Safety Organized Practice 2-day Foundational Institute - Trainers Guide

About SOP	Safety-organized practice (SOP) is an approach to child welfare that integrates a number of promising practices into a clear and consistent framework for social workers, supervisors, and managers.
How to use this trainers guide	The purpose of this document is to provide an overview of the curriculum, materials, and logistics needed to successfully facilitate and train the SOP foundational institute. This version of the trainer's guide has been updated from the original guide created by the Children's Research Center (CRC), a division of the National Council on Crime and Delinquency (NCCD).
Curriculum link	https://www.oercommons.org/authoring/21644-core-for-social-workers-module-4-assessment-part-1/view#h7
Required pre-requisite(s):	N/A; This course serves as a pre-requisite for all other SOP classes and offerings.
Course description	This foundational two-day institute introduces SOP which includes and draws from approaches such as solution-focused brief therapy, Signs of Safety, the Structured Decision Making® system (SDM), trauma-informed practice, appreciative inquiry, and cultural humility, paying particular attention to the use of effective facilitation skills to link them together.
Course length	2-day course; 9am – 4pm each day; two 15-minute breaks & a 60-minute lunch break each day
Course delivery	In-person class; offered as part of Core for Social Workers, as a standalone class and based on county request
Optimal number of trainers	Due to the duration and complex nature of this training, two trainers are optimal.
Optimal Group Size	This is an experiential workshop with many discussions and activities. No more than 40 people should be in the class.
Two-day training overview	**Day 1** • Introduction to Safety Organized Practice (SOP) and the California Integrated Core Practice Model (ICPM) • Strategic conversations about danger and safety • Safety Networks • Interviewing children **Day 2** • Harm and danger statements, safety goals • Key Mapping Concepts • Safety Mapping Demonstration • Collaborative Safety/Case Planning • Additional SOP Tools & Resources • Personal Action Plans & Wrap-up
Learning Objectives	**Knowledge:** K1: The trainee will be able to identify the goals, objectives, and values of SOP and its alignment with the Integrated Core Practice Model (ICPM) K2: The trainee will understand the key elements, values, tools and strategies of SOP and how they assist in effective engagement and collaboration with the family and their Child and Family team (CFT). K3: The trainee will learn how to utilize shared ICPM and SOP values to conduct balanced assessments and collaborative case plans that are trauma-informed, equitable, culturally relevant, individualized and behaviorally specific to improve outcomes from children, youth and families. **Skill:** S1: Utilizing a case example, the trainee will demonstrate the use of SOP techniques & strategies to engage the child and family in the development of an individualized, behaviorally specific, culturally relevant and trauma-informed case plans, including but not limited to the following: • Structured assessment tools (SDM/CANS) • Child interviewing techniques

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- Development of the safety network/circles of support
- Solution focused interviewing
- Harm & danger statements; Safety goals
- Safety Mapping; Child & Family Team Meetings
- Collaborative case/safety planning utilizing the safety network, teaming, etc.

Value:

V1: The trainee will value and endorse their role as a change agent.

V2: The trainee will reflect on the importance of teaming and collaboration with the Child & Family Team to truly engage families in their safety network development, assessments, and service plans that are culturally relevant, individualized, trauma-informed and behaviorally specific.

V3: The trainee will reflect on their own best practices and consider how to implement SOP into their day to day work with children and families.

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<tr><td>Handouts</td><td>

Handouts, PowerPoint slides, and Workbooks will be provided to participants electronically via the resource barn link. Participants will be asked to print the “Participant Workbook” that includes handouts for activities to be used during the training and PowerPoint slides if they choose.

<table>
<tr><th>Participant Workbook
(Required materials for class))</th><th>Participant Guide (Supplemental/Informational)</th></tr>
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DAY ONE HANDOUTS

1. Facilitated Dialogue Structure
2. Multicultural Guidelines for communicating across difference
3. ICPM Practice Principles
4. Truth about ACES
5. SOP SW Practice Definitions
6. Case Planning Worksheet
7. Quick Guide: Solution Focused Questions
8. Quick Guide: Circles of Support
9. 5 Protective Factors

DAY TWO HANDOUTS

10. Quick Guide: Harm & Danger Statements, Safety Goals
11. Safety Mapping/CFT Maps:
    a. Quick Guide: Safety Mapping
    b. Quick Guide: CFT Meetings
    c. CFT Meeting Maps Overview
    d. ER Meeting Map
    e. ER Meeting Map Fillable
    f. FM/FR Meeting Map
    g. FM/FR Meeting Map Fillable
    h. PP/NMD Meeting Map
    i. PP/NMD Meeting Map Fillable
    j. ER Meeting Map-Cheryl
12. Voice of SDM Assessment
13. Quick Guide: Behaviorally Based Case Plans
14. Comparing two plans

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1. Course Learning Objectives
2. Definitional tools/handouts:
    a. SOP Definition & Objectives
    b. Quick Guide – Intro to SOP
    c. SOP Glossary
    d. SOP Key Elements
    e. SOP Contributors
    f. CPM-SOP Crosswalk
    g. Quick Guide: SOP & ICPM
    h. CPM Guide: Social Workers
3. Ecomap example
4. Genograms
5. Child Interviewing:
    a. Quick Guide: Three Houses Tool
    b. Three Houses Example
    c. Quick Guide: Safety House Tool
    d. Zoe’s Safety House
6. Assessment with families
7. Bringing a trauma lens to child welfare
8. Cultural Humility Practice Principles
9. Cultural Humility Article
10. Family Safety Networks Article
11. SF Five Protective Factors
12. Core Meanings-Protective Factors
13. Mapping tools/handouts:
    a. 3 column map template
    b. CFT Meeting Maps Overview
    c. ER Meeting Map
    d. ER Meeting Structure & Content Guide
    e. FM/FR Meeting Map
    f. FM/FR Meeting Structure & Content Guide

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	15. SOP across the case continuum 16. My action plan	g. PP/NMD Meeting Map h. PP/NMD Meeting Structure & Content Guide i. CFT Meeting Key Issues & Questions by Meeting Purpose 14. Collaborative planning and action steps 15. Quick Guide: Safety Planning 16. SOP DV Timeline Tool 17. BBCP example with instructions 18. Cheryl Case Plan Example 19. The Golden Thread 20. SOP Documentation Strategies 21. SOP Tips from the Field 22. Resources-References
	Activity Materials **as separate attachments on the class page:**	***ICPM Activity Materials:*** 1. ICPM Activity Posters 2. ICPM Practice Principles ***Mapping Activity Materials:*** 1. Mapping Activity Roles 2. ER meeting map – fillable (word) 3. FM/FR meeting map – fillable (word) 4. PP/NMD meeting map – fillable (word)
	Additional handouts **as separate attachments on the class page:**	1. Three Houses – Safety House kit 2. Mapping with families cards
Trainer materials and supplies	***Activity Materials for in-person classes (modification may be made for virtual classes):*** ***1. Activity: ICPM Guiding Practice Principles*** ***1 set of laminated cards (ICPM Activity Posters) to hang up around the room before the beginning of class (for virtual classes, please use the handout: ICPM 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. Plans are relevant, transparent and related to the reason children were removed. • **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. The family is supported to make informed decisions about who should be part of the team. All important decisions should happen in teams. • **Natural supports** – individuals important to the child and family should be part of the child and family team. • **Collaboration and integration** – work cooperatively and share responsibility. Each team member must be committed to the team goals and the integrated team plan.	

- **Community-based** – 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.
- **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.
- **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 monitors progress and revises the plan accordingly. CANS helps us monitor change over time.

2. Activity: Safety Mapping Demonstration

- ***Mapping Roles: 2 laminated cards for each topic, 6 topics total:*** Collaborative Practice, Cultural Humility, Listening for Jargon, Solution Focused Questions, Trauma Informed Practice, Voice of SDM
- ***Mapping Activity Roles handout (1 for each table)***
- ***CFT Meeting Maps (use the one that applies to the case being mapped during the demonstration)***
  - ***ER Meeting Map***
  - ***FM/FR Meeting Map***
  - ***PP/NMP Meeting Map***

Classroom materials (in-person classes):

- ***SDM Manuals:*** There should be one California SDM manual per table.
- Computer / laptop to run the PowerPoint, a projector, a screen, speakers for the video
- Large Post-It flip chart paper and markers. It is optimal to conduct the case consultation on a dry-erase board, although it can be done on large Post-It paper as well.
- Colored sticker dots for "Walkabouts" activity.
- Instructor name tag or name tent
- Name tents for participants
- Sign-in sheets, Extra Registration forms, Extra Evaluation forms.
- Tables should have the following:

	• Participant workbooks w/registration and evaluation forms. • Markers, post-its, extra paper, pens, name tents, and at least one SDM manual per table.
Related classes/resources	Northern Academy Website: https://humanservices.ucdavis.edu/northern-academy/sop SOP Resource page: http://bit.ly/SafetyOrganizedPractice SOP Statewide toolkit: https://calswec.berkeley.edu/toolkits/safety-organized-practice

Class Agenda

Please note: This is a 2-day class, 9am – 4pm each day with two 15-minute breaks and a 60-minute lunch break. The times listed below are estimates only and can be adjusted as needed depending on audience, class discussions, etc.

DAY 1 – Suggested Agenda

Time	Training Content	Who/ materials
9:00am - 9:20am	Welcome and Introductions • Introduce yourself to the class - Share a bit about your experience and excitement about Introductions – background and what brings us here • Opening Circle: Find out who is in the room – years of experience, roles, caseload types, prior knowledge of SOP, what do you want to get out of this training? • Agenda • Preparation for Mapping • Group Agreements	Slides 1-5 Instructor name
9:20am – 9:50am	SOP Key Elements	Slides 6-22 Instructor name
9:50am – 10:30am	Strategic Conversations about Safety and Danger: A Balanced Assessment	Slides 23-40 Instructor name
10:30am-10:45am	BREAK	
10:45am – 11:30am	The Three Questions	Slides 41-54 Instructor name
11:30am – Noon	Solution Focused Questions	Slides 55-64 Instructor name
Noon – 1:00pm	LUNCH	
1:00pm – 1:30pm	Solution Focused Questions Practice	Slide 65 Instructor name
1:30pm – 2:30pm	Enhancing the Safety Network	Slides 66-80 Instructor name
2:30pm – 2:45pm	BREAK	
2:45pm-3:45pm	Interviewing Children	Slides 81-109 Instructor name
3:45pm – 4:00pm	Reflections on the day	Slides 110-112 Instructor name

DAY 2 – Suggested Agenda

Time	Training Content	Who/ materials
9:00am – 9:15am	Intro and reflection of yesterday Review of today's agenda	Slides 1-2 Instructor name

9:15am – 10:00am	Harm & Danger Statements	Slides 3-20 Instructor name
10:00am – 10:30am	Safety Goals	Slides 21-31 Instructor name
10:30am – 10:45am	BREAK	
10:45am – Noon	Introduction to Safety Mapping & CFTs Review of CFT Meeting Maps (ER, FM/FR, PP/NMD) Prep for Mapping Activity	Slides 32-55 Instructor name
Noon – 1:00pm	LUNCH	
1:00pm – 2:30pm	Safety Mapping Practice / Demonstration If you have two instructors, both will be helping facilitate & chart the mapping activity Debrief activity – how does this translate into practice?	Slides 56-62 Instructor name
2:30pm – 2:45pm	BREAK	
2:45pm – 3:25pm	Behaviorally Based Case Plans & Action Steps	Slides 63-86 Instructor name
3:25pm – 3:40pm	Tools & Strategies that support SOP	Slides 87-98 Instructor name
3:40pm – 4:00pm	Wrapping Up: SOP across the case continuum Personal Action Plans VIDEO: Dancing Guy Plus/Delta: Reflections on the 2-day training Evaluations	Slides 99-104 Instructor name

DAY 1 - POWERPOINT SLIDES AND TRAINER'S NOTES

- ☐ Room preparation PRIOR to beginning of training:
  1. Set out attendance sheet at sign-in table
  2. Set up "Walkabouts" (you can write two topics per chart paper, ***examples provided below***) – Have participants put a sticker dot or use a marker to indicate where they are on the scales as they enter the room:
     a. On a scale from 1 to 10 with "1" being a beginner and "10" being a super star, where would you rate yourself in using:
        i. Integrated Core Practice Model (ICPM)
        ii. Solution Focused Questions
        iii. Safety Mapping
        iv. Harm & Danger Statements
        v. Safety Goals
        vi. Safety Planning
        vii. Three Houses or Safety House
        viii. Safety Networks / Safety Circles Tool
  3. List name of training, names of instructors, and course # on flip chart paper
  4. Make sure tables have post it notes, markers, name tents, handouts as applicable, etc.
- ☐ ***Before introductions, briefly review walkabouts with the group:*** Instruct participants to review the walkabouts posted around the room to get an idea of

what people know in the room. If they know a lot about SOP we are going to try and fine tune your skills. Listen for what you do not know as well as what you know. Pocket what you know and add the new information. This will help you know what questions to ask us for the next level of training. The hard thing in adult learning is to be able to go to the next level of learning when you already do the practice. People do not know what they do not know – so we are looking for what they do not know. Same as with a family when you get a referral or a case. I know something but I am constantly looking for what I do not know so I have a better and clearer understanding.

- ☐ Trainer Introductions (Time: 10-15 minutes)
  - ✓ Introduce yourselves as trainers and go over logistics (lunch, breaks, bathrooms, attendance sheets, walk-in forms for those not listed on attendance sheet, etc.)
  - ✓ Share your experience and why you are excited about SOP
  - ✓ Sample intro: Welcome to the Safety Organized Practice (SOP) 2-day Foundational Institute hosted by Northern Academy. This training was originally presented as a 3-day training and was revised in January, 2016 and changed to a 2-day training. The most recent revision was completed in January, 2020. The original version was developed in partnership between Children's Research Center (CRC/developers of Structured Decision Making), California Department of Social Services (CDSS), and the California Regional Training Academies (RTAs).

- ☐ Participant Introductions: OPENING CIRCLE
  - ✓ Ask participants to form an Opening Circle around the room
  - ✓ ***Intro:*** Opening Circles provide an opportunity for everyone to share and participate, and also sets the participatory tone for the day.
  - ✓ ***Once they have formed a circle explain:*** For this opening circle, please share the following:
    - Your name, which county you are from, what your role is, how long you have been in your current role, and what do you want to get out of this training? Or what excites you about SOP?
  - ✓ As the trainer, please start the opening circle with your own information, which will be a refresh from the bio above. If there is more than one trainer, please have one go first and the other go last so that it is a smooth transition to the next activity.
  - ✓ Thank them for participating. Allow them to sit down and acknowledge the varying levels of experience in the room.

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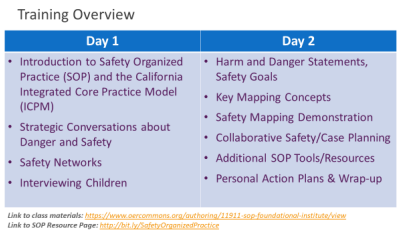
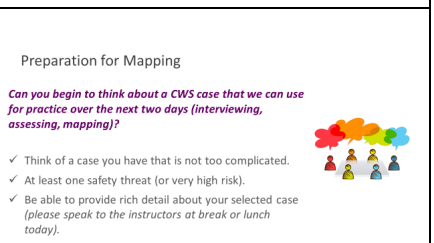
- ☐ Provide an overview of training topics that will be covered over the two-day training.
- ☐ This training is a mandatory pre-requisite to all other SOP trainings & skills labs. Please note: This training is foundational and briefly introduces you to SOP tools and strategies. You are strongly encouraged to attend additional SOP trainings and skills labs to deepen your practice!
- ☐ Please check our website under "Safety Organized Practice" to see additional SOP offerings: *https://humanservices.ucdavis.edu/northern-academy*
- ☐ Briefly review class materials. All materials for this class are on our resource barn and the participant workbook is required as it includes the activities for the class.
- ☐ ***Link to class materials:*** *https://www.oercommons.org/authoring/11911-sop-foundational-institute/view*
- ☐ ***Link to SOP Resource Page (for additional SOP tools, articles, quick guides, etc.):*** *http://bit.ly/SafetyOrganizedPractice*



- ☐ Before continuing with foundational concepts, prepare participants for the mapping activity that will occur on Day two.
- ☐ Ask them to think of a child welfare case that may be appropriate for the larger group mapping practice (not too complicated with a clear safety threat).
- ☐ Ensure that each table has an SDM manual.

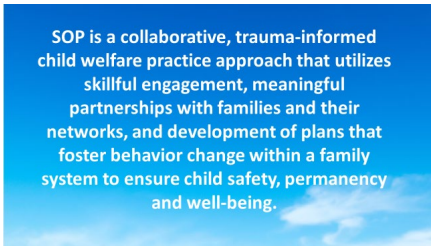
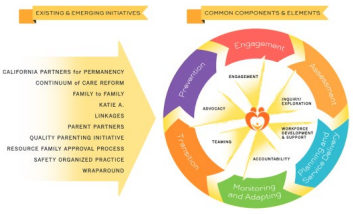


- ☐ ***PLEASE NOTE:*** If this class is part of Core, please remind the class of their group agreements they previously developed during Module 1. Ask the class – are there any changes or additions you would like to add to your group agreements? If not, move on to next segment: What is Safety Organized Practice
- ☐ ***If this is a standalone class (outside of Core) - See below:***
- ☐ Refer to handout in participant workbook: Facilitated Dialogue Structure
- ☐ Introduce the Facilitated Dialogue Structure for facilitating meetings. We are modeling this dialogue structure throughout this two – day training as we would use it during a CFT meeting. Group agreements are part of the CFT process to engage the team in how we want to work together.
- ☐ Our practices in our agencies and together should mirror how we work with families (also called a parallel process). We also want to make our own group agreements today to help create relationships and address challenges if they come up. Group Agreements are key to building rapport with families, creating shared language, expectations and staying focused on the purpose of the meeting.

- ☐ Organically develop a list of agreements that everyone can live with and ensure last agreements is for group to hold everyone accountable to their agreements throughout the 2 days.
- ☐ If they get stuck pose questions like, should there be a disagreement, should we have an agreement about how we'll deal with it? Think of a previous group experience or training you have had that was successful and worth your time … what made it so? What has made you feel comfortable in a classroom in the past?
- ☐ Suggested Talking Points:
  - ✓ Let them know that the process of creating agreements should become one of the tools in their toolbox.
  - ✓ They should be creating agreements with their families and before any meetings they have.
  - ✓ Creating agreements is trauma informed.
  - ✓ One way to successfully work across differences here is to create community agreements. Agreements are somewhere between a promise and a ground rule and they answer the question of how we want to work together throughout the workshop.

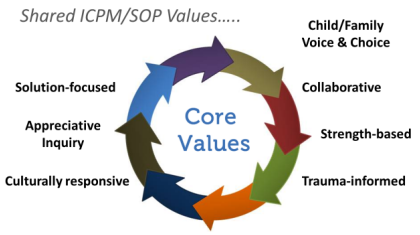
Suggestions:

- Be open to learning something new and broadening your perspectives
- One person talks at a time
- Avoid sidebar conversations
- Be conscientious with your cell phone use
- Be open to others' opinions, thoughts, feelings, etc. (no judgments)
- Being aware of the differences between intent and impact acknowledges that I may have the best of intentions when I speak, but my intentions do not guarantee that the impact will be benign. This should be a place of dialogue and group learning, but we need to be aware that what we say may be hard for someone else to hear, without our realizing it. This agreement is about recognizing this can happen and being on the lookout for it.
- Everyone always has the right to pass.
- Silence is a contribution.
- Share airtime and stick to time limits.
- Speak personally, for ourselves as individuals.
- Allow the trainer to keep us on track and bring us back if we get off track

• Maintain confidentiality • Participate and have fun! ☐ **NOTE:** It is good to go over the other agreements briefly, then ask the group: "Are folks OK with proceeding with these agreements? Does anyone want to offer a tweak or change to any of these?" A willingness to incorporate change can help signal to your group that this is truly a participatory and collaborative process.	
☐ ***Next segment: What is SOP and the Integrated Core Practice Model (ICPM)?***	
☐ Animation: Words automatically fade in. ☐ What do we mean when we say "SOP"? SOP is both a framework for practice and a set of tools and strategies that help child welfare staff achieve the Integrated Core Practice Model behaviors of engagement, assessment, teaming and planning with a family and their network. ☐ Refer to handouts in participant guide: Intro to SOP – Quick Guide, SOP Glossary, SOP Key Elements, SOP Contributors ☐ A network is critical, because children and families need people in their lives without expiration dates. ☐ SOP prioritizes prevention – it highlights early intervention with families to avoid trauma caused by unnecessary separation of children from their families whenever possible. ☐ SOP focuses on the social worker as practitioner and change agent	
☐ The California Child Welfare Core Practice Model, which has now been integrated into the Integrated Core Practice Model, has been in development by the counties since 2012. The intent was to create one unifying framework for California child welfare practice that incorporated the key elements of many other initiatives, such as those listed here. All of these, California counties have tried many promising practices to improve outcomes for children and families ☐ It was observed that many of the new practices had common elements ☐ CAPP and Katie A./Pathways to Well-Being gave the state its first exposure to thinking about the benefit of implementing a comprehensive model ☐ Many practices including SOP, were built upon to create the CPM and subsequently the ICPM.	

Safety Organized Practice

- ICPM & SOP share the underlying values of HOW we work with families
- SOP is comprised of what has been found to be important in Child Welfare social work practice.
- How do you practice as a social worker? How do you use social work skills to enhance the skills of those around you? What are your values as a social worker and how do you work with families in a respectful and ethical way?
- SOP involves taking a humble approach to the work and demonstrating a belief that families have their own answers and that it is our job to help them discover and build on those answers. It involves understanding the impact of trauma and that most everyone involved with child welfare is impacted by trauma.
- Further, it involves an awareness of the trauma the CW system itself creates for families and children and learning to practice in ways that acknowledge and try to reduce this impact. It involves taking a team approach and using skills to assist and encourage others to build their own supportive network and taking the time to instill hope and focus on what's good and right in people lives.

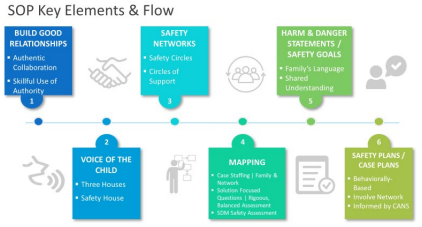


- Here are just some examples of SOP tools/strategies that support ICPM.
- For example, this includes things such as solution-focused questions for engagement, assessment and planning; the Three Houses/Safety House to engage the voices of children and youth; facilitated meeting dialogue structure as an engagement strategy for CFT meetings; Safety Circles/Circles of Support to build the network/child and family team; etc.

- This is an example of how the practice behaviors of ICPM align with tools of SOP.

ICPM Practice Behavior	SOP Tool
Use tools and approaches that amplify the **voices of children and youth**.	Three Houses, Safety House
Ask the family **what is working well and what they see as the solution** to the circumstances that brought them to the attention of the child welfare agency.	Three Questions, SFQs
Develop a **shared understanding** about safety, permanency, and well-being issues to be addressed with the team.	Harm and Danger Statements, Safety Goals
Facilitate **critical thinking**, discussion, mutual exploration of issues, and consensus building toward the goal of shared decision-making.	Mapping, Meeting Frameworks, Meeting Dialogue Structure

- These are the key elements of SOP including strategies used and how they flow together



Safety Organized Practice

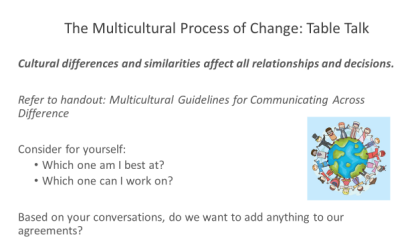
☐ The 3 primary goals of SOP: 1. Good working relationships: Achieved through *cultural humility; authentic teaming; appreciative inquiry; and trauma-informed, solution-focused and collaborative practice* 2. Critical thinking: Achieved through *mapping worries and what's working well to develop shared understanding of harm, danger and what needs to happen to ensure safety* 3. Enhanced safety, permanency, well-being: Achieved through *meaningful engagement of children/youth, families and their networks of support to achieve the least restrictive safe placement; customized, behaviorally-based plans; and shared accountability*	
☐ Review slide ☐ Goal: A family should expect to receive the same treatment and services regardless of what county they are in. This is what we are striving for.	
☐ Slide 1 of 3 ☐ Brief overview: Some of the intended outcomes of SOP when it is used and implemented to fidelity!	
☐ Slide 2 of 3	
☐ Slide 3 of 3 ☐ Any others missing from the list?	

