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 Four

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, Workbook pages have 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 may use the delete key to remove extra lines.

Course Themes

The central themes of the Intake in Child Welfare Track Training Day Three 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 Four Agenda

Intake in Child Welfare Track Training

Welcome, Team Agreements, and Agenda

Special Policy Circumstances

Special Policy Circumstances

BREAK

Ambivalence During an Intake Call

Ambivalence

Intake Learning Lab

Intake Learning Lab

LUNCH

Worker Safety and Well-being

Indirect Trauma

Worker Wellness and Self-Care

End-of-Day Values Reflection

Self-Reflection Activity

Learning Objectives

Day Four

Special Policy Circumstances
• Identify case circumstances in Intake reports that require specific responses.
Intake Learning Lab
• Formulate interview questions based on case scenarios.
• Apply SDM® screening and response tools to case scenarios.
• Assess scenario information to determine follow-up questions for reporters.
• Document Intake reports using behaviorally specific language in the narrative portion of the SDM® screening and response tool.
• Develop harm and worry statements based on scenarios.
Worker Safety and Well-being
• Identify, discuss, and apply strategies to promote their physical, psychological, and emotional safety and well-being.
• Discuss strategies that promote their physical, psychological, and emotional safety
• Discuss their self-care plan with an accountability partner and be able to seek out support when needed.
• Develop harm and worry statements based on scenarios.

Welcome

Special Policy Circumstances

Substance Affected Infants: Notification Requirement and CMARC Referrals

The Child Abuse Prevention and Treatment Act (CAPTA) of 1974 requires medical providers to notify DSS of any infant born affected by prenatal exposure to drugs or alcohol so that a Plan of Safe Care can be developed for the infant and the family. A Plan of Safe Care generally should address the needs of the infant and mother to ensure safety and support well-being. For cases screened in, there are specific requirements for Plans of Safe Care created by CPS-Assessments social workers, outlined in the policy guidance Child Welfare Resources for Substance Affected Infants and Plans of Safe Care [https://policies.ncdhhs.gov/wp-content/uploads/child-welfare-resources-for-substance-affected-infants-and-plan-of-safe-care.pdf].

The spirit and intent of this law is not for medical professionals to report child abuse and neglect. They are already required to do that. This law is intended to ensure that the developmental needs of these children are addressed and that mothers and parents receive the support they may need. Prenatal exposure to drugs and alcohol, and Fetal Alcohol Spectrum Disorders, can have significant impacts on child development that benefit from early intervention.

Intake caseworkers have two responsibilities when there is a report of a substance-affected newborn:

- To ensure that developmental needs are addressed, and a Plan of Safe Care will be developed by referral to Care Management for At-Risk Children (CMARC).
- To assess whether there are any safety concerns that meet the threshold for physical neglect or substance-affected newborn, and to make a screening decision.

The referral to CMARC *must occur before* the screening decision is made because of state confidentiality laws. Regardless of the screening decision, CMARC should assess the infant and family to provide necessary developmental screenings and, if there is no child welfare involvement, develop a Plan of Safe Care.

Use this space to record notes.

Substance Affected Infants: Screening for Maltreatment

Not all reports of substance-affected infants meet the statutory threshold for maltreatment. Intake caseworkers must gather information to assess if thresholds are met:

- Physical neglect, substance-affected newborn
- Child must be newborn up to 6 months for the allegation to apply

It is crucial that Intake caseworkers inquire about prescriptions and a mother's potential status in medication-assisted treatment. The application of C+B+I can support assessing whether the maltreatment threshold is met.

Any infant born exposed to substances that are not attributed to medical treatment, including medication-assisted treatment, and exposure is indicated by any of the following:

- Infant's positive toxicology screen for drugs or alcohol, other than prescribed AND
- A medical impact to the child (for example, hospitalization as a direct result of withdrawal or a medical condition that requires ongoing medical care that is directly attributed to the drugs or alcohol in the child's system); OR
- Demonstrating behavioral impact on the parent's ability to care for the infant; OR
- There are other maltreatment concerns, including the parent's ability to care for the infant, OR a pattern of substantiations or findings.
- A mother's positive toxicology screen at delivery for drugs or alcohol, other than as prescribed, AND there is a demonstration of a behavioral impact on the mother's ability to care for the infant.
- A mother's positive toxicology screen at delivery for drugs or alcohol, other than as prescribed, AND a pattern of substantiations, findings, or services for substance use.
- An infant has one of the following diagnoses: fetal alcohol syndrome (FAS), partial FAS, neurobehavioral disorder associated with prenatal alcohol exposure, alcohol-related birth defects, or alcohol-related neurodevelopmental disorder.

How do these criteria fit the C+B+I formula?

Substance Affected Infant: Knowledge Check

Activity: Substance Affected Infant Knowledge Check

The purpose of this activity is to reinforce understanding of the definition of a substance-affected infant.

What to do:

- Read each scenario.
- Determine if the scenario meets the threshold that defines a substance-affected infant.
- Be prepared to explain your reasoning.

Scenario 1: Mother's urine is positive for THC at birth. Reporter says she is engaged with and caring for infant.			
	Substance Affected Infant		Does not meet criteria for Substance Affected Infant
Explanation:			

Scenario 2: Mother tested positive for methamphetamines when 6 months pregnant. No positive toxicology for mother or infant at birth.			
	Substance Affected Infant		Does not meet criteria for Substance Affected Infant
Explanation:			

Scenario 3: Infant's urine is positive for opioids after birth. The infant is currently in the NICU and has been diagnosed with Neonatal Abstinence Syndrome.			
	Substance Affected Infant		Does not meet criteria for Substance Affected Infant
Explanation:			

Scenario 4: Mother and infant tested positive for benzodiazepines at birth. Verified she has a prescription to treat severe anxiety. She is refusing to hold the infant and saying she is worried she will hurt him if she goes home.			
	Substance Affected Infant		Does not meet criteria for Substance Affected Infant
Explanation:			

Intake Policy: Jigsaw Activity

Activity: Intake Policy Special Circumstances Jigsaw Activity

The purpose of this activity is to deepen understanding of several specific and less frequently encountered policy circumstances that require precise application during Intake and facilitate peer-to-peer learning.

