EVIDENT CHANGE

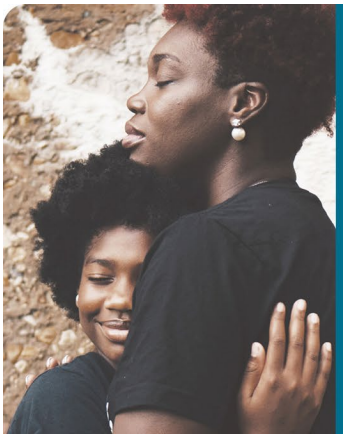
Inform Systems. Transform Lives.

TRAINER GUIDE

SDM® California Advanced Supervisor Training

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

February 2026



ABOUT EVIDENT CHANGE

Evident Change is a nonprofit that uses data and research to improve our social systems. For more information, call (800) 306-6223 or visit EvidentChange.org. You can also find us on social media by visiting Linktr.ee/EvidentChange.

CONTENTS

INTRODUCTION AND TIPS FOR TRAINING THIS MATERIAL

Note: Although this is called a two-day training, there is more material than can be covered in two days. The intention is for trainers to select either the hotline or the safety material to train along with the rest of the material, depending on the participant group.

It has become evident over the last 20 years that meaningful and ethical implementation of the Structured Decision Making® (SDM) system in California is more a leadership challenge than a training challenge. Supervisors are a crucial part of messaging, modeling, and supporting effective use of the SDM® system, so the first sections of this curriculum focus on the "why" of using the SDM system as designed to support decision making *before* workers have already made their judgments about the family. Help supervisors internalize that the assessments need to be the *starting point* for critical thinking and decision making.

Making time for the "How do you explain . . ." and "How do you listen . . ." activities is the priority, helping participants to explore their ambivalence about the SDM system and resolve it as much as possible. After that, the agenda is arranged by SDM assessment tool, with a deep dive into that assessment followed by skill-building activities to support that assessment. Notice that the PowerPoint file uses section names; and these or slide names are used in the agenda rather than slide numbers. After covering the Overview and Supervision sections, *use only the materials needed for the supervisors in the room*. The sections are discrete and can be pulled out to meet the needs of the participants as needed, containing an abundance of material to suit various audience needs and facilitator approaches.

It is suggested that trainers complete the assigned learning tasks prior to the session to become familiar with the content and anticipate, adjust, and suggest themes and discussion points as well as to ensure the integration of materials. While the agenda is an outline for the material, the PowerPoint slides contain detailed notes. The text in the Example portion is only a suggestion, and trainers are invited to make the delivery of content their own. Directions for activities can also be found within the trainer notes in the PowerPoint slides; but again, these are only suggestions, and instructors are encouraged to use creativity and ideas like flip chart carousel or Liberating Structures (see the "How Do I . . ." slide in particular) activities to promote engagement and allow for participation in various ways.

Finally, reserve time at the end of the training for the System Change and Next Steps section.

AGENDA

Time	Section	Main Points
DAY 1		
	Welcome	• Develop shared expectations to: » Invite all voices into the room; » Recognize and respect all perspectives; » Make necessary adjustments to ensure strong communication and a culture of shared ownership of the learning experience. • Model this as a parallel process when working with staff and families.
	SDM System Overview	• Review core values, concepts and research support of the SDM system. • Establish baseline SDM knowledge that allows for supervision of the practice. • Provide rationale for using decision theory to inform and create a logic flow for casework decisions. • Supervisors develop their own voice and ability to communicate the value of supported decision making.
	Supervision and the SDM System	• Discuss experiences and ideas for creating a learning culture where staff are supported in evolving from new practice to proficient and integrated practice. • Examine the various roles supervisors play and how to bring intention to the roles to provide various types of supervision. • Identify strategies supervisors may use to make connections to good SDM practice in a supervisory context. • Provide guidelines for supervisors' role in reviewing SDM assessments.
	SDM Tool Refresh: SDM Hotline Tools	• Review the decisions addressed by the hotline tools. » Screening decision » Response time • Discuss the use of overrides to minimize mistakes and establish best use. • Summarize the importance of item definitions. • Using the examples provided, practice using the definitions to make the intake screening decision. • Using the examples provided, practice using the definitions to make the response priority decision. Activity: Sal and Siblings vignettes
	Supervision Skill: Engagement and Interviewing Strategies	• Review key strategies for interviewing reporters. • Discuss the benefits of the caregiver + behavior + impact on the child (C + B + I) framework as a tool to gather relevant and necessary information from the reporter. • Explore the use of the interview ladder for gathering information at the hotline • Explore the use of the Open, Narrow, Close dialogue format for gathering information at the hotline. Activity: Police Officer Example and Therapist Example slide notes

Time	Section	Main Points
	SDM Tool Refresh: SDM Safety Assessment	• Review the logic flow and decisions addressed by the SDM safety assessment tool. • Summarize safety assessment policy and procedures. • Examine the definitions for understanding of safety thresholds. • Identify and discuss supervisory considerations specific to the safety assessment. » "Other" item » Individual variation of threshold understanding » Safety-planning efficacy » Difference between safety and risk
	Supervision Skill: Developing a Rigorous and Balanced Assessment to Plan for Safety	• Explain the definition of safety and its use in tool completion. • Using C + B + I to develop focus. • Distinguish between the purposes of a safety plan and a case plan. • The Three Questions: developing rigor and balance in your assessment • Introduce the scale as a method for assessing plan efficacy. Activities: Small-group Three Questions case review; demonstrate Eliciting, Amplifying, Reflecting, Start Over (EARS) and pair and interview each other about a concern using EARS.
	SDM Tool Refresh: SDM Risk Assessment	• Review the logic flow and decisions addressed by the risk assessment tool. • Explain the difference between safety and risk and its application to casework. • Summarize risk assessment policy and procedures. • Discuss the use of overrides to minimize mistakes and establish best use. • Practice communicating the difference between safety and risk to staff. Activity: Modeling this distinction to communicate with families: Talking With Families About Risk
	Supervision Skill: Planning for Targeted Intervention	• Expand understanding of the Three Questions to the case consult structure to assist in case planning. » Solution-focused inquiry » Safety and services » Developing and using networks • Explain the Dimensions of Success facilitation framework. • Apply the Dimensions of Success framework to the case consult structure to improve planning.
	SDM Tool Refresh: SDM Reunification Assessment	• Review the logic flow and decisions addressed by the reunification assessment tool. • Summarize reunification assessment policy and procedures. • Outline the specific components of the reunification assessment and the impact on decision making. » Safety assessment » Case plan progress » Parent–Child interactions » Recommendation guidelines » Alternative recommendation

Time	Section	Main Points
	Supervision Skill: Documentation and Progress Monitoring	• Identify key items to assess at each contact to inform the reunification assessment. • Demonstrate documentation options to support reunification decision. Include documentation for all sections of the tool using scales, C + B + I and the Three Questions.
	SDM Tool Refresh: SDM Risk Reassessment	• Review the logic flow and decision addressed by the risk reassessment tool. • Summarize risk reassessment policy and procedures. • Identify expectations of safety review at case closure.
	Supervision Skill: Goal-Setting and Behavior Change Management	• Increase the use of case reviews through review of the benefits and discussion of common errors. • Introduce coaching strategies as a parallel skill for staff to use with families. » Technical problems and adaptive challenges » Goal-setting strategies including rating and documentation of behavior-specific actions and plans.
	Supervisors: Key to Success	Summarize facilitative supervision skills <u>Activity</u> • Participants conduct self-assessment. • Rate current competence/confidence/capacity for each category. • Identify top three growth areas. • Choose one to set a goal about by identifying behavior-specific action steps.

Purpose
To introduce the training.

Example
Welcome to the Structured Decision Making® (SDM) assessments deep dive for supervisors training. We are going to spend the two days focused on learning the SDM® system on a deeper level, focusing on the segments most important to the participants in the room (hotline or safety, risk, reunification, risk reassessment) and strategies for supervisors. We will dive into the definitions, policies and procedures, and associated practice strategies to use with families.

Trainer Note
Have participants become acquainted with the training materials: SDM policy and procedures (P&P) manual (available for bookmarking on their work phones at ca.sdmdata.org/definitions), participant guide, and (optional) handout with PowerPoint slides for taking notes.

WELCOME AND INTRODUCTIONS

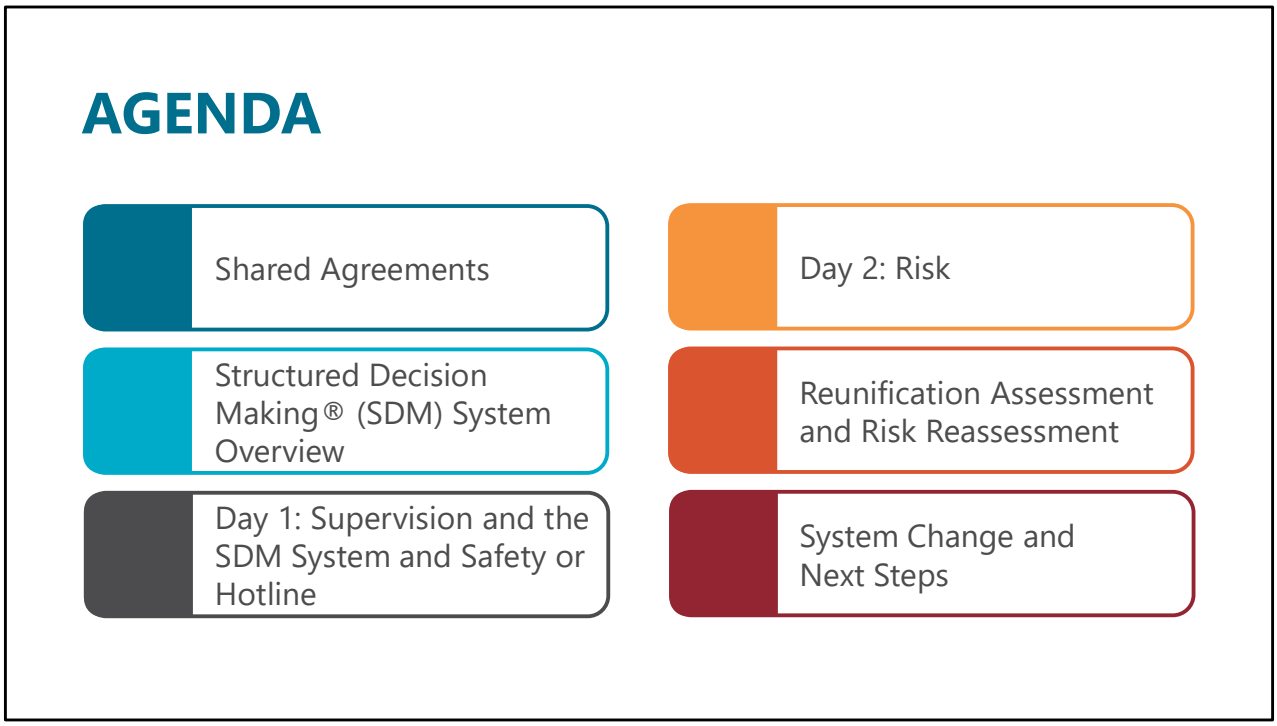
Purpose
To identify who is in the room.

Example
Before we get started, let's get to know each other a little better and get a sense of your familiarity with the SDM system.

Trainer Note
Have participants say:

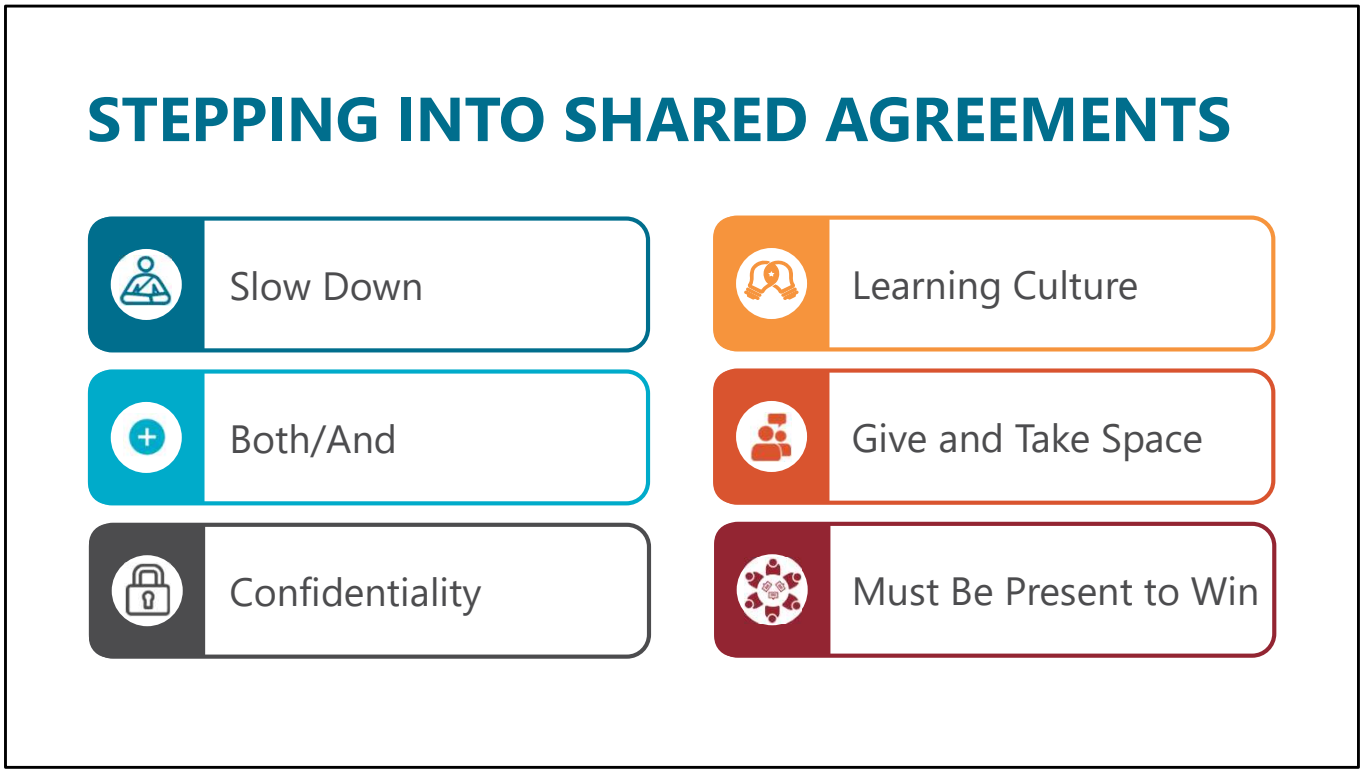
- Their name;
- What region they are from;
- Their role within the agency/department;
- How long they have been there;
- One thing they hope to get out of this training; and
- One thing they are looking forward to this weekend/month/season/etc.

You may write the list above on the board to help participants remember what information to provide during introductions. If the group is large, you can have participants spend five minutes introducing themselves in small groups.



Purpose
To receive an overview of the training agenda that emphasizes the training's "skill" focus.

Example
This advanced SDM training is designed to do two things. First, reset everyone's understanding about the core values and foundational concepts of the SDM system. That is what sections 1, 2, and 3 are, which will be covered in Day 1. Second, we want to deepen your knowledge of either the hotline tools or the safety assessment depending on which one you have the most contact with. And we want to cover the reunification assessment and risk assessment so that everyone knows what families need to work toward when we decide to open an ongoing services case. Finally, we will cover what we need to consider in our role as supervisors and leaders in promoting the systems changes that will make SDM system use with fidelity an embedded part of our workplace culture.



Purpose
To create shared expectations about how the group will operate and model ways to be clear about expectations when working and meeting with families.

Example
We should always take a few minutes to check in and agree on how we will work with one another to help prevent miscommunication.

This also helps us model how we aspire to work with families. Taking time to build strong shared agreements for our work is an essential first step. It sends the following messages.

- We and family members are in this together.
- We respect family members by inviting them to shape our process for working together.

Let's establish our own agreements for our time together. Here are some examples that we can start with.

Slow Down: In a workplace that is driven by deadlines and mandates, today we hope

to take a breath and slow down enough to really understand the material we have to cover.

Both/And: In a culture that tends to want the one "right answer," we can learn more from each other when we acknowledge that two things can be true at the same time from different perspectives.

Confidentiality: We can learn lessons from each other during our time together without retelling someone else's story (unless we ask their permission first). Confidentiality can also encourage each of us to say, "I don't know" without fear that it will be held against us after the training is over.

Learning Culture: We can make it ok to admit and learn from mistakes.

Give and Take Space: Those of us who often have a lot to say can give others more space to speak up. For those of us who tend to be on the quiet side, this is an invitation to speak up a little more and share our questions and insights with the rest of the group.

Must Be Present to Win: This is more than just a raffle prize rule. It means that when we resist distractions and the urge to multitask, we will get the most out of our learning experience together

This important activity also allows us to start on the right foot when meeting with our colleagues and supervisees. It helps us to be intentional about our time together, call up differences to attend to, and teach one another about how we like to be treated and share space.

Trainer Note
Write agreements on a flip chart as the class proposes additional ones that they would consider. Sometimes people will offer very vague ideas ("We should respect each other"). If so, you can ask for examples to deepen the discussion: "What do you mean by respect? What would that look like?"

Purpose
To get warmed up and thinking about what you currently know about the SDM system.

Trainer Note
Have participants "pair and share" how they explain the role of the SDM system in the work for five minutes each. Ask them to make a mental note about this as their personal "baseline" and to listen for ways to better understand how to talk to workers about the SDM system during our time together.

Purpose
To introduce the idea that supervisors need to guide the profession towards ethical, accurate use of the SDM system and that resistance to behavior change is normal (if not healthy) and to be expected.

Example
Did you know that health care workers (especially physicians) resisted hand washing for 150 years? This spanned from 1861, when Ignaz Semmelweis published his study that sanitizing the hands of physicians between examining cadavers and seeing patients drove mortality rates from 18% to less than 2%, until the 1990s when federal regulators insisted on infection control measures for hospital accreditation.

Trainer Note
Ask if anyone in the room has had a chance to study and learn Motivational Interviewing. If someone raises their hand, ask them to explain to the class why listing to a client's "status quo talk" is useful in asking them to consider seeking treatment or behavior change. If no one responds, make the point that people who resist behavior change need to be heard, understood, and gently provided feedback about the impact of their behavior on others in order to process the (normal) ambivalence they feel towards the desired behavior.

Example
Before we do an introduction to the SDM system, let's listen to each other about what we hear from staff, peers, or ourselves about why folks *do not* want to bother with using the SDM system.

Trainer Note
Spend five minutes or so listening to and reflecting the statements made in the room. Transition with something like, "as we review why the SDM system exists, keep an ear open for solutions the SDM system offers that might serve as feedback for our reluctant peers."

THE PROBLEM THE SDM SYSTEM IS TRYING TO SOLVE

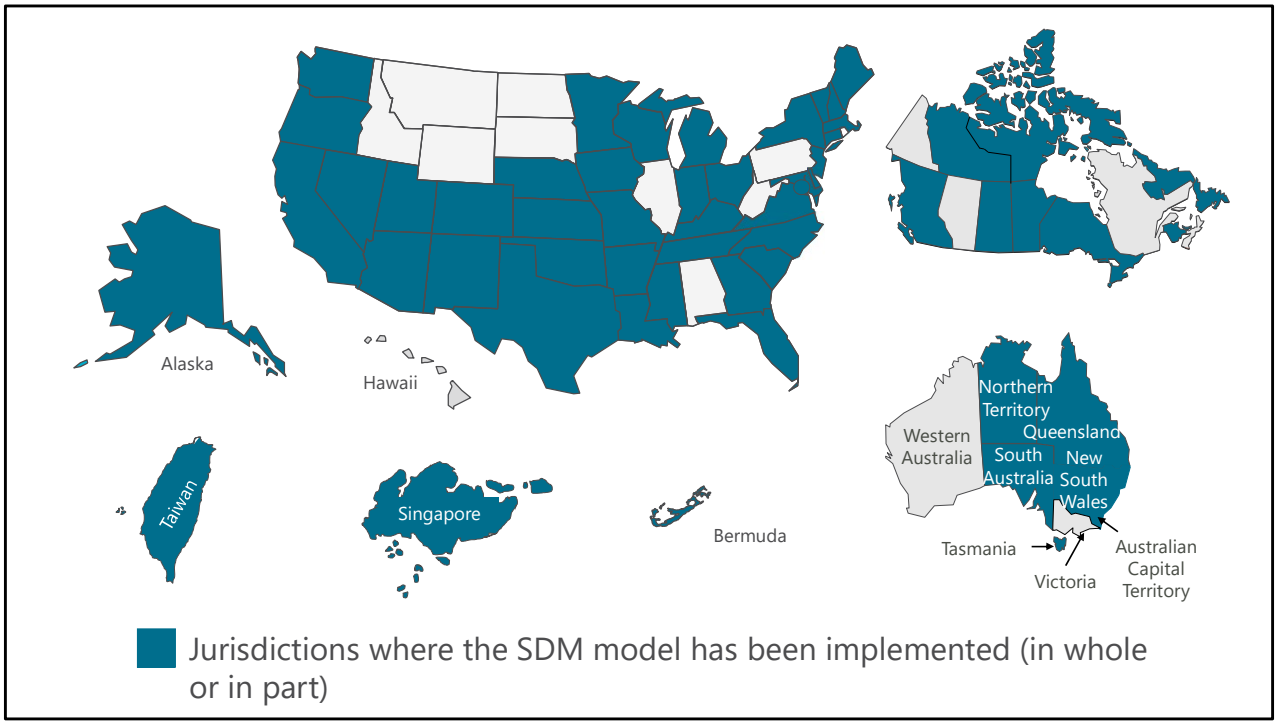
The Transformative Ideas of Daniel Kahneman

EVIDENT CHANGE

Purpose
To hear about the problem with inconsistent decision making in high-stakes situations similar to child protection work with families.

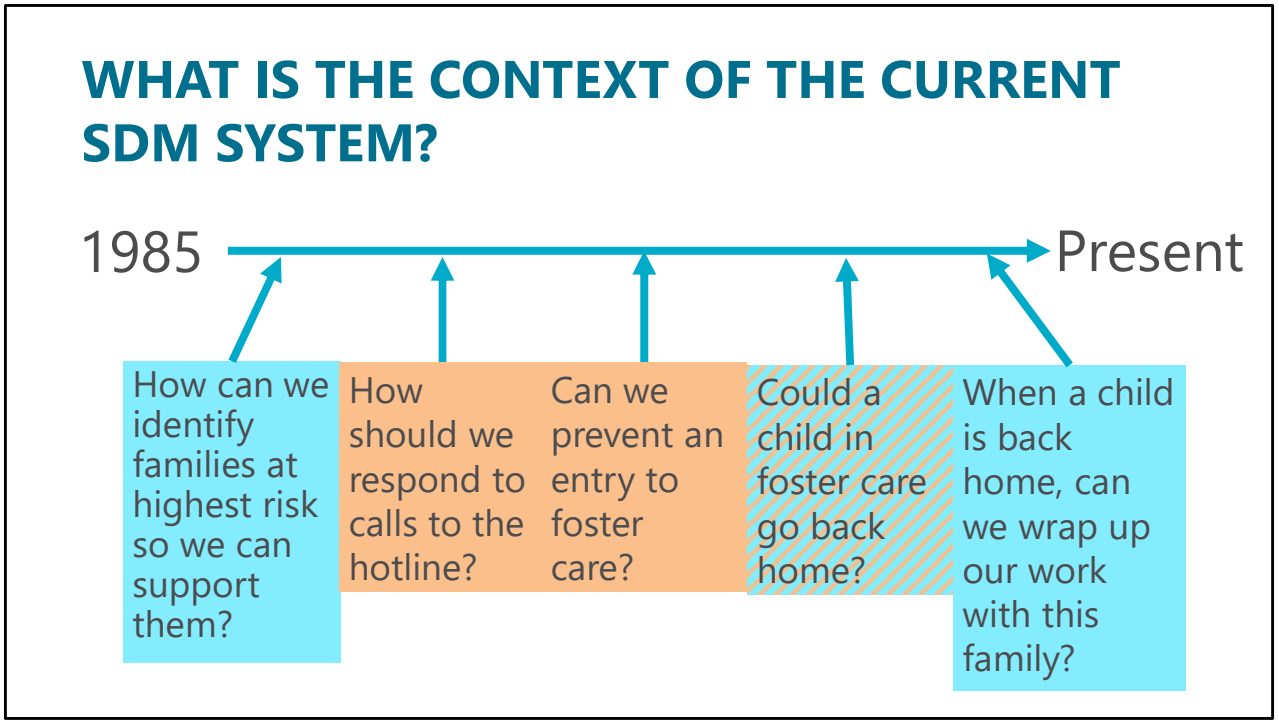
Trainer Note
The audio file will play when you get to this slide. Hover your pointer over the black rectangle if you need to pause the playback. You can learn about the episode this clip is from at https://hiddenbrain.org/podcast/the-transformative-ideas-of-daniel-kahneman/ and provide as much or as little context as you like. Learners typically understand the point without any extra explanation. You can also use just the first 4.5 minutes if you prefer.

At the end of the audio, ask the learners if they see any noise in the decisions made at various offices within their county. What s to that noise? How do they see the SDM system being useful in reducing noise? What are the obstacles our profession runs into when it comes to using the SDM system? How do we overcome those obstacles?



Purpose
To see that SDM system use has become widespread around the world.

Example
As you can see, today the SDM system (in whole or in part) is in the majority of US states. The SDM assessments are also used in Canada, Bermuda, Taiwan, Singapore, and Australia.



Purpose
To be introduced to the SDM system.

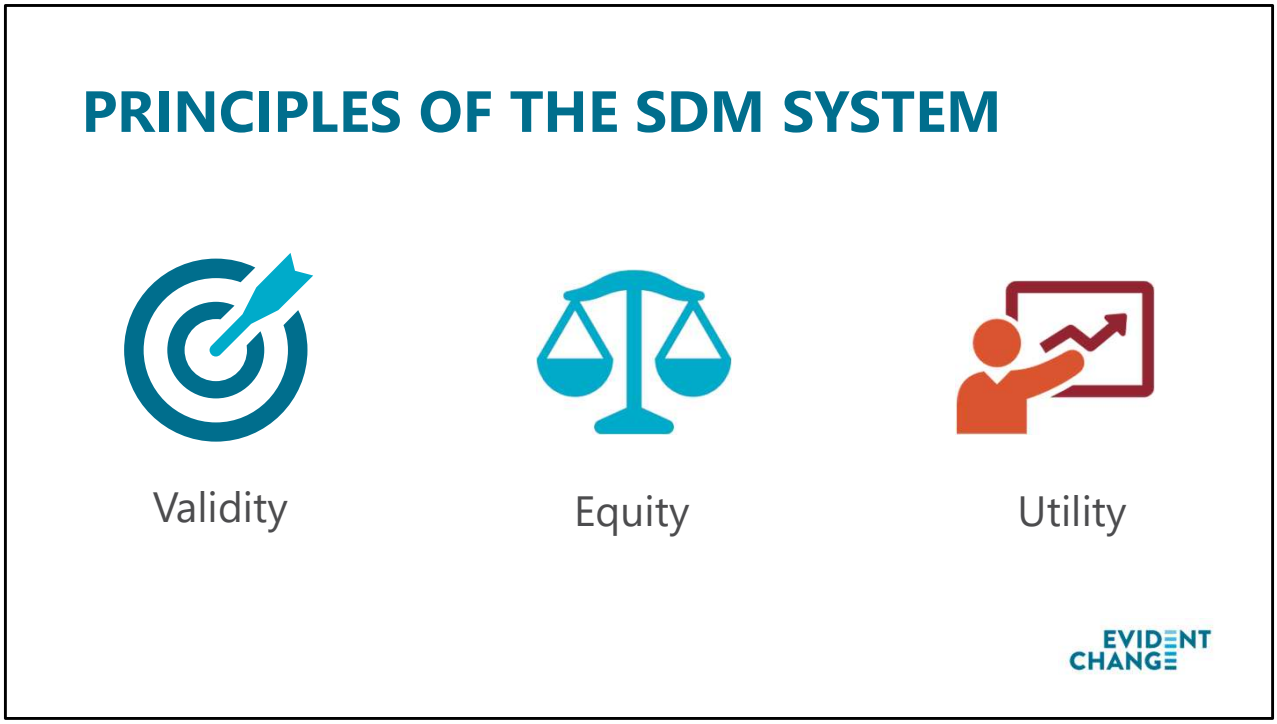
Resource
SDM Resources: Using the SDM System at Each Decision Point handout

Example
We wanted to ground our discussion today in a quick review of the core values and purpose of the SDM system. Let's start with some history.

- *Research and evaluation*: The first issue Evident Change was asked to help with in 1985 for the state of Alaska was to sort families by their risk of future system involvement so that limited resources available for prevention services could be focused on the families at highest risk. The items highlighted in blue are supported by research data and outcomes. As our field is still young and this research is still emerging, it is even more important to be intentional to review what is known in the field and integrate new research and practices into the assessments as appropriate.
- *Decision*: After that, states started asking for help with the decisions to screen in or out calls to their hotlines, identify safety threats and the possible need for an entry to foster care, and when children might safely return to their homes. These assessments are built around statutes, case law, and policy in the jurisdiction. These decisions highlighted in tan are based on consensus about statute, case law, and policy (with the reunification decision supported by a blend of both approaches). The SDM system is focused on key decision points and helps us be intentional about decisions. The SDM system emphasizes the importance of clear, concise decision points.
- *Support*: The SDM assessments support decision making. Assessments do not make decisions; workers do. The use of research and evidence helps a worker make better decisions. While the decisions are structured, no magic formula tells you what to do. No prescription exists. Point out that some staff would like to use SDM assessments

like a calculator that tells them what to do. As supervisors, our role is to remind them that the SDM system is more like a yoga mat. It supports the process, but we have to do our own yoga practice to get stronger in our critical decision making.

- *System*: The SDM assessments fit together, each with a different purpose. It is important to understand the function of each assessment and how the assessments fit together. Each assessment serves only one purpose, and it is important to know the purpose in order to get the best out of each.



Purpose
To be reintroduced to the principles that drive developing the SDM assessments.

Example
Each SDM assessment demonstrates these three qualities.

Validity: Validity is the idea that we are accurately measuring something—or, regarding decision making, that we get the decision right. Using a thermometer as an example, if my body temperature is 98.6 degrees, the thermometer should give me a reading of 98.6 degrees. Any other reading besides 98.6 degrees would not be accurate, or valid. If I have a fever, that is important information to have. It informs what kind of treatment may be necessary. We want to make sure that the decisions we reach using the SDM assessments are as accurate and consistent across races, ethnicities, regions, and offices as possible—or, in other words, that we get the decision right. Validity is one of the foundational pieces of the SDM model.

Equity: Equity represents the notion that once individuals are contacted by the child protection system, they are treated in a manner to ensure fairness in outcomes and their constitutional rights are respected. A thermometer should be tested to ensure that such demographics as gender, race, and ethnicity do not result in a less accurate reading. The instrument should be designed to measure an individual's temperature effectively regardless of whether the individual is White, Black, Latine, Asian, male, female, etc. All clients are going through a similar process with child protection, and the hope is that the assessments will support more objective decision making, helping to remove some of the bias that can creep in or go unnoticed and focus only on the information that is needed for the decision at hand. For example, the hotline tools focus only on the information collected regarding the allegation. Remember that the assessments do not make

decisions; people do. To pay attention to equity, we have to also pay attention to our own decisions, judgments, bias, and how those may be affecting the actions that we take as workers. We can create the most equitable assessment, but the assessment is only going to provide an outcome based on the information that you have gathered and applied, and the assessment does not take the action steps affecting children and families. The worker does. The hope is that the assessments support more equitable decision making. *Now, Evident Change is aware that societal patterns of over-surveillance of families of color will tend to bake in a bias toward higher risk scores; AND, because of the strength in correlation between past investigations and future system involvement, we cannot afford to ignore that data point in creating a risk assessment. As a result, we actually dial down the raw accuracy of the assessment in California and adjust the numerical cutoff points to create an equitable distribution across races.* [Italicized to make sure you make this point.]

Utility: Finally, utility refers to the idea of usefulness and ease of use. Workers should find the SDM system easy to use and helpful in their practice, both in decision making and in their work with families. Imagine the thermometer once more. The thermometer could be valid, reliable, and equitable, but is it a useful assessment if you cannot figure out how to turn it on? What about if you cannot read the display that shows the temperature? This thermometer would not be useful, and no one would use it. SDM assessments are designed to provide the worker useful information and support when making decisions while being accessible and easy to use. The data, if entered with fidelity, are also useful for policy makers and leaders when looking for trends and needing to allocate resources to serve families. As supervisors, let's help workers see the bigger picture that each individual answer on an assessment s to.

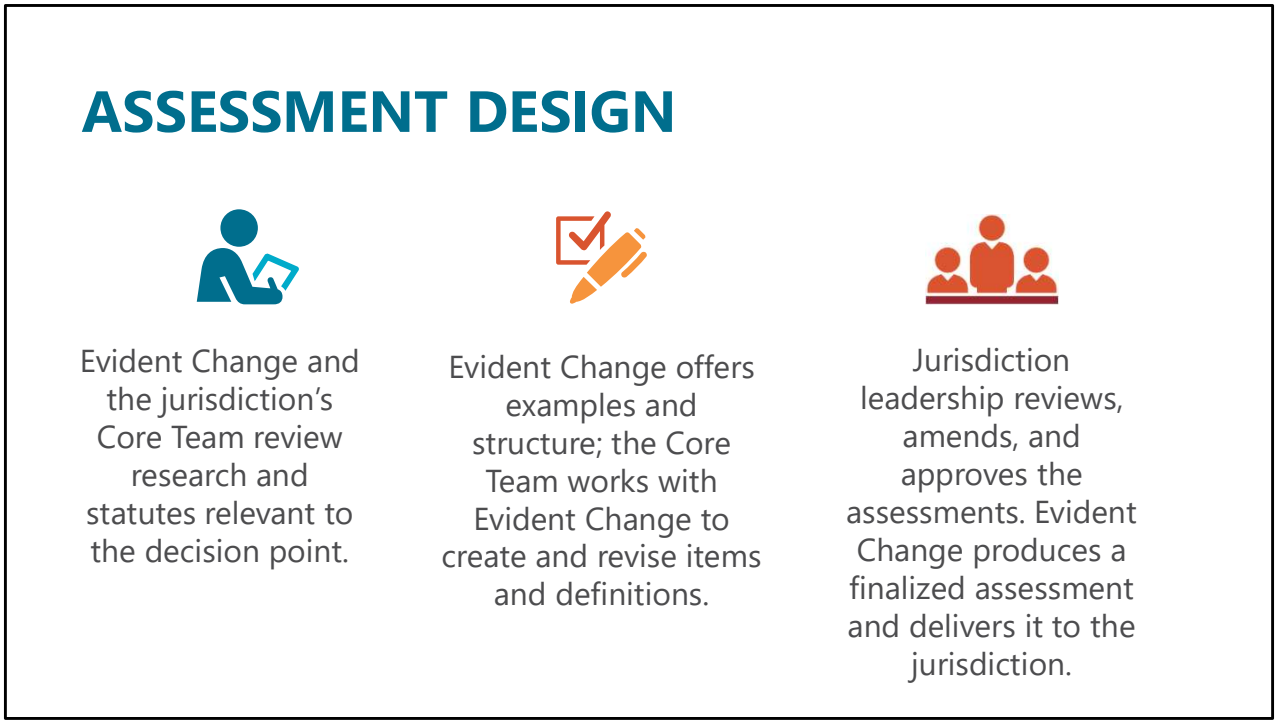
Before leaving this slide, I am going to ask you all to repeat these principles after me:

Validity
Equity
Utility

[Then, since the first time is usually lacking enthusiasm]

Okay, once more, with feeling:

Validity
Equity
Utility



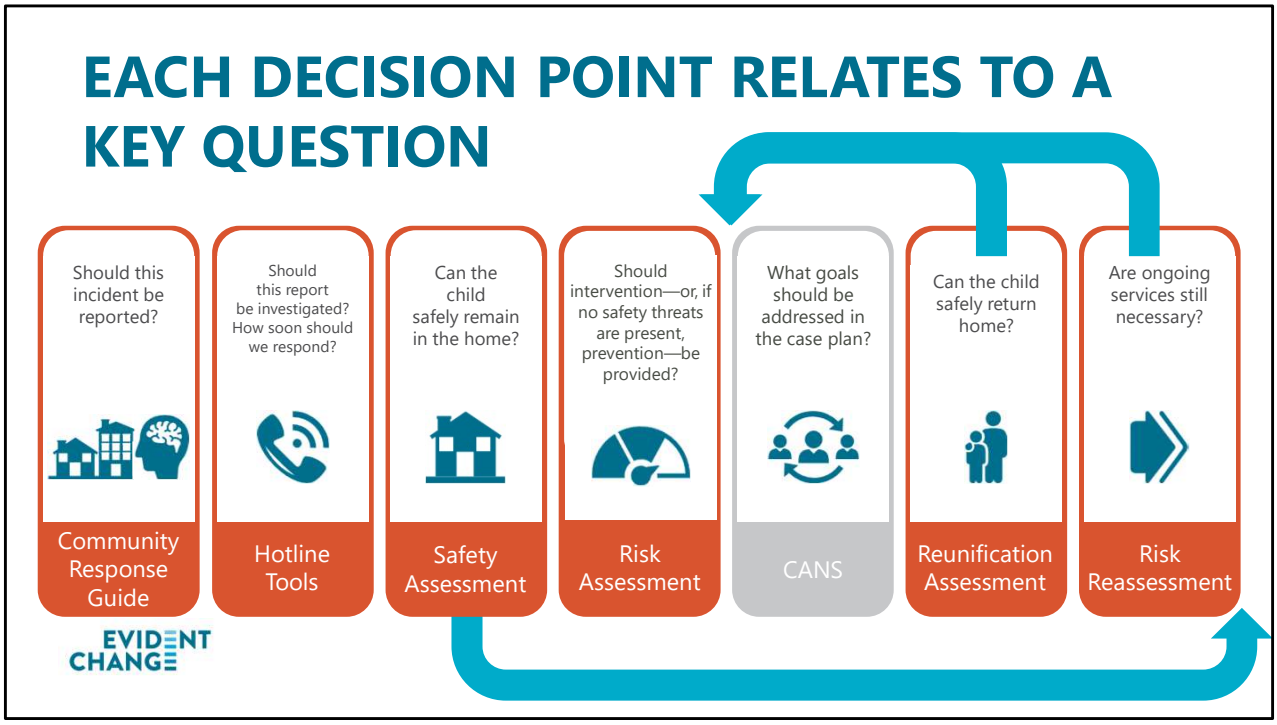
Purpose
To help connect the design process of the SDM assessments with the decisions they support.

Example
Sometimes the workforce is under the impression that Evident Change designs assessments and writes the definitions for them. Let's look at how that process actually works.

Evident Change's roots are in the field of social science research, so when the assessment is related to risk, we bring everything we know to the table about actuarial risk categorizations. When the assessment is related to screening calls to the hotline or safety, we consult the statutes, case law, and policies of the jurisdiction we are working in.

We bring all that, along with examples and choices from other jurisdictions, to the core team that has been recruited by the jurisdiction to recommend assessment structures, items, and definitions and the core team then selects items, structures, and definitions that they believe will work best in their jurisdiction.

Finally, the draft assessments are submitted to the leadership and legal representation for the jurisdiction to review, amend, and approve.



Purpose
To identify decision points addressed by SDM assessments and connect SDM assessments to System 2 thinking.

Example
Each of these decision points and key questions is supported by a particular assessment. We attempt to make these assessments as small as possible while still being effective. The idea is to have a suite of assessments where each one helps workers and supervisors think about one key decision, being aware of System 1 thinking and bringing System 2 thinking to bear.

We will not spend too much time covering the community response guide, as this is a community- and mandated reporter–facing assessment; but you should know that it exists and that important work is being done in this area to help reporters make better-informed decisions about when to report. This is a particularly important piece because we know that the disproportionality that we see in the child welfare system oftentimes starts at the decision to pick up the phone and make a report.

When a situation is reported, the SDM hotline tools are used to help the worker determine whether an in-person investigation is called for; and if so, how quickly to initiate it. If child welfare agencies had unlimited resources, we could respond immediately to every call that is screened in. Instead, we must decide which ones

require an immediate response from child protective services.

Once face-to-face contact is initiated, a decision is made to either protectively place a child or allow that child to remain in the home, with or without a safety plan. The SDM safety assessment helps with this decision.

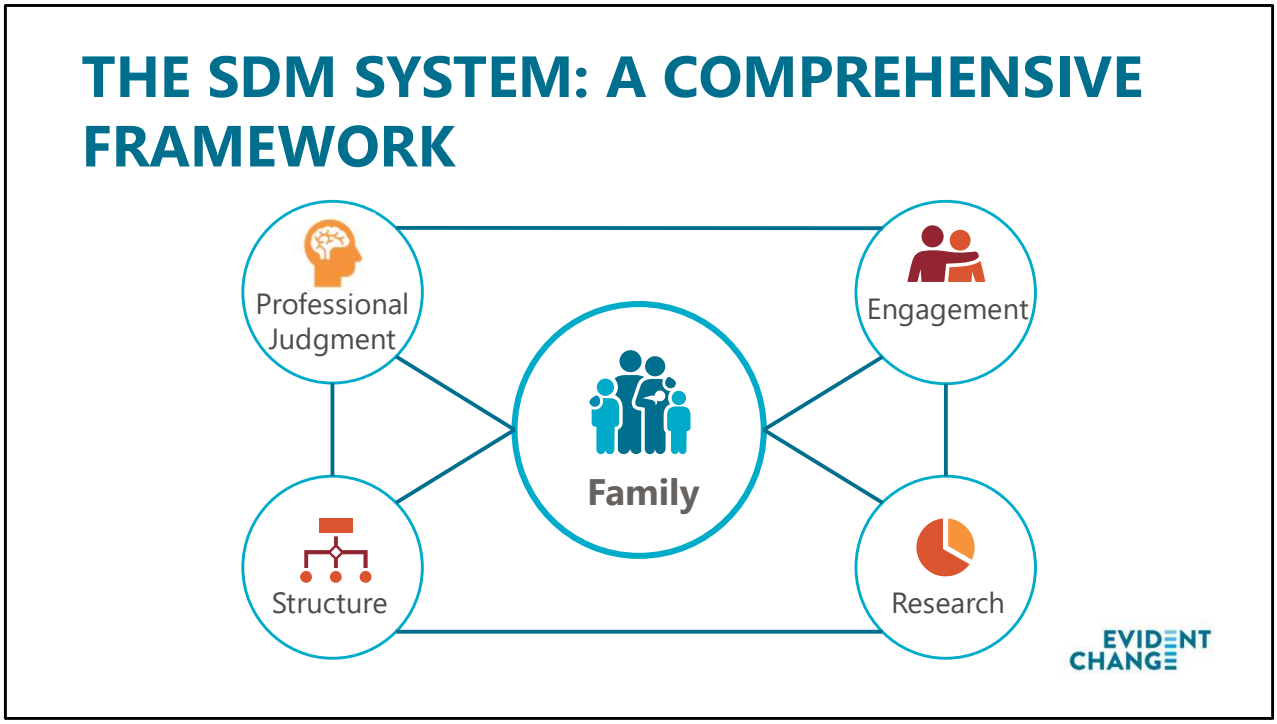
As the investigation proceeds, the SDM risk assessment identifies the likelihood of future system involvement for a child in the household. This likelihood, referred to as the family's risk level, is used to guide decisions about which referrals to close after the investigation is concluded, and which referrals to open for ongoing services or refer to prevention services.

Open cases in California will have a CANS assessment. **Evident Change is starting to ask agencies to intentionally use the questions and definitions contained in the SDM reunification assessment and SDM risk reassessment to structure goals and objectives on case plans** in combination with the CANS results**.** More about this at the end of this slide.

Then, at least every six months in California (and more often if your county has progress on the federal P1 measure on its system improvement plan [SIP]), the reunification assessment guides decisions about whether to continue to provide services or close the case. For children in out-of-home care, the reunification assessment guides decisions about whether to pursue reunification, continue reunification services, or change the permanency plan goal.

When children are in their home, the risk reassessment helps us determine if the risk level has come down enough that we can potentially end our work with a family.

These blue arrows remind us that when we do open a services case for a family, **the worker co-creating the initial case plan with the family needs to know what is on the reunification assessment and risk reassessment because the questions and criteria in them are going to inform when to start a trial home visit or close an in-home case.** The CANS will help provide a comprehensive assessment of needs, but it is not like a "final exam." And, we have one more reminder that we must assess for safety before we decide to close our work with a family.



Purpose
To highlight that the SDM assessments are part of a more comprehensive framework.

Example
The SDM model is a *component* of a comprehensive case management framework that uses a series of assessments to help child welfare workers assess situations and collaborate on critical decisions throughout our work with families.

The SDM model uses research and statutes to provide structure (it is right there in the name, right?) to practice strategies, offering caseworkers a framework for consistent decision making and giving agencies a way to target in-demand resources toward families who can benefit most.

The assessments are just one component of the decision-making "ecosystem" that we work in. By integrating engagement strategies, research, assessments, and professional judgment, the SDM model s to a full-system approach to help caseworkers best serve their clients.

AND, workers and supervisors have other parts of the work they need support with, like interviewing and engagement skills, education that s to professional judgment, cultural responsiveness to the diverse families we work with, etc.

The SDM assessments integrate and blend together effectively with good social work practice to allow assessment and decision-making processes to occur in partnership with families.

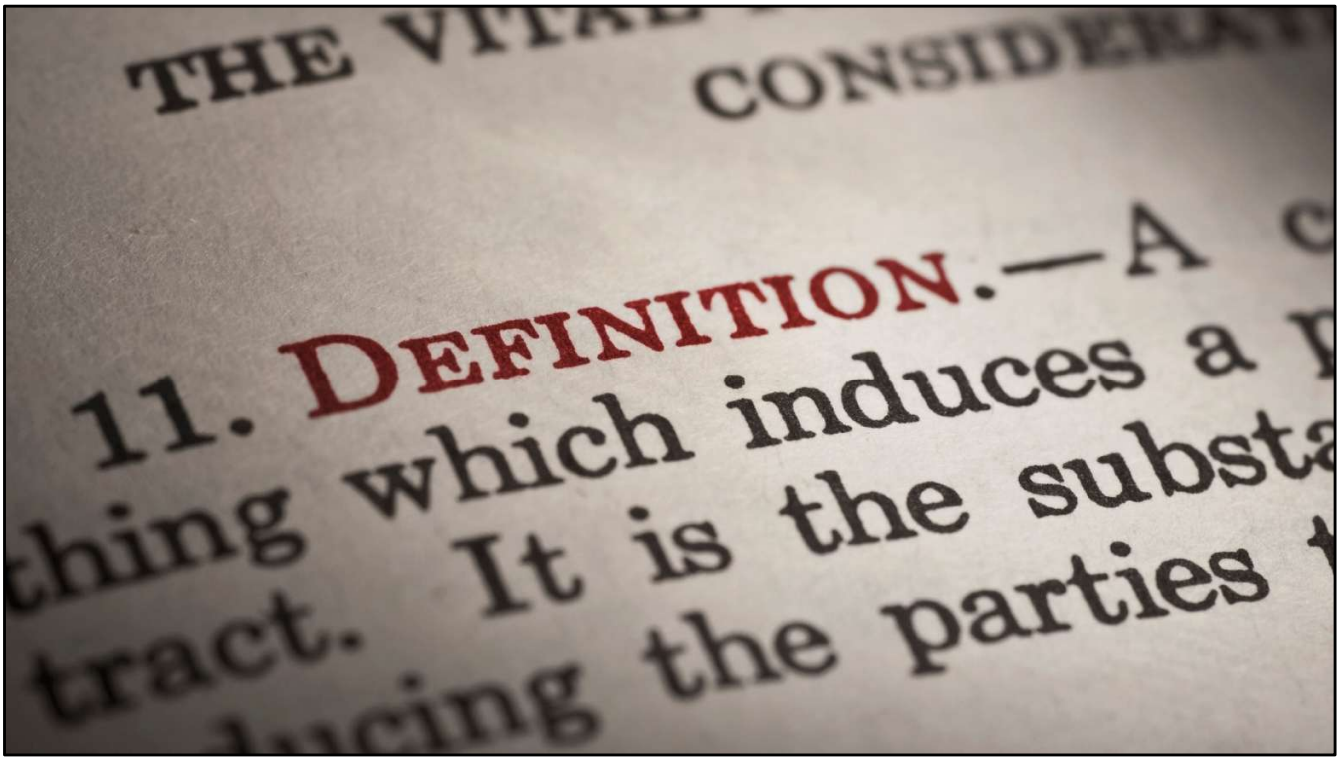
Purpose
To reflect on the biological and psychological reasons that these decisions involving children and families in child welfare are so hard.

Example
Raise your hand if you have heard the term "cognitive bias." In addition to the audio clip we listened to on "noise," what are some other cognitive biases you have heard of? [Let four to five people describe a bias they have heard about.] Do we think our profession is immune to cognitive biases? [most will agree with "no"] Raise your hand if you believe families deserve the best thinking we can bring to our work with them.

Trainer Note

Source: Kahneman, D. (2011). *Thinking, fast and slow*. Macmillan.

For your own greater understanding, watch
https://youtu.be/PirFrDVRBo4



Trainer Note
Ask participants how they define a relaxing activity. Elicit a few responses and point out that while some definitions are similar, for others there is a different threshold. Highlight the importance of consistent and clear definitions in developing thresholds. Generally defined, a relaxing activity is something that helps to reduce stress, promote calmness, and provide a sense of leisure or comfort. The issue is that it varies from person to person and may "look" very different for each. While some may identify activities like reading or meditating as relaxing, others may identify listening to music or working out. Ask participants to give a few examples of an activity that is scary. Does everyone share the same definition? Have participants think about the impact of varying definitions when mandated interventions may be required.

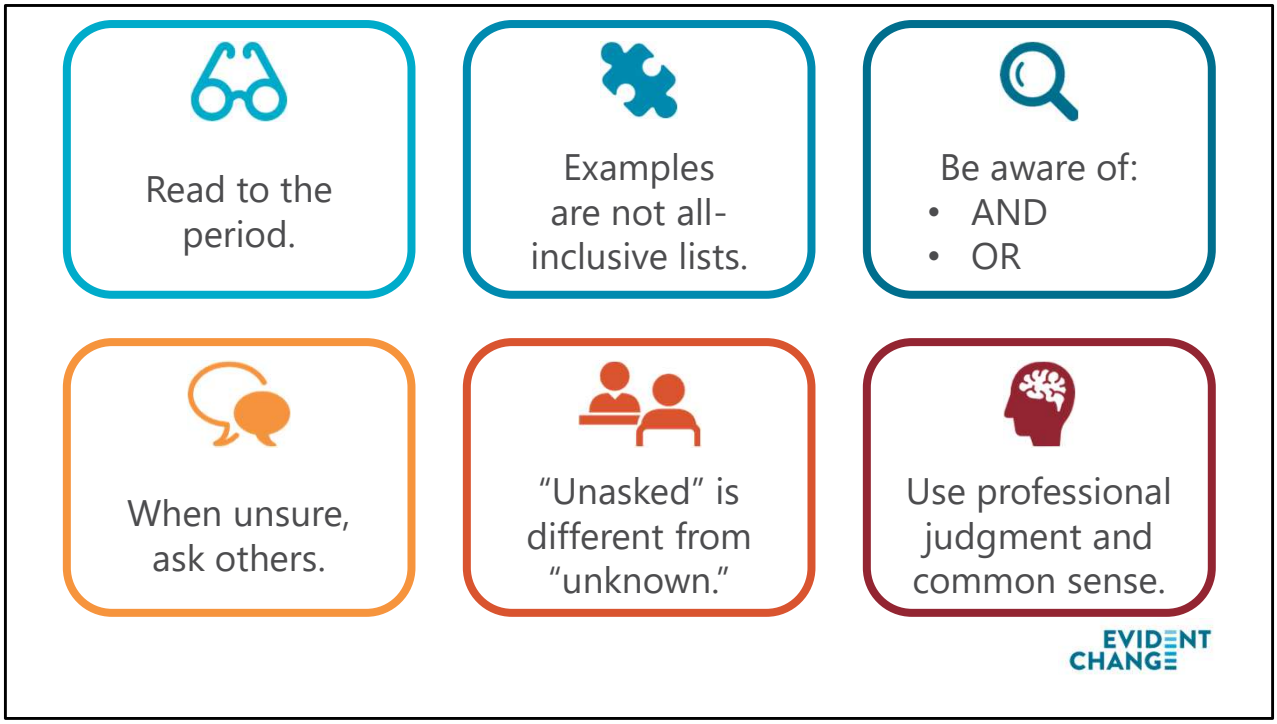
Example
If you hear nothing else that is said during this training, hear this part. You need to use the definitions. Definitions are the most important part of the SDM system. You need to *refer to* the definitions and *use* them when applying the SDM assessments.

The SDM item definitions and thresholds were carefully developed to build greater consistency and accuracy in use of the assessments, as supported by either research or consensus.

Definitions play a large role in creating equity in the SDM system. Families should be assessed using the same criteria. Our criteria, standards of care, and expectations for a person should not change based on their gender, their race or ethnicity, their sexuality, or what part of town they live in. We all interpret information differently. Outside of our conscious awareness, we fill in the blanks of what may not be known with our

imaginations and biases. What you think of as dangerous and what I think of as dangerous may be different based on our life experiences. The SDM definitions give everyone the same starting place. They tell us what "dangerous" is so that different workers do not have different interpretations of what this word means in the context of child safety. This helps to prevent our imaginations from running away with us.

