



NC DEPARTMENT OF
**HEALTH AND
HUMAN SERVICES**

Division of Social Services

North Carolina Department of Health and Human Services Child Welfare Pre-Service Training

Week Three

Core Participant's Workbook

November 2023



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This curriculum was developed by the North Carolina Department of Health and Human Services, Division of Social Services and revised by Public Knowledge® in 2022 and 2023.

Content in this training was created specifically for child welfare professionals in response to the Administration for Children and Families (ACF) policy regarding the integration of principles of equity, inclusion and diversity into the policies, practices, and training of child welfare workers by the North Carolina Department of Health and Human Services.

The training workshops are interactive in nature, and the focus is on practical knowledge and skills that participants can apply within the workplace while respecting the dignity of others, acknowledging the right of others to express differing opinions, and the right to freedom of speech and association.

The training is not intended to, and should not be understood to, solicit or require an employee to endorse or opine about beliefs, affiliations, ideals, or principles regarding matters of contemporary political debate or social action as a condition of employment and are not intended to, and should not be understood to, solicit or require an employee or applicant to describe their actions in support of, or in opposition to, those beliefs, affiliations, ideals, or principles.

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Instructions

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

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

Course Themes

The central themes of the Pre-Service Training are divided across Foundation Training and Core Training topics.

Foundation Training

- Pre-Work e-Learning
- Introduction to the Child Welfare System
- Identification of Child Abuse and Neglect
- Introduction to Child Development
- Historical and Legal Basis of Child Welfare Services
- Ethics and Equity in Child Welfare
- Key Issues in Child Welfare: Substance Use, Family Violence, and Mental Health
- Overview of Trauma-Informed Practice

Core Training

- Pre-Work e-Learning
- Child Welfare Overview: Roles and Responsibilities
- Introductory Learning Lab
- Diversity, Equity, Inclusion, and Bias
- Indian Child Welfare Act (ICWA)
- Engaging Families Through Family-Centered Practice
- Engaging Families Learning Lab
- Quality Contacts
- Overview of Child Welfare Processes: Intake and CPS Assessments
- Intake and CPS Assessments Learning Lab
- Overview of Child Welfare Processes: In-Home Services
- In-Home Services Learning
- Overview of Child Welfare Processes: Permanency Planning Services
- Permanency Planning Services Learning Lab
- Key Factors Impacting Families and Engaging Communities
- Documentation

- Documentation Learning Lab
- Self-Care and Worker Safety

Training Overview

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

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

Pre-Work Online e-Learning Modules

There is required pre-work for the North Carolina Child Welfare Pre-Service Training in the form of online e-Learning modules. Completion of the e-Learnings is required prior to attendance at the classroom-based training. The following are the online e-Learning modules:

1. Introduction to North Carolina Child Welfare Script
2. Child Welfare Process Overview
3. Introduction to Human Development
4. Maslow's Hierarchy of Needs
5. History of Social Work and Child Welfare Legislation
6. North Carolina Worker Practice Standards

Foundation Training

Foundation Training is instructor-led training for child welfare new hires that do not have a social work or child welfare-related degree. Staff with prior experience in child welfare or a social work degree are exempt from Foundation Training. The purpose of this training is to provide a foundation and introduction to social work and child welfare. After completing Foundation training, new hires will continue their training and job preparation with Core Training. Foundation Training is 28 hours (4 days) in length.

Core Training

Core Training is required for all new child welfare staff, regardless of degree or experience. This course will provide an overview of the roles and responsibilities of a child welfare social worker in North Carolina, including working with families throughout their involvement with the child welfare system. The course will provide opportunities for skills-based learning labs. Core Training includes 126 hours (18 days) of classroom-based training, completed over six consecutive weeks.

Throughout the pre-service training, learners may have required homework assignments to be completed within prescribed timeframes.

In addition to classroom-based learning, learners will be provided with on-the-job training at their DSS agencies. During on-the-job training, supervisors will provide

support to new hires through the completion of an observation tool, coaching, and during supervisory consultation.

Transfer of Learning

Transfer of learning means that learners apply the knowledge and skills they learned during the training back to their daily child welfare work at their DSS agencies. During the pre-service training, learners will complete a transfer of learning tool at various points:

- Pre-training
- During training
- Post-training

The transfer of learning tool will enable learners to create a specific action plan they can use to implement the training content on the job. A key component of successful child welfare practice is the involvement of supervisors in the reinforcement of new knowledge and skills. Supervisors will assist new workers in the completion and review of their transfer of learning tool and will support workers to apply what they have learned in training to their child welfare roles and responsibilities through action planning. Completion of the transfer of learning tool is required to complete the training course.

Training Evaluations

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


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

Week Three, Day One Agenda

Pre-Service Training: Child Welfare in North Carolina

I.	Welcome	9:00 – 9:30
Engaging Families through Family-Centered Practice (continued)		
II.	Developing Goals with the Family	9:30 -10:40
	BREAK	10:40 – 10:55
III.	Family Services Agreement	10:55 – 11:45
	LUNCH	11:45 – 12:45
IV.	Developing Goals with the Family Learning Lab	12:45 – 1:45
V.	Preparing the Child and Family for Court	1:45 – 2:00
	BREAK	2:00 – 2:15
V.	Preparing the Child and Family for Court (continued)	2:15 – 2:45
VI.	Family-Centered Practice Learning Lab	2:45 - 4:00

Welcome



- How are people feeling today?
- What was your main “takeaway” from yesterday?
- Is there any clean -up we need to do?
- Review agenda and learning objectives for the day

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Use this outlined space to record notes.

Engaging Families through Family-Centered Practice (continued)

Developing Goals with the Family

Learning Objectives

<ul style="list-style-type: none">• Define the difference between a goal and an objective.
<ul style="list-style-type: none">• Explain the importance of developing goals with the child and family.
<ul style="list-style-type: none">• Describe what it means to write a SMART goal.
<ul style="list-style-type: none">• Be able to effectively write SMART goals.

Activity: What Goals Do I Have?

In pairs, discuss a New Year's Resolution you had or something you really want or wanted to do in your life and then what happened to it.

- What is a New Year's Resolution you had?
- Something you really want or wanted to do in your life?
- What happens or happened to it?

Discuss things like:

- Did the life goal you shared happen?
- How did it happen?
- What helped you succeed?
- Why didn't it happen?
- What kept you from succeeding?

Compare your achievement or lack of achievement with your partner. Are there differences? Similarities?

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Debrief

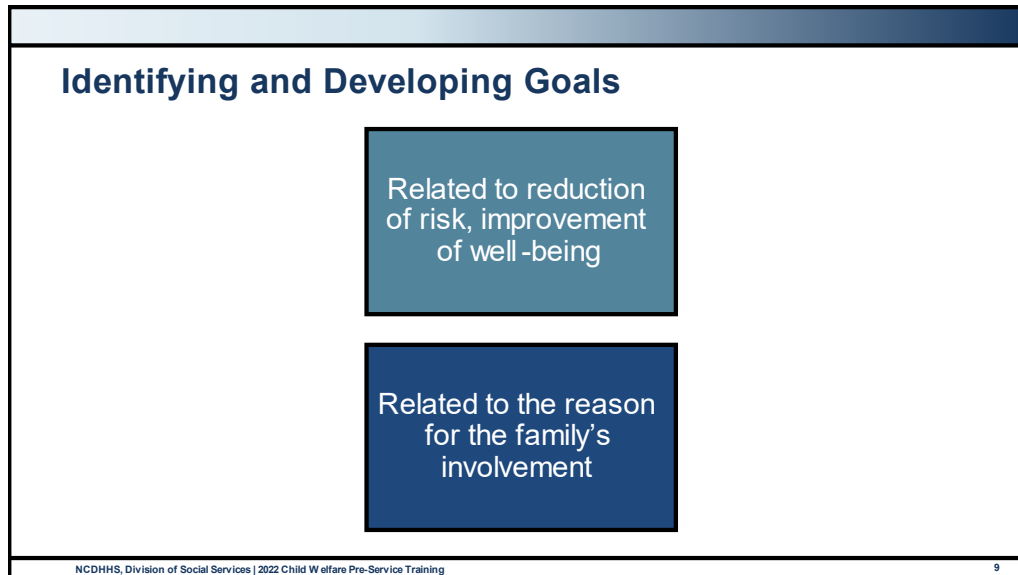
- How many people reached their goal?
- How many people did not?
- For those of you who were talking with someone who met their goal, what did you hear that was different for them?
- What is the difference between me and the family I'm working with?

Case Example:

A mom lost a child in a terrible accident. The accident was just that - an accident. She had left a younger child with an older child for a short period. The older child was actually old enough to care, generally, for the younger child. But an accident happened. Mom's other 5 children ended up being removed from her care. She worked hard on her service goals. She achieved all her goals. She paused one day and said to her social worker, "I'm afraid. What if I get my kids back, and I can't do it? What if I fail again? I'm so scared."

How do we respond to the mom's fears? What do we say? What does this conversation look like?

Identifying and Developing Goals

Prioritize Goals:

- What do both the social worker and the family agree upon?
- What could be quickly achieved?
- What is most needed? What will reduce risk or improve well-being the most?
- What does the family want to do?
- What resources are readily available?
- What is most closely related to the reason the child came into custody or the agency became involved in the family's life?

Other things to consider as you develop goals with the family include:

- What does the family identify as the problem?
- What does the social worker identify as the problem?
- What are the needs of the family as they relate to the identified problems?

Handout: Identifying Needs and Developing Goals

To be completed with your supervisor on a specific case. The recommendation is that this worksheet will be completed following an observation of a child and family team meeting.

1. What is the specific problem or issue related to why the agency is **continuing** to be involved with this family?

2. What does the family need to have happen concerning the problem or issue? What needs to occur for the child(ren) to be safe from possible abuse or neglect and/or to have the child(ren)'s needs met (i.e. psychological, mental, emotional, physical, educational, dental, medical, safety, security, nurturance, developmental, special needs or other)?

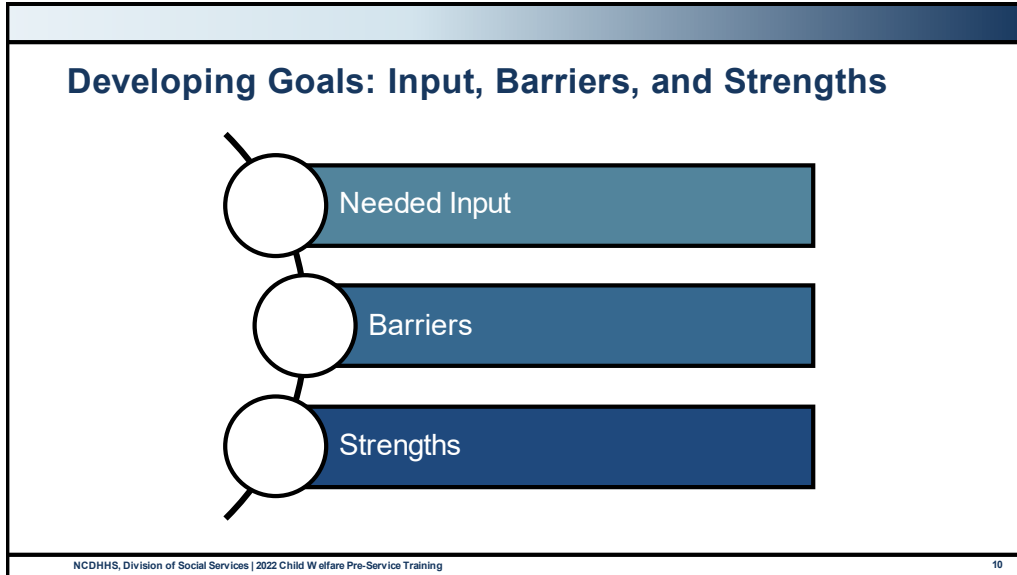
3. What would the situation look like if the need was met, and the problem/issue was resolved? Describe what it would be like for the child(ren) and family when the problem is resolved. What would this situation look like if the risk(s) of abuse and neglect were reduced or eliminated?

4. State the goal for the family using the description given in #3.

5. Does everyone agree that this is the goal and does everyone agree regarding the problems and issues? If not, list disagreement points.

6. List two agreed upon problems/issues. Name one need and state one goal that everyone agrees upon.

Developing Goals: Input, Barriers, and Strengths



What are some strengths you have that are resources to you as you develop goals?

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What will you see as a result of your efforts?

- What changes will you expect?
- Who or what will be changed?
- How can you determine if a change is occurring?
- How much change will occur? By when?
- How will you know if you are being successful in obtaining your goal?

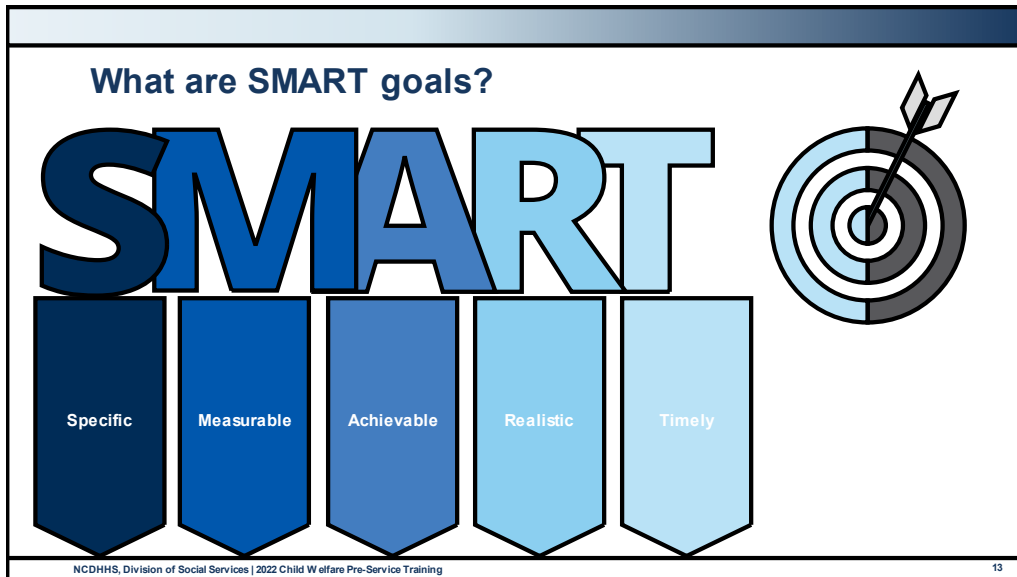
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Effective goal writing with families, using the SMART acronym, will help to achieve results. Keep in mind that goals should always have a connection to the reason or reasons the family is involved with your agency.

Questions and Reflections

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

What Are SMART Goals?



SMART goals are what separates a wish from a goal: they come with a plan.

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Handout: Goal Setting with SMART

Goals should be:**Specific****Measurable****Achievable****Realistic****Timely**

Goals and plans to achieve goals should be directly related to the reduction of risk and improvement of the well-being of children. The goals should also be related to the factors that contributed to the involvement of the child welfare agency in the family's life. Some action steps include the path to the reduction of risk or improvement of the well-being of children and families, but the connection should be made to why the agency is involved with the family.

Prioritize Goals:

- What do both the social worker and the family agree upon?
- What could be quickly achieved?
- What is most needed? What will reduce risk or improve well-being the most?
- What does the family want to do?
- What resources are readily available?
- What is most closely related to the reason the child came into custody or the agency became involved in the family's life?

Other things to consider as you develop goals with the family include:

- What does the family identify as the problem?
- What does the social worker identify as the problem?
- What are the needs of the family as they relate to the identified problems?

Goals should be written such that they describe the state of the children and family when risks of abuse and neglect are reduced or eliminated.

Explain to the family the consequences of entering into the plan and then not following through, such as court involvement, removal of the child from home, or the end result could be termination of parental rights. Explain to the family that entering into the Family Services Agreement is like a "contract." This is why the family needs to be a partner in the development of the goals and their plan. This is where real work and change will begin to take place.

Handout: SMART Goals Template

SMART goals help improve achievement and success. A SMART goal clarifies exactly what is expected and the measures used to determine if the goal is achieved and successfully completed.

A SMART goal is:

Specific: Answers the questions: Who? What? Where? When? Which? Why?

Measurable: The success toward meeting the goal can be measured. Answers the questions: How much? How many? How will we know it is accomplished?

Achievable: Can we see the family accomplishing the goal? Is it really achievable for them?

Realistic: The goals must be aligned with current tasks and projects, and focus on one defined area. The expected result must be included. Is the family willing and able to meet the goal? Does the goal coincide with the family's needs?

Timely: Goals must have a clearly defined timeframe, including a target or deadline date. How long will it take to achieve the goal?

Examples of Goals:

Not a SMART goal:

- Employee will improve their writing skills.

This goal does not identify a measurement or timeframe, nor identify why the improvement is needed or how it will be used.

SMART goal:

- The Department has identified a goal to improve communications with administrative staff by implementing an internal departmental newsletter.
- Elaine will complete a business writing course by January 2010.
- Elaine will publish the first monthly newsletter by March 2010.
- Elaine will gather input and/or articles from others in the department.
- Elaine will draft the newsletter for supervisor review.
- When approved by the supervisor, Elaine will distribute the newsletter to staff by the 15th of each month.

Strategies for Developing Effective Goals

Strategies for Developing Effective Goals		
Desired Effect	Specific Outcome	CFT Meetings
<ul style="list-style-type: none">• Increase• Decrease• Maintain• Reduce• Improve• Enable	<ul style="list-style-type: none">• Ability to• Skills for• Knowledge of• Confidence in• Likelihood• Incidence of understanding of	<ul style="list-style-type: none">• Best practice• Trust-based relationships• Planned event• Decision-making• Family engagement• Promotes unity• Shared understanding• Develop plans• Non-negotiables• Next steps

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Activity: Practice Writing Goals

In small groups, develop goals for these 3 statements. Discuss the objectives of each statement and then work together to develop goals using the SMART principles.

1. John agrees to become more involved in his daughter's life.
2. Sarah's parents agree to become more involved in Sarah's school work and academics.
3. Sarah's mother agrees to attend alcohol support groups.

You do not have any other details about John, Sarah, or Sarah's parents. Use your creative freedom to come up with the goals for how John will become more involved in his daughter's life, how Sarah's parents will become more involved in her schoolwork, and how Sarah's mother will attend an alcohol support group.

John agrees to become more involved in his daughter's life.

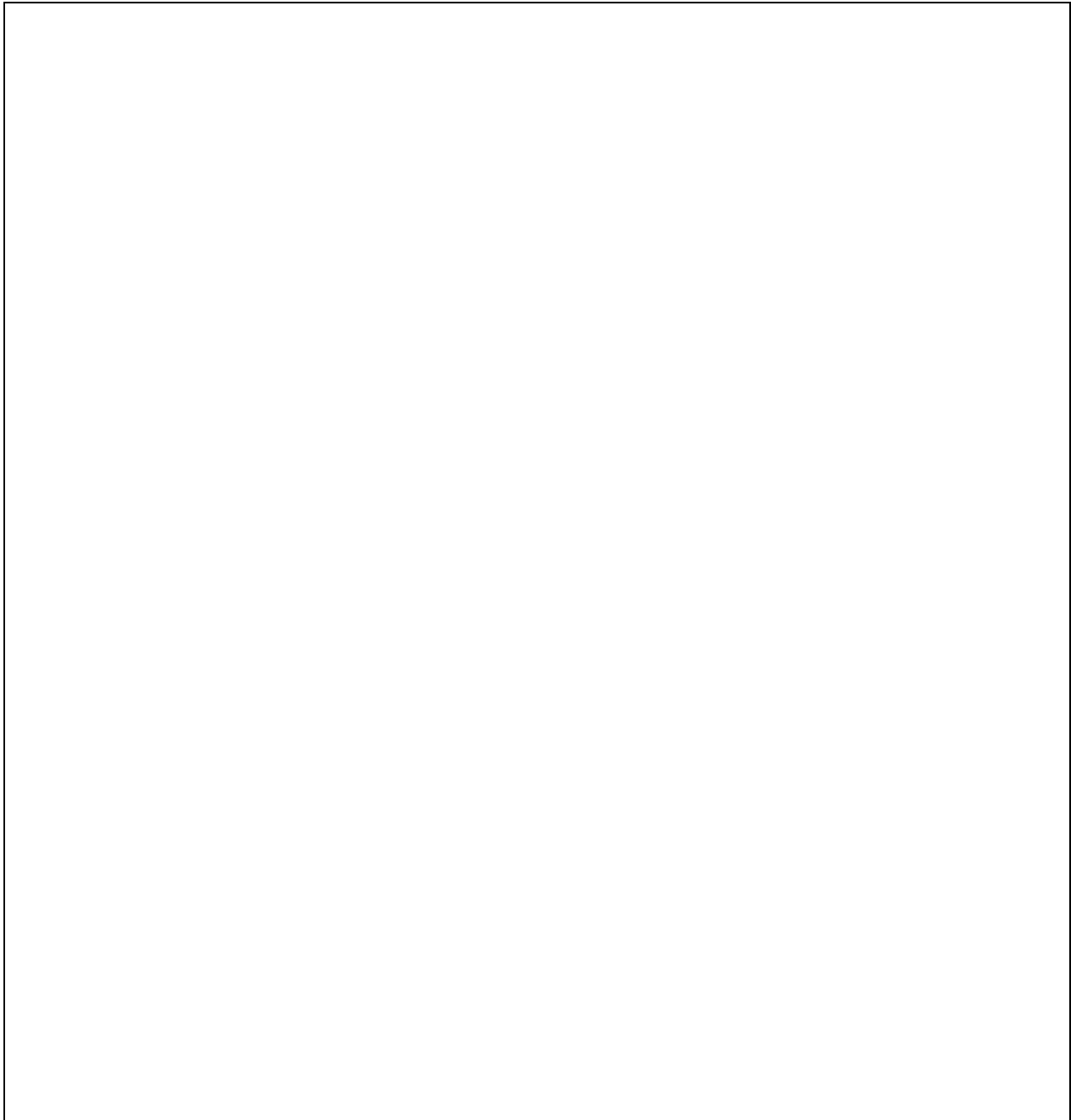
Sarah's parents agree to become more involved in Sarah's school work and academics.

Sarah's mother agrees to attend alcohol support groups.

Debrief

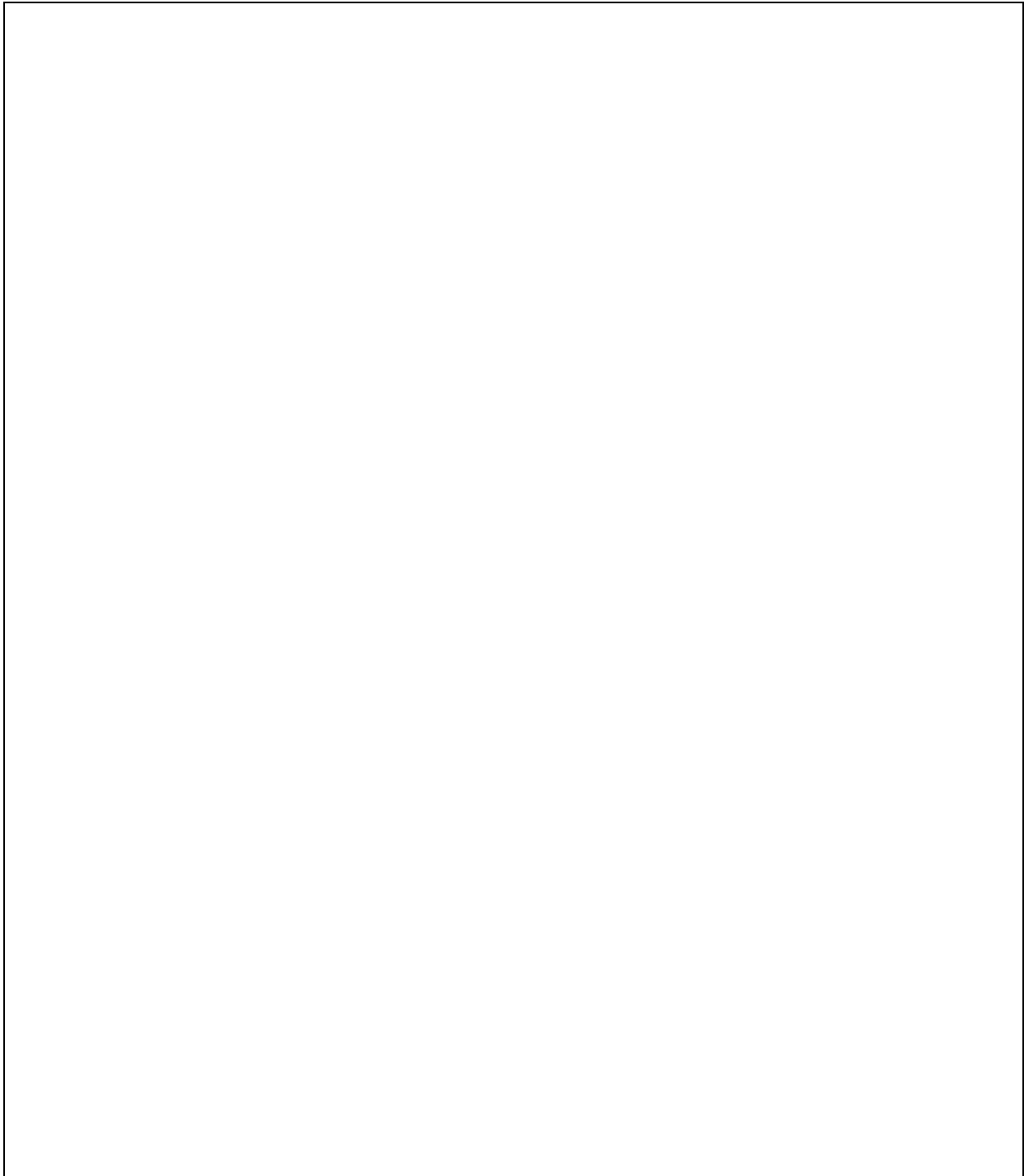
Consider the following questions:

- **What are the strengths of this goal?**
- **Does it meet all the SMART components?**
- **Are there weaknesses or challenges with this goal?**
- **Is there anything missing?**

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Questions and Reflections

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

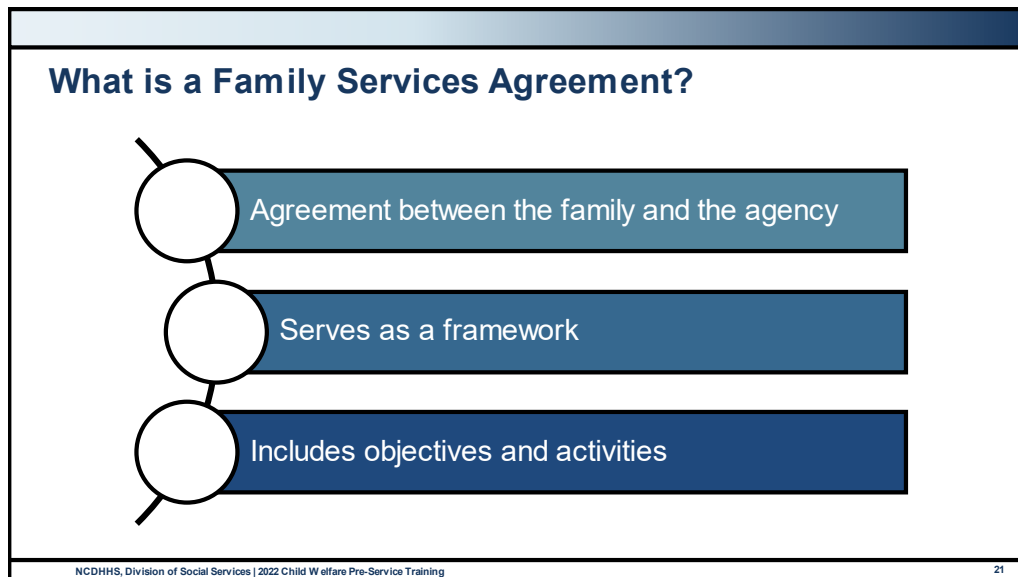
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Family Services Agreements

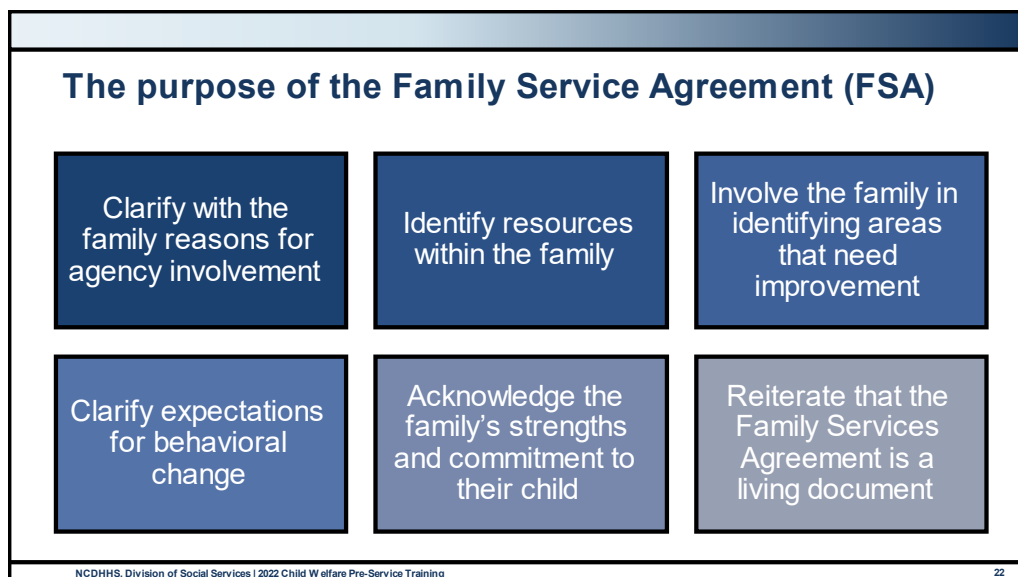
Learning Objectives

<ul style="list-style-type: none">• Describe the purposes of the Family Services Agreement and why the agreement is used in achieving safety, permanency, and well-being outcomes.
<ul style="list-style-type: none">• Explain how the Family Services Agreement guides case planning and services provision.
<ul style="list-style-type: none">• Discuss the importance of inclusion of the child and family's voice in completion of the Family Services Agreement and will be able to provide examples of how to do so.

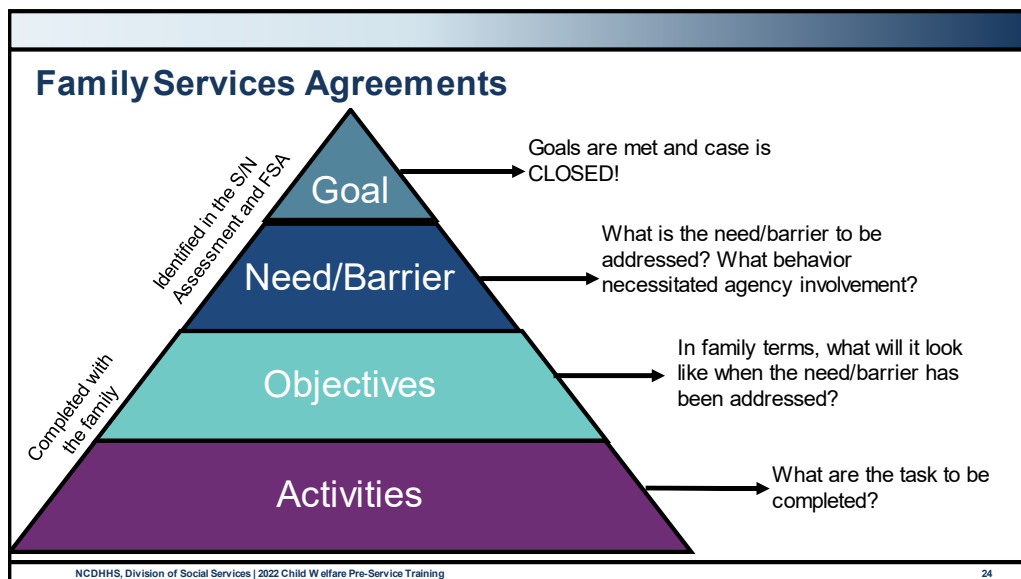
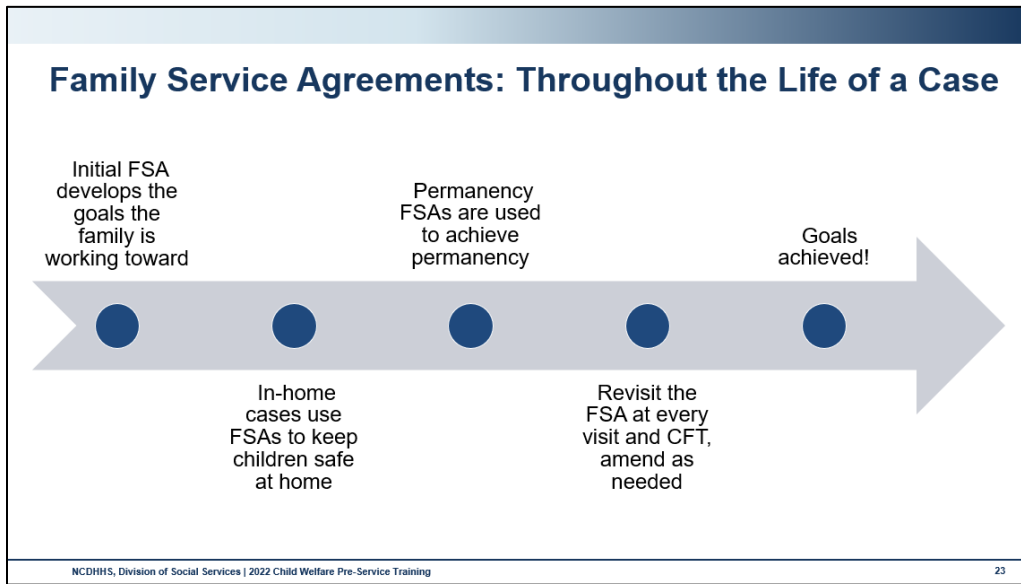
What is a Family Services Agreement?



The Family Services Agreement (FSA) serves as the framework on which the agency’s work with the family and child is based and drives the agency’s work with the family. The agreement documents the objectives and action steps that the family, agency, and other resources will take while working with the family. There is an In-Home FSA and a Permanency FSA.

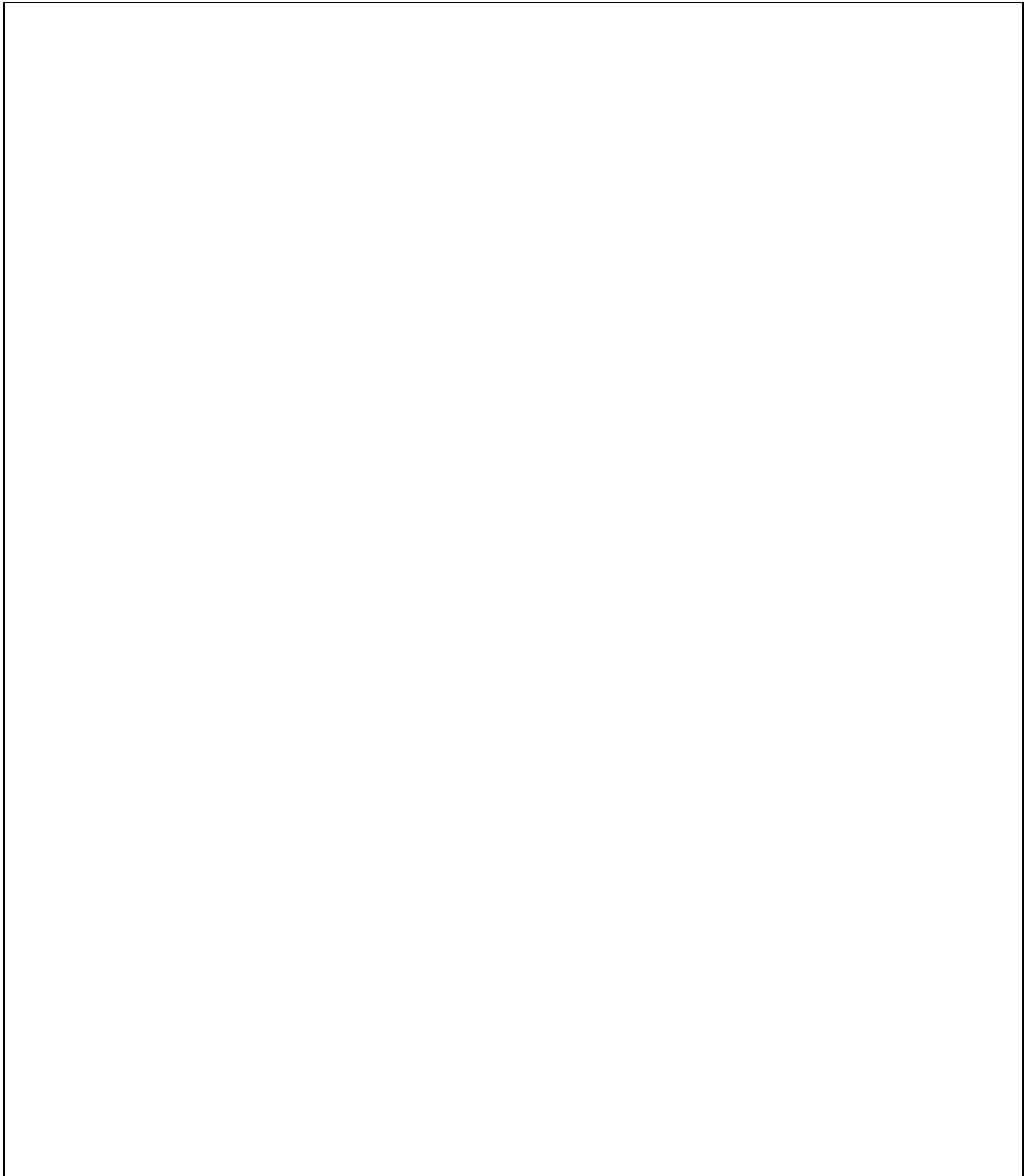


Family Service Agreements: Throughout the Life of a Case

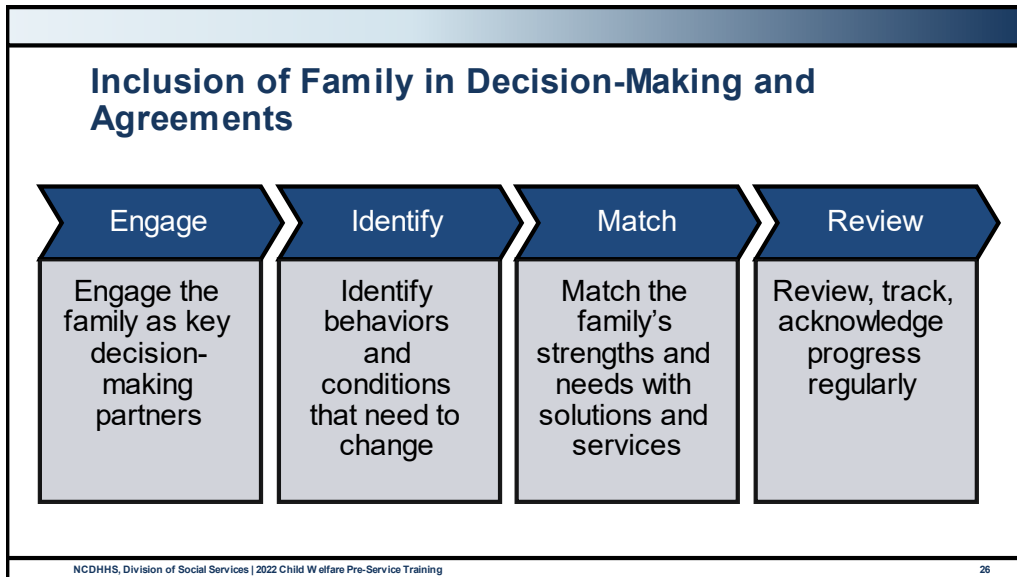


Questions and Reflections

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

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Inclusion of Family in Decision-Making and Agreements



Take a few minutes to brainstorm various strategies and ideas you can use in your practice to engage children and youth in the development of the Family Services Agreement.

Matching Services to the Family's Needs: Change Strategies and Interventions

Matching Services to the Family's Needs: Change Strategies and Interventions

- Individualized family assessment is essential
- Strategies and interventions must match specific outcomes
- Families must be provided options they believe will work for them
- Strategies and interventions must be selected based on the needs of the family and availability of strategies
- Less is more
- Assessment of progress should be ongoing

<https://www.childwelfare.gov/pubPDFs/cps2018.pdf>

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Children and Youth

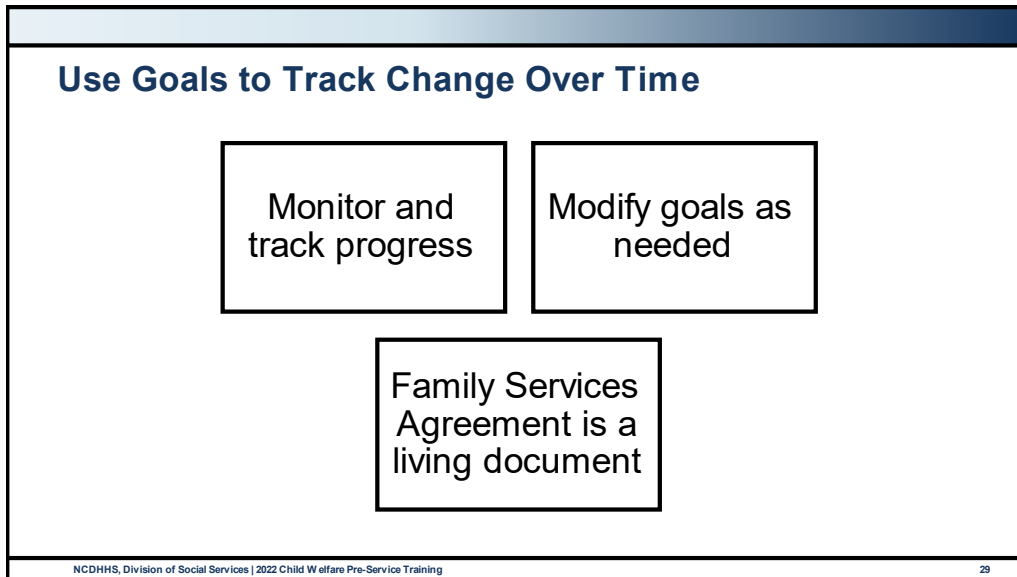
Strategies addressing the needs of children and youth are often in combination with family interventions. Some interventions address the trauma associated with maltreatment, and others target behaviors or emotions that may challenge parenting and increase the risk of future maltreatment.

Parents

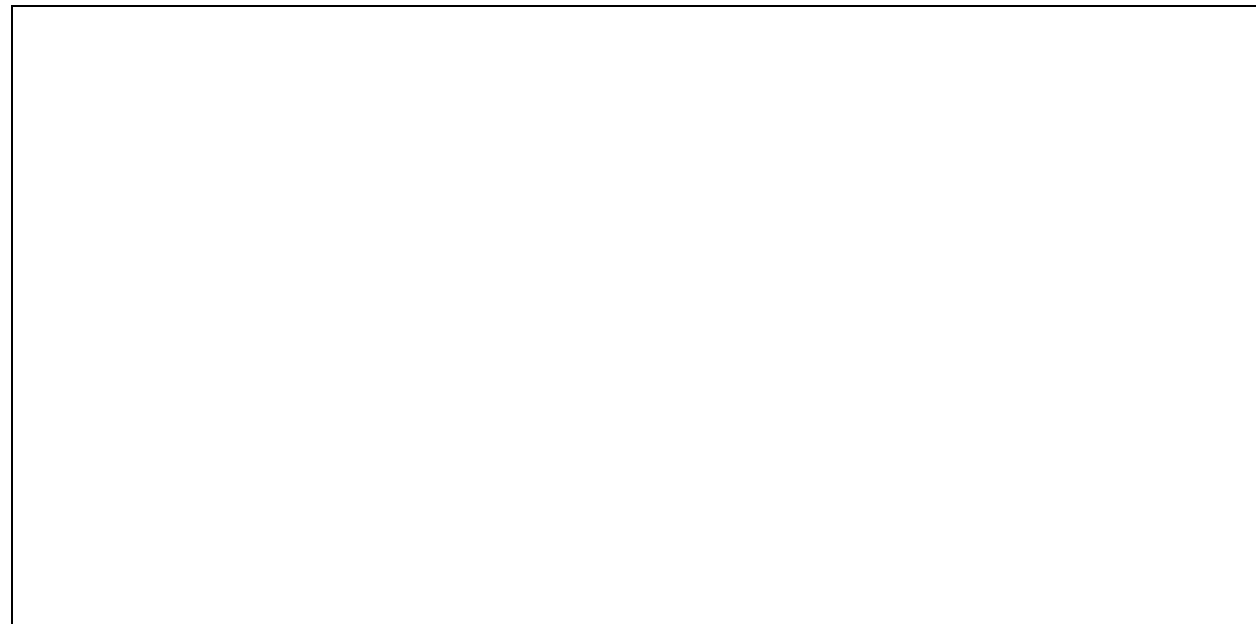
Parent-focused interventions often help to build protective capacities to enhance the safety and well-being of children, as well as address the parents' experiences of trauma and emotional well-being. These may be associated with adult functioning or specific to parents' caregiving roles. Two of the main adult functioning issues that contribute to risk and safety concerns for children are substance use disorder and mental health needs. There are numerous effective treatments for both, and matching depends on strong assessments. Some child maltreatment occurs because of a lack of knowledge about child development, unrealistic expectations of children, lack of empathy, or lack of understanding about the special needs of children. When results of the comprehensive family assessment conclude that strengthening family functioning and parent-child interaction will promote protective factors and reduce risk factors for child maltreatment, multidimensional, family-based strategies and interventions often are the best option.

Selecting and matching change strategies and interventions to outcomes and goals is a critical step in developing the Family Services Family Agreement. Use SMART thinking in setting goals in the Family Services Agreement and in re-visiting goals over time.