What to do:

- The training facilitator will form small groups and assign each group a special policy circumstance:
  - Conflicts of interest
  - Reports involving open child placement cases and institutional placements
  - Reports involving non-residents or maltreatment that occurs out of state
  - Reports involving allegations of misdemeanor or felony child abuse
- You will have 15 minutes to use the Worksheet: Intake Policy Special Circumstances to build comprehensive knowledge of prescriptive requirements in policy for your group's assigned circumstance.
- When time is up, there will be an information-sharing session.
- Complete the Worksheet: Intake Policy Special Circumstances Jigsaw Activity during the information-sharing session.

Worksheet: Intake Policy Special Circumstances

Group Topic:	
When does this policy apply?	
What are the key components of this policy?	
What decisions need to be made if this circumstance is present?	
What information do you need to make those decisions?	
What are the timeframes associated with this policy?	
Are notifications to other agencies required? If so, what is the process for making them?	
What are the documentation requirements?	

Worksheet: Intake Policy Special Circumstances Jigsaw Activity

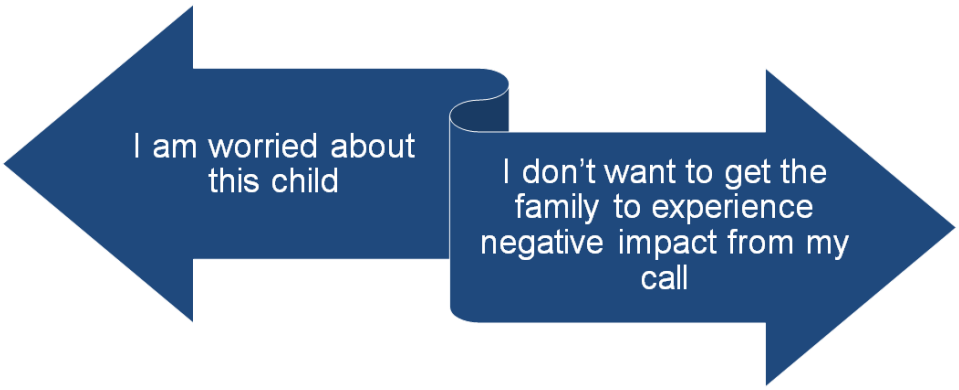
	Conflicts of interest	Reports involving open child placement cases and institutional placements
Key components		
Decisions if this circumstance is present?		
Relevant Information		
Timeframes		
Required notifications to other agencies and the process for making them		
Documentation requirements		

	Reports involving non-residents or maltreatment that occurs out of state	Reports involving allegations of misdemeanor or felony child abuse
Key components		
Decisions if this circumstance is present?		
Relevant Information		
Timeframes		
Required notifications to other agencies and the process for making them		
Documentation requirements		

Ambivalence During an Intake Call

Ambivalence

Ambivalence



Ambivalence is having conflicting feelings about wanting something to change and not wanting the change at the same time. Ambivalence occurs when someone simultaneously experiences contradictory emotions, attitudes, or desires toward the same person, object, or situation.

Why do you think we struggle to change?

What are some examples of ambivalence you have seen or can imagine in the intake process?

Recognizing Ambivalent Behaviors

Avoidance	Passivity	Anger/Hostility

How do you know you are encountering ambivalence?

What emotions might you feel when you encounter ambivalence?

List ways you might manage your emotions when you encounter ambivalence.

Calming and De-Escalation Strategies

Video: Calming and De-Escalation Strategies

Watch the "Calming and De-Escalation Strategies" video about identifying dysregulation and formulating strategies to support de-escalation [https://www.youtube.com/watch?v=R2PSExM-NhU].

What stood out to you about this information?

How will this help you when taking a reporter's call?

What from this video will you use when you get back to the office?

Worksheet: Calming and De-Escalation Strategies

Escalation

- We become escalated from a sense of threat or fear, real or perceived.
- Some brains are wired to expect harm or danger due to past experiences.
- When a person is stressed, angry, or scared, their survival brain becomes activated to keep them safe. This turns off the thinking part of the brain. People act on instincts, especially when reading non-verbal cues from others and the environment.

De-Escalation

- Use non-verbal cues to reduce the perception of threat.
    - Do not block or corner people who are upset, angry, or escalated.
    - Keep your body posture open and relaxed, even when difficult.
- It takes the body 20-30 minutes to come back to baseline after a real or perceived threat.

Strategies for De-Escalation	
Low and Slow	• Speech: use a low tone and slow speed • Body: move slowly, sit down, or lower the body to a more equal stance to the escalated person
Name it to Tame it	• Name emotions • Acknowledge feelings • Validate feelings, not behaviors
Regulate over Educate	• Focus on regulating yourself and the escalated person • Give physical space and time • Avoid discussions of consequences or introspection about how actions affect others • Refrain from sharing essential information at this time, as an escalated person cannot process or retain information

Validating Feelings Not Behaviors

During an intake call, individuals may express strong emotions, such as fear, frustration, or concern for a child. Validating feelings means acknowledging and naming those emotions without agreeing with or endorsing unsafe, harmful, or inappropriate behaviors. This distinction allows you to build trust, reduce defensiveness, and keep the conversation focused on gathering information and moving the intake forward in a respectful, professional way.

List ways to validate feelings without agreeing with behavior?

Skills Practice: Supporting the Ambivalent Reporter

Activity: Skills Practice: Supporting the Ambivalent Reporter

The purpose of this activity is to practice responding to ambivalent behaviors in ways that support the reporter.

