Child Welfare in North Carolina: Pre-Service Training

Participant Workbook

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services

May 2020

AGENDA

DAY ONE

9:00 – 10:00……	I. Welcome and Introductions
10:00—10:15……..	II. Norms
10:15-10:30……..	**BREAK**
10:30 –10:45…….	III. Ever Changing Child Welfare
10:45-11:45……	IV. Two Roles: Family-Centered Practice Activity
11:45 – 1:00 ……..	**LUNCH**
1:00-1:30……..	V. Nature, Purpose, and Structure of the Social Work Interview
1:30-2:15 …….	VI. Interviewing Strategies
2:15-2:30…….	VII. Narrative Interviewing
2:30-2:45	**BREAK**
2:45-2:50…….	VIII. Avoiding Pitfalls in Interviewing
2:50 – 3:15……	IX. Practicing Interview Strategies A. Effective Feedback B. Skills Practice
3:15-3:55……	X. Child Welfare Practice Foundation: Understanding Trauma
3:55-4:00……	XI. Wrap-up

My Symbol

- What was your symbol? What did it mean to you?

- How did it feel to leave your symbol in someone else's hands? What were you thinking?

- How did you feel about the "improvements" made to your symbol? Did the other person understand your symbol?

- How did it feel to "improve" someone else's symbol? Was it hard or easy?

- How is this experience like our work with families? What did you learn?

Source: *Partners in Change: A New Perspective on CPS*: Appalachian Family Innovations, 2001.

Stages of the Interview Process

Interviewer Considerations

Prepare: How well prepared am I for the interview?

- Am I clear about the purpose of the interview?
- What are some possible questions I can ask the individual/family?
- What feelings and concerns may be expressed by the individual/family?
- What feelings, doubts, fears, and emotions do I have?
- What are the laws and policies that relate to this situation?
- Have I reviewed the case history and/or background for this situation?
- What are possible questions the individual/family may ask me?
- What are the agency and/or community resources (including access information) that maybe appropriate for this family?

Engage: How will I engage the person/family in the interview process?

- How will I demonstrate caring and respect for the family?
- How will I demonstrate appreciation for cultural differences?
- How will I convey that I hear the family's concerns and feelings?
- What words will I use to convey that "judgements can wait"?
- How will I identify and discuss strengths with the family?
- How can my nonverbal language help me engage the family?

Information Gather: What techniques will I use to help the person/family disclose information?

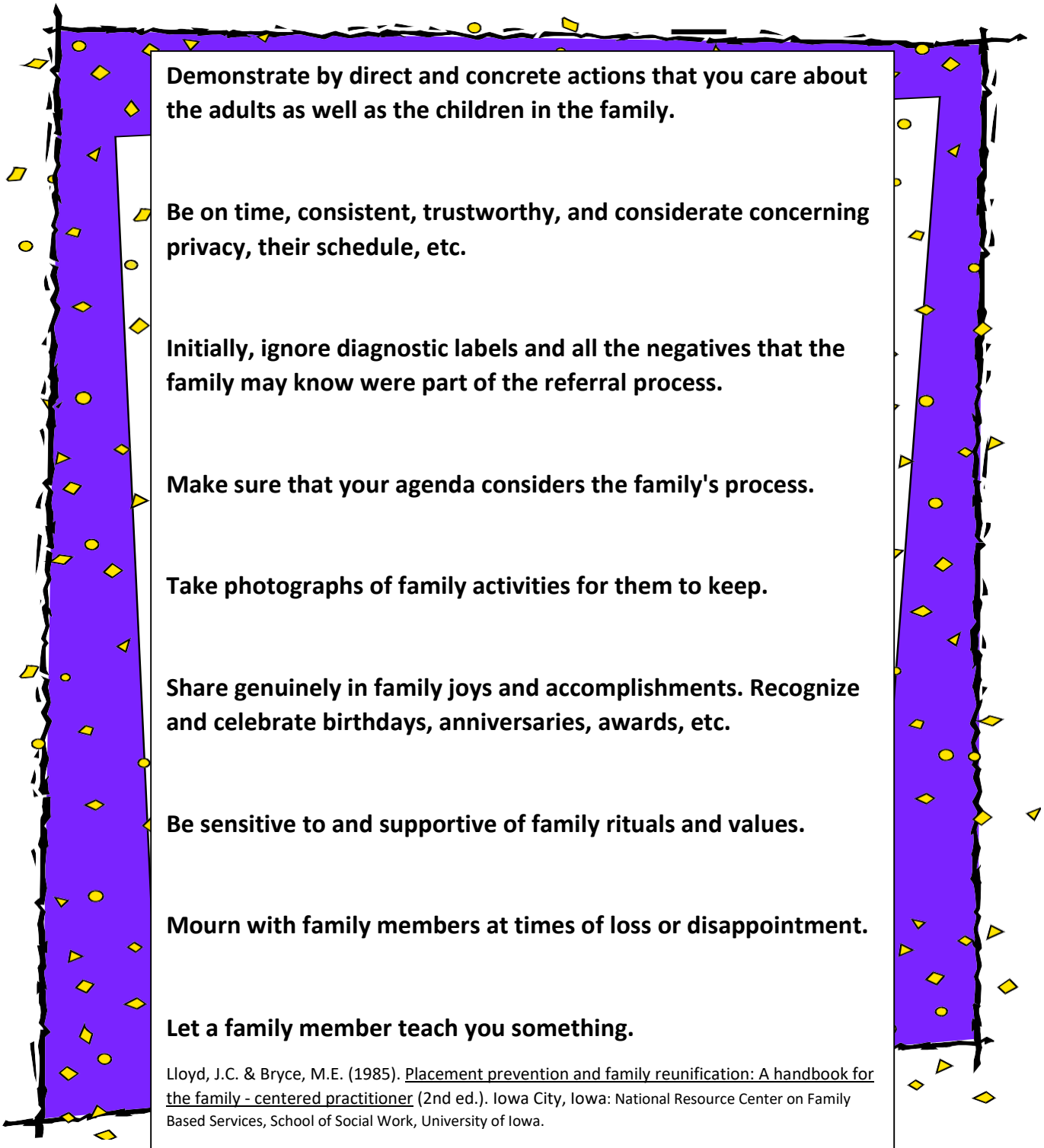
- How will I identify and deal with resistance and hostility?
- What types of questions can I use to gather information and build trust?
- What difficult questions or situations are likely to arise?
- How will I pace the interview so that the family feels heard and I cover the topics that are critical during this interview?

Closure: How will I close the interview?

- How will I assure that the intensity of the interview lessens toward the close of the interview?
- How will I highlight and review the decisions made during the interview?
- How will I express appreciation for the family's cooperation during the interview?
- How will I identify future actions or next steps?
- How will I assure that the family has my contact information?

Techniques for Developing Relationships

This list is only a beginning! Add, delete, adjust, and create to make the list comfortable for your families and for you!



Demonstrate by direct and concrete actions that you care about the adults as well as the children in the family.

Be on time, consistent, trustworthy, and considerate concerning privacy, their schedule, etc.

Initially, ignore diagnostic labels and all the negatives that the family may know were part of the referral process.

Make sure that your agenda considers the family's process.

Take photographs of family activities for them to keep.

Share genuinely in family joys and accomplishments. Recognize and celebrate birthdays, anniversaries, awards, etc.

Be sensitive to and supportive of family rituals and values.

Mourn with family members at times of loss or disappointment.

Let a family member teach you something.

Lloyd, J.C. & Bryce, M.E. (1985). Placement prevention and family reunification: A handbook for the family - centered practitioner (2nd ed.). Iowa City, Iowa: National Resource Center on Family Based Services, School of Social Work, University of Iowa.

Interviewing Methods Chart

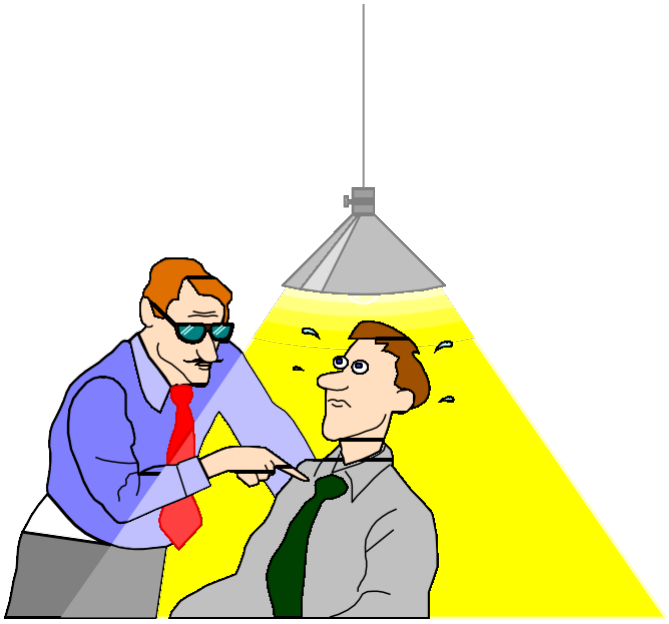
Strategy	Purpose	Benefits	Liabilities
Closed-ended questions **Probing Questions** **Yes/No Questions**	• To gather factual information regarding a specific content area • To obtain answers to specific questions.	• Can obtain a considerable amount of information in a short period of time.	• Limits potential responses of client to those directed by the interviewer. • Maybe threatening to the client; may encourage evasiveness or lying.
Open-ended Questions	• To gather a lot of information about a wide variety of topic areas • To gain insight regarding the client's feelings and perceptions about his situation	• Worker may discover information that he may not have thought to ask about. • Provides information to be used in the assessment; helps identify "process" level issues	• Takes considerable time. • Worker may need to sort through extraneous information to identify pertinent issues. • Client may use open format to digress and avoid discussing important topics.
Supportive responses **Active Listening**	• To communicate and demonstrate the caseworker's interest and concern. • To establish a positive casework relationship.	• Builds trust, communicates worker's interest and willingness to listen and help. • May have an enabling effect on the client. Client may feel better for having talked.	• The client has considerable control of the direction of the interview. • Little change may be generated; few goals set. • Does not always promote action

Clarification	• To promote client's insight into her behaviors and actions to enable change and participation in the casework process. • To enable the caseworker to better understand the dynamics of the client's problems and behaviors.	• Allows the worker to make an accurate assessment of causal and contributing problems. • Helps move to the process level in the interview. • Helps client attain insight into own feelings.	• May be threatening to the client. • The client may be unaware of or not want to discuss issues raised by the caseworker. • May result in client resistance
Summarization/ Redirection	• To keep the interview focused, on track. • To help the client organize his information	• Makes efficient use of time by keeping the discussion focused on pertinent topics. • Helps the client to organize her thinking and keep important points in mind. • Avoids becoming overwhelmed by details.	• A client who has been redirected may feel cut off, as if the caseworker is not listening to him • Over -direction by the worker may lead to moving too quickly off a topic, thus missing important information
Giving Options, Advice, or Suggestions	• To offer the client a range of possible solutions to his problems • To direct the client into positive action.	• Provides the client with potential solutions which he had not previously considered. • Encourages the client to try new solutions. • Keeps activities goaldirected	• May prevent the client from arriving at his own solutions to problems • Caseworker may be blamed for failures if the solution does not work.
Confrontation	• To push the client to admit and acknowledge problems, feelings, or behaviors, when other less directive interventions have failed to accomplish this	• Can precipitate movement quickly. • Can cut out manipulations and digressions by the client and focus discussion on the critical issues. • Can help the client become aware of her own resistance	• Cannot be accomplished without a well-established, supportive relationship. • May greatly increase resistance if not successful. • May require considerable follow-up support from the worker. • Takes time and commitment.

Miracle Question	• To get a clear, honest picture of what an individual truly wants their future to look like • To instill hope in an individual who feels hopeless	• Follow-up questions often inspire an individual to describe the solution in detailed behavioral terms. • These behavioral descriptions help identify the possibilities for taking small steps toward solving the concerns	• May lead to an unrealistic vision of what the "miracle" might be. • May need help seeing reality versus fantasy thinking.
Exception Questions	• To identify times when a problem could have occurred, but didn't • To identify existing skills and strengths in an individual that support problem solving and success • To identify details about what is different about those situations when problems are not occurring	• Helps the individual as well as the interviewer remember there were times when this behavior/issue wasn't happening • Gives hope for reducing the reoccurrence of the behavior/issue	• Individual may emphasize or become focused on circumstances that are different now
Scaling	• To open up an individual's frame of reference quickly, naturally, and respectfully • To gauge an individual's self-assessment of a wide range of topics associated with their confidence, hopefulness, willingness, and or progress	• Easy to use and is easily understood by children and adults • Can be used over the phone • Holds individuals accountable in a natural and non-confrontational manner • Provides a "baseline" for change from an individual's point of view • The "baseline" then provides opportunities for discussing change by discussing movement along the scale	• If there are no follow-up questions regarding what contributed to choosing the baseline number on the scale, the individual may not see the benefits of the question. • Lack of follow-up questions about movement along the scale may also lessen benefits of the scaling question.

Closed ended through confrontation:
Rycus, Judith S. and Hughes, Ronald C. (1998a). *Casework process and case planning in child protective services: A Training curriculum.* Columbus, Ohio: Institute for Human Services.
Miracle, Exception, Scaling:Berg, Insoo Kim. (1994). *Family-Based services.* New York: W.W. Norton and Co.

Plain Old Confrontation



- **Climate designated by circumstances**
- **Failure to clearly state your case**
- **Focus on the person rather than the behavior**
- **Allow no time for listening, responding, or negotiating**
- **Assume everyone is in agreement**

Caring Confrontation

- **Set the climate**
- **State your case**
- **Describe specifically the behavior you are confronting**
- **Listen and acknowledge**
- **Negotiate**
- **Reach and confirm agreements**

Bayless, Linda and Craig-Olsen, Heather. (1991). Group Preparation and Selection of Foster and /or Adoptive Families: A Training Manual. Atlanta, Georgia: Child Welfare Institute.

Miracle Question

Purpose

When a client struggles to identify an achievable, specific goal, the Miracle Question can be useful. Many workers ask this question with all clients, feeling that it gives a clear, honest picture of what clients truly want their future to look like. The Miracle Question can also instill hope in a hopeless client.

When the worker helps the client elaborate with follow-up questions, the responses to the Miracle Question frequently describe the solution in rather detailed behavioral terms. The more vivid and rich the description, the more possibilities for taking small steps toward solving their concerns.

Example

"I would like to ask you a strange question. Please go along with me if you will. Suppose that tonight, while you are sleeping, a miracle happens and the issues that brought me here today are solved. But, since you are asleep, you don't know that a miracle has happened. When you wake up tomorrow morning, what would be the first little clue that something was different?"

Follow-up Questions

- What else would you notice?
- What will you be **doing** that is different?
- (If the client talks about a change in feelings...) When you are feeling...what will you be **doing?**
- If you are doing...what will (your husband, children...) be doing?
- What would your (children, mother...) say is different?
- **Are there times now** that small pieces of this miracle happen **just a little bit**? What is different about those times?
- What would you have to do so that it would happen more often?
- What would have to happen more often for this miracle to take place?

Adapted from Berg, I. K. (1994). *Family-based services*. New York: W. W. Norton & Co.

Miracle Question: Case Examples

Example One: Case Study

A mother of four was exhausted and felt hopeless about herself and her family. Her husband was serving time for having sexually abused her two daughters, who were showing all sorts of unhealthy symptoms. Her two boys were "wild and uncontrollable." She had thought about killing herself many times. The children's schools were calling nearly every week to report one problem or another.

The worker, not knowing what else to do, and also feeling overwhelmed and hopeless, decided to ask the mother the Miracle Question. The mother thought about this a long time, then she slowly lifted her eyes, looked up at the ceiling and started to spell out how each of her four children would change and how she would feel like living again. The worker followed up by asking about the details of this miracle she had started to paint. She began to talk about the dreams for her family, how she wanted a close, loving family. She wanted a family whose members would help each other, support each other, and feel they were blessed with God's grace. The worker asked the mother when she had previously seen small pieces of the miracle. The mother described without hesitation in a firm voice how they used to go to church together every Sunday morning, and how happy she once felt. As she told about times when things had been better, she became more hopeful about herself and her children.

Example Two: Follow-up Questions

Worker: So, suppose you get up ahead of the children and get them up, get them ready for school. What would your children do differently that they didn't do this morning?

Client: I suppose they will be happy to see me up and bustling around because it means I am feeling good.

Worker: So, when they see you bustling around and getting them ready for school, what would they do different, that they didn't do this morning?

Client: Oh, they will want to get up, get their books ready, and then come downstairs for breakfast instead of parking themselves in front of the TV.

Worker: So, what would the children say they like about you on this special morning?

Client: They will say they like it when I am up and sending them off to school in a good mood. They seem to have a better day in school when they go off happy instead of getting out of the house all crying and me yelling and screaming at them.

(One small goal for this case then becomes finding out how mom can get up before the kids and get them ready for school.)

Source: Berg, I. K., & Kelly, S. (2000). *Building solutions in child protective services*. New York: W. W. Norton & Company

Exception Questions

Purpose

There are always exceptions, times that the problem could have occurred, but didn't. Exceptions mean that the client has the skills necessary to do something in a more successful way. Our task is to get the exceptions to happen more often. We are looking for what is different about those times.

Examples

- Are there times now or in the past when you were able to … (discipline without abuse, handle stress without drinking, keep the house clean)? How did you get that to happen?

- When was the last time that… (Johnny did what he was told without arguing, when you supervised the children well enough to please your neighbors, when you were taking your medicine)? What do you do so that the problem doesn't happen at those times?

- Are there days when you feel…(less overwhelmed, more in control of your temper, more hopeful about your situation)? What is different about those days?

- When was the last time you had a better day? What was different about that day that made it better? Where did that happen? Who was there with you? What might (those people) have noticed you doing differently that would tell them you were doing better?

- When are you already doing **some** of what you want (staying calm with the children, keeping the house clean, being a good mom)?

- When doesn't (the problem) happen? What is different about those times? What are you **doing** differently? How are you **thinking** differently?

- Tell me about times when this (arguing, depression, poor decisions) is a little less of a problem.

- How much of the time would you say (talking back, depression…) is a problem? Oh, so at least X% of the time it's not so bad. Can you tell me what is happening when it is not a problem?

- What is the longest time you have gone without (the problem)? How did you get that to happen?

- What are you doing or thinking that is helpful?
- Has anything worked in the past to resolve other issues that you might want to test out with this current situation?
- What other ways do you … (discipline your child, manage stress)?

Exception-Finding Questions Case Examples

- A parent who had previously lashed out at her child described a situation where she had become enraged but resisted the impulse to hit the child by taking a five-minute break in her bedroom.
- A child described being able to go to her grandmother's home when she felt unsafe because her parents had become too drunk to care for her.
- A man who had previously assaulted his stepson resisted the urge to do so on another occasion, even though the teenager had thrown a knife at him. He did this by telling himself, "If I hit him, the boy will only make a monkey of me again."
- A grandmother described a period where her drug-addicted daughter had faced up to her problems and acknowledged she was not caring adequately for her child. At that time the mother had sent the girl to live with her father for nine months while she detoxed herself.

Source: Berg, I. K., & Kelly, S. (2000). *Building solutions in child protective services*. New York: W. W. Norton & Company.

Scaling

Purpose

Perhaps the most versatile of any of the solution-focused tools, scaling questions are a very useful assessment tool. Scaling can be used to gauge confidence, hopefulness and safety; prioritize goals; measure progress toward goals and willingness to take action toward change; and much more. Scaling can be used with great success with even young children or over the phone.

Examples

- On a scale of 1 to 10, where 10 means you are willing to do anything to resolve this issue and 1 means you are not willing to do anything, where would you place yourself on the scale?

- On a scale of 1 to 10, where 1 is you have no control and a 10 is you are incomplete control, how much control or influence do you think you have over this situation?

- If 10 is your biggest concern and 1 is that you are not concerned about it at all, where would you place yourself as far as …? (goal)

- If 1 is that this report is completely bogus and 10 is that you are as worried as anyone is, how serious do you think this allegation is?

- If 1 is where you were when you first set these goals and 10 is all your goals are met, what number are you at today? (Follow up question): What have you done to get to that number? What would have to happen so that you would be just one number higher?

- If 10 is completely safe and 1 is scared to death every day, how safe would your daughter say she feels?

- ***Case Example***

A worker asked a teenager to compare how things were four weeks previously, when he had been hit by his stepfather and had run away, with the present using a 1-10 scale (1, the worst things could be, 10, the best things could be). The boy stated that, at the time he made the complaint, things were at a three, whereas the present score was a six. The worker then asked him what had made things better. The teenager indicated that "my stepfather is treating me a lot better now, he's letting me go out, he's still strict but he's listening to me and he hasn't hit me again."

Source: Turnell, A. & Edwards, S. (1999). *Signs of safety: A solution and safety-oriented approach to child protection casework*. New York: W. W. Norton & Co.

Uses of Scaling

Purpose

Perhaps the most versatile of any of the solution-focused tools, scaling questions are a very useful assessment tool. Scaling can be used for many purposes. For example:

As an assessment tool:

"On a scale of one to ten, where one is this is not at all the type of child you wanted to foster, and ten is he is exactly the type of child you hoped to care for, what number would you say this child is? What number would your husband say?"

"On a scale of one to ten, where one is this is the type of job that you have hated before, and a ten is this is the type of job that you would enjoy, what number would you say this job is?"

To set goals with clients:

"On a scale of one to ten, where one is not at all important to you and ten is very important to you, how would you rate finding suitable daycare for your children?

"On a scale of one to ten, where one is not important at all and ten is the most important thing to you, what number would you say children's school grades are? How about children being respectful to others?"

To evaluate the usefulness of a resource:

"On a scale of one to ten, where one is not at all helpful and ten is very helpful, how would you rate going to family counseling?"

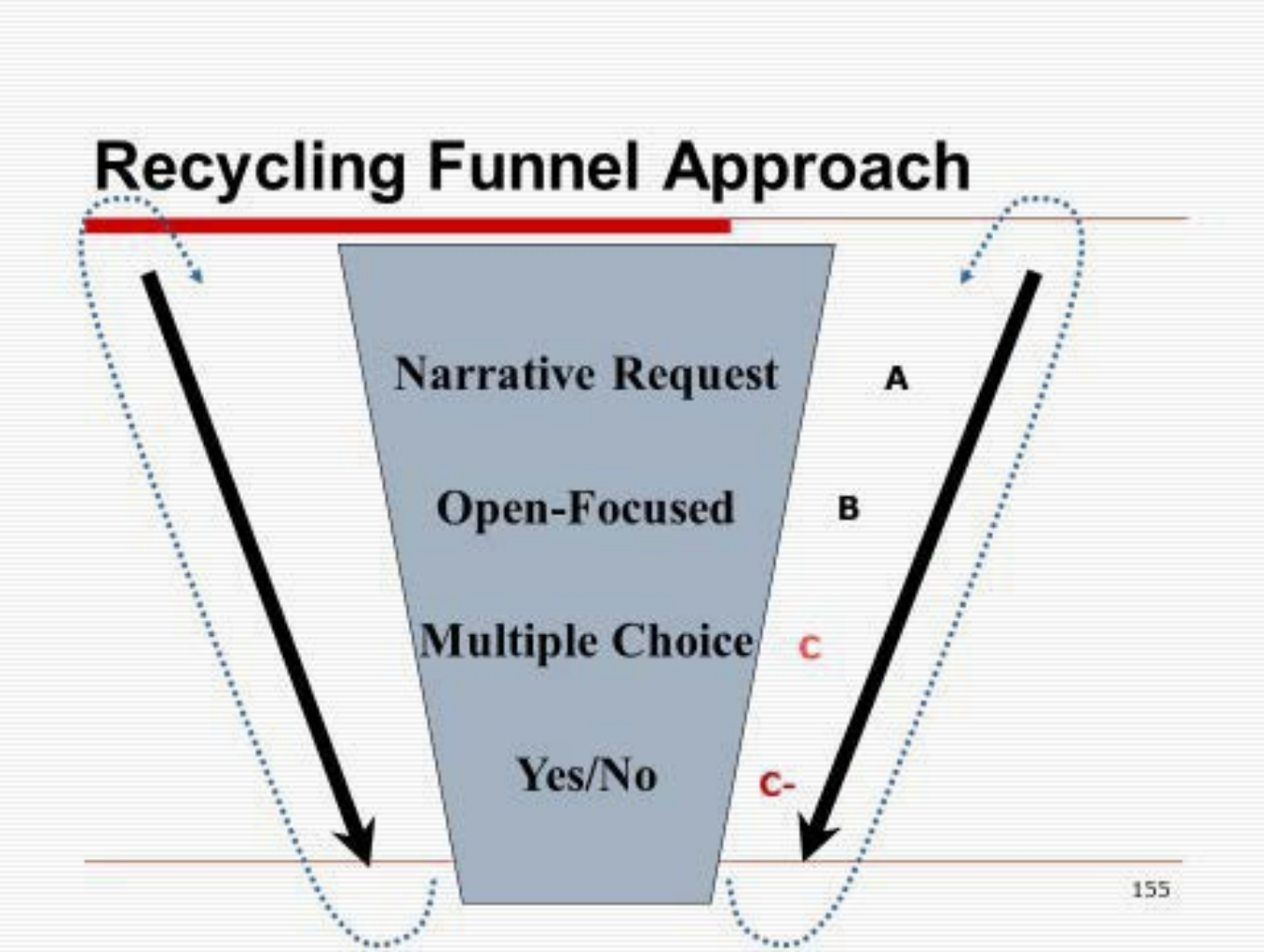
"On a scale of one to ten, where one is not helpful at all, and ten is very helpful, how helpful do you think getting a GED would be for you?"

To measure progress: (You might ask the same scaling question every time you visit a family to see whether they move up the scale.)

"On a scale of one to ten, where one is you are so depressed you barely made it out of bed and ten is you feel better today than you have in years, where would you place yourself?"

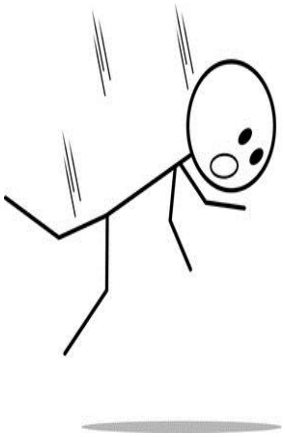
"On a scale of one to ten, where one is as bad as it can be and a ten is as good as it can be, what number would you say your son's behavior has been this week?"

Source: Turnell, A. & Edwards, S. (1999). Signs of safety: A solution and safety-oriented approach to children protection casework. New York: W.W. Norton & Co.



Source: Everson, Mark, Ph.D. *Child Forensic Interviewing. 2015. (Register for course at www.ncswlearn.org)*

Common Pitfalls in Interviewing



- ***Leading questions-*** when the answer is contained in the question. The client is lead into giving the answer the interviewer wants to hear.

- ***Disclosing inappropriate personal information-*** about yourself and your family

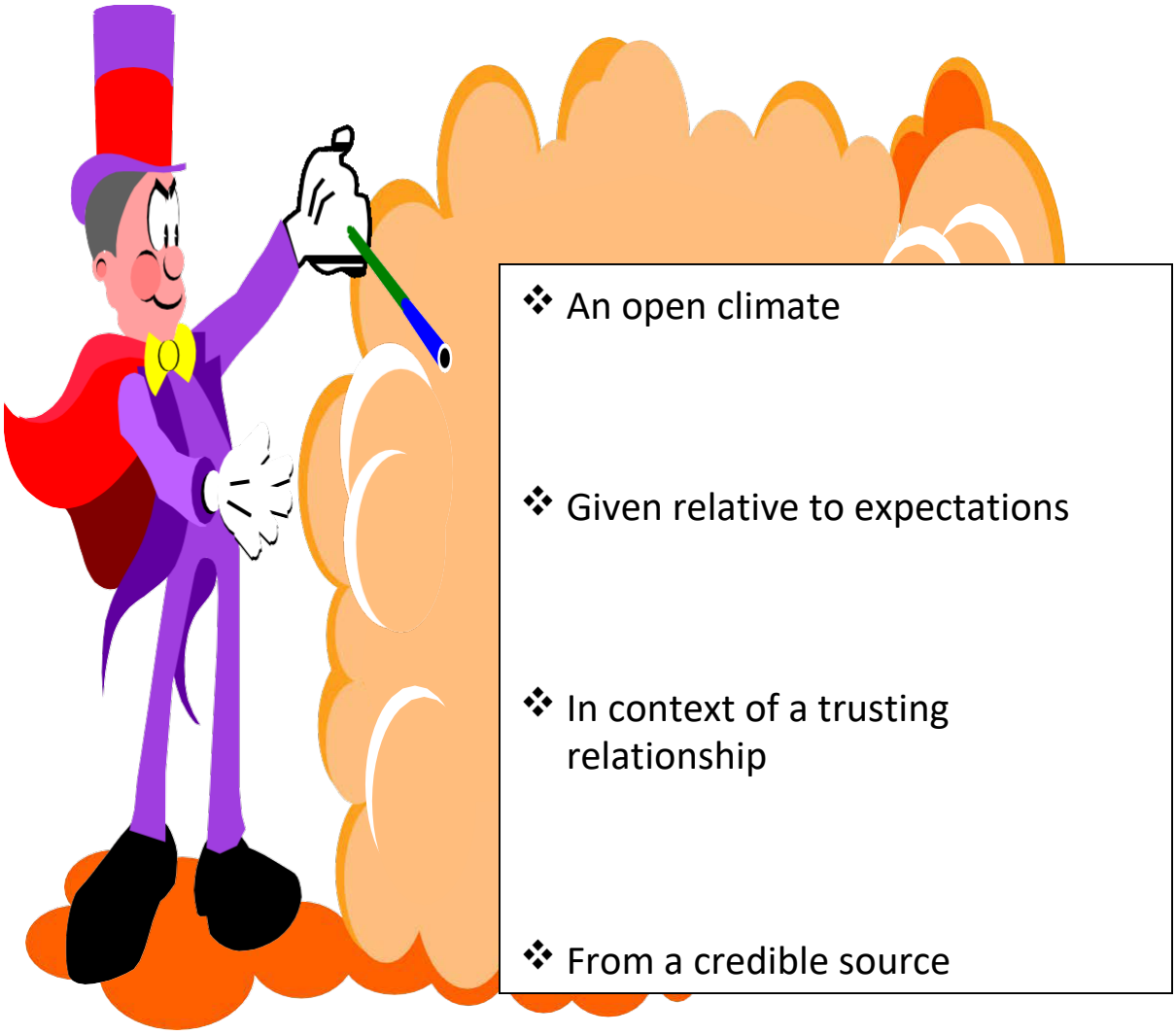
- ***Making promises you can't keep-*** Workers shouldnot make promises to families about things that may be out of our control.

- ***Handling hostile or accusatory statements***- workers must not be offended by comments family members may make to us or about us.

- ***Giving Solutions-*** Workers must be very careful not to fall into the trap of giving solutions to problems the family may present.

Rycus, Judith S. and Hughes, Ronald C. (1998c). Field guide to child welfare: Case planning and family-centered casework. Child Welfare League of America, Washington, D.C.

Conditions for Effective Feedback



- An open climate
- Given relative to expectations
- In context of a trusting relationship
- From a credible source


Qualities of Effective Feedback
Useful
Frequent
Specific
Well-timed
Direct
Helpful
Clear
Behavioral

Interview Methods Observer Chart

Closed ended/Probing/yes/no Questions
Open ended Questions
Supportive responses/Active Listening
Clarification
Summarization/redirection
Giving Options, Advise, or Suggestions
Confrontation
Miracle Question
Exception Questions
Scaling
Silence
Humor

Hey, I'm Bryce and I'm 9 years old. I just came to live with my grandma because my mom's boyfriend has been hitting her and then he got really mad one day and hit me in the face and I couldn't open my eye. I miss my mom and I'm worried about her-she's all I have; my dad died when I was 5 from drugs."

Bryce's grandmother reports that he is having nightmares and is very "jumpy." He scares easily at loud noises. Bryce is sometimes withdrawn and will not talk, and he has had a few anger outbursts.

National Child Traumatic Stress Network: (NCTSN)

Effects of Trauma on Children

Trauma may affect children's…	…in the following ways
Bodies	• Inability to control physical responses to stress • Chronic illness, even into adulthood (heart disease, obesity)
Brains (thinking)	• Difficulty thinking, learning, and concentrating • Impaired memory • Difficulty switching from one thought or activity to another
Emotions (feeling)	• Low self-esteem • Feeling unsafe • Inability to regulate emotions • Difficulty forming attachments to caregivers • Trouble with friendships • Trust issues • Depression, anxiety
Behavior	• Lack of impulse control • Fighting, aggression, running away • Substance abuse • Suicide

Child Welfare Information Gateway. (2014). *Parenting a Child Who Has Experienced Trauma.* Washington, DC: U. S. Department of Health and Human Services, Children's Bureau.

Possible Signs of Trauma in Children of Different Ages

Young Children (Ages 0-5)	School-Age Children (Ages 6-12)	Teens (Ages 13-18)
• Irritability, "fussiness" • Startling easily or being difficult to calm • Frequent Tantrums • Clinginess, reluctance to explore the world • Activity levels that are much higher or lower than peers • Repeating traumatic events over and over in dramatic play or conversation • Delays in reaching physical, language, or other milestones	• Difficulty paying attention • Being quiet or withdrawn • Frequent tears or sadness • Talking often about scary feelings and ideas • Difficulty transitioning from one activity to the next • Fighting with peers or adults • Changes in school performance • Wanting to be left alone • Eating much more or less than peers • Getting into trouble at home or school • Frequent headaches or Stomachaches with no apparent cause • Behaviors common to younger children (thumb sucking, bed wetting, fear of the dark)	• Talking about the trauma constantly, or denying that it happened • Refusal to follow rules, or talking back frequently • Being tired all the time, sleeping much more (or less) than peers, nightmares • Risky behaviors • Fighting • Not wanting to spend time with friends • Using drugs or alcohol, running away from home, or getting into trouble with the law

Child Welfare Information Gateway. (2014). *Parenting a Child Who Has Experienced Trauma.* Washington, DC: U. S. Department of Health and Human Services, Children's Bureau. (content in the table adapted from Safe Start Center (n.d.) *Tips for Staff and Advocates Working with Children: Polyvictimization*. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.)

Questions for Supervisor

Use this page to record questions you would like to ask your supervisor.

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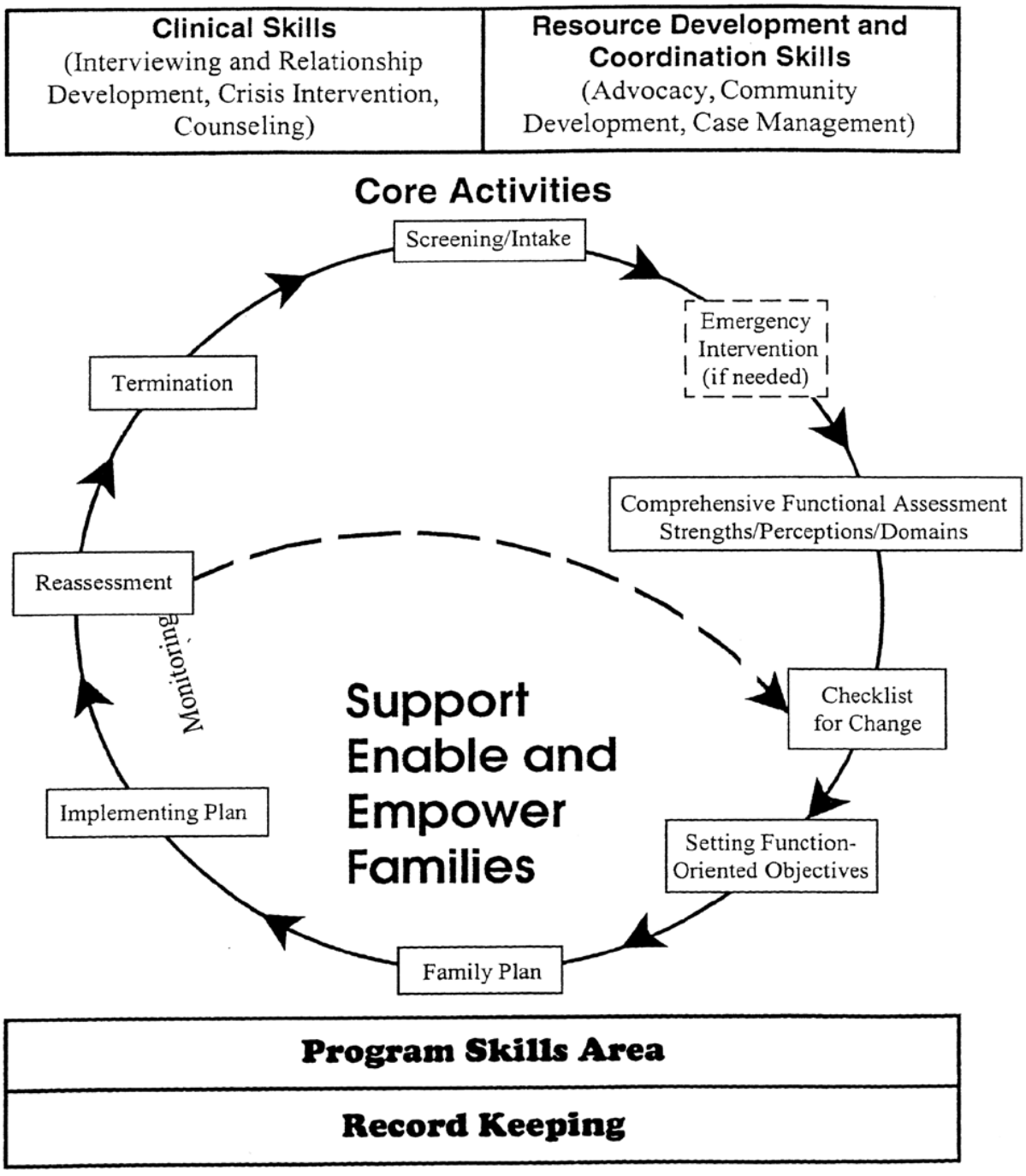
Agenda
DAY 2

9:00-9:15…….	I. Welcome and Introduction to the Family Assessment and Change Process
9:15-10:05…….	II. Assessment Process in Child Welfare A. Purpose of Assessments B. Functional Assessments
10:05-10:15……..	III. Strengths Perspective
10:15-10:30…….	BREAK
10:30-11:15…….	IV. Making Decisions
11:15-12:00……	V. NC General Statutes
12:00-1:15……	LUNCH
1:15-2:30…….	VI. Intake in Child Welfare A. Duties of Intake Worker B. Intake Policies C. Structured Intake Process
2:30-2:45……..	BREAK
2:45-3:30……	D. Intake Skills Practice
3:30-4:00…….	VII. Questions and Wrap-up

Family Assessment and Change Process



Adapted from *A Model For Excellence in Adult Services Administration and Social Work Practice*, a collaborative project of The Adult Services Branch and the Adult Programs Representatives of the N.C. Division of Social Services and CARES, School of Social Work, UNC-CH, 1992.

Family-Centered Assessments

- The family has the best information about itself.
- It is crucial for the worker to hear and understand the family's perceptions of the issue.
- Complete assessments include attempts which the family has already made to deal with the issue, things no one else may know.
- Change will not occur if the plans for a "solution" don't fit with the family's perception of the problem.
- Spending time with the family will reveal their strengths as well as their needs.
- Use of genograms and Ecomaps, as well as other tools, may greatly assist in completion of assessments, and only the family can give the full picture.

Sources of Assessment Information:

On-going observation of family members in their natural environment

+

Family and individual sessions

+

A social and family history obtained over time

+

Reports from other professionals

=

Family-Centered Assessment

Source: Lloyd, J. G. & Bryce, M. E. (1985). Placement prevention and family reunification: A handbook for the family-centered practitioner (2nd ed.). Iowa City: I0: National Resource Center on Family Based Services, School of Social Work, University of Iowa.

Assessment Domains

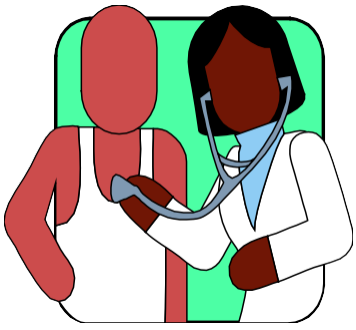
Social

Economic

Environmental

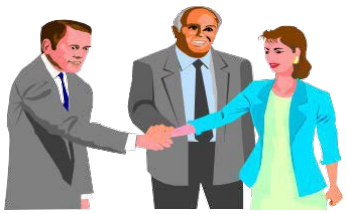
Mental Health

Activities of Daily Living



Physical Health

QUESTIONS TO CONSIDER IN A SEEMAP ASSESSMENT



Social—the family's social connection to the community.

- Who lives in the house? How are people connected to each other?
- What is the feeling when you enter the house? Comfortable? Tense? Why?
- How do people treat one another? How do they speak to and about one another to someone outside the family? How far away is this home from other homes? Would it be likely that people would be able to visit here easily?
- Who does visit the family? Ask questions to determine what individuals, organizations, and systems are connected to the family.
- Are those people/organizations/systems helpful or not?
- What do people in this family do for fun? What stories do they tell about themselves?
- What are the major interpersonal strengths about this family?
- What kind of social support systems the family can depend on?
- How does the family use resources in the community?
- How does the family interact with social agencies, schools, churches, neighborhood groups, extended family, or friends?
- Do the children attend school regularly? Are there behavior problems at school?
- Do not forget the importance of nontraditional connections a family may have.

Economic—the family's financial situation

- Are people willing to discuss their finances after a period of getting acquainted?
- Does the stated amount of income seem reasonable and possible to live on?
- If it does not, do members have any plan or idea what to do?
- Has the family made plans to use economic government services? Are food stamps, child support, TANF, LIEAP available to them? If not, why not?
- If income seems adequate but the residence and family members seem needy, is there any comprehensible explanation about where the money goes?

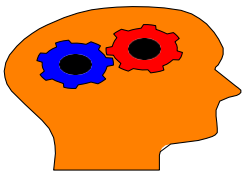
- Do the adults in the family demonstrate an awareness of how to budget the money that is available to them?
- Do people in this family tend to make workable fiscal decisions for themselves?
- What is the strongest economic skill each person in this family displays?
- Do they have enough money to make it through the month?
- Do they have any plan for where the money goes?
- Where does the money come from?
- Does the parent subsystem agree about the destination of any monies available?
- Are they content with the job they have? Have they considered changing job fields or careers? If so, what has prevented it?

Environmental—what is the family's environment like?

- Look at the residence from the outside. Is it kept up? In disrepair?
- What is the surrounding area like? Places for children to play?
- Are there obvious hazards around the house? Old refrigerators, cars, broken toys, glass, etc.?
- What is the feeling you get when you arrive at this residence? Do you know where this feeling comes from?
- Is the neighborhood comfortable or dangerous? Are there people walking around? Do you get a sense that people in this neighborhood would intervene if a child were in danger?
- Inside the residence, is there light and air?
- Is there any place to sit and talk?
- Are there toys appropriate for the ages of the children who live there? Or can you tell if someone creates a space for children to play?
- Is there a place for each person to sleep?
- Is it obvious that people eat here? Can you determine what kind of food is available for people who live here?
- Are there any pictures of family members or friends?
- Is there a working phone available to the family?
- Is there a SANITARY water supply available to the family? Are there readily available means of maintaining personal hygiene (toileting, bathing)
- SMOKE ALARM? Heat/air conditioning/fans
- What are the best features of this environment?

- Is their house structurally sound? Reasonably clean?
- Are there any health and safety issues?
- Do they have a phone?

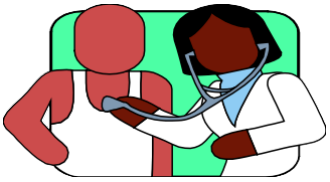
***Mental Health*—**the mental health issues with family members.



- Take a mental picture of the people in this family. What is their affect? Does it make sense, given the situation?
- Do members of this family have a history of emotional difficulties, mental illness, or impulse problems?
- Does anyone take medication for "nerves" or any other mental health condition?
- Are persons you interview able to attend to the conversation? Are there times when they seem emotionally absent during conversation?
- Do people make sense when they speak? Are they clearly oriented to time and location?
- When people speak to each other, does their communication make sense to you as well as to other family members?
- Are people able to experience pleasure in some things?
- Are there indicators that persons in this family have substance abuse addictions?
- Is there some awareness of the developmental differences between adults and smaller children?
- How do people in this family express anger?
- Can people in this family talk about emotions, or do they only "express"them?
- What is the major belief system in this family?
- Do members of this family seem generally okay with themselves?
- Is anyone exhibiting signs of depression? Remember that depression in children can show up as hyperactivity. Has anyone ever received counseling or been under the care of a physician for a mental health problem?
- Do their thoughts flow in ways you can understand? If you cannot understand the person, does the rest of the family act like they understand? There may be some cultural language habits that you will have to learn.
- Is anyone on medication? Are any of the medications for mental health related issues? (Examples, medications for depression, sleeping pills, anti-anxiety medications, tranquilizers, etc.) Are there funds to buy that medication?
  Is anyone abusing substances? What kind? Do they acknowledge a problem?

