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 Four

December 2025

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

info@pubknow.com
(800) 776-4229

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Instructions

This course was designed to guide child welfare professionals through the knowledge, skills, and behaviors needed to engage with families 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 4 Day 1 Agenda

Child Welfare in North Carolina Pre-Service Training: Core

Welcome and Introductions

Core Value: Family-Centered Practice

Family-Centered Practice Learning Lab

Child Welfare Process Part 1: Intake

Intake Process

BREAK

Intake Process, continued

Intake Process Learning Lab

LUNCH

SOP at Intake

Response

Two-Level Decision Consultation

Interviewing at Intake

BREAK

Interviewing at Intake, continued

Intake Learning Lab

Self-Reflection

Mindfulness

Pre-Service Training: Core Week 4 Day 1 Learning Objectives

Week 4 Day 1
Child Welfare Process Part 1: Intake
Intake Process
• Define and discuss the process of intake • Identify effective ways of engaging to gather information • Explain your role in the intake interviewing process

Core Week 4 Day 1

Core Value: Family-Centered Practice

Family-Centered Practice Learning Lab

Video: It Takes a Village: Collaboration is Key

Visit It Takes a Village Collaboration is Key for a video highlighting the impact of a family court's compassionate and strength-based approach to supporting families.

Notes

Activity: Collaboration Debrief Questions

What do these strings represent to you?

What does this web represent?

How does this relate to the real world?

How does it affect the "family"?

Who is responsible for keeping the web together or supporting the family?

What was the experience like for those of you dropping the support and stepping back from the circle?

For those of you staying to the end?

How does that relate to the real world?

What type of attitude or behavior is helpful to others when maintaining a family's web of collaboration?

What are some shared interests among the following roles—judge, parent attorney, parent advocate, court-appointed special advocate (CASA), court social worker, agency caseworker?

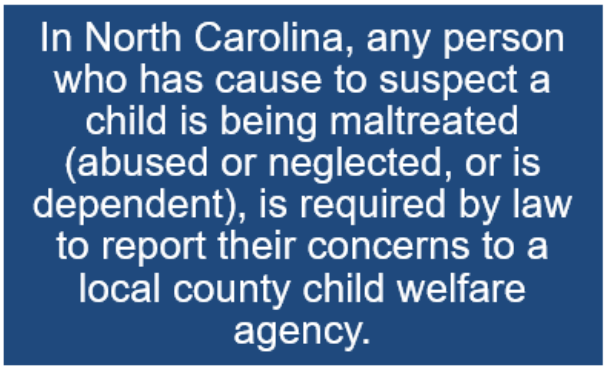
How do their responsibilities differ?

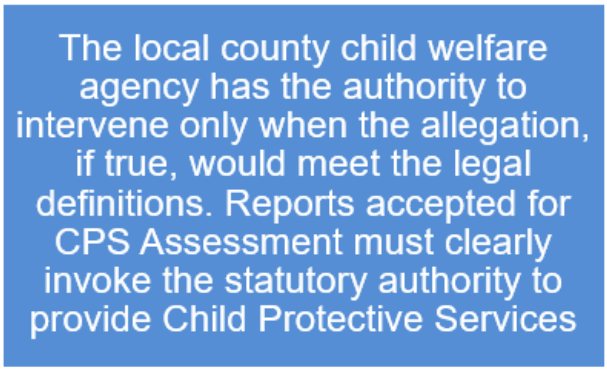
What role do trusting relationships play in supporting families?

Child Welfare Process: Intake

Intake Process

Purpose of Intake





In North Carolina, any person who has cause to suspect a child is being maltreated (abused or neglected, or is dependent) is required by law to report their concerns to a local county child welfare agency.

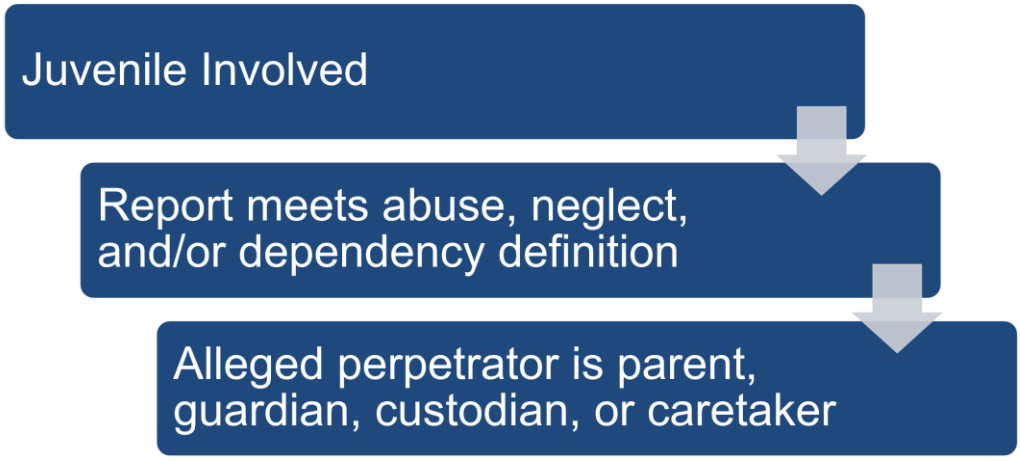
Once a report is received, the Child Protective Services (CPS) Intake process begins. This is the first and foundational step in the child welfare system. The work done at CPS Intake is critical. It sets the stage for all decisions that follow.

Intake workers must be careful, detailed, and thorough because the accuracy and completeness of the information gathered directly impact the safety of the child and the effectiveness of any intervention. The screening process requires knowledge of the statutory definitions of child abuse, neglect, dependency, and caretaker.

The local county child welfare agency has the authority to intervene only when the allegation, if true, would meet the legal definitions. Reports accepted for CPS Assessment must clearly invoke the statutory authority to provide Child Protective Services.

Notes

When Can DSS Become Involved with a Family?



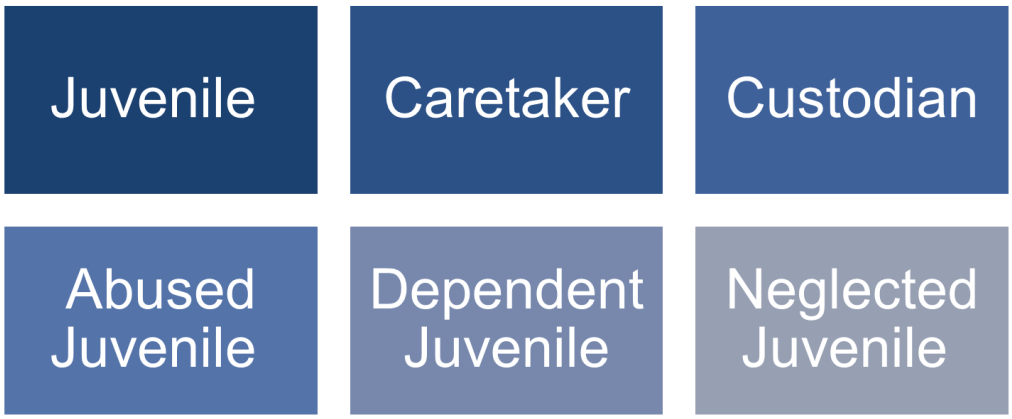
DSS agencies only have the authority to intervene when all three of the following are true:

- The victim child is a juvenile under the age of 18 years old
- The report meets the statutory definitions of abuse, neglect, and/or dependency
- The alleged perpetrator is a parent, guardian, custodian, or caretaker

The one exception to this rule is human trafficking allegations, in which the perpetrator does not have to be a parent, guardian, custodian, or caretaker.

Notes

North Carolina General Statute Definitions



A juvenile is: A person who has not reached the person's eighteenth birthday and is not married, emancipated, or a member of the Armed Forces of the United States.

Emancipation is a legal proceeding whereby minors aged 16 and 17 become legal adults. To become emancipated, the juvenile must petition the District Court for an order of emancipation.

Marriage or enlistment in the armed services automatically causes emancipation.

A caretaker is: Any person other than a parent, guardian, or custodian who has responsibility for the health and welfare of a juvenile in a residential setting. A person responsible for a juvenile's health and welfare means a stepparent; foster parent; an adult member of the juvenile's household; an adult entrusted with the juvenile's care; a potential adoptive parent during a visit or trial placement with a juvenile in the custody of a department; any person such as a house parent or cottage parent who has primary responsibility for supervising a juvenile's health and welfare in a residential child care facility or residential educational facility; or any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services.

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

A juvenile parent would be included in the definition of custodian.

"Entrusted with the care" is interpreted to be limited to situations where an adult has primary care and decision-making authority for the juvenile. In addition, a person "entrusted with the care" is a "person who has a significant degree of parental-type responsibility for the child." The "totality of the circumstances" must be considered when determining if someone is a caregiver and a temporary arrangement for supervision of a child is not equivalent to "entrusting a person with the care" of a child.

There are some nuances to determining if an adult is a caretaker. A decision tree is available in the intake policy to guide you through the process of determining if an alleged perpetrator is a caretaker.

*One caveat around caretakers and custodians at intake is that reports of sex trafficking do not require the alleged maltreater to be a parent or caretaker.

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

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

- Creates or allows to be created a substantial risk of serious physical injury to the juvenile by other than accidental means
- Uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior
- Commits, permits, or encourages the commission of a violation of following laws by, with, or upon the juvenile: first-degree forcible rape; second-degree forcible rape; statutory rape of a child by an adult; first-degree forcible sex offense: second-degree forcible sex offense; statutory sexual offense with a child by an adult; first-degree statutory sexual offense; sexual activity by a substitute parent or custodian; sexual activity with a student; unlawful sale, surrender, or purchase of a minor, crime against nature; incest,; preparation of obscene photographs, slides, or motion pictures of the juvenile; employing or permitting the juvenile to assist in a violation of the obscenity laws; dissemination of obscene material to the juvenile; displaying or disseminating material harmful to the juvenile; first and second degree sexual exploitation of the juvenile; promoting the prostitution of the juvenile; and taking indecent liberties with the juvenile
- Creates or allows to be created serious emotional damage to the juvenile; serious emotional damage is evidenced by a juvenile's severe anxiety, depression, withdrawal, or aggressive behavior toward himself or others
- Encourages, directs, or approves of delinquent acts involving moral turpitude committed by the juvenile
- Commits or allows to be committed an offense under human trafficking, involuntary servitude, sexual servitude against the child statutes

Moral turpitude includes situations where a parent encourages a child to shoplift and does not intervene to stop the child from shoplifting; or situations where a parent encourages a child to sell drugs or sets child up as a “drug runner. Providing alcohol/drugs to a child or consuming alcohol with a child meets the definition of “neglect,” not “moral turpitude.” An important note about this definition is that it includes the person who commits the act, as well as the person who allows the act to be committed.

A Dependent Juvenile is: A juvenile in need of assistance or placement because the juvenile has no parent, guardian, or custodian responsible for the juvenile's care or supervision or the juvenile's parent, guardian, or custodian is unable to provide for the juvenile's care or supervision and lacks an appropriate alternative childcare arrangement. In approximately 85% of CPS cases, the maltreatment type falls under this definition of neglect.

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

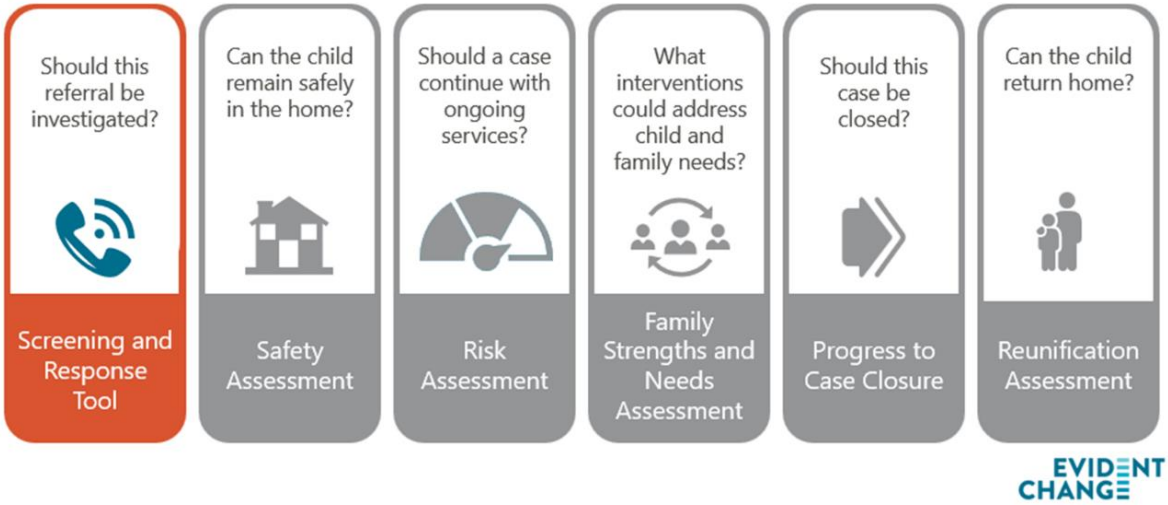
- Does not provide proper care, supervision, or discipline
- Has abandoned the juvenile
- Has not provided or arranged for the provision of necessary medical or remedial care
- Or whose parent, guardian, or custodian has refused to follow the recommendations of the Juvenile and Family Team made pursuant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

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

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

Notes

SDM Screening and Response Tool



The Intake screening and response tool is the first SDM tool utilized in the Child Welfare Process. The intake screening and response tool answers the questions:

- Does this report require a response?
- Which Track?
- How quickly?

Notes

SDM Screening and Response Tool Components

There are two components of the screening sections:

- Maltreatment allegations
- Screening decision

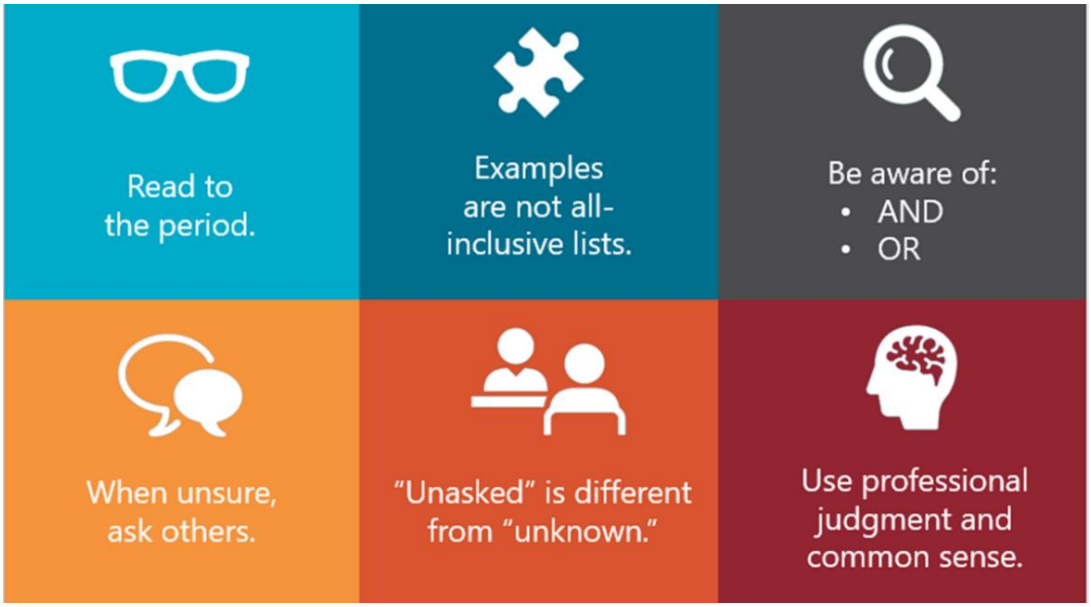
Screening is the first step in the Child Welfare Intake process. It answers the question "Should we screen in the report for CPS Assessment?" Response is the second step. It answers the question "how quickly should we respond?" There are two components of the response section:

- Response time and track assignment
- Final decision

The screening section informs the response section.

Notes

Using SDM Definitions



There are six tips for using SDM Definitions:

Read to the period: Read the full definition and the policy. Workers should read both the entire definition in the SDM assessment and the accompanying North Carolina policy. A common mistake can occur when workers take just a phrase or a piece of a definition or policy and then apply it inappropriately.

Examples are not all-inclusive lists: The examples in the definitions illustrate the threshold, nature, severity, and so forth of what is intended by the definition. If an example fits your situation, it does not necessarily mean the whole definition applies. Likewise, if your situation is not specifically listed in the examples, it does not mean the definition does not apply. Examples are meant to be illustrative, not all-encompassing lists.

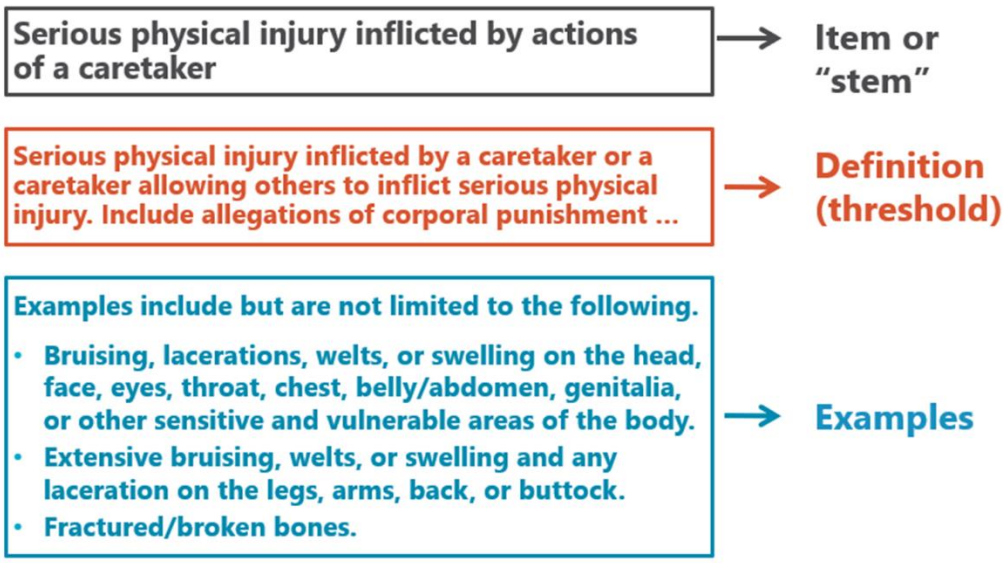
Be aware of AND and OR: If you see a big "AND," it means that the circumstances stated on both sides of "AND" must be true for the definition to apply. If you see a big "OR," it means one or the other circumstance must be true for the definition to apply.

When unsure, ask others: When an example or a definition does not make sense, do not be afraid to ask others. Group supervision or group discussion is a great way to increase knowledge, and it helps workers understand confusing areas.

"Unasked" is different from "unknown:" Remember that information that has not been asked about is different from information that is unknown. If you didn't ask, you can't select it on the assessment, but it might be a reminder to go back out and follow up with more questions.

Use professional judgment and common sense: For example, if the definition says that the child must be 10 years old and the child is a few days or weeks shy of turning 10, the child is substantially 10. Also note that if the definition is precise regarding age, such as on the risk assessment, the age of the child must precisely meet the definition rather than applying professional judgment.

Definition Components



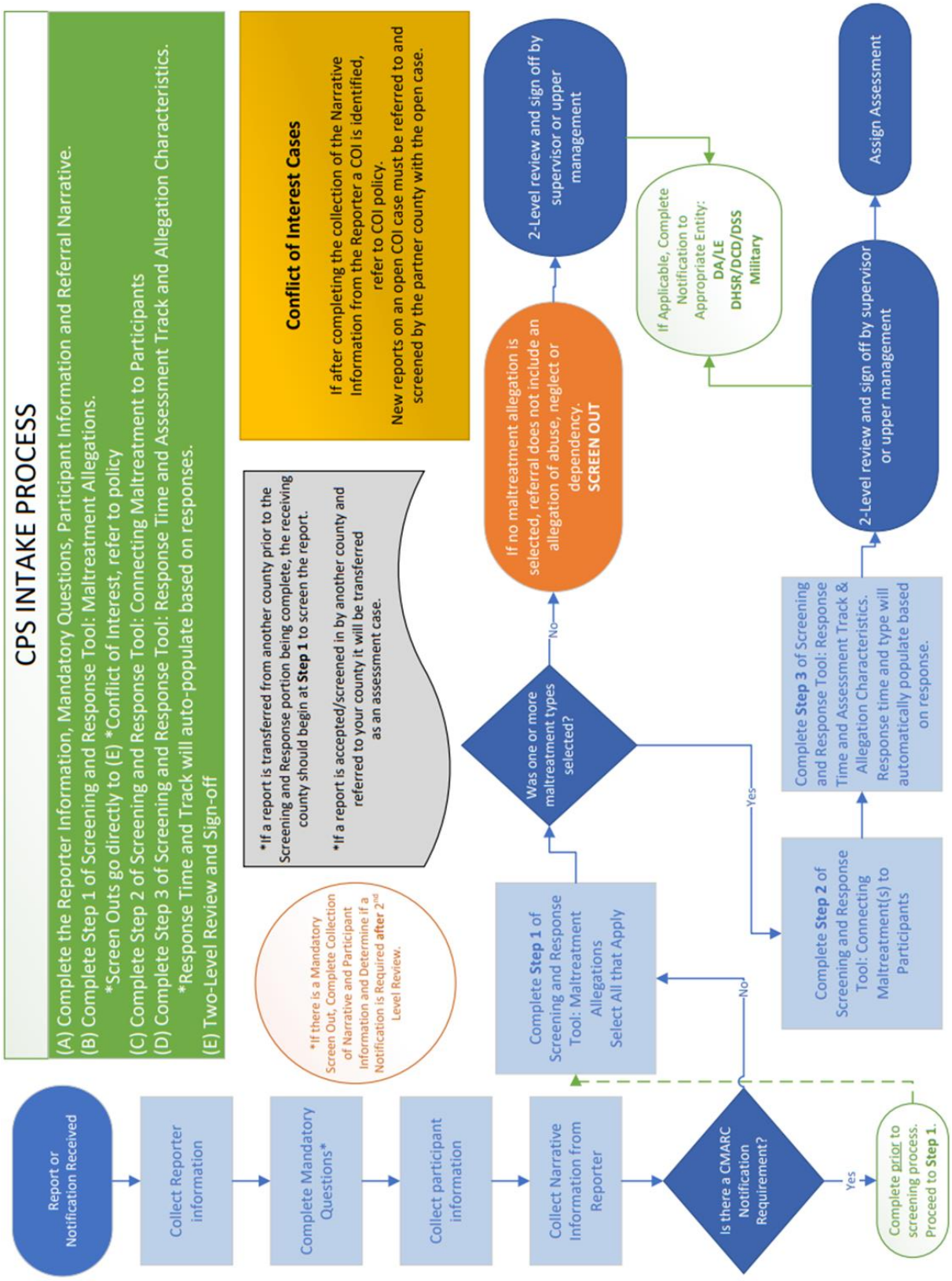
SDM items on the screening tool are also called "stems." Each item or stem has a corresponding definition and offers examples.

Definitions for each maltreatment allegation establish a threshold. Information gathered from the reporter must meet the threshold for the allegation to be selected.

Assessment items include examples, which are just that: examples. The list is not exhaustive, and caseworkers must consider whether all aspects of the definition are met. If information does not reach the threshold for any maltreatment allegation, the call is screened out.

Notes

CPS Intake Process



The SDM Screening and Response tool follows the CPS Intake Process:

- Complete Reporter information, mandatory questions, participant information, and referral narrative
- Complete Step 1: Maltreatment Allegations
- Complete Step 2: Connecting Maltreatment to Participants
- Complete Step 3: Response Time and Assessment track and Allegation Characteristics
- Two-level review and sign off

The screening process is an if/then system, not artificial intelligence (AI). The system does not allow for a slower response time; however, a supervisor override to a faster response time is possible.

Mandatory Questions include:

- Is the victim child under 18 years of age?
- Is the child a victim of fatality?
- Is this a near fatality, where a physician has determined that a child is in serious or critical condition as a result of sickness or injury caused by suspected abuse, neglect, or maltreatment?
- Is the child a resident of North Carolina?
- Where did the incident occur? (This question has a narrative box)
- Is the perpetrator a parent/caretaker?
- Are you aware of any relatives or kin supports for this family?
- Does this report include information about a child who is missing, abducted, or on runaway status?
- Are there concerns for Human Trafficking?
- Are there concerns for Domestic Violence?
- Is this a licensed facility or group home?

