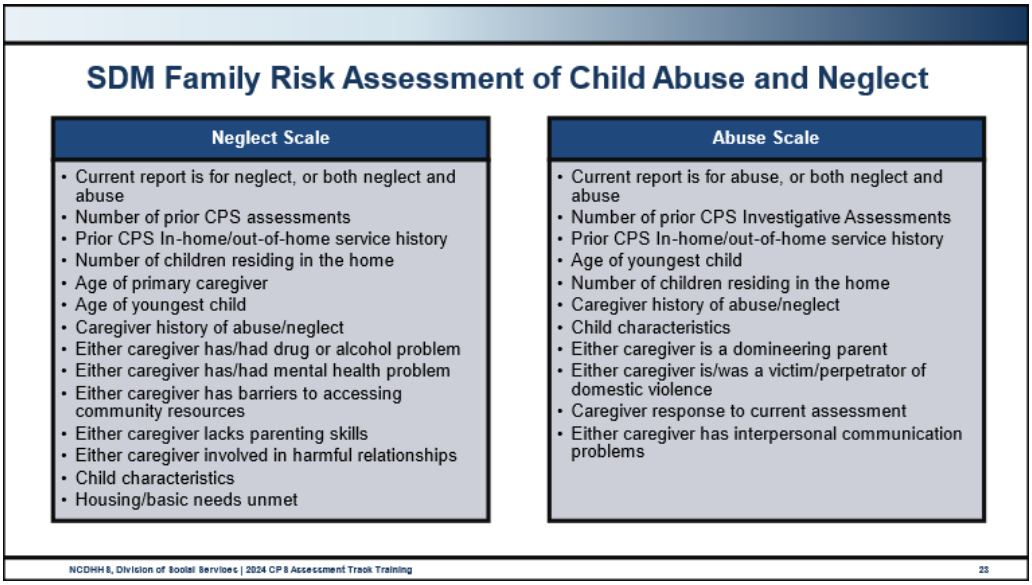
In your groups, create a poster by answering the following. In addition to your own knowledge and experience, please feel free to use the handout in your appendix entitled Protective Factors: Action Sheets.

**Define the Protective Factor in family-accessible language.**

**Name at least 5 ways that the presence of this protective factor buffers from risk and trauma.**

**Name at least 5 ways that this protective factor shows up in a family's life.**

## Risk Assessment Tool




Please refer to the DSS–5230: SDM Family Risk Assessment of Child Abuse/Neglect in the Appendix.

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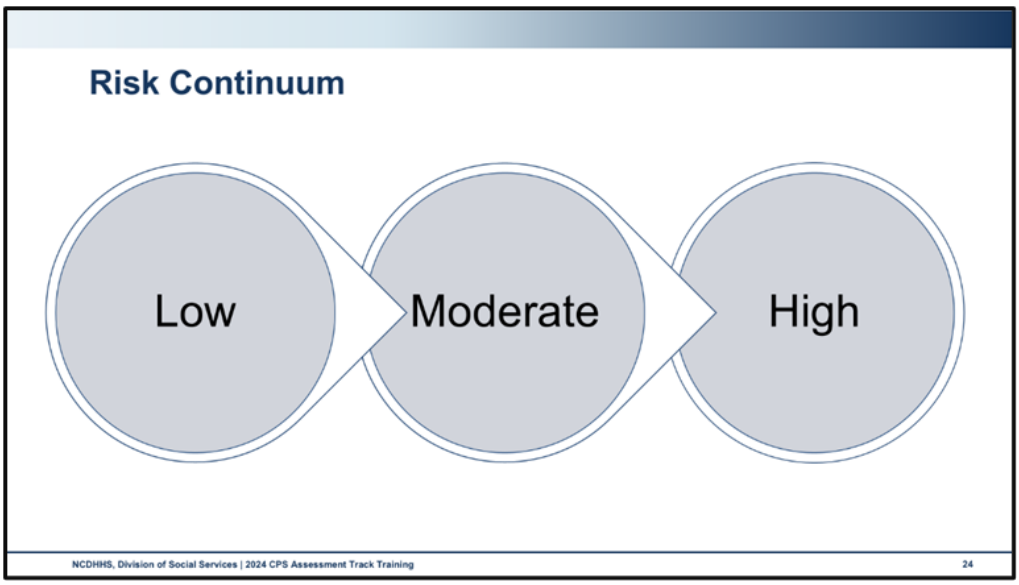


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## Skills Practice: Family Risk Assessment of Child Abuse and Neglect

Work with your group to:

- Review the information you have gathered about the Avilla Chavis family so far
- Complete a Family Risk Assessment of Child Abuse/Neglect for the family
- Answer the following questions.

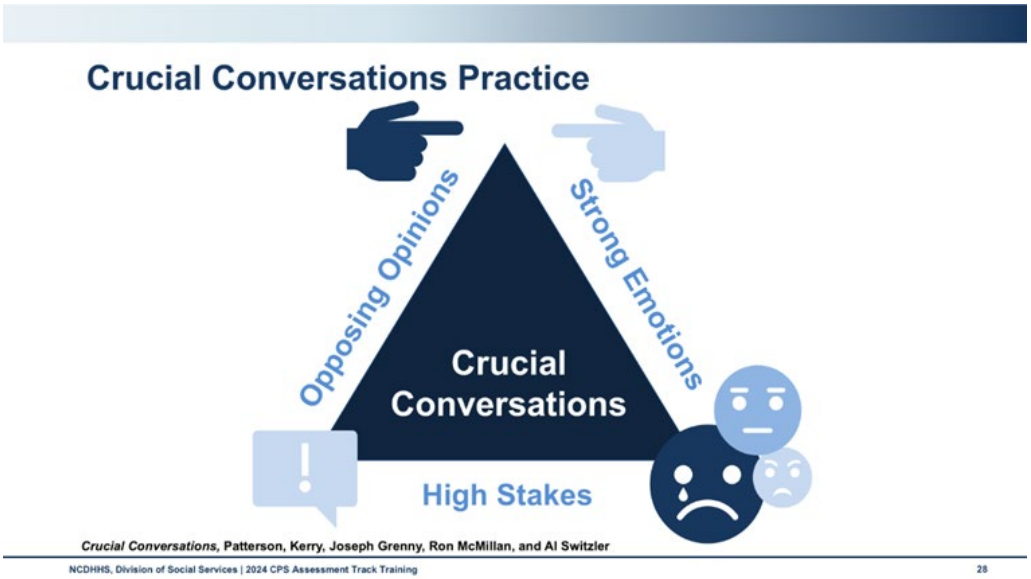
**What future risk of abuse did you identify?**

**What future risk of neglect did you identify?**

**How might the family mitigate harm from the risks you identified?**

# Crucial Conversations

## Crucial Conversations and Managing Conflict

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## Handout: Managing Crucial Conversations

| Steps | How Do I Do This? |
|---|---|
| Start with the Heart. | Start from a genuine, well-intentioned place. Stay focused on what you really want and your intentions for the conversation. |
| Learn to Look. | Look for signs of stress, conflict, and emotional elevation. Notice when your safety is at risk. Manage your own response tendencies. Look for language and behavior that could escalate the conversation. |
| Make it Safe. | Notice when others don't feel safe to respond, check to make sure you are listening well and validating. Keep highlighting the common goal. When you notice a risk, "step out" of the conversation and work to restore safety. |
| Master Your Stories. | Manage intended and unintended bias and check how you see others. "Stories" are assumptions we make for why others are doing what they are doing. Assumptions can interfere with your conversation. |
| State Your Path. | Share very specific concerns and a clear explanation of the purpose for the conversation. Talk about your experience and inquire about the ways of others. Speak cautiously to be clear and not too soft or too firm. |
| Explore Others' Perspectives. | Active listening becomes key, and empathy is critical. Validate the person's feelings while maintaining the importance of what needs to be accomplished. |
| Move to Action. | Make decisions and commit to action together. |

## Skills Practice: Crucial Conversations

Create a conversation plan for this crucial conversation with your assigned family member.

**Step 1: Start With Heart (Stay focused on what you really want)**

What do you need to accomplish in this conversation? How will you approach this conversation?

**Step 2: Learn to Look: (be aware of when a conversation is crucial and look for signs of risk to safety.**

What factors about this conversation do you anticipate will be crucial? What parts of the conversation may put safety at risk?

**Step 3: Make it Safe (Create a Safe Environment for Dialogue)**

How will you invite this family member to feel safe in this conversation?

**Step 4: Master My Stories (Challenge Assumptions and Fill in the Blanks)**

What assumptions need to be eliminated? What circumstances need to be addressed? What is not being considered here?

**Step 5: State Your Path (Share Your Facts, Story, and Purpose)**

How will you present the specific concerns? What will you say to share the purpose of the conversation?

**Step 6: Explore Others' Perspectives (Encourage Dialogue and Seek Mutual Understanding)**

| |
|---|
| What questions will you ask to encourage the family member to share their perspective? What will you say to validate the family member's feelings while emphasizing the importance of children's safety? |

**Step 7: Move to Action (Make Decisions and Commit to Action)**

| |
|---|
| How will you work with the family member to create an action plan? What needs to be included in that plan? |

## Debrief: Crucial Conversations Practice

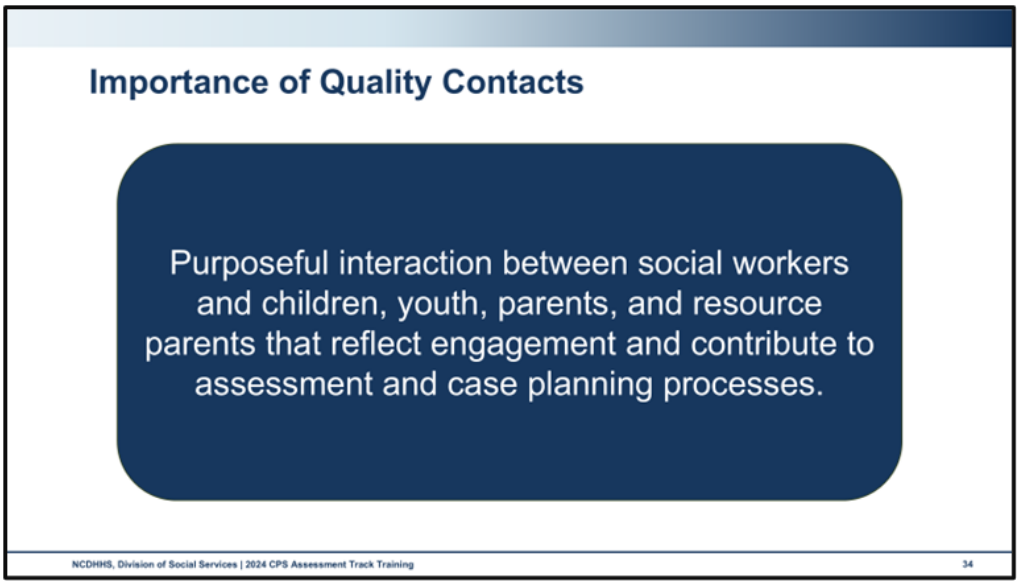
**What went well? What didn't?**

**What impact did your planning make on your conversation?**

**In thinking about your conversation, which components do you think you'll need to work on?**

# Quality Contacts

## Quality Contacts

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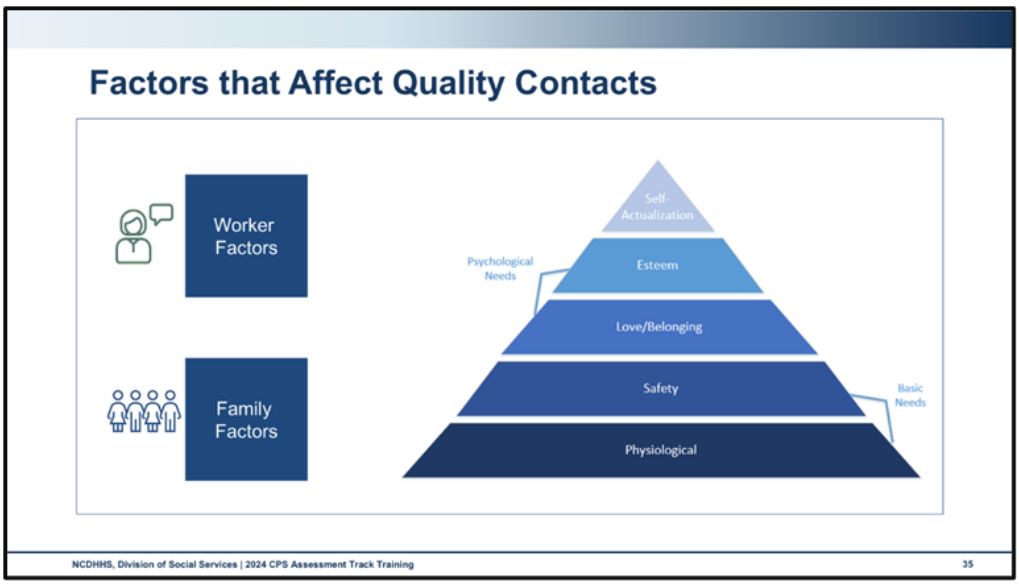


