NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

North Carolina Department of Health and Human Services
Intake in Child Welfare Track Training

Participant's Workbook
Day One

March 2026

PUBLIC KNOWLEDGE®
YOUR CATALYST FOR CHANGE

222 E. 18th Street, Unit C
Cheyenne, WY 82001
www.pubknow.com

info@pubknow.com
(800) 776-4229

This curriculum was developed by the North Carolina Department of Health and Human Services, Division of Social Services and revised by Public Knowledge® in 2024 and 2026.

Table of Contents

Instructions

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

If you are using this workbook electronically, each workbook page has text boxes for you to add notes and reflections. Due to formatting, if you are typing in these boxes, blank lines will be "pushed" forward onto the next page. To correct this, when you are done typing in the text box, you delete extra lines.

Course Themes

The central themes of the Intake in Child Welfare Track Training Day are divided across several course topics.

- Purpose and Legal Basis
- North Carolina Practice Model
    - Core Values
    - Essential Functions
- Overview of Intake
- Roles and Responsibilities in Intake
- Legal Definitions and Maltreatment Allegations
- Disproportionality in Child Welfare Services
- Intake Skills
    - Engaging Reporters
    - Gathering Information and Interviewing Skills
    - Collecting Narrative Information
    - Support Networks
    - Documentation
- Provisional Harm and Worry Statements
- SDM® Screening and Response Tool
- Overview of CPS Intake Process
- Intake Skills Learning Lab
- Intake Process
    - Selecting Maltreatment Allegations
    - Response Time and Track Assignments
    - Two-Level Review, Assignments, and Notifications
- Intake Process Learning Lab
- Special Policy Circumstances
- Ambivalence
- Intake Learning Lab
- Worker Safety and Well-being

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 Intake in Child Welfare Track 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. North Carolina Worker Practice Standards
2. Safety Organized Practice
3. Understanding and Assessing Safety and Risk
4. Understanding and Screening for Trauma

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 track 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 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.

Day One Agenda

Intake in Child Welfare Track Training

Welcome and Introductions

Training Resources

Team Agreements

Purpose and Legal Basis

North Carolina Practice Model

Purpose and Overview of Intake Services

BREAK

Roles and Responsibilities

NC Core Values Guide Our Work

Identifying and Addressing Bias

LUNCH

Key Factors in Reports of Child Abuse and Neglect

Legal Definitions and Maltreatment Allegations

BREAK

Maltreatment Definitions

End-of-Day Values Reflection

Self-Reflection Activity

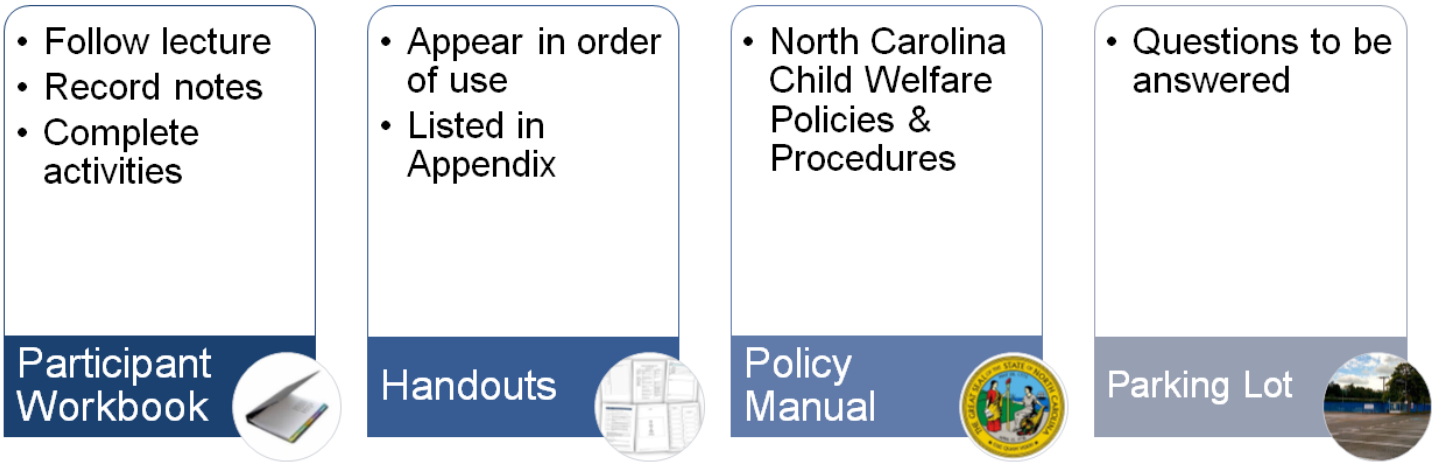
Learning Objectives

Day One

Purpose and Legal Basis
• Describe the goals and expected outcomes of CPS Intake.
• Describe the steps in the Intake process.
• Outline the job responsibilities of Intake workers.
• Describe the Intake worker's role in receiving, documenting, and screening allegations of child maltreatment.
• Explain mandated reporting requirements.
• Provide examples of how mental health and substance use concerns factor into maltreatment allegations.
• Describe the dynamics of intimate partner violence and how it impacts child safety.
• Explain types of human trafficking.
• Explain when DSS has the legal authority to intervene based on allegations of maltreatment.
• Distinguish between reports that involve a caretaker and those that do not.
• Describe the threshold for each maltreatment allegation.
Identifying and Addressing Bias
• Explain the concept of bias and how it impacts child welfare screening decision-making.
• Demonstrate methods of self-reflection and self-exploration to uncover biases that may influence work with children and families.
• Describe how biases may impact Intake screening decisions.
• Demonstrate an understanding of professional curiosity as a lifelong process of self-awareness and learning from others.

Welcome & Introductions

Training Resources



Available training resources/tools used during training include the following:

- Participant Workbook, which is used to follow lectures, record notes, and complete activities
- Handouts, which will appear in order of use
- Policy Manual, where the North Carolina Child Welfare Policies & Procedures are located
- Parking Lot, which is used to record questions to be answered

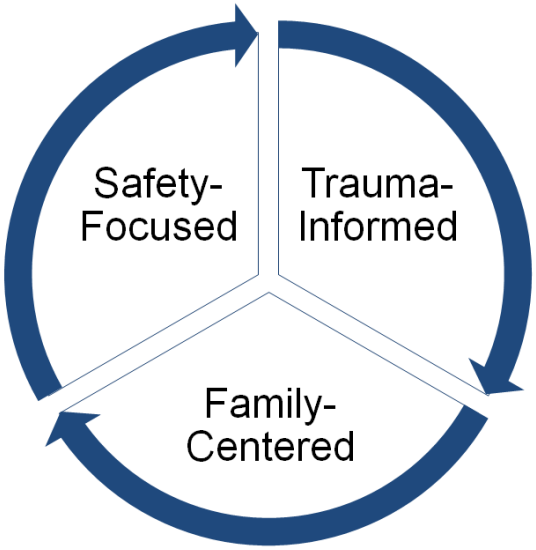
Team Agreements

Use this space to record shared team agreements for Intake in Child Welfare Track Training.

Purpose and Legal Basis

North Carolina Practice Model

Core Values



The North Carolina Practice Model is rooted in the core values of being safety-focused, trauma-informed, and engaging in family-centered practice. Values are fundamental beliefs or principles that guide and direct all aspects of any practice. Core values are a way to claim what is important in a complex system. They offer alignment across all layers of service delivery, keep us grounded as we carry out tasks and responsibilities within child welfare, and guide our practice.

Activity: Connecting to Our NC Core Values

The purpose of this activity is to craft definitions of the core values as a knowledge check that will be explored throughout the training.

What to do:

- Think about each concept (Safety-focused, Trauma-informed, and Family-centered) in terms of working with children and families
- Use one sticky note for each Core Value to write your first thought or response to each concept
- When you are finished, walk around the room and place your sticky notes on the correct flipchart paper/poster
- After you have placed your sticky notes, take a few minutes to walk around and read everyone's thoughts about the Core Values

Use this space to record your thoughts from this activity.

North Carolina Practice Model Roadmap

What is a Practice Model?

What are the three components of the North Carolina Practice Model?

The North Carolina Practice Model is designed to improve which child welfare outcome measures?

What are examples of positive outcomes for children and families when we take this approach to the work?

What are the five essential functions of the North Carolina Practice Model?

1.

2.

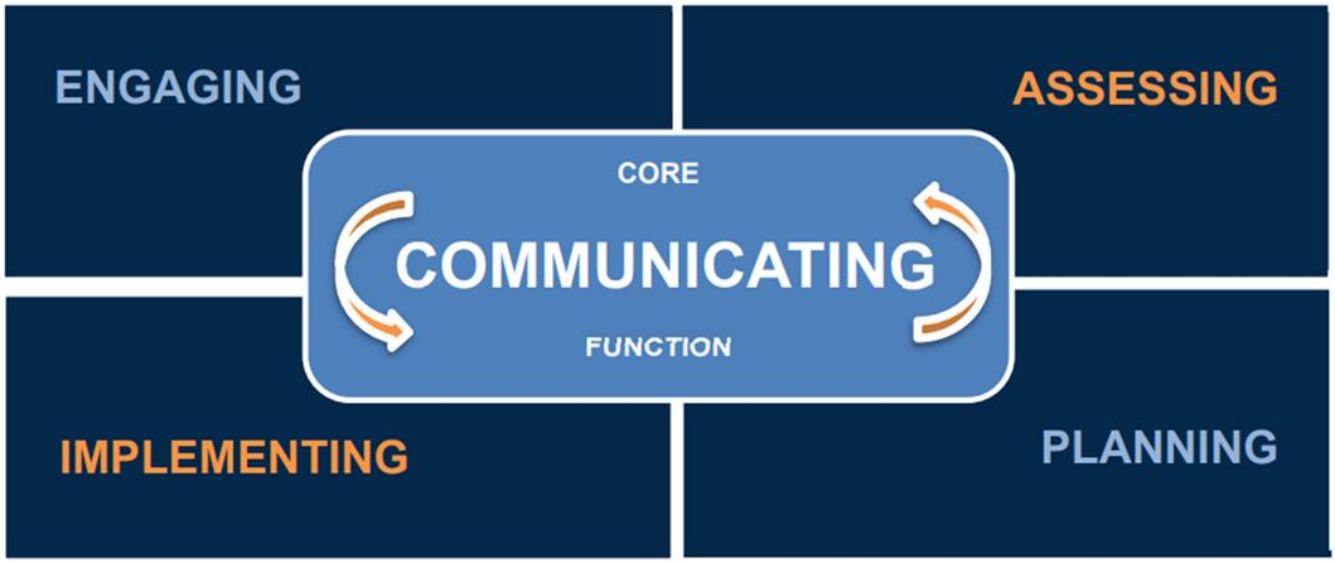
3.

4.

5.

Where have you encountered these components before now?

Learning Review: North Carolina Child Welfare Practice Standards



Practice standards provide guidance to workers on the concrete actions and behaviors they should be demonstrating to carry out the agency's Practice Model

The North Carolina Practice Standards define the skills, behaviors, and capacities required to perform essential functions of child welfare practice

The Five Essential Functions

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

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

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

Planning: Respectfully and meaningfully collaborating with families, communities, tribes, and other identified team members to set goals and develop strategies based on the continuous assessment of safety, risk, family strengths, and needs through a child and family team process. The team should regularly revisit plans to assess progress towards goals and make changes when needed.

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

Activity: North Carolina Child Welfare Practice Standards

The purpose of this activity is for learners to familiarize themselves with the structure of the Practice Standards by contemplating how the components of essential functions, key behaviors, and core activities fit together.

What to do:

Your training facilitator will inform you if this will be a small or large group activity.

Small Group Activity:

- The trainer will provide each small group with an envelope that contains two Essential Functions, with corresponding key behaviors and Practice Standards
- You will have three minutes to match the Core Activities and Key Behaviors with the correct Essential Function

OR

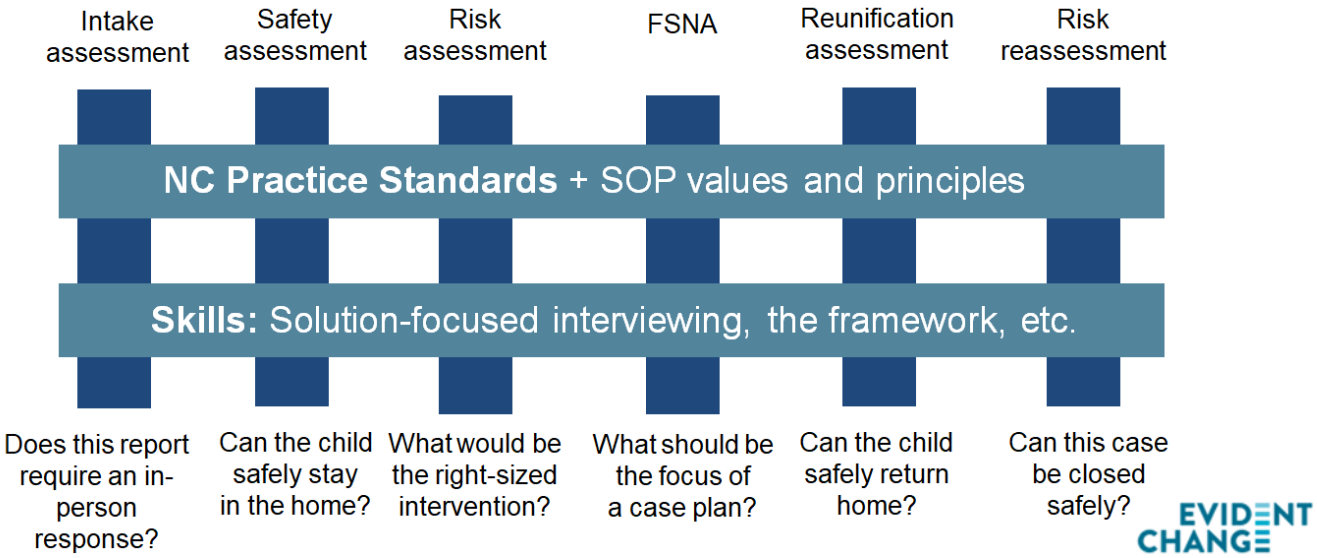
Large Group Activity:

- You will find Essential Function Activity cards throughout the room
- The training facilitator will provide you with 2-3 Key Behaviors and Core Activities cards
- You will have three minutes to match the Core Activity and Key Behaviors with the correct Essential Function by placing them together

For both activities, check your work against the Practice Standards Desk Guide found in Appendix A of this participant workbook.

