UCDAVIS
Continuing and Professional Education | Human Services Northern Academy

Safety Organized Practice
Foundational Institute

Participant Workbook – Table of Contents

Quick links: Class webpage SOP Resource page Statewide SOP Toolkit

SOP CFT Meeting Dialogue Structure

Meeting Stage	Key questions to guide each stage of the meeting
Purpose / Desired Outcome	• Overall, why are we meeting today? • What do we want to talk about? • What do we want to walk away with today, in this meeting? (A plan, list, decision, etc.)
Context	• Is there anything that might pull our attention away from our focus today?
Group Agreements	• How do we want to work with each other?
Network / Stakeholders (People and Community)	• Is everyone here that should be here? • If not, what should we do to get them here? (Genogram, Eco-map, Safety Circles, Cultural considerations)

Content	• Related to our purpose:
	  ○ What's working well?
	  ○ What are we worried about?
	  ○ What's the impact on the child?
	  ○ Gray Area? (Safety mapping)

Next Steps	• What steps do we need to take from here? • Who does what? • By when? • Next meeting date?
+/Δ Feedback	• What worked? • What should we do differently next time?

Back to table of contents

Multicultural Guidelines for Communicating Across Difference

- **Try On.** Try on each other's ideas, feelings, and ways of doing things for the purpose of greater understanding. Keep what you like and let go of the rest at the end of each interaction, discussion, session or meeting.

- **Okay to Disagree and NOT okay to blame, shame or attack ourselves or others** because of our differences. One of the necessary ingredients for differences to be expressed and valued is that people need to let go of the need to be, think or act the same.

- **Practice "Self-Focus" and use "I" Statements.** Begin by talking about your own experience. It is helpful to make "I" statements when speaking about your experience, rather than saying "you", "we" or "one". When you intend to refer to others, be specific about them, by name or group. This invites and creates space for multiple perspectives to be shared, especially when they are different than yours.
    - Learning from uncomfortable moments is an important part of this process, so pay attention to your feelings.

- **Be Aware of Intent and Impact.** Be aware that your good intentions may have a negative impact - especially across racial, gender or other cultural differences. Be open to hearing the impact of your statement.
    - If you want to "stretch" yourself, seek feedback from the individual before they bring it to your attention.

- **Practice Both/And Thinking.** Look for ways to fit ideas together and not set up an "either/or" process or a competition between ideas.
    - Look for the existence of many truths from the perspective of the many cultural backgrounds involved or that you are serving.

- **Notice Both Process and Content.** Notice both process and content during work sessions. Content is what we say, while process is how and why we say or do something and how the group reacts.
    - Notice who's active and who's not, who's interested and who's not, and ask about it.

- **Confidentiality** with regard to personal sharing is important. You can carry the work of the group, your own learning, stories and perspectives, and the public work from the group. Allow others to tell their own stories.
    - Ask first to see if an individual wants to follow up on the initial conversation.

This Multicultural Tool was created by VISIONS, Inc. - added info by Amy Stickles. VISIONS, Inc. is a nonprofit training and consulting enterprise providing a variety of services that support organizations, communities, and individuals as they continue to clarify their diversity-related goals and engage in a dynamic process of multicultural development. VISIONS, Inc. was established in 1984 as a nonprofit, educational organization. Today it is a 501(c)(3) entity with offices in Roxbury, Massachusetts, Rocky Mount, North Carolina, and is supported by a team of consultants around the United States and abroad. www.visions-inc.com. This version of the tool adapted by Northern California Training Academy 10/30/2019.

Back to table of contents

ICPM 10 Practice Principles

Family voice and choice

Each family member's perspective is intentionally elicited and prioritized during all phases of the teaming and service process. The team strives to find options and choices for the plan that authentically reflect the family members' perspectives and preferences.

Team-based

The team consists of individuals agreed upon by the family members and committed to the family through informal, formal, and community support, and service relationships. At times, family members' choices about team membership may be shaped or limited by practical or legal considerations, however, the family should be supported to make informed decisions about who should be part of the team. Ultimately, family members may choose not to participate in the process if they are unwilling to accept certain members.

Natural supports

The team actively seeks and encourages full participation of members drawn from the family members' networks of interpersonal and community relationships. The plan reflects activities and interventions drawn on sources of natural support. These networks include friends, extended family, neighbors, coworkers, church members, and so on.

Collaboration and integration

Team members work cooperatively and share responsibility to jointly develop, implement, monitor, and evaluate an integrated, collaborative plan. This principle recognizes that the team is more likely to be successful to accomplish its work when team members approach decisions in an open-minded manner, prepared to listen to, and be influenced by, other team members. Members must be willing to provide their own perspectives with a commitment to focus on strengths and opportunities in addressing needs, and work to ensure that others have opportunity to provide input and feel safe doing so. Each team member must be committed to the team goals and the integrated team plan. For professional team members, interactions are governed by the goals in the plan and the decisions made by the team. This includes the use of resources controlled by individual members of the team. When legal mandates or other requirements constrain decisions, team members must be willing to work creatively and flexibly to find ways to satisfy mandates while also working toward team goals.

Community-based

The team will strive to implement service and support strategies that are accessible and available within the community where the family lives. Children, youth, and family members will receive support so that they can access the same range of activities and environments as other families, children, and youth within their community that support their positive functioning and development.

Culturally respectful

The planning and service process demonstrates respect for, and builds on the values, preferences -including language preferences, beliefs, culture-and identity of the family members, and their community or tribe. Culture is recognized as the wisdom, healing traditions, and transmitted values that bind people from one generation to another. Cultural humility requires acknowledgement that professional staff most often cannot meet all elements of cultural competence for all people served. Professionals must ensure that the service plan supports the achievement of goals for change and is integrated into the youth's and family's cultures. Cultural humility and openness to learning foster successful empowerment and better outcomes.

Individualized

The principle of family voice and choice lays the foundation for individualization and flexibility in building the plan. While formal services may provide a portion of the help and support that a family needs, plans and resources must be customized to the specific needs of the individual child, youth, and family members. Each element of the family's service plan must be built on the unique and specific strengths, needs, and interests of family members, including the assets and resources of their community and culture.

Strengths-based

The service process and plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child, youth, and family members, their tribe and community, and other team members. The team takes time to recognize and validate the skills, knowledge, insight, and strategies that the family and their team members have used to meet the challenges they have encountered in their lives -even though sometimes these strengths have been inadequate in the past. This commitment to a strengths-based orientation intends to highlight and support the achievement of outcomes not through a focus on eliminating family member's deficits, but rather through an effort to utilize and increase their assets. This begins with a uniform and singular use of the CANS assessment. Doing so validates, builds on, and expands each family members' perspective (e.g., positive self-regard, self-efficacy, hope, optimism, and clarity of values, purpose, and identity), their interpersonal assets (e.g., social competence and social connectedness), and their expertise, skill, and knowledge.

Persistence

The team does not give up on, blame or reject children, youth, or their families. When faced with challenges or setbacks, the team continues working towards meeting the needs of the youth and family and towards achieving the team's goals. Undesired behavior, events, or outcomes are not seen as evidence of youth or family "failure" but, rather, are interpreted as an indication that the plan should be revised to be more successful in achieving the positive outcomes associated with the goals. At times, this requires team commitment to revise and implement a plan, even in the face of limited system capacity or resources.

Outcomes-based

The team ties the goals and strategies of the plan to observable or measurable indicators of success, monitors progress consistent with those indicators, and revises the CANS and service plan accordingly. This principle emphasizes that the team is accountable to the family, all the team members, systems of care which serve the children, youth, and families, and to the community. Tracking progress toward outcomes and goals keeps the plan on track and indicates need for revision of strategies and interventions as necessary. It also helps the team maintain hope, cohesion, and effectiveness and allows the family to recognize that things are, indeed, changing and progress is being made.

Adapted from the California Integrated Core Practice Model for Children, Youth, and Families (2018)

THE TRUTH ABOUT ACEs

WHAT ARE THEY?

ACEs are ADVERSE CHILDHOOD EXPERIENCES

The three types of ACEs include

ABUSE
- Physical
- Emotional
- Sexual

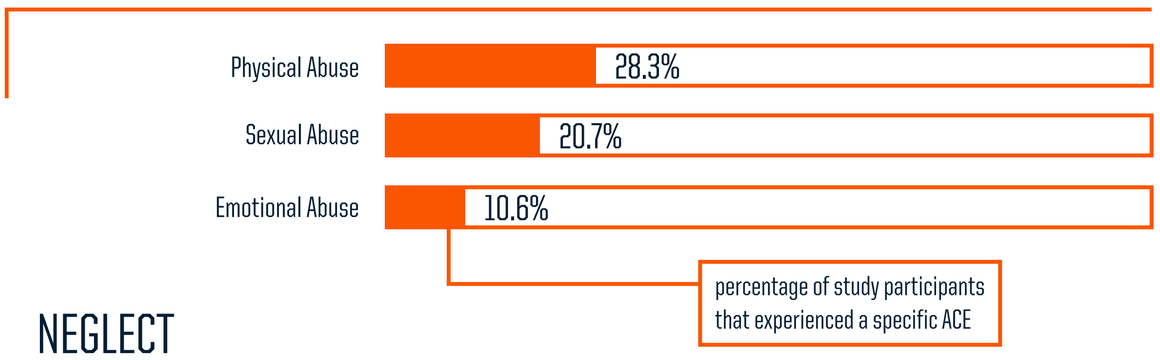
NEGLECT
- Physical
- Emotional

HOUSEHOLD DYSFUNCTION
- Mental Illness
- Mother treated violently
- Divorce
- Incarcerated Relative
- Substance Abuse

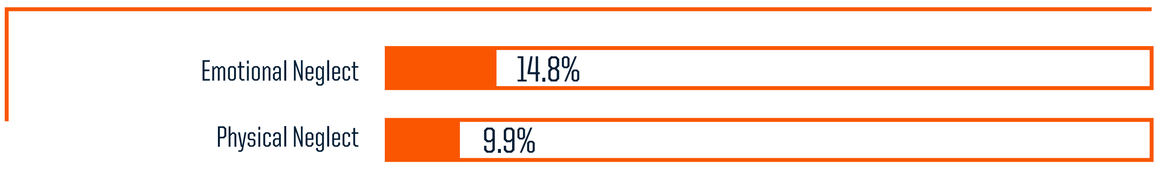
HOW PREVALENT ARE ACEs?

The ACE study revealed the following estimates:*

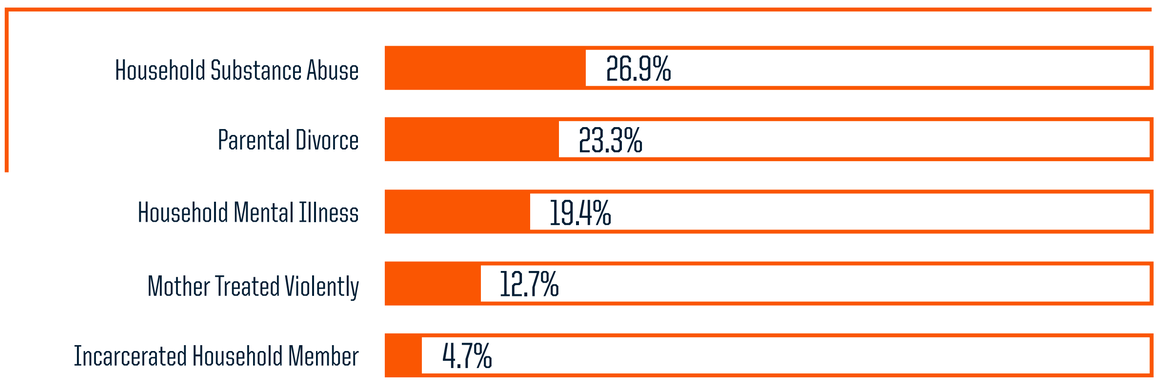
ABUSE



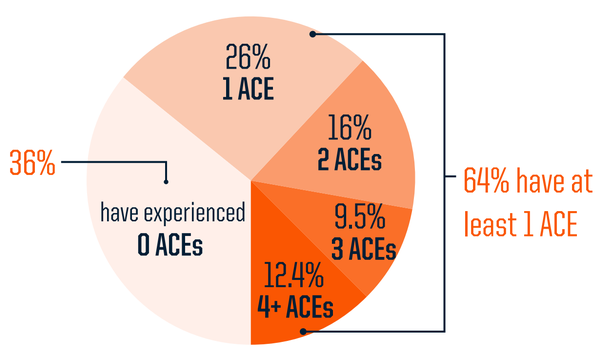
NEGLECT



HOUSEHOLD DYSFUNCTION

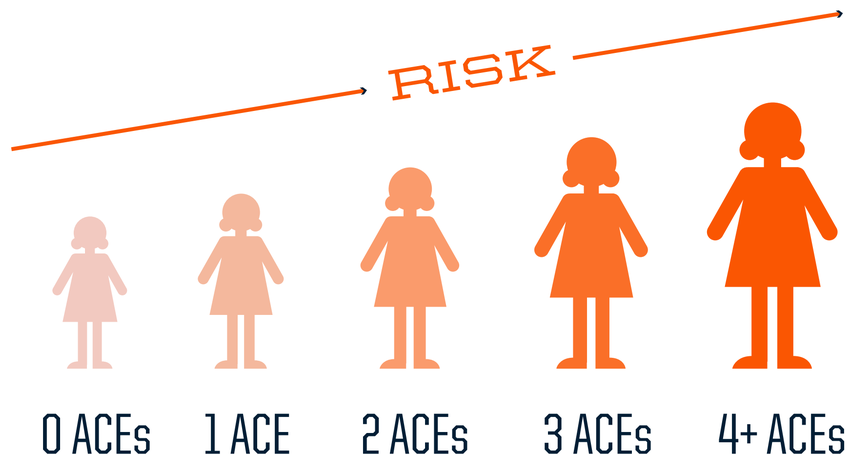


Of 17,000 ACE study participants:



WHAT IMPACT DO ACEs HAVE?

As the number of ACEs increases, so does the risk for negative health outcomes



Possible Risk Outcomes:

BEHAVIOR
- Lack of physical activity
- Smoking
- Alcoholism
- Drug use
- Missed work

PHYSICAL & MENTAL HEALTH
- Severe obesity
- Diabetes
- Depression
- Suicide attempts
- STDs
- Heart disease
- Cancer
- Stroke
- COPD
- Broken bones

rwjf.org/aces

Robert Wood Johnson Foundation

Back to table of contents

*Source: http://www.cdc.gov/ace/prevalence.htm

Safety Organized Practice

Social Worker Practice Definitions

The following definitions include foundational concepts of Social Work Practice and Safety Organized Practice (SOP). These Social Work practice approaches have been found to be vital to engaging with families in a respectful and ethical way: Cultural Humility, Solution-focused approach, Strength-based approach, Trauma Informed practice, Collaborative practice, and Appreciative Inquiry.

CULTURAL HUMILITY:

Cultural humility involves a humble approach to working with families and demonstrating a belief that families are the experts of their unique qualities and characteristics.