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## Worksheet: Competing Factors in Quality Contacts

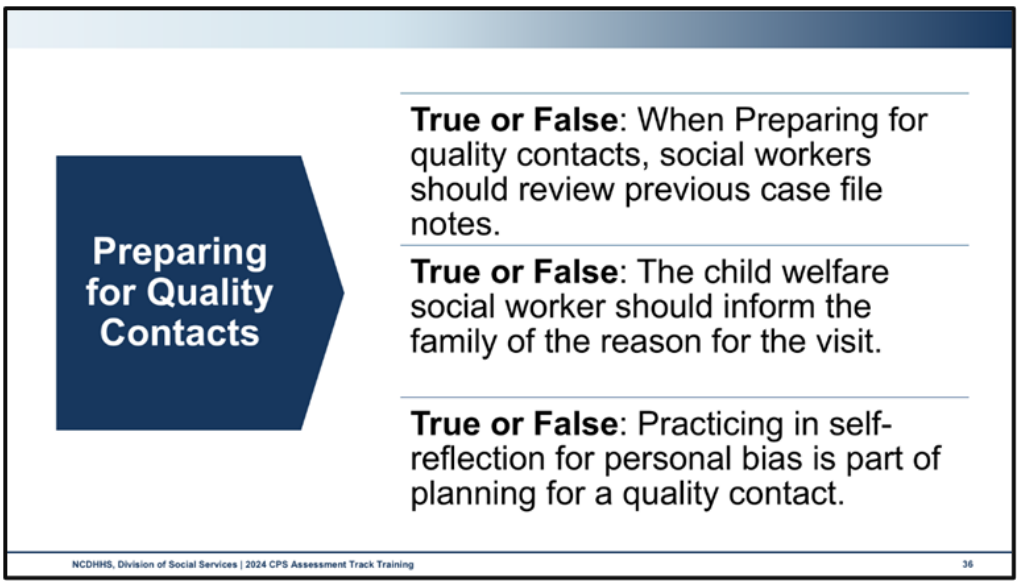
- Work with your group to brainstorm ideas on how to overcome barriers presented in each scenario.

**During your visit to the home, Mom's boss calls and texts several times during your visit.**

**Random people are coming in and out of the home during the visit, bringing up concerns about what can be shared due to confidentiality.**

**Children are in the room while discussing sensitive topics, such as intimate partner violence or parental substance misuse.**

**Suspected criminal activity is occurring during the visit, such as selling or using drugs.**




## Quiz: True or False

| | |
|---|---|
| When preparing for quality contacts social workers should review previous case file notes. | ☐ True<br>☐ False |
| The child welfare social worker should inform the family of the reason for the visit. | ☐ True<br>☐ False |
| Practicing self-reflection for personal bias is part of planning for a quality contact. | ☐ True<br>☐ False |

**What are four things you need to do to prepare for quality contact with a family member or collateral contact?**

| |
|---|
| |

## Activity: Planning for Quality Contacts

Ensuring quality contacts requires intentionality and planning. Work with your table group to list elements that require attention when planning your follow-up visit with the Avilla Chavis family

Consider the following:

**Questions and actions to assess if the safety plan is implemented and followed or requires adjustments.**

**Ideas to engage children of different ages and stages of development.**

**Education, information, referrals, or other support to provide to ensure the visit is meaningful.**

## Activity: Perspective Taking: Assessing Safety and Risk Through Quality Contacts

This is a perspective-taking activity. Perspective-taking requires that you share thoughts, feelings, and ideas that center on the perspective of the person you represent. It is different than role play in that your goal is to keep your assigned perspective in mind when engaging in the discussion, not act or pretend like you are in that role.

- Instead of pretending or acting like you feel an emotion, you could share considerations about how actions or statements could affect someone in your role.
    - Instead of acting or presenting to be offended, you could say “a statement like that could be offensive to someone in this role.”
- Focus on your assigned perspective only. This means that if you assigned a family member, you would not share a perspective with the social worker and vice versa.

| Assigned Person | |
|---|---|
| As you hear the presentation for the Quality Contact Visit approach, what thoughts, feelings, or ideas do you have from the perspective of your assigned person? | |
| | |

Debrief

| |
|---|
| |

## Activity: Contacts and Frequency Fill in the Blank

1. **At what visit, if needed, is the Temporary Parental Safety Agreement first developed?**
   When information is received and confirmed that a safety threat exists, often during _____ contact although may occur at a subsequent visit. TPSA must be revisited at each visit with the family to assess appropriateness of safety plan.

2. **How is the frequency of ongoing contact determined?**
   Safety and Risk to the children, determined by _____ and _____ Assessment.

3. **What is the minimum frequency of face-to-face contact with victim children and parents?**
   Twice monthly at least _____ calendar days apart.

4. **Are children interviewed with their parents during follow-up contacts?**
   The interview must be _____ from the parent/caretaker for at least part of the contact.

5. **How often must you visit the home during an open CPS Assessment?**
   Initiation and then _____ a month with the child in the home.

6. **Under what circumstances are you required to visit a non-resident parent's home?**
   If _____ are made against the non-resident parent, a home visit must be conducted prior to the child visiting that home.

7. **In addition to assessing for general safety, what three areas must you assess within the home at your visits?**
   _____ safety, _____ safety, and _____ sleep for infants.

8. **What is the minimum number of collateral contacts you are to contact during a CPS Assessment?**
   At least _____.

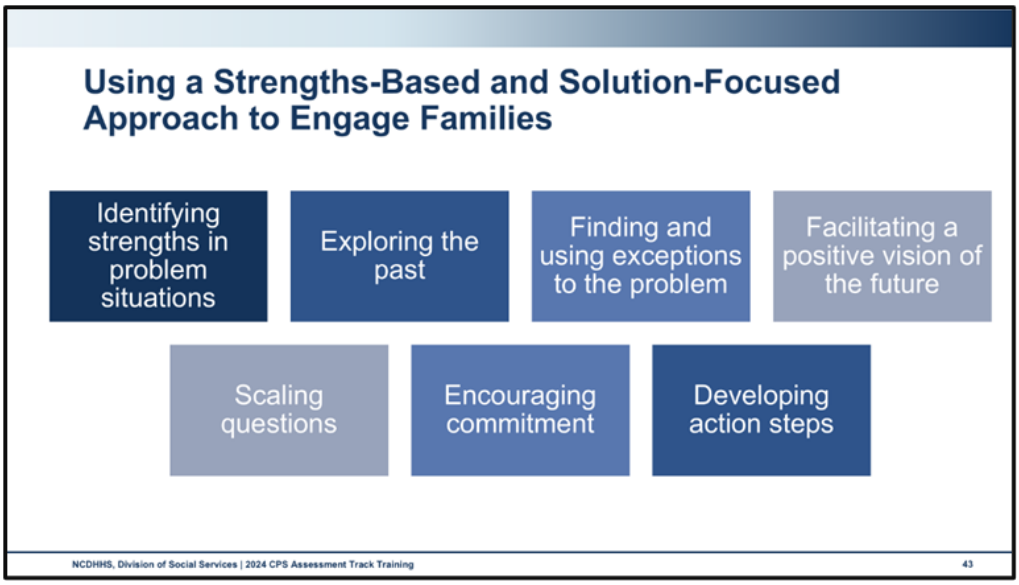
9. **Who should be included in family home visits/contacts?**
   All other _____ and _____ living in the home.

10. **At what visits do you review the TPSA?**
    At each _____ contact.

11. **When do you document case activities and actions?**
    Within _____ calendar days.

# Assessing Family Strengths and Needs

## Strengths-Based Approach to Assessment

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## Skills Practice: Strengths-Based Approach

- Take turns focusing on your partner's strengths in an area of their personal life.
- Your partner can choose any topic and share the topic with you before time begins.
- Interviewers will engage your partner, learn about the topic from them, and focus on strengths.

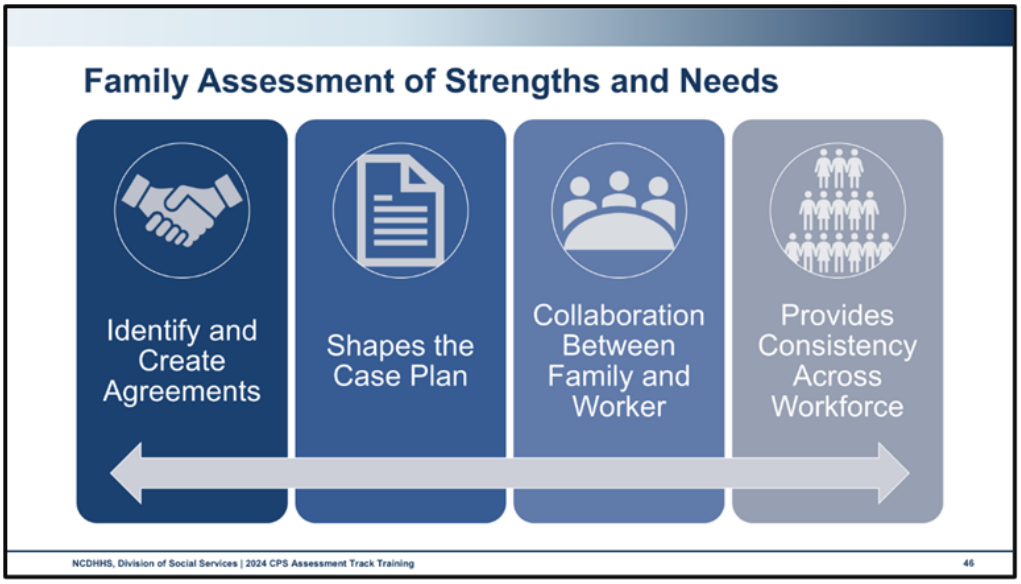
**What was that approach like for you?**

**How did your partner respond when you focused on their strengths?**

**How did it feel to have someone remark on and explore your strengths?**

**What of the strengths-based approach will you remember to do when you are in the field with families?**

## Family Strengths and Needs Assessment

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## Worksheet: Family Assessment of Strengths and Needs

Using the table below, brainstorm behavioral indicators that would correspond with your assigned FSNA item.