At the same time, they are not perfect. When testing for inter-rater reliability, the best we tend to get to is 75%. So that means that up to 25% of the time we will need to discuss with peers and use professional judgment for "wobblers."



Purpose
To learn the importance of understanding and using the item definitions in the P&P manual.

Example
As we said before, the tool does not make the decision; people do. The tool's outcome is only as good as the information used to complete it and the application of that information to the various item definitions.

Before we get into strategies for gathering that information, let's talk about the importance and structure of item definitions. As you will see in our practice activities and review of the manual, each item on the tools has a corresponding definition.

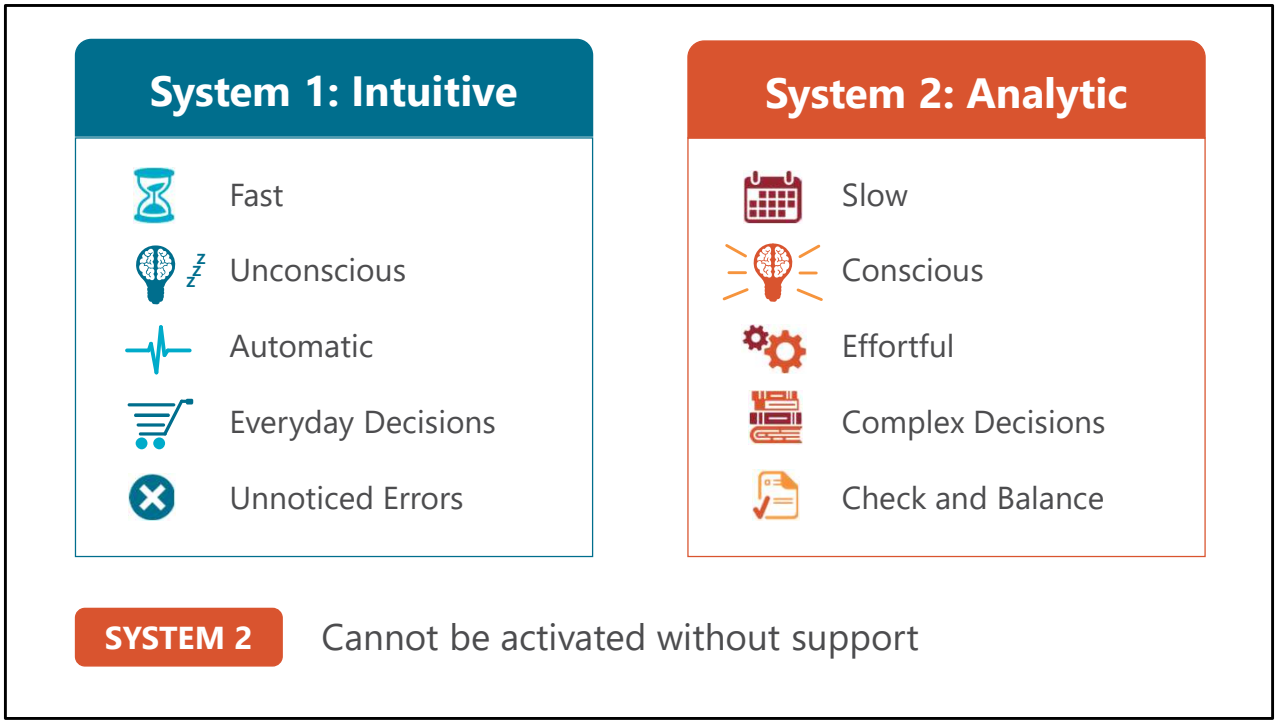
While you are interviewing reporters, be mindful of the assessment items and definitions, and make sure you gather information that allows you to answer each question. We will practice how to do that throughout this training.

Definitions establish threshold regardless of how the reporter labels the concern (e.g., "I'm calling to report neglect"). The screener listens for and documents specific facts that describe the child, the circumstances, the caregiver's behavior, and the impact of

that behavior on the child.

Definitions for each allegation type establish the threshold. Information gathered from the reporter must meet the threshold for the allegation to be selected. If the information does not reach the threshold for any allegation, the call is screened out.

Trainer Note
Ask participants if this is how they currently practice and what, if any, shifts in thinking or approach may be necessary to approach calls this way.



Purpose
To be introduced to System 1 and System 2 thinking.

Example
If I ask you what 2 plus 2 equals, how long does it take to answer? If I ask you what 2,375 divided by 7 equals, how long would it take for you to answer? What tools (e.g., paper and pencil) and support would you need to get the answer? If I asked you what the best way is to raise a child, would you even be able to give just one answer? The first question is a simple one. The second is more complicated but not really complex. The question about raising a child is complex because the child is going to present unique challenges based on their personality and family circumstances. Raise your hand if you would agree that families present with complex challenges.

Extensive research over the past 40 years has explored the way our brains work when taking in and making sense of information and then making decisions based on that information. One of the most prominent researchers in this area is the psychologist Daniel Kahneman, author of the books *Thinking, Fast and Slow* and *Noise*. While Kahneman wrote extensively in academic, peer-reviewed literature, these books written near the end of his career are accessible summations of his life's work that won him a Nobel Prize.

Kahneman conceptualizes two different ways that our brains process information and make decisions: the fast way and the slow way.

Another name for fast thinking is System 1, or intuitive thinking. This thinking occurs in the blink of an eye and makes rapid use of all the human nervous system's resources to make quick, effortless, and automatic decisions needed for survival. It can answer 2 plus 2

in the blink of an eye, and we use it for 99% of our everyday functioning. We intend no disrespect for System 1 thinking.

Another word for slow thinking is System 2, or analytic, thinking. This is a slower process better suited to address more complex decisions or problem solving. It requires a more deliberate process and takes longer. And when we face 2,375 divided by 7, we need to slow down and use pencil and paper or a calculator to work out that answer.

When we think about the high stakes of fast-paced child protection investigation work, we can all recognize how System 1 thinking serves us well in conducting assessments and making decisions quickly, especially in an emergency. The trouble is that System 1 thinking—our intuitive process—does not notice when it is wrong and it comes with built-in internal biases. We all have bias, even if we recognize that having biases can affect our decision making. Structured assessments allow us to combine System 1 and System 2 thinking to access the benefits of both and help create checks and balances for our own bias.

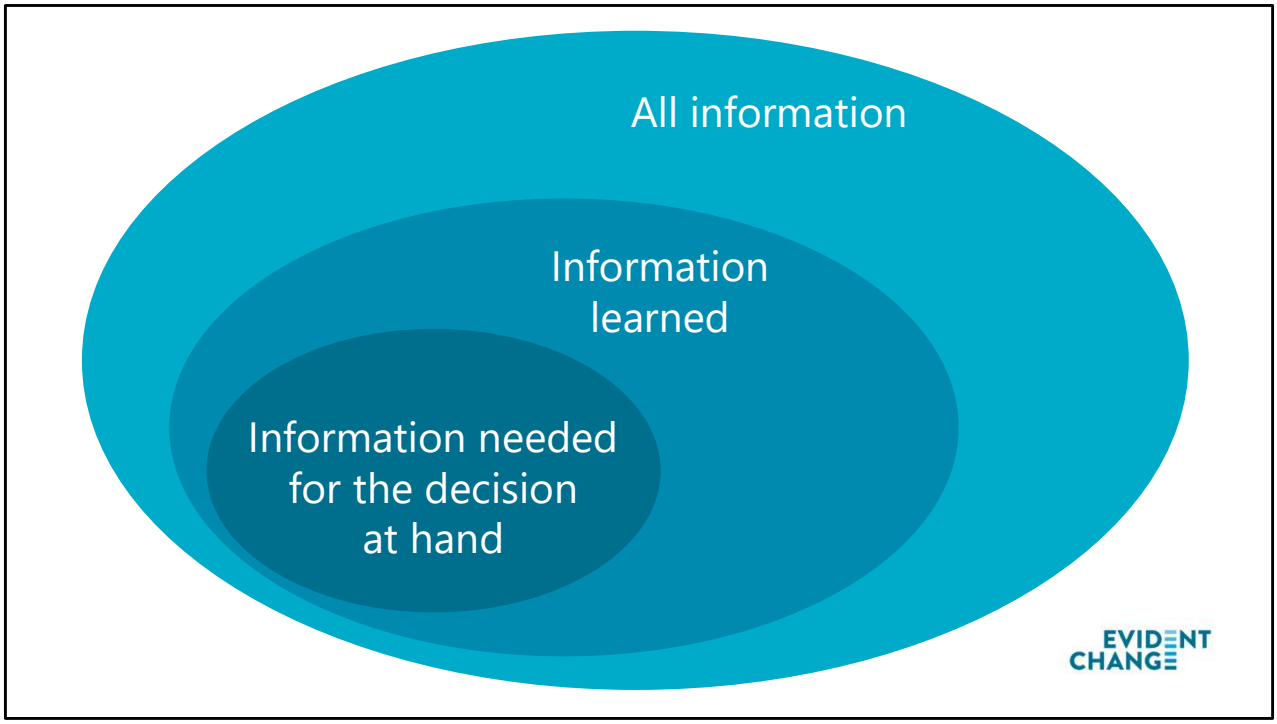
Especially when it comes to risk classification, Kahneman advocated for structuring decision-making processes. Evident Change stumbled onto the same idea in 1985 in our work with Alaska and has been striving to support workers with structured assessments ever since.

<u>Supervisors</u>
Supervisors should be clear about when System 1 thinking is being used, when System 2 thinking is being used, AND when the different systems should be used.

Help workers recognize when their System 1 thinking is driving their key decisions so much that they may subconsciously complete an SDM assessment with a bias based on their System 1 conclusions. You may see this if a worker is selecting or not selecting items in a way that is a stretch for the definition. Always bring staff back to comparing the SDM definition alongside facts from information gathering to explain decision making.

Appreciation for System 2 thinking at key decision points may not come naturally for workers who have a great deal of trust in their System 1 thinking. Supervisors can model the importance of System 2 thinking by *never* agreeing to a decision or deciding about a key decision point without consulting the relevant SDM assessment.

Learning about some common errors in System 1 thinking can help us spot moments in which it will be important to use System 2 thinking as a check and balance.



Purpose
To discuss the types of information available versus the information needed to make decisions, with an illustration of how SDM assessments focus on the information needed to make the decision at hand.

Example
Let's explore the term "critical thinking." We use the word "critical" two ways in English.

First, there is the idea of critical as absolutely essential. Think about what they track for a patient in critical care in the hospital. What are they paying attention to? [Wait for some answers, and help the class land on "vital signs."] The nurses and doctors in critical care are not asking about diet, exercise, family medical history, and that kind of thing; they are watching heart rate, oxygen saturation, whether we are breathing; the things that are keeping us alive. The three circles in this diagram represent types of information about a family and their usefulness in decision making.

The outer circle represents all the information about a family. We will never know *all* the information; it is impossible. The middle circle represents what we learn about the family through our work and any available information. The inner circle represents the information needed to make the decision at hand; this is where the SDM assessments are focused. The assessments help workers filter out the "noise" that can make decision making more difficult and focus on what is most critical to consider.

The other way we use the word "critical" is in the sense of "to critique"; and in this process, we want to critique our decisions to check that we are not responding from a place of bias, fear, or just "the way we have always done things."

EVIDENT CHANGE

Purpose
To understand that the assessment is not supposed to make the decision but guide decision making by providing a framework.

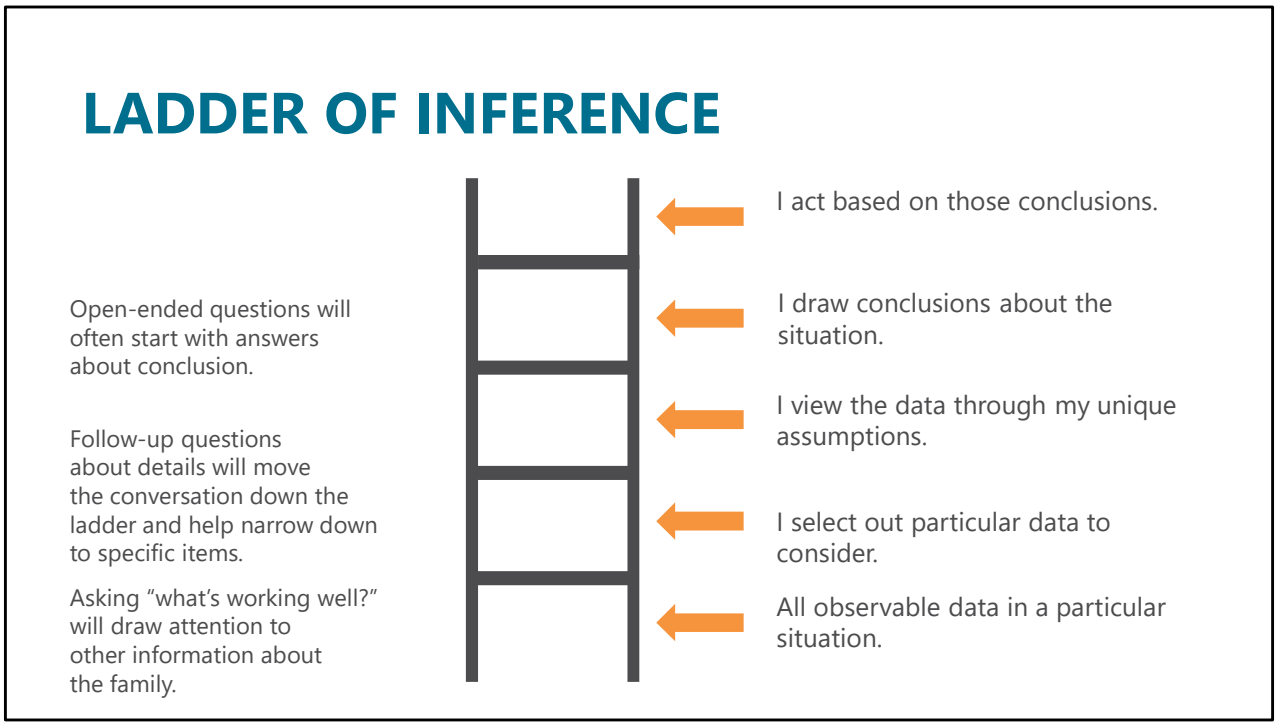
Example
Here is where the math problem example from a few slides ago gets dumped. [Ask participants to reflect on the difference between how we use a calculator and how we use a yoga mat.]

We have to help workers remember that just as the yoga mat cannot do the yoga for us, we have to use the SDM system to support our own critical thinking. It supports critical thinking by helping us focus on the information that matters at the decision point we face.

We could not take someone off the street, hand them the hotline tools, and tell them to make decisions about what referrals should be screened in or how quickly the agency should respond. The assessment's outcomes are directly related to the professional expertise and engagement skills used to gather the information and then apply that information to the definitions when completing the assessment.

It is important to remember that you, the worker, are making the decisions and taking the actions. The assessments and related policies, balanced with your professional expertise, are meant to help you make more accurate, consistent, and equitable decisions.

- Assessments do not make decisions. People do.
- Research and structured assessments combine with clinical judgment and experience to support decision making.
- Assessments should be integrated into solution-focused, family-centered practice.



Purpose
To see how the SDM system helps us avoid cognitive errors at multiple levels of the decision-making process.

Example
Here is a representation of the process we all go through in reaching conclusions that drive decisions and actions. At the bottom of this ladder is all the raw information around us that none of us can perceive without some filtering by our brains. As we move up this ladder, we trace the path of moving from what we see and hear to what we decide to act on.

While starting with open-ended questions at the beginning of an interview *may* elicit a complete and well-formed course of action based on rationality and equity, it is more likely to result in the noisy decision-making we currently see in child welfare. Asking questions the help us move down the ladder with attention to what biases and assumptions we make along the way is important to having full awareness about why we are choosing the actions we are choosing.

Trainer Note

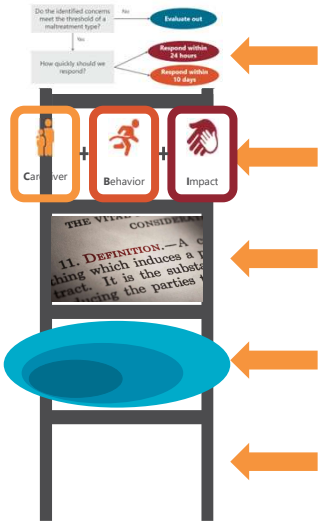
<u>Activity</u>
Ask participants to turn to a peer and share with each other questions they might use to move a conversation "down" the ladder to get specific details. After three to five minutes, ask participants to share a few questions with the rest of the class.

LADDER OF INFERENCE

Open-ended questions will often start with answers about conclusion.

Follow-up questions about details will move the conversation down the ladder and help narrow down to specific items.

Asking "what's working well?" will draw attention to other information about the family.



I act based on those conclusions.

I draw conclusions about the situation.

I view the data through my unique assumptions.

I select out particular data to consider.

All observable data in a particular situation.

Purpose
To illustrate how the SDM system helps us avoid cognitive errors at multiple levels of the decision-making process

Example
Let's take that same model and overlay the components of SDM that can save us some time in the process of choosing a course of action.

The first time-saver is helping us focus on the particular data that actually pertain to the decision at hand.

The next time-saver is using definitions to bypass our unique assumptions and, instead, use equitable standards for all families.

Next, we have guidance about conclusions that are justified in light of the information we have sifted through in considering the definitions.

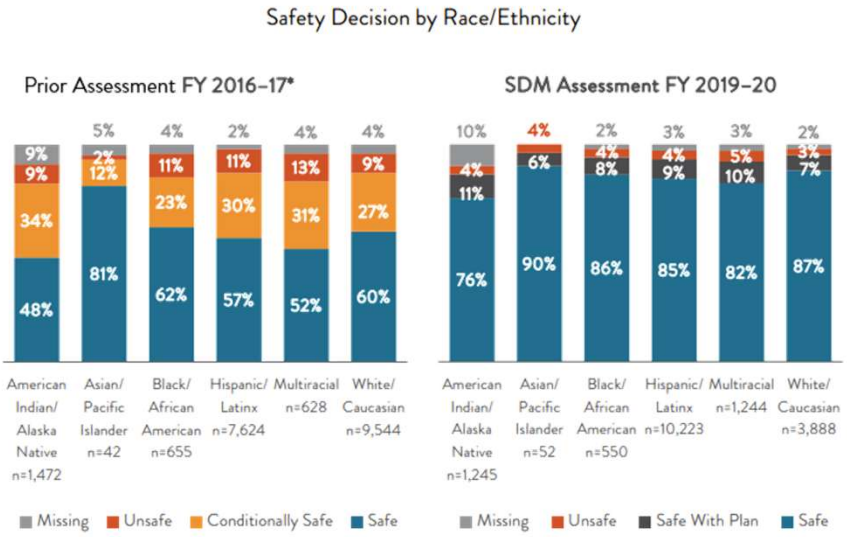
Finally, we have logic models that provide *initial* recommendations (because people make decisions, assessments do not make decisions).

Trainer Note

Activity

Ask participants to turn to a peer and share with each other how starting at the bottom of the ladder with the SDM model would be more efficient for supervision than old school practice of “listen to everything the worker brings, then sort it all out into some coherent conclusion.”

MEDIUM-SIZED STATE IN UNITED STATES



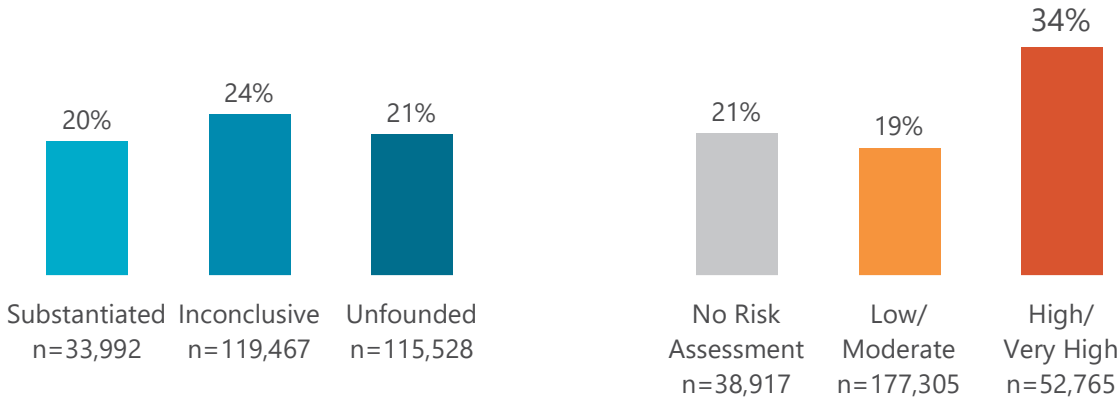
Purpose
To see the big picture regarding what the SDM system can help our profession achieve.

Example
Let's look at some of the outcomes that the SDM system can help us achieve if it is used correctly.

This study is not published, so we do not disclose the state. Note the wide disparity in finding safety threats between ethnicities using the prior assessment compared to the closer alignment with the SDM safety assessment. While we still need to get workers to *use* the assessment with American Indian families, ask participants which of these situations seems more equitable for families and why.

IS THE RISK ASSESSMENT VALID?

IT IS A BETTER INDICATOR OF FUTURE SYSTEM INVOLVEMENT THAN ALLEGATION CONCLUSIONS ARE.

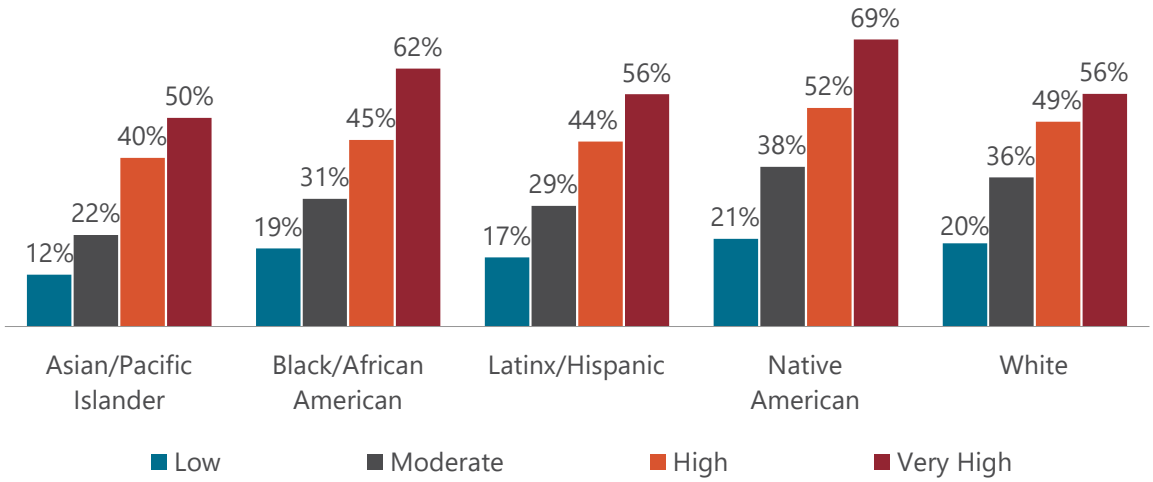


Purpose
To understand that while an allegation conclusion is required, it is not helpful in deciding which families would benefit from prevention services.

Example
While making a finding on allegations in investigations is required by penal code, it is of little use (no better than flipping a coin, actually) in deciding which families would benefit the most from prevention services.

Trainer Note
These are the data reported in the 2024 statewide management report for California. The recurrence sample includes children who were alleged victims involved in investigations in 2023 and compares 12-month subsequent maltreatment investigations across investigation conclusion and initial risk level. This analysis does not include children who were placed in out-of-home care for the entire outcome period.

HOW DO WE KNOW IT IS EQUITABLE, AND WHAT SHORTCOMINGS DO WE NOTICE?



Purpose
To learn about the risk validation results published in 2013 for California across race by household.

Example
Here we see the same stairstep pattern between the ethnicities, letting us know that the assessment works across race. We would prefer not to see the "crossover" between the 50% "very high" for Asian/Pacific Islander and the 52% "high" for Native American, but we can live with this pattern overall.

It is also important to understand that this system is not perfect, and Evident Change is always looking for the potential for disproportionality within the assessments. For example, after the 2013 risk revalidation study, Evident Change staff identified that one of the questions disproportionately affected Native American families. Evident Change staff worked with the state to revise that question in the assessment.

Trainer Note
If participants would like to review these data, direct them to https://docs.evidentchange.org/California/data-management-reports/ where they can look for "Risk Assessment Validation: A Prospective Study." Alternatively, they can go

directly to
https://docs.evidentchange.org/Pages/California/Content/Trainer%20Resources/Risk%20Assessment%20Validation%20A%20Prospective%20Study.pdf

See Table 18.

Purpose
To learn to distinguish safety threats from risk scores, and to understand that allegation conclusions are a required part of an investigation but are not the most important information when moving forward with families.

Example
What do we have to do when we have a deer in the road ahead of us? [Wait for a few answers.] Who can tell me how they decide to put up deer crossing signs up along parts of our highways? How do transportation officials hope we will react to these signs to prevent accidents? How can we use the risk assessment to *prevent* future system involvement?

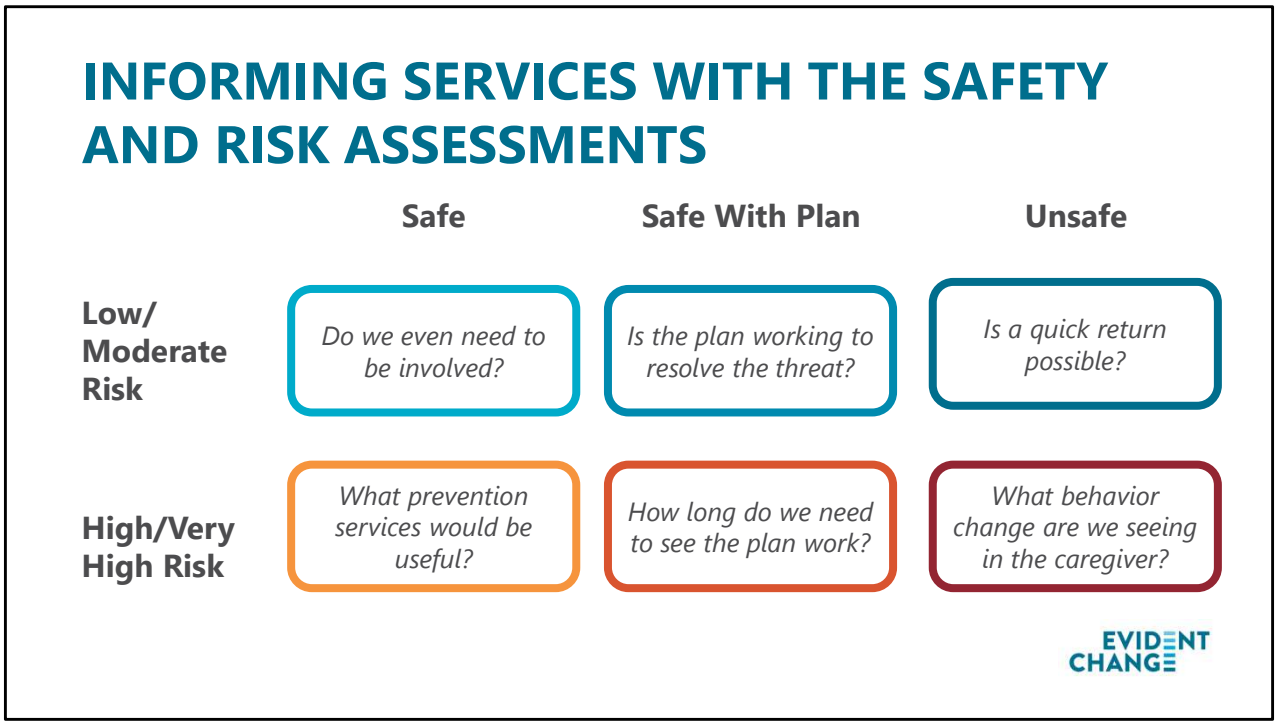
[Before clicking the animation, ask:]

Who can tell me why the rearview mirror in our cars is so small, and the windshield so large?

Across jurisdictions, we see that the allegation conclusion often drives the decision to open a case for services. But in repeated studies, we find that this data point has close to no predictive capacity to inform which families might be involved with our systems

again in the future.

Trainer Note
Make the point that the allegation conclusion might tell you what happened that caused a hotline call, but that outcome is much less important for determining the "right-sized intervention" for a family. The safety assessment and risk assessment give the "windshield" perspective.



Purpose
To understand investigation resolution support from the SDM assessments.

Example
On the last slide, we made a point to separate safety and risk. We do that, in part, so we can look at the intersection of the two and what we can consider for families based on the results.

This decision matrix can help us think about our work with the families through some decision support. For the families that were "safe" on the safety assessment and low/moderate risk, we can ask ourselves: Should we be involved with these families at all?

If we knew within 15–20 days that a family was safe and low/moderate risk, and we closed those investigations quickly, what impact would that have on caseloads?

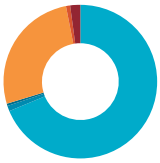
For the families who were "safe with plan" on the safety assessment and low or moderate risk, we can create a safety plan and keep the child in the home. These families had a temporary crisis; but based on being low/moderate risk, once this crisis is resolved, it is unlikely to recur. Very early (meaning even within the first 30 days),

we should ask, “Is the plan working?” and “Has the caregiver demonstrated actions of protection?” If so, we may be able to step out of that family’s life relatively quickly. (You should be sure the safety threat is resolved and be sure risk is still low or moderate.)

For the families who have a safety decision of “unsafe” and are low/moderate risk, we can ask, “Is a quick return home possible for these children?” A family with a one-time unfortunate event might fit this category if they do not have many other risk factors. Even if a removal was needed, a low risk level suggests that we may be able to return the child home quickly once the danger is resolved. With brief post-reunification support, we can verify that the child is safe and risk is still low or moderate, and close the case.

On the bottom row, for families with a finding of “safe” on the safety assessment who are also high or very high risk, we might ask, “What preventive actions can be taken to address the elevated risk factors?” These families may look stable in the moment, and we often are tempted to conclude that everything is okay and we can close the case after the referral. But nearly one in three high-risk families and one in two very high–risk families will be re-substantiated for abuse or neglect within two years. It would be better to engage the family in working toward sustainable safety now.

For families found to be “safe with plan” and high or very high risk, we might say, “We need to see the plan working a little longer to have comfort that it will stick.” The families who are “unsafe” on the safety assessment and have a high or very high risk level are those for whom we have the most concern. For these families, we need to see sustainable safety demonstrated for some time before feeling comfortable that these children can go home. Sustainable safety is reflected in the SDM reunification assessment, where we look at progress toward case plan goals, visitation (including the extent to which the caregiver demonstrates actions of protection during visits), and safety (including whether the original safety threat was resolved).



2024 DISTRIBUTION IN CALIFORNIA

	Safe	Safe With Plan	Unsafe
Low/ Moderate Risk	89,685 (70%)	4,758 (4%)	1,161 (1%)
High/ Very High Risk	23,382 (18%)	3,903 (3%)	5,720 (4%)

EVIDENT CHANGE

Purpose
To see the number of families in each category in California.

Example
Here is the distribution of all investigations in 2024. Of investigated families in California, 70% were safe and low or moderate risk; on the last slide, we talked about closing investigations for this block of families. What could happen to safety planning and monitoring when it was needed if most of these safe and low- or moderate-risk families had their investigations closed sooner rather than later? [Pause for some reflection and reaction.] If you need to plan how to invest prevention dollars in your county, which box would you want to prioritize?

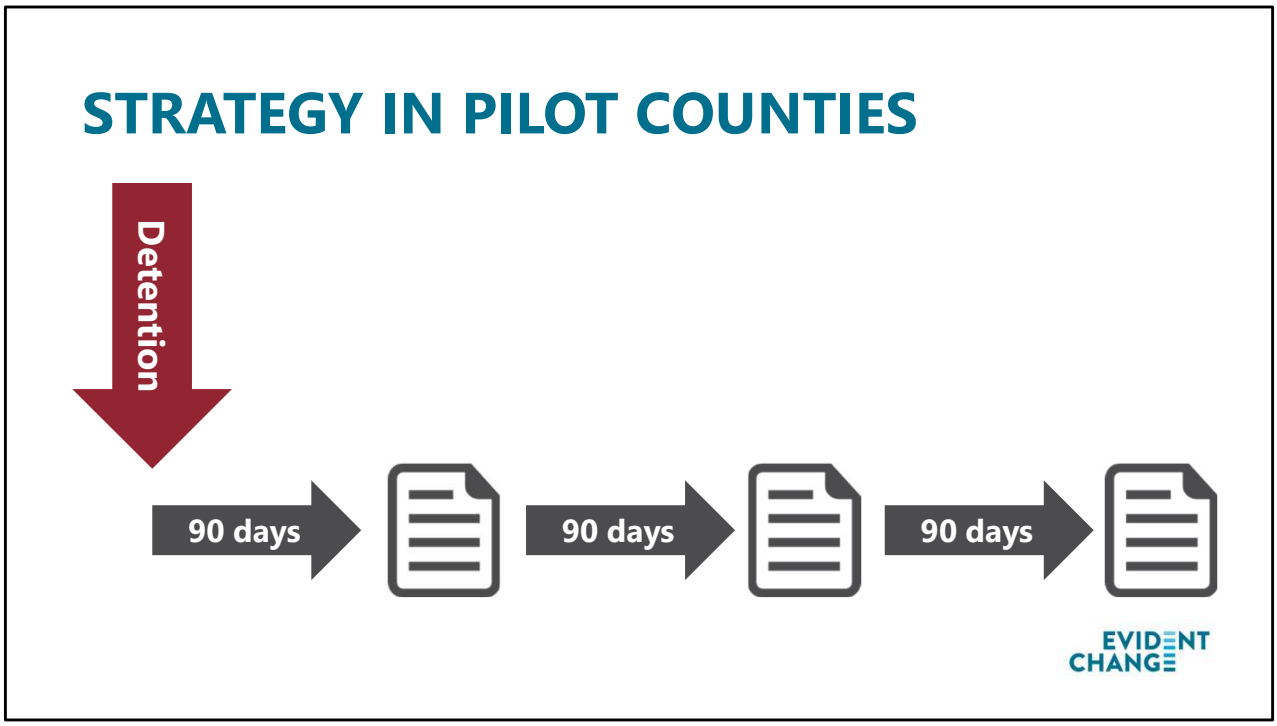
MICHIGAN REUNIFICATION ASSESSMENT STUDY (2005)

- Nine pilot counties implementing SDM reunification assessment
- Nine control counties continuing with traditional case management practice
- Followed reunification and permanency outcomes for 15 months

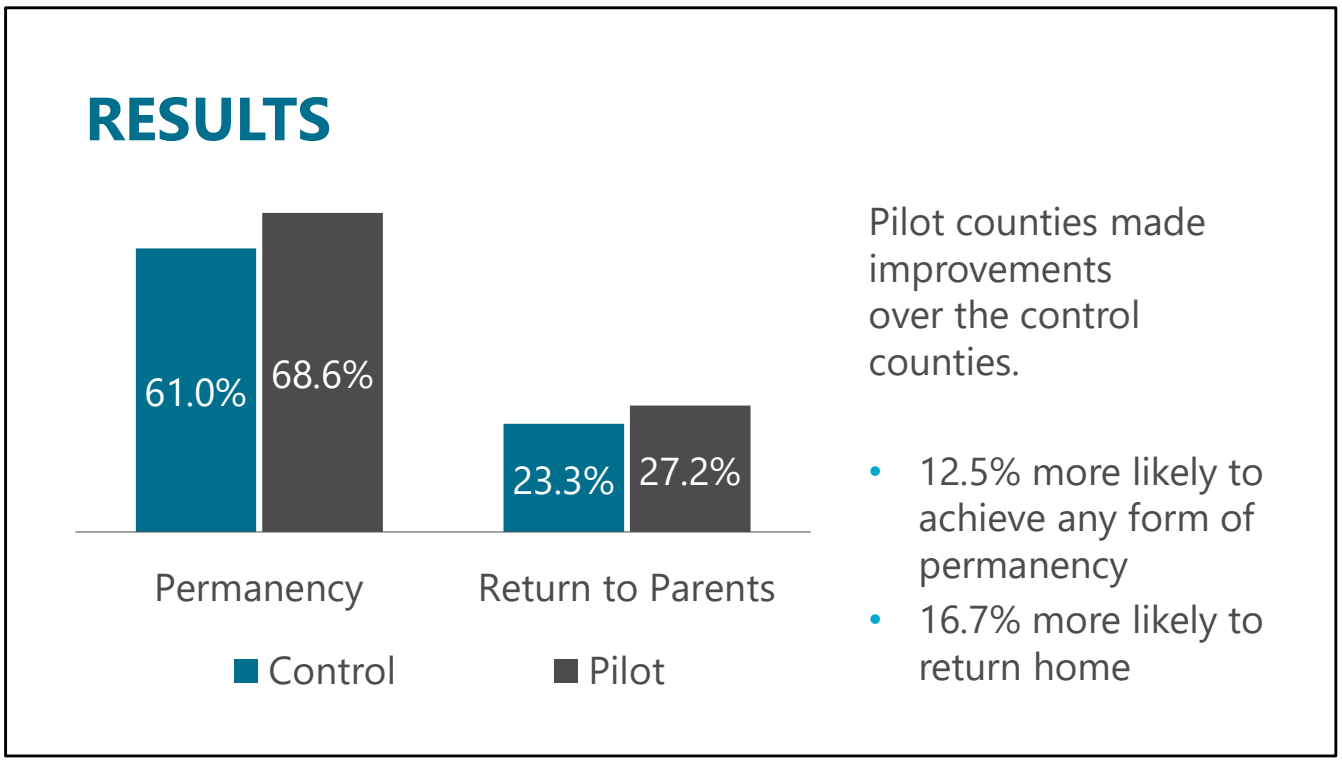
EVIDENT CHANGE

Example
Let's consider the impact of some of the other assessments, starting with the reunification assessment.

In 1998, a study was started with nine counties in Michigan piloting the SDM system, including the reunification assessment. Each county was matched with a similar county for comparison in the aggregate. Outcomes for youth were followed for 15 months. The results were published in 2005.



Example
In the study, the reunification assessment was used every 90 days to assess the family's progress.



Purpose
To see the findings from the Michigan study.

Example
Fifteen months after entering foster care, children served by pilot counties achieved permanency at a significantly higher rate than their counterparts in comparison counties (68.6% versus 61%).

In addition to the higher overall rate of permanency, children in pilot counties were more likely to be returned home than those in control counties; AND there was no significant difference in rates of reentry to foster care.

Ove

To be clear, this is a correlation finding, not a causation finding. There could be some cause other than the reunification assessment itself, like just reviewing for progress every 90 days, or the investment in leadership in focusing on this issue, or the assessment giving workers confidence in their recommendation that control county workers did not have.

Whatever the cause, if you were a kid stuck in foster care in Michigan at the time, would you rather be in a control county? Or a pilot county?

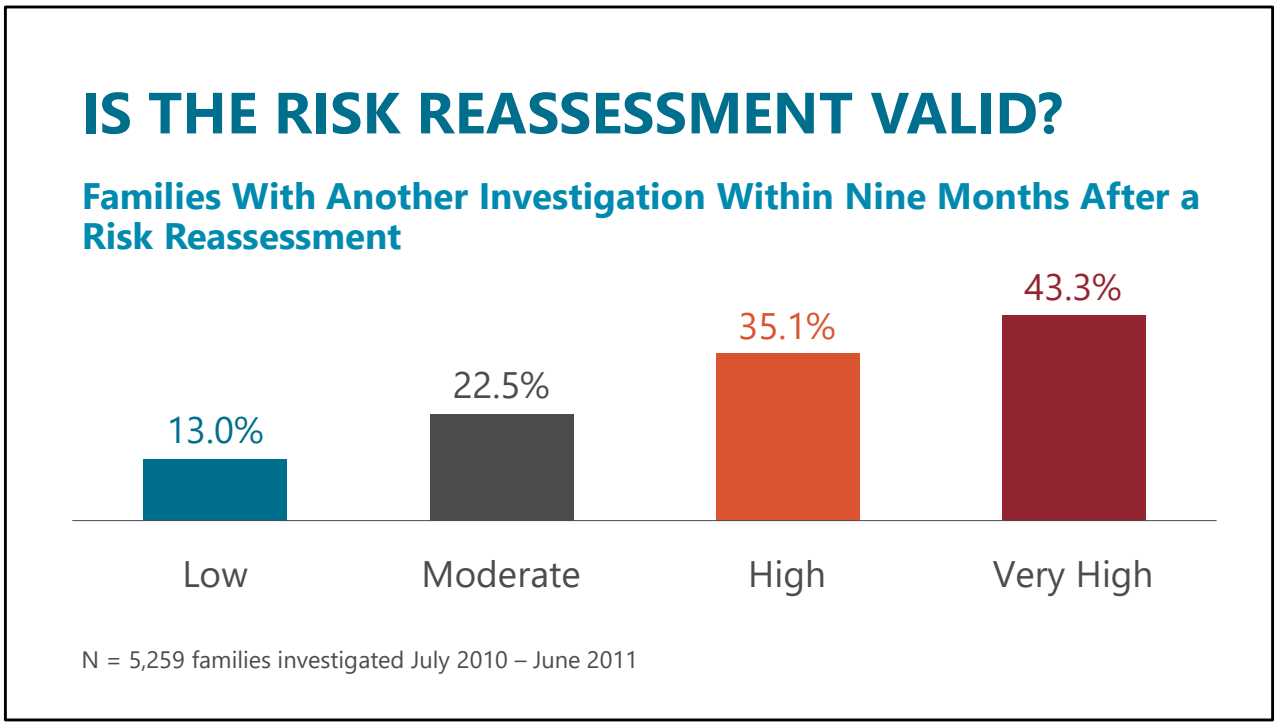
Trainer Note
Here is the math for the "more likely" calculations:

- Return home (27.2 − 23.3) / 23.3 = 16.7%
- Overall permanency (68.6 − 61) / 61 = 12.4%

Practice explaining this result several times before your first delivery and be prepared to answer some challenging questions. These could include "This is Michigan research; where is the California proof?" and "This seems like an old study; why hasn't it been replicated?"

A few points to remember here. A valid research study, even if it was done hundreds of years ago, is still valid today unless it is disproven. An example would be that a physician (Ignaz Semmelweis) in Vienna had proven by 1850 that if physicians washed hands between examining cadavers and working with patients, the death rate went from 20% of patients dying to nearly 0. They did not actually understand what infection was at the time, but we do not need to replicate that handwashing experiment today to know that it is an important practice for medical professionals.

Another point to highlight is that the Michigan study was very close to a randomized control trial because the intervention was applied to half of the population in the study and withheld from the other half. This was possible because there were only enough resources to begin the pilot in nine counties at the time, but there has not been an opportunity for a similar implementation since then. To construct a study that intentionally withheld intervention from half of families would never pass the current ethical standards for social science research.



Purpose
To see the validity findings for the risk reassessment.

Example
In the California revalidation study, the risk reassessment was found to categorize families accurately for correspondingly higher rates of investigations based on the risk score after case closure.

Note that this study was conducted on the risk reassessment in use in 2010 and 2011, and some revisions were made to the risk reassessment, which is currently in use across California. This result was published in 2013.

These are families from July 2010 through June 2011 whose investigations resulted in opening a new case AND who had a risk reassessment completed during the first eight months of the case opening. Note that having a new case opened does not necessarily mean it happened within that same period of July 2010 through June 2011; for example, an investigation might have started June 30, 2011, but the case may not have opened until August 2011. Outcome rates are within nine months of the risk reassessment date.

Purpose
To discuss a new explanation of the SDM system for workers.

Example
Let's revisit how we explain the structured decision support system to our staff. Now that you know the problem that the SDM system is trying to solve, the values with which it is developed, and the outcomes in terms of equity and accuracy, take a minute and list five key points that you would make in helping to explain the value of rigorous accurate use of the SDM assessments. [Give participants three to four minutes to jot down their list.]

Now that you have your list of key points, pair and share with someone close to you how you would explain the value of SDM assessments to a new worker now.

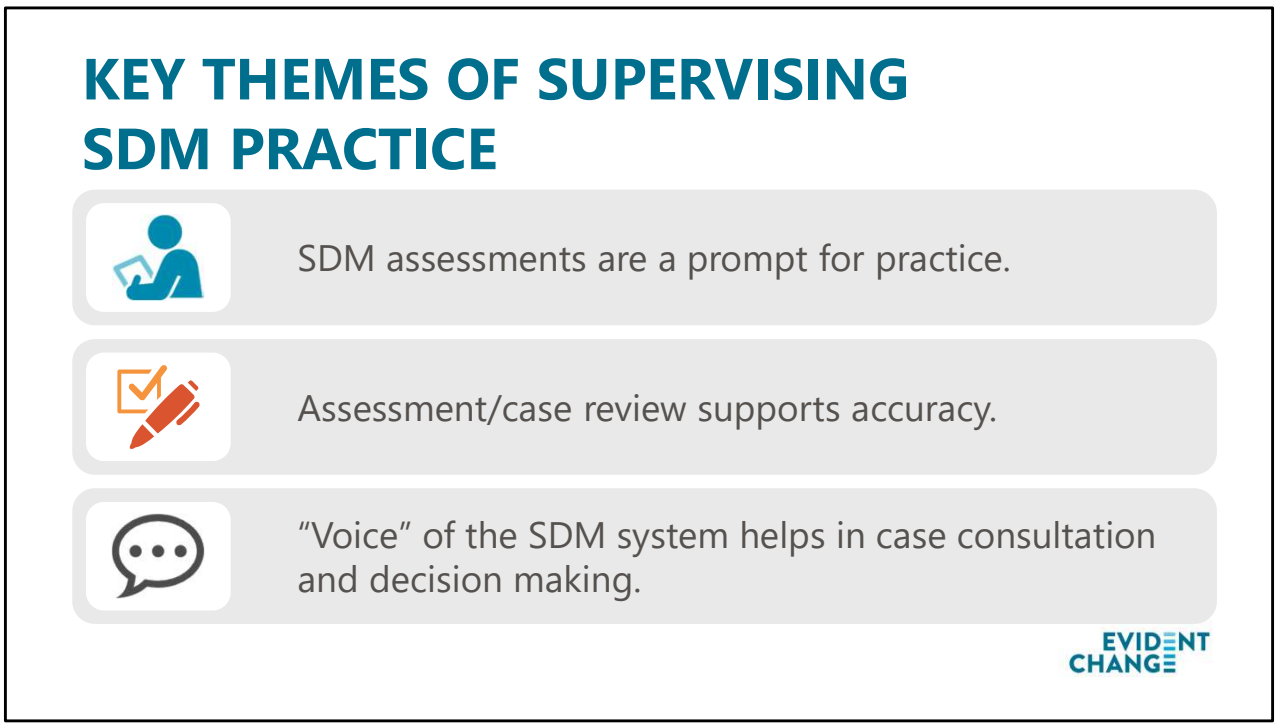
Trainer Note
Provide 10 minutes for participants to share with each other their talking points. Then, as a large group, debrief what participants heard from each other that made sense and that they would incorporate into their own explanations.

SUPERVISORS ARE KEY TO SDM SUCCESS

Purpose
To be introduced to supervisor concepts and the SDM system.

Example
Supervisors are the bridge between work in the field and leadership. As supervisors, you communicate information in both directions. This role is critical in our work, particularly as a system undergoes change.

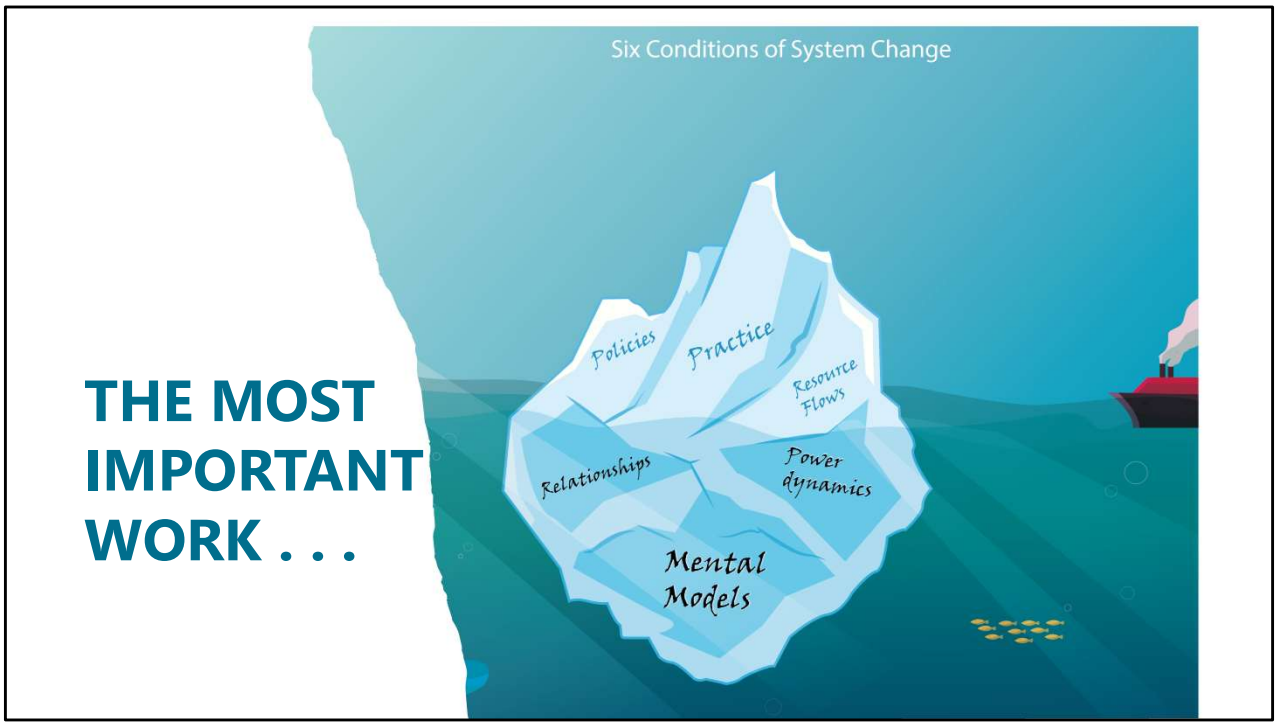
- You empower workers.
- You make the system work.
- You are pivotal to the agency's direction.



Purpose
To be introduced to some key themes of SDM assessments in supervision.

Example
We will review each of these in more detail, but here are three key themes of how we can address practice in supervision, as it relates to SDM assessments. As a supervisor, you are in the best position to communicate expectations and best practice for SDM assessments.

1. SDM assessments are prompts for practice, and supervisors can model this strategy in everyday supervisory conversations.
2. Creating supervisory habits related to reviewing assessments and the assessments' supporting documentation is essential in fostering caseworkers' development of knowledge and skills needed to conduct accurate assessments.
3. Finally, solution-focused supervision is the notion of working in partnership—that one is not working alone but as part of a team. Using the "voice" of the SDM system and your facilitation skills during supervision, case consultation, and family-centered meetings is key to balanced and rigorous information gathering and to ensure that the SDM assessments inform key decisions related to safety and case closure.



Purpose
To frame and illustrate the challenge we face in decreasing disproportionality in child protection work.

Example
Raise your hand if you have heard that disproportionality is a concern in our profession.

What does disproportionality look like in our work? [Get some answers about uneven decision making across race and ethnicity.]

Raise your hand if you support making our child protection work more equitable for families of color. [Hopefully, everyone raises their hand; this may feel perfunctory, but eliciting responses like this helps to highlight content for learners; and the following point is very important.]

Getting a system to change, especially in relation to deep-seated problems in society related to discrimination, is a tall order. Our legislation, CDSS guidance, and county-level leadership tend to focus on the top three issues in this iceberg. This is understandable because these are the most visible to all and accessible for revision.

But the issues below the waterline are what will really make a difference in our work. You might recognize that Safety-Organized Practice (SOP) is attempting to address the "relationships" and "power dynamics" portion of our system by providing practices and strategies for creating good working relationships with families and sharing power in decision making through safety planning and collaborative creation of harm, danger, and goal statements. The Core Practice Model describes behaviors designed to work in this space also.

But down here, at the base of the iceberg, is where we have failed to really make the shift needed to get the best use out of the SDM system here in California. Remember the audio clip about noise in decision making? Most of our workforce has *not* gotten that message. And while we have made progress in this state, especially in the Emergency Response aspects of our work, there are still many who continue the habit of doing the assessments as an afterthought, especially in initial court work and ongoing services.

We need your help in communicating that ethical practice includes knowing that (1) none of us can "unbias" our own thinking alone, and that (2) using the SDM assessments as a *starting* point for gathering the information needed to make decisions is crucial to reducing noise and treating families more fairly. Internalizing the values that drive the SDM system's design—being transparent and sharing power with families in the work that we do with them—is how we go from *compliance* with a mandate to *alliance* with families.

Trainer Note
Source document is available at
https://www.fsg.org/resource/water_of_systems_change/

CREATE A LEARNING ORGANIZATION

A place to:

- Think;
- Learn;
- Reflect;
- Collaborate;
- Offer support; and
- Grow.