What questions do you have about the CPS Intake Process map?

What stands out to you about this process map?

What are your thoughts about the mandatory questions?

Activity: Major Maltreatment Allegation Categories

The purpose of this activity is to help you become familiar with where and how to find policy and how to use it to inform decisions.

What to Do:

Navigate to the CPS Intake Policy, Protocol, and Guidance NC Child Welfare Manual, and find the Maltreatment Types section, which begins on Attachment A [https://policies.ncdhhs.gov/wp-content/uploads/CPS-Intake_October-2025.pdf].

What surprised you about the maltreatment allegation criteria?

What allegations might you have preconceived notions, or might your bias interfere with decision-making?

How do you imagine using the guidance at the different decision points (intake, assessment, planning)?

Key Takeaways

Reports accepted for CPS Assessment must clearly invoke the statutory authority to provide Child Protective Services

The screening process requires knowledge of the statutory definitions of child abuse, neglect, dependency, and caretaker

DSS agencies only have the authority to intervene when all three of the following are true:

- The victim child is a juvenile under the age of 18 years old
- The report meets the statutory definitions of abuse, neglect, and/or dependency
- The alleged perpetrator is a parent, guardian, custodian, or caretaker

The intake screening and response tool answers the questions:

- Does this report require a response?
- Which Track?
- How quickly?

SDM Screening and Response Tool has specific definitions that establish crucial thresholds

Notes

Intake Process Learning Lab

Activity: Determining Abuse Allegations

The purpose of this activity is to familiarize you with the SDM Intake process and the associated legal definitions.

Part One: Read the scenario and answer the following questions.

A single mother leaves her 7-year-old and 16-year-old children alone every Monday through Friday from 2:30 pm to 8 pm while she works. The children have access to food and water, but no adult supervision. The neighbors have reported that the 16-year-old frequently leaves the 7-year-old alone until 7:30 pm, just before the mother returns from work. The neighbor is not aware of any other adults or supports for the 7-year-old, who has, on occasion, asked the neighbor to heat a frozen pizza pocket, as he isn't allowed to since he burned his hand once before trying to use the stove.

Does the first scenario meet the legal threshold or not?

If it does, which maltreatment category does it meet and why?

What additional information is provided that supports your finding?

How would your decision change if the child were 9 years old instead of 7?

What words or phrases in the definition were key to your decision?

Part Two: Work in your group to create a scenario that meets the legal definition of the assigned maltreatment category.

Create your own scenario, do not USE or COPY any of the examples provided in your manual. Be creative and keep your scenarios to 2-4 brief sentences.

Assigned Maltreatment Category: _____

How did you use the manual to help you create your scenario?

What did you notice about the legal definitions listed in your Intake Manual?

How does age, vulnerability, or caregiver behavior affect your interpretation?

What is the significance of familiarizing yourself with these definitions?

SOP at Intake

Rigorous and Balanced Intake

What are we worried about?

What is working well?

What needs to happen next?

Every stage in working with a family must address these three main questions. The details of how we ask these questions and what content to focus on will change, but these are the three most central questions.

Why is it important to ask the three questions at intake?

What might be difficult about using the three questions at intake?

Activity: Three Questions

The Purpose of this activity is for you to practice using the three questions.

What to Do:

Read your group's assigned scenario and work with your group to identify information for the three questions listed based on your assigned "role":

Scenario 1: Jordan, age 9, has been coming to school with frequent stomachaches and has missed several days recently. Teachers notice Jordan often seems tired and sometimes falls asleep in class. The school counselor learns from Jordan that there are loud arguments at night at home, and sometimes Jordan doesn't feel safe.

One afternoon, Jordan is taken to the emergency room after falling on the playground and complaining of stomach pain. The medical team discovers Jordan is underweight for their age and has a healing bruise on the upper arm that Jordan can't clearly explain.

Later that evening, police are called to Jordan's home after neighbors report yelling and possible domestic violence. Police find the home cluttered, with little food in the refrigerator, and document that Jordan was present during the argument.

Assigned Role: _____

What are we worried about?

What is working well?

What needs to happen next?

Scenario 2: Maya, age 4, was dropped off late at preschool three times this week. Each time, her clothes were dirty and she had a strong odor. Teachers noticed Maya seemed unusually tired and sometimes said she didn't eat breakfast.

One day, Maya fell asleep during circle time and the teacher saw a small burn mark on her arm. When asked, Maya shrugged and said, "mom's lighter." The preschool staff became concerned and contacted the school nurse, who recommended Maya see a doctor.

At the clinic, the doctor observed that Maya was underweight, had multiple untreated dental cavities, and the burn on her arm was consistent with a lighter burn. The doctor also noticed Maya seemed anxious and clung tightly to her mother.

The same week, police conducted a traffic stop with Maya's mother for erratic driving. They discovered drug paraphernalia in the car. Maya was in the back seat, unrestrained. Police noted the mother appeared impaired and had difficulty providing basic information about Maya's care.

Assigned Role: _____

What are we worried about?

What is working well?

What needs to happen next?

Caretaker + Behavior + Impact (C+B+I Formula)

Activity: C+B+I Formula

The purpose of this activity is for you to explore the C+B+I formula and its application.

What to Do:

Read the scenario and complete the C+B+I formula.

Scenario: Police have been called three times for domestic violence in a home where three young children live. Tomas Jr. has a black eye and a bruised left cheek. Tomas tells you that last night his father hit him after he tried to stop a fight between his mother and father. Tomas says he is afraid to go home because his father was still angry this morning.

Identify the Caretaker(s)

Identify the Behavior(s)

Identify the Impact on the Child

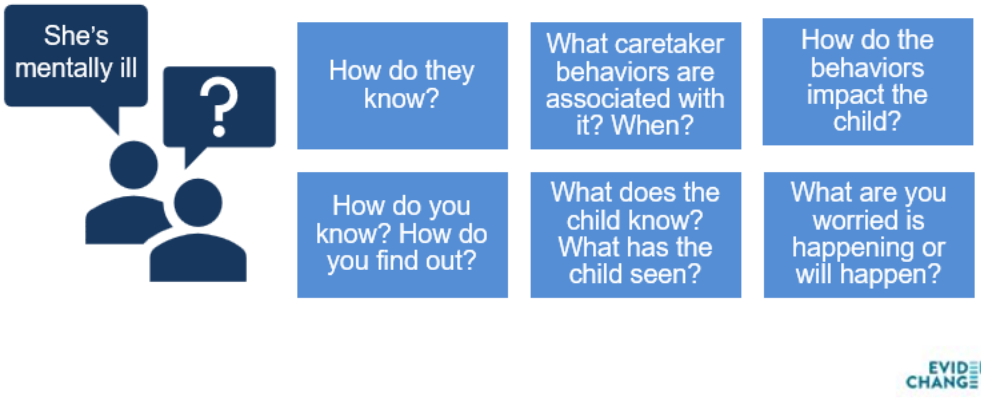
Buzzwords

Video: Buzzwords

Visit Buzzwords: Moving to Behavioral Descriptors to learn how language can mistakenly label families and not accurately describe observed behavior.

Notes

Generalizations vs Behavior and Impact



Generalizations, like Buzzwords, are “headlines” or shortcut terms often used to stand in for a more detailed set of facts we hold in our view. Different people have different notions of generalizations.

It is essential to capture behaviorally specific information, focusing on its impact on the child.

How often do you think you use "headline" terms in your daily life?

What is the danger for us as an organization if we use words like this in our supervision, in our court reports, or in our conversations with caretakers?

What can you do to be more intentional about avoiding generalizations?

Provisional Harm and Worry Statements

The process of crafting harm and worry statements begins with provisional statements at intake.

All reports contain a worry statement. However, if allegations of harm have not been made, a report may not have a harm statement.

What benefits do you see in utilizing provisional harm and worry statements at intake?

Key Takeaways

- The three questions should be used at every intake to gather information
- Different reporters come with different perspectives and have different concerns as it relates to their role(s) Different reporters come with different perspectives and have different concerns as it relates to their role(s)
- The focus of the child welfare process is on the impact of caretaker behavior on children (C+B+I)
- It is important to capture behaviorally specific information with a focus on the impact on the child
- The process of crafting harm and worry statements begins at intake with provisional statements

Notes

Response

Assessment Track

There are two assessment tracks:

- Investigative assessment
- Family assessment

Maltreatment allegations determine the track. The following maltreatment allegations require an Investigative Assessment response:

- Death of a child, maltreatment is suspected, and other children are in the home
- Near fatality, where a physician has determined that a child is in serious or critical condition as the result of sickness or injury caused by suspected abuse, neglect, or maltreatment
- Human trafficking, any allegation subtype
- Physical abuse, any allegation subtype
- Sexual abuse, any allegation subtype
- Emotional abuse, mental injury
- Encouraging or enabling delinquent offense, moral turpitude
- Unsafe living conditions, child exposed to a methamphetamine lab
- Medical neglect of a disabled infant with a life-threatening condition
- Abandonment

PATH NC and the SDM tool structure the response time and track the decision. Reports assigned to an investigative assessment based on the allegation or mandatory response answers cannot be changed to a family assessment track.

Reports that are not automatically assigned to an investigative assessment will lead Intake caseworkers to a short list of questions to determine if they should assign an investigative or family assessment.

Notes

Response Time

After the response track is determined, the next step is to assign a response time.

Activity: Response Time

The purpose of this activity is for you to become familiar with the response time criteria.

What to Do:

Review the “Response Time” handout, discuss with your partner, and answer the question below.

What do you notice about the immediate, within 24 hours, or within 72 hours response times?

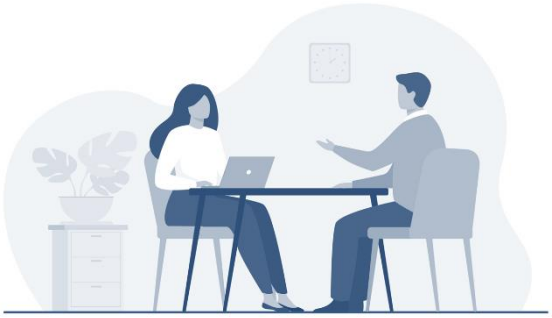
Handout: Response Time

Determining Response Time

Immediate	Initiation must occur at once, immediately after completion of the intake report. The situation is currently unsafe/harmful or will deteriorate to unsafe/harmful within the next 24 hours. Consider the child's age and developmental status, allegation severity, access of alleged perpetrator, and presence or absence of other responsible adults. A injury to a child age 3 years or younger A child is afraid to go home and/or has a credible fear of experiencing abuse in the care of the alleged perpetrator within the next 24 hours. A child needs urgent or emergent medical or mental health care for illness or injury due to alleged abuse. A family may leave their current location and CPS may not be able to find them. Forensic considerations would be compromised with a slower response. No food in the home or otherwise available to the children A child under the age of 8 is currently alone. A child 12 years or younger who self-reports to the county DSS agency. A Safe Surrender Infant
Within 24 Hours	A child has visible injuries due to neglect that do not require urgent or emergency medical care. The situation is currently unsafe/harmful or will deteriorate to unsafe/harmful within the next 72 hours. Consider the child's age and developmental status, allegation severity, and presence or absence of other responsible adults. A child needs urgent or emergent medical or mental health care for an illness or injury due to alleged neglect. When abuse allegations do not meet immediate response criteria then they should be given a 24-hour response.
Within 72 Hours	When neglect allegations do not meet the criteria for a response within 24 hours then they should be given a 72-hour response.

Two-Level Decision Consultation

Two-Level Decision Consultation



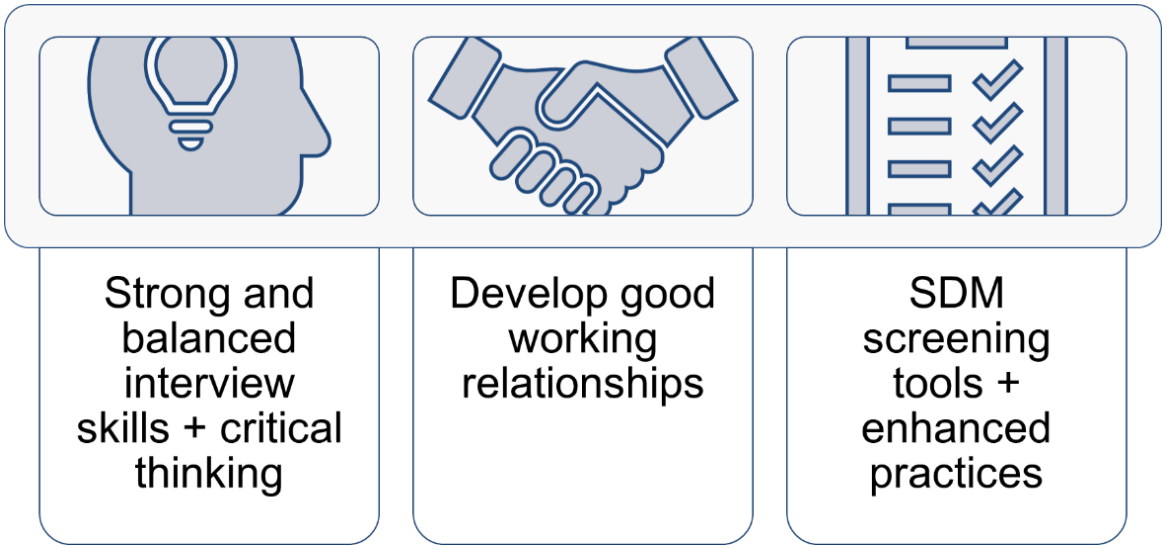
Two-level decisions must occur on every completed CPS Intake. The screening decision(s) must include a discussion between the Intake caseworker and a supervisor (or other management position) about Step 1 and Step 2 of the Screening and Response Tool.

When a supervisor does not have access to a higher-level manager for the second-level review when screening an intake report, the supervisor may send to another supervisor for second-level review.

Notes

Interviewing at Intake

Key Concepts of Intake Interviews



Relationships are the single most significant predictor of good outcomes in child welfare. Strong and balanced interviewing skills, combined with strong critical thinking, are key to making the best response decisions.

Developing good working relationships with reporting parties is key to getting important information about family strengths and network members.

The SDM screening tools, combined with enhanced practices, support both these concepts to achieve the best outcomes.

Notes

Engaging the Reporter

As an Intake Caseworker, it is up to *you* to lead the call in a way that gives you the best chance to get the right information.

Barriers to Information Gathering	Caller's motivation matters
	Caller has incomplete knowledge of facts
	Caller does not know what information is important
	Caller does not know specifics of the law
	Caller has emotional response to reporting
	Caller has unknown or conflicting motivation

The Intake caseworker must provide support and encouragement to the reporter by:

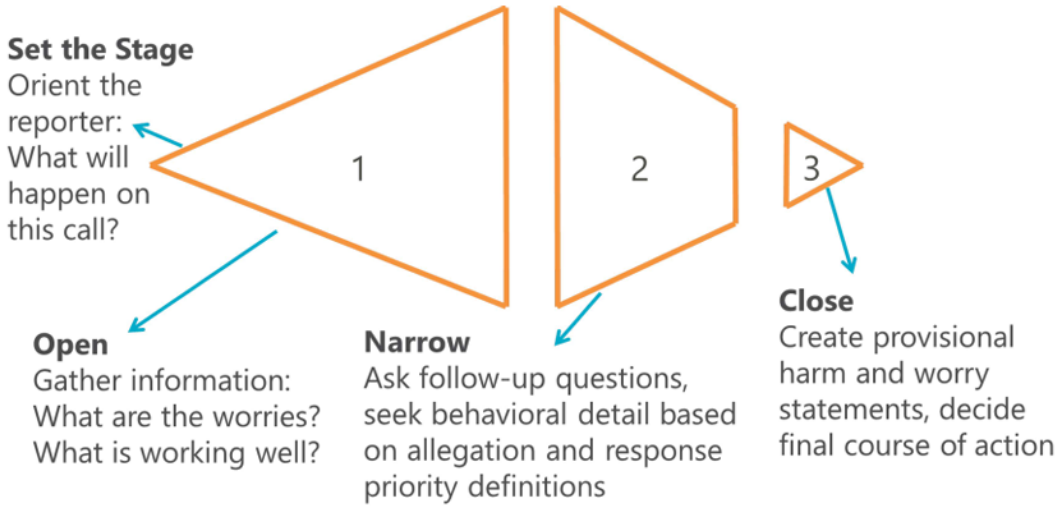
- Explaining the purpose of CPS (to ensure safety of children, and protect and strengthen the family)
- Emphasizing the importance of reporting
- Dealing with the fears and concerns of the reporter
- Discussing confidentiality regarding the CPS report, including the identity of the reporter

The SDM Screening and Response tool offers a roadmap to the intake process.

Notes

Interview Ladder

Handout: Using the Interview Ladder Approach to Questioning



The best information is provided by the reporter in their own words in response to **open-ended, nondirectional questions.**

- What did you observe?

If the caller does not provide enough information to complete the intake tools without further questioning, start with open-ended orienting questions.

- What about this situation concerned you?
- What about the incident caused you to call the hotline?

As the caller begins to share concerns, identify the allegation type and begin to navigate to the correct SDM definitions and subcategories for follow-up questions.

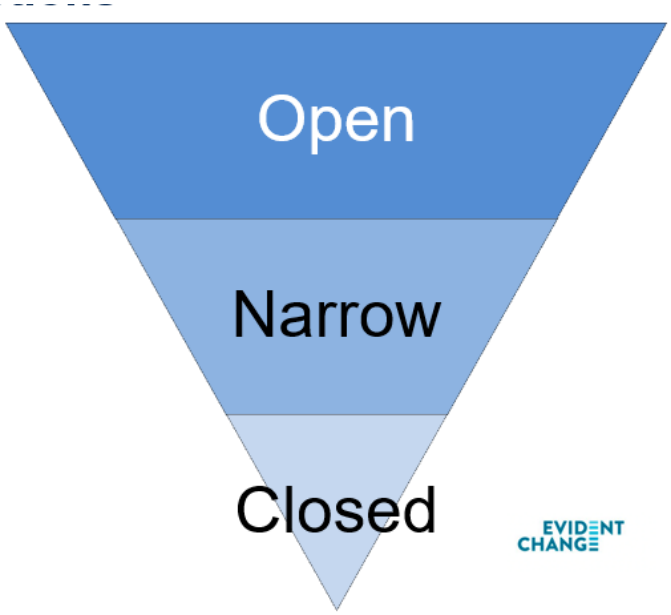
As you gather additional information, move on to **follow-up questions that begin to narrow**.

- I'm hearing that _____ aspect of the situation concerned you. Tell me more about that.

Begin to seek behavioral detail based on the thresholds described in the identified SDM definitions.

Finally, as you close, try some **fine-tuning questions**. Use your assessment definitions to ask questions that allow you to distinguish among different levels of response, and explore "missing link" questions.

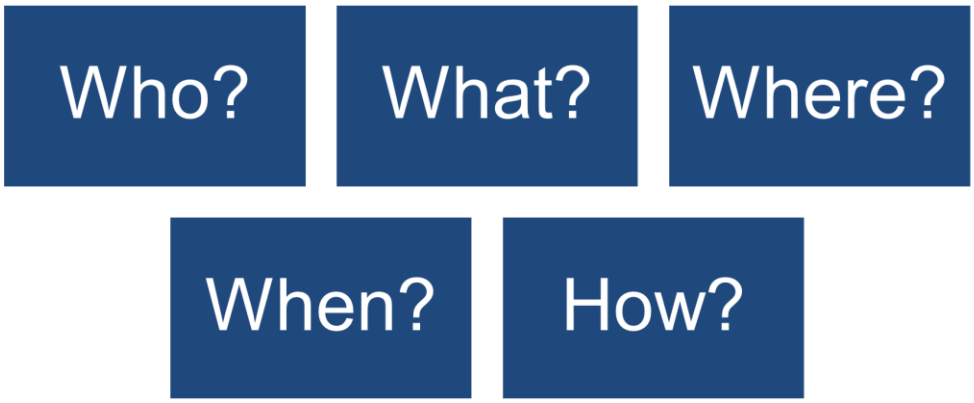
Ladder Questions



Using the open, narrow, closed interview ladder supports gathering needed information. All intake interviews should cover at least enough information to answer the major threshold questions of who, what, where, when, and how.

Notes

Threshold Questions

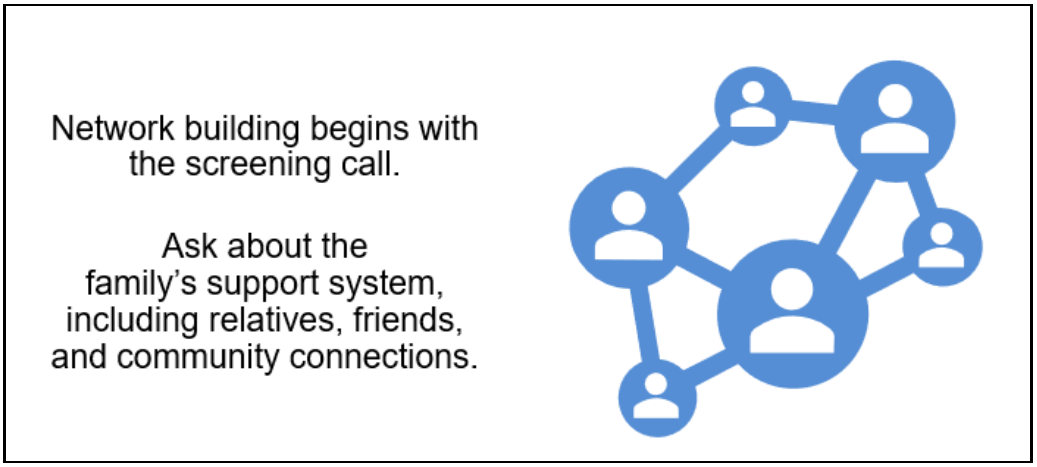


Regardless of the situation, every interview should gather enough information to answer the following core questions:

- Who was involved? Identify the victim, alleged perpetrator, caretaker or guardian, and any other relevant individuals
- What happened? Describe the injury or concerning behavior by the caretaker.
- Where did the incident occur? Note the location of the incident and where the child and alleged perpetrator are now
- When did it happen? Include timing, frequency, and duration. Consider whether the perpetrator will have future access to the child or other children
- How did people respond? Capture the child's response, the caretaker or guardian's response, and how the reporter became aware of the incident

Notes

Identifying Support Networks Begins at Intake



Identifying a family's network begins at the first call. Inquiring about a family support network can support safety planning, if needed.

Notes

Family Dynamics and Social Factors

Disproportionality and disparities in the child welfare system begin at intake.

Bias, individual experiences, and social context impact reporting and screening. We all have different views based on our own experiences, biases, and the families and social contexts in which we grew up. It is human nature for our minds to fill in gaps that a reporter has left out or hasn't said yet. This can lead to inconsistencies in the screening process.

Notes

What if the Answer is Unknown?

Suppose the reporter does not know or does not have information. In that case, you may need to rely on critical thinking and professional expertise to determine if the information you do have is sufficient to apply to a definition, while responding in the most protective manner. Supportive documentation is also crucial to provide a rationale for your decision. If information is unknown, it is important not to fill in the blanks with remote possibilities or to use it as a check-in to rule out concerns.

There may be times when you will need to adapt questions from the SDM tool.

Notes

Key Takeaways

- Relationships are the single most significant predictor of good outcomes in child welfare
- Strong and balanced interviewing skills and critical thinking are key to decision-making
- Tools, decision trees, and policy guide the process
- Using the open, narrow, closed interview ladder supports gathering needed information
- All intake interviews should cover at least enough information to answer who, what, where, when, and how
- Strengths-based interviewing skills are key to intake

Notes

Intake Learning Lab

Activity: Buzzwords

What to Do:

Find a partner and review the "Buzzwords Discussion" handout found on the following four pages. When you have read the materials, take turns sharing an intake using buzzwords, while your partner asks questions about the buzzwords to gather more information that is behaviorally specific and focuses on impact.

When ten minutes have passed, answer the questions below:

Which approaches were most effective in translating the buzzwords into behavioral descriptions?

Why?

What are areas in our work where you might find buzzwords?

Handout: Buzzwords Discussion Guide

Discussion Guide for Buzzwords

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

Instructions

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

Role-Playing Questions

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

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

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

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

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

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

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

Discussion Questions

1. As a group:

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

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

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

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

Children's Bureau

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Capacity Building
CENTER FOR STATES

Buzzwords: Moving to Behavioral Descriptors

What Are Buzzwords and Why Do They Matter?

