The following abridged interview with Angela Pittman of the Buncombe County Department of Social Services took place on Jan. 13, 2010, in her office. It was given with the express stipulation that individual DSS cases could not be discussed. Questions by reporter Nelda Holder are in italics.

*What's your title, Angela?*

My title is Social Work Program Administrator.

*How long have you been with Buncombe County?*

Well, I actually started my career here back in 1991 and left and came back. So I've been in the work now it's 17, 18 years. And I've been back with Buncombe County about five-and-a-half years.

*Where were you?*

As I said, I started my career here. I did a stint as a C.O.O. in Florida for a nonprofit, and then I was a DSS director for Swain County. And I also worked for the state for about five years. I've got sort of different viewpoints on all those jobs.

*Well let's start there. I'm very curious about North Carolina's structure. What are counties' not just responsibilities, but what are their obligations in terms of what's specific to them. What the state doesn't control, in other words. Where does the state fit, and where does the county fit?*

We are a state-supervised, county-administered system. So what that means if the state sets forth policy for us, and locally we implement in practice what those policies say. And all those policies are based on law, and there is federal guidance. The difference in us and a state [that] is a state-administered system is in other states, they would be employed by the state and here, as you know, we are local-government employees. So there's a difference. So that's the structure.

*So every county in the state basically operates under the same policy?*

Right

*Where do you get to differ as a county?*

Well, the state has tried very hard just in their guidance with us you know it's very difficult when you have a hundred counties to have consistency across those counties. And we rely on consultation from the state in order to make that happen. Counties meet together to discuss

what they're doing in certain areas to try to achieve that. So it's hard to pinpoint all of the differences. There's a real striving right now in the state to reach that place of consistency. But it is difficult with a hundred counties.

*And my understanding is that sometime in the last several years there was some kind of major change in how DSS works .....*

That was in 2001, and actually Buncombe County was one of the pilot counties. And some places call it "differential response," and we call it "multiple response." What we had done in the past is [for] every report of child abuse or neglect that we would see that met the statutory definition that we screen in, we treated the same way. We would go to the family's home without calling. We would interview the children alone in every situation regardless of what it was. And it was just much less family-centered and much less of a partnership at times. When multiple response came, it gave us the option, in all but the worst cases, to call ahead and say to the family I need to meet with you about such and such. It gives you the opportunity to interview a family together kids and parents. So it really did shift more toward that partnership versus pitting against each other.

*And where were you with this transition? Were you with the state then?*

I think at that time ... I think I was with Swain DSS at that time.

*So what's you thinking about that change?*

Well, I see it as a very positive change, and just to be honest with you I was a social worker. I've done the work. It's my philosophy that you can partner with families the way we used to do it depending on your skills as a social worker. I think this gives us greater permission to do that, so that it became more of a natural piece of everyone's practice versus, you know, with some social workers. I think it's a very positive change. It really gives you the opportunity to go into the situation saying: I don't know if what's in this report is true let's sit down and let's talk. And while I'm here, is there anything you need? Can I help connect you to food assistance? Is there anything you need for your kid? So it really opens that door to try to help people in a more holistic way.

*Can you walk me through receiving a complaint and tell me what happens?*

When we receive a report, we have an intake unit that takes those calls. They go through a structured intake, and the state has outlined for us what those questions are. And there are lots of questions. The questions

ask about strengths of the family, ask about why are you calling in, what are the concerns. Tries to really delineate what the issues are. Once we gather all of that information, there is actually a structured tool that we utilize that helps us figure out [whether] this [is] a report that falls under statute that we need to involuntarily insert ourselves into someone else's lives, or is it not. And we make a decision -- and its a two- level decision between a social worker and a supervisor we make a decision to take a report or not take that report.

*That's who makes the initial decision, is a social worker and ...?*

And a supervisor. Depending on what the allegations are, that dictates the time frame that we get out there. It can be from immediate to around 72 hours for neglect kinds of situations.