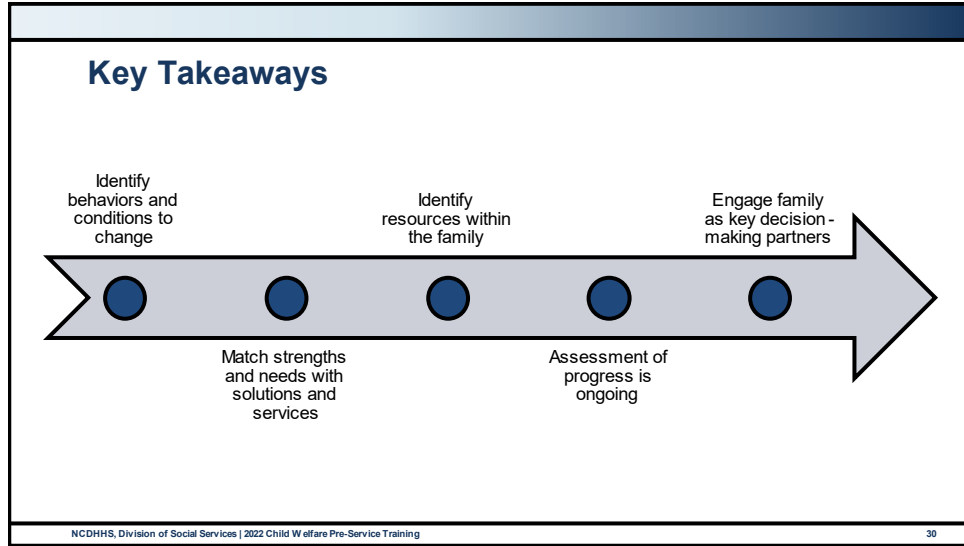
Using Goals to Track Change Over Time



Use the tracking of progress on the activities listed in the Family Services Agreement over time to re-enforce goals. Tracking progress on these activities should be part of every monthly visit and in every child and family team meeting, and goals should be modified as needed. Goals may be very concrete and may not stay relevant for the entire period between every CFT meeting. Therapy or treatment may be completed, or better success measures might emerge. The Family Services Agreement is a living document and should be used to guide practice.



Key Takeaways



Questions and Reflections

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

Developing Goals with the Family Learning Lab

Activity: Developing Goals with June

- Mother:** June Michaels – 25-year-old; White
- Father:** Alexander Thompson – 27-year-old; White
- Child(ren):** Michaela Thompson – 6-year-old; White; male
Luis Thompson – 4-year-old; White; female
Alix Thompson – 3-year-old; White; female

Background

June is a single mom with 3 children under the age of 6 years old. She works 2 jobs to be able to pay her bills, but there is no extra money. It is her turn to make cookies for her 6-year-old's class. She bought flour, sugar, chocolate chips, eggs, etc., and had the groceries sitting on the island in her kitchen. She planned to make the cookies after bathing her girls and putting them to bed. She could feel a migraine coming on and was concerned about being able to follow through with her cookie baking. The girls were extra "wild" on this night.

June got her 3-year-old out of the bath and got her ready for bed. She was helping her 4-year-old dry off when she heard her youngest laughing in the kitchen. She went to check on her and she had flour, sugar, and baking soda all over the kitchen and herself – including her newly washed hair. The chocolate chips were everywhere. As she got to her, the toddler was opening the sticks of butter and wiping them all over the counter. She had climbed up on a chair and onto the island and was a mess.

June's migraine had become full-blown while getting the children out of the bathtub. She grabbed her 3-year-old by the arm and began spanking her on her bottom. June cried as she cleaned her up and put her to bed.

The next morning, she got up early as she would have to run by the bakery and spend money they did not have before dropping her children at daycare and school. She began her waitress job at 8 a.m.

A child welfare worker showed up at June's house at 4 pm, as her youngest child had bruises on her buttocks and arm and there had been a report made to the child abuse hotline. During the discussion, June disclosed that she does not use corporal punishment -ever. The worker noticed her children were well-behaved and loving. There was a strong loving relationship between June and her children. The home was very clean and orderly. There was nutritional food available, and the children appeared healthy. June told her about her headaches and that she does not have health insurance. The children are on Medicaid. She cannot afford to go to the doctor. She does not receive child support. She works 40 hours as a waitress during the week and does bookkeeping from her house on nights and weekends for a local business. She

showed the worker her budget, which was tight. The interview with the 6-year-old matched the story June told and the worker was told by the child that she never saw mommy hit anyone until last night and mommy was crying.

June's mom and sister live in town. They have a good relationship, but they do not have money to help June. June's father's whereabouts are unknown. The children's father is working in construction in a nearby town. June and her children attend church regularly. June has one female friend from work, but she only talks to her at work. She has some old high school friends in the community but not much time for socializing.

Strengths/Needs

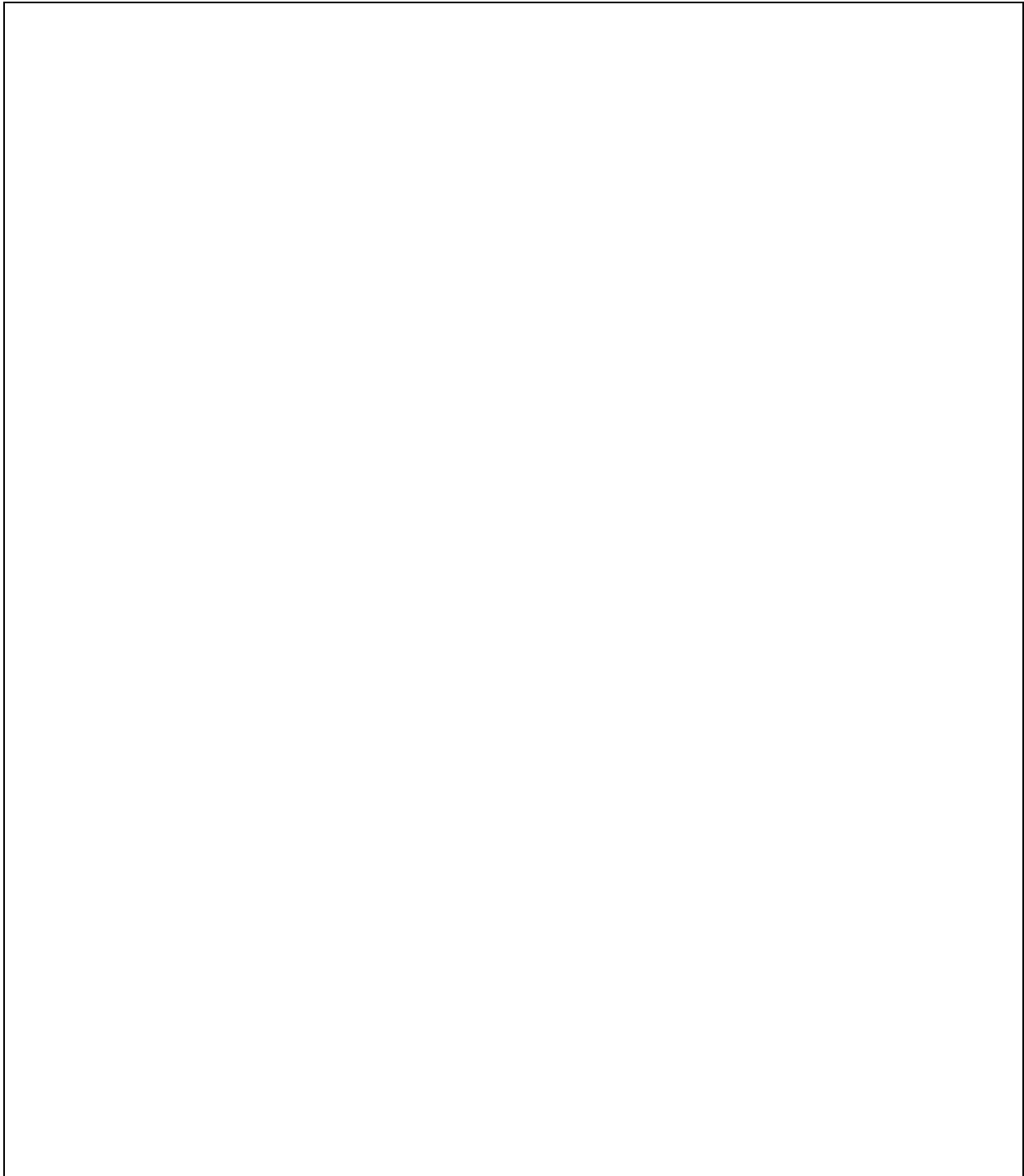
Strengths

Needs

Available Supports

Questions and Reflections

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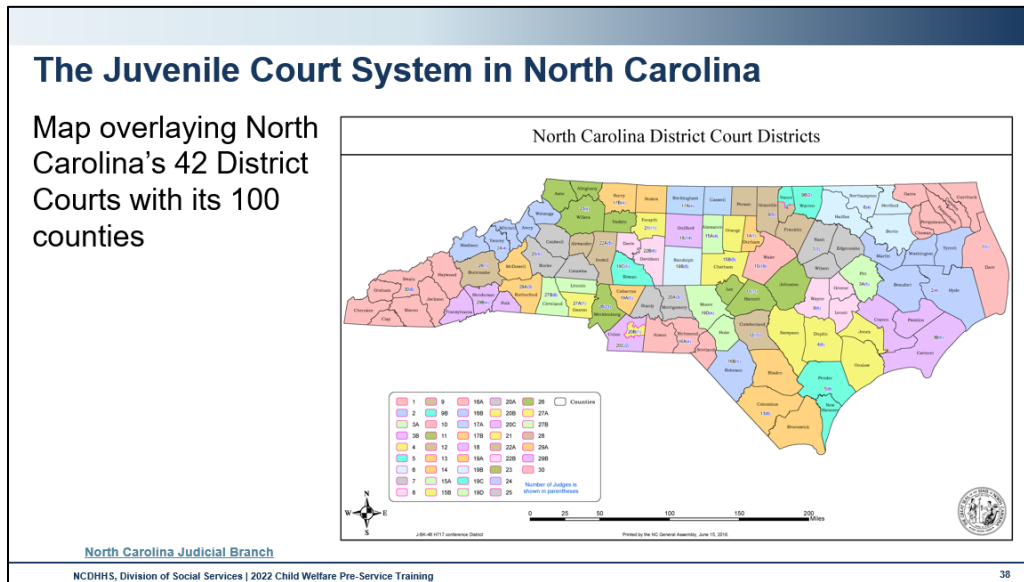
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Preparing the Child and Family for Court

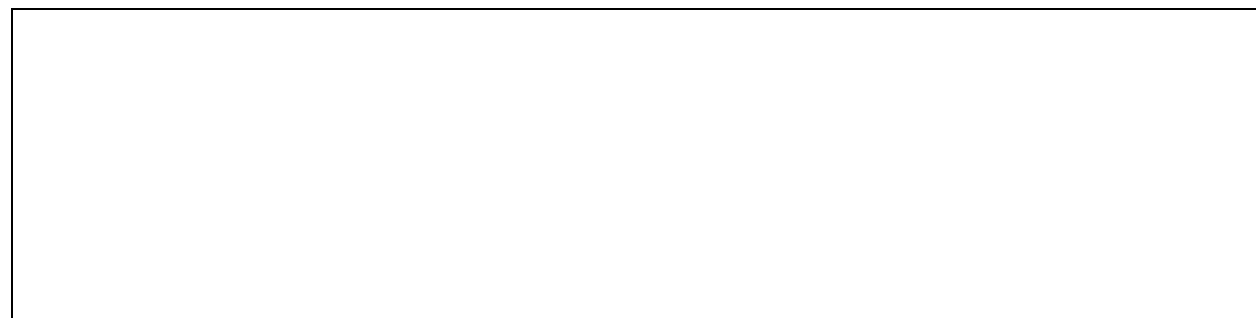
Learning Objectives

- | |
|------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• Describe and provide examples of strategies to prepare the child and family for court. |
| <ul style="list-style-type: none">• Explain the importance of debriefing with families after court hearings. |

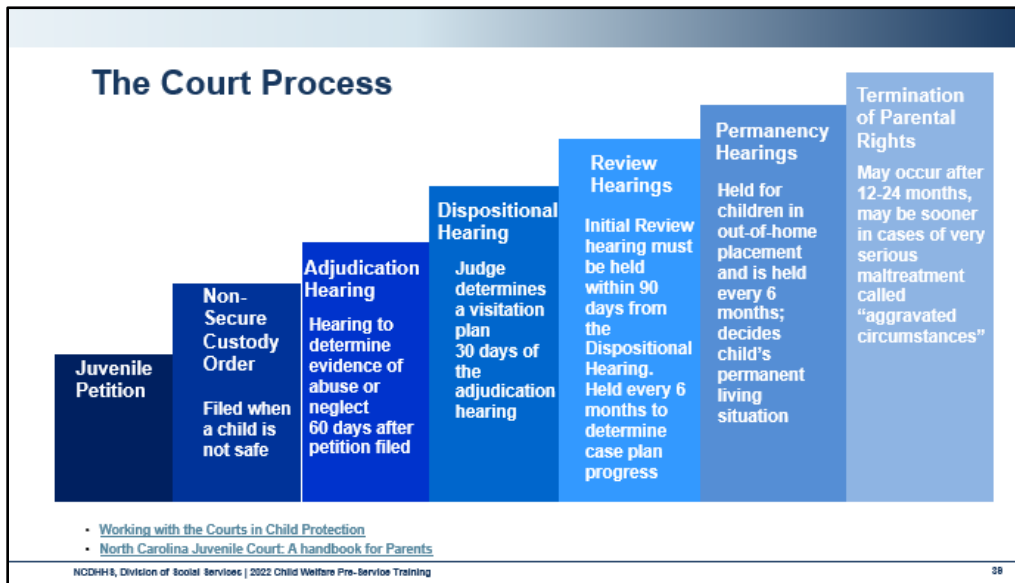
The Juvenile Court System in North Carolina



Courts and child welfare agencies must work hand-in-hand to achieve positive safety and permanency outcomes, including reunification, for children and families. Protecting the safety, well-being, and permanence of children is not only the role of the agency but of the community, including the court system. Even though the juvenile court process can be adversarial in nature, county child welfare agencies must use family-centered practice principles to guide every interaction with every person they encounter throughout the court process. This includes the judge, the family, the child, the agency’s attorney, the parent’s attorney, the Guardian ad Litem volunteer, the attorney advocate, the bailiff or sheriff’s deputy, and any other court personnel. Specifically, maintaining professional relationships with parents’ attorneys and attorney advocates in this process models for families and demonstrates to the court that partnerships are valued despite differences each group may have. Albeit only a small piece of the equation, these interactions can become a part of the teaching process to help families successfully navigate the child welfare system.



The Court Process



Handout: Glossary of Court and Legal Terms

Filing the Petition

Your agency must make reasonable efforts to protect children in their own homes and to prevent placement. Your agency must file a petition requesting adjudication of abuse, neglect, and/or dependency:

- When safety-related circumstances necessitate the need for immediate removal
- Due to the family's unwillingness to accept critically needed services and those services are necessary to keep the family intact
- When despite agency efforts to provide services, the family has made no progress toward providing adequate care for the child and those services are necessary to keep the family intact

A child protection proceeding is initiated by filing a petition. The decision to file a child maltreatment petition is made by the social worker and their supervisor, often in consultation with the agency's lawyer. The decision to file should always be based on safety considerations and not on how likely it is that the case can or cannot be won in court. As a result, child maltreatment petitions tend to concern children who are exposed to serious threats to their safety.

Initial Hearing/Non-Secure Custody Hearing

When a child is removed from their home, a nonsecure custody hearing must occur within seven days. As long as a child remains placed outside the home, nonsecure custody hearings must continue to be held until the disposition hearing is finished, unless the child's parent and their attorney agree to waive them. The initial hearing is the most critical stage in the child abuse and neglect court process. Many important decisions are made and actions are taken that chart the course for the remainder of the proceedings. At this hearing, the relationships between those involved in the process also are established, and the tone is set for their ongoing interactions. The main purpose of the initial hearing is to determine whether the child should be placed in substitute care or remain with or be returned to the parents pending further proceedings. The critical issue is whether in-home services or other measures can be put in place to ensure the child's safety.

Adjudication Hearing

This hearing must be held within 60 days of the date the petition was filed unless the judge decides there is a good reason to delay it. At the adjudication hearing, the court decides whether CPS can prove the allegations in its petition. The child welfare agency's attorney will present evidence through the testimony of the social worker, law enforcement officers, or other witnesses, including any experts. Documents such as medical records or photographs also may be entered into evidence. The attorneys for the parents and the child will have the right to question or cross-examine the witnesses

and present evidence. The parents may testify, as may other family members or neighbors who know the facts alleged in the petition or of the care the parents provided their children.

Dispositional Hearing

The dispositional hearing may occur on the same day as the adjudication hearing or may be up to 30 days later. At the dispositional hearing, the judge decides what the best plan is for the child and what services will be ordered. For example, the court may enter an order that mandates counseling and rehabilitative services. The judge will also decide where the child will live, whether any relatives can help take care of the child, and what type of visits the parent will have with their child. The judge may also order each parent to receive certain services, such as substance abuse treatment, parenting classes, or domestic violence counseling. Essentially, the dispositional hearing determines what will be required to resolve the problems that led to CPS intervention.

Review Hearing

The first review hearing must take place within 90 days of the dispositional hearing. After that, there must be a review hearing every 6 months, but often they occur more frequently. In addition, any party can ask for a review hearing at any time, if an attorney files a motion with the court. The review hearing is an opportunity to evaluate the progress that has been made toward completing the case plan and any court orders and to revise the plan as needed. At each review hearing, the judge is given information about what each parent has been doing, how the child is doing, and whether any needs haven't been addressed. The court must decide if the plan that was made during disposition is working and if any changes are needed. Review hearings should guide the case to permanency for the child.

Permanency Hearing

A permanency hearing is required within 12 months after a child is removed from their home. It may be held earlier if the judge decides that efforts to reunify the family are not required or will stop. Permanency hearings must be held at least every 6 months. At a permanency planning hearing, the parties present information to the judge so the judge can order a plan to achieve a safe, permanent home for the child within a reasonable period. The judge will decide whether the plan is to return the child home, to give a suitable person custody or guardianship of the child, to move toward termination of parental rights so the child can be adopted, or to keep more than one of these options open, sometimes referred to as concurrent planning. You will learn more about permanency hearings during the Permanency Planning Services section of this training.

Termination of Parental Rights

A termination of parental rights (TPR) hearing is divided into two stages, adjudication and disposition. At adjudication, the party requesting TPR must prove to the judge by clear and convincing evidence that grounds exist for termination. If the judge decides

that grounds do not exist, the judge will dismiss the case. If the judge decides that the grounds do exist, the judge moves to the disposition stage and must decide whether TPR is in the child's best interest.

Questions and Reflections

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

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Rights and Responsibilities

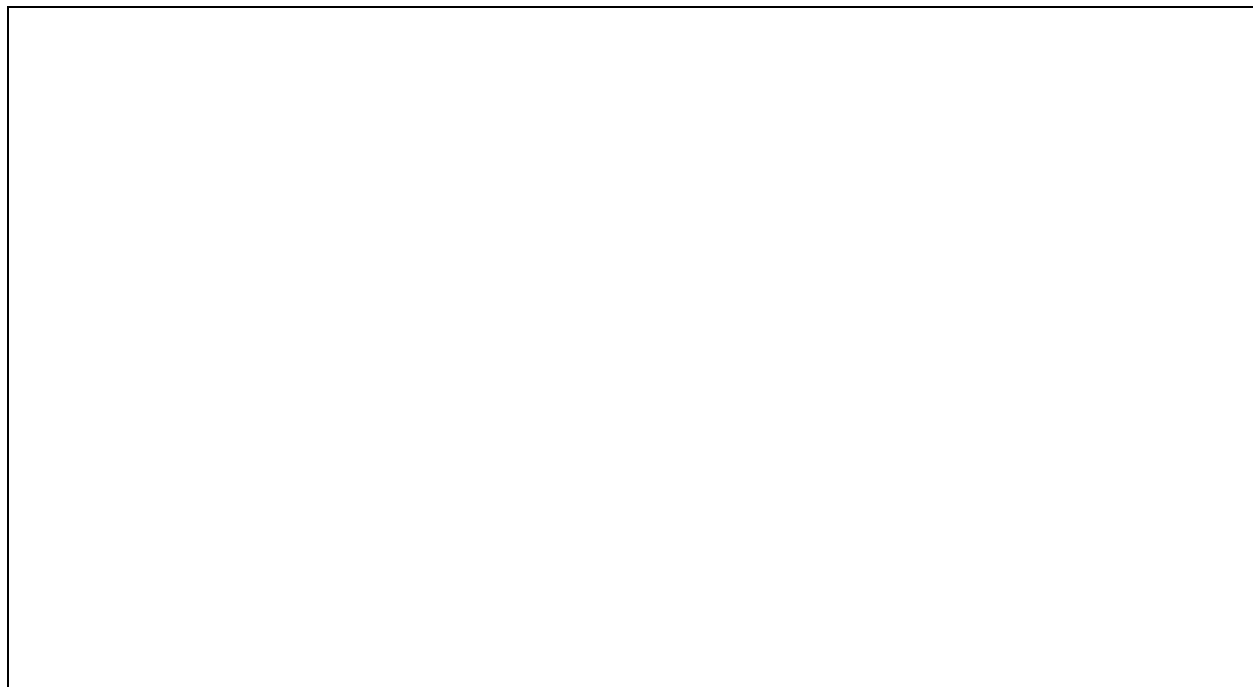
Rights and Responsibilities

- Right to an attorney
- Right to admit, deny allegations
- Right to a language interpreter
- Right to have attorney ask questions and present evidence
- Right to know what is in court file
- Right to see their child
- Right to approve non-emergency surgery, major medical care
- Right to services and assistance to prevent removal, reunification
- Right to be given a copy of the judge’s written decisions
- Right to appeal

• North Carolina Juvenile Court: A handbook for Parents
NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training 42

The North Carolina Juvenile Court: A Handbook for Parents is a great resource in North Carolina that can be used to help prepare parents for court. You should provide this resource to each parent you work with.

Parents are strongly encouraged to attend every hearing and be well-prepared to share their story with the judge and the court.



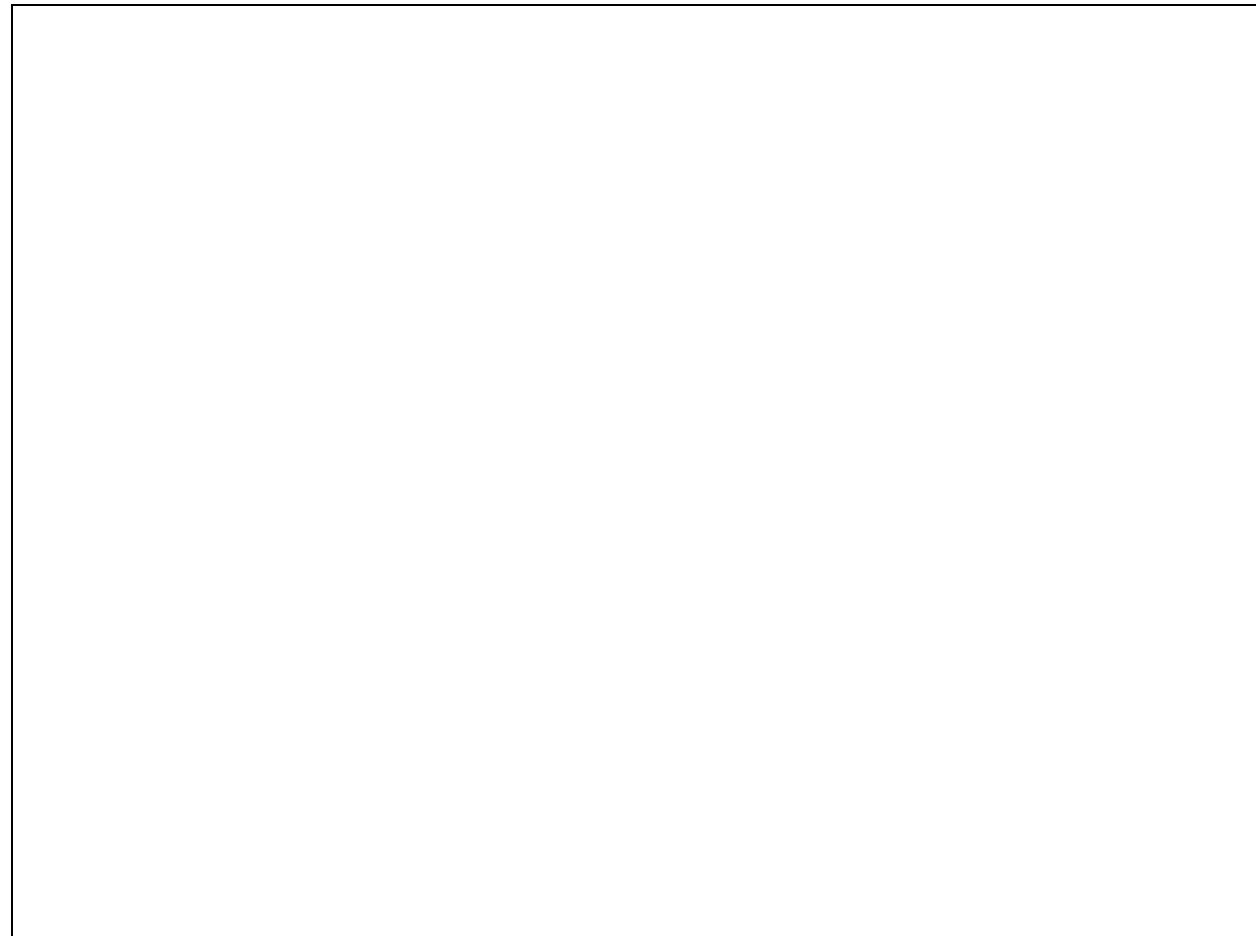
Social Worker's Role in Court Proceedings

Social Worker's Role in Court Proceedings

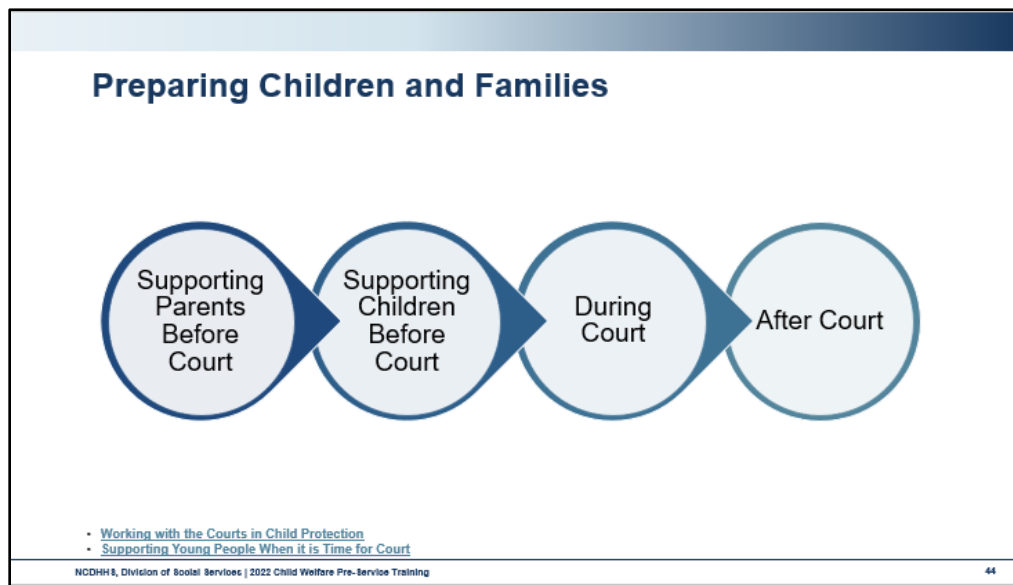
Court report	Testimony	Dress appropriately
Be on time	Engage the child and family	Collaboration

• [Working with the Courts in Child Protection](#)
• [Courtroom Preparation](#)

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Preparing Children and Families

**During Court**

You can't know in advance what will be decided in court, so don't make promises to parents and children you can't keep. If you are unsure what may happen during a particular court hearing, ask your agency's legal representative. During the hearing, avoid criticizing any parties in the case. It's okay to describe an individual's behavior as bad, but not the individual's. Additionally, parents shouldn't be hearing about your concerns or decisions that have been made or that you are recommending be made for the first time at the court hearing. In other words, you must always be providing parents with full disclosure. The information discussed during court shouldn't be a surprise to parents. You must provide parents with information regarding the steps in the intervention process, the requirements of the case plan, expectations, the consequences if the parents do not fulfill the expectations, and the rights of the parents to ensure that the family completely understands the process every time you meet with them.

After Court

In an ideal world, after a hearing, the attorney for the parent and/or the child should debrief about the experience. However, sometimes it will fall to the social worker or the child's caregiver to do this. Whoever does the debriefing should begin by thanking the parent and child for their courage and the part they played in the court process. Make sure they understand what happened, what the implications of the hearing are for the child, and what happens next. One of the goals of this discussion is to identify any support the parent and/or child might need going forward.

Handout: Preparing Children for Court

Most young people in foster care are invited to attend court, to be involved in the proceedings, and sometimes to testify. That's a good thing because hearing from children helps judges make appropriate decisions. But that doesn't mean being in court is easy for children. In fact, many young people report feeling anxious, angry, and frustrated with their experiences in court. However, when children are properly prepared for court and are supported afterward, these feelings can be minimized.

How People in Different Roles can Prepare Children for Court	
Attorney for the Child	The attorney for the child makes certain the child is aware of the hearing and lets the child know they are entitled, but not required, to attend. The attorney is the point person for familiarizing the child with all aspects of the hearing, explaining what is going to happen, and determining the child's preferences and wishes so they can be taken into consideration.
Child Welfare Social Worker	The social worker is also a source of information and can answer questions about the purpose and expectations of the hearing. Discussing who will be in court, what the child will see, and what is expected of the child will help alleviate stress and provide a better understanding of what to expect.
Guardian ad Litem (GAL)	The GAL is a specially trained person appointed by the court who volunteers their time to investigate the facts of a case and make recommendations to the court on what is in the child's best interest. The GAL can be a resource and can share insight if they have a connection with the child.
Foster Parent	Foster parents should support the child and provide reassurance about the hearing, answer questions, encourage participation, and support the child's decision whether to attend court.
Child's Parents	Where appropriate, the child's parents can speak to the child about the hearing, answer questions, encourage participation, and support the child's decision whether to attend court.
Judge	The judge can request that children attend their court hearings and can ask why a child is not in court. It is not the responsibility of the judge to prepare the children for court, but the judge can determine if a child has been prepared for court and proceed accordingly.

Source: <https://fosteringperspectives.org/fpv17n1/supporting.htm>

Key Takeaways

Key Takeaways

- Juvenile court assumes responsibility for ordering services and monitors child welfare cases
- Courts and child welfare agencies must work hand-in-hand
- Each case takes on a certain "life" and follow a prescribed path.
- Parents have certain rights and responsibilities
- Thorough preparation for court is key
- Prepare children and families before, support during, check-in after.

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Questions and Reflections

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

Family-Centered Practice Learning Lab

Video: [It Takes a Village – Collaboration is Key](#)

Visit: [It Takes a Village Collaboration is Key](#) for a video highlighting the impact of a family court’s compassionate and strength-based approach to supporting families.

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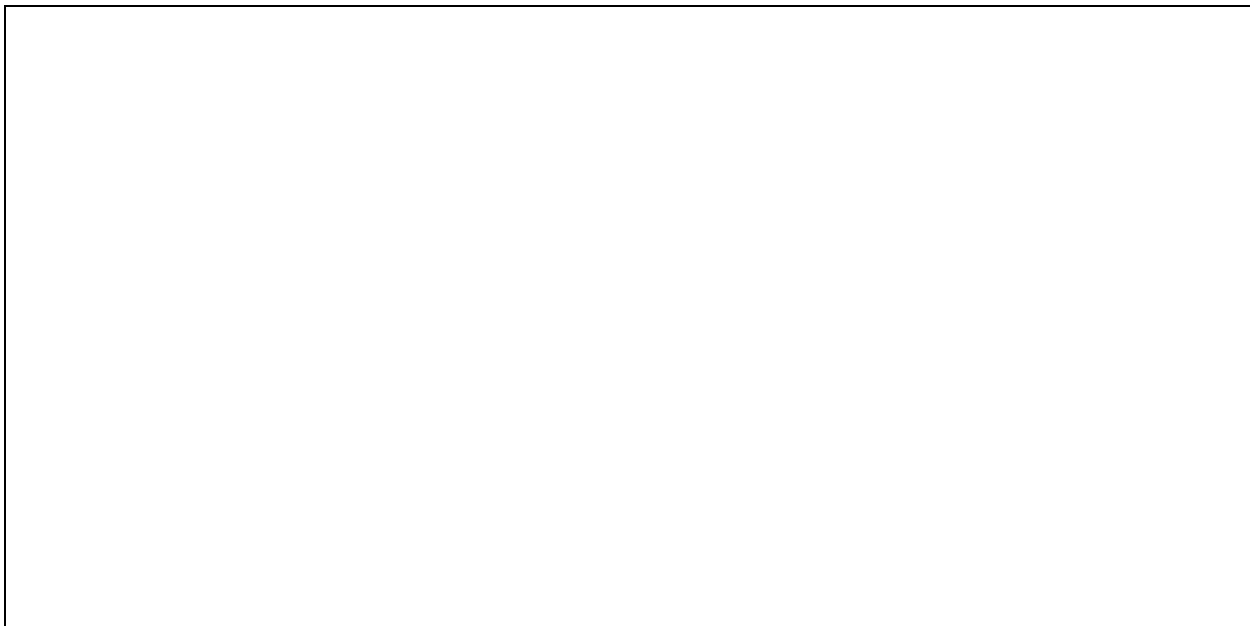
Activity: It Takes a Village – Collaboration is Key

Class participants will be assigned a role and quote from the videos viewed on the previous slide.

The purpose of the activity is to help learners to explain how various court and agency roles provide support to families and the collective impact of coordinated support and to identify opportunities for improving coordinated, multidisciplinary approaches and enhanced court-agency collaboration.

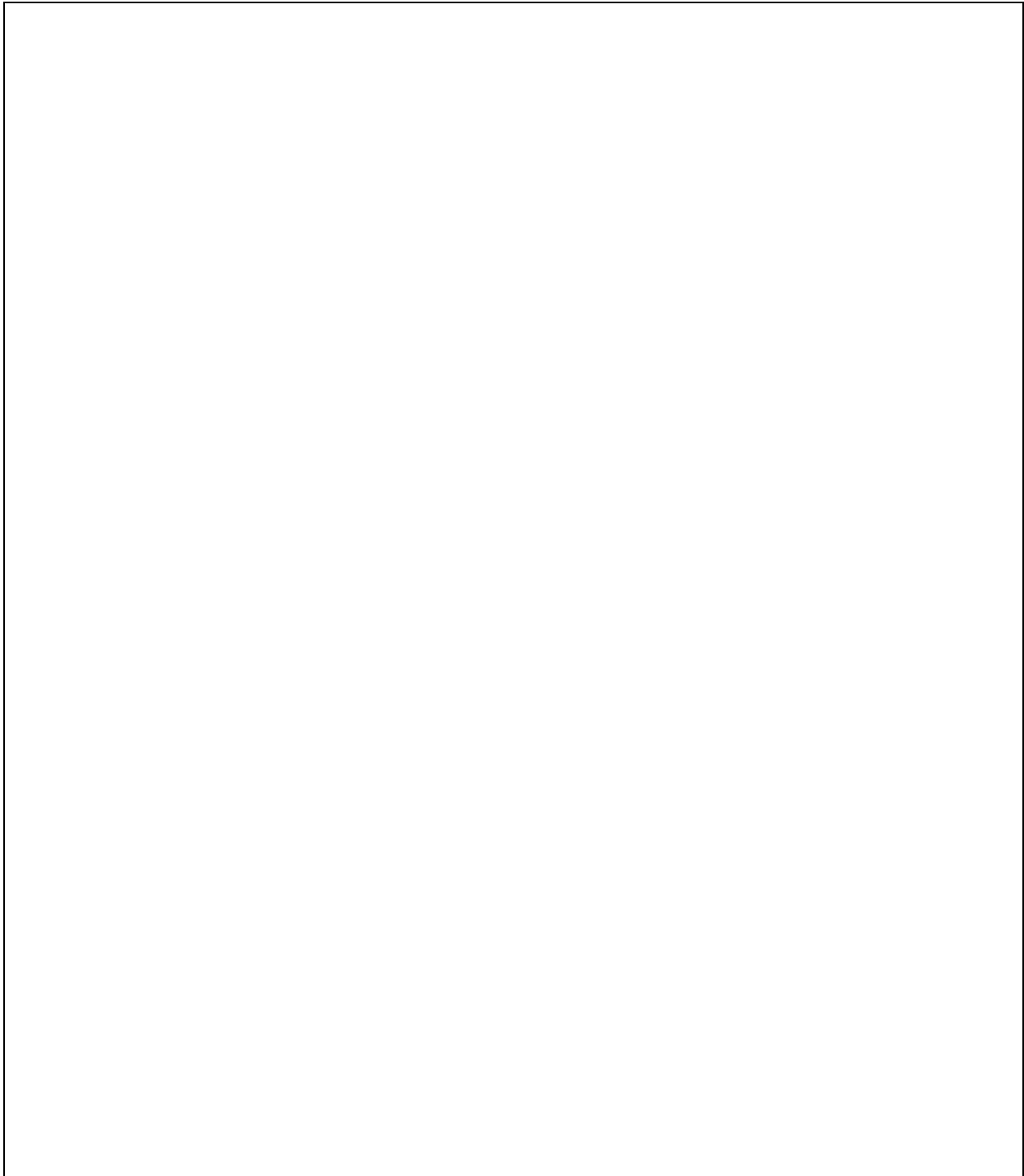
Debrief

- Reflect on the exercise and what the intersecting lines represent.
- What was the experience like for those of you dropping the support and stepping back from the circle? For those of you staying to the end? How does that relate to the real world?
- Explore whether the identified attitude or behavior helped others in performing their responsibilities and how.
- What are some shared interests among the following roles—judge, parent attorney, parent advocate, court-appointed special advocate (CASA), court social worker, and agency caseworker? How do their responsibilities differ?
- What role do trusting relationships play in supporting families?



Questions and Reflections

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

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Pre-Work Reminder

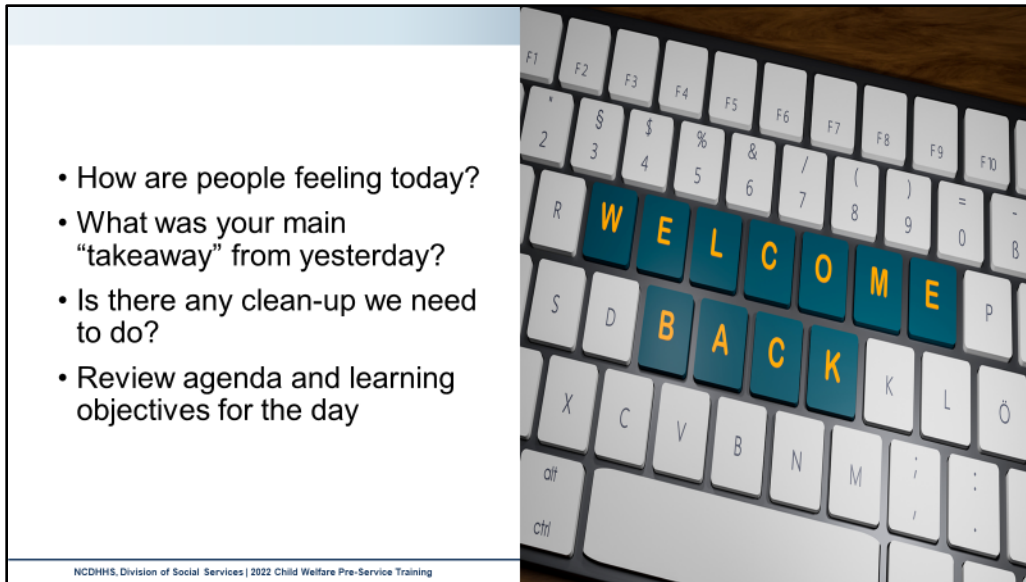
Before class tomorrow, please take some time to review the CPS Intake section of the Child Welfare Policy Manual and the Structured Intake Form and Instructions (DSS-1402) in your Tools Workbook.

Week Three, Day Two Agenda

Pre-Service Training: Child Welfare in North Carolina

I.	Welcome	9:00 – 9:30
	Quality Contacts	
II.	Why is Quality Important?	9:30 – 9:55
III.	Preparation for Quality Contacts	9:55 – 10:25
	BREAK	10:25 – 10:40
IV.	Quality Contacts	10:40 – 10:55
V.	Quality Contacts Learning Lab	10:55 – 11:45
	LUNCH	11:45 – 12:45
	Overview of Child Welfare Processes, Part 1: Intake and CPS Assessments	
VI.	Intake Process and Strategies	12:45 – 2:00
	BREAK	2:00 – 2:15
VI.	Intake Process and Strategies (continued)	2:15 – 3:05
VII.	Intake Learning Lab	3:05 – 3:50
	Pre-Work Reminder	3:50 – 4:00

Welcome



- How are people feeling today?
- What was your main “takeaway” from yesterday?
- Is there any clean-up we need to do?
- Review agenda and learning objectives for the day

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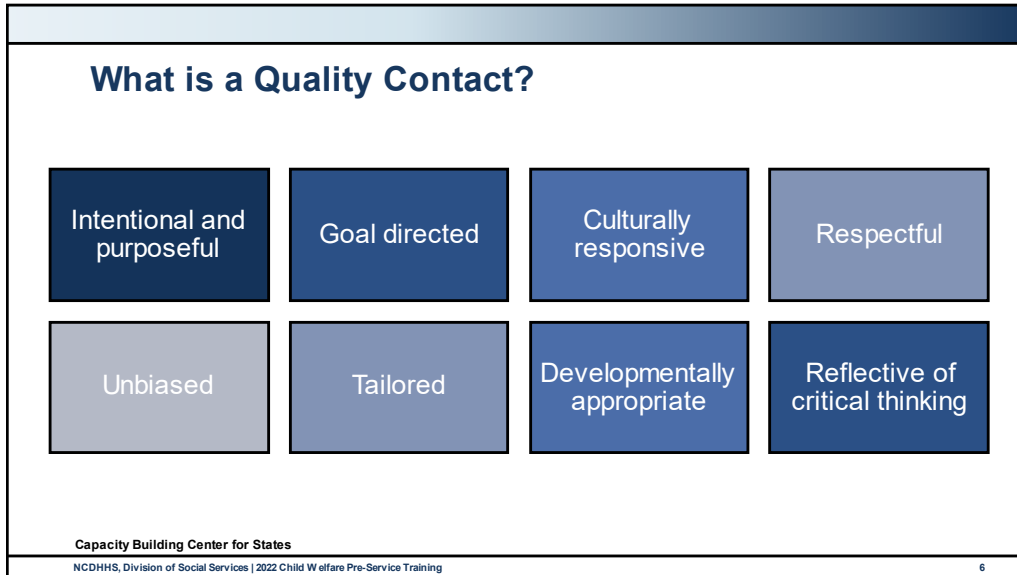
Quality Contacts

Learning Objectives

<ul style="list-style-type: none">• Describe the relationship between quality ongoing case contacts and child welfare outcomes.
<ul style="list-style-type: none">• Describe the core components of quality contacts.
<ul style="list-style-type: none">• Explain the importance of gathering and reviewing case information prior to conducting contacts.
<ul style="list-style-type: none">• Develop questions to engage children and families in assessment and case planning.
<ul style="list-style-type: none">• Describe strategies for facilitating quality contacts.

Why is Quality Important?

What is a Quality Contact?



Quality contacts are “Purposeful interactions between caseworkers and children, youth, parents, and resource parents that reflect engagement and contribute to assessment and case planning processes.”

How does each of these components contribute to quality interaction with children, youth, families, and caregivers?

Impact of Quality Contacts



What other impacts can you envision if we focus on providing quality contacts?

Policy Requirements

Policy Requirements			
Child	Parent or caregiver	Placement Provider	Collaterals
Use interviewing strategies appropriate to child's developmental level	Assess needs and identify services	Assess their needs on an ongoing basis	Talk with a variety of contacts to gather multiple perspectives
Assess safety and ongoing risk	Address issues relevant to the agency's involvement	Identify services to help them provide care	Exercise discretion to protect privacy and confidentiality
Assess well-being, identify child needs and services	Promote achievement of case goals	Discuss long-term care	
Observe the interaction between the child and their parent or caretaker	Allow for privacy and open and honest communication		
Speak with the <i>child</i> alone	Promote and support positive relationships between children and their parents		

NC Child Welfare Manual
NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training 8

The North Carolina Child Welfare Manual outlines the requirements for ongoing contact with children, parents or caregivers, placement providers, collaterals, and adult household members.

A quality contact must also include an assessment of the family's living environment and how it impacts child safety. You must tour the home and premises where the child sleeps, eats, and plays to assess safety.

If you plan to use your tablet, laptop, phone, or other technology to take notes during home visits, remember to ask families if they are okay with the use of technology and explain that you still intend to give your full attention. You also must be understanding if the family requests that you not use technology.