EVIDENT CHANGE

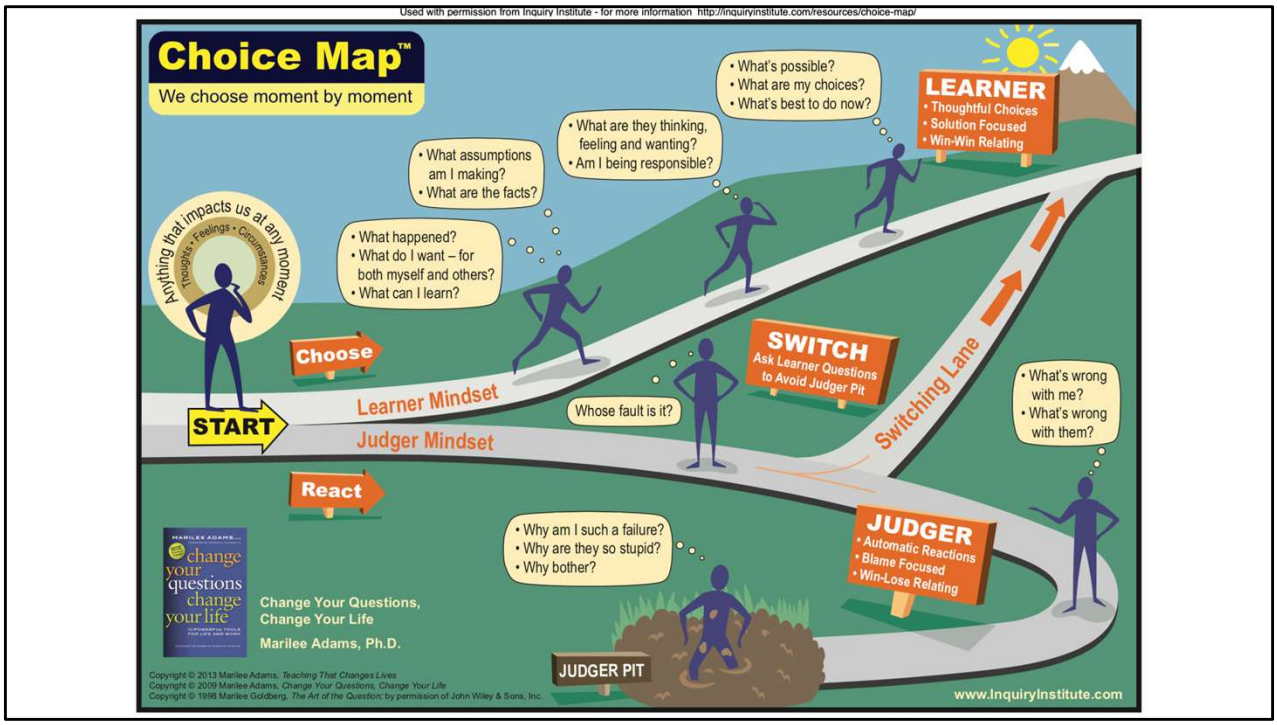
Purpose
To be introduced to the concept of a learning organization.

Example
A basic tenet of safety culture is that we cannot fire our way to safer systems. That means that we have to anticipate that mistakes will happen and we need to learn from them in an intentional way.

Trainer Note
This an opportunity for either a breakout session or a large-group discussion, depending on time.

Ask participants to raise their hands if they have ever experienced being fearful, being blamed, or having to defend themselves in their practice of child welfare. Ask: "What was that experience like? How did it affect you? How have you seen it affect your workers?"

Part of the implementation of a new assessment or new practice is cultivating an environment where staff feel safe to take the risk and expose their worries; their mistakes; and their needs for support, coaching, and development. That culture reflects a learning environment. And while it may not readily exist throughout the organization, you can create it within your unit, your program area, or your space.



Purpose
To be introduced to the choice map as a tool to aid awareness when creating a learning culture.

Trainer Note
Do not launch into an explanation; just ask the following question and let the learners explain what they see. This will draw them into the details.

Example
What do you see on this graphic?

How could the choice map be helpful at work and when we are sitting down with families? SOP is, at its core, about changing the questions that we ask of ourselves and of families.

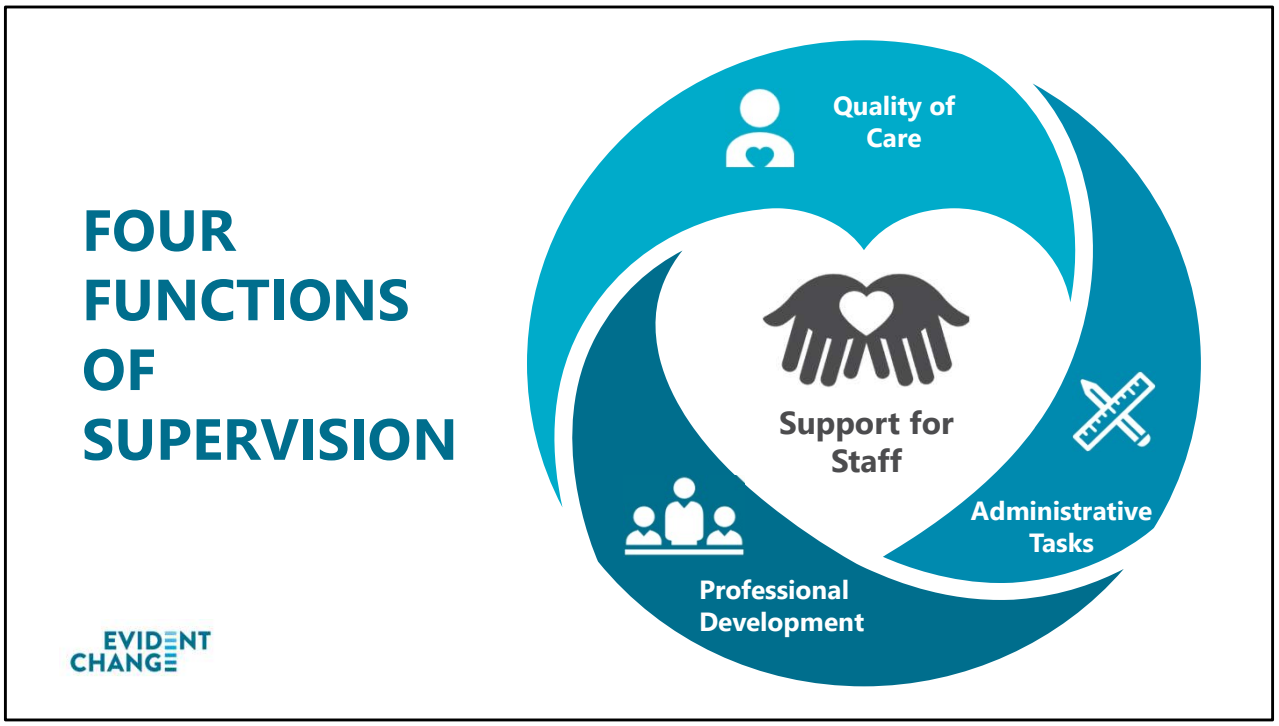
Trainer Note
Resist the impulse to explain the map. The participants will explain much of it for you in response to "What do you see?" Prepare in advance to share one of your own "switching stories." It is very important that you frame Judger as normal and ever-present; if we "go Judger on Judger," we just stay stuck; AND the emotions that come

up from Judger reactions are messengers that we need to understand and learn from.

Make the following points if they do not come up organically.

- The questions we ask shape how we think about a situation. Mindful awareness of what questions we are asking supports solution-focused practice and gathering the answers needed for our SDM assessments.
- Judger is normal and will be with us for the rest of our lives.
- Judger is the default reaction in part because it helps keep us alive and safe in dangerous situations.
- Learner is the "uphill" path, not the easy path.
- There are no unicorns or rainbows at the end of the Learner path; it can lead to hard conversations and hard truths.
- Learner *is* the only path that leads to growth and opportunities (notice that it exits the box through the break in the border).
- Switching Lane helps us find our way to the Learner mindset. Switching Lane questions include: Am I in the Judger mindset? Is this how I want to show up in this situation? In this situation, do I want to be a critic or a coach?
- You can ask, "Where do we find bias on the choice map?" The answer is that we find it everywhere, because our biases are always with us. But so are our values, and we need to attend to uncovering both of those so we can promote equity in our work with families.

Facilitate a discussion about the possible impact of using the choice map at every level of the organization to create trust, psychological safety, and a solution-focused mindset for using the SDM system.



Purpose
To be introduced to the four functions from the Yale School of Medicine, Department of Psychiatry Model.

Example
These four supervisory functions come from the Yale School of Medicine, Department of Psychiatry's model of supervision. You will notice that the center of this model is supporting staff in doing the hard, important work of assessing families and meeting their needs. In addition, *the accurate use of the SDM system and use of engagement skills are important for providing the quality of care that families deserve (and we put that at the top of the illustration to emphasis its importance to our work).*

Let's be very clear that support for staff is not the same thing as "coddling non-performing staff" because ensuring quality of care for families and getting administrative tasks done is still part of the work and always will be. Supporting staff works best in healthy workplaces, but that is another whole training (available through some of the CalAcademies if you want to advocate for healthier workplace environments; ask your management about getting that support from your regional academy).

After this next activity, we will dig into the nitty gritty regarding what we need to look out for when it comes to quality of assessments and care.

Trainer Note

<u>Activity</u>

Have participants pair and share how they navigate these four roles currently and what role the SDM system can play in promoting *professional development* and *quality of care*.

The Yale School of Psychiatry Model is available at https://files-profile.medicine.yale.edu/documents/3d0e1dc7-4d2e-4e6f-b5c6-b4f6139d9899

Purpose
To be reminded of the different ways supervision occurs.

Example
Supervision generally occurs in various ways and can be about gathering data as well as developing interventions. In general, there are three ways supervision usually happens.

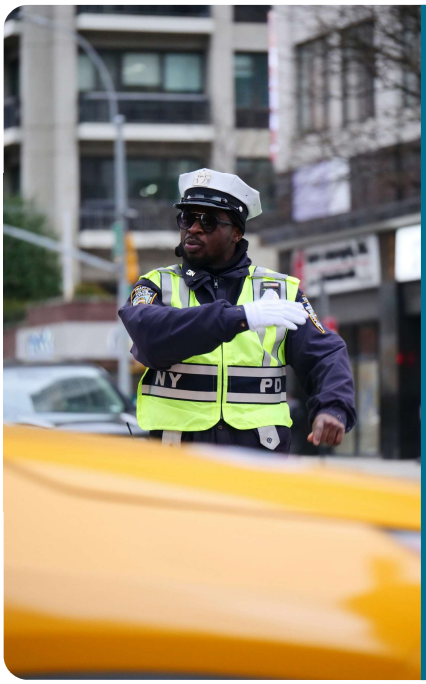
On-the-run supervision is the type of consultation that often happens in passing, such as in the hallway or during a quick visit to your office. A worker might pose a quick question seeking your guidance. This type of quick check-in can be helpful in addressing challenges that may have clear-cut answers; however, when faced with more challenging questions where an answer may not be so clear cut, this type of supervision may not be the most effective or beneficial.

A one-on-one supervision session may be warranted for more in-depth case consultations. Most supervisors formally meet one-on-one with their supervisees monthly or otherwise on a regular schedule. This type of supervision can provide an opportunity to gather the needed information from the worker; understand the decision or challenge they are facing; or reference relevant SDM assessments and policies, procedures, and standards of practice.

For example, you could review one completed case and associated assessments prior to the scheduled supervision session. During supervision, you could point out strengths and areas to improve. Another option might be to ask the worker ahead of time to identify a case or scenario that made them feel challenged or curious; you could then devote time to discuss it and help support the worker to generate ideas for moving ahead with the case. This would also be an effective way to note progress or areas of opportunity for

professional development.

Group supervision is a type of consultation that happens within a unit or team and provides time to discuss logistics, agency news, or a practice theme or topical area. For example, if your team has been struggling with gathering information on substance misuse, you can focus on the hotline tools items and definitions that could most often relate to substance misuse. Then you can contextualize it, concentrating on how the definitions guide how substance misuse is reflected in a new way. This will allow you to discuss interview approaches and questions that team members have used to get the details needed to complete screening criteria items accurately.



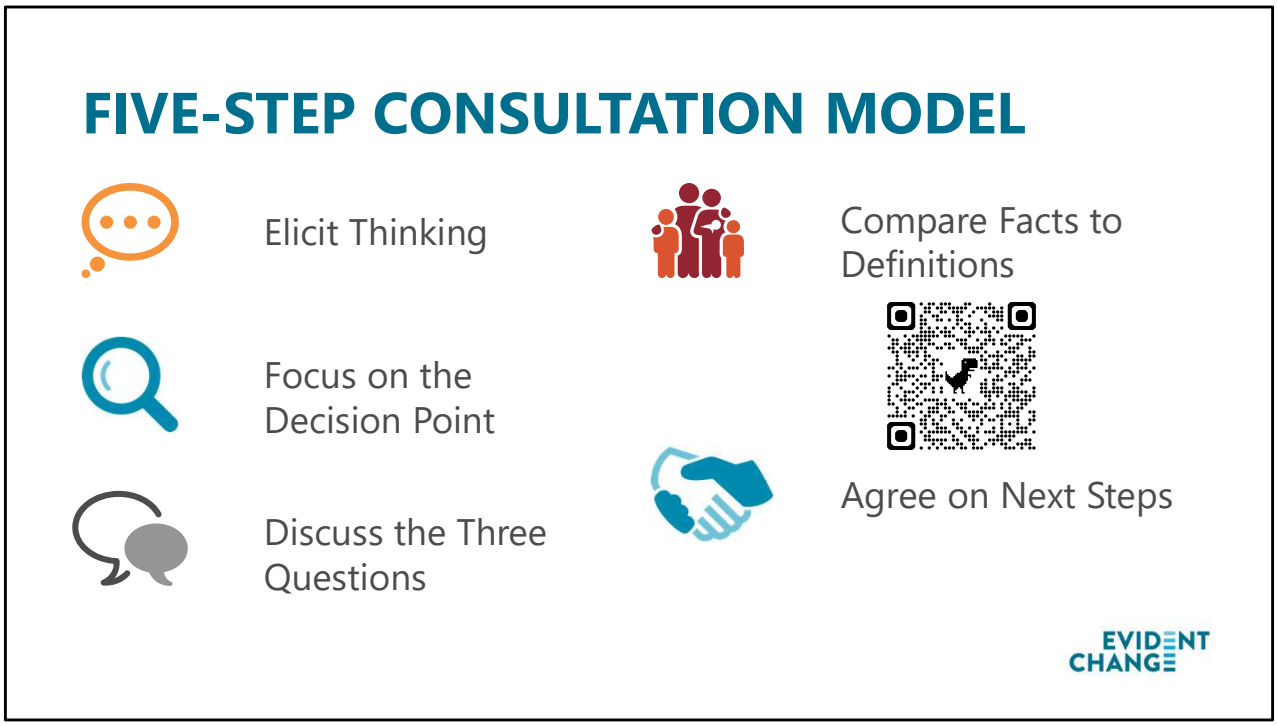
Purpose
To review the Common Mistakes handout in the participant guide.

Resource
Common Mistakes and How to Handle Them: Key Points for SDM Implementation handout

Example
Like the motorists in the photo, we all need a little direction from time to time. Turn to the Common Mistakes section of your participant guide. Take some time to read through all of them, write a checkmark for the ones you have seen in your own practice, and circle one or two that you would like to hear how others in the room handle.

Trainer Note

Activity (10–15 minutes)
Provide time for participants to read and reflect. Then, guide a discussion about items that a few folks would like help with.



Purpose
To be introduced to a simple model that includes referencing SDM definitions in even the most rushed of "on-the-fly" consultations.

Trainer Note
There are two ways to approach this slide depending on how you are doing on time.

Example
Introduce these five steps—top to bottom, left to right—for a quick consultation or supervision conversation. Elicit the worker's thinking to get their initial thoughts on what challenge they face and what their initial course of action would be. Then, slow down enough to clarify and focus on the decision point they actually face so we know which assessment to consider. Next, because we want to do a thorough and balanced assessment, we ask the Three Questions: What is working well, what we are worried about, and what might need to happen next?

Everyone, pull out your phone and aim the camera at the QR code (https://ca.sdmdata.org/definitions). This gives us access to the definitions in all of the assessments for WebSDM in California. Compare the facts that you have heard to the definitions in the assessment to gain clarity with the worker on what they know for

sure and what they still need to get from the family to complete the assessment accurately. Whether the definitions have been fully met and the decision seems clear or further information needs to be gathered before the definition is satisfied, agree with the worker on the next steps that they need to take.

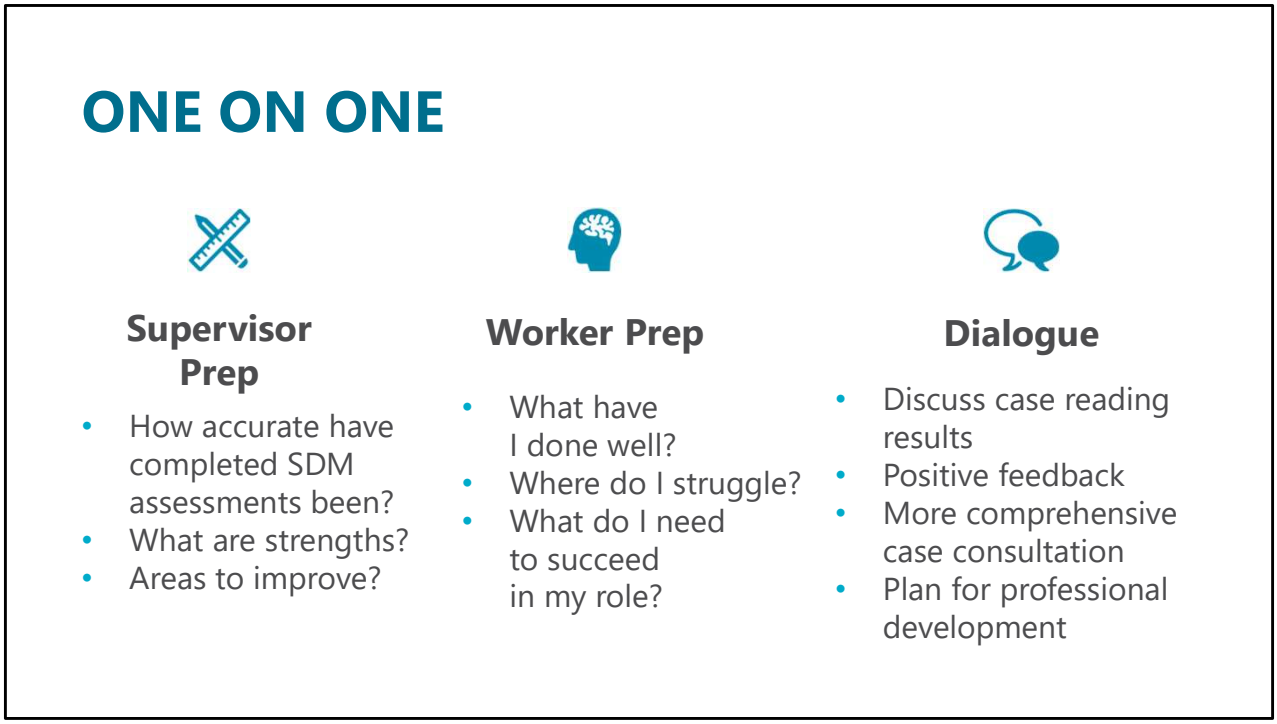
Trainer Note

If you have 50–75 minutes:
Walk participants through each of the five steps in this case consultation model. Remind them that the three questions in the middle are what are we worried about?, what is working well?, and what needs to happen next? Also ensure that they have access to the SDM definitions in the web browser on their mobile phone or other device, AND remind them to use those definitions during step 4.

Tell participants to get into groups of three and to assign one person to monitor progress through the five-step consultation model, one participant to present a recent case that they worked on, and the third person to act as the supervisor consulting on that case. Tell them to spend 10 minutes consulting on a case and then switch roles. Instruct the person who is going to monitor progress through the five-step consultation model to speak up and redirect the other two participants if they go off track or if they get stuck and need to move forward to the next step.

Move around the room to check on progress. Near the end of 30 minutes, tell the groups to pick a spokesperson to report out on the utility of the five-step consultation model. Bring everyone back together and ask for the spokesperson from each group to report out.

If you are short on time:
Walk participants through the five steps fairly quickly and remind them to use the SDM definitions website when they are on step 4. Ask for a volunteer to present a case and walk through the five steps as if you are their supervisor consulting on the decision.



Purpose
To review SDM connections in one-on-one supervision.-

Example
This type of supervision can provide an opportunity to gather the needed information from the worker; understand the decision or challenge the worker is facing; and reference relevant SDM assessments and policies, procedures, and standards of practice.

One-on-one supervision, or formal supervision, usually occurs at regular intervals, and it gives you more time to work through more complex conversations.

Since you can prepare and plan for a one-on-one supervision session with staff, you might review a few of your worker's completed assessments, especially if the worker is new in the role. By doing a case reading, you can identify areas for professional development, successes, or strengths. This can be helpful in structuring your time with the worker as well. You can invite the worker to prepare for the sessions by asking the worker to identify a case or scenario that made them feel challenged or curious, and you can make sure to devote time to discuss it and help support the worker to generate ideas for moving ahead. You can also ask the worker to think through their successes, struggles, and needs since your last supervision time.

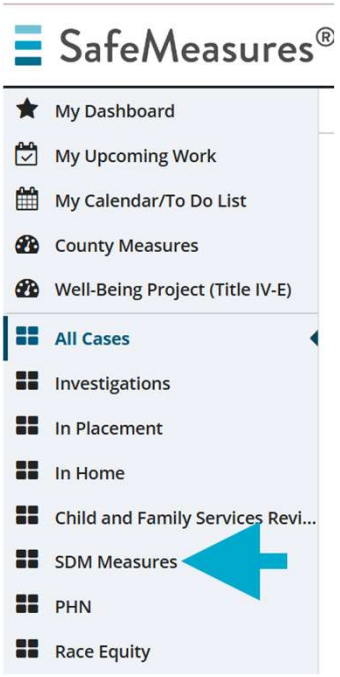
During your time together, the dialogue is less about finding an answer or making a decision. It is more about an exchange to develop growth and provide support. If you had the opportunity to complete a case reading of your worker's completed assessments, provide feedback on your observations. What are they doing well in? What are some areas you have noticed growth in? What are some areas that might benefit from additional support? What do they identify as a strength and an area of growth or

opportunity? Is there a case in which they would like more in-depth consultation? One-on-one supervision is a great opportunity to track progress and identify additional supports needed to support professional growth.

Trainer Note
Invite participants to consider and share the risks and benefits of this type of supervision. What would they need to feel more confident in providing one-on-one supervision?

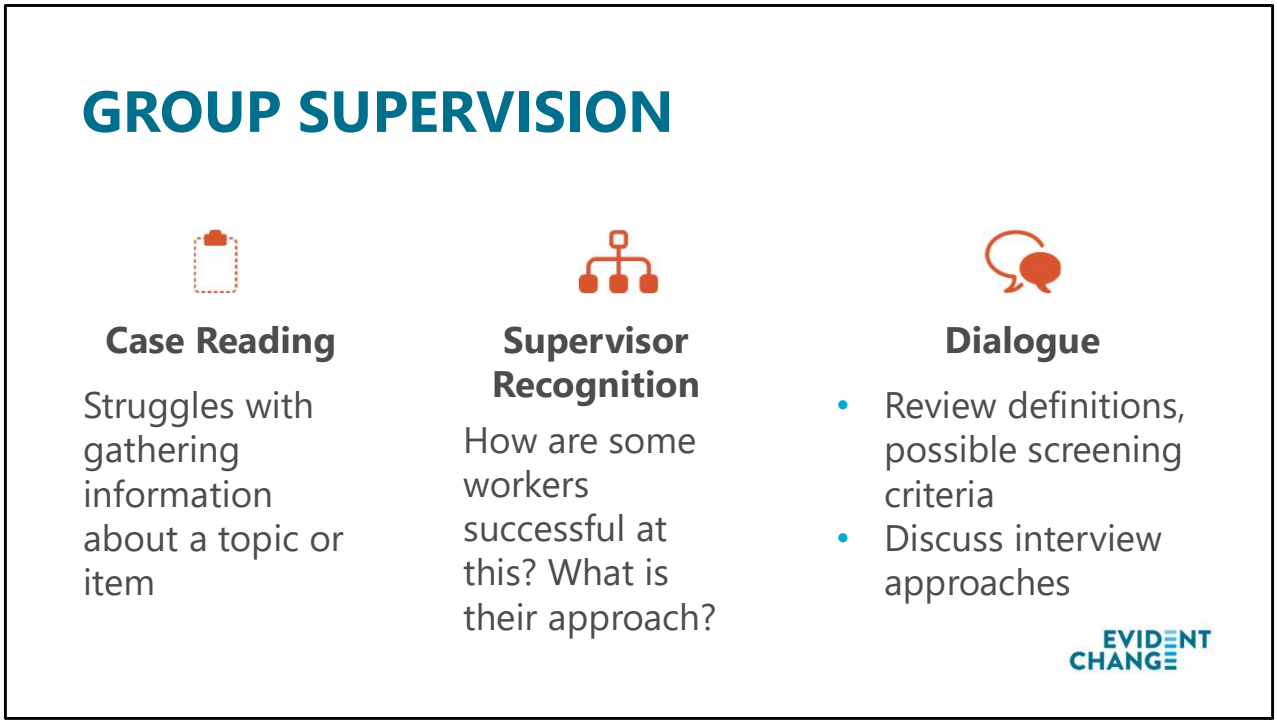
SAFEMEASURES®

More than 35 reports related to SDM assessment completion and results (as of 2025)



Purpose
To highlight that SafeMeasures® can provide insights that can be discussed in supervision.

Example
This is just a reminder that your SafeMeasures reports can help you prepare for supervision, identify trends in your unit, and plan work to get ahead of deadlines.



Purpose
To review SDM connections in group supervision.

Example
Group supervision is a type of consultation that happens within a unit or team. It provides time to discuss logistics, agency news, or a practice theme or topical area. For example, if your team has been struggling with gathering information on domestic violence, you can focus on the hotline tools items and definitions that could most often relate to domestic violence. The discussion can focus on challenges, wobbly situations that could go either way, reviewing definitions and different interviewing strategies that team members have used to get the details they need to complete screening criteria items accurately. This type of review and open discussion can also foster a learning environment among staff.

Trainer Note
Ask participants to reflect and discuss group supervision. Are you using group supervision now? Are you seeing a pattern that needs to be addressed in your unit? What are the struggles? What are you worried about? What are the successes and strengths? What is working well? What are the next steps in decision making that the SDM model can support?

FOSTERING LEARNING

	Low Standards	Standards
High Psychological Safety	Comfort Zone	Learning and High-Performance Zone
Low Psychological Safety	Apathy Zone	Anxiety Zone

EVIDENT CHANGE

Purpose
To see different conditions that can exist in a workplace.

Example
Psychological safety is characterized by being able to speak up, respectfully express disagreement and admit mistakes without fear of negative consequences.

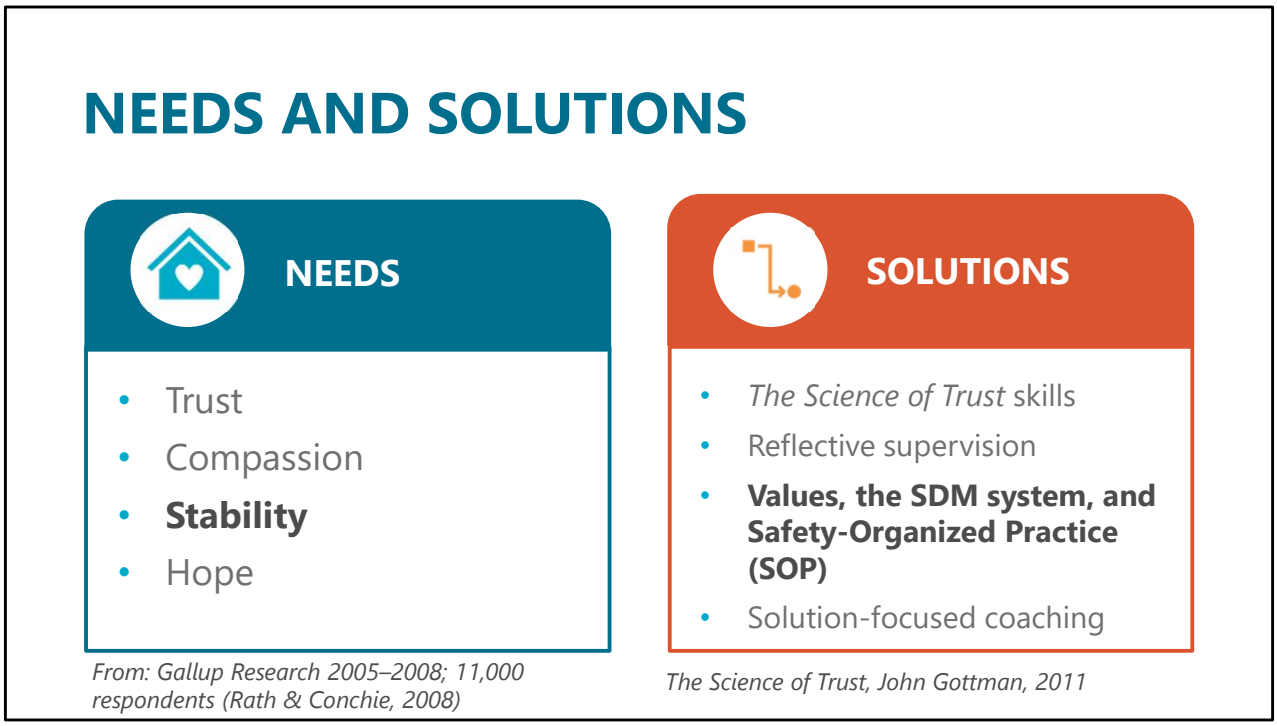
Consider two basic variables, psychological safety and standards/expectations. As shown in this table, the combination of high standards and high psychological safety s to learning and high-performance environments. However, when the components of psychological safety are low or nonexistent in your team, staff can struggle with apathy; and, alternatively, with anxiety when pushed too far.

When creating a learning environment and promoting a psychologically safe team environment, you foster resilience in the team and its individuals.

Here you can see the benefits of efforts toward enhancing that learning culture for your staff.

Trainer Note

Source: Edmonson, A. (2018). *The fearless organization*. Wiley.



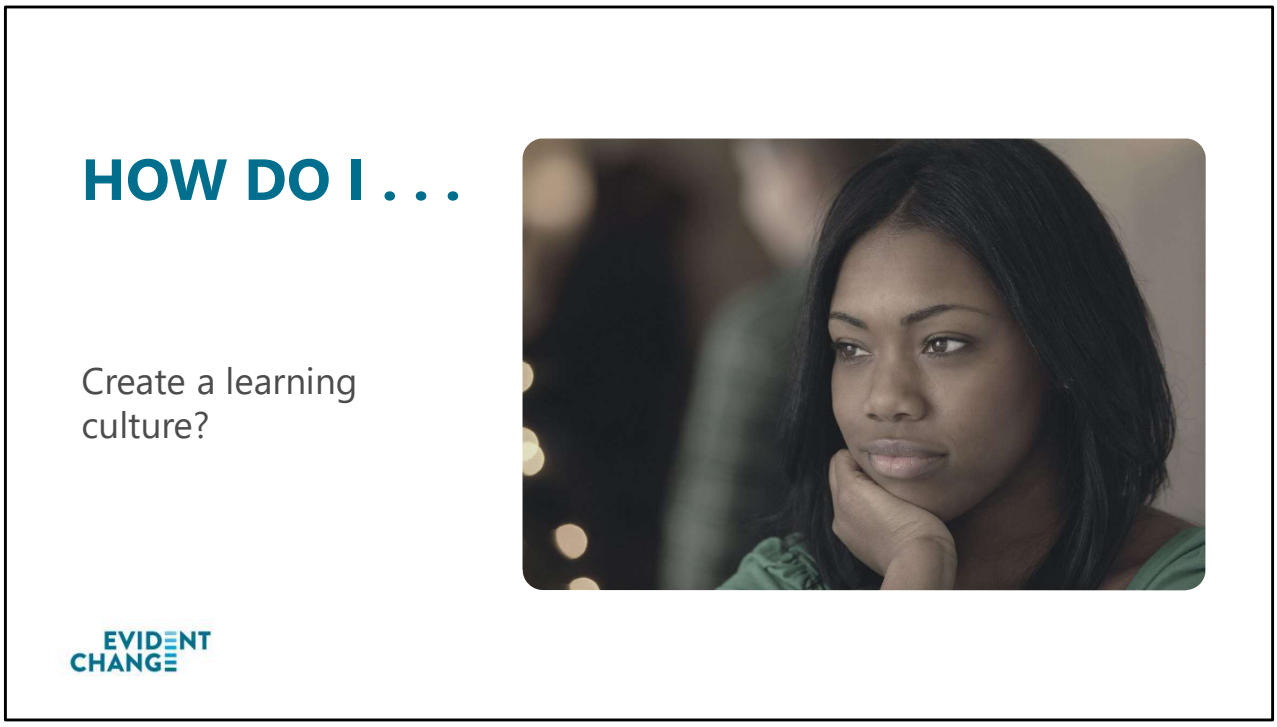
Purpose
To connect the training to meeting the four needs of team members.

Trainer Note
To highlight the role that the SDM system can play in providing stability in the work we do.

Example
Raise your hand if you have seen practice swing back and forth like a pendulum in your county. How could we all benefit from refusing to be swayed by fear and reactionary impulses in our work with families?

From 2005 to 2008, the Gallup research organization canvassed 10,000 workers around the world and ask them what are the things you most need from leadership in your workplace. The themes that came up to the top in their research were trust, compassion, stability, and hope. Then they went back and checked out these findings with another thousand workers from around the world who affirmed the findings. The *Book Science of Trust* by John Gottman has good instructions in it for skills that build and maintain trust. Some counties and jurisdictions are beginning to train supervisors in reflective supervision as a way to support and show compassion for the hard work

that staff are involved in with families. We can provide stability for our staff by reminding ourselves and them of the values that we hold important in working with families and by using the structure and definitions of SDM assessments (and the tools from SOP if your county uses them) to consistently train our staff regarding “this is how we make decisions around here." And using solution-focused questions and coaching can help instill hope for our workforce.

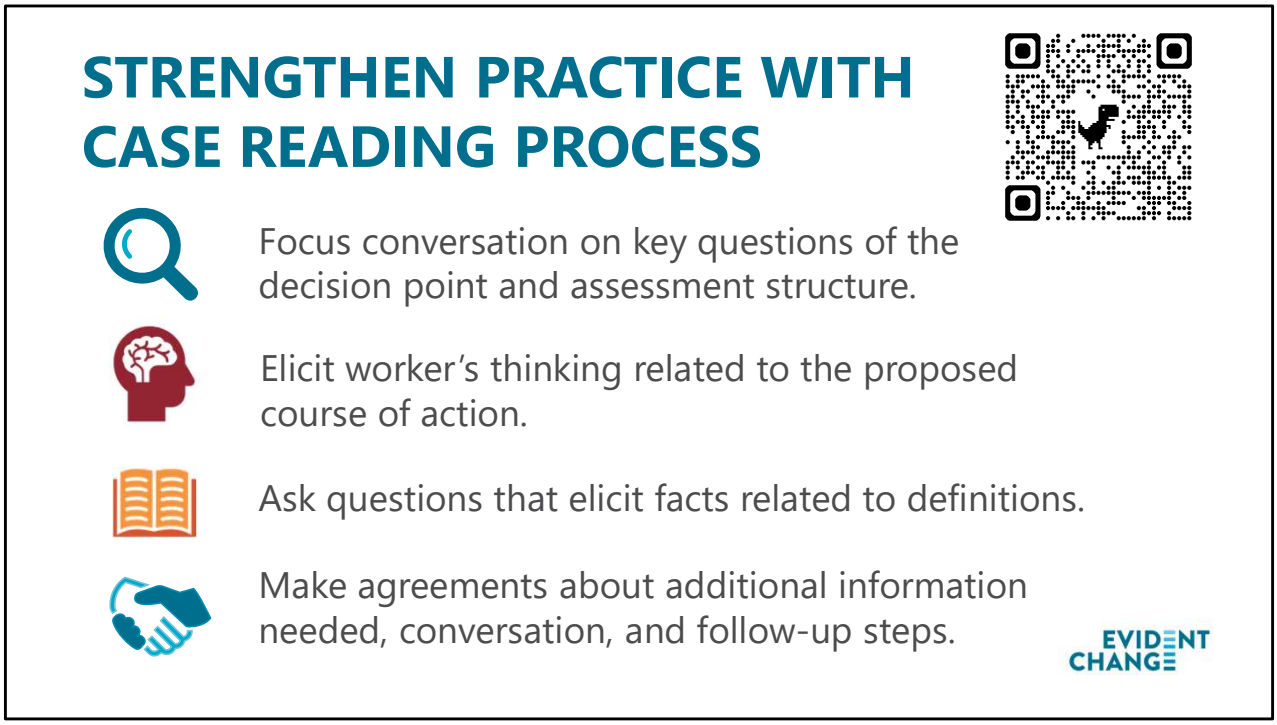


Purpose
To reflect and learn from one another about creating a learning culture.

Trainer Note

Options

A. Do a breakout/pair-and-share where each person answers the question, "How do I create a learning culture?"
B. Do the TRIZ activity described in https://www.liberatingstructures.com/6-making-space-with-triz/
C. Do 15% solutions described in https://www.liberatingstructures.com/7-15-solutions/
D. Try the Flip Chart Carousel described in https://www.thiagi.com/games/2017/9/12/flip-chart-carousel



Purpose
To have a starting place for completing case readings as a part of supervision.

Example
Here are some steps for using the case review process as a feedback loop to improve implementation.

Trainer Note

Activity
Have participants scan the QR code or go to https://docs.evidentchange.org/California and select the Case Reading and CQI Tools option in the navigation bar. Have them click on the CA SDM Case Reading Manual pdf and point out that there are Word document versions of the various case reading tools they can use depending on the program their staff work with families in.

BEFORE YOU FREAK OUT . . .

Case reading should be:

a. A small sample (one random selection per worker per month)
b. A small slice of the work (from event *x* to event *y* only)

EVIDENT CHANGE

Purpose
To be introduced to the limited expectation of using the case reading tools.

Resource
California SDM® Case Reading Manual

Example
Several California counties have found that investing a small amount of time for supervisors, CQI staff, and CFSR reviewers to look at case work through the lens of these case reading tools yields important gains in lessons learned and provides excellent feedback for workers, which, in turn, reduces the workload of supervisors who have fewer mistakes to correct.

Let's take a look at an example, Page 25 (as numbered on the bottom right of the page) in the California SDM case reading manual.

Trainer Note
Ask participants to volunteer to read the sections Who, How Many Records, etc.

SDM CASE REVIEW

- Policy, procedures, and practice standards are met
- Action steps, impact of decisions
- Critical thinking reflected
- Engagement and interviewing skills reflected

Purpose
To review components of a case reading.

Example
A case reading involves looking at a small sample of completed assessments and the associated documentation. When conducting a case reading, you will want to focus on these areas.

- *Policy, procedures, and practice standards are met.* Is the assessment completed appropriately? Is it completed on time? Are the necessary pieces of documentation completed, and do they meet the standards or expectations established?
- *Action steps and impact of decisions.* Is the assessment outcome clear? Is it clear how the worker arrived at that outcome? Are the action steps aligned?
- *Critical thinking reflected.* Did the worker provide rationale for the outcome? Is it clear why any criteria were or were not selected?
- *Engagement and interviewing skills reflected.* Is sufficient information provided? Is any information missing? Are "unknowns" documented as having been asked about?

Through this process, you may note areas of strength or opportunities for improvement that you can address in one-on-one supervision, or you may notice trends among staff to address in group supervision.

REINFORCE COMPLETION GUIDELINES

- Policy and procedures
- Completion instructions

EVIDENT CHANGE

Purpose
To have a starting place for completing case reading as a part of supervision.

Example
An area we like to focus on initially in case reviews is whether completion guidelines are being adhered to. Whether you are reviewing a sample of one worker's cases or looking for overall areas of needed support through cases of multiple workers, it is important to note any challenges related to when the assessment is being completed, on which cases or reports it is completed, and whether the process for moving toward a decision is being adhered to.

COMMON ERRORS

- Assessment was incomplete.
- Documentation is missing.
- Narrative does not support assessment outcomes.
- Results are not discussed with families.

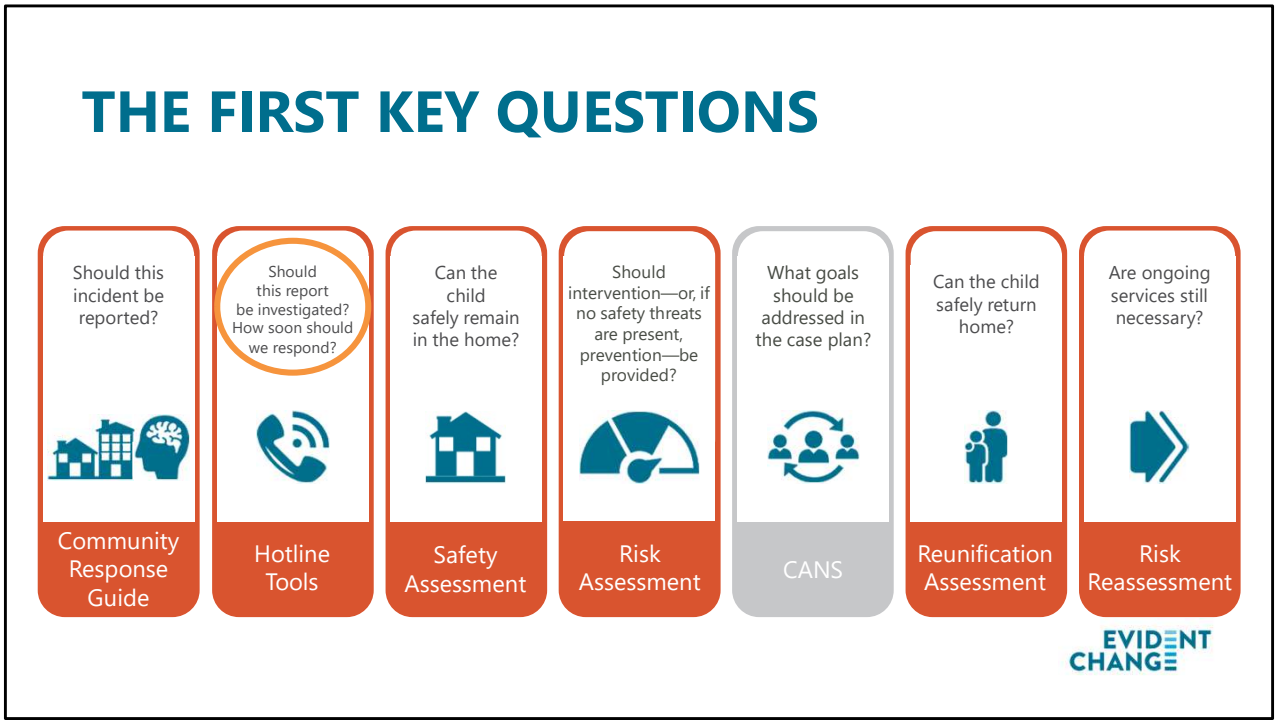
EVIDENT CHANGE

Purpose
To be introduced to common errors in review of the SDM assessment.

Example
It can be helpful to be on the lookout for some common errors we see through case reading.

- Ideal practice is for each assessment item selected to have corresponding documentation in case notes to show why the worker landed on the item—whether that is details to support an allegation, reasoning for response priority, explanations for overrides, or how a safety plan does or is unable to mitigate the safety threat. This is something to strive for.
- At times, we find that assessment answers and the narrative conflict. There may be explanations for this, or it may be in error. As supervisors, we cannot know if it is not documented clearly. Selecting cases to read in full, and specifically reviewing for SDM assessment completion, offers an opportunity to look for these kinds of mistakes and support workers in being clearer in documentation or identify roadblocks to consistency.
- We promote transparency with families. We want to talk with clients about the safety threats—the reasons we are concerned and involved. We want to be on the same page about what we are looking for in terms of safety as we move through intervention planning.

HOTLINE TOOLS



Purpose
To be oriented to which decision the hotline tools help with.

Example
Let's take a look at the hotline tools. They help us determine if a report meets the criteria to assign for an investigation and, if so, how quickly we should respond.

HOTLINE TOOLS POLICY AND PROCEDURES

Which Cases?	All referrals that are created in CWS/CMS.
Who?	Worker receiving the referral.
When?	"Immediately upon receipt of the call." You will notice that the policy and procedures (P&P) manual does not say "in so much time after the call." That is because it is designed to be completed *while* the caller is on the phone.
Decision	Does the referral meet the threshold to be assigned for an in-person response, and what is the response priority (and path of response for Differential Response counties)?

Purpose
To review the policy and procedures for screening and response in the participant guide.

Trainer Note
Review the completion instructions of the assessment.

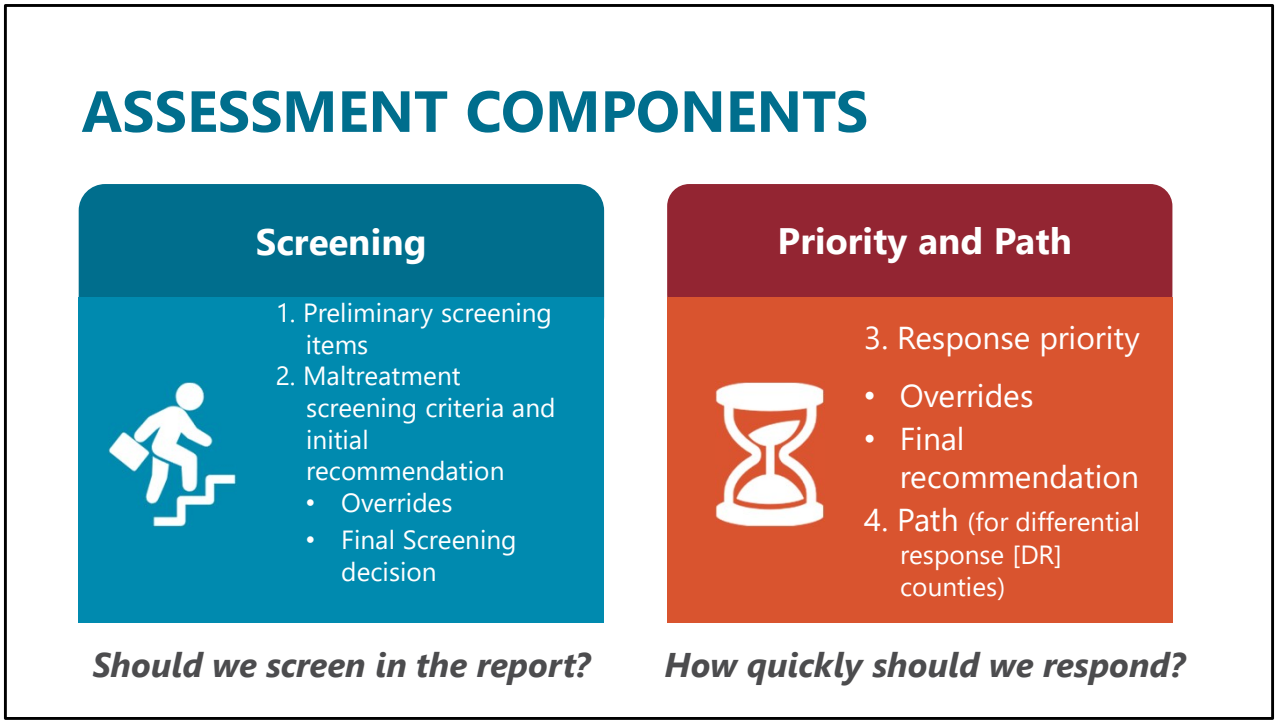
Example
The policies and procedures are in the P&P manual for your reference.

Which Cases: All reports that get documented in CWS/CMS (this would include "I&R" calls, although the use of this part of CWS/CMS is *very* uneven across California counties). The assessment is completed for all reports of child abuse/neglect. This includes reports by telephone and all other means, including new reports of child abuse/neglect on open cases.

Who: The hotline worker

When: The tool is designed to be used while on the call with the reporter, but no later than the end of the worker's shift.

Decision: The tool guides whether a report requires a CPS intervention AND, if so, how quickly to begin an investigation. And what path of response to select for differential response counties.



Purpose
To receive a high-level review of the SDM hotline tools.

Trainer Note
Ask participants to refer to the website they accessed for the Five-Step Consultation model to review the items and definitions.

Example
The hotline tools contain two main components. The screening portion helps us think through if the reported concerns should be screened in for investigation. There are preliminary screening items that indicate you do not need to complete the assessment. Note that a duplicate referral is when you have the same referral components (same victim/perpetrator pairing, same allegations, same incident) but a different referral source. For example, multiple people witnessed an incident of child abuse or neglect. One person calls in the report, which is accepted; and then later, another person calls in the same concerns, incident, etc. These are flagged in the Preliminary Screening step.

Next are maltreatment screening criteria. The instructions from the CDSS Manual of Policy and Procedures (MPP) include, amongst other criteria, "The allegation includes specific acts and/or behavioral indicators which are suggestive of abuse, neglect, or exploitation." At various points in the P&P manual's definitions, you will notice references to the MPP or "Division 31" regulations (because the CPS instructions are in Division 31 of the larger MPP).

Preliminary Screening: This section provides an early off-ramp for cases that meet certain criteria that would not make them eligible for investigation.

Appropriateness Of A Child Abuse/Neglect Report For Response: This section guides workers to select the specific criteria for all allegations indicated in the report under the appropriate maltreatment category. If any maltreatment criteria were selected, the report will be screened in for child protection investigation. Reports that do not meet any of the screen-in criteria will be screened out. There are both policy and discretionary override opportunities before a final decision is made. If a policy override is applied to screen in a report, no further SDM assessments are required.

Response Priority: Information gathered by agency staff must be analyzed to assess the urgency for response. The response time criteria structure this analysis to determine a response time level. This section has an opportunity for overrides as well. An override may be applied if, after consideration of response time criteria, the worker and supervisor determine that there are unique conditions not captured by the tool that warrant a different response time. The overrides available to select are those that accelerate or slow the response time by one level.

Path of Response Decision: For counties with differential response in place, this step will appear and prompts for considering with path of response to assign.

Trainer Note
The end of these notes include details about what parts apply to the hotline tools if questions arise about these references.

Example
So, this is what the items and definitions focus on.

If the concerns require an in-person response, the Response Priority section guides the decision about how quickly the response should occur. If your county has Differential Response, you will be asked to complete the Path of Response Decision section.

Trainer Note
If time permits or if questions arise, you can share the following from the California-DSS-Manual-CWS (also known as Division 31 regulations and also known as "MPP" in the SDM definitions) The italicized text is what the SDM tool focuses on in the item descriptions and definitions.

Section 31-105
- .15 Decision criteria. The decision whether or not an in-person investigation is necessary shall include, but not be limited to, consideration of the following factors:
- .151 The ability to locate the child alleged to be abused and/or the family.
- .152 The existence of an open case and the problem described in the allegation is being adequately addressed.
- .153 The allegation meets one or more of the definitions of child abuse,

exploitation or neglect contained in Sections 31-002(c)(9), 31-002(e)(13), or 31-002(n)(1).

- .154 The alleged perpetrator is a caretaker of the child or the caretaker was negligent in allowing, or unable or unwilling to prevent, the alleged perpetrator access to the child.
- .155 The allegation includes specific acts and/or behavioral indicators which are suggestive of abuse, neglect, or exploitation.
- .156 There is additional information from collateral contacts or records review which invalidates the reported allegation.
- .157 There are previously investigated unsubstantiated or unfounded reports from the same reporter with no new allegations or risk factors.

Section 31-002(c)(9)

"Child abuse" means the nonaccidental commission of injuries against a person. In the case of a child, the term refers specifically to the nonaccidental commission of injuries against the child by or allowed by a parent(s)/guardian(s) or other person(s). The term also includes emotional, physical, severe physical, and sexual abuse as defined in Sections 31-002(c)(7)(A) through (D).

(A) "Emotional abuse" means nonphysical mistreatment, the results of which may be characterized by disturbed behavior on the part of the child such as severe withdrawal, regression, bizarre behavior, hyperactivity, or dangerous acting-out behavior. Such disturbed behavior is not deemed, in and of itself, to be evidence of emotional abuse.

(B) "Physical abuse" means nonaccidental bodily injury that has been or is being inflicted on a child. It includes, but is not limited to, those forms of abuse defined by Penal Code Section 11165.3 as “willful harming or injuring of a child or the endangering of the person or health of a child.”

(C) "Severe physical abuse" means any single act of abuse which causes physical trauma of sufficient severity that, if left untreated, it would cause permanent physical disfigurement, permanent physical disability, or death; any single act of sexual abuse which causes significant bleeding, deep bruising, or significant external or internal swelling; or repeated acts of physical abuse, each of which causes bleeding, deep bruising, significant external or internal swelling, bone fracture, or unconsciousness.

(D) "Sexual abuse" means the victimization of a child by sexual activities, including, but not limited to, those activities defined in Penal Code Section 11165.1.

Section 31-002 (n)(1)

"Neglect" means the failure to provide a person with necessary care and protection.

