Children's Services
PRACTICE NOTES
For North Carolina's Child Welfare Workers
From the NC Division of Social Services and the Family and Children's Resource Program

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This publication for child welfare professionals is produced by the North Carolina Division of Social Services and the Family and Children's Resource Program, part of the Jordan Institute for Families within the School of Social Work at the University of North Carolina at Chapel Hill.

In summarizing research, we try to give you new ideas for refining your practice. However, this publication is not intended to replace child welfare training, regular supervision, or peer consultation—only to enhance them.

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INCREASING OUR FOCUS ON VISITS


When we give visits short shrift, we do so to the detriment of families.

The first round of federal Child and Family Services Reviews (CFSRs) found more frequent and higher-quality caseworker visits helped agencies do a better job of assessing risk of harm, assessing the need for alternative permanency options, identifying and providing needed services, and engaging children and parents in planning for their futures (NCSL, 2006).

This is cause for celebration, for it suggests an important connection between the frequency and quality of caseworker visits and the positive outcomes we seek.

It is also a wake-up call, because as a system we don't always do such a great job with visits. For example, in one national study 28% of parents receiving in-home services reported they had not seen a caseworker since the initial investigation; those who were being visited experienced long gaps between visits (Chapman, et al., 2003).

Why? Sometimes caseloads are so complex and so high that workers feel they have time to make only superficial contacts, or none at all. Daunting amounts of paperwork, staff turnover, and lack of resources can make it hard to prioritize visits.

Yet when we give visits short shrift, we do so to the detriment of families and children. We can do better.

To help you and your agency increase your focus on visits, this issue of *Practice Notes* offers some specific suggestions about working with parents and infants exposed to substances, enhancing monthly visits with children in out-of-home care, and responding to children when they ask "unanswerable" questions. ◆

What the CFSRs Tell Us about Visits

Results of the 2001 and 2002 federal CFSRs released by the US Department of Health and Human Services in 2004 demonstrated a significant relationship between caseworker visits and improved outcomes for children. When caseworkers were able to visit frequently with children in the child welfare system and their families, children were reunified with their families or placed into other permanent living arrangements in a more timely manner. Caseworker visits also were linked with:

- Providing services to protect children in the home, thus preventing removal;
- Managing the risk of harm to children;
- Establishing permanency goals for children;
- Achieving reunification, guardianship, and permanent placement with relatives;
- Preserving sibling connections while in foster care;
- Maintaining children's relationships with their parents;
- Successfully assessing needs and providing services to children and families;
- Involving children and parents in case planning; and
- Meeting children's educational, physical, and mental health needs.

Source: CWLA, 2005

CHILD WELFARE WORKER VISITS WITH CHILDREN IN OUT-OF-HOME CARE

When children enter foster care in North Carolina they are placed temporarily in the custody of their county department of social services (DSS). From the moment children enter care until they return home or go to another permanent placement, DSS agencies are responsible for ensuring these children are safe and receive the support and nurturing they need.

Federal law requires states to prove that 90% of foster children are visited monthly.

Evidence suggests that regular, high-quality visits with the child in his or her foster home are a great way for agencies to ensure they are living up to this responsibility. This article will describe steps being taken on the federal and state levels to enhance visits and suggest ways you and your agency can improve visits with children in care.

FEDERAL LAW

In fall 2006, Congress passed the Child and Family Services Improvement Act of 2006 (Public Law 109-288). Part of this legislation provided additional funding to support monthly worker visits to children in foster care, with an emphasis on activities designed to improve worker retention, recruitment, training, and ability to access the benefits of technology.

Along with this funding came a mandate: beginning October 1, 2007, states had to describe in their state plan standards for the **content** and **frequency** of worker visits with kids in care. In addition, PL 109-288 requires that by October 1, 2011, all states must be able to prove that 90% of all children in foster care are receiving monthly face-to-face visits with their workers, and that a majority of these visits are taking place in the residence of the child (e.g., in the foster home).

WORKER-CHILD VISITS IN NC

North Carolina's policy requires child welfare agencies to have at least monthly face-to-face contact with children in foster care. A majority of these visits must occur in the home where the child is placed. Policy also requires agencies to have monthly contact with placement providers about the child's needs and progress; at present contact with providers does not have to be face-to-face.