Safety Organized Practice

- Engagement with families is key to achieving positive outcomes!
- We listen to families, tribes, caregivers, and communities and respect and value their roles, perspectives, abilities, and solutions in all teaming and casework practice.
- We encourage and support families and youth speaking out about their own experiences and taking a leadership role in assessing, finding solutions, planning, and making decisions.
- We affirm the family's experiences and create achievable goals in collaboration with the family.
- We use solution-focused, trauma- informed engagement practices and approach all interactions with openness, respect, and honesty. We use understandable language. We describe our concerns clearly.
- We connect with families, children, youth, communities, tribes, and service providers to help build networks of formal and informal supports and support connections.

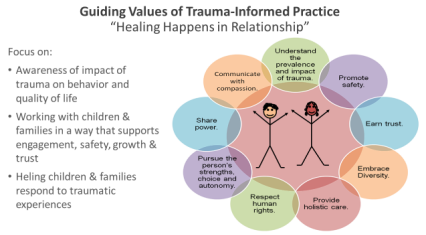
- One key element of engagement is cultural humility and responsiveness. Humility means teachable - For a lot of years we have discussed cultural competency and we have been trained on this topic … do you feel competent at other people's cultures? What does this title mean?
- The shift to cultural humility is coming from the idea that we cannot and do not need to be experts at someone else's culture. We do need to be in a space of inquiry so that we can allow each person we encounter to be the expert on their own culture. We do need to use questions and a genuine sense of curiosity about others to invite them to tell their story.
- If we remain teachable, we will be able to accomplish these goals. If we practice this type of cultural humility with others – both with our colleagues and with the families we serve … what would be different? How could it support the work we are doing with families?
- If we are not practicing this way, what barriers are created?

- Refer to handout in participant workbook: Multicultural Guidelines for Communication Across Difference
- Have participants review handout individually, then have a table talk and share your thoughts:
  - ✓ Consider for yourself:
    - Which one am I best at?
    - Which one can I work on?
- Debrief with group, then revisit Group Agreements. Is there anything we need to add? Update agreements as needed.



Safety Organized Practice

- ☐ Healing happens in relationships! Safety-organized practice draws heavily from the National Child Traumatic Stress Network's principles and strategies and from Bruce Perry's work at the National Trauma Academy, which focuses on trauma's impact on brain development and child development.
- ☐ Most of the children and many of the parents involved in the child welfare system have experienced some form of trauma. Symptoms of trauma can worsen already challenging situations and make the work of engagement and increasing child safety and permanency even more difficult.
- ☐ Reminder about ACES and correlation to trauma. For more information about ACES, refer participants to the handout in their participant workbook: "***Truth about ACES"***
- ☐ Trauma informed practice is a key value of SOP and:
  - ✓ Involves an awareness of trauma and the impact on behavior and quality of life for the entire family.
  - ✓ Assists helping professionals with focusing on the behavior of the person and what might motivate that behavior in the context of trauma.
  - ✓ Focuses on working with children and families in a way that supports engagement, safety, growth and trust.
  - ✓ Helps children and families respond to traumatic experiences



- ☐ Refer to handout in the participant workbook: SOP SW Practice Definitions
- ☐ Quick table talk: Assign each table a different principle on the slide and ask them to brainstorm for 5 minutes:
  - ✓ What ways have you seen or could you imagine this SW practice happening in child welfare?
- ☐ Quick report out: Have each group share their favorite one

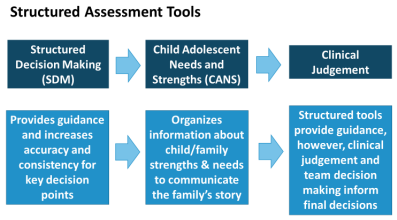
- ☐ ***Next segment: Strategic Conversations about Safety and Danger: A balanced assessment***
- ☐ Now we will move into talking about the importance of balanced assessments in child welfare

- ☐ SOP brings forward the importance of a "rigorous and balanced assessment." If we spend time on the questions of what has worked well, the answer to "next steps" become clearer. There will be solutions that come from what the family already does and therefore what the family is more likely to do again and be successful.

Safety Organized Practice

- We are trying to build on solutions that the family already uses. In SOP, the focus is on the family's voice: building from the family's ideas which helps us develop plans that are aligned with the family's culture.

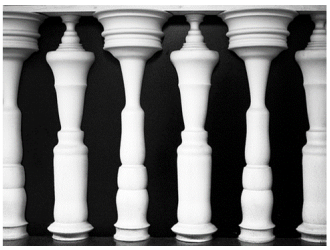
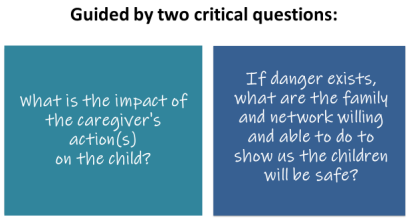
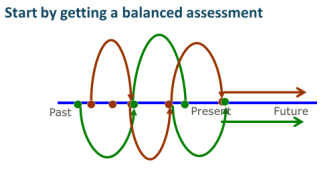
- SDM tools, CANS and SOP complement each other to help us develop a rigorous, comprehensive, balanced assessment of the child and family.
- The Structured Decision-Making system was designed to identify the key decisions in child welfare practice and then create evidence-based assessment tools that could help make those decisions accurately and consistently across even large counties and states. The SDM system is set up to bring the best of research to the important decisions of child welfare.
- CANs helps tell the family's story through prioritizing child and family strengths and needs. Participants are strongly encouraged to attend the CANS overview training to become familiar with the CANS items, how to use CANS in CFT Meetings and in the case planning process with children and families.



- This definition of Safety comes from Signs of Safety but helps hold the model together. Notice that safety is a VERB. It is more than the absence of danger.
- This is the foundation hand so complicated to see acts over time.
- Safety-Organized Practice provides an approach to child protection work that:
  - Is focused on enhancing child safety
  - Values working with families
  - Values reliable and valid assessments
  - Provides the field with practices and tools to concretely help their day-to-day work
  - Integrates rigorous, collaborative human judgment with research-built tools
- DISCUSSION: If this was the CWS definition of safety…and we shared it with families, providers, the courts…and this became 'north' on the compass and what we looked for in our **work…what, if anything, would change about CWS? What would change about your work**? Facilitate a discussion.

- We will begin by looking at an idea that is central to Safety-Organized Practice: that when we interview families, children and members of the community, we are not just interviewing for history of the Danger but also for a history of the safety that has occurred as well.

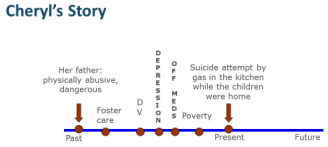
Safety Organized Practice

☐ Take a look at this image. What do you see? Notice how some say two faces looking at each other, others say a vase.	
☐ How about this image? Some will say pillars others will say people standing facing each other. ☐ ***Key point:*** Two people can look at the same situation and see two different things.	
☐ Services do not equal or demonstrate safety! ☐ For years we have used services as a way to measure safety – but does it really tell us parents can keep their children safe? How do we show the court that the parent can keep the child safe? ☐ If a parent does drugs and neglects their child, how do we know that will not happen again? ☐ We have used services – but is that really safety? Is being sober an act of protection? We would argue that it is not. Being sober means you are not doing what put your child in harm's way but what tells us it will not happen again?	
☐ Here is the work of SOP: ✓ Getting clear about the impact of the caregiver's action(s) on the child ✓ Being transparent with families about the behaviors that will keep the child safe (demonstrated over time, how the agency will measure these behaviors and how the network can support the family to achieve the safety goal(s)	
☐ We are going to talk about doing a balanced & rigorous assessment, where the history of 'safety' and 'strengths' is searched for as rigorously as the history of 'danger' and 'harm'.	

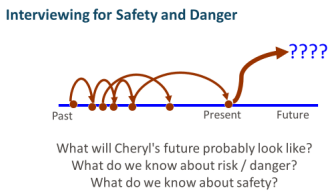
- The next series of slides demonstrates several aspects of what we will be learning, including the importance of a balanced assessment. This story is a compelling 'hook' to invite interest in learning how to develop a complete assessment.
- ***Cheryl's Story:***
  - ***Note for trainers:*** This is a true story – Cheryl's story has been around for a long time but is new for new workers. It is now being integrated throughout state curriculum i.e. Core, CANS, CFTM Facilitation, etc.
  - Cheryl is an African-American woman in her late 30s with two children (ages 4 and 6). She made a significant suicide attempt by turning on the gas in her oven while both children were home.
  - All three of them passed out and it was only through a neighbor smelling the gas and breaking down the door that more serious injuries were averted. The children were placed together in foster care; mother went to a psychiatric facility and was released 10 days later.
  - Cheryl is currently not suicidal and is expressing a lot of regret.

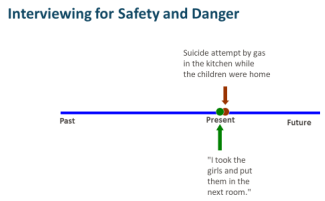
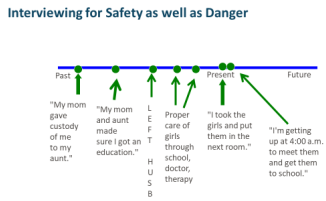
<u>You meet with her to do a standard assessment and this is what you learn:</u>

- Her father was abusive to her and her mother. He drank and smashed things around the home.
- Things got so bad that Cheryl went into foster care herself.
- As she got older, Cheryl engaged in relationships with men who were violent, including the father of the girls.
- This finally led to Cheryl being diagnosed with depression.
- More recently, she has gone off her medication.
- Even more recently, Cheryl lost her job as a clerk at a store, leaving the family dangerously close to poverty and not having enough food to eat or money to keep the heat on.

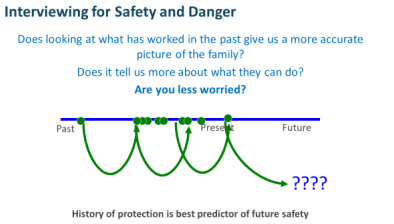
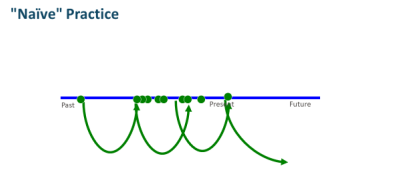
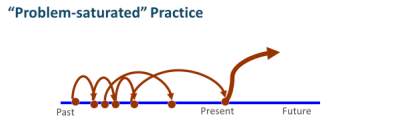
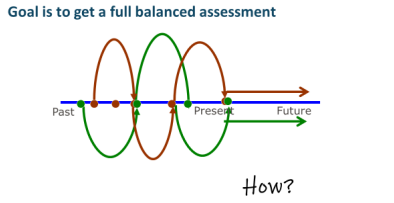


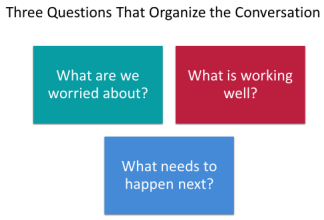
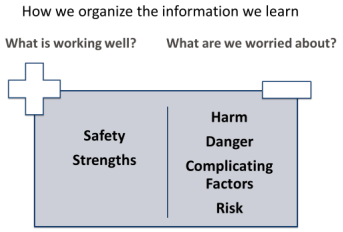
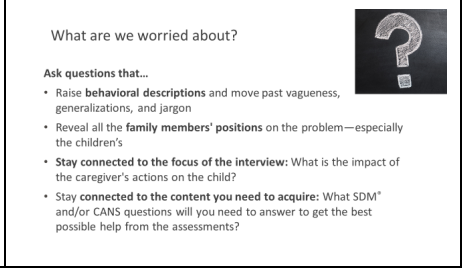
- PURPOSE: To help participants experience how our conclusions can be very pessimistic when we have only surfaced negatives.
- Normally when we hear a story like this we begin to 'connect the dots' to make sense of the story. We construct a narrative of events so we can make sense of it and compare it with other experiences, stories, and training.
- Given what we know, what would you say about Cheryl's future?
  - Are we in a position to make even a good educated guess?
  - What do we know about Danger? Probably a good deal. Where is your 'worry meter' based on what you know so far?



• What do we know about safety? Not really anything at all. • Does that get in our way of making a good guess about what Cheryl is likely able to do next to keep her kids safe in the future? • We need to become EQUALLY as rigorous at tracking the history of the parent's 'acts of protection' as we are at the history of the Danger. ☐ ***Take another look at Cheryl's past. How much trauma is present? How much do you think that impacts her ability to parent?***	
☐ To illustrate that when we begin to ask for details, if we are listening, we may hear positives as well. We need to be equally rigorous in searching for the 'history of protection' as well as the 'history of the harm'. ☐ When Cheryl tells us about this moment, we can ask for lots of details. ☐ We learn that before turning on the gas, she took the girls to the next room and opened a window. She even put a towel under the door to keep the gas from going into the girls' room. ☐ Was that a sufficient act of protection? No. Would it be enough to return her children and/or close the case? No. ☐ But might it be important for Cheryl to know and remember? It may help her as she deals with her sadness, grief and guilt about this event. ☐ Is it important for us as child welfare to know? As part of a longer story of her acts of protection, perhaps. We can use this to ask other questions like, 'Were there times you were protected by your parents, or things you have done to keep the girls safe'? ☐ And we might learn….	
☐ ….That the foster care arrangement was a familial one. No CPS involvement. ☐ And that Cheryl's mom always stayed in her life, and worked with her aunt—Cheryl's foster parent—to make sure she got a high school diploma. ☐ That Cheryl reached the point of leaving her husband and took out a restraining order when she saw how violent he could be with the girls watching, saying, 'I won't have my girls go through what I did'. ☐ That there are many examples of appropriate care Cheryl has shown the girls. Pediatrician says she has been terrific, kids all up to date; school says kids come to school dressed appropriately, on time, with work done. Both are very surprised about what happened. And finally, we learn… ☐ That Cheryl knows the foster mother who is taking care of her kids ('we went to high school together'). Cheryl has been getting up at 4 a.m., walking more than two miles from her home to the foster mom's home to get the girls up and off to school every morning since she got out of the psychiatric hospital.	

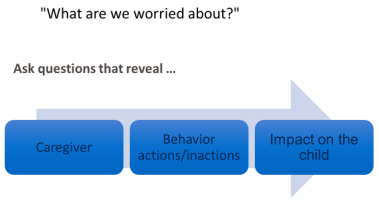
Safety Organized Practice

☐ Take a look at Cheryl's strengths. How do you think relationships helped to minimize the impact of her past trauma? How can we build on that?	
☐ Do we know a little more about safety now? ☐ We would say 'yes, we do'. Is this important for our work? Why? ☐ Where is your 'worry meter' now that you know more? Has it decreased? ☐ Key Point: We can't know *how* worried to be if we don't know both patterns of harm and protection.	
☐ If this was all we looked at, would it be enough? ☐ If we did, we think it would be fair to call this 'naïve practice'	
☐ Looking only at problems is an incomplete assessment ☐ But if this was all we looked at, would it be enough? Family therapist Michael White used to call this a 'problem-saturated story', a story that only considers the problem and the Danger. In its own way, this would be another kind naïve practice.	
☐ We are talking about doing a full assessment, where the history of 'safety' and 'strengths' is searched for as rigorously as the history of 'Danger' and 'harm'. ☐ In this training, we will focus on ways to do rigorous and thorough balanced assessments ☐ We will explore ways to engage with families in order to surface important behavioral detail about both worries and safety. ☐ We will learn: ✓ Very specific styles of questions that help families think about things in new ways. ✓ How to use assessment tools and their definitions to shape the most important information to seek at different key decision points. ✓ Ways to gather information from multiple perspectives. ✓ How to use an assessment with a family to create rigorous plans that leads to safety. ☐ **Table Group Discussion:** Ask people to discuss at their tables: ✓ How is this example like the current practice in your organization?	

✓ What is similar? ✓ What is different? ☐ **Then debrief with group	
☐ ***Next segment: The Three Questions*** ☐ Let's take a look at some practices for conducting a rigorous balanced assessment. ☐ The first practice that will help with that is the Three Questions.	
☐ In thinking about doing a rigorous, balanced assessment there are three basic questions as guides for helping us with our work. At their most basic, both SOP and SDM assessments can be boiled down to these three questions. ☐ Every interview and every stage in the life of a case (ER, FM, FR, PP, etc.) needs to cover these three main issues. ☐ And while they are very simple questions, sometimes in the heat of the moment—in the middle of a complicated assessment or home visit—it can be helpful to have simple maps or guides to remind us where we want to go. ☐ The details of how we ask these questions and what content to focus on will change, but these are the three most central questions. **They are valuable at every stage in the life of a child welfare case from screening to adoption.** ☐ These can also serve as a way of preparing the caregivers, family members, collaterals, and even the children for the interview. When we tell them, "I'm going to be asking you a lot of questions, but they all boil down to these three…" we help prepare the interviewee for what we are looking for. It starts us off on the right foot for collaboration and better helps them prepare to participate.	
☐ This is how we organize the first two questions: ✓ What is working well? ✓ What are we worried about?	
☐ It is easy to get in the middle of an interview and get carried on waves of information. You may follow up on things that have already been said, latch onto things that seem important at the time, then return to the office with the realization that you have a lot of information, but it may not all be relevant, and you may not have what you need. These prompts can help us plan in advance and create important questions "on the fly" when needed.	

- ☐ First, in all of the vital areas, we need questions that surface behavioral descriptions, not just headlines, jargon, and vague statements full of implications and innuendo. If a topic has been introduced and you realize you are unclear of the who, what, when, where, and how of it, you will need more questions. (More on this in a moment).
- ☐ Next, remember that any bit of information from one person's view is only that—one person's view. For critical areas, we need to know the views of all family members. This includes the very important views of the children, and we will spend almost all of the next module on strategies for doing that. When parents are telling you about their own lives, it is important to bring the conversation around to the impact on the child. Parent information is important to child protection to the extent that it reveals the impact on the child.
- ☐ Clearly, the points above have a way of expanding the interview. Getting more detail, more points of view, and extending conversa<on about parent behavior to understand impact on the child can substantially increase the scope of the interview. It's important to stay focused so that we do not collect all of this rich detail on every area of family life.
- ☐ Know where you are in terms of the key decision at hand, and rely on the relevant SDM assessment and/or CANS to help narrow your interview in useful ways. Determine the right tool to use before you go out and use the items on that assessment to create a frame through which you will look and ask questions. You do not need to limit yourself to the items on the tool—it's not an interview guide—but it can be an aid in helping to prioritize information.

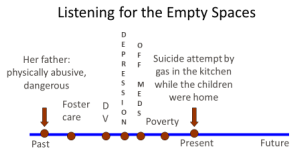
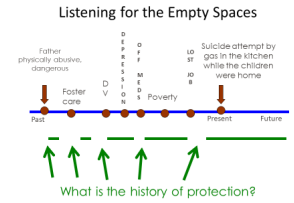
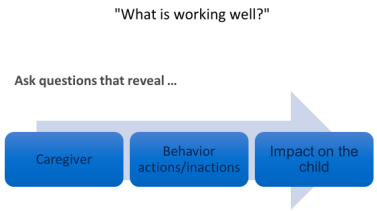
- ☐ When we are seeking out answers to "What are we worried about?" we need to make sure we don't have our focus open too wide.
- ☐ We can worry about a lot of things in families. But we want to use this framework as a way to focus our inquiry where it should be for child protective services.
- ☐ The key elements should be:
  - ✓ **Caregiver.** In child protection, if a stranger on the street, a teacher, or even an uncle who doesn't live with the child hurts the child, we may be saddened by it, but it may not require action by a child protection service.
  - ✓ **Behavior.** The caregiver has done something or failed to do something. It is a specific behavior. Can we get good at naming what that is?
  - ✓ **Impact.** There must be some significant impact on the child. What is it? Can we describe it? How can we see it? Who can we talk to?
- ☐ All of our work around figuring out the worries should be organized around this and we should be able to articulate this about any case we have open.
- ☐ What was the caregiver action? What was the impact on the child?



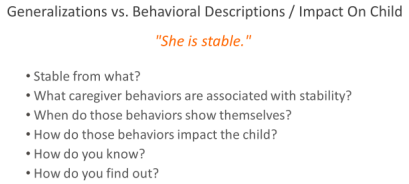
☐ We often do not use words or language that have anything to do with "impact on the child"
☐ To go a bit deeper, we will start with the notion of surfacing behavioral detail. We often rely on headline terms to convey information about a family. "Mom is mentally ill" is one example. It is natural for us to create time-saving devices when certain terms, like "mentally ill," stand for a fairly rich and detailed set of facts in our heads. The problem is that we each have different, though accurate, notions of this detail. Unfortunately, the standard set of details that come to mind when hearing the term "mentally ill" may not accurately reflect what is going on with this caregiver.
☐ Think: Do we open a case on every parent in our area who has a mental illness? (Actually get them to answer.) Why not? (See if they begin to say that the vast majority of parents with mental illness adequately protect their child. Minimal or no harmful impact.)
☐ Yet we include terms like this all the time in reports and discussions with supervisors, teams, and the courts, and we nod our heads as if we now know something important about this mom. We think we all agree on the meaning.
☐ To avoid falling into traps of headline terms, here are some ideas for questions to ask: (Go over these questions as examples. Ask for other ideas)
	Generalizations vs. Behavioral Descriptions / Impact On Child
	"She is mentally ill."
	• How does he/she know?
	• What caregiver behaviors are associated with it?
	• When do those behaviors show themselves?
	• How do those behaviors impact the child?
	• How do you know? How do you find out?
	  • What does the child know?
	  • What has the child seen?
	  • What are you worried is happening or will happen?

☐ Here is another example: Do we open a case on every parent in our area who is an alcoholic? Why not?
☐ What helps us to distinguish?
☐ Rather than simply stopping with "He's an alcoholic," we need to inquire about specific behavioral detail about impact on the child.
☐ Brief discussion: Ask the group:
  ➢ "What do you think about this?
  ➢ Do we use language like this?
☐ What is the danger for us as an organization if we use words like this in our supervision, in our court reports, in our conversations with parents?
	Generalizations vs. Behavioral Descriptions / Impact On Child
	"He is an alcoholic."
	• What does he drink? When does he drink? How often?
	• Where is the child when he drinks?
	• What caregiver behaviors are associated with it?
	• When do those behaviors show themselves?
	• How do those behaviors impact the child?
	• How do you know? How do you find out?

