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

Foundation Participant's Workbook

November 2023

PUBLIC KNOWLEDGE®
YOUR CATALYST FOR CHANGE

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

info@pubknow.com
(800) 776-4229

This curriculum was developed by the North Carolina Department of Health and Human Services, Division of Social Services and revised by Public Knowledge® in 2022 and 2023.

Content in this training was created specifically for child welfare professionals in response to the Administration for Children and Families (ACF) policy regarding the integration of principles of equity, inclusion and diversity into the policies, practices, and training of child welfare workers by the North Carolina Department of Health and Human Services.

The training workshops are interactive in nature, and the focus is on practical knowledge and skills that participants can apply within the workplace while respecting the dignity of others, acknowledging the right of others to express differing opinions, and the right to freedom of speech and association.

The training is not intended to, and should not be understood to, solicit or require an employee to endorse or opine about beliefs, affiliations, ideals, or principles regarding matters of contemporary political debate or social action as a condition of employment and are not intended to, and should not be understood to, solicit or require an employee or applicant to describe their actions in support of, or in opposition to, those beliefs, affiliations, ideals, or principles.

Table of Contents

Instructions

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

Foundation Training

- Pre-Work e-Learning
- Introduction to the Child Welfare System
- Identification of Child Abuse and Neglect
- Introduction to Child Development
- Historical and Legal Basis of Child Welfare Services
- Ethics and Equity in Child Welfare
- Key Issues in Child Welfare: Substance Use, Family Violence, and Mental Health
- Overview of Trauma-Informed Practice

Core Training

- Pre-Work e-Learning
- Child Welfare Overview: Roles and Responsibilities
- Introductory Learning Lab
- Diversity, Equity, Inclusion, and Bias
- Indian Child Welfare Act (ICWA)
- Engaging Families Through Family-Centered Practice
- Engaging Families Learning Lab
- Quality Contacts
- Overview of Child Welfare Processes: Intake and CPS Assessments
- Intake and CPS Assessments Learning Lab
- Overview of Child Welfare Processes: In-Home Services
- In-Home Services Learning
- Overview of Child Welfare Processes: Permanency Planning Services
- Permanency Planning Services Learning Lab
- Key Factors Impacting Families and Engaging Communities
- Documentation

- Documentation Learning Lab
- Self-Care and Worker Safety

Training Overview

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

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

Pre-Work Online e-Learning Modules
There is required pre-work for the North Carolina Child Welfare Pre-Service Training in the form of online e-Learning modules. Completion of the e-Learnings is required prior to attendance at the classroom-based training. The following are the online e-Learning modules:

1. Introduction to North Carolina Child Welfare Script
2. Child Welfare Process Overview
3. Introduction to Human Development
4. Maslow's Hierarchy of Needs
5. History of Social Work and Child Welfare Legislation
6. North Carolina Worker Practice Standards

Foundation Training
Foundation Training is instructor-led training for child welfare new hires that do not have a social work or child welfare-related degree. Staff with a background, degree, or experience in child welfare or a social work-related field are exempt from Foundation Training. The purpose of this training is to provide a foundation and introduction to social work and child welfare. After completing Foundation training, new hires will continue their training and job preparation with Core Training. Foundation Training is 28 hours (4 days) in length.

Core Training
Core Training is required for all new child welfare staff, regardless of degree or experience. This course will provide an overview of the roles and responsibilities of a child welfare social worker in North Carolina, including working with families throughout their involvement with the child welfare system. The course will provide opportunities for skills-based learning labs. Core Training includes 126 hours (18 days) of classroom-based training, completed over six consecutive weeks.

Throughout the pre-service training, learners may have required homework assignments to be completed within prescribed timeframes.

In addition to classroom-based learning, learners will be provided with on-the-job training at their DSS agencies. During on-the-job training, supervisors will provide support to new hires through the completion of an observation tool, coaching, and during supervisory consultation.

Transfer of Learning
Transfer of learning means that learners apply the knowledge and skills they learned during the training back to their daily child welfare work at their DSS agencies. During the pre-service training, learners will complete a transfer of learning tool at various points:

- Pre-training
- During training
- Post-training

The transfer of learning tool will enable learners to create a specific action plan they can use to implement the training content on the job. A key component of successful child welfare practice is the involvement of supervisors in the reinforcement of new knowledge and skills. Supervisors will assist new workers in the completion and review of their transfer of learning tool and will support workers to apply what they have learned in training to their child welfare roles and responsibilities through action planning. Completion of the transfer of learning tool is required to complete the training course.

Training Evaluations
At the conclusion of each week of training, learners will complete a training evaluation tool to measure satisfaction with training content and methods. The training evaluation tool is required to complete the training course. Training evaluations will be evaluated and assessed to determine the need for revisions to the training curriculum.

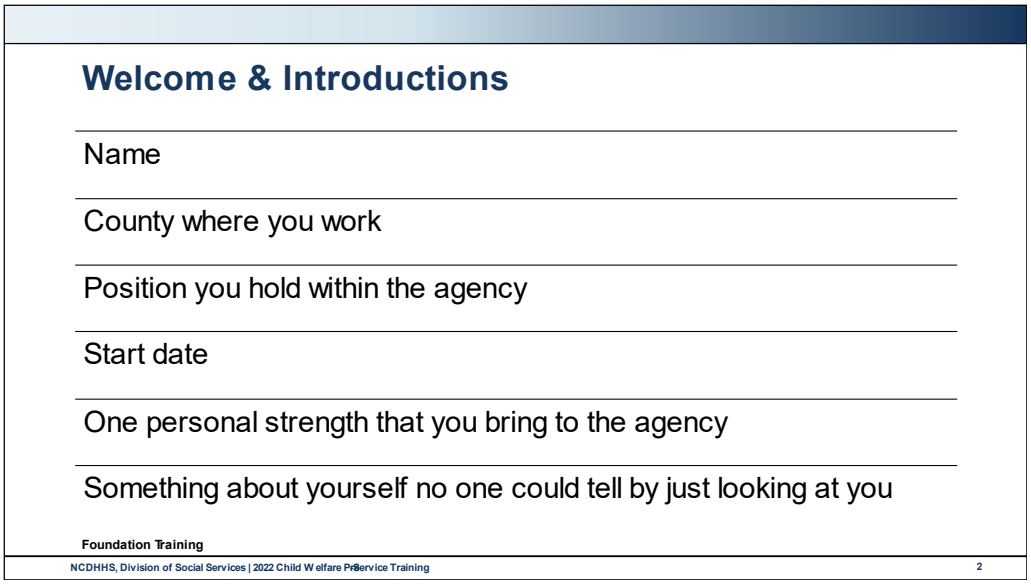
All matters as stated above are subject to change due to unforeseen circumstances and with approval.

Day One Agenda

Pre-Service Training: Child Welfare in North Carolina

I.	Welcome & Learning Objectives	9:00 - 9:50
	Introduction to the Child Welfare System	
II.	Goals of the Child Welfare System	9:50 – 10:15
	BREAK	**10:15 – 10:30**
III.	Goals of the Child Welfare System (continued)	10:30 - 11:05
IV.	Who Makes Up the Child Welfare System	11:10 – 12:00
	LUNCH	**12:00 – 1:00**
V.	Who Makes Up the Child Welfare System (continued)	1:00 – 1:15
	Identification of Child Abuse and Neglect	
VI.	What Is Child Maltreatment?	1:15 -2:00
	BREAK	**2:00 – 2:05**
VII.	What is Child Maltreatment (continued)	2:05 – 2:30
	BREAK	**2:30 – 2:45**
VIII.	What is Child Maltreatment (continued)	2:45 – 3:25
IX.	What is Neglect?	3:25 – 3:35
	Self-Care Exercise	3:35 – 4:00

Welcome & Introductions



Use this outlined space to record notes from the introduction activity.

Introduction to the Child Welfare System

Learning Objectives

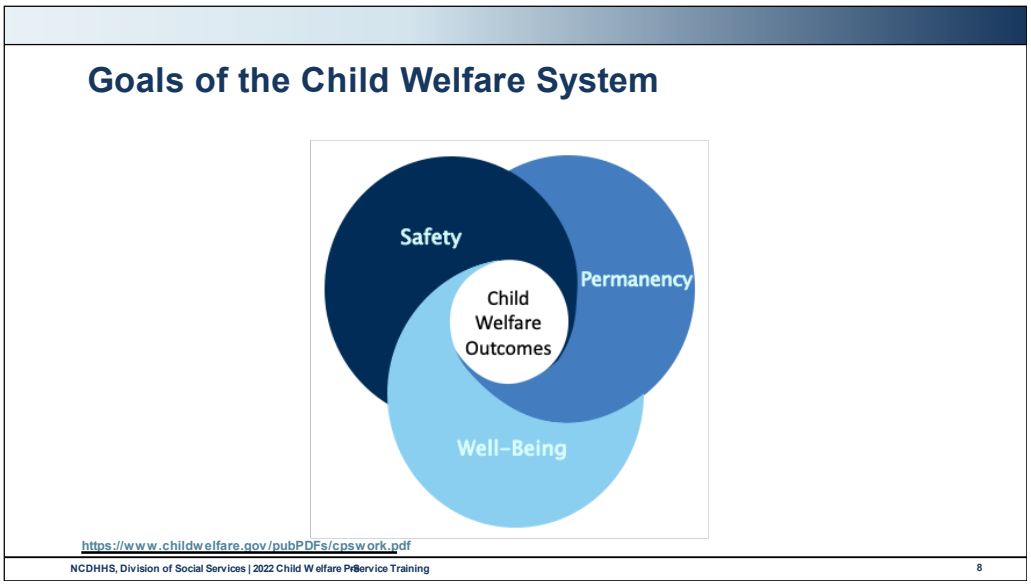
• Describe safety, permanency, and well-being, and why they are vital to child welfare
• Outline the goals of the child welfare system
• Explain the relationship between safety, permanency, and well-being, and how each informs case decisions
• Explain the various aspects of the child welfare system and how they interact
• Identify local resources and internal and external stakeholders
• Identify and describe their role and purpose in the child welfare system

Goals of the Child Welfare System

Video: Centering Families

Visit: Raven Sigure, 2019 Casey Excellence for Children Birth Mother Award Winner - YouTube **for a video demonstrating the direct impact our work has on families.**

Use this space to record notes.



The goal of child welfare is to promote the safety, permanency, and well-being of children and families by helping families care for their children successfully or, when that is not possible, helping children find permanency with kin or adoptive families.

Safety, permanency, and well-being are outcomes that local DSS agencies, the state, and federal government measure to ensure our work is effective in supporting families.

Video: Voices of Experience

Visit: Voice of Youth: Supporting Adolescents in Foster Care (1 of 8) - YouTube

As you are listening to their stories, think about how their experiences relate to safety, permanency, and well-being.

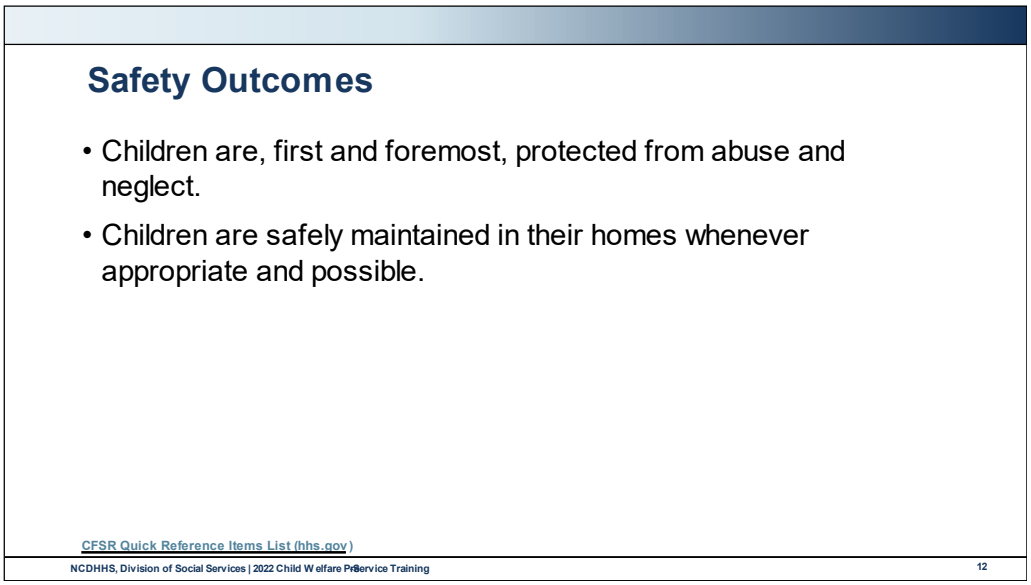
Use this space to record notes.

Debrief

How do you think the experiences shared by the youth in the video impacted their safety, permanency, and well-being?

Use this space to record notes.

Safety Outcomes

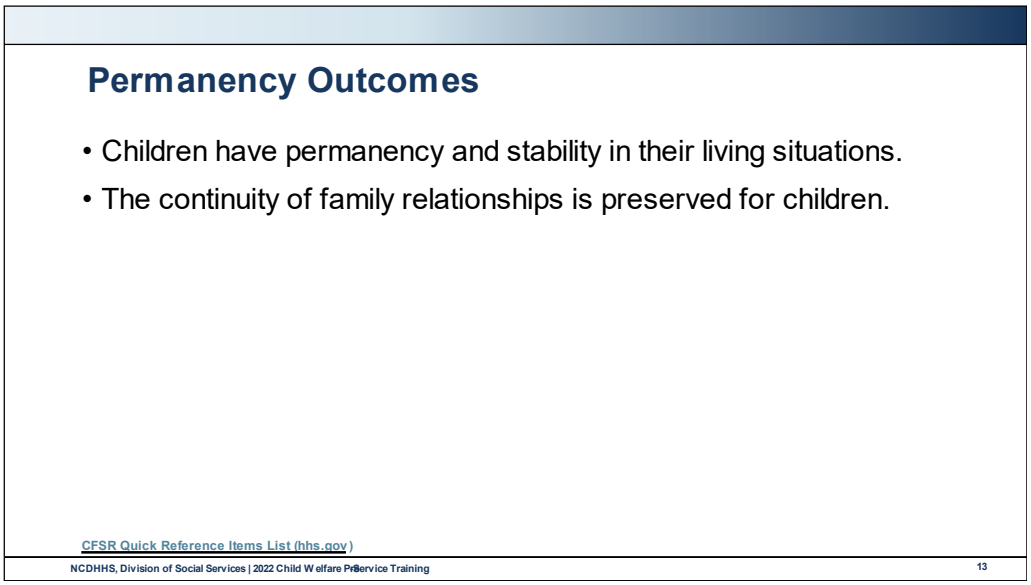


As we review the outcomes in more depth, consider two things:

1. **How will you support these outcomes in your role as a social worker – for example, what case management activities might you do to support safety, permanency, and well-being?**

2. **How might children and families you are working with experience their involvement in the child welfare system? How can you engage them in a family-centered way to achieve the outcomes they want?**

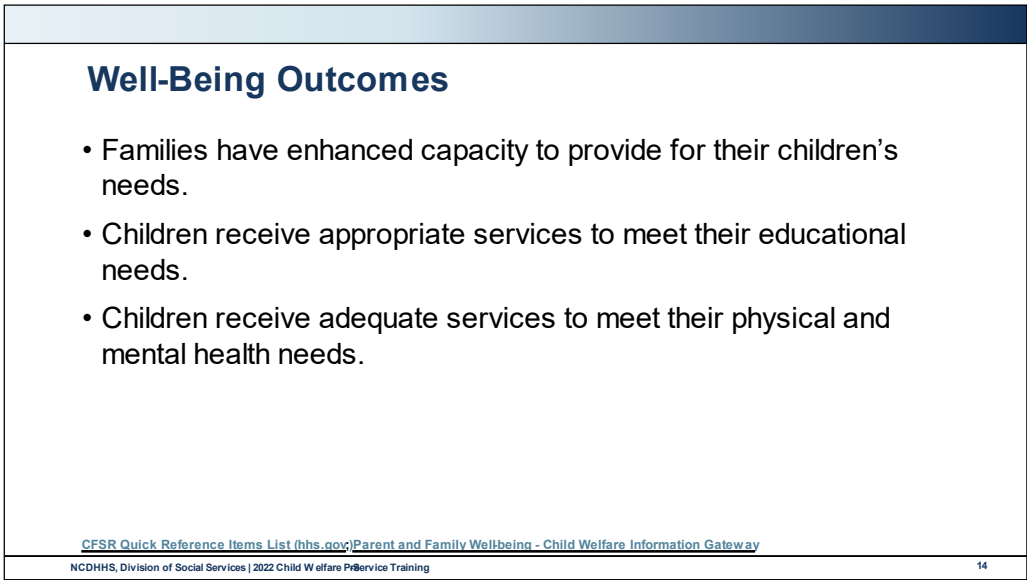
Permanency Outcomes



1. **How will you support these outcomes in your role as a social worker – for example, what case management activities might you do to support safety, permanency, and well-being?**

2. **How might children and families you are working with experience their involvement in the child welfare system? How can you engage them in a family-centered way to achieve the outcomes they want?**

Well-Being Outcomes



1. **How will you support these outcomes in your role as a social worker – for example, what case management activities might you do to support safety, permanency, and well-being?**

2. **How might children and families you are working with experience their involvement in the child welfare system? How can you engage them in a family-centered way to achieve the outcomes they want?**

Handout: Child and Family Services Review (CFSR)

CFSR Quick Reference Items List

OUTCOMES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Item 11: Did the agency make concerted efforts to promote, support, and/or maintain **positive relationships between the child in foster care and his or her mother and father** or other primary caregivers from whom the child had been removed through activities other than just arranging for visitation?

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

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

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

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

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

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

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

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

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

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

SYSTEMIC FACTORS

Statewide Information System

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

Case Review System

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

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

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

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

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

Quality Assurance System

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

Staff and Provider Training

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

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

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

Service Array and Resource Development

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

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

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

Agency Responsiveness to the Community

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

concerns of these representatives in the goals, objectives, and annual updates of the CFSP?

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

Foster and Adoptive Parent Licensing, Recruitment, and Retention

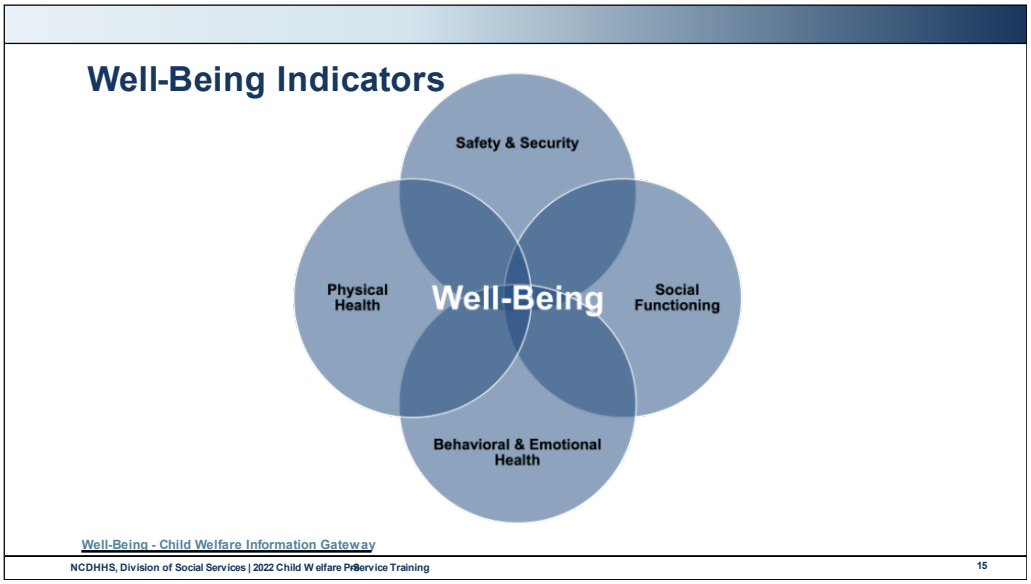
Item 33: How well is the foster and adoptive parent licensing, recruitment, and retention system functioning statewide to ensure that **state standards** are applied to all licensed or approved foster family homes or child care institutions receiving title IV-B or IV-E funds?

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

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

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

Well-Being Indicators



The indicators of well-being are:

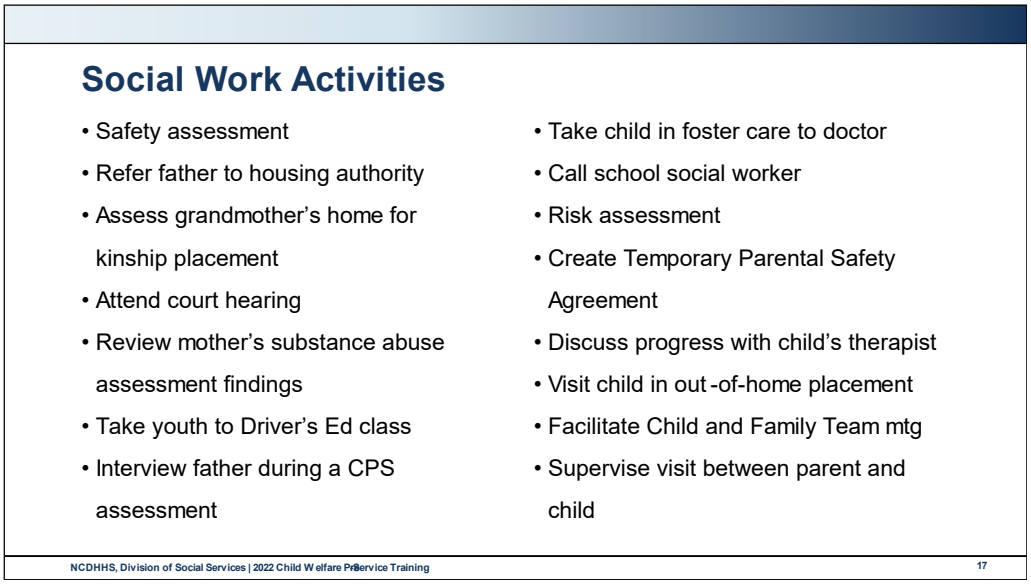
- Physical health and development.
- Safety and security, which includes housing; income and the ability to meet the basic needs.
- Social functioning and relationships, which includes relationships, community, and support networks
- Behavioral and Emotional health

Group Discussion:

Examples of factors that may influence well-being domains negatively:

Examples of factors that may influence well-being domains positively:

Activity: Social Worker Roles



Review the social work activities listed on the slide and write down the ones you think support your assigned group's outcome in the corresponding section below.

Safety:

Permanency:

Well-Being:

Debrief

Identify areas where there was overlap. How are safety, permanency, and well-being all related?

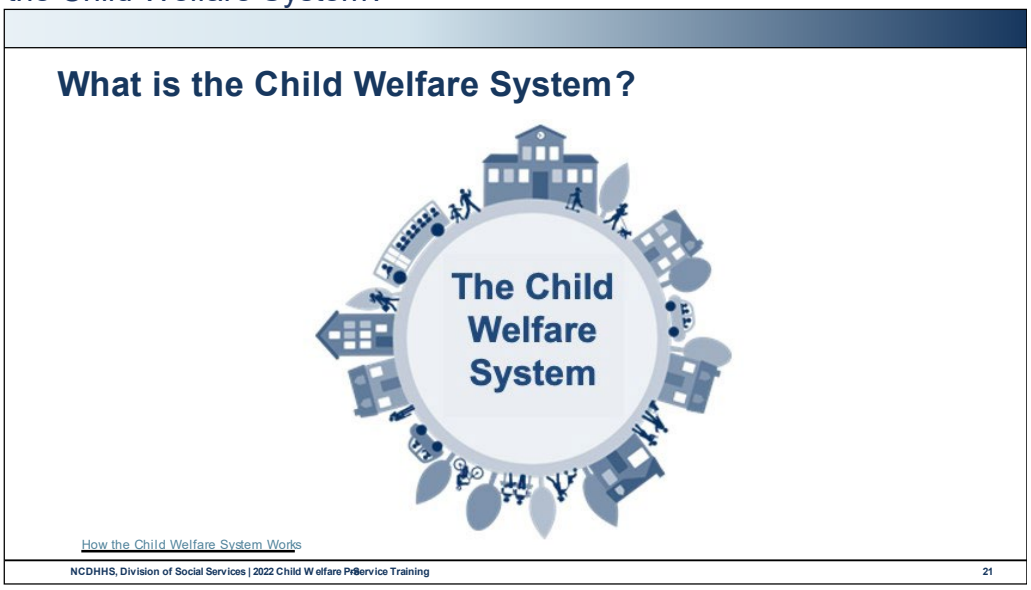
Use this space to records notes.

Questions and Reflections

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

Who Makes Up the Child Welfare System

What is the Child Welfare System?



The child welfare system is a group of services designed to promote the well-being of children by ensuring safety, achieving permanency, and strengthening families. It is NOT a single entity. DSS is part of a much bigger network of community and state level organizations working together for these outcomes. Keeping children safe is a community responsibility.

Group Discussion:

Who do you think are some of the key partners in the child welfare system?

Activity: Child Welfare System Roles

Review the *Child Welfare System Roles* handout then complete the worksheet for your assigned scenario.

Handout: Child Welfare System Roles

Behavioral and Mental Health

The behavioral and mental health system is made up of a variety of agencies and providers. These include psychiatric hospitals, out-patient clinics, therapists in private practice, day treatment programs, clubhouses, and residential and therapeutic group facilities. Resources are different in each community. Behavioral and mental health providers treat people with a variety of concerns, including mental illness and substance use disorders, and offers specialized counseling for problems that either contribute to or result from maltreatment. Behavioral health professionals also sometimes identify situations of suspected abuse and neglect in their clients and refer those families to DSS.

Care Management for At-Risk Children (CMARC)

CMARC is a free and voluntary program that helps families find and use community services. The program:

- Connects your family with services for children and families
- Supports your children in reaching their developmental potential
- Helps ensure that children are raised in healthy, safe and nurturing environments.

Referrals to CMARC are mandatory in some cases, including when infants are born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.

Child Advocacy Centers

Certified CACs provide services for families in their county who have children that have been a victim of sexual abuse. Each center has a multidisciplinary team that includes the District Attorney, law enforcement and a forensics investigator. The child can receive all these services at the center. Additional services provided to the family include individual and group counseling, information and referrals.

Child Support Services

Child Support Services are administered by DSS and available to parents and/or nonparent caretakers of minor children. Services provided include: location, establishment of paternity, establishment or modifying of child support orders, enforcement of child support orders, collection and processing of child support ordered payments.

Division of Child Development and Early Education

This Division of NCDHHS is responsible for the state pre-k program, funding a child care resource and referral system and administering North Carolina's Subsidized Child Care Assistance Program. The Division also partners with **Smart Start**, which provides community resources such as home visiting for families with young children. Smart Start serves every county in the state.

Division of Juvenile Justice and Delinquency Prevention

DJJDP ensures the safety of our communities and the well-being of our youth. The Division provides a full continuum of public safety interventions involving children and youth ages 6 through 17 alleged to, or have been found to, have committed an undisciplined or delinquent offense; in cases where youth are placed under court jurisdiction before their 18th birthday and require further interventions under the Juvenile Code (Chapter 7B), they may remain under juvenile justice court supervision or in commitment status when so ordered up until their 19th, 20th or 21st birthday, depending on their age and offense.

Foster Care Agencies

Private foster care agencies license and maintain foster homes for children in DSS custody. They are an important partner in providing appropriate placements for children and youth in out-of-home care and help coordinate services for children and youth placed in their homes.

Food and Nutrition Services

Food and Nutrition Services is a federal food assistance program administered by NCDHHS that provides low-income families the food they need for a nutritionally adequate diet. Benefits are issued via Electronic Benefit Transfer cards (EBT cards).

Health Care Providers

Health Care providers include hospitals, clinics, and private offices. These professionals identify and refer to DSS children who may have been maltreated. Health care professionals also conduct medical examinations to help determine if abuse or neglect occurred. Many of these exams are done through the Child Medical Evaluation Program. These examinations are often necessary for court proceedings. Medical professionals provide emergency and ongoing treatment for abused and neglected children.

Juvenile Courts

The Juvenile Court System hears legal matters related to abuse and neglect of children. The juvenile court system assures that the rights of both children and parents are protected. To accomplish this, the court appoints attorneys for parents and Guardian ad Litem volunteers for children. The judge reviews the Family Services Agreements for all children in DSS custody on a regular basis. As part of this review, the court will make recommendations regarding custody, visitation, and services for families.

Law enforcement Agencies

County DSS offices work with city police, county sheriff's departments regularly and the North Carolina State Bureau of Investigation, and federal law enforcement agencies in certain types of cases. Law enforcement officers may accompany child welfare workers on high risk investigative assessments to ensure the safety of children, family members and workers. Officers refer suspected situations of abuse and neglect to DSS and conduct criminal investigations of allegations of child abuse. In some cases, officers file criminal charges. Collaboration with law enforcement is one of the seven strategies in North Carolina's child welfare reform.

Medicaid

The state Medicaid agency provides insurance coverage for many low-income families and all children and youth in foster care and administers other benefits, such as CMARC. You will work with Medicaid and health care providers to ensure the dental, health and behavioral and mental health treatment needs of children are met.

North Carolina Tribes

There are seven state recognized tribes: Coharie (Sampson and Harnett counties); Lumbee (Robeson and surrounding counties); Haliwa-Saponi (Halifax and Warren counties); Sappony (Person County); Meherrin (Hertford and surrounding counties); Occaneechi Band of Saponi Nation (Alamance and surrounding counties); Waccamaw-Siouan (Columbus and Bladen counties) and one federally recognized tribes Eastern Band of Cherokee in North Carolina. There are also four Urban Indian Organizations: Guilford Native American Association (Guilford and surrounding counties), Cumberland County Association for Indian People (Cumberland County), Metrolina Native American Association (Mecklenburg and surrounding counties), and Triangle Native American Society (Wake and surrounding counties). There are state and federal laws (ICWA) governing cases involving American Indian children, and tribes are important partners for effectively serving these children and families.

School Systems

Teachers, aides, principals, counselors, nurses, and other personnel in schools frequently refer situations of suspected abuse or neglect to DSS. They also identify educational needs of children and provide the individualized educational resources necessary for some children who have experienced abuse and neglect. Schools are an important partner for meeting the well-being needs of children by helping to ensure educational stability and appropriate supports for children and youth with learning differences.

Work First Family Assistance

North Carolina’s Temporary Assistance for Needy Families (TANF) program, called Work First (WF), is based on the premise that parents have a responsibility to support themselves and their children.

The Work First program promotes a strengths-based, family-centered practice approach and shares in the mission of the NC Department of Health and Human Services, in collaboration with its partners, to protect the health and safety of all North Carolinians and provide essential human services.

Work First provides parents with short-term training and other services to help them become employed and move toward self-sufficiency. Families in which grandparents and relatives are caring for their relative children and legal guardians can receive services and support that prevent children from unnecessarily entering the foster care system.

Work First emphasizes three strategies: Diversion, Work and Retention.

Other Partner Organizations

Additional partner organizations that may be able to support children and families involved with DSS include:

- Employment services
- Housing Authorities
- Faith based organizations, such as churches, synagogues, and mosques
- Family Resource Centers
- Legal Aid
- Housing Authorities
- Mentoring programs, like Big Brothers/Big Sisters
- Vocational Rehabilitation

These programs may look different throughout the state. Work with your supervisor and county office to understand the resources available in your community.

Review your assigned scenario with your partner and work together to answer the questions listed at the bottom of the page.

Scenario 1:

Family assessment with an allegation of neglect. The mother is a single, 27-year-old female. It is alleged that she is living in her car with her children ages 7 and 9 and that the children are frequently absent from school and when they do attend, they have poor hygiene, dirty clothes and are hungry.

Potential Resources/Partners:

Work First

Housing authority

Employment Assistance

Food and nutrition assistance

Informal supports – family, extended family, friends who can assist with housing or childcare temporarily

Community organizations – United Way, faith organization, entities that may offer emergency assistance

- **If you were working with this family, what other agencies do you think would be involved?**

- **What agencies would you seek out to support this family?**

- **Are there any resources not listed on this handout you think would be beneficial?**

Review your assigned scenario with your partner and work together to answer the questions listed at the bottom of the page.

Scenario 2:

Family assessment with an allegation of a substance exposed infant. The mother is a 21-year-old female who currently lives with her boyfriend, the baby's father. The mother and baby both tested positive for methamphetamine at birth and hospital staff reported that the father appeared to be intoxicated.

Potential Resources/Partners:

Mental and behavioral health (substance use disorder assessment and services)- family based treatment facility if needed

CMARC (referral required in this case)

Informal resources who can support parents in getting clean (family, friends, 12 step programs)

Potential Juvenile Court involvement if the parents are unable to safely care for the infant

- **If you were working with this family, what other agencies do you think would be involved?**

- **What agencies would you seek out to support this family?**

- **Are there any resources not listed on this handout you think would be beneficial?**

Review your assigned scenario with your partner and work together to answer the questions listed at the bottom of the page.

Scenario 3:

Placement case: A sibling group of 3 has been in care for 2 years. The 15-year-old is placed in a group home away from his younger brother and sister – 11 and 9. He was recently suspended from school for threatening another student. Law enforcement was called and he was arrested.

Potential Resources/Partners:

Law enforcement and potentially juvenile court/DJJDP to resolve arrest

School

Group home provider

Behavioral and Mental Health Providers

Informal supports- find ways to increase connection to family- increase sibling and/or parent visitation; explore options for kinship placement

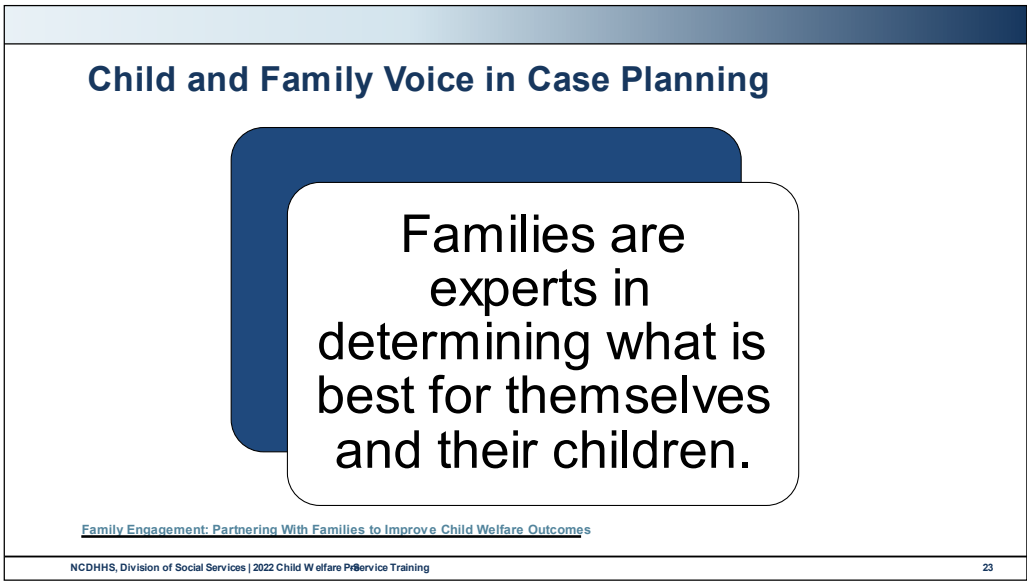
Ongoing involvement in juvenile court for placement case

- **If you were working with this family, what other agencies do you think would be involved?**

- **What agencies would you seek out to support this family?**

- **Are there any resources not listed on this handout you think would be beneficial?**

Child and Family Voice in Case Planning



Group Discussion:

Why do you think family voice is important in case planning?

Video: Child and Family Voice

Visit: Lifting Up Voices - YouTube

As you are listening to their experiences, think about the importance of lifting up the voices of those involved in child welfare cases.

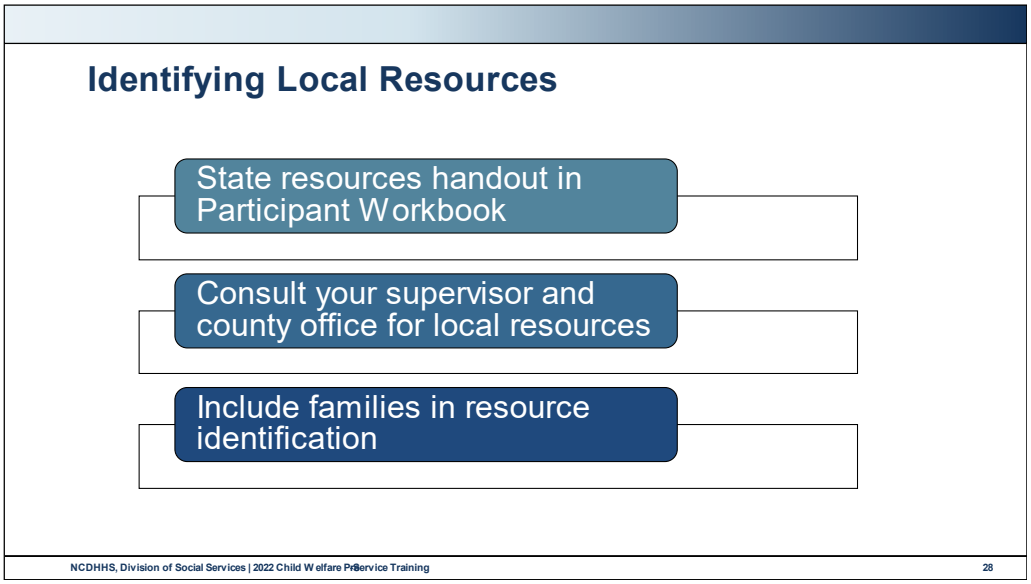
Use this space to record notes.

Debrief

What are some messages that stood out to you?

How will you apply this to your work as a social worker?

Identifying Local Resources



Ask your supervisor and colleagues for information about local resources. Your local agency may have complied a resource list, or a more experienced social worker in your office may have information readily available. Likewise, many local partners, like hospital social workers or courts, frequently keep resource directories that you can use. The United Way often publishes lists of local area agencies.

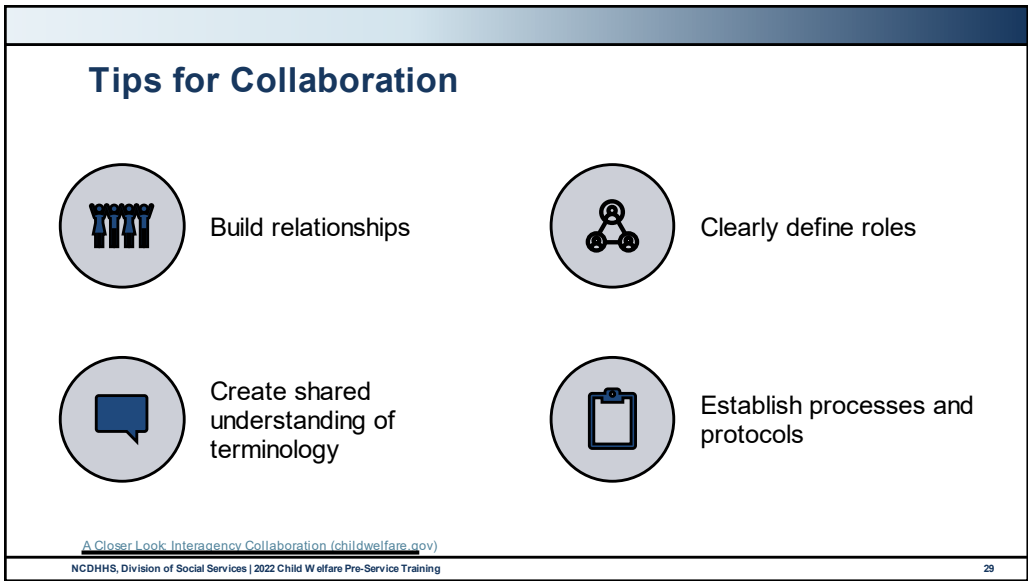
Handout: State Resources for North Carolina DSS Social Workers

NCDHHS Programs	
Work First Family Assistance: North Carolina's Temporary Assistance for Needy Families (TANF) program, called Work First (WF), is based on the premise that parents have a responsibility to support themselves and their children.	Applications in County DSS Office https://www.ncdhhs.gov/divisions/social-services/work-first-family-assistance
Food and Nutrition Services: North Carolina Food and Nutrition Services (formerly Food Stamps) are available for all households with limited income and resources.	Applications online or in County DSS Office: https://www.ncdhhs.gov/divisions/child-and-family-well-being/food-and-nutrition-services-food-stamps/apply-food-and-nutrition-services-food-stamps-nc
The Community Child Protection Team (CCPT) The CCPT is a group of community representatives who promote a community-wide approach to the problem of child abuse and neglect. Local teams identify and respond to gaps in the county's prevention/protection response, maximizing the use of limited resources.	https://www.ncdhhs.gov/divisions/social-services/child-welfare-services/community-child-protection-teams
Child Care Subsidy: Individuals may be eligible to receive child care assistance if: • You are working or are attempting to find work • You are in school or in a job training program • Your child is receiving child protective services • Your child needs care to support child welfare services or if your family is experiencing a crisis • Your child has developmental needs	Contact County Office to apply: https://ncchildcare.ncdhhs.gov/
Child Support Services: Services are available to parents and/or nonparent caretakers of minor children. Services provided include: location, establishment of paternity, establishment or modifying of child support orders, enforcement of child support orders, collection and processing of child support ordered payments.	Application online: https://ncchildsupport.ncdhhs.gov/ecoa/#home
Care Management for At-Risk Children (CMARC): CMARC is a free and voluntary program that helps families find and use community services. Children birth to age three who are at risk for developmental delay or disability, long-term illness and/or social, emotional disorders and children ages birth to five who have been diagnosed with developmental delay or disability, long-term illness and/or social, emotional disorder may be eligible for the program.	Contact: NC Medicaid Contact Center Phone: 888-245-0179 https://medicaid.ncdhhs.gov/beneficiaries/get-started/find-programs-and-services/care-coordination-children

Local Management Entity/Managed Care Organizations (LME/MCOs): LME/MCOs are responsible for managing Medicaid, state and local funding for North Carolinians who are uninsured or who receive Medicaid and seek services for mental health (MH) needs, substance use disorders (SUDs), intellectual/ developmental disabilities (IDD), and traumatic brain injuries (TBI).	https://www.ncdhhs.gov/providers/lme-mco-directory

Other Statewide Resources	
Child Medical Evaluation Program (CMEP) A Child Medical Evaluation (CME) is: • An outpatient medical evaluation of suspected child maltreatment. • Performed at the request of CPS during an open CPS Assessment. Provided by a qualified provider rostered with the North Carolina	https://www.med.unc.edu/cmep/
Child Advocacy Centers: Certified CACs provide services for families in their county who have children that have been a victim of sexual abuse. Each center has a multidisciplinary team that includes the District Attorney, law enforcement and a forensics investigator. The child can receive all these services at the center. Additional services provided to the family include individual and group counseling, information and referrals.	https://cacnc.org/
Domestic Violence Resources	• National Domestic Violence Hotline at 1-800-799-7233, available 24/7. TTY: 1-800-787-3224 • Domestic Violence Program Listing: https://ncadmin.nc.gov/domestic-violence-programs-directory-full-listing-0 • North Carolina Coalition Against Domestic Violence (NCCADV): https://nccadv.org/
North Carolina Child Treatment Program The North Carolina Child Treatment Program is a statewide effort to train mental health providers in evidence-based treatment models addressing childhood trauma, behavior, and attachment. The website provides information about clinicians.	https://www.ncchildtreatmentprogram.org/ program-roster
Smart Start	https://www.smartstart.org/smart-start-in-your-community

In partnership with DHHS, Smart Start provides services to families with young children, including home visiting and parent education. 75 partnerships serve all 100 counties.	
United Way of North Carolina	Call: 211 http://unitedwaync.org


Tips for Collaboration
Build relationships
Clearly define roles
Create shared understanding of terminology
Establish processes and protocols
A Closer Look: Interagency Collaboration (childwelfare.gov)
NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training
29

Handout: Family-Centered Principles of Partnership

From the NC Division of Social Services, Family Support and Child Welfare Services Section

The family-centered principles of partnership can be applied to working with other professionals and community supports. These principles include:

- Everyone desires respect
- Everyone needs to be heard
- Everyone has strengths
- Judgments can wait
- Partners share power
- Partnership is a process

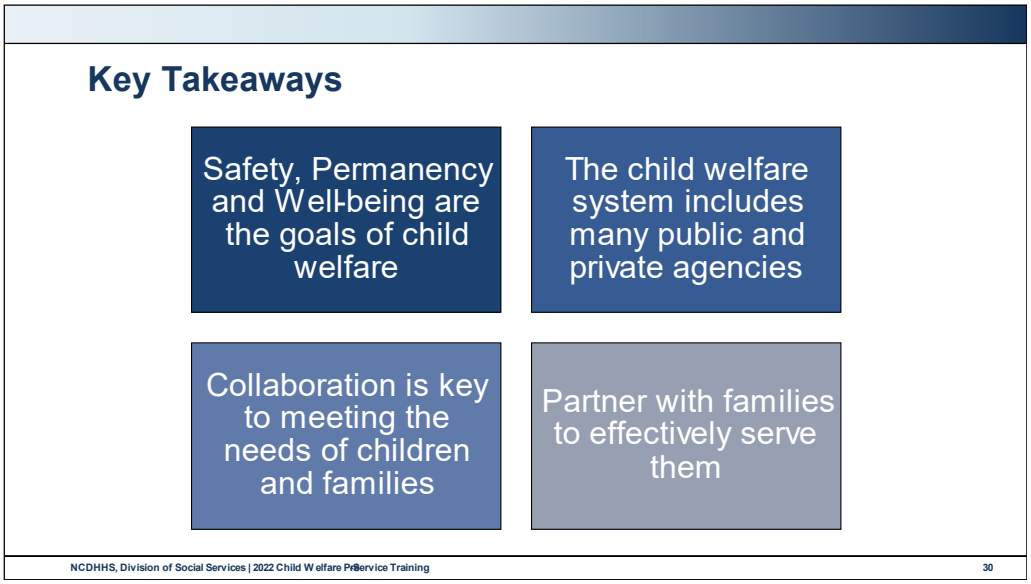
Tips for Collaboration:
Build relationships: Always engage with partners respectfully and show professional courtesy. Return emails and phone calls timely. Also take time to get to know them and the work of their agency.

Clearly define roles: Having a relationship with partners and understanding their work will help you clearly define roles. This helps with efficient service delivery and can prevent misunderstandings. It is also important that roles are defined in a way that the family understands.

Create shared understanding of terminology: When using terminology, especially to define goals, make sure there is a shared meaning. For example, as a social worker, you may need to define what DSS means by safety indicator to a school or mental health professional.

Establish processes and protocols: There may be formal processes in place for some multi-disciplinary teams, or certain referrals, but it is always helpful to establish processes and protocols when working with partners. For example, setting preferred methods of communication (phone or email); identifying regular meeting times, and letting people know who to contact in an emergency if they are working with a family and you are not on call.

Key Takeaways



Questions and Reflections

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

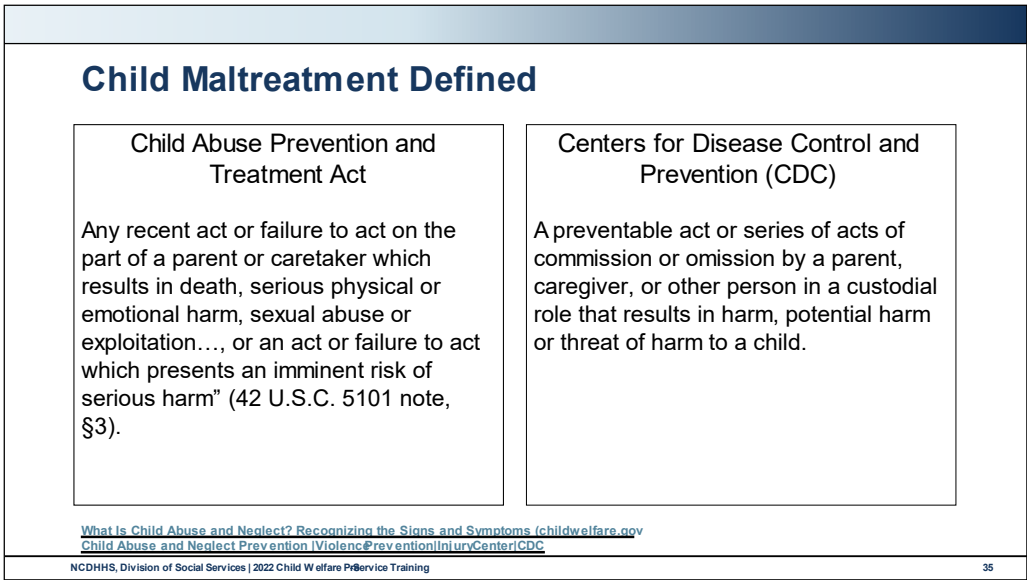
Identification of Child Abuse and Neglect

Learning Objectives

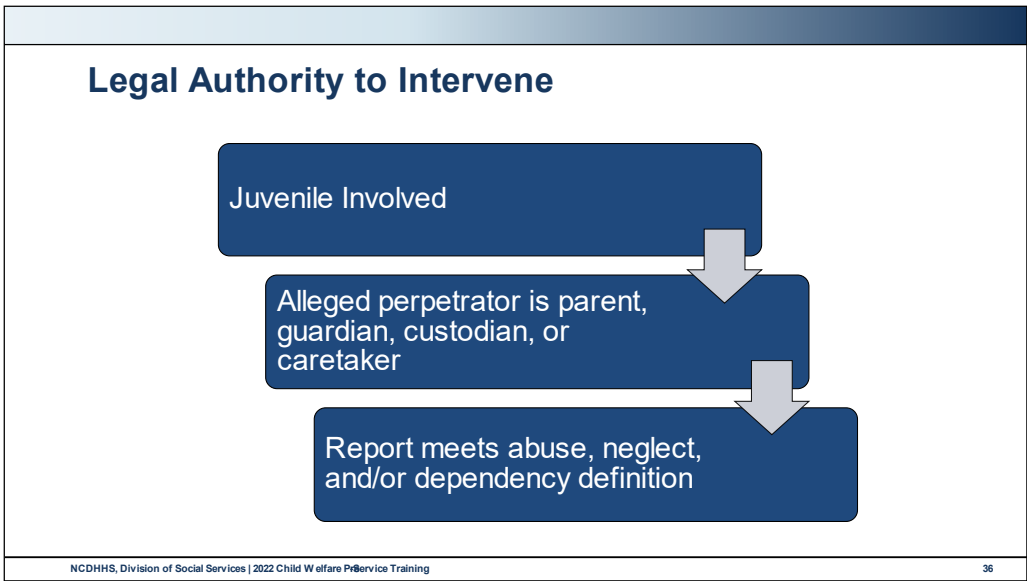
• Identify and define different types of child abuse
• Determine whether a report of maltreatment minimally meets the statutory guidelines for abuse neglect, or dependency.
• Determine whether a report of abuse minimally meets the statutory guidelines for abuse, neglect, or dependency.
• Differentiate between safety and risk when considering instances of abuse and neglect.

