NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

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

Participant Workbook
Week One

December 2025

PUBLIC KNOWLEDGE®
YOUR CATALYST FOR CHANGE

600 Airport Rd
Lakewood, NJ, 08701-5995
www.pubknow.com

info@pubknow.com
(800) 776-4229

This curriculum was developed by the North Carolina Department of Health and Human Services, Division of Social Services and revised by Public Knowledge® in 2024 and 2025.

Copyright © 2025 Public Knowledge®. All rights reserved. No part of this publication may be reproduced, distributed, or transmitted in any form without the written permission of the publisher.

Table of Contents

Instructions....9
Course Themes....9
Training Overview....11
Pre-Service Training: Core Topic Schedule....13
Pre-Service Training: Core Week 1 Day 1 Agenda....14
Pre-Service Training: Core Week 1 Day 1 Learning Objectives....15
Core Week 1 Day 1....16
Training Resources....16
Child Welfare Overview, Roles, and Responsibilities....17
North Carolina Department of Social Services (NC DSS) Practice Model....17
Child Welfare Roles and Responsibilities....18
Video: Centering Families....18
Goals of the Child Welfare System....19
Handout: How the Child Welfare System Works....19
Defining Safety, Permanency, and Well-Being....27
Handout: Child and Family Services Review (CSFR)....28
Core Values....33
Activity: Exploring Core Values....33
NC Practice Model Roadmap....35
Reflections....36
Individual Activity: Reflections....36
Practice Standards: Essential Functions....37
Essential Function: Communication....37
Handout: NC Practice Model Desk Guide....38
Communicating....47
Activity: Communicating: Mad Libs....47
Key Takeaways....48
North Carolina Social Worker Job Preview....49
Video: Everyday Impact: Child Welfare Worker Realistic Job Preview....49

Overview of DSS Structure and Positions 50
Practice Standards 50
Handout: North Carolina Worker Practice Standards 51
Activity: Understanding Roles and Responsibilities 52
Handout: North Carolina Child Welfare Job Responsibilities 53
Key Takeaways....57
Safety Focused Practice 58
Our Child Welfare Core Values 58
Defining Safety and Risk 59
Understanding Child Safety....60
Protective Capacity....61
Activity: What Does Safety Look Like?.... 64
Impact: C+B+I Formula 65
Child Maltreatment Defined 66
Risk Factors for Child Maltreatment....66
Handout: Risk and Protective Factors for Child Maltreatment.... 67
Signs of Abuse....69
Video: Signs of Abuse.... 69
Major Types of Child Abuse 70
Handout: What is Child Abuse and Neglect? 71
Handout: Cultural Healing Practices that Mimic Child Abuse.... 79
Activity: Recognizing Signs of Abuse 83
Bruising and Non-Accidental Injuries 84
Child Neglect....85
Developmental Impacts of Neglect.... 87
Neglect vs. Poverty 88
Key Takeaways....89
Pre-Work Reminder for Week 1 Day 3 90
Self-Awareness and Self-Reflection....90
Positive and Adverse Childhood Experiences, Trauma, and Resilience 90
Self-Reflection 91

Finding Your Why 91
Activity: Finding Your Why 91
Pre-Service Training: Core Week 1 Day 2 Agenda 92
Pre-Service Training: Core Week 1 Day 2 Learning Objectives 93
Core Week 1 Day 2 95
Overview of Child Welfare Services 95
Activity: Purpose of Child Protective Services 95
Legal Authority and Responsibilities 96
North Carolina Mandatory Reporting Law 98
Handout: North Carolina Mandatory Reporting Laws 99
Role of Mandated Reporters 100
Process for Reporting Suspected Maltreatment 101
Key Takeaways 102
Essential Function: Engaging 103
Engaging 103
Essential Function: Engaging 104
Handout: NC Practice Model Desk Guide: Engaging 105
Activity: Engaging Practice Standards 106
Core Value: Family-Centered Practice 107
Our Child Welfare Core Values 107
Underlying Beliefs of Family-Centered Practice 108
Strengths-Based Approach 110
Identifying Strengths 111
Strengths-based Strategies 112
Handout: Strengths-Based Principles 112
Activity: Strengths-Based Strategies 113
Key Takeaways 114
Values in Action: Practice Skills Learning Lab 115
Activity: Initial Face-to-Face Contact 115
Child Welfare Caseworker Introductions 116
Activity: Child Welfare Caseworker Introductions 117

Introductory Skills Practice: Communication & Engagement 118
Essential Function: Assessing 120
Assessing 120
Essential Function: Assessing 121
Handout: North Carolina Practice Model: Assessing 121
Activity: Assessing Practice Standards 122
Assessing 123
Video: Beneath the Surface 123
Assessing vs Assessment 124
Activity: Tools for Assessing 125
Safety Organized Practice and Structured Decision Making 126
Objectives of Safety Organized Practice (SOP®) 126
Handout: Safety Organized Practice 127
Balanced and Rigorous Approach 128
The Structured Decision Making (SDM®) System: A Comprehensive Framework 129
Handout: Structured Decision Making 129
Information Gathered 132
The Two-System Model of Thinking 133
Assessing Learning Lab 135
Activity: Engaging in the Assessing Process 135
Handout: Assessing in the Child Welfare Setting 136
Activity: Assessing: Has our perspective changed? 146
Initial Professional Development Goal 147
Worksheet: Initial Professional Development Goal 148
Key Takeaways 149
Pre-Work Reminder for Week 1 Day 3 150
Self-Awareness and Self-Reflection 150
Positive and Adverse Childhood Experiences, Trauma, and Resilience 150
Self-Reflection and Mindfulness Activity 151
Activity: Self-Reflection and Mindfulness 151
Pre-Service Training: Core Week 1 Day 3 Agenda 152

Pre-Service Training: Core Week 1 Day 3 Learning Objectives 153
Core Week 1 Day 3 154
Core Value: Trauma-Informed Practice 154
What is Trauma? 155
Video: What is Trauma? 155
Understanding the Brain: Hand Brain Model 156
Behaviors Associated with Trauma and an Offline Brain 158
Childhood Experiences: Positive and Adverse 159
Handout: Positive and Adverse Childhood & Community Experiences 159
Handout: Understanding ACES 160
Positive Childhood Experiences 162
Positive and Adverse Childhood Experiences (PACES) 163
Video: Positive Childhood Experiences 163
Resilience Scale 164
Skills Practice: Recognizing ACEs and PCEs 166
Handout: Evans Family Introduction 167
Trauma-Informed Practice 170
What It Means to Be Trauma Informed 171
Trauma-Informed Practice Defined 172
Key Takeaways 172
Learning Lab: Trauma-Informed Skills Practice 173
Skills Practice: Trauma-Informed 173
Debrief: Trauma-Informed Skills Practice 174
Key Takeaways 175
Essential Function: Planning 176
Planning 176
Handout: North Carolina Practice Model: Planning 177
Planning 178
Debrief: Planning for Others 178
Considerations for Child Welfare Practice 179
Consideration for Family Engagement 179

Professional Curiosity 179
Professional Curiosity 180
Intersectionality 181
Addressing Bias When Engaging Families 183
Considerations for Engaging Families 184
Essential Function: Implementing 188
Implementing 188
Handout: North Carolina Practice Model: Implementing 189
Activity: Milestones and Celebrations 190
Self-Reflection 192
Activity: Linked Notes 192
Handout: Tools to Calm Your Nervous System 193
Pre-Work Reminder 195
Appendix 196
Three Column Mapping 196
Pre-Work for Week 1 Day 3 197
Handout: Understanding ACEs 197
Bibliography of References 199
Day One 199
Day Three 205

Instructions

This course was designed to guide child welfare professionals through the knowledge, skills, and behaviors needed to engage with families needing 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 use this workbook electronically, the pages have text boxes for you to add notes and reflections. Due to formatting, blank lines will be "pushed" forward onto the next page if you are typing in these boxes. To correct this, when you are done typing in the text box, you may use the delete key to remove extra lines.

Course Themes

Core Training Themes

- Pre-Work e-Learning
- Child Welfare Overview, Roles, and Responsibilities
- North Carolina Practice Model
- Essential Function: Communicating
- Core Value: Safety-Focused
- Safety, Risk, and Protective Factors
- Identifying Child Abuse and Neglect
- Legal Authority and Responsibilities, Mandatory Reporting
- Essential Function: Engaging
- Core Value: Family-Centered Practice
- Introductory Learning Lab (Communicating and Engaging)
- Essential Function: Assessing
- Safety-Organized Practice (SOP) and Structured Decision Making (SDM)
- Assessing Learning Lab
- Core Value: Trauma-Informed Practice
- Trauma-Informed Practice Learning Lab
- Essential Function: Planning
- Considerations for Child Welfare Practice and Family Engagement
- Essential Function: Implementing
- Disproportionality in Child Welfare Services
- Indian Child Welfare Act (ICWA)
- Engaging Families Through Family-Centered Practice
- Narrative Interviewing with Learning Lab
- Crucial Conversations
- Engaging Families with Core Values and Essential Functions
- Involving Fathers, Non-Resident Parents, and Relatives with Learning Lab
- Collateral Contacts
- Using Family-Centered Practice to Engage Families Learning Lab

- Harm and Worry Statements
- Child and Family Teams (CFT) and CFT Meetings
- Child and Family Team Meeting Learning Lab
- SMART Goals with SMART Goals Learning Lab
- Quality Contacts with Learning Lab
- Ambivalence, the Change Process, and Conflict Management
- 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
- Caseworker Well-Being, Self-Care, Self-Awareness, 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 who 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 caseworker in North Carolina, including working with families throughout their involvement with the child welfare system. It will also 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 be required to complete homework assignments within prescribed timeframes.

In addition to classroom-based learning, learners will receive on-the-job training at their DSS agencies. During this training, supervisors will support new hires by completing an observation tool, coaching, and 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.

Pre-Service Training: Core Topic Schedule

Week 1:

- Child Welfare Overview
- North Carolina Practice Model
- Roles and Responsibilities
- Safety, Risk, and Protective Factors
- Introductory Learning Lab
- Assessing Learning Lab
- Safety-Organized Practice (SOP)
- Structured Decision Making (SDM)
- Trauma-Informed Practice

Week 2:

- Disproportionality in Child Welfare Services
- Considerations for Special Populations
- The Indian Child Welfare Act (ICWA)
- Family Engagement
- Narrative Interviewing
- Quality Contacts
- Structured Decision-Making (SDM)
- Safety Organized Practice (SOP)

Week 3:

- Developing Goals with Families
- Interviewing Skills
- Family Engagement
- Discord
- Crucial Conversations

Week 4:

- Intake
- CPS Assessments
- SDM Safety Assessment
- SDM Family Risk Assessment
- SDM Family Strengths and Needs Assessment

Week 5:

- In-home services
- Permanency

Week 6:

- Permanency
- Key factors impacting families
- Documentation
- Self-care and worker safety

Pre-Service Training: Core Week 1 Day 1 Agenda

Child Welfare in North Carolina Pre-Service Training: Core

Welcome and Introductions

Child Welfare Overview, Roles, and Responsibilities

What is our Why?

North Carolina Practice Model

BREAK

Essential Function: Communication

Roles and Responsibilities

LUNCH

Safety Focused

Core Value: Safety Focused

Defining Safety and Risk

Identification of Child Abuse and Neglect

BREAK

Identification of Child Abuse and Neglect, continued

Abuse

Neglect

Pre-Work Reminder

Self-Reflection

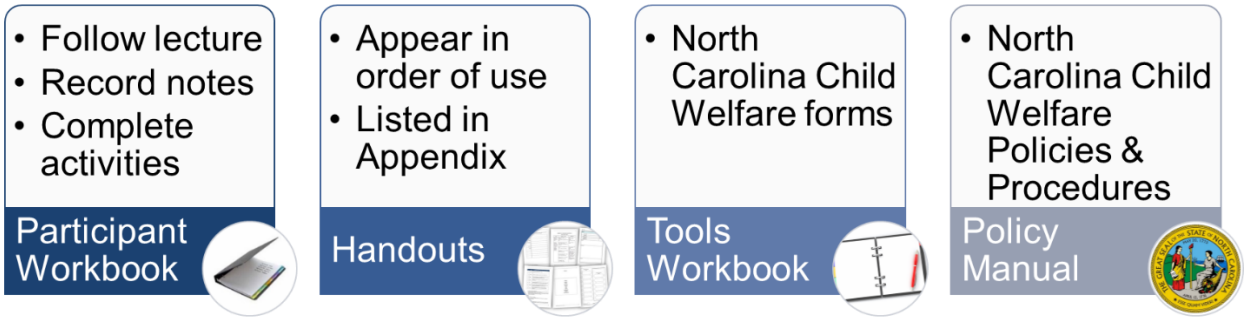
Finding your why

Pre-Service Training: Core Week 1 Day 1 Learning Objectives

Day 1
Child Welfare Overview, Roles, and Responsibilities
• Describe your role in supporting safety, permanency, and well-being outcomes for children and families. • Describe the responsibilities of various case management positions. • Explain your role as a child welfare caseworker. • Identify and define different types of child abuse. • Explain mandated reporting laws and when they are required to make reports of child abuse and neglect.
Safety Focused
• Distinguish between safety and risk when considering instances of abuse and neglect. • Identify and describe danger indicators and risk factors when working with children and families.

Core Week 1 Day 1

Training Resources



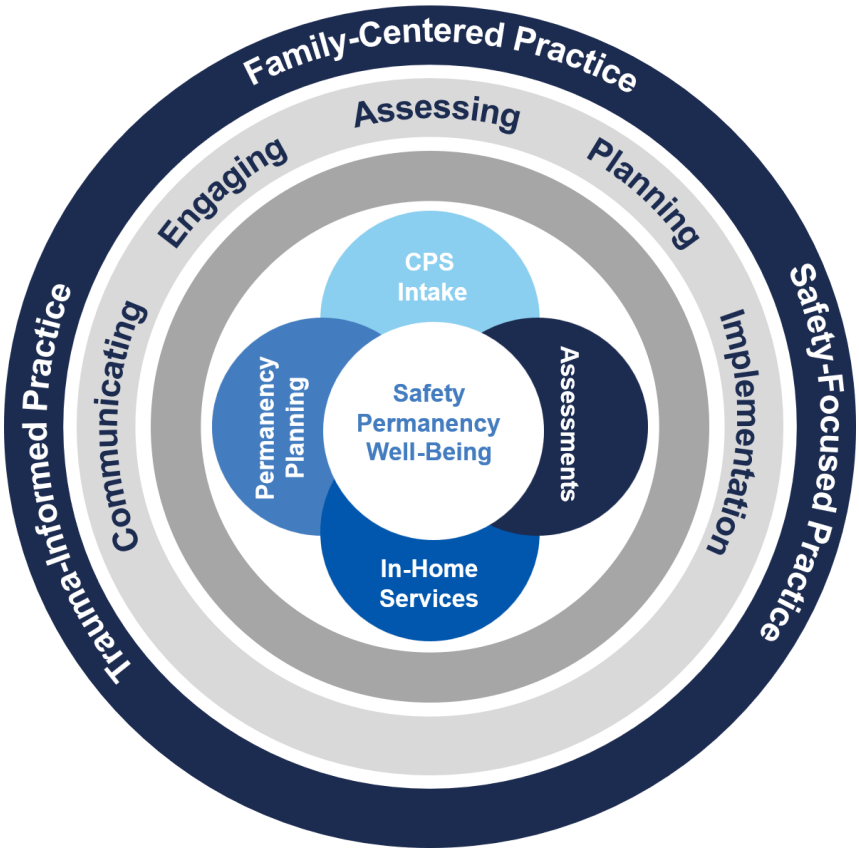
The participant workbook can be used electronically or printed. It is designed to help you follow in-class learning, offer activity instructions, and record notes. Whenever we have interactive exercises, like group discussions or activities, you will find directions for the activity and space to complete activity tasks in your workbooks.

Handouts or job aids will appear in the participant workbook in the use order. For example, if we are discussing North Carolina regulations, a handout of definitions and examples would appear directly after the page containing the slide image, followed by space for note-taking. Throughout the training, we will also direct you to the link for the North Carolina Child Welfare Policy Manual [https://policies.ncdhhs.gov/divisional-n-z/social-services/child-welfare-services/].

Use this space for notes

Child Welfare Overview, Roles, and Responsibilities

North Carolina Department of Social Services (NC DSS) Practice Model



The Graphic illustrates the North Carolina Department of Social Services (NC DSS) Practice Model

- The outer ring shows the Core Values: Trauma-Informed Practice, Family-Centered Practice, Safety Focused Practice
- The next ring shows the Essential Functions: Communicating, Engaging, Assessing, Planning, and Implementing.
- The center circle shows the goals of Child Welfare Services: Safety, Permanency, and Well-Being
- The four circles around the goals illustrate NC Child Welfare Caseworkers' roles in supporting children and families to achieve Safety, Permanency, and Well-Being: Intake, Assessments, In-Home, and Permanency Planning Services.

Pre-Service Training: Core is six weeks long. The first three weeks cover the foundational topics. In weeks four through six, we will discuss how to apply this foundation to our processes. See page 11 for more details about the Pre-Service Training: Core topic schedule.

Child Welfare Roles and Responsibilities

Video: Centering Families

Watch the Centering Families Video .

Notes

Goals of the Child Welfare System

Handout: How the Child Welfare System Works

How the Child Welfare System Works

The child welfare system is not a single entity. Many organizations in each community work together to strengthen families and keep children safe. Public agencies, such as departments of social services or child and family services, often contract and collaborate with private child welfare agencies and community-based organizations to provide services to families, such as in-home family preservation services, foster care, residential treatment, mental health care, substance use treatment, parenting skills classes, domestic violence services, employment assistance, and financial or housing assistance.

Child welfare systems are complex, and their specific procedures vary widely by State. The purpose of this factsheet is to give a brief overview of the purposes and functions of child welfare from a national perspective.

WHAT'S INSIDE

What is the child welfare system?

What happens when possible abuse or neglect is reported?

What happens after a report is screened in?

What happens in substantiated cases?

Summary

References

Appendix: The child welfare system

Child Welfare Information Gateway
PROTECTING CHILDREN ■ STRENGTHENING FAMILIES

Children's Bureau
An Office of the Administration for Children & Families

WHAT IS THE CHILD WELFARE SYSTEM?

The child welfare system is a group of services designed to promote the well-being of children by ensuring safety, achieving permanency, and strengthening families. While the primary responsibility for child welfare services rests with the States, the Federal Government supports States through program funding and legislative initiatives.

The Children's Bureau within the U.S. Department of Health and Human Services' Administration for Children and Families holds the primary responsibility for implementing Federal child and family legislation. The Children's Bureau works with State and local agencies to develop programs that focus on preventing child abuse and neglect by strengthening families, protecting children from further maltreatment, reuniting children safely with their families, and finding permanent families for children who cannot safely return home. For more information on child welfare legislation and policy, see Child Welfare Information Gateway's *Major Federal Legislation Concerned With Child Protection, Child Welfare, and Adoption*. For more on how child welfare programs are funded, see Information Gateway's Funding web section.

Most families first become involved with the child welfare system because of a report of suspected child abuse or neglect, which is also referred to as "child maltreatment." Child maltreatment is defined by CAPTA as serious harm (e.g., physical abuse, sexual abuse, emotional abuse, neglect) caused to children by parents or primary caregivers, such as extended family members or babysitters. Child maltreatment also can include harm that a caregiver allows to happen to a child or does not prevent from happening.

Each State has its own laws that define abuse and neglect, the reporting obligations of individuals, and the required State and local child protective services (CPS) agency interventions. In general, child welfare agencies do not intervene in cases of harm to children caused by acquaintances or strangers. These cases are generally the responsibility of law enforcement. (In those cases, criminal charges may be filed in court against the perpetrators of child maltreatment.) Some States authorize CPS

The Child Abuse Prevention and Treatment Act

The Child Abuse Prevention and Treatment Act (CAPTA), originally passed in 1974, brought national attention to the need to protect vulnerable children in the United States. CAPTA provides Federal funding to States in support of the prevention, assessment, investigation, and prosecution of child abuse and neglect as well as grants to public agencies and nonprofit organizations for demonstration programs and projects. Since it was signed into law, CAPTA has been amended several times, most recently by the CAPTA Reauthorization Act of 2010 (P.L. 111–320). For more information, see Information Gateway's *About CAPTA: A Legislative History*.

agencies to respond to all reports of alleged child maltreatment, while others authorize law enforcement to respond to certain types of maltreatment, such as sexual or physical abuse. To learn more about child maltreatment and State-by-State information about civil laws related to child abuse and neglect, visit Information Gateway's *What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms, Definitions of Child Abuse and Neglect*, and the State Statutes database. For data regarding child maltreatment as well as outcomes within the child welfare system, refer to the Children's Bureau's Statistics & Research web section.

Child welfare systems typically take the following actions:

- **Investigate reports** (receive and investigate reports of possible child abuse and neglect)
- **Support families** (provide prevention services to families that need assistance protecting and caring for their children to prevent entry into foster care)
- **Provide temporary safe shelter** (arrange for children to live with kin or foster families when they are not safe at home)
- **Seek to return children to their families when safety has improved or find other permanent arrangements** (arrange for reunification, adoption, or other permanent family connections for children leaving foster care)

The flowchart at the end of this factsheet provides an overview of the process described in the following sections.

WHAT HAPPENS WHEN POSSIBLE ABUSE OR NEGLECT IS REPORTED?

Any concerned person can report suspicions of child abuse or neglect, and reports may be made anonymously. Most reports are made by people called "mandatory reporters," who are individuals required by State law to report suspicions of child abuse and neglect. These reports are generally received by CPS workers and are either screened in or screened out. A report is screened in when there is sufficient information to suggest an investigation is warranted. A report may be screened out if there is not enough information on which to follow up on or if the situation reported does not meet the State's legal definition of abuse or neglect. In these instances, the CPS worker may refer the person reporting the incident to other community services or law enforcement for additional help.

For additional information about the child welfare system, refer to the following Information Gateway resources:

- *Making and Screening Reports of Child Abuse and Neglect*
- *Mandatory Reporters of Child Abuse and Neglect*
- Responding to Child Abuse & Neglect [webpage]

WHAT HAPPENS AFTER A REPORT IS SCREENED IN?

CPS caseworkers respond within a few hours to a few days after a report is entered depending on the type of maltreatment alleged, the potential severity of the situation, and requirements under State law. They may speak with the parents and other people in contact with the child, such as doctors, teachers, or child-care providers. They also may speak with the child, alone or in the presence of caregivers, depending on the child's age and level of risk. Children who are believed to be in immediate danger of continued maltreatment may be moved to a shelter, a foster home, or a relative's home during the investigation and while court proceedings are pending. The caseworker also engages the family to assess their strengths and needs and initiate connections to community resources and services.

At the end of the investigation, CPS caseworkers typically make one of two findings—unsubstantiated (unfounded) or substantiated (founded). These terms vary from State to State. Typically, a finding of unsubstantiated means there is insufficient evidence for the caseworker to conclude that the child was abused or neglected or that what happened does not meet the legal definition of child abuse or neglect. A finding of substantiated maltreatment typically means that an incident of child abuse or neglect, as defined by State law, is believed to have occurred. Some States have additional categories, such as "unable to determine," that suggest there is not enough evidence to either confirm or refute that abuse or neglect occurred.

if the agency determines that the authority of the juvenile court is necessary to keep a child safe, it will initiate a court action, such as a child protection or dependency proceeding. To protect the child, the court can issue temporary orders placing the child in shelter care during the investigation, ordering services, or ordering certain individuals to have no contact with the child. Later, at an adjudicatory hearing, the court hears evidence and decides whether maltreatment occurred and whether the child should be under the continuing jurisdiction of the court For additional information about the legal process, refer to Information Gateway's *Understanding Child Welfare and the Courts.*

Some jurisdictions employ an alternative, or differential, response system. In these jurisdictions, when the risk to the child is considered low, the CPS caseworker—rather than investigating the occurrence of abuse or neglect—focuses on assessing family strengths, resources, and difficulties and on identifying supports and services needed. To learn more about differential response, read Information Gateway's *Differential Response: A Primer for Child Welfare Professionals*.

Neglect

Nearly three-quarters of all child maltreatment cases are related to some form of neglect (Children's Bureau, 2020), which may be the result of a family's need for financial and related social supports. See the following Information Gateway resources to learn more about neglect and how to support families:

- Identification of Neglect [webpage]
- Family Support Policy and Program Support Approaches [webpage]
- *Acts of Omission: An Overview of Child Neglect*

WHAT HAPPENS IN SUBSTANTIATED CASES?

If a report of abuse or neglect is substantiated, the next steps for the child and parent depend on State or local policy, the severity of the maltreatment, an assessment of the child's immediate safety, the perceived risk of continued or future maltreatment, the services available to address the family's needs, and whether the maltreatment prompted the child's removal from the home and/or a protective court action. When a report is substantiated as a result of a court hearing, the court may enter a disposition ordering a parent to comply with services necessary to alleviate the abuse or neglect. Orders can also contain provisions regarding visitation requirements between the parent and the child, agency obligations to provide the parent with services, and services needed by the child.

Decisions about services and other next steps may be made by the CPS worker or the courts based on the following categories of perceived risk for future maltreatment:

- **Little or no risk.** The family's case may be closed with no services if a determination is made that the maltreatment was a one-time incident, the child is considered to now be safe, and there is little or no risk of future incidents. Any services the family needs will be provided through community-based resources and service systems—not the child welfare agency.
- **Low to moderate risk**. Referrals may be made to community-based or voluntary in-home child welfare services if the CPS worker believes the family would benefit from these services and the child's present and future safety would be enhanced. (This may happen even when no abuse or neglect is found if the family needs and is willing to participate in services.) Local family resource centers or other organizations can provide community-based services related to parent skill training, child care, housing needs, job training, substance use and mental health counseling, or respite and crisis care services.
- **Moderate to high risk**. The family may be offered voluntary in-home services to address safety concerns and help reduce the risks. If these are refused, the agency may seek intervention by the juvenile dependency court. The court may in turn require the family to cooperate with in-home services if it is believed the child can remain safely at home while the family addresses the issues contributing to the perceived risk of future maltreatment. If the child has already been seriously harmed, is

considered to be at high risk of serious harm, or the child's safety is threatened, the court may order the child's removal from the home or affirm the agency's prior removal of the child. The child may be placed with a relative or in foster care.

Central Registries for Child Maltreatment

Whether or not criminal charges are filed, the name of the person committing the abuse or neglect may be placed in a State child maltreatment registry if the abuse or neglect is confirmed. A registry is a central database that collects information about maltreated children and individuals who are found to have abused or neglected their children. These registries are usually confidential and used for internal child protective purposes only. Information about perpetrators, however, may be used in background checks for certain professions that involve working with children to help prevent children from coming into contact with individuals who may mistreat them.

For more information about these registries, see Information Gateway's *Establishment and Maintenance of Central Registries for Child Abuse or Neglect Reports*.

Depending on the severity of the case and other factors, children may be removed from their homes and placed in foster care. Most children in foster care are placed with relatives or foster families, but some may be placed in a group or residential setting. While in foster care, the child attends school and receives medical care and other services as needed. The child's family also receives services to support their efforts to reduce the risk of future maltreatment and to help them reunite with their child. Visits between parents and their children and between siblings are established as appropriate or according to the case plan.

Every child in foster care should have a permanency plan. Federal law requires the court to hold a permanency hearing, during which a child's permanency plan is developed. This should take place within 12 months of a child entering foster care and every 12 months thereafter. The courts may review each case more frequently to ensure the agency is actively pursuing permanency for the child. (See Information Gateway's Legal and Court Issues in Permanency web section for more information.) The child's family typically participates in developing the permanency plan for the child, as well as their own service plan. Family reunification, except in unusual and extreme circumstances, is the permanency plan for most children. In some cases, when prospects for reunification appear less likely, a concurrent permanency plan may be developed. If the efforts toward reunification are not successful, the plan may be changed to another permanent

arrangement, such as adoption or transfer of custody to a relative. For more information on reunification and concurrent planning, see Information Gateway's *Supporting Successful Reunifications*, *Concurrent Planning for Timely Permanence*, and *Concurrent Planning for Permanency for Children*.

In addition to receiving support in developing permanent legal and relational connections to family and other important people in their lives, older youth in foster care should receive transitional or independent living services to help prepare them for self-sufficiency in the event they leave foster care without a permanent family. Information Gateway's Achieving & Maintaining Permanency and Permanency for Youth webpages offer related resources. Depending on State law, youth may age out of foster care somewhere between the ages of 18 and 21.

SUMMARY

The goal of child welfare is to promote the well-being, permanency, and safety of children and families by helping families care for their children successfully or, when that is not possible, helping children find permanency with kin or adoptive families. Among children who enter foster care, most will return safely to the care of their own families or go to live with relatives or an adoptive family.

For more detailed information about the child welfare system, please refer to the resources listed below. For more information about the child welfare system in your State or local jurisdiction, contact your local public child welfare agency.

REFERENCES

Children's Bureau. (2020). *Child maltreatment 2018*. U.S. Department of Health and Human Services, Administration for Children and Families. https://www.acf.hhs.gov/cb/resource/child-maltreatment-2018

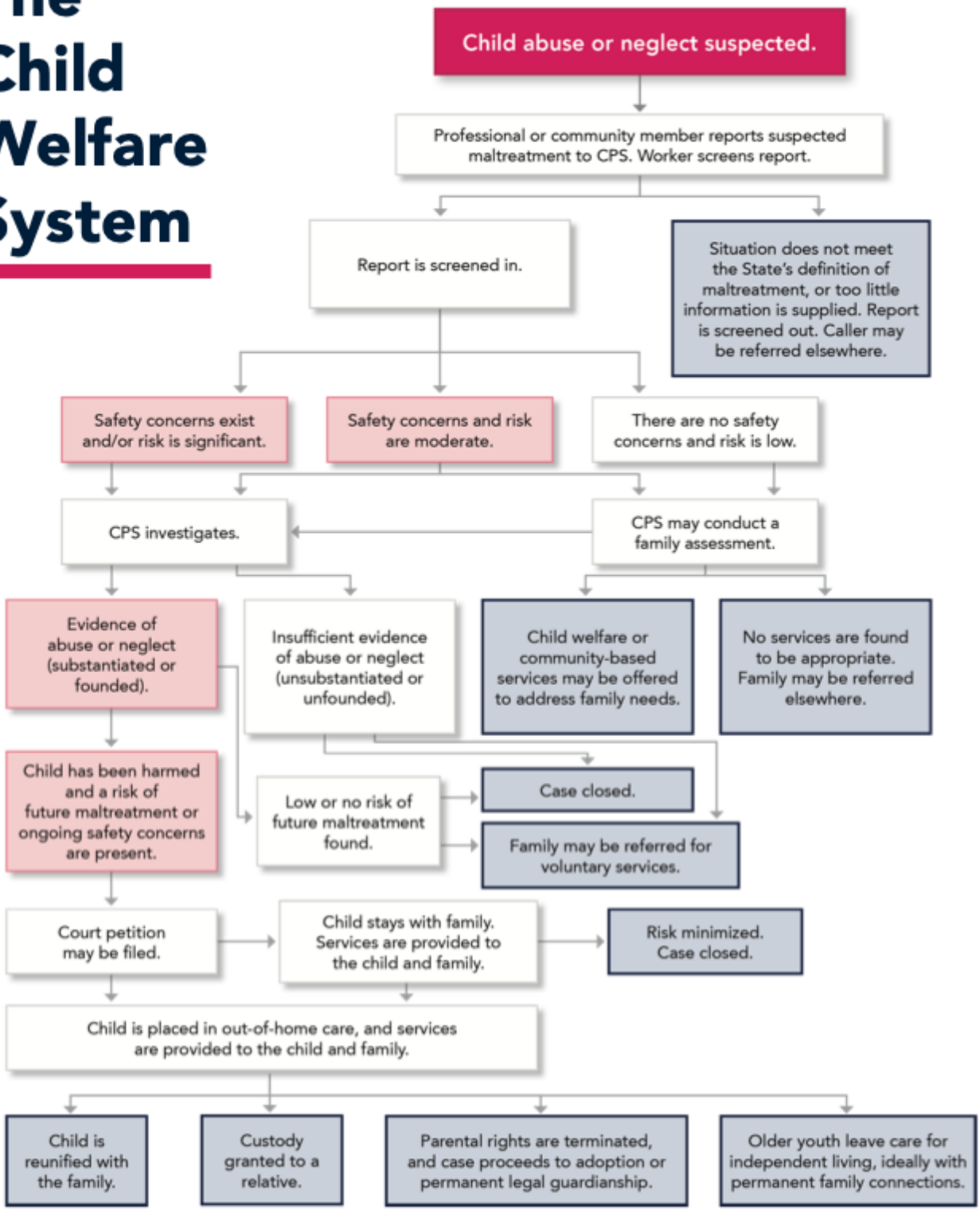
SUGGESTED CITATION:

Child Welfare Information Gateway. (2020). *How the child welfare system works*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubs/factsheets/cpswork/

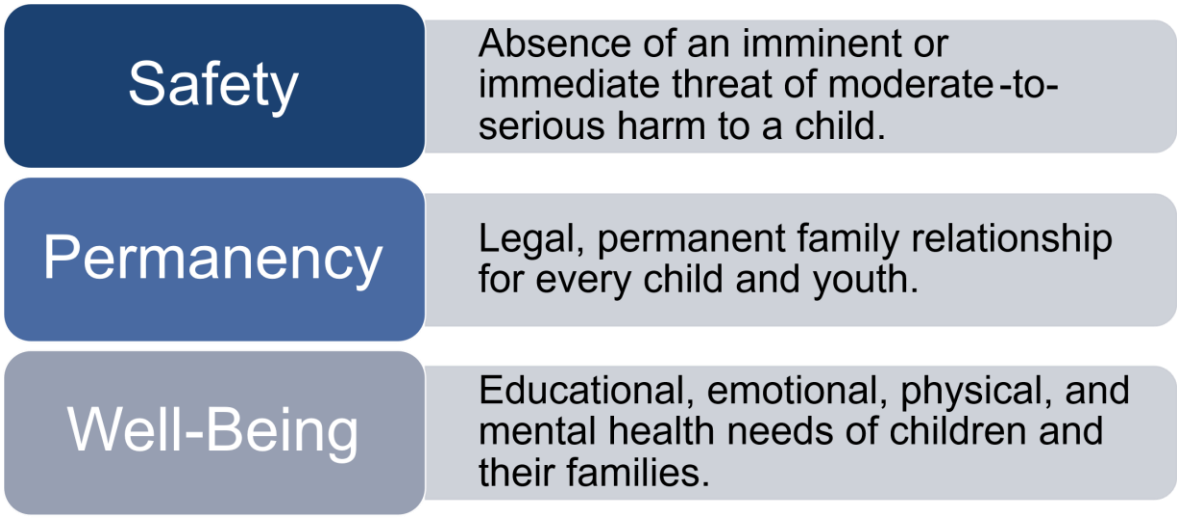
U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway. This publication is available online at https://www.childwelfare.gov/pubs/factsheets/cpswork/.

The Child Welfare System



Defining Safety, Permanency, and Well-Being



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

Safety outcomes:

- Children are, first and foremost, protected from abuse and neglect.
- Children are safely maintained in their homes whenever appropriate and possible.

Permanency is a legal, permanent family relationship for every child and youth.

Permanency outcomes:

- Children have permanency and stability in their living situations.
- The continuity of family relationships is preserved for children.
- Permanency is a legal, permanent family relationship for every child and youth.

Well-being is when the educational, emotional, physical, and mental health needs of children and their families are being met.

Well-being outcomes:

- Families have enhanced capacity to provide for their children's needs.
- Children receive appropriate services to meet their educational needs.
- Children receive adequate services to meet their physical and mental health needs.

Handout: Child and Family Services Review (CSFR)

CFSR Quick Reference Items List

OUTCOMES

Safety Outcome 1: Children are, first and foremost, protected from abuse and neglect.