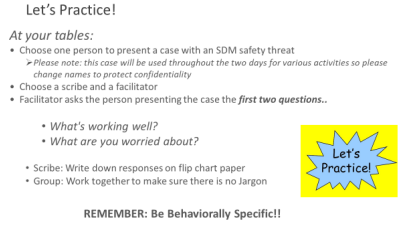
☐ This is the second question and we really want to start thinking about that rigorous, balanced assessment. ☐ Remember, if we ask only about the history of the harm and not about the history of protection, we don't know how worried we should be. If we inquire deeply about the history of protection—times the parent was able to respond to Danger and safety threats….. ☐ …..and we find he/she has not done very much in response that is really important for us to know. And if we inquire deeply about times the parent was	What's working well? *There is always a history of protection.* • Based in solution-focused questions. • If we do not know "what is working well," we do not know how worried to be. • Ask questions that rigorously surface the history of protection and how that history can be applied in the future for the child's safety. • "Listen for the empty spaces." 

able to protect his/her child, and we learn there have been many times, that also is really good for us to know.	
☐ It is important to seek out what is working well through "listening for the empty spaces" ☐ When we think about Cheryl's story we can fall into the practice of only asking about and listening for the history of the harm and Danger. It is understandable that we do this—we are listening to "scary" things and we were trained to track those items in our listening. But we can begin to do more.	
☐ It is important to look for what is working WELL ☐ Looking at Cheryl's story, **serious concerns** but **also lots of "empty spaces"** – where **time has passed, and we don't know what has happened in between**. ☐ Those **spaces could be filled with more of the concerns…**but **they may also be filled with moments of strength and safety.** ☐ Even in the list above there is evidence of things that might have worked well for a while. ☐ **Do you see "empty spaces"** where may be **evidence of Cheryl's strengths and safety?** ✓ She lost her job means **she once held a job** ✓ Stopped taking medication means she was **once on medication; how did that happen**? We learn **Cheryl sought therapy and medication herself –** Also, had **no prior CPS referrals despite challenges** she faced.	
☐ Working well, like worries, stays focused on impact. ☐ Just like with the "worries," we are likely to hear many answers to this question. All of it may be important, but only some of it is relevant to child welfare work. Are we most interested that a child is good at basketball? That a parent is good at crossword puzzles? My personal favorite is: Mom got new curtains. [Fill in the blank here w/ your own]. ☐ Those may be things that are "working well" but they are not our focus. We should begin sorting and listening through the "working well" for what the parents are doing that has a positive or protective impact on the child? ☐ ***NOTE:*** Depending on time, rather than giving the above examples, you could try to surface examples from the group. "Can you tell me about a 'working well' in one of your families that is really making a difference, that you can tell is making an 'impact on the child'? Can you tell me a 'working well' that isn't having much impact?"	

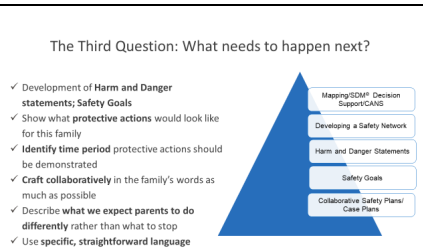
- ☐ Just like in the "worries," we need to be rigorous about getting behavioral detail regarding what is working well.
- ☐ In this example, what does "stable" mean?
  - ✓ How is it impacting the child?
  - ✓ Is it protecting the child? Does it have anything to do with the child?



- ☐ Have the groups work at their tables.
- ☐ For virtual classes: Use handout – Case Planning Worksheet
- ☐ For in-person classes: They will chart this on chart paper….make sure to tell them to keep the chart papers as we will be going back to these lists throughout the two days.
- ☐ Trainers walk around the room and help the group eliminate jargon and be behaviorally specific and to keep the focus on the safety/permanency/well-being of the child.



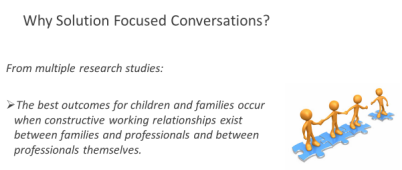
- ☐ 'What needs to happen next?' We will consider Mapping and SDM Decision support/CANS (utilizing the mapping demonstration), the development of Safety Networks, Harm and Danger Statements, Safety Goals and how this all relates to Safety Planning and Case Planning.



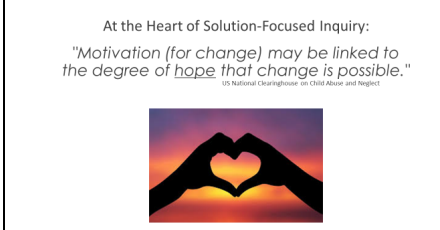
- ☐ ***Next segment: Solution-Focused Conversations***
- ☐ Refer to handout in the participant workbook: Solution Focused Questions Quick Guide
- ☐ Solution-Focused Inquiry is a different kind of practice than many of us were socialized in when we went to school.
- ☐ Developed by Steven DeShazer and Insoo Kim Berg in the 1980's and 90's, Solution-focused questions are a shift away from just looking for problems to a search for what works and helps people keep their children safe.
- ☐ It's important to be clear that **we are not talking about only using these kinds of questions,** but they can be a huge help for people moving out of the problem and into their own best solution building. **NOTE:** For counties already using Motivational Interviewing please note the alignment here.
- ☐ These questions also help us move away from being the expert and into a place of shared inquiry, openness and collaboration with family.

Safety Organized Practice

- PURPOSE: Begin to help make a case for why these are important practices to child welfare.
- Child welfare is still in many ways a young field. Nursing, for example, has been around since the 1850s. We are still just beginning to learn what really works in child welfare, what helps and what does not.
- One thing that becomes clear in research and common sense is that a good working relationship between family and worker is always one of the biggest predictors of success.
- By a good working relationship, we do not mean one where workers simply do everything families tell them. It is one of mutuality, of honesty, of transparency, where we say what we mean, and do what we say we will.\When we can do that, we are taking steps toward a good working relationship, and solution-focused questions are a tool to help us get there.
- They help us have a different kind of conversation with families.

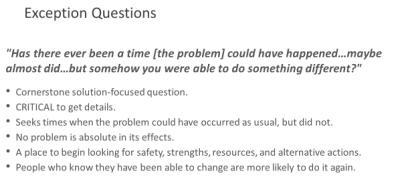


- If we had to pick one way to summarize how solution-focused questions can help or why they are useful, it might be this:
- *People will not change if they do not feel a sense that change is possible. They need hope.*
- These kinds of questions, and the good working relationships you will make, will help families find that hope.
- An example of this is found in Australia's history: "The stolen generation": Between 1910 and 1970, many indigenous children were forcibly removed from their families as a result of various government policies and in the name of assimilation into the white society. There was physical, emotional and sexual abuse and they received low levels of education (similar to Native American children). Many children were placed into slavery and were told that their parent either died or abandoned them. Parent saw that other people's children weren't being returned and eventually didn't show up for visits because it literally broke their hearts. Some parents never recovered from the grief.
- Trainer note: Signs of Safety was developed as a response to this and was the precursor to Safety Organized Practice. More info about the history of SOP can be found in the participant guide for this class.
- One of the things we need to be careful of in child welfare is not to destroy hope for families.

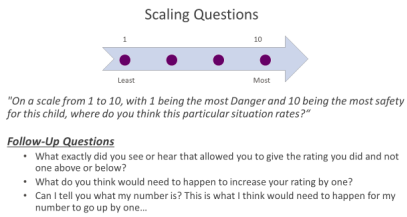


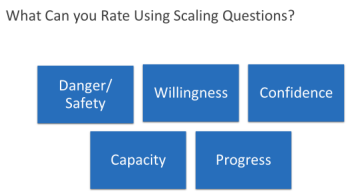
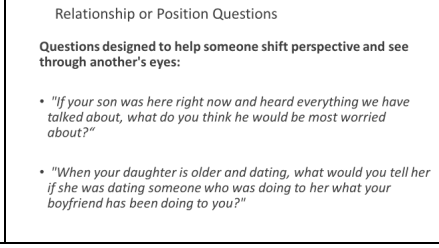
- These are the five types of solution-focused questions we are going to cover today - wrapped in a spirit of cultural humility and viewed through a multicultural lens.
- While Cultural Humility is not a Solution-focused practice, we can make sure that our inquiry stays in that humble place, especially when working across difference, that we can make sure to make our questions account for people's own unique cultural heritage, background and stories.
- Share developmental nature of solution-focused practice – takes time to learn to finesse and make questions natural and your own…
- Are any of these familiar? (**NOTE:** You can take some examples and offer brief feedback and/or do quick introductions of each kind of question).
- We are going to briefly walk through each of these in the next few slides

- Exception questions are the basic building block of all solution-focused practice. They have at their core a single idea: that no problem is absolute; that if the child is alive there are always some signs of safety—always some history of protection—that we can find and seek to grow with the parent. This is the basic form of an exception question.
- While the job of the interviewer is to tailor it to the specific moment and content you are asking about, this gives you a sense of the shape it takes and what you are looking for: times the problem could have happened, maybe almost did happen, but did not.
- If time allows, it can be useful to ask the group about the benefits of asking questions like this.
  - ✓ Do you ask these kinds of questions already?
  - ✓ What is the benefit for us as CPS?
  - ✓ What is the benefit for the family?
  - ✓ For relationship building?
  - ✓ For beginning to move toward change?



- Have you ever visited a doctor who asks you to describe your pain level where 10 = the worst pain you can imagine, and 0 = no pain at all? That is a scaling question. Pediatricians use the same scale with children who may not understand numbers very well by showing them an array of faces from a happy smile to a frown to a crying face.
- One thing scaling questions do for us is take an abstract or emotionally-charged idea (like how much pain, or how safe someone feels) and give it a concrete anchor.
- They also help us think along a continuum rather than on/off thinking. They turn light switches into dimmer switches.



☐ Have any of you tried these kinds of questions? How does it work for you? How do you think these can be helpful in our work? ☐ Scaling questions are typically framed using a scale of 0 to 10, where 0 is the least of something and 10 is the most of something. ☐ Traditionally, the 10 is the good thing and the 0 is the not--good thing. Using this pattern helps avoid confusion, i.e., was 10 the good thing or was 0 the good thing? ☐ The numbers on the scale have no 'real' meaning. ☐ Scaling questions answers are not evidence and are not based in research. ☐ TRAINERS: Allow discussion. Look for ideas such as: • We see families as being on a continuum versus all good or all bad; • It creates a way to get incremental change, which is more achievable than moving all the way from on to off.	
☐ Introduce various ways scaling questions can be used. ☐ Scaling questions can be used in many ways. Five big categories are shown here. ☐ <u>What's working well</u>? ✓ Danger and safety questions ✓ Progress questions ☐ <u>What are we worried about</u>? ✓ Danger and safety questions ✓ Progress questions ☐ <u>What should happen next</u>? ✓ Willingness, capacity and confidence questions ✓ Progress questions ☐ *The Danger and safety questions, in many ways, are the most important scaling questions we can ask ourselves, our supervisors, managers and most especially, the family. We want them to be thinking this through with us.*	
☐ Position questions can be very powerful in helping people begin to see their own situations through other people's eyes. ☐ Has anyone tried anything like this before?	

- When dealing with difficult behaviors or situations, you can ask questions in a way that demonstrates empathy and compassion.
- These questions acknowledge your understanding of the pain, fear or frustration that the family member may be experiencing.
- It also helps to point the way toward behaviors they may be engaged in that are helping but have not actually been recognized yet.
- Have people tried questions like this? Have you been able to get these kinds of details from the follow-up questions? How does it affect your work when you ask this?
- Notice the position question thrown on the bottom of the slide. Are you beginning to see how these might all work together?
- The last solution-focused question we are going to cover today is the preferred future question.
- Think about it this way: When things are bad, when you are stuck in a really bad place, it is really important to have a vision of where you want to go instead.
- In fact, it is going to be really hard to move anywhere if you do not have a sense of where you are going.
- These questions are a vehicle or tool for beginning to imagine where that place would be—where you want to go.

Coping and Preferred Future Questions

Coping
- "The things you have been going through are not easy. How do you think you have been able to do as well as you have?"

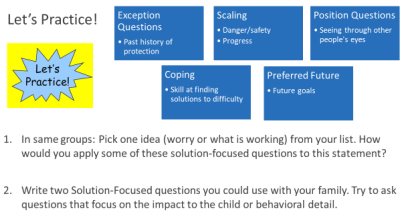
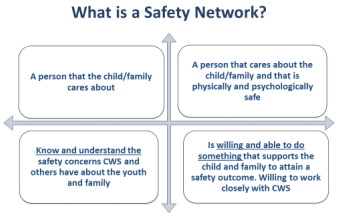
Preferred Future
- "You are pretty clear that this is not how you want things to be. How would you like things to be instead? What needs to happen for things to be like that?"
- "Ten years from now when your child is older, what story do you hope he/she has of this time?"

- Luck Luckey (formerly Alison Luckey as she is referred to in the video), when she was a senior social worker from San Diego County who had been learning about SOP for about a year. In the video, she talks about interviewing a mother after an infant has been injured in a car crash following a violent episode between the parents.
- Prior to the video, introduce the group to Luck and tell them they will see work she did for an emergency referral. Ask them to watch for three things.
  1. Where do they see her interviewing for safety as well as danger?
  2. Where do they see the Three Questions?
  3. Where do they see solution-focused questions?
- ***PLAY VIDEO***
- Afterward, have them respond to the above questions and answer the following.
  1. What do they think worked well?
  2. What concerns do they have?
  3. What difference do they think the approach made for this case?
- It is useful to emphasize that this case is so serious, the child will likely be removed no matter what Luck discovers. One might legitimately ask, "Why bother?" Luck's approach lays groundwork for a better working relationship between the mother and CPS that could significantly speed up reunification.

Why Solution-Focused Inquiry?

https://www.youtube.com/watch?v=a4pz_ymwFJ8

Safety Organized Practice

☐ For an advanced group, point out that about nine minutes in, Luck makes a danger statement with the mother just through asking questions.	
☐ Have groups get back together and look at the list they created using the two questions "what's working" "what are you worried about" and create two solution focused questions they could use to elicit information from the family. ☐ Refer to handout: Solution Focused Questions Quick Guide for examples ☐ For virtual classes, use handout: Case Planning Worksheet ☐ For in-person classes: Have one member of the group chart on your chart papers	
☐ ***Next segment: Enhancing the Safety Network*** ☐ Refer to handout in the participant workbook: Circles of Support Quick Guide ☐ What are safety networks? Why are they important in child welfare? ☐ A key component and goal of safety mapping is the Safety Network. Plans cannot be made to keep children safe without the involvement of a network.	
☐ What are safety networks?	
☐ What are safety networks?	
☐ Why safety networks? ➢ They are essential to supporting the family and ensuring long-term sustainable safety for children! ➢ CWS involvement is TEMPORARY. ➢ A once-a-month home visit IS NOT enough to ensure child safety. ➢ A network of PERMANENT support people is needed to enhance safety. ➢ **Families often have more people already involved in caring for their children than we know.**	

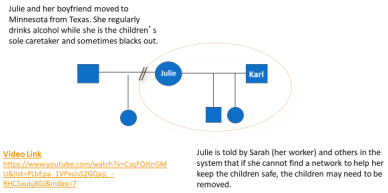
- We frequently ask people to engage in "services," even when it does not directly address the danger. We could utilize a similar "push" to bring more people to the work of enhancing daily safety for children.
- Identification of Safety Networks should start at intake / initial referrals. Intake workers should be asking about any support people available to support the family and provide safety for the children. This will assist investigative workers to determine if a safety plan can be created and / or identify support people that can be invited to the initial CFT Meeting.
- It is easy to believe people don't have anyone else in their lives to help them. We start believing that for good reasons.
- Sometimes that's what parents tell us because they want to maintain their privacy.
- A child welfare intervention is frequently experienced by families as intrusive and embarrassing.
- When we start talking about "who else is in your life," parents can be understandably reluctant to want to include anyone else.
- Sometimes, though, parents tell us "I don't have anyone" because they really believe it. And while it certainly is true that there are times and situations where parents really have "no one" they can turn to, often there are more people in and around a child's life that would step up if asked than a parent realizes. Our work can be an aid in helping parents begin to see and utilize those people well.
- ***Cases with more danger and more risk can benefit from larger networks and greater network involvement, but adding even one person can make a huge difference!***
- ***Tools to support network development & documentation:***
  - ✓ ***Genograms***
  - ✓ ***Eco-maps***
  - ✓ ***Safety Circles***

- ***No network = No plan***

We are working toward this goal:

- ***VIDEO INTRODUCTION:***
- I will show you a seven-minute video about networks and what it is like to be in one—from the perspective of someone who was in one. This video shows Julie, a mother who worked with Carver County CPS. Carver County is a small county in Minnesota with one of the longest running and strongest Signs of Safety implementations in the United States. Julie and Carver County CPS have graciously allowed us to see a little of their work together.
- As background, it is important for you to know that Julie came to Carver, Minnesota from Texas with her children and long-term boyfriend. In Texas, Julie struggled with a significant drinking problem and lost custody of her oldest daughter, who now lives with her father. In Carver, Julie's drinking has not decreased. She drinks regularly while she is the sole caretaker of the children and has passed out on occasion while caring for the kids.
- When Julie starts working with CPS workers in Carver County, they try to help her identify a network to help her and her partner ensure the children will be safe. While the CPS workers would like her to be sober, the focus is not on immediate sobriety; it is on finding a network that ensures her children are safe no matter what. Julie, quite understandably, says, "I just moved here from Texas—I don't know anyone!" And Sarah, her CPS worker, says, "We know, but none of us like where this is headed. You could lose custody of your children. What you are going to need to do is find some people. It's non- negotiable."
- This video is of Julie, a year after her Carver County CPS work was completed, being honest and direct with them as she remembers this part of their work together: building a network.
- Listen for what she says about the network—how she felt when she was first asked to find a network and what, if anything, has changed over time.
- ***VIDEO DEBRIEF***
- Trainers can ask about the following areas during the post-video conversation. They might want to pick three or four areas.
  - ✓ What did you notice about Julie's attitude at the start of the effort to build a network? Did it change? What helped it change? How does she talk about it at the beginning and at the end?
    - Teaching Point: Clients may start with one opinion about a network and shift over time.
  - ✓ "I had to make myself do things at first; I wasn't very good at it. There was no beer there; what are we going to do?" What did you think of this line?
    - Teaching Point: Clients who have used alcohol for many years may have very diminished sober-social skills. By asking them to build a network, we are asking them to do something that can be quite hard, but also very helpful.

Safety Network Example: Video from Carver County



- ✓ "They would make sure that I talked to somebody. 'If you don't hear from Julie, you need to call her.'" And then later: "I had people who would just nark me off. If you can get an insider, someone on the inside …"
    - Teaching Point: You can see the beginnings of the safety plan they had in place. There was more than just "if you don't see her, call her," but you can see the network was not just about support—it was about safety as well.
- ✓ Dan from Carver: "What was it like for you to ask these people to be in your network?" Julie: "I hated every minute of it. I didn't want to do it. My thought at first, 'I'm not going to stay here … I'm just playing to get along.'"
    - Teaching Point: She was not really embracing a change at the beginning, and, in fact, she was actually out to scam them in some ways ("I'm just playing to get along"). That did not stop her from making a change. Sometimes people start in a "pre-contemplative" place, where they have no insight into a needed change. That does not mean he/she will not take action, gain some insight eventually, or decide he/she wants to make a bigger change in the future. (We will come back to this point about insight in the next module.)
- ✓ Dan from Carver: "It didn't seem like Karl always narked you off." Julie: "Most of the time he narked me off. He would sneak off and go call her. There maybe were times he didn't, but he was just done. 'You have to put the kids first. The babies have to come first.'"
    - Teaching Point: It is hard to know without hearing from Karl, but Karl saying "You have to put the kids first" likely demonstrates that he was beginning to understand the importance of child safety, which is what we hope for in our work with families—that they begin to understand safety has to come first.

☐ Ask for other comments/questions as well.

☐ ***OTHER AREAS TO CONSIDER***

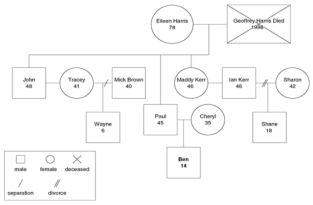
☐ Trainers can ask the group what they know about asking someone who has been drinking for years to be sober and using that as a case plan goal. Does that make sense? When would it be the right thing to do? Is sobriety the same thing as safety?

☐ Some workshop participants make the point that this occurred in a rural county, and the situation would be different elsewhere. While all jurisdictions and areas are different, it is likely the county's rural nature was not the biggest reason for the case's success—it was the worker's insistence that a network be formed and Julie's courage to try new things.

Safety Organized Practice

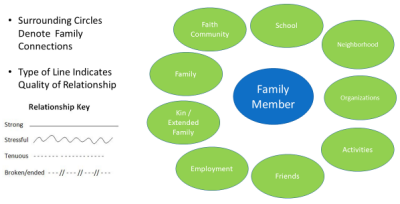
- ☐ Briefly review the genogram as a tool to document safety networks
- ☐ Used in: RED teams, Child & Family Team meetings, etc.
- ☐ An example of the genogram is in your participant guide on the class website

Genogram: A Graphic Representation of the Family Tree



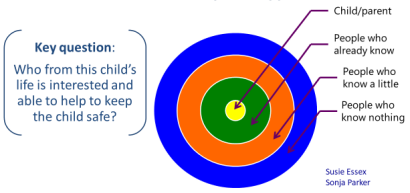
- ☐ Briefly review the eco-map tool
- ☐ Can be used in Child & Family Team meetings and case consultations/mappings to determine additional supports for the family
- ☐ An example of the ecomap tool is in your participant guide on the class website
- ☐ Briefly review the eco-map tool
- ☐ Can be used in Child & Family Team meetings and case consultations/mappings to determine additional supports for the family
- ☐ An example of the ecomap tool is in your participant guide on the class website
- ☐ Creating an ecomap is a graphic and useful way of assessing families in which the families themselves can participate. This method of diagramming depicts the family in their dynamic ecological system. Other important systems that influence the family are included in the ecomap.
- ☐ The ecomap also provides a picture of the important nurturing or conflict-laden connections between the family and the world; demonstrates the flow of resources, or lacks and deprivations; and highlights the nature of the interfaces and points of conflicts to be mediated, bridges to be built, and resources to be explored.
  - ✓ **"Who do you care about?" and "Who cares about you?"**
  - ✓ Extended family/friends who have cared for you or about you in the past

Eco-map: A visual representation of the family as a system



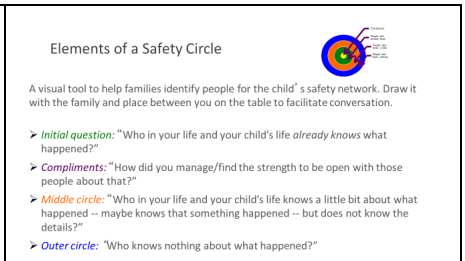
- ☐ We are going to introduce a tool that, like genograms and ecomaps, is a way to help workers and families begin to identify members of networks.
- ☐ The safety circles tool was developed by Susie Essex in England for holding a conversation with a family specifically about building networks.
- ☐ This is a dynamic process and is supported by inquiry and questions.
  - ✓ Who from the middle circle would you most want to move to the inner circle? Why?
  - ✓ What would tell you someone in your life was ready to move to the inner circle?
  - ✓ If I said you had to move someone to that inner circle for us to take the next step in this case, who would you pick?