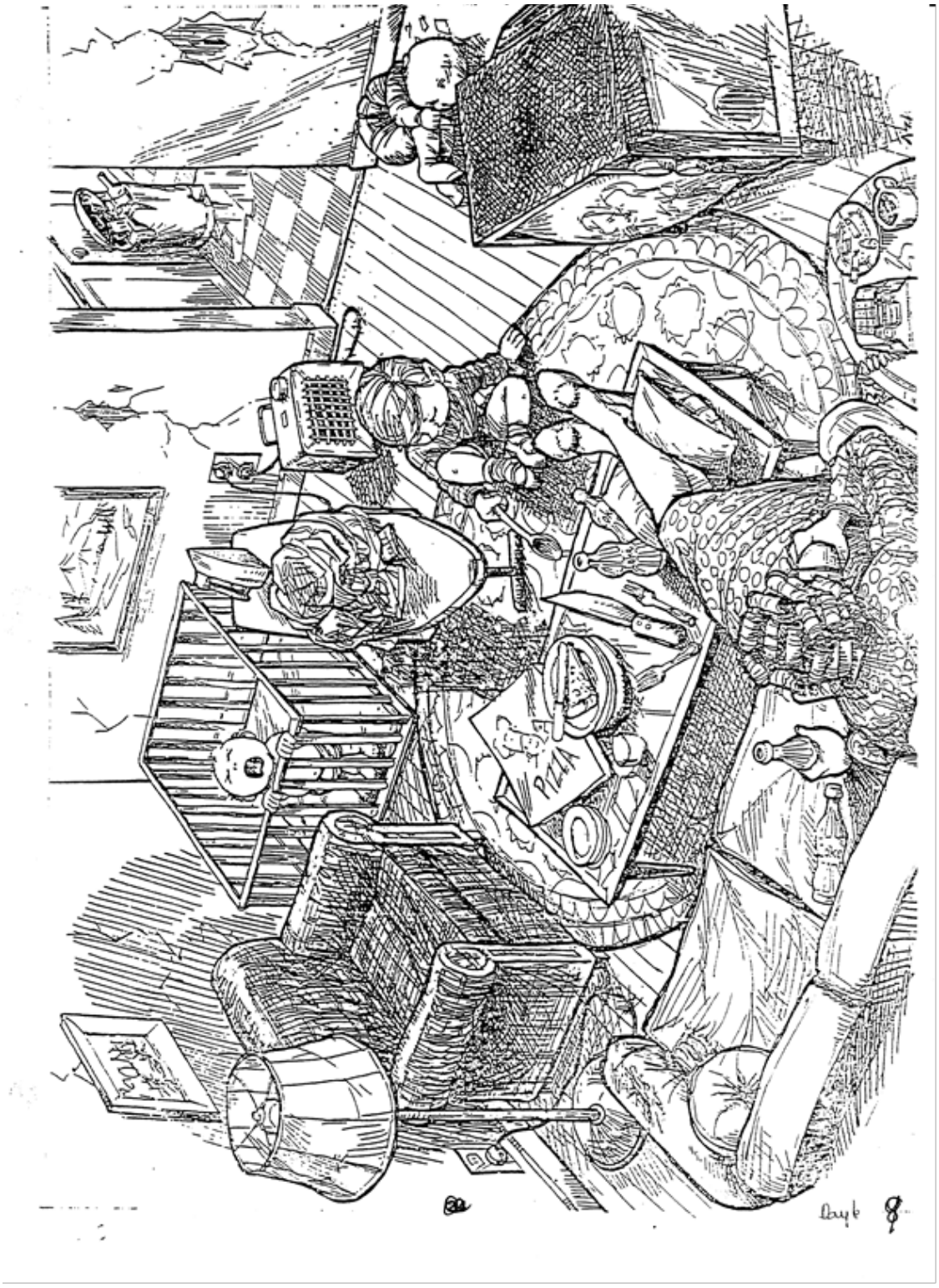
Activities of Daily Living (ADLs)—those activities people need to be able to accomplish to remain independent and self-sufficient: budget management, household management, capacity for employment, and schooling**.**

- Do adults in this family know how to obtain, prepare, and feed meals to children in this family?
- Do adults here know how to pay bills and handle money?
- Do people in this house know how to express themselves well enough to get their basic needs met?
- Do some people in this family speak the prevalent language of the community and English if their first language is different?
- Does the family engage in some activities of a spiritual nature?
- Are adults able to connect usefully with their children's schools, doctors and friends?
- Do the adults in the house demonstrate developmentally appropriate and accurate expectations of the children in the home?
- Does the family own a car?
- If not, are there neighbors close by who will give them rides? Is public transportation convenient and available?
- Do people in this family have the ability and willingness to keep the home safe and reasonably clean?
- What skill does this family demonstrate the most?
- Do the parents know how to discipline their children or adolescents?
- Do they need some support in learning how to manage or organize their household, or how to stretch their limited budget?
- Are they employable?

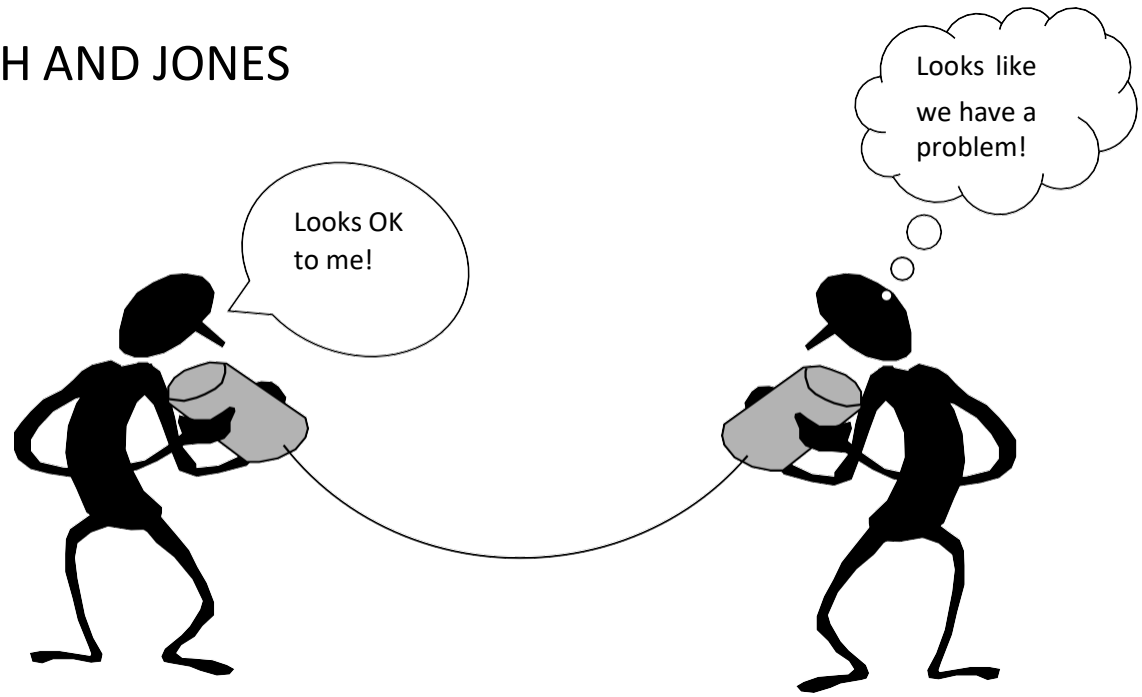


Physical Health—statistics show that individuals are much better at accurately describing how they are doing physically than doctors give them credit for, so pay attention. This is also the place where careful observation is essential.

- How do people in this family look? Skin? Teeth? Hair?
- Does anyone/everyone appear fatigued? Energetic?
- Is anyone chronically ill, taking medication, or physically disabled?
- Is anyone in this family using illegal drugs or abusing prescription drugs?
- Do people in this family eat healthy food and get exercise?
- Does anyone in this family smoke tobacco products?
- Are there any members of the family who appear to be significantly obese?
- Are there any members of the family who appear to be significantly underweight?
- How long has it been since members of the family had a physical examination?
- Are there older children who continue to have bedwetting problems?
- Do people have marks or bruises on their bodies? Wounds?
- Are any people in the home overdressed or in heavy makeup, perhaps to hide injuries?
- Have steps been taken to be sure that the area where small children live is reasonably free from life-threatening hazards?
- Do small children ride in safety seats or seatbelts?
- What is the healthiest thing this family does?
- What is the skin tone, hair quality, color of lips (especially with infants)
- Have the children had any vaccinations? Are they up to date?
- What is family member's ability to move? Are there signs of palsy or other unusual movements?
- Family's perception of their own physical health


PIZZA

SMITH AND JONES



Ms. Smith and Ms. Jones are child protective workers with a county DSS.

Ms. Smith, upon encountering the scene in the living room, described what she saw:

This mother is feeling overwhelmed by the responsibilities of caring for three children under the age of four years of age and is coping rather well. Even though she has no source of income and is dependent on welfare, she has been able to manage so that there is heat in the apartment and the rent is paid. There is no evidence of drinking or drug abuse and she is willing to talk with the worker. Johnny, the three-year old, is an active child and able to amuse himself with a spoon, while his brother, Paul, is lying peacefully in the room. This mother does need some help, however. A homemaker might be helpful in cleaning up the place a bit and making it safer and more sanitary. Because there is no imminent danger to the children, perhaps these services should be offered on a voluntary basis.

Ms. Jones, on the other hand, saw this:

This mother is almost incapacitated by her situation. While she has been able to accomplish the minimum responsibilities of housing and feeding the children, she does not have the ability to care for them or protect them. The knife, exposed wire and old, dirty dishes are evidence of her incapacity in keeping young children from harm. Two of her three children, Johnny and Paul, both appear to be somewhat retarded in their development and appear to be malnourished. Johnny's rhythmic motions with the spoon and Paul's isolation and unusual lack of mobility are danger signs. This mother is not in control of her household. She is probably not feeding the children properly, is not providing them with the stimulation they need to grow and develop normally and is not protecting them from the many hazards in their environment. This mother needs immediate intervention, forcibly if necessary, and placement may be considered.

(How we make Decisions in Child Protective Services, Susan Wells, Ph.D., American Bar Association, Nov. 1985.)

Decision-Making Factors in Child Welfare Services

Knowledge and Professional Experience

- ✓ human growth and child development
- ✓ family dynamics
- ✓ cultural considerations
- ✓ sexual abuse
- ✓ psychiatric and mental health issues
- ✓ domestic violence
- ✓ substance abuse
- ✓ impact of trauma on behavior and functioning
- ✓ other?

Values, beliefs, and attitudes

- ✓ differences in beliefs and values about child rearing, housekeeping, etc.
- ✓ influence of differing life experiences
- ✓ impact of prejudices and biases
- ✓ personal attitudes and opinions
- ✓ other?

Interviewing and Observation Skills

- ✓ use of variety of interviewing strategies/approaches
- ✓ commitment to holistic assessments
- ✓ ability to individualize assessments
- ✓ other?

Skills of Information Processing

- ✓ ability to suspend judgment while gathering the facts
- ✓ ability to avoid "jumping to conclusions" while gathering the facts
- ✓ ability to be objective in examination of the facts
- ✓ openness to input and feedback from team members
- ✓ other?

(Adapted from: How we make Decisions in Child Protective Services, Susan Wells, Ph.D., American Bar Association, Nov. 1985.)

When can DSS Intervene?

Adult* **+** Parent Guardian Custodian Caretaker	**Juvenile +**	**Dependency** **Neglect** **=** **Abuse** (One or combination of above)	**DSS Intervention**

*Juvenile Parent

All 3 of the above **MUST** be present for DSS Intervention

Definitions (as of May 2020)

Parent: the biological/adoptive mother or father of a child, including parents who are a juvenile.

Guardian: § 7B-600. Appointment of guardian.

In any case when no parent appears in a hearing with the juvenile or when the court finds it would be in the best interests of the juvenile, the court may appoint a guardian of the person for the juvenile. The guardian shall operate under the supervision of the court with or without bond and shall file only such reports as the court shall require. The guardian shall have the care, custody, and control of the juvenile or may arrange a suitable placement for the juvenile and may represent the juvenile in legal actions before any court. The guardian may consent to certain actions on the part of the juvenile in place of the parent including (i) marriage, (ii) enlisting in the Armed Forces of the United States, and (iii) enrollment in school. The guardian may also consent to any necessary remedial, psychological, medical, or surgical treatment for the juvenile. The authority of the guardian shall continue until the guardianship is terminated by court order, until the juvenile is emancipated pursuant to Article 35 of Subchapter IV of this Chapter, or until the juvenile reaches the age of majority.

Custodian: **§ 7B-101**. The person or agency that has been awarded legal custody of a juvenile by a court.

Caretaker: § 7B-101. Any person other than a parent, guardian, or custodian who has responsibility for the health and welfare of a juvenile in a residential setting. A person responsible for a juvenile's health and welfare means a stepparent, foster parent, an adult member of the juvenile's household, an adult entrusted with the juvenile's care, a potential adoptive parent during a visit or trial placement with a juvenile in the custody of a department, any person such as a house parent or cottage parent who has primary responsibility for supervising a juvenile's health and welfare in a residential child care facility or residential educational facility, or any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services. Nothing in this subdivision shall be construed to impose a legal duty of support under Chapter 50 or Chapter 110 of the General Statutes. The duty imposed upon a caretaker as defined in this subdivision shall be for this Subchapter only.

Juvenile: **§ 7B-101** - A person who has not reached the person's eighteenth birthday and is not married, emancipated, or a member of the Armed Forces of the United States.

Dependent juvenile: § 7B-101 - A juvenile in need of assistance or placement because

(i) the juvenile has no parent, guardian, or custodian responsible for the juvenile's care or

(ii) supervision or (ii) the juvenile's parent, guardian, or custodian is unable to provide for the juvenile's care or supervision and lacks an appropriate alternative child care arrangement.

Neglected juvenile: § 7B-101 - A juvenile who does not receive proper care, supervision, or discipline from the juvenile's parent, guardian, custodian, or caretaker; or who has been abandoned; or who is not provided necessary medical care; or who is not provided necessary remedial care; or who lives in an environment injurious to the juvenile's welfare; or the custody of whom has been unlawfully transferred under G.S. 14-321.2, or who has been placed for care or adoption in violation of law. In determining whether a juvenile is a neglected juvenile, it is relevant whether that juvenile lives in a home where another juvenile has died as a result of suspected abuse or neglect or lives in a home where another juvenile has been subjected to abuse or neglect by an adult who regularly lives in the home.

Abused juveniles: **§ 7B-101** - Any juvenile less than 18 years of age whose parent, guardian, custodian, or caretaker:

Physical

a. Inflicts or allows to be inflicted upon the juvenile a serious physical injury by other than accidental means;

Creates or allows to be created a substantial risk of serious physical injury to the juvenile by other than accidental means;

c. Uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior;

Sexual

d. Commits, permits, or encourages the commission of a violation of the following laws by, with, or upon the juvenile: first-degree rape, as provided in G.S. 14-27.2; rape of a child by an adult offender, as provided in G.S. 14-27.2A; second degree rape as provided in G.S. 14-27.3; first-degree sexual offense, as provided in G.S. 14-27.4; sexual offense with a child by an adult offender, as provided in G.S. 14-27.4A; second degree sexual offense, as provided in G.S. 14-27.5; sexual act by a custodian, as provided in G.S. 14-27.7; unlawful sale, surrender, or purchase of a minor, as provided in G.S. 14-43.14; crime against nature, as provided in G.S. 14-177; incest, as provided in G.S. 14-178; preparation of obscene photographs, slides, or motion pictures of the juvenile, as provided in G.S. 14-190.5; employing or permitting the juvenile to assist in a violation of the obscenity laws as provided in G.S. 14-190.6; dissemination of obscene material to the juvenile as provided in G.S. 14-190.7 and G.S. 14-190.8; displaying or disseminating material harmful to the juvenile as provided in G.S. 14-190.14 and G.S. 14-190.15; first and second degree sexual exploitation of the juvenile as provided in G.S. 14-190.16 and G.S. 14-190.17; promoting the prostitution of the juvenile as provided in G.S. 14-205.3(b); and taking indecent liberties with the juvenile, as provided in G.S. 14-202.1;

Emotional

e. Creates or allows to be created serious emotional damage to the juvenile; serious emotional damage is evidenced by a juvenile's severe anxiety, depression, withdrawal, or aggressive behavior toward himself or others;

Moral Turpitude

f. Encourages, directs, or approves of delinquent acts involving moral turpitude committed by the juvenile; or

Human Trafficking

g. Commits or allows to be committed an offense under G.S. 14-43.11 (human trafficking), G.S. 14-43.12 (involuntary servitude), or G.S. 14-43.13 (sexual servitude) against the child.

Chapter 7B Juvenile Code

(Current as of January 2016)
SUBCHAPTER I. ABUSE, NEGLECT, DEPENDENCY.
ARTICLE 1.

Purpose; Definitions

7B-101. Definitions.

As used in this Subchapter, unless the context clearly requires otherwise, the following words have the listed meanings:

(1) **Abused juveniles**. - Any juvenile less than 18 years of age whose parent, guardian, custodian, or caretaker:

a. Inflicts or allows to be inflicted upon the juvenile a serious physical injury by other than accidentalmeans;

b. Creates or allows to be created a substantial risk of serious physical injury to the juvenile by other than accidentalmeans;

c. Uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior;

d. Commits, permits, or encourages the commission of a violation of the following laws by, with, or upon the juvenile: first-degree rape, as provided in G.S. 14-27.2; rape of a child by an adult offender, as provided in G.S. 14-27.2A; second degree rape as provided in G.S. 14-27.3; first-degree sexual offense, as provided in G.S. 14-27.4; sexual offense with a child by an adult offender, as provided in G.S.14-27.4A; second degree sexual offense, as provided in G.S. 14-27.5; sexual act by a custodian, as provided in G.S. 14-27.7; unlawful sale, surrender, or purchase of a minor, as provided in G.S. 14-43.14; crime against nature, as provided in G.S. 14-177; incest, as provided in G.S. 14-178; preparation of obscene photographs, slides, or motion pictures of the juvenile, as provided in G.S. 14-190.5; employing or permitting the juvenile to assist in a violation of the obscenity laws as provided in G.S. 14-190.6; dissemination of obscene material to the juvenile as provided in G.S. 14-190.7 and G.S. 14-190.8; displaying or disseminating material harmful to the juvenile as provided in G.S.14-190.14 and G.S. 14-190.15; first and second-degree sexual exploitation of the juvenile as provided in G.S. 14-190.16 and G.S. 14-190.17; promoting the prostitution of the juvenile as provided in G.S. 14-205.3(b); and taking indecent liberties with the juvenile, as provided in G.S. 14-202.1;

e. Creates or allows to be created serious emotional damage to the juvenile; serious emotional damage is evidenced by a juvenile's severe anxiety, depression, withdrawal, or aggressive behavior toward himself or others;

f. Encourages, directs, or approves of delinquent acts involving moral turpitude committed by the juvenile;or

g. Commits or allows to be committed an offense under G.S. 14-43.11 (human trafficking), G.S. 14-43.12 (involuntary servitude), or G.S.14-43.13 (sexual servitude) against the child.

(2) **Aggravated circumstances**. - Any circumstance attending to the commission of an act of abuse or neglect which increases its enormity or adds to its injurious consequences, including, but not limited to, abandonment, torture, chronic abuse, or sexual abuse.

(3) **Caretaker.** - Any person other than a parent, guardian, or custodian who has responsibility for the health and welfare of a juvenile in a residential setting. A person responsible for a juvenile's health and welfare means a stepparent, foster parent, an adult member of the juvenile's household, an adult entrusted with the juvenile's care, a potential adoptive parent during a visit or trial placement with a juvenile in the custody of a department, any person such as a house parent or cottage parent who has primary responsibility for supervising a juvenile's health and welfare in a residential child care facility or residential educational facility, or any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services. Nothing in this subdivision shall be construed to impose a legal duty of support under Chapter 50 or Chapter 110 of the General Statutes. The duty imposed upon a caretaker as defined in this subdivision shall be for the purpose of this Subchapter

(7a) **Criminal history**. - A local, State, or federal criminal history of conviction or pending indictment of a crime, whether a misdemeanor or a felony, involving violence against a person.

(8) **Custodian.** - The person or agency that has been awarded legal custody of a juvenile by a court.

(9) **Dependent juvenile**. - A juvenile in need of assistance or placement because (i) the juvenile has no parent, guardian, or custodian responsible for the juvenile's care or supervision or (ii) the juvenile's parent, guardian, or custodian is unable to provide for the juvenile's care or supervision and lacks an appropriate alternative child care arrangement.

(11a) **Family assessment response**. - A response to selected reports of child neglect and dependency as determined by the Director using a family-centered approach that is protection and prevention oriented and that evaluates the strengths and needs of the juvenile's family, as well as the condition of the juvenile.

(11b) **Investigative assessment response**. - A response to reports of child abuse and selected reports of child neglect and dependency as determined by the Director using a formal information gathering process to determine whether a juvenile is abused, neglected, or dependent.

(14) **Juvenile**. - A person who has not reached the person's eighteenth birthday and is not married, emancipated, or a member of the Armed Forces of the United States.

(15) **Neglected juvenile**. - A juvenile who does not receive proper care, supervision, or discipline from the juvenile's parent, guardian, custodian, or caretaker; or who has been abandoned; or who is not provided necessary medical care; or who is not provided necessary remedial care; or who lives in an environment injurious to the juvenile's welfare; or the custody of whom has been unlawfully transferred under G. S. 14-321.2, or who has been placed for care or adoption in violation of law. In determining whether a juvenile is a neglected juvenile, it is relevant whether that juvenile lives in a home where another juvenile has died as a result of suspected abuse or neglect or lives in a home where another juvenile has been subjected to abuse or neglect by an adult who regularly lives in the home.

(16) **Petitioner**. - The individual who initiates court action, whether by the filing of a petition or of a motion for review alleging the matter for adjudication.

(17) **Prosecutor**. - The district attorney or assistant district attorney assigned by the district attorney to juvenile proceedings.

(18) **Reasonable efforts.** - The diligent use of preventive or reunification services by a department of social services when a juvenile's remaining at home or returning home is consistent with achieving a safe, permanent home for the juvenile within a reasonable period of time. If a court of competent jurisdiction determines that the juvenile is not to be returned home, then reasonable efforts means the diligent and timely use of permanency planning services by a department of social services to develop and implement a permanent plan for the juvenile.

(18a) **Responsible individual**. - A parent, guardian, custodian, or caretaker who abuses or seriously neglects a juvenile.

(18b) **Return home or reunification**. - Placement of the juvenile in the home of either parent or placement of the juvenile in the home of a guardian or custodian from whose home the child was removed by court order.

(19) **Safe home**. - A home in which the juvenile is not at substantial risk of physical or emotional abuse or neglect.

(19a) **Serious neglect.** - Conduct, behavior, or inaction of the juvenile's parent, guardian, custodian, or caretaker that evidences a disregard of consequences of such magnitude that the conduct, behavior, or inaction constitutes an unequivocal danger to the juvenile's health, welfare, or safety, but does not constitute abuse.

Child Maltreatment or Not?

Read each statement and determine whether or not there is some form of child maltreatment. Your answers should be based on the legal definition we have just discussed.

1. A 9-year-old has welt marks all over her buttocks. She says her mother spanked her for leaving her homework assignment at school.

2. A 4- month-old has a bald flattened spot on the back of her skull. The baby also looks extremely underweight. Neighbors report that the baby is heard cryingconstantly.

3. A 7-year-old girl, one of four siblings, is constantly berated by her parents. She is more severely punished than her brothers and sisters and she is not allowed to play outside after school or have friends over. The school makes a report after she stabs herself in the wrist with a pencil.

4. A 12-year-old goes to school in cold weather frequently missing key items of clothing socks, under garments, a hat, no sweater or coat.

5. An infant is born with a positive toxicology fordrugs.

6. Two children ages 4 and 7 have been found left alone in their apartment for several days.

7. Three young children told a neighbor that their mother has been lying on the living room floor unable to move for days. The children were left to fend for themselves.

8. The father of a 17-year-old swings a bat directly at the teen. The teen ducks and fortunately is not hit.

9. An 11-year-old attempting to protect Mom during an argument with Dad has bruises on his face and cuts on his hands and arms.

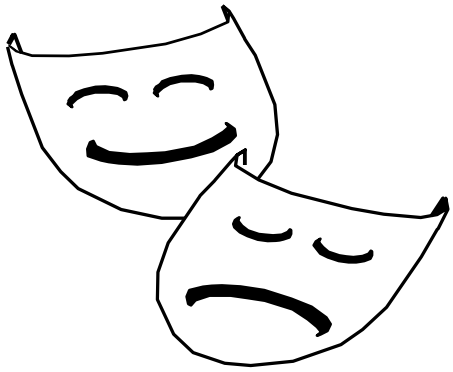
10. A10-year old says her stepfather examines her in between her legs while bathing her, to make sure she is clean. She said it doesn't bother her.

11. A 7-year-old told her teacher that her baby-sitters boyfriend kisses her on the mouth.

Intake Truth or Lie

Intake workers make the very first decisions in any child protective services case.

- Intake workers make the very first decisions in any child protective services case.
- Intake workers make the first safety assessments on a child welfare case.
- Intake workers make the decisions to screen a case 'in or out', alone, and without the supervisor's review.



- Intake's role is to determine if a CPS report should be referred for an assessment.
- Intake's role is to determine if the child in a CPS report has been maltreated.
- Intake's role is to determine if the alleged perpetrator in a CPS report is a parent or caretaker under NC law.

- Intake is one of only two areas of child welfare that can accept or screen out a potential case.
- If a report is screened out, the report is required to be recorded in the agency, but no other action is required.
- Intake's role is primarily the acceptance, screening, and assessment of possible child maltreatment referrals from various community resources.

Role and Purpose of Intake in Child Welfare Services

- The Intake unit's role in the provision of child welfare services is primarily the acceptance, *screening, and assessment* of possible child maltreatment referrals from various reporting sources throughout the community.

- Intake provides a means by which the community can report its concerns for children who may be in questionable, substandard, or dangerous situations.

- It is not the intake child welfare worker's role or the reporter's role to prove or disprove the allegation.

- The intake worker's job is to gather enough information from the reporter to determine whether *further assessment* is needed based on the safety and potential risk of harm of the condition / situation to the child.

- The worker makes *a screening decision* (along with their supervisor) based on certain criteria. This screening decision is never made alone. A two-level review is required for every CPS Report, usually consisting of the child welfare worker and his/her supervisor or another supervisor or a higher-level manager.

Effective Intake Skills

Listening closely to the information provided by the reporter.

- Ask probing questions in a non-threatening manner implementing a caller friendly, family centered approach.
- Clarify ambiguous information.
- Obtaining behaviorally specific information. For example:
    - Instead of, "their father messes with them." " Mr. Smith, their father, brags to his friends that when he is alone with Clara and Ruby, he puts his finger inside their vaginas."
    - Instead of, just saying, "Timmy says his dad hit him in the face, add other additional descriptions, "a large blue bruise is on Timmy's left cheek. It is shaped like a handprint."
- Obtaining as much identifying information as possible, names, dates, ages, schools, race, household members, parents, employment, residence, current location of the children, etc.
- Always asking the screening questions related to substance abuse and domestic violence.
- Trying to help the caller share family strengths as well as needs and concerns.
- BEING CALM- provide comfort, support, and reassurance to the reporter.
- Completing thorough check of agency files. **(Neither central registry checks nor phone calls to other agencies or counties is allowed until a report has been screened in by order of administrative rule.)**
- Having a thorough knowledge of CPS laws, policies, and procedures with the ability to explain this information in layman's terms.
- Having the ability to prioritize work based upon risks/potential risks to children.
- Having the ability to thoroughly document information in a logical and concise manner that focuses on parental behavior's effect on the safety of children.
- Having the ability to help the caller understand the reasons why DSS may need to follow-up later with the caller to clarify information in the report.
- Having an awareness of the importance of explaining to the caller if DSS has “Caller Identification,” (especially if the identifying information the caller is giving is different from information on the “calleridentification.”)
- Having the ability to work in a fast paced and crisis-oriented environment on an ongoing basis.

CPS Intake Policy Excerpts

https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/intake_-manual.pdf

- County child welfare agencies must receive, and screen all reports of abuse, neglect, or dependency, regardless of residency. The county child welfare agency has the authority to intervene only when the allegation, if true, would meet the legal definitions.
  (Intake: Policy & Legal Basis pgs. 3-5)

- The county child welfare worker must document and manage information about the report of suspected abuse, neglect, and/or dependency by creating a new CPS Intake in NC FAST or use the structured intake tool, North Carolina Division of Social Services' Structured Intake Form,(DSS-1402)
  (Intake: Collection of Information and Assessing Agency History, pg. 10)

- For all CPS Reports:
  - Two level decisions must occur on every CPS Intake completed.
  - The screening decision(s) must include a discussion between the CPS Intake worker and a supervisor (or other management position) about the tools consulted, priority and assessment response and a justification for those decisions.
  - All persons participating in the screening decision must sign the Structured Intake Report tool where indicated.

  (Intake: Two Level Decision Making, pg. 37)

- For all CPS Intake reports, there must be documentation that:
  - Written notice was sent to the person making the report within 5 business days after receipt of the report
  - The person making the report waived their right to notice; or
  - The person making the report refused to provide identifying information.

  (Intake: Notification, pg. 41)

■ The notice to the reporter must include:

a) A statement about whether the report was accepted for CPS Assessment based on statutory definitions, citing the relevant statutes, and identify the type of CPS Assessment that includes a brief description

b) The date the report was made

c) The identity of the alleged victim child; for instance, if the reporter specifically identifies the name of a child, use that name; however, if the name is unknown use the descriptor given by the reporter

d) Information regarding the process by which the reporter may obtain a review of the agency's decision not to accept the report for CPS Assessment

e) A statement about whether the report was referred to the appropriate state or local law enforcement agency

f) The identity of the county responsible for conducting the CPS Assessment, if different than the county that received the Intake

g) Information and resources on human trafficking, if the report is screened out

h) A statement that encourages the reporter to contact the agency if more information or concerns regarding the child or family surfaces

i) The name and contacted information for the assigned County child welfare worker, the supervisor, or other identified person.
(Intake: Notification, pgs. 41-42)

■ The timeframe for responding to reports of abuse, neglect, and/or dependency begins at the time the reporter contacts the county child welfare agency, assignment of the report for assessment must occur as soon as the Intake screening process is complete.
(Intake: Assignment of Report, pg. 36)

■Agencies must respond immediately when a report is determined to be a high-risk situation resulting from abuse, neglect or dependency. High-risk situations which require an immediate response include but not limited to:

- a child at imminent risk of harm resulting from neglect;
- physical abuse of a preschool child;
- a child under the age of six is left alone;
- a child being sexually abused;
- a child being tormented or tortured;
- a child in a life-threatening situation;
- a child under the age of 12 who self-refers or refuses to go home;
- a report of a child's death as a result of maltreatment and there are other children present in the home or if it is unknown if there are other children; and
- all reports of abandonment
- anytime the agency determines that an immediate response is indicated.

(These are examples of high-risk situations referenced throughout policy and within the Response Priority Screening Tools, pg. 89)

■ Whenever a report alleges that a non-caretaker has harmed, or there is evidence that a child has been harmed in violation of any criminal statute, child welfare agencies must:

- Give immediate verbal notifications to the District Attorney or designee
- Send subsequent written notification to the District Attorney within 48 hours
- Give immediate verbal notification to the appropriate local law enforcement agency
- Send subsequent written notification to the appropriate local law enforcement agency within 48 hours
- Notify military authority associated with alleged perpetrator

(Intake: Notification, pg. 39-40)

Intake Report for The Hobgood Family

Ms. Georgetta Grant called the Department of Social Services about a 10-year old boy who lives next to her. The neighborhood has several old fourplexes, and the boy, Burt Hobgood, and his mother, Sandy Hobgood, live upstairs from Ms. Grant. Burt came to her door this afternoon asking if she would be willing to give him some food. When she asked where his mother was, he said she had been gone since yesterday morning. He had eaten the peanut butter sandwiches and chips that she left for him, but now there is nothing left to eat. Burt told Ms. Grant that he didn't know when his mom would be back, and he was worried about her. He was in a hurry to get back to the apartment just in case his mother came home, because she would be mad if she knew he had left the apartment. She convinced him to stay with her long enough to eat some food and assured him that she would try to help him, so he would not be alone overnight again. When Ms. Grant gave Burt some soup and a sandwich, she noticed that he had a mark resembling a bruise on his arm. Ms. Grant looked at his legs when he stood up and saw bruises there as well. The skin was not broken, but the marks are straight and looked like they were caused by a belt. When she questioned Burt about the marks, he avoided answering. Ms. Grant asked, “Did you get a spanking from your mom?” and Burt shook his head, yes.

Ms. Grant explained to Burt that there were some people at the Department of Social Services who help children when they had problems. She would call for him, but she wanted him to stay with her while she called in case they had questions she could not answer. He was hesitant at first, but Ms. Grant reassured Burt that calling Social Services was the quickest way to get help for him.

Burt began to cry and told Ms. Grant that he was “so scared last night he couldn’t sleep” and “he was afraid of being alone again tonight and wanted someone to find his mother”. He also stated he was afraid that she might not be coming back home and that he had not eaten since yesterday and there was no more food in the house.

Ms. Grant then called Social Services and explained to the Intake Worker what Burt had just shared with her about being afraid and that there was no food in the house. She also described the marks that she sees on Burt. She explained to the worker that Burt and Sandy have lived upstairs for the last year or so. She believes that Sandy entertains often, although the police have not been called for noise or anything. Sometimes she does ask Sandy to have Burt turn his rap music down, since it tends to get rather loud late at night. She doesn't know where Burt's father is, but there are a couple of men who visit regularly.

Ms. Grant is worried that this young boy is not eating properly, is scared, and alone. She told the intake worker that she is retired, living on a fixed income, and cannot afford to feed Burt. She would be willing to help supervise him for short periods of time and help keep an eye out for him in case there are any more bruises, but she could not always know when he is being left alone. She said, "Somebody needs to be taking care of this boy. He could get into trouble up there. He is too young and immature to be left alone."

Ms. Grant says this is the first time she has ever observed marks on Burt, and she sees him about once a week. Ms. Grant has heard Burt mention grandparents, but she does not know their names or where they live. She knows of no other relatives.

Ms. Grant is not aware of any domestic violence issues or safety issues in the home. She is not sure if Ms. Hobgood uses illegal drugs but she suspects she drinks alcohol because of the parties she has every week. She cannot positively confirm Ms. Hobgood's use of either alcohol or drugs.

Ms. Grant says that Burt is usually clean and appears to be physically healthy. She also says Burt has good manners and is polite to her. He seems to love his mother and talks about her playing with him or taking him places. Ms. Hobgood has been working regularly until recently. She usually smiles and waves at Ms. Grant but otherwise, she keeps to herself and doesn't socialize with others in the building. Ms. Grant reports that she has not met Burt's father and that she does not have any information about Burt's relationship with his father.

Consider This!

Intake Case Considerations

- **Does the report involve a juvenile, according to NC law?**
- **Is the alleged perpetrator a parent or caretaker, according to NC law?**
- **Would the reported information, if true, meet the NC law definitions of *abuse*, *neglect* and/or *dependency*?**
- **If true, would the maltreatment create harm or a risk of harm to the child due to the action/inaction of the parent/caretaker?**
- **Based on information received in the report, how quickly should CPS respond?**

Agenda
Day 3

9:00-9:25……..	I. Investigative and Family Assessments in Child Welfare A. Assignment of reports B. Benefits of two approaches C. Hobgood family case application
9:25-9:55……	II. Getting Started with the Family A. First Impressions B. Purposes of First Contact/Visit C. Worker Preparation
9:55-10:45……	III. Interviewing Adults A. Safety Planning (Video)
10:45-11:00……	BREAK
11:00 -11:45……	IV. Interviewing Children
11:45-1:00……	LUNCH
1:00-1:45……	V. Investigative and Family Assessments A. Responsibilities B. Similarities and Differences C. Policies
1:45-2:00……	VI. Domestic Violence and Child Welfare
2:00-2:30……	VII. Structured Decision-Making
2:30-2:45……	BREAK
2:45-3:50……	VIII. Evaluating and Documenting Safety A. Safety Assessment Tool B. Safety Assessment (Hobgood Case)
3:50-4:00……	IX. Ingredients of a Case Decision

Benefits of Two Approaches to CPS Assessments

(Family Assessments and Investigative Assessments)

Having Two Approaches Provides Opportunities to:

- Ensure children are safe
- Use authority and resources more effectively
- Engage families and communities in efforts to nurture and protect children
- Enhance family cooperation and strengths
- Address an overloaded CPS system
- Spend more time with families at highest risk
- Provide services and resources matched to families' needs

Benefits of the Two Approaches:

- If we treat all reports in the same way ("one size fits all"), we may miss some clear need for immediate action to protect the safety of children in the most severe cases.
- If we use the traditional approach in all cases, we also may miss early opportunities to engage some families in services that could enable them to better parent their children.
- If we approach all families in an "adversarial" way, vital information about the strengths of the family, the supports they have, and their motivation to change could beoverlooked.
- We can better serve many of the families reported to CPS in ways that focus more on helping them rather than "punishing" them.

Adapted from*: Multiple Response is System Reform.* UNC-Chapel Hill. Jordan Institute for Families, 2003

Interviewing

CPS Assessments Policy

https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/assessments.pdf

Time Frames

1. Time clock for initiation begins at the time the_____is received by any NC county child welfare agency.

2. Family Assessment reports should be initiated within_____hours or sooner.

3. Face-to-face interviews with the parents or primary caretakers with whom the child resides must be conducted on the_____day the child is seen.

4. Face-to-face interviews with non-primary caretakers known to be living in the child's household must be conducted within_____days of initiating the CPS Assessment.

Characteristics of Both Investigative Assessment and Family Assessment

5. _____ _____ practice and the concept of involving parents in decision making throughout service is applicable to both types of assessments

6. Use interview_____least likely to increase the risk of harm to the alleged victim child or other children in the home.

7. All CPS Assessments must include documentation to reflect_____made to see the child within the statutory timeframes.

8. Initiation of a CPS Assessment must include_____to_____interviews with all children living in the home.

Interviewing

CPS Assessments Policy

(*continued)*

https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/assessments.pdf

Assessments with allegations of Domestic Violence

9. The_____must not be interviewed in the presence of the violent adult.

10. Do not disclose information concerning the non-offending parent/adult victim's safety plan during the interview with the_____.

11. The_____should be used to support the determination of safety and risk factors.

The Sequence of Interviews

12. Interview Sequence for Family Assessment

- _____
- _____
- _____
- _____

13. Interview Sequence for an Investigative Assessment:

- _____
- _____
- _____
- _____

14. Interview Sequence for an Domestic Violence Assessment:

- _____
- _____
- _____
- _____

The First Contact or Visit with Families

The <u>purpose</u> of the first contact or visit is to:

- explain your reason for calling or visiting the home
- begin clarifying worker and family roles
- start creating a positive working relationship
- describe and model a family-centered way of working together
- begin defining goals together

The four main areas for <u>worker preparation</u>:

1. <u>Words</u> to use in describing role, services provided, and your reason for calling or visiting
2. Several techniques for <u>rapport building</u> with the family.
3. **S**everal <u>initial questions</u> to open the discussion with the family;
4. Being prepared for <u>questions from the family</u>

Getting Started with a Family

I. Rapport Building Strategies

A. Use normal, everyday language

1. Avoid social work jargon
2. Use words that make the assessment process and services delivery "transparent"

B. Demonstrate Respect

1. Be clear about your reason for calling or visiting
2. Ask the family to suggest a convenient time (within a time frame you provide) for you to visit to discuss the referral
3. When visiting the home, wait to be invited in
4. Once inside the home, ask the family where they would like for you to sit
5. Avoid being directive with the family's environment, kids, etc.
6. Allow the family to set the pace of when you "get down to business"
7. Use words and phrases that are familiar to the family
8. Listen and respond with empathy to positive and negative feelings expressed by the family

C. Model Family-Centered Practice

1. Stress you and your agency are committed to partnering with families and finding ways to keep children safe and together with their families.

2. Look for opportunities to offer compliments and praise.

3. Demonstrate interest in the needs of the entire family.

4. Allow the family to be the experts on their own lives, feelings, and situation.

5. Encourage the family to share their views, values, experiences, perspectives, and other information about their culture.

6. Respond with a "judgments can wait" approach to intense emotions and questions expressed by the family.

D. Establish Ground Rules at the time you complete official Paperwork

1. How should the worker be introduced to friends, family, neighbors?
2. How to cancel appoints.
3. How to ask for time out.
4. How confidentiality will be respected.

II. Initial Questions

1. Are you aware of why I am calling (or visiting your home today)?

2. What concerns do you have about your children/family?

3. What types of things have you already tried to address the concerns?

4. Tell me about some things that are going well for your family.

5. What do you think is important for me to know about your family?

6. Tell me about a typical day in the life of your family.

Interviews

Interviews with Children

- Pay attention to the developmental age of the children.
- Acknowledge feelings.
- Get on the child's eyelevel.
- Give as many choices as possible.
- Don't be afraid to laugh! It's not necessary to be serious all the time.

Preverbal Children and Toddlers

- Does the child follow sounds?
- Does the child focus on the speaker?
- Does the child smile, coo, or make other sounds?
- Does the child physically respond when spoken to?
- Does the child speak? What words?

Interviewing Adolescents/Teens

- Ease into the interview by talking about general topics first.
- Let the teen lead early in the interview.
- Take a walk or sit outside for the interview, if appropriate, to lessen the teens stress level.
- Show the teen that you respect their opinion and value their input.
- Ask them what they would like to see happen as well as what their worst fears are.

Interviewing Families

- Before you do anything else, recognize the families as people with lives of their own!
- Think about which person you will speak to first.
- Notice the state of the environment and the moods of thepeople.
- Enter into the family's traditions and rituals whenever possible.
- Notice family strengths and comment on them.

When talking isn't their language….

BAG O' TOOLS

- **crayons**
- **watercolors or washable markers**
- **cheap newsprint or grocery bags**
- **coloring books**
- **plain paper dolls that can be decorated**
- **plastic figures**
- **dolls**
- **animal figures**
- **magazines**
- **balls**
- **jump ropes**
- **play dough**

Investigative Assessment and Family Assessment Responsibilities

- Establishing contact with all identified persons who might have information regarding the complaint, including family members, collateral sources, and the child;

- Approaching the family in a manner that communicates that the agency's interests and responsibilities are to protect children and strengthen families, not to establish guilt or innocence;

- Establishing trust and rapport with family members to encourage them to disclose pertinent information and participate fully in the problem-solving process;

- Conducting a fact-finding process by interviewing family members, extended family, collateral contacts, and other sources of data; through observation of the family's interactions; and through other types of data collection to determine current safety, assess future risk and validate or refute the referral information.

- Weighing the interacting effects of both safety and risk factors to establish the degree of safety to the child(ren) at the present time, and the level of risk of harm to the child(ren) in the foreseeable future;

- Identifying strategies and initiating immediate interventions to provide protection for children who are determined to be unsafe and to prevent the need for removal and placement, if possible;

- Completing appropriate documentation of all information to develop a safety agreement, substantiate or refute the referral complaint and the likelihood of future harm;

- Presenting appropriate testimony in situations when juvenile court action is required to protect the child;

- Preparing the family for ongoing service intervention and case transfer to the ongoing caseworker, if applicable.

Family-Centered Child Protective Services (Core 101), The Ohio Child Welfare Training Program

Family Assessments and Investigative Assessments
The Similarities of these Approaches

- The safety of the child is the first concern during both assessments
- Both approaches allow actions necessary to ensure safety of the child (i.e. petitioning the court for non-secure custody order, etc.)
- Using a family-centered approach is best practice and is effective during both types of assessment
- Holistic (SEEMAP) assessments are completed during both approaches
  - Family strengths are identified during both assessments
  - Information is gathered regarding the entire family situation and includes more than incident-specific information
- Both assessment approaches seek collaboration with the family
- Services delivery can occur during both assessments prior to the case decision
- The two roles of the worker, helper and protective agent, are vital in both types of assessment
- Both assessments: time frame for completion is "within 45 days"
- Both utilize the Structured Decision-Making Tools
- Both assessment approaches include contacts with collaterals
- Both approaches must adhere to the law related to obtaining permission to enter a residence

Benefits of the Family Assessment Approach

Benefits for Families

- Parents may view child welfare workers as friendly and helpful rather than critical and punitive.
- Parents may be more motivated to change the behaviors that put their children at continued risk of harm based on this new non-adversarial relationship.
- Families are more likely to be cooperative and motivated to voluntarily participate in services when they are approached in a less adversarial, more respectful manner
- Parents who feel involved in the process of strengthening their families will be more likely to make lasting changes, thereby reducing the likelihood they will relapse into neglectful behaviors.

Benefits for Children

- Children are more likely to be protected by parents who are engaged in a partnership process of making sustainable changes.
- More services will be available to vulnerable children and their families.
- Children may feel less threatened by child welfare workers who no longer separate them from their parents to talk and who treat their parents as partners in the process of change.

Benefits for Workers

- Workers will have an alternative to the investigative assessment approach that will give them more opportunity to teach and support families, thereby addressing the root causes of maltreatment.
- Workers are likely to encounter less resistance from families and will be able to work more effectively as partners with families.
- Workers will be able to assess families more efficiently because there are fewer marginal cases.
- Families will reveal more information that will help workers target areas for improvement, thereby increasing workers' ability to link the family with needed services and community supports.
- Workers will likely experience an increase in job satisfaction when returning to true social work practice and away from a hardline investigative approach.

Benefits for the Child Welfare System

- Two assessment approaches will help the system respond more effectively to the variety of conditions present in families referred to child protective services.
- The most serious abuse cases will be readily apparent, and immediate action will be facilitated.
- The child welfare system will do a better job of preventing child abuse and neglect.
- The rate of subsequent, repeat reports to CPS will go down.
- The child welfare system will likely be viewed by families as a partner and friendly resource.
- Worker turnover may be reduced.
- Over time, community responsibility for the protection of children from abuse and neglect will increase.
- Over time, community perceptions of the child welfare system will improve.

Source: *Partners in Change: A New Perspective on CPS,* Appalachian Family Innovations, 2005.

Investigative Assessment and Family Assessment Approaches
Policy Distinctions

Investigative Assessment	Family Assessment
Screen report. Abuse and certain Neglect cases are assigned to investigative track. (Approximately 10% of all child maltreatment reports in North Carolina are for abuse).	**Screen report**. Neglect or dependency cases can be assigned to Family Assessment track. (Approximately 90% of all child maltreatment reports in North Carolina are for neglect).
Investigative Assessment. After face-to-face interview with all children living in the home, an interview is conducted with the non-perpetrating parent and then the perpetrator and then collaterals.	**Family Assessment** is initiated by having face to face individual interviews with all children living in the home within 72 hours or sooner, based on the allegations and the situation. The worker must contact the parent/caretaker to schedule the initial family contact.
Collateral contacts: At least two collateral contacts (people significant to the case) must occur during the CPS Assessment. The county child welfare worker must contact all the collateral information sources identified by the family prior to making a case decision.	**Collateral Contacts:** At least two collateral contacts (people significant to the case) must occur during the CPS Assessment. The county child welfare worker must contact all the collateral information sources identified by the family prior to making a case decision. The parent will be with the county child welfare worker when contact is made if the parent chooses, and if the safety of the non-professional collateral information source is not compromised as a result.
Case decision within 45 days. The decision will be (1) substantiate or (2) unsubstantiate the report. Substantiate, the report and the perpetrator's name are entered in the Central Registry, and services are required. Unsubstantiate, services may be offered but are not required. (Such offers are rarely accepted.)	**Case decision** within 45 days. Decision can be (1) services needed, (2) services recommended, or (3) services not recommended, or (4) services provided, no longer needed If services needed, the report is entered into Central Registry, but no perpetrator is named, and services are required. If services recommended, services are voluntary. If services not recommended, services are not offered or required. If services provided, protective services no longer needed, any further services are voluntary.
Switching Approach/Track. A case assigned to the investigation track can be re-assigned to the Family Assessment track with supervisory approval.	**Switching Approach/Track**. A case assigned to the Family Assessment track can be re-assigned to the investigation track with supervisory approval. Re-assignment is mandatory if allegations/findings rise to the level of abuse.

Sources:

NC Child Welfare CPS Assessments Policy: https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/assessments.pdf

Adapted from: *Cornerstone 3 Self-Study Guide for Family Assessment, Appalachian Family Innovations,3-06*

Non-Resident Parents are Family, Too

Non-Resident Parent involvement is required whenever possible throughout the life of the case.

Who is a non-resident parent?
A non-resident, often described as a noncustodial parent, is a parent that does not typically live in the home where the child neglect, abuse, or dependency allegations are being assessed.

Diligent efforts to contact required.
The agency must make diligent efforts to contact that parent and get their input on the allegations as well as the overall safety and risk in the home. If this absent parent cannot be located, the record shall include documentation showing what efforts have been made to locate him/her.

Discussion with the non-resident Parent should include:

- The level of their involvement with their child,
- If their relatives may be a resource in supporting the child.
- If the non-resident parent or their family is not involved in the child's life, it may be beneficial to ask what it would take for them to become involved.

Resistance from the parent/primary caretaker parent to involve or discuss the non-resident parent:
At times, the parent/primary caretaker parent may report that the non-resident parent is not involved with the child to limit any involvement in the CPS assessment. This may provide a good opportunity to discuss the parent's relationship with each other as well as information about the non-resident parent's last contact with the child and what the quality of the contacts has been. The child may also be able to report on their own relationship with the non-resident parent as well as their contacts.