Although in the first round of the CFSRs North Carolina was one of only 10 states that received a "strength" rating in the area of worker visits with children (NRCFCPPP, 2006), our state began seeking to enhance practice in this area even before the passage of PL 109-288.

In 2006, the NC Division of Social Services launched a collaborative process to create a new tool to enhance foster care home visits. The development of the tool began with the formation of an advisory group comprised of representatives from private and public child placing agencies, the Division, its academic partners, and board members of the NC Foster and Adoptive Parent Association.

This advisory group helped create the **Monthly Foster Care Contact Record**, which has three main goals:

1. To focus discussion and attention on safety and well-being for children in foster care and their caregivers
2. To facilitate timely documentation and follow-up on identified needs, and
3. To support movement toward permanency for children in foster care.

All 100 county departments of social services in North Carolina were required to begin using the Contact Record

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QUESTIONS WORKERS CAN ASK THEMSELVES TO ENHANCE VISITS WITH FAMILIES

These questions, which appear in a 2006 report from the National Conference of State Legislatures, are designed to spark improvements in individual child welfare worker and agency performance. When assessing a visit, caseworkers might ask:

- Did I spend sufficient time planning the visit? Did I meet the goals established for the visit? What were the positive outcomes for the family associated with meeting my goals?
- What worked well during this visit, and how might I share my successful approaches with other agency staff? How will I track patterns in the success of specific approaches so that I might report those to my supervisor for possible incorporation into the agency's case practice procedures?
- What types of challenges did I experience during the visit? How might I have addressed those better? Are there specific areas in which I need additional guidance or training?
- What did I learn through the visit that needs to be addressed (family needs/goals and caseworker performance goals)?

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monthly as of July 1, 2008. The Monthly Foster Care Contact Record is intended to be used by foster care placement workers from North Carolina county departments of social services. County DSS agencies must use this tool at least once a month with each child in their custody. Agencies may use the tool more than once a month with a child if they wish.

TO LEARN MORE

To learn more about how to use of the Monthly Foster Care Contact Record and how to enhance monthly visits with children in foster care, take *Introduction to the Monthly Foster Care Contact Record*, a self-paced online course. To take the course, log in to your account on wwww.ncswLearn.org, select "Personalized Learning Portfolio" (PLP), select the "Online Courses," and click on the course name under "On Demand Online Courses."

The following sources will also help you learn more about visits with children in out-of-home:

- Caseworker Visits with Families, by Teija Sudol
  http://www.hunter.cuny.edu/socwork/nrcfcpp/info_services/Sudol_Info%20Pack_Caseworker%20Visits_July%202009.pdf
- Promoting Placement Stability and Permanency through Caseworker/Child Visits
  http://www.hunter.cuny.edu/socwork/nrcfcpp/

Ways Supervisors and Agencies Can Improve and Monitor Performance on Worker Visits

- Define clear expectations and policies around the ***frequency*** of social worker visits with children.
- Define clear expectations and policies around the ***quality*** of social worker visits with children.
- Assess and make efforts to align caseloads to allow adequate time for staff to visit children.
- Clarify guidelines on responsibility for visits when multiple staff or service providers are involved with the child.
- Define clear expectations and policies around documenting visits with children.
- Discuss the worker's visits with children during supervisor consultations.
- Conduct regular case reviews that target frequency and quality of social worker visits with children.
- Use data systems and reports to monitor performance on worker visits with children.

Source: MNDHHS, 2004

QUALITY WORKER VISITS

Quality child welfare worker visits in in-home services and foster care should be professional consultations that are:

- **Scheduled** to meet suggested national or prescribed state standards and the needs of children and families.
- *In the case of visits with children in foster care* **Mostly in the child's home** (i.e., the foster home) and at times convenient for children and foster parents.
- **Planned** in advance of the visit, with issues noted for exploration and goals established for the time spent together.
- **Open** enough to offer opportunities for meaningful consultation with children and parents.
- **Individualized**. For example, visits should include separate time for discussions with children and parents. This provides the opportunity to privately share their experiences and concerns and to ensure that issues that might not be disclosed when other family members are present are identified and addressed.
- **Focused on the case plan** and the completion of actions necessary to support children and families in achieving the goals established in their plans.
- **Exploratory** in nature, examining changes in the child's or family's circumstances on an ongoing basis.
- **Supportive and skill-building**, so children and families feel safe in dealing with challenges and change and have the tools to take advantage of new opportunities.
- **Well documented** so that the agency can follow up on commitments and decisions made during the visit.