How do the Core Activities and Key Behaviors connect to the work you do with children and families?

All Components Working Together



The fence analogy illustrates how the components of the Practice Model work together. Structured Decision Making® (SDM) Tools are used at key decision points and support answering key questions. NC Practice Standards and Safety Organized Practice (SOP) offer key activities and behaviors to support and stabilize quality casework practice. Skills and tools that align with SOP also stabilize practice.

Handout: Safety Organized Practice

EVIDENT CHANGE
Inform Systems. Transform Lives.

SAFETY-ORGANIZED PRACTICE

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

DEVELOPING GOOD WORKING RELATIONSHIPS

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

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

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

CRITICAL THINKING AND DECISION SUPPORT

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

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

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

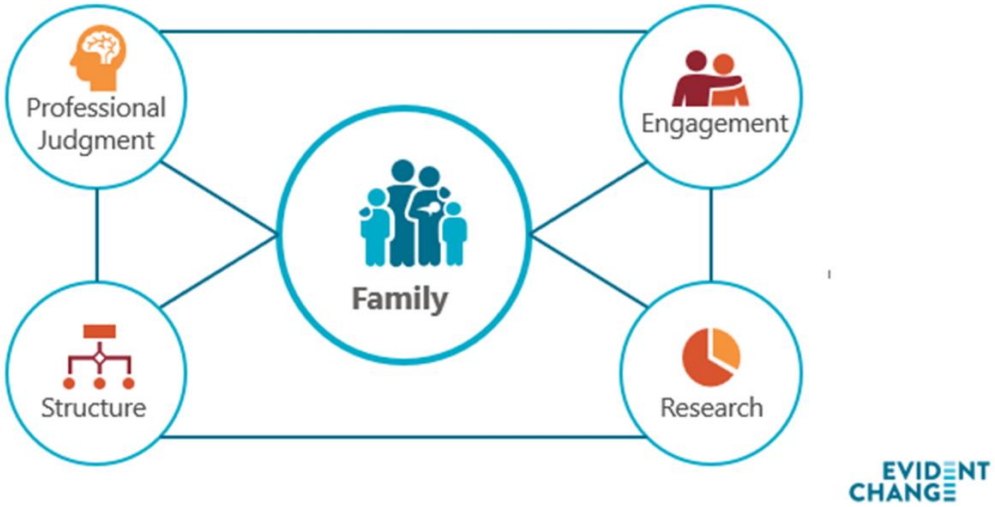
COLLABORATIVE PLANNING

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

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

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

Structured Decision Making (SDM®)



What is the SDM System?

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

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

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

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

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

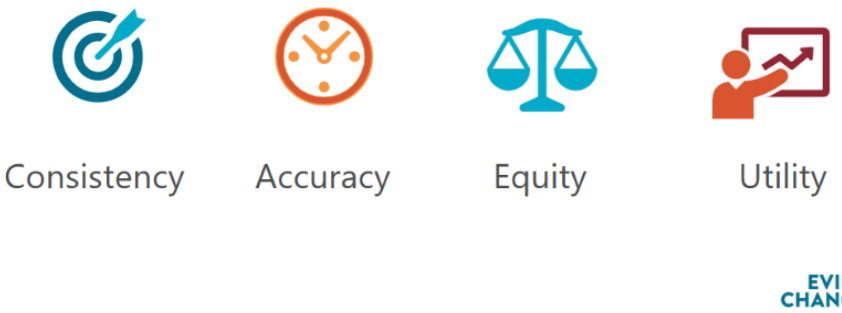
Policy: The policies for each SDM tool are tailored to individual jurisdictions based on legal and agency considerations—there is no "off-the-shelf" SDM assessment.

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

Goals of the SDM System

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

CORE PRINCIPLES OF SDM ASSESSMENTS



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

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

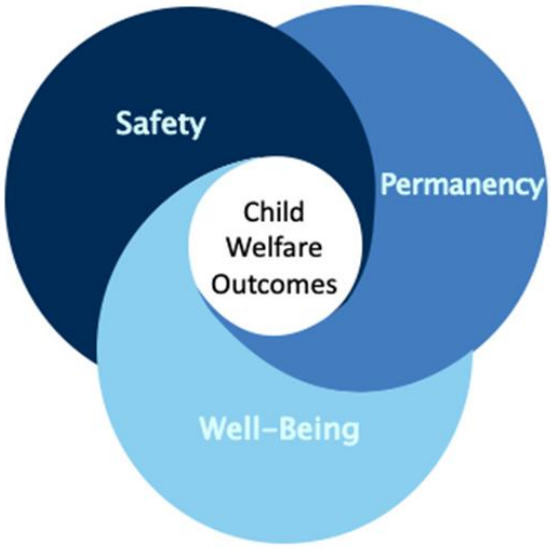
Accuracy: It is great to ensure people are coming to the same conclusion, but it is also important to measure the correct things and come to the correct conclusion. The SDM tools need to be valid and accurate, measuring the correct things. This update of the SDM assessments is based on North Carolina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

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

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

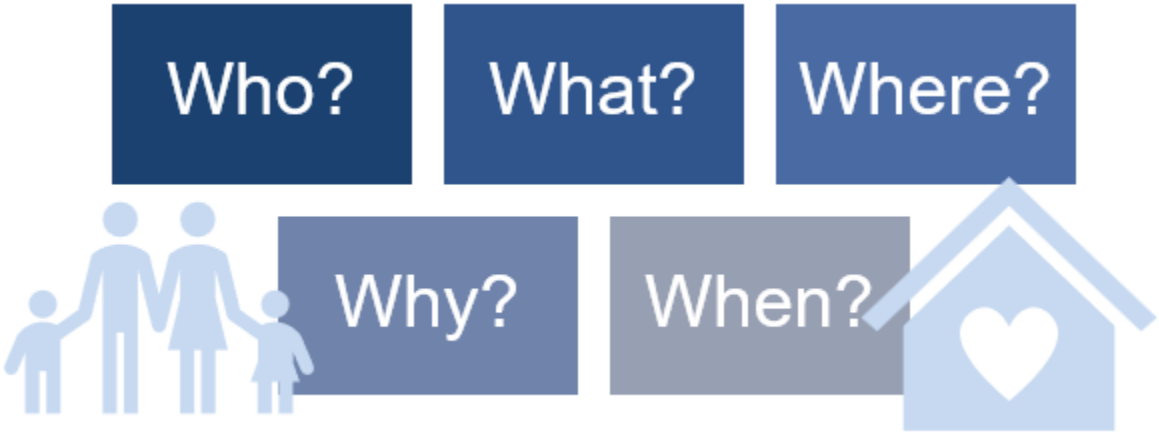
Purpose and Overview of Intake

Goals of Child Welfare Services



The goals of child welfare are to promote safety, permanency, and well-being for children and families by supporting families to care for their children successfully, or when that is not possible, supporting children to find permanency with kin or adoptive families. Safety, permanency, and well-being are outcomes that local DSS agencies, the state, and the federal government measure to ensure our work is effective in supporting families.

Purpose of Intake



Protective services are legally mandated, non-voluntary services for families that encompass specialized services when DSS is made aware of allegations of child maltreatment (abused, neglected, and/or dependent) or imminent risk of harm due to the actions of, or lack of protection by, the child's parent or caretaker.

The primary goal of CPS is to protect children from further maltreatment and to support and improve parental/caretaker abilities to assure a safe and nurturing home for each child. The task of the CPS is to determine if the child(ren) is/are abused, neglected, and/or dependent, or if the family needs services, and what level of intervention is necessary to assure safety.

What is the purpose of Children's Protective Services?

Who are the recipients of CPS?

What role does intake play in CPS?

Goal of CPS Intake

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

Intake decisions have significant and lasting impacts on children and families, determining whether DSS legally intervenes and whether allegations meet the threshold for abuse, neglect, or dependency. Intake workers must apply criteria objectively, recognizing the emotional and challenging nature of the work while avoiding assumptions or personal bias. During the intake process, rely on information provided by reporters to make decisions.

It is crucial to remember that during intake, caseworkers are not determining if maltreatment has occurred. The role of intake is to determine if a response from child welfare is legal and appropriate. When a report is screened in, the CPS Assessment worker will gather information to determine if the allegations are substantiated by facts (“true”) and if maltreatment has occurred.

What might a family experience from an intake decision to screen in for assessment?

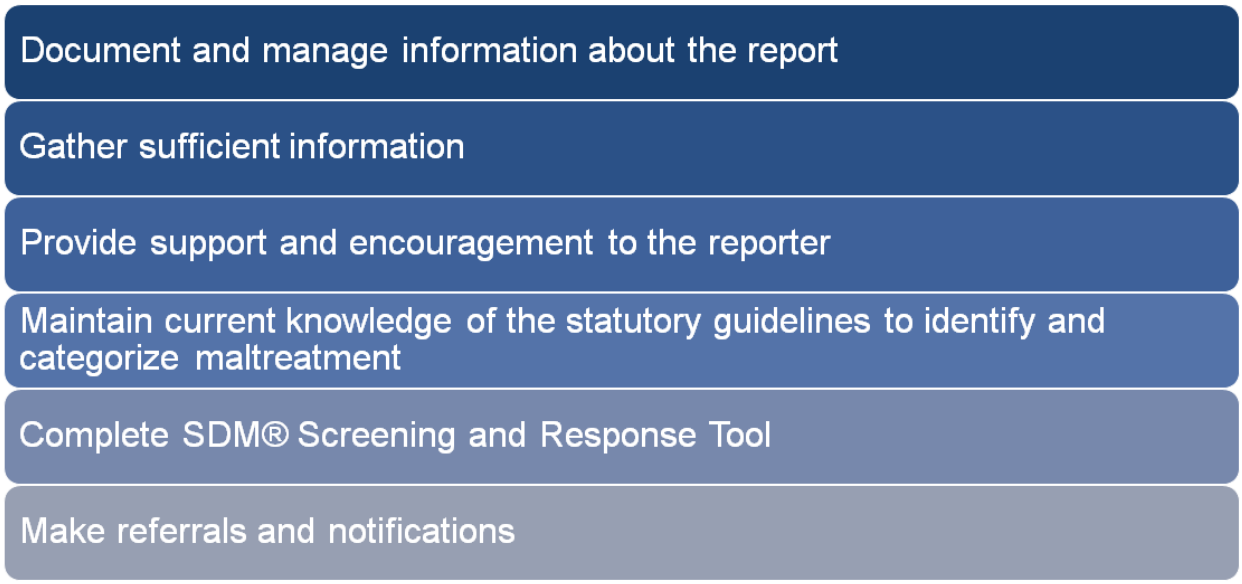
What might result from an intake decision?

What are some aspects you find rewarding about your work so far?

What are some aspects you find challenging?

Roles and Responsibilities of Intake Workers

Intake Caseworker Roles and Responsibilities



A general summary of the roles and responsibilities of intake caseworkers includes:

- Document and manage information about the report of suspected abuse, neglect, and/or dependency by creating a new CPS Intake in PATH NC Screening and Response Tool
- Gather sufficient information from the reporter to be able to:
  - Determine the reporter's concern
  - Identify and locate case participants
  - Determine if the report meets the statutory guidelines for child maltreatment
  - Assess the seriousness of the children's situation
  - Understand the relationship of the reporter to the family and the motives of the reporter
  - Identify collaterals who may have additional information for the assessment
- Provide support and encouragement to the reporter by:
  - Explaining the purpose of CPS (to ensure the 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
- Have current knowledge of the statutory guidelines to identify and categorize child abuse, neglect, and/or dependency allegations
- Complete the SDM® Screening and Response Tool as per policy
- Make referrals and notifications

Activity: Intake Caseworker Roles and Responsibilities

The purpose of this activity is to become familiar with the roles and responsibilities of Intake and identify strategies to manage competing demands.

What to do:

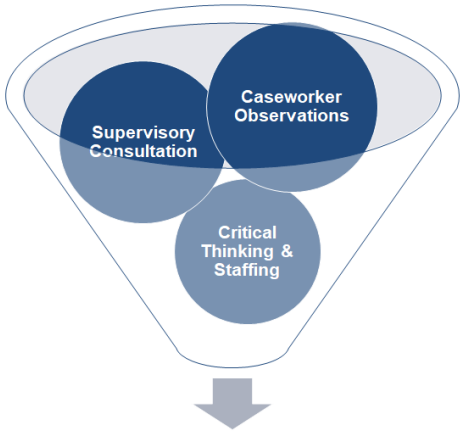
- Review policy summary descriptions of roles and responsibilities found above
- Working with a partner, spend five minutes discussing the activity questions below

How do you accomplish these tasks and responsibilities?

What do you do when stuck?

What impact does engagement have on your ability to fulfill your responsibilities?

Two-Level Decision Making



Two-Level Decision-Making

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

Two-level decisions for CPS Intake reports should involve the assigned caseworker and that worker's supervisor. However, there may be circumstances that require another Intake caseworker, another supervisor, or a higher-level manager in the agency to participate in a review or the decision-making. When a supervisor does not have access to a higher-level manager for a 2nd-level review during screening of an Intake report, the supervisor may send it to another supervisor for the 2nd-level review.

What are the benefits of staffing with your supervisor?

What decisions require two-level decisions on intake?

Roles and Responsibilities of Intake Workers

Activity: Roles and Responsibilities of Intake Workers

The purpose of this activity is to identify the tasks and responsibilities associated with intake and connect them to the practice standards.

What to do:

- Work with your group to review the key behaviors and core activities of your assigned function.
- Once you have a list, identify which step in the Intake process the task falls under. Some tasks may fall in multiple steps.