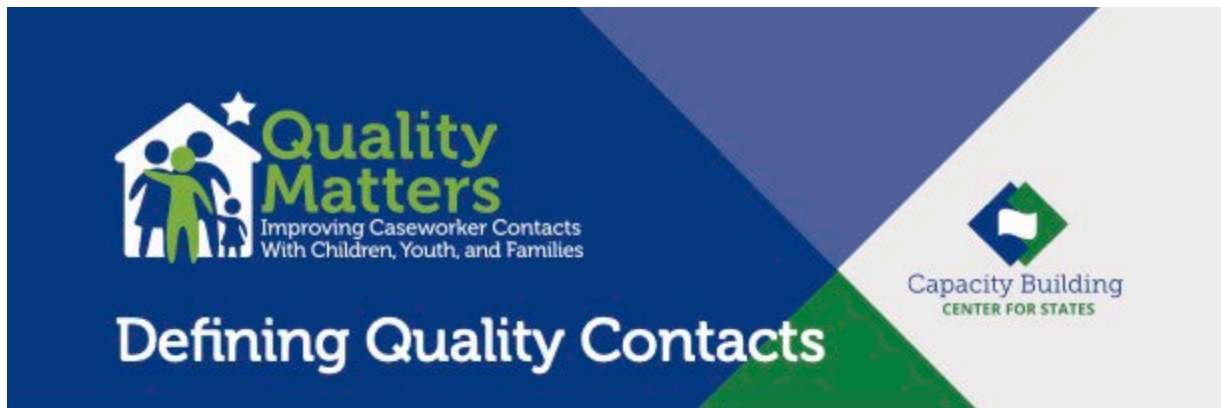
Strategies for Quality Contacts



A quality contact goes beyond a quick check-in with the child, youth, family member, or caregiver, and includes the following core components:

- Preparation and planning specific to the child, youth, and family's circumstances
- Assessment of safety, risk, permanency, and well-being, and progress toward individual case or permanency goals
- Engagement of children, youth, parents, and caregivers by the social worker through empathy, genuine care, and respect
- Dialogue that amplifies the youth and parents' voices, and promotes discussion and reflection on strengths, needs, and concerns
- Follow-up on tasks or concerns you've discussed previously, which might include difficult conversations about why things may not have happened as planned
- Decision-making and problem-solving to address needs and keep moving the case plan forward
- Documentation to support monitoring and follow-up

Handout: Defining Quality Contacts



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

What Are Quality Contacts?

Definition

Quality contacts are . . .

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

Core Components and Characteristics of Quality Contacts

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

Quality contacts incorporate the following components:

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

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

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

Exhibit 1. Characteristics of Quality Contacts

Intentional and Purposeful	Goal Directed	Culturally Responsive	Respectful
Unbiased	Tailored	Developmentally Appropriate	Reflective of Critical Thinking

Why Quality Contacts Are Important

Good casework practice depends on quality contacts.

Good Casework Practice

Quality contacts provide important opportunities for caseworkers to:

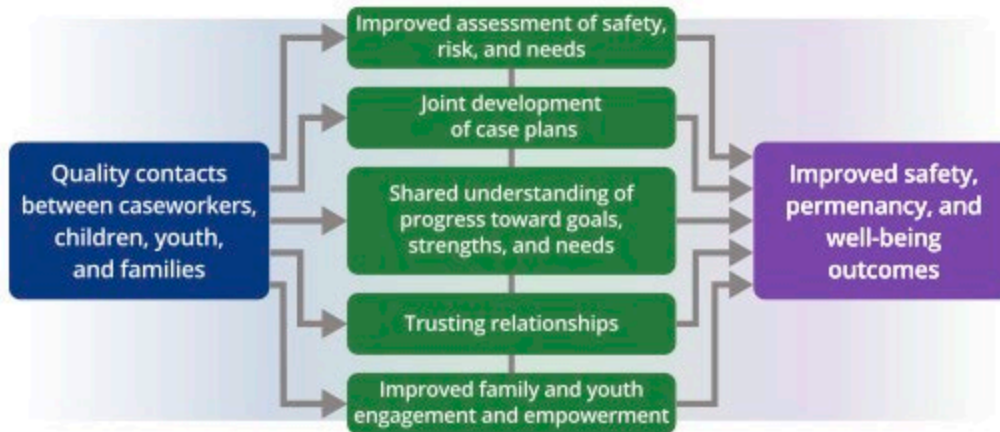
- Ensure child safety
- Make personal connections and develop trusting relationships with family members
- Observe children, youth, and families in their home settings (or other settings appropriate for the circumstances of the case)
- Work collaboratively with families to identify strengths, resources,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

Links to Positive Outcomes for Children and Families

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

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

Exhibit 2. The Impact of Quality Contacts



Federal Legislation and State Policies

Federal legislation¹ establishes State requirements for quality contacts in child welfare. The Child and Family Services Improvement Act of 2006, Public Law (P.L.) 109-288, requires each State's plan for child welfare services to describe standards for the content and frequency of caseworker visits for children and youth in foster care. The law specifies, **at a minimum**:

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

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

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

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

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

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

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

Common Challenges Affecting Quality Contacts

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

CFSR Findings

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

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

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

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

Factors That May Affect Quality Contacts

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

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

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

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

Key Phases and Activities in Quality Contacts

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

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

Exhibit 3. Key Phases of Quality Contacts



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

Exhibit 4. Key Quality Contact Casework Activities

Quality Contact Casework Activities	
Before the visit	
Schedule	<ul style="list-style-type: none"> Align visit frequency with national and State requirements and case circumstances. Consider the schedules of parents, resource parents, and youth/young adults in identifying the visit time. Consider the length and location of visits to support open and honest conversations.
Gather information and review	<ul style="list-style-type: none"> Gather and review case documents, service plans, and related data and information. Review documentation of the last contact to ensure follow-up was completed. Make any collateral contacts with key individuals in the case (e.g., therapist, treatment provider, doctor, school personnel) to assess progress and concerns.
Plan and prepare	<ul style="list-style-type: none"> Set a clear purpose and agenda for the visit. Identify issues and concerns to explore (with room for adaptation during the visit). Consider and plan for worker safety.

During the visit**Engage and collaborate**

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

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

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

Wrap up

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

After the visit**Document⁴**

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

Debrief

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

Follow up

- Follow up on commitments made and next steps.

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

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

Roles in Ensuring Quality Contacts

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

Exhibit 5. Roles in Ensuring Quality Contacts

Administrators	<ul style="list-style-type: none"> Set standards and policies for quality contacts. Build agency capacity. Review performance and introduce strategies for improvement based on identified challenges.
Program Managers	<ul style="list-style-type: none"> Monitor and support program staff in conducting quality contacts. Identify and address program barriers to quality contacts. Collaborate with IT, data, and CQI staff to promote system design and data collection that supports quality contacts.
Trainers	<ul style="list-style-type: none"> Help build staff knowledge and skills on conducting quality contacts.
Supervisors	<ul style="list-style-type: none"> Support caseworkers during all three phases of quality contacts. Discuss caseworker strengths and challenges in conducting visits, and promote critical thinking skills. Provide oversight to caseworker documentation of visits.
Caseworkers	<ul style="list-style-type: none"> Plan and conduct quality contacts. Engage children, youth, parents, and resource parents. Document key information. Work together with supervisors to enhance skills.
Children and Youth	<ul style="list-style-type: none"> Express thoughts, concerns, and needs. Partner in age appropriate decision-making and planning. Contribute to agency efforts to improve quality contacts.
Parents	<ul style="list-style-type: none"> Express thoughts and concerns related to their case plan. Partner in decision-making and planning. Contribute to agency efforts to improve quality contacts.
Resource Parents and Caregivers	<ul style="list-style-type: none"> Express thoughts and concerns related to child or youth well-being and needs, as well as their own. Contribute to agency efforts to improve quality contacts.
Information Technology Managers	<ul style="list-style-type: none"> Ensure information system makes relevant case information accessible to caseworkers, supervisors, and managers. Ensure that documentation of contacts reflects agency policies and practices.
Data and CQI Managers	<ul style="list-style-type: none"> Analyze, use, and share data to inform areas for improvement as part of the quality assurance and continuous quality improvement (CQI) processes.

Considerations for Building Capacity for Quality Contacts

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

1. Organizational resources

- Does the agency have adequate staff to meet frequency and quality standards?
- Do staff reflect the families served in the communities and speak the languages spoken in the community?
- Are caseloads, workloads, and responsibilities appropriate to enable caseworkers to conduct quality visits that meet State standards and promote positive outcomes? If not, what changes can the agency, supervisors, and caseworkers make?
- What additional resources do caseworkers need to support and enhance quality contacts?

2. Organizational infrastructure

- Does the agency have adequate policies and standards in place to ensure that caseworkers conduct quality contacts? Do policies and standards align with Federal guidance?
- Do practice guidelines support quality contact activities and documentation?
- What role do supervisors play in promoting frequent and quality contacts? How does the agency support supervision and coaching in these activities?
- Has the agency considered policies and mechanisms to support flextime or other accommodations for workers conducting visits during evening hours to avoid burn out?
- How does the agency monitor the quality and frequency of caseworker visits?
- How does the agency use data to inform and enhance contacts?
- What processes does the agency have in place to identify and address strengths, barriers, and challenges to quality contacts and improve effectiveness?
- How does the agency assess the impact of quality contacts on outcomes for children, youth, and families?

3. Organizational knowledge and skills

- Do caseworkers receive the right training and ongoing supports to understand policies and build skills necessary for conducting quality contacts?
- Do caseworkers have knowledge of the community, the culture(s), and the language(s) common to the community?
- Do supervisors have the knowledge and skills to support caseworkers?

4. Organizational culture and climate

- Does the agency have widespread understanding of the link between quality contacts, engagement, and positive outcomes for children, youth, and families?
- Does the agency culture support quality contacts?
- Does every level of the organization value quality contacts?


5. Organizational engagement and partnership

- How can the agency engage its State and community partners in supporting quality contacts?

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

Conclusion

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



Quality Matters
Improving Caseworker Contacts
With Children, Youth, and Families

To learn more about quality contacts and related Center for States publications and learning tools, visit the **Quality Matters: Improving Caseworker Contacts With Children, Youth, and Families** webpage at <https://capacity.childwelfare.gov/states/focus-areas/foster-care-permanency/quality-matters>

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This product was created by the Capacity Building Center for States under Contract No. HHSP233201400033C, funded by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.



Questions and Reflections

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

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Preparation for Quality Contacts

Before Visits

Schedule a visit:

- The frequency of visits should align with federal and state requirements for how often visits should occur, as well as the needs of the family or individual.
- Consider the schedules of the parents, resource parents, and youth to choose an appropriate time.
- Consider the length and the location of the visit to support open and honest conversations and build trust.

Gather and review information:

- Gather and review case documents, service plans, and related data and information.
- Review documentation of the last contact to ensure you've completed your action items and that you can follow up with the family or individual to confirm they have as well.
- Make any collateral contacts with key individuals in the case, such as therapists, treatment providers, doctors, or school personnel to assess progress and concerns.

Planning and preparing:

- Set a clear purpose and agenda for the visit.
- Identify issues and concerns to explore, allowing room for adaptation during the visit.
- Consider and plan for your own safety during the visit.

Are there other steps you can take before a visit to feel prepared and ready to engage the family?

During Visits

Engage and collaborate:

- Go back to your agenda and your plan and ensure that you have input from the person you're meeting with on the things to cover.
- Show genuine respect and empathy to the person.
- Address and mitigate your biases and avoid passing judgment.
- Ensure the person or family feels comfortable discussing the challenges and needs they have.
- Talk with adults and children or youth separately to provide privacy and to assess for safety.
- Communicate support and partnership to demonstrate that you are part of this family's team and are there for them
- Remember to listen! While you have prepared for this visit and you have a lot of information about this family, you also need to listen to make sure you're hearing what the family is sharing.

Focus on the case plan:

- Assess the safety and risk for the child, including identifying safety threats, vulnerabilities, and protective capacities.
- Explore the child and family's well-being.
- Ask developmentally appropriate questions and tailor your approach to each person.
- Identify strengths and opportunities for the child and family.
- Also identify any concerns, any circumstances that have changed, and any challenges they're facing.

Explore progress:

- Discuss the family's case goals, along with progress made since your last contact, and any action steps needed. Make sure you're using plain language and talking in a way that is engaging and accessible to the family.
- Observe what is happening in the home. Pay attention when you are touring the home and seeing where the child spends their time.
- Talk about what you and the agency will do to support the family to meet their goals, and what expectations the child and family need to meet.

Make adjustments:

- Discuss whether any changes need to be made to the case plan, and how those changes will be made. Talk with the child, family, or individual about who is responsible for those changes and reaching the new goals.

Wrap-up:

- When you have reached your goals and the family's goals for the visit, summarize what you have talked about, what next steps you all have, what action steps are needed and who is responsible. Take this opportunity to make arrangements and schedule your next visit, if possible.

Are there other things you can do during a visit to achieve your goals and engage the family?

After Visits

Document:

- Who was included in this contact.
- When and where the visit occurred.
- Your assessment of the child's safety and risk. What did you see as you walked around the home? Did you have concerns? Are you worried about any of the interactions you saw between the child and parents, caregivers, or providers?
- The child's well-being, including their mental health status, developmental milestones, behavior, any educational needs or strengths, social activities, and relationships.
- Progress toward case goals, as well as any changes to the plan or next steps needed.
- Any concerns shared by anyone included in the visit.
- Are there any new service needs? What did the child or family share about the services they're receiving?
- How did you show consideration for the child or family's culture? Did you take any specific steps to show respect for cultural traditions or needs?
- What follow-up is needed? What are the priorities based on what you learned during this visit?
- Ensure that your documentation highlights all action steps needed, who is responsible, and when the steps need to be completed.

Debrief each contact with your supervisor:

- Share your impressions, concerns, and any changes to the case plan (or any requests to change the plan).
- Reflect on how successful your approach was and how well you were able to engage and support the child or family. What challenges did you experience, and how can you address those before the next contact? What support do you need from your supervisor?

Follow-up:

- Follow-up on any commitments you made during the contact and achieve the action steps assigned to you.

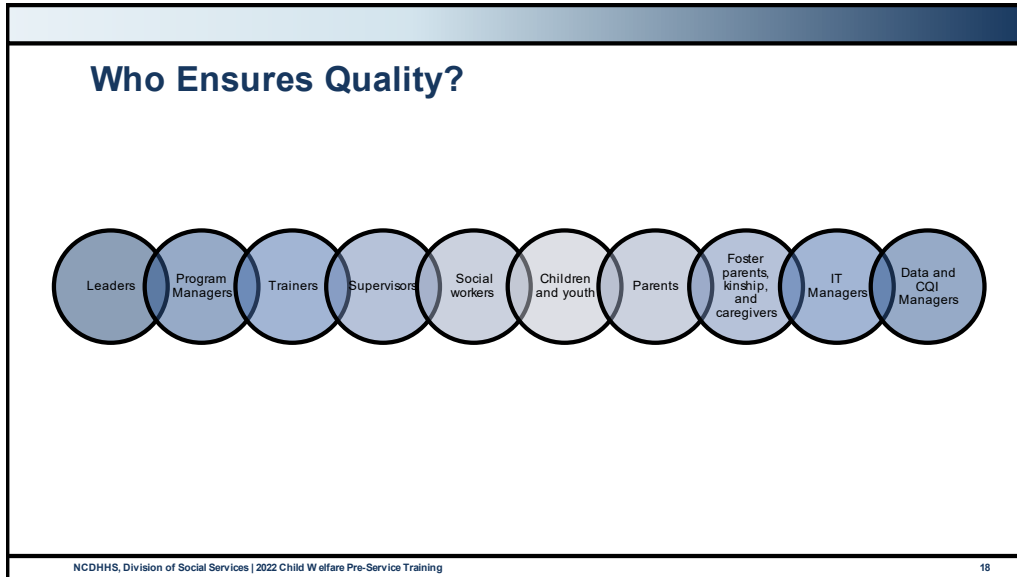
Are there other things you can do after a visit to confirm or modify your approach for the next contact?

Questions and Reflections

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

Quality Contacts

Who Ensures Quality



There are many people involved in making sure your contacts with children and families are high quality.

Who do you think could – and should – help ensure quality contacts?

Family-Centered Strategies

Family-Centered Strategies

- Engaging
- Inclusive
- Strengthening
- Supportive



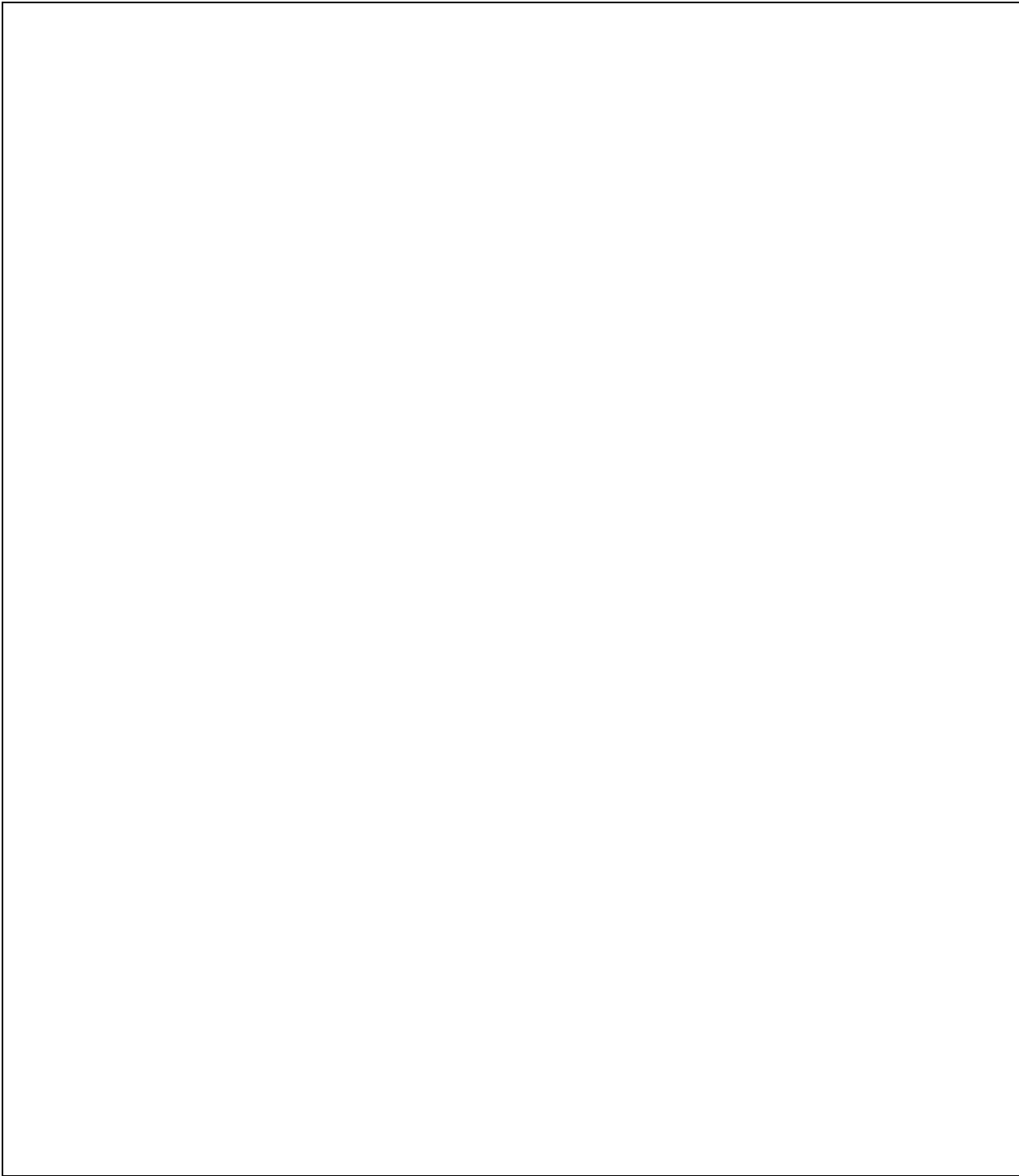
National Resource Center for Family Centered Practice
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Services delivered within family-centered practice must be engaging, and involve, strengthen, and support families.

Think back to when we talked about the components of quality contact. Which of those components contributes to family-centered practice?

Questions and Reflections

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

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Quality Contacts Learning Lab

Activity: Quality Contacts – June Michaels

Read the following scenario. For this activity, you will be a new worker on June's case, and this will be your first contact with June and her children. You will work in small groups to plan your first visit with June and complete the worksheet.

Mother: June Michaels – 25-year-old; White

Father: Alexander Thompson – 27-year-old; White

Child(ren): Michaela Thompson – 6-year-old; White; male

Luis Thompson – 4-year-old; White; female

Alix Thompson – 3-year-old; White; female

Background

June is a single mom with 3 children under the age of 6 years old. She works 2 jobs to be able to pay her bills, but there is no extra money. It is her turn to make cookies for her 6-year-old's class. She bought flour, sugar, chocolate chips, eggs, etc., and had the groceries sitting on the island in her kitchen. She planned to make the cookies after bathing her girls and putting them to bed. She could feel a migraine coming on and was concerned about being able to follow through with her cookie baking. The girls were extra "wild" on this night.

June got her 3-year-old out of the bath and got her ready for bed. She was helping her 4-year-old dry off when she heard her youngest laughing in the kitchen. She went to check on her and she had flour, sugar, and baking soda all over the kitchen and herself – including her newly washed hair. The chocolate chips were everywhere. As she got to her, the toddler was opening the sticks of butter and wiping them all over the counter. She had climbed up on a chair and onto the island and was a mess.

June's migraine had become full-blown while getting the children out of the bathtub. She grabbed her 3-year-old by the arm and began spanking her on her bottom. June cried as she cleaned her up and put her to bed.

The next morning, she got up early as she would have to run by the bakery and spend money they did not have before dropping her children at daycare and school. She began her waitress job at 8 a.m.

A child welfare worker showed up at June's house at 4 pm, as her youngest child had bruises on her buttocks and arm and there had been a report made to the child abuse hotline. During the discussion, June disclosed that she does not use corporal punishment -ever. The worker noticed her children were well-behaved and loving. There was a strong loving relationship between June and her children. The home was very clean and orderly. There was nutritional food available, and the children appeared

healthy. June told her about her headaches and that she does not have health insurance. The children are on Medicaid. She cannot afford to go to the doctor. She does not receive child support. She works 40 hours as a waitress during the week and does bookkeeping from her house on nights and weekends for a local business. She showed the worker her budget, which was tight. The interview with the 6-year-old matched the story June told and the worker was told by the child that she never saw mommy hit anyone until last night and mommy was crying.

June's mom and sister live in town. They have a good relationship, but they do not have money to help June. June's father's whereabouts are unknown. The children's father is working in construction in a nearby town. June and her children attend church regularly. June has one female friend from work, but she only talks to her at work. She has some old high school friends in the community but not much time for socializing.

Quality Contacts

You are a new worker on June's case, and this is your first contact with June and her children. Let's plan your first visit with June and her children. Remember that before visits, we are focused on scheduling, gathering and reviewing information, and preparing for the visit.

As we look at scheduling this visit with June, we're looking at the policy and legal requirements we must follow as well as June's schedule. We're going to try to find a safe, private place to meet, and determine a length of time that will be helpful and not overwhelming to June. We're also going to review the information that we have about June and her children and consider who else we should talk with before we meet June and her family. We also need to decide on a goal and an agenda for this contact and plan for our own safety.

Appoint one member of your group to be the reporter to share your ideas with the rest of the group.

What specific circumstances did you consider for this case?

What information specifically did you factor into when, where, and for how long you scheduled this visit with June?

What information did you review?

What was on your agenda?

What was the goal of the contact?

What issues and concerns did you add to your agenda?

What safety considerations did you include for yourself?

Key Takeaways

Key Takeaways

- There are multiple ways to conduct quality contacts, all centering around respecting the child and family
- Quality contacts must also be culturally responsive
- Quality contacts lead to better outcomes for children and families
- There are specific tasks for quality contacts before, during, and after visits

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Questions and Reflections

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

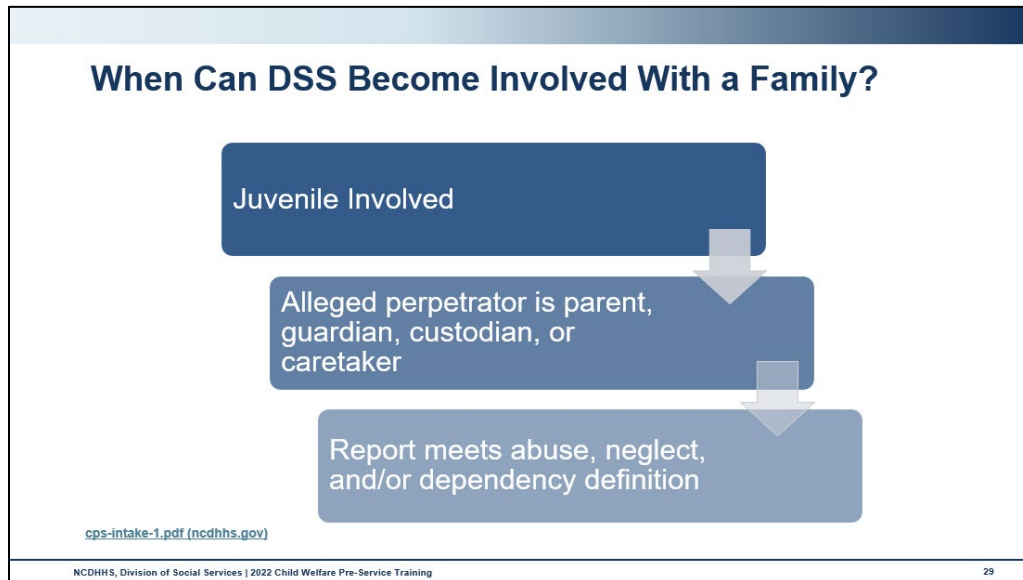
Overview of Child Welfare Processes, Part 1: Intake & CPS Assessments

Intake Process and Strategies

Learning Objectives

- | |
|--------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• Define and discuss the process of intake. |
| <ul style="list-style-type: none">• Identify effective ways of engaging to gather information. |
| <ul style="list-style-type: none">• Explain your role in the interviewing process. |

When Can DSS Become Involved with a Family?



The three major components must be present in a report of abuse, neglect, or dependency for DSS to become involved.

The report must allege:

- Maltreatment of a juvenile
- By a perpetrator who is a parent, guardian, custodian, or caretaker
- And the alleged maltreatment must meet the statutory definition of abuse, neglect, or dependency

Without these three elements being included in a formal intake report, DSS does not have the legal authority to become involved with a family. The one exception is if a report involves human trafficking, the alleged perpetrator does not have to be a parent, guardian, custodian, or caretaker.



Handout: North Carolina General Statute Definitions

A **juvenile** is: 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.

- Emancipation is a legal proceeding whereby minors aged 16 and 17 become legal adults. To become emancipated the juvenile must petition the District Court for an order of emancipation.
- Marriage or enlistment in the armed services automatically causes emancipation.

A **caretaker** is: 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.

A **custodian** is: The person or agency that has been awarded legal custody of a juvenile by a court.

- A juvenile parent would be included in the definition of custodian.
- The definition of "caretaker" is interpreted to include extended step-relatives, such as step-grandparents, step-aunts, step-uncles, and step-cousins, when these relatives are "entrusted with the juvenile's care."
- "Entrusted with the care" is interpreted to be limited to situations where a relative has primary care and decision-making authority for the juvenile. In addition, a person "entrusted with the care" is a "person who has a significant degree of parental-type responsibility for the child." The "totality of the circumstances" must be considered when making a determination if someone is a caregiver and a temporary arrangement for supervision of a child is not equivalent to "entrusting a person with the care" of a child.

An **abused juvenile** is: Any juvenile less than 18 years of age who is found to be a minor victim of human trafficking or whose parent, guardian, custodian, or caretaker:

- 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.
- Uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior.
- Commits, permits, or encourages the commission of a violation of following laws by, with, or upon the juvenile: first-degree forcible rape; second-degree forcible rape; statutory rape of a child by an adult; first-degree forcible sex offense:

second-degree forcible sex offense; statutory sexual offense with a child by an adult; first-degree statutory sexual offense; sexual activity by a substitute parent or custodian; sexual activity with a student; unlawful sale, surrender, or purchase of a minor, crime against nature; incest; preparation of obscene photographs, slides, or motion pictures of the juvenile; employing or permitting the juvenile to assist in a violation of the obscenity laws; dissemination of obscene material to the juvenile; displaying or disseminating material harmful to the juvenile; first and second-degree sexual exploitation of the juvenile; promoting the prostitution of the juvenile; and taking indecent liberties with the juvenile.

- 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.
- Encourages, directs, or approves of delinquent acts involving moral turpitude committed by the juvenile.
- Commits or allows to be committed an offense under human trafficking, involuntary servitude, or sexual servitude against the child statutes.

Moral turpitude includes situations where a parent encourages a child to shoplift and does not intervene to stop the child from shoplifting; or situations where a parent encourages a child to sell drugs or sets child up as a “drug runner. Providing alcohol/drugs to a child or consuming alcohol with a child meets the definition of “neglect,” not “moral turpitude.”

An important note about this definition is that it includes the person who commits the act, as well as the person who allows the act to be committed.

A **dependent juvenile** is: A juvenile in need of assistance or placement because the juvenile has no parent, guardian, or custodian responsible for the juvenile's care or supervision or the juvenile's parent, guardian, or custodian is unable to provide for the juvenile's care or supervision and lacks an appropriate alternative childcare arrangement.

In approximately 85% of CPS cases, the maltreatment type falls under this definition of neglect.

A **neglected juvenile** is: Any juvenile less than 18 years of age who is found to be a minor victim of human trafficking, or whose parent, guardian, custodian, or caretaker does any of the following:

- Does not provide proper care, supervision, or discipline.
- Has abandoned the juvenile.
- Has not provided or arranged for the provision of necessary medical or remedial care.
- Or whose parent, guardian, or custodian has refused to follow the recommendations of the Juvenile and Family Team made pursuant to Article 27A of this Chapter.
- Creates or allows to be created a living environment that is injurious to the juvenile's welfare.

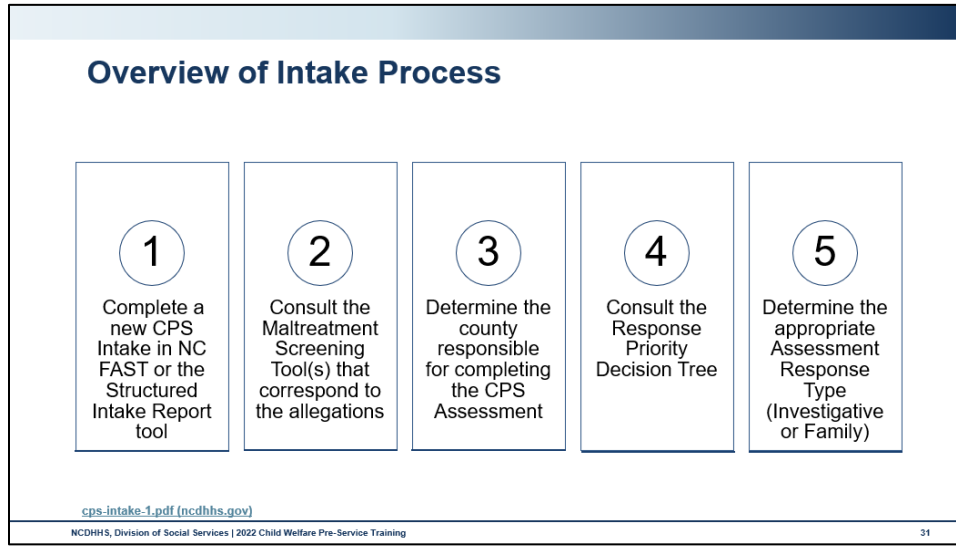
- Has participated or attempted to participate in the unlawful transfer of custody of the juvenile under G.S. 14-321.2.
- Has placed the juvenile for care or adoption in violation of law.

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.

Under the definition of neglect, remedial care is defined as those services, such as speech or physical therapy, that are necessary for the child's functioning, such as proper treatment for a hearing defect.

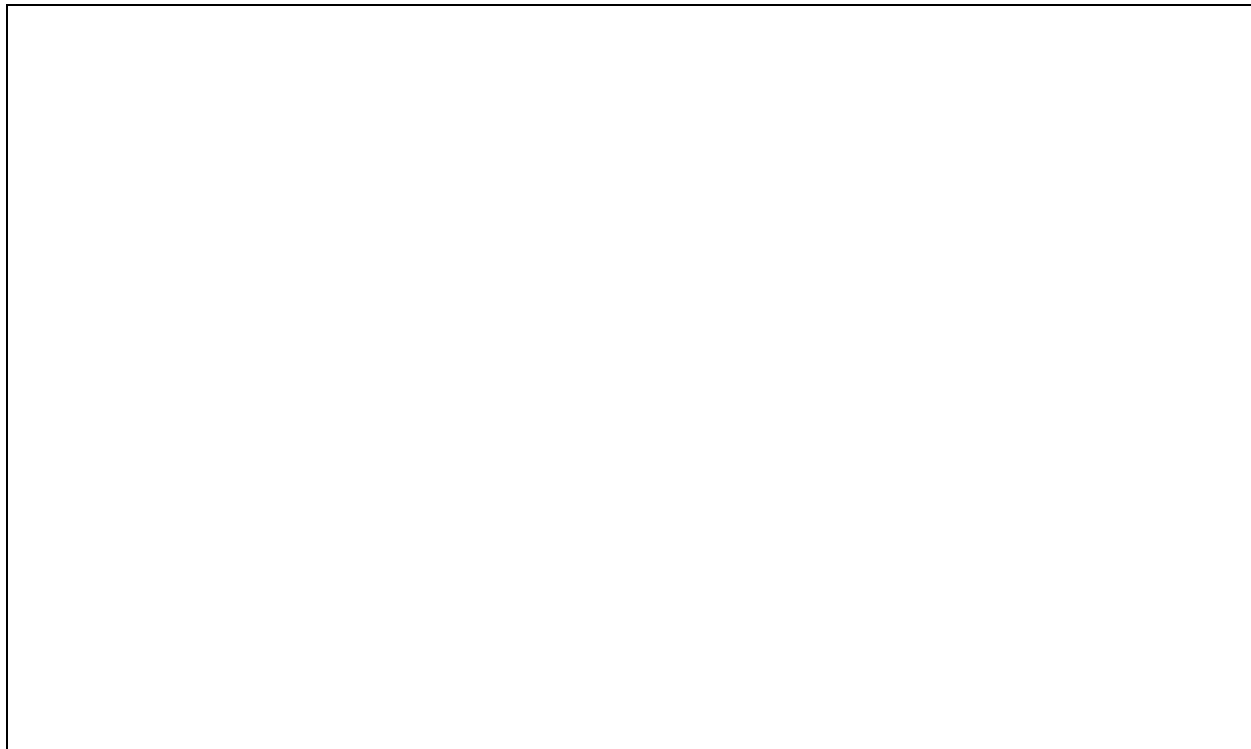
- Educational neglect does not become a DSS requirement for intervention until the school's efforts to assure attendance have been exhausted.

Overview of Intake Process



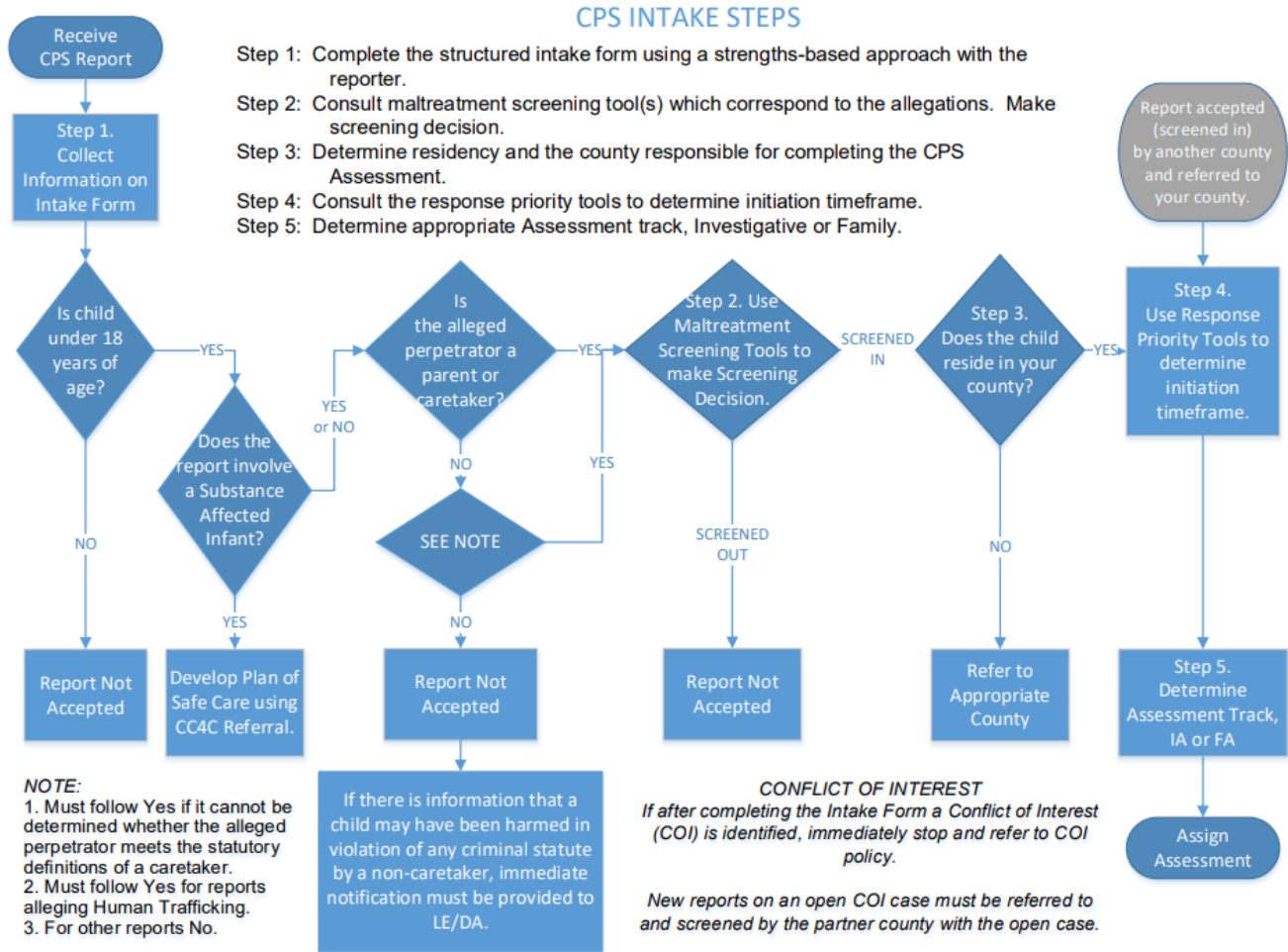
The goal of CPS Intake is to make consistent screening decisions using a structured intake process based on specific criteria.

During this process, Intake social workers are responsible for gathering information about who, what, when, where, and how related to the allegations of maltreatment, family strengths, and safety factors from reporters.



Handout: CPS Intake Steps

Intake Steps



Source: North Carolina Child Welfare Manual: Intake

Questions and Reflections

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

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Video: Buzzwords – Moving to Behavioral Descriptors

Visit: **Buzzwords - Moving to Behavioral Descriptors** for a video highlighting the impact of negative, subjective language in child welfare reporting and documentation.

Use this space to record notes.

Worksheet: Buzzwords Discussion Guide



Discussion Guide for Buzzwords

This tool is a role-playing activity, designed to help child welfare workers and supervisors become more familiar with the process of recognizing and translating buzzwords into descriptive language.

Instructions

- ▶ Individually, in a small group, or with a partner, use these guidelines and questions to practice translating buzzwords into objective descriptions.
- ▶ Before you begin, review the list in the “Buzzwords: Moving to Behavioral Descriptors” tip sheet and mark buzzwords you have heard or seen. Add other commonly used buzzwords that do not appear on the list. Remember, buzzwords are words used to describe behaviors or observations; they are not stereotypes or slang words.
- ▶ Select one person in your group to act as a reporting party. The reporting party should describe an incident using buzzwords. “Ms. Smith” can serve as a generic example of the subject of the report.
- ▶ Designate another person in your group to act as the child welfare/intake worker and practice using all, or some, of the open-ended role-play questions below to clarify circumstances when buzzwords are used.
- ▶ Make sure every participant has the opportunity to play the part of the child welfare worker.
- ▶ If you are completing this exercise individually, imagine yourself in each role and record your answers accordingly.
- ▶ Use the space provided for each question to record the reporting party’s responses.
- ▶ Once you have completed the role-playing activity, use the discussion questions below to talk about what you learned.

Role-Playing Questions

1. Can you give me an example of how Ms. Smith is (buzzword)? _____

2. When you say the child is (buzzword), what does that look like? _____

3. I can hear that you are (emotion). Tell me a little more about how Ms. Smith acts that makes her (buzzword). _____

4. I do not want to assume what you mean by (buzzword). Can you describe what you saw/experienced that makes him/her (buzzword)? _____



- 5. What you're saying sounds very concerning. Can you provide more details of the behaviors that make him/her (buzzword)? _____

- 6. You've just described him/her as (buzzword). Can you share an example(s) so I have a better understanding of your concern? _____

- 7. When you state that he/she is (buzzword), can you tell me more about the behaviors that can paint a better picture of what is meant by (buzzword)? _____

Discussion Questions

- 1. As a group:
 - Discuss which approaches were most effective in translating the buzzwords into behavioral descriptions and why. Record answer here: _____

 - List areas in your agency where you might find buzzwords (e.g., hotline/screening, case transfer summaries, court reports, supervision, etc.). _____

 - Brainstorm suggestions for next steps to implement this change in your agency. Record ideas here: _____

- 2. To improve child welfare decision-making, list what you are willing to do individually to ensure more descriptive language replaces unexamined, subjective buzzwords in child welfare reporting and documentation. _____



This product was created by the Capacity Building Center for States under Contract No. HHSP233201400033C, and funded by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Use this space to record notes during the activity.

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Handout: Buzzwords Tip Sheet



Buzzwords: Moving to Behavioral Descriptors



What Are Buzzwords and Why Do They Matter?

"Buzzwords" are popular words, phrases, or jargon frequently used to quickly communicate ideas in a particular field or in popular culture. Buzzwords often are harmless in meaning and impact. However, they can be misleading and damaging when used to describe individuals and families in child welfare settings. This publication looks at buzzwords in the context of words or phrases commonly used in child welfare reporting and documentation that can be subjective or carry negative connotations, and offers strategies to minimize their negative impact.

Buzzwords can begin as early as an intake call with a reporting party's description of a suspected child abuse or neglect case or a caseworker's interpretation of a reported incident, and can be repeated throughout the life of a case. Commonly used statements in child welfare reporting like "The child was filthy," and "The parents were hostile," can form negative characterizations that may lead to unintended biases and can create barriers to effective engagement if left unchecked. Because word choices can influence perceptions, frequently repeated negative buzzwords may affect how a caseworker views the child and family during the assessment and may directly impact decision-making. Buzzwords may also lead to labeling that can be difficult for families and individuals to overcome.

Some Potential Consequences of Using Unchecked Buzzwords:

The use of negative, subjective buzzwords may have potential consequences, including:

- ▶ Incomplete information that may impact assessment and decision-making
- ▶ Assumptions that could lead to a limited understanding of child and family needs and barriers to effective engagement
- ▶ Case planning and services that might not match actual needs
- ▶ Creation of stigma or false perceptions that result in unnecessary investigation, removal, or delayed reunification
- ▶ Unsupported decisions that are not in the best interest of the child and can affect safety, permanency, and well-being

In addition to the potential consequences listed above, the use of buzzwords may lead to further stigmatization related to race, ethnicity, or marginalized populations in child welfare. Buzzwords associated with poverty, substance use disorder, mental illness, race, ethnicity, or gender can create labeling that leads to bias and disparities among certain populations. For example, research points to racial bias by caseworkers and reporters as one of four likely contributing factors in

disproportionality (Child Welfare Information Gateway, 2016). Understanding the potential bias effect of buzzwords used to describe groups or individuals can help child welfare agencies further understand potential factors related to disproportionality. Similarly, understanding the potential impact of buzzwords on engagement, as well as assessment and decision-making, can help child welfare agencies achieve improved outcomes around child welfare safety, permanency, and well-being.

A Success Story:

As a part of the 2010 California Disproportionality Project Breakthrough Series, the Alameda County Department of Children and Family Services implemented and tested a project to eliminate unintended biases connected to disproportionality of child welfare investigations involving children of color. The project, Hot Words (Asking Questions and Using Language that Does Not Result in Bias), found that the effect of “hot words” was profound as they moved from intake to the investigation narrative, court reports, and beyond. By raising awareness of “hot words,” intake workers were more successful in obtaining context that led to a clearer understanding of allegations and a reduction in referrals assigned to be investigated (Alameda County Social Services Agency, 2010).

Strategies to Interrupt the Use of Buzzwords in Case Documentation:

Translating negative, subjective buzzwords into more descriptive language—objective language that describes the circumstances based on seen or heard facts and observations (see below for examples)—can have an immediate impact on assessment and decision-making and lead to better outcomes. It can also result in obtaining additional information about a family's circumstances that can help support assessment, decision-making, and individualized service delivery. The following strategies are designed to help child welfare workers and agencies increase awareness about the use and impact of buzzwords and take personal responsibility for initiating changes that can eliminate their negative impact.

- ▶ **Learn to recognize buzzwords.** Review the list below to help identify some of the most common buzzwords found in child welfare documentation. Consider creating a chart of commonly used buzzwords in your county or region to share with program managers and staff.
- ▶ **Know where buzzwords are commonly found:**
 - Intake/screening reports taken from child protective services (CPS) hotlines
 - Investigation reports and related documentation if intake reports are substantiated
 - Court reports related to child welfare investigations or juvenile delinquency cases
 - Case management documentation, such as mental and behavioral health assessments, progress reports, permanency plans, reports on wraparound services, and more
- ▶ **Be self-aware and take personal responsibility.** Be aware of the potential effect of repeating buzzwords in writing and verbally. When you see or hear a buzzword, ask

whether it could create unintended bias. Ask what the worker or reporting party means by the statement, or what evidence they have in order to provide context and clarification:

- Examples: “When you say he was unkempt, what does that look like?” and “Can you give me an example of when he acted hostile?”
- Engage families and children with open, respectful communication during assessment. Use age-appropriate language to communicate and understand responses. Ask clarifying questions to better understand labels and buzzwords used by the family or individual, and avoid repeating those labels in verbal and written documentation.
- **Recognize and translate buzzwords into more objective, behavior-based descriptions.** Objective, behavior-based language includes facts based on what is seen, heard, and observed. See Exhibit 1 for examples.

