Safety Organized Practice

An Implementation & Practice Guide for Child Welfare Supervisors

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Safety Organized Practice:
An Implementation and Practice Guide for Child Welfare Supervisors

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Introduction

Supervisors are the key to implementation of Safety Organized Practice (SOP)—and, indeed, any practice change in child welfare. More than training, more than policies and procedures, supervisors are the primary factor that will either ensure the success of SOP implementation or ensure that the practice is not implemented except by the most self-motivated, innovative social workers. Training of staff is necessary and vital; however, without supervisors making sure there is actual transfer of learning through coaching, modeling, support and guidance for social workers to try newly learned skills with children and families, training alone will not translate to systemic change in practice. Policies and procedures are necessary to set clear agency expectations for all staff, but they are mere words on a page unless supported by day-to-day expectations and coaching from supervisors around use of SOP tools and strategies with families.

The fact that supervisors are the key to SOP implementation and sustainability requires several important things from you, the supervisor. Above all, you must truly value the use of SOP. You must believe, embrace and espouse that using this approach to child welfare work will improve the experience and outcomes of children and families who encounter our systems, as well as improving the experience of staff with their own work. You must thoughtfully strategize and plan how you will best support SOP implementation with each worker on your team. You must be willing to try new practices first, to model not only newly learned skills but also the courage to jump in and try something different because it will be better for kids and families. You must gain knowledge of each of your employees’ strengths, challenges and areas for growth – understanding what they need to be able to try something new, while actively pushing them past their comfort zone.

And so, the fact that you are the key to the success of SOP implementation is both an exciting and perhaps daunting fact. It means that much responsibility for your staff and how they work with children and families rests on your shoulders. However, it also means that you have tremendous authority, power and influence on the work that is done and the outcomes that occur. We hope you find this deeply exciting, because you almost certainly went into this work to make a difference in the lives of children and families – and you have the ability, through use of SOP by your staff, to enable some of the best child welfare work possible.

It is our hope that this guide to SOP implementation and practice will help give you the tools and framework you need to translate the strategies of SOP to real-world change for staff, children and families.

Northern California Training Academy
June 2018
Overview of Safety Organized Practice

Safety-Organized Practice (SOP) is a collaborative child welfare practice model that aims to build and strengthen partnerships within a family and involve informal and formal support networks of friends, family, service providers and the child welfare agency. SOP uses strategies and techniques that align with the belief that a child and his or her family are the central focus and that partnership exists in an effort to find solutions that ensure safety, permanency and well-being for children.

SOP is both a framework for practice and a set of tools and strategies that help child welfare staff achieve engagement, assessment, teaming and planning with a family and their network. “Safety Organized Practice” is an umbrella term for the blending of a variety of solution-focused techniques, including the Consultation and Information Sharing Framework®/Safety Mapping, Structured Decision Making (SDM)®, Appreciative Inquiry, Cultural Humility, Group Supervision, Reflective Supervision, Family Networks of Support, the Three Houses and Safety House, and Trauma-Informed Practice. This approach is designed to enhance skills in family engagement, rigorous assessment and critical thinking to create sustained safety, permanency and well-being for children and their families.

Key Elements of SOP

Key elements or components of Safety Organized Practice include the following. For more detail, see Attachments, SOP Key Elements.

- **Strategies for skilled engagement** in SOP include the Three Questions, Solution-Focused Questions, Motivational Interviewing and Appreciative Inquiry. Through skillful use of these practices, the social worker becomes an intervention with the family.

- **Voices of children/youth** are brought forward in SOP because of the belief that children and youth likely witness much of what goes on in their families’ lives and can contribute to a comprehensive understanding of what is happening in the family, and that they often can and need to collaborate with other stakeholders in their own safety planning.

- **Child and Family Team (CFT) meetings** build agreements, decisions and plans between the Department, families, providers and other essential members of the youth’s and family’s support network. Meeting facilitators use a variety of strategies and skills for helping groups solve problems and build agreement to enhance the safety of children and families.

- **The Consultation and Information Sharing Framework® and Safety Mapping** are processes of dialogue and inquiry designed to help social workers, supervisors, families and extended networks work together to surface the different aspects of presenting factors, including harm, danger/risk, complicating factors, safety and strengths; identify areas in need of additional exploration; and move toward group agreements about what needs to happen next to ensure the safety of the child or youth.
• The **Safety Network** is 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 do something specific that supports the family and helps to keep the child safe.

• **Harm and Danger Statements** are short, simple, behaviorally-based statements that help youth, family members, collaterals and staff working with the family become very clear about what has happened in the past, why CWS is involved and what CWS staff worry may happen in the future if nothing changes.

• **Safety Goals** explain what the child/youth’s network will observe the parents doing on a regular basis that will prevent the identified SDM safety threat from occurring.

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

• Consistent, accurate use of **Structured Decision-Making** tools informs and supports our decision-making at all key decision points in referrals and cases.

• A **cultural humility** approach to the work requires that we are self-reflective of our own bias and history that we bring to the work with families.

• We work to create **trauma-informed** child and family service systems in which all involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, parents, family members and service providers.

### Why Safety Organized Practice?

Historic approaches to child welfare work – agency-driven and essentially relying on an individual parent to succeed or fail on their own with a boilerplate, service-based case plan – have not achieved the outcomes hoped for children and families. Nor does this feel like the best approach for many social workers and supervisors who are committed to ethical practice, cultural humility, strength-based strategies and social justice, and who came into this work wanting to help people genuinely and permanently improve their lives and the lives of their children.

While some parents are able to successfully meet the objectives of a service-driven case plan so that children can remain or return home, challenges remain. Many social workers have experienced a case where the parent finished all of their services, with the certificates of completion to prove it, but the worker still had a nagging feeling that they really hadn’t made the kind of change needed to keep their children safe. Other workers have seen families exceed expectations, making amazing life changes while surrounded by the support of formal service providers, only to have everything fall apart once the case closes and the parent is again isolated and alone. Further, in typical child welfare practice, the voices of children and youth are not adequately engaged. Children and youth are interviewed and assessed, but are not always meaningfully involved in defining and planning for safety.

Safety Organized Practice aims to address these and other limitations of past child welfare practice by providing tools, strategies and a framework for practice that gets to actual behavior change by the parent; development of natural support networks that will help ensure child safety
both during and after the case; and genuine, age-appropriate involvement of children and youth in their own case. Just a few differences between typical child welfare practice and Safety Organized Practice include:

<table>
<thead>
<tr>
<th><strong>Practice Area</strong></th>
<th><strong>Typical Child Welfare Practice</strong></th>
<th><strong>Safety Organized Practice</strong></th>
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<tbody>
<tr>
<td><strong>Engagement</strong></td>
<td>No specific approach or strategies for engagement are indicated; relies on each worker’s own approach to what engagement means; often translates to being friendly or nice in interactions</td>
<td>Skilled, intentional use of solution-focused questions, motivational interviewing and other specific tools as engagement strategies with children/youth, parents and the network</td>
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<td><strong>Voices of Children and Youth</strong></td>
<td>Children are typically not involved in safety planning or case planning</td>
<td>Children and youth’s voices are intentionally sought out using specific interviewing tools and incorporated into safety planning and case planning</td>
</tr>
<tr>
<td><strong>Case Plans</strong></td>
<td>Agency-driven, service-based and “cookie cutter,” often prescribing the same services for all parents (mental health services, substance abuse services and parenting classes)</td>
<td>Behaviorally-based, individualized and culturally sensitive; driven by the voices of the child, family and their people; involves the support of a network</td>
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<tr>
<td><strong>Safety Plans</strong></td>
<td>Frequently rely on the parent who caused the harm or risk to the child to keep the child safe</td>
<td>Require involvement of a safety network to ensure child safety</td>
</tr>
<tr>
<td><strong>Critical Thinking</strong></td>
<td>Does not involve clearly defined methods of applying critical thinking to case decisions</td>
<td>Provides a standardized method of documenting and critically thinking through all available information about a case</td>
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SOP takes abstract concepts – strength-based social work, engagement, teaming, assessment, case planning, critical thinking, even safety – and translates them into concrete tools and strategies for working with families. It helps social workers develop a deliberate, consistent skill set to translate these ideas into effective on-the-ground work with kids, families and their people. Use of SOP, like any practice approach, does not guarantee positive outcomes; however, it does provide a framework for best practice and a set of real-world tools that help social workers partner with children, youth, families and their networks to best set them up for success.
Safety Organized Practice and the Integrated Core Practice Model

SOP implementation in California began in the Northern Region in 2008 and over the past decade has been adopted by many counties across the state. In 2018, the California Department of Social Services rolled out the Integrated Core Practice Model (ICPM), which provides guidance and direction to support county child welfare, juvenile probation and behavioral health agencies and their partners in delivery of timely, effective, and collaborative services to children, youth, and families.

ICPM incorporates the California Child Welfare Core Practice Model (CPM), Katie A. Core Practice Model, Continuum of Care Reform (CCR) and other practice approaches to provide guiding principles and standards around expected practice behaviors for child welfare, behavioral health and juvenile probation.

ICPM Guiding Practice Principles

1. Family voice and choice
2. Team-based
3. Natural supports
4. Collaboration and integration
5. Community-based
6. Culturally respectful
7. Individualized
8. Strengths-based
9. Persistence
10. Outcomes-based

As seen from these principles, SOP aligns beautifully with ICPM. In essence, ICPM describes the “what” of child welfare work in California (practice behaviors around engagement, teaming, assessment, service planning and delivery, and transition) while SOP provides the “how” (practical, on-the-ground tools and strategies to translate these behaviors to real-world practice). The ICPM leadership behaviors of engagement, inquiry/exploration, advocacy, teaming and accountability also provide a parallel process for child welfare supervisors, managers and directors to conduct themselves in ways that mirror SOP approaches with families.

Child and Family Teams

The Child and Family Team (CFT) is the process through which the ICPM framework is implemented with children, youth and families. SOP provides a toolkit and strategies to meet State CFT mandates. Both SOP and CFT involve developing a team that includes the child/youth, family, their natural supports, the agency, the tribe, and appropriate service providers (including behavioral health providers, educational partners and others), with the purpose of identifying and meeting the needs of the child/youth and family to ensure safety, permanency and well-being.

CFT meetings bring this team (also called a network, in SOP) together at regular intervals, and work of the team continues outside the formal facilitated meetings. Required CFT meetings easily function as SOP meetings when SOP language, structure and strategies are utilized. SOP meetings meet the CFT mandate if requirements are met in three areas:

1. Required Participants
   To meet CFT requirements, team members must include the child/youth, family, social worker, child’s current caregiver, tribe, Foster Family Agency social worker and/or Short-Term Residential Therapeutic Program representative, as well as behavioral health when the child is receiving or may need specialty mental health services (SMHS), including Intensive Care Coordination (ICC), Intensive Home Based Services (IHBS), or Therapeutic Foster Care (TFC).
2. **Meeting Timing/Frequency**

CFT meetings must occur:

- Within 60 days of the child’s placement in foster care
- Every 90 days for youth receiving ICC, IHBS or TFC
- Every six months with case plan creation for youth not receiving SMHS
- For possible placement changes
- As frequently as needed to address needs of the child/youth, including the need for new or increased SMHS

3. **Focus on the Child/Youth’s Needs**

CFT meetings must include specific discussion regarding the placement, behavioral health and other needs of the child/youth, and a plan to meet those needs. The Child and Adolescent Needs and Strengths (CANS) must be completed through the CFT process and used to guide and inform the case plan.

Although State mandates do not require a CFT meeting until 60 days after removal, best practice and SOP support use of front-end prevention CFT meetings that attempt to minimize unnecessary trauma to children by safely preventing removal if possible. If removal is necessary to ensure safety, best practice and Safety Organized Practice support immediately bringing together the child, family and their team to explore possible relative placements, engage natural supports, and plan for needed next steps as early as possible in the referral or case.

**SOP & CANS**

As part of CCR, the California Department of Social Services selected the CANS as the formal initial and continuous child welfare assessment tool used within the CFT process to inform the case plan goals and placement decisions for the child, youth, and family. The CANS aligns with the intent of SOP to create plans for children, youth and families that are individualized and behaviorally-based.

The SOP CFT meeting process provides an organic, family-friendly way to complete the CANS, because engagement of the child’s and family’s team or network through a facilitated meeting process ideally will occur at the very beginning of a referral or case. At the first CFT meeting, using the SOP facilitated meeting dialogue structure means that information gathered about the needs (worries) and strengths (what is working well) of the child, parent and caregiver will enable the social worker, or other designated individual, to complete a draft CANS tool following the meeting. This draft CANS would be brought to the subsequent CFT meeting at which the case plan will be developed, and the social worker and/or CFT meeting facilitator would then ensure that behaviorally-based case plan objectives are developed for each need of the child, parent or caregiver identified on the CANS, supported by the youth’s strengths and parent or caregiver resources.

**Summary**

SOP, ICPM, CFT and CANS all have shared values and can be seamlessly integrated into one comprehensive approach to child welfare practice. Supervisors play an important role in helping social workers understand how all of these pieces fit together.

*For detailed information about the ICPM, see All County Information Notice (ACIN) No. I-21-18, The California Children, Youth, and Families Integrated Core Practice Model and the California Integrated Training Guide.*
Logic Model for Safety Organized Practice

**Principles**
- Safety
- Critical thinking
- Collaborative practice
- Meaningful engagement
- Teaming
- Trauma-focused agencies
- Cultural humility
- Organizational support
- Lifelong, loving families & connections

**Elements/Strategies**
- Appreciative Inquiry
- Behaviorally-Based Case Plans
- Child & Family Team Meetings
- Coaching
- Consultation & Information-Sharing Framework ©
- Domestic Violence Timeline
- Facilitated Meeting Dialogue Structure
- Ecomaps & Genograms
- Family-Focused Court Reports
- Harm & Danger (Risk) Statements
- Review, Evaluate, Direct (RED) Teams
- Safety Mapping
- Safety Circles/Networks
- Safety Goals
- Safety House
- Scaling Questions
- Solution-Focused Interviewing
- Structured Decision-Making
- Three Houses
- The Three Questions

**Short-Term Outcomes**
- Increased children's and youth's voice
- Increased networks of support for families
- Increased behaviorally-focused interventions
- Increased family engagement in collaborative case planning
- Increased placements with relatives or NREFMs

**Long-Term Outcomes**
- Increased safety for children
- Increased support systems for families
- Decreased recurrence of maltreatment
- Decreased re-entry rate
- Decreased time to permanency
- Increased collaborative teaming processes
- Decreased contested hearings
- Increased social worker satisfaction/retention
The Role of Supervision

Research demonstrates the central role of supervisors in aligning social workers’ direct practice with an agency’s practice model, such as SOP. A practice model provides staff with explicit guidance on how they are expected to work to achieve improved outcomes for children, youth and families (National Child Welfare Resource Center for Organizational Improvement, 2009, 2011). A recent study about the roles of supervisors cited the importance of supervision in ensuring that staff with a range of educational backgrounds and prior experience master and apply child welfare knowledge and skills and the agency’s practice model in their day-to-day practice (Hess, Kanak, & Atkins, 2009). Other studies have found that educational supervision or “task assistance” is associated with practitioners’ ability to achieve positive outcomes with children, youth and families (Mor Barak, Travis, Pyun, & Xie, 2009; Westbrook et al., 2006). Specifically, this research highlights child welfare supervisors’ roles in modeling, coaching, and engaging social workers in discussions relating to ethics and ethical decision-making (Lightfoot, 2013).

Research also has found that supervisory social and emotional support and interpersonal interactions play a significant role in reducing levels of social anxiety, stress, depression, and somatic complaints for frontline social workers, lessening burnout and lowering turnover (Juby & Scannapieco, 2007; Mor Barak et al., 2009; Renner, Porter, & Preister, 2009; Westbrook et al., 2006). One study found that when supervisors promote constructive organizational cultures – which focus on achievement, client responsiveness, and competency (as opposed to passive/defensive cultures that focus on conformity, rule following and blaming) – the probability of clients receiving needed services is almost five times greater (Glisson & Green, 2006).

Roles of the Child Welfare Supervisor

The role of a child welfare supervisor, in implementing SOP and in general, involves a number of key functions. The best known framework for child welfare supervision, developed by Kadushin and Harkness (2002), identifies three key roles for the supervisor: education, support, and administration. A fourth important role is the supervisor’s clinical function.

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<tr>
<th>Role</th>
<th>Function</th>
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<tr>
<td>Educational</td>
<td>Addressing the knowledge, attitudes and skills required to do the job effectively</td>
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<tr>
<td>Supervision</td>
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<tr>
<td>Supportive</td>
<td>Improving worker morale and job satisfaction by helping with job-related discouragement and giving staff a sense of worth as professionals, a sense of belonging in the agency, and a sense of security in their performance</td>
</tr>
<tr>
<td>Supervision</td>
<td></td>
</tr>
<tr>
<td>Administrative</td>
<td>Ensuring adherence to agency policy and procedures and provision of oversight to ensure accountability and effectiveness</td>
</tr>
<tr>
<td>Supervision</td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td>Developing the skills, understanding, capacities of the supervisee through the reflection of their practice; encouraging critical thinking and analytical skills; focusing on social work engagement interactions/strategies</td>
</tr>
<tr>
<td>Supervision</td>
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Based on the work of the National Resource Center for Family-Centered Practice and Permanency Planning and the National Child Welfare Center for Organizational Improvement; Bogo & McKnight, 2005; Collins-Camarago, 2006: Deal, 203; Kadushin & Harkness, 2002; Shulman, 1993, modified by Sue Lorbach, 2015.
THE FOUR ROLES OF A SUPERVISOR

Administrative Supervision “focuses on the efficient and effective delivery of services to achieve agency goals.” It is “planning, executing, monitoring, and evaluating activities to accomplish the work of the agency through the staff” (excerpted from Ohio Child Welfare Training Program [OCWTP] Supervisor Core Module I: Casework Supervision). It provides quality control of supervisees’ work, ensuring their work is appropriate and ethical, and involves activities such as:

- Aligning the unit’s work with the agency and unit goals
- Assigning cases
- Implementation of quality assurance strategies related to case management
- Addressing organizational and systemic barriers to staff performance
- Monitoring completion and timeliness of case-related activities

Educational Supervision is teaching caseworkers what they need to know in order to do the job, developing their “capacity and competence to perform their work tasks in accordance with practice expectations and standards” (Kadushin & Harkness, 2002). Supervision is important in reducing knowledge and skill barriers to staff performance and outcome achievement (excerpted from OCWTP Supervisor Core Module I: Casework Supervision). It includes activities such as:

- Orienting workers to their jobs
- Identifying learning needs of casework staff
- Conducting the transfer of learning from “knowing” to “doing”
- Directly observing caseworkers perform assigned tasks
- Directing, consulting, and guiding caseworkers as they interact and intervene with families and children
- Developing and managing individual development plans with casework staff
- Coaching — modeling task behavior, giving feedback, individualizing, reinforcing, and demonstrating
- Helping caseworkers understand how their own values and experiences may impact perceptions about families and case decisions
- Providing skill-building opportunities for caseworkers

Supportive Supervision is encouraging, strengthening, and empowering caseworkers to be productive, committed, mission-focused, and motivated to perform high-quality work (excerpted from OCWTP Supervisor Core Module I: Casework Supervision). Supportive supervision also involves:

- Helping staff become aware of and deal with their reactions to the emotional intensity of their work with families, such as managing anxiety and other strong reactions to families that maltreat their children
- Creating a safe, comfortable, and empowering environment that promotes high levels of caseworker performance
- Reducing psychological or emotional barriers to caseworker performance and outcome achievement
- Helping caseworkers develop confidence and realistic perspectives about the work, and deal with job-related stress and personal reactions to the work
- Addressing cultural issues that impact casework practice and caseworkers’ perception of families
- Providing positive reinforcement for effective performance

Clinical Supervision is another aspect of supervision that has similarities with Educational Supervision and Supportive Supervision. However, there are some unique aspects to Clinical Supervision as applied to child welfare, including:

- Developing the skills, understanding, capacities of the supervisee through reflection of their practice
- Encouraging critical thinking and analytical skills
- Focusing on social work engagement interactions and strategies
- Exploring family systems and situations in a biopsychosocial context
- Attending to interpersonal dynamics among family members that may contribute to child maltreatment

(Based on the work of the National Resource Center for Family-Centered Practice and Permanency Planning and the National Child Welfare Center for Organizational Improvement; Bogo & McKnight, 2005; Collins-Camarago, 2006: Deal, 203; Kadushin & Harkness, 2002; Shulman, 1993, modified by Sue Lorbach, 2015.)
In a 2010 study asking about the education, support and administration roles of the supervisor, respondents most frequently identified as the “most important” supervisory responsibilities those related to practice model implementation, including:

1. Case staffing and reviews, and developing and monitoring social workers’ practice (the education function);
2. Anticipating and managing personal safety risks, and preventing and addressing secondary traumatic stress and burnout of social workers (the support function); and
3. Recruiting and selecting staff (the administrative function) (Collins-Camargo & Millar, 2010).

Finally, the quality of supervision matters. Supervisory practice must align within the agency’s implementation of SOP. The Children and Youth Services Review (Frey, et al., 2012) identified four foundational characteristics of quality child welfare supervision:

1. Supervision aligns fully with the agency’s implementation of a practice model (such as SOP). It brings about quality interventions to fully implement the practice model in the service of meeting child safety, permanency and well-being outcomes.
2. Supervision supports competent and responsive collaborative team planning and decision-making in achieving improved outcomes for children and youth in the agency’s care.
3. Supervision supports and develops social workers’ capacity for analytic and critical thinking. It recognizes the unique and complex challenges that each family and child face and the often profoundly difficult nature of child welfare decision-making. Quality child welfare supervision provides structured, planned opportunities for social workers to develop self-reflection, an important element of critical thinking, by encouraging them to reflect on a strategic use of themselves in their work and by helping them use multiple perspectives and explanations to explore and challenge their own thinking about the children, youth and families with whom they work (Dill & Bogo, 2007).

4. Supervision ensures accountability to families, the agency, the agency’s public agency partners, and the community. Quality child welfare supervision attends to the quality of services provided under the ethical imperative, “do no harm,” to ensure accountability to clients (Center for Advanced Studies in Child Welfare, 2009). It also focuses on improvement of organizational performance as a whole (McBeath, Briggs, & Aisenberg, 2009) and the building of the learning culture of the agency (Austin & Hopkins, 2004).

In sum, child welfare supervisors have been described as the “standard bearers for good practice” (Spigner, 2011) and the linchpin to improving child welfare practice (Collins-Camargo, 2006). Supervisor support and direction is critical to implementation of SOP.
Overview of Implementation Science

Agency implementation of Safety Organized Practice requires a strategic approach to achieve real-world success as “standard practice” with children, youth and families. Supervisors play a vital role in this process, although responsibility rests at every level from the front line up to the highest tier of agency leadership to ensure implementation is achieved. At its core, “implementation” means simply that the practice we intend to do is actually happening in a consistent, reliable way across the agency to achieve better results for kids and families. Often, agencies think that training staff will result in changes to practice; however, training is just the beginning and by itself does not lead to comprehensive practice change.

In child welfare, and many other human services fields, interest has emerged in implementation science – a focused, active and effective approach to the implementation of evidence-informed practice and programming. Put simply, agencies want to know how to implement new practices successfully to achieve intended outcomes. The literature makes clear that “thoughtful and effective implementation strategies at multiple levels are essential to any systematic attempt to use the products of science to improve the lives of children, families and adults. That is, implementation is synonymous with coordinated change at system, organization, program and practice levels” (Barwick et al, 2005, p. 6).

Implementation Outcomes & Implementation Drivers

When implementing a new practice across an agency, there are three essential implementation outcomes, which supervisors play a critical role in supporting:

1. Changes in adult professional behavior (knowledge and skills of practitioners and other key staff members within an organization or system).
2. Changes in organizational structure and culture (values, philosophies, ethics, policies, procedures, decision-making) to bring about and support the changes in adult professional behavior.

As these outcomes remind us, asking staff to make changes in their professional behavior also requires a shift in organizational culture. Supervisors are uniquely responsible for climate and culture at the unit level, setting the tone for values, ethics and expectations about day-to-day implementation of practices, policies and procedures. Again, it is important to keep in mind that training alone does not translate into changes in behavior or organizational culture. To fully support a practice becoming standard practice, supervisors must keep in mind the bigger picture of implementation, which involves consideration of what is known as implementation drivers.

Successful implementation of any system change requires certain functions, structures and supports that act as “drivers” in the change process – meaning their presence is required to drive
or move the process forward. Implementation Drivers have been categorized as Competency, Organization and Leadership supports (National Implementation Research Network, n.d., retrieved from http://nirn.fpg.unc.edu/learn-implementation/implementation-drivers). One can also think of these drivers as mapping to the Education, Administrative and Support functions of supervision.

**PERFORMANCE ASSESSMENT (FIDELITY)**

<table>
<thead>
<tr>
<th>SUPPORT</th>
<th>DRIVER</th>
<th>EXAMPLES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competency</td>
<td>Selection</td>
<td>• Selecting staff who will implement first, based on attitude, receptivity to training, understanding of role</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Selecting implementation teams, trainers, coaches, evaluators</td>
</tr>
<tr>
<td></td>
<td>Training</td>
<td>• Imparting knowledge/skills related to the intervention or practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Teaching new ways of work</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lecture, demonstration, behavioral rehearsal</td>
</tr>
<tr>
<td></td>
<td>Coaching</td>
<td>• Supporting after training to translate to practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Building comfort with new practices</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Expanding on knowledge and skills from training</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Imparting “craft” knowledge (i.e., engagement, ethics, managing work flow, clinical judgment)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Providing emotional and personal support</td>
</tr>
<tr>
<td>Organization</td>
<td>Systems Intervention</td>
<td>• Support from management and leadership</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Creation of organizational culture and policies that support new practice</td>
</tr>
<tr>
<td></td>
<td>Facilitative Administration</td>
<td>• Support for eliminating system barriers, i.e., caseload sizes, worker safety, communication, process barriers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Creating a hospitable environment for practitioners to engage in new practice</td>
</tr>
<tr>
<td></td>
<td>Decision Support Data System</td>
<td>• Guiding practice based on data and continuous quality improvement</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Evaluating fidelity of practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Providing feedback loops so adjustments can be made as needed</td>
</tr>
<tr>
<td>SUPPORT</td>
<td>DRIVER</td>
<td>EXAMPLES</td>
</tr>
<tr>
<td>---------</td>
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</tr>
</tbody>
</table>
| LEADERSHIP | Technical | • Addressing issues of time, funding, equipment, etc.  
| | | • Timely responses to issues where the problem is clear and there is substantial agreement about how to solve it |
| | Adaptive | • Leadership for complex issues that lack clear or easy solutions  
| | | • Convening groups to identify problems, arriving at consensus regarding how to approach a solution, addressing systems issues or issues that lack a technical solution, such as secondary trauma |

Supervisors play a key role in supporting many of these drivers. Clearly, supervisors typically have a direct role in training, coaching and selection of staff; however, as the first-line level of leadership, they also play a part in Systems Intervention by providing a supportive environment at the unit level for staff to adopt new changes. For broader Facilitative Administration issues, supervisors may not have authority to address issues such as funding or hiring additional staff to reduce caseload size, but they can support workers to manage priorities, strategize about how to adopt new practices in the face of high workload, and advocate with managers and directors about the need for additional resources or positions.

### Stages of Implementation

In addition to Implementation Drivers, there are four specific functional stages of implementation:

<table>
<thead>
<tr>
<th>Stage</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Exploration</td>
<td>Creating an Implementation Team; assessing readiness for implementation; building readiness as needed.</td>
</tr>
<tr>
<td>2. Installation</td>
<td>Providing initial training for staff; establishing tools to assess fidelity; ensuring access to materials and equipment; updating tools and templates to guide consistent practice; revising policies and procedures; etc.</td>
</tr>
<tr>
<td>3. Initial Implementation</td>
<td>Practitioners are attempting to use newly learned skills in the context of an organization that is just learning how to change to support the new ways of work. This is the most fragile stage, where the awkwardness of trying new things and the difficulties with changing old ways of work are strong motivations for giving up and going back to comfortable routines (business as usual).</td>
</tr>
<tr>
<td>4. Full Implementation</td>
<td>50% or more of the intended staff are using the practice with fidelity and good outcomes. New ways of providing services are now the standard ways of work, and the implementation supports are the way the organization carries out its work. Leaders can come and go, but the practice will remain in place.</td>
</tr>
</tbody>
</table>

Many organizations remain stuck in the Initial Implementation stage of any practice change, including Safety Organized Practice. Sustaining changes to the point of full integration into daily work is not likely unless there is external support for change at the practice level (support from supervisors/coaches) and at the organization and system levels (support from Implementation Teams).
In other words, training staff is only one component of ensuring actual changes in practice take root. Supporting implementation of new practices, including SOP, means that all of these “drivers” must be addressed, and supervisors are a critical part of this.

**Early & Late Adopters**

A theory that can be helpful in working with your staff to implement SOP is called *diffusion of innovations*. This concept, developed by professor of communication studies Everett Rogers in 1962, seeks to explain how and at what rate new ideas, innovations or technologies spread. “Diffusion” is the process by which an innovation is communicated or dispersed over time among participants in a social system (Wikipedia, 2018). Some individuals tend to embrace new ideas, while others are entrenched in historic ways of doing things, with a range of responses between these two extremes. You and each of your staff will fall into one of these categories based on your typical level of openness to innovations:

<table>
<thead>
<tr>
<th>Adopter Category</th>
<th>% of Population</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovators</td>
<td>2.5%</td>
<td>Willing to take risks, have high social status, are social and have interaction with other innovators</td>
</tr>
<tr>
<td>Early adopters</td>
<td>13.5%</td>
<td>Have the highest degree of opinion leadership, high social status, more selective in adoption choice than innovators, more socially forward than late adopters</td>
</tr>
<tr>
<td>Early majority</td>
<td>34%</td>
<td>Adopt an innovation after a varying degree of time that is significantly longer than innovators and early adopters; seldom hold positions of opinion leadership in a system</td>
</tr>
<tr>
<td>Late majority</td>
<td>34%</td>
<td>Adopt an innovation after the average participant, with a high degree of skepticism and after the majority has adopted the innovation</td>
</tr>
<tr>
<td>Laggards/ traditionalists</td>
<td>16%</td>
<td>Last to adopt the innovation; show little opinion leadership, have an aversion to change agents, focus on “traditions”</td>
</tr>
</tbody>
</table>

The important takeaway of this model as it relates to SOP implementation is that you and each of your workers will have a natural tendency to fall into one of these categories. Based on your own experience with your staff, you can probably mentally sort each person into their category. Staff who demonstrate excitement and self-motivation in trying new approaches to their work are likely early adopters. Staff who profess that the old way is the right way and resist changes in practice tend to be the late majority or traditionalists.

When first implementing SOP, it is simply wasted time to focus on staff who you know tend to resist innovations. Instead, focus your energies on your team’s innovators and early adopters, modeling new tools and approaches for them and coaching them to try these themselves. Once the early adopters start trying the practice, it is essential to have them share stories and successes with their peers. The early majority will be willing to try a practice once they have heard from others that it is a positive change that can benefit them and the children and families they work with. The late majority will only jump on board once SOP has become standard practice for about
half of the team. The traditionalists will resist any change, possibly until they retire, but may eventually change once everyone else in the agency is using the practice.

The Value of Staff Voice

Perhaps the most important strategy that supports staff embracing SOP is hearing from their peers how they have benefited from the practice. Whenever you have a worker who is excited about a success or accomplishment they had with SOP, harness that energy by having them speak about their experience at unit meetings or group supervision. Excited social workers are the best vehicle for encouraging other staff to start “trying on” SOP.

Supervisor Action Plan for SOP Implementation

As you think about supporting Safety Organized Practice in your unit, we recommend that you consider your role in each of the implementation drivers and how you can strategically move your team forward in the practice. Important elements of SOP that require supervisory support and coaching include:

- Use of the Consultation and Information-Sharing Framework, Safety Mapping or SOP Child and Family Team (CFT) Meeting Frameworks to support information gathering, teaming and increased critical thinking.
- Use of Solution-Focused Questions and the Three Questions to increase engagement of families and bring information forward that will support decision-making in partnership with the family and their network of support.
- Building networks of support with families; supporting social workers in identifying and engaging a family’s network to build capacity for child safety, reduce time to reunification, and reduce reentry into care.
- Development of Harm and Danger Statements and Safety Goals to clarify the impact of actions on the child’s safety and well-being.
- Incorporating the voice of children and youth at the center of the intervention with families through the use of the Three Houses, Safety House and other strategies.
- Consistent and appropriate use of SDM tools and CANS to support decision-making and case planning with families and their networks.
- Aligning and integrating SOP into all practices in child welfare, including Child and Family Teams, adoption cases, youth transitioning to adulthood programs, the Child and Adolescent Needs and Strengths (CANS), implementation of the Integrated Core Practice Model (ICPM), and other initiatives, mandates and programs.

Following are some suggested steps supervisors can take to support SOP at each stage of implementation. These are by no means exhaustive lists; use your creativity and knowledge of your staff to identify the best steps to move the practice forward in your unit.
### 1. EXPLORATION STAGE

<table>
<thead>
<tr>
<th>Driver</th>
<th>Supervisor Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection</td>
<td>• Select staff in your unit who are “early adopters” and would be excited to learn SOP</td>
</tr>
</tbody>
</table>
| Coaching                        | • Participate in opportunities to begin learning about SOP  
• Begin discussing concepts of SOP with staff                                |
| Training                        | • Explore with staff what’s currently working well and what worries are about current practice  
• Have supportive conversations with staff to build their readiness to take on a change in practice |
| Systems Intervention            | • Participate on the SOP Implementation Team or Workgroup                                                                                      |
| Facilitative Administration     | • Identify barriers to readiness for staff and possible solutions, and communicate these to leadership                                        |
| Decision Support Data System    | • Have an understanding of your current outcome data that has resulted from practice as usual, especially data related to the federal outcome measures and your System Improvement Plan (SIP)  
• Understand your staff’s current frequency and fidelity of completion of SDM tools |
| Technical                       | • Identify clear technical problems that need resolution to support implementation                                                            |
| Adaptive                        | • Engage your unit in discussions about barriers to SOP implementation and developing solutions they can be part of                            |

### 2. INSTALLATION STAGE

<table>
<thead>
<tr>
<th>Driver</th>
<th>Supervisor Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection</td>
<td>• Select staff in your unit to implement various SOP tools or strategies first and provide opportunities for them to share their experience with peers</td>
</tr>
</tbody>
</table>
| Coaching                        | • Attend all SOP training modules to build a solid knowledge base for the practice and ensure you can reinforce training based on your own learning  
• Attend training on Group Supervision and Coaching  
• Ensure staff attend training and strategize with them about how to balance other responsibilities with time spent at training  
• Have staff do role-plays in unit meetings or in individual or group supervision |
| Training                        | • Know your staff’s strengths and areas for growth, and strategically work with those to help them “try on” a new practice that will be the best fit  
• Strategize with staff about where they will start in implementation (i.e., they will try the Three Houses with one child, they will do the Circles of Support with a parent)  
• Have supportive conversations with staff about feelings of anxiety or overwhelm at trying new practices  
• Celebrate early successes; have staff share with peers their excitement about the SOP work they have tried on |
| Systems Intervention            | • Participate in SOP implementation workgroup  
• Evaluate policies and tools that need revision to support SOP implementation, and begin work on these, i.e. templates for screener narratives, investigative narratives, case contact notes and court reports that mirror SOP language and practice  
• Review current case planning processes and identify needed changes |
### Facilitative Administration
- Begin using the same language and processes with staff that they use with families, i.e., using the Three Questions to guide unit meetings, using Solution-Focused Questions with staff to guide conversations about their implementation of SOP
- Identify system barriers as implementation begins, and communicate them up the chain of command
- Use creative strategies to build excitement around SOP, such as visual tools (posters, etc.), fun activities at staff meetings, sharing stories of early successes

### Decision Support Data System
- Track what steps your workers begin taking to implement new SOP practices, and on what cases, to start gathering qualitative data
- Work with the Implementation Team to develop fidelity measures and processes

### Technical
- Advocate for staff to have any needed equipment (i.e., iPhones so they can dictate contact notes to free up time for best practice)
- Ensure staff have ready access to SOP tools such as CFT meeting framework forms, Three Houses kits to take in the field, etc.