Adapted from the Nat'l Conference of State Legislatures, 2006

PARENTAL VISITS AND INFANTS WITH PRENATAL SUBSTANCE EXPOSURE

How to enhance visits between the least prepared parents and the most challenging infants.

Child welfare professionals play a critical role in visits between parents and their children in foster care. Before visits they are often responsible for making the preparations. During visits they play multiple roles: ensuring the safety of the child, supporting parent-child closeness to facilitate reunification, and assessing parents' progress and the parent-child relationship (Haight, et al., 2001). Afterwards, they talk with parents about what went well and explore ways to make the next visit better.

Under the best of circumstances, this is a lot to manage. When the visits involve infants and both the parent and the child are affected by substance abuse, things are even more complex.

Indeed, in their 2006 article "*Facilitating Visitation for Infants with Prenatal Substance Exposure*," Caroline Long Burry and Lois Wright suggest that when it comes to visitation between parents and infants affected by substance abuse, child welfare workers are often faced with having the least-prepared parents working toward reunification with the most challenging infants.

Here's what Burry and Wright have to say about making visitation work in this delicate situation.

INFANTS WITH PRENATAL SUBSTANCE EXPOSURE

Prenatal substance exposure, or PSE, is a condition that affects children from birth to age 2 who have had prenatal exposure to drugs, alcohol, or other medications beyond what was prescribed. In the U.S., between 10% to 15% of all newborns (or up to 400,000 babies a year) test positive for drugs or alcohol at birth (Christensen, 1997; SAMHSA, 1993).

In general, infants with PSE are more difficult to care for than other infants. Specifically, they are at higher risk for developmental delays, premature birth, poor muscle tone, apnea, growth inhibition, and increased rates of Sudden Infant Death Syndrome (Bauer, 1999; Howard, et al., 1989; Tyler, et al., 1997). Due to PSE, these infants may be easily overstimulated, have piercing and insistent cries, experience difficulty feeding and being comforted, sleep lightly and irregularly, and tend to be irritable and fussy (Bauer, 1999; Zuckerman, 1993).

PARENTS OF INFANTS WITH PSE

If an infant with PSE is in foster care, chances are the child's mother is involved with alcohol or other drugs. This can make parent-child visits difficult. According to Burry and Wright, challenges faced by parents struggling with substance abuse include:

- **Relapses**. When parents miss scheduled visits due to substance use, their children worry about them, the parent-child connection can be undermined, and parents may come to doubt their ability to parent.
- **Denial and Guilt**. These can interfere with a parent's motivation to change and ability to learn and demonstrate enhanced parenting skills.
- **Timeframes**. When parents struggle with addiction, reunification and family stability can be difficult to achieve within mandated timeframes.
- **Environmental Challenges**. It can be hard to achieve and sustain reunification if parents live in neighborhoods where drugs and alcohol are readily available, substance abuse is accepted, and many people have active addictions.
- **Impaired Parenting Behaviors**. Research suggests that parents with addictions may have a harder time parenting safely and effectively due to lack of knowledge, lack of support, and high stress.

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IMPACT OF CARETAKER COCAINE ABUSE ON THE FETUS AND YOUNG CHILD

Although low birth weight and small head circumference are common in infants prenatally exposed to cocaine, there are other factors that can cause these things. Physicians have not been able to attribute anything seen at birth directly to maternal cocaine use.

That said, the following **neonatal effects** have been observed in infants born to mothers who used cocaine during pregnancy:

- Motor abnormalities
- Seizures-tremors
- Increased risk of SIDS
- Irritability
- Hearing defects

Typically, these effects get worse in the first 9 months and then abate by the time the child is 2 years old.