Exhibit 1

- Example 1:
 - Subjective statement: “Mr. Smith was hostile and resisted removing Bobby from the home.”
 - Intervening question: “What did Mr. Smith do to create that impression?”
 - Objective description: “Mr. Smith responded with a loud, frustrated tone when the case manager raised the possibility of removing Bobby from the home to stay with his aunt.”
 - Document: When mentioning the possibility of removing Bobby from the home to stay with his aunt, Mr. Smith responded with a loud, frustrated tone.
- Example 2:
 - Subjective statement: “The counselor said Bobby always comes to school filthy.”
 - Intervening questions: “What does he look like?” and “How often did that happen?”
 - Objective description: “The counselor said Bobby came to school wearing the same clothing several days in a row and wore an oversized, torn, and dirty jacket.”
 - Document: The school counselor reported Bobby wore the same clothing with an oversized, torn, dirty jacket several days in a row.
- Example 3:
 - Subjective statement: “A neighbor says Ms. Smith is crazy and unstable.”
 - Intervening question: “Did the neighbor give examples of what makes Ms. Smith appear crazy?”
 - Objective description: “The neighbor says Ms. Smith rarely smiles, and he has seen her break down crying and come outside wearing pajamas to yell at her children.”
 - Document: The neighbor observed Ms. Smith crying and yelling at her children outside.

- ▶ **Write descriptive case notes and assessments.** Record facts, specific behaviors, and concrete observations in case notes and assessments. Use nouns and verbs to describe behavior, and avoid subjective language by limiting the use of value-based adjectives (e.g., “hostile” or “uncooperative”) (National Resource Center for In-Home Services, 2015). See Exhibit 1 for examples of ways to translate negative buzzwords into more descriptive, factual observation.
- ▶ **Train and engage partners.** Hold meetings or trainings with staff, community partners, Tribal partners, and other relevant parties to discuss the use and effect of buzzwords and the importance of interventions.
- ▶ **Review buzzwords in past case files and use them as teaching tools.** Train staff on how language can affect assessments and decisions, understanding of individualized needs, and access to appropriate services. Training should also emphasize the long-term impact of labeling.

Commonly Used Buzzwords in Child Welfare

Exhibit 2 presents a list of buzzwords and phrases commonly found in initial hotline intake/screening and case documentation that are sometimes used in a subjective manner.

Exhibit 2

Abusive	Filthy/dirty	Prostitution history
Addict	Frequent flier (runaway)	Resistant
Afraid	Hot-headed	Scared
Aggressive	Hostile	Sexually exploited
Alcoholic	Hysterical	Substance abuse history
Angry	Incorrigible	Terrified
Assaultive	Isolated	Threatening
Belligerent	Limited	Traffic in home
CPS history	Loud	Trouble maker
Crazy	Marginal (financial)	Unattended
Criminal history	Mental health history	Uncooperative
Defiant	Nasty	Uneducated
Destructive	Neglect	Unfit parent
Disruptive delinquent	No resources	Unkempt
Drug user	Noncompliant	Unstable
Dysfunctional	Nonresponsive	Unsupervised
Emotionally disturbed	Not engaged	Violent
Explosive	Out of control	Volatile
Failure to rehabilitate	People in and out of home	Weird
Father is absent	Promiscuous	Whooping and whipping

* The buzzwords in Exhibit 2 have been adapted from the Alameda County "Hot Words (Asking Questions and Using Language that Does Not Result in Bias)" project in conjunction with feedback from various stakeholder groups.

* Please note that some of the words listed above could be used to objectively describe an incident or situation. It is important to avoid using these, and similar terms, in a subjective manner without providing further context.

Key Reminders

- ▶ Increase awareness: Buzzwords begin as early as intake/screening; therefore, it's important to "unpack" buzzwords from the initial hotline call.
- ▶ Avoid subjective interpretations of buzzwords. How you define certain buzzwords is often different than what is meant and how others define the same buzzwords.
- ▶ Take personal responsibility: Remember, we all have used buzzwords as quick descriptors. You can stop the continuation of negative, subjective buzzwords in written documentation and verbal communications when you see or hear them by asking follow-up questions to describe related behaviors, actions, or observations.
- ▶ Provide objective descriptions: Take the sting out of buzzwords by making sure your case notes, court reports, case consultants, and all communications are free from subjective buzzwords.

References:

- Alameda County Social Services Agency. (2010). DCFS moves forward on the disproportionality project. (DCFS Press, Summer, 3). Retrieved from http://www.alamedasocialservices.org/public/departments/children_and_family_services/pdfs/dcfspressSummer10_DCFS_Press_-_Summer_2010.pdf
- Child Welfare Information Gateway. (2016). *Racial disproportionality and disparity in child welfare*. Issue Brief. Washington, DC: U.S. Department of Health and Human Services, Administration on Children, Youth and Families, Administration for Children and Families, Children's Bureau.
- National Resource Center for In-Home Services. (2015 draft). *Effective home visits with intact families: Safety decision-making, management, and documentation*. Developed for the Children and Family Services Agency, Washington, DC, based on a training from the Institute for Human Services, Ohio Department of Job and Family Services Training.



This product was created by the Capacity Building Center for States under Contract No. HHSP233201400033C, and funded by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

North Carolina Structured Intake Form (DSS-1402)

NC Structured Intake Form (DSS-1402)

North Carolina Department of Health and Human Services | Division of Social Services
Child Protective Services Structured Intake Form

1

Complete a new CPS Intake in NC FAST or the Structured Intake Report tool

Section I: Demographics

Date: _____ Time: _____

Received by (Name): _____ County: _____

Screening Decision: _____ Referred Due to Residency: _____

Assigned to: (County/Worker Name) _____

Referred to: (County Name) _____ Date/Time: _____

Confirmed with: _____

Was Safety Assessed Yes Date: _____ By: _____

No Reason: _____

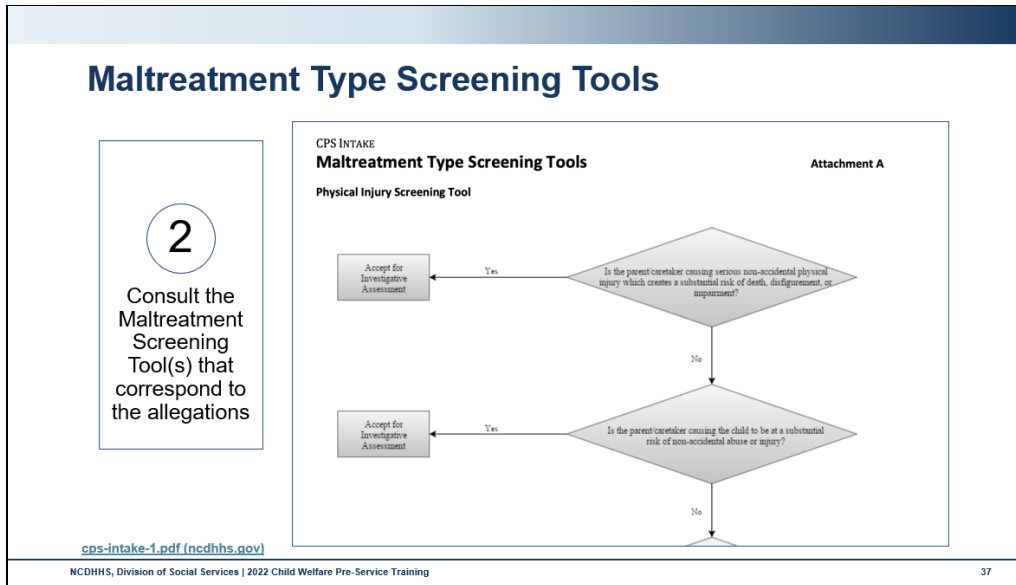
Type of Report: Abuse Neglect Dependency

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Using the form ensures that all the needed details are captured so accurate and informed intake assessments can be made consistently by all DSS agencies. Capturing this information is important:

- to make an accurate determination of whether or not the report should be accepted
- to determine whether or not the child is safe or at risk of harm
- to determine a required response time
- to be able to easily locate the child and family at home and school
- need the family's name to check the central registry and with other counties after the report is accepted
- to know if other people might be contacted for information if the report is accepted
- to know if there are environmental hazards the investigative worker needs to be aware of
- to establish worker safety or risk
- to establish a contact in case you need additional information
- to identify others who might be helpful in the case if it is accepted
- to know up front if there are substance or domestic violence issues and the extent of those issues

Maltreatment Type Screening Tools



For DSS to intervene there must be a report alleging maltreatment that meets the legal definition of abuse, neglect, or dependency of a juvenile by a parent or caretaker. It is the intake worker’s responsibility to determine that the report involves a juvenile and a parent or caretaker.

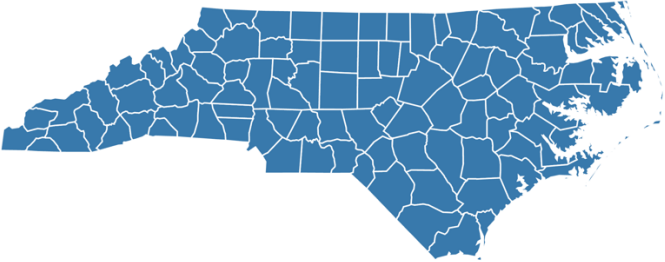


County Assignment

County Assignment

Local DSS Directory

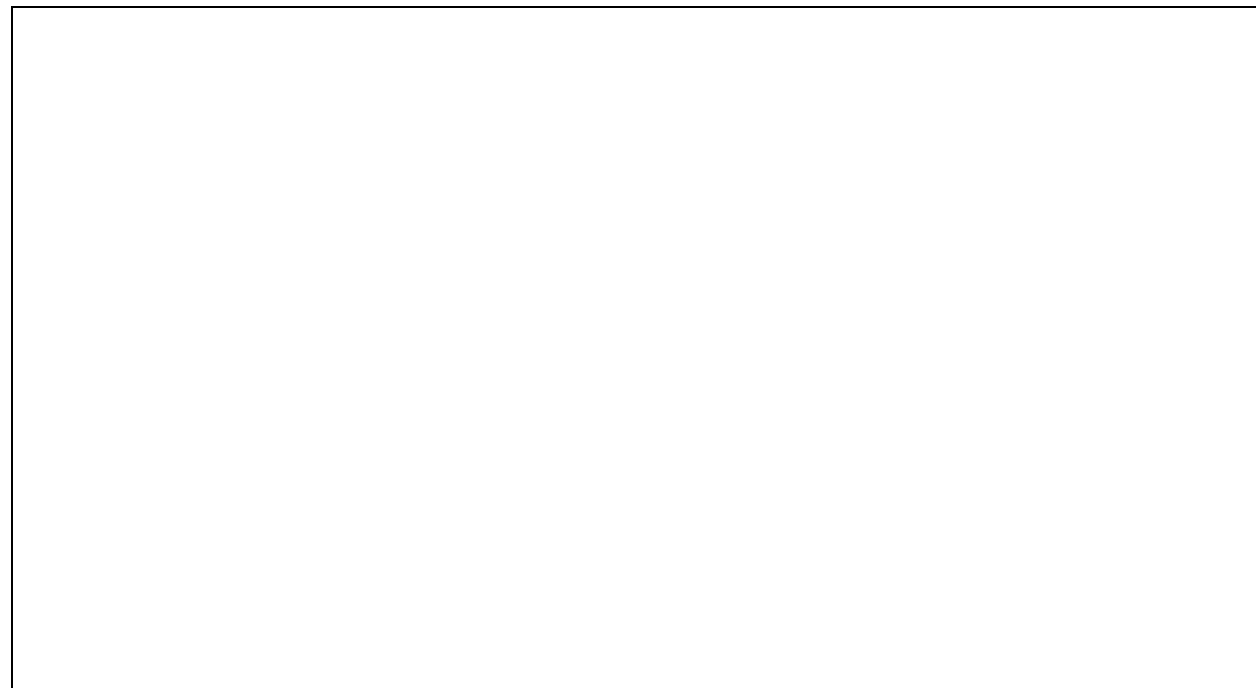
3
Determine the county responsible for completing the CPS Assessment



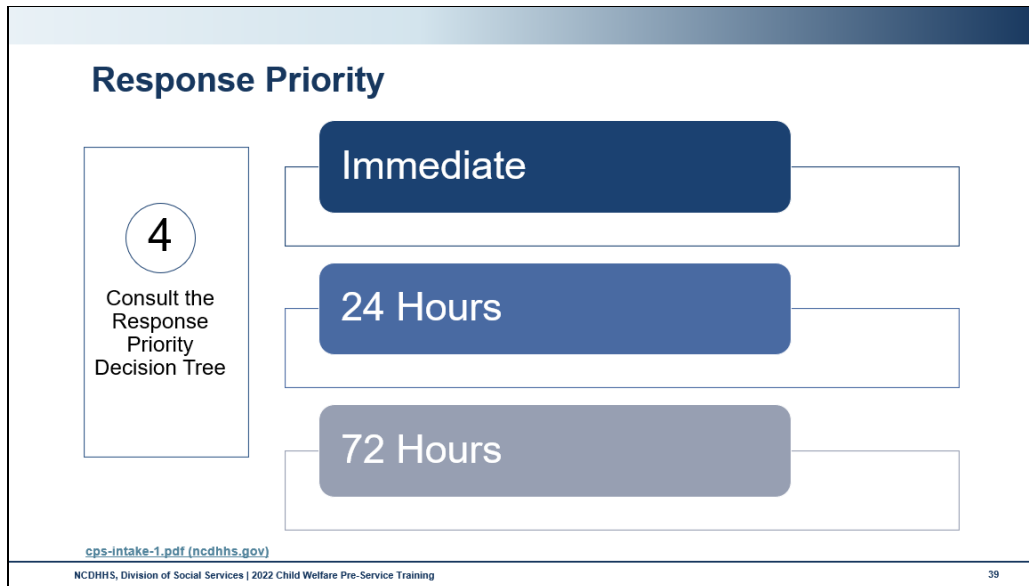
[cps-intake-1.pdf \(ncdhhs.gov\)](#)

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The intake worker who receives a call completes the Structured Intake form and screens the report for acceptance regardless of the child’s county of residence. If a report is screened in, the county where the child resides is responsible for completing the CPS Assessment. The worker who took the initial report provides all information to the county responsible and should inform the reporter that their information will be shared with another county who may contact them for additional information.

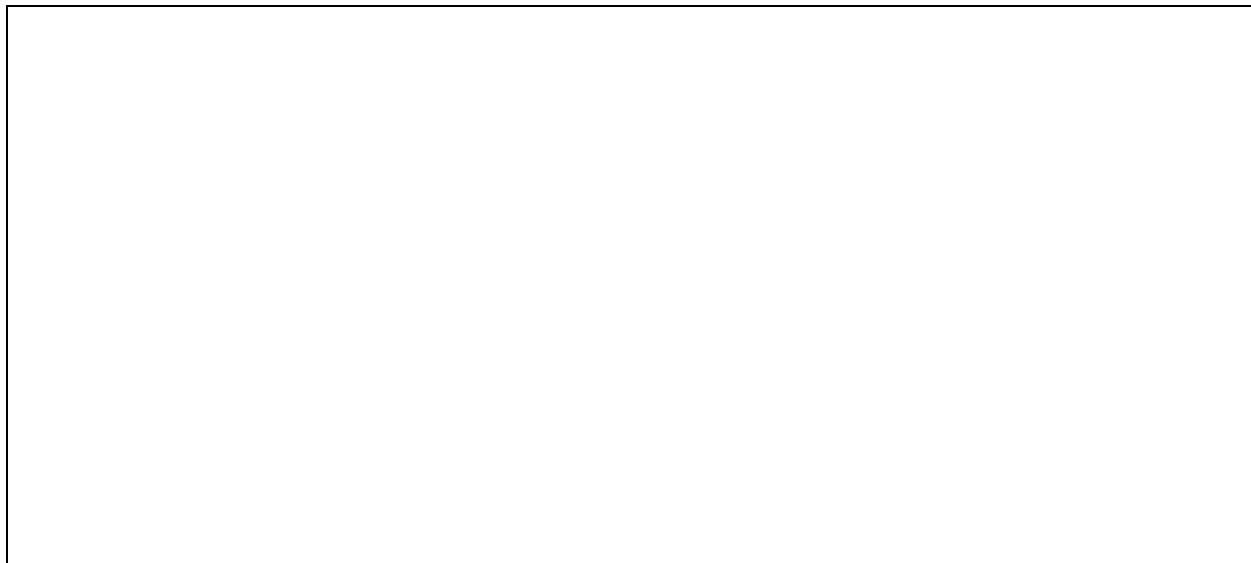


Response Priority

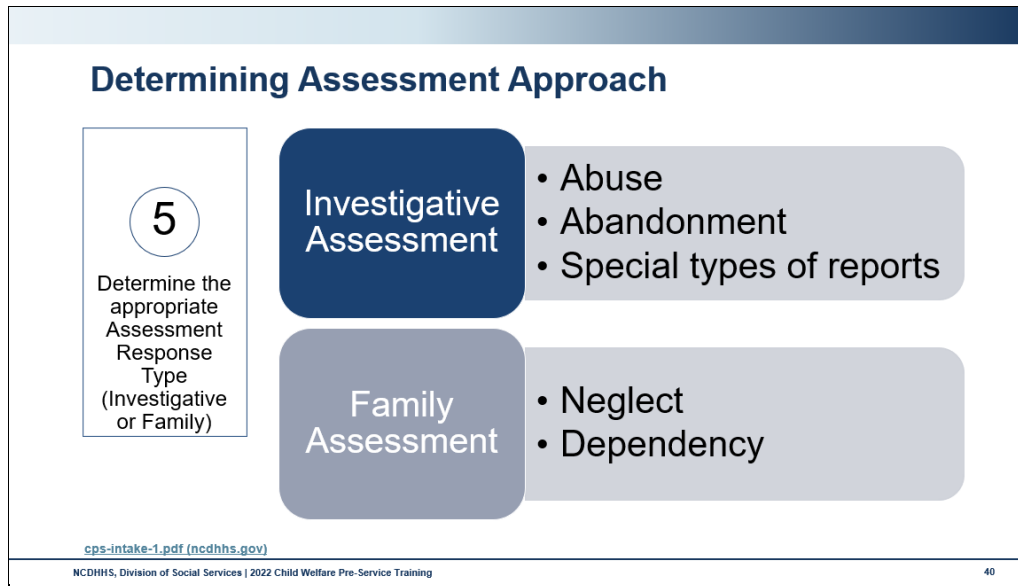


The county responsible for completing the CPS Assessment determines the response time using the Response Priority Decision Trees. There are seven Response Priority Decision Trees that correspond with different allegations.

There are three possible response times, immediate, 24 hours, and 72 hours. For immediate response, the initiation must occur at once after the completion of the intake report. The response time for allegations of physical abuse or sexual abuse must never exceed 24 hours, and the response time for allegations of neglect or dependency must never exceed 72 hours.

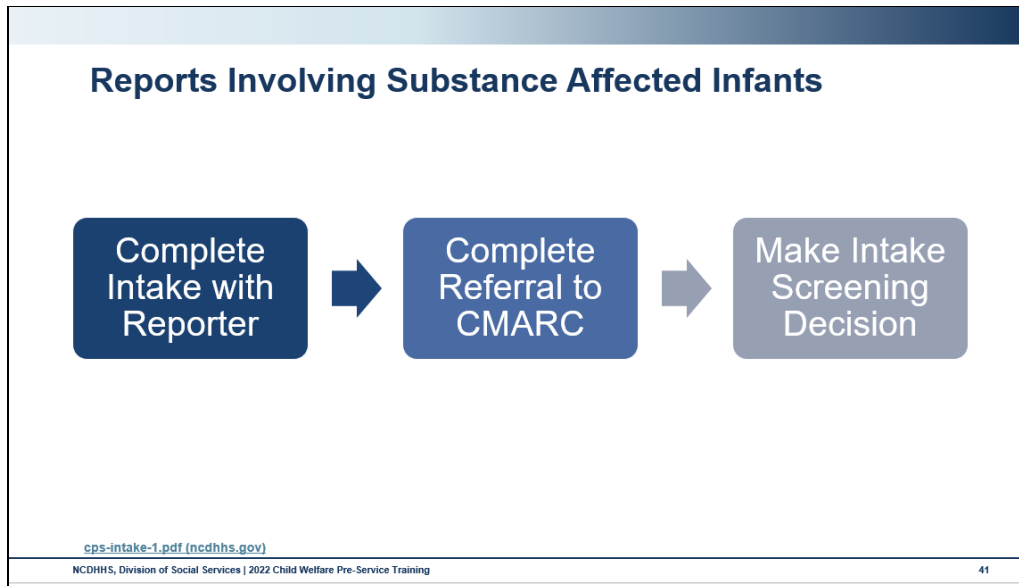


Determining Assessment Approach

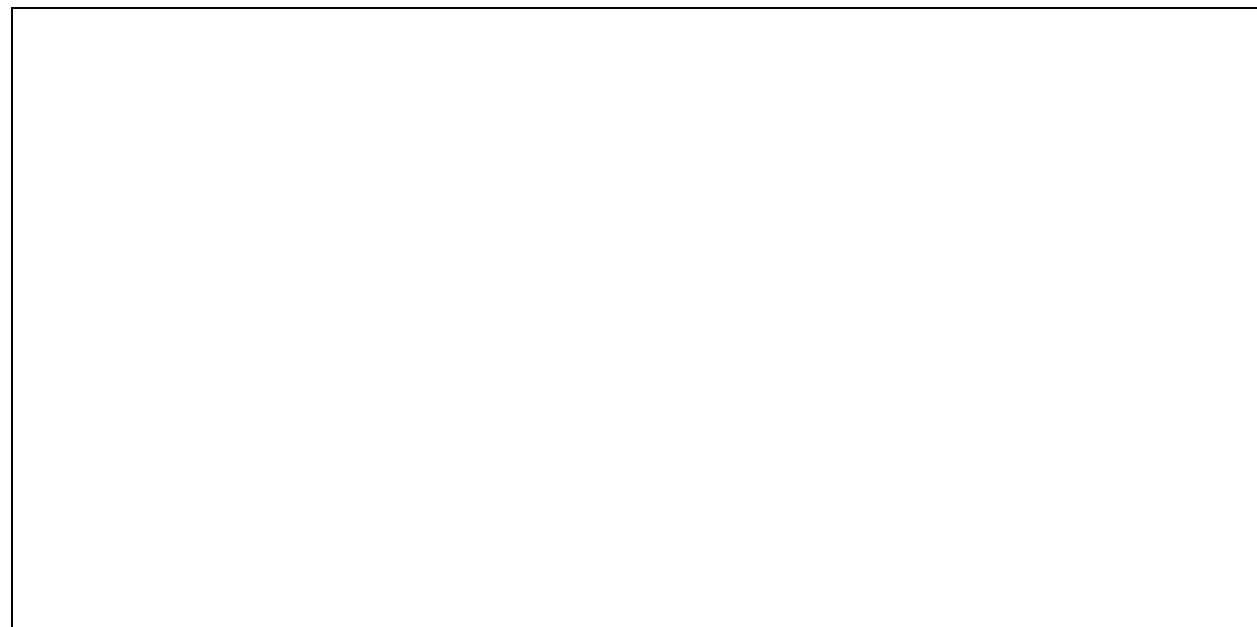


The county responsible for conducting the CPS Assessment determines the assessment approach at the time of the intake. An Investigative Assessment is a more traditional CPS investigative approach, and a Family Assessment is a more strength-based, family-centered, prevention-oriented approach. The output from the maltreatment type and response priority decision trees are recorded in the 1402 form, section VIII. When you are making an intake decision, you will refer to the tools in policy and then document the decision in Section VIII of the form.

Reports Involving Substance-Affected Infants



Infants who are born affected by prenatal exposure to drugs or alcohol are at risk of negative health and well-being outcomes throughout their childhood and there is an increased risk of child abuse or neglect in many of these situations. To ensure the best outcomes for these children, there are federal laws requiring that child welfare agencies are notified of infants in these circumstances and work with other public health and community agencies to adequately address the needs of the infant and family by developing a Plan of Safe Care.



Handout: Substance Affected Infant and Plan of Self Care

Child Welfare Resources for Substance Affected Infants & Plan of Safe Care

<p>Substance Affected Infants & Plan of Safe Care</p> <p>The North Carolina Division of Social Services recognizes the unique needs of infants and their parents and caregiver when substance use is a factor in the family's ability to safely maintain the infant in their own home.</p> <p>The purpose of this document is to provide local county child welfare workers with resources and guidance on assessing the safety of substance affected infants (SAI) remaining in the care of their parents and caretakers and creating a plan of care that focuses on the unique needs of substance exposed families.</p>
<p>Definitions - Terminology Glossary</p> <p>Substance Affected Infant:</p> <ul style="list-style-type: none"> • An infant has a positive urine, meconium or cord segment drug screen with confirmatory testing in the context of other clinical concerns as identified by current evaluation and management standard. • The infant's mother has had a medical evaluation, including history and physical, or behavioral health assessment indicative of an active substance use disorder, during the pregnancy or at time of birth. • An infant that manifests clinically relevant drug or alcohol withdrawal. • An infant affected by FASD with a diagnosis of Fetal Alcohol Syndrome (FAS), Partial FAS (PFAS), Neurobehavioral Disorder associated with Prenatal Alcohol Exposure (NDPAE), Alcohol-Related Birth Defects (ARBD), or Alcohol-Related Neurodevelopmental Disorder (ARND) • An infant has known prenatal alcohol exposure when there are clinical concerns for the infant per current evaluation and management standards. <p>Nighttime Parenting: A more appropriate term for what was once referred to as Safe Sleep. It acknowledges that there are differences in parenting at night and requires intentional actions by a parent to ensure safety during that time.</p>
<p>Child Abuse Prevention Treatment Act (CAPTA) Requirements</p> <p>CAPTA and the Comprehensive Addiction and Recovery Act (CARA) requires healthcare providers to notify CPS of all substance affected infants. The notification itself is not an allegation of maltreatment and requires the assigned intake worker to complete a thorough screening to determine whether the notice meets the definition of abuse, neglect, and/or dependency.</p> <p>CPS INTAKE</p> <p>During CPS Intake activities, the DSS-1402 is completed for all notifications and includes questions that are specific to SAI. The intake worker may need to support the healthcare provider in making the decision about the information that the healthcare provider can share. However, if this is a notification of a Substance Affected Infant (SAI), the Intake worker is still required to obtain as much information as possible in the completion of the</p>

Child Welfare Resources for Substance Affected Infants & Plan of Safe Care

intake form (DSS-1402). The intake worker should pay careful attention to the questions covered in Section VII under the sections of Substance Abuse and Substance Affected Infant.

Section I: Demographics

Basic demographic information is captured about the alleged victim child/infant. In instances where an infant is identified as a Substance Affected Infant (SAI) additional information should be gathered to assist the assessment worker in addressing safety for the SAI, the parents and other caretakers. Asking a question about the discharge date of the infant from the healthcare facility directly impacts the assessment of safety because remaining in the hospital is a safety measure.

Section VII: Abuse, Neglect and Dependency: Substance Abuse and Substance Affected Infant

Intake workers need to be aware of their own biases or cultural changes around societal acceptance of drug use, such as marijuana. Policy and the maltreatment tools found on the DSS 1402 guide intake staff not only in the collecting of information but in the screening decision itself. Intake staff must have knowledge of both policy and the 1402 to solicit the most information from a reporter. While speaking with the healthcare provider you must ask, "How does their substance abuse affect their ability to care for the child(ren)?" This can be found in the Substance Abuse maltreatment tool on the DSS-1402. Staff can also ask additional probing questions located in policy such as: "Is the parent using money to buy alcohol/drugs instead of providing basic necessities – car seat, crib, etc.?" This information helps to assess the level of drug/alcohol abuse and the impact on the child. Additional specific questions that should be asked must be related to the type of substance and its impact on the infant, if the child is having withdrawal symptoms or other medical needs, if there are toxicology screening results, and if the mother is receiving treatment related services. These types of questions help to identify the elements of a safety plan for the infant and their families.

This section also includes questions specific to SAI. When an infant has been identified as being affected by Fetal Alcohol Spectrum Disorder, a positive drug toxicology not related to Mother's prescribed and appropriate use of medications, or experiencing drug or alcohol withdrawal symptoms from a drug other than mother's prescribed and appropriate use of medication the report should be screened in. This list is not all inclusive. Child welfare staff should make plans to initiate substance affected infant cases prior to the child being discharged from the hospital to put an appropriate safety plan in place for the child. Please refer to the DSS-1402 for more detail on screening notifications for SAI.

If the decision is to screen out because this is a SAI notification by a healthcare provider and there are no maltreatment concerns documentation should indicate "SAI Notification with no maltreatment allegations." This decision should only be made after the maltreatment tools have been consulted and a second level review has been done of the intake report. Intake workers should complete the CMARC referral prior to making a screening decision to ensure that confidentiality is not compromised.

CPS FAMILY AND INVESTIGATIVE ASSESSMENTS

Safety Planning in Substance Affected Infant (SAI) Cases

2

Child Welfare Resources for Substance Affected Infants & Plan of Safe Care

When a report is accepted and the infant (0-6 months) is diagnosed by a medical provider as being a Substance Affected Infant (SAI) a Plan of Safe Care (POSC) must be developed prior to the infant being discharged from the hospital. Safety planning must include a needs assessment of the SAI, the parents/caretaker and other members of the family including any siblings in the home and how all identified needs will be addressed.

Open and transparent discussions must be held about any substance use disorder or mental health diagnoses, both past and present. Explain that the reason for asking this information is not to be punitive but to help create a plan that will keep their child safe. Talking with the family about any history with mental health or parental/family substance use disorder can help connect the family and child welfare with providers familiar to the family. These discussions with the parent and caretakers of the child/children must include:

- Discussions about how parents access illegal substances (this lets child welfare workers know how connected they are to the use of illegal substances)
- How often and under what circumstances do they use, known triggers– it is when you understand the “why” that you can help plan for the “how” to keep the child safe
- Discussions about stressors: new baby in the home, lack of sleep, financial challenges, stress on relationship, etc, and how these are impacted by substance use
- Plans for keeping the child/children safe knowing that the mother has recently used illegal substances (when the case is accepted and there is a positive toxicology report, there is no need to get the mother to admit use. The proof is already there, and it is best for the assigned worker to focus on future safety without getting caught up in the “denial dispute.”)
- Discussions about the significant risk of death for these children due to rollover deaths must be addressed in the POSC which is discussed below
- Discussions about safe sleep (just because a parent has a crib/bassinet does not mean the parent will use it and it is necessary for any workers who have contact with the family to have a conversation about the safety concerns of a substance using parent falling asleep while holding a child)
- Asking the question, “What would it look like if you protected your child as if you believed they could be at risk from your substance use?” (The answer should be used in the creation of the plan).

The NC Safety Assessment, DSS-5231, is designed to help county child welfare workers “assess whether a child(ren) is likely to be in immediate danger of serious harm which may require a protective intervention and to determine what safety interventions should be maintained or initiated to provide appropriate protection.” When using the DSS-5231, Part A: Factors Influencing Child Vulnerability, “Child is age 0-5” should be checked because this age group is unable to assist in protecting themselves. In Part B: Current indicators of Safety: At a minimum, Item number 1: 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 should be circled “yes” and “drug-exposed infant/child” should be checked. Based on the specific circumstances of the case, other safety indicators may also be present and should be marked and addressed accordingly.

In addition to the indicators of safety identified on the DSS-5231, safety planning for infants diagnosed as a SAI requires additional factors to be addressed in a POSC as the safety of the child is directly tied to the mother’s treatment plan and to the assessment of the ability of other caretakers to assist in the care and supervision of this infant (and any other children in the home). The POSC is developed with the parent/caretaker, family

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Child Welfare Resources for Substance Affected Infants & Plan of Safe Care

members, and any other community resources involved who can assist with ensuring the safety of the child. Each county child welfare agency may choose how the POSC is documented; however, documentation of a POSC must include each of the elements identified here.

Creating the Plan of Safe Care

Each part of the POSC listed below must be clearly documented and address the specific needs of the SAI and family.

Discharge Date:

It is best practice to initiate an assessment and begin the development of the POSC along with the Safety Assessment prior to the family leaving the hospital. There are instances when a SAI must remain in the hospital to overcome medical issues that arise from the mother's use of substances during pregnancy. In those instances, the needs and services of the SAI addressed in the POSC should begin on the date of discharge from the hospital.

Household Members and Affected Family or Caregivers of the infant:

Identify the household members: the mother and father, and those who will have caretaker responsibilities of the SAI, also noting if those household members are identified as using substances. When families are unable to identify a non-using, appropriate caretaker who can ensure the safety of the child within the home, the agency must consider an alternative placement and that should be documented within the POSC.

Other Identified Participants

The POSC should also identify any other family, friends, or professionals participating in service delivery to the SAI and family. Their participation should be documented to include role/relationship to the family and what assistance or services they will be providing. This should include the primary care physician of the SAI and how they will partner with the family to address the needs of the SAI. Those providing substance abuse services to the caretakers should also be included. If a Temporary Safety Provider is needed, they must be included in the POSC along with the assistance they plan to provide. This is not an exhaustive list and workers should engage everyone who is partnering with the family to ensure that the SAI and any other children in the home are safe.

Family Strengths and Goals:

Talking with the parent(s) about what they perceive as their strengths gives the county child welfare worker a place to begin the POSC. Have the family identify their goals once discharged from the healthcare facility. Goals can focus on breastfeeding, housing, smoking cessation, parenting support, substance abuse and mental health treatment, and recovery.

- **Identified Supports:** Have the family identify their supports such as a stable living environment, family and friends, and employment.
- **Safety Factors and Protective Factors Present:** Have a discussion with the parent(s) and family about what they see as an indicator of resilience, social connectedness, knowledge or parenting and child development, social and emotional competence of children.

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Child Welfare Resources for Substance Affected Infants & Plan of Safe Care

Infant Safety Plan

Developing an Infant safety plan or POSC should clearly identify and document the parent/caretaker(s) response regarding:

- **Nighttime Parenting (rebranding from Safe sleep)**-Have the parent explain their efforts they will take to ensure safe nighttime parenting. Ensure that resources for nighttime parenting are provided and parent(s) understanding of nighttime parenting.
- **Follow-up medical care**-In partnership with the healthcare provider have a discussion with the parent(s) regarding the current and future medical needs of the infant. Document upcoming appointments, the plans for referrals, and parental understanding of the information presented.
- **Basic needs**-Assess the basic needs of the infant within the home such as housing, food, crib, and diapers. If there are identified basic needs missing, those needs along with the plan for resolving those needs should be documented. Any other needs that the parent(s) or caretakers have identified must also be documented along with the plan of resolution.
- **Other**-Any additional needs that are specific to the infant must be documented and addressed.

Documentation must include the parent(s) agreement with the plan.

Parent Safety Plan

Infant safety is tied to parental behavior. Substance use causes impairments in judgement and behavioral changes that can create increased risk to the infant. Talking with the parent(s) about their safety plan and the risks to their child should they return to using substances post hospitalization is meant to be preventive not punitive. Elements of a parental safety plan must include:

A plan that addresses infant safety in the event of a parent returning to active substance abuse. Elements to include: (1) Names, phone numbers, the address of safe people who will keep the child safe if the parent engages in substances. (2) the location of the bag of supplies ready for the child if someone needs to come and get the child that includes food/formula, diapers, extra clothing, medications, pediatrician's number.

- **A Parent Recovery Support Plan** can include: (1) Identified Support person who agrees to check on parent regularly and agrees to protect the child(ren) if necessary. (2) Attendance at recovery support groups. (3) List of community resources to support having basic needs met. (4) Identified list of people who are not allowed in the home when the child(ren) are present. (5) A list of reasons to remain abstinent and in recovery. (6) List of mental health, substance use disorder, and physical health resources available in the community. (7) Completion of a mental health and substance use disorder assessment and engagement in recommended services. (8) Information on how to access harm reduction programs and naloxone in their community.
- **Mental Health and Substance Use Disorder:** Addresses engagement with a provider for an assessment and/or treatment recommendations that include safety for the child(ren). Explain the purpose of a release of information and parent(s) should be encouraged to complete one.
- **Parent Medical Care:** Medical Home or Post-Natal Care Plan that the parent(s) will use.
- **Other-** Any needs that are specific to their ability to ensure the safety of the child(ren)

Documentation must include that the parent(s) have agreed to the plan.

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Child Welfare Resources for Substance Affected Infants & Plan of Safe Care

Services

The POSC should also include a list of the organizations and points of contact for those services that the family is currently receiving such as FNS,

Medicaid, and treatment providers. Any additional organizations and their points of contact that the family identifies as a need should also be included in the POSC.

Parental Agreement

The POSC must be developed with the parent(s) and family and include any needs for all members of the household. Ensuring that the parent(s) understand that plan as written should also include parent signature on the plan that indicates their understanding and agreement. The POSC is separate from the completion of the Safety Assessment but can assist in the development of the family's safety plan. It is important for the assigned worker to include all appointment dates and service timeframes for the purposes of monitoring follow through of the plan to include in the case decision process.

Case Decision:

In addition to the completion of the 5010, staff must also complete the Structured Decision-Making Tools. Starting first with case decision making requirements:

- Consider and document the specific caretaker behavior that resulted in harm to the child/children.
- Identify the effects of abuse, neglect, and dependency on the child(ren).
- Identify steps taken by the agency or the parents to protect the child(ren).
- Complete the NC Family Risk Assessment (DSS-5230) tool. When completing the DSS-5230, there is likely going to be a score of at least 3 on the Neglect scale (N1. Current report is for neglect or both neglect and abuse will be marked with a point, N6. Age of youngest child in the home < 2 would be marked with a point, and N9. Either caretaker has/had a drug or alcohol problem will be marked with a point) giving the family a moderate rating.
- Complete the NC Family Assessment of Strengths and Needs (DSS-5229).
- Review the POSC for compliance to determine what still needs to be addressed to ensure safety.

The score on the DSS-5230 needs to be reviewed in collaboration with the strengths and needs assessed on the DSS-5229 to address the areas that could be seen as protective factors as well as areas that can place the child at greater risk. Combining these tools as well as the questions to be asked at the time of case closure will help lead staff and supervisors to the correct case decision.

Case Planning:

When there are continued safety concerns and a case decision is made to send a family to In Home services or Foster Care the POSC becomes a central part of the foundation for the initial Family Services Agreement (FSA). The plan should consist of behaviorally specific objectives and goals for

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Child Welfare Resources for Substance Affected Infants & Plan of Safe Care

the parent/caretakers to address to keep their child/children safe. The plan moves past the incident and into future safety for the child/children. The child welfare worker should include those components of the POSC that allows a parent to demonstrate improvements in the safety for the child(ren). Documentation of work with the parents may be included in the FSA or any other documentation tool the county child welfare agency has developed if all the elements in the safety plan are included.

Additional Resources

Child Welfare – ACF

<https://www.childwelfare.gov/pubPDFs/safecare.pdf>

National Center on Substance Abuse and Child Welfare

<https://ncsacw.samhsa.gov/topics/parental-substance-use-disorder.aspx>

Casey Family Programs

https://caseyfamilypro-wpengine.netdna-ssl.com/media/SC_Infant-Plans-of-Care.pdf

Handout: DSS-6191

Source: North Carolina Child Welfare Policy Manual Resources

DSS-6191

Purpose: Plans of Safe Care (POSC) are federally required for all infants born substance affected (SA). POSC for infants and families involved with Child Welfare supplement the NC Safety Assessment (DSS-5231). In POSC cases, at minimum, the Safety Assessment, Part A: *Factors Influencing Child Vulnerability*, "Child is age 0-5" should be checked because this age group is unable to assist in protecting themselves. In Part B: Current indicators of Safety: At a minimum, Item number 1: *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* should be circled "yes" and "drug-exposed infant/child" should be checked. This POSC document should focus on health needs and treatment for both mother and infant, developmental needs of the infant, parenting skills and attachment, and education for all caregivers on the special needs of a SA infant. [SAI and POSC Policy Link](#)

Name of Infant: _____ **DOB:** ___ / ___ / ___ **County** _____ **Case #** _____

Medical Facility: _____ **Admission date:** ___ / ___ / ___ **Discharge date:** ___ / ___ / ___

Name of Parent: _____ **DOB:** ___ / ___ / ___ **Name of Parent:** _____ **DOB:** ___ / ___ / ___

Household Members and Caregivers of the Infant:

Name	Age	Relationship to Infant	Name	Age	Relationship to Infant

Family Goals: (breastfeeding, housing, smoking cessation, parenting support, recovery)

Strengths and Protective Factors: (i.e., parental resilience, social connectedness, knowledge of parenting and child development, social and emotional competence of children)

Parental Substance Use and Mental Health History

Open and transparent discussions must be held about any substance use or mental health diagnoses, both past and present. The reason for asking this information is not to be punitive but to help create a plan that will keep the child/children safe. Talking about any history with mental health or parental/family substance use can help connect the family and child welfare with providers familiar to the family. These discussions must include:

How parent/s access substances:
How often and under what circumstances do they use, known triggers:
New stressors: new baby in the home, lack of sleep, financial challenges, stress on relationship, etc and how these are impacted by substance use:
Plans for keeping the child/children safe in the context of substance use, "What would protecting your child look like if you believe they are at risk from your substance use?" The focus is on future safety:

Infant Safety

Safety Element	Plan
<u>Medical Care</u> (Medical home, insurance, prescribed medications, specialists)	
<u>Safe Sleep</u> (Discuss high risk of death for these children due to rollovers, crib/bassinet safety and <u>specifically how it will be utilized</u> , discuss safety concerns of using parent falling asleep while feeding/holding, napping beside, infant)	

Safe Sleep Policy	
<u>Nighttime parenting</u> (Discuss the differences in parenting at night and the intentional actions to be taken by caregivers to ensure safe sleep)	
<u>Basic Needs</u> (housing, clothing, food, crib, bassinet, baby items, transportation)	

Parental Safety

Safety Element	Plan
<u>Relapse Plan</u> (Discuss how parent can identify the onset of a possible relapse and what are the needs of both the parent and child in the event of relapse, location of child's supply bag, including copy of POSC)	
<u>Recovery Support</u> (Identify supportive and non-supportive persons, who should and should not be around the child/children, recovery support groups, list reasons to remain abstinent and in recovery)	
<u>Mental Health and Substance Use Treatment</u> (Discuss providers and how parent will engage in services, current assessments, and recommendations)	
<u>Medical Care</u> (Medical home, insurance, prescribed medications, specialists, post-natal care needs)	

Safety Resources An important part of family and safety-centered practice is helping the family build and strengthen a safety network—made up of family, friends, and involved professionals. A safety network supports caregivers to develop and maintain a safety plan for the children even after professional services end or are no longer needed.

<https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/modified-manual-1/child-welfare-resources-for-using-safety-circles-to-build-safety-networks-december-2021.pdf>

Name	Relationship	Address	Phone Number	ROI Completed by Parent (Y/N)

Family Is Currently Involved in the Following Services:

Service	Organization	Contact person/Phone/Email	ROI Completed by Parent (Y/N)

New Family Services Referred or Recommended:

Service (indicate referred or recommended)	Organization	Contact person/Phone/Email	ROI Completed by Parent (Y/N)

Additional Comments/Information:

Signature and Review

Signature of parent /caregiver: _____ Date: ___ / ___ / ___ Print name: _____

Signature of parent /caregiver: _____ Date: ___ / ___ / ___ Print name: _____

Signature of staff: _____ Date: ___ / ___ / ___ Print name: _____

Signature of Supervisor: _____ Date: ___ / ___ / ___ Print name: _____

Review by (Date): ___ / ___ / ___

Ongoing Review Dates:

___ / ___ / ___

___ / ___ / ___

___ / ___ / ___

___ / ___ / ___

Key Takeaways

Key Takeaways

Three elements a report must have for DSS to legally intervene	Five steps to the intake process
Tools, decision trees, and policy guide the process	Strengths-based interviewing skills are key to intake

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Questions and Reflections

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

Intake Learning Lab

Activity: The Evans Family

Review the following handout titled Completed Intake Form – The Evans Family. Follow trainer instructions to complete the following activities:

- Identify allegation
- List additional questions you would have asked the reporter
- Complete Maltreatment Screening Tool
- Make Screening Decision
- Determine County assignment
- Determine Response Priority
- Determine the Type of Response

Handout: Completed Intake Form – The Evans Family

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Child Protective Services Structured Intake Form

Section I: Demographics

Date: January 27, 2023 Time: 10:00 am

Received by (Name): Intake Social Worker County: Guilford

Screening Decision: _____ Referred Due to Residency: _____

Assigned to: (County/Worker Name) _____

Referred to: (County Name) _____ 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: _____ Case Number: _____

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: Kim Evans Relationship: Paternal Grandmother

Address: 1248 S. Main Street, Summerfield NC 27358

Phone Number: 336-555-0202

Reporter waives right to notification? Yes No

Is the reporter available to provide further information, if needed? Yes No

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Child Protective Services Structured Intake Form

Section III: Maltreatment Information

Children's Information

Name (include nicknames)	Sex	Race	Ethnicity	Age/DOB	School/Child Care	Relationship to Perpetrator A	Relationship to Perpetrator B
Keisha Evans	F	B		15	Central High	daughter	
Kevin Evans	M	B		6	East Elementary	Son	
Angela Evans	F	B		10 Months	N/A	Daughter	

Parent/Caretaker's Information

Name (include aliases/nicknames)	Sex	Race	Ethnicity	Age/DOB	Employment/School
Shonda Evans	F	B		35	Unemployed
Rudy Evans	M	B			Deceased

Alleged Perpetrator's Information

Name (include aliases/nicknames)	Sex	Race	Ethnicity	Age/DOB	Employment/School
A. Shonda Evans	F	B		35	unemployed
B.					

Other Household Members

Name (include aliases/nicknames)	Sex	Race	Ethnicity	Age/DOB	Employment/School	Relationship

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Child Protective Services Structured Intake Form

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:

1672 Maple Street, Summerfield NC 27358. Family has lived at this address for 10 years.

Shonda phone: 336-555-0988

Driving Directions: It is two houses on the left after you cross Main Street. White house with swing set in front yard.