Item 1: Were the agency's responses to all **accepted child maltreatment reports initiated**, and **face-to-face contact** with the child(ren) made, within time frames established by agency policies or state statutes?

Safety Outcome 2: Children are safely maintained in their homes whenever possible and appropriate.

Item 2: Did the agency make concerted efforts to provide services to the family to **prevent** children's **entry into foster care or re-entry** after reunification?

Item 3: Did the agency make concerted efforts to **assess and address the risk and safety** concerns relating to the child(ren) in their own homes or while in foster care?

Permanency Outcome 1: Children have permanency and stability in their living situations.

Item 4: Is the child in foster care in a **stable placement** and were any changes in the child's placement in the best interests of the child and consistent with achieving the child's permanency goal(s)?

Item 5: Did the agency establish **appropriate permanency goals** for the child in a **timely manner?**

Item 6: Did the agency make concerted efforts to **achieve reunification, guardianship, adoption, or other planned permanent living arrangement** for the child?

Permanency Outcome 2: The continuity of family relationships and connections is preserved for children.

Item 7: Did the agency make concerted efforts to ensure that **siblings in foster care are placed together** unless separation was necessary to meet the needs of one of the siblings?

Item 8: Did the agency make concerted efforts to ensure that **visitation between a child in foster care and his or her mother, father, and siblings** was of sufficient frequency and quality to promote continuity in the child's relationships with these close family members?

Item 9: Did the agency make concerted efforts to **preserve the child's connections** to his or her neighborhood, community, faith, extended family, Tribe, school, and friends?

Item 10: Did the agency make concerted efforts to **place the child with relatives** when appropriate?

Item 11: Did the agency make concerted efforts to promote, support, and/or maintain **positive relationships between the child in foster care and his or her**

mother and father or other primary caregivers from whom the child had been removed through activities other than just arranging for visitation?

Well-Being Outcome 1: Families have enhanced capacity to provide for their children's needs.

Item 12: Did the agency make concerted efforts to **assess the needs** of and **provide services** to **children, parents, and foster parents** to identify the services necessary to achieve case goals and adequately address the issues relevant to the agency's involvement with the family?

Item 13: Did the agency make concerted efforts to involve the **parents and children** (if developmentally appropriate) **in the case planning** process on an ongoing basis?

Item 14: Were the **frequency and quality of visits between caseworkers and child(ren)** sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case goals?

Item 15: Were the **frequency and quality of visits between caseworkers and the mothers and fathers** of the child(ren) sufficient to ensure the safety, permanency, and well-being of the child(ren) and promote achievement of case goals?

Well-Being Outcome 2: Children receive appropriate services to meet their educational needs.

Item 16: Did the agency make concerted efforts to assess **children's educational needs**, and appropriately address identified needs in case planning and case management activities?

Well-Being Outcome 3: Children receive adequate services to meet their physical and mental health needs.

Item 17: Did the agency address the **physical health needs** of children, including dental health needs?

Item 18: Did the agency address the **mental/behavioral health needs** of children?

SYSTEMIC FACTORS

Statewide Information System

Item 19: How well is the **statewide information system** functioning statewide to ensure that, at a minimum, the state can readily identify the status, demographic characteristics, location, and goals for the placement of every child who is (or within the immediately preceding 12 months, has been) in foster care?

Case Review System

Item 20: How well is the case review system functioning statewide to ensure that each child has a **written case plan** that is developed jointly with the child's parent(s) and includes the required provisions?

Item 21: How well is the case review system functioning statewide to ensure that a **periodic review** for each child occurs no less frequently than once every 6 months, either by a court or by administrative review?

Item 22: How well is the case review system functioning statewide to ensure that, for each child, a **permanency hearing** in a qualified court or administrative body occurs no later than 12 months from the date the child entered foster care and no less frequently than every 12 months thereafter?

Item 23: How well is the case review system functioning to ensure that the filing of **termination of parental rights (TPR)** proceedings occurs in accordance with required provisions?

Item 24: How well is the case review system functioning to ensure that foster parents, pre-adoptive parents, and relative caregivers of children in foster care are **notified of, and have a right to be heard** in, any review or hearing held with respect to the child?

Quality Assurance System

Item 25: How well is the **quality assurance system** functioning statewide to ensure that it is (1) operating in the jurisdictions where the services included in the Child and Family Services Plan (CFSP) are provided, (2) has standards to evaluate the quality of services (including standards to ensure that children in foster care are provided quality services that protect their health and safety), (3) identifies strengths and needs of the service delivery system, (4) provides relevant reports, and (5) evaluates implemented program improvement measures?

Staff and Provider Training

Item 26: How well is the staff and provider training system functioning statewide to ensure that **initial training** is provided to all staff who deliver services pursuant to the Child and Family Services Plan (CFSP) that includes the basic skills and knowledge required for their positions?

Item 27: How well is the staff and provider training system functioning statewide to ensure that **ongoing training** is provided for staff that addresses the skills and knowledge needed to carry out their duties with regard to the services included in the CFSP?

Item 28: How well is the staff and provider training system functioning to ensure that **training** is occurring statewide for current or prospective **foster parents, adoptive parents, and staff** of state licensed or approved facilities (that care for children receiving foster care or adoption assistance under title IV-E) that addresses the skills and knowledge needed to carry out their duties with regard to foster and adopted children?

Service Array and Resource Development

Item 29: How well is the service array and resource development system functioning to ensure that the following array of services is **accessible** in all political jurisdictions covered by the Child and Family Services Plan (CFSP)?

1. Services that assess the strengths and needs of children and families and determine other service needs
2. Services that address the needs of families in addition to individual children in order to create a safe home environment
3. Services that enable children to remain safely with their parents when reasonable
4. Services that help children in foster and adoptive placements achieve permanency

Item 30: How well is the service array and resource development system functioning statewide to ensure that the services in item 29 can be **individualized** to meet the unique needs of children and families served by the agency?

Agency Responsiveness to the Community

Item 31: How well is the agency responsiveness to the community system functioning statewide to ensure that, in implementing the provisions of the Child and Family Services Plan (CFSP) and developing related Annual Progress and Services Reports (APSRs), the state engages in **ongoing consultation** with Tribal representatives, consumers, service providers, foster care providers, the juvenile court, and other public and private child- and family-serving agencies and includes the major concerns of these representatives in the goals, objectives, and annual updates of the CFSP?

Item 32: How well is the agency responsiveness to the community system functioning statewide to ensure that the state's services under the Child and Family Services Plan (CFSP) are **coordinated with services or benefits of other federal or federally assisted programs** serving the same population?

Foster and Adoptive Parent Licensing, Recruitment, and Retention

Item 33: How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that **state standards** are applied to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds?

Item 34: How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that the state complies with federal requirements for **criminal background clearances** as related to licensing or approving foster care and adoptive placements, and has in place a case planning process that includes provisions for addressing the safety of foster care and adoptive placements for children?

Item 35: How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the **diligent recruitment** of potential foster and adoptive families who reflect the ethnic and racial diversity of children in the state for whom foster and adoptive homes are needed is occurring statewide?

Item 36: How well is the foster and adoptive parent licensing, recruitment, and retention system functioning to ensure that the process for ensuring the effective use of **cross-jurisdictional resources** to facilitate timely adoptive or permanent placements for waiting children is occurring statewide?

Core Values

Activity: Exploring Core Values

In this activity, you'll work with a small group to explore one of three core values:

Safety-Focused, Trauma-Informed, or Family-Centered.

Here's what to do:

- You'll be assigned to a small group and given one core value to focus on.
- Each group will receive a flip chart and markers.
- Discuss what your assigned value means in practice and share real-life examples.
- As a group, create a poster that represents your discussion. You can use words, drawings, symbols, or whatever helps tell your story.

Safety-Focused

Think of a time when you helped someone feel safe—physically or emotionally.

What actions did you take to support their sense of safety?

How did you know it made a difference?

Trauma-Informed

Remember a moment when you noticed that someone's behavior might be influenced by past trauma.

How did you respond with empathy or adjust your approach?

What helped you recognize the need for a trauma-informed response?

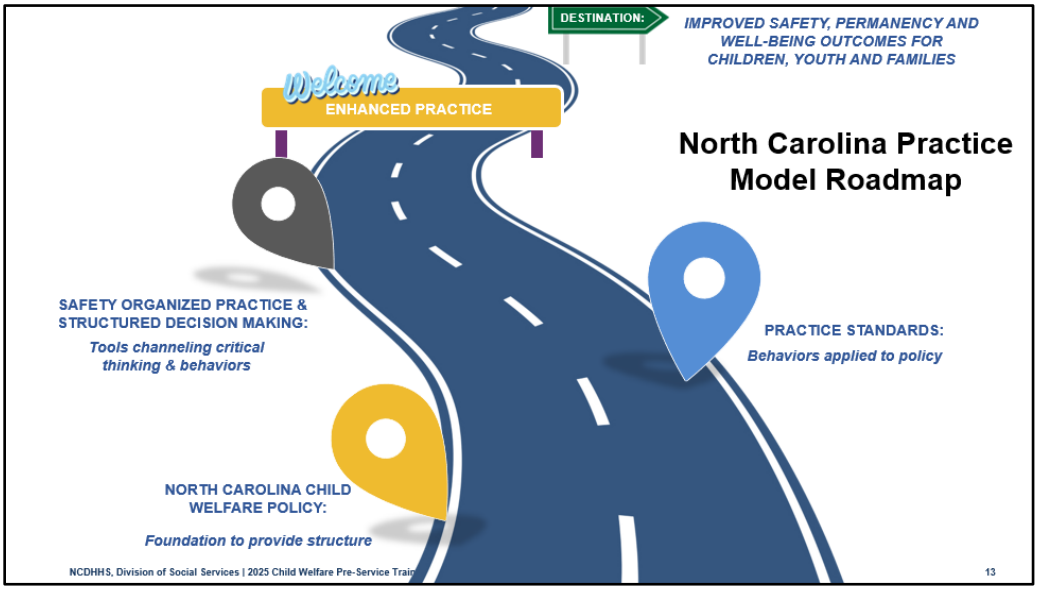
Family-Centered

Think of a time when you truly listened to a family's perspective.

What did you learn from their point of view?

How did that insight influence your decisions or actions?

NC Practice Model Roadmap



Core Values offer the foundational principles for which child welfare practice is based upon in North Carolina. Values can be a challenge to put into practice, as they are often conceptual and not measurable. The practice model brings the core values to life and is comprised of several components: Policy, the NC Practice Model, Structured Decision Making, and Safety Organized Practice.

The NC Practice Standards include five Essential Functions: communicating, engaging, assessing, planning, and implementing. Safety Organized Practice and Structured Decision Making (SDM) Tools support the essential functions and core values. The outcomes for the practice model include the overarching goals of the child welfare system: Safety, Permanency, and Well-Being.

The NC Practice Model offers a foundation for this course. Content will be presented on each component throughout to build a thorough understanding and applicable skills

Notes

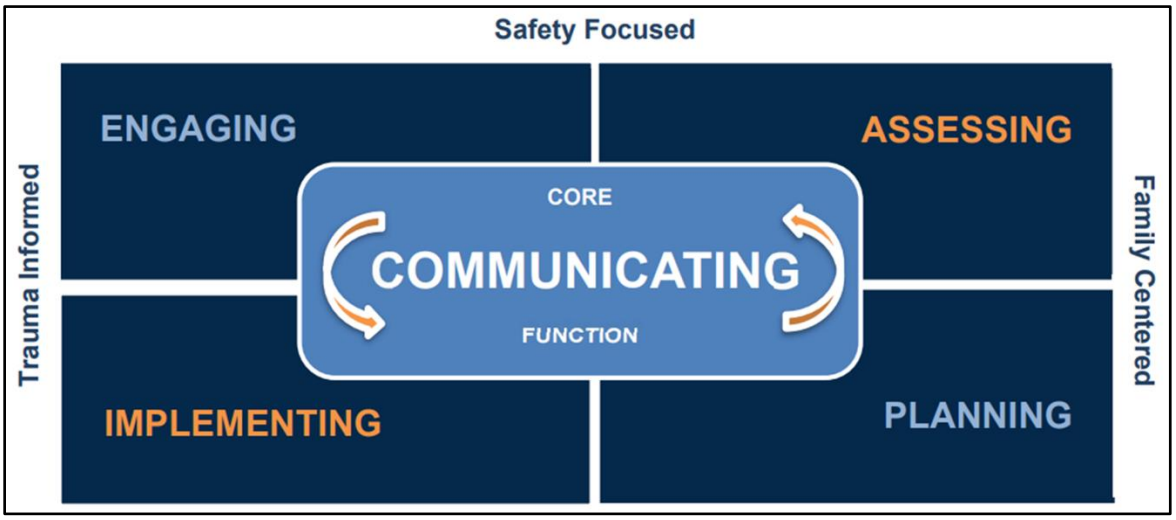
Reflections

Individual Activity: Reflections

Which component of the Practice Model feels like an area of strength for you?

What areas may be more of a challenge and will require your growth?

Practice Standards: Essential Functions



Essential Function: Communication

Timely and consistent sharing of spoken and written information so that **meaning** and **intent** are understood in the same way by all parties involved.

Open and honest communication underpins the successful performance of all essential functions in child welfare

Communicating is the first of our essential functions. Communicating is the core function, as it is foundational to all aspects of the practice model.

Communicating is timely and consistent sharing of spoken and written information so that meaning, and intent are understood in the same way by all parties involved. Open and honest communication underpins successful performance of all essential functions in child welfare. This definition brings to light the fact that communication is more than just speaking and writing; it is also checking for understanding, clarifying when needed, and building a common language.

Notes

Handout: NC Practice Model Desk Guide

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Worker Practice Standards Desk Guide

Practice Standards *are essential behaviors in working with agencies, staff, and families that apply to all members of the child welfare system, including leaders, supervisors, and workers. For workers, Practice Standards describe how they should interact with children, youth, and families from the beginning to the end of child welfare services. Each essential function has accompanying core activities, which embody that function, and practice standards, or desired behaviors that staff at all levels should be saying and doing to practice in accordance with the Practice Model and to help achieve positive outcomes for children, youth, and families.*

North Carolina's Practice Model Pyramid

What is a Practice Model?

Practice Models provide a framework or organizing principles to guide the agency to achieve their mission and values. (Child Welfare Policy and Practice Group. Adopting a Child Welfare Practice Framework)

What is a Practice Standard?

Practice Standards provide guidance to workers on the concrete actions and behaviors they should be demonstrating to carry out the agency's Practice Model. (Metz, A., Bartley, L., Blase, K. & Fixsen, D. (2011). A guide for creating practice profiles. Chapel Hill, NC: National Implementation Research Network, FPG, Child Development Institute, UNC.)

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

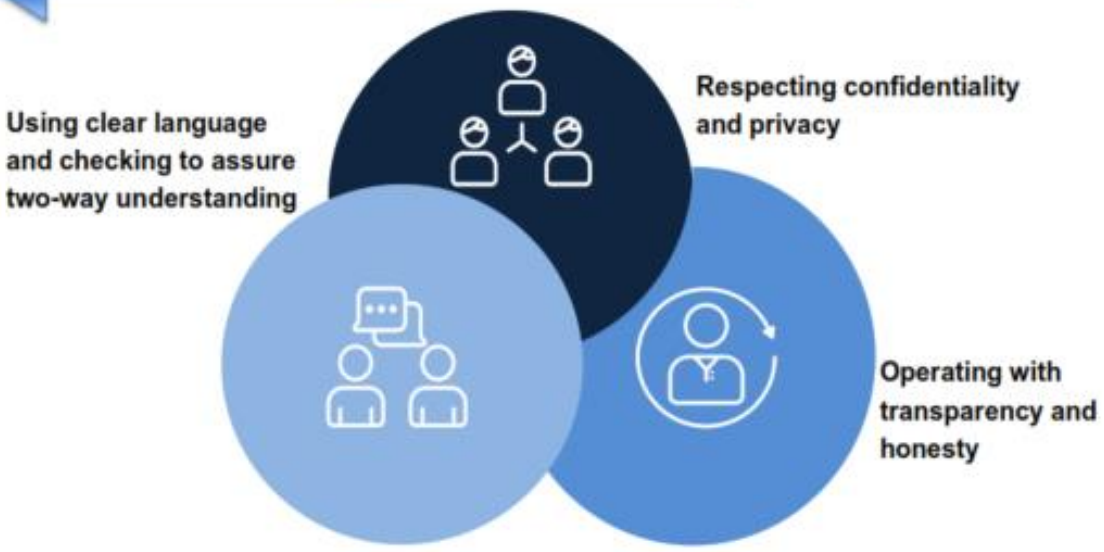
Division of Social Services

Key Behaviors and Core Activities

Communicating: *Timely and consistent sharing of spoken and written information so that meaning, and intent are understood in the same way by all parties involved. Open and honest communication underpins successful performance of all essential functions in child welfare.5j*

#1	Ensure clarity when communicating.
#2	Adapt communication to family needs and preferences and provide consistent information to all family members who need it.
#3	Allow time to enhance two–way communication with the family through questions and checks for understanding.
#4	Speak with the family and youth in a non-judgmental, respectful manner.
#5	Clearly and openly express to youth and the family what is expected from them and what they can expect from child welfare.
#6	Always tell the truth, including during difficult conversations, in a manner that promotes dialogue.
#7	Diligently respect confidentiality while sharing information when necessary and appropriate.

Communicating Core Activities



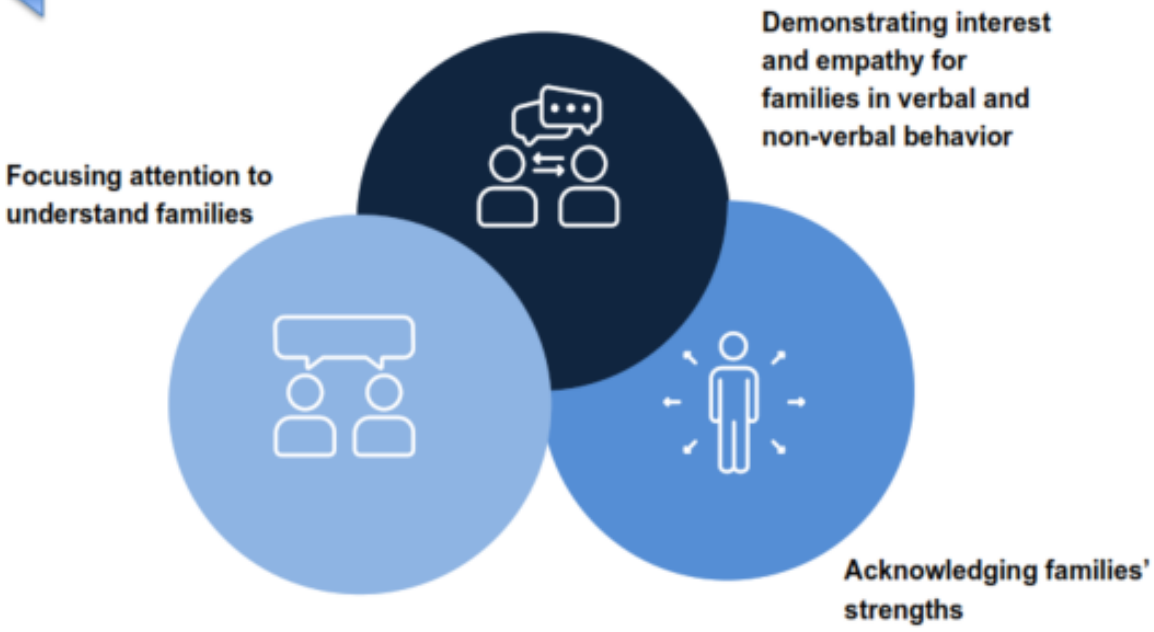
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Engaging: ***Empowering and motivating families to actively participate with child welfare in the functions of assessing, planning, and implementing by communicating openly and honestly with the family, demonstrating respect, and valuing the family's input and preferences. Engagement begins upon first meeting and continues throughout child welfare services.***

#1	Be fully present when meeting with the family.
#2	Prepare in advance to be able to connect with the family.
#3	Consider the family's perspective in all exchanges and actions.
#4	Recognize the family's perspectives and desires.
#5	Use body language to convey interest in the family.
#6	Acknowledge and celebrate strengths and successes.

Engaging Core Activities



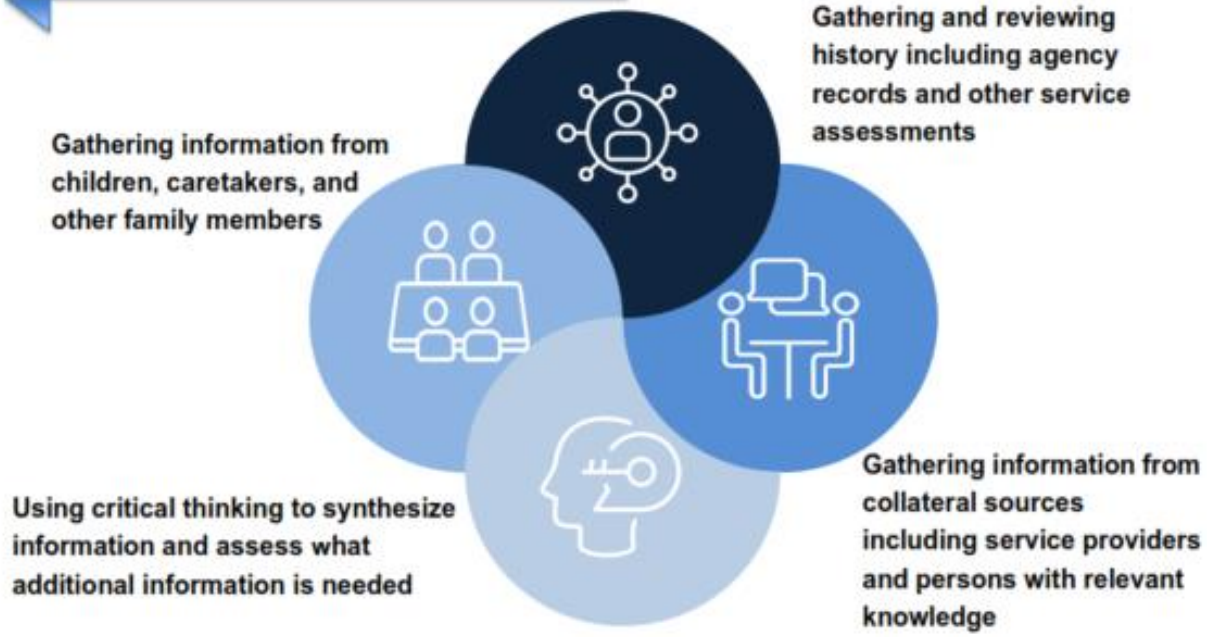
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Assessing: *Gathering and synthesizing information from children, families, support systems, agency records, and persons with knowledge to determine the need for child protective services and to inform planning for safety, permanency, and well-being. Assessing occurs throughout child welfare services and includes learning from families about their strengths and preferences.*

#1	Differentiate between information and positions.
#2	Take time to get to know the family and explain the assessment process.
#3	Ask questions based on information needed and at ease asking uncomfortable questions.
#4	Stay open to different explanations of events in the record, keeping biases in check.
#5	Balance what is read in the record and what the family shares.
#6	Obtain all sides if there are differing positions among collaterals, engaging the family in the process.
#7	Synthesize information and consider sources, relevance, and timelines.
#8	Remain non-judgmental when processing information.

Assessing Core Activities



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Planning: ***Respectfully and meaningfully collaborating with families, communities, tribes, and other identified team members to set goals and develop strategies based on the continuous assessment of safety, risk, family strengths, and needs through a child and family team process. Plans should be revisited regularly by the team to determine progress towards meeting goals and changes made when needed.***

#1	Engage the family in understanding assessment and history, focusing on strengths to customize the plan.
#2	Discover root causes and underlying reasons for the family's involvement.
#3	Believe and practice the importance of preparation both for self and for the family for teaming and planning.
#4	Actively engage the family in identifying their team.
#5	Promote the family's voice as the cornerstone of the meeting.
#6	Facilitate and engage participants throughout, acknowledging and managing conflict.
#7	Revisit case plan regularly, willing to modify or update as needed, but at a minimum per policy.

Planning Core Activities

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Implementing: *Carrying out plans that have been developed. Implementing includes linking families to services and community supports, supporting families to take actions agreed upon in plans and monitoring to assure plans are being implemented by both families and providers, monitoring progress on behavioral goals, and identifying when plans need to be adapted.*

#1	Support the family to take action.
#2	Work with the family to find solutions to problems.
#3	Explain to the family what services are and what they could do for the family to provide information and informed decisions.
#4	Offer an array of service providers to choose from if there are choices to be had.
#5	Advocate with and for the family with providers regarding what behavioral change is expected to ensure quality service delivery.
#6	Access natural supports in the community to assist the family to achieve their goals.
#7	Check in on an ongoing basis with the family on progress with the Family Services Agreement.
#8	Assess progress in implementing actions of the plan, making adjustments as needed.
#9	Track service delivery for the achievement of safety, permanency, and well-being outcomes for the family.

Implementing Core Activities

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Strategies for Applying Practice Standards in Your Everyday Work

Communicating

- Use clear understandable language, both when speaking and writing, avoiding acronyms and jargon.
- Understand the unique communication needs of the family, including communication preferences or language barriers. If barriers exist, ensure that appropriate language services are provided.
- Continually practice active listening, which means asking questions to both understand and show you are listening.
- Through your words and actions, show the family interest, respect, and empathy. Examples include leaning in when they speak, head nodding to show understanding, and being transparent with note taking.
- Make sure you understand and can explain the "why" behind certain requirements and decisions with the family.
- Always respect the family's right to privacy and be cognizant of who you are sharing information with, what you are sharing, where you are sharing, and why you are sharing.
- Have honest discussions with the family regarding expectations, both yours and theirs. Be sure to follow up and follow through on your conversations.
- Model transparency and honesty, including when information is not known, difficult, or incorrect.

Engaging

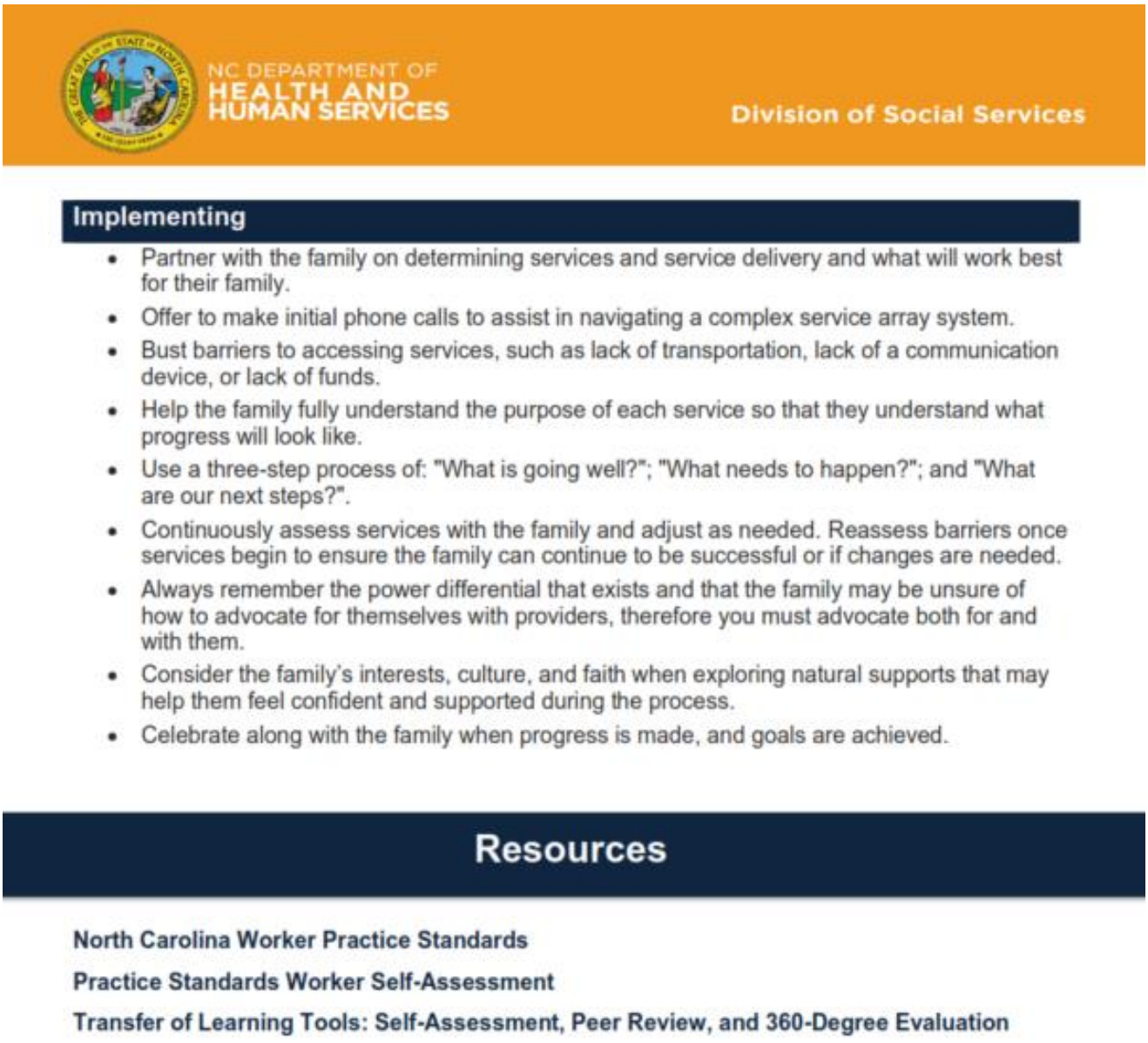
- Be fully present by eliminating any potential distractions.
- Review previous notes from meetings with the family and prepare follow-up questions and items to discuss. Demonstrating your preparedness shows the family that you respect your time together.
- Treat the family as the "expert" of their own situation. They know their strengths and struggles best.
- Put the family first in conversations and consider the perspective of the child and family. For example, engaging relatives for placement is important from an agency perspective, but can be extremely meaningful from the family's perspective.
- Show empathy and acknowledge any struggle experienced by the family when talking through courageous conversations.
- Empower the family to feel confident, encouraging their active involvement in problem solving and planning, and help the family identify their own strengths and successes.
- Engage the family through body language and demonstrate interest, empathy, and understanding when they speak.

Assessing

- Ask open-ended, strengths-based questions.
- Be transparent and share the purpose of gathering and assessing information, and who may be contacted as part of the process.
- Understand that assessing is an ongoing skill and never ends during the life of a case.
- Provide space for reflection on opinions and biases and how they could impact your work. Brainstorm strategies to mitigate bias with your supervisor.
- Prepare ahead and review what is in the record to understand what has worked for the family in the past, while also being cognizant of what the family is communicating with you in the present.
- Know what questions to ask that will elicit the most comprehensive answers and share along the way what is being learned by those questions.
- Gather information and observations from a wide variety of collateral sources, while understanding they may also can contain opinions and biases as well.
- Be inquisitive, not judgmental through the assessing process.
- Before contacting collaterals, engage the family in what information is being obtained and when you intend to make contact, when it is possible to do so.

Planning

- Create buy-in for the family by involving them from the beginning, ensuring that their voice is used throughout the plan.
- Fully process information gathered to best inform case planning.
- Dig deep to understand and address the root cause for child welfare involvement, using creative ideas and solutions that are congruent with the needs of the family.
- Check for plan alignment with the root cause of involvement. The family should not be asked to complete tasks that are not directly tied to concerns.
- Prepare yourself for Child and Family Team Meetings (CFTs) by thoroughly reviewing the case history, documenting questions, and consulting with your supervisor.
- Prepare the family for CFTs by explaining the purpose, letting them know what to expect, and engaging them in setting the agenda.
- Help the family identify relatives ,friends, and others to be involved in the planning process as an advocate and source of support.
- Thoroughly review plans to ensure that the plan's goals and objectives continue to tie back to the family's assessment and reason for involvement.
- Update the plan accordingly when tasks are completed so the family can see and feel progress.



How do these standards help you stay aligned with the core values of Safety-Focused, Family-Centered, and Trauma-Informed Practice?

Communicating

Activity: Communicating: Mad Libs

Using the prompts below, generate a list of words for this activity. Resist writing down the first word that pops into your head and consider your second thought.

Number	Prompt	Word
1	A phrase that expresses gratitude	
2	A verb that is a caseworker action	
3	Synonym for “safe”	
4	An emotion with a negative connotation	
5	Synonym for “partner”	
6	An emotion with a positive connotation	

Fill in the Mad Lib Communication Outline below utilizing the word list you created above. Place words in the outline that correspond with the assigned number above.

Hello._____ for meeting with me. I am a child welfare caseworker. My job is to _____ you and your family to make sure that your children are _____ and well cared for. I know that working with child welfare can feel _____. My goal is to _____ with you to make this process feel _____.

Key Takeaways

- Centering Families
- Goals of the Child Welfare System
- North Carolina Practice Model
- Core Values
- Essential Functions

Notes

North Carolina Social Worker Job Preview

Video: Everyday Impact: Child Welfare Worker Realistic Job Preview

Visit: Everyday Impact: Child Welfare Worker Realistic Job Preview to watch a video that was created as a realistic job preview for child welfare caseworkers. This video follows three caseworkers in North Carolina throughout their day on the job. Answer the questions after viewing the video.

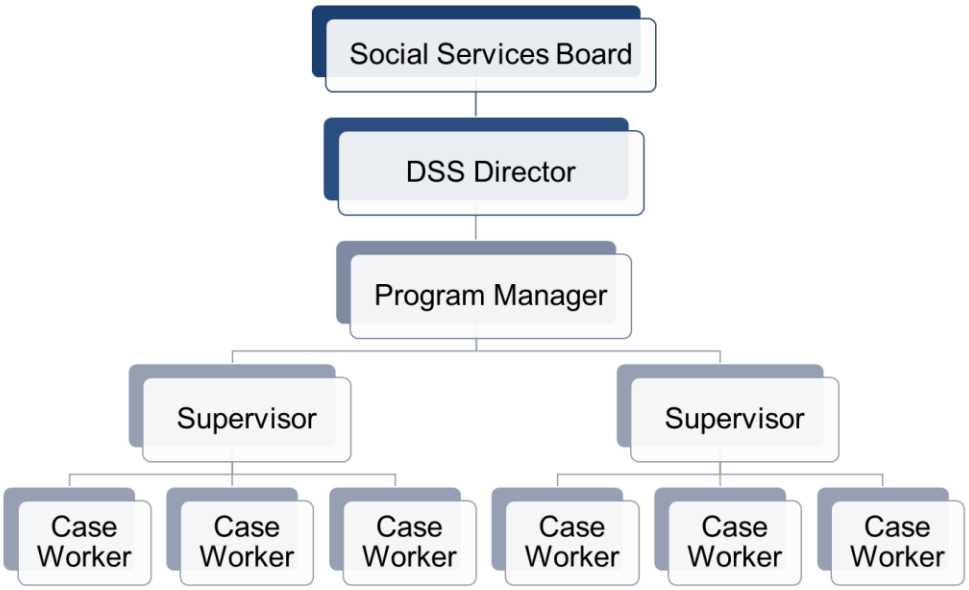
What stood out to you about the descriptions of being a child welfare caseworker?

What surprised you?

What did the caseworkers in the video share that makes you excited about this work?

What makes you nervous?