In the case of a child, the term refers to the failure of a parent(s)/guardian(s) or caretaker(s) to provide the care and protection necessary for the child's healthy growth and development. Neglect occurs when children are physically or psychologically endangered. The term includes both severe and general neglect as defined by Penal Code Section 11165.2 and medically neglected infants as described in 45 Code of Federal Regulations (CFR) Part 1340.15(b).

Purpose
To understand what overrides are and when their use may be appropriate.

Example
Let's look a closer look at the overrides and their purpose.

- We have overrides because actuarial research cannot account for unique situations.
- Using an override is the intention rather than manipulating the assessment by selecting an item when the facts do not meet the definition. This keeps the data accurate and useful.
- Some of the overrides at the hotline are a result of exceptions to statutes or local policies and practice. There are two types of overrides: discretionary and policy.
  - » Overrides on the hotline tools provide an opportunity to evaluate out a referral based on discretionary factors or to screen in or out for based on policy rationale. There may be reasons for an in-person response when the reporting party's information typically would lead to a decision to evaluate out. The tool also specifies a limited and carefully defined set of reasons why an in-person response may *not* be appropriate even though the reporting party's information meets the threshold for child abuse or neglect.. In all uses of overrides, it is best to consult with a supervisor to carefully review the facts that support the override even if your county does not require supervisor approval of the hotline tools.
  - » Overrides on the hotline tools specify policy reasons for either increasing or decreasing the response time. Overrides to decrease or increase the response level require supervisory approval.

Evident Change generally expects the override rate for SDM assessments to range between 5% and 10%, with the hotline tools generally having an override rate on the

higher end of that range. When override rates fall below 5%, there is concern that workers may not be using clinical judgment in making their decisions. When override rates rise above 10%, workers may not be using definitions properly or may be forcing the tool to reflect a different decision.

Let's review the P&P manual instructions related to screening overrides. We will look at overrides for the response time.

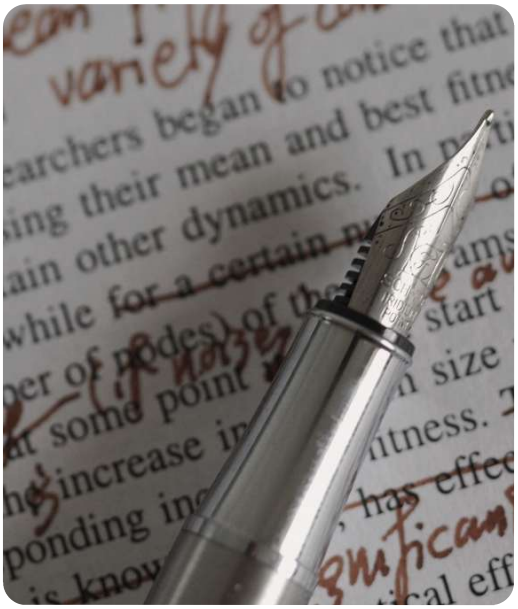
PURPOSE OF THE OVERRIDE

- Structure/research balanced with professional judgment
- Rare circumstances or situations
- Decision is *never* forced.

Purpose
To discuss the purpose of overrides.

Example
The assessment will resolve 95% of the reports you take; overrides will account for outlier situations. Total combined policy and discretionary overrides will likely fluctuate between 5% and 10%.

Trainer Note
Supervisors must keep an eye out for underuse or overuse of overrides.



COMMON OVERRIDE MISTAKES

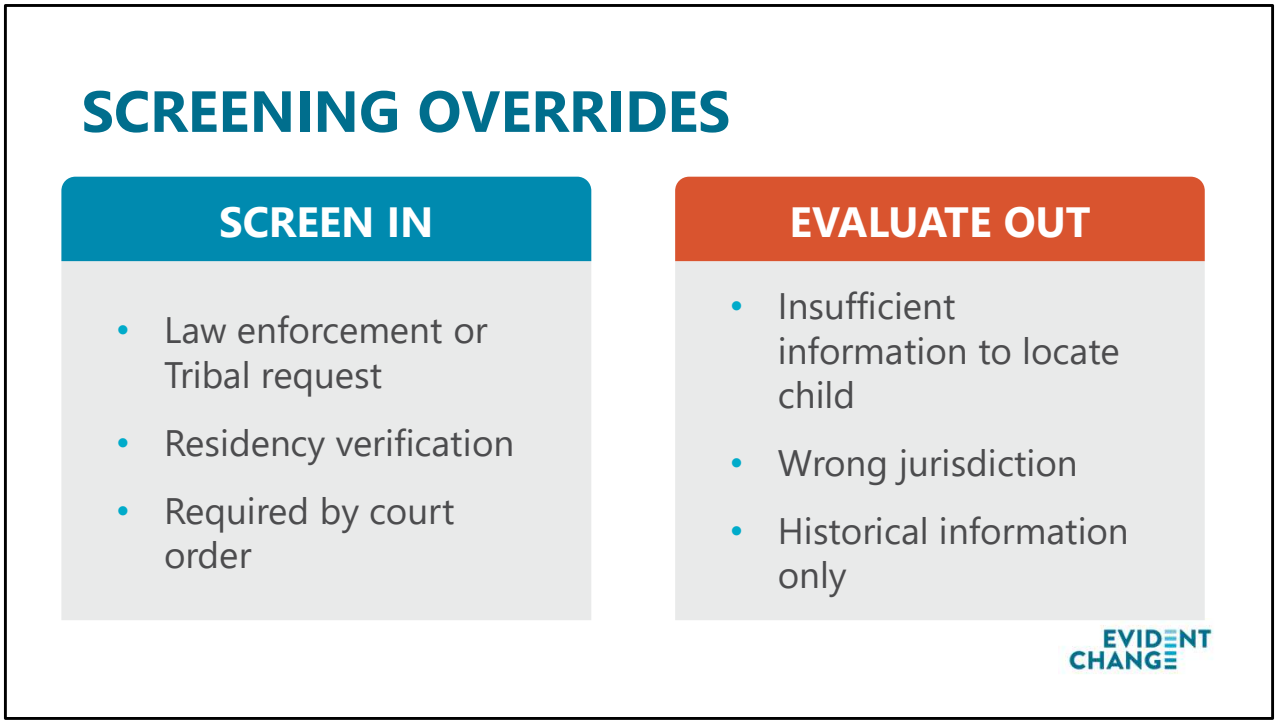
- Override is not based on facts.
- Information is irrelevant to decision.
- Information does not sufficiently support a different decision.

EVIDENT CHANGE

Purpose
To discuss common mistakes with overrides.

Example
When you apply an override, it is important to remember that the intention is to capture a specific scenario directed by policy and/or a unique situation that is not already reflected in the assessment. Common mistakes in applying overrides include an override not being based on facts; gathered information that, while important, does not relate to the decision at hand; and the information not sufficiently supporting a different decision. Another common error workers capturing their worry in the override section when it could have been captured under an assessment item. Another common error is to use overrides to support previous practices. When language, policy, and process change, a worker may need support in understanding how those changes could affect their day-to-day work, including how reports are being screened.

Trainer Note
Supervisors can help to surface those biases and ensure there are sufficient facts to support the use of an override.



Purpose
To review the overrides for screening.

Example
There are overrides for the screening decision that were developed in the workgroup and approved by California leadership to help capture unique circumstances when the screening decision may need to be altered from the tool recommendation.

Before applying an override, be sure to review the information you have gathered; consider all applicable items either selected or not; and pause to critically consider the reason you believe the recommendation of the tool does not match what you believe the recommendation should be. (Refer back to the Division 31 instructions in the notes for the Assessment Components slide.)

The policy overrides to screen a report in for non-investigatory response may apply when no abuse or neglect types are present, but a non-investigatory response is needed. This means there is a unique situation in which interventions are required or expected outside of a traditional child protection investigation.

The policy overrides to screen in include law enforcement or tribal requests (both

should be spelled out in county policies and procedures), residency verification, or court order. There are some screeners that express the belief that any time law enforcement calls, they have to screen in for an in-person response. Note that Division 31-101.4 says “The social worker shall respond to all referrals received from a law enforcement agency which allege abuse, neglect, or exploitation by completing the emergency response protocol,” but the report still has to allege abuse, neglect, or exploitation.

The policy overrides to evaluate out a report may apply when at least one abuse or neglect type is selected but no further formal interventions are required. A policy override to evaluate out may apply in situations including: There is insufficient information to locate child/family, the allegation is about a child in another jurisdiction, or the information is historical and the child is not currently endangered.

APPROVING USE OF OVERRIDES

- Fits or does not fit an existing item.
- Meets the definition threshold.
- Is supported by facts and professional judgment.
- Contributes to the decision.

Repeating patterns could mean the assessment needs revision.

Purpose
To discuss what to consider when approving overrides.

Example
Before approving the use of an override, it is important to ensure that the rationale provided is accurate.

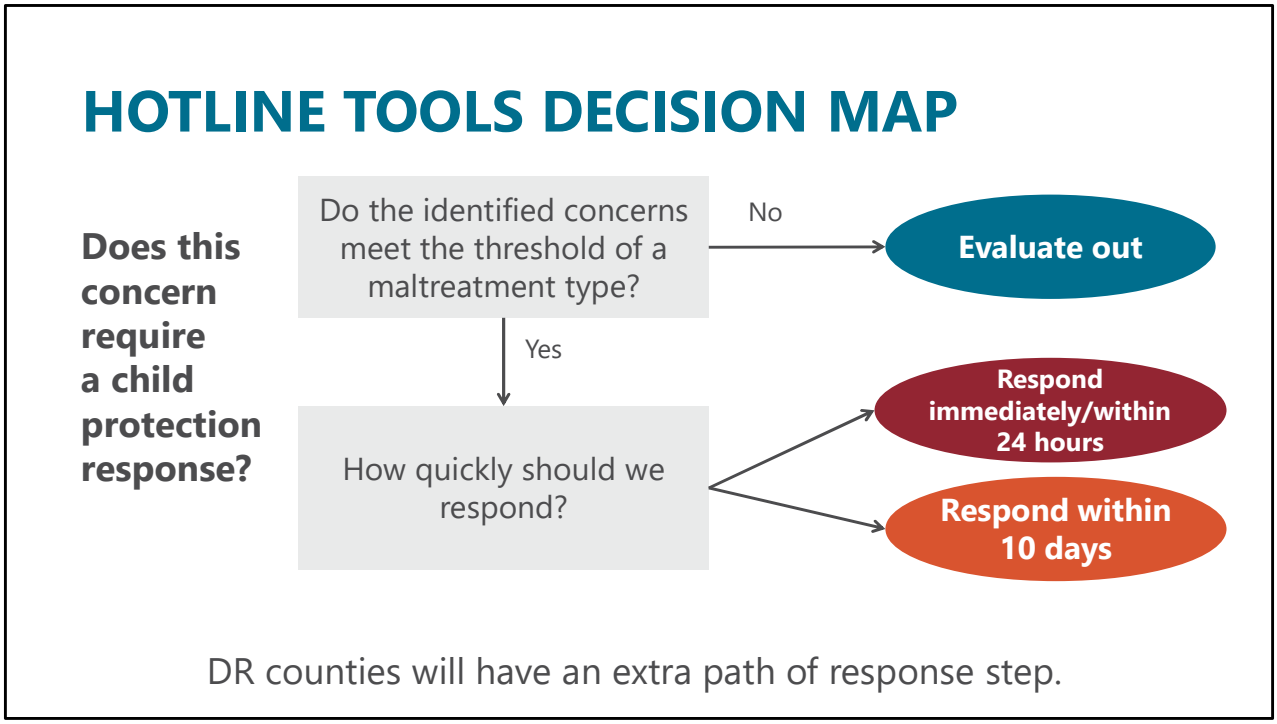
- Support the way in which the assessment was completed. For example, an override to screen in was applied; however, there is information in the referral that seems to meet the definition of one of the maltreatment types.
- Meets the definition for the override.
- Is supported by facts and professional judgment.
- Is to the decision rather than being used to document information that may be more appropriately captured elsewhere, is related to other decision points, or is potentially related to personal bias.

The use of overrides is expected. As a supervisor, each time you review the use of an override is an opportunity to check in with your staff on how they are using the assessment's definitions, gathering information, and applying the information. If you recognize that there are instances when workers are consistently applying overrides, it is an indication that either there may be something you want to look at closer on the tool or in practice. For example, if workers are regularly applying overrides to speed up response times, it may prompt you to look at:

- How the individual workers are completing the response time sections;
- If there are themes across the types of referrals that they are applying these overrides;
- If how to respond to these types of referrals warrants reconsideration of practice; and

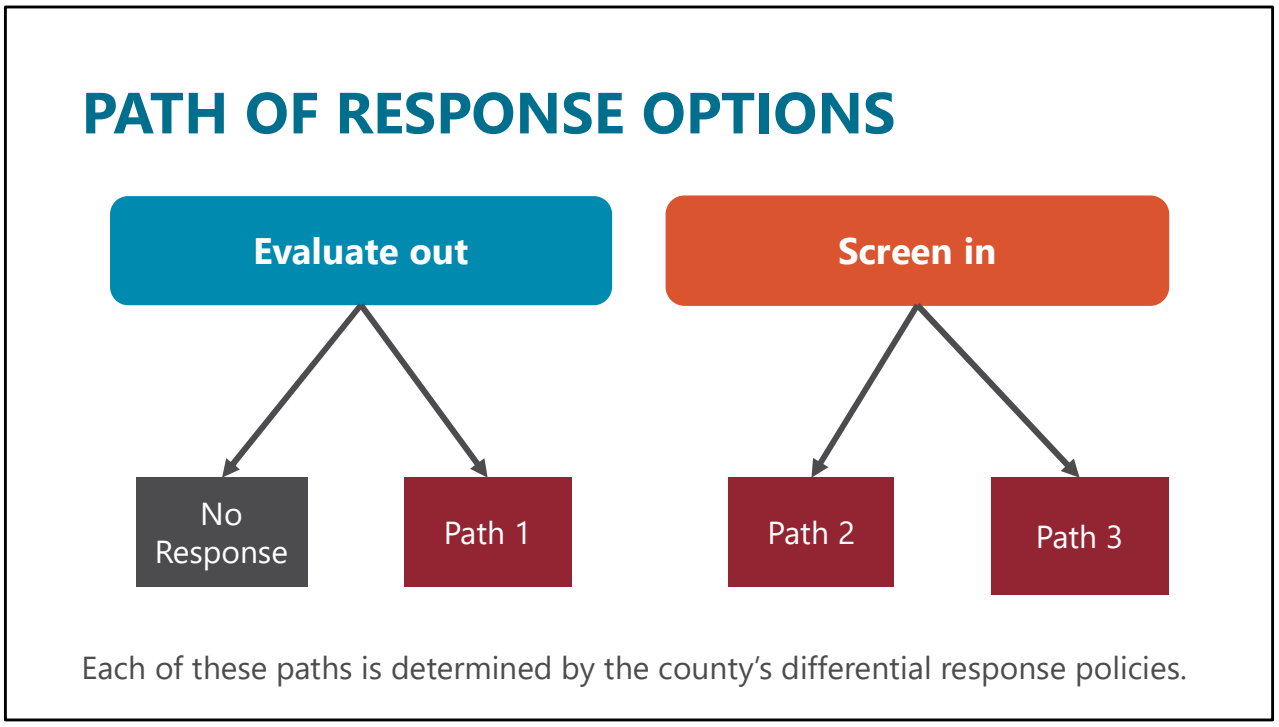
- If the tool is not appropriately capturing the immediacy of these types of referrals.

Using this information can be helpful with fine-tune practicing and assessment use or could indicate the need for a revision in the assessment. Use the Contact Help Desk (envelope) icon to send feedback to Evident Change.



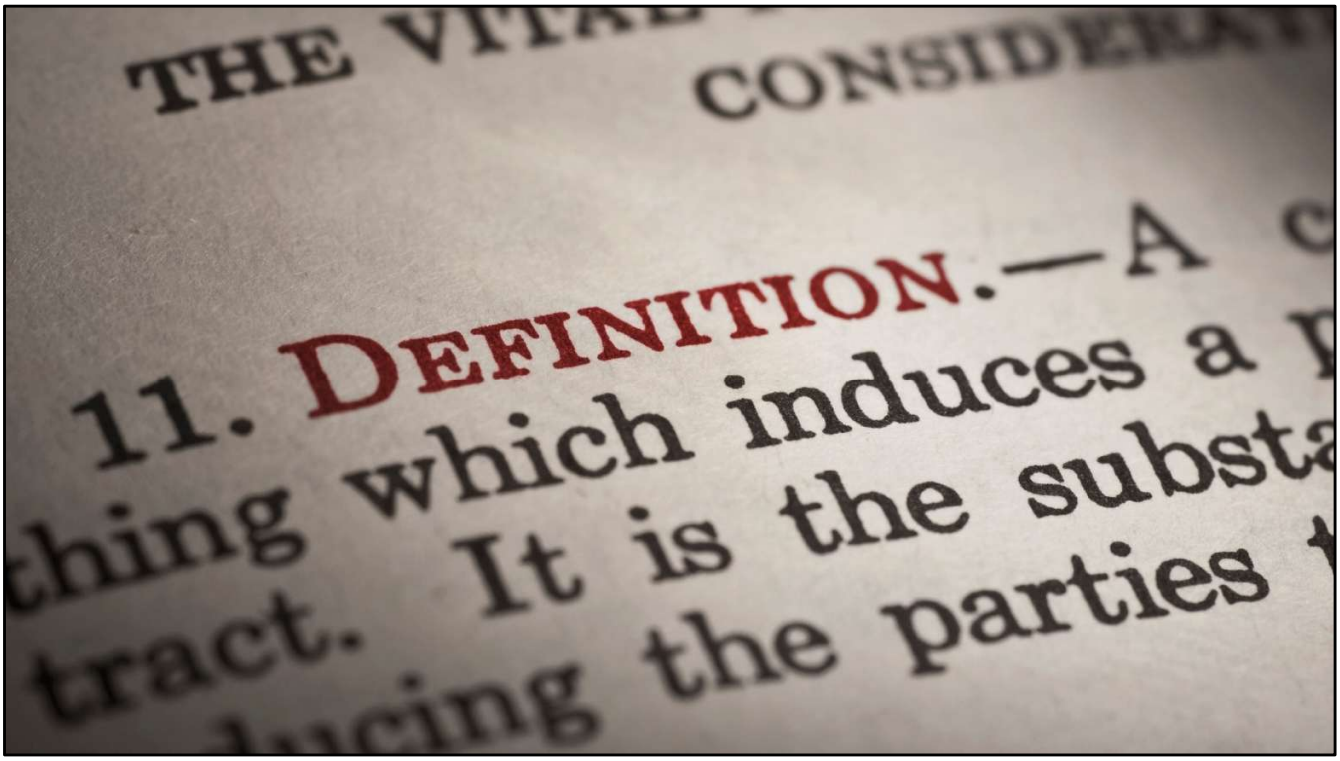
Purpose
To see the logic flow of the hotline tools.

Example
This graphic shows the presumptive decisions for the hotline tools. The hotline worker will consider the information gathered from the reporter and determine whether it meets the threshold of one or more of the screening criteria types. If no maltreatment types are selected, the outcome of the tool is to evaluate out. If maltreatment types are selected, the worker will consider criteria that lead to a path of response. The worker will move through a list of response criteria; if a definition for an item is met in the first section, the response time is immediate/within 24 hours. If no criteria are selected in that section, the worker will continue to move through the list until they reach the appropriate response time: immediate/24 hours or 10 days. Differential response counties have an extra path-of-response step to consider.



Purpose
To see the different pathways for differential response counties.

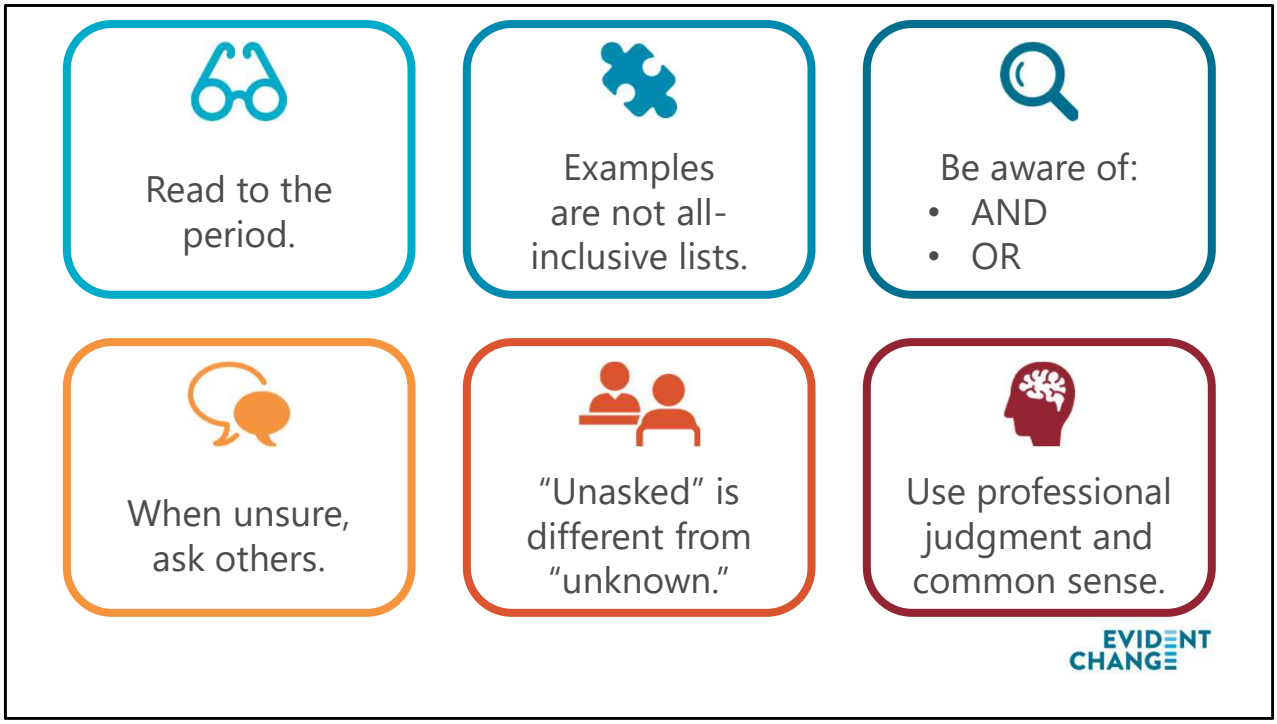
Example
Some counties in California have differential response programs in place. These path of response options were designed to help those counties determine what type of differential response would be most appropriate. The choices range from no response to Path 3, which is a response by the child protection agency on its own. But every county does this slightly differently; so, if you are in a differential response county, you will need to consult with your policy and procedures about how to make use of the path of response options.



Trainer Note
This slide will repeat in each assessment section. It offers a chance to underscore the importance of consulting the definitions.

Example
If you hear nothing else that is said during this training, hear this part. You need to use the definitions. Definitions are the most important part of the SDM system. You need to *refer to* the definitions and *use* them when applying the SDM assessments.

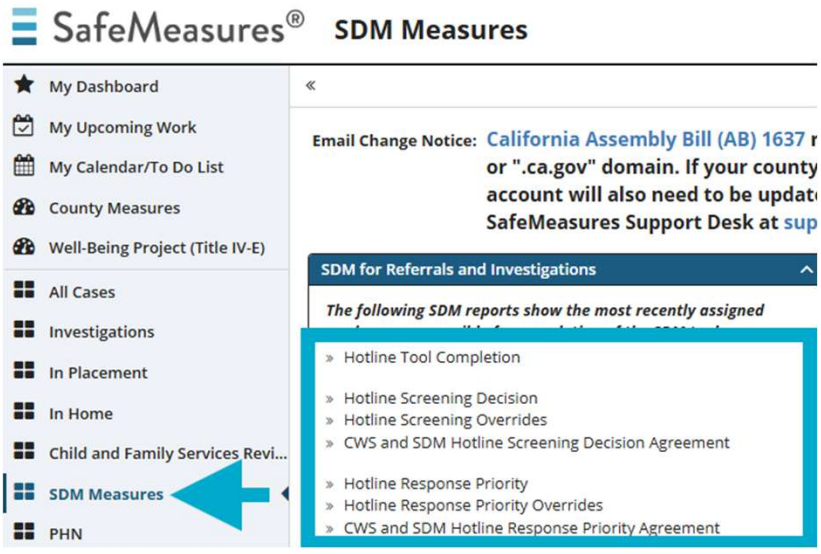
Remind yourself and your staff about this critical habit in using the SDM system.



Purpose
To be reminded of the importance of understanding and using the item definitions in the P&P manual.

Trainer Note
Review this information again with participants.

SAFEMEASURES



Purpose
To be reminded of SafeMeasures reports to support learning about how your staff are using the assessments.

Example
This is just a reminder that you take a closer look at your SDM outcomes by unit and worker using SafeMeasures reports.

HOTLINE ENGAGEMENT AND INTERVIEWING STRATEGIES

EVIDENT CHANGE

BOBBY—SKILLS PRACTICE WITH DEFINITIONS

The caller reported a concern about a 2-year-old, Bobby, who lives with his mother and father in a 10th-floor apartment downtown. The caller stated that they have seen a child standing on a chair, leaning out of the window, on multiple occasions. The caller said there are no safety bars or screens on the window, and it is always left open during this time of year. The caller has never seen an adult try to intervene when the child is at the window. Before calling, the caller went to the apartment to alert the caregivers. One caregiver answered the door drinking a beer after several minutes. Caller observed another adult asleep on a couch but did not see the 2-year-old. The caller said the caregiver was "not concerned" and asked the caller to just leave them alone. Caller observed the child in the window again later, which prompted the call.

EVIDENT CHANGE

Purpose
To be introduced to an exercise to train workers on how to think about definitions.

Example
Let's review this scenario, which can also be found in your participant guide on page ___. Think about which allegation type you may consider applying to this scenario.

Trainer Note

Answer: Child is currently unsupervised and in need of supervision.

Ask participants what additional information would they want to know. Remember that "unasked is different from unknown." What questions would they want to ask the reporter to help in their decision making? Are there additional allegations that they may consider?

DEFINITION PART	EVIDENCE NEEDED
Caregiver is present . . .	The caregivers were present at the apartment.
but not attending to the child	One was reported to be sleeping, and the other was "not concerned" about the child.
Injury has . . . been avoided due to third-party intervention.	The child has been observed leaning over the open and unsecured window 10 stories up (clearly a dangerous situation). Caregivers have not intervened, are inattentive to the child's actions, and have not attempted to secure the window.

Purpose
To be introduced to an exercise to train workers on how to think about definitions.

Example
Let's apply this strategy to evaluate whether we have the evidence necessary to determine if we have met the definition threshold. Look at each definition part. Keep in mind the evidence we need to know whether we have met the threshold for each part. Then, look at the information on the slide. This is an example of how to apply the information you have gathered in your investigation and how to apply it to the definition parts. From what we have already discussed, all the criteria here appear to be met with sufficient evidence.

OPTION 1	
Harmful or likely to be harmful to all children always	Any child would be in danger and would not manage safely in this environment.
OPTION 2: DEPENDS ON . . .	
Child's age and development	Child's age and development and what would be expected to happen to children of this age/development.
Child's physical ability	How strong, fast, big, and mobile the child is. How does this affect child safety in this environment?
Child's reasoning	Examples of child's reasoning and how this affects child safety in this environment.
Degree of caregiver guidance and supervision	The degree of supervision the caregiver provides to the child. What guidance has the caregiver given to the child to stay safe?

Purpose
To be introduced to an exercise to train workers on how to think about definitions.

Example
For the considerations relative to the child's ability to safely manage surroundings, let's look at two options.

Option 1 indicates that the inadequate supervision could lead to harm to all children, always. Put another way, this would include conditions where any child would be in danger and could not manage safely in this environment. For instance, a meth lab could catch fire no matter the age of the children in the home. Or a parent driving under the influence could harm or kill any person riding with them in the car.

Option 2 asks us to consider inadequate supervision and potential harms that would depend on the child's age and development, physical ability, and reasoning and the degree of caregiver guidance and supervision OR efforts to create safety for the child. Here, we can list those and ask what we would want to think about when considering each.

Let's look at an example using this exercise.

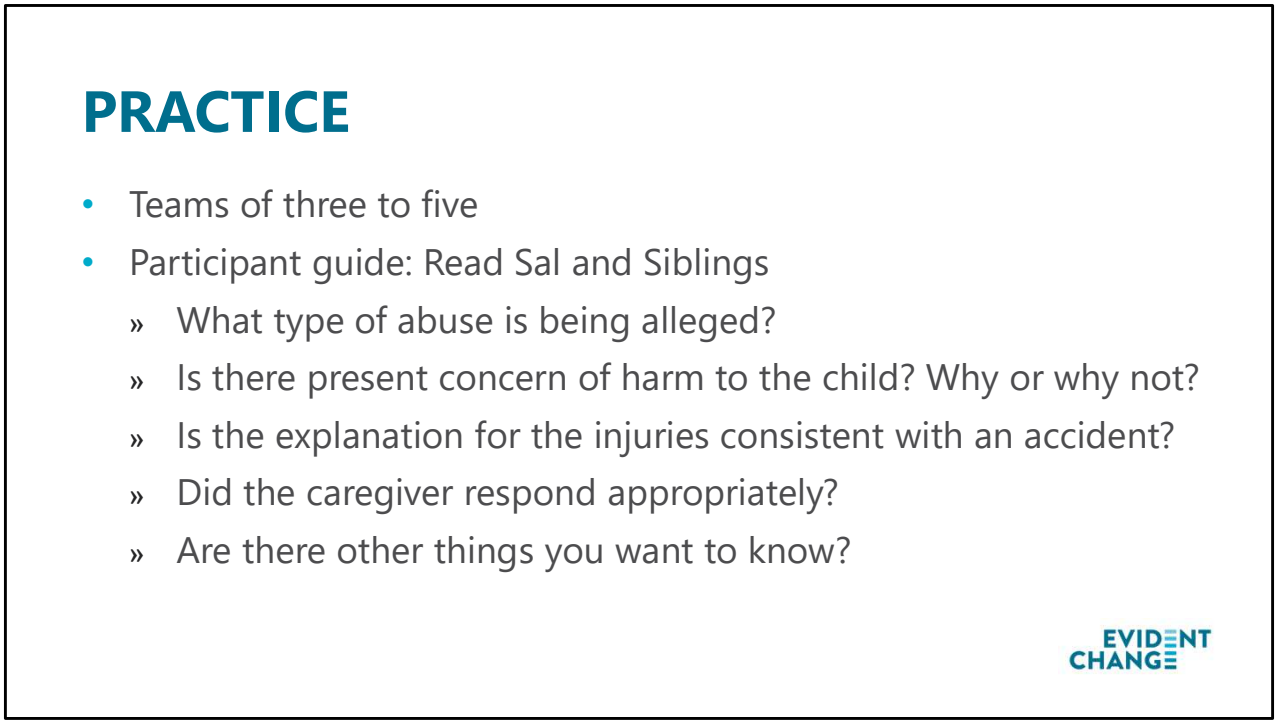
OPTION 1	
Harmful or likely to be harmful to all children always	Not applicable
OPTION 2: DEPENDS ON . . .	
Child's age and development	Child is 2 years old.
Child's physical ability	Child is walking and climbing and has demonstrated the ability to climb on a chair.
Child's reasoning	Child enjoys climbing, does not fear heights, and does not understand the danger of being close to the open window.
Degree of parental guidance and supervision	Caregivers were not observed to be attentive or aware of the child's actions. When made aware of the danger, caregiver said they were not concerned and told caller to leave them alone. Caller observed the child in the window again after letting caregivers know what they saw.

Purpose
To be introduced to an exercise to train workers on how to think about definitions.

Example
Now we must consider the final definition part, which presented two different options for meeting the evidence we need to know if it applies.

Option 1 does not apply because appropriate supervision is not the same for all children, all the time. This may not be inadequate supervision for a 14-year-old with no special needs; however, when considering a 2-year-old, we can see that this presents potential for harm. Last, the caregiver's response when the neighbor attempted to alert them to the dangers (brushing off the issue and the lack of supervision) gives us the evidence we need to determine that the threshold is met, and this allegation type should be selected.

In this scenario, there is an allegation of neglect due to the child's age and the caregivers' lack of supervision and lack of actions of protection.



Purpose
To become more familiar with the assessment definitions.

Trainer Note
The next two slides will be activities to familiarize the participants with screening decisions. The trainer manual contains additional scenarios for use at your discretion.

SAL—SKILLS PRACTICE WITH DEFINITIONS

The reporting party is an ER nurse. Paternal grandmother picked up Sal, who is 4 months old, from his mother's house; caregivers share custody. Grandmother was concerned that Sal was physically injured while in his mother's care, so she took him to the ER. The ER nurse said that Sal has a black eye, two bruises on his forehead, and scratches on his right thigh. The ER physician said the injuries are consistent with abuse. The nurse observed that Sal seems comfortable in the care of his paternal grandmother. The nurse said Sal's father came to the hospital. Sal's father and paternal grandmother are worried that the mother has a drinking problem and is abusing the child. According to the grandmother, the mother told her that Sal fell off the couch during naptime.

EVIDENT CHANGE

Purpose
To acknowledge the complexity of some of the SDM assessment definitions and introduce a practical approach in applying definitions.

Example
Review this scenario. How would you complete the hotline tools?

Questions to consider:

1. What type of abuse is being alleged?
2. Is there present concern of harm to the child? Why or why not?
3. Is the explanation for the injuries consistent with an accident?
4. Did the caregiver respond appropriately?
5. Are there other things you want to know?

Answer: *Allegation of "Physical Abuse, Other injury (exclude very minor injuries unless the child is under 1 year old)"*

A 4-month-old has a black eye, bruising to the face, and scrapes on the right thigh. (The scrapes may be considered superficial; however, bruising on the face is not.) The family shares concerns for physical abuse by the mother, who may have a drinking problem. We cannot confirm how Sal was injured. The child is vulnerable due to age and mobility.

Questions:

1. Were there other allegation types you considered?
2. Why or why not?

SIBLINGS—SKILLS PRACTICE WITH DEFINITIONS

A reporter said that two children—ages 10 and 7—are being neglected. According to the reporter, the caregivers are addicted to heroin, and they spend their money on drugs instead of rent or food for their children. Earlier this month, the caregivers were evicted from their home for failing to pay rent; the family is currently living in their car. The reporter said that the oldest child has diabetes, and she is concerned because the family no longer has a refrigerator to store the child's insulin. The children's clothes are reported to be stained, full of urine, and worn for many days in a row. Their clothes smell so bad that the stench drives other schoolchildren away. The children often must borrow acceptable clothing from the school's lost and found. The reporter also said that the children beat each other, and the caregivers do not intervene.

EVIDENT CHANGE

Purpose
To acknowledge the complexity of some of the SDM assessment definitions and introduce a practical approach in applying definitions.

Example
Review this scenario. How would you complete the hotline tools?

Questions to consider:

1. What type of abuse is being alleged?
2. Is there present concern of harm to the child? Why or why not?
3. Is the explanation for the injuries consistent with an accident?
4. Did the caregiver respond appropriately?
5. Are there other things you want to know?

Answers

Neglect: Child's health/safety is endangered
Medical care has not been provided for an acute or chronic condition and, as a result, the child has required or is likely to require hospitalization or surgery; or the condition may worsen to the extent that unnecessary permanent disability, disfigurement, or death results (since the diabetes is chronic and can result in organ damage or death).

General neglect: Inadequate clothing/hygiene
The caregiver has willfully or negligently failed to meet the child's basic needs for

clothing and/or hygiene to the extent that the child's daily activities are negatively impacted and/or the child develops or suffers a worsening medical condition. (It seems fair to say that having to borrow clothes from the school negatively impacts daily activities.)

Purpose
To practice with response priority assessment definitions.

Trainer Note
This can either be done as a large group or within small groups.

BETTY—RESPONSE PRIORITY PRACTICE

A neighbor called in about a 4-year-old girl, Betty, who is left alone for eight to 10 hours at a time while her single father is at work. Sometimes, a relative watches the girl, but today she was alone again. While playing with her doll in the front yard, the girl was approached by the neighbor, who asked who was taking care of her. She said that no one was home to take care of her. The neighbor reported that the child seemed content and had no medical needs. The neighbor also reported that she had never been inside the girl's house, but the exterior of the home appeared clean and well-maintained.

EVIDENT CHANGE

Purpose
To acknowledge the complexity of some of the SDM assessments and be introduced to a practical approach in deciding response priority.

Example
Read the scenario and determine the allegation type and response priority.

Let's take a closer look at breaking down this definition, seeing what we need to satisfy and practice doing so with an exercise.

Questions to consider:

1. What type of abuse is being alleged?
2. Is the information historical or current?
3. Is there present concern of harm to the child? Why or why not?

What allegation type should be selected?

Answer

General Neglect, inadequate supervision
Note that examples in the definition do not include a 4-year-old left alone for eight to 10 hours, but the situation still fits for "caregiver has made inadequate care arrangements."

What should the response time be?

Answer

Within 24 hours (no overrides)

Child is currently unsupervised and in need of supervision includes “the child is not receiving appropriate supervision from their caregiver, and there is no appropriate alternative plan for supervision within the next 10 days.”

NICU—RESPONSE PRIORITY PRACTICE

A nurse at the local hospital called in to report that a mother has just given birth, and both the mother and child had a positive toxicology screen for methamphetamine. The child was born underweight and is being admitted to the neonatal intensive care unit. It will take about two weeks for the infant to gain enough weight for discharge. This is the mother's first child. When asked about whether the mother has support and had preparations for the baby coming home, the nurse indicated that the delivery was sudden and unplanned, but they had not asked the mother about this.

EVIDENT CHANGE

Purpose
To acknowledge the complexity of some of the SDM assessment definitions and be introduced to a practical approach in applying definitions and deciding screening criteria and response time.

Example
Read the scenario and determine the allegation type and response time.

Let's take a closer look at breaking down this definition, seeing what we need to satisfy and practice doing so with an exercise.

Questions to participants:

1. What type of abuse is being alleged?
2. Is the information historical or current?
3. Is there present concern of harm to the child? Why or why not?

What allegation type should be selected?

Answer

Threat of neglect: Substance-affected newborn (in-home only).

There is an infant born and identified as affected by substance use.

AND

There is indication that the caregiver will be unable to fulfill the basic needs of the infant

upon discharge from the hospital.

When assessing caregiver's ability to provide minimum sufficient level of safe care, consider factors such as willingness to implement a plan of safe care, demonstrations of safe care of other children, plans for safe feeding, and availability of and willingness to use a support network.

Are you convinced that the second part of the definition ("AND there is indication that the caregiver will be unable to fulfill the basic needs of the infant upon discharge from the hospital") is met? If unsure, how would you resolve the decision to screen in or evaluate out?

What should the response priority be?

Answer

Within 10 days (no overrides)

The child and is safe at the hospital, and discharge date is likely more than 10 days.

Purpose
To understand the opportunity for hotline workers to engage callers in a way that leads to meaningful information and to understand the importance of interview skills while taking reports.

Example
By using the definitions and good techniques for conducting a balanced interview, you will be able to spot and ask additional questions about missing or “empty” spaces in the information provided by the caller.

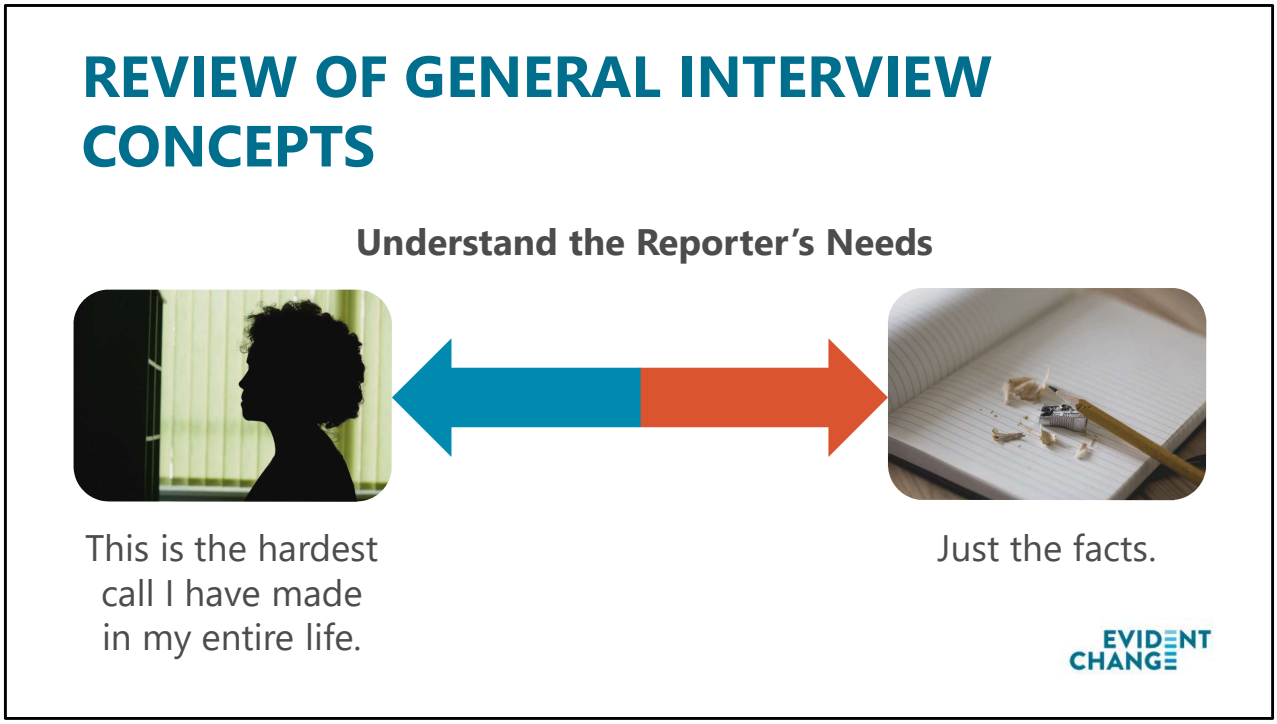
Purpose
To understand the importance of developing good working relationships with the reporting parties and families for best outcomes.

Example
Here are some important things to keep in mind as we think about integrating the use of SDM tools and practice into work with reporting parties at the hotline.

- Strong and balanced interviewing skills, combined with strong critical thinking, are key to making the best response decisions.
- Developing good working relationships with reporting parties is key to getting important information about family strengths and network members.
- The SDM hotline tools, combined with enhanced practices, support both these concepts to achieve the best outcomes.
- When all is said and done, the single biggest predictor of good outcomes in child welfare, according to a study by Farmer and Owen, is not the services or the interventions—it is the relationships we build. Those other things are important, but without a good working relationship between worker and family, everything else becomes much more difficult. In addition, building relationships with the support network—by including family members and other collaterals—is also important and helps support safety and child well-being.
- When we talk about relationships, we are talking about making sure families understand what is going on, giving them choices, being transparent, saying what we mean, and doing what we say we will do. When we start from this assumption—that relationships are key—it also causes a shift in how we need to think about assessment.

Adapted from Farmer, E., and Owen, M. (1995). *Child protection practice: Private risks and public remedies.* Her Majesty's Stationery Office.

GATHERING GOOD INFORMATION



Purpose
To emphasize the opportunity for hotline workers to engage callers in a way that leads to meaningful information and to understand the importance of interview skills while taking reports.

Example
Let's review some concepts that can support good interviewing during a screening call. Remember that the structure of the SDM assessments is a prompt for how we practice with families—in this case, with those who report concerns of child abuse and neglect.

When approaching a conversation with someone who is reporting concerns, consider the reporter's needs and motivations for calling, as well as the reporter's level of knowledge about how the child welfare system works. Use the hotline tools to explain the process and structure for making decisions about an agency response.

How might the needs and motivation of a mandated reporter differ from those of a family member or neighbor? Does that change your approach?

The "interview ladder" is one strategy that supports the gathering of complete, accurate, and detailed information about the concerns and the strengths of the family. We will explain more about this in a moment.

When the phone rings, the person on the other end could fall anywhere along this continuum. On one end, there could be a mandated reporter who must call frequently and routinely and has little investment in the call beyond discharging a duty. The mandated reporter just wants to give you the facts and be done with it.

On the other end of this continuum could be a family member who is calling for the first time ever and feels quite conflicted about it, but deeply worried. This person may want to tell you the entire history of the family and may need some calm and supportive words to go through with the report.

In both cases, you need the same information. In the former, your challenge will be to *get* the information you need. In the latter, your challenge will be to *focus* on the information you need. Either way, the SDM items and definitions serve as a road map.

Purpose
To highlight the three areas of inquiry.

Example
In thinking about doing a rigorous and balanced assessment, there are three basic questions that guide us in this work. SDM assessments can be boiled down to these three questions.

Every stage in working with a family needs to cover these three main issues. Even though these are simple questions, sometimes in the heat of the moment—in the middle of an intake call—it can be helpful to have simple maps or guides to remind us where we want to go. The details of how we ask these questions and what content to focus on will change, but these are the three most central questions.

These can also serve as a way of preparing the caller for our conversations. When we tell them, "I' m going to be asking you a lot of questions, but they all boil down to these three," we help prepare the caller for what we are looking for. It starts us off on the right foot for collaboration, and it helps them prepare to participate better.

GENERAL INTERVIEW CONCEPTS, CONTINUED

BARRIERS TO INFORMATION GATHERING

Caller:

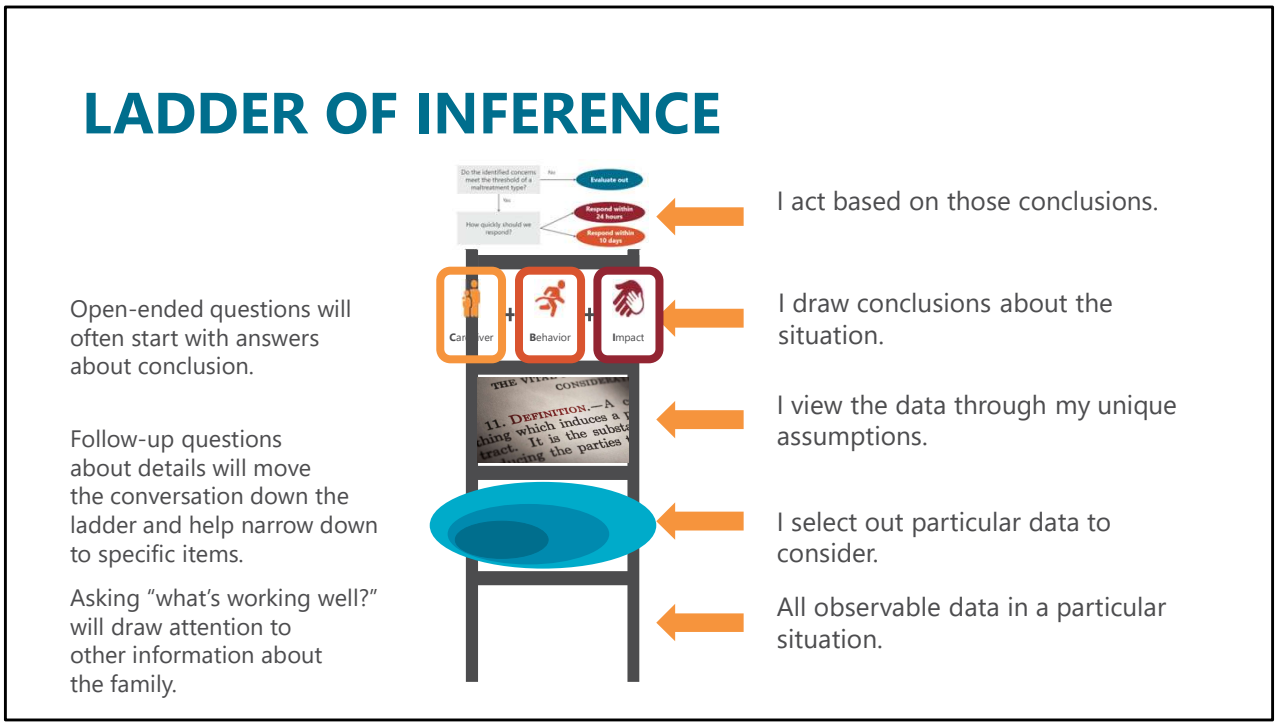
- Has incomplete knowledge of facts;
- Does not know what information is important;
- Does not know specifics of the law;
- Has an emotional response to reporting; or
- Has unknown or conflicting motivation.

EVIDENT CHANGE

Purpose
To be aware of barriers to information gathering.

Example
The road map the SDM system provides is essential to good screening. If you relied solely on whatever the caller chose to report, you may end the call without the information you need to make a good decision. There are many good reasons why callers are not prepared to tell you what you need to know.

As a screener, it is up to you to lead the call in a way that gives you the best chance to get the right information.



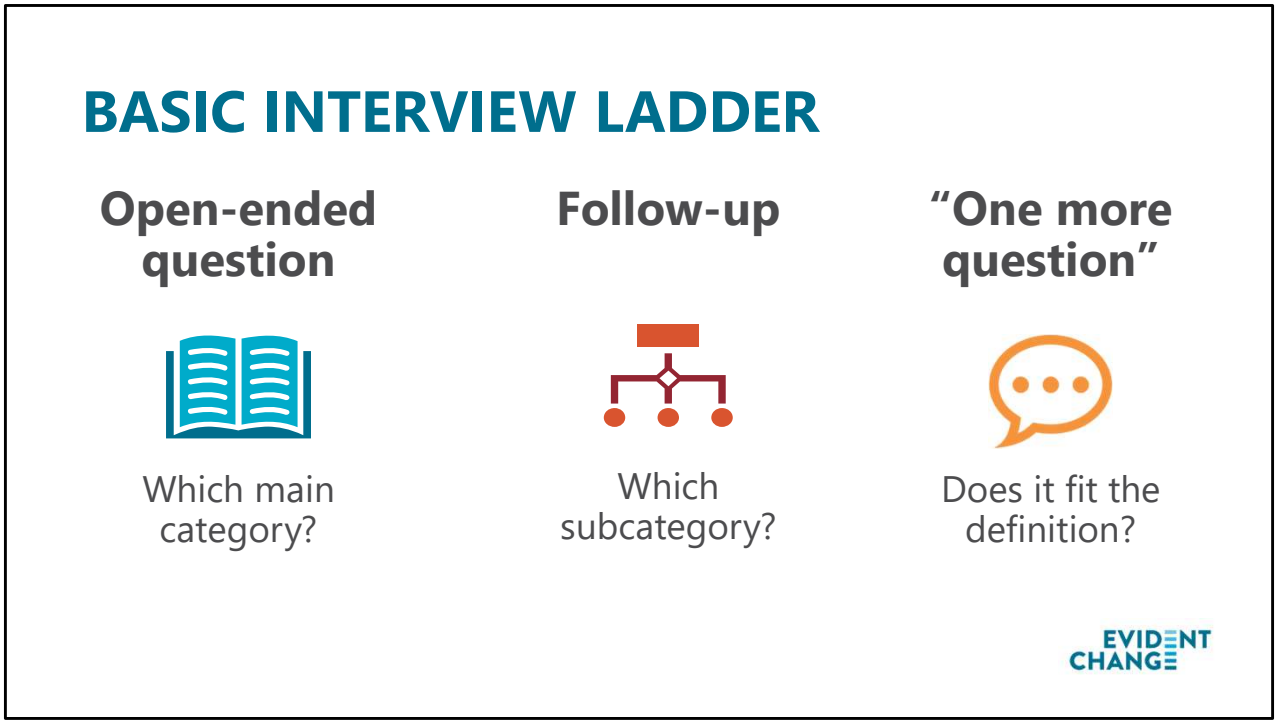
Purpose
To see the process of helping reporters provide specific details about their general concerns when they call.

Example
Remember this slide from the prior section? Let's discuss helping your screeners make use of the SDM system to move up and down the Ladder of Inference with awareness.

While starting with open-ended questions at the beginning of an interview *may* elicit a complete and well-formed narrative of a clear allegation, more often it will elicit a generalized conclusion about why the reporter is calling. Pulling up the definitions for the hotline tools will naturally help the screener focus the conversation to go from generalizations to specifics—and even to resilience, network, and protective capacities that have not historically been part of the conversation.

Trainer Note

Activity
Ask participants to turn to a peer and share with each other questions they might use to move a conversation "down" the ladder to get specific details. After three to five minutes, ask participants to share a few questions with the rest of the class. Then gather ideas from participants how they would share this with the screeners at their hotline.



Purpose
To be introduced to the interview ladder.

Example
When conducting an interview, even a brief one at screening, it is useful to begin with a basic open-ended question that allows the caller to tell us what they observed. Often, this will give us enough information to determine which screening criteria type is being reported.

As the caller describes the concerns, you should be able to narrow down the allegation types that may be of concern—is this about physical abuse, neglect, sexual abuse, emotional abuse, or a combination?

As we narrow down the allegation types, we might need to ask follow-up questions to gather details about the type of maltreatment. For example, "Did you actually see an injury? Can you describe it?"

Lastly, clarifying questions should be asked, using the definitions in the P&P manual to determine whether the concern meets the threshold contained in the definition. This is the "one more question" that is often necessary to make this determination.

USING THE LADDER DURING THE CALL

Open-Ended	• Listen for main categories (i.e., physical, sexual, emotional abuse; or neglect). • Begin to scan subcategory criteria on main screen.
Narrative-Based Follow-Up	• Open definitions for likely criteria. • Ask questions in areas that the definition requires. • Narrow down to possible criteria.
"One More Question"	• Create a narrative chain and compare available information with the definitions. • Where your chain is missing information, pose a detailed question. • If the chain is complete, select criteria.