*What are the kinds of reports that you would not follow up on?*

Anything that does not fall within the statute. We are very, very careful about what we actually screen in because we don't want to unnecessarily disrupt families' lives if children aren't at risk. So there has to be allegations that directly impact the safety of the child. And you've got to be able to have the caller articulate that and our staff has to be able to ask questions to get to that.

*How many social workers have you got?*

In child services, we have about a hundred social workers.

*Is that up or down?*

It's been about the same for the last three years.

*And your service numbers, are they up or down?*

You mean the families that we serve ongoing? We've seen somewhat of a decline in that. And I believe part of that is because we want to really focus on those families that really need our help. And those families that really need our help, those situations are so much more complex than they used to be. It's just sort of a different thing, I think, on child's welfare. And especially with the economy that helps roll into that complexity.

*So you get a complaint and the social worker and supervisor decide whether to follow up on it. And the form what's that form?*

It's a structured- intake form. That is one thing that the state did because

when you look at 100 counties, in the past everybody had their own way of doing that. And they do a structured- intake tool and structured decision- making tool to try to help with consistency.

*So you decide that intervention is necessary, what process do you follow?*

We assign the case to a social worker. They then go out and depending on if it's an abuse report, we typically don't call ahead, but for most every other report we try to call ahead; we go and meet with the family, we talk with the parents and anyone that lives in the home, we talk with the children. We ask the parents for collateral contacts or anyone that would have information about their family. We ask them at that time if they would like to sit in with us when we call those folks. If it's a report around a mental health or a medical or some other issue where there's some other documentation out in the community (school), then we'll obtain documents related to that. If we believe let me back up. If it's a situation where a child has been hurt physically we will usually do a child medical exam with the parents' consent. And if we have further questions, we can do a couple of things. We can request that the child see a forensic evaluator that will do several sessions with the child and give us some recommendations.

*Explain forensic evaluator.*

The forensic evaluator meets with the child they understand from us what questions we're trying to answer, and then in three or four sessions with that child they try to obtain additional information to help us make decisions.

*Who are they?*

They're licensed professional forensic evaluators, and they have to be specifically in that program. And we also utilize Chapel Hill quite often in helping to assess and pull together, if we have lots of information from lots of different professionals, we ask for medical opinions or we ask for a psychiatrist (to see them). So we really do rely heavily on the expertise of people that are in their professions when we are investigating an issue such as that. Does that make sense?

*[Yes.] And the process with the parents when someone is ... are there specific forms, specific steps that you go through with the parents.*

During an investigation? Yes. Every social worker, and this is an ongoing thing, is always assessing the risk in that family. And there are forms that we look at and that we fill out. But the social workers are also trained to ask questions around that to really get at what are the risks and safety

issues for this child. If there is an issue identified, we do a safety assessment and we come up with a plan in partnership with the family to discuss what can we do to alleviate the safety issue so that the child remains safely in your home. So those are sort of ongoing things we're doing throughout the case, because things can change as you're working with families, as you know.

*What kind of ongoing training do you have for social workers? What are their requirements, or are there (any)?*

There are . . . a certain number of continuing educational requirements they have to have each year, and I believe that's 25. And the state has lots of different trainings; there are a lot of different specialty trainings out there, like specifically for forensic investigators. There's a very specific training around looking at those very serious situations.

*Such as?*

Interviewing, specifically interviewing alleged perpetrators and how you try to [solicit] that information. And we also have trainings that we just do here internally for our staff. We also have a person who does training for us internally and she does ongoing training, so around policy, around practice, she actually goes out with social- work staff as in the supervisors and helps them hone their skills. So we really have an emphasis on that.

*What's your breakdown in terms of social workers and supervisors? What does that look like?*

The state does have a requirement for that, and it is one supervisor to five social workers. And we meet that.