- In the first column, transfer the underlined rating definitions for your assigned item.
- In the second column, identify at least two behavioral indicators that would warrant choosing that rating for your item.

| Rating definitions | Behavioral Indicators |
|---|---|
| a. | 1.<br><br>2. |
| b. | 1.<br><br>2. |
| c. | 1.<br><br>2. |
| d. | 1.<br><br>2. |

# Social Worker Safety

## Secondary Traumatic Stress and Vicarious Traumatization

### Video: Impacts of Secondary Traumatic Stress on the Child Welfare Workforce

https://www.qic-wd.org/impact-secondary-traumatic-stress-child-welfare-workforce

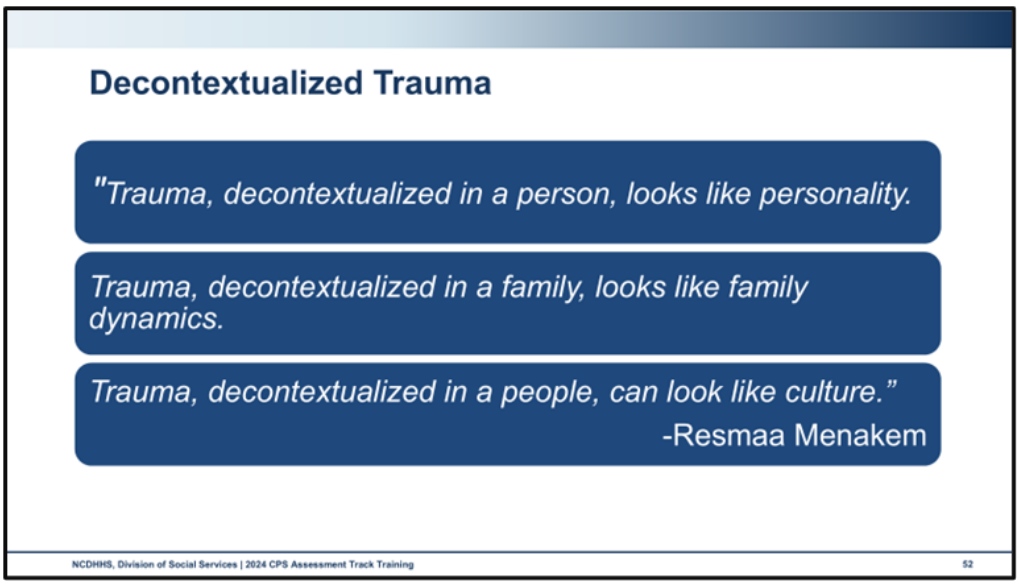
**Secondary Traumatic Stress, or STS**, is emotional distress that results when an individual hears about the firsthand trauma experiences of another. It is indirect exposure to threatening events that can result in the presence of posttraumatic stress symptoms.

**Compassion fatigue** is the physical and emotional exhaustion experienced by those who care for others who are in distress. It is a less clinical and less stigmatizing term and is often used interchangeably with Secondary Traumatic Stress.

**Vicarious trauma** occurs after empathic engagement with a traumatized client and changes the inner experience of a practitioner. This term focuses less on trauma symptoms and more on cognitive changes that occur following cumulative exposure to another person's trauma. The symptoms of vicarious trauma are disturbances in the cognitive frame of reference in the areas of trust, safety, control, esteem, and intimacy.

Source:


- Barbee, A., Purdy, L., and Cunningham, M. (2023, September). Secondary traumatic stress: definitions, measures, predictors and interventions. Quality Improvement Center for Workforce Development.
- Strand, V. C., and Sprang, G. (2018). Trauma Responsive Child Welfare Systems. Switzerland: Springer International Publishing.
- National Child Traumatic Stress Network. Secondary Traumatic Stress: A Fact Sheet for Child-Serving Professionals. Retrieved from https://www.nctsn.org/sites/default/files/resources/fact-sheet/secondary_traumatic_stress_child_serving_professionals.pdf

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## Worksheet: Socio-Ecological Model

With your group, brainstorm some of the factors that contribute to stress and trauma across the layers of the socio-ecological model.

**Individual**

**Interpersonal/Relational**

**Organizational**

**Community**

**Policy/Institutional**

**Society**

# End-of-Day Values Reflection

## Questions and Reflections

**Use this space to record reflections and questions about what you have learned today.**

# Bibliography of References

**Day Five**

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# Appendix: Handouts

## Protective Factors Action Sheets

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# PARENTAL RESILIENCE

PROTECTIVE & PROMOTIVE FACTORS

Being a parent can be a very rewarding and joyful experience. But being a parent can also have its share of stress. Parenting stress is caused by the pressures (stressors) that are placed on parents personally and in relation to their child:

- *typical events and life changes* (e.g., moving to a new city or not being able to soothe a crying baby)
- *unexpected events* (e.g., losing a job or discovering your child has a medical problem)
- *individual factors* (e.g., substance abuse or traumatic experiences)
- *social factors* (e.g., relationship problems or feelings of loneliness and isolation)
- *community, societal or environmental conditions* (e.g., persistent poverty, racism or a natural disaster)

Numerous researchers have concluded that how parents respond to stressors is much more important than the stressor itself in determining the outcomes for themselves and their children. **Parents are more likely to achieve healthy, favorable outcomes if they are resilient. Resilience is the process of managing stress and functioning well even when faced with challenges, adversity and trauma.**

Some stressors parents face can be managed easily so that problems get resolved; for example, calling a relative or friend to pick-up a child from school when a parent is delayed. But some stressors cannot be easily resolved. For example, parents cannot "fix" their child's developmental disability, erase the abuse they suffered as a child or be able to move out of a crime-plagued neighborhood. **Rather, parents are resilient when they are able to call forth their inner strength to proactively meet personal challenges and those in relation to their child, manage adversities, heal the effects of trauma and thrive given the unique characteristics and circumstances of their family.**

Demonstrating resilience increases parents' **self-efficacy** because they are able to see evidence of both their ability to face challenges competently and to make wise choices about addressing challenges. Furthermore, parental resilience has a positive effect on the parent, the child and the parent-child relationship. By managing stressors, parents feel better and can provide more nurturing attention to their child, which enables their child to form a secure emotional attachment. Receiving nurturing attention and developing a secure emotional attachment with parents, in turn, fosters the development of resilience in children when they experience stress.

Sometimes the pressures parents face are so overwhelming that their ability to manage stress is severely compromised. This is the case with parents who grew up in environments that create **toxic stress**. That is, as children, they experienced strong, frequent and prolonged adversity without the buffering protection of nurturing adult support. As a result, these parents may display symptoms of depression, anxiety, or other clinical disorders that inhibit their ability to respond consistently, warmly and sensitively to their child's needs. For example, depressive symptoms in either mothers or fathers are found to disrupt healthy parenting practices so that the child of a depressed parent is at increased risk of poor attachments, maltreatment and poor physical, neurological, social-emotional, behavioral and cognitive outcomes. However, numerous research studies show parents can be helped to manage clinical symptoms and reactions to their own histories of poor attachments and trauma, to protect children from adversity and trauma as best they can and to provide more nurturing care that promotes secure emotional attachment and healthy development in their children.

All parents experience stress from time-to-time. Thus, parental resilience is a process that all parents need in order effectively manage stressful situations and help ensure they and their families are on a trajectory of healthy, positive outcomes.

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# PARENTAL RESILIENCE: ACTION SHEET

## Your role as a caseworker

Having an open child welfare case is necessarily emotional and difficult for parents and can cause self-doubt that fundamentally undermines resilience. As a caseworker part of your role is to make the child welfare experience as constructive as possible by:

- Projecting a positive and strengths-based approach to the family
- Supporting the family as key decision-makers throughout the case planning process
- Making self-care a part of the case plan
- Encouraging the parent to explore their own past experiences of trauma and address how those experiences impact them in the present
- Normalizing the fact that parenting is stressful and helping the parent plan proactively about how to respond to stressful parenting situations
- Validating and supporting good decisions

## Questions to ask

- What helps you cope with everyday life?
- Where do you draw your strength?
- How does this help you in parenting?
- What are your dreams for yourself and family?
- What kind of worries and frustrations do you deal with during the day? How do you solve them?
- How are you able to meet your children's needs when you are stressed?
- How does your spouse or partner support you? When you are under stress, what is most helpful?
- What do you do to take care of yourself when you are stressed?

## What to look for

- Problem solving skills
- Ability to cope with stress
- Self-care strategies
- Help-seeking behavior
- Receiving mental health or substance abuse services if needed
- Not allowing stress to impact parenting

## Activities to do with parents

- Ask the parent to write down their self-care strategies and ensure that they are taking time for self-care each day.
- Ask the parent to identify situations they find stressful and make a plan in advance for how they will keep themselves calm and centered in these circumstances.

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# SOCIAL CONNECTIONS

PROTECTIVE & PROMOTIVE FACTORS

People need people. Parents need people who care about them and their children, who can be good listeners, who they can turn to for well-informed advice and who they can call on for help in solving problems. Thus, the availability and quality of social connections are important considerations in the lives of parents. **Parents' constructive and supportive social connections—that is, relationships with family members, friends, neighbors, co-workers, community members and service providers**—are valuable resources who provide:

- *emotional support* (e.g., affirming parenting skills or being empathic and non-judgmental)
- *informational support* (e.g., providing parenting guidance or recommending a pediatric dentist)
- *instrumental support* (e.g., providing transportation, financial assistance or links to jobs)
- *spiritual support* (e.g., providing hope and encouragement)

When parents have a sense of connectedness they believe they have people who care about them as individuals and as parents; they feel secure and confident that they have others with whom they can share the joy, pain and uncertainties that come with the parenting role; they seek timely assistance from people they have learned to count on when faced with challenges; and they feel empowered to "give back" through satisfying, mutually beneficial relationships. **Several research studies have demonstrated that—for both mothers and fathers—high levels of emotional, informational, instrumental or spiritual support is associated with positive parental mood; positive perceptions of and responsiveness to one's children; parental satisfaction, well-being and sense of competence; and lower levels of anger, anxiety and depression.**

Conversely, inadequate, conflicting or dissatisfying social connections can be the source of parental stress, rather than a buffer. For example, maternal and paternal grandparents may be very willing sources of informational and instrumental support to new parents, but their advice and manner of caregiving may be at odds with the new parents' beliefs and preferences. At the extreme end of the continuum of poor social connections are social isolation (i.e., the lack of available and quality relationships) and loneliness (i.e., feelings of disconnectedness from others). Social isolation is a risk factor consistently associated with disengaged parenting, maternal depression and increased likelihood of child maltreatment. Similarly, loneliness may be a major stressor that inhibits parents' ability to provide consistent, nurturing, responsive care to their children.

It may seem that increasing the number of people who could provide constructive social support to parents would be the "cure" for social isolation and loneliness. Providing opportunities for parents to create and strengthen sustainable, positive social connections is necessary but alone is not sufficient. Parents can feel lonely and isolated even when surrounded by others if relationships lack emotional depth and genuine acceptance. Thus, parents need opportunities to forge positive social connections with at least one other person that engender emotional, informational, instrumental or spiritual support so that meaningful interactions may occur in a context of mutual trust and respect.

Constructive and supportive social connections help buffer parents from stressors and support nurturing parenting behaviors that promote secure attachments in young children. Therefore, parents' high quality social connections are beneficial to both the adults and the children.

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# SOCIAL CONNECTIONS: ACTION SHEET

## Your role as a caseworker

As the family's caseworker you can help caregivers to think critically about their social network and how they could utilize it more effectively, as well as the skills and tools they need to expand it. The following strategies may assist you in engaging families in developing social connections:

- Model good relational behavior and use the case management process as an opportunity to help the caregiver develop stronger relational skills
- When engaging the family's broader network in teaming or other supports, be sensitive to the quality of existing relationships and help the family identify supporters in their network who will contribute positively
- Encourage the caregiver to expand or deepen their social network as part of the case plan
- If there are specific issues that serve as barriers for the family in developing healthy social connections such as anxiety or depression, encourage the family to address them

## Questions to ask

- Do you have friends or family members that help you out once in a while?
- Are you a member of any groups or organizations?
- Who can you call for advice or just to talk? How often do you see them?
- What kind of social support do you need?
- Do you find it easy or challenging to make friends? If it is challenging, what specific things represent a barrier for you?
- What helps you feel connected?

## What to look for

- Does the parent have supportive relationships with one or more persons (friends, family, neighbors, community, faith- based organizations, etc.)?
- Can the parent turn to their social network for help in times of need (for instance, when they need help with transportation, childcare or other resources)?
- Is the parent willing and able to accept assistance from others?
- Does the parent have positive relationships with other parents of same-age kids?
- Does the parent have skills for establishing and maintaining social relationships?
- Does the parent provide reciprocal social support to peers?

## Activities to do with parents

- Work with the parent to develop an EcoMap showing the people and institutions that are sources of support and/or stress in his or her life.
- Role play with the parent to help them practice skills in approaching another parent to develop a friendship. Have the parent choose a realistic scenario such as starting a conversation at a school event, on the playground or at a place of worship.