Purpose
To understand the importance of gathering as much information at the hotline as possible to make an accurate assessment.

Example
In most calls, start with open-ended questions and then begin to narrow down the main categories.

Open the definitions, then begin to ask follow-up questions to help narrow down possible criteria.

When you have narrowed down to the most likely category, think of the definition as if it were a chain, and see if you have the facts to connect all the links. If not, use the missing link to select the next question you must ask.

Purpose
To understand the necessary information to gather from a reporter.

Example
When gathering information from the caller, it is important to stay focused on the link between a caregiver's actions or behaviors and their impact (or likely impact) on the child if there are no interventions.

Whether in conversations with referral sources or family members, workers can encourage others to identify the child's caregivers, their behaviors, and the impact (or likely impact) of these behaviors on the child.

Although the caregiver may have done something or failed to do something, what we are most concerned about are behaviors that have had a significant impact on the child or could have an impact if no interventions were present.

Imagine that a mother drove home following a night out drinking at the bars. When she arrived home, her children were asleep and safe because their grandmother had been watching them. The next morning, the children noticed that their mother was a little grumpy, but it did not seem to bother them. While the mother's behavior is worrisome, it has no bearing on child protection because it did not seem to have any impact on the children. This may look different if the children were being watched at their grandparents' home and the mother went to pick them up to drive them home after her night out.

When thinking about the likely impact on the child, professional judgment is required. "Likely impact" is challenging because sometimes we might jump to the most drastic of scenarios; however, *the most drastic scenarios are not always the most likely*. When

considering the likely impact, it is important that you are also considering child vulnerabilities, what the caregiver's actions or protective actions are, what we know about behavioral patterns of the caregivers and probability of behaviors repeating, etc. Consultation with a supervisor may also be helpful when considering the likely impact if nothing were to change.

Focusing on "impact or likely impact on the child" requires practice. We will look at some strategies for digging for these behavioral details.

WHAT IS THE C, THE B, AND THE I?

Tomás Jr. has a black eye and bruised left cheek. Tomás tells you that last night, his father hit him when he tried to stop a fight between his mother and father. He says that he is afraid to go home because his father was still angry this morning.

Purpose
To see how to identify the parts of C + B + I.

Example
Please review this statement and identify all three parts of caregiver, behavior, and impact or likely impact on the child. If one or multiple components are not present, indicate "not present" for that component. How might the information support your decision making at each of these critical points?

Trainer Note
Ask participants to turn to a peer and work together to identify each aspect of C +B + I in the text about Tomás Jr. in three to five minutes. Ask the participants to report to the class.

UNKNOWN IS DIFFERENT FROM UNASKED

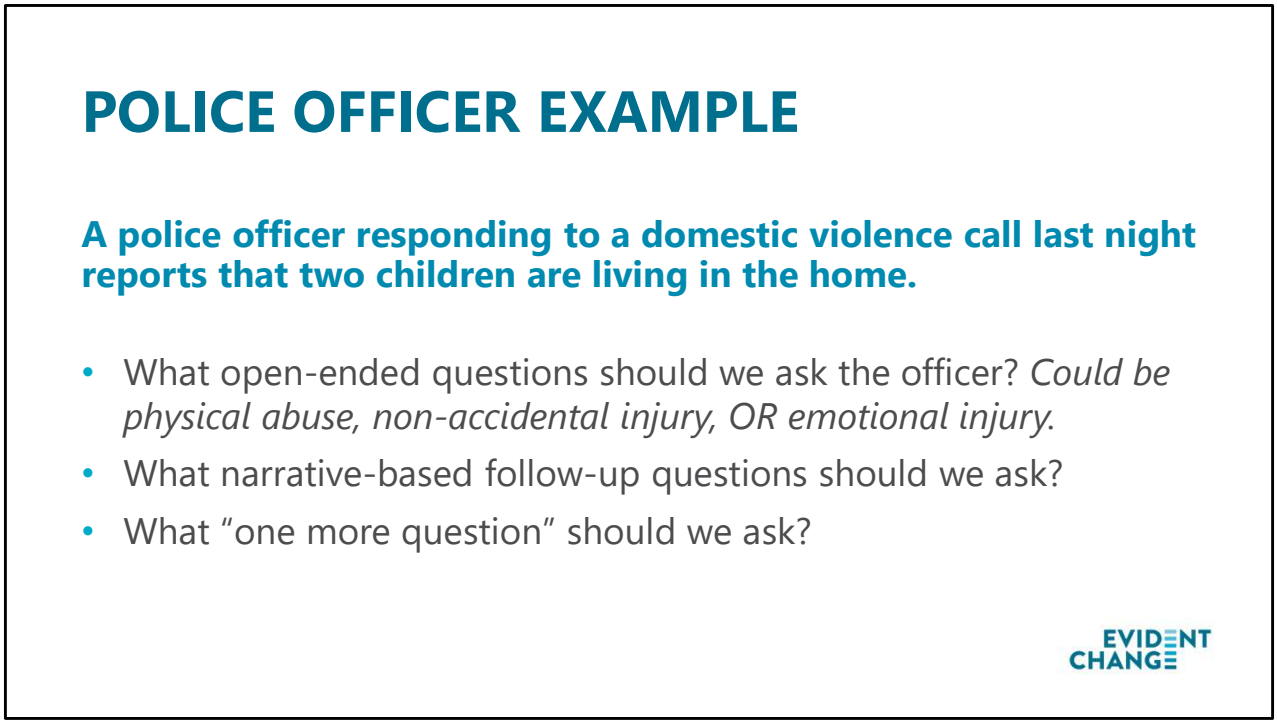
If information is *still* unknown, document attempts to gather it. Consultation, critical thinking, and professional expertise should guide our decisions. (Resist letting fear or "the way we've always done it" drive decisions.)

EVIDENT CHANGE

Purpose
To understand the importance of asking one more question.

Example
Sometimes, reporters do not have the information that might help you make an absolute determination or information that you can clearly relate to an allegation; however, a reporter not knowing information is different from never asking them. Asking one more question can be very important to gather that extra information that might lead you to feeling more confident in your decision making.

If the reporter does not know or does not have information, you may need to rely on consultation, critical thinking, and professional expertise to determine if the information you do have is enough to apply to a definition. Transparent documentation (like the last sentence in the NICU , which reflects that the nurse was asked but did not know an answer) is also crucial to provide rationale behind your decision. If information is unknown, it is important not to fill in the blanks with remote possibilities or catastrophizing. Remember, the instructions from CDSS include, amongst other criteria, "The allegation includes specific acts and/or behavioral indicators which are suggestive of abuse, neglect, or exploitation."



Purpose
To understand the importance of gathering the correct, needed information at the hotline to make an accurate assessment.

Resource
Hotline Information Collection Guide handout

Trainer Note
In teams of four to five people, generate some questions for each bullet point on the slide.

Activity
Ask small groups to generate questions that fit each of the three types on the slide. After five minutes, ask groups to report out. Listen for the following examples and reinforce their value. If some of these don't come up, mention them as ideas.

What information do we need to select a screening criteria item?

- What is the impact on the child?
- Did a non-accidental physical injury occur during the incident?
- Did the child suffer emotional injury?
- What are the child's vulnerabilities?

Narrative-based follow-up questions to ask the reporter include the following.

- Was any child injured, or did a child try to intervene? (If the officer says no, we can eliminate the category of physical abuse.)

- Was the child present during the incident?
- What was the nature of the incident?
- What was the child's reaction to the incident?
- How is the child feeling?

THERAPIST EXAMPLE

A therapist calls to report that during a session, an 11-year-old boy said he got in trouble and got a "whooping."

- What open-ended questions should we ask the therapist? *Could be physical abuse, subcategory non-accidental physical injury, or excessive or cruel punishment.*
- What narrative-based follow-up questions should we ask?
- What "one more question" should we ask?

EVIDENT CHANGE

Purpose
To understand the importance of gathering as much information at the hotline as possible to make an accurate assessment.

Resource
Hotline Information Collection Guide handout

Trainer Note
In teams of four to five people, generate some questions for each bullet point on the slide:

A therapist calls to report that during a session, an 11-year-old boy said he got in trouble and got a "whooping."

The allegation type could be physical abuse that caused or "likely . . . will cause" injuries, or emotional abuse due to "cruel, unusual, or excessive methods of discipline."

Narrative-based follow-up questions to ask the reporter include the following.

- Does the child have any injuries? If not, what level of force or objects were used? Was the impact on bare skin or over clothing?
- Who was the alleged perpetrator?
- According to the child, what was occurring just before he received a "whooping"?
- Who else was present during the incident?

<u>One More Question</u>

- Have you seen injuries on the child before?
- Has the child ever reported being "whooped" before?

Purpose
To be introduced to the thought behind the safety assessment and what decision we are trying to make.

Example
The safety threats on the SDM safety assessment relate to the questions "Is there imminent danger to the child?" and, if so, "Can the child remain safely in the home with a safety plan in place, or is a removal required?"

This is about the short term. When we talk about danger in the context of the SDM system, we are looking for serious and imminent threats to a child. "Serious" means that the harm would require medical or mental health attention or emergency services. If the worker does not think the threat can be mitigated, they would not leave the child in the home.

With the SDM system, workers assess safety when they first meet a family and then assess it again whenever their understanding of the family's safety changes. Whenever a worker is considering whether a child should be removed from the home, a new safety assessment should be completed.

DEFINITION OF SAFETY

Safety: Actions of protection, taken by the caregiver and network, that address the danger and are demonstrated over time

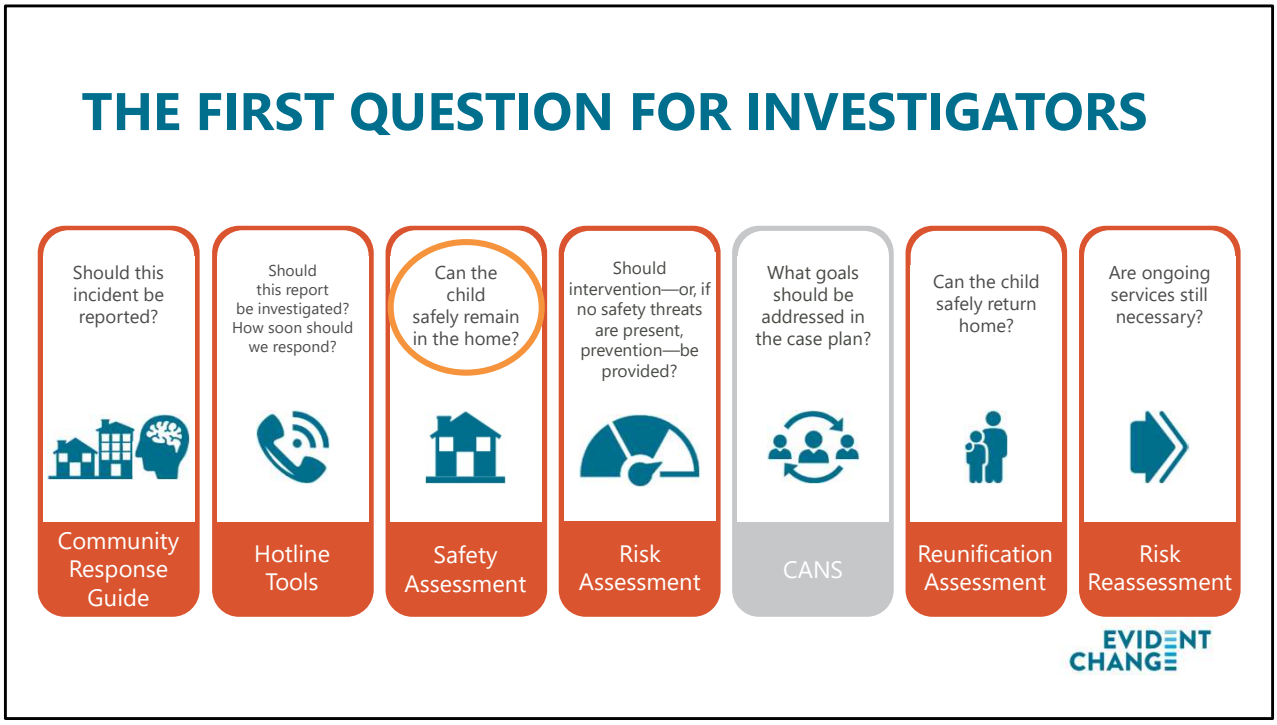
EVIDENT CHANGE

Purpose
To be introduced to our definitions of safety and belonging.

Example
Here is how we think about safety. Safety is:

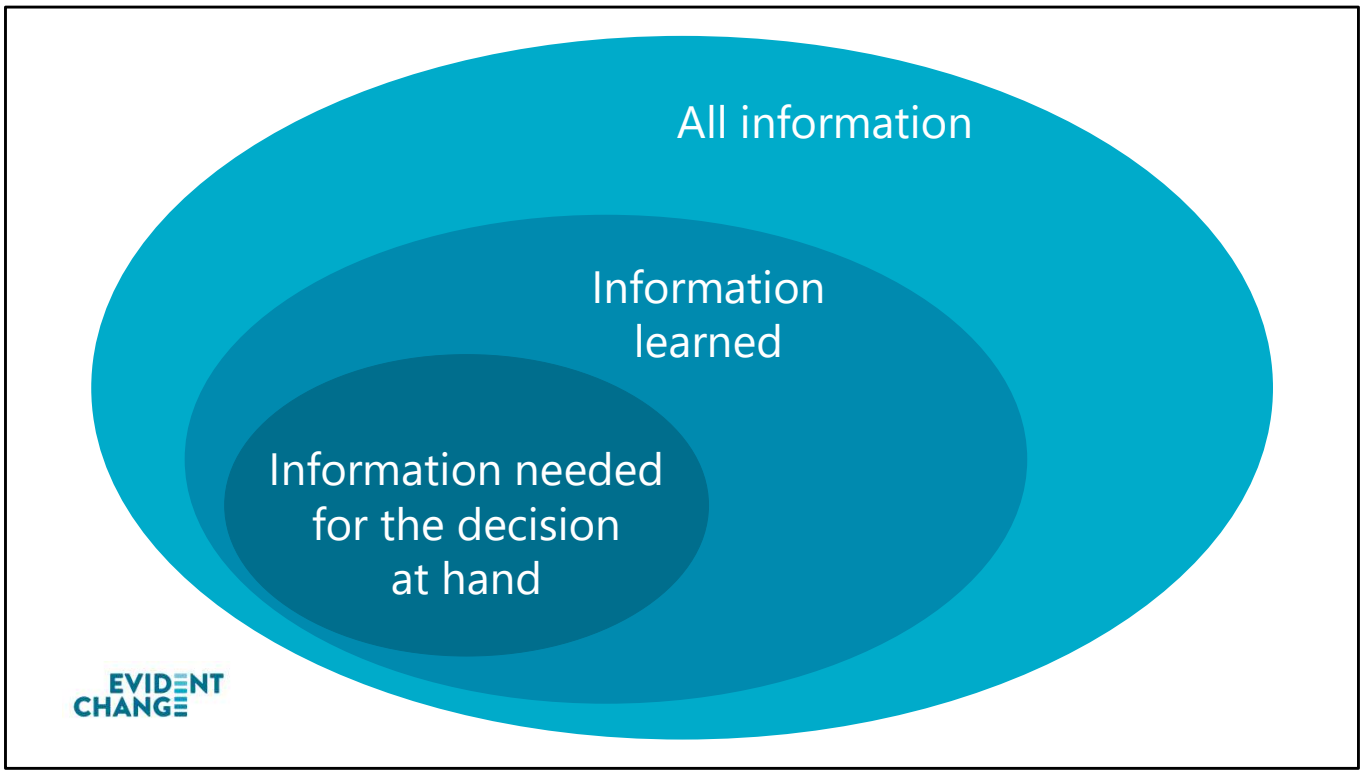
- An action—something that the caregiver does.
- The behavior we want to see (i.e., what is done in place of the behavior we are worried about).
- "North" on the compass that guides our work.

Boffa, J., & Podesta, H. (2004). Partnership and risk assessment in child protection practice. *Protecting Children, 19*(2), 35–49. Adapted over time by Andrew Turnell and members of the Massachusetts Child Welfare Institute.



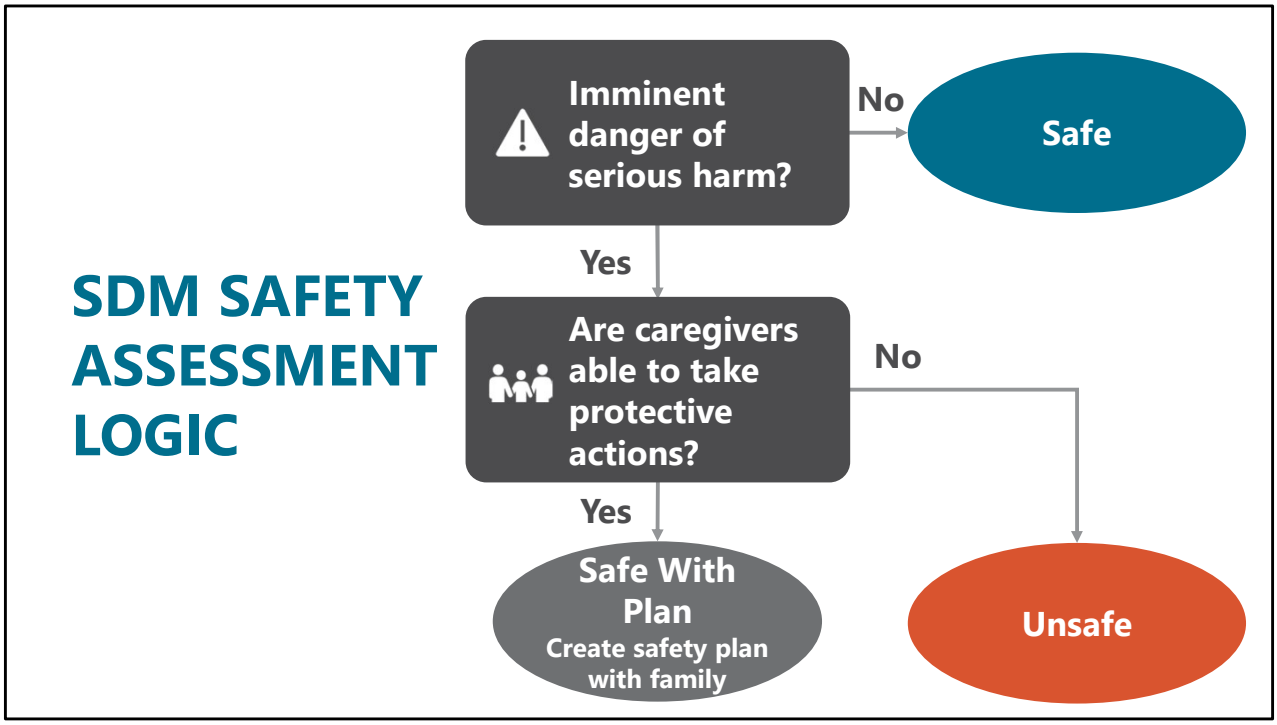
Purpose
To be oriented to which decision the safety assessment helps with.

Example
Let's take a look at the safety assessment. It helps us determine whether children can safely remain in the home. Before we conclude that they cannot, we need to make a concerted, good-faith effort to safety plan whenever possible.



Purpose
To discuss the types of information provided versus the information needed to make decisions about child safety.

Example
This diagram shows how structuring decisions helps us focus on the most important information needed to make a good point-in-time decision. The outer circle is the entirety of information about a family. We will never really know all of this. The middle circle represents what we learn about the family as we work with them. The inner circle is the information needed to make the decision at hand—which is where the SDM assessments focus workers.



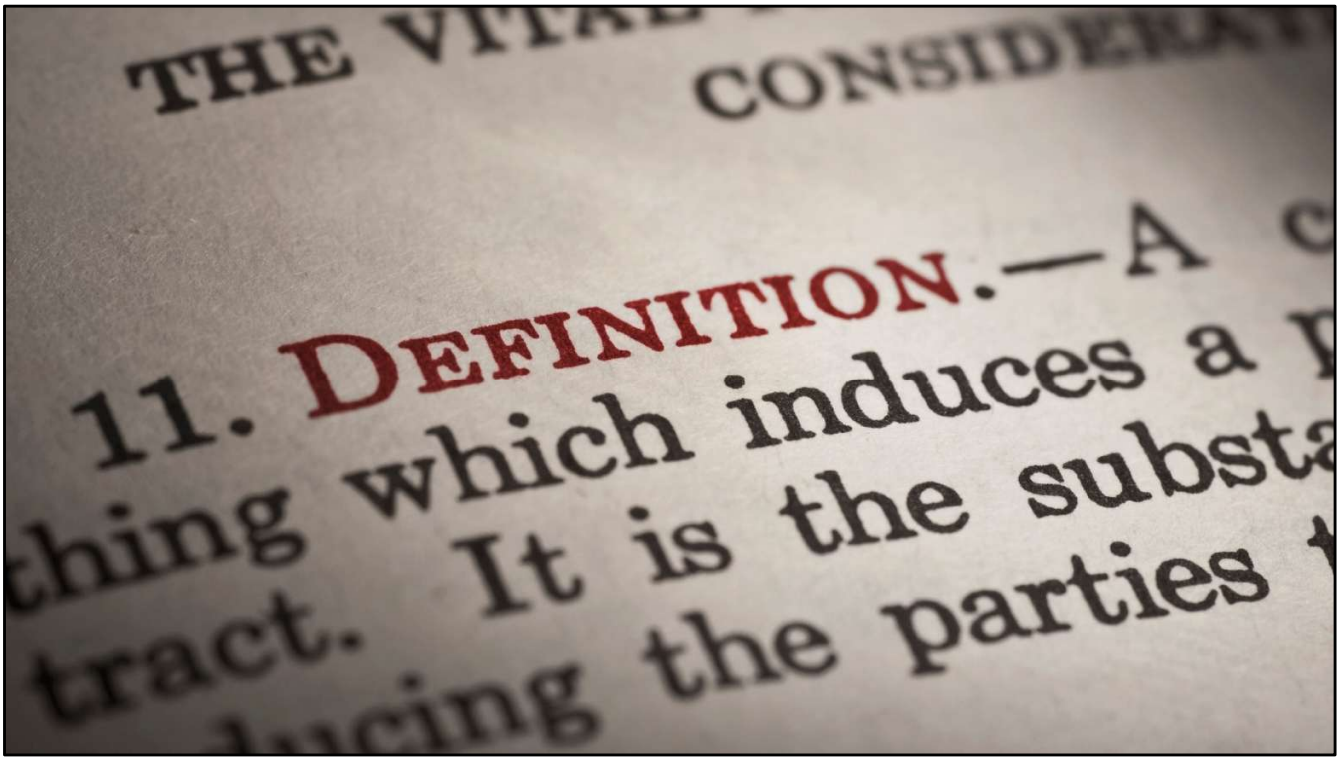
Purpose
To see how the safety assessment tool guides the safety decision.

Example
Here is a flow chart of the presumptive decisions for the safety assessment. You can see that the tool contains the two key questions that relate to a child's immediate safety.

Remember, if there is imminent danger of serious harm (meaning that one or more safety threats have been selected), we must do something about it. We cannot leave the child in the home without a safety plan in place to mitigate the danger in the short term. If caregivers can take protective actions and necessary intervention actions can be taken, the safety assessment decision is "safe with plan." If caregivers are unable to take protective actions with needed interventions available, the safety assessment decision is "unsafe," and a removal must be considered.

Here is a special note about the second question, "are the caregivers able to take protective actions?" it appears as a yes/no question on this slide, BUT it should be thought of as a process rather than a point in time question. The federal Child and Family Services Review (CFSR) expectation is that we make a concerted effort to avoid

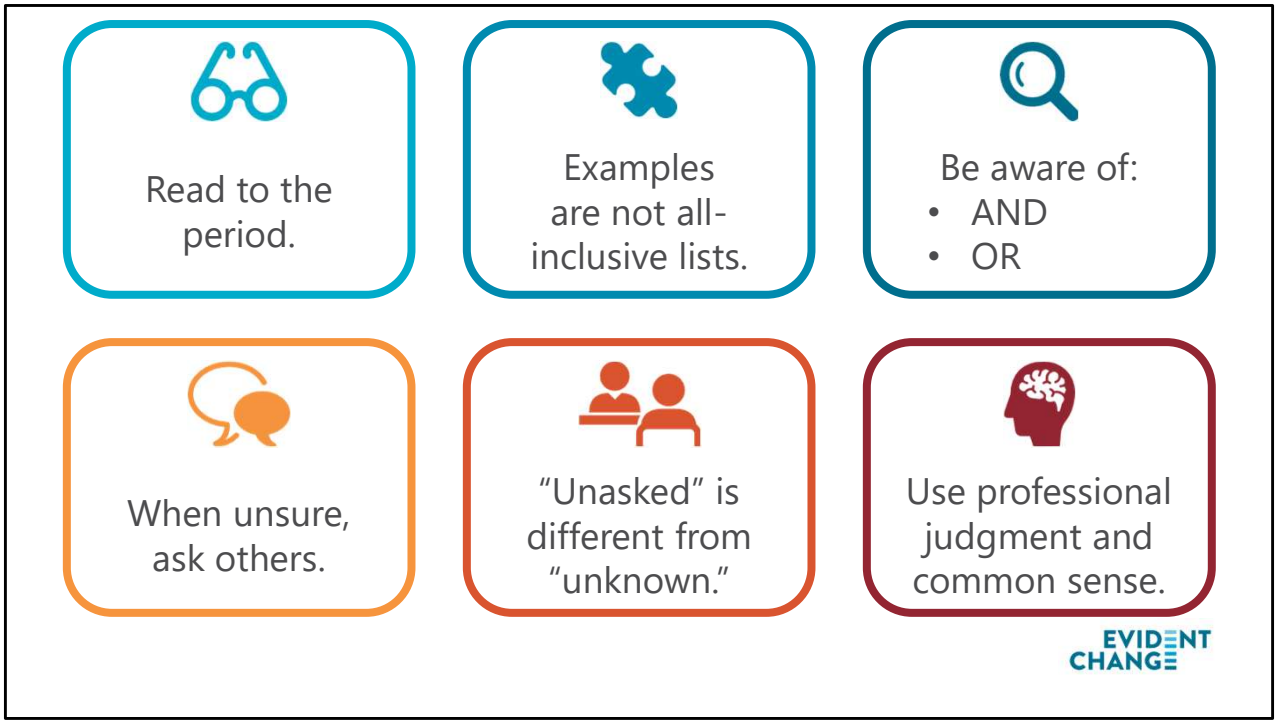
an entry to foster care, so the practice we hope to see is a good-faith attempt at safety planning whenever possible.



Trainer Note
This slide will repeat in each assessment section. It offers a chance to underscore the importance of consulting the definitions.

Example
If you hear nothing else that is said during this training, hear this part. You need to use the definitions. Definitions are the most important part of the SDM system. You need to *refer to* the definitions and *use* them when applying the SDM assessments.

Remind yourself and your staff about this critical habit in using the SDM system.



Purpose
To learn the importance of understanding and using the item definitions in the P&P manual.

Example
As we said before, the tool does not make the decision; people do. The tool's outcome is only as good as the information used to complete it and the application of that information to the various item definitions.

Before we get into strategies for gathering that information, let's talk about the importance and structure of item definitions. As you will see in our practice activities and review of the manual, each item on the hotline tools has a corresponding definition.

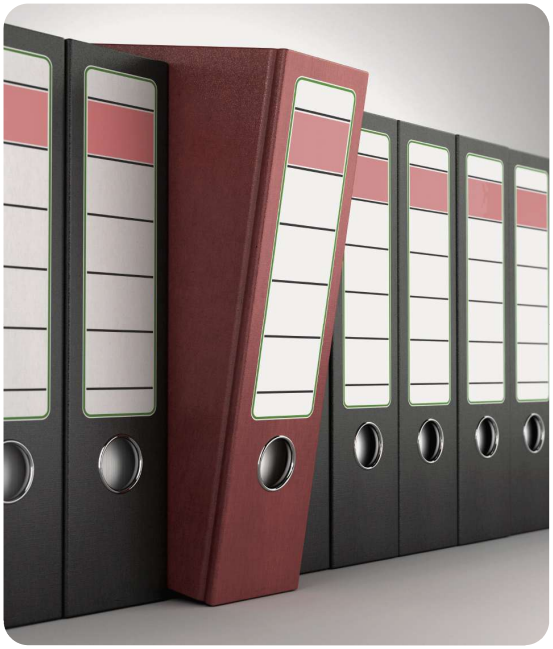
While you are interviewing reporters, be mindful of the assessment items and definitions, and make sure you gather information that allows you to answer each question. We will practice how to do that throughout this training.

Definitions establish threshold regardless of how the reporter labels the concern (e.g., "I'm calling to report neglect"). The screener listens for and documents specific facts

that describe the child, the circumstances, the behavior of the caregiver, and the impact of that behavior on the child.

Definitions for each allegation type establish the threshold. Information gathered from the reporter must meet the threshold for the allegation to be selected. If the information does not reach the threshold for any allegation, the call is screened out.

Trainer Note
Ask participants if this is how they currently practice and what, if any, shifts in thinking or approach may be necessary to approach calls this way.



SDM SAFETY ASSESSMENT POLICY AND PROCEDURES

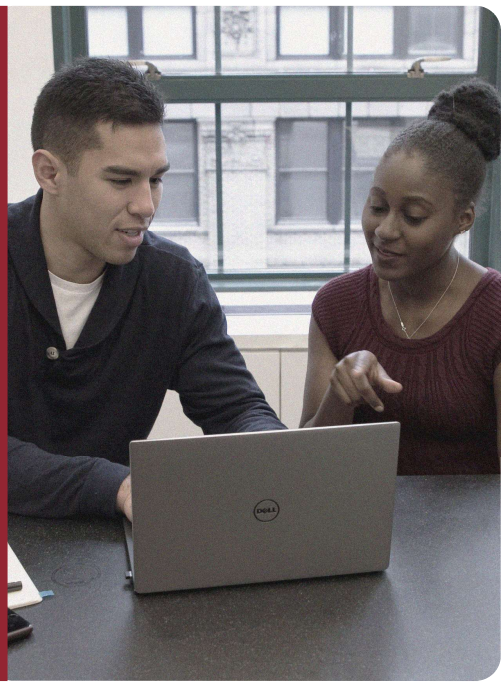
- Which cases
- Who
- When
- Decision

EVIDENT CHANGE

Purpose
To be introduced to the safety assessment tool's policy and procedures.

Trainer Note
Have participants go to the Safety Assessment Policy & Procedures section of https://ca.sdmdata.org/definitions or the same section of the combined P&P manual (in PDF). Have participants form small groups to review Which Cases, Who, When, and Decision. Ask participants share concerns or questions related to the completion of the assessment. Facilitate a large group report-out, considering the concerns or questions.

SAFETY ASSESSMENT CONSIDERATIONS FOR SUPERVISORS



Purpose
To understand supervisory input for safety assessments.

Resource
SDM P&P manual https://ca.sdmdata.org/definitions
Other Safety Threats handout (participant guide)

Example
A primary way that supervisors support workers is determining whether situations meet the threshold of imminent danger of serious harm, or if there is a plausible threat to cause serious harm. How do you think through and navigate that threshold question?

Trainer Note
Facilitate a discussion and highlight the need to help workers avoid false positives *and* false negatives.

Example
Another import supportive role is considering if a safety plan will mitigate any identified safety threat and offering ideas and suggestions to improve safety plans during consultation. It is impossible to know with 100% certainty that a safety plan will succeed; but using the SDM assessment as a support, combined with professional judgment, we can have a better idea of the plan's chance for success compared with using only one of those approaches. As a supervisor, you will have the opportunity to help your workers think through this decision as well.

On the safety assessment, under Safety Threats, you will notice safety threat 10, labeled "other." This is included because the assessment cannot capture every possible imminent

threat of serious harm to a child.

This is where professional judgment is vital. Once in a *very* great while, workers may come to you with unusual or unique circumstances that might not fit into one of the safety threats. By exploring those scenarios together, you can decide whether that scenario meets the threshold of imminent threat of serious harm. In a review of hundreds of entries for Other, they all fit under an existing threat (1–9); or they were a description of many risk issues that combined to make the worker really worried, but there was no description of imminent danger of serious harm.

So, if a worker selects "other," it will be up to you, as a supervisor, to determine whether that selection meets the threshold of a safety threat. Remember that a safety threat is an imminent threat of serious harm and represents conditions that, when present, prevent the worker from being able to leave the home without either removing the child or putting a safety intervention in place to ensure the child's safety.

If a worker selects "other," the situation still needs to meet this high threshold. Your job as a supervisor is to make sure that when "other" is selected, there is a truly unique circumstance that is not captured in the other safety threats but does rise to the same threshold.

There may be scenarios in which a worker will indicate a concern that may not quite rise to the level of a safety threat. Those circumstances are great teaching moments where you have a chance to review what "safety threat" means, what threshold is necessary for its presence, and what the worker can do about the concern outside of needing to set up a safety intervention or facilitate a removal.

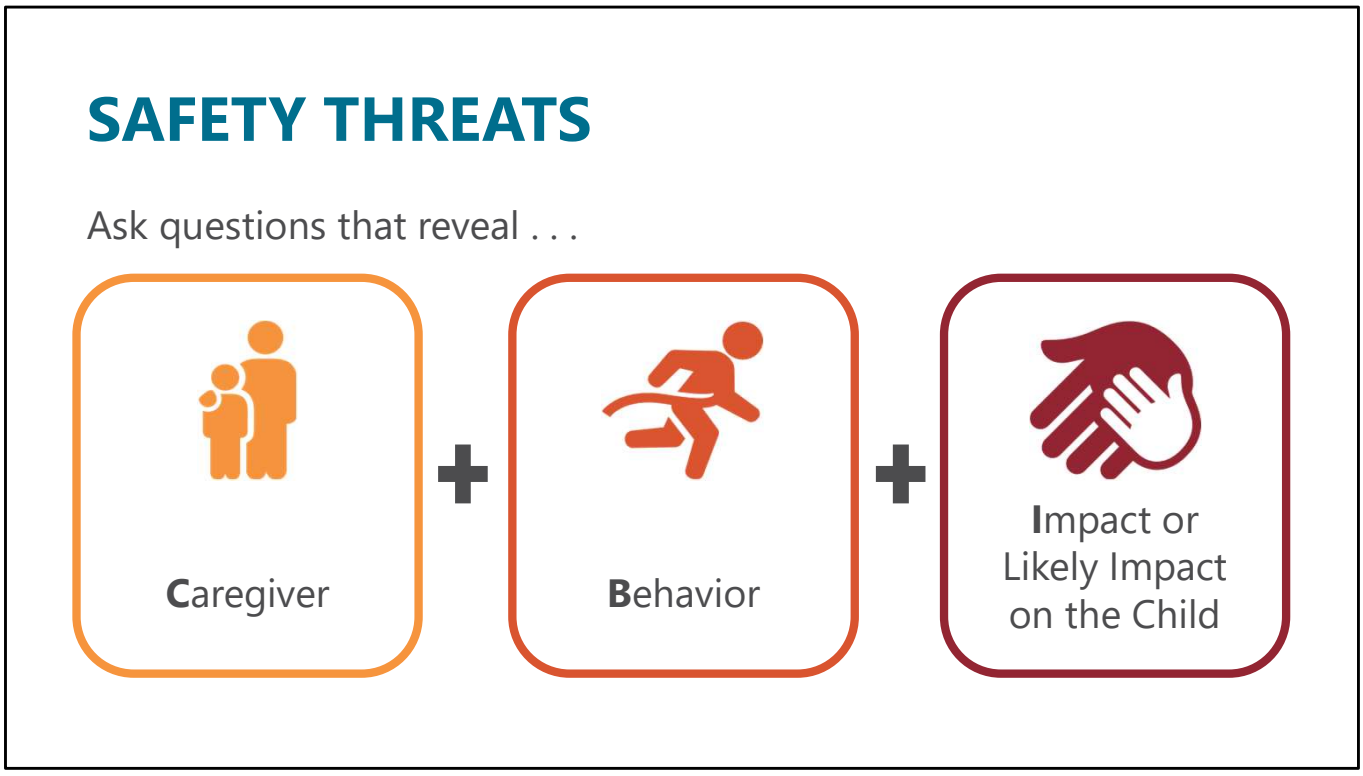
Selection of "other" should happen rarely. Remember, the safety threats are based on statute, case law, and state policy. When supporting a worker's selection of "other," make sure that other safety threats are not applicable instead. You also want to avoid using this item as a bucket for other information that describes risk but is not a safety threat.

Trainer Note

Activity
Refer participants to the Other Safety Threats handout in the participant guide. Have them get into pairs and answer the questions in the participant guide. (The first three fit under other safety threats, and the last two do not meet the threshold.)

Purpose
To understand the difference between safety threats and risk.

Example
Here is a reminder from the overview about the distinction between safety and risk and the low correlation that allegation conclusions have with future system involvement.



Purpose
To reflect on SOP concepts of caregiver, behavior, impact (C + B + I) and how they are addressed in the SDM safety assessment, in order to tee up content on the next section of the safety assessment: Safety Threats.

Trainer Note
C + B + I has been trained as an SOP concept. This is a refresher and an opportunity to again connect the dots between SOP and the SDM system.

Example
Remember the concept of C + B + I from the SOP skills you have been practicing. In addition to using the three-column map, focusing on the impact of a caregiver's behavior (shaped by underlying need) on the child can be a helpful construct as we assess safety. You will notice that the safety threats—the next section of the safety assessment—and their corresponding definitions align with the C + B + I formula. They focus attention on the caregiver's action or inaction that led to the impact on the child that meets CDSS imminent danger thresholds.

Activity
Have participants review the Other Safety Threats activity and discuss the answers as a class.

Purpose
To understand the difference between danger and risk.

Trainer Note
The "light" references relate to the graphic in the participant guide.

Resource
Distinguishing Between Danger, Risk, and Needs handout

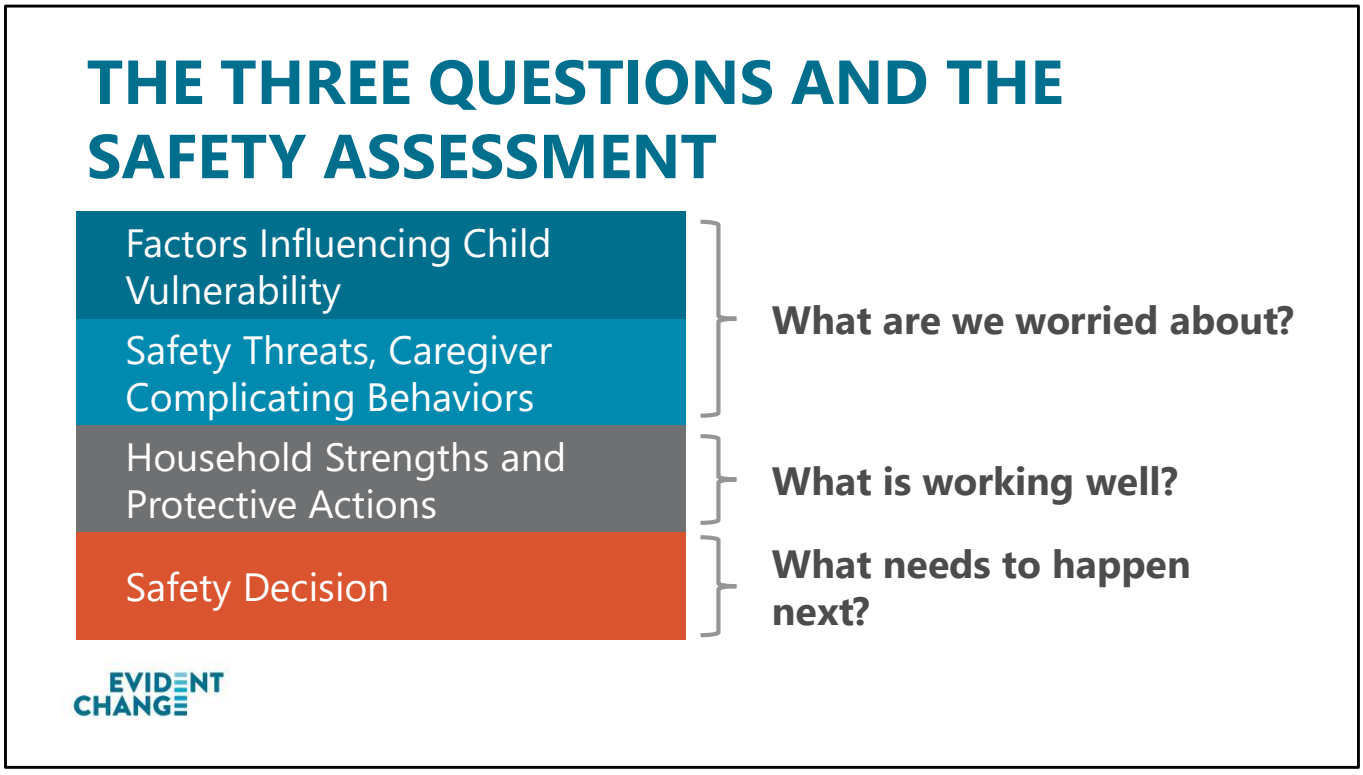
Example
Before we start discussing the safety assessment in more detail, it is important to remind ourselves of the distinction between safety, risk, and needs. Here is another way to think about it.

If you are experiencing the symptoms of a heart attack, it is a "red-light" moment requiring immediate action, like calling 911.

Risk refers to the likelihood of a future event happening. For example, if you are said to be at risk for heart disease or a heart attack, it means that you have conditions and characteristics present that increase your likelihood of having a heart attack. It is a "yellow-light" moment because you should slow down and learn about those risk factors and how they affect you. Some things that increase your risk for a heart attack, like family history of heart disease, cannot be changed—they will always be present and contributing to your risk level. Other factors, such as diet and exercise, are things that you

can modify to reduce your risk.

Which brings us to the “green-light” moments, which are when we need to get started with behavior changes that will mitigate the risk factors we can modify to reduce our risk.

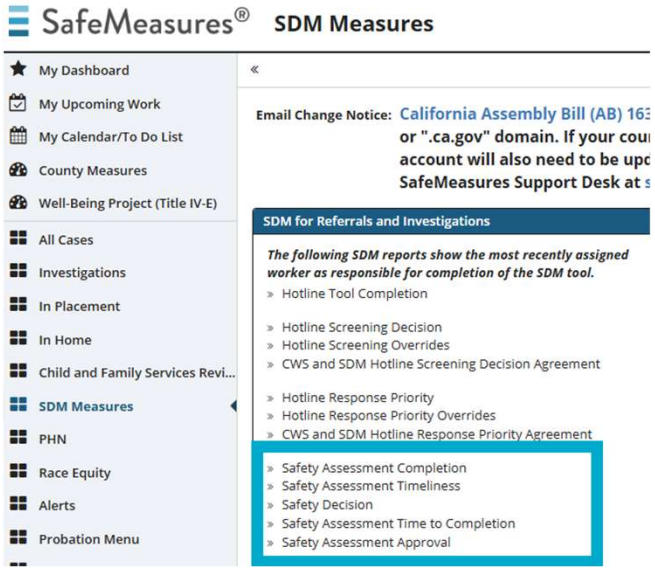


Purpose
To be reminded of the Three Questions and how to use them related to the safety assessment tool.

Example
In looking at the SDM safety assessment, you will notice that workgroup members worked hard to integrate the structure of the Three Questions and other key concepts into the framework of the assessment itself.

When gathering the information necessary to conduct the safety assessment, we recommend organizing your conversations with families around the Three Questions: What are we worried about? What is working well? What do you think needs to happen next to make this better? Workers can use these questions to start getting critical information about safety threats, complicating behaviors, strengths, and possible interventions; and they can then ask more detailed and pointed questions for further information and rigorous safety planning.

SAFEMEASURES



EVIDENT CHANGE

Purpose
To be reminded of SafeMeasures reports to support learning about how your staff are using the assessments.

Example
This is just a reminder that you take a closer look at your SDM outcomes by unit and worker using SafeMeasures reports.

WHAT DOES SAFETY LOOK LIKE?

EVIDENT CHANGE

Purpose
To discuss what is unsafe.

Trainer Note
For this group activity, form two groups for danger and two groups for protective factors, or however many groups are needed.

Set a timer for five minutes once participants start the activity.

Refer participants to the same image (What Does Safety Look Like?) in their participant guides.

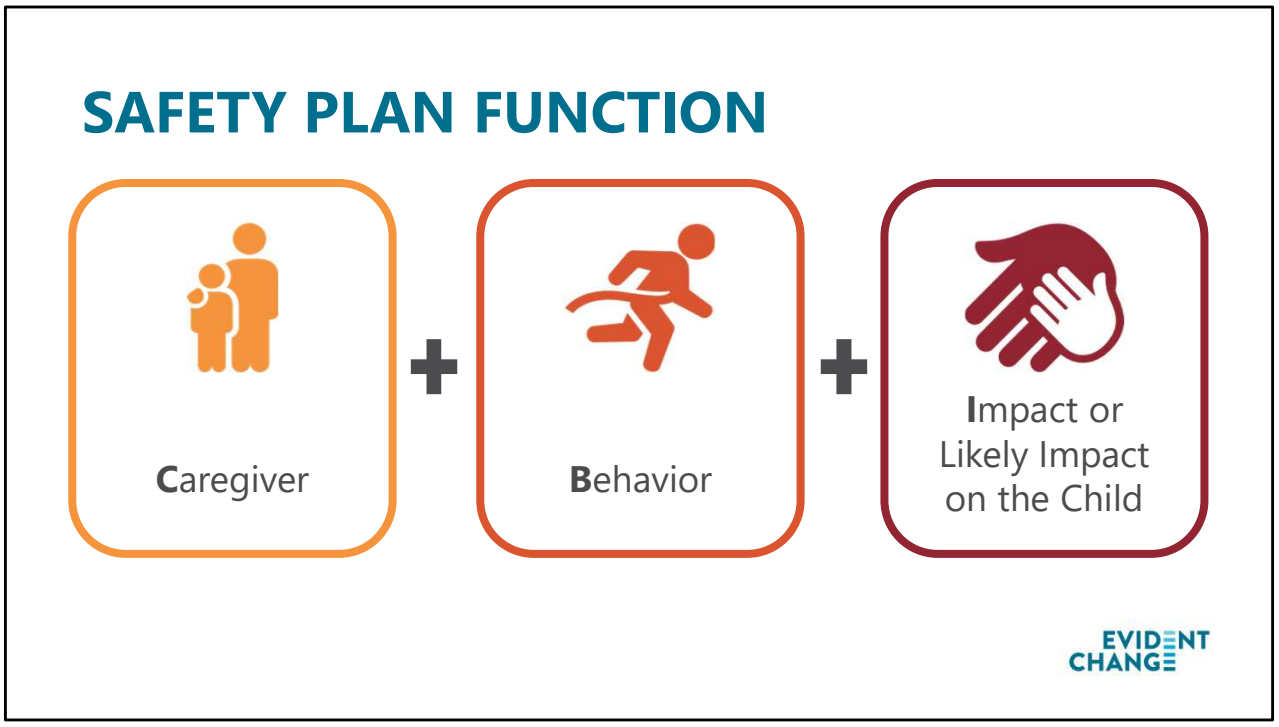
Divide the group. Assign some groups to identify what they are worried about regarding child safety from the picture and the others to identify what makes them less worried.

If the training is in person, write their responses in two columns on large flip-chart paper; label one column "Worries" and the other "Working Well." If the training is via web meeting, use the chat. The groups may have fun with this, exaggerating what they see and competing with each other.

Once the lists are filled, point out how perspectives vary and how it is evident that depending on perspective, we can see two very different pictures before us. Also note that while some things seemed far-fetched in the spirit of competition, what we see on the list is a lot of what we see in the field in terms of judgments workers are making, whether consciously or implicitly.

Note that the view or lens we take matters.

Resource
What Does Safety Look Like?

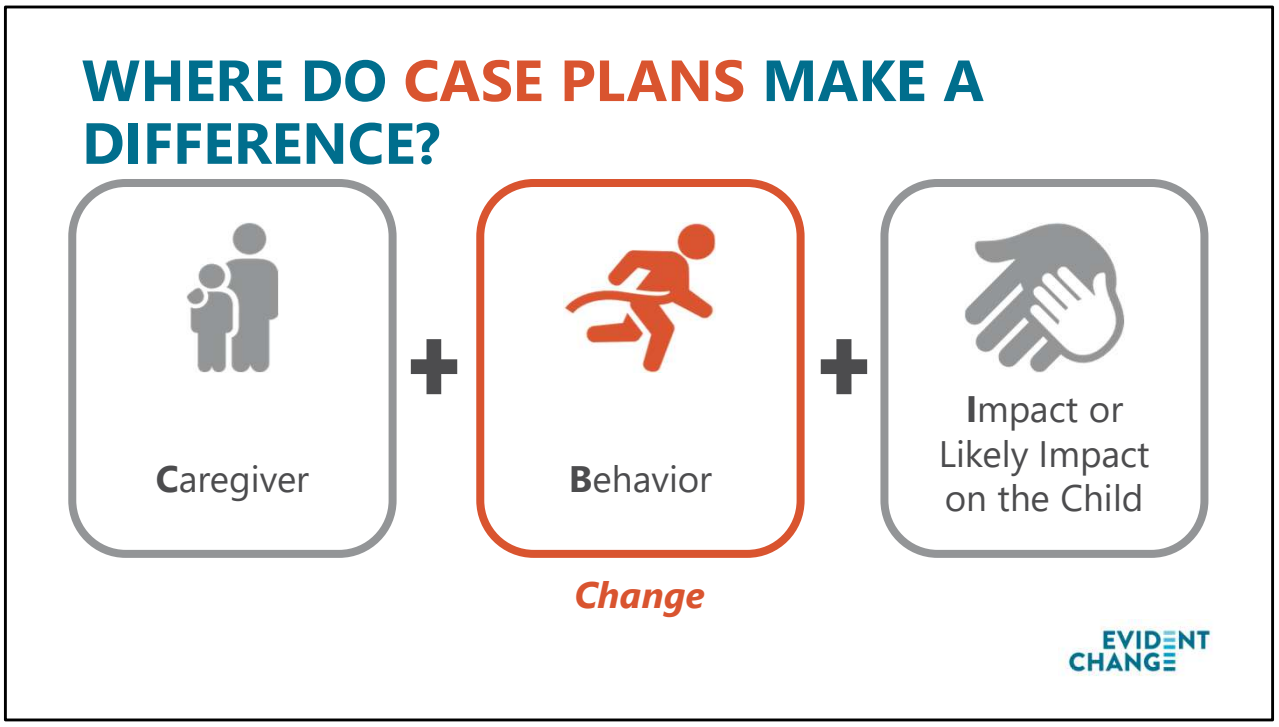


Purpose
To see where a safety plan makes a difference.

Trainer Note
These three slides work together to make the point about safety plans versus case plans.

Example
Safety plans are designed to interrupt the impact on the child.

Example
Keep in mind that caregiver behavior may still persist; but if they are willing to safety plan and have a safety network to do that with, "safe with plan" is an option.



Example
Case plans are designed to help caregivers change their behavior. We need to encourage and support behavior change to promote long-term safety, and it should be aligned with the goal statement.

Which brings us to an important reminder . . .

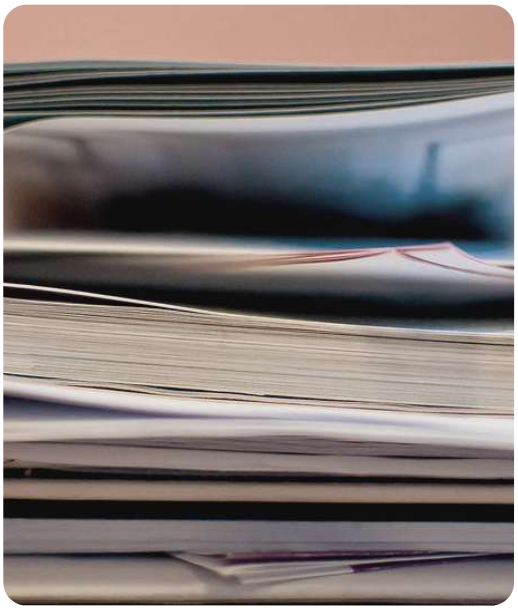
SAFETY AND SERVICES ARE NOT THE SAME THING

- Distinguish behavior change from service compliance.
- Services can be a bridge to new safe behaviors over time.

Purpose
To be reminded that service completion does not equal child safety—a safety plan could create safety before services get started, and services could happen and a household could still be unsafe.

Example
Services may support ongoing safety if active participation leads to behavioral changes. For example, a caregiver has significant substance use issues that lead to the child being placed outside of their home. Perhaps the caregiver attends regular meetings and continues to use substances, but the negative impact of their use on their child's safety and well-being continues. Even if they have attended every meeting as required, they have not demonstrated protective actions to ensure safety (even with a modified or new case plan objective). Alternatively, what if that caregiver not only attends the meetings but can also take steps to use what they have learned, access support members when needed, and work with you to develop a plan to ensure safety when the child returns? Services can be used to support or strengthen the bridge to safe, protective, and sustainable behaviors over time.

Trainer Note
Discuss with the group: What happens as a system when we understand that safety and services are not the same thing in regard to safety threats and planning for child safety?