When contacting the non-resident parent is assessed as aggravating the risk of harm to the child or to the custodial parent:

- There shall be specific information about the risk of harm documented in the case record to state the reasons why it was not in the best interest of the child's and/or custodial parent's safety to contact the absent parent. If not, a child welfare worker must continue to complete their diligent efforts to contact the non-resident parent.

North Carolina Child Medical Evaluation Program

www.med.unc.edu/cmep **919-843-9365**

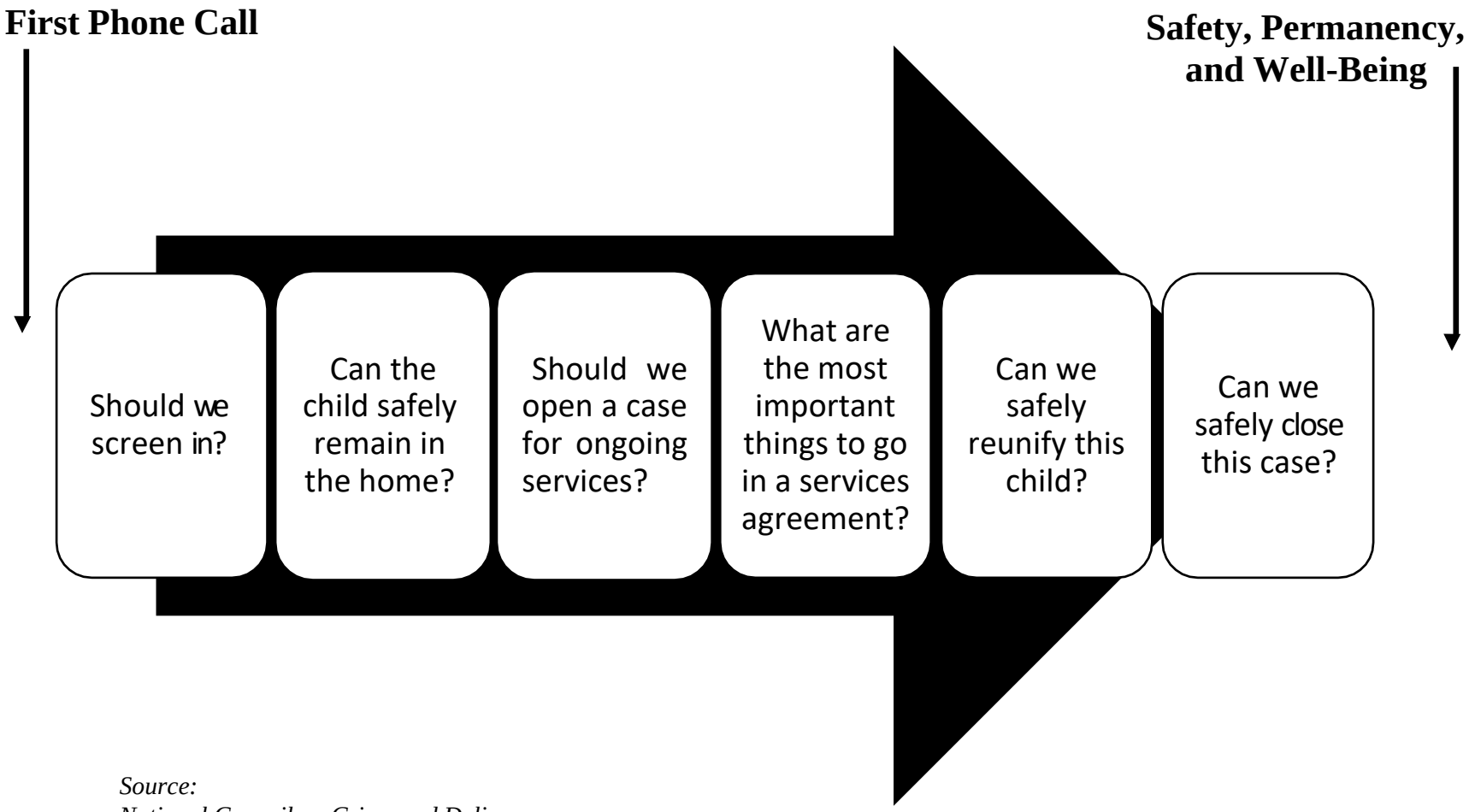
https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/assessments.pdf
(page 38)

NC CMEP provides a structured system for medical and mental health evaluations in alleged cases of child maltreatment. **These evaluations are performed at the request of the Departments of Social Services in the investigative assessment phase of a CPS case.** The examiners for these evaluations are **rostered** by the NC CMEP and have agreed to perform the evaluations in accordance with program guidelines. The NC CMEP office also provides case consultation (medical and social work investigations), assistance to child welfare workers to find providers, training on the identification of child maltreatment, administration of payment for rostered services, and recruitment for medical and mental health providers.

- **CME- Child Medical Evaluation:**
  Comprehensive medical evaluation and medical interview: The appointment consists of interviews of the child and caretaker for the purposes of obtaining medical and social history, a complete medical exam, documentation of any visible injuries or medical conditions indicative of abuse or neglect and includes diagnostic tests and screening as determined by the medical provider. Payment is made by Medicaid (if applicable) or by CMEP funds.
- **Role of the child welfare worker**: Locate a rostered provider to make an appointment, complete necessary forms (DSS 5143 consent), collect medical records to provide to CME provider, attend appointment to provide history, prepare the family for the exam. https://www.med.unc.edu/cmep/files/2018/01/dss-5143-jan07.pdf

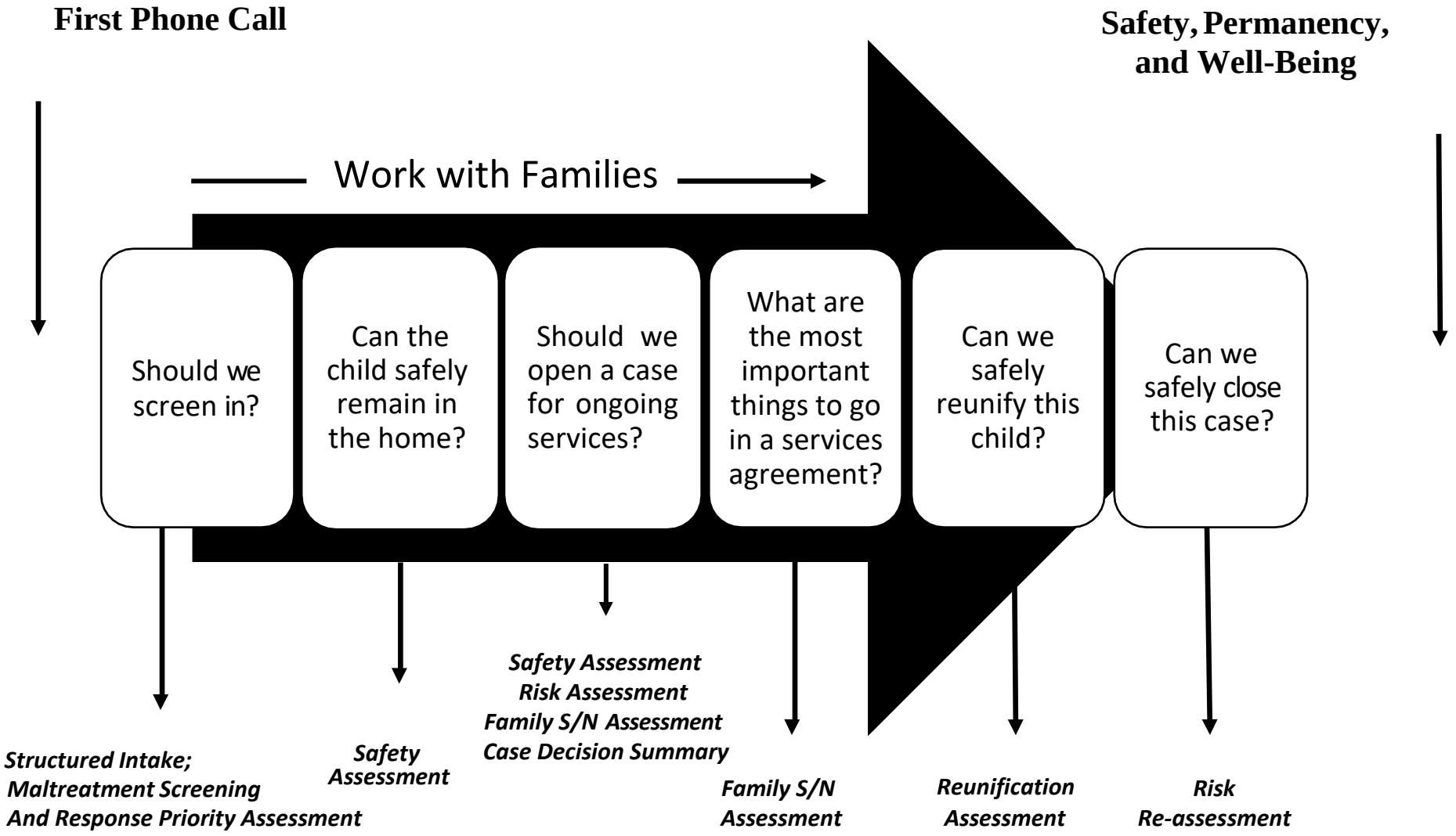
- **CFE- Child and Family Evaluation:** Provides forensically informed mental health evaluations for children/adolescents who are being investigated as possible victims of abuse or neglect. These evaluations typically include a review of salient records and interviews with the child, caregivers, as well as relevant collaterals. CFE evaluations are designed to provide assistance in decision making and case disposition, with an emphasis on treatment planning. These evaluations are requested and utilized in cases in which there has not been and is unlikely to be a determination of case decision through standard CPS investigative processes or CME. In cases of alleged physical or sexual abuse (and certain other forms of maltreatment) a CME is typically expected before a CFE will be authorized**.**
- **Role of the child welfare worker**: Locate a rostered provider, collect all records (prior history, evaluations, school records, medical records, etc.), complete authorization request and DSS 5143 and send to NCCMEP office (see contact info). The child welfare worker is required to provide a list of questions to the provider as a guide for the evaluation and recommendations for the case.

Key Decision-Making Points



Source:
National Council on Crime and Delinquency:
Children's Research Center

Structured Decision-Making Tools



Source: National Council on Crime and Delinquency: Children's Research Center

North Carolina Safety Assessment and the Temporary Parental Safety Agreement (DSS-5231 Rev. 01/2017)

Safety Assessment Purposes:

- To assess whether a child(ren) is likely to be in immediate danger of serious harm which may require a protective intervention
- To determine what safety intervention(s) should be initiated or maintained to provide appropriate protection of the child(ren)

Types of Family Safety Interventions (may use a combination of these safety interventions which are individualized based on the information you have as a result of your collaboration with the family)

Resource support refers to safety actions that address a shortage of family resources and resource utilization (such as obtaining heat, water, electricity, food, childcare, etc.), the absence of which directly threatens the safety of the child.

Social support includes actions that reduce social isolation. Social support may be used alone or in combination with other actions in order to reinforce and support the capacity of the parents or other caregivers.

Crisis management is specifically concerned with intervening to bring a halt to a crisis and to facilitate problem solving to bring a state of calm to a family. The purpose of crisis management is to quickly control the threat to the child's safety. Crisis management will often be employed along with other safety actions.

Separation or restriction refers to the removal of any household member from the home for a period of time or otherwise interfering with a parent's custodial rights. Separation is viewed as a temporary action. Separation may involve, among other things, the child temporarily moving to a safe environment, a friend moving into the home, the protective parent moving with the child to a safe environment, a parent agreeing not to have unsupervised contact with the child, a parent agreeing to forfeit decision-making authority over the child, or the alleged perpetrator agreeing to leave the home.

Separation or restriction should always be a LAST RESORT option for families. Safety Agreements involving separation are to include other activities to address the safety indicators and are PART of the plan, NOT THE PLAN. The timeframe for safety agreements utilizing separation or restriction would be hours, days, or in certain circumstances, weeks, but not months (without court oversight).

Temporary Parental Safety Agreements

Definition:

A Temporary Parental Safety Agreement is a voluntary & short-term safety intervention plan developed between a parent and a county child welfare agency if a child is in immediate danger in his or her own home because of a safety threat.

Goals of Temporary Parental Safety Agreements:

- Sufficient to manage safety;
- Reasonably tailored to the allegations provided in the CPS report and the child safety issues that exist within the family;
- Immediately available so that it is capable of being in operation the same day it is created; and
- A plan that includes actions and goals that are specific and measurable

Characteristics of Temporary Parental Safety Agreements:

- Collaboratively made with the family, child, and network;
- Intended to be short-term;
- A process, not an event;
- Not a guarantee;
- A method for keeping children safe;
- An intervention and change strategy;
- Create and include
  - ✓ a family-centered description of the identified safety threat(s)
  - ✓ Clear and observable guidelines about the contact between the children and parents, and how the children are to be protected from danger
  - ✓ Activities that will address/eliminate the safety threat(s)
  - ✓ A plan for monitoring
  - ✓ Signatures of family, child welfare worker, and social work supervisor
- Are voluntary and revocable

A Parent's Right to Revoke a Safety Agreement:

- May be revoked verbally or in writing
- The County child welfare agency must be notified by the parent of their vocation
- The County child welfare agency identifies the notification process
- Part F of the Safety Agreement: *Statement of Understanding and Agreement* provides information about the parent's right to revoke the agreement and provides a place for revoking the agreement

Temporary Parental Safety Agreements: Practice Requirements:

Visitation:

- Only the court may require supervised visitation between a parent and that parent's child
- An exception is when arrangement for supervised visits or "no contact" is totally voluntary on the part of the parent

Child and Family Team Meetings During a CPS Assessment

- When a Safety Agreement requiring separation or restriction is being proposed
- If non-secure custody is considered the only means of ensuring safety of the child

Source: NC Child Welfare Manual: CPS Assessments: Family & Investigative Assessments: Safety Planning, pages 16-21 https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/assessments.pdf

Initiation with the Hobgood Family

Pre-interview records check. One prior CPS record for the Hobgood family was found indicating a family assessment one year ago with a case decision of "services not recommended." Also, an eligibility services file was opened on the mother, Sandy, and three children about four years ago when a daughter, Helen, was born. Helen would now be four, an older brother Sam would be nine, and Burt, the oldest, is 10. The case was closed six months later, when Ms. Hobgood went back to work. The father of all three children was listed as Johnny Hobgood, address unknown. His occupation was listed as housepainter. Efforts to find him for child support were sporadically successful, since he worked irregularly and moved often.

Agency records show Ms. Hobgood is receiving food and energy assistance services. According to the records, Ms. Hobgood is now 28 years of age.

After reviewing the intake report, the family assessment worker decided to try to reach Burt's mother by phone, just in case she had arrived home within the short time that had passed since the report was received. There was no answer at the number provided on the intake report.

Interview with Burt

When the family assessment worker arrived at the apartment, Burt was slow to answer the door, but finally came out into the hallway of the building to talk with the worker. The worker and Burt talked quietly so that neighbors would not hear their conversation.

Burt is a small boy with shaggy light brown hair and blue eyes. He was wearing a T-shirt with Harley Davidson on it and cut-off jean shorts that looked as if he had been wearing them for several days. His shorts were covered with dirt and some spaghetti sauce. Burt appeared to be of average height and weight for his age. There were no immediately apparent physical problems. His eyes were clear, and his skin color appeared normal pink.

Burt said that they moved here when school started last year, so that his mom could "work in an office in town." This apartment is on the bus line for her to get to work. She had a car but had to stop driving. Burt didn't know a lot about that. He states that he and his mom usually get along OK and that they sometimes go to the movies and out to eat at McDonald's.

Burt thinks school is boring but goes because it gives him a place to meet some friends. He doesn't know too many kids, and there are no other kids in this apartment. Now, during the summer, he goes outside and looks for other kids, but he doesn't know the neighborhood and "doesn't want to get beat up", so he mainly stays around in the apartment. Burt offered to go and get some of the cartoons he has drawn. He ran into the apartment and came out with some pictures of action figures who were engaged in martial arts, blowing up other things, or getting blown up. Burt is a rising 5th grader. He has not failed a grade but has gotten some D's lately.

Burt last saw Sandy Hobgood yesterday morning. When asked by the worker where he thought his mother might be, Burt mumbled, “She gets real drunk sometimes and goes off with her friends, but she usually does not stay out all night.” She has done this once before since they lived here, but then he was in school, and there was plenty of food in the house. He gets free breakfast and lunch at school, so he was eating. He reluctantly showed the worker his legs and arms. There was one small group of bruises on his arm in the shape of fingertips as if someone had grabbed his arm tightly. There were linear bruises about an inch wide on both calves. The worker counted three of them. He said that his mom gets impatient with him when she is drinking and uses a belt and her hand on him when he talks back. He said he gets mad when she drinks. Burt said that there are also marks on his bottom like those on his legs. All the bruises were light blue in color, which indicated they were recently inflicted.

Burt has grandparents, John and Patricia Hobgood, who live a few hours away in Waynesville. His brother Sam and sister Helen live with them. He visits his brother and sister sometimes. His maternal grandmother is Irene Curtis and she lives closer. Sometimes he goes there on weekends. She lives in an old house with a garden and fishpond. He likes to fish, but she expects him to weed the garden, and he hates that.

Burt hasn’t seen his dad in over a year. He remembers playing ball with him when he was younger. He used to come around after he had finished a job and “had money to take mom out dancing”. Burt related that his dad has now completely stopped coming around even though mom would always allow him to stay with them. He related that his mom and dad yelled a lot when they were together, but he has never seen them fight or hit each other.

About thirty minutes after the child welfare worker’s arrival, Sandy Hobgood returned home with two bags of groceries in her arms. Ms. Hobgood appeared very surprised to see the worker and immediately asked if there was anything wrong with Burt. Burt went over to hug his mother and she put her arm around him and told him to go to his room and play while she talked to the worker. The worker asked Ms. Hobgood if it would be ok if they continued their conversation inside the apartment so they could have more privacy. Ms. Hobgood agreed and invited the worker into the apartment.

Interview with Sandy Hobgood

The child welfare worker explained that she was a family assessor from the Department of Social Services and that the reason for her visit was that someone called the Department of Social Services and said that Burt was left alone overnight, had no food to eat, and did not know when Ms. Hobgood would return. Ms. Hobgood became defensive. She stated that she had gone out with a friend the night before and time just slipped away from her. Ms. Hobgood went on to explain that she had fallen asleep at her friend’s apartment and after she awoke, she decided to go grocery shopping before she came home. Ms. Hobgood stated that she made Burt some sandwiches to eat so he would not get hungry. She also stated that she did not know it was a ‘crime’ to leave a boy the age of Burt alone overnight. Ms. Hobgood stated that he was ‘perfectly safe’ within the apartment. He was told not to leave his home. At this point the family assessor told Ms. Hobgood she can see she is concerned about her son having enough food to eat as evidenced by her making

sandwiches and bringing groceries home. The worker explained to Ms. Hobgood that the Department of Social Services has made some changes in the way they "do business" and that the agency is interested in how her family is doing in general and not just this one incident. The child welfare worker asked Ms. Hobgood if she is willing to work out plans with the worker today for Burt's supervision and care. Ms. Hobgood stated she still wasn't sure what she had done that was so horrible, but that she would be willing to work out a plan with the child welfare worker to make sure Burt was not left alone again. The worker commented to Ms. Hobgood that she recalls Ms. Hobgood mentioning that the apartment is safe place for Burt. She asked Ms. Hobgood if she would mind showing her around the apartment. The worker further explained that seeing the living environment of children who get referred to the Department of Social Services is required and helps workers become aware of things that parents are doing to take care of their children and keep them safe. Ms. Hobgood agreed to show the family assessor around the apartment.

The upstairs apartment has a kitchen, living room/dining room combination, two bedrooms, and a bath. The apartment was clean and there were no safety hazards noted. There was a smoke detector on the wall in the hall with active batteries. The apartment was sparsely furnished but had a table and chairs in the dining room, a sofa covered with a sheet, a single bed and dresser in Burt's room, and a double bed in Sandy Hobgood's room. There was an adequate amount of clothing in Burt's closet. The clothes appeared well worn but clean. There was a TV, DVD Player, and an Xbox gaming console in Burt's room that Burt was enjoying while the worker and Ms. Hobgood talked. Ms. Hobgood explained that Burt got the Xbox for Christmas. The refrigerator was empty, as were most of the cabinets in the kitchen. There was some rice in cupboard. The empty sandwich bags that had held the sandwiches that Ms. Hobgood had left for Burt, and an empty bag of potato chips were on the kitchen counter. Dirty dishes were stacked in the sink. Mrs. Hobgood mentioned that Burt cleans the supper dishes when she cooks.

When asked about the marks on Burt's legs, Ms. Hobgood became quite defensive. She admitted that she had hit Burt but said that it only happens when she has been drinking. She has not hit him like that in almost a year. [Later Burt corroborated the same story.] The drinking was triggered this time when the factory where Sandy works laid off almost 30 percent its work force. Since she had only worked there about a year, she was among the first to go. She got really scared and started to drink. When that happens, Burt starts to yell at her, and it makes her mad. She thought it was better to go away than risk hitting him again. She considers him a real resourceful kid, and she knew he'd ask for help if he needed it. She never intended to be away even one night. She figured the time "slipped away." When asked by the worker where Ms. Hobgood had hit Burt, she told her "on his legs and his butt." The worker asked for permission to examine Burt's buttocks to check for any marks or injuries. At first, Ms. Hobgood said she didn't think that was a good idea, because Burt didn't even like for her to see him with his pants down. The worker explained that she would need Ms. Hobgood's help in explaining to Burt why she needed to examine his buttocks and that she would want Ms. Hobgood to be present when she examines him. Ms. Hobgood stated she sure hoped there were no marks on his "butt" because she didn't intend to hurt him, just make him stop yelling at her. Later, upon examination of Burt's buttocks, two linear bruises about 1" wide each were found.

The child welfare worker asked Ms. Hobgood about her drinking and drug use. Ms. Hobgood admitted that she did drink sometimes although not often. She stated that she can go several months without drinking, and everything goes along well. Then something will "set her off" and she will start to drink. "It's not like I am a drunk in the street,"she kept saying. "I can control it." Ms. Hobgood stated that she drank to relax sometimes. She stated that caring for Burt alone was "more than she could take sometimes." She emphatically denied using any illegal drugs. She told the worker that she didn't even take over-the-counter meds unless she had to for a headache or something. When asked about her physical health, Ms. Hobgood said that neither she nor Burt was hardly ever sick. Ms. Hobgood appeared coherent and logical in her thought processes and speech. Her eyes were a little bloodshot. She states that she has never experienced any mental health problems or been treated for mental health issues. Ms. Hobgood did not report any abuse or neglect as a child.

Ms. Hobgood stated that she felt encouraged about being able to get a new job since her friend says that she can get her a job at a convenience store where she works. Ms. Hobgood said that she can live off unemployment until then. When asked about friendships and community activities, Ms. Hobgood said that she didn't have time for doing much outside the home. She stated that she has several friends she met at work and when she went out.

By the end of the interview, Ms. Hobgood had become calm and much less defensive. She answered all the worker's questions although she made it clear that she did not want to be involved with DSS. Ms. Hobgood stated "me and Burt have our moments" but overall, they get along pretty well. She did admit she had not made the best choice by leaving Burt home alone and stated that if she had a place to leave Burt for a while, she probably would not have left him by himself. She also answered questions about Burt's father; she explained that she had not seen him in over a year and that it had been even longer since he had paid child support. She shared with the worker that Mr. Hobgood's parents were probably the last ones to have had contact with him. The worker explained what a "collateral" was and Ms. Hobgood provided the contact information for Ms. Grant, the neighbor, as well as Mr. Hobgood's parents. She also suggested Burt's teacher since the teacher knows Burt very well.

The worker thanked Ms. Hobgood for explaining her situation to her and told her she would like to place the information they had just discussed, including Ms. Hobgood's plans for Burt's supervision, on a paper called a Safety Assessment, which is completed during this type of interview with a parent. Together the worker and Ms. Hobgood completed the Safety Assessment and the Temporary Parental Safety Agreement and Ms. Hobgood signed at the bottom. The worker explained the steps Ms. Hobgood would take if she "changed her mind" (revoked) and was no longer in agreement with the steps outlined on the Temporary Parental Safety Agreement. Before leaving the apartment, the worker provided Ms. Hobgood with a copy of the Safety Assessment and the agency's brochure explaining the family assessment approach. The worker invited Ms. Hobgood to call her at the number located on the Safety Assessment with any questions or concerns.

Agenda

Day 4

9:00-9:10……	I. Welcome and Overview
9:10-9:40……	II. Evaluating and Documenting Risk
9:40-10:15……	A. Ongoing Functional Assessment B. Risk Assessment
10:15-10:30……	BREAK
10:30-11:00……	III. Protective Factors IV. Father Involvement
11:00-11:30……	V. Assessment of Strengths and Needs
11:30-12:00……	
12:00-1:15……	VI. Making the Case Decision
	LUNCH
1:15-1:30……	VII. Explaining Decisions to families
1:30-2:40……	VIII. Child Sexual abuse A. Into the Light (video) B. Legal definitions C. Spectrum of Behaviors
2:40-2:55……	BREAK
2:55-3:15……	IX. Human Trafficking
3:15-3:25……	X. The Cycle of Trauma
3:25-3:45……	
3:45-4:00……	XI. Trauma and the Child Welfare Worker
	XII. Wrap-up

CPS Family Assessment
HOBGOOD FAMILY

During the family assessment, the following information was gathered.

Collateral Contacts

Mrs. Grant

When the family assessor and Ms. Hobgood were completing the safety assessment during the initial contact, Mrs. Grant was identified by Ms. Hobgood as a social support resource and a collateral. The worker and Ms. Hobgood discussed with Ms. Grant what it would mean to be a social support resource for Burt. During the discussion, Mrs. Grant stated that she was fond of Burt and that he dropped by from time to time for cookies. She said that she has never noticed marks or bruises on him before today. She told the worker and Ms. Hobgood that she would be willing to 'keep an eye on Burt' if the mother wanted her to because she was retired and at home most all the time. She would even provide care for Burt for short periods of time while his mom went shopping or whatever. She hated to see that Burt might have to leave home or be home alone while his mother went out to do errands. (During this discussion there was no reference to Mrs. Grant being the reporter.)

Paternal Grandparents

Another collateral contact identified by Ms. Hobgood were her in-laws. The worker offered Ms. Hobgood the option of being present when she talks with the in-laws. She told the worker she did not want to be present when she talked to them because she already knew what they would say about her. Ms. Hobgood provided the worker with the phone number for the in-laws.

The worker located the Hobgood's in Waynesville and spoke to them by phone. Mrs. Patricia Hobgood said that the younger two children have been with them for the last two years. After some pauses, Mrs. Hobgood said that Burt scares her and that they do not feel that they can care for him. Their home is small and because their son doesn't work regularly because of his back, he pays them no child support. In fact, they have legal custody of the two younger children, who are doing well in school and day care. Sandy visits them now and then.

Patricia Hobgood said, "Both Sandy and their son John have had some trouble with drinking". Sandy will do well for some periods of time and then go off and drink and disappear. Ms. Hobgood said she knows that Sandy was sometimes harsh with Burt, but she thought maybe she needed to do that to keep him in line. When he is there, he refuses to go to church with them and throws sticks and stones at the cows, sometimes hitting them hard. They are very sorry, but no, they cannot take Burt there. There is no room, they haven't enough money, and Burt will most likely teach the younger ones some of "his habits". They do not know where their son is now. They heard he might be in Greensboro.

Maternal Grandmother

Irene Curtis

Ms. Hobgood also identified her mother, Irene Curtis as a collateral when the worker asked about other family members who could be contacted. Ms. Hobgood stated she did not want to meet with her mother, but that she did want to hear the questions the worker asked her. The worker arranged to contact Mrs. Curtis by phone when Ms. Hobgood could bepresent.

When the child welfare worker reached Ms. Curtis by telephone, Ms. Curtis was distressed to hear that Burt had been left alone and had bruises and marks. She stated that Burt often acted out and that his mother had a hard time controlling him at times. Ms. Curtis stated that she knew her daughter drank but she did not think that it was a problem for her. She stated that Burt sometimes came over on Saturdays to visit but she could not handle him either when he got into one of those "moods." When asked how Burt would behave when he was in a 'mood', Ms. Curtis explained that he would not do as he was told, talked back to her, and threw things at the wall. Sometimes he would break things in her house when he was mad and then say that he didn't do it. When Ms. Curtis would try to discipline him, he would yell at her and say that he wasn't going to listen to her. Mrs. Curtis stated that she had many physical ailments and did not see how she could be of help to her daughter. She would continue to allow Burt to visit every now and again on Saturdays if he would behave.

Interview with Schoolteacher

Ms. Hobgood agreed that Burt's schoolteacher would also be a possible reference since she knows Burt very well. The worker and Ms. Hobgood arranged for a meeting with the schoolteacher at the community center since school was out for the summer. Burt's teacher had heard that Social Services was now including family members in these collateral contacts and she told the worker she could understand why it would be important for her to explain to Burt's mother her concerns about Burt's behavior at school. The visit with the school teacher presented a different picture of Burt. In school, he scowls a lot, and sometimes growls at the smaller children. He has broken some of the test tubes in the small chemistry lab and let the hamster out of its cage several times, laughing when everyone tried to capture it. He said he could "wring its neck pretty quick."

There was a fire in the classroom once, in the trashcan, that was quickly extinguished, but she has always thought that Burt had something to do with it. She doesn't remember his grades, but always felt he could do better than he does. She believes he is smart, but very angry right below the surface. She states that some of children in the class were afraid of him because he was always threatening to 'hurt someone.' She has brought him some clothes from her own son a few times. She sometimes sees the family, but often not.

Contact with Mr. Hobgood

Ms. Hobgood told the child welfare worker she did not know how to reach Burt's father and that his parents probably have had the last contact with him. The child welfare worker tried to contact Burt's dad by letter, as he did not have a phone according to Mr. Hobgood's parents. His parents stated that they last heard from him over a year ago. They think he left the state. The Hobgood's promised to tell the worker immediately if he tried to contact with them again. They stated that the last time they saw him "he was drunk and probably doped up.". The Hobgood's do not believe that Burt's father would be willing or capable of caring for Burt.

In addition to sending the letter to the last known address for Mr. Hobgood, the worker also drove to that address for Mr. Hobgood, but the apartment was vacant. The apartment manager was unable to provide any forwarding address information for Mr. Hobgood. Telephone Directory Assistance, Social Media and Google searches revealed no new phone numbers for Mr. Hobgood. Neither the worker nor the paternal grandparents have been able to locate Mr. Hobgood during the time of the family assessment.

CORE MEANINGS OF THE STRENGTHENING FAMILIES PROTECTIVE FACTORS

Protective Factor	Core Meaning
Parental Resilience	Resilience Related to General Life Stress a. managing the stressors of daily life and functioning well even when faced with challenges, adversity and trauma b. calling forth the inner strength to proactively meet personal challenges, manage adversities and heal the effects of one's own traumas c. becoming more self-confident and self-efficacious d. having faith; feeling hopeful e. believing that one can make and achieve goals f. solving general life problems g. having a positive attitude about life in general h. managing anger, anxiety, sadness, feelings of loneliness and other negative feelings i. seeking help for self when needed Resilience Related to General Parenting Stress a. calling forth the inner strength to proactively meet challenges related to one's child b. not allowing stressors to keep one from providing nurturing attention to one's child c. solving parenting problems d. having a positive attitude about one's parenting role and responsibilities e. seeking help for child when needed
Social Connections	a. Building trusting relationships; feeling respected and appreciated b. Having friends, family members, neighbors and others who: • provide emotional support (e.g., affirming parenting skills) • provide instrumental support/concrete assistance (e.g., providing transportation) • provide informational support/serve as a resource for parenting information • provide spiritual support (e.g., providing hope and encouragement) • provide an opportunity to engage with others in a positive manner • help solve problems • help buffer parents from stressors • reduce feelings of isolation • promote meaningful interactions in a context of mutual trust and respect c. Having a sense of connectedness that enables parents to feel secure, confident and empowered to "give back" to others

CORE MEANINGS OF THE STRENGTHENING FAMILIES PROTECTIVE FACTORS

Protective Factor	Core Meaning
Knowledge of Parenting and Child Development	Seeking, acquiring and using accurate and age/stage-related information about: a. parental behaviors that lead to early secure attachments b. the importance of • being attuned and emotionally available to one's child • being nurturing, responsive and reliable • regular, predictable and consistent routines • interactive language experiences • providing a physically and emotionally safe environment for one's child • providing opportunities for one's child to explore and to learn by doing c. appropriate developmental expectations d. positive discipline techniques e. recognizing and attending to the special needs of a child
Concrete Support in Times of Need	a. being resourceful b. being able to identify, find and 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 c. understanding one's rights in accessing eligible services d. gaining knowledge of relevant services e. navigating through service systems f. seeking help when needed g. having financial security to cover basic needs and unexpected costs
Children's Social and Emotional Competence	<u>Regarding the parent:</u> a. having a positive parental mood b. having positive perceptions of and responsiveness to one's child c. responding warmly and consistently to a child's needs d. being satisfied in one's parental role e. fostering a strong and secure parent-child relationship f. creating an environment in which children feel safe to express their emotions g. being emotionally responsive to children and modeling empathy h. talking with the child to promote vocabulary development and language learning i. setting clear expectations and limits j. separating emotions from actions k. encouraging and reinforcing social skills such as greeting others and taking turns l. creating opportunities for children to solve problems <u>Regarding the child:</u> a. developing and engaging in self-regulating behaviors b. interacting positively with others c. using words and language skills d. communicating emotions effectively

USING PROTECTIVE FACTORS TO HELP IDENTIFY RELEVANT STRENGTHS

Parental Resilience

- Caregiver exhibits self-awareness around issues that lead to stress, anger, depression or other emotional states that might impair his/her caregiving abilities
- Caregiver has self-awareness around aspects of the relationship/interactions with the child that he/she finds challenging
- Caregiver has effective self-care strategies already in place for when life feels overwhelmingor stressful
- Caregiver is able to clearly articulate things he/she enjoys most about each child and about caregiving
- Caregiver is willing to engage in structured activities that enhance feelings of connection with the child
- Caregiver utilizes proactive self-care strategies to address triggering situations

Social Connections

- Caregiver has a friend or family member who he/she trusts as a confidante or ally and who is willing to play a specific role in supporting the caregiver
- Caregiver has a trusted friend or family member who can take an active supporting role and is willing to play a specific role in maintaining the child's safety
- Caregiver is active in community organizations or social groups that:
  Provide alternatives to behavior(s) that may be contributing to child welfare issues
  Connect families to community supports that help address the issue(s) that originally brought the family into contact with the child welfare system

Knowledge of Parenting and Child Development

- Caregiver has a trustworthy source for parenting information that he/she is comfortable turning to when parenting feels overwhelming
- Caregiver has interest and curiosity around learning more about parenting and about his/her child as an individual
- Caregiver is interested in and willing to try out new parenting strategies

Concrete Support in Times of Need

- Caregiver knows how to access services or supports
- Caregiver is connected to friends or other individuals who can support his/her servicenavigation
- Caregiver is comfortable advocating for him/herself and the child
- Caregiver is able to articulate concrete needs

Social and Emotional Competence of Children

- Caregiver provides warm and consistent responses to the child
- Caregiver engages in activities with the child that support social emotional development
- Child exhibits age-appropriate ability to express emotions
- Child has a strong bond with thecaregiver
- Child has a strong bond with anotheradult
- Child has a strong bond with siblings or other children

Case Decisions

Case Decision Findings of an Investigative Assessment will be either:
Substantiated or Unsubstantiated.

Making a Determination

Determining whether a child is abused, neglected, or dependent requires careful assessment of all the information obtained during the Investigative Assessment process. In making a case decision it is important to assess not only that maltreatment has occurred, but what are the current safety issues, and is there future risk of harm and the need for protection. The following questions should provide the structure for making a case decision:

• Has the maltreatment occurred with frequency and/or is the maltreatment severe?

(This question applies to the history of the family, any and all maltreatment within the family should be considered when answering this question.)

• Are there current safety issues that indicate the child(ren) is likely to be in immediate danger of serious harm?

(**Note**: **If the child(ren) is separated from his/her parent or access is restricted and that separation/restriction continues to be necessary due to safety issues, then this question must be answered Yes.**

(This question applies to the situation at the time of the case decision.)

• Are there significant assessed risk factors that are likely to result in serious harm to the child(ren) in the foreseeable future?

(This question applies to the current assessed risk factors and how the family is or is not addressing them to result in long term positive behavioral changes.)

• Is the child in need of CPS In-Home or Out-of-Home Services (answer "yes" if the caretaker's protective capacity is insufficient to provide adequate protection and "no" if the family's protective capacity is sufficient to provide adequate protection)?

(This question applies to the situation at the time of the case decision. Services already begun, and safety measures taken during the assessment should be considered when answering this question.)

Making a Decision to Substantiate

To make a case decision to substantiate, the answer to one or more of the above questions must be yes, and there must be documentation to support the answers included on the case decision tool. Only in unusual circumstances should a supervisor and staffing team change the indicated structured case decision. In those cases, the supervisor should complete the "Rationale for Case Decision/Disposition" to justify the change.

Special Considerations

Note: In determining severity of maltreatment, consideration should be given to the degree of harm, level of severity, extent of injury, egregiousness, gravity and the seriousness of maltreatment.

In determining current safety, consider safety issues that exist at the time of making the case decision. If the decision of the Safety Assessment is Safe, and the findings of the Risk Assessment and the Family Assessment of Strengths and Needs are both Low, then the case would not be substantiated unless there are unusual circumstances.

Note: In cases where poverty is the sole factor of the maltreatment and services were offered and accepted by the parent/caretaker, the case decision should be unsubstantiated, unless there are unusual circumstances. In cases when poverty is the sole factor of the maltreatment, and there is an ongoing history/pattern of services being offered and declined and the pattern of maltreatment continues, it would be appropriate to substantiate if the answers to the above four questions are "yes," unless there are unusual circumstances.

Determining whether a child is abused, neglected, or dependent requires careful assessment of all information obtained during the Investigative Assessment process and the use of professional judgment. The agency Investigative Assessment process must focus on fact-finding. While initially the focus is on the allegations contained in the report, additional concerns related to the child or other children may be known to the agency or revealed during the assessment. The case decision must, therefore, reflect assessment of all evidence and facts available.

If the case decision is to unsubstantiate, a determination should be made as to what agency services or outside resources if any, would be helpful. These services can be offered, and referrals suggested, but the family may refuse.

Note: Cases Involving Domestic Violence
NC Child Welfare Policy CPS Assessments: Family & Investigative Assessments: Decision Making and Case Closure https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/assessments.pdf

When a case decision is made to substantiate due to domestic violence, it is not appropriate to substantiate on the abused parent (adult victim) in the home unless they have subjected their child to abuse or neglect. Understanding the dynamics of domestic violence is very complicated and brings in a different dimension. Is the abused parent (adult victim) unable to attend to the needs of the children due to fear or retaliation upon themselves and/or the children should they make efforts to provide for those needs? Has the violent partner disabled their ability to parent? Making a finding to substantiate against the abused parent (adult victim) for neglect-failure to protect should be made only if the abused parent (adult victim) subjected their child to abuse or neglect.

Case Decision Findings of the CPS Family Assessment Response

A finding of "services needed" shall be made if the answer to one or more of the questions on the Ongoing Needs and Safety Requirements concerning frequency and severity of maltreatment, current safety issues, risk of future harm, and child in need of CPS In-Home or Out-of-Home Services is "yes". There must be documentation to support the answers included on the case decision tool.

Only in unusual circumstances should a supervisor and staffing team change the indicated structured case decision. In those cases, the supervisor should complete the "Rationale for Case Decision/Disposition" to justify the change.

In determining severity of maltreatment, consideration should be given to the degree of harm, level of severity, extent of injury, egregiousness, gravity and the seriousness of maltreatment. In determining current safety, consider safety issues that exist at the time of making the case decision. If the decision of the Safety Assessment is "Safe", and the findings of the Risk Assessment and the Family Assessment of Strengths and Needs are both "Low", then the case would not be found "services needed," unless there are unusual circumstances. In those cases, the supervisor should complete the "Rationale for Case Decision/Disposition" to justify the change.

If the answers to the questions on the Case Decision Summary are "no", then the finding will be either "services provided, protective services no longer needed", "services recommended" or "services not recommended."

Findings for Family Assessments

The possible findings in Family Assessment are as follows:

Services Needed- This finding is appropriate for all CPS reports of neglect and dependency assigned to the Family Assessment response, where the safety issues and future risk of harm is so great that the agency must provide involuntary services to ensure the safety of the child. This finding must be made in every case the DSS believes the family must be involved with services (of any type, provided by any agency or individual) in order for the child to safely remain in the home.

The DSS should ask itself the question "would the child be safe if the family ever becomes non-compliant with services"? If the answer to that question is "no", a "services needed" finding must be made, and the DSS must continue to provide involuntary CPS in-home services. These are situations in which the safety and risk of harm is so great that you cannot walk away from this family without either providing services yourself or monitoring those provided by another agency or provider. Any case in which there is a finding of "Services Needed" must meet the criteria for opening 215, In-Home Services, which includes that "without effective preventive services, the child is at risk of being

placed in foster care." This finding will be reported to the Central Registry with no perpetrator information entered.

There may be instances during a Family Assessment that require the agency to file a petition with the Court in order to protect the child. The agency is not required to switch to an Investigative Assessment in these cases. A finding of "services needed" would be appropriate to document the safety and risk issues, and how they prevent the child from remaining safely in the home.

Services Recommended- This finding is appropriate for all CPS reports of neglect and dependency assigned to the Family Assessment response, where the safety of a child is not an issue and future risk of harm is not an issue. These are cases that the agency could "walk away from" if the family should choose not to agree, continue to participate in, or otherwise fail to comply with any one or all of the recommendations made by the agency. **This finding is not appropriate for cases in which the agency feels it needs to monitor compliance with the service recommendation due to safety or future risk of harm.**

Some situations in which this finding would be appropriate include, but are not limited to the following:

- When well-being (not safety related) needs were identified during the assessment and the family was engaged in services (either within the agency or in the community), **but at no time during the assessment did the potential risk of child maltreatment approach the level that involuntary services would be required.**

- When at the culmination of the assessment, the risk level is low and there are no identified safety issues, however some well-being issues have been identified, the child welfare worker should recommend and offer to assist to link the family to services that ameliorate the well-being issues. These services would be voluntary in nature.

Some situations where this finding would **not** be appropriate include, but are not limited to the following:

- If the agency makes recommendations that, if not completed, would lead to the agency accepting a new report, or would lead the agency to believe that the safety of the child would be compromised then the finding should be **Services Needed.**

- ❖ If at some point during the assessment the risk level would have been moderate or higher and the family may have been appropriate for In-Home Services, but services provided during the assessment brought the risk to a lower level, allowing the case to be closed. In this case the most appropriate finding would be **Services Provided, Protective Services no longer Needed.**

Note:
All services recommended, referred or provided during the assessment should be documented along with the response of the family. Any recommendations made to the family should be explained thoroughly in a face to face contact, and the family should be given the option to accept or reject service recommendations. This face to face explanation may take place during the assessment. However, in the rare instance that service recommendations are made at the time of case decision and have not been previously explained to the family, a visit within 7 days of the case decision must occur to thoroughly explain the new recommended service. The family still has the option to accept this new service. It is also recommended that the referral information be included in the written notification to the family

The agency would document this finding for any service referral deemed appropriate to meet the family's non-safety connected need. This finding is also used when the agency makes referrals to community partners and does not maintain an open service case with DSS.

This finding will be reported to the Central Registry with no perpetrator information entered.

Services Provided, Protective Services No Longer Needed – This finding is appropriate for all CPS reports of neglect and dependency assigned to the Family Assessment response, in which the safety of a child and future risk of harm were at some point in the assessment high enough to require involuntary services; and the successful provision of services during the assessment has mitigated the risk to a level in which involuntary services are no longer necessary to ensure the child's safety. For instance, if the initial assessment indicates a risk level of moderate or higher, and the family receives services which lead to a reduction in the risk level at the close of the assessment, such that involuntary services are no longer needed, the finding would be **Services Provided, Protective Services No Longer Needed**. If the risk level was never moderate or higher and non-safety related referrals are made the most appropriate finding would be **Services Recommended**.

Services Not Recommended - This finding is appropriate for all CPS reports of neglect (with the exception of abandonment and the special types of reports) and dependency assigned to the Family Assessment response, in which not only is the safety of a child not an issue and there is no concern for the future risk of harm to the child; but also, the family has no need for other non-safety related services

All services that are provided or referred for the family, as the result of the CPS assessment are required to be documented on the DSS-5104 in field #4. This documents service needs that began and continued for the child between the date of the report and up to 90 days after the case decision.

If a case is open for In-Home Services following substantiation or a finding of Services Needed, and a new report is accepted and assigned as a **Family Assessment**, the report should be assessed independently of the original report. If the most recent assessment identifies new risk and safety issues that would require In-Home Services, the finding should be **Services Needed.**

If at the end of the assessment the only needs that are identified are those that were found in the original report and are the result of the same incident, then the finding should be **Services Not Recommended**. There should be documentation in the record stating that the risk identified during the original CPS assessment continues, however no **new** risk or safety issues were identified, and the services being provided to reduce the original risk level will continue through the provision of In-Home Services.

Throughout the assessment there should be communication with the family explaining that the new assessment is not meant to re-assess the original report and that the services being provided to alleviate the previously identified risk level will continue apart from the new assessment.

If a new report is accepted which alleges a new incident that is similar, but distinct to that alleged in the first report, then a thorough assessment should be completed independently of the original report. If the information gathered during this assessment would lead to a risk rating of moderate or higher due to issues that are not a result of the circumstances of the original report, then a finding of **Services Needed** should be made.

Source: NC Child Welfare Policy: CPS Assessments: Family and Investigative Assessments

What Happens After the Case Decision?

The Necessary Steps

Type of Case Decision	Action Step	Time Frame for completion of the step	Manual Reference for more information
All case decisions	Complete the DSS 5104: (**Report to Central Registry**)	Within 10 days after the case decision	CPS Assessments: Notifications pg. 45
Case decisions of "Substantiation" or "Services Needed"	Have a face to face meeting with the family to discuss the case decision	Within 7 calendar days after the case decision	CPS Assessments: Required Timeframes pg. 10
All case decisions	Provide written notice to the reporter of the agency's findings/actions being taken/and review process	Within 5 working days of the case decision	CPS Assessments: Notifications pg. 45
Case decisions of substantiation of Abuse or "Serious neglect"	Have a face to face meeting with the family to discuss investigative assessment case decision and explain the RIL and Judicial Review process	Within 5 working days of the investigative assessment case decision	CPS Assessments: pg. 71
Case decisions of substantiation of abuse or "Serious neglect"	Provide "written notice" of the case decision during the face to face discussion of the case decision (notice must meet specific criteria)	In an expeditious manner following the investigative assessment case decision	Child Welfare Service Administrative letter: CWS- AL 01-2019 The letter is dated November 25, 2019, effective December 1, 2019.
Case decisions of substantiation of abuse or "Serious Neglect"	Complete the DSS 5104-a (**Responsible Individuals List Form**)	15 days after case decision, unless a juvenile petition or Judicial Review has been filed	CPS Assessments: MRS Requirements pg. 70 *NC DSS CPS Data Collection (Non-NC FAST) Appendix 1*
Case decisions of "Services Needed" Or "Substantiated" (In Home Services)	Continue the discussion of the purpose and membership of a CFT	During the 7-day face to face meeting that explains the case decision	In Home Services: Required Timeframes pg. 5
Case decisions of "Services Needed" Or "substantiated"	Develop Family Services Agreement (Schedule a CFT)	Within 30 days after the case decision	In Home Services: Required Timeframes pg. 5
Case decisions of "Services Needed	Have a face to face meeting with the family to inform them of the family assessment case decision	Within 7 working days of the case decision	In Home Services: Required Timeframes pg. 5

Central Registry

Quick Reference Sheet

What is the Central Registry?