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# KNOWLEDGE OF PARENTING AND CHILD DEVELOPMENT

PROTECTIVE & PROMOTIVE FACTORS

No parent knows everything about children or is a "perfect parent." An understanding of parenting strategies and child development helps parents understand what to expect and how to provide what children need during each developmental phase. All parents, and those who work with children, can benefit from increasing their knowledge and understanding of child development, including:

- physical, cognitive, language, social and emotional development
- signs indicating a child may have a developmental delay and needs special help
- cultural factors that influence parenting practices and the perception of children
- factors that promote or inhibit healthy child outcomes
- discipline and how to positively impact child behavior

Gaining more knowledge about child development and developing greater skills in parenting are particularly important given the recent advances in the fields of neuroscience, pediatrics and developmental psychology. **Scientists in these fields have provided much evidence of the critical importance of early childhood as the period in which the foundation for intellectual, social, emotional and moral development is established. Furthermore, numerous research studies show this foundation is determined by the nature of the young child's environments and experiences that shape early brain development.**

Developing brains need proper nutrition, regularly scheduled periods of sleep, physical activity and a variety of stimulating experiences. Developing brains also need attuned, emotionally available parents and other primary caregivers who recognize and consistently respond to the needs of young children, and interact with them in an affectionate, sensitive and nurturing manner. Such care gives rise to the development of a secure attachment between the child and the adult. Young children with secure attachments develop a sense of trust, feel safe, gain self-confidence and are able to explore their environments because they feel they have a secure base.

Numerous longitudinal studies have demonstrated that parental behaviors that lead to early secure attachments—and which remain warm and sensitive as children grow older—lay the foundation for social-emotional, cognitive and moral competencies across developmental periods. For example, when a young child solicits interaction through babbling or facial expressions and a parent responds in a similar manner, this type of parent-child interaction helps to create neural connections that build later social-emotional and cognitive skills. In addition, advances in brain research have shown that parental behaviors that forge secure emotional attachments help young children learn to manage stress. Secure attachments can offset some of the damage experienced by highly stressed young children as a result of trauma (e.g., maltreatment or exposure to violence.)

In contrast, parental care that is inconsistent, unresponsive, detached, hostile or rejecting gives rise to insecure attachments. Young children who experience insecure attachments display fear, distrust, anxiety or distress and are at risk for long-term adverse effects on brain development including developmental delays, cognitive impairments, conduct problems, psychopathology and relationship challenges. For example, young children who have limited adult language stimulation and opportunities to explore may not fully develop the neural pathways that support learning.

What parents do and how they treat children is often a reflection of the way they were parented. Acquiring new knowledge about parenting and child development enables parents to critically evaluate the impact of their experiences on their own development and their current parenting practices, and to consider that there may be more effective ways of guiding and responding to their children. Furthermore, understanding the mounting evidence about the nature and importance of early brain development enables both parents and those who work with children to know what young children need most in order to thrive: nurturing, responsive, reliable and trusting relationships; regular, predictable and consistent routines; interactive language experiences; a physically and emotionally safe environment; and opportunities to explore and to learn by doing.

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# KNOWLEDGE OF PARENTING AND CHILD DEVELOPMENT: ACTION SHEET

## Your role as a caseworker

Each contact you have with the family provides an important opportunity to link them to parenting resources, provide child development information and model and validate effective caregiving. You can:

- Connect parents to parenting education classes or home visiting as part of case planning
- Model appropriate expectations for the child
- Engage caregivers in dialogue when their expectations are not in line with the child's developmental phase
- Underline the importance of nurturing care to help the caregiver in valuing the importance of their own role
- Provide "just in time" parenting education: information a parent needs at the time when parenting issues arise
- Help the caregiver identify a series of trusted informants that they can turn to when they need parenting information

## Questions to ask

- What does your child do best and what do you like about your child?
- What do you like about parenting? What do you find challenging about parenting?
- How have you learned about parenting skills?
- How do you continue to learn about your child's development?
- What has helped you learn about yourself as a parent?
- Are there things that worry you about your child's development or behavior?
- Have other people expressed concern about your child?

## What to look for

- Do the caregivers understand and encourage healthy development?
- Are the caregivers able to respond and manage their child's behavior?
- Do the caregivers understand and demonstrate age-appropriate parenting skills in their expectations, discipline, communication, protection and supervision of their child?
- Does the child respond positively to the caregivers' approaches?
- Do the caregivers understand and value their parenting role?
- Do the caregivers have a reliable source for parenting information when issues come up?
- Are the caregivers involved in their child's school or preschool?
- Do the caregivers understand the child's specific needs (especially if the child has special developmental or behavioral needs)?

## Activities to do with parents

- Ask the parent what their hopes and dreams are for their child(ren). Discuss any worries the parent has about ensuring those hopes and dreams are met. Then discuss what the parent is doing today (or wants to do) to help achieve those hopes and dreams.
- Identify a particular parenting task the parent finds challenging (e.g., mealtimes, putting the child to bed). Provide the parent with information on strategies for this task. Ask them to practice these strategies and debrief on your next visit.

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# CONCRETE SUPPORT IN TIMES OF NEED

PROTECTIVE & PROMOTIVE FACTORS

All parents need help sometimes—help with the day-to-day care of children, help in figuring out how to soothe a colicky baby, help getting to the emergency room when a bad accident happens, help in managing one's own temper when fatigued or upset. When parents are faced with very trying conditions such as losing a job, home foreclosure, substance abuse, not being able to feed their family or trauma, they need access to concrete support and services that address their needs and help to minimize the stress caused by very difficult challenges and adversity. **Assisting parents to identify, find and receive concrete support in times of need helps to ensure they and their family receive the basic necessities everyone deserves in order to grow (e.g., healthy food, a safe environment), as well as specialized medical, mental health, social, educational or legal services.**

When parents are faced with overwhelmingly stressful conditions they need to seek help, but for some parents asking for help is not an easy thing to do. It may be embarrassing for some parents because it feels like an admission of incompetence; that they don't know how to solve their own problems or take care of their family. Other parents may not seek help because they don't know where to go for help, or the services needed have a stigma associated with them such as mental health clinics and domestic violence or homeless shelters. **Thus, parents need experiences that enable them to understand their rights in accessing services, gain knowledge of relevant services and learn how to navigate through service systems.** Family and child-serving programs must clearly communicate to parents that seeking help is not an indicator of weakness or failure as a parent. **On the contrary, seeking help is a step toward improving one's circumstances and learning to better manage stress and function well—even when faced with challenges, adversity, and trauma. When parents ask for help, it is a step toward building resilience.**

When parents seek help, it should be provided in a manner that does not increase stress. Services should be coordinated, respectful, caring and strengths-based. Strengths-based practice is grounded in the beliefs that:

- It is essential to forge a trusting relationship between parents and service providers and among service providers working with the same families
- Regardless of the number or level of adverse conditions parents are experiencing, they have assets within and around them, their family and their community that can be called upon to help mitigate the impact of stressful conditions and to create needed change
- Parents have unrealized resources and competencies that must be identified, mobilized and appreciated
- Parents must be active participants in the change process and not passive recipients of services
- Parents must first be guided through, and subsequently learn how to navigate, the complex web of health care and social service systems
- In addition to addressing each parent's individual difficulties, strengths-based practitioners must understand—and work to change—the structural inequities and conditions that contribute to these difficulties

A strengths-based approach helps parents feel valued because they are acknowledged as knowledgeable and competent. They develop a sense of self-confidence and self-efficacy because they have opportunities to build their skills, experience success and provide help to others. Thus, access to concrete support in times of need must be accompanied by a quality of service coordination and delivery that is designed to preserve parents' dignity and to promote their and their family's healthy development, resilience and ability to advocate for and receive needed services and resources.

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# CONCRETE SUPPORT IN TIMES OF NEED: ACTION SHEET

## Your role as a caseworker

As the family's caseworker your role is not just to provide referrals to needed services, but to identify any barriers the families may have in accessing those services. Helping families overcome those barriers is crucial to ensuring that their concrete needs are met. Such help may entail:

- Encouraging help seeking behavior
- Working with the family to understand their past experience with service systems and any stigma they attach to certain services
- Helping the family to navigate complex systems by explaining eligibility requirements, filling out forms or making a warm handoff to an individual who can help them negotiate getting access to the services they need
- Helping the caregiver understand their role as an advocate for themselves and their child

## Questions to ask

- What do you need to _____ (stay in your house, keep your job, pay your heating bill etc.)?
- What have you done to handle the problem? Has this worked?
- Are there community groups or local services that you have worked with in the past? What has been your experience accessing their services?
- Are there specific barriers that have made it difficult for you to access services in the past?
- How does dealing with these issues impact the way you parent?

## What to look for

- Is the caregiver open to accessing and utilizing services?
- Has the caregiver had positive experiences with services in the past?
- Does the caregiver have specific barriers (literacy, lack of transportation, etc.) that will make it difficult to access services?
- Are there personal behavioral traits (e.g., punctuality, willingness to share personal information, etc.) that the caregiver could address to more effectively utilize services?
- Does the caregiver try to buffer the child from the stress caused by the family's concrete needs?

## Activities to do with parents

- Ask the parent to identify one concrete need that, if met, would lighten his or her burden. Come up with a list of at least three possible avenues to get that need met (e.g., agencies to approach, people to ask for help, cutting back on other expenses).
- Talk to the parent about what their family's socioeconomic status was in their childhood and what effect that had on them. Discuss things their parents did or did not do to buffer them from the stress of poverty, to teach them the value of money or to make sure their needs were met.

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# SOCIAL-EMOTIONAL COMPETENCE OF CHILDREN

PROTECTIVE & PROMOTIVE FACTORS

Early childhood is a period of both great opportunity and vulnerability. Early childhood experiences set the stage for later health, well-being and learning. In the past, most of the focus was on building young children's academic skills in an effort to ensure they were prepared for school. **However, in recent years a growing body of research has demonstrated the strong link between young children's social-emotional competence and their cognitive development, language skills, mental health and school success.** The dimensions of social-emotional competence in early childhood include:

- self-esteem - good feelings about oneself
- self-confidence - being open to new challenges and willing to explore new environments
- self-efficacy - believing that one is capable of performing an action
- self-regulation/self-control - following rules, controlling impulses, acting appropriately based on the context
- personal agency - planning and carrying out purposeful actions
- executive functioning - staying focused on a task and avoiding distractions
- patience - learning to wait
- persistence - willingness to try again when first attempts are not successful
- conflict resolution - resolving disagreements in a peaceful way
- communication skills - understanding and expressing a range of positive and negative emotions
- empathy - understanding and responding to the emotions and rights of others
- social skills - making friends and getting along with others
- morality - learning a sense of right and wrong

These dimensions of social-emotional competence do not evolve naturally. The course of social-emotional development—whether healthy or unhealthy—depends on the quality of nurturing attachment and stimulation that a child experiences. Numerous research studies show that a relationship with a consistent, caring and attuned adult who actively promotes the development of these dimensions is essential for healthy social-emotional outcomes in young children. Actively promoting social-emotional competence includes activities such as:

- Creating an environment in which children feel safe to express their emotions
- Being emotionally responsive to children and modeling empathy
- Setting clear expectations and limits (e.g., "People in our family don't hurt each other.")
- Separating emotions from actions (e.g., "It's okay to be angry, but we don't hit someone when we are angry.")
- Encouraging and reinforcing social skills such as greeting others and taking turns
- Creating opportunities for children to solve problems (e.g., "What do you think you should do if another child calls you a bad name?")

Children who have experiences such as these are able to recognize their and others' emotions, take the perspective of others and use their emerging cognitive skills to think about appropriate and inappropriate ways of acting. Conversely, research shows children who do not have adults in their lives who actively promote social-emotional competence may not be able to feel remorse or show empathy and may lack secure attachments, have limited language and cognitive skills and have a difficult time interacting effectively with their peers. Evidence shows, however, that early and appropriate interventions that focus on social-emotional development can help to mitigate the effects of negative experiences in ways that lead to improved cognitive and social-emotional outcomes.