*And the supervisor is responsible for ....*

They're responsible to help direct the social workers. They're responsible for making two levels of decisions. Because the work is so important and it's very difficult and it's critical that the right decisions are made, we rely very heavily on two- level decision making. And sometimes it's more, but at the very least, two- level decision- making. So the supervisor's role is to know what's going on in their staff's caseload; they meet with them very frequently to talk about the families that staff are working with. They talk about progress that's being made, talk about safety and risk issues, talk about strengths of the family what are the protective capacities of the family. And then to talk about and make decisions around: Is this a family we need to work with ongoing. So their main role is that support and guidance about decisions and information.

*Now, when you are in a situation that requires a decision about whether or not to remove a child from the home, how is that decision made?*

Unless it is an on-the-spot emergency situation, we schedule a child-and-family team [meeting] with the family; we let the family know that they can bring whatever support that they would like to bring, whether that be the therapist they're seeing, a pastor, their mother. We all sit down and the safety issues and the risk issues are outlined from our perspective, and then we put all that on the table and then we talk about what that at this point, is it viable and is it safe for the child to remain in their home? What's another option? We always explore kinship options first, and that can be relatives of the parents or it could be a neighbor or a friend someone that child knows and that the parents are comfortable with and that DSS is comfortable with while we're working on addressing the risk issues with the parents. If that's not a viable option, then we would assume custody of the child. But during those team meetings it really is an opportunity for the family to put on the table any and every idea that they have. Because we only want it's our last resort to take a kid into DSS custody. We would much rather a child be with their own family if they can do so safely, or a kinship placement. In all of this, what I would say to you and the thing that runs throughout is we are legally mandated to insure child safety, so that's first and foremost our job. And to do that in the context of the family is critical, from our perspective, if at all possible.

*What is DSS empowered to do you have a complaint; you're doing an investigation what do you have the power to do with respect to requiring medical or mental evaluations of either the child or the family?*

In an investigative situation? Most of the time in an investigative situation, the focus is not on any evaluation. And I'm going to say most of the time because we can talk in generalities ... there's always specific situations. But the most common evaluation we use is the child medical exam or the child forensic evaluation in an investigation. Because we're trying to find information, we're trying to find out is there cause, is there other safety and risk issues to indicate to us we need to substantiate this situation or not. When you get into family in-home, which is where we work with families who do have a finding, or in foster care that's when we request parents to have an evaluation, because we believe that that can help us and help them try to figure out where we need to focus and where the safety and risk issues are coming from. If it's a case involved in court, normally the court has that authority and they can order that evaluation.

*So normally you wouldn't ask for an evaluation, but <u>can</u> you?*

We certainly could ask for that. I'm sitting here trying to go through my mind about anything I remember. We could ask for that, and if we felt that was critical to the situation and the parents didn't want to do that, and we truly felt that it was critical, then we would have to bring that in front of the court. ... We can't make them do that, in other words.

*But before you took a child, you could ask the Court for such an evaluation if that was important to making that decision?*

Absolutely.

*The Court involvement is the key in that aspect.*

Yes.

*Tell me some more about ... I think the term is family assessment.*

It goes back to the question you asked about the change in philosophy and multiple response. There are really two different routes that investigation can take. One is forensic evaluation, and that's abuse cases and some neglect cases if they're very, very serious, but mostly that's abuse cases sex abuse, physical abuse. And then everything else is a family assessment. And that's just a difference in approaches that we talked about. In a family assessment we call the family, we try to interview them together with kids, and that kind of thing.

*Now I picked this up in another state ... but the goal is reunification of the family if the kid's in custody?*

Yes.

*That is your goal?*

The goal is reunification, and we want to do that in 12 months or less. And we're charged with doing that by law, in 12 months or less.

*I didn't know that. Say more about that.*

Well, permanence family permanence is very important to kids, as we know. And so what we want to do when we do take custody of a child is as soon as possible help parents get connected to whatever they need in order to reduce that risk, get the kid connected to whatever the kid needs in order to move through what's happened, reconnect the family and get the child back in the home of course with things changed and its being safe within 12 months. I can send you some backup info to some of

these things.