A cultural humility perspective challenges us to learn from the people with whom we interact, reserve judgment, and bridge the cultural divide between our perspectives in order to facilitate well-being and promote improved quality of life. Such a perspective frees the observer from having to possess expert knowledge in order to maintain knowledge-based power, control, and authority over matters about which diverse populations are far more knowledgeable (Tervalon, M., and Murray-Garcia, J., 1998)

Hu-mil-i-ty, noun.
1. The quality or condition of being humble; lack of pride; modesty. 2. The act of modesty or self-abasement; submission (The American Heritage Dictionary of the English Language, 1973; p. 441)

SOLUTION-FOCUSED APPROACH:

A ***solution-focused approach*** involves collaborating with the client/family to identify his/her ideas of solutions that will work to ensure safety, permanency, and well-being of their child(ren). This approach encourages families to become part of the decision-making process and their strengths and resources are acknowledged. Solution focused interviewing is part of this approach and includes a set of different types of questions that can be used with families.

Types of solution focused interview questions include:

1. The Three Questions (what's working well, what are we worried about, what needs to happen next)
2. Exception questions
3. Scaling Questions
4. Miracle Questions
5. Coping Questions
6. Preferred Future Questions

STRENGTH-BASED APPROACH:

A ***strength-based approach*** focuses on identifying and building on strengths, capacities and resources within the family system that could be used to ensure safety and well-being of the child(ren). Strengths may include past and current efforts in protecting children from harm, maintaining loving parent-child relationships, accessing extended family and other support systems and making efforts to address past and current stress conditions including drug abuse, family violence, mental health issues, unemployment, etc., (The Pennsylvania Child Welfare Training Program, 2015).

Social Workers may utilize this approach in the use of Solution Focused questions, Motivational Interviewing, Use of "What's working well" and the "Consultation and Information Sharing Framework" to focus on family strengths and completion of the Structured Decision Making (SDM) Family Strengths and Needs assessment tool (FSNA).

TRAUMA INFORMED PRACTICE:

Trauma informed practice involves an awareness of trauma and its impact on behavior and quality of life in the lives of children and adults. This practice involves a recognition of and empathy for the pervasiveness of trauma and seeks to understand the connection between presenting behavior, thoughts, attitudes, coping strategies. Additionally, it is crucial to understand the impact of trauma that may be created by being involved with child welfare and to learn ways to acknowledge and try to reduce this impact.

The utilization of a trauma informed approach may assist a worker with focusing on the behavior of the person and what might be motivating that behavior in the context of how trauma can affect a person's coping mechanisms. This may further assist the worker in developing ways to interact with children and families in a way that supports engagement, safety, growth and trust.

Core Principles of Trauma Informed Practice:

1. Trauma awareness
2. Empowerment of those we work with
3. Physical and emotional safety
4. Trustworthiness
5. Choice and collaboration
6. Building on strengths and skills

COLLABORATIVE PRACTICE:

Collaborative Practice (otherwise known as "Partnership-Based Collaborative Practice") involves a collaborative team approach known as a best practice in the field of child welfare. This practice encourages the building of shared language, understanding and engagement with families to assist and empower them to build their own supportive network and safety plans.

Partnership-Based Collaborative Practice consists of seven interconnected strategies implemented in Olmstead County, Minnesota by Rob Sawyer and Sue Lohrbach. These seven strategies are shown to improve infrastructure in the child welfare system and include the following:

1. A Differential Response System
2. Front-loading the agency and community (Example: Targeted early intervention programs)
3. Formal risk/safety assessment (SDM)
4. A social work practice model (Safety Organized Practice)
5. Consultation and information sharing framework*
6. Group Supervision and group decision making (Example: RED teams)
7. Facilitated Family meetings (Example: FTMs)

*Use of the Consultation and Information Sharing Framework in RED teams, group supervision, case consultation, mapping with families, safety planning utilizing natural supports and community service providers.

APPRECIATIVE INQUIRY:

Appreciative inquiry involves a collaborative exploration into the "best" of people, their relationships, and the world around them. This practice mostly originates from David Cooperrider's work with organizations and systems at the Case Western School of Management in Ohio, US. Appreciative inquiry is the opposite of "problem-solving" and seeks to instill hope in families by focusing on what is going right and well in their lives. What we pay attention to grows and by paying attention to what's working instead of focusing solely on what's not working, social workers can contribute to positive change in individuals, groups, and organizations.

Social Workers can utilize this practice with families by using a solution-focused, strengths-based approach to help them recognize and build on their strengths and resources. This practice works best when workers support the "parallel process" by focusing and building on what is working well in their individual work and organizations as well. Appreciative inquiry may be used in multiple settings including by not limited to: family meetings and home visits, case consultation between supervisor and worker, group supervision, coaching, training, etc.

From multiple research studies:

The best outcomes for children and families occur when constructive working relationships exist between families and professionals and between professionals themselves. Good working relationships are the best predictor of good outcomes!

"Motivation (for change) may be linked to the degree of <u>hope</u> that change is possible," (US National Clearinghouse on Child Abuse and Neglect).

Case Planning Worksheet: Table group activities	
Reason for referral / child welfare involvement & SDM Safety Threat	
What's working well?	
What are you worried about?	
Harm Statement	
Danger Statement	
Safety Goal	

CASE PLAN SERVICE OBJECTIVE #1 **Parent:**	
CWS Drop Down Service Objective	
S.M.A.R.T. Service Objective	

Behaviorally based action steps to reach service objective *Remember to use language easily understood by people of any educational level.*	
Client Responsibilities (AKA Services)	
CASE PLAN SERVICE OBJECTIVE #2: **Name:**	
CWS Drop Down Service Objective	
S.M.A.R.T. Service Objective	
Behaviorally based action steps to reach service objective *Remember to use language easily understood by people of any educational level.*	
Client Responsibilities (AKA Services)	

CWS/CMS Case Plan Drop-Down Options

Please note that this is not a complete list, but was compiled for training purposes only.

Service Objectives
Able and willing to have custody. Show your ability and willingness to have custody of your children.
Accept disclosure made by child. Listen to and show acceptance and support of the disclosure made by your child.
Acquire adequate resources. Obtain resources to meet the needs of your child and to provide a safe home.
Acquire basic cooking skills. Demonstrate basic meal planning and cooking skills.
Acquire basic skills to seek employment. Be able to complete job applications and to participate in job interviews.
Acquire shopping, budgeting, and money management skills. Demonstrate developing/balancing a budget and to shop within your means.
Allow victim confrontation. Listen and respond appropriately when child is ready to confront you about your behavior.
Arrange child care/support during your absence. Be willing and able to arrange appropriate child care and supervision when you are away from home.
Complete Intimate partner violence Program. Attend and demonstrate progress in County Certified Intimate partner violence Prevention Plan.
Comply with visitation. Maintain a positive relationship with your child by participating in your visitation plan.
Control anger/negative behavior. Express anger appropriately and develop strategies for handling anger.
Cooperate w/Concurrent Services Planning. Work together with services to achieve legal permanency.
Cooperate to establish guardianship. Work together with staff to establish a guardianship for the child.
Develop Intimate partner violence Prevention Plan. Develop and use a specific intimate partner violence Relapse Prevention Plan for yourself.
Develop supportive interpersonal relationships. Develop positive support systems with friends and family.
Do not abuse alcohol. Stay sober and show your ability to live free from alcohol dependency.
Do not abuse drugs. Stay free from illegal drugs and show your ability to live free from drug dependency. Participate in all required drug tests.
Do not break the law. Do not break the law. Avoid arrests and convictions.
Do not involve you child in Dom. Viol. Do not involve your child in attempts to control or intimidate your partner.
Do not neglect your child's needs. Meet your child's physical, emotional, medical, and educational needs.
Do not physically abuse your child. Interact with your child without physical abuse or harm.

Do not sexually abuse your child.
Do not use physical punishment.
Eliminate danger to physical health. Remove identified dangers to your child's physical health.
Follow conditions of probation/parole. Follow all conditions of probation/parole.
Have no contact with your child. You will not contact your child by phone, in writing, or in person.
Improve basic self-care grooming, dressing, hygiene. Improve grooming, dressing, and hygiene.
Know age appropriate expectations. Show that you know age appropriate behavior for your child.
Maintain problem-free school behavior. Follow all school rules. Do not create any behavior problems at school.
Maintain suitable residence for child. Obtain and maintain a stable and suitable residence for yourself and your child.
Monitor/correct child's behavior. Show your ability to supervise, guide, and correct your child at home, school, and in the community.
Monitor child's health, safety, and well-being. Pay attention to and monitor your child's health, safety, and well-being.
Obtain/finalize adoption. Cooperate with staff person(s) working to finalize adoption for the child.
Obtain/maintain legal source of income. Have and keep a legal source of income.
Positive interaction during child visits. Be nurturing and supportive when you visit your child.
Prepare for independent living. Participate in independent living program.
Protect child from contact with abuser. You will not allow any contact between the abuser and your child.
Protect child from emotional harm. Protect your child from emotional harm.
Protect child from physical abuse. Show that you will not permit others to physically abuse your child.
Protect child from sexual abuse. Show that you will not permit others to sexually abuse your child.
Protect self from abusive relationships. Take appropriate action to avoid being a victim of further intimate partner violence.
Provide appropriate/adequate parenting. Consistently, appropriately, and adequately parent your child.
Provide care for child's special needs. Show your ability to understand your child's feelings and give emotional support.
Provide emotional support for child. Show your ability to understand your child's feelings and give emotional support.
Receive age appropriate services. Receive age appropriate, child-oriented services.
Refrain from intimate partner violence.

Do not behave in a manner that is verbally, emotionally, physically, or sexually abusive or threatening.
Stabilize behavioral health. Participate in medical or psychological treatment as directed by the court
Support placement with potential legal guardian. Participate positively with staff person(s) to support the child's placement with a potential legal guardian.
Support long term placement for the child. Participate positively with staff person(s) to support a long-term placement for the child(ren).
Take responsibility for actions. Show that you accept responsibility for your actions.
Treat others with respect.
Will complete vocational training. Enroll and complete vocational training.
Will remain in school until graduation/GED. Attend school on a regular basis until graduation or GED.
Planned Client Services/Client Responsibilities
Intimate partner violence Program
General Counseling
Psychiatric/Psychological Assessment
Psychotropic Medical Evaluation/Monitoring
Sexual Abuse
Therapeutic Day Treatment
Other (Education)
Parent Education Program
Special Education
Teaching and Demo Homemakers
Temporary Caretakers
Tutoring
Family Preservation Services
FP – Teaching and Demo
FP – Other
Counseling
Other (Substance use)
Substance use (inpatient)
Substance use (outpatient)
Substance use Testing
Twelve Step Program
Health/CHDP Services
Dental Visit
HEP-CHDP Equivalent Physical Exam
HEP-CHDP Physical Exam
HEP-Periodic Dental Exam
Medical Visit
Medication Management
Other (*Description Mandatory*)

Provide Medical Consent
Provide Medical/Dental Information
Independent Living Skills Program (ILSP)
ILP – Career/Job Guidance
ILP – Consumer Skills
ILP – Education
ILP – Health Care
ILP – Home Management
ILP – Housing Options/Locations
ILP – Interpersonal/Social Skills
ILP – Money Management
ILP – Other (*Description Mandatory*)
ILP – Parenting Skills
ILP – Time Management
ILP – Transitional Housing
ILP - Transportation
Case Management Services/Agency Responsibilities
Arrange and maintain placement
Arrange emergency shelter care
Arrange service delivery
Arrange transportation
Arrange visitation (*See "Visitation Schedule" below*)
Arrange/Refer legal consent
Obtain medical consent
Other (*Description Mandatory*)
Perform case planning activities
Provide crisis intervention
Referrals to community resources
SW planned contact (*See "Contact Schedule on next page*)
Transport client
Concurrent Planning
CSP – Assess for Adoptions
CSP – Disclosure to Birth Parents
CSP – Joint Assessment
CSP – Other (*Description Mandatory*)
CSP – Recommend Permanency Alternative
CSP – Refer/Complete Adopt. Home
CSP – Refer/Complete Guardian Assmt.
CSP – Refer/Complete Relinquishment
CSP – ID/Assess Permanency Plan
CSP – Place in Permanency Plan

S.M.A.R.T. Objectives and Service Descriptions

OBJECTIVES ARE:		EXAMPLE:
SPECIFIC	Objectives describe the specific behavioral outcomes that will result in achievement of the permanency goal. An objective clearly describes a behavior that must occur, or that must stop occurring, before the case is successfully closed. (Try to word objectives using positive terms.)	Specific Objective: Within 30 days, Mr. Lazarus will be able to explain to his social worker how he would use alternatives to corporal punishment methods and only use discipline methods that keep the children free from injury.
MEASURABLE	The parties to the plan must be able to reach consensus regarding whether the stated objectives have been accomplished.	Some criteria are easy to observe but more difficult to measure. For example, one cannot write a measurable objective related to home cleanliness by quantifying the amount of dirtthat is allowable in a home. A practical solution is an objective that **includes many observable behaviors that are associated with cleanliness.** For example, "the floor will be cleared of dirt, dust, debris, food, and garbage." The objective provides realistic and measurable criteria against which to measure home cleanliness.
ACHIEVABLE	Objectives must be realistic so that clients are able to accomplish them.	For example, "Over the next 6 months, Mr. Lazarus will demonstrate the ability to discipline his children during visits without using physical punishment" is achievable; "Mr. Lazarus will not discipline child" is neither achievable nor desirable.
RESULTS-FOCUSED	Objectives must be selected in the context of the factors that put the child at risk.	If the assessed problem is that the mother is alcoholic and has blackouts during which time the child receives no care, a relevant and result focused objective would be, "Ms. Lazarus will remain sober at all times she is supervising her children and will ensure that her children are adequately supervised at all other times as evidenced by social worker observation, service provider observation and no new referrals for neglect during the next 60 days."
TIME-LIMITED	A timeframe within which the objective can reasonably be expected to be completed should be included in the objective statement.	The assignment of a timeframe provides an additional criterion by which achievement of the objective can be measured. A time- limited would start or end with, "Within (number of days/months)…" or "whenever the parent…"

SOLUTION-FOCUSED QUESTIONS

NORTHERN CALIFORNIA TRAINING ACADEMY

SUMMARY

Solution-focused questions are a foundational skill and strategy of Safety Organized Practice that helps the social worker explore worries, what is working well and next steps with a family in a strength-based manner that is in itself an intervention.

WHY SOLUTION-FOCUSED QUESTIONS?

- Safety Organized Practice (SOP) views engagement as one of the primary functions of a social worker to help ensure child safety, permanency and well-being. Engagement is the art and skill of interacting with a family in ways that move them toward greater readiness for their own active participation in making change.
- Without engagement, families may complete required steps or services, but the chances are greatly reduced that they will genuinely internalize the need for change and make lasting, meaningful change. Skilled engagement, therefore, is critical to child safety.
- Effective engagement also helps individuals with a history of trauma step out of "fight/flight/freeze" mode so that they can access their best thinking.
- Masterful use of questions is one of the most effective engagement strategies, and an intervention in and of itself.