### Adaptive
- Continue to engage your unit in identifying system barriers to SOP implementation and developing solutions they can be part of
- Participate in problem-solving around complex challenges

### 3. EARLY IMPLEMENTATION STAGE

<table>
<thead>
<tr>
<th>Driver</th>
<th>Supervisor Tasks</th>
</tr>
</thead>
</table>
| Selection       | - As you hire new staff, assess their goodness of fit for the values and skills of SOP  
- Continue to monitor staff’s stage of readiness for implementation and move them toward ever greater implementation of SOP tools and strategies |
| Coaching        | - Model practices such as the Three Houses or facilitation of a Child and Family Team meeting (CFTM) in the field for staff and debrief with them afterward  
- Observe staff demonstrating practices (Three Houses, Safety House, Safety Mapping, Circles of Support, CFTMs, etc.) and engage them in a reflective feedback process  
- Continue to strategize with staff about how they will approach trying new SOP tools and expanding current use of tools and strategies  
- Continue supportive and reflective conversations with staff about the practice and their feelings about it  
- Begin Group Supervision and ensure that staff rotate presenting cases |
| Training        | - Repeat training yourself as needed to bolster your own understanding  
- Continue to prioritize training for staff  
- Provide refresher trainings on specific SOP skills or practices in unit meetings or group supervision  
- Have staff do role-plays or demonstrations in unit meetings or in individual or group supervision  
- Send out emails to staff with SOP quick tips or techniques to try  
- Review SOP Quick Guides in supervision |
| Systems Intervention | - Continue finalizing policies, tools and processes that support SOP implementation, i.e. templates, implementation of RED Teams, etc.  
- Ensure SOP language and framework is infused through all written documentation, including contact notes, court reports, case plans, etc.  
- Continue participating on SOP implementation team or workgroup |
### Facilitative Administration
- Ensure language and culture in your unit align with SOP, and advocate for this throughout the agency
- Put up posters or other visual reminders of SOP
- Identify new system barriers as they arise and communicate them up the chain of command
- Create regular ways to celebrate SOP successes that become part of agency culture, i.e., standing agenda items for peer sharing at meetings

### Decision Support Data System
- Continue tracking what steps your workers have taken to implement new practices, and on what cases, to gather qualitative data (a.k.a., “practice-based evidence”)
- Support development of tools to gather quantitative data on outcomes, as needed
- Observe staff in the field to assess fidelity to practice
- Use the SOP Supervisor Checklist and Practice Profiles to assess staff’s current skill level and move them toward higher levels of emerging and accomplished practice

### Technical
- Continue advocating for rapid solutions to technical problems as they arise

### Adaptive
- Continue unit discussions about barriers to SOP implementation develop solutions they can be part of
- Participate in problem-solving around complex challenges

### 4. FULL IMPLEMENTATION STAGE

<table>
<thead>
<tr>
<th>Driver</th>
<th>Supervisor Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coaching</td>
<td>Embed into the hiring process evaluation of applicants’ prior knowledge and skill of SOP, value alignment with SOP and willingness to learn new ways of working with families</td>
</tr>
<tr>
<td>Training</td>
<td>Continue to provide modeling, observation, reflective feedback and coaching for new and experienced staff</td>
</tr>
<tr>
<td></td>
<td>Continue to provide supportive supervision and address secondary trauma</td>
</tr>
<tr>
<td>Selection</td>
<td>Ensure new staff attend SOP training immediately</td>
</tr>
<tr>
<td></td>
<td>Ensure all other new staff training incorporates SOP language, tools and practices</td>
</tr>
<tr>
<td></td>
<td>Provide refresher trainings and reminders as needed</td>
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<tr>
<td></td>
<td>Have a consistent communication plan for SOP that includes quick tips, techniques to try, new ideas and creative developments from staff</td>
</tr>
<tr>
<td>Systems Intervention</td>
<td>Continue to evaluate improvements to tools and policies that support SOP practice</td>
</tr>
<tr>
<td></td>
<td>Continue SOP implementation workgroup as needed or delegate tasks to other agency workgroups once they are standard practice</td>
</tr>
<tr>
<td>Facilitative Administration</td>
<td>Engage in continued self-assessment of how you can best support SOP implementation</td>
</tr>
<tr>
<td></td>
<td>Identify any new system barriers and communicate them up the chain of command</td>
</tr>
<tr>
<td>Decision Support Data System</td>
<td>Do your part in the agency process to gather, track and evaluate outcome data</td>
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<td></td>
<td>Participate in Continuous Quality Improvement processes at the agency and unit level</td>
</tr>
<tr>
<td></td>
<td>Use the SOP Supervisor Checklist and Practice Profiles to assess staff’s current skill level and move them toward higher levels of emerging and accomplished practice</td>
</tr>
<tr>
<td></td>
<td>Complete SOP Case Reviews</td>
</tr>
<tr>
<td>Technical</td>
<td>Continue advocating for rapid solutions to technical problems as they arise</td>
</tr>
<tr>
<td>Adaptive</td>
<td>Continue to engage your unit in discussions about barriers to SOP implementation and develop solutions they can be part of</td>
</tr>
<tr>
<td></td>
<td>Continue to participate in problem-solving around complex challenges</td>
</tr>
</tbody>
</table>
The Full Implementation stage can also be thought of as sustainability. Supervisors must give continued attention over time to ensure that the practice continues after the focus on initial implementation. Workers will come and go, new mandates will be added, leaders will change, and practice will always evolve. One of the wonderful aspects of Safety Organized Practice is that it is continually evolving and expanding to incorporate new requirements, breakthroughs and best practices in the field. Thus, it is important to think of SOP implementation not as a one-time event but rather a continual process of training and coaching new workers, building depth and rigor of practice of existing staff, monitoring fidelity, enhancing agency supports for best practice, and creatively adapting to integrate new mandates and practices into the umbrella of SOP.

**Overview of Coaching**

Although all supervisor Implementation Drivers are important, coaching has a special role in ensuring SOP takes root as standard social work practice with children, youth and families. Coaching is a process by which the coach (supervisor) creates structured, focused interaction with learners (staff) and uses appropriate strategies, tools and techniques to promote desirable and sustainable change for the benefit of the learner, making a positive impact on the organization (Mink, Owen, & Mink, 1993; Cox, Bachkirova, & Clutterbuck, 2010).

The process of coaching is how supervisors drive and ensure transfer of learning from training to practice. For example, a University of Kansas study indicated that 85% of teachers who received ongoing support from instructional coaches implemented newly learned instructional methods, while in another study conducted by the same group, teachers who did not receive such support implemented newly learned strategies at a rate of only 10% (Joyce & Showers, 2002). In other words, training alone does not ensure implementation of new learning.

Coaching requires an atmosphere of trust and experimentation and a strengths-based learning environment that encourages growth. Coaching an individual social worker improves job performance and development while profoundly impacting the success of the child welfare
organization. Gallacher (1997) describes aspects that lead to authentic learning in the coaching process:

- Support and encouragement through the opportunity to review experiences, discuss feelings, describe frustrations, and check perceptions with a partner.
- Opportunity to fine-tune skills or strategies through technical feedback and technical assistance from a coaching partner.
- Time and encouragement to analyze practices and decision-making at a conscious level.
- Ability to adapt or generalize skills or strategies by considering what is needed to facilitate particular outcomes, how to modify the skill or practice to better fit interactions with specific families or practitioners, or what results may occur from using the skill or practice in different ways.
- Opportunities to reflect on what learners perceive or how they make decisions, which help improve their knowledge and understanding of professional practices and activities.

**Overview of Coaching Approaches**

Solution-focused practice and reflective practice are two approaches to coaching in child welfare. Both approaches provide a comprehensive framework to implement a coaching process, and each has tremendous potential to positively impact the adult learner. Note that approaches differ from models; approaches provide a holistic or overall philosophy for coaching, while models provide structure for coaching sessions.

**Solution-Focused Approach**

The solution-focused approach to coaching intends to facilitate purposeful, positive change by emphasizing resources and personal resilience (Grant, 2011). This approach is:

- based on solution building vs. problem solving;
- non-confrontational and non-judgmental;
- focused on the learner’s desired future rather than on past problems or current conflicts;
- led by the learner, who identifies and increases the frequency of current useful behaviors;
- focused on looking for exceptions to the problems identified (when the problem could have happened but did not); and
- built on the belief that small increments of change lead to large increments of change.

An important benefit of using a solution-focused approach to coaching is that it mirrors the solution-focused approach of SOP work with families. Use of solution-focused questions in
supervision helps workers build comfort with this approach, models the questioning structure used, and provides the benefit of a positive parallel process for staff.

**Reflective Practice**

Reflection is a strategy that should be used by every coach. However, it should also be considered as an overall approach—something that drives coaching. Reflective practice is based on the belief that learners can improve by consciously and systematically reflecting on their work performance (Farrell, 2008). Richards (1990) suggests self-inquiry and critical thinking can “help learners move from a level where they may be guided largely by impulse, intuition, or routine, to a level where their actions are guided by reflection and crucial thinking” (p. 5). As an overall approach to coaching, reflective practice enables the learner to drive their own learning process. Coaching child welfare learners focuses on improving advanced critical decision-making skills, which requires introspection, reflection, and personal meaning applied to distinct settings.

In a child welfare context, the purpose of coaching is acquisition and application of new skills to work with children and families. Building your own coaching skills as a supervisor is key to supporting social workers to develop the skills of Safety Organized Practice.

<table>
<thead>
<tr>
<th><strong>SKILLS OF MASTER COACHES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strategy</strong></td>
</tr>
</tbody>
</table>
| Ability to Set Goals | • Develop realistic and challenging coaching goals  
   • Evaluate readiness of the learner for coaching  
   • Identify an appropriate ending point in the formal coaching process  
   • Understand organizational system dynamics to identify appropriate goals |
| Observe and Assess Skill Level | • Design assignments that encourage experimentation, reflection, and learning  
   • Identify strategies for engaging the learner  
   • Observe and understand the learner’s strengths, progress and areas needing improvement |
| Provide Feedback and Facilitate Reflection and Transformation | • Help the learner appreciate his or her strengths and ability to overcome barriers  
   • Work with the learner to identify ongoing developmental supports and resources in his or her environment and to establish a transition or ending plan  
   • Practice active listening: attentiveness, clarifying, reflecting, synthesizing, giving feedback, and summarizing  
   • Maintain an objective, nonjudgmental stance  
   • Offer support and encouragement  
   • Help learner imagine new possibilities  
   • Adeptly challenge values, assumptions, and business practices  
   • Identify and manage resistance |
| Embed Principles of Adult Learning Into all Work With Learners | • Use specialized techniques to encourage learner independence and self-direction  
   • Build trust  
   • Complement learner’s learning style  
   • Maintain well-honed communication |

Coaching Brings Balance to Child Welfare Supervision
(from article in Spring 2017 Reaching Out newsletter on Coaching in Child Welfare)

In a typical day in the field of child welfare, a supervisor is asked to take on a number of distinct roles, often simultaneously. These roles can include administrative supervision, educational supervision, supportive supervision and clinical supervision.

While all four types of supervision are of equal importance, it’s not uncommon to hear child welfare supervisors say that administrative supervision can take up most of or even all of their time. Such a statement might initially set off a few alarm bells, but when taking into consideration the high turnover rate child welfare agencies face, this begins to make a little more sense; the administrative duties associated with hiring and training new staff are substantial, and new staff are bound to have a lot of basic but necessary questions as they get accustomed to their new and complicated work.

Unfortunately, when supervisory resources are mostly exhausted on only one of the four key areas of supervisory focus, social workers are only receiving basic support, with little attention paid to their development professionally or their exercise of critical thinking skills that would enable them to perform their duties without as much need for administrative support. Over time, this lack of support can result in a social worker feeling isolated in their work, which can ultimately result in the very turnover that has perpetuated the lack of support in the first place.

Coaching in child welfare is an intentional strategy to curb this self-perpetuating cycle and call out the importance of dedicating time to supportive and educational supervision. Coaching may also involve some clinical supervision by proxy, but the key strength of coaching is that it provides the social worker with time to sit down with their supervisor and communicate their challenges, recognize their strengths, and set goals for continuing to improve their skills. It also provides social workers with the comfort of knowing that they are not alone in their work and that there will be a set time for them to share their context with their supervisor in a safe, neutral environment.

Coaching in child welfare does not negate the need for administrative and clinical supervision, but rather works to develop a social worker’s critical decision making skills so that they do not feel the need to “play it safe” by asking a supervisor what to do every time a complicating factor arises. This further ensures that when a consultation is in fact necessary, the supervisor will be available to work through the issue with the social worker rather than simply telling them what to do.

Through the use of coaching, child welfare supervisors are provided with the appropriate time and space to focus on administrative, educational, supportive and clinical supervision equally, which stands to benefit not only the child welfare workers interested in growing professionally, but also the agency in terms of retention, hiring and training costs, and, most importantly, the children and families who are served by an increasingly stable and capable workforce.
Sustainability, Fidelity & Depth of Practice

Implementation of Safety Organized Practice is not a “one and done” event, but rather an ongoing process of developing agency culture and climate that supports the practice, training new and existing staff, coaching for continued skill development, and supporting increased depth of practice over time.

New hires arrive frequently in most child welfare agencies, and the process of selecting, training and on-boarding staff should pay careful attention to integration of SOP so that it provides the foundation for expectations of their work. Additionally, new state and federal mandates occur regularly, and thoughtful attention must be given to how these integrate with Safety Organized Practice so that they become complementary to rather than replacing or supplanting best practices. For example, California requirements around Child and Family Teaming (CFT) align well with Safety Organized Practice; however, if counties choose to outsource the CFT facilitation role to a contracted agency that uses a Wraparound model, the components of SOP that guide and inform facilitated family meeting structures may be lost. Care is needed to ensure fidelity to SOP is maintained even in the face of new practice requirements.

Supervisor Checklist

Supervisors have a critical function in supporting social workers to achieve fidelity and depth of practice in the tools and strategies of SOP. To that end, the Northern California Training Academy developed the Principles of Safety Organized Practice Supervisor Checklist. This fidelity assessment tool asks supervisors to rate staff in 12 different practice indicators for SOP:

1. Practitioner identifies, with the family, what is currently working well and/or has worked in the past, to provide safety for the child/youth.
2. Practitioner considers his/her own assumptions and beliefs and how they influence interactions with children and families.
3. Practitioner inquires about families’ cultural resources and supports.
5. Practitioner elicits the child/youth’s views to inform a balanced assessment (e.g., both positive and negative impacts of caregiver actions, worries and hopes for the future).
6. Practitioner makes decisions in collaboration with the parents, extended family and support network.
7. Practitioner works with parents to identify support network, extended family and community members who can help provide safety for the child or youth over time.
8. Practitioner uses tools that support identification of family resources (e.g., genograms, safety circles and ecomaps).
9. Practitioner utilizes micro-skills in conversation with family members to elicit information (e.g., Solution-Focused Questions, Appreciative Inquiry, Motivational Interviewing).
10. Practitioner creates detailed, short, behaviorally specific statements in clear, nonjudgmental language, using family’s language whenever possible, to communicate concerns, goals, and agreements. (e.g., utilizes harm & danger statement and safety goals).
11. Practitioner communicates past harm and future risk to family members in clear, simple, and behaviorally specific language.

12. Practitioner works with the family and their support network to create behaviorally specific plans, detailing the actions that all involved will take to keep the child or youth safe.

It is recommended that supervisors complete this tool for each of your staff at regular intervals, with enough time, practice and coaching in between ratings to allow for growth and development. For example, you could set Outlook reminders for yourself to complete the tool for each of your staff every six months, or each worker’s performance evaluation due date could trigger you to complete the tool for them annually.

To accurately complete the fidelity checklist, having conversations with staff about their work is useful; however, creating opportunities to observe their work firsthand is also vital. Although child welfare supervisors are extremely busy, taking the time to accompany your staff in the field is an important function of good supervision in general as well as critical for SOP coaching purposes. Suggestions for ways to gather the information needed to complete the fidelity checklist include:

- Participate in CFT meetings with your workers and observe their strategies for engagement, transparent sharing of worries, use of Solution-Focused Questions and Motivational Interviewing, and collaborative decision-making.
- Ask workers to show you their documentation of Safety Circles/Circles of Support, genograms and/or ecomaps.
- Ask workers to show you the Three Houses and Safety House tools they have completed with children/youth, and/or accompany them on a home visit when they are completing these tools.
- Ask workers to reflect on their own assumptions, beliefs and biases when staffing cases. If you have attended a meeting with the worker and family, engage in a reflective coaching conversation afterward about these issues.
- Ask workers how they work with families to identify culturally relevant resources and supports.
- Review CFT meeting documents, case plans and court reports for use of nonjudgmental language and the family’s own language.
- Conduct spot-checks of contacts in CWS/CMS to look for use of solution-focused questions and other SOP language, tools and strategies.
- Review safety plans and/or case plans to ensure they are behaviorally specific, with detailed actions to meet safety goals (or permanency goals, for Permanency Planning and Non-Minor Dependent cases).

For more information, see the attachment, Principles of Safety Organized Practice Supervisor Checklist.
Practice Profiles

The SOP practice profiles provide a more in-depth opportunity to evaluate worker fidelity to Safety Organized Practice. Generally speaking, practice profiles attempt to define the gradual progression of skill acquisition as a practitioner integrates a particular practice into their work. The intent of the SOP practice profiles is to assist with assessment of social workers’ current skill level and guide appropriate goal-setting as they work to deepen their skills in the practice.

Practice profiles exist for six key tools/areas of SOP: Safety Mapping, Integrating the Child’s Voice/Perspective, Harm and Danger Statements, Safety Planning, Safety Networks, and Safety Goals. These can be completed as part of your coaching process with staff by having them rate their own level of practice in these areas and then engaging in a reflective conversation about why they chose their rating, whether it is consistent with your own rating, and how to help them move up one level. The practice profiles can also be used in group supervision with staff.

For detailed information about the practice profiles, see the attachment, Practice Profiles for Safety Organized Practice: Handbook.

Group Supervision

Group supervision is a highly recommended skill and strategy for supervisors to implement in their units to support shared learning, collective problem-solving and a team-based critical thinking process regarding child welfare referrals or cases. Group supervision differs from a unit meeting, in that its focus is on case consultation or staffing. A worker (or workers) present to their unit a case they are struggling with, using a guided framework. The Child and Family Team (CFT) Meeting Frameworks for Emergency Response, Family Maintenance and Family Reunification, and Permanency Planning/Non-Minor Youth (see attachments) can be used for this purpose. These guides expand on the Consultation and Information Sharing Framework®, created by Sue Lorhbach in 1999, by incorporating current California mandates and best practices. Use of these guides in group supervision provides a helpful parallel process that mirrors CFT meetings with families.

In group supervision, the worker presents the family situation using the meeting framework to discuss current worries and what is working well, then the group discusses the referral or case as a team to ask good questions, share similar challenges or their experience of what has worked well in similar case situations, and develop needed next steps to address the case-carrying worker’s concerns or questions. Group supervision provides a structure for applied learning of SOP, in which all social workers benefit from shared problem-solving about the specific case or referral situation, which then can be extrapolated to similar case situations each worker may encounter themselves. The ultimate goal of group supervision is to enhance staff’s critical thinking skills and capacity to make appropriate case decisions as well as their ability to utilize suitable interventions and strategies with children, youth and families.
Over time, as social workers’ critical thinking skills improve, use of group supervision may even supplant some sessions of individual supervision, although it is highly recommended that supervisors use both supervision approaches.

Other Tips for Sustainability

Only when a practice model has become the day-to-day practice of social work with families does it become truly sustainable. Therefore, supervisors are strongly encouraged to consider how to bring SOP into the daily fabric of child welfare work. This can be set up for success through the initial implementation process by ensuring all documents, written tools, job aids, and processes reflect the language, tools and strategies of SOP. However, supervisors must also continue to keep SOP at the forefront of daily interactions with your staff.

When new mandates come up, do your part as a supervisor to ensure the conversation involves how to integrate them into SOP. Rather than viewing new mandates as an added duty or a replacement of an existing process, give careful consideration to how any new mandate integrates into SOP and how to message this to staff. SOP is a living, evolving practice, and its framework is broad enough to encompass new and complementary initiatives and mandates.

Conclusion

We hope this guide helps you as a supervisor in implementing and supporting Safety Organized Practice in your unit and your agency. Always remember that you hold tremendous responsibility and authority for whether and how your staff use SOP with kids and families. Modeling the language and strategies of SOP, having a thoughtful plan for how to infuse SOP into your supervision processes, using coaching as the key to transfer of learning, and addressing systemic needs and barriers around SOP implementation are critical tasks that you can complete to best support SOP in your agency. A host of additional resources about SOP is available to you in the attachments to this guide as well as online (see Online Resources on the following page).

We are excited to see what you will do to implement, support and sustain this best practice approach to child welfare work with your staff and in your agency.
Online Resources

Coaching in the Field of Child Welfare


Safety Organized Practice
https://www.oercommons.org/authoring/12342-safety-organized-practice-sop-resources/view

Reaching Out Child Welfare Practice Journal – Safety Organized Practice
References


Attachments: Safety Organized Practice Resources

SOP Glossary

Key Elements of SOP

Practice Briefs

- Appreciative Inquiry
- Cultural Humility
- Family Safety Networks
- Safety Mapping and the Consultation and Information Sharing Framework
- Solution-Focused Scaling Questions
- Tools for Integrating the Child’s Perspective

Quick Guides and Supervisor Guides

- Behaviorally-Based Case Plans – Quick Guide
- Behaviorally-Based Case Plans – Supervisor Guide
- Child and Family Team Meetings – Quick Guide
- Child and Family Team Meetings – Supervisor Guide
- Circles of Support – Quick Guide
- Circles of Support – Supervisor Guide
- Consultation and Information Sharing Framework – Quick Guide
- Harm & Danger Statements – Quick Guide
- Review, Evaluate, Direct (RED) Teams – Quick Guide
- Safety House – Quick Guide
- Safety House – Supervisor Guide
- Safety Mapping – Quick Guide
- Safety Planning – Quick Guide
- Safety Planning – Supervisor Guide
- Solution-Focused Questions – Quick Guide
- Solution-Focused Questions – Supervisor Guide
- Three Houses – Quick Guide
- Three Houses – Supervisor Guide

Child & Family Team (CFT) Meeting Frameworks

- Emergency Response
- Family Maintenance and Family Reunification
- Permanency Planning/Non-Minor Youth

Planning & Evaluation

- SOP Implementation Readiness Assessment
- Implementation Status Checklist: Safety Organized Practice
- Supervisor Fidelity Checklist
- Practice Profiles for Safety Organized Practice
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<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Acts of Protection</td>
<td>Behaviors demonstrated by the parent that result in safety for the child.</td>
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<tr>
<td>Appreciative Inquiry</td>
<td>Use of skilled questioning strategies to focus on what in a family system is already working, based on the idea that it is what we pay attention to that grows.</td>
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<tr>
<td>Behaviorally-Based Case Plans</td>
<td>Case plans that focus on specific, concrete strategies and actions to effectively and permanently change the parent’s behavior with regard to its impact on the child, rather than focusing on mere completion of or compliance with services.</td>
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<tr>
<td>Child &amp; Family Team (CFT) Meetings</td>
<td>Facilitated team meetings that bring together the child/youth, family, agency, providers and the family’s natural support network to explore worries and what’s working well, build agreements, and develop plans with clear next steps to ensure safety, permanency and well-being. Sometimes called Family Team Meetings or family meetings.</td>
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<tr>
<td>Circles of Support (Safety Circles)</td>
<td>A tool that involves asking the family who in their life knows everything about what got them involved with child welfare, who knows a little bit, and who knows nothing. The goal is to move protective individuals into the inner circle of people who know everything and ask them to be part of the Safety Network.</td>
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<tr>
<td>Collaborative Practice</td>
<td>A participatory team approach to child welfare that encourages the building of shared language, understanding and engagement with families to assist and empower them to build their own supportive network and safety plans.</td>
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<tr>
<td>Complicating Factors</td>
<td>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.</td>
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<tr>
<td>Consultation and Information Sharing Framework © Lohrbach, 1999</td>
<td>A process of dialogue and inquiry that helps the agency, family and their network work together to surface and assess risk, complicating factors, safety and strengths; identify areas in need of additional exploration; and move toward group agreements about what needs to happen next to ensure the safety of the child or youth.</td>
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<tr>
<td>Coping Question</td>
<td>A type of solution-focused question that asks the individual to reflect on how they have managed to cope with or manage a difficult or challenging situation.</td>
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<tr>
<td>Cultural Humility</td>
<td>The practice of demonstrating a belief that families are the experts on their unique qualities and characteristics; looking at our own personal history, biases and perspectives that impact interactions with others and interpretations of others’ behavior; willingness to actively self-reflect, recognize and set aside assumptions, admit mistakes, seek ongoing feedback, and make our best effort to change behavior; asking questions to understand historical trauma and institutional oppression; and actively collaborating with the youth, family, network and Tribe to identify and support culturally relevant actions in the safety/case plan.</td>
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<tr>
<td>Danger</td>
<td>Worries about future behavior by the caregiver that may cause further harm to the child.</td>
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<tr>
<td>Danger Statement</td>
<td>A simple, concise, behaviorally-based statement that helps family members, collaterals and the agency become very clear about who is worried about what caregiver behavior that may cause what specific future danger to the child.</td>
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<tr>
<td>Ecomap</td>
<td>A visual diagram that shows an individual or family in the context of their environment of people, services, systems and supports that surround them.</td>
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<td>Engagement</td>
<td>The process of skilled inquiry to identify, assess and plan for the needs of the child and family. Skilled engagement by a social worker is itself an intervention to help families start thinking differently about challenges and solutions and move them toward readiness for change.</td>
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<tr>
<td>Exception Question</td>
<td>A type of solution-focused question that asks the individual to identify times when a problem was not happening or when they have been successful in addressing a challenging situation.</td>
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<tr>
<td><strong>Facilitated Meeting Dialogue Structure</strong></td>
<td>A structured process for guiding any kind of facilitated family meeting; the structure includes the meeting purpose, context, group agreements, network/stakeholders, desired outcome, content (worries and working well), next steps and plus/delta.</td>
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<tr>
<td><strong>Family Time</strong></td>
<td>A preferred term for parent-child visitation that recognizes the true purpose and importance of time together for children and parents who have been separated.</td>
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<tr>
<td><strong>Four-Quad Map</strong></td>
<td>A version of Safety Mapping that involves categorizing topics discussed into four quadrants: (1) harm/danger, (2) complicating factors, (3) safety, and (4) supporting strengths, as well as next steps.</td>
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<tr>
<td><strong>Genogram</strong></td>
<td>A visual diagram of a family system, similar to a detailed family tree, which shows family members’ relationships, ages, genders, intergenerational behavior patterns, and other details.</td>
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<tr>
<td><strong>Gray Area</strong></td>
<td>Information that is speculative or incomplete and requires further action on the part of the agency to clarify or answer.</td>
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<tr>
<td><strong>Harm</strong></td>
<td>Past or present caregiver actions that resulted in negative impact to the child.</td>
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<tr>
<td><strong>Harm Statement</strong></td>
<td>A simple, concise, behaviorally-based statement that helps family members, collaterals and the agency become very clear about what past caregiver behaviors negatively impacted the child’s safety, and why CWS is involved.</td>
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<tr>
<td><strong>Mapping</strong></td>
<td>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.</td>
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<tr>
<td><strong>Miracle Question</strong></td>
<td>A specific type of preferred future question that asks a person to imagine they wake up and all of their problems are gone and to reflect on how they would know the trouble was over, what they would be doing, and how this would impact their life.</td>
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<tr>
<td><strong>Motivational Interviewing</strong></td>
<td>A collaborative counseling method for guiding a conversation to elicit and strengthen motivation for behavior change, address ambivalence about change, and evoke and strengthen an individual’s own motivation for change.</td>
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<tr>
<td><strong>Naïve Practice</strong></td>
<td>Child welfare practice that focuses only on supporting strengths rather than conducting a rigorous, balanced assessment that also evaluates harm, danger and acts of protection.</td>
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<tr>
<td><strong>Position Question</strong></td>
<td>A type of solution-focused question that asks the individual to look at an issue from the perspective or position of another person, such as their child, parent or partner.</td>
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<tr>
<td><strong>Preferred Future Question</strong></td>
<td>A type of solution-focused question that asks the individual to consider what their ideal outcome would be or what their future would look like if a problem were resolved.</td>
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<tr>
<td><strong>Problem-Saturated Practice</strong></td>
<td>Child welfare practice that focuses only on complicating factors, harm and danger, rather than conducting a rigorous, balanced assessment that also evaluates acts of protection, safety and supporting strengths.</td>
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<tr>
<td><strong>Review, Evaluate, Direct (RED) Teams</strong></td>
<td>A collaborative, daily process in which the child welfare agency and other identified team members collectively review reports of suspected child abuse and neglect received by the hotline, typically utilizing the Consultation and Information Sharing Framework®.</td>
</tr>
<tr>
<td><strong>Rigorous, Balanced Assessment</strong></td>
<td>The process of evoking and evaluating all available information about a family’s situation to ensure a comprehensive assessment that takes into account both what is working well in a family system and what the worries are, including harm and danger to the child.</td>
</tr>
<tr>
<td><strong>Risk</strong></td>
<td>The likelihood of future danger happening to a child.</td>
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<tr>
<td><strong>Safety</strong></td>
<td>Acts of protection demonstrated over time by the caregiver that effectively keep the child safe from future harm or danger.</td>
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<tr>
<td><strong>Safety Circles (Circles of Support)</strong></td>
<td>A tool that involves asking the family who in their life knows everything about what got them involved with child welfare, who knows a little bit, and who knows nothing. The goal is to move protective individuals into the inner circle of people who know everything and ask them to be part of the Safety Network.</td>
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<tr>
<td><strong>Safety Goals</strong></td>
<td>Derived from Harm/Danger or Risk Statements, Safety Goals are a clear, concise statement that describes what the parent’s behavior will look like so that everyone will know the child will be safe in his or her care.</td>
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<tr>
<td><strong>Safety House</strong></td>
<td>This tool engages the child/youth in a process of exploring what safety would look like in their home. The child identifies what the house rules are, who gets to live in the house, who gets to visit, and who is not allowed to visit, and scales how close to the house on the Safety Path they currently are.</td>
</tr>
<tr>
<td><strong>Safety Mapping</strong></td>
<td>A process of dialogue and inquiry to help social workers, supervisors, families and networks work together to explore presenting factors, including harm/danger, complicating factors, safety and strengths; identify areas in need of additional exploration; and plan for what needs to happen next to ensure the safety of the child or youth.</td>
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<tr>
<td><strong>Safety Network</strong></td>
<td>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.</td>
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<tr>
<td><strong>Safety Plan</strong></td>
<td>A short-term plan that specifically addresses what steps must be taken by the family and their network to keep the child safe in the care of his or her parents.</td>
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<tr>
<td><strong>Scaling</strong></td>
<td>A solution-focused strategy that asks individuals to rate their current evaluation of a situation by picking a number on a scale of 1-5 or 1-10. Scaling questions can be used to identify level of safety, confidence, commitment, capacity, or other quality related to a question at hand, and to explore what it would take for the person to get closer to the target goal.</td>
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<tr>
<td><strong>Solution-Focused Questions</strong></td>
<td>A strategy for working with families based on the idea that focusing on strengths and identifying what has worked before will uncover, draw out, and guide us toward solutions. Types of solution-focused questions include scaling, exception, coping, position and preferred future questions, including the miracle question.</td>
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<tr>
<td><strong>SOP Domestic Violence Timeline</strong></td>
<td>A tool that helps the social worker explore, with the parent, the history and pattern of domestic violence by the perpetrator and acts of protection by the survivor. The tool reframes survivor actions often labeled as “failure to protect,” instead recognizing that many actions historically viewed as neglectful are efforts to be protective.</td>
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<tr>
<td><strong>Strength-Based Practice</strong></td>
<td>An approach to child welfare work that focuses on identifying and building on strengths, capacities and resources within the family system that could be used to ensure safety and well-being of the child(ren).</td>
</tr>
<tr>
<td><strong>Structured Decision-Making (SDM)</strong></td>
<td>An evidence- and research-based system that identifies key points in a child welfare case where structured assessments are used to improve consistency and validity of each decision.</td>
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<tr>
<td><strong>Supporting Strengths</strong></td>
<td>Supporting strengths, sometimes just called strengths, are 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. Strengths may include past and current efforts to protect children from harm, loving parent-child relationships, accessing extended family and other support systems, and making efforts to address past and current stress conditions including drug abuse, family violence, mental health issues, unemployment, etc.</td>
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<tr>
<td><strong>Three-Column Mapping</strong></td>
<td>A simplified mapping process that explores presenting issues by sorting information into three columns based on the Three Questions: “What are we worried about? What is working well? What needs to happen next?”</td>
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<tr>
<td><strong>Three Houses</strong></td>
<td>This tool engages the child or youth to explore their perspective of what is working well, what they are worried about and what needs to happen next in their family. The worker guides the child in identifying what in their life, family or home environment goes in the House of Worries, House of Good Things and House of Dreams.</td>
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<tr>
<td><strong>Three Questions</strong></td>
<td>The Three Questions are a foundational tool of SOP that guides many other tools, meetings and conversations with a family and their network. The questions are: “What are we worried about? What is working well? What needs to happen next?”</td>
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<tr>
<td>Trauma-Informed</td>
<td>A trauma-informed child and family services system is one in which all individuals recognize and appropriately respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, service providers and staff.</td>
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<tr>
<td>Visit Coaching</td>
<td>Visit coaching, also known as family time coaching, is a trauma-informed, child-focused approach to court-ordered family visits that fundamentally differs from supervised visits because of the focus on the strengths of the individual parent and the specific emotional and developmental needs of each child. Visit coaching also emphasizes the coach’s consistent, positive, honest relationship with the parent as a primary factor in helping them identify and meet the needs of their child(ren), both during visits and long-term.</td>
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**SAFETY ORGANIZED PRACTICE (SOP) KEY ELEMENTS**

Safety Organized Practice (SOP) is a collaborative, trauma-informed child welfare practice model that utilizes skillful engagement, meaningful partnerships with families and their networks, and development of plans that foster behavior change within a family system to ensure child safety, permanency and well-being. SOP is both a framework for practice and a set of tools and strategies that help child welfare staff achieve engagement, assessment, teaming and planning with a family and their network. SOP provides on-the-ground tools to support achievement of federal child welfare outcome measures, including improved timely permanency and placement stability and reduced recurrence of maltreatment and re-entry to foster care.

This document provides an overview of the elements of practice that comprise SOP, as well as best practices and California state mandates that align with SOP. The SOP Key Elements include:

- Engagement Strategies
- Voices of Children/Youth
- Child and Family Team Meetings
- Consultation and Information Sharing Framework©/Mapping
- Safety Networks
- Harm and Danger or Risk Statements
- Safety Goals
- Safety Plans
- Behaviorally-Based Case Plans
- Cultural Humility
- Trauma-Informed Approach

Curricula, trainings, tip sheets, implementation support, fidelity tools and other resources are available to support development of social work skills and the workforce to improve child welfare practice through use of SOP. See https://www.oercommons.org/authoring/12342-safety-organized-practice-resources/view.

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<tr>
<th>KEY SOP ELEMENT</th>
<th>STRATEGIES OF ELEMENT</th>
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<tr>
<td>Engagement Strategies</td>
<td>Engagement is the process of skilled inquiry to identify, assess and plan for the needs of the child and family. Skilled engagement by a social worker is itself an intervention to help families start thinking differently about their challenges and solutions and move them toward readiness for change.</td>
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<td>The Three Questions</td>
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<td>Solution-focused questions</td>
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<td>Motivational Interviewing</td>
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<td>Appreciative Inquiry</td>
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These are general skills that apply to all of the other strategies/tools.

Engagement strategies in Safety Organized Practice include:

- The Three Questions: What is working well, what are we worried about, and what needs to happen next?
- Solution-focused questioning strategies, including use of scaling, exception, coping, position and preferred future questions, including the miracle question.
- Motivational Interviewing to help clients who are fearful, reluctant or in protest (“resistant”) increase readiness for change.
- Appreciative Inquiry, which helps practitioners focus on what is already working in order to help it grow.