SAFETY ASSESSMENT DOCUMENTATION

Workers should document:

- Evidence that supports item responses; and
- Specifics for safety interventions.

EVIDENT CHANGE

Purpose
To review the importance of documentation specific to the safety decision.

Example
Every agency has its own way of completing a narrative on the assessment. However, when you complete a narrative, it is vital to provide clear and concise statements of evidence that supports the selected safety threats.

The most effective documentation allows the reader to understand the worker's critical thinking that led to the decision.

Trainer Note
For additional references and information, refer to the P&P manual.

CONSIDER THE DIFFERENCE . . .

It was a dark and stormy night, and this was assigned at 5:30 p.m. The car was low on gas, so I had to stop for fuel. Adam was at his friend's house when I arrived, and the parents weren't sure which apartment he was at. When we met, he was fidgety and only wanted to talk about his newest toy.

A safety plan was developed with the parents and three safety network members to address Safety Threat 1. The harm statement was, "Adam's father, while angry about Adam's grades, struck him several times, leaving bruises and cuts on Adam's head and neck."

EVIDENT CHANGE

Purpose
To see how to start with the outcome of contact with a family in a way that focuses first on the critical decision point at hand, with supporting details following the "lede."

Example
Consider the use of a "journalistic" style of documentation, where the "lede" is the first line in the note. An example might be, "A safety plan was developed to address the safety threat evidenced by [harm or danger statement]. Five network members came together and agreed to the actions on the safety plan." This can help the worker focus on the critical thinking up front. Then, details can follow that first sentence to further explain the rationale for the main decision made. Among the details to record, be sure to include the following.

- Describe the current factors influencing child vulnerability (i.e., conditions resulting in a child being more vulnerable to danger).
- Describe any current safety threats you identified (i.e., behaviors or conditions that describe a child in imminent danger of serious harm). If no safety threats were identified, provide your rationale.
- Describe the caregiver's protective capacities and safety interventions that have been taken and how each one protected or protects the child from the identified

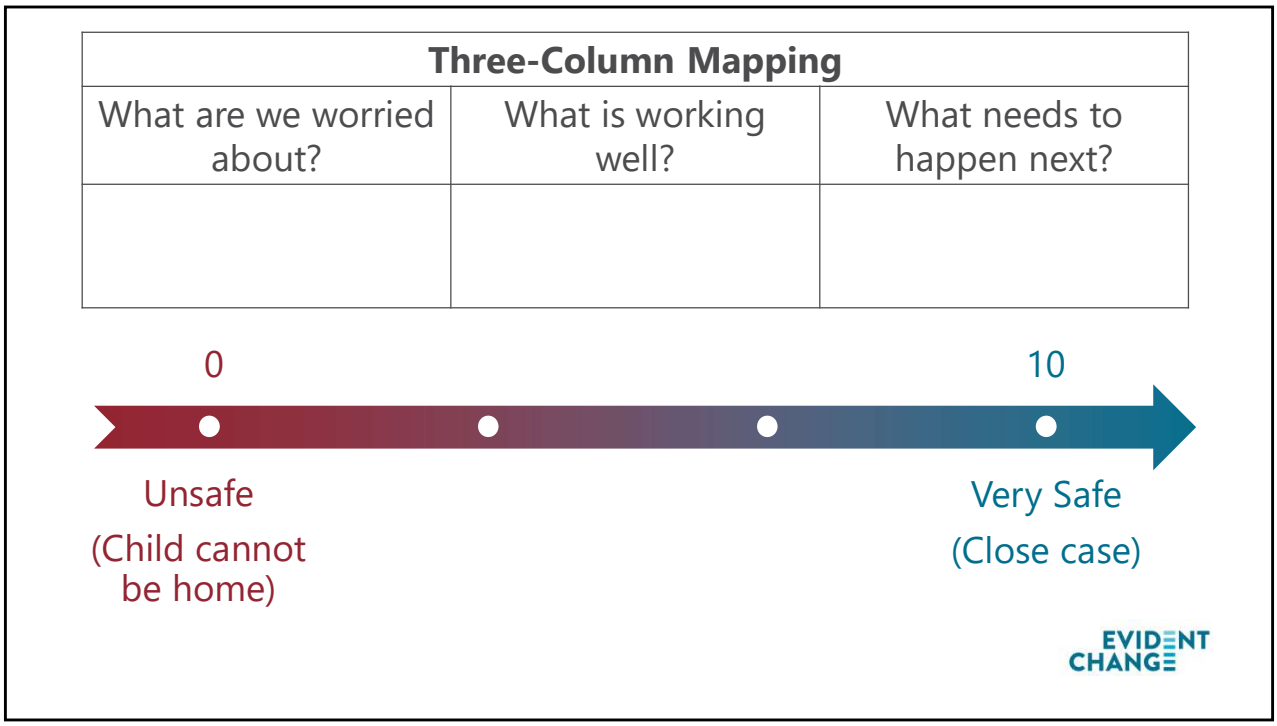
safety threats.

Supervisors

As a supervisor, you will find common errors when it comes to information gathering as part of any assessment. In some instances, not enough is known to accurately complete the assessment; or the information that is gathered is so general (e.g., lacking in behavioral details) that it does not provide enough information to make an accurate assessment.

Coach your workers to use the Three Questions, C + B+ I formula, and key questions from the safety assessment items and definitions to organize their initial contact with a family. It will take some time for them to become familiar with the assessment, and it is never expected or desired for workers to memorize it. The definitions should be consulted often; however, over time, workers will learn questions prompted by the assessment to ask when they are with the family.

Knowing the importance of information gathering and the common errors, what are some ways you can help workers develop these skills through supervision?



Purpose
To be introduced to three-column mapping.

Resource
Three-Column Map handout and Linking the Three Questions and Solution-Focused Questions

Example
If we combine the three questions with a scaling question, we get what is called a three-column map.

As you can see, it starts with the three questions as the primary way of organizing the map. One mantra we often repeat at Evident Change is, "If we don't know what is working well, we don't actually know how worried to be."

While it may seem very simple, this can be a powerful way to begin organizing your thinking. But it would be even more powerful to do this with a family. Review the Linking the Three Questions and Solution-Focused Questions. (provide a few minutes for participants to read through the handout) Which of these questions have some you tried out and found useful? (elicit responses from participants)

Activity
In small groups (three to five), discuss a case or investigation one of you is familiar with. Select a scribe to record what information falls under each of the three questions; and near the end, have each person give their rating from 0 to 10 for the safety in the home.

USING THE EARS MODEL

Elicit
Amplify
Reflect
Start over

EVIDENT CHANGE

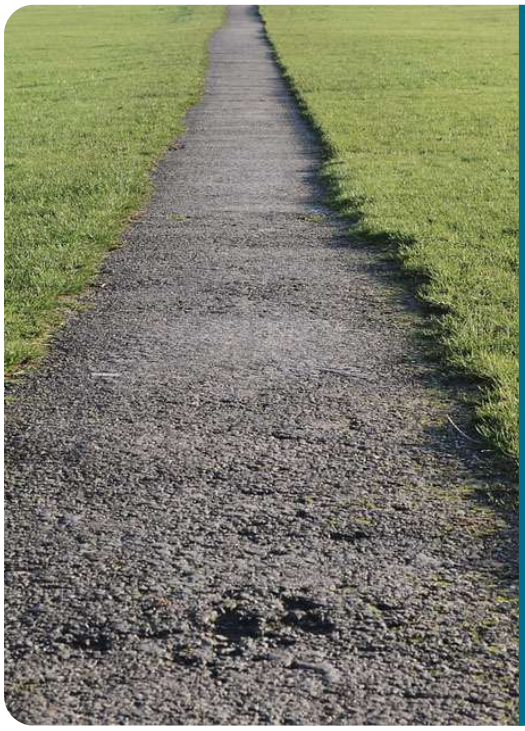
Purpose
To learn the solution-focused inquiry elicit, amplify, reflect, start over (EARS) cycle.

Resource
Possible Questions for an Appreciative Inquiry Interview handout

Example
Let's look at an alternative strategy for making a rigorous and balanced assessment.

Trainer Note
Explain and demonstrate the EARS cycle as a structure to frame the appreciative inquiry conversation.

Refer to the handout with exercise instructions. Demonstrate with a volunteer and have participants do the exercise in pairs.



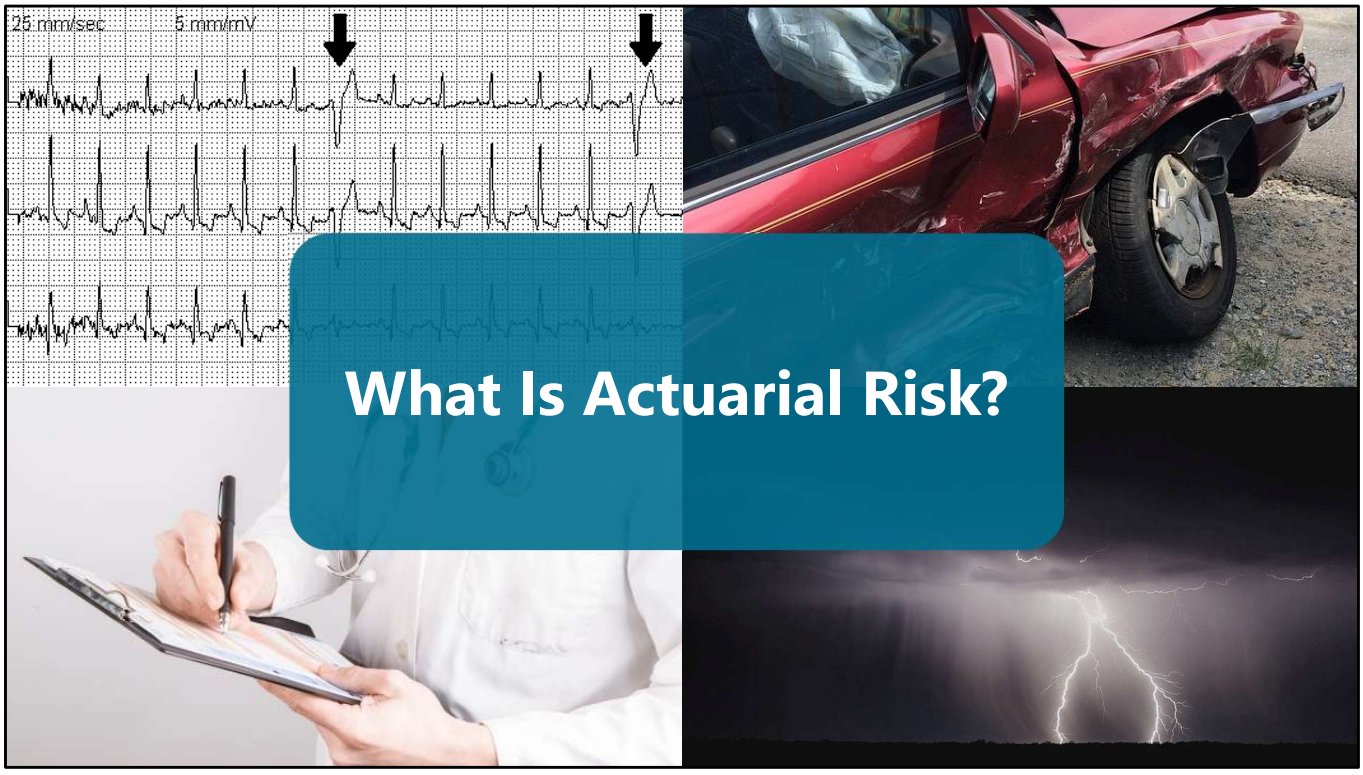
THE SDM RISK ASSESSMENT

Purpose
To be refreshed on the SDM risk assessment.

Example
Risk is about the long term and prevention of future system involvement. Instead of imminent danger of serious harm, we are asking about the probability that a family will be involved in a subsequent investigation in the next one to two years. That may sound like we are trying to predict the future, but we are really trying to assess the odds using a research-based actuarial assessment.

Purpose
To be oriented to which decision the risk assessment helps with.

Example
Let's look at the risk assessment. It helps us categorize the families we encounter into levels of risk of future system involvement. After assessing for safety, we need to turn our attention to this.



Purpose
To understand that the SDM risk assessment is an actuarial assessment.

Example
So, what do we mean by an actuarial risk assessment? Actuarial science is the method that insurance companies use to analyze what *actually happens* to their customers in order to anticipate what they should charge for insurance policies. This strategy, highly successful in that industry, is what Evident Change also used in constructing the SDM risk assessment for California.

Actuarial research is statistical analysis that classifies people based on the likelihood of certain behaviors. It is a simple statistical procedure for estimating the likelihood that a "critical" event will occur at some future time. The insurance industry uses this process to identify which drivers are more likely to have accidents and then bases their insurance premiums on this classification by factors such as driver's age or model of the car.

Teens and new drivers, for example, are identified as high risk regardless of any other characteristics because data show that they are involved in more accidents and are more likely to speed. Homes in areas of catastrophic natural disaster (flood, earthquake, fire) are considered high risk because those events are likely to recur and likely will damage homes if they do recur.

Health care also uses actuarial research to identify individuals at high risk for disease. In the media, we frequently hear about those at risk for heart disease, diabetes, or high blood pressure. These characteristics, in turn, are risk factors, some of which can be addressed to increase our life span.

In child protection, we seek to identify those individuals who are more likely to experience a recurrent investigation, so we can engage them in ongoing services to reduce the potential for subsequent harm.

RISK IS ABOUT LIKELIHOOD

Would you be glad to know whether the family you were working with had a . . .

- 1:2 chance of coming back?
- 1:6 chance?
- 1:12 chance?

EVIDENT CHANGE

Purpose
To discuss how risk in the SDM system is the likelihood of a family returning for investigation within 18 months.

Example
Risk in the SDM system is different from how many in child welfare currently use the term. In pop culture and in legislation, risk is equated with dire consequences resulting from certain behaviors. Raise your hand if you remember Tom Cruise in the 1983 movie *Risky Business*.

When we talk about risk, we are talking about the likelihood of a future investigation for a family for child abuse or neglect. Families at high risk are more likely to come back into contact with the system by having a subsequent referral and investigation, and they are the ones we want to target with additional supports and ongoing protective intervention services.

SDM RISK ASSESSMENT OFFERS A CLASSIFICATION SYSTEM

Classification

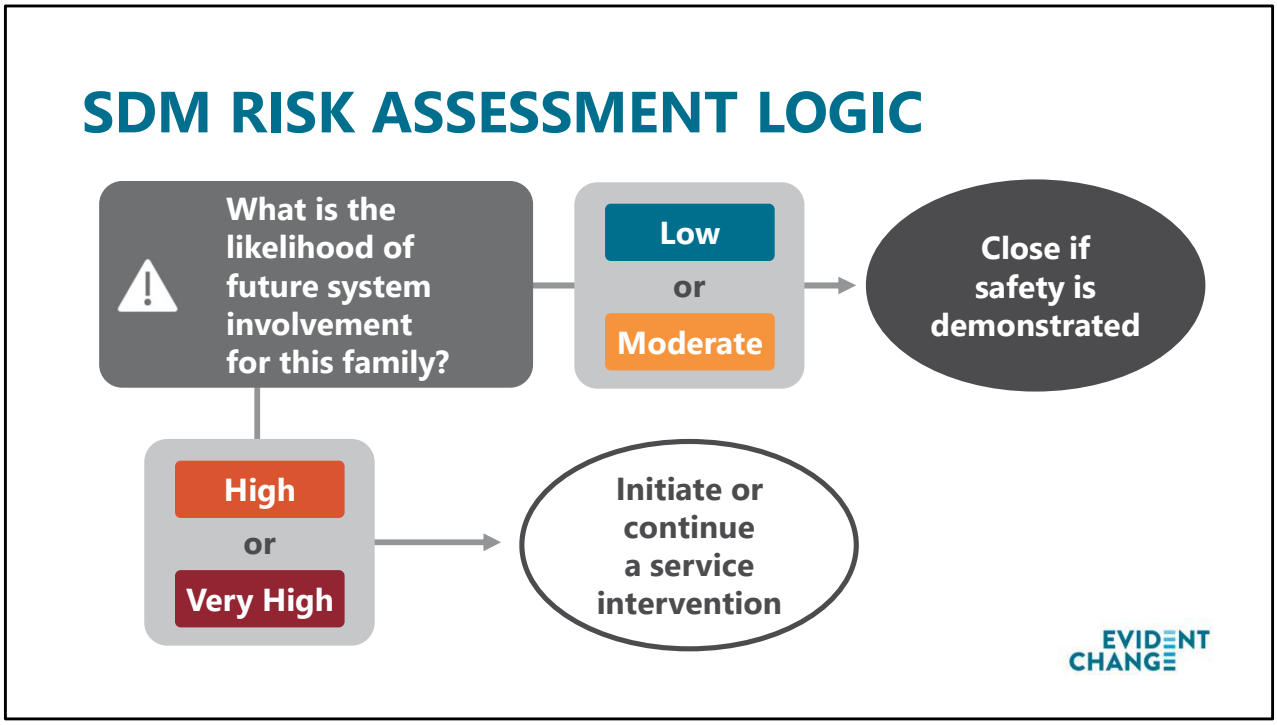
~~**Prediction**~~

EVIDENT CHANGE

Purpose
To differentiate the risk assessment as a classification system from a predictor.

Example
This is just another reminder that risk assessments cannot predict every future outcome. Instead, they help us get a better sense of which families are more likely to have another child protection investigation. They also help classify which families to consider for services in order to have the most significant impact on outcomes.

It is important to distinguish prediction from classification. The SDM system cannot predict who will maltreat a child any more than we can predict where the next earthquake will happen. That would take a crystal ball. Even among the lowest-risk families, a small percentage do maltreat their child again; and some high-risk families will not end up with agency involvement ever again. And we know that there are child maltreatment situations where the families are never involved with the agency, and we never learn about them. What the risk tool can do is classify families according to their likelihood of future child welfare involvement and/or investigation, which then allows workers to target resources to families at the highest risk for subsequent referral and investigative contact.



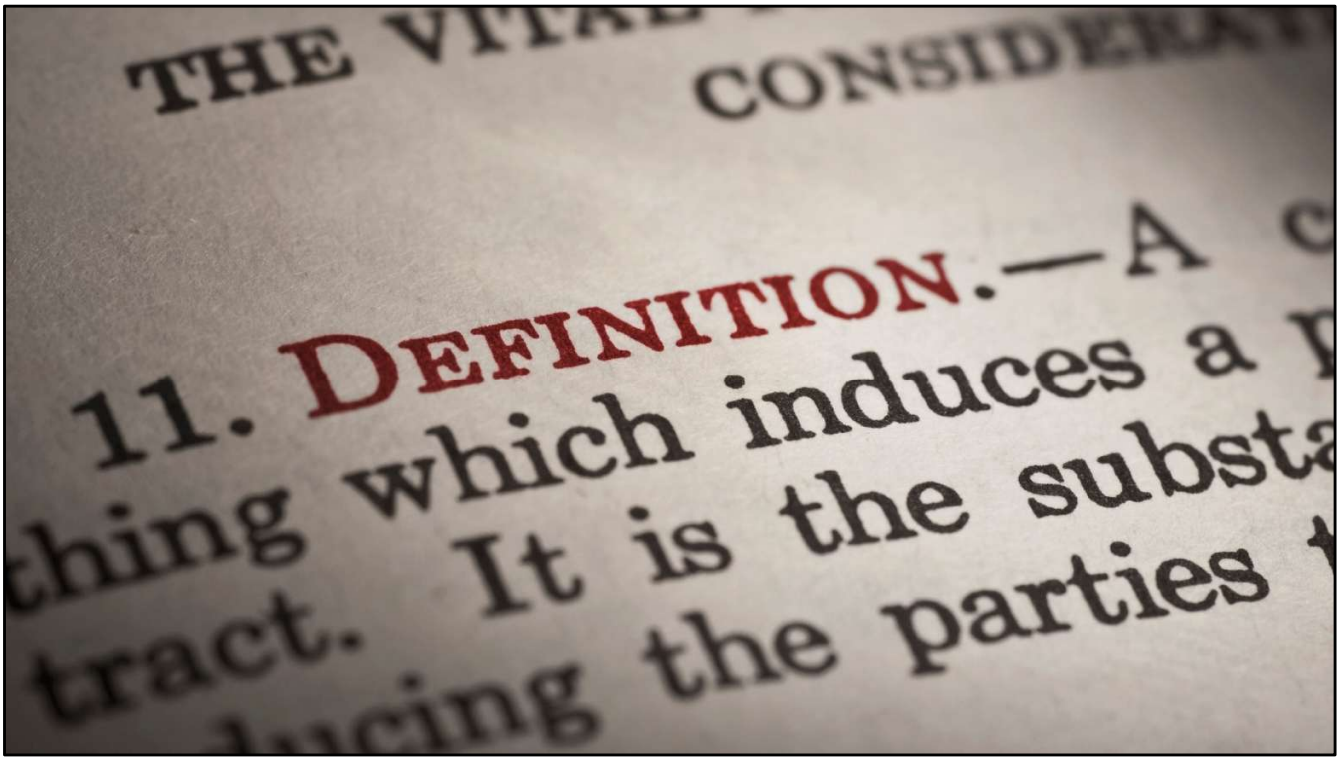
Purpose
To see how the risk assessment guides decision making on whether a family should receive service intervention or whether to consider case closure.

Example
The risk assessment identifies families with very high, high, moderate, or low probabilities of becoming involved with child welfare in the future. By completing the risk assessment, the worker gets an objective assessment of the likelihood that a family will return to child protection in the next 12 to 18 months.

Differences between the risk levels are substantial. High-risk families have significantly higher rates of subsequent referrals, investigations, and substantiations, and removals than low-risk families do.

The risk assessment is based on research examining the relationships between family characteristics and the outcomes of subsequent system involvement related to abuse or neglect. The assessment does not predict recurrence; it simply assesses whether a family is more or less likely to have future involvement with child protection. The results of the risk assessment help guide the decision of whether the family should receive intervention services or we should consider closing the investigation.

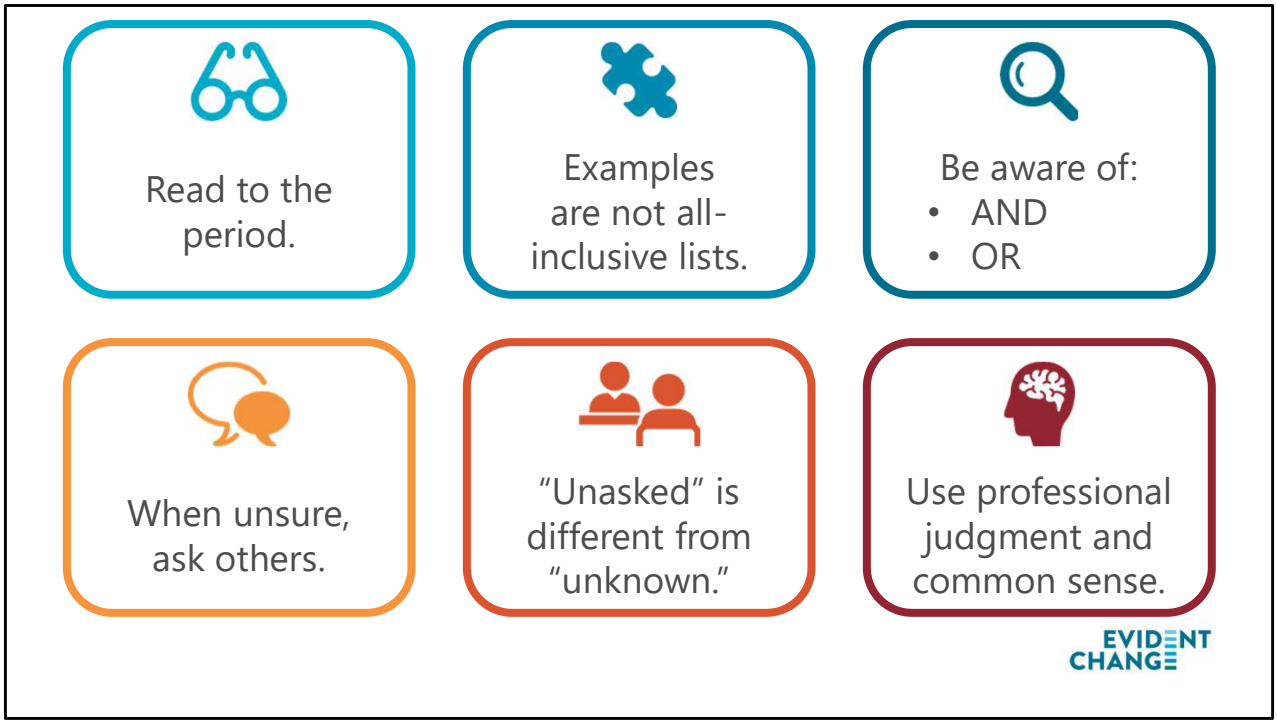
Between the final safety result and risk level, the agency has well-reasoned and researched information to inform its recommended action. The worker will discuss this recommendation with their supervisor before making a final decision.



Trainer Note
This slide will repeat in each assessment section. It offers a chance to underscore the importance of consulting the definitions.

Example
If you hear nothing else that is said during this training, hear this part. You need to use the definitions. Definitions are the most important part of the SDM system. You need to *refer to* the definitions and *use* them when applying the SDM assessments.

Remind yourself and your staff about this critical habit in using the SDM system.



Purpose
To be reminded of the importance of understanding and using the item definitions in the P&P manual.

Trainer Note
Review this information again with participants.

SDM RISK ASSESSMENT: TWO SCORES

- The 16 items are the best of several hundred tested.
- Neglect and abuse indices
- Final risk level

EVIDENT CHANGE

Purpose
To walk through the sections of the risk assessment tool.

Trainer Note
Direct participants to the risk assessment and supporting sections in the P&P manual available via the QR code (note that the pdf version at this link has the scores for each item, while the Definitions site used earlier in the training does not). Inform participants that the WebSDM application version looks different from the paper-based version of the risk assessment tool. In the automated version, workers select the answer to a risk item, and the SDM application automatically tallies and totals the neglect and abuse scores.

Example
One thing to know about our risk assessment is that hundreds of items were tested, and the 16 on the assessment were the "varsity team" among all of them. The risk assessment tool has two sections. The main section of the tool consists of the abuse and neglect indices, which are scored separately.

The first column on the paper-based version includes questions that relate to the likelihood of future involvement with the child protection system related to neglect, while the second column relates to the likelihood of future involvement related to abuse. You can see that several of the questions add to one score but not the other. This is because conditions correlated to an increase in the future chances of an investigation for neglect are slightly different from those that increase the chance of investigation for abuse.

In answering each item, include anything that would have been present on the date of the reported incident or that has become present since then. Think of a risk factor like an

"on" switch: Once it is turned on, it stays on for the purpose of this initial risk assessment tool.

If you lack the information necessary to answer a particular item, answer it as "no." However, supervisors should recognize that this degrades the assessment's utility and every effort should be made to gather the needed information.

The supplemental questions are designed to determine if revisions are needed to improve the tool's performance by potentially including additional, different questions that later show a stronger correlation to risk of future investigation than other items currently on the tool. The supplemental items will not affect the overall risk score; they are for aggregate data collection and later examination only.

After answering all items, you will have total scores for risk related to neglect and risk related to abuse. The SDM application will total the neglect and abuse scores automatically. The higher of the two classifications determines the family's scored risk level—you would not add them together. (For example, a family with 1 on the abuse index and 3 on the neglect index would be classified as moderate, as the neglect score is the higher of the two scores, and a 3 on the neglect index indicates a moderate risk level.)

Trainer Note

Activity
Assign small groups one to three risk items to review, discuss with one another, and plan for how to teach to the rest of the group during report-out. Ask them how they would determine or find the information.

Allow small groups some time to review the items and definitions together. Regroup and ask groups to report out and teach the whole group about each item as they were assigned.

RISK ASSESSMENT: OVERRIDES

- Case conditions that create very high risk
- Discretionary

EVIDENT CHANGE

Purpose
To understand supervisory input for risk assessments.

Resource
P&P manual, risk assessment

Example
Other than supporting accurate selection of items based on definitions, the primary supervisory task for the risk assessment is to approve overrides. Overrides are included on the risk assessment and the risk reassessment because no assessment can account for all possible situations. Even though overrides should be used only about 5–10% of the time, it is important to use them when appropriate.

As a supervisor, your responsibility is to approve or reject overrides your workers are considering. If a worker selected any of the case conditions that create very high risk, the process for approval or rejection should be straightforward: Is there evidence to support the specific condition that was selected? If yes, then it is appropriate. If not, ask for the worker's rationale for selecting it. Maybe it does not quite meet the definition, or maybe it should be a discretionary override.

Discretionary overrides require additional critical thought, as there are no options from which to select. One example of a discretionary override may be a case where, even though the family was assessed as low risk, you know the caregiver (1) recently had a parent or close family member pass away; (2) is experiencing severe situational depression (not diagnosed or recommended for treatment but is self-reporting symptoms); and (3) does not have support network members around for help. The case specifics would need to be considered, but this is one example of when a discretionary override may be appropriate. Another example would be a former foster

parent who injured a foster child in the past (so item 4 was selected), but no case was opened because the foster youth was moved from the home. However, a case *would have been opened* if it had been a biological child of the foster parent; and when a subsequent investigation found a safety threat for the biological children, the worker reasoned that item 3 would apply and considered adding a point to both risk scores.

On the other hand, just because a worker has a "worry" about a family does not mean that an override should be applied. The actuarial risk assessment is very good at what it does: classifying families based on the likelihood of future child protection involvement. As a supervisor, it will be vital to work through what is truly a unique circumstance and what might be worrying but not worthy of an override.

Supervisors should also be on alert for cases that do *not* have an override selected when their knowledge about the household raises concerns for them. Should the worker have selected one?

Finally, if risk is low or moderate and there is some other reason to open a case or refer to prevention services, do not feel pressured to override the risk score. Simply document the rationale for taking a different action than the score recommended. This will prevent households from being included in the wrong category during future revalidation studies.

RISK ASSESSMENT: ACTION TAKEN DIFFERS FROM RECOMMENDED ACTION

- Open or close
- Basis for choosing a different action

EVIDENT CHANGE

Purpose
To understand that selecting a different action than recommended is okay; it just needs to be explained.

Resource
P&P manual

Example
The last section of the risk assessment asks about the planned action. There will be some cases where the risk level is high and you agree that it is appropriate (i.e., no override is present); but for some other reason, working with that family may not be feasible.

In these cases, you would not want to use an override because initial risk scores cannot be lowered. Instead, you would indicate in the Planned Action section why you are taking an action that differs from the tool's recommendation.

For example, let's say a family was assessed as safe on the safety assessment and high risk on the risk assessment. You offered the family services, but they declined, and you had no legal basis to compel the family to engage in permanency services. You may need to close that case despite the high risk level. In this circumstance, you would want to thoroughly document the rationale for closing the case (the family did not agree to services, and you had no court order compelling them to work with you) as well as any efforts made to engage the family outside of a court order.

On the other hand, for a family assessed as safe on the safety assessment and high risk on the risk assessment, your planned action may be to close the case because the family already has a strong and large support network that will serve them in the same fashion that child protection would. If the family is already doing what you would be doing with them with a broad and dedicated support network, you may decide to close the case

even though you agree that the risk level is high.

SDM RISK ASSESSMENT: POLICY AND PROCEDURES

- Which cases
- Who
- When
- Decision

EVIDENT CHANGE

Purpose
To be introduced to the risk assessment tool policy and procedures.

Example
Now that you have an idea of how to complete the assessment tool, it is important to know a few details about when to use it and what to do with the results.

Trainer Note
Ask participants to look at the risk assessment tool's policy and procedures section in the P&P manual.

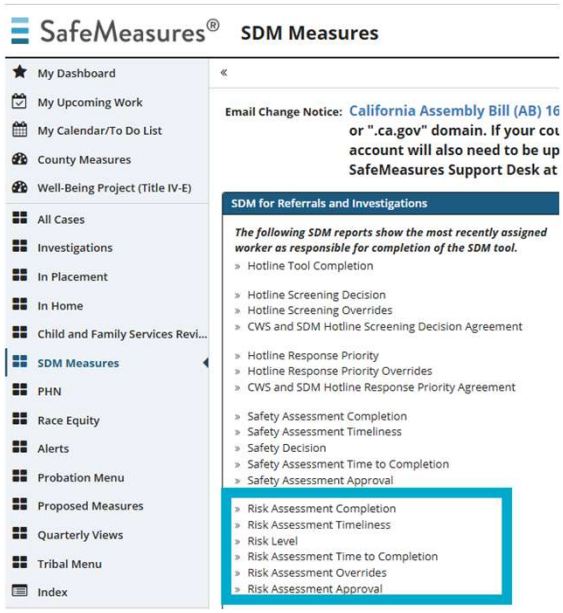
Walk through each section with participants.

Review policy and procedures for "which cases," "who," "when," and "decision" for which the risk assessment should be completed. Notice the change from January 2024 excluding investigations on already open cases.

Example
Raise your hand if you think lower caseloads for Emergency Response would be a good thing. [Most everyone in the room should raise their hand.] What could you do with an investigation where the household was safe and the risk was low or moderate sooner rather than later? [The answer that should come up is "close it."] In these investigations, the risk assessment tool can be completed shortly after the safety assessment tool is completed (when there are no safety threats and there is no evidence of abuse or neglect, for example). Other times, the worker and family will engage in mitigating safety threats, and risk assessment will come later in the process. And at other times, all information will not be available to complete the risk assessment while the worker

contacts collaterals, other professionals, and so on. As a rule, complete the safety assessment tool and then begin to probe for answers to risk items—do not leave the risk assessment tool to the end of the investigation process.

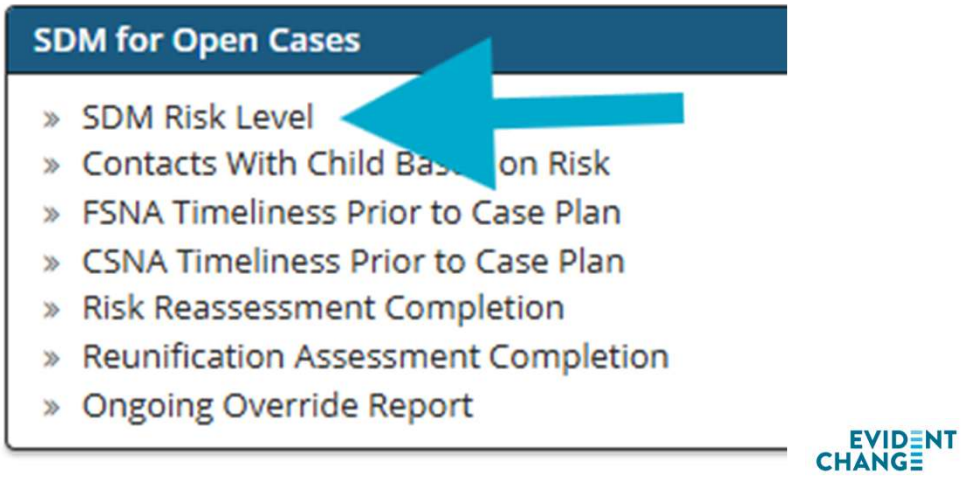
SAFEMEASURES



Purpose
To be reminded of SafeMeasures reports to support learning about how staff are using the assessments.

Example
This is just a reminder to take a closer look at your SDM outcomes by unit and worker using SafeMeasures reports.

SAFEMEASURES



Purpose
To be reminded of SafeMeasures reports to support learning about how staff are using the assessments.

Example
In Continuing Services, you can look for cases that might be ready to close sooner rather than later by checking the risk level for the families in your unit.

Purpose
To practice the risk assessment.

Resource
Risk Activity handout

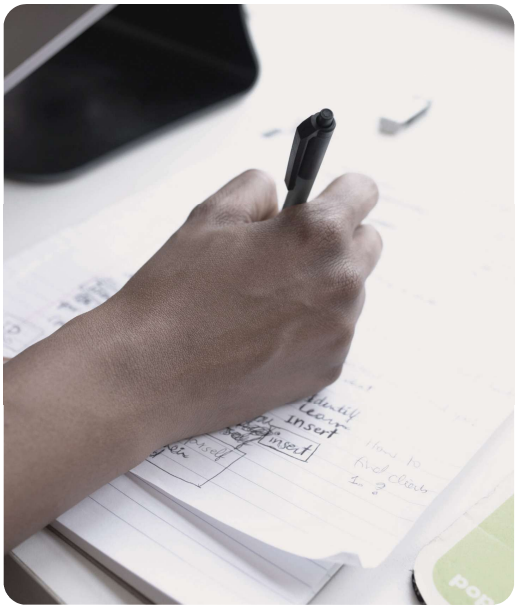
Trainer Note
Break participants into groups of two to three. Have them read each of the items listed in the risk activity and determine how they would be scored on the risk assessment. Lead a report-out when the whole group reconvenes.

RISK ASSESSMENT DOCUMENTATION

Workers should document:

- Evidence that supports item responses; and
- Whether the case-opening decision/action differs from the recommendation.

EVIDENT CHANGE



Purpose
To discuss the importance of documentation.

Example
As with all SDM tools, the case narrative should include evidence of specific observations that support the items selected for the risk assessment. All items selected should be supported with documentation. For example, an answer that the primary caregiver has a past or current substance use problem should accompany narrative describing the evidence that meets the definition's threshold for this. This may include self-report, specific witnessed events, treatment records, worker's observations, police records, etc.

In addition to including documentation that supports specific items, workers must also document the planned action decision if it differs from the recommended response.

PRACTICE

- Approve override
- Override risk level or recommend alternative action

EVIDENT CHANGE

Purpose
To practice working with overrides (knowing when to override the risk level versus approve alternative action, and when to do neither).

Resource
Override Worksheet handout

Activity
In groups of two to five, turn to the override worksheet where you will see several examples of workers' rationale to override a risk level or take alternative action. Discuss and come to consensus if you would approve the override as described or the alternative action to the assessment recommendation.

TALKING WITH FAMILIES ABOUT RISK

- Gather information
- Create a game plan
- Have a conversation

EVIDENT CHANGE

Purpose
To be introduced to talking about risk with families.

Resource
Talking With Families About Risk handout

Example
It may be useful to prepare for your interviews with families by looking at the risk assessment items and sequencing them logically. Before you even leave the office, look at the questions related to review of historical information. You can most likely answer these before you go out, but verify them with the family for accuracy.

Next, a number of questions pertain to children. It is often easy to begin an interview by asking about the children.

One question relates to housing. You are likely either in the house or aware that the family is unhoused. You can take a moment to confirm that you and the caregiver see this information in the same way. If not, what is different? Be sure you have enough information to answer the question.

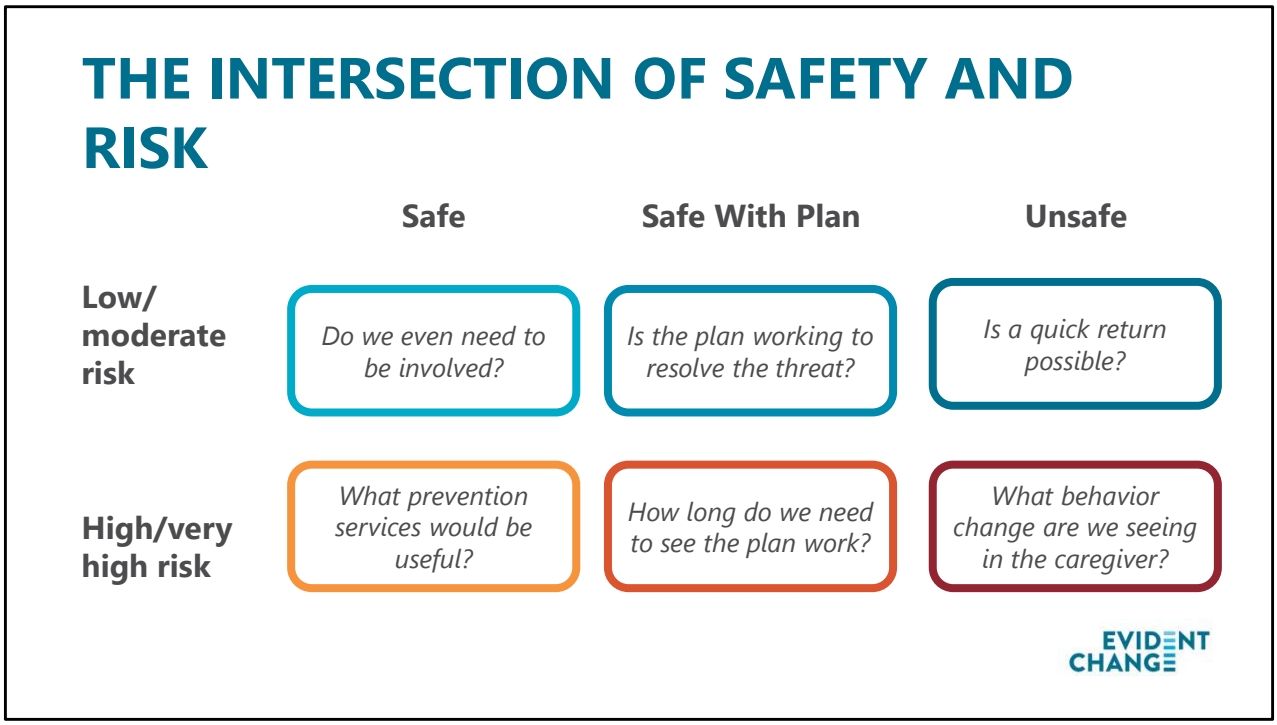
Some questions ask the caregivers about how they parent and their style or beliefs about parenting. You can introduce this conversation and keep track of what is said if you organize your interview notes in this way.

Finally, the most sensitive questions are about a caregiver's personal history. If you have done well in establishing a trusting relationship, you are more likely to get honest answers at this point.

The nice thing about keeping notes this way is that if you learn an important detail about a child while a caregiver is describing their journey, you can quickly get that piece of information to where you will be able to find it later.

Purpose
To highlight widespread lack of resources available and the use of the risk tool in targeting resources.

Example
Raise your hand if your county has unlimited resources to offer prevention services to every family involved in an investigation. [No one will raise their hand.] Because nearly every jurisdiction has more families referred to the hotline than they can serve, decisions about where to focus the limited resources available should be structured, consistent, and accurate. And we also want to make sure that these decisions have the greatest impact on reducing future system involvement for children. This is done by ensuring that our limited resources are being used to help the families who are at greatest risk of reentering the system and could benefit from the services we have available.



Purpose
To have the idea of investigation resolution support from the SDM assessments reinforced.

Example
On a prior slide in Day 1, we made a point to separate safety and risk. We do that in part so we can look at the intersection of the two and what we can consider for families based on the results.

This decision matrix can help us think about our work with the families through some decision support. For the families that are "safe" on the safety assessment and low/moderate risk, we can ask ourselves: Should we be involved with them at all?

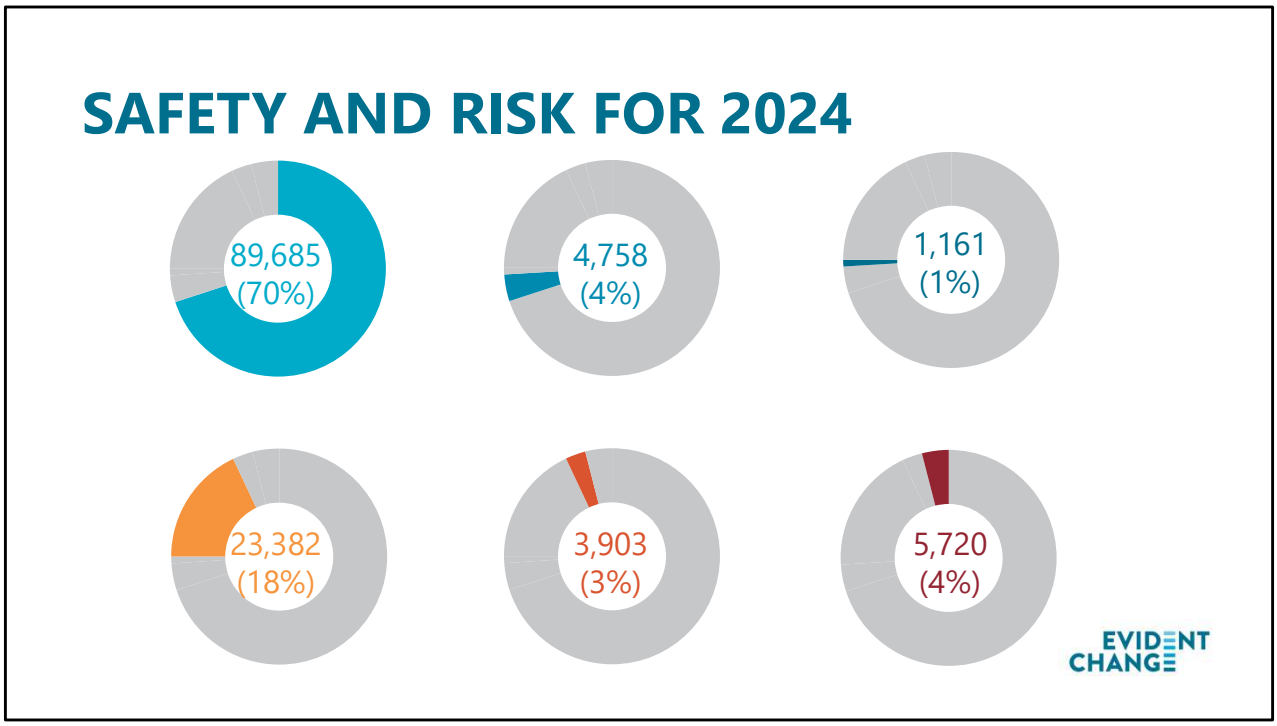
For the families who were "safe with plan" on the safety assessment and low/moderate risk, we can create a safety plan and keep the child in the home. These families had a temporary crisis; but because of being low/moderate risk, once this crisis is resolved, it is unlikely to recur. Very early (meaning even within the first 30 days), we should ask, "Is the plan working?" and "Has the caregiver demonstrated actions of protection?" If so, we may be able to step out of that family's life relatively quickly. (You should be sure the safety threat is resolved and that risk is still low or

moderate.)

For the families who have a safety decision of "unsafe" and are low/moderate risk, we can ask, "Is a quick return home possible for these children?" A family with a one-time unfortunate event might fit this category if they do not have many other risk factors. The safety assessment finding will likely be "unsafe" based on a single unfortunate event, but the risk level may be low as there were not lots of risk factors in the caregiver's life. Even if a removal was temporarily needed, a "low" risk level suggests that we may be able to return the child home quickly once the danger is resolved. With brief post-reunification support, we can verify that the child is safe and risk is still low or moderate and close the case.

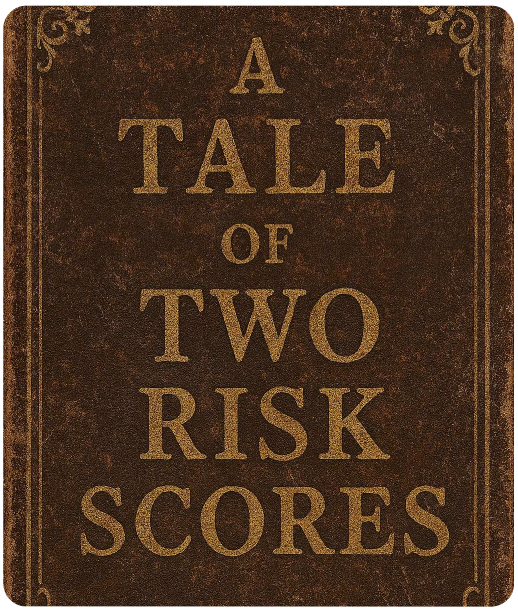
On the bottom row, for families with a finding of "safe" on the safety assessment who are also high or very high risk, we might ask, "What preventive actions can be taken to address the elevated risk factors?" These families may look stable in the moment, and we often are tempted to conclude that everything is okay and we can close the case after the referral. But nearly 18% of high-risk families and nearly 23% very high–risk families will be re-substantiated for abuse or neglect within two years. It would be better to engage the family in working toward sustainable safety now.

For families found to be "safe with plan" and high/very high risk, we might say, "We need to see the plan working a little longer to have comfort that it will stick." The families who are "unsafe" on the safety assessment and have a high/very high risk level are those for whom we have the most concern. For these families, we need to see sustainable safety demonstrated for some time before feeling comfortable that the children can go home. Sustainable safety is reflected in the SDM reunification assessment, where we look at progress toward case plan goals, visitation (including the extent to which the caregiver demonstrates actions of protection during visits), and safety (including whether the original safety threat was resolved).



Purpose
To see the percentage of safe and low-/moderate-risk families in California in 2024.

Example
Remember in the policy section when we asked if lower caseloads for ER workers would be a good thing? This 70% of families is where we can make a difference for the workforce. If we knew within 5–10 days that a family was safe and low or moderate risk and we closed those investigations quickly, what impact would that have on caseloads?



PRACTICE

- What jumps out about various items in the different households based upon the children's ages?
- Which items could benefit from services or support?
- Which items speak to the current circumstances for the children in the home?
- How could decisions about service interventions be guided by this information?

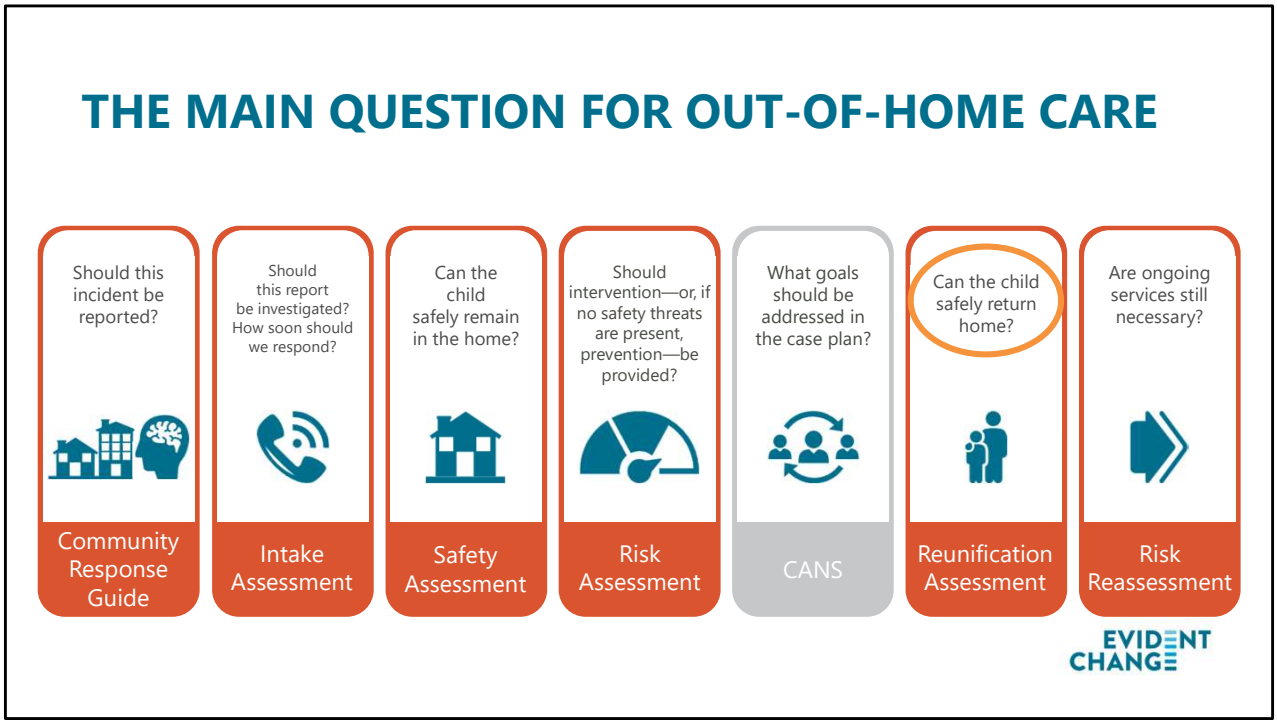
Purpose
To understand the nuance in risk scores between two households and consider the implications for service provision.

Trainer Note
Divide participants into teams of three to five.

Example
Open your participant guide to this activity. As a small group, follow the directions in the activity, assign a scribe to record your answers, and come up with answers to these questions.