THE THREE QUESTIONS

- The Three Questions are a guiding framework for SOP that is rooted in solution-focused questioning and infused through many other SOP tools and strategies. The Three Questions are a deceptively simple framework for exploring strengths, concerns and necessary next steps with a child, a parent, a family, their network, reporting parties, collaterals and anyone else involved in a case.

THE THREE QUESTIONS

1. **What's working well?**
2. **What are we worried about?**
3. **What needs to happen next?**

- The Three Questions are a component of many other strategies of SOP, including:
  - Guiding the discussion in Child and Family Team (CFT) meetings, Group Supervision, or Review, Evaluate, Direct (RED) Teams
  - Completing the Three Houses with children or youth: House of Good Things = working well, House of Worries = what we're worried about, House of Hopes & Dreams = what happens next
  - Providing a framework for SOP-based intake/ screening questions
  - Guiding other conversations or meetings with parents, youth, collaterals or agency staff

SOLUTION-FOCUSED QUESTIONS

- Solution-focused questions are an effective strategy to have conversations with people about what is already working well, or has worked well in the past, in order to successfully engage families, build their hope and belief that change is possible, and focus their energies on positive change.
- The solution-focused approach is based on a simple idea with profound ramifications: that what we pay attention to grows. This highlights the need to ask families and others about safety as rigorously as we ask about harm and danger, because identifying where there is already safety or has been safety in the past holds the solutions, at least in part, to future safety.
- Solution-focused questions also help us conduct a rigorous, balanced assessment by evoking discussion with network members, collaterals and other agency staff about acts of protection and family strengths, rather than focusing solely on what isn't working, which leaves us with only half of the picture.
- Solution-focused interviewing is also an excellent strategy to use with youth to help them focus on their strengths, build confidence in their skills and guide them toward positive choices.
- Solution-focused questions can also be used with resource parents or service providers to guide conversations about a child's or youth's behavior, with the goal of stabilizing a placement or identifying additional supports that may be needed.

TYPES OF SOLUTION-FOCUSED QUESTIONS

- **Exception Questions** ask individuals to think about times that the problem was not happening so they can explore what, when, where and how they were able to achieve success. They help people remember that the problem has not always been present, or can help clarify that there was no time when the problem was not happening, which is also important information.

  Example: "Was there a time that you (mom) were able to stay clean and sober? How were you able to achieve that? What was it like to parent your kids when you weren't drinking?"

  Example: "Was there a time in your relationship that you (dad) were not using violence or making mom stay away from her family and friends? What did your relationship look like during that time?"

  Example: "Are there times that (your foster child) is not acting out? What does his behavior look like at those times? What is happening in the home, at school or in his life when he is at his best?"

Back to table of contents

- **Coping Questions** ask people to reflect on how they were able to make it through something difficult, painful or challenging without resorting to problem behavior. Coping questions help build people's sense of self-efficacy and resilience and also show us what strategies they used for success.

  Example: "Wow, it's amazing that your sister died and you were still able to stay sober during that time. How were you able to manage that?"

  Example: "It shows so much strength that you got yourself and the kids out of the house after your boyfriend started using again. How were you able to do that?"

- **Position (or Relationship) Questions** ask a person to think about a situation or problem from someone else's perspective, or by putting themselves in the other's shoes. This helps them understand the impact of their actions or behavior on another person and see it from their eyes. Position questions can help build empathy and understanding of how one's own actions affect another person.

  Example: "If your son were here, what do you think he would say about how your drug use affects you as his dad?"

  Example: "If your mom were here, what do you think she would say about the kind of relationship she wants for you and your children?"

  Example: "If you put yourself in my shoes as the social worker, what would you be worried about?"

- **Preferred Future Questions** ask the person to think about what the best possible future would look like if they were able to change their issue or problem. They help build a vision for what things will look like when the problem is no longer happening, and assist in setting goals.

  Example: "If the best possible future happened and your child welfare case was closed, what would your life look like? Where would you be living? What would you be doing? How would you be parenting your children?"

TYPES OF SFQs

Exception
Coping
Position
Preferred Future
Scaling

- **The Miracle Question** is a special type of preferred future question that can help people get clarity on how the problem impacts their daily life and what life would look like without the problem happening.

  Example: "Imagine you woke up tomorrow and a miracle had happened over night, and all the trouble was gone. How would you know it was over? What would be different that would tell you the problem was no longer happening? What is the first thing you would be doing to start the day? What would the rest of your day look like? What would things look like for your children?"

- **Scaling Questions** are a powerful, flexible strategy that can be adapted to many situations to help gauge or clarify a person's (or all team members') perspective on an issue. The important thing about scaling questions is not necessarily the number that someone picks, but rather the chance to explore with them the *reasons* that they picked that number.
  - Follow-up questions are the key; for example, asking someone what it would take to move them up one number, or why they picked that number and not a lower or higher one. Follow-up questions help us get to the underlying reasons for someone's perspective and explore next steps.
- Scaling questions can be used to scale many different areas, including but not limited to:
  - Willingness
  - Confidence
  - Readiness
  - Agreement

  For example, how *willing* is someone to participate in a safety network, how *confident* are CFT participants that a plan will keep a child safe, how *ready* is a parent to make a change, how much do team members *agree* with the decision a team is making.

  Example: "On a scale of 1 to 10, where 1 is that you are not at all ready to stop using drugs, and 10 is that you are completely ready, where would you rate yourself today? How did you pick a 9? What would it take to move you from a 9 to a 10?" (Or: "Wow, you're very ready — what made you pick a 9 and not a 8? Have you ever been at a 9 before? What were the steps you took at that time?")

  Example: "On a scale of 1 to 10, where 1 is that you have no confidence that this plan will keep the child safe, and 10 is that you are completely confident the plan will keep the child safe, where would you rate? How did you pick a 4? What puts you at a 4 instead of a 3? (Or: "What would you need to see happen to be at a 5 instead of a 4? What would you need to see happen to be a 6?")

A NOTE ABOUT APPRECIATIVE INQUIRY

Appreciative inquiry is a term that is sometimes used interchangeably with solution-focused approaches. Appreciative inquiry is based on the belief that what we pay most attention to has the best chance of growing. Fundamentally, appreciative inquiry is the concept that asking questions about what is working will be more effective in creating change than focusing our attention primarily on the problem.

Beyond work with families, appreciative inquiry is an approach to organizational change that mirrors solution-focused questions used with families by helping social workers pay attention to what they are doing well and what good things they are already doing that they can build on to grow their skills. It is an important parallel process for agencies implementing Safety Organized Practice.

CIRCLES OF SUPPORT

NORTHERN CALIFORNIA TRAINING ACADEMY

SUMMARY

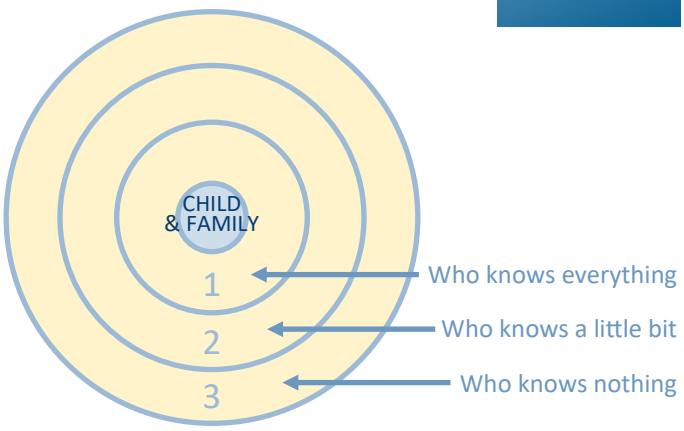
The Circles of Support is a tool to explore with a family who their natural support network is and who may be built into a formal Safety Network to help ensure the safety of the child in the care of the parent.

PREPARING WITH PARENTS

- The Circles of Support (sometimes called Safety Circles) can be done with a parent one-on-one — for example, in one of your first meetings with them — however, ideally it is completed in the context of a Child and Family Team (CFT) meeting.
  - If you complete it only with the parent, revisit it during a CFT so other participants have the chance to add to the network and share their perspective.
- Make the Circles of Support as open and transparent as possible; explain the process and why you want to do it. Inform the parents that:
  - Part of your job is to identify people who care about them/their child in order to help keep the child safe.
  - Building a Safety Network is a requirement for their child to come home/close their case.
- Ask the parent if they are willing to participate in the Circles of Support process.
  - If not, ask what their worries are. On a scale of 1-10, how willing are they to complete the process? What would it take to raise their number by one?
  - If they are still unwilling, let them know that you'll revisit it later, since building a Safety Network is necessary for children to return home/close a case.

COMPLETING THE CIRCLES OF SUPPORT

- Draw the circles as shown. Explain what each circle represents, then ask:
  1. "Who are the people in your life/your child's life who already know what happened that led to child welfare being involved with your family?"
  2. "Who are the people that know a little bit, who know something has happened, but don't know details?"
  3. "Who are the people in your life who don't know anything about what has happened?"
- Compliment the parent for the courage they have shown in talking with people about what has happened.
  - "I imagine it may have been difficult to tell [your mom, friend, etc.] what happened. How did you find the courage to do that?"
- Explore the network by asking for detail.
  - "Now that we have identified people in your life, can you tell me more about them?"



  - "How long have you known this person? Where/how did you meet them?"
  - "How would you describe their relationship with your child?"
  - "If your life were going how you hope it will be in the future, what role would this person play? What role would they play in your child's future?"
  - "On a scale of 1-10, how confident are you that this person will be able to help you/your family?"
- Explore with the parent/team what it would take to move people from the outer circles to the inner circle.
  - "Who else from the outer circles do you think needs to be part of the inner circle? How come?"
  - "Is there anyone in an outer circle you have thought about telling, but haven't yet? What would you need to feel comfortable talking to them?"
  - "Who would _____ *(in the inner circle)* say needs to be in the inner circle with him/her?"
  - "Who would your kids want to be in the inner circle? How come?"
  - "Who do you think I *(your social worker)* would want to have in the inner circle? Why?"
- If you completed the activity with only the parent, discuss scheduling a CFT meeting and inviting the people in circles 1 and 2. At the CFT, further develop the Circles of Support with the team.

HELPFUL TIPS

Ask the parents if there was someone who used to be important to them, but who they no longer talk to. What would it take for them to reach out to heal the relationship?

Be mindful of cultural aspects of a parent's reluctance to share information with people in their network. Explore what would help them overcome their discomfort.

Adults who aren't capable of being part of the safety plan can still be part of the network by supporting the parent.

ADDRESSING RELUCTANCE/AMBIVALENCE

- Parents may be reluctant to share information about their network. Express empathy and be clear about why the information is needed.
  - "I know this is tough for you, and I get that you don't want to do this. For us to be able to [move to unsupervised visits, return your child, close your case], I need to know more people are working together to keep your child safe. If you had to pick one person to attend a meeting, who I would tell all the good things I see you doing as well as what I'm worried about, who do you think it should be?"
- Ultimately, if a parent doesn't want a network involved, it is their choice. However, services do not equal safety. Continue to work through the parent's ambivalence while expressing the need for a Safety Network if the parent wants to achieve his/her goals (i.e., getting their child back, closing the case).

SAFETY NETWORK

- The next step is developing individuals identified in the Circles of Support process to actually become the child's Safety Network. Discuss with the family/team:
  - Of all these people, who do you think would be important to have as part of the Safety Network?
  - Is there anyone you would not want in the network? How come?
  - How will we decide whether someone is part of the Safety Network?
  - What do people need to know if they are going to be part of the Safety Network?
- If a family has no one who can be part of a Safety Network, or has an inadequate network to ensure child safety, building a network must be a primary part of the initial case plan.
- There is no specific number of people needed to be part of the network; every situation is different and determined by:
  - Level of risk and potential future danger
  - Age and vulnerability of children
- The Safety Network needs enough people to meet the day-to-day arrangements required in the safety plan.
- Genograms and ecomaps are useful tools for developing the Safety Network, as well as for family finding/ connection for the child.
- Additional questions that can help you explore a potential Safety Network include:
  - "Who are the people that you really trust?"
  - "Who are the people who know you at your best?"
  - "If you suddenly became sick, who would you trust the most with your children? Who would you want to take you to the doctor?"
  - "Who would your kids say they trust the most?"

SAFETY NETWORK

A safety network is a group of responsible adults (family, friends and professionals) who:

Care about the child and family

Are willing to meet with Child Welfare Services

Understand the concerns about harm and danger that CWS and others have

Are willing to do something that supports the family and helps keep the child safe

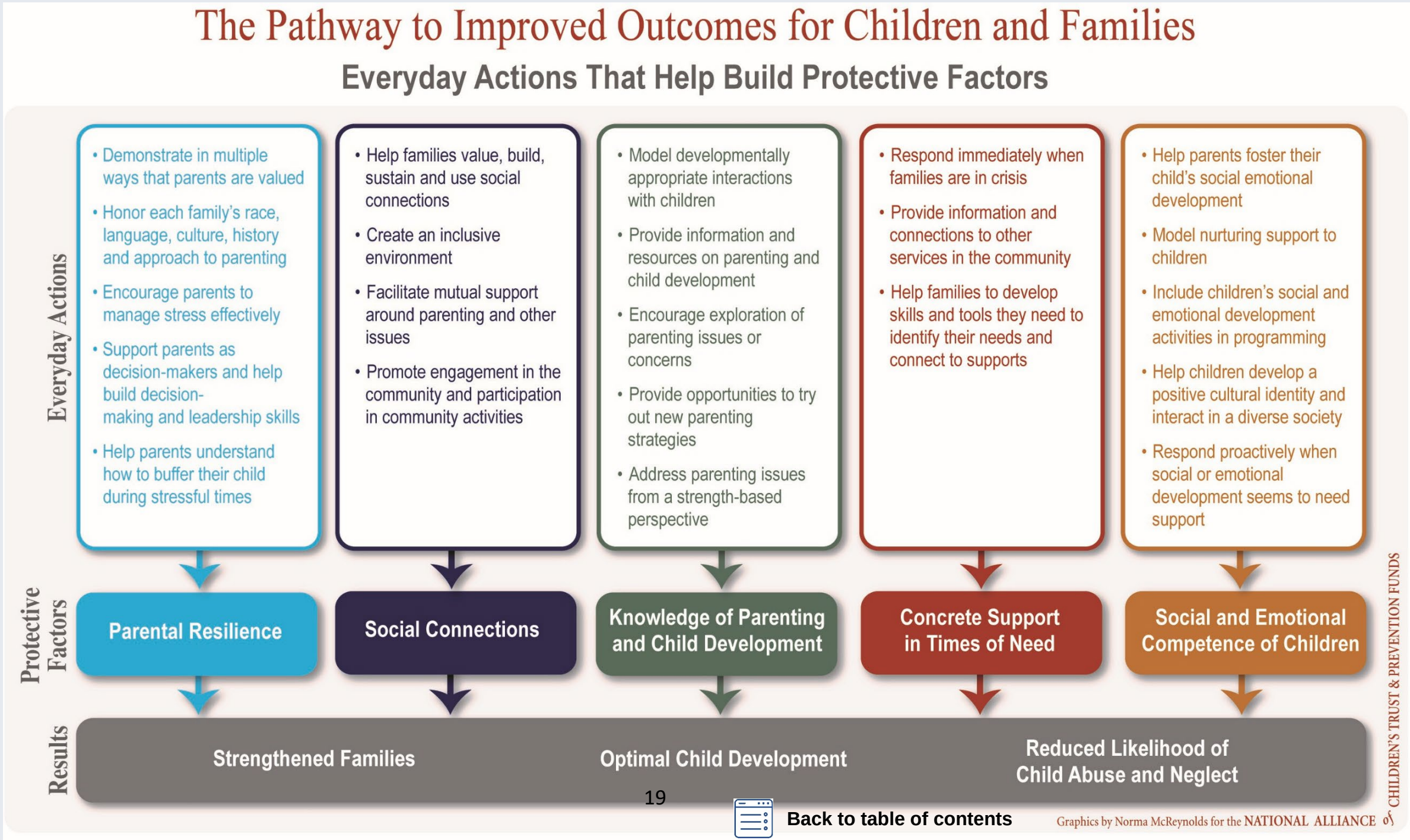
  - "If we had to pick one person to start with to come to a meeting to start sharing about our work together, who would you want it to be?"
- Talk directly to children/youth about who is important to them, who they love and who they feel safe with.
  - Children are able to complete genograms/family trees at a young age, to the extent of their developmental capacity.
  - Who is their favorite grownup, besides their mom or dad, to do fun things with?
  - If the child had a worry, which grownup would they talk to about it?
- If potential Safety Network members don't seem "appropriate":
  - Be willing to meet with anyone, even if it's not someone you think will be helpful.
  - Follow similar procedures for child visitation (i.e., background check) to assess for safety.
  - Someone who may not be able to help keep the child safe may be a valuable support in other ways, i.e., taking the parent to AA/NA meetings.
- Discuss with the network how accountability will be managed.
  - How do we make sure the network is doing what they agreed to do?
  - What will we do if the network does not do what they agreed to do?
  - How often will Child and Family Team meetings happen?