Each of these questioning approaches requires concrete skills that support family engagement/involvement and elicit understanding of the issues and perspectives. Information received informs the Consultation and Information Sharing Framework/Safety Mapping and Structured Decision Making (SDM) tools.
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<tr>
<td>Voices of Children/Youth</td>
<td>Two key principles in SOP are:</td>
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<td>1. The understanding that children and youth likely witness much of what goes on in their families’ lives and can contribute to a comprehensive understanding of what is happening in the family.</td>
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<td>2. The belief that children and youth often can and need to collaborate with other stakeholders in their own safety planning.</td>
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<td>Therefore, the extent to which a social worker can incorporate the child’s/youth’s perspective into their work is critical to successful child welfare practice.</td>
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<td>SOP supports children and youth being part of Child and Family Team (CFT) meetings, safety planning and case planning, as appropriate to their age and development. Additionally, SOP offers several specific tools/strategies for workers to engage children and youth in conversations about their families, their safety and their wishes for the future. These include:</td>
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<td>• Use of Three Houses/three questions to explore child’s/youth’s perspective of: What is working well, what they are worried about and what needs to happen next (House of Dreams, House of Worries, House of Good Things; age-relevant versions such as Three Computers; culturally-relevant tools such as Dream Catcher).</td>
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<td></td>
<td>• Use of the Safety House to include children’s perspective on what would keep them safe in the future.</td>
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<td>• Use of the Permanency House to explore the child or youth’s perspective regarding what would contribute to their feelings of safety and well-being in an adoptive or guardianship home and/or with other permanent connections.</td>
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<td>Child &amp; Family Team Meetings</td>
<td>The purpose of Child and Family Team (CFT) meetings, sometimes called Family Team Meetings or family meetings, is to build agreements, decisions and plans between the Department, families, providers and other essential members of the youth’s and family’s support network.</td>
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<td>Meeting facilitators, who may be the case-carrying social workers or dedicated positions, use a variety of strategies and skills for helping groups solve problems and build agreement to enhance the safety of children and families. Solution-focused techniques are a key skill that supports this process.</td>
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<td>• Facilitated meetings with the family and their network are utilized beginning on referral and throughout involvement with child welfare.</td>
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<td>• The meeting facilitator is skilled and uses visual documentation of the information gathered.</td>
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<td>• Family meeting includes the child/youth, if appropriate; family; family network of support; and providers, when relevant.</td>
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<td>• The facilitated meeting has a clear purpose, ground rules or agreements, and clear next steps at the end of the meeting.</td>
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<td>• Use of the Consultation and Information Sharing Framework, safety mapping/independence mapping/permanency mapping, risk/danger statements and safety goals, safety plans or case plans are among the strategies for gathering and sorting of information.</td>
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<td></td>
<td>• Facilitators use a cultural humility approach and trauma-informed approach, which may include Solution-Focused Questions, Appreciative Inquiry and other verbal and nonverbal skills.</td>
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### Consultation & Information Sharing Framework/Mapping

Both the Consultation and Information Sharing Framework® and Safety Mapping are a process of dialogue and inquiry designed to help social workers, supervisors, families and extended networks work together to surface the different aspects of presenting factors, including danger/risk, complicating factors, safety and strengths; identify areas in need of additional exploration; and move toward group agreements about what needs to happen next to ensure the safety of the child or youth.

Permanency Mapping and Independence Mapping are processes to assist youth and their teams to identify goals, barriers and tasks for the youth and their network, including professionals.

Safety Mapping or the Framework can be used in partnership with families and their network (such as at a CFT meeting), in individual supervision, in group supervision, in case staffings and in multidisciplinary team meetings. It is the foundation of the family meeting’s agenda, or “dialogue structure.”

Permanency Mapping or Independence Mapping can be used 1:1 with a youth, together with their network of support, or in supervision.

The Three Questions guide the information gathering process: “What are we worried about? What is working well? What do we think needs to happen next?” Greater depth and a trauma-informed approach can be achieved using Solution-Focused Inquiry and Appreciative Inquiry during these processes.
### Key SOP Element

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<tr>
<th>Key SOP Element</th>
<th>Strategies of Element</th>
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<tr>
<td><strong>Safety Networks</strong></td>
<td><strong>Creating and sharing danger statements, safety goals enhancing the safety network, and planning (SDM risk level—use results to help determine next steps)</strong></td>
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### Safety Networks

A key component of SOP is that ensuring child safety requires involvement of responsible adults other than the caregiver(s) who caused the harm or danger.

SOP, drawing on Signs of Safety and the Family Group Conferencing movement, offers strategies for building a “network” of people around the child, communicating the risk/danger to them and enlisting the network’s help in keeping the child safe.

By rigorously asking about formal and informal networks and using our power constructively, the family and community can become members of an expanded safety network that helps enhance safety for children. A safety network may also be thought of as the Child and Family Team.

The safety network is 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 do something specific that supports the family and helps to keep the child safe. Safety network members can include extended family, friends, neighbors, tribal members, service providers and anyone else who can play a role in ensuring safety. A much-used phrase in SOP is “No network, no plan.”

The **Circles of Support/Safety Circles** tool is often used in SOP to elicit names of people to be considered for the family’s network. This tool involves asking the family who in their life knows everything about their involvement with child welfare, who knows a little bit and who knows nothing. The goal is to move protective individuals into the inner circle of people who know everything and ask them to be part of the safety network.

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<tr>
<th>KEY SOP ELEMENT</th>
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| **Harm and Danger or Risk Statements** | **Harm and Danger Statements, or Risk Statements:**  
- Are clear statements of how the caregivers’ actions impact the child, resulting in harm, danger or risk.  
- Lay the groundwork for important “difficult conversations” to occur and build shared understanding of concerns.  
- Help ensure that we are talking with the youth, families and their networks about the most important things to address.  
- Are ideally crafted with the family and their network in the context of a Child and Family Team meeting.  
- Are written in plain language that youth and families can understand.  
- Are behavior-focused, not service-focused or task-focused.  
- Contain only the safety threat(s) identified by Structured Decision Making tools, not complicating factors.  

Harm and Danger Statements or Risk Statements can also be developed with an older youth and their network to address concerns about the youth’s ability to keep themselves safe. |
| **Safety Goals** | Safety Goals are derived from Harm/Danger or Risk Statements and describe what the parent’s behavior will look like so that everyone will know the child will be safe in his or her care.  
Safety Goals can also be used with older youth in Permanency Planning or Extended Foster Care to describe what a youth will be doing over time that will contribute to their own safety, with the support of their network/team. |
| **Safety Plans** | Safety Planning is a practice that is intended to prevent unnecessary child removals and solidify child safety in the home. It involves a facilitated meeting process with the family and their network to ensure child safety has been enhanced.  
Safety Plans focus on concrete actions for the child/youth, parent(s) and their network that will help them achieve the Safety Goal. |
| **Behaviorally-Based Case Plans** | A foundational principle of SOP behaviorally-based case plans is that services and safety are not the same thing. Service completion does not guarantee child safety. Behavior change, demonstrated and sustained over time, is the key to safety.  
Services that are individualized and specific can be a useful tool to help a parent achieve behavior change; however, any services should be regarded as the last piece of the case plan puzzle. In some circumstances, child safety can be attained with limited or no use of formal services.  
Case plan compliance is not the same thing as engagement, and compliance is much less successful in achieving behavior change. |

**Safety Goals**
Safety Goals explain what the child/youth’s network will observe the parents doing on a regular basis that will prevent the identified SDM safety threat from occurring.  

The Safety Plan is the method of addressing the Danger or Risk Statement and achieving the Safety Goal.  

**Safety Plans**
Safety Plans are short-term plans that specifically address the dangers the family and people identified in the safety network have agreed to resolve.  

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

A Safety Network is a necessary component of a Family Maintenance or Family Reunification case plan.
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<tr>
<th>KEY SOP ELEMENT</th>
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<tr>
<td>Cultural Humility</td>
<td>Cultural humility includes:</td>
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<td>A cultural humility approach to the work requires that we are self-reflective of our own bias and history that we bring to the work with families.</td>
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<td>“A cultural humility perspective challenges us to learn from the people with whom we interact, reserve judgment, and bridge the cultural divide between our perspectives in order to facilitate well-being and promote improved quality of life. Such a perspective frees the observer from having to possess expert knowledge in order to maintain knowledge-based power, control, and authority over matters about which diverse populations are far more knowledgeable.”</td>
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<tr>
<td>Trauma-Informed Approach</td>
<td>Trauma-informed child welfare practice is not a discrete task but rather involves the day-to-day work of the system as a whole. Child welfare systems that are trauma-informed are better able to address children’s safety, permanency, and well-being needs. Service improvements include more children receiving the trauma screening, assessment, and evidence-based treatment they need.</td>
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<td>A trauma-informed child- and family-service system is one in which all parties involved recognize and respond to the impact of traumatic stress on those who have contact with the system, including children, caregivers, and service providers.</td>
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<td>Programs and agencies within such a system infuse and sustain trauma awareness, knowledge, and skills into their organizational cultures, practices, and policies. They act in collaboration with all those who are involved with the child, using the best available science, to facilitate and support the recovery and resiliency of the child and family.</td>
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<td>National Child Traumatic Stress Network</td>
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<td>Trauma-informed child welfare practice also encourages practitioners to utilize a trauma lens when working with parents of children involved with the child welfare system. A trauma-informed approach:</td>
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<tr>
<td>• Promotes physical and psychological safety and resilience for children, youth, families and staff.</td>
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<td>• Demonstrates appropriate boundaries, task clarity, clear and consistent policies and reasonable expectations for providers, families, and youth.</td>
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<td>• Works toward active collaboration, including asking the youth/family to define their trauma, triggers, resilience factors and needs.</td>
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<td>• Prioritizes youth and families experiencing that their voice is heard, that they have choices, and that they have some power over their future.</td>
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<td>• Ensures cultural, language and historical factors are a part of assessment and planning.</td>
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<tr>
<td>• Emphasizes meaningful self-care for youth, families, and staff.</td>
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<tr>
<td>Adapted from THRIVE Trauma-Informed Master Training (2013)</td>
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# ADDITIONAL PRACTICES THAT ALIGN WITH SOP

In addition to tools and strategies that are part of Safety Organized Practice, SOP aligns with many California mandates and a number of other best practices with children and families.

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<tr>
<th>PRACTICE</th>
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<td><strong>Assessment Tools</strong></td>
<td>The teaming processes that are a foundation of SOP can be used to inform a variety of child and family assessment tools. These include State-mandated tools, such as:</td>
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<td><strong>Child and Adolescent Needs and Strengths (CANS)</strong></td>
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<td>CDSS selected the CANS as the functional assessment tool to be used with the Child and Family Team (CFT) process to guide case planning and placement decisions. The CANS is a multi-purpose assessment tool developed to assess well-being, identify a range of social and behavioral healthcare needs, support care coordination and collaborative decision-making, and monitor outcomes of individuals, providers, and systems. Completion of the CANS assessment requires effective engagement using a teaming approach. The CANS must be informed by CFT members, including the youth and family. The CANS assessment results must be shared, discussed, and used within the CFT process to support case planning and care coordination.</td>
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<td><strong>Level of Care (LOC) Protocol</strong></td>
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<td>The LOC Protocol uses a strength-based placement rate setting methodology to identify the individual care and supervision expectations needed to meet the daily needs of a child/youth, based on five Core Domains. The LOC Protocol should not be completed during a CFT meeting; however, a review of the LOC Protocol and Core Domains may be discussed to attain a better understanding of the needs of the child/youth. The CFT process also provides an opportunity to gather information from a variety of perspectives and sources to inform the LOC rate determination.</td>
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<tr>
<td><strong>Child &amp; Family Teaming</strong></td>
<td>SOP provides tools and strategies to meet State CFT mandates. Both SOP and CFT involve developing a team that includes the child/youth, family, their natural supports, the agency, the tribe and appropriate service providers (including behavioral health providers), with the purpose of identifying and meeting the needs of the child/youth and family to ensure safety, permanency and well-being for the child/youth. Additionaly, CFT meetings (sometimes known as Family Team Meetings) are a primary intervention in Safety Organized Practice. CFT meetings are the process of bringing together the family and their network for a specific purpose in order to develop a plan to address worries and next steps. Given California’s mandate for use of Child and Family Teaming (CFT) processes, the SOP Backbone Committee recommends that counties rename all existing team meeting processes “CFT meetings” and use the SOP framework and language to guide the meetings.</td>
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California counties use a variety of tools to assess the needs of children and families. Some are State-mandated, while others are used at the county level. All of these tools can be incorporated into the teaming processes of SOP. SDM is addressed separately below.
### Case decision points at which CFT meetings should happen include:

- **Safety Mapping**: The process of working with a family and their network to develop Harm and Risk/Danger Statements, Safety Goals and next steps/plans to work toward achieving those goals.
- **Emergency Removal**: Bringing together the family and their network after law enforcement has removed a child to determine if there is any way the child may be returned home safely.
- **Imminent Risk of Removal**: Bringing together the family and their network when it appears separation may be necessary, in order to determine if there is any plan that can keep the child safe in the care of his/her parents.
- **Safety Planning**: Developing a short-term plan to keep children safe in the care of their parents during an ER investigation; this may be part of an Emergency Removal or Immediate Risk of Removal CFT meeting.
- **Case Planning**: Developing the family’s case plan in a Voluntary or Court-Ordered Family Maintenance (FM) case, Family Reunification (FR) case, or Permanency Planning (PP) case.
- **Planning with Youth**: With the youth and their network, developing the Transitional Independent Living Plan or, for non-minor dependents, the Transitional Independent Living Case Plan.
- **Preventing Placement Disruptions**: Bringing together the child/youth, their caregiver and the network to develop a plan for intensive supports to help stabilize a placement.
- **Planning for Unsupervised Visits**: Developing a safe plan with the family and their network when moving from supervised to unsupervised visits.
- **Planning for Transition Home**: Developing a safe plan with the family and their network when a child is moving from FR to FM.
- **Addressing Needs of Children/Youth**: Planning for additional services and supports when children or youth have behavioral health, educational, placement or other needs.
- **Permanency Roundtable**: Bringing together a child’s/youth’s network to focus on identifying and securing a permanent plan for the child/youth.
- **Other**: Any other specific purpose when there is a worry that needs to be addressed by the family and their network/team.

### Continuum of Care Reform (CCR)

Continuum of Care Reform (CCR) provides a statutory and policy framework to ensure services and supports provided to a child/youth and his or her family are tailored toward the ultimate goal of the child/youth achieving and maintaining a stable, permanent family.

The tools and strategies of SOP support the values and intended outcomes of CCR. A foundational practice of SOP is team meetings that bring together the family and their network to support the least restrictive placement, case plan development, and planning to meet the child’s needs. Building and engaging the family’s natural support network and utilizing tools such as the Circles of Support helps identify relatives or non-related extended family members for placement and connection. Additionally, the voice of the child or youth is at the forefront in Safety Organized Practice. SOP provides an on-the-ground practice toolkit for achieving the goals of CCR.
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<td><strong>Domestic Violence Competent Practice – Safe and Together</strong></td>
<td>Recent advances in approaches to families where there is domestic violence pair the Safe and Together model with SOP. This perpetrator pattern-based approach views domestic violence as a <em>parenting choice</em> by the perpetrator, and uses skilled engagement with the survivor, the SOP Domestic Violence timeline tool, and other strategies such as separate networks for perpetrators and survivors to ensure safety for the children and survivor and accountability for the perpetrator. This model also highlights the need for rigorous, skillful assessment of complicating factors such as mental health concerns or substance abuse by the survivor to determine if these are actual causes of harm or danger, and/or if they are caused or exacerbated by the domestic violence. The goal is to keep the child with the survivor parent and avoid labeling survivor actions as “failure to protect,” instead recognizing that many actions we have historically viewed as neglectful are actually protective.</td>
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<tr>
<th>Family Time (Visit) Coaching</th>
<th>Family time or visit coaching differs fundamentally from supervised visits because of the focus on the strengths of the individual parent and the specific emotional and developmental needs of each child. Visit coaching also emphasizes the coach’s consistent, positive, honest relationship with the parent as a primary factor in helping them identify and meet the needs of their child(ren), both during visits and long-term. Visit coaching regards positive interactions and having fun with a parent as a universal need for all children. The structured process includes:</th>
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| Family Time coaching, also known as visit coaching, is a trauma-informed, child-focused approach to court-ordered family visits. “Family time” is a preferred term for parent-child visitation because it recognizes the true purpose and importance of time together for children and parents who have been separated. | • Helping parents articulate their children’s needs to be met in visits  
• Preparing parents for their children’s reactions  
• Helping parents plan to give their children their full attention at each visit  
• Helping parents cope with their feelings so that they can visit consistently and keep their anger and sadness out of the visit  
• Appreciating the parent’s strengths in meeting each child’s needs  
• Sharing with parents where they were not successful in meeting the child’s needs, and planning together to meet them in the next visit |

| Integrated Core Practice Model | Teaming is a core value and strategy of Safety Organized Practice. SOP supports the guiding practice principles of ICPM, including family voice and choice, a team-based approach, natural supports, collaboration and integration, community-based services and supports, culturally respectful practice, and a persistent, individualized, strength-based, outcome-based, trauma-informed approach. The SOP Key Elements described in this document translate to on-the-ground practice the ICPM behaviors of engagement, assessment, teaming, service planning and delivery, and transition. ICPM provides the “what” of good child welfare work, and SOP provides the “how.” |

<p>| <strong>The California Integrated Core Practice Model for Children, Youth, and Families (ICPM)</strong> provides practical guidance and direction to support county child welfare, juvenile probation, behavioral health agencies, and their partners in delivery of timely, effective and collaborative services to children, youth and families. | **Teaming is a core value and strategy of Safety Organized Practice. SOP supports the guiding practice principles of ICPM, including family voice and choice, a team-based approach, natural supports, collaboration and integration, community-based services and supports, culturally respectful practice, and a persistent, individualized, strength-based, outcome-based, trauma-informed approach. The SOP Key Elements described in this document translate to on-the-ground practice the ICPM behaviors of engagement, assessment, teaming, service planning and delivery, and transition. ICPM provides the “what” of good child welfare work, and SOP provides the “how.” |</p>
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<td><strong>RED Teams</strong></td>
<td>RED Teams utilize the Consultation and Information Sharing Framework to conduct a daily process of reviewing, as a team, reports of suspected child abuse and neglect received by the agency. RED Teams include the hotline social worker, supervisor, and other child welfare social workers or supervisors, as well as internal and external partners such as mental health, substance abuse providers, domestic violence advocates or other community providers, with the goal of providing a diverse and comprehensive evaluation of the information received and identification of additional information needed. Issues addressed in RED Teams include:  - Does the report of child maltreatment meet the statutory threshold for intervention?  - If the report does not meet the child protection intervention, should it be referred for child welfare or community services?  - Does the report present a child concern that can be addressed through an alternative response approach?</td>
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<td><strong>Structured Decision Making</strong></td>
<td>The SDM model consists of several assessments that help agencies work to reduce subsequent harm to children and to expedite permanency. These include:  - Screening and response priority assessments (hotline)  - Safety Assessment (mainly used during investigation phase; a new version exists for evaluation of foster placements)  - Risk Assessment (primarily used in investigation)  - Family Strengths and Needs Assessment (priorities for case planning)  - Risk Reassessment (evaluates safety of child in the home)  - Reunification Assessment (assists with whether to return child to home)  - Child Strengths and Needs Assessment (identifies priorities for case planning in cases where Family Reunification services have ended) The SDM model includes clearly defined service standards, mechanisms for timely reassessments, methods for measuring workload, and mechanisms for ensuring accountability and quality controls.</td>
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<td><strong>Team Decision-Making Meetings</strong></td>
<td>The TDM model began as a core strategy of Family to Family, a child welfare reform initiative developed by the Annie E. Casey Family Foundation. TDMs bring together a trained facilitator, agency staff, family, service providers and natural supports to address placement issues for children involved or potentially involved in foster care. TDMs take place when there is emergency removal or imminent risk of removal of a child from their family, when a potential placement change may occur for a child in foster care, or when a child is exiting placement (returning home). The primary purpose of TDMs is to make placement decisions for children and youth.</td>
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<td>As a predecessor to SOP, the TDM model lays important groundwork for several case decision points at which it is vital to bring together the agency, the family and their network. Many California counties have evolved their TDM practice to incorporate the language and tools of SOP. It is strongly recommended that, whatever an agency calls their meetings, they have a meeting with the family and their network when there has been an emergency removal of a child, prior to removal when there is imminent risk that a child may need to be separated from his or her parents, when a placement change is being considered, and prior to a child’s return home. Given California’s mandate for use of Child and Family Teaming (CFT) processes, the SOP Backbone Committee recommends renaming all existing team meeting processes “CFT meetings” and using the SOP framework and language to guide the meetings, while retaining the case decision points of TDM as part of the CFT meeting structure.</td>
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Appreciative Inquiry and Safety Organized Practice

Adapted from the Winter 2015 issue of Reaching Out

As the human and social service sectors continue the move to more strength-based practices, the concept and research of appreciative inquiry (AI) is often noted as serving as the theoretical underpinnings of the method. This practice brief describes the research and concepts of AI and how Safety Organized Practice (SOP) naturally evolved from the AI model.

AI is based on the premise that organizations change in the direction in which they inquire. An organization (or individual) that investigates problems will keep finding problems, while an organization (or individual) that investigates what to appreciate in itself will discover what’s successful. AI is the paradigm or philosophy one uses when asking questions and envisioning a future that fosters relationships and builds on the goodness in a person, a situation or an organization. By so doing, a system’s capacity for collaboration and change is enhanced.

AI was developed by David Cooperrider and Suresh Srivastva in the 1980s. Beginning as a theoretical model, Cooperrider and Srivastva argued that organizations are not "problems to be solved" but are centers of infinite human capacity—ultimately unpredictable, unknowable or a "mystery alive." This framework argues for the need to go beyond the deficit or problem focus of the field and, in the language of Safety Organized Practice, to focus on “what’s working well” in order to build on existing exceptions to problems, identify further solutions, and highlight strengths that are already present.

APPRECIATIVE INQUIRY AND THE ART OF ASKING QUESTIONS

In the early 1990s, appreciative inquiry founders developed a practical model to implement the theory—calling it the Four D’s:

- Discover
- Dream
- Design
- Deliver
Inherent and required within this process or paradigm is the "art of asking questions." Asking questions is something that is done by social service workers all day long, but it is in fact the way in which questions are asked that will elicit the responses that are obtained. The power of the question and how it is posed will impact the answer.

The "medical model" of health has been the main operating paradigm under which social services has functioned for more than a century. Under the medical model of health, practitioners seek information related to illness, problems, disease and disorders that are afflicting the community or individuals. Diagnosis and treatment are the standards of operation.

Appreciative inquiry, while having the same goals as the medical model of health, operates significantly differently by seeking strengths and making changes from that point. Several models in social services have been introduced which are making this shift. In Northern California and several other regions, Safety Organized Practice serves as a fully realized strengths-based human services practice model. By engaging families to identify their own strengths and support networks, SOP does not focus solely on problems, but rather assists families with finding pathways to well-being through their own support systems and problem-solving capacities.

A child welfare organization that has embraced SOP as an organizational framework also examines, embraces, and builds upon its own strengths to improve outcomes.

To read more about AI and SOP, please see the Safety Organized Practice edition of Reaching Out at http://bit.ly/ReachingOutJournal

References

Cultural Humility in Safety Organized Practice

_by Susan Brooks and Jason Borucki, Northern California Training Academy_

At the heart of the Safety Organized Practice approach to child welfare is the belief that a collaborative, partnership-based approach to working with children and families in care will engage families to participate in safety planning, which will ultimately result in better outcomes. For child welfare professionals informed by Safety Organized Practice, cultural humility plays a large role in this collaborative, partnership-based effort.

The culture of the child welfare agency and the culture of the children and families served by the agency are rarely the same, especially when breaking down the definition of culture and recognizing that cultures vary from one family to the next, or even within certain members of the same family. Even within the same self-identified cultural group, there may be different contexts with which cultural members identify themselves. For a child welfare worker who often deals with multiple families, cultures, and cultural contexts daily, "cultural competence" is an unrealistic goal.

In the place of cultural competence, cultural humility encourages child welfare workers to admit their lack of knowledge about different cultures, learn from the people with whom they interact, reserve judgment, and work to bridge the cultural divide between their perspectives and those of others. Within Safety Organized Practice, exhibiting cultural humility means asking as many questions as necessary to better understand the context of the children and families they are working with, as well as sharing the context of the agency with the family openly and honestly. This transparency, especially when presented during

"In place of cultural competence, cultural humility encourages child welfare workers to admit their lack of knowledge about different cultures, learn from the people with whom they interact, reserve judgement, and work to bridge the cultural divide between their perspectives and those of others."
initial or early interactions with the family, can build trust and set the tone for collaboration and partnership moving forward. More importantly, it will help to guard against many of the natural fears families in care often bring with them to their first meeting with child welfare, including a fear of being pre-judged, oppressed, and/or disrespected.

Given the inherent call for curiosity and openness in cultural humility, there may never be one set way to practice it or measure its complete success. Indeed, the cultural humility perspective requires a willingness to make mistakes and admit those mistakes openly and immediately when they are made (e.g., when a child welfare worker asks a question that includes an assumption that proves false). Recognizing one’s own culture (or the agency culture) and how that culture informs one’s own perspective and guides their questioning is just as important as any other element of cultural humility, and calling it out early and often will help children and families understand that they are involved in a collaborative effort -- one that will include agreements and changes over time, but one they are ultimately as much as part of as the child welfare worker. When this collaborative, partnership-based spirit is achieved, families will be more engaged to participate in their own safety planning.

**TEN PRINCIPLES OF CULTURAL HUMILITY**

1. Embrace the complexity of diversity
2. Be open to individual differences and the social experiences due to these differences
3. Reserve judgment
4. Relate to others in ways that are most understandable to them
5. Consider cultural humility as a constant effort to become more familiar with the worldview of the children and families we serve and the agency staff and community partners who serve them
6. Instill a collaborative effort in help-giving
7. Encourage staff and community partners to offer help that demonstrates familiarity with the living environment of children and families being served, building on their strengths while reducing factors that negatively affect the goals of safety, permanency, and well-being
8. “Know thyself” and the ways in which biases interfere with an ability to objectively listen to or work with others, including children and families, agency staff, and community partners
9. Critically challenge one’s “openness” to learn from others
10. Build organizational support that demonstrates cultural humility as an important and ongoing aspect of the work itself
To support rigorous and ongoing safety planning in child welfare, Safety Organized Practice offers strategies for building a network of people around the child, communicating the risk statement to those in the network and enlisting their help in keeping the children safe (meeting the safety goal). This network is a key element of safety planning and should be formed as early as possible, ideally before an agency makes a decision about whether to remove a child from the home. From there, a successful and strong family safety network can help support the family through post permanency.

**RATIONALE FOR BUILDING SAFETY NETWORKS**

- CWS involvement is temporary.
- A once-a-month home visit by a social worker 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 child welfare knows.
- CWS frequently ask clients to engage in "services," even when it does not directly address the danger. CWS could utilize a similar "push" to bring more people to the work of enhancing daily safety for children.
- Supporting the permanency and well-being of a child takes a “village” or a network of ongoing support, services, and love.
- Being specific about roles and responsibilities for each member of the network is critical; the more specific, the greater opportunity for success in meeting the child’s needs (for example: “Grandma will pick up her granddaughter, Jane, every Tuesday at 3:00 while mom goes to parenting class.”).

**WHAT IS A FAMILY SAFETY NETWORK?**

A group of family, friends, and professionals who:

- Care about the child
- Care about the family
- Are willing to meet with CWS
- Understand the harm/danger and risk concerns CWS and others have
- Are willing to do something that supports the family and helps keep the child safe
BUILDING THE NETWORK TO GO THE DISTANCE

The cultivation of a safety network is not just for “immediate” safety, but actually is the vehicle to promote long-lasting change that will continue to be enforced long after child welfare’s involvement ends. SOP makes the distinction between “safety planning” and “service planning,” noting that the culture of child welfare has been one of case management and service planning for some time—even while our goal is always the enhanced safety of children. SOP provides techniques and guidance for building a family safety network to enhance the daily, on-the-ground safety and well-being for children.

UTILIZING FAMILY SAFETY CIRCLES TO IDENTIFY THE FAMILY SAFETY NETWORK

The Family Safety Circle tool (sometimes called Circles of Support) is a visual tool to help child welfare professionals and family members have conversations about safety networks, the role of the safety networks and assessing who can be part of the safety network. Families identify the people that may be able to help them reach their safety goal, and provide ongoing permanency and well-being support to the child.

BUILDING A FAMILY SAFETY CIRCLE

Center: The child.

Inner circle: People in the family and the child’s life who already know what happened (that led to child welfare services being involved). People who know the child, and who the child trusts.

Middle circle: People in the family and child’s life who know a little, but not all, about what has happened, or know something happened but have very little information. People who could be of support to the child and family if asked to participate in the family's network of support.

Outer circle: People in the family and child’s life who don’t know anything about what has happened. Some questions that may help caregivers determine who is a part of their outer circle include:

- Who are the people who may be important to your child but that you would not have thought to call?
- Who are the people who you have not seen for a long time but you know care about you and your child?

MOVING PEOPLE FROM THE OUTER CIRCLES TO THE INNER CIRCLE

After the first attempt to fill out the family safety circle is completed, it is important to keep working with the family to identify additional supports and the potential for a higher levels of support from within the circle. It is also important to identify people who may be of risk to the child and/or caregivers who should remain in the

[Image of Family Safety Circle]

Adapted from Introducing an Integrated Safety Organized Practice, from the Northern California Training Academy and the NCCD Children’s Research Center
outer circle. Some of the following follow-up questions may be useful in attempting to move people from the outer circles to the inner circle, and to add additional supports into the circle:

- Who can you move from the outer circles to the inner circle? What would it take to get them there?
- Who else from these outer circles do you think needs to be part of this inner circle?
- Is there anyone in these two outer circles who you have thought about telling or come close to telling, but you haven't quite gotten there yet?
- Who would others who are close to you and your children say needs to be in this inner circle?
- Who would your child want to have in this inner circle?
- Who do you think your social worker would want in the inner circle?
- Who of all of these people do you feel most comfortable with/most understood by and think would be important to have as part of the safety network?

Safety Mapping and the Consultation and Information Sharing Framework

Adapted from the Winter 2015 issue of the Reaching Out child welfare practice journal

In several jurisdictions, the “Consultation and Information Sharing Framework” (® Lorhbach, 1999) is utilized for group supervision, case consultation, and family team meetings. Also known as “safety mapping” among counties that have implemented Safety Organized Practice, the framework is intended to help child welfare agencies cultivate a more collaborative, partnership-based approach to working with children and families in care. The framework supports critical thinking, reflection, clarity of concerns and direction for resolution.

The framework is typically completed using a white board to 1) collect, 2) organize and 3) analyze information prior to 4) deciding upon next steps. To accomplish this, the following information is collected and added to the framework during group supervision, case consultation and/or family team meetings:

Harm to child (reason for referral): The detail(s) of the incident(s) bringing the family to the agency’s attention, and any known pattern and history of past social service involvement/child harm.
**Risk statement(s):** The preliminary articulation of the perceived risk to the child(ren) and the context in which the risk is most concerning, reflecting any statutory basis/focus on which the report is accepted for further assessment. Risk statements are known as danger statements in some jurisdictions.

**Complicating factors:** Conditions/behaviors that contribute to greater difficulty for the family.

**Safety:** Any existing strengths demonstrated as protection over time and any pattern/history of exceptions to the abuse/neglect.

**Strengths/protective factors:** The assets, resources and capacities within the family, individuals and community. These strengths can be built upon to support safety for the child.

**Genogram/Ecomap:** A pictoral representation of family members, extended family members, cultural communities, pets (information regarding social environment); and a map of all current service providers involved with the family and the relationship between the child and parents/caregivers (information regarding service provision and fragmentation of service provision).

**Gray area:** This space is reserved for incoming information or current information that requires further query to understand its meaning. It is important to avoid speculation in decision making in child welfare. Noting questions, areas for clarification, and further exploration is key to a full and comprehensive assessment.

**Next steps:** Immediate actions regarding what needs to happen next to address the risk to the child. It is important that next steps are comprehensive (the who, what, when) while prioritizing those areas identified in the "reason for referral" section. Next steps and the timeframe for completion should be clear to all, the family, the network of support and the agency.

Solution-focused Scaling Questions and Safety Organized Practice

Adapted from the Winter 2015 issue of Reaching Out

Solution-focused questions are a key strategy of Safety Organized Practice. One specific solution-focused approach used in Safety Organized Practice is that of asking scaling questions. These questions often serve as an entry into Safety Organized Practice because they are relatively easy to learn and can yield significant results. Currently, many social workers, therapists, coaches and managers use scaling questions.

DIFFERENT TYPES OF SCALES

There are many ways of using scaling questions. The most frequent uses include:

- **The success scale**: On this scale, 10 is the desired situation and 0 is the situation in which nothing has been accomplished yet. The success to which this scale refers can be about anything you may find relevant in a particular situation.

- **The motivation scale**: On this scale, the 10 may be something like, “I am prepared to do a lot to achieve the goal,” and 0 may be, “I am not willing to do anything for it.” Going through the basic steps of the scaling question, clients often get more of a grip on their own motivation. They learn to regulate their own motivation and become capable of motivating themselves.

- **The confidence scale**: A 10 may be, “I have much confidence in being able to accomplish this,” and a 0 may be, “I have no confidence whatsoever.” Just like with the motivation scale, the client learns to regulate his/her own confidence. This can have a strong stimulating effect.
The independence scale: A 10 may be, “I know how I can proceed with this, and I don’t need help anymore,” and a 0 may be, “I don’t know how to proceed with this, and I need help.” The advantage of this scale is that it helps to keep services such as therapy from taking longer than strictly necessary. While the problem may not be completely solved, this does not have to mean that the professional help has to continue.

WHAT TO DO WHEN A CLIENT IS AT A 0

When clients say they are now at 0, they often want you to understand how serious their situation is. The coping question can then be asked; for example, “How do you manage to go on in these tough circumstances?” The coping question often helps people to find new energy to cope with their difficult situation. For instance, when the client says, “I manage to go on because I don’t want to disappoint my children,” the social worker can build on that by asking, “How would you know your children would not be disappointed?”

THE IMPORTANCE OF EFFECTIVE SCALE ANCHORS

When using scales, it is important to define your anchors carefully. Scales usually work best when the 10-position is defined in not too idealistic terms but rather in more realistic terms. Being idealistic in your definition of the 10-position has two disadvantages: 1) You can be sure that an ideal situation will never be achieved; and 2) It will trigger the client to scale the current situation lower. A too-idealistic 10 can demotivate.

PLAYING WITH SCALES

Whenever possible, be inventive and playful when using scales, if only because clients may do that, too. In a teambuilding session, a coach once used the scale walking technique. At a certain point, the coach invited the members to think about which steps forward they could take on the scale and then physically take a step when they knew what step it was. One after the other, the team members took a step forward. One person took a step backward. The participant explained, “I am very perfectionistic, and by taking a step backward, I want to symbolize that I am going to let things loose a bit more.” The coach responded, “Sounds good.”

OTHER KEY SOLUTION-FOCUSED QUESTIONS USED WITH FAMILIES AND THEIR NETWORK IN SOP

- **Past Success Question:** In attempting to respond to this question, the client may remember when he has already been able to cope with a problem or to solve it. Remembering one or more past successes is likely to increase the confidence and hopefulness of the client and usually helps the clients find ideas to take a step forward. Some examples of past success questions are:
  - “When have things already been a bit better?”
  - “Have you ever been able to solve such a problem before?”
  - “Have ever experienced a situation which is a bit like the situation you want to achieve?”

- **Preferred Future Question:** This is one of the most essential types of progress-focused questions. It is the question with which the social worker or coach invites the client to describe how he or she would like the situation to become. The social worker encourages the client patiently and curiously to vividly
describe the preferred future (or the 'desired situation'). The preferred future gets described in terms of concrete, positive results. A few ways in which the question can be posed are:

- “What does your preferred future look like?”
- “How do you want your situation to become?”
- “What would you like instead of the problem?”
- “How will you notice things will have become better?”