Use this space to record notes.

What is Child Maltreatment?



What commonalities do you see between these definitions?



Without these three elements being included in a formal intake report, DSS does not have the legal authority to become involved with a family.

Handout: North Carolina General Statute Definitions

N.C.G.S. Chapter 7B, Article 1, definitions (§ 7B-101)

N.C.G.S. § 7B-101(14) A **juvenile** is: A person who has not reached the person's eighteenth birthday and is not married, emancipated, or a member of the Armed Forces of the United States.

- Emancipation is a legal proceeding whereby minors aged 16 and 17 become legal adults. To become emancipated the juvenile must petition the District Court for an order of emancipation.
- Marriage or enlistment in the armed services automatically causes emancipation.

N.C.G.S. § 7B-101(3) A **caretaker** is: Any person other than a parent, guardian, or custodian who has responsibility for the health and welfare of a juvenile in a residential setting. A person responsible for a juvenile's health and welfare means a stepparent; foster parent; an adult member of the juvenile's household; an adult entrusted with the juvenile's care; a potential adoptive parent during a visit or trial placement with a juvenile in the custody of a department; any person such as a house parent or cottage parent who has primary responsibility for supervising a juvenile's health and welfare in a residential child care facility or residential educational facility; or any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services.

N.C.G.S. § 7B-101(8) A **custodian** is**:** The person or agency that has been awarded legal custody of a juvenile by a court.

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

N.C.G.S. § 7B-101(1)(a-g) An **Abused Juvenile** is**:** Any juvenile less than 18 years of age who is found to be a minor victim of human trafficking or whose parent, guardian, custodian, or caretaker:

- Inflicts or allows to be inflicted upon the juvenile a serious physical injury by other than accidental means.
- Creates or allows to be created a substantial risk of serious physical injury to the juvenile by other than accidental means.

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

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

N.C.G.S. § 7B-101(9) A **Dependent Juvenile** is**:** A juvenile in need of assistance or placement because the juvenile has no parent, guardian, or custodian responsible for the juvenile's care or supervision or the juvenile's parent, guardian, or custodian is unable to provide for the juvenile's care or supervision and lacks an appropriate alternative childcare arrangement.

In approximately 85% of CPS cases, the maltreatment type falls under this definition of neglect.

N.C.G.S. § 7B-101(15)(a-g) A **Neglected Juvenile** is**:** Any juvenile less than 18 years of age who is found to be a minor victim of human trafficking, or whose parent, guardian, custodian, or caretaker does any of the following:

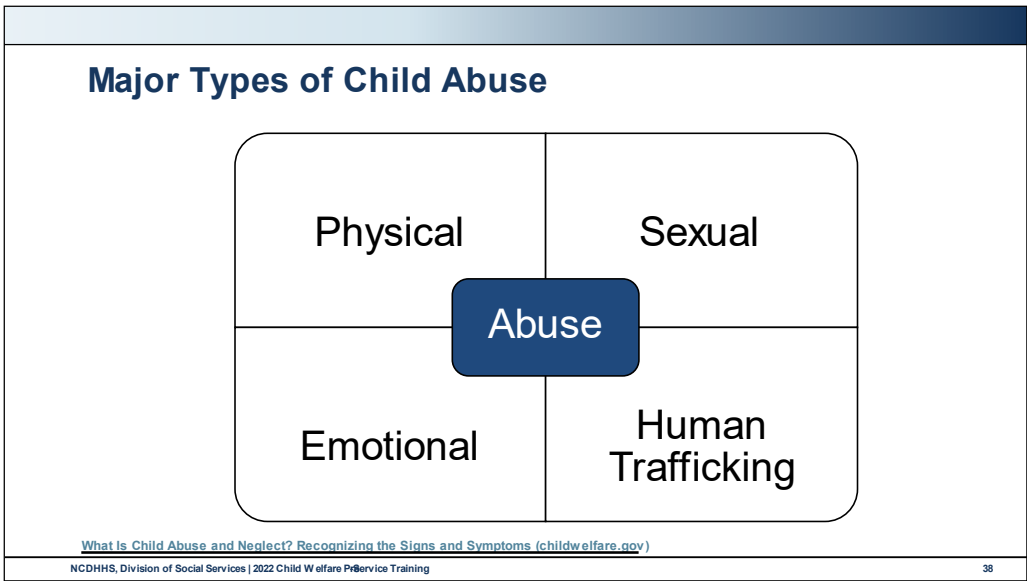
- Does not provide proper care, supervision, or discipline.
- Has abandoned the juvenile.
- Has not provided or arranged for the provision of necessary medical or remedial care.

- Or whose parent, guardian, or custodian has refused to follow the recommendations of the Juvenile and Family Team made pursuant to Article 27A of this Chapter.
- Creates or allows to be created a living environment that is injurious to the juvenile's welfare.
- Has participated or attempted to participate in the unlawful transfer of custody of the juvenile under G.S. 14-321.2.
- Has placed the juvenile for care or adoption in violation of law.

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

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

Educational neglect does not become a DSS requirement for intervention until the school’s efforts to assure attendance have been exhausted.



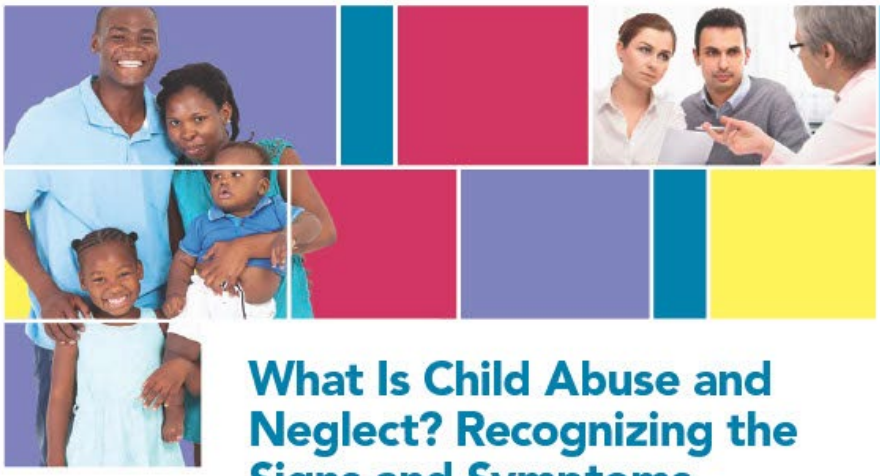
"**Physical abuse** is a nonaccidental physical injury to a child caused by a parent, caregiver, or other person responsible for a child and can include punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting (with a hand, stick, strap, or other object), burning, or otherwise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

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

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

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

Handout: What is Child Abuse and Neglect?



FACTSHEET

April 2019

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

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

WHAT'S INSIDE

Child Welfare Information Gateway

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

Children's Bureau

How Is Child Abuse and Neglect Defined in Federal Law?

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

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

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

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

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

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

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

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

What Are the Major Types of Child Abuse and Neglect?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recognizing Signs of Abuse and Neglect and When to Report

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

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

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

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

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

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

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

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

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

Signs of Physical Abuse

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

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

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

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

Signs of Neglect

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

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

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

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

Signs of Sexual Abuse

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

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

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

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

Signs of Emotional Maltreatment

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

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

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

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

The Impact of Childhood Trauma on Well-Being

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

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

Resources

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

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

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

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

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

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

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

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

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

References

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

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

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

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

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

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

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

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

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

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

Suggested Citation:

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

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

ACF

Children's Bureau

Handout: The North Carolina DSS Intake Maltreatment Screening Tools

Excerpt from the CPS Intake Policy, Protocol, and Guidance (May 2020) NC Child Welfare Manual

Sexual Abuse Screening Tool Directions

Is the parent/caretaker committing, permitting, or encouraging any sexual act with the child?

Sexual abuse is any incident of sexual contact involving a child that is inflicted, or allowed to be inflicted, by the parent/caretaker. Sexual abuse includes, but is not limited to the following: rape, intercourse, sodomy, fondling, oral sex, incest, or sexual penetration-digital, penile or foreign objects.

Is the parent/caretaker committing, permitting, or encouraging the child to participate in the preparation and/or dissemination of obscene material?

The use of children in the production of obscene films, photographs, and/or slides is sexual abuse. The parent/caretaker encouraging the child to watch obscene material is also sexual abuse.

Is the parent/caretaker displaying and/or disseminating obscene material to the child or encouraging the child to participate in a live sex act?

Any material that a reasonable person would consider obscene should not be shared with the child. The parent/caretaker is responsible for ensuring the child is not sexually exploited.

Is the parent/caretaker participating in the commercial sexual activity of the child?

This includes any action of the parent/caretaker to entice, force, encourage, supervise, support, advise, or protect the commercial sexual activities of the child.

Pursuant to 22 USC § 7102; 8 CFR § 214.11(a) and N.C.G.S. § 14-204(c), anyone under the age of 18 years that is involved in a commercial sex act is a victim of human trafficking. Under federal law (22 U.S. CODE § 7102), a commercial sex act is “any sex act on account of which anything of value is given to or received by any person.” For the purpose of criminal proceedings, force, fraud or coercion do not have to be present to prove that someone under the age of 18 years was a victim of sex trafficking.

A parent’s involvement in the prostitution of their child is abuse. This type of sexual abuse is human trafficking. Children whose parents commit this type of offense against them meet the definition of abused juvenile under N.C.G.S. §7B-101(1)(d) or N.C.G.S. §7B-101(1)(g).

Is the parent/caretaker allowing sibling sexual activity to occur?
When the parent/caretaker has knowledge that siblings are engaging in sexual activity and permits/encourages the continuation of this activity a CPS Assessment must occur. Reports alleging sexual activity between children under age 16 may provide cause to examine the supervision provided by their parents/ caretakers. If it is clear at Intake that the parent/ caretaker responded in a protective manner, keeping the health and well-being needs of the child at the forefront, a CPS Assessment is not required.

Reports Involving Sex Offenders

If a substantiated perpetrator or an individual convicted of a sexual offense against a child has established residence where another juvenile resides, the screening decision must be based upon the risk of the child being exposed to an injurious environment. For reports alleging an injurious environment, please consult the Injurious Environment Maltreatment Screening Tool.

Is the parent/caretaker intentionally permitting the child to engage in sexual activity?

The parent/caretaker has knowledge the child is engaging in sexual activity and permits/encourages the continuation of this activity. Relevant to screening these types of reports is whether the parent is condoning the behavior of a child under age 16 while the child is under their care and supervision. Reports alleging sexual activity between children under age 16 may provide cause to examine the supervision provided by their parent/caretakers. If it is clear at Intake that the parent/caretaker responded in a protective manner, keeping the health and well-being needs of the child at the forefront, a CPS Assessment is not required. It is important to get sufficient information at Intake regarding the behavior of the parent(s), as well as the behavior of the minor child(ren). When the parent has no knowledge of the child's sexual activity, the child's age, behaviors and developmental level impact whether a CPS Assessment is required. If the only allegation in the report is that a child age 16 or above is having sex without the parents' knowledge or the child is pregnant, then these reports should not be accepted. The legal age of consent in North Carolina is 16; therefore, consensual sexual activity of juveniles 16 and above is not, in and of itself, considered sexual abuse.

When a report involving parental knowledge and permission of sexual activity of an incompetent juvenile, a CPS Assessment must occur, regardless of the age of the juvenile, as an incompetent juvenile is not able to consent. A parent providing condoms and/or birth control to their children is not, in and of itself, considered permitting or encouraging their child to engage in sexual activity. The provision of birth control is considered a preventive measure in order to maintain the juvenile's health, which is consistent with N.C.G.S. § 90-21.5

(http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.5.html), Minor's consent sufficient for certain medical health services.

A CPS Assessment based on improper supervision must occur for the following situations:

- A 15-year-old engaging in risky sexual behavior (multiple partners, no protection) with parental knowledge and the absence of a protective response by the parent; or
  A child displaying sexualized behaviors that are inconsistent with normal child development and the parent has not responded in a protective manner.

Normal Child Sexual Development
Infancy (birth through one year) • Pair bonding • Genital play • Identification of gender
Toddler/Early Childhood (2 to 5 years) • Toilet training • Genital play • Interpersonal games: family, marriage, doctor, etc.
Latency (6 to 9 years) • Concrete interest in anatomic differences, pregnancy, birth • Private, occasional masturbation • Modesty about bodies • Increased secretive behavior among peers • Interest in socialization
Pre-adolescence (10 to 12 years) • Adaptation to initial signs of puberty • Development of secondary sexual characteristics • Strong friendships and budding romances • Playful hitting or tickling among peers

Sex Abuse Crimes

If a parent, guardian, custodian, or caretaker commits, permits, or encourages the commission of a violation of the following laws by, with, or upon the juvenile, then that adult has sexually abused the child. The information contained within this statute delineates specific sex abuse crimes. The Intake county child welfare worker must refer to this information when screening sexual abuse reports.

N.C.G.S. § 14-27.2. First-degree rape

(a) A person is guilty of rape in the first degree if the person engages in vaginal intercourse:

(1) With a victim who is a child under the age of 13 years and the defendant is at least 12 years old and is at least four years older than the victim; or
(2) With another person by force and against the will of the other person, and:

a. Employs or displays a dangerous or deadly weapon or an article which the other person reasonably believes to be a dangerous or deadly weapon; or
b. Inflicts serious personal injury upon the victim or another person; or
c. The person commits the offense aided and abetted by one or more other persons.

N.C.G.S. § 14-27.2A. Rape of a child by an adult offender

(a) A person is guilty of rape of a child if the person is at least 18 years of age and engages in vaginal intercourse with a victim who is a child under the age of 13 years.

N.C.G.S. § 14-27.3. Second-degree rape

(a) A person is guilty of rape in the second degree if the person engages in vaginal intercourse with another person:

(1) By force and against the will of the other person; or
(2) Who is mentally defective, mentally incapacitated, or physically helpless, and the person performing the act knows or should reasonably know the other person is mentally defective, mentally incapacitated, or physically helpless.

N.C.G.S. § 14-27.4. First-degree sexual offense

(a) A person is guilty of a sexual offense in the first degree if the person engages in a sexual act:

(1) With a victim who is a child under the age of 13 years and the defendant is at least 12 years old and is at least four years older than the victim; or
(2) With another person by force and against the will of the other person, and:

a. Employs or displays a dangerous or deadly weapon or an article which the other person reasonably believes to be a dangerous or deadly weapon; or
b. Inflicts serious personal injury upon the victim or another person; or
c. The person commits the offense aided and abetted by one or more other persons.

N.C.G.S. § 14-27.4A. Sexual offense with a child by an adult offender

(a) A person is guilty of sexual offense with a child if the person is at least 18 years of age and engages in a sexual act with a victim who is a child under the age of 13 years.

N.C.G.S. § 14-27.5. Second-degree sexual offense

(a) A person is guilty of a sexual offense in the second degree if the person engages in a sexual act with another person:

(1) By force and against the will of the other person; or
(2) Who is mentally defective, mentally incapacitated, or physically helpless, and the person performing the act knows or should reasonably know that the other person is mentally defective, mentally incapacitated, or physically helpless.

N.C.G.S. § 14-27.31 and §14-2732. Intercourse and sexual offenses with certain victims; consent no defense

If a defendant who has assumed the position of a parent in the home of a minor victim engages in vaginal intercourse or a sexual act with a victim who is a minor residing in the home; or if a person having custody of a victim of any age or a person who is an agent or employee of any person, or institution, whether such institution is private, charitable, or governmental, having custody of a victim of any age engages in vaginal intercourse or a sexual act with such victim, the defendant is guilty of a Class E felony. Consent is not a defense to a charge under this section.

N.C.G.S. § 14-43.14. Unlawful sale, surrender, or purchase of a minor

(a) A person commits the offense of unlawful sale, surrender, or purchase of a minor when that person, acting with willful or reckless disregard for the life or safety of a minor, participates in any of the following: the acceptance, solicitation, offer, payment, or transfer of any compensation, in money, property, or other thing of value, at any time, by any person in connection with the unlawful acquisition or transfer of the physical custody of a minor, except as ordered by the court. This section does not apply to actions that are ordered by a court, authorized by statute, or otherwise lawful.

N.C.G.S. § 14-177. Crime against nature

If any person shall commit the crime against nature, with mankind or beast, he shall be punished as a Class I felon.

N.C.G.S. § 14-178. Incest between certain near relatives

The parties shall be guilty of a felony in all cases of carnal intercourse between (i)

grandparent and grandchild, (ii) parent and child or stepchild or legally adopted child, or (iii) brother and sister of the half or whole blood. Every such offense is punishable as a Class F felony.

N.C.G.S. § 14-179. Incest between uncle and niece, and nephew and aunt

In all cases of carnal intercourse between uncle and niece, and nephew and aunt, the parties shall be guilty of a Class 1 misdemeanor.

N.C.G.S. § 14-190.5. Preparation of obscene photographs, slides and motion pictures

Every person who knowingly:

(1) Photographs himself or any other person, for purposes of preparing an obscene film, photograph, negative, slide or motion picture for the purpose of dissemination; or

(2) Models, poses, acts, or otherwise assists in the preparation of any obscene film, photograph, negative, slide or motion picture for the purpose of dissemination, shall be guilty of a Class 1 misdemeanor.

N.C.G.S. § 14-190.6. Employing or permitting minor to assist in offense under Article (26)

Every person 18 years of age or older who intentionally, in any manner, hires, employs, uses or permits any minor under the age of 16 years to do or assist in doing any act or thing constituting an offense under this Article and involving any material, act or thing he knows or reasonably should know to be obscene within the meaning of N.C.G.S. §14-190.1, shall be guilty of a Class I felony.

N.C.G.S. § 14-190.7. Dissemination to minors under the age of 16 years

Every person 18 years of age or older who knowingly disseminates to any minor under the age of 16 years any material which he knows or reasonably should know to be obscene within the meaning of N.C.G.S. §14-190.1 shall be guilty of a Class I felony.

N.C.G.S. § 14-190.8. Dissemination to minors under the age of 13 years

Every person 18 years of age or older who knowingly disseminates to any minor under the age of 13 years any material which he knows or reasonably should know to be obscene within the meaning of N.C.G.S. §14-190.1 shall be punished as a Class I felon.

N.C.G.S. § 14-190.14. Displaying material harmful to minors

(a) A person commits the offense of displaying material that is harmful to minors if, having custody, control, or supervision of a commercial establishment and

knowing the character or content of the material, he displays material that is harmful to minors at that establishment so that it is open to view by minors as part of the invited general public. Material is not considered displayed under this section if the material is placed behind "blinder racks" that cover the lower two thirds of the material, is wrapped, is placed behind the counter, or is otherwise covered.

N.C.G.S. § 14-190.15. Disseminating harmful material to minors; exhibiting harmful performances to minors

(a) Disseminating Harmful Material. - A person commits the offense of disseminating harmful material to minors if, with or without consideration and knowing the character or content of the material, he:
  (1) Sells, furnishes, presents, or distributes to a minor material that is harmful to minors; or
  (2) Allows a minor to review or peruse material that is harmful to minors.

(b) Exhibiting Harmful Performance. - A person commits the offense of exhibiting a harmful performance to a minor if, with or without consideration and knowing the character or content of the performance, he allows a minor to view a live performance that is harmful to minors.

(c) Defenses. - Except as provided in subdivision (3), a mistake of age is not a defense to a prosecution under this section. It is an affirmative defense to a prosecution under this section that:

  (1) The defendant was a parent or legal guardian of the minor.
  (2) The defendant was a school, church, museum, public library, governmental agency, medical clinic, or hospital carrying out its legitimate function; or an employee or agent of such an organization acting in that capacity and carrying out a legitimate duty of his employment.
  (3) Before disseminating or exhibiting the harmful material or performance, the defendant requested and received a driver's license, student identification card, or other official governmental or educational identification card or paper indicating that the minor to whom the material or performance was disseminated or exhibited was at least 18 years old, and the defendant reasonably believed the minor was at least 18 years old.
  (4) The dissemination was made with the prior consent of a parent or guardian of the recipient.

N.C.G.S. § 14-190.16. First degree sexual exploitation of a minor

(a) Offense. - A person commits the offense of first-degree sexual exploitation of a

minor if, knowing the character or content of the material or performance, he:

(1) Uses, employs, induces, coerces, encourages, or facilitates a minor to engage in or assist others to engage in sexual activity for a live performance or for the purpose of producing material that contains a visual representation depicting this activity; or

(2) Permits a minor under his custody or control to engage in sexual activity for a live performance or for the purpose of producing material that contains a visual representation depicting this activity; or

(3) Transports or finances the transportation of a minor through or across this state with the intent that the minor engages in sexual activity for a live performance or for the purpose of producing material that contains a visual representation depicting this activity; or

(4) Records, photographs, films, develops, or duplicates for sale or pecuniary gain material that contains a visual representation depicting a minor engaged in sexual activity.

(b) Inference. - In a prosecution under this section, the trier of fact may infer that a participant in sexual activity whom material through its title, text, visual representations, or otherwise represents or depicts as a minor is a minor.

(c) Mistake of Age. - Mistake of age is not a defense to a prosecution under this section.

N.C.G.S. § 14-190.17. Second degree sexual exploitation of a minor

(a) Offense. - A person commits the offense of second-degree sexual exploitation of a minor if, knowing the character or content of the material, he:

(1) Records, photographs, films, develops, or duplicates material that contains a visual representation of a minor engaged in sexual activity; or

(2) Distributes, transports, exhibits, receives, sells, purchases, exchanges, or solicits material that contains a visual representation of a minor engaged in sexual activity.

(b) Inference. - In a prosecution under this section, the trier of fact may infer that a participant in sexual activity whom material through its title, text, and visual representations or otherwise represents or depicts as a minor is a minor.

(c) Mistake of Age. - Mistake of age is not a defense to a prosecution under this section.

N.C.G.S. § 14-205.3(b) Promoting prostitution of a minor

(b) Any person who willfully performs any of the following acts commits the offense of promoting prostitution of a minor or mentally disabled

person:

(1) Advances prostitution as defined in N.C.G.S. §14-203, where a minor or profoundly mentally disabled person engaged in prostitution, or any person in prostitution in the place of prostitution is a minor or severely or profoundly mentally disabled at the time of the offense.
(2) Profits from prostitution by any means where the prostitute is a minor or is severely or profoundly mentally disabled at the time of the offense.
(3) Confines a minor or a severely or profoundly mentally disabled person against the person's will by the infliction or threat of imminent infliction of great bodily harm, permanent disability, or disfigurement or by administering to the minor or severely or profoundly mentally disabled person, without the person's consent or by threat or deception and for other than medical purposes, any alcoholic intoxicant or a drug as defined in Article 5 of Chapter 90 of the General Statutes (North Carolina Controlled Substances Act) and does any of the following:
    a. Compels the minor or severely or profoundly mentally disabled person to engage in prostitution.
    b. Arranges a situation in which the minor or severely or profoundly mentally disabled person may practice prostitution.
    c. Profits from prostitution by the minor or severely or profoundly mentally disabled person.

N.C.G.S. § 14-202.1. Taking indecent liberties with children

(a) A person is guilty of taking indecent liberties with children if, being 16 years of age or more and at least five years older than the child in question, he either:

(1) Willfully takes or attempts to take any immoral, improper, or indecent liberties with any child of either sex under the age of 16 years for the purpose of arousing or gratifying sexual desire; or
(2) Willfully commits or attempts to commit any lewd or lascivious act upon or with the body or any part or member of the body of any child of either sex under the age of 16 years.

Questions and Reflections

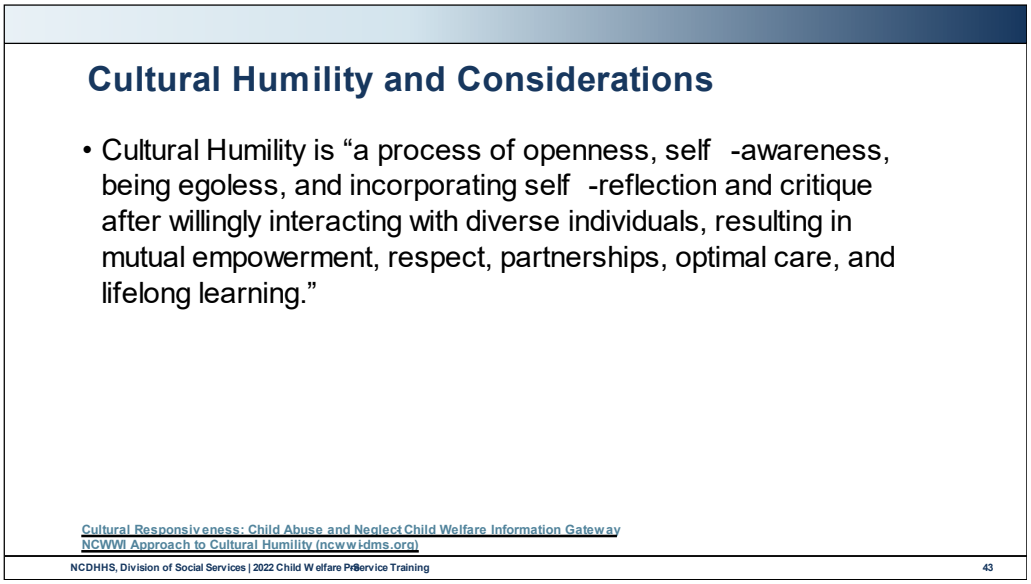
Use this space to record questions and reflections about what you have learned.

Video: Identifying Abuse and Neglect

Visit: Reaching Out: Child abuse, the different types and who's at risk for a video featuring professionals talking about major types of abuse and neglect and how to identify them.

Debrief

What are some of your takeaways from this video?



As a social worker, you will constantly be learning and need to be open to understanding differences and objectively assessing and applying definitions.

Handout: Cultural Humility Practice Principles

National Child Welfare Workforce Institute
LEARNING, LEADING, CHANGING

CULTURAL HUMILITY
PRACTICE PRINCIPLES[1]

CULTURAL HUMILITY is a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals, resulting in mutual empowerment, respect, partnerships, optimal care, and lifelong learning.[2]

Embrace the complexity of diversity: Everyone occupies multiple positions with related identities and statuses, which intersect to distinguish us as individuals

Be open to individual differences and the social experiences due to these differences: Intersecting group memberships affect people's expectations, quality of life, capacities as individuals and parents, and life chances

Reserve judgment: Cultural humility encourages a less deterministic, less authoritative approach to understanding cultural differences, placing more value on others' cultural expressions

Relate to others in ways that are most understandable to them: Culturally appropriate communication and interaction skills enable people to describe their experience in their own words, reducing the need of mastering a wide range of cultural beliefs and practices

Consider cultural humility as a constant effort to become more familiar with the worldview of others: Treat this practice as an ongoing process rather than an outcome, including an awareness and appreciation of everyone's physical and social environment

Instill a spirit of collaboration: Encourage all staff to become involved in mutually beneficial, non-paternalistic, and respectful working relationships with others, as well as considering the factors at play when defining important priorities and activities needed to achieve common goals

Demonstrate familiarity with children and families' living environments, building on strengths while reducing negative factors: Learn to identify, understand, and build on the assets and adaptive strengths of children and parents and engage in efforts to disrupt or dismantle social forces that act to disenfranchise and disempower them

Know yourself and the ways in which biases interfere with an ability to objectively listen to or work with others: Use self-reflection and self-critique to engage in a process of realistic, ongoing self-appraisal of biases and stereotypes to challenge the ingrained behaviors and ideas that you have toward others

Critically challenge one's "openness" to learn from others: Assess the barriers our attitudes and behaviors present to learning from others

Build organizational supports that demonstrate cultural humility as an important and ongoing aspect of the work itself: Include an assessment of the organizational environment, policies, procedures, knowledge, and skills connected to organizational practices to identify ways to employ and promote a cultural humility perspective

[1]Adapted from Ortega, R. M., & Coulborn, K. (2011). Training child welfare workers from an intersectional cultural humility perspective: A paradigm shift. Child Welfare, 90(5).
[2]Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. Journal of Transcultural Nursing, 27(3), 210–217.

NCWWI.org
Children's Bureau

Handout: Cultural Healing Practices That Mimic Child Abuse

SciMedCentral

Annals of Forensic Research and Analysis

Mini Review

Cultural Healing Practices that Mimic Child Abuse

Killion CM*

School of Nursing, Case Western Reserve University, USA

*Corresponding author
Cheryl M. Killion, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, Ohio, USA, Tel: (216) 368-0462; Email: cmk61@case.edu

Submitted: 02 June 2016

Accepted: 17 August 2017

Published: 21 August 2017

ISSN: 2378-9476

Keywords
- Child abuse
- Cultural healing practices
- Immigrants
- Ethnic minority groups
- Differential diagnosis

Abstract

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

INTRODUCTION

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

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

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

CULTURAL HEALING PRACTICES

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

The Vietnamese call wind, *phong* [6]. According to some, the wind can invade the body and cause a variety of illnesses including headaches, muscle aches, coughs, fevers, upper respiratory infections and sore throats [6]. To alleviate the symptoms of these

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

Killion (2017)
Email: cmk61@case.edu

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

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

Cupping is another ancient, though fairly common practice, which has been used throughout the Middle East, Asia, Latin America, and Eastern Europe. In the United States, this technique is practiced primarily by Russian immigrants and its use has been revitalized among naturalistic health providers, as well [3,9,11]. There are two types of *cupping*: wet and dry [11,12]. *Wet cupping*, also known as *hijama*, involves small cuts to the skin to draw blood and is thought to help rid the body of toxins [11]. In *dry cupping* the air, in an open-mouthed vessel, is heated and subsequently, the vessel is applied to the skin. Suction is produced by the cooling and contracting of the heated air and is thought to "draw out" the ailment as the heated air and the rim of the cup burn the skin [11] (Figure 2). The signs of *cupping* usually present on the patient's back, as multiple, grouped circular ecchymoses. Central ecchymosis or petechiae result from the suction effect of the heated air as it cools and contracts (Figure 3). *Dry cupping* is used to alleviate pain, primarily musculoskeletal, and inflammation. It is purported to increase blood flow and promote relaxation and well-being. Further, it is used as a type of deep tissue massage [12]. *Cupping* therapy is growing in popularity as an alternative treatment for a variety of conditions and diseases in patients of all ages, including athletes [12].

Another cultural healing practice is *moxibustion* (Figure 4). Originating in Asian medicine, this healing practice involves burning rolled pieces of moxa herb (mugwort or Artemisia vulgaris) directly over the skin above acupuncture points and allowing the herb to burn near the skin's surface until the onset of pain [3,13]. The lesions of *moxibustion* appear as a pattern of "discrete circular, target-like burns" that may be confused with cigarette burns from child abuse [9]. Moxibustion is one of the most commonly used treatments in traditional medicine

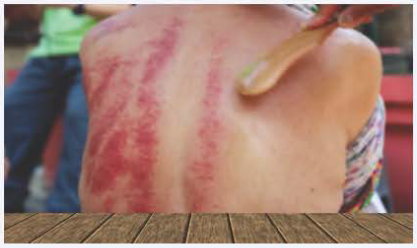


Figure 1 Gua Sha Procedure Performed on Shoulder and Back of Young Male.

Figure 2 Cupping as Cups are Being Removed.

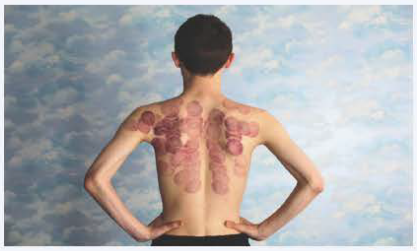


Figure 3 Boy's Back Following Cupping.

Figure 4 Moxa Stick.

Killion (2017)
Email: cmk61@case.edu

in East Asian cultures and is applied for a variety of symptoms, including fever and abdominal pain [3,13]. It is particularly effective in promoting energy (qi) and has been used to treat those experiencing chronic fatigue [14]. In Korea, contemporary studies indicate that *moxibustion* is being used in combination with conventional therapy to enhance immune functioning in children with cerebral palsy [15].

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

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

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

DISCUSSION AND CONCLUSION

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

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

REFERENCES

1. Committee on Child Maltreatment Research, Policy, and Practice for the Next Decade: Phase II: Board on Children, Youth, and Families: Institute of Medicine. New directions in child abuse and neglect research. In: Peterson AC, Joseph J, Feit M, editors. National Research Council. Washington: National Academies Press (US). 2014.
2. Christian CW, States LJ. Medical mimics of child abuse. AJR Am J Roentgenol. 2017; 208: 982-990.
3. Boos SC. Differential diagnosis of suspected child physical abuse. UpToDate. Snapshot of U.S. Immigration. National Conference of State legislatures. Retrieved from: https: //www.ncsl.org/research/immigration/us-immigration-snapshot-2016-aspx/
4. Chao MT, Wade C, Kronenberg F. Disclosure of complementary and alternative medicine to conventional medical providers: variation by race/ethnicity and type of CAM. J Natl Med Assoc. 2008; 100: 1341-1349.
5. Davis RE. Cultural health care or child abuse? The Southeast Asian practice of caogio. J Am Acad Nurse Pract. 2000; 12: 89-95.
6. Lam N, Castellanos A, Thomson K. A Vietnamese child with a rash on the back. Am Fam Physician. 2016; 93: 131-132.
7. Nielsen A, Kligler B, Koll BS. Addendum: Safety standards for guasha (press-stroking) and Ba guan (cupping). Complement Ther Med. 2014; 22: 446-448.
8. Spencer M Craft N LenameAl Swerdlin A Ladrigan M Berkowitz C. 2017: Cultural practices-child abuse recognition. Retrieved from https://www.visualdx.com/visualdx/diagnosis/culturpractices?moduledid=43&diagnosis/
9. Lilly E, Kundu RV. Dermatoses secondary to Asian cultural practices. Int J Dermatol. 2012; 51: 372-382.
10. Qureshi NA, Ali GI, Abushanab TS, El-OlermyAT, Alqaed MS, El-Subai IS. History of cupping (Hijama): a narrative review of literature. J Integr Med. 2017; 15: 172-181.
11. Rozenfeld E, Kalichman L. New is the well-forgottenold: the use of dry cupping in musculoskeletal medicine. J Bodyw Mov Ther. 2016; 20: 173-178.

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

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

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

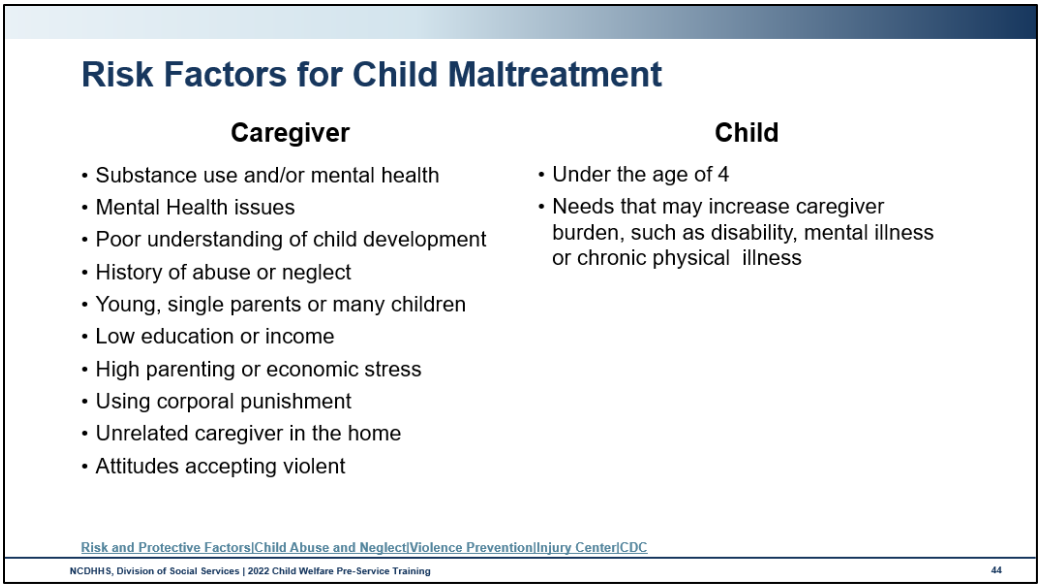
15. Hansen KK. Folk remedies and child abuse: A review with emphasis on caida de mollera and its relationship to shaken baby syndrome. Child Abuse Negl. 1997; 22: 117-127.

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

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

Cite this article

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



For children there are two significant risk factors for maltreatment. The first is age and the second is having needs that may increase caregiver burden, such as disability, mental illness, or chronic physical illness. Young children are not able to care for themselves so both of these risk factors are related to the level of care required which may increase parental stress. Young children and many children with chronic illnesses may be more isolated from other adults if they are not in school, and if they are not verbal, they cannot report maltreatment, which increases vulnerability. Caregiver risk factors can add to parental stress and decrease resiliency, increasing the risk of maltreatment.

Handout: Risk and Protective Factors for Child Maltreatment

From the Centers for Disease Control and Prevention

Risk Factors for Victimization

Individual Risk Factors

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

Risk Factors for Perpetration

Individual Risk Factors

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

Family Risk Factors

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

Community Risk Factors

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

Protective Factors for Child Abuse and Neglect

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

Individual Protective Factors

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

Family Protective Factors

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

Community Protective Factors

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

Activity: Recognizing Signs of Abuse Teach Back

Individually brainstorm signs you think would indicate abuse and neglect for your assigned topic. After five minutes, compare the lists your group created with the lists in the Reference Excerpt on the next two pages. Work with your group to develop content to teach your peers about the signs of abuse for your assigned topic. Use the space for each topic to record notes.

General Signs of maltreatment in children and adults

Child:
Adult:

Physical Abuse

Child:
Adult:

Sexual abuse

Child:
Adult:

Emotional abuse

Child:
Adult:

Reference Excerpt: Recognizing Signs of Abuse from the *What is Child Abuse and Neglect* Handout.

General signs of Maltreatment in children and adults:

Child

- Shows sudden changes in behavior or school performance
- Has not received help for physical or medical problems brought to the parents' attention
- Has learning problems (or difficulty concentrating) that cannot be attributed to specific physical or psychological causes
- Is always watchful, as though preparing for something bad to happen
- Lacks adult supervision ○ Is overly compliant, passive, or withdrawn
- Comes to school or other activities early, stays late, and does not want to go home
- Is reluctant to be around a particular person
- Discloses maltreatment

Parent

- Denies the existence of—or blames the child for— the child's problems in school or at home
- Asks teachers or other caregivers to use harsh physical discipline if the child misbehaves
- Sees the child as entirely bad, worthless, or burdensome
- Demands a level of physical or academic performance the child cannot achieve
- Looks primarily to the child for care, attention, and satisfaction of the parent's emotional needs
- Shows little concern for the child

Signs of Physical Abuse - Child

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

Signs of Physical abuse - Caregiver

- Offers conflicting, unconvincing, or no explanation for the child's injury or provides an explanation that is not consistent with the injury
- Shows little concern for the child

- Sees the child as entirely bad, burdensome, or worthless
- Uses harsh physical discipline with the child
- Has a history of abusing animals or pets

Signs of Sexual abuse - Child

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

Signs of Sexual abuse - Caregiver

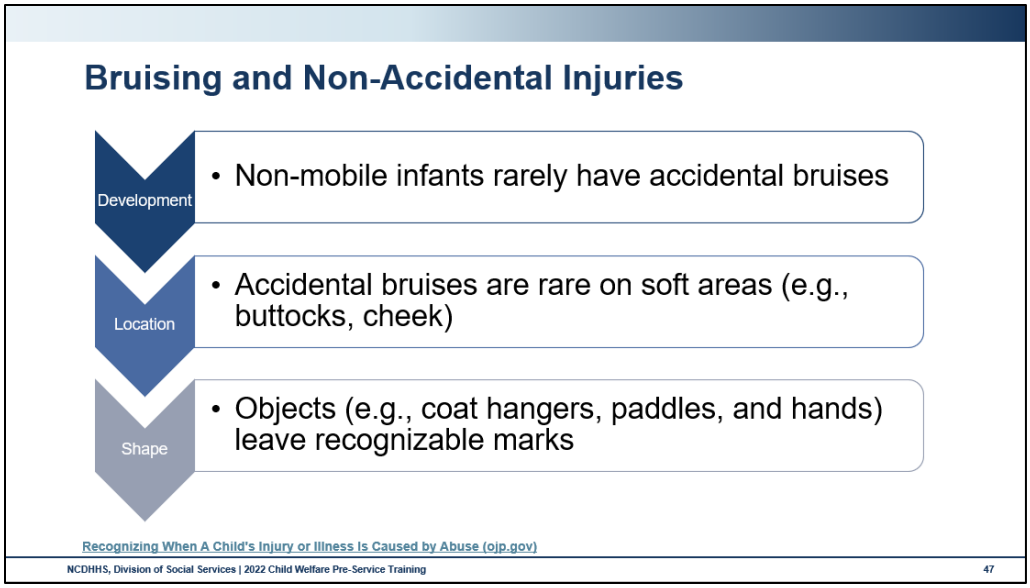
- Tries to be the child's friend rather than assume an adult role
- Makes up excuses to be alone with the child
- Talks with the child about the adult's personal problems or relationships

Signs of Emotional abuse - Child

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

Signs of Emotional abuse - Adult

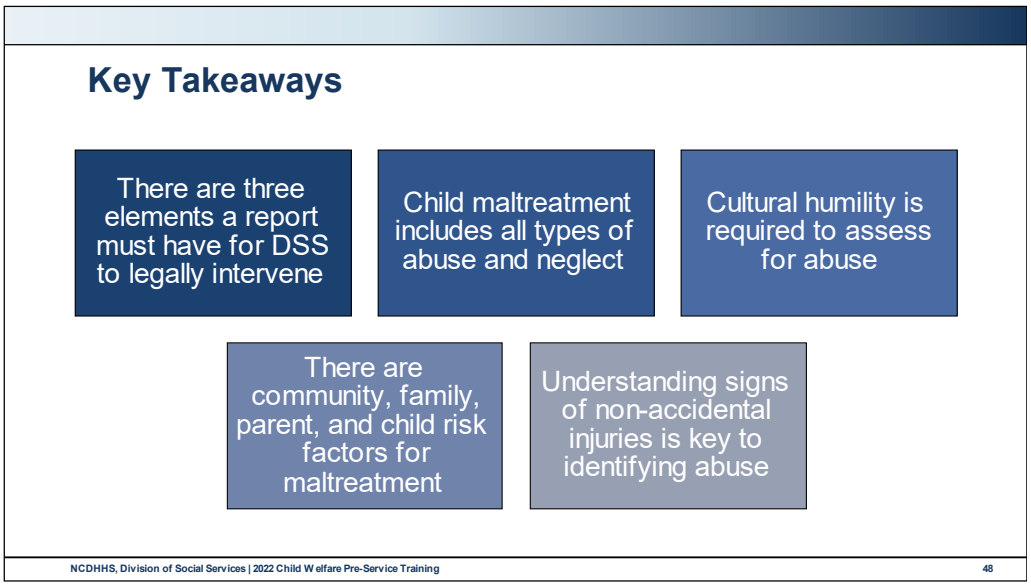
- Constantly blames, belittles, or berates the child
- Describes the child negatively
- Overtly rejects the child



We are social workers, not doctors, so we can never make medical determinations about physical abuse. However, it is important to be able to recognize the signs when completing an assessment or monitoring the safety of children ongoing. There are specific criteria that can help you determine if an injury, specifically a bruise, is accidental. Many of these signs, such as patterned bruises, bruising in atypical areas, multiple bruises from a single injury, and others trigger the policy requirement for a referral to the Child Medical Evaluation Program (CMEP) where a doctor will evaluate injuries to determine cause.

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

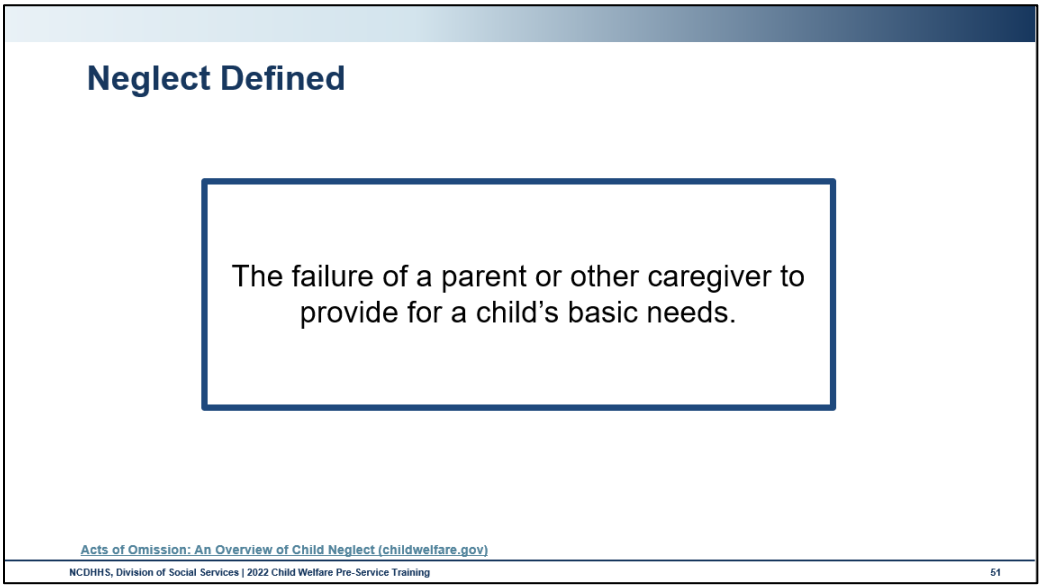
Key Takeaways



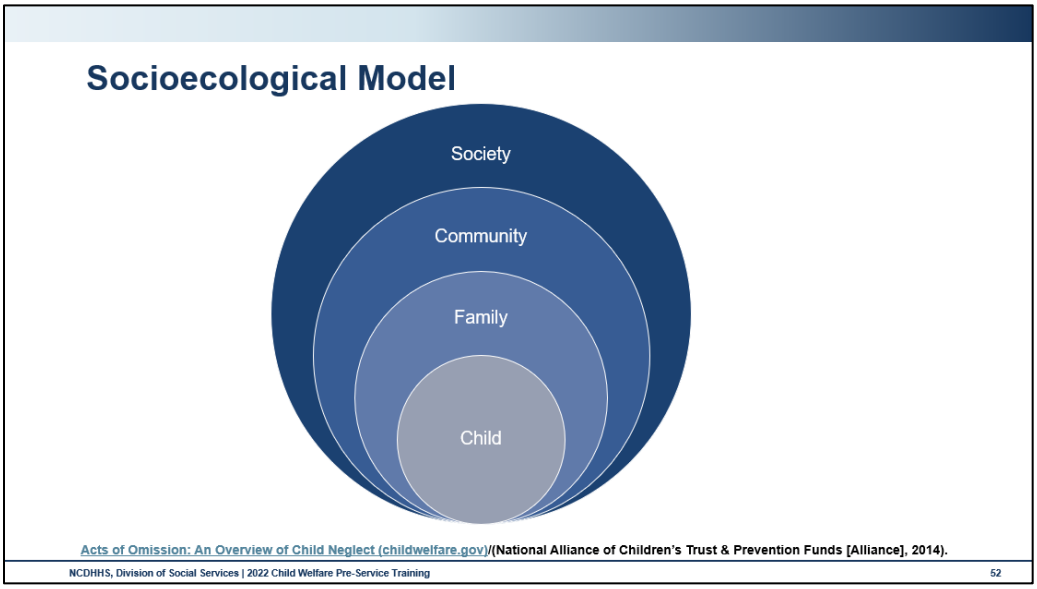
Questions and Reflections

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

What is Neglect?



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



At each of these levels there are factors that contribute to and protect against child neglect – risk factors and protective factors. Understanding that many factors beyond parents and caregivers contribute to neglect helps explain the complexity and nuance of the issue and will help you, as a social worker, use strengths-based approaches and preventive strategies with parents who need support.