OTHER USES OF NETWORKS & THE TOOL

- Networks don't only have to focus on safety. The network can tackle issues such as concurrent planning, healing from trauma, education success, transition to successful adulthood, and more.
- The Circles of Support is a great tool to use with older youth in permanency to explore who is important to them. Work with the youth to fill in who they are very close to in the middle, who they are somewhat close to in the next ring, and who they used to be close to in the outer circle.

Handout:
5 Protective Factors

CENTER FOR THE STUDY OF SOCIAL POLICY'S
strengthening families
A PROTECTIVE FACTORS FRAMEWORK



Back to table of contents

HARM & DANGER STATEMENTS

NORTHERN CALIFORNIA TRAINING ACADEMY

SUMMARY

Harm Statements and Danger Statements ensure everyone involved with a referral or case has shared understanding of the caregiver's actions that harmed the child and that create worry about possible future danger.

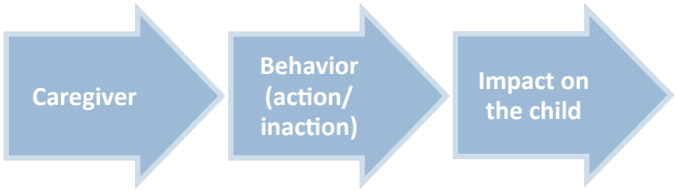
PURPOSE

- Harm Statements and Danger Statements (sometimes known as Risk Statements) are brief, behaviorally-based statements that help families, network members, service providers and staff become very clear about why Child Welfare is involved with the family and what we are worried may happen in the future.
- The purpose of these tools is to help *shared understanding* with the family and network regarding worries around the parent(s)' behavior and impact on the child, and also help focus the safety plan and/or case plan on the factors affecting the child's safety.
- Harm and Danger Statements are developed through the process of Safety Mapping in a Child and Family Team (CFT) meeting with a family and their network. Through this process, it is important to separate Harm and Danger from Complicating Factors.

HARM STATEMENT

- The Harm Statement describes in simple, behaviorally specific language the actions (or inactions) of the caregiver, and impact on the child, that brought the family to the attention of child welfare.

HARM STATEMENT ELEMENTS (PAST)



Harm Statements are about what already happened.

TERM	DEFINITION
HARM	Actual experiences of past/current harm to a child by a caregiver.
DANGER	Worries that the caregiver's behavior may cause harm to the child in the future.
COMPLICATING FACTORS	Things we are worried about but are not actual harm to the child by the caregiver.
SAFETY	Acts of protection by the caregiver demonstrated over time.
SUPPORTING STRENGTHS	Positive things in a family's life that do not specifically address the danger.

- There is not always a direct past impact on the child, even though what happened may be very worrisome. For example, mom passed out while the baby was in the crib, but the baby was fine. In these cases, you can create a Danger Statement alone, and/or create a Harm Statement that addresses how a parent's actions or inactions *could* have impacted the child. Sometimes parents are reluctant to agree to a Harm Statement in these situations; in that case, you can let it go and create a Danger Statement.

DANGER STATEMENT

- The Danger Statement is a clear, specific description of a parent's possible future behavior that may impact the child moving forward.
- The Danger Statement focuses on what we're worried will happen in the future if the parent's behavior does not change.
- The Danger Statement contains three parts: who is worried (possibly including the caregiver), the potential behavior (action/inaction) by the caregiver, and potential impact on the child.

DANGER STATEMENT ELEMENTS (FUTURE)

Danger Statements are worries about the future.

RISK STATEMENT

- The Risk Statement, developed by Sue Lorhbach, is similar to a Danger Statement but does not include who is worried, and adds context. Context is under what circumstances (who, what, when, where, how) the risk to the child may be present.
- The format of a Risk Statement is: **[Child's name] may be [risk] should [context].** For example: "Johnny may be seriously physically hurt should his dad get drunk and hit him on the back with a belt again."

DEVELOPING HARM & DANGER/RISK STATEMENTS

- Harm and Danger Statements should align with the safety threats identified on the SDM Safety Assessment tool, or if no safety threats were identified, the area(s) on the SDM Risk Assessment tool that we are worried will cause future danger to the child.
- Developing a provisional or "working" version of the Harm Statement can begin with the first phone call to the intake hotline, which is helpful in clarifying what is being reported about the parent's behavior and impact

on the child. However, the true Harm and Danger Statements that will be used throughout a referral or case must be developed with the family and their Safety Network.

Intake/Screening

- To develop a provisional Harm Statement, ask thorough questions to identify the parent's behavior and if there was impact on the child. For example, if the caller says the mother is "mentally ill" or "using drugs," how do they know this? What does her behavior look like? What is the impact on the child?
- Does the caller know if there has ever been a time that the problem was not happening for the family? What did the parent's behavior look like during that time?
- Are there other things the caller is worried about in the family, but which are not harm or danger to the child (i.e., complicating factors)?
- Include a provisional Harm Statement in the Screener Narrative and specify Complicating Factors identified.

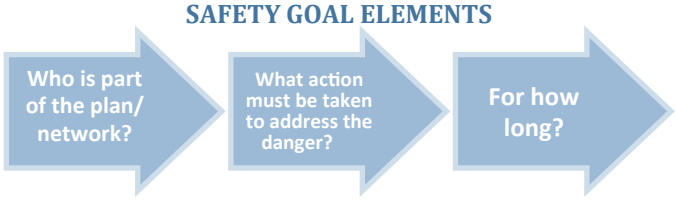
Investigating Social Worker

- After Intake has developed a working Harm Statement, the investigating social worker should schedule a CFT meeting to complete Safety Mapping and develop the true Harm and Danger Statements with the family and their network. *See SOP Quick Guide: Safety Mapping.*

SAFETY GOALS

- Safety Goals are developed from the Harm and Statements; they are clear statements, usually a few sentences long, about what actions the parent(s) or caregiver(s) will take, with the support of their network, to help everyone involved with the family know that the child will be safe.

SAFETY GOAL ELEMENTS



USE IN PLANS & COURT REPORTS

Safety Plans

- In the safety plan, state the Harm and Danger Statements and Safety Goal developed with the family.
- Use the Harm and Danger Statements and Safety Goal to develop a behaviorally-based safety plan with the family and their network. *See SOP Quick Guide: Safety Planning.*

Case Plans

- In the case plan, state the Harm and Danger Statements that were developed with the family, as well as the Safety Goal.
- Use the Harm and Danger Statements and Safety Goal to develop a behaviorally-based case plan with the family and their network. *See SOP Quick Guide: Behaviorally-Based Case Plans.*

Court Reports

- In the court report, document the Harm and Danger Statements that were developed with the family, as well as the Safety Goal.
- Discuss the parent(s)' progress toward the Safety Goal, using behaviorally-based language to explain your assessment of how they are or are not meeting the goal.

SAMPLE HARM STATEMENT, DANGER STATEMENT & SAFETY GOAL

Harm Statement	Danger Statement	Safety Goal
Dad punched mom in the face and stomach and tried to strangle her against a wall while she was holding the baby and 5-year-old Jeremy was in the room. Jeremy was terrified and told the police he thought his mom was going to die. Jeremy reported his dad calls his mom bad names and it makes him sad.	CWS, mom and grandma are worried that dad will hit, strangle or otherwise hurt mom in the future, and that the baby or Jeremy will get hurt when dad hurts mom; that the baby and Jeremy could have their brain development and well-being affected by watching their dad verbally or physically abuse, hit or strangle their mom; or that dad could even kill mom and the children will be left without their mother.	Dad will work with a network of family, friends and professionals to create a plan and show everyone that: • He understands the impact of witnessing violence on his children and will ensure they are never exposed to it again. • He will always refrain from hitting mom, choking her, or using any other forms of violence. • He will always co-parent with mom in ways that are respectful and polite, and never use name-calling or put-downs. Mom will work with a network of family, friends and professionals to create a plan and show everyone that: • She understands why she stayed in a relationship where there was violence, how to identify signs of violence, the impact on her children of witnessing violence, and how to keep herself and her children safe from exposure to violence in the future. • She will reach out to her support people to help her accept her feelings about being by herself and parenting separately. CWS will need to see this plan in place and working continuously for at least 6 months to reassess whether to recommend shared custody with dad.

Note: Use the parents' actual names, not "mom" or "dad," in the Harm Statement, Danger Statement and Safety Goal

SAFETY MAPPING

NORTHERN CALIFORNIA TRAINING ACADEMY

SUMMARY

Safety mapping is the process of examining, as a team, the worries (harm and risk/danger), what's working well, and what needs to happen next to ensure the safety of a child or youth in the care of their parent or caregiver.

PURPOSE

- The purpose of Safety Mapping is to develop shared understanding between CWS, the family, and others regarding worries about child safety, what's working well, and what needs to happen next on a referral or case.
- Through Safety Mapping, we work with a family and their network to develop Harm and Risk (also known as Danger) Statements, Safety Goals and next steps/plans to work toward achieving those goals.
- Preliminary Safety Mapping — which is more accurately *case consultation* — can occur with only agency staff to provide clarity about a referral or case, using the Consultation and Information Sharing Framework®.
- True Safety Mapping takes place with a family and their Safety Network in the context of a Child and Family Team (CFT) meeting with the family and their natural supports.
  - Without the family and their network present, key information will always be missing, and decision-making will be based on assumptions, inferences and incomplete facts.
  - Having the family and their network present is necessary to reduce implicit bias and ensure outcomes for children that best ensure safety, permanency and well-being.
  - Children/youth can participate in CFT meetings for Safety Mapping if appropriate to their age and development.
- Prior to conducting a Safety Mapping, ideally you will have completed:
  - The Three Houses and/or Safety House with the child to incorporate their voice into the CFT worries, working well and next steps.
  - The Circles of Support/Safety Circles process with the family to identify who should be part of the CFT meeting and become part of the Safety Network.

MAPPING WITH FAMILIES

- To document the Safety Mapping process, you can use the Consultation and Information Sharing Framework or the 4-quadrant mapping, which addresses harm/danger, complicating factors, acts of protection and supporting strengths (see diagram at upper right).
- Begin the Safety Mapping meeting by defining terms for the family, including:

Worries?	What's Working?	Next Steps?
Harm and Risk/ Danger	Safety (Acts of Protection)	What the family and Agency want to see happen and the network members agree to
Complicating Factors	Supporting Strengths	

  - **Harm** = Actual experiences of past/current harm to a child by a caregiver.
  - **Risk/Danger** = Worries that the caregiver's behavior may cause harm to the child in the future.
  - **Complicating Factors** = Things that worry us but are not harm to the child by the caregiver.
  - **Safety** = Acts of protection by the caregiver demonstrated over time.
  - **Supporting Strengths** = Things in a family's life that are positive but do not specifically address the danger or risk.
- Use the SOP Meeting Dialogue Structure (shown below) to guide the meeting flow:
  - Clearly define the **purpose** of the specific meeting; for example, "We are meeting to determine if a safety plan can be put in place that would allow the children to remain safely at home."
  - Set **group agreements** with the team about how they want to work with each other. This can be a brief process of just 2-3 minutes.
  - Discuss who is not present who should be part of the **Safety Network,** and who will reach out to them after the meeting.
  - Specify the **outcome** you hope to achieve, such as a decision, a safety plan or a case plan.

SOP MEETING DIALOGUE STRUCTURE

PURPOSE	Overall, why are we meeting today?
CONTEXT	Is there anything that might pull our attention away from our focus today?
GROUP AGREEMENTS	How do we want to work with each other?
NETWORK/ STAKEHOLDERS	Is everyone here who should be here? If not, what should we do to get them here?
DESIRED OUTCOME	What do we want to walk away with from this meeting (plan, decision, etc.)?
CONTENT	What are we worried about, and what's working well?
NEXT STEPS	What steps do we need to take? Who does what? By when? Next meeting date?
+/Δ FEEDBACK	What worked? What should we do differently next time?

- Use the Three Questions to focus on worries about why the family is involved with CWS:
  - What are we worried about?
    - Harm
    - Risk/danger
    - Complicating factors
  - What's working well?
    - Safety/acts of protection
    - Supporting strengths
  - What needs to happen next?
    - Safety plan or case plan with action steps
    - Next meeting date
- With the team, sort the "working well" into safety and supporting strengths.
- Sort the worries into harm, risk/danger or complicating factors.
- Create a Harm Statement, a Risk Statement (also known as a Danger Statement), and Safety Goal(s).

HARM STATEMENT

- Use the worries related to the parent(s)' past behavior and impact on the child to craft the Harm Statement with the family and their network.
- The Harm Statement is a clear, specific description of the parent's behavior and the negative impact on the child as a result. It includes *who reported the concern* (unless this violates reporting party confidentiality), *what happened specifically regarding the parent(s)' behavior*, and *impact on the child*.
- When you have come up with a working Harm Statement, scale agreement of the team about it and make any adjustments as needed.

RISK OR DANGER STATEMENT

- Use worries related to possible future behavior that may impact the child to craft the Risk Statement or Danger Statement.
- The Risk/Danger Statement addresses *who is worried* about what *future behavior by the parent* and its possible *impact on the child*.
- Scale with the team for agreement regarding the Risk/ Danger Statement and make adjustments as needed.