Enhancing the Safety Network: Circles of Safety and Support

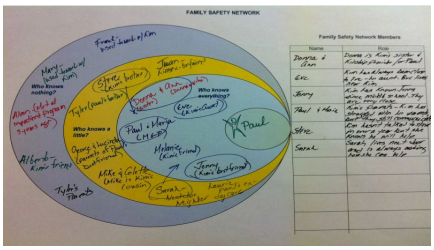


Safety Organized Practice

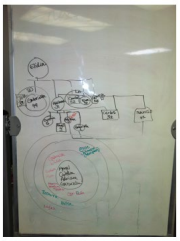
- ☐ Read key ideas on slide related to using the safety circles.
  - ✓ *Initial question:* "Who in your life and your child's life *already knows* what happened?"
  - ✓ *Compliments:* "How did you manage/find the strength to be open with those people about that?"
  - ✓ *Middle circle:* "Who in your life and your child's life knows a little bit about what happened -- maybe knows that something happened -- but does not know the details?"
  - ✓ *Outer circle: "*Who knows nothing about what happened?"
- ☐ Alternative questions for Transition Age Youth (TAY) (shared with permission, developed by San Luis Obispo County):
  - ✓ People who have had your back or have been there for you
  - ✓ People who can be counted on for something
  - ✓ People who seemed to care but actually did very little
  - ✓ Outside the circle: people you should probably avoid



- ☐ This example is based on a real case from Massachusetts that the Safety Circles was used in. Names have been changed and the case has been de-identified.
- ☐ This is what their safety circles looked like – with the child Paul at the center, and all the people circled who the parent, Kim, decided were safe.
- ☐ You can then see arrows that show who Kim is suggesting should move to the inner circle.
- ☐ One of the components of trauma-informed practice is to offer people choices. Allowing families to circle who they feel best about being in the network is an example of trauma-informed practice.

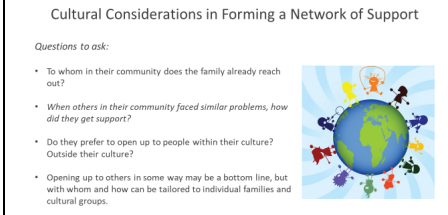


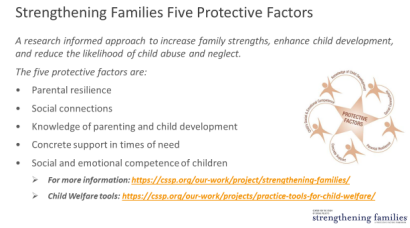
- ☐ This is another example, this time from San Diego County where before a family team meeting there was **both a genogram and a Safety Circles** completed.
- ☐ The genogram helped the family identify family members to the department, but the family reported that the safety circles helped them remember and think about people they would not have considered for a family team meeting.



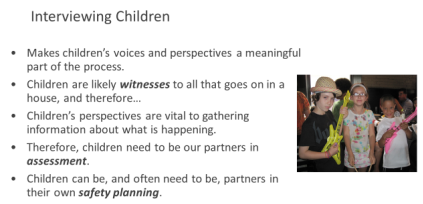
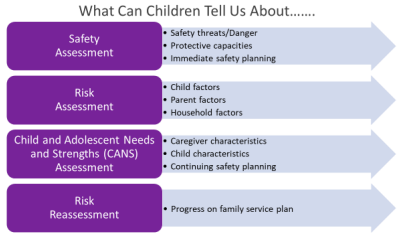
Example from Nicole Kelsay, San Diego County Child Welfare Supervisor

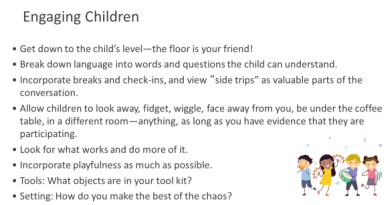
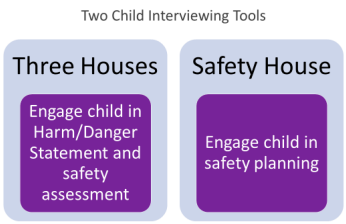
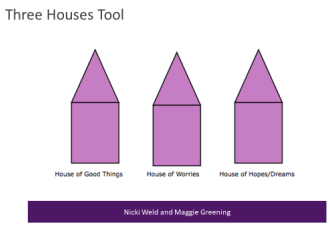
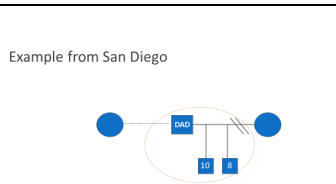
- ☐ Culture is integral to the work of creating networks. Some families from some cultures may have an easier time asking for help – others may be more reluctant or embarrassed to let anyone from their own culture and background know that something is amiss. It's important to stay open to both possibilities (be in that "culturally humble" place when talking to families.
- ☐ Having a network may be a "bottom line" – something we tell a family is critical to us feeling like their children are safe. Who is in that network is something we

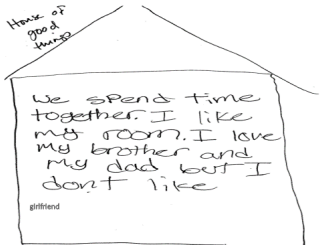
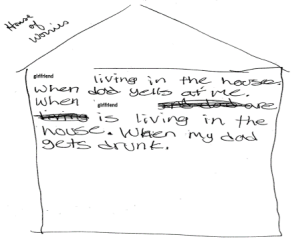


can have some flexibility on – we can ask families if they would want someone from their own cultural background to be in the network, someone different any why. ☐ NOTE: You may want to do some kind of short transition activity here. You can ask participants to get into pairs and think about one family they are working with now or in the recent past they thing could benefit from the safety circles conversation and why	
☐ Take the same case you have been working on at your tables. ☐ Refer to handouts in your workbook: Circles of support quick guide; Solution focused questions quick guide ☐ Discuss at your tables (5 minutes): ✓ How would you start the conversation about safety circles with this family? ✓ What questions could you ask to help the family identify natural supports they are willing to bring to the center of the circle? ☐ Debrief with larger group: ✓ What questions did you come up with? ✓ How do you document safety networks in your county? ✓ How do you ensure that networks are ongoing throughout the life of the case? Safety circles are a living document and should be updated regularly!	
☐ In addition to the safety network, these five protective factors are shown to be critical to enhancing safety and reducing likelihood of child abuse/neglect. ☐ Refer to handout in participant workbook: 5 protective factors ☐ Protective factors should be considered when workers are developing roles for the safety network. Additionally, protective factors are an important part of case planning (covered on Day 2). ☐ For example: ✓ Does the parent need support to build resiliency? ✓ How can the network support help increase social connections for the child and family? ✓ How can the network help the parent increase their knowledge of parenting and child development? ✓ Can the network provide some concrete supports for the parent (help with transportation, diapers, clothing, housing, child care, etc.)? ✓ How can the network help build social and emotional competence of children? ☐ Quick table talk: (Please refer to handout: 5 protective factors)	

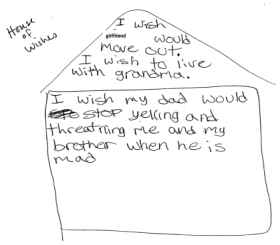
✓ Briefly review the handout at your tables – do you currently do any of these actions in your work? Which ones are you willing to try? How do you see these actions applying to your work with the Child & Family team?	
☐ ***Next segment: Interviewing Children*** ☐ Refer to Quick Guides for both the Safety house and 3 houses in the participant guide for this course. Additionally, there is a 3 houses kit (with templates, instructions and prompts) linked on the class webpage. ☐ We have spoken a lot already about the need to think through 'impact on the child'. What's the best way to get this information? One of the most important ways is to actually talk to the child and get their perspective. This section of the training talks about some practices that have been developed for doing that.	
☐ Voices of children/youth are brought forward in SOP because of the belief that they likely witness much of what goes on in their family and can contribute to a comprehensive understanding of what is happening and what they and their caregivers may need, and that they often can and need to collaborate with other stakeholders in their own safety planning. ☐ Allow five to 10 minutes for discussion, then ask for examples. If you want, one person can ask the group for ideas while another person writes down what they say. ☐ Feel free to ask questions to help make their points more concise (You had to slow yourself down to listen. How did you do that?). ☐ Discussion point: Why is it important to interview children? Look for ideas that include the following: ☐ Children have important information. They know what is happening in the family. ☐ Children are affected by what is happening. ☐ Children deserve to have information from us about what is happening to them. ☐ Parents often think that adult problems are hidden from the children, i.e., "The children don't know that we fight/smoke pot..." ☐ Additional points: ☐ It can be easy to forget that the reason we are involved with a family is because of a child—a child who can offer a lot of information. ☐ Often interviews with children end up focusing on just the incident, or include certain routine questions about disciplinary practices. But if we do that we can miss an opportunity to gain rich and important information from the children's perspectives. ☐ While there are appropriate boundaries around information, children are part of the process of our intervention, and it will help them to feel less victimized if they	

are included as much as is developmentally appropriate in conversations about them. ☐ **NOTE:** Some workers may react against making children responsible for their own safety, or "parentifying" them. We can agree that going that far would be inappropriate. What we are talking about is listening to children about what makes them feel unsafe, what would make them feel safe, and finding ways they can act to contribute to their safety. The techniques we are going to review in this section can help facilitate these conversations with children.	
☐ Review key points on slide	
☐ We may not always think about it, but the conversations we have with children can really help ensure we get the most out of our SDM tools. ☐ Remember, the SDM tools are only as good as the information we get—children can help enhance and verify our information.	
☐ Trainers: give examples when possible. ☐ What else can the child tell us about? Anything and everything!	
☐ If you were to think about all our work with children, you could break it down into four phases: Orientation, engagement, information exchange, and wrap-up. ☐ The <u>orientation phase</u> is our good--faith contract with the child. We are probably a stranger, and possibly someone he/she has been told to not talk to. We need to honestly, and in developmentally appropriate ways, explain who we are and why we are here. You probably have ways you have found that work for you. Anyone want to share what you use? ☐ The <u>engagement phase</u> gives space for the child to become comfortable with you, and also gives you an opportunity to get familiar with the child's style and abilities. You have to "read" the child. If he/she is prepped for this interview and is anxious about it, spending too long on engagement can impair his/her willingness to stay with you. Rushing can get into information exchange before the child is ready. There may be some specific tasks during this stage.	

☐ The information exchange can transition fairly gently, but make a clear transition to learning about what is happening in the child's family. The three questions we covered last Time form the focus in child interviews just as they do in adult interviews. Information exchange is about learning what is going well for the child and what worries he/she has, and you want to be sure you are talking about the family. ☐ The last stage is to thank the child for spending time with you and explore with the child what will happen next. Children do best when they know what to expect. We will come back to this at the end.	
☐ Review slide ☐ Are there other ideas you can think of for engaging with children?	
☐ **Three Houses** is exceptionally good for learning about Danger and safety from the child's perspective, though you will see that it also has value in beginning safety planning. ☐ The **Safety House** is exceptional for including the child in safety planning, but you will learn that it can also provide good information about safety and Danger.	
☐ Note: the 3 houses kit is on the class website and the quick guide is in your participant guide. ☐ This practice was developed by Nikki Weld and Maggie Greening, two child protection social workers in New Zealand, as they searched for ways to do assessment and planning. ☐ And while today we are primarily teaching it as a method for engaging children, I hope you will see that there is relevance for lots of populations, including adults. ☐ **NOTE:** Make connection between Three Houses and Three Questions. Also remind people there is handout and prompt sheets on this material in their packets.	
☐ This example comes from San Diego County. A single father of 8 and 10-year-old boys meets a woman in a bar. They start seeing each other, their relationship gets serious and she moves in with the family. ☐ Initially things go well, but one night she pulls a knife on the dad. The children are home, see this and are terrified. No injuries, but the police are called, CPS responds and dad is told that his girlfriend has to move out. He does this, but 6 months later she moves her back in.	

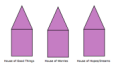
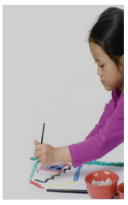
☐ The boys go to school the next day in tears, scared she's back. There is close relationship between school and CPS, they call, and CPS goes right back out. San Diego worker Holly Kohlerich responds, and she was just trained in 3 houses. She does this with the boys, and this is what they draw.	
☐ This first set of slides is the 8-year-old and this is his House of Good Things. ☐ Video games, lunch, TV, dad cooking, etc. The rifle represents shooting/hunting with dad ☐ – A time that they bond. ☐ **NOTE:** Check in with group on anxiety re: fire arms in the home. In this case, social worker Holly explored gun safety upon first visit with family and was not worried b/c they reported adherence to gun safety practices.	
☐ This is his House of Worries. Girlfriend tries to stab dad, I watch them through the crack of their bedroom.	
☐ This is his House of Wishes and Dreams – the boy wants to own a quad four-wheel motor bike but also says he wishes dad would stop yelling. ☐ This was not something that had come up in the assessment process before, and having it come up here allowed the worker to really have a conversation that she would not have been able to have otherwise.	
☐ These are the Three Houses of the ten-year old. This is his House of Good Things.	
☐ This is his house of worries	

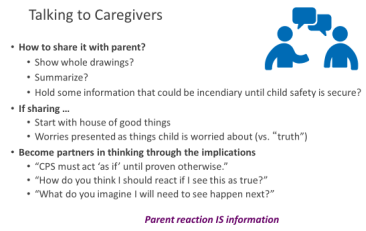
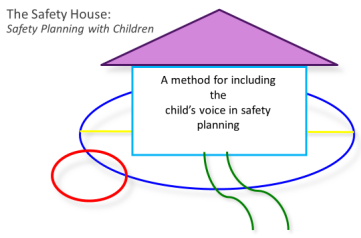
- This is his House of Wishes and Dreams.
- The worker took these houses to the father to show him. We will talk about this in a moment, but that is one of the powerful possibilities of this practice – having parents see their children's own houses. **NOTE:** Can ask what kind of difference we think this makes.
- When the father saw the drawing he cried, and this time HE kicked his girlfriend. The team soon had a TDM to plan next steps, and dad was able to get members of his network to attend including a local school bus driver. It is a small town, she knows the girl friend's car, and vouched to call CPS if she spots the car anywhere near dad's house. [TRAINERS can point out safety network]. The case closed successfully a few months later as dad was addressing his yelling, his drinking and, most importantly, was keeping the girlfriend away from the house.
- **NOTE:** It is potentially useful here to discuss what kind of difference having a tool like this makes, if the CPS team from San Diego would have had this same amount of information otherwise, etc.



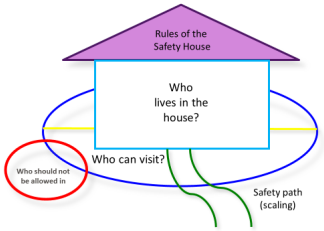
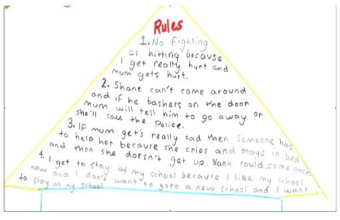
- To do Three Houses is pretty simple, and does not take a lot of preparation. A little planning and consideration is helpful when possible.
- First, before interviewing a child, it is good practice to get parent permission.
- However, there are times you will interview the child prior to parent involvement: if involving the parent in advance would compromise child safety, if there is worry that the parent will attempt to alter child's story prior to your interview, or you have to protect against the possibility or perception of interference. (These concerns are likely present when addressing allegations of serious abuse or neglect, or sexual abuse.)
- It is a good idea to equip your interview space with paper and crayons, and to carry blank paper and a few crayons or markers with you at all times. Then you are always ready. Find a good space for the interview—as good as is available. Privacy is important, child comfort is important, reducing distractions is important—all the usual considerations.
- It is best to interview the child alone whenever possible, but if the child cannot feel comfortable without a parent—as long as the parent is not suspected of sexual abuse or of intimidating the child— it can work with a parent in the room. Provide the parent with clear instructions about not answering for the child or responding to what the child says. It is generally best to interview one child at a time, especially in the early sessions. But again, if a child feels most comfortable with a sibling, you might need to do that. In some instances, interviewing with siblings on occasion can give new perspectives on how the children are doing.
- **NOTE:** If no one in the room can share examples of how they have handled these dilemmas, be prepared with your own examples to share or pose hypotheticals, e.g., How would someone handle a parent who refuses to allow you to do the Three Houses with the children alone? If no one comes up with it, share "ear shot" idea where parent is offered option of being around the corner within

Before the Child Interview

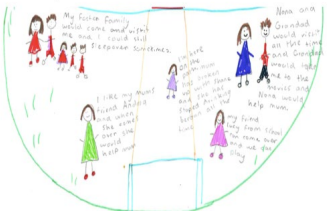
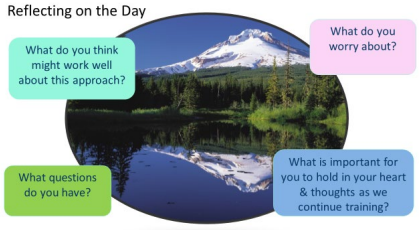
earshot, but not in the same room so the child has the sense the conversation is private.	
☐ **NOTE:** Read through key points. Point out that they should use a fresh piece of paper for each house whenever possible. ☐ EXAMPLE: We are now in an interview. You have finished orientation and engagement. You may use Three Houses to transition to information gathering, or you can start with verbal questions and introduce Three Houses later. There is no rule about that. Whenever it happens, these are the ways the developers suggest introducing Three Houses to the child. ☐ After explaining all Three Houses to the child, you can ask the child which one he/she would like to start with, the House of Worries or the House of Good Things. (Leave off the House of Dreams from this choice—that will be the last one.) Most of the time it's best to start with House of Good Things (what's working well) if the child has no preference. ☐ Give the child choices about crayon/marker/pen/pencil. You can even ask if the child wants to draw or wants you to draw. Whichever the child selects, ask him/her to draw a house, and then put in the house all the things that are good about the house in which they live (or that they worry about in their house). Let them know they can use words or pictures to show. Either way ensure that either the child or your writes notes to describe drawings. ☐ It is also appropriate to inform the child in advance of what will happen with this drawing in simple, age-appropriate ways. Until the drawing begins, you do not know what you will do with it, but it is only fair to make child aware of some basic things and then talk a little more later. The key here is to be honest, but not make a big deal of things that will create needless anxiety. For example, ask the child to make these drawings for you so that child does not expect that he/she can take them when child leaves. (If appropriate, you can offer to make a copy.) Mention that you may need to share the drawings with other people who are working hard to ensure they stay safe.	Introducing the Three Houses Explain to the child: • *"In the first house, we will include the things that you like in your life. That is the house of good things."* • *"In the second house, we will write or draw your worries. That is the house of worries."* • *"In the third house, we will write or draw how things would be if they got better. That is the house of dreams."* 
☐ As the child draws, you can (and should!) use classic conversational prompts to help bring additional detail to the surface. ☐ As with any child interview, be aware of terms that may carry different meanings for children than we think. For example, if the child draws mom's boyfriend in the house of worries and says, "He hurt me," and you happen to be investigating physical abuse, we may assume she has just confirmed physical abuse. But asking what the word hurt means, or how he hurt her, could just as easily reveal that he was combing her very snarled hair and it hurt, or that he hurt her feelings. ☐ As with any child interview, use non-leading questions that are as broad as possible. If you have to increase the amount of information embedded in the question, step down, giving as much option in the answer as possible, and as soon as the conversation has advanced, go back up to the highest--level question	Introducing the Three Houses **Clarification, details** "And then what happened?" **Awareness of child's process** "Do you want to take a break?" **Developmental awareness** "Tell me what the word 'hurt' means." **Non-leading** "What else do you think I should know about?" **Above all: It is a conversation!** 

possible. Just because you are drawing Three Houses with the child does not mean that any of the good techniques for child interviewing do not apply. ☐ Be mindful of how the child is doing. If he/she needs a bathroom break, a drink of water, or just a rest from the conversation, take a break! ☐ In the end, this is no different from any other interview with a child. It just includes a particularly helpful technique called Three Houses.	
☐ If you do share the child's drawing with the parent, it is usually good to let the parent see the good things first. It reduces defensiveness, helps the parent trust that you see the good things too, and adds credibility to the child's worries. ☐ When you show the House of Worries, describe it in that way. It is things the child worries about. Avoid saying, "Here are the facts I now know about you from what [child] said." ☐ The reality is that we do not know the truth and even if we did, it may be too charged to go in with truth blazing. Talk about things the child is worried about from his/her perspective and see if this can provide a way to get on a mutually agreeable page about what needs to happen in the future to help the child feel safe without going into power struggles over what has already happened. ☐ However, we cannot let a parent dismiss child's worries. Unless you are dealing with a demonstrable factual lie (which raises other questions about how the child is doing), you can let the parent know that you will need to act as if this is true until proven otherwise. Ask the parent what reasonable actions would be if this was true—what he/she thinks needs to happen next. ☐ You can get a range of reactions. Some parents are going to be very moved by seeing their children's Three Houses, and new opportunities for partnership and working together are going to occur as a result. However, these are not all "Hallmark movie moments" where every parent, when confronted by their child's Three Houses drawing, breaks down, confesses, turns over a new leaf, and becomes parent of the year. Some parents will deny any facts presented, no matter how compelling. As frustrating as that can be, in terms of assessment, it is very useful. ☐ **NOTE:** Again, elicit examples of times they shared Three Houses with a parent from group and be prepared to share your own.	
☐ Note: The Safety House Quick Guide is in your class participant guide. ☐ We are now going to look at another technique—a wonderful way of surfacing children's views of what kinds of safety plans they would need to really feel safe. ☐ Again, you may want to pay attention to the way this really allows children's voices to be connected to all parts of our work. ☐ The Safety House was developed by Sonja Parker, a child protection social worker and now trainer and consultant from Perth, Australia.	