Essential Function:	
Key Behaviors and Core Activities	**Identified Step in the Intake Process**

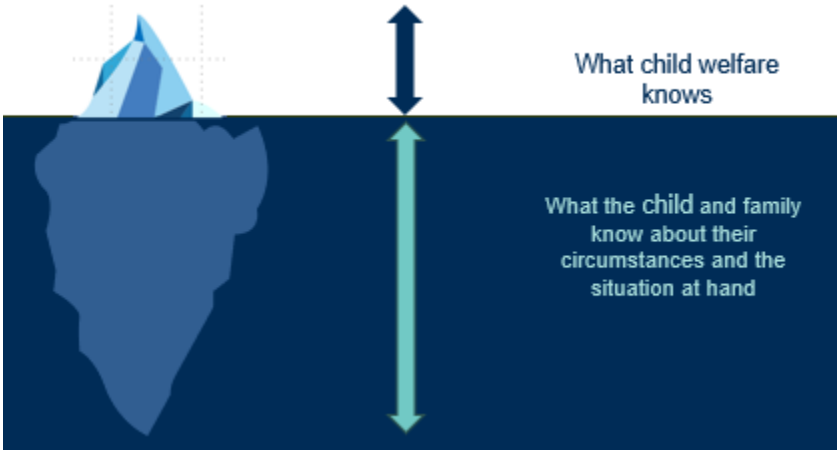
NC Core Values Guide Our Work

NC Core Values Guide Our Work

In child welfare, assessments gather information from the child and family, seek context to understand the family's circumstances, and assess future child safety. In your child welfare services roles, you must maintain a person-centered, family-centered, and trauma-informed mindset, learning from each individual or family what is most important to them. Professional curiosity and family-centered, trauma-informed practice involve an ongoing process of self-exploration and self-critique combined with the willingness to learn from others. It means entering a relationship with another person with the intention of honoring their beliefs, customs, and values. It means acknowledging differences and accepting that person for who they are.

Use this space to record notes.

Professional Curiosity



Families are the experts of their own lives. A family's knowledge and understanding of their circumstances and the situation at hand far exceeds what the child welfare agency knows.

How do you show professional curiosity during CPS Assessments?

How do you center families and include them in the decision-making process?

How have you seen and heard children and families included in the decision-making process?

Child Welfare Practice Strategies to Center Families

Activity: Child Welfare Practice Strategies to Center Families

The purpose of this activity is to reflect on how families are unique and apply that knowledge to overcoming barriers in child welfare interventions.

What to do:

Part 1: On your own, create a list of aspects of your childhood or current beliefs, customs, and traditions that make your family unique and may not be visible or known to outsiders.

What about your family culture would CPS be challenged to understand without explanation or context?

What in your culture might be interpreted negatively without that family context and information?

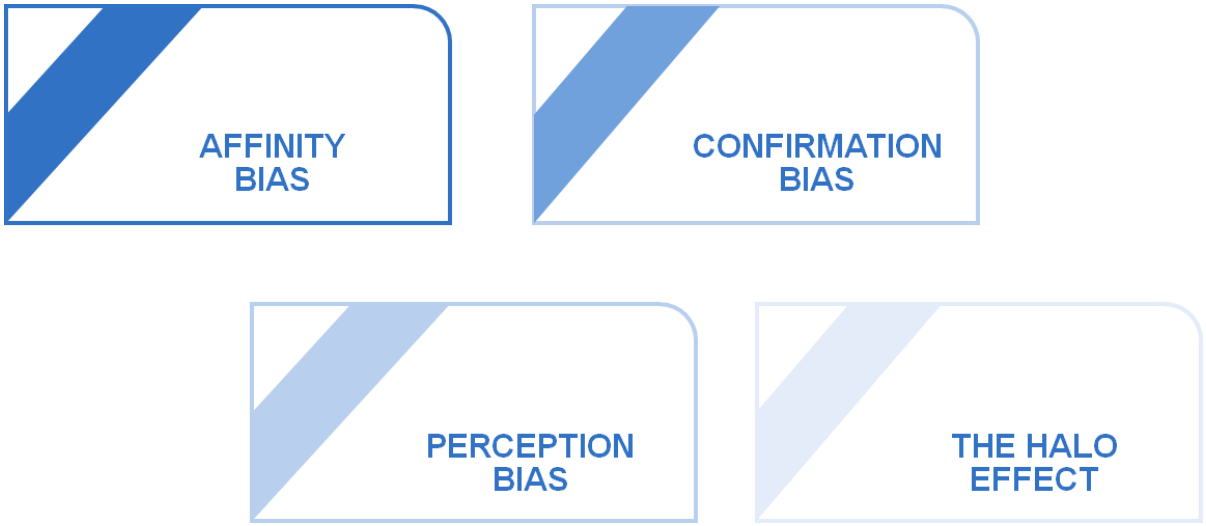
Part 2: In your small group, discuss your answers to Part 1, then answer the following questions:

How would CPS get your family to talk about those topics?

How do you practice professional curiosity with families in CPS?

Identifying and Addressing Bias

Bias



Affinity Bias: The tendency to warm up to similar people, favoring those who have things in common with us.

Confirmation Bias: Seeking out evidence that confirms our initial perceptions, ignoring contrary information.

Perception Bias: The tendency to form stereotypes and assumptions about certain groups that makes it difficult to make an objective judgment about individual members of those groups.

The Halo Effect: The tendency to think everything about a person is good because our first impression of them was good.

Explicit bias includes biases that are conscious or known- an individual is aware of these biases.

Implicit biases are unconscious biases and operate outside of one's awareness.

Use this space to record notes.

The Learning Edge of Discomfort

Comfort Zone: The familiar space where we feel safe.

Learning Zone: The space where we stretch our abilities but still feel in control.

Caution/Danger Zone: The area where fear and anxiety take over, often holding us back.

Activity: The Learning Edge of Discomfort

The purpose of this activity is to support the connection between potential biases, the discomfort that arises when we experience bias, and the opportunity to grow when we feel uncomfortable.

Will you know when you are in the Caution Zone?

What about this work have I found challenging, and what did I do about it?

How do I reflect on my own biases?

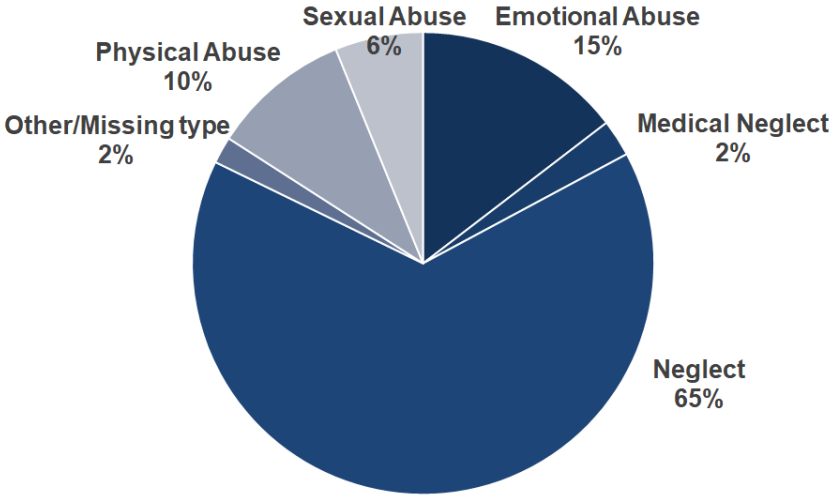
How might this be like what families experience during a child welfare intervention?

How do I mitigate or prevent negative impact from my biases?

How will you sit with the discomfort of the learning zone to learn about families?

Key Factors in Reports of Child Abuse and Neglect

Overview of Child Maltreatment Data



Source: Kids Count Data Center, 2023

Approximately 58% (62,304 of 107,536) referrals are screened in for assessment. That means almost half of the reports received are screened out. Children under 3, especially those under 1, are the subject of the most reports. Children can be placed into multiple categories. As a result, percent totals may exceed 100%.

What data stands out to you?

What data aligns with your personal experience?

Approximately 58% (62,304 of 107,536) referrals are screened in for assessment. That means almost half of the reports received are screened out. How does that statistic align with your experience conducting intakes?

What stands out to you all about the information presented on this slide compared to the handout on the next pages?

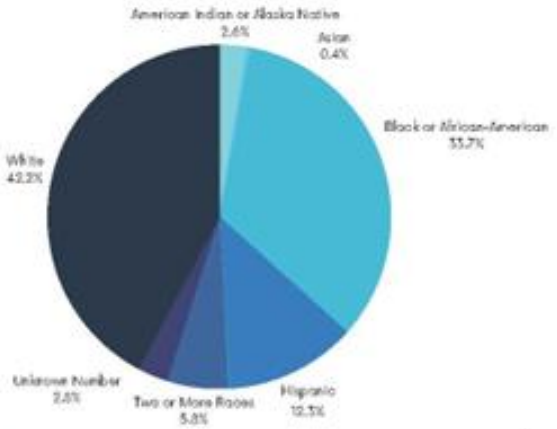
Handout: North Carolina Children 2024

NCDHHS

NORTH CAROLINA CHILDREN 2024

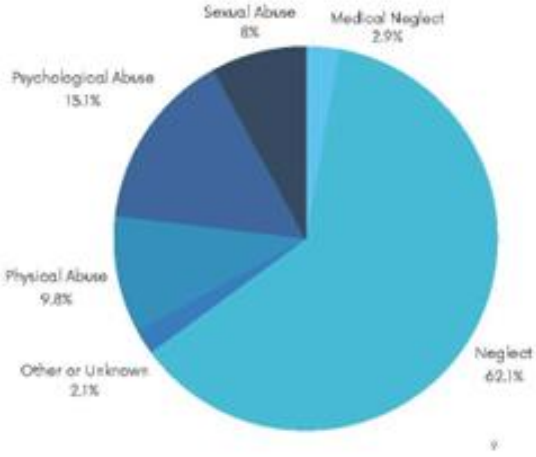
CHILD MALTREATMENT

- In 2022, North Carolina had 107,536 total referrals for child abuse and neglect.[1] All 62,304 reports were screened in for assessment.[2]
- There were 23,134 child victims of abuse or neglect in North Carolina in 2022, at a rate of 10.1 children per 1,000. This translates to a 15.2% decrease since 2018.[3]
- There were 15,590 first time victims in North Carolina in 2022, at a rate of 6.8 children per 1,000.[4]
- The largest age group of victims was children under one, representing 2,939 of the 23,134 cases.[5]



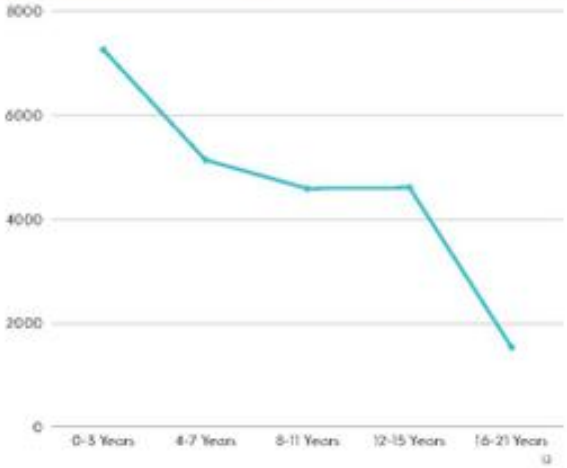
CHILD VICTIMS BY ETHNICITY OR RACE

TYPES OF MALTREATMENT VICTIMS



- 89% of child maltreatment perpetrators in 2022 were parents of the child. 15.8% were non-parents or had an unknown relationship.[7]
- 52% of North Carolina's child victims in 2022 were female while 48% were male.[8]
- Maltreatment related child fatalities increased in 2022 from 14 in 2018 to 93 in 2022.[9]

AGE DISTRIBUTION OF MALTREATMENT VICTIMS

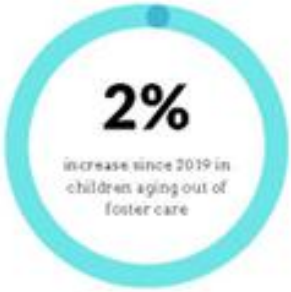


PLANS OF SAFE CARE

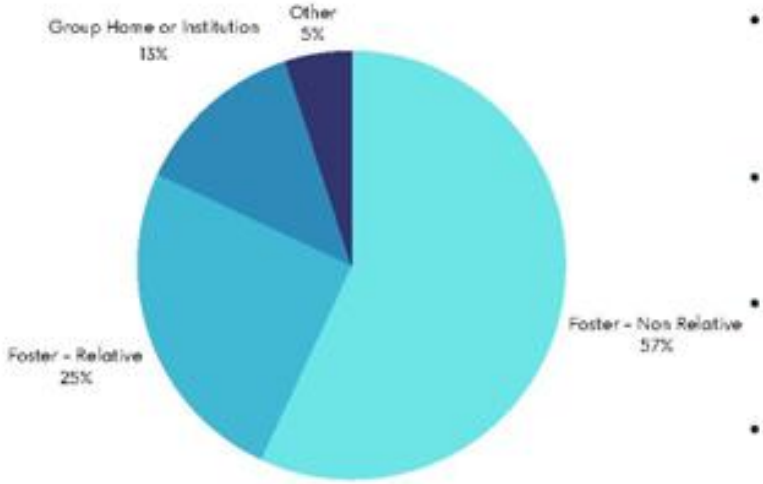
- In 2022, North Carolina reported 1,213 infants who were screened-in with prenatal substance exposure. 93.2% of those screened in had a plan of safe care.[10]

FOSTER CARE AND PERMANENCY

- 15,377 total children were served by the foster care system in FY 2022.[13]
- 11,258 were in care on the day of September 30th, 2022.[13]
- 5,124 children entered care during the FY 2022 while 4,119 exited during the same year.[13]
- 255 children in North Carolina aged out and exited the foster care in 2022. This is an increase from 175 in 2019 and represents a 2% increase.[14]
- Children in foster care in 2021 spent an average of 21.5 months in care.[15]

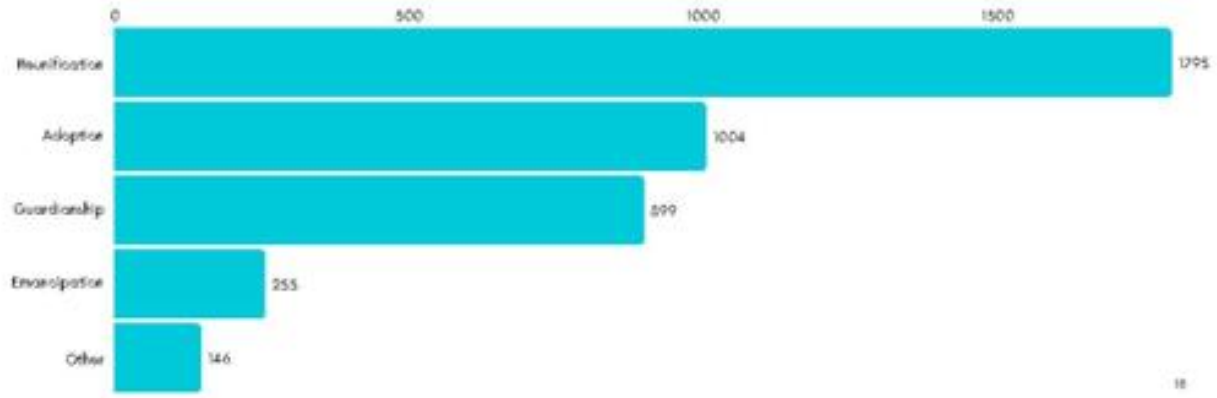


WHERE ARE CHILDREN IN FOSTER CARE STAYING?