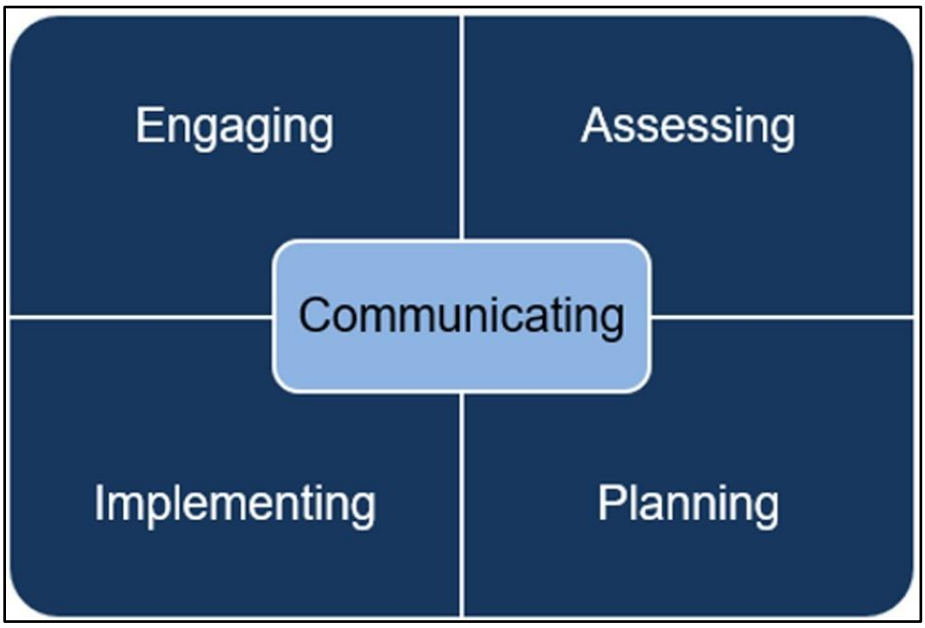
Overview of DSS Structure and Positions



Specific positions may vary based on the county, but the typical positions are:

- Intake
- CPS Assessments
- In-Home Services
- Permanency Planning
- Foster Home Licensing
- Adoptions

Practice Standards



Handout: North Carolina Worker Practice Standards

The North Carolina Practice Standards build skills and behaviors in the workforce that provide the groundwork for learning, and they are the foundation of North Carolina's Practice Model. The Practice Standards are anchored by our core values: safety-focused, trauma-informed, family-centered, and cultural humility. They are described in observable, behaviorally specific terms to illustrate how caseworkers will conduct the essential functions of child welfare and how supervisors and leaders will support them. The Practice Standards are divided into five essential functions: communicating, engaging, assessing, planning, and implementing.

Communicating: Using clear language and checking to assure two-way understanding. Timely and consistent sharing of spoken and written information so that meaning and intent are understood in the same way by all parties involved. Open and honest communication underpins the successful performance of all essential functions in child welfare.

Engaging: Focused attention to understand families. Empowering and motivating families to actively participate with child welfare by communicating openly and honestly with the family, demonstrating respect, and valuing the family's input and preferences. Engagement begins upon first meeting a family and continues throughout child welfare services.

Assessing: Gathering information from children, caretakers, and other family members. Gathering and synthesizing information from children, families, support systems, agency records, and persons with knowledge to determine the need for child protective services and to inform planning for safety, permanency, and well-being. Assessing occurs throughout child welfare services and includes learning from families about their strengths and preferences.

Planning: Synthesizing and integrating current and previous assessment information and family history to inform plans. Respectfully and meaningfully collaborating with families, communities, tribes, and other identified team members to set goals and develop strategies based on the continuous assessment of safety, risk, family strengths and needs through a child and family team process. Plans should be revisited regularly by the team to determine progress toward meeting goals and make changes when needed.

Implementing: Supporting families to take actions agreed upon in the plan and connecting families to services and community support. Carrying out plans that have been developed. Implementing includes linking families to services and community supports, supporting families to take actions agreed upon in plans and monitoring to assure plans are being implemented by both families and providers, monitoring progress on behavioral goals, and identifying when plans need to be adapted.

Activity: Understanding Roles and Responsibilities

Review the Job Responsibilities handout on the following page and be prepared to also reference the previous North Carolina Worker Practice Standards handout.

- *Everyone who is a number 1 will be an Intake caseworker.*
- *Everyone who is a number 2 will be a CPS Assessments caseworker.*
- *Everyone who is a number 3 will be an In-Home caseworker.*
- *Everyone who is a number 4 will be a Permanency Planning caseworker.*
- *Everyone who is a number 5 will be a Foster Home Licensing caseworker.*
- *Everyone who is a number 6 will be an Adoption caseworker.*

When you stop at each of the practice standard areas designated around the room, be prepared to answer the following questions based on your assigned worker role:

What role are you assigned?

What is this role's responsibility related to the practice standard you stopped at?

How did this activity help you see the connections between practice standards and specific job responsibilities?

What from this activity will you remember to apply in practice?

Handout: North Carolina Child Welfare Job Responsibilities

Intake Responsibilities

- Use a strengths-based approach to interview reporters
- Complete a new CPS Intake in NC FAST or Structured Intake Report tool
- Consult The Maltreatment Screening Tools that correspond to the allegations to determine if the allegations meet the legal definition of abuse, neglect, and/or dependency
- Make a screening decision in consultation with the supervisor
- Determine residency and the county responsible for completing the CPS Assessment
- Consult the Response Priority Decision Tree to determine the appropriate response time
- Determine the appropriate Assessment Response Type (Family or Investigative)
- Assign reports for CPS Assessment
- Send reporter notification letters

CPS Assessment Responsibilities

- Establish contact with all identified persons who might have information regarding the report, including family members, collateral sources, and the child
- Approach 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
- Establish trust and rapport with family members to encourage them to disclose pertinent information and participate fully in the problem-solving process
- Conduct 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 if:
    - Child maltreatment occurred
    - There is a risk of future maltreatment and the level of that risk
    - The child is safe within the home, and if not, what interventions can be implemented that will ensure the child’s protection and maintain the family unit intact if reasonably possible
    - Ongoing agency services are needed to reduce the risk of maltreatment occurring in the home; and
    - Out-of-home placement is necessary to protect the child from harm
- Weigh 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
- Identify strategies and initiate immediate interventions to provide protection for children who are determined to be unsafe and to prevent the need for removal and placement, if possible
- Complete appropriate documentation of all information to develop a safety agreement

- Substantiate or refute the report and the likelihood of future harm
- Present appropriate testimony in situations when juvenile court action is required to protect the child
- Determine if ongoing services are needed to reduce the risk of maltreatment occurring in the future
- Prepare the family for ongoing service intervention and case transfer to the ongoing caseworker, if applicable.

In-Home Services Responsibilities

- Provide the most intensive services and contacts to families with identified needs
- Deliver services within the context of the family's own community culture
- Monitor child safety and risk while in the home
- Engage children, youth, and families in the planning process while producing better outcomes of safety, permanence, and well-being for children
- Encourage families to develop a support network and show how this support network can assist them in planning for coping with future challenges

Permanency Planning

- Careful planning and decision-making with the family about placement, when necessary, and preparing the child, the child's family, and the foster family for separation and placement, including developing a family time and contact (visitation) agreement
- Assessing children's needs to ensure appropriate placement and services
- Arranging and monitoring a placement appropriate to the child's needs
- Involving the kinship network to provide planning, placement, and other support for the child and family
- Assessing family strengths and needs to determine the appropriate plan for service
- Developing and arranging community-based services to support the child and family
- Collaborating with other community service providers working with the family to ensure continuity of services and to prevent duplication of services
- Referring the child and family to needed services, including clinical treatment
- Collaborating with educational agencies to ensure school stability for the child and that all factors relating to the child's best interest are considered in determining the child's educational setting; all appropriate educational services are provided to the child; and documentation of educational planning is in the case file
- Providing ongoing assessment to determine the risk to the child and to guide the case planning process
- Working with the family to develop and implement the Permanency Planning Family Services Agreement

- Helping the family meet the Permanency Planning Family Services Agreement objectives by providing information, instruction, guidance, and mentoring related to parenting skills, and by monitoring and updating the agreement with the family
- Providing case planning and management
- Concurrent permanency planning with the family to develop alternative options to provide a permanent home for a child should reunification fail
- Supervising the placement to ensure the child receives proper care during placement
- Preparing for and participating in court proceedings
- Preparing for and facilitating Child and Family Team (CFT)/Permanency Planning Review (PPR) meetings
- Providing transportation for children in county child welfare agency custody when needed and not otherwise available, including visits with parents, siblings, and relatives
- Providing LINKS services to assist older youth in learning life skills necessary to make a successful transition from foster care to living on their own
- Ensuring placements across state lines comply with the Interstate Compact on the Placement of Children (ICPC)
- Recruiting and assessing relatives and other kin as potential caregivers
- Involving foster parents in planning and decision-making for children in county child welfare agency custody
- Preparing children for adoptive placements and maintaining life books
- Maintaining the permanency planning case record and thorough documentation of case activities

Adoptions

- Ensure timely permanence for children through legal adoption
- Ensure that each child, regardless of race, ethnicity, age, or handicapping condition, has an opportunity for placement in a permanent family
- Prepare and assist children in their transition to an adoptive family
- Support and strengthen the adoptive family
- Provide services to all members of the adoption triad
- Provide post-adoption services to optimize family functioning and prevent the dissolution of adoption

Licensing

- Recruiting, developing, and supervising foster care families and childcare facilities
- Submitting the “licensing application” and all supportive documents to the Licensing Authority (located in Black Mountain)
- Submitting re-licensure documentation every 2 years for licensed foster families
- Recruiting and assessing relatives and other kin as potential caregivers
- Assessing and periodically reassessing foster care homes and facilities to determine if the home or facility meets the needs of the children it serves
- Providing consultation, technical assistance, and Pre-service training (TIPS-MAPP: Trauma Informed Partnering for Permanency and Safety: Model Approach to Partnerships in Parenting) to assist prospective foster families in making an informed decision about fostering/adopting
- Involving foster parents in the planning and decision-making for children in foster care
- Providing in-service training regarding the benefits/challenges of shared parenting
- Facilitating foster/adopt options for children and preparing foster/adoptive parents

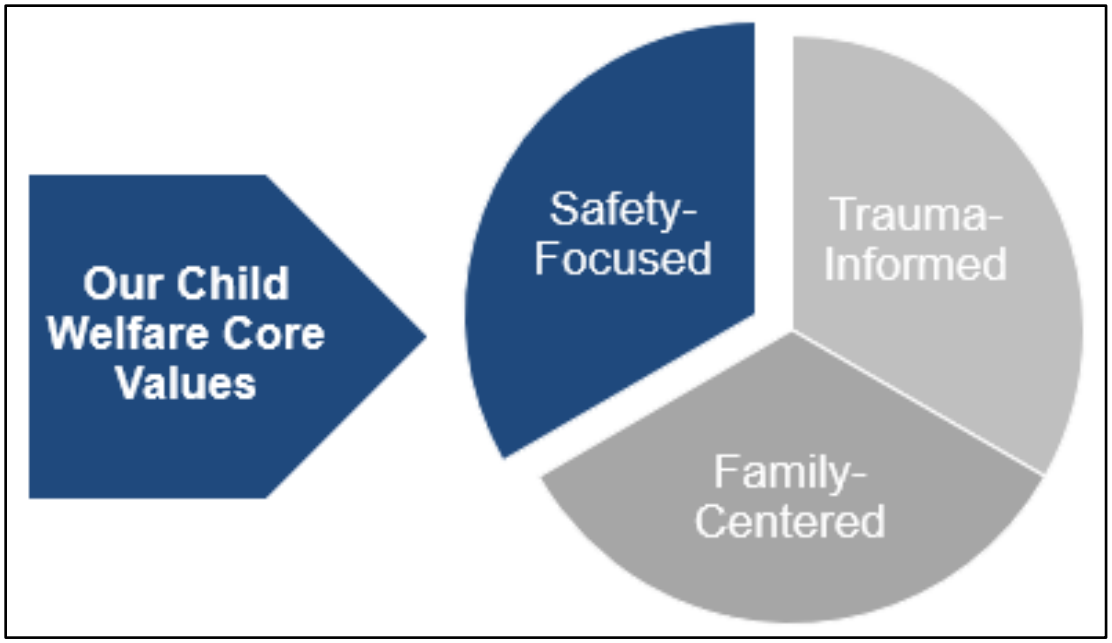
Key Takeaways

- Center family voice in all your work
- Safety, permanency and well-being are the goals of the child welfare system
- The Practice Standards are the foundation of good practice in all social work roles
- Specific job responsibilities vary based on program area
- Your supervisor is a resource to help you understand your role and responsibilities

Notes

Safety Focused Practice

Our Child Welfare Core Values



Child Welfare Services exists to protect children within the context of child abuse, neglect and dependency. This requires a focus on safety, which is a core value of the NC Child Welfare Practice Model.

Notes

Defining Safety and Risk

Child safety is fundamental to child welfare practice, as it is the agency's foremost responsibility to protect children and assure a safe environment. Your primary task in supporting child safety and family integrity is to assess current and future safety and risk for children and families. An allegation of abuse, neglect, or dependency creates a concern for child safety, and that is why DSS becomes involved, to ensure that children are safe. Even if maltreatment has occurred, it does not automatically mean that a child is currently unsafe. The discussion around safety and risk is complex, as how we talk about these concepts are nuanced.

Notes

Understanding Child Safety

Child Safety begins with determining the presence of safety threats and danger indicators. A safety threat is a situation, condition, or behavior that must meet the "safety threshold." The safety threshold is the point when a parent's behaviors, attitudes, emotions, intent, or circumstances create conditions that fall beyond the mere risk of future maltreatment and have become an actual imminent threat to the child's safety.

Safety threats are specific, observable, out of control, and imminent conditions that can have a serious effect on a **child**.

Within the context of child welfare, a child is safe when there is no safety threat or danger indicators present, or if the parent possesses sufficient protective capacities to manage any threat or danger.

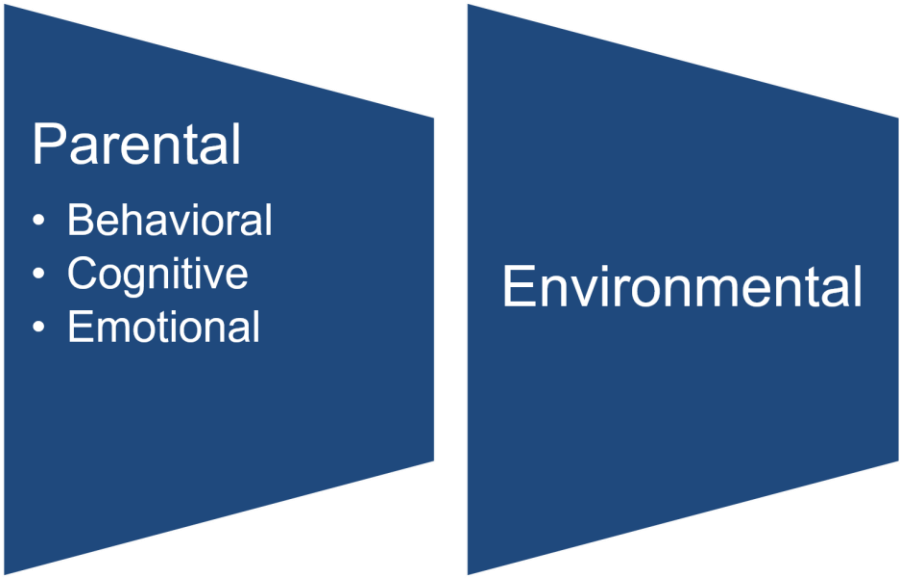
Within the context of child welfare, a child is unsafe when:

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

Safety is not merely the absence of danger; it is the presence of protection.

How does it feel to recognize that safety is as much about protection as it is about danger?

Protective Capacity



Protective Capacity is defined as the ability and willingness to mitigate or ameliorate the identified safety and risk concerns.

Behavioral characteristics are defined as specific actions and activities consistent with and resulting in parenting and protective vigilance. Questions to consider include: •

- Does the parent/caretaker have the capacity to care for the child?
- If the parent/caretaker has a disability (such as blindness, deafness, paraplegia, chronic illness), how has the parent/caretaker addressed the disability in parenting the child?
- Has the parent/caretaker acknowledged and acted to provide the needed support to effectively parent and protect the child?
- Does the parent/caretaker demonstrate activities that indicate putting aside one's own needs in favor of the child's needs (if appropriate)?
- Does the parent/caretaker demonstrate adaptability in a changing environment or during a crisis?
- Does the parent/caretaker demonstrate actions to protect the child?
- Does the parent/caretaker demonstrate impulse control related to a risk factor?
- Does the parent/caretaker have a history of protecting the child given any threats to the safety of the child?

Cognitive characteristics are defined as the parent/caretaker's specific intellect, knowledge, understanding, and perception that contributes to protective vigilance. Questions to consider include:

- Is the parent/caretaker oriented to time, place, and space? (reality orientation)
- Does the parent/caretaker have an accurate perception of the child?
- Does the parent/caretaker see the child as having strengths and weaknesses, or do they see the child as "all good" or "all bad"?

- Can the parent/caretaker recognize the child's developmental needs or if the child has special needs?
- How does the parent/caretaker process the external stimuli? (for example, a battered woman who believes she deserves to be beaten, because of something she has done)
- Does the parent/caretaker understand their role to provide protection to the child?
- Does the parent/caretaker have the intellectual ability to understand what is needed to raise and protect a child?
- Does the parent/caretaker accurately assess potential threats to the child?

Emotional characteristics are defined as the parent/caretaker's specific feelings, attitudes, and identification with the child and motivation that results in parenting and protective vigilance. Questions to consider include:

- Does the parent/caretaker have an emotional bond with the child?
- Is there a reciprocal connectedness between the parent/caretaker and the child?
- Is there a positive connection to the child?
- Does the parent/caretaker have empathy for the child when the child is hurt or afraid?
- Is the parent/caretaker flexible under stress?
- Can the parent/caretaker manage adversity?
- Is the parent/caretaker able to control their emotions?
- If emotionally overwhelmed, does the parent/caretaker reach out to others or expect the child to meet the parent/caretaker's emotional needs?
- Does the parent/caretaker consistently meet their own emotional needs via other adults, services?
- What are the dynamics of the relationship of and between multiple parents/caretakers?
- Is there domestic violence?
- What efforts have been made by the victim to protect the child? Does the victim align with the batterer?
- Does the parent/caretaker actively engage in a plan to protect the child from further harm? Is the plan workable?
- Does the parent/caretaker demonstrate actions that are consistent with verbal intent, or are their words and actions contradictory?

A statement by the parent/caretaker that he or she has the capacity to protect should be respected but observations of this capacity are important. Observations and supporting information include: A history of behavioral responses to crises may indicate what may likely happen. Spontaneous behavior will provide insight into how a parent/caretaker feels, thinks, and acts when they are or feel threatened.

Recognize that a parent/caretaker may initially react in anger or "righteous indignation" and that this initial reaction may be appropriate and natural. However, once the initial shock and emotional reaction subsides, does the parent/caretaker blame everyone else for the "interference"?

Environmental Protective Capacities. While the assessment of the parent/caretaker's protective capacities is critical, an assessment of environmental capacities may also mitigate the safety concerns/risk of harm to a child.

Below are several categories of environmental protective capacities to be considered:

- Family/kinship relationships that contribute to the protection of the child
- Informal relationships
- Agency supports
- Community supports
- Financial status
- Spiritual supports
- For American Indians, the tribe
- Concrete needs being met (food, clothing, shelter)

Scaling questions are a great way to assess risk with a parent/caretaker. When using scaling questions, the county child welfare worker needs to anchor the scale with specific descriptors for high and low numbers. The county child welfare worker should plan to ask follow-up questions. Identifying the number is just the beginning; the real value of scaling is in the follow-up questions. What does the parent/caretaker think makes it that number? What's one thing they could do to lower the risk?

NCDHHS. (June 2025). *NC Child Welfare Manual: Cross Function Topics, Risk & Use of Assessment Tools.*

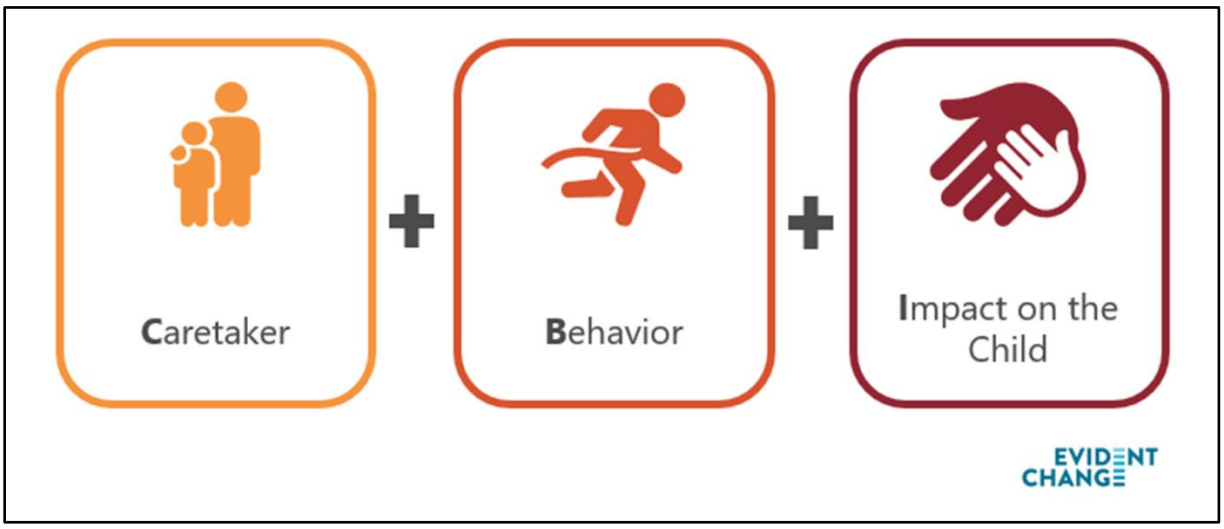
Notes

Activity: What Does Safety Look Like?

©2000-2016 Great Kids Inc.

Worries	Working Well

Impact: C+B+I Formula



Caretaker: Assess the legal caretaker's behavior at each stage of our involvement.

Behavior: The caretaker has taken some sort of action or inaction that has abused or neglected the child.

Impact on the child: A negative impact on the child must be present. We need to be able to name it and describe its effects. For example, if a caretaker uses illegal substances but always finds a safe and sober caretaker to watch their child prior to using, this concern does not meet the threshold of a danger indicator because there is no negative impact on the child. The caretaker is actively ensuring that their child is in a safe place while they use illegal substances.

The Cross Topic Functions policy defines a Safety Threshold as "the point when a parent's behaviors, attitudes, emotions, intent, or circumstances create conditions that fall beyond mere risk of future maltreatment and have become an actual immediate threat to the child(ren)'s safety. These conditions could reasonably result in the serious and unacceptable pain and suffering for a vulnerable child(ren)." Caretakers can have a range of behaviors. What makes something a child welfare concern is when the caretaker behaviors cause harm to children.

For example, if a child's parent is drinking to the point of intoxication several nights a week and each time passes out in the living room, then wakes up groggy yet sober in the morning, this may be a safety issue if the child is a toddler and requires direct supervision and there is no other caretaker to do that when the parent is unavailable. The same behavior by the parent of a seventeen-year-old who has access to a cell phone and drives themselves to school may indicate risk, although does not impact safety in the same manner.

One way to think about whether the threshold of a danger indicator is met is to use "caretaker plus behavior plus impact," or C+B+I. If a caretaker is engaging in a behavior—whether it's abuse or neglect—and there is an impact on the child, it is likely that the caretaker's behavior meets the threshold of a danger indicator.

Child Maltreatment Defined

Child Abuse Prevention and Treatment Act	Centers for Disease Control and Prevention (CDC)
Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation…, or an act or failure to act which presents an imminent risk of serious harm" (42 U.S.C. 5101 note, §3).	A preventable act or series of acts of commission or omission by a parent, caretaker, or other person in a custodial role that results in harm, potential harm or threat of harm to a child.

There are three consistent components to these definitions of child abuse and neglect:

- An act or failure to act
- by a parent or person in a caregiver role
- that results in harm or risk of harm to children.

Risk Factors for Child Maltreatment

Caretaker	Child
• Substance use and/or mental health • Mental Health issues • Poor understanding of child development • History of abuse or neglect • Young, single parents or many children • Low education or income • High parenting or economic stress • Using corporal punishment • Unrelated caretaker in the home • Attitudes accept violence	• Under the age of 4 • Needs that may increase caretaker burden, such as: – disabilities – mental illness – chronic physical illness – learning challenges

The Risk and Protective Factors for Child Maltreatment handout on the following page contains a list of risk and protective factors for individuals, families, and communities.

Handout: Risk and Protective Factors for Child Maltreatment

From the Centers for Disease Control and Prevention

Risk Factors for Victimization

Individual Risk Factors

- Children younger than 4 years of age
- Children with special needs that may increase caregiver burden (disabilities, mental health issues, and chronic physical illnesses)

Risk Factors for Perpetration

Individual Risk Factors

- Caregivers with drug or alcohol issues
- Caregivers with mental health issues, including depression
- Caregivers who don't understand children's needs or development
- Caregivers who were abused or neglected as children
- Caregivers who are young or single parents or parents with many children
- Caregivers with low education or income
- Caregivers experiencing high levels of parenting stress or economic stress
- Caregivers who use spanking and other forms of corporal punishment for discipline
- Caregivers in the home who are not a biological parent
- Caregivers with attitudes accepting of or justifying violence or aggression

Family Risk Factors

- Families that have household members in jail or prison
- Families that are isolated from and not connected to other people (extended family, friends, neighbors)
- Families experiencing other types of violence, including relationship violence
- Families with high conflict and negative communication styles

Community Risk Factors

- Communities with high rates of violence and crime
- Communities with high rates of poverty and limited educational and economic opportunities
- Communities with high unemployment rates
- Communities with easy access to drugs and alcohol
- Communities where neighbors don't know or look out for each other and there is low community involvement among residents
- Communities with few community activities for young people
- Communities with unstable housing and where residents move frequently
- Communities where families frequently experience food insecurity

Protective Factors for Child Abuse and Neglect

Protective factors may lessen the likelihood of children being abused or neglected. Identifying and understanding protective factors are equally as important as researching risk factors.

Individual Protective Factors

- Caregivers who create safe, positive relationships with children
- Caregivers who practice nurturing parenting skills and provide emotional support
- Caregivers who can meet the basic needs of food, shelter, education, and health services
- Caregivers who have a college degree or higher and have steady employment

Family Protective Factors

- Families with strong social support networks and stable, positive relationships with the people around them
- Families where caregivers are present and interested in the chil
- Families where caregivers enforce household rules and engage in child monitoring
- Families with caring adults outside the family who can serve as role models or mentors

Community Protective Factors

- Communities with access to safe, stable housing
- Communities where families have access to high-quality preschool
- Communities where families have access to nurturing and safe childcare
- Communities where families have access to safe, engaging after-school programs and activities
- Communities where families have access to medical care and mental health services
- Communities where families have access to economic and financial help
- Communities where adults have work opportunities with family-friendly policies

Risk and Protective Factors|Child Abuse and Neglect|Violence Prevention|Injury Center|CDC

Signs of Abuse

Video: Signs of Abuse

Video Link: Watch Signs of Abuse Video. After viewing the video, reflect on the following questions.

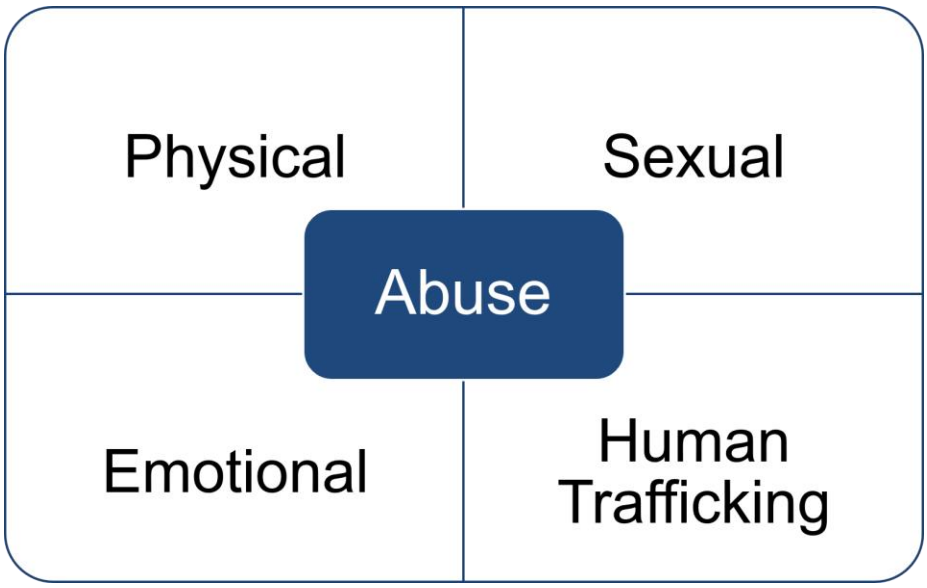
What stood out to you about the descriptions of child abuse?

What surprised you?

What makes you nervous to encounter?

How will you manage your feelings about what children have experienced?

Major Types of Child Abuse



The Child Welfare Information Gateways offers the following definitions:

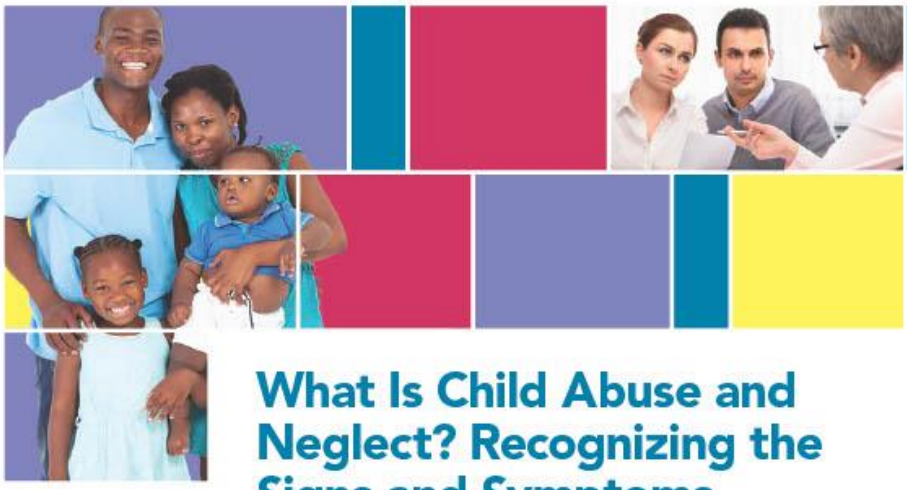
Physical abuse is a nonaccidental physical injury to a child caused by a parent, caretaker, or other person responsible for a child and can include punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise causing physical harm. Physical discipline, such as spanking or paddling, is not considered abuse as long as it is reasonable and causes no bodily injury to the child. Injuries from physical abuse could range from minor bruises to severe fractures or death.

Sexual abuse includes activities by a parent or other caretaker such as fondling a child's genitals, penetration, incest, rape, sodomy, indecent exposure, and exploitation through prostitution or the production of pornographic materials.

Emotional abuse (or psychological abuse) is a pattern of behavior that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats, or rejection and withholding love, support, or guidance. Emotional abuse is often difficult to prove, and, therefore, child protective services may not be able to intervene without evidence of harm or mental injury to the child.

Human trafficking is considered a form of modern slavery and includes both sex trafficking and labor trafficking. Sex trafficking is recruiting, harboring, transporting, providing, or obtaining someone for a commercial sex act, such as prostitution, pornography, or stripping. Labor trafficking is forced labor, including drug dealing, begging, or working long hours for little pay. Although human trafficking includes victims of any sex, age, race/ ethnicity, or socioeconomic status, children involved in child welfare, including children who are in out-of-home care, are especially vulnerable.

Handout: What is Child Abuse and Neglect?



FACTSHEET

April 2019

What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms

The first step in helping children who have been abused or neglected is learning to recognize the signs of maltreatment. The presence of a single sign does not necessarily mean that child maltreatment is occurring in a family, but a closer look at the situation may be warranted when these signs appear repeatedly or in combination. This factsheet is intended to help you better understand the Federal definition of child abuse and neglect; learn about the different types of abuse and neglect, including human trafficking; and recognize their signs and symptoms. It also includes additional resources with information on how to effectively identify and report maltreatment and refer children who have been maltreated.

WHAT'S INSIDE

How is child abuse and neglect defined in Federal law?

What are the major types of child abuse and neglect?

Recognizing signs of abuse and neglect and when to report

Resources

Child Welfare Information Gateway

Children's Bureau/ACYF/ACF/HHS
800.394.3366 | Email: info@childwelfare.gov | https://www.childwelfare.gov

Children's Bureau

How Is Child Abuse and Neglect Defined in Federal Law?

Federal legislation lays the groundwork for State laws on child maltreatment by identifying a minimum set of actions or behaviors that define child abuse and neglect. The Federal Child Abuse Prevention and Treatment Act (CAPTA), as amended and reauthorized by the CAPTA Reauthorization Act of 2010, defines child abuse and neglect as, at a minimum, "any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation (including sexual abuse as determined under section 111), or an act or failure to act which presents an imminent risk of serious harm" (42 U.S.C. 5101 note, § 3).

Additionally, it stipulates that "a child shall be considered a victim of 'child abuse and neglect' and of 'sexual abuse' if the child is identified, by a State or local agency employee of the State or locality involved, as being a victim of sex trafficking[1] (as defined in paragraph (10) of section 7102 of title 22) or a victim of severe forms of trafficking in persons described in paragraph (9)(A) of that section" (42 U.S.C. § 5106g(b)(2)).

Most Federal and State child protection laws primarily refer to cases of harm to a child caused by parents or other caregivers; they generally do not include harm caused by other people, such as acquaintances or strangers. Some State laws also include a child's witnessing of domestic violence as a form of abuse or neglect.

For State-specific laws pertaining to child abuse and neglect, see Child Welfare Information Gateway's State Statutes Search page at https://www.childwelfare.gov/topics/systemwide/laws-policies/state/.

[1] According to the Victims of Trafficking and Violence Protection Act of 2000, sex trafficking is categorized as a "severe form of trafficking in persons" and is defined as a "situation in which a commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such act has not attained 18 years of age." As of May 2017, States are required to have provisions and procedures in place as part of their CAPTA State Plans that require "identification and assessment of all reports involving children known or suspected to be victims of sex trafficking and…training child protective services workers about identifying, assessing, and providing comprehensive services for children who are sex trafficking victims, including efforts to coordinate with State law enforcement, juvenile justice, and social service agencies such as runaway and homeless youth shelters…"

To view civil definitions that determine the grounds for intervention by State child protective agencies, visit Information Gateway's *Definitions of Child Abuse and Neglect* at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/define/.

Child Maltreatment reports. These annual reports summarize annual child maltreatment and neglect statistics submitted by States to the National Child Abuse and Neglect Data System. They include information about victims, fatalities, perpetrators, services, and additional research. The reports are available at http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment.

Child Welfare Outcomes Report Data. This website provides information on the performance of States in seven outcome categories related to the safety, permanency, and well-being of children involved in the child welfare system. Data, which are made available on the website prior to the release of the annual report, include the number of child victims of maltreatment. To view the website, visit https://cwoutcomes.acf.hhs.gov/cwodatasite/.

What Are the Major Types of Child Abuse and Neglect?

Within the minimum standards set by CAPTA, each State is responsible for providing its own definitions of child abuse and neglect. Most States recognize four major types of maltreatment: physical abuse, neglect, sexual abuse, and emotional abuse. Additionally, many States identify abandonment, parental substance use, and human trafficking as abuse or neglect. While some of these types of maltreatment may be found separately, they can occur in combination. This section provides brief definitions for each of these types.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
This publication is available online at https://www.childwelfare.gov/pubs/factsheets/whatiscan/.

Physical abuse is a nonaccidental physical injury to a child caused by a parent, caregiver, or other person responsible for a child and can include punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise causing physical harm.[2] Physical discipline, such as spanking or paddling, is not considered abuse as long as it is reasonable and causes no bodily injury to the child. Injuries from physical abuse could range from minor bruises to severe fractures or death.