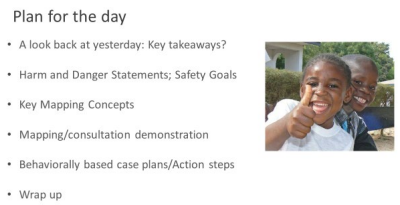
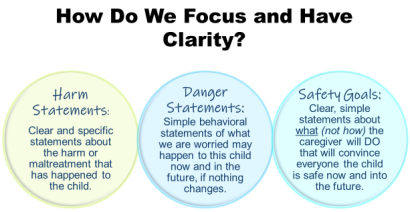
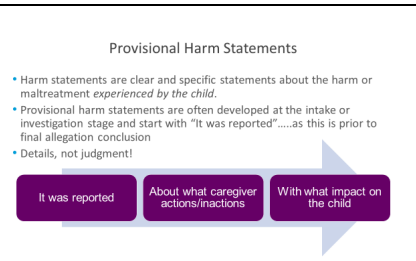
Safety Organized Practice

☐ This is the Safety House. It is also pretty simple in its form. It has five sections. ☐ Also remind people there is additional information and prompt sheets in the handout packet.	
☐ Before starting the Safety House interview with the child, it is useful to explain the process to the child. Show him/her the drawing like this. Tell him/her what you want to do. Do the "orientation" we talked about earlier so he/she understands what you are looking for and can participate. ☐ The Safety House interview begins by asking the child a solution-focused miracle question. Miracle questions are some of the most well-known questions from solution-focused inquiry. This one goes like this: **"This is your house, but it is your house if you always feel safe. All the reasons for working with you, all the things that worried you or scared you, have been taken care of."**	
☐ Review elements of Safety House	The Safety House Elements • **Overview:** This is your house in the future, when you always feel safe. • **Inner circle:** Who lives with you in this house? • **Outer circle around the house:** Who can come visit? • **Red circle to the side:** Who should not be allowed in? • **The roof:** What kind of rules does a house like this need to make sure you always feel safe? • **The path:** If the beginning of the path is where everyone is worried and [known danger is happening] and the end of the path is where this Safety House exists and no one is worried, where are you now? What do adults need to do so you can be one step closer to this house?
☐ Here you can see an example Sonja Parker made with 10-year-old Zoe as she prepared for her reunification. ☐ TRAINER NOTE: It can be good to read through each section, or at least some highlights.	Example Created with 10-year-old "Zoe" as part of planning for her reunification (with Sonja Parker) 
☐ A closer look: Who lives in this house?	Example: Who lives in the house? 
☐ When you get to this part of the Safety House, you say "in this house where you always feel safe, would there need to be any rules, rules to make sure you stayed safe? What would they be?	Example: Rules 

Safety Organized Practice

☐ A closer look: Who can visit?	Example: Who can visit? 
☐ A closer look: Who cannot come in?	Example: Who cannot come in? 
☐ Large group discussion: how they may use the Three Houses and/or Safety House tool in one of these functions.	Reflection and Application • Discuss how you might use the Three Houses and/or Safety House tool in one of these roles: • *Intake* • *Investigation/Assessment* • *Family Reunification* • *Family Maintenance* • *Permanency Planning* • *Adoptions* • *RFA / Placement* • *Community Partners* 
☐ Reflection on the day, ask questions on slide. If your group has energy, put them into pairs or small groups and have them answer these questions.	Reflecting on the Day 
☐ Do a plus / delta to gain feedback about Day one. ☐ Are there any upgrades for tomorrow?	Plus/Delta – How did today go? See you tomorrow! + Δ  ***For questions or to inquire about other trainings:*** Visit our website: http://humanservices.ucdavis.edu/academy Visit our SOP Resources Page: http://bit.ly/SafetyOrganizedPractice E-mail the Academy at: academy@ucdavis.edu 
☐ References	References • Berg, I. K. & Kelly, S. (2000). *Building solutions in child protective services.* New York, NY: Norton. • Boffa, J. & Armitage, E. (1999). The Victorian risk framework: Developing a professional judgment approach to risk assessment in child protection work. 7th Australian Conference on Child Abuse and Neglect, Perth, Australia. • Children's Research Center. (2008). Structured Decision Making®: An evidence-based approach to human services. Retrieved from http://www.nccd-crc.org/crc/pdf/2008_sdm_book.pdf • de Shazer, S. (1985). *Keys to solution in brief therapy.* New York, NY: Norton. • Department of Child Protection. (2011). *The signs of safety child protection practice framework.* Department of Child Protection, Perth, Australia. Retrieved from http://www.signsofsafety.net/westernaustralia • Johnson, W. (2004). *Effectiveness of California's child welfare Structured Decision Making® model: A prospective study of the validity of the California family risk assessment.* Sacramento, CA: California Department of Social Services. Retrieved from http://www.nccd-crc.org/crc/pubs/ca_sdm_model_feb04.pdf • Lohrbach, S., & Sawyer, R. (2004). Creating a constructive practice: Family and professional partnership in high-risk child protection case conferences. *Protecting Children, 19*(2): 26–35. • Turnell, A., & Edwards, S. (1999). *Signs of safety.* New York, NY: Norton • White, M., & Epston E. (1999). Narrative means to therapeutic ends. New York, NY: Norton

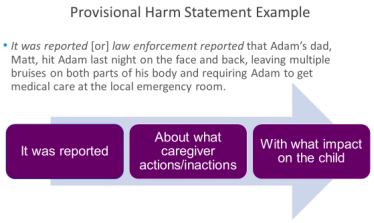
DAY 2 SLIDES & TRAINER NOTES

☐ Welcome to Day 2!	
☐ Review the plan for the day ☐ Any key takeaways from yesterday?	
☐ ***Next segment: Harm & Danger Statements*** ☐ Please refer to handout in participant workbook: Harm & Danger Statements/Safety Goals Quick Guide	
☐ These three gems can profoundly change our practice by keeping us grounded in safety. ☐ They can be touchstones you return to again and again, and how paradoxically hard it can be to be simple. ☐ **Discussion Questions** ✓ Has anyone already used one or more of these? What worked well about that? What was hard? ✓ What would it be like if every worker and every family and collateral had a clear picture of what would lead us to close a case, or return a child?	
☐ If you remember yesterday, we defined harm as something that has happened in the past that has impacted the child physically, developmentally or emotionally. ☐ Harm statements are "clear and specific statements about the harm or maltreatment that has happened to the child." This may be the easiest statement in many ways, because it is based on things that already happened. ☐ Provisional harm statements are often developed at the intake or investigation stage and start with "It was reported"…..as this is prior to final allegation	

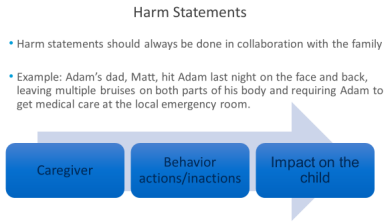
conclusion. **One easy formula for writing a good *provisional* harm statement is to think of it in three parts:**

- ☐ Begin with a brief phrase about who is saying that these things happened. Early on, all we may have is that someone called to report. You may not be able to say who is reporting, so you may have to say, "**It was reported**…"After you've gathered some information, you may be able to add some names to this because one or more people you interview may tell you things about what happened and may give you permission to share that with the family.
- ☐ Next, describe the facts about what the caregiver did, to the best of your knowledge. (We'll talk about disputes later.)
- ☐ Finally, describe the impact on the child.
- ☐ NOTE: It is often not possible to say "who reported." It's OK just to let people know they can say "it was reported" - there are many times when we can share "who reported" because they have already told the parent they made the report or shared this information.

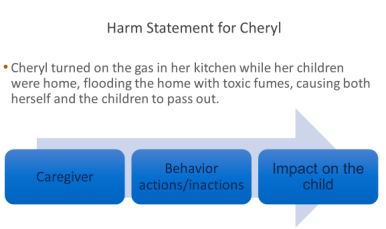
- ☐ Read example and then discuss (this is a provisional harm statement based on initial referral):
  - ✓ What do people think of this statement?
  - ✓ Is this clear? Concise?
  - ✓ How could you make use of a statement like this?



- ☐ After the Provisional Harm Statement is developed, it is critical that the statement is reviewed and revised with the family.
- ☐ We no longer use "It was reported" at the beginning of the statement. We simply list the caregiver, their behavior actions/inactions and the impact on the child.
- ☐ A good, clear mapping is the pre-work that will make it much easier to craft specific, behaviorally detailed harm statements with the family.
- ☐ It's surprising how hard it can be to locate a simple statement of harm in a case record, or get to a clear statement of harm in a court report or court testimony.
- ☐ When you can do this, putting it front and center during conversations with the family, the court, and the safety network (as well as the next worker to be assigned to the family's case), it can make a huge contribution to staying focused.



- ☐ Read example and discuss:
  - ✓ What do people think of this statement?
  - ✓ What do people appreciate about it?
  - ✓ What are people concerned about?
  - ✓ What would it be like for Cheryl to see this?



- ✓ Do people have ideas of any ways of making it even better?

☐ **NOTE:** If people have suggestions take a couple and offer your reflections. Often in these trainings group members do make good upgrades to these examples, but don't endorse a statement that gets too far away from the formula at this stage.

☐ ***REVIEW THESE POINTS:***

☐ The easiest place to begin crafting a danger statement is with a harm statement, because we will be most worried that the thing that ALREADY happened will happen AGAIN.

☐ What do you notice about the formula? (The last two elements are the same, except for the word "potential." The first box is also a "who" but instead of who reported, it is who is worried)

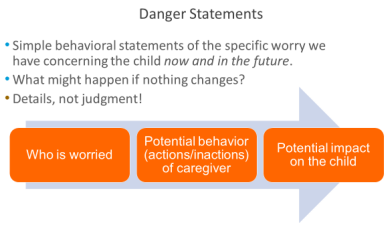
☐ The danger statement bears a strong resemblance to the harm statement, but instead of what already HAS HAPPENED, we convert the information to what we are worried MIGHT HAPPEN if nothing changes.

☐ By anchoring the danger statement in harm, we avoid getting worried about everything! And we build on the notion that the best predictor of future danger is past harm.

☐ There WILL be times when we do not have a harm statement but still have a danger statement.

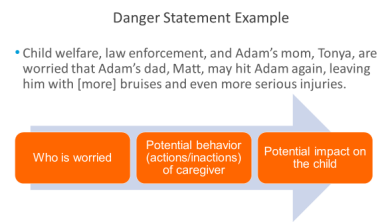
☐ ***ASK THE GROUP:*** Can you think of situations like this? (Examples: Hazardous living environment where there has been no impact on the child to date, a violent incident in the home where the child was sleeping, etc.).

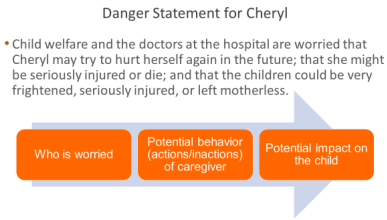
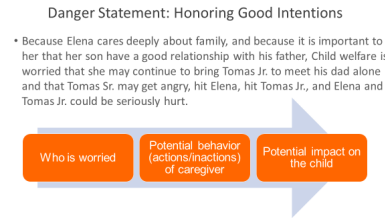
☐ The key here is to ensure that if there is no harm to make sure not all the "complicating factors" creep back into "danger." Historically, that is what has happened in child welfare. Find some way of prioritizing. Usually the SDM safety assessment is the best way to help this out. Items on the SDM safety assessment include both "harm" and "likely danger." If you have something that is not "harm" but you are thinking it may be "danger" check it against the SDM safety assessment.



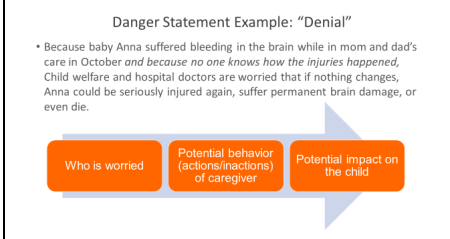
☐ Read statement and discuss:

- ✓ What do you think about this statement?
- ✓ What do people appreciate and what are people concerned about?
- ✓ What do you notice? (It lists a lot of people who are worried and it raises the stakes by saying "even more serious injuries.")
- ✓ What happens when a family hears that a lot of people are worried about this? Who could you include in the "people who are worried" section? (Safety network members, the parents, the children, the department, the judge, etc.)

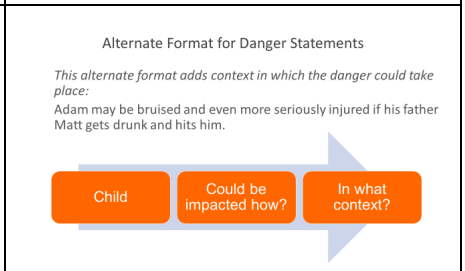


☐ The potential caregiver actions should resemble the actions of the caregiver included in the Harm Statement. ☐ The impact on the child section could include a repeat or continuation of what has already happened, and could raise the stakes by stating worry about things that will cause more harm. ☐ It's OK to have more than one danger statement per family, but be careful not to make too many. At some point it just becomes noise for the family and the professionals involved. ☐ While we think it is a good idea to try to start with the formula these danger statements have both a piece of 'art' as well as 'science'. What you are trying to do it to things – keep one foot firmly planted in the notion 'what is the agency most worried could happen if nothing else changes' and another foot firmly planted in 'how can we best communicate this clearly to the family"?	
☐ Read example and discuss: ✓ What do people think of this statement? ✓ What do people appreciate about it? What are people concerned about? ✓ What would it be like for Cheryl to see this? ✓ Do people have ideas of any ways of making it even better?	
☐ Let's take a look at some different examples and adaptations of danger statements. ☐ In this example, a Latina woman (Elena, not her real name) who held a deep belief that her son should have a relationship with his father (despite the fact that he was regularly violent with both her and her son) took her son to see his father against a stay-away order she had agreed to. Both she and her son were hit and hurt. ☐ While the agency made danger statements related to the father they also felt like it was important to make one for Elena, but did not want to make it "blaming" as it was very clear that she was following strong cultural convictions we could respect. ☐ Read example and discuss: ✓ What do people think of this statement? ✓ What do people appreciate about it? What are people concerned about? ✓ Does it get too "soft" or does it still hold the bottom like? ✓ What would it be like for Elena to see it? ✓ Do people have ideas of any ways of making it even better?	

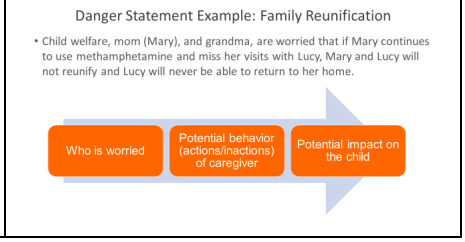
- In this example we have a situation that may be familiar to many of you – where there has been an injury to an infant and there is no clear acceptance of responsibility.
- These "denial" cases can be the most challenging a child welfare practitioner runs into.
- While we won't be able to spend lots of time talking about how to respond, the first step is clearly being able to communicate the agency's worry without falling into a circular "denial dispute."
- **NOTE:** You can playfully act out a denial dispute ("Just tell me you did it!" "I didn't do it!" "I know you did!"), then discuss:
  - ✓ What do people think of this statement?
  - ✓ What do people appreciate about it? What are people concerned about?
  - ✓ How would a statement like this help set us for forward work with the family? (It circumvents the denial dispute and puts the onus on future safety in situations where parents may never accept responsibility).



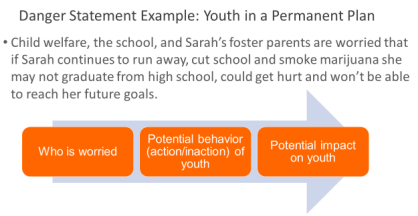
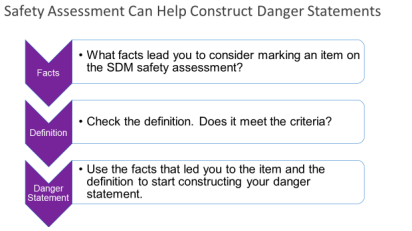
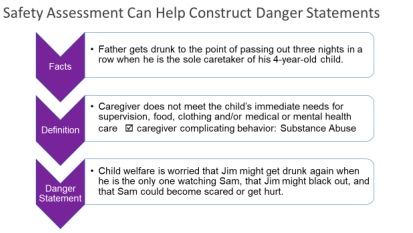
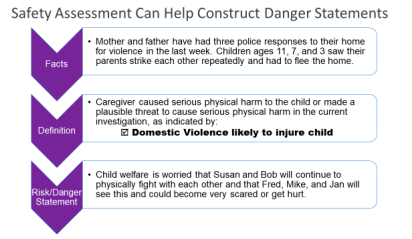
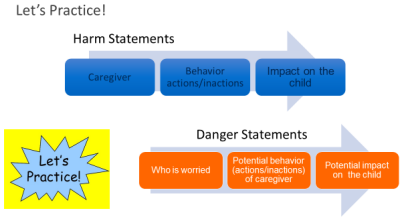
- Finally we can take the context into account and land that in the statement as well when it is relevant.
  - ✓ What do people think of this statement?
  - ✓ What do people appreciate about it?
  - ✓ What are people concerned about?
  - ✓ How would a statement like this help set us for forward work with the family? (It helps make the context where the safety needs to be grown clear).
- NOTE: Sometimes with these kinds of statements trainees worry that the responsibility is being shifted to the drinking. It is not – this would be a situation where the abuse has only happened when Matt is drinking (something that would have to be clarified first in the mapping) and so it could help us get clear what the context is where the safety needs to be created.

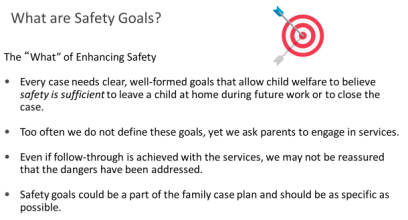


- Example of a danger statement for a family reunification case

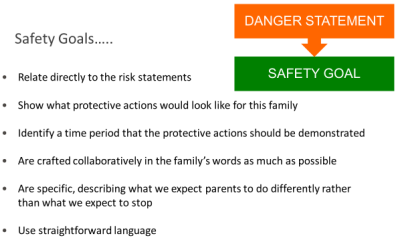


Safety Organized Practice

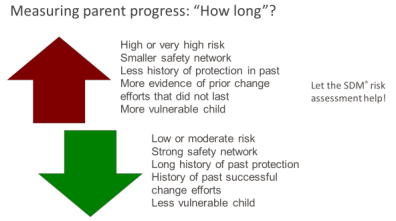
☐ Example of a danger statement for a youth in a permanent plan.	
☐ The SDM Safety Assessment is also a terrific tool at helping to construct a Danger Statement. Any time you find a situation meets the criteria for a safety threat on the SDM safety assessment you should consider using that to make a danger statement. ☐ Start with the facts (what led me to even think about selecting a safety threat on the safety assessment), move to the definition in the manual (does it meet criteria?) and then use the facts and that definition to construct a Danger Statement the family can understand and make sense of. Let's look at some examples.	
☐ Read example and then discuss: ☐ What do people think of this statement and the process for getting there?	
☐ Read example and then discuss: ☐ What do people think of this statement and the process for getting there? ☐ Could people imagine using the SDM Safety Assessment to help them do this?	
☐ Table group activity: Take the case you have been working on and sort the harm and danger. Then, work together to develop a harm and danger statement. ☐ Refer to handout: Harm & Danger Statement Quick Guide ☐ Instructions: ✓ Ask participants to construct harm and danger statements based on the case, write them down on flip chart paper, and post them around the room. ✓ Use the handout: Harm & Danger Statements Quick Guide for examples ✓ Once completed, have them walk around the room and put stickers or checkmarks next to the statements or parts of statements they most appreciate or think are most effective.	

☐ Debrief as a large group ✓ What parts of these statements do you think work the best? Why? ✓ What would it be like to share these with the family? ☐ Trainer notes: When people share their examples, be on alert for: ✓ Labels, jargon, over-professional language; ✓ Whether the person used the general formula; ✓ Whether potential impact to the child is clearly described; and ✓ Whether the events listed in the danger statement make sense or flow reasonably based on real actions the caregiver has taken. ✓ Also offer your feedback as you look around the room. Find parts of a few statements that you appreciate and offer "notes of caution" for those that appear problematic. ☐ Note: If the case you mapped did not have any past harm, do not try to force it in this exercise. Have the group just make danger statements based on the danger that is most likely to occur. If there is more than one pertinent danger, you can split up the group. Each group should work on one danger.	
☐ ***Next segment: Safety Goals*** ☐ Now we will work on Safety Goals. ☐ These will take us from the future we worry about to the future we want to create.	
☐ Refer to handout: Harm & Danger Statements Quick Guide (has safety goal formula and example) ☐ Safety Goals are the "what" of enhancing safety ✓ What would things look like if the danger statement was addressed? ✓ What would tell us that we could close the case? ✓ What would parents be doing differently in their care of their children? ☐ With a safety goal you stay away from a list of services and actually think: What would have to be going on in this family for me to feel like the danger had been addressed? ☐ It can be hard! Sometimes it may feel like you are having to exercise a muscle you haven't used as much before. We are much more used to thinking about "what services does the family have to complete" then "what actions of protection do I need to see demonstrated?"	

- ☐ In many ways the danger statement and the safety goal are opposites, or mirror images.
- ☐ You can't make a safety goal until you have a danger statement.
- ☐ Once you have a danger statement, though, you can begin to build—optimally with the family—a vision of what future safety for the child(ren) will look like.
- ☐ These three statements should work together to **tell a coherent story**. The harm is what has already happened. The danger is what we worry the harm, or something worse, will happen again. The goal is to replace the worrisome caregiver actions with new behavior that (because we've woven the thread throughout) will increase safety.
- ☐ **Be specific**. While the details of actions will follow later in the plans and actions steps, it's important to give enough of a view here of *what* it will LOOK like when there is safety to ensure that everyone is clear about what we'll need to see to close the case.
- ☐ To the greatest extent possible, **make these goals with the parent and safety network.**
- ☐ Whenever you can, **use family language**. When we say "measurable," we don't mean, "The mother will love her child 37% more," but that something people could agree on is or is not there.



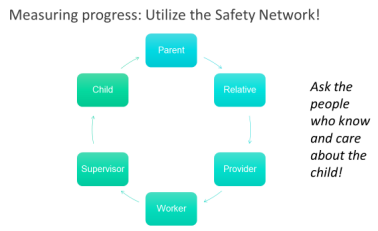
- ☐ The last part of the safety goal is "how long." This is tricky. In essence we are asking, "For how long does a parent need to demonstrate the specific actions of protection before we are comfortable walking away with enough confidence that harm will not recur?"
- ☐ There is no simple formula for this. And there are specific things worth considering:
  - ✓ **SDM risk level.** A higher risk level simply means there is a greater chance that some harm will occur in the future. The higher the risk, the longer we'll want to see acts of protection demonstrated before being persuaded that the harm won't occur again.
  - ✓ **Quality of the safety network.** A strong network will have a lot of ongoing contact with the family AND will "blow the whistle" by intervening or even reporting if things start to go badly. A limited or less reliable safety network might mean we need the parent to demonstrate the acts of protection longer so we are more confident they will continue.
  - ✓ Have the **changes the parent made "stuck?"** Is there a history of the parent making changes and sticking to them? Or do they start and stop?
  - ✓ **Vulnerability of the child**, or in other words, the ability of the child to participate in his/her own safety plan. A child with some self\protection capability (including telling another adult, calling police, emotional resilience, having a safe place to go, etc.) may lead me to see enough safety



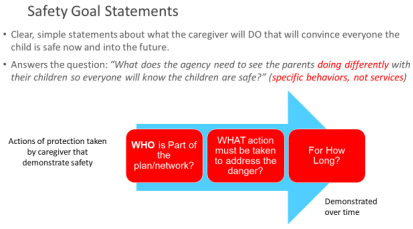
over a shorter demonstration of change by the parent. But for an infant or young child, i.e., a child emotionally unable to self-protect, perhaps as a result of trauma, or a child who is more isolated, I need to see a longer demonstration of acts of protection before I'm convinced these will continue after the authority walks away.

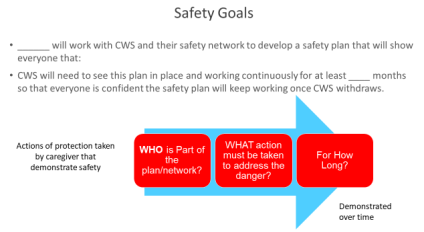
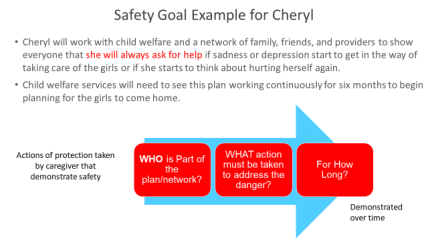
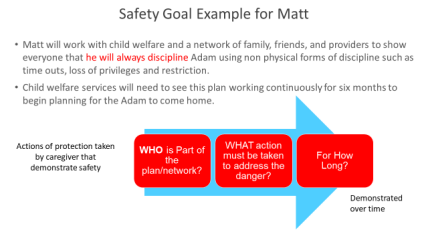
- ✓ It's also important to balance the certainty of these statements as you talk about them with the family and network. **They are guides, not rules.**

- ☐ Another way we help determine 'how long' is by not doing it all by ourselves.
- ☐ We ask the people who know and care about the child – how long do you think we should see these new "actions of protection" being demonstrated to know it is enough?
- ☐ There is likely no easy answer but here is a way you can poll the collective group wisdom.
- ☐ NOTE: This may continue to be hard for the group and it is OK to harken back to the "agree to disagree" agreement made at the beginning of the training. The other thing to ask the group to think about – how do we handle decisions about time now? It is often very randomly. Is this any worse?