Questions and Reflections

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

Activity: Self-Care Exercise/Breathing Meditation

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

Visit: https://www.uclahealth.org/marc/mpeg/01_Breathing_Meditation.mp3 for a breathing meditation exercise.

Day Two Agenda

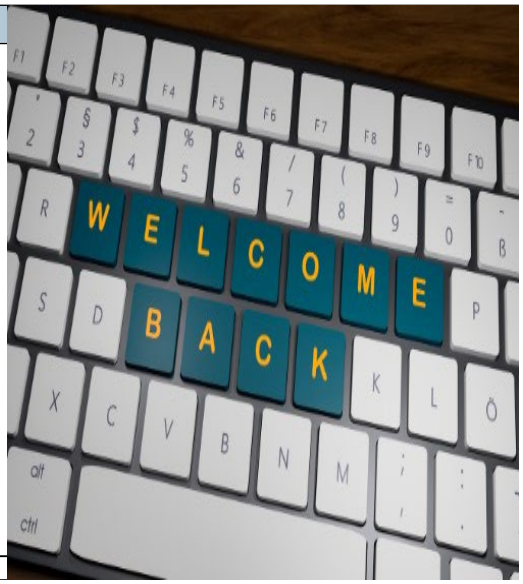
Pre-Service Training: Child Welfare in North Carolina

I.	Welcome & Learning Objectives	9:00 - 9:30
	Identification of Child Abuse and Neglect	
II.	What is Neglect? (continued)	9:30 – 10:10
III.	Introduction to Safety and Risk	10:10 - 10:40
	BREAK	**10:40 – 10:55**
	Historical and Legal Basis of Child Welfare Services	
IV.	National Child Abuse and Neglect Data (NCANDS)	10:55 -11:50
V.	History of Institutional Racism in Child Welfare	11:50 – 12:05
	Lunch	**12:05 – 1:05**
VI.	History of Institutional Racism in Child Welfare (continued)	1:05 – 1:35
VII.	Court Overview	1:35 – 2:40
	BREAK	**2:40 – 2:55**
	Ethics and Equity in Child Welfare	
VIII.	Introduction to Family-Centered Practice	2:55 – 3:40
IX.	Diversity, Equity, Inclusion, and Belonging	3:40 – 3:55
	Self-Care Exercise	3:55 – 4:00

Welcome

- How are people feeling today?
- What was your main "takeaway" from yesterday?
- Is there any clean-up we need to do?
- Review agenda for the day

NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training



Use this space to record notes.

Introduction to the Child Welfare System

Learning Objectives

• Describe safety, permanency, and well-being, and why they are vital to child welfare
• Outline the goals of the child welfare system
• Explain the relationship between safety, permanency, and well-being, and how each informs case decisions
• Explain the various aspects of the child welfare system and how they interact
• Identify local resources and internal and external stakeholders
• Identify and describe their role and purpose in the child welfare system

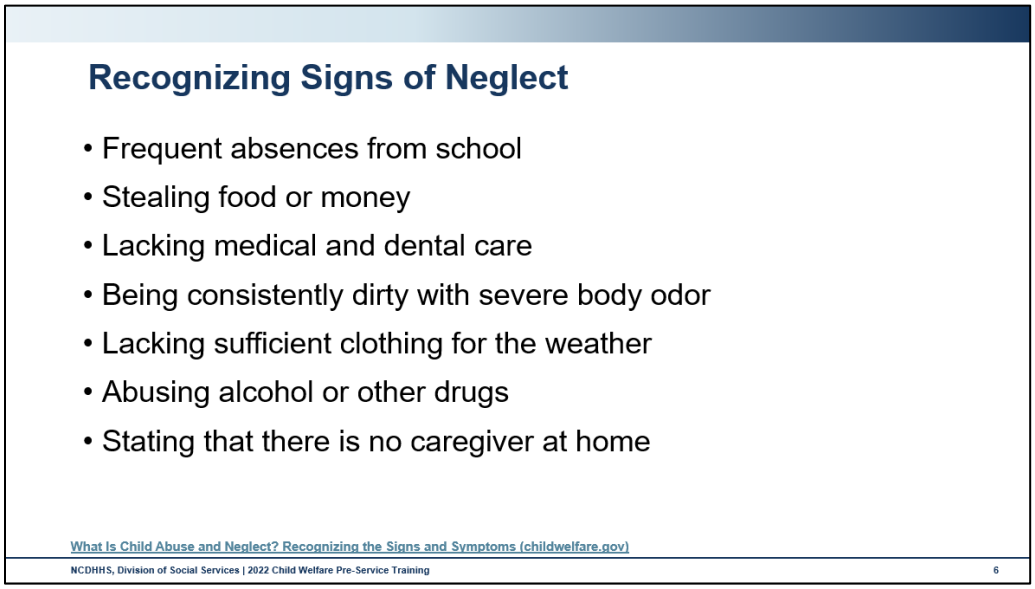
Use this space to record notes.

What is Neglect?

Neglect is by far the most prevalent form of maltreatment reported both nationwide and in North Carolina. Neglect is more commonly an omission of care and therefore can be more difficult to appropriately identify and define. North Carolina's definition of a neglected juvenile includes the following specific types of neglect:

- Improper care
- Improper supervision
- Improper discipline
- Abandonment
- Improper medical/remedial care
- Injurious environment including substance abuse, substance affected infants, and domestic violence
- Illegal placement/adoption

Recognizing Signs of Neglect



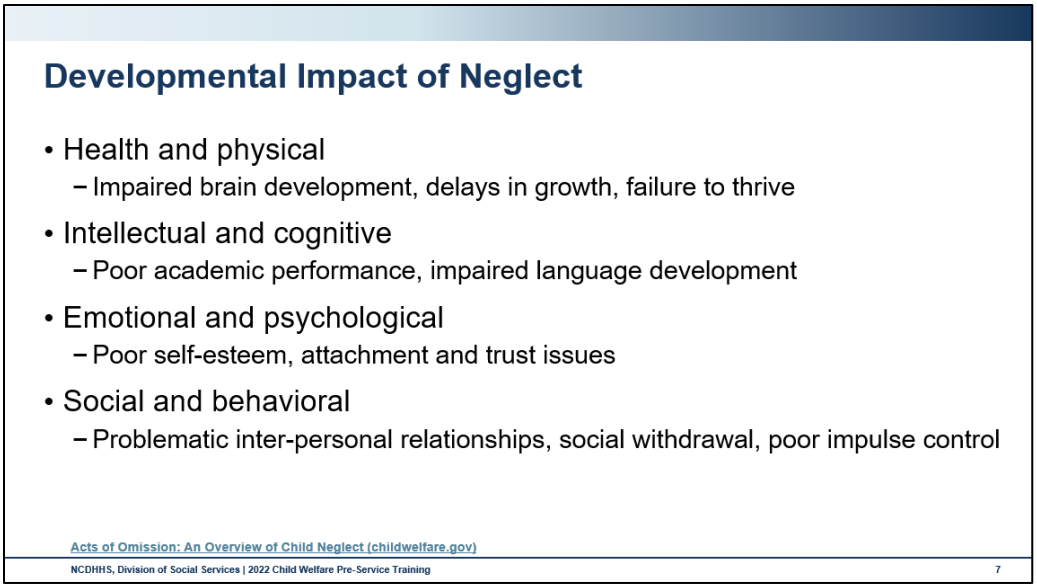
Improper care may present as lacking basic physical care and hygiene. Chronic lack of hygiene can cause disease or illness. Improper supervision includes being left unsupervised under the age of 8, or older if not developmentally appropriate for the child. Improper discipline can be using restraints, confinement, or depravation as a way to discipline a child. Improper medical or remedial care includes not receiving appropriate medical attention for injuries or illnesses.

An Injurious environment might be excessive filth, including exposed garbage, rotting food, animal and human excrement in living spaces, exposed wires, or unsecured areas where a child can fall. Other examples include being exposed to domestic violence, caregiver not meeting basic needs of child due to substance use, and prenatal exposure

to drugs or alcohol. It is critical to remember that substance use by a caregiver alone does not constitute neglect; it must have a direct impact on child safety.

Group Discussion:

Can you think of other potential indicators of neglect? Think critically about your suggestions, including what type of neglect you think it represents and why.



Child neglect has serious, potentially long-term consequences that seriously impact child development. Impact to these areas of development are interrelated, as issues in one area may influence growth in another. For example, impaired brain development can impact cognition and academic performance, which in turn impacts social development. Experiences of neglect can also have a traumatic effect, especially in severe cases. Child neglect is one common type of childhood trauma that results in distress, posttraumatic stress disorder, and posttraumatic stress symptoms. The developmental effects can also impact how children respond to stress and disrupt their ability to cope with adversity.

It is critical to understand that poverty is not the equivalent of neglect. Social workers must differentiate between neglectful situations and poverty. One distinction is if a family has access or means to provide something for a child and is intentionally not, versus if they are unable to access a resource. Identifying poverty as neglect also contributes to racial disproportionality in the child welfare system. Minority families are impacted by the stressors of poverty that increase risk factors and they may face child welfare system involvement due to reports related to poverty rather than neglect.

Activity: Identifying Poverty and Neglect

Read each scenario listed and determine if it reflects poverty or neglect. Write your answer on a separate post-it note for each scenario and place your note on the corresponding poster for each scenario.

1. **A family with two school aged children live in a house with no indoor plumbing.**

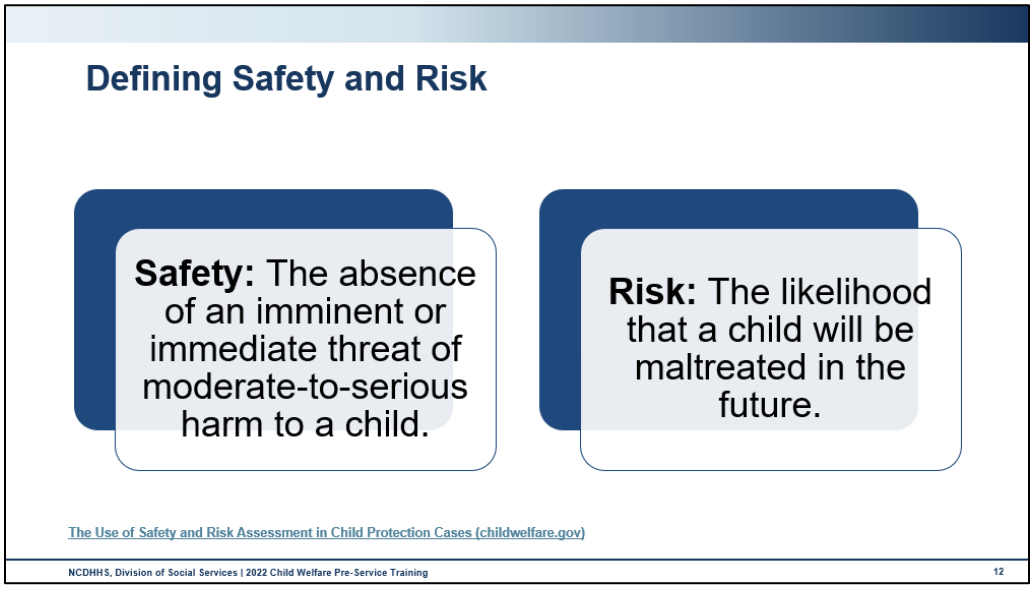
2. **A 14-year-old picks up her 9-year-old sister from the bus stop every day and makes her dinner every night while their mother works a late shift.**

3. **A family living in Section 8 housing has no electricity because of overdue payments.**

Questions and Reflections

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

Introduction to Safety and Risk

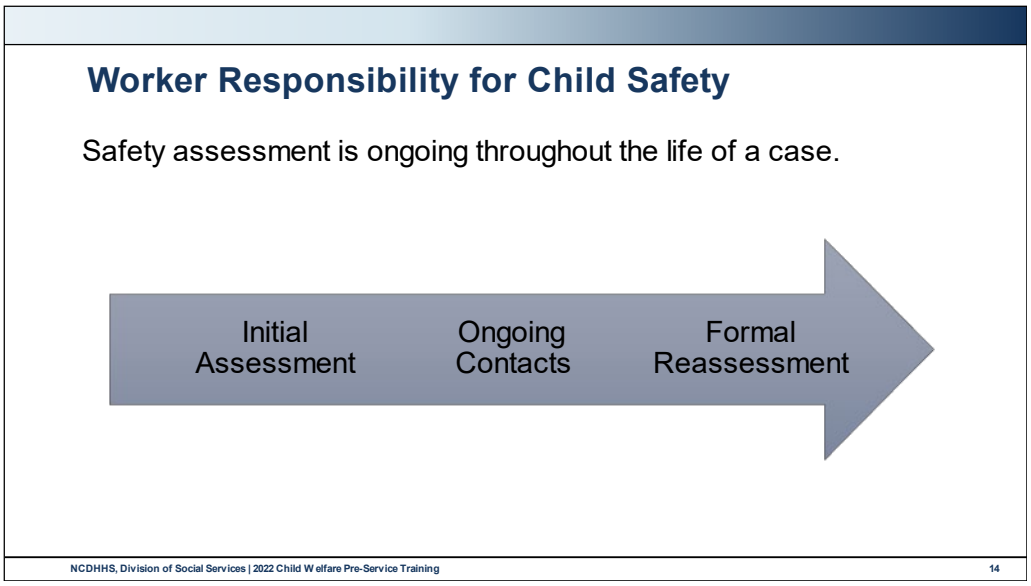


Safety and risk are **not** interchangeable terms. Safety applies to the need for action based on an immediate threat of harm. When looking at safety initially, the question you are asking is “can a child remain safely in the home?” Risk refers to the likelihood of future maltreatment and risk assessment is asking the question “should ongoing services be provided?”

Activity: Distinguishing Safety from Risk

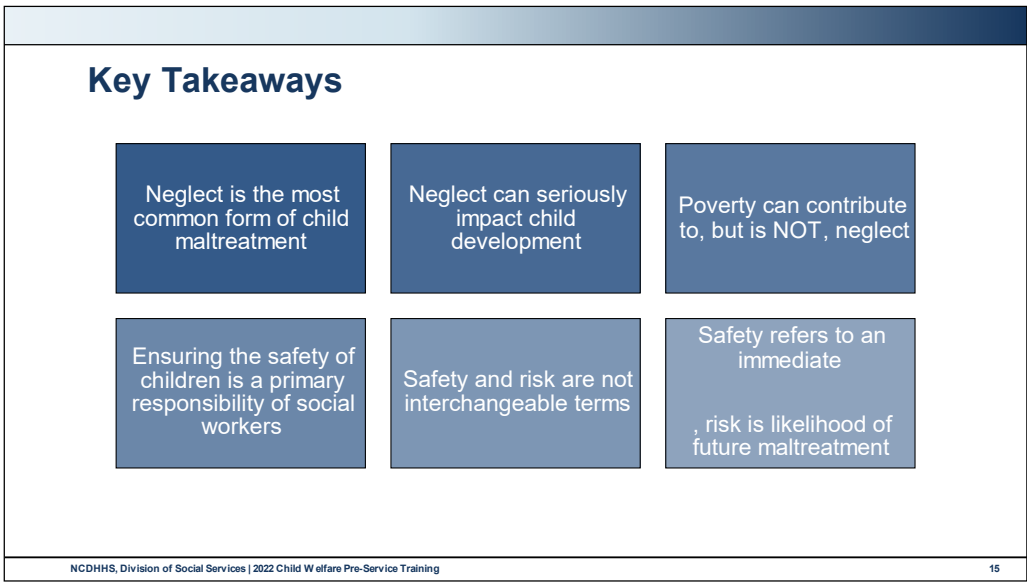
Consider whether the listed example represents a safety threat or risk factor. When instructed, you will move to the side of the room the trainer has indicated for your selection. Be prepared to explain your reasoning.

1. **An 8-year-old boy has a black eye and other abrasions on his face. He reports that his father hit him.**
2. **A mother of 3 children ages 3, 5, and 7 who is addicted to multiple substances.**
3. **A 16-year-old is expressing suicidal ideations and has articulated a plan; the school has notified her parents and they are not seeking treatment for her.**
4. **A boyfriend physically abuses the mother of his 2 children.**
5. **A family with 5 children in a two-bedroom apartment. The oldest children, who are 10 and 12 sleep on the floor and the apartment space is very crowded with belongings and messy.**



No matter what your role is, ensuring the safety of children is always your responsibility. Every time you visit a child, the frequency of which will depend on the type of case, you are assessing for safety. You will assess for safety by asking the family direct questions and observing their environment. You will also factor information from other people involved with the family into your safety assessment. This applies to in-home and out-of-home cases. Monitoring the safety of children in out-of-home placements is critical.

Key Takeaways



Questions and Reflections

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

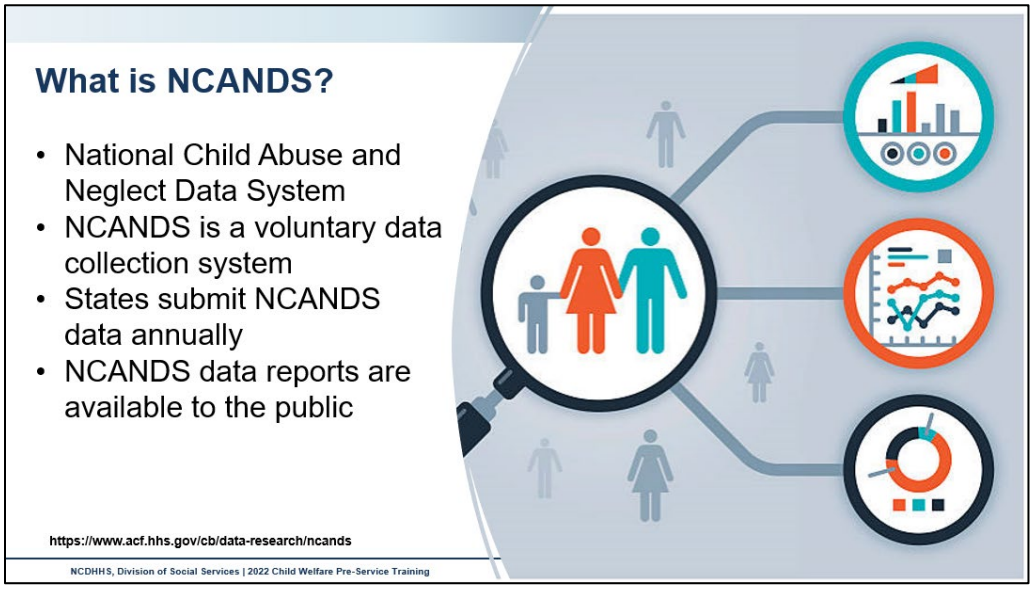
Historical and Legal Basis of Child Welfare Services

Learning Objectives

• Discuss the benefits of using data to improve outcomes for children and families, as well as the impact of relying on anecdotal information rather than data.
• Identify and analyze prospective data that directly impact the safety, permanency, and well-being of children and families.
• Explain the history of institutional racism in child welfare and its impact on disproportionality in child welfare.
• Discuss the impact of institutional racism in child welfare on the outcomes for children and families.
• Discuss how the court and child welfare agency work together to achieve safety, permanency, and well-being outcomes for children and families.
• Explain the various types f court hearings involving children and families and their roles in each of the hearings.
• Explain roles and responsibilities related to court and court-related activities.

Use this space to record notes.

National Child Abuse and Neglect Data



The National Child Abuse and Neglect Data System, known as NCANDS, is operated by the Children's Bureau within the US Department of Health and Human Services. NCANDS gathers information from all 50 states, the District of Columbia, and Puerto Rico about child abuse and neglect.

National Child Abuse & Neglect Data FFY2020

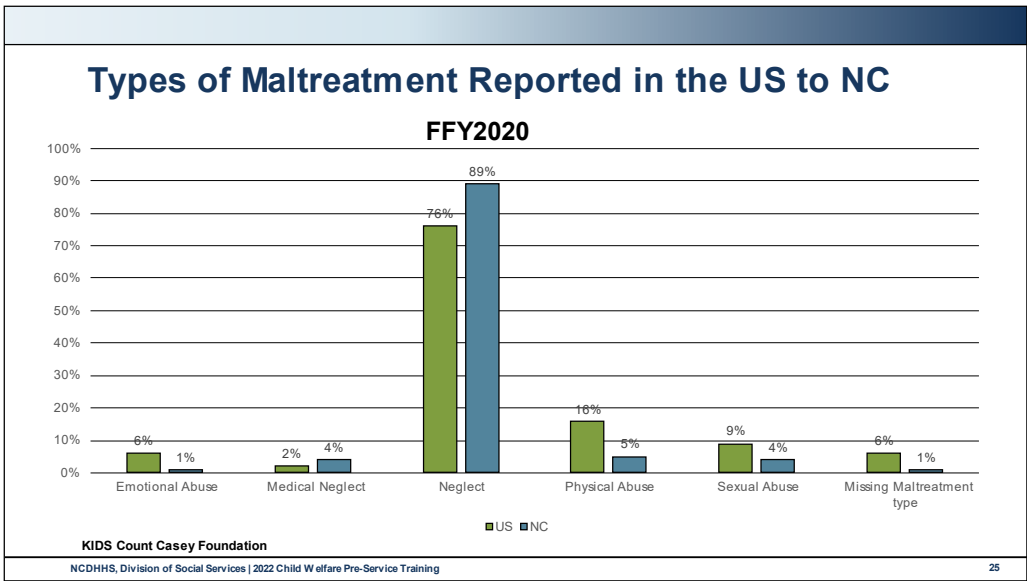
- States screened in 2.1 million reports of maltreatment (decrease of 10.5%)
- Education personnel report source shows the largest decrease of 27% (2019-20)
- About 3,145,000 children received either an investigation or alternative response – with 54% of these children receiving ongoing services
- Number of children confirmed as CA/N victims 614,931
- Of those confirmed victims, 52% were female
- A national estimate of 1,750 children died from abuse and neglect
- More than one-quarter (28.6%) of victims are in the age range of birth through 2 years old. Victims <1 year are 15.2% of all victims

NCANDS Data from the Children's Bureau

Child Abuse & Neglect Data in NC FFY2020

- About 108,029 children received either an investigation or alternative response (1 -2% higher than national avg), with 55% receiving ongoing services (1% higher than national avg)
- Number of children confirmed as CA/N victims 22,255 (1 -2% higher than national avg)
- Of those confirmed victims, 40% were 4 years old or younger (about 4% lower than national avg)
- Of reports made and screened in, 50% of victims were female

KIDSCount the Casey Foundation



This slide compares the types of maltreatment reported in the U.S. during the federal fiscal year 2020 and the types of maltreatment reported in North Carolina during that same time period.

Data: Why Is it Important?

Data informs decisions related to:

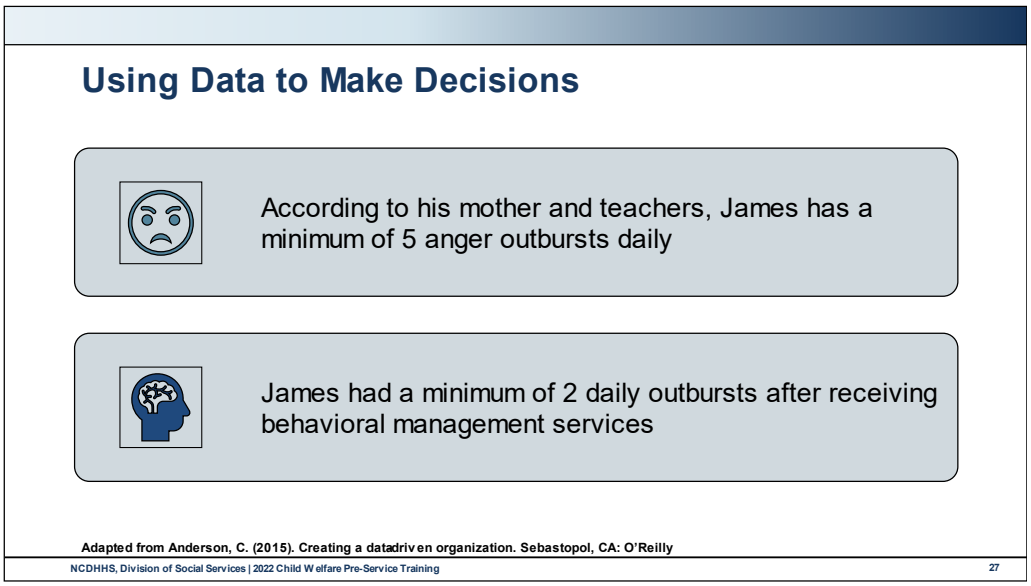
- who and what circumstances
- the effectiveness of services and strategies
- social worker performance and needs
- the status of the family in meeting case outcomes

Children's Bureau: Guide to Data-Driven Decision-Making Capacity Building Center for States

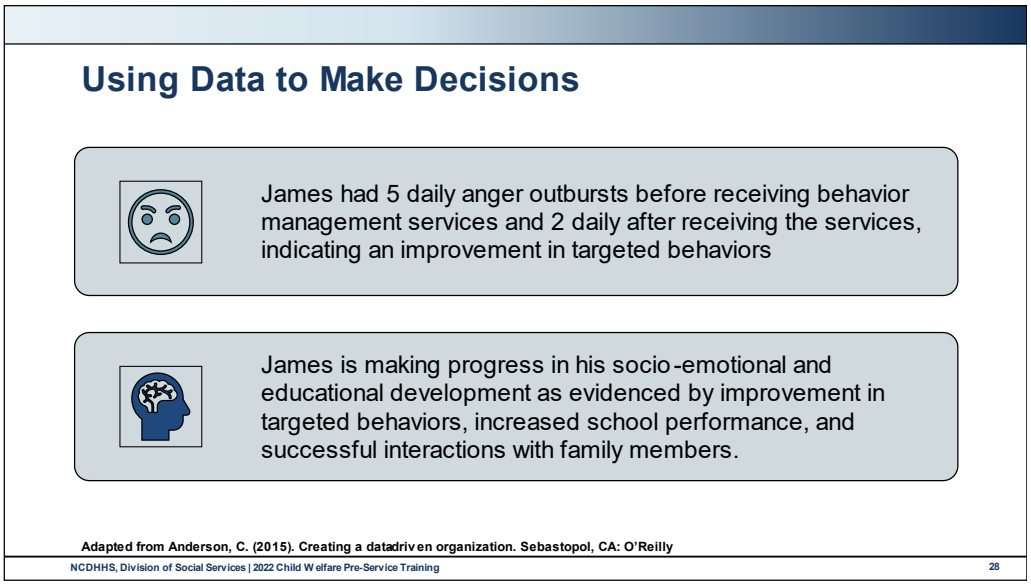
NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training 26

As social workers, you are constantly gathering data. You are considering whether the child is improving in school, if the family is reaching their goals, what the family needs to be safe and healthy. These data inform you as a social worker about all aspects of your work, including what services are needed and what resources the family has.

Using Data to Make Decisions



Data should be used at every level within the agency and the child welfare system as a whole.

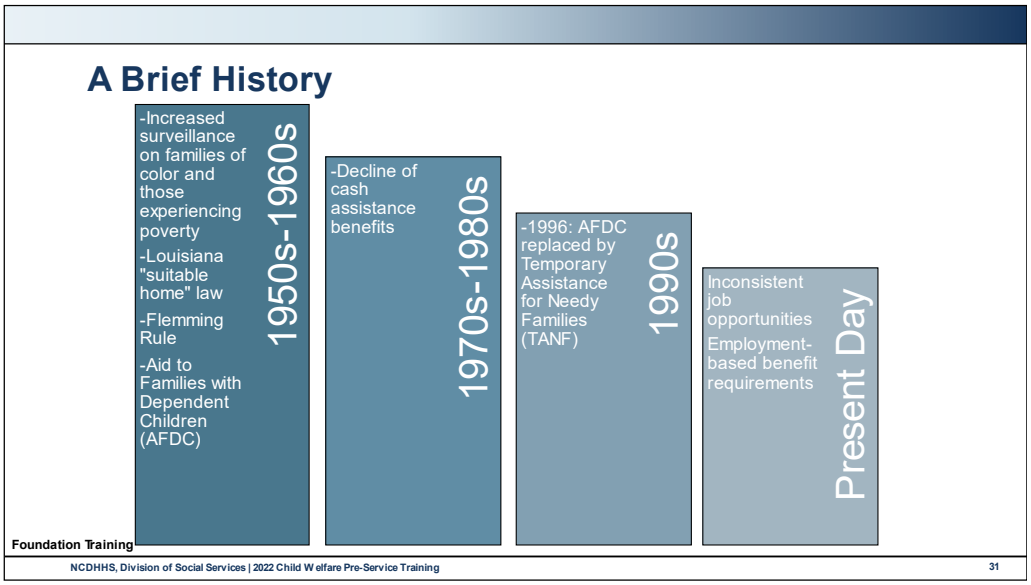


Quantitative and qualitative data (the numbers and our observations) and the collection of information from reliable sources assists social workers and agencies in making data-based decisions as well as in the long-term creating a body of evidence about best practices and services.

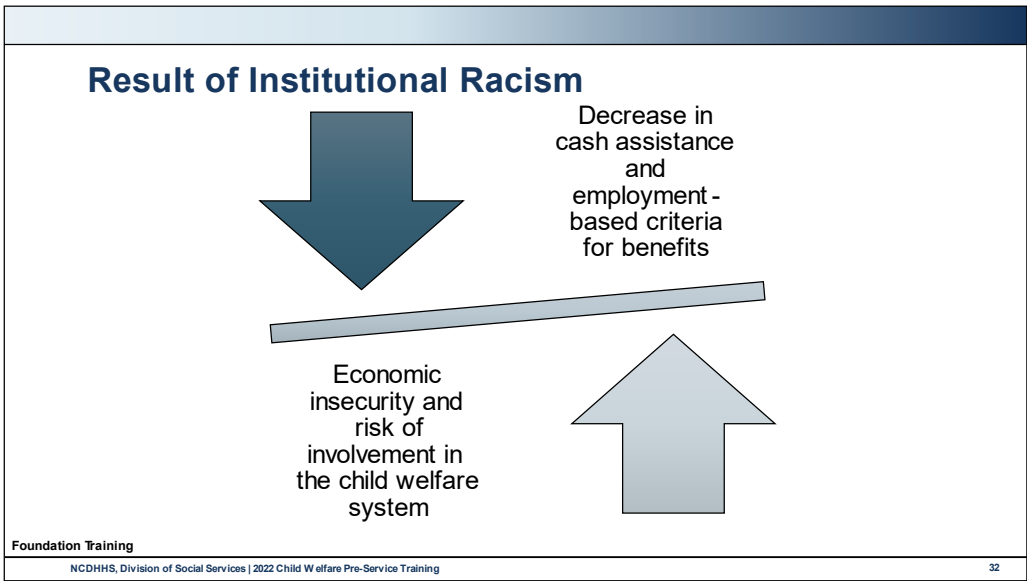
Questions and Reflections

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

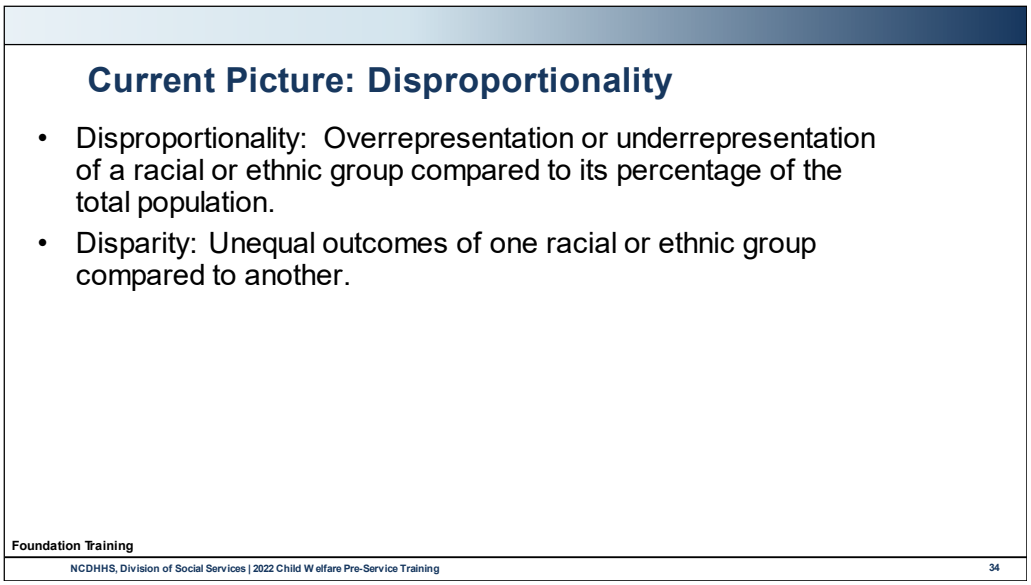
History of Institutional Racism in Child Welfare



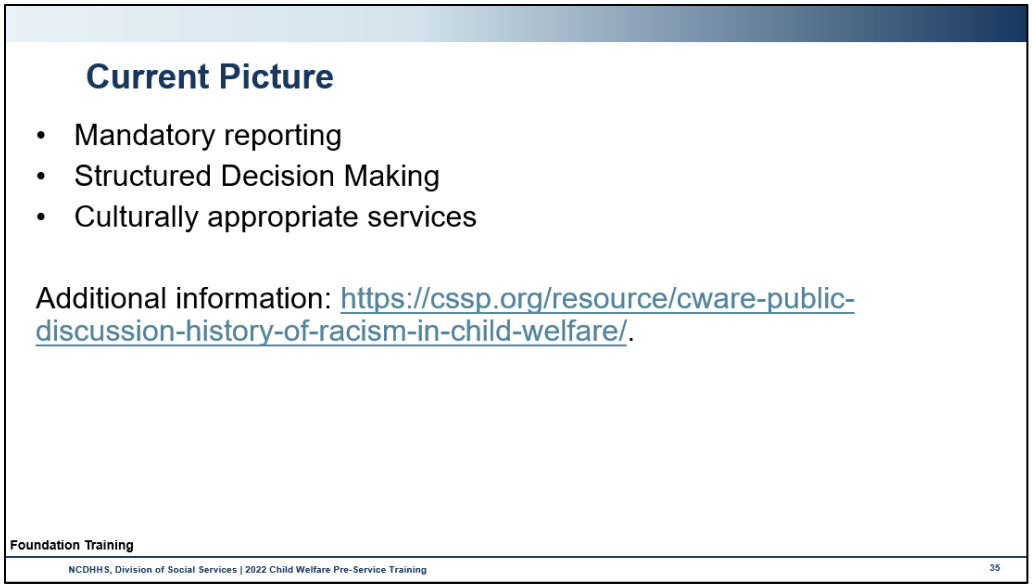
The national child welfare system has a relatively short history, although children have been placed in orphanages and private foster homes since the early 1800s. Since 1996, inconsistencies in job opportunities and the requirement of employment to access benefits leave families of color to be continually disproportionately subjected to economic insecurity and increases their risk of involvement with child welfare.



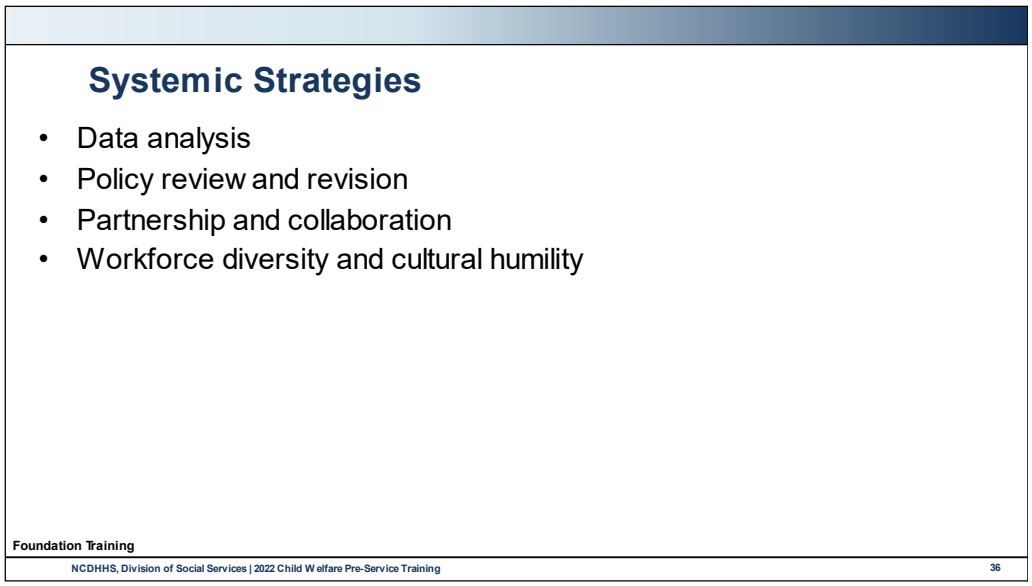
The result of continuing institutional and systemic racism is a seesaw of decreasing benefits to families needing them, who are disproportionately families of color, and thereby increasing their risk of having their children removed and placed into foster care.



In the last several years, children in multiple minority groups were overrepresented in child welfare, including American Indian/Alaskan Native children, who make up less than 1% of the national population but 2% of the foster care population, and black children, who make up 14% of the national population, but 20% of the foster care population. Latinx children have historically been underrepresented in foster care nationally, in 2018, they were overrepresented in 20 states. On the contrary, white children make up 50% of the national population, but 44% of the foster care population.



For families of color who become involved in the child welfare system, the services provided may not be culturally appropriate and may be expensive. Culturally responsive services are vital to meet the needs of children and families.

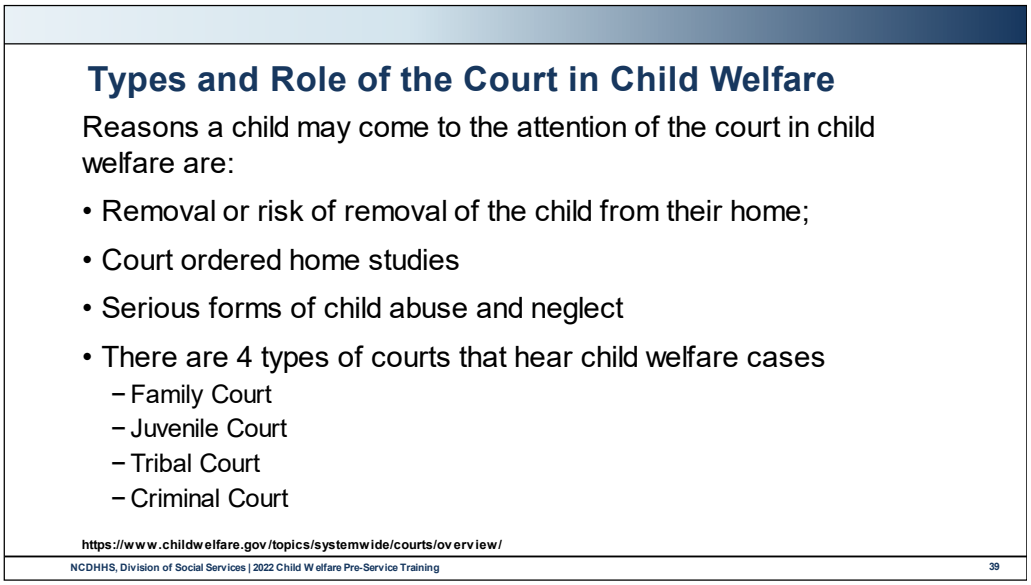


In order for sustained change to occur in racial disproportionality and disparity in child welfare, change must begin at the systems level and be supported by leadership. State and local agencies must examine the root causes of racist practices and disparity in order to effect change at each level of the child welfare system.

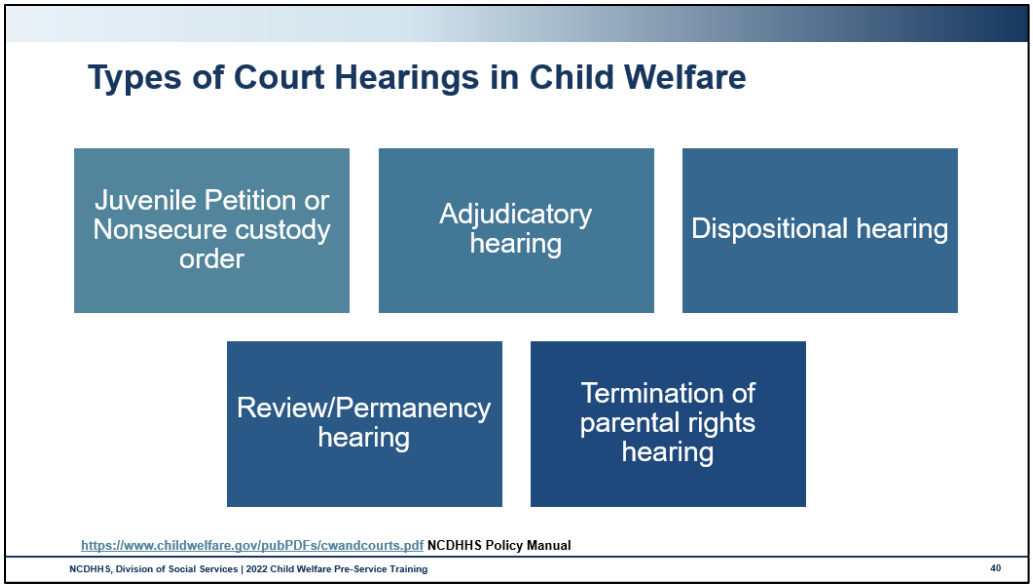
Questions and Reflections

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

Court Overview



In most States, if a case requires court involvement, it will come before either a juvenile or a family court. The one exception to this is children with American Indian/Alaskan heritage. Children with American Indian/Alaskan heritage are treated separately and come under the jurisdiction of the Indian Child Welfare Act, which empowers the child's Tribe and family in decisions affecting the child. Family and Juvenile courts determine whether or not a child remains in their home or is placed in another home.



Juvenile petition and non-secure custody hearings: During these hearings, the court decides if the child needs to be placed away from their parents or caregivers temporarily to ensure safety until a disposition is made. With Non-secure Custody Orders the court authorizes law enforcement officers to take immediate custody of a child who is deemed not safe in their home.

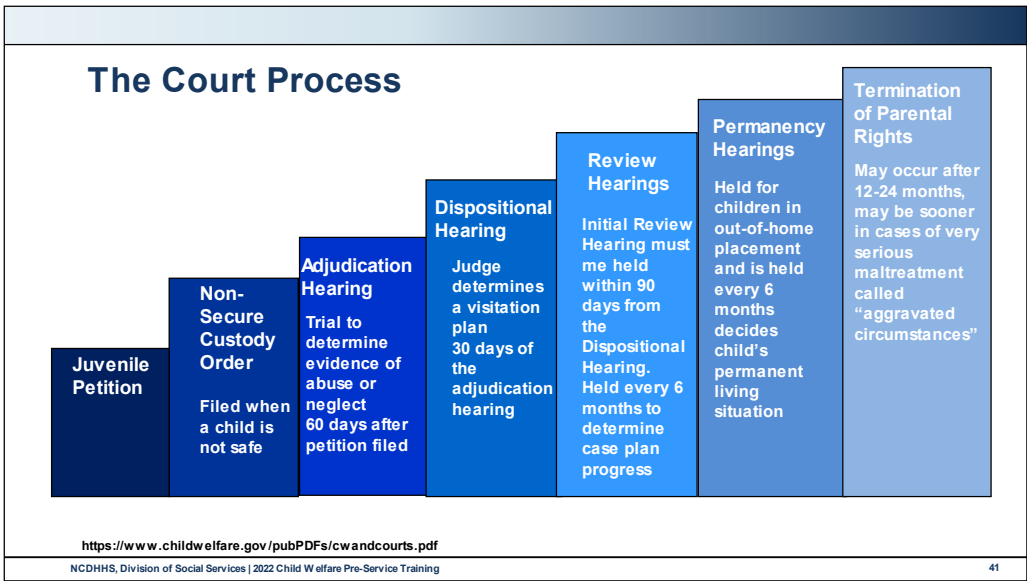
Adjudicatory hearing: This is a fact-finding hearing in which the court hears evidence and decides if a child was abused or neglected based on State law.

Dispositional hearing: If a child has been found to have been abused, neglected, or dependent the court makes decisions about custodial placement of the child (e.g., remaining with the parent or placement in out-of-home care), contact or visitation between the parent and child, and services for the parent and child. This hearing should take place immediately following the adjudication hearing and be concluded within thirty (30) days.

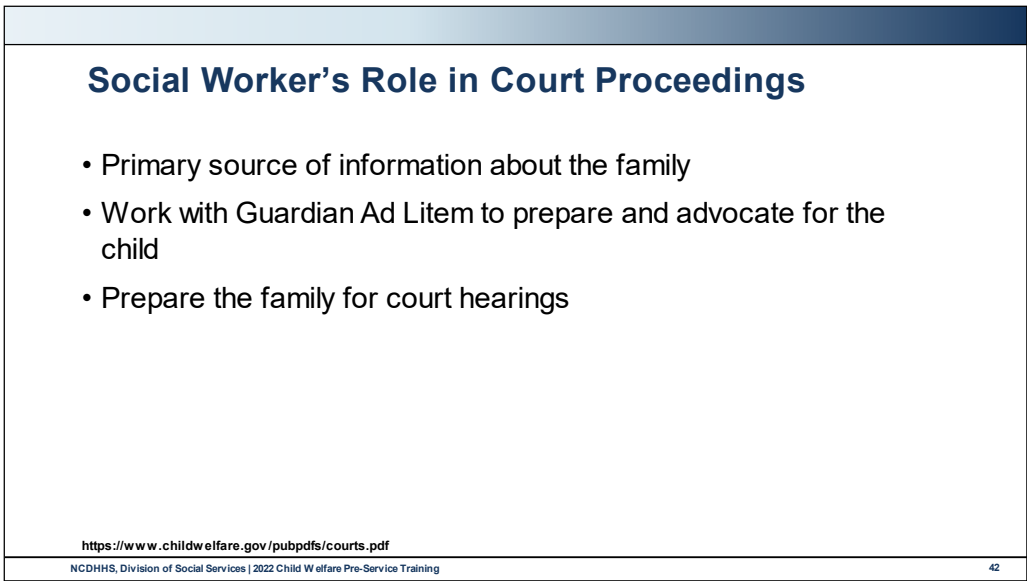
Review hearings sometimes called Permanency planning hearings: When a child is in their own home, a review hearing is held every 6 months to ensure progress is being made on the case plan. The initial review or permanency hearing is held with ninety (90) days from the Dispositional Hearing. When a child is in out-of-home placement these hearings are called Permanency Planning Hearings

Permanency hearing: These hearings are for children in the custody of the county DSS and must be held within 6 months of a child's placement in out-of-home care to determine a firm plan for the child's permanent placement upon exiting out-of-home care.

Termination of parental rights hearing: If a court determines that a child in out-of-home care cannot be safely reunited with his or her parent, a termination of parental rights hearing may be held to free the child for adoption.

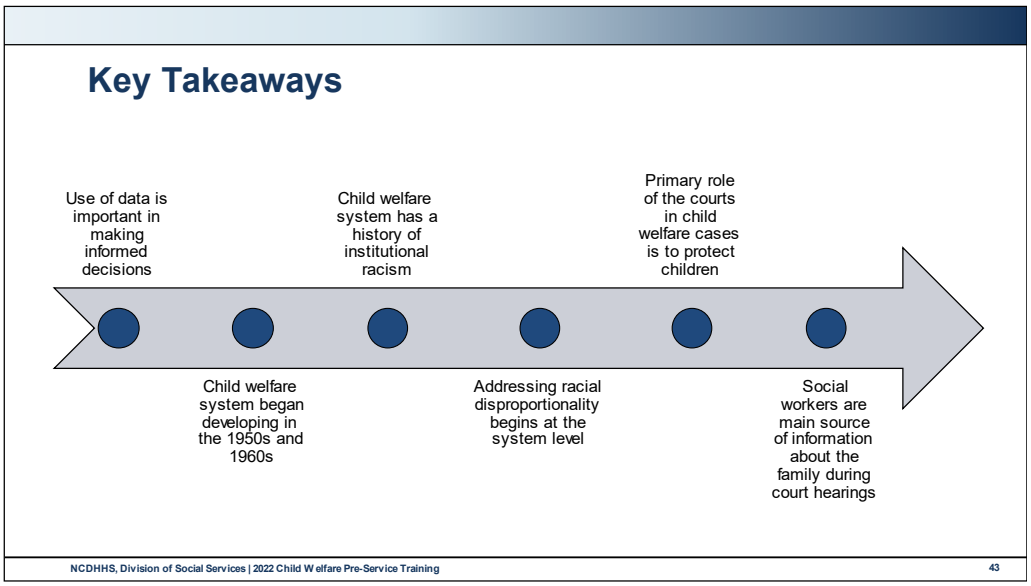


After a child welfare agency receives a report of suspected child abuse, neglect, or abandonment—also referred to as "maltreatment"—the legal process typically progresses through the steps listed on the slide if the court is involved.



Judges expect social workers to dress appropriately, be on time, show that they have engaged the child and family, and present well-organized and well-documented court reports. A collaborative style is also necessary to maximize positive family, agency, and court outcomes. Quality court reports afford social workers the best opportunity to communicate information to the court and to influence its decision. Most court reports include copies of the family's case plan and sections on reasonable efforts the agency has made to either keep the children with their parents or to reunify the child with their parents.