North Carolina G.S. § 7B-311 requires the Department of Health and Human Services (DHHS) to maintain a Central Registry of child abuse and neglect cases. DHHS shall also maintain in the Central Registry dependency cases and child fatalities that are the result of alleged maltreatment. This statute makes it mandatory for the Director of the county child welfare agency to report to the Central Registry all cases of child abuse, neglect, and dependency accepted for CPS assessment.

Child Welfare Worker's /Agency's Responsibility?

***During the CPS Assessment*:**

After a two-party review and an agency decision to accept a report for a CPS Assessment, county child welfare agencies are required to conduct a search of the Central Registry. (It is not acceptable to conduct the Central Registry check during the screening process and prior to the decision to accept the report for a CPS Assessment.) Intake: Collection of Information and Assessing Agency History

After a Case Decision is Made:

Once a case decision is made the statute requires the agency to report the case findings to the central registry. County child welfare agencies make the required reports to the Central Registry by use of the Report to the Central Registry/CPS Application, Form DSS-5104. The DSS-5104 is used as the application for protective services. It documents the receipt of a report of abuse, neglect, or dependency. Data is to be entered within ten (10) working days after a case decision is made as to whether abuse, neglect, or dependency is found. In all Family Assessment case regardless of case decision no perpetrator is named in the Central Registry. In Investigative Assessments when the case decision is substantiated a perpetrator is named in Central Registry. Each child must have a copy of a completed DSS-5104 paper form in their case record. Although there may be multiple DSS-5104 paper forms for one assessment, there is only one form number per assessment.

How is the Central Registry Information Used?

The county director in order to identify: a. Whether a child who is the subject of a current CPS Assessment has been previously reported as abused, neglected or dependent; b. Whether a child is a member of a family in which a child fatality has occurred previously and there is suspicion that the death was due to abuse, neglect or dependency; c. Whether an adult suspected of current abuse, neglect or dependency has had previous substantiations for abuse, neglect or dependency; and/or d. Whether an adult is appropriate to be a temporary safety provider during a current CPS Assessment. The central registry may only be accessed for temporary safety provider placements during a current (open) CPS Assessment. Once a case decision has been made, further assessments of kin for kinship placements must request information from the RIL or internal agency records, not the central registry.

Source: **NCDSS CPS Data Collection (Non NCFAST) Appendix 1**
https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/modified-manual-1/appendix-1-cps-data-collection.pdf

Responsible Individuals List (RIL)

Quick Reference Sheet

What is the RIL?

The Responsible Individuals List (RIL) is used to identify parents, guardians, caretakers, or custodians that have been named as responsible individuals in all substantiated cases of abuse and /or serious neglect. Only case decisions made as a result of an Investigative Assessment can result in RIL placement.

The responsible individual's name shall be placed on the RIL, only after one of the following has occurred:

- The responsible individual is properly notified of their right to request a Judicial Review and fails to file a petition (AOC-J-131) for a Judicial Review in a timely manner: (within 15 days of the receipt of the case decision/possible RIL placement)
- The court determines that the individual is a responsible individual as a result of a hearing on the individual's petition for judicial review; or
- The individual is criminally convicted as a result of the same incident involved in the Investigative Assessment (The DA shall inform the director of the result of a criminal proceeding)

Child Welfare Worker's/Agency's Responsibility?

The child welfare worker shall make face-to-face contact with the alleged responsible individual **in an expeditious manner** of the case decision of abuse and/or serious neglect, to explain the reason for the decision, to provide written notice of the decision (including the steps to request a judicial review) and to explain the potential for the individual's name to be placed on the RIL. (It is permissible for a child welfare worker other than the child welfare worker that conducted the assessment to deliver the case decision notice.)

If it is not possible to make face-to-face contact with the alleged responsible individual to deliver the written notice in **an expeditious manner** the child welfare worker shall make diligent and persistent efforts to make contact. If the worker is unsuccessful in contacting the alleged responsible individual, the notice shall be sent by registered or certified mail, return receipt requested and addressed to the individual at the individual's last known address.

How is the RIL Information Used?

Information from the RIL is only available to authorized persons for the sole purpose of determining the fitness of individuals to care for or adopt children. RIL checks are mandated for foster parent and adoptive parent applicants, temporary safety providers, and kinship care providers. The RIL may not be used as part of the employment process unless the employee will have responsibility for caring for children (either on a temporary or permanent basis).

Source: **NC DSS CPS Data Collection (Non NCFAST)**
https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/modified-manual-1/appendix-1-cps-data-collection.pdf

Into the Light: A Documentary about Child Sexual Abuse

Video Processing Questions

1. What do the statistics say about who experiences sexual abuse?

2. What feelings do the sexual abuse survivors describe?

3. What explanations do the survivors provide for why they didn't tell anyone about the abuse?

4. What impact did the sexual abuse have on the lives of the survivors?

Child Sexual Abuse

Defining Sexual Abuse Without the Legal Terms:

- a sexual act imposed on a child who lacks the emotional, maturational, and cognitive development necessary for adult sexual interaction
- the ability to lure a child into a sexual relationship is based upon the all-powerful and dominant position of the adult which is in sharp contrast to the child's age, dependency, and subordinate position
- Authority and power enable the perpetrator implicitly or directly to coerce the child into sexual compliance

What to Do if You Suspect a Child Has Been Sexually Abused:

- Remain calm
- Conceal any emotions you may have (shock, anger, etc)
- Listen more than you talk (show interest and concern)
- Avoid making assumptions
- Allow the child to set the pace
- Make no promises (but do tell them what you are going to do next)
- Limit your questions

Limit Your Questions to the Following:

- What happened?
- When did it happen?
- Where did it happen?
- Who did it?
- How do you know this person? (if relationship with alleged abuser is unclear)

As Soon As Possible, Consult Your Supervisor for Guidance On Next Steps

Adapted from: www.childhelp.org/SpeakUpBeSafe

Child Sexual Abuse
Possible Signs and Indicators

- Sexual behavior or knowledge that's inappropriate for the child's age
- Pregnancy or a sexually transmitted infection particularly if under age 14
- Blood in the child's underwear
- Statements that he or she was sexually abused
- Abuse of other children sexually
- Changes in eating, sleeping, hygiene
- Has difficulty walking or sitting
- Suddenly refuses to change for gym or to participate in physical activities
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Attaches very quickly to strangers or new adults in their environment
- Frequent yeast or urinary infections.
- Pain and irritation of the genitals.
- Runs away

Child Sexual Abuse
Possible Caregiver Indicators

- Unduly protective of the child or severely limits the child's contact with other children, especially of the opposite sex
- Has unrealistic expectations of child development or behavior forage
- Is secretive and isolated
- Has rigid, severe discipline, strict rules
- Is jealous or controlling with family members
- Insists on time alone with a child with no interruptions
- Refuses to allow a child sufficient privacy or to make their own decisions on personal matters.
- Insists on physical affection such as kissing, hugging or wrestling even when the child clearly does not want it.
- Is overly interested in the sexual development of a child or teenager.
- Frequently walks in on children/teenagers in the bathroom.
- Treats a particular child as a favorite, making them feel 'special' compared with others in the family.
- Picks on a particular child.
- Shows lack of emotional involvement with the child, especially when assistance is being sought for the child.
- Shows hesitation to seek medical help and/or unconvincing explanation of a child's injuries.

Child Sexual Abuse
Possible Family Characteristics

- marked role reversal between mother and daughter.
- extreme paternal dominance.
- severe overreaction to child receiving any kind of sex education.
- social isolation from the rest of community and attempt to isolate children.

Warning Signs and Indicators of Sex Trafficking

- Unexplained absences from school
- Reluctant to explain signs of physical abuse such as burn marks, bruises or cuts
- Less appropriately dressed than before
- Sexualized behavior
- Overly tired in class
- Withdrawn, depressed, distracted or checked out
- Brags about making or having lots of money
- Displays expensive clothes, accessories or shoes
- New tattoo (tattoos are often used by pimps as a way to brand victims. Tattoos of a name, symbol of money or barcode could indicate trafficking)
- Older boyfriend or new friends with a different lifestyle
- Talks about wild parties or invites other students to attend parties
- Shows signs of gang affiliation? (i.e. a preference for specific colors, notebook doodles of gang symbols, etc.)

Source: Shared Hope International: www.sharedhope.org

Other Warning Signs for Child Sex Trafficking

- Chronic runaway/homeless youth.
- Excess amount of cash in their possession (reluctant to explain its source).
- Hotel keys and key cards.
- Lying about age/false ID.
- Inconsistencies when describing and recounting events.
- Unable or unwilling to give local address or information about parent(s)/guardian.
- Presence or fear of another person (often an older male or boyfriend who seems controlling).
- High number of reported sexual partners at a young age.
- Sexually explicit profiles on social networking sites.
- Inability or fear of social interaction.
- Demeanor exhibiting fear, anxiety, depression, submissiveness, nervousness.
- Is not enrolled in school or repeated absence from school.
- Does not consider self a victim.
- Loyalty to positive feelings toward pimp/trafficker. May try to protect pimp/trafficker from authorities.
- Prepaid cell phone.

Thorn: Digital Defenders of Children https://www.wearethorn.org/

Common Indicators of Human Trafficking

- Does the person appear disconnected from family, friends, community organizations, or houses of worship?
- Has a child stopped attending school?
- Has the person had a sudden or dramatic change in behavior?
- Is a juvenile engaged in commercial sex acts?
- Is the person disoriented or confused, or showing signs of mental or physical abuse?
- Does the person have bruises in various stages of healing?
- Is the person fearful, timid, or submissive?
- Does the person show signs of having been denied food, water, sleep, or medical care?
- Is the person often in the company of someone to whom he or she defers? Or someone who seems to be in control of the situation, e.g., where they go or who they talk to?
- Does the person appear to be coached on what to say?
- Is the person living in unsuitable conditions?
- Does the person lack personal possessions and appear not to have a stable living situation?
- Does the person have freedom of movement? Can the person freely leave where they live? Are there unreasonable security measures?

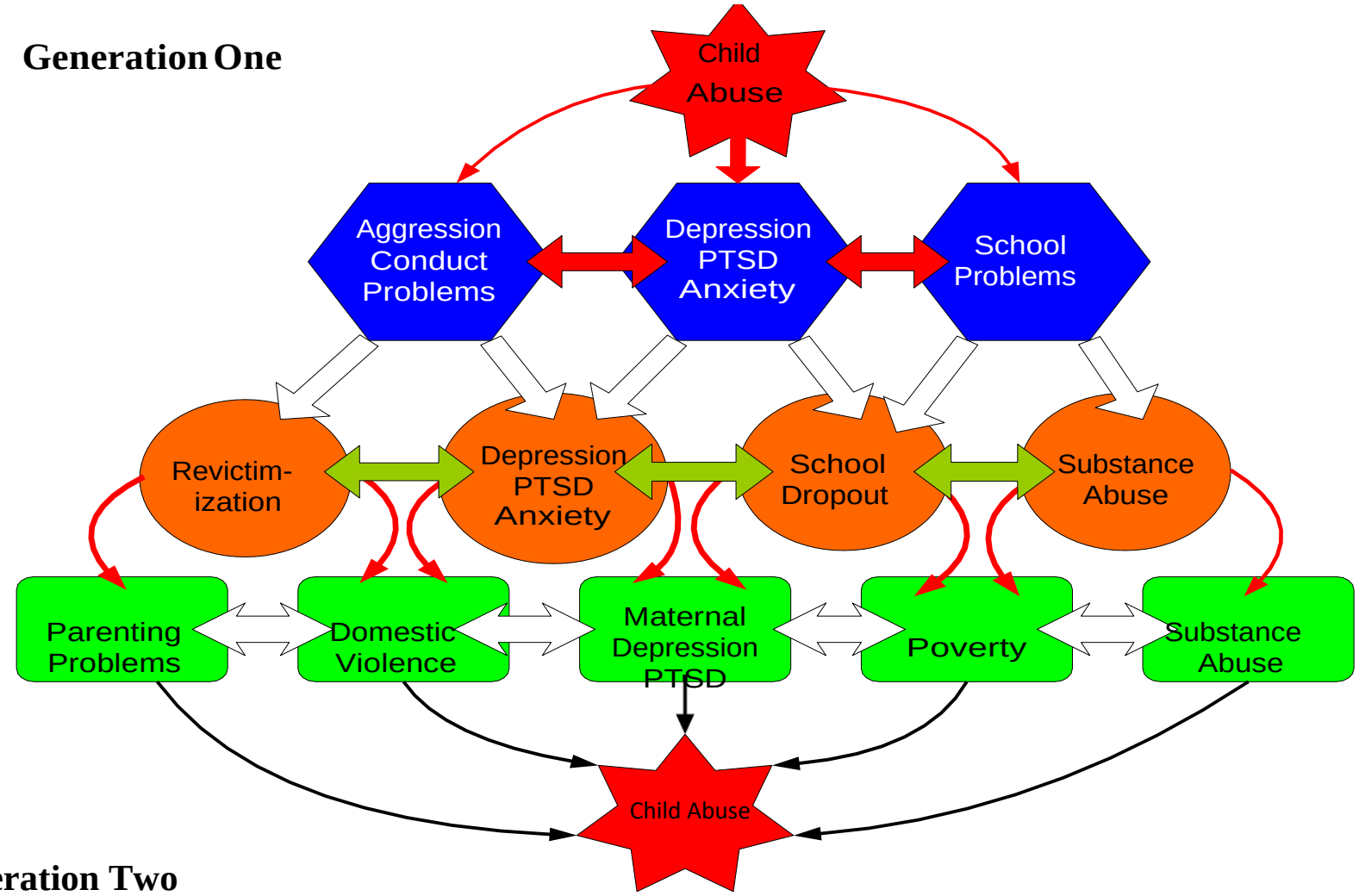
Not all indicators listed above are present in every human trafficking situation, and the presence or absence of any of the indicators is not necessarily proof of human trafficking.

Websites for Further Reading About Human Trafficking

Project NO REST https://www.projectnorest.org/

Department of Home Land Security
http://www.dhs.gov/bluecampaign/indicators-human-trafficking

Model for Intergenerational Transmission of Child Maltreatment



NCTSN The National Child Traumatic Stress Network

Birth Parents with Trauma Histories and the Child Welfare System

A Guide for Child Welfare Staff

KAREN'S STORY

Karen has two children, Jonathan, age 3 and Crystal, age 6. Karen was reported to child welfare authorities by Crystal's teacher, who was concerned about Crystal's excessive absences from school. The investigation revealed that Karen's boyfriend physically abused her and her children, and evidence emerged that she had physically abused them as well. There were several attempts to engage her in services, but because of her lack of follow-through and the ongoing safety concerns, her children were removed from her home and have been in foster care for six months.

Linda, Karen's caseworker, has referred Karen to parenting classes, domestic violence services, and for a mental health evaluation. Karen has not followed through on the referrals, is often not home when Linda has a scheduled visit, and when the foster parent last brought the children for visitation, Karen was alternately angry and defensive towards Linda and the foster parent and disengaged from her children. Linda is concerned because of the amount of time Crystal and Jonathan have been in foster care. A decision will be made shortly about their permanency plan, and Linda believes that she hasn't been able to engage Karen in either addressing her family's issues or identifying her strengths, much less come up with a plan that builds on them. Linda's supervisor asked Karen why she has made no progress and noted that the last visit between Karen and her children got "out of control," but did not offer any concrete suggestions to Linda as to how she could have handled it differently. When Linda tries to talk with Karen about the urgency of the situation, Karen minimizes her concerns and appears increasingly angry towards Linda and thesystem.

Just as many children in the child welfare system have experienced different kinds of trauma[1], many birth parents involved with child welfare services have their own histories of childhood and/or adult trauma. Untreated traumatic stress has serious consequences for children, adults, and families. Traumatic events in childhood and adolescence can continue to impact adult life, affecting an adult's ability to regulate emotions, maintain physical and mental health, engage in relationships, parent effectively, and maintain family stability. Parents' past or present experiences of trauma can affect their ability to keep their children safe, to work effectively with child welfare staff, and to respond to the requirements of the child welfare system. Providing trauma-informed services can help child welfare

[1] *In this fact sheet, trauma refers to events outside the typical range of human experience—that is, events involving actual or threatened risk to the life or physical integrity of individuals or someone close to them.*

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS).

workers and parents meet the child welfare system's goals of safety, permanency, and well-being of children and families.

How Can Trauma Affect Parents?

A history of traumatic experiences may:

Compromise parents' ability to make appropriate judgments about their own and their child's safety and to appraise danger; in some cases, parents may be overprotective, and, in others, they may not recognize situations that could be dangerous for the child.

Make it challenging for parents to form and **maintain** secure and trusting **relationships**, leading to:

- Disruptions in relationships with infants, children, and adolescents, and/or negative feelings about parenting; parents may personalize their children's negative behavior, resulting in ineffective or inappropriate discipline.
- Challenges in relationships with caseworkers, foster parents, and service providers and difficulties supporting their child's therapy.

Impair parents' capacity to regulate their emotions.

Lead to poor self-esteem and the development of **maladaptive coping strategies**, such as substance abuse or abusive intimate relationships that parents maintain because of a real or perceived lack of alternatives.

Result in **trauma reminders**—or "triggers"—when parents have extreme reactions to situations that seem benign to others. These responses are especially common when parents feel they have no control over the situation, such as facing the demands of the child welfare system. Moreover, a child's behaviors or trauma reactions may remind parents of their own past trauma experiences or feelings of helplessness, sometimes triggering impulsive or aggressive behaviors toward the child. Parents also may seem **disengaged or numb** (in efforts to avoid trauma reminders), making engaging with parents and addressing the family's underlying issues difficult for caseworkers and other service providers.

Impair a parent's **decision-making ability**, making future planning more challenging.

Make the parent more **vulnerable to other life stressors**, including poverty, lack of education, and lack of social support that can worsen trauma reactions.

Although parents may experience the child welfare system as re-traumatizing because it removes their power and control over their children, there is potential for it to support their trauma recovery and strengthen their resilience. Caseworkers, as representatives of the child welfare system, can themselves serve as triggers to parents with trauma histories or can, through careful use of non-threatening voice and demeanor, be bridges to hope and healing. Viewing birth parents through a "trauma lens" helps childwelfare staff—and parents themselves—see how their traumatic experiences have influenced their perceptions, feelings, and behaviors.[2]

How can caseworkers use a trauma-informed approach when working with birth parents?[3]

Caseworkers cannot reverse the traumatic experiences of parents, but they can:

[2] *Although the focus of this fact sheet is birth parents, we acknowledge that other adults—including non-parent partners, grandparents, and step-parents—may also have histories of traumatic experiences and could benefit from trauma-informed child welfare practice as well.*

[3] *For information about trauma-informed child welfare practice go to www.NCTSN.org/products/child-welfare-trauma-training-toolkit-2008.*

Understand that parents' anger, fear, or avoidance may be a reaction to their own past traumatic experiences, not to the caseworker him/herself.

Assess a parent's history to understand how past traumatic experiences may inform current functioning and parenting.

Remember that traumatized parents are not "bad" and that approaching them in a punitive way, blaming them, or judging them likely will worsen the situation rather than motivate a parent.

Build on parents' desires to be effective in keeping their children safe and reducing their children's challenging behaviors.

Help parents **understand the impact of past trauma on current functioning and parenting**, while still holding them accountable for the abuse and/or neglect that led to involvement in the system. For many parents, understanding that there is a connection between their past experiences and their present reactions and behavior can empower and motivate them.

Pay attention to ways trauma can play out during case conferences, home visits, visits to children in foster care, court hearings, and so forth. **Help parents anticipate their possible reactions** and develop different ways to respond to stressors and trauma triggers

Refer parents to trauma-informed services whenever possible. Parents will be more likely to attend services that address their needs. Generic interventions that do not take into account parents' underlying trauma issues—such as parenting classes, anger management classes, counseling, or substance abuse groups—may not be effective.

Become knowledgeable about evidence-supported trauma interventions to include in service planning. Linkages with programs that deliver trauma-informed services can support caseworkers in developing a plan that meets their clients' needs.[4]

Advocate for the development and use of trauma-informed services in the community.

How can child welfare professionals protect themselves from secondary traumatic stress?

When child welfare staff work with traumatized families and directly see or hear of traumatic events, they can experience extreme distress and sometimes secondary or vicarious traumatic stress.[5] Supervisors, caseworkers, and administrators can—and should—find ways to take care of themselves and their staff and to address their own trauma reactions. Simply taking a walk at lunch or recognizing when they are getting overwhelmed or frustrated can make a difference.

Staff supervision can also be used to process the experience of working with traumatized clients.

This fact sheet is one in a series of factsheets discussing parent trauma in the child welfare system. To view others, go to http://www.nctsnet.org/resources/topics/child-welfare-system

[4] *For information on adult trauma treatments and interventions, go to: National Center for PTSD at http://www.ptsd.va.gov; Sidran Institute at http://www.sidran.org; California Evidence-based Clearinghouse for Child Welfare at http://www.cebc4cw.org; and the National Registry of Evidence-based Programs and Practices at http://www.nrepp.samhsa.gov. For help locating local adult trauma services, contact area rape crisis centers, domestic violence shelters, or Red Cross chapters.*

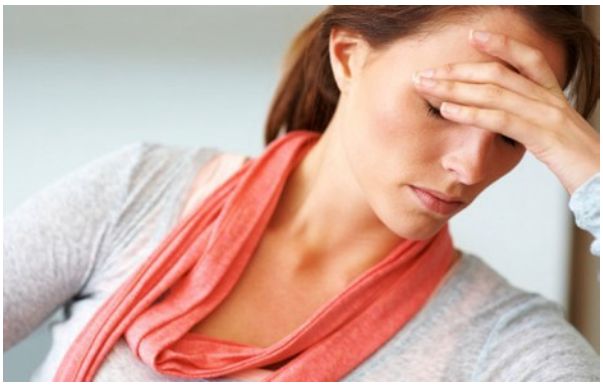
[5] *Secondary or vicarious traumatic stress (also called compassion fatigue) describes trauma reactions in helping professionals following extensive exposure to clients' retelling of their trauma experiences, for more information on self-care, go to: http://www.nctsnet.org/nctsn_assets/pdfs/CWT3_SHO_STS.pdf*

NCTSN The National Child Traumatic Stress Network

Secondary Traumatic Stress

A Fact Sheet for Child-Serving Professionals

"…We are stewards not just of those who allow us into their lives but of our own capacity to be helpful..."[1]



Each year more than 10 million children in the United States endure the trauma of abuse, violence, natural disasters, and other adverse events.[2] These experiences can give rise to significant emotional and behavioral problems that can profoundly disrupt the children's lives and bring them in contact with child-serving systems. For therapists, child welfare workers, case managers, and other helping professionals involved in the care of traumatized children and their families, the essential act of listening to trauma stories may take an emotional toll that compromises professional functioning and diminishes quality of life. Individual and supervisory awareness of the impact of this indirect trauma exposure—referred to as **secondary traumatic stress**—is a basic part of protecting the health of the worker and ensuring that children consistently receive the best possible care from those who are committed to helping them.

Our main goal in preparing this fact sheet is to provide a concise overview of secondary traumatic stress and its potential impact on child-serving professionals. We also outline options for assessment, prevention, and interventions relevant to secondary stress, and describe the elements necessary for transforming child-serving organizations and agencies into systems that also support worker resiliency.

How Individuals Experience Secondary Traumatic Stress

Secondary traumatic stress is the emotional duress that results when an individual hears about the firsthand trauma experiences of another. Its symptoms mimic those of post-traumatic stress disorder (PTSD). Accordingly, individuals affected by secondary stress may find themselves re-experiencing personal trauma or notice an increase in arousal and avoid-ance reactions related to the indirect trauma exposure. They may also experience changes in memory and perception; alterations in their sense of self-efficacy; a depletion of personal

This project was funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), US Department of Health and Human Services (HHS). The views, policies, and opinions expressed are those of the authors and do not necessarily reflect those of SAMHSA or HHS.

resources; and disruption in their perceptions of safety, trust, and independence. A partial list of symptoms and conditions associated with secondary traumatic stress includes[3]

Hypervigilance

Hopelessness

Inability to embrace complexity

Inability to listen, avoidance of clients

Anger and cynicism

Sleeplessness

Fear

Chronic exhaustion

Physical ailments

Minimizing

Guilt

Clearly, client care can be compromised if the therapist is emotionally depleted or cognitively affected by secondary trauma. Some traumatized professionals, believing they can no longer be of service to their clients, end up leaving their jobs or the serving field altogether. Several studies have shown that the development of secondary traumatic stress often predicts that the helping professional will eventually leave the field for another type of work.[4,5]

Understanding Who is at Risk

The development of secondary traumatic stress is recognized as a common occupational hazard for professionals working with traumatized children. Studies show that from 6% to 26% of therapists working with traumatized populations, and up to 50% of child welfare workers, are at high risk of secondary traumatic stress or the related conditions of PTSD and vicarious trauma.

Any professional who works directly with traumatized children, and is in a position to

Secondary Traumatic Stress and Related Conditions: Sorting One from Another

Secondary traumatic stress refers to the presence of PTSD symptoms caused by at least one indirect exposure to traumatic material. Several other terms capture elements of this definition but are not all interchangeable with it.

- ***Compassion fatigue***, a label proposed by Figley[4] as a less stigmatizing way to describe secondary traumatic stress, has been used interchangeably with that term.

- *Vicarious trauma* refers to changes in the inner experience of the therapist resulting from empathic engagement with a traumatized client.[13] It is a theoretical term that focuses less on trauma symptoms and more on the covert cognitive changes that occur following cumulative exposure to another person's traumatic material. The primary symptoms of vicarious trauma are disturbances in the professional's cognitive frame of reference in the areas of trust, safety, control, esteem, and intimacy.

- ***Burnout*** is characterized by emotional exhaustion, depersonalization, and a reduced feeling of personal accomplishment. While it is also work-related, burnout develops as a result of general occupational stress; the term is not used to describe the effects of indirect trauma exposure specifically.

- *Compassion satisfaction* refers to the positive feelings derived from competent performance as a trauma professional. It is characterized by positive relationships with colleagues, and the conviction that one's work makes a meaningful contribution to clients and society.

hear the recounting of traumatic experiences, is at risk of secondary traumatic stress. That being said, risk appears to be greater among women and among individuals who are highly empathetic by nature or have unresolved personal trauma. Risk is also higher for professionals who carry a heavy caseload of traumatized children; are socially or organizationally isolated; or feel professionally compromised due to inadequate training.[6-8] Protecting against the development of secondary traumatic stress are factors such as longer duration of professional experience, and the use of evidence-based practices in the course of providing care.[7]

Identifying Secondary Traumatic Stress

Supervisors and organizational leaders in child-serving systems may utilize a variety of assessment strategies to help them identify and address secondary traumatic stress affecting staff members.

The most widely used approaches are *informal self-assessment* strategies, usually employed in conjunction with formal or informal education for the worker on the impact of secondary traumatic stress. These self-assessment tools, administered in the form of questionnaires, checklists, or scales, help characterize the individual's trauma history, emotional relationship with work and the work environment, and symptoms or experiences that may be associated with traumatic stress.[4,9]

Supervisors might also assess secondary stress as part of a *reflective supervision model*. This type of supervision fosters professional and personal development within the context of a supervisory relationship. It is attentive to the emotional content of the work at hand and to the professional's responses as they affect interactions with clients. The reflective model promotes greater awareness of the impact of indirect trauma exposure, and it can provide a structure for screening for emerging signs of secondary traumatic stress. Moreover, because the model supports consistent attention to secondary stress, it gives supervisors and managers an ongoing opportunity to develop policy and procedures for stress-related issues as they arise.

Formal assessment of secondary traumatic stress and the related conditions of burnout, compassion fatigue, and compassion satisfaction is often conducted through use of the Professional Quality of Life Measure (ProQOL).[7,8,10,11] This questionnaire has been adapted to measure symptoms and behaviors reflective of secondary stress. The ProQOL can be used at regular intervals to track changes over time, especially when strategies for prevention or intervention are being tried.

Strategies for Prevention

A multidimensional approach to prevention and intervention—involving the individual, supervisors, and organizational policy—will yield the most positive outcomes for those affected by secondary traumatic stress. The most important strategy for preventing the development of secondary traumatic stress is the triad of psychoeducation, skills training, and supervision. As workers gain knowledge and awareness of the hazards of indirect trauma exposure, they become empowered to explore and utilize prevention strategies to both reduce their risk and increase their resiliency to secondary stress. Preventive strategies may include self-report assessments, participation in self-care groups in the workplace, caseload balancing, use of flextime scheduling, and use of the self-care accountability buddy system. Proper rest, nutrition, exercise, and stress reduction activities are also important in preventing secondary traumatic stress.

Prevention

- Psychoeducation
- Clinical supervision
- Ongoing skills training
- Informal/formal self-report screening
- Workplace self-care groups (for example, yoga or meditation)
- Creation of a balanced caseload
- Flextime scheduling
- Self-care accountability buddy system
- Use of evidence-based practices
- Exercise and good nutrition

Strategies for Intervention

Although evidence regarding the effectiveness of interventions in secondary traumatic stress is limited, cognitive-behavioral strategies and mindfulness-based methods are emerging as best practices. In addition, caseload management, training, reflective supervision, and peer supervision or external group processing have been shown to reduce the impact of secondary traumatic stress. Many organizations make referrals for formal intervention from outside providers such as individual therapists or Employee Assistance Programs. External group supervision services may be especially important in cases of disasters or community violence where a large number of staff have been affected.

Intervention

- Strategies to evaluate secondary stress
- Cognitive behavioral interventions
- Mindfulness training
- Reflective supervision
- Caseload adjustment
- Informal gatherings following crisis events (to allow for voluntary, spontaneous discussions)
- Change in job assignment or work group
- Referrals to Employee Assistance Programs or outside agencies

The following books, workbooks, articles, and self-assessment tests are valuable resources f o r further information on self-care and the management of secondary traumatic stress:

Volk, K.T., Guarino, K., Edson Grandin, M., & Clervil, R. (2008). *What about You? A Workbook for Those Who Work with Others.* The National Center on Family Homelessness. http://508.center4si.com/SelfCareforCareGivers.pdf

Self-Care Assessment Worksheet
http://www.ecu.edu/cs-dhs/rehb/upload/Wellness_Assessment.pdf

Hopkins, K. M., Cohen-Callow, A., Kim, H. J., Hwang, J. (2010). Beyond intent to leave: Using multiple outcome measures for assessing turnover in child welfare. *Children and Youth Services Review*, 32,1380-1387.

Saakvitne, K. W., Pearlman, L. A., & Staff of TSI/CAAP. (1996). *Transforming the Pain: A Workbook on Vicarious Traumatization*. New York: W.W. Norton.

Van Dernoot Lipsky, L. (2009). *Trauma Stewardship: An everyday guide to caring for self while caring for others.* San Francisco: Berrett-Koehler Publishers.

Compassion Fatigue Self Test
http://www.ptsdsupport.net/compassion_fatugue-selftest.html

ProQOL 5 http://proqol.org/ProQol_Test.html

Rothschild, B. (2006). *Help for the helper. The psychophysiology of compassion fatigue and vicarious trauma*. New York: W.W. Norton.

Worker Resiliency in Trauma-Informed Systems: Essential Elements

Both preventive and interventional strategies for secondary traumatic stress should be implemented as part of an organizational risk-management policy or task force that recognizes the scope and consequences of the condition. The Secondary Traumatic Stress Committee of the National Child Traumatic Stress Network has identified the following concepts as essential for creating a trauma-informed system that will adequately address secondary traumatic stress. Specifically, the trauma-informed system must

Recognize the impact of secondary trauma on the workforce.

Recognize that exposure to trauma is a risk of the job of serving traumatized children and families.

Understand that trauma can shape the culture of organizations in the same way that trauma shapes the world view of individuals.

Understand that a traumatized organization is less likely to effectively identify its clients' past trauma or mitigate or prevent future trauma.

Develop the capacity to translate trauma-related knowledge into meaningful action, policy, and improvements in practices.

These elements should be integrated into direct services, programs, policies, and procedures, staff development and training, and other activities directed at secondary traumatic stress.

"We have an obligation to our clients, as well as to ourselves, our colleagues and our loved ones, not to be damaged by the work we do."[12]

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About the National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

TAKING CARE OF YOURSELF

Putting Protective Factors into Play for Yourself

Child welfare work is hard. When you spend all day working with families who need a lot of support, it can be difficult to focus on your own well-being. One of the best things about the Protective Factors Framework is that it applies to everyone – including you and your family! Thinking about how to put protective factors into play in your own life can help you keep going in the face of the daily challenges of doing child welfare work.

Personal Resilience

What do you do to take care of yourself? Try to plan ahead of time so that when you are having a bad day you can:

- Do something that helps you to relax, feel calm and take your mind off of the stress you are experiencing.
- Take a break if you need it (this can be as simple as asking your partner to make dinner or a friend to take care of the kids, or taking a personal day from work).
- Remind yourself of why you do this work. Reflect on what drew you to social work as a career and what you want to achieve for children and families in your community through your work.
- Take time to remember the impact you have made in the lives of others – through your work ,in your extended family, in your neighborhood or in your community.
- Get help from a supervisor or a coworker if you need it.
- Find a way on an ongoing basis to release the emotional stress related to the work. Allow yourself physical & emotional enhancers. Take care of yourself by eating well, getting rest, creating separation from work. Identify actions that help you to decompress.
- Recognize your own humanness and learn ways to separate who you are as a person from what the job requires you to do.

Social Connections

Are there people in your life who can support you during rough times and help you recharge outside of work? Make sure that you benefit from positive relationships with others:

- Cultivate a supportive environment at work so that you and your coworkers have time to get to know each other and can turn to each other for support when needed.
- Spend time with family, spiritual groups, clubs, hobbies, sports, recreation or any other activity that removes you from the stress of work. Look into joining groups or organizations as a way to meet new people. Book clubs, school organizations, religious communities or clubs focused on a hobby you enjoy can be great places to start.
- When you're having a tough day due to backlog on cases or a particularly challenging family, don't hesitate to reach out to colleagues.
- Use unit meetings as an opportunity to do a staffing of a challenging case to obtain different perspective.
- Reach out to friends and loved ones for help and support. And when they're having a bad day, make sure that you do your best to help them in return.

Knowledge of Parenting and Child Development

If you are a parent yourself, the challenges faced by children in the child welfare system can hit especially close to home. It can be difficult to keep a healthy perspective on your children's development and your own parenting when you come home. Even if you are not a parent, or don't have children living at home, it is important to check your assumptions and understanding about parenting and child development through your interactions with families that are struggling.

- Just as parents can catch their children being good, we can all support each other as parents by "catching" good parenting in action. Recognize and pat yourself on the back when you have kept your cool during a stressful situation.
- Remember that parenting is part learned and part natural and that goes for you as well even though you are a "professional." Take time to find out more about child development and effective parenting. Try out the information in your own home and make it part of the knowledge base you bring to families.
- Take time to think about beliefs you hold about parenting and parent/child relationships and how it impacts your child welfare work. Are there things in your own experience that may be coloring your response to families?

Concrete Support in Times of Need

Everyone needs support at different times in their lives. As a child welfare worker, you are probably more attuned than many community members to the resources available in your community. What do you do when you need support yourself? Some ways to shore up your concrete supports include:

- Stay aware of community resources available to help with issues that can come up for any family, such as substance abuse, mental health issues, domestic violence and material needs. Those can be valuable connections in a time of crisis not just for the families you work with but for yourself, a friend or a member of your extended family.
- If you've had a very difficult case that has not ended well, don't hesitate to ask your supervisor or agency administrator for counseling assistance for yourself and others within your unit.
- Put money into savings when things are going well. An emergency fund that can cover 2-3 months of living expenses is ideal, in case you should face illness, unemployment or unexpected expenses.
- Talk to friends, neighbors and family members to be sure you have people lined up who can pick up your child from school when you aren't able to or give you a ride to work if your car breaks down. You can do the same for them, and know you can count on each other when you're in a pinch.

Social and Emotional Competence of Children

Many of us get into child welfare because we care about children. Take time in your work to connect with the children in your caseload – and remember the importance of your work and the effect you have on them and their lives.

AGENDA

Day 5

Welcome/Check-In
9:00-9:10

9:10-9:55 ..... I. CPS In-Home Services
- A. Family Assessment and Change Process
- B. The Role of the In-Home Services Worker
- C. In-Home Services Policies

9:55-10:10 ..... II. Child and Family Teams

10:10-10:25 ..... III. Critical Thinking and the Planning Process

10:25-10:40… ..... BREAK

10:40-11:00 ..... IV. In-Home Family Services Agreement

11:00-11:50 ..... V. Guidelines for Setting Objectives
- A. SMART Objectives

11:50-1:05 ..... LUNCH

1:05-2:00…….. B. Skills Practice:
Setting Objectives with the Family

2:00-2:30 ..... VI. In-Home Services Updates
- A. Risk Reassessment
- B. Family Strengths and Needs
- C. Family Services Agreement Update

2:30-2:45 ..... BREAK

2:45-3:45 ..... VII. System Induced Trauma
- A. Video: "Henry"
- B. Invisible Suitcases

3:45-4:00 ..... VIII. Your Role
- A. Video: "The Ounce"
- B. Closing

Consider This!

CPS In-Home Services Case Considerations

- Are the parents or caretakers willing and able to work on a services agreement?
- Would the family benefit from the services of Family Preservation or Intensive Family Preservation Services?
- Is progress being made toward the goal, objectives, and activities outlined in the agreement.
- Does the need for CPS involvement continue?
- Does the child need placement because of increased risk of harm?

The Four Values of In-Home Services

1. Responsive

We will utilize a timely and accurate family-specific approach that identifies risk and increases protective factors through skill acquisition to prevent further child maltreatment.

2. Capable

We will recognize the family as the expert and an important stakeholder, capitalizing on family history, strengths, and supports to partner for solutions.

3. Accountable

We will remain current in our knowledge and implementation of proven practice, and participate in coaching supervision, to remain accountable to our stakeholders.

4. Preventive

We will exhaust all efforts through modeling, coaching, collaborating, and evaluating as part of the systemic prevention of future child maltreatment and agency custody.

Four Values developed by NC DSS In-Home Services Redesign Workgroup, 2014. See:
https://files.nc.gov/ncdhhs/documents/files/dss/dcdl/childwelfareservices/CWS-19-2014.pdf

CPS In-Home Services

Frequency of Contacts with Families

When Risk Assessment Rating is High

Face-to-face contact with victim children

- Must occur at least once a week
- At least two of the contacts must occur in the home if the child is not with a Temporary Safety Provider
- Include an observation of the relationship and interaction between the parent/caretaker once a month

Face-to-face contact with parent(s)/caretaker(s)

- Must occur at least once a week

Face-to-face contact with other household members

- Includes all other children in the home
- Must occur at least twice a month

When Risk Assessment Rating is Moderate

Face to face contact with the victim children:

- To meet requirements, the contact must be of quality and sufficient to ensure the safety, permanency and well-being of the child. It must also include an individual contact with each child that is older than an infant. This contact must be in part alone from the parent/caretaker
- Must be at least 2 times per month: at least one visit in the first half of the month and the second visit in the second half of the month or at least 15 days apart
- Additional visits as needed at intervals to assure the child's safety
- Must include observation of the interaction and relationship between the child(ren) and parent/caretaker at least once a month
- At least one of the contacts must occur in the home if the child is not with a Temporary Safety Provider.

Face-to-face contact with parents/primary caretaker

- Must be at least 2 times per month: at least one visit in the first half of the month and the second visit in the second half of the month or at least 15 days apart
- Must emphasize the behavior change identified as a need in the IH-FSA

Face-to-face contact with other household members:

- Includes all other children in the home
- Must occur at least once a month

Contact with non-resident parents

- Attempts to identify or locate a parent must occur monthly
- Contact must occur at least monthly with a non-resident parent who has been located but was not responsible or associated with the safety or risk of harm to the child. The frequency and type of contact must be determined in a case staffing.

Contacts with collaterals

- Must occur at least twice a month

Documentation must include the diligent efforts made and/or rationale for contacts not completed at the frequency specified above

REDUCTION OF FREQUENCY OF CONTACTS

Contact frequency must continue until:

- The risk level in the home is reduced or the case is staffed for a reduction of contacts and the reason for that reduction is documented

The option to reduce the number of required monthly contacts, on a moderate risk case, must only occur with the supervisor and child welfare worker discussing the rationale, and must:

- Occur after a discussion with the family and collaterals
- There is a clear reduction in risk
- Be based on the family's progress on changing the identified behaviors, and the lessening of safety and risk concerns in the home
- Be clearly documented

The option to reduce contacts for high risk cases must only occur after a supervisor and child welfare worker discuss the rationale and only occur when:

- A child is in a safe, stable arrangement with a Temporary SafetyProvider
- The frequency of contacts with the parent(s) or any child not in the Temporary Safety Provider placement must not be reduced
- Intensive Family Preservation Services (IFPS) is in place. Contacts by IFPS must be documented and shared with the In-Home services county child welfare worker. Contact by the In-Home services child welfare worker must be a minimum of twice per month while IFPS is involved.

Required contacts must never be reduced to less than once a month because of the on-going need to assess for risk and safety. This includes:

- face-to-face individual contact with both the victim child(ren) and all parents or primary caretakers in the home in which the child resides
- observing the interaction and the relationship between the child(ren) and the primary caretaker(s).

Source: NCDSS Child Welfare Manual, In-Home Services: Required Contacts, pgs. 17-24

Child and Family Teams (CFTs)

- **ALWAYS includes the family (no family…no CFT)**
  - **Family identifies other team members**
  - **Team membership may change as the case changes**
  - **Team members are committed to helping the family develop plans for the safety, permanence, and well-being of the children**
  - **Strengths and needs of the family are discussed**
  - **Joint decision-making and support are the goals**
  - **Family services agreements are developed during these meetings**
  - **Team meetings are WITH the family, not ABOUT the family**

Child and Family Team Meetings:
Required Timeframes
Throughout the Life of a Child Welfare Case

During the Assessment Phase

- To explore safety arrangements and possible placements if the children must be removed
- Prior to filing a petition
- Initial planning for a CFT is initiated even if a CFT is not held during the assessment phase

(NC Child Welfare Policy: CPS Assessments, Required time frames pg. 9)

During In-Home Services

- To review the Temporary Parental Safety Agreement (TPSA)
- For quarterly reviews of the IH-FSA
- To update the Family Services Agreement to address safety or high-risk concerns, including, but not limited to:
  - Identification of a new safety threat
  - High risk "stuck cases"
- When requested by the family
- At critical decision points, to include possible out-of-home placement
- When a child is placed with a TSP and the parent cannot be located and/or there is no parent to make decisions regarding the child
- At six months after development of the In-Home Family Services Agreement:
  - There is a lack of progress as indicated by no activities completed nor any behavioral changes demonstrated that mitigate risk; or
  - The child(ren) in the care of a TSP are unable to return home
- Prior to and within 30 days of case closure in cases that are repeat recipients of CPS In-Home or received Permanency Planning services to specifically address the plan the family will follow to prevent repeat maltreatment.

(NC Child Welfare Policy: In Home Services, Review of Services/Family Services Agreements, pgs. 31-32.

During Permanency Planning and Adoption

- Any time there is a change in the permanent plan
- Any time there is a need to change placement
- Any time there is a significant change in the case, including a school change
- Any time the family requests a meeting

(NC Child Welfare Policy: Permanency Planning Services, Required Timeframes, pg. 11)

Non-Resident Parents are Family, Too

Involving Non-Resident Parent in CFT Meetings

Non-Resident parents (who may or may be non-custodial parents) must be involved in the CFT meeting unless there is a valid conflict or safety issue, and this must be clearly documented in the case record. The agency shall use alternate methods to involve the non-resident parent in case planning if it is determined that the parent cannot participate in the CFT meeting due to a conflict or safety issue. Some alternate methods that might be used include:

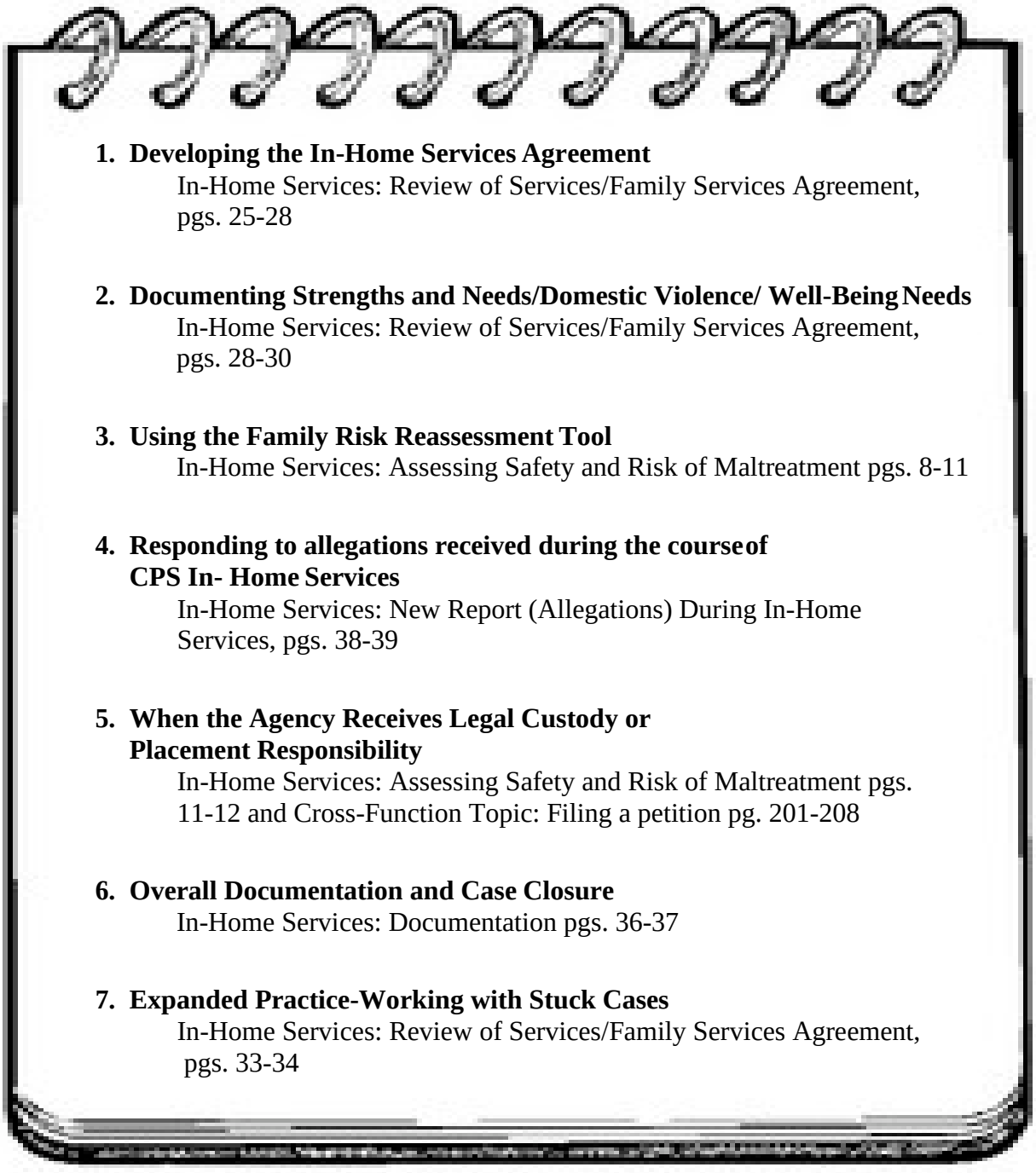
- The absent parent can participate over the phone
- The absent parent can send written concerns and ideas for case planning
- The absent parent can choose a proxy who will represent his/her concerns and wishes
- A separate plan can be completed with the absent parent
- The absent parent should be given the opportunity to share in the case planning and should be encouraged to do so throughout the life of the case.
- In cases where there are volatile relationships among family members, one strategy that has been successful in some cases is the use of meetings done in "stages". This involves having one group of family and supports meet to discuss their ideas for addressing safety and risk, they would then be excused, and the other family group would discuss their ideas. If possible, both groups are then brought together to look at the common areas and finalize the plan.