List any information about the family's American Indian Heritage: None on paternal side, maternal unknown

List any information about the parent(s) or caretaker(s) Military Service: None

Family's Primary Language: English

Collateral Contacts: Others who may have knowledge of the situation (include name, address, and phone number):

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Child Protective Services Structured Intake Form

Do you have any information about the children’s other maternal or paternal relatives (include name, address, and phone number)?

Reporter is paternal grandmother (see reporter information). Mother is estranged from her family since her brother sexually abused Keisha.

Has the family ever been involved with this agency or any other community agency? Do you know of other reports about the family?

Previous cases in 2019 and 2012. Reporter does not remember exact circumstances, but knows the first case was related to neglecting Keisha and her wandering around as a young child. History of sexual abuse came up in last case.

What

What happened to the child(ren), in simple terms?

Since Rudy died 8 months ago Mrs. Evans (Shonda) has struggled to take care of the children. Reporter believes that she stays in her room and sleeps most of the day. When reporter comes by the home, she often sees Kevin caring for Angela. She went over around 5 yesterday and Kevin was trying to give Angela a bath because she had a very dirty diaper. Reporter states that house is "a huge mess" and she is concerned that Mrs. Evans does not do enough grocery shopping or provide proper food for the children. Angela is not in daycare and reporter does not know what Mrs. Evans does with Angela during the day while they are alone together.

Did you see physical evidence of abuse or neglect? If yes, please describe. Kevin and Angela are unsupervised.

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Child Protective Services Structured Intake Form

The house is a mess and there is not enough food for three children in the home.

Is there anything that makes you believe the child(ren) is/are in immediate danger? Shonda lets Kevin care for Angela while she sleeps in the home, that could be dangerous.

Has there been any occurrence of domestic violence in the home? no

Are you concerned about a family member's drug/alcohol use? no

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? It has been going on since Rudy died, but I saw Kevin giving Angela a bath last night.

When was the last time you saw the child(ren)? Last night.

Where

Current location of child(ren), parent/caretaker, perpetrator? Shonda is at home. Kevin and Keisha are in school. Angela is at home.

How

How do you know what happened to the family? I see it when I go over there.

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Child Protective Services Structured Intake Form

How long has this being going on? About 8 months.

Section IV: Family Strengths

What are the strengths of this family? Tell me anything good about this family. Shonda really loves the kids. All the kids get along with each other.

How do family members usually solve this problem? What have you seen them do in the past? I don't really know, I helped out a lot after the first time DSS was called on them.

What is it about this family's culture that is important to know? _____

Section V: Safety Factors

Are you aware of any safety problems with a social worker going to the home? If so, what? no

Calling DSS is a big step, what do you think can be done with the family to make the child(ren) safer? Shonda needs help taking care of the kids. She is too depressed or something and needs help with her grief so she can manage better.

Is there anything you can do to help this family? I can help out with the kids some, but I still work part time.

Has anything happened recently that prompted you to call today? Seeing Kevin give Angela a bath scared me.

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.

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Child Protective Services Structured Intake Form

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? _____

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Child Protective Services Structured Intake Form

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 Unknown

If yes, describe _____

Sex Trafficking and Labor Trafficking

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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? Yes No Unknown

If so, who? Who is benefiting from the trafficking? _____

Is a parent or caretaker involved? Yes No Unknown

If yes, how? _____

Is the child being exchanged for something of value or to pay a debt? Yes No Unknown

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 Unknown

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

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Child Protective Services Structured Intake Form

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? _____

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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? _____

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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? _____

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Child Protective Services Structured Intake Form

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?

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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)? _____

North Carolina Department of Health and Human Services | Division of Social Services

Child Protective Services Structured Intake Form

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?

6 year old Kevin is often left responsible for caring for 18 month old Angela while Mrs. Evans sleeps. Reporter witnessed him trying to bathe Angela last night while Mrs. Evans was asleep in her room.

How is the parent/caretaker's ability to provide supervision compromised? Including information regarding the use of substances and mental health issues.

Mrs. Evans has been struggling since her husband died. She recently lost her job due to poor attendance and seems to spend most of her time alone in her room, possible sleeping.

What are your supervision concerns? The children have to care for each other. I am also concerned she is not taking care of the baby during the day. Kevin is too young to be looking after Angela all the time even if she's in the house, if she's not paying attention. Angela could have drowned in the tub with Kevin bathing her.

N/A **Injurious Environment**

What is it about the child(ren)'s living environment that makes it unsafe? _____

North Carolina Department of Health and Human Services | Division of Social Services

Child Protective Services Structured Intake Form

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.

Does the parent/caretaker have a pattern of disciplining inappropriately? _____

Is the child(ren) fearful of the parent/caretaker? _____

Do you know what prompted the parent/caretaker to discipline the child(ren)? _____

North Carolina Department of Health and Human Services | Division of Social Services

Child Protective Services Structured Intake Form

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.

Is the parent/caretaker ensuring the child(ren) received necessary medical/remedial care? _____

Is the parent/caretaker ensuring the child(ren) receives a basic education? _____

Is the parent/caretaker providing drugs/alcohol to the child(ren)? _____

N/A **Dependency**

Is the child without a parent/caretaker? _____

Is the parent/caretaker lacking capacity or unavailable to provide care and supervision to the child without having an appropriate alternative child care arrangement?

What other circumstances may make the child(ren) dependent?

North Carolina Department of Health and Human Services | Division of Social Services

Child Protective Services Structured Intake Form

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

Dependency

And/Or

- Substance Abuse
- Domestic Violence

Response Time

- Immediate
- 24 Hours
- 72 Hours

Report Not Accepted

If the report was not accepted, explain the reason(s): _____

North Carolina Department of Health and Human Services | Division of Social Services

Child Protective Services Structured Intake Form

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: _____ Position: _____ Date: _____

Name/Signature: _____ Position: _____ Date: _____

Worksheet: Evans Family Intake Form

Mother: Shonda Evans, 35, Black

Father: Rudy Evans (deceased), 38 Black

Child(ren): Keisha, 15, Black

Kevin, 6, Black

Angela, 18 months, Black

Paternal Grandmother: Kim Evans 60 (lives nearby)

Known at intake:

- Paternal Grandmother, Kim Evans is the reporter.
- Rudy Evans died approximately 8 months ago, and the family has struggled since his death.
- Shonda Evans lost her job recently and spends most of her time sleeping in her room.
- While Mrs. Evans is in her room, she leaves Kevin and Angela unattended.
- Reporter went over to their home the day before the report and found Kevin trying to bathe Angela unattended. Mrs. Evans was in her bedroom with the door closed at the time.
- Reporter also expressed concerns that Mrs. Evans is alone with Angela all day and she does not know how she is cared for during the day.
- Reporter also expressed concern that there is not enough food in the house and she doesn't know if Mrs. Evans is feeding the children well.
- Reporter also expressed concern about the condition of the home being too messy and Mrs. Evans not staying on top of housekeeping.
- 15-year-old Keisha is in high school and has extracurricular activities and does not get home until 6 or 7 PM every day.
- Reporter indicated that the family has a history of In-Home cases with the family.

Previous History

- 2010: CPS Assessment finding Services Needed. An In-Home case was opened for three months. At that time, Keisha was three and was found wandering the streets. Mrs. Evans could not be located. She took parenting classes and the case was closed in 2011.
- 2019: CPS Assessment finding Services Needed. An In-home case was opened for six months. The report alleged that Mrs. Evans beats her children and leaves bruises and that the children were dirty and had untreated medical needs. Mrs. Evans admitted to physical discipline but denied abuse. Services were needed due to supervision issues. During the case, Keisha disclosed that her maternal

uncle, Jake Brown sexually abused her. Mrs. Evans believed Keisha and called the police. Criminal charges were filed. During the in-home case, Mrs. Evans received counseling from the local mental health center with Dr. Felicia Jones. She was diagnosed with depression and prescribed medication.

Current Report Notes:

Person/Role: information known at intake

Name	Age	Sex	Race	Role	HH Status

Report Information

Allegation	Caregiver Behavior	Safety Concern

Maltreatment Screening Tool:

Which tool(s) did you use? Why?

What was the outcome of the tool?

County Assignment:

What county did you assign this CPS Assessment to?

Response Priority:

Which Response Priority Decision Tool did you use? Why?

What response time did you assign?

Assessment Approach:

Which CPS Assessment track is appropriate for this case (Investigative Assessment or Family Assessment)?

Why is this the appropriate track?

Questions and Reflections

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

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Pre-Work Reminder

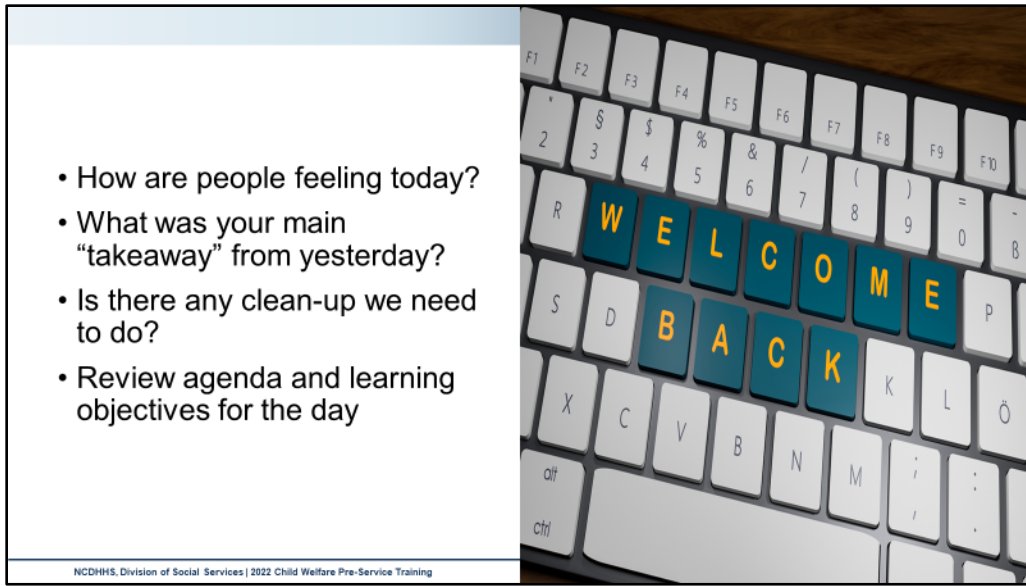
Before we meet tomorrow, please take some time to review and become familiar with the Assessments section of the Child Welfare Policy Manual and review the CPS Assessment Documentation Tool and Instructions in your Tools Workbook (DSS-5010).

Week Three, Day Three Agenda

Pre-Service Training: Child Welfare in North Carolina

I.	Welcome	9:00 – 9:30
	Overview of Child Welfare Processes, Part 1: Intake and CPS Assessments (continued)	
II.	Overview of CPS Assessments	9:30 – 10:35
	BREAK	10:35 – 10:50
III.	Safety vs. Risk	10:50 – 11:30
IV.	Caregiver Protective Capacities	11:30 – 11:50
	LUNCH	11:50 – 12:50
V.	Tools for Assessments	12:50 – 1:05
VI.	Safety Assessment	1:05 – 1:50
	BREAK	1:05 – 2:05
VII.	CPS Assessment Learning Lab	2:05 – 3:35
	Pre-Work Reminder	3:35 – 3:40
	Self-Care Exercise	3:40 – 4:00

Welcome



- How are people feeling today?
- What was your main “takeaway” from yesterday?
- Is there any clean-up we need to do?
- Review agenda and learning objectives for the day

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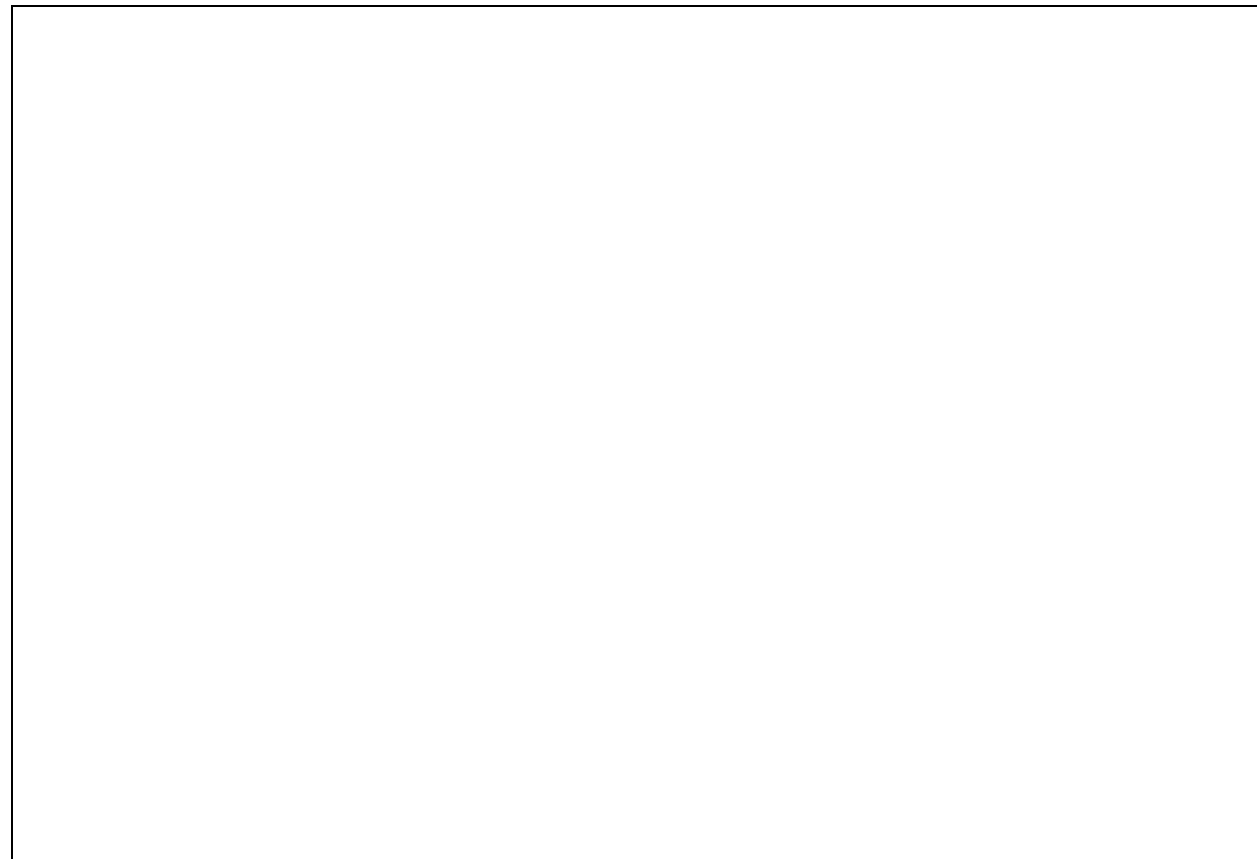
Use this space to record notes.

Overview of Child Welfare Processes, Part 1: Intake and CPS Assessments (continued)

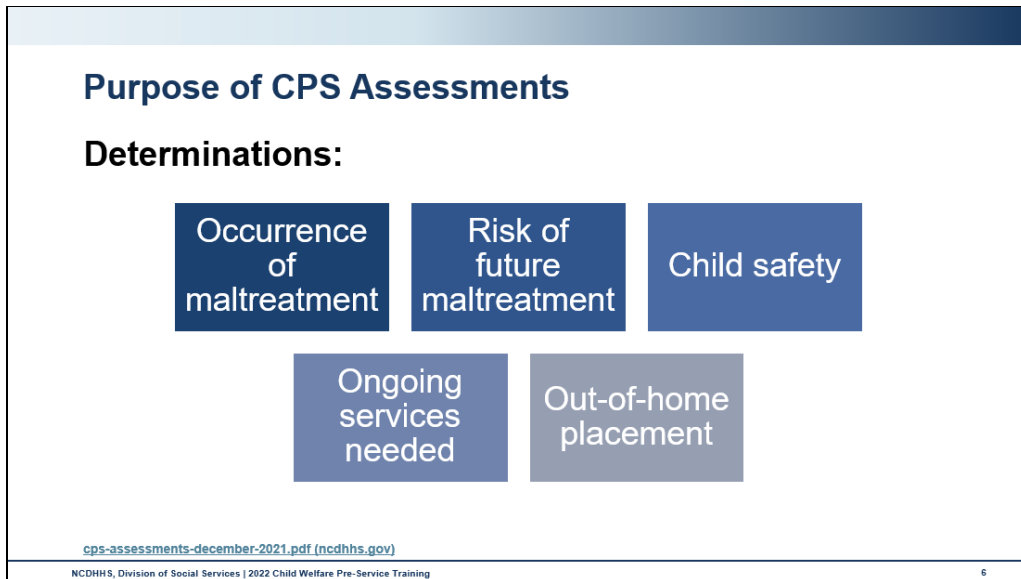
Overview of CPS Assessments

Learning Objectives

- | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none">• Identify which assessment response is appropriate for different cases to assess reports of abuse, neglect, and/or dependency. |
| <ul style="list-style-type: none">• Distinguish between Family and Investigative Assessments. |
| <ul style="list-style-type: none">• Describe the CPS Assessment Process. |
| <ul style="list-style-type: none">• Identify cases that have special policy requirements in CPS Assessments. |



Purpose of CPS Assessments



The primary goal of CPS Assessments is to protect children from further maltreatment and to support and improve parental abilities to assure a safe and nurturing home for each child.

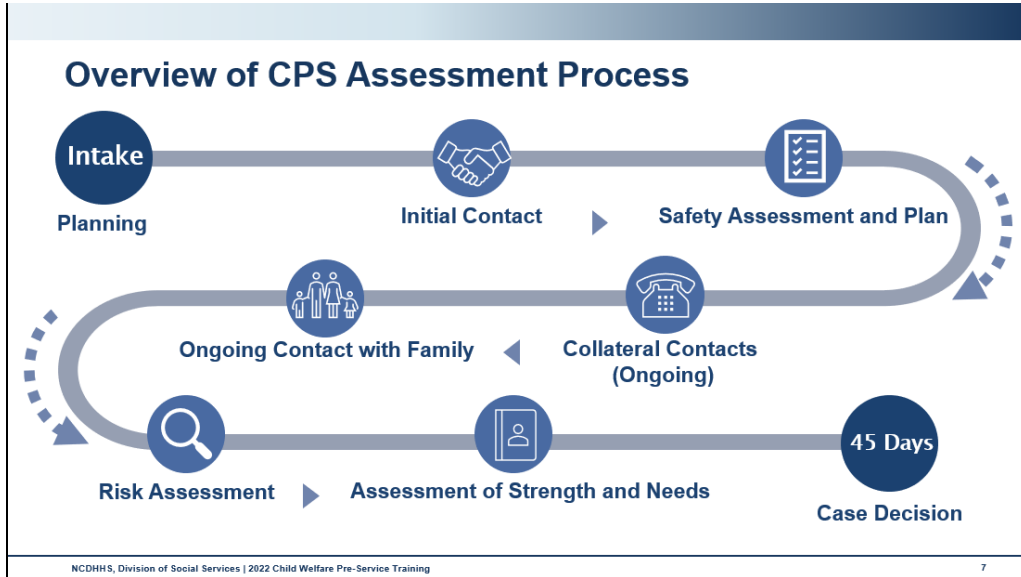
What are some skills that you think are especially important for CPS Assessment workers to have?

Handout: Investigative 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.

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

Overview of CPS Assessment Process



This diagram illustrates major milestones in a CPS assessment, but you will find in practice that tasks are rarely linear. For example, if a new safety threat emerges during a CPS assessment, a new Safety Assessment for the family must be completed.



Handout: Investigative Assessment and Family Assessment Approaches

Policy Distinctions

Investigative Assessment	Family Assessment
<p>Screen report: Abuse and certain Neglect cases are assigned to investigate track. (Approximately 10% of all child maltreatment reports in North Carolina are for abuse.)</p>	<p>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).</p>
<p>Investigate 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.</p>	<p>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.</p>
<p>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.</p>	<p>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.</p>
<p>Case Decision within 45 days. The decision will be (1) substantiate or (2) unsubstantiate the report. <u>Substantiate</u> the report and the perpetrator’s name ae entered in the Central Registry and services are required. <u>Unsubstantiate</u> services may be offered but are not required. (Such offers are rarely accepted.)</p>	<p>Case Decision within 45 days. The purpose of the case decision is to determine whether a family is in need of child protective services. Decision can be (1) Child Protective Services Needed, (2) Services Provided, Child Protective Services No Longer Needed, or (3) Child Protective Services Not Needed. If <u>services needed</u>, the report is entered into Central Registry, but perpetrator is not named, and services are required. If <u>services provided, protective services no longer needed</u>, any further services are voluntary.</p>
<p>Switch Approach/Track. A case assigned to the investigation track can be re-assigned to the Family Assessment track with supervisory approval.</p>	<p>Switch 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.</p>

Sources:

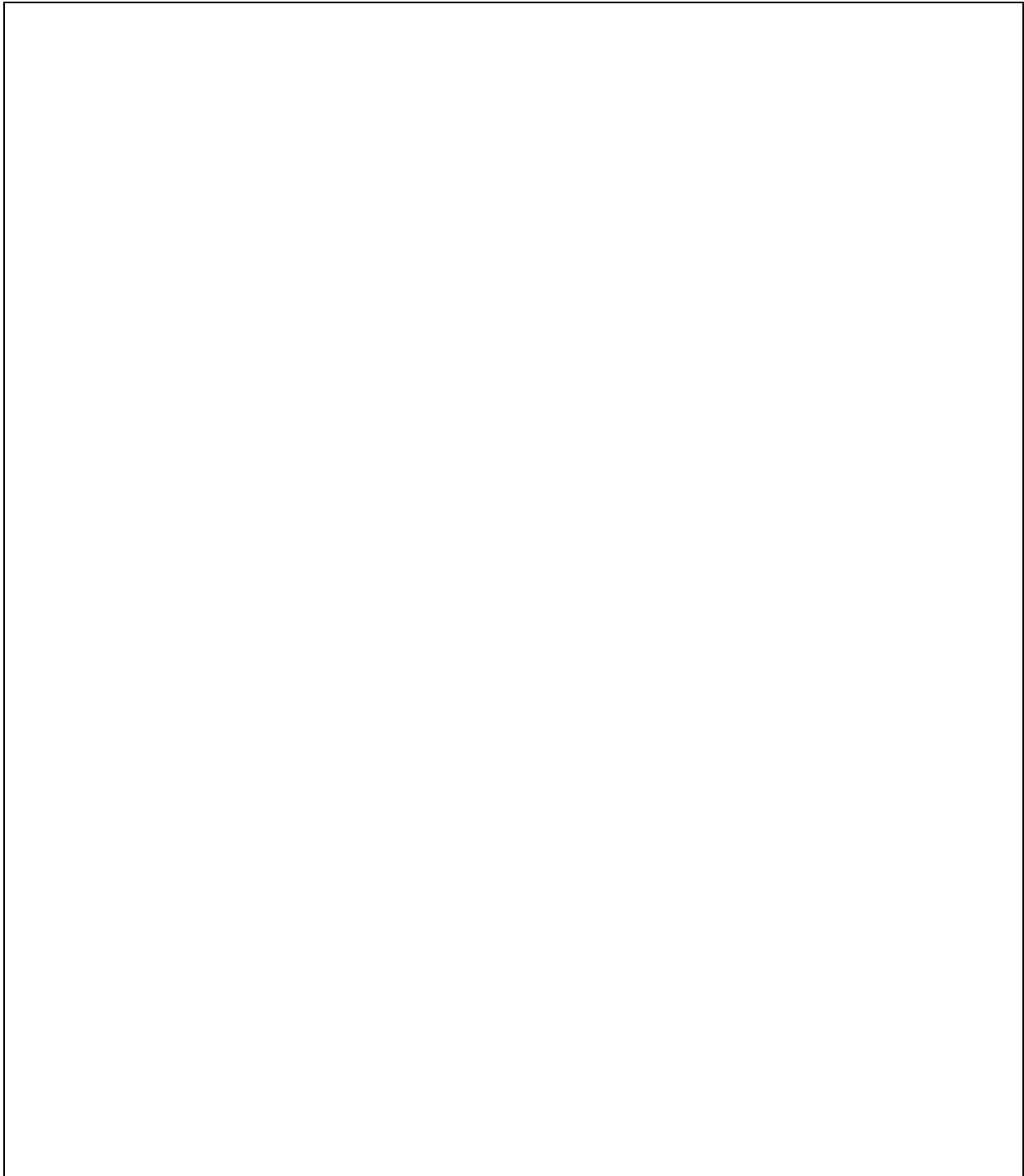
- NC Child Welfare CPS Assessments Policy: <https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/assessments.pdf>
- Adapted from: *Cornerstone 3 Self-Study Guide for Family Assessment, Appalachian Family Innovations, 3-06*

Handout: Similarities in Family Assessments and Investigative Assessments

- The safety of the child is the first concern during both assessments.
- Both approaches allow actions necessary to ensure the safety of the child (i.e., petitioning the court for non-secure custody order).
- Using a family-centered approach is the 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.
- Both assessments: the time frame for completion is “within 45 days.”
- Both utilize 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.

Questions and Reflections

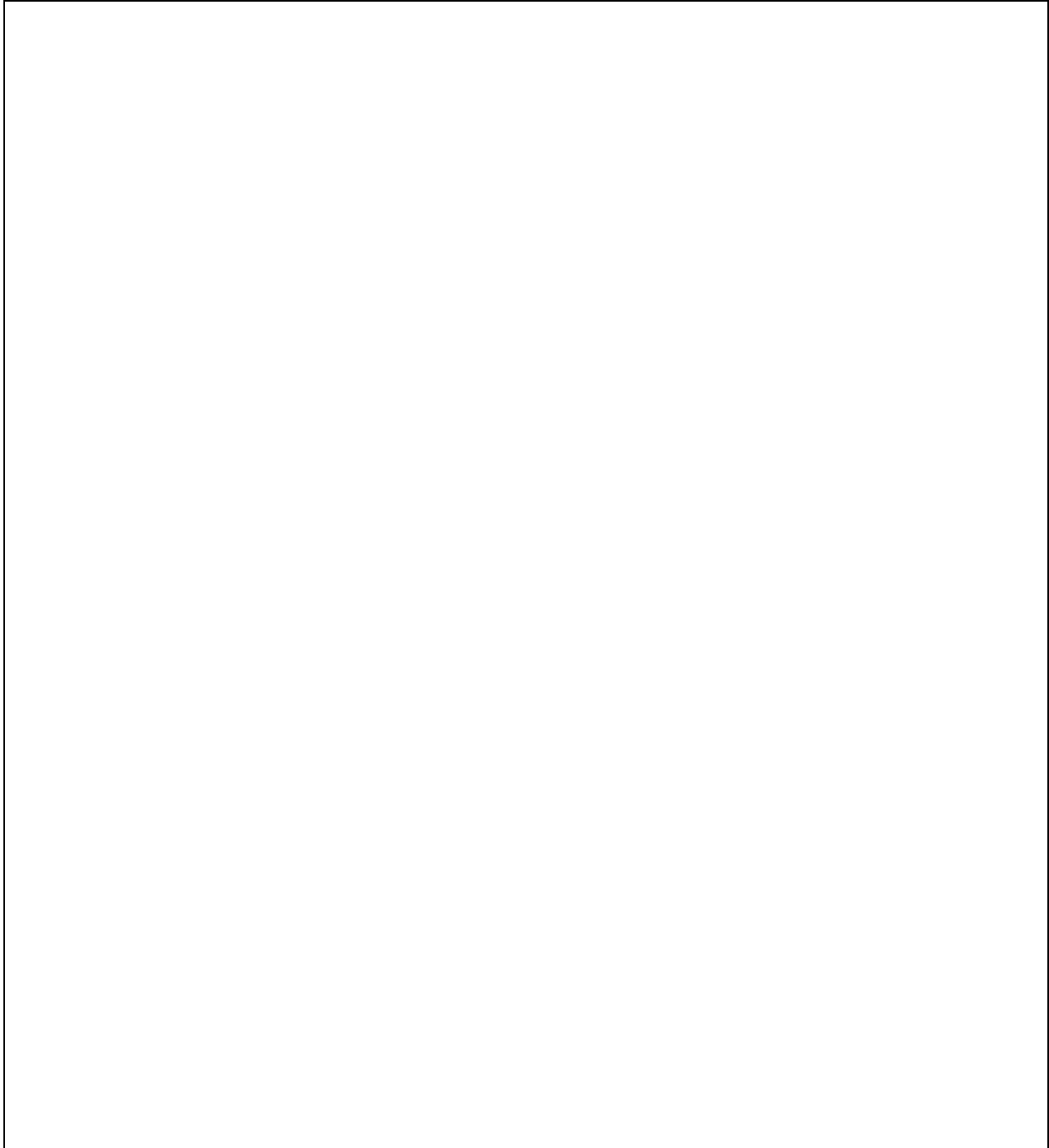
Use this space to record questions and reflections about what you have learned.

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Activity: Do You See What I See?

Follow the trainer's instructions for the activity.

**Why do you think we did this exercise in training today?
How would you want to be treated if you were in the family's place?**

A large, empty rectangular box with a thin black border, intended for the participant to write their responses to the questions above.

Special Categories of Cases in CPS Assessment

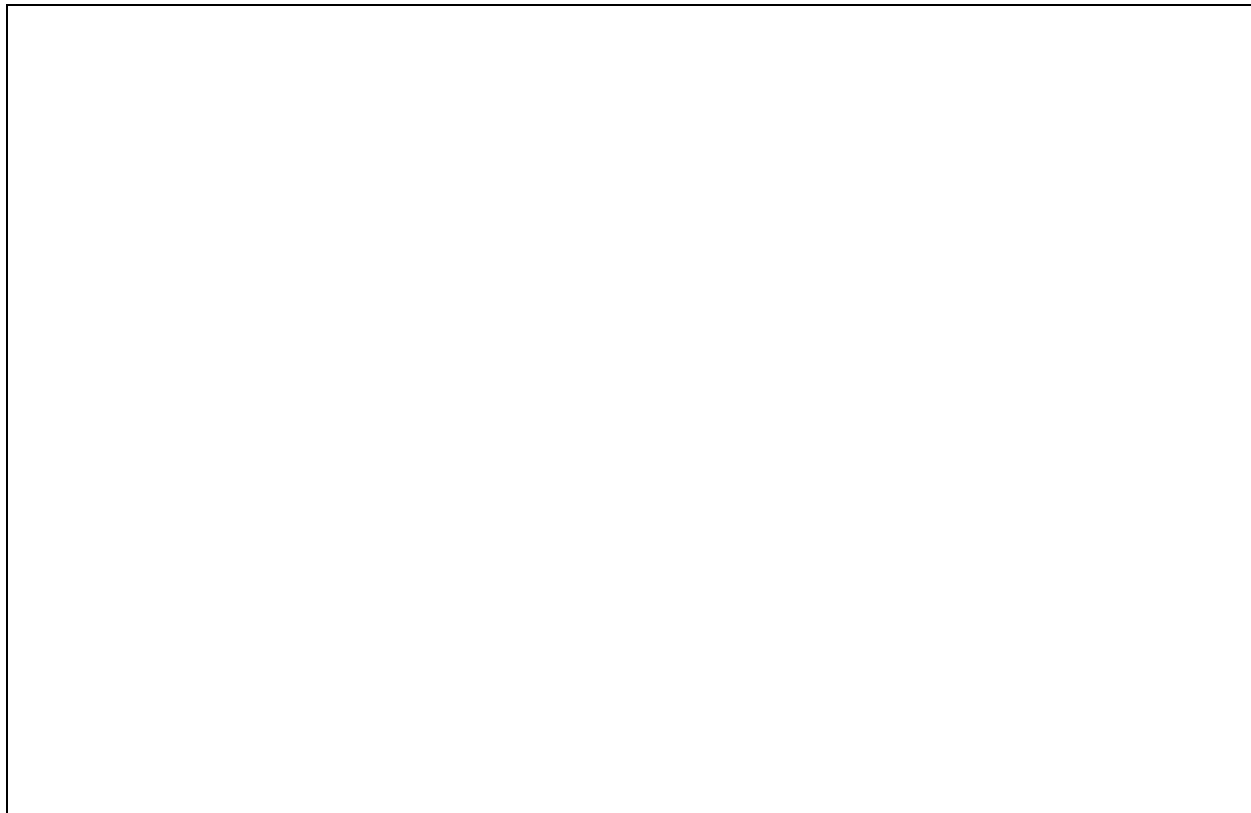
Special Categories of Cases in CPS Assessment

- Domestic Violence
- Substance Affected Infant
- Human Trafficking
- CPS Assessments Involving More Than One County
- CPS Assessments in Out-of-Home Placements
- Malicious CPS Reports
- Medical Neglect of Infants with Life-Threatening Conditions

[cps-assessments-december-2021.pdf \(ncdhhs.gov\)](#)

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There are specific types of cases in CPS Assessments that have different policy requirements.



Assessments Involving Domestic Violence

Assessments Involving Domestic Violence

Prior to Initial Contact

- Check for protective orders
- Check with local law enforcement
- Plan for safety

During Initial Contact

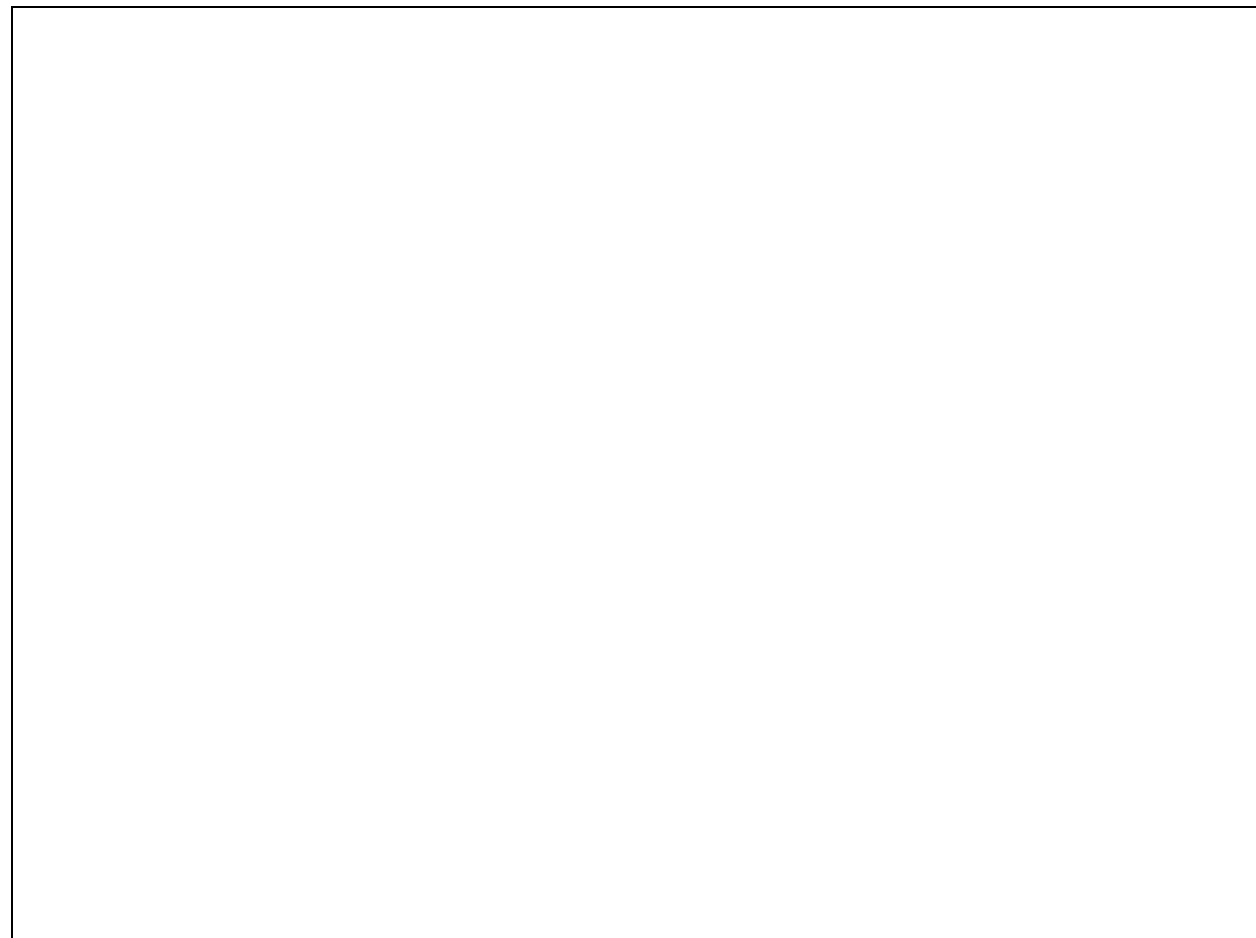
- Utilize appropriate interviewing protocol
- Interview non-offending parent and alleged perpetrator separately

Use Tools During Assessment

- Children’s Domestic Violence Assessment Tool (DSS-5237)
- Non-Offending Parent/Adult Victim Domestic Violence Tool (DSS-5235)
- Domestic Violence Perpetrator Assessment Tool (DSS-5234)

[cps-assessments-december-2021.pdf \(ncdhhs.gov\)](#)

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[Handout: Assessments Involving Domestic Violence Policy](#)**Excerpt from the North Carolina Child Welfare Manual: Cross-Function (May 2020) and CPS Assessments Policy (December 2021)****Purpose**

Following are the six principles developed through the Child Well-Being and Domestic Violence Task Force to address the intersection of child safety, permanence, well-being, and domestic violence.

- Enhancing a non-offending parent/adult victim's safety enhances their child(ren)'s safety.
- Domestic violence perpetrators may cause serious harm to the child(ren).
- Domestic violence perpetrators, not their victims, should be held accountable for their actions and the impact on the well-being of the non-offending parent/adult victim and child victims.
- Appropriate services, tailored to the degree of violence and risk, should be available for non-offending parent/adult victims leaving, returning to, or staying in abusive relationships. These services should also be available for child victims and perpetrators of domestic violence.
- Child(ren) should remain in the care of the non-offending parent/adult victim whenever possible.
- When the risk of harm to the child(ren) outweighs the detriment of being separated from the non-offending parent/adult victim, alternative placement should be considered.

The primary focus in cases involving domestic violence is the assessment of the risk posed to the child(ren) by the presence of domestic violence. The goals of CPS interventions in cases involving domestic violence are:

- Ensure the safety of the child(ren).
- All family members will be safe from harm.
- The non-offending parent/adult victim will receive services designed to protect and support them.
- The child(ren) will receive services designed to protect, support, and help them cope with the effects of domestic violence.
- The alleged perpetrator of domestic violence will be held responsible for their abusive behavior.
- The incidence of child maltreatment co-occurring with domestic violence will be reduced.

The challenge in providing CPS interventions in domestic violence situations is to keep the child(ren) safe without:

- Penalizing the non-offending parent/adult victim and
- Escalating the violent behavior of the alleged perpetrator of domestic violence.

Definition

Domestic violence is defined as the establishment of control and fear in an intimate relationship using violence and other forms of abuse including but not limited to:

- Physical abuse,
- Emotional abuse,
- Sexual abuse,
- Economic oppression,
- Isolation,
- Threats,
- Intimidation, and
- Maltreatment of the children to control the non-offending parent/adult victim.

While victims and families may experience and be affected by domestic violence in different ways, there are still core aspects of domestic violence that are consistent across racial, socio-economic, educational, and religious lines:

- The primary goal of a domestic violence perpetrator is to obtain and maintain power and control over their partner.
- While domestic violence may “present” as an incident of violence or neglect, it is rather a pattern of abuse, which may include violent incidents.
- Domestic violence is not simply discord between intimate partners but rather a progressive, intentional, patterned use of abusive behaviors.

Legal Basis

The N.C.G.S. § Chapter 50-B also defines domestic violence according to the relationship between the parties and behaviors or actions that constitute domestic violence, as well as its available relief. North Carolina General Statutes also identify certain misdemeanor and felony criminal offenses that often occur in the context of domestic violence, such as assault, stalking, violation of a Domestic Violence Protection Order, domestic criminal trespass, harassing telephone calls, communicating a threat, and strangulation.

Prior to Initial Contact

Assessments with allegations of domestic violence, require activities that must occur prior to the initial contact with the family and include but are not limited to:

- Contact the Administrative Office of the Courts (or county Clerk of Superior Court) and/or complete a search of VCAP to determine if a domestic violence protective order exists; and
- Contact local law enforcement agencies and/or conduct a criminal record check on the alleged perpetrator of domestic violence.

Guidance – How you should do it

Each parent or caretaker is only responsible for their own actions to provide safe, nurturing care for their child(ren).

INTERACTION WITH NON-OFFENDING PARENT/CARETAKER

The Non-Offending Parent/Adult Victim Domestic Violence Assessment Tool (DSS-5235) contains scaled assessment questions and should be used to support the determination of safety and risk factors.

The inability to speak with the non-offending parent/adult victim alone may be an indication of the level of control the perpetrator of domestic violence exerts over the family, and an indication of high risk. The presence of relatives or friends may also affect disclosure and safety.

Information concerning resources and referrals to services should immediately be given to the non-offending parent/adult victim and child(ren) (as appropriate).

With cases involving domestic violence, the safety of the child(ren) is closely linked to the safety of the non-offending parent/adult victim. So, domestic violence cases also include a secondary focus on the safety of the adult victim. The non-offending parent/adult victim of domestic violence is the expert at predicting the domestic violence perpetrator's reactions. Therefore, the development of the family safety plan or services agreement is driven by the non-offending parent/adult victim based on what they think they are capable of and willing to do to ensure safety for their child(ren) and themselves.

A Safety Plan is a tool used by domestic violence advocates in providing services to non-offending parents/adult victims. The Personalized Domestic Violence Safety Plan (DSS-5233) contains suggested steps that may be useful for county child welfare agencies in:

- Safety planning with the non-offending parent/adult victim and
- Assisting in the development of service agreements.

Keep in mind that a perpetrator (or their legal representative) can subpoena the contents of a case file. For the protection of the victim, the county child welfare services agency should make decisions on where and how domestic violence safety plans are maintained.

To develop and monitor a coordinated services plan for every case with domestic violence, the county child welfare worker should:

- Seek out and utilize the consultation of a domestic violence expert throughout the life of the case.
- Communicate with a domestic violence perpetrator's probation or parole officer regarding any current abuse.
- Reach out and make connections with school social workers and teachers to gain information about the child(ren)'s day-to-day functioning.
- Work closely with Work First to create plans together. This is especially true when Work First may already be providing or can assist in referring a family for domestic violence services.

INTERACTION WITH THE CHILD(REN)

The Children's Domestic Violence Assessment Tool, DSS-5237, contains scaled assessment questions and should be used to support the determination of the safety and risk factors.

Every child reacts differently when exposed to domestic violence. Some children develop debilitating conditions, while others show no negative effects from exposure to

violence. As a result, it is important to interview the child(ren) regarding their involvement and/or exposure to domestic violence, as well as their general safety and well-being. It is important to recognize that older children are more likely to minimize reports of parental fighting. Younger children may be more spontaneous and less guarded with the information they share. See the Impact on Children section of the Cross Function topic of Risk.

INTERACTION WITH THE ALLEGED PERPETRATOR

The Domestic Violence Perpetrator Assessment Tool (DSS-5234) contains scaled assessment questions and should be used to support the determination of the safety and risk factors.

Interaction with the alleged perpetrator of domestic violence provides the opportunity to observe and document behaviors relative to the allegations, both positive and “concerning.” This observation supplements information obtained from:

- Police reports;
- Criminal records;
- Hospital/medical records;
- The child(ren); and
- The non-offending parent/adult victim.

It is important to note that the alleged perpetrator of domestic violence may attempt to:

- Present themselves as the “victim”;
- Charm the county child welfare worker;
- Gain control of the interview; and/or
- Deny any domestic violence, insisting that the relationship is “perfect.”

During interaction with the perpetrator, the county child welfare worker should:

- Focus on information from third-party reports such as law enforcement, medical providers, or the Administrative Office of the Courts.
- Follow up on legal accountability and/or treatment and other service referrals for the alleged perpetrator of domestic violence.
- Convey to the alleged perpetrator of domestic violence that based on what happened (citing as much information as possible without compromising confidentiality or safety of the child(ren), non-offending parent/adult victim, and/or the reporter) they will be required to take steps to stop the violence and ensure that the child(ren) are safe.
- Avoid debates and arguments with the alleged perpetrator of domestic violence. This is crucial. The focus of CPS is not to convince the alleged perpetrator of domestic violence to admit violent behavior but discuss how to ensure the child(ren)’s safety with them.
- Set limits within the interaction with the alleged perpetrator of domestic violence and document the behaviors that make setting limits necessary and their capacity to respect those efforts.

COLLATERAL CONTACTS

- It should be remembered that domestic violence usually occurs in private and collaterals may not always be aware of the violence.
- Collateral contacts being unaware of the occurrence of violence does not mean that it is not happening.

Forms

Children's Domestic Violence Assessment Tool (DSS-5237), Non-Offending Parent/Adult Victim DV Assessment Tool (DSS-5235), DV Perpetrator Assessment Tool (DSS-5234), Personalized DV Safety Plan (DSS-5233)

Assessments Involving Substance-Affected Infants

Assessments Involving Substance Affected Infants	
Plans of Safe Care	
Family Strengths and Needs	Services
Infant Safety Plan	Nighttime Parenting (Safe Sleep)
Parent Safety Plan	Parental Agreement

[cps-assessments-december-2021.pdf \(ncdhhs.gov\)](#)
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If a report involving substance-affected infants is accepted for CPS Assessment, the county child welfare social worker must create a “Plan of Safe Care” for the infant and family.

Why do you think Plans of Self Care are an important part of practice?

What do you think Plans of Self Care should include? Why?

Assessments Involving Human Trafficking

Assessments Involving Human Trafficking

Check the following to see if the child or youth has been reported missing.