**The Exception Seeking Question:** In progress-focused change, an assumption is that the intensity of problems fluctuates constantly. There will always have been situations in which the problem was less intense and when things were better. These situations are identified and analyzed because they will often help to find ideas to solve the problem. An example of how exception-seeking questions may be asked is:

- “Are there times when the problem does not happen? When was this? What was different? How did you make that happen?”

**The Miracle Question** is a sequence of questions which invite the client to vividly describe a day after which the problem has miraculously disappeared. It is in fact a special case of the desired situation question. It often leads to hope, energy and ideas for steps forward. One possible phrasing for the question follows:

- “Suppose our meeting is over, you go home, do whatever you planned to do for the rest of the day. And then, sometime in the evening, you get tired and go to sleep. And in the middle of the night, when you are fast asleep, a miracle happens and all the problems that brought you here today are solved just like that. But since the miracle happened overnight nobody is telling you that the miracle happened. When you wake up the next morning, how are you going to start discovering that the miracle happened? What else are you going to notice?”

**The Coping Question:** This is a good question to try when normal strategies to solve problems don't seem to work anymore. An example of a situation in which you can use the coping question is when your client says he or she is now at a zero on the scale. The basic form of the question is: “How do you manage to keep going?” But there are many other ways of phrasing the question. Additional examples of coping questions include:

- How do you manage to deal with such difficult situations each day?
- What helps you to keep going even though things are really hard?
- It is admirable how you have been able to keep on going under such difficult circumstances. How did you do that?
- How did you manage to cope before you gave up?

Tools for Integrating the Child's Perspective in Child Welfare

Adapted from the Northern California Academy's child welfare practice journal

Reaching Out

This article looks at two tools that can help children share their perspective in a way that contributes to child welfare risk assessment and safety planning and is appropriate to their level of development.

THE THREE HOUSES INFORMATION-GATHERING TOOL

The Three Houses is an information-gathering tool designed specifically to build rapport with children and youth, and discover their feelings and thoughts about their families and the child welfare intervention. The process used to complete the Three Houses allows social workers to bring forward the voice of children and young people in the safety planning process. It was designed in 2003 by New Zealand child welfare workers and trainers Nicki Weld and Maggie Greening in response to feedback from family and youth court judges who identified a lack of children and family voice in the safety plans they had reviewed. Within the Safety Organized Practice (SOP) framework, the tool allows child welfare professionals ask the three key questions of SOP – "What are we worried about? What's working well? What needs to happen next?" – in a way that children can understand and respond to.

THE PROCESS

Social workers using the tool will present the child with pictures of three houses, or let the child draw their own. Children will have the opportunity to draw their own answers into the houses or have the child welfare worker record their responses. The tool can generally be explained to children as follows:

House of Worries: “This is the house where you can draw, write, or talk to me about those things in your home that worry you, that make you feel scared, upset, or sad.”

House of Good Things: “This is the house where you can draw, write, or tell me about those things in your home that make you happy, feel safe, and are fun.”

House of Hopes and Dreams: “This is the house where you can draw, write, or talk to me about what would be different in your house if your house of worries could go away.”

SHARING THE THREE HOUSES

After completing the Three Houses, the social worker will explain to the child what will happen next and ask the child if it is okay to share their Three Houses, and, if so, with whom.

If it seems safe for the child, the Three Houses will then be shared with the parents. When safe, sharing the houses is very important, as parents and others should understand how the child is seeing their situation so that they can make better informed decisions during the safety planning process. The Three Houses can also identify areas or situations of trauma that the child has experienced and should be included in the case plan. Working with children to identify trauma exposure is a critical area of assessment.

THE SAFETY HOUSE INFORMATION GATHERING TOOL

The Safety House tool, developed in 2009, grew out of a desire to include children’s voices and ideas in the safety planning process. It is used with a child or youth as part of the overall safety planning process and is designed to help the child or youth make sense of and participate in this safety planning process.

In using the Safety House tool, the outline of the house is first drawn by the child; then, the worker uses the structure of the Safety House to elicit the child or young person’s views about the specific safety arrangements that would need to be in place to make sure that any worries were addressed. The child’s views are recorded in the Safety House in both pictures and words. The child or young person then creates a “safety path” to their Safety House, locating themselves on the safety path as a way of representing his/her assessment (or scaling) of current safety within the family.

The Safety House is primarily a safety planning tool for use with children, but its use is not restricted to formal safety planning. The Safety House can also be used to seek a child’s views as part of the development of a reunification plan or as part of a family preservation program (seeking the child’s views on what would need to happen for him/her to remain in the care of his/her family and continue to be safe in relationship to the worries). It can also be used as part of a rapid-response conferencing process in a situation when a child may have been hospitalized following a significant alleged non-accidental injury. Wherever adults are talking together to explore future safety, the Safety House can assist in bringing this conversation to children in ways that they can make sense of and actively participate in the case plan.
BEHAVIORALLY-BASED CASE PLANS

SUMMARY

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

BASIC PRINCIPLES

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

ENGAGING THE FAMILY

- Behaviorally-based case plans cannot be created without the guidance, active participation and willingness of the family and their Safety Network.
- Engagement skills, including use of solution-focused questions, are critical to the case planning process and the family’s willing participation in the plan.
  - The more a family perceives the case plan as their idea, the more they will buy in to it.
  - A parent talking about “jumping through hoops” on their case plan is a sign to the social worker to work on engagement in case planning.
- Case plan development should occur after there has been a Child and Family Team (CFT) meeting (ideally before removal, but if the child has been removed, within 24 hours to 2 weeks after) to do Safety Mapping with the family and network; this can also be done as a “kitchen table” mapping. The Safety Mapping process helps us focus and develop the Harm Statement, Danger Statement and Safety Goal(s). Harm and Danger Statements and Safety Goals created with the family are key to developing behaviorally-based case plan objectives.

• Best practice and State mandates require that a CFT meeting occur to develop the case plan with the family and their team/network.
  - Complete the SDM Safety and Risk Assessments and a draft of the Child and Adolescent Needs & Strengths (CANS) before the CFT meeting where the case plan will be developed.
- Involvement of the family’s network of natural supports in case planning is critical to help define and describe what the parent’s behavior will look like when the worrisome behavior is not happening.
- Involve children/youth in case planning as they wish and as developmentally appropriate.
  - For younger children, you can utilize the Three Houses and/or the Safety House to incorporate the child’s vision of their parent’s future positive behavior into the plan.
  - Older children usually can explain their perspective on what their mom or dad is like when parenting at their best, and they can be part of a CFTM to develop the family’s case plan (if they wish).
- Always involve the Tribe in the CFT and case planning for ICWA cases. This is legally required and also vital to help build a culturally relevant plan for the family.

BUILDING THE CASE PLAN

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

HELPFUL TIPS

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

Use a trauma-informed lens when assessing reasons for the parent’s behavior, and make sure the case plan objectives help get to the underlying trauma.
○ Only include more objectives if there are genuinely more than 3 different sources of harm/danger.

○ The plan should focus on action steps that will help with the primary safety concern first.

○ If a parent does not have a network, building one should be an objective of the initial case plan.

○ Generally, when multiple safety concerns exist, substance abuse and/or mental health concerns should be prioritized before parent education, housing or employment, as success in these areas typically relies on the parent’s sobriety and stabilized mental health.

○ Mental health and substance abuse often need to be addressed simultaneously, as substance abuse is often self-medication of mental health challenges. However, for some individuals, it makes sense to treat one issue or the other first. If the parent has service providers for substance abuse or mental health, coordinate with them about how to best address and sequence treatment for both issues.

○ Consider whether parenting classes are genuinely necessary to resolve the safety concerns. Unless parenting was the primary safety issue, parent education — if needed — should typically follow other case plan objectives.

**USING A SOLUTION-FOCUSED APPROACH**

○ Building a behaviorally-based case plan requires skilled engagement, a willingness to partner with the family and their team to creatively identify strategies, and understanding that the family and their network are best equipped to describe what the parent’s behavior will look like when the problem is not happening.

○ Solution-Focused Questions are a critical tool to guide the case plan conversation during the CFT meeting, including:

  ○ Exception questions to help the family and their team/network identify when the concerning behavior wasn’t happening, i.e., “Has there ever been a time when you were able to stay clean and sober? How did you manage to do that? How was your parenting different when you were clean; what did it look like?”

  ○ Position/relationship questions to identify behavior from other perspectives, i.e., “What would your son say is his favorite thing about you as a mom when you’re sober?” “What new behaviors might your children want to see you doing to feel safe that no one will get hurt in your house again?”

**VISITATION/FAMILY TIME**

○ Visitation, or “family time,” is one of the most important pieces of the case plan. Family time should happen in the least restrictive way that is safely possible; for example, with a member of the network supervising, and/or in a location such as the home of a family member or friend.

○ In the CFT meeting, be sure to address what visitation could look like with the support of the network, what activities the parent can do during family time to show behaviors that will help them meet the safety goal, and at what case decision points visitation may be reassessed or made less restrictive.

**DOCUMENTING THE CASE PLAN**

○ After creating the case plan as part of a CFT meeting with the family and their network and selecting the top three or so objectives to address the Danger and Safety Goal, find the CWS/CMS objective that best fits these objectives. In the description section, rewrite the CWS/CMS objective language as a SMART objective, as developed with the family, and include the action steps/strategies to meet the objective.

○ Use language the family can understand. Write for a sixth-grade reading level. Avoid acronyms or jargon.

**HELPFUL TIPS**

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

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

**CREATING OBJECTIVES THAT ARE “SMART”**

<table>
<thead>
<tr>
<th>TERM</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td>Specific</td>
<td>Objectives should be written simply and should clearly define what the person will do.</td>
</tr>
<tr>
<td>Measurable</td>
<td>Objectives should be measurable so there is tangible evidence that they were accomplished.</td>
</tr>
<tr>
<td>Achievable</td>
<td>Objectives should be possible for the person to achieve.</td>
</tr>
<tr>
<td>Relevant</td>
<td>Objectives should be focused on something that relates to why the family is involved with child welfare (i.e., the objective is relevant to the Danger Statement and Safety Goal).</td>
</tr>
<tr>
<td>Results-Focused</td>
<td>Objectives are outcomes, not activities. They describe, in future perfect tense, the behavior the parent will have done that tells us the child is safe.</td>
</tr>
<tr>
<td>Time-Limited</td>
<td>Objectives should be linked to a timeframe.</td>
</tr>
</tbody>
</table>
• Objectives are outcomes, not activities. They describe, in future perfect tense (“will have ______”), the behavior the parent will have done that tells us the child is safe. Action steps detail the activities and strategies the parent will undertake to meet the objective, with the support of their network.

• Work around the CWS/CMS Microsoft Word case plan template as needed to develop a family-friendly plan that reflects the work you did with the family and their network. You can keep services under the Objective action steps or put them in the Client Responsibilities section, depending on practice in your county.

• Add the Danger Statement and Safety Goal that were developed with the family and network to the first page of the case plan document.

### INCORPORATING THE CANS

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

#### CANS CAREGIVER RESOURCES & NEEDS

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

• A draft of the CANS should be brought to the case planning CFT meeting. Ideally, information to inform the CANS would have been gathered during an ER CFT meeting. Otherwise, the social worker, Behavioral Health staff or whoever is responsible for completing the CANS would need to interview the child/youth, parents, resource parent, teacher and other providers and natural supports to gather the information to complete the draft CANS.

• CANS items that are identified as a priority need by the Child and Family Team must be incorporated into the case plan. The team should identify which priority needs to take action on and what other needs they expect to improve as a result. Priority items where the child needs to build a strength should also be included with a plan for how to achieve this.

• The CANS Caregiver section, completed for each parent (and resource parent), helps to prioritize areas of need that affect the parent’s ability to care for the child. Create case plan objectives that address the priority needs for each parent, utilizing the Caregiver Resources as strengths that can help address areas of need where possible.

### SPECIAL CASE ISSUES

• In cases where there is domestic violence, defined as a pattern of perpetrator behavior characterized by coercion and control, separate networks should be developed for each parent, and separate CFT meetings should occur to develop the case plan for each parent. Additionally, visitation should occur at a different time and location for the perpetrator than for the survivor of the violence.

• In cases where a youth has dual status (involvement with Child Welfare and Juvenile Probation), Probation needs to be part of the CFT and case planning process with the social worker, youth, family and their network.

### CASE PLAN ACCOUNTABILITY

• Add to the case plan the frequency of CFT meetings, when the network will check in on the progress of the plan, and how the parents, network and social worker will hold the mother, father and each other accountable for following through.

  - CFT meetings are required at least every 6 months with the case plan for all children in foster care, and every 90 days for children receiving Intensive Care Coordination, Intensive Home-Based Services or Therapeutic Foster Care services.

• At each CFT meeting, review the case plan with the team to assess progress and make any updates as needed. Be sure to address how the parent has demonstrated progress toward their behavioral objectives as a measure for whether family time can become less restrictive.
CASE PLAN OBJECTIVE EXAMPLES

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

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

Safety Network Example

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

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

Substance Abuse Example

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

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

Client Responsibilities

Substance Abuse Services
- Dad agrees to go to 90 NA meetings in the next 90 days, find a sponsor within 14 days, talk to the sponsor about his plan with CWS, and ask the sponsor to be part of his network. He will talk to the social worker and network about what he has learned in NA, the strategies he thinks will help him stay clean long-term, and how he has practiced them.

- Dad agrees to drug test as directed by the social worker. He understands that failure to test will be counted as a positive test.

Mental Health Example

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

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

CLIENT RESPONSIBILITIES

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

Domestic Violence Example

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

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

CLIENT RESPONSIBILITIES

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

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

SUMMARY

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

ROLE OF THE SUPERVISOR

- Supervisors are the key to helping staff transition from service-driven case plans to behaviorally-based case plans. The role of the supervisor includes:
  - Promoting the expectation that staff will create behaviorally-based case plans with families.
  - Helping staff understand the importance of skilled engagement in creating a case plan that has the full buy-in of the parents and their network.
  - Ensuring staff have developed Harm and Danger Statements and Safety Goals with families before developing the behaviorally-based case plan.
  - Ensuring staff hold Child and Family Team (CFT) meetings with families and their networks to develop the behaviorally-based case plan.
  - Ensuring the CANS is integrated as part of the CFT and priority needs/strengths inform the case plan.
  - Modeling creation of behaviorally-based case plan objectives and action steps.
  - Ensuring staff conduct family finding and build safety networks with the family and their natural supports.
  - Making sure the voice of the child/youth is included in the case planning process.

COMMON BARRIERS FOR STAFF

- Common barriers for social workers to creating behaviorally-based case plans include:
  - Lack of knowledge or confidence in how to develop behaviorally-specific objectives and action steps.
  - Lack of skill in developing Harm and Danger Statements and Safety Goals with families that inform development of behaviorally-based plans.
  - Worry about using creative or individualized solutions to families’ challenges rather than formal, cookie-cutter services.
  - Concerns that developing a behaviorally-based case plan with the family and their network in a CFT meeting will be too time-consuming.
  - Lack of skill or experience in helping families develop Safety Networks or engaging the network.

- For these reasons, it is critical that the supervisor set the expectation for, model, and practice developing behaviorally-based case plans with social workers who are new to this practice.

GETTING STARTED

- In your next supervision meeting after a social worker attends training on behaviorally-based case plans, discuss with them:
  - What do they like about these kinds of case plans?
  - What worries and questions do they have?
  - How will they work with the family to develop their network and engage them in case planning?
  - On a scale of 1-10, how willing are they to try using a CFT process to create a behaviorally-based case plan? On a scale of 1-10, how confident are they in their ability to create a behaviorally-based case plan? What are the barriers, and what strategies are needed to overcome them?
  - With the worker, look over a current case plan for a family and discuss how it could be made behaviorally-based rather than service-driven.
  - Discuss expectations for when services are indicated as part of a case plan and how they will link to behavior change.
  - Discuss use of family-friendly language in case plans and how the worker will ensure the family and network participate in creating the objectives and action steps.

GOAL SETTING & COACHING

1. Have the worker identify one family with whom they will conduct a CFT meeting to develop the case plan within the next few weeks. Attend the meeting with the worker, if at all possible. Discuss in supervision:
   - How was the process for the worker?
   - How did they feel about their ability to engage the family and network in developing case plan objectives and action steps?
   - What did they do in the case plan process that they are proud of and would do again next time?
   - What is something they wish they had done differently? What are their ideas to try next time?
   - On a scale of 1-10, how comfortable is the worker now with creating their next behaviorally-based case plan with a family?

2. Have the worker take the case plan information from the CFT meeting, put it in the CWS/CMS case plan section and customize the Word document to reflect the case plan objectives and action steps developed with the family. Review with them in supervision.

3. Develop a plan with the worker to move toward behaviorally-based case plans with all families on their caseload; i.e., they could start with all new families assigned to them from now on, then work to develop behaviorally-based plans with all families on their caseload for their next case plan update.
Child and Family Team (CFT) meetings are a primary intervention in Safety Organized Practice. CFT meetings are the process of bringing together the family and their network for a specific purpose in order to develop a plan to address worries and next steps.

**SOP AND CFT MEETINGS**

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

**WHEN SOP CFT MEETINGS OCCUR**

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

<table>
<thead>
<tr>
<th>SOP CFT MEETING DIALOGUE STRUCTURE</th>
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<tr>
<td><strong>Purpose</strong></td>
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<tr>
<td><strong>Context</strong></td>
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<tr>
<td><strong>Group Agreements</strong></td>
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<tr>
<td><strong>Network/Stakeholders</strong></td>
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<tr>
<td><strong>Desired Outcome</strong></td>
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<tr>
<td><strong>Content</strong></td>
</tr>
<tr>
<td><strong>Next Steps</strong></td>
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<tr>
<td><strong>+/Δ Feedback</strong></td>
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</tbody>
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- **Planning with Youth**: With the youth and their team, developing the Transitional Independent Living Plan or, for non-minor dependents, the Transitional Independent Living Case Plan.
- **Preventing Placement Disruptions**: Bringing together the child/youth, their caregiver and the network/team to develop a plan for intensive supports to help stabilize a placement.
- **Planning for Unsupervised Visits**: Developing a safe plan with the family and their network when moving from supervised to unsupervised visits.
- **Planning for Transition Home**: Developing a safe plan with the family and their network when a child is moving from FR to FM.
- **Developing Aftercare Plans**: Bringing together the family and their network to develop an aftercare plan that the network will implement in an ongoing manner after the case is closed.
- **Addressing Needs of Children/Youth**: Planning for additional services and supports when children or youth have behavioral health, educational, placement or other needs.
- **Permanency Roundtable**: Bringing together a child’s/youth’s team to focus on identifying and securing a permanent plan for the child/youth.
- **Other**: Any other specific purpose when there is a worry that needs to be addressed by the family and network/team.

**MEETING PARTICIPANTS**

- The quality of the network or team you build is vital to a successful CFT meeting process. Use tools such as genograms, ecomaps and the Circles of Support/Safety Circles with the parents, child and extended family to identify who should be part of the CFT meeting and become part of the network/team.
• Offer children and youth the chance to attend CFT meetings, as appropriate to age and development.
  o If the child/youth does not want to participate, complete the Three Houses and/or Safety House with the child to incorporate their voice into the worries, working well and next steps at the CFTM.
• For families in Emergency Response referrals or FM/FR cases, work with the parent and child/youth to identify and select CFT meeting participants. Skilled engagement with parents can almost always result in their willingness to include necessary team members, even if they are initially reluctant and afraid to do so.
• For youth in Permanency Planning or Extended Foster Care, work with the youth to identify and select CFT members. They may wish to include important adults, friends, or their boyfriend/girlfriend on their team.

### MEETING STRUCTURE & DOCUMENTATION

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

### POTENTIAL CHILD & FAMILY TEAM MEMBERS

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

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

### CALIFORNIA STATE MANDATES FOR CFT & CANS

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

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

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

1. **Required Participants**
   To meet CFT requirements, team members must include the child/youth, family, social worker, child’s current caregiver, tribe, Foster Family Agency social worker and/or Short-Term Residential Therapeutic Program *(STRTP)* representative, as well as behavioral health staff when the child is receiving or may need specialty mental health services *(SMHS)*, including Intensive Care Coordination *(ICC)*, Intensive Home Based Services *(IHBS)*, or Therapeutic Foster Care *(TFC)*.

2. **Meeting Timing/Frequency**
   CFT meetings must occur:
   o **Within 60 days of the child’s placement in foster care**
   o **Every 90 days for youth receiving ICC, IHBS or TFC**
   o **Every 6 months with case plan creation for youth not receiving SMHS**
   o **For possible placement changes**
   o **As frequently as needed to address needs of the child/youth, including the need for new or increased SMHS**

3. **Focus on the Child/’Youth’s Needs**
   CFT meetings must include specific discussion regarding the placement, behavioral health and other needs of the child/youth, and a plan to meet those needs. The Child and Adolescent Needs and Strengths *(CANS)* must be completed in partnership with the Child and Family Team and used to inform the case plan.

### SOP & CANS

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

### Summary

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

SUMMARY

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

ROLE OF THE SUPERVISOR

- Supervisors play a critical role in ensuring consistent, meaningful use of Safety Organized Practice Child and Family Team (CFT) meetings. This includes:
  - Promoting the value and importance of CFT meetings with staff.
  - Ensuring staff hold CFT meetings for imminent risk of removal, safety planning, case planning, placement changes, return home, case closure, and other key case decision points.
  - Modeling meeting facilitation for staff.
  - Attending CFT meetings and ensuring the worker is direct, honest and clear about the safety concerns that led to the involvement of CWS.
  - Ensuring staff conduct family finding and build safety networks with the family and their natural supports.
  - Making sure the voice of the child/youth is included.
  - Ensuring the CFT meeting process is used to complete the CANS.
- While dedicated CFTM facilitators are an outstanding resource, SOP also recommends that all social workers be capable of using CFTM facilitation as a tool with families.

COMMON BARRIERS FOR STAFF

- Staff typically cite time as a barrier to CFTMs. Help them understand that CFTMs replace rather than add to work by saving time that would have been spent on multiple meetings, calls or interviews. The family’s network can also assist with many case-related tasks.
- Social workers often feel anxious about facilitating CFT meetings and need modeling, encouragement and support to facilitate their first meeting.
  - Once staff attend meeting facilitation training, have them try facilitating within a week after the training.
  - Use the “see one, scribe one, do one” model to have staff observe a CFTM, then scribe while someone else facilitates, then facilitate. Be cautious of staff getting stuck in the “see” or “scribe” phase; practicing facilitation is the only way to develop a level of comfort with it.
- Some social workers struggle to be completely direct and transparent with families about the harm, danger and worries that brought the family to the attention of CWS. Attend CFT meetings regularly with your staff, and use reflective coaching strategies to provide feedback.

GETTING STARTED

- Talk with your worker about CFT meetings.
  - What do they like about CFT meetings?
  - What worries or questions do they have?
  - How will they work with the family to develop their network?
  - Are they willing to try facilitating a meeting? If not, what are the barriers and what strategies are needed to overcome them?
  - On a scale of 1-10, how comfortable do they feel facilitating? What would it take to move up one?
- Discuss how the worker will use a trauma-informed approach in CFTMs. This includes being transparent about the process, giving the family choices whenever possible (such as letting the family sit first and decide to start with Worries or Working Well), observing meeting participants for trauma responses, and providing closure at the end of the meeting.

GOAL SETTING & COACHING

1. Have the worker identify one family with whom to conduct a “kitchen table” CFTM within the next week (i.e., a mapping with just the parents or the parents and one or two support people). Discuss in supervision:
   - How was the process for the worker?
   - Were they able to engage the family in identifying worries, working well and next steps?
   - What did the worker do in the meeting that they are proud of and would do again next time?
   - What is something they wish they had done differently? What are their ideas to try next time?
   - On a scale of 1-10, how comfortable is the worker now with facilitating their next CFTM?
2. Have the worker identify a family with whom to conduct a more formal CFTM within the next week, with the extended network present. Discuss in supervision the same questions listed above.
3. Have the worker document the CFT meeting in CWS/CMS; review their contact note and provide feedback.
4. Have the worker use a CFT meeting to create a behaviorally-based safety plan or case plan (including use of the CANS for the case plan). Discuss:
   - What do they think they did well in using the CFTM to create the safety plan or case plan? What is one thing they would change for next time?
5. Have the worker incorporate information from CFTMs into a court report. Discuss:
   - What do they think they did well in incorporating CFTMs into the report? What is one thing they would change for next time?
The Circles of Support is a tool to explore with a family who their natural support network is and who may be built into a formal Safety Network to help ensure the safety of the child in the care of the parent.

**PREPARING WITH PARENTS**

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

**COMPLETING THE CIRCLES OF SUPPORT**

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

**HELPFUL TIPS**

- Ask the parents if there was someone who used to be important to them, but who they no longer talk to. What would it take for them to reach out to heal the relationship?
- Be mindful of cultural aspects of a parent’s reluctance to share information with people in their network. Explore what would help them overcome their discomfort.
- Adults who aren’t capable of being part of the safety plan can still be part of the network by supporting the parent.
ADDRESSING RELUCTANCE/AMBIVALENCE

- Parents may be reluctant to share information about their network. Express empathy and be clear about why the information is needed.
  - “I know this is tough for you, and I get that you don’t want to do this. For us to be able to move to unsupervised visits, return your child, close your case, I need to know more people are working together to keep your child safe. If you had to pick one person to attend a meeting, who I would tell all the good things I see you doing as well as what I’m worried about, who do you think it should be?”

- Ultimately, if a parent doesn’t want a network involved, it is their choice. However, services do not equal safety. Continue to work through the parent’s ambivalence while expressing the need for a Safety Network if the parent wants to achieve his/her goals (i.e., getting their child back, closing the case).

SAFETY NETWORK

- The next step is developing individuals identified in the Circles of Support process to actually become the child’s Safety Network. Discuss with the family/team:
  - Of all these people, who do you think would be important to have as part of the Safety Network?
  - Is there anyone you would not want in the network? How come?
  - How will we decide whether someone is part of the Safety Network?
  - What do people need to know if they are going to be part of the Safety Network?

- If a family has no one who can be part of a Safety Network, or has an inadequate network to ensure child safety, building a network must be a primary part of the initial case plan.

- There is no specific number of people needed to be part of the network; every situation is different and determined by:
  - Level of risk and potential future danger
  - Age and vulnerability of children

- The Safety Network needs enough people to meet the day-to-day arrangements required in the safety plan.

- Genograms and ecomaps are useful tools for developing the Safety Network, as well as for family finding/connection for the child.

- Additional questions that can help you explore a potential Safety Network include:
  - “Who are the people that you really trust?”
  - “Who are the people who know you at your best?”
  - “If you suddenly became sick, who would you trust the most with your children? Who would you want to take you to the doctor?”
  - “Who would your kids say they trust the most?”

SOP QUICK GUIDE: CIRCLES OF SUPPORT

- A safety network is a group of responsible adults (family, friends and professionals) who:
  - Care about the child and family
  - Are willing to meet with Child Welfare Services
  - Understand the concerns about harm and danger that CWS and others have
  - Are willing to do something that supports the family and helps keep the child safe

- “If we had to pick one person to start with to come to a meeting to start sharing about our work together, who would you want it to be?”

- Talk directly to children/youth about who is important to them, who they love and who they feel safe with.
  - Children are able to complete genograms/family trees at a young age, to the extent of their developmental capacity.
  - Who is their favorite grownup, besides their mom or dad, to do fun things with?
  - If the child had a worry, which grownup would they talk to about it?

- If potential Safety Network members don’t seem “appropriate”:
  - Be willing to meet with anyone, even if it’s not someone you think will be helpful.
  - Follow similar procedures for child visitation (i.e., background check) to assess for safety.
  - Someone who may not be able to help keep the child safe may be a valuable support in other ways, i.e., taking the parent to AA/NA meetings.

- Discuss with the network how accountability will be managed.
  - How do we make sure the network is doing what they agreed to do?
  - What will we do if the network does not do what they agreed to do?
  - How often will Child and Family Team meetings happen?

OTHER USES OF NETWORKS & THE TOOL

- Networks don’t only have to focus on safety. The network can tackle issues such as concurrent planning, healing from trauma, education success, transition to successful adulthood, and more.

- The Circles of Support is a great tool to use with older youth in permanency to explore who is important to them. Work with the youth to fill in who they are very close to in the middle, who they are somewhat close to in the next ring, and who they used to be close to in the outer circle.
CIRCLES OF SUPPORT

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

GETTING STARTED

- Ask the worker to review their notes from Circles of Support (sometimes called Safety Circles) training with you.
  - What do they like about the Circles of Support tool?
  - What worries do they have about using it?
  - What questions do they have?
  - On a scale of 1-10, how comfortable do they feel trying it out?
- Discuss how they will go about trying it the first time.
- Have them role play doing the tool with you.

GOAL SETTING & COACHING

1. Have the worker identify a parent to try out the Circles of Support with one-on-one in the next week. Discuss at supervision:
   - How was the process of completing the tool?
   - How did the parent respond?
   - Was the worker able to engage the parent in a way that he or she answered questions and participated?
   - Does the worker feel the tool elicited more, or different, information if they had they interviewed the parent differently? In what way?
   - How many individuals were identified?
   - What did the worker observe or learn about the impact of trauma on the parent or family system?
   - What did the worker think they did well that they would do again next time?
   - What is something the worker wishes they had done differently? What are their ideas to try next time?

2. Have the worker complete the Circles of Support process during a Child and Family Team (CFT) meeting. Attend the meeting if possible. Discuss afterward:
   - How was the process of completing the tool?
   - How did the group respond?
   - Were there any group conflicts that arose during the discussion? How did the worker resolve them?
   - How many individuals were identified?
   - Was the worker able to begin developing a viable Safety Network?
   - What did the worker observe or learn about trauma and the family system?
   - What did they think they did well that they would do again next time?
   - What would they like to do differently next time?
   - What other steps will the worker take to continue expanding the network?

USING THE TOOL IN DOCUMENTATION

1. Have the worker document completion of the Circles of Support in CWS/CMS.
   - Review their contact note and provide feedback.
   - Ensure relatives identified through the process are documented appropriately in CWS/CMS.

2. Have the worker use information from the Circles of Support to inform a Safety Plan or behaviorally-based case plan. Discuss:
   - How was the Safety Network involved in the developing the plan?
   - How will the worker help the Safety Network ensure accountability to the plan?
   - How will the worker monitor the plan?
   - What do they think they did well in creating the case plan? What would they change for next time?
   - Continue to discuss the plan’s effectiveness in ensuring child safety, and how the worker is monitoring this, regularly in supervision.

3. Have the worker incorporate the Circles of Support into a court report. Discuss: What do they think they did well? What would they change for next time?
CONSULTATION & INFORMATION SHARING FRAMEWORK®

The Consultation & Information Sharing Framework® is a tool to structure staffings, consultations or Child and Family Team (CFT) meetings about a referral or case. It is both a tool to guide the staffing or meeting and to document and organize the information discussed.

The Framework helps guide social workers and supervisors to ensure they:

- Gather all information needed to make decisions about a referral or case, through effective engagement and interviewing skills and approaches.
- Organize all available information about a family’s situation and child safety, using categories to assist in sorting complex information.
- Use critical thinking skills to clarify information that is unknown, incomplete, or speculative (guessing).
- Develop risk statements to help analyze information, with a clear description of the actual risk (harm/danger) to the child/youth, as well as the context (behaviors and/or environments) that must be remedied through safety goals and next steps.

The Framework can be used in internal (i.e., staff only) consultations or staffing regarding referrals and cases, including:

- Individual case consultation between a worker and supervisor or group of workers and supervisors.
- Group supervision, with a supervisor and their unit.
- Review, Evaluate, Direct (RED) Teams, which are a group decision-making process for Emergency Response hotline calls received. See SOP Quick Guide: RED Teams

Additionally, the Framework can be used as the guiding agenda for Child and Family Team (CFT) meetings to explore with the family and their network the harm/risk, safety, supporting strengths and next steps needed.

COMPLETING THE FRAMEWORK

The Framework tool is shown below. Walking through it line by line, here is how to complete it.

### Reason for Referral
- Detail re: incidents bringing the family to the attention of the agency. Impact on children.
- Pattern/history

### Risk Statement(s)
- Risk to children
- Context of risk

### Complicating Factors
- Condition/behaviors that contribute to great difficulty for the family
- Presence of research-based risk factors (SDM)

### Safety/Belonging
- Strengths demonstrated as protection/connection over time
- Pattern/history of exceptions

### Strengths/Protective Factors
- Assets, resources, capacities within family, individual community
- Presence of research-based protective factors

### Purpose/Focus of Consultation/Meeting
- What is the worker/team looking for in this consult? Purpose of meeting?
Complicating Factors
- Complicating factors are conditions that cause difficulty for the child or family but are not specifically the parents’ behavior and its impact on the child. On their own, these factors would not be a reason for removal.
- In the research-based risk factors line, note identified areas of risk from the SDM Risk Assessment.

Genogram/Ecomap
- Provide a brief genogram (like a family tree) and/or ecomap (diagram of the family’s connection with services and other supports) to provide information about who is in the family and what supports are present.

Gray Area
- Gray Area refers to information about the family, the referral, or the safety of the child that we don’t know, are guessing at, or are making up ideas about. It requires further inquiry, investigation or information.

Next Steps
- What is needed for the agency to not be involved with the family? What are the goals of the family? Of the agency? Where does the family/agency want to be?
- Immediate Progress = what needs to happen right now to ensure child safety?
- What acts of safety/protection are required?
- What are the specific next steps, who will do them, and by when?

Safety/Belonging
- Safety is acts of protection by the parent or caregiver that mitigate the danger, demonstrated over time.
- Belonging is acts of connection, or people who are important to the child, demonstrated over time.
- Safety and belonging are shown by a history or pattern of exceptions to the behavior that is causing harm or danger to the child, i.e., times that the parent was clean and sober, times when their mental health was stable, times when family violence was not happening, etc.

Strengths/Protective Factors
- Strengths are positive things about a family or their situation that in and of themselves do not ensure safety, including assets, resources and capacities within the family or community.
- Strengths are also the presence of research-based protective factors per the SDM Family Strengths & Needs Assessment (FSNA).

Purpose/Focus of Consultation/Meeting
- Case Consultation: What specifically is the worker looking for in having this case consult?
- Meeting: What is the purpose of the child and family team meeting? (For example, to make a decision about removal, placement, return home or case closure.)

Current Ranking
- On a scale of 1-10, where do we rate how safe the child is right now?
- Where does the agency rate it? Where do the parents rate it? Where does the network rate it?

Partnering (Scaling)
- Scale the family’s and network’s willingness, confidence and capacity to keep the child safe.

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Sample Questions to Ask to Complete the Consultation & Information Sharing Framework®

**Genogram**
- Married? Significant relationship? Male? Female?
- Other people who provide support? Friends? Daycare? School? Work? Tribal connections?
- Race/ethnicity/cultural identity/considerations?

**Ecomap**
- Who else is involved with the family? Formal service providers? Practical support people? Tribe? Elders?
- Nature of relationships? Supportive? Hurtful? Other?

**Gray Area**

**Reason for Referral**
- What brought the family to the attention of the agency? Provide details; move from generalities to specifics.
- Who is reported to have done what to whom? Specifically what are the descriptions of what happened?
- What is known about the impact on the children? Their actions/reactions? How vulnerable is the child (age, special needs, etc.)?
- What, if any, alternative explanations are there?
- What is known about any previous pattern and history of behavior?