CPS In-Home Services

Policies Related to the Duties of the Worker

NC DSS Child Welfare Manual

https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/in-home_manual.pdf



1. **Developing the In-Home Services Agreement**
   In-Home Services: Review of Services/Family Services Agreement, pgs. 25-28

2. **Documenting Strengths and Needs/Domestic Violence/ Well-Being Needs**
   In-Home Services: Review of Services/Family Services Agreement, pgs. 28-30

3. **Using the Family Risk Reassessment Tool**
   In-Home Services: Assessing Safety and Risk of Maltreatment pgs. 8-11

4. **Responding to allegations received during the course of CPS In- Home Services**
   In-Home Services: New Report (Allegations) During In-Home Services, pgs. 38-39

5. **When the Agency Receives Legal Custody or Placement Responsibility**
   In-Home Services: Assessing Safety and Risk of Maltreatment pgs. 11-12 and Cross-Function Topic: Filing a petition pg. 201-208

6. **Overall Documentation and Case Closure**
   In-Home Services: Documentation pgs. 36-37

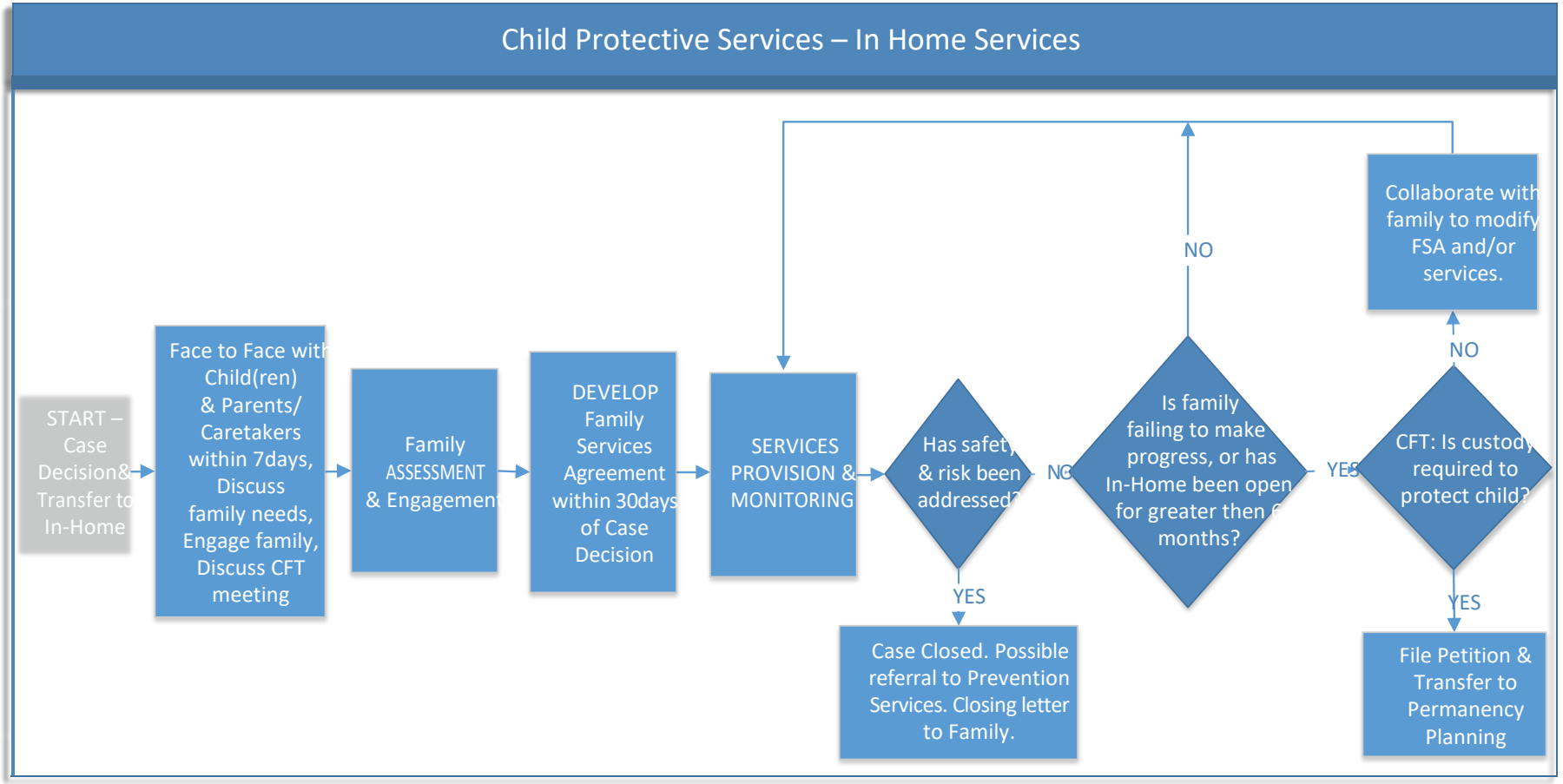
7. **Expanded Practice-Working with Stuck Cases**
   In-Home Services: Review of Services/Family Services Agreement, pgs. 33-34

CPS In-Home Services

Checklist of Forms and Activities

- Change **DSS 5027** to show services code change and change in worker
- Develop **In-Home Family Services Agreement** (within 30 days of case decision of substantiation or services needed)
- Hold first **Child and Family Team Meeting** (90 days after the development of the Initial Family Services Agreement)
- Utilize the **North Carolina Family Meeting Preparation (optional)** for documentation of the Child and Family Team Meeting.
- Update **In-Home Family Services Agreement** (every 90 days or when circumstances warrant it)
- **Complete Risk Reassessment tool** (every 90 days or when circumstances warrant it)
- **Update Strengths/Needs Assessment tool** (every 90 days or when circumstances warrant it)

In-Home Services: Required Timeframes



ASSESSMENT which:

- Builds upon the information obtained during the CPS Assessment,
- Assesses the concerns behind the presenting safety or risk issue,
- Expands on the family's and family member's strengths,
- Assesses any history of trauma,
- Increases knowledge regarding family's and family member's well-being needs (parents & children), and
- Engages family in the process, including preparation for the CFT meeting.

DEVELOP the FSA in a CFT meeting which:

- Identifies and builds upon the family's strengths,
- Identifies the behaviors and/or conditions that put the child at risk of harm,
- Describes the desired behavior and/or condition, expected changes and what it will look like when the plan has been accomplished,
- Addresses child well-being needs,
- Identifies services to address child well-being needs,
- Establishes responsibility for the identified tasks, and
- Establishes a timeframe.

SERVICES PROVISION & MONITORING, to include:

- Ongoing monitoring of safety, risk of maltreatment and well-being,
- Ongoing contact with child(ren) and parents/ caretakers (frequency determined by risk),
- Home visits, school visits, etc.,
- Refer for or Provide services to address identified needs,
- Contacts with service providers and extended family members as needed,
- Staffing with supervisor, and
- CFTs quarterly or more frequently if needed.

Reference: NC Child Welfare Manual: In Home Services

Steps in Family Services Agreement Planning

1) ***Identify the Presenting Problem*** (The reason the case was referred for service; the visible need, problem, or behavior that presents a safety or risk concern of maltreatment for a child.)

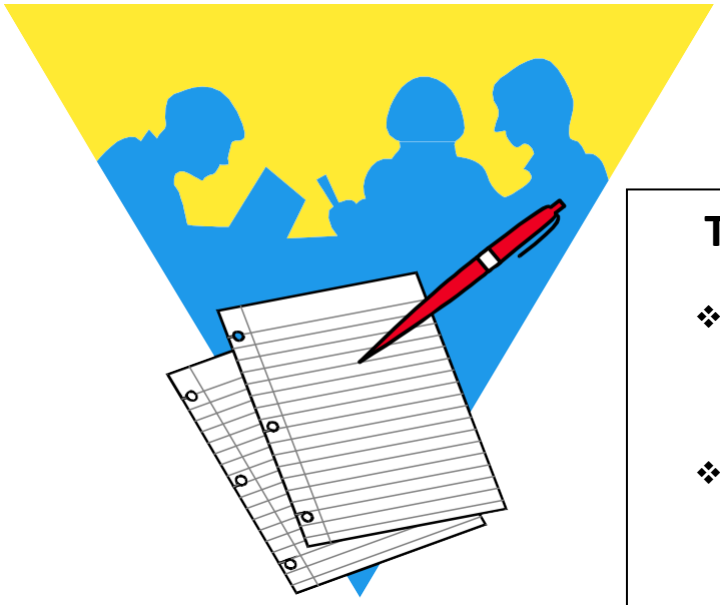
2) ***Assess the Family Situation*** (assess risk of harm to the child; determine causal and contributing factors to risk; identify the family's problems or needs; identify strengths and resources in the family and the community to address and resolve the family's problems or needs.)

3) ***Formulate Goals and Objectives*** (clearly identify and describe the desired outcomes of service intervention, which are based on the assessment.)

4) ***Identify Intervention Activities*** (how, where, when and who implements specific activities to assure that goals and objectives are met. Includes activities of all parties, including family members, worker, and other professionals.)

5) ***Reassessment****:* After a prescribed timeframe, review the plan, evaluate our success, and revise the plan as necessary.

Case Planning and *Family-Centered Casework (Core 102), Ohio Child Welfare* Training Program



The Family Services Agreement

- Guides all the agency's work with the family and child from intake through case closure and aftercare services
- Documents what must change for the parents to meet the needs of the child and provide documentation of the changes that have or have not occurred

The purpose of the Family Services Agreement planning process is to:

- clarify with the family the reasons for DSS involvement
- focus on the safety, risk, and permanence needs of the child
- involve the family in identifying areas that need improvement
- clarify expectations for behavioral change with all persons involved
- acknowledge the family's strengths and commitment to their child

The agreement must address:

- the services to be provided or arranged
- the visitation plan designed to maintain links with the family
- the expectations of the family, agency, placement provider and community members
- the target dates
- expected outcomes

Non-Resident Parents are Family Too
Development of In-Home Family Services Agreements:

Both resident and non-resident parents should participate in the development of the agreement.

- Involving a non-resident parent and or their relative supports in the planning for a child could possibly prevent future maltreatment, placement, and lengthy stays for children in foster care.

- Even if a parent is incarcerated, (in-state or out-of-state), they should be contacted to determine if they can assist in identifying any strengths or needs of the family, receive their input on the In-Home Family Services Agreement, determine if there are any possible relatives that may be a resource in supporting the child, and determine what level of involvement they can maintain particularly around the planning for and contact with their child. To locate a parent that is in prison, contact the **NC Department of Corrections** Records Office at 919-716-3200. Contact numbers and addresses for specific prisons can be found on the NC Division of Prisons website **http://www.doc.state.nc.us/dop/index.htm**. All inmates have a case manager or social worker that can assist in contacting a prisoner.

- If a non-resident parent is not involved in the planning, it may be beneficial to ask what it would take for them to become involved as well as if they have any relatives that maybe a resource in supporting the child. Documentation should reflect this discussion. An example of this would be a non-resident parent who has expressed a desire not to be involved in the child's life, who has never been involvement in the child's life, who refuses any contact with the child, provides no possible relative supports and refuses to cooperate with the social worker in the development of an agreement

- Prior to completing the In-Home Family Services Agreement, a Family Assessment of Strengths and Needs should be completed with an involved non-resident parent.

ACHIEVING THE PERMANENCY PLAN

GOAL
Permanency Plan

NEED
Current Behavior

OBJECTIVE
Changed Behavior

ACTIVITIES
Steps

S M A R T Objectives

S pecific

M easurable

A chievable

R ealistic

T imely

Guidelines for Setting Objectives

- **Objectives should be small, simple, and realistic.**
- **Objectives should be stated as the presence of an appropriate, alternative behavior rather than as the absence of an inappropriate, undesirable behavior.**
- **Objectives should be stated in concrete, measurable, observable, and behavioral terms.**
- **Objectives should be important to the family.**
- **Family members should view the objective as involving hard work.**

USING PROTECTIVE FACTORS TO DEVELOP CASE PLAN TASKS AND ACTIVITIES

Protective Factor	Sample Objective	Sample Tasks / Activities
Parental Resilience	The mother will consistently identify and meet her own physical and emotional care needs.	• Mother will call her sister when feeling overwhelmed. • Mother will take a positive self-care action every day, such as walking for 20 minutes, taking a hot bath, listening to favorite music, talking with her sister, etc. • Mother will create a self-calming routine and follow it when she feels frustrated, angry or out-of-control.
Knowledge of Parenting and Child Development	Both parents will work together to demonstrate expectations for their four-year-old child which are consistent with the child's age and developmental stage.	• Both parents will enroll in a parenting education class. • Both parents will practice a new parenting strategy learned in the parenting class and write down the outcome. • Both parents will fill out the "Ages and Stages Questionnaire" and identify any subsequent questions or concerns. • Both parents will meet with the child's preschool teacher or pediatrician to discuss the results of the "Ages and Stages Questionnaire."
Social Connections	The mother will identify and engage in positive peer relationships that serve as a source of support.	• Mother will ask her neighbor to care for her child and make use of this support if she does not feel able to do so in a safe way. • Mother will invite another mother from her child's school to go to the movies or other recreational activity. • Mother will talk to her counselor about the barriers she has identified that interfere with her ability to engage socially. • Mother will engage in reciprocal support with friends (e.g., ride sharing, making meals together, babysitting trade). • Mother will join a church group and participate in social activities.
Concrete Support in Times of Need	The parents and caseworker will work together to address issues contributing to stress in the family.	• Parents and caseworker will identify an agreed-upon list of issues contributing to stress in the family and an agreed-upon action plan to address those issues. • Parents and caseworker will identify and select an agreed-upon service provider. • Caseworker will provide bus tokens and parents will attend scheduled appointments with the service provider. • Caseworker and parents will work together to complete applications for benefits and/or services.
Social and Emotional Competence of Children	The father and mother will provide for the twelve-year-old child's social and emotional development.	• Father and mother will talk with their child's teacher and basketball coach about additional supports the child needs to work through the trauma experienced. • Father and mother will schedule counseling appointments and bring the child to the appointments. • Father and mother will schedule and jointly participate in interactive recreational activities (e.g., hiking, bowling, sports events) with their child at least one time per month. • Father and mother will encourage their child to invite friends to the home for a movie night or other fun activity.

In-Home Services
The Hobgood Family: 3 Months Later

With the support of In-Home Services, Sandy Hobgood has been working on the objectives of the service agreement for nearly three months. She had agreed to ensure supervision of Burt at all times and to use alternate discipline that did not leave marks or bruises on Burt. Ms. Hobgood also agreed to attend substance abuse counseling following her assessment at Mental Health. Ms. Grant had agreed to provide supervision of Burt when Ms. Hobgood needed to go out for the evening if she provided snacks and called her in advance before sending Burt over. Burt had agreed to not yell at his mother and go to his room and entertain himself when his mother wanted to have a drink.

Ms. Hobgood was adamant about not wanting to attend parenting classes. She stated that she would rather have the social worker provide her some brochures to read, since she liked reading. The social worker agreed and provided several pamphlets, on-line sites that were geared toward parenting school aged children and recorded videos of Supernanny. Ms. Hobgood was to review the materials and discuss questions and lessons learned with the social worker during their scheduled twice per month. Ms. Hobgood felt that these activities would be more beneficial to her. During some of the home visits, it was apparent to the social worker that Ms. Hobgood had not read the materials or reviewed the videos. When asked about the lack of participation, Ms. Hobgood stated that she had gotten busy looking for a job. Ms. Hobgood stated that when she did watch the videos, sometimes the techniques being discussed were too time consuming to use with Burt. She stated that Burt was doing fine, and she had not lost her temper with him since the initial incident.

Ms. Hobgood stated that she had done the assessment at Mental Health, but did not see the need for ongoing services with them. She attended six of the twelve visits scheduled. Ms. Hobgood stated that she felt that she could stop drinking at any time and did not need the help of another formal agency telling her what to do.

During one of the visits, Burt stated that his mother was doing better, but she continued to drink alcohol. He stated that instead of yelling at his mother, he just went to his room. Burt admitted that he was still angry with his mother for leaving him home alone and not calling. Burt stated that school was fine, but he did not make friends very easily. Burt stated most of the kids just ignored him so he would force them to play the games he wanted during recess. During visits, observations of Burt showed no marks or bruises. Burt told the social worker that he thought it was funny when his mother tried to put him in time out or try to take away his Xbox. Burt stated that most of the time, his mother just let him have his way. Burt's immunizations are current, and Ms. Hobgood stated that Burt has not had a physical in over two years.

The worker talked with Ms. Grant and she stated that Burt had come over several times since the service agreement had been developed. She stated that she loved having Burt over because he was fun to watch TV with. Ms. Grant stated that she never had any problems with

him, but sometimes Ms. Hobgood did not send snacks as the service agreement had stated. Ms. Grant stated that she gave him a sandwich and some juice, but she could not always have something for him. Ms. Grant stated that she spoke with Sandy and she stated that Burt just liked eating at Ms. Grant's house.

Collateral contacts with Ms. Hobgood's mother, Irene Curtis, were made. Ms. Curtis stated that she knew that Sandy was drinking on several occasions, but Burt was safe with the neighbor and she was happy about that. She stated that she has been calling more and providing more support to her daughter. Ms. Curtis stated that Burt still could come over for some week-end visits, but transportation was an issue.

Collateral contacts with Mr. and Ms. Hobgood revealed that since they already had Burt's siblings, they did not want to get more involved with the family. They stated that they had not heard from their son, Johnny, and still had no idea of how to contact him. The Hobgoods stated that they would attend the CFT to make sure that Burt was safe with Sandy.

Collateral contacts with Burt's teacher, Ms. Johnson, revealed that Burt was still receiving lower than average grades. She stated that Burt seemed angry most of the time and continued to bully some of the smaller kids. Ms. Hobgood agreed to have Burt tested by the school psychologist. The psychologist's report revealed that Burt has dyslexia as well as some anger issues. Ms. Johnson stated that she had attempted to contact Ms. Hobgood about developing an IEP for Burt and received no response to her calls or her letters. Ms. Johnson stated that she felt Burt needed to talk with a counselor, but she needed Ms. Hobgood's permission to make the follow-up referral. Ms. Johnson also stated that she had not observed any bruises to Burt since he started in her class. Ms. Johnson agreed to attend the CFT if the meeting could be scheduled after school hours and Ms. Hobgood had no objections.

The social worker reviewed the Family Risk Reassessment and Family Strengths and Needs with Ms. Hobgood and discussed concerns with her progress. Ms. Hobgood stated that she is doing better with Burt and wishes the agency would just leave them alone. Ms. Hobgood and the worker discussed the attendees for the CFT and scheduled the meeting for next week.

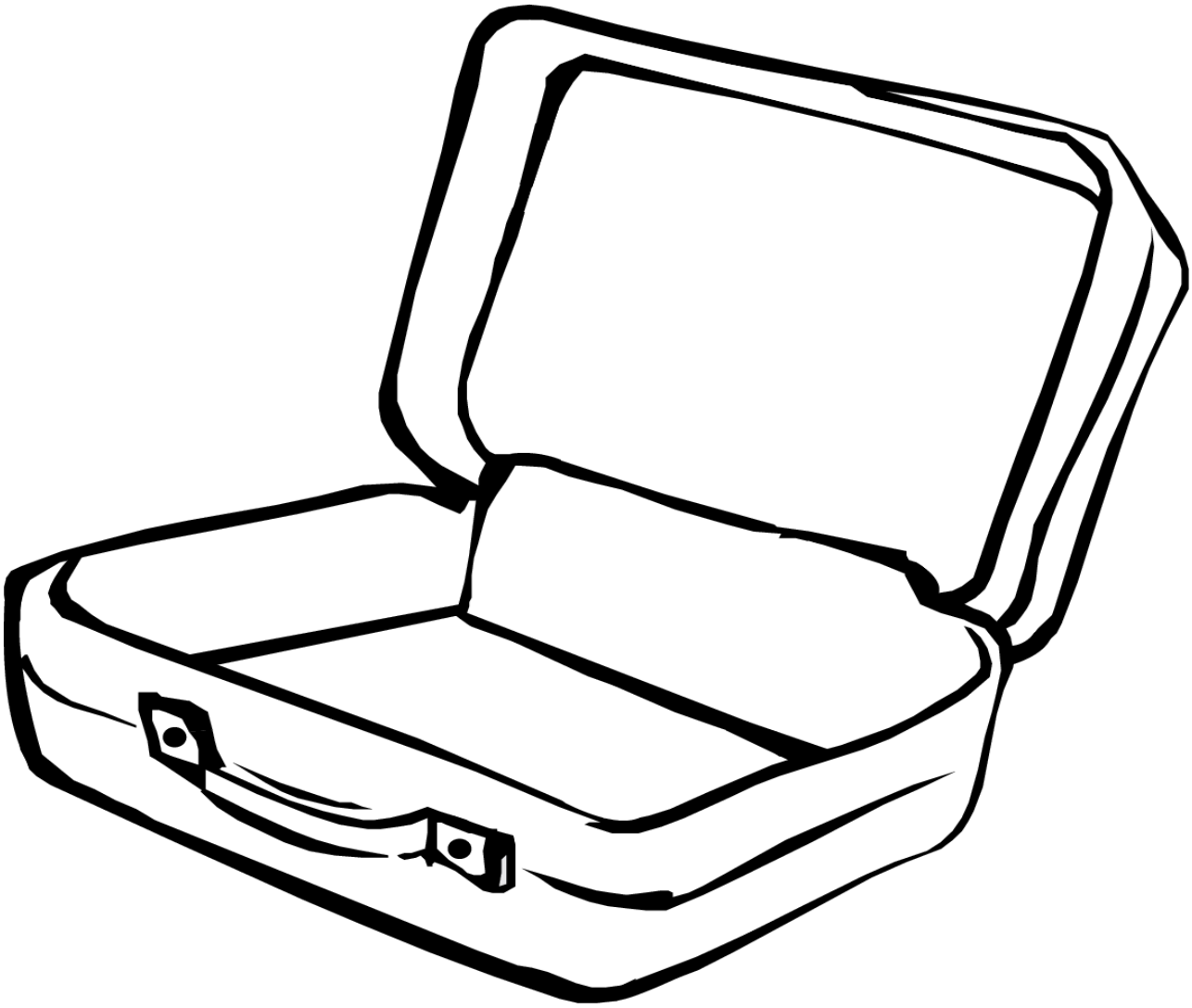
HENRY

What are some contributing factors that might be causing traumatic stress in Henry's life?

What were some indicators/signs Henry showed of traumatic stress?

What could have been done differently to lessen the effects of trauma on Henry?

How does the very system designed to make children safe sometimes cause additional unintentional trauma?



Tips for Enhancing the Overall Well-Being of Children and Their Families

- Build a trusting relationship with the child and family
- Have quality interactions with the child and family (this means fully engaging and listening)
- Do not make commitments or promises that you may not be able to keep
- Involve the child and parents in decisions that affect their lives
- Let the child know that they 'matter' to you and are not 'just another case'.
- Maintain regular communication with the child and parents/caregivers
- Create a healing environment for the child (one that is consistent, orderly, predictable)
- Focus on the child and parent's strengths and resilience
- Assure relationships and situations avoid re-traumatizing children
- Work with children to discover their "triggers" of past traumas and ways to stay safe both physically and psychologically
- Focus on strengths; what parents and children CAN do and identify their existing coping skills
- Ask children and parents for their ideas about how they want to be helped

Resource: Chadwick Trauma Informed Systems Project, 2013

AGENDA
DAY SIX

9:00 – 9:10……	I. Welcome and Who Else Needs to Know About Permanency Planning?
9:10 – 9:30……	II. Introduction to Permanency Planning Services A. Function of Permanency Planning B. Roles of the Permanency Planning Worker and Licensing Worker
9:30 – 10:30……	III. Permanency Planning Policy and Decisions A. Permanency Defined B. Recent Laws and Policies C. Placement Decisions
10:30 – 10:45……	BREAK
10:45 – 11:00……	III. Permanency Planning Policy and Decisions, cont. D. Promoting Normalcy for Foster Youth
11:00 – 11:45……	IV. Permanency Planning Strategies A. Impact of Moves B. Pre-placement visits
11:45-1:00……	LUNCH
1:00 – 2:40……	IV. Permanency Planning Strategies, cont. C. Shared Parenting D. Preparation Considerations Activity
2:40-2:55……	BREAK
2:55-3:45……	V. Video: ReMoved
3:45 – 4:00……	VI. Closing

Foster Home Licensing: *Forms and Activities*

Form Name/Location https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/modified-manual-1/fhlicensing.pdf	**Form Number**
Foster Home License Application	DSS-5016
Foster Home Relicense Application	DSS-5157
Foster Home Fire Inspection	DSS-1515
Foster Home Environmental Conditions Report	DSS-5150
Water Hazard Safety Assessment	DSS-5018
Individual Water Safety Plan	DSS-5018 (a)
Medical History	DSS-5017
Medical Evaluation	DSS-5156
Responsible Individual List (RIL) Information Request	DSS-5268

Foster Home Licensing Activity	**Resources**
Recruiting and supporting prospective foster/kinship families	***Treat them Like Gold: A Best Practice Guide for Partnering with Resource Families*** https://www.ncdhhs.gov/divisions/social-services/publications **Child Welfare Capacity Building Collaborative** https://capacity.childwelfare.gov/ **AdoptUSKids** https://adoptuskids.org/ **National Resource Center for Diligent Recruitment (publication library)** https://adoptuskids.org/for-professionals/publications
Conducting Pre-Service Training for prospective resource families	The required 30-hour Pre-Service training group sessions utilized most often: **TIPS-MAPP** (Trauma Informed Partnering for Safety and Permanence: Model Approach to Partnerships in Parenting)
Completing the Mutual Home Assessment for Prospective Resource Families	**Foster Home Licensing Manual:** https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/fhlicensing.pdf
Conducting at least quarterly face to face visits with licensed foster parents to assess compliance with licensing requirements	

Permanency Plans: Definitions

NC Child Welfare Policy Manual
Permanency Planning: Permanency Options, pg. 87-103

Reunification

To return the child to the biological parents or caretaker from whom the child was removed.

Adoption

To take a child into one's own family by a legal process and raise as one's own child. Adoption is the permanency plan offering the most stability to the child who cannot return to his parents.

Legal Guardianship (with relatives or other kin)

To be legally placed in charge of the affairs of a minor:

1. The custodian has authority to make important decisions (marriage; enlisting in the armed forces; enrollment in school; any necessary remedial, psychological, medical, or surgical treatment) concerning the child and is not subject to supervision by the social services agency.
2. The child cannot be removed without court proceedings.
3. If the youth is between 14 and 17 years of age, the youth may be eligible for Kinship Guardianship Assistance Program (KinGAP).
4. Biological parents continue to have visitation rights, unless visits or parental rights have been terminated by the court.

Legal Custody

To act in a parental role for a minor as outlined by a court order.

1. Legal Custody is less "legally secure" than adoption or guardianship.
2. Legal Custody may be terminated based on a change in circumstances, regardless of fitness of the guardian.
3. The specific rights and responsibilities of the legal custodian are spelled out in the court order and may be as extensive as that of a guardian or the rights and responsibilities may be limited.

Another Planned Permanent Living Arrangement (APPLA)

To reside in a family setting which has been maintained for at least the previous 6 concurrent months.

1. Other permanency options have been determined to be inappropriate.
2. DSS retains legal custody.
3. This plan shall only be an appropriate primary permanency plan for youth who are age 16 or 17.
4. The youth and caregiver have made a mutual commitment of emotional support.
5. The youth and caregiver are requesting that the placement be made permanent.

WHAT ARE THE DIFFERENCES BETWEEN ADOPTION, GUARDIANSHIP, AND CUSTODY?

Adoption	Guardianship	Custody
Birth Parent rights are terminated, either by voluntary relinquishment or by involuntary court action.	Birth parent rights may or may not be terminated.	Birth parent rights may or may not be terminated.
The adoptive parent is given all the rights and responsibilities that once belonged to the birth parents.	Guardian is given legal responsibility for the child and assumes rights or care, custody, and supervision of the child.	Custodian is given legal responsibility to provide care and supervision for the child. Extent of authority is not specified in law and requires specification in the court order.
Adoption is a permanent, lifelong legal relationship.	Birth parent maintains residual rights which include consent to adoption.	Birth parent maintains residual rights which include consent to adoption.
	Guardianship lasts until the child turns 18 or is emancipated, or the guardianship is terminated by juvenile court order.	Custody lasts until the child turns 18 or is emancipated, or custody is terminated by juvenile court order.
	Guardian may be removed upon showing of unfitness.	Custodian may be changed on the basis of change in circumstances upon petition to the court.

Fostering Connections to Success and Increasing Adoptions Act of 2008

(H.R. 6893/P.L. 110-351)

The Fostering Connections to Success and Increasing Adoptions Act (H.R. 6893/P.L. 110-351) provided help to hundreds of thousands of children and youth in foster care by promoting permanent families for them through relative guardianship and adoption and improving education and health care. Additionally, it extended federal support for youth to age 21. The act also offered many American Indian children important federal protections and support.

Fostering Connections provides increased support for kinship caregivers, increased incentives for children to be adopted out of foster care, and efforts to improve outcomes for children in foster care and those who age out of care. While North Carolina already had in place some of the mandates of this federal law, the following are provisions that affect child welfare policy and practice in our state:

- **Notice to Relatives When Children Enter Care.** Requires agencies to provide notice to all adult grandparents and other adult relatives of a child within 30 days after the child is removed from his or her home.
- **Adoption Assistance.** Increases opportunities for more children with special needs to receive federally supported adoption assistance without regard to the income of the birth families from whom they were originally removed.
- **Health Care Coordination**. Requires the state Division of Social Services to work with the state Medicaid agency to create a plan to (1) coordinate health care for children in care to ensure appropriate screenings, assessments, and follow-up treatment; (2) share critical information with appropriate providers; and (3) provide oversight of prescription medications.
- **Educational stability.** Requires child welfare agencies to coordinate with local education agencies to ensure that children remain in the school they are enrolled in at the time of placement into foster care, unless that would not be in the child's best interests. Includes increased federal funding to cover education-related transportation costs.
- **Making older children who exit foster care eligible for additional supports.** Clarifies that children 16 and older who are adopted from foster care or who exit foster care to live with a relative guardian are eligible for independent living services and for education and training vouchers.
- **Helping older youth successfully transition from foster care.** Requires agencies to help youth develop a detailed personal transition plan during the 90-day period immediately before they exit from care.

Preventing Sex Trafficking and Strengthening Families Act of 2014 (Public Law 113-183)

Key Provisions Effective October 2015

The Preventing Sex Trafficking and Strengthening Families Act of 2014 (P.L. 113-183) was signed into law by President Barack Obama on September 29, 2014. The purpose of this legislation is to identify and protect children and youth at risk of sex trafficking, improve opportunities for children and youth in foster care, support permanency, improve adoption incentive payments, and extend the family connections grant program.

Preventing Sex Trafficking Component:

- Child welfare agencies must identify, report, and document services for any youth who is at risk of becoming a sex trafficking victim or who is a sex trafficking victim, including those not removed from the home, or those who have run away from foster care.
- Child welfare agencies must develop and implement protocols to locate children missing from foster care (and determine whether the child is a sex trafficking victim)
- Project NO REST (North Carolina Organizing and Responding to the Exploitation and Sex Trafficking of Children): Five-year grant with Administration for Children and Families (ACF) awarded to the University of North Carolina at Chapel Hill School of Social Work will help implement P.L. 113-183 and increase awareness of human trafficking affecting children and youth involved in the NC child welfare system

Strengthening Families/Supporting Permanency Components:

"Reasonable and Prudent Parent Standard"

- Agencies must implement a "reasonable and prudent parent standard" for decisions made by a foster parent (or a designated official for a childcare institution)
- Reasonable and prudent standard means:
  - ✓ Careful and sensible parental decisions that maintain the health, safety, and best interests of a child
  - ✓ While encouraging the emotional and developmental growth of the child
  - ✓ Used when determining whether to allow a child in foster care to participate in extracurricular, enrichment, cultural, and social activities
- This "reasonable and prudent parent standard" is intended to promote "normalcy" for youth in care, allowing youth to engage in healthy and developmentally appropriate activities that promote well-being
- The Reasonable and Prudent Parent Standard became state law in North Carolina in 2015.
- NC Resources: NC Child Welfare Manual: Permanency Planning Services: Preparing Parents, Children and Providers for Placement pg. 43-44.
  - ✓ *Reasonable and Prudent Parenting Activities Guide*
  - ✓ *Applying the Reasonable and Prudent Parent Standard*

Preventing Sex Trafficking and Strengthening Families Act of 2014

(Public Law 113-183)
Strengthening Families/Supporting Permanency Components (cont.)

Another Planned Permanent Living Arrangement (APPLA)

- Can be a primary or concurrent permanency plan for youth 16 and older
- Used only when other options such as reunification, adoption, guardianship, or custody are not appropriate or not in the best interests of the youth
- Permanency planning hearing must document agency's efforts to ensure that caregiver is following the "reasonable and prudent parent standard"

Case Planning/Transition Planning

- Youth ages 14 and older must be allowed to participate in the development of his/her own case plan
- Youth has the option to identify and add 2 members to the planning team (who are not the child welfare worker or the foster parent)
- One individual identified by the youth may be designated as an advisor regarding the application of the "reasonable and prudent parent standard"
- Applies to initial case plan and any revisions to the case plan
- Youth in agency custody, beginning at age 14, and each year until youth is discharged from care, receives a copy of consumer credit reports and is assisted with interpreting and resolving any inaccuracies
-

Strengthening Families/Supporting Permanency Components continued on next page

Preventing Sex Trafficking and Strengthening Families Act of 2014 (Public Law 113-183)

Strengthening Families/Supporting Permanency Components (cont.)

Documents to Accompany Youth Leaving Foster Care

- At least 90 days before youth attains 18 years of age, North Carolina policy requires a determination of availability and/or provides assistance obtaining thesedocuments
- Documents to be provided to youth 18 and older leaving foster care:
  - ✓ Certified copy of youth's birth certificate
  - ✓ Social Security card
  - ✓ Health Insurance Information (such as Expanded Medicaid to age 26 per Affordable Care Act)
  - ✓ Health/Medical Records (such as Immunization records and Child Health History Form (DSS-5207)
  - ✓ Education Records (such as Education Status Component (DSS-5245)
  - ✓ Driver's License or identification card

Placement of Children in Foster Care with Siblings

- Sibling defined to include:
  - ✓ An individual who is considered by State law to be a sibling of the child
  - ✓ An individual would have been considered a sibling of the child under State law but for a termination or other disruption of parental rights, such as the death of a parent.
- Relative notification to include diligent efforts to notify relatives and other persons with legal custody of a sibling of a youth in nonsecure custody
- Provides opportunity for adult siblings and/or adults with custody of a sibling to be placement resources and/or participate in the case planning for a youth in custody
  Review at least quarterly the ability to place siblings together, if availability of a placement for all is the reason the siblings are not placed together.

For more information about the Preventing Sex Trafficking and Strengthening Families Act see:
http://www.ncsl.org/documents/cyf/Preventing_Sex_Trafficking_and_Strengthening_Families_Act.pdf

Applying the Reasonable and Prudent Parent Standard

1. Is this activity reasonable and age-appropriate?
2. Are there any foreseeable hazards?
3. How does this activity promote social development?
4. How does this activity normalize the experience of foster care?
5. Will this activity violate a court order, juvenile justice order, a safety plan, a case plan, or a treatment plan or person-centered plan (PCP)?
6. Will this activity violate any policy or agreement of my licensing agency or the child's custodial agency?
7. If appropriate, have I received consultation from my case worker and/or the child's caseworker?
8. If able and appropriate, have I consulted with this child's birth parents about their thoughts and feelings about their child participating in this particular activity?
9. Will the timing of this activity interfere with a sibling or parental visitation, counseling appointment, or doctor's appointment?
10. Who will be attending the activity?
11. Would I allow my birth or adopted child to participate in this activity?
12. How well do I know this child?
13. Is there anything from this child's history (e.g. running away, truancy) that would indicate he may be triggered by this activity?
14. Does this child have any concerns about participating in this activity?
15. Has this child shown maturity in decision making that is appropriate for his age and ability?
16. Does this child understand parental expectations regarding curfew, approval for last minutes changes to the plan and the consequences for not complying with the expectations?
17. Does this child know who to call in case of an emergency?
18. Does this child understand his medical needs and is he able to tell others how to help him if necessary?
19. Can this child protect himself?
20. When in doubt, refer to number 7.

Adapted from Florida's *Caregiver Guide to Normalcy*

http://www.kidscentralinc.org/caregiver-guide-to-normalcy/

REASONABLE AND PRUDENT PARENTING ACTIVITIES GUIDE

The Reasonable & Prudent Parenting Standard is a requirement for IV-E agencies per Federal Law PL 113-183 and it became SL 2015-135 in North Carolina. The reasonable and prudent parent standard means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encouraging the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of North Carolina to participate in extracurricular, enrichment, cultural, and social activities. Normal childhood activities include, but are not limited to, extracurricular, enrichment, and social activities, and may include overnight activities outside the direct supervision of the caregiver for a period of over 24 hours and up to 72 hours.

This tool is a guide to identify what activities caregivers have the authority (includes signing permissions/waivers) to give permission for a child or youth's participation without the prior approval of their local child welfare agency or licensing agency. The first column in the table shows a category of activities, the second column identifies specific activities within that category that a caregiver has the authority to give permission (or sign whatever might be a part of the activity) without obtaining the agency's approval. The third column identifies those activities that do require the agency's or court's approval.

It is important to realize this is simply a guide as to who has the authority to provide permission. It does not automatically mean that every foster child or youth can participate in any of these activities. It does mean that a reasonable & prudent parent standard is applied in making the decision. The standard is applied to each child and youth individually, based on the totality of their situation. One tool that can be used by caregivers to help apply critical thinking in making these decisions is the Applying the Reasonable & Prudent Parent Standard.

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
1. Family Recreation	• Movies • Community Events such as concert, fair, food truckrodeo • Family Events • Camping • Hiking • Biking using a helmet • Other sporting activities using appropriate protective gear • Amusement park • Fishing (must follow NC General Statute Chapter 113: Any one over age 16 must have a license)	• Any of these events or activities lasting over 72 hours • Target Practice (gun, bow and arrow, cross bow at either formal range or private property) must have local child welfare agency approval and be supervised by adult age 18 or over, abiding by all laws.
2. Water Activities (Children must be closely supervised and use appropriate safety equipment for water activities)	• Structured water activities with trained professional guides and /or lifeguards: rivertubing, river rafting, water amusement park, swimming at community recreation pool. • Unstructured water activities with adult supervision: boating wearing a life jacket, swimming	• Any of these events or activities lasting over 72 hours

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
3. Hunting (using gun, bow and arrow)		Must have local child welfare agency approval, should have biological parent approval and would require the following: • Child/youth must take the NC Hunter's Safety Class • Supervision by a person at least 18 years old or over, who has also taken the above safety course • Documentation that the requirements are met are provided to the local child welfare agency in advance
4. Social/Extra-curricular activities	• Camps • Field Trips • School related activities such as football games, dances • Church activities that are social • Youth Organization activities such as Scouts • Attending sports activities • Community activities • Social activities with peers such as dating, skateboarding, playing in a garage band, etc • Spending the night away from the caregiver's home	• Any of these events or activities lasting more than 72 hours • Target Practice (gun, bow and arrow, cross bow at either formal range or private property) must have local child welfare agency approval and be supervised by adult age 18 or over, abiding by all laws. • Playing on a sports team such as school football would require both the birth parents' approval and the local child welfare agency approval

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
5. Motorized Activities	Children and caregivers must comply with all laws and use appropriate protective/safety gear. Any safety courses that are required or available to operate any of the vehicles/equipment listed must be taken. Children <u>riding in</u> a motorized vehicle with an adult properly licensed if required including but not limited to: • Snowmobile • All-terrain vehicle • Jet ski • Tractor • Golf cart • Scooter • Go-carts • Utility vehicle • Motorcycle State laws must be followed regarding operating motorized equipment or vehicle including but not limited to: • Snowmobile	• Children may not be a passenger on a lawnmower.

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed any time an activity is in conflict with any court order or supervision/safety plan)		
	• All-terrain vehicle (must be 8 years of age to operate and anyone less than 12 years of age may not operate an engine capacity of 70 cubic centimeter displacement or greater; no one less than 16 may operate an engine capacity of 90 cubic centimeter displacement or greater and NO ONE under 16 may operate unless they are under the continuous visual supervision of a person 18 years or older per NC § 20-171.15) • Jet ski (may be 14 years of age with boating safety certification, otherwise must be 16 or older-NC § 75A-13.3) • Tractor (must be 15 to operate NC § 20-10) • Golf cart (must be 16 to operate NC § 153A-245) • Scooter/Moped (No one under age 16 may operate a moped and no license is required NC § 20-10.1)	

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed any time an activity is in conflict with any court order or supervision/safety plan)		
	• Go-carts • Utility vehicle • Lawn mower may not be operated by anyone below age 12 • Motorcycle (No one under 16 may acquire a license or learner's permit. No one less than 18 may drive a motorcycle with a passenger. NC § 20-7)	

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed any time an activity is in conflict with any court order or supervision/safety plan)		
6. Driving	The following persons can be the required second signature for a youth's permit or license: • Youth's parent or guardian • A person approved by the parent or guardian • A person approved by the Division • Specifically for children in custody: Guardian ad litem or attorney advocate; a case worker; or someone else identified by the court of jurisdiction The youth who is 16 or older may acquire insurance and is responsible for the premium and any damages caused by the youth's negligence. This does not preclude a foster parent from adding a youth to their insurance. A driver's permit is required to "practice" driving in NC and cannot be obtained prior to age 15.	

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed anytime an activity is in conflict with any court order or supervision/safety plan)		
7. Travel	All travel within the United States less than 72 hours	• All travel more than 72 hours • All travel outside the country
8. Employment/Babysitting	Youth 14 years and older and following NC § 95-25.5. • Interview for employment • Continuation of current employment • Does not interfere with school *Sexually aggressive and physically assaultive youth may not babysit other children	Youth is 13 years or younger
9. Religious Participation	Attend or Not attend a religious service of the child's choice	Notify worker when the child and the biological parent and/or foster parent choices are in conflict.
10. Cell Phone		This is a collaborative decision between the placement provider, the local child welfare agency worker, and the youth.

Child Activity Category	Examples of normal Childhood Activities caregivers can approve independently	Examples of childhood activities the local child welfare agency or licensing agency must approve or obtain a court order
(Local child welfare agency or licensing agency approval or new court order is needed any time an activity is in conflict with any court order or supervision/safety plan)		
11. Child's Appearance	• Interventions requiring medical treatment for lice and ring worm	• When the child and biological parent choices are in conflict such as with perms, color, style, relaxers, etc. • Ear piercings must include biological parent in decision • Permanent or significant changes including but not limited to: o Piercing (Per NC § 14-400 it is illegal for anyone under 18 to receive a piercing (other than the ears) without consent of custodial parent or guardian. o Tattoos (Per NC § 14-400 it is illegal for anyone under 18 to receive a tattoo.)
12. Leavingchildhome alone		• The issue of being left alone (in any situation) needs to be discussed and agreed upon in CFT.

*Adapted from Washington State Caregiver Guidelines for Foster Childhood Activities

Every Student Succeeds Act (ESSA)

What is it?

Every Student Succeeds Act (ESSA) is a 2015 federal law that provides key protections for children in foster care. The law supports the Fostering Connections to Success and Increasing Adoptions Act of 2008 by detailing the critical process of continuous collaboration between local child welfare agencies and education agencies that will address educational stability and improving educational outcomes for children in foster care.

Why is it so important?

Because children in foster care: [1]

- Experience much higher levels of residential and school instability than their peers
- Experience significantly more unscheduled school placement changes
- Are much more likely to struggle academically and to fall behind in school
- At age 17 are significantly less likely to graduate from high school or obtain post-secondary education

Because school stability reduces loss and contributes to social and emotional well-being for children

What are the goals? [2]

- Decrease the number of school placement changes for children in foster care
- Ensure immediate enrollment of foster children when school placement change is necessary
- Remove/limit barriers to educational stability (such as transportation costs and enrollment documentation)
- Ensure that foster youth receive equivalent educational opportunities as the general population

What does the child welfare worker do?

- Prioritize obtaining and documenting information regarding the educational status of all children on your caseload (see DSS 5245 and DSS 5137)
- Prioritize the collaboration between your agency and your local education agency to ensure that:
  - ✓ Every child remains in his or her school of origin unless a determination is made that it is not in his or her best interest (see DSS 5137)
- Provide educational status information to child placement providers

Where is this information documented?

- Child Education Status (DSS 5245) OR
- NC Best Interest Determination Form (DSS 5137)
- Foster Child Notification of Placement (Change) Form (DSS 5133)
- Foster Child Immediate Enrollment Form (DSS 5135)

[1]National Youth in Transition Database. Unpublished analyses (April 2016). Administration on Children, Youth, and Families, Health and Human Services.

[2]"Every Student Succeeds Act: Ensuring Educational Stability for Children and Youth in Foster Care in North Carolina," NC Division of Social Services and NC Department of Public Instruction: Joint Guidance. January, 2017.

Placement Decisions

Kinship Care:

Kinship is the self-defined relationship between two or more people and is based on biological, legal, and/or strong family-like ties. When children cannot be assured safety in their own homes, the best alternative resource can often be found within the extended family and other kin.

In keeping with Federal law, North Carolina law and policy require that, when a juvenile must be removed from his home, the county DSS Director shall give preference to an adult relative or other kin when determining placement provided that (1) the placement is assessed by the agency to be in the best interests of the child in terms of both safety and nurture; and (2) the prospective caregiver and the living situation are assessed and determined to meet relevant standards.

Reference: NC Child Welfare Policy Manual: Permanency Planning, Placement Decision Making, Maintaining One Single, State Placement, pgs. 37-41

Siblings:

Siblings must be placed together, whenever possible, unless contrary to the child's well-being or safety. Through the eyes of the child, it is traumatic to be removed from parents and home. To be separated from siblings adds to the impact of loss and trauma. When siblings can remain together in an out of home placement, there can be a greater sense of continuity of family. Frequently, older children will have had some responsibilities for caring for younger siblings when in their own home, and they may feel worried and protective regarding these siblings if separated from them. Likewise, the younger siblings may have looked to their older siblings for comfort and guidance.