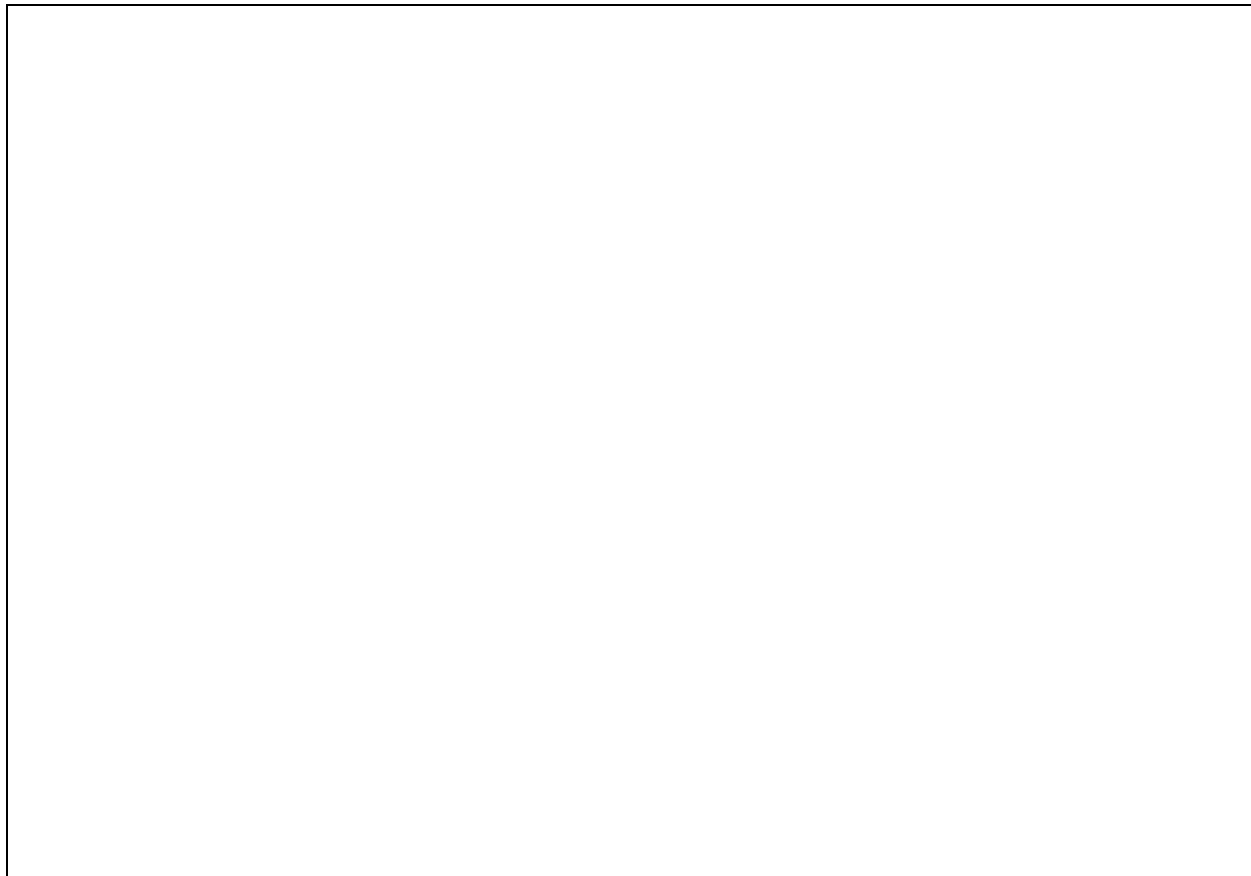
- The National Center for Missing and Exploited Children
- The North Carolina Center for Missing Persons
- The appropriate local law enforcement agency

Notify the U.S. Department of Health and Human Services Office on Trafficking in Persons to facilitate the provision of interim assistance if the child or youth is a foreign national.

[cps-assessments-december-2021.pdf \(ncdhhs.gov\)](#)

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Human trafficking cases are always assigned to the Investigative Assessment track and have an immediate response time.



Handout: Assessments Involving Human Trafficking Policy

Excerpt from the North Carolina Child Welfare Manual: Cross-Function (May 2020)**Human Trafficking**

A child who is sold, traded, or exchanged for sex or labor is an abused and neglected juvenile, regardless of the relationship between the victim and the perpetrator.

Child welfare agencies must identify, document case records, and determine appropriate services for the child(ren) and youth who are believed to be, or at risk of being, victims of human trafficking.

This includes child(ren) and youth for whom the agency has an open CPSA or an open CPS In-Home Services case, but who have not been removed from the home, child(ren) who are involved with Permanency Planning, and youth who are receiving LINKS services.

DefinitionsFederal Law

The Trafficking Victims Protection Act (22 U.S.C. 7102) defines

“severe forms of trafficking in persons”:

- Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion or in which the person induced to perform such an act has not attained 18 years of age; or
- The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services using force, fraud, or coercion for subjection to involuntary servitude, peonage, debt bondage, or slavery.

“commercial sex act” as any sex act because of which anything of value is given to or received by any person.

State Law**N.C. G.S. 14-43.11 Human Trafficking**

A person commits the offense of human trafficking when that person (i) knowingly or in reckless disregard of the consequences of the action recruits, harbors, transports, provides, or obtains by any means another person with the intent that the other person be held in involuntary servitude or sexual servitude or (ii) willfully or in reckless disregard of the consequences of the action causes a minor to be held in involuntary servitude or sexual servitude.

N.C. G.S. 14-43.10(a)(3) Involuntary Servitude – The term includes the following:

- The performance of labor, whether for compensation, or whether or not for the satisfaction of a debt; and
- By deception, coercion, or intimidation using violence or the threat of violence or by any other means of coercion or intimidation.

N.C. G.S. 14-43.10(a)(5) Sexual Servitude – The term includes the following:

- Any sexual activity as defined in G.S. 14-190.13 for which anything of value is directly or indirectly given, promised to, or received by any person, which conduct

is induced or obtained by coercion or deception or which conduct is induced or obtained from a person under the age of 18 years; or

- Any sexual activity as defined in G.S. 14-190.13 that is performed or provided by any person, which conduct is induced or obtained by coercion or deception, or which conduct is induced or obtained from a person under the age of 18 years.

N.C.G.S. 7B-101(1) Abused Juveniles

Any juvenile less than 18 years of age (i) who is found to be a minor victim of human trafficking under G.S. 14-43.15 or (ii) whose parent, guardian, custodian, or caretaker:

- a) Inflicts or allows to be inflicted upon the juvenile a serious physical injury by other than accidental means;
- b) 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;
- 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 N.C.G.S. §14-27.2; rape of a child by an adult offender, as provided in N.C.G.S. §14-27.2A; second degree rape as provided in N.C.G.S. §14-27.3; first degree sexual offense, as provided in N.C.G.S. §14-27.4; sexual offense with a child by an adult offender, as provided in N.C.G.S. §14-27.4A; second degree sexual offense, as provided in N.C.G.S. §14-27.5; intercourse and sexual offenses with certain victims; consent no defense, as provided in N.C.G.S. §14-27.31 and N.C.G.S. §14-27.32; unlawful sale, surrender, or purchase of a minor, as provided in N.C.G.S. §14-43.14; crime against nature, as provided in N.C.G.S. §14-177; incest, as provided in N.C.G.S. §14-178 and N.C.G.S. §14-179; preparation of obscene photographs, slides, or motion pictures of the juvenile, as provided in N.C.G.S. §14-190.5; employing or permitting the juvenile to assist in a violation of the obscenity laws as provided in N.C.G.S. §14-190.6; dissemination of obscene material to the juvenile as provided in N.C.G.S. §14-190.7 and N.C.G.S. §14-190.8; displaying or disseminating material harmful to the juvenile as provided in N.C.G.S. §14-190.14 and N.C.G.S. §14-190.15; first and second degree sexual exploitation of the juvenile as provided in N.C.G.S. §14-190.16 and N.C.G.S. §14-190.17; promoting the prostitution of the juvenile as provided in N.C.G.S. §14-205.3(b); and taking indecent liberties with the juvenile, as provided in N.C.G.S. §14-202.1, regardless of the age of the parties; or
- 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 N.C.G.S. §14-43.11 (human trafficking), N.C.G.S. §14-43.12 (involuntary servitude), or N.C.G.S. §14-43.13 (sexual servitude) against the child.

N.C.G.S. 7B-101(15) Neglected Juvenile.

Any juvenile less than 18 years of age (i) who is found to be a minor victim of human trafficking under G.S. 14-43.15 or (ii) whose parent, guardian, custodian, or caretaker does not provide proper care, supervision, or discipline, 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 who has been placed for care or adoption in violation of the 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 because of suspected abuse or neglect or lives in a home where another juvenile has been subjected to abuse by an adult who regularly lives in the home.

**Protocol – What you must do
Identifying a Victim of Human Trafficking**

A child(ren) who is sold, traded, or exchanged for sex or labor is an abused and neglected juvenile.

Required Notifications and Verifications

Within 24 hours of accepting a report with allegations involving human trafficking or when the county child welfare services agency becomes aware that a child(ren) may have been trafficked, it must:

- Check the National Center for Missing and Exploited Children to see if the child(ren) or youth has been reported missing;
- Check the North Carolina Center for Missing Persons to see if the child(ren) or youth has been reported missing;
- Check with the appropriate local law enforcement agency to see if the child(ren) or youth has been reported missing/runaway;
- Notify the U.S. Department of Health and Human Services Office on Trafficking in Persons (OTIP) to facilitate the provision of interim assistance if the child(ren) is a foreign national. The county child welfare worker must contact OTIP Child Protection Specialists at childtrafficking@acf.hhs.gov or (202) 205-4582 and provide:
 - Child's name, age, location, and country of origin;
 - Location of exploitation and suspected form of trafficking; and
 - County child welfare worker's contact information or other preferred point of contact (e.g., the worker's supervisor).

Safety Considerations

County child welfare workers must collaborate with human trafficking victim organizations and advocates to address the unique circumstances and safety issues for the child(ren) who are victims of human trafficking.

Determining and Utilizing Appropriate Resources

When a county child welfare services agency has an open CPSA, CPS In-Home Services, or Permanency Planning case where trafficking of the child(ren) is suspected or confirmed, the county child welfare worker must provide appropriate information and resources to the family. Referrals to other agencies and resources are instrumental in the identification and screening of victims and the provision of ongoing services. These referrals must be made in accordance with the needs of the child(ren).

Role of the Parent, Guardian, Custodian, or Caretaker

In cases where the perpetrator of human trafficking is not the parent, guardian, custodian, or caretaker, the county child welfare worker must assess and address the parent's ability and/or willingness to keep the child(ren) safe.

CPS Assessment Documentation Tool

CPS Assessment Documentation Tool (DSS-5010)

NORTH CAROLINA CPS ASSESSMENT DOCUMENTATION TOOL

County #: Case #:

Assigned Worker: Supervisor:

I. HOUSEHOLD / FAMILY COMPOSITION/ INDIVIDUAL CASE DECISION INFORMATION

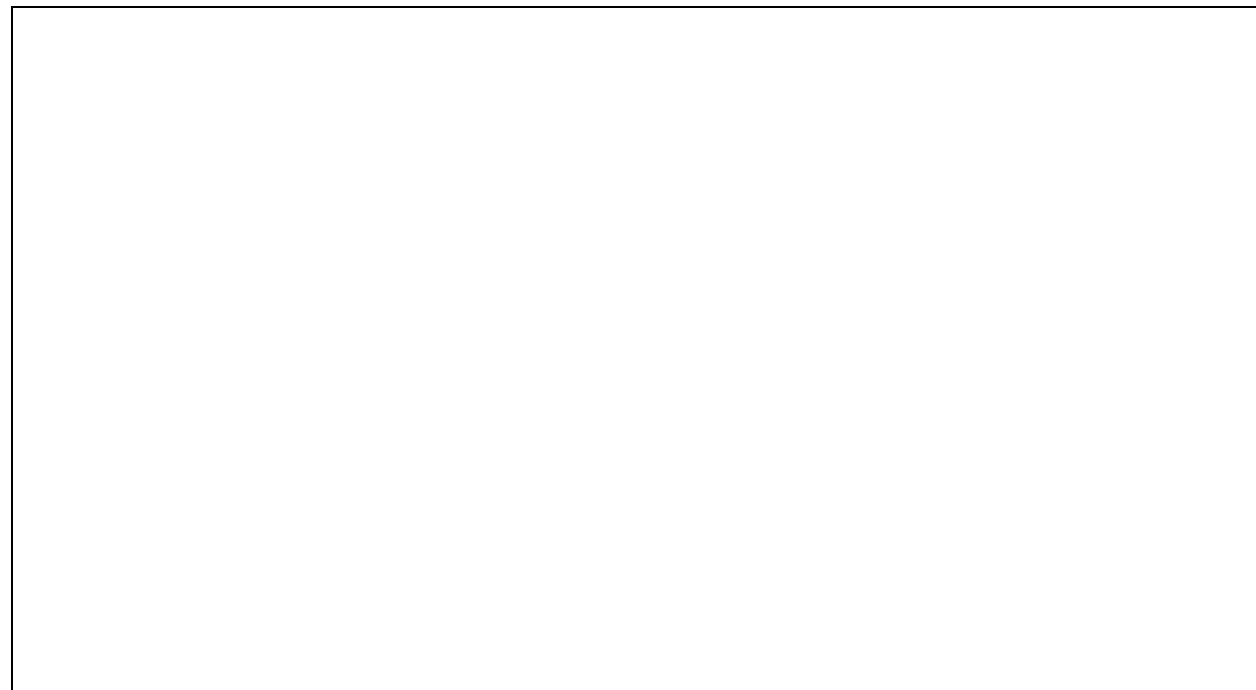
a. Child full name/nickname	b. SIS # (11 digits)	c. Child's date of birth	d. Child's race	e. Child's ethnicity	f. Child's sex	g. Are you part of Federally recognized tribe? If so what tribe	h. Child's school / grade	i. Child's primary language	j. Child's status	k. Social Security Number
1.					<input type="checkbox"/> male <input type="checkbox"/> female				<input type="checkbox"/> R <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> O	
2.					<input type="checkbox"/> male <input type="checkbox"/> female				<input type="checkbox"/> R <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> O	
3.					<input type="checkbox"/> male <input type="checkbox"/> female				<input type="checkbox"/> R <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> O	
4.					<input type="checkbox"/> male <input type="checkbox"/> female				<input type="checkbox"/> R <input type="checkbox"/> A <input type="checkbox"/> V <input type="checkbox"/> O	

[cps-assessments-december-2021.pdf \(ncdhhs.gov\)](#)

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The social worker assigned to the case is responsible for completing the CPS Assessment Documentation Tool (DSS-5010) tool. If you are on-call or assisting with a case, you are also responsible for filling in any information you've gathered.

This tool, like an assessment, is ongoing. You should start completing the information as soon as you are assigned a case and update it timely to reflect any new information or activities, like meetings with the family or phone calls with collateral contacts.



Key Takeaways

Key Takeaways

- There are two approaches to CPS Assessments
- Certain types of cases have special policy requirements
- The CPS Assessment Documentation tool captures the "big picture" of cases
- Ongoing references for use: The Policy Manual, your Participant Workbook, and the Tools Workbook

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Questions and Reflections

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

Safety vs. Risk

Learning Objectives

<ul style="list-style-type: none">• Identify threats and risk factors when working with children and families.
<ul style="list-style-type: none">• Differentiate between safety and risk when considering instances of abuse and neglect.
<ul style="list-style-type: none">• Identify protective capacities when working with children and families.
<ul style="list-style-type: none">• Articulate how protective capacities mitigate risk when considering child and family circumstances.

Defining Safety and Risk

Defining Safety and Risk

Safety: The absence of an imminent or immediate threat of moderate-to-serious harm to a child.

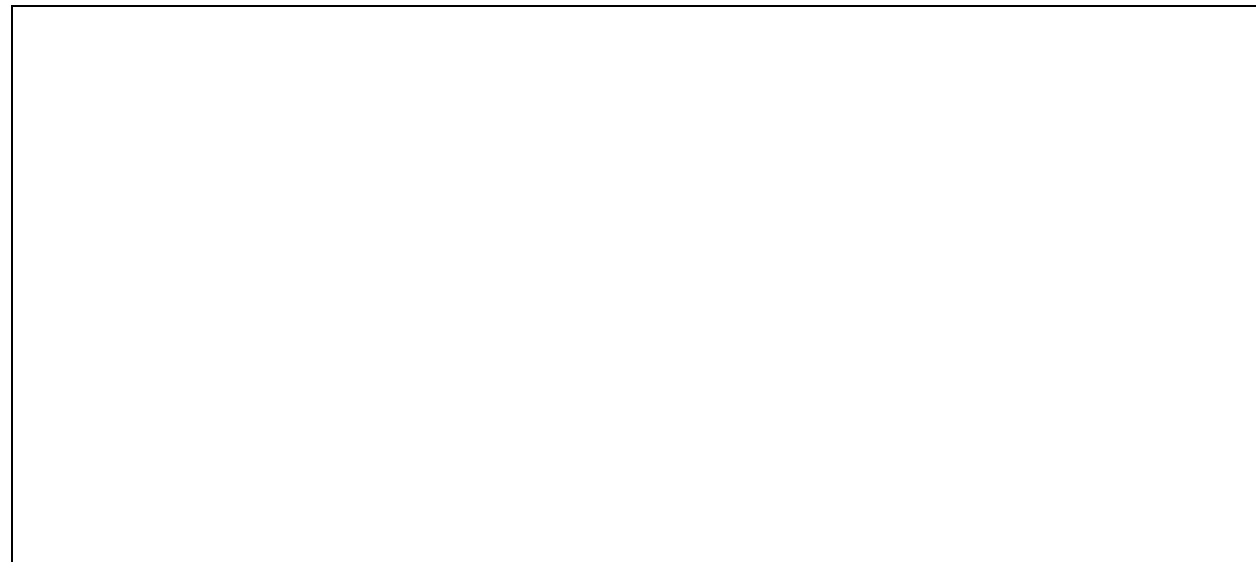
Risk: The likelihood that a child will be maltreated in the future.

[The Use of Safety and Risk Assessment in Child Protection Cases \(childwelfare.gov\)](https://www.childwelfare.gov/topics/prevention/prevention-practices/child-protection/safety-risk-assessment/)

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Two key activities that are critical in CPS Assessments and continue throughout the life of a case are the assessment of safety and risk. Safety and risk are **not** interchangeable terms. Safety applies to the need for action based on an immediate threat of harm. Risk refers to the likelihood of future maltreatment.

Safety and risk can present in any combination- you may have a case where a child is unsafe, but there is low risk. Conversely, you might have a safe child with high risk. Understanding the difference between safety and risk and how they guide case decisions is critical.



Understanding Child Safety

Understanding Child Safety

Safety is not merely the absence of danger.

Safety is the presence of protection.

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[The Use of Safety and Risk Assessment in Child Protection Cases \(childwelfare.gov\)](https://www.childwelfare.gov)

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A child is safe if there is no safety threat (immediate threat of danger), or if the parent possesses sufficient protective capacities to manage any threat.

A child is unsafe when:

- A safety threat exists within the family,
- The child is vulnerable to the treat, and
- Caregivers have insufficient protective capacities to manage or control threats.



Understanding Risk

Understanding Risk

Static

Dynamic

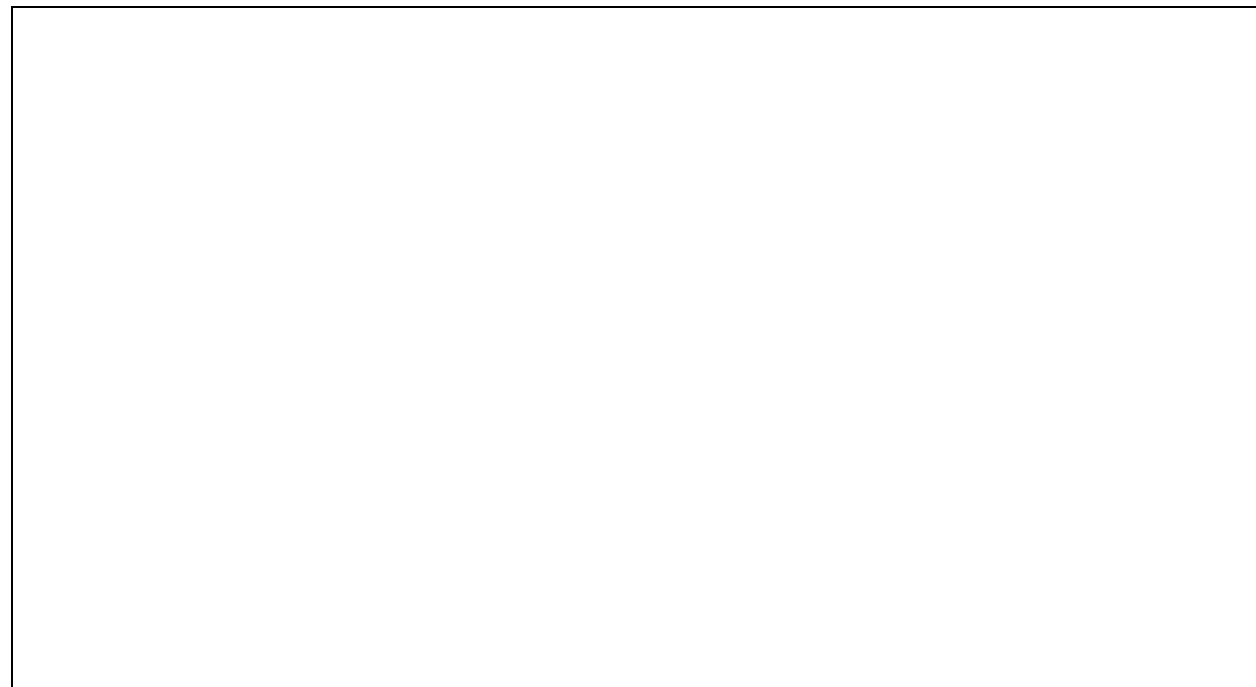
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The Use of Safety and Risk Assessment in Child Protection Cases (childwelfare.gov)




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Risk is conditions or characteristics that are associated with the likelihood of future maltreatment. Note that factors are associated with the risk of future maltreatment, but do **not** predict it. They are different from safety threats because they do not pose an immediate threat of harm to the child. Some risk factors are static, meaning they do not change over time and some risk factors are dynamic, meaning they change over time and impact risk differently based on their status. We rate risk on a scale from low to high to help guide case decisions.

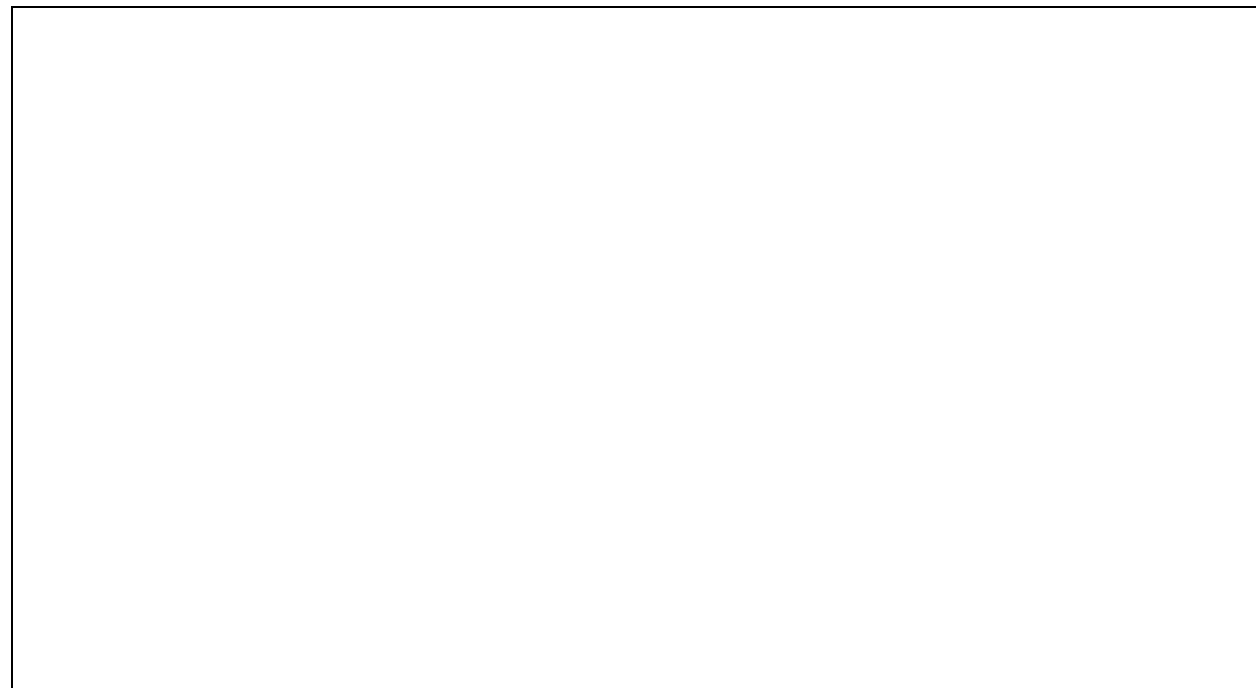


Distinguishing Safety and Risk

Distinguishing Safety and Risk	
 SAFETY ASSESSMENT	 RISK ASSESSMENT
Is there an immediate threat of serious harm?	What is the likelihood of future system involvement?
Informs: <i>The removal decision</i>	Informs: <i>A prevention opportunity</i>
All items are connected to North Carolina law and/or contain caretaker, behavior, impact on the child	All items have a statistical connection to future outcomes we are hoping to avoid
	
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Determining child safety helps inform the removal decision and a determination that a child is unsafe requires immediate action. Determining risk creates an opportunity to provide services or interventions that prevent future maltreatment.

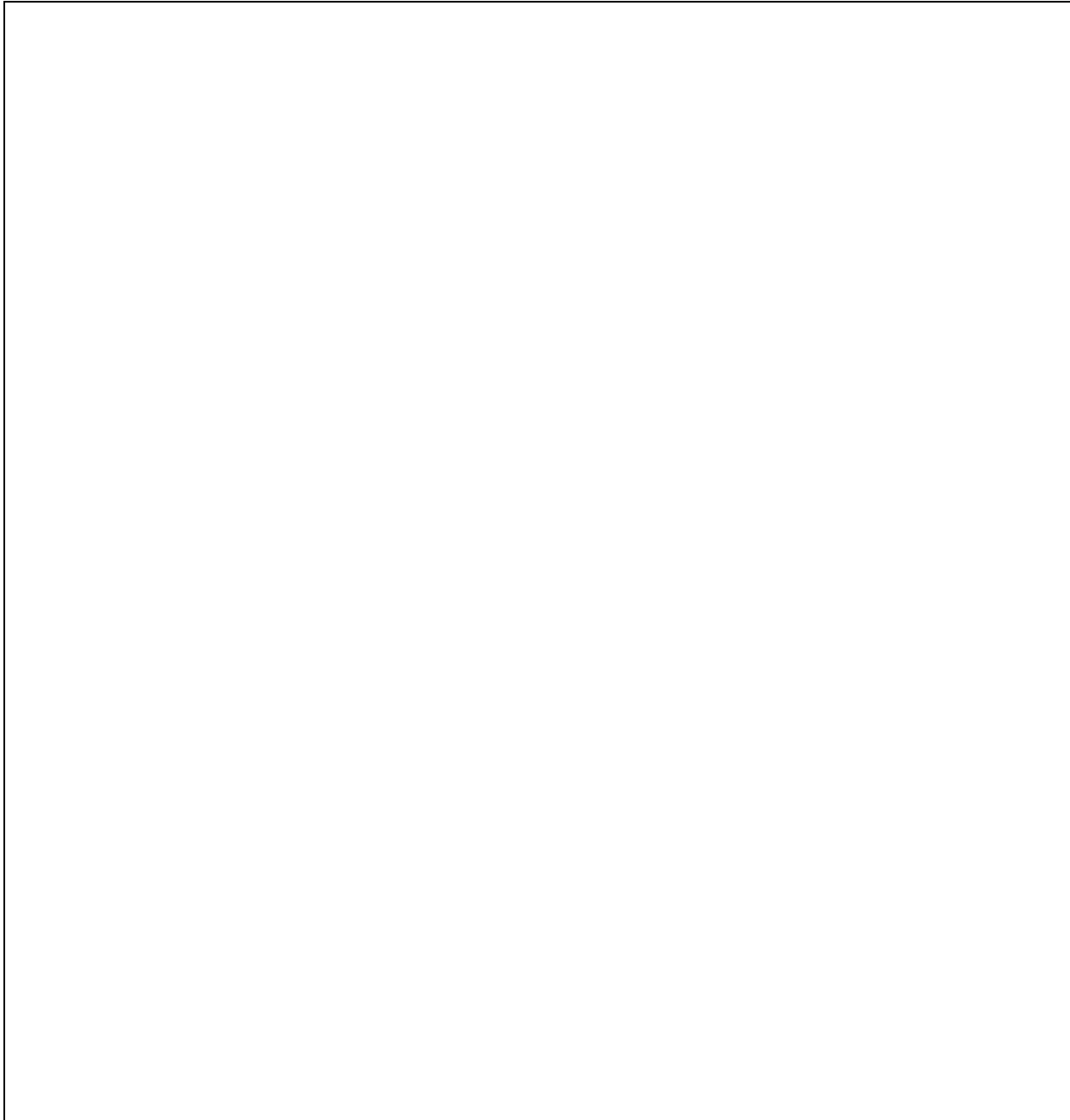
Safety threats are related to the definitions of abuse, neglect, and dependency in North Carolina law. They can be determined by looking at the impact of caregiver behavior on a child. Risk factors are conditions that have a statistical connection to future outcomes we want to avoid but are not immediately impacting child safety.



Activity: Distinguishing Safety from Risk

- Review your assigned scenario with your work group and decide if the situation represents risk or safety.
- Be prepared to present your determinations and discuss your reasoning during the debrief.

Use this space to record notes from the activity.

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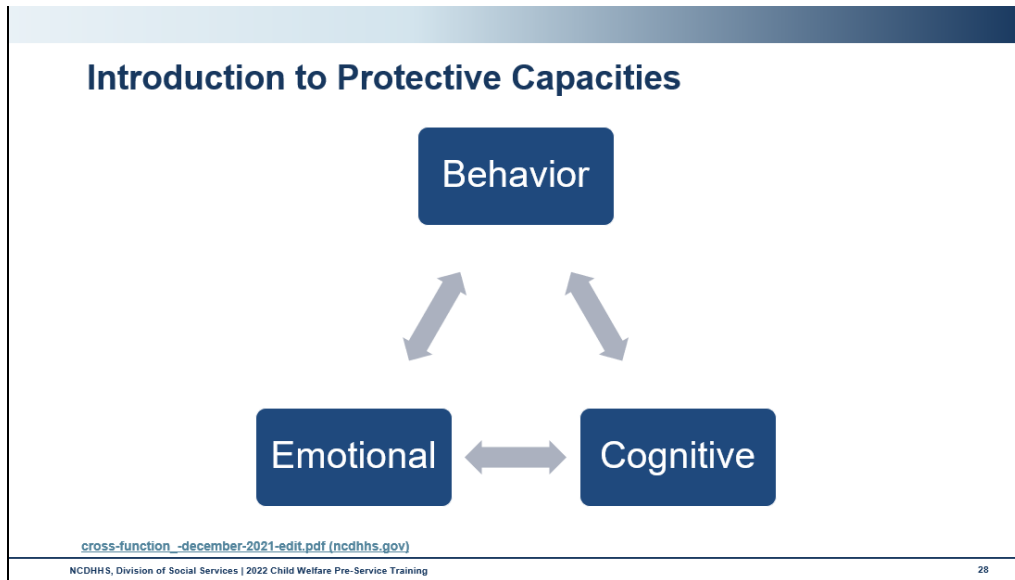
Questions and Reflections

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

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Caregiver Protective Capacities

Introduction to Protective Capacities



Understanding a parent or caregiver’s ability to care for and protect their child or children is a key part of assessment and decision-making regarding safety and risk.

Why do you think considering protective capacities is an important part of the assessment?

Handout: Assessing Protective Capacities

Protective capacities are family strengths or resources that reduce, control, and/or prevent threats of serious harm from arising or having an unsafe impact on a child. Not all strengths are protective capacities. Strengths must have a particular element to be a protective capacity; an element relevant to mitigating the safety threat.

Protective capacities are strengths that are specifically relevant to child safety. They may include intellectual skills; physical care skills; motivation to protect; positive attachments; social connections; resources such as income, employment, or housing.

Protective capacities need to be both accessible and actionable. Actionable means that the caretaker will use these protective capacities on their own without external provocation.

The following chart provides a variety of strengths that may exist as protective capacities based on their ability to be used to mitigate case-specific safety threats.

Intellectual Skills

- Knowledge of child development as it relates to safety and well-being.
- Capacity and willingness to demonstrate empathy for the child's needs or condition.
- Ability and willingness to recognize and respond to a child's needs.
- Ability and willingness to defer one's own need (gratification) to meet a child's needs.
- Ability and willingness to control potentially harmful impulses related to child safety.
- Ability to understand the impact of his/her own actions which may result in maltreatment or active safety threats.

Motivation to Protect

- Caretaker is accepting in his/her role as caregiver to nurture and protect the children.
- Caretaker identifies and accepts the caregiving role.

Positive Attachments

- Caregiver is not in a co-dependent relationship.
- Caretaker is emotionally tied to healthy family members.
- Caretaker is not in a violent familial or social relationship.

Social Connections

- Caretaker interacts appropriately with neighbors in a manner that assures child safety and well-being.
- Caretaker interacts appropriately and cooperates with the child's school.
- Caretaker demonstrates appropriate boundaries with friends, family, and others.
- Caretaker behaves in a manner with others that ensure child safety and well-being.

- Caretaker behaves in a manner that does not frighten the child or other family members.
- Caretaker has friends that serve as social support to ensure child safety and well-being.
- Caretaker has close relationships with family members who support child safety and well-being.
- Personal or familial supports exist and are available to share care-giving tasks and responsibilities.
- Personal or familial supports are available to provide material and interpersonal resources.
- Caretaker can demonstrate reciprocity in their social network.
- Caretaker belongs to a church that provides spiritual and emotional support.
- Caretaker lives in a neighborhood where neighbors regularly socialize and share care-giving and other tasks.
- Caretaker is geographically close to supportive family members.

Resources

- Caregiver has employment that provides for the family's basic needs: housing, basic utilities, food, clothing, medical care, and transportation.

Community

- Neighborhood is safe from street crime, gangs, and drug dealing.
- The authority is held by legitimate public servants.
- Community has an interest in the well-being of families and children.
- Community is welcoming of diversity.

Health

- Health insurance coverage is available.
- Family has access to medical care.
- Family has adequate transportation to utilize medical services.
- Family has a primary healthcare provider.
- Family does not frequently switch doctors or hospitals for medical care.
- Family has access to dental care.

Mental Health

- Mental health services are available to children and adults.
- Mental health services are accessible (no long waiting lists)
- Transportation to mental health services is available.
- Prescriptions for mental health conditions are affordable

Child Care

- Child care is affordable.
- Transportation for child care is available.
- Child care is a safe stimulating and nurturing environment for the child.
- Parent interacts with the child care provider.
- Parent trusts child care provider.
- Child care is licensed.

Employment

- Caretaker is employed.
- Caretaker does not frequently lose jobs.
- Caretaker's employment is legal.
- Caretaker's employment skills are adequate to maintain financial stability.

Key Takeaways

Key Takeaways

Safety and risk are not interchangeable terms	Safety refers to an immediate threat
Risk is likelihood of future maltreatment	Caregiver Protective Capacities can mitigate safety threats and risk

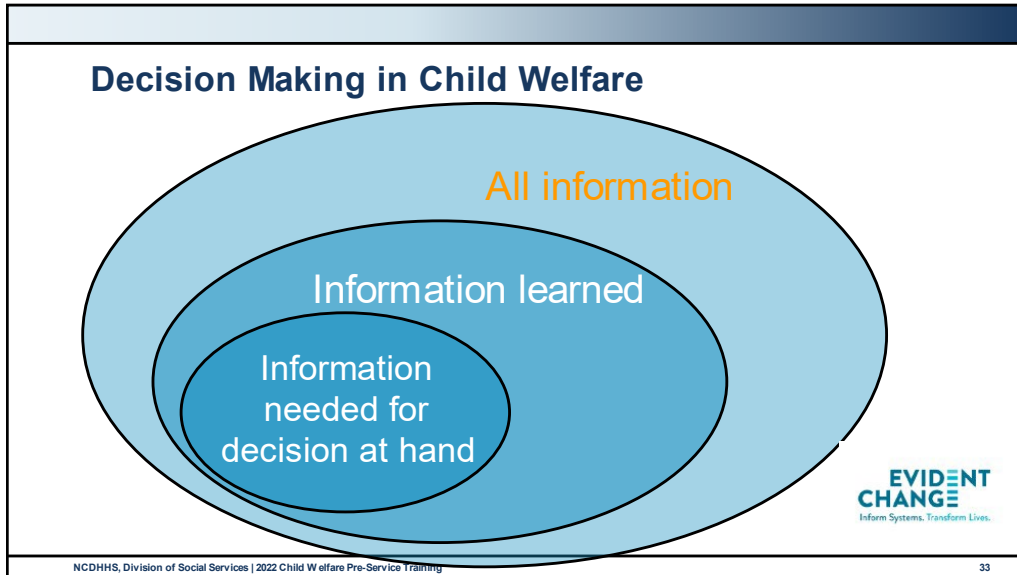
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Questions and Reflections

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

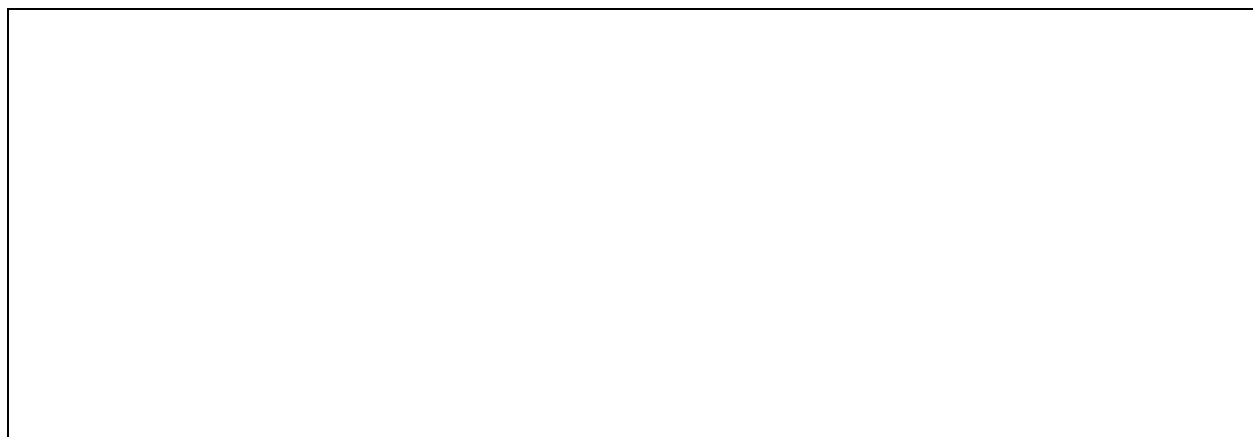
Tools for Assessment

Decision-Making in Child Welfare

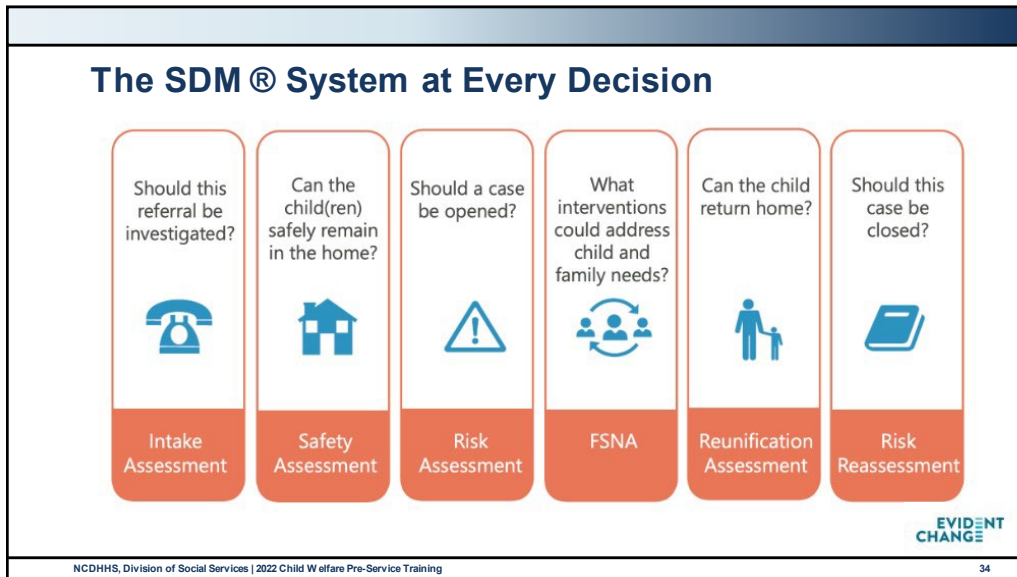


Structured decision-making tools help us focus on the most important information needed to make a specific point-in-time decision, such as “can the child remain safely in the home?”

In this graphic, the outer circle is the entirety of information about a family. We will never really know ALL of this. The middle circle represents what we learn about the family as we work with them. It should be a substantial amount of information, but not all of it is needed to answer that question. The inner circle represents the information needed to make that decision about safety. The assessment tool is structured and contains questions that focus on that specific information and guide us through the decision-making process.



The SDM® System at Every Decision




The Safety Assessment, Risk Assessment, and Family Strength and Needs Assessment are all used during the CPS Assessment phase to help us make these critical decisions. The Risk Reassessment is used in in-home and placement cases and the Reunification Assessment is used in placement cases.


Keeping the questions associated with each decision point in mind helps us understand the “why” when we are assessing families. We are asking this question, making this visit, and calling this doctor because we need to have enough information to understand if the child can remain safely in the home.





Tools are a Prompt for Practice

Tools are a Prompt for Practice

 Tools do not make decisions.

 People make decisions.

 +  **Tools help people make better decisions.**

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NCCD Children's Research Center







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Using tools helps guide consistent, reliable, and objective assessment to support decisions; increases consistency and accuracy in decisions; and helps social workers, supervisors, and administrators plan and appropriately allocate resources so we are serving families in the most appropriate setting.

The tools also create a common language and can help reduce bias and other errors in decision-making. Just because you are using the tool, however, does not mean you do not need to be aware of your own biases and ensure that you respond to the family circumstances objectively.



Using SDM[®] Tools

 Read to the period.	 Examples are not all-inclusive lists.	 Be aware of: • AND • OR
 When unsure, ask others.	 "Unasked" is different from "unknown."	 Use professional judgment and common sense.

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Read to the period. This means reading the entire definition. One common mistake is applying a phrase of a piece of a definition inappropriately.

Examples are not all-inclusive lists. The examples in definitions offer illustrations about the threshold, nature, and severity intended by the definition. An example that fits your situation does not necessarily mean the whole definition applies. Likewise, the lack of a specific example does not necessarily mean the definition does not apply to a circumstance.

Be aware of "and" and "or". When you see a big "AND" the circumstances state on both sides of the "AND" must be true for the definition to apply.

When unsure, ask others. When an example or a definition does not make sense, or you are not sure how to apply it, do not be afraid to ask others. Group discussion is a great way to increase knowledge and help everyone understand confusing areas.

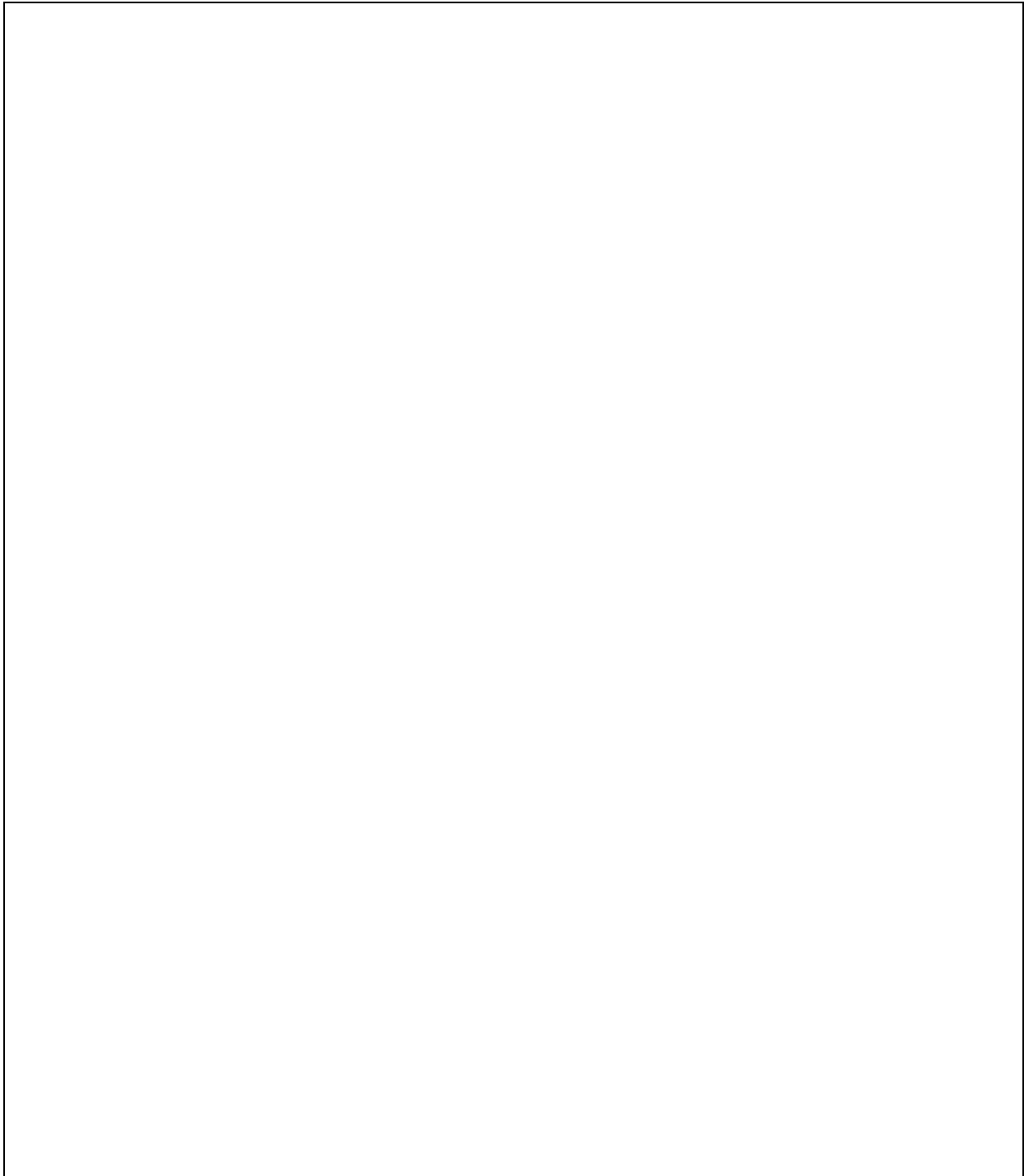
"Unasked" is different from "unknown." Remember that information that has not been asked about is different from unknown information. If the reporter has not provided information, is something present that could help meet the definition? Sometimes the answer is simply "no" if we lack information.