**Strengths/Protective Factors**
- How are the children doing? What is known about their development? What kind of activities do they participate in? If in school, what is known about academic progress? General descriptions – Intelligent? Attractive? Active? Outgoing? Empathic? Humor? Who are the adults in their life that provide good support? Friends and social interactions? Responsibilities at home (chores, pet care, etc.), extracurricular activities, job?
- What is known about safe and effective parenting practices – time outs (age appropriate), time in (catching children being good and complimenting), revocation of privileges (reasonable), etc.?
- What is known about attentive parenting – knowledge about child schedules and activities, school work and activities, follow up on health concerns, dental health, and mental health?
- What is known about parent employment? How long employed? How does the money resource the family/children in terms of basic needs and extras?
- What is known about parent education levels and completion? What plans to continue or complete?
- What is known about parent health, physical/mental?
- What adult supports do the parent(s) have? Who do they turn to when they need help?
### Complicating Factors

- What internal resources do the parents have – how have they managed difficult or stressful times successfully in the past? When were there times that they might have made unhealthy choices and did something healthier instead?
- How do the caregivers manage frustration? Anger?
- Transportation available? Public transportation accessible? Car? Driver’s license?
- Daycare? Competent caregiver? Evidence of communication between parents and provider?
- Hazards out of reach? Leave information for older children on how to reach them? Children know their full names and names of parents, where they live, phone numbers? Guns locked and ammunition locked separately? Smoke and carbon monoxide detectors in place and operational? Evidence of well-child checks and medical attention when needed? Immunizations up-to-date?
- Parents engaged in play? Knowledge about how to interact with children given ages and stages?
- Observations of interactions by social worker and other involved adults?
- Knowledge of community resources?
- Parent activities? Church? Sports? Community?
- Safe sleep practices? (Are infants in their own sleeping space? Proper ventilation? Free of bedding, toys, etc.?)
- What is known about the care of pets? Are they fed, trained, interactions with children, shots, etc.?

### Risk Statement(s)

- Member of a marginalized population – history of oppression/denied access/opportunity?
- Evidence of animal/pet cruelty?

### Safety

- What strengths have been demonstrated as protection over time? Caregivers free of alcohol/drugs? Children well cared for and thriving? Basic needs met over time?
- Support people active in safety plan development and implementation? Safety plans tested and working? Constructive working relationship between social worker and family members (straightforward conversations, shared understanding of goals, willingness to disclose and work through gaps and challenges, etc.)? Collaboration among professionals (involved providers talking with each other alongside family members)?
- Caregivers meeting medical, dental and mental health needs of children consistently? Evidence of stability and security of care for children – parenting and/or co-parenting and primary and multiple attachments. Evidence of parents/caregivers providing consistent care and supervision for children specific to their developmental and any additional needs?
- Caregiver behaviors and emotions regulated? Details?
- Caregiver able to respond to child distress and provide calm environment? Details?
- Living environment free of hazards/toxins? Details?
- Living environment free of major stressors and/or those stressors managed and supports in place? Details?

### Belonging

- What relationship strengths have been demonstrated as meaningful connection over time? Attachment with a primary caregiver? Length of time in that person’s care? Multiple attachments with consistent caregivers?
- Evidence of relationships with additional competent adults? Siblings? Others? Details? How enduring have these relationships been? Pattern and history of contact?
- Connections to culture? Ethnicity? Sense of identity? Opportunities to learn family primary language? Access to and opportunities to learn cultural practices and traditions? Access to extended family?
- Relationships consistent and stable? Child/young person able to count on these relationships on a daily basis? Seek help? Seek support? Evidence of child/young person seeking help and/or support?

### Risk Statement(s)

- What are you worried will happen to the child(ren)? (RISK) – Specific detail, specific people named, in language everyone can understand.
- When are you most worried that will happen? (CONTEXT) – Specific detail, specific people/actions named, in language everyone can understand.
- (Child name) may be (risk) when/if (context).

### Safety/Belonging Statement(s)

- The risk of __________ to __________ (child name) when__________ (context) is being/has been addressed by __________ (safety/belonging that addresses the context of risk). Provide specific detail, specific people/actions named, in language everyone can understand.

Adapted from Lorbach ®2000
HARM & RISK/DANGER STATEMENTS

SUMMARY

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

PURPOSE

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

TERM | DEFINITION
--- | ---
**HARM** | Actual experiences of past/current harm to a child by a caregiver.

- **DANGER/RISK** | Worries that the caregiver’s behavior may cause harm to the child in the future.

- **COMPLICATING FACTORS** | Things we are worried about but are not actual harm to the child by the caregiver.

- **SAFETY** | Acts of protection by the caregiver demonstrated over time.

- **SUPPORTING STRENGTHS** | Positive things in a family’s life that do not specifically address the danger.

HARM STATEMENT

- The Harm Statement is a clear, specific description of the parent(s)’ past (or current) behavior and what harm happened to the child as a result.
- The Harm Statement contains three parts: who reported the concern (unless this violates reporting party confidentiality), what happened specifically, and impact on the child.

- **HARM STATEMENT ELEMENTS**
  - It was reported
  - What caregiver actions
  - Impact on the child

- **DANGER STATEMENT ELEMENTS**
  - Who is worried
  - What caregiver actions
  - Impact on the child

- **DEVELOPING HARM & RISK/DANGER STATEMENTS**
  - Harm and Risk or Danger Statements should align with the safety threats identified on the SDM Safety Assessment tool, or if no safety threats were identified, the area(s) on the SDM Risk Assessment tool that we are worried will cause future danger to the child.
  - Developing a preliminary or “working” version of the Harm and Risk/Danger Statement can begin with the first phone call to the intake hotline, which is helpful in beginning to identify the harm that happened to the child, what we are worried may happen and what are the complicating factors involved. However, the true Harm and Risk/Danger Statements should be developed with the family and their Safety Network.

Intake/Screening

- Ask thorough questions to identify the parent’s behavior and the impact on the child. For example, if the caller says the mother is “mentally ill” or “using drugs,” how do they know this? What does her behavior look like? What is the impact on the child?
• Does the caller know if there has ever been a time that the problem was not happening for the family? What did the parents’ behavior look like during that time?
• Are there other things the caller is worried about in the family, but which are not harm or danger to the child?
• Include a preliminary Harm and/or Risk or Danger Statement in the Screener Narrative. Also specify any Complicating Factors that were identified.

Investigating Social Worker
• After Intake has developed a working Harm and Risk/Danger Statement, the investigating social worker should schedule a CFT meeting to conduct Safety Mapping with the family and develop the true Harm and Danger Statements with the family and their network. See SOP Quick Guide: Safety Mapping.

SAFETY GOALS
• Safety Goals are developed from the Harm and Risk/Danger Statements; they are clear statements, usually a few sentences long, about what actions the caregiver(s) will take to help everyone involved with the family know that the child will be safe.
• Safety Goals serve as the “goalpost” for what it will look like when the family successfully completes their safety plan or case plan.
• As much as possible, use the family’s own language to create the Safety Goal.
• Make sure the Safety Goal clearly states the agency’s bottom lines that will affect its decision-making.
• Safety Goals should align with the Risk/Danger Statement, SDM Safety Assessment and Family Strengths and Needs Assessment.

SAMPLE HARM STATEMENT, RISK/DANGER STATEMENT & SAFETY GOAL

<table>
<thead>
<tr>
<th>Harm Statement</th>
<th>Danger Statement</th>
<th>Safety Goal</th>
</tr>
</thead>
</table>
| The police reported that dad punched mom in the face and tried to strangle her while she was holding the baby and 4-year-old Jeremy was in the room. | CWS, mom and grandma are worried that dad will do something to hurt mom in the future and that the baby or Jeremy will get hurt when dad hurts mom, that the baby and Jeremy could have their brain development and well-being affected by watching their dad hit or strangle their mom, or that dad could even kill mom and the children will be left without their mother. | Dad will work with a network of family, friends and professionals to create a plan that will show everyone that:
• He will not text, call or contact mom or her family members outside an agreed-upon schedule.
• He will make sure mom has total access to her own money and full control over seeing her own family and friends.
• He will always refrain from calling mom names, hitting her, or using any other forms of violence.
Mom will work with a network of family, friends and professionals to create a plan that will show everyone that:
• She will reach out to her support people to manage her feelings about being by herself.
• She understands the reasons she stayed in a relationship where there was violence, how to identify signs of violence, and how to keep herself and her children safe from exposure to violence in the future.
CWS will need to see this plan in place and working continuously for at least 6 months to reassess whether to recommend shared custody with dad. |

Note: Use the parents’ actual names, not “mom” or “dad,” in the Harm Statement, Risk/Danger Statement and Safety Goal.
SAFETY ORGANIZED PRACTICE QUICK GUIDE

RED TEAMS

SUMMARY

Review, Evaluate, Direct (RED) Teams are a group decision-making process at the Intake/Screening level to evaluate hotline referrals and determine the appropriate child welfare intervention and response time.

PURPOSE

- The purpose of Review, Evaluate, Direct (RED) Teams is to provide a multidisciplinary group decision-making process as part of the screening decision for calls to the Child Welfare hotline. Potentially all hotline calls received by the agency are reviewed by the group to determine if referrals meet criteria for an in-person response and whether an immediate or 10-day response is indicated.
- RED Teams use a group consultation framework to support information-gathering, analysis and decision-making about the appropriate response to CWS referrals. Instead of the decision resting on one person, a group determines the necessity and timing of a response.
- RED Teams also can help ensure that the Structured Decision Making (SDM®) hotline tool is completed accurately and improve consistency of CWS agency decision-making.
- Each county determines its own criteria for which referrals are reviewed as part of the RED Team process. Ideally, every suspected child abuse report made to the hotline would be reviewed by the RED Team; however, in larger jurisdictions, this may not be feasible.
  - The RED Team process should never cause a delay in response time for immediate referrals; each county should structure their process accordingly.

RED TEAM MEMBERS

- Members of RED Teams include Child Welfare staff and supervisors, other county partners (such as Mental Health or Public Health) and community partners when possible, as determined by each county.
  - For new referrals on open cases, the case-carrying social worker should participate in the RED Team staffing of the new referral.

POSSIBLE RED TEAM MEMBERS

<table>
<thead>
<tr>
<th>Hotline screener</th>
<th>Domestic violence advocates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Response supervisor</td>
<td>Mental or behavioral health providers</td>
</tr>
<tr>
<td>Additional CWS social workers or supervisors</td>
<td>Substance Use Disorder specialists</td>
</tr>
<tr>
<td>Tribal social workers</td>
<td>Law enforcement</td>
</tr>
<tr>
<td>Public Health Nurses or other medical providers</td>
<td>Members of other appropriate community agencies</td>
</tr>
</tbody>
</table>

- All members of the RED Team are considered to have an important voice in the RED Team process. Community partners attending for the first time may need training regarding SDM definitions and Welfare and Institutions Code (WIC) §300.

RED TEAM PROCESS

- Generally, RED Teams are scheduled every weekday, once or twice per day (i.e., daily at 8:30am), depending on the volume of calls received by the agency.
- The RED Team process is typically as follows:
  - The SDM Policy and Procedure Manual and WIC are in the room to reference as referrals are discussed.
  - The screener or social worker who took the hotline call (or another CWS staff person, if necessary) presents the referral out loud to the group.
  - While the social worker presents the referral, another team member organizes the information on a white board or computer projector screen, using the Consultation and Information Sharing Framework® or a similar case staffing tool.
- Areas discussed about each referral include:
  - Reason for referral
  - Who is in the family (genogram)
  - Family supports (ecomap)
  - Review of CWS history
  - Harm/risk/danger
  - Complicating factors
  - Safety/acts of protection
  - Supporting strengths
  - Gray area (unknown/incomplete information)
  - Next steps
- Team members ask questions to ensure information is clear and adequate to make an appropriate decision.
  - If there are many areas of speculation or questions that cannot be answered, the team may ask the screener to call back the reporting party to obtain additional information.
- Be mindful of and call out issues related to cultural humility and bias in decision-making.
- Once the information is organized and documented, the team determines if the report requires an in-person response and in what timeframe.
  - The group reviews the SDM Hotline Tool to ensure it was completed accurately and that any items marked meet the appropriate definition.
  - For in-person responses, the group determines the appropriate response priority and whether it should be a joint response with another agency.
- If SDM overrides are utilized, the reason should be well-documented, and it should be noted that the RED Team made the decision to override.

Working with the Child

- Use the Safety House to incorporate the child’s voice into case planning in Family Maintenance cases or transition planning in Family Reunification cases.
- Make the Safety House process as open and transparent as possible to parents and the child.
  - Explain to the parent(s) that the purpose of the tool is to get the child’s perspective about what needs to happen to ensure his or her safety at home.
- Evaluate, on a case-by-case basis, whether to do the tool with siblings together or separately.
  - Completing it with siblings may reassure younger children and engage teens.
  - Completing it separately with each child can help you get information from their unique perspective.
- Explain to the child what the Safety House is and why you want to complete it.
  - “The Safety House is your ideas about how your home would be if you felt safe all the time. We’ll talk about who can be at the house and what the rules of the house are so you can feel safe.”
- Ask the child’s permission to do the Safety House and tell them about confidentiality limits.
  - “Sometimes when I do the Safety House, kids tell me things I feel worried about and have to talk with other people about, but if so, I’ll tell you I have to do that. Are you still OK to do the activity with me?”
- If the child wants an adult to stay near, ask them to sit apart from you and the child to quietly observe.
- Help the child draw the house framework as needed (or provide a pre-drawn template, if the child prefers).
  - Let them write or draw as much as they want.
  - Offer to write or draw if they don’t want to.
- Check in with the child as you go.
- Watch for signs of trauma or stress; this can include the child seeming distracted or unable to sit still, “spacing out” or “checking out,” or even leaving the activity. Know when kids have had enough, and stop if needed.

Interviewing for the Tool

- Have the child draw themselves in the inner circle of the house, with space to draw other people.
- Guide the child in completing the Safety House by asking the following questions.

People Who Live in the Safety House

- “Who else would live in your Safety House with you?”

What People Need to Do in the Safety House

- “Imagine that your home with your mom/dad was safe, and you felt as safe and happy as possible. What kinds of things would your mom/dad be doing?”
- “What are the important things your mom/dad would do in your Safety House to make sure you are safe?”
- “Are there any important things that need to be in your Safety House to make sure you are always safe?”

Visiting the Safety House

- “Who would come visit you in your Safety House to help make sure you are safe?”
- “When they visit you in your Safety House, what are the important things they need to do to help you be safe?”
- “How often would they visit?”

Rules of the Safety House

- “What do you think the rules of the house would be so that you and everyone would know that nothing like ________ would ever happen again?” (Use the child’s specific worries from the Three Houses or other prior interviews.)
- “What else?” (Keep prompting for more rules.)
- “If your (sister/brother/grandma/auntie) was here, what would they say the rules should be?”

People the Child Doesn’t Feel Safe With

- “When you go home to live with mom/dad, is there anyone who might live with you or come to visit who you would not feel completely safe with?”
Path to the Safety House

- “If the beginning of the path is where everyone was very worried and you weren’t able to live with your mom/dad, and the end of the path at the front door is where all those worries are fixed and you will be completely safe living with mom/dad, where do you think you are now?”
- “If the beginning of the path is that you feel very worried that if you go home to live with mom/dad, she/he will start _______ again and not be able to look after you, and the end of the path at the door is that everything in your Safety House is happening and you’re not worried at all that mom/dad will _______ again, where are you right now?”
- “What would need to happen for you to take one step closer to the door?”
- Work to elicit concrete details from the child to narrow the focus specifically on the impact of the caregiver’s actions, identifying harm/danger and safety.

WRAPPING UP

- Explain you would like to share the child’s Safety House with their parent(s).
  - Ask the child if they want to be there to share it or want you to do so without them.
  - If they do not consent to share with their parent(s), ask if there is a “safe” person they would like to share their Safety House with.
- In cases of immediate child safety threats, explain what you need to do and why, and what will happen next.
- End with closure of the Safety House process.
  - Tell the child they did a great job and give specific praise whenever possible.
    - For example: “You wrote so well! You were so clear about what the rules are in your Safety House! It’s so brave how you were able to say exactly who could visit and who couldn’t.”
  - Ask if they have any worries about doing the Safety House or if they think there is anything you should change for next time you complete it with another child.
  - Thank them for doing the Safety House with you.

SHARING WITH PARENTS

- Begin by explaining the Safety House process and ask what the parent thinks the child might have said about their Safety House.
  - Who do they think the child would want to live in the house?
  - Who do they think the child wanted to visit them, and who did not want to ever visit the house?
  - What do they think the child would want the rules to be?

- Show the Safety House to the parent. Ask what they notice most, what their child’s Safety House brings up for them, and what they think needs to happen next.
- Observe the parent’s reaction to the child’s words and pictures.
  - Do they agree with the child’s house rules?
  - Do they agree about who can live there, visit and not visit?
  - Are there rules the parent thinks need to be added to keep the child safe?
- Ask the parent what they think would need to happen for the Safety House to be a reality.
- On a scale of 1-5 (or 1-10), how ready does the parent think they are to create the Safety House the child described?
  - Use scaling coaching to explore the parent’s self-scoring. For example, if they are a 3, what would it take to get them to a 4? If they are a 5, why are they a 5 and not a 4?

UTILIZING THE INFORMATION

Using the Safety House with the Network

- Use the Safety House to bring the child’s voice into the Child and Family Team (CFT) meeting process.
  - A child should never be returned home if there is not a Safety Network in place that has been part of a CFT meeting process.
- When developing a Family Maintenance case plan or a plan for transition home that incorporates the child’s Safety House, specify how the Safety Network will support the plan.
- Develop “fire drills” to test the capacity of the Safety Network to follow through on the plan.
  - For example, if the plan is that the child will call grandma to be picked up if mom or dad are doing ________, have the child actually practice calling grandma once a week and have grandma come to the house.

Case Plans

- Use the information the child provided for the Safety House to help define what behaviorally-based case plan objectives for the parent(s) would look like.

Court Reports

- Use the information gained in the Safety House process to incorporate the child’s/youth’s perspective, in their own words, into your court report.
THE SAFETY HOUSE

GETTING STARTED

- Ask the worker to review their notes from Safety House training with you.
  - What do they like about the Safety House?
  - What worries do they have about using it?
  - What questions do they have?
  - On a scale of 1-10, how comfortable do they feel trying it out?
- Discuss how they will go about trying it the first time.
- Have them role play doing the tool with you.
- Discuss how the worker will use a trauma-informed approach to using the tool (being transparent about the process, giving the child choices whenever possible, observing the child for possible trauma responses, letting the child decide if the tool can be shared with others, providing closure at the end of completing the tool).

GOAL SETTING & COACHING

1. Have the worker identify one child to try out the Safety House with in the next week. Discuss at supervision:
   - How was the process of completing the tool?
   - How did the child respond?
   - Was the worker able to engage the child in a way that he or she answered questions and participated?
   - Does the worker feel the tool elicited more, or different, information if they had they interviewed the child differently? In what way?
   - What did the worker observe or learn about the impact of trauma on the child?
   - What did the worker do well that they would do again next time?
   - What is something the worker wishes they had done differently? What are their ideas to try next time?
2. Have the worker identify an older youth to complete the tool with in the next week. Discuss at supervision:
   - How did the worker adapt their way of introducing and using the tool with an older youth?
   - Was there anything surprising or different about completing it with an older youth?
   - What did the worker do well that they would do again next time?
   - What would they do differently next time?
   - On a scale of 1-10, how comfortable is the worker now with using the tool?
3. Have the worker talk to a child’s parent(s) about their Safety House. Discuss at supervision:
   - How did the parent receive the information? Did the worker observe or learn any new information by discussing the tool with the parent?
   - Did the parent agree with the child’s perspective on the rules, who can live at or visit the house, etc.?
   - Did the worker scale the parent’s readiness on the Safety Path for having the child come home?
4. Have the worker discuss the Safety House with the Safety Network at a Child & Family Team (CFT) meeting to develop a Family Maintenance case plan or a transition plan for return home, as applicable.
   - How did the child’s Safety House inform the plan?
   - How will the network ensure the child’s vision of the Safety House becomes real?
   - On a scale of 1-10, how confident is the worker in the parents’ and network’s ability to keep the child safe? (Explore their answer.)
5. Have the worker document completion of the Safety House in CWS/CMS; review their contact note and provide feedback.
6. Have the worker use information from the Safety House to create a behaviorally-based case plan. Discuss:
   - How did use of the Safety House make this case plan different than service-based case plans?
   - What does the worker think they did well in creating the case plan? What is one thing they would change for next time?
7. Have the worker incorporate the Safety House into a court report. Discuss: What do they think they did well in the report? What would they change for next time?
SAFETY MAPPING

**SUMMARY**

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

**PURPOSE**

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

**MAPPING WITH FAMILIES**

- To document the Safety Mapping process, you can use the Consultation and Information Sharing Framework or the 4-quadrant mapping, which addresses harm/danger, complicating factors, acts of protection and supporting strengths (see diagram at upper right).
- Begin the Safety Mapping meeting by defining terms for the family, including:
  - **Harm** = Actual experiences of past/current harm to a child by a caregiver.
  - **Risk/Danger** = Worries that the caregiver’s behavior may cause harm to the child in the future.
  - **Complicating Factors** = Things that worry us but are not harm to the child by the caregiver.
  - **Safety** = Acts of protection by the caregiver demonstrated over time.
  - **Supporting Strengths** = Things in a family’s life that are positive but do not specifically address the danger or risk.
- Use the SOP Meeting Dialogue Structure (shown below) to guide the meeting flow:
  - Clearly define the purpose of the specific meeting; for example, “We are meeting to determine if a safety plan can be put in place that would allow the children to remain safely at home.”
  - Set group agreements with the team about how they want to work with each other. This can be a brief process of just 2-3 minutes.
  - Discuss who is not present who should be part of the Safety Network, and who will reach out to them after the meeting.
  - Specify the outcome you hope to achieve, such as a decision, a safety plan or a case plan.

**SOP MEETING DIALOGUE STRUCTURE**

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Overall, why are we meeting today?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Context</td>
<td>Is there anything that might pull our attention away from our focus today?</td>
</tr>
<tr>
<td>Group Agreements</td>
<td>How do we want to work with each other?</td>
</tr>
<tr>
<td>Network/Stakeholders</td>
<td>Is everyone here who should be here? If not, what should we do to get them here?</td>
</tr>
<tr>
<td>Desired Outcome</td>
<td>What do we want to walk away with from this meeting (plan, decision, etc.)?</td>
</tr>
<tr>
<td>Content</td>
<td>What are we worried about, and what’s working well?</td>
</tr>
<tr>
<td>Next Steps</td>
<td>What steps do we need to take? Who does what? By when? Next meeting date?</td>
</tr>
<tr>
<td>+/- Feedback</td>
<td>What worked? What should we do differently next time?</td>
</tr>
</tbody>
</table>
• Use the Three Questions to focus on worries about why the family is involved with CWS:
  ○ What are we worried about?
    ▪ Harm
    ▪ Risk/danger
    ▪ Complicating factors
  ○ What’s working well?
    ▪ Safety/acts of protection
    ▪ Supporting strengths
  ○ What needs to happen next?
    ▪ Safety plan or case plan with action steps
    ▪ Next meeting date
• With the team, sort the “working well” into safety and supporting strengths.
• Sort the worries into harm, risk/danger or complicating factors.
• Create a Harm Statement, a Risk Statement (also known as a Danger Statement), and Safety Goal(s).

HARM STATEMENT

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

RISK OR DANGER STATEMENT

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

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

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

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

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

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

SAFETY GOAL

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

SAFETY OR CASE PLANNING

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

ENDING THE MAPPING

• Do a “plus/delta” process with the team, asking what worked well and what should be different next time.
• Whenever possible, schedule your next CFT meeting with the team when wrapping up the current meeting.
SAFETY ORGANIZED PRACTICE QUICK GUIDE

SAFETY PLANNING

SUMMARY

Safety plans focus on specific strategies to ensure short-term safety from the harm or danger that happened or may happen imminently to the child as a result of the parent’s or caregiver’s behavior.

STRUCTURED DECISION-MAKING (SDM)

- When a referral is received on a parent or other caregiver, social workers must assess whether any safety threats are present that require creating a safety plan or possible removal of the child. Safety threats are imminent situations that are likely to have immediate, severe effects on child(ren). The SDM Safety Assessment tool is used to determine if any safety threats are present.
- Safety plans are necessary when the SDM Safety Assessment tool is completed accurately, per the SDM definitions, and the Safety Decision is not “Safe.” If there are no safety threats marked on the Safety Assessment, a safety plan is not necessary and should not be made.
- Because federal law and trauma-informed social work practice support keeping children at home whenever safely possible, it is critical to create a safety plan with the family and their network to keep the child in the care of the parents whenever this can be safely achieved. When this is possible, the Safety Assessment safety decision is “Safe with plan.”
- If after working with the family and their network, no plan can be developed that will keep the child safe with their caregiver, the Safety Assessment safety decision is “Unsafe,” and the child must be removed. However, social workers have an ethical duty to work with the family and their network to try to develop a plan before determining that there is no option but removal.

ENGAGE THE FAMILY & THEIR NETWORK

- Safety plans cannot be created without the involvement of safe, responsible adults other than the caregiver(s) who caused the harm or danger.
- Having a Child and Family Team (CFT) Meeting is the best way to involve the network in a safety plan.
- Safety network members can include extended family, friends, neighbors, tribal members, service providers and anyone else who can play a role in ensuring safety.
- Children with sufficient developmental capacity can have a role in and should be informed of the safety plan.
- When ICWA applies, make every effort to involve the Tribe in developing the safety plan, and include culturally appropriate supports in the plan.
- The parent/caregiver and safety network members must agree, in writing, to fulfill the action steps assigned to them in the plan.

BUILDING THE SAFETY PLAN

- Convene a CFT meeting with the parent and other adults whose involvement is needed to keep the child safe, and use the SOP safety mapping process to develop the plan.
- Safety plans may not last longer than 30 days and ideally will last only 2 to 3 weeks or until the next CFT meeting, whichever comes first.
  - Keep a laser focus on the harm and danger that created the safety threat. Action steps should directly relate to the parent’s behavior and its impact on the child.
  - Clearly state the safety threats/immediate worries that require creating the plan.
- Specify the SDM in-home interventions that let you assess that safety interventions can mitigate the safety threats.
- Specify safety plan action steps, who will complete them, and timeframes.
- Action steps must include:
  - Proactive activities by the caregiver and safety network that will prevent harm to the child.
  - Immediate referrals to services that will be made, but remember that services do not equal safety.
  - When and how the social worker will monitor the plan, including in-person and other contacts.
- Ways safety network members may assist include but are not limited to:
  - Being willing/able to care for the child at a moment’s notice when parents are not being protective
  - Holding parents/caregivers accountable in completing action steps
  - Notifying the social worker immediately if concerns for the well-being of the child(ren) arise
- Safety network members must understand their role and be able and willing to carry out their responsibilities.
- The plan must be signed by everyone involved, and a copy of the plan given to the parent(s) and the network.

A NOTE ON SERVICES

Services should have a limited role in safety plans unless putting a service in place actually contributes to child safety. For example, getting a child immediately into day-care would be an appropriate service in a safety plan if the safety threat was that the parent does not meet the child’s need for supervision because they are making inappropriate child care arrangements and these arrangements do not provide minimal safety for the child.

Other services, such as mental health services, take time to impact caregiver behavior, so although a referral to a service (i.e., “The parent will go to County Mental Health for a walk-in assessment tomorrow”) may be part of a plan, this should not be relied upon to ensure safety.
MONITORING THE SAFETY PLAN

- Remember that safety plans are for short-term protection of children and should not exceed 30 days.
- You must consistently monitor safety plans to make sure safety goals are met. This includes:
  o Making announced as well as unannounced visits as often as needed to ensure the plan is keeping the child safe.
  o Communicating regularly with the safety network to discuss any worries that parent(s) may not be meeting safety goals.
  o Revising the plan and modifying safety goals and action steps as needed to address identified or new safety threats.
- If parents or network members are not following through, more intensive interventions may be needed, up to and including removal of the child.
- Never close a referral or case with an open safety plan. A current safety plan implies there is still an active safety threat. Safety threats must be resolved before closing a referral or case.
- If safety threats have not been mitigated by the 30-day timeframe to either close or promote the referral, the ongoing worker must incorporate all remaining interventions from the safety plan into the case plan.
- The SDM Risk Assessment needs to be completed within 30 days of the first in-person visit or prior to making a decision whether a referral should close or promote, whichever is sooner.

SAFETY PLANS IN ONGOING CASES

- Safety plans are not just for ER referrals. Workers must continue to assess for active safety threats throughout the case, with both biological and resource parents.
- Always assess child safety using the lens of the SDM Safety Assessment during monthly visits. If you identify an active safety threat on an open case, follow the process outlined in this guide.
- The Safety Assessment and Risk Assessment need to be done for new referrals on open cases.

<table>
<thead>
<tr>
<th>SAFETY PLANS VS. CASE PLANS</th>
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</thead>
<tbody>
<tr>
<td><strong>SAFETY PLANS</strong></td>
</tr>
<tr>
<td>Short-term</td>
</tr>
<tr>
<td>Focus on immediate actions by the parent(s) and other adults that are necessary to keep the child safe</td>
</tr>
<tr>
<td>Referrals to services may be included but should be directly related to resolving the current safety threat</td>
</tr>
<tr>
<td>Allow child(ren) to remain in the home during an ER investigation through specific, timely actions that mitigate identified safety threats</td>
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NOTE: For newborns affected by substance abuse or withdrawal symptoms resulting from prenatal drug or alcohol exposure, safety plan action steps must address both the health and safety needs of the newborn and the substance abuse treatment needs of the caregiver to ensure the safety and well-being of the newborn, per California law.
SAFETY ORGANIZED PRACTICE SUPERVISORS’ GUIDE

SAFETY PLANNING

**SUMMARY**

Safety plans focus on specific strategies, with the support of a safety network, to ensure short-term safety when there is a current SDM Safety Threat (harm or danger to the child that results from the parent’s or caregiver’s behavior).

**SUPERVISORS’ ROLE**

- Supervisors have a critical role in ensuring social workers are trained and coached in an ongoing manner regarding:
  - When a safety plan is necessary
  - Who needs to participate in developing a safety plan
  - What needs to be included in a safety plan
  - How to follow up on a safety plan
- Both Emergency Response and Ongoing (Family Maintenance, Family Reunification and Permanency Planning) supervisors and staff need to have a thorough understanding of why, when and how to create safety plans.
- Review the SOP Safety Planning Quick Guide to ensure you have a thorough understanding of safety planning requirements and best practices.
- Put in place a policy that all safety plans must have supervisor approval.

**STRUCTURED DECISION-MAKING (SDM)**

- Make sure social workers understand a safety plan is needed any time there is a current safety threat as determined by the SDM Safety Assessment tool definitions.
  - If there are no safety threats marked (or that could be marked) on the Safety Assessment, a safety plan is not necessary and should not be made.
- Train social workers that federal law and trauma-informed social work practice support keeping children at home whenever safely possible.
  - Help social workers understand they have an ethical duty to work with the family and their network to explore whether there is a way to keep the child safely at home with the support of other safe adults before determining that there is no option but removal.
- Train social workers that safety is the bottom line. If after working with the family and their network, no plan can be developed that will keep the child safe with their caregiver, the Safety Assessment safety decision is “Unsafe,” and the child must be removed.
- Ensure social workers understand SDM definitions and are applying them accurately.

**ENSURING INVOLVEMENT OF NETWORKS**

- Make sure social workers understand that safety plans cannot be created without the involvement of safe, responsible adults other than the caregiver(s) who caused the harm or danger.

- Require that your staff hold Child and Family Team (CFT) meetings to involve safety networks in safety planning. (At the ER phase, these are sometimes called Team Decision-Making meetings, Family Team meetings, or Safety Mappings.) Whenever possible, attend these meetings; as the supervisor, your role is to make sure the plan that is created will keep the child safe.
- Assess whether social workers are adequately involving children with sufficient developmental capacity in safety planning; provide any needed coaching around this.
- Remind social workers to involve the Tribe in developing safety plans where ICWA applies.
- Continually assess individual workers’ training and coaching needs regarding safety planning.

**SAFETY PLAN MONITORING**

- Create a tracking system to monitor safety plan timeframes and follow-up in your unit.
- Ensure the social worker is consistently monitoring safety plans to make sure safety goals are met. This includes:
  - Making announced as well as unannounced visits as often as needed to ensure child safety.
  - Communicating regularly with the safety network.
  - Revising the plan and modifying safety goals and action steps as needed.
- Never approve closure of a referral or case with an open safety threat. Safety threats must be resolved before closing a referral or case.
- If the safety threat has been resolved, the worker must complete another SDM Safety Assessment prior to closure of the referral to verify that there are no current safety threats and the child is safe.

**SAFETY PLAN CHECKLIST**

Does the safety plan include:

- Safe, responsible adults other than the parent or caregiver who caused the harm or danger
- The interventions that enable the SW to assess that safety interventions can mitigate the SDM safety threats
- Action steps, who will complete them, and timeframes
- Proactive activities by the caregiver and safety network that will prevent harm to the child
- When and how the social worker will monitor the plan, including in-person and other contacts
- Signatures of the parents/caregivers and network members agreeing to their role in the plan
- An overall timeframe of no longer than 30 days
- If safety threats have not been mitigated by the 30-day timeframe to either close or promote the referral, make sure all remaining interventions from the safety plan are incorporated into the case plan.
- Ensure the worker completes the SDM Risk Assessment within 30 days of the first in-person visit or prior to making a decision whether a referral should close or promote, whichever is sooner.

**SAFETY PLANS IN ONGOING CASES**

- Supervisors of Ongoing (FM/FR/PP) units also need to make sure their staff are constantly assessing for safety, whether children are placed in the home or in out-of-home placement.
- Train Ongoing workers to always assess child safety using the lens of the SDM Safety Assessment during monthly visits at home or in placement.
- Make sure the SDM Safety Assessment and Risk Assessment are done for new referrals on open cases.

**NOTE:** For newborns affected by substance abuse or withdrawal symptoms resulting from prenatal drug or alcohol exposure, safety plan action steps must address both the health and safety needs of the newborn and the substance abuse treatment needs of the caregiver to ensure the safety and well-being of the newborn, per California law.
SOLUTION-FOCUSED QUESTIONS

**SUMMARY**

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

**WHY SOLUTION-FOCUSED QUESTIONS?**

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

**THE THREE QUESTIONS**

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

**THE THREE QUESTIONS**

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

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

**SOLUTION-FOCUSED QUESTIONS**

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

**TYPES OF SOLUTION-FOCUSED QUESTIONS**

- Exception Questions ask individuals to think about times that the problem was not happening so they can explore what, when, where and how they were able to achieve success. They help people remember that the problem has not always been present, or can help clarify that there was no time when the problem was not happening, which is also important information.
  - Example: “Was there a time that you (mom) were able to stay clean and sober? How were you able to achieve that? What was it like to parent your kids when you weren’t drinking?”
  - Example: “Was there a time in your relationship that you (dad) were not using violence or making mom stay away from her family and friends? What did your relationship look like during that time?”
  - Example: “Are there times that (your foster child) is not acting out? What does his behavior look like at those times? What is happening in the home, at school or in his life when he is at his best?”
• **Coping Questions** ask people to reflect on how they were able to make it through something difficult, painful or challenging without resorting to problem behavior. Coping questions help build people’s sense of self-efficacy and resilience and also show us what strategies they used for success.

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

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

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

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

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

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

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

• **Scaling Questions** are a powerful, flexible strategy that can be adapted to many situations to help gauge or clarify a person’s perspective on an issue. The important thing about scaling questions is not necessarily the number that someone picks, but rather the chance to explore with them the reasons that they picked that number.

  - Follow-up questions are the key; for example, asking someone what it would take to move them up one number, or why they picked that number and not a lower or higher one. Follow-up questions help us get to the underlying reasons for someone’s perspective and explore next steps.

  • Scaling questions can be used to scale many different areas, including but not limited to:
    - Willingness
    - Confidence
    - Readiness
    - Agreement

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

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

  *Example:* “On a scale of 1 to 10, where 1 is that you have no confidence that this plan will keep the child safe, and 10 is that you are completely confident the plan will keep the child safe, where would you rate? How did you pick a 4? What puts you at a 4 and not a 5? Have you ever been at a 4 before? What were the steps you took at that time?”

  *Example:* “On a scale of 1 to 10, where 5 is that you believe this plan will keep the child safe, where would you rate? How did you pick a 5 instead of a 4? What would you need to see happen to be at a 5 instead of a 4? What would you need to see happen to be a 6?”

### A NOTE ABOUT APPRECIATIVE INQUIRY

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

Beyond work with families, appreciative inquiry is an approach to organizational change that mirrors solution-focused questions used with families by helping social workers pay attention to what they are doing well and what good things they are already doing that they can build on to grow their skills. It is an important parallel process for agencies implementing Safety Organized Practice.
Solution-focused questions are a foundational skill and strategy of Safety Organized Practice that helps the social worker explore worries, what is working well and next steps with a family in a strength-based manner that is in itself an intervention.