Because it is important to place siblings together, the agency shall recruit and prepare foster families who are willing to take sibling groups. Foster families need special preparation regarding issues of sibling relationships among children in foster care, as well as the impact of separation and loss on those relationships.

Reference: NC Child Welfare Policy Manual: Permanency Planning Services: Placement Decision Making: Maintaining One, Single, Stable Placement pgs. 35

Discipline Policy for Children in Agency Custody:
Corporal Punishment is not allowed

Children who have been abused or neglected do not respond appropriately to corporal punishment, since often they have already experienced and survived extreme discipline from their parents.

Kinship Care Providers:
Kinship care providers may not be aware of the impact of abuse and may be reluctant to agree to a non-corporal punishment policy. The agency shall discuss and formalize a child-specific alternative discipline plan for children in agency custody.

Licensed Providers:
Agency policy and practice shall ensure that licensed placement providers are verbally informed of and provided with written policy addressing the following issues regarding discipline:

- Child discipline must be appropriate to the child's chronological age, intelligence, emotional make-up, and experience
- No cruel, severe, or unusual punishment shall be allowed
- Corporal punishment is prohibited
- Deprivation of a meal for punishment, isolation for more than one-hour, verbal abuse, humiliation, or threats about the child or family will not be tolerated

Reference: NC Child Welfare Policy Manual: Permanency Planning Services: Preparing Parents, Children and Providers for Placement pgs. 44

Voluntary Placement Agreements (VPA)

Voluntary Placement Agreements (VPA) should not be used in cases of abuse or neglect. A VPA may be appropriate when:

- a parent or guardian is requesting time-limited placement due to a family crisis; or
- the Court orders a parent to arrange for placement for a child adjudicated delinquent or undisciplined

The agreement shall be signed by the agency representative and the parent or guardian. A VPA does not confer on the agency the degree of authority and control that judicially obtained legal custody confers. A VPA cannot exceed 90 consecutive days without a court hearing that results in a judicial determination that the placement is in the best interests of the child.

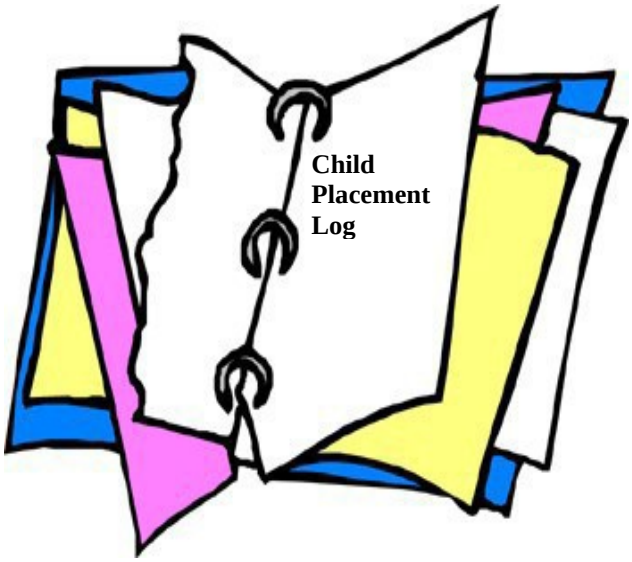
Kinship Guardianship Assistance Program (KinGAP)

What: Legal guardianship is granted to an individual who demonstrates a strong commitment to permanently caring for a youth between the ages 14-17 who demonstrates a strong attachment to the prospective legal guardian. Monthly cash assistance begins the month after legal guardianship is established.

When: Court determines that reunification and adoption are not appropriate permanency options for a youth 14-17 years old who is the placement responsibility of a County DSS and has been placed in the licensed foster home of the prospective guardian for a minimum of 6 months.

Permanency Planning and Foster Home Licensing

Key Documentation Policies



A log shall be maintained in each **child's record** which outlines the child's placement history. This log should contain a record of the child's prior placements with names of caregivers, addresses, dates of placement and specific reasons for the move.
NC Child Welfare Policy Manual, Permanency Planning Services: Documentation and Recording Keeping pg. 117-121.
A log shall be maintained in the **foster parent's record** which includes a chronological record of all placements of children receiving care in the home, including the dates of the care and an assessment of the care.

(10A NCAC 70G .0506CLIENT RECORDS)

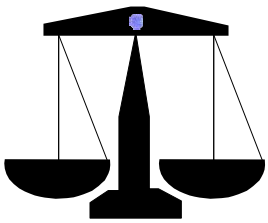
A child's record shall contain **annual pictures** of the child. Pictures in the case record and with the court report keep those involved with the child focused on the child's sense of time and the urgency for permanence.

Additional pictures of the child can be maintained in the record or **Lifebook** so that they are available to the child, his/her family or his/her adoptive family after resolution of the case.

Completion and maintenance of the Lifebook is a joint responsibility among social worker, foster parent, and the birth family.

Lifebook must start within 30 days of a child coming into care. Early in the work with the family, the social worker should begin building the child's life book by taking and procuring photographs of the child, birth family and foster placement.
Policy Manual, Permanency Planning: Out of Home Placement Services: Ongoing Placement Services, pgs. 55-57

Juvenile Court Case Statutory Timeline



DAY 0: Juvenile Petition and Non-Secure Order filed

DAY 7: Initial hearing to determine need for continued nonsecure custody (may be continued for up to ten business days with consent). Subsequent Hearings within seven business days and then 30 calendar day intervals.

DAY 60: Adjudicatory hearing no later than 60 days from filling unless continued

DAY 90: Dispositional Hearing should take place immediately following adjudication. If not, it shall be concluded within 30 days of the adjudication hearing.

DAY 180: Review of custody order must be held within 90 days of disposition with a subsequent review within six months.

DAY 365: Permanency Planning Hearing must be held within 12 months of initial order removing custody and may be combined with reviews with subsequent permanency planning hearings at least every six months.

Source: **NC Child Welfare Policy: Cross Function Topics, Juvenile Court**. https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/cross-function.pdf

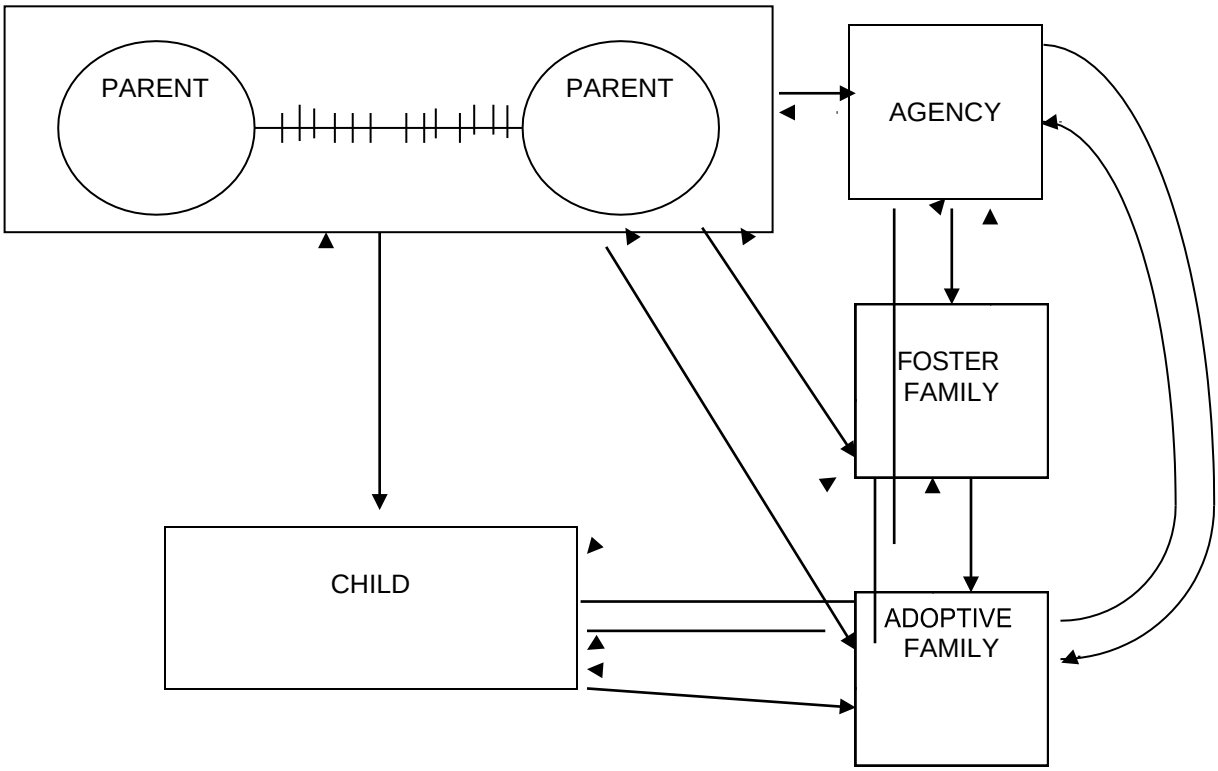
Frequency of Contacts

During Provision of Permanency Planning Services

Worker	Type of Contact	With Whom	Frequency
Permanency Planning Worker	Face-to-face	The Child, Child's Parent(s)/Caretakers AND Placement Provider	A face-to-face contact with the child and at least one placement provider (if more than one resides in the home) must occur within 7 days of initial and subsequent placements. Face-to-face contact must be made with all parents or caretakers within 7 days of initial placement.
Permanency Planning Worker	Face-to-face	The Child	At least once monthly (which includes alone time) The majority of the visits (4 out of 6) must be held in the child's residence
Permanency Planning Worker	Face-to-face	The Placement Provider (licensed or kinship)	Monthly, with at least one placement provider (if more than one adult caretaker resides in the home) At least once per quarter with both spouses and any other adult caretakers who reside in the home.
Permanency Planning Worker	Contact of some type	COLLATERALS (Persons significant to the child's case other than placement providers)	Contact when indicated by the child and family's needs.
Permanency Planning Worker	Face-to-face	Child's Parent(s)	Face-to-face contact with all parents or caretakers at least monthly, if reunification is the primary or secondary plan If the parent is living in a home to which the child could be returned, half of these contacts must be held in the parent's home.(3 out of 6
Foster Home Licensing Worker	Face-to-face	Placement Provider	Minimum of quarterly, with at least half of these visits occurring in the foster home. Coordinate with Permanency Planning worker whenever possible.

Source: NC Child Welfare Policy Manual, Permanency Planning Services: Out of Home Placement Services: Required Contacts

Alliance Model of Child Welfare Practice



The above diagram, the "**Alliance Model,**" is a way of viewing the many partnerships in child welfare services that impact the child's safety, permanence, and well-being. The lines and arrows in the diagram represent the alliances among the important people in the child's life: the birth families, the foster families, the adoptive families, and the agencies.

Shared Parenting represents an active alliance among all important adults in the child's life. It is the goal of these important adults to work together as a team to form a positive alliance with the birth parents. The positive alliance with the birth parents benefits the child and all the team members.

The goal of this team of adults is to maintain, preserve, and strengthen the connection between the child and his/her birth parents. When the child perceives that the adults are aligned and working as a team, the child benefits emotionally and psychologically and can focus on the tasks of childhood.

Adapted from Thomas D. Morton, "Partnerships in Parenting." Child Welfare Institute and *Trauma Informed Partnering for Safety and Permanence: Model Approach to Partnerships in Parenting Leaders Guide*, 2013. Used by permission: Children's Alliance of Kansas.

Shared Parenting Benefits Everyone!

Benefits for the Child

- Consistency of care
- Separate alliances do not have to be formed
- Child can be children (vs. worrying about the parents)
- Fully informed foster parents = child's needs more fully met

Benefits for the Birth Parents

- Can play a role in child's adjustment to foster home
- Can feel valued through sharing their insights with foster parents
- Can experience decreased anxiety about child's care
- Can learn new skills for managing difficult behaviors

Benefits for the Foster Parents

- Can ease child's adjustment in the home by gaining valuable information
- Child's behavior may improve
- May experience less conflicts with birthparents
- May be able to continue to play a role in child's life after reunification

Benefits for the Agency

- May reduce worker time (transportation, supervising visits, etc.)
- Less conflicts and emotional upheaval of children after visits
- Plan for permanence may proceed more quickly

Making Shared Parenting Work

NC Child Welfare Policy Manual
Permanency Planning Services: Shared Parenting, pg. 82-86

A social worker should facilitate a face to face meeting between the birth parents and foster parents within 14 days of placement to ensure that the partnership has a strong beginning and is supported by the agency. This requires planning by social workers so that both families understand the purpose of the meeting (to discuss the care of the child, not "the case".)

Every effort must be made to locate any absent/non-residential parents. Including non-residential parents early in the shared parenting meetings encourages both parents of the child to become more involved in the child's life. (Depending on the nature of the relationship between the residential parent and the absent/non-residential parent, a separate meeting between each birth parent and foster parent may be necessary).

A meeting site that is a neutral location that allows for privacy is important. Sometimes neighborhood recreation or social centers are good options instead of the agency office.

Tips that social workers can use:

- Ask foster and birth parents at placement how they would like to meet (consider facilitating a conference call or web meeting if distance prevents a parent from attending a face to face meeting)

- Describe shared parenting meetings in positive terms

- Serve as positive role model to foster parents and birthparents
  - Talk positively about birth parent to foster parent
  - Talk positively about foster parent to birthparent
  - Maintain confidentiality
  - Describe foster parent in non- identifying terms at placement

- Brief foster parents on birth parents' fears and needs and help foster parents understand these needs.

- Talk openly with all about their concerns
- Share information essential to shared parental responsibilities with foster parents and birth parents, i.e., medical information, school progress, goals, and the child's strengths and needs

- Set clear boundaries and ground rules for contact that include input from the birth family, the foster family, and the agency
  - Address personal and emotional safety issues for the child, birth family, and foster family
  - Set ground rules regarding phone calls, visitation, transportation

- ❖ Assist foster parent/ birth parent in managing conflict
  - o Recognize fears of both parties
  - o Focus on strengths
  - o Look beyond behaviors to identify needs
  - o Develop interventions that meet needs

- ❖ Assist foster parent/ birth parent in understanding cultural differences
  - o Cultivate a mutual understanding and appreciation of religious beliefs and practices
  - o Openly discuss differences in rituals, family experiences, dress and appearance preferences, etc.

- ❖ Convey the benefits of aligning around parenting and discipline practices to insure consistency for the child

- ❖ Facilitate conversations between birth parent/ foster parent
  - o Discuss non- threatening topics
  - o Find common areas of interest
  - o Recognize both families' strengths
  - o Use of self- disclosure
  - o Reflect feelings
  - o Encourage exchange of information between birth parent and foster parent, i.e. favorite foods, toys, sleep behaviors, pictures, school progress, etc.

- ❖ Encourage foster parent and birth parent to attend all school and medical appointments

- ❖ Encourage the two families to work on the child's life book together with the child

- ❖ Encourage the two families to attend parenting classes together

- ❖ Initiate discussion with families about strategies that they may use that will support the child's relationship and attachment with both sets of parents in order to avoid dividing the child's alliance.

Non-Resident Parents are Family, Too

Involving Non-Resident Parents in Shared Parenting

Both maternal and paternal parents should be involved in a shared parenting meeting.

The social worker is responsible for engaging both maternal and paternal parents in the planning process for the child. A parent that has been referred to as absent or non-resident may have more information than the DSS may have thought they were able to share regarding the child's development. Working to develop an early partnership that includes that absent parent may provide an excellent foundation for them to not only become more involved in their child's life, but also may be a resource the child can reunify with and or be a long-term support.

Ask the question: How can the DSS obtain the absent parent's involvement?

- If the birth mother and father have a tenuous relationship, consider facilitating separate meetings between each birth parent with the foster parent.
- If one birth parent is unable to travel a long distance for a meeting, consider facilitating a phone conference call or web meeting to begin developing a relationship between the birth and foster parent.

Preparing for Permanency Planning

Preparing the Family of Origin

- Why remove?
- Reunify?
- Involvement in move
  - information
  - schedule
  - paper trail
  - supports
  - regret
  - planning
- Anger and frustration acknowledged
- Future possibilities

Preparing the Child

- Developmentally accurate
- Provide full and complete information
- Support over time
- Repetition
- Watch, listen, and analyze
- History

Preparing the Foster Caregiver

- Provide full and complete information
- Emphasize the connection between the child and the birth family
- Ensure access to social worker
- Make them feel part of the team
- Give them a sense of the future

Preparing the Adoptive Caregiver

- Provide full and complete information
- Emphasize the connection between the child and the birth family
- Ensure access to social worker
- Adoption issues over the life cycle

Adapted from: Beeler, NG, Rycus, JS & Hughes, RC. (1988). Effects of abuse and neglect on child development: A training curriculum. Columbus, OH: Institute for Human Service

Consider This!

Permanency Planning Case Considerations

- **Were all reasonable efforts made to protect the child in his/her home?**
- **Were reasonable efforts made to offer safe, permanent, nurturing, substitute care in the least restrictive, most homelike setting where visitation with the birth parents can be easily arranged, if appropriate?**
- **Were the child and parents prepared for the removal and separation and explained the reasons for removal, the legal process involved, and the need for an Out of Home Services Agreement?**
- **Was the placement resource chosen based on the child's needs, provided with the necessary information prior to the child's arrival and provided with sufficient resources to meet the child's physical, medical, and psychological needs?**
- **Were reunification services made available to the child and his parents, guardian, or custodian after removal from the home, unless the juvenile court determined that reunification would be futile or inconsistent with the child's need for a safe, permanent home within a reasonable amount of time?**

NC Child Welfare Policy Manual: Permanency Planning

Agenda
Day Seven

9:00 –9:10……..	I. Welcome
9:10–10:30…….	II. Family Services Agreement
10:30 – 10:45……	**BREAK**
10:45 – 11:15…….	III. Family Time
11:15 – 11:25…….	IV. Change Activity
11:25–11:50……..	V. Monitoring and Reassessment A. Re-evaluating the Family Services Agreement B. Relapse and Motivation
11:50 –12:00…….	VI. Case Updates A. Purpose B. Reassessment Requirements
12:00 – 1:15 …….	**LUNCH**
1:15 – 1:30 …….	VII. Progress Section of Services Agreements
1:30-2:30 ……..	VIII. Placement Reassessment Requirements A. Family Strengths/Needs B. Permanency Planning Reviews C. Family Reunification Assessment
2:30-2:45……..	**BREAK**
2:45-3:15……..	D. Services Agreement Review
3:15-3:30 ……	IX. Progress: A Foster Youth Example Video
3:30-4:00……..	X. Wrap-up

Hobgood Foster Care Permanency Planning Scenario

Monday morning following the child welfare worker's last visit a phone call was received from the school reporting that Burt had numerous large bruises on his arms and legs. The reporter stated that Burt had informed the school authorities that his mother had left on Saturday night and he had not seen her since. He had not eaten since then, except for some crackers and potato chips he found in the cabinet. This report was screened in and accepted for neglect: inappropriate supervision, inappropriate discipline, improper care, and substance abuse. A response time of immediate was determined due to Burt being at immediate risk of harm from neglect and the family assessment track waschosen.

The child welfare worker attempted to reach Burt's mother by phone and at home, but there was no response. Unable to reach Burt's mother, worker arrived at school and found Burt eating a sandwich the school cafeteria had provided for him. Burt said that he had not eaten since Saturday, as there was no food in the house that "he could cook." When questioned by the worker, Burt stated that his mom started drinking again Saturday afternoon, and when he yelled at her "not to do that again," she started hitting him. His bruises were light blue, although darkening, and appeared to be in the shape of belt marks. When asked about the bruises, Burt reluctantly told the worker that his mom hit him with the belt. He did not know where she went when she left but he had not heard from her since. Burt reported that this was the first time he had seen his mom drink and the first time she had hit him since the child welfare worker had been coming to his house.

A phone call to the neighbor, Ms. Grant, revealed that she had gone out of town Saturday and had not returned until late Sunday night. She thought that Burt and his mother were doing fine. She had contact with Sandy Hobgood at least once or twice a week and saw Burt nearly every day. She was disappointed to hear that Sandy was gone again. She stated, "I thought they were doing so well!"

A review of the worker's contacts with Ms. Hobgood revealed that she had completed an assessment at Mental Health but did not see the need for ongoing treatment with them. She attended six of the twelve visits scheduled. Ms. Hobgood had not wanted to take parenting classes but wanted the child welfare worker to provide her with material about alternative discipline techniques, which she would review with the worker. The child welfare worker had done so but it was obvious during visits that Ms. Hobgood had not reviewed the materials. She had tried putting Burt in time out and taking his Xbox away, but Burt had laughed at her. Ms. Hobgood had pretty much just let Burt do what he wanted instead. Burt also met with the school psychologist and was diagnosed with dyslexia and anger issues. Ms. Hobgood had failed to follow-up with meeting with the school to develop an IEP for Burt. During visits both at home and at school, he stated that everything was going well, there had been no hitting, he had not been left alone, and he was eating regularly.

Based upon all the available information and the absence of Burt's mother, the child welfare worker assessed the safety level to be unsafe for Burt to remain in the home. The child welfare worker staffed this information, by phone, with her supervisor and determined that an alternative placement for Burt was needed. Since Burt's mother was unavailable to provide input regarding placement, the worker contacted the paternal grandparents and maternal grandmother. Both expressed concern about Burt but reported they could not be fulltime placement resources for him (as they had explained during the first CFT meeting held when child welfare services first became involved with Burt and his mother. Due to the mother's absence and the need to assure Burt's immediate safety there was no way to complete a CFT prior to Burt coming into custody. The two-level decision was made by the child welfare worker and the Supervisor to seek custody of Burt. The child welfare worker assumed temporary custody of Burt and brought him back to the agency. The child welfare worker completed the paperwork and the judge signed the juvenile petition and order for non- secure custody granting DSS custody of Burt. A seven-day hearing was scheduled for Thursday (four days fromnow).

Since there were no relatives or kin willing or able to provide placement for Burt and since the agency is still unable to locate Burt's father, a foster home was selected. The McDougals have been foster parents for almost 13 years. "Mr. Mac" or "Mac," as he is called by the foster children in their home, has worked at the local sheet rock manufacturing plant almost his entire adult life. "Mrs. Mac" is a retired special needs school teacher who sells Avon products from her home. They have two adult birth sons who are on their own now. The McDougals have plenty of experience with boys Burt's age and have attended several trainings regarding working with children with behavioral issues including anger issues. They live within 5 miles of Burt's home and are in the same school district.

Burt had mixed feelings when he was told he would have to move. He is angry because he doesn't want to leave his mom or his home. Burt is afraid that his mother will be mad because he told the school about her leaving him at home alone. He is also relieved that he won't be home alone again tonight and will not have to go hungry.

The child welfare worker took Burt to the McDougal's, introduced Burt to the family, and did a tour of the house. The child welfare worker then took Burt to lunch and made sure that he felt comfortable staying with the McDougals, which he said he did. The child welfare worker explained to Burt that once she speaks to his mother, she would arrange for family time/visits between them and that she would be back to see him day after tomorrow. The child welfare worker also explained to Burt that she would be working with his mother to try and get him back home as soon as possible.

Sandy Hobgood called the agency the next day after Burt was placed. She was angry that Burt was not able to come home right away since she was "back" and available to care for him. Ms. Hobgood stated that she felt the agency over-reacted by removing Burt. She admitted that she was drinking 'a little' when Burt had "set her off" and she hit him with the belt. Ms. Hobgood expressed that she did not intend to leave Burt alone overnight, but she was so angry with him that she thought she should get out of the apartment for a while. She went to a friend's house and they had gone out that night and she admits that the drinking continued into the next day. She said that she never drank for that long before. She stated that she was really 'stressed out'. Ms. Hobgood wanted to know what she had to do to get Burt back home.

The worker told Ms. Hobgood that a CFT would be a good place to begin making some plans to get Burt back. Ms. Hobgood agreed, and a meeting was scheduled for the next day. The child welfare worker also arranged that a visit would take place with Ms. Hobgood and Burt after the CFT. Social worker also explained to Ms. Hobgood about shared parenting meetings and asked if she would be willing and able to talk to the foster parents for a bit about Burt and how to take care of him. Ms. Hobgood agreed. SW asked Ms. Hobgood to come in about 30 minutes prior to the meeting to complete some paperwork.

The next day prior to the CFT the worker and Ms. Hobgood completed the ICWA checklist and determined that Burt was not ICWA eligible. They also completed the foster care Medicaid application, Health History Form, and Child Education Status Component. The child welfare worker informed Ms. Hobgood that a physical was scheduled for next week for Burt.

The child and family team included the paternal grandparents, the maternal grandmother, the neighbor, Ms. Grant, and Burt's teacher. Ms. Hobgood also agreed to allow the McDougals to attend as well. Despite continued efforts the child welfare worker was still unable to locate Burt's father. At the meeting, Burt's paternal grandparents still do not feel able to care for Burt fulltime nor have they had any contact with his father. Ms. Curtis, Burt's maternal grandmother, attended the meeting and reported how upset she became when she learned that her daughter had left Burt alone again. She decided that with her age and current health problems, there was no way she could take him into her home. She would be willing to have him on an occasional weekend "if it would help." Mrs. Grant agreed to offer support in terms of supervision for brief periods of time, but she cannot be a fulltime resource for Burt. The McDougals told Ms. Hobgood Burt could live with them until she was able to arrange for him to return home. Ms. Hobgood told the McDougals she was relieved to learn they have experience parenting boys and that Burt will not have to change schools while in their home. Burt also attended the meeting. He said he likes the McDougals but wants to come home.

During the meeting the family services agreement was completed with Ms. Hobgood agreeing to make an appointment with a counselor to begin discussing ways to manage stress. A Family Time and Contact (Visitation) plan was also completed with Burt and his mom. At the conclusion of the meeting, the child welfare worker met with Ms. Hobgood and the foster parents and reminded them of the purpose of a shared parenting meeting. Ms. Hobgood and the foster parents discussed Burt's likes, dislikes, routine, things that "make him lose his temper" etc. The child welfare worker gave the foster parents copies of the Health and Education status components. The foster parents and the child welfare worker agreed that it was okay for Burt's mom to come to his physical nextweek.

The family assessment case decision on this new report (based on a new safety assessment, risk assessment, strengths and needs assessment, and the structured case decision) was to find "services needed" and to continue Burt's foster home placement until his safety could be assured in his home.

NORTH CAROLINA
SAFETY ASSESSMENT

Case Name: Hobagood
Case #: 23456 Date: 4-3-2017
County Name: AnyCounty
Date Report Received: 4-3-2017
Social Worker Name: Sally Jones
Children: Burt Hobagood
Caretakers: Sandy Hobagood

Part A. FACTORS INFLUENCING CHILD VULNERABILITY
These are conditions resulting in child's inability to protect self. Mark all that apply to any child.

- ☐ Child is age 0-5.
- ☐ Child has diagnosed or suspected medical or mental condition, including medically fragile.
- ☐ Child has limited or no readily accessible support network.
- ☐ Child has diminished mental capacity.
- ☐ Child has diminished physical capacity.
- ☒ None apply

The vulnerability of each child needs to be considered throughout the assessment. Younger children and children with diminished mental or physical capacity or repeated victimization should be considered more vulnerable. Complete this assessment based on the most vulnerable child.

Part B. CURRENT INDICATORS OF SAFETY
The following list is comprised of safety indicators, defined as behaviors or conditions that describe a child being in imminent danger of serious harm. Assess the above household for each of the safety indicators. Mark "yes" for any and all safety indicators present in the family's current situation and mark "no" for any and all of the safety indicators absent from the family's current situation based on the information at the time. Mark all that apply.

1. Yes (No) Caretaker caused and/or allowed serious physical harm to the child or made a plausible threat to cause serious physical harm in the current assessment as indicated by:

   - ☐ Serious injury or abuse to the child other than accidental.
   - ☐ Caretaker fears he/she will maltreat the child.
   - ☐ Threat to cause harm or retaliate against the child.
   - ☐ Substantial or unreasonable use of physical force.
   - ☐ Drug-exposed infant/child
   - ☐ Caretaker committed act that placed child at risk of significant/serious pain that could result in impairment or loss of bodily function.
   - ☐ Caretaker intended to hurt child and does not show remorse.
   - ☐ Death of a child.

   Comments: _____

2. Yes (No) Child sexual abuse is suspected to have been committed by:

   - ☐ Parent;
   - ☐ Other caretaker; OR
   - ☐ Unknown person AND the parent or other caretaker cannot be ruled out, AND circumstances suggest that the child's safety may be of immediate concern.

   Comments: _____

3. Yes (No) Caretaker is aware of the potential harm AND unwilling, OR unable to protect the child from serious harm or threatened harm by others. This may include physical abuse, emotional abuse, sexual abuse, or neglect. (Domestic violence behaviors should be captured under Indicator 10.)

- ☐ Caretaker fails to protect child from serious harm or threatened harm by other family members, other household members, or other having regular access to the child.
- ☐ An individual(s) with recent, chronic, or severe violent behavior resides in the home or caretaker allows access to the child.

Comments:

4. Yes (No) Caretaker's explanation or lack of explanation for the injury to the child is questionable or inconsistent with the type of injury, and the nature of the injury suggests that the child's safety may be of immediate concern.

- ☐ Medical exam shows injury is the result of abuse; caretaker offers no explanation, denies, or attributes to an accident.
- ☐ Caretaker's explanation for the observed injury is inconsistent with the type of injury.
- ☐ Caretaker's description of the cause of the injury minimizes the extent of harm to the child.
- ☐ Caretaker's and/or collateral contacts' explanation for the injury has significant discrepancies or contradictions.

Comments:

5. (Yes) No Caretaker fails to provide supervision to protect child from potentially serious harm.

- ☐ Caretaker present but child wanders outdoors alone, plays with dangerous objects, or on window ledges, etc.
- ☒ Caretaker leaves child alone (period of time varies with age and developmental status).
- ☒ Caretaker makes inadequate/inappropriate child care arrangements or plans very poorly for child's care.
- ☒ Caretaker's whereabouts are unknown.

Comments: Burt states his mother left Saturday night and he has not seen her since & that he does not know where she is.

6. (Yes) No Caretaker does not meet the child's immediate needs for food or clothing.

- ☒ No food provided or available to the child, or child is starved/deprived of food/drink for long periods.
- ☐ Child appears malnourished.
- ☐ Child is without minimally warm clothing in cold months.

Comments: Burt's mother did not leave any food for him (except Chips & crackers) when she left Saturday night. It is now Monday & Burt has not had anything to eat since Saturday night.

7. Yes (No) Caretaker does not meet the child's immediate needs for medical or critical mental health care (suicidal/homicidal).

- ☐ Caretaker does not seek treatment for child's immediate medical condition(s) or does not follow prescribed treatments.
- ☐ Child has exceptional needs that parents cannot/will not meet.
- ☐ Child is suicidal and parents will not take protective action.
- ☐ Child is homicidal and parents will not take protective action.
- ☐ Child shows effects of maltreatment (i.e. emotional symptoms, lack of behavior control, or physical symptoms).

Comments:_____

8. Yes (No) Physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.

- ☐ Leaking gas from a stove or heating unit.
- ☐ Dangerous substances or objects stored in unlocked lower shelves or cabinets, under sink, or in the open.
- ☐ Lack of water, heat, plumbing, or electricity and provisions are inappropriate (i.e. using stove as heat source).
- ☐ Open/broken/ missing windows.
- ☐ Exposed electrical wires.
- ☐ Excessive garbage or rotted or spoiled food that threatens health.
- ☐ Serious illness/significant injury due to current living conditions (i.e. lead poisoning, rat bites, etc.)
- ☐ Evidence of human or animal waste throughout the living quarters.
- ☐ Guns and other weapons are not stored in a locked or inaccessible area.
- ☐ Dangerous drugs are being manufactured on premises with child present.

Comments:_____

9. (Yes) No Caretaker's current substance abuse seriously impacts his/her ability to supervise, protect, or care for the child.

- ☐ The caretaker is currently high on drugs or alcohol.
- ☒ There is a current, ongoing pattern of substance abuse that leads directly to neglect and/or abuse of the child.

Comments: Ms. Hollywood admitted previously that she left Burt alone after drinking too much. Burt states she was drinking both times she left him alone in the apartment.

10. Yes (No) Domestic violence exists in the household and poses an imminent danger of serious physical harm and/or emotional harm to the child.

- ☐ Child was in immediate danger of serious physical harm by being in close proximity to an incident(s) of assaultive behavior/domestic violence between adults in the household. This includes the child(ren) being in visual or hearing proximity of domestic violence events in the home.

Comments:_____

11. Yes (No) Caretaker persistently describes the child in predominantly negative terms or acts toward the child in negative ways, AND these actions make the child a danger to self or others, suicidal, act out aggressively, or severely withdrawn.

- ☐ Caretaker repeatedly describes the child in a demeaning or degrading manger (i.e. as evil, possessed, stupid, ugly, etc.)
- ☐ Caretaker repeatedly curses and/or puts child down.
- ☐ Caretaker repeatedly scapegoats a particular child in the family.
- ☐ Caretaker blames child for a particular incident, or distorts child's behavior as a reason to abuse.
- ☐ Caretaker repeatedly expects unrealistic behavior(s) for the child's age/developmental stage.
- ☐ Caretaker views child as responsible for the caretaker's or family's problems.

Comments:_____

12. Yes (No) Caretaker's physical ability, emotional stability, developmental status, or cognitive deficiency seriously impairs his/her current ability to supervise, protect, or care for the child.

- ☐ Caretaker has a physical condition that seriously impairs his/her ability to parent the child.
- ☐ Emotional instability, acting out, or distorted perception is seriously impeding ability to parent.
- ☐ Depression or feelings of hopelessness/helplessness immobilize the caretaker, who then fails to maintain child/home.
- ☐ Caretaker is overwhelmed by child's dysfunctional emotional, physical, or mental characteristics.
- ☐ Caretaker's cognitive delays result in lack of knowledge about basic parenting skills.

Comments:_____

13. Yes (No) Family currently refuses access to or hides the child and/or seeks to hinder an assessment.

- ☐ Family currently refuses access to the child and cannot or will not provide the child's location.
- ☐ Family removed the child from a hospital against medical advice.
- ☐ Family has previously fled in response to a CPS assessment.
- ☐ Family has a history of keeping the child away from peers, school, or other outsiders for extended periods to avoid CPS assessment.
- ☐ Family is otherwise attempting to block or avoid CPS assessment.

Comments:_____

14. Yes (No) Current circumstances, combined with information that the caretaker has or may have previously maltreated a child in his/her care, suggest that the child's safety may be of immediate concern based on the severity of the previous maltreatment or the caretaker's response to the previous incident.

- ☐ Prior death of a child.
- ☐ Prior serious harm to any child.
- ☐ Termination of parental rights.
- ☐ Prior removal of any child.
- ☐ Prior CPS substantiation or services needed finding.
- ☐ Prior threat of serious harm to child.
- ☐ Caretaker failed to benefit from previous professional help.

Comments:_____

15. Yes (No) Child is fearful of caretaker, other family members, or people living in or having access to the home.

- ☐ Child cries, cowers, cringes, trembles, or exhibits or verbalizes fear in relation to certain individuals.
- ☐ Child exhibits anxiety, nightmares, or insomnia related to a situation associated with a person in the home.
- ☐ Child fears unreasonable retribution/retaliation from caretaker, others in the home, or others having access to the child.

Comments:_____

16. (Yes) No Other (specify): Burt has numerous large bruises on his arms & legs & he reports his mother hit him with a belt.

Initials ____

Initials ____

THE ALLEGATIONS ALONE DO NOT CONSTITUTE THE NEED FOR A SAFETY INTERVENTION/SAFETY AGREEMENT.

If any Indicators of Immediate Safety are marked "Yes", skip the bottom of this page and continue on the next page.

If all Indicators of Immediate Safety 1 through 16 are "No",

check this box ☐ Safe and complete the part below (the remaining pages do not need to be completed).

SIGNATURES			
Child's Parent or Legal Guardian:	Date Signed:	Child's Parent or Legal Guardian:	Date Signed:
Child's Parent or Legal Guardian:	Date Signed:	CPS Social Worker:	Date Signed:
Other Party:	Date Signed:	CPS Supervisor:	Date Signed:

Who Can I Contact?		
CPS Social Worker's Name:	Phone Number:	Email Address:
CPS Supervisor's Name:	Phone Number:	Email Address:

PART C: SAFETY INTERVENTIONS

Directions: For each factor identified in Section B, consider the resources available in the family and the community that might help to keep the child(ren) safe. Check each response necessary to protect the child(ren) and explain below.

Family Safety Interventions (Safe with a plan)

- ☐ 1. Monitoring and/or use of direct services by county child welfare agency.
- ☐ 2. Use family, neighbors, or other individuals in the community in the development and implementation of a safety agreement.
- ☐ 3. Use community agencies or services.
- ☐ 4. The alleged perpetrator will leave or has left the home--either voluntarily or in response to legal action.
- ☐ 5. A protective caretaker will move or has moved to a safe environment with the child(ren) and there are no restrictions on protective caretaker's access to the child(ren).
- ☐ 6. Identification of a Temporary Safety Provider by the parent with the social worker monitoring.
  - ☐ A Temporary Safety Provider will move into the family home.
  - ☐ The child(ren) will reside in the home of a Temporary Safety Provider.

  Explain why responses 1-5 were insufficient.

Child Welfare Safety Intervention (Unsafe)

- ☒ 1. Removal of any child in the household; interventions 1-6 do not adequately ensure the child(ren)'s safety.

Explain why a Family Safety Intervention (1-6) could not be used to protect the child.

Burt's mother & father could not be located and therefore were not available to discuss identifying a temporary safety provider. In addition, the maternal & paternal grandparents indicate they can not be a placement/safety resource.

PART D: SAFETY DECISION

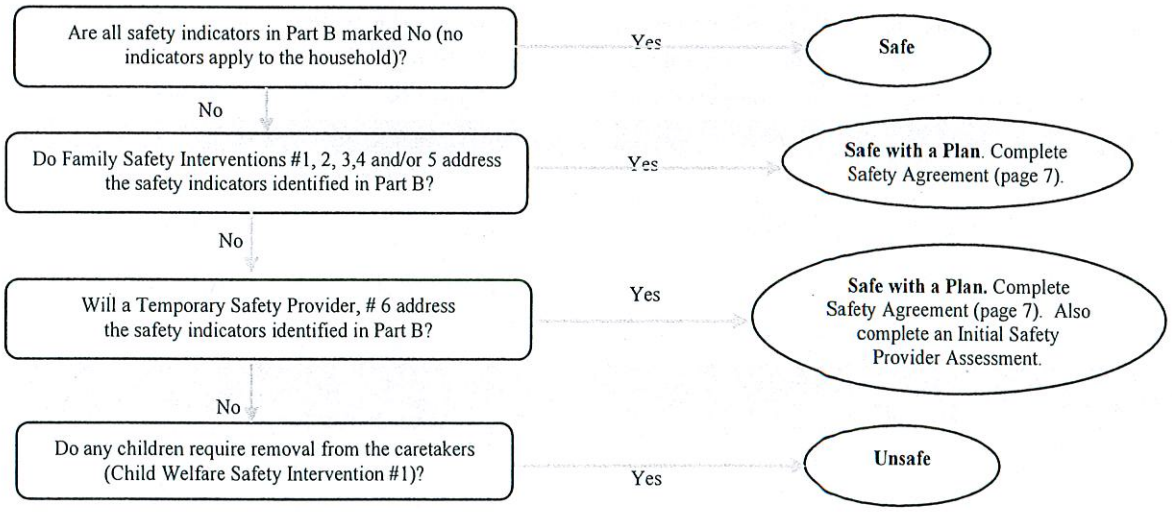
Directions: Identify the safety decision by checking the appropriate line below. Check one line only. This decision should be based on the assessment of all safety indicators, child vulnerability, and any other information known about this case.

A. Safe: There are no children likely to be in immediate danger of serious harm. (Indicators of Immediate Safety all marked No, Marked Safe on Page 5).

B. Safe with a plan: _____ One or more safety indicators are present; Safety Agreement required.

- ☐ Family Safety Interventions 1, 2, and/or 3 will address safety indicators.
- ☐ The alleged perpetrator left the home.
- ☐ A protective caretaker moved to a safe environment with the child(ren).
- ☐ Use of a Temporary Safety Provider.

C. Unsafe: X ☒ One or more children were removed in response to legal action.



PART E: SAFETY AGREEMENT

Purpose: A safety agreement is used only when there is a specific threat to a child in the immediate or foreseeable future. The plan must be created with the family and must be written in practical, action-oriented language.

Instructions: The social worker and the family complete this document. Describe what tasks will be done to assure safety, by whom, how often, and duration. The tasks identified should include actions that need to be taken to keep child(ren) safe now, address risks to safety, and/or are necessary for the child(ren) to be able to return to the home (if the child(ren) leaves the home). Indicate how the social worker will be monitoring the plan. The social worker then reviews it with each parent, guardian, custodian and caretaker who will sign the agreement. The social worker ensures that the parent or caretaker has read and/or understands the document and has initialed each applicable field. The social worker will work with the family to arrange for a review of the plan. The social worker then provides a copy to each person who signs the form.

Family Name:			Date:	
What is the specific situation or action that causes the child to be unsafe? What is the safety threat?	**What actions need to be taken right now to keep the child safe?**	**Who is responsible for ensuring that these actions are taken?**	**Timeframe for completing the actions**	**Responsible Party's initials**

PART F: STATEMENTS OF UNDERSTANDING AND AGREEMENT

PARENT OR CARETAKER	INITIALS
1. I (the parent or caretaker) agree that I participated in the development of and reviewed this safety agreement. I agree to work with the providers and services as described above.	
2. My participation in this agreement is not an admission of child abuse or neglect on my part and cannot be used as an admission of child abuse or neglect.	
3. I understand that I have the right to revoke and/or have the Temporary Parental Safety Agreement reviewed at any time. (See bottom of page.) I also understand that if a Safety Agreement cannot be agreed upon or if the actions in the Safety Agreement are not followed, the county child welfare agency may have the authority to request that the court make a determination on how the child(ren)'s safety will be assured.	
4. I (the parent or caretaker) confirm that this agreement does not conflict with any existing court order, or if I am affected by a court order, all parties affected by the court order agree to this safety agreement on a temporary basis.	
5. I (the parent or caretaker) understand that CPS may refer for further services, may restrict access to my child(ren), or may ask the court to order that I complete services or place the child in foster care.	
6. If a Temporary Safety Provider is utilized, I understand that CPS will share any information with the Temporary Safety Provider for the safety and welfare of my child while the child lives in that home or the Temporary Safety Provider resides in the family home.	
7. This safety agreement will cease to be in effect when I am notified by my social worker or CPS is no longer providing services to my family.	
TEMPORARY SAFETY PROVIDER	
1. If the parent is unable to provide a safe environment for the child and the court names the county child welfare agency as the child's legal custodian, I will be given consideration as a placement for the child if I agree and continued placement is determined to be safe.	
2. If I (the person providing care as Temporary Safety Provider) am unable to carry out this plan successfully, or if the child in my care is considered to be in an unsafe situation, the child will be moved to a different placement and further CPS involvement may be necessary, including court intervention.	

SIGNATURES

Child's Parent or Legal Guardian:	Date Signed:	Child's Parent or Legal Guardian:	Date Signed:
Child's Parent or Legal Guardian:	Date Signed:	CPS Social Worker:	Date Signed:
Other Party:	Date Signed:	CPS Supervisor:	Date Signed:
Temporary Safety Provider:	Date Signed:	Temporary Safety Provider:	Date Signed:

Who Can I Contact? (Who can I contact if circumstances change, if I have questions about CPS involvement, or if I have questions about this safety agreement? Who do I contact to revoke any or all parts of this agreement?)		
CPS Social Worker's Name:	Phone Number:	Email Address:
CPS Supervisor's Name:	Phone Number:	Email Address:

REVOCATION: I revoke my consent to the Temporary Parental Safety Agreement.

Signed: _____ **Date:** _____

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

Case Name: Hobgood **Case #:** 23456 **Date:** 04/04/17

County Name: Anywhere **Social Worker Name:** Sally Jones **Date Report Received:** 04/03/17

Children: Burt Hobgood

Primary Caretaker: Sandy Hobgood **Secondary Caretaker:** NA

(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 — 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 — 1

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

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

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

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

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

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

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

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

A3. Prior CPS in-home/out-of-home service history
a. No 0
b. One or more apply ..... 1 — 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 — 1

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

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

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

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

N11. Either caretaker has barriers to accessing community resources

a. No..... 0
b. One or more apply.....1 1
☐ Difficulty finding/obtaining resources
X Refusal to utilize available resources

N12. Either caretaker lacks parenting skills

a. No..... 0
b. One or more apply.....1 1
X Inadequate supervision of children
X Uses excessive physical/verbal discipline
X Lacks knowledge of child development

N13. Either caretaker involved in harmful relationships

a. No..... 0
b. Yes.....1 0

N14. Child characteristics

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

N15. Housing/basic needs unmet

a. Not applicable 0
b. One or more apply.....1 0
☐ Family lacks clothing and/or food
☐ Family lacks housing or housing is unsafe

A9. Either caretaker is/was a victim/perpetrator of domestic violence

a. No 0
b. Yes.....1 0
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 0
☐ 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 0
☐ Lack of communication impairs functioning
☐ Poor communication impairs functioning

TOTAL NEGLECT RISK SCORE 8 **TOTAL ABUSE RISK SCORE 3**

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	_X_ 3–5	___ Moderate
_X_ 6–16	___ 6–12	_X_ 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:** ____/____/____

NORTH CAROLINA
FAMILY ASSESSMENT OF STRENGTHS AND NEEDS

Case Name: Hobgood Case #: 23456 Date 4/4/17
County Name: Anyone Date Report Received: 4/3/17
Social Worker Name: Sally Jones Circle either Initial or Reassessment #: 1 2 34 5:
Children: Burt Hobgood
Caretaker(s): Sandy Hobgood

Some items apply to all household members while other items apply to caretakers only. Assess items for the specified household members, selecting one score only under each category. Household members may score differently on each item. When assessing an item for more than one household member, record the score for the household member with the greatest need (highest score).

Caretakers are defined as adults living in the household who have routine responsibility for child care. For those items assessing caretakers only, record the score for the caretaker with the greatest need (highest score) when a household has more than one caretaker.