Neglect is the failure of a parent or other caregiver to provide for a child's basic needs. Neglect generally includes the following categories:

- Physical (e.g., failure to provide necessary food or shelter, lack of appropriate supervision)
- Medical (e.g., failure to provide necessary medical or mental health treatment, withholding medically indicated treatment from children with life-threatening conditions)[3]
- Educational (e.g., failure to educate a child or attend to special education needs)
- Emotional (e.g., inattention to a child's emotional needs, failure to provide psychological care, permitting a child to use alcohol or other drugs)

Sometimes cultural values, the standards of care in the community, and poverty may contribute to what is perceived as maltreatment, indicating the family may need information or assistance. It is important to note that living in poverty is not considered child abuse or neglect. However, a family's failure to use available information and resources to care for their child may put the child's health or safety at risk, and child welfare intervention could be required. In addition, many States provide an exception to the definition of neglect for parents who choose not to seek medical care for their children due to religious beliefs.[4]

Sexual abuse includes activities by a parent or other caregiver such as fondling a child's genitals, penetration, incest, rape, sodomy, indecent exposure, and exploitation through prostitution or the production of pornographic materials. Sexual abuse is defined by CAPTA as "the employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or assist any other person to engage in, any sexually explicit conduct or simulation of such conduct for the purpose of producing a visual depiction of such conduct; or the rape, and in cases of caretaker or interfamilial relationships, statutory rape, molestation, prostitution, or other form of sexual exploitation of children, or incest with children" (42 U.S.C. § 5106g(a)(4)).

Emotional abuse (or psychological abuse) is a pattern of behavior that impairs a child's emotional development or sense of self-worth. This may include constant criticism, threats, or rejection as well as withholding love, support, or guidance. Emotional abuse is often difficult to prove, and, therefore, child protective services may not be able to intervene without evidence of harm or mental injury to the child (Prevent Child Abuse America, 2016).

Abandonment is considered in many States as a form of neglect. In general, a child is considered to be abandoned when the parent's identity or whereabouts are unknown, the child has been left alone in circumstances where the child suffers serious harm, the child has been deserted with no regard for his or her health or safety, or the parent has failed to maintain contact with the child or provide reasonable support for a specified period of time. Some States have enacted laws—often called safe haven laws—that provide safe places for parents to relinquish newborn infants. Information Gateway produced a publication as part of its State Statutes series that summarizes such laws. *Infant Safe Haven Laws* is available at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/safehaven/.

[2] Nonaccidental injury that is inflicted by someone other than a parent, guardian, relative, or other caregiver (i.e., a stranger) is considered a criminal act that is not addressed by child protective services.

[3] Although it can apply to children of any age, withholding of medically indicated treatment is a form of medical neglect that is defined by CAPTA as "the failure to respond to…life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions…" CAPTA does note a few exceptions, including infants who are "chronically and irreversibly comatose," situations when providing treatment would not save the infant's life but merely prolong dying, or when "the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane."

[4] The CAPTA amendments of 1996 (42 U.S.C. § 5106i) added new provisions specifying that nothing in the act be construed as establishing a Federal requirement that a parent or legal guardian provide any medical service or treatment that is against the religious beliefs of the parent or legal guardian.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
This publication is available online at https://www.childwelfare.gov/pubs/factsheets/whatiscan/.

Parental substance use is included in the definition of child abuse or neglect in many States. Related circumstances that are considered abuse or neglect in some States include the following:

- Exposing a child to harm prenatally due to the mother's use of legal or illegal drugs or other substances
- Manufacturing methamphetamine in the presence of a child
- Selling, distributing, or giving illegal drugs or alcohol to a child
- Using a controlled substance that impairs the caregiver's ability to adequately care for the child

For more information about this issue, see Information Gateway's *Parental Substance Use as Child Abuse* at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/parentalsubstanceuse/.

Human trafficking is considered a form of modern slavery and includes both sex trafficking and labor trafficking. Sex trafficking is recruiting, harboring, transporting, providing, or obtaining someone for a commercial sex act, such as prostitution, pornography, or stripping. Labor trafficking is forced labor, including drug dealing, begging, or working long hours for little pay (Child Welfare Information Gateway, 2018). Although human trafficking includes victims of any sex, age, race/ethnicity, or socioeconomic status, children involved in child welfare, including children who are in out-of-home care, are especially vulnerable (Child Welfare Information Gateway, 2018).

For more information, see Information Gateway's webpage on human trafficking at https://www.childwelfare.gov/topics/systemwide/trafficking/ and the State statutes on the definitions of human trafficking at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/definitions-trafficking/.

Recognizing Signs of Abuse and Neglect and When to Report

It is important to recognize high-risk situations and the signs and symptoms of maltreatment. If you suspect a child is being harmed, reporting your suspicions may protect him or her and help the family receive assistance. Any concerned person can report suspicions of child abuse or neglect. Reporting your concerns is not making an accusation; rather, it is a request for an investigation and assessment to determine if help is needed.

Some people (typically certain types of professionals, such as teachers or physicians) are required by State laws to report child maltreatment under specific circumstances. Some States require all adults to report suspicions of child abuse or neglect. Individuals required to report maltreatment are called mandatory reporters. Information Gateway's *Mandatory Reporters of Child Abuse and Neglect* discusses the laws that designate groups of professionals or individuals as mandatory reporters. It is available at https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/manda/?hasBeenRedirected=1.

For information about where and how to file a report, contact your local child protective services agency or police department. Childhelp's National Child Abuse Hotline (800.4.A.CHILD) and its website (https://www.childhelp.org/hotline/) offer crisis intervention, information, resources, and referrals to support services and provide assistance in more than 170 languages.

For information on what happens when suspected abuse or neglect is reported, read Information Gateway's *How the Child Welfare System Works* at https://www.childwelfare.gov/pubs/factsheets/cpswork/.

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
This publication is available online at https://www.childwelfare.gov/pubs/factsheets/whatiscan/.

A child may directly disclose to you that he or she has experienced abuse or neglect. Childhelp's *Handling Child Abuse Disclosures* defines direct and indirect disclosure and provides tips for supporting the child. It is available at https://www.childhelp.org/story-resource-center/handling-child-abuse-disclosures/.

While it's important to know the signs of physical, mental, and emotional abuse and neglect, which are provided later in this factsheet, the following signs of general maltreatment also can help determine whether a child needs help:

- Child
  - Shows sudden changes in behavior or school performance
  - Has not received help for physical or medical problems brought to the parents' attention
  - Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes
  - Is always watchful, as though preparing for something bad to happen
  - Lacks adult supervision
  - Is overly compliant, passive, or withdrawn
  - Comes to school or other activities early, stays late, and does not want to go home
  - Is reluctant to be around a particular person
  - Discloses maltreatment
- Parent
  - Denies the existence of—or blames the child for—the child's problems in school or at home
  - Asks teachers or other caregivers to use harsh physical discipline if the child misbehaves
  - Sees the child as entirely bad, worthless, or burdensome
  - Demands a level of physical or academic performance the child cannot achieve
  - Looks primarily to the child for care, attention, and satisfaction of the parent's emotional needs
  - Shows little concern for the child
- Parent and child
  - Touch or look at each other rarely
  - Consider their relationship entirely negative
  - State consistently they do not like each other

The preceding list is not a comprehensive list of the signs of maltreatment. It is important to pay attention to other behaviors that may seem unusual or concerning. Additionally, the presence of these signs does not necessarily mean that a child is being maltreated; there may be other causes. They are, however, indicators that others should be concerned about the child's welfare, particularly when multiple signs are present or they occur repeatedly.

For information about risk factors for maltreatment as well as the perpetrators, see the webpage Risk Factors That Contribute to Child Abuse and Neglect, which is available at https://www.childwelfare.gov/topics/can/factors/, and the webpage Perpetrators of Child Abuse & Neglect, which is available at https://www.childwelfare.gov/topics/can/perpetrators/.

Signs of Physical Abuse

A child who exhibits the following signs may be a victim of physical abuse:

- Has unexplained injuries, such as burns, bites, bruises, broken bones, or black eyes
- Has fading bruises or other noticeable marks after an absence from school
- Seems scared, anxious, depressed, withdrawn, or aggressive
- Seems frightened of his or her parents and protests or cries when it is time to go home
- Shrinks at the approach of adults
- Shows changes in eating and sleeping habits
- Reports injury by a parent or another adult caregiver
- Abuses animals or pets

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
This publication is available online at https://www.childwelfare.gov/pubs/factsheets/whatiscan/.

Consider the possibility of physical abuse when a parent or other adult caregiver exhibits the following (Prevent Child Abuse America, 2018):

- Offers conflicting, unconvincing, or no explanation for the child's injury or provides an explanation that is not consistent with the injury
- Shows little concern for the child
- Sees the child as entirely bad, burdensome, or worthless
- Uses harsh physical discipline with the child
- Has a history of abusing animals or pets

Signs of Neglect

A child who exhibits the following signs may be a victim of neglect (Tracy, 2018a):

- Is frequently absent from school
- Begs or steals food or money
- Lacks needed medical care (including immunizations), dental care, or glasses
- Is consistently dirty and has severe body odor
- Lacks sufficient clothing for the weather
- Abuses alcohol or other drugs
- States that there is no one at home to provide care

Consider the possibility of neglect when a parent or other caregiver exhibits the following (Tracy, 2018b):

- Appears to be indifferent to the child
- Seems apathetic or depressed
- Behaves irrationally or in a bizarre manner
- Abuses alcohol or other drugs

Signs of Sexual Abuse

A child who exhibits the following signs may be a victim of sexual abuse (American Academy of Child and Adolescent Psychology, 2014; Rape, Abuse and Incest National Network [RAINN], 2018a):

- Has difficulty walking or sitting
- Experiences bleeding, bruising, or swelling in their private parts
- Suddenly refuses to go to school
- Reports nightmares or bedwetting
- Experiences a sudden change in appetite
- Demonstrates bizarre, sophisticated, or unusual sexual knowledge or behavior
- Becomes pregnant or contracts a sexually transmitted disease, particularly if under age 14
- Runs away
- Reports sexual abuse by a parent or another adult caregiver
- Attaches very quickly to strangers or new adults in their environment

Consider the possibility of sexual abuse when a parent or other caregiver exhibits the following (RAINN, 2018b):

- Tries to be the child's friend rather than assume an adult role
- Makes up excuses to be alone with the child
- Talks with the child about the adult's personal problems or relationships

Signs of Emotional Maltreatment

A child who exhibits the following signs may be a victim of emotional maltreatment (Prevent Child Abuse America, 2016):

- Shows extremes in behavior, such as being overly compliant or demanding, extremely passive, or aggressive
- Is either inappropriately adult (e.g., parenting other children) or inappropriately infantile (e.g., frequently rocking or head-banging)
- Is delayed in physical or emotional development
- Shows signs of depression or suicidal thoughts
- Reports an inability to develop emotional bonds with others

Consider the possibility of emotional maltreatment when the parent or other adult caregiver exhibits the following (Prevent Child Abuse America, 2016):

- Constantly blames, belittles, or berates the child
- Describes the child negatively
- Overtly rejects the child

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
This publication is available online at https://www.childwelfare.gov/pubs/factsheets/whatiscan/.

The Impact of Childhood Trauma on Well-Being

Child abuse and neglect can have lifelong implications for victims, including on their well-being. While the physical wounds may heal, there are many long-term consequences of experiencing the trauma of abuse or neglect. A child or youth's ability to cope and thrive after trauma is called "resilience." With help, many of these children can work through and overcome their past experiences.

Children who are maltreated may be at risk of experiencing cognitive delays and emotional difficulties, among other issues, which can affect many aspects of their lives, including their academic outcomes and social skills development (Bick & Nelson, 2016). Experiencing childhood maltreatment also is a risk factor for depression, anxiety, and other psychiatric disorders (Fuller-Thomson, Baird, Dhrodia, & Brennenstuhl, 2016). For more information on the lasting effects of child abuse and neglect, read *Long-Term Consequences of Child Abuse and Neglect* at https://www.childwelfare.gov/pubs/factsheets/long-term-consequences.

Resources

The National Child Traumatic Stress Network's factsheet *What Is Child Traumatic Stress?* (https://www.nctsn.org/resources/what-child-traumatic-stress) defines child traumatic stress and provides an overview of trauma, trauma signs and symptoms, and how trauma can impact children. Find more resources that strive to raise the standard of care and improve access to services for traumatized children, their families, and communities on the National Child Traumatic Stress Network at http://www.nctsn.org/.

The Centers for Disease Control and Prevention (CDC) web section, Child Abuse and Neglect: Consequences, provides information on the prevalence, effects, and physical and mental consequences of child abuse and neglect as well as additional resources and a comprehensive reference list. You can visit it at https://www.cdc.gov/violenceprevention/childabuseandneglect/consequences.html.

Stop It Now! is a website that provides parents and other adults with resources to help prevent child sexual abuse. The site offers direct help to those with questions or concerns about child abuse, prevention advocacy, prevention education, and technical assistance and training. The website is available at http://www.stopitnow.org/.

The American Academy of Pediatrics' The Resilience Project gives pediatricians and other health-care providers the resources they need to more effectively identify, treat, and refer children and youth who have been maltreated as well as promotes the importance of resilience in how a child deals with traumatic stress. The webpage is available at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/resilience/Pages/Resilience-Project.aspx.

Information Gateway has produced webpages and publications about child abuse and neglect:

- The Child Abuse and Neglect webpage (https://www.childwelfare.gov/topics/can/) provides information on identifying abuse, statistics, risk and protective factors, and more.
- The Reporting Child Abuse and Neglect webpage (https://www.childwelfare.gov/topics/responding/reporting/) provides information about mandatory reporting and how to report suspected maltreatment.
- Information Gateway also has several publications that cover understanding and preventing maltreatment:
  - *Child Maltreatment: Past, Present, and Future:* https://www.childwelfare.gov/pubs/issue-briefs/cm-prevention/
  - *Preventing Child Abuse and Neglect:* https://www.childwelfare.gov/pubs/factsheets/preventingcan/
  - *Understanding the Effects of Maltreatment on Brain Development* https://www.childwelfare.gov/pubs/issue-briefs/brain-development/

This material may be freely reproduced and distributed. However, when doing so, please credit Child Welfare Information Gateway.
This publication is available online at https://www.childwelfare.gov/pubs/factsheets/whatiscan/.

The **CDC** *produced Preventing Child Abuse & Neglect* (https://www.cdc.gov/violenceprevention/childabuseandneglect/fastfact.html), which defines the many types of maltreatment and the CDC's approach to prevention.

Prevent Child Abuse America is a national organization dedicated to providing information on child maltreatment and its prevention. You can visit its website at http://preventchildabuse.org/.

A list of organizations focused on child maltreatment prevention is available on Information Gateway's National Child Abuse Prevention Partner Organizations page at https://www.childwelfare.gov/organizations/?CWIGFunctionsaction=rols:main.dspList&rolType=Custom&RS_ID=75&rList=ROL.

References

American Academy of Adolescent Psychology. (2014). *Sexual abuse*. Retrieved from https://www.aacap.org/AACAP/Families_and_Youth/Facts_for_Families/FFF-Guide/Child-Sexual-Abuse-009.aspx

Bick, J., & Nelson, C. A. (2016). Early adverse experiences and the developing brain. *Neuropsychopharmacology, 41*, 177–196. Retrieved from https://www.nature.com/articles/npp2015252. doi: 10.1038/npp.2015.252

Child Welfare Information Gateway. (2018). *Human trafficking: Protecting our youth*. Retrieved from https://www.childwelfare.gov/pubPDFs/trafficking_ts_2018.pdf

Fuller-Thomson, E., Baird, S. L., Dhrodia, R., & Brennenstuhl, S. (2016). The association between adverse childhood experiences (ACEs) and suicide attempts in a population-based study. *Child: Care, Health and Development, 42*, 725–734. doi: 10.1111/cch.12351

Prevent Child Abuse America. (2016). *Fact sheet: Emotional child abuse*. Retrieved from http://www.preventchildabuse.org/images/docs/emotionalchildabuse.pdf

Prevent Child Abuse America. (2018). *Recognizing child abuse: What parents should know*. Retrieved from https://nic.unlv.edu/pcan/files/recognizing_abuse.pdf

Rape, Abuse and Incest National Network. (2018a). *Child sexual abuse*. Retrieved from https://rainn.org/articles/child-sexual-abuse

Rape, Abuse and Incest National Network. (2018b). *Warning signs for young children*. Retrieved from https://www.rainn.org/articles/warning-signs-young-children

Tracy, N. (2018a). *Signs of child neglect and how to report child neglect*. Retrieved from https://www.healthyplace.com/abuse/child-abuse-information/signs-of-child-neglect-and-how-to-report-child-neglect

Tracy, N. (2018b). *What is child neglect?* Retrieved from https://www.healthyplace.com/abuse/child-abuse-information/what-is-child-neglect

Suggested Citation:

Child Welfare Information Gateway. (2019). *What is child abuse and neglect? Recognizing the signs and symptoms*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau.

U.S. Department of Health and Human Services
Administration for Children and Families
Administration on Children, Youth and Families
Children's Bureau

ACF

Children's Bureau

Handout: Cultural Healing Practices that Mimic Child Abuse

Annals of Forensic Research and Analysis

Cultural Healing Practices that Mimic Child Abuse

Mini Review | Open Access | Volume 4 | Issue 2
Article DOI : https://doi.org/10.47739/2378-9476/1042

Killion CM*
+ Show More

Corresponding Authors
Cheryl M. Killion, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, Ohio, USA, Tel: (216) 368-0462

Abstract

Child abuse is an invisible epidemic that has serious short and long term ramifications for the affected children, their families and society at large. Making a diagnosis that suggests or confirms child abuse can be challenging because many medical conditions resemble child abuse and cultural healing practices often result in the appearance of child maltreatment. In this review several cultural healing practices are described, including coining (caogio), cupping (hijama), guasha, moxibustion, and caida de mollera. Many of these cultural approaches are ancient practices that still exist, today. Also, certain birthmarkings, (Mongolian spots) may present in a manner that suggests child abuse. To insure an accurate differential diagnosis, the importance of being culturally sensitive and aware of specific belief systems and practices of cultural groups is underscored.

Keywords

Child abuse; Cultural healing practices; Immigrants; Ethnic minority groups; Differential diagnosis.

CITATION

Killion CM (2017) Cultural Healing Practices that Mimic Child Abuse. Ann Forensic Res Anal 4(2): 1042.

INTRODUCTION

Child abuse is a devastating and invisible epidemic with significant ramifications for the affected children, their families, and society at large. Short and long term physical, mental, cognitive, and developmental sequelae, with serious consequences, are involved and may even result in the death of a child [1]. Effective measures to prevent, identify, and stop child maltreatment are crucial for insuring the health and safety of vulnerable infants and children. However, making a diagnosis that suggests or confirms child abuse can be challenging. A number of physical conditions, including those that cause fractures, and disorders of cutaneous, hemorrhagic, or metabolic origins can mimic child maltreatment [2]. Moreover, certain cultural healing practices may result in the appearance of child abuse.

Undoubtedly, a diagnosis of child abuse should never be overlooked and must be reported. However, a differential diagnosis is important, to avoid misinterpretations that may result in unfortunate legal consequences [2,3]. In this review an overview is provided of commonly used cultural healing practices and related physical manifestations that often mimic child abuse. Although most of these practices have ancient origins, they are currently being used by segments of the population and include practices such as coining (caogio), spooning (guasha), cupping (hijama), moxibustion, and a range of strategies to treat sunken or fallen fontanel (caida de mollera).

During the last few decades, the volume of immigrants to the United States has grown exponentially and the immigrants' demographic characteristics and countries of origin have changed over time. Although in the 1990s immigrants came to the United States primarily from Latin America and Europe, currently and increasingly immigrants are more likely to have origins in South and East Asia [4]. Sizable numbers are also arriving from the Caribbean, the Middle East, and Sub-Saharan Africa [4]. As immigrants become immersed in the American culture, they retain many of their cultural traditions and practices. Also, members of ethnic minority groups born in the U.S. and having a longer history and presence in the country, often engage in health practices distinct from conventional medicine in the United States [5]. Health care providers are urged to be sensitive to, and knowledgeable about, alternative health belief systems and approaches to care because some of these alternative practices may seem counter to Western medicine and/or are perceived to be potentially harmful.

CULTURAL HEALING PRACTICES

Coining or caogio, is an example of an ancient healing practice still being practiced, today. This dermabrasion therapy, which involves intense rubbing of the skin, is used by Vietnamese, Cambodians, and Laotians to treat a variety of illnesses [6,7]. Although Southeast Asian cultures differ somewhat in their belief systems, their use of caogio is based on similar principles. The origin of caogio is based on Taoist philosophy which considers health to be a balance between physical, moral, and internal and external forces. According to this healing practice, there are three major causative categories of illness: physical, metaphysical, and supernatural. Maintaining harmony with nature is a central tenet [6]. Conditions that cause disease include excessive emotions, incorrect diet, or imbalance between hot and cold energies and bad wind [6,7].

The Vietnamese call wind, phong [6]. According to some, the wind can invade the body and cause a variety of illnesses including headaches, muscle aches, coughs, fevers, upper respiratory infections and sore throats [6]. To alleviate the symptoms of these illnesses, the forces are balanced by using herbal remedies and dermabrasion. Ointment or oil is applied to the skin and intensive rubbing takes place [3,6,7]. Cao gio involves creating friction on the skin to restore balance. The

purpose of caogio is to release excessive air or to rub or scratch out the wind. The procedure is used on various parts of the body, though primary locations for application are the posterior thorax, shoulders, chest, temples, and forehead [6]. If the coin rubbing procedure leaves a red mark, caogiois considered to be effective. Usually, caogio results in linear erythematous patches, petechiae, or purpura [3,6,7]. Although most of the complications associated with this practice have been minor burns, a few cases of serious complications from coining have been reported requiring skin grafts when the heated oil on the skin caught fire [3]. Certainly, abuse should be suspected, if such markings are noticed on children, not from groups who traditionally use this practice. Careful history-taking and follow-up are warranted for those who have caogio applied regularly.

A practice similar to coining is spooning or guasha, which is used in China to rid the body of illness. This procedure results in a linear pattern of ecchymosis on the patient's skin when a spoon or spoon-like tool, made of porcelain, jade, bone, horn or similar material, is used to rub the wet skin [7-9]. Skin eruptions may be generated that resemble a pine tree pattern, with long vertical marks along the spine and paralleling the ribcage as may also be seen in caogio [10] (Figure 1).

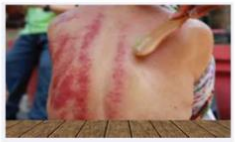


Figure 1: Gua Sha Procedure Performed on Shoulder and Back of Young Male.

Cupping is another ancient, though fairly common practice, which has been used throughout the Middle East, Asia, Latin America, and Eastern Europe. In the United States, this technique is practiced primarily by Russian immigrants and its use has been revitalized among naturalistic health providers, as well [3,9,11]. There are two types of cupping: wet and dry [11,12]. Wet cupping, also known as hijama, involves small cuts to the skin to draw blood and is thought to help rid the body of toxins [11]. In dry cupping the air, in an open-mouthed vessel, is heated and subsequently, the vessel is applied to the skin. Suction is produced by the cooling and contracting of the heated air and is thought to "draw out" the ailment as the heated air and the rim of the cup burn the skin [11] (Figure 2).

Figure 2: Cupping as Cups are Being Removed.

The signs of cupping usually present on the patient's back, as multiple, grouped circular ecchymoses. Central ecchymosis or petechiae result from the suction effect of the heated air as it cools and contracts (Figure 3).

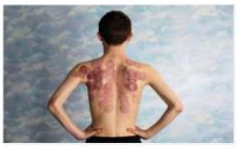


Figure 3: Boy's Back Following Cupping.

Dry cupping is used to alleviate pain, primarily musculoskeletal, and inflammation. It is purported to increase blood flow and promote relaxation and well-being. Further, it is used as a type of deep tissue massage [12]. Cupping therapy is growing in popularity as an alternative treatment for a variety of conditions and diseases in patients of all ages, including athletes [12].

Another cultural healing practice is moxibustion (Figure 4).

Figure 4: Moxa Stick.

Originating in Asian medicine, this healing practice involves burning rolled pieces of moxa herb (mugwort or Artemisia vulgaris) directly over the skin above acupuncture points and allowing the herb to burn near the skin's surface until the onset of pain [3,13]. The lesions of moxibustion appear as a pattern of "discrete circular, target-like burns" that may be confused with cigarette burns from child abuse [9]. Moxibustion is one of the most commonly used treatments in traditional medicine in East Asian cultures and is applied for a variety of symptoms, including fever and abdominal pain [3,13]. It is particularly effective in promoting energy (qi) and has been used to treat those experiencing chronic fatigue [14]. In Korea, contemporary studies indicate that moxibustion is being used in combination with conventional therapy to enhance immune functioning in children with cerebral palsy [15].

Caida de mollera (fallen fontanel), a serious infant health condition, is treated by culturally bound strategies in Mexico, Guatemala, and other Central American countries. This condition refers to the presence of a sunken anterior fontanel in an infant and is believed, in some Latin American subcultures, to cause a variety of symptoms including poor feeding, irritability and diarrhea [9,16]. The folk treatment for caida de mollera may present the physical symptoms associated with shaken baby syndrome or abusive head trauma [9,16].

Central to the concept of caida de mollera is the belief that an infant has experienced some sort of trauma resulting in a "fallen fontanel" [16]. It is important to recognize that the trauma may be unwitnessed and simply conjectured by family members or an indigenous healer, if a baby has a particular constellation of symptoms. The traumatic event may be thought to lead to organ displacement in which the movement of a body part from its proper location results in illness [16]. Specifically, the trauma is thought to force the fontanel downward, the head contents sink and the palate falls creating a bolita or bump on the roof of the mouth, obstructing the feeding process. The most commonly quoted causes in folk medicine of caida de mollera are distinct from the biomedical explanation of the resulting poor feeding, leading to dehydration, malnutrition, and a depressed fontanel [9,16]. Rather, causes of caida de mollera are attributed to the quick separation of the nipple from the mouth of a feeding baby, traveling on a bumpy road, rocking too fast, allowing the baby to suck on an empty body, and improper carrying, holding, and dressing an infant [9,17].

Attempts to correct this condition may involve oral suction over the fontanel by a curandero or folk healer, slapping of the soles of the feet of the infant, pushing upon the palate in the mouth, or shaking the infant vertically while holding the baby upside down. The shaking is usually nonviolent and generally thought not to cause significant resultant injury [3,16,17]. However delays in addressing the dehydration, the likely cause of the sunken fontanel is potentially life threatening. Although caida de mollera is an unlikely cause of shaken baby syndrome (abusive head trauma) the immediate addressing of an infant's symptoms is imperative as an attempt is made to align biomedical approaches to care with those supportive of the lay explanatory models of healing [17]. Priorities of care include careful history taking, addressing the physical symptoms of the child and educating the parents.

DISCUSSION AND CONCLUSION

Several cultural healing practices with which health providers should be familiar, have been presented. The physical manifestation of these practices may be confused with, or misinterpreted, as child abuse. Being sensitive to cultural beliefs and maintaining a nonjudgmental attitude will help in obtaining an accurate history and a careful examination, and in differentiating manifestations of cultural healing practices from signs of physical abuse. Knowledge of these cultural healing practices can facilitate a differential diagnosis, may lead to the initiation of appropriate therapy and can avert the negative consequences of an incorrect evaluation of and/or report of suspected child abuse. However, special consideration must be given when medical complications from such cultural healing practices do occur and/or if the safety of an infant or child is perceived to be in jeopardy because of these practices.

Beyond the clinician making a diagnosis and advancing appropriate treatment, it is also prudent to understand why use of these ancient practices persists. The power of cultural healing practices must be acknowledged despite limited evidence of the scientific efficacy of some of these practices. Populations, that engage in alternative healing practices, often seek to connect with, and become empowered by, their cultural heritage. At the same time, they may be struggling to process the values and approaches of the dominant culture with its conventional medicine [18]. The clinician must endeavor to bridge that gap with respect and cultural sensitive.

REFERENCES

1. Committee on Child Maltreatment Research, Policy, and Practice for the Next Decade: Phase II: Board on Children, Youth, and Families: Institute of Medicine. New directions in child abuse and neglect research. In: Peterson AC, Joseph J, Feit M, editors. National Research Council. Washington: National Academies Press (US). 2014.

2. Christian CW, States LJ. Medical mimics of child abuse. AJR Am J Roentgenol. 2017; 208: 982-990.

3. Boos SC. Differential diagnosis of suspected child physical abuse. UpT?oDate. Snapshot of U.S. Immigration. National Conference of State legislatures. Retrieved from: https: //www.ncsl.org/research/ immigration/us-immigration-snapshot-2016-aspx/

4. Chao MT, Wade C, Kronenberg F. Disclosure of complementary and alternative medicine to conventional medical providers: variation by race/ethnicity and type of CAM. J Natl Med Assoc. 2008; 100: 1341- 1349.

5. Davis RE. Cultural health care or child abuse? The Southeast Asian practice of caogio. J Am Acad Nurse Pract. 2000; 12: 89-95.

6. Lam N, Castellanos A, Thomson K. A Vietnamese child with a rash on the back. Am Fam Physician. 2016; 93: 131-132.

7. Nielsen A, Kligler B, Koll BS. Addendum: Safety standards for guasha (press-stroking) and Ba guan (cupping). Complement Ther Med. 2014; 22: 446-448.

8. Spencer M Craft N LenameAl Swerdlin A Ladrigan M Berkowitz C. 2017: Cultural practices-child abuse recognition. Retrieved from https://www.visualdx.com/visualdx/diagnosis/culturpractices?mod uledid=43&diagnosis/

9. Lilly E, Kundu RV. Dermatoses secondary to Asian cultural practices. Int J Dermatol. 2012; 51: 372-382.

10.Qureshi NA, Ali GI, Abushanab TS, El-OlermyAT, Alqaed MS, El-Subai IS. History of cupping (Hijama): a narrative review of literature. J Integr Med. 2017; 15: 172-181.

11.Rozenfeld E, Kalichman L. New is the well-forgottenold: the use of dry cupping in musculoskeletal medicine. J Bodyw Mov Ther. 2016; 20: 173-178.

12.Yoon C, Cho YS, Park S, Chung SP, Choi YH. Epidemiology of burns caused by moxibustion in Korea. Burns. 2016; 42: 1588-1592.

13.Ying T, Ma C, Shang Q, Liu D. Effects of moxibustion on immune function in children with cerebral palsy. Zhongguo Zhen Jiu. 2016; 36: 12-16.

14.Kim M, Kim JE, Lee HY, Kim AR, Park HJ, Kwon OJ, et al. Moxibustion for cancer-related fatigue: study protocol for a randomized controlled trial. BMC Complement Altern Med. 2017; 17: 353.

15.Hansen KK. Folk remedies and child abuse: A review with emphasis on caida de mollera and its relationship to shaken baby syndrome. Child Abuse Negl. 1997; 22: 117-127.

16.Pachter LM, Weiler SC, Baer RD, Garcia de Alba Garcia JE, Glazer M, Trotter R, et al. Culture and dehydration: a comparative study of Caida de la Mollera (Fallen fontanel) in Three Latino Populations. J Immigr Minor Health. 2016; 18: 1066-1075.

17.Moghaddam JA, Momper SL, Fong TJ. Discrimination and participation in traditional healing for American Indians and Alaska Natives. J Community Health. 2013; 38: 1115-1123.

Activity: Recognizing Signs of Abuse

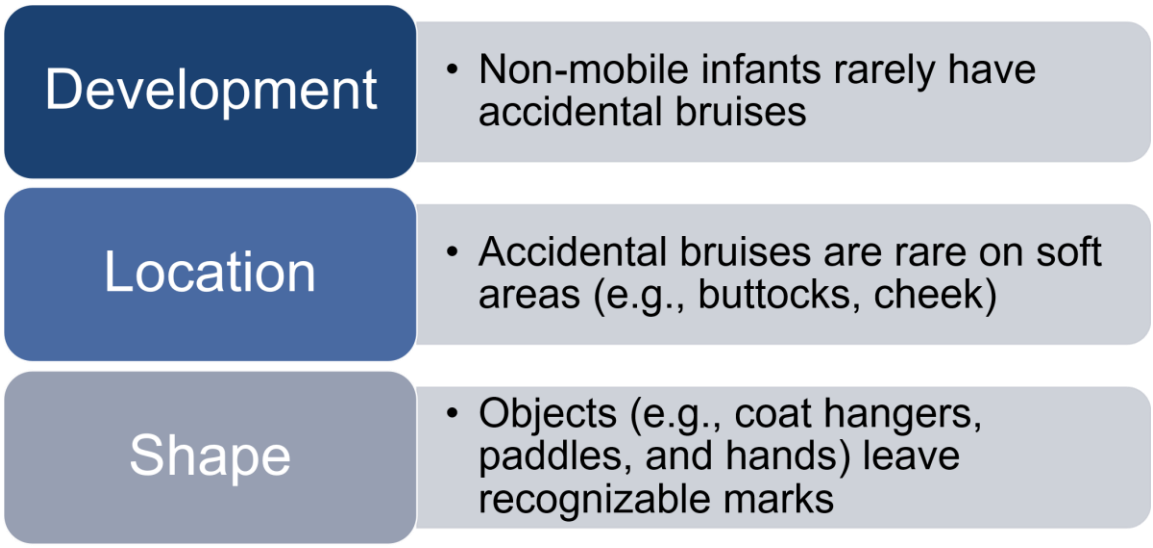
Brainstorm signs of physical, sexual, and emotional abuse based on your current knowledge of maltreatment definitions.

Physical Abuse

Sexual Abuse

Emotional Abuse

Bruising and Non-Accidental Injuries



We are caseworkers, not doctors, so we can never make medical determinations about physical abuse. However, it is important to be able to recognize the signs when completing an assessment or monitoring the safety of children ongoing.

Many of these signs, such as patterned bruises, bruising in atypical areas, multiple bruises from a single injury, and others trigger the policy requirement for a referral to the Child Medical Evaluation Program (CMEP) where a doctor will evaluate injuries to determine the cause.

While you do not have to make this determination, recognizing signs and being able to appropriately document them and communicate history in a referral to CMEP is critical for them to do a comprehensive evaluation.

Notes

Child Neglect

> The failure of a parent or other caretaker to provide for a child's basic needs.

Neglect is by far the most prevalent form of maltreatment reported both nationwide and in North Carolina. In 2020, over 85 percent of CPS Assessment cases were responding to neglect. Child neglect is the inability of a parent or caretaker to meet a child's basic needs, potentially placing the child at risk of serious harm. As we discussed earlier, maltreatment can be the commission or omission of an act. Neglect is more commonly an omission and therefore can be more difficult to appropriately identify and define.

North Carolina's law specifies multiple types of neglect including:

- Death of a Child
- Physical Neglect
- Unsafe Living Conditions
- Unsafe Clothing and Hygiene
- Unsafe Food/Nutrition
- Unsafe Supervision
- Unsafe Discipline
- Exposure to Violence in the Home/Injurious Environment
- Substance Affected Infant
- Parent, Guardian, or Custodian Has Refused to Follow the Recommendations of the Juvenile and Family Team
- Medical Neglect
    - Physical Health
    - Mental Health
- Educational Neglect
- Transfer of Custody (Illegal Placement/Adoption)
- Parent Requests to Dismiss Safe Surrender
- Abandonment
- Dependency
- Safe Surrender Infant

General signs of neglect include:

- Frequent absences from school
- Stealing food or money
- Lacking medical and dental care
- Being consistently dirty with severe body odor

- Lacking sufficient clothing for the weather
- Abusing alcohol or other drugs (must be accompanied by unsafe conditions, harm/ impact to the child)
- Stating that there is no caretaker at home

Some examples specific to the common types of neglect:

Unsafe Clothing and Hygiene can be seen if chronic lack of hygiene causes disease or illness. For example, if a baby's diaper is left unchanged for extended periods of time. Inadequate, unsafe clothing is also neglect if it exposes the child to frostbite.

Unsafe supervision includes being left unsupervised under the age of 8, or older if not developmentally appropriate for the child.

Unsafe discipline can be using restraints, confinement, or depravation to discipline a child.