**ROLE OF THE SUPERVISOR**

- Supervisors have two primary roles in supporting use of solution-focused approaches:
  1. Teaching, coaching and setting the expectation for staff to use solution-focused questions in their work.
  2. Modeling their own use of solution-focused approaches with staff to provide a parallel process that treats social workers as they are expected to treat families.
- Supervisors must take active steps to assess use of solution-focused questions by staff, which includes a plan for regularly accompanying social workers in the field, attending Child and Family Team (CFT) meetings whenever possible, and reviewing contact notes, court reports and other documentation for evidence of solution-focused strategies.

**SUPPORTING USE OF THE THREE QUESTIONS**

- The Three Questions of Safety Organized Practice (SOP) are rooted in solution-focused questioning and provide a foundation for many other SOP tools and strategies. Although very simple to use, expectations must be set for staff regarding use of the Three Questions.

**THE THREE QUESTIONS**

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

**SUPPORTING SOLUTION-FOCUSED QUESTIONS**

- The solution-focused approach is based on a simple idea with profound ramifications: that what we pay attention to grows. This is true for both families and social workers. Focusing on what is working well with parents, youth and staff leads to more effective change than focusing on deficits.
- To support use of solution-focused questions with staff, supervisors need to be well-versed in using these types of questions themselves, set expectations for using them with families, and model them in work with staff. This

...does not mean we ignore problems or areas for growth, but that the best way to find solutions to these problems is by focusing on the existing strengths that can help provide the solutions to the problems.

- A supervisor or agency creating a climate of appreciative inquiry and solution-focused interactions is critical to having social workers who do the same with children, youth, parents, resource parents and others.

**TYPES OF SOLUTION-FOCUSED QUESTIONS**

- Following are types of solution-focused questions that supervisors can use directly with staff, as well as supporting staff to use with families. For more information, and examples to use with families, see: SOP Quick Guide: Solution-Focused Questions.
- **Exception Questions** ask people to think about times that a problem was not happening so they can explore how they were able to achieve success.
  
  *Example with staff:* “Was there a time that you (social worker) were able to feel more on top of your work and everything you had to do? What was happening for you at that time?”

- **Coping Questions** ask people to reflect on how they were able to make it through something difficult or challenging; they help build self-efficacy and resilience.
  
  *Example with staff:* “I’m amazed you were able to handle the father’s anger so calmly and engage him in such difficult circumstances, even though you were in the middle of an emergency placement change and filing two court reports. How did you manage that?”

- **Position (Relationship) Questions** ask a person to think about a situation from someone else’s perspective, or by putting themselves in the other’s shoes.
  
  *Example with staff:* “If the mom were here, what do you think she would say are the reasons she didn’t get a restraining order?”

- **Preferred Future Questions** ask the person to think about what the best possible future would look like if they were able to change their issue or problem.
  
  *Example with staff:* “If the best possible outcome happened on this case, what would that look like?”

- **Scaling Questions** can be used with families or staff to help gauge perspective on an issue. The important thing is not necessarily the number that someone picks, but rather the chance to explore with them the reasons that they picked that number. Follow-up questions help get to the underlying reasons for someone’s perspective and explore next steps.
- Scaling questions can be used to self-evaluate many different areas, including but not limited to willingness, confidence, readiness and agreement.

**Example with staff:** “On a scale of 1 to 10, where 1 is that you have no confidence in your ability to facilitate a CFT meeting, and 10 is that you are completely confident in your ability, where would you rate? How did you pick a 5? What puts you at a 5 instead of a 4? (Or: “What would you need to see happen to be at a 6 instead of a 5? What would you need to see happen to be a 7?”)

### APPRECIATIVE INQUIRY

- Appreciative inquiry is an approach to supervision and organizational change that builds on solution-focused questions and helps social workers pay attention to what they are doing well and what good things they are already doing that they can build on to grow their skills.

- Creating a culture of appreciative inquiry is an important parallel process for agencies implementing Safety Organized Practice.
  - **Appreciating** is the act of recognizing the best in people and the world around us, affirming past and present strengths, successes and potential.
  - **Inquiring** is the act of exploration and discovery, asking questions and being open to seeing new potential and possibilities.

- Appreciative inquiry also relies on the concept that the language we use and the questions we ask affect the system (or person) being observed. Thus, asking questions about what is working will be more effective in creating change than focusing our attention primarily on the problem.

- Appreciative inquiry involves valuing what we are like at our best, imagining how things could be, building on what we already do well and participating together in creating what could be.
  - In practice, it is the art and skill of supervisors asking questions that explore strengths, successes and possibilities for the best by initiating guided conversations with staff that explore what they are proud of in their work.

- The EARS model *(adapted from Philip Decter and Andrew Turnell)* is another way of thinking about using appreciative inquiry with staff. EARS stands for:
  - **Eliciting:** Drawing out from the worker a positive example of work to focus on
  - **Amplifying:** Helping the worker dig into the details (what, when, how) of the work
  - **Reflecting:** Helping the worker make meaning of what happened and reflect on their practice
  - **Summarizing:** Wrapping up and consolidating lessons to carry forward

### SOP SUPERVISORS’ GUIDE: SOLUTION-FOCUSED QUESTIONS

<table>
<thead>
<tr>
<th>Type of Question</th>
<th>Example Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eliciting</strong></td>
<td>• Can you tell me about a piece of work you have done recently that you feel particularly good about?</td>
</tr>
<tr>
<td></td>
<td>• Can you tell me about a family you worked with where you felt stuck and yet still made some progress?</td>
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<tr>
<td></td>
<td>• Can you tell me about a situation at work that had the potential to become a “train wreck” but where you still managed to salvage a small component that you felt okay about?</td>
</tr>
<tr>
<td><strong>Reflecting</strong></td>
<td>• Where did this happen? When did this happen? Who else was involved?</td>
</tr>
<tr>
<td></td>
<td>• What did you try? What did you see happen?</td>
</tr>
<tr>
<td></td>
<td>• How did you make this happen? What else did you do? What else?</td>
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<tr>
<td></td>
<td>• How did you get the idea to do it that way?</td>
</tr>
<tr>
<td></td>
<td>• What was the hardest part of doing this piece of work for you? So even though that part was hard, how did you keep it going?</td>
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<tr>
<td></td>
<td>• What would the person you worked with say you did to contribute to achieving this outcome?</td>
</tr>
<tr>
<td><strong>Amplifying</strong></td>
<td>• How did you know what you were doing was helping?</td>
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<tr>
<td></td>
<td>• What differences did you see in the person you were working with that told you what you were doing was working?</td>
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<tr>
<td></td>
<td>• What is the thing that you feel proudest about in this situation?</td>
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<td></td>
<td>• If we had a videotape of you doing that (the proudest thing), what would we see on the videotape? What are the practices that go into doing that? What steps went into those practices?</td>
</tr>
<tr>
<td><strong>Summarizing</strong></td>
<td>• Imagine you are ready to close this family’s case. What would you be seeing in your last home visit with them?</td>
</tr>
<tr>
<td></td>
<td>• What is one small thing you can do right now that would enable you to stay calm when the parent is giving you a really hard time?</td>
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<td></td>
<td>• How would you like to respond instead? What would it take in order to be able to do that?</td>
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<td></td>
<td>• If this example of your best work were to happen regularly, what would people be seeing you do?</td>
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<td></td>
<td>• What from this piece of work would you like to bring into other similar situations?</td>
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<td></td>
<td>• What suggestions from this experience would you offer to your coworkers?</td>
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<td></td>
<td>• When you think about this piece of work, what was the most important thing you learned? What would you like to do with that learning?</td>
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<td></td>
<td>• What does this experience say about what you value and what is important to you in your work?</td>
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<td></td>
<td>• What does this say about your hopes and dreams for yourself in doing this work?</td>
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<tr>
<td></td>
<td>• What does this say about what you are committed to and what you stand for in this work?</td>
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<td></td>
<td>• What is one thing you think you would like to try doing differently next time?</td>
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<td></td>
<td>• How can you build even more on the success you had in this situation?</td>
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<td></td>
<td>• What are the lessons you are learning from this that you most want to remember?</td>
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<td></td>
<td>• What would you most like to share with others?</td>
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<td></td>
<td>• What have you learned or re-learned about yourself or your work from this conversation?</td>
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<tr>
<td></td>
<td>• What kind of difference, if any, does it make to hear yourself say these things out loud today?</td>
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</tbody>
</table>
The Three Houses is an information-gathering tool used to elicit the child’s perspective on what’s working well, what they are worried about, and what they think needs to happen with their family.

**SUMMARY**

- **The Three Houses**
  - The House of Good Things: Things that you like or that make you feel happy or safe
  - The House of Worries: Things that make you feel sad, mad, bad or scared
  - The House of Hopes & Dreams: How your life would be if all your worries were better

**HELPFUL TIPS**

- Don’t refer to information that wasn’t told to you by the child.
- Be sensitive to nonverbal cues and “I don’t know.”
- Try the “Three Classrooms” for kids having difficulties at school.

**PREPARING PARENTS**

- Make the Three Houses process as open and transparent as possible to parents.
- Explain the process and why you want to complete it with the child. Show the parent a picture of the tool so they understand what it will look like.
- If the child is in the parent’s care, obtain their consent.
- Ask if they want to do the tool with you before you complete it with their child.
- If meeting the child for the first time, invite them to introduce you to the child, and/or ask what will help put the child at ease.

**WORKING WITH THE CHILD**

- Evaluate, on a case-by-case basis, whether to do the tool with siblings together or separately.
  - Completing it with siblings may reassure younger children and engage teens. Completing it separately can give information from each child’s perspective.
- Introduce yourself: “Part of my job is to help kids and their families with worries they are having. I talk to lots of kids, and one thing that helps me do that is something called the Three Houses. Can I show you what that is?”
- Ask the child’s permission to do the activity and tell them about confidentiality limits: “Sometimes kids tell me things I feel worried about and have to talk with other people about, but if so, I’ll tell you I have to do that. Are you still OK to do the activity with me?”
- If the child wants an adult to stay near, ask them to sit apart from you and the child to quietly observe.
- Give the child the choice of you or them drawing, and/or drawing something other than houses (i.e., cars, apartments). Use a separate piece of paper for each house so they can be shown one at a time to the parents.

**WRAPPING UP**

- Ask what the child wants to call their houses. They can also draw a picture for the name (i.e., sun = Good Things, cloud = Worries).
- Ask if they want to write or want you to write.
  - It is usually easier for children to draw and workers to write their words next to the drawings.
  - If they have you write, use their exact words.
  - If it gets hard for the child to talk and write, offer to take over the writing if they want.
  - Always check in with the child about what you write or draw with them.
- Ask whether they want to start with the House of Good Things or the House of Worries.
- Work to elicit concrete details from the child to narrow the focus specifically on the impact of the caregiver’s actions, identifying harm/danger and safety.
- Watch for signs of trauma or stress; this can include the child seeming distracted or unable to sit still, “spacing out” or “checking out,” or even leaving the activity. Know when kids have had enough, and stop if needed.
SHARING WITH PARENTS

- Begin by asking what the parent thinks the child might have said about their good things, worries, and hopes and dreams.
- Start by showing them the House of Good Things first.
- Ask what the parent notices most about their child’s Three Houses, what it brings up for them, and what they think needs to happen next.
- Observe the parent’s reaction to the child’s words and pictures; a lack of response may signal greater danger for the child.
- Ask the parent what they think would need to happen for the child’s House of Dreams to come true.

HELPFUL QUESTIONS & PROMPTS FOR COMPLETING THE THREE HOUSES

QUESTIONS FOR CHILDREN

Introduction
- I’ve been talking to your mom and dad about some worries in your home; is it OK if I talk to you?
- Where would you like to start?

House of Good Things
- This is the house where you can draw, write, or tell me about the things in your house that make you happy or feel safe or that are fun.
- What do you like about school?
- What are your favorite things to do at home? Who do you most like doing those things with?
- What is your favorite thing about your mom/dad?
- What things make you happy or feel good?
- What would other people say you are good at?
- Is there anything else you’d like to put in this house?

House of Worries
- This is the house where you can draw, write or talk to me about things in your home that worry you or make you feel scared, upset or sad.
- Lots of kids I talk to have worries, which are things that make us feel sad, mad, bad or scared. Are there any worries you might have? Can we put those in your house of worries?
- Is there anything or anyone that makes you feel sad at home or school? Bad? Mad? Scared?
- Is there anything else you think should be in this house?

House of Hopes & Dreams
- This is the house where you can draw, write or tell me about what would be different in your house if your House of Worries could go away.
- If all the worries at home were gone, what would you like to have happening?
- What would be different if all the worries were gone?
- What else would you like to have in your house of hopes and dreams that would help with the worries?
- Is there anything else you’d like to put in this house?

QUESTIONS FOR OLDER YOUTH

Introduction
- There’s an activity I’m thinking of trying with your younger brother or sister — will you try it out for me?
- I’m learning to use this tool, and I was wondering if you’d be willing to do it and tell me what you think?

UTILIZING THE INFORMATION

Case Plans
- Use the Three Houses to help define what behaviorally-based case plan objectives would look like from the child’s perspective. What would the parent need to do in order to make the child’s House of Hopes and Dreams a reality?

Court Reports
- Use the information gained in the Three Houses process to incorporate the child’s/youth’s perspective, in their own words, into your court report.

Structured Decision-Making
- Use the information from the Three Houses process to inform the Family Strengths & Needs Assessment.

House of Good Things
- What does a good day look like for you?
- What do you feel best about in your life right now?
- What things do you think you are good at?
- Who is someone who matters to you? What do you think they would say you are good at?
- Who helps keep you safe?
- How do you help keep yourself safe?

House of Worries
- What’s something you don’t feel so good about?
- What are your top three worries?
- What makes things worse at home?
- Are there thoughts and feelings you have that make you get in trouble or do unsafe things?

House of Hopes & Dreams
- When you were little, what did you want to be when you grow up? What do you want to be now?
- What would the person who matters most to you say you are good at?
- What are the two best/two worst things you experienced with your parent(s) that you want/don’t want to pass on to children of your own?
- What’s one thing that would help with the bad stuff?
- What are the two best/two worst things you experienced with your parent(s) that you want/don’t want to pass on to children of your own?
- What’s one thing you can start today that will help keep you safe/help you feel OK? What other help do you need?

QUESTIONS TO EXPLORE TRAUMA SYMPTOMS

- How are you sleeping? Is it hard to fall asleep or stay asleep? Or do you feel like you sleep too much?
- How is your eating? Do you feel less hungry than you used to? Or do you feel like you’re eating more?
- Do you ever have headaches or stomachaches?
- Do you ever feel anxious or worried? Tell me more...
- Do you feel like you can pay attention OK at school? When you feel sad or scared, what helps you feel better?

PROMPTS/REFLECTIONS
- “Sometimes it’s hard to know what to say…”
- “Other kids sometimes…”
- “That’s really brave.”
SAFETY ORGANIZED PRACTICE SUPERVISORS’ GUIDE

THE THREE HOUSES

The Three Houses is an information-gathering tool used to elicit the child’s perspective on what’s working well, what they are worried about, and what they think needs to happen with their family.

GETTING STARTED

- Ask the worker to review their notes from Three Houses training with you.
  - What do they like about the Three Houses?
  - What worries do they have about using it?
  - What questions do they have?
  - On a scale of 1-10, how comfortable do they feel trying it out?
- Discuss how they will go about trying it the first time.
- Have them role play doing the tool with you.
- Discuss how the worker will use a trauma-informed approach to using the tool (being transparent about the process, giving the child choices whenever possible, observing the child for possible trauma responses, letting the child decide if the tool can be shared with others, providing closure at the end of completing the tool).

GOAL SETTING & COACHING

1. Have the worker identify one child with whom they have a positive relationship to try out the Three Houses with in the next week. Discuss at supervision:
   - How was the process of completing the tool?
   - How did the child respond?
   - Was the worker able to engage the child in a way that he or she answered questions and participated?
   - Does the worker feel the tool elicited more, or different, information than usual? In what way?
   - What did the worker do well that they would do again next time?
   - What is something the worker wishes they had done differently? What are their ideas to try next time?
2. Have the worker identify an older youth to complete the tool with in the next week. Discuss at supervision:
   - How did the worker adapt their way of introducing and using the tool with an older youth?
   - Was there anything surprising or different about completing it with an older youth?
   - What did the worker do well that they would do again next time? What would they do differently next time?
3. Have the worker identify a case where they have been struggling to engage a child or youth, then complete the Three Houses with them in the next week. Discuss:
   - Did the worker learn any new information that they hadn’t known before?

Did the worker:
- Ask the child for permission to do the tool?
- Give the child choices about who would draw, what to draw (houses or other), and what to call the houses?
- Ask if he/she wanted to start with Good Things or Worries?
- Avoid referring to information not supplied by the child?
- Watch for signs of trauma response?
- Ask the child if it would be OK with them to share with their parent?
- Thank the child and provide closure?
- Share the tool with the parent?
- Document completion of the tool in CWS/CMS?
- Use it to inform the Family Strengths & Needs Assessment?
- Document the child’s voice in the case plan & court report?
## SOP CHILD & FAMILY TEAM (CFT) MEETING FRAMEWORK – EMERGENCY RESPONSE

**Date:**  
**Meeting Type:**  
- [ ] Case Consultation  
- [ ] RED Team  
- [ ] Safety Mapping w/Parent(s)  
- [ ] Emergency Removal  
- [ ] Risk of Removal  
- [ ] Other:  

**Meeting Participants:** 

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

---

### WHAT ARE WE WORRIED ABOUT?

**Reason for Referral/Harm**

- Detail re: incident(s) bringing the family to the attention of the agency, specifically the parents’ behavior and impact on the child(ren)
- Pattern or history of similar worries
- Results of SDM Hotline Tool (for RED Team) or Safety Assessment (for CFT meeting; specify safety threats)
- Create a Harm Statement as appropriate

### WHAT'S WORKING WELL?

**Safety**

- Current or past safety, defined as acts of protection demonstrated over time by the parent(s) or a network member
- Pattern or history of exceptions to worries

### WHAT NEEDS TO HAPPEN NEXT?

**Safety Goal**

- What the parents’ behavior will look like so that we know the child is safe over time
- Short-term safety goal, if Safety Plan is put in place
- Well-being goals for child/youth

---

### Danger

- Worries about future danger to child(ren) (parents’ behavior that may impact the child)
- Context of danger (under what circumstances the risk to the child is present, i.e., when, where, how, who)
- Create a Danger Statement with the team

### Supporting Strengths

- Circumstances, resources, cultural supports, parent capacities that are good but do not ensure safety
- Research-based protective factors (parental resilience, knowledge of parenting/child development, social connections, concrete support in times of need, children’s social & emotional competence)

### Gray Area

- Incomplete information
- Things we are speculating about or making up
- Inferences, assumptions and possible biases
- Questions we need to answer

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### Complicating Factors

- Things that are challenging for the family but that are not harm or danger to the child
- SDM Risk Assessment risk factors & risk level
- Presence of other research-based risk factors (young or single parent, parenting stress, poverty, social isolation, poor parent-child relationships)

### Safety/Support Network

- Individuals who can help ensure child safety
- Other supports to the family, child or youth
- How the network has helped protect in the past
- Who is a resource for relative/NREFM placement
- Family finding/Circles of Support

### Next Steps

- Next steps needed to address the risk/danger
- Safety Plan (involving the support of the Network) if there is a current SDM safety threat and the child will remain home
- What, who, by when, etc.
- Next meeting date

### Needs of Child/Youth (inform draft CANS)

- Age 0-5: Behavioral/Emotional, Family Function, Early Education, Social/Emotional, Developmental, Medical, Risk Bx/Factors, Perinatal, Cultural, Dyadic, ACEs
- Age 6+: Behavioral/Emotional, Life Function, Social Function, Placement, Education, Medical, Risk Bx, Cultural, ACEs
- Assessments completed (Regional Ctr., MH, CSEC)

### Strengths of Child/Youth (inform draft CANS)

- Age 0-5: Family Strengths, Interpersonal, Natural Supports, Resiliency, Relationships Permanency, Playfulness, Family Spiritual/Religious
- Age 6+: Family Strengths, Interpersonal, Educational Setting, Talents/Interests, Spiritual/Religious, Cultural Identity, Community Life, Natural Supports, Resiliency

---

For parents, document where appropriate under Danger, Complicating Factors, Safety and Supporting Strengths their Needs and Resources related to: Supervision, Involvement with Care, Knowledge, Social Resources, Residential Stability, Medical/Physical, Mental Health, Substance Use, Developmental, Safety [and for kids 0-5, Family Relationship to System, Legal Involvement, Organization]
### SOP CHILD & FAMILY TEAM (CFT) MEETING FRAMEWORK – EMERGENCY RESPONSE

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

#### Meeting Participants:
List the participants attending the meeting.

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

### WHAT ARE WE WORRIED ABOUT?

- **Reason for Referral/Harm**

### WHAT’S WORKING WELL?

- **Safety/Acts of Protection**

### WHAT NEEDS TO HAPPEN NEXT?

- **Safety Goal**

### Danger

- **Supporting Strengths**

### Gray Area

- **Complicating Factors**

### Safety/Support Network

- **Next Steps**

### Needs of Child/Youth

- **Strengths of Child/Youth**

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DRAFT Rev. 09/14/2018
### SOP CHILD & FAMILY TEAM (CFT) MEETING FRAMEWORK – FAMILY MAINTENANCE/FAMILY REUNIFICATION

**Date:** ____________

**Meeting Met Statutory Requirements for CFT:** ☐ Yes ☐ No

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

**Participants:** _____________________

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

*Include or complete genogram and ecomap as appropriate.*

<table>
<thead>
<tr>
<th>WHAT ARE WE WORRIED ABOUT?</th>
<th>WHAT’S WORKING WELL?</th>
<th>WHAT NEEDS TO HAPPEN NEXT?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Worries that Need to Be Addressed</strong></td>
<td><strong>Safety</strong></td>
<td><strong>Safety Goal/Vision</strong></td>
</tr>
<tr>
<td>• Worries that need to be addressed in the case plan or transition plan</td>
<td>• Acts of protection or protective behaviors by the parent(s) demonstrated over time</td>
<td>• What the parent’s behavior will look like so that we know the child is safe and can return home or so the case can close</td>
</tr>
<tr>
<td>• Child’s/youth’s perspective on worries</td>
<td>• Parent’s resources from CANS if the resource rises to the level of safety/acts of protection</td>
<td>• Well-being goals for child/youth</td>
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<thead>
<tr>
<th>Harm &amp; Danger</th>
<th>Supporting Strengths</th>
<th>Gray Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Develop harm/danger statement(s) if not yet done</td>
<td>• Positive things, resources, assets, capacities that are good but do not ensure safety</td>
<td>• Incomplete information</td>
</tr>
<tr>
<td>• Any new worries about harm, danger or risk</td>
<td>• Cultural supports, traditions</td>
<td>• Things we are speculating about</td>
</tr>
<tr>
<td>• Unresolved or new safety threats</td>
<td>• Parent’s and/or caregiver’s resources from CANS</td>
<td>• Inferences, assumptions and possible biases</td>
</tr>
<tr>
<td>• Parent CANS Needs that are harm or danger</td>
<td>• Safety/Support Network (Child &amp; Family Team)</td>
<td>• Questions we need to answer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Complicating Factors</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Things that are challenging for the family, child or youth but that are not harm or danger</td>
<td>• Next steps, including behaviorally-based case plan objectives, to address the worries/safety concerns and the child/youth, parent and caregiver Priority Needs (and Strengths to Build) identified by CANS &amp; CFT</td>
</tr>
<tr>
<td>• Current risk level from SDM Risk Reassessment</td>
<td>• Specify what, who, by when, etc.</td>
</tr>
<tr>
<td>• Parent CANS Needs that are complicating factors</td>
<td>• Next CFT meeting date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Needs &amp; Strengths to Build of Child/Youth (CANS)</th>
<th>Strengths of Child/Youth (CANS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Assessments completed (Regional Ctr., MH, CSEC)</td>
<td>• Level of Care considerations (physical, behavioral/emotional, educ., health, permanency/family)</td>
</tr>
<tr>
<td>• Level of Care considerations (physical, behavioral/emotional, educ., health, permanency/family)</td>
<td>• Relative/NREFM placement &amp; connection</td>
</tr>
</tbody>
</table>

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

Scale any of the following: current safety; readiness for next steps (transition or closure); participants’ willingness, confidence and/or capacity to follow the plan.
## SOP CHILD & FAMILY TEAM (CFT) MEETING FRAMEWORK – FAMILY MAINTENANCE/FAMILY REUNIFICATION

### Date: ____________________

**Meeting Met Statutory Requirements for CFT:** □ Yes □ No

**Meeting Type:** □ Case Consultation □ Case Planning CFT □ Placement CFT □ Transition Home CFT □ Case Closure CFT □ Other: _____________________

**Participants:** ____________________

**Purpose/Focus of Meeting:** ____________________

*Include or complete genogram and ecomap as appropriate.*

<table>
<thead>
<tr>
<th>WHAT ARE WE WORRIED ABOUT?</th>
<th>WHAT’S WORKING WELL?</th>
<th>WHAT NEEDS TO HAPPEN NEXT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current Worries that Need to Be Addressed</td>
<td>Safety/Acts of Protection</td>
<td>Safety Goal/Vision</td>
</tr>
<tr>
<td>Harm &amp; Danger</td>
<td>Supporting Strengths</td>
<td>Gray Area</td>
</tr>
<tr>
<td>Complicating Factors</td>
<td>Safety/Support Network (Child &amp; Family Team)</td>
<td>Next Steps</td>
</tr>
<tr>
<td>Needs &amp; Strengths to Build of Child/Youth (CANS)</td>
<td>Strengths of Child/Youth (CANS)</td>
<td></td>
</tr>
</tbody>
</table>
**SOP CHILD & FAMILY TEAM (CFT) MEETING FRAMEWORK – PERMANENCY PLANNING/NON-MINOR YOUTH**

**Date:** ________________
**Meeting Met Statutory Requirements for CFT:** □ Yes □ No

**Meeting Type:** □ Case Consultation □ Case Planning CFT □ Placement CFT □ 90-Day Transition CFT □ Other: ______________________

**Participants:** ______________________

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

---

### WHAT ARE WE WORRIED ABOUT?

<table>
<thead>
<tr>
<th>Current Worries that Need to Be Addressed</th>
<th>Permanency/Independence/Belonging/Safety</th>
<th>WHAT NEEDS TO HAPPEN NEXT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Worries that need to be addressed in the case plan or transition plan</td>
<td>• Permanency, connection and belonging for the child/youth</td>
<td>• Permanency, connection, belonging, independence, well-being and/or self-safety goal for the child or youth</td>
</tr>
<tr>
<td>• Child’s/youth’s perspective on worries</td>
<td>• Youth’s self-safety, if applicable</td>
<td>• TILP goals</td>
</tr>
</tbody>
</table>

### Permanency/Independence/Belonging/Safety

| • Barriers to permanency, connection and belonging, or finalization of permanent plan | • Positive things, resources and capacities that are good but do not ensure permanency, connection, belonging or self-safety | • Incomplete information |
| • Any worries about youth’s self-safety | • Cultural supports, traditions | • Things we are speculating about |
| • Concerns about placement stability | • Caregiver (Resource Parent) CANS Needs | • Inferences, assumptions and possible biases |
| • Caregiver (Resource Parent) CANS Needs | | • Questions we need to answer |

### Supporting Strengths

<table>
<thead>
<tr>
<th>Complicating Factors</th>
<th>Safety/Support Network (Child &amp; Family Team)</th>
<th>Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Things that are challenging for the child or youth but that are not affecting permanency, belonging or self-safety</td>
<td>Individuals in the Child and Family Team or others who can support the youth’s plan and goals</td>
<td>Next steps, including behaviorally-based case plan objectives, to address worries and the child/youth and caregiver needs (and strengths to build) identified by CANS &amp; CFT</td>
</tr>
<tr>
<td>• Impact of past trauma on the youth</td>
<td></td>
<td>• Next CFT meeting date</td>
</tr>
</tbody>
</table>

### Needs & Strengths to Build of Child/Youth (CANS)

**Age 0-5:** Behavioral/Emotional, Family Function., Early Education, Social/Emotional, Developmental, Medical, Risk/Bx/Factors, Perinatal, Cultural, Dyadic, ACEs

**Age 6+:** Behavioral/Emot., Life Funct., Social Funct., Placement, Educ., Medical, Risk Bx, Cultural, ACEs

**Assessments completed (Regional Ctr., MH, CSEC)**

**Level of Care considerations (physical, behavioral/emotional, educ., health, permanency/family)**

### Strengths of Child/Youth (CANS)

**Age 0-5:** Family Strengths, Interpersonal, Natural Supports, Resiliency, Relationships Permanency, Playfulness, Family Spiritual/Religious

**Age 6+:** Family Strengths, Interpersonal, Educational Setting, Talents/Interests, Spiritual/Religious, Cultural Identity, Community Life, Natural Supports, Resiliency

---

**NOTE:**

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

---

Scale current permanency/belonging; readiness for next steps; participants’ willingness, confidence and/or capacity to follow the plan.
**SOP CHILD & FAMILY TEAM (CFT) MEETING FRAMEWORK – PERMANENCY PLANNING/NON-MINOR YOUTH**

Date: ___________________  Meeting Met Statutory Requirements for CFT: ☐ Yes ☐ No

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

Participants: ____________________________

Purpose/Focus of Meeting: ____________________________

Include or complete genogram and ecomap as appropriate.

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Current Worries that Need to Be Addressed</td>
<td>Permanency/Belonging/Safety</td>
<td>Permanency/Independence/Safety Goal</td>
</tr>
<tr>
<td>Permanency/Belonging/Safety</td>
<td>Supporting Strengths</td>
<td>Gray Area</td>
</tr>
<tr>
<td>Complicating Factors</td>
<td>Safety/Support Network (Child &amp; Family Team)</td>
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</tr>
<tr>
<td>Needs &amp; Strengths to Build of Child/Youth (CANS)</td>
<td>Strengths of Child/Youth (CANS)</td>
<td></td>
</tr>
</tbody>
</table>
Safety Organized Practice (SOP) Implementation Readiness Assessment

The following checklist presents some of the most important planning factors to consider when implementing Safety Organized Practice (SOP). It is not intended to be an exhaustive step-by-step planning manual, but to support a thoughtful discussion of planning and implementation issues.

<table>
<thead>
<tr>
<th>PLANNING AND IMPLEMENTATION FACTORS</th>
<th>NOTES (i.e., Tasks, Due Dates &amp; Those Responsible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Leadership Readiness:</td>
<td></td>
</tr>
<tr>
<td>Ensure that agency leadership understands the SOP model, its core practice tenets and its alignment with agency mission and culture, and is able to articulate the reasons that the agency has chosen to adopt the model.</td>
<td></td>
</tr>
<tr>
<td>• What child welfare practice model, if any, does the jurisdiction currently use? Is there alignment of core values, family-centered practice, and practice principles between the agency practice model and SOP? Is there alignment between the agency’s current safety and risk assessment process/tools and SOP? <em>(It is important to recognize the extent of the changes a jurisdiction might be undertaking when they start down this road, and the important role that change agents, trainers, and consultants can play in helping jurisdictions think through key questions that accompany the change process.)</em></td>
<td></td>
</tr>
<tr>
<td>• Does agency leadership understand the practice tenets of SOP? <em>(For example, cultural humility, engagement with families and their support systems, balanced and rigorous assessments that incorporate the perspective of all those involved to build safety plans that enhance actual safety instead of reliance upon service completion, and that all written documentation of the family’s progress should be reflective of this teaming approach, etc.)</em></td>
<td></td>
</tr>
<tr>
<td>• What will the communication plan be to build “readiness” for implementation within the agency? How will leadership partner with supervisors and key staff, champions, or political support to build understanding about the importance of SOP implementation? How will communication be intentional and purposeful as it relates to implementation, building consensus and integrating input?</td>
<td></td>
</tr>
<tr>
<td>• How will the agency engage external stakeholders (i.e. parents, youth, court, religious organizations, court, political support, etc.) to communicate about and build consensus around the desired outcomes, with using SOP as a possible practice to meet these outcomes?</td>
<td></td>
</tr>
</tbody>
</table>
**PLANNING AND IMPLEMENTATION FACTORS**

<table>
<thead>
<tr>
<th></th>
<th><strong>NOTES</strong> (i.e., Tasks, Due Dates &amp; Those Responsible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How will the agency work with stakeholders, both internal and external, to identify what role they might play in implementation?</td>
<td></td>
</tr>
<tr>
<td>• How does the agency’s current safety and risk assessment approach impact/inform other areas of practice, organizational culture, supervisory practice, teamwork, and child, youth, and family outcomes? What other areas of change may be necessary in order to achieve improved outcomes?</td>
<td></td>
</tr>
<tr>
<td>• Are there available resources that will be dedicated to ensure sufficient training and coaching? What resources can be dedicated? Internal staff capacity? External support from the Regional Training Academy (RTA)? What would partnership need to look like between the agency and the RTA?</td>
<td></td>
</tr>
<tr>
<td>• Is the leadership necessary to launch and sustain this practice approach present at the state and county levels? <em>(E.g., public agency leaders, judges, policy leaders, employee union leaders.)</em></td>
<td></td>
</tr>
</tbody>
</table>
## Timing and Sequencing of Implementation:
Managing large-scale implementation can be exciting and successful, especially when planning is done ahead of time, with regular monitoring and communication between leadership and those implementing the practice.

<table>
<thead>
<tr>
<th>PLANNING AND IMPLEMENTATION FACTORS</th>
<th>NOTES (i.e., Tasks, Due Dates &amp; Those Responsible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In what program areas will implementation begin? Will data be utilized to determine this? Are there program areas with more urgency for the practice?</td>
<td></td>
</tr>
<tr>
<td>• What agency trainings or system of training could this training leverage or build off of? (For example, regular training happens during the week in unit meetings, so how could those unit meetings be a platform for ongoing SOP training/coaching?)</td>
<td></td>
</tr>
<tr>
<td>• Has an implementation timeline been developed?</td>
<td></td>
</tr>
<tr>
<td>• Has the partnership between the agency’s trainers (or those responsible for training) and the RTA been worked out? If so, what does this capacity tell us about pace and timing of implementation?</td>
<td></td>
</tr>
<tr>
<td>• Are there any special key policy and administrative regulation requirements or milestones that will need to be met for the project to proceed? (I.e., are there any “showstopper” review checkpoints?)</td>
<td></td>
</tr>
<tr>
<td>• How are supervisors part of the implementation planning efforts? How can this be expanded or enhanced?</td>
<td></td>
</tr>
<tr>
<td>• Who will monitor implementation? Is there an “implementation team,” or a group of people who will provide feedback to leadership, or those responsible for dedication or resources and support?</td>
<td></td>
</tr>
<tr>
<td>• What should we expect during the initial phase of implementation? What short-term and long-term outcomes do we want to see? What timelines do we have to reach these short-term and long-term outcomes?</td>
<td></td>
</tr>
<tr>
<td>• How will we know to “spread” to other program areas?</td>
<td></td>
</tr>
</tbody>
</table>
### PLANNING AND IMPLEMENTATION FACTORS

3. **Training, Ongoing Supervisory Support and Coaching:**

   Capacity building is essential to sustain SOP practice, and supervisors are the key. External trainers and coaches may be used to strengthen the supervisors’ ability to understand and use the SOP practice approach, to coach the practice within their units, and to sustain the practice within the organization.

   - How will leadership be part of continued learning and deepen their understanding of SOP? How will leadership model SOP practice? How will staff at different levels model a learning organization?
   - Will there be flexibility in sequencing or offering some or all SOP modules?
   - What is the agency’s strategy to train and coach the implementers of SOP?
   - If external trainers and coaches are needed, then how can the role of the RTA and the agency’s staff trainers be clarified? What kinds of agreements are needed between the RTA and the agency around roles and responsibilities?
   - Are all trainers/coaches knowledgeable and experienced in the SOP framework and familiar with the California Child Welfare Core Practice Model/Integrated Core Practice Model?
   - How and at what point will leaders/managers be trained and coached? At what point will they be trained and coached?
   - How will supervisors be trained and coached? At what point will they be trained and coached?
   - How will workers be trained and coached? At what point will they be trained and coached?
   - How will key partners (e.g., parents, youth, family, resource parents, community judges, key medical personnel, CASA, policymakers) need to be oriented or trained?
   - How will practice leaders be identified, developed and supported?
   - What training materials will need to be developed or used for workers? Supervisors? Coaches?
   - How will training and coaching as implementation support be sustained?
   - How will existing Core/new worker/new supervisor training curricula be revised or modified to integrate the new curriculum? How will training and coaching be adapted for existing staff roles within the agency using SOP practice, while ensuring fidelity to the practice?