What to do:

Working individually or with a partner:

- Identify a reporter's potential feelings in the scenario below
- Create statements that validate the feeling and responses that promote moving the interview forward while respecting the reporter's perspective, without giving information
- This skills practice focuses on the "Name it to tame it" strategy: acknowledge and validate the emotion, then move the interview forward by asking thoughtful questions
- The goal is not to share information with the reporter, correct their responses, or lecture them

When time is up, find a partner to practice. If you worked with a partner in the first portion of the activity, choose a new partner for the skills practice.

- Each partner will take turns practicing the statements and responses that they created
- The listening partner will provide feedback about how the statement and response felt to hear
- The sharing partner will edit their statements and responses based on feedback and repeat the practice
- After five minutes, switch roles and repeat the practice process

Scenario:

You are an intake worker, and you are on the phone with a school social worker who has called to report an allegation of neglect. She has provided some information saying that the child has dirty clothes, that the teacher has complained about his smell, and that his parents are unresponsive when you call. As you start asking follow-up questions for more detail about her concerns, she becomes frustrated and states that she is tired of CPS never doing their job or responding, and that she is a professional who knows what to look for. She says she has reported this family multiple times, and CPS has never done anything.

How did it feel to not "correct" the reporter or give information to defend the CPS process?

How was your partner's feedback supportive of your ability to respond to ambivalent reporters in your day-to-day work?

Intake Learning Lab

Make a Report/Take a Report

Activity: Make a Report/Take a Report

What to do:

- In groups of three, you will each practice taking an Intake report, making a report to CPS Intake, and using components of the Screening and Response Tool to make decisions.
- As the **reporter**, you will have a document that provides information about a scenario. Assume that this is all the information available about this scenario. When asked a question not addressed in the scenario, the reporter should say they do not know. The scenario will explain the reporter's role and relationship to the family.
- As the **interviewer**, you will conduct an Intake interview. Your role is to take this report from a community member and conduct the interview as if you are in your office. For this practice, you will not complete the Screening and Response Tool, although you can take notes during the interview if it is helpful.
- As the **observer**, you will document the call and complete components of the Screening and Response Tool using the Worksheet: Taking a Report - Observer. Observers are encouraged to take notes during the call.
- The interview will last twelve minutes
- When time is up, spend five minutes completing your notes, and allowing the Observer to finish completing the Screening and Response Tool components.
- When time is up, provide strengths-based, behaviorally specific feedback to the interviewer
- In your feedback, consider:
    - Use of communication and engagement skills
    - Structure of the interview (setting the stage, opening, narrowing, closing)
    - Using threshold-based follow-up questions
    - Use of follow-up questions to move from generalizations to behaviorally specific information
    - Use of harm and worry statements
- Next, compare the information known to the reporter to the information gathered on the call.
    - Was there any information known to the reporter that was not obtained by the Intake worker?
    - If so, discuss questions that could have been asked to obtain this additional information.
- Finally, have the observer share the outcome of the Screening and Response Tool components and their documentation.
- Use this opportunity to provide constructive feedback on the documentation.
- Consider:
    - Does the documentation use clear, objective, behaviorally specific language?
    - Does the documentation clearly articulate how the threshold for an allegation was met, or why it was screened out?
- Discuss the screening decision.
    - Is there a consensus that this is the correct decision?
    - If the reporter had additional information that was not captured in the interview, would that information change the decision?
- Switch roles and responsibilities, repeating until all three people have played each role.

Worksheet: Taking a Report – Interviewer Scenario 1

Use this space to record notes during your interview.

Worksheet: Taking a Report – Observer Scenario 1

Collect Reporter Information

Name:
Relationship:
Address:
Phone Number:
Reporter waives right to notification? ☐ Yes ☐ No
Is the reporter available to provide further information, if needed? ☐ Yes ☐ No

Complete Mandatory Questions [Check Yes or No]

Yes	No	Question
		Is the victim child under 18 years of age?
		Is the child a victim of fatality?
		Is this a near fatality, where a physician has determined that a child is in serious or critical condition as a result of sickness or injury caused by suspected abuse, neglect, or maltreatment?
		Is the child a resident of North Carolina?
		Where did the incident occur? (This question has a narrative box)
		Is the perpetrator a parent/caretaker?
		Are you aware of any relatives or kin supports for this family?
		Does this report include information about a child who is missing, abducted, or on runaway status?
		Are there concerns for Human Trafficking?
		Are there concerns for Domestic Violence?
		Is this a licensed facility or group home?

Collect Participant Information

Child(ren)					
Name	Sex	Race	Ethnicity	Age/DOB	School/Daycare

Parents/Caretakers					
Name	Sex	Race	Ethnicity	Age/DOB	Employer/ School

Other Household Members					
Name	Sex	Race	Ethnicity	Age/DOB	Employer/ School

Relationships		
Parent/Caretaker	Is the _____ of	Child

Collect Narrative Information

Is there a CMARC notification requirement? [Circle your selection]

Yes	Complete CMARC Notification before continuing Screening and Response Tool
No	Continue with maltreatment allegation selection

Select Maltreatment Allegations [Check your selection(s)]

Refer to the Maltreatment Type section of the SDM Screening & Response Tool Policy and Procedures Manual for specific guidance when completing this section [https://policies.ncdhhs.gov/wp-content/uploads/SDM-Screening-and-Response-Instructions-Manual-January-2026-1.pdf].

	ABUSE
☐	Human Trafficking ☐ Child Sex Trafficking ☐ Child Labor Trafficking ☐ Child Trafficking
☐	Physical Abuse ☐ Serious Physical Injury ☐ Unexplained Physical Injury ☐ Excessive or Cruel Punishment ☐ Substantial Risk of Physical Harm
☐	Sexual Abuse ☐ Sexual Act on a Child by an Adult Caretaker or Other Adult in the Household ☐ Physical or Behavioral Indicators Consistent with Sexual Abuse ☐ Exposure to Sexually Explicit Conduct or Materials ☐ Sexual Exploitation ☐ Knowingly Allowing a Person with a History of Sexual Offenses Against Minors to Have Unsupervised and/or Unrestricted Access to the Child ☐ Substantial Risk of Sexual Abuse
☐	Emotional Abuse, Mental Injury
☐	Moral Turpitude, Encouraging and Enabling Delinquent Offense

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

Was one or more maltreatment allegations selected? [Circle your selection]

Yes	Continue to connect maltreatment allegations to participants
No	Screen Out

Connect Maltreatment Allegations to Participants

Maltreatment Type	Alleged Perpetrator	Alleged Child Victim

Select Response Time and Assessment Track

Refer to pages 18-22 of the SDM Screening & Response Tool Policy and Procedures Manual for specific guidance when completing this section [https://policies.ncdhhs.gov/wp-content/uploads/SDM-Screening-and-Response-Instructions-Manual-January-2026-1.pdf].

Assessment Track			
	Family Assessment		**Investigative Assessment**

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

Worksheet: Taking a Report – Interviewer Scenario 2

Use this space to record notes during your interview.

Worksheet: Taking a Report – Observer Scenario 2

Collect Reporter Information

Name:
Relationship:
Address:
Phone Number:
Reporter waives right to notification? ☐ Yes ☐ No
Is the reporter available to provide further information, if needed? ☐ Yes ☐ No

Complete Mandatory Questions [Check Yes or No]

Yes	No	Question
		Is the victim child under 18 years of age?
		Is the child a victim of fatality?
		Is this a near fatality, where a physician has determined that a child is in serious or critical condition as a result of sickness or injury caused by suspected abuse, neglect, or maltreatment?
		Is the child a resident of North Carolina?
		Where did the incident occur? (This question has a narrative box)
		Is the perpetrator a parent/caretaker?
		Are you aware of any relatives or kin supports for this family?
		Does this report include information about a child who is missing, abducted, or on runaway status?
		Are there concerns for Human Trafficking?
		Are there concerns for Domestic Violence?
		Is this a licensed facility or group home?

Collect Participant Information

Child(ren)

Name	Sex	Race	Ethnicity	Age/DOB	School/Daycare

Parents/Caretakers

Name	Sex	Race	Ethnicity	Age/DOB	Employer/ School

Other Household Members

Name	Sex	Race	Ethnicity	Age/DOB	Employer/ School

Relationships

Parent/Caretaker	Is the _____ of	Child

Collect Narrative Information

Is there a CMARC notification requirement? [Circle your selection]

Yes	Complete CMARC Notification before continuing Screening and Response Tool
No	Continue with maltreatment allegation selection

Select Maltreatment Allegations [Check your selection(s)]

Refer to the Maltreatment Type section of the SDM Screening & Response Tool Policy and Procedures Manual for specific guidance when completing this section [https://policies.ncdhhs.gov/wp-content/uploads/SDM-Screening-and-Response-Instructions-Manual-January-2026-1.pdf].

ABUSE	
☐	Human Trafficking ☐ Child Sex Trafficking ☐ Child Labor Trafficking ☐ Child Trafficking:
☐	Physical Abuse ☐ Serious Physical Injury ☐ Unexplained Physical Injury ☐ Excessive or Cruel Punishment ☐ Substantial Risk of Physical Harm
☐	Sexual Abuse ☐ Sexual Act on a Child by an Adult Caretaker or Other Adult in the Household ☐ Physical or Behavioral Indicators Consistent with Sexual Abuse ☐ Exposure to Sexually Explicit Conduct or Materials ☐ Sexual Exploitation ☐ Knowingly Allowing a Person with a History of Sexual Offenses Against Minors to Have Unsupervised and/or Unrestricted Access to the Child ☐ Substantial Risk of Sexual Abuse
☐	Emotional Abuse, Mental Injury
☐	Moral Turpitude, Encouraging and Enabling Delinquent Offense
☐	Death of a Child

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

Was one or more maltreatment allegations selected? [Circle your selection]

Yes	Continue to connect maltreatment allegations to participants
No	Screen Out

Connect Maltreatment Allegations to Participants

Maltreatment Type	Alleged Perpetrator	Alleged Child Victim

Select Response Time and Assessment Track

Refer to pages 18-22 of the SDM Screening & Response Tool Policy and Procedures Manual for specific guidance when completing this section [https://policies.ncdhhs.gov/wp-content/uploads/SDM-Screening-and-Response-Instructions-Manual-January-2026-1.pdf].

Assessment Track			
	Family Assessment		**Investigative Assessment**

Response Time					
	Immediate		**Within 24 Hours**		**Within 72 Hours**

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

Worksheet: Taking a Report – Interviewer Scenario 3

Use this space to record notes during your interview.

Worksheet: Taking a Report – Observer Scenario 3

Collect Reporter Information

Name:
Relationship:
Address:
Phone Number:
Reporter waives right to notification? ☐ Yes ☐ No
Is the reporter available to provide further information, if needed? ☐ Yes ☐ No

Complete Mandatory Questions [Check Yes or No]

Yes	No	Question
		Is the victim child under 18 years of age?
		Is the child a victim of fatality?
		Is this a near fatality, where a physician has determined that a child is in serious or critical condition as a result of sickness or injury caused by suspected abuse, neglect, or maltreatment?
		Is the child a resident of North Carolina?
		Where did the incident occur? (This question has a narrative box)
		Is the perpetrator a parent/caretaker?
		Are you aware of any relatives or kin supports for this family?
		Does this report include information about a child who is missing, abducted, or on runaway status?
		Are there concerns for Human Trafficking?
		Are there concerns for Domestic Violence?
		Is this a licensed facility or group home?

Collect Participant Information

Child(ren)

Name	Sex	Race	Ethnicity	Age/DOB	School/Daycare

Parents/Caretakers

Name	Sex	Race	Ethnicity	Age/DOB	Employer/ School

Other Household Members

Name	Sex	Race	Ethnicity	Age/DOB	Employer/ School

Relationships

Parent/Caretaker	Is the _____ of	Child

Collect Narrative Information

Is there a CMARC notification requirement? [Circle your selection]

Yes	Complete CMARC Notification before continuing Screening and Response Tool
No	Continue with maltreatment allegation selection

Select Maltreatment Allegations [Check your selection(s)]

Refer to the Maltreatment Type section of the SDM Screening & Response Tool Policy and Procedures Manual for specific guidance when completing this section [https://policies.ncdhhs.gov/wp-content/uploads/SDM-Screening-and-Response-Instructions-Manual-January-2026-1.pdf].

ABUSE	
☐	Human Trafficking ☐ Child Sex Trafficking ☐ Child Labor Trafficking ☐ Child Trafficking:
☐	Physical Abuse ☐ Serious Physical Injury ☐ Unexplained Physical Injury ☐ Excessive or Cruel Punishment ☐ Substantial Risk of Physical Harm
☐	Sexual Abuse ☐ Sexual Act on a Child by an Adult Caretaker or Other Adult in the Household ☐ Physical or Behavioral Indicators Consistent with Sexual Abuse ☐ Exposure to Sexually Explicit Conduct or Materials ☐ Sexual Exploitation ☐ Knowingly Allowing a Person with a History of Sexual Offenses Against Minors to Have Unsupervised and/or Unrestricted Access to the Child ☐ Substantial Risk of Sexual Abuse
☐	Emotional Abuse, Mental Injury
☐	Moral Turpitude, Encouraging and Enabling Delinquent Offense

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

Was one or more maltreatment allegations selected? [Circle your selection]

Yes	Continue to connect maltreatment allegations to participants
No	Screen Out

Connect Maltreatment Allegations to Participants

Maltreatment Type	Alleged Perpetrator	Alleged Child Victim

Select Response Time and Assessment Track

Refer to pages 18-22 of the SDM Screening & Response Tool Policy and Procedures Manual for specific guidance when completing this section [https://policies.ncdhhs.gov/wp-content/uploads/SDM-Screening-and-Response-Instructions-Manual-January-2026-1.pdf].

Assessment Track			
	Family Assessment		**Investigative Assessment**

Response Time					
	Immediate		**Within 24 Hours**		**Within 72 Hours**

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

Worker Safety and Well-being

Indirect Trauma

Worker Safety Begins With You

Video: Impact of Secondary Traumatic Stress on the Child Welfare Workforce

Watch the Impact of Secondary Traumatic Stress on the Child Welfare Workforce video at https://qic-wd.org/impact-secondary-traumatic-stress-child-welfare-workforce.

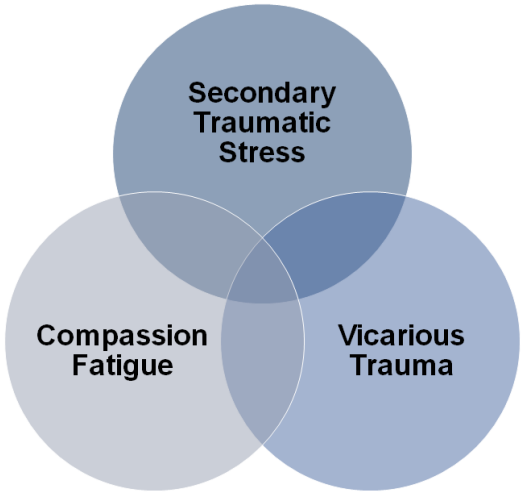
What does it mean to say that child welfare work can "trigger" you?

Think for a moment about what might trigger you in the work of child welfare. What are your plans to handle that emotional response in the moment?

From whom can you elicit support when you are triggered?

What tools will help you overcome triggers?

Indirect Trauma



Secondary Traumatic Stress, or STS, is emotional distress that results when an individual hears about the firsthand trauma experiences of another. It is indirect exposure to threatening events that can result in the presence of posttraumatic stress symptoms.

Compassion fatigue is the physical and emotional exhaustion experienced by those who care for others who are in distress. It is a less clinical and less stigmatizing term and is often used interchangeably with Secondary Traumatic Stress.

Vicarious trauma occurs after empathic engagement with a traumatized client and changes the inner experience of a practitioner. This term focuses less on trauma symptoms and more on cognitive changes that occur following cumulative exposure to another person's trauma. The symptoms of vicarious trauma are disturbances in the cognitive frame of reference in the areas of trust, safety, control, esteem, and intimacy.

Burnout (as related to indirect trauma) is a state of physical, emotional, and mental exhaustion that can develop over time when workers are repeatedly exposed to others' trauma and high-stress situations. It is often marked by feeling depleted, detached, or numb, and less effective at work, and it can be intensified when the ongoing demands of the role outpace opportunities for rest, support, and recovery.

Secondary traumatic stress (STS), compassion fatigue (CF), and vicarious trauma (VT) are common among child welfare workers.). Indirect trauma may occur when people hear about, see evidence or images, or are exposed to other means of traumatic events through persistent and close contact with trauma survivors. This definition is quite literally the definition of your job: to hear children and families relate their stories of trauma and support them as they seek healing, safety, and family integrity.

Use this space for notes.

Decontextualized Trauma

> Trauma, decontextualized in a person, looks like personality.
>
> Trauma, decontextualized in a family, looks like family dynamics.
>
> Trauma, decontextualized in a people, can look like culture.
>
> ~ *Resmaa Menakem*

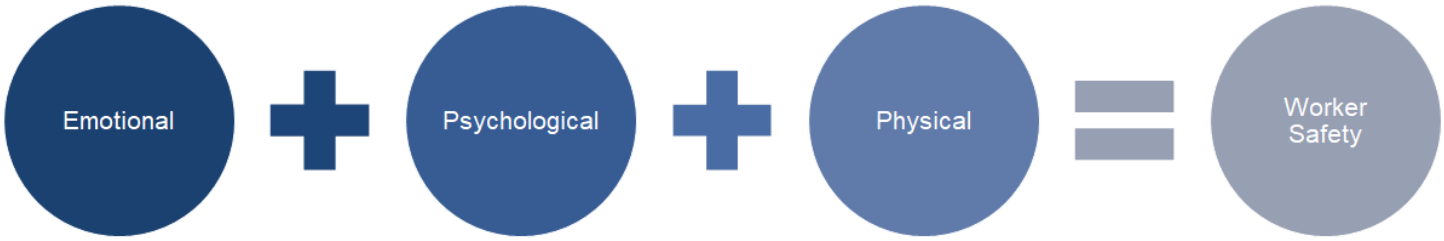
The American Psychological Association Dictionary of Psychology defines decontextualization as “the dissociation of a traumatic event from the context in which it occurred."

Many factors about child welfare create the conditions for indirect trauma to occur. One of the dynamics that occurs when trauma is ever-present in our lives is that our coping behaviors can become decontextualized from the trauma. Because these behaviors are repeated and normalized within the child welfare profession, they can be seen as part of the normal way of managing indirect trauma. However, it is a collective trauma response.

The fact that these dynamics feel normal is due to the collective nature of the experience. So many caseworkers within child welfare share these behaviors and characteristics out of the normalization and decontextualization of trauma, not because it is “normal.” The good news is that we can begin shifting the workforce toward resilience and healing. The first step is bringing the context back and normalizing the behaviors and responses to stress and trauma.

What are other elements we often consider a “normal” part of the child welfare industry that could be symptoms of trauma?

Defining Worker Safety



Emotional safety is about the ability to identify feelings and feel safe enough to express feelings authentically.

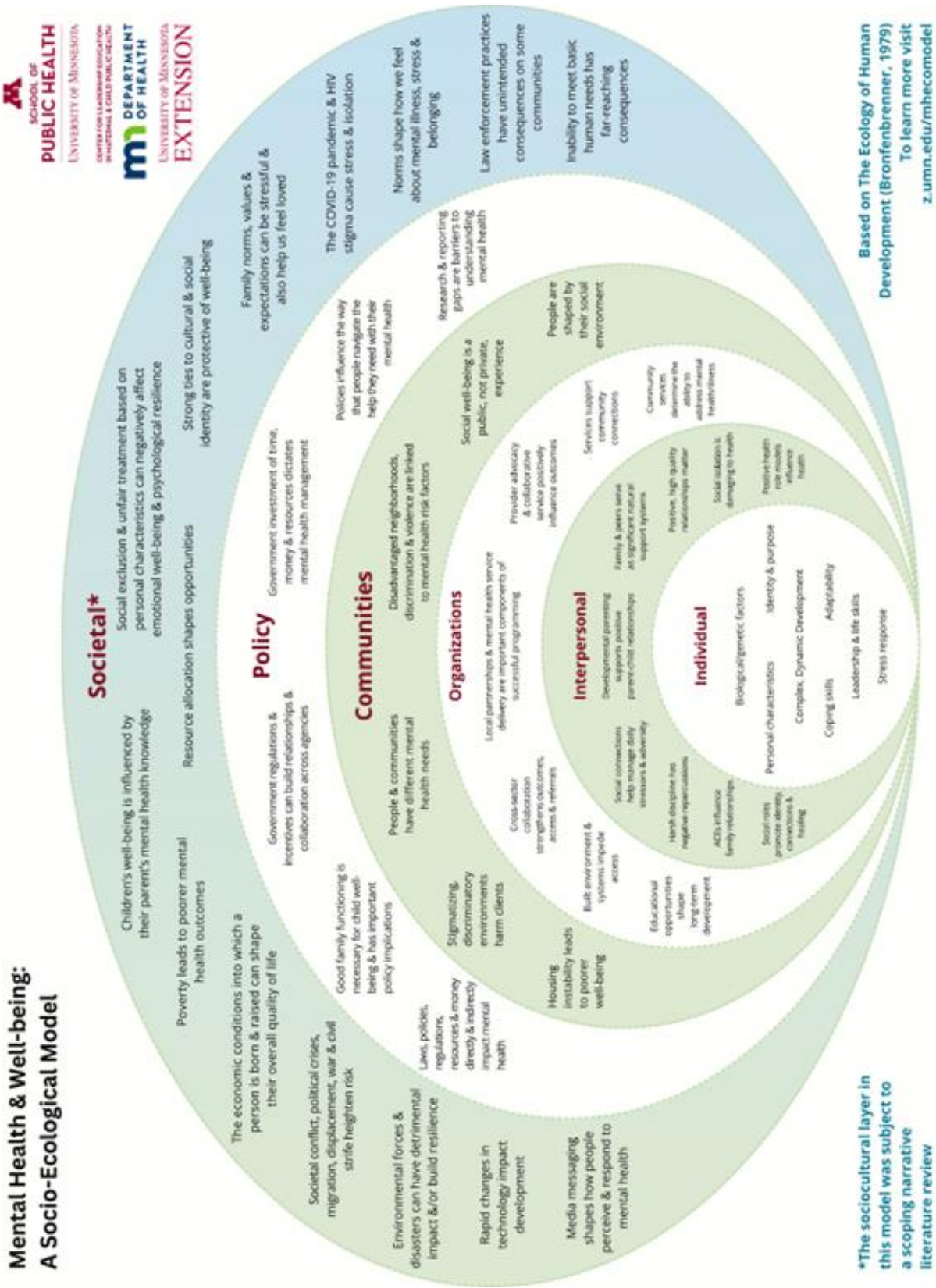
Psychological safety is the belief that punishment or humiliation will not be consequences for speaking up about ideas, questions, concerns, or making mistakes.

Physical safety is about being protected from physical aggression and violence and minimizing the possibility of injury.

Use this space to record notes.

Socio-Ecological Model

Handout: Layers of the Socio-Ecological Model



Activity: Applying the Socio-Ecological Model to Well-being

The purpose of this activity is to acknowledge the factors influencing stress and trauma experienced as part of the child welfare workforce.

What to do:

- Work with your group to brainstorm the factors that contribute to stress and trauma at each layer of the socio-ecological model.
- Identify at least five or six factors for each layer and whether you have control over factors in each layer.

Individual

Interpersonal & Relational

Organization

Community

Policy & Institutional

Society

Michaels, C., Blake, L., Lynn, A., Greylord, T., & Benning, S. (2022, April 18). Mental health and well-being ecological model. Center for Leadership Education in Maternal & Child Public Health, University of Minnesota–Twin Cities. https://mch.umn.edu/resources/mhecomodel/.

Worker Wellness and Self-Care

Planning for Self-Care

Self-care planning is a tool for claiming our ability to prevent and intervene in the impact of stress and building support in the areas where we have control. Self-care can be easier said than done in the fast-paced, emotionally charged, crisis-intervention, non-9-to-5 nature of child welfare. Having the opportunity to express how this work affects us will help us function better. Recognizing how we decontextualize trauma and using the socio-ecological model to bring context back to trauma will help us move toward healthier ways to process trauma.

There will be barriers to completing your self-care plan. Being aware of these barriers and planning for them will increase your likelihood of successfully using your self-care plan. Assess and make plans for when the impact is greater, claiming control where possible, even in uncontrollable circumstances.

As you begin to consider your own self-care, think about where you have support, where you need to build coping and support systems, what will be challenging for you, consider any barriers that may be present, and what might come easily. Record your thoughts below.

Dimensions of Well-Being

Wellness is a dynamic, holistic process of becoming aware of and making choices toward a healthy, fulfilling life.

Rather than being defined solely by the absence of illness, wellness is an active pursuit that encompasses multiple interconnected dimensions. The Dimensions of Wellness framework provides a comprehensive approach to understanding and supporting overall self-care and well-being.

Prevention techniques:

- Psychoeducation
- Clinical supervision
- Ongoing skills training
- Informal/formal self-report screening
- Workplace self-care groups (for example, yoga or meditation)
- Creation of a balanced caseload
- Flextime scheduling
- Self-care accountability buddy system
- Use of evidence-based practices
- Exercise and good nutrition

Intervention techniques:

- Strategies to evaluate secondary stress
- Cognitive behavioral interventions
- Mindfulness training
- Reflective supervision
- Caseload adjustment
- Informal gatherings following crisis events (to allow for voluntary, spontaneous discussions)
- Change in job assignment or workgroup
- Referrals to Employee Assistance Programs or outside agencies

Activity: Dimensions of Well-Being

The purpose of this activity is to promote self-care and peer support.

What to do:

- With your partner, spend 15 minutes discussing your Self-Care Plans.
- If the plan they have from Pre-Service is working, share what is working.
- If you need to create a new plan, use this time to create one with your partner's support.
- Think of your partner as your Self-Care Accountability Partner, someone to whom you are accountable when they ask how you are doing on your self-care, as your supervisor might support your accountability in supervision.
- Answer the following questions:

How well is your self-care plan working for you today?

Where are you successful?

Where do you need support?

What are the barriers?

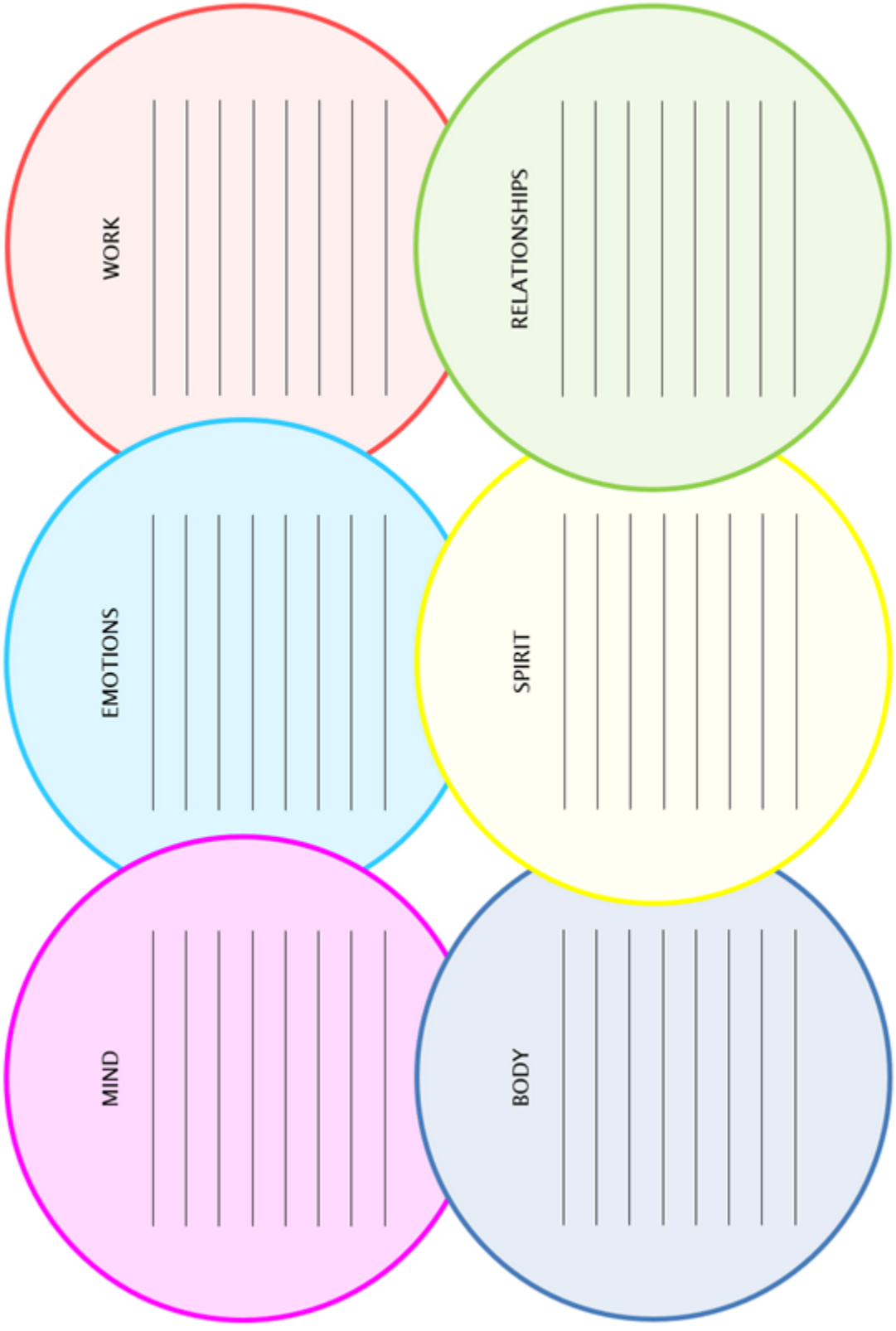
How did it feel to talk about your Self-Care Plan?

How was this experience similar to what parents or caregivers might feel when we talk with them about self-care or well-being?

How does this experience inform your conversations with families about balancing work and life responsibilities?

What will you commit to doing differently to care for yourself in the future?

Worksheet: Self-Care Strategies



End-of-Day Reflection and Check-In

Self-Reflection Activity

Worksheet: Reflection and Check-In

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

Bibliography of References

Day Four

American Psychological Association. (2018, April 19). *APA Dictionary of Psychology*. American Psychological Association. https://dictionary.apa.org/decontextualization

Barbee, A., Purdy, L., & Cunningham, M. (2023, September). *Secondary traumatic stress: definitions, measures, predictors, and interventions*. Quality Improvement Center for Workforce Development. https://www.qic-wd.org/blog/secondary-traumatic-stress-definitions-measures-predictors-and-interventions

Capacity Building Center for States. (n.d.). *The child welfare worker safety guide*. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. https://ncwwi.org/files/Incentives__Work_Conditions/The_Child_Welfare_Worker_Safety_Guide.pdf

Dartmouth Trauma Interventions Research Center. (2020, May 15). *Calming & de-escalation strategies* [Video]. YouTube. https://www.youtube.com/watch?v=R2PSExM-NhU

Fragoso, S. (Host). (2020, November 15). How do we heal? (with Resmaa Menakem) [Audio podcast episode]. *Talk Easy with Sam Fragoso*. https://talkeasypod.com/resmaa-menakem/

Hellman, C. M., Robinson-Keilig, R. A., Dubriwny, N. M., Hamill, C., & Kraft, A. (2018). Hope as a coping resource among parents at risk for child maltreatment. *Journal of Family Social Work, 21*(4–5), 365–380. https://doi.org/10.1080/10522158.2018.1469559

Lizano, E. L., He, A. S., & Leake, R. (2021). Caring for our child welfare workforce: A holistic framework of worker well-being. *Human Service Organizations: Management, Leadership & Governance,* 1-12. https://ncwwi-dms.org/resourcemenu/resource-library/organizational-culture-and-climate/1659-a-holistic-framework-for-child-welfare-worker-well-being/file.

Loignon, A., & Wormington, S. (2024, April 10). *How leaders can build psychological safety at work*. Center for Creative Leadership. https://www.ccl.org/articles/leading-effectively-articles/what-is-psychological-safety-at-work/

Michaels, C., Blake, L., Lynn, A., Greylord, T., & Benning, S. (2022, April 18). *Mental health and well-being ecological model*. University of Minnesota – Twin Cities. https://mch.umn.edu/resources/mhecomodel/

Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.

National Child Traumatic Stress Network. (2011). *Secondary traumatic stress: A fact sheet for child-serving professionals*. Switzerland: Springer International Publishing.

North Carolina Department of Health and Human Services. (2019). *NC DSS appendix 6: Best practice for social worker well-being*. https://policies.ncdhhs.gov/wp-content/uploads/appendix-6-best-practice-for-social-worker-well-being.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 Department of Health and Human Services, Division of Social Services, Child Welfare Services. (2021, March). *Substance affected infants and plans of safe care*. Child Welfare Policy

Resources. https://policies.ncdhhs.gov/wp-content/uploads/child-welfare-resources-for-substance-affected-infants-and-plan-of-safe-care.pdf

Patterson, K., Grenny, J., McMillan, R., & Switzler, A. (2002). *Crucial conversations*. McGraw-Hill Contemporary.

Quality Improvement Center for Workforce Development (QIC-WD). (n.d.). *Impact of secondary traumatic stress on the child welfare workforce*. https://qic-wd.org/

Qualls, M. (2021, March 31). *4 things to know about emotional safety. First things first*. https://firstthings.org/4-things-to-know-about-emotional-safety/

Saakvitne, K. W. (1996). *Transforming the pain: A workbook on vicarious traumatization*. W.W. Norton & Company.

Strand, V. C., & Sprang, G. (2018). *Trauma responsive child welfare systems*. Springer International Publishing.

Syracuse University. (n.d.). *8 Dimensions of Wellness*. Syracuse University Wellness Initiative. https://wellness.syr.edu/8-dimensions-of-wellness/