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

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

Some Potential Consequences of Using Unchecked Buzzwords:

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

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

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

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

A Success Story:

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

Strategies to Interrupt the Use of Buzzwords in Case Documentation:

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

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

Screening and Response

Activity: Screening and Response

The purpose of this activity is to practice the Intake screening decision process.

What to Do:

Your group will be assigned a few vignettes below. In your group, review each assigned vignette, and identify the maltreatment allegation as well as the screening and response decisions.

Be prepared to share your work with the larger group.

VIGNETTE 1	
The reporting party is an emergency room nurse. Sal, who is 4 months old, was picked up from his mother's house by his paternal grandmother. The caretakers share custody. The grandmother was concerned that Sal was physically injured while in his mother's care, so she took him to the emergency room. The ER nurse said Sal has two small bruises on his forehead and scratches on his right thigh. The nurse observed that Sal seemed comfortable in the care of his paternal grandmother. The nurse said Sal's father came to the hospital. Sal's father and paternal grandmother are worried that the mother has a drinking problem and is abusing the child. The nurse reported that the mother told the grandmother that Sal fell off the couch during naptime. The grandmother said that Sal is not rolling over yet.	
Maltreatment Allegation	
Screening Decision	
Response Decision	

VIGNETTE 2	
A hospital social worker called to report that a 9-year-old boy was taken to the emergency room via ambulance after he tried to jump off a school bus. The boy's mother arrived at the ER about 30 minutes after the child arrived and was overheard making inappropriate comments, including saying she wished her son succeeded in killing himself when he tried to jump off the bus. The child also said he was going to stab himself with a knife; she told him to go ahead. When hospital staff talked with the boy, he said his mother calls him a lot of names and often sends him to bed without dinner for no reason. ER staff described the mother as acting hateful toward him, and she told hospital staff that they were rewarding him for his bad behavior by being nice to him.	
Maltreatment Allegation	
Screening Decision	
Response Decision	

VIGNETTE 3	
The reporter is concerned about his cousin, Jade, who is 16. Jade's mother does not sell drugs but is helping Jade to do so. The reporter said Jade told him she had made $500 so far from selling drugs that her mother helped her obtain. The reporter said Jade has to give her mother half the money earned from selling drugs. Jade is okay with that because she wants to help her mom out. When asked if there were any other concerns for Jade in her home, the reporter said, "Isn't that enough? Someone needs to go check on her!"	
Maltreatment Allegation	
Screening Decision	
Response Decision	

VIGNETTE 4	
A police officer responded to a call that two children—ages 8 and 5, were seen in a park unsupervised for about 25 minutes. As the officer approached the children, the father jogged across the baseball field toward the playground where they were. The officer noticed the children's father coming from about three blocks away toward him and the children. The officer said he was concerned because the children were near a busy area with a lot of traffic and noticed the 5-year-old playing near the street. The father told the officer that he left to buy cigarettes and asked the 8-year-old to watch her sibling. The father did not appear to be under the influence. The father was engaged and appropriate with the children when he arrived. There were no other kids or adults in the park.	
Maltreatment Allegation	
Screening Decision	
Response Decision	

VIGNETTE 5	
A hospital social worker called about a mother who was admitted after giving birth at home this morning. EMS was there when the baby was born and helped with delivery. After birth, the baby required oxygen, and EMTs had to do initial resuscitation methods. The mother had no prenatal care and had a drug screen upon being admitted. The reporter said the mother did come to the ER during her pregnancy, and during those visits (at least once, if not twice), she tested positive for amphetamines and cocaine. The mother declined a referral to the health department for prenatal care or substance abuse treatment. Upon birth of the child, the mother tested positive for cocaine and amphetamines, and the baby tested positive for cocaine. The baby showed no signs of withdrawal. The reporter said that any small baby born outside of the hospital would probably need oxygen but could not say for sure if drugs had anything to do with this birth. A meconium test was done, but the results won't be back for five to seven days. According to the reporter, the mother told the provider that she did not use drugs during her pregnancy, but she is aware that her urine and the baby tested positive. However, the baby is doing well medically, and the plan is to discharge them the following morning. The reporter does not know if the mother has what she needs for the baby. The social worker did report that the mother has three other children and is aware that at least one of those children is in the care of a relative because of the mothers' substance use.	
Maltreatment Allegation	
Screening Decision	
Response Decision	

VIGNETTE 6	
A doctor called to report that he saw an 8-year-old boy who came in for treatment of a head injury, bruised shoulder, and possible broken ribs. The doctor reported that the boy said he hurt himself that afternoon while riding his bike in the neighborhood; he was attempting a trick he saw on YouTube. The mother does not speak English, and the doctor could not confirm how the injury occurred. When the doctor was asked if there was a concern for maltreatment, he said the mother seemed attentive and caring toward the boy, and the boy could have gotten these injuries as reported. The doctor said he was reporting to the county per hospital protocol.	
Maltreatment Allegation	
Screening Decision	
Response Decision	

FAMILY MEMBERS	NARRATIVE
Vignette 9	
• Mother • Father • Girl, age 14	During a routine checkup this morning, a 14-year-old girl told her doctor that she wishes she could go to school, but her parents aren't letting her. The girl said she knows that the school has called her house and left messages asking about her attendance. She also heard her mother hang up the phone when the school called to ask to talk to her. When asked, the mother told the doctor that her daughter is enrolled in school, and she gave the school's name and address. The clinic social worker called the school and was told that the girl is currently enrolled but has not been attending. The school reported that the girl has missed 16 days of school so far this year, and it is only November. The school also reported that the child has not returned any of the assignments sent to her home; as a result, she has fallen significantly behind. The school has not yet contacted child protection, but it has made several phone calls to the family, sent two letters, and attempted a home visit without success in seeing the girl or speaking with her mother. According to the clinic social worker, the school thought the family moved without providing forwarding information. The clinic social worker verified the address and contact information with the girl, and it matches the address the school has.
Vignette 10	
• Mother • Girl, newborn	A hospital social worker called about a mother who was admitted after giving birth at home this morning. EMS was there when the baby was born and helped with delivery. After birth, the baby required oxygen, and EMTs had to do initial resuscitation methods. The mother had no prenatal care and had a drug screen upon being admitted. The reporter said the mother did come to the ER during her pregnancy, and during those visits (at least once, if not twice), she tested positive for amphetamines and cocaine. The mother declined a referral to the health department for prenatal care or substance abuse treatment. Upon birth of the child, the mother tested positive for cocaine and amphetamines, and the baby tested positive for cocaine. The baby showed no signs of withdrawal. The reporter said that any small baby born outside of the hospital would probably need oxygen but could not say for sure if drugs had anything to do with this birth. A meconium test was done, but the results won't be back for five to seven days. According to the reporter, the mother told the provider that she did not use drugs during her pregnancy, but she is aware that her urine and the baby tested positive. However, the baby is doing well medically, and the plan is to discharge them the following morning. The reporter does not know if the mother has what she needs for baby. The social worker did report that the mother has three other children and is aware that at least one of those children is in the care of a relative because of the mother's substance use.
Vignette 11	
• Mother • Boy, age 8	A doctor called to report that he saw an 8-year-old boy who came in for treatment of a head injury, bruised shoulder, and possible broken ribs. The doctor reported that the boy said he hurt himself that afternoon while riding his bike in the neighborhood; he was attempting a trick he saw on YouTube. The mother does not speak English, and the doctor could not confirm how the injury occurred. When the doctor was asked if there was a concern for maltreatment, he said the mother seemed attentive and caring toward the boy, and the boy could have gotten these injuries as reported. The doctor said he was reporting to the county per hospital protocol.

Provisional Harm and Worry Statements

Activity: Provisional Harm and Worry Statement

Using the “Evans Family Intake” handout that follows, consider what you know about drafting provisional harm and worry statements at intake to answer the prompts below:

Is there an allegation that harm has occurred, including physical or emotional?

If yes, draft a provisional harm statement below including:

- Who says
- What caretaker actions/inactions
- Impact on the child

If no, this report does not have a provisional harm statement.

Provisional Harm Statement:

What is the reporter worried may happen if the family and network do not take enhanced action of protection? Consider:

- What is the reporter worried will happen to the child if nothing else changes?
- In what situations or context are we worried this could happen?

Provisional Worry Statement:

Handout: Evans Family Intake

Intake Screening and Response for Evans Family:

Mother:	Shonda Evans, 34, Black
Father:	Rudy Evans (deceased), 38 Black
Children:	Keisha, 14, Black
	Kevin, 5, Black
	Angela, 11 months, Black

Report:

Paternal Grandmother, Kim Evans is the reporter.

The children's father, Rudy Evans, died approximately 8 months ago, and the family has struggled since his death.

Mother, Shonda Evans, lost her job recently and spends most of her time sleeping in her room.

While Mrs. Evans is in her room, she leaves Kevin and Angela unattended.

Reporter went over to their home the day before the report and found Kevin trying to give Angela a bath unattended. Mrs. Evans was in her bedroom with the door closed at the time.

Reporter also expressed concerns that Mrs. Evans is alone with Angela all day and she does not know how she is cared for during the day.

Reporter also expressed concern that there is not enough food in the house and she doesn't know if Mrs. Evans is feeding the children well.

Reporter also expressed concern about the condition of the home being too messy and Mrs. Evans not staying on top of housekeeping.

15-year-old Keisha is in high school and has extracurricular activities and does not get home until 6 or 7 PM every day.

Reporter indicated that the family has a history of In-Home cases with the family.

Screening	Unsafe supervision/child left alone
Response	Family Assessment Response, 72 hour

Self-Reflection

Mindfulness Activity

This activity is a guided mindfulness exercise. Mindfulness is a type of meditation where you focus on being aware in the present moment, while acknowledging and accepting your feelings, thoughts, and bodily sensations without judgment. There is no wrong way to do this exercise.

Make yourself comfortable. Close your eyes if you are comfortable doing so. This exercise itself will last about five minutes, and there will be a chime sound when it is over.

When it has concluded, you are free to go, or if you have any questions, the training facilitators will be here.

Pre-Service Training: Core Week 4 Day 2 Agenda

Child Welfare in North Carolina Pre-Service Training: Core

Welcome

Child Welfare Process Part 2: CPS Assessments

Overview of CPS Assessments

Special Categories of Cases in CPS Assessment

CPS Assessment Process

BREAK

Child Welfare Process Part 2: CPS Assessments, continued

Preparing for Initial Contact

Observations

LUNCH

SDM Safety Assessment

SDM Safety Assessment

BREAK

SDM Safety Assessment, continued

Safety Assessment Learning Lab

Safety Planning Beyond the Safety Assessment

Self-Reflection

Mindfulness

Pre-Service Training: Core Week 4 Day 2 Learning Objectives

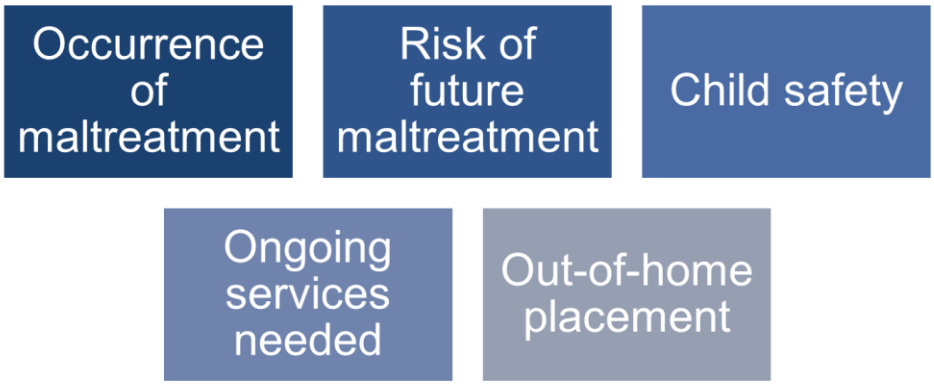
Day 2
Child Welfare Process Part 2: CPS Assessments
Overview of CPS Assessments
• Identify which assessment response is appropriate for different cases to assess reports of abuse, neglect, and/or dependency • Distinguish between Family and Investigative Assessments • Describe the CPS Assessment Process • Identify cases that have special policy requirements in CPS Assessments
Preparing for Initial Contact
• Identify safety threats • Describe how caregiver behavior impacts child safety • Demonstrate narrative interviewing techniques • Describe how to complete the North Carolina Safety Assessment and when it is used • Demonstrate strategies for engaging families in the assessment process
SDM Safety Assessment
• Identify appropriate safety interventions based on case scenarios • Articulate the connection between current indicators of safety and Temporary Parental Safety Agreements • Explain the appropriate use of temporary safety providers • Demonstrate family engagement skills when safety planning with children and families

Core Week 4 Day 2

Child Welfare Process Part 2: CPS Assessments

Overview of CPS Assessments

Purpose of CPS Assessments



During the assessment period, the primary goal of CPS Assessments is to protect children from further maltreatment and to support and improve parental abilities to assure a safe and nurturing home for each child. They do this by determining:

- If child maltreatment occurred
- If there is a risk of future maltreatment and the level of that risk
- If the child is safe in the home, and if not, what interventions can be put in place to ensure the child's protection and maintain the family unit intact if possible
- If ongoing agency services are needed to reduce the risk of maltreatment occurring in the future
- If out-of-home placement is necessary to protect the child from harm

These determinations are made by:

- Engaging and interviewing the family throughout the course of the assessment
- Observing interactions among the child, sibling, parents and household members
- Observing the family's environment, including their home and neighborhood
- Gathering information from other sources who may have information about the alleged maltreatment, family dynamics, or risk or safety of the children. These other sources may include extended family members, neighbors or friends, or professionals, including law enforcement, medical professionals, or school staff
- Analyzing information gathered and using structured decision-making tools

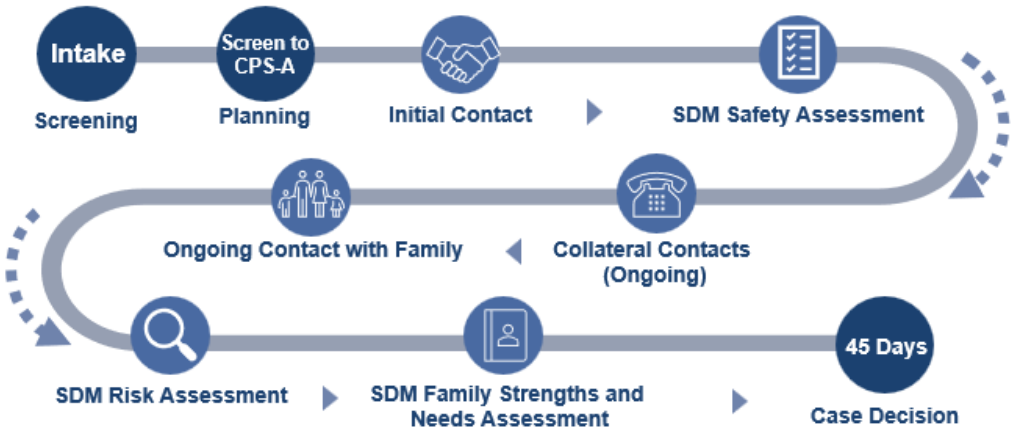
Handout: Investigative and Family Assessment Responsibilities

- Establishing contact with all identified persons who might have information regarding the complaint, including family members, collateral sources, and the child;
- Approaching the family in a manner that communicates that the agency's interests and responsibilities are to protect children and strengthen families, not to establish guilt or innocence;
- Establishing trust and rapport with family members to encourage them to disclose pertinent information and participate fully in the problem-solving process;
- Conducting a fact-finding process by interviewing family members, extended family, collateral contacts, and other sources of data; through observation of the family's interactions; and through other types of data collection to determine current safety, assess future risk and validate or refute the referral information.
- Weighing the interacting effects of both safety and risk factors to establish the degree of safety to the child(ren) at the present time, and the level of risk of harm to the child(ren) in the foreseeable future.
- Identifying strategies and initiating immediate interventions to provide protection for children who are determined to be unsafe and to prevent the need for removal and placement, if possible;
- Completing appropriate documentation of all information to develop a safety agreement, substantiate or refute the referral complaint and the likelihood of future harm;
- Presenting appropriate testimony in situations when juvenile court action is required to protect the child;
- Preparing the family for ongoing service intervention and case transfer to the ongoing caseworker, if applicable.

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

What skills do you think are important for CPS Assessment caseworkers to have?

Overview of CPS Assessments Process



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

CPS process consists of the following milestones:

- Intake
- Initial contact
- NC SDM Safety Assessment
- Ongoing contact with the family
- Collateral contacts
- SDM Risk Assessment
- SDM Family Strengths and Needs Assessment
- Case Decision including two-level consultation with supervisor

Notes

CPS Assessment Approaches

The Family assessment track is a response to selected reports of child neglect and dependency using a family-centered approach that is service-oriented, based on a family's identified needs, and building on the family's strengths.

The Investigative assessment allows us to focus resources on responding to cases where there are serious concerns about child safety. These cases have faster response times, and the process is a traditional investigative approach where the child is interviewed first, before meeting with the parents.

Review the “Policy Distinctions” handout on the following page and answer the questions below.

What are the differences between the two approaches, and why do they matter?

What questions do you have about the differences between the two assessment approaches?

Handout: Policy Distinctions

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

North Carolina Right to Enter a Residence Law

Handout: North Carolina Right to Enter a Residence Law

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

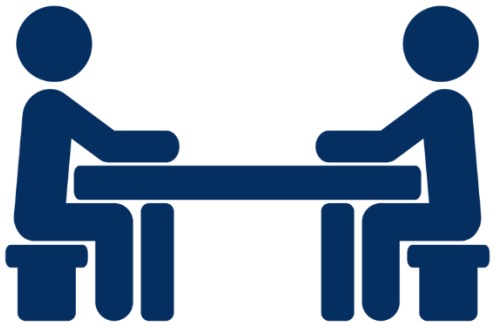
(h) The director or the director's representative may not enter a private residence for assessment purposes without at least one of the following:

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

Note: If the first condition applies and you believe a juvenile is in imminent danger of death or physical injury, you should still contact your supervisor and law enforcement before trying to enter.

Notes

Do You See What I See?



Activity: Do You See What I See?

Why do you think we did this exercise in training today?

How would you want to be treated if you were in the family's place?

Special Categories of Cases in CPS Assessment

Assessments Involving Domestic Violence

The primary focus in cases involving domestic violence is the assessment of the risk posed to the children by the domestic violence. The goals in a CPS Assessment are to:

- Ensure the safety of the children
- Keep all family members safe from harm
- Provide services to the non-offending parent to protect and support them
- Provide services to children to protect and support them and help them cope with the effects of domestic violence
- Create accountability for the actions of the parent who is perpetrating the domestic violence
- Reduce child maltreatment

Notes

Handout: Assessments Involving Domestic Violence Policy

Excerpt from the North Carolina Child Welfare Manual: Cross-Function (May 2020) and CPS Assessments Policy (December 2021)

Purpose

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

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

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

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

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

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

Definition

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

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

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

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

Legal Basis

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

Prior to Initial Contact

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

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

Guidance – How you should do it

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

INTERACTION WITH NON-OFFENDING PARENT/CARETAKER

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

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

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

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

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

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

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

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

- Seek out and utilize the consultation of a domestic violence expert throughout the life of the case.
- Communicate with a domestic violence perpetrator's probation or parole officer regarding any current abuse.
- Reach out and make connections with school social workers and teachers to gain information about the child(ren)'s day-to-day functioning.

- Work closely with Work First to create plans together. This is especially true when Work First may already be providing or can assist in referring a family for domestic violence services.

INTERACTION WITH THE CHILD(REN)

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

Every child reacts differently when exposed to domestic violence. Some children develop debilitating conditions, while others show no negative effects from exposure to violence. As a result, it is important to interview the child(ren) regarding their involvement and/or exposure to domestic violence, as well as their general safety and well-being. It is important to recognize that older children are more likely to minimize reports of parental fighting. Younger children may be more spontaneous and less guarded with the information they share. See the Impact on Children section of the Cross Function topic of Risk.

INTERACTION WITH THE ALLEGED PERPETRATOR

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

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

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

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

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

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

- Focus on information from third-party reports such as law enforcement, medical providers, or the Administrative Office of the Courts.
- Follow up on legal accountability and/or treatment and other service referrals for the alleged perpetrator of domestic violence.
- Convey to the alleged perpetrator of domestic violence that based on what happened (citing as much information as possible without compromising

confidentiality or safety of the child(ren), non-offending parent/adult victim, and/or the reporter) they will be required to take steps to stop the violence and ensure that the child(ren) are safe.
- Avoid debates and arguments with the alleged perpetrator of domestic violence. This is crucial. The focus of CPS is not to convince the alleged perpetrator of domestic violence to admit violent behavior but discuss how to ensure the child(ren)'s safety with them.
- Set limits within the interaction with the alleged perpetrator of domestic violence and document the behaviors that make setting limits necessary and their capacity to respect those efforts.

COLLATERAL CONTACTS

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

Forms

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

Assessments Involving Substance-Affected Infants

Plans of Safe Care	
Family Strengths and Needs (DSS-5229)	• Identified supports • Safety factors and protective factors present
Infant Safety Plan (DSS-6191)	• Nighttime Parenting (Safe Sleep) • Follow-up medical care • Basic needs
Parent Safety Plan (DSS-6191)	• Parent recovery plan • Services • Parental Agreements

When a report is accepted and a medical provider diagnoses the infant (0-6 months) as being a Substance Affected Infant (SAI), a Plan of Safe Care (POSC, DSS-6191) must be developed prior to the infant being discharged from the hospital

Plans of Safe Care are written to:

- Ensure the safety and well-being of infants following release from the care of healthcare providers
- Address the health and substance use disorder treatment needs of the affected family member(s)
- Ensure the provision of services to address the identified needs of the infant and family

Why do you think Plans of Safe Care are an essential practice?

What should be included in the Plan of Safe Care?

Substance Affected Infants & Plan of Safe Care

The North Carolina Division of Social Services recognizes the unique needs of infants and their parents and caregiver when substance use is a factor in the family's ability to safely maintain the infant in their own home.

The purpose of this document is to provide local county child welfare workers with resources and guidance on assessing the safety of substance affected infants (SAI) remaining in the care of their parents and caretakers and creating a plan of care that focuses on the unique needs of substance exposed families.

Definitions - Terminology Glossary

Substance Affected Infant:

- An infant has a positive urine, meconium or cord segment drug screen with confirmatory testing in the context of other clinical concerns as identified by current evaluation and management standard.
- The infant's mother has had a medical evaluation, including history and physical, or behavioral health assessment indicative of an active substance use disorder, during the pregnancy or at time of birth.
- An infant that manifests clinically relevant drug or alcohol withdrawal.
- An infant affected by FASD with a diagnosis of Fetal Alcohol Syndrome (FAS), Partial FAS (PFAS), Neurobehavioral Disorder associated with Prenatal Alcohol Exposure (NDPAE), Alcohol-Related Birth Defects (ARBD), or Alcohol-Related Neurodevelopmental Disorder (ARND)
- An infant has known prenatal alcohol exposure when there are clinical concerns for the infant per current evaluation and management standards.

Nighttime Parenting: A more appropriate term for what was once referred to as Safe Sleep. It acknowledges that there are differences in parenting at night and requires intentional actions by a parent to ensure safety during that time.

Child Abuse Prevention Treatment Act (CAPTA) Requirements

CAPTA and the Comprehensive Addiction and Recovery Act (CARA) requires healthcare providers to notify CPS of all substance affected infants. The notification itself is not an allegation of maltreatment and requires the assigned intake worker to complete a thorough screening to determine whether the notice meets the definition of abuse, neglect, and/or dependency.