Unsafe medical includes not receiving appropriate medical attention for physical health needs such as injuries or illnesses. Unsafe medical also includes not providing for the child's mental health needs.

Unsafe living conditions might be excessive filth, including exposed garbage, rotting food, animal and human excrement in living spaces, exposed wires, or unsecured areas where a child can fall.

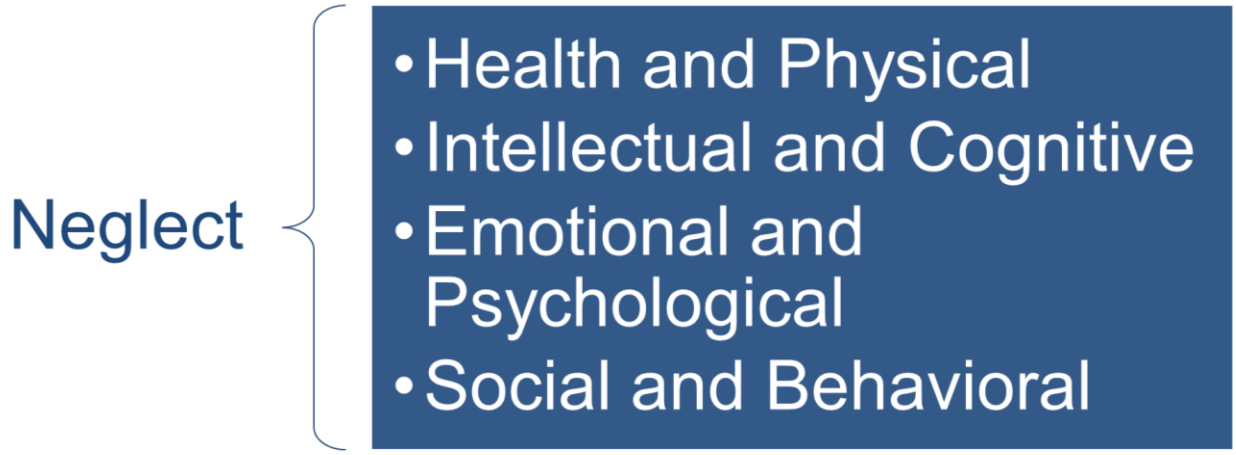
Exposure to Violence in the Home/Injurious Environment for example, can include being exposed to domestic violence.

A caretaker not meeting basic needs of a child due to substance use would fall under one of the very specific neglect types mentioned based on what they have been deprived of and the impact on child safety. It is critical to remember that substance use by a caretaker alone does not constitute neglect; it must have a direct impact on child safety.

Substance Affected Infant is its own type of neglect and has a direct impact on the child.

Notes

Developmental Impacts of Neglect



It is usually easier to identify the effects of other types of abuse, but child neglect has serious, potentially long-term consequences that seriously impact child development.

Research has shown that neglect, especially chronic neglect, affects child development in four areas:

- Health and development
- Intellectual and cognitive development
- Emotional and psychological development
- Social and behavioral development

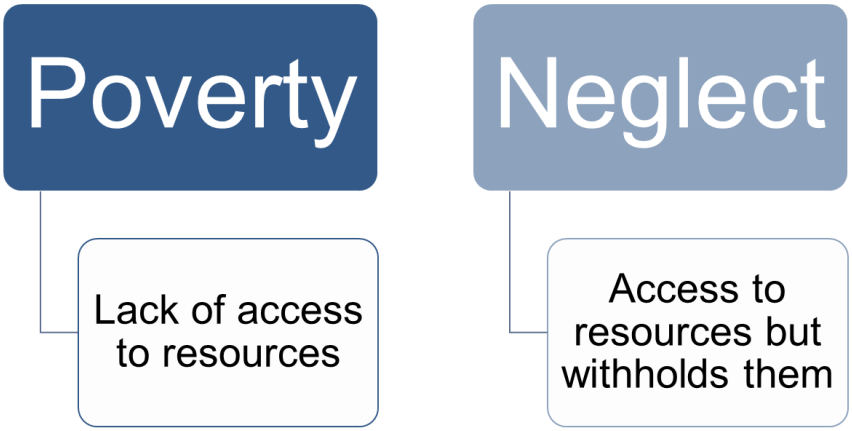
Below are examples of specific ways each of these areas of development can be affected.

- Malnutrition impacts health and physical development, which can lead to impaired brain development, delays in growth, or failure to thrive.
- Delayed intellectual and cognitive development can cause poor academic performance or impaired language development.
- Impacts on emotional and psychological development can be seen in poor self-esteem, attachment, and trust issues.
- Social and behavioral development can be affected, resulting in problems with interpersonal relationships, social withdrawal, and poor impulse control.

The impact on these areas of development is interrelated, as issues in one area may influence growth in another. For example, impaired brain development can impact cognition and academic performance, which in turn impacts social development.

Experiences of neglect can also have a traumatic effect, especially in severe cases. Child neglect is one common type of childhood trauma that results in distress, posttraumatic stress disorder, and posttraumatic stress symptoms. The developmental effects can also impact how children respond to stress and disrupt their ability to cope with adversity.

Neglect vs. Poverty



It is critical to understand that poverty is not the equivalent of neglect. A study reported by the Children's Bureau indicated that children from low socioeconomic status households were about seven times more likely to be neglected than children in higher socioeconomic households. Poverty increases the risk of neglect by worsening related risks like family stress and access to concrete resources like healthy food and housing. Lack of housing and transportation, in addition to lack of access to substance use disorder treatment, are common themes in child neglect cases.

Caseworkers must differentiate between neglectful situations and poverty. One distinction is whether a family has access or means to provide something for a child and intentionally chooses not to do so, versus if they do not have access to a resource. Considering the child's safety is always paramount and considering poverty as a contributing factor can prevent unnecessary removals and place the focus on providing concrete services for families to protect and provide for their children.

Notes

Key Takeaways

- Child maltreatment includes all forms of abuse and neglect.
- A family's perspective is required to assess for abuse.
- There are community, family, parent, and child risk factors for maltreatment.
- Understanding signs of non-accidental injuries is key to identifying abuse.
- Neglect is the most common form of child maltreatment.
- Neglect can seriously impact child development.
- Poverty can contribute to neglect, but is NOT the same as neglect.

Notes

Pre-Work Reminder for Week 1 Day 3

Self-Awareness and Self-Reflection

Before day three of this training, complete a short pre-work assignment on implicit bias, found at https://implicit.harvard.edu/implicit/takeatest.html. The assignment takes about 10 minutes.

There are many studies on implicit bias. Project Implicit is a non-profit organization and international collaboration between researchers whose goal is to educate the public about hidden biases. For more than 20 years, Harvard has been conducting Implicit Association Tests (IAT) as part of Project Implicit. Anyone can sign up to take a series of online tests and get results on biases based on reaction times, measured in milliseconds, to words or pictures.

Please complete the Race IAT before Day 3 of training this week to inform our discussions. You will not be asked to share your results with other learners or with the instructors. This is just for your self-reflection and will give you context for the training topics.

You are encouraged to visit the Project Implicit website as a tool for self-discovery and exploration.

Positive and Adverse Childhood Experiences, Trauma, and Resilience

Before day three of this training, complete a short pre-work assignment on positive and adverse childhood experiences, trauma, and resilience. Please read the handout *Understanding ACEs*, found in the Appendix of this handbook, and visit two websites to read the articles. This will support our lessons on day three when we discuss positive and adverse childhood experiences, trauma, and resilience

- What ACEs and PCEs do you have? [https://www.pacesconnection.com/blog/got-your-ace-resilience-scores]
- Resilience [https://www.albertafamilywellness.org/what-we-know/resilience-scale/].

Self-Reflection

Finding Your Why

Activity: Finding Your Why

Step 1: Look for Passion

When have you felt a sense of meaning?

When finding your purpose, begin by looking at the past. Don't merely project into the future or imagine how it might show up. Where has it shown up already?

Think of the moment you're most proud of, whether at work or in your personal life. These aren't necessarily your biggest wins, but the things you've done that have made you feel good.

What were you doing? When have you been at your best personally or professionally? Name and sketch a moment (such as a project or scenario) when you, your team, or your organization shone brightest.

Step 2: Look for People

Who were you serving?

The most powerful purpose is often in service of others—people outside your own walls, like your customers, your community, or society at large. When you look back at your meaningful moments personally or professionally, who were you working to help? Be specific.

Step 3: Look for Impact

What impact did you have?

When you consider the people you served, what's the impact you had on their lives? How did they benefit from the work that you do? Also ask, what's the impact you want to have? And how do you want to improve people's lives?

Step 4: Why You Exist

Now, bring these ingredients together into a simple purpose statement. Stretch beyond what you're currently doing and imagine the impact you want to have in the future.

We exist to _____
(desired impact)

in order to serve _____
(intended audience)

Pre-Service Training: Core Week 1 Day 2 Agenda

Child Welfare in North Carolina Pre-Service Training: Core

Welcome and Introductions

Overview of Child Welfare Process

Overview of Child Welfare Process

Mandated Reporting

Essential Function: Engaging

Engaging

BREAK

Core Value: Family-Centered Practice

Using a Strengths-based Perspective

Values in Action: Practice Skills Learning Lab

Skills Practice: Communicating and Engaging

LUNCH

Essential Function: Assessing

Essential Function: Assessing

Safety Organized Practice and Structured Decision Making

Safety Organized Practice (SOP)

BREAK

Structured Decision Making (SDM)

Assessing Learning Lab

Pre-Work Reminder

Self-Reflection

Mindfulness Activity

Pre-Service Training: Core Week 1 Day 2 Learning Objectives

Day 2
Overview of Child Welfare Process
• Describe your role in supporting safety, permanency, and well-being outcomes for children and families. • Describe the responsibilities of various case management positions. • Explain your role as a child welfare caseworker. • Identify and define different types of child abuse. • Explain mandated reported laws and when they are required to make reports of child abuse and neglect.
Essential Function: Engaging
• Describe the process of engaging • Identify effective ways of engaging to gather information • Demonstrate strategies for engaging families • Reflect on ways to incorporate engaging skills and behaviors into their own child welfare practice.
Core Value: Family-Centered Practice
• Describe family-centered practice. • Explain the importance of a family-centered approach in working with children and families. • Explain how family-centered practice increases family engagement. • Demonstrate family-centered practice while interviewing children and families. • Reflect on ways they can incorporate the skills and behaviors into their own child welfare practice.
Using a Strengths-Based Perspective
• Identify the components of a strengths-based perspective. • Discuss the benefits of using a strengths-based perspective. • Explore techniques and strategies to discover family strengths. • Give examples of how to use strengths to address a family's needs

Values in Action: Practice Skills Learning Lab
• Connect the NC Practice Model to your role as a caseworker. • Demonstrate introducing yourself to a parent and describing your role. • Demonstrate introductory and rapport-building interviewing skills. • Discuss the value of providing a description of your role in every professional encounter. • Reflect on ways they can incorporate the skills and behaviors into their own child welfare practice.
Essential Function: Assessing
• Describe the process of assessing. • Identify information needed to comprehensively assess situations in child welfare cases. • Demonstrate critical thinking skills and professional judgment. • Reflect on ways they can incorporate the skills and behaviors into their own child welfare practice.
Safety Organized Practice and Structured Decision Making
• Identify the three objectives of Safety-Oriented Practice (SOP) • Understand the principles and purpose of structured decision making and safety-organized practices in child welfare services • List the three questions that support a balanced and rigorous approach • Explain how SDM tools and SOP support better decision-making and thorough assessments • Describe the two-system model of thinking

Core Week 1 Day 2

Overview of Child Welfare Services

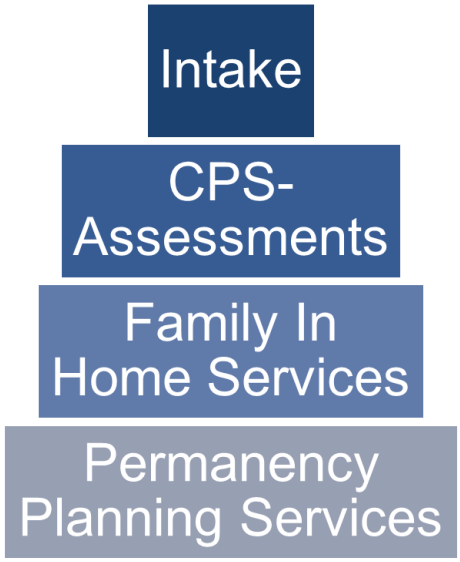
Activity: Purpose of Child Protective Services

Review the excerpt from child welfare policy that outlines the purpose of Child Protective Services, all of which are essential. Highlight the words or phrases that feel especially important to you.

Protective services are legally mandated, non-voluntary services for families that encompass specialized services for maltreated children (abused, neglected, and/or dependent) and those who are at imminent risk of harm due to the actions of, or lack of protection by, the child's parent or caregiver. Child Protective Services, provided by county child welfare agency, are designed to protect children from further harm and to support and improve parental/caregiver abilities in order to assure a safe and nurturing home for each child. Generally, such services provided in the homes of these families are preventive, rehabilitative, and nonpunitive with efforts directed toward identifying and remedying the causes of the maltreating behavior. This is accomplished through parent/caregiver cooperation and consent or, in the event conditions pose serious issues for the child's safety, through the agency's petition to the court. The county child welfare agency's foremost responsibility is to protect the child and to assure a safe environment. The removal of a child from their home should only occur when the risk of harm to the child is so great that safety cannot be assured in the home. The decision to remove a child should be based on an analysis of the risk of harm balanced with implementing reasonable efforts to ensure safety within the family.

North Carolina Department of Health and Human Services, Division of Social Services. (2020). *CPS Purpose & Philosophy, Legal Basis, Administration: NC Child Welfare manual*. https://policies.ncdhhs.gov/wp-content/uploads/purpose.pdf

Legal Authority and Responsibilities



NC Statute outlines the role of the county director of social services and grants legal authority to carry out the responsibility to ensure that child protective services are provided for all children who are abused, neglected, or dependent. The statute requires that the director and staff should have a clear understanding of the legal authority for providing services.

Intake and CPS Assessments

Receiving reports of abuse, neglect, and dependency

Reporting to the District Attorney and local Law Enforcement if there is evidence of child abuse or whenever a child has been physically harmed in violation of any criminal statute by any person other than the child's parent, guardian, custodian or caretaker

CPS Assessments

Making a prompt and thorough CPS assessment, using either the family Assessment response, or the Investigative Assessment response in order to ascertain the facts of the case, the extent of the injury or condition resulting from abuse, neglect, or dependency, and the risk of harm to the child, in order to determine whether protective services should be provided and/or a petition should be filed

Deciding whether the immediate removal of the child or children is necessary for their safety and protection

Providing or arranging for protective services if immediate removal is not necessary

Signing a petition seeking to invoke the jurisdiction of the court for the protection of the child or children in accordance with N.C.G.S.§ 7B403 if the parent or other caretaker refuses to accept the protective services provided or arranged by the Director

Reporting to the District Attorney and local Law Enforcement if there is evidence of child abuse or whenever a child has been physically harmed in violation of any criminal statute by any person other than the child's parent, guardian, custodian, or caretaker

Family In Home Services

Deciding whether the immediate removal of the child or children is necessary for their safety and protection

Providing or arranging for protective services if immediate removal is not necessary

Signing a petition seeking to invoke the jurisdiction of the court for the protection of the child or children in accordance with N.C.G.S.§ 7B403 if the parent or other caretaker refuses to accept the protective services provided or arranged by the Director

Reporting to the District Attorney and local Law Enforcement if there is evidence of child abuse or whenever a child has been physically harmed in violation of any criminal statute by any person other than the child's parent, guardian, custodian or caretaker

Permanency Planning Services

Providing or arranging for protective services if immediate removal is not necessary

Reporting to the District Attorney and local Law Enforcement if there is evidence of child abuse or whenever a child has been physically harmed in violation of any criminal statute by any person other than the child's parent, guardian, custodian or caretaker

North Carolina Mandatory Reporting Law

§ 7B-301. Duty to report abuse, neglect, dependency, or death due to maltreatment.

(a) Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found…

We are all mandated reporters and there are circumstances when working with an open case where you are required to report suspected maltreatment. North Carolina law protects for people who make reports in good faith. The full text of the law Is listed in the following Mandatory Reporting Laws handout.

What is your biggest takeaway from this information about mandatory reporting?

Handout: North Carolina Mandatory Reporting Laws

§ 7B-301. Duty to report abuse, neglect, dependency, or death due to maltreatment.

(a) Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found. The report may be made orally, by telephone, or in writing. The report shall include information as is known to the person making it including the name and address of the juvenile; the name and address of the juvenile's parent, guardian, or caretaker; the age of the juvenile; the names and ages of other juveniles in the home; the present whereabouts of the juvenile if not at the home address; the nature and extent of any injury or condition resulting from abuse, neglect, or dependency; and any other information which the person making the report believes might be helpful in establishing the need for protective services or court intervention. If the report is made orally or by telephone, the person making the report shall give the person's name, address, and telephone number. Refusal of the person making the report to give a name shall not preclude the department's assessment of the alleged abuse, neglect, dependency, or death as a result of maltreatment.

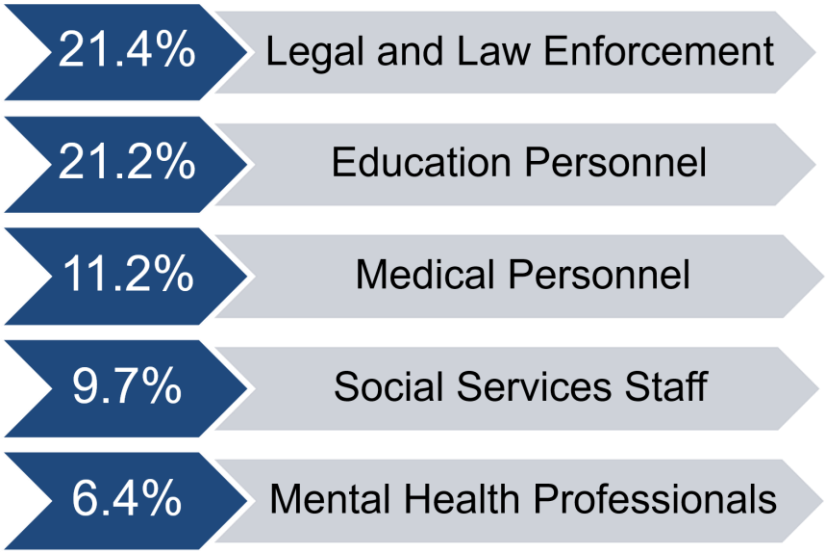
(b) Any person or institution who knowingly or wantonly fails to report the case of a juvenile as required by subsection (a) of this section, or who knowingly or wantonly prevents another person from making a report as required by subsection (a) of this section, is guilty of a Class 1 misdemeanor.

(c) Repealed by Session Laws 2015-123, s. 3, effective January 1, 2016. (1979, c. 815, s. 1; 1991 (Reg. Sess., 1992), c. 923, s. 2; 1993, c. 516, s. 4; 1997-506, s. 32; 1998-202, s. 6; 1999-456, s. 60; 2005-55, s. 3; 2013-52, s. 7; 2015-123, s. 3.)

§ 7B-309. Immunity of persons reporting and cooperating in an assessment.

Anyone who makes a report pursuant to this Article; cooperates with the county department of social services in a protective services assessment; testifies in any judicial proceeding resulting from a protective services report or assessment; provides information or assistance, including medical evaluations or consultation in connection with a report, investigation, or legal intervention pursuant to a good-faith report of child abuse or neglect; or otherwise participates in the program authorized by this Article; is immune from any civil or criminal liability that might otherwise be incurred or imposed for that action provided that the person was acting in good faith. In any proceeding involving liability, good faith is presumed. (1979, c. 815, s. 1; 1981, s. 469, s. 8; 1993, c. 516, s. 9; 1998-202, s. 6; 1999-456, s. 60; 2005-55, s. 9; 2019-240, s. 18.)

Role of Mandated Reporters

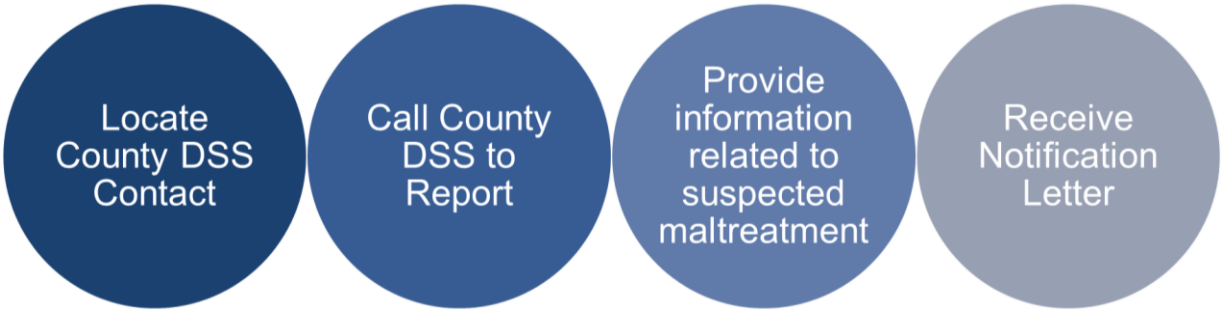


Most reports come from professionals with specific knowledge and frequent contact with children, including but not limited to school personnel, law enforcement, medical personnel, and caseworkers.

A report to DSS is the starting point for potential agency involvement with the family. Certain criteria must be met at intake for DSS to have the legal authority to intervene. People making reports are often not aware of the specific legal criteria but have a concern that child maltreatment has or will occur. It is the responsibility of the intake worker to gather enough information from the reporter to make an appropriate determination about how to proceed in response to a report.

Notes

Process for Reporting Suspected Maltreatment



There are several times in your role as a caseworker that you are required to report abuse, neglect, or dependency in open cases. These include new allegations of maltreatment in in-home or out-of-home placement cases and when a new child is born to a family with an open in-home case. New allegations discovered by DSS in the course of a CPS assessment do not require a separate intake.

Reporters need to provide:

- Name and address of the juvenile/child
- Name and address of parent, guardian or caretaker(s)
- Age of the juvenile/child
- Names and ages of other children/juveniles in the home
- The preset whereabouts of the child if not at the home address
- The nature and extent of the injury or condition resulting from the abuse or neglect
- Any other information the reporter believe might be helpful in establishing the need for protective services or court intervention

The information shared is confidential and will not be shared with the family, and if you prefer to remain anonymous, this does not prevent the county from investigating your concerns.

What information does a reporter need to share with Intake when they call about suspected maltreatment?

Key Takeaways

- Child protection is a community responsibility
- You are a Mandated Reporter
- Most reports of child maltreatment are from professionals
- NCGS§7B grants legal authority to DSS to provide child protective services when a report is made of suspected maltreatment
- DSS provides preventive, rehabilitative, and nonpunitive services to children and families to identify and remedy child abuse and neglect

Notes

Essential Function: Engaging

Engaging

Empowering and motivating families to actively participate with child welfare in the functions of assessing, planning, and implementing by communicating openly and honestly with the family, demonstrating respect, and valuing the family's input and preferences. Engagement begins upon first meeting and continues throughout child welfare services.

The Practice Standards define engagement as "empowering and motivating families to actively participate with child welfare in assessing, planning, and implementing by communicating openly and honestly with the family, demonstrating respect, and valuing the family's input and preferences. Engagement begins upon first meeting and continues throughout child welfare services."

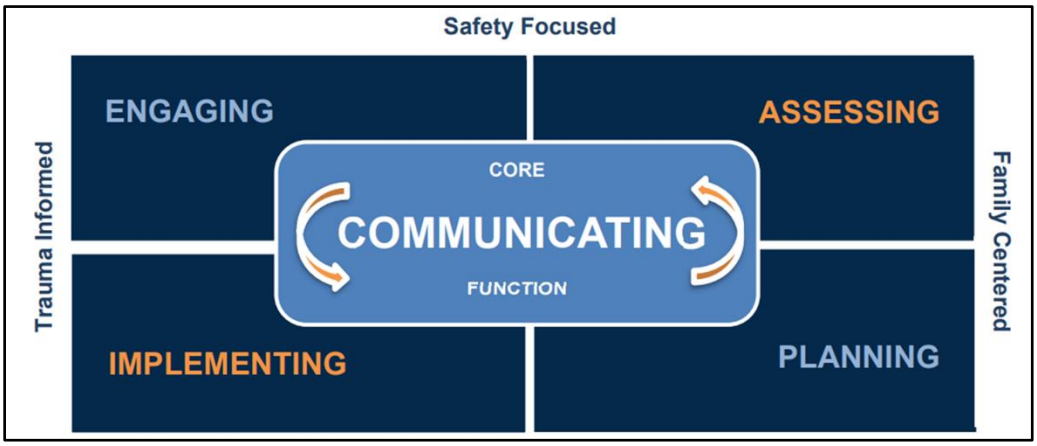
Child Welfare services are legally mandated and non-voluntary. Engaging children, parents, and families in non-voluntary services requires intention and skill.

It is important to remember that the function of engaging is not interchangeable with the concept of engagement.

- Engaging is how we go about meeting the goal of empowering and motivating families to participate in the child welfare process
- Engagement often refers to behaviors and skills

Notes

Essential Function: Engaging



Engagement is about inviting families into the child welfare process and supporting them to contribute and partner along the way. Communication is a key component of engagement, as are demonstrations of respect and value of the family's insight, input, and preferences. Engagement begins at first contact and continues throughout the child welfare services continuum.

"One of the most challenging yet vital aspects of our work is engaging children, parents, and families in services they did not choose. These non-voluntary services often come with resistance, fear, and mistrust. Our goal is to engage families in ways that foster connection, build trust, and promote meaningful participation.

Notes

Handout: NC Practice Model Desk Guide: Engaging

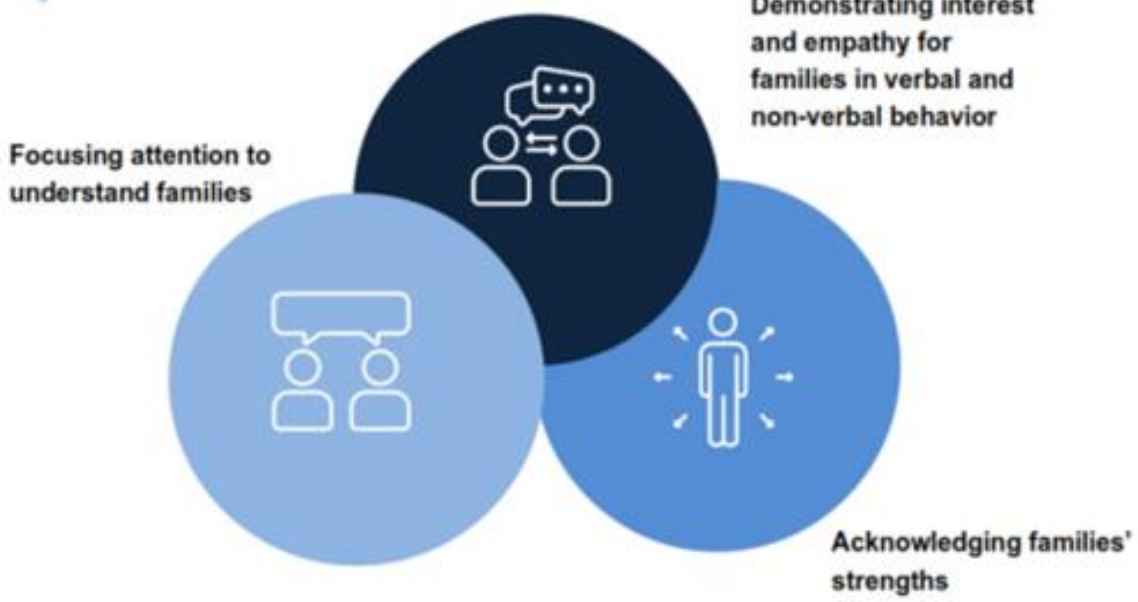
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Engaging: *Empowering and motivating families to actively participate with child welfare in the functions of assessing, planning, and implementing by communicating openly and honestly with the family, demonstrating respect, and valuing the family's input and preferences. Engagement begins upon first meeting and continues throughout child welfare services.*

#1	Be fully present when meeting with the family.
#2	Prepare in advance to be able to connect with the family.
#3	Consider the family's perspective in all exchanges and actions.
#4	Recognize the family's perspectives and desires.
#5	Use body language to convey interest in the family.
#6	Acknowledge and celebrate strengths and successes.

Engaging Core Activities



Activity: Engaging Practice Standards

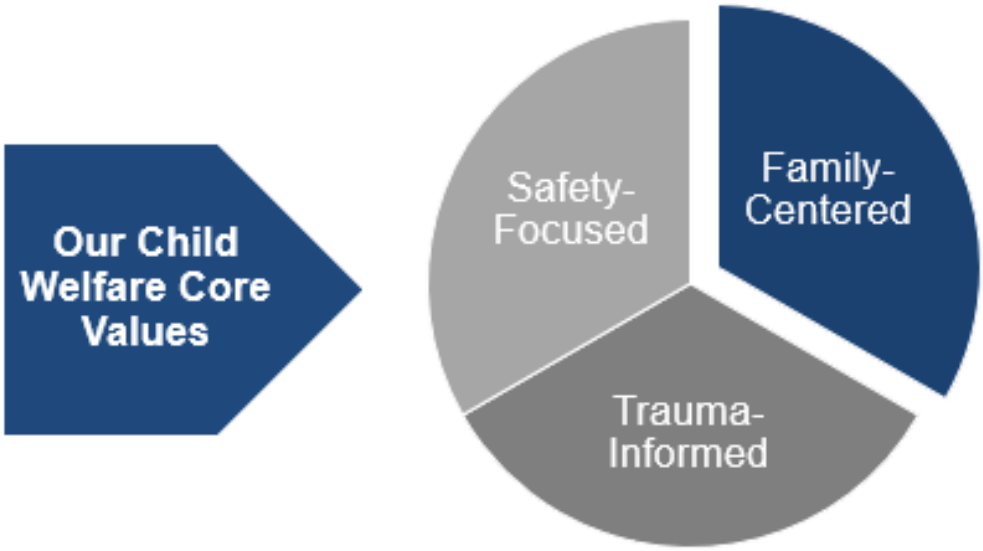
Review the NC Practice Model: Engaging Handout and discuss the questions below with a partner:

How do the key behaviors support the empowerment and motivation of families to participate actively in the child welfare process?

How do the Engaging core activities lessen the power differential between caseworkers and families?

Core Value: Family-Centered Practice

Our Child Welfare Core Values



Family-Centered Practice is a core value of the North Carolina Child Welfare Practice Model and is based upon the premise that the best way to meet a person's needs is within their family and that the most effective way to ensure safety, permanency and well-being is to provide service that consider the family context. Family-Centered practice is critical in non-voluntary, legally mandated services to support collaboration and to avoid punitive or coercive practices

Notes

Underlying Beliefs of Family-Centered Practice

Worksheet: Ten Beliefs of Family-Centered Practice

Families are the experts of their own lives, and are shaped by their history, heritage, values, beliefs, neighborhoods, communities, and social groups. Family Centered Practice is grounded in ten underlying beliefs:

- Safety of the children is the first concern
- Children have a right to their family
- The family is the fundamental resource for nurturing children
- Parents should be supported in their efforts to care for their children
- Children can flourish in different types of families
- A crisis is an opportunity for change
- Inappropriate interventions can do harm
- Families who seem hopeless can grow and change
- Family members are our partners
- It is our job to instill hope

Describe your beliefs about family-centered practice and why your agency is working with the family.

Share your statements with a partner, and then your partner will share their statements with you. You will provide each other feedback, which should include:

- How did you receive this message as a parent? What was that like for you?
- How safe and secure did you feel in the receipt of the message?
- What engagement of the social worker did you see or feel?
- What could be improved?

What would happen if we believed that children have a right to their family without the belief that parents should be supported in their efforts to care for their children?

What would happen if we believed family is a fundamental resource for nurturing children with a limited definition of family?

What about believing a crisis is an opportunity for change, without believing families who seem hopeless can grow and change?

Strengths-Based Approach

Identifying strengths is a key component of engagement and family-centered practice. A strengths-based approach considers family's strengths in addition to challenges, which supports a more holistic view of the family. There are at least three ways that strengths-based approaches benefit children and families:

- Influencing the extent of clients' engagement in services
- Increasing family efficacy and empowerment, and
- Enhancing families' relationship-building capacity and their support networks

Benefits of focusing on strengths when working with children, youth, and families include:

- Children, youth, and families will feel heard, building trust between you and the family.
- With increased trust, children, youth, and families may be more likely to disclose information to you.
- In addition to engaging in services, children, youth, and families may be more likely to engage in case planning and decision-making.
- Children, youth, and families can build confidence when we focus on strengths. They may be more likely to identify more of their own strengths (and strengths in their families) as we identify ones that we see.

What other benefits can you see when focusing on strengths when we work with children, youth, and families?

Identifying Strengths

Strengths-Based	Deficit-Based
At-potential	At-risk
Strengths	Problems
Opportunity	Crisis
Empower	Control
Child and family-centered	Mandate-focused
Support	Fix
Child and family-determined	Expert and system-oriented

Shifting child welfare from focusing on deficits and problems to building on strengths is a crucial part of family-centered practice.

Our language impacts our ability to build capacity and strengths with children, youth, and families. In order to truly identify and build strengths, we must examine our approach. We can make simple changes, such as changing our language from saying a youth is “at risk” to focusing on them being “at potential”, and we can also tackle larger challenges, such as changing the focus of our system from compliance to celebrating success. This is true not just with how we talk with and about children, youth, and families, but how we document information about them. If our referrals and reports highlight strengths in children, youth, and families, we create a broader space to focus and build on those strengths.

What differences can you see in child welfare as we move from focusing on deficits to strengths?

What worries do you have about a focus on strengths?

What benefits do you see?

Strengths-based Strategies

Handout: Strengths-Based Principles

The following principles are the foundation of both leading and implementing this practice:

- An absolute belief that every individual has potential, and that their unique strengths and skills will help create their story, not their limitations. Instead of "I'll believe it when I see it", this principle says, "I believe, and I will see."
- What we focus on becomes people's reality. We need to focus on strengths, not labels, and seeing challenges as opportunities to build capacity and not something to avoid.
- The language we use with children and families creates reality for children, youth, and families, and for us as a child welfare system.
- We must believe that change is inevitable, and also that all people have the urge to succeed and to be of use to other people and their communities.
- Positive change occurs within authentic relationships. People need to know that they are cared for unconditionally. A strengths-based approach is about supporting change in children and families, not fixing them.
- We all have our own story and our own reality. We need to respect each person's story and start our work with what is important to them, not to us.
- People have more confidence to try new things when they can start where they are with what they know. As we've discussed before, we need to meet people where they are and work alongside them.
- Building strengths and building capacity is a dynamic process. Each person or family will face challenges and changes throughout the process, and that is part of growing and learning.
- Collaborating with children, youth, and families is essential, and we need to value our different experiences and histories. Effective change takes teamwork and intentional collaboration. It truly does take a village to raise a child!

Hammond, Wayne, and Zimmerman, Rob. "A Strengths-Based Perspective." Resiliency Initiatives, resiliencyinitiatives.ca. (January 2012). https://www.ilgateways.com/docman-docs/faculty-resources/itc-resources/2526-oa-6-a-strengths-based-perspective/file

Activity: Strengths-Based Strategies

Review the Strengths-based Principles handout and choose one principle that stands out to you. Using that principle, create two strategies to support a strengths-based approach to child welfare work.

Strategy #1

Strategy #2

Key Takeaways

- Child protection is a community responsibility
- You are a mandated reporter
- Most reports of child maltreatment are from professionals
- Engaging families means communicating openly and honestly with the family, demonstrating respect, and valuing the family's input and preferences
- Family-centered practice is the most effective way to engage families and work together toward safety, permanency, and well-being

Notes

Values in Action: Practice Skills Learning Lab

Activity: Initial Face-to-Face Contact

The first face-to-face encounter with a family is a crucial moment to continue engagement efforts. This encounter offers an opportunity to communicate clearly about who you are and what your role is and actively listen to support gaining family perspectives and insight, while being professional, kind, informative, and responsive.