5 OF 5

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# SOCIAL AND EMOTIONAL COMPETENCE OF CHILDREN: ACTION SHEET

## Your role as a caseworker

It is important to increase caregivers' awareness of the importance of early relationships and of their role in nurturing their child's social-emotional development by:

- Providing concrete tips and resources to caregivers to help them build their skills
- Staying attuned to trauma and how it impacts the child's relationships with significant adults and, as they grow, with peers
- Connecting the family to resources that can help support the child's social-emotional development—these might be simple (such as classes like Second Step, or books and games that help children to name or recognize their emotions) or more intensive (such as mental health counseling)
- Providing families with support in dealing with children's attachment issues and/or challenging behaviors
- Taking time to explain and discuss children's behavior with caregivers when they are "acting out" due to trauma

## Questions to ask

- How is the emotional relationship between you and your child?
- How do you express love and affection to your child?
- How do you help your child express his or her emotions?
- In what situations are your child's emotions hard for you to deal with?

## What to look for

- Do the caregivers know how to encourage social-emotional development and apply a range of age-appropriate disciplinary strategies?
- Does the caregiver create an environment in which the child feels safe to express emotions?
- Is the caregiver emotionally responsive to the child?
- Does the caregiver model empathy?
- Does the caregiver set clear expectations and limits (e.g., "People in our family don't hurt each other")?
- Does the caregiver separate emotions from actions (e.g., "It's okay to be angry, but we don't hit someone when we are angry")?
- Does the caregiver encourage and reinforce social skills such as greeting others and taking turns?
- Does the caregiver create opportunities for children to solve problems? (e.g., "What do you think you should do if another child calls you a bad name?")?

## Activities to do with parents

- Have the parent sketch out (or write out) an interaction with their child. Begin with an experience that typically makes the child happy, sad, frustrated or angry. Then have the parent illustrate or describe what the child does when he or she feels those emotions, how the parent responds and how the child responds. Identify and talk through positive or negative patterns in the interaction.
- Ask the parent to think of an adult who they loved as a child. What was it about the relationship with that adult that made it so important? Ask them what elements of that relationship they can replicate in their relationship with their child(ren).

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# DSS-5230: Family Risk Assessment of Child Abuse/Neglect

**NORTH CAROLINA**
**SDM® FAMILY RISK ASSESSMENT OF CHILD ABUSE/NEGLECT**

**Case Name:** _____ **Case #:** _____ **Date:** _____

**County Name:** _____ **Social Worker Name:** _____ **Date Report Received** _____

**Children:** _____

**Primary Caretaker:** _____ **Secondary Caretaker:** _____

**(Regardless of the type of allegations reported, ALL items on the risk assessment are to be completed.)**

**RISK OF FUTURE NEGLECT** **SCORE**

**N1. Current report is for neglect or both neglect and abuse**
a. No....0
b. Yes....1 ____

**N2. Number of prior CPS assessments** *(take highest score)*
a. None....0
b. One or more family assessments....1
c. One or more investigative assessments....2 ____

**N3. Prior CPS in-home/out-of-home service history**
a. No....0
b. Yes....1 ____

**N4. Number of children residing in the home at time of current report**
a. Two or fewer....0
b. Three or more....1 ____

**N5. Age of primary caretaker** *(note: score is either 0 or -1)*
a. 30 or older....-1
b. 29 or younger....0 ____

**N6. Age of youngest child in the home**
a. 3 or older....0
b. 2 or younger....1 ____

**N7. Number of adults residing in home at time of report**
a. Two or more....0
b. One or none....1 ____

**N8. Caretaker(s) history of abuse/neglect**
a. No....0
b. Yes....1 ____

**N9. Either caretaker has/had a drug or alcohol problem**
a. No....0
b. One or more apply....1 ____
Primary: ☐ Within last 12 months ☐ Prior to last 12 months
Secondary: ☐ Within last 12 months ☐ Prior to last 12 months

**N10. Either caretaker has/had a mental health problem**
a. No....0
b. One or more apply....2 ____
Primary: ☐ Within last 12 months ☐ Prior to last 12 months
Secondary: ☐ Within last 12 months ☐ Prior to last 12 months

**RISK OF FUTURE ABUSE** **SCORE**

**A1. Current report is for abuse or both neglect and abuse**
a. No....0
b. Yes....1 ____

**A2. Number of prior CPS investigative assessments**
a. None....0
b. One or more....2 ____

**A3. Prior CPS in-home/out-of-home service history**
a. No....0
b. One or more apply....1 ____
☐ Prior case open for in-home, CPS services
☐ Prior case open for foster care services

**A4. Age of youngest child in the home**
a. 4 or under....0
b. 5 or older....1 ____

**A5. Number of children residing in home at time of current report**
a. Two or fewer....0
b. Three or more....1 ____

**A6. Caretaker(s) history of abuse/neglect**
a. No....0
b. Yes....1 ____

**A7. Child characteristics**
a. Not applicable....0
b. One or more apply....1 ____
☐ Developmental disability
☐ Mental Health and/or behavioral problems
☐ History of delinquency

**A8. Either caretaker is a domineering parent**
a. No....0
b. Yes....1 ____

**CONTINUE TO PAGE 2**

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**N11. Either caretaker has barriers to accessing community resources**
a. No....0
b. One or more apply....1 _____
☐ Difficulty finding/obtaining resources
☐ Refusal to utilize available resources

**N12. Either caretaker lacks parenting skills**
a. No....0
b. One or more apply....1 _____
☐ Inadequate supervision of children
☐ Uses excessive physical/verbal discipline
☐ Lacks knowledge of child development

**N13. Either caretaker involved in harmful relationships**
a. No....0
b. Yes....1 _____

**N14. Child characteristics**
a. Not applicable....0
b. One or more apply....1 _____
☐ Mental Health and/or behavioral problems
☐ Medically fragile/failure to thrive diagnosis
☐ Developmental disability
☐ Learning disability
☐ Physical disability

**N15. Housing/basic needs unmet**
a. Not applicable....0
b. One or more apply....1 _____
☐ Family lacks clothing and/or food
☐ Family lacks housing or housing is unsafe

**TOTAL NEGLECT RISK SCORE** _____

**A9. Either caretaker is/was a victim/perpetrator of domestic violence**
a. No....0
b. Yes....1 _____
Primary:
☐ Victim within last 12 months
☐ Victim prior to last 12 months
☐ Perpetrator within last 12 months
☐ Perpetrator prior to last 12 months
Secondary:
☐ Victim within last 12 months
☐ Victim prior to last 12 months
☐ Perpetrator within last 12 months
☐ Perpetrator prior to last 12 months

**A10. Caretaker(s) response to current assessment**
a. Not applicable....0
b. One or more apply....1 _____
☐ Caretaker unmotivated to improve parenting skills
☐ Caretaker viewed situation less seriously than worker
☐ Caretaker failed to cooperate satisfactorily

**A11. Either caretaker has interpersonal communication problems**
a. No....0
b. One or more apply....1 _____
☐ Lack of communication impairs functioning
☐ Poor communication impairs functioning

**TOTAL ABUSE RISK SCORE** _____

**SCORED RISK LEVEL**
Assign the family's risk level based on the highest score on either scale, using the following chart:

| Neglect Score | Abuse Score | Risk Level |
|---|---|---|
| ☐ -1–2 | ☐ 0–2 | ☐ Low |
| ☐ 3–5 | ☐ 3–5 | ☐ Moderate |
| ☐ 6–16 | ☐ 6–12 | ☐ High |

**OVERRIDES**
Policy: Override to high; mark appropriate reason.

☐ 1. Sexual abuse cases where the perpetrator is likely to have access to the child victim.
☐ 2. Cases with non-accidental physical injury to an infant.
☐ 3. Serious non-accidental physical injury warranting hospital or medical treatment.
☐ 4. Death (previous or current) of a sibling as a result of abuse or neglect.

Discretionary: Override (increase or decrease **one level** with supervisor approval). Provide reason below.

Reason: _____

**OVERRIDE RISK LEVEL:** ☐ Low ☐ Moderate ☐ High

**Social Worker:** _____ **Date:** _____

**Supervisor's Review/Approval of Override:** _____ **Date:** _____

DSS-5230 Revised 11-09 Child Welfare Services

**NORTH CAROLINA**
**SDM® FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT**
**DEFINITIONS**

Only one household should be assessed on a risk assessment form. If the allegations involve maltreatment in two households and both have responsibilities for child care, complete **two** separate risk assessments. In situations where the parents are not living together, a family risk assessment of abuse/neglect will **only** be completed on the home of the alleged perpetrator.

The primary caretaker is the adult (typically, the parent) living in the household who assumes the most responsibility for child care. When two adult caretakers are present and the worker is in doubt about which one assumes the most child care responsibility, the adult legally responsible for the child involved in the incident should be selected. If this rule does not resolve the question, the legally responsible adult who is an alleged perpetrator should be selected. **Only *one* primary caretaker can be identified (per form/household).**

The secondary caretaker is defined as an adult living in the household who has routine responsibility for child care, but less responsibility than the primary caretaker. A live-in partner can be a secondary caretaker even though he/she has minimal responsibility for the care of the child.

**NEGLECT SCALE**

**N1. Current report is for neglect or both neglect and abuse**

a. Score 0 if the current report is not for neglect.

b. Score 1 if the current report is for neglect or both abuse and neglect. This includes any allegations under assessment even if not identified in the original report.

**N2. Number of prior CPS assessments**
Use Central Registry to count all maltreatment reports for all children in the home which were assigned for CPS assessment (both family assessments and investigative assessments) for any type of abuse or neglect prior to the report resulting in the current assessment. Include prior assessments that resulted in temporary or permanent placement of a child, even if that child is no longer in the home. If information is available, include prior maltreatment assessments conducted in other states.

a. Score 0 if there were no CPS assessments prior to the current report.

b. Score 1 if there were one or more family assessments prior to the current report.

c. Score 2 if there were one or more investigative assessments prior to the current report (if there were both one or more prior family assessments and one or more prior investigative assessments, score 2).

**N3. Prior CPS in-home or out-of-home service history**
Contact other counties and states where there is believed to be prior CPS service history on this family.

a. Score 0 if this family has not received CPS in-home or out-of-home services as a result of a prior finding of "substantiated" or "services needed" report of abuse and/or neglect.

b. Score 1 if this family has received CPS in-home or out-of-home services as a result of a prior finding of "substantiated" or "services needed" report of abuse or neglect, or is receiving CPS in-home or out-of-home services at the time of the current assessment.

**N4. Number of children residing in the home at time current report**
Number of individuals under 18 years of age *residing* in the home at the time of the current report. If multiple families reside in the home, count all children. Children within a residential placement but in the custody of the caretaker(s) should be counted as residing in the home. If a child is on runaway status, is removed, whether placed in foster care or with a safety resource as a result of current CPS involvement, count the child as residing in the home (I.E. if there was never closure of

current CPS Services whether In-Home or Out-of-Home being provided and a new report is made, count the child as in the home).

a. Score 0 if two or fewer children were residing in the home at the time of the current report.

b. Score 1 if three or more children were residing in the home at the time of the current report.

**N5. Age of primary caretaker**

Age at the time of current assessment.

a. Score -1 if the primary caretaker is 30 or older at the time of the current report.

b. Score 0 if the primary caretaker is 29 or younger at the time of the current report.

**N6. Age of youngest child in the home**

Choose the appropriate score given the current age of the youngest child in the household where the maltreatment incident reportedly occurred. Youngest children within a residential placement but in the custody of the caretaker(s) should be counted as residing in the home. If a child is on runaway status, is removed, whether placed in foster care or with a safety resource as a result of current CPS involvement, count the child as residing in the home (I.E. if there was never closure of current CPS Services whether In-Home or Out-of-Home being provided and a new report is made, count the child as in the home).

a. Score 0 if the youngest child is 3 years old or older at the time of the current report.

b. Score 1 the youngest child is 2 years old or younger at the time of the current report.

**N7. Number of adults residing in home at time of report**

Count number of individuals 18 years of age or older *residing* in the home at time of the current report.

a. Score 0 if two or more adults were residing in the home at the time of the current report.

b. Score 1 if one or no adults were residing in the home at the time of the current report.