Use professional Judgment and common sense.



Questions and Reflections

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

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Safety Assessment

Learning Objectives

<ul style="list-style-type: none">• Identify safety threats.
<ul style="list-style-type: none">• Describe how caregiver behavior impacts child safety.
<ul style="list-style-type: none">• Demonstrate narrative interviewing techniques.
<ul style="list-style-type: none">• Describe how to complete the North Carolina Safety Assessment and when it is used.
<ul style="list-style-type: none">• Demonstrate strategies for engaging families in the assessment process.

Overview of Safety Assessment Process

Overview of Safety Assessment Process

The assessment of safety is an ongoing process that starts at the time a case is accepted for a CPS Assessment and continues until case closure.

Intake Accepted

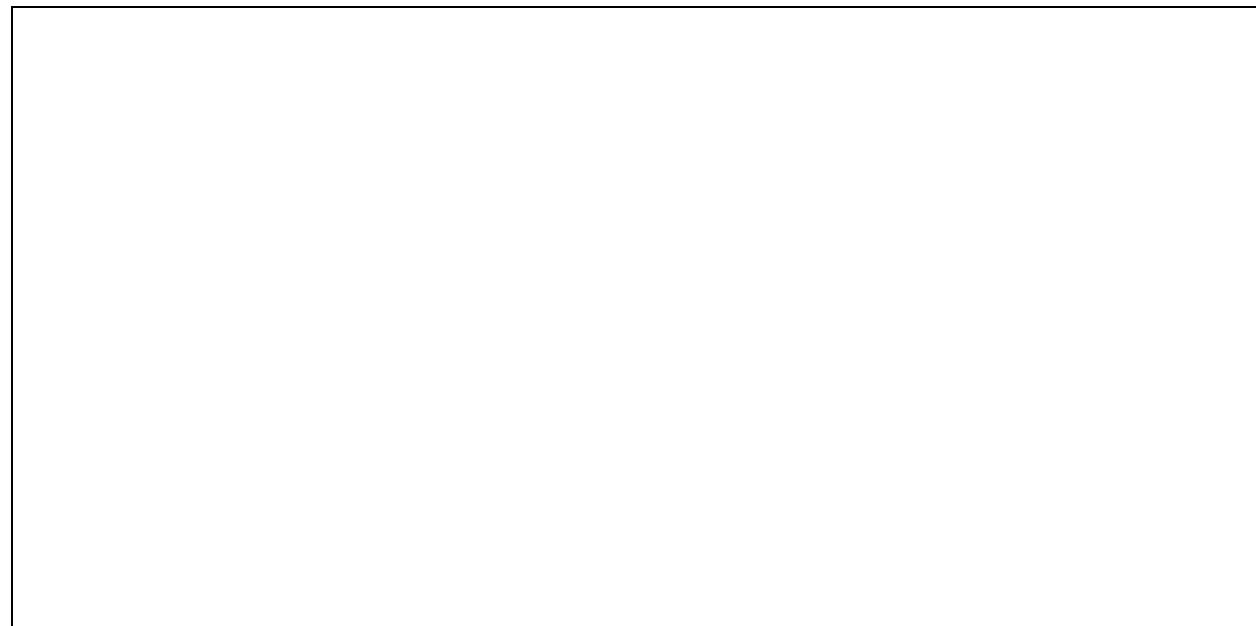
Every Contact

Case Closure

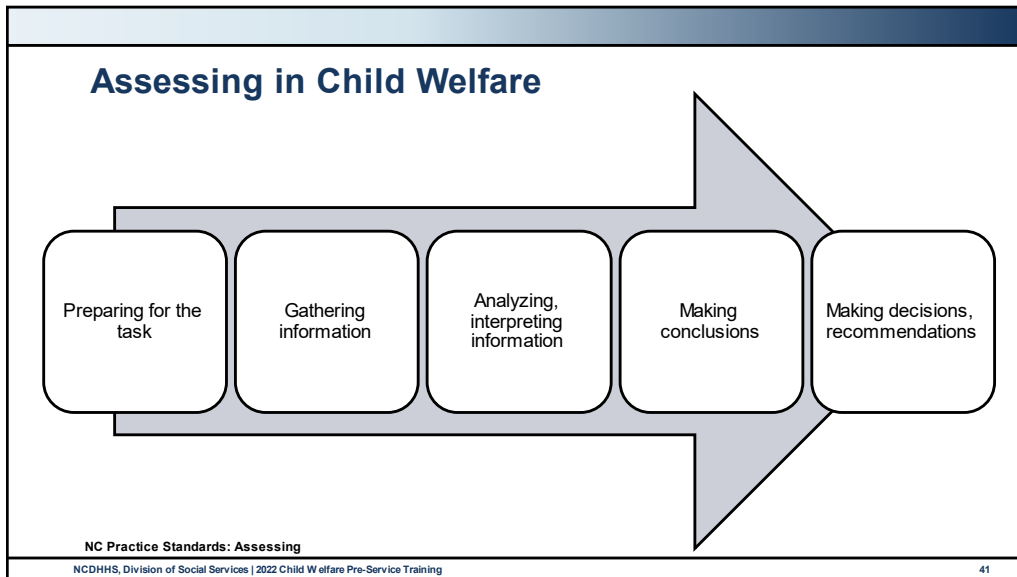
[cross-function_december-2021-edit.pdf \(ncdhhs.gov\)](#)

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Our policy manual outlines critical information about child safety and safety assessment. It says, “the primary concern of Child Welfare Services is protecting children. When a safety threat is identified, the county child welfare services agency must respond and develop a plan of safety. At no time should a county child welfare worker leave a child(ren) in unsafe circumstances. The intent of safety planning is to reach an agreed-upon plan with the family that imposes the lowest level of intrusiveness possible while assuring a child(ren)’s safety. The assessment of safety is an ongoing process that starts at the time a case is accepted for CPS Assessment and continues until case closure.”



Assessing in Child Welfare



Recall the steps of assessing in child welfare:

1. Preparing for the task
2. Gathering information from family members, other professionals, people in the family’s network, and other documented records
3. Analyzing, prioritizing, and interpreting the information
4. Making conclusions
5. Making decisions and recommendations



Preparing for the First Contact

There are multiple aspects of the visit to consider:

- Understanding the report and gathering additional information about the family
- Preparing for the logistics of the visit
- Planning for the meeting with the family

What do you think is the first step when you are assigned a new intake report?

Questions and Reflections

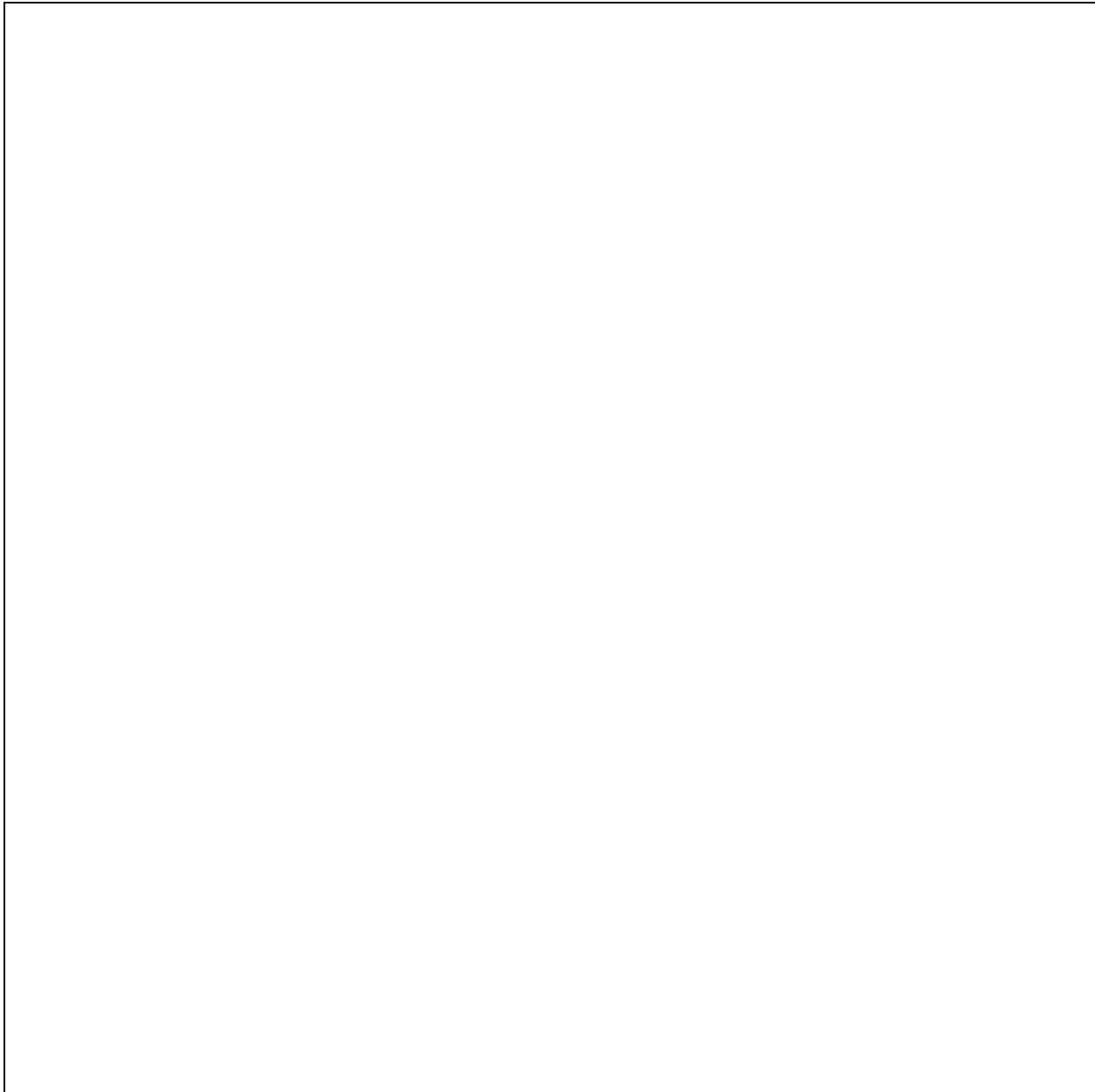
Use this space to record questions and reflections about what you have learned.

Activity: Preparing for the First Contact

Work with your group to discuss your assigned aspect of preparing for the first visit.

- Group 1: Understanding the report and gathering additional information about the family.
- Group 2: Preparing for logistics of the visit.
- Group 3: Planning for the meeting with the family.

Use this space to record notes.

A large, empty rectangular box with a thin black border, intended for recording notes during the activity.

North Carolina Right to Enter a Residence Law

North Carolina Right to Enter a Residence Law

- 1 The reasonable belief that a juvenile is in imminent danger of death or serious physical injury.
- 2 The permission of the parent or person responsible for the juvenile's care.
- 3 The accompaniment of a law enforcement officer who has legal authority to enter the residence.
- 4 An order from a court of competent jurisdiction.

N.C.G.S. §7B-302(h)
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Handout: North Carolina Right to Enter a Residence Law

N.C.G.S. § 7B-302 Assessment by director; military affiliation; access to confidential information; notification of person making the report.

(h) The director or the director's representative may not enter a private residence for assessment purposes without at least one of the following:

- (1) The reasonable belief that a juvenile is in imminent danger of death or serious physical injury.
- (2) The permission of the parent or person responsible for the juvenile's care.
- (3) The accompaniment of a law enforcement officer who has legal authority to enter the residence.
- (4) An order from a court of competent jurisdiction

Key Takeaways

Key Takeaways

- Safety assessment is an ongoing process throughout the life of a case
- Ensuring child safety is our primary responsibility
- Preparing for initial contact with a family is a key step in the assessment process
- In most circumstances, you cannot legally enter a private residence without permission, law enforcement escort, or a court order

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Questions and Reflections

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

CPS Assessment Learning Lab

Activity: Initial Interviews – Evans Family

Refer to the previous Evans Family Scenario to complete the sections below.

What is the order in which you will interview the family?

What would you like to know?

Once the list of items we need to know has been determined, the class will work through the following sections to brainstorm ideas.

Part I: Identify Information

Part II: Identify Sources

Part III: Prioritize Interviews

Part IV: Develop Questions

Activity: Initial Observation – Evans Family

Listen and observe as the trainers demonstrate an interview with Kevin. Note: This is not the first time Kevin is being interviewed.

Use the observation worksheet to record notes.

Worksheet: Observation of Mock Interview with Kevin

1. **What would Kevin say about the worker’s ability to engage him increasing a sense of psychological safety?**

2. **Did the worker give Kevin choices?**

3. **Did the worker hear Kevin’s voice?**

4. Did the worker create a safe physical space for the conversation to occur?

5. Did the worker accurately reflect what Kevin was saying?

6. Did the worker make a successful effort to lessen the power differential?

7. Did the worker demonstrate respect for Kevin?

8. Did the worker demonstrate genuineness in interactions with Kevin?

9. Did the worker demonstrate empathy in interactions with Kevin?

10. Did engagement with Kevin occur?

11. Did the worker “hear” Kevin?

12. If you were providing this worker feedback on the interview, what would you say?

Questions and Reflections

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

A large, empty rectangular box with a thin black border, intended for the user to write their questions and reflections. The box occupies most of the page's vertical space below the introductory text.

Peworkk Reminder

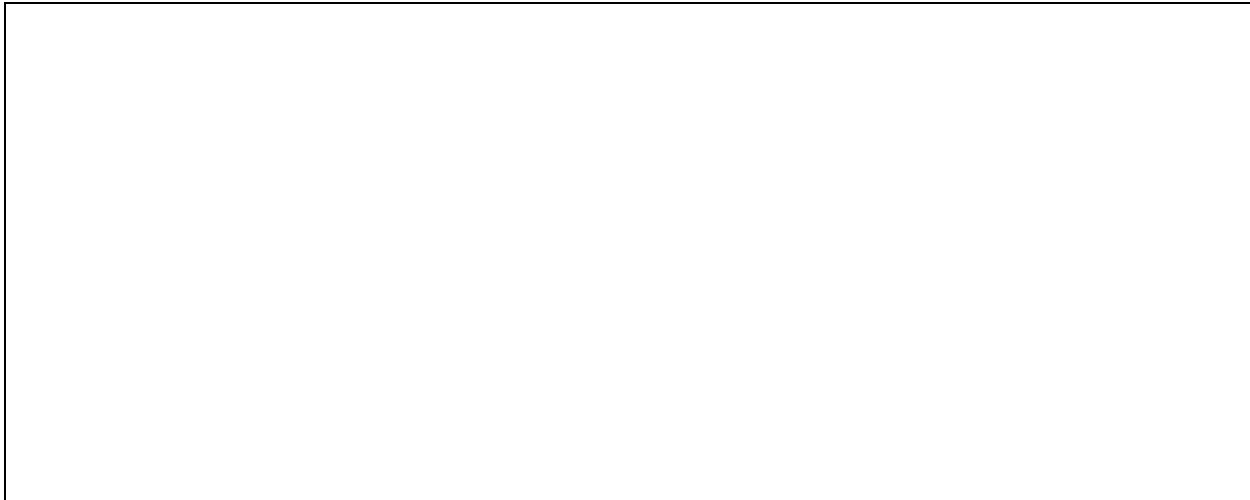
Before returning next week, please review the following tools and instructions as pre-work:

- North Carolina Safety Assessment (DSS-5231)
- Family Risk Assessment of Abuse/Neglect (DSS 5230)
- Family Assessment of Strengths and Needs (DSS 5229)

Self-Care Exercise

Prioritizing Self-Care

Brainstorm and identify self-care strategies to help identify and manage the challenges of our work, be aware of personal vulnerabilities, and achieve more balance in life.



Activity: Self-Care Exercise/Breathing Meditation

Mindfulness is a type of meditation where you focus on being aware of the present moment while acknowledging and accepting your feelings, thoughts, and bodily sensations without judgment. There is no wrong way to do this exercise. This exercise itself will last about five minutes and there will be a chime sound when it is over.

Visit: https://d1cy5zxxhbcbk.cloudfront.net/guided-meditations/01_Breathing_Meditation.mp3 for a guided meditation exercise.

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Appendix: Handouts

Identifying Needs and Developing Goals.....	Error! Bookmark not defined.
Goal Setting with SMART	Error! Bookmark not defined.
SMART Goals Template.....	Error! Bookmark not defined.
Glossary of Court and Legal Terms.....	Error! Bookmark not defined.
Preparing Children for Court.....	Error! Bookmark not defined.
Defining Quality Contacts	Error! Bookmark not defined.
North Carolina General Statute Definitions.....	Error! Bookmark not defined.
CPS Intake Steps	Error! Bookmark not defined.
Buzzwords Tip Sheet	Error! Bookmark not defined.
Substance Affected Infant and Plan of Self Care	Error! Bookmark not defined.
Investigative and Family Assessment Responsibilities.....	Error! Bookmark not defined.
Investigative Assessment and Family Assessment Approaches	Error! Bookmark not defined.
Similarities in Family Assessments and Investigative Assessments .	Error! Bookmark not defined.
Assessments Involving Domestic Violence Policy	Error! Bookmark not defined.
Assessments Involving Human Trafficking Policy	Error! Bookmark not defined.
Assessing Protective Capacities	Error! Bookmark not defined.
North Carolina Right to Enter a Residence Law	Error! Bookmark not defined.

Identifying Needs and Developing Goals

To be completed with your supervisor on a specific case. The recommendation is that this worksheet will be completed following an observation of a child and family team meeting.

1. What is the specific problem or issue related to why the agency is **continuing** to be involved with this family?

2. What does the family need to have happen concerning the problem or issue? What needs to occur for the child(ren) to be safe from possible abuse or neglect and/or to have the child(ren)'s needs met (i.e. psychological, mental, emotional, physical, educational, dental, medical, safety, security, nurturance, developmental, special needs or other)?

3. What would the situation look like if the need was met, and the problem/issue was resolved? Describe what it would be like for the child(ren) and family when the problem is resolved. What would this situation look like if the risk(s) of abuse and neglect were reduced or eliminated?

4. State the goal for the family using the description given in #3.

5. Does everyone agree that this is the goal and does everyone agree regarding the problems and issues? If not, list disagreement points.

6. List two agreed upon problems/issues. Name one need and state one goal that everyone agrees upon.

Goal Setting with SMART

Goals should be:

Specific

Measurable

Achievable

Realistic

Timely

Goals and plans to achieve goals should be directly related to the reduction of risk and improvement of the well-being of children. The goals should also be related to the factors that contributed to the involvement of the child welfare agency in the family's life. Some action steps include the path to the reduction of risk or improvement of the well-being of children and families, but the connection should be made to why the agency is involved with the family.

Prioritize Goals:

- What do both the social worker and the family agree upon?
- What could be quickly achieved?
- What is most needed? What will reduce risk or improve well-being the most?
- What does the family want to do?
- What resources are readily available?
- What is most closely related to the reason the child came into custody or the agency became involved in the family's life?

Other things to consider as you develop goals with the family include:

- What does the family identify as the problem?
- What does the social worker identify as the problem?
- What are the needs of the family as they relate to the identified problems?

Goals should be written such that they describe the state of the children and family when risks of abuse and neglect are reduced or eliminated.

Explain to the family the consequences of entering into the plan and then not following through, such as court involvement, removal of the child from home, or the end result could be termination of parental rights. Explain to the family that entering into the Family Services Agreement is like a "contract." This is why the family needs to be a partner in the development of the goals and their plan. This is where real work and change will begin to take place.

SMART Goals Template

SMART goals help improve achievement and success. A SMART goal clarifies exactly what is expected and the measures used to determine if the goal is achieved and successfully completed.

A SMART goal is:

Specific: Answers the questions: Who? What? Where? When? Which? Why?

Measurable: The success toward meeting the goal can be measured. Answers the questions: How much? How many? How will we know it is accomplished?

Achievable: Can we see the family accomplishing the goal? Is it really achievable for them?

Realistic: The goals must be aligned with current tasks and projects, and focus on one defined area. The expected result must be included. Is the family willing and able to meet the goal? Does the goal coincide with the family's needs?

Timely: Goals must have a clearly defined timeframe, including a target or deadline date. How long will it take to achieve the goal?

Examples of Goals:

Not a SMART goal:

- Employee will improve their writing skills.

This goal does not identify a measurement or timeframe, nor identify why the improvement is needed or how it will be used.

SMART goal:

- The Department has identified a goal to improve communications with administrative staff by implementing an internal departmental newsletter.
- Elaine will complete a business writing course by January 2010.
- Elaine will publish the first monthly newsletter by March 2010.
- Elaine will gather input and/or articles from others in the department.
- Elaine will draft the newsletter for supervisor review.
- When approved by the supervisor, Elaine will distribute the newsletter to staff by the 15th of each month.

Glossary of Court and Legal Terms

Filing the Petition

Your agency must make reasonable efforts to protect children in their own homes and to prevent placement. Your agency must file a petition requesting adjudication of abuse, neglect, and/or dependency:

- When safety-related circumstances necessitate the need for immediate removal
- Due to the family's unwillingness to accept critically needed services and those services are necessary to keep the family intact
- When despite agency efforts to provide services, the family has made no progress toward providing adequate care for the child and those services are necessary to keep the family intact

A child protection proceeding is initiated by filing a petition. The decision to file a child maltreatment petition is made by the social worker and their supervisor, often in consultation with the agency's lawyer. The decision to file should always be based on safety considerations and not on how likely it is that the case can or cannot be won in court. As a result, child maltreatment petitions tend to concern children who are exposed to serious threats to their safety.

Initial Hearing/Non-Secure Custody Hearing

When a child is removed from their home, a nonsecure custody hearing must occur within seven days. As long as a child remains placed outside the home, nonsecure custody hearings must continue to be held until the disposition hearing is finished, unless the child's parent and their attorney agree to waive them. The initial hearing is the most critical stage in the child abuse and neglect court process. Many important decisions are made and actions are taken that chart the course for the remainder of the proceedings. At this hearing, the relationships between those involved in the process also are established, and the tone is set for their ongoing interactions. The main purpose of the initial hearing is to determine whether the child should be placed in substitute care or remain with or be returned to the parents pending further proceedings. The critical issue is whether in-home services or other measures can be put in place to ensure the child's safety.

Adjudication Hearing

This hearing must be held within 60 days of the date the petition was filed unless the judge decides there is a good reason to delay it. At the adjudication hearing, the court decides whether CPS can prove the allegations in its petition. The child welfare agency's attorney will present evidence through the testimony of the social worker, law enforcement officers, or other witnesses, including any experts. Documents such as medical records or photographs also may be entered into evidence. The attorneys for the parents and the child will have the right to question or cross-examine the witnesses and present evidence. The parents may testify, as may other family members or neighbors who know the facts alleged in the petition or of the care the parents provided their children.

Dispositional Hearing

The dispositional hearing may occur on the same day as the adjudication hearing or may be up to 30 days later. At the dispositional hearing, the judge decides what the best plan is for the child and what services will be ordered. For example, the court may enter an order that mandates counseling and rehabilitative services. The judge will also decide where the child will live, whether any relatives can help take care of the child, and what type of visits the parent will have with their child. The judge may also order each parent to receive certain services, such as substance abuse treatment, parenting classes, or domestic violence counseling. Essentially, the dispositional hearing determines what will be required to resolve the problems that led to CPS intervention.

Review Hearing

The first review hearing must take place within 90 days of the dispositional hearing. After that, there must be a review hearing every 6 months, but often they occur more frequently. In addition, any party can ask for a review hearing at any time, if an attorney files a motion with the court. The review hearing is an opportunity to evaluate the progress that has been made toward completing the case plan and any court orders and to revise the plan as needed. At each review hearing, the judge is given information about what each parent has been doing, how the child is doing, and whether any needs haven't been addressed. The court must decide if the plan that was made during disposition is working and if any changes are needed. Review hearings should guide the case to permanency for the child.

Permanency Hearing

A permanency hearing is required within 12 months after a child is removed from their home. It may be held earlier if the judge decides that efforts to reunify the family are not required or will stop. Permanency hearings must be held at least every 6 months. At a permanency planning hearing, the parties present information to the judge so the judge can order a plan to achieve a safe, permanent home for the child within a reasonable period. The judge will decide whether the plan is to return the child home, to give a suitable person custody or guardianship of the child, to move toward termination of parental rights so the child can be adopted, or to keep more than one of these options open, sometimes referred to as concurrent planning. You will learn more about permanency hearings during the Permanency Planning Services section of this training.

Termination of Parental Rights

A termination of parental rights (TPR) hearing is divided into two stages, adjudication and disposition. At adjudication, the party requesting TPR must prove to the judge by clear and convincing evidence that grounds exist for termination. If the judge decides that grounds do not exist, the judge will dismiss the case. If the judge decides that the grounds do exist, the judge moves to the disposition stage and must decide whether TPR is in the child's best interest.

Preparing Children for Court

Most young people in foster care are invited to attend court, to be involved in the proceedings, and sometimes to testify. That's a good thing because hearing from children helps judges make appropriate decisions. But that doesn't mean being in court is easy for children. In fact, many young people report feeling anxious, angry, and frustrated with their experiences in court. However, when children are properly prepared for court and are supported afterward, these feelings can be minimized.

How People in Different Roles can Prepare Children for Court	
Attorney for the Child	The attorney for the child makes certain the child is aware of the hearing and lets the child know they are entitled, but not required, to attend. The attorney is the point person for familiarizing the child with all aspects of the hearing, explaining what is going to happen, and determining the child's preferences and wishes so they can be taken into consideration.
Child Welfare Social Worker	The social worker is also a source of information and can answer questions about the purpose and expectations of the hearing. Discussing who will be in court, what the child will see, and what is expected of the child will help alleviate stress and provide a better understanding of what to expect.
Guardian ad Litem (GAL)	The GAL is a specially trained person appointed by the court who volunteers their time to investigate the facts of a case and make recommendations to the court on what is in the child's best interest. The GAL can be a resource and can share insight if they have a connection with the child.
Foster Parent	Foster parents should support the child and provide reassurance about the hearing, answer questions, encourage participation, and support the child's decision whether to attend court.
Child's Parents	Where appropriate, the child's parents can speak to the child about the hearing, answer questions, encourage participation, and support the child's decision whether to attend court.
Judge	The judge can request that children attend their court hearings and can ask why a child is not in court. It is not the responsibility of the judge to prepare the children for court, but the judge can determine if a child has been prepared for court and proceed accordingly.

Source: <https://fosteringperspectives.org/fpv17n1/supporting.htm>

Defining Quality Contacts



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

What Are Quality Contacts?

Definition

Quality contacts are . . .

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

Core Components and Characteristics of Quality Contacts

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

Quality contacts incorporate the following components:

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

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

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

Exhibit 1. Characteristics of Quality Contacts

Intentional and Purposeful	Goal Directed	Culturally Responsive	Respectful
Unbiased	Tailored	Developmentally Appropriate	Reflective of Critical Thinking

Why Quality Contacts Are Important

Good casework practice depends on quality contacts.

Good Casework Practice

Quality contacts provide important opportunities for caseworkers to:

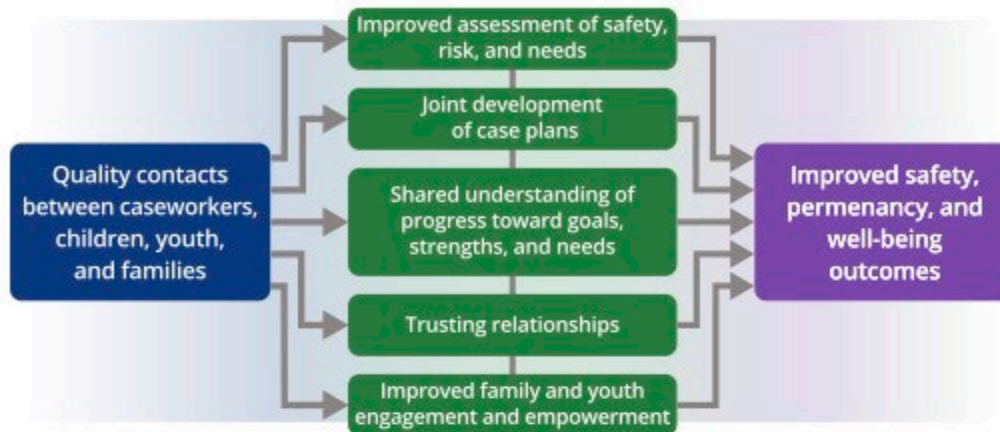
- Ensure child safety
- Make personal connections and develop trusting relationships with family members
- Observe children, youth, and families in their home settings (or other settings appropriate for the circumstances of the case)
- Work collaboratively with families to identify strengths, resources,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

Links to Positive Outcomes for Children and Families

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

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

Exhibit 2. The Impact of Quality Contacts



Federal Legislation and State Policies

Federal legislation¹ establishes State requirements for quality contacts in child welfare. The Child and Family Services Improvement Act of 2006, Public Law (P.L.) 109–288, requires each State's plan for child welfare services to describe standards for the content and frequency of caseworker visits for children and youth in foster care. The law specifies, **at a minimum**:

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

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

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

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

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

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

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

Common Challenges Affecting Quality Contacts

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

CFSR Findings

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

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

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

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

Factors That May Affect Quality Contacts

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

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

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

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

Key Phases and Activities in Quality Contacts

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

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

Exhibit 3. Key Phases of Quality Contacts



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

Exhibit 4. Key Quality Contact Casework Activities

Quality Contact Casework Activities	
Before the visit	
Schedule	
<ul style="list-style-type: none"> Align visit frequency with national and State requirements and case circumstances. Consider the schedules of parents, resource parents, and youth/young adults in identifying the visit time. Consider the length and location of visits to support open and honest conversations. 	
Gather information and review	
<ul style="list-style-type: none"> Gather and review case documents, service plans, and related data and information. Review documentation of the last contact to ensure follow-up was completed. Make any collateral contacts with key individuals in the case (e.g., therapist, treatment provider, doctor, school personnel) to assess progress and concerns. 	
Plan and prepare	
<ul style="list-style-type: none"> Set a clear purpose and agenda for the visit. Identify issues and concerns to explore (with room for adaptation during the visit). Consider and plan for worker safety. 	

During the visit**Engage and collaborate**

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

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

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

Wrap up

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

After the visit**Document⁴**

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

Debrief

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

Follow up

- Follow up on commitments made and next steps.

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

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

Roles in Ensuring Quality Contacts

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

Exhibit 5. Roles in Ensuring Quality Contacts

Administrators	<ul style="list-style-type: none"> Set standards and policies for quality contacts. Build agency capacity. Review performance and introduce strategies for improvement based on identified challenges.
Program Managers	<ul style="list-style-type: none"> Monitor and support program staff in conducting quality contacts. Identify and address program barriers to quality contacts. Collaborate with IT, data, and CQI staff to promote system design and data collection that supports quality contacts.
Trainers	<ul style="list-style-type: none"> Help build staff knowledge and skills on conducting quality contacts.
Supervisors	<ul style="list-style-type: none"> Support caseworkers during all three phases of quality contacts. Discuss caseworker strengths and challenges in conducting visits, and promote critical thinking skills. Provide oversight to caseworker documentation of visits.
Caseworkers	<ul style="list-style-type: none"> Plan and conduct quality contacts. Engage children, youth, parents, and resource parents. Document key information. Work together with supervisors to enhance skills.
Children and Youth	<ul style="list-style-type: none"> Express thoughts, concerns, and needs. Partner in age appropriate decision-making and planning. Contribute to agency efforts to improve quality contacts.
Parents	<ul style="list-style-type: none"> Express thoughts and concerns related to their case plan. Partner in decision-making and planning. Contribute to agency efforts to improve quality contacts.
Resource Parents and Caregivers	<ul style="list-style-type: none"> Express thoughts and concerns related to child or youth well-being and needs, as well as their own. Contribute to agency efforts to improve quality contacts.
Information Technology Managers	<ul style="list-style-type: none"> Ensure information system makes relevant case information accessible to caseworkers, supervisors, and managers. Ensure that documentation of contacts reflects agency policies and practices.
Data and CQI Managers	<ul style="list-style-type: none"> Analyze, use, and share data to inform areas for improvement as part of the quality assurance and continuous quality improvement (CQI) processes.

Considerations for Building Capacity for Quality Contacts

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

1. Organizational resources

- Does the agency have adequate staff to meet frequency and quality standards?
- Do staff reflect the families served in the communities and speak the languages spoken in the community?
- Are caseloads, workloads, and responsibilities appropriate to enable caseworkers to conduct quality visits that meet State standards and promote positive outcomes? If not, what changes can the agency, supervisors, and caseworkers make?
- What additional resources do caseworkers need to support and enhance quality contacts?

2. Organizational infrastructure

- Does the agency have adequate policies and standards in place to ensure that caseworkers conduct quality contacts? Do policies and standards align with Federal guidance?
- Do practice guidelines support quality contact activities and documentation?
- What role do supervisors play in promoting frequent and quality contacts? How does the agency support supervision and coaching in these activities?
- Has the agency considered policies and mechanisms to support flextime or other accommodations for workers conducting visits during evening hours to avoid burn out?
- How does the agency monitor the quality and frequency of caseworker visits?
- How does the agency use data to inform and enhance contacts?
- What processes does the agency have in place to identify and address strengths, barriers, and challenges to quality contacts and improve effectiveness?
- How does the agency assess the impact of quality contacts on outcomes for children, youth, and families?

3. Organizational knowledge and skills

- Do caseworkers receive the right training and ongoing supports to understand policies and build skills necessary for conducting quality contacts?
- Do caseworkers have knowledge of the community, the culture(s), and the language(s) common to the community?
- Do supervisors have the knowledge and skills to support caseworkers?

4. Organizational culture and climate

- Does the agency have widespread understanding of the link between quality contacts, engagement, and positive outcomes for children, youth, and families?
- Does the agency culture support quality contacts?
- Does every level of the organization value quality contacts?


5. Organizational engagement and partnership

- How can the agency engage its State and community partners in supporting quality contacts?

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

Conclusion

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



Quality Matters
Improving Caseworker Contacts
With Children, Youth, and Families

To learn more about quality contacts and related Center for States publications and learning tools, visit the **Quality Matters: Improving Caseworker Contacts With Children, Youth, and Families** webpage at
<https://capacity.childwelfare.gov/states/focus-areas/foster-care-permanency/quality-matters>

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This product was created by the Capacity Building Center for States under Contract No. HHSP233201400033C, funded by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.



North Carolina General Statute Definitions

A **juvenile** is: 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.

- Emancipation is a legal proceeding whereby minors aged 16 and 17 become legal adults. To become emancipated the juvenile must petition the District Court for an order of emancipation.
- Marriage or enlistment in the armed services automatically causes emancipation.

A **caretaker** is: 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.

A **custodian** is: The person or agency that has been awarded legal custody of a juvenile by a court.

- A juvenile parent would be included in the definition of custodian.
- The definition of "caretaker" is interpreted to include extended step-relatives, such as step-grandparents, step-aunts, step-uncles, and step-cousins, when these relatives are "entrusted with the juvenile's care."
- "Entrusted with the care" is interpreted to be limited to situations where a relative has primary care and decision-making authority for the juvenile. In addition, a person "entrusted with the care" is a "person who has a significant degree of parental-type responsibility for the child." The "totality of the circumstances" must be considered when making a determination if someone is a caregiver and a temporary arrangement for supervision of a child is not equivalent to "entrusting a person with the care" of a child.

An **abused juvenile** is: Any juvenile less than 18 years of age who is found to be a minor victim of human trafficking or whose parent, guardian, custodian, or caretaker:

- 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.
- Uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior.
- Commits, permits, or encourages the commission of a violation of following laws by, with, or upon the juvenile: first-degree forcible rape; second-degree forcible rape; statutory rape of a child by an adult; first-degree forcible sex offense; second-degree forcible sex offense; statutory sexual offense with a child by an adult; first-degree statutory sexual offense; sexual activity by a substitute parent or custodian; sexual activity with a student; unlawful sale, surrender, or purchase of a minor, crime against nature; incest; preparation of obscene photographs, slides, or motion pictures of the juvenile; employing or permitting the juvenile to assist in a violation of the obscenity laws; dissemination of obscene material to the juvenile; displaying or disseminating material harmful to the juvenile; first and second-degree sexual

exploitation of the juvenile; promoting the prostitution of the juvenile; and taking indecent liberties with the juvenile.

- 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.
- Encourages, directs, or approves of delinquent acts involving moral turpitude committed by the juvenile.
- Commits or allows to be committed an offense under human trafficking, involuntary servitude, or sexual servitude against the child statutes.

Moral turpitude includes situations where a parent encourages a child to shoplift and does not intervene to stop the child from shoplifting; or situations where a parent encourages a child to sell drugs or sets child up as a "drug runner. Providing alcohol/drugs to a child or consuming alcohol with a child meets the definition of "neglect," not "moral turpitude."

An important note about this definition is that it includes the person who commits the act, as well as the person who allows the act to be committed.

A **dependent juvenile** is: A juvenile in need of assistance or placement because the juvenile has no parent, guardian, or custodian responsible for the juvenile's care or supervision or the juvenile's parent, guardian, or custodian is unable to provide for the juvenile's care or supervision and lacks an appropriate alternative childcare arrangement.

In approximately 85% of CPS cases, the maltreatment type falls under this definition of neglect.

A **neglected juvenile** is: Any juvenile less than 18 years of age who is found to be a minor victim of human trafficking, or whose parent, guardian, custodian, or caretaker does any of the following:

- Does not provide proper care, supervision, or discipline.
- Has abandoned the juvenile.
- Has not provided or arranged for the provision of necessary medical or remedial care.
- Or whose parent, guardian, or custodian has refused to follow the recommendations of the Juvenile and Family Team made pursuant to Article 27A of this Chapter.
- Creates or allows to be created a living environment that is injurious to the juvenile's welfare.
- Has participated or attempted to participate in the unlawful transfer of custody of the juvenile under G.S. 14-321.2.
- Has placed the juvenile for care or adoption in violation of law.

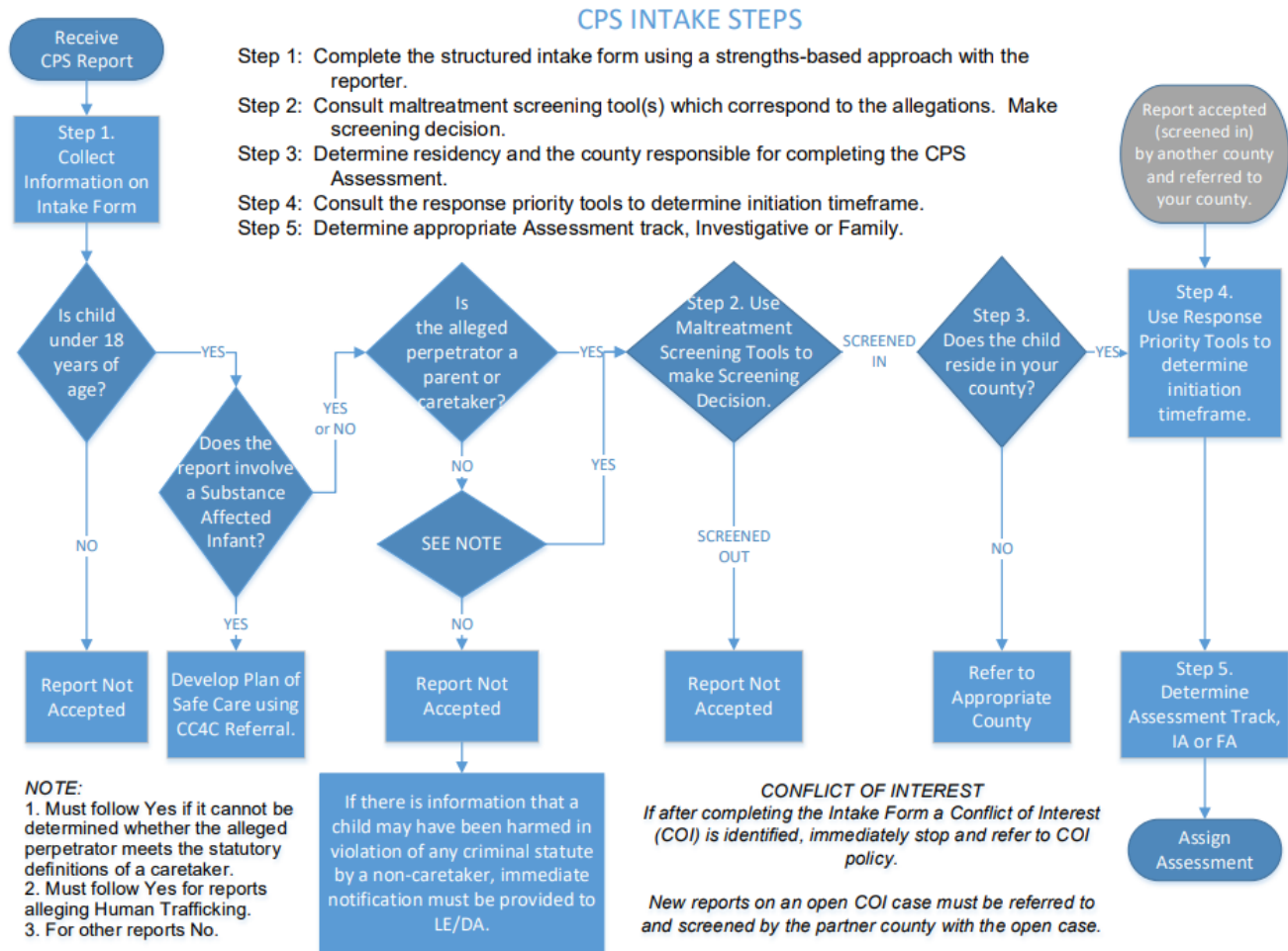
In determining whether a juvenile is a neglected juvenile, it is relevant whether that juvenile lives in a home where another juvenile has died as a result of suspected abuse or neglect or lives in a home where another juvenile has been subjected to abuse or neglect by an adult who regularly lives in the home.

Under the definition of neglect, remedial care is defined as those services, such as speech or physical therapy, that are necessary for the child's functioning, such as proper treatment for a hearing defect.

- Educational neglect does not become a DSS requirement for intervention until the school's efforts to assure attendance have been exhausted.

CPS Intake Steps

Intake Steps



Source: North Carolina Child Welfare Manual: Intake

Buzzwords Tip Sheet



Buzzwords: Moving to Behavioral Descriptors



What Are Buzzwords and Why Do They Matter?

“Buzzwords” are popular words, phrases, or jargon frequently used to quickly communicate ideas in a particular field or in popular culture. Buzzwords often are harmless in meaning and impact. However, they can be misleading and damaging when used to describe individuals and families in child welfare settings. This publication looks at buzzwords in the context of words or phrases commonly used in child welfare reporting and documentation that can be subjective or carry negative connotations, and offers strategies to minimize their negative impact.

Buzzwords can begin as early as an intake call with a reporting party’s description of a suspected child abuse or neglect case or a caseworker’s interpretation of a reported incident, and can be repeated throughout the life of a case. Commonly used statements in child welfare reporting like “The child was filthy,” and “The parents were hostile,” can form negative characterizations that may lead to unintended biases and can create barriers to effective engagement if left unchecked. Because word choices can influence perceptions, frequently repeated negative buzzwords may affect how a caseworker views the child and family during the assessment and may directly impact decision-making. Buzzwords may also lead to labeling that can be difficult for families and individuals to overcome.

Some Potential Consequences of Using Unchecked Buzzwords:

The use of negative, subjective buzzwords may have potential consequences, including:

- ▶ Incomplete information that may impact assessment and decision-making
- ▶ Assumptions that could lead to a limited understanding of child and family needs and barriers to effective engagement
- ▶ Case planning and services that might not match actual needs
- ▶ Creation of stigma or false perceptions that result in unnecessary investigation, removal, or delayed reunification
- ▶ Unsupported decisions that are not in the best interest of the child and can affect safety, permanency, and well-being

In addition to the potential consequences listed above, the use of buzzwords may lead to further stigmatization related to race, ethnicity, or marginalized populations in child welfare. Buzzwords associated with poverty, substance use disorder, mental illness, race, ethnicity, or gender can create labeling that leads to bias and disparities among certain populations. For example, research points to racial bias by caseworkers and reporters as one of four likely contributing factors in

disproportionality (Child Welfare Information Gateway, 2016). Understanding the potential bias effect of buzzwords used to describe groups or individuals can help child welfare agencies further understand potential factors related to disproportionality. Similarly, understanding the potential impact of buzzwords on engagement, as well as assessment and decision-making, can help child welfare agencies achieve improved outcomes around child welfare safety, permanency, and well-being.

A Success Story:

As a part of the 2010 California Disproportionality Project Breakthrough Series, the Alameda County Department of Children and Family Services implemented and tested a project to eliminate unintended biases connected to disproportionality of child welfare investigations involving children of color. The project, Hot Words (Asking Questions and Using Language that Does Not Result in Bias), found that the effect of “hot words” was profound as they moved from intake to the investigation narrative, court reports, and beyond. By raising awareness of “hot words,” intake workers were more successful in obtaining context that led to a clearer understanding of allegations and a reduction in referrals assigned to be investigated (Alameda County Social Services Agency, 2010).