Long-term effects. An extensive literature review of early childhood outcomes shows that although there are effects, there is no consistent association between prenatal cocaine exposure and physical growth, developmental test scores, receptive/expressive language, motor scores (after 7 months of age), and parent/teacher reports on child behavior.

Source: Greenbaum, 2008

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TEACHING PARENTING SKILLS

To help overcome these challenges, Burry and Wright suggest sending the following messages to parents with addictions who have PSE infants:

- **Be reliable and consistent**. Help parents understand that because babies with PSE often have a hard time soothing themselves and transitioning smoothly from one emotional state to another, they have a special need for routines. Without them, infants' moods are more likely to quickly switch from a happy state to a miserable one without an intervening period of gradually increasing fussiness. Being consistent and reliable in caregiving promotes attachment and supports the development of self-regulation in babies with PSE.
- **Learn to read your child's signals**. Babies with PSE are easily overstimulated. Therefore it is important to teach parents to decipher their babies' signals about their readiness for play or receive other stimulation. Teach parents that yawning, sneezing, hiccuping, looking away, or stiffening can all be signals that their babies are ready for stimulation. When they see those signals, parents should stimulate one sensory pathway at a time by showing a picture book (visual stimulation), singing or playing a CD (auditory stimulation), or quietly massaging the babies' limbs (kinesthetic stimulation).
- **Respond quickly**. Infants with PSE can find it difficult to delay gratification; they should be attended to promptly. Teach parents it is impossible to spoil an infant and that meeting their child's needs nurtures them and fosters attachment that will help them develop properly and form healthy relationships later in life.
- **Tell other caregivers what works with your baby**. Use visits to help parents become the experts on their babies. As they gain confidence and competence, encourage them to share their knowledge with their child's other caregivers. For example, a mother might tell the staff of the daycare that will be caring for her child after reunification about her baby's needs and about strategies that help calm her child.

VISITATION AND PERMANENCY PLAN DECISIONS

The conditions for reunification should always be clearly defined in terms of parenting ability and child safety. Yet because infants with PSE are so vulnerable and their needs so significant, agencies must use particular care when making decisions about the child's permanency plan—especially if the parent has a history of substance abuse.

Visits with Parents in In-Patient Treatment

If parents are in an in-patient setting, visitation should be planned in conjunction with the treatment staff at that facility. Some hospitals have the ability to supervise visits and visits are considered part of the parents' treatment plan. Others do not and it is a case-by-case determination as to whether it is appropriate for you to bring the child to the facility. As parents exhibit a level of recovery and begin managing their symptoms, you should consider the length and frequency of the visits depending on the amount of stress a parent can successfully handle. Monitoring the parent's progress and compliance in treatment will help you determine when to make changes to the visitation plan (FCRP, 2007).

For this reason, Burry and Wright suggest workers use the following questions to enhance decision making about reunification of infants with PSE:

- Has the parent realized and acknowledged the effect of substance abuse on himself or herself and the child? The parent's ability to keep the child safe cannot be accurately assessed without asking this question.
- Has the parent demonstrated the parenting behaviors required to meet the baby's needs? During visitation, has the parent shown that he or she can and will provide adequate care for the baby on his or her own, without supervision?
- How might relapses affect the quality and consistency of the parenting this infant will receive after reunification? If relapses occurred during the period of visitation, how did the parent handle them?
- How stable is the parent's recovery?
- Does the parent have sufficient supports place, should a relapse occur? During the treatment period, did relatives and other support people show that they will take appropriate action to keep the child safe if the parent experiences periods of relapse or instability?

Workers can use these questions as a guide as they monitor visits. Their answers to these questions, combined with input from others involved in treatment and visitation (e.g., foster parents, addiction counselors, etc.) can help agencies reach appropriate permanency plan decisions for infants with PSE and their families. ◆

Facilitating Visitation for Infants with Prenatal Substance Exposure, by Caroline Long Burry and Lois Wright, is available in the journal *Child Welfare*, 85, pp. 899-918. <www.cwla.org>.