Key Takeaways



Questions and Reflections

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

Ethics and Equity in Child Welfare

Learning Objectives

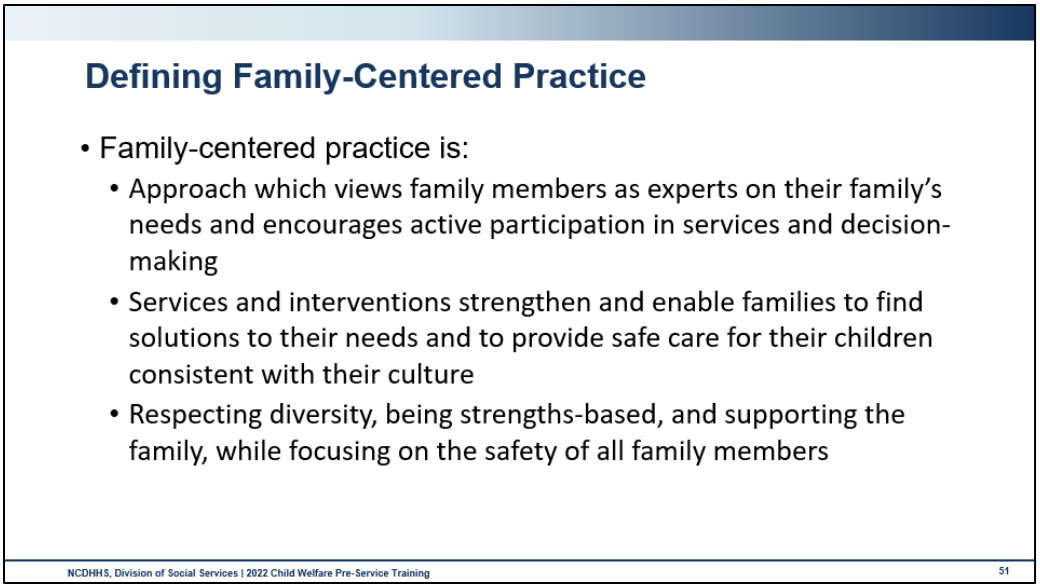
• Describe the behaviors and elements that encompass family-centered practice and how they impact safety, permanency, and well-being.
• Describe the concepts of diversity, equity, inclusion, and belonging.
• Identify your own bias and describe how it may impact your case practice.
• Describe how the NASW Code of Ethics guides case decision making, as well as professional conduct in the field.
• Describe how to treat families with dignity and respect in all interactions.
• Describe why it is important to maintain professional boundaries.
• Describe strategies to maintain and manage professional boundaries in the workplace and with families.
• Describe a family's right to confidentiality.
• Describe situations when information can and cannot be released and the steps that must be taken when confidentiality is breached.

Use this space to record notes.

Introduction to Family-Centered Practice

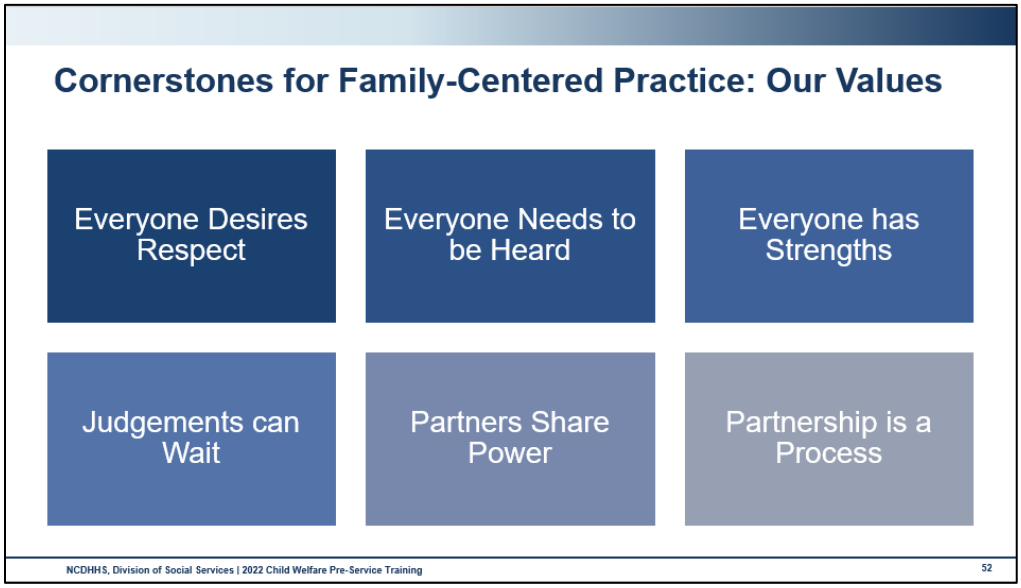
Activity: What Does Family Mean to You?

- **Take a few moments to think about how you would define family.**
- **Who is included in your definition of family?**
- **Who is excluded?**
- **What were some of the factors you considered in developing your definition?**



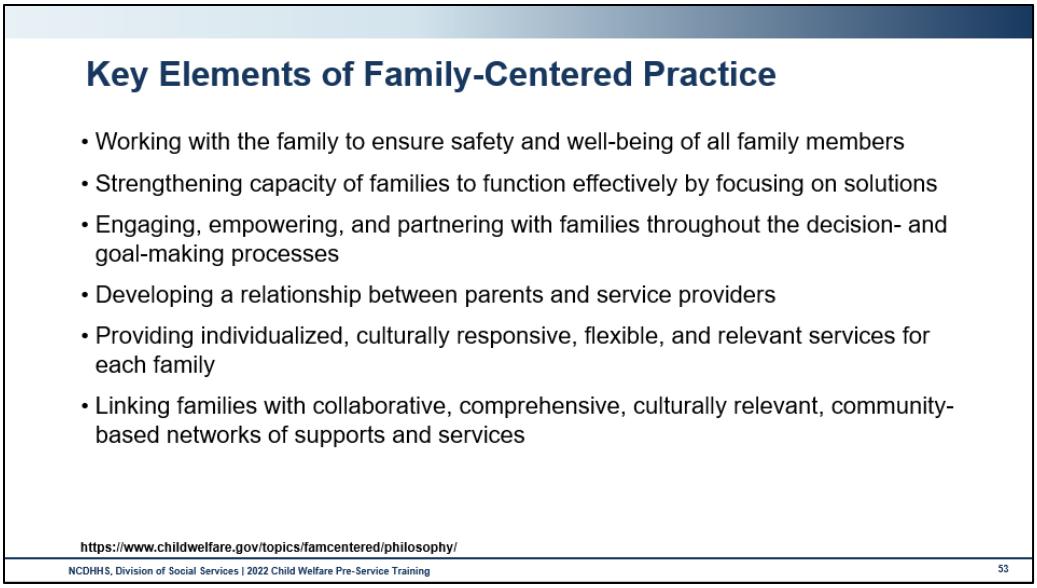
Family-centered practice means that you respect diversity, are strengths-based, and support the family, while focusing on the safety of all family members.

Cornerstones for Family-Centered Practice: Our Values

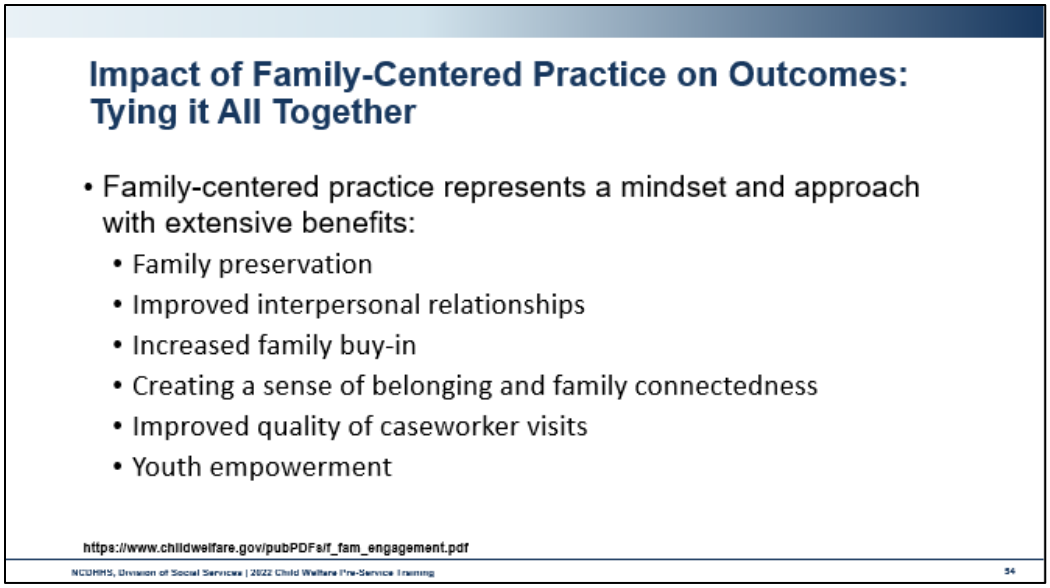


These principles are the cornerstones for family-centered practice and were written as guidelines for the relationships between social workers and families. They also serve as a foundation for all relationships in child welfare such as the worker and community resource agency, the worker and supervisor, and foster parents and the child's parents. We must approach every interaction and every relationship using these principles.

What are some examples of how these principles might look in practice that you remember from your pre-work e-learning modules?



Family-centered services are based upon the belief that the best place for children to grow up is in a family and the most effective way to ensure children's safety, permanency, and well-being is to provide services that engage, involve, strengthen, and support families.



In child welfare practice, families are recognized as experts in determining what is best for themselves and their children. Prioritizing family voice in decision-making and planning processes enhances the fit between family needs and services and increases the likelihood that families will access services that will achieve their goals.

Video: Family Engagement – Dad's Rock!

Visit: Dad's Rock! for a video about fathers on their journey to deepen their bonds with their children and the professionals working to improve father engagement.

Debrief

Group discussion:

What statements from the dads or from the professionals did you hear in the video that you want to remember?

What did you hear in the video that supported the "why" in support of engaging fathers?

Questions and Reflections

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

Diversity, Equity, Inclusion, and Belonging

What is Diversity, Equity, Inclusion, and Belonging?

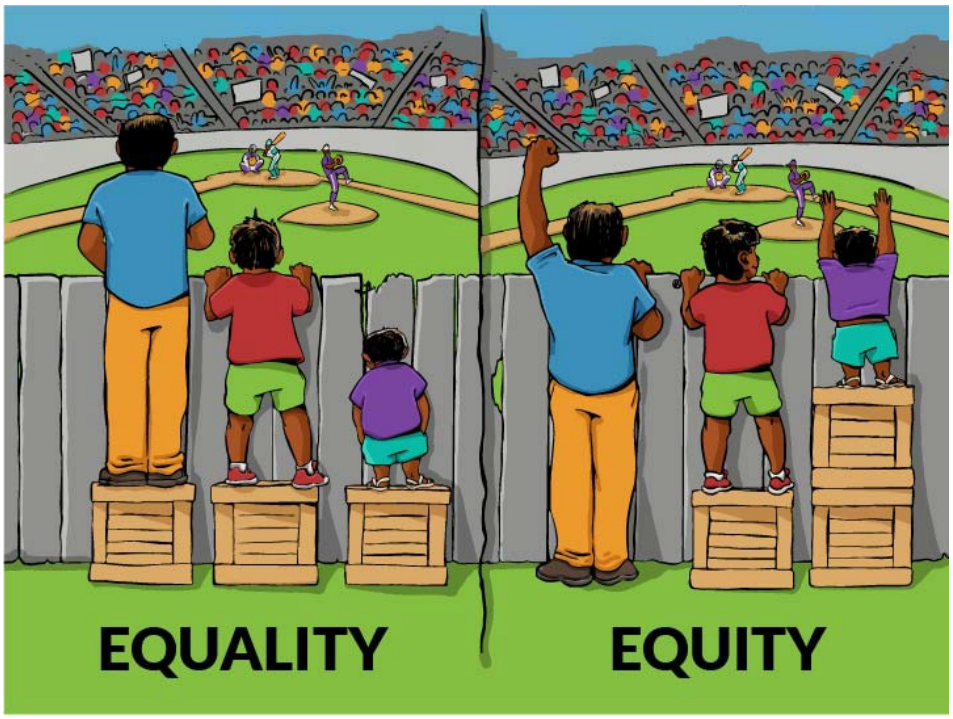
- **Diversity:** A group reflective of the society in which it exists and operates, representing both inherent and acquired differences. Inherent differences you are born with (gender, ethnicity, and sexual orientation) and acquired differences you gain from experience.
- **Equity:** Equity recognizes that each person has different circumstances and allocates the exact resources and opportunities needed for each to reach an equal outcome. Equality means each individual or group of people is given the same resources or opportunities.
- **Inclusion:** The achievement of an environment in which all individuals are treated fairly and respectfully, have equal access to opportunities and resources, and can contribute fully and authentically to society or to the specific organization's or institution's success.
- **Belonging:** Creating an environment that ensures the activation of the full human experience by engaging and maximizing the potential of the individual, and integrating their views, beliefs, and values.

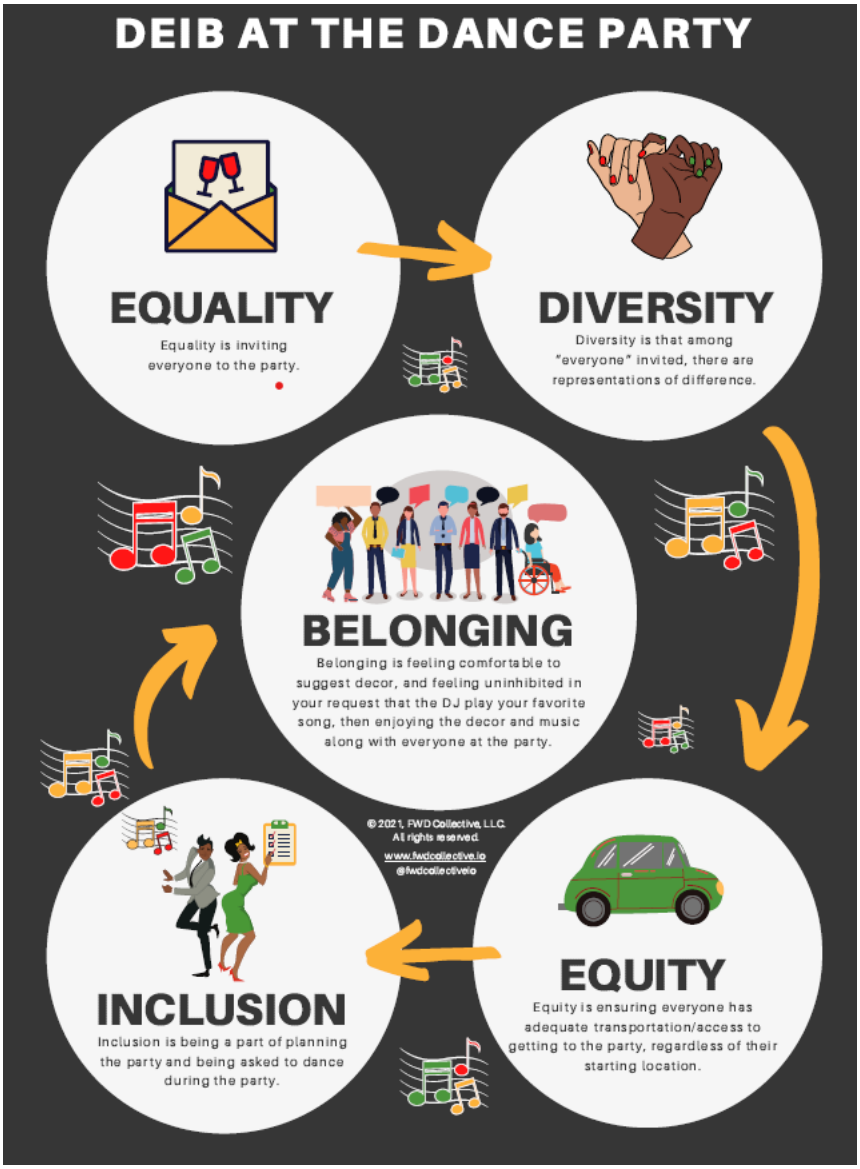
FWD Collective, LLC. (2021). (rep.)*Diversity, Equity, Inclusion, Belonging*FWD Collective, LLC.

NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training 58

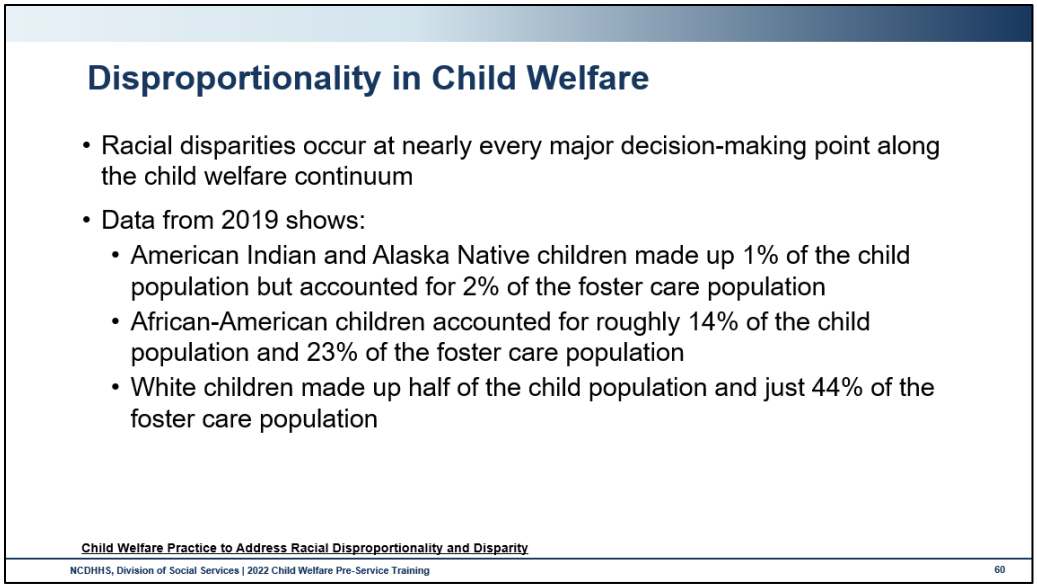
Diversity, Equity, Inclusion and Belonging, also referred to as DEIB, are the four pillars that drive real impact in creating a society where everyone is invited, has access and resources, feels welcomed, and feels valued.

Equality vs. Equity: Image credit - Interaction Institute for Social Change | Artist: Angus Maguire.

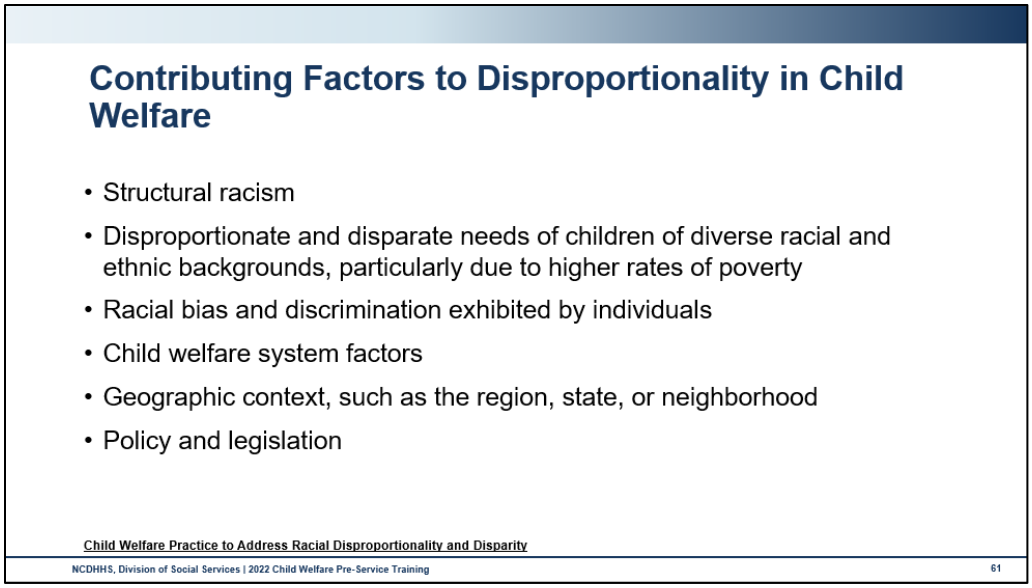




If we don't consider equity, inclusions, diversity, or belonging, who doesn't get included in the party? Who misses out? And what do the rest of us miss out on if some people are not invited?



The pervasive issue of racial disparity in child welfare has long presented troubling implications for children and families of color. The concept of DEIB is essential in developing inclusive practices that work to dismantle historical and systemic racial biases in the field of child welfare.



Structural racism stemming from the accumulation of historical and cultural factors that have allowed racial inequities to endure and adapt over time.

Children and families of diverse racial and ethnic backgrounds may have a disproportionate need for child welfare services due to a range of factors that put them at greater risk for being reported for child maltreatment—most notably, poverty. Poverty does not equate to abuse or neglect, but it is a risk factor that can interfere with a parent's ability to care for their children by restricting access to basic needs, such as housing, food, and health care. The stress of living in economic deprivation can also affect parenting capacity, resulting in inconsistent discipline, the inability to respond to a child's emotional needs, or a failure to prevent or address potential safety risks.

Bias and human decision-making by mandated reporters, caseworkers, and other personnel may play a role in perpetuating poorer outcomes for families of diverse racial and ethnic backgrounds who come into contact with the child welfare system.

Child welfare system factors like the lack of resources for families of diverse racial and ethnic backgrounds.

Differences in disproportionality across geographies may reflect variations in child welfare policy and practice, historical circumstances, and a range of demographic, socioeconomic, and community factors found in specific regions across the country. For example, one study found that African American, Hispanic, and White children living in diverse neighborhoods are more likely to be reported to CPS than children of their same race or ethnicity living in homogenous neighborhoods.

Policy and legislation, such as a lack of policies targeting the needs of families of diverse racial and ethnic backgrounds, along with the presence of policies that negatively target these families likely contribute to their increased involvement with the child welfare system.

Questions and Reflections

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

Activity: Self-Care Exercise/Body-Sound Meditation

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

Visit: https://www.uclahealth.org/marc/mpeg/Body-Sound-Meditation.mp3 for a meditation exercise.

Day Three Agenda

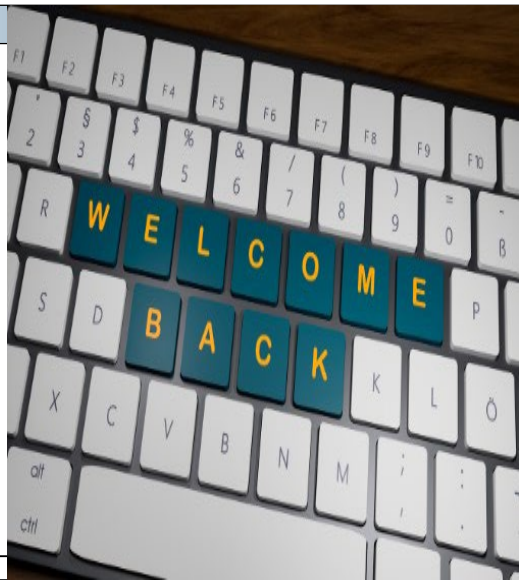
Pre-Service Training: Child Welfare in North Carolina

I.	Welcome & Learning Objectives	9:00 - 9:30
	Ethics and Equity in Child Welfare	
II.	Diversity, Equity, Inclusion, and Belonging (continued)	9:30 – 10:05
III.	NASW Code of Ethics	10:05 - 10:25
	BREAK	**10:25 – 10:40**
IV.	Treating Families with Dignity and Respect	10:40 -11:15
V.	Professional Boundaries	11:15 – 11:55
VI.	Confidentially	11:55 – 12:15
	LUNCH	**12:15 – 1:15**
	Key Issues in Child Welfare: Substance Use, Family Violence, and Mental Health	
VII.	Overview of Substance Use	1:15 – 2:10
	BREAK	**2:10 – 2:25**
VIII.	Overview of Domestic and Family Violence	2:25 – 3:30
IX.	Mental Health in Child Welfare: Needs and Diagnoses	3:30 – 3:50
	Self-Care Exercise	3:50 – 4:00

Welcome

- How are people feeling today?
- What was your main "takeaway" from yesterday?
- Is there any clean-up we need to do?
- Review agenda for the day

NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training



Use this space to record notes.

Ethics and Equity in Child Welfare

Learning Objectives

• Describe the behaviors and elements that encompass family-centered practice and how they impact safety, permanency, and well-being.
• Describe the concepts of diversity, equity, inclusion, and belonging.
• Identify your own bias and describe how it may impact your case practice.
• Describe how the NASW Code of Ethics guides case decision making, as well as professional conduct in the field.
• Describe how to treat families with dignity and respect in all interactions.
• Describe why it is important to maintain professional boundaries.
• Describe strategies to maintain and manage professional boundaries in the workplace and with families.
• Describe a family's right to confidentiality.
• Describe situations when information can and cannot be released and the steps that must be taken when confidentiality is breached.

Use this space to record notes.

Diversity, Equity, Inclusion, and Belonging

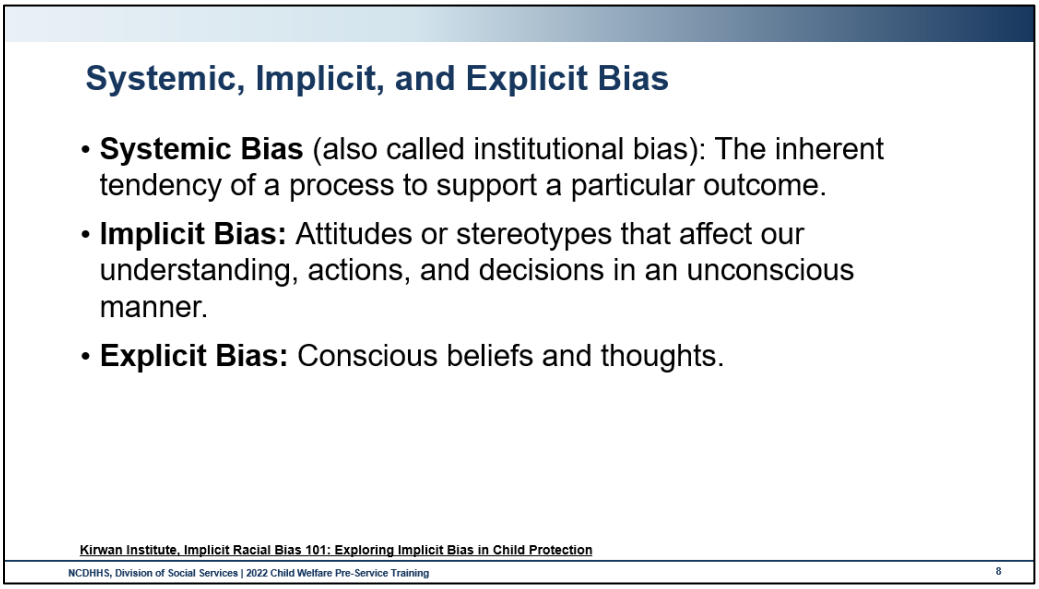
Activity: Father-Son

Read the scenario then answer the discussion questions.

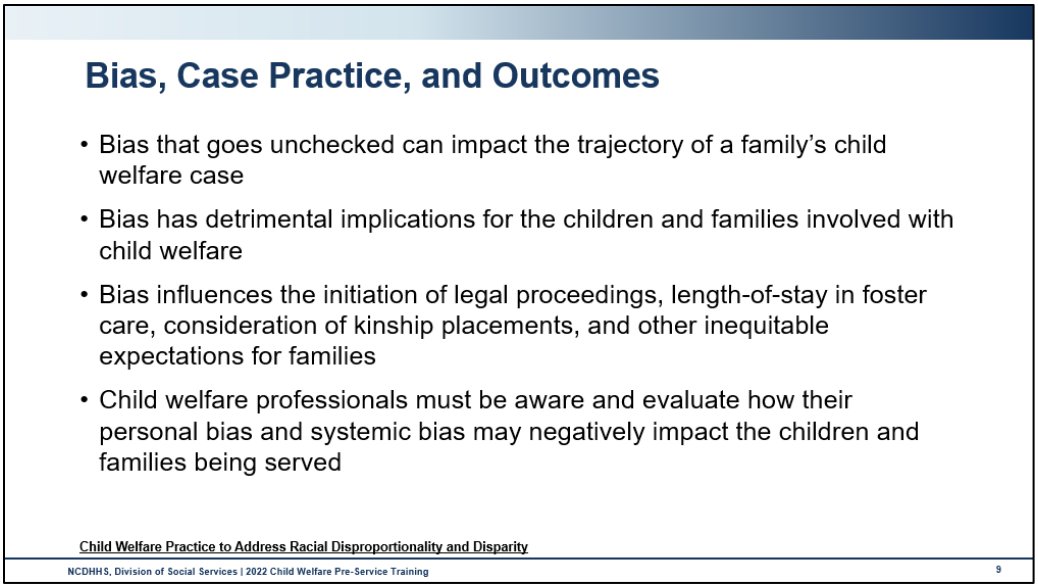
A father and son were involved in a car accident in which both the father and the son were seriously injured. The father was taken by ambulance to one hospital across town and the son was taken by ambulance to the nearby children's hospital. Once at the hospital, the son was immediately wheeled into an emergency operating room. A surgeon was called. Upon arrival and seeing the patient, the attending surgeon exclaimed "Oh my God, it's my son!"

Can you explain this?
What solutions did you come up with?

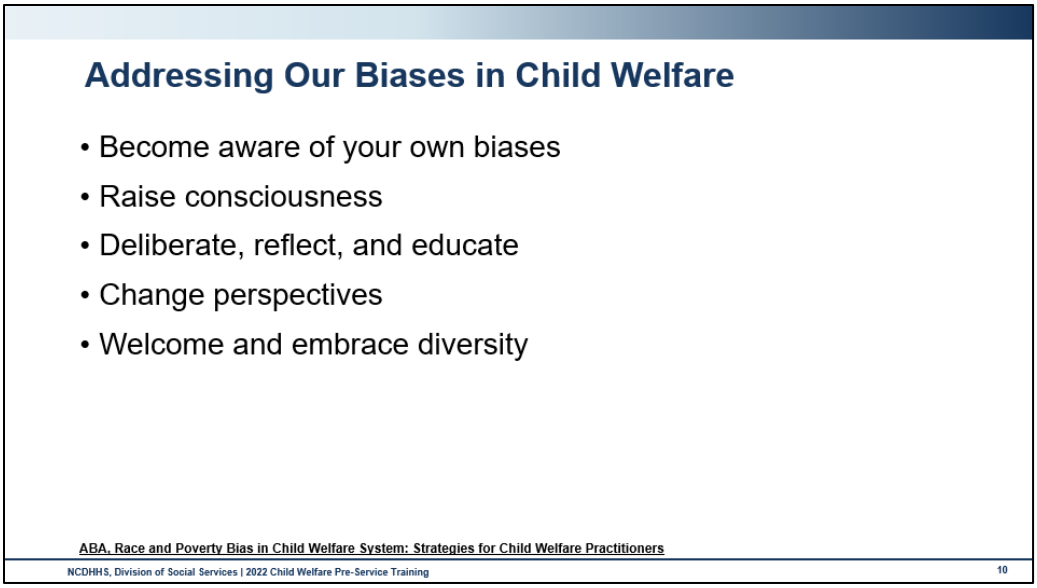
Systemic, Implicit, and Explicit Bias



Systemic biases are barriers maintained by institutions while implicit and explicit biases are ones upheld by individuals. Child welfare professionals must address their own biases when working with families.



Biases can impact our work with families in the child welfare system. Bias that goes unchecked can impact the trajectory of a child welfare case for many families. While implicit bias is not always negative, it can lead to discriminatory actions.



Addressing implicit bias is an ongoing process that you must commit to in order to have a child welfare system that the families we work with truly deserve, one that does not treat them differently because of their race, income, or other factors. As child welfare professionals, it is our job to take steps to combat our own biases affecting our cases and to work together to make systemic changes that benefit families.

Activity: Addressing Our Bias

Use this space to record how you think bias could impact the children and families that you may work with and some strategies you can use to identify and address your own bias.

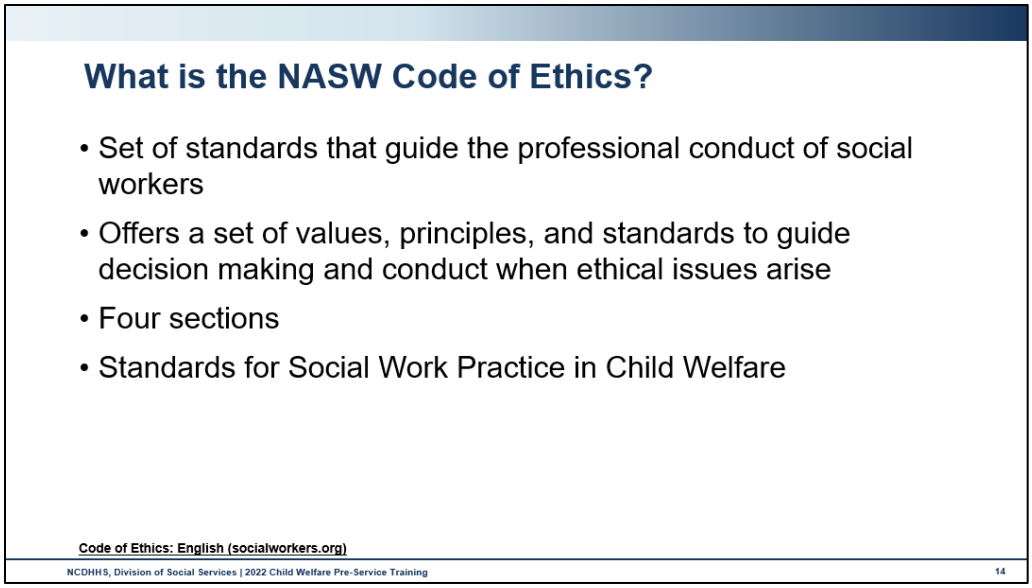
Please note, although the trainers may ask for volunteers to share ideas, there is no pressure to share your own bias or experience with bias.

CHILD	FAMILY	STRATEGIES

Questions and Reflections

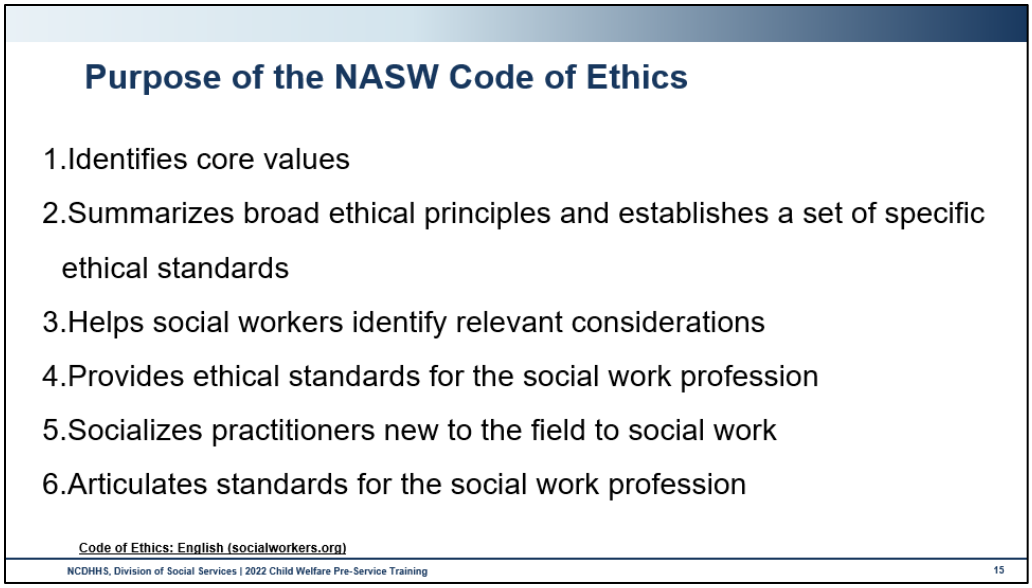
Use this space to record questions and reflections about what you have learned.

NASW Code of Ethics

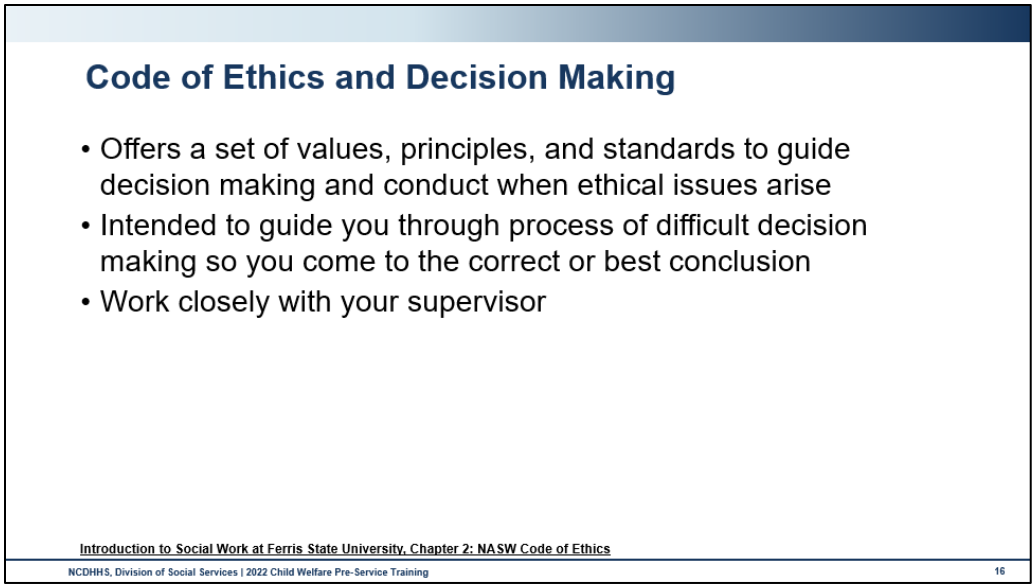


The Code is divided into four sections:

1. The first Section, "Preamble", summarizes the social work profession's mission and core values.
2. The second section, Purpose of the NASW Code of Ethics, provides an overview of the Code's main functions and a brief guide for dealing with ethical issues or dilemmas in social work practice.
3. The third section, Ethical Principles, presents broad ethical principles, based on social work's core values, that inform social work practice.
4. The final section, Ethical Standards, includes specific ethical standards to guide social workers' conduct and to provide a basis for adjudication.



Professional ethics are at the core of social work. The profession has an obligation to articulate its basic values, ethical principles, and ethical standards. The NASW Code of Ethics sets forth these values, principles, and standards to guide social workers' conduct and to hold social workers to a high standard of professionalism.



Service

One of social work's primary goals is to help people who are in need and to address social problems (Cournoyer, 2011). This value defines what social workers should be responsible for and the dedication to their job. As a social worker, you are encouraged to volunteer your time and professional skills with no expectation of significant financial return (Reamer, 2011). Social workers need to be dedicated to their delivery of services and be fully committed to assisting to a client's needs.

Social Justice

Social Justice is a significant value for all social workers, as we seek to promote equality for all people. This is often done by advocating for fair laws or policies, on behalf of clients (Cournoyer, 2011). When promoting social justice, social workers have a specific focus on vulnerable and oppressed individuals or groups of people (Reamer, 2006).

Dignity and Worth of a Person

As a social worker, you must respect that individuals come from a variety of different backgrounds and cultures and that all people deserve to be treated with respect. Social workers should certainly support equality without assigning levels of worth to an individual or group and it is important to honor in the uniqueness of all individuals. Social workers should also be consistent with all values, ethical principles, and ethical standards of the profession when working with clients (Reamer, 2006). As social workers, one of your duties is to help others find their worth as a person.

Importance of Human Relationships

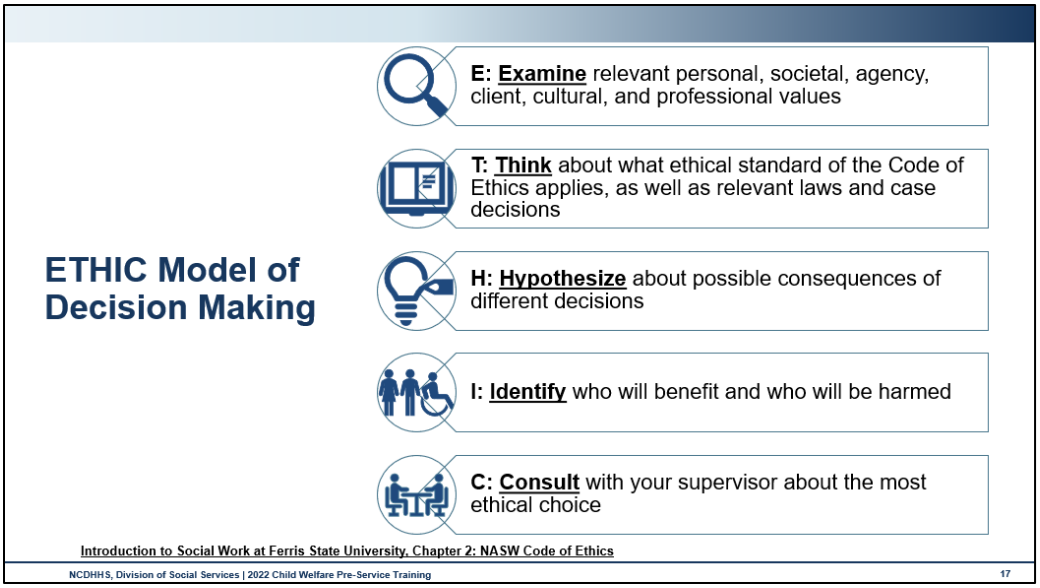
While recognizing the worth of all individuals, social workers should also respect the relationship of humans as they are important for change or working through dilemmas (Reamer, 2011). Social workers should work to strengthen relationships among people of all backgrounds. Relationships are a key in being successful in the field and promoting all ethics and values.

Integrity

Integrity is a significant value as it underlines the trustworthy manner all social workers should demonstrate. Social workers should be honest, responsible, and promote the ethical practices to the fullest (Reamer, 2006). You should also be aware of the profession's mission, vision, values, and ethical standards and apply them in a consistent manner as well as promote all ethical practices for any agency they are affiliated with. Social workers should take pride in their work.

Competence

Social workers should frequently enhance their professional knowledge and skills. As a social worker, it is important to continue to strive to best serve clients and represent the profession. Social workers must be competent in their practice and also know when they do not have the knowledge base or skill set, and therefore must refer out for services.



There are many tips and suggestions for ethical problem solving. The following questions are helpful to ask when making ethical decisions:

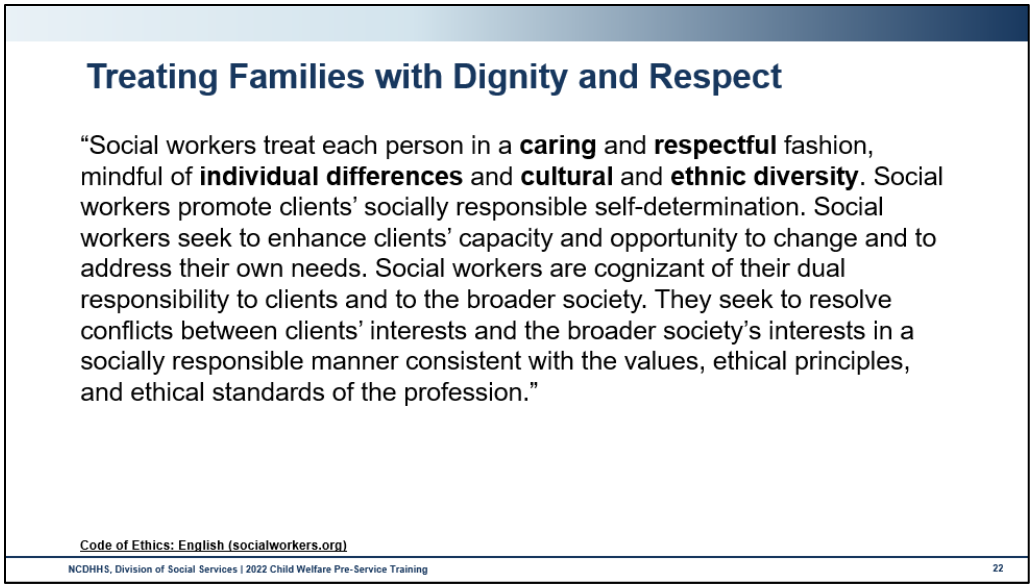
- Who is my client?
- What obligations do I owe my client?
- Do I have professional obligations to people other than my clients? If so, what are my obligations?
- What are my own personal values? Are these values compatible with the professions six core values?
- What are my ethical priorities when these value sets are not identical?
- What is the ethical way to respond when I have conflicting professional responsibilities to different people?

Questions and Reflections

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

Treating Families with Dignity and Respect

Dignity and respect are cornerstones for family-centered practice. Without dignity and respect, family-centered practice is not possible.



When you are building relationships with the families you work with, it is important to:

- Develop professional relationships based upon principles of respect, client motivation, and opportunities for change
- Encourage clients to self-determine and make decisions that affect their lives in partnership with you
- Work to convey empathy where structures and systems have worked to oppress and marginalize the family
- Support the family to understand problematic behaviors while respecting their inherent dignity and worth
- Work in solidarity with families to facilitate empowerment

Activity: Dignity and Respect

Take a few minutes to think about what dignity and respect means to you. Record your answers to the following questions:

What are some examples of times when you have been treated with dignity and respect in the past?
What about times when that was lacking? What was that experience like for you?
How can you treat families with dignity and respect?
Discuss what you have individually brainstormed with the group at your table and think of any new ideas that have not yet been shared. After the timer goes off, one person from each table will go up to the poster and write down one idea for strategies of how you can treat families with dignity and respect. This is a competition, and you cannot duplicate ideas.

Questions and Reflections

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

Professional Boundaries

Activity: Are These Professional Boundaries?

Listen to the scenario being read. If you think the scenario is a violation of a professional boundary, place a circle over that scenario. We will then have open discussion for each scenario and decide if we agree with our original determinations.

1. You didn't have time to stop for lunch before a home visit. The family can hear your stomach growling and offers you the lunch that they are all enjoying. You accept their invitation and eat lunch with them.

2. You buy a small gift for one of the teens you work with to congratulate them for improving their GPA and getting into college.

3. One of the families you work with has asked for your personal email so they can send you pictures from their son's recital. You do not give it to them and ask them to share the pictures at your next home visit.

4. You always greet one of your families with a hug and comfort them with a hug whenever they're upset.

5. One of the parent's you work with has sent you a Facebook friend request because it's easier for them to communicate via Facebook messenger. You accept their friend request.

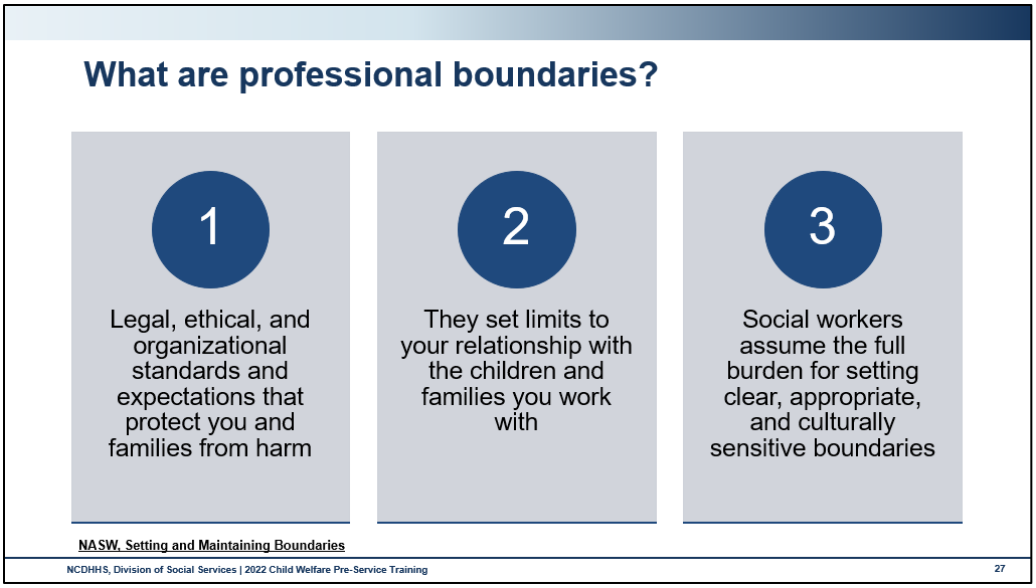
6. A family you work with invited you to their daughter's birthday party. You know it will mean a lot to the daughter if you go, so you attend.

7. You have extra tickets in your personal seats to the football game this weekend. One of the teens you work with is a huge fan and it would be a great opportunity for them to go with their dad. You offer them the tickets.

8. One of the families you work with knows it's your birthday. They bought you a birthday gift. You decline to accept the gift.