- ☐ This is a simple way to begin crafting safety goals.
- ☐ First, <u>the "who."</u> We began with "who said" (harm statement) and then shifted to "who is worried" (danger statement). For safety goals statements we will use names of the people who are part of the safety network.
- ☐ In essence, this establishes that there are people who care about the child's safety and are committed to helping and watching that the caregiver is doing what needs to be done. The safety network is the "jury" that must be persuaded that the child is safe.
- ☐ Next, a safety goal describes <u>what action or behavior must be taken to address the danger</u>. Please note that the goal is not a list of specific action steps (that comes later) or expressed as completing services, gaining insight, or having clean drug screens. It's not expressed as what a parent STOPS doing**. It's extremely important to craft this part of the safety goal in terms of actions/behavior change the parent will demonstrate. Consider: What is the overall behavior change sustained over time to show the child will be safe (tied directly to danger).** Anchor what the caregiver needs to do differently in the caregiver's behaviors that had everyone worried. What could the caregiver do instead? This ties the safety goal to the danger statement.
- ☐ **Note: The traditional way of thinking about safety: Take the case (*take a big step*), wait a few months (*take another big step*). If NOTHING BAD HAPPENS, the child is safe! Close the case!**
  - ✓ ***Question: Is this a good measure of child safety? Why not?***

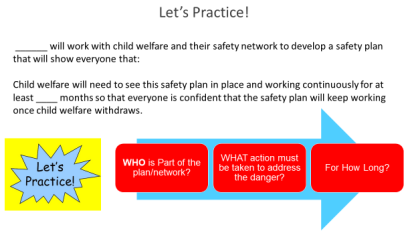


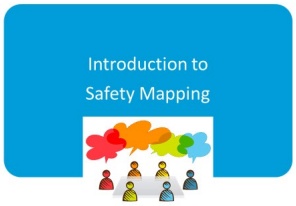
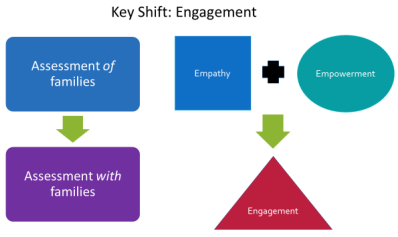
☐ The last part is tough. Who remembers the definition of safety? (Make sure the "demonstrated over time" part is mentioned.) For example, with Cheryl's case, the issue is her depression and everyone is worried that Cheryl could try to kill herself again and her daughters could die with her or find her dead. How long would we need to see that Cheryl is managing her depression? When will we feel safe returning her children to her care?	
☐ This is what the formula looks like	
☐ Review example ☐ In the example, the dates are connected to typical court status review timelines (every six months), and "planning for the girls to come home" here would be whatever next steps make sense – moving from no visitation to supervised visitation; supervised visitation to unsupervised visitation; unsupervised to trial home visit; etc. ✓ What stands out for you? ✓ How does making the connection to court timelines help or hurt? ✓ What works well? What worries you about this? (Worries may include that it doesn't lay out a plan. That's okay—this is just the goal. We'll get into the connection to plans in a moment). ✓ How do you think Cheryl would respond to this? What would she appreciate? What would concern her? ✓ What do people think about putting a timeline on our work? ✓ What would be the benefit for us? ✓ For families? ✓ How do we make these decisions now?	
☐ Review example	

Safety Organized Practice

- ☐ Safety goals and safety plans are not the same thing. Sometimes people can get confused between the safety goal and the safety plan, and **there is some inevitable overlap between them**.
- ☐ One way to think about it: The **Safety Goal** is a statement, **a vision of what** the caregiver will be doing differently to show they are addressing the danger statement. It can change over time, but only if the danger statement changes.
- ☐ The **Safety Plan** is a series of steps or guidelines. It is **the "how"**—how will the caregiver get to the goal? Plans can change more frequently than goals do as they get tested and different network members come in and out of the family's life.
- ☐ You can think about it like this: When you get into a car and use a GPS what is the first thing you need to do? [Put in your destination] What does the GPS then give you? [Turn\by\turn directions]
- ☐ The Safety Goal is the destination. The plans and action steps we will talk about shortly are turn-by-turn directions.

- ☐ ***Table group activity:*** Take the case you have been working on and work together to sort what's working well into safety and strengths to develop a Safety Goal
- ☐ Refer to handout: Harm and Danger Statement Quick Guide
- ☐ Instructions:
  - ✓ Ask participants to construct safety goals based on the case, write them down on flip chart paper, and post them around the room.
  - ✓ Remind participants that this should NOT include specific action steps, just a simple statement of what behavior the parent/caregiver will be doing differently to demonstrate safety over time.
  - ✓ Once completed, have them walk around the room and look at the safety goals. If the group has the energy, have them again put stickers or checkmarks next to the goals or parts of goals they most appreciate or think are most effective.
- ☐ Debrief as a large group
  - ✓ What parts of these safety goals do you think work best? Why?
  - ✓ What would it be like to share these with the family?
- ☐ When people share their examples, be on alert for:
  - ✓ Labels, jargon, over-professional language;
  - ✓ Whether the person used the general formula; and
  - ✓ If the safety goal was achieved, would it respond to the danger statement?
- ☐ Also offer your feedback as you look around the room. Find parts of a few goals that you appreciate and offer "notes of caution" for those that appear problematic.

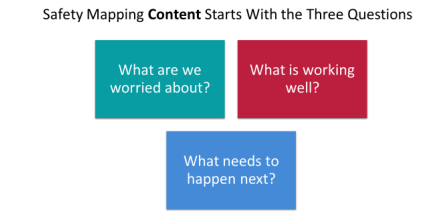


☐ ***Next segment: Introduction to Safety Mapping*** ☐ Refer to handout: Safety Mapping Quick Guide ☐ This section introduces the concept of mapping and its connection to the SDM system. ☐ At its core, mapping is a process for bringing people together – it could be a worker and a family, a supervisor and a worker, a case consult or a complex case review – with a process to help organize collective thinking and the information that is known, all in an attempt to move to greater and greater agreement about next steps. ☐ While there are a few different versions of mapping that come out of Signs of Safety practice, you should know that mapping is about the process of coming together to try to reach group agreement. ☐ While this module introduces mapping as something that would aid an individual worker, a case consultation or supervision, **where this really takes off is in using it with a family.**	
☐ What is mapping? Mapping is <u>not</u> a form ☐ It's a facilitated process that helps a group gather information, organize that information, then try to move to group agreements. ☐ It helps institutionalize critical thinking and allows us to ask three questions and learn the position, or perspective, of all the parties. ☐ Mapping contains a framework that helps us organize the information we receive into some useful categories for anyone participating in a child welfare work to make sense of. ☐ **Once that information is organized it may be a little easier – not easy, but just a little easier – to reach group agreement with the people who matter most in the case**: the child, his/her family and the personal and professional network around them.	
☐ What is the formula for true engagement? Empathy & Empowerment! ☐ Traditionally in social work and in child welfare we have seen assessment as a fully professional activity. We put something – or someone – under our study, we gather information and analyze that information. It's a powerful tool and it can still serve us well. ☐ But it is incomplete if we are truly thinking about partnership-based work. In this approach, the people we are working with are no different than us. If you were all of a sudden working with a child welfare professional (or any other helper) would you want the assessment to be something totally done "to" you? You might want the helper's expertise, but you would also, likely, want to be included, want your best critical thinking and ideas brought into the	

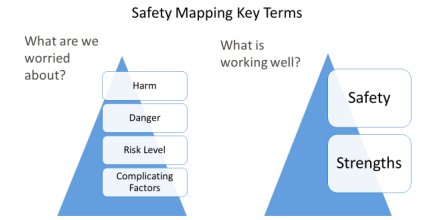
conversation. We could call this "assessment with" instead of just "assessment on". That's what this mapping process tries to do.	
☐ Review key points. Make additional point that mapping is a collaborative assessment and planning process that can be used at many points in case work: ✓ Individual Supervision ✓ Group Supervision ✓ Family team meetings ✓ At the kitchen table ✓ Case consultation ✓ Guides discussions at home visits	 **What:** Safety mapping is a process of gathering and organizing the information to reach joint understanding and agreement. **Why:** A regular problem in child welfare is the lack of *understanding*, *participation*, and *agreement* between the family and the organization (and within the organization itself). **How:** Can be used with the family to guide an assessment and planning conversation *and* can be used in supervision or case consultation. **Safety Mapping is the framework used to facilitate a Child and Family Team Meeting**
☐ There are some core assumptions or values that underlie this mapping process. Read key points. ☐ Think of your mapping experiences, could one of these elements have made it better?	Core Safety Mapping Values & Beliefs  **Relationships** are the most significant factor in promoting child safety, permanency, and well-being. **The words we use matter**—building a series of shared agreements over time to reach a larger goal requires that we share some common language. **Organizing information about safety and danger to children is not easy**—it can be hard to admit we might be wrong. **The more that information is effectively organized** among all the key people involved, the more likely it is that effective decisions can be made.
☐ Refer to handout in participant workbook: Facilitated Dialogue Structure ☐ We're going to start walking through the mapping process. Remember how we talked about relationships matter, the words we use matter, you start developing that in the initial parts of the mapping i.e. developing purpose, connecting, agreements…. ☐ Mapping begins by setting the context for the mapping and engaging the family. This is the way social workers can prepare families for the meeting ahead of time. ☐ **Purpose / Desired Outcome:** you start by asking about purpose. What does the person seeking the consult or the group attending the consult want to get out of it? Is it a decision, a plan, something else? If it involves a decision of some kind, which SDM assessment can help with that decision? ☐ **Context:** Check for any distractions that may pull attention away from the focus of the meeting. Does anyone have time constraints? ☐ **Group Agreements:** How do we want to work with each other? Facilitator charts group agreements on flip chart paper or dry erase board. Please refer to ***page 14*** in the trainers guide for more information and examples of group agreements. ☐ **Network / Stakeholders / People and Community:** Next move to these questions: Who is in the family? Who cares about the child? Who do we wish could be in this room if at all possible for this conversation? What can we do to get everyone here that should be here? Tools: Genogram, Eco-map, Safety Circles.	Dialogue Structure: Facilitating Meetings **Meeting Stage** | **Key Questions to guide each stage of the meeting** Purpose/Desired Outcome | Why are we meeting today? What do we want to talk about? What do we want to walk away with today (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/Child & Family Team | Is everyone here that should be here? If not, what should we do to get everyone here that should be here? (Genogram, ecomap, Safety Circles/Circles of Support, cultural considerations, safety considerations) Content | What's working well, What are we worried about? What is the impact on the child(ren)? Gray Areas? (Safety Mapping process) 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?

- ☐ **Cultural Considerations:** What is the race, gender, ethnicity, sexual orientation, etc. of the family and the people who care about the child? What role, if any, do these important parts of identity play in ability to enhance safety for the child?
- ☐ **Content:** This is the safety mapping portion of the meeting using the three questions as a guideline: What's working well? What are we worried about? What's the impact on the child? Gray Area?
- ☐ **Next Steps:** What steps do we need to take from here? This is the time to define the roles of all participants and the timelines for each action step. How will this plan be monitored? Then, schedule a follow-up meeting.
- ☐ **Plus/Delta:** What worked well during this meeting? What should we do differently next time?

- ☐ Mapping begins with the three questions, what are we worried about, what is working well and what needs to happen, and then moves into much more detail.
- ☐ Please note that the word "worry" is by design. Ask what the difference is for them when you ask what they are worried about vs. telling them that the agency is "concerned" about them. Someone usually says it feels more respectful and human. That's the point – it is more likely to build engagement.
- ☐ As we go through this I would like to ask you to think, what parts of this framework feel like it would be helpful in your work? What parts are "value added" to your practice? And what worries might you have? Think about it as we move forward.



- ☐ Next, we look at two of the three questions and see that they divide up into smaller categories.
- ☐ When we talk about "what are we worried about" we are talking about harm, Danger and complicating factors. When we talk about 'what is working well' we are talking about strengths and safety.
- ☐ Trainer note: Some counties put the SOP definitions up in their CFTM rooms for reference.
- ☐ The words we use matter and different people often say the same words but mean different things. This is the common language SOP helps us to develop so that the agency and the family can always be on the same page.
- ☐ What you can see is that <u>harm</u> is always about the past. Something has happened and has already impacted the child.
- ☐ <u>Danger</u> is about the future. It is what we are worried about. As some of you may remember from the first module, one of the core concepts of Signs of Safety is being able to distinguish "what has gone on in the past" with "what we are worried about happening in the future." Knowing about the past is particularly helpful in informing "what we are worried about in the future." Remember, the best predictor of future maltreatment is past maltreatment.



SOP Mapping Definitions

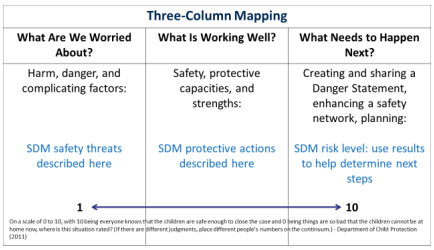
Harm	Past or present caregiver actions that resulted in negative impact to the child.
Danger	Worries about future behavior by the caregiver that may cause further harm to the child.
Complicating Factors	Circumstances in or around the family that are worrisome, cause stress, or complicate a family's ability to ensure safety, but that in themselves are not harm or danger to a child.
Safety	Acts of protection demonstrated over time by the caregiver that effectively keep the child safe from future harm or danger.
Supporting Strengths	Qualities, circumstances or capacities in a family that are positive or beneficial, but are not, in themselves, acts of protection that result in child safety.
Safety Network	A group of family, friends and professionals who care about the child, are willing to meet with CWS, understand the harm/danger concerns, and are willing to take specific action that supports the family and helps to keep the child safe.
Mapping	A structured process of exploring, with a family, worries (harm, danger, and complicating factors); what's working well (safety/acts of protection and supporting strengths); and what needs to happen next to ensure child safety, permanency and well-being.

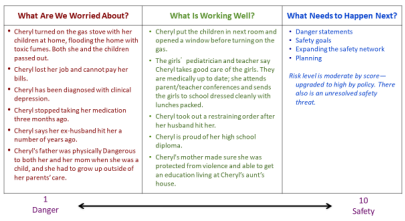
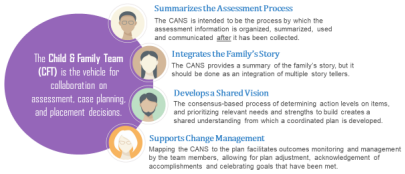
- ☐ Risk Level here is the same definition of risk we use when we think of SDM. Risk is about likelihood or probability. Think about a high-risk pregnancy – when someone has been classified as having a high-risk pregnancy it doesn't mean something bad will happen, it means that based on the characteristics of the mother or unborn baby, they "look like" other mothers/children that have tough times during birth. That's how SDM used Risk and what mean when we are using the word here.
- ☐ Statistically, the best predictor of future harm is past/current harm. It is thankfully not a guarantee but our ability to know what we are worried about happening in the future (the Danger) and how worried we should be (the risk) rest on understanding of what has gone on in the past (the harm). An important thing here thought is going to be our ability to distinguish what is real harm vs. what are things that are "less than optimal" but may not be harm.
- ☐ One key is distinguishing harm and Danger from other things that may not be impacting the child.
- ☐ **Ask yourself: what questions do I need to ask to understand the impact of the caregiver's actions on the child? Difficult things that are not harm can happen to and within families.**
- ☐ ***Trainer's Note*:** "Risk" and "Danger" are slightly different although they are often used interchangeably in child welfare work (i.e. SDM uses "risk", SOP has traditionally used "Danger statement", Consultation Framework uses "risk statement," etc.); Danger is what we are worried will happen in the future if nothing changes; Risk is about HOW worried we should be about the danger occurring.
- ☐ ***Complicating factors*** are different. They are things that are worrisome and concerning, but in and of themselves are not caregiver actions that are impacting the child. In general, child welfare agencies are good at opening cases because of harm and Danger, but cases often can stay open for years because of complicating factors.
- ☐ **NOTE:** You can have brief discussion here about what people think about these definitions but keep moving through material.
- ☐ **All families have some signs of safety**. The **best predictor** of future protection is past protection.
- ☐ Without searching for examples of protection, it is difficult to know the extent of the signs of Danger or to determine how protection could be enhanced and measured in the present and future.
- ☐ **Safety**: This definition of safety helps hold the model together – the model is 'safety organized' because the work is organized around safety. Notice that safety is a VERB. **It is more than the absence of Danger.**
- ☐ The key is to consider the definition: are these *actions* of protection demonstrated *over time*? Or are these things good and helpful … but maybe not safety?

- ***DISCUSSION:*** If this was child welfare's definition of safety…and we shared it with families, providers, the courts…and this became 'north' on the compass and what we looked for in our work…what, if anything, would change about child welfare services? What would change about your work?
- **Supporting strengths**: Strengths are good, positive things in families, but until they become acts of protection demonstrated over time, they are not the same as safety. This includes skills of living, coping skills, and/or cultural/familial histories of recovery or support that are important but do not directly support the provision of protection.
- Just as with harm/Danger, what distinguishes safety and strengths is also that a caregiver has taken an action that has protected the child or mitigated the Danger.
- If it is an action that has done this, it is safety. If not, it is a good thing, but it is a strength or a protective capacity, not safety.
- Just like the best predictor of future maltreatment is past maltreatment, the best predictor of future "acts of protection" is past actions of protection.
- All families have some history of being able to keep their children safe, all families have some 'signs of safety'. If we don't look for them though we are missing ½ of our "balanced assessment.

- Cover subtle difference in definitions for danger and risk – they a very similar and can cause some confusion due to being used interchangeably depending on what tools & strategies are being used
- SOP uses Danger Statements; SDM and Consultation and Information Sharing Framework refers to Risk vs. Danger

- This is what is called "three-column" mapping. As you can see, it starts with the three questions as the primary way of organizing the map. This is an excellent tool for having conversations with families, home visits, etc.
- While it may seem very simple, this can be a powerful way to begin organizing your thinking. But it would be even more powerful to do this with a family.
- Take a piece of paper with you to a home visit, put it on its side, and put the three questions on the top.
- Let the family see what you are doing – it helps them understand what our work is about.
- You will also notice there is **a scale** on each of these maps. Just as we heard in Luck's story, the scale helps with two things – it can help assess really "where does everyone think things are" when it comes to Danger and safety. And once we have a number it can help us think through 'small steps' when we ask

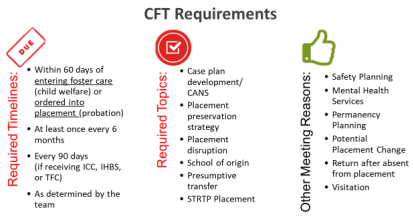


ourselves and our clients "what would things have to look like for the scale to improve by one number"? ☐ And this where the SDM sections would go: Safety threats are worries, protective capacities are things that are working well. The risk level helps us to determine next steps.	
☐ If we were to lay out a basic version of a three-column map with Cheryl's information, here is what it would look like. There is not a lot of detail here yet, but you can see how a basic sorting of the information starts to look like. ☐ *NOTE: Trainers could use this moment to ask a discussion question:* ✓ *Any thoughts about what it would be like for Cheryl to do this with a worker?* ✓ *What would you be worried about, if anything, in doing this with Cheryl? Why?* ✓ *What do you think might be helpful in doing this with Cheryl? Why?*	Cheryl's Three Column Map 
☐ Refer to handout: CFT Meetings Quick Guide ☐ At the heart of SOP and ICPM: Teaming Practices ✓ State-mandated practice for one integrated team process for all needs related to a child/youth and family while in foster care ✓ Team of people identified with the family ✓ Supports the team in addressing strengths and needs and coordinating care (using CANS) ✓ CFT meetings (CFTMs) are <u>one</u> component of CFTs ✓ Team meetings are critical opportunities to demonstrate the principles of effective core practice, including empathy, empowerment, and awareness about the impact of trauma. ***<u>For more information:</u>*** ACL 16-89 (CFTs), ACL 18-09 (CANS & CFTs) and ACL 18-23 (CFT FAQ) **CFT Practice** https://cdss.ca.gov/inforesources/foster-care/child-and-family-teams **CANS Practice** https://cdss.ca.gov/inforesources/foster-care/cans/the-cans-tool/cans-resources **CFT/CANS Toolkit:** https://calswec.berkeley.edu/cftcans-implementation-support-toolkit	The Child and Family Team 
☐ The CANS is **an information integration tool** that is used to identify the needs and strengths of children/youth and their families. ☐ Consensus ratings by multiple informants help achieve **collaborative, consensus-based assessment** – a common language framework that aids understanding of presenting issues, impact, and effectiveness across multiple levels: family, program, system.	CANS: Enhancing and Supporting the CFT 

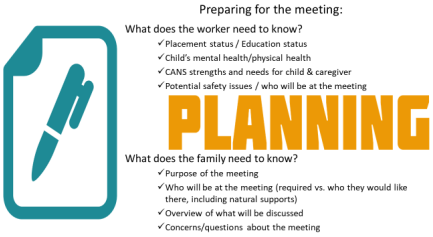
Safety Organized Practice

- ☐ The CANS is to be completed as part of a **group process** with core stakeholders.
- ☐ **Multiple points of view are represented and consensus on the level of action needed** to address each identified need and strength leads to a clear, mutually agreeable action plan.

- ☐ Review best practices for CFT meetings
- ☐ 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 development for youth not receiving SMHS
  - ✓ For possible placement changes (includes placement in an STRTP
  - ✓ As frequently as needed to address needs of the child/youth, including need for SMHS (The need for SMHS may also include TFC, hospitalization, medication, changes in medication, etc.)
- ☐ CFT meetings must include:
  - ✓ Specific discussion regarding the placement, behavioral health, and other needs of the child/youth
  - ✓ A plan to meet those needs
  - ✓ Use of the CANS for communication and case planning
- ☐ An SOP CFT meeting meets the State mandate when requirements are met for:
  - ✓ Participants
  - ✓ Timing/frequency
  - ✓ Topics covered (including CANS)



- ☐ Meetings require a lot of planning!
- ☐ Worker prep:
  - ✓ Placement status
  - ✓ Education
  - ✓ Child's mental health/physical health
  - ✓ CANS strengths and needs for child & caregiver
- ☐ Preparing the child and family: It is very important that we prepare the family for the CFT!
  - ✓ Imagine you are a parent and your child was brought into care or custody. What would you need to understand?
- ☐ The following items should be discussed with the family prior to each meeting:



- ✓ Purpose for the meeting
- ✓ Who will be at the meeting (including safety network)
- ✓ Overview of what will be discussed
- ✓ Concerns/questions about the meeting

- ☐ Refer participants to their mapping handouts in the participant workbook.
- ☐ ***Please note:*** The structure & content guides are in the participant guide, as they are informational only and are not being used for group activities.
- ☐ *Northern Academy has created some new CFT meeting maps that are based on service component (ER/Safety Planning, FR/FM, and PP/NMD) and adapted from the Consultation and Information Sharing Framework ® Sue Lohrbach, 1999 (primarily used in RED teams and Group Supervision practices).*
- ☐ The SOP CFT meeting maps use the Three Column SOP mapping format and also start to bring in the CANS. They map closely to each other but shift slightly to reflect the priorities of cases as they move through the system.
- ☐ Give a brief review of the mapping handouts as listed on the slide:
  - ✓ Safety Mapping Quick Guide
  - ✓ CFT Meetings Quick Guide
  - ✓ ER Meeting Map
  - ✓ ER Meeting Structure & Content Guide
  - ✓ FM/FR Meeting Map
  - ✓ FM/FR Meeting Structure & Content Guide
  - ✓ PP/NMD Meeting Map
  - ✓ PP/NMD Meeting Structure & Content Guide
  - ✓ CFT Meeting Key Issues & Questions by Meeting Purpose
  - ✓ ER Meeting Map – Cheryl
  - ✓ Blank versions of all 3 maps for note taking/mapping activity
- ☐ Please note: Some Counties use the Consultation and Information Sharing Framework, some use the 3-column map some may use the other mapping documents as shown in these slides.
- ☐ What are the key benefits for the CFT Meeting Maps?
  - ✓ Allows identification of "complicating factors" and filling in "gray area" to easily show what the risks are and how they directly impact the child
  - ✓ Allows for ease in case transfer and reduces need for the family to retell their story
  - ✓ Provides one place for genogram, strengths, safety, and complicating factors

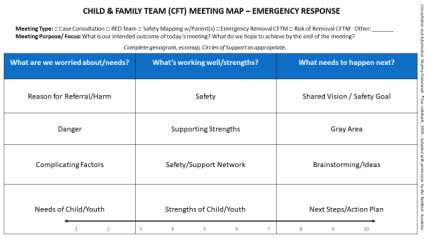
Overview of Mapping Documents / Handouts

Handout title	Purpose of handout
Safety Mapping Quick Guide	Overview of Safety Mapping
CFT Meetings Quick Guide	Overview of CFT Meetings
ER Meeting Map	CFT meeting map for ER/Safety Planning Meetings
ER Meeting Structure & Content Guide	Instructions for CFT meeting map for ER/Safety Planning Meetings
FM-FR Meeting Map	CFT meeting map for FM/FR Meetings
FM/FR Meeting Structure & Content Guide	Instructions for CFT meeting map for FM/FR Meetings
PP-NMD Meeting Map	CFT meeting map for PP/NMD Meetings
PP/NMD Meeting Structure & Content Guide	Instructions for CFT meeting map for PP/NMD Meetings
CFT Meeting Key Issues & Questions by Meeting Purpose	Overview of key issues/questions to ask by CFT meeting purpose
ER Meeting Map – Cheryl	Sample CFT Meeting Map – ER/Safety Planning for Cheryl's case

Safety Organized Practice

- ✓ Comprehensive approach to elicit information and organize information
- ✓ Assists with critical thinking and decision making
- ✓ Can be used with families (as in safety mapping) or as a consultative tool for supervision or consultation
- ✓ Incorporates needs and strengths of the child and caregivers from CANS
- ✓ Any others?