PRACTICE UPDATE: USING DATA TO ENGAGE NEW PARTNERS

In May 2009, we told you about beginning efforts by Pitt County Department of Social Services to use its data to engage community partners in its foster care program. Since that time, Program Manager Margaret Dixon and her team have created a Community Action Team that is taking their program into exciting new territory.

Here's how it's happened. After a preliminary meeting with community partners last February, the Pitt County DSS team reviewed their own data in detail and considered their own experiences with children in care and foster families. In the process, they recognized the progress they've made in recent years in two key areas: reducing the number of children coming into care and decreasing the amount of time children spend in care. They also pinpointed three indicators they hoped to target for improvement:

- Increasing the use of kinship care
- Increasing placement stability, and
- Finding more homes for teens.

The DSS team realized that their community outreach effort needed to focus not only on recruiting more foster families, but also on supporting, training, and retaining those families already in the system.

"THE DATA HOOKED OUR COMMUNITY"

On April 28, 2009, Pitt County DSS hosted a day-long community event to engage key stakeholders. They shared "the good, the bad, and the ugly": the areas of progress for children and families involved in foster care and the areas where community help is needed.

"It really occurred to me that it was the presentation about the data that really hooked our community," Dixon said. "These are the true facts. We're all in this together. These kids are going to age out into our community, and we'll be using another pot of money to provide services for them if we don't meet their needs now."

The day also included a panel of three young women currently or previously in care. These women shared their stories and insights, in particular about the impact of placement with relatives, placement instability, and the myths and misconceptions about fostering teens. By providing a sense of the real lives behind the numbers, these young women galvanized the people in the room to take action.

Working in small groups, participants brainstormed a list of specific strategies they and their respective organizations could take to make improvements in the three selected indicators. At the end of the day, approximately 20 people signed up to be a part of the ongoing Action Team to implement the recommended strategies.

Since then, the Action Team has continued to meet, both as a large group and in smaller work groups focused on recruitment and retention. The team also sent surveys to former and current foster families to seek their input.

COMMUNITY CONTRIBUTIONS

Key community partners have played a major role in carrying out the team's goals. Michael Baldwin, from WITN-Channel 7 in Greenville, is working with the team on a weekly spot about DSS for the local news. Janice Jacobson of the Adams & Longino public relations firm has worked with the team to develop a logo, motto, DVD, and other marketing materials to build continued community support and involvement. Action Team members with technical savvy are in the process of helping DSS develop a website for this effort, which will be entitled "Under Our Wings."

But that's not all! Pastor Rodney Cole of the Church's Outreach Network has led an effort in partnership with DSS to establish a One Church, One Child program in Pitt County. One local church already sent in an unsolicited $1,000 donation after reading about the team's efforts in the newspaper. The owner of a local day care center not only agreed to donate space for MAPP classes, but also offered to pay his staff to provide child care for the evening meetings.

"I've been so pleasantly surprised at the support we've received," Dixon says. "I've just been amazed." To other agencies who might feel alone in meeting families' needs, Dixon says, "You won't know until you ask. Tell your community partners what you need. We all have an investment in the success of these children. These are the community's children, not just DSS's."

FORUM FOR SUPERVISORS: WORKING WITH SUBSTANCE ABUSING FAMILIES

Join us for a 90-minute **webinar** for supervisors from county DSS Work First and Child Welfare programs on January 21, 2010 from 10:30 a.m. – 12:00 p.m. Topic: case planning and supervision with substance abusing families.

Registration opens December 14 and closes January 8. To register, log in to wwww.ncswLearn.org, select Personalized Learning Portfolio (PLP), and select the Webinar option. To suggest a specific substance-abuse related question you'd like the webinar to address, contact Vilma Gimenez at vgimenez@email.unc.edu.

WHAT TO DO AND SAY WHEN A CHILD ASKS AN UNANSWERABLE QUESTION

by Rose Marie Wentz, MPA (Reprinted from Permanency Planning Today, Summer 2008)

A 7-year-old child just placed in care asks, "When do I get to go home?"

A caseworker is talking to a 15-year-old about permanency and asks the young man if he wants to be adopted. He quickly says, "NO" and walks out of the room.