- Data from 2021 shows that 6,193 children in foster care within North Carolina were living with non-relatives while 2,671 stayed with a relative.[16]
- 1,370 children were staying in group homes while 76 children were classified as runaways.[16]
- The average length of stay in foster care before exit to reunification was 16.6 months.[17]
- The average length of stay in foster care before exit to adoption was 34.7 months.[17]

CHILDREN EXITING FOSTER CARE BY REASON, 2021



REFERENCES

1. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 2-1: Screened-In and Screened-Out Referrals, 2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

2. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 3-1: Children Who Received an Investigation or Alternative Response, 2018-2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

3. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 3-3: Child Victims, 2018-2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

4. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 3-4: First Time Victims, 2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

5. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 3-5: Victims by Age, 2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

6. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 3-7: Victims by Race of Ethnicity, 2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

7. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 3-9: Victims by Relationship to Their Perpetrators, 2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

8. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 3-6: Victims by Sex, 2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

9. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 3-8: Maltreatment Types of Victims, 2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

REFERENCES

10. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 3-12: Screened-in Infants with Prenatal Substance Exposure Who Have a Plan of Safe Care, 2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

11. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 4-2: Child Fatalities, 2018-2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

12. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022). Child Maltreatment 2022. Report from the States to the National Child Abuse and Neglect Data System: Table 3-5: Victims by Age, 2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2022.pdf

13. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2022 Adoption and Foster Care Analysis and Reporting System (AFCARS), FY 2013 – FY 2022. Retrieved March 14, 2024 from https://www.acf.hhs.gov/cb

14. Annie E. Casey Foundation, Kids Count Data Center. (2022). Children Exiting Foster Care by Exit Reason in North Carolina, 2022. Retrieved March 14, 2024 from https://datacenter.aecf.org/data/tables/6277-children-exiting-foster-care-by-exit-reason?loc=1&loct=2#detailed/2/35/false/2048,574,1729,37,871,870,573,869,36,868/2631,2636,2632,2633,2630,2629,2635,2634/13050,13051

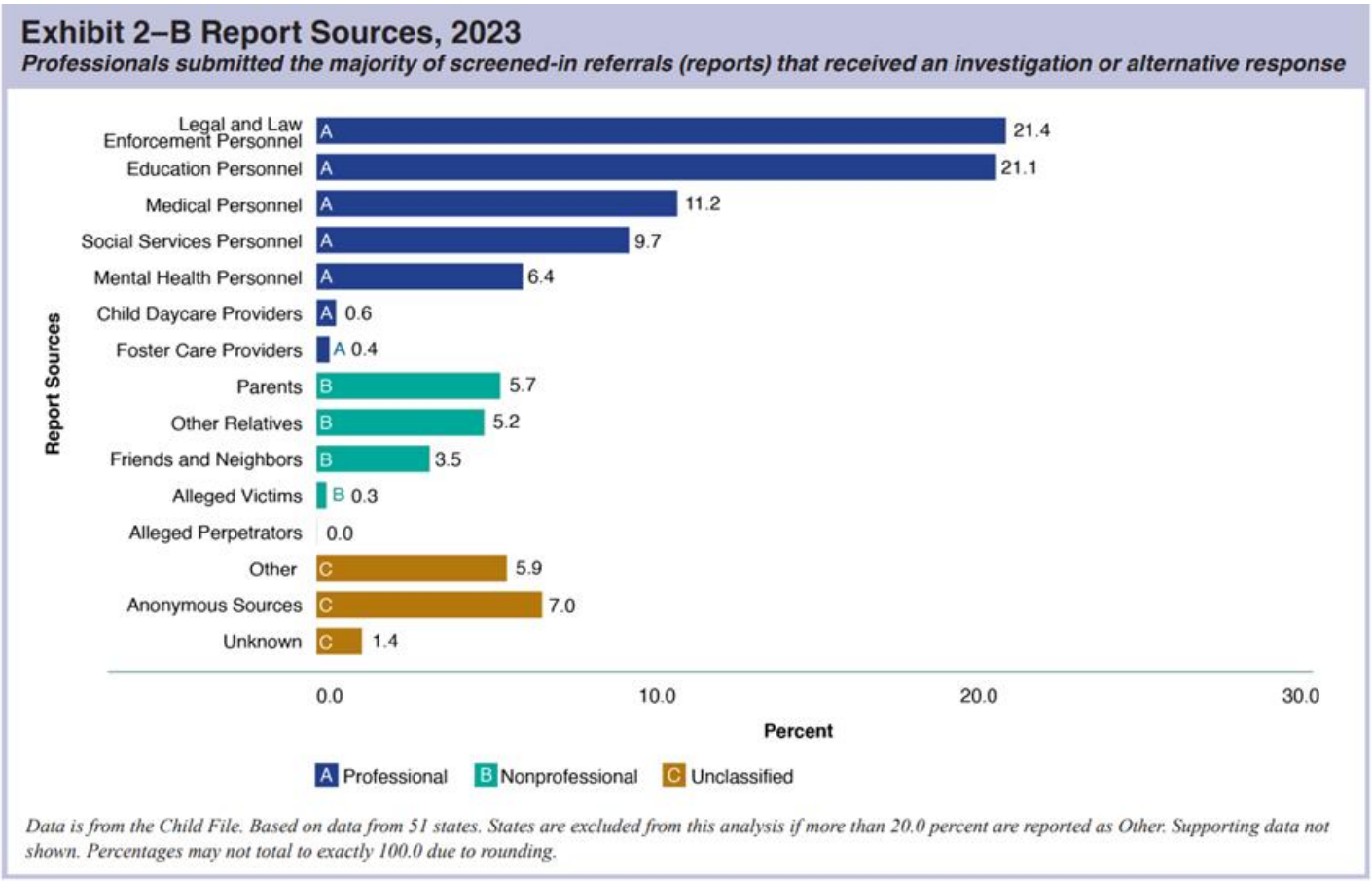
15. Child Tends, State Level Data for Understanding Child Welfare in the United States (2023). Average Length of Time in Foster Care, 2021. Retrieved March 14, 2024 from https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states

16. Annie E. Casey Foundation, Kids Count Data Center. (2022). Children in Foster Care by Placement Type in North Carolina, 2021. Retrieved March 14, 2024 from https://datacenter.aecf.org/data/tables/6247-children-in-foster-care-by-placement-type?loc=1&loct=2#detailed/2/35/false/2048/2622,2621,2623,2620,2625,2624,2626/12994,12995

17. Child Tends, State Level Data for Understanding Child Welfare in the United States (2023). Permanency, 2021. Retrieved March 14, 2024 from https://www.childtrends.org/publications/state-level-data-for-understanding-child-welfare-in-the-united-states

18. Annie E. Casey Foundation, Kids Count Data Center. (2022). Children Exiting Foster Care by Exit Reason, 2021. Retrieved March 14, 2024 from https://datacenter.aecf.org/data/tables/6277-children-exiting-foster-care-by-exit-reason?loc=35&loct=2#detailed/2/35/false/2048/2631,2636,2632,2630,2629,2635,2634/13050,13051

Mandatory Reporting in North Carolina



North Carolina Mandatory Reporting Statutes

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

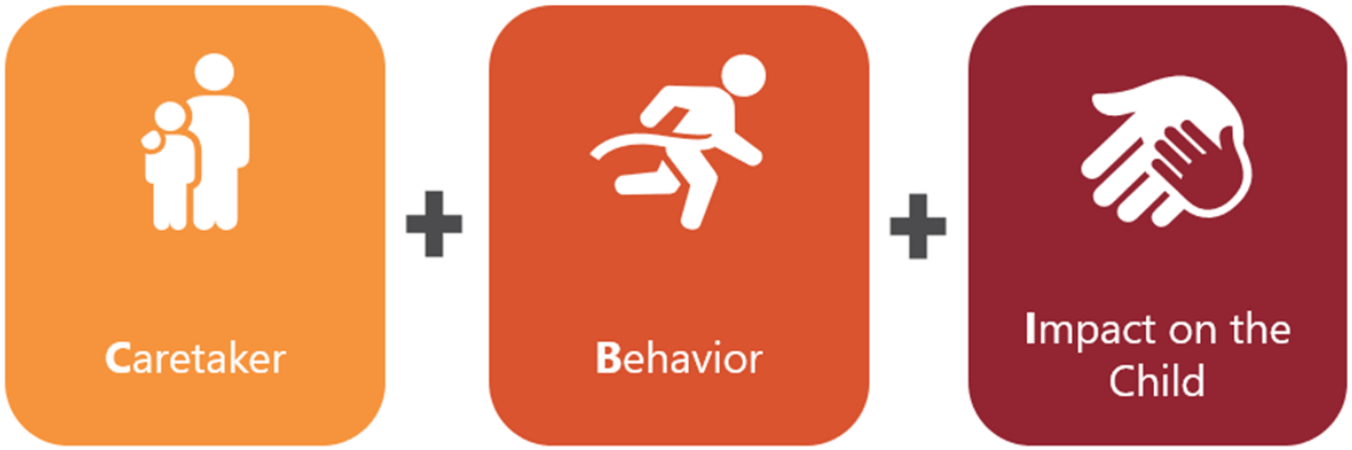
(a) Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by GS 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile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

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

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

Source: North Carolina General Statutes, Chapter 7B - Juvenile Code. Retrieved from: https://www.ncleg.gov/Laws/GeneralStatuteSections/Chapter7B

Impact



EVIDENT CHANGE

Your role as an Intake caseworker is to ask questions and encourage reporters to provide specific behavioral details about the impact on the child in the intake skills section. When a reporter discusses a key factor, you need to ask follow-up questions to determine if and how the caretaker's behavior impacts child safety. The C+B+I formula helps us determine and describe how caretaker behaviors impact the child..

Impact is "when a parent's behavior, attitudes, emotions, intent, or circumstances create conditions that fall beyond mere risk of maltreatment and have become an actual imminent threat to a child's safety." Impact is a discussion of the harm caused to children because of their parents' and caretakers' behaviors.

Sometimes caretaker behaviors create situations that are undesirable for children, children are negatively impacted, and these circumstances do not meet the statutory thresholds for abuse, neglect, or dependency.

Another key reminder is that there are circumstances that affect children and are not due to caretaker behaviors. Poverty is one of those circumstances. It is important to remember that poverty does not equate to neglect.

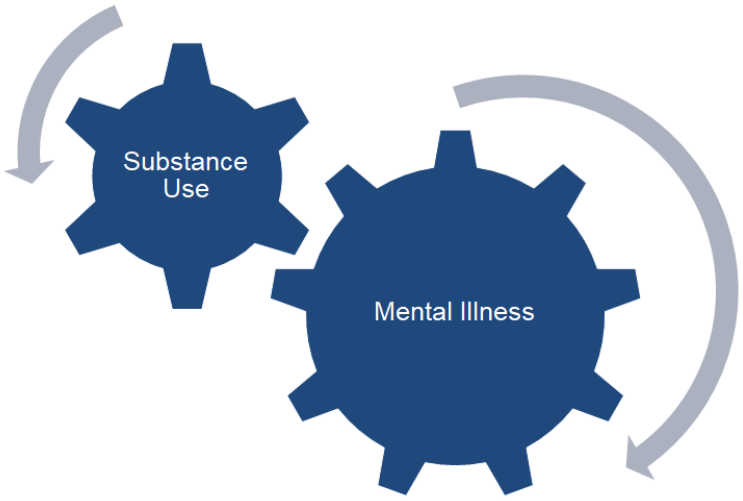
Use this space to record notes.

Complicating Factors for Child Welfare Interventions

Bias and stigma related to mental health, substance use, domestic violence, and human trafficking can influence perceptions and reporting. Effective engagement with families requires understanding the impact of these conditions, the available services, and strategies to support parents while ensuring child safety.

Our responsibility at intake is to remain objective. We must focus on the allegations, apply the statutory criteria, and avoid making assumptions about families or situations based on stigma or personal beliefs. At the same time, effective engagement requires understanding how these factors may impact families, knowing what services and supports are available, and balancing that understanding with our primary responsibility to ensure child safety.

Mental Illness and Substance Use



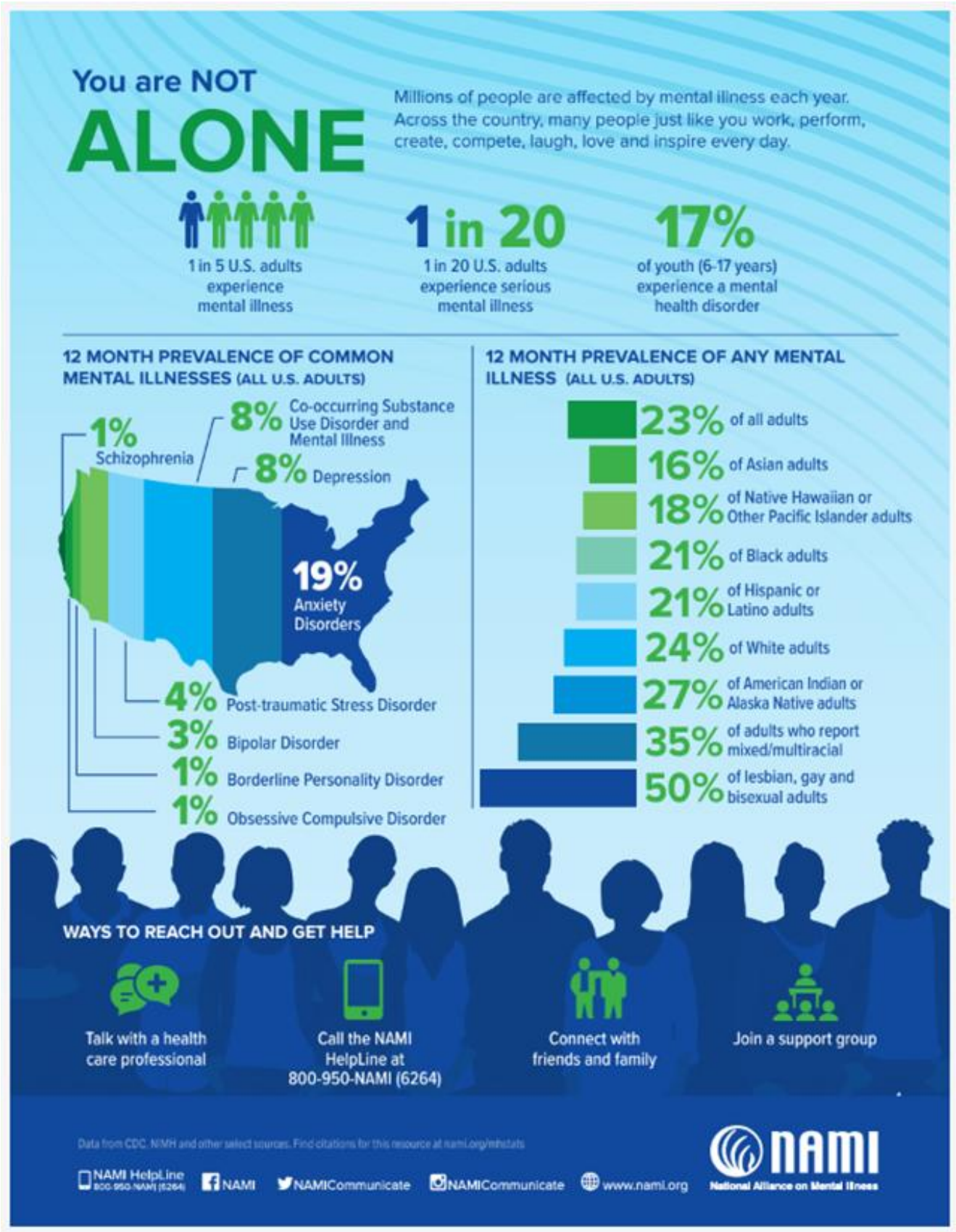
Mental illness and substance use are common in the U.S. population and are significant risk factors for child abuse and neglect, though their presence alone does not constitute maltreatment.

- One in five adults experiences mental illness, and one in 20 experiences serious mental illness
- Two million children live with a parent who has a substance use disorder

Intake workers must assess safety and risk when mental illness or substance use are factors, using the caretaker + behavior + impact on the child formula to determine if the threshold for an allegation is met. Bias and stigma related to mental health and substance use can influence perceptions and reporting; intake workers must remain objective and avoid assumptions when screening reports.

Use this space to record notes.

Handout: You Are Not Alone



Handout: Understanding Substance Use Disorders: What Child Welfare Staff Need to Know

UNDERSTANDING SUBSTANCE USE DISORDERS: WHAT CHILD WELFARE STAFF NEED TO KNOW

National Center on Substance Abuse and Child Welfare

In the United States, over 21 million U.S. children 18 and under live with a parent who has misused a substance in the past year; of those, 2 million live with a parent with a substance use disorder (SUD).[1] While these children will not all experience abuse or neglect, research shows these children are at increased risk of several poor outcomes, such as: 1) emotional, cognitive, behavioral, and social problems;[2] 2) maltreatment;[3] 3) increased foster care placement;[4] and 4) higher rates of neonatal abstinence syndrome.[5] For many families, parental substance use and co-occurring mental health disorders are common reasons families come into contact with child welfare.[6]

WHEN WORKING WITH FAMILIES AFFECTED BY SUDS, CONSIDER THE FOLLOWING FACTORS RELATED TO PARENTAL SUBSTANCE USE:

SUDs are complex, progressive, and treatable diseases of the brain that profoundly affect how people act, think, and feel: SUDs affect an individual's social and emotional well-being and family life, resulting in psychological and often physiological dependence. People with a SUD may also have a co-occurring mental health disorder.

Common misperceptions and myths: Many people incorrectly believe that a parent with a SUD can stop using alcohol and illicit drugs with willpower alone, or they would be able to stop using if they just loved their children. These misperceptions and myths create stigma that can have negative impacts on a person's recovery.

Relapse rates for SUDs are like other chronic medical conditions such as diabetes or hypertension: Since SUDs are a chronic brain disease, a return to use, or relapse, especially in early recovery, is possible. Therefore, SUDs should be treated like any other chronic illness. A recurrence of symptoms, or return to use, is an opportunity to examine a parent's current treatment and recovery support needs and adjust them if necessary.

Professionals can successfully manage and treat SUDs and other co-occurring mental health disorders: Successful treatment is individualized and generally includes psychosocial therapies, recovery supports, and when clinically indicated, medications. Recovery specialists and peers with lived experience can assist parents with accessing and engaging in services and overcoming barriers to recovery. For more information on co-occurring mental health disorders, visit the Child Welfare Information Gateway's page on co-occurring mental health and substance use disorders and the Substance Abuse and Mental Health Services Administration's (SAMHSA) page on co-occurring disorders and other health conditions.

SUDs can affect each member of the family, relationships, and parenting: SUDs can contribute to a chaotic and unpredictable home life, inconsistent parenting, and lack of appropriate care for children. Treatment and recovery support must not focus solely on the parent's substance use or mental health concern; it takes a family-centered approach that accounts for the needs of each affected family member (e.g., Al-Anon Family Groups, Alateen, NAMI Family Support Group and other family support services).

1

Recognize co-occurrence of trauma: Trauma is a common experience associated with SUDs. Substance use might be an individual's way to cope. An effective practice integrates a trauma-informed approach that not only recognizes the signs and symptoms, but also avoids causing further harm and re-traumatization.

Disparities affect outcomes. Although there is little variance in the prevalence of SUDs by race and ethnicity,[7] disparities do exist in treatment services and outcomes.[8] Data for families affected by parental substance use indicates that Black, Indigenous, and persons of color are disproportionately represented in the child welfare system and face disparate access to substance use disorder and mental health treatment.[9,10,11,12,13] Disparities also exist at each of the decision points across the child welfare continuum; they contribute to racial and ethnic minority children experiencing lengthier placement in out-of-home care, they are less likely to reunify and they are overrepresented in group and residential placements.[14] Equitable access to evidence-based treatment is an integral part of the services for families affected by SUDs and child welfare.

LEARN MORE

The National Center on Substance Abuse and Child Welfare (NCSACW) developed this tool as part of a series of tip sheets for child welfare workers who serve families affected by SUDs.For more information and practice tips on working with families affected by SUDs and child welfare, read:

Understanding Screening and Assessment of Substance Use Disorders – Child Welfare Practice Tips

Understanding Engagement of Families Affected by Substance Use Disorders – Child Welfare Practice Tips

Identifying Safety and Protective Capacities for Families with Parental Substance Use Disorders and Child Welfare Involvement

Child Welfare and Planning for Safety: A Collaborative Approach for Families with Parental Substance Use Disorders and Child Welfare Involvement

For more information about different substances and additional resources and links to drug fact sheets, visit SAMHSA's page *Know the Risks of Using Drugs*.

Understanding Substance Use Disorders, Treatment, and Family Recovery: A Guide for Child Welfare Professionals is a self-paced and free tutorial that provides specific information about SUDs, engagement strategies, and the treatment and recovery process for families affected by SUDs. Continuing education units are available upon completion.

NCSACW's page on *Resources to Advance Equity* provides additional resources; along with state and local examples, related online trainings, videos, and webinars.

The Child Welfare Information Gateway's page on *Disproportionality* provides resources on issues such as overrepresentation in the child welfare system, underrepresentation in support services, inequitable investigations for suspected cases of maltreatment, and disparities in decision-making. It also provides resources on pursuing racial and LGBTQ (lesbian, gay, bisexual, transgender, and questioning) equity in child welfare.

The Substance Abuse and Mental Health Services Administration and the National Institute on Drug Abuse websites offer comprehensive information about treatment for SUDs, mental health, equitable services, and treatment location services.

ENDNOTES

[1]Ghertner, R. (2022). *National and State Estimates of Children with Parents Using Substances, 2015-2019* Washington, DC: US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. https://aspe.hhs.gov/sites/default/files/documents/f34eb24c1aff645bed0a6e978c0b4d16/children-at-risk-of-sud.pdf

[2]Peleg-Oren, N., & Teichman, M. (2006). Young children of parents with substance use disorders (SUD): A review of the literature and implications for social work practice. *Journal of Social Work Practice in the Addictions, 6*(1-2), 49–61. https://doi.org/10.1300/J160v06n01_03

[3]Kepple N. J. (2018). Does parental substance use always engender risk for children? Comparing incidence rate ratios of abusive and neglectful behaviors across substance use behavior patterns. *Child Abuse & Neglect, 76*, 44–55. https://doi.org/10.1016/j.chiabu.2017.09.015

[4]Ghertner, R., Waters, A., Radel, L., & Crouse, G. (2018). The role of substance use in child welfare caseloads. *Children and Youth Services Review, 90*, 83–93. https://doi.org/10.1016/j.childyouth.2018.05.015

[5]Hirai, A. H., Ko, J. Y., Owens, P. L., Stocks, C., & Patrick, S. W. (2021). Neonatal abstinence syndrome and maternal opioid-related diagnoses in the US, 2010-2017. *JAMA, 325*(2), 146–155. https://doi.org/10.1001/jama.2020.24991

[6]Child Welfare Information Gateway. (2021). *Parental substance use: A primer for child welfare professionals*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau.

[7]Center for Behavioral Health Statistics and Quality. (2021). *Racial/ethnic differences in substance use, substance use disorders, and substance use treatment utilization among people aged 12 or older (2015-2019)* (Publication No. PEP21-07-01-001). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from https:// www.samhsa.gov/data/

[8]Acevedo, A., Panas, L., Garnick, D., Garcia, D.A., Miles, J., Ritter, G., & Campbell, K. (2019, October 1). Disparities in the treatment of substance use disorders: Does where you live matter? *The Journal of Behavioral Health Services & Research, 45*(4), 533-549. doi: 10.1007/s11414-018-9586-y

[9]Substance Abuse and Mental Health Services Administration. (2020). *The Opioid Crisis and the Black/African American Population: An Urgent Issue*. Publication No. PEP20-05-02-001. U.S. Department of Health and Human Services, Office of Behavioral Health Equity. https://store.samhsa.gov/sites/default/files/SAMHSA_Digital_Download/PEP20-05-02-001_508%20Final.pdf

[10]Larochelle, M. R., Slavova, S., Root, E. D., Feaster, D. J., Ward, P. J., Selk, S. C., Knott, C., Villani, J., & Samet, J. H. (2021). Disparities in opioid overdose death trends by race/ethnicity, 2018–2019, from the HEALing Communities Study. *American Journal of Public Health, 111*, 1851-1854. https://doi.org/10.2105/AJPH.2021.306431

[11]Cummings, J. R., Wen, H., Ko, M., & Druss, B. G. (2014). Race/ethnicity and geographic access to Medicaid substance use disorder treatment facilities in the United States. *JAMA Psychiatry, 71*(2), 190-196. https://doi.org/10.1001/jamapsychiatry.2013.3575

[12]Cummings, J. R., Wen, H., Ko, M., & Druss, B. G. (2014). Race/ethnicity and geographic access to Medicaid substance use disorder treatment facilities in the United States. *JAMA Psychiatry, 71*(2), 190-196. https://doi.org/10.1001/jamapsychiatry.2013.3575

[13]National Conference of State Legislatures. (2021). *Disproportionality and race equity in child welfare*. https://www.ncsl.org/research/human-services/disproportionality-and-race-equity-in-child-welfare.aspx

[14]Cummings, J. R., Wen, H., Ko, M., & Druss, B. G. (2014). Race/ethnicity and geographic access to Medicaid substance use disorder treatment facilities in the United States. *JAMA Psychiatry, 71*(2), 190-196. https://doi.org/10.1001/jamapsychiatry.2013.3575

CONTACT US

Email NCSACW at *ncsacw@cffutures.org*

Visit the website at *https://ncsacw.acf.hhs.gov*

Call toll-free at *866.493.2758*

This resource is supported by contract number 75520422C00001 from the Children's Bureau (CB), Administration for Children and Families (ACF), co-funded by the Substance Abuse and Mental Health Services Administration (SAMHSA). The views, opinions, and content of this resource are those of the presenters and do not necessarily reflect the views, opinions, or policies of ACF, SAMHSA or the U.S. Department of Health and Human Services (HHS).

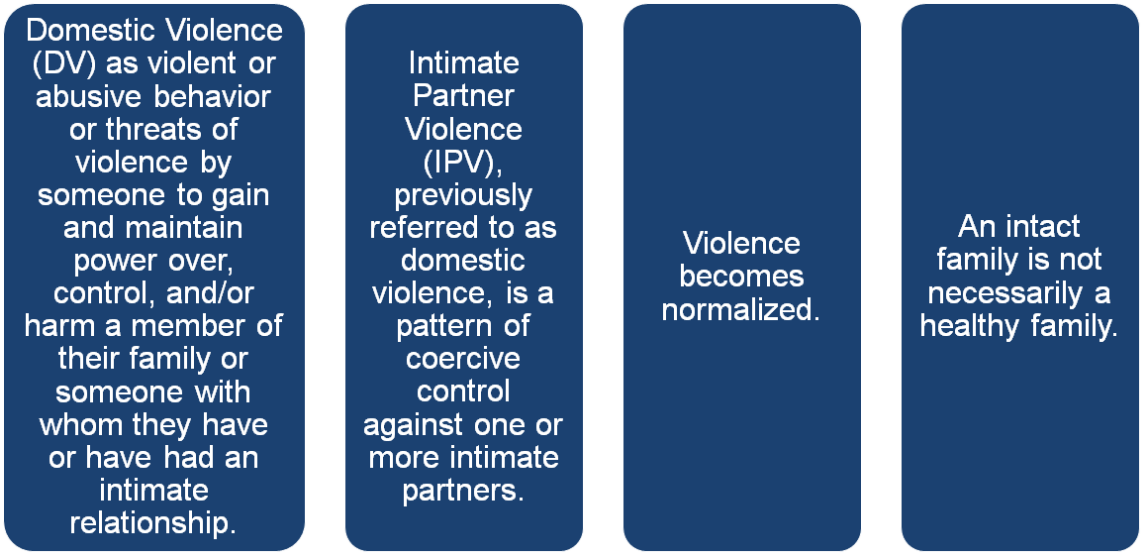
National Center on Substance Abuse and Child Welfare

& ACF

SAMHSA Substance Abuse and Mental Health Services Administration

3

Definition of Domestic Violence



Domestic Violence (DV) is violent or abusive behavior or threats of violence by someone to gain and maintain power over, control, and/or harm a member of their family or someone with whom they have or have had an intimate relationship.

Intimate Partner Violence (IPV), previously referred to as domestic violence, is a pattern of coercive control against one or more intimate partners.

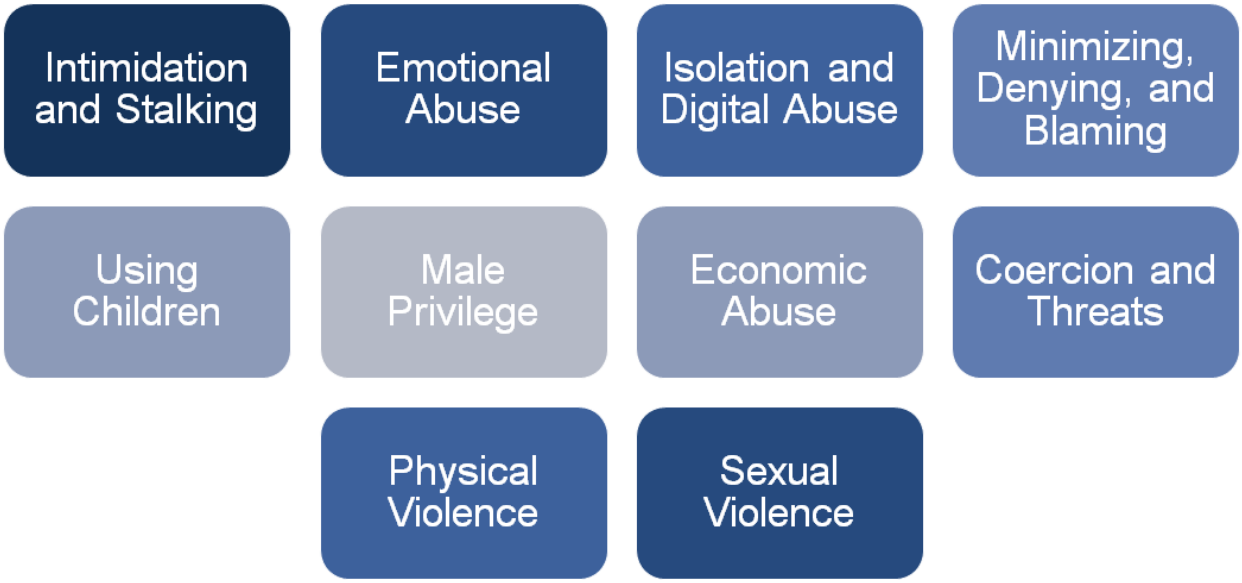
DV and IPV are patterns of power and control that can become normalized for victims, making it difficult for them to recognize or disclose the abuse.

Understanding domestic violence and intimate partner violence dynamics during Intake is critical for gathering the right information, identifying the alleged perpetrator, and supporting safe assessment planning. Screeners must clearly define domestic violence and intimate partner violence for reporters, ask the mandatory screening question, and document objectively while actively monitoring for bias

Understanding the dynamics of domestic violence when screening reports is critical because it helps you understand key information to gather and who the alleged perpetrator of child maltreatment is. Details captured in the narrative are especially important for the assessment worker to plan for safety for themselves and the whole family when initiating an assessment in cases where domestic violence is a factor. Asking if domestic violence is a concern is a mandatory question and you need to be prepared to communicate the definition of domestic violence to reporters. This is also a topic where we need to be aware of potential bias and ensure decisions are made based on allegations presented and policy requirements and that language in documentation is objective and behaviorally-specific.

Use this space to record notes.

Domestic and Intimate Partner Violence



Domestic violence is defined in North Carolina DHHS DSS child welfare policy 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."

Use this space to record notes.

Handout: Power and Control Wheel

Use this space to record notes.

Source: Created by the Domestic Abuse Intervention Project in Duluth, MN.

What is Human Trafficking?

NC Child Welfare defines human trafficking as “a child who is sold, traded, or exchanged for anything, or to settle a debt, regardless of whether the child is used for labor or sex.”

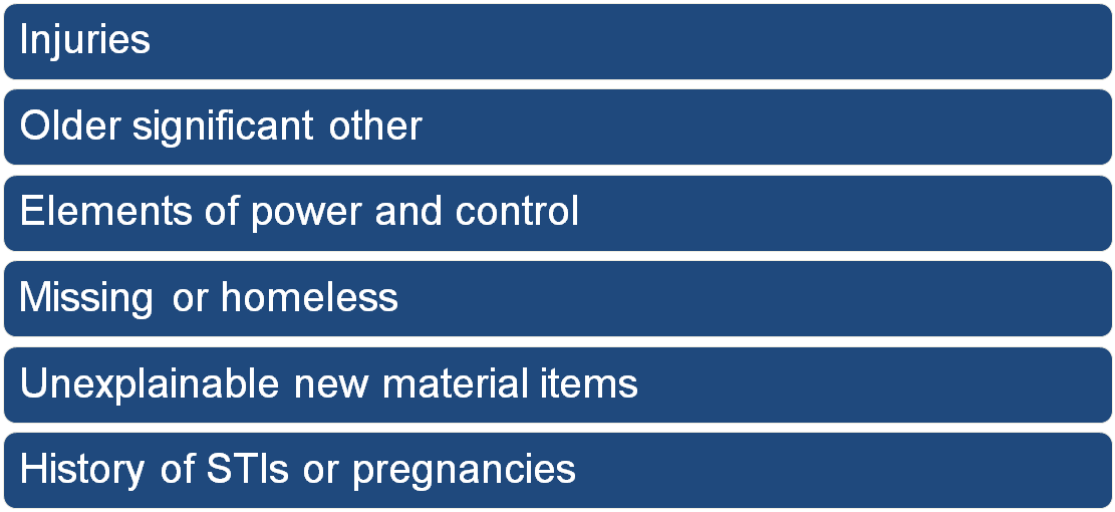
NC consistently ranks in the top 10 in the country for human trafficking

Video: Common Myths About Human Trafficking

Watch the “Common Myths About Human Trafficking” video at https://youtu.be/u-wQQEy4ECE.

Use this space to record notes.

Signs of Youth Trafficking



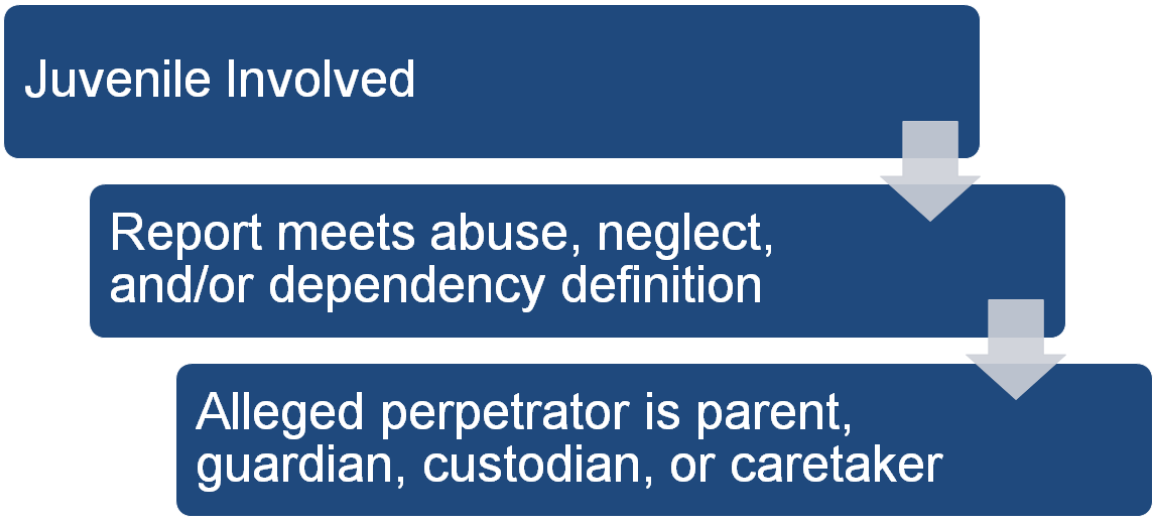
Outward signs of youth who are being trafficked may appear as simple as difficult behavior or resistance to assistance, but could also take on more extreme characteristics:

- Confirmed or reported uses of hotels for parties or sexual encounters
- They have injuries that are unaccounted for
- They have tattoos or branding that may indicate the trafficker's name, initials or symbols associated with an organization
- They have an older significant other
- Elements of power and control with a significant other
- They are missing or homeless
- They have money, cell phone, new hair, nails, or material items that cannot be explained or accounted for
- They have a history of multiple and/or anonymous sexual partners
- They have a history of sexually transmitted infections or pregnancies

What other signs have you encountered or are aware of that may be key indicators that a child is involved or at risk of human trafficking?

Legal Definitions and Maltreatment Allegations

When Can DSS Become Involved With a Family?



Potential DSS involvement with a family begins with a report of suspected child abuse, neglect, or dependency to a county. DSS has the legal authority to intervene with children and families based on allegations of abuse, neglect, or dependency. This is governed by law and policy.

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

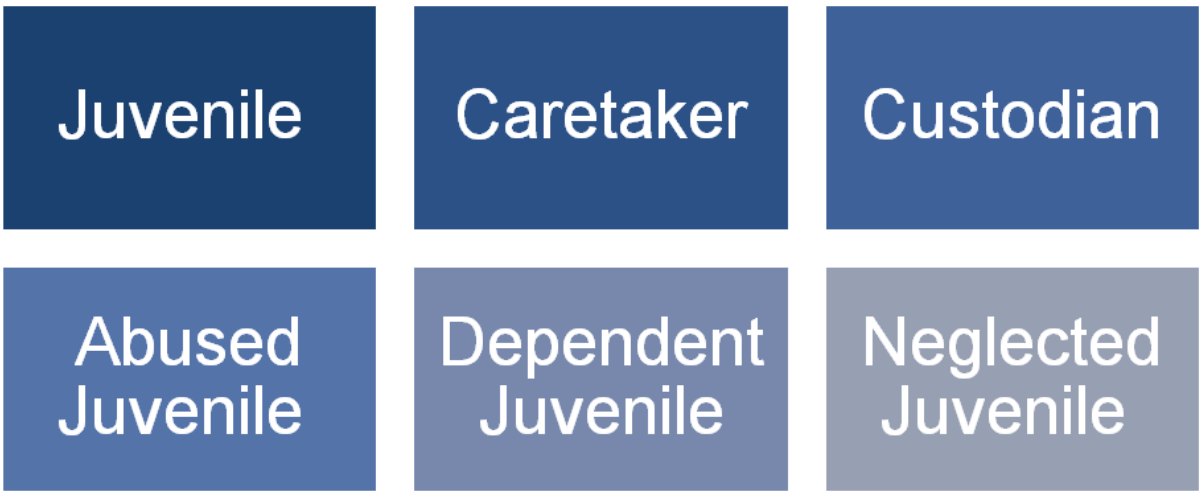
- Maltreatment of a juvenile
- And the alleged maltreatment must meet the statutory definition of abuse, neglect, and/or dependency
- By a perpetrator who is a parent, guardian, custodian, or caretaker

Reports that do not involve maltreatment of a child by a parent, guardian, custodian, or caretaker (except human trafficking allegations) will be automatically screened out and sent to a supervisor for a 2nd level review. Without these three elements being included in a formal intake report, DSS does not have the legal authority to become involved with a family.

The one exception is if a report involves human trafficking, the alleged perpetrator does not have to be a parent, guardian, custodian, or caretaker.

Use this space to record notes.

North Carolina General Statute Definitions



Using the legal definitions of juvenile, caretaker, custodian, abused juvenile, dependent juvenile, and neglected juvenile allows us to determine when DSS can intervene with a family and when abuse, neglect, or dependency has occurred. There are tools throughout the intake process that help you apply these definitions.

Based on your previous review of these definitions, what is the definition of a juvenile?

Based on your previous review of these definitions, what is the definition of a caretaker?

Based on your previous review of these definitions, what is the definition of a custodian?

Handout: NCGS 07.7B 101 Definitions

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

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

- Marriage or enlistment in the armed services automatically causes emancipation.

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

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

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

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

- Inflicts or allows to be inflicted upon the juvenile a serious physical injury by other than accidental means.
- Creates or allows to be created a substantial risk of serious physical injury to the juvenile by other than accidental means.
- Uses or allows to be used upon the juvenile cruel or grossly inappropriate procedures or cruel or grossly inappropriate devices to modify behavior.
- Commits, permits, or encourages the commission of a violation of following laws by, with, or upon the juvenile: first-degree forcible rape; second-degree forcible rape; statutory rape of a child by an adult; first-degree forcible sex offense: second-degree forcible sex offense; statutory sexual offense with a child by an adult; first-degree statutory sexual offense; sexual activity by a substitute parent or custodian; sexual activity with a student; unlawful sale, surrender, or purchase of a minor, crime against nature; incest; preparation of obscene photographs, slides, or motion pictures of the juvenile; employing or permitting the juvenile to assist in a violation of the obscenity laws; dissemination of obscene material to the juvenile; displaying or disseminating material harmful to the juvenile; first and second-degree sexual exploitation of the juvenile; promoting the prostitution of the juvenile; and taking indecent liberties with the juvenile.

- Creates or allows to be created serious emotional damage to the juvenile; serious emotional damage is evidenced by a juvenile's severe anxiety, depression, withdrawal, or aggressive behavior toward himself or others.
- Encourages, directs, or approves of delinquent acts involving moral turpitude committed by the juvenile.
- Commits or allows to be committed an offense under human trafficking, involuntary servitude, or sexual servitude against the child statutes.

Moral turpitude includes situations where a parent encourages a child to shoplift and does not intervene to stop the child from shoplifting; or situations where a parent encourages a child to sell drugs or sets a 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 GS 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.

Source: North Carolina General Statutes, Chapter 7B - Juvenile Code.
https://www.ncleg.gov/Laws/GeneralStatuteSections/Chapter7B

What stood out to you in this definition of Juvenile?

What is the difference between a caretaker and a custodian?

Why does it matter which category someone falls into?

What is unique about the Dependent Juvenile category compared to the Abused Juvenile and Neglected Juvenile categories?

Applying Caretaker Definition

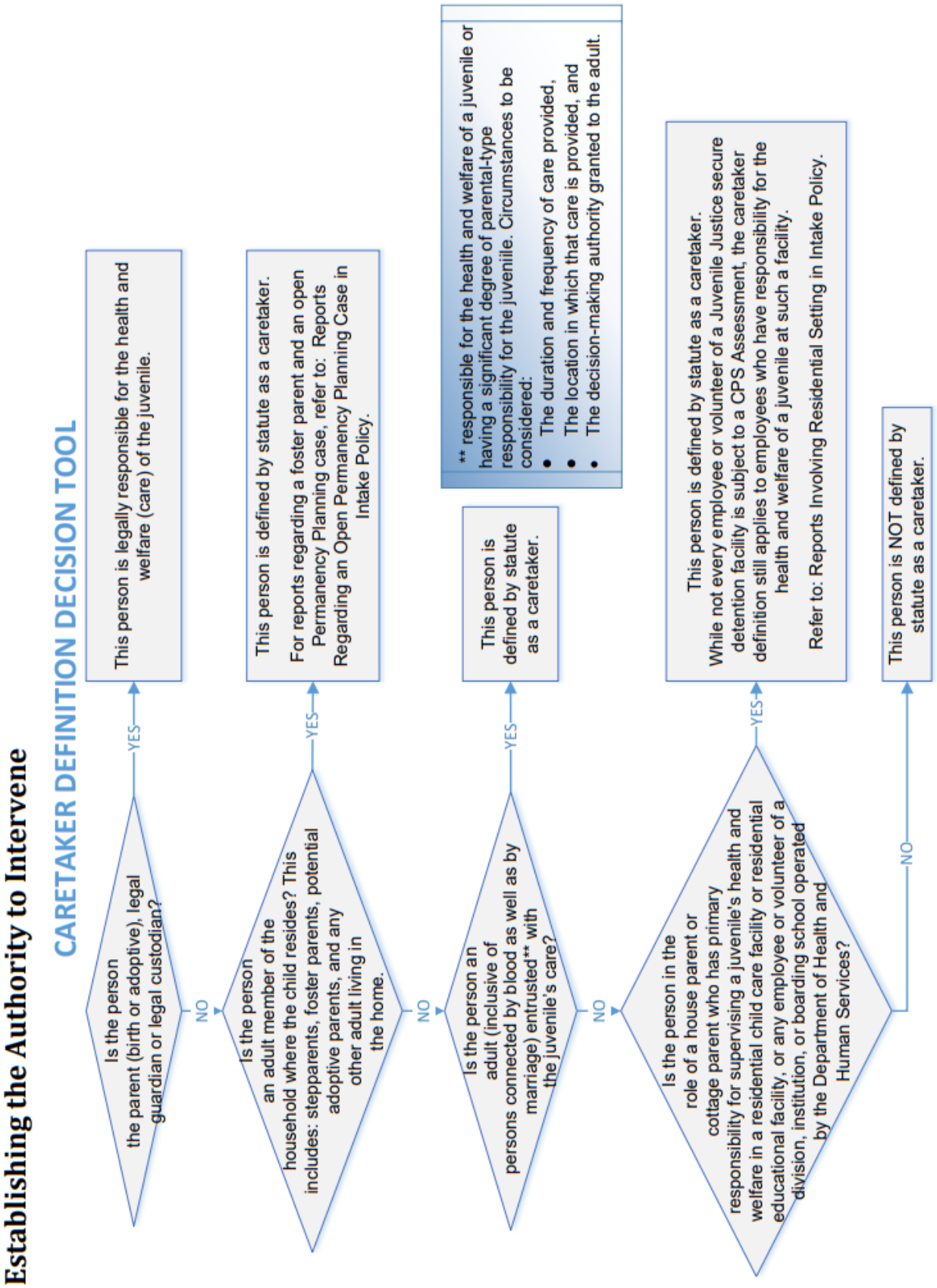
Activity: Skills Practice: Applying Caretaker Definition

The purpose of this activity is to practice applying caretaker definitions with a case scenario.

What to do:

- With your group, review your assigned scenario and, using the caretaker definitions from the Handout: NCGS 07.7B 101 Definitions, and the Handout: Caretaker Definition Decision Tool, determine whether the alleged perpetrator met the statutory requirements for a caretaker at the time the maltreatment occurred.
- Be prepared to share your group's decisions and reasons for the decision.

Handout: Caretaker Definition Decision Tool



Scenario 1:

Allegation: Sexual abuse; Any sexual act on a child by an adult caretaker or other adult in the household. The school counselor reported that a six-year-old student disclosed that her stepfather comes into her room at night and “touches her private parts.”			
Alleged perpetrator: Stepfather, lives in the home with mother, child, and two siblings.			
	Caretaker		Not a Caretaker
Explain your decision:			

Scenario 2:

Allegation: Physical neglect, unsafe supervision. A neighbor reported that a three-year-old was wandering around an apartment complex alone at night. When the neighbor returned the child to his apartment, his 22-year-old babysitter was asleep on the couch, and the apartment smelled strongly of marijuana. The babysitter regularly watches the child in the evenings and on weekends while his parents go out.			
Alleged perpetrator: Babysitter			
	Caretaker		Not a Caretaker
Explain your decision:			

Scenario 3:

Allegation: Physical neglect, unsafe discipline. A teacher reported that an eight-year-old came to school with welts on the back of his legs and buttocks. When asked what happened, he said that his grandmother "whooped" him when he wouldn't stop playing video games to eat dinner and do his homework. The teacher stated that the grandmother lives close by and watches the children from when they get off the bus until their mother gets home from work around 8 p.m. daily. The children also spend significant time at her house on weekends while their mother works.			
Alleged perpetrator: Grandmother			
	Caretaker		Not a Caretaker
Explain your decision:			

Scenario 4:

Allegation: Physical Abuse, serious physical injury inflicted by the action of a caretaker. A hospital social worker reported that a 15-year-old was brought to the emergency room with a broken arm, several fractured ribs, and significant scrapes and bruising all over his torso. The 15-year-old said that he was outside, refused to comply with a directive from a direct care staff member at his group home, and that the direct care staff member threw him to the ground in a restraint and then dragged him across the driveway inside.			
Alleged perpetrator: Direct care staff member at group home			
	Caretaker		Not a Caretaker
Explain your decision:			

Scenario 5:

Allegation: Physical abuse, substantial risk of physical harm. Law enforcement called to report a man had been arrested for a DUI while driving with three children in the car. The children are reported to be his two nieces and a nephew. They all live together with his brother, who is the children's father.			
Alleged perpetrator: Uncle			
	Caretaker		Not a Caretaker
Explain your decision:			

Scenario 6:

Allegation: Physical abuse, excessive or cruel punishment. A grandmother called to report that when she picked up her 18-month-old grandson from daycare, he had bruises that looked like a handprint on his arm and red marks on his back. The daycare administrator denied that any incident occurred, but the grandmother said the injuries are new from when she dropped him off in the morning and she suspects it was his teacher because at pick-up she told the grandmother the child had "pushed her to her limits" today.			
Alleged perpetrator: Daycare employee			
	Caretaker		Not a Caretaker
Explain your decision:			

Maltreatment Definitions

Activity: Maltreatment Definitions

The purpose of this activity is to promote a deeper understanding of the maltreatment definitions and begin practicing explaining them to reporters of abuse and or neglect in accessible terms.

What to do:

Step One:

- The training facilitator will assign each table group a type of maltreatment.
- Access the NC Child Welfare Manual: CPS Intake, Protocol, and Guidance at https://policies.ncdhhs.gov/wp-content/uploads/PATH-NC-Intake-Manual-January-2026-1.pdf OR the SDM® screening and response tool policy and procedures manual at https://policies.ncdhhs.gov/wp-content/uploads/SDM-Screening-and-Response-Instructions-Manual_FINAL-20252-1.pdf to review the full maltreatment definitions.
- In your table group, spend ten minutes reviewing your assigned maltreatment type and brainstorming reporter-accessible definitions you might share during an Intake call.

Step Two:

- Find a partner from another table group and take turns practicing your maltreatment explanation in reporter-accessible language.
- One of you will play the role of reporter, and one will act as the Intake Caseworker.
- Offer feedback to your partner on their explanation.
- Edit your reporter-accessible maltreatment definition and practice again.
- Repeat until you both feel comfortable that your explanations are accessible to reporters.

Step Three:

- Return to your original table group from part one.
- Spend five minutes sharing the feedback that you received and your edited maltreatment explanation with the table group.
- Compare and contrast your reporter-accessible maltreatment language.
- Spend 15 minutes writing a list of what other information you will need to know/ask about to assess whether a report meets the assigned maltreatment definition.
- Record your other information needed (or questions) on a poster/flipchart paper.

Reporter-Accessible Explanation of Maltreatment:

As you were taking notes, what stood out to you about the definitions today that you hadn't noticed before?

What tips do you have for gaining clarity around the definitions and feeling more comfortable applying them?

What key tool could you use to better understand contributing factors, like substance use or mental health conditions, to help you make screening decisions?

Self-Reflection Training Wrap-Up

Self-Reflection Activity

Worksheet: Reflection and Check-In

Reflection and Check-In	
 Strengths Reflection	
Opportunities for Growth Reflection	
 "Aha" Moments	

Bibliography of References

Day Three

Annie E. Casey Foundation. (2025). *Children who are confirmed by child protective services as victims of maltreatment by maltreatment type in North Carolina, 2023* [Data set]. Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau; Kids Count Data Center; National Child Abuse and Neglect Data System (NCANDS) Child File. https://datacenter.aecf.org/data/tables/9906-children-who-are-confirmed-by-child-protective-services-as-victims-of-maltreatment-by-maltreatment-type?loc=35&loct=2#detailed/2/35/false/2545/3885,3886,3887,3888,3889,3890/19240,19241.

Child Welfare Information Gateway. (2021). *Definitions of domestic violence*. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://www.childwelfare.gov/resources/ definitions-domestic-violence/.

DePanfilis, D. (2018). *Child Protective services: A guide for caseworkers*. U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, Office on Child Abuse and Neglect. https://kids.myflfamilies.com/documents/46076.pdf

Evident Change & North Carolina Department of Health and Human Services. (2024). *North Carolina Safety-Organized Practice Training Series: Three Questions and Three-Column Mapping* [curriculum]. https://ncswlearn.org/plp/catalog/curriculum.aspx?cid=631

Evident Change & North Carolina Department of Health and Human Services. (2025). *North Carolina Safety-Organized Practice Training Series: Introducing safety-organized practice* [curriculum]. https://ncswlearn.org/default.aspx

Evident Change & North Carolina Department of Health and Human Services. (2025). *North Carolina Safety-Organized Practice Training Series: Structured Decision-Making Risk Assessment Overview* [curriculum]. https://ncswlearn.org/plp/catalog/curriculum.aspx?cid=614.

Evident Change & North Carolina Department of Health and Human Services. (2025). *SDM® safety assessment policy and procedure manual*. https://policies.ncdhhs.gov/wp-content/uploads/North-Carolina-SDM-Safety-Manual_FINAL-2025.pdf.

Evident Change & North Carolina Department of Health and Human Services. (2025). *SDM® screening and response tool policy and procedures manua*l. https://policies.ncdhhs.gov/wp-content/uploads/SDM-Screening-and-Response-Instructions-Manual_FINAL-20252-1.pdf.

Juvenile Code, NCGS §7B-101 Abuse, Neglect, Dependency Definitions. (1979, rev. 2021). https://www.ncleg.net/EnactedLegislation/Statutes/HTML/ByChapter/Chapter_7B.html

Juvenile Code. NCGS § 7B-301 Duty to report abuse, neglect, dependency, or death due to maltreatment. (1979, rev. 2015). https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_7B/GS_7B-301.pdf.

Juvenile Code. NCGS § 7B-309 Immunity of persons reporting and cooperating in an assessment. https://www.ncleg.gov/EnactedLegislation/Statutes/PDF/BySection/Chapter_7B/GS_7B-309.pdf.

Minoff, E., & Citrin, A. (2022). *Systemically Neglected: How Racism Structures Public Systems to Produce Child Neglect*. Center for the Study of Social Policy. https://www.pacesconnection.com/fileSendAction/fcType/0/fcOid/525155359613901497/filePointer/525155359613901521/fodoid/525155359613625469/Systemically-Neglected-How-Racism-Structures-Public-Systems-to-Produce-Child-Neglect.pdf.

National Alliance on Mental Illness. (2025). *You are not alone* [Fact sheet]. https://www.nami.org/wp-content/uploads/2025/10/NAMI_YouAreNotAlone_2025.pdf

National Center on Substance Abuse and Child Welfare. (n.d.). *Understanding substance use disorders: What child welfare staff need to know*. U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau & Substance Abuse and Mental Health Services Administration. https://ncsacw.acf.gov/files/tips-staff-need-to-know-508.pdf.

National Domestic Violence Hotline. (n.d.). *Types of abuse*. https://www.thehotline.org/resources/types-of-abuse/

National School of Healthcare Science. (2022). *Understanding different types of bias*. Nshcs.hee.uk. National Health Services Health Education England. https://nshcs.hee.nhs.uk/about/equality-diversity-and-inclusion/conscious-inclusion/understanding-different-types-of-bias/.

North Carolina Division of Social Services & North Carolina State University, the Center for Family and Community Engagement. (2017). *Domestic violence policy and best practice in child welfare participant workbook*. https://www.ncdhhs.gov/documents/files/dss/training/domestic-violence-workbook/download.

North Carolina Department of Health and Human Services, Division of Social Services. (2023). *Worker practice standards desk guide*. https://www.ncdhhs.gov/cw-worker-north-carolina-worker-practice-standards-desk-guide/open

North Carolina Department of Health and Human Services, Division of Social Services. (2023). *North Carolina practice standards worker assessment*. https://www.ncdhhs.gov/cw-worker-north-carolina-worker-assessment-all-practice-standards/open.

North Carolina Department of Health and Human Services, Division of Social Services, Economic and Family Services, Continuous Quality Improvement. (2023, October). *Domestic violence (DV)* [PowerPoint slides from October regional meeting].

North Carolina Department of Health and Human Services, Division of Social Services. (2020). *NC child welfare manual: CPS purpose & philosophy, legal basis, administration*. https://policies.ncdhhs.gov/wp-content/uploads/purpose.pdf

North Carolina Department of Health and Human Services, Division of Social Services. (2025). *NC Child Welfare Manual: CPS assessments policy, protocol, and guidance*. https://policies.ncdhhs.gov/wp-content/uploads/PATH-NC-Assessments-October-2025.pdf.

North Carolina Department of Health and Human Services, Division of Social Services. (2025). *NC child welfare manual: Cross-function topics*. https://policies.ncdhhs.gov/wp-content/uploads/Cross-Functions-Nov-2025.pdf.

North Carolina Department of Health and Human Services. (2026). *NC child welfare manual: CPS intake policy, protocol, and guidance*. https://policies.ncdhhs.gov/wp-content/uploads/PATH-NC-Intake-Manual-January-2026-1.pdf

North Carolina Human Trafficking Commission. (2020, December 16). *Common myths about human trafficking* [Video]. https://youtu.be/u-wQQEy4ECE.

North Carolina Judicial Branch. (2025). *North Carolina Human Trafficking Commission*. https://www.nccourts.gov/commissions/human-trafficking-commission.

Staats, C., Capatosto, K., Tenney, L., & Mamo, S. (2017). *State of the science: Implicit bias review*. Kirwan Institute for the Study of Race and Ethnicity https://offices.depaul.edu/academic-affairs/academicdiversity/Documents/State%20of%20Science%20Implicit%20Bias%20Review.pdf.

U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2025). *Child Maltreatment 2023*. https://www.acf.hhs.gov/cb/data-research/child-maltreatment.

Appendix A: North Carolina Child Welfare Practice Standards Desk Guide

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Worker Practice Standards Desk Guide

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

North Carolina's Practice Model Pyramid

What is a Practice Model?

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

What is a Practice Standard?

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

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

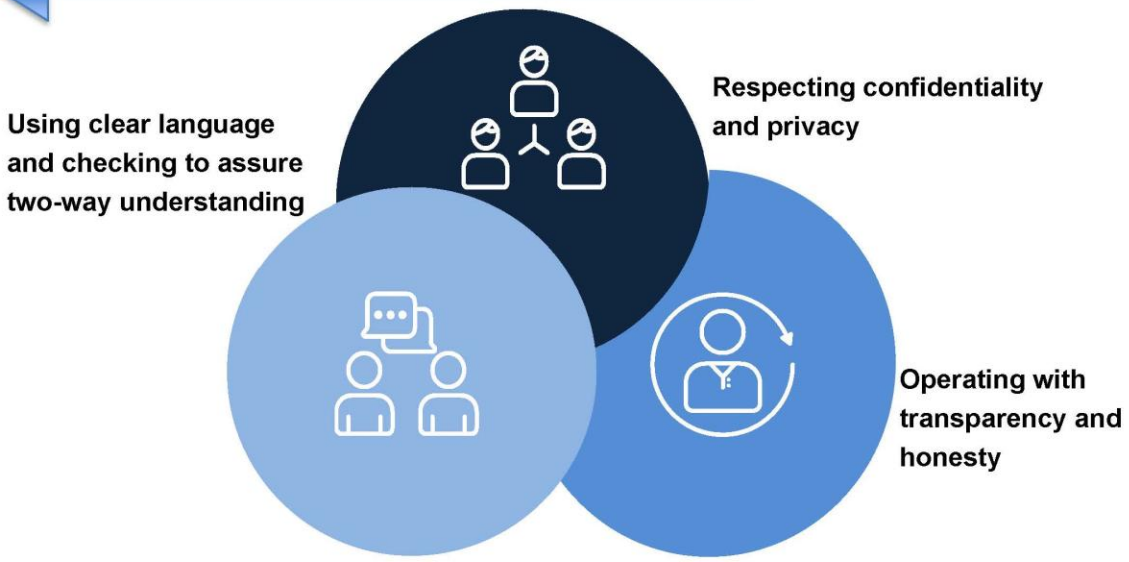
Division of Social Services

Key Behaviors and Core Activities

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

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

Communicating Core Activities

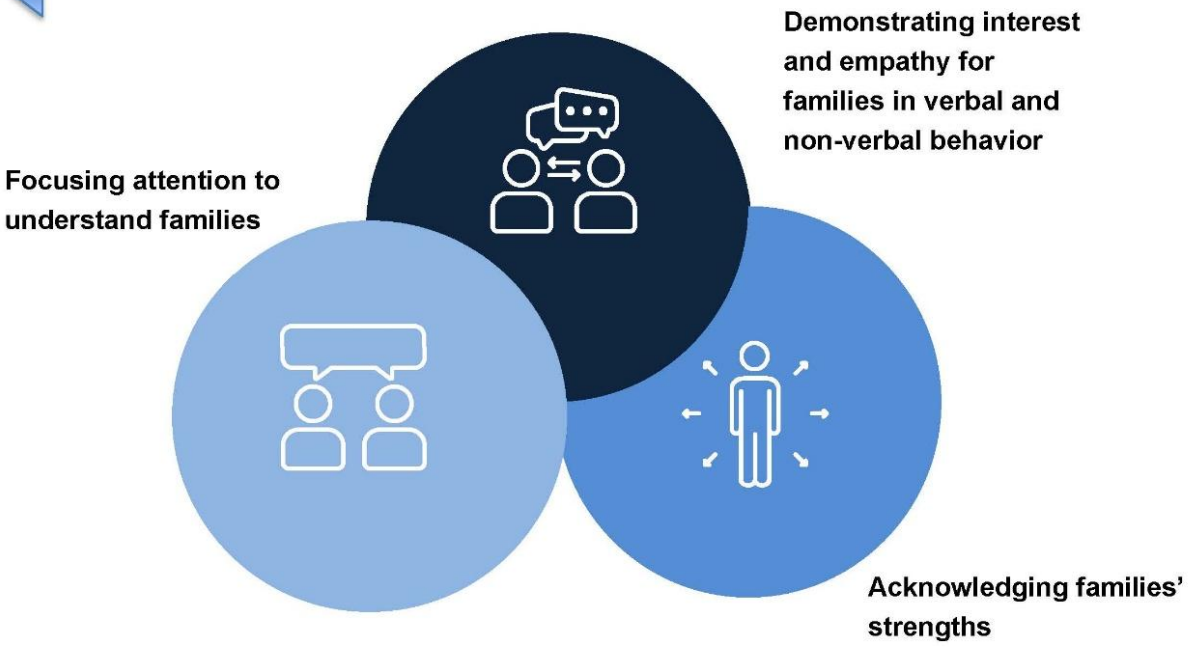


NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services

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

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

Engaging Core Activities

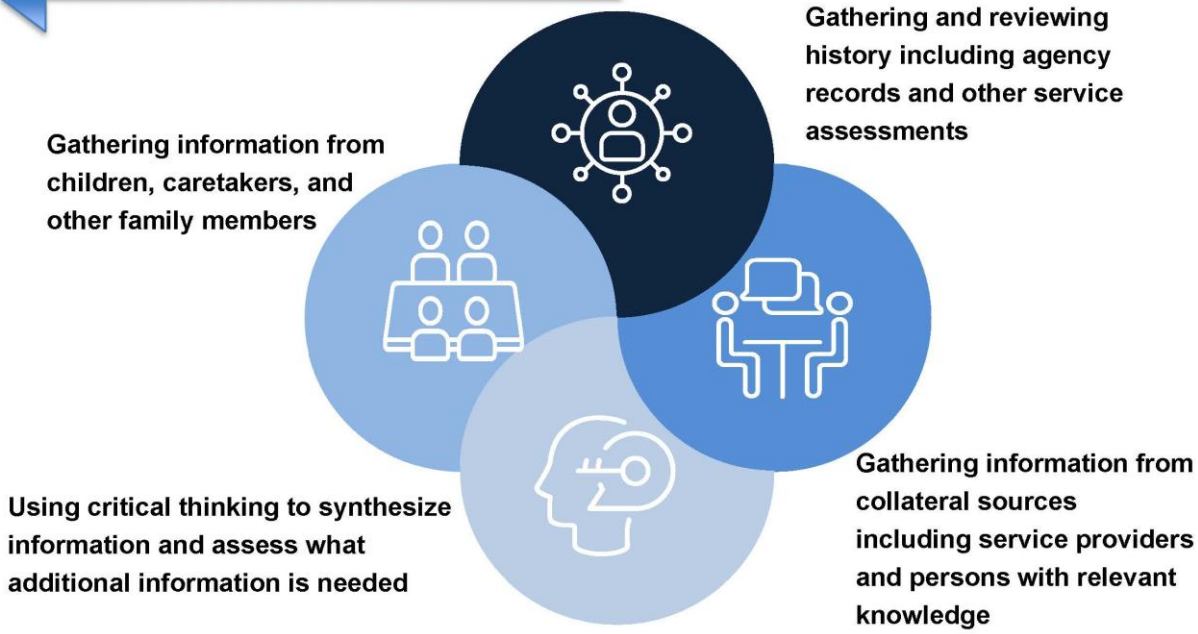


NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services

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

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

Assessing Core Activities

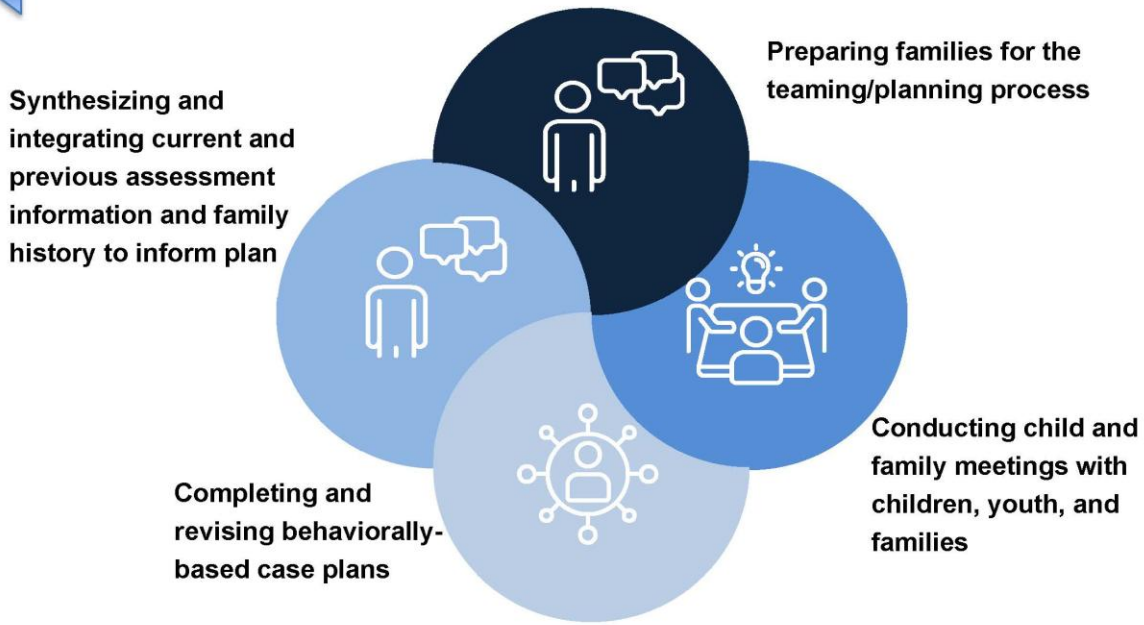


NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services

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

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

Planning Core Activities



NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services

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

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

Implementing Core Activities

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Strategies for Applying Practice Standards in Your Everyday Work

Communicating

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

Engaging

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

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Assessing

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

Planning

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

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

Implementing

- Partner with the family on determining services and service delivery and what will work best for their family.
- Offer to make initial phone calls to assist in navigating a complex service array system.
- Bust barriers to accessing services, such as lack of transportation, lack of a communication device, or lack of funds.
- Help the family fully understand the purpose of each service so that they understand what progress will look like.
- Use a three-step process of: "What is going well?"; "What needs to happen?"; and "What are our next steps?".
- Continuously assess services with the family and adjust as needed. Reassess barriers once services begin to ensure the family can continue to be successful or if changes are needed.
- Always remember the power differential that exists and that the family may be unsure of how to advocate for themselves with providers, therefore you must advocate both for and with them.
- Consider the family's interests, culture, and faith when exploring natural supports that may help them feel confident and supported during the process.
- Celebrate along with the family when progress is made, and goals are achieved.

Resources

North Carolina Worker Practice Standards

Practice Standards Worker Self-Assessment

Transfer of Learning Tools: Self-Assessment, Peer Review, and 360-Degree Evaluation