CPS INTAKE

During CPS Intake activities, the DSS-1402 is completed for all notifications and includes questions that are specific to SAI. The intake worker may need to support the healthcare provider in making the decision about the information that the healthcare provider can share. However, if this is a notification of a Substance Affected Infant (SAI), the Intake worker is still required to obtain as much information as possible in the completion of the

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

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

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

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

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

CPS FAMILY AND INVESTIGATIVE ASSESSMENTS

Safety Planning in Substance Affected Infant (SAI) Cases

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

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

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

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

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

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

Creating the Plan of Safe Care

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

Discharge Date:

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

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

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

Family Strengths and Goals:

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

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

Infant Safety Plan

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

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

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

Parent Safety Plan

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

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

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

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

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

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

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

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

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

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

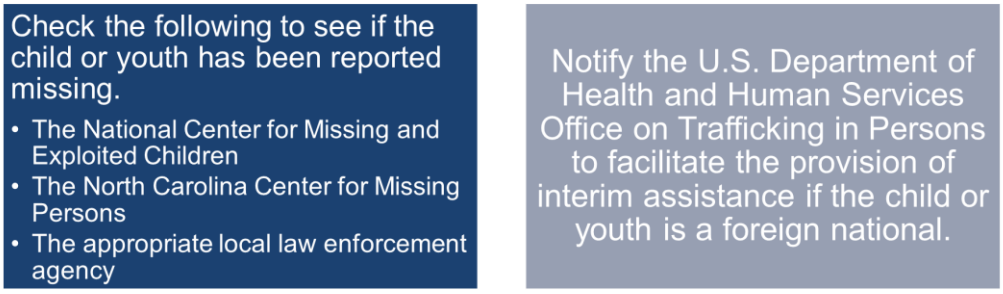
The score on the DSS-5230 needs to be reviewed in collaboration with the strengths and needs assessed on the DSS-5229 to address the areas that could be seen as protective factors as well as areas that can place the child at greater risk. Combining these tools as well as the questions to be asked at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

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

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

Additional Resources
Child Welfare – ACF https://www.childwelfare.gov/pubPDFs/safecare.pdf National Center on Substance Abuse and Child Welfare https://ncsacw.samhsa.gov/topics/parental-substance-use-disorder.aspx Casey Family Programs https://www.casey.org/media/SC_Infant-Plans-of-Care.pdf

Assessments Involving Human Trafficking



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

Specific requirements for human trafficking Investigative Assessments include:

- Check the National Center for Missing and Exploited Children to see if the child or youth has been reported missing
- Check the North Carolina Center for Missing Persons to see if the child or youth has been reported missing
- Check with the appropriate local law enforcement agency to see if the child or youth has been reported as runaway or missing
- Notify the U.S. Department of Health and Human Services Office on Trafficking in Persons to facilitate the provision of interim assistance if the child or youth is a foreign national

Notes

Handout: Assessments Involving Human Trafficking Policy

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

Human Trafficking

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

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

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

Definitions

Federal Law

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

“severe forms of trafficking in persons”:

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

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

State Law

N.C. G.S. 14-43.11 Human Trafficking

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

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

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

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

- Any sexual activity as defined in G.S. 14-190.13 for which anything of value is directly or indirectly given, promised to, or received by any person, which conduct is induced or obtained by coercion or deception or which conduct is induced or obtained from a person under the age of 18 years; or
- Any sexual activity as defined in G.S. 14-190.13 that is performed or provided by any person, which conduct is induced or obtained by coercion or deception, or which conduct is induced or obtained from a person under the age of 18 years.

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

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

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

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

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

d) Commits, permits, or encourages the commission of a violation of the following laws by, with, or upon the juvenile; first degree rape, as provided in N.C.G.S. §14-27.2; rape of a child by an adult offender, as provided in N.C.G.S. §14-27.2A; second degree rape as provided in N.C.G.S. §14-27.3; first degree sexual offense, as provided in N.C.G.S. §14-27.4; sexual offense with a child by an adult offender, as provided in N.C.G.S. §14-27.4A; second degree sexual offense, as provided in N.C.G.S. §14-27.5; intercourse and sexual offenses with certain victims; consent no defense, as provided in N.C.G.S. §14-27.31 and N.C.G.S. §14- 27.32; unlawful sale, surrender, or purchase of a minor, as provided in N.C.G.S. §14-43.14; crime against nature, as provided in N.C.G.S. §14-177; incest, as provided in N.C.G.S. §14-178 and N.C.G.S. §14-179; preparation of obscene photographs, slides, or motion pictures of the juvenile, as provided in N.C.G.S. §14-190.5; employing or permitting the juvenile to assist in a violation of the obscenity laws as provided in N.C.G.S. §14-190.6; dissemination of obscene material to the juvenile as provided in N.C.G.S. §14-190.7 and N.C.G.S. §14-190.8; displaying or disseminating material harmful to the juvenile as provided in N.C.G.S. §14-190.14 and N.C.G.S. §14-190.15; first and second degree sexual exploitation of the juvenile as provided in N.C.G.S. §14-190.16 and N.C.G.S. §14-190.17; promoting the prostitution of the juvenile as provided in N.C.G.S.

§14- 205.3(b); and taking indecent liberties with the juvenile, as provided in N.C.G.S. §14-202.1, regardless of the age of the parties; or

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

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

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

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

Any juvenile less than 18 years of age (i) who is found to be a minor victim of human trafficking under G.S. 14-43.15 or (ii) whose parent, guardian, custodian, or caretaker does not provide proper care, supervision, or discipline, or who has been abandoned; or who is not provided necessary medical care; or who is not provided necessary remedial care; or who lives in an environment injurious to the juvenile's welfare; or who has been placed for care or adoption in violation of the law. In determining whether a juvenile is a neglected juvenile, it is relevant whether that juvenile lives in a home where another juvenile has died because of suspected abuse or neglect or lives in a home where another juvenile has been subjected to abuse by an adult who regularly lives in the home.

Protocol – What you must do

Identifying a Victim of Human Trafficking

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

Required Notifications and Verifications

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

- Check the National Center for Missing and Exploited Children to see if the child(ren) or youth has been reported missing;
- Check the North Carolina Center for Missing Persons to see if the child(ren) or youth has been reported missing;
- Check with the appropriate local law enforcement agency to see if the child(ren) or youth has been reported missing/runaway;
- Notify the U.S. Department of Health and Human Services Office on Trafficking in Persons (OTIP) to facilitate the provision of interim assistance if the child(ren) is a foreign national. The county child welfare worker must contact OTIP Child

Protection Specialists at childtrafficking@acf.hhs.gov or (202) 205-4582 and provide:

- Child's name, age, location, and country of origin;
- Location of exploitation and suspected form of trafficking; and
- County child welfare worker's contact information or other preferred point of contact (e.g., the worker's supervisor).

Safety Considerations

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

Determining and Utilizing Appropriate Resources

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

Role of the Parent, Guardian, Custodian, or Caretaker

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

Key Takeaways

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

Notes

CPS Assessment Process

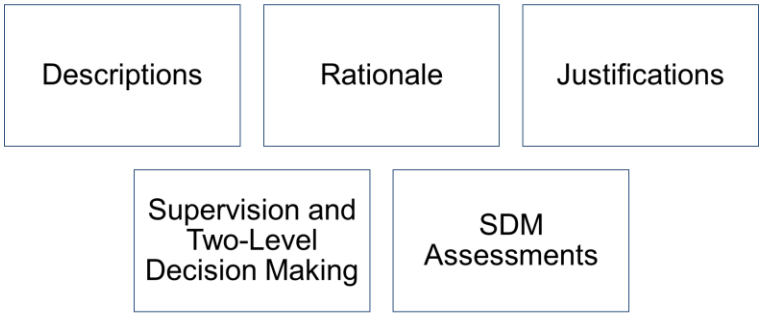
Practice Standards in Assessment

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

The five essential functions, communicating, assessing, engaging, planning, and implementing, are required components of every CPS Assessment. Each function plays a crucial role in ensuring that we assess safety adequately. However, it is easy to confuse the essential function of Assessing with the Assessment process. An assessment is a snapshot in time; the function of assessing is dynamic and ongoing throughout the life of a case.

Notes

Areas of CPS Assessment



- A description of the actions taken (contacts made) and services provided
- A description of the ongoing assessment of risk, safety, and health or well-being of the child
- The rationale for the involvement of the local county child welfare agency and service delivery on an ongoing basis
- The basis for what the local county child welfare agency considers sufficient contact
- A description of all diligent efforts to make contacts, if not achieved;
  A description of the family's progress or barriers toward addressing safety threats or risk
- Supervisor/ Assessment caseworker and group/unit case conferences, including any two-level decisions made
- Justification for any missed policy or protocol requirements (missed timeframes, etc.)
- Documentation for any new allegations and actions taken
- Any other efforts by the local county child welfare agency to achieve child safety and protection, family preservation, and prevention of future abuse, neglect, and/or dependency
- The North Carolina Safety Assessment (DSS-5231)
- The North Carolina SDM Risk Assessment (DSS-5230)
- The North Carolina SDM Family Strengths and Needs Assessment and the Child's Strength and Needs Assessment, when applicable, (DSS5229) on all cases going to In Home or Permanency Planning services;

Assessment is ongoing, and every new piece of information learned adds to your understanding of the bigger picture. Documentation helps you create that big picture, both for yourself and for others. When you document effectively, your supervisor or another caseworker should be able to review it and understand what is going on in a case. It will also help you with other forms of documentation, like preparing for court if needed.

Safety-Focused Assessments

Safety-focused assessment requires an understanding of the concepts of danger, risk, and need:

- Danger is imminent and could be life threatening
- Risk refers to the likelihood of a negative future event
- Needs are factors that can reduce risk and eliminate danger.

These concepts can be illustrated by considering heart related concerns:

- Danger: major heart pains
- Risk: conditions and characteristics that increase the likelihood for a heart attack, such as family history of heart disease
- Needs: factors that can be modified to reduce risk and eliminate danger

Safety-focused practice requires that we focus on danger indictors and safety threats while acknowledging and managing risk and needs.

The SDM tools used in CPS-Assessment align to these concepts:

- Safety Assessment assesses for danger
- Risk assessment assesses risk
- FSNA assesses for Needs

Notes

Activity: Danger, Risk, and Needs

The purpose of this activity is to practice applying concepts of danger, risk, and needs to case vignettes.

What to Do:

Read each statement and determine if it is a danger, risk, or need.

Gabriel, age 4, was walking on the side of a busy street alone.

☐Danger ☐Risk ☐Need ☐None

Caretaker shared that they are not familiar with how to discipline their child.

☐Danger ☐Risk ☐Need ☐None

Caretaker was diagnosed with depression, which is being managed and has no impact on their 8-year-old child.

☐Danger ☐Risk ☐Need ☐None

Caretaker has a history of abuse or neglect as a child.

☐Danger ☐Risk ☐Need ☐None

Caretaker stays out all night drinking while her 4- and 5-year-olds are cared for by their grandparent.

☐Danger ☐Risk ☐Need ☐None

Rigorous and Balanced Assessment

The three questions are a foundation for all assessments.

When we ask, “What are we worried about?” we are identifying and naming the concerns. Worries include safety threats, danger indicators, risk factors, needs, and other circumstances that create worry.

“What’s working well” includes protective capacities, protective factors, strengths, and support networks.

“What needs to happen next” marks the shift from assessment to action. Responses here might include safety planning interventions, ideas for services or referrals, steps to uncover the root cause, and other actionable items.

Why is it important to keep the three questions in mind throughout the CPS-Assessment process?

What might happen if we only focus on the worries? Or only focus on what’s working well?

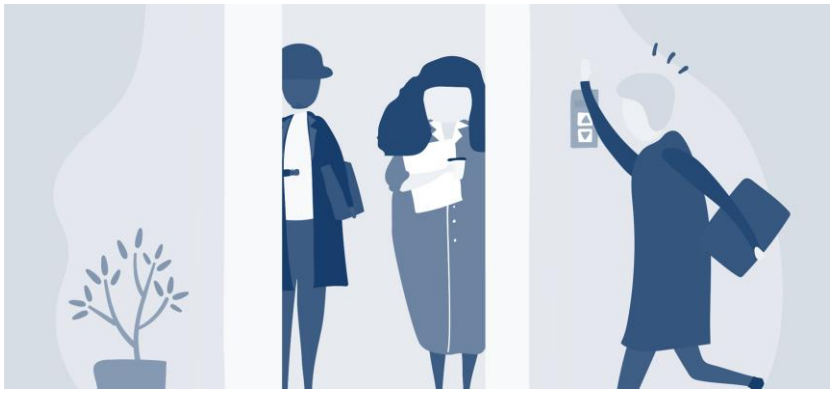
Key Takeaways

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

Notes

Preparing for Initial Contact

Initial Contact



What do you think is the first step when you are assigned an intake?

How do you prepare for that first, initial contact with a family?

Activity: Preparing for Initial Contact Activity - Evans Family

The purpose of this activity is to provide you with an opportunity to prepare for initiation using case scenario information.

Part One

Work with your group to consider the Evans Family Intake Report and brainstorm answers to each topic below, then write your responses on individual flip charts.

1. Identify information you need for assessment
2. Identify sources of information
3. Prioritize interviews based on policy and critical thinking
4. Consider how you will engage the family in the CPS process
5. Develop questions and interview techniques

What were some trends you noticed?

What was something you really liked from another group?

Who has information most relevant to the safety of the Evans children?

What was the reasoning behind your interview prioritization?

Part Two

Work with your group to review the questions you developed and identify 2-3 questions to rewrite so that they align more closely with a narrative interviewing style.

What was it like for you to think about your questions from another perspective?

What do you think the benefits are of using a narrative interviewing style?

How might a narrative style encourage partnership between you and the family?

What does this activity suggest about the importance of planning for contacts with families?

Observations

Observing the Child, Family, and Home Environment

- Physical condition
  - Child
  - Parents
- Emotional status
  - Child
  - Parents
- Need for supports during interview
- Parents' reaction to agency concerns
- Interactions – verbal and nonverbal
- Physical environment of the home and neighborhood

Observation is a critical component of information gathering in child welfare assessments, complementing interviews by providing real-time insights into the child's physical and emotional condition, family dynamics, and environmental factors.

Key areas for observation include the child's physical and emotional status, caregiver behaviors and reactions, family interactions, and the physical condition of the home and neighborhood—all of which inform decisions about child safety and risk.

The need for support during interviews must be assessed, including whether children or caregivers require interpreters, translators, or other accommodations to ensure effective communication and accurate understanding.

Observations must be accurately documented, with clear connections drawn between what is seen and how it impacts child safety, risk of maltreatment, and family functioning.

Understanding observed conditions and behaviors helps assess threats and protective factors, guiding decisions about service needs and interventions to support child and family well-being.

Remember, as you are making observations, signs of poverty do not equal neglect.

If the only contributing factor to what you observe is poverty, then neglect is not present.

Handout: Home Environment Safety Checklist

This safety factor checklist is not all-inclusive. It can be used to help guide the social worker's safety assessment. This checklist should be discussed with the parent or caretaker of all children during all investigations.

Answer the following questions with Yes, No, or Not Applicable:

Poisons

1. Are dangerous/poisonous items kept out child's reach? (i.e. medicines, lighters, matches, dye, bleach, poisons, cleansers, mothballs, motor oil, antifreeze)

Fire Hazards

1. Are utilities obtained legally?
2. If electricity/gas are off, is the means of heating and lighting safe? (i.e. candles should not be near curtains and no open flames)
3. If heating with a fireplace, wood heaters, etc., is there a protective barrier between the heater and the child? (i.e. gate, screen guard, etc.)
4. Is there a safe place for the child to be while the parent is cooking or unable to give the child their full attention? (i.e. playpen, crib, highchair)
5. Are electrical cords/plugs in good condition)? (i.e. no loose wires coming out of the wall)
6. Are electrical outlet covers on all plugs not in use?
7. Is there a fire extinguisher in the home in working condition?
8. Is there a working smoke alarm in the home? (test it)
9. Is the temperature of the hot water heater between 120 and 130 degrees Fahrenheit?

Drowning Hazards

1. Is there constant supervision while the child is bathing or near water?
2. Are toilet seats kept down and do sinks and tubs drain properly to prevent unwanted collections of water? (Child can drown in less than 2 inches of water)
3. If mop buckets are used in the home, are they emptied and stored away after use?
4. If the home has a pool, is the pool properly safe guarded with a fence and life-saving devices?

Firearm Hazards

1. If guns are in the home, are they locked away from children?
2. Is ammunition kept in a separate place from the firearms and is it locked away or out of the child's reach?

Car Safety

1. Does the child have a car seat?

General Safety

1. Does the child have a safe and secure sleeping space? (Children have suffocated when sleeping with adults; they have fallen off adult beds and sofas and have become lodged between the wall and the bed).
2. Is the home free of rat or roach infestation? (Both carry diseases that can be harmful to adults and children.)
3. Are kitchen knives stored out of children's reach?
4. Is there a caretaker available to provide supervision if the parent has to leave the home for any amount of time? (Children should not be left without proper adult supervision.)
5. Is the inside of the home free of any hazardous debris? (Undisposed trash, cans, bottles, etc.)
6. Is the outside of the home free of any hazardous debris? (Undisposed trash, cans, bottles, glass, exposed rusty nails, tall grass, weeds, car parts, etc.)

Video: How to Read People – Decode Seven Body Language Cues

Visit How to Read People to learn how to read nonverbal body language cues to help us understand some of the unspoken communication during family interactions.

What was something new you had not considered before now?

How can decoding body language help you in your assessments?

What might you need to keep in mind about body language and engaging with children and families?

How might your own body language be a barrier to engagement with children and families?

What Do You See?

Assessing child safety and family risk requires both interviews and direct observation, especially of behaviors, interactions, and the physical environment in which the family lives. Observing the physical environment is essential, as living conditions—ranging from well-kept homes to severely disordered spaces—can provide important context for understanding family functioning and potential safety concerns.

Respectful observation is critical, even in challenging environments. Workers must remain nonjudgmental and avoid outward reactions, recognizing that many families are doing the best they can under difficult circumstances.

Safety and risk must be assessed throughout the entire home, including all rooms and living spaces, with attention to hazards, cleanliness, and structural conditions. Documenting observations clearly and objectively supports comprehensive assessments and helps link environmental factors to child safety and family dynamics.

Safety and risk must be assessed throughout the entire home, including all rooms and living spaces, with a focus on hazards, cleanliness, and structural integrity. It is crucial that you hold conversations with family about these topics. You must also document observations clearly and objectively to support a comprehensive assessment and help link environmental factors to child safety and family dynamics.

Activity: What Do You See?

Pay attention to how you respond and feel when you see these images and reflect on any biases you might hold so that you can mitigate those biases when you are in a family's home that challenges your beliefs or values.

What to Do:

The trainers will display several slides of various home environments. Record your observations of the home environment in the following spaces.

Living room: children aged 13 months, 2 years, and 5 years

Observations:

What assessment could you make from just these notes and the picture of the living room?

What did you see that raised safety and risk concerns?

What else do we need to know?

Bathroom: children aged 13 months, 2 years, and 5 years

Observations:

What assessment could you make from just these notes and the picture of the living room?

What did you see that raised safety and risk concerns?

What else do we need to know?

Kitchen: children aged 13 months, 2 years, and 5 years

Observations:

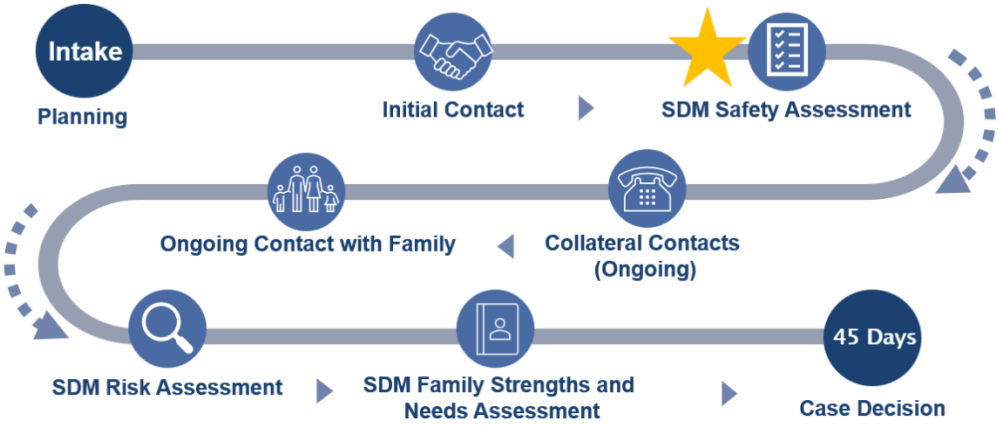
What assessment could you make from just these notes and the picture of the living room?

What did you see that raised safety and risk concerns?

What else do we need to know?

SDM Safety Assessment

Overview of CPS Assessment Process

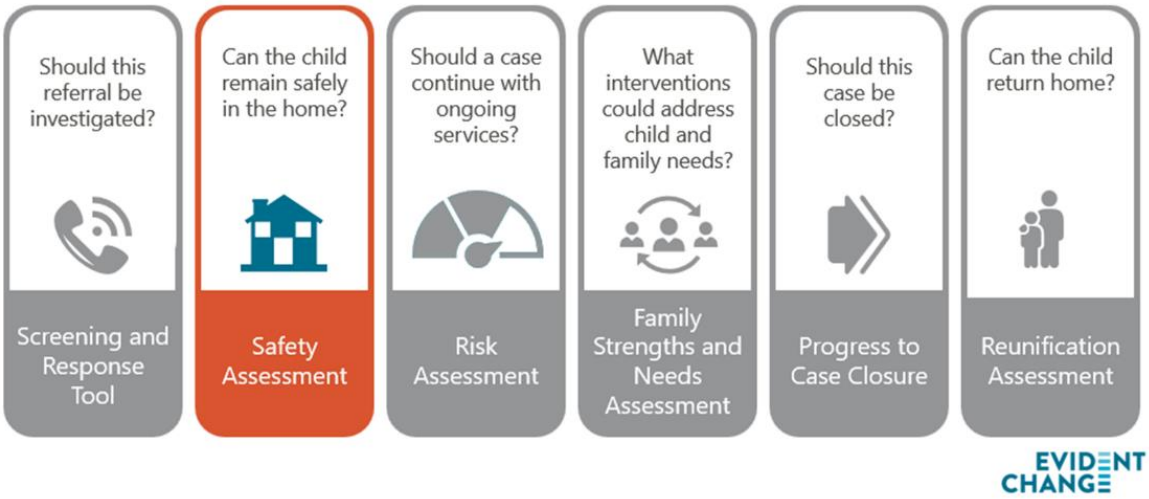


The Safety Assessment Tool is introduced after initial family contact, serving as a structured step in the broader child protection assessment process. Structured Decision Making (SDM) tools support informed decision-making, but they are only one component of a comprehensive social work assessment that includes engagement, observation, and professional judgment.

Familiarity with the Safety Assessment Tool is essential, as it plays a critical role in evaluating child safety and guiding next steps in case planning.

Notes

SDM Safety Assessment



The safety assessment answers the question, “Can the child remain safely in the home?” Policy outlines the required timeframes and decision points of when a safety assessment must be completed.

Notes

Activity: SDM Safety Assessment Policy Hunt

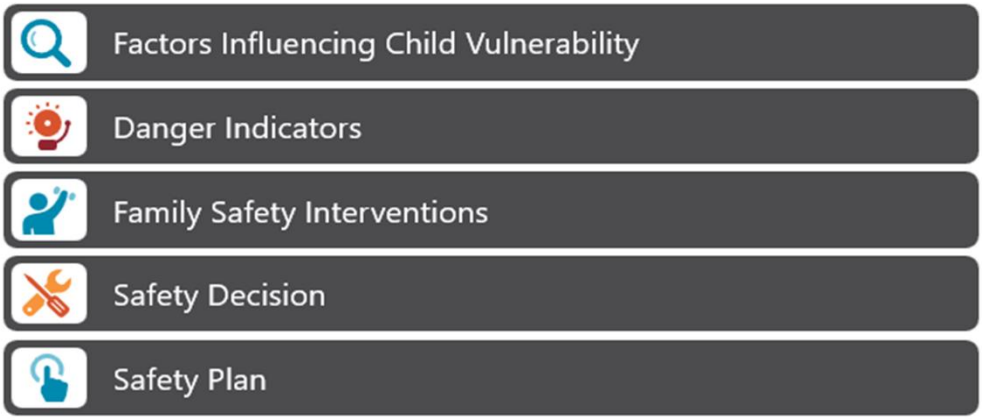
Work with your partner to complete the SDM Safety Assessment Policy Hunt.