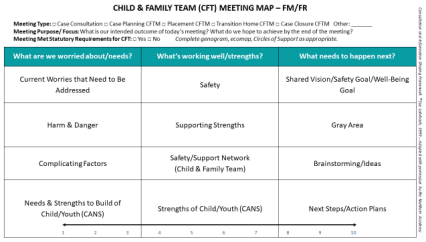
- ☐ The next three slides reflect three different meeting maps that integrate the Consultation and Information Sharing Framework from Sue Lohrbach with the Three Column SOP mapping format and also start to bring in the CANS. There are three different tools, one for ER, one for FM/FR (including VFM), and one for PP/NMD cases. They map closely to each other but shift slightly to reflect the priorities of cases as they move through the system.
- ☐ The ER CFT Meeting Map can be used for internal referral staffing, RED Teams, kitchen table mappings or formally facilitated CFT meetings at the ER level.
- ☐ ***Please note:*** The meeting maps can be completed electronically during internal case consultations, etc. but should not be typed into during an in-person CFT meetings with the family (charting using flip chart paper is ideal and strongly recommended). However, typing into the electronic form is a useful way to capture the information during virtual CFT meetings.



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

What are we worried about/needs?	What's working well/strengths?	What needs to happen next?
Reason for Referral/Harm	Safety	Shared Vision / Safety Goal
Danger	Supporting Strengths	Gray Area
Complicating Factors	Safety/Support Network	Brainstorming/Ideas
Needs of Child/Youth	Strengths of Child/Youth	Next Steps/Action Plan

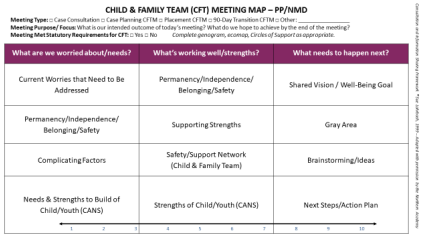
- ☐ The FM/FR CFT Meeting Map can be used for internal case consultations, kitchen table mappings or formally facilitated CFT meetings at the FM/FR level.



CHILD & FAMILY TEAM (CFT) MEETING MAP – FM/FR

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
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 Plans

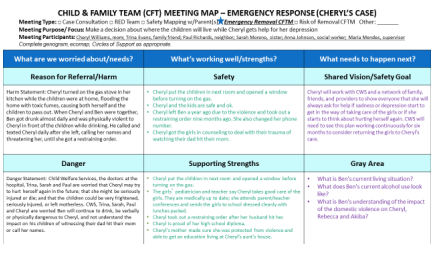
- ☐ The PP/NMD CFT Meeting Map can be used for ILP meetings, 90-day transition plans, placement changes, permanency meetings, formally facilitated CFT meetings at the PP/NMD level.



CHILD & FAMILY TEAM (CFT) MEETING MAP – PP/NMD

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
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

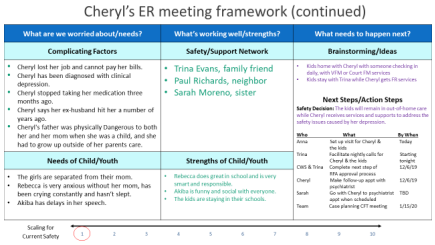
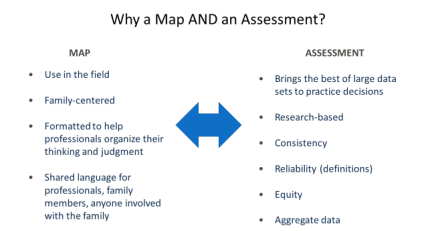
- ☐ Refer to handout: ER Meeting Map – Cheryl
  - ✓ What do you notice?
  - ✓ What might we add to the Gray Area?
  - ✓ What information are we missing?



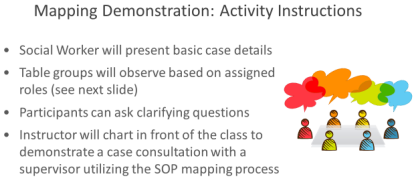
CHILD & FAMILY TEAM (CFT) MEETING MAP – EMERGENCY RESPONSE (CHERYL'S CASE)

What are we worried about/needs?	What's working well/strengths?	What needs to happen next?
Reason for Referral/Harm	**Safety**	**Shared Vision/Safety Goal**
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.	• 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 left Ben a year ago due to the violence and took out a restraining order nine months ago. She also changed her phone number. • Cheryl got the girls in counseling to deal with their trauma of watching their dad hit their mom.	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.
Danger	**Supporting Strengths**	**Gray Area**
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, confused, and traumatized if this occurs. CWS, Trina, Sarah and Cheryl are worried that 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.	• Cheryl put the children in next room and opened a window before turning on the gas. • The girls' pediatrician and teacher say Cheryl takes good care of the girls. They are medically up to date; she attends parent/teacher conferences and consistently sends the girls to school dressed clearly with lunches packed. • Cheryl took out a restraining order after her husband hit her. • Cheryl is proud of her high school diploma. • Cheryl's mother made sure she was protected from violence and able to get an education living at Cheryl's aunt's house.	• 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?

Safety Organized Practice

☐ Please note: Most counties may use a simplified version of this such as the three columns.	
☐ Any thoughts about how the information is organized on the map? ✓ Additions? ✓ Questions? ✓ What does this practice look like in your agency?	
☐ Maps are very helpful when organizing information and creating a document the family can see and understand. ☐ But alone, each worker may have different ideas about whether or not something constitutes Danger. ✓ The SDM assessments aren't usually helpful to have on the kitchen table with the family. ✓ The map can be helpful in that situation. ✓ The SDM assessments also allow information about individual families to be aggregated so the agency has good information about the families served. ✓ Maps can't provide aggregate data ☐ So you might be asking, why do we need a map and an assessment? How do they work together? ☐ One example is to use the Assessment tools to get clear – what is the critical information we need to acquire to make the decision we are at right now? Then use the map to help gather and organize that information. Together it produces a process that contains both collaboration and a consistent result. ☐ Another example might look like this: I start safety mapping with the family to help build a relationship and gather the information I need. I bring that to the risk assessment which helps me understand that likelihood that this family may maltreat their child again. Together – the relationship I have made with the family and the information I now know about the likelihood of future maltreatment – helps the family and I to make good decisions and good plans.	
☐ ***Next segment: Safety Mapping Practice Activity*** ☐ Prepare for mapping demonstration: Assign roles to tables – hand out laminated role cards to each table (see next slide) ☐ Remind the class of our group agreements – importance of maintaining safety in the room during this practice activity.	

- ☐ Please allow at least 1 hour, 30 minutes for this exercise.
- ☐ Provide an overview of the activity that is about to begin. Please refer to next slide for "Mapping Roles" that will be assigned to each table during the activity.
- ☐ ***WHAT:*** A live demonstration of a consultation utilizing one of the CFT Meeting Maps (based on service component of case presented by social worker / ER, FM/FR, PP/NMD)
  - ✓ ***This is a case consultation between the worker and their supervisor, the family is not present. This would be an example of a conversation to gather all information to prepare the worker for next steps, prepare for the next CFT meeting, at a key decision point, etc.***
- ☐ ***WHY:*** To let everyone experience the process and let them see it applied to a case from their jurisdiction/county, which can increase their understanding of the process and how useful it can be to their practice.



- ☐ ***Applicable Handouts for trainers:***
  - ✓ CFT Meeting Maps (for reference)
  - ✓ Laminated Mapping Role cards (hand out mapping role cards to each table…trainers will check in with participants throughout the mapping activity, or at the end…at trainer's discretion)
- ☐ ***Applicable Handouts for participants (participant workbook):***
  - ✓ Facilitated Dialogue Structure (for reference)
  - ✓ SOP Definitions (for reference)
  - ✓ CFT Meeting Maps (for reference)
  - ✓ Voice of SDM Assessment handout (to provide more information about the importance of using SDM in the mapping process).
- ☐ ***Mapping a case involves the following steps:***

Step 1: Selecting a Case

- ☐ It is important to choose the case for this exercise wisely. Early in the day, tell the group that you will be doing a case consult and ask if anyone is willing to talk about a case that the group can learn from.
- ☐ Always have at least two examples to choose from before deciding. Look for a case that you can use as an example throughout Day 2 to make harm statements, danger statements, and safety goals. Try to select a case with a clear incident of past harm from which danger statements and safety goals can easily be created. At a minimum, choose a case that will lead to a clear danger statement.

Cases to Avoid

- ☐ Cases with lengthy histories that will take a long time to write up.
- ☐ Cases based solely on a child's actions and the danger in which his/her actions are putting him/herself or others. Mapping will work for those cases, but they are not great training examples.

- ☐ Cases in which there appears to be no harm or danger, but strong measures have been taken with the family already. These cases put facilitators in the position of displaying poor work and deciding how much or little to comment on it.

Step 2: Board Set Up and Handouts

- ☐ Set up board with the headings from the appropriate CFT Meeting Map
- ☐ Suggestion for participants: refer to Facilitated Dialogue Structure handout during the mapping activity.

Step 3: Agreements and Mapping Roles

- ☐ Create agreements with the group about the consult.
- ☐ Information. This demonstration is designed to show how the framework helps to organize information. You may not learn everything you wish you could know about the family.
- ☐ "I don't know" is okay. Because the worker talking about his/her work has just today agreed to do this, he/she has not reviewed the record and may not be able to answer each question the facilitator asks. It is okay to say "I don't know."
- ☐ The facilitator asks the questions. This is to avoid the phenomenon in case consults where the worker giving information is asked many questions by many people. The facilitator promises to check in with the group at several points for questions he/she is not asking that should be asked, but those questions should be directed at the facilitator, not at the worker.
- ☐ Watch out for judgments. If anyone finds him/herself in a place of judgment about the worker, either positive ("Wow, what good work") or negative ("Wow, what terrible work"), recognize that the whole story is not clear. Remember that we do not know everything about the case rather than using judgments or assumptions.

- ☐ *Mapping Roles: Each group will be assigned one of the following roles during the mapping activity. The facilitator will check in with each table throughout the activity.*
- ☐ Assign mapping roles for each table/group as outlined on the slide. Place mapping role signs on each table.
- ☐ Explain each role so that participants know what to listen for during the activity. Encourage them to write down questions and thoughts during the mapping activity.
- ☐ Please note: There are different options for trainers to consider when checking in with participants in regards to their specific mapping "roles".
- ☐ ***Option 1:*** You can check in with the various roles throughout the mapping activity as it comes up, although this may take more time.
- ☐ ***Option 2:*** You can go through the entire mapping activity then check in with each table to solicit their thoughts, questions, and feedback regarding their specific role.
- ☐ Exception: Voice of SDM table will likely be asked to weigh in on what the SDM definitions are during the mapping in regards to the specific case being mapped.

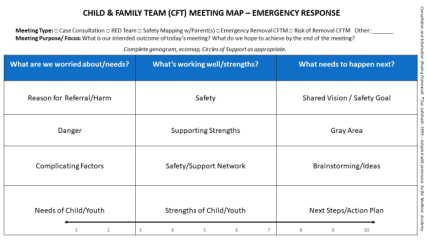
Definitions of roles and things to look for during the mapping:

- ☐ ***Voice of SDM:*** The voice of the SDM assessment. If the worker giving the consult is at a key decision point with which an SDM assessment would help, the

facilitator will check in with the "voice of the SDM assessment." This person looks at the SDM assessment to keep the group on track to gather all the information needed for the assessment. For more information, see "The Voice of the SDM Assessment" in the "Introducing Safety- Organized Practice" packet.

- ☐ ***Trauma Informed Practice:*** Listen for any evidence of trauma informed practice in the case consultation. Is the trauma of child welfare involvement considered? Is there a history of trauma for parent or child that may be impacting the current family situation?
- ☐ ***Cultural humility:*** Ask about race, culture, religion, ethnicity, etc., and the role it has played in the work so far. How have any differences between the worker and the family played out in their relationship? Do the recommended services and supports reflect the individual needs and cultural identities of the child and family? Are services and resources fair and equitable?
- ☐ ***Listening for Jargon:*** Listen for any jargon, stereotypes and/or generalizations, he's an "alcoholic," she's "stable," etc. Listen for opportunities to be more behaviorally specific i.e. what is the actual impact on the child in behavioral terms? Are the action steps in the safety plan and/or case plan behaviorally specific and easy to understand?
- ☐ ***Solution Focused Questions:*** Were any Solution Focused Questions used with the family? What Solution Focused would you have for the family? Any suggestions for SF questions the worker can use with the family being mapped?
- ☐ ***Collaborative Practice:*** Listen for inclusion of child, parent, network, service provider, agency voices. How was child & family voice & choice highlighted and lifted up? Any recommendations for improvement?
- ☐ ***Move to next slide to begin the mapping (choose appropriate meeting map based on the case selected for the activity)***

- ☐ FOR REFERENCE: Please use applicable meeting map for mapping demonstration
- ☐ This meeting map has been designed for an ER mapping and incorporates Needs and Strengths of the child/youth that informs the first draft of the CANS



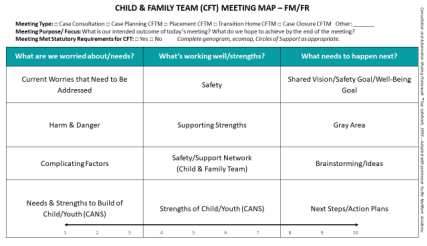
CHILD & FAMILY TEAM (CFT) MEETING MAP – EMERGENCY RESPONSE

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? 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	Shared Vision / Safety Goal
Danger	Supporting Strengths	Gray Area
Complicating Factors	Safety/Support Network	Brainstorming/Ideas
Needs of Child/Youth	Strengths of Child/Youth	Next Steps/Action Plan

1 2 3 4 5 6 7 8 9 10

- ☐ FOR REFERENCE: Please use applicable meeting map for mapping demonstration
- ☐ This meeting map has been designed for an FR or FM mapping and incorporates Needs and Strengths of the child/youth from CANS



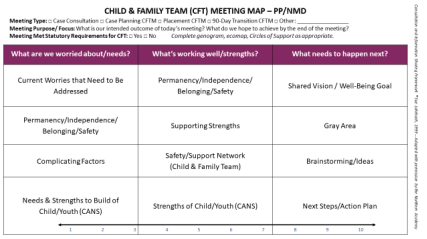
CHILD & FAMILY TEAM (CFT) MEETING MAP – FM/FR

Meeting Type: □ Case Consultation □ Case Planning CFTM □ Placement CFTM □ Transition Home CFTM □ Case Closure CFTM Other: _____
Meeting Purpose/ Focus: What is our intended outcome of today's meeting? What do we hope to achieve by the end of the meeting?
Meeting Met Statutory Requirements for CFT: □ Yes □ No *Complete genograms, ecomaps, 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
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 Plans

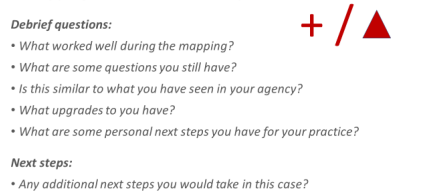
1 2 3 4 5 6 7 8 9 10

- ☐ FOR REFERENCE: Please use applicable meeting map for mapping demonstration
- ☐ This meeting map has been designed for a PP/NMD mapping and incorporates Needs and Strengths of the child/youth from CANS


CHILD & FAMILY TEAM (CFT) MEETING MAP – PP/NMD

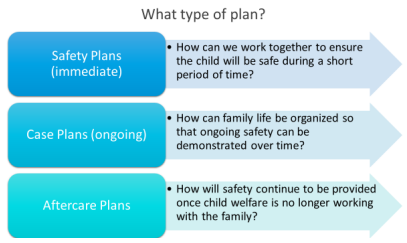
What are we worried about/need?	What's working well/strengths?	What needs to happen next?
Current Worries that Need to Be Addressed	Permanency/Independence/ Belonging/Safety	Shared Vision / Well-Being Goal
Permanency/Independence/ Belonging/Safety	Supporting Strengths	Gray Area
Complicating Factors	Safety/Support Network (Child & Family Team)	Brainstorming/Ideas
Needs & Strengths to Build of Child/Youth (CANS)	Strengths of Child/Youth (CANS)	Next Steps/Action Plan

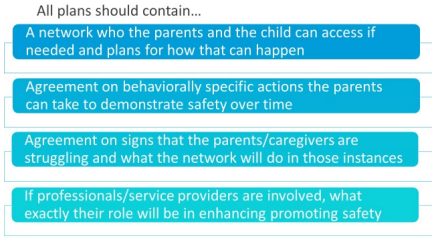
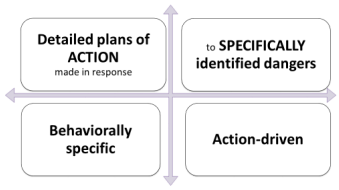
- ☐ ***Step 13: Plus/Delta on the Process***
  - ✓ Debrief the process using questions on the slide
  - ✓ ***Follow-up with the Social Worker who mapped the case:*** If possible, leave the mapping on the board for the Social Worker to take a picture of it.



- ☐ ***Next segment: Behaviorally Based Case Plans & Action Steps***
- ☐ Refer to handout in participant workbook: BBCP Quick Guide
- ☐ Once we have created Harm and Danger Statements and the well-formed Safety Goals, we can engage the family in the development of behaviorally based case plans that are individualized and include specific action steps to meet their needs and incorporate their strengths. Action steps outline the behavior changes we want to see to ensure safety (acts of protection over time). These plans are not reliant on service compliance, although services are often included to support the behavior changes.
- ☐ There is no doubt that you are already doing planning in many forms in your work: Case plans, safety plans, etc. What we hope to be able to show is how these SOP practices can help you make plans that are even more rigorous, collaborative, and focused on specific action steps with support from the support network. We will talk about what goes into making these plans and then get a chance to practice.

- ☐ Large group discussion: Have participants look at the three types of plans (safety plan, case plan, and aftercare plan) and discuss the following questions:
  - ✓ What do you notice? How different is this from what you do now? What comes to mind when you think of planning this way?
  - ✓ You may be asking where do action steps and plans like Cheryl's go – are they case plans? Safety plans? Something else?
  - ✓ ASK: Do you have any thoughts about that?
- ☐ These practices and these kinds of actions steps can be incorporated in *any and all of our planning work:*
- ☐ Whether it is safety plans related to immediate safety for children, case plans and for more ongoing work or the informal aftercare plans some agencies make

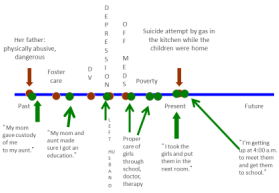


when closing a case, we can think about adding danger statements, safety goals and the action steps the family and the network has agreed to take as well. ☐ For example: Some counties and agencies make sure they put danger statements and safety goals on all of their case plans, and make sure that every case plan has an item related to "growing the network". Some counties make informal aftercare plans, and you can use danger statements there as well saying something like –" if the [Danger Statement] comes back you should….." ☐ These practices help ensure the parents know what the immediate worry is we are trying to respond to.	
☐ Review slide – all plans should contain these elements!	
☐ PURPOSE: To point out that safety plans are detailed and focused on identified dangers. ☐ **Safety plans are detailed**. We will not settle for vague notions of change. ☐ **Safety plans are about ACTIONS**. Plans will not be about the absence of, or merely time passing without, an adverse event. Plans will state clearly what caregivers DO. ☐ Safety plans will not require caregivers to take actions, no matter how noble, desirable, or good, unless those **actions specifically address the identified danger.** By focusing on things that directly respond to the identified danger, we are more likely to protect the child from repeated trauma. ☐ DISCUSSION: ☐ What are some things we often throw into case plans that sound great, and we'd love ALL caregivers to do them, but may have absolutely nothing to do with the danger that brought the family to CPS (e.g., get your children to school, keep house clean, don't break the law and stay clean and sober)? ☐ There is nothing wrong with these goals IF they directly relate to danger, but we want to keep plans clear of extraneous requirements that may serve only to distract from the real issues, increase defensiveness, and overwhelm families in ways that make hope impossible.	