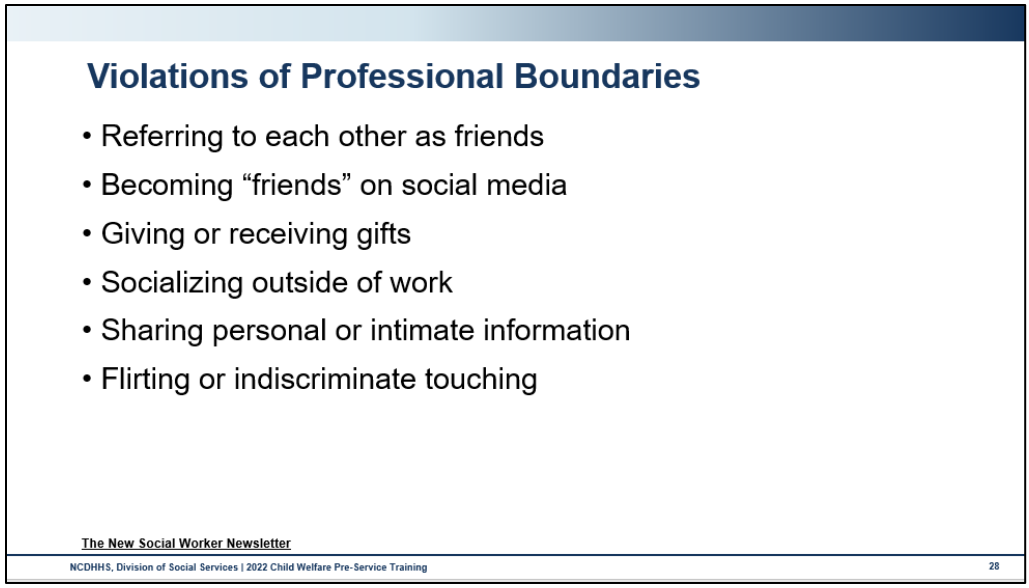
9. You were just assigned a new case. The family's history with drug abuse reminds you a lot of your own family's history. During your initial meeting with the family, you talk about details of your history and the steps your mother went through that helped her turn her life around.

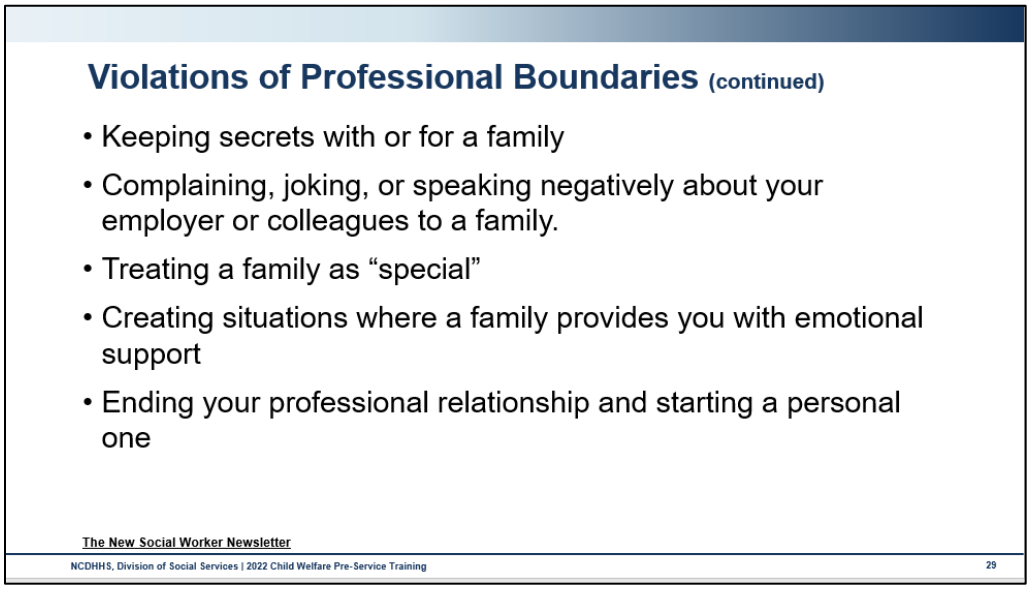
10. Your agency has a new policy that prohibits client transportation. A father you are working with does not have a way to get to his job and is going to be fired if he misses another shift. You offer to give him a ride.



Violations of boundaries can lead to a need for long-term psychological help for the people affected. When professional boundaries are not upheld, the families you work with may experience a failure to have the problems for which help was sought dealt with, worsening of the original problems, and impaired ability to approach or trust other professionals. The social worker who violates boundaries will be affected through disciplinary actions and professional sanctions, which could include termination of employment and occasionally through civil or criminal prosecution.

The NASW Code of Ethics sets clear guidelines for maintaining professional boundaries. You should reference the Code, but keep in mind, if you are ever in doubt, consult with your supervisor.





Boundary violations are acts that breach the social worker-client relationship, and they happen when social workers exploit the relationship and misuse their power.

Maintaining Professional Boundaries

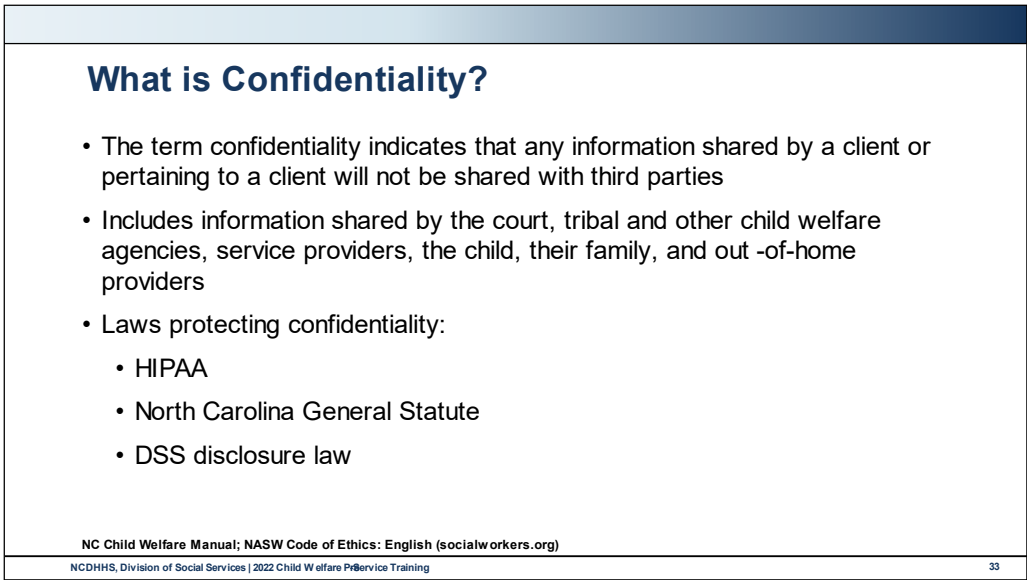
- Consider your place of power and potential for harm if misused
- Set clear expectations
- Be clear about your roles and responsibilities
- Be assertive, let families know if they are behaving inappropriately
- Avoid disclosing your personal information
- Respond to boundary-crossings in real time
- Be discriminate in your use of social media
- Maintain privacy and confidentiality
- Engage in critical reflection
- Consult with your supervisor

NASW, Setting and Maintaining Boundaries

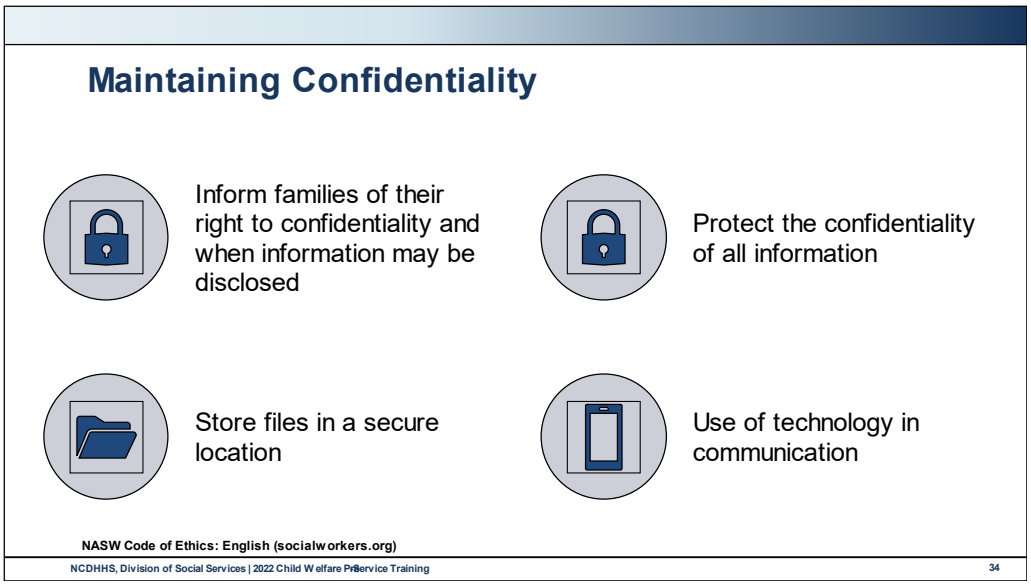
Questions and Reflections

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

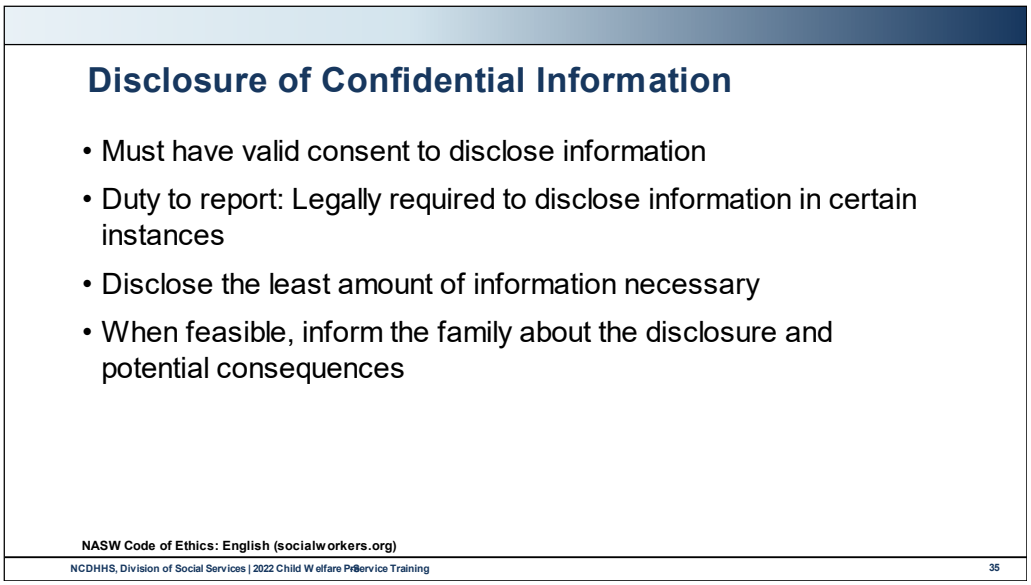
Confidentiality



When children and families become part of the child welfare system, an overwhelming amount of their private family information becomes known to people outside their family. Confidentiality is extremely important for social workers as you have a duty to maintain confidentiality with all clients.



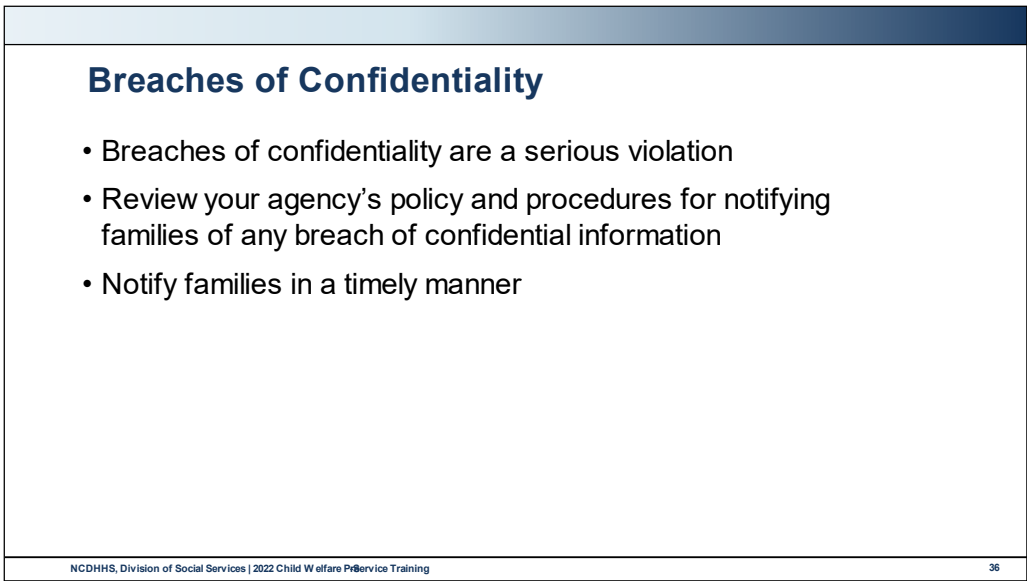
When you are first meeting with a family, you must inform them of their rights to confidentiality. This discussion should occur as soon as possible when you first meet and as needed thereafter.



Under North Carolina laws, you are a mandated reporter and have a legal obligation to report to the designated authority if a someone discloses any of the following:

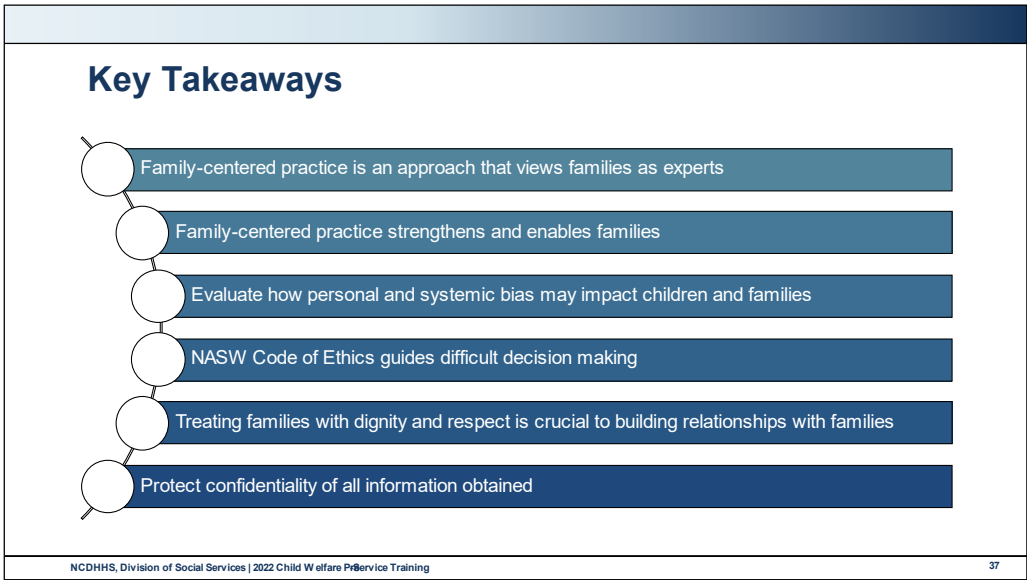
- They are going to harm or kill another person
- Abuse or neglect of a child, person with a disability, or a senior citizen
- Have a plan to commit suicide and admit to wanting to commit suicide

However, in all instances, social workers should disclose the least amount of confidential information necessary and only information that is directly relevant to the purpose for which the disclosure is made should be revealed.



A breach of confidentiality is considered malpractice and should be taken very seriously. Your agency should have policies and procedures in place for notifying families of any breach of confidential information in a timely manner. You should review your agency's policy and talk with your supervisor to be sure you understand your agency's requirements should a breach of information occurs.

Key Takeaways



Questions and Reflections

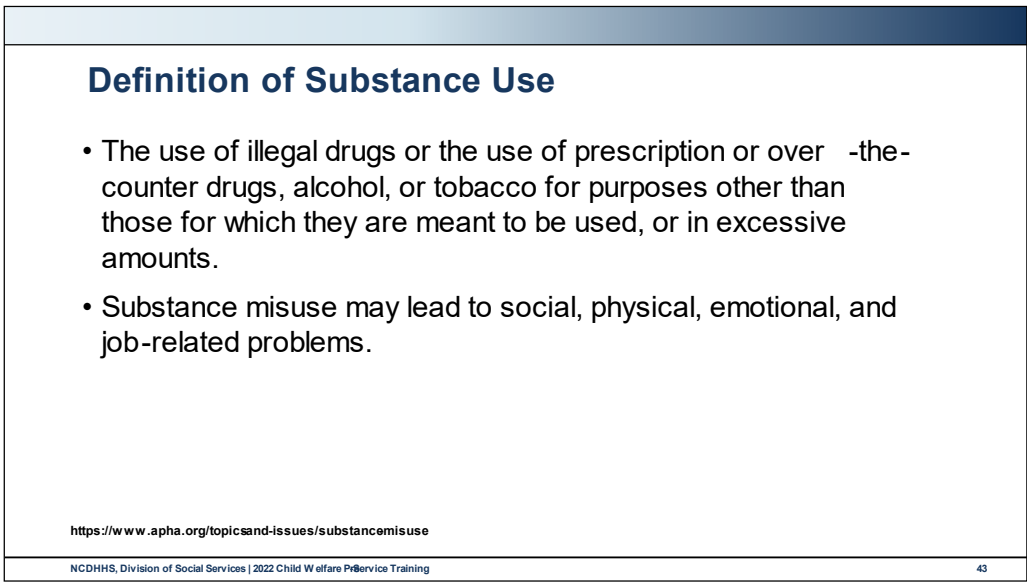
Use this space to record questions and reflections about what you have learned.

Key Issues in Child Welfare: Substance Use, Family Violence, and Mental Health

Overview of Substance Use

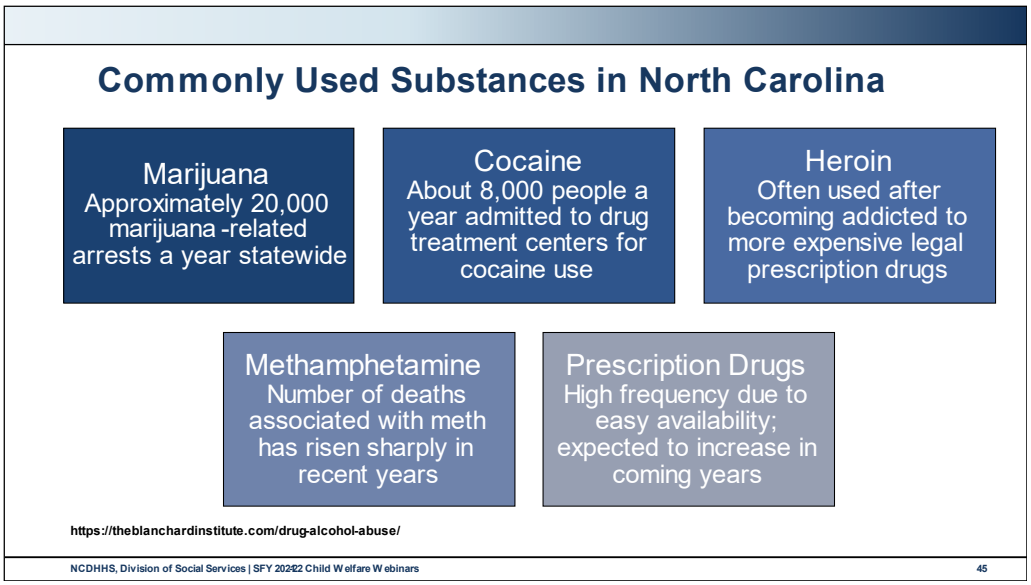
Learning Objectives

• Describe risk factors due to parental substance use.
• Explain how substance use is often utilized as a coping mechanism.
• Educate parents about the dangers of substance use in child safety and well-being.



Video: North Carolina Drug and Alcohol Statistics

Visit: Overdose Death Rise in North Carolina for a news video discussing the rise in North Carolina overdose deaths and the impact of the COVID-19 pandemic on substance misuse.



These five substances represent approximately 90% of the causes for treatment admissions in North Carolina.

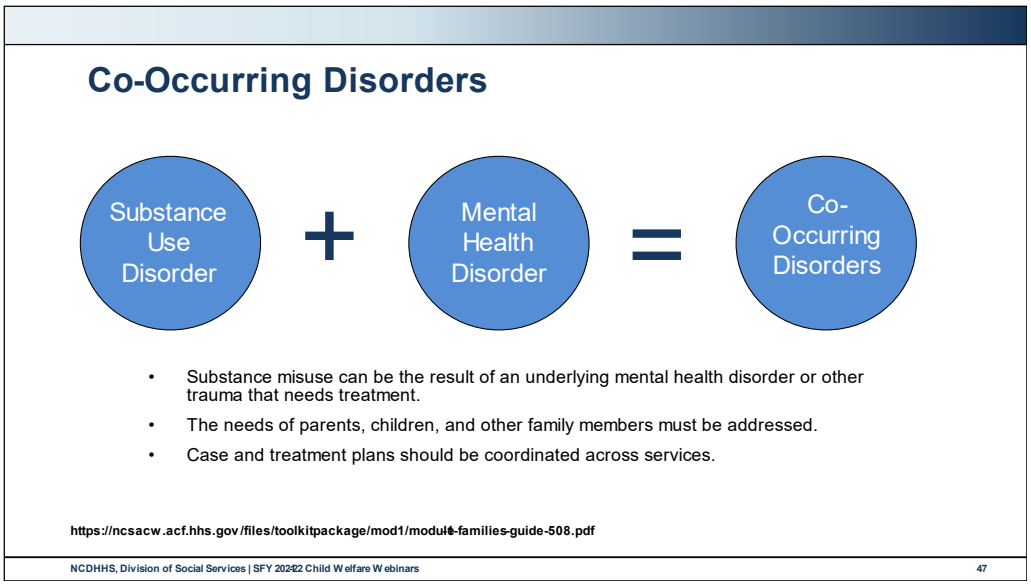
Protective & Risk Factors

Risk Factors	Protective Factors
• Exposure to alcohol prenatally	• Parental involvement
• Genetic predisposition to addiction	• Effective parenting
• Parents who misuse drugs and alcohol	• Strong parent-child bond
• Child abuse and maltreatment	• Availability of community resources
• Inadequate supervision	• Involvement in positive social activities
• Peer pressure	• Strong positive relationships outside of family
• Poverty	• Positive self-image

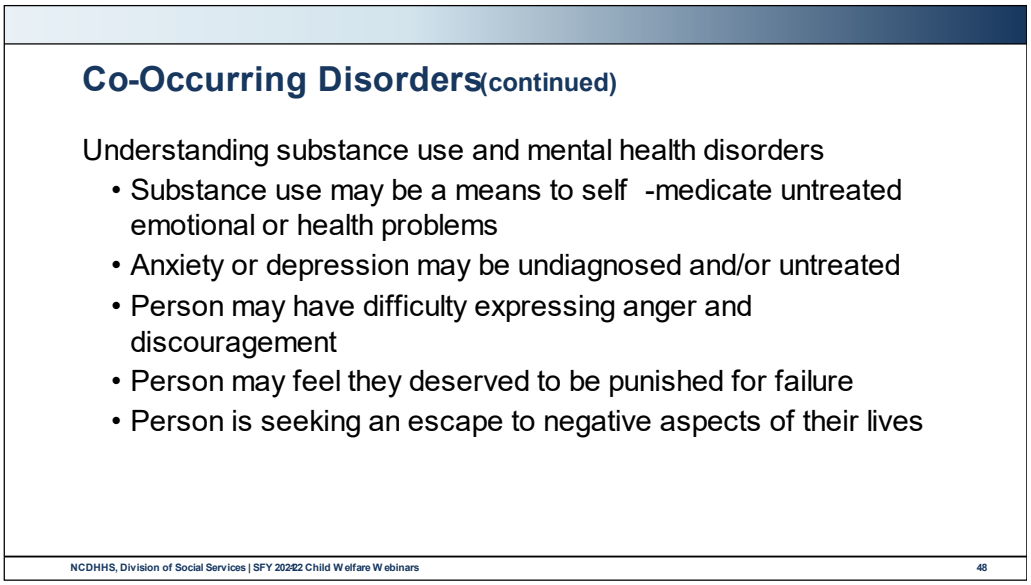
https://nida.nih.gov/publications/preventing-drug-use-among-children-adolescents/chapter-1-risk-factors-protective-factors/what-are-risk-factors and https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf

NCDHHS, Division of Social Services | SFY 2021-22 Child Welfare Webinars 46

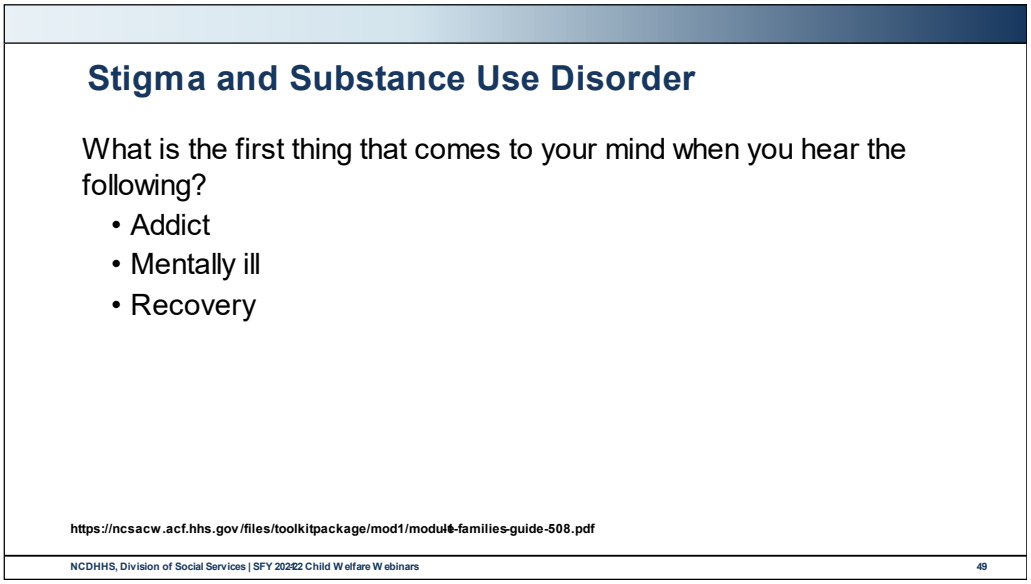
Assessing protective and risk factors plays a huge role in our ability to work with families and achieve positive outcomes. For every given situation, we must understand potential risks associated with a higher likelihood of negative outcomes and protective factors that reduce a risk factor's impact. When talking about substance use, risk factors can increase a person's chances for substance misuse, while protective factors can reduce the risk.



A co-occurring disorder is when a person has a concurrent substance use and mental health disorder. According to the National Alliance on Mental Illness, between a third to half of individuals suffering from mental health disorders also battle addiction and vice versa.



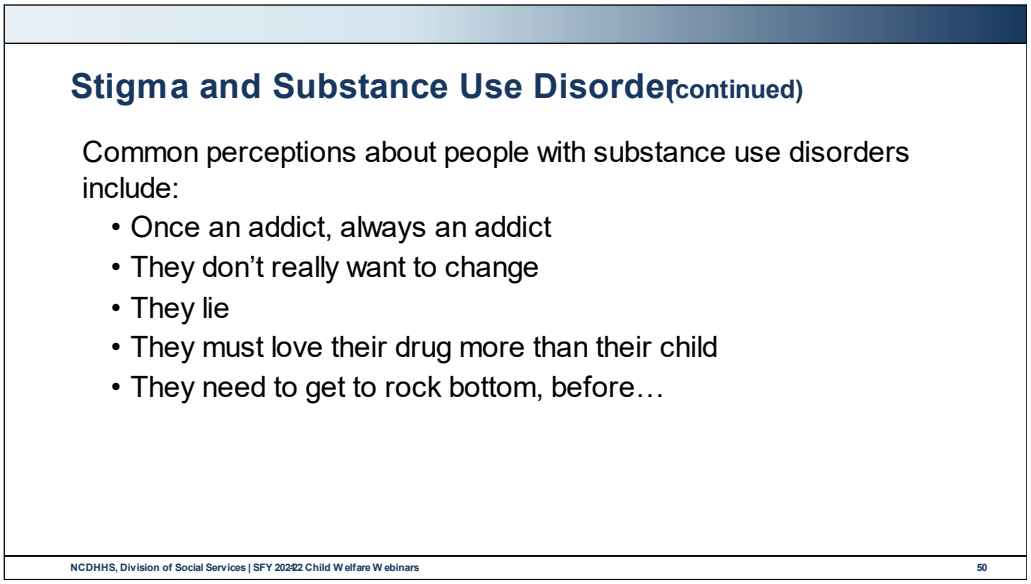
Stigma and Substance Use Disorder



It is very important to recognize your own thoughts and perceptions as you approach this work. Your experience may affect the way you view someone who uses drugs or alcohol, particularly when you are thinking about how children are affected.

Use this space to record your answers to the questions on the slide.

Addict:
Mentally ill:
Recovery:



For people with substance use disorders, stigma negatively influences health outcomes and mental well-being. Fear of being judged or discriminated against can prevent people with substance use disorders, or those who are at risk of having substance use disorders, from getting the help they need.

Video: Language Considerations

Visit: How Do You Talk About Addiction? For a video focusing on the use of language to counter stigma when working with people with substance use disorders. Although the course was designed for health care practitioners, the strategies discussed apply to all human service professionals.

Use this space to record notes.

Questions and Reflections

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

Language Examples

Avoid:	Use Instead:
Addict	Person with a substance use disorder
	Person with a serious substance use disorder
Addicted to X	Has an X disorder
	Has a serious X disorder
	Has a substance use disorder involving X (use if more than one substance is involved)
Addiction	Substance use disorder
	Serious substance use disorder

https://ncsacw.acf.hhs.gov/files/toolkitpackage/mod1/module-families-guide-508.pdf

NCDHHS, Division of Social Services | SFY 2021-22 Child Welfare Webinars 53

Language Examples (continued)

Avoid:	Use Instead:
Drug/Substance Abuser	Person with a substance use disorder
	Person who uses drugs (if not qualified as a disorder)
	Reference to “abuse” as misuse or substance use disorder
Alcoholic	Person with an alcohol disorder
	Person with a serious alcohol disorder
Former/Reformed Addict/Alcoholic	Person in recovery
	Person in long-term recovery

NCDHHS, Division of Social Services | SFY 2021-22 Child Welfare Webinars 54

Language Examples (continued)

✗ Avoid:	✓ Use Instead:
Drug Habit	Substance use disorder
	Compulsive or regular substance use
Clean	Abstinent
Dirty	Actively using
	Positive for substance use
Recreational, Casual, or Experimental Users (as opposed to those with a use disorder)	People who use drugs for non-medical reasons
	People starting to use drugs
	People who are new to drug use

Addiction as a Coping Mechanism and Healthy Alternatives

- Coping mechanisms are compulsions, or habits formed over time, that serve to help a person manage particular situations or stress levels.
- Healthy alternatives to addiction as a coping mechanism include:
  - Exercise
  - Mindfulness meditation
  - Spirituality
  - Positive reframing
  - Humor
  - Problem-solving
  - Art, journaling, or creative expression
  - Communication and support
  - Giving back

https://americanaddictioncenters.org/sobrietyguide/coping-mechanism

Recovery in the Context of Family

- Substance misuse affects the whole family.
- Adults (who have children) primarily identify themselves as parents, even if they don't have physical custody of their child.
- The parenting role and parent –child relationship cannot be separated from treatment.
- Adult recovery should have a parent –child component including substance use prevention for the child.

https://ncsacw.acf.hhs.gov/files/toolkitpackage/mod1/module-families-guide-508.pdf

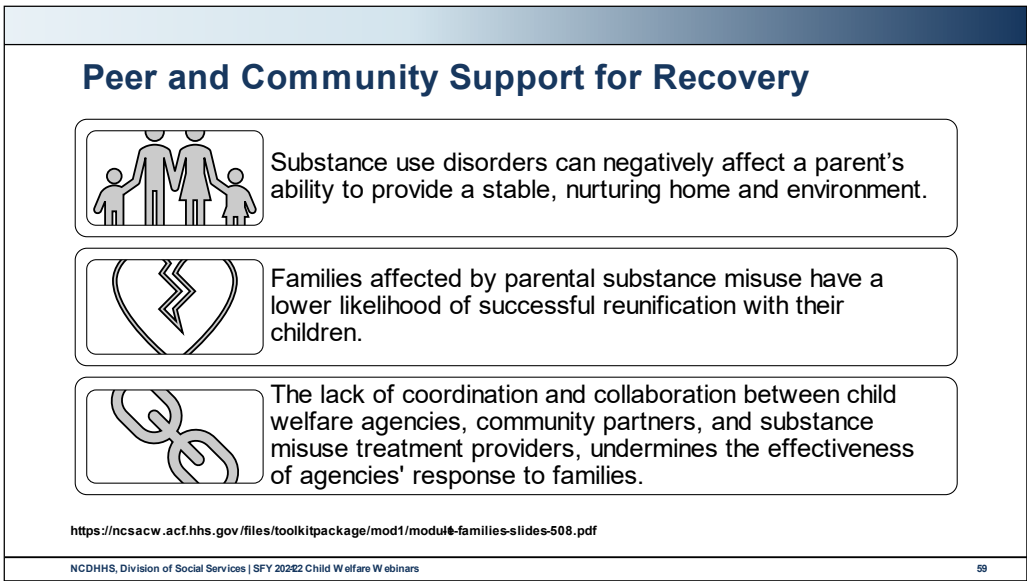
NCDHHS, Division of Social Services | SFY 2021-22 Child Welfare Webinars 57

Recovery in the Context of Family (continued)

Parent's Recovery	Child's Well-being	Family's Recovery
• Parenting skills and competencies • Family connections and resources • Parental mental health • Medication management • Parental substance use • Domestic violence	• Well-being/behavior • Development/health • School readiness • Trauma • Mental health • Adolescent substance use • At-risk youth prevention	• Basic necessities • Employment opportunities • Housing • Childcare • Access to transportation • Family counseling • Specialized parenting skills

NCDHHS, Division of Social Services | SFY 2021-22 Child Welfare Webinars 58

When serving a family holistically, the focus is on the individual's recovery, the child's well-being, and the family's recovery and well-being as a whole.



Child welfare workers, courts, substance use disorder treatment providers, and community partners need to work together to address parents' substance use disorders to prevent removal and provide services to support permanency.

Questions and Reflections

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

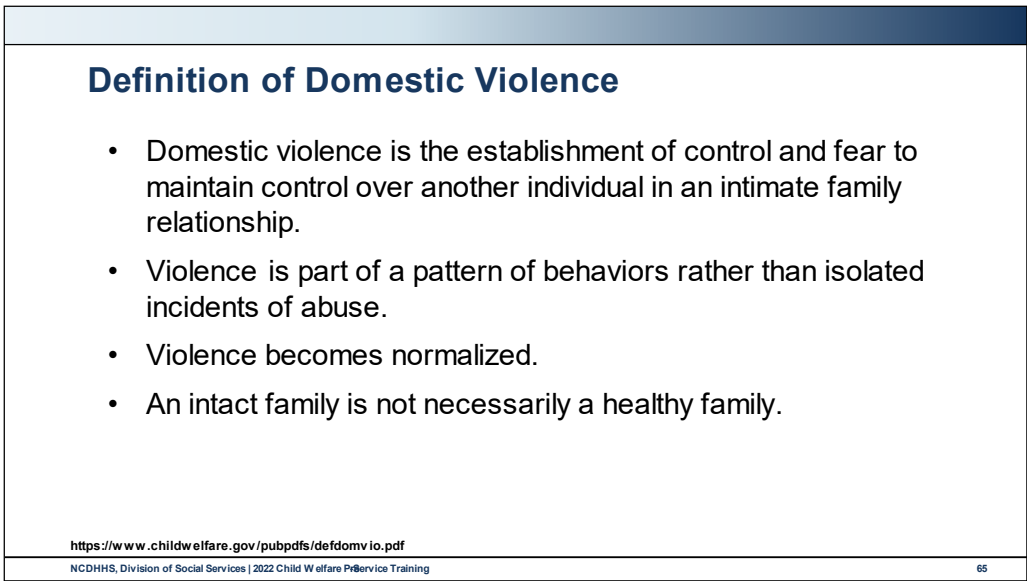
Overview of Domestic and Family Violence

Learning Objectives

• Define and identify signs of domestic violence.
• Describe the Cycle of Violence.
• Describe the importance of confidentiality and identify the unique dynamics of domestic violence within families.
• Identify your own bias as it relates to domestic violence.
• Describe the direct impact of domestic violence on children.
• Describe considerations and steps to take to ensure safety.

Activity: Domestic Violence

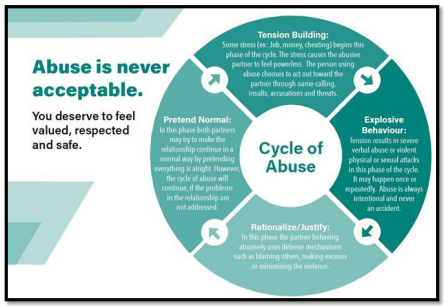
- Each table will create a group poster of your current experience and knowledge with domestic violence.
- Be creative! Feel free to use words, drawings, symbols.
- Be prepared to present your poster to the larger group.



Domestic Violence is 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 abuse, emotional abuse, sexual abuse, economic oppression, isolation, threats, intimidation, and maltreatment of the children to control the non-offending parent victim.

Cycle of Violence

- 70% of persons who perpetrate partner violence also abuse their children
- 75% of persons who perpetrate partner violence witnessed abuse between their parents
- 50% of persons who perpetrate partner violence experienced abuse themselves as children



http://www.preventionoffamilyviolence.com/

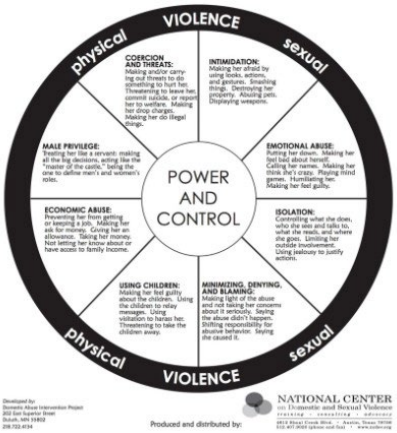
NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training 66

This graphic helps visualize what the cycle of violence looks like for people experiencing domestic violence.

- The Tension Building Phase begins the cycle where stress causes the abusive partner to feel powerless.
- The Explosive Behavior Phase is where incidents of abuse occur, and tensions continue to build.
- The Rationalize/Justify Phase is where the person perpetrating abuse makes excuses or minimizes the violence, and the
- Pretend Normal Phase is also commonly called the “honeymoon” stage where the person perpetrating abuse asks forgiveness and both partners may try to make the relationship seem normal by pretending everything is alright.

The Power and Control Wheel

- Is gender-specific since men commit majority of domestic violence assaults
- Domestic violence can also be committed by females and in same-sex relationships



http://www.ncdsv.org/ncd_links.html

NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training 67

In contrast with the Cycle of Violence, the Wheel doesn't imply these experiences happen in a certain order, but rather, in combination, with the pattern of power and control holding the wheel together at its center. By naming the power differences, we can more clearly provide advocacy and support for victims, accountability, and opportunities for change for offenders, and system and societal changes that can end violence.

The Power and Control Wheel (continued)

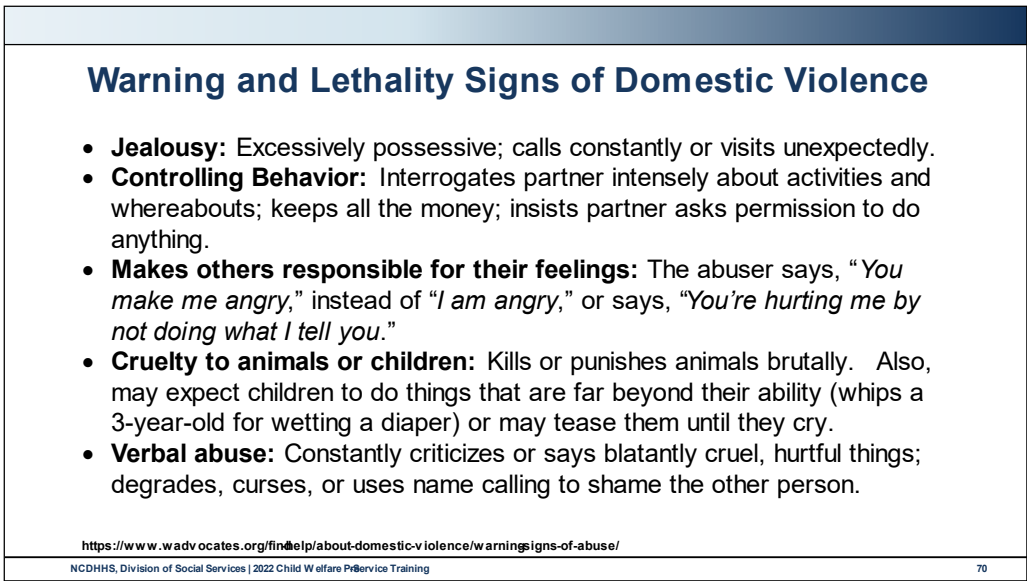
- Most common tactics of abusive partners
  - Economic abuse - to deny the survivor access to money
  - Coercion and threats - like convincing the survivor to do something illegal
  - Intimidation - to keep the survivor fearful
  - Emotional abuse - such as degrading the survivor
  - Isolation - controlling when the survivor can leave the home
  - Minimizing, denying, and blaming - such as gaslighting
  - Using the children - including threatening to file for custody if the survivor leaves
  - Male privilege - to define men's and women's roles

NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training 68

Video: Learn to Recognize Domestic Violence

Visit: Learn to Recognize Domestic Violence for a video where victims and officers explain the domestic violence Power and Control Wheel and how to recognize relationship red flags.

Use this space to record notes.



This slide highlights behaviors that a family member may likely disclose to you or that you may even observe during interactions with the family. These warning signs can also be considered "lethality factors", circumstances that can be used to determine the likelihood that a relationship could escalate to lethal violence. Lack of the lethality factors does not necessarily indicate that violence will not become lethal. It is important to allow individuals to rely on their own instincts in assessing risk and safety planning. The following handout includes a broad list of behaviors that are considered warning signs of an abusive relationship.

Handout: Warning Signs of Domestic Violence

- **Pushes partner for quick involvement:** Comes on strong, claiming, "*I've never felt loved like this by anyone*."
- **Jealousy:** Excessively possessive; calls constantly or visits unexpectedly.
- **Controlling Behavior:** Interrogates partner intensely about activities and whereabouts; keeps all the money; insists partner asks permission to do anything.
- **Unrealistic expectations:** Expects partner to be the perfect and meet his or her every need.
- **Isolation:** Cuts partner off from family and friends.
- **Blames others for problems or mistakes:** It's always someone else's fault when anything goes wrong.
- **Makes others responsible for his or her feelings:** The abuser says, "*You make me angry*," instead of "*I am angry*," or says, "*You're hurting me by not doing what I tell you*."
- **Hypersensitivity:** Is easily insulted, claiming hurt feelings when he or she is really mad.
- **Cruelty to animals or children:** Kills or punishes animals brutally. Also, may expect children to do things that are far beyond their ability (whips a 3-year-old for wetting a diaper) or may tease them until they cry.
- **Use of force during sex:** Being thrown or held down against their will during sex.
- **Verbal abuse:** Constantly criticizes or says blatantly cruel, hurtful things; degrades, curses, or uses name calling to shame the other person.
- **Rigid roles:** Expects partner to serve, obey and remain at home.
- **Sudden mood swings:** Switches from sweet to violent in minutes.
- **Past battering:** Admits to hitting a mate in the past but says the person "*made*" them do it.
- **Threats of violence:** Says things like, "*I'll break your neck*," or "*I'll kill you*," and then dismisses them with, "*I didn't really mean it*."
- **Controlling behaviors using social media or technology:** Monitoring use of cell phone and social media or not allowing cell phone or social media use or using technology to isolate and/or track the other person.

Current Data Trends

National Data

- 1 in 3 women and 1 in 4 men in the United States have experienced some form of physical violence by an intimate partner.
- In 2018, domestic violence accounted for 20% of all violent crime.
- 65% of all murder-suicides involve an intimate partner; 96% of the victims of these crimes are female.

North Carolina Data

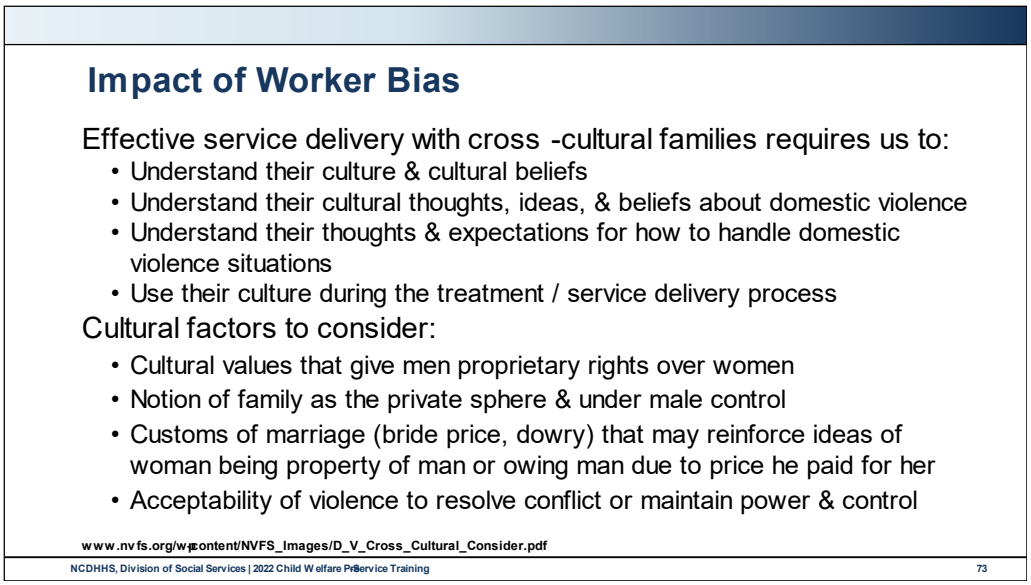
- 35.2% of women and 30.3% of men have experienced some form of physical violence by an intimate partner.
- In a 24-hour survey period in 2020, local and state hotlines answered 540 calls, averaging more than 23 calls every hour.
- In 2020, there were 91 intimate partner homicides.
- From July 2021 - June 2022, 36% of individuals receiving shelter services were children.

https://nccadv.org/domesticviolence-info/nc-stats

Impact of Domestic Violence on Children and Families

- Child may be direct victim of abuse or suffer from exposure to the violence.
- May negatively affect the child's healthy development and academic performance.
- May result in behavioral issues impacting the child's future relationships and opportunities.
- May impact the quality of parenting the child receives from the survivor parent:
  - May interfere with the adult survivor's relationship with the child
  - Ability to protect or care for the child
  - Encourage harsher parenting
  - Increase risk for mental or behavioral health problems (i.e., depression, substance abuse)

https://dvchildwelfare.org/resources/factsheet/

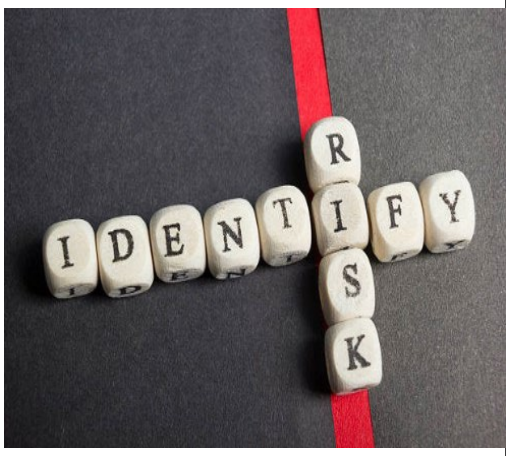


How we understand domestic and family violence may vary and this very much impacts how we approach and respond to survivors or victims of domestic violence. Understanding the role culture plays in how we view domestic violence allows us to engage family members with compassion and empathy and gain insight into their specific experiences. Let's pause for a moment and reflect on what we documented on our posters from the activity earlier. Would you change anything on your poster after learning more about domestic violence?

Intersection of Domestic Violence and Child Welfare

Primary Focus

- Assessment of risk posed to the child



North Carolina DHHSS Child Welfare Policy Manual

NCDHHS, Division of Social Services | 2022 Child Welfare Preservice Training 74

In cases where domestic violence has occurred, whether before or during CPS involvement, the primary focus is the assessment of risk posed to the child(ren) by the presence of domestic violence.

CPS Intervention Goals

Ensure the safety of the child(ren)

All family members will be safe from harm

Non-offending parent/adult victim receives services designed to protect and support them

Child(ren) receive services to protect, support, and help them cope

Alleged perpetrator held responsible for their abusive behavior

Incidence of child maltreatment co-occurring with domestic violence will be reduced

Keep children safe without:

- Penalizing non-offending parent/adult victim
- Escalating violent behavior of the alleged perpetrator

North Carolina DHHSS Child Welfare Policy Manual

NCDHHS, Division of Social Services | 2022 Child Welfare Preservice Training 75

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

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

Principles to Address Intersection of Child Safety, Permanence, Well-Being, and Domestic Violence

1. Enhancing a non-offending parent/adult victim's safety enhances their child(ren)'s safety.
2. Domestic violence perpetrators may cause serious harm to the child(ren).
3. Domestic violence perpetrators, not their victims, should be held accountable for their actions and the impact on the well-being of the non-offending parent/adult victim and child victims.