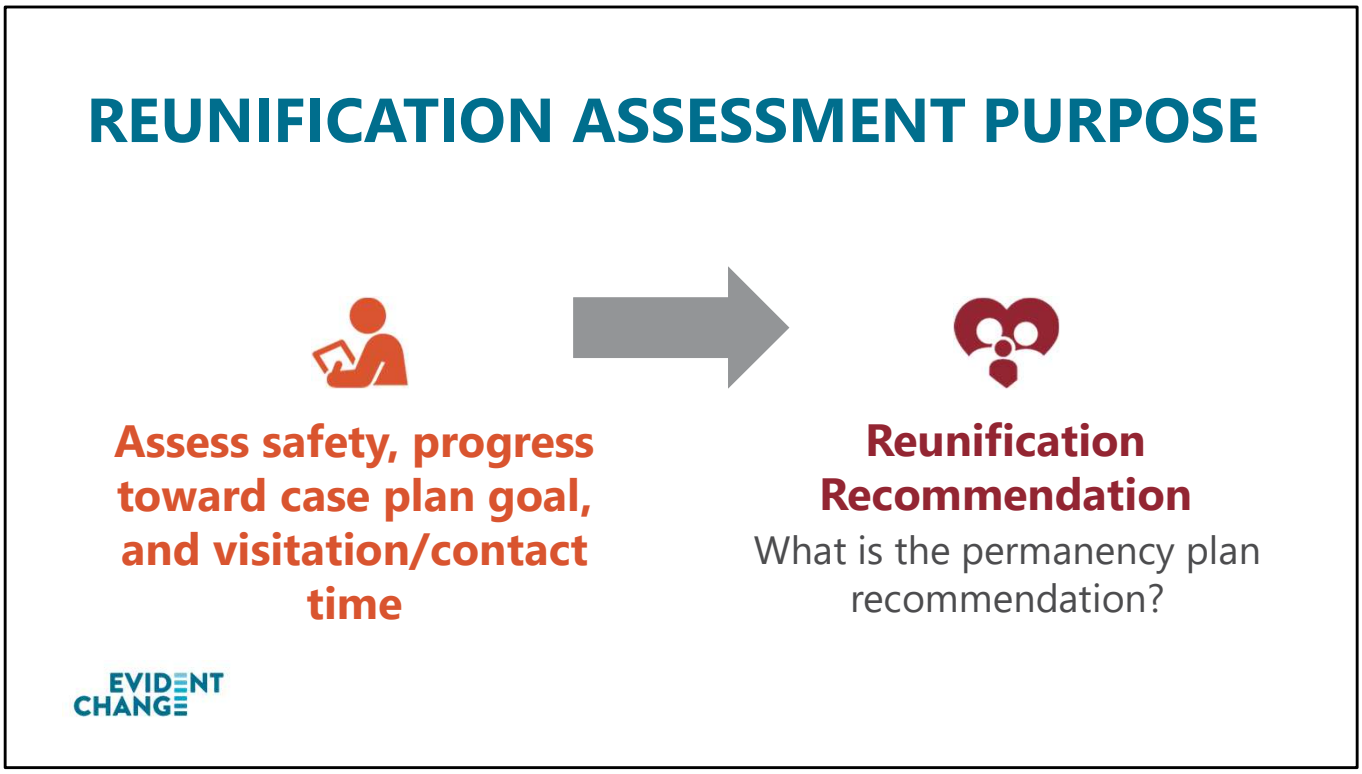
Trainer Note
If participants ask, the numbers in the table are the numeric weight assigned in the assessment to the answers selected for each household. In the debrief, the three-teens household has many more "static" items selected. The three-under-5 household has several items that could be mitigated with services if the family would participate in them, so we might consider investing more time in helping the second household see the value in prevention services than the first one. Also, what would they want to know from the worker before closing the first household despite the risk score?

Purpose
To segue into the reunification assessment.



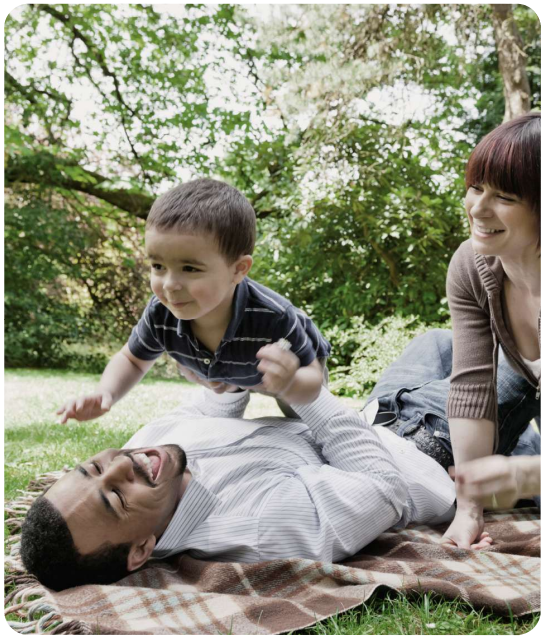
Purpose
To be oriented to which decision the reunification assessment helps with.

Example
Let's look at the reunification assessment. It can help with two important issues. One is what should be on the case plan. Now, we can see on this slide that the CANS is the statewide mandated assessment related to this question; *but*, the reunification assessment can tell us what the *core* issues are to address for a successful case plan. Consider the difference between an X-ray image and an MRI. The X-ray will tell us if there are fractured or dislocated bones, fluid in lungs, or some tumors present in soft tissue. They are quick and readily available for emergencies. An MRI, on the other hand, can give a detailed picture of all the soft tissue, neurological structures like our brains and spinal cords, and organs and joints in greater detail. But they are more complex to set up, schedule, and administer so they take more time and effort than X-rays. Both are useful and in combination can assist with determining a best course of action for regaining health.



Purpose
To be oriented to the reunification assessment's purpose.

Example
For families with a child in out-of-home care and a goal of reunification, the SDM reunification assessment will help the worker determine when a child can safely return to the home or when a change in permanency goal should be considered.



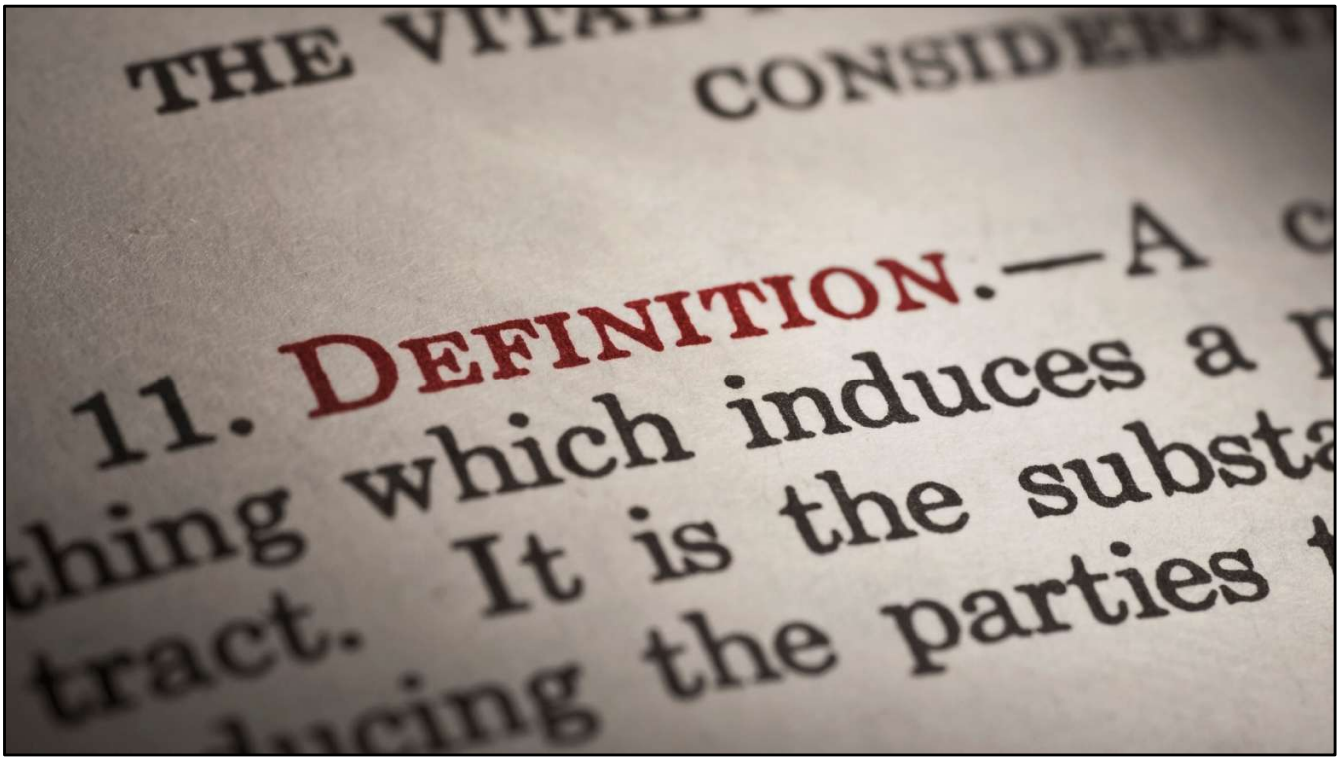
REUNIFICATION ASSESSMENT: THREE MAIN SECTIONS

- Case Plan Progress
- Visitation Evaluation
- Safety Assessment

EVIDENT CHANGE

Purpose
To have a high-level overview of the reunification assessment components.

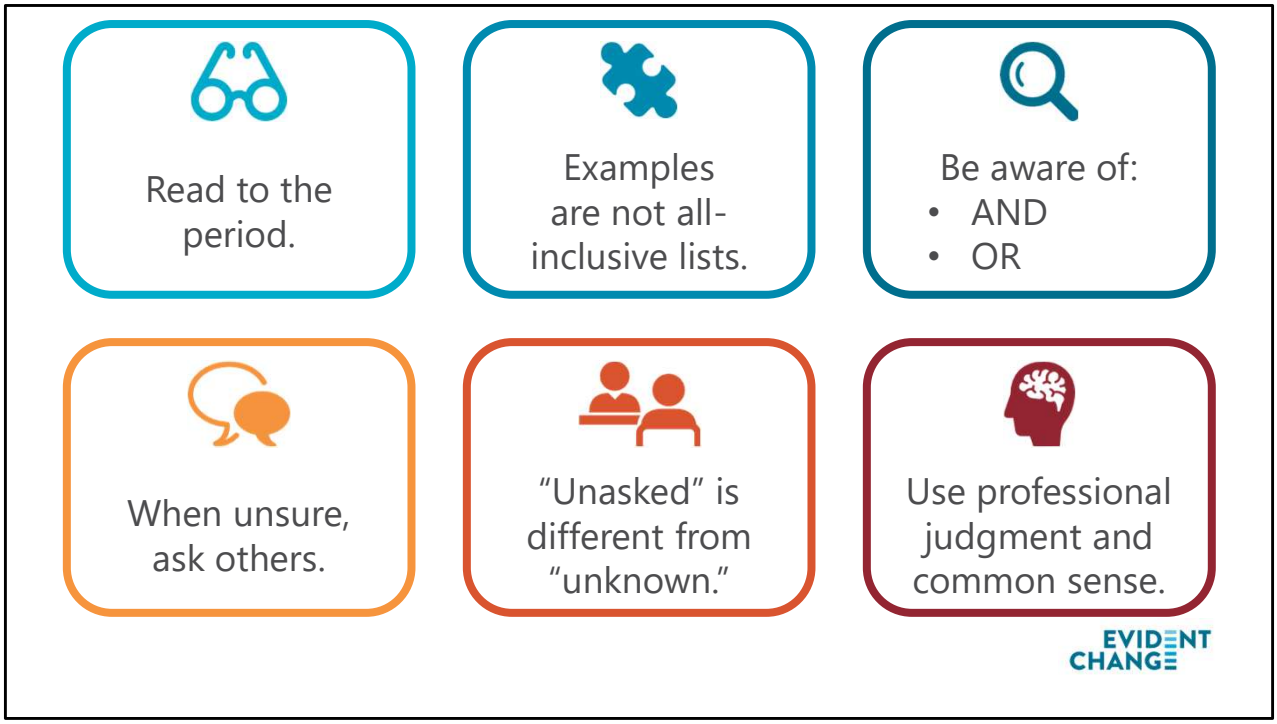
Example
The SDM reunification assessment includes a case plan progress assessment of the caregiver's behavior change, an assessment of visitation, and an assessment of safety. These result in a recommendation to reunify, maintain reunification services, or change the permanency goal. When developing the reunification assessment, workgroup members identified three main components of their decision making: safety, risk mitigation in terms of behavioral changes as indicated by progress toward achieving case plan goals, and visitation assessment. Workgroup members weighted the most important components in order as: (1) safety, (2) case plan progress when thinking about sustainability, and (3) demonstration of behavioral change through an assessment of visitation. When we look more closely at the assessment, you will see how each of these components factors into the reunification recommendation.



Trainer Note
This slide will repeat in each assessment section. It offers a chance to underscore the importance of consulting the definitions.

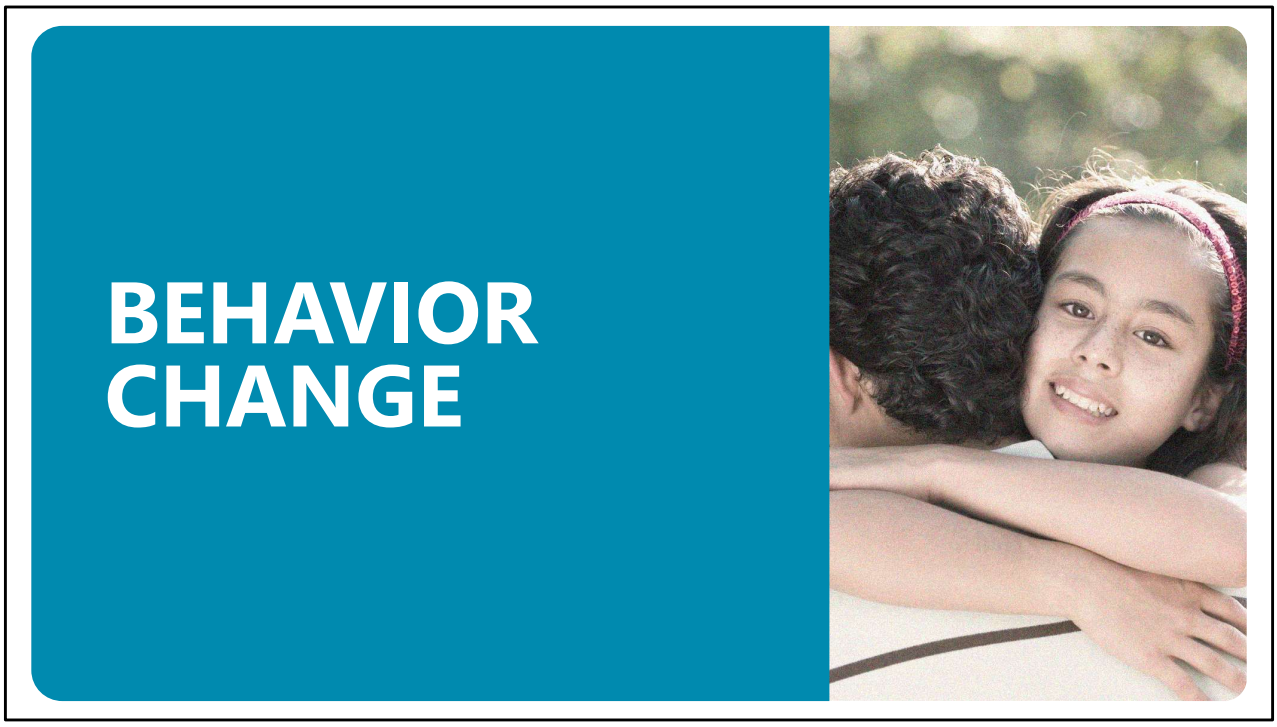
Example
If you hear nothing else that is said during this training, hear this part. You need to use the definitions. Definitions are the most important part of the SDM system. You need to *refer to* the definitions and *use* them when applying the SDM assessments.

Remind yourself and your staff about this critical habit in using the SDM system.



Purpose
To be reminded of the importance of understanding and using the item definitions in the P&P manual.

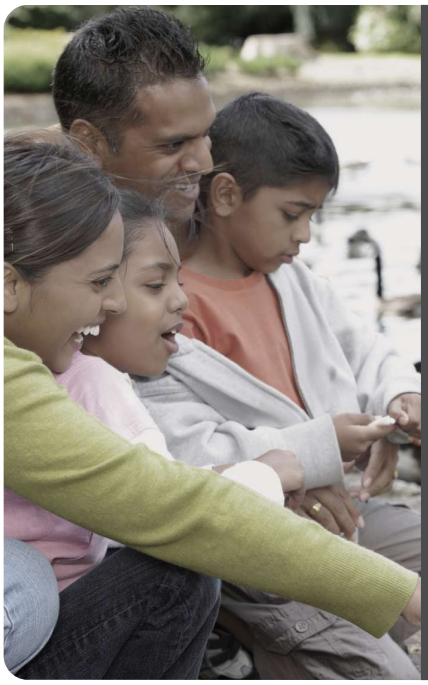
Trainer Note
Review this information again with participants.



Purpose
To dive deeper into Section A: Reunification Risk Reassessment.

Trainer Note
This is the title of the section, but *emphasize* that the focus is on the caregiver's behavior change.

Example
The reunification assessment begins with an assessment of behavior change by the caregivers in the household to which the child may be returned. The worker must assess behavior change described in the case plan and how the initial risk concerns were reduced or determine if more progress needs to be seen (and if the caregivers need more support), paying attention to static versus dynamic factors. If the case plan is not addressing behavior change, the worker must make changes so that it does and submit the revisions to court.



VISITATION PLAN EVALUATION

Purpose
To look at Section B, Visitation Plan Evaluation.

Example
This section looks at caregivers' actions to maintain engagement with each child in out-of-home care, as well as their behavior with and around each child during these visits. When completing this section, focus on interactions during the period under review, either since placement or since the last reunification assessment.

The first item looks at the visitation attendance and how the caregiver is following the visitation agreement. Assess whether the caregiver consistently follows the visitation agreement schedule, inconsistently follows the visitation agreement, or does not follow the visitation agreement.

The second item looks at the caregiver's behavior during contact with the child. When answering this item and evaluating appropriate limit setting and discipline, consider the setting; the child's energy, development, and emotions; and the limited time the caregiver and each child have together.

If the caregiver's behavior is within the range of healthy parenting responses and

demonstrates a good understanding of child development and their child's personality, likes, and dislikes, answer this item "strong" or "adequate." A caregiver's expression or display of normal parental exhaustion or frustration should not alone disqualify a caregiver from these answers.

If the caregiver does not demonstrate behavior within the range of healthy parenting responses, demonstrating little to no understanding of child development and limited interest in displaying positive parenting techniques or limited ability to do so, answer this item "limited" or "destructive."

If there are two caregivers, answer each of these items individually for each caregiver. If there is a difference between the caregiver's actions and engagement, be sure to describe the discrepancy with behavior-specific detail.

Purpose
To look at Section C: Reunification Safety Assessment.

Trainer Note
As of 2026, the safety section does not appear unless the other two sections are "acceptable" in California, but that will change when it is revised; so be aware of this change in future deliveries.

Example
The reunification assessment also includes the reunification safety assessment on the household to which the child may be returned.

The worker must address the safety threats identified at removal and any new or emerging safety threats. Documentation of how the initial safety threats were resolved is required. A child may be reunified if a safety threat exists as long as a protective intervention is in place (and documented) to ensure the child's safety.

When completing this section, you should first review the safety assessment that led to the child's removal and determine whether any of the identified safety threats are still present. If the answer is yes, consider whether any interventions can be implemented to mitigate these concerns.

If none of the original safety threats are present, assess the home for all other safety threats on the safety assessment to determine whether any are present. If so, determine if any

interventions can be implemented to mitigate them.

Your answers to the questions in this section will lead to one of the following safety decisions.

Safe
No current safety threats have been identified at this time. If a child were to return home today, there would be no current safety threats; and any safety threats that were previously identified have been addressed through caregivers demonstrating protective actions.

Safe with plan
If a child were to return home today, one or more current safety threats would be present; however, caregivers are working with a safety network and demonstrating protective actions or interventions that address safety threats. The family is progressing toward safety, and case plan modifications must include interventions to address safety threats.

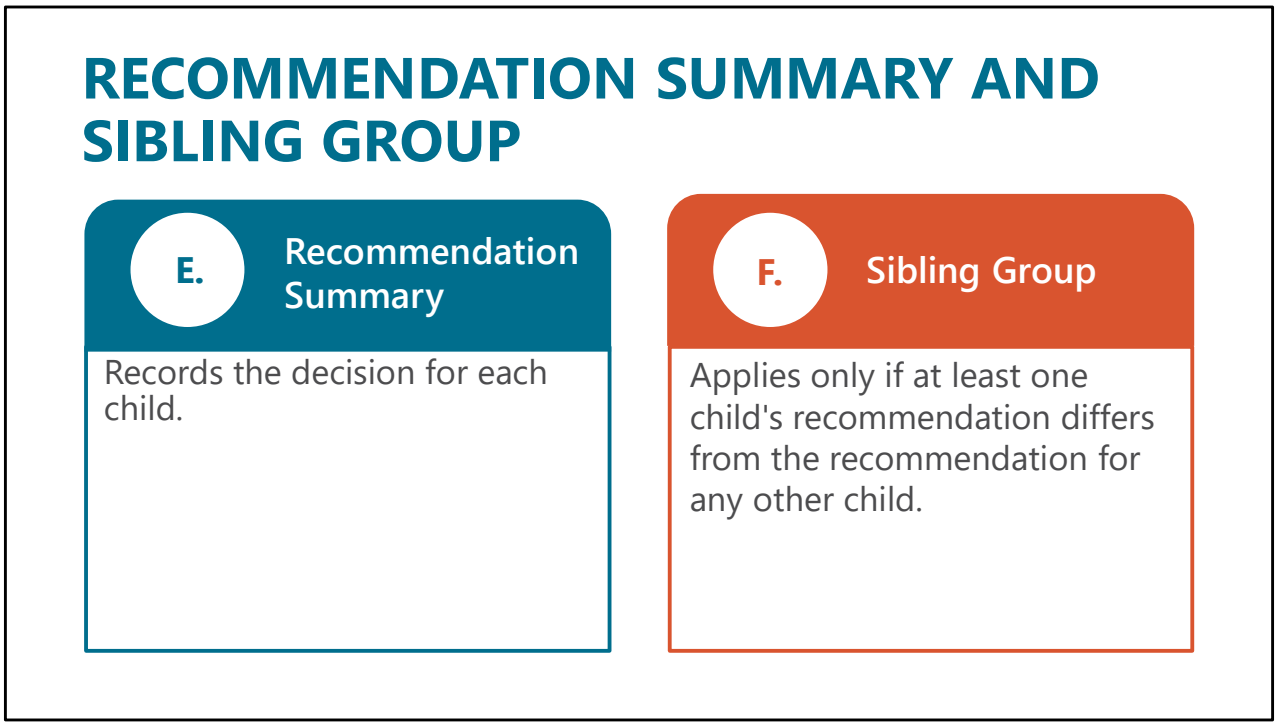
Unsafe
One or more safety threats are present, and continued placement is the only protective intervention because no caregiver is demonstrating protective actions. Without continued placement, one or more children will likely be in danger of immediate harm.

PLACEMENT/ PERMANENCY PLAN GUIDELINES

Purpose
To review the outcomes, recommendations, and next steps from the reunification assessment.

Example
The recommendations are designed to consider progress on all three sections. The expectation is that if the safety threats have been resolved or can be resolved through safety planning, and caregivers are making at least a little progress in behavior change and visits, then reunification should be the recommendation. Before we look at the final recommendations, let's look at Section D: Placement/Permanency Plan Guidelines.

Complete one of the decision trees for each child receiving family reunification (FR) services, depending on whether they were over or under age 3 upon entry to foster care, and enter the results in Section E. Complete for each child. Consult with supervisor and appropriate statutes and regulations.



Purpose
To review the use of the Recommendation Summary and Sibling Group sections.

Trainer Note
These sections are labeled as Sections E and F in the P&P manual, but they do not display the same way in WebSDM. Review slide and point out where to find the related content in the P&P manual. Ask if there are any questions.

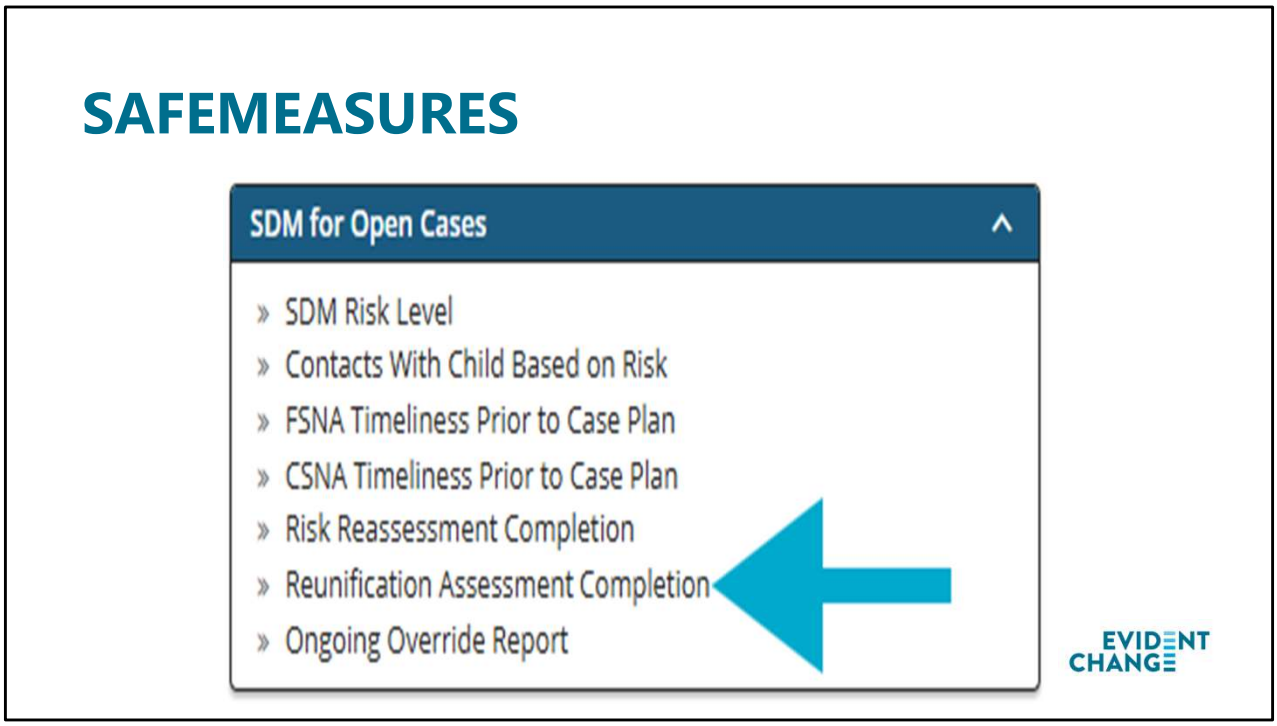
Hold a short discussion about "How do counties decide the sibling question?" because Evident Change is neutral on the question.

Purpose
To practice gathering and reviewing information to help inform reunification decisions.

Resource
Reunification Assessment Treasure Hunt handout

Example
Turn to the Reunification Assessment Treasure Hunt handout in the participant guide. Work on your own to fill in the blanks. [Give participants five to 10 minutes.]

Now that you have made some progress, work as a small group to compare notes and help your peers fill in any blanks they need help with.



Purpose
To remind supervisors that they have SafeMeasures reports to support learning about how their staff are using the assessments.

Example
This is just a reminder that you take a closer look at your SDM outcomes by unit and worker using SafeMeasures reports.

Purpose
To understand the role of supervision in monitoring and adapting our work with families well in advance of doing this assessment.

Resource
Reunification Discussion Guide handout

Example
When a teacher or professor provides a study guide for the final exam in a class, what is helpful about that? [Discussion should bring up that it helps students prepare for the exam.] If we wait until the night before the exam to pull the study guide out, will we get the best benefit from having the guide in the first place? If not, what is the better use for the study guide? [Discussion should bring up that using the study guide early and often throughout the semester would help students track their progress to being prepared for the exam.]

This is how supervisors need to support their workers and families towards reunification *from Day 1*.

[Refer participants to the Reunification Discussion Guide handout and provide time to read it alone.]

Activity
Turn to a neighbor. Discuss what the impact would be of having this conversation with caregivers every month. Discuss what the impact would be on preparedness to complete

the reunification assessment if covering these topics in every case consultation or individual supervision on FR cases.

Supervisors play a central role in setting workplace culture and tone, modeling practice, and ensuring technical pieces of practice are addressed. So, in addition to modeling healthy working relationships and shared decision making with workers and families, they are checking that assessments are completed according to policy, accurately completed based on narrative support in case records, and used to support decision making to advance the best outcomes for children and families.

ASSESS DURING EACH CONTACT

- Any change in safety (vulnerability, safety threats, protective capacity, interventions we could try out with the safety network)
- Quality of interactions during visits
- Demonstration of skills (not just compliance with services)
- Any change in needs (identification of new needs or reduced level of need)

EVIDENT CHANGE

Purpose
To know about a few areas to focus on when meeting with families during ongoing services.

Example
While the SDM model does not dictate what workers do on contacts, the SDM framework provides a way of thinking about key functions of a contact. These include the following.

- Always assess and inquire about safety. What protective actions are the caregivers demonstrating? Is the network working? Is there growth in the size of the safety network? Are safety interventions working?
- What is the quality and quantity of visitation? What supports do the caregivers need to be successful in visits?
- What progress is being made toward case plan objectives? Are family members participating in services *and* demonstrating *behavioral* change? If not, why? Are new needs or strengths emerging? Do case plan goals need to be updated or revised?

Refer back to the Five Step Consultation Model; consider how it might be useful in

maintaining focus in supervision.

Activity
Turn to a neighbor. In pairs, discuss: “How can I promote recording the progress families make *throughout* the time we work toward reunification rather than relying on a last-minute review of case notes?”

BALANCED INFORMATION GATHERING

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

EVIDENT CHANGE

Purpose
To be reminded that these are important questions throughout our work with families.

Example
These three questions serve as the framework for our work with supports and families. These may seem simple, but they are key to ensuring that our assessment practice stays rigorous and balanced. What are some "working well" questions we might want to have handy in FR consultations? [Elicit ideas from participants; you can record them on easel pad paper if available.]

Trainer Note
Some ideas to mention if they do not come up include the following.

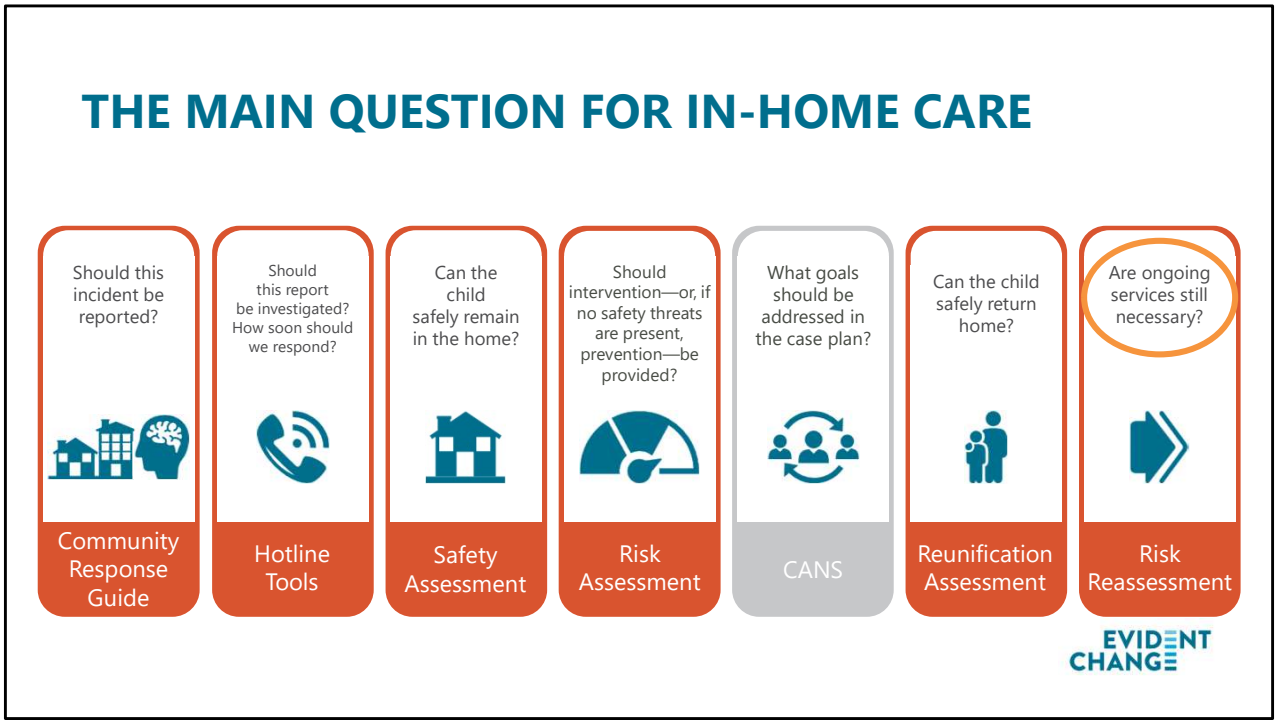
- What protective actions and behavioral changes are being demonstrated?
- What behavioral changes is the caregiver demonstrating?
- What has changed about their support network or use of supports?
- What has been observed during caregiver–child interactions?
- How does the caregiver think caregiver–child time has gone? What about the child?
- What follow-up actions may be needed if reunification efforts are to continue?
- What follow-up actions are needed if a change in permanency plan is recommended?
- What follow-up actions will support a smooth and successful transition and reunification?

Purpose
To be introduced to the risk reassessment.

Example
We will now learn about the risk reassessment for in-home cases. This assessment applies to cases where the child is still in the home or has been reunified. If one child remains in the home while another one was protectively placed, the reunification assessment is used to support decision making related to reunification. The review of the family's case plan progress, safety, and caregiver–child interactions can also be used to assess progress and support the family and the child who is in the home.

Most workers are concerned about their caseload size. The size of your caseload depends on partly on how many new cases are being opened and partly on how many cases are being closed. The decision to close a case is not easy. There are competing pressures. On one hand, you want to get your caseloads down. You may have time limits for how many months of service you can provide for a family. These considerations make us lean toward closing cases. On the other hand, we can be fearful of closing a case because we do not want to see headlines that say a child was harmed after we close the case. We also see unmet needs that may remain with a family. Do you ever feel confident that everything will be okay after we leave?

The risk reassessment helps balance these competing forces by having us focus on the most important information related to case closure: likelihood of future involvement and the household's current safety.



Purpose
To be oriented to which decision the risk reassessment helps with.

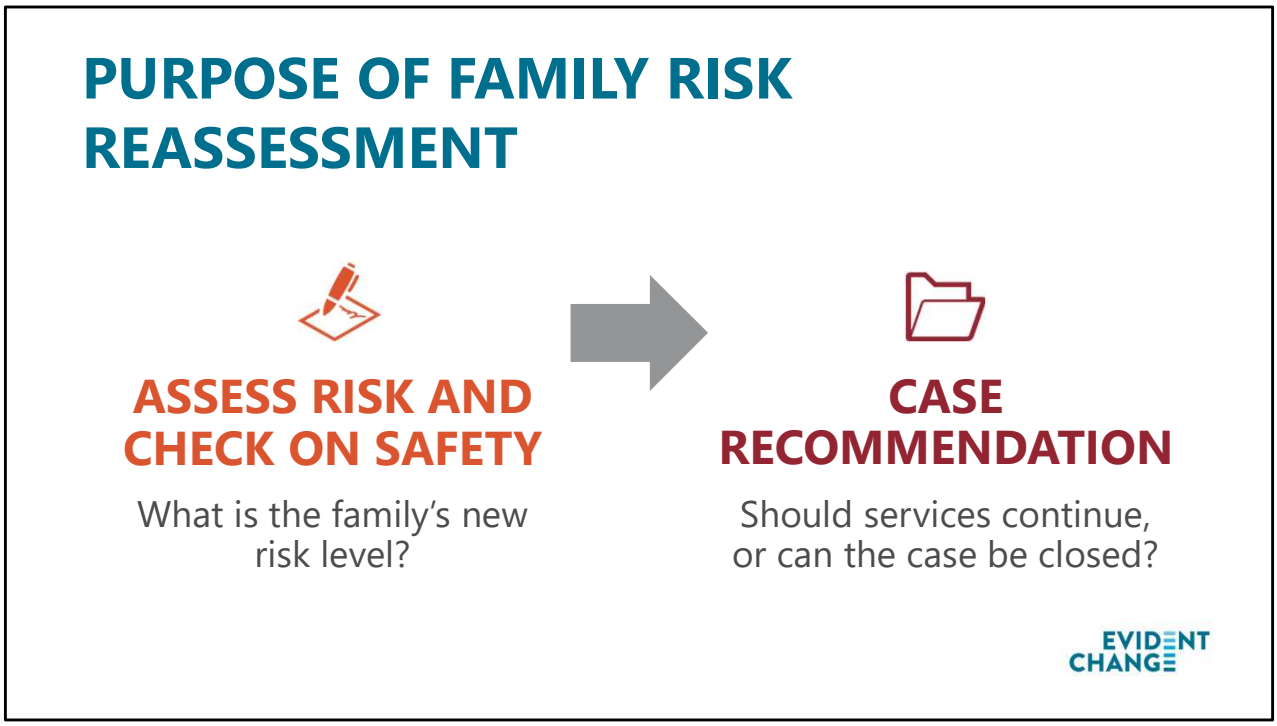
Example
The SDM system identifies several key decision points throughout the life of a child protection case. Each decision point and key question has a corresponding assessment that is designed to help guide the worker in making that decision.

We just have gone through the reunification assessment and are at a new decision point, which is whether to close or continue ongoing services. The risk reassessment is used at a review point with families who have received ongoing services after a child protection investigation. It is used whether a child has stayed in the home or been reunified. The risk reassessment is similar to the initial risk assessment in that it provides a classification of the likelihood of future involvement with child protection based on the presence of certain factors.

There are also mitigating factors on the assessment to consider. Remember that for a family to get to this point with child protection, it has been determined that there were concerns that met the threshold of requiring an in-person response (hotline tools), safety has been assessed (maybe multiple times), and there was a consideration of risk factors that contribute to the likelihood of future involvement (risk assessment).

Are there questions about any of the decision points leading to this?

Trainer Note
Walk participants through the questions and decision points.



Purpose
To review the risk reassessment's purpose.

Example
The family risk reassessment is completed at regular periods in the case review process, and it is used for in-home cases.

Reassessments provide an opportunity to measure progress and decide whether to close a case or continue to provide services. If the case will remain open, the updated risk level and safety outcome can be prompts to review the case plan objectives and service intensity.

First, we will look at the tool itself; and then, we talk about policies and procedures.

RISK REMINDERS

Purpose
To be reminded about risk.

Example
There are a few important things to remember about risk as we dive into the risk reassessment. At the end of the child protection response, the final risk level, a review of safety, and professional judgment are used to determine whether families should continue to receive ongoing protective intervention services or if the case can close. The risk reassessment items show a relationship or correlation to the likelihood of future involvement with child protection.

RISK IS ABOUT LIKELIHOOD

Would it help to know whether the family you were working with had a . . .

- 1:2 chance of coming back?
- 1:6 chance?
- 1:12 chance?

EVIDENT CHANGE

Purpose
To discuss how risk is the likelihood of a family having future involvement with child protection.

Example
Risk in the SDM system is different from how you may currently use the term. When we talk about risk, we are talking about the likelihood of future involvement. Families at high or very high risk are more likely to come back into contact with the agency by having a subsequent referral and investigation. At this point of involvement with a family, there is some opportunity to mitigate risk and address any safety threats that may have been present; and, combined with other observations and professional judgment, we need to consider if our work with the family should end or continue. Risk is not a predictor. High and very high risk classifications do not mean that a family will absolutely return to the attention of child protection, just as low and moderate risk classifications do not mean they absolutely will not.

Like we just talked about, risk in the SDM system is actuarial risk, similar to what is used for determinations of car insurance and health outcomes. You may know from experience that certain factors, if present, make it more likely for you to have a heart attack or medical condition. With car insurance, certain factors, if present, have been found to make it more likely that an accident will occur; and therefore, coverage costs more. You may also know that certain factors in your overall risk classification you have some control over, and other factors you may have very little or no control over. We will talk more about these two types of risk factors and how that information may be helpful in supporting a decision or recommendation.

Trainer Note
If you would like to demonstrate the probabilities listed on the slide, consider acquiring the following props to show as you explain.

- A coin (1:2 chance)
- A six-sided die (1:6 chance)
- A 12-sided die (1:12 chance)

Purpose
To review the types of risk factors on the risk reassessment.

Example
All risk reassessment items have a correlation to the likelihood of future involvement with child protection. The scored risk level is the cumulative score for all items. While all items have a strong correlation to the likelihood of future CPS involvement, there is a slight distinction between static and dynamic risk factors.

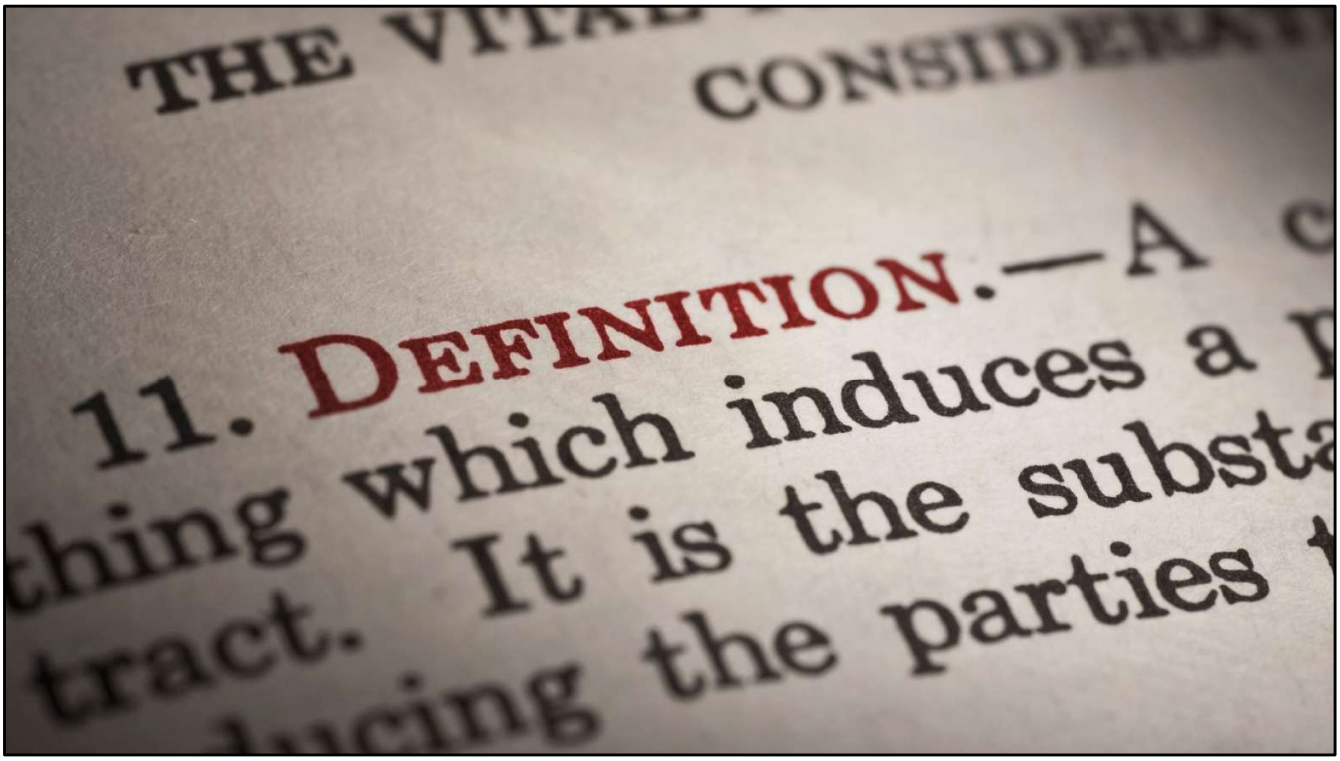
As we just discussed, items 1–4 are *static risk factors* that reflect conditions or circumstances present in the household when the investigation was accepted. Static risk factors do not change over time, with interventions, or with caregiver behavioral change (though our knowledge of what happened may change).

Items 5–10 are *dynamic risk factors* that reflect conditions or circumstances learned about or observed since the last assessment or reassessment. Dynamic risk factors also correlate to the likelihood of future involvement with child protection but may change or be influenced by interventions or caregiver behavioral changes.

When considering next actions or recommendations, it is important to identify

opportunities to support families in mitigating risk by considering the overall risk classification and distinguishing static from dynamic risk factors. If safety threats are no longer present but there is still a high or very high risk classification, consider reviewing which factors are contributing to the score. Are there opportunities to support the family in addressing the dynamic risk factors? If you are recommending to close interventions with the family, can you provide rationale as to why even through there is risk, the caregiver's behavior changes or family functioning are supporting safety and risk mitigation?

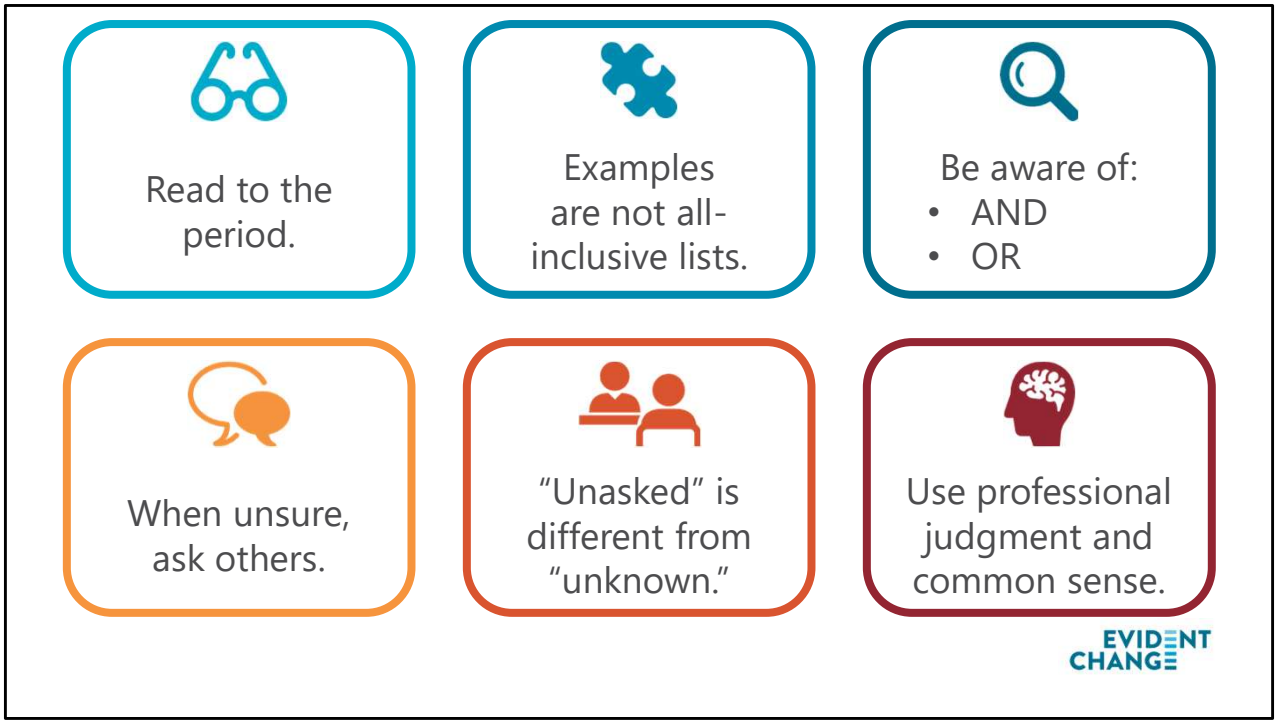
If a worker is seeking consultation and having trouble with making a recommendation, consider reviewing the risk reassessment outcome. What of the risk score is generated from static versus dynamic factors? How has the worker supported their assessment and recommendation? Are behavior changes and observations noted? Differentiating risk that is generated by static from risk generated by dynamic factors in the overall classification can help to support rationale.



Trainer Note
This slide will repeat in each assessment section. It offers a chance to underscore the importance of consulting the definitions.

Example
If you hear nothing else that is said during this training, hear this part. You need to use the definitions. Definitions are the most important part of the SDM system. You need to *refer to* the definitions and *use* them when applying the SDM assessments.

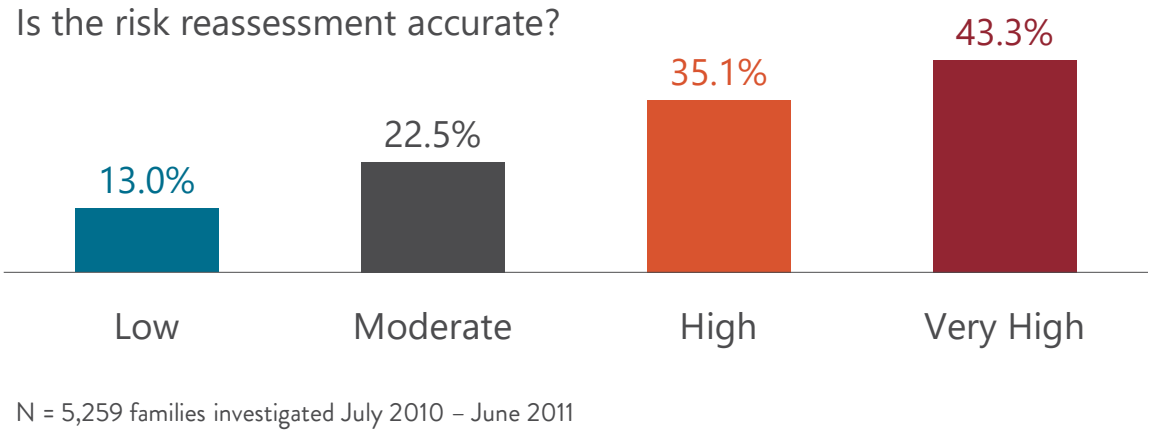
Remind yourself and your staff about this critical habit in using the SDM system.



Purpose
To be reminded of the importance of understanding and using the item definitions in the P&P manual.

Trainer Note
Review this information again with participants.

Families With Another Investigation Within Nine Months After a Risk Reassessment



N = 5,259 families investigated July 2010 – June 2011

Purpose
To see the findings from the last revalidation study, which included the risk reassessment.

Example
In the same 2013 study mentioned in the SDM system overview, the risk reassessment was found to categorize families accurately for their rates of being assigned for a subsequent investigation after case closure.

Purpose
To be encouraged to consider talking with families early about reassessment and reviews.

Example
Let's say that you have a job evaluation six months into your new employment that determines whether you get to keep your job. What would be helpful to know about the evaluation when you start the job?

You might want to know what is included in the evaluation, what you are being evaluated on, or what you need to do to get a good score and the steps to get there.

Families want to know the same thing about how they can be successful in ending their child protection involvement. Reassessment starts on Day 1 of the plan. During the review period, we talk to the family at each visit about how they are doing, what progress are they making, what they need to continue doing to make progress, and what may be making things challenging if progress is not happening. That is why it is important to talk about reassessment, reviews, and decision making early: to make sure families understand the process, see the goals, have a chance to discuss expectations of each other, etc.

Reassessment components can be useful if shared with the family at the beginning of the case so that everyone is on the same page. The intention is to have the conversation about working toward supporting safety and addressing needs. Have a conversation about what both the agency and family can do or will do to increase the chance of getting the case closed (progress toward case plan objectives, meeting child needs, having healthy adult relationships, and addressing need areas).

When it is time to conduct a formal reassessment, it should not be a surprise but rather a moment to pause and take a "snapshot" of where we are and decide where we should go

from here. The partnership with the family is about making real change that the family wants in order to increase safety and reduce risk. It is not about service compliance but about behavioral change.

Trainer Note
Consider asking questions to facilitate discussion.

- Why is it important to discuss reassessment with families from the start? What are the benefits?
- How can we help families understand the reassessment process and feel supported in achieving their goals?
- How does this compare with and integrate with the CANS results? What would we do if all the objectives that reduced risk to "moderate" were accomplished, but there were still needs identified on the CANS? (Note that Evident Change is neutral on this answer, and counties need to establish how to navigate this situation and support families into the future.)

Purpose
To discuss risk in small groups.

Resource
Small-Group Discussion on Risk section of Risk Reassessment Practice handout

Trainer Note
Have participants form small groups to discuss talking with the family about risk. Post the questions on the next slide.

SHARE . . .

1. How often do you talk to families about their risk level currently?
2. What do those conversations look like?
3. Can you think of a time when it was easy to talk to a family about their risk level? A time when it was difficult? What made the difference?
4. What support would help you have conversations with families about risk?

EVIDENT CHANGE

Purpose
To reflect on current practice and ways to improve discussing risk with families.

Trainer Note
Provide five to 10 minutes for participants to share; then take five minutes to discuss as a large group.

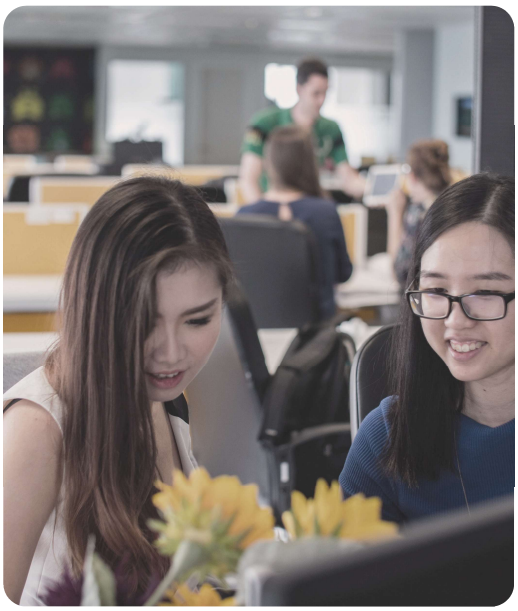
Purpose
To review the policy and procedures for the risk reassessment.

Trainer Note
If participants do not already have a copy of the P&P manual, they can scan the QR code with their phone or go to ca.sdmdata.org/definitions on a laptop.