ROLE OF THE WORKER

If you are the assigned social worker and you are not facilitating the meeting, you still have a critical role to play in the Safety Mapping process. It is important that you are:

***CLEAR**—Use language the family can understand, and check in with them to gauge understanding*

***DIRECT**—Be very transparent with the family about why CWS is involved, what the harm was and what worries you have about future risk and danger*

***TRAUMA-INFORMED**—Use a trauma lens in your interactions with the child, youth and parents during the meeting, and in your assessment of why the parent caused the neglect or abuse*

***SELF-AWARE**—Be mindful of your level of engagement in the meeting and with the family, your nonverbal communication, and the possibility for implicit bias*

SHARED AGREEMENT

Safety Mapping is about reaching a place of mutual understanding, not necessarily mutual agreement. Every member of the team may not agree with every piece (Harm Statement, Risk/Danger Statement, etc.). This is OK, because insight and safety are not the same thing.

The goal is to develop shared understanding of the worries, what's working well, and next steps. While acceptance of responsibility is preferable, it is neither necessary nor sufficient to create safety. Even if agreement can't be achieved about the harm/danger and what caused it, families and parents can still work toward providing safety for their children. Additionally, parental acceptance of responsibility does not in and of itself ensure safety.

SAFETY GOAL

- Work with the family and their network in the CFT meeting to develop the Safety Goal, which is what the future will look like with regard to the parent's behavior that will keep the child safe.
- Incorporate the child's voice into the Safety Goal, either by having them present, if appropriate to their age and development, or by using the Three Houses or Safety House, completed before the meeting.
- The Safety Goal should be behaviorally specific and describe what the parent, with the support of their network, will be doing to ensure child safety.
- Scale with the team their level of confidence that the Safety Goal, if achieved, would be sufficient to ensure safety of the child.
  - Make any adjustments to the Safety Goal as needed until all team members feel very confident that it would ensure safety.

SAFETY OR CASE PLANNING

- Depending on the purpose of the specific meeting, work with the team to develop behaviorally-based objectives for either a safety plan (short-term plan to address immediate safety threats) or case plan (longer-term plan to address behavior change over time) to meet the Safety Goal.
- If a decision is made that the child(ren) must be removed, discuss with the team how this can happen in the best way to minimize trauma to the child.

ENDING THE MAPPING

- Do a "plus/delta" process with the team, asking what worked well and what should be different next time.
- Whenever possible, schedule your next CFT meeting with the team when wrapping up the current meeting.

SEE ADDITIONAL SOP QUICK GUIDES FOR MORE INFORMATION:

- BEHAVIORALLY-BASED CASE PLANS
- CONSULTATION & INFORMATION SHARING FRAMEWORK
- HARM & RISK/DANGER STATEMENTS
- SAFETY PLANNING

CHILD & FAMILY TEAM MEETINGS

NORTHERN CALIFORNIA TRAINING ACADEMY

SUMMARY

Child and Family Team (CFT) meetings are a primary intervention in Safety Organized Practice. CFT meetings are the process of bringing together the family and their network for a specific purpose in order to develop a plan to address worries and next steps.

SOP AND CFT MEETINGS

- A foundational principle of Safety Organized Practice (SOP) is that teaming with a family and building their network are necessary, critical practices to ensure child safety, permanency and well-being.
- Another core principle of SOP is that the person who caused the harm or danger to the child cannot ensure child safety on their own until they have demonstrated acts of protection over a sufficient period of time; therefore, a network of other adults who care about the child is needed to help ensure safety.
- Child and Family Team (CFT) meetings — also known as CFTMs, Family Team Meetings, or SOP family meetings — are a process of bringing together the child/youth, parent(s) or other caregiver(s), and the family's network/ team for a specific purpose in order to discuss what's working well, worries and next steps.

WHEN SOP CFT MEETINGS OCCUR

- A common misunderstanding is that SOP CFT meetings are specifically for the process of Safety Mapping; however, this is only one way in which an SOP CFT meeting can be used. Some ways and case decision points at which CFT meetings can be used include:
  - **Safety Mapping:** The process of working with a family and their network to develop Harm and Risk/ Danger Statements, Safety Goals and next steps/ plans to work toward achieving those goals.
  - **Emergency Removal:** Bringing together the family and their network after law enforcement has removed a child to determine if there is any way the child may be returned home safely.
  - **Imminent Risk of Removal:** Bringing together the family and their network when it appears removal may be necessary, in order to determine if there is any plan that can keep the child safe in the care of his/her parents.
  - **Safety Planning:** Developing a short-term plan to keep children safe in the care of their parents during an Emergency Response investigation; this may be part of an Emergency Removal or Immediate Risk of Removal CFT meeting.
  - **Case Planning:** Developing the family's case plan in a Voluntary or Court-Ordered Family Maintenance (FM) case, Family Reunification (FR) case, or Permanency Planning (PP) case.

SOP CFT MEETING DIALOGUE STRUCTURE

PURPOSE	Why specifically are we meeting today?
CONTEXT	Is there anything that might pull our attention away from our focus today?
GROUP AGREEMENTS	How do we want to work with each other?
NETWORK/ STAKEHOLDERS	Is everyone here who should be here? If not, what should we do to get them here?
DESIRED OUTCOME	What do we want to walk away with from this meeting (plan, decision, etc.)?
CONTENT	Related to our purpose, what are we worried about, and what's working well?
NEXT STEPS	What steps do we need to take? Who does what? By when? Next meeting date?
+/Δ FEEDBACK	What worked? What should we do differently next time?

  - **Planning with Youth:** With the youth and their team, developing the Transitional Independent Living Plan or, for non-minor dependents, the Transitional Independent Living Case Plan.
  - **Preventing Placement Disruptions:** Bringing together the child/youth, their caregiver and the network/team to develop a plan for intensive supports to help stabilize a placement.
  - **Planning for Unsupervised Visits:** Developing a safe plan with the family and their network when moving from supervised to unsupervised visits.
  - **Planning for Transition Home:** Developing a safe plan with the family and their network when a child is moving from FR to FM.
  - **Developing Aftercare Plans:** Bringing together the family and their network to develop an aftercare plan that the network will implement in an ongoing manner after the case is closed.
  - **Addressing Needs of Children/Youth:** Planning for additional services and supports when children or youth have behavioral health, educational, placement or other needs.
  - **Permanency Roundtable:** Bringing together a child's/youth's team to focus on identifying and securing a permanent plan for the child/youth.
  - **Other:** Any other specific purpose when there is a worry that needs to be addressed by the family and network/team.

MEETING PARTICIPANTS

- The quality of the network or team you build is vital to a successful CFT meeting process. Use tools such as genograms, ecomaps and the Circles of Support/Safety Circles with the parents, child and extended family to identify who should be part of the CFT meeting and become part of the network/team.

- Offer children and youth the chance to attend CFT meetings, as appropriate to age and development.
  - If the child/youth does not want to participate, complete the Three Houses and/or Safety House with the child to incorporate their voice into the worries, working well and next steps at the CFTM.
- For families in Emergency Response referrals or FM/FR cases, work with the parent and child/youth to identify and select CFT meeting participants. Skilled engagement with parents can almost always result in their willingness to include necessary team members, even if they are initially reluctant and afraid to do so.
- For youth in Permanency Planning or Extended Foster Care, work with the youth to identify and select CFT members. They may wish to include important adults, friends, or their boyfriend/girlfriend on their team.

POTENTIAL CHILD & FAMILY TEAM MEMBERS

Child/youth	Social worker	Family's neighbors
Mom	Child's clinician	Family friends
Dad	Child's teacher	Youth's friends
Siblings	Child's resource parent	Parent's sponsor
Tribe	Child's CASA	Parent's clinician
Parent's significant other	Youth's significant other	Parent's substance abuse counselor
Extended family (aunts, uncles, grandparents)	Child's/youth's mental health case manager	Other individuals important to the family

Note: *This is not an exhaustive list; anyone important to a child or family should be invited to be part of the CFT.*

MEETING STRUCTURE & DOCUMENTATION

- Use the SOP Meeting Dialogue Structure *(previous page)* to guide the agenda and flow of any CFT meeting.
- Be clear about the specific purpose of a given meeting and develop next steps related to that purpose.
- Use the Three Questions with the team, related to the specific purpose of the meeting:
  - What are we worried about?
  - What's working well?
  - What needs to happen next?
- For meetings to address concerns around child safety, use the Safety Mapping process (Harm/Danger, Complicating Factors, Safety, Supporting Strengths) or the SOP CFT Meeting Framework to map and document the meeting.
- Always address the child's behavioral health, placement and other needs as part of the meeting to meet State mandates around CFTs *(see column at right)*.
- Document CFTMs that meet the State mandates in CWS/CMS using the instructions provided in All County Letter (ACL) 17-104.
- CFT meetings should happen as often as needed to check on the plan, ensure the network is following through, revisit child safety, and address new needs.

CALIFORNIA STATE MANDATES FOR CFT & CANS

Child and Family Teams (CFT) are a State-mandated practice for developing a child and family team plan around all needs related to a child/youth and family while the child is in foster care. The intention for the CFT process is integration of care across practice models, services, strategies and plans.

SOP provides a toolkit and strategies to meet State CFT mandates. Both SOP and CFT involve developing a team that includes the child/youth, family, their natural supports, the agency, the tribe, and appropriate service providers (including behavioral health providers), with the purpose of identifying and meeting the needs of the child/youth and family to ensure safety, permanency and well-being for the child/youth.

CFT meetings easily function as SOP meetings when SOP language, structure and strategies are utilized. SOP meetings can meet the CFT mandate if requirements are met in three areas:

1. **Required Participants**
   To meet CFT requirements, team members must include the child/youth, family, social worker, child's current caregiver, tribe, Foster Family Agency social worker and/or Short-Term Residential Therapeutic Program (STRTP) representative, as well as behavioral health staff when the child is receiving or may need specialty mental health services (SMHS), including Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), or Therapeutic Foster Care (TFC).
2. **Meeting Timing/Frequency**
   CFT meetings must occur:
   - Within 60 days of the child's placement in foster care
   - Every 90 days for youth receiving ICC, IHBS or TFC
   - Every six months with case plan creation for youth not receiving SMHS
   - For possible placement changes
   - As frequently as needed to address needs of the child/youth, including the need for new or increased SMHS
3. **Focus on the Child/Youth's Needs**
   CFT meetings must include specific discussion regarding the placement, behavioral health and other needs of the child/youth, and a plan to meet those needs. The Child and Adolescent Needs and Strengths (CANS) must be completed in partnership with the Child and Family Team and used to inform the case plan.

SOP & CANS
The SOP CFT meeting process provides an organic, family-friendly way to complete the CANS. At the first CFTM, the information you gather about the needs and strengths of the child, parent and caregiver will enable completion of a draft CANS tool. Bring the draft CANS to the subsequent CFTM at which the case plan will be developed, and ensure case plan objectives are developed for the priority needs identified on the CANS, supported by the youth's strengths and parent or caregiver resources.

Summary
Counties can meet the mandates of CFT within the SOP framework by creating policies for SOP child and family team meetings that are consistent with the requirements of CFT mandates regarding timing, participants, child-focused planning and the CANS.

CHILD & FAMILY TEAM MEETING MAPS

The Safety Organized Practice Child and Family Team (CFT) Meeting Maps are intended as a prompt for best practice in completing a variety of team-based approaches in child welfare, including formal facilitated CFT meetings with children, youth, families and their networks; informal Safety Mappings with families in their homes; and in-office referral/case staffings, including group supervision and Review, Evaluate, Direct (RED) Teams.

The Maps align the overall guiding Three Questions of SOP (What are we worried about? What's working well? What needs to happen next?) with information covered in the Consultation and Information Sharing Framework developed by Sue Lohrbach, while also adding a specific focus on the child's needs and strengths to bring the Child and Adolescent Needs and Strengths (CANS) into the process.

While the amount of information included in the Maps may look overwhelming, the intent is not that the facilitator cover this line by line in the meeting, but rather that the Maps serve as a prompt for best practice to help facilitators, social workers and supervisors attend to what should be covered as part of each CFT meeting. Because different stages of a referral or case necessitate a focus on different issues to be discussed (either in internal agency staffings or at the CFT meeting by the child/youth, family and their people), there are three parallel yet distinct Maps to be used as a referral/case moves through the system, described below.

Emergency Response

The ER CFT meeting map focuses on the safety-related reasons that a family came to the attention of Child Welfare. Its primary purpose is to sort harm, danger, complicating factors, safety and supporting strengths; develop Harm and Danger Statements and the Safety Goal; and guide development of a safety plan to keep a child safely at home, or if this is not possible, an initial action plan for what happens next. The ER map may be used for:

- Case staffing (social worker, supervisor and other internal staff) or group supervision
- RED Teams (a collaborative decision-making process for hotline referrals)
- Safety Mapping with a family and their network ("kitchen table mapping")
- Front-end ER CFT meetings (i.e., what may have previously been called TDMs) to bring together the family and their network to attempt to safety plan to keep a child at home with the support of a network, or to address placement if a child must be separated because no plan can be created to keep them at home safely.

Family Maintenance/Family Reunification

The FM/FR CFT meeting map can be used in voluntary or court-ordered Family Maintenance cases and in Family Reunification cases. Its primary purpose is to explore current worries/working well and develop a case plan or other action plan based on current needs. The FM/FR map may be used for:

- Case staffing (social worker, supervisor and other internal staff) or group supervision
- CFT meeting to develop or revise the case plan (incorporating CANS)
- CFT meeting to address a child's change of placement (or to work to prevent change of placement)
- CFT meetings to plan transition to unsupervised visits, child's transition home, or FM case closure

Permanency Planning/Non-Minor Dependent

The PP/NMD CFT meeting map shifts the focus from safety to other permanency and well-being issues. Safety is still included as a potential topic, because youth may have self-safety issues such as cutting, running away, CSEC, substance use, etc., and also because at times there can be safety concerns for youth in the care of resource parents. The PP/NMD map may be used for:

- Case staffing (social worker, supervisor and other internal staff) or group supervision
- CFT meeting to develop or revise the case plan (incorporating CANS) or TILP (as age-appropriate)
- CFT meeting to address a child's/youth's change of placement (or to work to prevent change of placement)
- 90-Day Transition Plan meeting for NMDs exiting care

Back to table of contents

CHILD & FAMILY TEAM (CFT) MEETING MAP – EMERGENCY RESPONSE

Meeting Type: ☐ Case Consultation ☐ RED Team ☐ Safety Mapping w/Parent(s) ☐ Emergency Removal CFTM ☐ Risk of Removal CFTM ☐ Other: _____

Meeting Purpose/ Focus: What is our intended outcome of today's meeting or consultation? What do we hope to achieve by the end of the meeting?

Complete genogram, ecomap, Circles of Support as appropriate.