S-CODE	TITLE	TRAITS	SCORE
S1.	**Emotional/Mental Health**	a. Demonstrates good coping skills ..... -3	
		b. No known diagnosed mental health problems 0	
		c. Minor or moderate diagnosed mental health problems 3	
		d. Chronic or severe diagnosed mental health problems 5	**0**
S2.	**Parenting Skills**	a. Good parenting skills ..... -3	
		b. Minor difficulties in parenting skills 0	
		c. Moderate difficulties in parenting skills 3	
		d. Destructive parenting patterns 5	**3**
S3.	**Substance Use**	a. No/some substance use 0	
		b. Moderate substance use problems 3	
		c. Serious substance use problems 5	**3**
S4.	**Housing/Environment/ Basic Physical Needs**	a. Adequate basic needs ..... -3	
		b. Some problems, but correctable 0	
		c. Serious problems, not corrected 3	
		d. Chronic basic needs deficiency 5	**0**
S5.	**Family Relationships**	a. Supportive relationships ..... -2	
		b. Occasional problematic relationship (s) 0	
		c. Domestic discord 2	
		d. Serious domestic discord/domestic violence 4	**0**
S6.	**Child Characteristics**	a. Age-appropriate, no problem ..... -1	
		b. Minor problems 0	
		c. One child has severe/chronic problems 1	
		d. Child(ren) have severe/chronic problem(s) 3	**1**
S7.	**Social Support Systems**	a. Strong support network ..... -1	
		b. Adequate support network 0	
		c. Limited support network 1	
		d. No support or destructive relationships 3	**1**

S8. Caretaker(s) Abuse/ Neglect History	a. No evidence of problem.....0 b. Caretaker(s) abused/neglected as a child..... 1 c. Caretaker(s) in foster care as a child .....2 **d.** Caretaker(s) perpetrator of abuse/neglect in the last five years……..3	**0**
S9. Communication/ Interpersonal Skills	a. Strong skills ..... -1 b. Appropriate skills ..... 0 c. Limited or ineffective skills ..... 1 d. Hostile/destructive 2	**1**
S10. Caretaker(s) Life Skills	a. Good life skills ....-1 b. Adequate life skills.....0 c. Poor life skills.....1 **d.** Severely deficient life skills ……...2	**1**
S11. Physical Health	a. No adverse health problem.....0 b. Health problem or disability .....1 c. Serious health problem or disability 2	**0**
S12. Employment/Income Management	a. Employed ..... …-1 b. No need for employment.....0 c. Underemployed..... 1 d. Unemployed ……..…….2	**2**
S13. Community Resource Utilization	a. Seeks out and utilizes resources .....-1 b. Utilizes resources .....0 c. Resource utilization problems .....1 d. Refusal to utilize resources..... 2	**1**

Based on this assessment, identify the primary strengths and needs of the family. Write S code, score, and title.

	STRENGTHS				**NEEDS**		
	S Code	Score	Title		S Code	Score	Title
1.	S4	0	Housing/Environment	1.	S3	3	Substance Use/Abuse
2.	S5	0	Family Relationships	2.	S2	3	Parenting Skills
3.	S11	0	Physical Health	3.	S12	2	Employment/Income

Children/Family Well-Being Needs:

1. Educational Needs: Follow up with school counselor t develop an IEP for Burt.

2. Physical Health Needs: No needs identified at this time.

3. Mental Health Needs: Possible counseling for Burt regarding anger and grief related to foster care placement.

Social Worker:_____ Date: _____

Supervisor's Review/Approval:_____ Date:

_____

XII. TWO-LEVEL REVIEW STAFFING AND CASE DECISION SUMMARY

Case Decision Summary

Give rationale for both "yes" and "no" answers to the following questions.

1. Has the maltreatment occurred with frequency and/or is the maltreatment severe?
   ☒ YES ☐ NO

2. Are there current safety issues that indicate the child(ren) is likely to be in immediate danger of serious harm?
   ☒ YES ☐ NO

   (Note: If the child(ren) is separated from his/her parents or access is restricted and that separation/restriction continues to be necessary due to safety issues, then this question must be answered "yes".)

3. Are there significant assessed risk factors that are likely to result in serious harm to the child(ren) in the foreseeable future?
   ☒ YES ☐ NO

4. Is the child in need of CPS In-home Services or Out-of-home Services (answer "yes" if the caretaker's protective capacity is insufficient to provide adequate protection and "no" if the family's protective capacity is sufficient to provide adequate protection)?
   ☒ YES ☐ NO

Rationale for Case Decision & Disposition

Document the factual information regarding the findings as they relate to the allegations of abuse, neglect, and/or dependency, including behaviorally specific information regarding the frequency and severity of maltreatment, safety issues, and future risk of harm. Include information to support Yes and No answers above.

Sandy Hobgood left her son, Burt, alone in their home for 2 days without adequate food and no responsible adult supervision for the second known time. This the second "services needed" finding for the same issues even though services and a temporary parental safety agreement had been made between the agency and Ms. Hobgood. Ms. Hobgood admitted becoming upset with Burt after drinking alcohol which resulted in her hitting him with a belt that left numerous bruises on his arms and legs. This is a clear violation of the safety agreement. Therefore, Burt was removed from his mother's home to ensure his safety. Since neither the mother nor father could be located to discuss temporary placement providers, Burt was placed in foster care. Ms. Hobgood called the agency the day after Burt's placement in the foster home. While Ms. Hobgood is currently minimizing her behaviors, she has made the connection between the stress she is under and her problematic behaviors. Ms. Hobgood stated she is eager to work toward reunification.

Assessment completed within the specified timeframe: ☒ YES ☐ NO If no, explain:

Family notified of the delay in making case decision: ☒ YES ☐ NO Document the discussion here or in narrative:

Optional Supervisor Use Only

Optional comments or clarification by the supervisor can be noted here.

If the case decision and/or disposition is different from that indicated in the above Rationale for Case Decision and Disposition, the supervisor must provide documentation to justify the decision

and/or disposition.

NORTH CAROLINA CPS ASSESSMENT DOCUMENTATION TOOL

Children

NAME	AGE	Case Decision for each Child	Maltreatment Findings *(Complete for Substantiated Investigative Assessments ONLY)*	
1. Burt Hobgood	10	☐ Substantiated (enter maltreatment finding(s) in next two columns) ☐ Unsubstantiated ☒ Services Needed ☐ Services Recommended ☐ Services Not Recommended ☐ Services Provided, No Longer Needed	☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Delinquent Acts Involving Moral Turpitude Human Trafficking: ☐ Sexual ☐ Labor ☐ Dependency	Neglect: ☐ ☐ Imp. Supervision ☐ Improper Care Improper Discipline: ☐ w/ injuries ☐ w/out injuries ☐ Environment Injurious: ☐ Domestic Violence ☐ Substance Abuse ☐ Abandonment ☐ Safe Surrender ☐ Improper medical/ remedial care ☐ Violation of Adoption Law
2.		☐ Substantiated (enter maltreatment finding(s) in next two columns) ☐ Unsubstantiated ☐ Services Needed ☐ Services Recommended ☐ Services Not Recommended ☐ Services Provided, No Longer Needed	☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Delinquent Acts Involving Moral Turpitude Human Trafficking: ☐ Sexual ☐ Labor ☐ Dependency	Neglect: ☐ ☐ Imp. Supervision ☐ Improper Care Improper Discipline: ☐ w/ injuries ☐ w/out injuries ☐ Environment Injurious: ☐ Domestic Violence ☐ Substance Abuse ☐ Abandonment ☐ Safe Surrender ☐ Improper medical/ remedial care ☐ Violation of Adoption Law
3.		☐ Substantiated (enter maltreatment finding(s) in next two columns) ☐ Unsubstantiated ☐ Services Needed ☐ Services Recommended ☐ Services Not Recommended ☐ Services Provided, No Longer Needed	☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Delinquent Acts Involving Moral Turpitude Human Trafficking: ☐ Sexual ☐ Labor ☐ Dependency	Neglect: ☐ ☐ Imp. Supervision ☐ Improper Care Improper Discipline: ☐ w/ injuries ☐ w/out injuries ☐ Environment Injurious: ☐ Domestic Violence ☐ Substance Abuse ☐ Abandonment ☐ Safe Surrender ☐ Improper medical/ remedial care ☐ Violation of Adoption Law
4.		☐ Substantiated (enter maltreatment finding(s) in next two columns) ☐ Unsubstantiated ☐ Services Needed ☐ Services Recommended ☐ Services Not Recommended ☐ Services Provided, No Longer Needed	☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Delinquent Acts Involving Moral Turpitude Human Trafficking: ☐ Sexual ☐ Labor ☐ Dependency	Neglect: ☐ ☐ Imp. Supervision ☐ Improper Care Improper Discipline: ☐ w/ injuries ☐ w/out injuries ☐ Environment Injurious: ☐ Domestic Violence ☐ Substance Abuse ☐ Abandonment ☐ Safe Surrender ☐ Improper medical/ remedial care ☐ Violation of Adoption Law

5.		☐ Substantiated (enter maltreatment finding(s) in next two columns) ☐ Unsubstantiated ☐ Services Needed ☐ Services Recommended ☐ Services Not Recommended ☐ Services Provided, No Longer Needed	☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Delinquent Acts Involving Moral Turpitude Human Trafficking: ☐ Sexual ☐ Labor ☐ Dependency	Neglect: ☐ ☐ Imp. Supervision ☐ Improper Care Improper Discipline: ☐ w/ injuries ☐ w/out injuries ☐ Environment Injurious: ☐ Domestic Violence ☐ Substance Abuse ☐ Abandonment ☐ Safe Surrender ☐ Improper medical/ remedial care ☐ Violation of Adoption Law
6.		☐ Substantiated (enter maltreatment finding(s) in next two columns) ☐ Unsubstantiated ☐ Services Needed ☐ Services Recommended ☐ Services Not Recommended ☐ Services Provided, No Longer Needed	☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Delinquent Acts Involving Moral Turpitude Human Trafficking: ☐ Sexual ☐ Labor ☐ Dependency	Neglect: ☐ ☐ Imp. Supervision ☐ Improper Care Improper Discipline: ☐ w/ injuries ☐ w/out injuries ☐ Environment Injurious: ☐ Domestic Violence ☐ Substance Abuse ☐ Abandonment ☐ Safe Surrender ☐ Improper medical/ remedial care ☐ Violation of Adoption Law
7.		☐ Substantiated (enter maltreatment finding(s) in next two columns) ☐ Unsubstantiated ☐ Services Needed ☐ Services Recommended ☐ Services Not Recommended ☐ Services Provided, No Longer Needed	☐ Physical Abuse ☐ Emotional Abuse ☐ Sexual Abuse ☐ Delinquent Acts Involving Moral Turpitude Human Trafficking: ☐ Sexual ☐ Labor ☐ Dependency	Neglect: ☐ ☐ Imp. Supervision ☐ Improper Care Improper Discipline: ☐ w/ injuries ☐ w/out injuries ☐ Environment Injurious: ☐ Domestic Violence ☐ Substance Abuse ☐ Abandonment ☐ Safe Surrender ☐ Improper medical/ remedial care ☐ Violation of Adoption Law

Parents / Caretakers

Parent / Guardian / Custodian / Caretaker / Agency / Foster Home / Group Care / Institution	**Relationship to Child**	**Perpetrator**
1. Sandy Hobgood	mother	☐ Yes ☐ No ☒ N/A
2.		☐ Yes ☐ No ☐ N/A
3.		☐ Yes ☐ No ☐ N/A
4.		☐ Yes ☐ No ☐ N/A
5.		☐ Yes ☐ No ☐ N/A
6.		☐ Yes ☐ No ☐ N/A

(*Complete for Investigation Assessments only*)

☐ At least one of the perpetrators is a candidate for placement on the RIL.
(if so all required letters must be placed in the record and delivered as policy requires.)

Disposition of Case

Case closed (date): ☐ Transferred to: County (date):

☐ Case transferred to CPS In-home Services (date):
☒ Case transferred to CPS Out-of-home Services (date): 4/3/17
☐ Case transferred to Voluntary Services (date):

Staffing

Names of others present for staffing: Sally Jones, Jane White, Ryan Odom

Name of CPR contact (if applicable):

Social worker signature:_____ Date:_____

Supervisor's signature:_____ Date: _____

☐ 5104 completed and submitted

XIII. ONGOING SERVICES (☐ N/A for this section)

This section must be completed for cases that continue to In-Home or Out-of -Home Services

The Structured Documentation Instrument (DSS-5010) documents the **s**ocial activities, **e**conomic situation, **e**nvironmental issues, **m**ental health needs, **a**ctivities of daily living, **p**hysical health needs, and **s**ummary of strengths (SEEMAPS) identified during the completion of a CPS Assessment. This information, along with the outcomes from the Risk Assessment and the Strengths and Needs Assessment should guide the development of the Ongoing Needs and Safety Requirements document and should detail the needs and the activities intended to prevent foster care placement of child for whom, absent effective preventive services, the plan would be removal from the home.

Identify the Family Strengths and/or Protective Safety Factors in Place:

Ms. Hobgood states she loves Burt and wants him back home. Mom and Burt are in good physical health. Paternal Grandparents, maternal grandmother and Mr. Grant (neighbor) are involved in case planning for Burt. Maternal grandmother and Ms. Grant are willing to provide short term care for Burt. Ms. Hobgood realizes stress has contributed to her problematic behaviors.

The Ongoing Needs and Safety Requirements document on the next page is not used for Group Care or Institutional Assessments but may be used for licensed family foster home and kinship care providers that are receiving continued CPS services as caretakers to children in their home.

Continuing Needs and Safety Requirements

This document communicates the county child welfare agency's concerns, identifies services or actions the agency believes will assist in addressing those concerns, and states requirements to maintain your child(ren)'s safety. The activities to ensure your children's safety must remain in effect until a Family Services Agreement is developed. The county child welfare agency will work with you and your family to develop a Family Services Agreement to specify how the agency will work with you, your family, your family supports, and service providers to reduce the safety and/or risk and, when applicable, to improve the well-being of your children.

The following strengths, needs, and concerns regarding your child(ren)'s present safety or that put them at risk of future harm were identified during the CPS Assessment.

Ms. Hobgood left Burt alone for two days without supervision or food
Ms. Hobgood left bruises on Burt as a result of inappropriate discipline
Ms. Hobgood admits drinking alcohol before these incidents occurred impairing her judgment and ability to provide the needed care and supervision for Burt.

The following activities and/or services have been recommended for your family and will be discussed during the development of your Family Services Agreement.

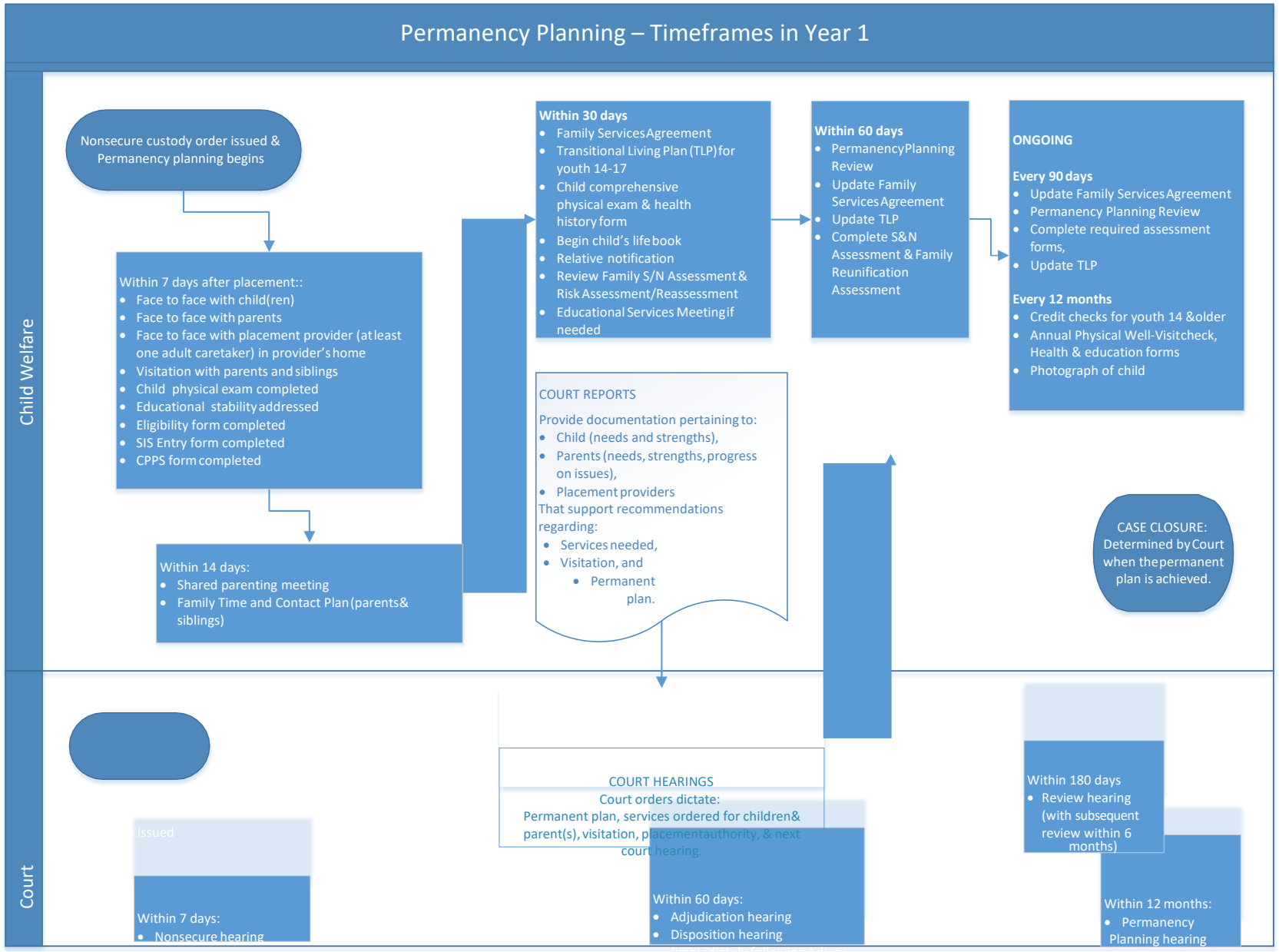
Social Worker (SW) will meet with Ms. Hobgood to discuss parenting issues relevant to Burt's age, expectations, nutrition and discipline
Ms. Hobgood will continue her mental health treatment for drinking and exploration of other ways of dealing with stress.
SW and Ms. Hobgood will meet with school counselor regarding ways to help Burt with his dyslexia.
SW will arrange for Ms. Hobgood to meet with Work First worker to explore services that may

The following activities (agreed to in your Temporary Parental Safety Agreement) to ensure the safety of your children must continue until development of the Family Services Agreement.

N/A

SIGNATURES (Received and Reviewed)			
Child's Parent or Legal Guardian: X	Date Signed:	Child's Parent or Legal Guardian: X	Date Signed:
Child's Parent or Legal Guardian: X	Date Signed:	CPS Social Worker: X	Date Signed:

Required Timeframes



Medical Homes for Children in Permanency Planning (Placement) Services

What are the Health Concerns for Children in Foster Care?

- Nearly all (87-95%) of children in care have at least one physical health problem; more than half have more than one.
- Health issues commonly experienced by children in care include growth delays, neurological impairments, vision and hearing deficits, malnutrition, anemia, respiratory problems, chronic ear infections, severe allergies, and failure to thrive.
- Children in care also have high rates of developmental problems including language disorders, social skills deficits, delayed motor skills, learning disabilities, and cognitive impairments.
- Children in care also have high rates of behavioral health issues. It is estimated that 50% to 80% require mental health services, compared to 20% of children not in foster care.
- Children sometimes enter foster care with chronic health issues that have been poorly managed.
- Problems in the provision of health care services to children in foster care include duplication, fragmentation, and gaps in services due to lack of continuity and coordination of care and poor communication among providers.

What is a Medical Home?

A medical home is a partnership between the family and the family's primary health care provider. Through this partnership, the medical home provides a single point of entry to a system of care that facilitates access to medical and nonmedical services, including social services. In a medical home, a physician leads a team which delivers and directs care that is comprehensive (sick and preventive/well care), compassionate, coordinated, continuous, culturally effective, accessible and family-centered. A medical home allows primary care providers (i.e., pediatricians or family physicians), parents, child welfare professionals, and other stakeholders to identify and address all of a child's physical and mental health needs promptly and as a team.

The U.S. Maternal and Child Health Bureau endorses the medical home as the model for 21st century primary care for everyone, especially children with special health care needs, which includes children in foster care.

Use of the medical home approach with children in foster care is also strongly supported by federal law. In October 2008, President Bush signed into law the Fostering Connections to Success and Increasing Adoptions Act. Part of this law directs states to establish a medical home and oversight of prescription medication, including psychotropic drugs, for every child in foster care (Center for Public Policy Priorities, 2008; Children's Defense Fund, 2008). The overall goal of this provision in the law is to ensure continuity of health care for all children in foster care.

What are the Benefits for Children in Foster Care?

- Coordination of care provided by a medical home
- Consistent, ongoing relationship with a primary health care provider and team who know the child well
- Assurance that medical/health records aren't lost
- Improved quality of care, with fewer errors and preventable complications
- Less missed school and missed time from work for parents
- Easier access to specialists
- More preventive health care

What can a child welfare worker do?

- **Know the medical homes in your community**. Contact your local CCNC (Community Care North Carolina) network for a complete list of medical home providers.
- **Ensure the children you work with have a medical home**. If a child in your caseload does not have a medical home, work with CCNC to establish one.
- **Educate Families**. At every stage of child welfare work (Assessment, In-Home, Foster Care, and Adoptions), make a point of talking with birth and resource families about the benefits of medical homes. If they or the child are Medicaid eligible, encourage them to enroll with CCNC.
- **Partner with medical homes**. Make it clear to others that you understand the benefits of the medical home approach. Child and Family Team meetings (CFTs) are a great place to do this.
- **Partner with the foster and biological parents.** Ensure foster parents have all the medical background information/documentation available upon placement of the child. Encourage the child's foster parents and biological parents to attend medical visits together when possible.
- **Partner with CCNC care managers.** Work with your local care mangers to expand care management services, improve information flow, and maintain continuity in the event of a change in placement.

Sources:
NC Pediatric Society, Fostering Health NC: http://www.ncpeds.org/?page=FHNC
Fostering Perspectives, Volume 19, No. 1 (November 2014), http://fosteringperspectives.org/fpv19n1/kids_pages_v19n1.htm
Fostering Perspectives, Volume 14, No. 2 (May 2010), http://fosteringperspectives.org/fpv14n2/FPv14n2.pdf

Foster Care 18 to 21

Background

- In 2015, the North Carolina General Assembly revised **N.C.G.S. 108A-48** to extend the provision of foster care benefits to young adults between 18 years of age and up to 21 years of age (effective January 2017)
- Federal Law: Fostering Connections and Increasing Adoptions Act of 2008 allows states to receive federal Title IV-E reimbursement for costs associated with supports for young adults to remain in foster care up to age 21

Benefits of Foster Care 18 to 21

- Creates increased opportunities for success and overall well-being for young adults previously in foster care
- Offers positive adult connections and a network of support during transition to self-sufficiency
- Young adults participating in the program are more likely to obtain a high school diploma, enroll in college, and are less likely to be perpetrators of crimes
- Allows young adults to experience independence while having a "safety net" to fall back on

Eligibility Criteria

In order to receive *Foster Care 18 to 21* benefits and services the young adult must meet at least one of the following criteria:

1. Enrolled in high school or a program leading to an equivalent credential; or
2. Enrolled in an institution that provides postsecondary or vocational education; or
3. Participating in a program or activity designed to promote or remove barriers to employment; or
4. Employed for at least 80 hours per month; or
5. Incapable of completing the educational or employment requirements due to a medical condition or a disability.

The Young adult must also:

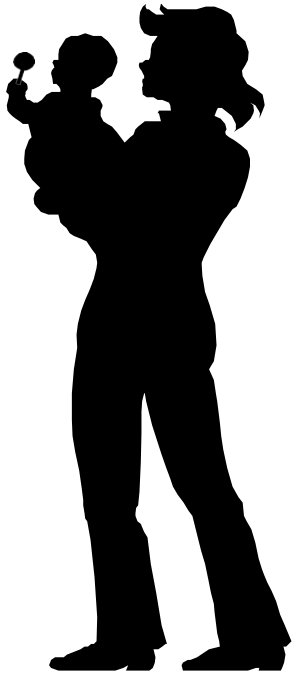
- Have been in foster care upon his/her 18th birthday; and
- Be 18 years of age, but not yet 21 years of age; and
- Enter into a Voluntary Placement Agreement with a county child welfare agency and agree to abide by the provisions of the agreement.

Placement Options for Foster Care 18 to 21

- Foster Care Home/Facility (Family Foster Home, Therapeutic Foster Home, Group Home
- College/University Dormitory (On-Campus, Off Campus, or College Co-Ops)
- Semi-supervised Independent Living Settings (shared housing, extended relative/family friend)

Purpose of Family Time

- Reassurance
- Education
- Assessment
- Documentation and Court Information



"Visitation is the single most important factor in maintaining the relationship between the child and the biological parent while the child is in placement."

-Peg Hess and Kathleen Proch, "Visiting: The Heart of Reunification"

Thinking through Family Time

Once the decision has been made that a child will be in a new setting, whether in foster care or an adoptive home, the next series of decisions should be about maintaining connections between the child and his or her primary caretakers. The following are issues to consider:

- **Start Date.** When should visitation be started? What is this decision based upon... child's developmental stage, safety (what indicators are available to support a decision to withhold visitation because of safety issues?), agency expediency?

- **Type of Visitation.** Will the visitation be face-to-face, supervised, unsupervised, or a sibling visit? If, based upon recognized indicators, face-to-face is not possible, what other connections with the family can be encouraged? List specific developmentally appropriate ideas (photos, telephone calls, letters, sharing of life book, adult-to-adult conversations, videos, audiotapes) and dates and methods of accomplishment.

- **Location.** Where should visitation take place? Is this decision in the best interests of child and family? Does this decision consider family (foster, adoptive, birth) schedules, as well as the schedule of the child?

- **Positive or Negative Indicators.** What specific behavioral indicators during this visit will support or restrict plans for reunification or adoptive placement? These indicators should primarily be related to the reasons for placement and should be examined for cultural or class bias.

- **Goals.** Have the goals ("SMART") of the visit been clearly discussed with parents, other involved parties, and agencies?

- **Monitoring.** How will the visit be monitored and evaluated, and by whom?

- **Participation.** Who needs to be involved in the planning process? Possible individuals are: parents (birth, foster, adoptive), grandparents, relatives, teacher, mental health or court counselor, and GAL.

BUILDING PROTECTIVE FACTORS DURING CASEWORK VISITS

Casework visits are opportunities to engage with caregivers and children in ways that both support the family and build protective factors. Your interactions with the caregiver and child are small interventions that can help the family move toward meeting goals in their case plan. Visits allow you to observe and reinforce what is going right, while also gently providing support, advice and encouragement when caregivers or children are struggling. The following tips can help caseworkers build protective factors among the families they serve.

Parental Resilience

- Project a positive and strengths-based approach to the family.
- Encourage the caregiver to talk about stresses or challenges they are experiencing (either in caring for the child or in life in general). Provide empathetic support and help the caregiver to problem solve around these challenges.
- Validate and support good decisions.
- Ask what the caregiver enjoys doing with the child and emphasize opportunities to build these activities into regular routines.
- Support the family as key decision-makers throughout the case planning process.
- Encourage the caregiver to explore his or her own past experiences of trauma and to address how those experiences might impact them in the present.
- Normalize the fact that parenting is stressful and help the caregiver plan out responses to stressful parenting situations.
- Encourage self-care strategies.

Knowledge of Parenting and Child Development

- Observe parent-child interactions and provide positive coaching around supporting child development, nurturing the child or behavior management strategies.
- Model nurturing behavior in your interactions with the child.
- Model appropriate expectations for the child.
- When the caregiver's expectations are not in line with the child's developmental stage, engage the caregiver in a conversation about how to provide more developmentally appropriate responses.
- Ask the caregiver about his or her parenting challenges and recommend resources that can be used to address those challenges.
- Connect the caregiver to parenting education classes or resources as part of case planning.
- Help the caregiver to value the caregiving role by underlining the positive impact that nurturing care has on a child.
- Provide "just in time" parenting education (i.e., information a caregiver needs when new parenting issues arise). Provide and discuss tip sheets related to issues the child or caregiver is dealing with.
- Help the caregiver identify trusted informants who can provide parenting information.

Social Connections

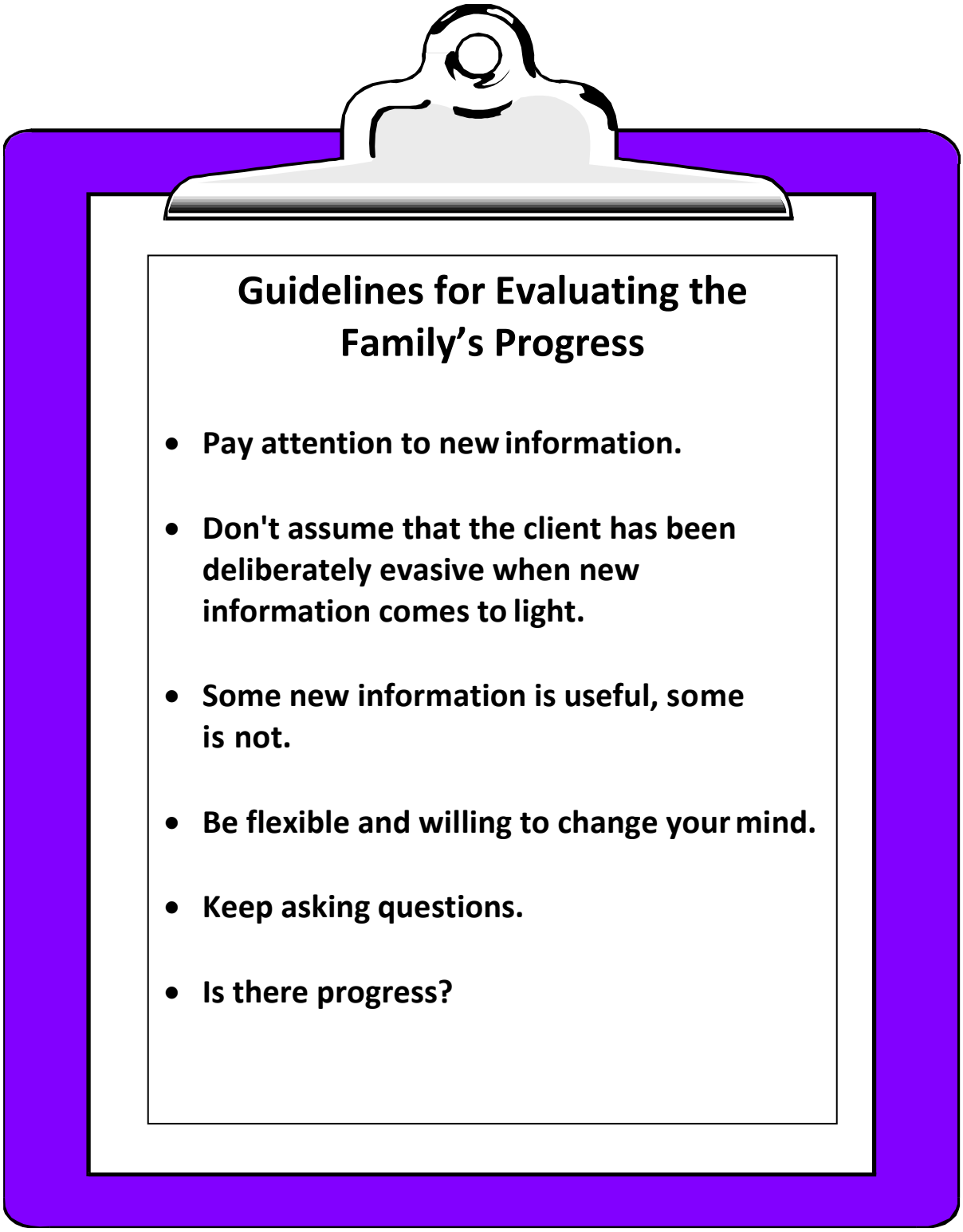
- Model good relational behavior and use the case management process to help the caregiver strengthen relational skills.
- Help the caregiver reflect on the dynamics in his or her existing relationships and identify supporters who contribute positively.
- Encourage the caregiver to expand or deepen his or her social network.
- Encourage the caregiver to address personal or family issues (e.g., anxiety, depression) that serve as barriers to developing healthy social connections.

Concrete Support in Times of Need

- Help the caregiver to identify concrete needs that are causing stress in the family and connect the caregiver with resources to address those needs.
- Encourage help seeking behavior.
- Work with the family to understand any past experience with service systems and any stigma they attach to certain services.
- Help the family to navigate complex systems by explaining eligibility requirements, helping to fill out forms or making a warm handoff to someone who can help the family access the services they need.
- Help caregivers understand their role as an advocate for themselves and their children.

Social Emotional Competence of Children

- Provide warm and consistent support to the child.
- Look for signs of trauma in the child. When a child exhibits signs of trauma, connect the child and caregiver to mental health resources and help the caregiver to understand and interpret the behavior as stemming from trauma.
- Increase the caregiver's awareness of the importance of early relationships.
- Help the caregiver full understand the importance of their role in nurturing the child's social-emotional development.
- Provide the caregiver with concrete tips and resources to help build the child's social and emotional competence.
- Encourage family play by bringing play supplies (e.g., a board game, crayons) to the visit.
- Connect the family to resources that support the child's social-emotional development.
- Help the caregiver address the child's attachment issues and/or challenging behaviors.
- Teach and model social skills, such as sharing, taking turns and positive conflict resolution.


Guidelines for Evaluating the Family's Progress
• Pay attention to new information.
• Don't assume that the client has been deliberately evasive when new information comes to light.
• Some new information is useful, some is not.
• Be flexible and willing to change your mind.
• Keep asking questions.
• Is there progress?

Analyzing a Relapse

- What was different about this relapse?

- How did the family member(s) end the episode?

- What was learned from the episode that can be used in the future?

- What does the family member do between episodes to avoid relapses?

- When is the family member more vulnerable to relapse?

- Are there any larger system issues that cause a "ripple effect"?

Adapted from: Berg, 1. K. (1994). Family based services: A solution focused approach. New York: W. W. Norton & Company

A Story of Progress

Dr. Carl Henley is a recently-retired professor at the UNC-CH School of Social Work. Several years ago, he suffered a rare spinal stroke, which left his left side paralyzed. Medical practitioners were not sure if he would ever regain use of his left side again, but, from day one, Dr. Henley was convinced that he would recover. His progress has been slow but steady, and today he is not only walking but playing golf! We asked him what tips he had for staying motivated throughout his recovery, and these are his words of wisdom:

- Try not to have unrealistic expectations.
- Burnout comes from trying to solve the entire problem at once.
- Set small, realistic goals so you can enjoy some successes along the way
- When progress is slow, people are inclined to give up and say, "What's the use?"
- Keep up with your successes and your "failures," so you know what you do well and where you can improve.
- Celebrate your successes, however small.
- Take time to entertain yourself and do things you enjoy.
- Have a goal, something you are looking forward to, and reward yourself when you get there.
- Don't be afraid to change what you're doing if it isn't working-talk to someone about your frustrations.
- Recognize that not everything you're going to do is going to be successful. Don't beat yourself up when things don't work out.
- Remember the joke: How many social workers does it take to change a light bulb? Answer: One. But the light bulb must really WANT to change.

These motivational tips can be applied personally and to your clients. Remember that your motivation will directly impact your clients' motivation. In addition to teaching them motivational skills, you can set a good example for your clients by taking care of yourself along the way, celebrating your successes, and striving to improve your own practice.

Hobgood Permanency Planning - 60 days later

Burt has been in foster care with the McDougals for 60 days. Initially, Burt was quiet and compliant at school and with the McDougals. As he became more comfortable there, he began testing the rules at home and at school. At home he uses profanity constantly and yells when he doesn't get his way. When angry, he may throw things that are at hand and has broken some decorations around the house and one lamp. The McDougals are concerned about the fact that Burt has some history as a fire setter. They learned about some waste basket and outdoor fires that he set and then couldn't control. They are monitoring him closely. His angry outbursts seem to be decreasing somewhat. He sees a counselor at the mental health center to work on anger management. Burt describes the visits as "dorky" but does not currently refuse to go. Burt also has an IEP at school and is working on ways to manage his dyslexia and improve his grades. Mrs. McDougal is also working with him at home on his homework and his grades are improving. He is growing closer to Mr. McDougal and lately has begun to call him affectionately "Big Mac."

Sandy Hobgood has worked diligently to co-operate with the terms of the family services agreement. She has attended substance abuse counseling and individual counseling through mental health regularly. Sandy is also actively participating in AA at the local church and parenting sessions with the child welfare worker. During visits with Burt and her child welfare worker, she appears clear-eyed, has not smelled of alcohol, and maintains that she is not drinking. Sandy acts appropriately with Burt during visits and is trying to incorporate some of the parenting and appropriate discipline techniques she has learned if Burt misbehaves. Sandy and the McDougals are continuing to have regular shared parenting meetings. The McDougals and Sandy regularly discuss Burt's behavior at their home and school, especially what techniques work best to control his behavior. Mrs. McDougal, Sandy, and the school have met to discuss Burt's dyslexia and ways to manage it. She constantly tells the worker that she wants Burt to come home and is willing to do whatever it takes to get him returned to her.

Sandy has maintained good contact with Burt, although she misses some visits when she cannot arrange a ride. She has lost her driver's license for a year, after driving off the road when drinking, just after Burt came into custody. She always calls when she can't get a ride or has to work and has to cancel. She does stay in regular telephone contact with Burt and the McDougals. When she cancels a visit, Burt's pattern is that he becomes angry about something unrelated to the visit or gets very sad and quiet. Very recently, after a missed visit, Mr. Mac found Burt out in the shed crying. Later, he told Mr. Mac, "Women can't always be trusted, can they?" The next day he "accidentally" broke one of Mr. Mac's high school trophies.

For a week or two after Burt was placed, Sandy bounced around, living with friends, looking for work, and not finding any. However, a month and a half ago, Sandy obtained a solid job at a grocery store as a cashier.

Sandy has reconnected with her mother, Irene Curtis, who also says Sandy has not been drinking around her. Sandy's mother maintains that she would not allow drinking in her home. Sandy moved into an apartment with her mother about 6 weeks ago after getting the job and convincing her mother

that she was getting her life together because of Burt. Sandy is planning on getting her own place in the future when she can save enough for the deposits. She will have to pay to move in, but she is happy to stay with her mother for now. The court sanctioned Burt's unsupervised visitations with Sandy Hobgood as long as Ms. Curtis was at home to provide additional support and oversight. Ms. Curtis has been agreeable to allowing Burt to visit her home. In the past month, she allowed him to have two overnight visits that have gone well. Sandy was especially pleased that she was able to spend the extra time with Burt. Ms. Curtis feels that Sandy has really changed and says she is willing to allow Sandy and Burt to live with her as long as Sandy "does what she needs to do."

Johnny Hobgood has continued to be an absent parent, despite the agency's best efforts to locate him. Child support enforcement cannot locate him because he is not working at least not "on the books." His parents have not had any contact with him. They are still quite resistant to having visits between Burt and his siblings. Ms. Curtis calls them "stiff-necked" and says she hopes to get them to see Burt sometime soon. She says she is a little more comfortable around Burt and believes the McDougals, Mr. Mac especially, have been very good for Burt. Ms. Curtis still doesn't feel that she would be able to care for Burt alone.

At school, Burt went through a series of in-school suspensions as a result of angry outbursts early in his placement. He broke a desk, curses at the teachers, and makes fists at other smaller students, although he has not hit anyone that they have seen. Lately, though the suspensions have lessened somewhat. He has made a couple of friends with students who are not troublemakers. His grades are stabilizing and, although they have not gone up much, they are not getting any worse. Right now, he is passing everything. The IEP and extra attention he is receiving from Mrs. McDougal seem to be helping.

Burt is conflicted about what he wants. Most of the time Burt says he wants to go home to his mother and wonders how soon he can go, but other times he expressed concerns that his mother won't be able to keep her life together. He remembers what it was like when Sandy would get drunk, hit him, and leave him alone. Burt is afraid that it will happen again. Sometimes he expresses the wish that he might be able to stay with the McDougals forever "like a son."

Sandy Hobgood has been cooperating with all the recommendations of the family services agreement and is anxious to get Burt placed back with her and her mother. The overnight visits have gone very well although Sandy admits Burt can be very difficult to control sometimes and she gets angry with him when he acts out. Sandy's mother says she is willing to help her daughter, but she also says she would report her to DSS in "a heartbeat" if she goes off the wagon or hits Burt. Ms. Curtis would like for Burt to be reunited with Sandy but is not sure Sandy can handle Burt without additional help and support from DSS, especially until Sandy is well established in her alcohol recovery. Sandy admits that she was negligent in her parenting of Burt in the past, but she believes her problems were related to the stress of not having a regular job and trying to pay bills. She also admits that she used alcohol to forget her problems. She has learned healthier ways to deal with stress and feels her life is taking a new direction. She states that she thinks Burt needs to be with her and she needs to be with him.

Permanency Planning Services
Checklist of Forms and Activities

Forms website: https://policies.ncdhhs.gov/divisional/social-services/forms

Form Name	Form Number/Location
SIS Client Entry Form	DSS-5027
Relative Notifications	DSS-5316, DSS-5317, DSS-5318
Indian Child Welfare Act Compliance Checklist	DSS-5291
Initial Provider Assessment Kinship Care Comprehensive Assessment	DSS-5203 DSS 5204
Health History Form	DSS-5207
General Authorization for Treatment/Medication	DSS-1812
Child Education Status	DSS-5245
Best Interest Determination Form	DSS-5137
Foster Child Immediate Enrollment Form	DSS-5135
Permanency Planning Review & Family Services Agreement	DSS-5240
CFT Planning Form and/or CFT Safety Meeting Form	
Monthly Permanency Planning Contact Form	DSS-5295
Family Time & Contact Form	DSS-5242
Family Reunification Assessment	DSS-5227
Strengths/Needs Assessment	DSS-5229
Child Placement Report/Adoption Assistance	DSS-5094; DSS-5095
Notice to Parent Regarding Proposed Change in Placement	DSS-5189I
Notice to Parent Regarding Change in Placement	DSS-5189II
Notice to Permanency Planning Review	DSS-5189III
Notice to Parent Regarding Permanency Planning Review Outcome	DSS-5189IV
Voluntary Placement Agreement Foster Care 18 to 21	DSS-5097
Monthly Contact Record for Foster Care 18 to 21	DSS-5098
Transitional Living Plan for Youth/Young Adults in Foster Care	DSS 5096(a)(b)(c)(d)
Permanency Planning Activities	
Referrals for Medicaid and IV-E Determination (DSS 5120)	
Physical Exam (completed within 7 days of coming into DSS Custody; DSS-5206)	
30 Day Comprehensive Visit for Infants/Children/Youth in DSS Custody (DSS-5208)	
Shared Parenting Meeting (no later than 14 days after placement)	
Begin Child's Life Book Development (within 30 days of placement and continue throughout the lifetime of the case)	
Child and Family Team (CFT) Meeting Preparation and Notifications	
Permanency Planning Review (PPR) notifications and meeting	
Court Reports	
Referrals for services from community agencies	
12-month Permanency Planning Hearing	
LINKS Referral (required for ages 13 and up)	
Transitional Living Plans (required for ages 14 and up)	

Agenda

Day Eight

9:00 – 9:10 ……	I. Welcome
9:10 – 9:50 ……..	II. Family Reunification
9:50 – 10:10 ……..	III. Termination of Parental Rights
10:10 – 10:30 ……..	IV. Adoption A. What is Adoption?
10:30 – 10:45 ……	**BREAK**
10:45-11:10……	Adoption, cont. B. Adoption Terms Match Game
11:10 – 11:30…….	C. Adoption Policy Discussion
11:30 – 11:40……..	D. Legal Side of Adoption
11:40-12:00…….	E. Adoption True of False
12:00 – 1:15 ……..	**LUNCH**
1:15-1:40……	Adoption, cont. F. Sensitive Issues
1:40-2:00……..	V. Case Closure
2:00-2:15……..	VI. Closing and Next Steps

Reunification

"Family reunification is the planned process of reconnecting children in out-of-home care with their families by means of a variety of services and supports to the children, their families, and their foster parents or other service providers. It aims to help children and families achieve and maintain their optimal level of reconnection-from full reentry of the child into the family system to other forms of contact, such as visiting, that affirm the child's membership in the family."

The Reunification Process

Phase I: Bridging: creating a connection between the child's home and the foster family

Goals:

- Preserving the child's history
- Informing the child of family events
- Transferring strategies
- Modeling cooperation

Strategies and Tasks:

- Meeting with the fosterparents
- Establishing the biological parent-foster parent relationship

Phase II: Opening: re-fitting a child into a family that has adapted to his/her absence and re-shifted his/her roles within the family-takes place on a physical and psychological level; finding tasks for all the members to participate in also helps reunite the family successfully.

- Physical space
- Family image
- Social/educational environment

Phase III: Building: there's usually a honeymoon phase of about two weeks following reunification, and family members need to be encouraged to think about and feel positively about what will happen when the honeymoon is over; the worker is looking for opportunities to highlight the sense of family that is forming and praise parents and other family members for using new strategies and applying new skills

Tasks:

- Family meetings
- Recreation
- Traditions and rituals
- Others:

Source: Maluccio, A., Warsh R., & Pine, *B. (1993). Together again.* Washington, DC: Child Welfare League of America.

Reunification Practice

Using the Hobgood case, answer the following questions.

Bridging group

- What specific steps would you take to maintain the connection between family members during the placement?

- What are the "red flags" you should be looking for?

Opening group

- How exactly will you go through the reunification process?

- What needs to be said to each of the participants?

Building group

- How will you know if reunification is going well?

- What type of post-reunification supports might be needed?

Consider This!

Reunification Case Considerations

- **Have the issues that caused the removal been addressed and resolved?**
- **Have the parents made changes in their behavior and circumstances that were making the child unsafe and placing the child at risk?**
- **Have other issues that affect safety and risk been observed and documented?**
- **Has a reduction in risk and an increase in safety to the child been observed and documented?**
- **Have the visits with the child demonstrated the parent's ability to now care for the child?**
- **Has a trial placement been considered to observe changes in the parent's ability to care for the child? Has the court approved this plan?**
- **Is there some confidence that the family will not relapse? Are appropriate supports in place to prevent relapse?**
- **Have reasonable efforts been made to identify, locate, and involve all the parents in the planning process, including both legal and biological fathers?**
- **Has the child's grief and need to reconnect to the family been recognized?**
- **Would this child be removed today?**

(NCDSS Child Welfare Manual: Permanency Planning)

§ 7B-1111. Grounds for terminating parental rights

(a) The court may terminate the parental rights upon a finding of one or more of the following:

(1) The parent has abused or neglected the juvenile. The juvenile shall be deemed to be abused or neglected if the court finds the juvenile to be an abused juvenile within the meaning of G.S. 7B-101 or a neglected juvenile within the meaning of G.S. 7B-101.

(2) The parent has willfully left the juvenile in foster care or placement outside the home for more than 12 months without showing to the satisfaction of the court that reasonable progress under the circumstances has been made in correcting those conditions which led to the removal of the juvenile. Provided, however, that no parental rights shall be terminated for the sole reason that the parents are unable to care for the juvenile on account of their poverty.

(3) The juvenile has been placed in the custody of a county department of social services, a licensed child-placing agency, a child-caring institution, or a foster home, and the parent, for a continuous period of six months next preceding the filing of the petition or motion, has willfully failed for such period to pay a reasonable portion of the cost of care for the juvenile although physically and financially able to do so.

(4) One parent has been awarded custody of the juvenile by judicial decree or has custody by agreement of the parents, and the other parent whose parental rights are sought to be terminated has for a period of one year or more next preceding the filing of the petition or motion willfully failed without justification to pay for the care, support, and education of the juvenile, as required by said decree or custody agreement.