### NOTES

(i.e., Tasks, Due Dates & Those Responsible)
- What types of ongoing advanced and/or refresher training sessions will be included in the ongoing implementation and training plan?
- How will we evaluate the training’s effectiveness?
- How will transfer of learning be supported and assessed?

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>4. Practice Informing Policy and Policy Enabling Practice Cycles:</strong> Feedback loops between agency leadership (those responsible to address system barriers and allocate resources) and practice leaders who are engaged with direct practice must be put into place during all phases of implementation.</td>
<td></td>
</tr>
</tbody>
</table>

- How will the agency facilitate a group of stakeholders who convene regularly to oversee the progress and process of implementation? What are the roles and tasks of the leadership team/advisory team? Who are the critical stakeholders that are important to this process? Who are the people that would support in this leadership role?
- How will agency leadership be able to receive regular input from all stakeholders that are involved (parent partners, youth, social workers, supervisors, courts, CASA, advocacy groups, service providers, Regional Training Academy, other training partners, continuous quality improvement staff, etc.) in regards to the progress and the process of the implementation?
- What will be regular times when decisions are made to acknowledge successes, resolving barriers, and support continuous implementation?
- What are the roles and tasks of an implementation team?
- How, in what frequency, and by whom will leadership be informed about SOP implementation processes, progress, and resources that are needed?
- What kind of initial and ongoing communication is needed with agency partners? Is there “permission” needed from Boards of Supervisors, commissions, or oversight groups? Will regular communication aid in maintaining this “permission”?
- What will be the process for assessing new workflow (e.g., reducing/eliminating redundancies in new vs. old assessments, forms, policy, etc.)?
5. **Workload Impact:**

Balanced and culturally responsive assessments and meaningful/effective planning with families will pay off in the long run, but during the initial phases of implementation, time to attend trainings and coaching sessions might take some juggling for agency staff.

- What will be the process for assessing new workflow (e.g., reducing/eliminating redundancies in new vs. old assessments, forms, policy)?
- What is the expected impact on present roles and responsibilities of social workers? Supervisors?
- What is the expected workload impact for social workers? Will caseloads be held or reduced during training (such as no new cases)?
- What is the expected workload impact for supervisors during training, coaching, etc.? Are there ways to reduce supervisory workload by combining supervision and coaching?
- Are there plans for coverage while staff members are at SOP training? How will supervisors and managers balance workload when staff members are away during training?
- Will these changes be considered a fundamental change to the work environment and require union negotiation?
### PLANNING AND IMPLEMENTATION FACTORS

#### 6. Quality Assurance, Fidelity Assessment, Performance Measurement and Evaluation:

It is important to know ahead of time what the agency hopes the impact of SOP will have on family-level outcomes and on its staff. It is important to think about how this information will be ascertained during each phase of implementation. A strong CQI process will be key for practice sustainability and to ensure successful outcomes.

- **What will be the process for data collection? Fidelity? Observation/feedback? Who will oversee this function? Who will gather data?**
- **What kind of quality assurance process will be used for this work that is any different than what is being used now?**
- **Will some kind of fidelity assessment for accountability be essential as a way of helping to ensure that workers and supervisors are implementing the safety/risk/practice model in the right way? Is a fidelity assessment available, such as the SOP Practice Profiles? If not, what form of fidelity assessment will be supported? Who will do the fidelity assessment? How?**
- **What resources are available to conduct evaluation/CQI efforts?**
- **If a practical and affordable evaluation design needs to be developed, have the following strategies been taken into consideration?**
  - Ensuring automation of tools (SDM, CWS/CMS, Practice Profiles) is completed in close consultation with system developers to increase reliability in data collection.
  - Rely on the agency MIS system data related to referral accepted, substantiated, rates of placement, rates of recidivism, length of stay, rates of re-placement.
  - Conduct an early “baseline” surveys of front-line workers (to be repeated later to measure change).
  - Conduct early “baseline” surveys of parents by involving former child welfare clients as interviewers (to be repeated later to measure change).
  - Focus groups of front-line workers, parents, supervisors and/or other stakeholders.
  - Case record reviews.
  - Qualitative “within-case” set of interviews of 10-20 families, their worker, and the supervisor associated with that case.
  - Economic analysis of cost savings. (See Fiscal Planning section.)
<table>
<thead>
<tr>
<th>PLANNING AND IMPLEMENTATION FACTORS</th>
<th>NOTES (i.e., Tasks, Due Dates &amp; Those Responsible)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To the extent that outcome measurement and evaluation is inevitably both a clinical and organizational intervention, how can the evaluation process be grounded in guiding family-centered core values and principles?</td>
<td></td>
</tr>
<tr>
<td>• What form of outcomes measurement and budget analysis will be needed to document the economic value of this approach? (e.g., cost savings from placement diversion, lower rates of repeated child maltreatment, reduced length of stay).</td>
<td></td>
</tr>
<tr>
<td>• For each evaluation strategy chosen, who will be responsible for doing it, what will it cost, what is the funding source?</td>
<td></td>
</tr>
<tr>
<td>• Does an external evaluation contractor need to be identified, and how will they be chosen – sole source, RFP, other method?</td>
<td></td>
</tr>
</tbody>
</table>
### PLANNING AND IMPLEMENTATION FACTORS

#### 7. Fiscal Planning:

Full implementation of a practice model within a child welfare organization takes years, and sustaining/evolving/building upon the practice even longer. It is essential to think about necessary funding and resources long-term to ensure sustainability.

- Once the scope of work, training plan, and sequencing/timing has been outlined, what is the budget needed to implement this project over the first 3-5 years?
- If a jurisdiction is planning to use supervisor and worker coaches as a way to sustain the transfer of learning, what kind of funding can the jurisdiction provide to support this in Year 1? Year 2? Year 3?
- Can Title IV-E or other federal funds be used to help support implementation?
- What will the Regional Training Academy provide, such as direct and indirect costs?
- Are there any other resources from stakeholders available for support?
- Are there savings that can be accrued by implementing in 2 or more counties at the same time or in close proximity time-wise?
- What are the most feasible funding sources?
- Could certain local or state foundations be a source of political, program, technical assistance or financial support?
- Are there any agency internal resources that can be repurposed to support implementation (such as quality assurance staff being assigned to the implementation team or training staff being assigned to provide training/coaching)?
Implementation Status Checklist: Safety Organized Practice

This Implementation Checklist has been designed to highlight key installation tasks to assist your county in preparing to make full and effective use of Safety Organized Practice (SOP) with the families you serve. Based on other implementation efforts, we know that attending to key installation/implementation domains creates the conditions for a more successful start-up of new services.

Depending on who in your county is tasked with supporting implementation of SOP, the activities on the checklist will provide some general guidance to keep SOP implementation tasks on track. This checklist is a working document and may continue to evolve and should be adapted to the jurisdiction needs. Users need not see all of these items as “must-dos,” but rather as considerations, and can utilize this checklist to stimulate thinking and consider lessons learned from other jurisdictions.

In this checklist, the “responsible party” is based on a linked teaming structure which includes a Steering Committee (example: Executive Leadership Team) and an Implementation Team. Additional workgroups or task teams are identified as needed for specific tasks.
<table>
<thead>
<tr>
<th>Stage-Related Activities for Implementation</th>
<th>Responsible Party</th>
<th>Status and Progress To-Date</th>
<th>Potential Risk or Barriers</th>
<th>Plan to Address Potential Risks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Establish implementation team and ensure leadership commitment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Develop selection criteria for implementation team members (e.g., typically identify someone with authority, permission, time to lead the team and be the key person to move the work forward along with a core group of staff; team may include directors, supervisors, line staff, etc.; ideally should be a cross-section of staff with possibly more representation from any unit/region that may be the first to implement.)</td>
<td>Steering Committee or Executive Team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Develop Charter (or Terms of Reference) to articulate core roles and responsibilities (including time commitment) (Key roles may include: Point person responsible for setting meetings, agendas, communication out or up, timelines and deliverables. Other members responsible for contributing (may be the first to attend training and coaching), carrying word (buy-in) and practice (coaching); ongoing review of data.)</td>
<td>Steering Committee or Executive Team develop initially with additional revisions by the Implementation Team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. Leadership team involvement, buy-in and support (Leadership buy-in and involvement is critical; leadership needs to be involved in all aspects of implementation in some way; vital that leadership regularly gives the message of full support for SOP practice and implementation.)</td>
<td>Steering Committee or Executive Team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Develop site selection process (if this did not occur during exploration)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Develop method to select the office or unit to begin implementation (For example: Engage in a facilitated process with data to Steering Committee to determine where to begin implementation (could be a unit such as ER or a geographic area or office). Consider where there are strengths in practice as well as where there are areas for improvement.)</td>
<td>Steering Committee or Executive Team</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Assess office or unit buy-in and readiness (staff and supervisors) (Considerations: May want to start where there is enthusiasm and willingness for the new practice versus the area or office where there may be poor outcomes plus resistance to the practice. Look for multiple levels of readiness – front line staff as well as a supervisor who is not resistant to SOP. Want a supervisor who can model and move the work forward along with their workers.)</td>
<td>Steering Committee or Executive Team</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3. Develop communication plan (both initial and ongoing)

**a. With Internal Stakeholders**  
Consider:
- Who needs to hear about SOP implementation  
- When (initially and ongoing)  
- By whom  
- What information needs to be given about SOP ("What will be changing and what will be staying the same")  
- What information needs to be given about the training and coaching plan  
- Consider particular communication with important audiences such as county counsel, union representatives and others

Also consider the role listening sessions or focus groups can play in conveying communication about SOP and the above.

<table>
<thead>
<tr>
<th>Child Welfare (CW) Director, Steering Committee and Implementation Team</th>
</tr>
</thead>
</table>

**b. With External Stakeholders**  
Consider when/how communication needs to occur with:
- Contracted providers  
- Non-contracted community providers  
- Court personnel  
- Other county agencies  
- Other?

Consider timing and staging of this – it may be better to begin some initial communication at the beginning and then deeper orientations as implementation moves forward.

<table>
<thead>
<tr>
<th>CW Director, Steering Committee and Implementation Team</th>
</tr>
</thead>
</table>

### 4. Consider potential structural and functional changes needed (e.g. policies, schedules, space, time, materials, re-allocation of roles and responsibilities, new positions needed)

**NOTE:** This list is not meant to be complete but to provide 'starter-dough' for Child Welfare Director, Steering Committee and the Implementation Team to consider. Some of this should be considered prior to training, some will be easier to consider post-training.

<table>
<thead>
<tr>
<th>CW Director, Steering Committee, or Implementation Team</th>
</tr>
</thead>
</table>

**a. With Hotline/Intake work:**
- Role of enhanced use of Solution-Focused Questions and Three Questions Framework at intake  
- Inquiry about possible Safety Network members at intake  
- Potential changes to documentation of hotline narrative to match with mapping format (i.e., preliminary Harm Statement, Complicating Factors, Strengths, Safety/Acts of Protection)  
- Other?

Also consider role of RED Team (Review, Evaluate and Direct) or similar process to bring group together for using mapping to conduct mini case-consultations at hotline when making decisions.

### With Investigations work:
- Role of enhanced use of Solution-Focused Questions and rigorous and balanced assessment  
- Deepened use of working with/across difference approaches  
- Role of conversation aids for working with children (such as Three Houses or Safety House)
- Development of regular case consultation process
- Deepened use of SDM Safety and Risk Assessment in aiding decision-making
- Development and documentation of Harm and Danger Statements and Safety Goals
- Identification of family networks
- Use of networks in all Safety Plans that get developed
- Deepened use of action steps and behaviorally-based language in all Safety Plans
- Regular case consultations, joint mappings and facilitated case transfer processes using integrated SOP strategies between investigation and ongoing staff for referrals being opened
- Changes to documentation (use of framework and other parts of SOP in regular documentation)
- Connection to facilitated Child and Family Team (CFT) meeting structures (i.e., CFT, Team Decision-Making (TDM), etc.)
- Other?

<table>
<thead>
<tr>
<th>c. With Family Maintenance work:</th>
<th>CW Director, Steering Committee or Implementation Team and FM staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Role of enhanced use of Solution-Focused Questions and rigorous and balanced assessment</td>
<td></td>
</tr>
<tr>
<td>- Deepened use of working with/across difference approaches</td>
<td></td>
</tr>
<tr>
<td>- Role of conversation aids for working with children (such as Three Houses or Safety House)</td>
<td></td>
</tr>
<tr>
<td>- Development of regular case consultation process for FM cases</td>
<td></td>
</tr>
<tr>
<td>- Use of Safety Organized Practice strategies during quality caseworker visits and supporting documentation to conduct collaborative “mini-assessments” with family members</td>
<td></td>
</tr>
<tr>
<td>- Deepened use of SDM Safety and Risk Re-Assessments in aiding decision-making</td>
<td></td>
</tr>
<tr>
<td>- Refinement of Harm and Danger Statements and Safety Goals and linking to Case Plan, referrals to community providers, etc.</td>
<td></td>
</tr>
<tr>
<td>- Identification of family networks</td>
<td></td>
</tr>
<tr>
<td>- Use of networks in all Safety Plans and Case Plans</td>
<td></td>
</tr>
<tr>
<td>- Deepened use of action steps and behaviorally-based language in all Safety Plans and Case Plans integrated with collaborative use of the Family Strengths and Needs Assessment (FSNA) or Child and Adolescent Needs and Strengths (CANS) tools</td>
<td></td>
</tr>
<tr>
<td>- Regular case consultations at key decision points and with particular cases (e.g. high child vulnerability, “stuck” cases, prior to case closure, etc.)</td>
<td></td>
</tr>
<tr>
<td>- Connection to facilitated Child and Family Team (CFT), TDM or other meeting structures</td>
<td></td>
</tr>
<tr>
<td>- Other?</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>d. With Family Reunification work:</th>
<th>CW Director, Steering Committee or</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Role of enhanced use of Solution-Focused Questions and rigorous and balanced assessment</td>
<td></td>
</tr>
</tbody>
</table>
- Deepened use of working with/across difference approaches
- Role of conversation aids for working with children (such as Three Houses or Safety House)
- Development of regular case consultation process for FR cases
- Deepened use of SDM Reunification Assessment in aiding decision-making
- Use of Safety Organized Practice strategies during quality caseworker visits and supporting documentation to conduct collaborative “mini-assessments” with family members.
- Refinement of Harm and Danger Statements and Safety Goals and linking to CasePlans, Family Visitation Plans and referrals to community providers
- Deepened use of progressive family visitation plans (including use of networks and direct links to Danger and Goal Statements)
- Deepened use of action steps and behaviorally based language in all Case Plans integrated with collaborative use of the Child and Adolescent Needs and Strengths (CANS) tool
- Regular case consultations at key decision points and with particular cases (e.g. high child vulnerability, “stuck” cases, prior to reunification, etc.)
- Connection to CFT, TDM or other facilitated meeting structures
- Other?

<table>
<thead>
<tr>
<th>Implementation Team and FR staff</th>
</tr>
</thead>
</table>

#### e. With Permanency and Transition Age Youth Services work:
- Role of enhanced use of Solution-Focused Questions and rigorous and balanced assessment
- Deepened use of working with/across difference approaches
- Role of conversations aids for working with youth (such as Three Houses, mapping with transition age youth or future house)
- Development of regular case consultation process of cases
- Deepened use of SDM Reunification Assessment in aiding decision-making
- Refinement of Harm and Danger Statements and Safety/Permanency/Independence Goals linking to Case Plans and referrals to community providers
- Deepened use of action steps and behaviorally-based language in all Case Plans integrated with the use of the Child and Adolescent Needs and Strength (CANS) tool
- Regular case consultations at key decision points and with particular cases (e.g. high child vulnerability, “stuck” cases, prior to permanency, emancipation conferences, etc.)
- Connection to CFT, TDM or other facilitated meeting structures
- Other?

| CW Director, Steering Committee or Implementation Team and Permanency and Youth Services staff |

#### f. With Facilitated Family Team Meetings (CFT, TDM and others):
- Role of enhanced use of Solution-Focused Questions and rigorous and balanced assessment
- Deepened use of working with/across difference approaches

| CW Director, Steering Committee, Implementation |

SOP Implementation Checklist

Rev. 06/06/2018
- Linking of facilitation structure with “rolling agenda” and mapping framework
- Use of SOP language and tools as the way to implement Child and Family Teaming
- Ability to provide multiple kinds of meetings at different critical junctures (imminent risk of removal/safety planning, emergency removal, case planning, placement decisions, STRTP approval, permanency roundtable, transition home, case closure, emancipation conferences, etc.)
- Other?

<table>
<thead>
<tr>
<th>5. Develop staging process for implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a. To be considered:</strong></td>
</tr>
<tr>
<td>- Early implementer strategy: Beginning with those most excited about the change</td>
</tr>
<tr>
<td>- Piloting strategy: Beginning with smaller workgroups</td>
</tr>
<tr>
<td>- Full implementation: Beginning with a plan for implementing across the whole organization</td>
</tr>
<tr>
<td>- A mix of all the above</td>
</tr>
</tbody>
</table>

Team and CFT Facilitator staff
6. Developing training, coaching and orientation plan; identify resources and begin

**NOTE:** Ensure if there are different training/coaching providers that curriculum and approach is linked

<table>
<thead>
<tr>
<th>a. Initial orientation and “kickoff”</th>
<th>CW Director, Steering Committee, Imp. Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify key stakeholders that need initial orientation</td>
<td></td>
</tr>
<tr>
<td>Include time for workgroups and considerations of structural changes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. Supervisor/leadership team training and coaching plan</th>
<th>CW Director, Steering Committee, Imp. Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial/Foundation training</td>
<td></td>
</tr>
<tr>
<td>Use of deeper-dive SOP modules and more in-depth training</td>
<td></td>
</tr>
<tr>
<td>Coaching plan: practice and demonstration</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c. Worker training and coaching plan</th>
<th>Plan developed by CW Director, Steering Comm, Imp. Team in coordination with training partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial/Foundation training</td>
<td></td>
</tr>
<tr>
<td>Use of deeper-dive SOP modules and more in-depth training</td>
<td></td>
</tr>
<tr>
<td>Coaching plan: practice and demonstration</td>
<td></td>
</tr>
</tbody>
</table>

Consider training-for-trainer strategies for large staff dissemination and/or identify other training resources as needed.

<table>
<thead>
<tr>
<th>d. Child and family team meeting facilitator training and coaching plan</th>
<th>Plan developed by CW Director, Steering Comm, Imp. Team in coordination with training partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial/Foundation training</td>
<td></td>
</tr>
<tr>
<td>Use of deeper-dive modules and more in-depth training</td>
<td></td>
</tr>
<tr>
<td>Use of co-facilitation format for early skill development of meeting facilitators</td>
<td></td>
</tr>
<tr>
<td>Coaching plan: practice and demonstration</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>e. Develop plan and infrastructure for ongoing coaching</th>
<th>CW Director, Steering Committee, Implementation Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider:</td>
<td></td>
</tr>
<tr>
<td>Coaching to be provided by outside sources</td>
<td></td>
</tr>
<tr>
<td>Development of internal coaches; potential coaching positions</td>
<td></td>
</tr>
<tr>
<td>Supervisors as coaches</td>
<td></td>
</tr>
</tbody>
</table>

7. Link to evaluation and CQI efforts

<table>
<thead>
<tr>
<th>a. Develop evaluation plan</th>
<th>CW Director, Steering Committee, Implementation Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Create logic model</td>
<td></td>
</tr>
<tr>
<td>Identify “hard” data expected to change in short-term</td>
<td></td>
</tr>
<tr>
<td>Identify “soft” data expected to change in short-term</td>
<td></td>
</tr>
<tr>
<td>Identify long-term changes</td>
<td></td>
</tr>
<tr>
<td>Identify fidelity measures particular for this site and implement</td>
<td></td>
</tr>
<tr>
<td>Create pre- and post- measures (can include baseline worker surveys as well)</td>
<td></td>
</tr>
<tr>
<td><strong>Link all to ongoing CQI efforts</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. If not currently in place, develop system to capture critical data</th>
<th>CW Director, Steering Comm Imp. Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider use of Safe Measures and potential requests that can be made to CRC data team to help support this work</td>
<td></td>
</tr>
</tbody>
</table>
8. Establish feedback loops

<table>
<thead>
<tr>
<th>Feedback from:</th>
<th>CW Director, Steering Committee, Implementation Team and entire organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Staff to implementation team</td>
<td></td>
</tr>
<tr>
<td>➢ Feedback from implementation team to leadership</td>
<td></td>
</tr>
<tr>
<td>➢ Feedback from data-gathering personnel to implementation team and leadership</td>
<td></td>
</tr>
<tr>
<td>➢ Feedback and ongoing communication from leadership to rest of organization</td>
<td></td>
</tr>
<tr>
<td>➢ Plan for updating implementation plan as needed</td>
<td></td>
</tr>
<tr>
<td>➢ Communication between stakeholders should “model the model” in all feedback</td>
<td></td>
</tr>
<tr>
<td>loops.</td>
<td></td>
</tr>
</tbody>
</table>
**Practice Model Summary**

Safety Organized Practice (SOP) is a collaborative child welfare practice approach that aims to build and strengthen partnerships within a family and involve the informal support networks of friends, family and the agency. SOP uses strategies and techniques that align with the belief that a child and his or her family are the central focus and that the partnership exists in an effort to find solutions that ensure safety, permanency, and well-being for children.

Safety Organized Practice is informed by an integration of practices and approaches including Solution-focused Practice, Signs of Safety, Structured Decision Making/Risk and Safety Assessment research, Group Supervision and Interactional Supervision, Appreciative Inquiry, Motivational Interviewing, Cultural Humility, and Trauma-Informed Practice.

**Goal of the Supervisor Checklist**

The goal of the Supervisor Checklist is to develop a fidelity assessment tool that allows agencies to gather feedback from supervisors on their workers’ current level of mastery of the skills and behaviors that are the hallmark of SOP. Fidelity is defined as the degree to which a practice as implemented corresponds with the practice as described or intended. Supervisors should be able to complete the tool independently, based on their regular interactions with workers. Results from the tool are intended to be shared as aggregate or group information at the agency level with the goal of being one piece of a larger fidelity assessment process. Additionally, the checklist should also support clinical supervision and dialogue with each worker as it helps them more systematically reflect on strong practice skills as well as skills that may need to be strengthened.

**Tool Reliability**

In assessing the psychometric properties of the tool among 338 child social workers, it was determined that the checklist could be shortened from 25 to 12 items. A combination of statistical and substantive reviews was used to condense the original checklist to 12 items. These 12 items were then evaluated in terms of reliability and potential differences across supervisors due to variation in training and hierarchical nesting (i.e., relationships between county, supervisor, and worker). Reliability evidence was reviewed in both the single-level and multilevel (nested) context. Evidence suggests that the instrument meets acceptable standards for reliability in both contexts.
Principles of Safety-Organized Practice (SOP): Supervisor Checklist

This survey asks questions related to practice indicators for SOP. Please select the rating that best fits the practitioner’s way of working with families overall, including every individual in that family. You are asked to rate the practitioner on a scale of 0 to 3, from “Never practicing this way” to “Consistently practices this way in a range of contexts.”

<table>
<thead>
<tr>
<th>Never</th>
<th>Emergent Practice</th>
<th>Accomplished Practice</th>
<th>Distinguished Practice</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practitioner does not implement skill or abilities in any context.</td>
<td>Building skills and abilities and creating an infrastructure to do so.</td>
<td>Practitioner is able to apply skills and abilities independently but in a limited range of settings and contexts.</td>
<td>Practitioner applies skills and abilities in a wide range of settings and contexts. They can do so independently and consistently while continuing to grow and improve.</td>
<td>Practitioner is not able to demonstrate skill or ability in current position.</td>
</tr>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
<tr>
<td>1. Practitioner identifies, with the family, what is currently working well and/or has worked in the past, to provide safety for the child/youth.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Practitioner considers his/her own assumptions and beliefs and how they influence interactions with children and families.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Practitioner inquires about families’ cultural resources and supports.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Practitioner shares openly, directly and transparently the worries of Child Welfare Services.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Practitioner elicits the child/youth’s views to inform a balanced assessment (e.g., both positive and negative impacts of caregiver actions, worries and hopes for the future).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Practitioner makes decisions in collaboration with the parents, extended family and support network.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Practitioner works with parents to identify support network, extended family and community members who can help provide safety for the child or youth over time.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Practitioner uses tools that support identification of family resources (e.g., genograms, safety circles and ecomaps).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Practitioner utilizes micro-skills in conversation with family members to elicit information (e.g., Solution-Focused Questions, Appreciative Inquiry, Motivational Interviewing).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. Practitioner creates detailed, short, behaviorally specific statements in clear, nonjudgmental language, using family’s language whenever possible, to communicate concerns, goals, and agreements. (e.g., utilizes harm &amp; danger statement and safety goals).</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Practitioner communicates past harm and future risk to family members in clear, simple, and behaviorally specific language.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. Practitioner works with the family and their support network to create behaviorally specific plans, detailing the actions that all involved will take to keep the child or youth safe.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
PRACTICE PROFILES FOR SAFETY ORGANIZED PRACTICE: HANDBOOK

DEVELOPED BY NCTA, CENTER FOR HUMAN SERVICES, UNIVERSITY OF CALIFORNIA DAVIS
VERSION DATE: 3/5/2018
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The Northern California Training Academy would like to thank the many contributors and expert reviewers who contributed to the development of the SOP Practice Profiles. We would like to pay special recognition to Nancy Hafer, MS, Nancy Goodman, MSW and Geri Wilson, MSW for their early work on the development and review of the profiles.
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About the Safety Organized Practice (SOP) Practice Profiles

Practice profiles attempt to define the **linear and gradual progression of skill acquisition** as a practitioner integrates a particular practice into their work. The SOP practice profiles were developed with an understanding that skill acquisition is not a linear process and is impacted by a variety of external factors. The SOP practice profiles define the **characteristics of skill** rather than the frequency that various SOP skills and tools are completed. The intent of the SOP practice profiles is to assist practitioners in assessing their current skill and to help guide appropriate goal setting as they work to deepen their skills in the practice.

Practice profiles have been developed for six key tools/areas of Safety Organized Practice. The areas tools/areas are:

- **Safety Mapping**
- **Integrating the Child’s Voice/Perspective**
- **Harm and Risk/Danger Statements**
- **Safety Planning**
- **Safety Networks**
- **Safety Goals**

As a practitioner works to develop skills using these techniques, the practice profiles can be used to help determine where they are in the development of their practice as well as what areas they can work to deepen.

**Growth Stages**

Skill acquisition is broken down into three broad stages (emergent, accomplished and distinguished). Each level is further broken into three sublevels to account for the gradual nature of skill development.

- **Emergent Practice** (Built Infrastructure and Now Using): The practitioner has taken action to integrate the practice into their work at a basic level. Moved beyond the act of thinking about integrating the practice but is demonstrating behaviors to use the practice.

- **Accomplished Practice** (Gaining Consistency and Collaborating): The practitioner has moved beyond working independently on the practice area and has begun to involve others in the process with consistency.

- **Distinguished Practice** (Innovating and Sustaining): The practice is integrated in the practitioner’s daily work with families and no longer perceives there are separate steps to be taken in implementing the practice. At the upper level of distinguished practice, it is anticipated that the practitioner is fully engaged in the particular practice area and such integration is seamlessly integrated into daily work activities. Additionally, efforts may be made to advance the practice and/or find ways to sustain the practice.
The definition for each level of practice has been written to showcase what practice would look like at the highest point of each level. The following example for Safety Mapping illustrates how a practitioner would move from a low end of Accomplished Practice to the midpoint.

Example: A practitioner whose rating of “4” for the practice area Content might have the parents, the grandparents, and a neighbor at the meeting to participate in a Safety Mapping process. The practitioner would ask each person the three questions and include their perspective on the map before adding the agency’s perspective. If they put each person’s perspective in their own words, instead of paraphrasing them, it would move their rating up to a “5.”

Using the practice profiles to guide professional development goal setting

When setting goals for the practitioner or as part of a coaching process, it is key to remember gradual progression. Development goals should be set to move from one step to the next, within practice levels, rather than from one practice level to the next. For example, as a practitioner you may choose a month-long goal of moving from a “1” in “emergent practice” to a “3.” At the end of the month, during a coaching session or alone, one may take a moment to reflect and assess the progress made. Some questions to consider during this assessment process include: Were there challenges to overcome? What helped? Did other areas of practice benefit or falter because of the extra effort put into developing this skill? New goals should be continuously set. These goals should be incremental, based on growth, and take into consideration unique situations.
Framework for the Practice Profiles

The SOP practice profiles are built upon the following Dialogue Structure, which should be used as a guide in the phrasing to be used while working with practitioners.

<table>
<thead>
<tr>
<th>Dialogue Structure Area</th>
<th>Key Aspects to Guide the Use of SOP Profiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>Provides the intended reasons for using a particular SOP strategy and the importance of verbally describing the process of using a SOP strategy and checking for understanding</td>
</tr>
<tr>
<td>Context</td>
<td>Importance of assessing the overall context for the meeting/activity.</td>
</tr>
<tr>
<td>Group Agreements</td>
<td>Building shared understanding and agreement on how everyone will work together to achieve the group’s desired outcomes.</td>
</tr>
<tr>
<td>Network/Stakeholders</td>
<td>Identifying and ensuring that everyone is included in the use of a particular SOP strategy who should be included.</td>
</tr>
<tr>
<td>Desired Outcome</td>
<td>The intended outcome(s) for using a particular SOP strategy. It should provide you with a guide for what to “walk away with” when using a particular strategy (a plan, list, decision, etc.).</td>
</tr>
<tr>
<td>Content</td>
<td>The “what” of the particular SOP strategy.</td>
</tr>
<tr>
<td>Next Steps</td>
<td>The ability to which the desired outcomes from the SOP strategy are utilized for subsequent case activities.</td>
</tr>
</tbody>
</table>
Using the Practice Profiles in Coaching

As a coach/supervisor, the practice profiles will provide you with concrete definitions for what the various elements of SOP should look like in practice and can help you work with your learners in developing professional development goals. The following is an EXAMPLE of how the practice profiles may be implemented:

Coaching an Individual

- **First coaching session using the practice profiles:**
  - Share the practice profile document with the learner. Use the FAQ document to answer questions.
  - Select one practice profile (i.e., Safety Mapping or Safety Planning) to complete in the coaching session. If possible, choose an area that the learner has been working on developing.
  - Read through the practice profile and have the learner rate their current level of skill acquisition in that area.
  - Give the learner a copy of all the practice profiles and ask them to look them over before your next coaching session.

- **Follow-up coaching sessions:**
  - Refer to goals set during the previous session. Ask the learner how they are progressing toward their goal(s).
  - If sample work is shared, use the practice profiles to help gauge proficiency. Provide examples from the practice profiles to explain your suggestions.

Coaching a Group

- **First coaching session using the practice profiles:**
  - Share the practice profile document with the learners. Use the FAQ document to answer questions.
  - Select one practice profile (i.e., Safety Mapping or Safety Planning) to complete in the coaching session. If possible, choose an area that the learners have been working on developing.
  - Read through the practice profile and have each learner in the group rate their own individual current level of skill acquisition.
  - Use the rating process to facilitate group discussion on the practice.
  - Give the learner a copy of all the practice profiles and ask them to look them over before your next coaching session.

- **Follow-up coaching sessions:**
  - Refer to goals set at the previous session. Ask learners how they are progressing toward their goal(s).
  - If sample work is shared, use the practice profiles to help gauge proficiency. Provide examples from the practice profiles to explain your suggestions.
<table>
<thead>
<tr>
<th>Stakeholders</th>
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<tbody>
<tr>
<td>Creates a Safety Map individually with a single client or solely in conjunction with a supervisor or coach in an office setting. Understands how the absence of family members and stakeholders affects the safety mapping process.</td>
<td>Prior to the mapping, has discussed with the family the importance of having some network participation, and includes the family in determining who the people will be who participate. With the family, works to include at least one other person in the meeting. Develops a plan to include the perspectives and voices of missing participants. Meets (or invites) other professionals to share information about the family and possible stakeholders to inform the Safety Map.</td>
<td>Everything in Accomplished Practice, plus: Reaches out to network members before the mapping session to help them understand the purpose/process of the mapping. Has robust participation by members of the network in the mapping session. Ensures the voice of the child is clear, and when possible actively involves the child. Ensures the safety of the group by anticipating possible conflict among participants and setting up alternative ways of participating, i.e., telephone access.</td>
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<tr>
<th>Group Agreements</th>
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<tr>
<td>Lays out a series of pre-made group agreements designed to help provide direction on how people will work together during the mapping.</td>
<td>Provides some pre-made group agreements but also strives to elicit group agreements from the family and the Safety Network members attending the meeting.</td>
<td>Everything in Accomplished Practice, plus: Takes time to explain the purpose behind having group agreements and uses questions to help the family develop the majority of the agreements. Worker adds only when a major area is being missed. Where appropriate, uses group agreements in particular to promote a safe environment in which the child can share his/her perspective, experiences and hopes.</td>
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### Purpose

**Safety Mapping** is a process of dialogue and inquiry designed to help social workers, families and extended networks work together to surface the different aspects of danger and safety present in the family and move toward group agreements about what needs to happen next to ensure the safety of the child.

<table>
<thead>
<tr>
<th>Purpose</th>
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<tbody>
<tr>
<td>Describes Safety Mapping as a tool to organize information about danger and safety into three categories: ▪ What are we worried about? ▪ What's working well? ▪ What are the next steps?</td>
</tr>
<tr>
<td>Describes Safety Mapping as ▪ A tool to organize information about danger and safety into an assessment and planning process that maps the harm, danger, complicating factors, and existing safety and strengths. ▪ A collaborative tool used with families and their network to develop a relationship of trust and gain their perspective on the events that brought CWS into their lives and to help them reach their goals. ▪ An approach to assessment and safety planning that focuses the conversation, assessment and planning on child safety and the impact of the caregiver’s actions. Displays an integration of mapping with other decision support tools (i.e., SDM) to develop rigorous Safety Goals and Safety Plans.</td>
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<tr>
<td>Everything in Accomplished Practice, plus: Describes safety mapping as a process of building shared understanding and agreement among all stakeholders re: the danger, safety, and risk to the child.</td>
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<td><strong>Safety Mapping (continued)</strong></td>
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<td><strong>Context</strong></td>
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<td><strong>Desired Outcomes</strong></td>
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### Integrating the Child’s Perspective

Two key principles in SOP are (1) the understanding that children likely witness much of what goes on in their families’ lives and can contribute to a comprehensive understanding of what is currently happening in the family, and (2) the belief that children often can and need to collaborate with other stakeholders in their own safety planning. Therefore, the extent to which a social worker can **incorporate the child’s perspective** into their work is critical to successful child welfare practice.