Strategies to Interrupt the Use of Buzzwords in Case Documentation:

Translating negative, subjective buzzwords into more descriptive language—objective language that describes the circumstances based on seen or heard facts and observations (see below for examples)—can have an immediate impact on assessment and decision-making and lead to better outcomes. It can also result in obtaining additional information about a family’s circumstances that can help support assessment, decision-making, and individualized service delivery. The following strategies are designed to help child welfare workers and agencies increase awareness about the use and impact of buzzwords and take personal responsibility for initiating changes that can eliminate their negative impact.

- ▶ **Learn to recognize buzzwords.** Review the list below to help identify some of the most common buzzwords found in child welfare documentation. Consider creating a chart of commonly used buzzwords in your county or region to share with program managers and staff.
- ▶ **Know where buzzwords are commonly found:**
 - Intake/screening reports taken from child protective services (CPS) hotlines
 - Investigation reports and related documentation if intake reports are substantiated
 - Court reports related to child welfare investigations or juvenile delinquency cases
 - Case management documentation, such as mental and behavioral health assessments, progress reports, permanency plans, reports on wraparound services, and more
- ▶ **Be self-aware and take personal responsibility.** Be aware of the potential effect of repeating buzzwords in writing and verbally. When you see or hear a buzzword, ask

whether it could create unintended bias. Ask what the worker or reporting party means by the statement, or what evidence they have in order to provide context and clarification:

- Examples: “When you say he was unkempt, what does that look like?” and “Can you give me an example of when he acted hostile?”
- Engage families and children with open, respectful communication during assessment. Use age-appropriate language to communicate and understand responses. Ask clarifying questions to better understand labels and buzzwords used by the family or individual, and avoid repeating those labels in verbal and written documentation.
- **Recognize and translate buzzwords into more objective, behavior-based descriptions.** Objective, behavior-based language includes facts based on what is seen, heard, and observed. See Exhibit 1 for examples.

Exhibit 1

- Example 1:
 - Subjective statement: “Mr. Smith was hostile and resisted removing Bobby from the home.”
 - Intervening question: “What did Mr. Smith do to create that impression?”
 - Objective description: “Mr. Smith responded with a loud, frustrated tone when the case manager raised the possibility of removing Bobby from the home to stay with his aunt.”
 - Document: When mentioning the possibility of removing Bobby from the home to stay with his aunt, Mr. Smith responded with a loud, frustrated tone.
- Example 2:
 - Subjective statement: “The counselor said Bobby always comes to school filthy.”
 - Intervening questions: “What does he look like?” and “How often did that happen?”
 - Objective description: “The counselor said Bobby came to school wearing the same clothing several days in a row and wore an oversized, torn, and dirty jacket.”
 - Document: The school counselor reported Bobby wore the same clothing with an oversized, torn, dirty jacket several days in a row.
- Example 3:
 - Subjective statement: “A neighbor says Ms. Smith is crazy and unstable.”
 - Intervening question: “Did the neighbor give examples of what makes Ms. Smith appear crazy?”
 - Objective description: “The neighbor says Ms. Smith rarely smiles, and he has seen her break down crying and come outside wearing pajamas to yell at her children.”
 - Document: The neighbor observed Ms. Smith crying and yelling at her children outside.

- ▶ **Write descriptive case notes and assessments.** Record facts, specific behaviors, and concrete observations in case notes and assessments. Use nouns and verbs to describe behavior, and avoid subjective language by limiting the use of value-based adjectives (e.g., “hostile” or “uncooperative”) (National Resource Center for In-Home Services, 2015). See Exhibit 1 for examples of ways to translate negative buzzwords into more descriptive, factual observation.
- ▶ **Train and engage partners.** Hold meetings or trainings with staff, community partners, Tribal partners, and other relevant parties to discuss the use and effect of buzzwords and the importance of interventions.
- ▶ **Review buzzwords in past case files and use them as teaching tools.** Train staff on how language can affect assessments and decisions, understanding of individualized needs, and access to appropriate services. Training should also emphasize the long-term impact of labeling.

Commonly Used Buzzwords in Child Welfare

Exhibit 2 presents a list of buzzwords and phrases commonly found in initial hotline intake/screening and case documentation that are sometimes used in a subjective manner.

Exhibit 2

Abusive	Filthy/dirty	Prostitution history
Addict	Frequent flier (runaway)	Resistant
Afraid	Hot-headed	Scared
Aggressive	Hostile	Sexually exploited
Alcoholic	Hysterical	Substance abuse history
Angry	Incorrigible	Terrified
Assaultive	Isolated	Threatening
Belligerent	Limited	Traffic in home
CPS history	Loud	Trouble maker
Crazy	Marginal (financial)	Unattended
Criminal history	Mental health history	Uncooperative
Defiant	Nasty	Uneducated
Destructive	Neglect	Unfit parent
Disruptive delinquent	No resources	Unkempt
Drug user	Noncompliant	Unstable
Dysfunctional	Nonresponsive	Unsupervised
Emotionally disturbed	Not engaged	Violent
Explosive	Out of control	Volatile
Failure to rehabilitate	People in and out of home	Weird
Father is absent	Promiscuous	Whooping and whipping

* The buzzwords in Exhibit 2 have been adapted from the Alameda County "Hot Words (Asking Questions and Using Language that Does Not Result in Bias)" project in conjunction with feedback from various stakeholder groups.

* Please note that some of the words listed above could be used to objectively describe an incident or situation. It is important to avoid using these, and similar terms, in a subjective manner without providing further context.

Key Reminders

- ▶ Increase awareness: Buzzwords begin as early as intake/screening; therefore, it's important to "unpack" buzzwords from the initial hotline call.
- ▶ Avoid subjective interpretations of buzzwords. How you define certain buzzwords is often different than what is meant and how others define the same buzzwords.
- ▶ Take personal responsibility: Remember, we all have used buzzwords as quick descriptors. You can stop the continuation of negative, subjective buzzwords in written documentation and verbal communications when you see or hear them by asking follow-up questions to describe related behaviors, actions, or observations.
- ▶ Provide objective descriptions: Take the sting out of buzzwords by making sure your case notes, court reports, case consultants, and all communications are free from subjective buzzwords.

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This product was created by the Capacity Building Center for States under Contract No. HHSP233201400033C, and funded by the Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

Substance Affected Infant and Plan of Self Care

Child Welfare Resources for Substance Affected Infants & Plan of Safe Care

Substance Affected Infants & Plan of Safe Care
<p>The North Carolina Division of Social Services recognizes the unique needs of infants and their parents and caregiver when substance use is a factor in the family's ability to safely maintain the infant in their own home.</p> <p>The purpose of this document is to provide local county child welfare workers with resources and guidance on assessing the safety of substance affected infants (SAI) remaining in the care of their parents and caretakers and creating a plan of care that focuses on the unique needs of substance exposed families.</p>
Definitions - Terminology Glossary
<p>Substance Affected Infant:</p> <ul style="list-style-type: none"> • An infant has a positive urine, meconium or cord segment drug screen with confirmatory testing in the context of other clinical concerns as identified by current evaluation and management standard. • The infant's mother has had a medical evaluation, including history and physical, or behavioral health assessment indicative of an active substance use disorder, during the pregnancy or at time of birth. • An infant that manifests clinically relevant drug or alcohol withdrawal. • An infant affected by FASD with a diagnosis of Fetal Alcohol Syndrome (FAS), Partial FAS (PFAS), Neurobehavioral Disorder associated with Prenatal Alcohol Exposure (NDPAE), Alcohol-Related Birth Defects (ARBD), or Alcohol-Related Neurodevelopmental Disorder (ARND) • An infant has known prenatal alcohol exposure when there are clinical concerns for the infant per current evaluation and management standards. <p>Nighttime Parenting: A more appropriate term for what was once referred to as Safe Sleep. It acknowledges that there are differences in parenting at night and requires intentional actions by a parent to ensure safety during that time.</p>
Child Abuse Prevention Treatment Act (CAPTA) Requirements
<p>CAPTA and the Comprehensive Addiction and Recovery Act (CARA) requires healthcare providers to notify CPS of all substance affected infants. The notification itself is not an allegation of maltreatment and requires the assigned intake worker to complete a thorough screening to determine whether the notice meets the definition of abuse, neglect, and/or dependency.</p> <p><u>CPS INTAKE</u> During CPS Intake activities, the DSS-1402 is completed for all notifications and includes questions that are specific to SAI. The intake worker may need to support the healthcare provider in making the decision about the information that the healthcare provider can share. However, if this is a notification of a Substance Affected Infant (SAI), the Intake worker is still required to obtain as much information as possible in the completion of the</p>

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Substance Affected Infant & Plan of Safe Care
 Child Welfare Policy Manual Resources
 March 2021

Child Welfare Resources for Substance Affected Infants & Plan of Safe Care

intake form (DSS-1402). The intake worker should pay careful attention to the questions covered in Section VII under the sections of Substance Abuse and Substance Affected Infant.

Section I: Demographics

Basic demographic information is captured about the alleged victim child/infant. In instances where an infant is identified as a Substance Affected Infant (SAI) additional information should be gathered to assist the assessment worker in addressing safety for the SAI, the parents and other caretakers. Asking a question about the discharge date of the infant from the healthcare facility directly impacts the assessment of safety because remaining in the hospital is a safety measure.

Section VII: Abuse, Neglect and Dependency: Substance Abuse and Substance Affected Infant

Intake workers need to be aware of their own biases or cultural changes around societal acceptance of drug use, such as marijuana. Policy and the maltreatment tools found on the DSS 1402 guide intake staff not only in the collecting of information but in the screening decision itself. Intake staff must have knowledge of both policy and the 1402 to solicit the most information from a reporter. While speaking with the healthcare provider you must ask, "How does their substance abuse affect their ability to care for the child(ren)?" This can be found in the Substance Abuse maltreatment tool on the DSS-1402. Staff can also ask additional probing questions located in policy such as: "Is the parent using money to buy alcohol/drugs instead of providing basic necessities – car seat, crib, etc.?" This information helps to assess the level of drug/alcohol abuse and the impact on the child. Additional specific questions that should be asked must be related to the type of substance and its impact on the infant, if the child is having withdrawal symptoms or other medical needs, if there are toxicology screening results, and if the mother is receiving treatment related services. These types of questions help to identify the elements of a safety plan for the infant and their families.

This section also includes questions specific to SAI. When an infant has been identified as being affected by Fetal Alcohol Spectrum Disorder, a positive drug toxicology not related to Mother's prescribed and appropriate use of medications, or experiencing drug or alcohol withdrawal symptoms from a drug other than mother's prescribed and appropriate use of medication the report should be screened in. This list is not all inclusive. Child welfare staff should make plans to initiate substance affected infant cases prior to the child being discharged from the hospital to put an appropriate safety plan in place for the child. Please refer to the DSS-1402 for more detail on screening notifications for SAI.

If the decision is to screen out because this is a SAI notification by a healthcare provider and there are no maltreatment concerns documentation should indicate "*SAI Notification with no maltreatment allegations.*" This decision should only be made after the maltreatment tools have been consulted and a second level review has been done of the intake report. Intake workers should complete the CMARC referral prior to making a screening decision to ensure that confidentiality is not compromised.

CPS FAMILY AND INVESTIGATIVE ASSESSMENTS

Safety Planning in Substance Affected Infant (SAI) Cases

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When a report is accepted and the infant (0-6 months) is diagnosed by a medical provider as being a Substance Affected Infant (SAI) a Plan of Safe Care (POSC) must be developed prior to the infant being discharged from the hospital. Safety planning must include a needs assessment of the SAI, the parents/caretaker and other members of the family including any siblings in the home and how all identified needs will be addressed.

Open and transparent discussions must be held about any substance use disorder or mental health diagnoses, both past and present. Explain that the reason for asking this information is not to be punitive but to help create a plan that will keep their child safe. Talking with the family about any history with mental health or parental/family substance use disorder can help connect the family and child welfare with providers familiar to the family. These discussions with the parent and caretakers of the child/children must include:

- Discussions about how parents access illegal substances (this lets child welfare workers know how connected they are to the use of illegal substances)
- How often and under what circumstances do they use, known triggers– it is when you understand the “why” that you can help plan for the “how” to keep the child safe
- Discussions about stressors: new baby in the home, lack of sleep, financial challenges, stress on relationship, etc, and how these are impacted by substance use
- Plans for keeping the child/children safe knowing that the mother has recently used illegal substances (when the case is accepted and there is a positive toxicology report, there is no need to get the mother to admit use. The proof is already there, and it is best for the assigned worker to focus on future safety without getting caught up in the “denial dispute.”)
- Discussions about the significant risk of death for these children due to rollover deaths must be addressed in the POSC which is discussed below
- Discussions about safe sleep (just because a parent has a crib/bassinet does not mean the parent will use it and it is necessary for any workers who have contact with the family to have a conversation about the safety concerns of a substance using parent falling asleep while holding a child)
- Asking the question, “What would it look like if you protected your child as if you believed they could be at risk from your substance use?” (The answer should be used in the creation of the plan).

The NC Safety Assessment, DSS-5231, is designed to help county child welfare workers “assess whether a child(ren) is likely to be in immediate danger of serious harm which may require a protective intervention and to determine what safety interventions should be maintained or initiated to provide appropriate protection.” When using the DSS-5231, Part A: Factors Influencing Child Vulnerability, “Child is age 0-5” should be checked because this age group is unable to assist in protecting themselves. In Part B: Current indicators of Safety: At a minimum, Item number 1: 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 should be circled “yes” and “drug-exposed infant/child” should be checked. Based on the specific circumstances of the case, other safety indicators may also be present and should be marked and addressed accordingly.

In addition to the indicators of safety identified on the DSS-5231, safety planning for infants diagnosed as a SAI requires additional factors to be addressed in a POSC as the safety of the child is directly tied to the mother’s treatment plan and to the assessment of the ability of other caretakers to assist in the care and supervision of this infant (and any other children in the home). The POSC is developed with the parent/caretaker, family

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members, and any other community resources involved who can assist with ensuring the safety of the child. Each county child welfare agency may choose how the POSC is documented; however, documentation of a POSC must include each of the elements identified here.

Creating the Plan of Safe Care

Each part of the POSC listed below must be clearly documented and address the specific needs of the SAI and family.

Discharge Date:

It is best practice to initiate an assessment and begin the development of the POSC along with the Safety Assessment prior to the family leaving the hospital. There are instances when a SAI must remain in the hospital to overcome medical issues that arise from the mother’s use of substances during pregnancy. In those instances, the needs and services of the SAI addressed in the POSC should begin on the date of discharge from the hospital.

Household Members and Affected Family or Caregivers of the infant:

Identify the household members: the mother and father, and those who will have caretaker responsibilities of the SAI, also noting if those household members are identified as using substances. When families are unable to identify a non-using, appropriate caretaker who can ensure the safety of the child within the home, the agency must consider an alternative placement and that should be documented within the POSC.

Other Identified Participants

The POSC should also identify any other family, friends, or professionals participating in service delivery to the SAI and family. Their participation should be documented to include role/relationship to the family and what assistance or services they will be providing. This should include the primary care physician of the SAI and how they will partner with the family to address the needs of the SAI. Those providing substance abuse services to the caretakers should also be included. If a Temporary Safety Provider is needed, they must be included in the POSC along with the assistance they plan to provide. This is not an exhaustive list and workers should engage everyone who is partnering with the family to ensure that the SAI and any other children in the home are safe.

Family Strengths and Goals:

Talking with the parent(s) about what they perceive as their strengths gives the county child welfare worker a place to begin the POSC. Have the family identify their goals once discharged from the healthcare facility. Goals can focus on breastfeeding, housing, smoking cessation, parenting support, substance abuse and mental health treatment, and recovery.

- **Identified Supports:** Have the family identify their supports such as a stable living environment, family and friends, and employment.
- **Safety Factors and Protective Factors Present:** Have a discussion with the parent(s) and family about what they see as an indicator of resilience, social connectedness, knowledge or parenting and child development, social and emotional competence of children.

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Infant Safety Plan

Developing an Infant safety plan or POSC should clearly identify and document the parent/caretaker(s) response regarding:

- **Nighttime Parenting (rebranding from Safe sleep)**-Have the parent explain their efforts they will take to ensure safe nighttime parenting. Ensure that resources for nighttime parenting are provided and parent(s) understanding of nighttime parenting.
- **Follow-up medical care**-In partnership with the healthcare provider have a discussion with the parent(s) regarding the current and future medical needs of the infant. Document upcoming appointments, the plans for referrals, and parental understanding of the information presented.
- **Basic needs**-Assess the basic needs of the infant within the home such as housing, food, crib, and diapers. If there are identified basic needs missing, those needs along with the plan for resolving those needs should be documented. Any other needs that the parent(s) or caretakers have identified must also be documented along with the plan of resolution.
- **Other**-Any additional needs that are specific to the infant must be documented and addressed.

Documentation must include the parent(s) agreement with the plan.

Parent Safety Plan

Infant safety is tied to parental behavior. Substance use causes impairments in judgement and behavioral changes that can create increased risk to the infant. Talking with the parent(s) about their safety plan and the risks to their child should they return to using substances post hospitalization is meant to be preventive not punitive. Elements of a parental safety plan must include:

A plan that addresses infant safety in the event of a parent returning to active substance abuse. Elements to include: (1) Names, phone numbers, the address of safe people who will keep the child safe if the parent engages in substances. (2) the location of the bag of supplies ready for the child if someone needs to come and get the child that includes food/formula, diapers, extra clothing, medications, pediatrician's number.

A Parent Recovery Support Plan can include: (1) Identified support person who agrees to check on parent regularly and agrees to protect the child(ren) if necessary. (2) Attendance at recovery support groups. (3) List of community resources to support having basic needs met. (4) Identified list of people who are not allowed in the home when the child(ren) are present. (5) A list of reasons to remain abstinent and in recovery. (6) List of mental health, substance use disorder, and physical health resources available in the community. (7) Completion of a mental health and substance use disorder assessment and engagement in recommended services. (8) Information on how to access harm reduction programs and naloxone in their community.

- **Mental Health and Substance Use Disorder:** Addresses engagement with a provider for an assessment and/or treatment recommendations that include safety for the child(ren). Explain the purpose of a release of information and parent(s) should be encouraged to complete one.
- **Parent Medical Care:** Medical Home or Post-Natal Care Plan that the parent(s) will use.
- **Other-** Any needs that are specific to their ability to ensure the safety of the child(ren)

Documentation must include that the parent(s) have agreed to the plan.

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Services

The POSC must be developed with the parent(s) and family and include any needs for all members of the household. Ensuring that the parent(s) understand that plan as written should also include parent signature on the plan that indicates their understanding and agreement. The POSC is separate from the completion of the Safety Assessment but can assist in the development of the family's safety plan. It is important for the assigned worker to include all appointment dates and service timeframes for the purposes of monitoring follow through of the plan to include in the case decision process.

The POSC should also include a list of the organizations and points of contact for those services that the family is currently receiving such as FNS, Medicaid, and treatment providers. Any additional organizations and their points of contact that the family identifies as a need should also be included in the POSC.

Parental Agreement

The POSC must be developed with the parent(s) and family and include any needs for all members of the household. Ensuring that the parent(s) understand that plan as written should also include parent signature on the plan that indicates their understanding and agreement. The POSC is separate from the completion of the Safety Assessment but can assist in the development of the family's safety plan. It is important for the assigned worker to include all appointment dates and service timeframes for the purposes of monitoring follow through of the plan to include in the case decision process.

Case Decision:

In addition to the completion of the 5010, staff must also complete the Structured Decision-Making Tools. Starting first with case decision making requirements:

- Consider and document the specific caretaker behavior that resulted in harm to the child/children.
- Identify the effects of abuse, neglect, and dependency on the child(ren).
- Identify steps taken by the agency or the parents to protect the child(ren).
- Complete the NC Family Risk Assessment (DSS-5230) tool. When completing the DSS-5230, there is likely going to be a score of at least 3 on the Neglect scale (N1. Current report is for neglect or both neglect and abuse will be marked with a point, N6. Age of youngest child in the home < 2 would be marked with a point, and N9. Either caretaker has/had a drug or alcohol problem will be marked with a point) giving the family a moderate rating.
- Complete the NC Family Assessment of Strengths and Needs (DSS-5229).
- Review the POSC for compliance to determine what still needs to be addressed to ensure safety.

The score on the DSS-5230 needs to be reviewed in collaboration with the strengths and needs assessed on the DSS-5229 to address the areas that could be seen as protective factors as well as areas that can place the child at greater risk. Combining these tools as well as the questions to be asked at the time of case closure will help lead staff and supervisors to the correct case decision.

Case Planning:

When there are continued safety concerns and a case decision is made to send a family to In Home services or Foster Care the POSC becomes a central part of the foundation for the initial Family Services Agreement (FSA). The plan should consist of behaviorally specific objectives and goals for

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the parent/caretakers to address to keep their child/children safe. The plan moves past the incident and into future safety for the child/children. The child welfare worker should include those components of the POSC that allows a parent to demonstrate improvements in the safety for the child(ren). Documentation of work with the parents may be included in the FSA or any other documentation tool the county child welfare agency has developed if all the elements in the safety plan are included.

Additional Resources

Child Welfare – ACF

<https://www.childwelfare.gov/pubPDFs/safecare.pdf>

National Center on Substance Abuse and Child Welfare

<https://ncsacw.samhsa.gov/topics/parental-substance-use-disorder.aspx>

Casey Family Programs

https://caseyfamilypro-wpengine.netdna-ssl.com/media/SC_Infant-Plans-of-Care.pdf

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DSS-6191

Source: North Carolina Child Welfare Policy Manual Resources

DSS-6191

Purpose: Plans of Safe Care (POSC) are federally required for all infants born substance affected (SA). POSC for infants and families involved with Child Welfare supplement the NC Safety Assessment (DSS-5231). In POSC cases, at minimum, the Safety Assessment, Part A: *Factors Influencing Child Vulnerability*, "Child is age 0-5" should be checked because this age group is unable to assist in protecting themselves. In Part B: Current indicators of Safety: At a minimum, Item number 1: *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* should be circled "yes" and "drug-exposed infant/child" should be checked. This POSC document should focus on health needs and treatment for both mother and infant, developmental needs of the infant, parenting skills and attachment, and education for all caregivers on the special needs of a SA infant. [SAI and POSC Policy Link](#)

Name of Infant: _____ DOB: ___ / ___ / ___ County _____ Case # _____

Medical Facility: _____ Admission date: ___ / ___ / ___ Discharge date: ___ / ___ / ___

Name of Parent: _____ DOB: ___ / ___ / ___ Name of Parent: _____ DOB: ___ / ___ / ___

Household Members and Caregivers of the Infant:

Name	Age	Relationship to Infant	Name	Age	Relationship to Infant

Family Goals: (breastfeeding, housing, smoking cessation, parenting support, recovery)

Strengths and Protective Factors: (i.e., parental resilience, social connectedness, knowledge of parenting and child development, social and emotional competence of children)

Parental Substance Use and Mental Health History

Open and transparent discussions must be held about any substance use or mental health diagnoses, both past and present. The reason for asking this information is not to be punitive but to help create a plan that will keep the child/children safe. Talking about any history with mental health or parental/family substance use can help connect the family and child welfare with providers familiar to the family. These discussions must include:

How parent/s access substances:
How often and under what circumstances do they use, known triggers:
New stressors: new baby in the home, lack of sleep, financial challenges, stress on relationship, etc and how these are impacted by substance use:
Plans for keeping the child/children safe in the context of substance use, "What would protecting your child look like if you believe they are at risk from your substance use?" The focus is on future safety:

Infant Safety

Safety Element	Plan
Medical Care (Medical home, insurance, prescribed medications, specialists)	
Safe Sleep (Discuss high risk of death for these children due to rollovers, crib/bassinet safety and <u>specifically how it will be utilized</u> , discuss safety concerns of using parent falling asleep while feeding/holding, napping beside, infant)	

<u>Safe Sleep Policy</u>	
Nighttime parenting (Discuss the differences in parenting at night and the intentional actions to be taken by caregivers to ensure safe sleep)	
Basic Needs (housing, clothing, food, crib, bassinet, baby items, transportation)	

Parental Safety

Safety Element	Plan
<u>Relapse Plan</u> (Discuss how parent can identify the onset of a possible relapse and what are the needs of both the parent and child in the event of relapse, location of child's supply bag, including copy of POSC)	
<u>Recovery Support</u> (Identify supportive and non-supportive persons, who should and should not be around the child/children, recovery support groups, list reasons to remain abstinent and in recovery)	
<u>Mental Health and Substance Use Treatment</u> (Discuss providers and how parent will engage in services, current assessments, and recommendations)	
<u>Medical Care</u> (Medical home, insurance, prescribed medications, specialists, post-natal care needs)	

Safety Resources An important part of family and safety-centered practice is helping the family build and strengthen a safety network—made up of family, friends, and involved professionals. A safety network supports caregivers to develop and maintain a safety plan for the children even after professional services end or are no longer needed.

<https://policies.ncdhhs.gov/divisional/social-services/child-welfare/policy-manuals/modified-manual-1/child-welfare-resources-for-using-safety-circles-to-build-safety-networks-december-2021.pdf>

Name	Relationship	Address	Phone Number	ROI Completed by Parent (Y/N)

Family Is Currently Involved in the Following Services:

Service	Organization	Contact person/Phone/Email	ROI Completed by Parent (Y/N)

New Family Services Referred or Recommended:

Service (indicate referred or recommended)	Organization	Contact person/Phone/Email	ROI Completed by Parent (Y/N)

Additional Comments/Information:

Signature and Review

Signature of parent /caregiver: _____ Date: ___ / ___ / ___ Print name:

Signature of parent /caregiver: _____ Date: ___ / ___ / ___ Print name:

Signature of staff: _____ Date: ___ / ___ / ___ Print name:

Signature of Supervisor: _____ Date: ___ / ___ / ___ Print name:

Review by (Date): ___ / ___ / ___

Ongoing Review Dates:

___ / ___ / ___

___ / ___ / ___

___ / ___ / ___

___ / ___ / ___

Investigative 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.

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

Investigative Assessment and Family Assessment Approaches

Policy Distinctions

Investigative Assessment	Family Assessment
<p>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).</p>	<p>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).</p>
<p>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.</p>	<p>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.</p>
<p>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.</p>	<p>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.</p>
<p>Case decision within 45 days. The decision will be (1) substantiate or (2) unsubstantiate the report. <u>Substantiate</u>, the report and the perpetrator's name are entered in the Central Registry, and services are required. <u>Unsubstantiate</u>, services may be offered but are not required. (Such offers are rarely accepted.)</p>	<p>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 <u>services needed</u>, the report is entered into Central Registry, but no perpetrator is named, and services are required. If <u>services recommended</u>, services are voluntary. If <u>services not recommended</u>, services are not offered or required. If <u>services provided</u>, protective services no longer needed, any further services are voluntary.</p>
<p>Switching Approach/Track. A case assigned to the investigation track can be re-assigned to the Family Assessment track with supervisory approval.</p>	<p>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.</p>

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*

Similarities in Family Assessments and Investigative Assessments

- The safety of the child is the first concern during both assessments.
- Both approaches allow actions necessary to ensure the safety of the child (i.e., petitioning the court for non-secure custody order).
- Using a family-centered approach is the 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.
- Both assessments: the time frame for completion is “within 45 days”.
- Both utilize 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.

Assessments Involving Domestic Violence Policy

Excerpt from the North Carolina Child Welfare Manual: Cross-Function (May 2020) and CPS Assessments Policy (December 2021)

Purpose

Following are the six principles developed through the Child Well-Being and Domestic Violence Task Force to address the intersection of child safety, permanence, well-being, and domestic violence.

- Enhancing a non-offending parent/adult victim's safety enhances their child(ren)'s safety.
- Domestic violence perpetrators may cause serious harm to the child(ren).
- Domestic violence perpetrators, not their victims, should be held accountable for their actions and the impact on the well-being of the non-offending parent/adult victim and child victims.
- Appropriate services, tailored to the degree of violence and risk, should be available for non-offending parent/adult victims leaving, returning to, or staying in abusive relationships. These services should also be available for child victims and perpetrators of domestic violence.
- Child(ren) should remain in the care of the non-offending parent/adult victim whenever possible.
- When the risk of harm to the child(ren) outweighs the detriment of being separated from the non-offending parent/adult victim, alternative placement should be considered.

The primary focus in cases involving domestic violence is the assessment of the risk posed to the child(ren) by the presence of domestic violence. The goals of CPS interventions in cases involving domestic violence are:

- Ensure the safety of the child(ren).
- All family members will be safe from harm.
- The non-offending parent/adult victim will receive services designed to protect and support them.
- The child(ren) will receive services designed to protect, support, and help them cope with the effects of domestic violence.
- The alleged perpetrator of domestic violence will be held responsible for their abusive behavior.
- The incidence of child maltreatment co-occurring with domestic violence will be reduced.

The challenge in providing CPS interventions in domestic violence situations is to keep the child(ren) safe without:

- Penalizing the non-offending parent/adult victim and
- Escalating the violent behavior of the alleged perpetrator of domestic violence.

Definition

Domestic violence is defined as the establishment of control and fear in an intimate relationship using violence and other forms of abuse including but not limited to:

- Physical abuse,
- Emotional abuse,
- Sexual abuse,

- Economic oppression,
- Isolation,
- Threats,
- Intimidation, and
- Maltreatment of the children to control the non-offending parent/adult victim.

While victims and families may experience and be affected by domestic violence in different ways, there are still core aspects of domestic violence that are consistent across racial, socio-economic, educational, and religious lines:

- The primary goal of a domestic violence perpetrator is to obtain and maintain power and control over their partner.
- While domestic violence may “present” as an incident of violence or neglect, it is rather a pattern of abuse, which may include violent incidents.
- Domestic violence is not simply discord between intimate partners but rather a progressive, intentional, patterned use of abusive behaviors.

Legal Basis

The N.C.G.S. § Chapter 50-B also defines domestic violence according to the relationship between the parties and behaviors or actions that constitute domestic violence, as well as its available relief. North Carolina General Statutes also identify certain misdemeanor and felony criminal offenses that often occur in the context of domestic violence, such as assault, stalking, violation of a Domestic Violence Protection Order, domestic criminal trespass, harassing telephone calls, communicating a threat, and strangulation.

Prior to Initial Contact

Assessments with allegations of domestic violence, require activities that must occur prior to the initial contact with the family and include but are not limited to:

- Contact the Administrative Office of the Courts (or county Clerk of Superior Court) and/or complete a search of VCAP to determine if a domestic violence protective order exists; and
- Contact local law enforcement agencies and/or conduct a criminal record check on the alleged perpetrator of domestic violence.

Guidance – How you should do it

Each parent or caretaker is only responsible for their own actions to provide safe, nurturing care for their child(ren).

INTERACTION WITH NON-OFFENDING PARENT/CARETAKER

The Non-Offending Parent/Adult Victim Domestic Violence Assessment Tool (DSS-5235) contains scaled assessment questions and should be used to support the determination of safety and risk factors.

The inability to speak with the non-offending parent/adult victim alone may be an indication of the level of control the perpetrator of domestic violence exerts over the family, and an indication of high risk. The presence of relatives or friends may also affect disclosure and safety.

Information concerning resources and referrals to services should immediately be given to the non-offending parent/adult victim and child(ren) (as appropriate).

With cases involving domestic violence, the safety of the child(ren) is closely linked to the safety of the non-offending parent/adult victim. So, domestic violence cases also include a secondary focus on

the safety of the adult victim. The non-offending parent/adult victim of domestic violence is the expert at predicting the domestic violence perpetrator's reactions. Therefore, the development of the family safety plan or services agreement is driven by the non-offending parent/adult victim based on what they think they are capable of and willing to do to ensure safety for their child(ren) and themselves. A Safety Plan is a tool used by domestic violence advocates in providing services to non-offending parents/adult victims. The Personalized Domestic Violence Safety Plan (DSS-5233) contains suggested steps that may be useful for county child welfare agencies in:

- Safety planning with the non-offending parent/adult victim and
- Assisting in the development of service agreements.

Keep in mind that a perpetrator (or their legal representative) can subpoena the contents of a case file. For the protection of the victim, the county child welfare services agency should make decisions on where and how domestic violence safety plans are maintained.

To develop and monitor a coordinated services plan for every case with domestic violence, the county child welfare worker should:

- Seek out and utilize the consultation of a domestic violence expert throughout the life of the case.
- Communicate with a domestic violence perpetrator's probation or parole officer regarding any current abuse.
- Reach out and make connections with school social workers and teachers to gain information about the child(ren)'s day-to-day functioning.
- Work closely with Work First to create plans together. This is especially true when Work First may already be providing or can assist in referring a family for domestic violence services.

INTERACTION WITH THE CHILD(REN)

The Children's Domestic Violence Assessment Tool, DSS-5237, contains scaled assessment questions and should be used to support the determination of the safety and risk factors.

Every child reacts differently when exposed to domestic violence. Some child(ren) develop debilitating conditions, while others show no negative effects from exposure to violence. As a result, it is important to interview the child(ren) regarding their involvement and/or exposure to domestic violence, as well as their general safety and well-being. It is important to recognize that older children are more likely to minimize reports of parental fighting. Younger children may be more spontaneous and less guarded with the information they share. See the Impact on Children section of the Cross Function topic of Risk.

INTERACTION WITH THE ALLEGED PERPETRATOR

The Domestic Violence Perpetrator Assessment Tool (DSS-5234) contains scaled assessment questions and should be used to support the determination of the safety and risk factors.

Interaction with the alleged perpetrator of domestic violence provides the opportunity to observe and document behaviors relative to the allegations, both positive and "concerning." This observation supplements information obtained from:

- Police reports;
- Criminal records;
- Hospital/medical records;
- The child(ren); and
- The non-offending parent/adult victim.

It is important to note that the alleged perpetrator of domestic violence may attempt to:

- Present themselves as the “victim”;
- Charm the county child welfare worker;
- Gain control of the interview; and/or
- Deny any domestic violence, insisting that the relationship is “perfect.”

During interaction with the perpetrator, the county child welfare worker should:

- Focus on information from third-party reports such as law enforcement, medical providers, or the Administrative Office of the Courts.
- Follow up on legal accountability and/or treatment and other service referrals for the alleged perpetrator of domestic violence.
- Convey to the alleged perpetrator of domestic violence that based on what happened (citing as much information as possible without compromising confidentiality or safety of the child(ren), non-offending parent/adult victim, and/or the reporter) they will be required to take steps to stop the violence and ensure that the child(ren) are safe.
- Avoid debates and arguments with the alleged perpetrator of domestic violence. This is crucial. The focus of CPS is not to convince the alleged perpetrator of domestic violence to admit violent behavior but discuss how to ensure the child(ren)’s safety with them.
- Set limits within the interaction with the alleged perpetrator of domestic violence and document the behaviors that make setting limits necessary and their capacity to respect those efforts.

COLLATERAL CONTACTS

- It should be remembered that domestic violence usually occurs in private and collaterals may not always be aware of the violence.
- Collateral contacts being unaware of the occurrence of violence does not mean that it is not happening.

Forms

Children’s Domestic Violence Assessment Tool (DSS-5237), Non-Offending Parent/Adult Victim DV Assessment Tool (DSS-5235), DV Perpetrator Assessment Tool (DSS-5234), Personalized DV Safety Plan (DSS-5233)

Assessments Involving Human Trafficking Policy

Excerpt from the North Carolina Child Welfare Manual: Cross-Function (May 2020)

Human Trafficking

A child who is sold, traded, or exchanged for sex or labor is an abused and neglected juvenile, regardless of the relationship between the victim and the perpetrator.

Child welfare agencies must identify, document case records, and determine appropriate services for the child(ren) and youth who are believed to be, or at risk of being, victims of human trafficking. This includes child(ren) and youth for whom the agency has an open CPSA or an open CPS In-Home Services case, but who have not been removed from the home, child(ren) who are involved with Permanency Planning, and youth who are receiving LINKS services.

Definitions

Federal Law

The Trafficking Victims Protection Act (22 U.S.C. 7102) defines

“severe forms of trafficking in persons”:

- Sex trafficking in which a commercial sex act is induced by force, fraud, or coercion or in which the person induced to perform such an act has not attained 18 years of age; or
- The recruitment, harboring, transportation, provision, or obtaining of a person for labor or services using force, fraud, or coercion for subjection to involuntary servitude, peonage, debt bondage, or slavery.

“commercial sex act” is any sex act because of which anything of value is given to or received by any person.

State Law

N.C. G.S. 14-43.11 Human Trafficking

A person commits the offense of human trafficking when that person (i) knowingly or in reckless disregard of the consequences of the action recruits, harbors, transports, provides, or obtains by any means another person with the intent that the other person be held in involuntary servitude or sexual servitude or (ii) willfully or in reckless disregard of the consequences of the action causes a minor to be held in involuntary servitude or sexual servitude.

N.C. G.S. 14-43.10(a)(3) Involuntary Servitude – The term includes the following:

- The performance of labor, whether for compensation, or whether or not for the satisfaction of a debt; and
- By deception, coercion, or intimidation using violence or the threat of violence or by any other means of coercion or intimidation.

N.C. G.S. 14-43.10(a)(5) Sexual Servitude – The term includes the following:

- Any sexual activity as defined in G.S. 14-190.13 for which anything of value is directly or indirectly given, promised to, or received by any person, which conduct is induced or obtained by coercion or deception or which conduct is induced or obtained from a person under the age of 18 years; or

- Any sexual activity as defined in G.S. 14-190.13 that is performed or provided by any person, which conduct is induced or obtained by coercion or deception, or which conduct is induced or obtained from a person under the age of 18 years.

N.C.G.S. 7B-101(1) Abused Juveniles

Any juvenile less than 18 years of age (i) who is found to be a minor victim of human trafficking under G.S. 14-43.15 or (ii) whose parent, guardian, custodian, or caretaker:

- h) Inflicts or allows to be inflicted upon the juvenile a serious physical injury by other than accidental means;
- i) Creates or allows to be created a substantial risk of serious physical injury to the juvenile by other than accidental means;
- j) Uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior;
- k) 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 N.C.G.S. §14-27.2; rape of a child by an adult offender, as provided in N.C.G.S. §14-27.2A; second degree rape as provided in N.C.G.S. §14-27.3; first degree sexual offense, as provided in N.C.G.S. §14-27.4; sexual offense with a child by an adult offender, as provided in N.C.G.S. §14-27.4A; second degree sexual offense, as provided in N.C.G.S. §14-27.5; intercourse and sexual offenses with certain victims; consent no defense, as provided in N.C.G.S. §14-27.31 and N.C.G.S. §14-27.32; unlawful sale, surrender, or purchase of a minor, as provided in N.C.G.S. §14-43.14; crime against nature, as provided in N.C.G.S. §14-177; incest, as provided in N.C.G.S. §14-178 and N.C.G.S. §14-179; preparation of obscene photographs, slides, or motion pictures of the juvenile, as provided in N.C.G.S. §14-190.5; employing or permitting the juvenile to assist in a violation of the obscenity laws as provided in N.C.G.S. §14-190.6; dissemination of obscene material to the juvenile as provided in N.C.G.S. §14-190.7 and N.C.G.S. §14-190.8; displaying or disseminating material harmful to the juvenile as provided in N.C.G.S. §14-190.14 and N.C.G.S. §14-190.15; first and second degree sexual exploitation of the juvenile as provided in N.C.G.S. §14-190.16 and N.C.G.S. §14-190.17; promoting the prostitution of the juvenile as provided in N.C.G.S. §14-205.3(b); and taking indecent liberties with the juvenile, as provided in N.C.G.S. §14-202.1, regardless of the age of the parties; or
- l) 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;
- m) Encourages, directs, or approves of delinquent acts involving moral turpitude committed by the juvenile; or
- n) Commits or allows to be committed an offense under N.C.G.S. §14-43.11 (human trafficking), N.C.G.S. §14-43.12 (involuntary servitude), or N.C.G.S. §14-43.13 (sexual servitude) against the child.

N.C.G.S. 7B-101(15) Neglected Juvenile.

Any juvenile less than 18 years of age (i) who is found to be a minor victim of human trafficking under G.S. 14-43.15 or (ii) whose parent, guardian, custodian, or caretaker does not provide proper care, supervision, or discipline, 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 who has been placed for care or adoption in violation of the 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 because of suspected abuse or neglect or lives in a home where another juvenile has been subjected to abuse by an adult who regularly lives in the home.

Protocol – What you must do

Identifying a Victim of Human Trafficking

A child(ren) who is sold, traded, or exchanged for sex or labor is an abused and neglected juvenile.

Required Notifications and Verifications

Within 24 hours of accepting a report with allegations involving human trafficking or when the county child welfare services agency becomes aware that a child(ren) may have been trafficked, it must:

- Check the National Center for Missing and Exploited Children to see if the child(ren) or youth has been reported missing;
- Check the North Carolina Center for Missing Persons to see if the child(ren) or youth has been reported missing;
- Check with the appropriate local law enforcement agency to see if the child(ren) or youth has been reported missing/runaway;
- Notify the U.S. Department of Health and Human Services Office on Trafficking in Persons (OTIP) to facilitate the provision of interim assistance if the child(ren) is a foreign national. The county child welfare worker must contact OTIP Child Protection Specialists at childtrafficking@acf.hhs.gov or (202) 205-4582 and provide:
 - Child's name, age, location, and country of origin;
 - Location of exploitation and suspected form of trafficking; and
 - County child welfare worker's contact information or other preferred point of contact (e.g., the worker's supervisor).

Safety Considerations

County child welfare workers must collaborate with human trafficking victim organizations and advocates to address the unique circumstances and safety issues for the child(ren) who are victims of human trafficking.

Determining and Utilizing Appropriate Resources

When a county child welfare services agency has an open CPSA, CPS In-Home Services, or Permanency Planning case where trafficking of the child(ren) is suspected or confirmed, the county child welfare worker must provide appropriate information and resources to the family. Referrals to other agencies and resources are instrumental in the identification and screening of victims and the provision of ongoing services. These referrals must be made in accordance with the needs of the child(ren).

Role of the Parent, Guardian, Custodian, or Caretaker

In cases where the perpetrator of human trafficking is not the parent, guardian, custodian, or caretaker, the county child welfare worker must assess and address the parent's ability and/or willingness to keep the child(ren) safe.

Assessing Protective Capacities

Protective capacities are family strengths or resources that reduce, control, and/or prevent threats of serious harm from arising or having an unsafe impact on a child. Not all strengths are protective capacities. Strengths must have a particular element to be a protective capacity; an element relevant to mitigating the safety threat.

Protective capacities are strengths that are specifically relevant to child safety. They may include intellectual skills; physical care skills; motivation to protect; positive attachments; social connections; resources such as income, employment, or housing.

Protective capacities need to be both accessible and actionable. Actionable means that the caretaker will use these protective capacities on their own without external provocation.

The following chart provides a variety of strengths that may exist as protective capacities based on their ability to be used to mitigate case-specific safety threats.

Intellectual Skills

- Knowledge of child development as it relates to safety and well-being.
- Capacity and willingness to demonstrate empathy for the child's needs or condition.
- Ability and willingness to recognize and respond to a child's needs.
- Ability and willingness to defer one's own need (gratification) to meet a child's needs.
- Ability and willingness to control potentially harmful impulses related to child safety.
- Ability to understand the impact of his/her own actions which may result in maltreatment or active safety threats.

Motivation to Protect

- Caretaker is accepting in his/her role as caregiver to nurture and protect the children.
- Caretaker identifies and accepts the caregiving role.

Positive Attachments

- Caregiver is not in a co-dependent relationship.
- Caretaker is emotionally tied to healthy family members.
- Caretaker is not in a violent familial or social relationship.

Social Connections

- Caretaker interacts appropriately with neighbors in a manner that assures child safety and well-being.
- Caretaker interacts appropriately and cooperates with the child's school.
- Caretaker demonstrates appropriate boundaries with friends, family, and others.
- Caretaker behaves in a manner with others that ensure child safety and well-being.
- Caretaker behaves in a manner that does not frighten the child or other family members.
- Caretaker has friends that serve as social support to ensure child safety and well-being.
- Caretaker has close relationships with family members who support child safety and well-being.
- Personal or familial supports exist and are available to share caregiving tasks and responsibilities.

- Personal or familial supports are available to provide material and interpersonal resources.
- Caretaker can demonstrate reciprocity in their social network.
- Caretaker belongs to a church that provides spiritual and emotional support.
- Caretaker lives in a neighborhood where neighbors regularly socialize and share caregiving and other tasks.
- Caretaker is geographically close to supportive family members.

Resources

- Caregiver has employment that provides for the family's basic needs: housing, basic utilities, food, clothing, medical care, and transportation.

Community

- Neighborhood is safe from street crime, gangs, and drug dealing.
- The authority is held by legitimate public servants.
- Community has an interest in the well-being of families and children.
- Community is welcoming of diversity.

Health

- Health insurance coverage is available.
- Family has access to medical care.
- Family has adequate transportation to utilize medical services.
- Family has a primary healthcare provider.
- Family does not frequently switch doctors or hospitals for medical care.
- Family has access to dental care.

Mental Health

- Mental health services are available to children and adults.
- Mental health services are accessible (no long waiting lists)
- Transportation to mental health services is available.
- Prescriptions for mental health conditions are affordable

Child Care

- Child care is affordable.
- Transportation for child care is available.
- Child care is a safe stimulating and nurturing environment for the child.
- Parent interacts with the childcare provider.
- Parent trusts child care provider.
- Child care is licensed.

Employment

- Caretaker is employed.
- Caretaker does not frequently lose jobs.
- Caretaker's employment is legal.
- Caretaker's employment skills are adequate to maintain financial stability.

North Carolina Right to Enter a Residence Law

N.C.G.S. § 7B-302 Assessment by director; military affiliation; access to confidential information; notification of person making the report.

(h) The director or the director's representative may not enter a private residence for assessment purposes without at least one of the following:

- (1) The reasonable belief that a juvenile is in imminent danger of death or serious physical injury.
- (2) The permission of the parent or person responsible for the juvenile's care.
- (3) The accompaniment of a law enforcement officer who has legal authority to enter the residence.
- (4) An order from a court of competent jurisdiction