Access the CPS Assessment Policy, Protocol, and Guidance Policy, focusing on the Safety Planning Section: https://policies.ncdhhs.gov/wp-content/uploads/PATH-NC-Assessments-October-2025.pdf

Use policy to answer the following questions:

- The NC Safety Assessment must be completed during _____ CPS Assessments to address ___ _____ _____ and the parent/caretaker's capacity to ensure safety for the children.
- The safety assessment must be completed and documented at the following intervals (check all that apply):
    - Before meeting with the family based upon the allegations in the report.
    - At the time of initial contact, during a home visit, and prior to allowing the child to remain in the household
    - Prior to case decision
    - After completing each collateral contact
    - Prior to removal of a child from the home
    - Prior to the return home of a child in cases where caretaker temporarily arranges for the child to stay outside the home with a Temporary Safety Provider as part of the safety intervention
    - Any change in circumstances
    - If a new report is received
    - At the presence of a safety issues revealed during the assessment phase
- A safety must be used when there is a specific _____ or risk of harm identified.
- Safety plans must be developed _____
- Include at least one _____ _____ _____
- Use the _____ restrictive intervention to ensure safety of the children
- Include a _____ _____ _____ when the parent chooses this as a safety intervention
- Identify in behaviorally specific teams the _____ or _____ as well as action steps everyone has agreed to do
- If there are no safety interventions that can ensure safety, a _____ must be filed.

SDM Safety Assessment: Five Components

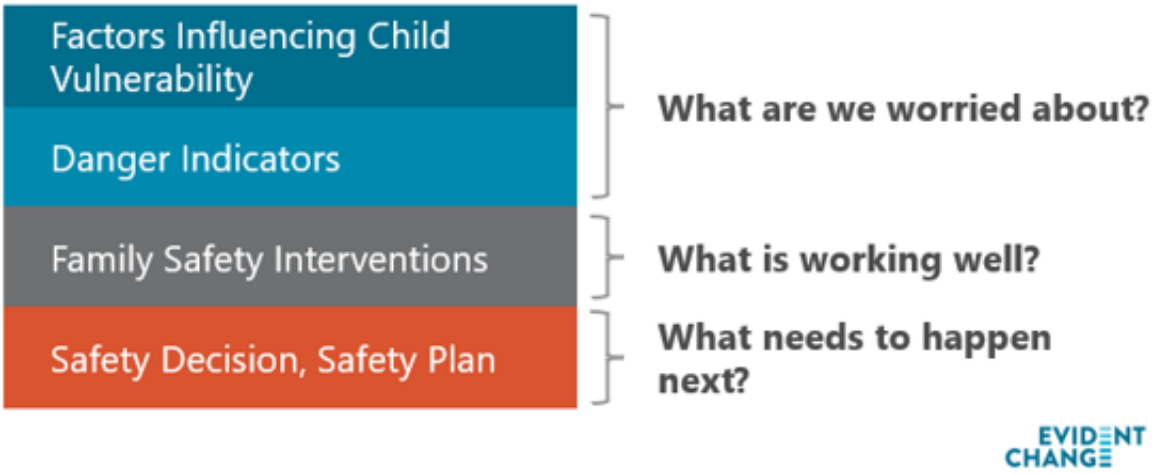


The safety assessment consists of five parts: indicators influencing child vulnerability, danger indicators, safety interventions, safety decision-making, and the safety plan. Definitions are a crucial part of the SDM system, supporting consistent criteria for fair assessments. The manual outlines the safety assessment, definitions, and the policy and procedure. Each section includes stems or items, definitions, and examples.

You can access the SDM® Safety Assessment Policy and Procedures Manual on the North Carolina Child Welfare website: https://policies.ncdhhs.gov/wp-content/uploads/North-Carolina-SDM-Safety-Manual.pdf.

Notes

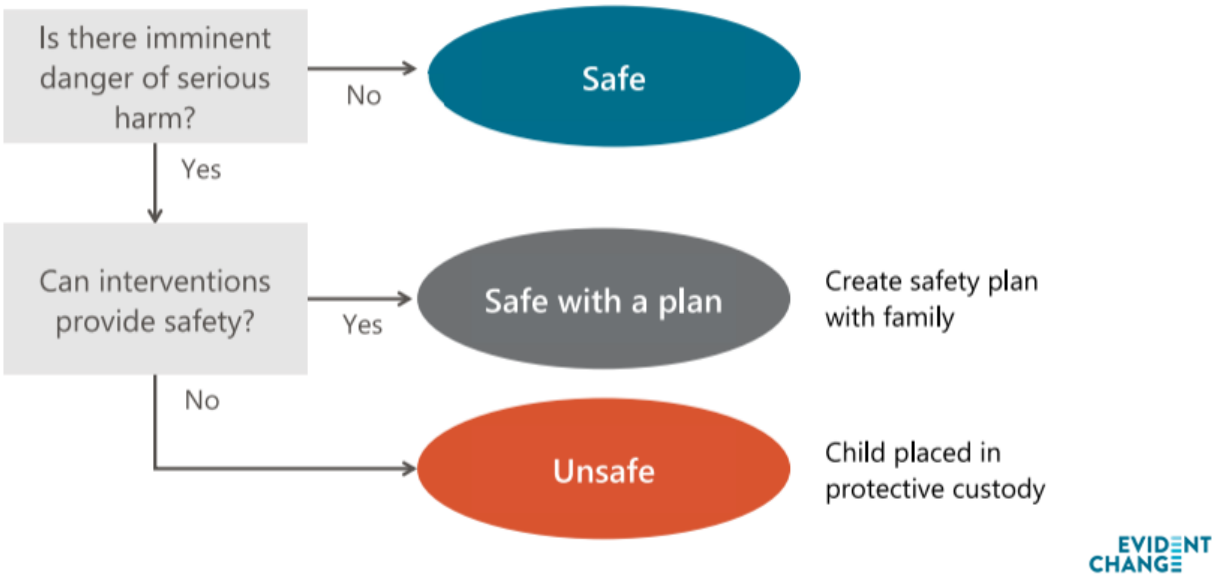
Three Questions and the Safety Assessment



It is recommended that you organize your interviews and conversations with families around the Three Questions: What are we worried about? What is working well? What needs to happen next to make this better? Using the Three Questions will support you as you gather critical information about danger indicators, complicating factors, strengths, and possible interventions. You can then ask more detailed and pointed questions for further information and rigorous safety planning.

Notes

Safety Assessment Logic



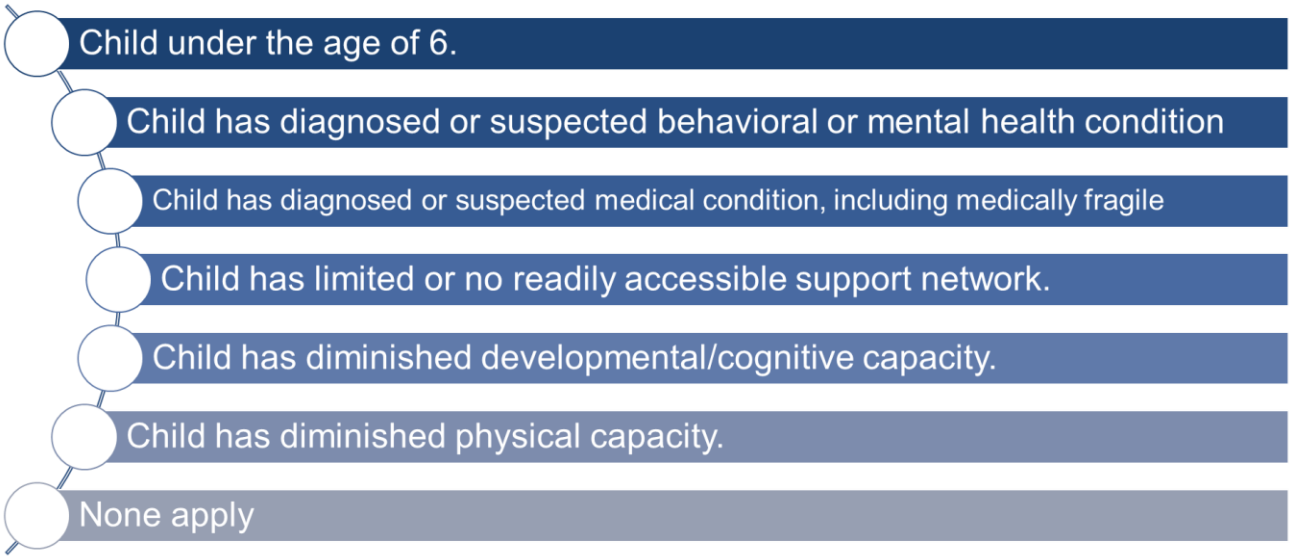
This graphic shows the presumptive decisions for the safety assessment. First, the assessment asks if there is imminent danger of serious harm. If the answer is no, the tool's presumptive safety decision is "safe." If the answer is yes, the next question asks if any safety interventions were identified and agreed to by the caretakers. If yes, the safety plan developed with the family needs to mitigate the danger, and the safety decision is "safe with a plan." If no, the safety decision is "unsafe," and immediate action will be needed to protectively place the child.

The Safety Assessment has three potential outcomes:

- Safe: indicates unidentified danger indicators and no indication of imminent danger of serious harm based on currently available information
- Safe with a plan: indicates one or more danger indicators are present and can be mitigated with interventions that will allow the children to remain in the home at this time
- Unsafe: one or more danger indicators are present, and placement is the only protective intervention possible

Notes

Part A: Factors Influencing Child Vulnerability



Behaviors and conditions can make children more vulnerable. The presence of vulnerability does not mean a danger indicator is present or that a child is unsafe.

Factors that influence child vulnerability provide a lens through which caseworkers must view safety needs.

Notes

Activity: Factors Influencing Child Vulnerabilities

The purpose of this activity is for participants to apply the factors influencing child vulnerability to a case scenario.

What to Do:

Case Vignette: Samantha (age 17) is one of four children in the home. Children are ages 6–17. Sophie (age 7) is diagnosed with ADHD and depression. Sophie has recently been expressing some suicidal ideation. None of the children are known to have diminished developmental or cognitive capacity. Samantha is currently in a wheelchair because she broke her leg during a soccer game and will be in the wheelchair for at least another month.

Name the factors influencing child vulnerability:

Explain why you selected this response:

Part B: Danger Indicators

Part B assesses Danger Indicators. There are 14 danger indicators on the safety assessment.

The C+B+I formula is a tool used to assess whether the danger indicator is present and there is impact to the child, which would indicate that the definition or threshold for that danger indicator has been met. A danger indicator should only be selected when the information collected (such as interviews, criminal and agency records, and collateral contacts) points to safety issues. Impact should be documented in the notes section provided.

Caretaker: Assess the legal caretaker's behavior.

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.

Notes

Activity: Danger Indicator Practice

The purpose of this activity is for you to practice assessing for danger indicators using case scenarios.

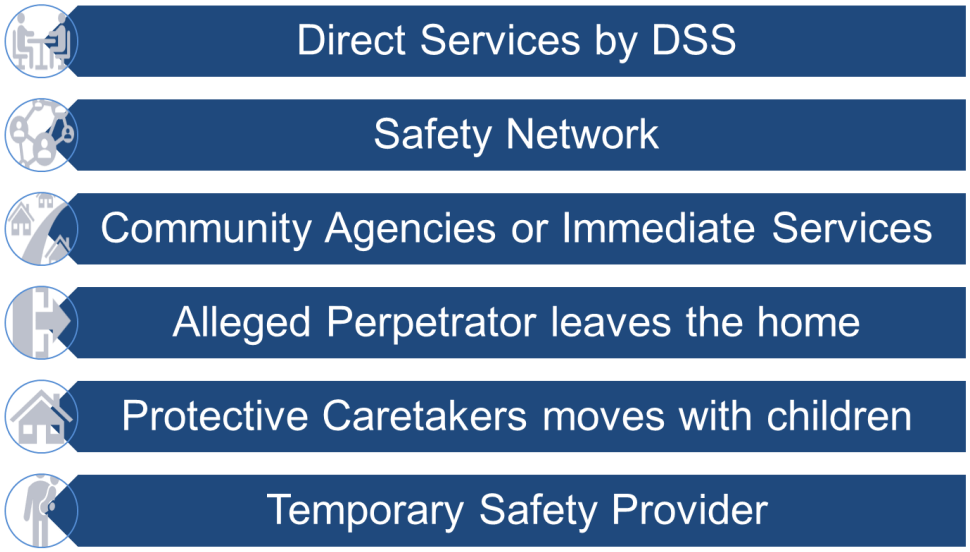
What to Do:

Work with your group to use the Safety Assessment Part B to assess for danger indicators.

VIGNETTE	DANGER INDICATOR
#1. There is current harm or an identified current threat of harm to a child, AND the caretaker does not act.	
#2. Caretaker leaves the child alone without a plan to meet their needs.	
#3. The caretaker may blame the child for a particular incident or for family problems, AND the child exhibits severe anxiety related to situations in the household.	
#4. Serious illness or significant injury has occurred due to living conditions, and these conditions persist (e.g., lead poisoning, rat bites, severe infestation of pests, including cockroaches and bedbugs, causing negative medical health effects).	
#5. Prior death of a child as a result of action or inaction fo a current household member, and the child has a physical injury that is concerning but did not warrant medical attention.	
#6. The child's caretaker(s) have responded appropriately and made reasonable efforts to help the child modify their behavior.	

VIGNETTE	DANGER INDICATOR
#7. Caretaker's explanation for the observed injury is inconsistent with the type of injury.	

Part C: Family Safety Interventions



Part C is completed only if one or more danger indicators were identified and the family agrees to take an action step to help develop a safety plan. For each of the danger indicators selected in part B, consider the resources available in the family and community that might help keep the child safe.

Family Safety Interventions include:

- Use of direct services by the county child welfare agency
- Include family, neighbors, or other community members in the development and implementation of a safety plan
- The alleged perpetrator has left the home voluntarily or in response to legal action
- A protective caretaker will move or has moved to a safe environment with the children
- Use of a Temporary Safety Provider (TSP)

The decision of whether to use a family safety intervention or to remove a child from the home hinges on whether there are sufficient resources to put a safety plan in place

Notes

Activity: Part C: Family Safety Interventions Practice

The purpose of this activity is for you to assess case scenario information and apply it to the Part C family safety interventions.

What to Do:

Listen to (or read) the case vignettes and name the family safety interventions that would be marked on Part C of the Safety Assessment for that vignette. Then explain why you made that selection.

Practice A:

A safety plan was put in place to mitigate a danger indicator. The child attempted to intervene when dad was hitting mom and was injured as a result. According to the safety plan, the mother (who is not the alleged perpetrator) and the child will relocate to a relative's home. Both parents agreed that this would give them time to work on themselves and engage with therapeutic providers to address current concerns. They also plan to have their pastor facilitate weekly check-ins about their child. The pastor has agreed to support the family and will contact the caseworker if needed.

- ☐Direct Services by DSS
- ☐Safety Network
- ☐Community Agencies or Immediate Services
- ☐Alleged Perpetrator leaves the home
- ☐Protective Caretakers moves with children
- ☐Temporary Safety Provider

Why did you select that family safety intervention?

Practice B:

A report was called in on a single dad who takes an Uber every Saturday to go drinking with his buddies. The dad's three children are ages 8, 12, and 16. Dad's sister watches the kids when he goes out. When Dad returns home, he is intoxicated, and the children are sleeping. When they wake up on Sunday, Dad is groggy, but he fixes breakfast for them and gets them ready for the day.

☐Direct Services by DSS

☐Safety Network

☐Community Agencies or Immediate Services

☐Alleged Perpetrator leaves the home

☐Protective Caretakers moves with children

☐Temporary Safety Provider

Why did you select that family safety intervention?

Temporary Safety Providers (TSP)

Temporary Safety Providers (TSPs) are voluntary interventions where an individual identified by the parent or caregiver provides short-term care for the children outside of their home or provides supervision of the parent's contact with the children in their home. TSPs must only be considered if all other options are exhausted.

Examples of situations where a TSP might be appropriate are:

- If a parent is incarcerated and has a known release date and will be able to care for the child after the release
- A safety concern related to dangerous housing will be eliminated by repair or a move
- A parent has a spot in a residential treatment facility that allows children but has a brief, specified wait prior to admission

A Temporary Safety Provider is the person(s) used as a safety intervention when a parent makes a plan to protect their children with someone else on a short-term basis, with approval from the local child welfare agency regardless of whether the TSP is moving into the family's home or providing care to the child in the TSP home.

Notes

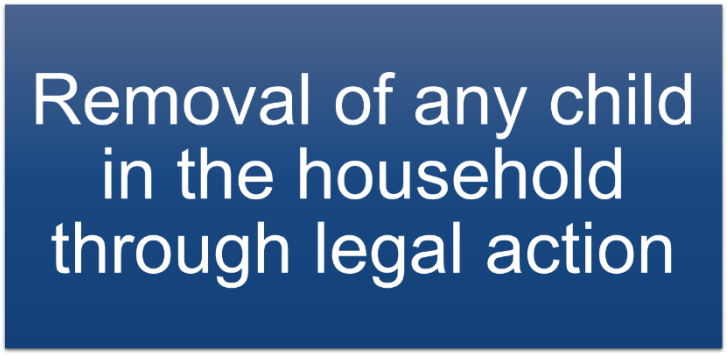
Handout: TSP Best Practices

TEMPORARY SAFETY PROVIDERS AND SAFETY PLANS: BEST PRACTICES

Temporary safety providers (TSPs) should be used as a last resort when there are no other options to keep the child safe. They are meant to allow the caretakers time to address a danger indicator. Follow these best practices when considering a TSP for a family.

- When completing the SDM safety assessment, caseworkers must include detailed information regarding the caretaker's behavior, its impact on child, and why the impact cannot be mitigated with safety interventions 1–5. This process also informs discussions with the family.
- Having conversations with families about using a TSP can be difficult. Transparency is crucial, and harm and worry statements could be especially helpful. Approach these discussions in a non-coercive manner. Present the agency's bottom lines and the need to provide immediate safety for the child, such as by saying, "We have some ideas that could help address the danger to your child. We want to hear what you think we could all do together to help, and we can build from there."
- Caseworkers must explain TSPs, and caretakers must understand that TSPs are only used for a limited time—as are the safety interventions—while everyone involved works diligently to mitigate the danger. Caseworkers must clearly explain the observable behaviors and changes required to alleviate the danger.
- Caretakers must decide they want to use a TSP. Caseworkers can provide it as an option, but caretakers must agree. Caretakers need to see and understand that the plan is voluntary. If the TSP is restricting the caretaker's rights and the caretaker does not voluntarily agree, consultation with the agency's legal representation should occur to discuss filing a petition.
- Filing a petition is a potential outcome if safety cannot be assured with a safety plan, but it should not be presented as a threat.
- The TSP must be identified first by the caretaker and then approved by DSS using the initial provider assessment TSP. This is different from the initial provider assessment for kinship. DSS has to review the family's choice for TSP and document why they would or would not approve the family's recommendation; consult the initial provider assessment to determine this. While the child is in the TSP's home, DSS should help support the family though activities such as home visits to ensure the child's basic needs are met and the caretakers continue to make progress on safety plan items.
- Caseworkers need to actively assist the family to resolve this temporary separation. If the situation changes and separation will last longer, collaborate with the family in moving toward a different, long-term solution.

Child Welfare Safety Interventions

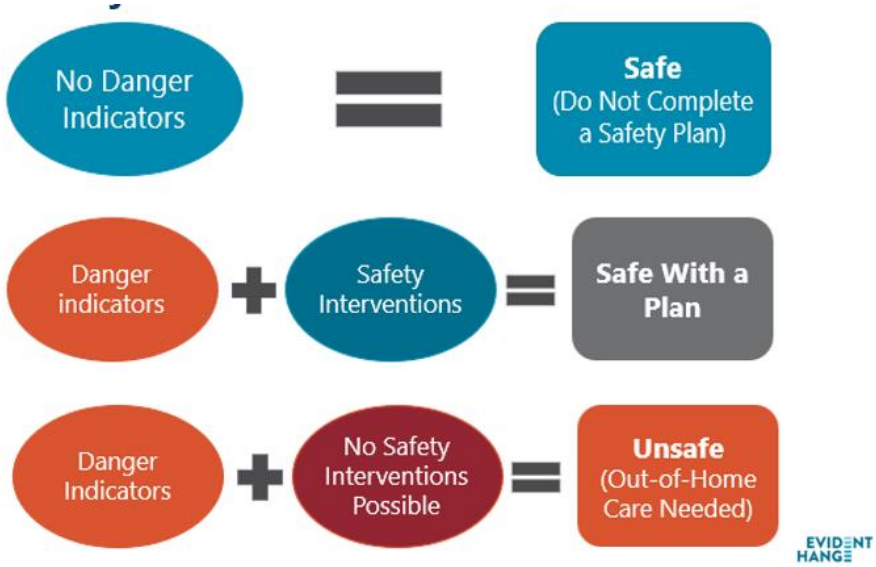


The fundamental question answered by the SDM Safety Assessment is “Can the child remain safely in the home?” Despite our best efforts, there are times when family safety interventions are not available or insufficient to protect children. Without this level of intervention, one or more children will likely be in imminent danger of serious harm. In such cases, the agency intervenes and the child is removed from the home through legal action.

Removal is the most intrusive intervention. Engaging and partnering with families in the child welfare process is a crucial component in identifying family safety interventions that promote child safety in the home.

In what ways does having a family-centered, safety-focused, and trauma-informed practice prevent removal?

Part D: Safety Decision



For cases where the child is unsafe, caseworkers must explain why the interventions explored were insufficient or not possible and removal was necessary. Documentation of danger indicators and interventions is required in both the safety assessment and the corresponding case documentation that answers these four questions:

- What did we consider doing to mitigate the danger?
- Did someone consider moving into the home to mitigate the danger? Why was that not possible?
- Did a safe caretaker consider going with the child to live with a relative or fictive kin? Why was that not possible?
- Did the caretaker consider having the child temporarily live with a relative or fictive kin? Why was that not possible?

There are three safety decisions:

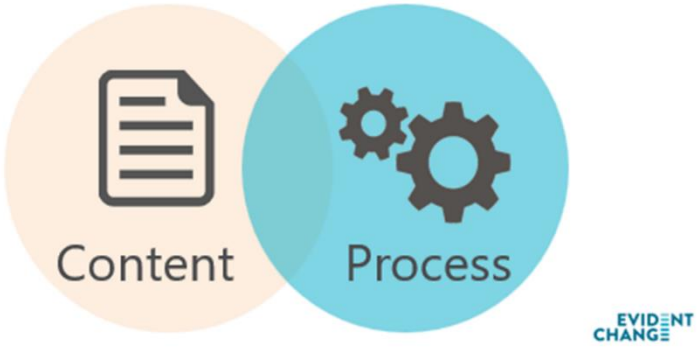
Safe: no danger indicators were selected on the safety assessment

Safe with a plan: at least one danger indicator was selected on the safety assessment, and family safety interventions were identified to mitigate safety concerns

Unsafe: at least one danger indicator was selected on the safety assessment, and no family safety interventions were possible; therefore, child welfare intervention is necessary

Only safety concerns represented by the presence of danger indicators are addressed in the safety plan. There may be additional work with the family to address risk factors. This occurs outside of the safety assessment and planning process.

Safety Planning



For the safety decision “safe with a plan,” a safety plan must be created that addresses danger indicators. Safety plans are built upon the family safety interventions identified in Part D of the safety assessment.

Safety plans are not just forms; they are an agreement between the family, the family’s support network, and the agency as to how the children will remain safe in the home.

The steps to safety planning include:

3. Assess: gather information, using critical thinking and family engagement skills
4. Describe: create at least one statement person danger indicator, simple, family accessible language
5. Orient: explain to the family what a safety plan is
6. Identify: creating safety requires more than just the family
7. Act: safety plans include action steps to keep the child safe
8. Agree: all participants must agree to the plan
9. Monitor, build, assess: create a timetable and measurements for safety plan review

Always make available a copy of the plan for the family.

Notes

Handout: Steps for Safety Planning

STEPS FOR SAFETY PLANNING

Part E: Safety Plan

Part E of the safety assessment consists of the Safety Plan:

- Explanation of what harm has occurred
- Who has agreed to be part of this plan
- What the agency and/or the family is worried will happen to the child's safety if nothing else changes
    - Describe the danger indicator using Caregiver + Behavior+ Impact formula
    - What will be done to address the danger indicator
    - Who is responsible
    - Indicators that the plan is working
    - What will happen if the plan is not working

Notes

Safety Planning

When discussing effective safety plans, it's essential to recognize that these are not merely documents—they're dynamic tools designed to protect individuals in moments of genuine danger. Effective Safety Plans require consideration of the following:

- Is an action plan for controlling the threat
- Responds to clearly identified danger indicators
- Is short-term
- Must include the family, network, and older children
- Has clear backup and monitoring plans
- Designates clear times for review

Notes

Activity: Safety Planning Skills Practice

The purpose of this activity is to build your capacity to "check their own work" regarding effective safety planning.