WHAT ARE WE WORRIED ABOUT/NEEDS?	WHAT'S WORKING WELL/STRENGTHS?	WHAT NEEDS TO HAPPEN NEXT?
Reason for Referral/Harm • Detail re: incident(s) bringing the family to the attention of the agency, specifically the parents' behavior and impact on the child(ren) • Pattern or history of similar worries • Results of SDM Hotline Tool (for RED Team) or Safety Assessment (for CFT meeting; specify safety threats) • Create a Harm Statement with the team if applicable **Danger** *(informs draft CANS)* • Worries about future danger to child(ren) (parents' behavior that may impact the child) • Create Danger Statement with the team if applicable **Complicating Factors** *(informs draft CANS)* • Things that are challenging for the family but that are not harm or danger to the child • SDM Risk Assessment risk factors & risk level • Presence of other research-based risk factors (young or single parent, parenting stress, poverty, social isolation, poor parent-child relationships) **Needs of Child/Youth** *(informs draft CANS)* • Discuss • Age 0-5: Behavioral/Emotional, Family Funct., Early Educ., Social/Emotional, Developmental, Medical, Risk Bx/Factors, Perinatal, Cultural, Dyadic, ACEs • Age 6+: Behavioral/Emot., Life Funct., Social Funct., Placement, Educ., Medical, Risk Bx, Cultural, ACEs • Assessments completed (Regional Ctr., MH, CSEC) • Placement/presumptive transfer issues	**Safety** *(informs draft CANS)* • Current or past safety, defined as acts of protection demonstrated over time by the parent(s) or a network member • Pattern or history of exceptions to worries **Supporting Strengths** *(informs draft CANS)* • Circumstances, resources, cultural supports, parent capacities that are good but do not ensure safety • Research-based protective factors (parental resilience, knowledge of parenting/child development, social connections, concrete support in times of need, children's social & emotional competence) **Safety/Support Network** • Individuals who can help ensure child safety • Other supports to the family, child or youth • How the network has helped protect in the past • Who is a resource for relative/NREFM placement • Family finding/Circles of Support • If removal, discussion of concurrent planning **Strengths of Child/Youth** *(informs draft CANS)* • Age 0-5: Family Strengths, Interpersonal, Natural Supports, Resiliency, Relationships Permanency, Playfulness, Family Spiritual/Religious • Age 6+: Family Strengths, Interpersonal, Educational Setting, Talents/Interests, Spiritual, Cultural Identity, Community Life, Natural Supports, Resiliency	**Shared Vision/Safety Goal** • What the parents' behavior will look like so that we know the child is safe over time • Short-term safety goal, if a Safety Plan is put in place **Gray Area** *(create flip chart if needed)* • Incomplete information • Things we are speculating about or making up • Inferences, assumptions and possible biases • Questions we need to answer • Also create Parking Lot flip chart if needed to capture off-topic issues that need follow-up **BRAINSTORMING/IDEAS** • Ideas around next steps • Avoid reality-testing ideas at this point; just get everyone's ideas for what could/should happen **NEXT STEPS/ACTION PLAN** • Next steps needed to address the risk/danger • Safety Plan (involving the support of the Network) if there is a current SDM safety threat and a plan is able to be developed that can address the safety threat and keep the child safely at home • If it is not possible to create a Safety Plan that will mitigate the safety threat, next steps should address possible placement with relatives/NREFMs • Specify what action steps, who, timeframes, etc. • Next meeting date

For parents, document where appropriate under Danger, Complicating Factors, Safety and Supporting Strengths their Needs and Resources related to: Supervision, Involvement with Care, Knowledge, Social Resources, Residential Stability, Medical, Mental Health, Substance Use, Developmental, Safety [and for kids 0-5, Family Rel. to System, Legal Involvement, Organization]

1 2 3 4 5 6 7 8 9 10

Scale for Safety: 1 = Safety Plan Needed, 10 = Safe Enough to Close | Scale family's willingness, confidence and/or capacity to follow the plan.

CHILD & FAMILY TEAM (CFT) MEETING MAP – EMERGENCY RESPONSE

Meeting Type: ☐ Case Consultation ☐ RED Team ☐ Safety Mapping w/Parent(s) ☐ Emergency Removal CFTM ☐ Risk of Removal CFTM ☐ Other:

Meeting Purpose/ Focus: What is our intended outcome of today's meeting or consultation? What do we hope to achieve by the end of the meeting?

Complete genogram, ecomap, Circles of Support as appropriate.

WHAT ARE WE WORRIED ABOUT/NEEDS?	WHAT'S WORKING WELL/STRENGTHS?	WHAT NEEDS TO HAPPEN NEXT?
Reason for Referral/Harm	**Safety** *(informs draft CANS)*	**Shared Vision/Safety Goal**
Danger *(informs draft CANS)*	**Supporting Strengths** *(informs draft CANS)*	**Gray Area** *(create flip chart if needed)*
Complicating Factors *(informs draft CANS)*	**Safety/Support Network**	**BRAINSTORMING/IDEAS**
Needs of Child/Youth *(informs draft CANS)*	**Strengths of Child/Youth** *(informs draft CANS)*	**NEXT STEPS/ACTION PLAN**

For parents, document where appropriate under Danger, Complicating Factors, Safety and Supporting Strengths their Needs and Resources related to: Supervision, Involvement with Care, Knowledge, Social Resources, Residential Stability, Medical, Mental Health, Substance Use, Developmental, Safety [and for kids 0-5, Family Rel. to System, Legal Involvement, Organization]

1 2 3 4 5 6 7 8 9 10

Scale for Safety: 1 = Safety Plan Needed, 10 = Safe Enough to Close | Scale family's willingness, confidence and/or capacity to follow the plan.

Back to table of contents

CHILD & FAMILY TEAM (CFT) MEETING MAP – FAMILY MAINTENANCE/FAMILY REUNIFICATION

Meeting Type: ☐ Case Consultation ☐ Case Planning CFTM ☐ Placement CFTM ☐ Transition Home CFTM ☐ Case Closure CFT ☐ Other: _____

Meeting Purpose/Focus: What is our intended outcome of today's meeting or consultation? What do we hope to achieve by the end of the meeting?

Meeting Met Statutory Requirements for CFT: ☐ Yes ☐ No *Complete genogram, ecomap, Circles of Support as appropriate.*

WHAT ARE WE WORRIED ABOUT/NEEDS?	WHAT'S WORKING WELL/STRENGTHS?	WHAT NEEDS TO HAPPEN NEXT?
Current Worries that Need to Be Addressed • Worries that need to be addressed in the case plan or transition plan • Include child's/youth's perspective on worries **Harm & Danger** • Develop harm/danger statement(s) if not yet done • Any new worries about harm, danger or risk • Unresolved or new safety threats • Parent CANS Caregiver Needs that rise to the level of harm or danger **Complicating Factors** • Things that are challenging for the family, child or youth but that are not harm or danger • Current risk level from SDM Risk Reassessment • Parent CANS Caregiver Needs that are complicating factors **Needs & Strengths to Build of Child/Youth (CANS)** • Discuss needs and worries for the child/youth • Discuss CANS items that are Needs and Strengths to Build of the youth and identify Target Needs & Anticipated Outcomes • Other assessments completed (Regional Ctr., MH, CSEC) • Level of Care considerations (physical, behavioral/ emotional, educ., health, permanency/family) • Placement/presumptive transfer issues	**Safety** • Acts of protection or protective behaviors by the parent(s) demonstrated over time • Parent's resources from Caregiver Resources on CANS if they rise to the level of safety/acts of protection **Supporting Strengths** • Positive things, resources, assets, capacities that are good but do not ensure safety • Cultural supports, traditions • Parent's and/or caregiver's Caregiver Resources from CANS that do not rise to level of safety **Safety/Support Network (Child & Family Team)** • Individuals who can help ensure safety • Other supports to the child, youth and/or family • Who in the Child & Family Team can support the child, youth and family in meeting goals of the plan • Relative/NREFM placement & connection • Concurrent planning **Strengths of Child/Youth (CANS)** • Note CANS items that are strengths of the youth and discuss whether/how they should be brought into planning	**Shared Vision/Safety Goal/Well-Being Goal** • Create Safety Goal, if not previously done: What the parent's behavior will look like so that we know the child is safe and can return home or so the case can close (shared vision for parents' behavior; ties to needs/strengths from CANS) • Create well-being goals for child/youth (shared vision of their positive future; ties to needs/strengths from CANS) **Gray Area** *(create flip chart if needed)* • Incomplete information • Things we are speculating about • Inferences, assumptions and possible biases • Questions we need to answer • Also create Parking Lot flip chart if needed to capture off-topic issues that need follow-up **BRAINSTORMING/IDEAS** • Ideas around next steps • Avoid reality-testing ideas at this point; just get everyone's ideas for what could/should happen **NEXT STEPS/ACTION PLAN** • Next steps, including behaviorally-based case plan objectives, to address the worries/safety concerns and the child/youth, parent and caregiver needs and strengths identified by CANS & CFT • Specify what, who, by when, etc. • Next CFT meeting date

NOTE: For parents, document where appropriate (Harm & Danger, Complicating Factors, Safety, Supporting Strengths) their Needs & Resources related to: Supervision, Involvement with Care, Knowledge, Social Resources, Residential Stability, Medical/Physical, Mental Health, Substance Use, Developmental, Safety (and for kids 0-5, Family Rel. to System, Legal Involvement, Organization)

1 2 3 4 5 6 7 8 9 10

Scale any of the following: current safety; readiness for next steps (transition or closure); participants' willingness, confidence and/or capacity to follow the plan.

CHILD & FAMILY TEAM (CFT) MEETING MAP – FAMILY MAINTENANCE/FAMILY REUNIFICATION

Meeting Type: ☐ Case Consultation ☐ Case Planning CFTM ☐ Placement CFTM ☐ Transition Home CFTM ☐ Case Closure CFT ☐ Other:

Meeting Purpose/Focus: What is our intended outcome of today's meeting or consultation? What do we hope to achieve by the end of the meeting?

Meeting Met Statutory Requirements for CFT: ☐ Yes ☐ No *Complete genogram, ecomap, Circles of Support as appropriate.*

WHAT ARE WE WORRIED ABOUT/NEEDS?	WHAT'S WORKING WELL/STRENGTHS?	WHAT NEEDS TO HAPPEN NEXT?
Current Worries that Need to Be Addressed	**Safety**	**Shared Vision/Safety Goal/Well-Being Goal**
Harm & Danger	**Supporting Strengths**	**Gray Area** *(create flip chart if needed)*
Complicating Factors	**Safety/Support Network (Child & Family Team)**	**BRAINSTORMING/IDEAS**
Needs & Strengths to Build of Child/Youth (CANS)	**Strengths of Child/Youth (CANS)**	**NEXT STEPS/ACTION PLAN**

NOTE: For parents, document where appropriate (Harm & Danger, Complicating Factors, Safety, Supporting Strengths) their Needs & Resources related to: Supervision, Involvement with Care, Knowledge, Social Resources, Residential Stability, Medical/Physical, Mental Health, Substance Use, Developmental, Safety (and for kids 0-5, Family Rel. to System, Legal Involvement, Organization)

1 2 3 4 5 6 7 8 9 10

Scale any of the following: current safety; readiness for next steps (transition or closure); participants' willingness, confidence and/or capacity to follow the plan.

Back to table of contents

CHILD & FAMILY TEAM (CFT) MEETING MAP – PERMANENCY PLANNING/NON-MINOR YOUTH

Meeting Type: ☐ Case Consultation ☐ Case Planning CFT ☐ Placement CFT ☐ 90-Day Transition CFT ☐ Other: _____

Meeting Purpose/ Focus: What is our intended outcome of today's meeting or consultation? What do we hope to achieve by the end of the meeting?

Meeting Met Statutory Requirements for CFT: ☐ Yes ☐ No *Complete genogram, ecomap, Circles of Support as appropriate.*

WHAT ARE WE WORRIED ABOUT/NEEDS?	WHAT'S WORKING WELL/STRENGTHS?	WHAT NEEDS TO HAPPEN NEXT?
Current Worries that Need to Be Addressed • Worries that need to be addressed in the case plan, transition plan, placement decision, etc. **Permanency/Independence/Belonging/Safety** • Barriers to permanency, connection and belonging, or finalization of permanent plan • Any worries about youth's self-safety or community safety • Concerns about placement stability • Caregiver (Resource Parent) CANS Needs **Complicating Factors** • Things that are challenging for the child/youth or family but that are not affecting permanency, belonging or safety • Impact of past trauma on the youth • Caregiver (Resource Parent) CANS Needs **Needs & Strengths to Build of Child/Youth (CANS)** • Discuss needs and worries for the child/youth • Discuss CANS items that are Needs and Strengths to Build of the youth and identify Target Needs & Anticipated Outcomes • Other assessments done (Reg. Ctr., MH, CSEC) • Level of Care considerations (physical, behavioral/ emotional, educ., health, permanency/family) • Placement/presumptive transfer issues	**Permanency/Independence/Belonging/Safety** • Permanency, connection and belonging for the child/youth • Youth's self-safety and community safety, if applicable **Supporting Strengths** • Positive things, resources and capacities that are good but do not ensure permanency, connection, belonging or self-safety • Cultural supports, traditions • Caregiver (Resource Parent) CANS Resources **Safety/Support Network (Child & Family Team)** • Individuals in the Child and Family Team or others who can support the youth's plan and goals **Strengths of Child/Youth (CANS)** • Note CANS items that are strengths of the youth and discuss whether/how they should be brought into planning	**Shared Vision/Well-Being Goal** • Shared vision for well-being of the child/youth, including permanency, connection, belonging, independence, and/or self-safety goals; also address vision for any caregiver needs • Ties to needs/strengths from CANS **Gray Area** *(create flip chart if needed)* • Incomplete information • Things we are speculating about • Inferences, assumptions and possible biases • Questions we need to answer • Also create Parking Lot flip chart if needed to capture off-topic issues that need follow-up **BRAINSTORMING/IDEAS** • Ideas around next steps • TILP goals and TILCP objectives, as applicable **NEXT STEPS/ACTION PLAN** • Next steps, including behaviorally-based case plan objectives, to address worries and the child/youth and caregiver needs (and strengths to build) identified by CANS & CFT • Next CFT meeting date

NOTE: For caregivers, document where appropriate their Needs & Resources related to: Supervision, Involvement with Care, Knowledge, Social Resources, Residential Stability, Medical/Physical, Mental Health, Substance Use, Developmental, Safety (and for kids 0-5, Family Relationship to System, Legal Involvement, Organization)

1 2 3 4 5 6 7 8 9 10

Scale current permanency/belonging; readiness for next steps; participants' willingness, confidence and/or capacity to follow the plan.

Back to table of contents

CHILD & FAMILY TEAM (CFT) MEETING MAP – PERMANENCY PLANNING/NON-MINOR YOUTH

Meeting Type: ☐ Case Consultation ☐ Case Planning CFT ☐ Placement CFT ☐ 90-Day Transition CFT ☐ Other:

Meeting Purpose/ Focus: What is our intended outcome of today's meeting or consultation? What do we hope to achieve by the end of the meeting?

Meeting Met Statutory Requirements for CFT: ☐ Yes ☐ No *Complete genogram, ecomap, Circles of Support as appropriate.*

WHAT ARE WE WORRIED ABOUT/NEEDS?	WHAT'S WORKING WELL/STRENGTHS?	WHAT NEEDS TO HAPPEN NEXT?
Current Worries that Need to Be Addressed	**Permanency/Independence/Belonging/Safety**	**Shared Vision/Well-Being Goal**
Permanency/Independence/Belonging/Safety	**Supporting Strengths**	**Gray Area** *(create flip chart if needed)*
Complicating Factors	**Safety/Support Network (Child & Family Team)**	**BRAINSTORMING/IDEAS**
Needs & Strengths to Build of Child/Youth (CANS)	**Strengths of Child/Youth (CANS)**	**NEXT STEPS/ACTION PLAN**

NOTE: For caregivers, document where appropriate their Needs & Resources related to: Supervision, Involvement with Care, Knowledge, Social Resources, Residential Stability, Medical/Physical, Mental Health, Substance Use, Developmental, Safety (and for kids 0-5, Family Relationship to System, Legal Involvement, Organization)

1 2 3 4 5 6 7 8 9 10

Scale current permanency/belonging; readiness for next steps; participants' willingness, confidence and/or capacity to follow the plan.

CHILD & FAMILY TEAM (CFT) MEETING MAP – EMERGENCY RESPONSE (CHERYL'S CASE)

Meeting Type: ☐ Case Consultation ☐ RED Team ☐ Safety Mapping w/Parent(s) ☒ Emergency Removal CFTM ☐ Risk of Removal CFTM ☐ Other: _____

Meeting Purpose/ Focus: Make a decision about where the children will live while Cheryl gets help for her depression.

Meeting Participants: Cheryl Williams, mom; Trina Evans, family friend; Paul Richards, neighbor; Sarah Moreno, sister; Anna Johnson, social worker; Maria Mendes, supervisor

Complete genogram, ecomap, Circles of Support as appropriate.

WHAT ARE WE WORRIED ABOUT/NEEDS?

Reason for Referral/Harm

- Cheryl turned on the gas stove with her children at home, flooding the home with toxic fumes. Both she and the children passed out.
- When Cheryl and Ben were together, Ben hit Cheryl, threw objects at her, called her names and controlled all of the finances. He also got drunk almost every night.
- Ben was calling Cheryl every day and calling her names and threatening her until she got a restraining order.

Harm statement: Cheryl turned on the gas stove in her kitchen while the children were at home, flooding the home with toxic fumes, causing both herself and the children to pass out. When Cheryl and Ben were together, Ben got drunk almost daily and was physically violent to Cheryl in front of the children while drinking. He called and texted Cheryl daily after she left, calling her names and threatening her, until she got a restraining order.

Danger *(informs draft CANS)*

Danger Statement: Child Welfare Services, the doctors at the hospital, Trina, Sarah and Paul are worried that Cheryl may try to hurt herself again in the future; that she might be seriously injured or die; and that the children could be very frightened, seriously injured, or left motherless. CWS, Trina, Sarah, Paul and Cheryl are worried Ben will continue to drink, be verbally or physically dangerous to Cheryl, and not understand the impact on his children of witnessing their dad hit their mom or call her names.

WHAT'S WORKING WELL/STRENGTHS?

Safety *(informs draft CANS)*

- Cheryl left Ben a year ago due to the violence and took out a restraining order nine months ago. She also changed her phone number.

Supporting Strengths *(informs draft CANS)*

- Cheryl put the children in next room and opened a window before turning on the gas.
- Cheryl and the kids are safe and ok.
- Cheryl got the girls in counseling to deal with their trauma of watching their dad hit their mom.
- Trina was able to get approved last night as an emergency relative caregiver.
- Paul, Trina and Sarah agree that Cheryl is a wonderful mom. She loves the girls more than anything and puts them first.

Safety/Support Network

- Trina Evans, family friend
- Paul Richards, neighbor
- Sarah Moreno, sister

Strengths of Child/Youth *(informs draft CANS)*

- Rebecca does great in school and is very smart and responsible.
- Akiba is funny and social with everyone.
- The kids are staying in their schools.

WHAT NEEDS TO HAPPEN NEXT?

Shared Vision/Safety Goal

- Cheryl will work with CWS and a network of family, friends, and providers to show everyone that she will always ask for help if sadness or depression start to get in the way of taking care of the girls or if she starts to think about hurting herself again. CWS will need to see this plan working continuously for six months to consider returning the girls to Cheryl's care.

Gray Area *(create flip chart if needed)*

- What is Ben's current living situation?
- What does Ben's current alcohol use look like?
- What is Ben's understanding of the impact of the domestic violence on Cheryl, Rebecca and Akiba?

BRAINSTORMING/IDEAS

- Kids home with Cheryl with someone checking in daily, with VFM or Court FM services
- Kids stay with Trina while Cheryl gets FR services
- Kids stay with Aunt Sarah
- Kids stay with Paul next door
- Child Welfare assess Ben as non-offending parent
- Cheryl ask her mom if she can take the kids in case Trina can't keep them
- Sarah or Trina supervise visitation
- CWS evaluate unsupervised visitation
- Cheryl attend residential mental health treatment
- Cheryl attend mental health outpatient services

Complicating Factors *(informs draft CANS)*

- Cheryl lost her job and cannot pay her bills.
- Cheryl stopped taking her medication three months ago because she could not afford her copayment.
- Ben cut Cheryl off financially after she left.

Needs of Child/Youth *(informs draft CANS)*

- The girls are separated from their mom.
- Rebecca is very anxious without her mom, has been crying constantly and hasn't slept.
- Akiba has delays in her speech.

NEXT STEPS/ACTION PLAN

- **Safety Decision:** The kids will remain in out-of-home care while Cheryl receives services and supports to address the safety issues caused by her depression.

Who	What	By When
Anna	Set up visit for Cheryl & the kids	Today
Trina	Facilitate nightly calls for Cheryl & the kids	Starting tonight
CWS & Trina	Complete next step of RFA approval process	12/6/19
Cheryl	Make follow-up appt with psychiatrist	12/6/19
Sarah	Go with Cheryl to psychiatrist appt when scheduled	TBD
Team	Case planning CFT meeting	1/15/20

For parents, document where appropriate under Danger, Complicating Factors, Safety and Supporting Strengths their Needs and Resources related to: Supervision, Involvement with Care, Knowledge, Social Resources, Residential Stability, Medical, Mental Health, Substance Use, Developmental, Safety [and for kids 0-5, Family Rel. to System, Legal Involvement, Organization]

1 2 3 4 5 6 7 8 9 10

Scale for Safety: 1 = Safety Plan Needed, 10 = Safe Enough to Close | Scale family's willingness, confidence and/or capacity to follow the plan.

The Voice of SDM Assessment

When

1. In a group supervision mapping session THAT

2. Has a PURPOSE related to a KEY DECISION (i.e., whether to remove a child, open a case, develop a safety plan/case plan, return a child, change permanency goal, or close a case).

Why

- To help focus the mapping.

- To help distinguish danger from complicating factors.

How

1. One person in the group is designated the "voice" of the SDM assessment.

2. That person has the relevant SDM assessment and definitions open, and keeps track throughout the mapping.

3. The "voice" of the SDM assessments should ask to pause if:

    a. The group is spending more than a few moments on information that is not relevant;
    b. The group is getting stuck on whether something is a danger versus a complicating factor or a strength versus safety;
    c. The group is misidentifying something as a danger versus a complicating factor or safety versus a strength; or
    d. The group is moving toward "what needs to happen" before covering all relevant information.

4. If pausing, the "voice" should read the relevant item and/or definition. The mapper should then direct questions to help raise the necessary information.

Example

1. In a family team meeting, the group is talking about the extensive arguing and occasional physical fights between parents. Some see this as harm; others see it as a complicating factor. The purpose of the meeting is to decide whether the child needs to be removed. The "voice" should read the SDM safety threat definition for domestic violence. The questioner should then use the definition to craft questions that will raise behavioral detail that, based on the definition, will help sort whether in this family, the domestic violence creates imminent danger of serious harm, based on caregiver actions and the impact on the child.

2. In a family team meeting to determine whether a child should be reunified, if the group is on a tangent about an issue related to the child's behavior in school that is unrelated to risk, visitation, or safety, the "voice" should pause and redirect the mapping to any aspects of the SDM reunification assessment that have not been mentioned.

BEHAVIORALLY-BASED CASE PLANS

NORTHERN CALIFORNIA TRAINING ACADEMY

SUMMARY

Behaviorally-based case plans focus on specific, concrete strategies and actions to effectively and permanently change the parent's behavior with regard to its impact on the child, rather than mere completion of or compliance with services.

BASIC PRINCIPLES

- A foundational principle of behaviorally-based case plans in Safety Organized Practice is that services and safety are not the same thing.
  - Service completion does not guarantee child safety. Behavior change, demonstrated and sustained over time, is the key to safety.
- In some circumstances, child safety can be attained without use of formal services.
- Services that are individualized and specific can be a useful tool to help a parent achieve behavior change; however, any services should be regarded as the last piece of case planning.
- *Compliance* is not the same as *engagement*. Engagement is about focusing on what people do right and what is important to families. Engagement takes work, but the plan will not succeed without it. Compliance is far less successful in achieving behavior change.
- A Safety Network is a necessary component of a Family Maintenance (FM) or Family Reunification (FR) case plan. This Quick Guide focuses on case plans for FM/FR cases.

ENGAGING THE FAMILY

- Behaviorally-based case plans *cannot* be created without the guidance, active participation and willingness of the family and their Safety Network.
- Engagement skills, including use of solution-focused questions, are critical to the case planning process and the family's willing participation in the plan.
  - The more a family perceives the case plan as their idea, the more they will buy in to it.
  - A parent talking about "jumping through hoops" on their case plan is a sign to the social worker to work on engagement in case planning.
- Case plan development should occur after there has been a Child and Family Team (CFT) meeting (ideally before removal, but if the child has been removed, within 24 hours to 2 weeks after) to do Safety Mapping with the family and network; this can also be done as a "kitchen table" mapping. The Safety Mapping process helps us focus and develop the Harm Statement, Danger Statement and Safety Goal(s). Harm and Danger Statements and Safety Goals created with the family are key to developing behaviorally-based case plan objectives.
- Best practice and State mandates require that a CFT meeting occur to develop the case plan with the family and their team/network.
  - Complete the SDM Safety and Risk Assessments and a draft of the Child and Adolescent Needs & Strengths (CANS) before the CFT meeting where the case plan will be developed.
- Involvement of the family's network of natural supports in case planning is critical to help define and describe what the parent's behavior will look like when the worrisome behavior is not happening.
- Involve children/youth in case planning as they wish and as developmentally appropriate.
  - For younger children, you can utilize the Three Houses and/or the Safety House to incorporate the child's vision of their parent's future positive behavior into the plan.
  - Older children usually can explain their perspective on what their mom or dad is like when parenting at their best, and they can be part of a CFTM to develop the family's case plan (if they wish).
- Always involve the Tribe in the CFT and case planning for ICWA cases. This is legally required and also vital to help build a culturally relevant plan for the family.

BUILDING THE CASE PLAN

- For an FM/FR case plan, keep a laser focus on what will alleviate the harm and danger that led to the family's CWS involvement and will meet the safety goal.
  - Avoid cookie cutter case plans that prescribe "the trifecta" of generic services — (1) parenting, (2) mental health, and (3) substance abuse — for all parents regardless of reason for CWS involvement.
  - Avoid casework drift; make sure the case plan actually addresses the harm/danger (impact on the child) and why CWS is involved, rather than focusing on complicating factors.
  - Including too many different case plan objectives can overwhelm a family and result in paralysis in moving forward. With the family and their network, pick the top three objectives for each parent that are genuinely necessary to ensure child safety.

HELPFUL TIPS

Services are useful on case plans only insofar as they support the parent to make and sustain actual behavior change. When including a service, specify expectations for the parent's behavior beyond mere attendance.

Use a trauma-informed lens when assessing reasons for the parent's behavior, and make sure the case plan objectives help get to the underlying trauma.

- Only include more objectives if there are genuinely more than 3 different sources of harm/danger.

- The plan should focus on action steps that will help with the primary safety concern first.
- If a parent does not have a network, building one should be an objective of the initial case plan.
- Generally, when multiple safety concerns exist, substance abuse and/or mental health concerns should be prioritized before parent education, housing or employment, as success in these areas typically relies on the parent's sobriety and stabilized mental health.
- Mental health and substance abuse often need to be addressed simultaneously, as substance abuse is often self-medication of mental health challenges. However, for some individuals, it makes sense to treat one issue or the other first. If the parent has service providers for substance abuse or mental health, coordinate with them about how to best address and sequence treatment for both issues.
- Consider whether parenting classes are genuinely necessary to resolve the safety concerns. Unless parenting was the primary safety issue, parent education — if needed — should typically follow other case plan objectives.

USING A SOLUTION-FOCUSED APPROACH

- Building a behaviorally-based case plan requires skilled engagement, a willingness to partner with the family and their team to creatively identify strategies, and understanding that the family and their network are best equipped to describe what the parent's behavior will look like when the problem is not happening.
- Solution-Focused Questions are a critical tool to guide the case plan conversation during the CFT meeting, including:
  - Exception questions to help the family and their team/network identify when the concerning behavior wasn't happening, i.e., "Has there ever been a time when you were able to stay clean and sober? How did you manage to do that? How was your parenting different when you were clean; what did it look like?"
  - Position/relationship questions to identify behavior from other perspectives, i.e., "What would your son say is his favorite thing about you as a mom when you're sober?" "What new behaviors might your children want to see you doing to feel safe that no one will get hurt in your house again?"
  - Preferred future questions to identify the family's vision for what could be, i.e., "When this is all behind you, what will be different for you and your children?" "If you woke up tomorrow and all of your problems were gone, how would things be different for you and your family?"
  - Scaling to identify the family's and network's willingness to participate in the plan, agreement to the plan, and confidence that the plan will ensure safety. Remember to ask how the person got to the number they picked and what it would take to move up one (or why they did not pick a lower number).

Make sure case plan objectives are clear, understood and agreed to by the parent and their network, and realistically achievable in the timeframe of the case plan (i.e., six months).

When including services, avoid specifying one provider in case the parent is not able to enroll in their services due to waiting lists or they aren't a good fit.

HELPFUL TIPS

VISITATION/FAMILY TIME

- Visitation, or "family time," is one of the most important pieces of the case plan. Family time should happen in the least restrictive way that is safely possible; for example, with a member of the network supervising, and/or in a location such as the home of a family member or friend.
- In the CFT meeting, be sure to address what visitation could look like with the support of the network, what activities the parent can do during family time to show behaviors that will help them meet the safety goal, and at what case decision points visitation may be reassessed or made less restrictive.

DOCUMENTING THE CASE PLAN

- After creating the case plan as part of a CFT meeting with the family and their network and selecting the top three or so objectives to address the Danger and Safety Goal, find the CWS/CMS objective that best fits these objectives. In the description section, rewrite the CWS/CMS objective language as a SMART objective, as developed with the family, and include the action steps/strategies to meet the objective.
- Use language the family can understand. Write for a sixth-grade reading level. Avoid acronyms or jargon.

CREATING OBJECTIVES THAT ARE "SMART"

TERM	DEFINITION
Specific	Objectives should be written simply and should clearly define what the person will do.
Measurable	Objectives should be measurable so there is tangible evidence that they were accomplished.
Achievable	Objectives should be possible for the person to achieve.
Relevant *and* **Results-Focused**	Objectives should be focused on something that relates to why the family is involved with child welfare (i.e., the objective is relevant to the Danger Statement and Safety Goal). Objectives are outcomes, not activities. They describe, in future perfect tense, the behavior the parent will have done that tells us the child is safe.
Time-Limited	Objectives should be linked to a timeframe.

- Objectives are outcomes, not activities. They describe, in future perfect tense ("will have _____"), the behavior the parent will have done that tells us the child is safe. Action steps detail the activities and strategies the parent will undertake to meet the objective, with the support of their network.
- Work around the CWS/CMS Microsoft Word case plan template as needed to develop a family-friendly plan that reflects the work you did with the family and their network. You can keep services under the Objective action steps or put them in the Client Responsibilities section, depending on practice in your county.
- Add the Danger Statement and Safety Goal that were developed with the family and network to the first page of the case plan document.

INCORPORATING THE CANS

- The CANS is an information integration tool that is designed to be the output of a collaborative assessment process. Completion of the CANS requires effective engagement using a teaming approach. The CANS must be informed by members of the CFT, including the youth and family. The CANS must be discussed, used and shared within the CFT process to support case planning and care coordination.

CANS CAREGIVER RESOURCES & NEEDS

DOMAIN	DEFINITION
Supervision	Capacity to provide the level of monitoring and discipline needed by the child/youth. Discipline is defined in the broadest sense, and includes all of the things that parents/caregivers can do to promote positive behavior with their children.
Involvement with Care	Participation in the child/youth's care and ability to advocate for the child/youth.
Knowledge	Knowledge of the child/youth's strengths and needs and any problems experienced by the child/youth; ability to understand the rationale for the treatment or management of these problems.
Social Resources	Social assets (extended family) and resources the caregiver can bring to bear in addressing the multiple needs of the child/youth and family.
Residential Stability	Housing stability of the caregiver(s).
Medical/ Physical	Medical and/or physical problems the caregiver(s) has that prevent or limit ability to provide care for the child/youth.
Mental Health	Any serious mental health issues (not including substance abuse) that limit capacity to provide care for the child/youth.
Substance Use	Any notable substance use by caregivers that limit capacity to provide care.
Developmental	Limited cognitive capacity or developmental disabilities that challenges the caregiver's ability to provide care for the child/youth.
Safety	Ability to maintain the child/youth's safety within the household. Does not refer to the safety of other family or household members based on danger presented by the caregiver.

- A draft of the CANS should be brought to the case planning CFT meeting. Ideally, information to inform the CANS would have been gathered during an ER CFT meeting. Otherwise, the social worker, Behavioral Health staff or whoever is responsible for completing the CANS would need to interview the child/youth, parents, resource parent, teacher and other providers and natural supports to gather the information to complete the draft CANS.
- CANS items that are identified as a priority need by the Child and Family Team must be incorporated into the case plan. The team should identify which priority needs to take action on and what other needs they expect to improve as a result. Priority items where the child needs to build a strength should also be included with a plan for how to achieve this.
- The CANS Caregiver section, completed for each parent (and resource parent), helps to prioritize areas of need that affect the parent's ability to care for the child. Create case plan objectives that address the priority needs for each parent, utilizing the Caregiver Resources as strengths that can help address areas of need where possible.

SPECIAL CASE ISSUES

- In cases where there is domestic violence, defined as a pattern of perpetrator behavior characterized by coercion and control, separate networks should be developed for each parent, and separate CFT meetings should occur to develop the case plan for each parent. Additionally, visitation should occur at a different time and location for the perpetrator than for the survivor of the violence.
- In cases where a youth has dual status (involvement with Child Welfare and Juvenile Probation), Probation needs to be part of the CFT and case planning process with the social worker, youth, family and their network.

CASE PLAN ACCOUNTABILITY

- Add to the case plan the frequency of CFT meetings, when the network will check in on the progress of the plan, and how the parents, network and social worker will hold the mother, father and each other accountable for following through.
  - CFT meetings are required at least every 6 months with the case plan for all children in foster care, and every 90 days for children receiving Intensive Care Coordination, Intensive Home-Based Services or Therapeutic Foster Care services.
- At each CFT meeting, review the case plan with the team to assess progress and make any updates as needed. Be sure to address how the parent has demonstrated progress toward their behavioral objectives as a measure for whether family time can become less restrictive.

CASE PLAN OBJECTIVE EXAMPLES

Here are some examples of what behaviorally-based case plan objectives with family-friendly language might look like.

- Use the parent's name, not "Mom" or "Dad."
- Under each objective, include the specific action steps (activities or strategies) to achieve that objective; these go in the description section of the CWS/CMS case plan.
- Descriptions of services, and how parents will show the changes made by participating in them, can go in the Client Responsibilities section of the CWS/CMS case plan.
- Real-life case plan objectives and action steps the parent and network will do should always be developed with the parent and members of the network.

Safety Network Example

Objective: Mom agrees to have developed a positive support network with friends and family who will help her keep her children safe, and have demonstrated how she has used her network at least once per month for 6 months.
CANS Caregiver Need: Social Resources (2)

Action Steps: Mom agrees to:

- Invite her sister and AA sponsor to join her network in the next week.
- Within 2 weeks, come up with a list of people within who might be supports for her and activities that will help her build her network**.**
- Work with her network and social worker to complete the Safety Circles in the next month, move at least one person into the center, and invite that person to the next Child and Family Team meeting.
- [Children's names] can call any of the safety people at any time, and they will come visit right away. The network will have at least 3 "fire drills" in the next 3 months where they practice this. After each fire drill, the children will share how safe they feel, and the plan will be updated as needed.

Substance Abuse Example

Objective: Dad agrees to have demonstrated that he can remain clean and sober for the next 6 months and that he has followed a plan to maintain his sobriety.
CANS Caregiver Need: Substance Abuse (3)

Dad agrees he will:

- Work with his sponsor to develop a plan to maintain his sobriety. He agrees to have the plan developed in the next 30 days and will refine it for the following 5 months. He will share the plan with his network and social worker.
- Within one week, tell his network what he does when he is thinking about using and develop ways for his network to help him during those times.
- In the next 2 weeks, tell his network 3 things that have helped him stay sober in the past. He and the network agree to find ways to help him continue to do the things that have worked.

CLIENT RESPONSIBILITIES

Substance Abuse Services

- Dad agrees to go to 90 NA meetings in the next 90 days, find a sponsor within 14 days, talk to the sponsor about his plan with CWS, and ask the sponsor to be part of his network. He will talk to the social worker and network about what he has learned in NA, the strategies he thinks will help him stay clean long-term, and how he has practiced them.
- Dad agrees to drug test as directed by the social worker. He understands that failure to test will be counted as a positive test.

Mental Health Example

Objective: Mom agrees to have developed 3 ways to manage and control her depression and will have demonstrated those skills to her therapist and network for the next 6 months.
CANS Caregiver Need: Mental Health (2)

Action Steps: Mom agrees that she will:

- Within 3 weeks, meet with a therapist and develop a plan together to manage her depression, and share this with the social worker and her network. The network members agree one of them will check in every day and ask Mom how the plan is going. If this does not work, Mom will work with the social worker to develop another way to meet her objective of managing her depression.
- Re-evaluate her medication in the next 60 days and show that she can follow that plan for the next 6 months.
- Call her dad or another network member if she is starting to feel depressed to the point that she does not want to do anything, and they will come over right away.

CLIENT RESPONSIBILITIES

Counseling/Mental Health Services

- Mom agrees to attend weekly therapy sessions to work on developing a plan to manage her depression so that she can demonstrate her ability to care for her child when she is becoming depressed.
- Members of the network agree to take turns watching [child] when Mom goes to see her therapist. They will also help with transportation if there is a problem.
- Mom agrees to work with the social worker and her network on her plan to manage her depression and let her social worker know what is working for her.
- Mom agrees to meet with a psychiatrist within 4 weeks to evaluate the use of medication for her depression.

Domestic Violence Example

Objective: Dad agrees that he will have demonstrated for 6 months that he has used 5 ways of resolving conflict that don't scare his partner or children and use only words.

Action Steps: Dad agrees to develop a plan with his brother and another network member for what he will do when he feels upset, stressed or angry. A network member will check in with dad daily to see how he followed through with his plan.

CLIENT RESPONSIBILITIES

Domestic Violence Services

Dad agrees he will go to all of his batterers' intervention meetings each week. After every meeting, he will call a network member and talk about what he learned and how he will practice it. He will practice, then talk to a network member about what he thought he did well and what he wants to do differently next time.

Counseling Services

Dad agrees he will go to counseling every week for at least 16 weeks, starting within 2 weeks, to talk about growing up with a dad who hit his mom, the feelings and actions of anger and sadness he has because of that, and his awareness of how hitting his children's mom is a parenting choice. He will practice using tools he learns in counseling and discuss how he has practiced with the counselor, social worker and his network.

Comparing Two Plans

What is the difference between these two plans?

Plan 1

- Cheryl needs to go to the therapist weekly to work on depression, its causes, and the impact it has on her life.
- Cheryl needs to go to the psychiatrist at least monthly to make sure she is taking her medication and it is working properly.
- Cheryl needs to attend a therapeutic group for "women facing depression" weekly so she can hear how other women have responded to it.
- Cheryl needs to go to a job retraining course.
- Cheryl needs to go to a parenting class.

Plan 2

- Cheryl agrees to present the following to her children and to her safety network.
- Neighbor Paul, sister Sarah, foster mother Trina, and outreach worker Betsy all agree to be part of Cheryl's safety network.
- Cheryl will ask for help with the children if she feels higher than a 7 on a 10-point scale for depression.
- Cheryl will not be alone if she is thinking about hurting herself again and will ask for help from someone in the network if this happens.
- Cheryl agrees to keep a logbook of her work in resisting the worst of her depression. She will rank the impact of her depression every day in the book and detail everything that is helping her reduce that impact.
- Paul, Sarah, and Trina all agree to call or visit once daily (one in the morning, one in the afternoon, one in the evening.) They will talk to Cheryl, ask how she is doing, and rank the impact of depression on her. They also will talk to the kids and ask them how they are doing. When the whole network visits, they will also write in the logbook and ensure the children have their phone numbers as well.
- Betsy will visit the home two to three times per week, and she or her team will be available 24 hours a day if Cheryl wants to call. During her visits, she will also rank the impact of depression on Cheryl and write in the logbook. Betsy will work with Cheryl to make sure she goes to the doctor.
- Cheryl, the safety network, and CPS will meet to review this plan again in three weeks.

SOP ACROSS THE CASE CONTINUUM

NORTHERN CALIFORNIA TRAINING ACADEMY

EMERGENCY RESPONSE → **PERMANENCY**

COLLABORATIVE PRACTICE — CULTURAL HUMILITY — SDM© — SOLUTION-FOCUSED QUESTIONS — THE THREE QUESTIONS — TRAUMA-INFORMED TECHNIQUES

HOTLINE

- Ask the caller the Three Questions
- Ask about Harm and worries about Danger
- Ask about Safety/ Acts of Protection and Strengths
- Ask about natural supports and possible Safety Network members
- Develop a preliminary Harm Statement
- SDM Hotline Tool
- Document use of SOP in Screener Narrative
- Use RED Team process to determine agency response

INVESTIGATION

- SDM Safety & Risk Assessments
- Use Solution-Focused Questions (SFQs) when interviewing
- Use Motivational Interviewing (MI) if parents are reluctant/in protest
- Ask parents and collaterals the Three Questions
- Ask about Harm, Danger, Safety and Strengths
- Ask about natural supports and possible Safety Network members
- Complete Safety Mapping with the family
- Complete the Three Houses with each child/youth
- Document use of SOP in contact notes and Investigation Narrative

RISK OF REMOVAL

- SDM Safety & Risk Assessments
- SFQs & 3 Questions
- Use MI if parents are reluctant/in protest
- Have a Child & Family Team Meeting (CFTM) with the family and Safety Network
- Develop Harm and Danger Statements and Safety Goals
- Complete the Circles of Support with the parents, or ideally in the risk of removal CFT meeting
- Create a Safety Plan, if safely possible; Safety Network members must be part of the plan
- Scale for confidence in the plan keeping the children safe
- If separation is necessary, discuss relative placement options at the CFTM
- Document use of SOP in contact notes and Investigation Narrative

COURT INTAKE/FAMILY REUNIFICATION

- SFQs & 3 Questions
- Use MI if parents are reluctant/in protest
- Have a CFTM with the Network to make a behaviorally-based case plan; address CANS Needs and Strengths in the plan
- Discuss how the Network can support Visits/Family Time
- Use Visit Coaching
- Add Danger Statement & Safety Goal to case plans and court reports
- Hold CFTMs if children may need to change placements; revisit relatives at any placement change
- Complete the Safety House with each child before return home
- Document use of SOP in contact notes
- SDM Reunification Reassessment

FAMILY MAINTENANCE

- SFQs & 3 Questions
- Use MI if parents are reluctant/in protest
- If not done in ER, have a CFTM with the Safety Network to develop Harm and Danger Statements and Safety Goals
- Have a CFTM with the Safety Network to develop a behaviorally-based case plan
- Create a plan for regular CFTMs and how the Safety Network will monitor the plan
- Add Danger Statement & Safety Goal to case plans and court reports
- If not done in ER, do the Three Houses with each child
- Complete the Safety House with each child
- Document use of SOP in contact notes
- SDM Risk Reassessment

ADOPTION

- SFQs & 3 Questions
- Do Three Houses & Safety House with the child based on their adoptive placement
- Have CFTMs regularly to discuss progress toward permanency, identify needs and strengths via CANS, and update case plan
- Revisit relatives when any placement change is needed

PERM. PLANNING/ NON-MINOR DEP.

- SFQs & 3 Questions
- Have CFTMs regularly to discuss progress toward permanency or independence, identify needs and strengths via CANS, and update case plan
- If self-harm, create Harm and Danger Stmts./Safety Goals
- Utilize the Network to support youth in achieving their goals
- Document use of SOP in contact notes

SOLUTION-FOCUSED QUESTIONS

- Coping questions
- Exception questions
- Position questions
- Preferred future questions
- Scaling

Rev. 06/18/2018

Back to table of contents

SOP ACROSS THE CASE CONTINUUM

NORTHERN CALIFORNIA TRAINING ACADEMY

EMERGENCY RESPONSE → PERMANENCY

COLLABORATIVE PRACTICE — CULTURAL HUMILITY — SDM© — SOLUTION-FOCUSED QUESTIONS — THE THREE QUESTIONS — TRAUMA-INFORMED TECHNIQUES

HOTLINE	INVESTIGATION	RISK OF REMOVAL	COURT INTAKE/FAMILY REUNIFICATION	FAMILY MAINTENANCE	ADOPTION
					PERM. PLANNING/ NON-MINOR DEP.

Back to table of contents

MY ACTION PLAN

What personal action steps are you willing to commit to once you leave this training and return to your office?

1. *What have you heard in the last three days that you really value?*

_____

_____

_____

2. *What two to four practices/tools do you wish you could implement right now?*

_____

_____

_____

3. *What kind of help would you need to begin this journey?*

_____

_____

_____

4. *What will be your very first step?*

_____

_____

_____