* * * * * * * * *

It is not always easy to talk with a child who is in care, especially when the child asks questions that cannot be easily answered or resists talking to the worker. We know that having high quality worker/child contact will help a child be safe and reach timely permanency and will provide the worker with an opportunity to assess the child's well-being. Here are some suggestions on how to address tough questions.

When can I go home?

Assure the child that the adults are working to make that decision and the child does not have to be responsible. Young children often believe their actions control adults and thereby need to be reassured on this point.

Think about the connection issues that home represents and ask the child questions about those connections on visits, such as: *Who would you like to see? Who do you miss? Can you draw me a picture of your house? What makes it a safe, fun, or happy place? What would make where you live right now feel more like a home to you?*

Avoid giving the child a long description about the legal timelines or failing to answer the child because you cannot provide a specific date. By exploring the child's view of home, time, and what the child wants, it is likely the worker can answer those questions and meet the child's need to maintain connections while in care.

I don't want to be adopted

Youth often feel that agreeing to adoption is being disloyal to their parents, or they are afraid to admit they want to be adopted for fear of being rejected. Ask questions such as: *Can you describe an ideal family that would support you having contact with everyone you love? What does "being adopted" mean to you? Is there anything you are afraid will happen if you are adopted?*

For additional resources and other ideas on how to talk to teens about families and permanency, visit: http://www.rglewis.com/families for teens key questions sept03.htm

What grade are you in? What is your favorite subject?

School age children think adults are kind of silly for asking these same questions over and over. It can also seem disrespectful to the child that you did not take the time to read or remember facts about the child. If the case is new to you, be sure to learn the basic information about the child before the contact. To learn about how the child is doing at school you may want to ask: *What would be the best/worst thing that could happen at your school? On a scale of 1 to 10, where 10 is the best day ever at school and 1 is the worst, what number describes the type of day you had? Why was it number X? What could happen that would make it one number better?*

If I am really good, can I go home?

This may be the child's way of bargaining, a stage of grief and loss. Children often have perceptions *continued p. 8*

SUGGESTIONS ON HOW TO CONDUCT AN INTERVIEW

- The worker should observe interactions between the foster parent and child (for children/youth of all ages). Ask the child and caregiver for some time to just observe rather than using the entire time for a formal interview.
- Workers should conduct some of their visit with the child out of sight and sound distance of others. This will allow for the child to share more openly.
- Visits should be conducted by a consistent worker, preferably the worker responsible for case planning and case decisions, to encourage the child to know and trust the worker.

Source: Wentz, 2008

- Workers will be more effective if they understand children's developmental ages; how children handle grief, loss, and separation; the special needs of abused and neglected children (such as parentified children); and the child's sense of time. To achieve the outcomes of safety, permanency, and well-being, we must develop a relationship with the child, which requires time and the skill to engage the child in a conversation at his or her developmental level. As one state manager said, the goal is that there be NO "drive by visits." It is not enough to meet the quantity measurement of one contact a month – it is critical to have **quality** interactions with the child.

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WHEN A CHILD ASKS AN UNANSWERABLE QUESTION *continued from page 7*

that what they did caused them to be placed in foster care. A worker may be tempted to answer, *"What you do does not make a difference as to when you go home."* Instead, use this as an opportunity to talk about the child's perceptions of foster care, whether the child feels responsible for what occurred, or if the child needs help handling grief and loss. *If you go home what would that be like? What would be the best thing? What might not be so good? It sounds like you are really missing your home. Tell me what you miss the most? What would you do on your first day back at home? What would you do differently when you are back at your home that would make things better? What would your parent do?*

Assessing nonverbal children can be even more difficult. The National Resource Center for Permanency and Family Connections suggests questions for the caseworker to use with the foster parents or relative caregivers. These include:

- What is it like for you to care for this child?
- What has been the effect on your family of having this child placed here?
- What did you expect it to be like?
- Describe who this child is.
- What about the child is easiest and most pleasurable?
- How has the child changed since coming to live here?
- How has the child adjusted to this placement?