SAFETY PLAN STRATEGIES:

What to Do:

Review the "Safety Plan Checklist" handout that follows this activity, then discuss with your partner which of the six effective safety planning strategies correspond to each of the hot spots listed on the safety planning checklist. When you have finished, answer the questions below.

What areas of safety planning do you feel confident?

What areas of safety planning are you concerned?

Handout: Safety Plan Checklist

HOT SPOTS	SOLUTIONS	COVERED?
The only intervention is that the alleged perpetrator promises not to repeat a behavior.	Network/other caretaker will monitor behavior.	
There is jargon in the harm or worry statements.	Craft family-friendly harm and worry statements with the family using their own words.	
Network agrees to help, but no legal caretaker is included.	At least one legal caretaker agrees to the interventions.	
The caretaker is coerced into agreeing under the threat of a child's removal.	Explain the planning process to caretaker/network. Include them in planning so they freely consent to the plan.	
The survivor is left to keep an alleged perpetrator out of the home without the alleged perpetrator's consent.	• Alleged perpetrator agrees to the plan. • The survivor and children leave to be safe and together. • A network member comes to stay in the home to monitor.	
The only intervention is a temporary restraining order.	Any restraining order is augmented with additional safety planning.	
A survivor is expected to protect the children when they are not demonstrating their own protection.	Network members contribute to keep young children safe.	
A caretaker's constitutional rights (fourth and 14th amendments) are violated: Caretaker is forced to leave home or is deprived of visits with child; non-caretaker is given custody without consent or knowledge.	• Gain informed consent for interventions. • Consider that a protective caretaker may have to leave with the children to be safe and together. • If no caretaker is available to help with a safety plan, custody may be the only option.	
A safety plan is written when protective custody is not really being considered.	• Carefully review danger indicator definitions. • Document efforts to gain agreements with the family for future safety and write a "referral closing" letter or promote to a case for ongoing services.	
The safety plan does not have a time limit.	Include a date and time, no later than 14 days from the initial safety plan being signed, to review the plan. The safety plan can be reviewed prior to 14 days at the request of any participant. If/when a safety plan exceeds 45 days, a review of that plan must be completed with the caretaker(s).	
There is no *clear* way to monitor whether the safety plan is working, and there is no fail-safe behavior if it is not working.	Clearly describe the behavior that will affirm that the plan is working and who will do what if it is not (e.g., whom they will contact, how they will intervene). If this is not possible, the household may be found unsafe.	
The voice of the child is missing.	Remember to include the voice of the child for both impact and keeping the child safe as age appropriate. Using the Three Houses or Safety House can help.	

Educational neglect is not a safety issue and should not lead to a safety plan. Also, reports of unsafe discipline will not lead to a safety plan unless it becomes abuse as in danger indicator 1. Please consult with your supervisor on danger indicators that may lead to a safety plan.

Three Things to Remember about Safety Plans

It is important to distinguish between behavior change and service compliance.

Children are central to the safety planning process; include them when planning for safety with the family. Use SOP tools such as the three houses and the safety house. Use simple language and explain the plan to the children who are impacted.

It's important to determine when and how children should be on the plan, as children are not responsible for planning for their own safety. Safety Assessing and Planning are dynamic processes, and safety plans can evolve over time.

What happens as a system when we all understand that safety and services are not the same thing as danger indicators and safety planning?

SOP Tools that can support Safety Planning

SOP tools compliment your work when embedded into day-to-day practice:

Caretaker + behavior + impact on the child. All of our assessment work should revolve around understanding "caretaker + behavior + impact on the child." All the danger indicators in the SDM safety assessment are based on this formula and will be extremely helpful in identifying whether there is truly a danger indicator. If a caretaker's behavior doesn't have a significant impact on the child, it likely will not rise to a danger on the SDM safety assessment, and there will be no need for a safety plan.

Three-column mapping. You can use three-column mapping, along with solution-focused questions, to help gather and organize information and support critical thinking with the family around the three questions: what are we worried about, what is working well, and what needs to happen next.

Solution-focused questions. Solution-focused questions, or SFQs, are the starting point for a more detailed discussion with families about these plans. In addition to using them to start a more detailed discussion, SFQs can help build hope for families. SFQs are at the core of all SOP tools.

Harm and worry statements. Harm and worry statements help create a shared understanding of what maltreatment has already occurred and what DSS worries might happen if nothing is done to address the danger indicator. Harm and worry statements can serve as a starting place for deep, meaningful discussions with families about a plan to control the danger indicator.

Building networks. A cornerstone of SOP is to engage at least one additional person who could not have caused the harm to be part of the safety plan. SOP has several tools that workers can use with families to help them identify network members, such as the Circles of Safety and Support, ecomap, Support Network Grid, and genogram.

Safety House and Three Houses. The Safety House and Three Houses can be used with children to include their voice in the assessment and safety planning process.

Key Takeaways

- Observations of the child, family and home environment are key components of safety assessment
- The NC Safety Assessment Tool helps us answer the question, ”Can the child remain safely in the home?"
- When assessing safety indicators consider the caregiver behavior at its impact on the child
- Harm and Worry statements help us communicate safety concerns with families
- TPSAs are short-term, behaviorally specific, and respond directly to the identified safety threat
- Safety Agreements address specific threats and are time-limited
- Safety Agreements must involve the family's network
- TSPs are time-limited and should only be used if a less intrusive intervention is not sufficient
- "Safe with a plan" requires a TPSA
- "Unsafe" requires DSS to take custody of a child

Notes

Safety Assessment Learning Lab

Activity: Safety Planning Practice

The purpose of this activity is for you to practice creating safety plans by reflecting on a sample safety plan.

What to Do:

Review the “Sample Safety Plan” handout, which offers an example of a completed safety plan.

When you are finished, find a partner and discuss the questions below.

What did you notice about the plan?

How does it achieve or miss the mark?

What could make this plan better?

Handout: Sample Safety Plan

Background: It was reported that the family home was without electricity and had a leaky roof and broken windows in the living room, as well as trash, choking hazards, and unsanitary items inside the home (nail gun and nails, animal feces, stacks of broken furniture) that were accessible to the children, ages 2 to 9. This report was accepted for an investigative assessment. Upon assessment, the home was found to have some safe areas (bedrooms, bathroom, kitchen, and den) and other unsafe areas (living room).

Gina and John agreed to participate in safety planning and identified network members who agreed to participate with the family.

Maternal grandmother Sofia Perez cannot be a temporary safety provider due to the strict rules about children living on the retirement property where she currently resides; however, she can assist with the safety plan in other ways.

Gwen Morris and Greg Salgado, friends and neighbors of Gina and John, also declined to be temporary safety providers but agreed to assist the family in other ways.

Peter Gordman, pastor of the church the family attends, has paid the outstanding electric bill, which allowed the electricity to be restored. Pastor Gordman has agreed to continue to assist the family financially if needed and when he and the church are financially able. He also has agreed to be part of the safety plan.

Due to the unavailability of network members to be temporary safety providers, it was determined that the unsafe area could be removed from the children's access, and the children were allowed to stay in the home with a safety plan in place.

While the worker was in the home, Gina cleaned up the animal feces, and John put the broken furniture, nail gun, and nails outside in the shed. John also set up a baby gate to block the children from entering the living room.

WHAT HARM HAS OCCURRED?

Harm statement: It was reported that the family home was without electricity and had a leaky roof and broken windows in the living room, as well as trash, choking hazards, and unsanitary items inside the home (nail gun and nails, animal feces, stacks of broken furniture) that were accessible to the children, ages 2 to 9.

Worry statement: Rico (9), Sara (6), Hector (5), Maya (3), and Luis (2) could be physically harmed or become ill (experience lack of electricity and exposure to inclement weather, ingest and choke on items on the floor, get sick from sleeping on bedding with dog feces, have stacked furniture or other items fall on them, or injure themselves with the nail gun) if Gina and John are not able to clean, restore utilities, and maintain a hazard-free living environment.

WHO HAS AGREED TO BE PART OF THIS SAFETY PLAN? (THIS MUST INCLUDE CHILD'S CARETAKER)

FAMILY MEMBER OR NETWORK MEMBER	CONTACT DETAILS	
	PHONE	EMAIL
Gina Thomas, mother	XXX-XXX-XXXX	
John Thomas, father	XXX-XXX-XXXX	
Sofia Perez, maternal grandmother	XXX-XXX-XXXX	
Gwen Morris, mother's friend and neighbor	XXX-XXX-XXXX	
Greg Salgado, father's friend and neighbor	XXX-XXX-XXXX	
Peter Gordman, pastor	XXX-XXX-XXXX	

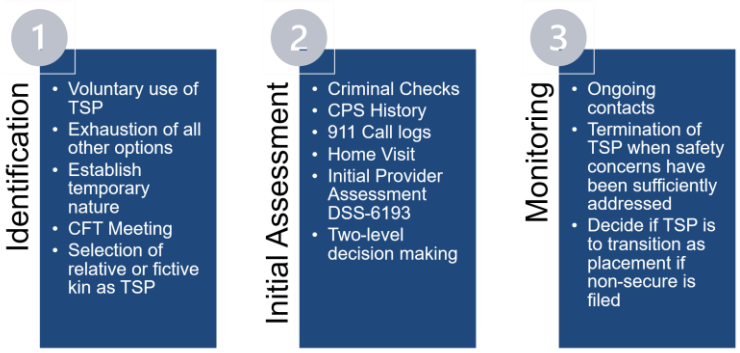
WHAT IS THE AGENCY AND/OR THE FAMILY WORRIED WILL HAPPEN TO THE CHILD'S SAFETY IF NOTHING ELSE CHANGES?

Describe the danger indicator (caretaker + behavior + impact on child)	What will be done to address the danger indicator until the next updated agreement? (proactive/ reactive)	Who will do it?	How will we know it is working?	What will people do if they believe the agreement is not working?
No adults were ensuring the children were safe, and the home contained an unsanitary environment where the children could have become sick or injured.	Gina and John agree to block off the living room (which has a hole in the roof and broken windows) until this room is cleaned, repaired, and approved by the caseworker. The grandmother agrees to come over and watch the children when Gina and John work on repairing the hole in the roof and the windows in the den.	Gina and John Sofia DSS caseworker	The caseworker will contact the maternal grandmother and confirm her willingness to go to Gina and John's home to watch the children during the times Gina and John are working on the hole in the roof and the broken windows in the living room until the family and DSS agree that the home is clean and hazard free.	Contact the caseworker immediately.
John left a nail gun and nails in reach of the children.	Gina and John agree to keep the nail gun and other tools stored in the shed, locked, and out of the children's rea	Gina and John	Sofia, Greg, and Gwen agreed to check on the children each of the next three days to ensure hazards are cleared and the children are safe. Greg will come in the mornings before the children go to school; Gwen will come in the evenings around dinnertime. On the third day, Sofia, Greg, and Gwen will let the caseworker know whether hazards have been found in the home and if the children are safe.	If hazards are found in the home, Greg will remove the hazards and contact Sarah, the caseworker.
Gina and John could not pay the electric bill, and the home was very cold. Food rotted without refrigeration, meals could not be prepared, and the children could not navigate safely through the cluttered home in the dark.	Gina and John had the electricity turned back on and agreed to reach out to their church for help maintaining electricity while the children were living there. Peter Gordman, the pastor at Gina and John's church, has agreed to help pay Gina and John's electric bill next month, and Peter will share whether another plan needs to be explored after this month.	Gina and John Pastor Peter Gordman	Caseworker will return home in 72 hours to confirm that the electricity is still on. Peter has agreed to contact the caseworker if Gina or John needs help paying their electric bill and the church cannot assist them.	John, Gina, or Peter will reach out to the caseworker if neither party can pay the electric bill.

Describe the danger indicator (caretaker + behavior + impact on child)	What will be done to address the danger indicator until the next updated agreement? (proactive/ reactive)	Who will do it?	How will we know it is working?	What will people do if they believe the agreement is not working?
Clutter in the home has reached a stage where the family, especially children, are at risk of heavy objects falling on them and injuring them. If there were a fire, people could become trapped as it would be difficult to exit.	With help from his friend Greg, John agreed to create clear walkways throughout the home by removing trash piles and stacks of furniture that might fall on the children or cause them to trip and fall. Greg will come to the house tomorrow by noon to help John clear the clutter.	John Greg	Caseworker will return to the home within 72 hours to confirm that the items in the "what will be done" column have been completed and see whether Greg and John need more time. Greg and John will share photos of their work with the caseworker when this task is complete.	John or Greg will reach out to the caseworker if they need more time to clear the clutter.
Gina and John have been unable to keep fresh food in the home or ensure the children are fed regularly. They also have not been able to keep up with the puppies' needs, and the feces left around could make the children sick.	Gina and John agree to keep a minimum supply of fresh food (not spoiled or rotten) in the home or have a plan for obtaining food, such as eating at their friend Gwen's house or going to the food bank. Gina and John agree to ensure that the children's sleeping area is free of animal feces by cleaning up after puppies (such as replacing dirty puppy pads) and keeping puppies out of the sleeping area (such as in a kennel instead). Network members will check the food supply in the home when they visit and ask the children what they are eating. Everyone in the family has agreed to "do chores" that include taking the puppies outside to the toilet every two hours and ensuring the puppies sleep in the kennel and not in the children's beds.	Gina and John Gwen Greg Sofia	The caseworker will check in with the family and the network to make sure that there is a minimum supply of fresh food in the home, that the family has a plan for obtaining food, and that sleeping areas are free of animal feces when she comes to the home on day 3.	Gina, John, Gwen, Greg, and Sofia will let the caseworker know if fresh food is not being kept in the house and if animal feces is found in the children's sleeping areas.

Safety Planning Beyond the Safety Assessment

Temporary Safety Provider



There are steps to implementing a Temporary Safety Provider as a component of Safety Planning. Prior to the child's placement with TSP, the following is required by policy:

- Background checks: criminal, CPS records including PATH NC, agency and RIL, 911 response logs
- Initial Provider Assessment DSS-6193 which includes a home visit and signatures
- Approval of the Initial Provider Assessment by supervisor, which must be signed within three days

Whenever a plan is made for children to leave the home, a Child and Family Team meeting is required as soon as possible.

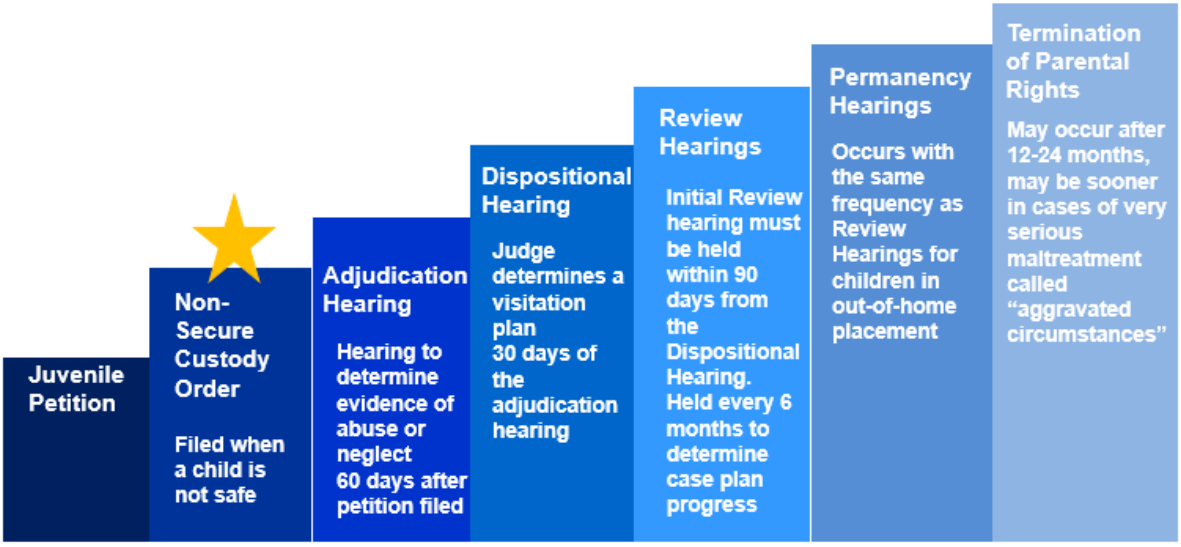
If the use of the TSP includes a provision that the TSP will supervise contact of the parents with the child, it must be clear that the arrangement remains voluntary on the parents' part. If at any time the parent is not in agreement with the need for the contact to be supervised, the county child welfare services agency must file a petition in juvenile court.

Monitoring the use of TSP throughout the assessment is required:

- Face-to-face contact with the victim children must occur at least once a week
- Face-to-face contact with the parent/caretaker must occur at least once a week
- Face-to-face contact with TSP must occur at least once a week, and observations must be made of the relationship between the TSP and parent/caretaker
- Face-to-face contact with all household members as needed to ensure the safety of the children
- To terminate use of a TSP, all three actions are required:
- Hold a CFT
- Develop a plan for return of the children to the care of their parent

- Perform a home visit in the parents' home within 24 hours after the children's return to the home. An interview with the children, separate from the parent, must occur within 24 hours after the children's return to the home

Filing a Petition



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

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

A CFT meeting is required when a petition is filed. It should be held before the court, if possible, to try to minimize trauma and make the process less adversarial.

The decision to take custody of a child is one of the most significant decisions a DSS Agency makes. While there are cases where it is necessary for the safety of the child, understanding how to engage children and families in safety planning effectively is critical to prevent unnecessary removal and trauma.

Notes

Key Takeaways

- Whenever a plan is made for children to leave the home, a Child and Family Team meeting is required as soon as possible
- If at any time the parent is not in agreement with the need for the contact to be supervised, the county child welfare services agency must file a petition in juvenile court
- When the safety decision on the safety assessment is **unsafe**, legal action is required
- Reasonable efforts are required to prevent custody

Notes

Self-Reflection

Mindfulness

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

When it has concluded, you are free to go, or if you have any questions, the training facilitators will be here.

Pre-Service Training: Core Week 4 Day 3 Agenda

Child Welfare in North Carolina Pre-Service Training: Core

Welcome and Introductions

Child Welfare Process Part 2: CPS Assessments, continued

Safety Assessment Learning Lab

BREAK

Child Welfare Process Part 2: CPS Assessments, continued

Additional Information to Support Assessment

LUNCH

SDM Family Risk Assessment of Child Abuse/Neglect

Risk Assessment

Structured Decision Making: Family Strengths and Needs Assessment

Family Assessment of Strengths and Needs

BREAK

Assessment Case Decisions

CPS Assessment Learning Lab

Self-Reflection

Mindfulness

Pre-Service Training: Core Week 4 Day 3 Learning Objectives

Day 3
Child Welfare Process Part 2: CPS Assessments, continued
Additional Information to Support Assessment
• Describe appropriate information to obtain from collateral contacts based on case circumstances • Demonstrate interviewing techniques • Explain what information can be shared with collateral contacts during CPS Assessments
SDM Family Risk Assessment of Child Abuse/Neglect
Risk Assessment
• Identify risk factors in child welfare cases • Identify protective capacities in child welfare cases • Describe how to complete the Family Risk Assessment of Abuse and Neglect Tool and when it is used • Apply findings of the family Risk Assessment of Abuse and Neglect Tool to next steps in case planning • Demonstrate strategies for engaging families in the assessment process
Family Assessment of Strengths and Needs
• Identify and describe family strengths • Identify and describe family needs • Describe how to complete the Family Strengths and Needs Assessment • Apply findings of the Family Strengths and Needs Assessment to case decisions and planning • Demonstrate strategies for engaging families in the assessment process
Assessment Case Decisions
• Describe the appropriate criteria for safe case closure • Incorporate information from assessment process into case decision • Explain the importance of supporting children and families through closure or transition

Core Week 4 Day 3

Child Welfare Process Part 2: CPS Assessments

Safety Assessment Learning Lab

Activity: Communicating Safety Plans

The purpose of this activity is for you to consider the importance of communication styles and how similar language can have differing meanings.

You training facilitator will lead you through an exercise. When the exercise is over, consider the following:

- How did this exercise feel?
- What challenged you about this exercise?
- How many of you completed the drawing?
- How easy was it to continue listening when you felt like you were not understanding?
- How does this exercise relate to safety planning with families?
- How will you know if a family member is confused or does not understand what you are saying?

Evans Family Safety Assessment Parts A-D

Activity: Completing the SDM Safety Assessment Skills Practice

Review the “Evans Family Case Scenario Initiation” handout on the following page, then find a partner and together complete Parts A-D of the DSS-5231 NC Safety Assessment.

You can access the DSS-5231 NC Safety Assessment on the state website, North-Carolina-SDM-Safety-Manual.pdf, or use the handout provided by trainers.

Use this space to create a Three Column Map for the Evans Family

Handout: Evans Family Case Scenario-Initiation

Interview Summaries

Shonda Evans-Mrs. Evans

- Mrs. Evans said that managing since her husband died has been very difficult. They had a good relationship, and he helped a lot with the kids. He worked an early shift and would always meet Kevin at the bus and pick Angela up from daycare.
- When asked her preference for what she wants to be called, Mrs. Evans explained that she prefers the term “Mrs.” over “Ms.” as it honors her marriage even after her husband’s passing.
- Mrs. Evans worked as a receptionist at an office until 3 weeks ago. The company changed its structure, and she was laid off. Angela had been in daycare until that time. She pulled Angela out of daycare to save money.
- Mrs. Evans stated that she has felt especially bad since losing her job. She says she spends most of the day looking at social media on her phone or watching TV. She said she takes care of Angela, feeds her meals and snacks, changes her diapers, and plays with her. She keeps Angela in her room with her during the day.
- Mrs. Evans stopped attending counseling and taking medication approximately two years ago. She says she is always so tired now and can sleep during the day but has a hard time falling asleep at night. Mrs. Evans states that she feels sad and hopeless most days since she lost her job but denies any thoughts of wanting to harm herself. She denied any current or previous substance misuse.
- On the day of the bath incident, Mrs. Evans admits she was unaware that Kevin was giving Angela a bath. She said Kevin has tried to be “the man of the house” since his father died and says she feels like she has been relying on Keisha and Kevin too much to help around the house. When Angela fell out of the tub and hurt her head, Kevin was very upset and didn’t know what to do. He was crying, which is what alerted Mrs. Evans to the situation. She calmed the children down and got ice for Angela’s head. When the bruise started to form, Mrs. Evans called the oncall nurse at the pediatrician's office, who indicated that Angela didn’t have to be seen immediately because she was eating and drinking fine. Mrs. Evans brought Angela to the doctor the next day and everything was okay. She understands that Kevin giving Angela a bath can be dangerous and says she spoke to Kevin about not bathing Angela without an adult helping. Mrs. Evans said that she knew Kevin sometimes fed Angela dinner.
- Mrs. Evans tries to be at the bus stop every day to get Kevin but has missed it a few times in the last few weeks. On those days, the school called, and when Mrs. Evans did not answer, they contacted the grandmother, Kim Evans, who picked Kevin up to take him home.
- Mrs. Evans said Keisha is doing well in school and is a big help, she is very busy with her extracurricular activities.
- Mrs. Evans said her support system is her mother-in-law, her friend from high school who lives in town, and two older women from church. She feels disconnected from all these people since Mr. Evans’ death.

- Mrs. Evans found her previous counseling helpful.
- Mrs. Evans expressed concern about money. She has some income from Mr. Evans' Social Security but does not think they can manage bills very long if she is unemployed.
- Mrs. Evans reports that she grounds Keisha and takes away her phone if she gets in trouble, that she spanks Kevin when he gets in trouble, and she will pop Angela on the hand if she is trying to get something she shouldn't have.
- Mrs. Evans says she loves her children more than anything in the world and will do anything to keep them. She understands that Kevin should not be caring for Angela and agrees that more support from her mother-in-law would be good for the children.
- Mrs. Evans stated that she believes her sadness is due to grief and is not her depression returning.

Keisha Evans

- Keisha attends school, has a B+ average, and is a cheerleader and in chorus.
- Keisha said she wakes herself up in the morning, eats breakfast and lunch at school, and usually makes something for herself when she gets home.
- Keisha reported that her mother has seemed sad since her father died. She got a lot worse since she lost her job. Keisha says she tries to stay busy and out of the house as much as she can because it makes her sad to see her mom like this.
- Keisha tries to help with the dishes and says she makes Kevin dinner most nights and eats with him. She also supervises his homework.
- Keisha said she hasn't really thought about what her mom does at home with Angela all day, but that Angela seems fine.
- Keisha says her mother does spank Kevin and he cries but it doesn't leave any marks.