*What is the standard or requirement, if there is one for contact between family and child when a child is in custody?*

When a child is initially removed from their parents, at that moment what we want to do is let both of them leave that meeting knowing when they're going to see each other next, and we try to do that very quickly unless there's a compelling reason to not do that and it's related to safety of that kid. And it really just depends on the need of the child and the age of the child. When we look at infants, certainly we do that with more frequency, but the expectation is that it's a very regular thing, that it's as frequent as it needs to be for that individual family. Because you want to keep those connections, and that goes back to the whole reunification piece within 12 months. You want to keep those connections going for that child (or) the people that that child's known.

*So in your overall caseload ... if you take custody of a child, kind of what's the breakdown in OK, we take custody in "X" number and this percentage goes back within a year, but this percentage either you get longer custody, or where does adoption come in?*

Adoption comes in if the family hasn't made progress within that 12 months. If they've made some progress and it's looking like they're going to be able to do what they need to do, we'll continue working with the family. If the family truly hasn't engaged at all and isn't making any progress, we do concurrent planning. There's always a Plan A and a Plan B for the child, because we don't want kids languishing in foster care. And I can get you those numbers. I don't have them right off the top of my head, but I can get you that information. What I will say is we've had really good success with our family in-home social-work staff in working with families, and they are able to keep -- the families that they work with, 97 percent of those remain safely in their homes or the homes of kin. The percentage of kids coming into care is comparatively small. Now, I'm sure it doesn't seem small for that child or family.

*What is your situation with foster care? Are you well supplied with homes? Do you need homes?*

We always need additional foster homes. Right now, I think we have around 95 to 98 homes right now, but we can always use more family foster homes. We just had a big recruitment event in November.

*And when a child is in DSS custody, what are the educational requirements? How quickly must they be if they're removed from their own school what's the educational requirement?*

Well, that is certainly one of our things that we focus on. And it's something that the federal government looks at, too. What I will tell you is we try everything possible to keep that kid in their home school, and try to keep the child placed in their home community, so that that piece doesn't change for them as much. You know, they're already removed from their family, so we want to change the least amount of things possible. If that is not possible, we immediately would get them enrolled in another school. So there should not be a lapse there because that piece is very important.

*And if you have a child who is home- schooled due to disability, what do you do?*

What we've done in those situations is we obtain and get whatever they need to continue that track, because it's not an option for them to go to school.

*And what kind of time frame would that be?*

The expectation would be the same time frame -- in a very timely manner. The federal government and the state government do what they call the Child and Family Services Review, and they look at safety, permanence and wellbeing for kids that we're involved with. It's really what guides our practice. Some of the key areas are education, health, mental health, medical and dental needs. There is a really especially when kids come into care focus on those things to ensure that they're getting what they need in those areas.

*So what would be your norm once again, if you have a particular child who's coming in under medical care, what would be your norm for getting them into medical care inside the custody framework?*

Well, we try anytime we bring a child into care, disabled or not, to keep that child connected if they have a medical home. We try to keep that child connected there. And we would do that very quickly. When children come into custody, we're required to have a physical exam done within a very short period of time. So that would sort of be the first step, but if there were any serious medical issues we would certainly address those immediately.

*And you say there's a physical exam within a short period of time?*

It needs to be scheduled within seven days of the child's coming into care. That's for a multitude of reasons. It's for the child's safety; it's also for us to figure out, you know, is there anything some kids haven't had

maybe a medical exam in some time.

*OK. I have some financial questions that I don't know if you have answers to. I would like to know what the normal cost is what the overall cost is for a child who comes into custody.*

Are you talking about the rate that we pay foster parents to care for children?

*Well, what I really want to know is two things: I want to know what you are paying out, to whom, and what you are receiving, from whom. How does this work financially?*

The state sets a rate for foster parents, dependent on the age of the child. For 0-5, it's $475 now this is for family foster homes; this isn't for any specialized care. Rates can increase if there are special needs of children. Children 6-12, its $581, and then children 13 and over, it's $634. And that pays for their room and their board, you know, the things that they need. There are federal funding streams that help reimburse counties for expenses for kids in care, depending on their situations. And there's also, if kids don't fall under that kind of eligibility piece, there's assistance from the state to help pay for that, which you know it's not insignificant. Kids, when they come into care, receive Medicaid, so their mental health and their medical needs are paid for by Medicaid. If you're asking me what's the overall cost of a kid that's been in care for six months, that's a more difficult question. And I could get you maybe some articles about that, but that's a more difficult question.

*I guess, when you say there are federal funding streams, I guess I want to know what you're able to pull in to cover costs.*

So you want to know the overall amount, cost of care, which I can try to find. And then the federal reimbursement, right? For those kids that do qualify for that piece . . . who are 4E eligible, they have to meet certain eligibility requirements depending on the homes that they come from and it's based on a lot of different things, which [are outlined in [the manual]. That reimbursement rate is 75 percent, and 25 percent county. And then if it's a child that isn't eligible for 4E funding from the federal government, it's a 50-50 split for payment with the state and the local government/and the county.

*And 4E funding applies to what?*

It applies to children .. let me make sure I'm saying this correctly; let me look in here. Federal 4E is based on the income of the family and it's based on where the kid was living at the time the child was removed.

*We're talking lower income, then?*

Yeah. There's a whole booklet that kind of asks you questions to guide you to determine that eligibility. ...

*Do you have any idea how many kids that you have in custody are on disability payment?*

I do not.

*Is that anything you track?*

Oh yes.

*And so I'm understanding that what you're saying is that if the child is on disability, your policy is to take that payment.*

Yes. Well, because it's there to take care of the child, and we have to take care of the child.

*And you mentioned something about Medicaid and use of Medicaid when a child is in DSS custody. When, and under what authority can you or do you use the family's medical insurance?*

Well, when kids are in care they're covered by Medicaid, so that's their primary insurance. (Leaves to check information.) . . . We do have a handful of kids who come into care who have private insurance. So private insurance pays first, and then Medicaid will pick up the rest of it, if there was any left over. ... But that's really rare.

*Oh, and the other piece of that if a child is in custody, do the parents have any say- so involving medical treatment?*

Unless, yes we try to work with the parents, especially if there's a medical home. We try to keep that child in that medical home. Unless there's a compelling reason, we certainly try to do that.

*Can you talk to me a little bit about therapeutic foster care what that constitutes? What's special about that?*

It's a higher level, obviously, of foster care. The foster parents who are therapeutic foster parents have additional training to understand and know how to be able to deal with additional behaviors of a child or additional situations. So it's just that knowledge base there's a certain number of hours that they have to have above and beyond the regular

family foster home hours. And they have to be licensed you know, approved by Medicaid and all that. They're usually with a child- placing organization who have low ratios of a program manager very much like our supervision and that program manager consults with and helps those families work with the kids in their home. So it's more intensive.

*How often do you run out of homes in Buncombe County, or do you usually able to keep kids here?*

We absolutely try our best to keep kids here. What we have to look at is what are the needs of the child, what are the skills and the strengths of the family, and then try to make the best match. If there are special needs around mental health, or medical issues, we would look for a family foster home that could work with that child.

*And how far away, conceivably, would you send a child?*

Again, it really depends on what that child's needs are. Unfortunately, when you look at some of the high levels of care or specialized needs, we're not always able to meet those in Buncombe County.

*And what kind of needs are those?*

Significant mental health issues or medical issues -- and when I say significant I mean above what we kind of usually see. We really look for a family, so that we want to make that initial match so that kids don't have to move. So we really look for a family who can meet their needs. But it is our desire to keep kids in, or as close to Buncombe County as possible. And again, it's one of those things that -- just from a practice perspective, for that kid -- makes sense if you're reunifying with family.

*If you're doing a family assessment and you decide that you're going to take custody of a child, how are parents notified of that?*

Well, again, we would ask the parents and whoever they wanted to bring in support to come to a child/family team meeting, and we would have that discussion there. So we would bring out what we think are the safety and risk issues, and we would ask the family, how can we work together to alleviate this, and in the meantime what can be the plan for your kids.

*And would they know, coming in there would you explain to them this is what we're going to talk about so bring whoever you need or want?*

Certainly. You know, that's one of the first principles of partnership with families, is that honesty piece. The other thing I would say is unless there's a compelling reason not to. For instance, if you thought [that] if

the family knew that you were going in that direction, would they run. You know something that had given you indications or something like that. ...

*All right tell me one more thing, 'cause you've been at this a number of years. Tell me anything you want to say -- let's put it that way about this business and what it requires of your staff.*

Wow. ... It's a very difficult job to balance, and look at, and work with families every day. To make sure that kids are safe. To make sure that we're partnering with families in the very most family-centered way possible. And I think for our staff, they are an extremely committed bunch of people that are passionate about this work and believe in the work and want to get the work .. want to get it right. They know what that takes, and they go above and beyond with families to assist them with their needs and to ensure that kids are safe and it's a very difficult job. We have an amazing community that participates in the protection of kids, and I think that's important.

*Say more about that.*

Well, we have lots of advocates in our community who work to implement strategies to prevent child abuse. We have Dr. Cindy Brown, who's our child medical provider, who's amazing. She does all of our child medical exams and is so committed to making sure kids are safe, but finding the truth, to make sure families aren't damaged. So I think the combination of the community along with our staff and the dedication that they bring is what helps us to continue to strive to always improve our practice. We will always, no matter what, be striving to improve what we do ... . And that's part of my job. I'm very passionate about that. ... I just kind of want to throw this in there because this has been critical for us. We have the lowest turnover that we've ever had, and that's been in the past three years. And part of the reason for that is because our commissioners and our county manager have been very dedicated to making sure we have competitive salaries and benefit packages, and that we really are able to recruit fully qualified, seasoned social worker staff. And it makes a real difference. That's knowledge in the case.

*That's really important.*

It's very important. And ultimately, you know the reason it's so important for me is it impacts families. You know if someone's knocking on my door, I would like for them to have experience and all the training that they can have and know how to work with me, versus someone without

that. And it gives you a better sense of assurance.

*I'm going to ask you some questions that I think you can't answer. If you can answer that, please do.*

OK.

*Have you had, or what would you do with a claim of medical neglect if you got a charge of medical neglect because the family did not have a primar- care physician for the child?*

(Pulls out manual.) What we would do is we would look at the structured intake form. And then more specifically about proper medical or remedial care. OK? So it gives you guidance, and it says: Is the parent or caretaker failing to provide proper medical care or remedial care? And it says here that this would include the refusal or failure to seek, obtain, or maintain those services necessary medical, dental, or mental health care to treat the child. It talks about what wouldn't constitute taking the report failure to provide child with immunizations or routine well- child care in and of itself doesn't.

*I really appreciate that. Let me ask that question a little differently, then. Are you familiar with any or many or some claims ever coming in, complaints every coming in, of medical neglect because of lack of a primary care physician. Is that anything you're familiar with?*

I can't say to you any numbers or what I would say is we have received some of those.

*And I would also like to know if staff has any training, or what your experience might be with two types of medical situations. One is working with Chronic Fatigue Syndrome. Are you aware of any special training for staff, or any kind of education in dealing with children with that diagnosis?*

What I would say to you to answer that and I really am trying to avoid any case- specific stuff, and I know that you know that our staff is only required to go to a medical training, one basic training, and then they have opportunity for additional training. So there's opportunity for that. And I'd like to leave it at that.

*OK. I would have the same question regarding a medical term called Factitious Disorder by Proxy.*

That's the same answer.

*Do you know if there is specialized training in either of those, like in the*

*additional training that social workers can do?*

We actually actually we've been working with Dr. Brown, who I mentioned before, to talk about that. She does a statewide group as well to talk about the need around that.

*Around both of those?*

Around the Fictitious Disorder.

*I think that's it. Thank you so much.*

Thank you.