North Carolina DHHSS Child Welfare Policy Manual

Principles to Address Intersection of Child Safety, Permanence, Well-Being, and Domestic Violence (continued)

4. Appropriate services, tailored to the degree of violence and risk, should be available for non-offending parent/adult victims leaving, returning to, or staying in abusive relationships. These services should also be available for child victims and perpetrators of domestic violence.
5. Child(ren) should remain in the care of the non-offending parent/adult victim whenever possible.
6. When the risk of harm to the child(ren) outweighs the detriment of being separated from the non-offending parent/adult victim, alternative placement should be considered.

North Carolina DHHSS Child Welfare Policy Manual

Questions and Reflections

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

Activity: Self-Care Exercise/Body-Scan Meditation

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

Visit: https://www.uclahealth.org/marc/mpeg/Body-Scan-Meditation.mp3 for a meditation exercise.

Day Four Agenda

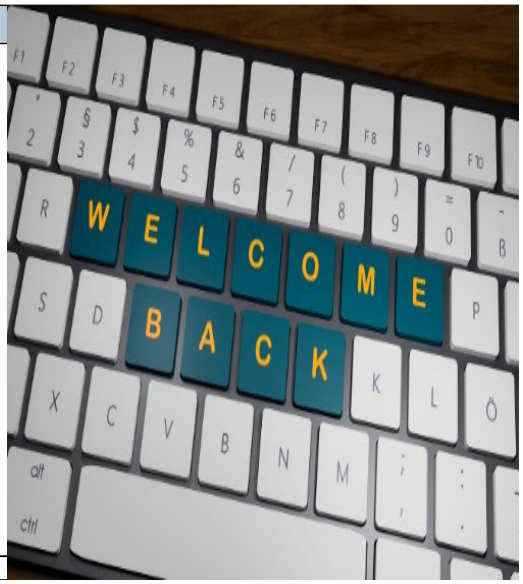
Pre-Service Training: Child Welfare in North Carolina

I.	Welcome & Learning Objectives	9:00 - 9:30
	Key Issues in Child Welfare: Substance Use, Family Violence, and Mental Health	
II.	Mental Health in Child Welfare: Needs and Diagnoses	9:30 – 10:15
	Overview of Trauma Informed Practice	
III.	Overview of Trauma and Adverse Childhood Experiences (ACEs)	10:15 -10:45
	BREAK	**10:45 – 11:00**
IV.	Overview of Trauma and Adverse Childhood Experiences (ACEs) (continued)	11:00 – 12:10
V.	How Trauma Impacts Families and Child Development	12:10 – 12:30
	LUNCH	**12:30 – 1:30**
VI.	How Trauma Impacts Families and Child Development (continued)	1:30 – 2:10
VII.	Trauma-Informed Child Welfare Systems	2:10 – 2:30
	BREAK	**2:30 – 2:45**
VIII.	Foundation Training Wrap-Up	2:45 – 3:15
	Self-Care Exercise	3:15 – 3:30

Welcome

- How are people feeling today?
- What was your main "takeaway" from yesterday?
- Is there any clean-up we need to do?
- Review agenda and learning objectives for the day

NCDHHS, Division of Social Services | 2022 Child Welfare Pre-Service Training



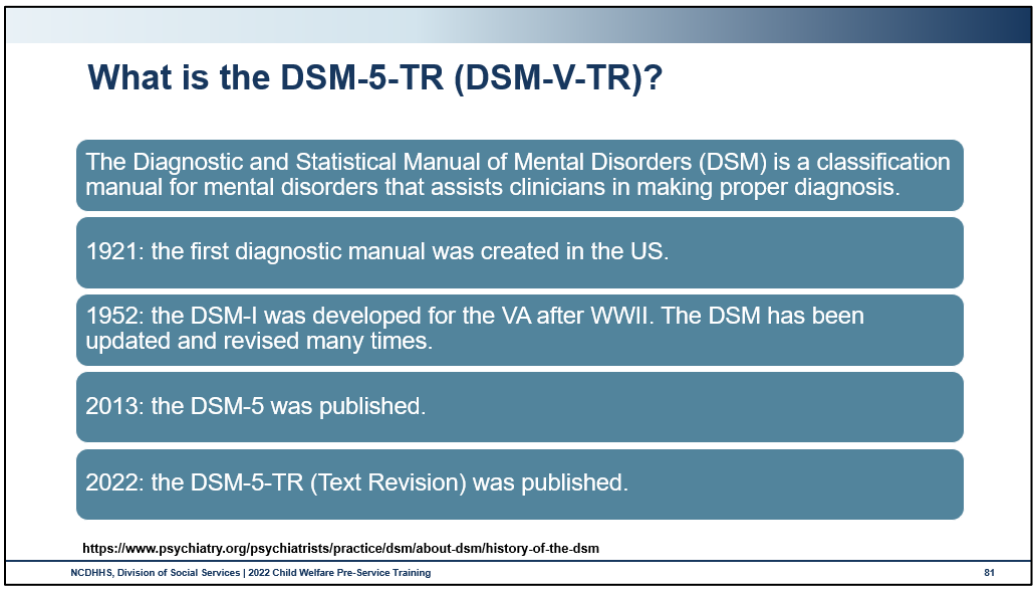
Use this space to record notes.

Key Issues in Child Welfare: Substance Use, Family Violence, and Mental Health

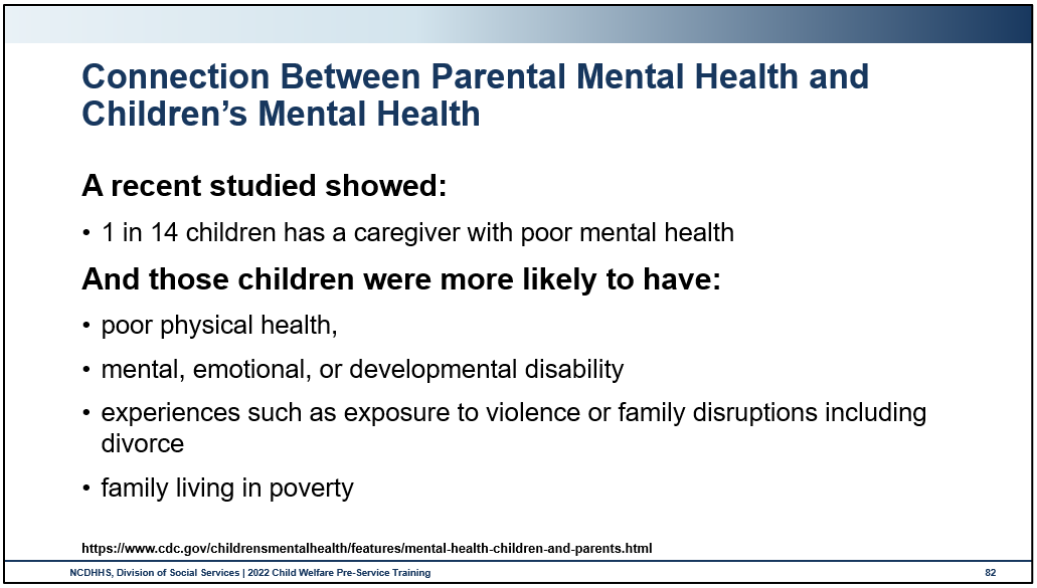
Mental Health in Child Welfare: Needs and Diagnoses

Learning Objectives

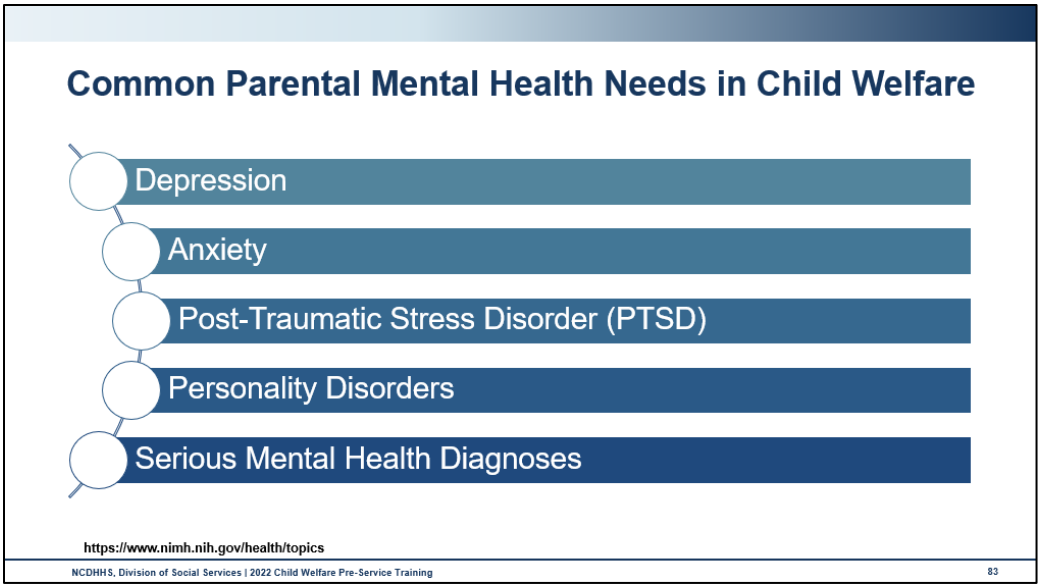
• Describe the most common mental health needs and diagnoses of children and parents in the child welfare system, and the impact on their physical and emotional well-being.
• Describe the impact of trauma on child development.



The most current edition is the DSM-5-TR was published in 2022. The work on this edition began in the Spring of 2019 and consisted of over 200 experts who focused on four cross-cutting issues: Culture, Sex and Gender, Suicide, and Forensics. The DSM-5 was also reviewed by a work group on equity and inclusion to ensure attention to risk factors, such as racism and discrimination and the use of non-stigmatizing language. The result of this latest revision was clarifications to certain diagnostic criteria related to gender, sexual identity, and suicide.



Just because a parent has a mental health diagnosis does not mean they cannot parent their child. Several factors should be assessed when working with parents who face mental health challenges, such as: the severity of the symptoms, the treatment plan, how old the child is, the support the family has, and other safety, risk, and protective factors.



Depression is a disorder of the brain. There are a variety of causes, including genetic, biological, environmental, and psychological factors. Depression can happen at any age. Depression is more than just a feeling of being sad or "blue" for a few days. More than 19 million teens and adults in the United States have depression, and the feelings do not go away. These feelings persist and interfere with everyday life.

Anxiety disorders are conditions where anxiety does not go away and can get worse over time. Anxiety is a feeling of fear, dread, and uneasiness. It might cause you to sweat, feel restless and tense, and have a rapid heartbeat. It can be a normal reaction to stress. For example, you might feel anxious when faced with a difficult problem at work, before taking a test, or before making an important decision. Anxiety can help you to cope by giving you a boost of energy or helping you focus. But for people with anxiety disorders, the fear is not temporary and can be overwhelming and effect their daily functioning. Panic disorders and phobias are sub-classifications within anxiety disorders.

Post-traumatic stress disorder (PTSD) is a condition that some people develop after they experience or see a traumatic event. The traumatic event may be life-threatening, such as combat, a natural disaster, a car accident, or sexual assault. But sometimes the event is not necessarily a dangerous one. For example, the sudden, unexpected death of a loved one can also cause PTSD. Researchers don't know why some people get PTSD and others don’t. PTSD is usually diagnosed if symptoms occur longer than four weeks and interfere with daily living.

Personality disorders are a group of mental illnesses. They involve long-term patterns of thoughts and behaviors that are unhealthy and inflexible. The behaviors cause serious problems with relationships and work. People with personality disorders have trouble dealing with everyday stresses and problems. They often have stormy relationships with other people. Personality disorders can be difficult to treat. Examples of the most common personality disorders are: Borderline Personality, Anti-social Personality, and Obsessive-Compulsive Personality.

Serious Mental Health Diagnoses are the most difficult to treat. The most common serious mental health diagnosis for parents who encounter child welfare is Schizophrenia. It is a serious brain illness. People who are diagnosed with Schizophrenia may hear voices that aren't there. They may think other people are trying to hurt them. Sometimes they don't make sense when they talk. This disorder makes it hard for them to keep a job or take care of themselves or others.

Questions and Reflections

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

Video: Impact of Parental Mental Health on Children

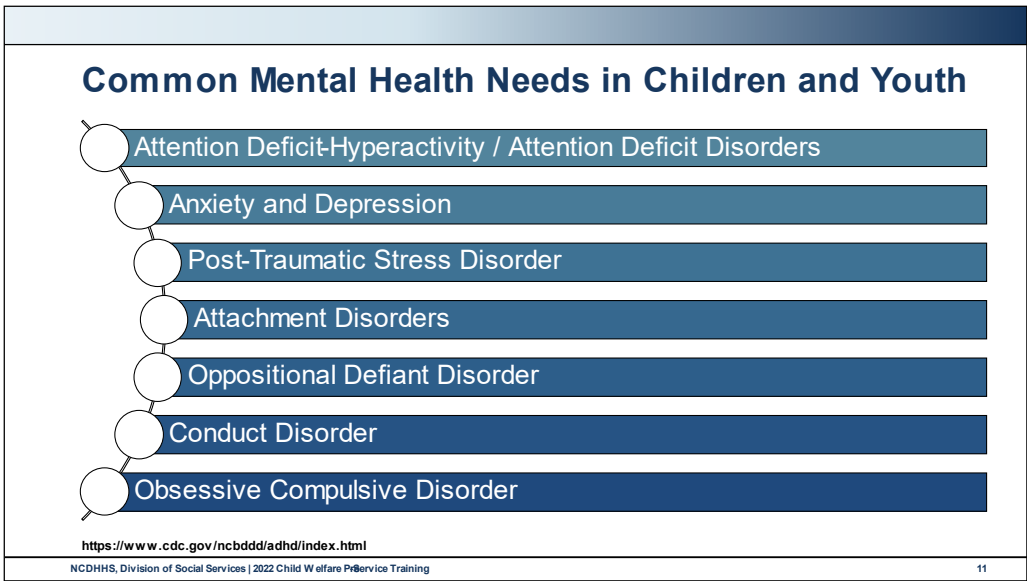
Visit: How I Overcame Struggles with a Parent with Mental Illness for a video featuring how the Chief Wellness Officer of ALTWELL overcame struggles with living with a parent who has a mental illness.

Use this space to record notes.

Debrief

Group Discussion

What interventions or services do you think could have helped this family?
What were some of the key takeaways from this video?



Worksheet: Mental Health Needs in Children and Youth

Work with your table group to match the bulleted names of common mental health needs on the slide to the appropriate description of the mental health needs listed below.

When children experience a traumatic event, they can have difficulty coping with the stress the event caused. A child could experience trauma directly or could witness it happening to someone else. When children develop long term symptoms from a stressful event, which are upsetting or interfere with their relationships and activities, they may be diagnosed with post-traumatic stress disorder _____.

_____ are disorders that can develop in young children who have problems attaching emotionally to others. Parents, caregivers, or physicians may notice that a child has problems with emotional attachment as early as their first birthday. Most children with these disorders have had severe problems or difficulties in their early relationships. They may have been physically or emotionally abused or neglected. Some have experienced inadequate care in an institutional setting or other out-of-home placement. Others have had multiple traumatic losses or changes in their primary caregiver. A related disorder is Reactive Attachment Disorder (RAD). Children with RAD are less likely to interact with other people because of negative experiences with adults in their early years. They have difficulty calming down when stressed and do not look for comfort from their caregivers when they are upset. These children may seem to have little to no emotions when interacting with others.

_____is one of the most common neurodevelopmental disorders of childhood. It is usually first diagnosed in childhood and often lasts into adulthood. Children with this disorder may have trouble paying attention, may act without thinking about what the result will be. In other words, being impulsive, or overly active. Children do not just grow

out of these behaviors. The symptoms continue, can be severe, and can cause difficulty at school, at home, or with friends.

_____ is diagnosed when children show an ongoing pattern of aggression toward others, and serious violations of rules and social norms at home, in school, and with peers. These rule violations may involve breaking the law and result in arrest. Children are more likely to get injured and may have difficulties getting along with peers. Examples of behaviors include:

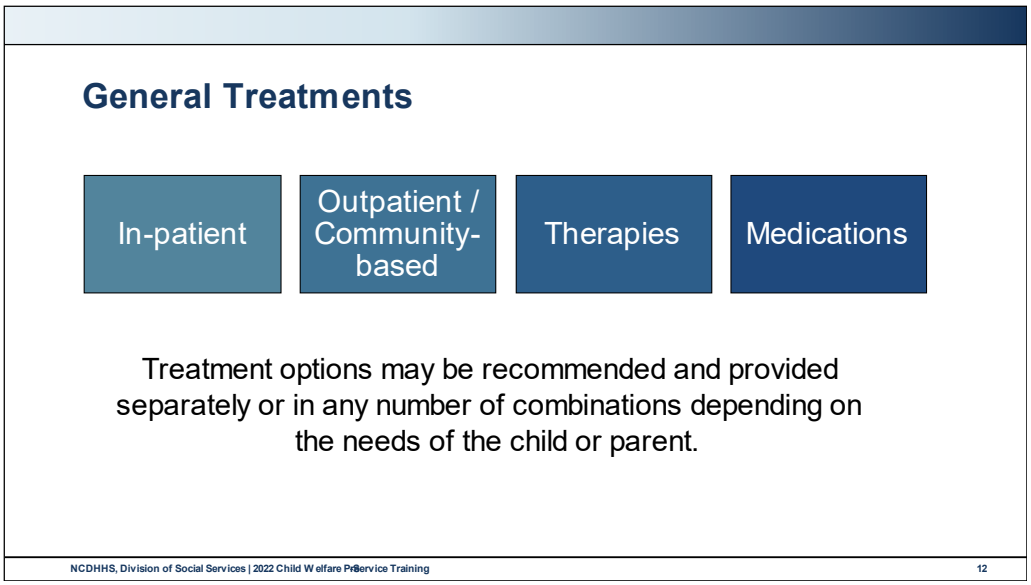
- Breaking serious rules, such as running away, staying out at night when told not to, or skipping school
- Being aggressive in a way that causes harm, such as bullying, fighting, or being cruel to animals
- Lying, stealing, or damaging other people's property on purpose

An _____ is when a child has unwanted thoughts, and the behaviors they feel they must do because of these thoughts, happen frequently, take up a lot of time (more than an hour a day), interfere with their activities, or make them very upset. A common myth is that this disorder means being really neat and orderly. Sometimes, behaviors may involve cleaning, but many times the person is too focused on one thing that must be done over and over, rather than on being organized. Thoughts and behaviors affected by this disorder can also change over time.

_____ usually starts before 8 years of age, but no later than 12 years of age. Children with this disorder are more likely to act defiant around people they know well, such as family members, a regular care provider, or a teacher. Children with this disorder show these behaviors more often than other children their age. Examples of behaviors include:

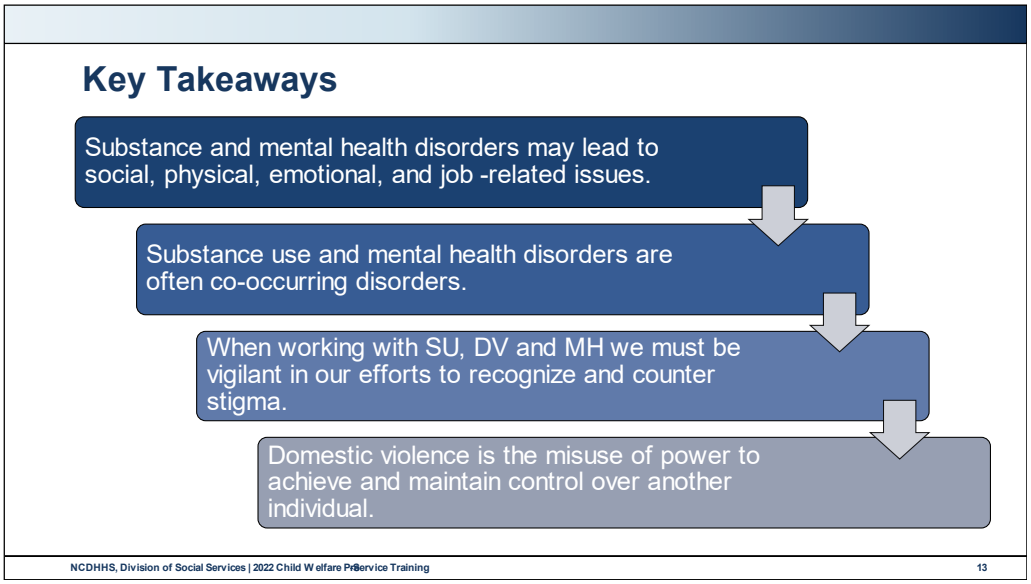
- Often being angry or losing one's temper
- Often arguing with adults or refusing to comply with adults' rules or requests
- Often resentful or spiteful
- Deliberately annoying others or becoming annoyed with others
- Often blaming other people for one's own mistakes or misbehavior

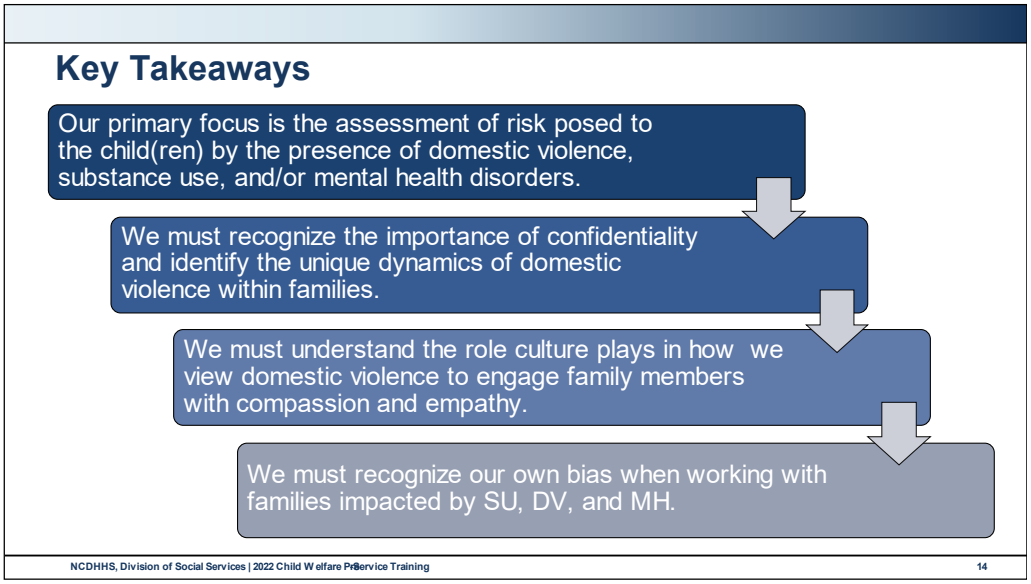
While some fears and worries are typical in children, persistent or extreme forms of fear and sadness could be due to _____or _____. Both of these mental health needs have increased over the past 10 years. Children with _____disorders have fears and worries that do not go away and that interfere with their daily lives at home and school. Children who have been diagnosed with _____ experience their symptoms over time, and these symptoms interfere with their daily life and in extreme cases can lead to suicide.



A comprehensive evaluation by a mental health professional will determine if a child or parent has a mental health disorder. The mental health professional may recommend medication, talk therapy, or often a combination of both. The least restrictive treatment is outpatient or community-based interventions. There may be a wide selection of community mental health providers or none depending on where in the state you are located. Some children and adults may need more intensive treatment requiring them to be admitted to an in-patient facility or hospital. When children and adults are determined to be a harm to self or others, it is often recommended that they be assessed for inpatient treatment.

Key Takeaways





Questions and Reflections

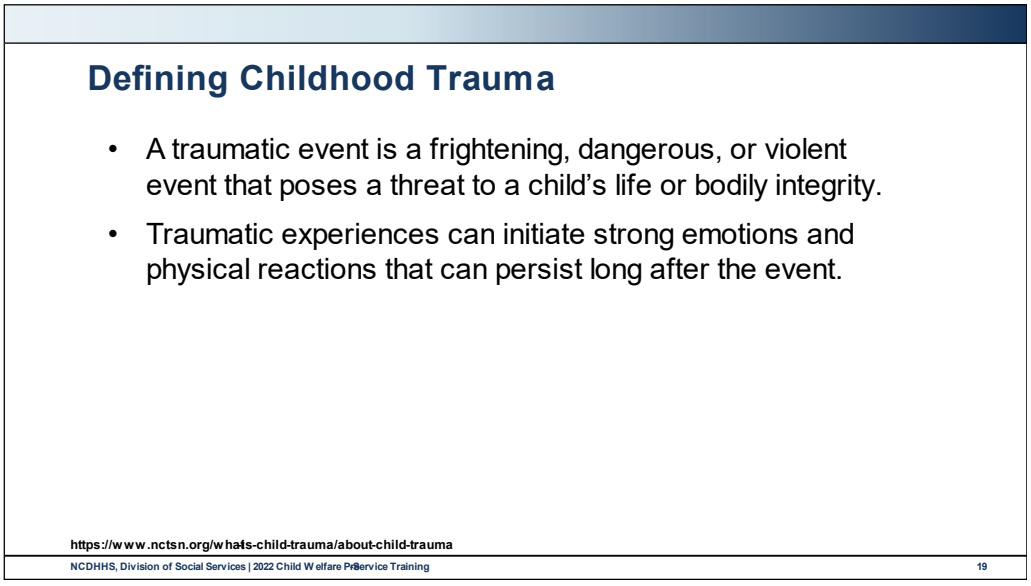
Use this space to record questions and reflections about what you have learned.

Overview of Trauma-Informed Practice

Overview of Trauma and Adverse Childhood Experiences (ACEs)

Learning Objectives

• Define and discuss the definition of childhood trauma and its impact throughout a lifetime.
• Describe Adverse Childhood Experiences (ACEs) and explain how to assess children and families for ACEs.
• Describe how a family's risk and protective factors can prevent occurrences of ACEs.



Children may feel terror, helplessness, or fear, as well as physiological reactions such as heart pounding, vomiting, or loss of bowel or bladder control. Children who experience an inability to protect themselves or who lacked protection from others to avoid the consequences of the traumatic experience may also feel overwhelmed by the intensity of physical and emotional responses.

Even though adults work hard to keep children safe, dangerous events still happen. This danger can come from outside of the family (such as a natural disaster, car accident, school shooting, or community violence) or from within the family, such as domestic violence, physical, or sexual abuse, or the unexpected death of a loved one.

Activity: Small Group Brainstorm

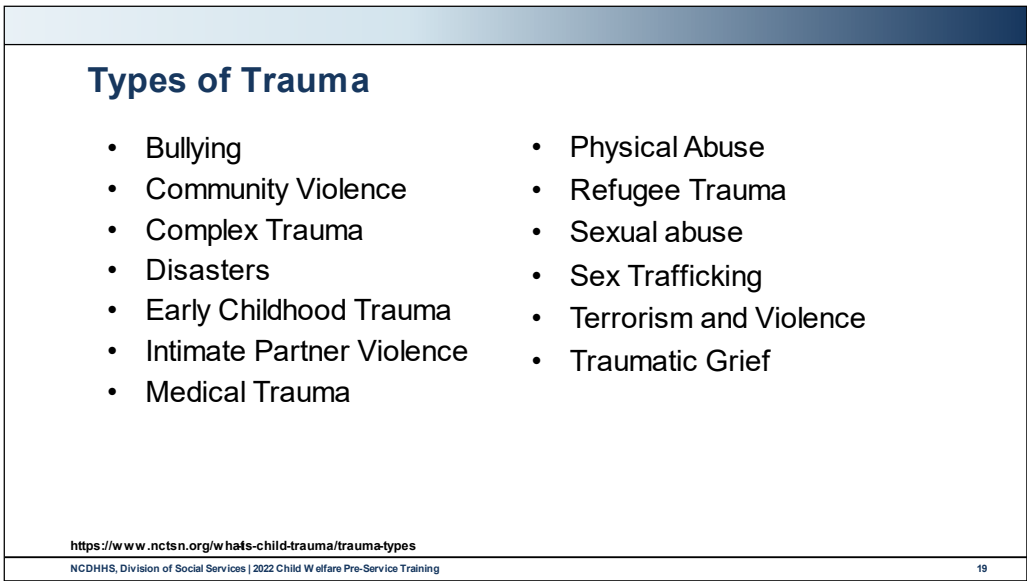
Work with your table group and think about examples of traumatic events that could negatively affect children and families.

Use this space to record notes. Be prepared to share ideas with the class.

Examples of Traumatic Experiences

- Physical, sexual, or psychological abuse and neglect (including trafficking)
- Natural and technological disasters or terrorism
- Family or community violence
- Sudden or violent loss of a loved one
- Substance use disorder (personal or familial)
- Refugee and war experiences (including torture)
- Serious accidents or life-threatening illness
- Military family-related stressors (e.g., deployment, parental loss or injury)

https://www.nctsn.org/what-is-child-trauma/trauma-types



_____ - While many children adjust well after a death, other children have ongoing difficulties that interfere with everyday life and make it difficult to recall positive memories of their loved ones.

_____ involves the giving or receiving of anything of value (money, shelter, food, clothing, drugs, etc.) to any person in exchange for a sex act with someone under the age of 18.

_____ describes both children's exposure to multiple traumatic events—often of an invasive, interpersonal nature—and the wide-ranging, long-term effects of this exposure.

_____ include hurricanes, earthquakes, tornadoes, wildfires, tsunamis, and floods, as well as extreme weather events such as blizzards, droughts, extreme heat, and windstorms.

_____ is exposure to intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim.

_____ generally refers to the traumatic experiences that occur to children aged 0-6.

_____ refers to a set of psychological and physiological responses of children and their families to single or multiple medical events.

_____ occurs when a parent or caregiver commits an act that results in physical injury to a child or adolescent.

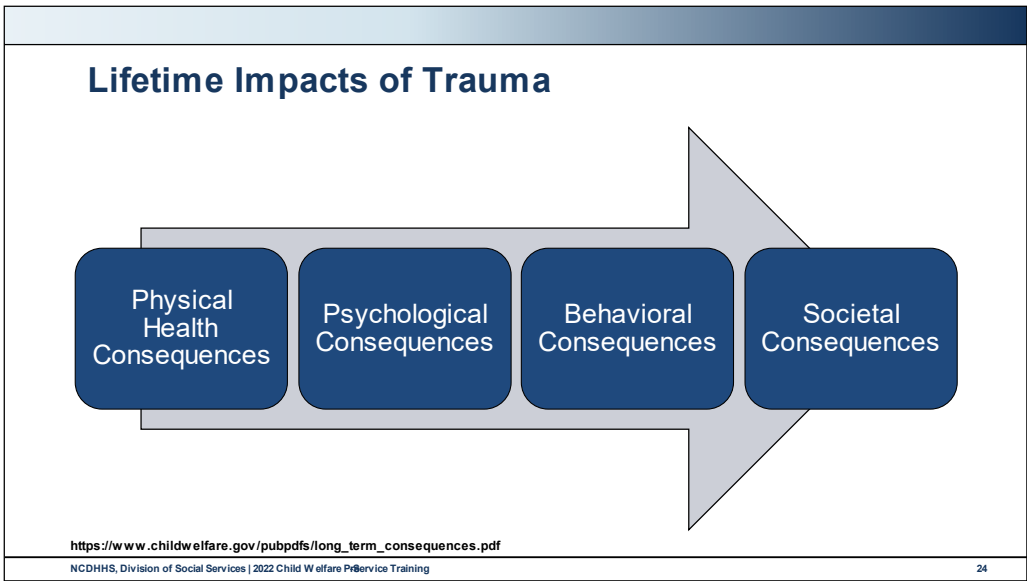
_____ is a deliberate and unsolicited action that occurs with the intent of inflicting social, emotional, physical, and/or psychological harm to someone who often is perceived as being less powerful.

Many _____, especially children, have experienced trauma related to war or persecution that may affect their mental and physical health long after the events have occurred.

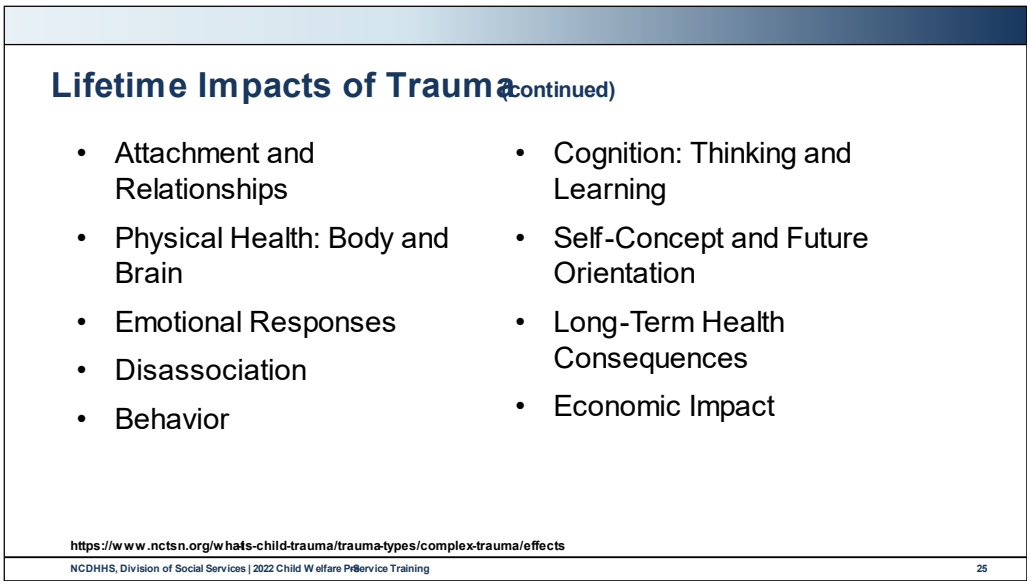
_____ is any interaction between a child and an adult (or another child) in which the child is used for the sexual stimulation of the perpetrator or an observer.

_____ also referred to as domestic violence, occurs when an individual purposely causes harm or threatens the risk of harm to any past or current partner or spouse.

_____ - Families and children may be profoundly affected by mass violence, acts of terrorism, or community trauma in the form of shootings, bombings, or other types of attacks.



A child's reactions to abuse or neglect can have lifelong and even intergenerational impacts. Childhood maltreatment can be linked to later physical, psychological, and behavioral consequences as well as costs to society as a whole.



Forming Attachments and Relationships

The majority of abused or neglected children have difficulty developing a strong healthy attachment to a caregiver. Children who do not have healthy attachments have been shown to be more vulnerable to stress. They have trouble controlling and expressing emotions and may react violently or inappropriately to situations. Our ability to develop healthy, supportive relationships with friends and significant others depends on our having first developed those kinds of relationships in our families. A child with a complex trauma history may have problems in romantic relationships, in friendships, and with authority figures, such as teachers or police officers.

Physical Health: The Body and Brain

Stress in an environment can impair the development of the brain and nervous system. An absence of mental stimulation in neglectful environments may limit the brain from developing to its full potential. Children with complex trauma histories may develop chronic or recurrent physical complaints, such as headaches or stomachaches. Adults with histories of trauma in childhood have been shown to have more chronic physical conditions and problems and are more likely to engage in risky behaviors that compound these conditions such as smoking, substance use, and diet and exercise habits that lead to obesity.

Emotional Responses

Children who have experienced complex trauma often have difficulty identifying, expressing, and managing emotions, and may have limited language for feeling states. They often internalize and/or externalize stress reactions and as a result may experience significant depression, anxiety, or anger. Their emotional responses may be unpredictable or explosive. For a child with a complex trauma history, reminders of

various traumatic events may be everywhere in the environment, and they may react with trembling, anger, sadness, or avoidance.

Disassociation

When children encounter an overwhelming and terrifying experience, they may disassociate, or mentally separate themselves from the experience. They may perceive themselves as detached from their bodies, and somewhere else in the room watching what is happening to their bodies. They may feel as if they are in a dream or some altered state that is not quite real or as if the experience is happening to someone else. Or they may lose all memories or sense of the experiences having happened to them, resulting in gaps in time or even gaps in their personal history. At its extreme, a child may cut off or lose touch with various aspects of the self.

Behavior

Complexly traumatized children may behave in ways that appear unpredictable, oppositional, volatile, and extreme. A child who feels powerless or who grew up fearing an abusive authority figure may react defensively and aggressively in response to perceived blame or attack, or alternately, may at times be overcontrolled, rigid, and unusually compliant with adults. If a child dissociates often, this will also affect behavior. Such a child may seem “spacey”, detached, distant, or out of touch with reality. Complexly traumatized children are more likely to engage in high-risk behaviors, such as self-harm, unsafe sexual practices, and excessive risk-taking such as operating a vehicle at high speeds. They may also engage in illegal activities, such as alcohol and substance use, assaulting others, stealing, running away, and/or prostitution, thereby making it more likely that they will enter the juvenile justice system.

Cognition: Thinking and Learning

When children grow up under conditions of constant threat, all their internal resources go toward survival. When their bodies and minds have learned to be in chronic stress response mode, they may have trouble thinking a problem through calmly and considering multiple alternatives. They may find it hard to acquire new skills or take in new information. They may struggle with sustaining attention or curiosity or be distracted by reactions to trauma reminders. They may show deficits in language development and abstract reasoning skills. Many children who have experienced complex trauma have learning difficulties that may require support in the academic environment.

Self-Concept and Future Orientation

Children learn their self-worth from the reactions of others, particularly those closest to them. Caregivers have the greatest influence on a child’s sense of self-worth and value. Abuse and neglect make a child feel worthless and despondent. A child who is abused will often blame him- or herself. It may feel safer to blame oneself than to recognize the parent as unreliable and dangerous. A complexly traumatized child may have feelings of

shame, guilt, low self-esteem, and poor self-image. They may perceive the world as a meaningless place in which planning and positive action is futile; they see themselves as powerless and “damaged”. They have trouble feeling hopeful. Having learned to operate in “survival mode,” the child lives from moment-to-moment without pausing to think about, plan for, or even dream about a future.

Long-Term Health Consequences

Traumatic experiences in childhood have been linked to increased medical conditions throughout the individuals’ lives. There is a proven connection between childhood trauma exposure and chronic illness such as heart disease and cancer, and early death.

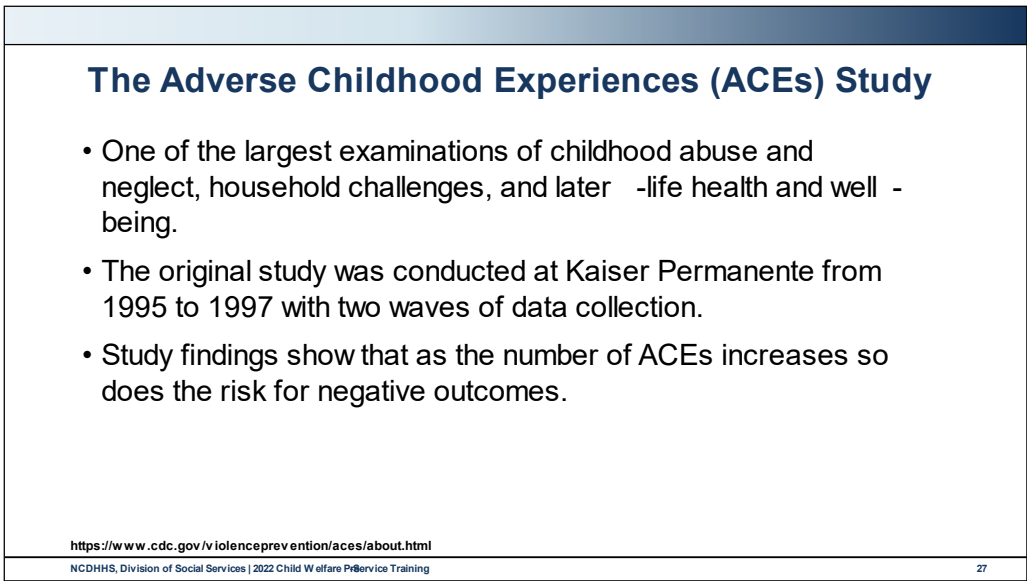
Economic Impact

The cumulative economic and social burden of complex trauma in childhood is extremely high. This includes both direct costs for the immediate needs of maltreated children (hospitalization, mental health care, child welfare systems, and law enforcement) and indirect costs for special education, juvenile delinquency, mental health and health care, the adult criminal justice system, and lost productivity to society.

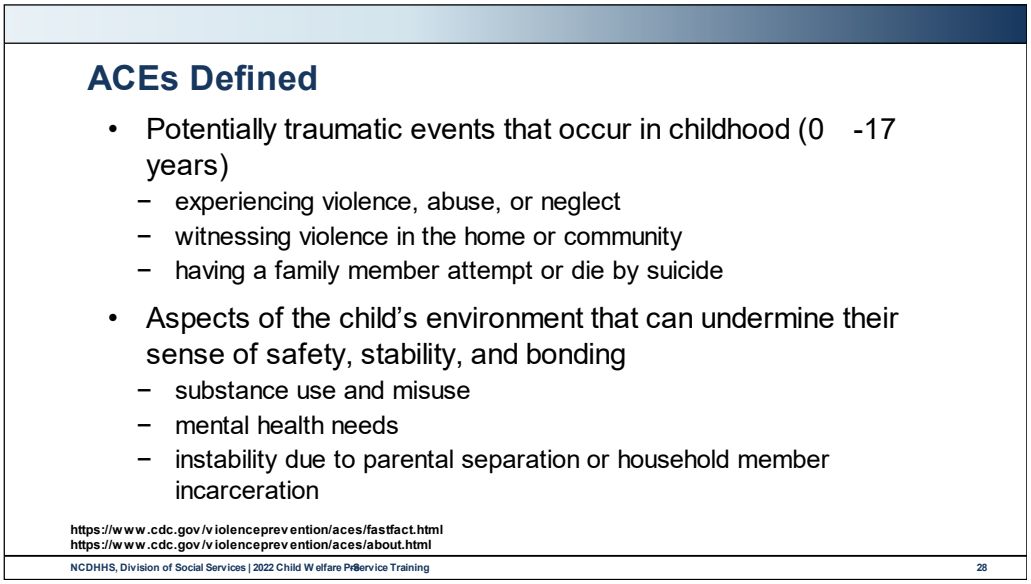
Video: How Childhood Trauma Affects Health Across a Lifetime

Visit: How Childhood Trauma Affects Health Across a Lifetime for a Ted Talk featuring Pediatrician Nadine Burke Harris explaining that the repeated stress of abuse, neglect, and parents struggling with mental health or substance abuse issues has real, tangible effects on the development of the brain. Note: The first 4:41 minutes of the video are applicable to our work in child welfare.

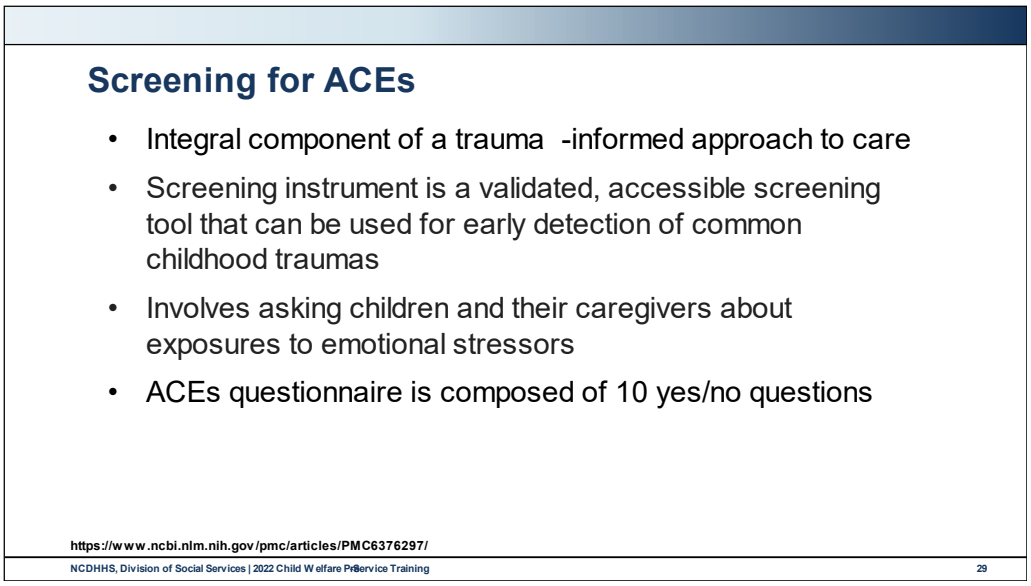
Use this space to record notes.



As social workers in child welfare, it is important for us to understand and recognize the correlation between ACEs and negative health and well-being outcomes, to strengthen the ability of the family to protect and care for their own children and to minimize harm to children and youth.



ACEs are a way to screen for and describe childhood trauma, and to measure the potential impacts of the ACEs.



Screening for ACEs involves asking children and their caregivers about exposures to the emotional stresses that may impact their health. Screening with these 10 yes/no questions generates the child's 'ACE Score', by giving one point for each 'yes' answer. The more "yeses" one has, the more likely they are to experience emotional and physical health issues.

Activity: ACEs Questionnaire

Please complete the ACEs survey on the following page for yourself. You will not be asked to share your responses.

This reflective activity will help to increase your own awareness of the types of experiences you have had and to think about any supportive factors and coping skills that have helped you become more resilient and work toward overcoming traumatic events.

As you discover your personal ACEs score it is also important to reflect on your own resiliency and make note of the supportive factors and coping skills that have helped you achieve positive outcomes. Much of our work with children and families draws upon the ability to help individuals recognize internal and external opportunities of support and services that can help them also overcome traumatic events.

Use this space to record notes.

Handout: Adverse Childhood Experiences (ACEs) Questionnaire

Place an X in the box next to Yes or No to answer each question. If you are using this document electronically, double-click to place an X in the appropriate box.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

   Yes ☐ No ☐

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

   Yes ☐ No ☐

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

   Yes ☐ No ☐

4. Did you often or very often feel that… No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

   Yes ☐ No ☐

5. Did you often or very often feel that… You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   Yes ☐ No ☐

6. Were your parents ever separated or divorced?

   Yes ☐ No ☐

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   Yes ☐ No ☐

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   Yes ☐ No ☐

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   Yes ☐ No ☐

10. Did a household member go to prison?

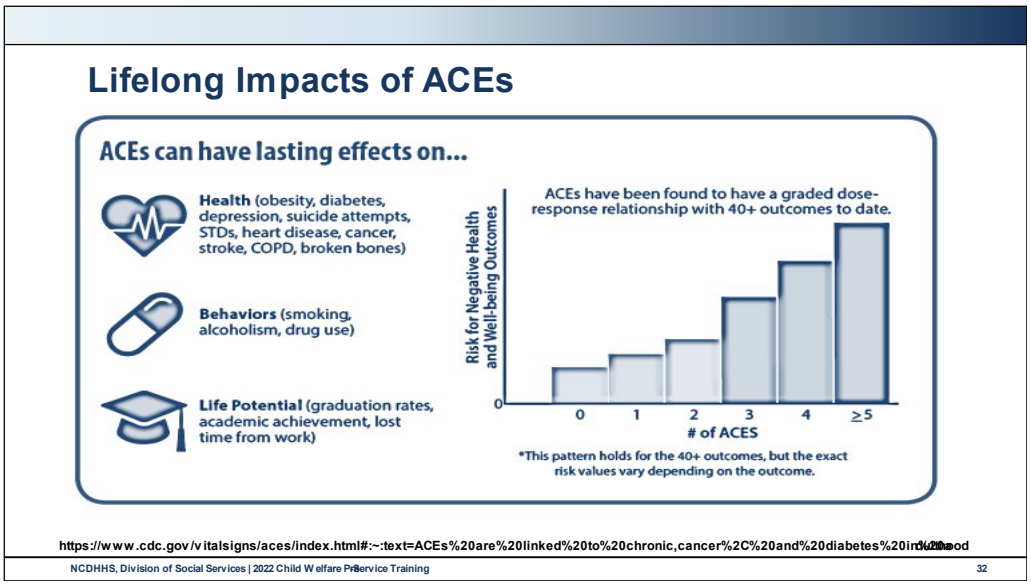
    Yes ☐ No ☐

Now, add up the number of times you selected "Yes". This number is your ACE Score.

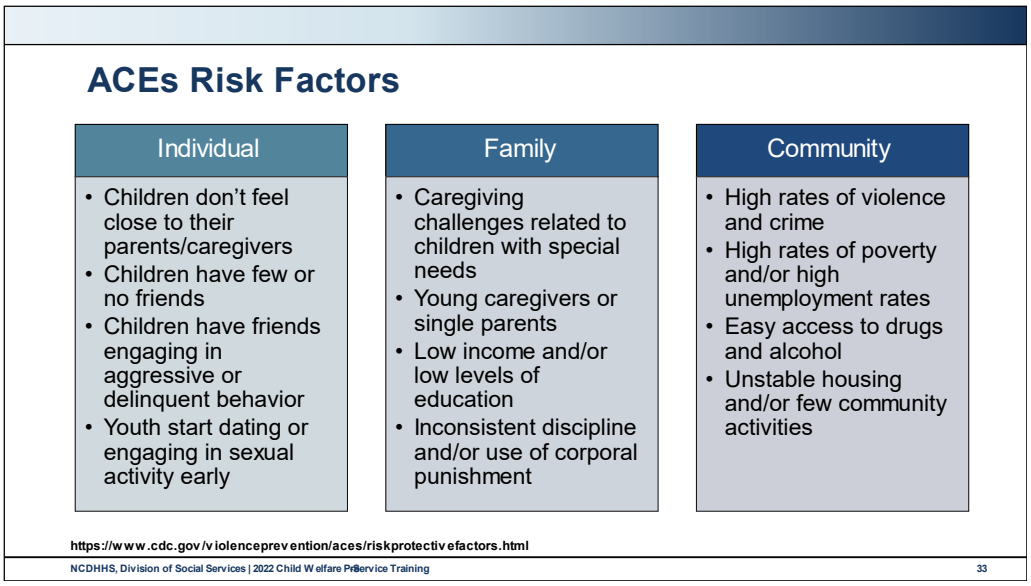
An ACE score of 4 or higher increases the risk of disease and social and emotional issues.