**N8. Either caretaker has history of abuse/neglect**

a. Score 0 if neither caretaker was abused and or neglected as a child, based on credible statements by the caretaker(s) or others.

b. Score 1 if credible statements were provided by the caretaker(s) or others regarding whether *either or both* caretakers were abused and or neglected as children.

**N9. Either caretaker has/had a drug or alcohol problem**

Either caretaker has/had alcohol/drug abuse problems, evidenced by use causing conflict in home, extreme behavior/attitudes, financial difficulties, frequent illness, job absenteeism, job changes or unemployment, driving under the influence (DUI), traffic violations, criminal arrests, disappearance of household items (especially those easily sold), or life organized around substance use.

a. Score 0 if neither caretaker has or has ever had a drug or alcohol problem, or has some substance use problems that minimally impact family functioning.

b. Score 1 if either caretaker has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Such interference is evidenced by the following:

- Substance use that affects or affected employment; criminal involvement; marital or family relationships; and/or caretaker's ability to provide protection, supervision, and care for the child;
- An arrest in the past two years for DUI or refusing breathalyzer testing;

- Self-report of a problem;
- Treatment received currently or in the past;
- Multiple positive urine samples;
- Health/medical problems resulting from substance use and/or abuse;
- The child's diagnosis with fetal alcohol syndrome or exposure (FAS or FAE), or the child's positive toxicology screen at birth and the primary caretaker was the birthing parent.

Legal, non-abusive prescription drug use should not be scored. Abuse of legal, prescription drugs should be scored.

Indicate whether the drug and/or alcohol problem was/is present DURING the last 12 months and/or was present PRIOR to the last 12 months by the primary or secondary caretaker.

**N10. Either caretaker has/had a mental health problem**

a. Score 0 if the caretaker(s) does not have a current or past mental health problem and caretaker demonstrates good coping skills.

b. Score 2 if credible and/or verifiable statements by either caretaker or other indicate that either caretaker:

- Has been diagnosed as having a significant mental health disorder as indicated by a DSM Axis I condition determined by a mental health professional;
- Has had repeated referrals for mental health/psychological evaluations; or
- Was recommended for treatment/hospitalization or was treated/ hospitalized for emotional problems.

Indicate whether the mental health problem was/is present DURING the last 12 months and/or was present PRIOR to the last 12 months by the primary or secondary caretaker.

**N11. Either caretaker has barriers to accessing community resources**

a. Score 0 if the caretaker(s) has no need for community resources; caretaker(s) seeks out resources that are not immediately available; or caretaker(s) accesses and utilizes community resources.

b. Score 1 if the caretaker(s) experiences resource utilization problems as evidenced by the following:

- Caretaker(s) do not know about resources available in the community or caretaker(s) cannot or do not attempt to identify available resources;
- Caretaker(s) are unable to access available resources; or
- Caretaker(s) refuse to utilize/accept available community resources.

**N12. Either caretaker lacks parenting skills**

a. Score 0 if caretaker(s) displays parenting patterns which are age-appropriate for children in the home, including providing adequate supervision, realistic expectations and appropriate discipline.

b. Score 1 if caretaker(s) lacks parenting skills as evidenced by the following:

- Inadequate supervision of children;
- Use of excessive physical/verbal discipline; or

- Lacks knowledge of child development: Caretaker's lack of knowledge regarding child development and/or age-appropriate expectations for children.

**N13. Either caretaker involved in harmful relationships**

a. Score 0 if neither caretaker is involved in harmful relationships.

b. Score 1 if either caretaker is involved in any harmful adult relationships, including any of the following:

- Adult relationships outside the home which are harmful to domestic functioning or child care, such as criminal activities;

- Current relationship or domestic discord inside the home, including frequent arguments, degradation, or blaming. Open disagreement on how to handle child problems/discipline. Frequent and/or multiple transient household members. Violent acts that cause minor or no injury to any household member and are not assessed as "domestic violence;" or

- Domestic violence, defined as the establishment of control and fear in an intimate relationship through the use of violence and other forms of abuse including but not limited to physical, emotional, or sexual abuse; economic oppression; isolation; threats; intimidation; and maltreatment of the children to control the non-offending parent/adult victim. Domestic violence may be evidenced by repeated history of leaving and returning to abusive partner(s), repeated history of violating court orders by the perpetrator of domestic violence, repeated history of violating safety plans, involvement of law enforcement and/or restraining orders, or serious or repeated injuries to any household member.

**N14. Child characteristics**

a. Score 0 if no child in the household exhibits characteristics described below.

b. Score 1 if any child in the household exhibits any of the characteristics described below. Mark all that apply.

- Mental health and/or behavioral problem: Any child in the household has mental health or behavioral problems not related to a physical or developmental disability. This could be indicated by a DSM Axis I diagnosis, receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking prescribed psychoactive medications.

- Any child is medically fragile or diagnosed with failure to thrive.

  » Medically fragile: Medically fragile describes a child who has any condition diagnosed by a physician that can become unstable and change abruptly, resulting in a life-threatening situation; and which requires daily, ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members, and requires the routine use of a medical device or of assistive technology to compensate for the loss of usefulness of a body function needed to participate in the activities of daily living, and child lives with ongoing threat to his or her continued well-being. Examples include a child who requires a trach-vent for breathing or a g-tube for eating.

  » Failure to thrive: A diagnosis by a physician that the child has failure to thrive.

- Developmental disability: A severe, chronic condition due to mental and/or physical impairments which has been diagnosed by a physician or mental health professional. Examples include mental retardation, autism spectrum disorders, and cerebral palsy.

- Learning disability: Child has an individualized education program (IEP) to address a learning disability such as dyslexia. Do not include an IEP designed solely to address mental health or behavioral problems. Also include a child with a learning disability diagnosed by a physician or mental health professional who is eligible for an IEP but does not yet have one, or who is in preschool.

- Physical disability: A severe acute or chronic condition diagnosed by a physician that impairs mobility, sensory, or motor functions. Examples include paralysis, amputation, and blindness.

**N15. Housing/basic needs unmet**

a. Score 0 if the family has adequate housing, clothing, and food; or if the family has minor housing, clothing, and food problems that can be corrected using resources available to the family, and the family is willing to correct these problems.

b. Score 1 if the family has serious housing, clothing, and food problems that are not easily correctable or which the family is not willing to correct. This may include condemned or inhabitable housing, chronic homelessness, and lack of clothing and/or food.

**ABUSE SCALE**

**A1. Current report is for abuse or both neglect and abuse**

a. Score 0 if the current report is not for abuse.

b. Score 1 of the current report is for abuse or both abuse and neglect. This includes any allegations under assessment even if not identified in the original report.

**A2. Number of Prior CPS investigative assessments**
Use Central Registry to count all CPS investigative assessments for all children in the home for any type of abuse or neglect prior to the report resulting in the current assessment. If information is available, include prior maltreatment investigations conducted in other states.

a. Score 0 if there were no CPS investigative assessments prior to the current report.

b. Score 2 if there were one or more CPS investigative assessments prior to the current report.

**A3. Prior CPS in-home or out-of-home service history**
Contact other counties and states where there is believed to be prior CPS history on this family.

a. Score 0 if this family has not received CPS **in-home or out-of-home** services as a result of a prior finding of "substantiated" or "services needed" report of abuse and/or neglect.

b. Score 1 if this family has received CPS **in-home or out-of-home** services as a result of a prior finding of "substantiated" or "services needed" report of abuse or neglect, or is receiving CPS **in-home or out-of-home** services at the time of the current assessment.

**A4. Age of youngest child in the home**
Choose the appropriate score given the current age of the youngest child in the household where the maltreatment incident reportedly occurred. Youngest children within a residential placement but in the custody of the caretaker(s) should be counted as residing in the home. If a child is on runaway status, is removed, whether placed in foster care or with a safety resource as a result of current CPS involvement, count the child as residing in the home (I.E. if there was never closure of current CPS Services whether In-Home or Out-of-Home being provided and a new report is made, count the child as in the home).

a. Score 0 if the youngest child in the home was 4 years of age or younger at the time of the current report.

b. Score 1 if the youngest child in the home was 5 years of age or older at the time of the current report.

**A5. Number of children residing in home at time of current report**

Number of individuals under 18 years of age *residing* in the home at the time of the current report. If multiple families reside in the home, count all children. Children within a residential placement but in the custody of the caretaker(s) should be counted as residing in the home. If a child is on runaway status, is removed, whether placed in foster care or with a safety resource as a result of current CPS involvement, count the child as residing in the home (I.E. if there was never closure of current CPS Services whether In-Home or Out-of-Home being provided and a new report is made, count the child as in the home).

a. Score 0 if two or fewer children were residing in the home at the time of the current report.

b. Score 1 if three or more children were residing in the home at the time of the current report.

**A6. Either caretaker has history of abuse/neglect**

a. Score 0 if neither caretaker was abused and or neglected as a child, based on credible statements by the caretaker(s) or others.

b. Score 1 if credible statements were provided by the caretaker(s) or others regarding whether *either or both* caretakers were abused and or neglected as children.

**A7. Child characteristics**

a. Score 0 if no child in the household exhibits characteristics described below.

b. Score 1 if any child in the household exhibits any of the characteristics described below. Mark all that apply.

- Developmental disability: A severe, chronic condition due to mental and/or physical impairments which has been diagnosed by a physician or mental health professional. Examples include mental retardation, autism spectrum disorders, and cerebral palsy.

- Mental health and/or behavioral problem: Any child in the household has mental health or behavioral problems not related to a physical or developmental disability. This could be indicated by a DSM Axis I diagnosis, receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking prescribed psychoactive medications.

- History of delinquency: Any child has been referred to juvenile court for delinquent behavior, being undisciplined, entering into diversion plans, or status offense behavior. Status offenses not brought to court attention but which create stress within the household should also be scored here, such as children who run away from home, are habitually truant from school, or have drug or alcohol problems.

**A8. Either caretaker(s) is a domineering parent**

a. Score 0 if neither caretaker is a domineering parent.

b. Score 1 if *either* caretaker is domineering over child(ren), evidenced by rude remarks/behavior or controlling, abusive, unreasonable and/or excessive rules; or is overly restrictive, overreacts, is unfair, or is berating.

**A9. Either caretaker involved in domestic violence**

a. Score 0 if neither caretaker is a victim/perpetrator of domestic violence.

b. Score 1 if either caretaker is in a relationship characterized by domestic violence, defined as the establishment of control and fear in an intimate relationship through the use of violence and other forms of abuse, including but not limited to physical, emotional, or sexual abuse; economic oppression; isolation; threats; intimidation; and maltreatment of the children to control the non-offending parent/adult victim. Domestic violence may be evidenced by repeated history of leaving and returning to abusive partner(s), repeated history of violating court orders by the perpetrator of domestic violence, repeated history of violating safety plans, involvement of law enforcement and/or restraining orders, or serious or repeated injuries to any household member.

Indicate whether the domestic violence occurred DURING the last 12 months and/or was PRIOR to the last 12 months by the primary or secondary caretaker.

**A10. Caretaker(s) response to current assessment**

a. Score 0 if the caretaker(s) responded appropriately to the current assessment; the caretaker(s) regard the incident as serious and cooperate with the worker and are motivated to improve parenting skills.

b. Score 1 if any of the following apply to the current situation:

- Either caretaker is unmotivated to take steps necessary or recommended to improve parenting skills;
- Either caretaker views the current situation less seriously than worker or minimizes the level of harm to the child; and/or
- Either caretaker fails to cooperate satisfactorily by refusing involvement in the assessment and/or refuses access to the child(ren) during the assessment, etc.

An initial reaction of fear or anger at the process of being reported to CPS should be addressed through a discussion with the caretaker(s) before considering scoring any of the above.

**A11. Either caretaker has interpersonal communication problems**

a. Score 0 if family communication is functional and personal boundaries and emotional attachments are appropriate. Minor disagreements and/or lack of communication may occur, but only occasionally interfere with family interactions.

b. Score 1 if either caretaker's communication problems impair the ability to maintain positive relationships, make friends, keep a job, or meet the needs of family members.