(5) The father of a juvenile born out of wedlock has not, prior to the filing of a petition or motion to terminate parental rights, done any of the following:

a. Filed an affidavit of paternity in a central registry maintained by the Department of Health and Human Services; provided, the petitioner or movant shall inquire of the Department of Health and Human Services as to whether such an affidavit has been so filed and the Department's certified reply shall be submitted to and considered by the court.

b. Legitimated the juvenile pursuant to provisions of G.S. 49-10, G.S. 49-12.1, or filed a petition for this specific purpose.

c. Legitimated the juvenile by marriage to the mother of the juvenile.

d. Provided substantial financial support or consistent care with respect to the juvenile and mother.

e. Established paternity through G.S. 49-14, 110-132, 130A-101, 130A-118, or other judicial proceeding.

Grounds for terminating parental rights, cont.

(6) That the parent is incapable of providing for the proper care and supervision of the juvenile, such that the juvenile is a dependent juvenile within the meaning of G.S. 7B-101, and that there is a reasonable probability that such incapability will continue for the foreseeable future. Incapability under this subdivision may be the result of substance abuse, mental retardation, mental illness, organic brain syndrome, or any other cause or condition that renders the parent unable or unavailable to parent the juvenile and the parent lacks an appropriate alternative child care arrangement.

(7) The parent has willfully abandoned the juvenile for at least six consecutive months immediately preceding the filing of the petition or motion, or the parent has voluntarily abandoned an infant pursuant to G.S. 7B-500 for at least 60 consecutive days immediately preceding the filing of the petition or motion.

(8) The parent has committed murder or voluntary manslaughter of another child of the parent or other child residing in the home; has aided, abetted, attempted, conspired, or solicited to commit murder or voluntary manslaughter of the child, another child of the parent, or other child residing in the home; has committed a felony assault that results in serious bodily injury to the child, another child of the parent, or other child residing in the home; or has committed murder or voluntary manslaughter of the other parent of the child. The petitioner has the burden of proving any of these offenses in the termination of parental rights hearing by (i) proving the elements of the offense or (ii) offering proof that a court of competent jurisdiction has convicted the parent of the offense, whether or not the conviction was by way of a jury verdict or any kind of plea. If the parent has committed the murder or voluntary manslaughter of the other parent of the child, the court shall consider whether the murder or voluntary manslaughter was committed in self-defense or in the defense of others, or whether there was substantial evidence of other justification.

(9) The parental rights of the parent with respect to another child of the parent have been terminated involuntarily by a court of competent jurisdiction and the parent lacks the ability or willingness to establish a safe home.

Grounds for terminating parental rights continue on next page

Grounds for terminating parental rights, cont.

(10) Where the juvenile has been relinquished to a county department of social services or a licensed child-placing agency for the purpose of adoption or placed with a prospective adoptive parent for adoption; the consent or relinquishment to adoption by the parent has become irrevocable except upon a showing of fraud, duress, or other circumstance as set forth in G.S. 48-3-609 or G.S. 48-3-707; termination of parental rights is a condition precedent to adoption in the jurisdiction where the adoption proceeding is to be filed; and the parent does not contest the termination of parental rights.

(11) The parent has been convicted of a sexually related offense under Chapter 14 of the General Statutes that resulted in the conception of the juvenile.

For a judge to grant Termination of Parental Rights, one or more of the grounds must be met, and the decision must be determined to be in the child's best interests. In most situations, the court will consider the level and appropriateness of the agency's efforts in providing services to the parents when deciding for termination of parental rights. If the parent has committed the murder or voluntary manslaughter of the other parent of the child, the court shall consider whether the murder or voluntary manslaughter was committed in self-defense or in the defense of others, or whether there was substantial evidence of other justification.

Thoughts on
Termination of Parental Rights

" . . . defining family reunification as the successful outcome of placement appears to undermine both (1) the essential process of assessing with parents their interests in parenting, and (2) the practitioner's ability to achieve permanency for children."

Hess, P. & and Folaron, G. (1991, July/August). Ambivalences: A challenge to permanency for children. *Child Welfare* (Vol. LXX no. 4). p. 421

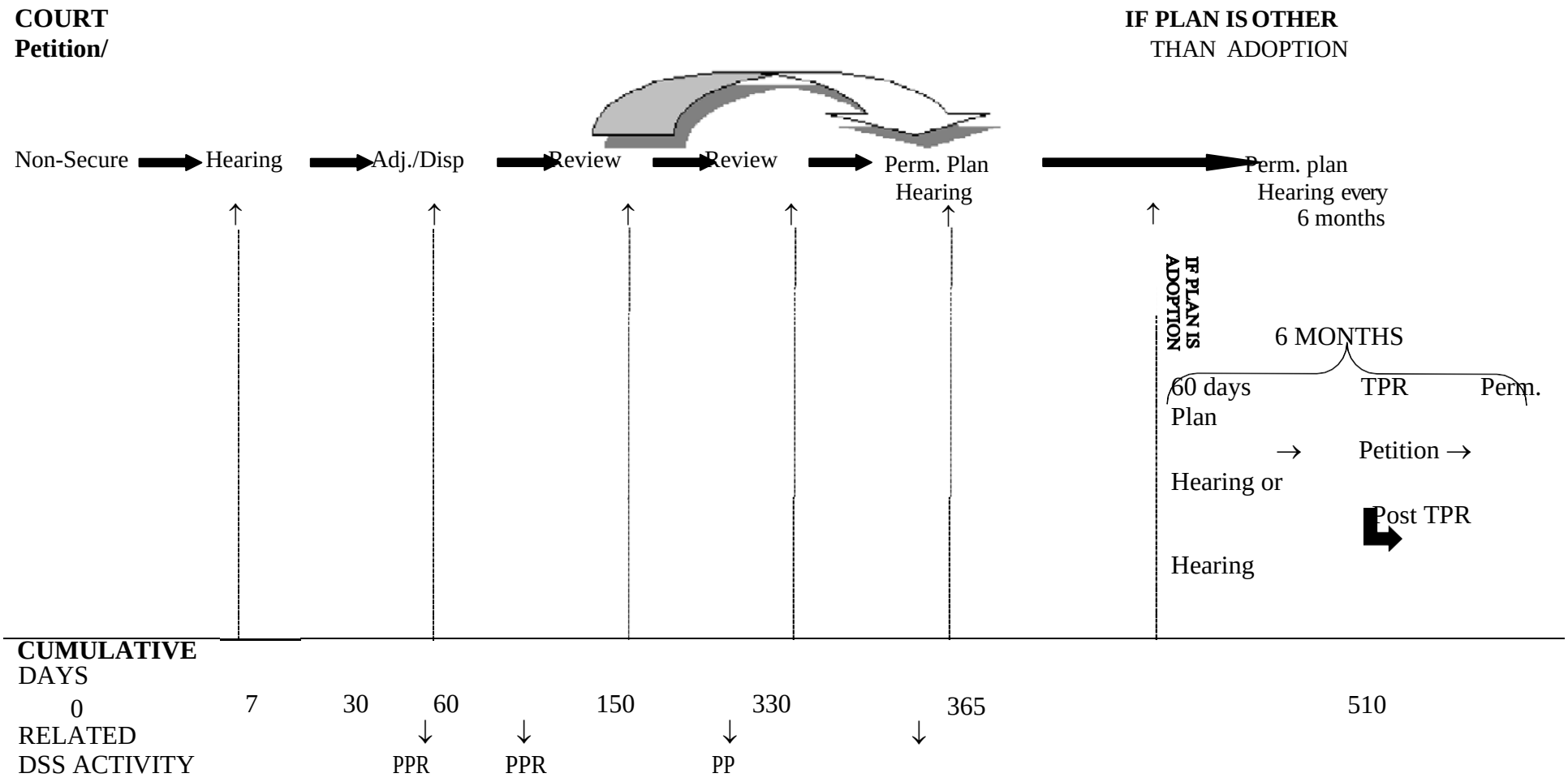
"Home life is the highest and finest product of civilization. It is the greatest molding force of mind and character. Children should not be deprived of it except for urgent and compelling reasons."

"Some judges require an overwhelming amount of evidence before they will separate a child from his natural mother, so strong is the assumption that the child must be best off with his mother."

Geiser, R. (1973). The illusion of caring: children in foster care. Boston: Beacon Press.

". . . I have come to the conclusion that termination of parental rights is not a wise option unless there is a prospective adoptive parent available for the child. Otherwise, many children will be in the legal and psychological limbo of having no person they can identify as a parent."

The Honorable Patricia R. Tamilia. (1992). A response to elimination of the reasonable efforts required prior to termination of parental rights status, University of *Pittsburgh Law* Review (Vol. 54:139). pp. 217-218.


COURT
Petition/
IF PLAN IS OTHER
THAN ADOPTION
Non-Secure
Hearing
Adj./Disp
Review
Review
Perm. Plan
Hearing
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6 months
IF PLAN IS
ADOPTION
6 MONTHS
60 days
Plan
TPR
Petition
Perm.
Hearing or
Post TPR
Hearing
CUMULATIVE
DAYS
0
7
30
60
150
330
365
510
RELATED
DSS ACTIVITY
PPR
PPR
PP

Permanency Plans

- Reunification
- Adoption
- Legal Guardianship
- Legal Custody
- Another Planned Permanent Living Arrangement (APPLA)
- **Reinstatement of Parental Rights**

"Reinstatement of Parental Rights"

Definition: (G.S. 7B-1114) A legal proceeding (as of October 2011 in NC) that restores all rights, powers, privileges, immunities, duties, and obligations of the former parent of the juvenile.

Who Can File a Motion:

1. A juvenile whose parent's rights have been terminated (by court order or through relinquishment) in North Carolina (or another state)
2. The juvenile's guardian ad litem attorney
3. A county DSS with custody of the juvenile.

Prior Conditions Which Must Be Satisfied:

1. The juvenile must be 12 years of age or, if younger, must allege extraordinary circumstances

2. The juvenile must not have a legal parent, not be in an adoptive placement; and not likely to be adopted within a reasonable amount of time.

3. The TPR order was entered at least three years before the filing of the motion, unless the court has found or the juvenile's attorney advocate and the county DSS stipulate that the juvenile's permanent plan is no longer adoption.

Additional Provisions of the Law:

1. The law outlines criteria that the court will take into consideration in determining whether reinstatement of parental rights is in the juvenile's best interest and should become the permanent plan. (such as whether the parent whose rights may be reinstated has remedied the conditions that led to the juvenile's removal from the home, what services would be needed by the juvenile and parent if the rights were reinstated, etc.)
2. If the court determines that reinstatement is the permanent plan, the court may order visitation as well as trial placement.

Adoption Match Game

1. Confidential Intermediary Services	**A.** The summary written collaboratively by the family and the social worker which describes the family requesting to adopt a child. The summary includes background information on the family, including the qualities they have which would match well with the prospective adoptive child.
2. Child Adoptive Summary	**B.** Based on favorable reports submitted by the supervising agency, the clerk of court enters the final decree, which completes the legal adoption of the child. After this decree is received, the parents can apply for a new birth certificate for the child with their last name.
3. Agency Adoption	**C**. A report written by the social worker about a particular child describing the characteristics of the child and the type of parents the child needs. The summary is sent to other agencies and placed on Resource Exchange Listings in an effort to find the most appropriate parents.
4. Pre-Placement Assessment	**D**. Services provided to an adult adoptee, biological parent, or an adult lineal descendant of a deceased adoptee, to facilitate contact or share identifying information with the written consent of the parties involved.
5. Direct Placement	**E**. An individual or non-profit entity that assists biological parents in locating and evaluating prospective parents **without charge**.
6. NC Kids	**F.** Part review of a child's life and part diary, it is begun when the child enters the foster care system and describes the child's earlier life, experiences in the foster care system, significant people in the child's life as well as medical and educational information.
7. Adoption Facilitator	**G**. Following relinquishment, the agency takes legal custody of the child and is responsible for placement of the child in an adoptive home.
8. Relinquish-ment	**H**. The process by which a parent independently chooses an individual or relative to become the parent for his or her child. A placing agency completes a pre-placement assessment of the prospective adoptive parents, which is then filed with the Petition for Adoption.
9. Decree of Adoption	**I.** Financial assistance to support the extra burden on the parents adopting a special needs child. Eligibility for assistance is based on the needs of the child, not the prospective parents. Assistance can take the form of monthly financial payments, Medicaid, vendor payments for physical or emotional treatment, and/or post adoption services.
10. Lifebooks	**J.** Program provided by the Division of Social Services to assist local agencies in finding families who "match" the needs of children awaiting adoption. Includes the Photo Adoption Listing Service for children awaiting adoption.
11. Adoption Assistance	**K**. The process by which a parent voluntarily gives up legal rights to his or her child to an agency for placement. The revocation period for the biological parent to change his/her mind and withdraw the relinquishment is 7 days regardless of the age of the minor.

Safe Surrender of Newborns

What everyone needs to know about North Carolina's Law

Safe Surrender:
It's in your hands.

In an emergency:
911

What is the new Safe Surrender Law? An infant up to 7 days old may be left with a responsible adult, legally and anonymously. This is North Carolina state law, properly called the "Infant Homicide Prevention Act."

Why is there such a law? The risk of homicide on the first day of life is 10 times greater than the rate during any other time of life. Every year, several babies are either killed or left to die in North Carolina by a parent in crisis, who may feel they have no other choice. The law hopes to provide such parents a way to surrender their unwanted newborn safely and anonymously.

Who can receive an infant through safe surrender? The law states that a baby may be surrendered to "any responsible adult." Some people are especially cited: on-duty health care provider, law enforcement officer, social services worker or emergency medical services worker. However, "any responsible adult" could mean just about anyone.

What happens to these babies? An adult who receives the baby is required to keep it safe and warm, and to call 911 or the local department of social services right away. They should know that the surrendering parent is not required to give any identifying information. The goal is to have the baby adopted into a safe and loving home as quickly as possible.

How big a problem is infanticide and child homicide? In our state, an average of two infants are killed or left unprotected to die every year. Every two weeks, a North Carolina child is killed by a parent or caregiver in some form of child abuse.

Has the law worked? No official numbers exist, but since the law was enacted in 2001, at least two newborns have been highlighted in the media as having been safely surrendered. However, at the same time, a number of newborns have also been abandoned unsafely or killed (six have died). Public awareness is crucial to help parents know this option exists, and also to alert the public that receiving a surrendered newborn is legal. Help us spread the word by copying and distributing this fact sheet.

What about fathers? Don't they have rights too? There is a natural concern that a woman may have a baby and surrender it without the father knowing it exists. Any man who hears of a surrendered infant and believes it may be his should come forward.

Is Safe Surrender the same as Safe Haven? Many states have what are called Safe Haven laws. These designate places where a baby may be surrendered. North Carolina's law is unique in that it designates people, not places.

Adoption Policy Information

Services to Birth Parents:

The agency shall help parents reaching the decision to relinquish their child to the agency for adoptive placement to have a thorough understanding of the impact of adoption on the child's and their lives.

The individual signing the relinquishment must be offered a copy of the relinquishment, be advised that counseling services are available through the agency and be advised of their right to independent counsel.

Services to the Child:

The child's statement should not be the sole determinant of the decision to plan for adoption.

In cases where adoption is the plan:

- the agency should seek relinquishments from the birth parents or a petition for termination of parental rights shall be filed within 60 days of the agency's decision that the goal is adoption.
- The agency must develop a child's specific written strategy for recruitment of an adoptive home if a family is not identified.
- The child's worker shall prepare a written assessment of the child

Each child who is available for adoption shall be assessed for eligibility for adoption assistance based on the child's circumstances and special needs.

Placement with current caretakers for adoption should be the first consideration unless it can be clearly documented that it would be contrary to the child's welfare and best interests.

When a specific family is chosen for the child, the child's worker shall provide the child with information about the family and prepare the child for the anticipated number of visits with the prospective adoptive parents.

Services to Adoptive Applicants:

The agency shall have a plan for ongoing recruitment of adoptive families for children.

A preplacement assessment:

- Shall be developed with the prospective adoptive family. The preplacement assessment shall be prepared and presented to the adoptive applicants for review.
- The applicants must be provided in writing with notice of the agency's decision regarding approval or denial of approval for adoption within 30days after the study is completed.
- Each agency shall have a procedure for allowing an individual who has received an unfavorable preplacement assessment to have the assessment reviewed by the agency.

The Agency Adoption Committee shall be composed of a minimum of three persons, including a person from the agency in a management position in children's services, the child's social worker, and the adoption worker.

The possibility and availability for adoption assistance for the child being considered shall be discussed with the adoptive parents.

Post placement services shall be provided to the adoptive family. A face to face visit must be made within the first week of placement and then at least monthly with the child and the adoptive parents by the family's social worker.

The agency will cooperate with the adoptive parents in the legal adoption procedure.

Post adoption services shall be made available after the Decree of Adoption has been issued.

Source: NCDSS Adoption Services Manual: https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/adoptions-1.pdf

Developed by: Sue Dickinson, FRTC

Consider This!

Adoption Case Considerations

- Have all relative placement options been considered and eliminated?
- Has the child's ethnic and cultural needs been considered and addressed?
- Has the best interest of the child been considered and documented?
- Are the parents willing to relinquish their rights, or is the agency ready to proceed with the termination of parental rights?
- Do legal grounds for termination of parental rights exist?
- Is the child already living with caretakers who are willing to adopt?
- Has a pool of potential adoptive families been recruited?
- How soon can the child be placed in an adoptive home?
- How long will the court process take?
- Who will help the child through the placement process?
- Has the child's needs and strengths been thoroughly assessed and evaluated?
- Has a placement option that will be able to meet the child's needs been identified?
- What is the child's relationship with siblings, and should they be placed together?
- Is the child able to accept parenting'?

(NCDSS Adoption Services Manual) https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/adoptions-1.pdf

Steps through an Adoption

- The adoption process is a complex mix of emotional and legal bonding that occurs between a child and a family. The following is a simplified description of what occurs from the time the decision is made that adoption is in the best interests of a child through the completion of the legal connection.

- An assessment of the child is written and distributed through various means (letters, adoption fairs, adoption exchanges, etc.). The Internet is being used more and more extensively to share information about waiting children. New laws push this process along.

- Prospective adoptive families work with a social worker to complete a pre-placement assessment. Although the focus is on the placement of children, information about prospective adoptive families is critical in making the best possible connections between families and children.

- Adoption teams or committees study the available information to match the strengths and needs of the child with the strengths and interests of the family. When a "match" seems right, the child and family are introduced to each other, first on paper and then in person.

- If all proceeds well, the child will begin visiting and then be placed with the adoptive family to begin the process of constructing a new family.

- When the Petition for Adoption is filed, the court orders that a report on the adoptive family be completed. The report is completed by a social worker who visits with the family and observes the process of bonding. The social worker is also available to offer assistance when the growing pains are difficult and when special help is needed to maintain the new family.

- Legal notices of the adoption proceedings are sent to all "interested parties," who then are given a certain amount of time to respond.

- The report on the adoption is filed at the court, after which the court sets a hearing or disposition date. (Most adoptions are finalized without a formal hearing.)

- The decree of adoption is awarded at the hearing.

Types of Adoptions

Relative adoption *occurs when the child is placed for adoption by the parent or legal guardian with an adopting family who are grandparents, great grandparents, aunts/uncles, great aunts/uncles, 1st cousins, or siblings of the child. Pre-placements are not required in relative adoptions. Relative adoption helps to preserve the child's sense of identity and family history.*

Stepparent adoption *occurs when the spouse of a biological parent of the child desires to establish a legal parent-child relationship with a child. Consents, relinquishments, or a termination of parental rights must be obtained related to the child's other biological parent. The county DSS may provide the needed services in obtaining sufficient information to produce the Report to the Court on proposedAdoption.*

Direct/Independent Placement *occur when a* woman who is pregnant or a parent who already has a child chooses another person(s) to whom she will release her child, without working through an agency. North Carolina statute requires that a pre- placement assessment be completed on the prospective parents. In North Carolina such a "private" or "independent" adoption is legal. In other states it would be illegal.

Agency Adoptions *occur when c*hildren in the custody of a county department of social services or a licensed child-placing agency and who are legally free to be adopted into permanent homes are matched with prospective parents who have applied through an agency to adopt. Children who are adopted by the family who fostered them are another example of an agency adoption. Most older and special needs children who are adopted are adopted by their foster parents.

Foster-to-adopt adoption occurs when a foster family chooses to adopt the child in its care. It is especially appropriate if the child has formed a close relationship with his or her foster family. This has the advantage of continuity—the child does not have to move and adjust to a new environment

Legal Risk Adoptions *occur when a child is placed with prospective adoptive parents (who must be licensed as foster parents) before all legal ties to the biological parent have been severed. A legal risk is taken by the prospective parents when it appears that the birth family is resolved in its decision to relinquish the child. It reduces the number of moves the child will experience*

International Adoptions *occur when adoptions* are completed through agencies that connect prospective parents with children who are overseas and available for adoption. Historically, Korea allowed more of its children to be adopted in the United States than any other country. Currently, children from China comprise the largest number of international adoptees.

Adult Adoption*s occur when* an adult adopts any other adult (with their consent) with the exception of their own spouse.

ADOPTION TRUE OR FALSE

1. **A criminal history check including a fingerprint check must be conducted prior to placement of a child in the custody or placement authority of DSS with prospective adoptive parents.**

2. **Identifying information such as the adoptive or biological parent's names, addresses, or other personal information cannot legally be disclosed to the birth parent, adult adoptee, or the adoptive parent in either an agency adoption or a direct placement adoption.**

3. **If a child is 12 years of age or turns 12 before the issuance of a Decree of Adoption, the child 's consent to the adoption is needed.**

4. **A preplacement assessment is legally required in all agency or direct placement adoptions.**

5. **Once a parent(s) signs a consent or relinquishment of their child for adoption, it cannot be taken back.**

6. **A person who is in this country illegally or is not a US citizen cannot adopt a child.**

7. **A birth mother can advertise in the newspaper for an adoptive family for her child.**

8. **Any person may adopt any other individual whether adult or child, with the exception of their own spouse.**

9. **Parents who adopt a child internationally and the adoption is completed in the foreign country do not have to readopt the child in the U.S. when they return to N.C.**

10. **Even after an unrelated adoptive parent has adopted a child, grandparents still retain the right to visit their grandchild.**

11. **No adoptive family has ever willingly given up their adopted child.**

12. **A child who has not been legally freed for adoption at the time placement occurs is known as a legal risk adoption. This means that the adoptive family is taking a risk that the birth parent/s will not change their mind and withdraw their relinquishment or consent for placement of the child during the revocation period.**

Consider This!

Case Closure Case Considerations

Have the contributing factors to risk or maltreatment been addressed and eliminated or reduced to a minimal level of risk?

Have the service providers and other persons significant to the case been contacted and has discussion occurred around current family functioning, current risk level, or any remaining concerns.

Or

Have the children been placed into other permanent family situations in which there is no risk of maltreatment?

WORKSHEET: USING PROTECTIVE FACTORS AS A LENS TO MONITOR PROGRESS TOWARD CASE CLOSURE

Worker name _____

Family name _____

Date last updated _____

Just as we monitor other aspects of case progress, we also want to stay attuned to changes in the family's protective factors. In the end, as families transition out of their engagement with the child welfare system, we want to be able to demonstrate that:

- The family made progress on their own protective factors goals
- The family can reliably draw upon their protective factors in ways that help prevent a repeat of the issues that brought them in contact with the system
- The family has a plan in place for continuing to build their protective factors once they are no longer involved with the system

The chart below can be used in multiple ways, including:

- In early engagement with caregivers to discuss and agree on the type of growth in protective factors that could be used to indicate progress
- In family team meetings or other conversations with partners who are also supporting the family
- To help staff in documenting growth in family strengths for court reports and other case progress reports
- To support decisions about case closure

The form below includes possible indicators of family progress, with room for your notes.

Questions to ask	Indicators of change as framed by protective factors
Has caregiver functioning acceptably improved?	**Strengthened Parental Resilience** ϒ Improved problem-solving skills ϒ Better able to cope with stress/does not allow stress to impact parenting ϒ Self-care strategies in place
	Social and Emotional Competence of Children ϒ Caregiver is emotionally responsive to the child(ren) ϒ Caregiver has created an environment in which the child(ren) demonstrates a sense of safety to express his/her emotions ϒ Caregiver separates emotions from actions ϒ Caregiver provokes age-appropriate social-emotional responses and encourages/reinforces social skills ϒ Caregiver creates opportunities for the child(ren) to explore and solve problems
	Other Indicators and Notes

Questions to ask	Indicators of change as framed by protective factors
Has caregiver's willingness and ability to reach out to others in times of need changed?	**Strengthened Parental Resilience** ϒ Improved help-seeking behavior ϒ Receiving mental health or substance abuse services as needed
	Enhanced Social Connections ϒ Caregiver has supportive relationships ϒ Caregiver has a network he/she can turn to for help ϒ Caregiver has relationship-building skills
	Concrete Supports ϒ Caregiver is open to accessing and using services ϒ Caregiver has enhanced skills in accessing supports when needed
	Other Indicators and Notes
Does the caregiver have realistic expectations for the child(ren)?	**Knowledge of Parenting and Child Development** ϒ Caregiver is more confident in his/her parenting skills ϒ Caregiver has a new appreciation for his/her nurturing role ϒ Caregiver has developed a balance between parenting and self-care ϒ Caregiver better understands/encourages healthy development ϒ Caregiver better understands/employs age-appropriate responses to the child(ren)'s behaviors ϒ Child(ren) responds more positively to the caregiver's approach ϒ Caregiver is effectively linked to early childhood resources ϒ Caregiver is involved in the child(ren)'s early childhood activities ϒ Caregiver understands the child(ren)'s special needs and how best to meet those needs
	Social and Emotional Competence of Children ϒ Caregivers sets clear and age-appropriate expectations/limits ϒ Caregiver has created an environment in which the child(ren) can safely express his or her emotions ϒ Caregiver is emotionally responsive to the child(ren)
	Other Indicators and Notes

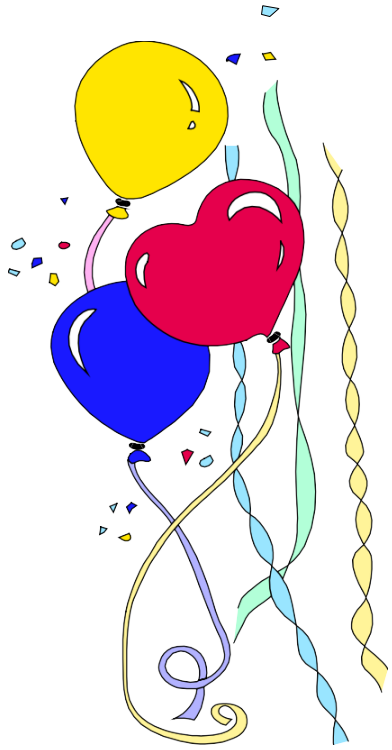
Indicators of Closure

The following are situations or conditions under which case closure should be considered or implemented:

- Family is coping-not cured
- Acceptable attainment of plan objectives
- Basic needs are being met
- Support system is developed which will exist after you leave
- Necessary services from other agencies are in place
- Family has identified one advocate whom they trust
- Plan for future crisis management has been identified
- Risk levels have been reduced or eliminated

Preparing for a Successful Closure

- **Start preparing for closure on the first day of service.**
- **Focus on building a support system for the family throughout the intervention.**
- **Discuss the family's feelings about ending their connections with the agency. Point out the family's successes.**
- **Prepare for possible setbacks.**
- **Develop a plan for ending agency involvement with the family.**
- **Beware of the "termination crisis."**
- **Celebrate with the family by recognizing their accomplishments.**



Child Protective Services Structured Intake Form

Section I: Demographics

Date: January 9, 2017 Time: 2:10 PM

Received by (Name): Evelyn S. Work County: Any County

Screening Decision: Screened In Referred Due to Residency: n/a

Assigned to: (County/Worker Name) Hugh Timely

Referred to: (County Name) n/a Date/Time: _____

Confirmed with: _____

Was Safety Assessed ☐ Yes Date: _____ By: _____

☐ No Reason: _____

Type of Report: ☐ Abuse ☒ Neglect ☐ Dependency

If referring to another county for assessment, do not complete the information below:
Family Assessment ☒ Investigative Assessment ☐

Initiation Response Time: Immediate ☒ 24 Hours ☐ 72 Hours ☐

Case Name: Hobgood, Sandy Case Number: 23456

This report involves: Conflict of Interest ☐ Out of Home Placement ☐ Request for Assistance ☐

Substance Affected Infant notification by a healthcare provider ☐

Please refer to the Child Protective Services Structured Intake Form Instructions (DSS-1402ins) for guidance and additional information on conducting a thorough intake interview and filling out this form.

Section II: Reporter Information

Name: Georgetta Grant Relationship: neighbor

Address: 453 Stone Ridge Dr. Apt 6, Anytown, NC

Phone Number: 919-000-2345

Reporter waives right to notification? ☐ Yes ☒ No

Is the reporter available to provide further information, if needed? ☒ Yes ☐ No

Section III: Maltreatment Information

Children's Information

Name (include nicknames)	Sex	Race	Age/DOB	School/ Child Care	Relationship to Perpetrator A	Relationship to Perpetrator B
Burt Hobgood	M	W	10		son	

Parent/Caretaker's Information

Name (include aliases/nicknames)	Sex	Race	Age/DOB	Employment/School
Sandy Hobgood	F	W	?	

Alleged Perpetrator's Information

Name (include aliases/nicknames)	Sex	Race	Age/DOB	Employment/School
A. Sandy Hobgood	F	W	?	
B.				

Other Household Members

Name (include aliases/nicknames)	Sex	Race	Age/ DOB	Employment/ School	Relationship
unknown					

Is the alleged perpetrator a relative who lives outside of the home? ☐ Yes ■ No

Does the relative entrusted with the care of the child have a significant degree of parental-type responsibility for the child? ☐ Yes ☐ No

If yes, what is the duration of the care provided by the adult relative?

If yes, what is the frequency of the care provided by the adult relative?

What is the location in which that care is provided?

What is the decision-making authority that has been granted to that adult relative?

Address and phone number(s) of all household members, including the length of time at current address, include former addresses if the family is new to the area:

453 Stone Ridge Dr. Apt #5

Anytown, NC Phone: 919-222-9876

Driving Directions: From Main St., Anytown, NC, turn left on Hwy 421 S., go 2 miles and turn right on Stone Ridge Dr., Apartments on the left

List any information about the family's American Indian Heritage: I don't know if they are of Indian Heritage

List any information about the parent(s) or caretaker(s) Military Service: unknown

Family's Primary Language: English

Collateral Contacts: Others who may have knowledge of the situation (include name, address, and phone number):

unknown

Do you have any information about the children's other maternal or paternal relatives (include name, address, and phone number)?

Names unknown

a couple of men visit regularly, but I don't know if they are relatives or not

Has the family ever been involved with this agency or any other community agency? Do you know of other reports about the family?

unknown

What

What happened to the child(ren), in simple terms?

Reporter states: Burt came to my door a few minutes ago. (I live in the same apartments). He asked for some food. He said he had eaten the peanut butter sandwiches his mother had left for him and that there was nothing else in the house to eat. He said he did not know when his mother would be home. He said he was worried about her. Burt told me that he was "so scared last night he couldn't sleep," and "he was afraid of being along again tonight and wanted someone to find his mother." He also told me that he was afraid she might not be coming back home and that he had not eaten since yesterday and that there was no more food in the house. Burt has several bruises on his arms and legs that look like they were caused by a belt.

Did you see physical evidence of abuse or neglect? If yes, please describe. Reporter states: I saw two bruises today on his arms and the bruises on his legs are about an inch wide and they look like they were caused by a belt. Burt told me he got a spanking from his mother by nodding his head yes when I asked him. Reporter states that this is the first time she has seen bruises on Burt and that she sees him about once per week.

Is there anything that makes you believe the child(ren) is/are in immediate danger? Yes, He told me his mother had been gone since yesterday

morning and that he was worried about her. I believe this child is too young and immature to be left alone.

Has there been any occurrence of domestic violence in the home? I don't know

Are you concerned about a family member's drug/alcohol use? I don't know anything but I do wonder if she drinks during the parties I hear going on in the apartment.

Human trafficking occurs when individuals buy, sell, trade, or exchange people for the purposes of sex or labor. To your knowledge, has the child been a victim of trafficking? ☐ Yes ■ No

If yes, describe

Does the child have any distinguishing characteristics (physical or other)? ☐ Yes ■ No

If yes, describe

When

Approximately when did this incident occur? He is alone now, but he was at my door about 1:45pm today. I don't know when he got the spanking from his mother.

When was the last time you saw the child(ren)? About 2:00pm today when he went back to his apartment.

Where

Current location of child(ren), parent/caretaker, perpetrator? I don't know where his mother is. Burt is in his apartment now.

How

How do you know what happened to the family? Burt told me he was alone last night and that he was scared and that he has not seen his mother today.

How long has this being going on? Burt says he has not seen his mother since yesterday.

Section IV: Family Strengths

What are the strengths of this family? Tell me anything good about this family. Burt is always dressed appropriately for the weather. He seems to love his mother and talks about her playing with him and taking him places.

Ms. Hobgood works.

How do family members usually solve this problem? What have you seen them do in the past? I am not sure.

What is it about this family's culture that is important to know? I don't know but it seems that Ms. Hobgood like to "keep to herself"

Section V: Safety Factors

Are you aware of any safety problems with a social worker going to the home? If so, what? I don't know of any safety problems

Calling DSS is a big step, what do you think can be done with the family to make the child(ren) safer? Talking to his mother

Is there anything you can do to help this family? I will "keep an eye" on Burt for his mother if she wants me to.

Has anything happened recently that prompted you to call today? Burt telling me he was alone last night and that he didn't know when his mother would be back.

Section VI: Health Insurance Information

Does the child(ren) have health insurance? If yes, what type?

☐ Medicaid ☐ Private Insurance/HMO ☐ Health Choice ☐ Other ☐ No Insurance

Where does the child(ren) receive regular health care?

☐ Health Department ☐ Hospital Clinic ☐ Community Health Center ☐ Private Doctor/HMO ☐ Other

☐ No Regular Care

The following questions are intended as a guide. These questions are not meant to replace the narrative already completed in this report. If the questions that correspond with the specific allegations earlier in this report have already been answered, then that information should not be repeated. When these categories are not relevant to the allegations reported, indicate this by checking the N/A (not applicable) box above the first question in each category.

Section VII: Abuse, Neglect, and Dependency

☒ N/A

Physical Abuse

Where was the child(ren) when the abuse occurred? _____

_____

_____

Describe the injury. For example; Thursday, May 23, 2016, a.m. or p.m., red and blue mark, 1'' by 4'' shaped like a belt mark, fresh or fading, etc.

_____

_____

_____

What part of the body was injured? _____

_____

Is there need for medical treatment? _____

What is the parent/caretaker's explanation? _____

_____

What is the child(ren)'s explanation? _____

_____

What led to the child(ren)'s disclosure or brought the child(ren) to your attention? _____

_____

Did anyone witness the abuse? _____

Are any family members taking protective action? _____

Have you had previous concerns about this family? _____

_____

Is/are the child(ren) currently afraid of the alleged perpetrator? How do you know this?

_____

_____

Is/are the child(ren) afraid to go home? How do you know this? _____

_____

☒ N/A **Moral Turpitude**

Does the parent/caretaker encourage, direct, or approve of the child(ren) participating in illegal activities such as shoplifting, fraud, selling drugs/alcohol? If so, what activity or activities is the child(ren) participating in that the parent is allowing?

_____

_____

☒ N/A **Sexual Abuse**

Where was the child(ren) when the abuse occurred? _____

_____

To whom did the child(ren) disclose the abuse? _____

_____

Did the child(ren) disclose directly to the reporter? _____

What is the age of the alleged perpetrator and his/her relationship to the child(ren)? _____

_____

What is the alleged perpetrator's access to the victim and other children? _____

_____

What steps are being taken to prevent further contact between the perpetrator and the child(ren)? _____

_____

_____

Has the child(ren) had a medical exam? _____

☒ N/A **Human Trafficking**

General

Does the child have any distinguishing marks or tattoos? ☐ Yes ☐ No

If yes, describe _____

_____

Sex Trafficking and Labor Trafficking

Is the child a victim of sex trafficking or labor trafficking? ☐ Yes ☐ No ☐ Unknown

If so, who are the people involved? _____

_____

_____

How often have you observed the activities or behaviors that make you suspect trafficking of the child? _____

_____

_____

Do you know where this is happening? ☐ Yes ☐ No ☐ Unknown

If yes, describe _____

Is anyone else involved in the trafficking? If so, who? Who is benefiting from the trafficking? _____

_____

Is a parent or caretaker involved? ☐ Yes ☐ No

If yes, how? _____

_____

Is the child being exchanged for something of value or to pay a debt? Tell me what you know about how the child is being trafficked.

_____

_____

Labor Trafficking

Is the child working long hours for little or no pay? ☐ Yes ☐ No

If yes, describe_____

_____

Residency and Movement

Has the child been promised things, such as a job, money, or improved circumstances, in exchange for moving from one location to another, whether residence, community, city, state, or country? ☐ Yes ☐ No ☐ Unknown

If yes, what was promised? _____

_____

_____

Is the child a resident of North Carolina? ☐ Yes ☐ No ☐ Unknown

If no, where is the child from and how did they get to North Carolina? _____

_____

Is the child traveling with an adult to whom they are not related or with whom their relationship is unclear? _____

_____

☒ N/A **Emotional Abuse**

How does the child(ren) function in school? _____

_____

What symptoms does the child(ren) have that would indicate psychological, emotional, social impairment?

_____

_____

_____

Are there any psychological or psychiatric evaluations of the child(ren)? _____

_____

Is the child(ren) failing to thrive or developmentally delayed? _____

_____

Is there a bond between the parent/caretaker and the child(ren)? _____

_____

What has the parent/caretaker done that is harmful? _____

_____

How long has this situation been going on and what changes have been observed? _____

_____

☒ N/A **Domestic / Family Violence**

Has the child ever called 911, intervened, or been physically harmed during violent incidents between adults?

Has anyone in the family been hurt or assaulted? If so, describe the assault or harm (what and when). If so, who has been hurt? Who is hurting the child and other family members? Please describe the injuries specifically.

Can you describe how the violence is affecting the child(ren)? _____

Is the child fearful for his/her life, for the lives of other family members including pets, or fearful for the non-offending adult victim's life?

Is there a history of domestic violence? Is the violence increasing in frequency? _____

Have the police ever been called to the house to stop assaults against either the adults or the child(ren)? Was anyone arrested? Were charges filed?

Are there weapons present or have weapons been used? _____

Are there power and control dynamics that pose risk to a child's well-being? _____

Does the batterer interfere with the non-offending parent/adult victim's ability to meet the child's well-being needs?

_____

Where is the child(ren) when the violent incidents occur? _____

_____

Has any family member stalked another family member? Has a family member taken another family member hostage?

_____

_____

Do you know who is caring for and protecting the child(ren) right now?

_____

_____

What is the non-offending parent/adult victim's ability to protect him/herself and the child(ren)? _____

_____

What steps were taken to prevent the perpetrator's access to the home? (shelter, police, restraining order)

_____

_____

_____

Can you provide information on how to contact the non-offending parent/adult victim alone? _____

_____

☒ N/A **Substance Abuse**

What specific drugs are being used by the parent/caretaker? _____

_____

What is the frequency of use? _____

Do the child(ren) have knowledge of the drug use? _____

How does their substance abuse affect their ability to care for the child(ren)? _____

_____

Are there drugs, legal or illegal, in the home? If so, where are they located? _____

_____

_____

Do the children have access to the drugs? _____

_____

Has the parent ever experienced blackouts? _____

Is there adequate food in the house? _____

Have the children been exposed to a Methamphetamine or other drug manufacturing laboratory? Are chemicals accessible to the children? Have the children been present during a cook? What have you seen that makes you think there is a Methamphetamine or other drug manufacturing laboratory in the home?

_____

_____

_____

_____

☒ N/A **Substance Affected Infant**

Has the infant been identified as substance affected by the health care provider involved in his/her delivery or care?

_____

_____

Did the infant have a positive drug toxicology? If yes, for what substances? _____

_____

Is the infant experiencing drug or alcohol withdrawal symptoms? What is the present physical condition of the infant?

_____

_____

Is the infant's exposure to substances related to the mother's prescribed and appropriate use of medications? If yes, what is the medication and for what condition is it treating? Have you verified with the prescribing provider?

_____

_____

Has the infant been diagnosed with Fetal Alcohol Syndrome (FAS), Partial FAS, Neurobehavioral Disorder Associated with Prenatal Alcohol Exposure (NDPAE) or an alcohol related birth defect?

_____

_____

Did the mother have a positive drug or alcohol toxicology screen during the pregnancy or at the time of the birth? Was there a medical evaluation or behavioral health assessment that indicated she had an active substance use disorder during the pregnancy or at the time of birth?

_____

_____

Is the substance use having an impact on the mother's ability to care for the infant? If so, what behaviors have you seen that demonstrate this?

_____

_____

What is the attitude of the mother or other caretakers toward the infant? _____

_____

Are you aware of the family having any history that indicates there is an unresolved substance use disorder related to a prior case of child abuse and neglect?

_____

_____

If the infant is in the hospital, when is he/she scheduled to be released? _____

_____

Based on what you know about the infant and family, would they benefit from any of the following services/resources?

☐ Evidence-Based Parenting Programs
☐ Mental health provider (LME/MCO)
☐ Home visiting programs, if available
☐ Housing resources
☐ Food resources (WIC, SNAP, food pantries)
☐ Assistance with transportation
☐ Identification of appropriate childcare resources
☐ Other: _____

☒ N/A **Abandonment**

How long has the parent/caretaker been gone? _____

Did the parent/caretaker say when they would return? _____

_____

Did the parent/caretaker make arrangements with someone to care for the child(ren)? _____

_____

_____

Are the alternative caretakers adequate? Do they wish to continue to provide care for the child(ren)?

Have they been in recent contact with the parent/caretaker?

Is your concern that the child(ren) were abandoned or that the caretaker is not an adequate provider?

☐ N/A **Supervision**

Is the child(ren) left alone? If yes, how long is the child(ren) unsupervised, what is the age and developmental status of the child(ren), what is the child(ren)'s ability to contact emergency personnel, is the child(ren) caring for siblings or other children, is the child(ren) afraid to be left alone, what time of day is the child(ren) left alone?

Yes, Burt has been alone since the morning of January 8, 2017.

How is the parent/caretaker's ability to provide supervision compromised? Including information regarding the use of substances and mental health issues.

unknown

What are your supervision concerns? Burt has no food and was scared last night

☐ N/A **Injurious Environment**

What is it about the child(ren)'s living environment that makes it unsafe? He is alone, but I don't know anything about the inside of the apartment

☒ N/A **Illegal Placement for Adoption**

Is the parent/caretaker placing the child for adoption in exchange for money or other compensation?

Is the parent/caretaker placing the child for adoption without executing a consent for adoption?

Is the parent/caretaker placing the child in violation of the Interstate Compact on the Placement of Children?

☐ N/A **Improper Discipline**

If the child(ren) is injured from discipline, please describe the injuries in specific detail; also describe any instrument used to discipline.

There are bruises on his arms and legs. The bruises on the legs are marks like what a belt might leave.

Does the parent/caretaker have a pattern of disciplining inappropriately? I don't know

Is the child(ren) fearful of the parent/caretaker? He said he didn't want his mother to be mad that he left the apartment.

Do you know what prompted the parent/caretaker to discipline the child(ren)? I don't know

☐ N/A **Improper Care / Improper Medical / Improper Remedial Care**

Does the parent/caretaker provide adequate food, clothing, or shelter? If you feel the parent/caretaker is failing to provide the child(ren) with proper care, describe in detail what the child(ren) is lacking.

The mother left some food, but not enough food

Is the parent/caretaker ensuring the child(ren) received necessary medical/remedial care? unknown

Is the parent/caretaker ensuring the child(ren) receives a basic education? unknown

Is the parent/caretaker providing drugs/alcohol to the child(ren)? unknown

☐ N/A **Dependency**

Is the child without a parent/caretaker? Burt saw his mother yesterday morning

Is the parent/caretaker lacking capacity or unavailable to provide care and supervision to the child without having an appropriate alternative child care arrangement?

I don't know

Is the child unaccompanied? ■ Yes ☐ No ☐ Unknown

Can you provide the location of the parent/caretaker? ☐ Yes ■ No

If yes, please provide _____

What other circumstances may make the child(ren) dependent?

I don't know

Section VIII: Maltreatment Screening Tools

Indicate which of the following screening tools were consulted in the screening of this report:

Abuse:
- ☐ Physical Injury
- ☐ Emotional Abuse
- ☐ Cruel/Grossly Inappropriate Behavior Modification
- ☐ Sexual Abuse
- ☐ Moral Turpitude
- ☐ Human Trafficking

Neglect:
- ■ Improper Care
- ■ Improper Supervision
- ■ Improper Discipline
- ☐ Improper Medical/Remedial Care
- ☐ Illegal Placement/Adoption
- ■ Injurious Environment
- ☐ Abandonment

■ **Dependency**

And/Or
- ☐ Substance Abuse
- ☐ Substance Affected Infant
- ☐ Domestic Violence

Response Priority Decision Tree

After consulting the appropriate Maltreatment Screening Tool(s), if the decision is to accept the report, then consult the Response Priority Decision Tree(s). Indicate which of the following Response Priority Decision Tree(s) were consulted and the response required (immediate, 24 hours, 72 hours).

☐ Physical Abuse ☐ Sexual Abuse ☐ Human Trafficking ☐ Moral Turpitude ■ Neglect

☐ Dependency ☐ Emotional Abuse

This report is being accepted for:

☐ **Abuse:**
- ☐ Physical Injury
- ☐ Sexual Abuse
- ☐ Emotional Abuse
- ☐ Moral Turpitude

Human Trafficking:
- ☐ Sex Trafficking
- ☐ Labor Trafficking

■ **Neglect:**
- ■ Improper Care
- ■ Improper Supervision
- ■ Improper Discipline
- ☐ Improper Medical/Remedial Care
- ☐ Illegal Placement/Adoption
- ☐ Injurious Environment
- ☐ Abandonment

And/Or
- ☐ Substance Abuse
- ☐ Domestic Violence

☐ **Dependency**

Response Time

■ Immediate ☐ 24 Hours ☐ 72 Hours

Report Not Accepted

If the report was not accepted, explain the reason(s): _____

_____

_____

If referrals were made for outreach, services or other agencies: _____

_____

Section IX: Mandated Reports

This report involves a child care setting. Allegations were reported to the Division of Child Development

and Early Education (staff) _____ on (date) _____.

Division of Child Development and Early Education (DCDEE) contact information:

Phone: 919-527-6500 Fax: 919-715-1013

This report involves a residential facility. Allegations were reported to the Division of Health Services

Regulation (staff) _____ on (date) _____.

Division of Health Services Regulation (DHSR) contact information:

Phone: 1-800-624-3004 Fax: 919-715-7724

This report involves a foster parent licensed by a county child welfare agency or a private foster care agency. Allegations were reported to the Division of Social Services, Regulatory and Licensing Office

(staff) _____ on (date) _____.

Phone: 828-669-3388 Fax: 828-669-3365

Allegations of criminal maltreatment reported to the DA and law enforcement on the following dates:

Oral Report: _____ Written Report: _____

Section X: Signatures

A two-level review was given by (include name, position, and date):

Name/Signature: Hugh Timely Position: Intake Social Worker Date: Jan. 9, 2017

Name/Signature: Hugh Timely Supervisor Position: CPS Supervisor Date: Jan. 9, 2017