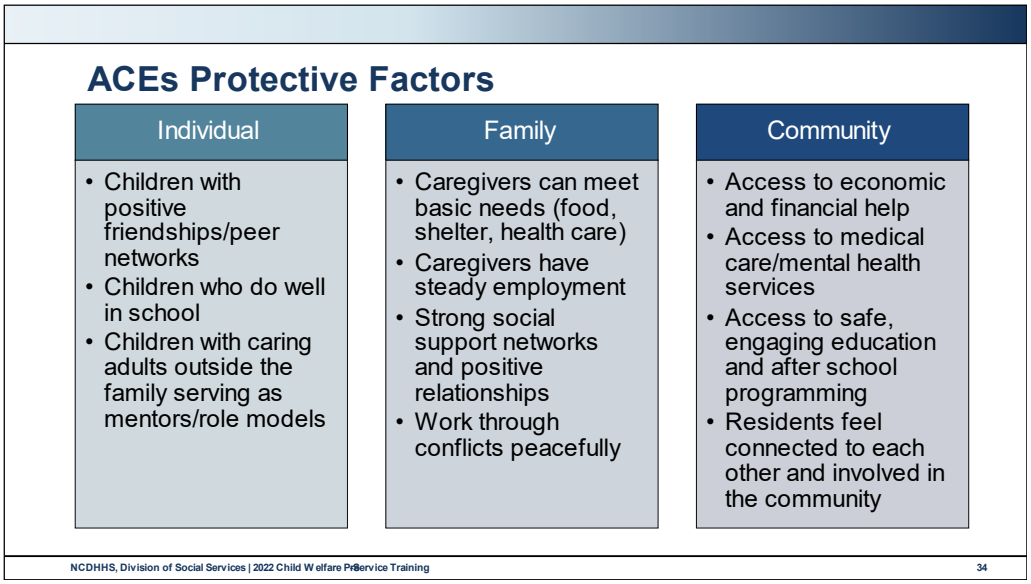
Questions and Reflections

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



ACEs are common. About 61% of adults surveyed across 25 states reported they had experienced at least one type of ACE before age18, and nearly 1 in 6 reported they had experienced four or more types of ACEs.





The slides highlight some of the most common risk and protective factors for ACEs. Please refer to the following handout for a complete list excerpted from the Centers for Disease Control and Prevention (CDC) website.

Handout: Risk & Protective Factors for ACEs

From the Centers for Disease Control and Prevention

Risk Factors for ACEs

Individual and Family Risk Factors

- Families experiencing caregiving challenges related to children with special needs (for example, disabilities, mental health issues, chronic physical illnesses)
- Children and youth who don't feel close to their parents/caregivers and feel like they can't talk to them about their feelings
- Youth who start dating early or engaging in sexual activity early
- Children and youth with few or no friends or with friends who engage in aggressive or delinquent behavior
- Families with caregivers who have a limited understanding of children's needs or development
- Families with caregivers who were abused or neglected as children
- Families with young caregivers or single parents
- Families with low income
- Families with adults with low levels of education
- Families experiencing high levels of parenting stress or economic stress
- Families with caregivers who use spanking and other forms of corporal punishment for discipline
- Families with inconsistent discipline and/or low levels of parental monitoring and supervision
- Families that are isolated from and not connected to other people (extended family, friends, neighbors)
- Families with high conflict and negative communication styles
- Families with attitudes accepting of or justifying violence or aggression

Community Risk Factors

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

Protective Factors for ACEs

Individual and Family Protective Factors

- Families who create safe, stable, and nurturing relationships, meaning, children have a consistent family life where they are safe, taken care of, and supported
- Children who have positive friendships and peer networks
- Children who do well in school
- Children who have caring adults outside the family who serve as mentors/role models
- Families where caregivers can meet basic needs of food, shelter, and health services for children
- Families where caregivers have college degrees or higher
- Families where caregivers have steady employment
- Families with strong social support networks and positive relationships with the people around them
- Families where caregivers engage in parental monitoring, supervision, and consistent enforcement of rules
- Families where caregivers/adults work through conflicts peacefully
- Families where caregivers help children work through problems
- Families that engage in fun, positive activities together
- Families that encourage the importance of school for children

Community Protective Factors

- Communities where families have access to economic and financial help
- Communities where families have access to medical care and mental health services
- Communities with access to safe, stable housing
- Communities where families have access to nurturing and safe childcare
- Communities where families have access to high-quality preschool
- Communities where families have access to safe, engaging after school programs and activities
- Communities where adults have work opportunities with family-friendly policies
- Communities with strong partnerships between the community and business, health care, government, and other sectors
- Communities where residents feel connected to each other and are involved in the community
- Communities where violence is not tolerated or accepted

ACEs don’t have a single cause, and they can take several different forms. Many factors contribute to ACEs, including personal traits and experiences, parents, the family environment, and the community itself. To prevent ACEs and protect children from neglect, abuse, and violence, it’s essential to address each of these factors.

Video: Prevention Strategies

Visit: We Can Prevent ACEs for a video that highlights strategies to create safe, stable, nurturing relationships and environments for all children.

Use this space to record notes.

Prevention Strategies

Strategy	Approach
Strengthen economic supports to families	• Strengthening household financial security • Family-friendly work policies
Promote social norms that protect against violence and adversity	• Public education campaigns • Legislative approaches to reduce corporal punishment • Bystander approaches • Men and boys as allies in prevention
Ensure a strong start for children	• Early childhood home visitation • High-quality childcare • Preschool enrichment with family engagement
Teach skills	• Social-emotional learning • Safe dating and healthy relationship skill -building programs • Parenting skills and family relationship approaches

https://www.cdc.gov/violenceprevention/aces/prevention.html

NCDHHS, Division of Social Services | 2022 Child Welfare Pre-service Training 36

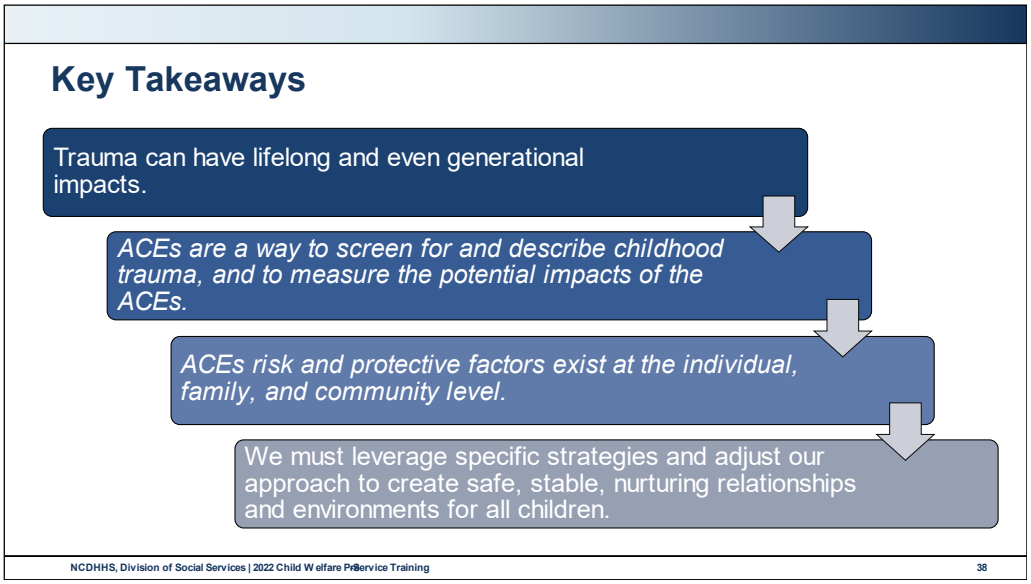
Prevention Strategies (continued)

Strategy	Approach
Connect youth to caring adults and activities	• Mentoring programs • After-school programs
Intervene to lessen immediate and long -term harms	• Enhanced primary care • Victim-centered services • Treatment to lessen the harms of ACEs • Treatment to prevent problem behavior and future involvement in violence • Family-centered treatment for substance use disorders

NCDHHS, Division of Social Services | 2022 Child Welfare Pre-service Training 37

The slides list the six strategies developed by the CDC to help states and communities take advantage of the best available evidence to prevent ACEs.

Key Takeaways



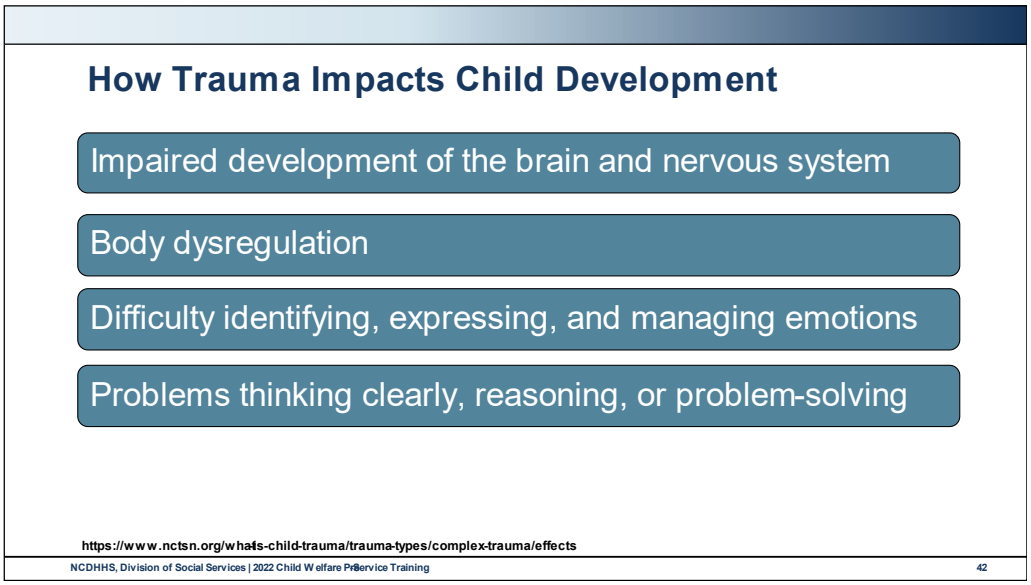
Questions and Reflections

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

How Trauma Impact Families and Child Development

Learning Objectives

• Describe the impact of trauma on child development.
• Discuss the impacts of unresolved childhood trauma on family functioning.
• Explain how families heal together and their role in providing support and identifying trauma-informed interventions.
• Explain the impact of unresolved trauma on protective capacities.
• Provide examples of strategies that help children and families feel physically and emotionally safe when engaging in conversations regarding trauma.



When childhood trauma occurs, and children are unable to cope, it can have a negative impact on child development. Studies show that children who have experienced trauma are more likely to engage in risky behaviors and develop physical ailments.

Video: Trauma and the Brain

Visit: Through Our Eyes Children Violence and Trauma for a video from the Office of Victims of Crime discussimg how violence and trauma affect children and brain development, including the serious and long-lasting consequences for their physical and mental health.

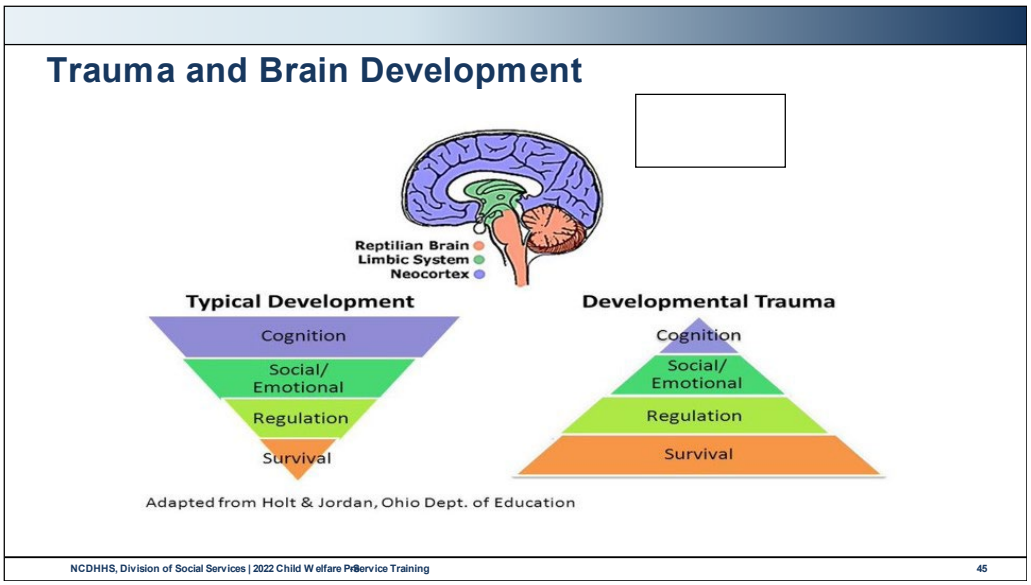
Debrief

Use this space to record notes.

Record one captured moment from watching the video:

How do we put a system around children that is trauma informed?

What do we do to help rewire the brain?



Trauma creates disruption in the limbic system (green area on this slide) of the brain which stores emotional responses to experiences. The amygdala (the orange area) is the “fear center” of the brain. Trauma response & memory is stored in the amygdala.

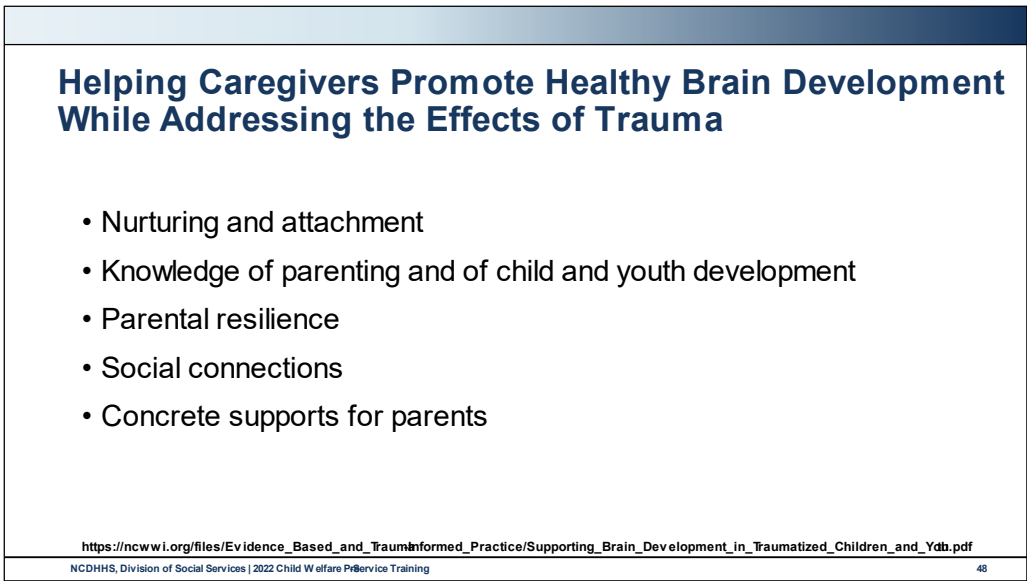
This is the reason that traumatized children commonly have a lot of emotions when recalling traumatic experiences. When the amygdala is activated during a traumatic experience, it interferes with the hippocampus. The hippocampus is involved with recall of memory, particularly long-term memory. During a traumatic event the amygdala will send a “fear” signal to the neocortex. The neocortex is the center for higher brain functions, such as perception, decision-making and language. When a child experiences a severe traumatic event or repeated traumatic events, this signal to the neocortex can become “hyper-sensitive.” The brain, in an effort to survive, will put itself in a constant state of fear. In this state of fear and heightened sense of stress, the amygdala will send a message of Fight, Flight, Freeze, or Fawn. In this state, it becomes difficult for the brain to learn and develop, and the neocortex becomes less developed.

- Fight is your body's way of facing any perceived threat aggressively.
- Flight means your body urges you to run from danger.
- Freeze is your body's inability to move or act against a threat.
- Fawn occurs when your body's stress response is to try to please someone to avoid conflict.

Your body may also do combination of the responses during a traumatic event—you may start with fight and end up in a fawning state. Your brain and body will make its first fear response in less than ONE second. That is how quickly your reptilian brain tries to keep you safe.

Questions and Reflections

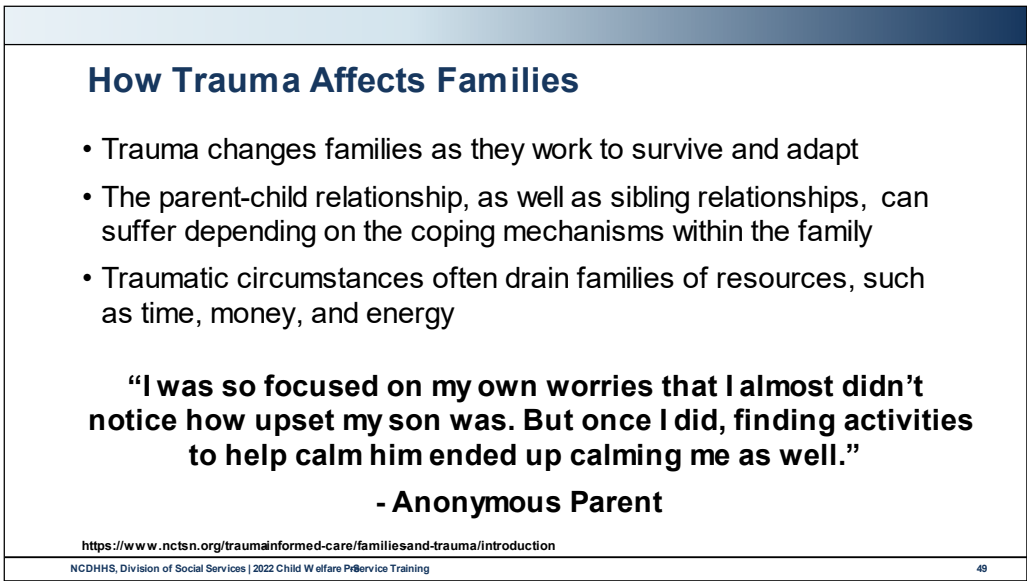
Use this space to record questions and reflections about what you have learned.



Both young children and teens benefit from quality time with their caregivers and adult mentors who help them:

- Organize tasks and set priorities
- Practice making decisions
- Master new skills
- Seek healthy adventures and take positive risks
- Minimize stress
- Adopt healthy lifestyles and allow time for plenty of sleep

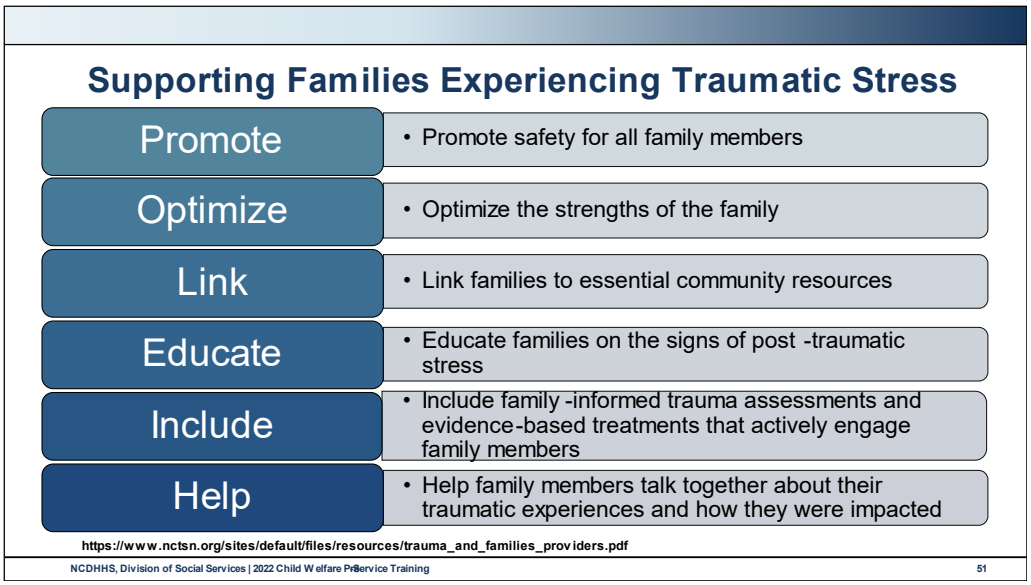
With support, children can build their own resilience and continue to overcome traumatic events.



Research demonstrates that trauma has a range of impacts on individual family members, their relationships with each other, and overall family functioning. Individuals all respond differently to traumatic events. Most people have developed coping mechanisms and have family support to help them through these events. A parents' protection, nurturance, and guidance speeds recovery and supports their children's coping in the face of trauma. When parents are not available or are struggling with their own reactions or behavioral and/or physical health problems, they may have trouble staying attuned with their children's reactions and responses to the traumatic experience.

Activity: Safe Faces – Safe Places

Safe Face: Record the name of a person who is still living and part of your life, that is your calming person; the person who helps you regulate and find your balance.
Safe Place: record your personal safe place; the place where you instantly feel calmer, more in control, and protected.
Why: Record two or three reasons why that person is your safe face, and that place is your safe place.



As social workers we should partner with families to attain safety and access to family centered, trauma specific services that put families in the “driver’s seat” and empower them to plot their own courses of recovery and healing in the aftermath of trauma. Family informed trauma treatments can help to build stronger families and hold promise for benefiting future generations.

Video: Building Resiliency to Heal from Trauma

Visit: How Resilience is Built for a video describing how responsive exchanges with adults help children build the skills they need to manage stress and cope with adversity.

While watching this short video, use this space to record a few ideas, key words, or phrases about how you can help build resilience with the children you work with in your role as a social worker.

Debrief

Use this space to record the ways in which you can build resiliency within families and your community.

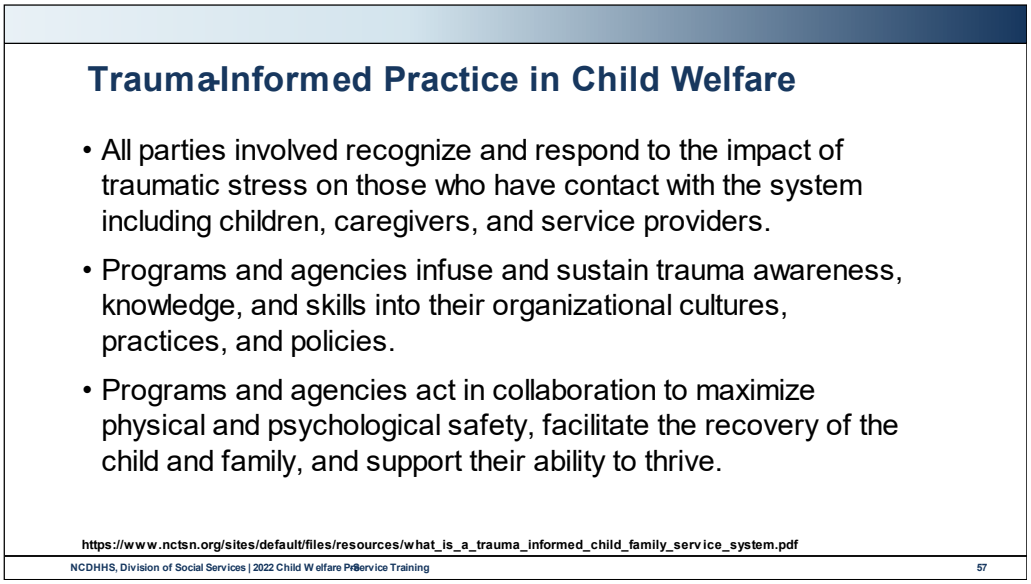
Questions and Reflections

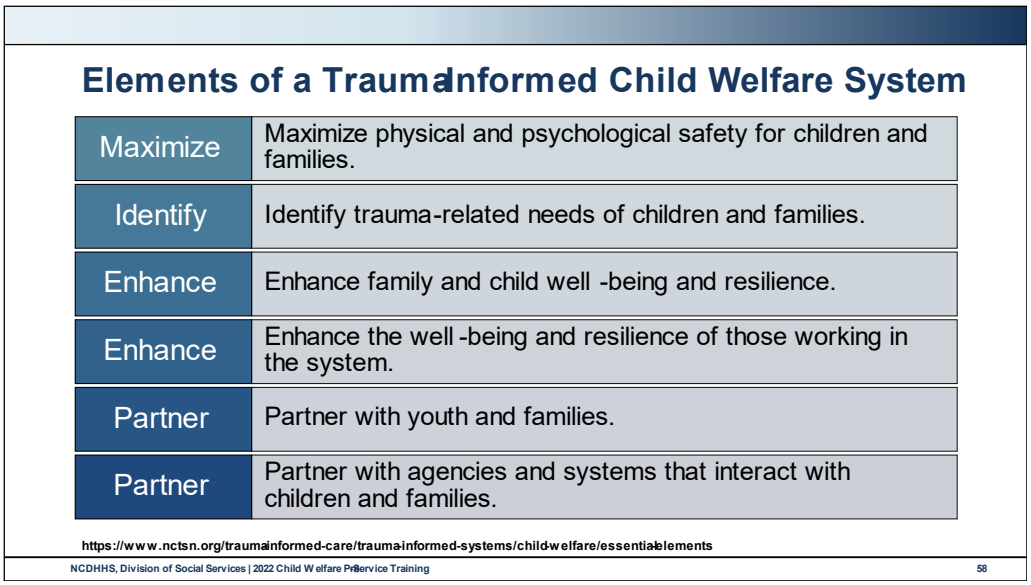
Use this space to record questions and reflections about what you have learned.

Trauma-Informed Child Welfare Systems

Learning Objectives

- Discuss trauma-informed practice and our role in ensuring trauma-informed casework.





Given the prevalence of trauma and traumatic stress reactions among child welfare system-involved children, families, caregivers, professionals, and other stakeholders, it is critical that child welfare professionals link families with trauma-informed treatment and services and integrate an understanding of trauma into their own practice.

Implementing Trauma-Informed Practice

- Routinely screen for trauma exposure and related symptoms.
- Use evidence-based, culturally responsive assessment and treatment for traumatic stress and associated mental health symptoms.
- Make resources available to children, families, and providers on trauma exposure, its impact, and treatment.
- Engage in efforts to strengthen the resiliency and protective factors of children and families impacted by and vulnerable to trauma.

https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems/child-welfare

Implementing Trauma-Informed Practice (continued)

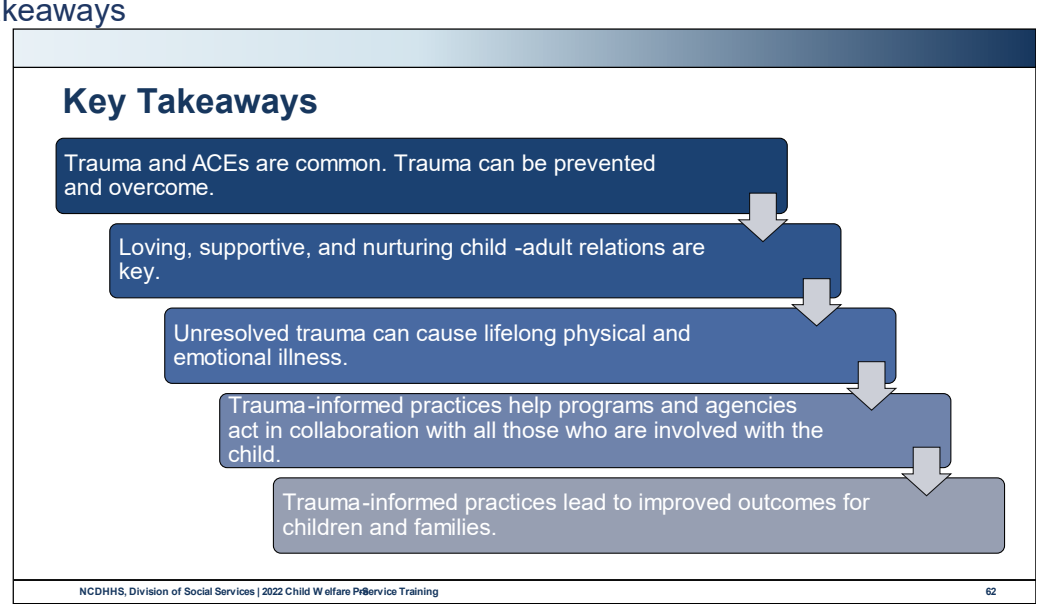
- Address parent and caregiver trauma and its impact on the family system.
- Emphasize continuity of care and collaboration across all child-serving systems.
- Maintain an environment of care for staff that addresses, minimizes, and treats secondary traumatic stress, and that increases staff wellness.

Improved Outcomes of Trauma-Informed Practice

- Fewer children requiring crisis services
- Decreased use of psychotropic medications
- Fewer foster home placements, disruptions, and re -entries
- Reduced length of stay in out -of-home care
- Improved child functioning and increased well -being

https://caseyfamilypro-wpengine.netdna-ssl.com/media/SComm_Traumainformed-1.pdf

Key Takeaways

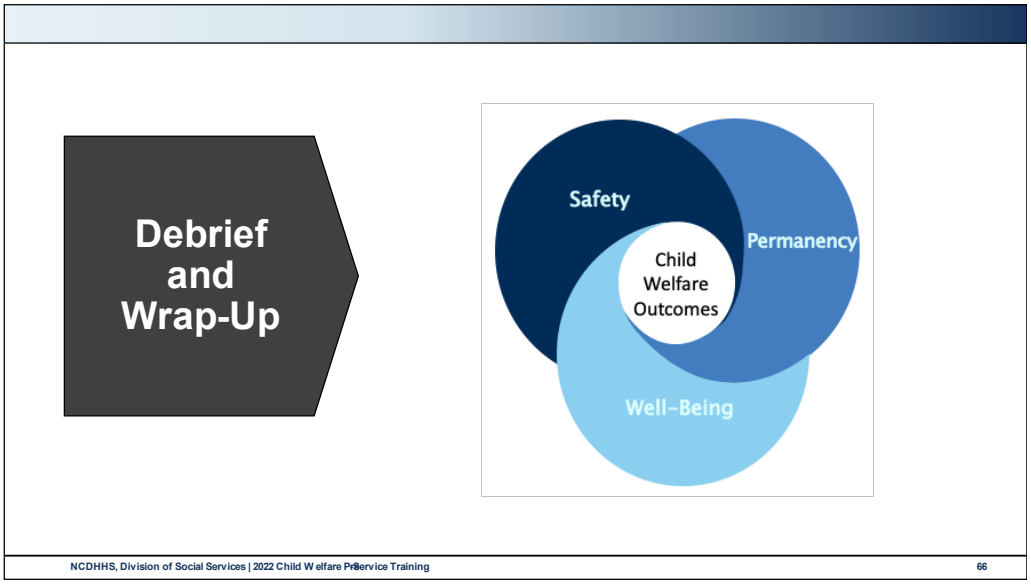


Questions and Reflections

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

Foundation Training Wrap-Up

Foundation Training Overview



This graphic reminds us, the goal of child welfare is to promote the safety, permanency, and well-being of children and families by helping families care for their children successfully or, when that is not possible, helping children find permanency with kin or adoptive families.

Here are some additional reminders of what you have learned during Foundation training:

- DSS, as the child welfare agency, and you as a social worker, have significant responsibility in ensuring these outcomes.
- The child welfare system involves a much broader network of stakeholders, including other state and local government agencies, service providers, and communities and families themselves.
- The system working together to provide support, services, and resources is key to ensuring positive outcomes for children and families.
- Listening to children and families is key to understanding how they experience the child welfare system, and how we can best help them achieve safety, permanency and well-being in a way that is meaningful to them.

Questions and Reflections

Use this space to record elements of the content that have stood out during your training experience. Include any personal success you wish to celebrate as you recognize growth in your knowledge of ensuring safety, permanency, and well-being for the children and families you will serve.

Activity: Self-Care Exercise/Body-Scan Meditation

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

Visit: https://www.uclahealth.org/marc/mpeg/01_Breathing_Meditation.mp3 for a meditation exercise.

Bibliography of References

Day 1

- Sigure, Raven (2019, January 18) *2019 Casey Excellence for Children Birth Mother Award Winner,* https://www.youtube.com/watch?v=gK9s2naRdJQ
- U.S. Department of Health & Human Services (N.D.) Child Welfare Information Gateway, Search A to Z https://www.childwelfare.gov/atozindex/
- Children's Bureau, An Office of the Administration for Children & Families (2010, October) How the Child Welfare System Works, https://www.childwelfare.gov/pubPDFs/cpswork.pdf
- The Annie E. Casey Foundation (2013, January 16) Voice of Youth: Supporting Adolescents in Foster Care (1 of 8) https://www.youtube.com/watch?v=vu_BAayToJA
- Child and Family Services Reviews - Quick Reference Items List (N.D.) https://www.acf.hhs.gov/sites/default/files/documents/cb/cfsr_quick_reference_list.pdf
- U.S. Department of Health & Human Services (N.D.) Child Welfare Information Gateway, Well-Being, https://www.childwelfare.gov/topics/systemwide/well-being/
- Children's Bureau, An Office of the Administration for Children & Families (2021, July) Family Engagement: Partnering With Families to Improve Child Welfare Outcomes, https://www.childwelfare.gov/pubPDFs/f_fam_engagement.pdf
- Casey Family Programs, Lifting Up Voices (2021, March 30) Lifting Up Family and Alumni Voices, https://www.youtube.com/watch?v=AAEcQq3GIlA
- The National Technical Assistance and Evaluation Center (2008, September) A Closer Look: Interagency Collaboration, https://www.childwelfare.gov/pubPDFs/interagency.pdf
- Children's Bureau, Child Welfare Information Gateway (2019, April) What Is Child Abuse and Neglect? Recognizing the Signs and Symptoms, https://www.childwelfare.gov/pubPDFs/whatiscan.pdf
- Centers for Disease Control and Prevention (N.D.) Retrieved October 24, 2022, Child Abuse and Neglect Prevention, https://www.cdc.gov/violenceprevention/childabuseandneglect/index.html
- Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention (2014) Understanding Child Maltreatment, www.cdc.gov/violenceprevention/pdf/cm-factsheet--2013.pdf
- North Carolina General Assembly, (N.D.) Retrieved October 24, 2022, Chapter 7b - Juvenile Code, https://www.ncleg.gov/Laws/GeneralStatuteSections/Chapter7B
- Cook Children's Health Care System (2016, April 15) Reaching Out: Child abuse, the different types and who's at risk. Abuse Hotline 1-800-4-A-CHILD, https://www.youtube.com/watch?v=cs_scHiNfnI
- R. M., & Coulborn, K. (2011). Training child welfare workers from an intersectional cultural humility perspective: A paradigm shift. Child Welfare, 90(5). 2 Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural

humility: A concept analysis. Journal of Transcultural Nursing, 27(3), 210–217 as cited by NCWWI Approach to Cultural Humility (ncwwi-dms.org)

- U.S. Department of Health & Human Services (N.D.) Child Welfare Information Gateway, Cultural Responsiveness: Child Abuse and Neglect https://www.childwelfare.gov/topics/systemwide/cultural/can/
- Mayo Clinic (N.D.) Slide show: Birthmarks https://www.mayoclinic.org/birthmarks/sls-20076683?s=4
- Centers for Disease Control and Prevention, CDC 24/7: Saving Lives, Protecting People (N.D.), https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html
- U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau Child Maltreatment 2020 (2020), https://www.acf.hhs.gov/sites/default/files/documents/cb/cm2020.pdf
- Children's Bureau, An Office of the Administration for Children & Families (2018, July) Acts of Omission: An Overview of Child Neglect, https://www.childwelfare.gov/pubPDFs/acts.pdf
- Harvard Psychology (2020), Self-care - Making yourself a priority in your life, https://harvardpsychology.wixsite.com/psychspace/self-care
- University of Buffalo, School of Social Work (N.D.), Introduction to Self-Care https://socialwork.buffalo.edu/resources/self-care-starter-kit/introduction-to-self-care.html
- No Author (N.D.) https://d1cy5zxxhbcbkk.cloudfront.net/guided-meditations/01_Breathing_Meditation.mp3
- Mayo Clinic, Healthy Lifestyle (N.D.), Mindfulness Exercise, https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/mindfulness-exercises/art-20046356

Day 2

- Children's Bureau, An Office of the Administration for Children & Families (2021,April) Child Welfare Practice to Address Racial Disproportionality and Disparity, https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf
- Children's Bureau, Child Welfare Information Gateway (2018, July) Acts of Omission: An Overview of Child Neglect, https://www.childwelfare.gov/pubPDFs/acts.pdf
- Children's Bureau, An Office of the Administration for Children & Families (2021, March) The Use of Safety and Risk Assessments in Child Protection Cases, https://www.childwelfare.gov/pubPDFs/safety_risk.pdf
- Family and Children's Resource Program, part of the Jordan Institute for Families UNC-Chapel Hill School of Social Work (2016, December 1) Distinguishing Safety and Risk in the Real World, https://fcrp.unc.edu/wp-content/uploads/sites/309/2017/09/SafetyAndRisk.pdf
- Children's Bureau, Administration for Children and Families, United States Department of Health and Human Services (2021). National Child Abuse and Neglect Data System (NCANDS). https://www.acf.hhs.gov/cb/data-research/ncands
- The Annie E. Casey Foundation. (n.d.). KIDS COUNT Data Center. https://datacenter.kidscount.org/
- Children's Bureau: Guide to Data-Driven Decision-Making Capacity Building Center for States
- Anderson, C. (2015). Creating a data-driven organization. Sebastopol, CA: O'Reilly
- Elisa Minoff and Alexandra Citrin (2022, March) Center for the Study of Social Policy, Systemically Neglected: How Racism Structures Public Systems to Produce Child Neglect, https://cssp.org/resource/systemically-neglected/
- National Conference of State Legislatures, (Retrieved 2022, November 2) Disproportionality and Race Equity in Child Welfare, https://www.ncsl.org/research/human-services/disproportionality-and-race-equity-in-child-welfare.aspx
- Center for the Study of Social Policy, (Retrieved 2022, November 2) Systemically Neglected: How Racism Structures Public Systems to Produce Child Neglect, https://cssp.org/resource/systemically-neglected
- North Carolina Collaborative for Children, Youth and Families, (Retrieved 2022, November 2) North Carolina System of Care, https://nccollaborative.org/what-is-system-of-care/
- U.S. Department of Health & Human Services (N.D.) Child Welfare Information Gateway, Overview: Courts, https://www.childwelfare.gov/topics/systemwide/courts/overview/
- Children's Bureau, Child Welfare Information Gateway (2016, October) Understanding Child Welfare and the Courts, https://www.childwelfare.gov/pubPDFs/cwandcourts.pdf
- U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau,

Office on Child Abuse and Neglect, (2006) Working with the Courts in Child Protection, https://www.childwelfare.gov/pubpdfs/courts.pdf

- U.S. Department of Health & Human Services (N.D.) Child Welfare Information Gateway, Philosophy and Key Elements of Family-Centered Practice, https://www.childwelfare.gov/topics/famcentered/philosophy/
- Children's Bureau, Child Welfare Information Gateway (2021, July) Family Engagement: Partnering With Families to Improve Child Welfare Outcomes, https://www.childwelfare.gov/pubPDFs/f_fam_engagement.pdf
- Dan Comer, (2014, Jan 10) Engagement Part 3: "A Success Story", https://www.youtube.com/watch?v=-Vz5TRIhVaQ
- FWD Collective, LLC. (2021). (rep.). Diversity, Equity, Inclusion, Belonging. FWD Collective, LLC.
- Children's Bureau, Child Welfare Information Gateway (2021, April) Child Welfare Practice to Address Racial Disproportionality and Disparity, https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf
- (N.D.) https://www.uclahealth.org/marc/mpeg/Body-Sound-Meditation.mp3
- UCLA Health (N.D.) Guided Meditations, https://www.uclahealth.org/marc/mindful-meditations#english

Day 3

- Culture Plus Consulting, (N.D.) 'A-HA' Activities For Unconscious Bias Training, https://cultureplusconsulting.com/2018/08/16/a-ha-activities-for-unconscious-bias-training/
- Kirwan Institute for the Study of Race and Ethnicity, Center for the Study of Social Policy, (N.D.) Implicit Racial Bias 101: Exploring Implicit Bias in Child Protection, https://kirwaninstitute.osu.edu/implicit-bias-101
- Children's Bureau, Child Welfare Information Gateway (2021, April) Child Welfare Practice to Address Racial Disproportionality and Disparity, https://www.childwelfare.gov/pubPDFs/racial_disproportionality.pdf
- American Bar Association (N.D.) Race and Poverty Bias in the Child Welfare System: Strategies for Child Welfare Practitioners, https://www.americanbar.org/groups/public_interest/child_law/resources/child_law_practiceonline/january---december-2019/race-and-poverty-bias-in-the-child-welfare-system---strategies-f/
- National Association of Social Workers, (N.D.) (Retrieved 2022, November 2), Code of Ethics, https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English
- Colton J. Cnossen, PressBooks, (N.D.) (Retrieved 2022, November 2), Introduction to Social Work, https://pressbooks.pub/ferrisintroductiontosocialwork/chapter/chapter-2-nasw-code-of-ethics/
- Merriam-Webster, (N.D.) (Retrieved 2022, November 2) Dignity, https://www.merriam-webster.com/
- National Association of Social Workers, (2011, November) Leadership Ladders: Steps to a Great Career in Social Work, https://careers.socialworkers.org/documents/Professional%20Boundaries.pdf
- White Hat Communications, (N.D.) (Retrieved 2022, November 2) Client Relationships and Ethical Boundaries for Social Workers in Child Welfare, https://www.socialworker.com/feature-articles/ethics-articles/Client_Relationships_and_Ethical_Boundaries_for_Social_Workers_in_Child_Welfare/
- National Association of Social Workers, (2011, November) Leadership Ladders: setting and maintaining professional boundaries, https://careers.socialworkers.org/documents/Professional%20Boundaries.pdf
- National Association of Social Workers, (N.D.) (Retrieved 2022, November 2), Code of Ethics, https://www.socialworkers.org/About/Ethics/Code-of-Ethics/Code-of-Ethics-English
- National Center on Substance Abuse and Child Welfare, (N.D.) (Retrieved 2022, November 2) Child Welfare and Alcohol and Drug Use Statistics, https://ncsacw.acf.hhs.gov/research/child-welfare-and-treatment-statistics.aspx
- Overdose death rise in North Carolina, (2022, March 23) https://www.youtube.com/watch?v=do89PkViro4

- The Blanchard Institute, (N.D.) (Retrieved 2022, November 2) North Carolina Drug and Alcohol Abuse Statistics, https://theblanchardinstitute.com/drug-alcohol-abuse/
- National Institute on Drug Abuse, Advanced Addiction Science, (N.D.) (Retrieved 2022, November 2), https://nida.nih.gov/
- Substance Abuse and Mental Health Services Administration, 2019, July 18, Risk and Protective Factors, https://www.samhsa.gov/sites/default/files/20190718-samhsa-risk-protective-factors.pdf
- National Center on Substance Abuse and Child Welfare, (N.D.) (Retrieved 2022, November 2) Understanding the Multiple Needs of Families Involved with the Child Welfare System, https://ncsacw.acf.hhs.gov/files/toolkitpackage/mod1/module-1-families-guide-508.pdf
- How do you talk about addiction? Stigma & Language, 2020, March 6, https://www.youtube.com/watch?v=mCf7jXHYSSI
- American Addiction Centers, (2022, September 9) Addiction as a Coping Mechanism and Healthy Alternatives, https://americanaddictioncenters.org/sobriety-guide/coping-mechanism
- Child Witnesses to Domestic Violence, (2022, December) Definitions of Domestic Violence, https://www.childwelfare.gov/pubpdfs/defdomvio.pdf
- Valley Center for Prevention of Family Violence, (N.D.) (Retrieved 2022, November 2) Cycle of Violence, http://www.preventionoffamilyviolence.com/
- National Center on Domestic and Sexual Violence, (N.D.) (Retrieved 2022, November 2) Cycle of Violence, http://www.ncdsv.org/ncd_links.html
- Learn to recognize domestic violence with the “Power and Control Wheel”, (2019, October 25) https://www.youtube.com/watch?v=SekGeyKqf9c
- Women’s Advocates, (N.D.) (Retrieved 2022, November 2) Warning Signs of Abuse, https://www.wadvocates.org/find-help/about-domestic-violence/warning-signs-of-abuse/
- North Carolina Coalition Against Domestic Violence, (N.D.) (Retrieved 2022, November 2) NC Statistics on Domestic Violence, https://nccadv.org/domestic-violence-info/nc-stats
- QIC, Domestic Violence in Child Welfare, (N.D.) (Retrieved 2022, November 2) Child Welfare and Domestic Violence: The Impact on Children and Families, https://dvchildwelfare.org/resources/factsheet/
- Guileine F. Kraft, PhD, LGSW, Caravel Institute Webinar Series, (N.D.) (Retrieved 2022, November 2) Domestic Violence: Cross-Cultural Considerations, https://www.nvfs.org/wp-content/NVFS_Images/D_V_Cross_Cultural_Consider.pdf
- American Psychiatric Association, (N.D.) (Retrieved 2022, November 2) DSM History, https://www.psychiatry.org/psychiatrists/practice/dsm/about-dsm/history-of-the-dsm
- Centers for Disease Control and Prevention, (N.D.) (Retrieved 2022, November 2) Mental health of children and parents —a strong connection, https://www.cdc.gov/childrensmentalhealth/features/mental-health-children-and-parents.html

- National Institute of Mental Health, (N.D.) (Retrieved 2022, November 2) Health Topics, https://www.nimh.nih.gov/health/topics
- Guided Meditations, (N.D.) (Retrieved 2022, November 2) https://www.uclahealth.org/marc/mpeg/Body-Scan-Meditation.mp3
- UCLA Health, (N.D.) (Retrieved 2022, November 2) https://www.uclahealth.org/programs/marc/free-guided-meditations/guided-meditations#english

Day 4

- Good Morning America Digital, (2022, June 9) How I overcame struggles with a mentally ill parent, depression and substance abuse, https://www.youtube.com/watch?v=x0DxoCue_OM
- Centers for Disease Control and Prevention, (N.D.) (Retrieved 2022, November 2) Attention-Deficit / Hyperactivity Disorder (ADHD), https://www.cdc.gov/ncbddd/adhd/index.html
- The National Child Traumatic Stress Network, (N.D.) (Retrieved 2022, November 2) About Child Trauma, https://www.nctsn.org/what-is-child-trauma/about-child-trauma
- The National Child Traumatic Stress Network, (N.D.) (Retrieved 2022, November 2) Trauma Types, https://www.nctsn.org/what-is-child-trauma/trauma-types
- Children's Bureau, Child Welfare Information Gateway (2019, April), Long-Term Consequences of Child Abuse and Neglect, https://www.childwelfare.gov/pubpdfs/long_term_consequences.pdf
- The National Child Traumatic Stress Network, (N.D.) (Retrieved 2022, November 2) Effects, https://www.nctsn.org/what-is-child-trauma/trauma-types/complex-trauma/effects
- Burke Harris, Nadine, How childhood trauma affects health across a lifetime, (2015, February 17) https://www.youtube.com/watch?v=95ovIJ3dsNk
- Centers for Disease Control and Prevention, (N.D.) (Retrieved 2022, November 2) About the CDC-Kaiser ACE Study, https://www.cdc.gov/violenceprevention/aces/about.html
- Centers for Disease Control and Prevention, (N.D.) (Retrieved 2022, November 2) Fast Facts: Preventing Adverse Childhood Experiences, https://www.cdc.gov/violenceprevention/aces/fastfact.html
- National Library of Medicine, (2019, February 24) How to screen for ACEs in an efficient, sensitive, and effective manner, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6376297/
- Aces Too High News, (N.D.) (Retrieved 2022, November 2) What ACEs/PCEs do you have? https://acestoohigh.com/got-your-ace-score/
- Centers for Disease Control and Prevention, (2021, August 23) Adverse Childhood Experiences (ACEs), https://www.cdc.gov/vitalsigns/aces/index.html#:~:text=ACEs%20are%20linked%20to%20chronic,cancer%2C%20and%20diabetes%20in%20adulthood
- Centers for Disease Control and Prevention, (N.D.) (Retrieved 2022, November 2) Risk and Protective Factors, https://www.cdc.gov/violenceprevention/aces/riskprotectivefactors.html
- Centers for Disease Control and Prevention, (2018, April 5) We Can Prevent ACEs, https://www.youtube.com/watch?v=8gm-lNpzU4g
- Centers for Disease Control and Prevention, (N.D.) (Retrieved 2022, November 2) Prevention Strategies, https://www.cdc.gov/violenceprevention/aces/prevention.html
- BBC News, (2016, February 18) The PTSD brains of children & soldiers, https://www.youtube.com/watch?v=jsxpW55ysk4

- Children's Bureau, Child Welfare Information Gateway (2011, August), Supporting Brain Development in Traumatized Children and Youth, https://ncwwi.org/files/Evidence_Based_and_Trauma-Informed_Practice/Supporting_Brain_Development_in_Traumatized_Children_and_Youth.pdf
- The National Child Traumatic Stress Network, (N.D.) (Retrieved 2022, November 2) Introduction, https://www.nctsn.org/trauma-informed-care/families-and-trauma/introduction
- The National Child Traumatic Stress Network, (2011, February 2011) Trauma and Families: Fact Sheet for Providers, https://www.nctsn.org/sites/default/files/resources/trauma_and_families_providers.pdf
- Center on the Developing Child, Harvard University, (2015, April 22) How Resilience is Built, https://www.youtube.com/watch?v=xSf7pRpOgu8
- The National Child Traumatic Stress Network, (N.D.) (Retrieved 2022, November 2) What is a Trauma-Informed Child and Family Service System?, https://www.nctsn.org/sites/default/files/resources/what_is_a_trauma_informed_child_family_service_system.pdf
- The National Child Traumatic Stress Network, (N.D.) (Retrieved 2022, November 2) Essential Elements, https://www.nctsn.org/trauma-informed-care/trauma-informed-systems/child-welfare/essential-elements
- The National Child Traumatic Stress Network, (N.D.) (Retrieved 2022, November 2) Child Welfare, https://www.nctsn.org/trauma-informed-care/creating-trauma-informed-systems/child-welfare
- Casey Family Programs, Casey.org, (N.D.) (Retrieved 2022, November 2) Why should child protection agencies become trauma-informed?, https://caseyfamilypro-wpengine.netdna-ssl.com/media/SComm_Trauma-informed-1.pdf
- UCLA Health, (N.D.) (Retrieved 2022, November 2) https://www.uclahealth.org/marc/mpeg/01_Breathing_Meditation.mp3
- Mayo Clinic, (N.D.) (Retrieved 2022, November 2) Mindfulness exercises, https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/mindfulness-exercises/art-20046356

Appendix: Handouts

Child and Family Services Review (CFSR)

CFSR Quick Reference Items List

OUTCOMES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SYSTEMIC FACTORS

Statewide Information System

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

Case Review System

Item 20: How well is the case review system functioning statewide to ensure that

each child has a **written case plan** that is developed jointly with the child's parent(s) and includes the required provisions?