**NORTH CAROLINA DEPARTMENT OF SOCIAL SERVICES**
**SDM® FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT**
**POLICY AND PROCEDURES**

The Family Risk Assessment determines the level of risk of future harm in the family and determines the level of service to be provided to each family. It identifies families which have high, moderate, or low probabilities of future risk of abuse or neglect of their children. By completing the risk assessment, the worker obtains an objective appraisal of the likelihood that a family will maltreat their children in the next 18 months. The difference between the risk levels is substantial. High-risk families have significantly higher rates than low risk families of subsequent reports and substantiations and are more often involved in serious abuse or neglect incidents.

The risk scales are based on research on cases with "substantiated" or "services needed" abuse or neglect that examined the relationships between family characteristics and the outcomes of subsequent abuse and neglect. The scales do not predict recurrence simply that a family is more or less likely to have another incident without intervention by the agency. One important result of the research is that a single instrument should not be used to assess the risk of both abuse and neglect. Different family dynamics are present in abuse and neglect situations. Hence, separate scales are used to assess the future probability of abuse or neglect.

**Complete both the abuse and neglect scales regardless of the type of allegation(s) reported or assessed. All items on the risk assessment scales are completed.** ***The assigned social worker must make every effort throughout the assessment to obtain the information needed to answer each assessment question.*** **However, if information cannot be obtained to answer a specific item, score the item as "0."**

**Which cases:** All CPS maltreatment reports assigned for an assessment that involve a family caretaker. This does not apply to reports involving child care facilities; residential facilities such as group homes or DHHS facilities. This does apply to non-licensed living arrangements, the non-custodial parents home or licensed family foster homes.

**Who completes:** Social worker assigned to complete the assessment.

**When:** The risk assessment shall be completed and documented prior to the case decision. It is one of the elements considered in making the case decision.

A risk assessment shall also be completed when a new CPS report occurs in an open CPS In-Home or Out-of-Home Services case.

For children coming into the agency's legal custody through delinquency, the risk assessment shall serve as the baseline assessment documentation.

**Decision:** The risk assessment identifies the level of risk of future maltreatment and guides the case decision including whether to close a report or open a case for CPS In-Home or Out-of-Home Services.

**Appropriate Completion:** Only **one** household can be assessed on the risk assessment form. If the allegations involve maltreatment in two households and both have responsibilities for childcare, complete two separate Risk Assessment tools. In situations where the parents are not living together, a Family Risk Assessment of Abuse/Neglect will only be completed on the home of the alleged perpetrator.

In situations where an adult relative is entrusted with the care of the child and is the alleged perpetrator, the risk assessment is conducted in the home where the child resides. In some cases (for example, joint custody cases), it may be difficult to identify the household in which the children reside. The household which provides the majority of the child care should be selected. If that fails, choose the household where the CA/N incident took place.

Some items are very objective (such as prior CPS In/Out-of-Home Service history or the age of the caretaker). ***Others*** require the worker to use discretionary judgment based on his or her assessment of the family.

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Following scoring all items in each scale, the assigned social worker totals the score for each scale and determines the risk level by checking the appropriate boxes in the risk level section. The highest score from either scale determines the risk level.

**Overrides**

**Policy Overrides**

Policy overrides reflect incident seriousness and child vulnerability concerns, and have been determined by the agency to be case situations that warrant the highest level of service from the agency regardless of the risk scale score. If any policy override reasons exist, the risk level is increased to high.

After completing the risk scales, the assigned social worker indicates if any policy override reasons exist. If more than one reason exists, indicate the primary override reason. Only one reason can be selected. All overrides must be approved in writing by the supervisor.

**Discretionary Overrides**

The assigned social worker also indicates if there are any discretionary override reasons. A discretionary override is used to increase or decrease the risk level by one increment in any case where the assigned social worker feels the risk level set by the scales is too low or too high. All overrides must be approved in writing by the supervisor.

Discretionary overrides should be used only in exceptional cases.

## Managing Crucial Conversations

| Steps | How Do I Do This? |
|---|---|
| Start with the Heart. | Start from a genuine, well-intentioned place. Start a conversation gently. |
| Learn to Look. | Look for signs of stress, conflict, and emotional elevation. Notice when your safety is at risk. Manage your own response tendencies. Look for language and behavior that could escalate the conversation |
| Make it Safe. | Notice when others don't feel safe to respond, check to make sure you are listening well and validating. Keep highlighting the common goal. When you notice a risk, "step out" of the conversation and work to restore safety. |
| Master Your Stories. | Manage intended and unintended bias and check how you see others. "Stories" are assumptions we make for why others are doing what they are doing. Assumptions can interfere with your conversation. |
| State Your Path. | Share very specific concerns and a clear explanation of the purpose for the conversation. Talk about your experience and inquire about the ways of others. Speak cautiously to be clear and not too soft or too firm. |
| Explore Others' Perspectives. | Active listening becomes key, and empathy is critical. Validate the person's feelings while maintaining the importance of what needs to be accomplished. |
| Move to Action. | Make decisions and commit to action together. |

## Defining Quality Contacts


Good child welfare practice relies on quality contacts between caseworkers and children, youth, parents, and resource parents (foster parents and other caregivers). Moreover, quality contacts ensure child safety, support permanency planning, and promote child and family well-being. Developed by the Capacity Building Center for States (the Center) as a suite of products and learning tools, **Quality Matters: Improving Caseworker Contacts With Children, Youth, and Families** supports public child welfare agencies and contracted service providers in conducting quality contacts. This issue brief—the first product in the suite—provides a foundation for understanding what quality contacts are, what they look like, why they are important, and how a child welfare agency can set the stage for their successful implementation.

# What Are Quality Contacts?

## Definition

**Quality contacts are . . .**

Purposeful interactions between caseworkers and children, youth, parents, and resource parents that reflect engagement and contribute to assessment and case planning processes. These face-to-face interactions often are referred to as "home visits" or "caseworker visits."

## Core Components and Characteristics of Quality Contacts

As a cornerstone of casework practice, quality contacts reflect a focused exchange of ideas and information (Atif & National Resource Center for Child Protective Services, 2010). These contacts should go beyond a "friendly visit to chat about how the kids are doing" and represent a professional consultation (National Resource Center for Family-Centered and Permanency Planning, 2008).

Quality contacts incorporate the following components:

- **Preparation and planning** tailored to the specific circumstances of the child or youth and family
- **Assessment** of:
  - Safety, risk, permanency, and well-being
  - Progress toward individual case goals
- **Engagement** of children, youth, parents, and resource parents by the caseworker through use of empathy, genuineness, and respect
- **Dialogue** that values the youth and parent voice and promotes reflection on strengths, needs, and concerns
- **Follow-up** on tasks or concerns discussed previously (this may include difficult conversations about why certain things did not happen as planned)

- **Decision-making and problem solving** to address needs and move the case plan forward
- **Documentation** to support monitoring and follow-up

Federal, State, and local guidelines establish a foundation for a quality contact, while attributes of good casework practice are demonstrated throughout. Exhibit 1 highlights the characteristics of a quality contact.

**Exhibit 1. Characteristics of Quality Contacts**


# Why Quality Contacts Are Important

Good casework practice depends on quality contacts.

## Good Casework Practice

Quality contacts provide important opportunities for caseworkers to:

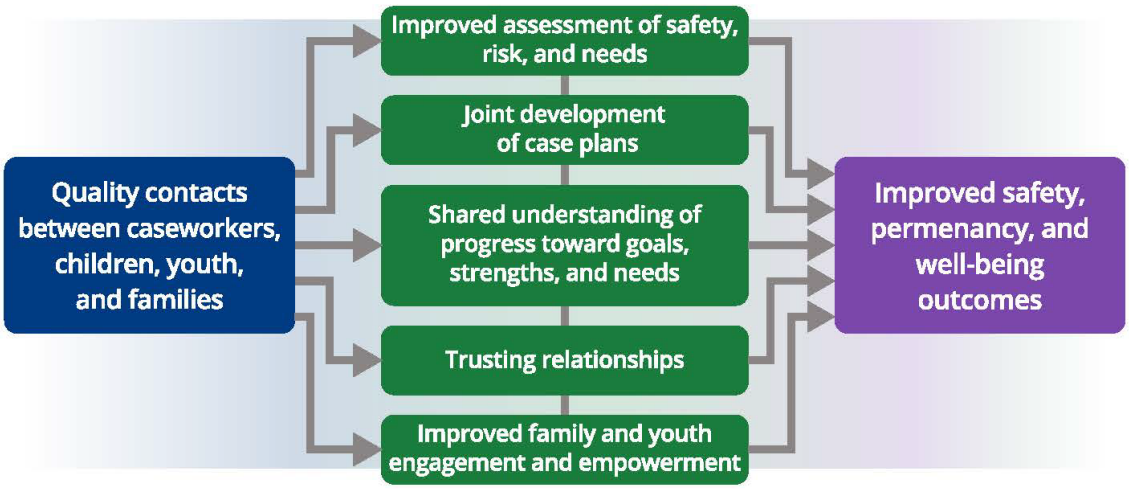
- Ensure child safety
- Make personal connections and develop trusting relationships with family members
- Observe children, youth, and families in their home settings (or other settings appropriate for the circumstances of the case)
- Work collaboratively with families to identify strengths, resources, challenges, and needs and to problem solve
- Develop case plans jointly with the family and assess ongoing progress toward case goals
- Understand and address the specific needs of children, youth, parents, and caregivers and identify opportunities for support
- Reaffirm the parents' and the agency's accountability for child safety, permanency, and well-being (National Conference of State Legislatures, 2006)

## Links to Positive Outcomes for Children and Families

Analyses from Round 1 of Federal Child and Family Services Reviews (CFSRs) (2001–04) identified relationships between the frequency and quality of caseworker visits with children and State performance on outcomes related to safety, permanency, and well-being. Findings also showed relationships between caseworker visits and assessment of children's risk of harm, parent involvement in case planning, assessment of needs, and service provision (Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services, 2003). (For a discussion on more recent rounds of CFSR findings, see "Common Challenges Affecting Quality Contacts.")

Exhibit 2 illustrates a theory of connections between quality contacts and improved outcomes.

**Exhibit 2. The Impact of Quality Contacts**




# Federal Legislation and State Policies

Federal legislation[1] establishes State requirements for quality contacts in child welfare. The Child and Family Services Improvement Act of 2006, Public Law (P.L.) 109–288, requires each State's plan for child welfare services to describe standards for the content and frequency of caseworker visits for children and youth in foster care. The law specifies, **at a minimum:**

- Monthly visits for each child and youth in out-of-home care
- Well-planned visits focused on issues relevant to case planning and service delivery to ensure child safety, permanency, and well-being

Subsequently enacted, the Child and Family Services Improvement and Innovation Act of 2011, P.L. 112–34, includes the following provisions that add to the requirements for caseworker visits:

- For fiscal year (FY) 2015 and thereafter, States must ensure that at least 95 percent of children and youth in foster care receive caseworker visits once a month while in care (increased from 90 percent during 2012–14).
- At least 50 percent of the total number of monthly visits made by caseworkers to children and youth in foster care must occur in the child's or youth's residence.
- States must submit reports on their caseworker visit performance to the Children's Bureau.[2]

P.L. 112-34 also allocates funding to support monthly worker visits and improvements in the quality of the visits with an emphasis on enhanced decision-making.

In addition to Federal laws, States commonly have written standards expressed in State and local agency policies for the frequency and content of caseworker visits with children, youth, and parents. State child welfare information systems collect data related to the frequency and quality of visits to support State child welfare policies and practices as well as Federal reporting requirements.

[1] To keep informed on changes in child welfare legislation, see Child Welfare Information Gateway's webpage on Federal laws at https://www.childwelfare.gov/topics/systemwide/laws-policies/federal/

[2] For data on State caseworker visits for children in foster care, see the Child Welfare Outcomes Report Data at https://cwoutcomes.acf.hhs.gov/cwodatasite/

# Common Challenges Affecting Quality Contacts

States often face challenges in achieving the benchmarks set in Federal legislation and State standards, as evidenced in CFSR findings.