Ask participants to turn to the risk reassessment's policy and procedures for "which cases," "who," and "when." Then, review the policies with them, asking volunteers to read a section aloud.

Purpose
To practice completing the risk reassessment.

Trainer Note
Have participants complete the risk reassessment practice in the participant guide. Review the answers as a large group.



RISK REASSESSMENT COMPONENTS

- Risk Reassessment
- Scored Risk Level
- Overrides
- Final Risk Level
- Planned Action

EVIDENT CHANGE

Purpose
To walk through each section of the risk reassessment.

Trainer Note
If participants all knew the answers in the last activity, you can move quickly through this slide.

Example
Let's look at the components of the risk reassessment.

The risk reassessment includes some risk factors that appear on the original SDM risk assessment, and it includes items related to the family's behavioral changes and progress toward their case plan goals. The outcome of this assessment is a new risk level that helps the worker decide if the case should remain open or if it can be closed.

The following items are what are sometimes called static risk factors. These risk factors are mostly unchanged from the original risk assessment, unless you have learned new information about those conditions.

Item R1 refers to number of neglect or abuse CPS investigations prior to the investigation that led to the case opening. It can change from the initial risk assessment only if the worker learned about history that was not known when the investigation was initially conducted.

Item R2 refers to the household previously being referred for ongoing CPS services prior to the current case opening. Again, this can change only if new information has surfaced.

Item R3 refers to the primary caregiver's history of abuse or neglect as a child. When you are completing this assessment, make sure that you are consistent with identifying the primary caregiver.

Item R4 refers to child characteristics. Some differ from the initial risk assessment because research shows that these characteristics are associated with a higher likelihood of future involvement for families who have received ongoing services. This score can change from the initial risk assessment if a child's condition changes or if information about a child's condition changes.

The rest of the risk items pertain to the period since the last assessment or reassessment. These are sometimes called dynamic or fluid items. The caregiver's behaviors and family functioning can reflect movement or changes.

Item R5 refers to any new investigations since the initial risk assessment or last reassessment.

Item R6 refers to alcohol and/or drug use since the last assessment or reassessment. This item should be answered for both caregivers, but only the caregiver with the least demonstrated progress receives a score.

Item R7 refers to adult relationships in the home and asks whether there were any harmful or tumultuous relationships or domestic violence.

Item R8 refers to the primary caregiver's mental health since the last assessment or reassessment.

Item R9 refers to the primary caregiver providing physical care of the child.

Item R10 evaluates progress toward case plan tasks. Remember: The better the case plan, the easier it is to evaluate progress. For R10, look at the plan's goals and objectives and consider how far the caregivers have come toward meeting them based on whether they are demonstrating new skills and behaviors consistent with the case plan tasks. If there are two caregivers, answer for both, and count the score of the caregiver with the least progress.

A scored risk level will be determined by responses to these risk items. There is also information related to which items are driving the risk level (static or dynamic). This information can be helpful when considering your recommendation. Paying attention to which items are contributing to the overall score can be useful when determining if a change in case plan goals is needed or if caregivers are demonstrating protective

behaviors despite a having a risk level of “high” or “very high.”

Next, there is a safety review. This section provides an opportunity to consider current safety threats and protective actions. *This is not a substitute for a full safety assessment*. A full list of safety threats and the corresponding definitions are included in the safety assessment in the manual. These should be used to support consistency in identifying and defining safety threats.

Following the risk and override sections, there is a “Final Risk Level" and "Planned Action—Worker Recommendation” section. The worker should select what action would be taken and provide rationale.

Only use the risk reassessment for cases in which *all children* are in the home. If one or more children in the family are in out-of-home care, then *all children* should be assessed using the reunification assessment.

DOCUMENTATION

- Risk reassessment narrative should include evidence that supports item responses.
- Document reasons for every recommendation.

Purpose
To discuss the importance of documentation on the risk reassessment.

Example
Narratives can be organized around all tool items. The narrative should include evidence of the professional observations that led to the responses for each item. Be sure to indicate if the item's score does not reflect the family perspective and show why you answered it as you did despite the family's perspective. Provide documentation about static and dynamic risk factors, behavior change, and resolution (or lack thereof) of safety threats through the caregiver's protective actions.

Trainer Note

Activity
In small groups, have learners look at each item on the risk reassessment and write down a sentence or two that, if they saw it in the narrative their worker recorded, would support one of the answers to that item. Tell them to assign a scribe and be ready to report what they came up with. As a large group, use easel paper to put all the items up on the walls and have each scribe go around an write their best option for each item. Then have all learners use markers to put checkmarks next to the ones they feel are the strongest statements.

SUPERVISORS' ROLE IN REVIEWING RISK REASSESSMENTS

Purpose
To be reminded to consider these items before approving a risk reassessment.

Example
Supervisors play a central role in setting workplace culture and tone, modeling practice, and ensuring technical pieces of practice are addressed. These technical responsibilities include ensuring that assessments are completed according to policy, accurately completed based on narrative support in case records, and used to support decision making to advance the best outcomes for children and families.

That requires taking time to review SDM assessments as part of the overall case record. Key areas of review include:

- Correct households assessed;
- Correct use of definitions;
- Completion of assessments according to policy;
- Adequate gathering and documenting of information and pursuit of missing or conflicting information; and
- Evidence of following the structure of the SDM assessment with families.

Risk Reassessment

- Make sure that the worker considers household conditions based on the current review period.

- Ensure that the risk reassessment is used to review progress. If there is a new investigation on an open case, ensure that facts uncovered in the investigation are reflected in the next risk reassessment.
- Support workers in understanding static versus dynamic risk factors.
- Support workers in talking about risk and safety with families.
- Help workers find balance in professional decision making and use of the assessments, policies, and structures in place.

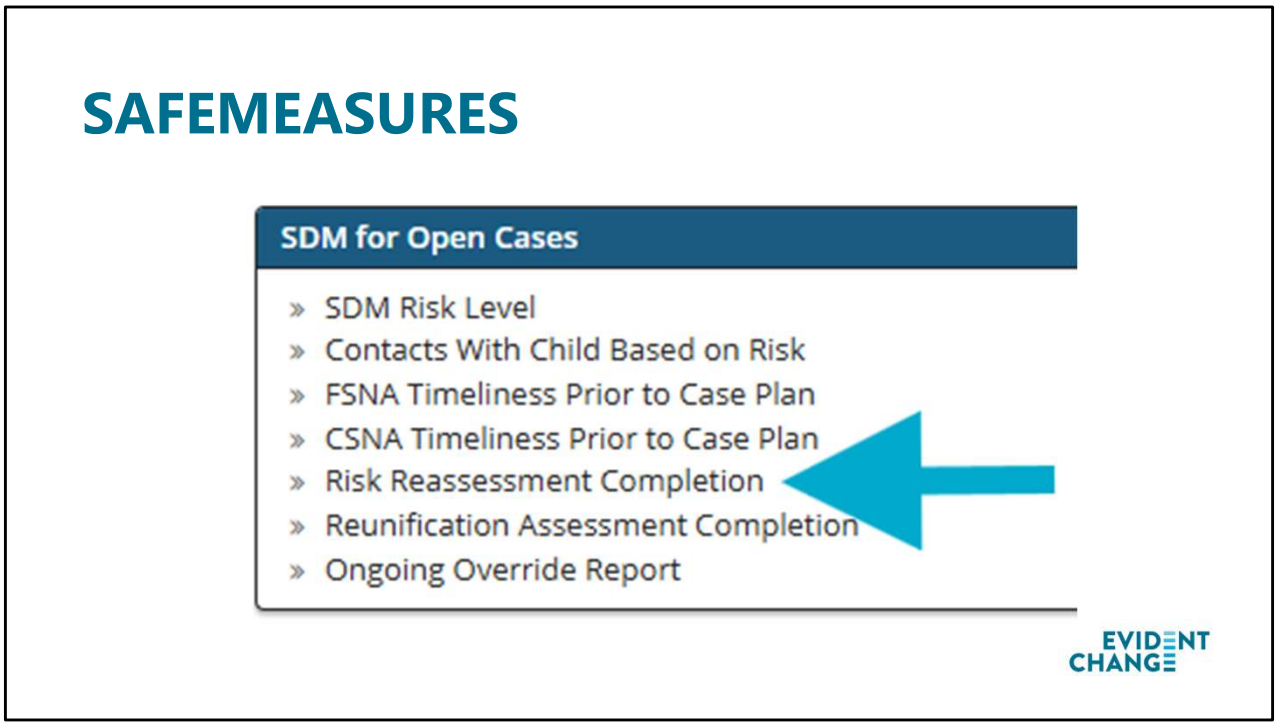
Also, have you discussed any discrepancies? Are there discrepancies between the assessment outcome and what you *think* it should be? Is your assessment different from your worker's? If so, why?

Taking a minute to review these steps before completing or approving a referral can help ensure more consistent, accurate, and equitable decisions for children and families.

Purpose
To be reminded that safety assessment is continuous.

Example
All workers are responsible for assessing safety routinely. This is a reminder that the most recent safety assessment result must be “safe” prior to closing a case.

If a worker notes new or unresolved safety threats, ensure that documentation details the outstanding threats. If the safety threats have been resolved, ensure that an updated safety assessment and documentation support how safety threats were resolved.

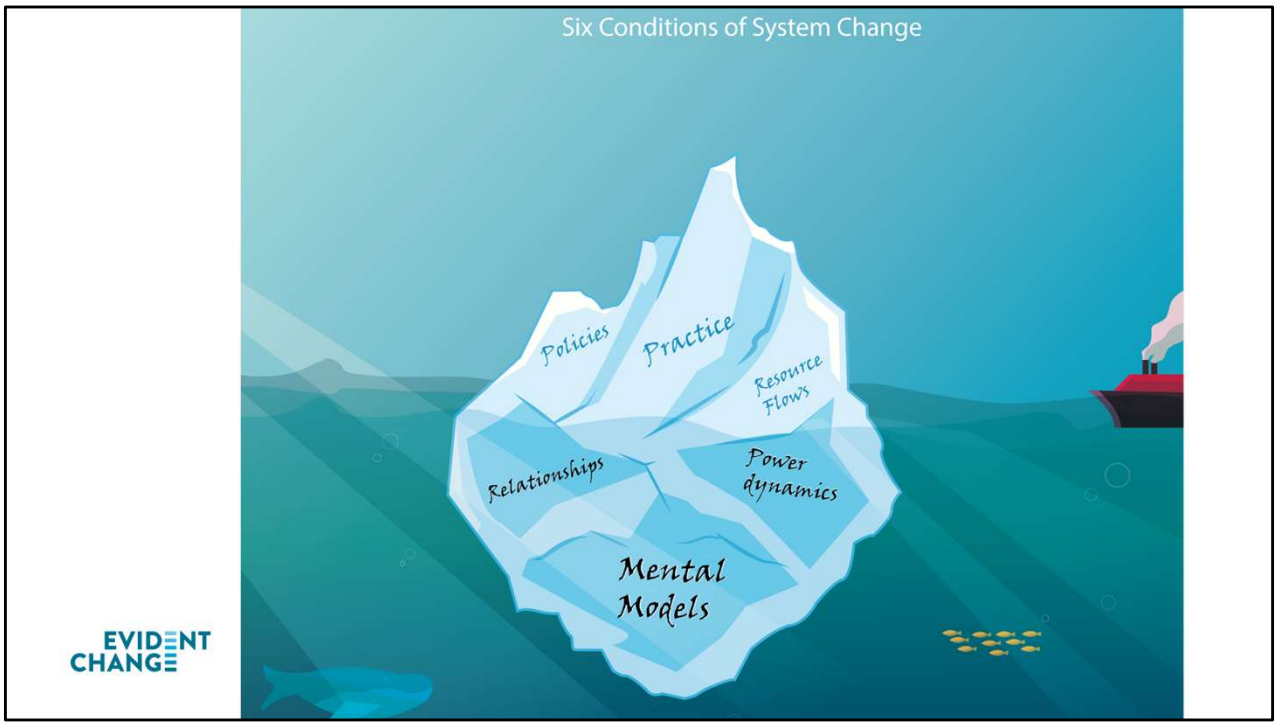


Purpose
To be reminded of SafeMeasures reports to support learning about how your staff are using the assessments.

Example
This is just a reminder that you take a closer look at your SDM outcomes by unit and worker using SafeMeasures reports.

SYSTEM CHANGE AND NEXT STEPS

EVIDENT CHANGE



Purpose
To be reminded about the six conditions that need to be addressed for system change.

Example
As we wrap up our time together, let's review the challenge that we face in implementing and supervising the use of the SDM system. If we look again at this iceberg analogy, we can see that there are six aspects of system change that we need to pay attention to in order to be successful. The three above the water line are policies, practices, and resource flows (which include budgets, staffing levels, and contracting for services in the community). When we undertake any attempt to improve a system, our leadership and the legislature that writes the laws we work under are naturally attracted to working on these three areas above the water line. This is because they are visible and easy to impact by rewriting legislation, rewriting policies, or even inventing a set of tools like the SDM system.

But these three items below the water line—the quality of relationships, the patterns of power dynamics, and the mental models with which we operate—also need to be addressed, or our attempt at system change is doomed to fail. Consider the values expressed in SOP trainings or the publication of the California core practice model.

Those efforts are designed to get us to think about the quality of relationship we form with families and how we share power in a transparent attempt to smooth out power dynamics between agencies and families. Also embedded in those efforts are shifts in mental models. The idea that families can change is a shift in a mental model. The idea that behavior change can happen before insight is developed is another shift in our mental model about motivation. One idea that we need your help with to embed in the mental models under which our workers operate is that using a structured decision-support system is an important step in treating families *ethically and equitably* across races and ethnicities.

Shifting and shaping mental models in a workforce, however, takes time and dedicated effort by the leadership of that workforce. It takes mindful awareness to message, model, and support uptake of a behavior based on the values proposition that families deserve the best practice we can muster when assessing and making decisions about how to proceed in our work with them. Let's talk a little bit about the adaptive challenges we face when we are trying to work below the water line of this iceberg versus the technical challenges we face when we are working on issues above the water line.

ADAPTIVE CHALLENGES

Adaptive challenges are real-world problems in which data are conflicting or ambiguous, people can reasonably disagree, and a clear-cut plan for proceeding does not exist.

EVIDENT CHANGE

Purpose
To learn how to approach adaptive challenges.

Resource
Technical Problems, Adaptive Challenges, and Approaches to Learning handout

Example
Adaptive challenges almost always require supervisors and staff to slow down and ask more questions.

- Read the handout. What do you think?
- How do you respond when workers come to you with an adaptive challenge but want a technical answer?
- Be clear with workers that adaptive challenges are challenges that you will work on together. There will not be one right answer, and often you will have to troubleshoot to find a solution. Workers will not be on their own in addressing adaptive challenges.

Creeping Charlie Example: Overrun with Creeping Charlie, you tried a natural weed killer and ended up attracting insects that ate the plants; then tried a different one that ended up killing the grass; and then tried a third, which finally worked. Adaptive challenges are an experiment—you will not know what works until you start and have tried something.

TECHNICAL PROBLEMS

A technical problem yields a right answer by applying an appropriate and premade plan. Think tasks or questions with clear answers.

EVIDENT CHANGE

Purpose
To learn how to approach technical problems.

Example
Problems like these, where straightforward answers can be found or accessed, are technical problems. Technical problems have technical responses, which turn into technical knowledge. This is knowledge that workers can learn from you or another reference and generally does not change (unless a policy changes, of course).

A technical problem yields a right answer through application of an appropriate and premade plan. Think tasks or questions with clear answers.

Purpose
To consider the proper supervisory response to technical problems versus adaptive challenges.

Example
Resist the urge to offer a technical solution to an adaptive challenge that requires the worker to think through and solve the problem themself. Here is a little-talked-about problem with the SDM system. When Alaska asked Evident Change in 1985 to help them allocate services and resources to the families at highest risk for future system involvement, Evident Change provided a technical solution. It used a known technology, an actuarial risk model, to assist the state in identifying those families.

What Evident Change did not consider was that getting a profession to adopt this model as the best way to do its work and approach decision making is an enormous *adaptive challenge*. They began to address this issue by partnering with California practitioners to develop SOP more than a decade ago, but that effort has only affected some narrow aspects of sound critical thinking. So here we are, in this training, asking for your help. Supervisors, now that you know what the system is trying to accomplish and have some more of the details about how the assessments work, how do you see you and your staff making progress toward meaningful integration of the SDM system in your work? Let's explore things to consider in the answer to this question.

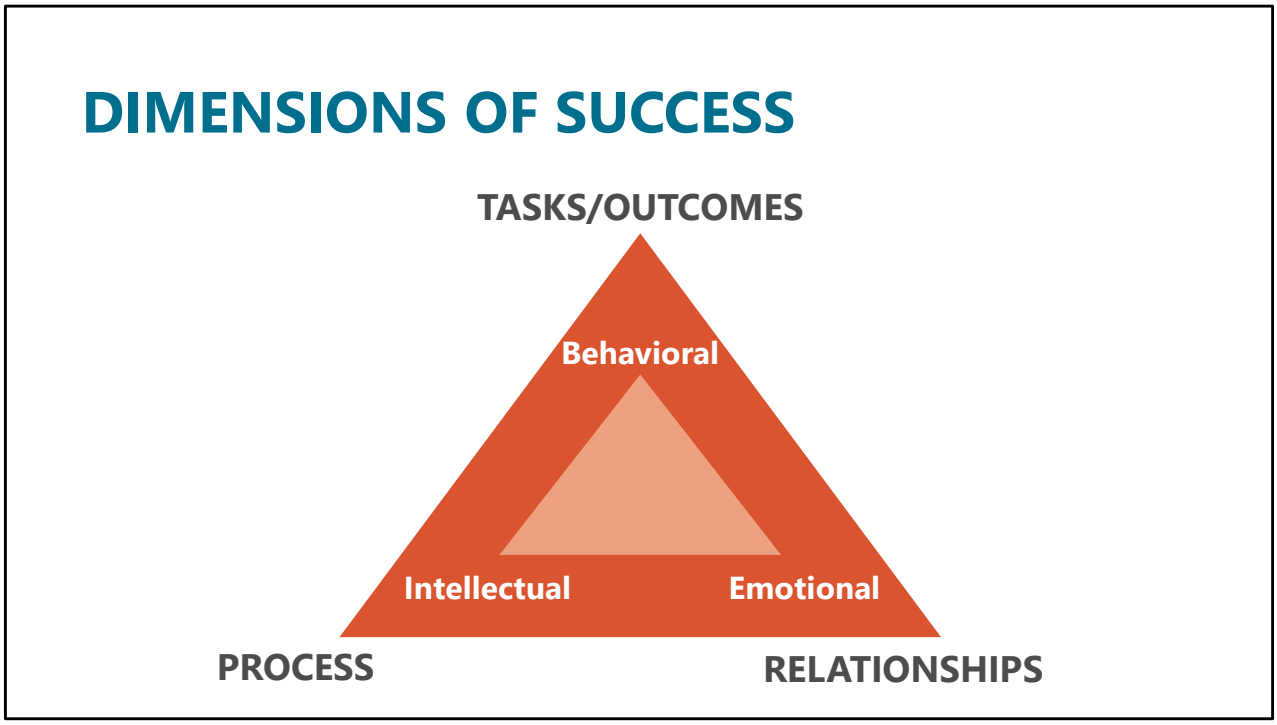
MIRRORING WORK WITH FAMILIES IN SUPERVISION

Purpose
To be introduced to how supervision can mirror practice skills used with families.

Example
SDM implementation is intended to support best practices with families. These are approaches that should be demonstrated and practiced in supervision as well. Find ways in your daily interactions with workers to do the following.

- Establish a working partnership where the worker's ideas are sought and encouraged.
- Use descriptions with details about behavior instead of generalizations and ask workers to do the same when describing allegations, safety threats, and risk.
- Identify workers' strengths and ask workers to do the same. Similarly, discuss exceptions to the family's problem pattern.

Workers will begin to do the same in their work with families.

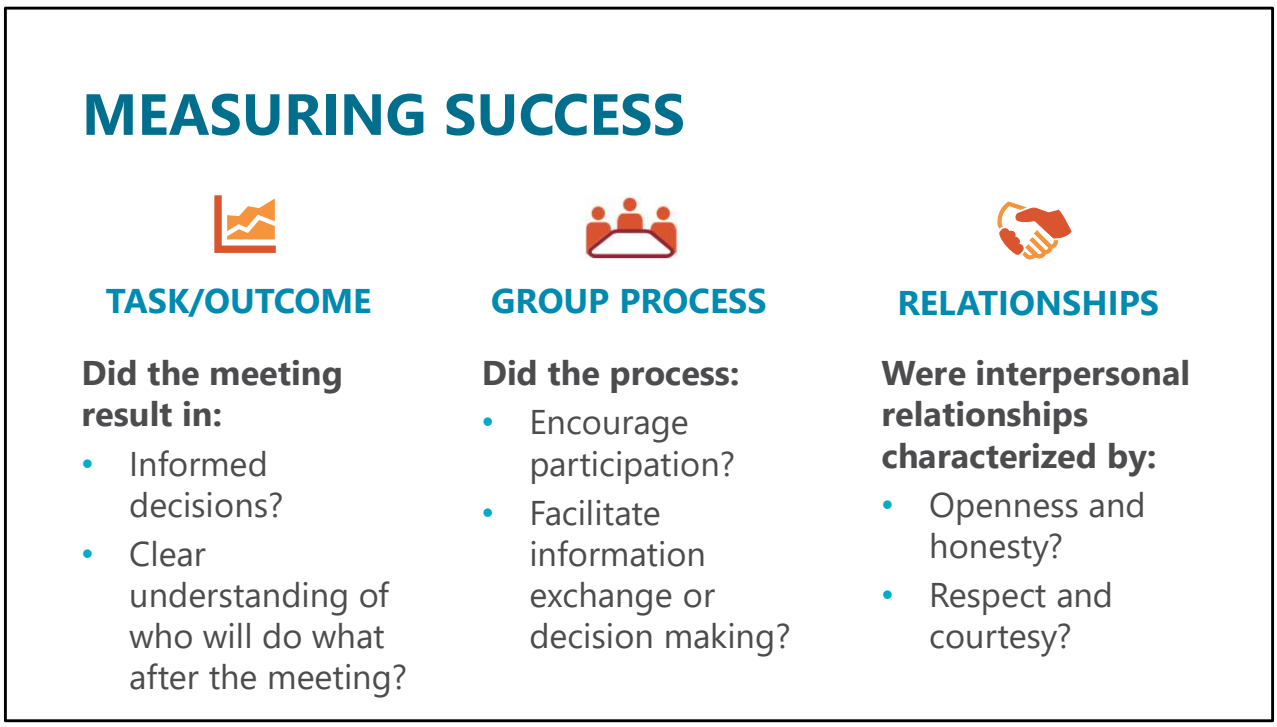


Purpose
To learn the three dimensions of success for any meeting—in this case, we are applying it to supervision.

Trainer Note
Describe each label on the outside of the triangle and then how it relates to the labels on the inside of the triangle.

- Relationships ("the why") characterized by openness, honesty, and a collaborative attitude.
  - » Emotional or affective ("emotional muscle") = slowing down process, noticing emotions, environment supportive of relationships/builds trust
- Process ("the how") that is characterized by participation and the exchange of information in ways that promote understanding and decision making.
  - » Intellectual or cognitive = concepts, linkages, strategies for execution of new behaviors
- Tasks/outcomes ("the what") from this process based on informed decisions, clear and shared understandings, and clarity about roles.
  - » Behavioral = clear expectations, actions, new results

<u>Key Points</u>
1. Process supersedes content every single time. We need to pay equal attention to all three dimensions to get the most successful outcomes.
2. Supervisors must help workers connect with the work affectively or emotionally, not just intellectually, before they will shift their behavior or practice.



Purpose
To define how you know if you are attentive to all three dimensions of success.

Example
Review signs of success for each dimension. Ask if participants have any other ideas for measuring success to add.

Purpose
To highlight the importance of integrating SDM hotline tools, safety assessment, risk assessment, reunification assessment, and risk reassessment in your work.

Resource
Transfer of Learning Activities handout

Example
Let's wrap up by focusing on how integrating SDM assessment trainings helps us work better with families. This combined approach allows us to ensure child safety while also providing the necessary support to families, allowing us the support we need at different decision points throughout the life of a case.

As we think about this integration, consider: How will understanding the *why* behind using the SDM system affect *how* you message it, model it, and support your staff in its intended use? What strategies can we use to make sure we balance safety and support effectively?

Let's look at some strategies that research on adult learning best practices would suggest.

Trainer Note
Give participants time to read through the Transfer of Learning Activities handout.

Example
How might you have to change your support strategies for each individual worker? What are some of the challenges, and how might they differ between staff? Everyone copes with changes differently, even if they are excited, ready, or anticipating change.

As a supervisor, you have to be aware of your own reactions and needs regarding change so that you can better manage yourself and, in turn, support your staff. Supervisors are crucial to achieving successful implementation and ongoing refinement of work. Can you imagine what a difference it would make for you and your staff if you were not feeling prepared or supported during a big change? How would that possibly translate to your staff? What would it look like if you felt confident, supported, and prepared for change?

Trainer Note
Review the steps in the handout with participants as needed and as fits with the flow of the discussion.

SUPERVISION AS PROFESSIONAL LEADERSHIP

- What skills do you bring as a facilitator of change?
- How do you support a worker's practice change process over time?
- How can you communicate the values that will equate SDM use with ethical practice as a mental model?

Purpose
To start thinking more concretely about your supervisor role as facilitative.

Trainer Note
Review the two questions in breakout sessions first and report out responses, or just review them as a large group.

Our profession will not become more fair and equitable without leadership by supervisors.

REFLECTION WITH OTHERS

What are two ways you will incorporate the SDM system, the hotline tools, and the safety assessment into your practices as a supervisor?

EVIDENT CHANGE

Purpose
To think about how to incorporate these supervisory strategies into your work.

Example
Break up into small groups. In your groups, please think about the strategies we have discussed and talk about how you will incorporate at least two of these into your supervisory strategies with staff. Make a commitment to follow through on the two ideas; then schedule a check in with a peer in four to six weeks to report to each other on progress.

Trainer Note
Facilitate report-out after group comes back together, generating a few ideas that participants are willing to share.

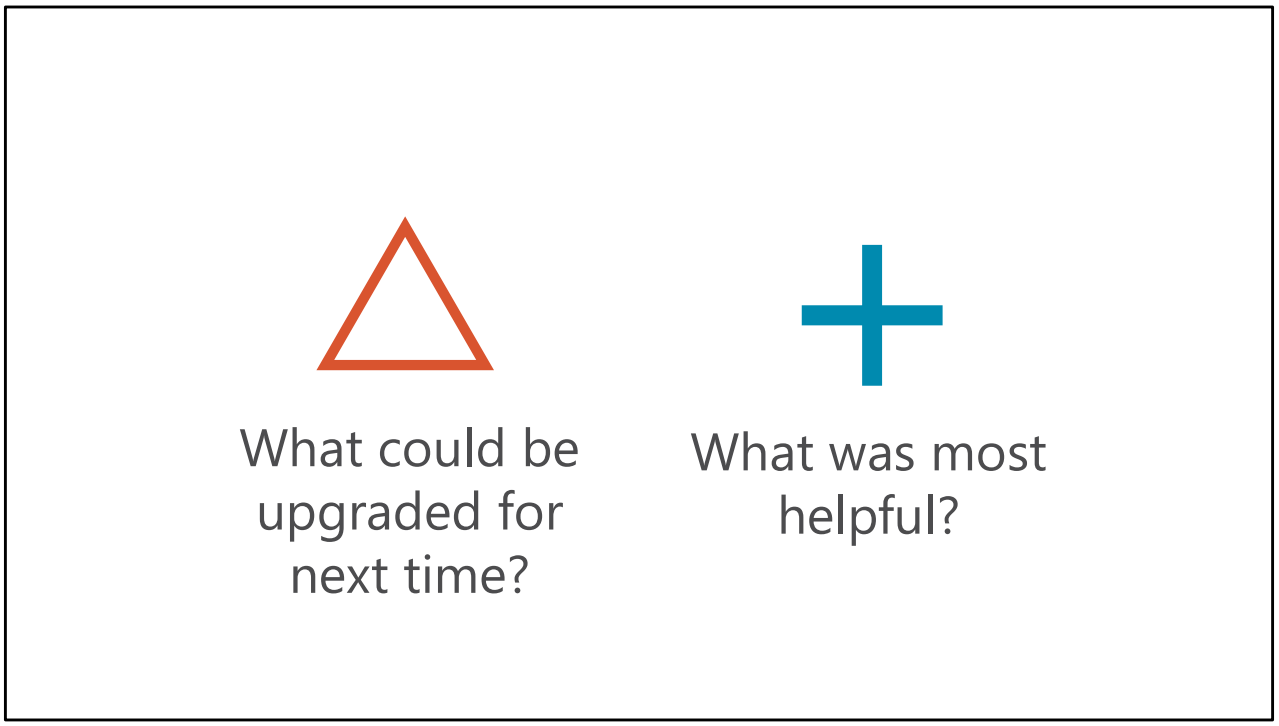
DEBRIEF: WHAT HAVE YOU LEARNED ABOUT . . .

- Yourself and your practice?
- What is changing and what is staying the same?
- What help you need?
- What you need from leadership?
- What you need from Evident Change?

Purpose
To discuss what you have learned about practice during this training.

Trainer Note
Have participants consider the questions above, elicit responses, and engage participants in discussion about what they have learned or what the SDM system has prompted them to think about in their practice.

Conclude by going around and asking each person to state one thing they learned that they committed to doing.



Trainer Note
Have participants answer the following questions on a sticky note at their table and leave it for the facilitator to collect and review.

- What is one thing you wish we had talked about today that should be added?
- What are some top takeaways from today's training?
- What are some barriers that currently exist?
- What was most helpful for you about our time together?

Purpose
To cover any burning questions that have not already been covered.

Example
Let's pause and ask: What is something you wish we had covered but did not?

Trainer Note
If the topic is too complicated to address in the time remaining, encourage learners to send it to the email address on the next slide. Otherwise, have the discussion that fits with the time remaining.

THANK YOU & QUESTIONS

EvidentChange.org
(800) 306-6223
Info@EvidentChange.org

Purpose
To know how to contact Evident Change if in need of support after the training.

Example
Thank you for your time and attention. We hope this advanced training session gave you more insight into the "why" of the SDM system and equipped you with more details and skills related to assessments you use. *Do not hesitate* to call or email Evident Change about challenges or questions you have about the SDM system or SOP and the role of one in the other. CDSS maintains a relationship with them to provide ongoing technical assistance to California counties.

SDM RESOURCES

USING THE SDM SYSTEM AT EACH DECISION POINT

Hotline Tools		Should this be screened in?
Safety Assessment		Can the child safely remain in the home?
Risk Assessment		Should this case be opened for services?
Risk Reassessment		Should this case be closed?
Reunification Assessment		Can the child return home?

CALIFORNIA SDM SYSTEM OVERVIEW

See policy and procedures sections for each assessment for complete details.

SDM TOOL	DECISION	WHICH CASES	WHO	WHEN
Hotline tools	How should we respond to this referral?	All referrals created in CWS/CMS.	Worker receiving the referral	Immediately. Tool should be used *during* call with reporter to guide questions and screening assessment.
Safety assessment*	Can the child remain safely at home?	All in-person responses.	Assigned worker	**Always:** Process completed during first face-to-face contact with at least one victim child in the household (record within 48 hours).
Risk assessment	Should intervention be provided? At what service level?	**Recommended:** All in-person responses. **Required:** All substantiated and inconclusive in-person responses.	Assigned worker	Within 30 calendar days of first face-to-face contact.
Family strengths and needs assessment† (sunsetting in 2026)	Focus of case plan	All open cases.	Worker responsible for case plan	**Initial:** Prior to initial case plan. **Review:** For voluntary, within 30 days prior to case plan; for court-ordered, within 65 days prior to case plan.

SDM TOOL	DECISION	WHICH CASES	WHO	WHEN
Reunification reassessment	Can child be returned home, should reunification efforts continue, or should the permanency goal be changed?	Cases with at least one child in out-of-home care with goal of return home.	Assigned worker	At a minimum, every six months from removal. If adequate time has passed to demonstrate progress on the case plan, it is recommended to complete this assessment every 90 days.
Risk reassessment Closing safety assessment	Can this case be closed? If not, what level of service?	All open cases where *all* children are in the home.	Assigned worker	**Division 31:** Review every six months. **Voluntary cases:** No more than 30 calendar days prior to case plan completion or case-closure recommendation. **Court-ordered cases:** No more than 65 calendar days prior to case plan completion or case-closure recommendation. **All cases:** Sooner if there are new circumstances or new information affecting risk.

*The SDM safety assessment for family homes is used for allegations of harm by a legal caregiver. The SDM safety assessment for substitute care provider homes should be used when the referral alleges maltreatment by a substitute care provider.

†California's SDM family strengths and needs assessment (FSNA) is no longer updated and maintained as an active assessment, per California Department of Social Services (CDSS) guidelines. This legacy version is available for use in case planning during the transition period to full implementation of the Child and Adolescent Needs and Strengths assessment.

SDM SYSTEM OBJECTIVES

For Leadership

Prioritizes use of resources

Ensures statutory compliance

Provides data to inform policy and guide resource development

For Managers and Supervisors

Provides framework for continuous quality improvement

Ensures implementation fidelity

Assists with workload management

Provides strategies for supervision and coaching

For Workers

Prioritizes information gathering

Improves transparency in decision making

Provides tools for talking with clients

Maintains service standards

For Families

Ensures fair and equitable assessments

Provides common language for conversations with workers

Improves consistency of decisions that affect them

Improves case planning

REVIEW OF SDM SYSTEM FUNDAMENTALS

SDM DEFINITIONS MATTER.

READ TO THE PERIOD.

When reading SDM definitions, be sure to first read the entire "stem" or foundational definition before looking beyond to examples and conditions. If the stem of the definition is not read first, information that follows may be taken out of context and selected or eliminated in error.

EXAMPLES ARE JUST EXAMPLES.

The purpose of the definition examples is to illustrate the severity, threshold, or type of situation that might be seen in a family's situation. Definition examples cannot include every possible instance of circumstances covered by the definition. Sometimes an aspect of a case might appear much like the definition example, but the definition stem does not fit the situation. Sometimes, the exact situation will not be listed as an example, but the definition does apply.

BE AWARE OF AND, OR, AND "AND/OR."

"AND" means that both conditions on either side of the "AND" must be true in order for the definition to apply. "OR" means that only one condition on either side of the "OR" must be true for the definition to apply. "And/or" means either one or both of the conditions may be true. "AND" or "OR" may sometimes appear multiple times in one sentence or section of a definition.

WHEN UNSURE, USE CONSULTATION AND CLINICAL JUDGMENT.

SDM assessments and their definitions do not make decisions—caseworkers do. The definitions are designed to structure workers' assessment and thought processes, but they are not a replacement for the value of experience and judgment in making decisions about families.

"UNASKED" IS DIFFERENT FROM "UNKNOWN."

When thinking about completing an SDM assessment, remember that "form prompts practice." Assessment items are designed to be part of a conversation with the family. Learning how to use the assessment should include learning how to prepare for that conversation and the important questions to ask in completing the assessment.

COMMON MISTAKES AND HOW TO HANDLE THEM: KEY POINTS FOR SDM IMPLEMENTATION

SUPERVISOR TIP: Think about the key case management question at hand when trying to decide which SDM tool to use on which household and when.

SAFETY ASSESSMENT

1. ENSURE THAT THE WORKER CAREFULLY REVIEWED THE DEFINITIONS AND THAT THE RESPONSE IS CONSISTENT WITH THE DEFINITIONS.

Common mistake: A worker has selected caregiver complicating factor of development/cognitive impairment because the mother has an IQ of 79.

How to handle: Refer the worker to the definition. Point out that developmental delay alone does not warrant selecting the item. Inquire as to whether there is reason to believe the mother lacks critical knowledge that makes it more difficult to safety plan.

Common mistake: A worker selected item 4 because the house is very dirty and an 8-year-old child is sleeping on a mattress on the floor.

How to handle: Refer the worker to the definitions. Ask the worker to explain what is hazardous or immediately threatening about the environment.

2. BE SURE THE WORKER HAS GATHERED ENOUGH INFORMATION.

When the referral contains information that, if true, would constitute a safety threat, it is important to thoroughly gather sufficient information before concluding that the threat does not exist. Note: It is reasonable to rely on more general interviews and observations to determine the presence or absence of safety threats that are not part of the referral and for which there are no indicators of presence.

Common mistake: Reporter said that the child had a very bad black and blue mark on his jaw. It was swollen, making it hard for the child to talk. The child indicated that his father punched him. Spring break began the day before, and despite the worker's efforts to reach the child at home it was nearly two weeks before the worker saw the child. The injury was not visible and the child denied being injured by his father. His father was in the next room during the interview. The worker closed the referral that night with no safety threats selected.

How to handle: The severity of the reported actions by father (punching child in face) warrants further investigation. An injury that obvious may have been noticed by others. At the very least, consider having the worker re-contact the reporter for more information and attempt to interview the child in a safer place.

3. WORKER SHOULD MAKE EVERY REASONABLE ATTEMPT TO WORK WITH FAMILY AND OTHERS TO DEVELOP AN IN-HOME SAFETY INTERVENTION BEFORE DECIDING ON REMOVAL.

Common mistake: A safety threat was identified, and child was removed. No household strengths or protective actions were selected.

How to handle: Ask worker to describe efforts to identify protective capacities and develop a safety plan. If these efforts were absent or insufficient, review circumstances with worker to determine whether a family meeting would be appropriate at this point to attempt to develop a safety plan.

4. A SAFETY PLAN SHOULD BE CLEAR AND SHOULD IMMEDIATELY AND SUFFICIENTLY MITIGATE ALL IDENTIFIED SAFETY THREATS.

Common mistake: The safety threat identified was that child sexual abuse was suspected and child safety may be of immediate concern. The child provided a convincing disclosure of ongoing sexual abuse by mother's boyfriend. The police interviewed the boyfriend once, and he denied. The district attorney is inclined to believe that something happened but is holding off on charging because of concerns with the child's ability to testify. The mother is siding with the boyfriend and is angry at the child for disclosing. The worker left the child in the home with a safety plan that included an agreement from mother that she would not let the boyfriend around the child and would not retaliate against the child. That was the full safety plan.

How to handle: Ask worker how plan will be monitored. If there is no plan for monitoring, help worker create one.

5. THE SAFETY (AND RISK) ASSESSMENT SHOULD BE DONE ON THE HOUSEHOLD OF THE CAREGIVER ALLEGED TO HAVE MALTREATED THE CHILD.

Common mistake: The child lives with mother but visits father two nights per week and every other weekend. The report is that while child is visiting father, father is physically abusive. The worker interviewed the child, who confirms extremely abusive corporal punishment by father. The worker met with mother, who is not abusive. The worker closed the referral as substantiated, and the safety assessment, done on mother's household, shows no safety threats.

How to handle: Advise the worker to meet with father and conduct a safety assessment and risk assessment of father's household. The worker should also meet with mother, but SDM assessments on her household would be done only if there is an allegation of failure to protect.

RISK ASSESSMENT

1. COMPLETE RISK ASSESSMENT ON THE CORRECT HOUSEHOLD. THE RISK ASSESSMENT SHOULD BE DONE ON A HOUSEHOLD WHERE A PARENT OR LEGAL GUARDIAN ALLEGED TO HAVE ABUSED OR NEGLECTED THE CHILD LIVES.

Common mistake: Risk level was "moderate," but an override was used to increase risk to "high" to offer services to the foster family.

How to handle: The risk assessment should not be used to assess risk in a foster home. If the allegation was against the foster parents, the worker should use a substitute care provider safety assessment to assess the safety of the foster home. There is no risk assessment for substitute care providers currently.

2. BE SURE THE WORKER HAS GATHERED ENOUGH INFORMATION.

Common mistake: Worker made a single home visit, during which safety threats were identified and a child was placed. The next day, the worker submitted a completed safety assessment and risk assessment. Risk level was "moderate."

How to handle: Compare risk assessment to safety assessment, screener narrative, and prior history of family. Identify any risk items that appear incorrect. Additionally, look at risk items scored as "0" and ask worker how they reached conclusion (e.g.,, that primary caregiver was NOT abused or neglected as child). If worker has not gathered sufficient information to conclude that risk factors are absent, remind worker that accuracy is the first priority and further interviewing appears necessary. *Note*: If county practice is to transfer to another worker at the point of removal, then county should determine a plan for completing risk assessment.

3. ENSURE THAT THE WORKER CAREFULLY REVIEWED THE DEFINITIONS AND THAT THE RESPONSE IS CONSISTENT WITH THE DEFINITIONS.

Common mistake: Several references in contact notes and other assessments indicate that primary caregiver has a serious substance abuse problem, but substance abuse is not selected as a risk factor.

How to handle: Ask worker to explain decision to select no current or historic substance abuse problem. Review definition with worker and go over all of the information to the contrary. If worker has a good justification, ask for this to be detailed in narrative. Otherwise, correct the assessment.

Common mistake: Risk factor selected indicating three or more prior neglect investigations, but two of them were when the mother was a minor and was neglected by her parents.

How to handle: Review the definition with worker. Only select prior investigations in which an adult in the household was an alleged perpetrator.

4. WORKERS SHOULD ATTEMPT TO ENGAGE HIGH- AND VERY HIGH–RISK FAMILIES IN ONGOING SERVICES, REGARDLESS OF SUBSTANTIATION DECISION.

Common mistake: Very high risk, inconclusive referral is closed without promoting to a case.

How to handle: Review worker's explanation and ask worker what efforts they used to engage family in voluntary services or to at least connect family with community services. If efforts were substantial, be sure worker documented these efforts. If efforts were lacking, discuss with worker the purpose of risk assessment and why it is so important to get services to higher-risk families. Consider re-contacting family with worker in effort to engage. If worker frequently struggles with engagement, consider additional training and/or coaching on engagement.

5. WORKERS SHOULD NOT OFFER ONGOING SERVICES TO LOW- OR MODERATE-RISK FAMILIES UNLESS THERE IS AN UNRESOLVED SAFETY THREAT.

Common mistake: Scored risk level was "moderate," and worker applied a discretionary override to "high"; the reason given was that it was so the family could receive services.

How to handle: Increase risk level only if you believe the family is more likely than the scored risk level indicates to experience reinvolvement with the child protective system in the future. A rationale for this belief must be provided. Discuss with the worker some of the research that suggests that providing services to lower-risk families does not reduce subsequent involvement but does use resources that are now unavailable for higher-risk families. Offer ideas for how family's *needs* may be better met through community resources.

6. THE WORKER COMPLETES A NEW INITIAL RISK ASSESSMENT FOR AN INVESTIGATION FOR A HOUSEHOLD WITH AN OPEN CASE.

Common mistake: For many years initial risk assessments were expected on investigations for households in open cases and out of habit the worker has done one for a recent investigation.

How to handle: Refer to the policy change in January 2024 eliminating this expectation. The ongoing worker can use the information gathered in the investigation to complete a risk reassessment to monitor and adapt the case plan as needed.

RISK REASSESSMENT

1. ENSURE THAT ONLY THE APPROPRIATE TIME PERIODS ARE CONSIDERED.

Common mistake: Worker rated family as not having addressed substance use problem. Notes reveal that caregiver has completed treatment and been clean and sober for five months. Worker stated that family did not address problem for the first seven months the case was open.

How to handle: Review definitions and ask worker to focus on current review period. Correct rating and adjust score and, if needed, decision.

REUNIFICATION ASSESSMENT

1. ENSURE THAT THE RESPONSE TO ITEM 1 REFLECTS THE CORRECT, CURRENT RISK LEVEL (I.E., THE RISK LEVEL DETERMINED AT THE BY THE MOST RECENT INITIAL RISK ASSESSMENT).

Common mistake: The initial risk level was "very high." The result of the first reunification risk assessment was "high." This is the second reunification assessment. Item 1, initial risk level, is answered "high."

How to handle: Review definition with worker. Be sure there was no risk assessment since the initial risk level. If needed, correct R1. If this affects risk level, review entire reunification reassessment and decision.

2. ENSURE THAT VISITATION IS CALCULATED CORRECTLY AND DOCUMENTED.

Common mistake: Visitation is indicated to be "strong/adequate"; but the narrative does not explain how many visits were available, how many were made, or what their quality was.

How to handle: Ask worker to "show their work" for the calculation of how many visits were available and how many were missed. Be sure the correct quantity rating is given. Ask worker for details of parent performance on visits. If worker has details, ask for these to be explained in narrative (briefly and concisely). If worker does not have information, help worker identify ways to get input for this review. Then make a plan for explaining expectations to parents now for use during next review period, and discuss ways worker can occasionally observe.

3. Ensure that the correct decision tree is used.

Common mistake: Child was removed two years ago at age 2. Worker used decision tree for children over age 3.

How to handle: Explain to worker that it is the age of the child at *removal* that determines which tree to use. Redo tool with the correct tree.

FIVE-STEP CONSULTATION MODEL

Elicit worker thinking related to proposed course of action.

Focus conversation on key questions of the decision point and assessment structure.

Engage in conversation with a focus on definitions, using the Three Questions structure.

Ask questions that elicit family facts related to *definitions* and relevant decisions.

Agree about additional information needed, conversation, and follow-up steps with family.

HOTLINE TOOLS

BOBBY—SKILLS PRACTICE WITH DEFINITIONS

The caller reported a concern about a 2-year-old, Bobby, who lives with his mother and father in a 10th-floor apartment downtown. The caller stated that they have seen a child standing on a chair, leaning out of the window on multiple occasions. The caller said there are no safety bars or screens on the window, and it is always left open during this time of year. The caller has never seen an adult try to intervene when the child is at the window. Before calling, the caller went to the apartment to alert the caregivers. One caregiver answered the door drinking a beer after several minutes. Caller observed another adult asleep on a couch but did not see the 2-year-old. The caller said the caregiver was "not concerned" and asked the caller to just leave them alone. Caller observed the child in the window again later, which prompted the call.

SAL—SKILLS PRACTICE WITH DEFINITIONS

The reporting party is an ER nurse. Paternal grandmother picked up Sal, who is 4 months old, from his mother's house; caregivers share custody. Grandmother was concerned that Sal was physically injured while in his mother's care, so she took him to the ER. The ER nurse said that Sal has a black eye, two bruises on his forehead, and scratches on his right thigh. The ER physician said the injuries are consistent with abuse. The nurse observed that Sal seems comfortable in the care of his paternal grandmother. The nurse said Sal's father came to the hospital. Sal's father and paternal grandmother are worried that the mother has a drinking problem and is abusing the child. According to the grandmother, the mother told her that Sal fell off the couch during naptime.

SIBLINGS—SKILLS PRACTICE WITH DEFINITIONS

A reporter said that two children—ages 10 and 7—are being neglected. According to the reporter, the caregivers are addicted to heroin, and they spend their money on drugs instead of rent or food for their children. Earlier this month, the caregivers were evicted from their home for failing to pay rent; the family is currently living in their car. The reporter said that the oldest child has diabetes, and she is concerned because the family no longer has a refrigerator in which to store the child's insulin. The children's clothes are reported to be stained, full of urine, and worn for many days in a row. Their clothes smell so bad that the stench drives other schoolchildren away. The children often must borrow acceptable clothing from the school's lost and found. The reporter also said that the children beat each other, and the caregivers do not intervene.

BETTY—RESPONSE PRIORITY PRACTICE

A neighbor called in about a 4-year-old girl, Betty, who is left alone for eight to 10 hours at a time while her single father is at work. Sometimes, a relative watches the girl, but today she was alone again. While playing with her doll in the front yard, the girl was approached by the neighbor, who asked who was taking care of her. She said that no one was home to take care of her. The neighbor reported that the child seemed content and had no medical needs. The neighbor also reported that she had never been inside the girl's house, but the exterior of the home appeared clean and well-maintained.

NICU—RESPONSE PRIORITY PRACTICE

A nurse at the local hospital called in to report that a mother has just given birth, and both the mother and child had a positive toxicology screen for methamphetamine. The child was born underweight and is being admitted to the neonatal intensive care unit. It will take about two weeks for the infant to gain enough weight for discharge. This is the mother's first child. When asked about whether the mother has support and had preparations for the baby coming home, the nurse indicated that the delivery was sudden and unplanned, but they had not asked the mother about this.

HOTLINE INFORMATION COLLECTION GUIDE

THE INFORMATION WE NEED

WHO?

Who is the referral source? Who are they worried about? Who was involved?

- Identity of the referral source (name, phone, address, relationship to child, method of contact, source of contact)
- Identity of the child/ren (name, sex, DOB, present location, school/daycare, name of person living with, relationship, ethnicity)
- Identity of parent/guardian, current caregiver, foster parent (name, phone, address, relationship to child, marital status, ethnicity, DOB)
- Identity of other witnesses/sources of information (name, address, relationship to child, agency, phone)
- American Indian or other Indigenous identity

WHAT?

What is the referral source worried about? C + B + I

- Type of maltreatment
- Severity of maltreatment: results, injuries, conditions (sustained or likely, size, color, location on body, when inflicted, by whom, with what)
- Description of child's emotional and/or physical symptoms
- Description of what the caregiver is or is not doing and how it impacts the child
- Description of child's environment
- Description of events, what happened, why it happened
- Medical attention or immediate mental health services required
- Were services already provided? What were the diagnosis and results?

WHEN?

When did the incident occur? When is the safety threat active?

- Description of when the incident occurred
- Specific and detailed dates, times, frequency, duration
- Multiple occurrences
- Specific timeframe

WHERE?

Where did the alleged incident occur? Where is the family now?

- Description of child's environment
- Description of where the caregivers were during alleged incident
- Description of where the family is now
- Jurisdiction

WHY?

Why did the referral source choose to make the referral today? Why did this happen?

- Surrounding circumstances that led to the alleged maltreatment
- Was the alleged abuser impaired by substances, mental health, or otherwise out of control when incident occurred?
- Alleged abuser's intent
- Why did the referral source choose to report the information now?

WHAT IS WORKING WELL?

Who displays acts of protection? How did the parents respond?

- What do you know about family strengths and resilience?
- Information on parental knowledge and response
- What does the caregiver know about the maltreatment? What was their response?
- Who are people the child or caregivers turn to for help?
- What is your relationship to the family, and in what ways can you support them?

HOW TO GET THE INFORMATION WE NEED

The items in the assessment boil down to C + B + I. So, this is the most crucial information to gather. Beyond that, asking the following questions can help workers gain information useful in a child protection referral/investigation. Please note that this is not an all-inclusive list and is meant to serve as a starting point for conversations. It is best to start with open-ended questions, then ask follow-up questions for clarity.

GETTING STARTED

- What do you have concerns about? What is going on in the family? Why did you call CPS today?
- How do you know about the maltreatment? What have you observed or heard? From who?
- What behaviors are concerning to you and why? How does that impact the child?
- When will the alleged perpetrator have access to the alleged victim?
- When did the alleged maltreatment occur? How long did it last? How many times did it happen?

SEXUAL ABUSE

- What did the child say happened? Who did the child say did this?
- Does that person live with the child? How did this happen to come up?
- What is it about the child's behavior that concerns you? How often does the child behave this way? When did it start? Has someone asked the child about this behavior?
- Has the child seen a doctor? What do exam and/or tests show?
- Who saw this happen? What exactly did they see?
- What exactly does the caregiver do? How often does this happen?
- How do you know the children are aware?
- What do the children say about how it makes them feel?
- What happens that makes it seem the caregiver is doing this on purpose for sexual gratification?
- Is there an attempt to do this secretly?
- Are the children asked not to talk about it?

EMOTIONAL INJURY

- What does the caregiver do that is upsetting to the child? How often? How long has it been going on?
- What effect does this have on the child (mood, behavior, relationships, school)?
- What is your knowledge of the caregiver's alignment, perceptions, or view of the child?
- How is the caregiver's behavior contributing to the child's condition?

- Is the child suicidal or self-harming?

PHYSICAL ABUSE

- Did you see the injury? Did someone tell you about it? Who?
- Can you describe in detail the injury (sustained or likely, size, color, location on body, when inflicted, by whom, with what)?
- Did the children require medical attention?
- Who else was present when this happened? Who else knows about this?
- Describe how the child/caregiver reacted immediately after incident that caused injury.
- What did the child (or someone else) tell you about what the caregiver did to punish the child?
- From your perspective, was this intentional? What makes you think so?
- How surprised were you that the child was not injured?
- Did the alleged abuser say anything right before or right after?
- How was the caregiver handling the child?
- Did you see the caregiver do something dangerous near the child or threaten the child?

DOMESTIC VIOLENCE (DV)

- Has there been any police contact at the home? Describe.
- What was the nature of the altercation between caregivers?
- Where exactly was the child? What was the child doing during the altercation (e.g. intervening, being held by one caregiver)?
- What was the potential for harm given the child's proximity to the incident?
- Do you know if anyone else in the home, besides the alleged victims, has been hurt? Describe.
- Do you know if any weapons are in the home? If yes, what kind and who has access?
- Does the child see the DV? How does the child know about the DV?
- What happens between the caregivers? Did the caregivers seem aware of the child's presence? Did the caregivers take any action to protect the child?
- Are family members afraid or intimidated by the alleged perpetrator? If yes, describe.

FUNCTIONING/VULNERABILITIES/COMPLICATING FACTORS

- Can you describe each child in the home? Their functioning? How do they communicate? What is their general mood and temperament?
- Do any of the children have a suspected or diagnosed medical or mental disorder? