NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Social Services

North Carolina Department of Health and Human Services
Permanency Planning Services Track Training

Participant's Workbook
Day Two

October 2024

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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.

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Instructions

This course was designed to guide child welfare professionals through the knowledge, skills, and behaviors needed to engage with families 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 in the future.

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 delete to remove extra lines.

Course Themes

The central themes of the Permanency Planning Track Training are divided across several course topics.

- Purpose, Practice Standards, and Legal Aspects
- Diversity, Equity, Inclusion, and Belonging
- Indian Child Welfare Act of 1978 (ICWA)
- Communicating
- Family Engagement
- Assessing in Permanency Planning Services
- Trauma-Informed Care
- Permanency Plans and Concurrent Planning
- Attachment
- Family Time
- Shared Parenting
- Working with Relatives
- Partners in the Permanency Planning Process
- Permanency Planning with the Family
- Permanency Planning Family Services Agreement
- Child and Family Team Meetings
- Authentically Engaging Children and Youth
- Family-Centered Permanency Planning
- Quality Contacts
- Preparing for Permanency
- Engaging Relatives
- Placement

- Placement with Relatives
- Monitoring the FSA
- Achieving Permanency
- Adoption
- Documentation
- Worker Safety

Training Overview

Training begins at 9:00 a.m. and ends at 4:00 p.m. If a holiday falls on the Monday of training, the training will begin on Tuesday at 9:00 a.m. This schedule is subject to change if a holiday falls during the training week or other circumstances occur. The time for ending training on Fridays may vary and trainees need to be prepared to stay the entire day.

Attendance is mandatory. If there is an emergency, the trainee must contact the classroom trainer and their supervisor as soon as they realize they will not be able to attend training or if they will be late to training. If a trainee must miss training time in the classroom, it is the trainee's responsibility to develop a plan to make up missed material.

Pre-Work Online e-Learning Modules

There is required pre-work for the Permanency Planning 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 (TOL) Tool

The Permanency Planning Track Training Transfer of Learning (ToL) tool is a comprehensive and collaborative activity for workers and supervisors to work together in identifying worker goals, knowledge gain, and priorities for further development throughout the training process. In four distinct steps, the worker and supervisor will highlight their goals and action plan related to participating in training, reflect on lessons and outstanding questions, and create an action plan to support worker growth. The tool should be started prior to beginning the Permanency Planning Track Training and re-visited on an ongoing basis to assess growth and re-prioritize actions for development.

Part A: Training Preparation: Prior to completing any eLearning and in-person Track Training sessions, the worker and supervisor should meet to complete Part A: Training

Preparation. In this step, the worker and supervisor will discuss their goals for participation in training and develop a plan to meet those goals through pre-work, other opportunities for learning, and support for addressing anticipated barriers.

Part B: Worker Reflections During Training: The worker will document their thoughts, top takeaways, and outstanding questions regarding each section. This level of reflection serves two purposes. First, the practice of distilling down a full section of training into three takeaways and three remaining questions requires the worker to actively engage with the material, subsequently forming cognitive cues related to the information for future use in case practice. Second, prioritizing takeaways and questions by section allows workers to continually review information to determine if questions are answered in future sessions and supports the development of an action plan by requiring workers to highlight the questions they find most important.

Part C: Planning for Post-Training Debrief with Supervisor: The worker considers the takeaways and questions they identified in each section and creates a framework to transfer those takeaways and questions into an action plan.

Part D: Post-Training Debrief with Supervisor: Provides an opportunity for the supervisor and worker to determine a specific plan of action to answer outstanding questions and to further support worker training.

While this ToL is specific to the Track Training in North Carolina, workers and supervisors can review the takeaways and questions highlighted by the worker in each section of training on an ongoing basis, revising action steps when prior actions are completed, and celebrating worker growth and success along the way.

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.

Learning Objectives

Day 2

Assessing in Permanency Planning Services
• Learners will be able to identify safety threats and risk factors when working with children and families.
• Learners will be able to describe their responsibilities to ensure child safety.
• Learners will be able to identify protective factors when working with children and families.
• Learners will be able to articulate how protective factors mitigate risk when considering specific case scenarios.
• Learners will be able to describe the results of the structured decision-making tools and determine the next steps to support children and their families.
• Learners will be able to describe the importance of considering cultural differences in their assessments of caregivers.
• Learners will be able to demonstrate empathetic listening.
• Learners will be able to employ various interviewing techniques to access information and assess options.
• Learners will be able to demonstrate strength-based and solution-focused strategies to interview children and families.
Trauma-Informed Care
• Learners will be able to recognize the states of development and the impact of trauma on those stages.
• Learners will be able to assess when developmental growth and needs are not being met and identify appropriate services and interventions.
• Learners will be able to describe risk factors due to parental substance misuse.
• Learners will be able to educate parents about the dangers of substance misuse, relating those dangers to child safety and well-being.
• Learners will be able to define and identify signs of domestic violence.
• Learners will be able to describe the importance of confidentiality and identify the unique dynamics of domestic violence within families.
• Learners will be able to describe the direct impact of domestic violence on children.
• Learners will be able to describe the impact of the mental health needs of children and their parents on their physical and emotional well-being.

Assessing Learning Lab
• Learners will be able to identify safety threats and risk factors when working with children and families.
• Learners will be able to demonstrate strength-based and solution-focused strategies to interview children and families.
Permanency Plans and Concurrent Planning
• Learners will be able to assess permanency options on a case-by-case basis and document concurrent plans as required by policy.
• Learners will be able to describe the benefits of reunification for children.
• Learners will describe the interconnection of legal, relational, and cultural permanence.

Day Two Agenda

Permanency Planning Services Track Training

I. Welcome

Assessing in Permanency Planning Services

II. Safety and Risk

III. Protective Factors and Capacities

IV. Assessing

V. Cultural Considerations, Bias, and Impact on Assessment

VI. Interviewing

Trauma-Informed Care

VII. Trauma-Informed Practice

VIII. Key Factors Impacting Families

Assessing Learning Lab

Permanency Plans and Concurrent Planning

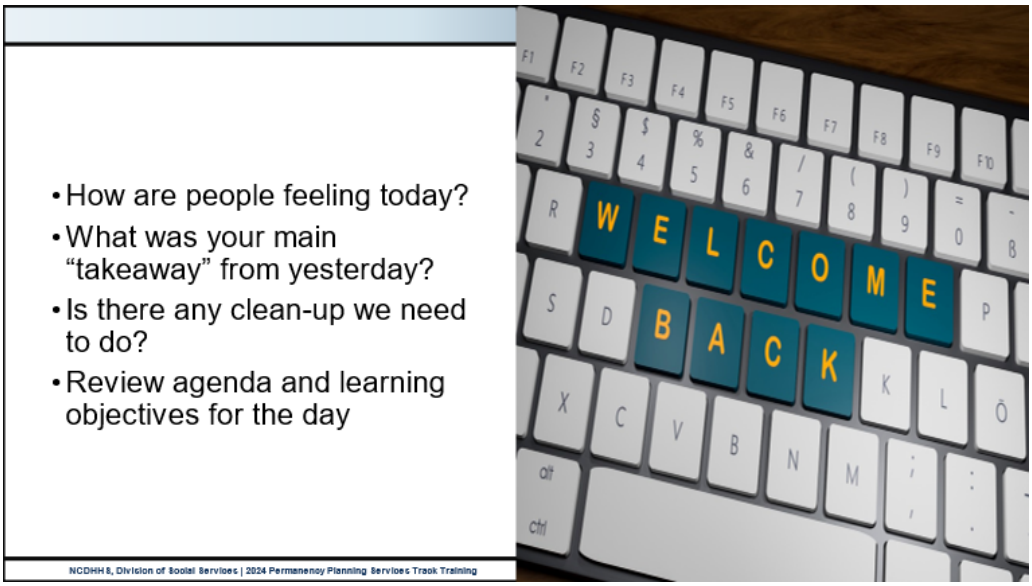
IX. Permanency Plans

X. Concurrent Planning

XI. Preparing for Performance

End-of-Day Values Reflection

Welcome



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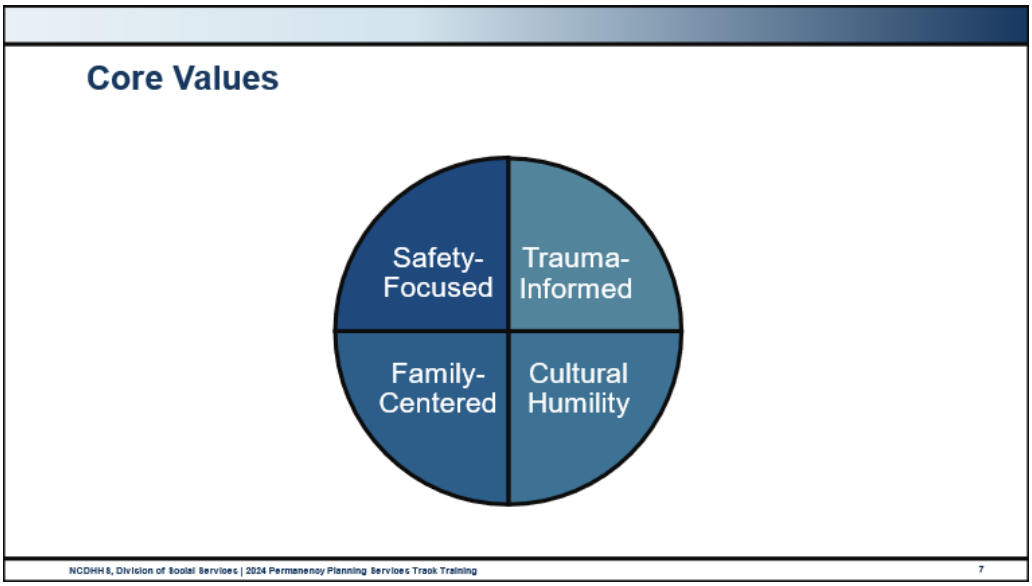
Assessing in Permanency Planning Services

Safety and Risk



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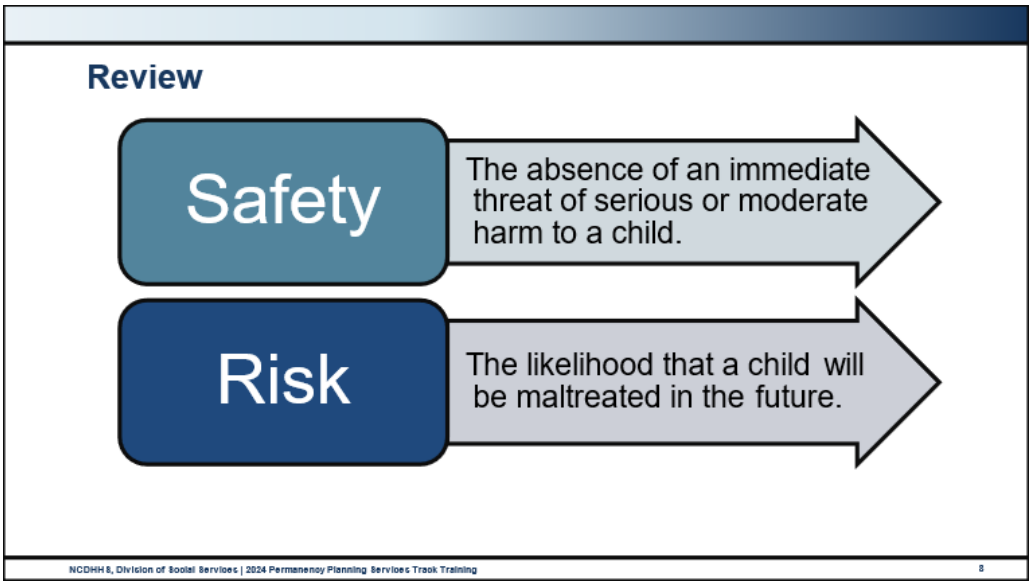

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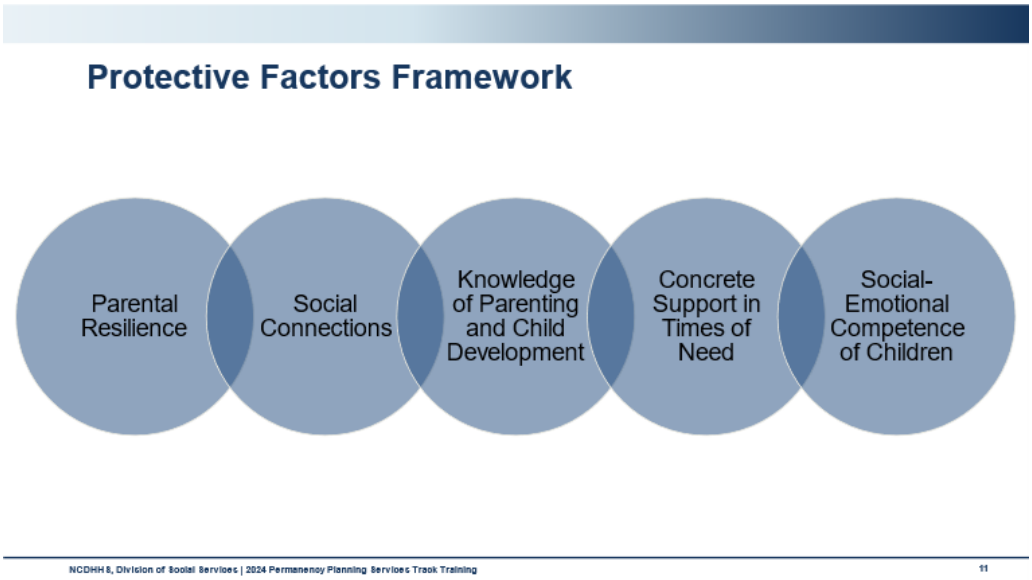
Protective Factors and Capacities



Parental Resilience: Managing stress and functioning well when faced with challenges, adversity, and trauma.

Social Connections: Positive relationships that provide emotional, informational, instrumental, and spiritual support.

Knowledge of Parenting and Child Development: Understanding child development and parenting strategies that support physical, cognitive, language, social, and emotional development.

Concrete Supports in Times of Need: Access to concrete support and services that address a family's needs and help minimize stress caused by challenges.

Social and Emotional Competence of Children: Family and child interactions that help children develop the ability to communicate clearly, recognize and regulate their emotions, and establish and maintain relationships.

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Handout: Protective Factors Action Sheet

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PARENTAL RESILIENCE

PROTECTIVE & PROMOTIVE FACTORS

Being a parent can be a very rewarding and joyful experience. But being a parent can also have its share of stress. Parenting stress is caused by the pressures (stressors) that are placed on parents personally and in relation to their child:

- *typical events and life changes* (e.g., moving to a new city or not being able to soothe a crying baby)
- *unexpected events* (e.g., losing a job or discovering your child has a medical problem)
- *individual factors* (e.g., substance abuse or traumatic experiences)
- *social factors* (e.g., relationship problems or feelings of loneliness and isolation)
- *community, societal or environmental conditions* (e.g., persistent poverty, racism or a natural disaster)

Numerous researchers have concluded that how parents respond to stressors is much more important than the stressor itself in determining the outcomes for themselves and their children. **Parents are more likely to achieve healthy, favorable outcomes if they are resilient. Resilience is the process of managing stress and functioning well even when faced with challenges, adversity and trauma.**

Some stressors parents face can be managed easily so that problems get resolved; for example, calling a relative or friend to pick-up a child from school when a parent is delayed. But some stressors cannot be easily resolved. For example, parents cannot "fix" their child's developmental disability, erase the abuse they suffered as a child or be able to move out of a crime-plagued neighborhood. **Rather, parents are resilient when they are able to call forth their inner strength to proactively meet personal challenges and those in relation to their child, manage adversities, heal the effects of trauma and thrive given the unique characteristics and circumstances of their family.**

Demonstrating resilience increases parents' **self-efficacy** because they are able to see evidence of both their ability to face challenges competently and to make wise choices about addressing challenges. Furthermore, parental resilience has a positive effect on the parent, the child and the parent-child relationship. By managing stressors, parents feel better and can provide more nurturing attention to their child, which enables their child to form a secure emotional attachment. Receiving nurturing attention and developing a secure emotional attachment with parents, in turn, fosters the development of resilience in children when they experience stress.

Sometimes the pressures parents face are so overwhelming that their ability to manage stress is severely compromised. This is the case with parents who grew up in environments that create **toxic stress**. That is, as children, they experienced strong, frequent and prolonged adversity without the buffering protection of nurturing adult support. As a result, these parents may display symptoms of depression, anxiety, or other clinical disorders that inhibit their ability to respond consistently, warmly and sensitively to their child's needs. For example, depressive symptoms in either mothers or fathers are found to disrupt healthy parenting practices so that the child of a depressed parent is at increased risk of poor attachments, maltreatment and poor physical, neurological, social-emotional, behavioral and cognitive outcomes. However, numerous research studies show parents can be helped to manage clinical symptoms and reactions to their own histories of poor attachments and trauma, to protect children from adversity and trauma as best they can and to provide more nurturing care that promotes secure emotional attachment and healthy development in their children.

All parents experience stress from time-to-time. Thus, parental resilience is a process that all parents need in order effectively manage stressful situations and help ensure they and their families are on a trajectory of healthy, positive outcomes.

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PARENTAL RESILIENCE: ACTION SHEET

Your role as a caseworker

Having an open child welfare case is necessarily emotional and difficult for parents and can cause self-doubt that fundamentally undermines resilience. As a caseworker part of your role is to make the child welfare experience as constructive as possible by:

- Projecting a positive and strengths-based approach to the family
- Supporting the family as key decision-makers throughout the case planning process
- Making self-care a part of the case plan
- Encouraging the parent to explore their own past experiences of trauma and address how those experiences impact them in the present
- Normalizing the fact that parenting is stressful and helping the parent plan proactively about how to respond to stressful parenting situations
- Validating and supporting good decisions

Questions to ask

- What helps you cope with everyday life?
- Where do you draw your strength?
- How does this help you in parenting?
- What are your dreams for yourself and family?
- What kind of worries and frustrations do you deal with during the day? How do you solve them?
- How are you able to meet your children's needs when you are stressed?
- How does your spouse or partner support you? When you are under stress, what is most helpful?
- What do you do to take care of yourself when you are stressed?

What to look for

- Problem solving skills
- Ability to cope with stress
- Self-care strategies
- Help-seeking behavior
- Receiving mental health or substance abuse services if needed
- Not allowing stress to impact parenting

Activities to do with parents

- Ask the parent to write down their self-care strategies and ensure that they are taking time for self-care each day.
- Ask the parent to identify situations they find stressful and make a plan in advance for how they will keep themselves calm and centered in these circumstances.

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SOCIAL CONNECTIONS

PROTECTIVE & PROMOTIVE FACTORS

People need people. Parents need people who care about them and their children, who can be good listeners, who they can turn to for well-informed advice and who they can call on for help in solving problems. Thus, the availability and quality of social connections are important considerations in the lives of parents. **Parents' constructive and supportive social connections—that is, relationships with family members, friends, neighbors, co-workers, community members and service providers**—are valuable resources who provide:

- *emotional support* (e.g., affirming parenting skills or being empathic and non-judgmental)
- *informational support* (e.g., providing parenting guidance or recommending a pediatric dentist)
- *instrumental support* (e.g., providing transportation, financial assistance or links to jobs)
- *spiritual support* (e.g., providing hope and encouragement)

When parents have a sense of connectedness they believe they have people who care about them as individuals and as parents; they feel secure and confident that they have others with whom they can share the joy, pain and uncertainties that come with the parenting role; they seek timely assistance from people they have learned to count on when faced with challenges; and they feel empowered to "give back" through satisfying, mutually beneficial relationships. **Several research studies have demonstrated that—for both mothers and fathers—high levels of emotional, informational, instrumental or spiritual support is associated with positive parental mood; positive perceptions of and responsiveness to one's children; parental satisfaction, well-being and sense of competence; and lower levels of anger, anxiety and depression.**

Conversely, inadequate, conflicting or dissatisfying social connections can be the source of parental stress, rather than a buffer. For example, maternal and paternal grandparents may be very willing sources of informational and instrumental support to new parents, but their advice and manner of caregiving may be at odds with the new parents' beliefs and preferences. At the extreme end of the continuum of poor social connections are social isolation (i.e., the lack of available and quality relationships) and loneliness (i.e., feelings of disconnectedness from others). Social isolation is a risk factor consistently associated with disengaged parenting, maternal depression and increased likelihood of child maltreatment. Similarly, loneliness may be a major stressor that inhibits parents' ability to provide consistent, nurturing, responsive care to their children.

It may seem that increasing the number of people who could provide constructive social support to parents would be the "cure" for social isolation and loneliness. Providing opportunities for parents to create and strengthen sustainable, positive social connections is necessary but alone is not sufficient. Parents can feel lonely and isolated even when surrounded by others if relationships lack emotional depth and genuine acceptance. Thus, parents need opportunities to forge positive social connections with at least one other person that engender emotional, informational, instrumental or spiritual support so that meaningful interactions may occur in a context of mutual trust and respect.

Constructive and supportive social connections help buffer parents from stressors and support nurturing parenting behaviors that promote secure attachments in young children. Therefore, parents' high quality social connections are beneficial to both the adults and the children.

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SOCIAL CONNECTIONS: ACTION SHEET

Your role as a caseworker

As the family's caseworker you can help caregivers to think critically about their social network and how they could utilize it more effectively, as well as the skills and tools they need to expand it. The following strategies may assist you in engaging families in developing social connections:

- Model good relational behavior and use the case management process as an opportunity to help the caregiver develop stronger relational skills
- When engaging the family's broader network in teaming or other supports, be sensitive to the quality of existing relationships and help the family identify supporters in their network who will contribute positively
- Encourage the caregiver to expand or deepen their social network as part of the case plan
- If there are specific issues that serve as barriers for the family in developing healthy social connections such as anxiety or depression, encourage the family to address them

Questions to ask

- Do you have friends or family members that help you out once in a while?
- Are you a member of any groups or organizations?
- Who can you call for advice or just to talk? How often do you see them?
- What kind of social support do you need?
- Do you find it easy or challenging to make friends? If it is challenging, what specific things represent a barrier for you?
- What helps you feel connected?

What to look for

- Does the parent have supportive relationships with one or more persons (friends, family, neighbors, community, faith- based organizations, etc.)?
- Can the parent turn to their social network for help in times of need (for instance, when they need help with transportation, childcare or other resources)?
- Is the parent willing and able to accept assistance from others?
- Does the parent have positive relationships with other parents of same-age kids?
- Does the parent have skills for establishing and maintaining social relationships?
- Does the parent provide reciprocal social support to peers?

Activities to do with parents

- Work with the parent to develop an EcoMap showing the people and institutions that are sources of support and/or stress in his or her life.
- Role play with the parent to help them practice skills in approaching another parent to develop a friendship. Have the parent choose a realistic scenario such as starting a conversation at a school event, on the playground or at a place of worship.

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KNOWLEDGE OF PARENTING AND CHILD DEVELOPMENT

PROTECTIVE & PROMOTIVE FACTORS

No parent knows everything about children or is a "perfect parent." An understanding of parenting strategies and child development helps parents understand what to expect and how to provide what children need during each developmental phase. All parents, and those who work with children, can benefit from increasing their knowledge and understanding of child development, including:

- physical, cognitive, language, social and emotional development
- signs indicating a child may have a developmental delay and needs special help
- cultural factors that influence parenting practices and the perception of children
- factors that promote or inhibit healthy child outcomes
- discipline and how to positively impact child behavior

Gaining more knowledge about child development and developing greater skills in parenting are particularly important given the recent advances in the fields of neuroscience, pediatrics and developmental psychology. **Scientists in these fields have provided much evidence of the critical importance of early childhood as the period in which the foundation for intellectual, social, emotional and moral development is established. Furthermore, numerous research studies show this foundation is determined by the nature of the young child's environments and experiences that shape early brain development.**

Developing brains need proper nutrition, regularly scheduled periods of sleep, physical activity and a variety of stimulating experiences. Developing brains also need attuned, emotionally available parents and other primary caregivers who recognize and consistently respond to the needs of young children, and interact with them in an affectionate, sensitive and nurturing manner. Such care gives rise to the development of a secure attachment between the child and the adult. Young children with secure attachments develop a sense of trust, feel safe, gain self-confidence and are able to explore their environments because they feel they have a secure base.

Numerous longitudinal studies have demonstrated that parental behaviors that lead to early secure attachments—and which remain warm and sensitive as children grow older—lay the foundation for social-emotional, cognitive and moral competencies across developmental periods. For example, when a young child solicits interaction through babbling or facial expressions and a parent responds in a similar manner, this type of parent-child interaction helps to create neural connections that build later social-emotional and cognitive skills. In addition, advances in brain research have shown that parental behaviors that forge secure emotional attachments help young children learn to manage stress. Secure attachments can offset some of the damage experienced by highly stressed young children as a result of trauma (e.g., maltreatment or exposure to violence.)

In contrast, parental care that is inconsistent, unresponsive, detached, hostile or rejecting gives rise to insecure attachments. Young children who experience insecure attachments display fear, distrust, anxiety or distress and are at risk for long-term adverse effects on brain development including developmental delays, cognitive impairments, conduct problems, psychopathology and relationship challenges. For example, young children who have limited adult language stimulation and opportunities to explore may not fully develop the neural pathways that support learning.

What parents do and how they treat children is often a reflection of the way they were parented. Acquiring new knowledge about parenting and child development enables parents to critically evaluate the impact of their experiences on their own development and their current parenting practices, and to consider that there may be more effective ways of guiding and responding to their children. Furthermore, understanding the mounting evidence about the nature and importance of early brain development enables both parents and those who work with children to know what young children need most in order to thrive: nurturing, responsive, reliable and trusting relationships; regular, predictable and consistent routines; interactive language experiences; a physically and emotionally safe environment; and opportunities to explore and to learn by doing.

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KNOWLEDGE OF PARENTING AND CHILD DEVELOPMENT: ACTION SHEET

Your role as a caseworker

Each contact you have with the family provides an important opportunity to link them to parenting resources, provide child development information and model and validate effective caregiving. You can:

- Connect parents to parenting education classes or home visiting as part of case planning
- Model appropriate expectations for the child
- Engage caregivers in dialogue when their expectations are not in line with the child's developmental phase
- Underline the importance of nurturing care to help the caregiver in valuing the importance of their own role
- Provide "just in time" parenting education: information a parent needs at the time when parenting issues arise
- Help the caregiver identify a series of trusted informants that they can turn to when they need parenting information

Questions to ask

- What does your child do best and what do you like about your child?
- What do you like about parenting? What do you find challenging about parenting?
- How have you learned about parenting skills?
- How do you continue to learn about your child's development?
- What has helped you learn about yourself as a parent?
- Are there things that worry you about your child's development or behavior?
- Have other people expressed concern about your child?

What to look for

- Do the caregivers understand and encourage healthy development?
- Are the caregivers able to respond and manage their child's behavior?
- Do the caregivers understand and demonstrate age-appropriate parenting skills in their expectations, discipline, communication, protection and supervision of their child?
- Does the child respond positively to the caregivers' approaches?
- Do the caregivers understand and value their parenting role?
- Do the caregivers have a reliable source for parenting information when issues come up?
- Are the caregivers involved in their child's school or preschool?
- Do the caregivers understand the child's specific needs (especially if the child has special developmental or behavioral needs)?

Activities to do with parents

- Ask the parent what their hopes and dreams are for their child(ren). Discuss any worries the parent has about ensuring those hopes and dreams are met. Then discuss what the parent is doing today (or wants to do) to help achieve those hopes and dreams.
- Identify a particular parenting task the parent finds challenging (e.g., mealtimes, putting the child to bed). Provide the parent with information on strategies for this task. Ask them to practice these strategies and debrief on your next visit.

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CONCRETE SUPPORT IN TIMES OF NEED

PROTECTIVE & PROMOTIVE FACTORS

All parents need help sometimes—help with the day-to-day care of children, help in figuring out how to soothe a colicky baby, help getting to the emergency room when a bad accident happens, help in managing one's own temper when fatigued or upset. When parents are faced with very trying conditions such as losing a job, home foreclosure, substance abuse, not being able to feed their family or trauma, they need access to concrete support and services that address their needs and help to minimize the stress caused by very difficult challenges and adversity. **Assisting parents to identify, find and receive concrete support in times of need helps to ensure they and their family receive the basic necessities everyone deserves in order to grow (e.g., healthy food, a safe environment), as well as specialized medical, mental health, social, educational or legal services.**

When parents are faced with overwhelmingly stressful conditions they need to seek help, but for some parents asking for help is not an easy thing to do. It may be embarrassing for some parents because it feels like an admission of incompetence; that they don't know how to solve their own problems or take care of their family. Other parents may not seek help because they don't know where to go for help, or the services needed have a stigma associated with them such as mental health clinics and domestic violence or homeless shelters. **Thus, parents need experiences that enable them to understand their rights in accessing services, gain knowledge of relevant services and learn how to navigate through service systems.** Family and child-serving programs must clearly communicate to parents that seeking help is not an indicator of weakness or failure as a parent. **On the contrary, seeking help is a step toward improving one's circumstances and learning to better manage stress and function well—even when faced with challenges, adversity, and trauma. When parents ask for help, it is a step toward building resilience.**

When parents seek help, it should be provided in a manner that does not increase stress. Services should be coordinated, respectful, caring and strengths-based. Strengths-based practice is grounded in the beliefs that:

- It is essential to forge a trusting relationship between parents and service providers and among service providers working with the same families
- Regardless of the number or level of adverse conditions parents are experiencing, they have assets within and around them, their family and their community that can be called upon to help mitigate the impact of stressful conditions and to create needed change
- Parents have unrealized resources and competencies that must be identified, mobilized and appreciated
- Parents must be active participants in the change process and not passive recipients of services
- Parents must first be guided through, and subsequently learn how to navigate, the complex web of health care and social service systems
- In addition to addressing each parent's individual difficulties, strengths-based practitioners must understand—and work to change—the structural inequities and conditions that contribute to these difficulties

A strengths-based approach helps parents feel valued because they are acknowledged as knowledgeable and competent. They develop a sense of self-confidence and self-efficacy because they have opportunities to build their skills, experience success and provide help to others. Thus, access to concrete support in times of need must be accompanied by a quality of service coordination and delivery that is designed to preserve parents' dignity and to promote their and their family's healthy development, resilience and ability to advocate for and receive needed services and resources.

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CONCRETE SUPPORT IN TIMES OF NEED: ACTION SHEET

Your role as a caseworker

As the family's caseworker your role is not just to provide referrals to needed services, but to identify any barriers the families may have in accessing those services. Helping families overcome those barriers is crucial to ensuring that their concrete needs are met. Such help may entail:

- Encouraging help seeking behavior
- Working with the family to understand their past experience with service systems and any stigma they attach to certain services
- Helping the family to navigate complex systems by explaining eligibility requirements, filling out forms or making a warm handoff to an individual who can help them negotiate getting access to the services they need
- Helping the caregiver understand their role as an advocate for themselves and their child

Questions to ask

- What do you need to _____ (stay in your house, keep your job, pay your heating bill etc.)?
- What have you done to handle the problem? Has this worked?
- Are there community groups or local services that you have worked with in the past? What has been your experience accessing their services?
- Are there specific barriers that have made it difficult for you to access services in the past?
- How does dealing with these issues impact the way you parent?

What to look for

- Is the caregiver open to accessing and utilizing services?
- Has the caregiver had positive experiences with services in the past?
- Does the caregiver have specific barriers (literacy, lack of transportation, etc.) that will make it difficult to access services?
- Are there personal behavioral traits (e.g., punctuality, willingness to share personal information, etc.) that the caregiver could address to more effectively utilize services?
- Does the caregiver try to buffer the child from the stress caused by the family's concrete needs?

Activities to do with parents

- Ask the parent to identify one concrete need that, if met, would lighten his or her burden. Come up with a list of at least three possible avenues to get that need met (e.g., agencies to approach, people to ask for help, cutting back on other expenses).
- Talk to the parent about what their family's socioeconomic status was in their childhood and what effect that had on them. Discuss things their parents did or did not do to buffer them from the stress of poverty, to teach them the value of money or to make sure their needs were met.

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SOCIAL-EMOTIONAL COMPETENCE OF CHILDREN

PROTECTIVE & PROMOTIVE FACTORS

Early childhood is a period of both great opportunity and vulnerability. Early childhood experiences set the stage for later health, well-being and learning. In the past, most of the focus was on building young children's academic skills in an effort to ensure they were prepared for school. **However, in recent years a growing body of research has demonstrated the strong link between young children's social-emotional competence and their cognitive development, language skills, mental health and school success**. The dimensions of social-emotional competence in early childhood include:

- self-esteem - good feelings about oneself
- self-confidence - being open to new challenges and willing to explore new environments
- self-efficacy - believing that one is capable of performing an action
- self-regulation/self-control - following rules, controlling impulses, acting appropriately based on the context
- personal agency - planning and carrying out purposeful actions
- executive functioning - staying focused on a task and avoiding distractions
- patience - learning to wait
- persistence - willingness to try again when first attempts are not successful
- conflict resolution - resolving disagreements in a peaceful way
- communication skills - understanding and expressing a range of positive and negative emotions
- empathy - understanding and responding to the emotions and rights of others
- social skills - making friends and getting along with others
- morality - learning a sense of right and wrong

These dimensions of social-emotional competence do not evolve naturally. The course of social-emotional development—whether healthy or unhealthy—depends on the quality of nurturing attachment and stimulation that a child experiences. Numerous research studies show that a relationship with a consistent, caring and attuned adult who actively promotes the development of these dimensions is essential for healthy social-emotional outcomes in young children. Actively promoting social-emotional competence includes activities such as:

- Creating an environment in which children feel safe to express their emotions
- Being emotionally responsive to children and modeling empathy
- Setting clear expectations and limits (e.g., "People in our family don't hurt each other.")
- Separating emotions from actions (e.g., "It's okay to be angry, but we don't hit someone when we are angry.")
- Encouraging and reinforcing social skills such as greeting others and taking turns
- Creating opportunities for children to solve problems (e.g., "What do you think you should do if another child calls you a bad name?")

Children who have experiences such as these are able to recognize their and others' emotions, take the perspective of others and use their emerging cognitive skills to think about appropriate and inappropriate ways of acting. Conversely, research shows children who do not have adults in their lives who actively promote social-emotional competence may not be able to feel remorse or show empathy and may lack secure attachments, have limited language and cognitive skills and have a difficult time interacting effectively with their peers. Evidence shows, however, that early and appropriate interventions that focus on social-emotional development can help to mitigate the effects of negative experiences in ways that lead to improved cognitive and social-emotional outcomes.

5 OF 5

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SOCIAL AND EMOTIONAL COMPETENCE OF CHILDREN: ACTION SHEET

Your role as a caseworker

It is important to increase caregivers' awareness of the importance of early relationships and of their role in nurturing their child's social-emotional development by:

- Providing concrete tips and resources to caregivers to help them build their skills
- Staying attuned to trauma and how it impacts the child's relationships with significant adults and, as they grow, with peers
- Connecting the family to resources that can help support the child's social-emotional development—these might be simple (such as classes like Second Step, or books and games that help children to name or recognize their emotions) or more intensive (such as mental health counseling)
- Providing families with support in dealing with children's attachment issues and/or challenging behaviors
- Taking time to explain and discuss children's behavior with caregivers when they are "acting out" due to trauma

Questions to ask

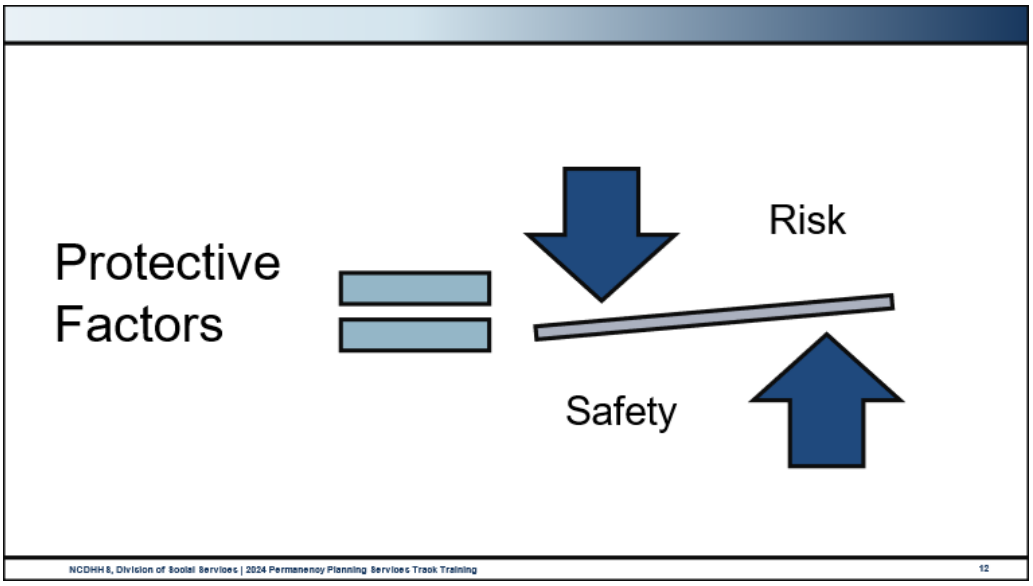
- How is the emotional relationship between you and your child?
- How do you express love and affection to your child?
- How do you help your child express his or her emotions?
- In what situations are your child's emotions hard for you to deal with?

What to look for

- Do the caregivers know how to encourage social-emotional development and apply a range of age-appropriate disciplinary strategies?
- Does the caregiver create an environment in which the child feels safe to express emotions?
- Is the caregiver emotionally responsive to the child?
- Does the caregiver model empathy?
- Does the caregiver set clear expectations and limits (e.g., "People in our family don't hurt each other")?
- Does the caregiver separate emotions from actions (e.g., "It's okay to be angry, but we don't hit someone when we are angry")?
- Does the caregiver encourage and reinforce social skills such as greeting others and taking turns?
- Does the caregiver create opportunities for children to solve problems? (e.g., "What do you think you should do if another child calls you a bad name?")?

Activities to do with parents

- Have the parent sketch out (or write out) an interaction with their child. Begin with an experience that typically makes the child happy, sad, frustrated or angry. Then have the parent illustrate or describe what the child does when he or she feels those emotions, how the parent responds and how the child responds. Identify and talk through positive or negative patterns in the interaction.
- Ask the parent to think of an adult who they loved as a child. What was it about the relationship with that adult that made it so important? Ask them what elements of that relationship they can replicate in their relationship with their child(ren).



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Activity: Protective Factors Exploration

Work with your group to:

- Define your assigned Protective Factor in family-accessible language.
- Name at least 5 ways that the presence of this protective factor buffers from risk and trauma.
- Name at least 5 ways that this protective factor shows up in a family's life.

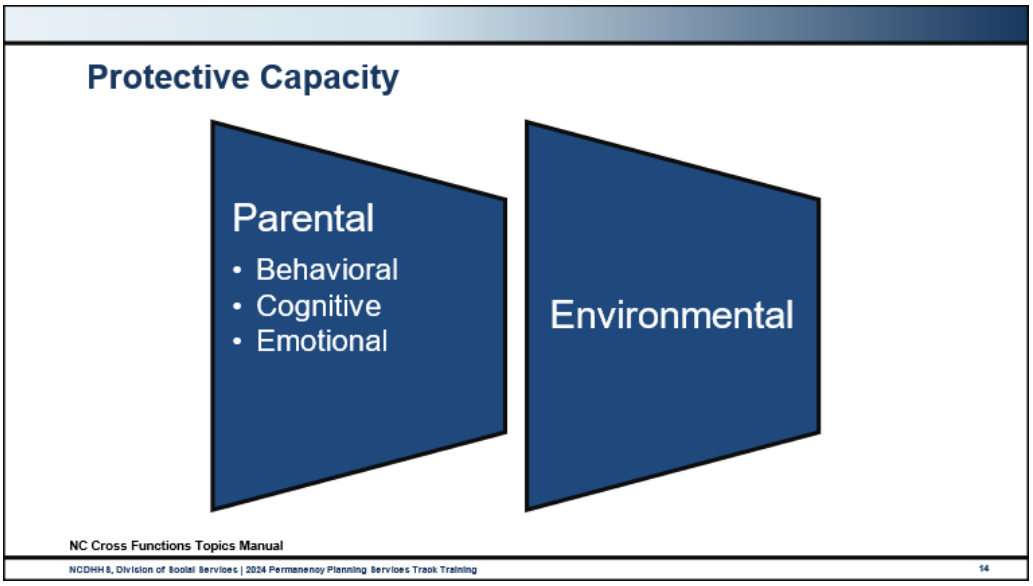
Parental Resilience

Social Connections

Knowledge of Parenting and Child Development

Concrete Support in Times of Need

Social-Emotional Competence of Children



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Handout: Protective Capacity

Protective capacity is defined as the ability and willingness to mitigate or ameliorate the identified safety and risk concerns. Protective capacity can be demonstrated by a parent through their statements, actions, and reactions. Protective capacity exists both within the parent/caretaker and within the family environment.

Parent/caretaker protective capacity should be assessed in three domains:

- Behavior characteristics
- Cognitive characteristics
- Emotional characteristics

Behavioral characteristics are defined as specific actions and activities consistent with and resulting in parenting and protective vigilance. Questions to consider include:
• Does the parent/caretaker have the capacity to care for the child? If the parent/caretaker has a disability(ies) (e.g., blindness, deafness, paraplegia, chronic illness), how has the parent/caretaker addressed the disability in parenting the child? • Has the parent/caretaker acknowledged and acted to provide the needed support to effectively parent and protect the child? • Does the parent/caretaker demonstrate activities that indicate putting aside one's own needs in favor of the child's needs (if appropriate)? • Does the parent/caretaker demonstrate adaptability in a changing environment or during a crisis? • Does the parent/caretaker demonstrate actions to protect the child? • Does the parent/caretaker demonstrate impulse control related to a risk factor? • Does the parent/caretaker have a history of protecting the child given any threats to the safety of the child?

Cognitive characteristics are defined as the parent/caretaker's specific intellect, knowledge, understanding, and perception that contributes to protective vigilance. Questions to consider include:
• Is the parent/caretaker oriented to time, place, and space? (i.e., reality orientation) • Does the parent/caretaker have an accurate perception of the child? Does the parent/caretaker see the child as having strengths and weaknesses, or do they see the child as "all good" or "all bad"? • Can the parent/caretaker recognize the child's developmental needs or if the child has special needs? • How does the parent/caretaker process the external stimuli? (e.g., a battered woman who believes she deserves to be beaten because of something she has done) • Does the parent/caretaker understand their role to provide protection to the child? • Does the parent/caretaker have the intellectual ability to understand what is needed to raise and protect a child? • Does the parent/caretaker accurately assess potential threats to the child?

Emotional characteristics are defined as the parent/caretaker's specific feelings, attitudes, and identification with the child and motivation that results in parenting and protective vigilance. Questions to consider include:
• Does the parent/caretaker have an emotional bond with the child? Is there a reciprocal connection between the parent/caretaker and the child? Is there a positive connection to the child? • Does the parent/caretaker have empathy for the child when the child is hurt or afraid? • Is the parent/caretaker flexible under stress? Can the parent/caretaker manage adversity? • Is the parent/caretaker able to control their emotions? If emotionally overwhelmed, does the parent/caretaker reach out to others or expect the child to meet the parent/caretaker's emotional needs? • Does the parent/caretaker consistently meet their own emotional needs via other adults, services?

Environmental Protective Capacities

While the assessment of the parent/caretaker's protective capacities is critical, an assessment of **environmental capacities** may also mitigate the safety concerns/risk of harm to a child. Below are several categories of environmental protective capacities to be considered.
• Family/kinship relationships that contribute to the protection of the child • Informal relationships • Agency supports • Community supports • Financial status • Spiritual supports • For American Indians, the tribe • Concrete needs being met (e.g., for food, clothing, shelter).

Citation: Cross Function Topics

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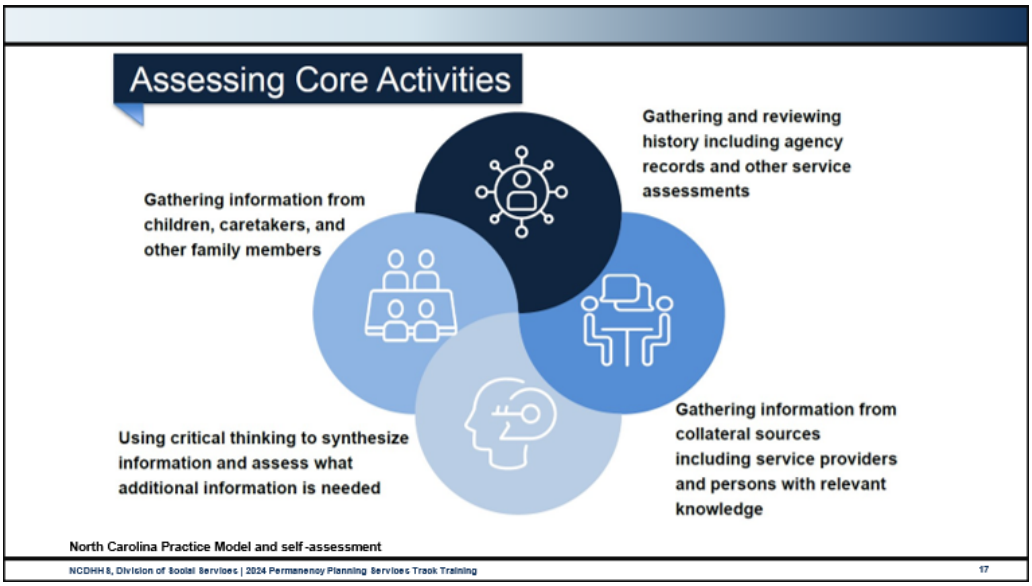
Assessing



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Worksheet: North Carolina Practice Standards – Assessing

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North Carolina Worker Assessment: Assessing

Introduction

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

There are four Assessing core activities: (1) gathering information from children, caretakers, and other family members, (2) gathering and reviewing history, including agency records and other service assessments, (3) gathering information from collateral sources including service providers and persons with relevant knowledge, and (4) using critical thinking to synthesize information, assess what additional information is needed, and inform decision making.

Table 1. Core Activity: Gathering information from children, caretakers, and other family members

Practice Standard 1: Differentiates between information and positions				
	A	S	N	Notes
I moderate information gathering sessions	(1)	(2)	(3)	
I gather information that supports all positions	(1)	(2)	(3)	
I understand my own biases that may cloud positions	(1)	(2)	(3)	
Practice Standard 2: Takes time to get to know families and explain the assessment process				
	A	S	N	Notes
I take time to conversationally gather the family's story	(1)	(2)	(3)	
I use engagement to build family participation in assessment process	(1)	(2)	(3)	
I get a picture of the family's hopes, aspirations, challenges, and worries	(1)	(2)	(3)	
I explain the assessment process, reiterating purpose	(1)	(2)	(3)	
I authentically share with the family about the process	(1)	(2)	(3)	

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I keep in mind the culture of the family when gathering information	(1)	(2)	(3)	

Practice Standard 3: Asks questions based on information needed and at ease asking uncomfortable questions				
	A	S	N	Notes
I ask open-ended, strengths-based questions	(1)	(2)	(3)	
I understand what type of questions elicit the best type of answers	(1)	(2)	(3)	
I have the ability to hear difficult information without reaction	(1)	(2)	(3)	
I engage in crucial conversations	(1)	(2)	(3)	
I utilize a narrative approach to gather perspectives on historical information	(1)	(2)	(3)	

Table 2. Core Activity: Gathering and reviewing history, including agency records and other service assessments

Practice Standard 4: Stays open to different explanations of events in the record, keeping biases in check				
	A	S	N	Notes
I continuously gather information	(1)	(2)	(3)	
I am diligent in pursuing information	(1)	(2)	(3)	
I understand how to factor historical information into current situation	(1)	(2)	(3)	
I keep an open mind	(1)	(2)	(3)	

Practice Standard 5: Balances what is read in the record and what families share				
	A	S	N	Notes
I review information ahead of meeting the family, but ask them to share their perspective	(1)	(2)	(3)	

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I identify in the record what has historically worked well for the family	(1)	(2)	(3)
I have an understanding of what biases I hold when reviewing history	(1)	(2)	(3)

Table 3. Core Activity: Gathering information from collateral sources including service providers and persons with relevant knowledge

Practice Standard 6: Obtains all sides if there are differing positions among collaterals, engaging families in the process				
	A	S	N	Notes
I seek out wide number of collaterals and balance collateral sources	(1)	(2)	(3)	
I obtain information from as many collaterals as time permits	(1)	(2)	(3)	
I consider all relevant collateral sources	(1)	(2)	(3)	
I am honest with families when I must reach out to collaterals the family is unhappy with and explain why	(1)	(2)	(3)	
I let the family help identify collaterals and ask their permission before contacting	(1)	(2)	(3)	

Table 4. Core Activity: Using critical thinking to synthesize information, assess what additional information is needed, and inform decision making

Practice Standard 7: Synthesizes information and considers sources, prioritization, and timelines				
	A	S	N	Notes
I continually gather information	(1)	(2)	(3)	
I understand assessment is ongoing process in determining needs	(1)	(2)	(3)	
I rank information received based on relevance and priority	(1)	(2)	(3)	

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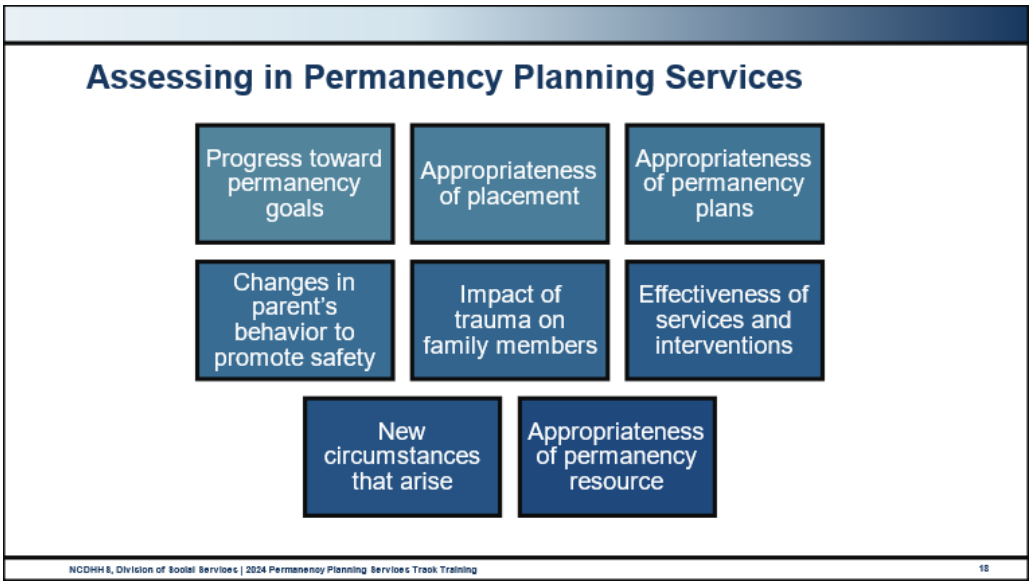
I prioritize information that negatively impacts children to address first	(1)	(2)	(3)	
Practice Standard 8: Remains non-judgmental when processing information				
	A	S	N	Notes
I am inquisitive from the beginning of assessment process	(1)	(2)	(3)	
I understand the family's community as they define it	(1)	(2)	(3)	
I operate with cultural humility	(1)	(2)	(3)	
I persevere in gathering information, follow the information	(1)	(2)	(3)	
I understand not all information is relevant	(1)	(2)	(3)	
I normalize reactions family has to information and assessment results	(1)	(2)	(3)	
I understand fight, flight, or freeze response	(1)	(2)	(3)	

What did this self-assessment reveal about yourself?

In what areas are you strong?

In what areas do you require growth?

What are two things you can do to build your capacity in your area of growth?



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Activity: Holistic Assessment

Using the information in your assigned envelope, work with your group to identify which areas listed below can be assessed with the tools and activities in your envelope. Record the identified tools and activities in the space below each appropriate area. Keep in mind that some tools and activities can assess multiple areas.

Household economic status

Family/household social network, including household make-up, relationships with extended family members, and community engagement (including faith and/or cultural community)

Parent/caretakers' mental and/or behavioral health

Parent/caretakers' physical health

Parent/caretakers' educational, cognitive, communication, and decision-making capacity

Parent/caretakers' relationship status (including an assessment of any history of relationship conflict or domestic violence)

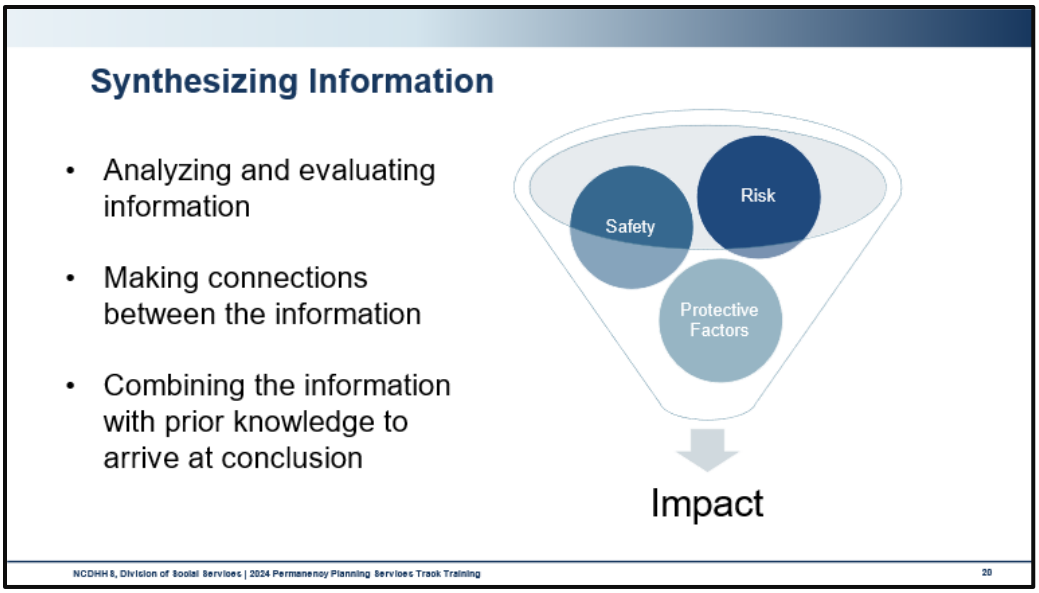
Parent/caretakers' knowledge of child development and parenting skills

Trauma history for all family members

Parent/caretakers' substance abuse history

Other household conditions include but are not limited to:

- Household physical and environmental conditions
- Household routines
- Transportation availability



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Using SDM when Assessing Safety and Risk

Timeframe	Reunification Assessment, Risk Reassessment & Strengths and Needs Assessment
Within 30 days of case decision	• Review and use Risk Assessment completed during CPS Assessments or In-Home Services • Review and use Family Assessment of Strengths and Needs completed during CPS Assessments or In-Home Services unless additional information obtained uncovers needs that impact safety and/or risk
Every 90 days thereafter in coordination with PPR	• Complete both Family Assessment of Strengths and Needs and Family Reunification Assessment NOTE: When a child has been placed back in the home for a trial home visit, the Family Risk Reassessment is completed in place of the Family Reunification Assessment
Within 30 days of recommending return of custody to the parent and case closure	• Complete Family Assessment of Strengths and Needs

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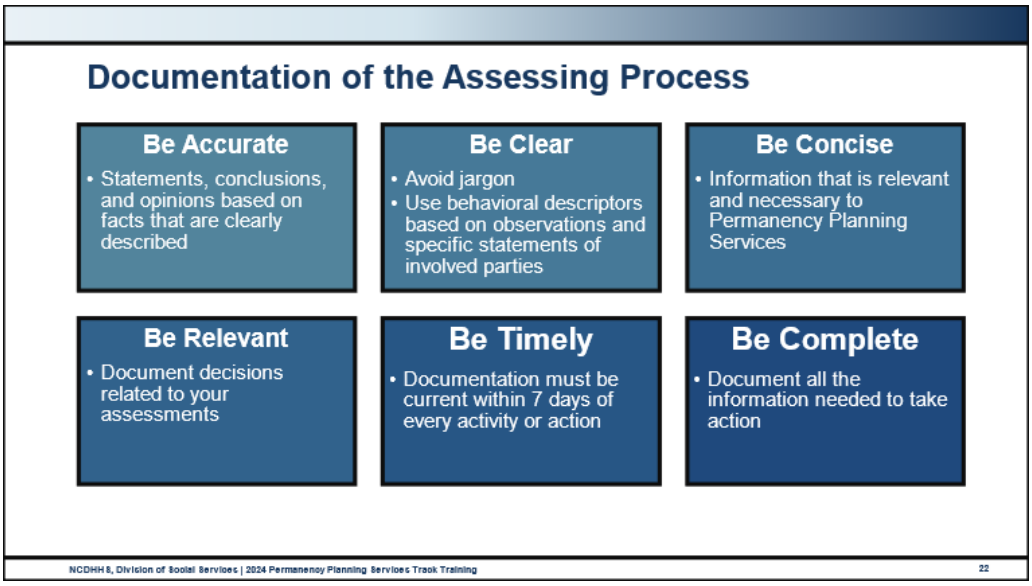

Utilize this checklist to ensure you are creating quality documentation:

- Be Accurate – Statements, conclusions, and opinions must be based on facts that are clearly described.
- Be Clear – Jargon should be avoided, and the descriptions of circumstances should be written using behavioral descriptors based on observations and specific statements of involved parties.
- Be Concise – Records should only contain information that is relevant and necessary to Permanency Planning Services.
- Be Relevant – Documentation of decisions with respect to risk and safety assessments, and other information gathered during the assessment process.
- Be Timely - Documentation, including narrative, must be current within 7 days of every activity or action.
- Be Complete – Documentation contains all the information needed to take action, for example, contact names, dates, times, and locations.

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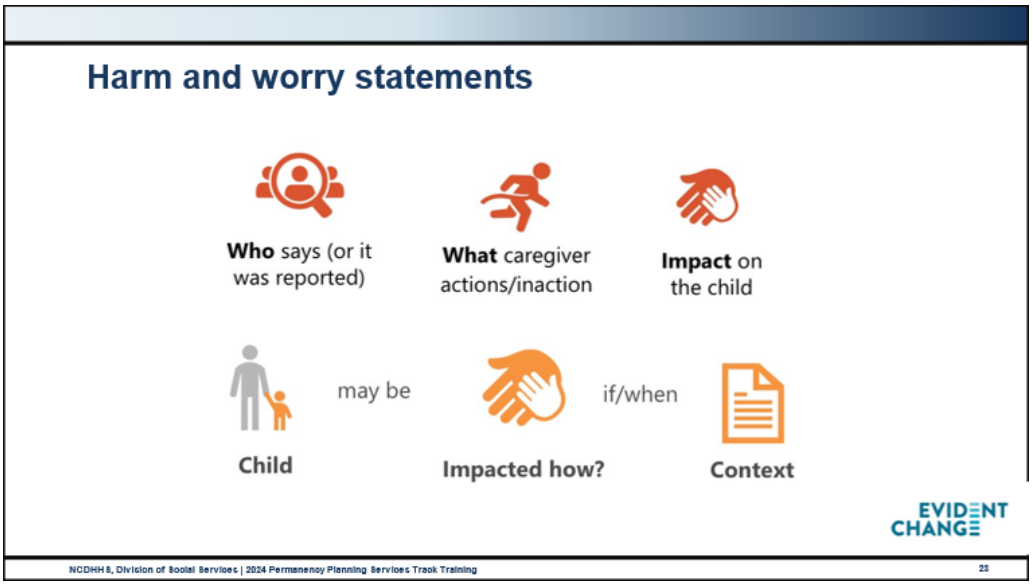


Harm statements are clear and specific statements about the harm or maltreatment experienced by a child. They represent the safety concern. The harm statement includes specific details:

- Who reported the concern (when it is possible to share) and what was reported
- What exactly happened, including the specific caregiver behavior, and
- The impact on the child.

For example, “On Tuesday, it was reported that mom passed out from drinking and her 4-year-old left the home, walked into traffic, and was hit by a car, breaking her leg.”

While it is never a guarantee about the future, a clear understanding of the past (harm) is our best guide to understanding what we should be worried about in the future.

Worry statements answer two questions:

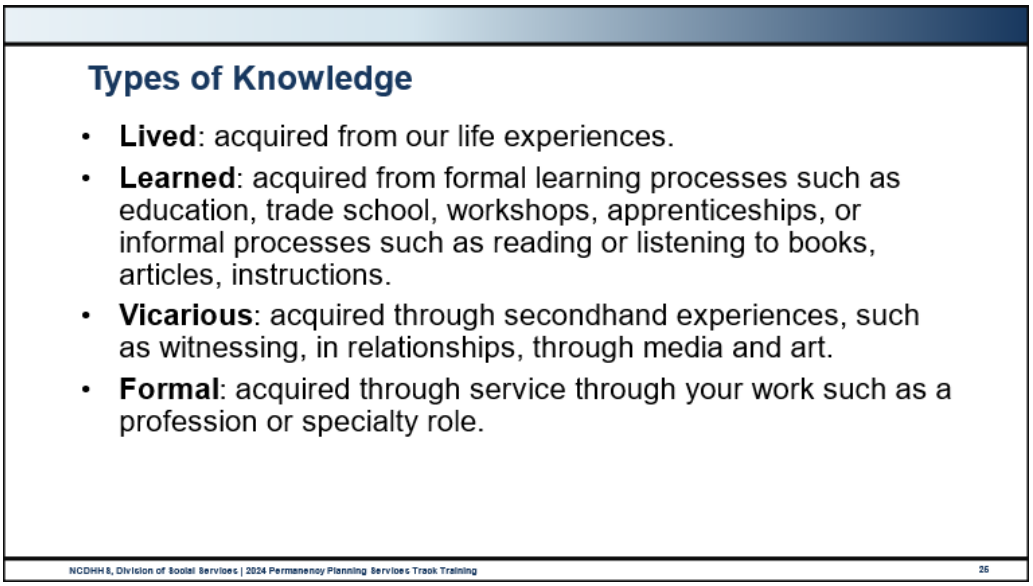
- What are we worried will happen to the children if nothing else changes?
- In what situations or context are we worried this could happen?

Worry statements are composed of the following:

- Child…
- may be impacted how?...
- if/when?

For example, “Four-year-old child may be injured if mom is not sober and providing supervision.”

Cultural Considerations, Bias, and Impact on Assessment



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Activity: Key Factors and Considerations

Taking this concept about knowledge types a step further, consider the knowledge you hold about various factors and circumstances you will encounter in your child welfare practice.

For each factor presented:

- Using a scale of one to ten, rate how much knowledge you hold about this factor and its impact on families. One represents no knowledge of the factor and ten represents deep understanding within multiple contexts.
- Consider how you gained this knowledge - through lived, learned, vicarious, or formal experiences.
- Name one way you can access knowledge other than your own in order to expand your awareness and understanding of this factor.

Mental Health

How much knowledge do you hold of Mental Health dynamics and their impact on families? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What types of experiences contributed to your knowledge? ☐Lived ☐Learned ☐Vicarious ☐Formal
One way you can access knowledge different than your own:

Substance Misuse, Substance Use Disorder, and Substance-Affected Infants

How much knowledge do you hold of Substance Misuse, Substance Use Disorder, and Substance-Affected Infants dynamics and their impact on families? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What types of experiences contributed to your knowledge? ☐Lived ☐Learned ☐Vicarious ☐Formal
One way you can access knowledge different than your own:

Domestic and Intimate Partner Violence

How much knowledge do you hold of Domestic and Intimate Partner Violence dynamics and their impact on families? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What types of experiences contributed to your knowledge? ☐Lived ☐Learned ☐Vicarious ☐Formal
One way you can access knowledge different than your own:

Human Trafficking

How much knowledge do you hold of Human Trafficking dynamics and their impact on families?
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What types of experiences contributed to your knowledge?
☐Lived ☐Learned ☐Vicarious ☐Formal
One way you can access knowledge different than your own:

Poverty

How much knowledge do you hold of Poverty dynamics and their impact on families?
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What types of experiences contributed to your knowledge?
☐Lived ☐Learned ☐Vicarious ☐Formal
One way you can access knowledge different than your own:

LGBTQIA+ Children, Youth, and Families

How much knowledge do you hold of LGBTQIA+ Children, Youth, and Families dynamics and their impact on families?
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What types of experiences contributed to your knowledge?
☐Lived ☐Learned ☐Vicarious ☐Formal
One way you can access knowledge different than your own:

Pregnant and Parenting Teens

How much knowledge do you hold of Pregnant and Parenting Teens dynamics and their impact on families?
☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What types of experiences contributed to your knowledge?
☐Lived ☐Learned ☐Vicarious ☐Formal
One way you can access knowledge different than your own:

Cognitive Limitations of Parents

How much knowledge do you hold of Cognitive Limitations of Parents dynamics and their impact on families? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What types of experiences contributed to your knowledge? ☐Lived ☐Learned ☐Vicarious ☐Formal
One way you can access knowledge different than your own:

Systemic Oppression

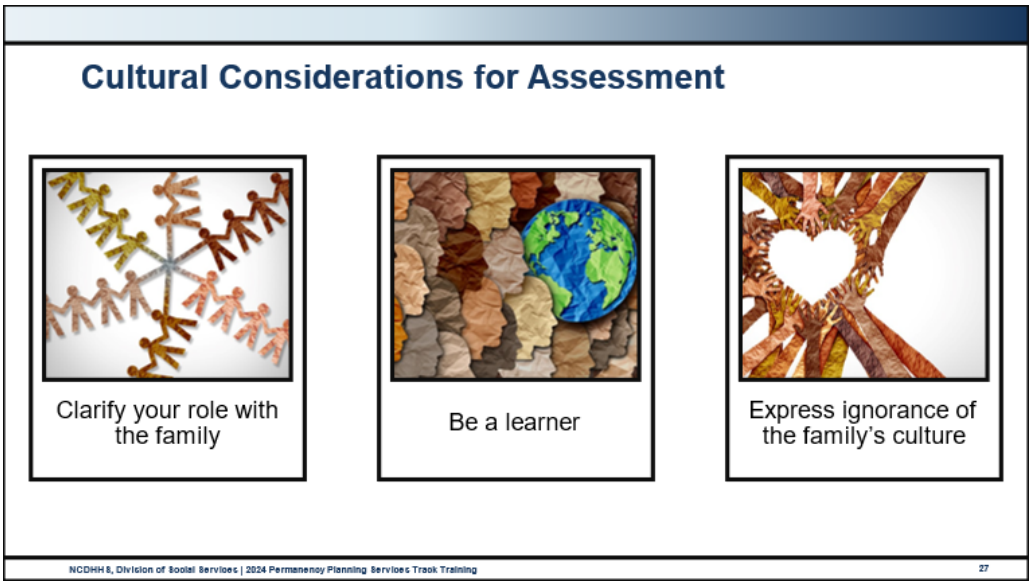
How much knowledge do you hold of Systemic Oppression dynamics and their impact on families? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What types of experiences contributed to your knowledge? ☐Lived ☐Learned ☐Vicarious ☐Formal
One way you can access knowledge different than your own:

Neurodivergence

How much knowledge do you hold of Neurodivergence dynamics and their impact on families? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10
What types of experiences contributed to your knowledge? ☐Lived ☐Learned ☐Vicarious ☐Formal
One way you can access knowledge different than your own:

Regardless of what we know about these areas of focus, we will never be experts on how these factors and areas show up or impact the lives of the children and families we serve. As family-centered social workers who practice cultural humility, we are fortunate to have the experts with us in all we do. The families we serve are the experts.

Citation: Shepherd, A. & Sturtevant-Gilliam, A. (2023, Oct).
Extending the Table: Facilitating Community Engagement and Collaboration [Workshop Session]. Facilitating Community Engagement and Collaboration Workshop, WNC Nonprofit Pathways, Asheville, NC, US.



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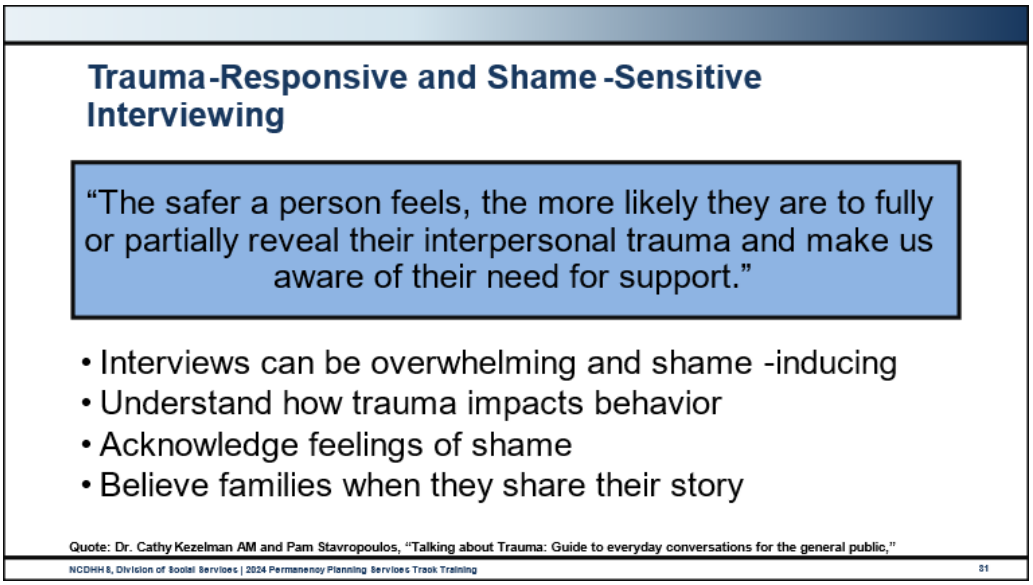
Interviewing

Video: Empathetic Listening

https://youtu.be/SnCJIjQxbeY?si=sXK8LKRERr4mQ3td

What is one takeaway from this video?

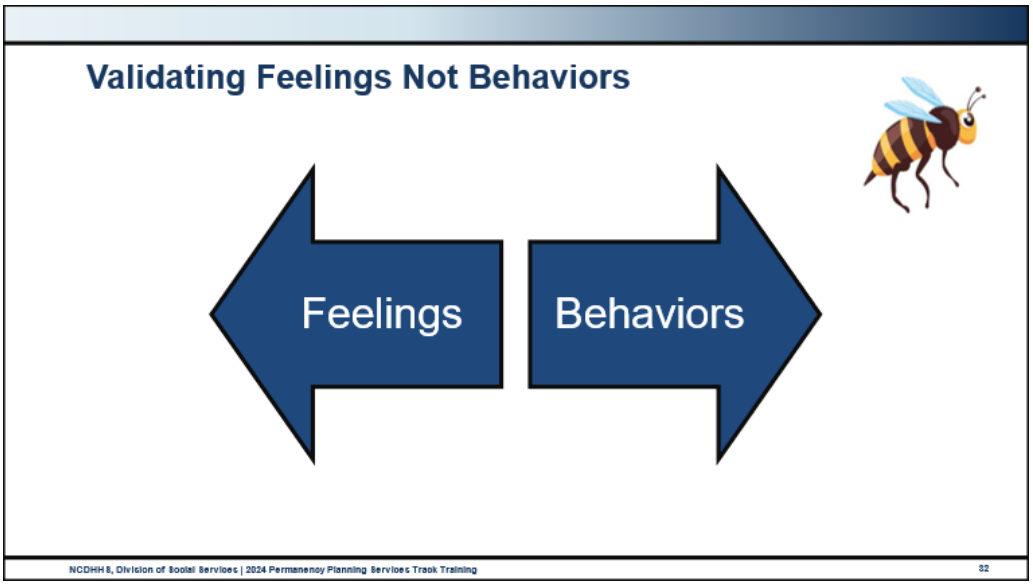
How do you think empathetic listening will support you in your work with children and families?



What do you do to reduce the power differential between yourself and parents to support families feeling safe to discuss trauma?

How do you react to their experience and feelings about the trauma they endured?

How do you recognize feelings of shame without exacerbating these feelings?



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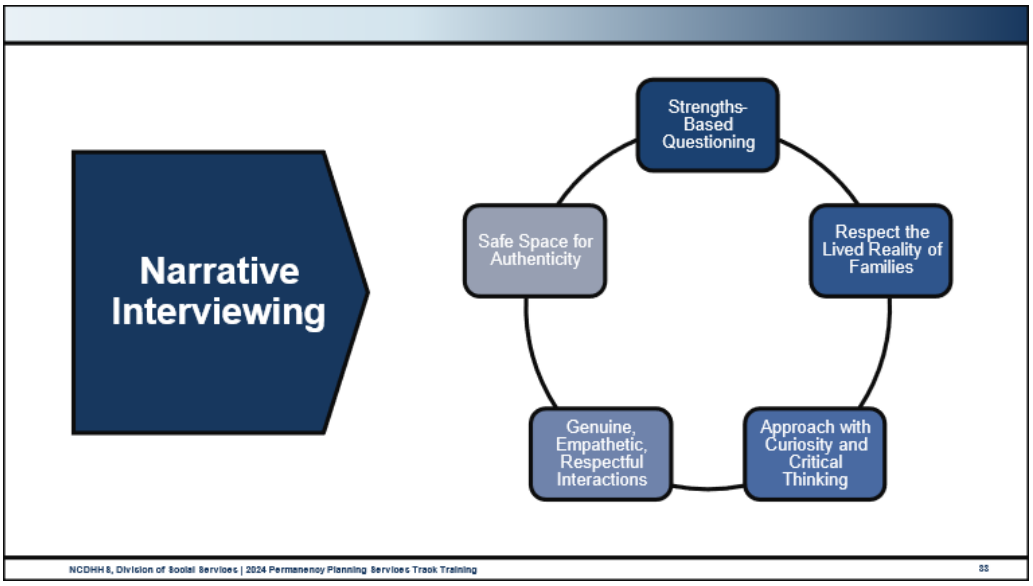

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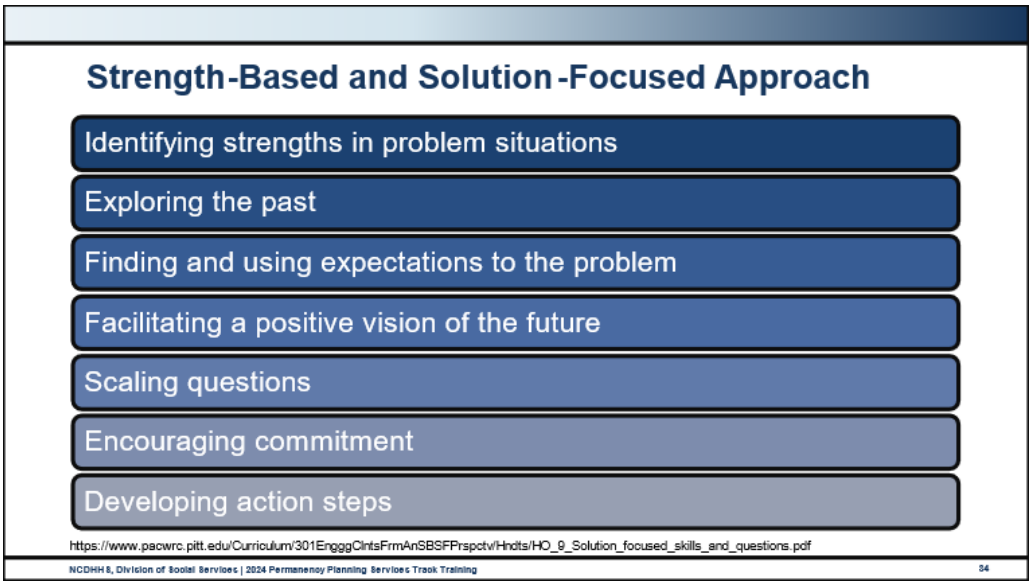

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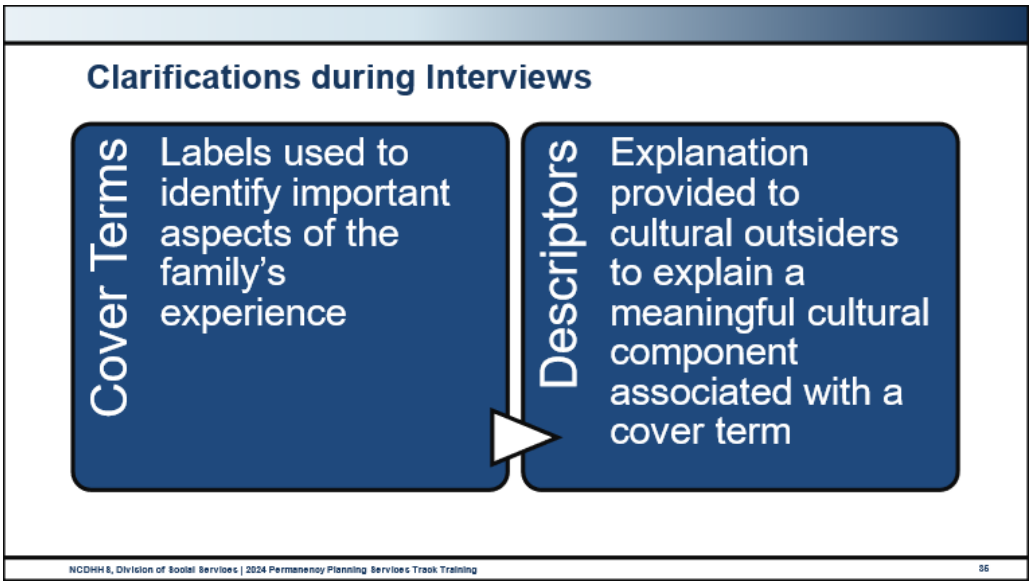
Handout: Solution-Focused Interviewing Skills and Questions

Open Ended Questions	
Questions that encourage the client to use their own words and to elaborate on a topic.	• Can you tell me about your relationship with your parents? • Tell me about your parenting experience. • Who are your supports and how do they help you? • Note: identify and reflect to clients any strengths or positive qualities clients may reveal in their responses to the open-ended questions.
Summarizing	
Periodically state back to the client his/her thoughts, actions, and feelings.	• So, what I hear you saying is… • If I understand you correctly, you are saying that... • So, what you are saying is... • Right?
Tolerating/Using Silence	
Allow 10, 15, 20 seconds or so to allow clients to come up with their own responses. Avoid the temptation to fill in silence with advice.	
Complimenting	
Acknowledging client strengths and past success.	• As you were talking, I noticed that you have many strengths. You have..., • In the past, you have had successes evident by your ability to....
Affirming Client's Perception	
Perception is some aspect of a person's self-awareness or awareness of their life. They include a person's thoughts, feelings, behaviors, and experiences. Affirmation of the client's perceptions is similar to reflective listening in form but does not isolate and focus on the feeling component per se, but on the client's larger awareness.	• That is very smart of you, let's explore this further... • You have a high-level of self-awareness, how would you like to use this information to move forward....
Working with Client's Negative or Inaccurate Perceptions	
Perceptions, even negative ones like suicide or assaultive behaviors should be explored to understand the full context. Some perceptions may be obviously inaccurate and reflect a person's denial of	• What's happening in your life that tells you that hitting or suicide might be helpful in this situation? • How does it feel to say, "I don't want to do this anymore?"

a problem. Avoid an immediate educative or dissuading response to negative or inaccurate perceptions. Listening and understanding are the social worker's first obligations.	• How might your life be different if you did hit him? • What are the pros and cons of your reaction?
Returning the Focus to the Client	
Clients tend to focus on the problem and/or what they would like others to do differently. In the Solution-Focused approach, the client is encouraged to return the focus to themselves and to possible solutions.	• "My kids are lazy. They don't realize that I need help sometimes." Response: "What gives you hope that this problem can be solved?" • "I wish my parents would get with it. A 10:00 pm curfew on weekends is ridiculous." Response: "When things are going better, what will your parents notice you doing differently?" • "My teachers are too hard. If they would back off all the homework and give more help, my grades would improve." Response: "What is it going to take to make things even a little bit better?" • "If my boss would stop criticizing me and treating me like a child, I could be more productive." Response: "If your boss was here and I asked him what you could do differently to make it just a little easier for him not to be so critical, what do you think he would say?"
Exception Questions	
Exception questions help clients think about times when their problems could have occurred but did not – or at least were less severe. Exception questions focus on who, what, when, and where (the conditions that helped the exception to occur) - NOT WHY; should be related to client goals.	• Are there times when the problem does not happen or is less serious? When? How does this happen? • Have there been times in the last couple of weeks when the problem did not happen or was less severe? • How was it that you were able to make this exception happen? • What was different about that day? • If your friend (teacher, relative, spouse, partner, etc.) were here and I were to ask him what he noticed you doing differently on that day, what would he say? What else?
Coping Questions	
Coping questions attempt to help the client shift his/her focus away from the problem elements and toward what the	• What have you found that is helpful in managing this situation?

client is doing to survive the painful or stressful circumstances. They are related in a way to exploring for exceptions.	• Considering how depressed and overwhelmed you feel, how is it that you were able to get out of bed this morning and make it to our appointment (or make it to work)? • You say that you're not sure that you want to continue working on your goals. What is it that has helped you to work on them up to now?
Scaling Questions	
Scaling questions invite clients to put their observations, impressions, and predictions on a scale from 0 to 10, with 0 being no chance, and 10 being every chance. Questions need to be specific, citing specific times and circumstances.	• On a scale of 0 to 10, with 0 being not serious at all and 10 being the most serious, how serious do you think the problem is now? • On a scale of 0 to 10, what number would it take for you to consider the problem to be sufficiently solved? • On a scale of 0 to 10, with 0 being no confidence and 10 being very confident, how confident are you that this problem can be solved? • On a scale of 0 to 10, with 0 being no chance and 10 being every chance, how likely is it that you will be able to say "No" to your boyfriend when he offers you drugs? • What would it take for you to increase, by just one point, your likelihood of saying "No"? • What's the most important thing you have to do to keep things at a 7 or 8?
Indirect Relationship Questions	
Indirect questions invite the client to consider how others might feel or respond to some aspect of the client's life, behavior, or future changes. Indirect questions can be useful in asking the client to reflect on narrow or faulty perceptions without the worker directly challenging those perceptions or behaviors.	• How is it that someone might think that you are neglecting or mistreating your children? • Has anyone ever told you that they think you have a drinking problem? • If your children were here (and could talk, if the children are infants or toddlers), what might they say about how they feel when you and your wife have one of those serious arguments? • At the upcoming court hearing, what changes do you think the judge will expect from you to consider returning your children?

	• How do you think your children (spouse, relative, caseworker, employer) will react when you make the changes we talked about?
Miracle Questions	
The Miracle Question is a special type of preferred future question that can help people get clarity on how the problem impacts their daily life and what life would look like without the problem happening.	• Imagine you woke up tomorrow and a miracle had happened overnight, and all the trouble was gone. How would you know it was over? What would be different that would tell you the problem was no longer happening? What is the first thing you would be doing to start the day? What would the rest of your day look like? What would things look like for your children? • If you could wave a magic wand and things were different, what would that new state of being look like? What would it take to get there without the magic wand?



Knowing what to do during an interview when you encounter Cover Terms is highly important to remaining nonjudgmental and avoiding making assumptions. It also allows us to center the family in the interview process.

Here are a few examples:

- Consider a teen who says, "He was being mental." You could explore with the client a descriptor by saying, "I wonder how a 'mental person' would be described."
- Or maybe a mom tells you she "whupped" her kids. You could follow up with a descriptor question, such as, "What exactly happens when a child is 'whupped'?"
- Or perhaps a dad tells you he is "dosing." You could state, "I am not fully sure I understand dosing. Could you explain it to me?"

We may think we know what "mental" "whupped" or "dosing" means, as we probably have our own definitions of these words. However, culture highly influences these definitions and because we may be from a different cultural group than the children and families we work with, we must ask instead of using our own definition.

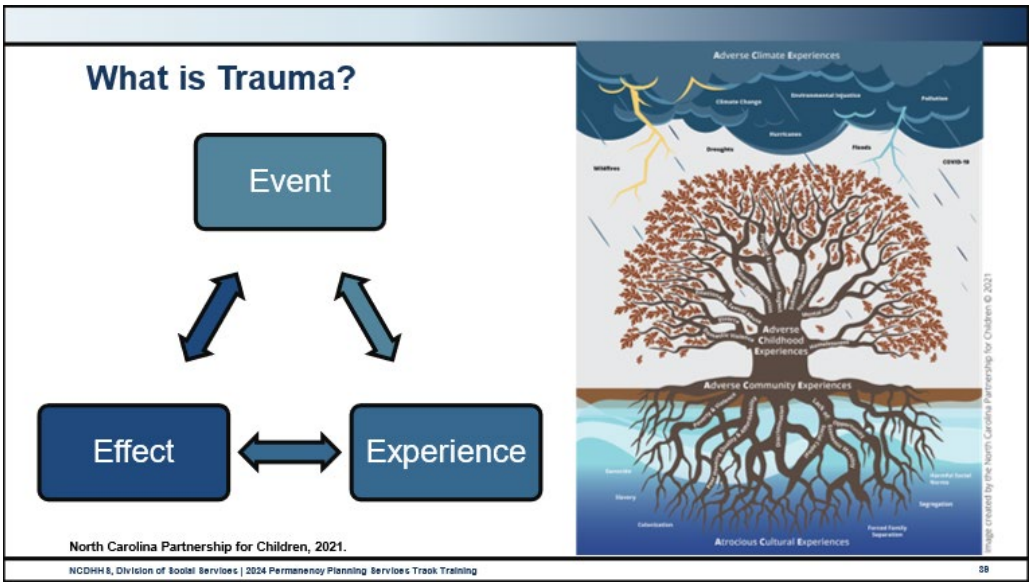
Use this space to record notes.

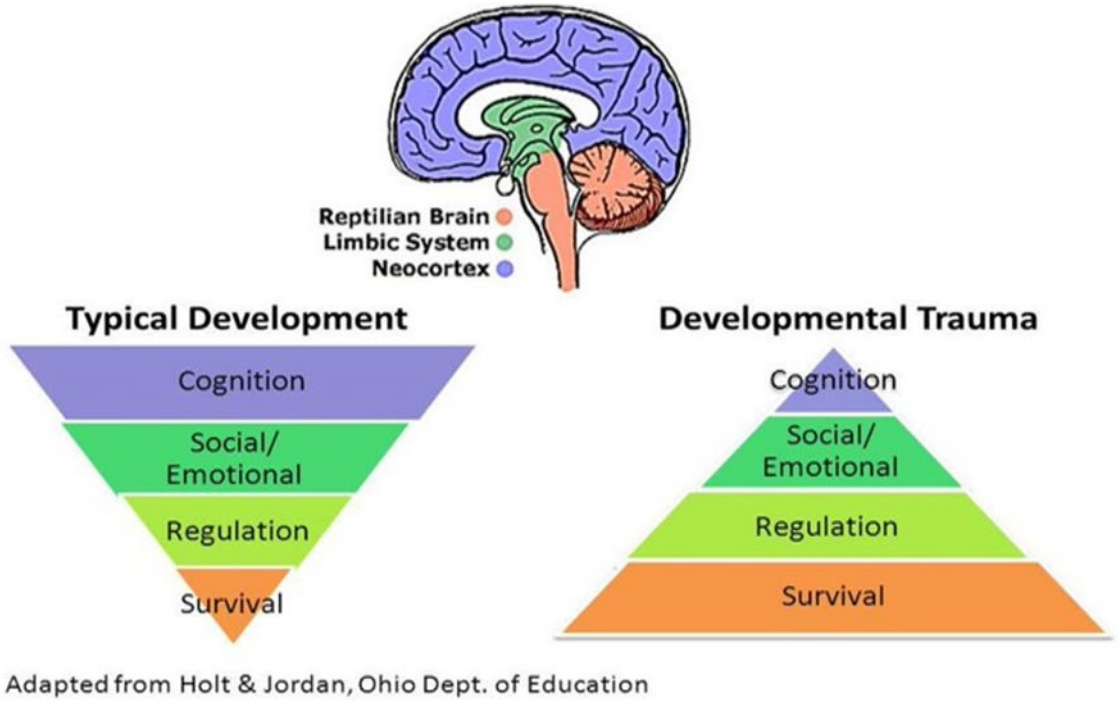
Reflection and Check-In

Refer to the Record of Reflections and Values handout at the end of the Appendix and use the space to record values reflections from what you learned in this section of training. Your values reflections should include concepts learned that resonate with you and include any "aha moments".

Trauma-Informed Care

Trauma-Informed Practice





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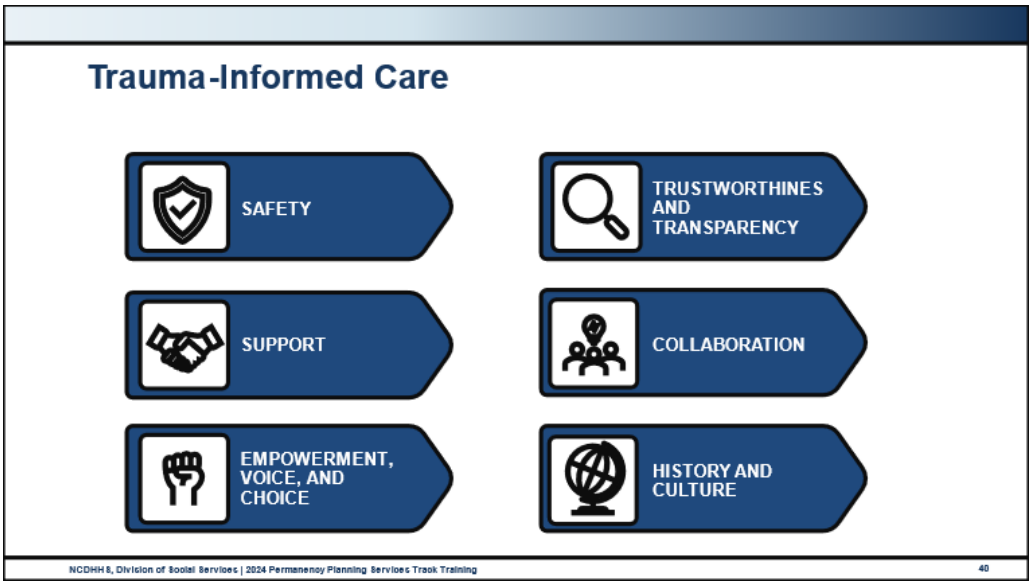

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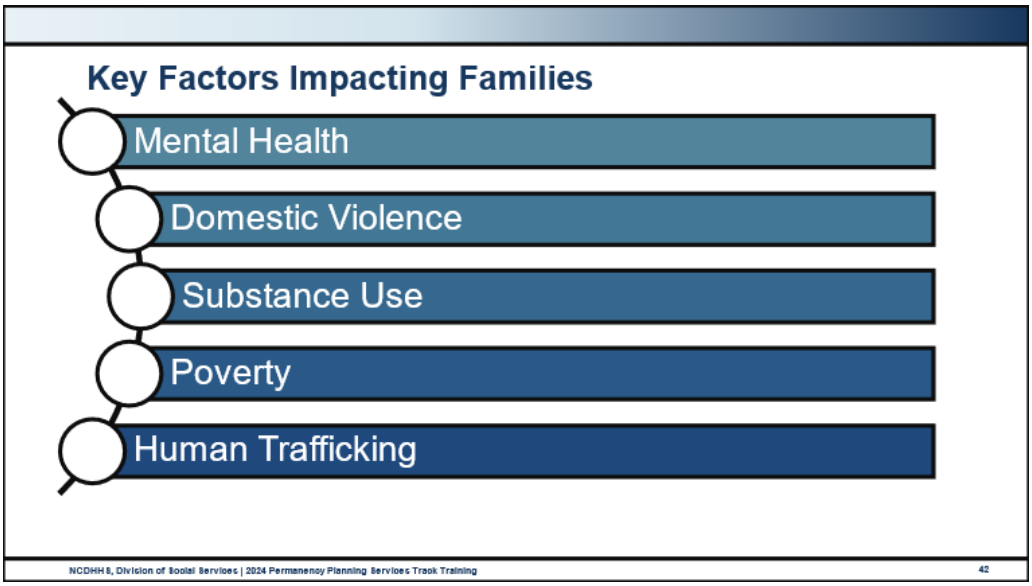
Key Factors Impacting Families



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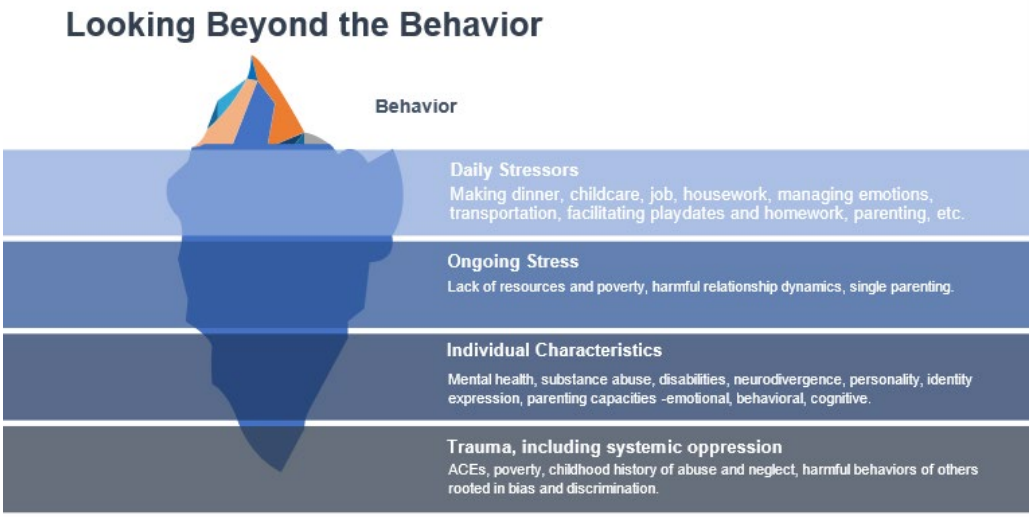

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Activity: Trauma-Informed Language

Using the Words Matter handout on the following page, work with your group to discuss how you can use trauma-informed language with families who are facing mental health challenges, substance use and misuse disorder, human trafficking, and domestic violence. Be specific when discussing communication and language.

Mental Health Challenges

Substance Use or Misuse Disorder

Human Trafficking

Domestic Violence

Handout: Words Matter

NIDAMED

Words Matter
Terms to Use and Avoid When Talking About Addiction

This handout offers background information and tips for providers to keep in mind while using person-first language, as well as terms to avoid to **reduce stigma** and **negative bias when discussing addiction**. Although some language that may be considered stigmatizing is commonly used within social communities of people who struggle with substance use disorder (SUD), clinicians can show leadership in how language can destigmatize the disease of addiction.

Stigma and Addiction

What is stigma?

Stigma is a discrimination against an identifiable group of people, a place, or a nation. Stigma about people with SUD might include inaccurate or unfounded thoughts like they are dangerous, incapable of managing treatment, or at fault for their condition.

Where does stigma come from?

For people with SUD, stigma may stem from antiquated and inaccurate beliefs that addiction is a moral failing, instead of what we know it to be—a chronic, treatable disease from which patients can recover and continue to lead healthy lives.

How does stigma affect people with SUD?

- Feeling stigmatized can reduce the willingness of individuals with SUD to seek treatment.[1,2]
- Stigmatizing views of people with SUD are common; this stereotyping can lead others to feel pity, fear, anger, and a desire for social distance from people with SUD.[2]
- Stigmatizing language can negatively influence health care provider perceptions of people with SUD, which can impact the care they provide.[3]

How can we change stigmatizing behavior?

- When talking to people with SUD, their loved ones, and your colleagues, use non-stigmatizing language that reflects an accurate, science-based understanding of SUD and is consistent with your professional role.
- Because clinicians are typically the first points of contact for a person with SUD, health professionals should "take all steps necessary to reduce the potential for stigma and negative bias."[3] Take the first step by learning the terms to avoid and use.
- Use person-first language and let individuals choose how they are described.[4] Person-first language maintains the integrity of individuals as whole human beings—by removing language that equates people to their condition or has negative connotations.[5] For example, "person with a substance use disorder" has a neutral tone and distinguishes the person from his or her diagnosis.[6]

What else should I keep in mind?

It is recommended that "substance use" be used to describe all substances, including alcohol and other drugs, and that clinicians refer to severity specifiers (e.g., mild, moderate, severe) to indicate the severity of the SUD. This language also supports documentation of accurate clinical assessment and development of effective treatment plans.[7] When talking about treatment plans with people with SUD and their loved ones, be sure to use evidence-based language instead of referring to treatment as an intervention.

Visit **NIDAMED** for resources at **drugabuse.gov/nidamed**

NIH National Institute on Drug Abuse

Terms to Avoid, Terms to Use, and Why

Consider using these recommended terms to reduce stigma and negative bias when talking about addiction.

Instead of...	Use...	Because...
• Addict • User • Substance or drug abuser • Junkie	• Person with substance use disorder[8] • Person with opioid use disorder (OUD) or person with opioid addiction [when substance in use is opioids] • Patient	• Person-first language. • The change shows that a person "has" a problem, rather than "is" the problem.[7] • The terms avoid eliciting negative associations, punitive attitudes, and individual blame.[7]
• Alcoholic • Drunk	• Person with alcohol use disorder • Person who misuses alcohol/engages in unhealthy/hazardous alcohol use	
• Former addict • Reformed addict	• Person in recovery or long-term recovery • Person who previously used drugs	
• Habit	• Substance use disorder • Drug addiction	• Inaccurately implies that a person is choosing to use substances or can choose to stop.[6] • "Habit" may undermine the seriousness of the disease.
• Abuse	**For illicit drugs:** • Use **For prescription medications:** • Misuse • Used other than prescribed	• The term "abuse" was found to have a high association with negative judgments and punishment.[9] • Legitimate use of prescription medications is limited to their use as prescribed by the person to whom they are prescribed. Consumption outside these parameters is misuse.
• Opioid substitution replacement therapy • Medication-assisted Treatment (MAT)	• Opioid agonist therapy • Medication treatment for OUD • Pharmacotherapy • Medication for a substance use disorder • Medication for opioid use disorder (MOUD)	• It is a misconception that medications merely "substitute" one drug or "one addiction" for another.[6] • The term MAT implies that medication should have a supplemental or temporary role in treatment. Using "MOUD" aligns with the way other psychiatric medications are understood (e.g., antidepressants, antipsychotics), as critical tools that are central to a patient's treatment plan.
• Clean	**For toxicology screen results:** • Testing negative **For non-toxicology purposes:** • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not currently or actively using drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.[10] • Set an example with your own language when treating patients who might use stigmatizing slang. • Use of such terms may evoke negative and punitive implicit cognitions.[7]
• Dirty	**For toxicology screen results:** • Testing positive **For non-toxicology purposes:** • Person who uses drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.[10] • May decrease patients' sense of hope and self-efficacy for change.[7]
• Addicted baby	• Baby born to mother who used drugs while pregnant • Baby with signs of withdrawal from prenatal drug exposure • Baby with neonatal opioid withdrawal/ neonatal abstinence syndrome • Newborn exposed to substances	• Babies cannot be born with addiction because addiction is a behavioral disorder—they are simply born manifesting a withdrawal syndrome. • Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.[10] • Using person-first language can reduce stigma.

References

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5937046
2 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5854406
3 https://www.tandfonline.com/doi/abs/10.1080/10826084.2019.1581221?journalCode=isum20 (link is external)
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8 https://psycnet.apa.org/record/2018-44736-001 (link is external)
9 https://www.sciencedirect.com/science/article/abs/pii/S0955395909001546?via%3Dihub (link is external)
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June 21, 2021

Activity: Key Factors Impacting Families

Work with your group to create a poster showing the impact your assigned key factor has on children and families.

What stands out to you with this activity?

How do you feel about your skill level in assessing?

What resources will you need to continue to build this skill?

What did your group discuss regarding using trauma-informed language with families facing each key factor?

Reflection and Check-In

Refer to the Record of Reflections and Values handout at the end of the Appendix and use the space to record values reflections from what you learned in this section of training. Your values reflections should include concepts learned that resonate with you and include any "aha moments".

Assessing Learning Lab

Activity: Case Review

Review case-specific documentation provided by the trainers for the Lewis/Jackson-Bailey family.

Use the Three-Column Mapping worksheet on the following page to document:

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

Document your work on a flip chart for large group discussion.

Use this space to record individual notes as you work with your group.

Worksheet: Case Review Sheet: Three-Column Mapping

For this activity, we will familiarize ourselves with three-column mapping.

The three-column mapping tool is a Safety Organized Practice that supports the organization of your assessment and interviewing activities and findings in a clear, balanced way. Three-column mapping can be utilized for yourself, as we are practicing here, and can be utilized with families, in CFT meetings, or in supervision to promote collaboration and transparency.

The three columns correspond with the three essential questions:

- **What are you worried about?** captures safety concerns and risk factors.
- **What is working well?** highlights strengths, protective capacities, and protective factors.
- **What needs to happen next?** lists actions that the family, the social worker, or other safety network or CFT members must take to resolve the concerns.

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

Assessing: Case Review Activity

Continuing Needs and Safety Requirements (DSS-5010a) - Lewis Family

This document communicates the county child welfare agency's concerns, identifies services or actions the agency believes will assist in addressing those concerns, and states requirements to maintain your child(ren)'s safety. The activities to ensure your children's safety must remain in effect until a Family Services Agreement is developed. The county child welfare agency will work with you and your family to develop a Family Services Agreement to specify how the agency will work with you, your family, your family supports, and service providers to reduce the safety and/or risk and, when applicable, to improve the well-being of your children.

The following strengths, needs, and concerns regarding your child(ren)'s present safety or that put them at risk of future harm were identified during the CPS Assessment.

1. Strengths:

George and William provide a safe living space for Raymond and Van.

George and William are supportive of the children's interests: George is the assistant coach of Van's basketball team and William attends every game; they read graphic novels with Raymond and William plays video games with him; they spend time together as a family at the skate park and watching Raymond's favorite anime.

Monica had good parenting skills when she parented full-time. She supported Raymond in remembering tasks by giving reminders and setting up to-do lists and sticker charts. She gave consequences like losing video game time.

2. Needs and Concerns:

George hurts Raymond when he whups him. The last time, George broke Raymond's rib and bruised his spine when whupping him.

Raymond has ADHD and has trouble remembering to finish chores or put his things away. He has a hard time focusing on school and it's even worse at home. Raymond needs more support in being organized, and completing his chores and the expected tasks. George does not want to baby Raymond and says he doesn't know any other way to change his behavior than to whup him.

Raymond and Van are both scared of George and that he will hurt Raymond again. Van worries to the point that they cannot focus on school and when with friends.

Monica is one year into her two-year prison sentence for writing bad checks and shoplifting. Being in jail caused the children to go live with their father full time and made it so Monica could not intervene when things were hard at George's house. Monica is not able to be here for her children the way they need her right now.

The following activities and/or services have been recommended for your family and will be discussed during the development of your Family Services Agreement.

George will learn different parenting skills to be able to support Raymond in meeting the family's expectations. Raymond will have the support he needs to be successful at doing the things that are expected of him at home, in school, and anywhere else he goes. This may mean different medication, therapeutic services, and caregivers who are knowledgeable and have the parenting skills he needs. Monica will have a plan for her release from prison that will support her in providing for her family with a safe and stable place to live and the resources to pay bills and for other things the family wants and needs without having to break the law.
The following activities (agreed to in your Temporary Parental Safety Agreement) to ensure the safety of your children must continue until the development of the Family Services Agreement.
N/A-the children are in foster care

Lewis Family Case Summary

Mother: Monica Lewis, she/her, 42, Black, incarcerated

Father: George Jackson-Bailey, he/him, 45, Black, shift manager at McDonald's

Stepfather: William Bailey-Jackson, he/him, 46, White, cashier/stocker at a grocery store

Children: Van (legal Vanessa) Jackson, they/them, 14, Black, 8th Grade at Johnson Middle School

Raymond Jackson, he/him, 10, Black, 4th Grade at Johnson Elementary School

CPS History

Six months ago: CPS Family Assessment for neglect, unsafe discipline. Child Protective Services not needed as the safety of the children was not an issue and there was no concern for the future risk of harm to the children. Report alleged marks and bruises left on Raymond's buttocks because of spanking by his father, George. Slight bruising was observed on the upper buttocks and lower back. George expressed remorse. Interviews and collaterals indicated it was an isolated incident.

CPS Report

The report was made by Ms. McIntyre, the school counselor at Johnson Elementary School.

Report alleges that Raymond came to school today complaining of pain. Raymond told his teacher that he got into trouble the night before for "talking back" to his dad. The teacher sent Raymond to the school counselor, who observed redness, light purple bruising, and swelling on Raymond's buttocks, visible just above the waistband of his shorts, which sit lower on his hips, and bruising that could be fingerprints on Raymond's left arm. When the school counselor asked Raymond about what happened, Raymond said, "I don't want to get Dad into trouble." He wouldn't speak about the matter any further.

The report was screened in as neglect, unsafe discipline. Family Assessment, 24-hour response.

Summary of Initiation

The Social Worker contacted George via phone to explain that the report had been received. A Home Visit is scheduled for 4 p.m. the same day to initiate the report with all household members.

Summary of Household Member Interviews

- The children have been living with their biological father, George, and George's husband, William, since their mother, Monica, went to prison a little over a year ago. Before this change, George and William had been consistently involved in the children's lives, caring for them several days a week and attending school events. George and William have been in a relationship for five years and married for three.
- The family described that George handled disciplining the children and that he usually would remove privileges for Raymond or ground Van, meaning they cannot leave the house to hang out with friends if they misbehave. William will give directions and reminders of expectations, and when that is not sufficient, he will say, "I'm gonna have to talk to your dad about this," when he notices behaviors that are not acceptable. Van doesn't get into much trouble. Raymond says, "I am always in trouble." For "bigger stuff," Raymond gets spankings from George. When asked about "bigger stuff," the family described the following:
    - Yesterday, Raymond told his dad he had finished his homework and logged onto the Xbox. When George went to make dinner, he found the homework lying on the floor, unfinished and covered in juice. The juice container had been left on the counter without a lid and had been knocked over, spilling juice all over the floor. George said that he "snapped" and went to "confront" Raymond. George asked Raymond why he lied, and Raymond said he didn't lie, he must have forgotten.
    - George indicated that he cannot tolerate this level of disrespect. He "lost it," meaning he grabbed Raymond and began to "whup" him. Raymond was trying to get away, but George held his arm tightly while hitting his butt with his open hand. At one point, Raymond's pants fell down, and George continued to hit his unclothed buttocks.
    - When asked about behaviors that result in discipline, George described Raymond as being "constantly disrespectful" and "full of attitude." He went on to say that Raymond will "look right at you and hear what you say, then do the opposite." George made comments that Raymond is a "troublemaker" and that "his mama let him get away with all sorts of things that don't stand at this house."
- William and Van were not home when the incident occurred.
- Raymond is diagnosed with ADHD.
- He takes Adderall every day unless they forget in the rush of the morning to get to school. This happens about once a week.
- Raymond says that he just gets distracted a lot and cannot remember to finish things.
- George, William, and Van gave the following examples of Raymond's forgetfulness: Raymond leaves his shoes in the hallway and the milk on the counter after making a bowl of cereal; he drops his backpack on the floor and leaves the door open when he comes in from school; and he is always losing something, like a stuffed animal, his homework, etc.

- George indicated that Raymond doesn't have this level of issue at school so it's obvious that he just doesn't care and does not respect the household at home.
- George says he is "at a loss" for what to do with Raymond and that he "better shape up" because things cannot continue like this.
    - William indicated that he tries to give Raymond reminders to clean up although this often isn't enough because Raymond just gets distracted again before completing his task. Wiliam said that Raymond is a good kid but that he doesn't follow through, which George takes personally. William said he hasn't spent much time around kids, so he really isn't sure what is fair.
    - Van indicated that they try to stay with friends or at school events as often as possible. When asked specifically if there was a reason that they didn't want to be at home, Van looked at their dad, then looked away and shrugged.

Interview with Van and Raymond

- George granted permission for the children to be interviewed privately.
- When asked if they were scared at home:
    - Raymond said he is always scared that his dad is going to "whup" him. Raymond described getting spankings almost daily and then a "whupping," like yesterday, once or twice a week. Raymond says it doesn't always hurt as badly as the one yesterday and he doesn't always get marks. He cannot remember how often that happens. Raymond says he tries his best to remember to do things and sometimes he can but other times he cannot. He said worrying about getting in trouble makes him more forgetful. Raymond says he misses his mom because these things never happened when he lived with her. Raymond says that William tries to help him remember things, but he can't always remember.
    - Van says that it seems to be getting worse. They are not sure what is going on with their dad, and they think that maybe he just "can't handle kids full time." Van says that they don't like the constant yelling and nagging, so they stay out of the house whenever they can. Van said that when they heard about yesterday, they got really scared that one day, their dad is going to "really hurt" Raymond.

Home Visit Walkthrough

- Raymond and Van share a bedroom in the two-bedroom apartment.
- No concerns were noted within the home.

Collateral Contact with Ms. Rosa, the neighbor who occasionally watches Raymond

Ms. Rosa indicated that Raymond is a sweet child who sometimes stays with her if his dad must run an errand. She has gotten him off the bus six or seven times since Raymond moved in with his dad about a year ago.

Ms. Rosa said that she knows that Raymond worries about being a good kid, as he has told her that he keeps “messing up” with his dad regarding chores and cleaning up after himself. Although she does hear George yelling sometimes, Ms. Rosa wasn’t aware of any spanking or problems.

Ms. Rosa agreed that if there was ever trouble between George and Raymond, George could send Raymond to her apartment. She is always home after school and on the weekends because she is a “real homebody.”

Information and Coaching

Social Worker provided information about ADHD and common behaviors in elementary-aged children. George and William identified a link between Raymond’s behaviors and the behaviors indicated in the handout.

Another handout, titled “Alternatives to Spanking” was provided. George, William, and the Social Worker reviewed together. George and William selected several options to try.

Safety Planning

An NC Safety Assessment was completed at the initial home visit.

- Child Vulnerabilities: Child has a diagnosed or suspected medical or mental condition
- Current Indicators of Safety:
    - #1: Caregiver caused and/or allowed serious physical harm to the child or made a plausible threat to cause serious physical harm in the current assessment.
    - # 15: Child is fearful of caretakers, other family members, or people living in or having access to the home.
- Safety Decision: Safe with a plan
- Safety Agreement:
    - George and William agree to use discipline techniques that are not physical, such as removing privileges or having Raymond finish cleaning a mess with directions and support. This means George will not spank or whup Raymond.
    - George agrees that if he is having a hard time talking to Raymond without using spanking or whupping, or if Raymond is feeling scared, Raymond can go to Ms. Rosa’s house for a time out or George can step outside to cool down or leave the house if William or Van are home to supervise Raymond.

New Report on Open Case (NROC)

On Saturday, the day after the initial report was initiated, DSS received a new report.

The report was made by Law Enforcement.

Report alleges that 911 was called by Rosa Ward. Around 8:30 pm, Rosa heard glass break upstairs in the family's apartment and the father yelling and heavy footsteps. Raymond and Van arrived at her apartment at 9:00 pm, scared and upset. Raymond's back was swollen and red with bruises starting to form along his spine; Raymond was having trouble walking and complained of his back hurting.

Law Enforcement arrived on the scene. From information gathered by the officers, George whupped Raymond for breaking some glass dishes. Raymond has swelling and bruising along his back. George is being arrested for misdemeanor child abuse. DSS is requested to assess the situation for the children.

Report was screened in as abuse, Investigative Assessment, immediate response.

Summary of NROC Initiation

On-call responded immediately.

The On-call Social Worker briefly met with George before Law Enforcement escorted him to jail. Interviews were completed with Van, Raymond, and Ms. Rosa. William had a family emergency and was out of state.

Information Gathered in Interviews

- George lectured Raymond for more than an hour after the Social Worker left yesterday. He blamed Raymond for causing trouble with DSS.
- Raymond had been trying to "be good" all day and was cleaning the kitchen. He stacked up all the dirty dishes from dinner on the counter and went to play Xbox. George had come in and when he opened the dishwasher, the unsteady pile fell, breaking all the glass dishes. George went into Raymond's room, grabbed his arm, and "whupped" him on the back, butt, and upper legs. Van told their dad to stop and that they would take Raymond to Ms. Rosa. This got George's attention, but he wouldn't let Raymond go. Raymond pulled away. Raymond and Van ran to Ms. Rosa's house.
- Ms. Rosa had no idea of the extent of what was going on, but she was very concerned for the children. When she saw Raymond's back, she knew she had to call for help.
- Raymond's back was observed to be swollen, with faint purplish coloring along his left side, on his buttock, and on his upper right leg, just under the buttock.
- George was arrested for misdemeanor child abuse. Due to this occurring on a Saturday, his first court appearance would not occur until the following Monday.

- Ms. Rosa said that George's yelling and mean behavior scared her. She was glad she could intervene today but isn't in a place to stay involved. She had to think about her own health.

Medical Assessment

Due to the location and amount of swelling and pain, Raymond was evaluated at the ER. It was found that Raymond had one fractured rib on the left side and inflammation running from his mid spine to his upper leg. Per the ER physician, the injuries, although primarily superficial, occurred surrounding vital organs. Had the injuries been more severe, internal injury to vital organs would have been likely.

Reasonable Efforts

- Safety planning with the family.
- Information regarding child behaviors and coaching around non-physical discipline techniques.
- Efforts to secure temporary safety provider placement.
- William was unable to return to the house immediately, as he was managing a critical medical situation with his mother out of state.
- Ms. Rosa declined placement due to fear of retaliation with George.
- Michelle Boyd, maternal aunt, was unable to provide placement due to an acute hospitalization as a result of flu requiring IV fluids.
- Samantha Warren, Van's best friend's mother, was unable to be reached for placement.

Custody

Since George was arrested and would not be released before Monday at his first appearance in court and no Temporary Safety Provider could be located, the Department filed a petition alleging abuse, neglect, and dependency and a non-secure custody order, bringing Van and Raymond into foster care.

Placement Information

Laverne Hampton (she/her), a 70-year-old white woman who is currently retired, although she works part-time at a bookstore. Laverne is a retired schoolteacher and has been fostering for the last 10 years. She usually provides placement for younger children, although she felt compelled to accept placement outside of her comfort zone to keep the children together. She can transport the children to and from school, but Laverne doesn't drive after dusk or before dawn due to limited night vision. Laverne is very active in her church, Temple Baptist, and volunteers at the local food bank.

Contact with Monica

Efforts were made to reach the prison case manager on the day of the report and throughout the weekend, but Monica could not be reached by the social worker until Monday after the children entered care. On the same day as custody, she was served with a juvenile petition, summons, and non-secure order.

During this contact, the following information was provided by Monica:

- Raymond has struggled with following through with tasks and remembering things to do his entire life. When the children lived with Monica, she often would give lots of prompts and reminders, boarding on nagging, to support Raymond. As he got older, she developed sticker charts and checklists to support him in getting through necessary tasks.
- Monica only saw the children once during her sentence, as the prison was far from George's home, and resources were not available. Monica said she didn't want the children to see her in jail, so she didn't push to make it happen.
- Monica is worried about how she will manage Raymond's behavior after not seeing them for a while and the anger she thinks the children feel toward her since she left them with George. She said she would need support to do this when they start visiting again.
- Monica and Van have always been close, and Monica worries about her incarceration's toll on Van. Van came out as non-binary three years ago, and Monica feels this is brave. She is very supportive of Van's expression of themselves. Monica believes that Van needs more gender-affirming health care.
- Monica knew that full-time parenting would be difficult for George and William, as she knows that George has high expectations of her children, showing respect and managing their chores and responsibilities. George and William were great for the weekend or an occasional week, but full-time is different. Monica isn't surprised that Goerge was spanking Raymond, although she is shocked at the level of abuse that has occurred.
- Monica has about 10 months remaining on her two-year sentence,
- Monica was in foster care as a child and has experienced significant trauma in her early life. She and her sister, Michelle, are close. She is not connected to any other family and, since her incarceration, has lost friendships. Monica would like the children to live with Michelle whenever that is possible.

NORTH CAROLINA
SDM® FAMILY RISK ASSESSMENT OF CHILD ABUSE/NEGLECT

Case Name: Lewis, Monica **Case #:** **Date:**
County Name: **Social Worker Name:** **Date Report Received**
Children: Raymond Jackson and Van Jackson
Primary Caretaker: George Jackson-Bailey **Secondary Caretaker:** William Jackson-Bailey

(Regardless of the type of allegations reported, ALL items on the risk assessment are to be completed.)

RISK OF FUTURE NEGLECT	SCORE
N1. Current report is for neglect or both neglect and abuse a. No....0 b. Yes....1	1
N2. Number of prior CPS assessments *(take highest score)* a. None....0 b. One or more family assessments....1 c. One or more investigative assessments....2	1
N3. Prior CPS in-home/out-of-home service history a. No....0 b. Yes....1	0
N4. Number of children residing in the home at time of current report a. Two or fewer....0 b. Three or more....1	0
N5. Age of primary caretaker *(note: score is either 0 or -1)* a. 30 or older....-1 b. 29 or younger....0	-1
N6. Age of youngest child in the home a. 3 or older....0 b. 2 or younger....1	0
N7. Number of adults residing in home at time of report a. Two or more....0 b. One or none....1	0
N8. Caretaker(s) history of abuse/neglect a. No....0 b. Yes....1	0
N9. Either caretaker has/had a drug or alcohol problem a. No....0 b. One or more apply....1 Primary: ☐ Within last 12 months ☐ Prior to last 12 months Secondary: ☐ Within last 12 months ☐ Prior to last 12 months	0
N10. Either caretaker has/had a mental health problem a. No....0 b. One or more apply....2 Primary: ☐ Within last 12 months ☐ Prior to last 12 months Secondary: ☐ Within last 12 months ☐ Prior to last 12 months	0

RISK OF FUTURE ABUSE	SCORE
A1. Current report is for abuse or both neglect and abuse a. No....0 b. Yes....1	1
A2. Number of prior CPS investigative assessments a. None....0 b. One or more....2	0
A3. Prior CPS in-home/out-of-home service history a. No....0 b. One or more apply....1 ☐ Prior case open for in-home, CPS services ☐ Prior case open for foster care services	0
A4. Age of youngest child in the home a. 4 or under....0 b. 5 or older....1	0
A5. Number of children residing in home at time of current report a. Two or fewer....0 b. Three or more....1	0
A6. Caretaker(s) history of abuse/neglect a. No....0 b. Yes....1	0
A7. Child characteristics a. Not applicable....0 b. One or more apply....1 ☐ Developmental disability ☑ Mental Health and/or behavioral problems ☐ History of delinquency	1
A8. Either caretaker is a domineering parent a. No....0 b. Yes....1	1

CONTINUE TO PAGE 2

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N11. Either caretaker has barriers to accessing community resources — 0
- a. No....0
- b. One or more apply....1
  - ☐ Difficulty finding/obtaining resources
  - ☐ Refusal to utilize available resources

N12. Either caretaker lacks parenting skills — 1
- a. No....0
- b. One or more apply....1
  - ☐ Inadequate supervision of children
  - ☑ Uses excessive physical/verbal discipline
  - ☑ Lacks knowledge of child development

N13. Either caretaker involved in harmful relationships — 0
- a. No....0
- b. Yes....1

N14. Child characteristics — 1
- a. Not applicable....0
- b. One or more apply....1
  - ☑ Mental Health and/or behavioral problems
  - ☐ Medically fragile/failure to thrive diagnosis
  - ☐ Developmental disability
  - ☐ Learning disability
  - ☐ Physical disability

N15. Housing/basic needs unmet — 0
- a. Not applicable....0
- b. One or more apply....1
  - ☐ Family lacks clothing and/or food
  - ☐ Family lacks housing or housing is unsafe

TOTAL NEGLECT RISK SCORE 3

A9. Either caretaker is/was a victim/perpetrator of domestic violence — 0
- a. No....0
- b. Yes....1
  - Primary:
    - ☐ Victim within last 12 months
    - ☐ Victim prior to last 12 months
    - ☐ Perpetrator within last 12 months
    - ☐ Perpetrator prior to last 12 months
  - Secondary:
    - ☐ Victim within last 12 months
    - ☐ Victim prior to last 12 months
    - ☐ Perpetrator within last 12 months
    - ☐ Perpetrator prior to last 12 months

A10. Caretaker(s) response to current assessment — 1
- a. Not applicable....0
- b. One or more apply....1
  - ☐ Caretaker unmotivated to improve parenting skills
  - ☑ Caretaker viewed situation less seriously than worker
  - ☑ Caretaker failed to cooperate satisfactorily

A11. Either caretaker has interpersonal communication problems — 0
- a. No....0
- b. One or more apply....1
  - ☐ Lack of communication impairs functioning
  - ☐ Poor communication impairs functioning

TOTAL ABUSE RISK SCORE 4

SCORED RISK LEVEL

Assign the family's risk level based on the highest score on either scale, using the following chart:

Neglect Score	Abuse Score	Risk Level
☐ -1–2	☐ 0–2	☐ Low
☑ 3–5	☑ 3–5	☑ Moderate
☐ 6–16	☐ 6–12	☐ High

OVERRIDES

Policy: Override to high; mark appropriate reason.

- ☐ 1. Sexual abuse cases where the perpetrator is likely to have access to the child victim.
- ☐ 2. Cases with non-accidental physical injury to an infant.
- ☐ 3. Serious non-accidental physical injury warranting hospital or medical treatment.
- ☐ 4. Death (previous or current) of a sibling as a result of abuse or neglect.

Discretionary: Override (increase or decrease **one level** with supervisor approval). Provide reason below.

Reason: _____

OVERRIDE RISK LEVEL: ☐ Low ☐ Moderate ☐ High

Social Worker: _____ **Date:** _____

Supervisor's Review/Approval of Override: _____ **Date:** _____

DSS-5230 Revised 11-09 Child Welfare Services

NORTH CAROLINA
SDM® FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT
DEFINITIONS

Only one household should be assessed on a risk assessment form. If the allegations involve maltreatment in two households and both have responsibilities for child care, complete **two** separate risk assessments. In situations where the parents are not living together, a family risk assessment of abuse/neglect will **only** be completed on the home of the alleged perpetrator.

The primary caretaker is the adult (typically, the parent) living in the household who assumes the most responsibility for child care. When two adult caretakers are present and the worker is in doubt about which one assumes the most child care responsibility, the adult legally responsible for the child involved in the incident should be selected. If this rule does not resolve the question, the legally responsible adult who is an alleged perpetrator should be selected. **Only *one* primary caretaker can be identified (per form/household).**

The secondary caretaker is defined as an adult living in the household who has routine responsibility for child care, but less responsibility than the primary caretaker. A live-in partner can be a secondary caretaker even though he/she has minimal responsibility for the care of the child.

NEGLECT SCALE

N1. Current report is for neglect or both neglect and abuse

a. Score 0 if the current report is not for neglect.

b. Score 1 if the current report is for neglect or both abuse and neglect. This includes any allegations under assessment even if not identified in the original report.

N2. Number of prior CPS assessments
Use Central Registry to count all maltreatment reports for all children in the home which were assigned for CPS assessment (both family assessments and investigative assessments) for any type of abuse or neglect prior to the report resulting in the current assessment. Include prior assessments that resulted in temporary or permanent placement of a child, even if that child is no longer in the home. If information is available, include prior maltreatment assessments conducted in other states.

a. Score 0 if there were no CPS assessments prior to the current report.

b. Score 1 if there were one or more family assessments prior to the current report.

c. Score 2 if there were one or more investigative assessments prior to the current report (if there were both one or more prior family assessments and one or more prior investigative assessments, score 2).

N3. Prior CPS in-home or out-of-home service history
Contact other counties and states where there is believed to be prior CPS service history on this family.

a. Score 0 if this family has not received CPS in-home or out-of-home services as a result of a prior finding of "substantiated" or "services needed" report of abuse and/or neglect.

b. Score 1 if this family has received CPS in-home or out-of-home services as a result of a prior finding of "substantiated" or "services needed" report of abuse or neglect, or is receiving CPS in-home or out-of-home services at the time of the current assessment.

N4. Number of children residing in the home at time current report
Number of individuals under 18 years of age *residing* in the home at the time of the current report. If multiple families reside in the home, count all children. Children within a residential placement but in the custody of the caretaker(s) should be counted as residing in the home. If a child is on runaway status, is removed, whether placed in foster care or with a safety resource as a result of current CPS involvement, count the child as residing in the home (I.E. if there was never closure of

current CPS Services whether In-Home or Out-of-Home being provided and a new report is made, count the child as in the home).

a. Score 0 if two or fewer children were residing in the home at the time of the current report.

b. Score 1 if three or more children were residing in the home at the time of the current report.

N5. Age of primary caretaker

Age at the time of current assessment.

a. Score -1 if the primary caretaker is 30 or older at the time of the current report.

b. Score 0 if the primary caretaker is 29 or younger at the time of the current report.

N6. Age of youngest child in the home

Choose the appropriate score given the current age of the youngest child in the household where the maltreatment incident reportedly occurred. Youngest children within a residential placement but in the custody of the caretaker(s) should be counted as residing in the home. If a child is on runaway status, is removed, whether placed in foster care or with a safety resource as a result of current CPS involvement, count the child as residing in the home (I.E. if there was never closure of current CPS Services whether In-Home or Out-of-Home being provided and a new report is made, count the child as in the home).

a. Score 0 if the youngest child is 3 years old or older at the time of the current report.

b. Score 1 the youngest child is 2 years old or younger at the time of the current report.

N7. Number of adults residing in home at time of report

Count number of individuals 18 years of age or older *residing* in the home at time of the current report.

a. Score 0 if two or more adults were residing in the home at the time of the current report.

b. Score 1 if one or no adults were residing in the home at the time of the current report.

N8. Either caretaker has history of abuse/neglect

a. Score 0 if neither caretaker was abused and or neglected as a child, based on credible statements by the caretaker(s) or others.

b. Score 1 if credible statements were provided by the caretaker(s) or others regarding whether *either or both* caretakers were abused and or neglected as children.

N9. Either caretaker has/had a drug or alcohol problem

Either caretaker has/had alcohol/drug abuse problems, evidenced by use causing conflict in home, extreme behavior/attitudes, financial difficulties, frequent illness, job absenteeism, job changes or unemployment, driving under the influence (DUI), traffic violations, criminal arrests, disappearance of household items (especially those easily sold), or life organized around substance use.

a. Score 0 if neither caretaker has or has ever had a drug or alcohol problem, or has some substance use problems that minimally impact family functioning.

b. Score 1 if either caretaker has a past or current alcohol/drug abuse problem that interferes with his/her or the family's functioning. Such interference is evidenced by the following:

- Substance use that affects or affected employment; criminal involvement; marital or family relationships; and/or caretaker's ability to provide protection, supervision, and care for the child;
- An arrest in the past two years for DUI or refusing breathalyzer testing;

- Self-report of a problem;
- Treatment received currently or in the past;
- Multiple positive urine samples;
- Health/medical problems resulting from substance use and/or abuse;
- The child's diagnosis with fetal alcohol syndrome or exposure (FAS or FAE), or the child's positive toxicology screen at birth and the primary caretaker was the birthing parent.

Legal, non-abusive prescription drug use should not be scored. Abuse of legal, prescription drugs should be scored.

Indicate whether the drug and/or alcohol problem was/is present DURING the last 12 months and/or was present PRIOR to the last 12 months by the primary or secondary caretaker.

N10. Either caretaker has/had a mental health problem

a. Score 0 if the caretaker(s) does not have a current or past mental health problem and caretaker demonstrates good coping skills.

b. Score 2 if credible and/or verifiable statements by either caretaker or other indicate that either caretaker:

- Has been diagnosed as having a significant mental health disorder as indicated by a DSM Axis I condition determined by a mental health professional;
- Has had repeated referrals for mental health/psychological evaluations; or
- Was recommended for treatment/hospitalization or was treated/ hospitalized for emotional problems.

Indicate whether the mental health problem was/is present DURING the last 12 months and/or was present PRIOR to the last 12 months by the primary or secondary caretaker.

N11. Either caretaker has barriers to accessing community resources

a. Score 0 if the caretaker(s) has no need for community resources; caretaker(s) seeks out resources that are not immediately available; or caretaker(s) accesses and utilizes community resources.

b. Score 1 if the caretaker(s) experiences resource utilization problems as evidenced by the following:

- Caretaker(s) do not know about resources available in the community or caretaker(s) cannot or do not attempt to identify available resources;
- Caretaker(s) are unable to access available resources; or
- Caretaker(s) refuse to utilize/accept available community resources.

N12. Either caretaker lacks parenting skills

a. Score 0 if caretaker(s) displays parenting patterns which are age-appropriate for children in the home, including providing adequate supervision, realistic expectations and appropriate discipline.

b. Score 1 if caretaker(s) lacks parenting skills as evidenced by the following:

- Inadequate supervision of children;
- Use of excessive physical/verbal discipline; or

- Lacks knowledge of child development: Caretaker's lack of knowledge regarding child development and/or age-appropriate expectations for children.

N13. Either caretaker involved in harmful relationships

a. Score 0 if neither caretaker is involved in harmful relationships.

b. Score 1 if either caretaker is involved in any harmful adult relationships, including any of the following:

- Adult relationships outside the home which are harmful to domestic functioning or child care, such as criminal activities;

- Current relationship or domestic discord inside the home, including frequent arguments, degradation, or blaming. Open disagreement on how to handle child problems/discipline. Frequent and/or multiple transient household members. Violent acts that cause minor or no injury to any household member and are not assessed as "domestic violence;" or

- Domestic violence, defined as the establishment of control and fear in an intimate relationship through the use of violence and other forms of abuse including but not limited to physical, emotional, or sexual abuse; economic oppression; isolation; threats; intimidation; and maltreatment of the children to control the non-offending parent/adult victim. Domestic violence may be evidenced by repeated history of leaving and returning to abusive partner(s), repeated history of violating court orders by the perpetrator of domestic violence, repeated history of violating safety plans, involvement of law enforcement and/or restraining orders, or serious or repeated injuries to any household member.

N14. Child characteristics

a. Score 0 if no child in the household exhibits characteristics described below.

b. Score 1 if any child in the household exhibits any of the characteristics described below. Mark all that apply.

- Mental health and/or behavioral problem: Any child in the household has mental health or behavioral problems not related to a physical or developmental disability. This could be indicated by a DSM Axis I diagnosis, receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking prescribed psychoactive medications.

- Any child is medically fragile or diagnosed with failure to thrive.

  » Medically fragile: Medically fragile describes a child who has any condition diagnosed by a physician that can become unstable and change abruptly, resulting in a life-threatening situation; and which requires daily, ongoing medical treatments and monitoring by appropriately trained personnel, which may include parents or other family members, and requires the routine use of a medical device or of assistive technology to compensate for the loss of usefulness of a body function needed to participate in the activities of daily living, and child lives with ongoing threat to his or her continued well-being. Examples include a child who requires a trach-vent for breathing or a g-tube for eating.

  » Failure to thrive: A diagnosis by a physician that the child has failure to thrive.

- Developmental disability: A severe, chronic condition due to mental and/or physical impairments which has been diagnosed by a physician or mental health professional. Examples include mental retardation, autism spectrum disorders, and cerebral palsy.

- Learning disability: Child has an individualized education program (IEP) to address a learning disability such as dyslexia. Do not include an IEP designed solely to address mental health or behavioral problems. Also include a child with a learning disability diagnosed by a physician or mental health professional who is eligible for an IEP but does not yet have one, or who is in preschool.

- Physical disability: A severe acute or chronic condition diagnosed by a physician that impairs mobility, sensory, or motor functions. Examples include paralysis, amputation, and blindness.

N15. Housing/basic needs unmet

a. Score 0 if the family has adequate housing, clothing, and food; or if the family has minor housing, clothing, and food problems that can be corrected using resources available to the family, and the family is willing to correct these problems.

b. Score 1 if the family has serious housing, clothing, and food problems that are not easily correctable or which the family is not willing to correct. This may include condemned or inhabitable housing, chronic homelessness, and lack of clothing and/or food.

ABUSE SCALE

A1. Current report is for abuse or both neglect and abuse

a. Score 0 if the current report is not for abuse.

b. Score 1 of the current report is for abuse or both abuse and neglect. This includes any allegations under assessment even if not identified in the original report.

A2. Number of Prior CPS investigative assessments

Use Central Registry to count all CPS investigative assessments for all children in the home for any type of abuse or neglect prior to the report resulting in the current assessment. If information is available, include prior maltreatment investigations conducted in other states.

a. Score 0 if there were no CPS investigative assessments prior to the current report.

b. Score 2 if there were one or more CPS investigative assessments prior to the current report.

A3. Prior CPS in-home or out-of-home service history

Contact other counties and states where there is believed to be prior CPS history on this family.

a. Score 0 if this family has not received CPS **in-home or out-of-home** services as a result of a prior finding of "substantiated" or "services needed" report of abuse and/or neglect.

b. Score 1 if this family has received CPS **in-home or out-of-home** services as a result of a prior finding of "substantiated" or "services needed" report of abuse or neglect, or is receiving CPS **in-home or out-of-home** services at the time of the current assessment.

A4. Age of youngest child in the home

Choose the appropriate score given the current age of the youngest child in the household where the maltreatment incident reportedly occurred. Youngest children within a residential placement but in the custody of the caretaker(s) should be counted as residing in the home. If a child is on runaway status, is removed, whether placed in foster care or with a safety resource as a result of current CPS involvement, count the child as residing in the home (I.E. if there was never closure of current CPS Services whether In-Home or Out-of-Home being provided and a new report is made, count the child as in the home).

a. Score 0 if the youngest child in the home was 4 years of age or younger at the time of the current report.

b. Score 1 if the youngest child in the home was 5 years of age or older at the time of the current report.

A5. Number of children residing in home at time of current report

Number of individuals under 18 years of age *residing* in the home at the time of the current report. If multiple families reside in the home, count all children. Children within a residential placement but in the custody of the caretaker(s) should be counted as residing in the home. If a child is on runaway status, is removed, whether placed in foster care or with a safety resource as a result of current CPS involvement, count the child as residing in the home (I.E. if there was never closure of current CPS Services whether In-Home or Out-of-Home being provided and a new report is made, count the child as in the home).

a. Score 0 if two or fewer children were residing in the home at the time of the current report.

b. Score 1 if three or more children were residing in the home at the time of the current report.

A6. Either caretaker has history of abuse/neglect

a. Score 0 if neither caretaker was abused and or neglected as a child, based on credible statements by the caretaker(s) or others.

b. Score 1 if credible statements were provided by the caretaker(s) or others regarding whether *either or both* caretakers were abused and or neglected as children.

A7. Child characteristics

a. Score 0 if no child in the household exhibits characteristics described below.

b. Score 1 if any child in the household exhibits any of the characteristics described below. Mark all that apply.

- Developmental disability: A severe, chronic condition due to mental and/or physical impairments which has been diagnosed by a physician or mental health professional. Examples include mental retardation, autism spectrum disorders, and cerebral palsy.

- Mental health and/or behavioral problem: Any child in the household has mental health or behavioral problems not related to a physical or developmental disability. This could be indicated by a DSM Axis I diagnosis, receiving mental health treatment, attendance in a special classroom because of behavioral problems, or currently taking prescribed psychoactive medications.

- History of delinquency: Any child has been referred to juvenile court for delinquent behavior, being undisciplined, entering into diversion plans, or status offense behavior. Status offenses not brought to court attention but which create stress within the household should also be scored here, such as children who run away from home, are habitually truant from school, or have drug or alcohol problems.

A8. Either caretaker(s) is a domineering parent

a. Score 0 if neither caretaker is a domineering parent.

b. Score 1 if *either* caretaker is domineering over child(ren), evidenced by rude remarks/behavior or controlling, abusive, unreasonable and/or excessive rules; or is overly restrictive, overreacts, is unfair, or is berating.

A9. Either caretaker involved in domestic violence

a. Score 0 if neither caretaker is a victim/perpetrator of domestic violence.

b. Score 1 if either caretaker is in a relationship characterized by domestic violence, defined as the establishment of control and fear in an intimate relationship through the use of violence and other forms of abuse, including but not limited to physical, emotional, or sexual abuse; economic oppression; isolation; threats; intimidation; and maltreatment of the children to control the non-offending parent/adult victim. Domestic violence may be evidenced by repeated history of leaving and returning to abusive partner(s), repeated history of violating court orders by the perpetrator of domestic violence, repeated history of violating safety plans, involvement of law enforcement and/or restraining orders, or serious or repeated injuries to any household member.

Indicate whether the domestic violence occurred DURING the last 12 months and/or was PRIOR to the last 12 months by the primary or secondary caretaker.

A10. Caretaker(s) response to current assessment

a. Score 0 if the caretaker(s) responded appropriately to the current assessment; the caretaker(s) regard the incident as serious and cooperate with the worker and are motivated to improve parenting skills.

b. Score 1 if any of the following apply to the current situation:

- Either caretaker is unmotivated to take steps necessary or recommended to improve parenting skills;
- Either caretaker views the current situation less seriously than worker or minimizes the level of harm to the child; and/or
- Either caretaker fails to cooperate satisfactorily by refusing involvement in the assessment and/or refuses access to the child(ren) during the assessment, etc.

An initial reaction of fear or anger at the process of being reported to CPS should be addressed through a discussion with the caretaker(s) before considering scoring any of the above.

A11. Either caretaker has interpersonal communication problems

a. Score 0 if family communication is functional and personal boundaries and emotional attachments are appropriate. Minor disagreements and/or lack of communication may occur, but only occasionally interfere with family interactions.

b. Score 1 if either caretaker's communication problems impair the ability to maintain positive relationships, make friends, keep a job, or meet the needs of family members.

NORTH CAROLINA DEPARTMENT OF SOCIAL SERVICES
SDM® FAMILY RISK ASSESSMENT OF ABUSE/NEGLECT
POLICY AND PROCEDURES

The Family Risk Assessment determines the level of risk of future harm in the family and determines the level of service to be provided to each family. It identifies families which have high, moderate, or low probabilities of future risk of abuse or neglect of their children. By completing the risk assessment, the worker obtains an objective appraisal of the likelihood that a family will maltreat their children in the next 18 months. The difference between the risk levels is substantial. High-risk families have significantly higher rates than low risk families of subsequent reports and substantiations and are more often involved in serious abuse or neglect incidents.

The risk scales are based on research on cases with "substantiated" or "services needed" abuse or neglect that examined the relationships between family characteristics and the outcomes of subsequent abuse and neglect. The scales do not predict recurrence simply that a family is more or less likely to have another incident without intervention by the agency. One important result of the research is that a single instrument should not be used to assess the risk of both abuse and neglect. Different family dynamics are present in abuse and neglect situations. Hence, separate scales are used to assess the future probability of abuse or neglect.

Complete both the abuse and neglect scales regardless of the type of allegation(s) reported or assessed. All items on the risk assessment scales are completed. ***The assigned social worker must make every effort throughout the assessment to obtain the information needed to answer each assessment question.*** **However, if information cannot be obtained to answer a specific item, score the item as "0."**

Which cases: All CPS maltreatment reports assigned for an assessment that involve a family caretaker. This does not apply to reports involving child care facilities; residential facilities such as group homes or DHHS facilities. This does apply to non-licensed living arrangements, the non-custodial parents home or licensed family foster homes.

Who completes: Social worker assigned to complete the assessment.

When: The risk assessment shall be completed and documented prior to the case decision. It is one of the elements considered in making the case decision.

A risk assessment shall also be completed when a new CPS report occurs in an open CPS In-Home or Out-of-Home Services case.

For children coming into the agency's legal custody through delinquency, the risk assessment shall serve as the baseline assessment documentation.

Decision: The risk assessment identifies the level of risk of future maltreatment and guides the case decision including whether to close a report or open a case for CPS In-Home or Out-of-Home Services.

Appropriate Completion: Only **one** household can be assessed on the risk assessment form. If the allegations involve maltreatment in two households and both have responsibilities for childcare, complete two separate Risk Assessment tools. In situations where the parents are not living together, a Family Risk Assessment of Abuse/Neglect will only be completed on the home of the alleged perpetrator.

In situations where an adult relative is entrusted with the care of the child and is the alleged perpetrator, the risk assessment is conducted in the home where the child resides. In some cases (for example, joint custody cases), it may be difficult to identify the household in which the children reside. The household which provides the majority of the child care should be selected. If that fails, choose the household where the CA/N incident took place.

Some items are very objective (such as prior CPS In/Out-of-Home Service history or the age of the caretaker). ***Others*** require the worker to use discretionary judgment based on his or her assessment of the family.

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Following scoring all items in each scale, the assigned social worker totals the score for each scale and determines the risk level by checking the appropriate boxes in the risk level section. The highest score from either scale determines the risk level.

Overrides

Policy Overrides

Policy overrides reflect incident seriousness and child vulnerability concerns, and have been determined by the agency to be case situations that warrant the highest level of service from the agency regardless of the risk scale score. If any policy override reasons exist, the risk level is increased to high.

After completing the risk scales, the assigned social worker indicates if any policy override reasons exist. If more than one reason exists, indicate the primary override reason. Only one reason can be selected. All overrides must be approved in writing by the supervisor.

Discretionary Overrides

The assigned social worker also indicates if there are any discretionary override reasons. A discretionary override is used to increase or decrease the risk level by one increment in any case where the assigned social worker feels the risk level set by the scales is too low or too high. All overrides must be approved in writing by the supervisor.

Discretionary overrides should be used only in exceptional cases.

NORTH CAROLINA
STRENGTHS & NEEDS ASSESSMENT

County _____ **Case Number:** _____

Case Name: Lewis, Monica Date Assessment Completed: _____ Date Report Received: _____
Social Worker Name: _____ Indicate either Initial or Reassessment and #: 1 2 3 4 5: _____
Children: Raymond Jackson and Van Jackson
Caregiver(s): George Jackson-Bailey and William Jackson-Bailey

Some items apply to all household members while other items apply to caregivers only. Assess items for the specified household members, selecting one score only under each category. Household members may score differently on each item. When assessing an item for more than one household member, record the score for the household member with the greatest need (highest score).

Caregivers are defined as adults living in the household who have routine responsibility for child care. For those items assessing caregivers only, record the score for the caregiver with the greatest need (highest score) when a household has more than one caregiver.

S-CODE TITLE	TRAITS	SCORE
S1. Emotional/Mental Health	a. Demonstrates good coping skills.....-3 b. No known diagnosed mental health problems.....0 c. Minor or moderate diagnosed mental health problems.....3 d. Chronic or severe diagnosed mental health problems.....5	0
S2. Parenting Skills	a. Good parenting skills.....-3 b. Minor difficulties in parenting skills.....0 c. Moderate difficulties in parenting skills.....3 d. Destructive parenting patterns.....5	5
S3. Substance Use	a. No/some substance use.....0 b. Moderate substance use problems.....3 c. Serious substance use problems.....5	0
S4. Housing/Environment/ Basic Physical Needs	a. Adequate basic needs.....-3 b. Some problems, but correctable.....0 c. Serious problems, not corrected.....3 d. Chronic basic needs deficiency.....5	-3
S5. Family Relationships	a. Supportive relationships.....-2 b. Occasional problematic relationship (s).....0 c. Domestic discord.....2 d. Serious domestic discord/domestic violence.....4	0
S6. Child Characteristics	a. Age-appropriate, no problem.....-1 b. Minor problems.....0 c. One child has severe/chronic problems.....1 d. Child(ren) have severe/chronic problem(s).....3	1
S7. Social Support Systems	a. Strong support network.....-1 b. Adequate support network.....0 c. Limited support network.....1 d. No support or destructive relationships.....3	1

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NORTH CAROLINA
STRENGTHS & NEEDS ASSESSMENT

S8. Caregiver(s) Abuse/ Neglect History	a. No evidence of problem ..... 0 b. Caregiver(s) abused/neglected as a child ..... 1 c. Caregiver(s) in foster care as a child ..... 2 d. Caregiver(s) perpetrator of abuse/neglect in the last five years..... 3	0
S9. Communication/ Interpersonal Skills	a. Strong skills ..... -1 b. Appropriate skills ..... 0 c. Limited or ineffective skills ..... 1 d. Hostile/destructive 2	0
S10. Caregiver(s) Life Skills	a. Good life skills..... -1 b. Adequate life skills ..... 0 c. Poor life skills ..... 1 d. Severely deficient life skills 2	0
S11. Physical Health	a. No adverse health problem ..... 0 b. Health problem or disability ..... 1 c. Serious health problem or disability 2	0
S12. Employment/Income Management	a. Employed ..... -1 b. No need for employment ..... 0 c. Underemployed ..... 1 d. Unemployed 2	-1
S13. Community Resource Utilization	a. Seeks out and utilizes resources ..... -1 b. Utilizes resources ..... 0 c. Resource utilization problems ..... 1 d. Refusal to utilize resources 2	0

Based on this assessment, identify the primary strengths and needs of the family. Write S code, score, and title.

STRENGTHS

	S Code	Score	Title
1.	S4	-3	Housing/Environment/Basic Physical Needs
2.	S12	-1	Employment/Income Management
3.	S8	0	Caregiver Abuse/Neglect History

NEEDS

	S Code	Score	Title
1.	S2	5	Parenting Skills
2.	S6	1	Child Characteristics
3.	S7	1	Social Supports

Children/Family Well-Being Needs:

1. Educational Needs: Raymond says he has a hard time paying attention at school and that it's hard to get work done on time
2. Physical Health Needs: Van says that they would like to explore a new doctor who is gender affirming
3. Mental Health Needs: _____

Social Worker: _____ Date: _____

Supervisor's Review/Approval: _____ Date: _____

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NORTH CAROLINA
FAMILY ASSESSMENT OF STRENGTHS AND NEEDS
INSTRUCTIONS

DEFINITIONS

Some items apply to all household members while other items apply to caregivers only. Persons who are in the home during many of the hours of supervision (e.g., mother's boyfriend who is in the home most evenings but has a different address and and so would not meet the definition as a caretaker) are to be considered household members. **Assess items for the specified household members, selecting one score only under each category. Household members may score differently on each item. When assessing an item for more than one household member, record the score for the household member with the greatest need (highest score).** In cases where two households are involved, a separate Family Strengths and Needs Assessment shall be completed on both households.

S1. Emotional/Mental Health

a. Demonstrates good coping skills.
Caregiver(s) takes initiative to deal with problems in a constructive manner.

b. No known diagnosed mental health problems.
Caregiver(s) has no known diagnosed emotional or mental health problems. May require a mental health evaluation.

c. Minor or moderate diagnosed mental health problems.
Caregiver(s) has moderate diagnosed emotional or mental health disorders (such as depression, anxiety, and anger/impulse control) that interfere with ability to problem solve, deal with stress, and effectively care for self and/or child(ren).

d. Chronic or severe diagnosed mental health problems.
Caregiver(s) has severe and/or chronic diagnosed emotional or mental health disorders making caregiver(s) incapable of problem solving, dealing with stress, or effectively caring for self and/or child(ren).

S2. Parenting Skills

a. Good parenting skills.
Caregiver(s) displays parenting patterns which are age appropriate for child(ren) in the areas of expectations, discipline, communication, protection, and nurturing.

b. Minor difficulties in parenting skills.
Caregiver(s) has basic knowledge and skills to parent but may possess some unrealistic expectations and/or may occasionally utilize inappropriate discipline.

c. Moderate difficulties in parenting skills.
Caregiver(s) acts in an abusive and/or neglectful manner, such as causing minor injuries (no medical attention required), leaving child(ren) with inadequate supervision, and/or exhibiting verbal/emotional abusive behavior.

d. Destructive parenting patterns.
Caregiver(s) has a history and/or currently acts in a manner that results in high risk of serious injury or death of a child, or results in chronic or serious injury (medical attention required), abandonment or death of a child. Caregiver(s) exhibits chronic and severe verbal/emotional abuse.

S3. Substance Use

a. No/some substance use.
Household members display no substance use problems or some substance use problems that minimally impact family functioning.

b. Moderate substance use problems.
Household members have moderate substance use problems resulting in such things as disruptive behavior and/or family dysfunction which result in a need for treatment.

c. Serious substance use problems.
Household members have chronic substance use problems resulting in a chaotic and dysfunctional household/lifestyle, loss of job, and/or criminal behavior.

NORTH CAROLINA
FAMILY ASSESSMENT OF STRENGTHS AND NEEDS
INSTRUCTIONS

S4. Housing/Environment/Basic Physical Needs

a. Adequate basic needs.
Family has adequate housing, clothing, and food.

b. Some Problems, but correctable.
Family has correctable housing, clothing and food problems that affect health and safety needs and family is willing to correct.

c. Serious problems, not corrected.
Numerous and/or serious housing, clothing and food problems that have not been corrected or are not easily correctable and family is not willing to correct.

d. Chronic basic needs deficiency.
House has been condemned or is uninhabitable, or family is chronically homeless and without clothing and/or food.

S5. Family Relationships

a. Supportive relationship.
A supportive relationship exists between household members.

b. Occasional problematic relationship(s). Relationship(s) is occasionally strained but not disruptive.

c. Domestic discord.
Current relationship or domestic discord, including, frequent arguments, degradation, or blaming. Open disagreement on how to handle child problems/discipline. Frequent and/or multiple transient household members. Violent acts that cause minor or no injury to any household member and are not assessed as "domestic violence".

d. Serious domestic discord/domestic violence.
A pattern of relationship discord or domestic violence. Physical, emotional, or sexual abuse, economic oppression, isolation, threats, intimidation, and maltreatment of the children to control the non-offending parent/adult victim. Repeated history of leaving and returning to abusive partner(s). Repeated history of violating court orders by the perpetrator of domestic violence. Repeated history of violating safety plans. Involvement of law enforcement and/or restraining orders. Serious or repeated injuries to any household member.

S6. Child Characteristics

For children under the age of three, any identification of need on this item requires that a referral to Early Intervention be made using the DSS-5238. For assistance in determining whether or not a developmental need is present you may access the North Carolina Infant Toddler Program eligibility conditions of: "Established Conditions" or "Developmental Delay" (definitions can be found at: http://www.ncei.org). Additional information on developmental milestones can be found at: http://www.pedstest.com/). This site shows a developmental screening that may be used by families or any staff working with the child. At any time that a Social Worker or a parent expresses some concern about how a child is developing, contact your local CDSA for consultation or to make a referral. If a DSS agency needs technical assistance on eligibility for the early intervention program or how to make a referral, please contact the early intervention program state office or your local CDSA (http://www.ncei.org).

a. Age-appropriate, no problems.
Child(ren) appears to be age appropriate, no problems.

b. Minor problems.
Child(ren) has minor physical, emotional, medical, educational, or intellectual difficulties addressed with minimal or routine intervention.

c. One child has severe/chronic problems.
One child has severe physical, emotional, medical, educational, or intellectual problems resulting in substantial dysfunction in school, home, or community which strain family finances and/or relations.

d. Children have severe/chronic problem.
More than one child has severe physical, emotional, medical, or intellectual problems resulting in substantial dysfunction in school, home, or community which strain family finances relationships.

NORTH CAROLINA
FAMILY ASSESSMENT OF STRENGTHS AND NEEDS
INSTRUCTIONS

S7. Social Support Systems

a. Strong support network.
Household members have a strong, constructive support network. Active extended family (may be blood relations, kin, or close friends) provide material resources, child care, supervision, role modeling for parent and child(ren), and/or parenting and emotional support.

b. Adequate support network.
Household members use extended family, friends, and the community to provide adequate support for guidance, access to child care, available transportation, etc.

c. Limited support network.
Household members have a limited or negative support network, are isolated, and/or reluctant to use available support.

d. No support or destructive relationships.
Household members have no support network and/or have destructive relationships with extended family and the community.

S8. Caregiver(s) Abuse/Neglect History

a. No evidence of problem.
No caregiver(s) experienced physical or sexual abuse or neglect as a child.

b. Caregiver(s) abused or neglected as a child.
Caregiver(s) experienced physical or sexual abuse, or neglect as a child.

c. Caregiver(s) in foster care as a child.
Caregiver(s) abused and/or neglected as a child and was in foster care or other out-of-home placement due to abuse/neglect.

d. Caregiver(s) perpetrator of abuse and/or neglect.
Caregiver(s) is a substantiated perpetrator of physical and/or sexual abuse, or neglect.

S9. Communication/Interpersonal Skills

a. Strong skills. Communication facilitates family functions, personal boundaries are appropriate, emotional attachments are appropriate.

b. Appropriate skills.
Household members are usually able to communicate individual needs and needs of others and to maintain both social and familial relationships; minor disagreements or lack of communication occasionally interfere with family interactions.

c. Limited or ineffective skills.
Household members have limited or ineffective interpersonal skills which impair the ability to maintain positive familial relationships, make friends, keep a job, communicate individual needs or needs of family members to schools or agencies.

d. Hostile/destructive.
Household members isolate self/others from outside influences or contact, and/or act in a hostile/destructive manner, and/or do not communicate with each other. Negative communication severely interferes with family interactions.

S10. Caregiver(s) Life Skills

a. Good life skills.
Caregiver(s) manages the following well: budgeting, cleanliness, food preparation and age appropriate nutrition, housing stability, recognition of medical needs, recognition of educational needs, and problem solving.

b. Adequate life skills.
Minor problems in some life skills do not significantly interfere with family functioning; caregiver(s) seeks appropriate assistance as needed.

c. Poor life skills.
Caregiver(s) has poor life skills which create problems and interfere with family functioning; caregiver(s) does not appropriately utilize available assistance.

d. Severely deficient life skills.

NORTH CAROLINA
FAMILY ASSESSMENT OF STRENGTHS AND NEEDS
INSTRUCTIONS

Deficiencies in life skills severely limit or prohibit ability to function independently and to care for child(ren); caregiver(s) is unable to or refuses to utilize available assistance.

S11. Caregiver's Physical Health

a. No adverse health problem.
Caregiver(s) does not have health problems that interfere with the ability to care for self or child(ren).

b. Health problem or disability.
Caregiver(s) has a disability, disease or chronic illness that interferes with daily living and/or ability to care for self or child(ren).

c. Serious health problem or disability.
Caregiver(s) has a disability, disease or chronic illness that severely limits or prohibits ability to provide; for self or child(ren).

S12. Employment/Income Management

a. Employed.
Caregiver(s) is employed with sufficient income to meet household needs, regardless of source of income.

b. No need for employment.
Caregiver(s) may be out of labor force but has sufficient income to meet household needs, regardless of source of income.

c. Underemployed.
Caregiver(s) is employed with insufficient income to meet household needs.

d. Unemployed.
Caregiver(s) needs employment and lacks income required to meet household needs.

S13. Community Resource Utilization

a. Seeks out and utilizes resources.
Household members take initiative to access community resources that are available, or seek out those not immediately available in the community, or have no need for community resources.

b. Utilizes resources.
Household members access resources and services available in the community.

c. Resource utilization problems.
Household members do not know about and/or do not access community resources.

d. Refusal to utilize resources.
Household members refuse to accept available community services when offered.

Children/Family Well-Being

In cases that are substantiated and opened for more than thirty days from the date of substantiation, there shall be documentation in the case record that includes the following items as they are applicable:

Child/Family Education Needs:

a. Special education classes, when applicable;
b. Normal grade placement, if child is school age;
c. Services to meet the identified educational needs, unless no unusual educational needs are identified;
d. Early intervention services, unless these services are not needed;
e. Advocacy efforts with the school, unless the child is not school age or there have been no identified needs that are unmet by the school; and
f. How the educational needs of the child/family have been included in the case planning, unless the child is not school age or has no identified education needs.

NORTH CAROLINA
FAMILY ASSESSMENT OF STRENGTHS AND NEEDS
INSTRUCTIONS

Child/Family Physical Health Needs:

a. Whether the child/family has received preventive health care and if not, the efforts the agency will take to ensure that this care is obtained;
b. Whether the child/family has received preventive dental care and if not, the efforts the agency will take to ensure that this care is obtained;
c. Whether the child/family has up-to-date immunizations and if not, what efforts the agency will take to obtain them;
d. Whether the child/family is receiving treatment for identified health needs and if not, what efforts the agency will take to obtain the treatment;
e. Whether the child/family is receiving treatment for identified dental needs and if not, what efforts the agency will take to obtain the treatment.

Child/Family Mental Health Needs

Whether the child/family is receiving appropriate treatment for any identified mental health needs and if not, what efforts the agency will take to obtain such treatment.
This information must be documented on the Family Strengths and Needs Assessment.

POLICY AND PROCEDURES

The family assessment of strengths and needs (FASN) is a tool designed to evaluate the presenting strengths and needs of the family of a child alleged or confirmed to have been a CA/N victim. The FASN assists the worker in determining areas of family strengths and needs that should be addressed with a family open for In-Home or Permanency Planning Services.

Which cases: All CPS maltreatment reports assigned for an assessment that involve a family caregiver. This does not apply to reports involving child care facilities, residential facilities such as group homes or DHHS facilities. This does apply to non-licensed living arrangements, the non-custodial parents home or licensed family foster homes.

Who completes: Social Worker assigned to complete the FASN during a CPS Assessment, In-Home and/or Permanency Planning.

When: The FASN must be completed and documented prior to the time the case decision for a CPS Assessment is made. It is one of the elements considered in making the case decision. The Structured Documentation Instrument (DSS-5010) requires the documentation of the **s**ocial activities, **e**conomic situation, **e**nvironmental issues, **m**ental health needs, **a**ctivities of daily living, **p**hysical health needs, and **s**ummary of strengths (SEEMAPS). SEEMAPS along with other findings of the assessment provide a basis for the FASN.

In CPS In-Home Services, the FASN must be completed at the time of the In-Home Family Services Agreement updates and within 30 days prior to case closure. A FASN should be completed with an involved noncustodial parent. Their identified needs should also be addressed within the In-Home Family Services Agreement whether on the same one or on a separate agreement.

In Permanency Planning (whether the agency holds legal custody and the child remains in the home or is placed outside of the home), the FASN must track with the required scheduled Permanency Planning Review meetings. The assessment must also be completed within 30 days of recommending custody be returned to the parent(s)/caretaker(s), and case closure. A parent that has been described as absent or noncustodial should be engaged to become involved with the planning of their child. Complete a FASN with that parent within the same time frames.

NORTH CAROLINA
FAMILY ASSESSMENT OF STRENGTHS AND NEEDS
INSTRUCTIONS

The FASN must be completed when the agency has legal custody and the child has been placed back in the home for a trial home visit and a Permanency Planning Review meeting falls within that trial home visit period.

Decision: The FASN identifies the strengths and highest priority needs of caregivers and children that must be addressed in the service agreement. Goals, objectives, and interventions in a service agreement should relate to one or more of the priority needs. If the child(ren) has more than one chronic/severe problem, all should be listed under children's well-being needs.

Appropriate Completion

Complete all items on the FASN scale for the caregiver(s). As used here, "caregiver" means the person or persons who routinely are responsible for providing care, supervision, and discipline to the children in the household. This may include biological, adoptive or step-parents, other legal guardian, or other adults living in the home who have caregiver responsibilities. If the allegations involve maltreatment in two households and both have responsibilities for childcare, complete two separate FASN tools.

In situations where an adult relative is entrusted with the care of the child and is the alleged perpetrator, the FASN tool is conducted in the home where the child resides.

The identified needs should be addressed within the Family Services Agreement.

Scoring Individual Items:

Select one score only under each item which reflects the highest level of need for any caregiver in the family, and enter in the "Score" column. For example, if the mother has some substance abuse problems and the father has a serious substance abuse problem, item S3 would be scored "5" for serious substance use problems."

The worker will list in order of greatest to least, the strengths and needs identified. These strengths and needs will be utilized in the case planning process.

Children/Family Well-Being Needs

In completing a FASN, several factors identify data related to the family and child's well-being. List those factors identified as specific family and child needs (health, mental health, educational needs). See DEFINITIONS section for examples.

NORTH CAROLINA
STRENGTHS & NEEDS ASSESSMENT

County _____ **Case Number:** _____

Case Name: Lewis, Monica Date Assessment Completed: _____ Date Report Received: _____
Social Worker Name: _____ Indicate either Initial or Reassessment and #: 1 2 3 4 5: _____
Children: Raymond Jackson and Van Jackson
Caregiver(s): Monica Lewis

Some items apply to all household members while other items apply to caregivers only. Assess items for the specified household members, selecting one score only under each category. Household members may score differently on each item. When assessing an item for more than one household member, record the score for the household member with the greatest need (highest score).

Caregivers are defined as adults living in the household who have routine responsibility for child care. For those items assessing caregivers only, record the score for the caregiver with the greatest need (highest score) when a household has more than one caregiver.

S-CODE TITLE	TRAITS	SCORE
S1. Emotional/Mental Health	a. Demonstrates good coping skills.....-3 b. No known diagnosed mental health problems.....0 c. Minor or moderate diagnosed mental health problems.....3 d. Chronic or severe diagnosed mental health problems.....5	0
S2. Parenting Skills	a. Good parenting skills.....-3 b. Minor difficulties in parenting skills.....0 c. Moderate difficulties in parenting skills.....3 d. Destructive parenting patterns.....5	-3
S3. Substance Use	a. No/some substance use.....0 b. Moderate substance use problems.....3 c. Serious substance use problems.....5	0
S4. Housing/Environment/ Basic Physical Needs	a. Adequate basic needs.....-3 b. Some problems, but correctable.....0 c. Serious problems, not corrected.....3 d. Chronic basic needs deficiency.....5	0
S5. Family Relationships	a. Supportive relationships.....-2 b. Occasional problematic relationship (s).....0 c. Domestic discord.....2 d. Serious domestic discord/domestic violence.....4	-2
S6. Child Characteristics	a. Age-appropriate, no problem.....-1 b. Minor problems.....0 c. One child has severe/chronic problems.....1 d. Child(ren) have severe/chronic problem(s).....3	1
S7. Social Support Systems	a. Strong support network.....-1 b. Adequate support network.....0 c. Limited support network.....1 d. No support or destructive relationships.....3	0

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NORTH CAROLINA
STRENGTHS & NEEDS ASSESSMENT

S8. Caregiver(s) Abuse/ Neglect History	a. No evidence of problem ..... 0 b. Caregiver(s) abused/neglected as a child ..... 1 c. Caregiver(s) in foster care as a child ..... 2 d. Caregiver(s) perpetrator of abuse/neglect in the last five years..... 3	2
S9. Communication/ Interpersonal Skills	a. Strong skills ..... -1 b. Appropriate skills ..... 0 c. Limited or ineffective skills ..... 1 d. Hostile/destructive 2	-1
S10. Caregiver(s) Life Skills	a. Good life skills..... -1 b. Adequate life skills ..... 0 c. Poor life skills ..... 1 d. Severely deficient life skills 2	2
S11. Physical Health	a. No adverse health problem ..... 0 b. Health problem or disability ..... 1 c. Serious health problem or disability 2	0
S12. Employment/Income Management	a. Employed ..... -1 b. No need for employment ..... 0 c. Underemployed ..... 1 d. Unemployed 2	2
S13. Community Resource Utilization	a. Seeks out and utilizes resources ..... -1 b. Utilizes resources ..... 0 c. Resource utilization problems ..... 1 d. Refusal to utilize resources 2	1

Based on this assessment, identify the primary strengths and needs of the family. Write S code, score, and title.

STRENGTHS

	S Code	Score	Title
1.	S2	-3	Parenting Skills
2.	S5	-2	Family Relationships
3.	S9	-1	Communication/Interpersonal Skills

NEEDS

	S Code	Score	Title
1.	S10	2	Caregiver Life Skills
2.	S12	2	Employment/Income Management
3.	S6	1	Child Characteristics

Children/Family Well-Being Needs:

1. Educational Needs: Raymond says he has a hard time paying attention at school and that its hard to get work done on time
2. Physical Health Needs: Van says that they would like to explore a new doctor who is gender affirming
3. Mental Health Needs: _____

Social Worker: _____ Date: _____

Supervisor's Review/Approval: _____ Date: _____

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Activity: Harm and Worry Statements

Work with your group to create harm and worry statements for your assigned identified need from the Family Assessment of Strengths and Needs.

Use the Harm and Worry Statements worksheet on the following page to record your statements.

Transfer your statements to a flip chart for large group discussion.

Worksheet: Harm and Worry Statements

Harm Statement

Harm statements include clear, specific statements about the harm or maltreatment that has happened to the child. Harm statements involve what has already happened and why DSS is involved. Provide behaviorally-specific details.

Harm Statement Practice

It was reported…	Caregiver action or inaction…	Impact on the child…

Worry Statement

Worry statements are simple behavioral statements about the specific worry DSS has about this child, now and for the future. Worry statements indicate what we continue to be worried about if nothing changes in the future. Two questions answered by the worry statement:

- What is the agency most worried about will happen to the child if nothing changes?
- When or in what context are they most worried this could happen?

Worry Statement Practice

Child		Impacted how		Context
	may be		If/when	

Activity: Assessment Considerations

Worksheet: Assessment Considerations for the Lewis/Jackson-Bailey Family

The circumstances for consideration, as they relate to the Lewis/Jackson-Bailey family, are that the children just entered care and you are preparing for your initial visits with the children, parents, and placement provider.

With your group, generate a list of considerations to address in your initial visit for your assigned scenario group. Consider what has been happening in their lives that require specific check-in, individual characteristics that need to be assessed during this time of transition, feelings, and emotions about recent events and entry into foster care, and any cultural considerations that may require your support at this juncture.

Document your work on a flip chart for large group discussion.

The Children – Van and Raymond

The Mother – Monica

The Father and Stepfather – George and William

The Placement Providers – Laverne

Skills Practice: Interviewing

Practice will be with the current Lewis/Jackson-Bailey family, with opportunities to interview the children (Van or Raymond), the mother (Monica), the father (George), and the service provider (Laverne).

The trainers will provide observation sheets. In your groups, you will each be assigned one role.

Interviewer: One person will be the Permanency Planning Services social worker who has just been invited into the home and received permission to speak with the child alone or is interviewing one of the parents. Your goal is to use family-centered strategies as you practice the 7-minute interview with the assigned family member. During this time, you need to meet legal standards, engage the family members, learn about the family culture, gather information about how they are adjusting to the new situation, and explore any new information they might share. You are to demonstrate engagement and interviewing strategies to understand this family's strengths and needs. Remember that you must assess for safety and risk, as well as behavioral changes that provide ongoing safety. You can tag the observer in for assistance but only after 4 minutes.

Interviewee: One person will act as the child, parent, or foster parent being interviewed. Your goal is to respond as you believe your scenario person might and to seek understanding through questions. If the interviewer engages you and asks open-ended questions, share more detailed information with them.

Observer: One person will be an observer, taking notes to give strengths-based feedback. You will observe and provide feedback in the debrief to the interviewer. If the interviewer gets stuck, they can tag you in to finish the interview at the 4-minute mark.

Prepare before practicing by looking at the notes you received and the information we have previously discussed about solution-focused and strengths-based questions. You may also consider the Protective Factors Action Sheets and pick one of the protective factors that is critical to your interview and make sure to utilize at least one protective factors question.

Refer to the Observation and Feedback Quick Tips handout on the following page for guidance.

Handout: Observation and Feedback Quick Tips

Observation Quick Tips:

- Clear your mind and practice area of distractions
- Listen and observe intently and with purpose
- Look for strengths and opportunities for growth

Feedback Quick Tips:

- Ask your partner what they felt most comfortable doing and what was more difficult for them.
- Actively listen to your partner.
- Provide feedback building upon their self-assessment.
- Be clear, concise, and behaviorally specific.
- Be open and honest.
- Start by identifying their strengths.
- Provide feedback on opportunities for improvement.
- Maintain their self-esteem without diminishing attention to the opportunities.
- Provide tips and suggestions.
- Guide them in brainstorming and selecting the next steps.

Note: Apply SMART principles to feedback: Specific, Measurable, Achievable, Realistic, and Timely.

Receiving Feedback Quick Tips:

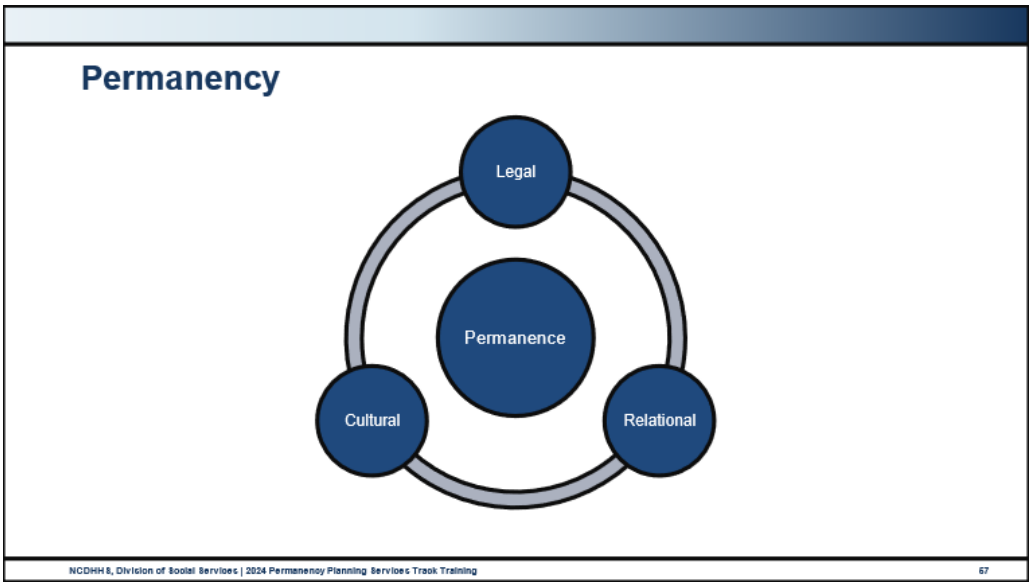
- Be open.
- Understand that growth is a constant process.
- We all learn from each other no matter what our role.
- Accept positive feedback.
- Have grace for yourself.
- The classroom is a safe place to practice and make mistakes.
- Strategize the next steps.
- Be clear about what works for you and what doesn’t in the learning process so the next steps are tailored to your needs.

Reflection and Check-In

Refer to the Record of Reflections and Values handout at the end of the Appendix and use the space to record values reflections from what you learned in this section of training. Your values reflections should include concepts learned that resonate with you and include any "aha moments".

Permanency Plans and Concurrent Planning

Permanency Plans



Use this space to record notes.

Video: Permanency Stories from Former Youth in Care

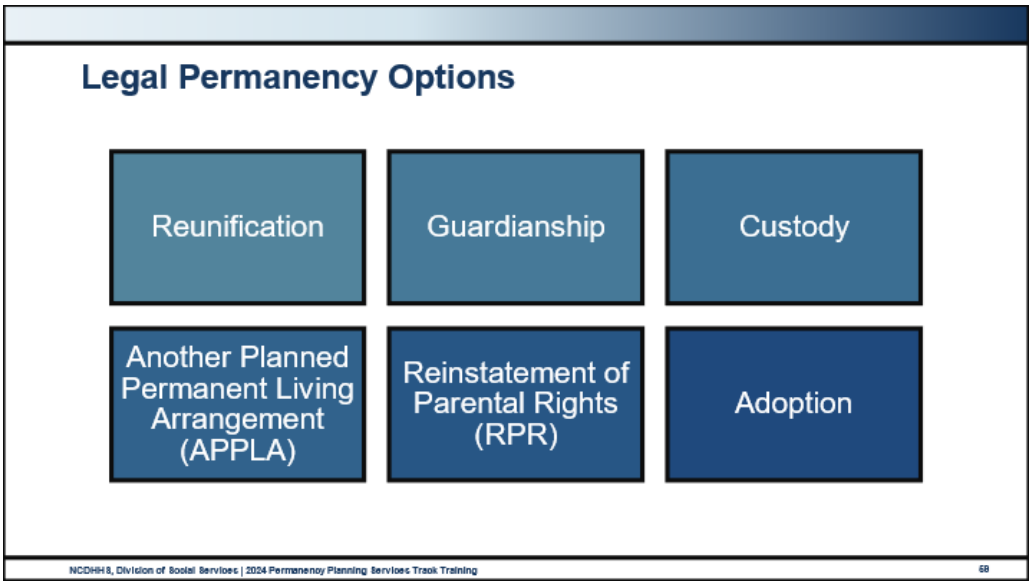
https://www.youtube.com/watch?v=3nO2r0s7_3w

Three layers of permanence:

- **Legal**: a legally established relationship through reunification, custody, adoption, or guardianship or a child's relationship with a parenting adult as recognized by law.
- **Relational**: an emotional attachment between the child and caregivers and other family members and kin or recognizing the many types of important long-term relationships that help a child feel loved and connected.
- **Cultural**: a continuous connection to family, tradition, race, ethnicity, culture, language, and religion.

Take notes about the ways that the three layers of permanence are expressed in this video:

Legal	Relational	Cultural



Use this space to record notes.

Activity: Permanency Card Shuffle

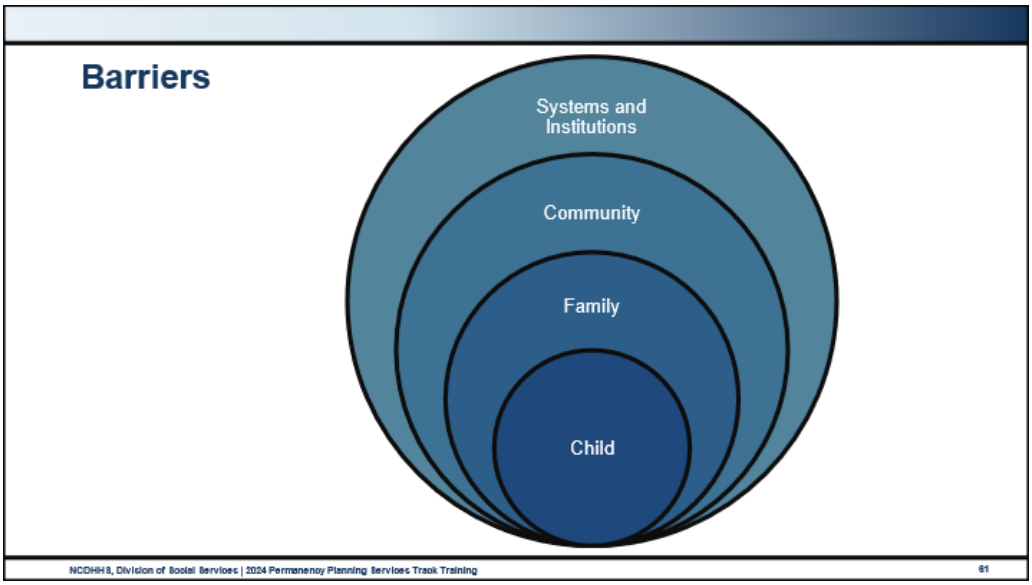
The trainers will facilitate a game using two decks of cards.

One deck represents each permanency outcome:

- Reunification
- Guardianship
- Custody
- APPLA
- TPR
- Adoption

The second deck represents the requirements of the various permanency outcomes.

The goal of the game is to match the requirements to the respective permanency outcome.



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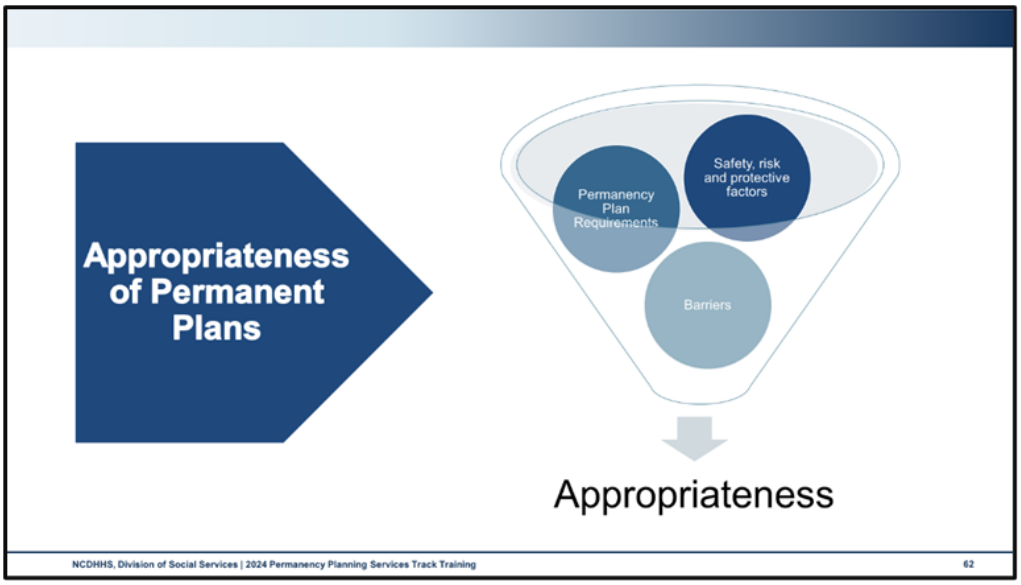

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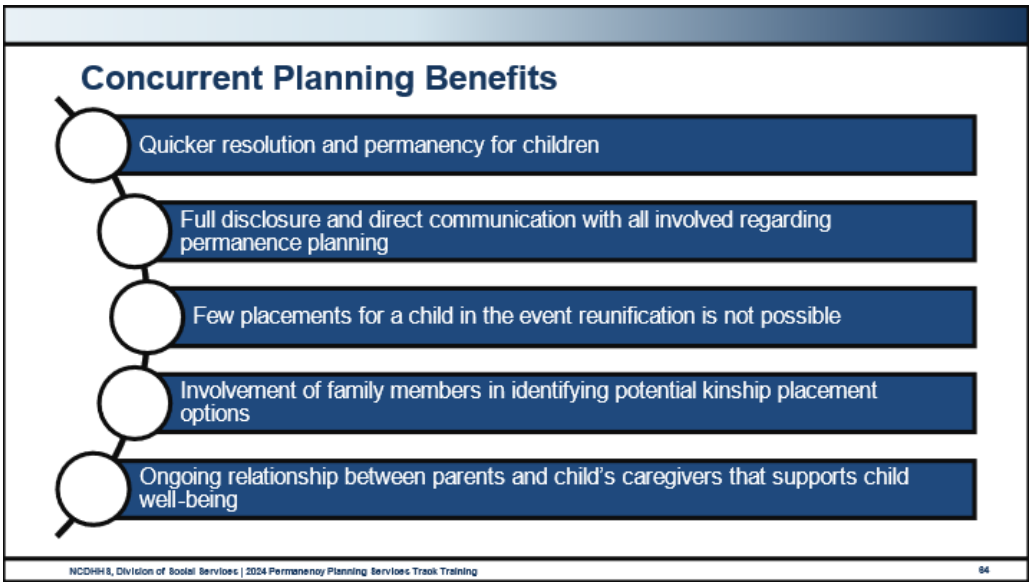
Concurrent Planning



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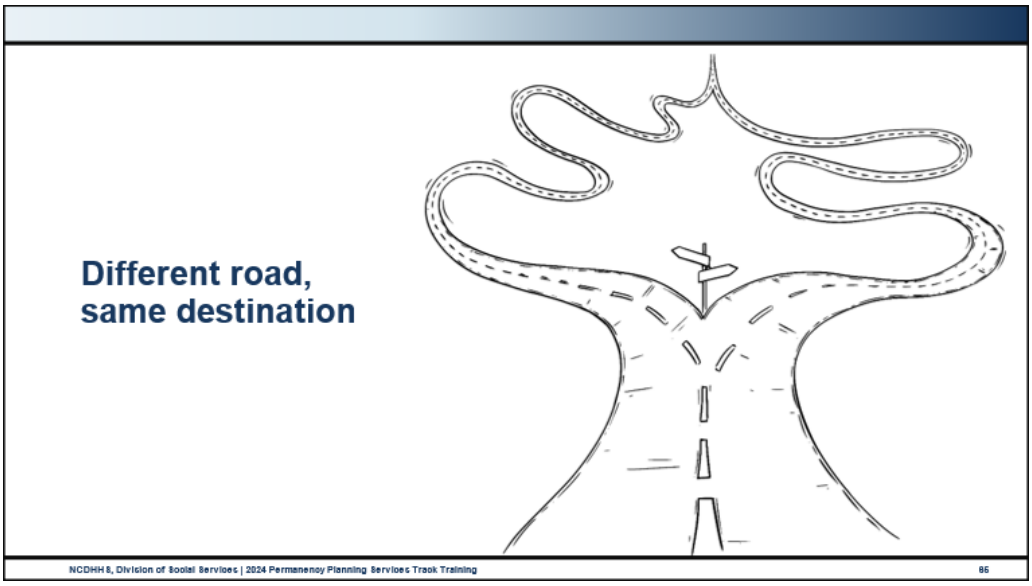


Use this space to record notes.

Activity: Both/And

The idea of “Both/And” is that two things that may feel conflicting can be true at the same time, such as spending time with the birth family, which can promote successful adoption.

You may complete this activity independently or with a partner, whichever works best for your learning.

Based on the activity on the slip of paper you selected, record how that activity supports both reunification and adoption in the appropriate box below.

Shared Parenting

Family Time

Sibling Visits

Child and Family Team Meetings

Therapy for Parent

Therapy for Child

Domestic Violence Services for Parents

Developmental Assessment for Child

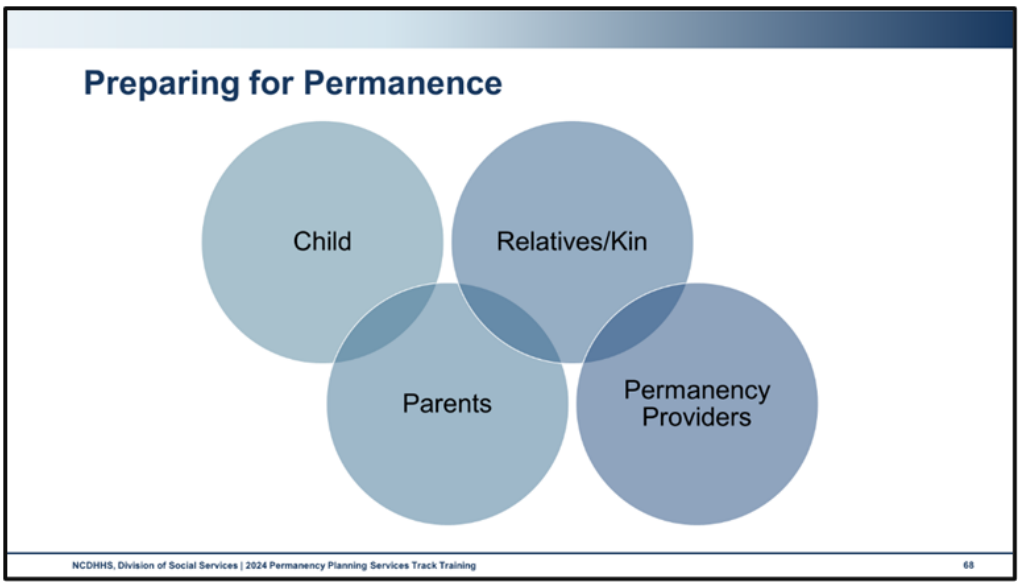
Parenting Classes for Parent

Substance Misuse/Substance Use Disorder Treatment

Contacting Relatives

Seeking a Pre-adoptive Family

Preparing for Permanence



Use this space to record notes.

Reflection and Check-In

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End-of-Day-Values Reflection

Use this space to record questions and reflections about what you have learned.

In small groups at your table, share at least one value from this training today that will shape how you support and advocate for families in Permanency Planning Services.

Use this space to record notes from the group conversation.

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Appendix: Handouts

Protective Factors Action Sheet

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PARENTAL RESILIENCE

PROTECTIVE & PROMOTIVE FACTORS

Being a parent can be a very rewarding and joyful experience. But being a parent can also have its share of stress. Parenting stress is caused by the pressures (stressors) that are placed on parents personally and in relation to their child:

- *typical events and life changes* (e.g., moving to a new city or not being able to soothe a crying baby)
- *unexpected events* (e.g., losing a job or discovering your child has a medical problem)
- *individual factors* (e.g., substance abuse or traumatic experiences)
- *social factors* (e.g., relationship problems or feelings of loneliness and isolation)
- *community, societal or environmental conditions* (e.g., persistent poverty, racism or a natural disaster)

Numerous researchers have concluded that how parents respond to stressors is much more important than the stressor itself in determining the outcomes for themselves and their children. **Parents are more likely to achieve healthy, favorable outcomes if they are resilient. Resilience is the process of managing stress and functioning well even when faced with challenges, adversity and trauma.**

Some stressors parents face can be managed easily so that problems get resolved; for example, calling a relative or friend to pick-up a child from school when a parent is delayed. But some stressors cannot be easily resolved. For example, parents cannot "fix" their child's developmental disability, erase the abuse they suffered as a child or be able to move out of a crime-plagued neighborhood. **Rather, parents are resilient when they are able to call forth their inner strength to proactively meet personal challenges and those in relation to their child, manage adversities, heal the effects of trauma and thrive given the unique characteristics and circumstances of their family.**

Demonstrating resilience increases parents' **self-efficacy** because they are able to see evidence of both their ability to face challenges competently and to make wise choices about addressing challenges. Furthermore, parental resilience has a positive effect on the parent, the child and the parent-child relationship. By managing stressors, parents feel better and can provide more nurturing attention to their child, which enables their child to form a secure emotional attachment. Receiving nurturing attention and developing a secure emotional attachment with parents, in turn, fosters the development of resilience in children when they experience stress.

Sometimes the pressures parents face are so overwhelming that their ability to manage stress is severely compromised. This is the case with parents who grew up in environments that create **toxic stress**. That is, as children, they experienced strong, frequent and prolonged adversity without the buffering protection of nurturing adult support. As a result, these parents may display symptoms of depression, anxiety, or other clinical disorders that inhibit their ability to respond consistently, warmly and sensitively to their child's needs. For example, depressive symptoms in either mothers or fathers are found to disrupt healthy parenting practices so that the child of a depressed parent is at increased risk of poor attachments, maltreatment and poor physical, neurological, social-emotional, behavioral and cognitive outcomes. However, numerous research studies show parents can be helped to manage clinical symptoms and reactions to their own histories of poor attachments and trauma, to protect children from adversity and trauma as best they can and to provide more nurturing care that promotes secure emotional attachment and healthy development in their children.

All parents experience stress from time-to-time. Thus, parental resilience is a process that all parents need in order effectively manage stressful situations and help ensure they and their families are on a trajectory of healthy, positive outcomes.

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PARENTAL RESILIENCE: ACTION SHEET

Your role as a caseworker

Having an open child welfare case is necessarily emotional and difficult for parents and can cause self-doubt that fundamentally undermines resilience. As a caseworker part of your role is to make the child welfare experience as constructive as possible by:

- Projecting a positive and strengths-based approach to the family
- Supporting the family as key decision-makers throughout the case planning process
- Making self-care a part of the case plan
- Encouraging the parent to explore their own past experiences of trauma and address how those experiences impact them in the present
- Normalizing the fact that parenting is stressful and helping the parent plan proactively about how to respond to stressful parenting situations
- Validating and supporting good decisions

Questions to ask

- What helps you cope with everyday life?
- Where do you draw your strength?
- How does this help you in parenting?
- What are your dreams for yourself and family?
- What kind of worries and frustrations do you deal with during the day? How do you solve them?
- How are you able to meet your children's needs when you are stressed?
- How does your spouse or partner support you? When you are under stress, what is most helpful?
- What do you do to take care of yourself when you are stressed?

What to look for

- Problem solving skills
- Ability to cope with stress
- Self-care strategies
- Help-seeking behavior
- Receiving mental health or substance abuse services if needed
- Not allowing stress to impact parenting

Activities to do with parents

- Ask the parent to write down their self-care strategies and ensure that they are taking time for self-care each day.
- Ask the parent to identify situations they find stressful and make a plan in advance for how they will keep themselves calm and centered in these circumstances.

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SOCIAL CONNECTIONS

PROTECTIVE & PROMOTIVE FACTORS

People need people. Parents need people who care about them and their children, who can be good listeners, who they can turn to for well-informed advice and who they can call on for help in solving problems. Thus, the availability and quality of social connections are important considerations in the lives of parents. **Parents' constructive and supportive social connections—that is, relationships with family members, friends, neighbors, co-workers, community members and service providers**—are valuable resources who provide:

- *emotional support* (e.g., affirming parenting skills or being empathic and non-judgmental)
- *informational support* (e.g., providing parenting guidance or recommending a pediatric dentist)
- *instrumental support* (e.g., providing transportation, financial assistance or links to jobs)
- *spiritual support* (e.g., providing hope and encouragement)

When parents have a sense of connectedness they believe they have people who care about them as individuals and as parents; they feel secure and confident that they have others with whom they can share the joy, pain and uncertainties that come with the parenting role; they seek timely assistance from people they have learned to count on when faced with challenges; and they feel empowered to "give back" through satisfying, mutually beneficial relationships. **Several research studies have demonstrated that—for both mothers and fathers—high levels of emotional, informational, instrumental or spiritual support is associated with positive parental mood; positive perceptions of and responsiveness to one's children; parental satisfaction, well-being and sense of competence; and lower levels of anger, anxiety and depression.**

Conversely, inadequate, conflicting or dissatisfying social connections can be the source of parental stress, rather than a buffer. For example, maternal and paternal grandparents may be very willing sources of informational and instrumental support to new parents, but their advice and manner of caregiving may be at odds with the new parents' beliefs and preferences. At the extreme end of the continuum of poor social connections are social isolation (i.e., the lack of available and quality relationships) and loneliness (i.e., feelings of disconnectedness from others). Social isolation is a risk factor consistently associated with disengaged parenting, maternal depression and increased likelihood of child maltreatment. Similarly, loneliness may be a major stressor that inhibits parents' ability to provide consistent, nurturing, responsive care to their children.

It may seem that increasing the number of people who could provide constructive social support to parents would be the "cure" for social isolation and loneliness. Providing opportunities for parents to create and strengthen sustainable, positive social connections is necessary but alone is not sufficient. Parents can feel lonely and isolated even when surrounded by others if relationships lack emotional depth and genuine acceptance. Thus, parents need opportunities to forge positive social connections with at least one other person that engender emotional, informational, instrumental or spiritual support so that meaningful interactions may occur in a context of mutual trust and respect.

Constructive and supportive social connections help buffer parents from stressors and support nurturing parenting behaviors that promote secure attachments in young children. Therefore, parents' high quality social connections are beneficial to both the adults and the children.

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SOCIAL CONNECTIONS: ACTION SHEET

Your role as a caseworker

As the family's caseworker you can help caregivers to think critically about their social network and how they could utilize it more effectively, as well as the skills and tools they need to expand it. The following strategies may assist you in engaging families in developing social connections:

- Model good relational behavior and use the case management process as an opportunity to help the caregiver develop stronger relational skills
- When engaging the family's broader network in teaming or other supports, be sensitive to the quality of existing relationships and help the family identify supporters in their network who will contribute positively
- Encourage the caregiver to expand or deepen their social network as part of the case plan
- If there are specific issues that serve as barriers for the family in developing healthy social connections such as anxiety or depression, encourage the family to address them

Questions to ask

- Do you have friends or family members that help you out once in a while?
- Are you a member of any groups or organizations?
- Who can you call for advice or just to talk? How often do you see them?
- What kind of social support do you need?
- Do you find it easy or challenging to make friends? If it is challenging, what specific things represent a barrier for you?
- What helps you feel connected?

What to look for

- Does the parent have supportive relationships with one or more persons (friends, family, neighbors, community, faith- based organizations, etc.)?
- Can the parent turn to their social network for help in times of need (for instance, when they need help with transportation, childcare or other resources)?
- Is the parent willing and able to accept assistance from others?
- Does the parent have positive relationships with other parents of same-age kids?
- Does the parent have skills for establishing and maintaining social relationships?
- Does the parent provide reciprocal social support to peers?

Activities to do with parents

- Work with the parent to develop an EcoMap showing the people and institutions that are sources of support and/or stress in his or her life.
- Role play with the parent to help them practice skills in approaching another parent to develop a friendship. Have the parent choose a realistic scenario such as starting a conversation at a school event, on the playground or at a place of worship.

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KNOWLEDGE OF PARENTING AND CHILD DEVELOPMENT

PROTECTIVE & PROMOTIVE FACTORS

No parent knows everything about children or is a "perfect parent." An understanding of parenting strategies and child development helps parents understand what to expect and how to provide what children need during each developmental phase. All parents, and those who work with children, can benefit from increasing their knowledge and understanding of child development, including:

- physical, cognitive, language, social and emotional development
- signs indicating a child may have a developmental delay and needs special help
- cultural factors that influence parenting practices and the perception of children
- factors that promote or inhibit healthy child outcomes
- discipline and how to positively impact child behavior

Gaining more knowledge about child development and developing greater skills in parenting are particularly important given the recent advances in the fields of neuroscience, pediatrics and developmental psychology. **Scientists in these fields have provided much evidence of the critical importance of early childhood as the period in which the foundation for intellectual, social, emotional and moral development is established. Furthermore, numerous research studies show this foundation is determined by the nature of the young child's environments and experiences that shape early brain development.**

Developing brains need proper nutrition, regularly scheduled periods of sleep, physical activity and a variety of stimulating experiences. Developing brains also need attuned, emotionally available parents and other primary caregivers who recognize and consistently respond to the needs of young children, and interact with them in an affectionate, sensitive and nurturing manner. Such care gives rise to the development of a secure attachment between the child and the adult. Young children with secure attachments develop a sense of trust, feel safe, gain self-confidence and are able to explore their environments because they feel they have a secure base.

Numerous longitudinal studies have demonstrated that parental behaviors that lead to early secure attachments—and which remain warm and sensitive as children grow older—lay the foundation for social-emotional, cognitive and moral competencies across developmental periods. For example, when a young child solicits interaction through babbling or facial expressions and a parent responds in a similar manner, this type of parent-child interaction helps to create neural connections that build later social-emotional and cognitive skills. In addition, advances in brain research have shown that parental behaviors that forge secure emotional attachments help young children learn to manage stress. Secure attachments can offset some of the damage experienced by highly stressed young children as a result of trauma (e.g., maltreatment or exposure to violence.)

In contrast, parental care that is inconsistent, unresponsive, detached, hostile or rejecting gives rise to insecure attachments. Young children who experience insecure attachments display fear, distrust, anxiety or distress and are at risk for long-term adverse effects on brain development including developmental delays, cognitive impairments, conduct problems, psychopathology and relationship challenges. For example, young children who have limited adult language stimulation and opportunities to explore may not fully develop the neural pathways that support learning.

What parents do and how they treat children is often a reflection of the way they were parented. Acquiring new knowledge about parenting and child development enables parents to critically evaluate the impact of their experiences on their own development and their current parenting practices, and to consider that there may be more effective ways of guiding and responding to their children. Furthermore, understanding the mounting evidence about the nature and importance of early brain development enables both parents and those who work with children to know what young children need most in order to thrive: nurturing, responsive, reliable and trusting relationships; regular, predictable and consistent routines; interactive language experiences; a physically and emotionally safe environment; and opportunities to explore and to learn by doing.

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KNOWLEDGE OF PARENTING AND CHILD DEVELOPMENT: ACTION SHEET

Your role as a caseworker

Each contact you have with the family provides an important opportunity to link them to parenting resources, provide child development information and model and validate effective caregiving. You can:

- Connect parents to parenting education classes or home visiting as part of case planning
- Model appropriate expectations for the child
- Engage caregivers in dialogue when their expectations are not in line with the child's developmental phase
- Underline the importance of nurturing care to help the caregiver in valuing the importance of their own role
- Provide "just in time" parenting education: information a parent needs at the time when parenting issues arise
- Help the caregiver identify a series of trusted informants that they can turn to when they need parenting information

Questions to ask

- What does your child do best and what do you like about your child?
- What do you like about parenting? What do you find challenging about parenting?
- How have you learned about parenting skills?
- How do you continue to learn about your child's development?
- What has helped you learn about yourself as a parent?
- Are there things that worry you about your child's development or behavior?
- Have other people expressed concern about your child?

What to look for

- Do the caregivers understand and encourage healthy development?
- Are the caregivers able to respond and manage their child's behavior?
- Do the caregivers understand and demonstrate age-appropriate parenting skills in their expectations, discipline, communication, protection and supervision of their child?
- Does the child respond positively to the caregivers' approaches?
- Do the caregivers understand and value their parenting role?
- Do the caregivers have a reliable source for parenting information when issues come up?
- Are the caregivers involved in their child's school or preschool?
- Do the caregivers understand the child's specific needs (especially if the child has special developmental or behavioral needs)?

Activities to do with parents

- Ask the parent what their hopes and dreams are for their child(ren). Discuss any worries the parent has about ensuring those hopes and dreams are met. Then discuss what the parent is doing today (or wants to do) to help achieve those hopes and dreams.
- Identify a particular parenting task the parent finds challenging (e.g., mealtimes, putting the child to bed). Provide the parent with information on strategies for this task. Ask them to practice these strategies and debrief on your next visit.

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CONCRETE SUPPORT IN TIMES OF NEED

PROTECTIVE & PROMOTIVE FACTORS

All parents need help sometimes—help with the day-to-day care of children, help in figuring out how to soothe a colicky baby, help getting to the emergency room when a bad accident happens, help in managing one's own temper when fatigued or upset. When parents are faced with very trying conditions such as losing a job, home foreclosure, substance abuse, not being able to feed their family or trauma, they need access to concrete support and services that address their needs and help to minimize the stress caused by very difficult challenges and adversity. **Assisting parents to identify, find and receive concrete support in times of need helps to ensure they and their family receive the basic necessities everyone deserves in order to grow (e.g., healthy food, a safe environment), as well as specialized medical, mental health, social, educational or legal services.**

When parents are faced with overwhelmingly stressful conditions they need to seek help, but for some parents asking for help is not an easy thing to do. It may be embarrassing for some parents because it feels like an admission of incompetence; that they don't know how to solve their own problems or take care of their family. Other parents may not seek help because they don't know where to go for help, or the services needed have a stigma associated with them such as mental health clinics and domestic violence or homeless shelters. **Thus, parents need experiences that enable them to understand their rights in accessing services, gain knowledge of relevant services and learn how to navigate through service systems.** Family and child-serving programs must clearly communicate to parents that seeking help is not an indicator of weakness or failure as a parent. **On the contrary, seeking help is a step toward improving one's circumstances and learning to better manage stress and function well—even when faced with challenges, adversity, and trauma. When parents ask for help, it is a step toward building resilience.**

When parents seek help, it should be provided in a manner that does not increase stress. Services should be coordinated, respectful, caring and strengths-based. Strengths-based practice is grounded in the beliefs that:

- It is essential to forge a trusting relationship between parents and service providers and among service providers working with the same families
- Regardless of the number or level of adverse conditions parents are experiencing, they have assets within and around them, their family and their community that can be called upon to help mitigate the impact of stressful conditions and to create needed change
- Parents have unrealized resources and competencies that must be identified, mobilized and appreciated
- Parents must be active participants in the change process and not passive recipients of services
- Parents must first be guided through, and subsequently learn how to navigate, the complex web of health care and social service systems
- In addition to addressing each parent's individual difficulties, strengths-based practitioners must understand—and work to change—the structural inequities and conditions that contribute to these difficulties

A strengths-based approach helps parents feel valued because they are acknowledged as knowledgeable and competent. They develop a sense of self-confidence and self-efficacy because they have opportunities to build their skills, experience success and provide help to others. Thus, access to concrete support in times of need must be accompanied by a quality of service coordination and delivery that is designed to preserve parents' dignity and to promote their and their family's healthy development, resilience and ability to advocate for and receive needed services and resources.

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CONCRETE SUPPORT IN TIMES OF NEED: ACTION SHEET

Your role as a caseworker

As the family's caseworker your role is not just to provide referrals to needed services, but to identify any barriers the families may have in accessing those services. Helping families overcome those barriers is crucial to ensuring that their concrete needs are met. Such help may entail:

- Encouraging help seeking behavior
- Working with the family to understand their past experience with service systems and any stigma they attach to certain services
- Helping the family to navigate complex systems by explaining eligibility requirements, filling out forms or making a warm handoff to an individual who can help them negotiate getting access to the services they need
- Helping the caregiver understand their role as an advocate for themselves and their child

Questions to ask

- What do you need to _____ (stay in your house, keep your job, pay your heating bill etc.)?
- What have you done to handle the problem? Has this worked?
- Are there community groups or local services that you have worked with in the past? What has been your experience accessing their services?
- Are there specific barriers that have made it difficult for you to access services in the past?
- How does dealing with these issues impact the way you parent?

What to look for

- Is the caregiver open to accessing and utilizing services?
- Has the caregiver had positive experiences with services in the past?
- Does the caregiver have specific barriers (literacy, lack of transportation, etc.) that will make it difficult to access services?
- Are there personal behavioral traits (e.g., punctuality, willingness to share personal information, etc.) that the caregiver could address to more effectively utilize services?
- Does the caregiver try to buffer the child from the stress caused by the family's concrete needs?

Activities to do with parents

- Ask the parent to identify one concrete need that, if met, would lighten his or her burden. Come up with a list of at least three possible avenues to get that need met (e.g., agencies to approach, people to ask for help, cutting back on other expenses).
- Talk to the parent about what their family's socioeconomic status was in their childhood and what effect that had on them. Discuss things their parents did or did not do to buffer them from the stress of poverty, to teach them the value of money or to make sure their needs were met.

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SOCIAL-EMOTIONAL COMPETENCE OF CHILDREN

PROTECTIVE & PROMOTIVE FACTORS

Early childhood is a period of both great opportunity and vulnerability. Early childhood experiences set the stage for later health, well-being and learning. In the past, most of the focus was on building young children's academic skills in an effort to ensure they were prepared for school. **However, in recent years a growing body of research has demonstrated the strong link between young children's social-emotional competence and their cognitive development, language skills, mental health and school success**. The dimensions of social-emotional competence in early childhood include:

- self-esteem - good feelings about oneself
- self-confidence - being open to new challenges and willing to explore new environments
- self-efficacy - believing that one is capable of performing an action
- self-regulation/self-control - following rules, controlling impulses, acting appropriately based on the context
- personal agency - planning and carrying out purposeful actions
- executive functioning - staying focused on a task and avoiding distractions
- patience - learning to wait
- persistence - willingness to try again when first attempts are not successful
- conflict resolution - resolving disagreements in a peaceful way
- communication skills - understanding and expressing a range of positive and negative emotions
- empathy - understanding and responding to the emotions and rights of others
- social skills - making friends and getting along with others
- morality - learning a sense of right and wrong

These dimensions of social-emotional competence do not evolve naturally. The course of social-emotional development—whether healthy or unhealthy—depends on the quality of nurturing attachment and stimulation that a child experiences. Numerous research studies show that a relationship with a consistent, caring and attuned adult who actively promotes the development of these dimensions is essential for healthy social-emotional outcomes in young children. Actively promoting social-emotional competence includes activities such as:

- Creating an environment in which children feel safe to express their emotions
- Being emotionally responsive to children and modeling empathy
- Setting clear expectations and limits (e.g., "People in our family don't hurt each other.")
- Separating emotions from actions (e.g., "It's okay to be angry, but we don't hit someone when we are angry.")
- Encouraging and reinforcing social skills such as greeting others and taking turns
- Creating opportunities for children to solve problems (e.g., "What do you think you should do if another child calls you a bad name?")

Children who have experiences such as these are able to recognize their and others' emotions, take the perspective of others and use their emerging cognitive skills to think about appropriate and inappropriate ways of acting. Conversely, research shows children who do not have adults in their lives who actively promote social-emotional competence may not be able to feel remorse or show empathy and may lack secure attachments, have limited language and cognitive skills and have a difficult time interacting effectively with their peers. Evidence shows, however, that early and appropriate interventions that focus on social-emotional development can help to mitigate the effects of negative experiences in ways that lead to improved cognitive and social-emotional outcomes.

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SOCIAL AND EMOTIONAL COMPETENCE OF CHILDREN: ACTION SHEET

Your role as a caseworker

It is important to increase caregivers' awareness of the importance of early relationships and of their role in nurturing their child's social-emotional development by:

- Providing concrete tips and resources to caregivers to help them build their skills
- Staying attuned to trauma and how it impacts the child's relationships with significant adults and, as they grow, with peers
- Connecting the family to resources that can help support the child's social-emotional development—these might be simple (such as classes like Second Step, or books and games that help children to name or recognize their emotions) or more intensive (such as mental health counseling)
- Providing families with support in dealing with children's attachment issues and/or challenging behaviors
- Taking time to explain and discuss children's behavior with caregivers when they are "acting out" due to trauma

Questions to ask

- How is the emotional relationship between you and your child?
- How do you express love and affection to your child?
- How do you help your child express his or her emotions?
- In what situations are your child's emotions hard for you to deal with?

What to look for

- Do the caregivers know how to encourage social-emotional development and apply a range of age-appropriate disciplinary strategies?
- Does the caregiver create an environment in which the child feels safe to express emotions?
- Is the caregiver emotionally responsive to the child?
- Does the caregiver model empathy?
- Does the caregiver set clear expectations and limits (e.g., "People in our family don't hurt each other")?
- Does the caregiver separate emotions from actions (e.g., "It's okay to be angry, but we don't hit someone when we are angry")?
- Does the caregiver encourage and reinforce social skills such as greeting others and taking turns?
- Does the caregiver create opportunities for children to solve problems? (e.g., "What do you think you should do if another child calls you a bad name?")?

Activities to do with parents

- Have the parent sketch out (or write out) an interaction with their child. Begin with an experience that typically makes the child happy, sad, frustrated or angry. Then have the parent illustrate or describe what the child does when he or she feels those emotions, how the parent responds and how the child responds. Identify and talk through positive or negative patterns in the interaction.
- Ask the parent to think of an adult who they loved as a child. What was it about the relationship with that adult that made it so important? Ask them what elements of that relationship they can replicate in their relationship with their child(ren).

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Protective Capacity

Protective capacity is defined as the ability and willingness to mitigate or ameliorate the identified safety and risk concerns. Protective capacity can be demonstrated by a parent through their statements, actions, and reactions. Protective capacity exists both within the parent/caretaker and within the family environment.

Parent/caretaker protective capacity should be assessed in three domains:

- Behavior characteristics
- Cognitive characteristics
- Emotional characteristics

Behavioral characteristics are defined as specific actions and activities consistent with and resulting in parenting and protective vigilance. Questions to consider include:
• Does the parent/caretaker have the capacity to care for the child? If the parent/caretaker has a disability(ies) (e.g., blindness, deafness, paraplegia, chronic illness), how has the parent/caretaker addressed the disability in parenting the child? • Has the parent/caretaker acknowledged and acted to provide the needed support to effectively parent and protect the child? • Does the parent/caretaker demonstrate activities that indicate putting aside one's own needs in favor of the child's needs (if appropriate)? • Does the parent/caretaker demonstrate adaptability in a changing environment or during a crisis? • Does the parent/caretaker demonstrate actions to protect the child? • Does the parent/caretaker demonstrate impulse control related to a risk factor? • Does the parent/caretaker have a history of protecting the child given any threats to the safety of the child?

Cognitive characteristics are defined as the parent/caretaker's specific intellect, knowledge, understanding, and perception that contributes to protective vigilance. Questions to consider include:
• Is the parent/caretaker oriented to time, place, and space? (i.e., reality orientation) • Does the parent/caretaker have an accurate perception of the child? Does the parent/caretaker see the child as having strengths and weaknesses, or do they see the child as "all good" or "all bad"? • Can the parent/caretaker recognize the child's developmental needs or if the child has special needs? • How does the parent/caretaker process the external stimuli? (e.g., a battered woman who believes she deserves to be beaten because of something she has done) • Does the parent/caretaker understand their role to provide protection to the child? • Does the parent/caretaker have the intellectual ability to understand what is needed to raise and protect a child? • Does the parent/caretaker accurately assess potential threats to the child?

Emotional characteristics are defined as the parent/caretaker's specific feelings, attitudes, and identification with the child and motivation that results in parenting and protective vigilance. Questions to consider include:
• Does the parent/caretaker have an emotional bond with the child? Is there a reciprocal connection between the parent/caretaker and the child? Is there a positive connection to the child? • Does the parent/caretaker have empathy for the child when the child is hurt or afraid? • Is the parent/caretaker flexible under stress? Can the parent/caretaker manage adversity? • Is the parent/caretaker able to control their emotions? If emotionally overwhelmed, does the parent/caretaker reach out to others or expect the child to meet the parent/caretaker's emotional needs? • Does the parent/caretaker consistently meet their own emotional needs via other adults, services?

Environmental Protective Capacities

While the assessment of the parent/caretaker's protective capacities is critical, an assessment of **environmental capacities** may also mitigate the safety concerns/risk of harm to a child. Below are several categories of environmental protective capacities to be considered.
• Family/kinship relationships that contribute to the protection of the child • Informal relationships • Agency supports • Community supports • Financial status • Spiritual supports • For American Indians, the tribe • Concrete needs being met (e.g., for food, clothing, shelter).

Citation: Cross Function Topics

Beyond a Trauma-Informed Approach and Towards a Shame-Sensitive Practice

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Beyond a trauma-informed approach and towards shame-sensitive practice

Luna Dolezal [1]✉ & Matthew Gibson[2]

In this article, we outline and define for the first time the concept of shame-sensitivity and principles for shame-sensitive practice. We argue that shame-sensitive practice is essential for the trauma-informed approach. Experiences of trauma are widespread, and there exists a wealth of evidence directly correlating trauma to a range of poor social and health outcomes which incur substantial costs to individuals and to society. As such, trauma has been positioned as a significant public health issue which many argue necessitates a trauma-informed approach to health, care and social services along with public health. Shame is key emotional after effect of experiences of trauma, and an emerging literature argues that we may 'have failed to see the obvious' by neglecting to acknowledge the influence of shame on post-trauma states. We argue that the trauma-informed approach fails to adequately theorise and address shame, and that many of the aims of the trauma-informed are more effectively addressed through the concept and practice of shame-sensitivity. We begin by giving an overview of the trauma-informed paradigm, then consider shame as part of trauma, looking particularly at how shame manifests in post-trauma states in a chronic form. We explore how shame becomes a barrier to successful engagement with services, and finally conclude with a definition of the shame-sensitive concept and the principles for its practice.

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Introduction

"Shame has ruled my whole life" – Anonymous, trauma survivor

"Trauma leads to shame. Trauma determines the content of shame. Shame pushes the body into a traumatic response. The more I learn about the two, the more I am convinced of their deep connection to one another." – Lucia Osborne-Crowley (Osborne-Crowley, 2020)

Experiences of trauma are widespread, and there exists a wealth of evidence directly correlating trauma to a range of poor social and health outcomes which incur substantial costs to individuals and to society. As such, trauma has been positioned as a significant public health issue which, as Magruder et al. (2017) argue, necessitates a 'trauma-informed approach' (TIA) to public health policy agendas. Shame is key emotional aftereffect of trauma, and an emerging literature argues that we may "have failed to see the obvious" by neglecting to acknowledge the influence of shame on post-trauma disorders (Taylor, 2015). In this article, we argue that effectively addressing the post-traumatic state necessitates a clear understanding of shame, its phenomenology and its effects. We demonstrate that shame is a core aftereffect of traumatic experiences and argue that being sensitive to shame addresses many issues related to trauma, while also supporting good practice for all that come into contact with human services. We outline and define for the first time the concept of shame-sensitivity and the principles for shame-sensitive practice. We begin by giving an overview of the trauma-informed paradigm, then consider shame as part of trauma, looking particularly at how shame manifests in the post-traumatic state in a chronic form. We explore how shame becomes a barrier to successful engagement with services, and finally conclude with a definition of the shame-sensitive concept and the principles for its practice. Offering strategies for shame-sensitive practice, this article highlights the need for shame competence in health, care and social services.

The trauma-informed approach

While trauma has been studied for over one hundred years it was not until the 1980s and 1990s that the topic had sufficient inter-disciplinary support to develop into a field of research and produce a theory of trauma. While there is no unified approach or understanding of trauma, most agree that it entails an event that involves "threats to life or bodily integrity, or a close personal encounter with violence and death" (Herman, 1992, p. 33), and that the experience of this event is overwhelming, resulting in long lasting effects which can encompass significant alterations to one's experience of self, others and the world (SAMHSA, 2014). Particularly significant are experiences of trauma in early life, or Adverse Childhood Experiences (ACEs), such as abuse, deprivation, violence, witnessing of violence, neglect and disrupted attachment, among others (Poole and Greaves, 2012). Also significant are experiences of trauma in later life, such as interpersonal violence, sexual assault, warfare, tyranny under oppressive regimes, natural disasters, domestic abuse, among many others (Pattison, 2000, p. 96). While trauma can lead to post-traumatic stress disorder (PTSD) or other trauma or stressor-related disorders, which are classified as psychopathologies in the *Diagnostic and Statistical Manual 5th Edition* (DSM-V), not all post-trauma states or experiences warrant being classified as pathological or fall under the umbrella of a disorder. Nonetheless, research demonstrates that individuals who have experienced trauma can have adverse outcomes in all areas of life, and that these effects can endure across a lifetime.

The interest in trauma, and its links to health and social outcomes, increased following the publication of the Felitti et al. (1998) paper on ACEs. With a sample of close to ten thousand, it is one of the largest investigations of childhood abuse and neglect, concluding that there is a strong relationship between "the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults" (Felitti et al., 1998, p. 245). This study has been influential in subsequent research into trauma and the development of policy for services that seek to address issues related to adversity and trauma. There is now a large body of research that demonstrates that individuals who have experienced trauma can have adverse outcomes in all areas of life, and that these effects can endure across a lifetime. These individuals are significantly more likely to suffer from a range of "social, psychiatric, psychological, behavioural and physical problems" (Knight, 2019, p. 80), such as chronic health issues, mental health problems and substance use problems, as well as being correlated with social outcomes such as homelessness, violence, marital problems and incarceration, among others (Banaj and Pellicano, 2020).

The term "trauma-informed" was introduced by Harris and Fallot in 2001 as a means to integrate an understanding of trauma and its aftereffects into mental health services, following the evidence that a significant number of individuals accessing mental health services were survivors of physical and sexual abuse (Harris and Fallot, 2001). Adopting a TIA attempts to embed an understanding of how experiences of trauma can become central to an individual's life course and life outcomes, having a profound negative effect on social outcomes, emotional wellbeing, mental and physical health, along with health-relevant behaviour (Poole and Greaves, 2012), impeding an individual's ability to seek out and engage with health and social services that are designed to help them (Barrett, 2019). TIAs involve a paradigm shift in how services and professionals respond to patients and clients, attempting to address root causes rather than surface symptoms, reframing the core diagnostic question from enquiring, "What is wrong with you?" to understanding, "What happened to you?" (Kimbery and Wheeler, 2019, p. 42; SAMHSA, 2014). This approach recognises that "any person seeking services or support might be a trauma survivor" and that "systems of care need to recognise, understand and counter the sequelae of trauma to facilitate recovery" (Goodman et al., 2016, p. 748).

Central to the TIA is an understanding that typical emotional, psychological and social aftereffects of trauma directly impede an individual's ability to seek out and engage with the human services that are designed to help them (Barrett, 2019). In addition, when trauma survivors do manage to engage with the services that may help them, the interactions they have with organisations, staff and care providers, who do not recognise and understand their trauma and its aftereffects, may inadvertently lead to a further disengagement and entrenchment of the problems (e.g., substance use, mental ill health) that these services are designed to diagnose and treat. The central contention of the TIA is that applying a 'trauma lens' can powerfully elucidate the root causes of ill health, health-related behaviours and social difficulties, leading to more effective interventions, support, diagnoses and treatments. This has led to the redesigning and reconceptualization of some health, care and social services, using the TIA paradigm as a way to structure the way that care is delivered (Gerber, 2019; SAMHSA, 2014; Wilson et al., 2013).

In a Western context, TIA has gained influence in international policy making circles. For example, in the United States there are many programmes designed to integrate the TIA at federal, state and community levels (Melz et al., 2019). Within the United Kingdom, the Scottish and Welsh Government are seeking to

develop and integrate the TIA into a range of public services. (Scottish Government, 2020; Welsh Government, 2021). This is equally the case in England, with Plymouth leading the way by seeking to become the United Kingdom's first 'trauma informed city' (Plymouth City Council, n.d.). The TIA is not only being advanced geographically but also practically, being applied to an ever-greater range of public services including children and youth, education, and health services, probation, and policing.

Critiques and limitations

The TIA is not without criticism. Conceptually, 'trauma' is a far-ranging concept that covers a wide range of experiences, and also a broad spectrum of outcomes. In considering how the concept of 'trauma' has been advanced in the TIA, Wastell and White (2017) argue that there are fundamental problems with how original research on trauma experiences has been interpreted for policy and practice. They argue that the original science underpinning our understanding of trauma expresses uncertainty and tentative conclusions, but that this inconclusiveness has been removed in the translation to practice in the TIA, resulting in definitive answers and concepts that are no longer consistent with the foundations of trauma research. Their concerns raise important conceptual and philosophical questions regarding how trauma is defined and understood, and how this is translated into practice.

Equally, there are conceptual implications as a result of the link between trauma and the original ACEs study. As the concept of trauma was boosted by the publication and promotion of the ACEs study, the case for the TIA is often justified by the research on ACEs. However, as Berliner and Kolko (2016) argue, not all harmful or stressful life experiences that the ACEs study examined were traumas; the two are not synonymous. Furthermore, there are those who have criticised the concept of adversity used in the original ACEs study to argue that not only do the components fail to identify adverse experiences (a parental separation is considered an adverse experience when this could be a protective one, for example) but that it is also a very narrow concept that misses many other forms of adversity, particularly wider individual, social and community forms of adversity such as chronic illness, or on-going social harms like poverty, deprivation or discrimination (White et al., 2019). There are on-going academic and practical debates relating to how to address the effects of trauma and ACEs. For example, Steptoe et al. (2019) argue there is a need for more information on approaches that address ACEs, while Asmussen et al. (2019) review a range of interventions that seek to address ACE-related trauma. To address such criticisms, some policy makers have included broader forms of adversity in the conceptualisation of the TIA, such as the Trauma Informed Plymouth Network who discuss 'Adverse Community Environments' (Trauma Informed Plymouth Network, n.d.). While such acknowledgements help the policy to address a wider range of experiences, it takes the conceptualisation of the TIA further away from the original idea of addressing 'trauma' per se.

Moreover, there are some criticisms regarding some TIA practices. Within the TIA, there is typically some form of screening used to identify trauma and refer for treatment, and that the screening tool is usually the ACE checklist or an adaptation of it (Schulman and Maul, 2019). Notwithstanding the issues of what the ACEs checklist actually measures (as discussed above), one of the authors of the original ACEs study has since argued that it has been misappropriated and misapplied to service delivery and professional practice, cautioning against its use in such a way (Anda et al., 2020). Furthermore, there is evidence that this medicalised model of screening, referring and treating does not sit well with more socially oriented services, with Kerns et al. (2016) finding practitioners feeling uneasy about the use of screening tools to identify trauma. Joy and Beddoe (2019), meanwhile, criticise the ACE tool for not being sensitive to culture, race, poverty and wider issues of power, while Kelly-Irving and Delpierre (2019) argue the ACE tool is not appropriate for individual level assessment.

Linked to these conceptual and operational issues have been criticisms of how a trauma perspective has been implemented into policy and practice (UK Parliament, 2018). Despite existing guidance that has been given on the TIA (e.g., SAMHSA), Donisch et al.'s (2016) research into the opinions and experiences of professionals involved in working in a trauma-informed way found uncertainty about how to actually implement the TIA in practice. Their research found substantial variation in how the TIA was defined and understood among practitioners, and highly idiosyncratic implementations of practices across systems. As they note, there are "varying terms, [a] lack of common lexicon, and differences across systems in knowledge and skills" related to the TIA, and what is lacking is a unified conceptualisation and operationalisation of the approach (Donisch, 2016, p. 131).

The TIA was developed within a specific context to work with people who had most likely experienced trauma. The wider application of this approach to different contexts and more diverse populations, for whom trauma may not be the main issue, inevitably brings complexities and challenges. Conceptual questions are raised about whether 'trauma' is the most appropriate lens through which to organise practice and services. Furthermore, there are operational and implementational questions regarding how the TIA is successfully put into practice in a consistent manner that is supported by a robust evidence base. The point is not that the TIA is not a useful way to frame policy and practice, but that it may not be the most effective way to frame all policy and practice for all groups. The question is not just what do we gain by using the TIA, but also what is left out?

In what follows, we discuss how a consideration of shame, along with its impacts and effects, is missing in the TIA. We argue that this omission will be detrimental, leading to the potential ineffectiveness of trauma-informed interventions. As a necessary supplement to any TIA, we argue for the concept and practice of shame-sensitivity.

Shame

Shame has recently been included in the diagnostic criteria for PTSD in the DSM-V under the umbrella of "persistent negative emotional states" (Taylor, 2015). Hence, shame has recently come to be identified in the trauma literature as part of a constellation of negative emotions (along with fear, horror, anger, guilt) that are common for trauma survivors in post-trauma states. Understanding shame and its role in post-trauma states is, as shall be discussed below, central to the success of the TIA.

Shame is a defining and central feature of human experience and all human relationships, intimately linked to one's self-perception, social worth, identity, relationships and position within a social group, while also being connected to social control and power through the normative boundaries which determine what is shameful and what is not in a particular society or culture (Dolezal, 2015a, p. 107). Because of its significance and prominence in both personal experience and within social life, shame is considered by many to be the "master emotion" (Scheff, 2004). Shame is commonly characterised as a negative self-conscious emotion; it is an experience that arises when we are concerned about how we are seen and judged by others. We feel shame when we are seen by another or others (whether they are present, imagined or simply a viewpoint that has been internalised) to be flawed in some crucial way, or when some part of our core self is perceived to be inadequate, inappropriate, or immoral.

The term 'shame' should be considered an umbrella term that refers to a whole range of experiences, including cognate emotions such as embarrassment, chagrin, mortification and humiliation. As James Gilligan usefully notes, in the same way "that we use the term 'flower' as a generic term to refer to a wide variety of different but related plants" then the term 'shame' encompasses a wide range of experiences including: "feelings of being slighted, insulted, disrespected, dishonoured, disgraced … demeaned … treated with contempt, ridiculed … mocked, rejected … feelings of inferiority, inadequacy … of being a failure, 'losing face', and being treated as if [one is] insignificant, unimportant or worthless" (Gilligan, 2003, p. 1155). What is common to all of these experiences is a sense of being judged negatively by others, and a feeling of being worth less than others.

During a shame experience, we can feel deeply and often irreparably flawed, unworthy and unlovable, and that our social position and our social bonds are under threat. Shame can provoke powerful feelings of despair, inferiority, powerlessness, defectiveness and self-contempt, to name a few. In addition, shame itself is shameful and taboo. As such, shame is an "iterated emotion," (Dolezal and Lyons, 2017, p. 258); its experience can lead to an intensification or multiplication of itself, leading to a "feeling trap" (Herman, 2011, p. 266) where "one can become ashamed because one is ashamed" (Taylor, 2015). For these reasons shame is usually avoided, shunned or kept secret at all costs, both individually and collectively.

While shame is a negative experience for an individual, it is an inevitable and necessary part of human life. Healthy shame can lead to the expression of positive attributes such as modesty, humility and gratitude, along with respect for oneself and for others. It can also be a powerful motivating force for personal growth and change, and in forging harmonious and meaningful relationships with others (Ng, 2020; Sanderson, 2015). However, healthy shame is very easily distorted and can become 'unhealthy', "maladaptive" or "destructive" (Sanderson, 2015, p. 22). As John Bradshaw notes, "shame as a healthy human emotion can be transformed into shame as a state of being… [which] is to believe that one's being is flawed, that one is defective as a human being. [Shame] becomes toxic and dehumanising" (Bradshaw, 2005, p. xvii). Toxic shame, Sanderson notes, "paradoxically severs connections, destroys social bonds and can lead to antisocial behaviour" (Sanderson, 2015, p. 22). Toxic shame is corrosive and pernicious, and can lead to a pervasive and enduring sense of inferiority, inadequacy, defectiveness, along with a sense of not being worthy of respect, love or connection. It is an experience that can be organise one's self, life and world, having a deep significance and impact on an individual and their life chances.

A typical shame response involves being overwhelmed with an intense feeling of conspicuousness and a strong sense of being judged by others, along with painful and negative emotions centred around one's feelings of inadequacy, all triggered by a mishap, mistake or transgression which has been 'witnessed' by others (whether they are present, imagined or internalised). This sort of shame response is commonly called "acute shame" (Dolezal, 2015a), insofar as it is a discrete emotional reaction in response to a trigger or event. In contrast, the toxic or pathological shame described above has a very different phenomenological profile, usually occurring in a chronic form. While chronic shame shares many of the painful features of acute shame, such as emotional pain, self-consciousness, a sense of visibility, it is not experienced as a discrete reaction of emotional torment and hyper-self-consciousness. Nor, as the term might imply, is it a state of perpetually feeling shame. Instead, chronic shame is frequently characterised, firstly, by the nagging and persistent *possibility of shame*, and secondly by a persistent sense of inadequacy, defilement, failure and lesser self-worth. Chronic shame can be characterised by what Leon Wurmser terms a "shame attitude" (Pattison, 2000, p. 85), where one's entire personality and character is structured around shame and shame avoidance.

Chronic shame is an elusive experience for several reasons. First, while 'chronic shame' is a term that appears in psychological, psychiatric and psychotherapeutic literatures, there is no clear definition of what constitutes chronic shame and it has been described through a variety of terms including "dispositional shame," (Leeming and Boyle, 2004) "shame-proneness" (Harris-Perry, 2011), "toxic shame," (Bradshaw, 2005) and being "shame-based" (Lloyd and Sieff, 2015), among others. There is no clear epidemiological data regarding the prevalence of chronic shame, nor is there any clear diagnostic criteria through which individuals can be 'diagnosed' as suffering from chronic shame, or understand their 'symptoms' to be mild, moderate, serious or severe (Pattison, 2000, p. 96).

Second, chronic shame is commonly characterised by the nagging and persistent *possibility of shame*, where, for the most part, shame itself is not necessarily realised in experience. Instead, what comes to dominate experience is a pernicious form of anticipated shame, or a persistent and heightened "shame anxiety," of which an individual may, or may not, be aware (Dolezal, 2021; Pattison, 2000). Shame anxiety appears in experience as a corrosive, undermining and persistent fear or anxiety about being objectified, judged, labelled and rejected by others; it is a persistent "fear of disgrace and being looked at by others with contempt" (Wilson et al., 2006, p. 125). This shame anxiety ultimately becomes connected to negative self-beliefs and self-conceptions; one comes to believe that the "core-self is defective, inadequate and unacceptable to others" (Sanderson, 2015, p. 24). It is important to note that shame anxiety may not be experienced as shame. Instead, it may be dominated by shame avoidance and, as such, characterised by emotions such as fear, anxiety, self-consciousness, stress or powerful impulses to hide, avoid or escape, along with negative feelings about the self, characterised by a sense of inadequacy, defilement or deficiency in relation to others.

While chronic shame has many causes (e.g., societal expectations, stigma and discrimination, psychopathology), it is clear that a significant cause of persistent chronic shame is trauma, where childhood relational trauma and traumatic experiences in later life are strongly correlated with experiences of chronic shame and shame anxiety (DeYoung, 2015; Kalsched and Sieff, 2015; Pattison, 2000). There is also evidence that chronic shame plays a role in PTSD symptom severity (Cunningham, 2020; La Bash and Papa, 2014; Lee et al., 2001). In fact, common defensive scripts or shame-avoidant behaviours seen among those who live with maladaptive chronic shame "bear a strong resemblance," as Taylor notes, "to the prominent symptoms and behaviours" associated with PTSD (Taylor, 2015). And many experiences related to shame, such as chronic rumination, flashbacks, emotional avoidance, intrusions, hyper-arousal, dissociation and fragmented states of mind are similar to experiences associated with trauma and post-trauma states (Budden, 2009, pp. 1035–1036; Theisen-Womersley, 2021, pp. 210–211).

Shame and trauma

There is a growing literature that explores the centrality of shame for individuals who have experienced trauma (Budden, 2009; Cunningham, 2020; DeYoung, 2015; Goldblatt, 2013; Herman, 2011; Lee et al., 2001; Øktedalen et al., 2014; Plante et al., 2022; Saraiya and Lopez-Castro, 2016; Sieff, 2015; Taylor, 2015; Theisen-Womersley, 2021; Wilson et al., 2006). Trauma research has seen the recent development of the idea that "shame and trauma

are inextricably linked" (Theisen-Womersley, 2021, p. 211), where some argue that "post-traumatic shame" is a key experience that shapes post-trauma states (Theisen-Womersley, 2021), while others have come to theorise and describe PTSD as a "shame disorder" (Herman, 2011; Salter and Hall, 2020), with evidence demonstrating that chronic shame plays a role in PTSD symptom severity (Cunningham, 2020; Lee et al., 2001). Overall, this body of research argues that shame is a world-organising affect for many trauma survivors and that shame is behind much of the maladaptive behaviour associated with trauma, PTSD and other post-trauma states.

The cause of shame in post-trauma states is complex, but there seem to be a multitude of overlapping factors which render shame a predominant, if not the dominant, emotional experience following trauma. Research demonstrates that shame can brought on by: the traumatic experience itself (Budden, 2009; Lloyd and Sieff, 2015); incorrect or inaccurate feelings of blame or responsibility for what happened in the traumatic event (e.g., "it was my fault…", "this wouldn't have happened if I had just…") (Bhuptani and Messman, 2021; Kalsched and Sieff, 2015; Wilson et al., 2006); feelings of defilement and unlovability as a result of neglect or abuse, particularly in childhood (Pattison, 2000); rumination about one's behaviours, actions and reactions at the time of the trauma (Lee et al., 2001); the sense of being damaged or defiled as a result of having experienced trauma or having a trauma diagnosis, such as PTSD (Herman, 2011); the symptoms of PTSD or a post-trauma state (Lee et al., 2001); the labels attached to one's identity as a result of trauma and post-trauma outcomes (e.g., "victim", "survivor", "addict", "homeless") (DeYoung, 2015; Theisen-Womersley, 2021); the coping mechanisms one engages in to cope with trauma (Herman, 2011; Taylor, 2015); fear of judgement by others if they discover one's trauma (Øktedalen et al., 2014); the social taboos associated with the trauma that one has experienced (e.g., childhood sexual abuse by a family member) (Banaj and Pellicano, 2020); revealing trauma in clinical and psychotherapeutic encounters (DeYoung, 2015; Goldblatt, 2013; Lanksy, 2000); falling short of one's own ideals and standards (Goldblatt, 2013; Kalsched and Sieff, 2015); and because of the taboo and shameful nature of shame itself (Herman, 2011; Taylor, 2015; Wilson et al., 2006). Hence, in addressing the impact of emotions for trauma survivors, for the treatment of PTSD, and within the TIA, Taylor's question "have we failed to see the obvious?" with respect to "the influence of shame on posttrauma disorders" seems particularly pertinent (Taylor, 2015).

Understanding shame, and in particular chronic shame, as a keystone sequela of trauma experiences has the potential to elucidate the root cause of a range of maladaptive behaviours associated with trauma. The lack of trust and empathy within intersubjective encounters suggested by some to be characteristic of trauma survivors (Wilde, 2019) are accounted for affectively through understanding shame as central to post-trauma states. However, as noted above, chronic shame is difficult to identify and 'diagnose'; it is an elusive experience that is often 'disguised' or 'camouflaged' by other experiences and feelings. The relational psychotherapist Patricia DeYoung notes that what those who suffer from chronic shame, "may not daily or consciously expect to be annihilated by shame. However, the threat is always around somewhere, just out of awareness, kept at bay" (DeYoung, 2015, p. 19). DeYoung describes chronic shame as "silent," where some of her clients who suffer from chronic shame do not even know that they are anticipating shame (and related strategies to avoid shame) with debilitating frequency. What they live with is not shame, but "what it costs them to keep from falling into shame" (DeYoung, 2015, p. 19). Bradshaw concurs writing that for those living with toxic shame, "everything is organised around preventing exposure" (Bradshaw, 2005, p. 139). As a result, what characterises the experience of chronic shame in post-trauma states is not enduring or repetitive experiences of shame but rather an atmosphere of anticipated shame, or shame anxiety, that leads to compensatory behaviours or experiences.

In this way, in experiences of chronic shame, shame *itself* often becomes invisible and what dominates experience is other behaviour or feelings which are used to help circumvent or avoid shame, or to mask or cope with the pain of shame. As Pattison notes, individuals who experience chronic shame "live their lives trying to avoid occasions and relationships that might provoke painful shame experiences" (Pattison, 2000, p. 83). DeYoung concurs: "the pain [of shame] can be unbearable. To save ourselves, we push shame away as fast as we can, covering for it with more tolerable states of being" (DeYoung, 2015, p. xii). Helen Block Lewis discusses this experience as "bypassed shame" (Lewis, 1971), where the self is not conscious of feeling shame directly, and instead bypasses or 'displaces' shame for other emotions, states or experiences (Brown, 1998, p. 146).

As a result, living with chronic shame can lead to a range of compensatory behaviours; these are powerful "defensive scripts" (Kaufman, 1993, p. 113; Pattison, 2000, p. 111), "strategies" (Sanderson, 2015, p. 24) or patterns and habits of interaction, which make it possible for an individual to avoid the social threat, pain and emotional anguish that comes with shame and its chronic anticipation. Lanksy links these to the experience of living with trauma, stating the "posttraumatic state gives rise to shame and to defences that keep shame arousing awareness from consciousness" (Lanksy, 2000, p. 133). Wilson et al. concur, noting that, "the powerful emotions of posttraumatic shame … are associated with a broad range of avoidance behaviours: isolation, detachment, withdrawal, hiding, nonappearance, self-imposed exile, cancellation of appointments, surrender of responsibilities, emotional constriction, psychic numbing, emotional flatness, and non-confrontation with others" (Wilson et al. 2006, p. 138). These avoidance behaviours help an individual protect themselves from shame through avoidance, or "by placing it outside of conscious awareness" (Sanderson, 2015, p. 24). In this way, shame can, as Wilson et al. note, "operate unconsciously in trauma complexes and initiate self-destructive and self-defeating modalities of behaviour" (Wilson et al., 2006, p. 129). Hence, instead of shame, what is seen externally are other reactions, responses and behaviours that "mask the shame" (Ng, 2020, p. 30).

The psychiatrist Donald Nathanson theorises "the compass of shame", where shame-avoidance behaviours follow four common patterns: withdrawal, avoidance, attack other and attack self (Nathanson, 1992, pp. 305–377). Common defensive behaviours include a variety of different reactions, all of which are damaging both to oneself and to one's social bonds, such as anger, aggression, hostility, violence, narcissism, depression, perfectionism, apathy, withdrawal, avoidance, excessive deference, among others (Nathanson, 1992; Pattison, 2000). These common defensive reactions to shame are, as Taylor notes, "consistent with many of the symptoms and comorbidities of PTSD" and post-trauma states, including anger, violence, addiction, isolation, feelings of hopelessness and helplessness which can progress to depression and even suicide ideation (Taylor, 2015). What becomes problematic in understanding and treating trauma and the post-trauma states is that these avoidance behaviours for shame are "easily misread" (Theisen-Womersley, 2021, p. 212) and shame often becomes invisiblized and, consequently unacknowledged, in efforts to provide care, treatment and support.

In fact, it has been demonstrated that shame is a "potent treatment barrier" for trauma survivors (Saraiya and Lopez-Castro, 2016), leading to outright avoidance, and to dropping out and attrition once engaged with care and services. As Plante et al. note, shame "generates an urgent need to hide and conceal the

defective self from exposure" (Plante et al., 2022). Indeed, there is ample evidence that the 'necessity' to avoid shame or shameful exposure can interfere with individuals accessing healthcare (Dolezal, 2015b; Dolezal and Lyons, 2017; Lazare, 1987), and also prevent individuals from reporting traumatic incidents such as abuse, sexual assault and violence (Hlavka, 2017; Weiss, 2010). In addition, shame prevents the reporting of shame itself, as individuals "in clinical settings are sometimes reluctant to disclose feelings of shame out of fear from being exposed and rejected" (Øktedalen et al., 2014, p. 600). In these complex and overlapping ways, shame experiences lead to concealment and avoidance, consistent with the "hallmark symptoms" of PTSD and post-trauma states (Saraiya and Lopez-Castro, 2016).

Hence, in the context of seeking help through health, care or social services, individuals who are chronically anxious about shameful exposure may avoid seeking help in the first place, may regularly miss appointments, may avoid disclosing honest details about traumatic events, lifestyle or circumstances, may fail to follow through with treatments, and may conceal diagnoses and coping behaviours from friends, family and professionals (Dolezal and Lyons, 2017). In fact, not only is shame a barrier to accessing services, it is very easily exacerbated and incited in the context of seeking help from professionals; professional practice and public policy are frequently "vectors of shame, humiliation, and inequality" (Salter and Hall, 2020, p. 10). Moreover, shame is a relational emotion that is frequently present in clinical and care encounters (Dolezal, 2015b; Lazare, 1987). Interactions with care professionals can compound feelings of shame, as these interactions often involve unequal power relationships, a fear of being judged, the scrutiny and exposure of one's potentially 'shameful' past, circumstances, lifestyle, coping behaviours, body, illnesses, along with other vulnerabilities. Despite shame's ubiquity and its obvious impact in encounters with health and care professionals, there is evidence that addressing shame is routinely avoided in clinical and therapeutic encounters, as practitioners themselves are reluctant to acknowledge shame or address experiences which may lead to shame or embarrassment (Lewis, 1971).

It seems clear that being attuned to experiences of shame and chronic shame, along with the common 'scripts' and 'strategies' deployed to avoid shame and shameful exposure, becomes central to achieving trauma-informed practice, and in fact central to facilitating individuals to seek help and engage with health, care and social services. However, a consideration of shame, along with its impacts and effects, has not been part of the conceptualisation of the TIA, nor an explicit focus in its practice. Indeed, shame is rarely even mentioned in the academic and grey literature about the TIA.

To address this lacuna, we argue for shame-sensitivity to be central to the theory, policy and practice of any TIA. However, the relevance of shame-sensitivity is by no means limited to the TIA. As everyone experiences shame or is vulnerable to shame, shame-sensitivity is of general benefit to all populations and provides a unified framework for good care when working with people more humanely. We do not argue that shame-sensitivity should replace a 'trauma lens'. Rather we argue that shame-sensitivity, and using a 'shame lens', is both necessary for, and has wider application than, the TIA.

Shame-sensitivity

Shame-sensitivity is a concept and practice for health and human services. There are three central components to the concept. The first is that shame is inevitable. We all have the capacity to experience shame (with a debate about a very small number of individuals (Kosson et al., 2015)), while many vulnerable people live with chronic shame. Interactions with services can, and often do, evoke shame in the people who engage with those services. Second, because shame is a highly unpleasant experience, humans have evolved and developed strategies to avoid shame, and these strategies influence an individual's thoughts, behaviours and social interactions, usually for the worse. Third, it is incumbent upon services that work with people to acknowledge and respond appropriately to people's shame in order to mitigate its potential negative effects and impacts. In other words, services need to be shame-sensitive.

While there are a variety of ways to implement shame-sensitivity in practice, and these should be tailored to the specificity of the service provision in question, we outline three key principles for shame-sensitive practice, which we refer to as the 3As: acknowledging shame, avoiding shaming, and addressing shame.

Acknowledging shame.

Individual understanding of shame: Practitioners working in human services must have 'shame competence'. They must have a theoretical and practical understanding of what shame is, how it operates, how it is evoked, how it can be hidden, and understand the behaviours that are used to cope with shame. Not only must individual practitioners be sensitive to the experience of shame in others, but they must also be sensitive to shame within themselves, understanding how shame experiences can affect their own thinking, actions, behaviour and attitudes towards others. Practitioners must also have an understanding of how shame circulates between individuals and within organisations, and also be able to understand when shaming is present in policy and practice.

Organisational understanding of shame: Individual shame competence cannot take place without a system of support that accepts the existence, importance, and significance of shame; both for the practitioners themselves and for patients/clients/service users. This involves the fostering of emotional communication within professional practice, where speaking about and understanding emotions, and their effects, within professional practice becomes commonplace (Gibson, 2014). In particular, the taboo regarding shame, and shameful or stigmatised states and experiences, must be directly addressed. An organisational perspective not only recognises the possibility for the evocation of shame by individuals but also the possibility that organisational policies and procedures can evoke shame in staff and patients/clients/service users.

Appreciating the differential experience of shame: A significant part of individual acknowledgement of shame is understanding how people come to experience shame, knowing that the boundaries for what is considered shameful can vary for individuals and for different groups. There are variable pressures, standards, contexts, histories and expectations placed on individuals and groups, which can result in shifting signification of what is considered 'shaming' or 'shameful'. By ensuring there is meaningful engagement and collaboration with different communities and groups to understand their particular sensitivities to shame, along with common behavioural responses to avoid the experience of shame, organisations can support individual and collective knowledge and understanding.

Recognising shame and shaming: Acknowledging shame moves beyond knowledge of shame theory to also include being able to recognise shame and shaming in experience and practice. Not only is shame frequently hidden and notoriously difficult to admit to, but it is also taboo and shameful. People go to great lengths to hide shame and what they consider to be shameful. Practitioners and organisations must become adept at using a 'shame lens' to identify shame through both

physiological, psychological and social indicators. Practitioners must become aware of common verbal, paralinguistic, and nonverbal cues that may indicate a shame state (Gibson, 2015; Herman, 2011; Retzinger, 1995). These include postural and embodied cues (e.g., covering the face, blushing, downcast eyes, etc.), common terms used instead of shame (e.g., 'self-conscious', 'embarrassed', 'foolish', 'worthless', 'inept', 'inferior', etc.), paralinguistic cues (e.g., stammering, silence, long pauses, etc.). Practitioners must also become adept at recognising bypassed shame, through knowledge and recognition of common avoidance behaviours for shame (cf. 'the compass of shame'). Practitioners must also become alert to shame dynamics within interpersonal encounters, recognising that shame is a "two-way street" and "contagious" (Theisen-Womersley, 2021, p. 212). This means it can transfer from client, patient or service user to the practitioner, infecting an entire interaction. Practitioners must also have an understanding of how shame circulates within professional organisations and institutions and be able to identify, and also address, implicit and explicit shaming in policy and practice.

Avoiding shaming.

- *Avoiding individual shaming*: Any individual can explicitly seek to shame another person, whether this is a manager to manager, manager to employee, employee to manager, employee to employee, employee to patient/client/service user. With knowledge and understanding of shame and shame dynamics, individuals within a shame-sensitive organisation, practising shame-sensitivity, would actively seek to avoid shaming others. However, they should also be sensitive to the potential for implicit shaming, recognising that any relationship where there are power differences can be inherently shame-inducing (Dolezal, 2015b; Lazare, 1987; Ng, 2020). Individuals engaging with services are expected to expose their vulnerabilities (including their physical bodies, their lifestyle, their illnesses, mental health status, and potentially share intimate details about their past, their families, their feelings etc.), which are then the subject of scrutiny and professional assessment. Practitioners must remain alert to, and continuously assess, how the language they use, their demeanour, questioning style, emotional expression and other interpersonal dynamics may inadvertently produce a shame response (Ford et al., 2021). Furthermore, consideration must be given to interpersonal dynamics, based on gender, race, ethnicity, language-spoken, disability, age, religious identification, along with other factors in particular situations (e.g., a female police officer may be the most 'shame appropriate' practitioner to interact with a female victim of sexual assault). Practitioners should also avoid stereotyping, labelling and other stigmatising ways of engaging with individuals. It is imperative to remain responsive to individuals and their unique circumstances and to genuinely acknowledge distress.
- *Avoiding collective shaming*: Many initiatives rely on shame as the affective driver of the change they hope to promote (e.g., shame is frequently used in public health campaigns, for example, to combat obesity or improve hygiene (Brewis and Wutich, 2019)). Such shaming attempts are examples of how whole groups of people can be targets for shame. While there are some initiatives that have an explicit aim to shame groups of people, there are many other initiatives, policies and procedures that have the effect of shaming groups of people, even when this is not intended. Avoiding collective shaming involves being alert to how shaming may become implicit within policy and practice, for instance through the use of stigmatising language, or through creating dynamics of blame and individual responsibility for circumstances or conditions that may be resulting from structural conditions (e.g., poverty, obesity) or that may stem from a post-trauma coping behaviour (e.g., addiction, mental ill health).
- *Evaluating impact of practice for shaming*: Not all proactive attempts to avoid shaming will be successful. To ensure that there is a reflexive feedback system to inform the proactive shaming avoidance attempts, organisations and practitioners must conduct and engage in a process of ongoing evaluation of the impact of their practice, policies, and procedures on the people they come into contact with; both within (employees) and without (patients/clients/service users) of the organisation (Dolezal et al., 2021). This involves vulnerability, and requires critical reflection on past and future practice. There must be willingness to admit mistakes, openness to critical reflection and flexibility to make responsive changes in policy and practice. Furthermore, organisations must create and systematise nuanced and collaborative understandings of how shaming is produced, and how shame is experienced, as a result of their policies and practices, avoiding attributing blame and shame to individuals where there is a disconnect between policy and operational capacity, especially in cases of chronic underfunding. Collective accountability for shame-sensitive or shame-reducing practice begins with mutually-agreed goals and frames of reference; such as an institutional code of conduct, or a shame-proofing toolkit (Dolezal et al., 2021). Cultures and practices of shaming and blaming must be avoided within organisations (Creed et al., 2014). Cultures of dignity, openness, learning and emotional intelligence should be fostered.

Addressing shame.

Addressing individual shame: Being able to address individual experiences of shame requires an understanding of how and why a person experiences their shame and finding ways to work through or around it. This, firstly, means understanding the person in their context and personal history, which will highlight the reasons for the shame experience. Secondly, it necessitates creating a sense of emotional safety (Gibson, 2019), where individuals feel able to talk about their experiences without fear of judgement, criticism, or ridicule, and also with a belief they will be understood and accepted for sharing their feelings. Thirdly, issues related to the experience of shame must be directly discussed in an empathetic and sensitive manner. Language and terminology must be carefully chosen, as the term 'shame' can itself be shame-inducing. Alternative phrasing might be more appropriate (e.g., 'feeling judged', 'feeling self-conscious', 'embarrassment', etc.). Unacknowledged and unspoken shame can give the "toxic beliefs that are inherent in shame" some legitimacy (Gibson, 2015, p. 339) and bringing these beliefs out in the open provides the opportunity to unburden the person from shame and reduce the influence it has on interactions. Furthermore, such sensitive discussion of shame requires attentiveness to the person's needs for support and connection after sensitive disclosures of shame or shame-inducing states, events or circumstances.

Supporting shame resilience: While attempts to address shame can occur in any interaction, the effects of shame and disclosing shame can have longer term consequences (Dearing and Tangney, 2011). The experience of shame can leave individuals to "feel isolated … and shy away from reaching out to people who may be able to offer help for fear of rejection and further shame" (Gibson, 2015, pp. 339–340). Shame-sensitive practice, organisations, and systems, therefore, need to embed shame resilience into the ways they address shame. At the heart of shame resilience is the development and deepening of social bonds (Brown, 2006). It is imperative that practitioners engage in practice that creates and promotes sustainable relationships with and within any organisation (Gibson, 2015). Organisations and services need to ensure continuity with individual practitioners so meaningful relationships grounded in familiarity, trust and empathy can be developed. Practitioners and services need to be proactive in reaching out to individuals, especially when they disengage. Individuals should not be made to feel cut off, disconnected or discarded from services. Structural factors such as the availability of appointment times, accessibility of clinical spaces, ease through which one can contact the service, length of waiting lists, duration of service, continuity between services, must be continually assessed to ensure that individuals feel supported and a sense of connection is maintained. Furthermore, friend and family networks must be supported so that individuals have sustainable networks of support. In addition, practitioners must be supported by their organisations and institutions to have the time, support and resources to engage in genuinely relational practice, fostering connection, empathy and trust with the individuals they are working with and supporting.

Actively fostering the conditions for shame-sensitive practice: Organisations must actively work to create the conditions, policy and practices that promote shame-sensitivity, where relationships based on dignity, respect, empathy and trust are the first priority within workplaces and when delivering services. Practitioners must be supported within organisations to have the personal, professional and operational capacity to work in a shame-sensitive manner.

Combating the systemic causes of shame: The systemic forces which shape and define what is considered shameful or stigmatised are not immutable. In addition, many causes of trauma (e.g., social deprivation, domestic abuse) have their roots in societal and structural conditions which can be changed and improved. Practitioners, along with leaders and managers within organisations, must be given the resources and encouraged to be engaged in making meaningful changes. This will happen through creating cultures of engaged practice and political activity, where individuals are encouraged to write to local councillors or Members of Parliament, carry out research, engage with academic partners, become involved in local and national political campaigns, engage with media outlets, etc., with the overall aim of advocating and agitating for more humane and shame-sensitive changes in law, policy and practice (Gibson, 2019, p. 199).

Conclusions

Having the capacity, on the levels of policy, organisations and individual practitioners, to address shame directly is imperative considering the how impactful shame can be for those who have experienced trauma and post-trauma states. Being attentive to shame, and acknowledging its significance for individuals, in health and social care contexts, can improve both engagement and outcomes. Using a 'shame lens' alongside a 'trauma lens' is necessary for TIAs to achieve the goal of redesigning services to be more sensitive and supportive, with the ultimate aim of avoiding retraumatisation and any additional harm. As a result, TIAs must begin to integrate shame-sensitive practice. There are obvious overlaps and synergies with the main principles which guide TIAs, however focusing through a 'shame lens' will reveal significant affective dynamics that are otherwise occluded, overlooked or ignored.

Shame-sensitivity and using the 'shame lens' within organisations will enable more humane services which address and acknowledge a significant affective dimension of seeking help, namely shame and self-consciousness. Following the evidence that shame is a significant force within encounters with professionals within health, care and social services, introducing a 'shame lens' to the way these services are conceptualised and conducted, has the potential to transform interactions between professionals and patients/clients/service users, as well as among colleagues within services and organisations. The emotional intelligence that shame-competence affords will give practitioners greater awareness of social dynamics which will help manage interactions and relationships within encounters with more empathy, humanity and sensitivity. Having more awareness of emotions and emotional dynamics within workplaces has been linked to a range of positive outcomes, such as ability to handle stress, improved job performance, job satisfaction and leadership skills (Magny and Todak, 2021, p. 958). Understanding shame, in particular, can uncover and unlock a range of usually occluded dynamics between individuals and within institutions that have negative or damaging effects (Creed et al., 2014).

While shame-sensitive practice is essential for the TIA, it should be acknowledged that shame is a universal experience, and that shame-sensitive practice should be integrated into all service delivery, and not just seen as an accompaniment to trauma-informed care. All individuals experience shame, and this can be easily exacerbated in contexts where there are unequal power relations, such as in encounters with doctors, social workers, police and other health and care professionals. In addition, shame-sensitive practice is not intended to be a solution for the social ills that lead individuals to need to engage with services. The integration of this approach must be within broader societal efforts to reduce conditions that produce chronic shame, stigma and trauma, such as poverty, destitution, deprivation, long-term unemployment, violence, sexual assault, domestic abuse, displacement, etc. These principles for practice will be most effective in environments that have long-term viability and also are also well-resourced, where there is also widespread public confidence in services and organisations.

Offering an outline of the concept and the practice of shame-sensitivity, this article has highlighted what is needed for human services to effectively face shame and shaming and mitigate their negative impacts and effects. We argue that principles of shame-sensitivity, and the practice that goes along with it, are the starting point for any interactions, organisational changes, and policy developments. The corollary of this is that these principles and practices should precede a TIA, that they will address many of the issues that people face following trauma, but where additional care and support is needed these principles should be integrated into the TIA.

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Practice Model Self-Assessment

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North Carolina Practice Standards Worker Assessment

North Carolina Worker Assessment

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

The North Carolina Worker Assessment tool is a companion document to the Practice Standards. This assessment is a useful tool to evaluate ways in which you incorporate the Practice Standards into your own practice and areas to improve upon. Assessments are used as a quality improvement measure and will support your learning to enhance your skills and behaviors. This assessment tool can be used in a variety of ways, such as a self-assessment, peer review, or a 360-degree evaluation. Following the assessment tool is an Action Plan you will complete where you will identify the specific actions you plan to take to implement the behaviors of the Practice Standards into your work paying particular attention to the areas noted as occurring 'sometimes' or 'never.'

Self-Assessment
A self-assessment is your evaluation of your own practice, behaviors, and attitudes, in particular your implementation of the Practice Standards within your work. When completing the assessment tool as a self-assessment, you will complete the tool on your own following the below instructions. Reflective, thoughtful, and honest responses to each item will provide you with the information necessary to improve your practice to the benefit of the children and families you work with.

Peer Review
A peer review is an evaluation of your practice and professional work by others in similar positions who you work with. A peer review provides a structured framework for other workers to assess and provide feedback to you on your work and implementation of the Practice Standards. When completing the assessment tool as a peer review, you will ask other workers to complete the tool as an evaluation of your work following the below instructions. You can use the information gathered through the peer review as you complete your action plan.

360-Degree Evaluation
A 360-degree evaluation is a process where you receive confidential and anonymous feedback on your practice and work from others who work around you, including leaders in your organization, your supervisor, and other workers. It's important that a 360-degree evaluation be completed by a variety of your colleagues in different positions. A 360-degree evaluation is a helpful assessment that will provide you with greater insight and understanding of your practice and behaviors, particularly those that relate to the Practice Standards. When completing the assessment tool as a 360-degree evaluation, you will ask leaders, supervisors, workers, and other staff within your organization to complete the tool as an evaluation of your work following the below instructions. You can use the information gathered through the 360-degree evaluation as you complete your action plan.

Instructions
The North Carolina Worker Assessment tool is divided into several sections; there is one section for each corresponding Practice Standard. Each section may be completed in one sitting or completed over time. The assessment should be completed individually, and keep in mind the assessment will be looking at your practice as a whole.
Each core activity within the Practice Standards is broken down into three stages: optimal, developmental, and insufficient. These stages should be used to anchor the ratings in the assessment. Each stage is a steppingstone to the

next allowing you to gradually improve your skill set as a child welfare professional. This assessment will help you, as a learner, identify goals and objectives to begin integrating the Practice Standards into your work.

The assessment is completed by determining which number on the rating scale corresponds best to your own practice behaviors. There is also space to take notes where a rationale for the rating can be added. Each behavior will be rated on a three-point scale: (1) always, (2) sometimes, (3) never.

1. Always: I implement this standard consistently in my own child welfare practice
2. Sometimes: I inconsistently implement this standard in my own child welfare practice
3. Never: I never implement this standard in my own child welfare practice

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North Carolina Worker Assessment: Communicating

Introduction

Communicating is defined as 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.

There are four Communicating core activities: (1) use clear language and checking to assure two-way understanding, (2) using respectful, non-judgmental, and empowering language, (3) operating with transparency, and (4) respecting confidentiality and privacy.

Table 1. Core Activity: Using clear language and checking to assure two-way understanding

Practice Standard 1: Ensure clarity when communicating				
	A	S	N	Notes
I use clear, specific, understandable oral and written communication	(1)	(2)	(3)	
I share important information with families verbally and in writing	(1)	(2)	(3)	
Practice Standard 2: Adapt communication to family needs and preferences, and provide consistent information to all family members who need it				
	A	S	N	Notes
I consider language barriers, preferences, literacy, and tailor communication	(1)	(2)	(3)	
I use preferred gender pronouns	(1)	(2)	(3)	
I attend to the child and family's language and use their words	(1)	(2)	(3)	
I ask families for their communication preferences	(1)	(2)	(3)	
I share appropriate information, provide consistent information	(1)	(2)	(3)	
Practice Standard 3: Allow time to enhance two-way communication with families through questions and checks for understanding				
	A	S	N	Notes

I seek to allow enough time for two-way communication	(1)	(2)	(3)
I inform families of time limits, fully present, schedule follow-up meeting	(1)	(2)	(3)
I actively listen to families, reflect back	(1)	(2)	(3)
I ask questions for deeper understanding	(1)	(2)	(3)
I encourage and respond to questions from families, confirm understanding	(1)	(2)	(3)

Table 2. Using respectful, non-judgmental, and empowering language

Practice Standard 4: Speak with youth and families in a non-judgement, respectful manner				
	A	S	N	Notes
I convey interest and respect through body language	(1)	(2)	(3)	
I use consistently objective, strengths-based language	(1)	(2)	(3)	
I regularly seek out families' feelings, validate them	(1)	(2)	(3)	

Table 3. Operating with transparency and honesty

Practice Standard 5: Clearly and openly express to youth and families what is expected from them and what they can expect from child welfare				
	A	S	N	Notes
I explain the role of child welfare, what to expect, decision points, timeframes	(1)	(2)	(3)	
I fully inform families of options and opportunities, seek options from families	(1)	(2)	(3)	

I follow through with commitments, explain changing circumstances	(1)	(2)	(3)	
I set timeframes for responses to questions, follow through	(1)	(2)	(3)	
I answer questions honestly	(1)	(2)	(3)	
Practice Standard 6: Always tell the truth, including during difficult conversations, in a manner that promotes dialogue				
	A	S	N	Notes
I acknowledge mistakes and misunderstandings	(1)	(2)	(3)	
I acknowledge when information is not known, cannot be shared	(1)	(2)	(3)	
I consistently model transparency and honesty	(1)	(2)	(3)	
I share important information without threatening or attacking, promotes dialogue	(1)	(2)	(3)	

Table 4. Core Activity: Respecting confidentiality and privacy

Practice Standard 7: Diligently respect confidentiality while sharing information when necessary and appropriate				
	A	S	N	Notes
I clarify and follow legal expectations for confidentiality, explain what can be shared	(1)	(2)	(3)	
I follow-up with my supervisor on what can be shared	(1)	(2)	(3)	
I take the release of information process seriously	(1)	(2)	(3)	
I ensure families know their right to revoke release of information	(1)	(2)	(3)	
I anticipate and minimize breaches of confidentiality	(1)	(2)	(3)	

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I understand that families perceive confidentiality as isolating, discuss confidentiality, obtain releases	(1) (2) (3)

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North Carolina Worker Self-Assessment: Engaging

Introduction

Engaging is defined as empowering and motivating families to actively participate with child welfare by communicating openly and honestly with the family, demonstrating respect, and valuing the family's input and preferences. Engagement begins upon first meeting a family and continues throughout child welfare services.

There are three Engaging core activities: (1) Focused attention to understand families, (2) demonstrating interest and empathy for families in verbal and non-verbal behavior, and (3) acknowledging family strengths.

Table 1. Core Activity: Focused attention to understand families

Practice Standard 1: Fully present when meeting with families				
	A	S	N	Notes
I attend to families, ignore other distractions	(1)	(2)	(3)	
I explain notetaking, present and paying attention	(1)	(2)	(3)	
I acknowledge the statements of families	(1)	(2)	(3)	
I am aware of cultural norms and family preferences	(1)	(2)	(3)	
I allow families to finish speaking	(1)	(2)	(3)	
I establish rapport	(1)	(2)	(3)	
Practice Standard 2: Prepares in advance to be able to connect with families				
	A	S	N	Notes
I develop clarifying and follow-up questions	(1)	(2)	(3)	
I prepare questions, is flexible based on meeting dynamics	(1)	(2)	(3)	
I prepare for interactions based on individual needs	(1)	(2)	(3)	

I remember action items for future discussions	(1)	(2)	(3)	
I collaborate with families, brings understanding to all interactions	(1)	(2)	(3)	
I understand, adjust to cultural considerations and preferences	(1)	(2)	(3)	
Practice Standard 3: Considers the family's perspective in all exchanges and actions				
	A	S	N	Notes
I operate with belief that families are experts of their own situation	(1)	(2)	(3)	
I listen and acknowledge families' perspective	(1)	(2)	(3)	
I ask questions to understand	(1)	(2)	(3)	
I treat families as essential partners	(1)	(2)	(3)	
I show respect by including families in planning	(1)	(2)	(3)	
I include families in decision making	(1)	(2)	(3)	
I appropriately build relationships with families from other cultural groups	(1)	(2)	(3)	

Table 2. Core Activity: Demonstrating interest and empathy for families in verbal and non-verbal behavior

Practice Standard 4: Recognizes the family's perspectives and desires				
	A	S	N	Notes
I empower families to feel confident and comfortable	(1)	(2)	(3)	
I provide opportunity for families to co-lead conversation	(1)	(2)	(3)	

I engage with families to check-in after tough situations	(1)	(2)	(3)	
I recognize the power dynamics in uncomfortable situations	(1)	(2)	(3)	
I am open minded	(1)	(2)	(3)	
I engage families in problem solving, encourage ownership	(1)	(2)	(3)	
Practice Standard 5: Use body language to convey interest to families				
	A	**S**	**N**	**Notes**
I maintain eye contact	(1)	(2)	(3)	
I lean in when speaking	(1)	(2)	(3)	
I am mindful of facial expressions and nod my head affirmatively	(1)	(2)	(3)	
I understand culture may play a role in body language	(1)	(2)	(3)	

Table 3. Core Activity: Acknowledging family strengths

Practice Standard 6: Acknowledge and celebrate strengths and successes				
	A	**S**	**N**	**Notes**
I build on small successes and verbally recognize progress	(1)	(2)	(3)	
I am consistently strengths-based and objective	(1)	(2)	(3)	
I identify positives	(1)	(2)	(3)	
I take a holistic approach, focusing on strengths	(1)	(2)	(3)	

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I encourage families to identify their strengths	(1) (2) (3)

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North Carolina Worker Assessment: Assessing

Introduction

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

There are four Assessing core activities: (1) gathering information from children, caretakers, and other family members, (2) gathering and reviewing history, including agency records and other service assessments, (3) gathering information from collateral sources including service providers and persons with relevant knowledge, and (4) using critical thinking to synthesize information, assess what additional information is needed, and inform decision making.

Table 1. Core Activity: Gathering information from children, caretakers, and other family members

Practice Standard 1: Differentiates between information and positions				
	A	S	N	Notes
I moderate information gathering sessions	(1)	(2)	(3)	
I gather information that supports all positions	(1)	(2)	(3)	
I understand my own biases that may cloud positions	(1)	(2)	(3)	
Practice Standard 2: Takes time to get to know families and explain the assessment process				
	A	S	N	Notes
I take time to conversationally gather the family's story	(1)	(2)	(3)	
I use engagement to build family participation in assessment process	(1)	(2)	(3)	
I get a picture of the family's hopes, aspirations, challenges, and worries	(1)	(2)	(3)	
I explain the assessment process, reiterating purpose	(1)	(2)	(3)	
I authentically share with the family about the process	(1)	(2)	(3)	

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I keep in mind the culture of the family when gathering information	(1)	(2)	(3)	

Practice Standard 3: Asks questions based on information needed and at ease asking uncomfortable questions				
	A	S	N	Notes
I ask open-ended, strengths-based questions	(1)	(2)	(3)	
I understand what type of questions elicit the best type of answers	(1)	(2)	(3)	
I have the ability to hear difficult information without reaction	(1)	(2)	(3)	
I engage in crucial conversations	(1)	(2)	(3)	
I utilize a narrative approach to gather perspectives on historical information	(1)	(2)	(3)	

Table 2. Core Activity: Gathering and reviewing history, including agency records and other service assessments

Practice Standard 4: Stays open to different explanations of events in the record, keeping biases in check				
	A	S	N	Notes
I continuously gather information	(1)	(2)	(3)	
I am diligent in pursuing information	(1)	(2)	(3)	
I understand how to factor historical information into current situation	(1)	(2)	(3)	
I keep an open mind	(1)	(2)	(3)	

Practice Standard 5: Balances what is read in the record and what families share				
	A	S	N	Notes
I review information ahead of meeting the family, but ask them to share their perspective	(1)	(2)	(3)	

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I identify in the record what has historically worked well for the family	(1)	(2)	(3)
I have an understanding of what biases I hold when reviewing history	(1)	(2)	(3)

Table 3. Core Activity: Gathering information from collateral sources including service providers and persons with relevant knowledge

Practice Standard 6: Obtains all sides if there are differing positions among collaterals, engaging families in the process				
	A	S	N	Notes
I seek out wide number of collaterals and balance collateral sources	(1)	(2)	(3)	
I obtain information from as many collaterals as time permits	(1)	(2)	(3)	
I consider all relevant collateral sources	(1)	(2)	(3)	
I am honest with families when I must reach out to collaterals the family is unhappy with and explain why	(1)	(2)	(3)	
I let the family help identify collaterals and ask their permission before contacting	(1)	(2)	(3)	

Table 4. Core Activity: Using critical thinking to synthesize information, assess what additional information is needed, and inform decision making

Practice Standard 7: Synthesizes information and considers sources, prioritization, and timelines				
	A	S	N	Notes
I continually gather information	(1)	(2)	(3)	
I understand assessment is ongoing process in determining needs	(1)	(2)	(3)	
I rank information received based on relevance and priority	(1)	(2)	(3)	

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I prioritize information that negatively impacts children to address first	(1)	(2)	(3)	
Practice Standard 8: Remains non-judgmental when processing information				
	A	S	N	Notes
I am inquisitive from the beginning of assessment process	(1)	(2)	(3)	
I understand the family's community as they define it	(1)	(2)	(3)	
I operate with cultural humility	(1)	(2)	(3)	
I persevere in gathering information, follow the information	(1)	(2)	(3)	
I understand not all information is relevant	(1)	(2)	(3)	
I normalize reactions family has to information and assessment results	(1)	(2)	(3)	
I understand fight, flight, or freeze response	(1)	(2)	(3)	

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North Carolina Worker Assessment: Planning

Introduction

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

There are Four Planning core activities: (1) synthesizing and integrating current and previous assessment information and family history to inform plans, (2) preparing families for the teaming/planning process, (3) conducting child and family team meetings with children, youth, and families, and (4) completing and revising behaviorally based case plans.

Table 1. Core Activity: Synthesizing and integrating current and previous assessment information and family history to inform plans

Practice Standard 1: Engages family in understanding assessment and history, focusing on strengths to customize plans				
	A	S	N	Notes
I transparently share assessments with families	(1)	(2)	(3)	
I see family input into what has and hasn't worked in the past, apply information	(1)	(2)	(3)	
I partner with families owning their plan, creating buy-in	(1)	(2)	(3)	
Practice Standard 2: Discovers root causes and underlying reasons for family involvement				
	A	S	N	Notes
I seek input from others with knowledge of family history, keep an open mind	(1)	(2)	(3)	
I focus plan on identified needs, tied to assessment	(1)	(2)	(3)	
I ask questions and seek information to help families understand root cause	(1)	(2)	(3)	
I discuss DSS concerns with family, get feedback	(1)	(2)	(3)	

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Table 2. Core Activity: Preparing families for the teaming/planning process

Practice Standard 3: Believes and practices the importance of preparation, both for self and for the family, for teaming and planning				
	A	S	N	Notes
I come to meeting prepared based on review of information	(1)	(2)	(3)	
I prepare families for meetings ahead of time, providing copies of documents	(1)	(2)	(3)	
I consider adjustments to better accommodate families	(1)	(2)	(3)	
I ensure families understand CFTs are their meetings, explains rights	(1)	(2)	(3)	
I ask families who they would like to invite to meetings	(1)	(2)	(3)	
I ask families what they want to accomplish during meetings	(1)	(2)	(3)	
Practice Standard 4: Actively engages family in identifying their team				
	A	S	N	Notes
I explain to families the purpose of teams, role they play	(1)	(2)	(3)	
I explore ways to involve children in CFT	(1)	(2)	(3)	
I work with families to identify supports, encourage families to invite to meetings	(1)	(2)	(3)	
I explain why having support is important	(1)	(2)	(3)	
I creatively explore and troubleshoot with families past supports	(1)	(2)	(3)	

Table 3. Core Activity: Conducting child and family team meetings with children, youth, and families

Practice Standard 5: Promotes family voice as the cornerstone of the meeting

	A	S	N	Notes
I encourage families to start meetings sharing strengths or concerns	(1)	(2)	(3)	
I encourage children and youth to participate	(1)	(2)	(3)	
I reinforce strengths of families through meeting, share protective capacity examples	(1)	(2)	(3)	
I provide families options about aspects of meetings to engage families	(1)	(2)	(3)	
Practice Standard 6: Facilitates and engages participants throughout, acknowledging and managing conflict				
	A	S	N	Notes
I set and reinforce boundaries and expectations throughout meetings	(1)	(2)	(3)	
I make sure all voices are heard and expressed during meetings	(1)	(2)	(3)	
I show empathy and acknowledge how distressing situation may be, provide support	(1)	(2)	(3)	
I am clear on concerns, ask families to identify solutions	(1)	(2)	(3)	
I diffuse situations when conversations escalate	(1)	(2)	(3)	
I manage emotions in the room well	(1)	(2)	(3)	

Table 4. Core Activity: Completing and revising behaviorally based case plans.

Practice Standard 7: Actively involves families in developing behavioral based case plans				
	A	S	N	Notes
I co-create plans that are flexible and individualized	(1)	(2)	(3)	

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I invite families to identify issues they want to change, include in plan	(1)	(2)	(3)	
I utilize harm and danger statements to identify safety issues	(1)	(2)	(3)	
I plan with families not for or about families	(1)	(2)	(3)	
I structure plan around behaviors desired to change, not completion of programs	(1)	(2)	(3)	
I prioritize tasks in plans and break down tasks into manageable steps	(1)	(2)	(3)	
Practice Standard 8: Revisits the case plan regularly, willing to modify or update as needed, but at a minimum per policy				
	A	S	N	Notes
I bring subject of case plan into every conversation	(1)	(2)	(3)	
I ensure families have a copy of their case plan	(1)	(2)	(3)	
I update plans with every success to show progress, keep families motivated	(1)	(2)	(3)	

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North Carolina Worker Assessment: Implementing

Introduction

Implementing is defined as 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.

There are three Implementing core activities: (1) supporting families to take actions agreed upon in the plan and connecting families to services and community support, (2) collaborating with providers and informal supports in the community to help families achieve desired outcomes, and (3) coaching with families and partnering with providers to assure plans are being implemented, progress is made, and outcomes achieved.

Table 1. Core Activity: Supporting families to take actions agreed upon in the plan and connecting families to services and community support

Practice Standard 1: Supports families to take actions				
	A	S	N	Notes
I prioritize the family's availability and convenience when providing support	(1)	(2)	(3)	
I offer to call or link families to providers as a first step	(1)	(2)	(3)	
I show families through actions and words that I am interested in their success	(1)	(2)	(3)	
Practice Standard 2: Works with families to find solutions to challenges				
	A	S	N	Notes
I ask questions tailored to individual family needs to identify challenges to engaging in services	(1)	(2)	(3)	
I ask families what their concerns about services and service delivery	(1)	(2)	(3)	
I advocate for families and help them navigate the system	(1)	(2)	(3)	
I ensure families are participating in the amount of services they can handle	(1)	(2)	(3)	
I support families in their service prioritization	(1)	(2)	(3)	

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Practice Standard 3: Explains to families what services are and what they could do for the family to provide information and informed decisions				
	A	S	N	Notes
I engage families in conversation about purpose of recommended service	(1)	(2)	(3)	
I check-in for families' understanding of services purpose on ongoing basis	(1)	(2)	(3)	
I provide families with contact information for service providers	(1)	(2)	(3)	
I make suggestions on the frequency families should follow-up with providers	(1)	(2)	(3)	
I ensure recommended services are behaviorally specific, not duplicative	(1)	(2)	(3)	
I seek to understand and empathize families' concerns related to services	(1)	(2)	(3)	
Practice Standard 4: Offers an array of service providers to choose from if there are choices to be had				
	A	S	N	Notes
I identify resources available and provide information to families	(1)	(2)	(3)	
I offer to think with the families as they decide on service providers	(1)	(2)	(3)	
I point out service providers based on knowledge of families' history	(1)	(2)	(3)	

Table 2. Core Activity: Collaborating with providers and informal supports in the community to help families achieve desired outcomes

Practice Standard 5: Advocates with and for families with providers on what behavioral change is expected to ensure quality service delivery				
	A	S	N	Notes
I communicate with providers and families about agreed upon behavioral changes being sough	(1)	(2)	(3)	

I share with providers relevant assessment and case plan information	(1)	(2)	(3)	
I provide feedback to providers, ask questions about services	(1)	(2)	(3)	
I regularly check-in, monitor service delivery	(1)	(2)	(3)	
I escalate problems to my supervisor	(1)	(2)	(3)	
I understand what treatment being provided, what is expected, and evidence of results	(1)	(2)	(3)	
I ensure services delivered are tailored to meet families' needs	(1)	(2)	(3)	
Practice Standard 6: Accesses natural supports in the community to assist families to achieve their goals				
	A	S	N	Notes
I engage families to identify community supports	(1)	(2)	(3)	
I educate families regarding how to access community resources	(1)	(2)	(3)	
I encourage families to reach out to other systems	(1)	(2)	(3)	
I facilitate meetings between families and support systems	(1)	(2)	(3)	

Table 3. Core Activity: Coaching with families and partnering with providers to assure plans are being implemented, progress is made, and outcomes achieved

Practice Standard 7: Checks-in on an ongoing basis with families on progress with the Family Service Agreement				
	A	S	N	Notes
I routinely ask families if services are good match	(1)	(2)	(3)	
I provide families feedback if they are or are not making efforts	(1)	(2)	(3)	

I follow-up with families when appointments missed to identify challenges	(1)	(2)	(3)	
I problem solve with families to find solutions to challenges	(1)	(2)	(3)	
I reassess barriers once services begun	(1)	(2)	(3)	
Practice Standard 8: Assesses progress in implementing actions of plan, making adjustments as needed				
	A	S	N	Notes
I work with families to identify when changes needed in service delivery	(1)	(2)	(3)	
I troubleshoot when goals not achieved to determine root cause	(1)	(2)	(3)	
I engage collaterals about progress made and additional service needs	(1)	(2)	(3)	
I make changes in actions in plan when necessary, not when convenient	(1)	(2)	(3)	
I celebrate wins when goals achieved	(1)	(2)	(3)	
Practice Standard 9: Tracks service delivery for achievement of safety, permanency, and well-being outcomes for the family				
	A	S	N	Notes
I routinely check-in with service providers on progress	(1)	(2)	(3)	
I assess successful completion of service in connection with desired behavior change	(1)	(2)	(3)	
I consider the long-term outcomes when determining achievement of outcomes	(1)	(2)	(3)	

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North Carolina Worker Action Plan

Action Planning

This Action Plan will help you identify the specific actions you plan to take to implement the behaviors of the Practice Standards into your work. While you complete the Action Plan, pay particular attention to the behaviors noted as happening 'sometimes' or 'never' and identify specific actions to address these areas.

	Practice Standard Behavior	As a result of what I learned through this assessment, I am going to…	I will know I am succeeding with this objective when…
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Solution-Focused Interviewing Skills and Questions

Open Ended Questions	
Questions that encourage the client to use their own words and to elaborate on a topic.	• Can you tell me about your relationship with your parents? • Tell me about your parenting experience. • Who are your supports and how do they help you? • Note: identify and reflect to clients any strengths or positive qualities clients may reveal in their responses to the open-ended questions.
Summarizing	
Periodically state back to the client his/her thoughts, actions, and feelings.	• So, what I hear you saying is… • If I understand you correctly, you are saying that... • So, what you are saying is... • Right?
Tolerating/Using Silence	
Allow 10, 15, 20 seconds or so to allow clients to come up with their own responses. Avoid the temptation to fill in silence with advice.	
Complimenting	
Acknowledging client strengths and past success.	• As you were talking, I noticed that you have many strengths. You have... • In the past, you have had successes evident by your ability to....
Affirming Client's Perception	
Perception is some aspect of a person's self-awareness or awareness of their life. They include a person's thoughts, feelings, behaviors, and experiences. Affirmation of the client's perceptions is similar to reflective listening in form but does not isolate and focus on the feeling component per se, but on the client's larger awareness.	• That is very smart of you, let's explore this further... • You have a high-level of self-awareness, how would you like to use this information to move forward....
Working with Client's Negative or Inaccurate Perceptions	
Perceptions, even negative ones like suicide or assaultive behaviors, should be explored to understand the full context. Some perceptions may be obviously inaccurate and reflect a person's denial of a problem. Avoid an immediate educative or dissuading response to negative or inaccurate perceptions.	• What's happening in your life that tells you that hitting or suicide might be helpful in this situation? • How does it feel to say, "I don't want to do this anymore?" • How might your life be different if you did hit him? • What are the pros and cons of your reaction?

Listening and understanding are the social worker's first obligations.	
Returning the Focus to the Client	
Clients tend to focus on the problem and/or what they would like others to do differently. In the Solution-Focused approach, the client is encouraged to return the focus to themselves and to possible solutions	• "My kids are lazy. They don't realize that I need help sometimes." Response: "What gives you hope that this problem can be solved?" • "I wish my parents would get with it. A 10:00 pm curfew on weekends is ridiculous." Response: "When things are going better, what will your parents notice you doing differently?" • "My teachers are too hard. If they would back off all the homework and give more help my grades would improve." Response: "What is it going to take to make things even a little bit better?" • "If my boss would stop criticizing me and treating me like a child, I could be more productive." Response: "If your boss was here and I asked him what you could do differently to make it just a little easier for him not to be so critical, what do you think he would say?"
Exception Questions	
Exception questions help clients think about times when their problems could have occurred but did not – or at least were less severe. Exception questions focus on who, what, when, and where (the conditions that helped the exception to occur) - NOT WHY; should be related to client goals.	• Are there times when the problem does not happen or is less serious? When? How does this happen? • Have there been times in the last couple of weeks when the problem did not happen or was less severe? • How was it that you were able to make this exception happen? • What was different about that day? • If your friend (teacher, relative, spouse, partner, etc.) were here and I were to ask him what he noticed you doing differently on that day, what would he say? What else?
Coping Questions	
Coping questions attempt to help the client shift his/her focus away from the problem elements and toward what the client is doing to survive the painful or stressful circumstances. They are related in a way to exploring for exceptions.	• What have you found that is helpful in managing this situation? • Considering how depressed and overwhelmed you feel, how is it that you were able to get out of bed this morning and make it to our appointment (or make it to work)? • You say that you're not sure that you want to continue working on your goals. What is it that has helped you to work on them up to now?

Scaling Questions	
Scaling questions invite clients to put their observations, impressions, and predictions on a scale from 0 to 10, with 0 being no chance, and 10 being every chance. Questions need to be specific, citing specific times and circumstances.	• On a scale of 0 to 10, with 0 being not serious at all and 10 being the most serious, how serious do you think the problem is now? • On a scale of 0 to 10, what number would it take for you to consider the problem to be sufficiently solved? • On a scale of 0 to 10, with 0 being no confidence and 10 being very confident, how confident are you that this problem can be solved? • On a scale of 0 to 10, with 0 being no chance and 10 being every chance, how likely is it that you will be able to say “No” to your boyfriend when he offers you drugs? • What would it take for you to increase, by just one point, your likelihood of saying “No”? • What’s the most important thing you have to do to keep things at a 7 or 8?
Indirect Relationship Questions	
Indirect questions invite the client to consider how others might feel or respond to some aspect of the client’s life, behavior, or future changes. Indirect questions can be useful in asking the client to reflect on narrow or faulty perceptions without the worker directly challenging those perceptions or behaviors.	• How is it that someone might think that you are neglecting or mistreating your children? • Has anyone ever told you that they think you have a drinking problem? • If your children were here (and could talk, if the children are infants or toddlers), what might they say about how they feel when you and your wife have one of those serious arguments? • At the upcoming court hearing, what changes do you think the judge will expect from you to consider returning your children? • How do you think your children (spouse, relative, caseworker, employer) will react when you make the changes we talked about?

Miracle Questions	
The Miracle Question is a special type of preferred future question that can help people get clarity on how the problem impacts their daily life and what life would look like without the problem happening.	• Imagine you woke up tomorrow and a miracle had happened overnight, and all the trouble was gone. How would you know it was over? What would be different that would tell you the problem was no longer happening? What is the first thing you would be doing to start the day? What would the rest of your day look like? What would things look like for your children? • If you could wave a magic wand and things were different, what would that new state of being look like? What would it take to get there without the magic wand?

Words Matter

NIDAMED

Words Matter
Terms to Use and Avoid When Talking About Addiction

This handout offers background information and tips for providers to keep in mind while using person-first language, as well as terms to avoid to **reduce stigma** and **negative bias when discussing addiction**. Although some language that may be considered stigmatizing is commonly used within social communities of people who struggle with substance use disorder (SUD), clinicians can show leadership in how language can destigmatize the disease of addiction.

Stigma and Addiction

What is stigma?

Stigma is a discrimination against an identifiable group of people, a place, or a nation. Stigma about people with SUD might include inaccurate or unfounded thoughts like they are dangerous, incapable of managing treatment, or at fault for their condition.

Where does stigma come from?

For people with SUD, stigma may stem from antiquated and inaccurate beliefs that addiction is a moral failing, instead of what we know it to be—a chronic, treatable disease from which patients can recover and continue to lead healthy lives.

How does stigma affect people with SUD?

- Feeling stigmatized can reduce the willingness of individuals with SUD to seek treatment.[1,2]
- Stigmatizing views of people with SUD are common; this stereotyping can lead others to feel pity, fear, anger, and a desire for social distance from people with SUD.[2]
- Stigmatizing language can negatively influence health care provider perceptions of people with SUD, which can impact the care they provide.[3]

How can we change stigmatizing behavior?

- When talking to people with SUD, their loved ones, and your colleagues, use non-stigmatizing language that reflects an accurate, science-based understanding of SUD and is consistent with your professional role.
- Because clinicians are typically the first points of contact for a person with SUD, health professionals should "take all steps necessary to reduce the potential for stigma and negative bias."[3] Take the first step by learning the terms to avoid and use.
- Use person-first language and let individuals choose how they are described.[4] Person-first language maintains the integrity of individuals as whole human beings—by removing language that equates people to their condition or has negative connotations.[5] For example, "person with a substance use disorder" has a neutral tone and distinguishes the person from his or her diagnosis.[6]

What else should I keep in mind?

It is recommended that "substance use" be used to describe all substances, including alcohol and other drugs, and that clinicians refer to severity specifiers (e.g., mild, moderate, severe) to indicate the severity of the SUD. This language also supports documentation of accurate clinical assessment and development of effective treatment plans.[7] When talking about treatment plans with people with SUD and their loved ones, be sure to use evidence-based language instead of referring to treatment as an intervention.

Visit **NIDAMED** for resources at **drugabuse.gov/nidamed**

NIH National Institute on Drug Abuse

Terms to Avoid, Terms to Use, and Why

Consider using these recommended terms to reduce stigma and negative bias when talking about addiction.

Instead of...	Use...	Because...
• Addict • User • Substance or drug abuser • Junkie • Alcoholic • Drunk • Former addict • Reformed addict	• Person with substance use disorder[8] • Person with opioid use disorder (OUD) or person with opioid addiction [when substance in use is opioids] • Patient • Person with alcohol use disorder • Person who misuses alcohol/engages in unhealthy/hazardous alcohol use • Person in recovery or long-term recovery • Person who previously used drugs	• Person-first language. • The change shows that a person "has" a problem, rather than "is" the problem.[7] • The terms avoid eliciting negative associations, punitive attitudes, and individual blame.[7]
• Habit	• Substance use disorder • Drug addiction	• Inaccurately implies that a person is choosing to use substances or can choose to stop.[6] • "Habit" may undermine the seriousness of the disease.
• Abuse	**For illicit drugs:** • Use **For prescription medications:** • Misuse • Used other than prescribed	• The term "abuse" was found to have a high association with negative judgments and punishment.[9] • Legitimate use of prescription medications is limited to their use as prescribed by the person to whom they are prescribed. Consumption outside these parameters is misuse.
• Opioid substitution replacement therapy • Medication-assisted Treatment (MAT)	• Opioid agonist therapy • Medication treatment for OUD • Pharmacotherapy • Medication for a substance use disorder • Medication for opioid use disorder (MOUD)	• It is a misconception that medications merely "substitute" one drug or "one addiction" for another.[6] • The term MAT implies that medication should have a supplemental or temporary role in treatment. Using "MOUD" aligns with the way other psychiatric medications are understood (e.g., antidepressants, antipsychotics), as critical tools that are central to a patient's treatment plan.
• Clean	**For toxicology screen results:** • Testing negative **For non-toxicology purposes:** • Being in remission or recovery • Abstinent from drugs • Not drinking or taking drugs • Not currently or actively using drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.[10] • Set an example with your own language when treating patients who might use stigmatizing slang. • Use of such terms may evoke negative and punitive implicit cognitions.[7]
• Dirty	**For toxicology screen results:** • Testing positive **For non-toxicology purposes:** • Person who uses drugs	• Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.[10] • May decrease patients' sense of hope and self-efficacy for change.[7]
• Addicted baby	• Baby born to mother who used drugs while pregnant • Baby with signs of withdrawal from prenatal drug exposure • Baby with neonatal opioid withdrawal/ neonatal abstinence syndrome • Newborn exposed to substances	• Babies cannot be born with addiction because addiction is a behavioral disorder—they are simply born manifesting a withdrawal syndrome. • Use clinically accurate, non-stigmatizing terminology the same way it would be used for other medical conditions.[10] • Using person-first language can reduce stigma.

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June 21, 2021

Observation and Feedback Quick Tips

Observation Quick Tips:

- Clear your mind and practice area of distractions
- Listen and observe intently and with purpose
- Look for strengths and opportunities for growth

Feedback Quick Tips:

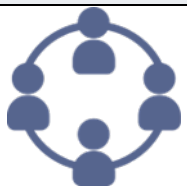
- Ask your partner what they felt most comfortable doing and what was more difficult for them.
- Actively listen to your partner.
- Provide feedback building upon their self-assessment.
- Be clear, concise, and behaviorally specific.
- Be open and honest.
- Start by identifying their strengths.
- Provide feedback on opportunities for improvement.
- Maintain their self-esteem without diminishing attention to the opportunities.
- Provide tips and suggestions.
- Guide them in brainstorming and selecting the next steps.

Note: Apply SMART principles of Specific, Measurable, Achievable, Realistic, and Timely with feedback.

Receiving Feedback Quick Tips:

- Be open.
- Understand that growth is a constant process.
- We all learn from each other no matter what our role.
- Accept positive feedback.
- Have grace for yourself.
- The classroom is a safe place to practice and make mistakes.
- Strategize the next steps.
- Be clear about what works for you and what doesn't in the learning process so the next steps are tailored to your needs.

Record of Reflections and Values

Reflection and End of Day Values Sheet		
		
Self-Values Reflection	Reasonable Efforts	Two Level Decision-Making

Reflection and End of Day Values Sheet		
		
Self-Values Reflection	Reasonable Efforts	Two Level Decision-Making