## CFSR Findings

The Children's Bureau CFSR process monitors State child welfare programs to ensure conformity with Federal requirements, assess the experiences of children and families receiving child welfare services, and assist States in enhancing their capacity to achieve positive outcomes. Two items examined in the CFSR case reviews specifically address quality contacts:

- Item 14: Caseworker visits with child
- Item 15: Caseworker visits with parents

Findings from CFSR Round 2, which ended in 2010, indicated that States generally needed improvement on both caseworker visit items (Mitchell, Thomas, & Parker, 2014). A content analysis of Round 2 final reports identified common challenges to CFSR outcomes across States and revealed that caseworker visits with children did not focus adequately on case-planning issues, service delivery, and goal attainment. Analyses also suggested challenges in working with birth parents, particularly fathers (Mitchell et al., 2014).

Recent analyses of final reports in CFSR Round 3 by the Center suggest that States continue to experience challenges with conducting quality caseworker visits. In all 19 final reports of States that completed CFSR Round 3 reviews in FY 2015 and FY 2016,[3] both "caseworker visits with child" and "caseworker visits with parents" were identified as areas needing improvement. The proportion of applicable cases in each State that rated as a strength for these items varied widely. While performance in both areas were poor, generally States performed better on visits with children (item 14) than they did on visits with parents (item 15).

## Factors That May Affect Quality Contacts

Multiple factors may play a role in the frequency and quality of caseworker contacts, including:

- Gaps in caseworker knowledge and skills, including knowledge of effective engagement practices, competencies in ongoing safety assessment, and skills with difficult conversations
- High caseworker caseloads and workloads
- Competing priorities for caseworkers and families, which may lead to rescheduling visits or may impinge on the time and planning devoted to the contact
- Crisis management, which may draw caseworker focus away from the recommended visit components
- Long travel distances to foster home placements in rural areas or other counties
- Frequent staff turnover

States should consider these factors, as well as individual professional development needs, as they adopt strategies for building capacity for conducting quality caseworker visits (discussed further below).

[3] Analyses included States that conducted CFSR Round 3 reviews in FY 2015 and FY 2016 and for which reports were available to the Center team by February 2017.

# Key Phases and Activities in Quality Contacts

While quality contacts are an integral part of routine casework, they are just one part of the varied supports and services provided to children, youth, and families. Federal requirements of monthly visits are ***minimum*** requirements, and caseworkers need to adjust to accommodate case circumstances and to complement other supports, services, and events within the case.

A quality contact consists of more than just the time spent in the home; it begins before the visit and continues during and after. Exhibit 3 illustrates the three key phases of quality contacts.

### Exhibit 3. Key Phases of Quality Contacts


Exhibit 4 presents key casework activities during each phase that contribute to a meaningful visit. The table synthesizes and adapts guidance provided in multiple training and practice resources (Albers, n.d.; Atif & National Resource Center for Child Protective Services, 2010; Institute for Human Services, 2011a & b; National Resource Center for Family-Centered Practice and Permanency Planning, 2008 a & b). While every visit may be different and flexibility is important, Exhibit 4 provides some general guidelines.

### Exhibit 4. Key Quality Contact Casework Activities

| Quality Contact Casework Activities |
|---|
| **Before the visit** |
| **Schedule**<br>• Align visit frequency with national and State requirements and case circumstances.<br>• Consider the schedules of parents, resource parents, and youth/young adults in identifying the visit time.<br>• Consider the length and location of visits to support open and honest conversations. |
| **Gather information and review**<br>• Gather and review case documents, service plans, and related data and information.<br>• Review documentation of the last contact to ensure follow-up was completed.<br>• Make any collateral contacts with key individuals in the case (e.g., therapist, treatment provider, doctor, school personnel) to assess progress and concerns. |
| **Plan and prepare**<br>• Set a clear purpose and agenda for the visit.<br>• Identify issues and concerns to explore (with room for adaptation during the visit).<br>• Consider and plan for worker safety. |

## During the visit

**Engage and collaborate**

- Review the objectives and agenda for the visit and incorporate input from the child, youth, parent, and/or resource parent into the agenda.
- Demonstrate genuineness, empathy, and respect for each family member.
- Suspend biases and avoid judgments.
- Make sure children, youth, parents, and resource parents feel comfortable discussing challenges and needs.
- Talk with adults and children or youth separately to allow for privacy in sharing concerns.
- Communicate support and partnership.
- Listen!

**Focus on the case plan, explore progress, and make adjustments**

- Assess child safety and risk (including identification of safety threats, vulnerabilities, and protective capacities).
- Explore well-being of the child or youth and family.
- Ask developmentally appropriate questions.
- Discuss case goals, progress toward goals since the last visit, and actions needed—in language that all participants can understand.
- Identify strengths and opportunities for the child or youth and family.
- Identify concerns, changing circumstances, and challenges.
- Observe what is happening in the home.
- Discuss what the agency will do to support the family to meet identified needs and expectations for the child or youth and family.
- Make needed changes to the case plan.

**Wrap up**

- Conclude visit with a summary, next steps, and actions needed.
- Make arrangements for the next visit.

## After the visit

**Document**[4]

- Document key information, observations, and decisions in a concrete, concise, and nonjudgmental manner.
- Record information, as appropriate and in accordance with agency policies:
  - Participants
  - Date and location
  - Assessment of child safety and risk
  - Child or youth well-being (related to health, mental health, development, behavior, education, social activities, and relationships)
  - Progress toward case goals and any changes to case plan or tasks
  - Concerns expressed by the child, youth, parent, or resource parent
  - Observations on the home environment and interactions
  - Additional service needs
  - Cultural considerations
  - Follow-up activities and priorities
- Highlight actions needed, the person responsible, and target dates for easy reference.

**Debrief**

- Discuss visit and key directions with supervisor.
- Reflect on successful approaches during visits, challenges experienced, and areas for development in conducting quality contacts.

**Follow up**

- Follow up on commitments made and next steps.

[4] Visit the quality contacts webpage for more information: https://capacity.childwelfare.gov/states/focus-areas/foster-care-permanency/quality-matters

Supervisors provide critical support to caseworkers across each of the three phases. At the individual level, supervisors deliver support through supervisory conferences, coaching, and skill building, and at the group level through unit learning activities and peer sharing.

# Roles in Ensuring Quality Contacts

Within a child welfare system, multiple players contribute to the achievement of quality contacts. Exhibit 5 highlights various roles and responsibilities.

### Exhibit 5. Roles in Ensuring Quality Contacts

| | |
|---|---|
| Administrators | • Set standards and policies for quality contacts.<br>• Build agency capacity.<br>• Review performance and introduce strategies for improvement based on identified challenges. |
| Program Managers | • Monitor and support program staff in conducting quality contacts.<br>• Identify and address program barriers to quality contacts.<br>• Collaborate with IT, data, and CQI staff to promote system design and data collection that supports quality contacts. |
| Trainers | • Help build staff knowledge and skills on conducting quality contacts. |
| Supervisors | • Support caseworkers during all three phases of quality contacts.<br>• Discuss caseworker strengths and challenges in conducting visits, and promote critical thinking skills.<br>• Provide oversight to caseworker documentation of visits. |
| Caseworkers | • Plan and conduct quality contacts.<br>• Engage children, youth, parents, and resource parents.<br>• Document key information.<br>• Work together with supervisors to enhance skills. |
| Children and Youth | • Express thoughts, concerns, and needs.<br>• Partner in age appropriate decision-making and planning.<br>• Contribute to agency efforts to improve quality contacts. |
| Parents | • Express thoughts and concerns related to their case plan.<br>• Partner in decision-making and planning.<br>• Contribute to agency efforts to improve quality contacts. |
| Resource Parents and Caregivers | • Express thoughts and concerns related to child or youth well-being and needs, as well as their own.<br>• Contribute to agency efforts to improve quality contacts. |
| Information Technology Managers | • Ensure information system makes relevant case information accessible to caseworkers, supervisors, and managers.<br>• Ensure that documentation of contacts reflects agency policies and practices. |
| Data and CQI Managers | • Analyze, use, and share data to inform areas for improvement as part of the quality assurance and continuous quality improvement (CQI) processes. |

# Considerations for Building Capacity for Quality Contacts

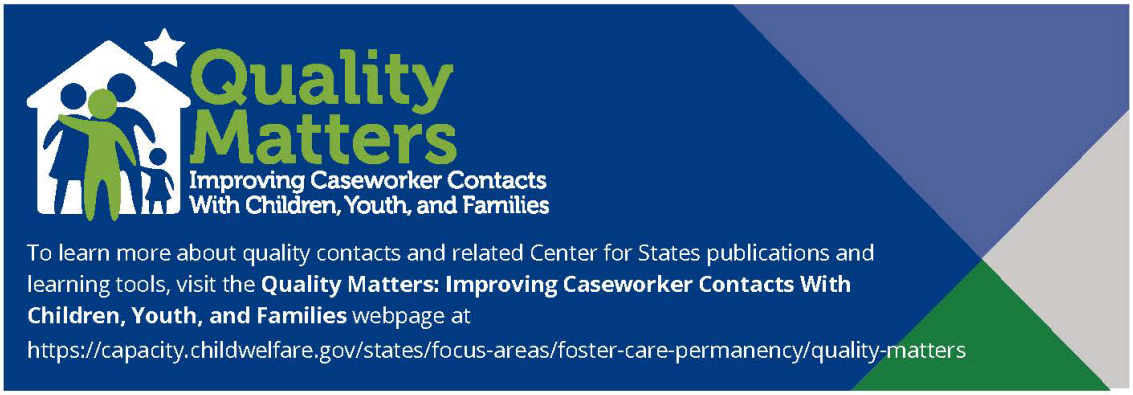
To build agency capacity for quality contacts, State and agency leadership and program managers may want to consider the following questions relating to various aspects of capacity.[5] The classification of these considerations reflects the five dimensions of capacity as defined by the Child Welfare Capacity Building Collaborative (2015).

1. **Organizational resources**
   - Does the agency have adequate staff to meet frequency and quality standards?
   - Do staff reflect the families served in the communities and speak the languages spoken in the community?
   - Are caseloads, workloads, and responsibilities appropriate to enable caseworkers to conduct quality visits that meet State standards and promote positive outcomes? If not, what changes can the agency, supervisors, and caseworkers make?
   - What additional resources do caseworkers need to support and enhance quality contacts?
2. **Organizational infrastructure**
   - Does the agency have adequate policies and standards in place to ensure that caseworkers conduct quality contacts? Do policies and standards align with Federal guidance?
   - Do practice guidelines support quality contact activities and documentation?
   - What role do supervisors play in promoting frequent and quality contacts? How does the agency support supervision and coaching in these activities?
   - Has the agency considered policies and mechanisms to support flextime or other accommodations for workers conducting visits during evening hours to avoid burn out?
   - How does the agency monitor the quality and frequency of caseworker visits?
   - How does the agency use data to inform and enhance contacts?
   - What processes does the agency have in place to identify and address strengths, barriers, and challenges to quality contacts and improve effectiveness?
   - How does the agency assess the impact of quality contacts on outcomes for children, youth, and families?
3. **Organizational knowledge and skills**
   - Do caseworkers receive the right training and ongoing supports to understand policies and build skills necessary for conducting quality contacts?
   - Do caseworkers have knowledge of the community, the culture(s), and the language(s) common to the community?
   - Do supervisors have the knowledge and skills to support caseworkers?
4. **Organizational culture and climate**
   - Does the agency have widespread understanding of the link between quality contacts, engagement, and positive outcomes for children, youth, and families?
   - Does the agency culture support quality contacts?
   - Does every level of the organization value quality contacts?
5. **Organizational engagement and partnership**
   - How can the agency engage its State and community partners in supporting quality contacts?

[5] The Center adapted and expanded these questions from questions developed for State legislators by the National Conference of State Legislators (2006).

# Conclusion

A comprehensive and strategic approach to conducting quality contacts is critical to good casework practice and improving outcomes for children, youth, and families. Continuous improvement of quality contacts requires efforts at all levels of a child welfare agency to enhance and align agency culture, policies, data collection, knowledge and skills, supervision, and frontline practices. This issue brief—the first in a set of "building blocks"—establishes a foundation for understanding and communicating about quality contacts, components and characteristics of quality contacts, and key activities to undertake to achieve quality contacts, as well as considerations for capacity building.



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