Kevin Evans

- Kevin attends elementary school and says he likes it.
- Kevin says he is a big boy and tries to help mommy out with the baby.
- Kevin says he isn't allowed to give Angela baths anymore after "she got hurt." Kevin described that Angela was very slippery when he lifted her out of the bath, and she fell and bonked her head on the toilet. Angela started to cry, and Kevin got very worried that he couldn't calm her down. Kevin said he was so scared that "he hurt Angela real bad." Kevin indicated that mom came and got Angela ice and told him to calm down. Kevin says he will never give Angela another bath, that scared him.
- Kevin said his mom is really sad since his dad died and started crying when talking about it.
- Kevin eats breakfast and lunch at school, he said that Keisha makes him dinner most nights, but sometimes he heats food for him and Angela in the oven if his mom is asleep and Keisha is not home.
- Kevin had scraped knees, he said he fell on the playground and had no other visible marks or bruises.

Angela Evans

- Mrs. Evans said Angela can say a few words, but she did not speak during the initial visit.
- Angela did walk around the living room. She picked up a book when the social worker asked her to and was able to point at pictures.
- Angela cried when she separated from her mother.
- Angela had a purplish, raised marking on her forehead above her right eye. The mark was about 1.5 inches in diameter and somewhat oblong in shape.
- Angela appeared to have very dry, cracked skin on her arms and legs and had a diaper rash.

Kim Evans-Paternal Grandmother, Collateral Contact

- Mrs. Evans said that she did not want to call CPS but felt that her daughter-in-law has pushed her away since her son's death.
- Mrs. Evans said she did not have concerns about how her son and daughter-in-law took care of the children prior to his death.
- Mrs. Evans says she only works part-time now and wants to be a help to the family.
- Mrs. Evans is worried that Angela is not getting the care she needs during the day. When she stops in, her daughter-in-law appears groggy and is always in her room with Angela with the door closed.
- Mrs. Evans has seen Kevin try to make Angela dinner and snacks on multiple occasions. She said the other day he told her he was giving Angela a bath because he fed her dinner and she got really messy, and he didn't want his mom to get mad.

House Walk Through

The initial home safety check noted the following:

- Dirty dishes were stacked in the sink and on the counters and kitchen table.
- There were also dirty dishes in other rooms in the house.
- The refrigerator contained minimal food. On this day, an open pack of hotdogs was found, with four hot dogs left in the package.
- There was a carton of milk – sell by date was checked – the milk was out of date and smelled sour.
- There was a 6 pack of Jello in the little plastic containers.
- There were two lbs. of raw ground beef in the refrigerator.
- In the cabinet were two large boxes of cereal – Cheerios.
- There was some dry biscuit mix and a cornbread mix.
- There was a can of spaghetti sauce and a box of spaghetti.
- There is one bathroom in the home and the toilet had not been flushed after use – although it could flush.
- There is hot and cold running water in the home.
- The home has electricity and there are no exposed wires
- Sleeping space was examined and the following was noted:

- One double bed for mom with a crib in the room for Angela. Keisha and Kevin each have twin beds in their own rooms.
- Mrs. Evans does have a car with a car seat for Angela and a booster for Kevin.

Medical Consultation

While at the home, Caseworker and Mrs. Evans contacted Greentree Pediatrics. It was confirmed Mrs. Evans contacted the pediatrician at the time of the incident, and it was determined she did not need to be seen the same day. Angela was seen the day after the injury and was medically cleared.

Safety Concern Discussion

- Kim Evans is willing to help support the family by stopping by the home one or two times a day. Mrs. Evans agrees that Kim Evans will check in each morning and after school each day to monitor and support her ability to meet the children's needs.
- When asked about Kevin heating food in the oven, Mrs. Evans stated that she was unaware that Kevin had been using the oven or stovetop. Kim Evans offered to buy knob covers for the range, and Mrs. Evans agreed to install them.
- The social worker engages Mrs. Evans in conversation about the impact of grief on her mental health and ability to provide safety and care for her children at this time. Mrs. Evans agrees that she is experiencing grief. She struggles to acknowledge the impact on her ability to care for her children. Mrs. Evans indicated that she would be willing to explore mental health services and grief counseling, or a support group.

Evans Family Harm and Worry Statements

Activity: Harm and Worry Statement Skills Practice

The purpose of this activity is to practice writing harm and worry statements using a case scenario.

What to Do:

With your partner, use the specific information you identified in the previous activity to construct harm and worry statements that address the identified danger indicators for the Evans Family:

Reminder: Identified Danger Indicators

- 4: Caretaker fails to provide supervision to protect the child from potentially serious harm
- 10: Caretaker's physical ability, mental health, or cognitive status seriously impairs their ability to maintain/obtain appropriate supervision, protection, or care for the child.

Harm Statement

It was reported	Caretaker action/inaction	Impact on the child

Worry Statement

Child	May be impacted how	If/when context

Evans Family Part E Safety Plan

Safety planning is completed in partnership with families. Due to the inability to simulate family input in the training environment, the safety plan will be utilized without access to family voice.

Activity: Part E: Safety Plan Skills Practice

The purpose of this activity is to practice creating a safety plan using case scenario information.

What to Do:

Find another pair and together form a group of four. In your group, complete Part E of DSS-2531 SDM Safety Assessment for the Evans Family, using the "Part E: Safety Plan" handout on the following page.

Access directions on the state website North-Carolina-SDM-Safety-Manual.pdf.

Check your work by considering the following:

- Is it an action plan for changed behavior?
- Response to clearly identified danger indicators?
- Is it short-term?
- Does it include family, network, and older children?
- Does it have clear backup and monitoring plans?
- Does it describe a clear time for review?

When prompted to do so, write your response to "what is the agency and/or the family worried will happen to the children's safety if nothing else changes" on the designated flip charts.

Handout: Part E: Safety Plan

Part E: Safety Plan				
What harm has occurred				
Who has agreed to be a part of the safety plan				
What is the agency and/or the family worried will happen to the children's safety if nothing else changes				
Describe the Danger Indicator	What will be done to address the danger indicator until the next updated safety plan (proactive/reactive)	Who will do it?	How will we know it is working?	What will people do if they believe the safety plan is not working?

Additional Information to Support Assessment

Collateral Contacts

Collateral contacts are essential sources of information in the assessment process, offering insights that may not be shared directly by the family. Professionals and non-professionals within the family's networks, such as educators, counselors, or social service providers, can serve as collateral contacts.

Families should be informed about the role of collaterals in the assessment process.

Notes

Policy Requirements and Confidentiality

Approaching and interacting with collaterals in a manner that respects child and family privacy and maintains confidentiality is key.

Policy requires contacting at least two collateral sources during the CPS Assessment phase, though more may be needed depending on the case. Specific allegations and intake documentation may dictate who must be contacted.

Collateral contacts should be individuals with meaningful knowledge of the family, such as those identified by the family, listed on the CPS Intake Form, or affiliated with agencies currently involved with the family. Their input should be gathered early and documented using the CPS Documentation Tool.

Confidentiality is critical when engaging collateral contacts. Caseworkers must identify themselves and explain the purpose of the interview without sharing details of the allegation or other sensitive information. Information should flow one way—from the collateral to the worker.

Harm and worry statements help establish a shared understanding with the family about DSS involvement. While specific allegations may not be shared with every collateral, a general, family-centered approach to discussing safety concerns is encouraged.

Notes

Interviewing Considerations

Building Relationships: Engagement skills support trust-building, even in brief interactions. Timely communication and respectful behavior help foster cooperation.

Clearly Define Roles: Collaterals need to understand DSS's role and their own. Clarifying roles reduces confusion and supports collaboration, especially with professionals and family members.

Create Shared Understanding of Terminology: Caseworkers should avoid jargon and acronyms. Use clear, family-centered language, like harm and worry statements to ensure everyone understands the concerns.

Establish Processes and Protocols: Caseworkers should explain their role, the purpose of the interview, and how information will be used. Maintain confidentiality—information should flow from the collateral to DSS only.

Notes

Additional Resources to Support Assessment

Consultation with healthcare providers is required when injuries are alleged or found on a child who is under three years of age and/or non-verbal.

- Consultation for the child must be sought from a healthcare provider.
- Consultation may be obtained virtually, by phone, or in person.
- Consultation must occur before completion of the Safety Assessment
- This is not required when the screened-in report comes from a healthcare provider or agency

The Child Medical Evaluation Program has four main components:

- Administrative office staffed by caseworkers and medical providers who are a resource for accessing available consultations during CPS Assessments.
- Child Medical Evaluation consultations: An outpatient medical evaluation of suspected child maltreatment completed by rostered providers
- Regional Abuse Medical Specialists (RAMS): consultation for cases with specific concerns for children three and under where there are concerns for unexplained or poorly explained injuries, sexually transmitted infections, lives in a home another child has died in as a result of abuse or neglect, cases with concern for medical child abuse, or where medical neglect is alleged for a child who is medically complex and meets other criteria.
- Clinical Assessment of Protective Parenting (CAPP) completed by rostered providers: an empirically-supported program that assesses the current risk and potential of future harm that a caretaker may pose to a child and assists in identifying services that will enhance a parent's capacity to provide for their child's needs

Notes

Ongoing Quality Contacts

Contact frequency is based on safety and risk:

- CPS requires at least two face-to-face contacts per month, spaced 7 days apart,
- More frequent visits may be needed depending on safety concerns.
- Supervisors should be consulted to determine appropriate contact levels

Ongoing contacts support safety and assessment:

- Each contact helps ensure child safety, assess risk, monitor safety plans, track progress, and identify family strengths and needs
- If a Safety Plan is in place, workers must observe caregiver behavior, review the plan with the family, and revise interventions if safety threats persist or progress is not evident

Quality contacts require intentional practice:

- Effective contacts involve preparation, engagement, follow-up, and documentation.
- Caseworkers should use empathy and active listening to support meaningful dialogue and decision-making

Notes

Activity: Interview Observation

Listen and observe as the trainers demonstrate an interview with Kevin.

Note: This is not the first time Kevin is being interviewed.

Use the observation worksheet below to record notes.

What would Kevin say about the worker's ability to engage him in creating a sense of psychological safety?
Did the worker give Kevin choices?
Did the worker hear Kevin's voice?
Did the worker create a safe physical space for the conversation to occur?
Did the worker accurately reflect what Kevin was saying?
Did the worker make a successful effort to lessen the power differential?
Did the worker demonstrate respect for Kevin?

Did the worker demonstrate genuineness in interactions with Kevin?
Did the worker demonstrate empathy in interactions with Kevin?
Did engagement with Kevin occur?
Did the worker “hear” Kevin?
If you were providing this worker feedback on the interview, what would you say?

Key Takeaways

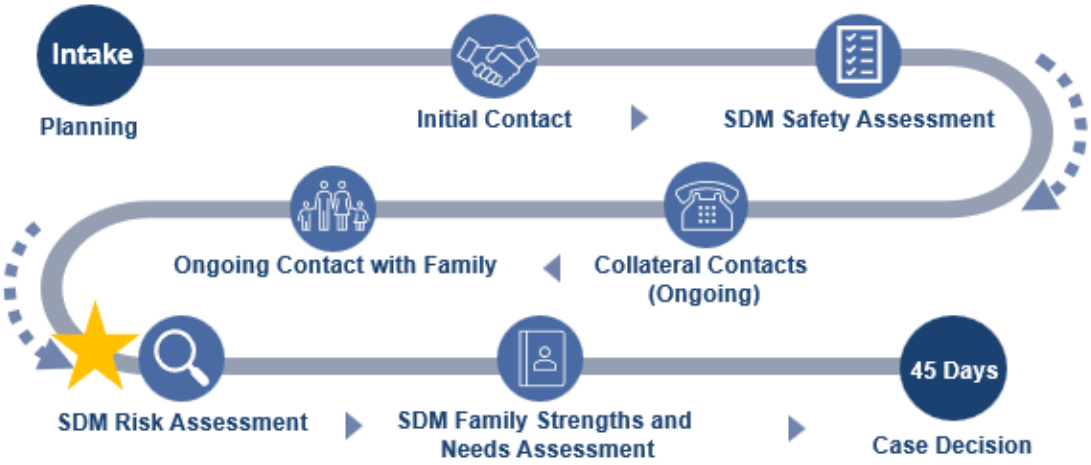
- Collaterals contacts are necessary for comprehensive assessment
- Information sharing with collaterals is a one-way street
- CMEP and CFE are statewide resources to enhance assessments
- Monitoring a Safety Plan ongoing is critical

Notes

SDM Family Risk Assessment of Child Abuse/Neglect

Risk Assessment

Overview of CPS Assessment Process



The SDM® Risk Assessment is required to be completed within 45 calendar days of the CPS report, before or at the time of case closure. Structured Decision Making (SDM) tools support informed decision-making, but they are only one component of a comprehensive social work assessment that includes engagement, observation, and professional judgment.

Familiarity with the Risk Assessment Tool is essential, as it plays a critical role in guiding next steps in case planning.

Notes

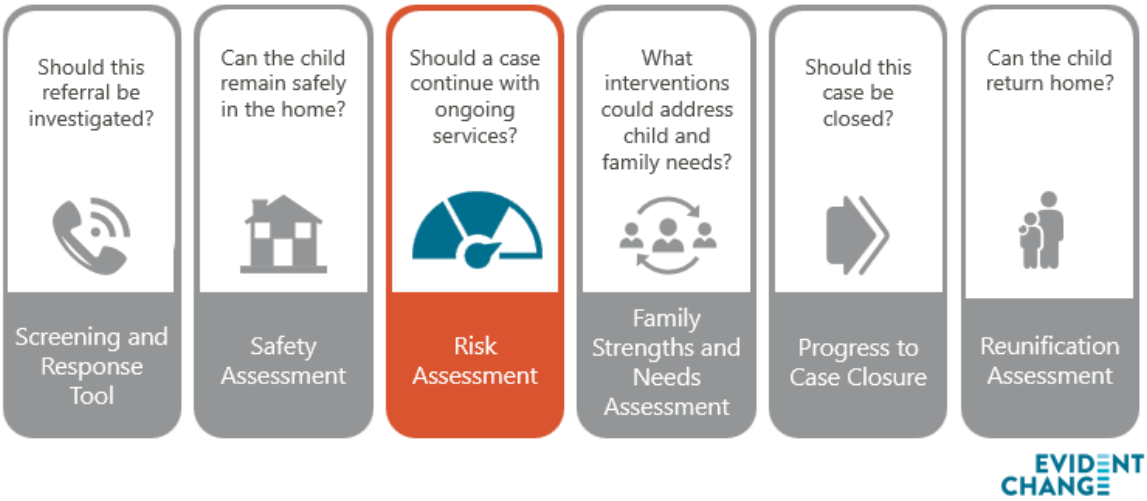
Family-Centered Risk Assessment

Activity: Family-Centered Risk Assessment Skills Practice

The purpose of this activity is to promote reinforcement and memory of strategies to help caseworkers take a family-centered approach to assessing risk.

What skills and strategies have you learned that will help you take a family-centered approach to risk assessment?

Family Risk Assessment of Abuse/Neglect DSS-5230



The SDM® Risk Assessment supports answering the questions about whether a case should continue with ongoing services. Risk refers to the likelihood of future maltreatment; the SDM® Risk Assessment evaluates the risk of future system involvement. The SDM® Risk Assessment is an actuarial tool that utilizes a classification system, rather than a prediction system.

SDM® Risk Assessment is completed based on all information obtained during the assessment including:

- Face to face interviews with and observations of parents, caretakers, others living in the home, and the children
- Pertinent collateral contacts and safety network members
- Documented records such as criminal and medical records

Notes

SDM® Risk Assessment Overview

There are three sections of the SDM Risk Assessment DSS-5230:

- Neglect and Abuse Indices: single stream of questions, scored separately
- Scored Risk Level: total score calculated from responses to index items
- Override: provide for policy or discretionary override, if applicable

PATH NC automatically scores and totals the neglect and abuse scores. You can access the SDM® Risk Assessment Policies and Procedures Manual on the NC Child Welfare website: https://policies.ncdhhs.gov/wp-content/uploads/North-Carolina-SDM-Risk-Assessment_FINAL-2025-1.pdf.

Notes

Understanding Risk Levels

FINAL RISK LEVEL	FINAL SAFETY ASSESSMENT DECISION		
	Safe	Safe With a Plan	Unsafe
Low	Do not open a case	Open an in-home case	Open an out-of-home case
Moderate			
High	Refer to prevention services		

EVIDENT CHANGE

Risk assessment results do not impact case decisions, as the presence of a danger indicator is required to make a finding of substantiation or services needed.

Risk Assessment scores can provide context for risk factors and facilitate prevention service coordination in the absence of safety threats or danger indicators.

§ 7B-300. Protective services. "…to prevent abuse or neglect, to improve the quality of childcare, to be more adequate parents, guardians, or caretakers, and to preserve and stabilize family life."

This graphic illustrates recommendations for case outcomes based on the outcomes of the SDM® Safety Assessment and Risk Assessment.

How do you imagine the scores of the SDM Risk Assessment can support crucial conversations with families?

Identifying Risk Items

Activity: Identifying Risk Items Skills Practice

The purpose of this activity is to practice using SDM Risk Assessment with case scenarios.

What to Do:

Look up the SDM® Risk Assessment Policy & Procedure Manual on the state website: North Caroline SDM® Risk Assessment.

Consider the definitions when screening the scenarios below

Scenario	Corresponding Risk Item	Score
A Family has three prior investigative assessments: two for neglect and one for abuse		
A 3-year-old child is diagnosed with autism		
At the time of the assessment, four children lived in the home (ages 3, 5, 7, and 9)		
Dad has a history with DSS as a child victim		
Current CPS assessment involves Mom and is for neglect		
Dad denies having a drinking problem and has never received treatment. He drinks every day, has lost his job due to showing up drunk multiple times, and was arrested last month for drunk driving while the kids were in the car		
A family with a 2-year-old child is experiencing homelessness, living in their car during winter months, with potential temperatures in the low 30s		
Caretaker was hit in the face by their partner (secondary caretaker), in front of her 5-year-old, two days ago, which prompted a call to DSS.		

Scenario	Corresponding Risk Item	Score
Caretaker disclosed that this is not the first time their partner has abused them		
There is only one caretaker residing in the home		

Key Takeaways

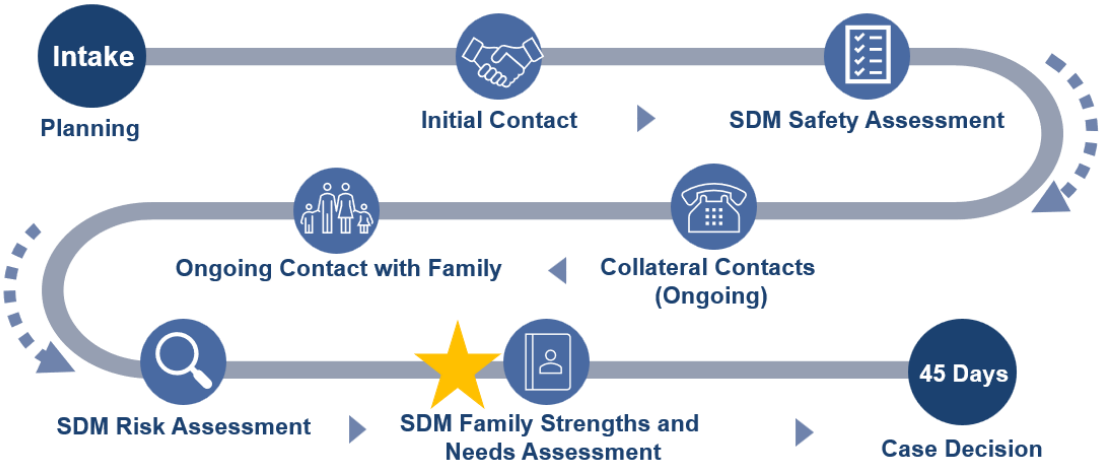
- Risk is assessed throughout the life of a case
- The Family Risk Assessment of Abuse or Neglect helps understand the need for future DSS involvement
- Risk scores are on a continuum: low, moderate, and high
- Risk factors are associated with the likelihood of future maltreatment
- Family engagement is key to assessing risk

Notes

Structured Decision Making: Family Strengths and Needs Assessment

Family Assessment of Strengths and Needs

Overview of CPS Assessment Process



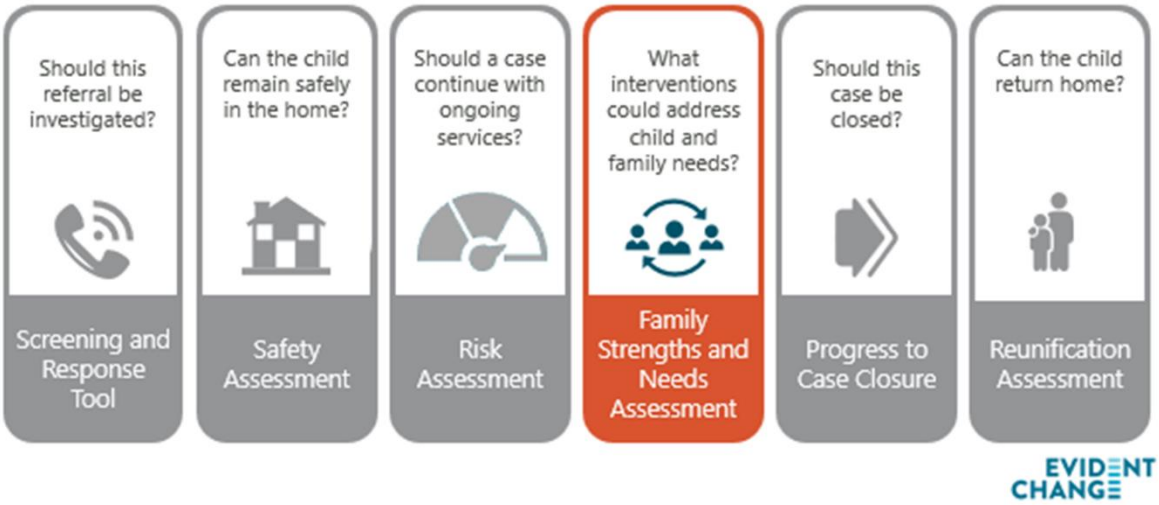
The SDM Family Strengths and Needs Assessment is required to be completed within 45 calendar days of the CPS report, before or at the time of case closure if the case is going to In Home or Foster Care. The Child Strengths and Needs Assessment must be completed within the exact timeframes when Child Characteristics are identified on the FSNA.

Structured Decision Making (SDM) tools support informed decision-making, but they are only one component of a comprehensive social work assessment that includes engagement, observation, and professional judgment.

Familiarity with the FSNA Tool is essential, as it plays a critical role in guiding next steps in case planning.

Notes

NC Family Strengths and Needs Assessment

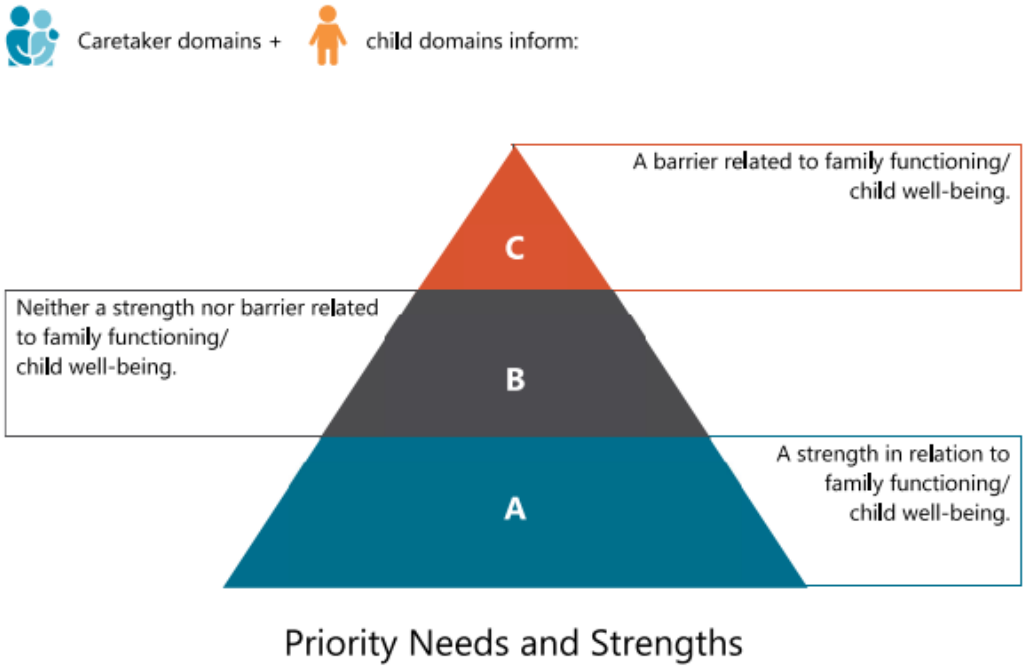


The purpose of the FSNA is to identify and prioritize the needs of a family to be addressed in a case plan. Many families we work with have multiple needs, but we can't focus on everything at once. Where to start? The FSNA also ensures that we see not only the needs of families, but also their strengths. Knowing both the priority needs and the strengths prepares us to develop a case plan in conjunction with the family.