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<tr>
<th>Purpose</th>
<th>Emergent Practice</th>
<th>Accomplished Practice</th>
<th>Distinguished Practice</th>
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<tbody>
<tr>
<td></td>
<td>Builds trust and positive connections with the child/youth.</td>
<td>Everything in Emergent Practice, plus:</td>
<td>Everything in Accomplished Practice, plus:</td>
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<tr>
<td></td>
<td>Gathers information regarding current danger, safety and overall family functioning and inform casework processes.</td>
<td>Engages caregivers and other stakeholders in building a shared understanding of the child’s perspective relative to danger, safety and overall family functioning.</td>
<td>Where appropriate, enables the child/youth to share his or her perspective, experiences and hopes for the next steps to increase safety, permanency and well-being</td>
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<td></td>
<td>Discusses with caregivers the impact of their actions on the child/youth.</td>
<td>Builds agreement on how the child’s/youth’s perspective will inform next steps to increase safety, permanency and well-being</td>
<td>Where appropriate, enables the child’s/youth’s active involvement in key points of the casework and safety planning process.</td>
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<tr>
<th>Group Agreements</th>
<th>Emergent Practice</th>
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<th>Distinguished Practice</th>
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<tbody>
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<td></td>
<td>Actively checks for understanding and agreement with the child/youth and caregivers regarding the purpose and desired outcomes of incorporating the child's/youth's perspective.</td>
<td>Everything in Emergent Practice, plus:</td>
<td>Everything in Accomplished Practice, plus:</td>
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<tr>
<td></td>
<td>Builds shared understanding and agreement with the child/youth on process of eliciting their perspective, specifically focusing on how and under what circumstances this information will be shared.</td>
<td>Builds shared understanding and agreement among family and other stakeholders on how everyone will work together to elicit the child’s perspective; incorporates this in the plan to increase safety, permanency and well-being.</td>
<td>Uses group agreements to promote working relationships in which participants can share their individual contexts, perspectives and differences of opinion regarding the child’s/youth’s perspective, experiences and hopes.</td>
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<td></td>
<td>Actively uses these group agreements to foster open discussion among caregivers and network members regarding the child’s perspective and how this impacts their work to increase safety, permanency and well-being.</td>
<td>Where appropriate, uses group agreements to promote a safe environment in which the child/youth can share their perspective, experiences and hopes.</td>
<td>Where appropriate, uses group agreements to promote a safe environment in which the child/youth can share their perspective, experiences and hopes.</td>
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<tr>
<th>Stakeholders</th>
<th>Emergent Practice</th>
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<th>Distinguished Practice</th>
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</thead>
<tbody>
<tr>
<td>Uses information from the child's/youth's perspective to inform assessment, planning and decision making independently or in conjunction with their supervisor/coach.</td>
<td>Everything in Emergent Practice, plus:</td>
<td>Everything in Accomplished Practice, plus:</td>
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<tr>
<td>Engages the child to elicit his/her perspective.</td>
<td>Works with family to identify other individuals or organizations that have an investment in including the child’s/youth’s perspective to inform next steps to increase safety, permanency and well-being.</td>
<td>When appropriate and possible, actively includes the child/youth in the next steps to increase safety, permanency and well-being.</td>
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<tr>
<td>Engages caregivers in discussion of the child’s/youth’s perspective.</td>
<td>Works to include these individuals or organizations in the planning and/or decision-making process</td>
<td>Ensures the safety of the group by anticipating possible conflict among participants and setting up alternative ways of participating, i.e., telephone access.</td>
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<tr>
<td>Meets (or invites) other professionals to share information about the child’s perspective.</td>
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### Integrating the Child’s Perspective (continued)

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<th>Emergent Practice</th>
<th>Accomplished Practice</th>
<th>Distinguished Practice</th>
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<tr>
<td><strong>Context</strong></td>
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<tr>
<td>Has awareness that the child's/youth’s caregivers and CWS may have conflicting priorities regarding the inclusion of the child's/youth’s perspective in the casework process.</td>
<td>Asks the child/youth, caregivers and stakeholders about what things may get in the way of including the child’s perspective in the process of increasing child safety.</td>
<td>Everything in Accomplished Practice, plus: Brainstorms with child/youth, family and Safety Network how to mitigate individual and systemic barriers to including the child's/youth’s perspective, experience and hopes.</td>
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<tr>
<td><strong>Content</strong></td>
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<tr>
<td>Uses a variety of interviewing techniques and tools, (e.g., Three Houses tool, Safety House, Appreciative Inquiry, Solution-Focused Questions) to elicit the child's/youth’s perspective, focusing especially on:</td>
<td>Works to elicit concrete details from the child/youth to narrow the focus specifically on the impact of the caregiver’s actions, identifying danger and safety. Where appropriate actively facilitates the child's/youth’s articulation of their perspective to caregivers and other professionals.</td>
<td>Everytning in Accomplished Practice, plus: Where appropriate, facilitates the child's/youth's active participation in key points of the casework process.</td>
</tr>
<tr>
<td><strong>Desired Outcomes</strong></td>
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<tr>
<td>The child/youth feels their perspective has been heard by CWS. An understanding of the child's/youth’s perspective to inform casework process and decision-making. Shared understanding of the child’s/youth’s perspective with the caregiver.</td>
<td>Everything in Emergent Practice, plus: Shared understanding with all stakeholders on the child's/youth’s perspective on danger, safety and risk. Shared agreement on how this will inform the next steps to increase safety, permanency and well-being.</td>
<td>Everything in Accomplished Practice, plus: The child/youth feels that his/her perspective and hopes are heard by the stakeholders and that he or she made a contribution to increase his or her safety.</td>
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<td><strong>Next Steps</strong></td>
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<tr>
<td>Uses information from the interview process to inform the casework process.</td>
<td>Everything in Emergent Practice, plus: In collaboration with caregivers and other stakeholders, actively integrates the child's/youth’s perspective into goal setting and safety planning processes.</td>
<td>Everything in Accomplished Practice, plus: Where appropriate, facilitates the child's/youth’s continued involvement in the Safety Goal setting and planning processes.</td>
</tr>
<tr>
<td>Purpose</td>
<td>Emergent Practice</td>
<td>Accomplished Practice</td>
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<td></td>
<td>Built Infrastructure and Now Using</td>
<td>Gaining Consistency and Collaborating</td>
</tr>
<tr>
<td>Harm and Risk/Danger Statements</td>
<td>Describes Harm and Risk/Danger Statements as key elements of Safety Mapping that are about what happened to the child that brought them to the attention of CWS and about what might happen in the future.</td>
<td>Describes Harm and Risk/Danger Statements as key elements of Safety Mapping that have clear and specific statements about the harm to the child in the care of the parents.</td>
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</tbody>
</table>

**Harm statements and danger statements (or risk statements) are short, simple, behavior-based statements that can be used to help family members, collaterals and staff working with the family become very clear about what has happened in the past, why CWS are involved with families and what CWS staff worry may happen in the future. They lay the groundwork for the important “difficult conversations” to occur and help ensure that we are talking about the most important things to address with the families with whom we work.**

- **Harm Statement**
  1. Who reported (“or it was reported that…”).
  2. What happened to the child, where, when, etc.
  3. The impact it had on the child.

- **Danger Statement**
  1. “CWS is worried that….” (or the SW and other professionals or others in the family network are worried that…).
  2. Behavior/action of the parents (what parents might do).
  3. Possible impact on the child (what we are worried may happen to the child, or what may happen to the child again).

- Describes the development of Harm and Risk/Danger Statements as important to clearly identify the caregiver actions that have a harmful effect on the child, so that everyone understands the worries about danger and the reason for CWS involvement.

**Group Agreements**

- Uses Harm and Risk/Danger Statements to engage caregivers in the casework process and checks for their understanding and agreement with these statements.
- Fosters open discussion among family, and professionals regarding the Harm and Risk/Danger Statements.
- Engages the family, their network and other stakeholders in the safety mapping process to develop Harm and Risk/Danger Statements.
  - Uses group agreements to promote working relationships in which participants can share their individual contexts, perspectives and differences of opinion to inform the development of the statements.
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<td></td>
<td>Develops Harm and Risk/Danger Statements as an individual activity or in consultation with a supervisor to identify harm and danger. Shares statements with caregivers and checks for understanding.</td>
<td>Works with the family to identify stakeholders in the child’s safety. Develops a plan to share the Harm and Risk/Danger Statements with the family, Safety Network and professionals. Ensures the safety of the group by anticipating possible conflict among participants and setting up alternative ways of participating, i.e., telephone access.</td>
<td>Everything in Accomplished Practice, plus: Ensures the voice of the child/youth is clear, and when possible actively involves the child/youth in the development of Harm and Risk/Danger Statements.</td>
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<tr>
<td>Context</td>
<td>Voices concern that other casework demands will impact the ability to develop Harm and Risk/Danger Statements in the course of an assessment or investigation. Has awareness that the caregivers and CWS may have conflicting priorities re: the purpose and use of Harm &amp; Risk/Danger Statements.</td>
<td>Asks about the individual and systemic barriers that challenge the family and professionals’ understanding of and agreeing with the Harm and Risk/Danger Statements. Is aware that participants may have other commitments that make it difficult to reach agreement on the statements.</td>
<td>Brainstorms with family and Safety Network how to mitigate individual and systemic barriers to the group’s reaching shared understanding and agreement regarding the Harm and Risk/Danger Statements.</td>
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<tr>
<td>Content</td>
<td>Uses Harm and Risk/Danger Statements as an individual activity or in consultation with a supervisor to identify harm and danger. Preliminary Harm Statements often include clinical, professional language to describe caregiver actions and the impact on the child.</td>
<td>Refines any preliminary Harm and Risk/Danger Statements with the family, network and other professionals to include all voices in describing the harm to the child and the reason for CWS involvement. Statements begin to reflect the behavioral descriptions of caregiver actions and the impact on the child.</td>
<td>Guides the group process to: * Formulate shared Harm and Risk/Danger Statement. * Ensure that statements are described in specific behavioral terms. * Identify concrete logistical next steps for the group to meet. Actively checks for shared understanding and agreement with all participants regarding the iterative safety mapping process and identified next steps. Checks in with the child (as appropriate) to determine their understanding and agreement with the Harm and Risk/Danger Statements.</td>
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<tr>
<td>Desired Outcomes</td>
<td>A Harm and Danger Statement that uses the reason for referral and available case history to describe: 1. What happened 2. The impact to the child 3. What CWS is worried about</td>
<td>A Harm and Danger Statement that describes the harm, safety threats and worries to the family, their network and other professionals so there is a clear understanding of why CWS is involved with the child and family. Harm and Danger Statement becomes the platform for developing the Safety Goals (what it needs to look like for reunification or case closure).</td>
<td>A Harm and Danger Statement has been developed with the family, network and other professionals that includes a description of the harm that resulted from the caregiver’s behaviors and the stakeholders’ worries about future harm. The network then collaborates to use the Harm &amp; Danger Statement to co-develop the Safety Goals (what) and Safety Plan (how).</td>
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<td>Reflection</td>
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<tr>
<td>Holds the preliminary Harm and Danger Statement as a theory of what may have happened and what could happen in the future if nothing changes.</td>
<td>Refines the Harm and Danger Statement with the family to reflect more concrete behavioral descriptions of what specifically occurred.</td>
<td>Facilitates a space where all stakeholders can reflect on and critically think about their understanding of the facts that led to the Harm and Danger Statement.</td>
<td>Stakeholders hold a balanced view of how not just the history of harm, but also the history of protection, contributes to how worried we should be about future danger.</td>
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<tr>
<td>Discusses theories about the Harm and Risk/Danger Statements with supervisor or other professionals.</td>
<td>Invites others' perspectives and is more open to exploring alternative reasons the harm may have happened or that it may not have occurred as originally suspected.</td>
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<tr>
<td>Refines the Harm and Danger Statement with the family to reflect more concrete behavioral descriptions of what specifically occurred.</td>
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<td>Invites others' perspectives and is more open to exploring alternative reasons the harm may have happened or that it may not have occurred as originally suspected.</td>
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<tr>
<td>Facilitates a space where all stakeholders can reflect on and critically think about their understanding of the facts that led to the Harm and Danger Statement.</td>
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<tr>
<td>Stakeholders hold a balanced view of how not just the history of harm, but also the history of protection, contributes to how worried we should be about future danger.</td>
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<th>Next Steps</th>
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<tbody>
<tr>
<td>Uses Harm and Risk/Danger Statements individually to focus the harm and danger to the child and determine next steps in service planning and provision.</td>
<td>Ties Harm and Risk/Danger Statements in the context of Safety Mapping to engage the family, their network and professionals in the development of concrete, measurable actions (Safety Plan) that, when demonstrated over time, will ensure child safety.</td>
<td>Uses Harm and Risk/Danger Statements in the context of Safety Mapping so that the family, their network and other professionals develop a clear understanding of what it needs to look like for CWS to be satisfied that the child is safe.</td>
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<td>Follows up with caregivers to attend to the needs of the child.</td>
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For questions regarding California’s Practice Profiles, or this tool and permission to use please contact Melanie Schindell, mschindell@ucdavis.edu

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<th></th>
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<td></td>
<td>Built Infrastructure and Now Using</td>
<td>Gaining Consistency and Collaborating</td>
<td>Innovating and Sustaining</td>
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<tr>
<td><strong>Safety Planning</strong></td>
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<tr>
<td><strong>Safety Plans</strong></td>
<td>specifically address dangers the family and people identified in the Safety Network have agreed to resolve. The Safety Plan is the <em>method</em> of addressing the Danger Statement and <em>achieving</em> the Safety Goal.</td>
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<tr>
<td><strong>Purpose</strong></td>
<td>Describes Safety Planning as a process to address immediate danger to the child and focuses on the family taking specific actions to mitigate the risk.</td>
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<td>Describes Safety Planning as:</td>
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<td>• A process that includes the voices of the parents, children and Safety Network as integral parts.</td>
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<td>• A process to address the Danger Statement and achieve the Safety Goal.</td>
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<td></td>
<td>Describes Safety Planning as:</td>
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<td>• A process that involves multiple meetings to ensure child safety has been enhanced.</td>
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<td>• An ongoing practice with the family’s Safety Network throughout family’s involvement with CWS.</td>
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<td>• A practice intended to prevent child removals and increase timely reunification.</td>
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<tr>
<td><strong>Group Agreements</strong></td>
<td>Actively checks for understanding and agreement among caregivers to the identified safety plan and goals.</td>
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<td>Builds shared understanding and agreement among all family Safety Network members on how the network will work together to ensure child safety.</td>
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<tr>
<td></td>
<td>Actively uses group agreements to foster open discussion among family Safety Network members.</td>
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<tr>
<td></td>
<td>Uses group agreements to promote working relationships in which participants can share their individual contexts, perspectives and differences of opinion to inform the development of the safety plan.</td>
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<tr>
<td><strong>Stakeholders</strong></td>
<td>Creates a safety plan individually or in conjunction with their supervisor (coach).</td>
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<td></td>
<td>Engages the family to reach agreement on implementing the safety plan. Understands how the absence of family members and stakeholders affects the safety planning process.</td>
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<td></td>
<td>Includes the family in determining who will attend the safety planning meeting.</td>
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<td></td>
<td>Develops a plan to include the perspectives and voices of missing participants.</td>
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<td></td>
<td>Meets (or invites) other professionals to share information about the family and possible stakeholders to inform the safety plan.</td>
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<td></td>
<td>Everything in Accomplished Practice, <em>plus</em>:</td>
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<tr>
<td></td>
<td>Ensures the voice of the child/youth is clear, and when possible actively involves the child in the Safety Planning process.</td>
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<td></td>
<td>Ensures the safety of the group by anticipating possible conflict among participants and setting up alternative ways of participating, i.e., telephone access.</td>
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<tr>
<td><strong>Context</strong></td>
<td>Has awareness that the caregivers and CWS may have conflicting priorities regarding the purpose and content of the safety plan.</td>
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<td></td>
<td>Asks participants about what things may get in the way of participating fully in safety planning.</td>
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<td></td>
<td>Asks about the individual and systemic barriers that challenge the group, particularly the family and Safety Network, in safety planning.</td>
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<td>Is aware that Safety Planning is a group process and that participants may have other commitments that make it difficult to engage.</td>
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<td></td>
<td>Brainstorms with family and Safety Network on how to mitigate individual and systemic barriers to the safety planning process.</td>
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</table>
### Emergent Practice

- Uses the safety plan to inform what services might be offered to the family.
- Discusses specific actions by caregivers and Safety Network that may either prevent the removal of the child or promote reunification.

### Accomplished Practice

- Shares safety plan with child, family, Safety Network and stakeholders and checks for understanding and agreement for participation and implementation.
- Checks for participants’ compliance with safety plan and makes modifications as necessary.
- Comes prepared with ideas about potential actions the family and Safety Network can take.
- Uses the Danger Statement and Safety Goal to inform plan.

### Distinguished Practice

- Guides the group process to:
  - Formulate shared danger statement and Safety Goal to inform plan.
  - Ensure that the danger statement and Safety Goals are described in specific behavioral terms.
  - Identify the child’s role in the plan if appropriate.
  - Identify the process by which the group will test and modify the safety plan.
  - Identify concrete logistical next steps for the group to meet.
- Actively checks for shared understanding and agreement with all participants regarding the safety planning process and each participant’s responsibilities in the plan.
- Checks in with the child (as appropriate) to determine their understanding and agreement with the danger statement, Safety Goal and plan.

### Desired Outcomes

- A plan that includes tasks for caregiver to keep their child safe.
- Agreement by family members to implement plan.
- Shared understanding and agreement on the safety planning process and goals.
- Shared understanding and agreement on the danger, safety and risk level for the child. Each network member will receive a copy of the safety plan written in clear and easy to understand way describing what the next steps are to ensure child safety.
- A safety plan with action steps that are perceived by family Safety Network members as being meaningful and feasible within specific timeframes.
- Shared understanding and agreement by all participants on their individual roles and responsibilities.
- Shared understanding and agreement among network members of what it will look like when the children are safe and the case can close.

### Reflection

- Assesses the family’s capacity to comply with safety plan in supervision.
- Creates space for participants to focus on the merits of the plan and their confidence in their ability to implement the plan while encouraging the group to reflect on how to make the process more useful.
- Actively engages Safety Network members to critically evaluate their group process.
- Specifically focuses on ways to increase understanding, agreement and collaboration.
- Assesses facilitation of group process in supervision.
- Engages the Safety Network to describe how they will know the safety plan is effective.

### Next Steps

- Uses Safety Plan individually to focus casework and determine next steps in service planning and provision.
- Engages the family, their network and professionals to stay focused on the Safety Plan they developed in partnership.
- Checks in with the child/youth and the family to determine their comfort with the plan and the action steps taken so that the child is safe and CWS can close the case.
- Schedules subsequent meetings when necessary to review the safety plan and the continuing roles of the Safety Network to check for compliance and success of the plan.
<table>
<thead>
<tr>
<th>Purpose</th>
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<tbody>
<tr>
<td>describes a safety network as individuals who support caregivers.</td>
<td>describes a safety network as a group of individuals who would work with CWS to increase child safety.</td>
<td>describes a safety network as a group of individuals who are invested in ensuring a child's safety and collaborate to identify Safety Goals, create a safety plan and actively implement the plan.</td>
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<th>Group Agreements</th>
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<td>is aware that caregivers and CWS may have conflicting priorities regarding identification of possible Safety Network members and their role in safety planning.</td>
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<td>Asks caregivers for a list of family and friends who are past and current supports to their family. Uses the Safety Circles activity with caregiver to expand the Safety Network. Helps caregivers to critically think through whom else may be included in Safety Network.</td>
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<td>Safety Networks (continued)</td>
<td>A list of potential individuals who may want to participate in a family meeting.</td>
<td>Agreement from the Safety Network to support the caregiver’s safety plan. Understanding and agreement from the Safety Network on their responsibilities to implement the safety plan.</td>
<td>Shared understanding and agreement among the Safety Network members regarding group agreements, next steps and their mutual roles in increasing child safety. The Safety Network implements the plan and is able to follow through on their roles.</td>
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<td>Reflection</td>
<td>Assesses the family’s capacity use their Safety Network.</td>
<td>Engages caregivers to evaluate the strength of their Safety Network. Elicits their concerns and identifies the strengths of the members.</td>
<td>Creates space for network members to critically evaluate their relationships. Elicits from them the strengths of their network as well as its challenges. Brainstorms ways to address challenges.</td>
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<td>Next Steps</td>
<td>Plans at least one follow-up meeting with family and Safety Network.</td>
<td>Checks in with the family and Safety Network regularly to determine if the plan is adequate to meet the child’s safety needs. Follows up with caregivers to determine if additional Safety Network members should be included.</td>
<td>Ensures that the Safety Network shares the understanding that the safety plan is a process and there is a need for ongoing assessment of its effectiveness (linking with desired outcomes). Checks in with the child and the family to determine their comfort with the plan and actions of the Safety Network. Schedules subsequent meetings when necessary to review the safety plan and the continuing roles of the Safety Network to check for compliance and success of the plan.</td>
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Emergent Practice  
Built Infrastructure and Now Using

Accomplished Practice  
Gaining Consistency and Collaborating

Distinguished Practice  
Innovating and Sustaining

### Safety Goals

Often in child welfare, goals are *service-driven* rather than *safety-driven*. A key element of Safety Organized Practice is the use of simply written goals that clearly and unambiguously address the danger. These goals should address the danger or risk of danger; be collaboratively created with the family members, and when that is not possible, include the presence of choices for the family; be written in clear, everyday language; and describe the presence of new, observable behaviors or actions (particularly with the children) rather than the absence of old problematic behaviors.

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<td></td>
<td>Describes Safety Goal setting as a process to create tasks for caregivers to mitigate the danger or risk of danger to their children.</td>
<td>Describes the process of developing Safety Goals as a collaborative effort to identify case plan tasks with the caregivers, Safety Network and stakeholders. Describes Safety Goal setting as a process that allows the agency, caregivers and Safety Network to plan for the future safety of the child and makes the Safety Plan more meaningful and relevant to the caregivers. Describes Safety Goals as providing focus and direction for comprehensive safety planning.</td>
<td>Describes the process of developing Safety Goals as identifying what the Safety Network and the agency and other stakeholders, would need to see the caregivers doing, in the care of their children, to make the team secure that the child protection concerns have been addressed and the child will be safe in their care in relation to the identified dangers or risks for danger to the child. (all need to be demonstrated) Describes Safety Goals as the actions the team sees demonstrated over time. Recognizes goal setting as a process (rather than a single event) that will need revisiting multiple times to ensure child safety is continually enhanced.</td>
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<td>Develops agency Safety Goals because it is an agency requirement.</td>
<td>Develops individual agency and caregiver Safety Goals with the caregivers and others. Engages caregivers in a dialogue to build shared understanding and agreement on content and purpose of Safety Goals.</td>
<td>Ensures group agreements create a safe environment in which participants can share individual contexts, perspectives and differences of opinion to inform the development of the Safety Goals.</td>
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<tr>
<th>Stakeholders</th>
<th>Emergent Practice</th>
<th>Accomplished Practice</th>
<th>Distinguished Practice</th>
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<td></td>
<td>Creates Safety Goals individually or in supervision and shares with caregivers.</td>
<td>Conducts Safety Goal setting as a group process which could include the family, their network and other professionals. Describes the impact of the absence of key stakeholders in the Safety Goal setting process.</td>
<td>Conducts Safety Goal setting as a group process with the family, the Safety Network and agency staff and other professionals. Arranges meetings in advance to help insure accessibility to everyone who wishes to participate in the process.</td>
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<th>Distinguished Practice</th>
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<td></td>
<td>Is aware that the caregivers and the agency may have conflicting priorities regarding the content and purpose of the Safety Goals.</td>
<td>Asks participants what may get in the way of actively participating in Safety Goal setting. Asks about individual and systemic barriers that challenge the group, particularly the caregivers and the Safety Network, in Safety Goal setting.</td>
<td>Brainstorms with caregivers and others on how to mitigate individual and systemic barriers to setting Safety Goals.</td>
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<td>Emergent Practice</td>
<td>Accomplished Practice</td>
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<tr>
<td><strong>Content</strong></td>
<td>Creates Safety Goals individually or in consultation with supervisor for the caregivers. There is no reference to danger statements, risk of danger statements, or caregiver resources.</td>
<td>Uses the danger statement or risk for danger to inform Safety Goal content and purpose. Draws on caregivers' resources and abilities (past acts of protection) in the development of Safety Goals.</td>
<td>Everything in Accomplished Practice, plus: Provides opportunities for the child's concerns to be incorporated in the Safety Goal setting process. Actively includes the child in the process of setting goals as appropriate. Safety Goals are clear about what behavioral changes need to occur over what time frame where everyone is satisfied that the child is safe.</td>
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<tr>
<td><strong>Desired Outcomes</strong></td>
<td>A plan that includes Safety Goals for the caregiver(s) to keep child safe. Safety goals are written as tasks to be completed by the caregivers.</td>
<td>Safety Goals clearly identify the behavioral changes needed to increase child safety. Safety Goals are written in clear language the caregivers understand. Safety Goals are directly related to the danger statements or the risk for danger statements.</td>
<td>Safety goals have clear time frames that all stakeholders, the Safety Network and agency staff could see demonstrated for them to be confident that safety would continue once the case was closed. Safety goals clearly inform next steps and safety plan. Safety goals are used to measure progress of increased child safety.. Shared understanding and agreement of the Safety Goals by caregivers, the Safety Network and stakeholders.</td>
</tr>
<tr>
<td><strong>Reflection</strong></td>
<td>Assesses the caregiver's capacity to achieve the Safety Goals developed.</td>
<td>Engages caregivers to evaluate the plan developed to achieve the Safety Goals that have been developed.</td>
<td>Creates space for the caregiver and other Safety Network members to critically evaluate the Safety Goals that have been developed. Elicits from them the strengths of their network as well as its challenges in achieving the Safety Goals. Brainstorms ways to address challenges.</td>
</tr>
<tr>
<td><strong>Next Steps</strong></td>
<td>Uses the Safety Goals to inform what services might be offered to the family.</td>
<td>Uses Safety Goal setting to engage the family, their network and professionals to develop an understanding of what specific resources will assist to activate change in the caregivers' behavior which are necessary to promote child safety by the caregivers and their network. Considers resources that maybe outside the traditional options prescribed.</td>
<td>Maintains focus on the Safety Goals established by the team and continually tracks progress toward achieving the goals. Considers the stage the caregivers are at in achieving the goals to determine the next steps which are needed to achieve child safety. Schedules ongoing meetings with the caregivers and network to review the relevance of current goals and needs for developing future goals.</td>
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Frequently Asked Questions (FAQs)

WHAT DO I NEED TO KNOW ABOUT THE DESIGN OF THE PROFILES? (PURPOSE)

- The SOP Practice Profiles were designed to outline characteristics of various skill levels rather than the frequency in which tasks associated with the practice are completed.

- To account for the gradual nature of skill development, the practice level definitions have been written to showcase what practice would look like at the highest point of each level.

- Workers will generally make the most progress if they focus on a few key skill aspects at a time, and then reflect on their practice to select the next areas to improve.

- They are an attempt to describe a set of complex and dynamic skills. It is important to hold on to the fact that there is a multidimensional and cumulative relationship to these profiles.

HOW DO I BEST USE PRACTICE PROFILES IN SUPERVISION? (CONTEXT)

- We strongly encourage utilizing SOP practice profiles as a coaching support tool as opposed to an audit tool used for performance appraisal.

- Supervisors must set aside their “hierarchical hat” when coaching workers on integrating a new or deeper practice into their daily activities. It is essential to create shared understanding and agreement with one another about the purpose and process of the practice profiles assessment prior to setting performance goals and timelines. Ideally, the two processes might be kept distinct from each other – coaching using the practice profiles as distinct from performance appraisal.

- It is best practice to use all of the practice profiles together and not just one in isolation; however, some workers may need to take them in linear order, e.g. learn to ask Three Questions first, then Safety Map with the family, and then form good Harm/Danger Statements.

- Using the practice profiles to guide group supervision allows the supervisor to shift the conversation from workers seeking answers solely from the supervisor to peer-to-peer case consultation structured by the practice profile content.

- Orienting new social workers to child welfare practice can be a challenge. The practice profiles remind the supervisor and the worker that learning is a developmental process. Be sure to set the stage for acceptance of gradual practice development, and avoid placing undue pressure on staff to become proficient right away.
WHICH WORKERS DO I USE THIS WITH? (STAKEHOLDERS)

- It is best to select the “early adopters” of SOP in your unit who have already expressed an interest in deepening their practice skills.

- Give workers the option of “trying on” the new practices for a bit, and then check in to see if they are open to formalizing the coaching process with you.

- Encourage those who are disinterested to observe or shadow other staff using SOP practices in the field before making a commitment to coaching.

WHERE DO I BEGIN AND WHAT SHOULD I EXPECT TO ACHIEVE? (DESIRED OUTCOMES)

1. Begin with a conversation that follows the Dialogue Structure (supervisors can model the use of this structure in any conversation or meeting) to identify one another’s best hopes and worst fears of using the practice profiles in supervision.

2. Make clear agreements about how often you will meet and for how long (e.g. once a month for two hours or every other week for one hour), and be explicit about how this will be used internally. Workers will be more open and vulnerable if they trust this won’t be used against them as part of a performance appraisal.

3. Lastly, follow the steps below to identify the specific goals of the caseworker seeking to assess and deepen his/her SOP skill level.

WHAT ARE THE STEPS FOR GOAL SETTING WITH EACH WORKER? (CONTENT)

1. Once agreements are clear, supervisors and workers should walk through the profiles together to determine the key areas of interest to the worker and supervisor (e.g. use of Three Questions with families, crafting Harm/Danger Statements, Three Houses with children).

2. Outline measurable skills/behaviors the worker will integrate into practice over a specified amount of time rather than seek strategy usage on every case.

   Examples:

   a. Use Three Questions with caregivers on 5 cases in next 30 days.

   b. Do the Three Houses with 2 children or sibling groups in next 2 weeks.

   c. Do Safety Circles activity to expand the network with one family by next Friday.

HOW DO I MEASURE PROGRESS? (FEEDBACK & NEXT STEPS)

- It is best to begin by having the worker reflect on what s/he did well since you last met, and what s/he would like to do differently going forward. Ask the worker to do a current rating based on projected goals. For example, she wanted to reach a level 5, but may have done some work at a level 6.
• Share what you observed that was aligned with the goals set and what, if anything, you would encourage the worker to try next time.
• Ask the worker to set goals to achieve the originally set skill level (if not yet achieved), or to set new practice goals to move skill level targets up by one, like you did last time.
• Congratulate the worker on progress to date! Keep the focus on what is working well and celebrate the small successes as you go.
Safety Organized Practice: Safety Planning
Practice Profiles Rating Summary Sheet

Directions: After working through the practice profile assessment tool with your mentee/staff person, please use this summary scoring sheet.

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Dialogue Structure</th>
<th>Level (1-9)</th>
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<td>Safety Planning</td>
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Safety Planning specifically addresses dangers the family and people identified in the safety network have agreed to resolve. The Safety Plan is the method of addressing the Danger Statement and achieving the Safety Goal.
Safety Organized Practice: 
Incorporating the Child’s Perspective 
Practice Profiles Rating Summary Sheet

Directions: After working through the practice profile assessment tool with your mentee/staff person, please use this summary scoring sheet.

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<thead>
<tr>
<th>Rater’s Name:</th>
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<tbody>
<tr>
<td>Role:</td>
<td>☐ Coach ☐ Supervisor ☐ Self ☐ Other:</td>
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<td>Date:</td>
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<td>Is follow-up planned:</td>
<td>☐ Yes ☐ No</td>
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Incorporating the Child’s Perspective

Two key principles in safety-organized practice are (1) the understanding that children likely witness much of what goes on in their families’ lives and can contribute to a comprehensive understanding of what is currently happening in the family, and (2) the belief that children often can and need to collaborate with other stakeholders in their own safety planning.

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<td>7</td>
<td>8</td>
<td>9</td>
</tr>
</tbody>
</table>
Safety Organized Practice:
Harm and Risk/Danger Statements
Practice Profiles Rating Summary Sheet

Directions: After working through the practice profile assessment tool with your mentee/staff person, please use this summary scoring sheet.

<table>
<thead>
<tr>
<th>Rater’s Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Role:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Coach</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Is follow-up planned:</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Dialogue Structure</th>
<th>Level (1-9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm &amp; Risk/Danger Statements</td>
<td>Purpose</td>
<td>Emergent</td>
</tr>
<tr>
<td>Harm statements and risk/danger statements are short, simple behavior-based statements which can be used to help family members, collaterals and staff working with the family become very clear about what has happened in the past, why CWS is involved with families and what CWS staff worry may happen in the future.</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Group Agreements</th>
<th>1 2 3 4 5 6 7 8 9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harm &amp; Risk/Danger Statements</td>
<td>Stakeholders</td>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Harm statements and risk/danger statements are short, simple behavior-based statements which can be used to help family members, collaterals and staff working with the family become very clear about what has happened in the past, why CWS is involved with families and what CWS staff worry may happen in the future.</td>
<td>Context</td>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Harm statements and risk/danger statements are short, simple behavior-based statements which can be used to help family members, collaterals and staff working with the family become very clear about what has happened in the past, why CWS is involved with families and what CWS staff worry may happen in the future.</td>
<td>Content</td>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Harm statements and risk/danger statements are short, simple behavior-based statements which can be used to help family members, collaterals and staff working with the family become very clear about what has happened in the past, why CWS is involved with families and what CWS staff worry may happen in the future.</td>
<td>Desired Outcomes</td>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Harm statements and risk/danger statements are short, simple behavior-based statements which can be used to help family members, collaterals and staff working with the family become very clear about what has happened in the past, why CWS is involved with families and what CWS staff worry may happen in the future.</td>
<td>Reflection</td>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>Harm statements and risk/danger statements are short, simple behavior-based statements which can be used to help family members, collaterals and staff working with the family become very clear about what has happened in the past, why CWS is involved with families and what CWS staff worry may happen in the future.</td>
<td>Next Steps</td>
<td>1 2 3 4 5 6 7 8 9</td>
</tr>
</tbody>
</table>
### Safety Organized Practice: Safety Networks

**Practice Profiles Rating Summary Sheet**

**Directions:** After working through the practice profile assessment tool with your mentee/staff person please use this summary scoring sheet.

<table>
<thead>
<tr>
<th>Rater’s Name:</th>
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</thead>
<tbody>
<tr>
<td>Role:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>☐ Coach ☐ Supervisor ☐ Self ☐ Other</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Is follow-up planned:</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Dialogue Structure</th>
<th>Emergent</th>
<th>Accomplished</th>
<th>Distinguished</th>
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</thead>
<tbody>
<tr>
<td>Safety Networks</td>
<td>Purpose</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Group Agreements</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stakeholders</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Context</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Content</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Desired Outcomes</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reflection</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Next Steps</td>
<td>1 2 3 4 5 6 7 8 9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Safety Organized Practice: Safety Goals**

**Practice Profiles Rating Summary Sheet**

**Directions:** After working through the practice profile assessment tool with your mentee/staff person, please use this summary scoring sheet.

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Dialogue Structure</th>
<th>Level (1-9)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Emergent</td>
<td>Accomplished</td>
</tr>
<tr>
<td>Safety Goals</td>
<td>Purpose</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td></td>
<td>Group Agreements</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td></td>
<td>Stakeholders</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td></td>
<td>Context</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td></td>
<td>Content</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td></td>
<td>Desired Outcomes</td>
<td>1 2 3 4 5 6</td>
</tr>
<tr>
<td></td>
<td>Reflection</td>
<td>1 2 3 4 5 6</td>
</tr>
</tbody>
</table>

A key element of Safety Organized Practice is the use of simply written goals that clearly and unambiguously address the danger. These goals should:

- Address the danger or risk of danger
- Be collaboratively created with the family members and when that is not possible, include the presence of choices for the family
- Be written in clear, everyday language
- Describe the presence of new, observable behaviors or actions, particularly with the children, rather than the absence of old problematic behaviors

For questions regarding California’s Practice Profiles or this tool, and permission to use, please contact Melanie Schindell, mschindell@ucdavis.edu

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Safety Organized Practice: Safety Mapping
Practice Profiles Rating Summary Sheet

**Directions:** After working through the practice profile assessment tool with your mentee/staff person, please use this summary scoring sheet.

<table>
<thead>
<tr>
<th>Rater’s Name:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Role:</td>
<td>☐ Coach ☐ Supervisor ☐ Self ☐ Other:</td>
</tr>
<tr>
<td>Date:</td>
<td></td>
</tr>
<tr>
<td>Is follow-up planned:</td>
<td>☐ Yes ☐ No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Practice Area</th>
<th>Dialogue Structure</th>
<th>Level (1-9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Mapping</td>
<td>Purpose</td>
<td>Emergent</td>
</tr>
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<td>Stakeholders</td>
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<td></td>
<td>Context</td>
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<td></td>
<td>Desired Outcomes</td>
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</tr>
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<td></td>
<td>Reflection</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Next Steps</td>
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</tr>
</tbody>
</table>

Safety Mapping is a process of dialogue and inquiry designed to help social workers, families and extended networks work together to surface the different aspects of danger and safety present in the family and move toward group agreements about what needs to happen next to ensure the safety of the child.