These suggestions and many more for how to ask children, youth, and caregivers questions based on the developmental age of the child can be found at: http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/visitingModule3.pdf

OTHER RESOURCES

Following are other resources for how to have quality contacts with children:

- **Interviewing Children**. Rosemary Vasquez, LCSW, CASAnet Resources. http://www.casanet.org/library/advocacy/interviewing.htm
- **Interviewing Children with Disabilities**. Northern California Training Academy, University of California, Davis. http://humanservices.ucdavis.edu/academy/pdf/interview_children_disabilities.pdf
- **Talking to Teens in the Justice System: Strategies for Interviewing Adolescent Defendants**, Witnesses, and Victims. American Bar Association Juvenile Justice Center Juvenile Law Center, Youth Law Center. Lourdes M. Rosado, Editor. http://www.njdc.info/pdf/maca2.pdf
- **Worker's Role: Visits with Children**. Children and Family Services Division, Iowa Department of Human Services. http://www.dhs.state.ia.us/docs/02.08-Worker_Role_in_Visitation.pdf

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REFERENCES

Children's Services Practice Notes, vol. 15, no. 1 (December 2009)

Bauer, CR. (1999). Perinatal effects of prenatal drug exposure. *Clinics in Perinatology, 26,* 87-105.

Burry, C. L., & Wright, L. (2006). Facilitating visitation for infants with prenatal substance exposure. Child Welfare, 85, 899-918.

Chapman, M. V., Gibbons, C. B., Barth, R. P., McCrae, R. S., & National Survey of Children and Adolescent Well-Being. (2003). Parental views of in-home services: What predicts satisfaction with child welfare workers? *Child Welfare, 82,* 571–596.

Child Welfare League of America. (2005). CWLA 2005 Children's Legislative Agenda. Accessed December 1, 2009 from <http://www.cwla.org/advocacy/2005legagenda04.htm>

Christensen, D. (1997, November 6). Researchers take a second look at effect of cocaine use during pregnancy. *Medical Tribune,* Al.

Family and Children's Resource Program. (2007). In the Best Interest of the Child: Making the Most of Visitation [curriculum]. Chapel Hill, NC: Jordan Institute for Familes, UNC-Chapel Hill School of Social Work.

Greenbaum, J. (2008). *The impact of caretaker cocaine abuse on the fetus and young child* [seminar]. Presented at the American Professional Society on the Abuse of Children Colloquium, Phoenix, Arizona.

Haight, W., Black, J., Workman, C., & Tata, L. (2001). Parent-child interaction during foster care visits. Social Work, 46, 325-338.

Howard, J., Beckwith, L., Rodning, C, & Krospenske, V. (1989). *The development of young children of substance-abusing parents: Insights from seven years of intervention and research.* Zero to Three, 9(5), 8-12.

Minnesota Department of Health and Human Services. (2004). PIP TIPS: Item 13 visits with parents. Accessed December 1, 2009 from <http://www.dhs.state.mn.us/main/groups/children/documents/pub/dhs_id_027244.pdf>.

National Conference of State Legislatures. (2006, Sept.). *Child welfare caseworker visits with children and parents*. Washington, DC: Author. <http://www.ncsl.org/programs/cyf/caseworkervisits.htm>.

National Resource Center for Family-Centered Practice and Permanency Planning. (2006). *Promoting placement stability and permanency through caseworker/child visits*. New York: Hunter College School of Social Work. <http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/caseworker_child_visiting_curriculum.pdf>

Substance Abuse and Mental Health Services Administration. (1993). *Improving treatment for drug-exposed infants*. Washington, DC: U.S. Department of Health and Human Services.

Tyler, R., Howard, J., Espinosa, M., & Doakes, S.S. (1997). Placement with substance-abusing mothers vs. placement with other relatives: Infant outcomes. *Child Abuse and Neglect, 21,* 337-348.

Wentz, R. M. (2008, Summer). What To Do and Say When a Child Asks an Unanswerable Question. Permanency Planning Today. Accessed December 1, 2009 from <http://www.hunter.cuny.edu/socwork/nrcfcpp/downloads/newsletter/ppt-summer-2008.pdf>.