Safety Organized Practice

- A reminder of Cheryl's story. (Brief review before we look at Cheryl's case plan). From our initial assessment we learn…..
- Cheryl is an African-American woman in her late 30s with two children (ages 4 and 6).
  - She made a significant suicide attempt by turning on the gas in her oven while both children were home.
  - All three of them passed out and it was only through a neighbor smelling the gas and breaking down the door that more serious injuries were averted. Children were placed together in foster care; mother went to a psychiatric facility and was released 10 days later; she is currently not suicidal and is expressing a lot of regret.
- You meet with her to do a standard assessment and this is what you learn:
  - Her father was abusive to her and her mother. He drank and smashed things around the home.
  - Things got so bad that Cheryl went into foster care herself.
  - As she got older, Cheryl engaged in relationships with men who were violent, including the father of the girls.
  - This finally led to Cheryl being diagnosed with depression.
  - More recently, she has gone off her medication.
  - Even more recently, Cheryl lost her job as a clerk at a store, leaving the family dangerously close to poverty and not having enough food to eat or money to keep the heat on.
- As you ask more about her childhood and earlier history, you learn:
  - Her father was abusive to her and her mother. He drank and smashed things around the home.
  - That the foster care arrangement was a familial one. No CPS involvement.
  - That Cheryl's mom always stayed in her life, and worked with her aunt—Cheryl's foster parent—to make sure she got a high school diploma.
  - That Cheryl reached the point of leaving her husband and took out a restraining order when she saw how violent he could be with the girls watching, saying, "I won't have my girls go through what I did".
  - That there are many examples of appropriate care Cheryl has shown the girls. Pediatrician says she has been terrific, kids all up to date; school says kids come to school dressed appropriately, on time, with work done.
  - Both are very surprised about what happened. And finally we learn…
  - That Cheryl knows the foster mother who is taking care of her kids ('we went to high school together').
  - Cheryl has been getting up at 4 a.m., walking more than two miles from her home to the foster mom's home to get the girls up and off to school every morning since she got out of the psychiatric hospital.
- ***Given all of this, let's look at a couple of different kinds of plans CPS could make with Cheryl.***

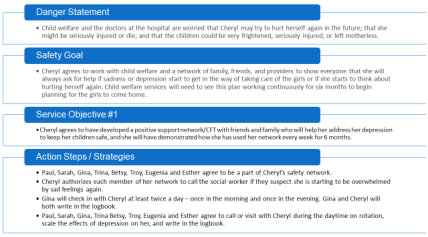
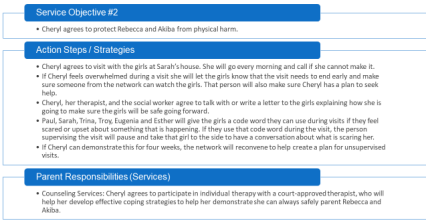
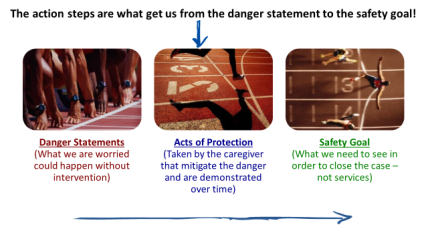
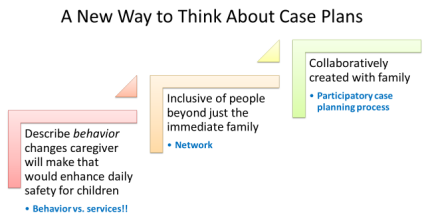
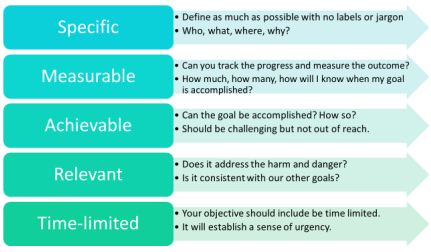
A reminder of Cheryl's Story



Safety Organized Practice

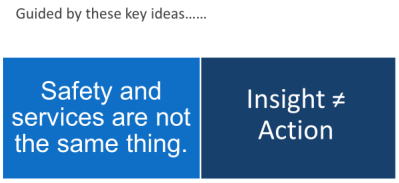
☐ Let's compare and contrast the following two plans for Cheryl ☐ Review Plan #1 ☐ Refer participants to handout in participant workbook: Comparing two plans	What is the difference between these two plans? • ***Refer to Handout: Comparing two plans*** (Plan # 1) ➢ Cheryl needs to visit the therapist weekly to work on depression, its causes, and its impact on her life. ➢ Cheryl needs to visit the psychiatrist at least monthly to ensure she is taking her medication and it is working properly. ➢ Cheryl needs to attend a therapeutic group weekly for "women facing depression" 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 parenting classes. 
☐ Review Plan #2	Cheryl agrees to present the following to her children and her safety network: (Plan # 2) ➢ Neighbor Paul, sister Sarah, foster mother Trina, and outreach worker Betsy agree to be part of Cheryl's safety network. ➢ Cheryl will ask for help with the children if she is feeling higher than a 7 on a 10-point depression scale. ➢ Cheryl will not be alone if she is thinking about hurting herself again; she will ask for help from someone in the network if this happens. ➢ Cheryl agrees to keep a log of her work in resisting the worst of her depression. She will rate the impact of her depression in the book daily and detail everything that is helping her reduce that impact.
☐ Plan #2 continued ☐ Discussion: See next slide	(Plan # 2) ➢ 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 rate her depression' s impact on her. They will talk to the kids and ask them how they are. When the network visits, they will also write in the log and ensure that the children have their phone numbers. ➢ Betsy will visit the home two to three times a week. Either she or other team members will be available 24 hours a day if Cheryl wants to call. During her visits, Betsy will rate depression's impact on Cheryl and write in the log. Betsy will work with Cheryl to make sure she goes to the doctor. ➢ Cheryl, the safety network, and CPS will review this plan again in 3 weeks.
☐ Discussion points: What do you notice about each? What works well in each? What do you worry about in each? ☐ How is Cheryl talked about in each? How is the "philosophy" different in each? ☐ CRITICAL POINTS: We are not going to eliminate services as a part of plans. Sometimes, services are essential stepping stones and the only way for a family to reach their goal. What we do hope to accomplish is to never mistake a list of services for a safety plan. ☐ Also point out the detailed guidelines in Plan 2 and how it does not attempt to "get the depression out" of the family—we cannot do that. It helps create a path to safety, even with depression. The point is not to replace Plan 1 with Plan 2, but to incorporate them together, being sure not to make plans on people but with people. ☐ These action steps are the vehicle that takes the family from the Danger Statement to the Safety Goal.	**What Did You Notice?** (Plan # 1) • Probably what you usually see • Cookie-cutter • Service-driven • Parent could complete services and we still would not know if safety for the child was achieved (Plan # 2) • Behaviorally specific • Customized for parent/family • Meaningful engagement with services that address the safety threat • Involves a support network with specific roles • Demonstrates behavior change

Safety Organized Practice

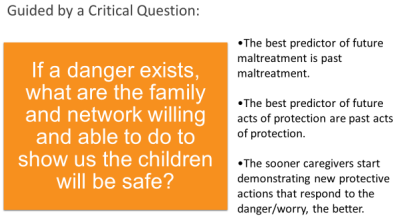
☐ Cheryl's behaviorally based case plan example: How would this look in a CWS/CMS? ☐ What do we need to see to know the safety goals are met?	
☐ Cheryl's case plan example (continued) ☐ What services will help support Cheryl to be successful? Services should be individualized and directly related to the safety goal(s) and objectives! ☐ Are safety network members appropriately included? ☐ Are the objectives and action steps SMART and easy to measure? ☐ Refer to handouts in participant guide for further examples: ✓ BBCP Example with instructions ✓ Cheryl Sample Case Plan	
☐ Review slide	
☐ Review slide	
☐ A reminder of SMART objectives – briefly review	

Safety Organized Practice

- Safety and services are not the same thing: If safety and services are not the same thing, then what will our plans be composed of? Action-steps. And by the way – there is still a role for services for sure – but it supports this movement toward action and safety, not the other way around. Services are 'stepping stones' to actions that can create safety.
- Insight does not equal Action: When we think about the kinds of plans we have we can think about our beliefs or orientation to change. Most of us got trained or socialized in this kind of orientation: That individuals, families, children – really anyone – has to have insight before they will take action. That people have to "see" they have a problem before they will be willing to take serious steps to address the problem.
- We often feel better if people demonstrate insight into their behavior, but insight does not equal action or behavior change, and people are capable of changing behavior even in the absence of insight. However, behavior change often ultimately leads to insight.
- What if we thought about it another way though – that sometimes it is the act of taking a step, taking some kind of action that actually is what produces the insight and desire to maintain the change?
- What if we created plans that called for ACTIONS to begin immediately, with the notion that once the actions begin, often, insight will follow?
- Many years of research into cognitive behavioral therapy would support this notion, sometimes I need to take action to see the benefit of the change.

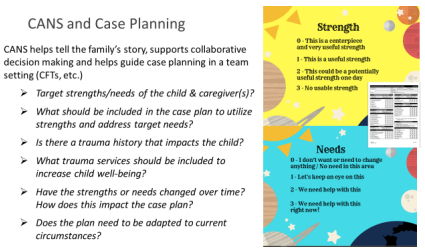


- What if our bottom line for the plans we made was not about "insight" the parents had or didn't have (very hard to measure!) and instead was this question: What is the family willing and able to do to show us that their children will be safe?
- If the family and the network are not willing to do anything about the danger, that is very important information. However, families and networks are not always asked this question directly when we focus more on services and insight-related ideas.
- Read bullet points.
- The best predictor of future maltreatment is past maltreatment.
- The best predictor of future acts of protection are past acts of protection.
- The sooner caregivers start demonstrating new protective actions that respond to the danger/worry, the better.
- Ask the group: What possibilities would this paradigm shift open up in working with people? How might it help us in moving forward with people who may not see the problem in the same way as CWS? What concerns would people have?



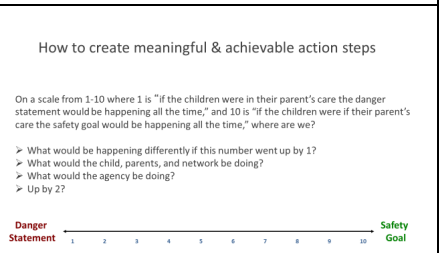
Safety Organized Practice

- A reminder about CANS – important to consider priority strengths and needs during CFTMs and case planning process!
- Target needs are those needs we think that by supporting, we can resolve the need and achieve anticipated outcomes in other areas of need. For example, if a child's anxiety is causing them to have poor school attendance and poor school achievement, the target need would be anxiety, and anticipated outcomes would include school attendance and achievement.

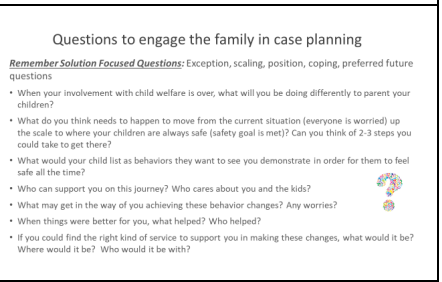


- A reminder – remember our earlier discussion about the Five Protective Factors? How will you utilize these protective factors as part of the case planning process?
- What types of action steps and strategies can be implemented as part of the case plan objectives to help us reach the safety goal(s)?

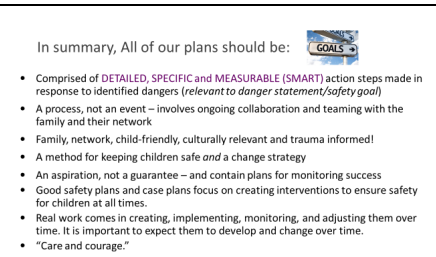
- Creating action steps for any of our plans requires first that everyone is clear about the dangers that need to be addressed (Danger Statements) and what the family needs to do to address the dangers (the Safety Goals). Once we have those, we can use a scaling question to help get clear about next steps.
- Think about this scaling question:
- *On scale from 1-10 where 1 is 'if the children were in their parent's care the danger statement would be happening all the time' and 10 is 'if the children were in their parent's care the safety goal would be happening all the time' where are we? What would be happening differently if this number went up by 1? What would the child, parents and network be doing? What would the agency be doing? Up by 2?*
- **NOTE:** Have some discussion about this scale. It is designed to help create action steps directly related to the Danger Statement and Safety Goal you are working with. What would it be like to try this with a parent and family?



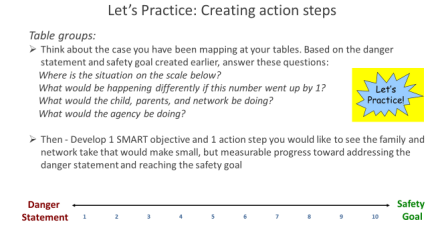
- Instructor asks:
- Can you think of any other question you could ask?
- What services do you think work the best?
- What have you seen be the most successful?



- A few other things we'll say about plans that may challenge our thinking:
- Plans need to be made collaboratively with the family, child, and network. We can come up with the best plans, but if the family doesn't "own it," all the plan becomes is protection from liability.
- Plans are a process not an event. A plan isn't something you can set and then set sail--you will need to keep coming back to it time and again.
- Plans are a roadmap not a guarantee. The plan provides direction, but we should not fall into naive practice: We are *always* assessing safety and danger at whatever point in the process we are at.
- These are not just a method of keeping children safe--these are an intervention themselves, a way to help people begin to make change.
- "Care and courage" is a phrase by Andrew Turnell of what he thinks workers and agencies need that try to make these kinds of plans.



- Refer to Behaviorally Based Case Plan Quick Guide – Refer to page 4 of the guide for examples of case plan objectives and behaviorally based action steps
- Same table groups: Have groups write down the best versions of the danger statement and of the safety goal created earlier on chart paper. Draw a 1-to-10 scale in between and place the situation on the scale based on the question below.
- Table group activity: Think about the case you have been mapping at your tables.
- Based on the danger statement and safety goal created earlier, answer these questions:
  - ✓ *Where is the situation on the scale (from 1-10)?*
  - ✓ *What would be happening differently if this number went up by 1?*
  - ✓ *What would the child, parents, and network be doing?*
  - ✓ *What would the agency be doing?*
- Then - Develop 1 SMART objective and 1 action step you would like to see the family and network take that would make small, but measurable progress toward addressing the danger statement and reaching the safety goal
- On a scale from 1 to 10 where 1 is the danger statement would be happening all the time if the child was in the parent's care and 10 is the safety goal would be happening all the time if the child was in the parent's care, where would you place the situation?
- What would be happening differently if this number went up by one? What would the child, parents, and network be doing? What would the agency be doing? Ask groups to use this scaling question to develop one objective and one strategy/action step the parent/family could take that would help to show they are progressing from the danger statement to the safety goal.



- ☐ After approximately 10 minutes, take ideas from the group (instructor charts the answers)
- ☐ It is likely that some ideas will be bigger steps than just "up by one." If that is the case, ask the person giving the idea, "Do you think if the parent did that it would be just 'up by one,' or do you think it might be more than one? What would up by one look like?"
- ☐ Conclude the exercise by asking the worker whose case this is to select which action steps, if any, he/she might take back to the family. Also ask him/her to debrief the day as a whole. Ask: What kind of difference, if any, will it make to have the danger statements, safety goals, and action steps that we created?

- ☐ The Golden Thread: See handout in the Participant Guide
- ☐ Briefly review the key points – this is how it all fits together.

SDM Safety Threat:
- SDM Safety Threat = Harm
- SDM Risk identifies complicating factors (or harm, if impact on the child)
- CANS should reflect caregiver needs that link to harm/danger and safety

Petition & Harm Statement
- Petition ties to the SDM Safety Threat
- Harm Statement created with the family and network
- Petition uses legal language
- Both about the same issues

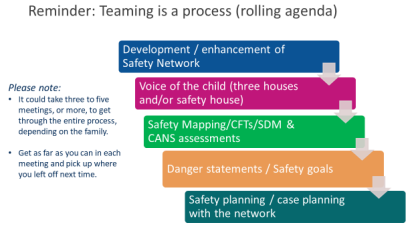
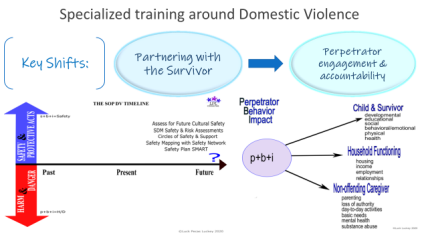
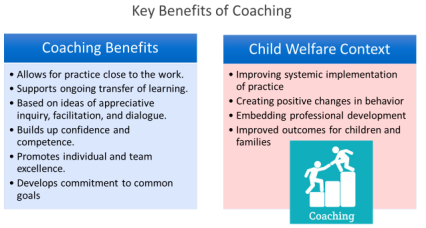
Danger Statement
- Danger Statement ties to SDM Safety Threat, Petition and Harm Statement
- Created with the family and network

Safety Goal
- Safety Goal ties to SDM Safety Threat, Petition, Harm & Danger Statements
- Created with the family and network

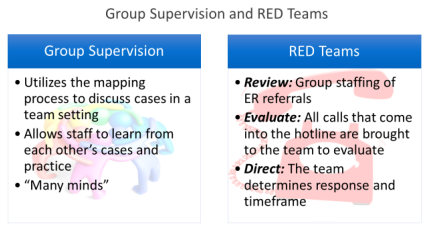
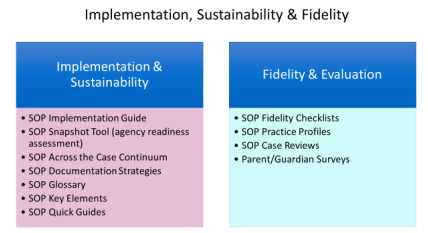
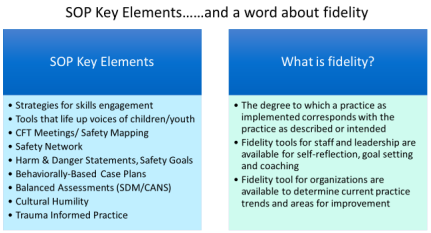
Case Plan Objectives
- Case Plan Objectives tie to SDM Safety Threat, Petition, Harm & Danger Statements & Safety Goal
- Behaviorally-based
- SMART
- Linked to CANS Target Needs related to Harm/Safety Threat

Case Plan Activities/Action Steps
- Case Plan Activities tie to SDM Safety Threat, Petition, Harm & Danger Statements & Safety Goal & Behaviorally-based Objectives
- With the support of the Network
- Linked to CANS Target Needs and applicable Caregiver Resources

Behavior Change (or not…)
- Behavior change measurement is tied to the SDM Safety Threat, Petition, Harm & Danger Statements & Safety Goal & Bx-based Objectives & Activities
- SDM Risk Reassessment

▪ FR to FM ▪ FM to closure ▪ If no behavior change, PP	
☐ This is what using SOP with a family will look like over the life of a case. Not always a linear process, but important to touch on each piece at some point.	
☐ ***Next segment: Tools & strategies that support SOP***	
☐ Review slide (next several slides expand on these) ☐ Additional SOP classes (Northern Academy): https://humanservices.ucdavis.edu/northern-academy/sop	
☐ Please note: There are many specialized SOP trainings available, including classes specific to Domestic Violence during which you will learn about the SOP DV Timeline Tool (included in your participant guide). ☐ Please check our website for available offerings	
☐ One of the key strategies you should think about as you start any new practice is the use of coaching. ☐ Many of us are used to attending training in this work, and training does serve a purpose [Read key ideas from slide]. But what we have learned from research and our own personal experiences is that training is not enough. ☐ For practices to be sustained, training really needs to be supplemented by coaching and modeled/supported by all levels of the agency. Coaching can greatly impact your ability to deepen your skill level. ☐ ***Please note:*** If your County does not utilize a coach, you can still seek out peers or other "SOP Champions" at your workplace to help mentor and coach you.	

Safety Organized Practice

☐ Coaching is…….[read key ideas from 'coaching' box on the slide]. Coaches are not necessarily "experts" in SOP. Often the coach is just a little further out ahead than the trainers! But they are someone who can help an individual or group plan to try something new, then after, help them reflect on what worked well and what was hard about it. ☐ Some studies show coaching can increase levels of retention of knowledge, skill level and transfer to practice by up to 95%!!! ☐ The point here is not that "coaching is better than training"– but that we need both! ☐ Northern Academy Coaching resources: https://humanservices.ucdavis.edu/coaching-human-services	
☐ Review slide	
☐ Review slide: These are some examples of existing tools. Many of these tools are on our SOP Resource page (see next slide). Some tools are still being finalized and will be on the Statewide SOP Toolkit (in development).	
☐ The SOP key elements are outlined in the handout in the participant guide: Key elements of SOP ☐ ***Important note about fidelity to the practice:*** Each of the key elements or components of SOP, implemented to fidelity, is necessary to say SOP is being "implemented" in a given agency. ☐ Some counties say they are "using SOP" or consider themselves an "SOP agency", however, they may only be using one or tool strategies, and may not be using the tools to fidelity (as they are intended to be used). ☐ There are several SOP fidelity tools available through Northern Academy to help your agency assess & evaluate SOP implementation & fidelity	

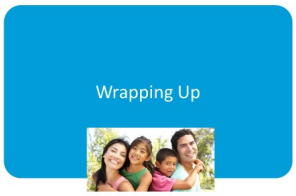
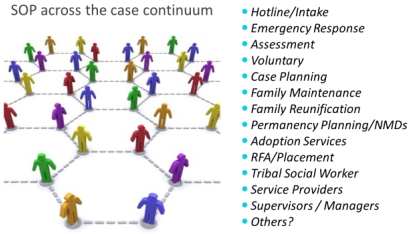
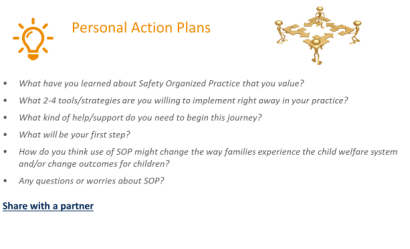
Safety Organized Practice

- ☐ Please refer to handout in your participant guide: SOP Documentation Strategies
- ☐ There is increasing interest by Counties and CDSS to assess the use of SOP with families across the state
- ☐ Use of SOP is often difficult to measure & identify due to the lack of consistent documentation standards, expectations and practices
- ☐ Large group discussion – consider the questions on the slide:
  - ✓ What does SOP documentation look like?
  - ✓ What are some ideas you have for documenting use of SOP with children and families?
  - ✓ Does your county have an SOP documentation policy?
  - ✓ Why is it important to document the tools and strategies we use with families?
- ☐ Debrief – possible ideas:
- ☐ It is important for us to be able to describe the quality of our interactions with children/youth and what tools and strategies are working well to engage the family and what may not work as well – this will help us as we monitor and adapt the case plan, ensuring our services and case plans continue to meet the needs of the child/family, enhance our court reports/status review reports to be more specific, etc.

- ☐ Introduce the SOP Resource Page as an excellent resource for more information! This website includes links to SOP videos, articles, tools, webinars, quick guides, etc.
- ☐ Optional if you have time: Bring up the website to show participants how to utilize this page. SOP Resource page link: http://bit.ly/SafetyOrganizedPractice

- ☐ Counties are not required to use SOP, but choose to do so because of the potential positive impact on outcomes for children, youth and families.
- ☐ The SOP Backbone Committee is made up of members from the Regional Training Academies (RTAs; Northern, Southern, Bay and Central), California Department of Social Services (CDSS), Casey Family Programs, CalSWEC and county representatives from each region. The Northern Academy has primary responsibility for Committee coordination.

Safety Organized Practice

☐ The SOP toolkit contains a comprehensive range of tools to support agencies in implementing SOP and practicing to fidelity. ☐ Link to toolkit: https://calswec.berkeley.edu/toolkits/safety-organized-practice ☐ The toolkit was developed by California's SOP Backbone Committee, which is made up of members from the Regional Training Academies (RTAs; Northern, Southern, Bay and Central), CDSS, Casey Family Programs, CalSWEC and county representatives from each region. ☐ The RTAs provide SOP training, coaching and technical assistance in their geographic areas, including supporting counties in implementing the toolkit. If you would like more information, check out the website at the URL listed here, go to the main CalSWEC website and click on Quick Links – Toolkits – SOP Toolkit, or contact your local RTA.	
☐ Review highlights on slide	
☐ ***Next segment: Wrapping Up***	
☐ How will you apply the elements of SOP across the child welfare continuum? ☐ Refer to handout in participant workbook : SOP across the case continuum ☐ Have participants take 5 minutes to review the handout and share with a partner how they would apply these elements based on their role in child welfare	
☐ Refer to the handout "My Action Plan" and have participants individually answer the questions. ☐ If there is time, have them share their ideas with a partner.	

Safety Organized Practice

☐ Close the workshop with some inspiration and humor - We like to close this workshop with a short video. ☐ We will leave you with a vision of particularly successful implementation, one that takes place quickly and effectively. This closing inspiration for a successful implementation comes…from a dancing guy. ☐ After the video thank them for being willing to be a "lone nut" or to follow one.	Thoughts on Implementation….From the "Dancing Guy"  https://www.youtube.com/watch?v=fW8amMCVAJQ&list=PLbEpa_1VPxsJsS2GQajL_-RHC5xukj8Gl&index=3
☐ Final Plus/Delta (if there is time) ☐ Complete evaluations	Please complete your evaluations!  ***For questions or to inquire about other trainings:*** Visit our website: https://humanservices.ucdavis.edu/northern-academy Visit our SOP Resources Page: http://bit.ly/SafetyOrganizedPractice Visit the SOP Foundational Institute Class Materials page: https://www.oercommons.org/authoring/11911-sop-foundational-institute/view E-mail the Academy at: academy@ucdavis.edu
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