Think about how you might feel if you got a phone call and learned that a Child Welfare caseworker was coming to your home for the first time.

What would you want to know if someone from Child Welfare Services were to come to your home to talk with you about your family?

What would you want a Child Welfare caseworker to tell you when interacting with them in person for the first time?

Child Welfare Caseworker Introductions

Your initial introduction is the beginning of engaging with a family.

Introduction examples for Child Welfare Roles:

Intake [Check with your supervisor, as your county may have a scripted introduction]

Hello. Thank you for calling. My name is _____. I am a Child Welfare Intake Caseworker. It's my job to listen to your concerns and ask questions so that the Division of Social Services can screen them for an appropriate response. I must ask several mandatory questions during this process. Please do your best to answer with the information you have. Let's begin. Please tell me your name.

Child Protective Services Assessments

Hi, it's nice to meet you. My name is _____. I am an Assessment Caseworker in your county. I know anyone can call in and say whatever they want about you and your family, and in many cases, the concerns called in are not 100% accurate to a family's situation. My job is to meet with your family and understand your real story.

In-Home

Good morning, My name is _____. I am an In-Home Services caseworker with Cleveland County DSS, Child Welfare Services. My job is to help you keep your child in your home safely. I am here today to meet and learn about you and your family so we can work together to keep your children safe in your home."

Permanency Planning

Hello. I'm _____, a Permanent Planning Caseworker with Roberson County DSS. I have been assigned to your case, and I hope we can partner to reunite your family.

Foster Home Licensing

Good Afternoon. My name is _____ and I am a Foster Home Licensing Caseworker with Cherokee County DSS. I understand you are interested in becoming a licensed foster parent. I am here to work with and support you through this process.

Activity: Child Welfare Caseworker Introductions

This activity gives you a chance to practice how you introduce yourself to families. A thoughtful introduction helps build trust, set the tone, and begin a respectful relationship.

What You'll Do:

- Think about how you want to introduce yourself when meeting a family for the first time.
- Read the introduction examples for several child welfare services roles.
- Write an introduction that feels authentic to you and your role. As you write, consider:
    - What message do you want to send about who you are and how you work?
    - How can your introduction help build rapport and reduce any power differences?

Write your introduction:

Introductory Skills Practice: Communication & Engagement

Now that you've crafted your introduction, it's time to practice using it. This activity will help build your communication and engagement skills by role-playing your first interaction with a parent or caretaker.

What you'll do:

- Working in groups of three people, you will each assume a different role: caseworker, parent, and observer.
- Each person will have 90 seconds to introduce themselves and answer any questions the parents ask them.
- When time is up, the caseworker will give themself feedback on what they did well, then listen to feedback from the parent and the observer.
- The feedback will be two minutes long.
- When feedback is over, you will switch places.
- Your triad will repeat this cycle until all three of you have had an opportunity to play each role.

Roles:

Caseworker: You will have one minute to introduce yourself to the parent using your written introduction. Please answer any questions the parent has for you.

Parent: You will listen to the caseworker's introduction, reflect on one thing the caseworker says, and ask one question.

Observer: As an observer, you will keep time and take notes of what you hear and see the caseworker doing well and what challenges them. The introduction is 90 seconds, and the feedback session is two minutes long. Tell your group when the time is up for each section.

Observer Notes:

What is one thing you will remember to do when you introduce yourself to children and families in the field?

Essential Function: Assessing

Assessing

Gathering and synthesizing information from children, families, support systems, agency records, and persons with knowledge to determine the need for child protective services and to inform planning for safety, permanency, and well-being. Assessing occurs throughout child welfare services and includes learning from families about their strengths and preferences.

Assessing is more than just gathering facts—it's about understanding the full picture of a child and family's situation. According to the NC Child Welfare Practice Standards, assessing is defined as: gathering and synthesizing information from children, families, support systems, agency records, and persons with knowledge to determine the need for child protective services and to inform planning for safety, permanency, and well-being.

This means we're not just collecting data; we're interpreting it, connecting the dots, and using it to make informed decisions that support families and protect children.

Assessing is a critical but challenging task for caseworkers, so it makes sense that there are aspects of it you find difficult.

What is the hardest part about assessing?

Essential Function: Assessing

Handout: North Carolina Practice Model: Assessing

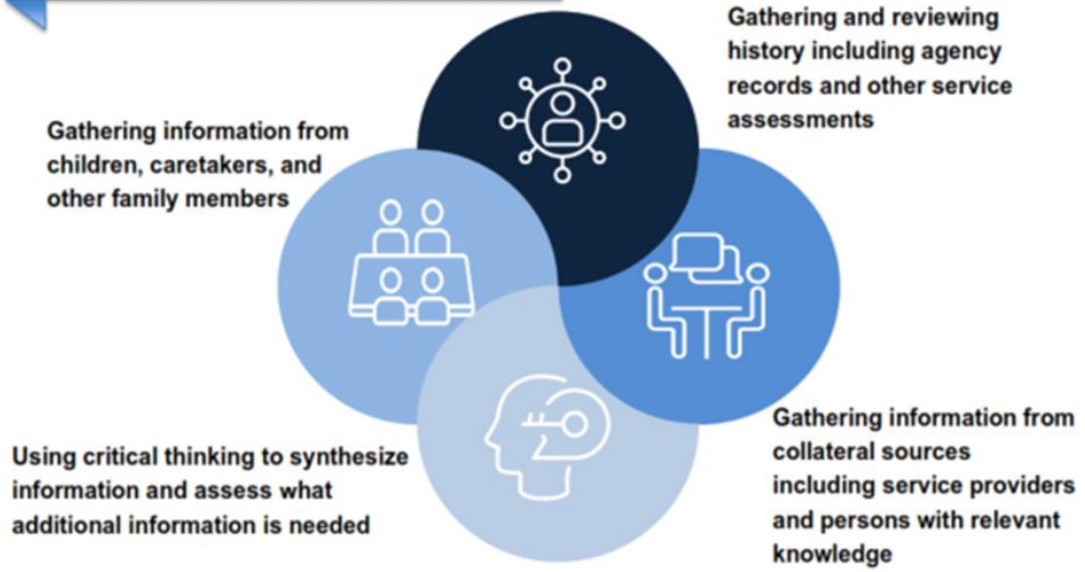
NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Assessing: *Gathering and synthesizing information from children, families, support systems, agency records, and persons with knowledge to determine the need for child protective services and to inform planning for safety, permanency, and well-being. Assessing occurs throughout child welfare services and includes learning from families about their strengths and preferences.*

#1	Differentiate between information and positions.
#2	Take time to get to know the family and explain the assessment process.
#3	Ask questions based on information needed and at ease asking uncomfortable questions.
#4	Stay open to different explanations of events in the record, keeping biases in check.
#5	Balance what is read in the record and what the family shares.
#6	Obtain all sides if there are differing positions among collaterals, engaging the family in the process.
#7	Synthesize information and consider sources, relevance, and timelines.
#8	Remain non-judgmental when processing information.

Assessing Core Activities



Activity: Assessing Practice Standards

With a partner, discuss the following questions:

How do the key behaviors support gathering and synthesizing information to determine the need for child protective services?

How do the key behaviors and core activities inform planning for safety, permanency, and well-being?

In what ways do the core activities promote a focus on safety and family-centered practice?

Assessing

Video: Beneath the Surface

Video Link: Watch the video Beneath the Surface. After viewing the video, answer the following questions:

What are your first reactions to this video clip?

What messages did you see in this video?

Why do you think those messages are important for our work with families, particularly in assessments?

Assessing vs Assessment

Assessing is an essential function and core to child welfare practice. While assessing isa dynamic and ongoing process, an assessment is a time-limited process or event. While assessments are crucial, they are only one part of the process of assessing.

In short, assessment is a product; assessing is a practice. Both are essential, but understanding the difference helps us stay engaged, curious, and responsive in our work.

Notes

Activity: Tools for Assessing

What you'll do:

In this activity, we'll identify the tools available to you that help you assess situations effectively.

Tools or skills involved in the practice of assessing:

Which tools or skills on this list feel the most useful for assessing?

Which tools or skills feel the most challenging to incorporate?

Safety Organized Practice and Structured Decision Making

Objectives of Safety Organized Practice (SOP®)

Developing good working relationships

Using critical thinking and decision-support tools

Building collaborative plans to enhance daily child safety

EVIDENT CHANGE

SOP is an approach to day-to-day child welfare casework that is designed to help all the key stakeholders involved with a child, focused on safety, permanency, and well-being.

Notes

Handout: Safety Organized Practice

EVIDENT CHANGE
Inform Systems. Transform Lives.

SAFETY-ORGANIZED PRACTICE

Safety-organized practice describes a collaborative approach to child welfare casework that helps all those involved with the child stay focused on assessing and enhancing daily child safety. This approach includes three objectives.

DEVELOPING GOOD WORKING RELATIONSHIPS

Rigorous and balanced interviewing involves asking families about their concerns and the times they kept their child(ren) safe—and building on what has worked well.

Including the child's voice in casework means using tools to help children contribute to case planning in ways that are developmentally appropriate.

A common language allows professionals and family members to use the same words to describe the same situations.

CRITICAL THINKING AND DECISION SUPPORT

A collaborative assessment and planning framework is a group process to organize and analyze ambiguous case information, increasing clarity about the work and next steps.

The Structured Decision Making® system in tandem with professional judgment ensures that key child welfare decisions are made in ways that are consistent with research and policy.

Worry statements (known as "danger statements" in some jurisdictions) are crafted using simple, non-judgmental language to provide rationale for continued child welfare involvement.

COLLABORATIVE PLANNING

Clear goals for the agency and family describe what needs to happen for the case to be closed.

Support networks offer a child and the child's parents a group of people who understand their situation and agree to act to help keep the child safe.

Behavior-based plans include detailed actions that parents agree to take to ensure their child(ren) are safe.

Balanced and Rigorous Approach

All families have strengths. Families are complex and nuanced. When we seek information to inform our assessment without partnering with families, we disregard their autonomy, complexity, and strengths. This result is a limited picture of what is happening within the family's dynamic and leaves us without all the information needed for informed decision-making that is safety-focused, family-centered, and trauma-informed. Offering a balanced and rigorous approach is a way to support families, aligning us with our core values.

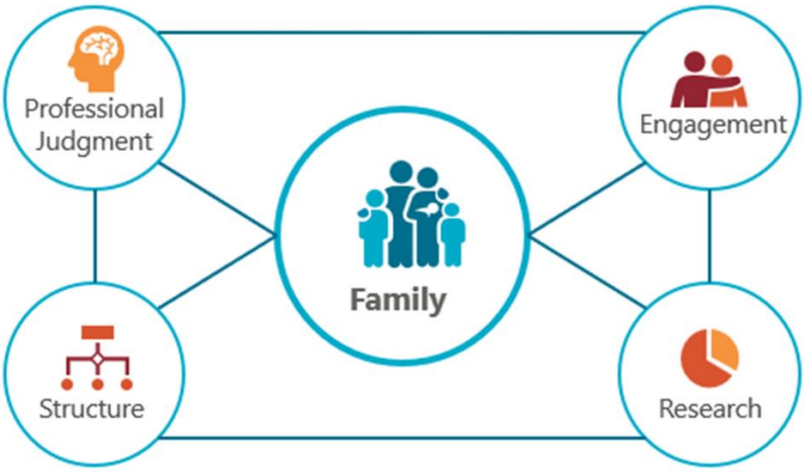
Questions are also interventions. They impact the people we are talking with when we ask them. The idea behind a rigorous and balanced assessment is that we need to be strategic about the questions we ask and how we ask them. We can ask questions that leave families feeling hopeful and invited into a partnership. We can also ask questions that leave families feeling disempowered, hopeless, and angry at us and at the world.

Three Column Mapping

What are we worried about?	What is working well?	What needs to happen next?

The Structured Decision Making (SDM®) System: A Comprehensive Framework

Handout: Structured Decision Making



What is the SDM System?

The SDM system is a decision-support system informed by research, policy, and best practices. Let's break down the important pieces of this statement.

Decision: The SDM system focuses on key decision points and helps us to be intentional about decisions. It is easy to drift through decisions—especially those regarding case closing. The SDM system emphasizes the importance of clear, concise decision points.

Support: The SDM assessments support decision making; they do not make decisions. Assessments do not make decisions; caseworkers do. While the decisions are structured, no magic formula tells you what to do.

System: The SDM assessments fit together, each with a different purpose. It is important to understand the function of each assessment and how they fit together. Each SDM assessment serves only one purpose, and it is important to know the purpose of that assessment to get the best out of it.

Research: It is important to include research in our work. Remember, though, that our field is young and this research is still emerging.

Policy: The policies for each SDM tool are tailored to individual jurisdictions based on legal and agency considerations—there is no "off-the-shelf" SDM assessment.

Best practices: Assessments support caseworkers in understanding the most effective practices and strategies in the social services field.

Goals of the SDM System

The SDM model consists of a comprehensive set of assessment tools that guide each critical decision in the life of a child protection case. However, no matter which assessment tool you are using, the goals of the SDM system are the same: (1) to promote safety; (2) to reduce subsequent harm to children; and (3) to facilitate timely permanency, including reunification whenever it is safe to do so.

Benefits of Structured Decision

Decision theory supports the idea that the process of making decisions in highly complex situations and circumstances can benefit from a breakdown of that complexity into component parts and a more methodical approach. The SDM system does this in a couple of ways.

First, the SDM system looks at the critical decision points that occur during a family's involvement with the child welfare system; for each one, the SDM system has a relevant assessment.

Second, the SDM system helps caseworkers slow down their thought process at any decision point with a framework in which to think about these complex decisions.

Decision theory helps us see the value in breaking down complex situations into more manageable pieces. The framework of the SDM system brings consistent methodology to our work.

The SDM system is a research-based decision-support system. This means that we have a set of tools to help us make decisions at certain points in the life of a child protection case. We do that through designing tools that help increase the consistency, accuracy, equity, and utility of our decision making. Let's review each of these core principles.

Consistency: Ensures that given the same information, caseworkers come to the same conclusion. When caseworkers use the same assessments with the same definitions, they will come to more consistent decisions.

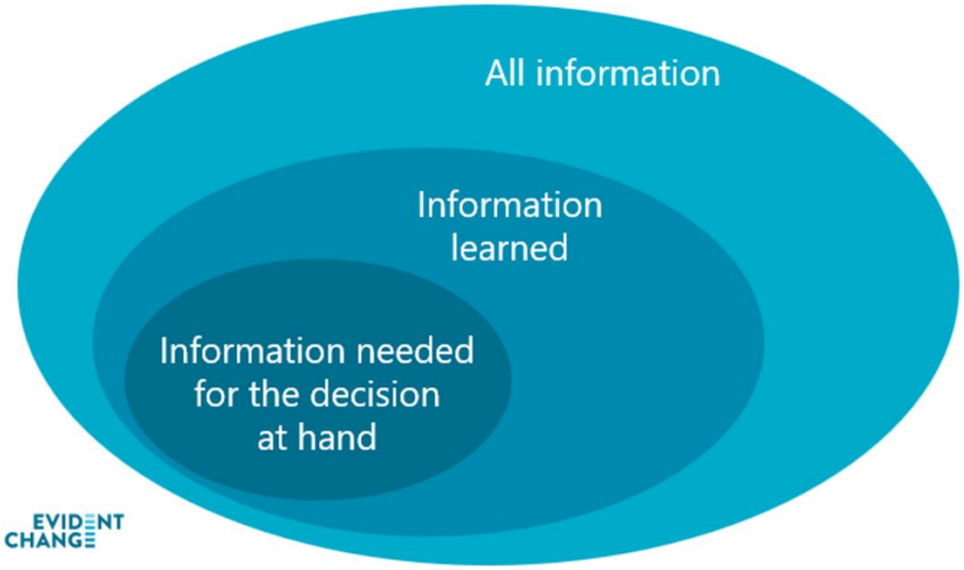
Accuracy: It is great to ensure people are coming to the same conclusion, but it is also important to measure the correct things and come to the correct conclusion. The SDM tools need to be valid and accurate, measuring the correct things. This update of the SDM assessments is based on North Carolina law, policy, and the most recent research on what goes into a successful decision at each of the SDM decision points.

Equity: SDM tools aim to be fair and equitable through the process of leveling the playing field. All families are going through the same process, based on the same decision-making criteria. For example, this equity begins with a safety assessment that focuses on caretaker behavior and impact on the child within DSS's thresholds for danger indicators warranting child welfare involvement.

Utility: Finally, we use field testing to test utility. Utility is making sure that the tools are useful—that they work in everyday practice. We want to make sure that the tools will work for caseworkers in the field and that they will be helpful in practice and decision making. DSS supervisors and caseworkers completed field testing on the SDM assessments and provided feedback on ease of use as well as the tool's usefulness.

Notes

Information Gathered



Assessing requires knowing what information is important.

Assessing will yield information that is not needed for the decision at hand. This diagram shows how structuring decisions helps us focus on the most important information needed to make a good point-in-time decision.

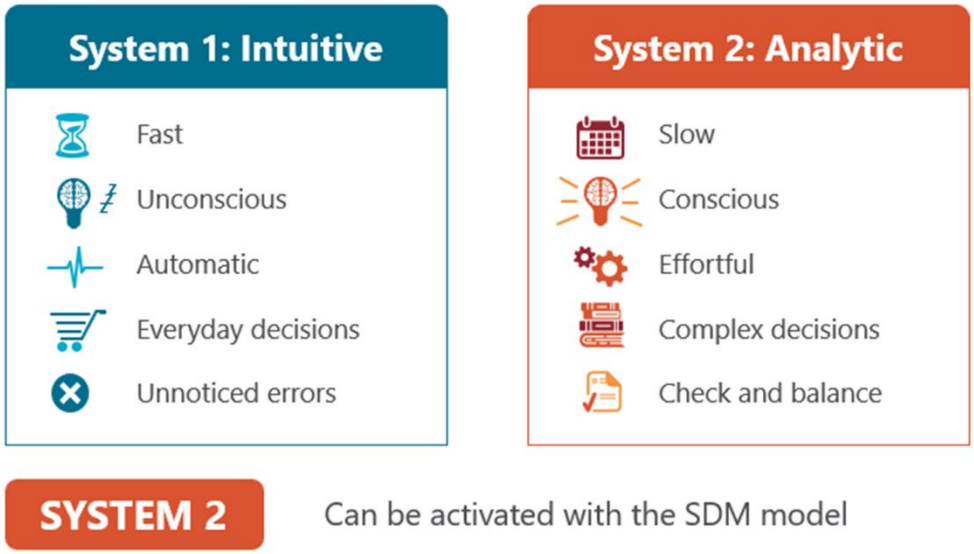
The outer circle contains all the information about a family. We will never really know all of this.

The middle circle represents what we learn about the family as we work with them.

The inner circle is the information needed to make the decision at hand, which is where the SDM assessments help caseworkers to focus.

How do you imagine managing all the information you will receive while assessing?

The Two-System Model of Thinking



Extensive research over the past 40 years, and especially in the past 10 years or so, has explored how our brains work in taking in and making sense of information and then making decisions based on that information. One of the most prominent researchers in this area is psychologist Daniel Kahneman. While Kahneman has written extensively in academic, peer-reviewed literature, his book Thinking, Fast and Slow, written at the end of his career, is an accessible summation of his life's work and helped him win a Nobel Prize.

The Two Systems of Thinking come from Daniel Kahneman's book Thinking, Fast and Slow. Kahneman theorized two ways our brains process information: System 1, or "fast" thinking, and System 2, or "slow" thinking.

System 1 thinking is a more intuitive process, occurring in the blink of an eye, and it makes rapid use of all the human nervous system's resources to make quick, effortless, and automatic decisions needed for survival. System 1 thinking, however, is prone to error. Importantly, even when errors are made, System 1 does not notice when it is wrong.

System 2 thinking is more of an analytic process. This is a slower process in which more complex decisions and problem solving occur. It requires a more deliberate, conscious process and takes longer.

Child Welfare casework requires both systems. SDM tools support activation of System 2 for decision making. When we think about the high stakes of fast-paced child protection investigation work, we can all recognize how System 1 thinking serves us pretty well in conducting assessments and making decisions quickly. The trouble is that System 1 thinking—our intuitive process—does not notice when it is wrong! Structured assessment instruments allow us to combine these two types of thinking to access the benefits of both.

What system of thinking are you most comfortable using?

Which system do you feel is important to make sense of all the information you have learned, and which information is needed for the decision?

How does it feel to know you have SDM and SOP to support you in your assessing and decision-making processes?

Assessing Learning Lab

Activity: Engaging in the Assessing Process

Engagement with the family begins before your first contact with them and will continue throughout your time working with this family. Prioritizing family voice in the decision-making and planning process enhances the fit between family needs and services and increases the likelihood that families will access services that will achieve their goals.

- Group 1 is assigned to the Reveles family
- Group 2 is assigned to the Anderson family
- Group 3 is assigned to the Jaynes family

Take 10 minutes to read Part I: Scenario for your assigned family in the following handout titled *Assessing in the Child Welfare Setting*. Respond to the corresponding questions.

After the timer goes off, you will discuss your responses to the questions in groups at your table and make note of similarities and differences in your responses.

Take another 10 minutes to read Part II of the family scenario and respond to the corresponding questions. Then discuss in your groups.

Handout: Assessing in the Child Welfare Setting

Part I: Scenario

Group 1 - Reveles Family

The agency received a report from a ninth-grade teacher at the city high school regarding Angel Reveles. She is 14 years old. She came to school with bruises on the back of her legs and fingerprint bruises on her upper arms. She had a black eye and swollen black and blue cheek. She told her friends that her boyfriend had gotten angry with her for talking to another boy. Her boyfriend was older and not in the same school. The teacher found Angel crying in the bathroom and talked to her about what happened. Angel said her father had really beat her when he saw her grades the night before. He expected her to get all A's and she was having problems in algebra class. Angel's father has his own landscaping business, and her mother works as a waitress/hostess in a Mexican restaurant. Angel's family was originally from Mexico and has been in the United States for 10 years. Angel has one younger sister – 11 years old and a younger brother – 6 years old. Angel was extremely upset and blurted out that Angel's uncle (dad's brother) and his wife and 1 female child (a 2-year-old) have all just moved into Angel's home. Angel and her sister moved out of their own room and are now sharing a room with their younger brother. She said it is hard to study and do her homework. Then Angel got very upset because she was not supposed to talk about her uncle's family living in their home. She begged her teacher not to tell anyone. The teacher reported that she told Angel that the teacher felt this was part of the family's problems right now and that she had to tell child protective services about Angel's bruises and why she got them.

Group 2 – Anderson Family

The agency received a report from a neighbor on Amy (age 2 – female), Jessie (age 4 male), Andrea (age 8 – female), and John (age 9 – male). John told his friend's mom (the neighbor) that he wished he could live with them. They didn't have any food in their house and his dad and mom fought all the time. When his parents were not fighting, they were sleeping. John said his house was cold and sometimes the lights did not work. The neighbor had noticed that the children were outside a lot or at neighbors' houses and that Andrea often was taking care of Amy and Jessie. The Anderson family had just recently moved into the neighborhood which was a very rural part of the county. The home they lived in was old and run down. The children were dirty, and their teeth were rotten. The children kept colds and coughs. When the neighbor asked about the family in church, she was told that it was rumored that the parents used crystal meth. The family is white, and the parents are in their late 20's. No one reportedly knows of extended family members in the area. The children said they moved to Mississippi from Arkansas.

A law enforcement check revealed that the local law enforcement had just been informed of crystal meth use and possible manufacturing of crystal meth by the Andersons in the Anderson home.

Group 3 – Jaynes Family

The agency received a report of sexual abuse regarding 12-year-old Tamara Jaynes.

Tamara was seen by the Health Department physician. She was in the Health Department for a pregnancy test. She was brought in by her 16-year-old female cousin. Tamara's pregnancy test was negative, but the doctor noted trauma to Tamara's vaginal area. Tamara asked for a birth control prescription. The girls were evasive and nervous. The doctor asked the girls why they thought Tamara needed a pregnancy test. Tamara began crying and finally told the doctor that her mom forced her to have sex with her mom's live-in boyfriend and her mom was there and telling her what to do. Tamara said that her mom has always had sex with boyfriends in front of Tamara, even when she was little, she was on a pallet on the floor next to her mom's bed. This was the first time she made Tamara do anything. Tamara has an older sister (Jenna) who has run away from home and is living with friends. Jenna and her mom were always fighting, and mom would physically hurt Jenna with extension cords, hairbrushes, and whatever she could get her hands on at the time. Tamara has tried to be good and not get into trouble. She does what her mom says to avoid the beatings and the fights, but she doesn't want to have sex or get pregnant. The doctor asked Tamara about her father. Tamara said she knows her father, but her mom never lets her go to her dad's home or her other grandmother's home. Her mom always says bad things about her father and his family, and her mom says her dad is a drunk.

Tamara said that her mom is black, and her dad is Choctaw Native American, and her mom is angry that her dad quit sending child support.

The doctor reported that Tamara is currently at the Health Department and does not want to go home. She seems to be an intelligent girl and genuine in what she is telling about her reasons to not go home.

Part I Questions

Professional Relationships – Engagement of the Child and Family in the Assessment Process

What are the first steps you would take to begin the assessment process?

Who would you interview first?

What are your initial thoughts/assumptions about the members of the family and the situation?

What are the cultural aspects that might affect the engagement of family members?

What about your thoughts/assumptions/attitudes/planned behavior-action might hinder the engagement of family members and a possible working relationship?

Preparatory Empathy

List the members of the family and talk about what you think each person is feeling in this family. What could possibly be going on with each person?

How do you think each person is going to react to child protective services becoming involved with the family?

What approach will you use to establish a working relationship with each family member?

Part II: Scenario

Group 1 – Reveles Family

Angel Reveles – 14-year-old Mexican American 9th grade female

Martha Reveles – 11-year-old Mexican American 6th grade female

John Reveles – 6-year-old Mexican American 1st grade male

Raphael Reveles – father - 33-year-old Mexican American

Rose Reveles – mother – 32-year-old Mexican American

Joseph Reveles – Raphael's brother - 22-year-old male

Mina Reveles – Joseph's wife – 19-year-old female

Mary Reveles – 2-year-old child of Joseph and Mina

Angel's family are legal residents of the United States. As the child welfare worker, you interviewed Angel, Martha, and John at school. The children report things are usually ok in their home. They love their mother and father. The family does not have a lot of money, but they have food and a nice house. They attend church at the Catholic Church every Sunday and the children all play soccer in the city league. The children report that their dad is very strict and usually whips them with a belt as punishment. Angel stated that her father and mother expect her to get good grades and get a scholarship for college. She wants to be a teacher. Joseph's family moving in has caused uproar in the house. Everyone is always arguing and there is lots of talking and noise. The baby cries a lot and there is no place to read and study. Angel became angry and upset that the teacher talked about her dad's brother and family living in their house. Angel and Martha are afraid their dad is going to get very angry that the worker is involved in the family and Joseph's family might get sent back to Mexico. The girls are scared that they will be blamed for bringing problems to the family. A visit to the home reveals a nicely kept home even though the furniture is sparse, and the home is small. Rose Reveles was at home and became tearful that the child protective service worker had talked to her children at school and that her husband would be very upset. Rose spoke mostly Spanish, and the worker had a difficult time communicating with Rose. She did not admit to anyone living in the home besides the immediate family. She said that her husband's brother had come for a visit but had left the home. She asked the worker if it was necessary for the worker to talk to her husband. Rose said that she could talk to him. It would be bad for the worker to talk to him.

Group 2 – Anderson Family

Amy Anderson - age 2 – female

Jessie Anderson - age 4 – male - Headstart

Andrea Brown - age 8 – female – 3rd grade

John Jackson - age 9 – male – 3rd grade (failed first grade)

Joanna Anderson – mother - 26-year-old female – white

Bobby Anderson – father – 28-year-old male – white

As the worker, you have included law enforcement in the investigation. While they are preparing to investigate the family for crystal meth manufacturing, you interview John and Andrea at school. You learn that John and Andrea are not Bobby Anderson's children and they each have different fathers. Jackson is Joanna's maiden name. Joanna's family, which includes the children's grandmother and grandfather, live in Pine Bluff, Arkansas. John and Joanna lived with their grandparents and were happy there until their mother married Bobby Anderson 4 years ago (right before Jessie was born) and their mother decided she needed to have John and Andrea with her. Andrea said that she is afraid that she and her siblings will be put in foster homes and not see each other if she talks about her mom and Bobby. Bobby has told John and Andrea about growing up in foster care and how foster care is worse than any place. John and Andrea want their mom to leave Bobby because they fight and take drugs and get really "weird". Bobby is always afraid of the cops and is making his own drugs. Andrea said she is afraid of Bobby as he has whipped all of them with a belt and throws things at everyone including their mother. Upon examination, Andrea has several bruises of various colors on her back, legs, arms, and buttocks. She said she gets whippings almost every day. John has severe bruises on his buttocks and on the back of his legs from a whipping he just received. Bobby accused him of stealing five dollars from him. John said that Bobby was always accusing him of things he did not do. The children reported that their mother also gets beat up by Bobby. The children reported their mom acting weird and then sleeping or crying. Andrea and John said they wanted to go to their grandmother and grandfather's home in Pine Bluff and they want Amy and Jessie to go too. Jessie was seen at Head Start and no marks were found but he was dirty (as were the other children). All children had rotten teeth and colds. The Head Start teacher reported Jessie has kept a cough and ear infection for a month and that he appears to be developmentally behind the other children.

Group 3 – Jaynes Family

Tamara Jaynes – 12-year-old African American/Native American

(Choctaw) female

Jenna Jaynes – 15-year-old African American female

Linda Jaynes – 31-year-old African American female

Phillip Martin – Tamara's father; Native American from Choctaw Tribe, 31 years old

Rick Smith – Jenna's father; African American male, 32 years old

Bill Booker – Linda's live-in boyfriend, White male, 25 years old

Ellen Jensen – 16-year-old cousin (maternal relative)

As the worker, you interview Tamara at the Health Department. Tamara refuses to go home. She was hysterical and says that if her mom forces her to have sex like that again she will kill herself. She talked about killing her mom and Bill Booker. She is worried about her sister. She did not know why her sister left home but now she thinks she knows. Her mom probably was trying to make her sister do the same thing. Ellen Jensen said that her mom works all the time and that she has several brothers and sisters and there is no room for Tamara to stay with them. Linda's grandmother is old, but she lives about five miles away. Tamara said she thought she could stay there. Tamara doesn't know what is wrong with her mom. Tamara is taken to the agency office after obtaining a temporary order for custody. Linda Jaynes is called to come into the agency office to discuss the situation. The police are included in the interview. Linda stated that Tamara was lying and that she is jealous of Linda's relationship with Bill Booker. She said that Tamara is a behavior problem just like her "slut of a sister". Linda said she kicked Jenna out of the house because Bill told Linda that Jenna was "coming on to him". Linda did not know where Jenna was, and she did not care. When Linda was asked about possible relative placement, she opposed Tamara going to live with her own father, her father's family, or Linda's mother. Tamara's dad was a drunk and Linda's mother was a witch. When Linda was sexually abused by her own father her mother didn't do anything. She insisted on Tamara going to live in a shelter, saying it would teach her a lesson to not lie. Jenna was found at a friend's house. Jenna said her mom was a "head case". She said that her mom was all about men and sex. She would do whatever the man asked just to keep him around. Bill Booker was talking dirty to Jenna and trying to get her to have sex with him, but she told her mom and that is when her mom kicked her out of the house.

Part II Questions

After initial interviews, what are your initial reactions and feelings about each family member? Are the family members acting as you expected?

Are there cultural aspects that you did not think about before but are now more evident? How will these affect your engagement with each family member?

How are you going to engage each of the family members in the assessment process? What are you going to do to enter a professional relationship with each of these family members?

Is there anyone you would like to leave out of the engagement process and with whom you would choose not to enter a working relationship? Is this an appropriate decision? What if it is appropriate to engage this person but you do not want to work with him/her – what do you need to do?

Strengths-Based Approach

Based on the information that you have been given, what are the strengths of this family? Of various family members?

Is there anyone involved in the family situation for whom you cannot find any strengths? Discuss the possible strengths of this person with the group.

How can these strengths be used to engage the family in working with the agency worker to improve the family situation and prevent abuse/neglect from occurring?

.

How will the caseworker know that the working relationship is developing? What will they see? What may change? What may improve?

What does the worker need to do to engage each family member?

What cultural factors does the worker need to think about in the engagement process?

How will the worker know that the working relationship is developing?

Activity: Assessing: Has our perspective changed?

Revisit your work from the previous *Introduction to Assessing* activity. You were asked to complete the sentence *"The hardest part about assessing is…"* Now that you have completed the Assessment Learning Lab, take a few minutes to think about this sentence again.

Has your response changed? If so, how is it different?

How is your response the same?

If it is the same, why do you think that is?

Initial Professional Development Goal

As homework tonight, please identify one goal for improving your assessing skills and complete the following Initial Professional Development Goal Worksheet.

When you return to your office schedule a time to meet with your supervisor to review this Professional Development Goal. Start seeking feedback from your supervisor and peers early in your career. Although, it can be challenging, be comfortable with real feedback. This is where real growth can occur in your practice. We have an ethical obligation to the population we serve to be as skilled as we can possibly be, and we have an ethical obligation to continue to grow in our professional skills.

Worksheet: Initial Professional Development Goal

Identify one initial professional development goal to improve your assessing skills:

What are the steps to achieving this goal?

What resources do you need to achieve this goal?

Key Takeaways

- Key skill in child welfare practice
- Identify services, resources, and supports that families need
- There are 5 steps to comprehensive and accurate assessments
- Begins before your first contact
- Never complete. It is an ongoing process.
- Engagement and strengths-based approach

Pre-Work Reminder for Week 1 Day 3

Self-Awareness and Self-Reflection

Before day three of this training, complete a short pre-work assignment on implicit bias, found at https://implicit.harvard.edu/implicit/takeatest.html. The assignment takes about 10 minutes.

There are many studies on implicit bias. Project Implicit is a non-profit organization and international collaboration between researchers whose goal is to educate the public about hidden biases. For more than 20 years, Harvard has been conducting Implicit Association Tests (IAT) as part of Project Implicit. Anyone can sign up to take a series of online tests and get results on biases based on reaction times, measured in milliseconds, to words or pictures.

Please complete the Race IAT before Day 3 of training this week to inform our discussions. You will not be asked to share your results with other learners or with the instructors. This is just for your self-reflection and will give you context for the training topics.

You are encouraged to visit the Project Implicit website as a tool for self-discovery and exploration.

Positive and Adverse Childhood Experiences, Trauma, and Resilience

Before day three of this training, complete a short pre-work assignment on positive and adverse childhood experiences, trauma, and resilience. Please read the handout *Understanding ACEs*, found in the Appendix of this handbook, and visit two websites to read the articles. This will support our lessons on day three when we discuss positive and adverse childhood experiences, trauma, and resilience

- What ACEs and PCEs do you have? [https://www.pacesconnection.com/blog/got-your-ace-resilience-scores]
- Resilience [https://www.albertafamilywellness.org/what-we-know/resilience-scale/].

Self-Reflection and Mindfulness Activity

Activity: Self-Reflection and Mindfulness

I used to think…	But now I know…

How will your new thinking impact children and families?

What are your next steps to put this information into practice?

Pre-Service Training: Core Week 1 Day 3 Agenda

Child Welfare in North Carolina Pre-Service Training: Core

Welcome and Reflections on Day 2

Core Value: Trauma-Informed Practice

Core Value: Trauma-Informed Practice

What is Trauma?

Childhood Experiences: Positive and Adverse

BREAK

Trauma-Informed Practice

Trauma-Informed Defined

Trauma-Informed Skills Practice Learning Lab

Skills Practice: Trauma-Informed

Essential Function: Planning

LUNCH

Considerations for Child Welfare Practice

Pre-Work: Self-Assessment of Bias

Consideration for Family Engagement

BREAK

Essential Function: Implementing

Self-Reflection

Linked Notes

Tools to Calm Your Nervous System

Week 1 Post-Training Assessment

Pre-Service Training: Core Week 1 Day 3 Learning Objectives

Day 3
Core Value: Trauma-Informed Practice
• Define trauma and its potential short-term and long-term impact. • Understand the principles of trauma-informed practice and how to apply the principles to practice. • Recognize the signs and symptoms of trauma. • Practice skills to promote workforce wellness and self-care, and to regulate your nervous system.
Essential Function: Planning
• Describe the impact of bias on working with children and families. • Apply their understanding of their biases and the potential impact biases may have on their interactions with children and families. • Explain the importance of bias awareness and humility in working with children and families. • Demonstrate your awareness of a child or family's unique customs and heritage while interviewing them.
Consideration for Family Engagement
• Describe the impact of bias on working with children and families. • Apply their understanding of their biases and the potential impact biases may have on their interactions with children and families. • Explain the importance of bias awareness and humility in working with children and families. • Demonstrate your awareness of a child or family's unique customs and heritage while interviewing them.
Essential Function: Implementing
• Describe the impact of bias on working with children and families. • Apply their understanding of their biases and the potential impact biases may have on their interactions with children and families. • Explain the importance of bias awareness and humility in working with children and families. • Demonstrate your awareness of a child or family's unique customs and heritage while interviewing them.

Core Week 1 Day 3

Core Value: Trauma-Informed Practice

A trauma-informed system is one that incorporates trauma awareness, knowledge, and responsiveness into the organizational structures, practices, and policies. Trauma-informed is a core value of the North Carolina Child Welfare Practice Model.

According to the National Child Traumatic Stress Network, a trauma-informed system is one in which programs and agencies embed and sustain trauma awareness, knowledge, and skills into their organizational structures, practices, and policies and use the best available science to "maximize physical and psychological safety, facilitate the recovery of the child and family, and support their ability to thrive."

Throughout this training, we will relate our work, policies, and processes to our shared North Carolina values – to be Safety-Focused, Family-Centered, and Trauma-Informed. Values describe the mindset we bring and the approach we take to child welfare practice. We will return to these shared values throughout training. Let's take a few minutes to talk about how our work is trauma-informed.

As we further explore the ways in which we practice a focus on trauma-informed practice, let's delve deeper into the concepts of trauma, Positive and Adverse Childhood Experiences, and resilience.

Notes

What is Trauma?

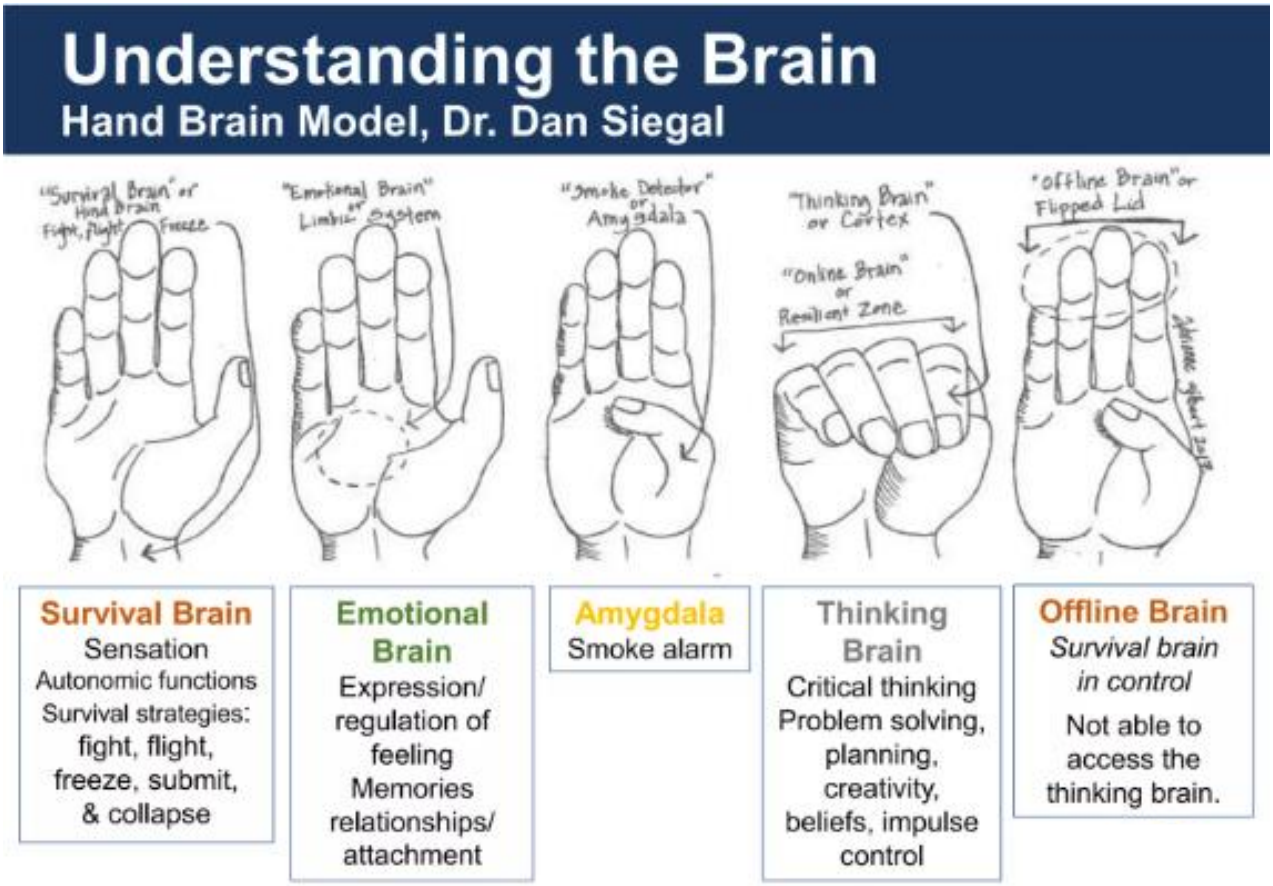
Video: What is Trauma?

Video Link: Watch the video What is Trauma?. After viewing the video, answer the questions below.

What stood out to you about the explanation of trauma in the video?

What societal factors can contribute to trauma?

Understanding the Brain: Hand Brain Model



Hand Brain Model was designed to explain how the brain works to people of all ages. The **Survival Brain** is the part of the brain that automatically responds to perceived danger with a fight, flight, freeze, submit, or collapse response. The **Emotional Brain** is responsible for expressing and regulating feelings and managing memories, relationships, and attachment. The **Amygdala** is the brain's smoke alarm/danger detector. The Thinking Brain is responsible for critical thinking, problem solving, planning, creativity, beliefs, and impulse control. The **Survival Brain** is in control when the Thinking Brain is offline; then everything the **Thinking Brain** is responsible for is not accessible.

Notes

Siegel. D.J. (2012). *The Developing Mind: How Relationships and the Brain Shape Who We Are*, 2nd Ed. New York, NY: The Guilford Press.

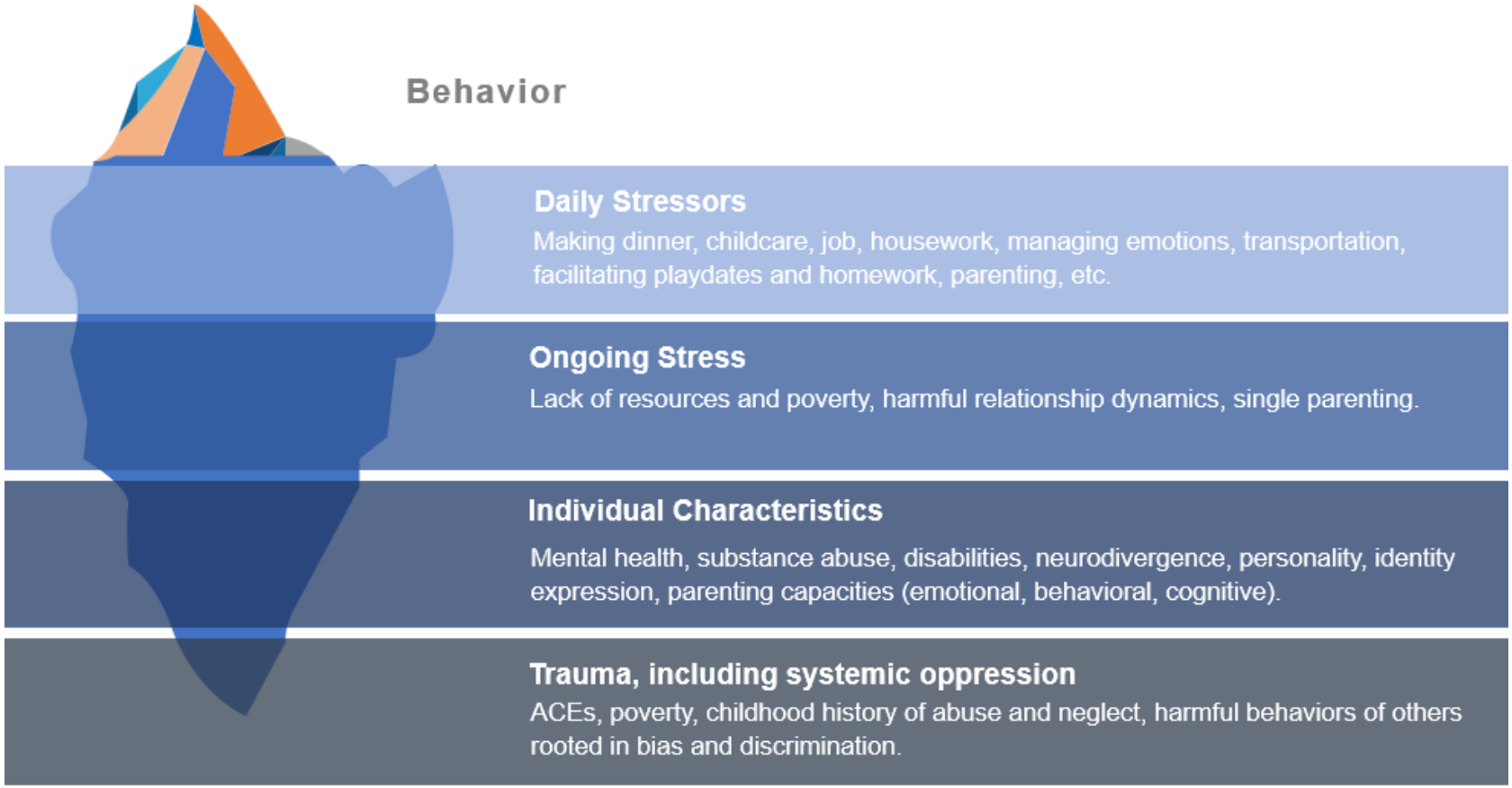
Siegal, D. (2021). *Dr. Dan Siegel's Hand Model of the Brain*. https://drdansiegel.com/hand-model-of-the-brain/

When have you seen someone flip their lid?

What led to that moment?

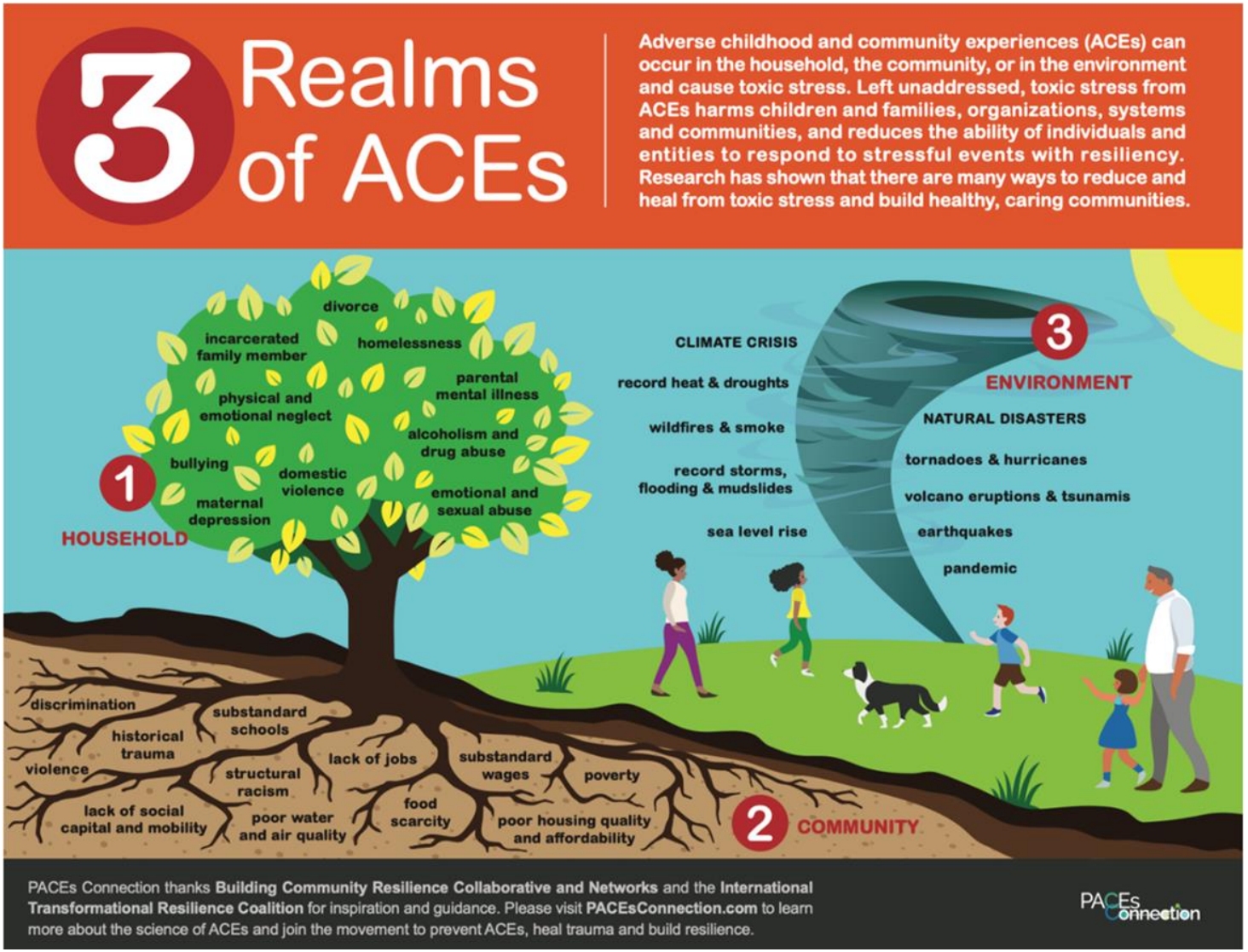
How were they behaving that let you know their Thinking Brain was no longer online?

Behaviors Associated with Trauma and an Offline Brain



Childhood Experiences: Positive and Adverse

Handout: Positive and Adverse Childhood & Community Experiences

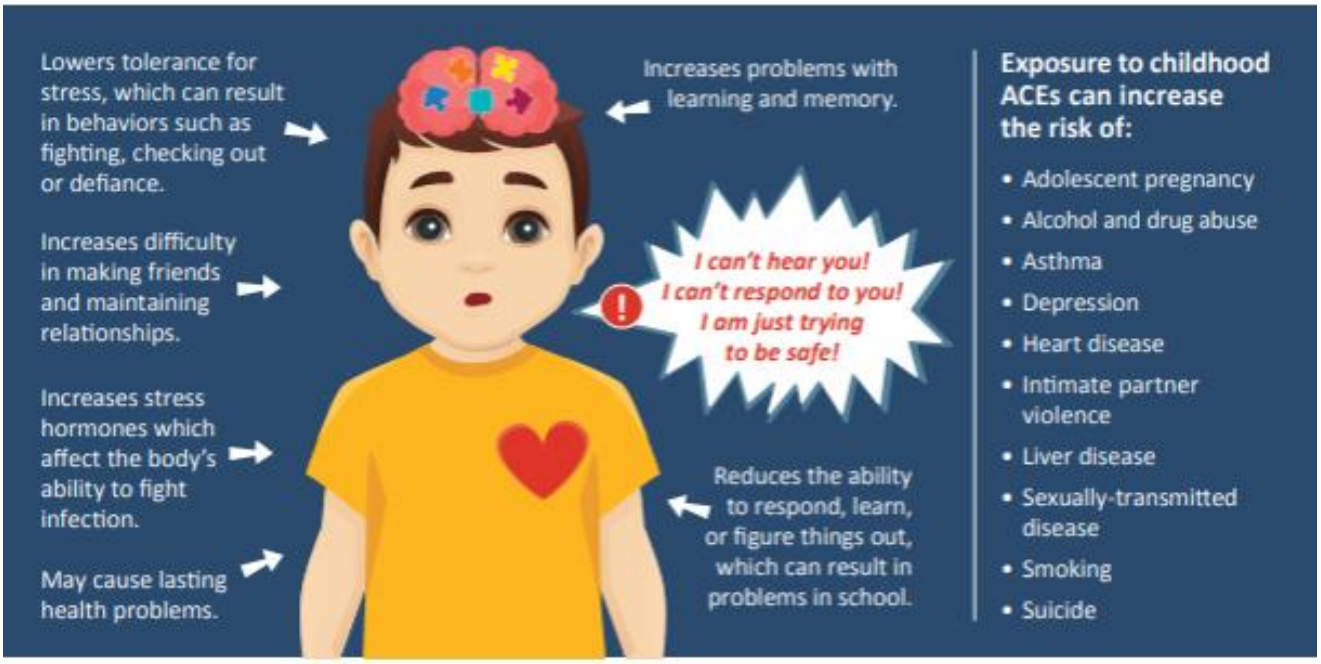


Handout: Understanding ACES

Adverse Childhood Experiences

Understanding ACEs

ACEs (Adverse Childhood Experiences) are serious childhood traumas that can result in toxic stress. Prolonged exposure to ACEs can create toxic stress, which can damage the developing brain and body of children and affect overall health. Toxic stress may prevent a child from learning or playing in a healthy way with other children, and can cause long-term health problems.



ACEs (Adverse Childhood Experiences) can include:

- Abuse: Emotional / physical / sexual
- Bullying / violence of / by another child, sibling, or adult
- Homelessness
- Household: Substance abuse / mental illness / domestic violence / incarceration / parental abandonment, divorce, loss
- Involvement in child welfare system
- Medical trauma
- Natural disasters and war
- Neglect: Emotional / physical
- Racism, sexism, or any other form of discrimination
- Violence in community

SURVIVAL MODE RESPONSE

Toxic stress increases a child's heart rate, blood pressure, breathing and muscle tension. Their thinking brain is knocked off-line. Self-protection is their priority.

Parents and caregivers can help. **Turn over to learn about resilience.**

PACEs Connection | WITH SUPPORT FROM Family Hui

This resource was reviewed by the California Collaborative ACEs Learning and Quality Improvement Collaborative (CALQIC) Patient Community Advisory Board.

Help children identify, express and manage emotions.

Create safe physical and emotional environments. (home, school, community, systems).

Understand, prevent and respond to ACEs.

"...One of the biggest myths that we have to bust is that if you have experienced childhood adversity, there's nothing we can do about it."

– Nadine Burke Harris, MD, MPH, FAAP, Surgeon General of California

What is resilience?

Research shows that if caregivers provide a safe environment for children and teach them how to be resilient, that helps reduce the effects of ACEs.

What does resilience look like?

Having resilient parents and caregivers who know how to solve problems, have healthy relationships with other adults, and build healthy relationships with children.

Building attachment and nurturing relationships:

Adults who listen and respond patiently to a child in a supportive way, and pay attention to a child's physical and emotional needs.

Building social connections.

Having family, friends, neighbors, community members who support, help and listen to children.

Meeting basic needs:

Provide children with safe housing, nutritious food, appropriate clothing, and access to health care and good education, when possible. Make sure children get enough sleep, rest, and play.

Learning about parenting, caregiving and how children grow:

Understand how caregivers can help children grow in a healthy way, and what to expect from children as they grow.

Building social and emotional skills:

Help children interact in a healthy way with others, manage emotions, communicate their feelings and needs, and rebound after loss and pain.

Resources:

- National Parent Helpline
  1-855-4A PARENT
  (1-855-427-2736)
- Number Story
- ACEs Too High
- PACEs Connection
  - *Resource Center*
  - *Parenting with PACEs*

Special thanks to the Community & Family Services Division at the Spokane (WA) Regional Health District for developing and sharing the original parent hand-out.

©2021 PACEs Connection. English 11/10

PACEs Connection | WITH SUPPORT FROM Family Hui

Positive Childhood Experiences

PCE'S are Positive Childhood Experiences. PCE's can mitigate the impact of adverse childhood experiences with positive childhood experiences. Studies showed a decrease in adult mental and relational health associated with seven primary positive childhood experiences which include:

- feel able to talk to your family about feelings
- feel your family stood by you during difficult times
- enjoy participating in community traditions
- feel a sense of belonging in high school
- feel supported by friends
- have at least two non-parent adults who took genuine interest in you
- feel safe and protected by an adult in your home

Notes

Positive and Adverse Childhood Experiences (PACES)

Video: Positive Childhood Experiences

Visit: Tree Analogy to watch a video explaining Positive and Adverse Childhood Experiences (PACES) with a tree analogy.

Notes

Resilience Scale

Positive and Adverse Childhood Experiences work together, along with one's DNA and personality, to contribute to what we call a Resilience Scale. You may recall this image from your pre-work on PACEs. This image illustrates what we refer to as a Resilience Scale. The fulcrum represents what a child is born with. This includes their DNA and personality (or the essence they are born with).

The balance on top of the fulcrum holds their life experiences. On the left are the Adverse Childhood Experiences or negative experiences. On the right are the Positive Childhood Experiences or positive experiences. Notice the different sizes of the boxes on each side of the fulcrum. Each positive and adverse experience carries a different weight for each person. Someone could have one positive support that weighs so much that it outweighs the total weight of ten adverse experiences.

Extensive research shows that PCEs can mitigate or buffer the detrimental impacts of ACEs on mental, emotional, and physical health outcomes in both childhood and adulthood. Individuals with multiple ACEs but also numerous PCEs demonstrate significantly lower rates of adult depression, anxiety, behavioral problems, and chronic diseases compared to those with ACEs alone. For example, even among children reporting four or more ACEs, those with higher levels of PCEs have reduced risk of negative health outcomes such as depression and behavioral issues.

PCEs influence outcomes independently of ACEs, meaning they can foster well-being even in the presence of adversity. PCEs contribute to neurobiological resilience, helping normalize stress response systems disrupted by trauma. They promote secure attachment, emotional regulation, social skills, and self-efficacy, counteracting toxic stress from ACEs. Positive relationships with caregivers, safe environments, and community support are critical components modulating this interaction. PCEs reduce the likelihood of mental health disorders, including depression, anxiety, PTSD, and behavioral disorders. PCEs also support positive physical health outcomes, decreasing risk for chronic illnesses related to toxic stress. Even for children with several adverse childhood experiences, having positive experiences can reduce negative outcomes.

What types of adversity might children on your caseload face?

What types of adversity might the parents and caretakers on your caseload have experienced?

What types of positive supports might have been offered to children and families on your caseload?

What types of positive experiences come to mind that could outweigh multiple adverse experiences? And why?

In your role as a child welfare caseworker, what positive supportive experiences can you offer children and families?

Image source: Alberta Family Wellness Initiative. (2025). Resilience scale. Alberta Family Wellness Initiative. https://www.albertafamilywellness.org/what-we-know/resilience-scale

Skills Practice: Recognizing ACEs and PCEs

Review the Evans Family scenario and identify ACEs and PCEs for each family member. When you are finished, discuss your observations with a partner.

Person	ACEs	PCEs
Shonda		
Rudy		
Keisha		
Kevin		
Angela		

Handout: Evans Family Introduction

Family members:

Mother:	Shonda Evans, 34, Black
Father:	Rudy Evans (deceased), 38 Black
Children:	Keisha, 14, Black
	Kevin, 5, Black
	Angela, 11 months, Black
Grandmothers:	Kim Evans, 59, Black, Rudy's mother (paternal grandmother)
	Cicely Brown, 58, Black, Shonda's mother (maternal grandmother)

The Evans family is a close-knit family. They attend church twice weekly, and the children participate in youth groups. The family lives in a neighborhood close to their church and the elementary, middle, and high schools, with a park and sidewalks. The family is financially secure. Both parents worked until father Rudy's recent death of cardiac arrest at work (one month ago).

Rudy had life insurance through his work at a local factory, working the early shift from 6:00 a.m. to 2:00 p.m. This shift enabled Rudy to meet Kevin's bus after school and pick up Angela from day care. Rudy was an involved father and often spent time playing at the park with the children.

Mother Shonda works as an office receptionist, where she has been employed since before Kevin was born. Shonda struggled with post-partum depression after Keisha was born and sought counseling. She began taking medication to manage her depression and stayed on it for some years. Due to the severity of her post-partum depression, Shonda and Rudy waited a long time before having more children. Rudy's mother, Kim, was helpful after Kevin was born, which helped Shonda navigate the depression she felt after his birth. After Angela was born, Shonda's mother, Cicely, visited to help the family. Though she did not say so, Shonda felt that Kim had been more helpful and less judgmental than her own mother, with whom she had a challenging relationship.

Keisha attends high school, has a B+ average, and is on the cheerleading squad and in choir. She is close friends with two other girls on the cheerleading team. She enjoys spending the night with them sometimes and is looking forward to learning how to drive. Keisha sings in the choir at church and is active in the youth group. When Keisha was nine, her Uncle Jake began visiting them often. He showed up at church and started having Sunday lunches with her family, which her mom seemed to enjoy. Uncle Jake made her feel special, and he began to take her shopping after church while her mom was fixing lunch. Uncle Jake began touching her inappropriately and sexually abused her during their drive to and from shopping. Keisha was afraid to tell her mom for two years. When she was eleven, child welfare showed up at their house, saying her mom had beaten them and that they were dirty. Keisha did not know why someone would report that, because they were always taking baths, although her mom and dad did spank them when they got into trouble. One day her mom told her that they should not have any secrets between them and Keisha felt safe enough to tell her mom what Uncle

Jake had been doing. Her mom told her dad and together they called the police. Keisha had to talk to the police and go to an interview at a center, where they asked her about what Uncle Jake had done. Keisha told the truth and Uncle Jake confessed, going to prison for his crimes. Keisha went to counseling at a center after this happened.

Kevin is in kindergarten and enjoys school. He is a bright boy who recently learned to read and can do his addition tables. Kevin enjoys playing baseball and playing on the playground, where the swings are his favorite. Kevin enjoyed throwing the baseball with his father, who taught him how to swing a bat. Kevin likes to watch cartoons on TV and enjoys shows about animals.

Angela is a chubby eleven-month-old baby who is developmentally on-target. She crawls and is beginning to walk and say words that her family recognizes. Angela has a favorite stuffed giraffe and is attached to her parents. She enjoys spending time with her dad and likes to go to the park with him and be in the swings.

Child Welfare History:

When Keisha was three years old, child welfare opened a case to assess supervision when a neighbor found her wandering the street in the neighborhood. CPS conducted an assessment and found that services were needed, opening an In-Home case. The family worked with child welfare for three months. Shonda and Rudy took parenting classes, and the case was closed.

When Keisha was 11 and Kevin was an infant, it was reported that Shonda hit the children and left bruises, that the children were dirty, and that they had untreated medical needs. Child Welfare opened a case to assess the family and determined that services were needed due to supervision concerns. During the open In-home case, Keisha disclosed that her uncle, Jake Brown, Shonda's brother, had sexually abused her. Shonda and Rudy believed Keisha, called the police, and cooperated with the criminal investigation. Criminal charges were filed, and Jake plead guilty to sexual assault of a child. Jake went to prison. 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. The In-Home case was open for six months and closed with a favorable resolution of supervision concerns.

Childhood History:

Rudy was raised by his mother, Kim, and father, Brian, with three siblings. They were strongly religious and attended church twice weekly. Both Kim and Brian sang in the church choir and actively participated in church functions, such as picnics and gatherings. Brian served in the Army for many years and was a strict disciplinarian. Kim worked part-time after all her children were in school. Brian passed away two years ago, and Kim has struggled with the loss of her husband. Rudy was close to his father and was very sad when he passed away. Rudy's two sisters are married and live in the state, but they are not close by. Kim lives close to the family, in the next neighborhood over.

Rudy joined the Air Force right after high school and began working at a local factory at age 21, when he got out of the Air Force after three years of service. Rudy and Shonda met at a church picnic and were married quickly when they discovered that she was

pregnant. When Rudy was a child, his oldest sister died in a car accident at 16 years old.

Shonda was raised by her mother, Cicely, with her younger brother, Jake. Their father went to prison when Shonda was very young, and her mother rarely spoke of her father. Shonda had no relationship with her father's family growing up. Cicely worked hard to provide for Shonda and Jake, sometimes having two jobs. She worked in bars and taverns, which caused her to work long, late hours, during which Shonda would be responsible for caring for Jake. Cicely drank a lot and frequently came home from work intoxicated. She was arrested for drinking and driving twice in Shonda's childhood. One time, Cicely stayed overnight in jail, and the next morning, when Shonda woke up, she did not know where her mom was. By this point, Shonda was familiar with how to care for Jake and made them both breakfast. They missed school that day, and her mother was very angry when she came home, and they had not gone to school. Shonda did not know her mother's family, who all lived in Atlanta, and they had no family support during her childhood. Shonda began staying out late with older kids and adults when she was 14, since her mother worked until 2:00 a.m. and would not know. When she was 15, Shonda was drugged and raped at a party, although she never told anyone about this incident. Shonda graduated high school and began working as a receptionist. She continued living with her mother until she met Rudy and they got married. Shonda joined the church after she started dating Rudy and feels accepted by and connected to the congregation. Shonda has made a few close friends at church and has attended bible study classes in the past.

Trauma-Informed Practice

Trauma-Informed Practice: Six Core Principles

Safety:

Families and child welfare workers feel physically and psychologically safe.

Trustworthiness and Transparency:

Decisions are made with transparency, and with the goal of building and maintaining trust.

Peer Support:

Child and family safety decisions are team decisions and no one person should make decisions about families alone. Consulting with your peers and supervisor is viewed as integral to child welfare service delivery.

Collaboration:

Child welfare services are family-centered interventions to assess and provide child and family safety. As a representative of the government, power differences between child welfare workers and families, and among organizational staff, are leveled to support shared decision-making.

Empowerment:

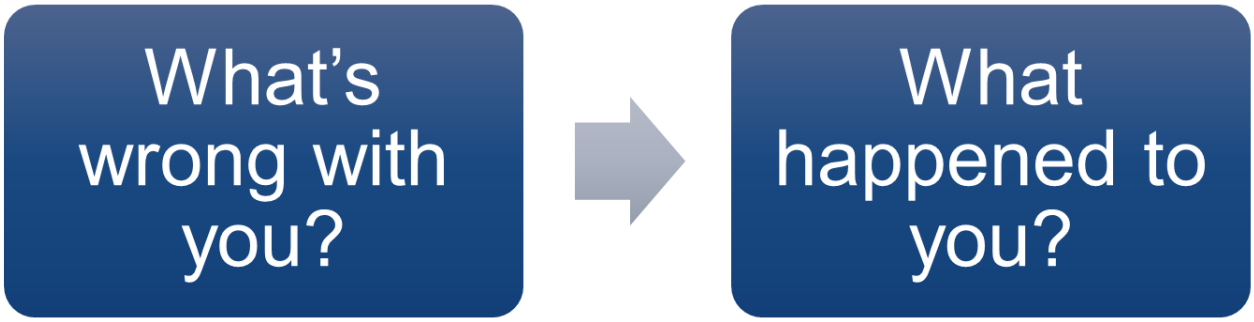
Each person's voice matters in the process. Especially the voices of those most impacted by the decisions. Child and family strengths are recognized, built on, and validated — this includes a belief in resilience and the ability to grow, change, and heal from trauma.

Humility and Responsiveness:

Biases, stereotypes (based on race, ethnicity, sexual orientation, age, geography), and historical trauma are recognized and addressed. Child welfare workers are responsible for engaging in crucial conversations with families with the understanding that families are the experts on their own lives, strengths, and challenges.

Notes

What It Means to Be Trauma Informed



Delores Subia BigFoot describes trauma-informed care this way, "A way to view trauma-informed care is as caring for all others as relatives. Being a good relative means caring for others, actively working to decrease their discomfort, and seeking to eliminate conditions that may harm them. In Indian Country, an understanding of generosity respect, belonging, connectedness, and other virtues is reflected in being a good relative. Trauma-informed care is a recent term for an approach to providing emotional and physical support and safety in a way that recognizes the impact of trauma and potential trauma triggers. This approach is very different from the experiences of many of our tribal members, who have experienced or witnessed violence and threats in care settings. Implementing trauma-informed principles comes naturally as we apply a cultural understanding of being a good relative."

Here are some basic tips for how to put this into practice as a child welfare caseworker:

- Provide adequate information about the child welfare process, why you are there, and what you will be doing.
- Seek to understand their customs, beliefs, and experiences.
- Maintain awareness of your surroundings and behaviors of those around.
- Do everything you can to ensure physical and psychological safety throughout the process.
- Identify the distressing experience by asking "what happened to you" vs "what's wrong with you".
- Define the experience and don't let the experience define the person.
- Move from what was before to what is now by staying present in the moment and supporting families in doing the same.
- Recognize that memories, reminders, and triggers don't need to be devastating.
- Learn, teach, and practice healthy self-care skills.

In this way, we can hold another person's story with care; honor their story with our full presence; and offer them our hope-building services. Trauma-informed practice helps improve our physical, emotional, and psychological wellbeing. Importantly, it helps prevent secondary traumatic stress.

Trauma-Informed Practice Defined

Key Takeaways

- Focus on humility
- Continually engage in self-awareness
- Ask if you're being comprehensive and collaborative
- Recognize institutional racism persists
- Consider the impact of biases

Notes

Learning Lab: Trauma-Informed Skills Practice

Skills Practice: Trauma-Informed

The purpose of this activity is to provide an opportunity to use trauma-informed practice skills in a safe learning environment and receive feedback from your peers.

In groups of three, each person will play a role in a series of three cycles of role play or skills practice.

Person 1 – shares a distressing experience
Person 2 – listens and responds with trauma-informed principles and skills
Person 3 – an observer who keeps time

Person 1 will share a story of a challenging or awkward experience. Please, be mindful of the story you share. Think of something to share that affords your peers the opportunity to use trauma-informed skills, but nothing that will cause harm or discomfort for them to hear.

Person 2 will listen to person 1's story and respond with trauma-informed principles and practice their trauma-informed skills. Person 2's job is to be curious and caring, providing support and asking questions.

Person 3 will be an observer who keeps time and makes note of the trauma-informed skills they observe person 2 demonstrating.

Each role play will last for five minutes, then you will share feedback for two minutes. The observer will keep time for the group.

During feedback, person 2 will share what they thought they did well, then person 1 will share strengths-based feedback, and then person 3 (the observer) will share strengths-based feedback.

When the two minutes of feedback are up, switch roles and repeat the five-minute practice and two-minute feedback.

Observer Notes

Debrief: Trauma-Informed Skills Practice

What stood out to you from this exercise?

What was it like for you when you told your story to have someone support you with a trauma-informed approach?

When you shared your story, what did it feel like to have a third person present who did not engage with you?

How will this impact how you hear and respond to children and families in the field?

What is one thing that you will remember to do in the future?

Key Takeaways

- Be supportive
- Actively curate an environment of safety and trust
- Listen with humility
- Respond with curiosity
- Empower the speaker

Notes

Essential Function: Planning

Planning

Planning is defined as respectfully and meaningfully collaborating with families, communities, tribes, and other identified team members to set goals and develop strategies based on the continuous assessment of safety, risk, family strengths, and needs through a child and family team process. Plans should be revisited regularly by the team to determine progress towards meeting goals ad make changes when needed.

Planning is one of the essential functions of the NC Child Welfare Practice Model. Planning refers to the dynamic process of creating plans with those most impacted and those supporting them. The team should revisit the plans regularly to determine progress towards meeting goals and make changes when needed.

Planning is an opportunity to center the family, focus on safety, and move forward with the child welfare process in a trauma-informed manner.

What plans are you responsible for creating with children, parents, and support networks within your child welfare role?

Handout: North Carolina Practice Model: Planning

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Planning: ***Respectfully and meaningfully collaborating with families, communities, tribes, and other identified team members to set goals and develop strategies based on the continuous assessment of safety, risk, family strengths, and needs through a child and family team process. Plans should be revisited regularly by the team to determine progress towards meeting goals and changes made when needed.***

#1	Engage the family in understanding assessment and history, focusing on strengths to customize the plan.
#2	Discover root causes and underlying reasons for the family's involvement.
#3	Believe and practice the importance of preparation both for self and for the family for teaming and planning.
#4	Actively engage the family in identifying their team.
#5	Promote the family's voice as the cornerstone of the meeting.
#6	Facilitate and engage participants throughout, acknowledging and managing conflict.
#7	Revisit case plan regularly, willing to modify or update as needed, but at a minimum per policy.

Planning Core Activities

Planning

Debrief: Planning for Others

Planning is more than writing the plan itself; it is a collaborative process between you and the family. Planning is the respectful and meaningful collaboration with others. A "plan" is the written version of actions that describe decisions made during collaboration. Plans are dynamic and need to be changed to reflect current circumstances.

When you were writing plans, was there more information you would like to have known in order to better plan for your partner?

When you heard the plan crafted for you, how did that feel?

How well did your partner's plan fit for you?

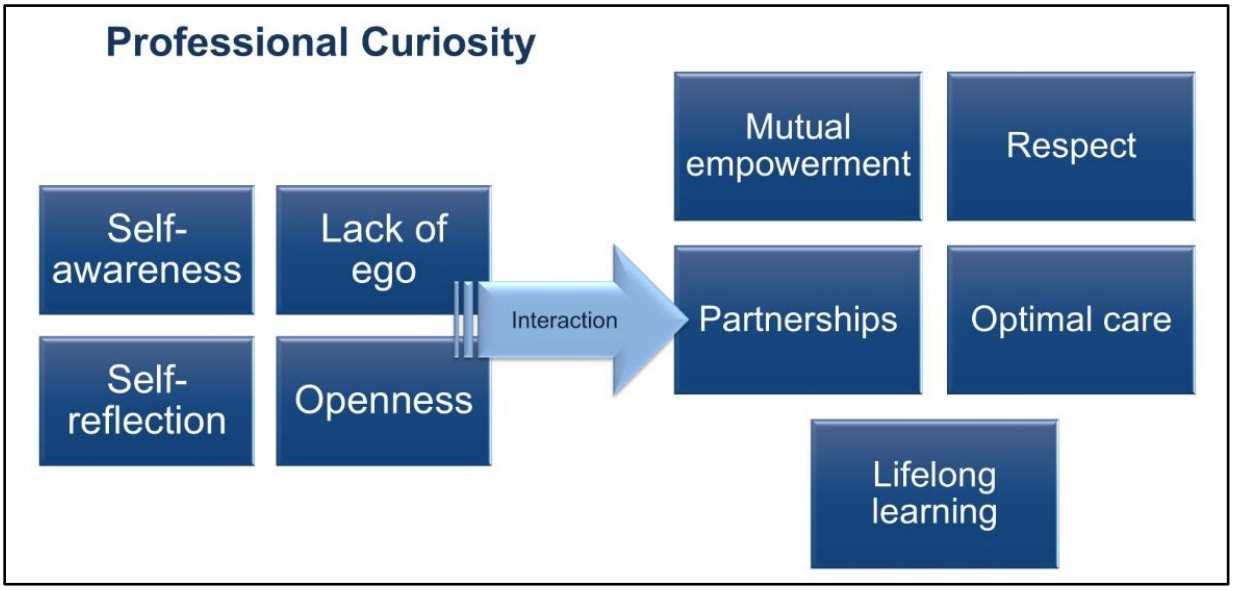
What would make your plan better?

What will you take from this activity into your casework practice?

Considerations for Child Welfare Practice

Consideration for Family Engagement

Professional Curiosity



Professional curiosity about people from different social circles and parts of the world requires that we engage in a dynamic and lifelong process of focusing on our self-reflection and critiquing our interactions as we acknowledge our own biases. We can think of this as a "process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with others, resulting in mutual empowerment, respect, partnerships, optimal care, and lifelong learning."

The concept of professional curiosity recognizes that intersecting identities shift over time, requiring us to be curious and continuously learning about each family's unique customs and heritage to adapt to those shifting identities. The idea of intersecting identities, or intersectionality, is that social categories like race, class, and gender are interconnected, and create overlapping and independent systems of discrimination or disadvantage.

Notes

Professional Curiosity

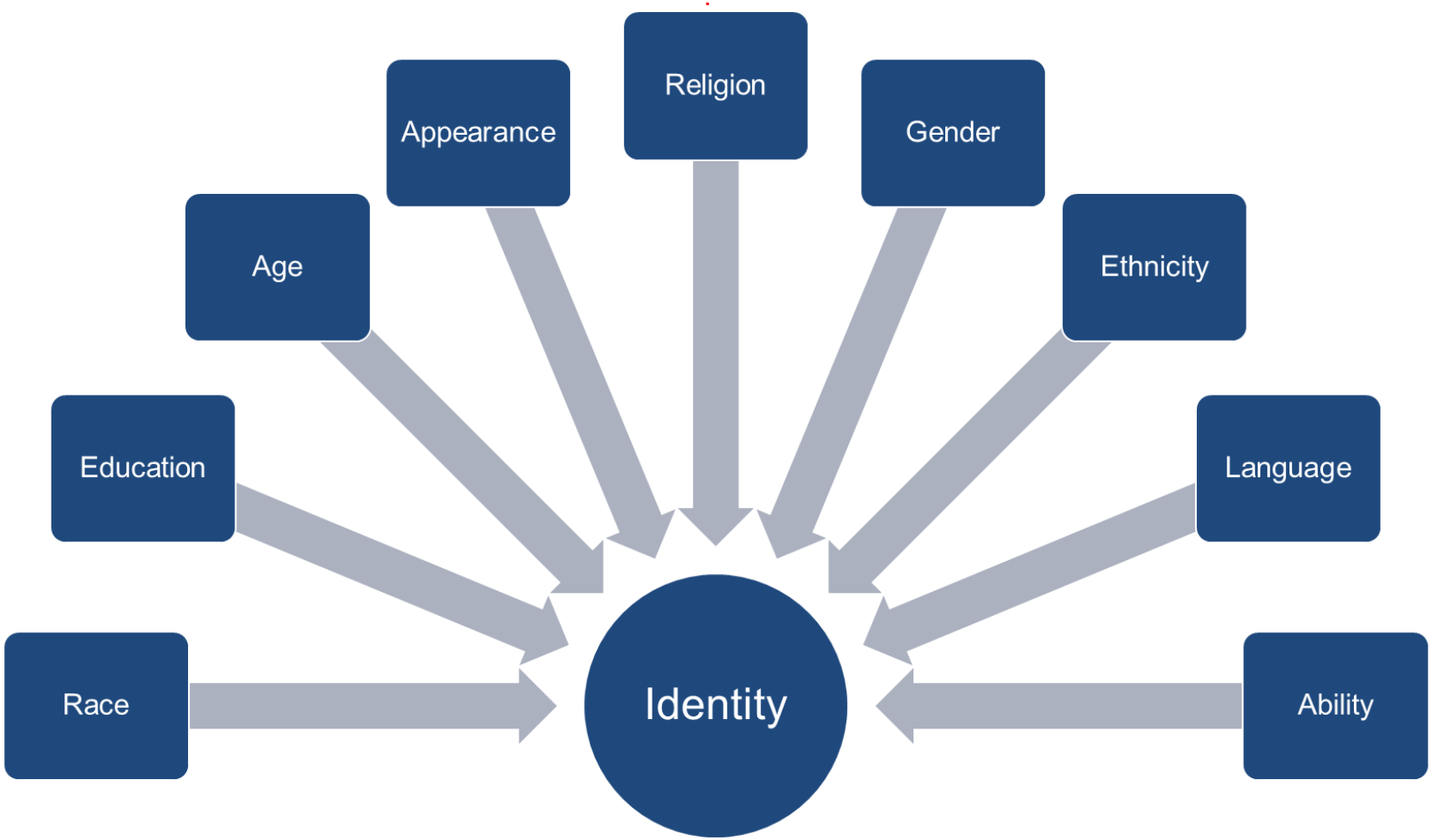
There are three key steps to practicing professional curiosity:

Noticing dissonance. Dissonance is found in those moments when something feels off or inconsistent. It might be a mismatch between what someone says and what they do, or between what we expect and what we observe.

Exploring evidence and managing tension is about refraining from jumping to conclusions and instead gathering more information. We ask thoughtful questions, stay present, and manage any discomfort that arises in ourselves or others.

Making sense of what's happening with reason, critical thinking, and reflexivity. We reflect on what we've learned, consider our own assumptions, and work in partnership with the person to understand the full picture.

Intersectionality



How might their identities impact how our families experience the child welfare system?

How will their identities influence how they engage with us?

What difference might it make if someone holds multiple identities simultaneously, such as non-English-speaking, on a wheelchair, Hindi, and a girl with dark skin from India?

Addressing Bias When Engaging Families

Lifelong learning and self-reflection	Recognizing power imbalances	Institutional accountability
• Be curious • Families are the experts	• Share power with families • Collaborate with families	• Family-centered and Individually responsive services • Response to feedback

Consider your privilege or your lack of disadvantage. How does that create a barrier between you and the families you serve?

Consider whether your local agency (and the North Carolina system) provides family-centered and individually responsive services, such as translators, interpreters, and other services for families with limited English?

Is your agency responsive when families share frustrations about instances where their family values or identity were not respected?

Considerations for Engaging Families

Considering how bias might influence my work:

What happens when we have miscommunication?

What might cause me to behave differently with a family?

Would it make a difference if the parent was very young or very old?

What difference might it make if they had only gone through the eighth grade versus a parent with a PhD?

What religion, nationality, language, or ethnicity might make me uncomfortable working with a family?

How might it influence my work with families if a child or parent lived with profound physical disabilities?

How would I respond if a child or parent lived with a serious mental illness?

How do my own biases impact how I work with families?

How do my own biases influence how I perceive families?

Mitigating my biases:

How will I recognize my bias against children and families?

How will I recognize my bias against peers or other professionals?

How can I practice and demonstrate positive intent?

How do I overcome my bias to treat all families the same, with curiosity and caring?

How do I respond to miscommunication?

How can I navigate miscommunication with families?

How do you bring positive intent into your work with families?

How can you react when there is miscommunication or if a family member is upset or frustrated?

Essential Function: Implementing

Implementing

Carrying out plans that have been developed.

Implementing includes linking families to services and community supports, supporting families to take actions agreed upon in plans and monitoring to assure plans are being implemented by both families and providers, monitoring progress on behavioral goals, and identifying when plans need to be adapted.

Implementing is the fifth essential functions of the NC Child Welfare Practice Model. Your role is to partner with the family to determine services and service delivery, and what will work best for their family. You can help the family understand the purpose of each service and explore what progress might look like for them. Consider using three-column mapping with the family for this exploration. You might offer to make initial phone calls to assist the family in navigating a complex service array system. It is important to consider the family's values, interests, and beliefs when exploring natural supports that may help them feel confident and supported during the process.

Implementing is an opportunity to center the family, focus on safety, and move forward with the child welfare process in a trauma-informed manner. Your role is to continuously assess services with the family, explore potential barriers, and adjust if changes are needed.

Handout: North Carolina Practice Model: Implementing

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Implementing: ***Carrying out plans that have been developed. Implementing includes linking families to services and community supports, supporting families to take actions agreed upon in plans and monitoring to assure plans are being implemented by both families and providers, monitoring progress on behavioral goals, and identifying when plans need to be adapted.***

#1	Support the family to take action.
#2	Work with the family to find solutions to problems.
#3	Explain to the family what services are and what they could do for the family to provide information and informed decisions.
#4	Offer an array of service providers to choose from if there are choices to be had.
#5	Advocate with and for the family with providers regarding what behavioral change is expected to ensure quality service delivery.
#6	Access natural supports in the community to assist the family to achieve their goals.
#7	Check in on an ongoing basis with the family on progress with the Family Services Agreement.
#8	Assess progress in implementing actions of the plan, making adjustments as needed.
#9	Track service delivery for the achievement of safety, permanency, and well-being outcomes for the family.

Implementing Core Activities

Activity: Milestones and Celebrations

Change can be a slow process. Even when change is essential and required, it happens incrementally. Working with families within the implementing function requires that we acknowledge that change happens in stages and to name these milestones. Additionally, celebrating success, even small successes is a key component of implementing. By honoring the milestones and celebrating success, you support a strengths-based and balanced approach.

To practice these implementation components, consider the problem identified earlier today in the planning section and complete the chart below.

Identify your desire for change and what motivates you to resolve this problem.

Why do you want this change to occur?

What might happen if the change does not occur?

List several milestones for the change process.

List behavior changes that might be observed as signs of success.

Identify ways to celebrate these milestones when they are reached.

Self-Reflection

Activity: Linked Notes

This is a self-reflection and exploration of other people's thoughts about this week.

To begin, you will write a response to the prompt below. When you are finished, please pass your workbook to the person on your left and receive a workbook from the person on your right. Read through their response to the prompt and add a sentence or phrase that relates to the original prompt, builds upon or extends your peer's thoughts, or even disagrees with them. You could also start a new comment.

When you are done, pass the workbook to your left again and take the workbook from the peer on your right. Continue this cycle until you get your workbook back again.

When you get your workbook back, take a moment to read what has been written and compare your thoughts to your peers' thoughts.

Something I learned from the ideas, concepts, and discussions this week is…

Handout: Tools to Calm Your Nervous System

As a trauma informed care provider, you will need to know how to calm your own nervous system. You need a calm nervous system to:

- Remain calm in emergency situations.
- Utilize your thinking brain to gather the information needed to adequately assess safety and risk.
- Engage in a manner that allows you to deeply connect, actively listen, and take in a lot of information, including verbal and non-verbal communication while assessing the environment.
- Be trustworthy and transparent.
- Co-regulate and support children and families to calm their nervous systems.
- Collaborate in decision making.
- Support the voices most impacted by decisions to be directly part of decision-making processes.
- Behave with humility and respond to people being the expert of their own life.

Tools to calm the nervous system include connection and grounding techniques.

Connection

For some, connection to others is how they find their center when stressed. Some of you may like to talk to a friend, family member, or partner when you are stressed. Or maybe some of you don't want to talk when you are stressed but you want to be held, hugged, or just in the presence of someone with whom you feel safe and comfortable. This is called co-regulation. Humans naturally tend to sync up with others. Some people will get amped up with you and some will stay calm and then you will find yourself calming down just being in their calm presence. Sometimes getting amped up or just talking with someone can help you get the stressful energy out, metabolize it, and then you may feel ready to calm down and move on.

Grounding

Grounding is a process of connecting with the present moment. Breathing, humming, physical awareness, and the Five Senses exercises are different grounding activities. Grounding is helpful in crises when you do not have the luxury of walking away, of talking or hugging the stress out, or cannot hum or sing to relax.

Physical grounding is primarily about sensing the physical sensations in the body that connect with the Earth and ground. This includes feeling your back and bottom touching the chair holding you up, and the bottom of your feet on the floor beneath you. As you become aware of what is holding you up, you can also send messages to the muscles in that area to relax, letting the chair and floor hold you.

Breathing Exercises help you regulate your nervous system. Breath is the one way you can directly access your nervous system voluntarily. You can think of it as a volume knob. You can engage particular breathing exercises to turn up the volume on your nervous system, increase energy and alertness, and different types of breathing exercises to turn down the volume and calm your nervous system. In general, long deep slow breaths will help turn the volume down and calm your nervous system. There are

many breathing exercises that can assist you in doing this. You can always look up a video online to guide you in a variety of breathing exercises intended to bring relaxation. We will practice one here that you can easily do even while in a meeting and directly engaging with families.

Humming is a self-soothing technique. There is a primary nerve called the Vagus nerve responsible for regulating the nervous system. Humming, singing, and chanting are known for toning the Vagus nerve because of the proximity between the vocal cords and the Vagus nerve. Humming, chanting, and singing create a vibration that then vibrates the Vagus nerve and sends signals of safety that help calm the entire nervous system. You may know people who hum while working, doing dishes, or rocking in the rocking chair. It's similar to a cat purring.

Five Senses (sometimes called the 5-4-3-2-1) is a grounding exercise that allows you to count down from five while identifying things you perceive with your senses. In this exercise you will silently identify:

- 5 things you see
- 4 things you hear
- 3 things you feel
- 2 things you smell
- 1 thing you taste.

This takes less than one minute and can be done with your eyes open. It is a useful skill to ground yourself when circumstances are overwhelming in a client's home or during an emergency response.

Pre-Work Reminder

>> Save page for pre-work reminder once Week 2 is completed

Appendix

Three Column Mapping

Three Column Mapping

What are we worried about?	What is working well?	What needs to happen next?

Pre-Work for Week 1 Day 3

Handout: Understanding ACEs

Adverse Childhood Experiences

Understanding ACEs

ACEs (Adverse Childhood Experiences) are serious childhood traumas that can result in toxic stress. Prolonged exposure to ACEs can create toxic stress, which can damage the developing brain and body of children and affect overall health. Toxic stress may prevent a child from learning or playing in a healthy way with other children, and can cause long-term health problems.

ACEs (Adverse Childhood Experiences) can include:

- Abuse: Emotional / physical / sexual
- Bullying / violence of / by another child, sibling, or adult
- Homelessness
- Household: Substance abuse / mental illness / domestic violence / incarceration / parental abandonment, divorce, loss
- Involvement in child welfare system
- Medical trauma
- Natural disasters and war
- Neglect: Emotional / physical
- Racism, sexism, or any other form of discrimination
- Violence in community

SURVIVAL MODE RESPONSE

Toxic stress increases a child's heart rate, blood pressure, breathing and muscle tension. Their thinking brain is knocked off-line. Self-protection is their priority.

Parents and caregivers can help. **Turn over to learn about resilience.**

PACEs Connection | WITH SUPPORT FROM Family Hui

This resource was reviewed by the California Collaborative ACEs Learning and Quality Improvement Collaborative (CALQIC) Patient Community Advisory Board.

Help children identify, express and manage emotions.

Create safe physical and emotional environments. (home, school, community, systems).

Understand, prevent and respond to ACEs.

"...One of the biggest myths that we have to bust is that if you have experienced childhood adversity, there's nothing we can do about it."

– Nadine Burke Harris, MD, MPH, FAAP, Surgeon General of California

What is resilience?

Research shows that if caregivers provide a safe environment for children and teach them how to be resilient, that helps reduce the effects of ACEs.

What does resilience look like?

Having resilient parents and caregivers who know how to solve problems, have healthy relationships with other adults, and build healthy relationships with children.

Building attachment and nurturing relationships:

Adults who listen and respond patiently to a child in a supportive way, and pay attention to a child's physical and emotional needs.

Building social connections.

Having family, friends, neighbors, community members who support, help and listen to children.

Meeting basic needs:

Provide children with safe housing, nutritious food, appropriate clothing, and access to health care and good education, when possible. Make sure children get enough sleep, rest, and play.

Learning about parenting, caregiving and how children grow:

Understand how caregivers can help children grow in a healthy way, and what to expect from children as they grow.

Building social and emotional skills:

Help children interact in a healthy way with others, manage emotions, communicate their feelings and needs, and rebound after loss and pain.

Resources:

- National Parent Helpline
  1-855-4A PARENT
  (1-855-427-2736)
- Number Story
- ACEs Too High
- PACEs Connection
  - *Resource Center*
  - *Parenting with PACEs*

Special thanks to the Community & Family Services Division at the Spokane (WA) Regional Health District for developing and sharing the original parent hand-out.

©2021 PACEs Connection. English 11/10

PACEs Connection | WITH SUPPORT FROM Family Hui

Bibliography of References

Day One

Administration for Children and Families. (n.d.). *Child and Family Services Reviews Quick Reference Items List*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://acf.gov/sites/default/files/documents/cb/cfsr_quick_reference_list.pdf

American Public Human Services Association (APHSA). (2021, May 21). *Poverty and neglect are not the same — it's time to realign our response*. [Blog]. Aphsa.org, Catalyst blog. https://aphsa.org/resources/poverty-and-neglect-are-not-the-same/

The Annie E. Casey Foundation. (2020). *Child welfare practice to address racial disproportionality and disparity*. Baltimore, MD: The Annie E. Casey Foundation. https://www.aecf.org/resources/disparities-and-disproportionality-in-child-welfare

CalSWEC Online, (2019, April 29) Child Welfare Worker Realistic Job Preview, https://www.youtube.com/watch?v=2aoOYAwgp2o&list=PLNYfSDZN2XUpWQ62KzijZDZ_g2VEjlSGD&index=1

Casey Family Programs. (January 18, 2019). *Jeremiah Donier Birth Dad Winner*. [Video]. Youtube.com, Casey Family Programs channel. https://www.youtube.com/watch?v=yxBeN5-Rq_E&t=249s

Centers for Disease Control and Prevention. (2024). *About Child Abuse and Neglect*. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Child Abuse and Neglect Prevention. https://www.cdc.gov/child-abuse-neglect/about/index.html

Centers for Disease Control and Prevention. (2024). *Risk and Protective Factors.* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. Child Abuse and Neglect Prevention. https://www.cdc.gov/child-abuse-neglect/risk-factors/index.html

Child Welfare Information Gateway. (2018). *Acts of Omission: An Overview of Child Neglect.*[Bulletin]. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. https://ocfcpacourts.us/wp-content/uploads/2020/06/Acts_of_Omission_000978.pdf

Child Welfare Information Gateway. (2019). *What is child abuse and neglect? Recognizing the signs and symptoms*. Washington, DC: U.S. Department of Health and Human Services, Children's Bureau. https://www.childwelfare. gov/resources/what-child-abuse-and-neglect-recognizing-signs-and-symptoms/Centers for Disease Control and Prevention, Violence Prevention, (2022, April 6) *Child Abuse and Neglect.* https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html

Child Welfare Information Gateway. (2020). *How the Child Welfare System Works*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://api.childwelfare.gov/resources/how-child-welfare-system-works/

Children's Bureau, (2021) *Child Maltreatment 2020.* U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2020.pdf

Child Welfare Information Gateway. (2021). *The Use of Safety and Risk Assessments in Child Protection Cases*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau. Retrieved from https://www.childwelfare.gov/topics/systemwide/laws-policies/statutes/safety-risk/

Child Welfare Information Gateway. (n.d.). *Supervising for Quality Child Welfare Practice*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://cwig-prod-prod-drupal-s3fs-us-east-1.s3.amazonaws.com/public/documents/effective_supervision.pdf

Children's Bureau (2014, July 23) *Child and Family Services Reviews Quick Reference Items Lis*t. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.acf.hhs.gov/sites/default/files/documents/cb/cfsr_quick_reference_list.pdf

Children's Bureau. (n.d.). *Round Four Child and Family Services Reviews Fact Sheet*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://acf.gov/sites/default/files/documents/cb/CFSR_General_Fact_Sheet.pdf

Child Welfare Information Gateway. (2020). *How the Child Welfare System Works*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://api.childwelfare.gov/resources/how-child-welfare-system-works/

Evident Change. (2024). *Introducing Safety-Organized Practice* [curriculum].

Evident Change. (2025). *SDM Safety and Risk Assessment and FSNA Training* [curriculum].

Hill, P. L., & Turiano, N. A. (2014). Purpose in life as a predictor of mortality across adulthood. *Psychological science*, *25* (7), 1482–1486. https://doi.org/10.1177/0956797614531799)

IDEO U. (August 1, 2024). *How to define your purpose: A four-step activity to get you started*. [Blog]. www.ideou.com. https://www.ideou.com/blogs/inspiration/activity-4-steps-to-define-your-purpose.

Killion, Cheryl M. (2017). "Cultural Healing Practices that Mimic Child Abuse." *Ann Forensic Res Anal* 4(2): 1042. https://doi.org/10.47739/2378-9476/1042.

LinkedIn and Imperative. (2016). *2016 Workforce Purpose Index: Purpose at Work: The largest global study on the role of purpose in the workforce*. https://www.imperative.com/wp-content/uploads/2023/04/Imperative-2016-Workforce-Purpose-Index.pdf

Lund, Therese Roe, and Jennifer Renne. (2009). *Child Safety: A guide for judges and attorneys.* American Bar Association and ACTION for Child Protection, Inc.: United States of America. https://www.americanbar.org/content/dam/aba/administrative/child_law/child-safety-guide.pdf

Maryland Courts. (2018, Apr 30). *Guardian Video Series: Types & Signs of Abuse* [video]. Youtube.com, Maryland Courts channel. https://www.youtube.com/watch?v=tCbsZFa1VRw

Mayo Clinic, (2022, October 11*) Birthmarks*. [Slideshow]. https://www.mayoclinic.org/birthmarks/sls-20076683?s=4

North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. (2011, June 1). *Dear County Director Letter-Supervision in Child Welfare: A Summary of the 2009 Best Practice Study*. https://www.ncdhhs.gov/documents/files/dss/dcdl/childwelfareservices/cws-15-11/download

North Carolina Department of Health and Human Services, Division of Social Services. (2021). *DSS Worker Practice Standards Desk Guide*. https://www.ncdhhs.gov/cw-worker-north-carolina-worker-practice-standards-desk-guide/open

North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. (n.d.). *Everyday Impact: Child Welfare Worker Realistic Job Preview* [video]. Dropbox.com. https://www.dropbox.com/scl/fo/wu4s22b7ouc96gyvtmmik/h?preview=1_15_24_rjp_v6b+(1080p).mp4&rlkey=wrxfiviurth20lg80pv1d3b9l&dl=0

North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. (May 2020). *NC Child Welfare Manual: CPS Purpose & Philosophy, Legal Basis, Administration, Administration and Staffing, Mandated Services.* https://policies.ncdhhs.gov/wp-content/uploads/purpose.pdf

North Carolina Department of Health and Human Services, Division of Social Services. (2021). *DSS Worker Practice Standards Desk Guide*. https://www.ncdhhs.gov/cw-worker-north-carolina-worker-practice-standards-desk-guide/open

North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. (2025, Jun). *NC Child Welfare Manual: Cross-Function Topics, Safety*. https://policies.ncdhhs.gov/wp-content/uploads/Cross-Functions-October-2025.pdf

North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. (2025, Oct). PATH NC Assessment, Child Medical Evaluation Program (CMEP)/ Clinical Assessment of Protective Parenting (CAPP). *NC Child Welfare Manual: CPS Assessments Policy, Protocol, and Guidance*. https://policies.ncdhhs.gov/wp-content/uploads/PATH-NC-Assessments-October-2025.pdf

North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. (2025, Oct). PATH NC Assessment, Child Medical Evaluation

Program (CMEP)/ Clinical Assessment of Protective Parenting (CAPP). *NC Child Welfare Manual: CPS Assessments Policy, Protocol, and Guidance*. https://policies.ncdhhs.gov/wp-content/uploads/CPS-Intake_October-2025.pdf

Office of Juvenile Justice and Delinquency Prevention. (2002). *Recognizing When a Child's Injury or Illness is Caused by Abuse*. US Department of Justice, Office of Justice Programs, Office of Juvenile Justice and Delinquency Prevention. Retrieved from https://www.ojp.gov/pdffiles1/ojjdp/160938.pdf.

Public Knowledge. (n.d.). No*rth Carolina Child Welfare Practice Model*. North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. https://ncpracticestandards.pubknow.com/?page_id=13

Thompson, Karl. (August 2, 2025). *What percentage of your life will you spend at work?* Revisesociology.com. https://revisesociology.com/2016/08/16/percentage-life-work/.

Day Two

Child Welfare Information Gateway, Children's Bureau, (2021, June 11) *Child Maltreatment 2019: Summary of Key Findings*, U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/pubPDFs/canstats.pdf

Child Welfare Information Gateway, Children's Bureau, (2023) *Mandatory Reporters of Child Abuse and Neglect*, U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://acf.gov/sites/default/files/documents/cb/cm2023.pdf

Evident Change. (2024). *Three Questions and Three-Column Mapping: Making a Rigorous and Balanced Assessment* [curriculum].

Evident Change. (2025). *SDM® Safety and RISK Assessment and FSNA Training* [curriculum].

Hammond, W., & Zimmerman, R.A. (2012). *A strengths-based perspective*. Resiliency Initiatives. https://www.ilgateways.com/docman-docs/faculty-resources/itc-resources/2526-oa-6-a-strengths-based-perspective/file

Juvenile Code, Article 3. – Screening of Abuse and Neglect Complaints. North Carolina Stat. §7B-301 Duty to report abuse, neglect, dependency, or death due to maltreatment. (1979, rev. 2015). https://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_7B.html

Juvenile Code, Article 3. – Screening of Abuse and Neglect Complaints. North Carolina Stat. §7B-302 notification of person making the report. (1979, rev. 2021). https://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_7B.html

Juvenile Code, Article 3. – Screening of Abuse and Neglect Complaints. North Carolina Stat. §7B-309 Immunity of persons reporting and cooperating in an assessment. (1979, rev. 2019). https://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_7B.html

National Technical Assistance and Evaluation Center. (2008*). An Individualized, Strengths-Based Approach in Public Child Welfare Driven Systems of Care*. https://ncwwi.org/files/Vision_Mission_Values/Individualized_strengths-based_approach.pdf

North Carolina Department of Health and Human Services, Division of Social Services. (2021). *DSS Worker Practice Standards Desk Guide*. https://www.ncdhhs.gov/cw-worker-north-carolina-worker-practice-standards-desk-guide/open

North Carolina Department of Health and Human Services, Division of Social Services. (2020, May). *CPS Purpose & Philosophy, Legal Basis, Administration: NC Child Welfare manual*. https://policies.ncdhhs.gov/wp-content/uploads/purpose.pdf

North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. (2025, Jun). *NC Child Welfare Manual: Cross-Function Topics, Safety*. https://policies.ncdhhs.gov/wp-content/uploads/Cross-Functions-October-2025.pdf

North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. (2025, Oct). PATH NC Assessment, Child Medical Evaluation Program (CMEP)/ Clinical Assessment of Protective Parenting (CAPP). *NC Child Welfare Manual: CPS Assessments Policy, Protocol, and Guidance*. https://policies.ncdhhs.gov/wp-content/uploads/PATH-NC-Assessments-October-2025.pdf

North Carolina Department of Health and Human Services, Division of Social Services, Child Welfare Services. (2025, Oct). PATH NC Assessment, Child Medical Evaluation Program (CMEP)/ Clinical Assessment of Protective Parenting (CAPP). *NC Child Welfare Manual: CPS Assessments Policy, Protocol, and Guidance*. https://policies.ncdhhs.gov/wp-content/uploads/CPS-Intake_October-2025.pdf

Sarheed Jewels Kuwait. (2011, Sep 1). *Powerful video Can't explain it just watch*. [Video]. Youtube.com, Sarheed Jewels Kuwait channel. https://youtu.be/D38S9o_6qnc

The University of Iowa National Resource Center for Family Centered Practice. (n.d.). *What is Family Centered Practice?* https://nrcfcp.uiowa.edu/what-is-family-centered-practice.

Day Three

Alberta Family Wellness Initiative. (2025). *Resilience scale*. Alberta Family Wellness Initiative. https://www.albertafamilywellness.org/what-we-know/resilience-scale

Audage, N. (2021). Positive and Adverse Childhood Experiences (PACEs): What Happens in Childhood Matters. PacesConnection.com [Blog]. https://www.pacesconnection.com/blog/better-normal-march-26-positive-and-adverse-childhood-experiences-paces-what-happens-in-childhood-matters

Bethell, C., Jones, J., Gombojav, N., Linkenbach, J., & Sege, R. (2019). Positive childhood experiences and adult mental and relational health in a statewide sample: Associations across adverse childhood experiences levels. *JAMA Pediatrics, 173*(11), e193007. https://doi.org/10.1001/jamapediatrics.2019.3007

BigFoot, D.S. & Deframboise, T. (2018). *A trauma-Informed Approach to working with Tribes. Collaborating with Tribal Communities Webinar Series: Webinar 3.* Suicide Prevention Resource Center. Presented March 21, 2023.

Buffalo Center for Social Research. (2025). *What is Trauma-Informed Care?* University at Buffalo, Buffalo Center for Social Research. https://socialwork.buffalo.edu/social-research/institutes-centers/institute-on-trauma-and-trauma-informed-care/what-is-trauma-informed-care.html

Center on Child Wellbeing & Trauma. (2025). *Positive Childhood Experiences (PCEs).* https://childwellbeingandtrauma.org/healing-and-prevention/positive-childhood-experiences/

Centers for Disease Control and Prevention. (2024, October 8). *About adverse childhood experiences*. U.S. Department of Health and Human Services. https://www.cdc.gov/aces/about/index.html

Child Welfare Information Gateway. (2020). *The Importance of a Trauma-Informed Child Welfare System*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/resources/importance-trauma-informed-child-welfare-system/.

Khan, S. (2021). *Cultural Humility vs. Cultural Competence – and Why Providers Need Both*. Healthcity.bmc.org. Boston Medical Center. https://healthcity.bmc.org/policy-and-industry/cultural-humility-vs-cultural-competence-providers-need-both

Miyagawa, L. (2020, Mar 16). *Practicing Cultural Humility when Serving Immigrant and Refugee Communities*. EthnoMed. https://ethnomed.org/resource/practicing-cultural-humility-when-serving-immigrant-and-refugee-communities/

North Carolina Department of Health and Human Services, Division of Social Services. (2021). *DSS Worker Practice Standards Desk Guide*. https://www.ncdhhs.gov/cw-worker-north-carolina-worker-practice-standards-desk-guide/open

Oklahoma Human Services. (2020). *Child Welfare Core Curriculum, Module 1*. Oklahoma Human Services, Child Welfare Learning. Used with permission from author.

Oxford English Dictionary. (1963). Intersectionality. In *Oxford English Dictionary.* https://www.oed.com/search/dictionary/?scope=Entries&q=intersectionality

Philadelphia Aces. (n.d.). *Philadelphia ACE survey*. Retrieved from https://www.philadelphiaaces.org/philadelphia-ace-survey

Project Implicit. (2011). *Take a Test*. Harvard University. https://implicit.harvard.edu/implicit/takeatest.html

Sege, Bob. (2021). *Tree Analogy.* [Video]. Youtube.com, DCS Training channel. https://www.youtube.com/watch?v=AfX0wBWpfLU

Siegel. D.J. (2012). *The Developing Mind: How Relationships and the Brain Shape Who We Are, 2nd Ed*. New York, NY: The Guilford Press.

Siegal, D. (2021). *Dr. Dan Siegel's Hand Model of the Brain*. https://drdansiegel.com/hand-model-of-the-brain/

Smith, E. (2024, December 11). *What is professional curiosity?* [Podcast]. www.researchinpractice.org.uk. Research in Practice. https://www.researchinpractice.org.uk/all/content-pages/podcasts/what-is-professional-curiosity/

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's concept of trauma and guidance for a trauma-informed approach* (HHS Publication No. SMA 14-4884). U.S. Department of Health and Human Services. https://library.samhsa.gov/sites/default/files/sma14-4884.pdf

Trauma-Informed Care Implementation Resource Center. (2025). *What is Trauma-Informed Care?* Center for Health Care Strategies. https://www.traumainformedcare.chcs.org/what-is-trauma-informed-care/

YW boston. (2017, Mar 29). *What is intersectionality and what does it have to do with me?* [Blog]. eliminating racism, empowering women YW boston. https://www.ywboston.org/2017/03/what-is-intersectionality-and-what-does-it-have-to-do-with-me/