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

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

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

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

Quality Assurance System

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

Staff and Provider Training

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

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

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

Service Array and Resource Development

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

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

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

Agency Responsiveness to the Community

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

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

Foster and Adoptive Parent Licensing, Recruitment, and Retention

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

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

Item 35: How well is the foster and adoptive parent licensing, recruitment, and

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

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

Child Welfare Systems Role

Behavioral and Mental Health

The behavioral and mental health system is made up of a variety of agencies and providers. These include psychiatric hospitals, out-patient clinics, therapists in private practice, day treatment programs, clubhouses, and residential and therapeutic group facilities. Resources are different in each community. Behavioral and mental health providers treat people with a variety of concerns, including mental illness and substance use disorders, and offers specialized counseling for problems that either contribute to or result from maltreatment. Behavioral health professionals also sometimes identify situations of suspected abuse and neglect in their clients and refer those families to DSS.

Care Management for At-Risk Children (CMARC)

CMARC is a free and voluntary program that helps families find and use community services. The program:

- Connects your family with services for children and families
- Supports your children in reaching their developmental potential
- Helps ensure that children are raised in healthy, safe and nurturing environments.

Referrals to CMARC are mandatory in some cases, including when infants are born and identified as being affected by substance abuse or withdrawal symptoms resulting from prenatal drug exposure, or a Fetal Alcohol Spectrum Disorder.

Child Advocacy Centers

Certified CACs provide services for families in their county who have children that have been a victim of sexual abuse. Each center has a multidisciplinary team that includes the District Attorney, law enforcement and a forensics investigator. The child can receive all these services at the center. Additional services provided to the family include individual and group counseling, information and referrals.

Child Support Services

Child Support Services are administered by DSS and available to parents and/or nonparent caretakers of minor children. Services provided include: location, establishment of paternity, establishment or modifying of child support orders, enforcement of child support orders, collection and processing of child support ordered payments.

Division of Child Development and Early Education

This Division of NCDHHS is responsible for the state pre-k program, funding a child care resource and referral system and administering North Carolina's Subsidized Child Care Assistance Program. The Division also partners with **Smart Start**, which provides

community resources such as home visiting for families with young children. Smart Start serves every county in the state.

Division of Juvenile Justice and Delinquency Prevention

DJJDP ensures the safety of our communities and the well-being of our youth. The Division provides a full continuum of public safety interventions involving children and youth ages 6 through 17 alleged to, or have been found to, have committed an undisciplined or delinquent offense; in cases where youth are placed under court jurisdiction before their 18th birthday and require further interventions under the Juvenile Code (Chapter 7B), they may remain under juvenile justice court supervision or in commitment status when so ordered up until their 19th, 20th or 21st birthday, depending on their age and offense.

Foster Care Agencies

Private foster care agencies license and maintain foster homes for children in DSS custody. They are an important partner in providing appropriate placements for children and youth in out-of-home care and help coordinate services for children and youth placed in their homes.

Food and Nutrition Services

Food and Nutrition Services is a federal food assistance program administered by NCDHHS that provides low-income families the food they need for a nutritionally adequate diet. Benefits are issued via Electronic Benefit Transfer cards (EBT cards).

Health Care Providers

Health Care providers include hospitals, clinics, and private offices. These professionals identify and refer to DSS children who may have been maltreated. Health care professionals also conduct medical examinations to help determine if abuse or neglect occurred. Many of these exams are done through the Child Medical Evaluation Program. These examinations are often necessary for court proceedings. Medical professionals provide emergency and ongoing treatment for abused and neglected children.

Juvenile Courts

The Juvenile Court System hears legal matters related to abuse and neglect of children. The juvenile court system assures that the rights of both children and parents are protected. To accomplish this, the court appoints attorneys for parents and Guardian ad Litem volunteers for children. The judge reviews the Family Services Agreements for all children in DSS custody on a regular basis. As part of this review, the court will make recommendations regarding custody, visitation, and services for families.

Law enforcement Agencies

County DSS offices work with city police, county sheriff's departments regularly and the North Carolina State Bureau of Investigation, and federal law enforcement agencies in

certain types of cases. Law enforcement officers may accompany child welfare workers on high risk investigative assessments to ensure the safety of children, family members and workers. Officers refer suspected situations of abuse and neglect to DSS and conduct criminal investigations of allegations of child abuse. In some cases, officers file criminal charges. Collaboration with law enforcement is one of the seven strategies in North Carolina's child welfare reform.

Medicaid

The state Medicaid agency provides insurance coverage for many low-income families and all children and youth in foster care and administers other benefits, such as CMARC. You will work with Medicaid and health care providers to ensure the dental, health and behavioral and mental health treatment needs of children are met.

North Carolina Tribes

There are seven state recognized tribes: Coharie (Sampson and Harnett counties); Lumbee (Robeson and surrounding counties); Haliwa-Saponi (Halifax and Warren counties); Sappony (Person County); Meherrin (Hertford and surrounding counties); Occaneechi Band of Saponi Nation (Alamance and surrounding counties); Waccamaw-Siouan (Columbus and Bladen counties) and one federally recognized tribes Eastern Band of Cherokee in North Carolina. There are also four Urban Indian Organizations: Guilford Native American Association (Guilford and surrounding counties), Cumberland County Association for Indian People (Cumberland County), Metrolina Native American Association (Mecklenburg and surrounding counties), and Triangle Native American Society (Wake and surrounding counties). There are state and federal laws (ICWA) governing cases involving American Indian children and tribes important partners for effectively serving these children and families.

School Systems

Teachers, aides, principals, counselors, nurses, and other personnel in schools frequently refer situations of suspected abuse or neglect to DSS. They also identify educational needs of children and provide the individualized educational resources necessary for some children who have experienced abuse and neglect. Schools are an important partner for meeting the well-being needs of children by helping to ensure educational stability and appropriate supports for children and youth with learning differences.

Work First Family Assistance

North Carolina’s Temporary Assistance for Needy Families (TANF) program, called Work First (WF), is based on the premise that parents have a responsibility to support themselves and their children.

The Work First program promotes a strengths-based, family-centered practice approach and shares in the mission of the NC Department of Health and Human Services, in collaboration with its partners, to protect the health and safety of all North Carolinians and provide essential human services.

Work First provides parents with short-term training and other services to help them become employed and move toward self-sufficiency. Families in which grandparents and relatives are caring for their relative children and legal guardians can receive services and support that prevent children from unnecessarily entering the foster care system.

Work First emphasizes three strategies: Diversion, Work and Retention.

Other Partner Organizations

Additional partner organizations that may be able to support children and families involved with DSS include:

- Employment services
- Housing Authorities
- Faith based organizations, such as churches, synagogues, and mosques
- Family Resource Centers
- Legal Aid
- Housing Authorities
- Mentoring programs, like Big Brothers/Big Sisters
- Vocational Rehabilitation

These programs may look different throughout the state. Work with your supervisor and county office to understand the resources available in your community.

State Resources for North Carolina DSS Social Workers

NCDHHS Programs	
Work First Family Assistance: North Carolina's Temporary Assistance for Needy Families (TANF) program, called Work First (WF), is based on the premise that parents have a responsibility to support themselves and their children.	Applications in County DSS Office https://www.ncdhhs.gov/divisions/social-services/work-first-family-assistance
Food and Nutrition Services: North Carolina Food and Nutrition Services (formerly Food Stamps) are available for all households with limited income and resources.	Applications online or in County DSS Office: https://www.ncdhhs.gov/divisions/child-and-family-well-being/food-and-nutrition-services-food-stamps/apply-food-and-nutrition-services-food-stamps-nc
The Community Child Protection Team (CCPT) The CCPT is a group of community representatives who promote a community-wide approach to the problem of child abuse and neglect. Local teams identify and respond to gaps in the county's prevention/protection response, maximizing the use of limited resources.	https://www.ncdhhs.gov/divisions/social-services/child-welfare-services/community-child-protection-teams
Child Care Subsidy: Individuals may be eligible to receive child care assistance if: • You are working or are attempting to find work • You are in school or in a job training program • Your child is receiving child protective services • Your child needs care to support child welfare services or if your family is experiencing a crisis • Your child has developmental needs	Contact County Office to apply: https://ncchildcare.ncdhhs.gov/
Child Support Services: Services are available to parents and/or nonparent caretakers of minor children. Services provided include: location, establishment of paternity, establishment or modifying of child support orders, enforcement of child support orders, collection and processing of child support ordered payments.	Application online: https://ncchildsupport.ncdhhs.gov/ecoa/#home
Care Management for At-Risk Children (CMARC): CMARC is a free and voluntary program that helps families find and use community services. Children birth to age three who are at risk for developmental delay or disability, long-term illness and/or social, emotional disorders and children ages birth to five who have been diagnosed with developmental delay or disability, long-term illness and/or social, emotional disorder may be eligible for the program.	Contact: NC Medicaid Contact Center Phone: 888-245-0179 https://medicaid.ncdhhs.gov/beneficiaries/get-started/find-programs-and-services/care-coordination-children

Local Management Entity/Managed Care Organizations (LME/MCOs): LME/MCOs are responsible for managing Medicaid, state and local funding for North Carolinians who are uninsured or who receive Medicaid and seek services for mental health (MH) needs, substance use disorders (SUDs), intellectual/ developmental disabilities (IDD), and traumatic brain injuries (TBI).	https://www.ncdhhs.gov/providers/lme-mco-directory

Other Statewide Resources	
Child Medical Evaluation Program (CMEP) A Child Medical Evaluation (CME) is: • An outpatient medical evaluation of suspected child maltreatment. • Performed at the request of CPS during an open CPS Assessment. Provided by a qualified provider rostered with the North Carolina	https://www.med.unc.edu/cmep/
Child Advocacy Centers: Certified CACs provide services for families in their county who have children that have been a victim of sexual abuse. Each center has a multidisciplinary team that includes the District Attorney, law enforcement and a forensics investigator. The child can receive all these services at the center. Additional services provided to the family include individual and group counseling, information and referrals.	https://cacnc.org/
Domestic Violence Resources	• National Domestic Violence Hotline at 1-800-799-7233, available 24/7. TTY: 1-800-787-3224 • Domestic Violence Program Listing: https://ncadmin.nc.gov/domestic-violence-programs-directory-full-listing-0 • North Carolina Coalition Against Domestic Violence (NCCADV): https://nccadv.org/
North Carolina Child Treatment Program The North Carolina Child Treatment Program is a statewide effort to train mental health providers in evidence-based treatment models addressing childhood trauma, behavior, and attachment. The website provides information about clinicians.	https://www.ncchildtreatmentprogram.org/ program-roster
Smart Start	https://www.smartstart.org/smart-start-in-your-community

In partnership with DHHS, Smart Start provides services to families with young children, including home visiting and parent education. 75 partnerships serve all 100 counties.	
United Way of North Carolina	Call: 211 http://unitedwaync.org

Handout: Family-Centered Principles of Partnership

From the NC Division of Social Services, Family Support and Child Welfare Services Section

The family-centered principles of partnership can be applied to working with other professionals and community supports. These principles include:

- Everyone desires respect
- Everyone needs to be heard
- Everyone has strengths
- Judgments can wait
- Partners share power
- Partnership is a process

Tips for Collaboration:
Build relationships: Always engage with partners respectfully and show professional courtesy. Return emails and phone calls timely. Also take time to get to know them and the work of their agency.

Clearly define roles: Having a relationship with partners and understanding their work will help you clearly define roles. This helps with efficient service delivery and can prevent misunderstandings. It is also important that roles are defined in a way that the family understands.

Create shared understanding of terminology: When using terminology, especially to define goals, make sure there is a shared meaning. For example, as a social worker, you may need to define what DSS means by safety indicator to a school or mental health professional.

Establish processes and protocols: There may be formal processes in place for some multidisciplinary teams, or certain referrals, but it is always helpful to establish processes and protocols when working with partners. For example, setting preferred methods of communication (phone or e-mail); identifying regular meeting times, and letting people know who to contact in an emergency if they are working with ta family and you are not on call.

North Carolina General Statute Definitions

N.C.G.S. Chapter 7B, Article 1, definitions (§ 7B-101)

N.C.G.S. § 7B-101(14) A **juvenile** is: A person who has not reached the person's eighteenth birthday and is not married, emancipated, or a member of the Armed Forces of the United States.

- Emancipation is a legal proceeding whereby minors aged 16 and 17 become legal adults. To become emancipated the juvenile must petition the District Court for an order of emancipation.
- Marriage or enlistment in the armed services automatically causes emancipation.

N.C.G.S. § 7B-101(3) A **caretaker** is: Any person other than a parent, guardian, or custodian who has responsibility for the health and welfare of a juvenile in a residential setting. A person responsible for a juvenile's health and welfare means a stepparent; foster parent; an adult member of the juvenile's household; an adult entrusted with the juvenile's care; a potential adoptive parent during a visit or trial placement with a juvenile in the custody of a department; any person such as a house parent or cottage parent who has primary responsibility for supervising a juvenile's health and welfare in a residential child care facility or residential educational facility; or any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services.

N.C.G.S. § 7B-101(8) A **custodian** is**:** The person or agency that has been awarded legal custody of a juvenile by a court.

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

N.C.G.S. § 7B-101(1)(a-g) An **Abused Juvenile** is**:** Any juvenile less than 18 years of age who is found to be a minor victim of human trafficking or whose parent, guardian, custodian, or caretaker:

- Inflicts or allows to be inflicted upon the juvenile a serious physical injury by other than accidental means.
- Creates or allows to be created a substantial risk of serious physical injury to the juvenile by other than accidental means.

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

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

N.C.G.S. § 7B-101(9) A **Dependent Juvenile** is**:** A juvenile in need of assistance or placement because the juvenile has no parent, guardian, or custodian responsible for the juvenile's care or supervision or the juvenile's parent, guardian, or custodian is unable to provide for the juvenile's care or supervision and lacks an appropriate alternative childcare arrangement.

In approximately 85% of CPS cases, the maltreatment type falls under this definition of neglect.

N.C.G.S. § 7B-101(15)(a-g) A **Neglected Juvenile** is**:** Any juvenile less than 18 years of age who is found to be a minor victim of human trafficking, or whose parent, guardian, custodian, or caretaker does any of the following:

- Does not provide proper care, supervision, or discipline.
- Has abandoned the juvenile.
- Has not provided or arranged for the provision of necessary medical or remedial care.

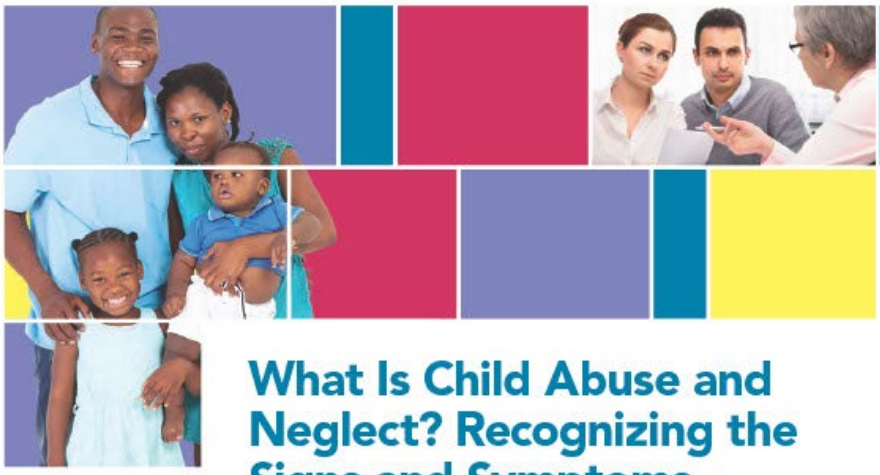
- Or whose parent, guardian, or custodian has refused to follow the recommendations of the Juvenile and Family Team made pursuant to Article 27A of this Chapter.
- Creates or allows to be created a living environment that is injurious to the juvenile's welfare.
- Has participated or attempted to participate in the unlawful transfer of custody of the juvenile under G.S. 14-321.2.
- Has placed the juvenile for care or adoption in violation of law.

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

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

Educational neglect does not become a DSS requirement for intervention until the school’s efforts to assure attendance have been exhausted.

What is Child Abuse and Neglect?



FACTSHEET

April 2019

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

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

WHAT'S INSIDE

Child Welfare Information Gateway

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

Children's Bureau

How Is Child Abuse and Neglect Defined in Federal Law?

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

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

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

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

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

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

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

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

What Are the Major Types of Child Abuse and Neglect?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recognizing Signs of Abuse and Neglect and When to Report

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

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

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

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

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

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

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

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

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

Signs of Physical Abuse

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

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

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

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

Signs of Neglect

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

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

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

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

Signs of Sexual Abuse

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

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

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

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

Signs of Emotional Maltreatment

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

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

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

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

The Impact of Childhood Trauma on Well-Being

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

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

Resources

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

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

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

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

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

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

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

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

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

References

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

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

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

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

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

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

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

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

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

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

Suggested Citation:

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

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

ACF

Children's Bureau

The North Carolina DSS Intake Maltreatment Screening Tools

Excerpt from the CPS Intake Policy, Protocol, and Guidance (May 2020) NC Child Welfare Manual

Sexual Abuse Screening Tool Directions

Is the parent/caretaker committing, permitting, or encouraging any sexual act with the child?

Sexual abuse is any incident of sexual contact involving a child that is inflicted, or allowed to be inflicted, by the parent/caretaker. Sexual abuse includes, but is not limited to the following: rape, intercourse, sodomy, fondling, oral sex, incest, or sexual penetration-digital, penile or foreign objects.

Is the parent/caretaker committing, permitting, or encouraging the child to participate in the preparation and/or dissemination of obscene material?

The use of children in the production of obscene films, photographs, and/or slides is sexual abuse. The parent/caretaker encouraging the child to watch obscene material is also sexual abuse.

Is the parent/caretaker displaying and/or disseminating obscene material to the child or encouraging the child to participate in a live sex act?

Any material that a reasonable person would consider obscene should not be shared with the child. The parent/caretaker is responsible for ensuring the child is not sexually exploited.

Is the parent/caretaker participating in the commercial sexual activity of the child?

This includes any action of the parent/caretaker to entice, force, encourage, supervise, support, advise, or protect the commercial sexual activities of the child.

Pursuant to 22 USC § 7102; 8 CFR § 214.11(a) and N.C.G.S. § 14-204(c), anyone under the age of 18 years that is involved in a commercial sex act is a victim of human trafficking. Under federal law (22 U.S. CODE § 7102), a commercial sex act is “any sex act on account of which anything of value is given to or received by any person.” For the purpose of criminal proceedings, force, fraud or coercion do not have to be present to prove that someone under the age of 18 years was a victim of sex trafficking.

A parent’s involvement in the prostitution of their child is abuse. This type of sexual abuse is human trafficking. Children whose parents commit this type of offense against them meet the definition of abused juvenile under N.C.G.S. §7B-101(1)(d) or N.C.G.S. §7B-101(1)(g).

Is the parent/caretaker allowing sibling sexual activity to occur?
When the parent/caretaker has knowledge that siblings are engaging in sexual activity and permits/encourages the continuation of this activity a CPS Assessment must occur. Reports alleging sexual activity between children under age 16 may provide cause to examine the supervision provided by their parents/ caretakers. If it is clear at Intake that the parent/ caretaker responded in a protective manner, keeping the health and well-being needs of the child at the forefront, a CPS Assessment is not required.

Reports Involving Sex Offenders

If a substantiated perpetrator or an individual convicted of a sexual offense against a child has established residence where another juvenile resides, the screening decision must be based upon the risk of the child being exposed to an injurious environment. For reports alleging an injurious environment, please consult the Injurious Environment Maltreatment Screening Tool.

Is the parent/caretaker intentionally permitting the child to engage in sexual activity?

The parent/caretaker has knowledge the child is engaging in sexual activity and permits/encourages the continuation of this activity. Relevant to screening these types of reports is whether the parent is condoning the behavior of a child under age 16 while the child is under their care and supervision. Reports alleging sexual activity between children under age 16 may provide cause to examine the supervision provided by their parent/caretakers. If it is clear at Intake that the parent/caretaker responded in a protective manner, keeping the health and well-being needs of the child at the forefront, a CPS Assessment is not required. It is important to get sufficient information at Intake regarding the behavior of the parent(s), as well as the behavior of the minor child(ren). When the parent has no knowledge of the child's sexual activity, the child's age, behaviors and developmental level impact whether a CPS Assessment is required. If the only allegation in the report is that a child age 16 or above is having sex without the parents' knowledge or the child is pregnant, then these reports should not be accepted. The legal age of consent in North Carolina is 16; therefore, consensual sexual activity of juveniles 16 and above is not, in and of itself, considered sexual abuse.

When a report involving parental knowledge and permission of sexual activity of an incompetent juvenile, a CPS Assessment must occur, regardless of the age of the juvenile, as an incompetent juvenile is not able to consent. A parent providing condoms and/or birth control to their children is not, in and of itself, considered permitting or encouraging their child to engage in sexual activity. The provision of birth control is considered a preventive measure in order to maintain the juvenile's health, which is consistent with N.C.G.S. § 90-21.5

(http://www.ncleg.net/EnactedLegislation/Statutes/HTML/BySection/Chapter_90/GS_90-21.5.html), Minor's consent sufficient for certain medical health services.

A CPS Assessment based on improper supervision must occur for the following situations:

- A 15-year-old engaging in risky sexual behavior (multiple partners, no protection) with parental knowledge and the absence of a protective response by the parent; or
  A child displaying sexualized behaviors that are inconsistent with normal child development and the parent has not responded in a protective manner.

Normal Child Sexual Development
Infancy (birth through one year) • Pair bonding • Genital play • Identification of gender
Toddler/Early Childhood (2 to 5 years) • Toilet training • Genital play • Interpersonal games: family, marriage, doctor, etc.
Latency (6 to 9 years) • Concrete interest in anatomic differences, pregnancy, birth • Private, occasional masturbation • Modesty about bodies • Increased secretive behavior among peers • Interest in socialization
Pre-adolescence (10 to 12 years) • Adaptation to initial signs of puberty • Development of secondary sexual characteristics • Strong friendships and budding romances • Playful hitting or tickling among peers

Sex Abuse Crimes

If a parent, guardian, custodian, or caretaker commits, permits, or encourages the commission of a violation of the following laws by, with, or upon the juvenile, then that adult has sexually abused the child. The information contained within this statute delineates specific sex abuse crimes. The Intake county child welfare worker must refer to this information when screening sexual abuse reports.

N.C.G.S. § 14-27.2. First-degree rape

(b) A person is guilty of rape in the first degree if the person engages in vaginal intercourse:

(1) With a victim who is a child under the age of 13 years and the defendant is at least 12 years old and is at least four years older than the victim; or
(2) With another person by force and against the will of the other person, and:

a. Employs or displays a dangerous or deadly weapon or an article which the other person reasonably believes to be a dangerous or deadly weapon; or
b. Inflicts serious personal injury upon the victim or another person; or
c. The person commits the offense aided and abetted by one or more other persons.

N.C.G.S. § 14-27.2A. Rape of a child by an adult offender

(a) A person is guilty of rape of a child if the person is at least 18 years of age and engages in vaginal intercourse with a victim who is a child under the age of 13 years.

N.C.G.S. § 14-27.3. Second-degree rape

(b) A person is guilty of rape in the second degree if the person engages in vaginal intercourse with another person:

(1) By force and against the will of the other person; or
(2) Who is mentally defective, mentally incapacitated, or physically helpless, and the person performing the act knows or should reasonably know the other person is mentally defective, mentally incapacitated, or physically helpless.

N.C.G.S. § 14-27.4. First-degree sexual offense

(b) A person is guilty of a sexual offense in the first degree if the person engages in a sexual act:

(1) With a victim who is a child under the age of 13 years and the defendant is at least 12 years old and is at least four years older than the victim; or
(2) With another person by force and against the will of the other person, and:

a. Employs or displays a dangerous or deadly weapon or an article which the other person reasonably believes to be a dangerous or deadly weapon; or
b. Inflicts serious personal injury upon the victim or another person; or
c. The person commits the offense aided and abetted by one or more other persons.

N.C.G.S. § 14-27.4A. Sexual offense with a child by an adult offender

(a) A person is guilty of sexual offense with a child if the person is at least 18 years of age and engages in a sexual act with a victim who is a child under the age of 13 years.

N.C.G.S. § 14-27.5. Second-degree sexual offense

(b) A person is guilty of a sexual offense in the second degree if the person engages in a sexual act with another person:

(1) By force and against the will of the other person; or
(2) Who is mentally defective, mentally incapacitated, or physically helpless, and the person performing the act knows or should reasonably know that the other person is mentally defective, mentally incapacitated, or physically helpless.

N.C.G.S. § 14-27.31 and §14-2732. Intercourse and sexual offenses with certain victims; consent no defense

If a defendant who has assumed the position of a parent in the home of a minor victim engages in vaginal intercourse or a sexual act with a victim who is a minor residing in the home; or if a person having custody of a victim of any age or a person who is an agent or employee of any person, or institution, whether such institution is private, charitable, or governmental, having custody of a victim of any age engages in vaginal intercourse or a sexual act with such victim, the defendant is guilty of a Class E felony. Consent is not a defense to a charge under this section.

N.C.G.S. § 14-43.14. Unlawful sale, surrender, or purchase of a minor

(d) A person commits the offense of unlawful sale, surrender, or purchase of a minor when that person, acting with willful or reckless disregard for the life or safety of a minor, participates in any of the following: the acceptance, solicitation, offer, payment, or transfer of any compensation, in money, property, or other thing of value, at any time, by any person in connection with the unlawful acquisition or transfer of the physical custody of a minor, except as ordered by the court. This section does not apply to actions that are ordered by a court, authorized by statute, or otherwise lawful.

N.C.G.S. § 14-177. Crime against nature

If any person shall commit the crime against nature, with mankind or beast, he shall be punished as a Class I felon.

N.C.G.S. § 14-178. Incest between certain near relatives

The parties shall be guilty of a felony in all cases of carnal intercourse between (i)

grandparent and grandchild, (ii) parent and child or stepchild or legally adopted child, or (iii) brother and sister of the half or whole blood. Every such offense is punishable as a Class F felony.

N.C.G.S. § 14-179. Incest between uncle and niece, and nephew and aunt

In all cases of carnal intercourse between uncle and niece, and nephew and aunt, the parties shall be guilty of a Class 1 misdemeanor.

N.C.G.S. § 14-190.5. Preparation of obscene photographs, slides and motion pictures

Every person who knowingly:

(3) Photographs himself or any other person, for purposes of preparing an obscene film, photograph, negative, slide or motion picture for the purpose of dissemination; or

(4) Models, poses, acts, or otherwise assists in the preparation of any obscene film, photograph, negative, slide or motion picture for the purpose of dissemination, shall be guilty of a Class 1 misdemeanor.

N.C.G.S. § 14-190.6. Employing or permitting minor to assist in offense under Article (26)

Every person 18 years of age or older who intentionally, in any manner, hires, employs, uses or permits any minor under the age of 16 years to do or assist in doing any act or thing constituting an offense under this Article and involving any material, act or thing he knows or reasonably should know to be obscene within the meaning of N.C.G.S. §14-190.1, shall be guilty of a Class I felony.

N.C.G.S. § 14-190.7. Dissemination to minors under the age of 16 years

Every person 18 years of age or older who knowingly disseminates to any minor under the age of 16 years any material which he knows or reasonably should know to be obscene within the meaning of N.C.G.S. §14-190.1 shall be guilty of a Class I felony.

N.C.G.S. § 14-190.8. Dissemination to minors under the age of 13 years

Every person 18 years of age or older who knowingly disseminates to any minor under the age of 13 years any material which he knows or reasonably should know to be obscene within the meaning of N.C.G.S. §14-190.1 shall be punished as a Class I felon.

N.C.G.S. § 14-190.14. Displaying material harmful to minors

(a) A person commits the offense of displaying material that is harmful to minors if, having custody, control, or supervision of a commercial establishment and

knowing the character or content of the material, he displays material that is harmful to minors at that establishment so that it is open to view by minors as part of the invited general public. Material is not considered displayed under this section if the material is placed behind "blinder racks" that cover the lower two thirds of the material, is wrapped, is placed behind the counter, or is otherwise covered.

N.C.G.S. § 14-190.15. Disseminating harmful material to minors; exhibiting harmful performances to minors

(d) Disseminating Harmful Material. - A person commits the offense of disseminating harmful material to minors if, with or without consideration and knowing the character or content of the material, he:

(1) Sells, furnishes, presents, or distributes to a minor material that is harmful to minors; or

(2) Allows a minor to review or peruse material that is harmful to minors.

(e) Exhibiting Harmful Performance. - A person commits the offense of exhibiting a harmful performance to a minor if, with or without consideration and knowing the character or content of the performance, he allows a minor to view a live performance that is harmful to minors.

(f) Defenses. - Except as provided in subdivision (3), a mistake of age is not a defense to a prosecution under this section. It is an affirmative defense to a prosecution under this section that:

(1) The defendant was a parent or legal guardian of the minor.

(2) The defendant was a school, church, museum, public library, governmental agency, medical clinic, or hospital carrying out its legitimate function; or an employee or agent of such an organization acting in that capacity and carrying out a legitimate duty of his employment.

(3) Before disseminating or exhibiting the harmful material or performance, the defendant requested and received a driver's license, student identification card, or other official governmental or educational identification card or paper indicating that the minor to whom the material or performance was disseminated or exhibited was at least 18 years old, and the defendant reasonably believed the minor was at least 18 years old.

(4) The dissemination was made with the prior consent of a parent or guardian of the recipient.

N.C.G.S. § 14-190.16. First degree sexual exploitation of a minor

(c) Offense. - A person commits the offense of first-degree sexual exploitation of a

minor if, knowing the character or content of the material or performance, he:

(1) Uses, employs, induces, coerces, encourages, or facilitates a minor to engage in or assist others to engage in sexual activity for a live performance or for the purpose of producing material that contains a visual representation depicting this activity; or

(2) Permits a minor under his custody or control to engage in sexual activity for a live performance or for the purpose of producing material that contains a visual representation depicting this activity; or

(3) Transports or finances the transportation of a minor through or across this state with the intent that the minor engages in sexual activity for a live performance or for the purpose of producing material that contains a visual representation depicting this activity; or

(4) Records, photographs, films, develops, or duplicates for sale or pecuniary gain material that contains a visual representation depicting a minor engaged in sexual activity.

(e) Inference. - In a prosecution under this section, the trier of fact may infer that a participant in sexual activity whom material through its title, text, visual representations, or otherwise represents or depicts as a minor is a minor.

(f) Mistake of Age. - Mistake of age is not a defense to a prosecution under this section.

N.C.G.S. § 14-190.17. Second degree sexual exploitation of a minor

(d) Offense. - A person commits the offense of second-degree sexual exploitation of a minor if, knowing the character or content of the material, he:

(1) Records, photographs, films, develops, or duplicates material that contains a visual representation of a minor engaged in sexual activity; or

(2) Distributes, transports, exhibits, receives, sells, purchases, exchanges, or solicits material that contains a visual representation of a minor engaged in sexual activity.

(e) Inference. - In a prosecution under this section, the trier of fact may infer that a participant in sexual activity whom material through its title, text, and visual representations or otherwise represents or depicts as a minor is a minor.

(f) Mistake of Age. - Mistake of age is not a defense to a prosecution under this section.

N.C.G.S. § 14-205.3(b) Promoting prostitution of a minor

(d) Any person who willfully performs any of the following acts commits the offense of promoting prostitution of a minor or mentally disabled

person:

(1) Advances prostitution as defined in N.C.G.S. §14-203, where a minor or profoundly mentally disabled person engaged in prostitution, or any person in prostitution in the place of prostitution is a minor or severely or profoundly mentally disabled at the time of the offense.
(2) Profits from prostitution by any means where the prostitute is a minor or is severely or profoundly mentally disabled at the time of the offense.
(3) Confines a minor or a severely or profoundly mentally disabled person against the person's will by the infliction or threat of imminent infliction of great bodily harm, permanent disability, or disfigurement or by administering to the minor or severely or profoundly mentally disabled person, without the person's consent or by threat or deception and for other than medical purposes, any alcoholic intoxicant or a drug as defined in Article 5 of Chapter 90 of the General Statutes (North Carolina Controlled Substances Act) and does any of the following:
    a. Compels the minor or severely or profoundly mentally disabled person to engage in prostitution.
    b. Arranges a situation in which the minor or severely or profoundly mentally disabled person may practice prostitution.
    c. Profits from prostitution by the minor or severely or profoundly mentally disabled person.

N.C.G.S. § 14-202.1. Taking indecent liberties with children

(b) A person is guilty of taking indecent liberties with children if, being 16 years of age or more and at least five years older than the child in question, he either:

(1) Willfully takes or attempts to take any immoral, improper, or indecent liberties with any child of either sex under the age of 16 years for the purpose of arousing or gratifying sexual desire; or
(2) Willfully commits or attempts to commit any lewd or lascivious act upon or with the body or any part or member of the body of any child of either sex under the age of 16 years.

Cultural Humility Practice Principles

National Child Welfare Workforce Institute
LEARNING, LEADING, CHANGING

CULTURAL HUMILITY
PRACTICE PRINCIPLES[1]

CULTURAL HUMILITY is a process of openness, self-awareness, being egoless, and incorporating self-reflection and critique after willingly interacting with diverse individuals, resulting in mutual empowerment, respect, partnerships, optimal care, and lifelong learning.[2]

Embrace the complexity of diversity: Everyone occupies multiple positions with related identities and statuses, which intersect to distinguish us as individuals

Be open to individual differences and the social experiences due to these differences: Intersecting group memberships affect people's expectations, quality of life, capacities as individuals and parents, and life chances

Reserve judgment: Cultural humility encourages a less deterministic, less authoritative approach to understanding cultural differences, placing more value on others' cultural expressions

Relate to others in ways that are most understandable to them: Culturally appropriate communication and interaction skills enable people to describe their experience in their own words, reducing the need of mastering a wide range of cultural beliefs and practices

Consider cultural humility as a constant effort to become more familiar with the worldview of others: Treat this practice as an ongoing process rather than an outcome, including an awareness and appreciation of everyone's physical and social environment

Instill a spirit of collaboration: Encourage all staff to become involved in mutually beneficial, non-paternalistic, and respectful working relationships with others, as well as considering the factors at play when defining important priorities and activities needed to achieve common goals

Demonstrate familiarity with children and families' living environments, building on strengths while reducing negative factors: Learn to identify, understand, and build on the assets and adaptive strengths of children and parents and engage in efforts to disrupt or dismantle social forces that act to disenfranchise and disempower them

Know yourself and the ways in which biases interfere with an ability to objectively listen to or work with others: Use self-reflection and self-critique to engage in a process of realistic, ongoing self-appraisal of biases and stereotypes to challenge the ingrained behaviors and ideas that you have toward others

Critically challenge one's "openness" to learn from others: Assess the barriers our attitudes and behaviors present to learning from others

Build organizational supports that demonstrate cultural humility as an important and ongoing aspect of the work itself: Include an assessment of the organizational environment, policies, procedures, knowledge, and skills connected to organizational practices to identify ways to employ and promote a cultural humility perspective

[1]Adapted from Ortega, R. M., & Coulborn, K. (2011). Training child welfare workers from an intersectional cultural humility perspective: A paradigm shift. Child Welfare, 90(5).
[2]Foronda, C., Baptiste, D. L., Reinholdt, M. M., & Ousman, K. (2016). Cultural humility: A concept analysis. Journal of Transcultural Nursing, 27(3), 210–217.

NCWWI.org
Children's Bureau

Cultural Healing Practices That Mimic Child Abuse

SciMedCentral Annals of Forensic Research and Analysis

Mini Review

Cultural Healing Practices that Mimic Child Abuse

Killion CM*

School of Nursing, Case Western Reserve University, USA

*Corresponding author
Cheryl M. Killion, Case Western Reserve University, 10900 Euclid Avenue, Cleveland, Ohio, USA, Tel: (216) 368-0462; Email: cmk61@case.edu

Submitted: 02 June 2016
Accepted: 17 August 2017
Published: 21 August 2017
ISSN: 2378-9476

Keywords
- Child abuse
- Cultural healing practices
- Immigrants
- Ethnic minority groups
- Differential diagnosis

Abstract

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

INTRODUCTION

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

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

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

CULTURAL HEALING PRACTICES

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

The Vietnamese call wind, *phong* [6]. According to some, the wind can invade the body and cause a variety of illnesses including headaches, muscle aches, coughs, fevers, upper respiratory infections and sore throats [6]. To alleviate the symptoms of these

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

Killion (2017)
Email: cmk61@case.edu

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

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

Cupping is another ancient, though fairly common practice, which has been used throughout the Middle East, Asia, Latin America, and Eastern Europe. In the United States, this technique is practiced primarily by Russian immigrants and its use has been revitalized among naturalistic health providers, as well [3,9,11]. There are two types of *cupping*: wet and dry [11,12]. *Wet cupping*, also known as *hijama*, involves small cuts to the skin to draw blood and is thought to help rid the body of toxins [11]. In *dry cupping* the air, in an open-mouthed vessel, is heated and subsequently, the vessel is applied to the skin. Suction is produced by the cooling and contracting of the heated air and is thought to "draw out" the ailment as the heated air and the rim of the cup burn the skin [11] (Figure 2). The signs of *cupping* usually present on the patient's back, as multiple, grouped circular ecchymoses. Central ecchymosis or petechiae result from the suction effect of the heated air as it cools and contracts (Figure 3). *Dry cupping* is used to alleviate pain, primarily musculoskeletal, and inflammation. It is purported to increase blood flow and promote relaxation and well-being. Further, it is used as a type of deep tissue massage [12]. *Cupping* therapy is growing in popularity as an alternative treatment for a variety of conditions and diseases in patients of all ages, including athletes [12].

Another cultural healing practice is *moxibustion* (Figure 4). Originating in Asian medicine, this healing practice involves burning rolled pieces of moxa herb (mugwort or Artemisia vulgaris) directly over the skin above acupuncture points and allowing the herb to burn near the skin's surface until the onset of pain [3,13]. The lesions of *moxibustion* appear as a pattern of "discrete circular, target-like burns" that may be confused with cigarette burns from child abuse [9]. Moxibustion is one of the most commonly used treatments in traditional medicine

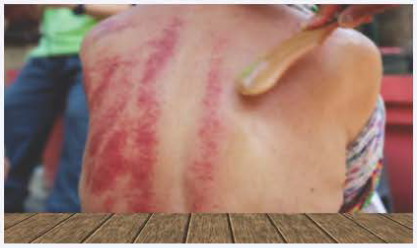


Figure 1 Gua Sha Procedure Performed on Shoulder and Back of Young Male.

Figure 2 Cupping as Cups are Being Removed.

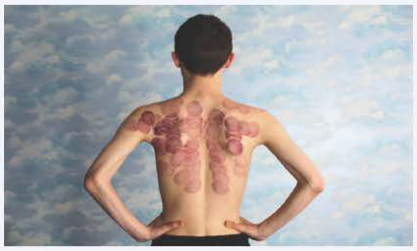


Figure 3 Boy's Back Following Cupping.

Figure 4 Moxa Stick.

Killion (2017)
Email: cmk61@case.edu

in East Asian cultures and is applied for a variety of symptoms, including fever and abdominal pain [3,13]. It is particularly effective in promoting energy (qi) and has been used to treat those experiencing chronic fatigue [14]. In Korea, contemporary studies indicate that *moxibustion* is being used in combination with conventional therapy to enhance immune functioning in children with cerebral palsy [15].

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

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

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

DISCUSSION AND CONCLUSION

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

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

REFERENCES

1. Committee on Child Maltreatment Research, Policy, and Practice for the Next Decade: Phase II: Board on Children, Youth, and Families: Institute of Medicine. New directions in child abuse and neglect research. In: Peterson AC, Joseph J, Feit M, editors. National Research Council. Washington: National Academies Press (US). 2014.
2. Christian CW, States LJ. Medical mimics of child abuse. AJR Am J Roentgenol. 2017; 208: 982-990.
3. Boos SC. Differential diagnosis of suspected child physical abuse. UpToDate. Snapshot of U.S. Immigration. National Conference of State legislatures. Retrieved from: https: //www.ncsl.org/research/immigration/us-immigration-snapshot-2016-aspx/
4. Chao MT, Wade C, Kronenberg F. Disclosure of complementary and alternative medicine to conventional medical providers: variation by race/ethnicity and type of CAM. J Natl Med Assoc. 2008; 100: 1341-1349.
5. Davis RE. Cultural health care or child abuse? The Southeast Asian practice of caogio. J Am Acad Nurse Pract. 2000; 12: 89-95.
6. Lam N, Castellanos A, Thomson K. A Vietnamese child with a rash on the back. Am Fam Physician. 2016; 93: 131-132.
7. Nielsen A, Kligler B, Koll BS. Addendum: Safety standards for guasha (press-stroking) and Ba guan (cupping). Complement Ther Med. 2014; 22: 446-448.
8. Spencer M Craft N LenameAl Swerdlin A Ladrigan M Berkowitz C. 2017: Cultural practices-child abuse recognition. Retrieved from https://www.visualdx.com/visualdx/diagnosis/culturpractices?moduledid=43&diagnosis/
9. Lilly E, Kundu RV. Dermatoses secondary to Asian cultural practices. Int J Dermatol. 2012; 51: 372-382.
10. Qureshi NA, Ali GI, Abushanab TS, El-OlermyAT, Alqaed MS, El-Subai IS. History of cupping (Hijama): a narrative review of literature. J Integr Med. 2017; 15: 172-181.
11. Rozenfeld E, Kalichman L. New is the well-forgottenold: the use of dry cupping in musculoskeletal medicine. J Bodyw Mov Ther. 2016; 20: 173-178.

Killion (2017)
Email: cmk61@case.edu

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

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

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

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

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

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

Cite this article

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

Risk and Protective Factors for Child Maltreatment

From the Centers for Disease Control and Prevention

Risk Factors for Victimization

Individual Risk Factors

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

Risk Factors for Perpetration

Individual Risk Factors

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

Family Risk Factors

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

Community Risk Factors

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

Protective Factors for Child Abuse and Neglect

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

Individual Protective Factors

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

Family Protective Factors

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

Community Protective Factors

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

Warning Signs of Domestic Violence

- **Pushes partner for quick involvement:** Comes on strong, claiming, "*I've never felt loved like this by anyone*."
- **Jealousy:** Excessively possessive; calls constantly or visits unexpectedly.
- **Controlling Behavior:** Interrogates partner intensely about activities and whereabouts; keeps all the money; insists partner asks permission to do anything.
- **Unrealistic expectations:** Expects partner to be the perfect and meet his or her every need.
- **Isolation:** Cuts partner off from family and friends.
- **Blames others for problems or mistakes:** It's always someone else's fault when anything goes wrong.
- **Makes others responsible for his or her feelings:** The abuser says, "*You make me angry*," instead of "*I am angry*," or says, "*You're hurting me by not doing what I tell you*."
- **Hypersensitivity:** Is easily insulted, claiming hurt feelings when he or she is really mad.
- **Cruelty to animals or children:** Kills or punishes animals brutally. Also, may expect children to do things that are far beyond their ability (whips a 3-year-old for wetting a diaper) or may tease them until they cry.
- **Use of force during sex:** Being thrown or held down against their will during sex.
- **Verbal abuse:** Constantly criticizes or says blatantly cruel, hurtful things; degrades, curses, or uses name calling to shame the other person.
- **Rigid roles:** Expects partner to serve, obey and remain at home.
- **Sudden mood swings:** Switches from sweet to violent in minutes.
- **Past battering:** Admits to hitting a mate in the past but says the person "*made*" them do it.
- **Threats of violence:** Says things like, "*I'll break your neck*," or "*I'll kill you*," and then dismisses them with, "*I didn't really mean it*."
- **Controlling behaviors using social media or technology:** Monitoring use of cell phone and social media or not allowing cell phone or social media use or using technology to isolate and/or track the other person.

Adverse Childhood Experiences (ACEs) Questionnaire

Place an X in the box next to Yes or No to answer each question. If you are using this document electronically, click to place an X in the appropriate box.

Prior to your 18th birthday:

1. Did a parent or other adult in the household often or very often… Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?

   Yes ☐ No ☐

2. Did a parent or other adult in the household often or very often… Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?

   Yes ☐ No ☐

3. Did an adult or person at least 5 years older than you ever… Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?

   Yes ☐ No ☐

4. Did you often or very often feel that… No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?

   Yes ☐ No ☐

5. Did you often or very often feel that… You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   Yes ☐ No ☐

6. Were your parents ever separated or divorced?

   Yes ☐ No ☐

7. Was your mother or stepmother:
   Often or very often pushed, grabbed, slapped, or had something thrown at her? Or sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? Or ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   Yes ☐ No ☐

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   Yes ☐ No ☐

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   Yes ☐ No ☐

10. Did a household member go to prison?

    Yes ☐ No ☐

Now add up the number of times you selected "Yes". This number is your ACE Score.

An ACE score of 4 or higher increases the risk of disease and social and emotional issues.

Risk and Protective Factors for ACEs

From the Centers for Disease Control and Prevention

Risk Factors for ACEs

Individual and Family Risk Factors

- Families experiencing caregiving challenges related to children with special needs (for example, disabilities, mental health issues, chronic physical illnesses)
- Children and youth who don't feel close to their parents/caregivers and feel like they can't talk to them about their feelings
- Youth who start dating early or engaging in sexual activity early
- Children and youth with few or no friends or with friends who engage in aggressive or delinquent behavior
- Families with caregivers who have a limited understanding of children's needs or development
- Families with caregivers who were abused or neglected as children
- Families with young caregivers or single parents
- Families with low income
- Families with adults with low levels of education
- Families experiencing high levels of parenting stress or economic stress
- Families with caregivers who use spanking and other forms of corporal punishment for discipline
- Families with inconsistent discipline and/or low levels of parental monitoring and supervision
- Families that are isolated from and not connected to other people (extended family, friends, neighbors)
- Families with high conflict and negative communication styles
- Families with attitudes accepting of or justifying violence or aggression

Community Risk Factors

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

Protective Factors for ACEs

Individual and Family Protective Factors

- Families who create safe, stable, and nurturing relationships, meaning, children have a consistent family life where they are safe, taken care of, and supported
- Children who have positive friendships and peer networks
- Children who do well in school
- Children who have caring adults outside the family who serve as mentors/role models
- Families where caregivers can meet basic needs of food, shelter, and health services for children
- Families where caregivers have college degrees or higher
- Families where caregivers have steady employment
- Families with strong social support networks and positive relationships with the people around them
- Families where caregivers engage in parental monitoring, supervision, and consistent enforcement of rules
- Families where caregivers/adults work through conflicts peacefully
- Families where caregivers help children work through problems
- Families that engage in fun, positive activities together
- Families that encourage the importance of school for children

Community Protective Factors

- Communities where families have access to economic and financial help
- Communities where families have access to medical care and mental health services
- Communities with access to safe, stable housing
- Communities where families have access to nurturing and safe childcare
- Communities where families have access to high-quality preschool
- Communities where families have access to safe, engaging after school programs and activities
- Communities where adults have work opportunities with family-friendly policies
- Communities with strong partnerships between the community and business, health care, government, and other sectors
- Communities where residents feel connected to each other and are involved in the community
- Communities where violence is not tolerated or accepted

ACEs don’t have a single cause, and they can take several different forms. Many factors contribute to ACEs, including personal traits and experiences, parents, the family environment, and the community itself. To prevent ACEs and protect children from neglect, abuse, and violence, it’s essential to address each of these factors.