The FSNA informs case planning over time. It serves as a mechanism for monitoring service referrals made to address the family needs. Unlike the risk assessment tool, which looks only at statistically relevant items, the FSNA provides a comprehensive overview of family functioning in areas related to caretakers' ability to parent and protect their children. It can also guide reassessment, as the family's functioning changes over the life of their case.

Notes

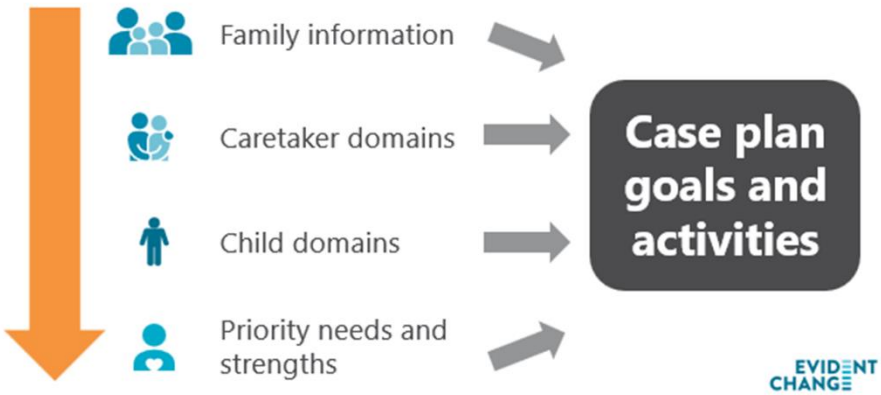
FSNA Structure



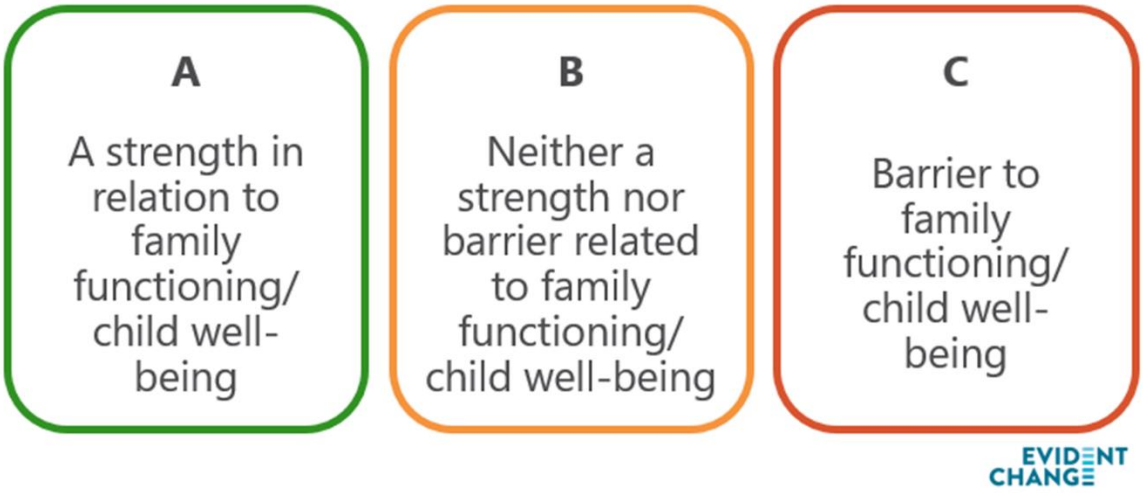
The FSNA is structured with several components:

- Family Information, including household context, which has sections for social and ethnic identity important to caretakers and connecting heritage, traditions, values, beliefs, identity, and caretaking
- Caretaker Strengths and Needs Domains
- Child Strengths and Needs Assessment
- Prioritization of Strengths and Needs

If there is more than one caretaker in the home, complete a separate assessment for each one.



Item Thresholds



Each domain has three levels:

A: Strength in relation to family functioning/child well-being

B: Neither a strength nor a barrier related to family functioning/child well-being

C: Barrier to family functioning/child well-being

There are no numerical or weights associated with scoring. Any domain designated as C must be considered and prioritized to include in the case plan.

Notes

FSNA Practice

Activity: FSNA Skills Practice

The purpose of this activity is become familiar with the definitions for each domain.

Working in small groups or pairs, consider the vignettes and how they would be scored on the FSNA.

Utilize the SDM® FSNA Policy & Procedures Manual, accessed on the state website NC SDM® FSNA Manual

Item	Vignette	Score
SN1. Emotional/Mental Health	Parent has depressive symptoms and anxiety. She was taking medication and seeing a therapist but recently stopped both for no clear reason. Her mental health has been declining and occasionally affects her children. For example, sometimes she will feel too depressed to cook, so the 10-year-old must prepare dinner for her siblings most days of the week, or at times, the parent's anxiety will keep her from taking her children to social events	
SN2. Caretaking Skills and Practices	Parent is warm and nurturing with his young children. He understands typical development well and provides age-appropriate toys and activities for his children. He has significantly supported his children during the pandemic, helping them transition from virtual learning back to in-person schooling by helping them with homework and structuring their study time.	
SN3. Substance Use	Parent's ongoing alcohol use resulted in him leaving his young children unsupervised, which led to the current involvement of child protection. He is often passed out or at the bar when he should be caring for the children. On two previous occasions, he drove under the influence, which resulted in him being arrested.	
SN4. Basic Physical Needs	Parent is currently unemployed and struggling to pay rent. They are worried that they and their family may be evicted since they cannot afford rent this month. Family has sought out emergency resources and employment opportunities. The home had no water before child protection	

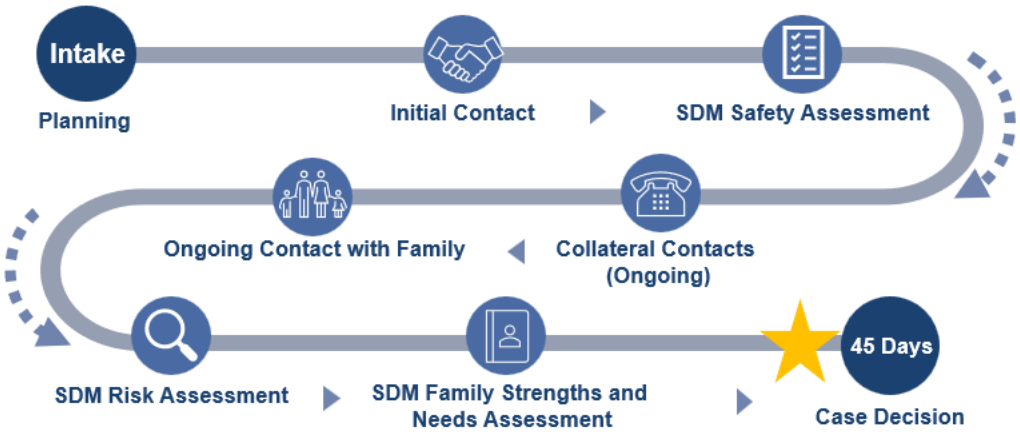
Item	Vignette	Score
	intervention because the parent is three months behind on rent and water bills. Parent secured water from the store and the kids took baths next door at the neighbor's home.	
SN5. Resource Utilization	Caretaker had just given birth to her first child. Caretaker has obtained WIC to ensure her baby is getting what they need to stay healthy	
SN6. Household Relationships	Parent is the only adult in the household. They have friends and family who visit the household, but none participate in caregiving for the children	
SN7. Domestic Violence	Parent is not currently in an intimate relationship, has no documented DV history, and has taken protective steps to avoid violent relationships.	
SN8. Social Support System	Parent relies on her sister and one of the child's grandparents to provide emotional support and help with childcare when she feels overwhelmed. She is active in a local group that mentors youth and can depend on several close friends from her church. She is comfortable reaching out for support when needed and has done this recently	
SN9. Physical Health and Wellness	Parent has migraines that occur about every week. He is less able to be present for his children during these times, but he still can provide for his children's basic needs	
SN10. Coping Skills	When parent gets stressed, she can step back from what is stressing her out, count to 10, and calm down before responding. She enjoys running, and she uses that as an outlet when highly stressed. She is kind and patient with her children, even when they misbehave	
SN11.Challenging Child Characteristics	Caretaker's 14-year-old is habitually getting in trouble at school. He has been suspended twice and is on probation for stealing a car. The caretaker dropped the 14-year-old off in front of the DSS office and drove away	
CSN1. Family of Origin Relationships	A 12-year-old has a "decent" relationship with her parent and sister. She reported that her 14-year-	

Item	Vignette	Score
	old brother has behavioral issues, and that this occasionally causes stress and discord at hoe. Despite this, the child reports feeling connected with her family, even while in placement.	
CSN2. Social Relationships and Skills	A 15-year-old is student council president and swim team captain, and she has a group of close-knit friends. She has strong relationships with her friends and their parents and is a skilled communicator in conflict. She is often the mediator and organizer of her friend group.	
CSN3. Relationships with Caretakers	A 13-year-old feels uneasy about being placed because they did not know their caretaker before the placement. They have struggled to adjust to their caretaker's new rules, and they have gotten into several arguments with the caretaker about things such as curfew or social activities. The child reports feeling unhappy in their placement and wants to go home to their parents as soon as possible. Caretakers have never had a teenager placed with them before and are feeling very overwhelmed, causing more conflict between them and the child	
CSN4. Physical and Cognitive Development	The primary doctor of an 8-year-old reports that the child's development is on par with other children in her age group.	
CSN5. Emotional/Behavioral Health	A 15-year-old struggles to articulate her feelings and respond to them in healthy ways. She often acts out when she does not get her way. Recently, when her caretakers grounded her, she began screaming and threw two plates across the room, breaking them. She struggles with depression and recently stopped taking her medication. She has lost interest in all her hobbies.	
CSN6. Physical Health	A 4-year-old has asthma that requires a nebulizer and an inhaler. She needs an adult to help administer her medications, and her caretakers encourage her to communicate how she feels	

Item	Vignette	Score
	when she needs her medication. She hasn't had an asthma attack in the last year.	
CSN7. Substance Use	A 15-year-old reportedly binge drinks multiple times a week. He has been hospitalized for alcohol poisoning twice, and he has spent time in rehab to safely detox. He is failing nearly every class because he skips school to drink. He promises he is done drinking; however, he has said this before and continued to drink.	
CSN8. Life Skills	A 17-year-old in out-of-home care has been at their part-time job for almost two years. They have $2500 saved up and will earn about $100 a week more if they take the promotion that has been offered. They know how to manage a household budget and manage their money well. They regularly keep their room clean and help complete household chores. They are interested in other ways to maintain a household day to day and regularly ask caretakers about learning new skills.	
CSN9. Education/ Employment/Day Program	A 16-year-old is doing well overall in school. They are exceeding expectations in most of their classes but struggle a bit with math. The student asks for assistance and advocates for themself.	

Assessment Case Decisions

Assessment Decision

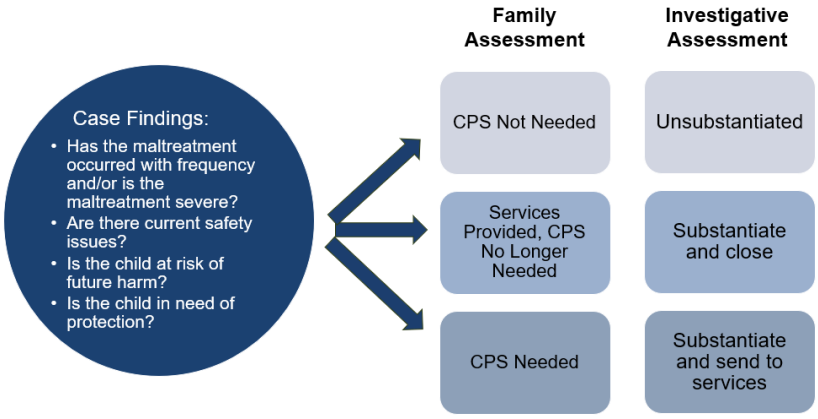


By the end of the 45-day CPS Assessment period, the following core responsibilities will be complete:

- Engage and Assess: Make initial contact with the family, complete the Safety Assessment tool, and conduct ongoing contact to monitor safety and assess risk, strengths, and needs
- Implement Supports: Create and monitor a Safety Plan if needed, and implement strategies to address identified needs
- Gather and Document: Contact collaterals and the family's safety network, document all activities in the PATH NC, and synthesize information for decision-making
- Consult and Decide: Regularly consult with your supervisor and, before day 45, make a case decision

Notes

Case Decisions



Determining whether a child is abused, neglected, and/or dependent requires careful assessment of all the information obtained during the CPS Assessment process.

The following questions must be answered in determining the case decision. A “yes” response to any of these questions indicates a need for ongoing child welfare intervention.

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

Are there current safety issues?

Is the child at risk of future harm?

Is the child in need of protection?

Case decision is a two-level decision, so, at a minimum, should include the caseworker and supervisor. Findings must be correct based on legal definitions of abuse, neglect, and dependency, and how they relate to child maltreatment.

Notes

CASE FINDINGS:

Case findings for **Investigative Assessments** are Substantiate OR Unsubstantiate.

Case findings for **Family Assessments** include:

- Child Protective Services Needed: This finding is appropriate when neglect and/or dependency was found to have occurred, and where there are safety issues and a future risk of harm, the agency must provide non-voluntary protective services to ensure the safety of the child. The finding of Child Protective Services Needed must be made, and the local county child welfare agency must continue to provide involuntary CPS In-Home Services in every case the agency believes:
    - The family must be involved with services (of any type, provided by any agency or individual) for the child to safely remain in the home OR
    - The child would not be safe if the family ever becomes noncompliant with services.

- Services Provided, Child Protective Services No Longer Needed: This finding is appropriate for all CPS reports of neglect and dependency assigned to the Family Assessment Track in which the safety of a child and future risk of harm were at some point in the assessment high enough to require non-voluntary services, but the successful provision of services during the assessment has mitigated the risk to a level in which involuntary services are no longer necessary to ensure the child's safety. To close cases with this finding, at the time of case decision, the child cannot have current or ongoing neglect and/or dependence concerns, and the safety and future risk of harm of the child is not an issue. This case decision can only be chosen when non-voluntary protective services are not required to keep the children safe. A case decision of Services Provided is not appropriate for cases where the family is engaged in service provision that if ended once the case is closed would result in safety concerns for the children.

- Child Protective Services Not Needed: This finding is appropriate for all CPS reports of neglect and dependency assigned to the Family Assessment Track in which the safety of the child is not an issue, there is no concern for the future risk of harm to the child. This case decision is chosen when non-voluntary protective services are not required to keep the children

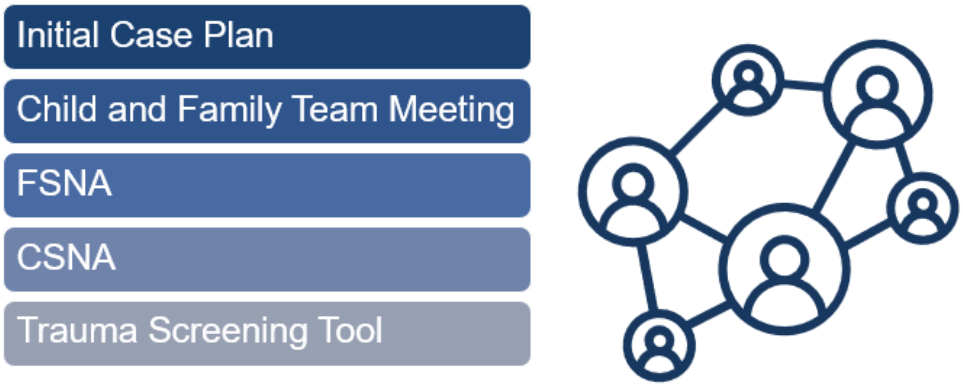
Notifications

The following individuals must be notified in writing of the CPS Assessment case decision within 5 business days:

- Parents and caregivers including those assumed of maltreatment, primary caretakers for the children and other parents as appropriate
- Any agency in which the court has vested legal custody
- The licensing authority as appropriate
- Responsible Individuals List (RIL), if needed
- The Central Registry, which is accomplished through completion of the assessment in PATH NC
- All reporters

Notes

Case Transfer Tasks: Opportunities to Engage



When transferring a case to ongoing services, such as In-Home or Permanency Planning, additional tasks are required:

- Initial case plan
- Child and family team meeting
- FSNA
- CSNA for cases where challenging child characteristics are identified as a need and all children for all Permanency Planning cases
- Trauma Screening Tool

Completion of these tasks is an opportunity to engage the family in the case transfer process.

How might you engage the family in the transfer process using these required tasks?

What factors exist during the transfer period that can create challenges to engagement?

Key Takeaways

- The purpose of the FSNA is to identify and prioritize the needs of a family to be addressed in a case plan
- The CSNA is completed in specific circumstances to prioritize child-specific needs
- Assessment case decisions are based on a synthesis of all information gathered during the CPS Assessment
- Case decision options vary between Family and Investigative Assessments
- Engage families in ongoing conversations about next steps in a case

Notes

CPS Assessment Learning Lab

Evans Family Risk Assessment

Activity: Evans Family Risk Assessment Skills Practice

The purpose of this activity is for participants to practice completing SDM Risk Assessment DSS-5230 utilizing a case scenario.

What to Do:

Review the "Evans Family Case Update" Handout that follows this activity.

Complete the DSS-5230 SDM Family Risk Assessment of Child Abuse/Neglect

- Access on the state website North Caroline SDM Risk Assessment
- Use the DSS-5230 handout provided by training facilitators

Handout: Evans Family Case Update

Collateral Contacts

Ms. Anne Tate, LPC, counselor at Family Hope Services

- Ms. Tate confirmed that Family Hope Services received Social Worker's referral regarding an intake for Shonda Evans.
- Ms. Tate indicated that two voice messages had been left for Mrs. Evans with no return call. Social Worker confirmed the contact information for Mrs. Evans.

Dr. Steven Fener, school counselor at Kevin's elementary school

- Dr. Fener reports that this school year Kevin has been tardy at least twice a week and that his teacher has expressed concerns about Kevin being emotional in class (crying) and isolating from his peers.
- Dr. Fener said Mrs. Evans has not been responsive to attempts by the school to contact her to schedule a conference this year.
- Prior to this school year, there is no history of concerns about Kevin.

Sarah Wexler, Practice Administrator, Greentree Pediatrics

- All the Evans children are up to date on shots and have regular EPSDT screening visits.
- Mrs. Evans brought Angela in a week ago. She was prescribed an ointment for a significant diaper rash and diagnosed with eczema. Mrs. Evans was provided with care instructions for treating her skin ongoing.
- The practice is aware of Keisha's history of sexual abuse. They know she participated in counseling at the time, but it was discontinued after about 18 months.
- No concerns are noted in any of the children's charts regarding health and wellbeing.

Mrs. Denise Shaver, friend of Mrs. Evans

- Social worker met with Mrs. Shaver and Mrs. Evans together. Mrs. Shaver is the wife of the pastor at Mrs. Evans' church. She expressed deep concern that Mrs. Evans is struggling the way she is.
- Mrs. Shaver has organized a meal train for the Evans family so a church member will stop by 3 nights a week with a prepared dinner for the Evans family. Mrs. Shaver says that Mrs. Evans has agreed to this help and to invite the church member to stay for dinner for additional company.
- Mrs. Shaver has offered to come pick up the Evans family on Sunday morning to take them to church and Sunday School. There is a widow's group that meets once a month at a church member's house and she would be happy to connect Mrs. Evans to that network.

Quality Contact Follow Up Documentation

- Grandma Kim Evans said that Mrs. Evans accepts help when she stops by the home, but has not called for help or support. She stated that on several occasions, Mrs. Evans had been asleep when she showed up at the home in the afternoon and expressed concern that Mrs. Evans had been leaving Angela without supervision while she slept.
- Kevin shared that one day at dinner time, his mama was asleep, and Keisha was not yet home from school. He and Angela were hungry, so he made sandwiches for them to eat. When Keisha got home late, she sent him and Angela to bed. Kim Evans stated that one day Keisha called and told her that Mrs. Evans was sleeping a lot of the time and had not been fixing them dinner for the past several days, so she had fixed sandwiches for them and put the little kids to bed. She explained that Keisha told her that on other nights, Kevin had fixed sandwiches before she got home.
- Mrs. Evans stated that she had called about a widows' grief support group that Mrs. Shaver told her about. It happens during the evenings so Mrs. Evans worked with Mrs. Shaver to enroll Kevin and Angela in the childcare offered at the same time. Mrs. Evans is set to attend her first group in a week.
- Mrs. Evans indicated that members of the church have brought food to the home and she is grateful for this although she has not invited people to stay to eat with the family.
- Mrs. Evans stated that she was appreciative of Mrs. Shaver's offer to take the family to church and she plans to take her up on this next week.

Evans Family Case Decision

Activity: Evans Family Assessment/Case Decision Skills Practice

The purpose of this activity is to practice making a case decision based upon a case scenario.

What to Do:

Consider the information gathered so far in the CPS Family Assessment for the Evans Family and answer the following questions:

Has maltreatment occurred with frequency and/or is the maltreatment severe?	
Are there current safety issues?	
Is the child at risk of future harm?	
Is the child in need of protection?	

How does it feel to make a case decision for the Evans family?

What would make these decisions easier?

Evans Family Strengths and Needs Assessment

There is sufficient information in the case scenario presented in this training to indicate that the following would be identified as needs and carried over to the In-Home Case Plan:

- SN1 Emotional/Mental Health
- SN2 Caretaking Skills and Practices

There is not sufficient information in the case scenario to complete the FSNA in its entirety.

Activity: Evans Family FSNA Skills Practice

The purpose of this activity is to apply various tools learned, such as narrative interviewing, ecomapping, or genograms, to gather information about how the family's beliefs, values, traditions, and experiences shape them. This activity also prepares learners to gather all necessary information for the FSNA.

What to Do:

Working in small groups, consider the various techniques presented throughout the training that could be utilized to engage with the family to gather sufficient information to complete the FSNA. Each group will be assigned different techniques and tools to complete. Supportive materials for the techniques and tools can be found in Week Two Day One materials:

Group 1: Narrative interviewing

Group 2: Three Column Mapping, the Linking the Three Questions and Solution-focused Questions handout, and the Solution-focused Interviewing Skills & Questions handout

Group 3: Genogram, Eco-map, and Circle of Safety & Supports

Identify a person in your group to write down your ideas and share them with the larger group when the activity is over.

You have ten minutes for this skills practice.

How will you use the assigned tool to engage the family to understand their beliefs, values, traditions, norms, and past and present experiences to complete the FSNA

Use this space for notes or to draw tools (ecomap, genogram, Three column mapping, Circle of Safety & Support)

Self-Care Exercise

Mindfulness Activity

Spend a few minutes reflection on what you have learned about your new position with Child Welfare Services and how it will impact your work/life balance, self-care, and well-being.

How will you manage the work/life balance of the challenging work in child welfare?

To what things will you need to pay special attention to make sure you take care of yourself?

Appendix

Interviewing Strategies for Ambivalence and the Stages of Change

Activity: Question Matching ANSWER KEY

Question Types:

- Decisional Balance
- Evoking
- Exploring Goals and Values
- Looking back/Looking forward
- Questioning Extremes
- Scaling Question

Complete the table below by matching the types of questions to the examples.

Question Type	Question
Scaling Question	On a scale of 0 to 10, 0 being unimportant and 10 being extremely important, where would you say this change is currently in terms of your priorities?
Decisional Balance	What do you like about your present situation? What concerns you about it?
Looking back/ Looking forward	How would you like things to be different one year from now?
Evoking	What would you like to do differently next time?
Exploring Goals and Values	What in your life is most important to you right now?
Questioning Extremes	What is the worst thing that could happen if you change? What is the best thing?

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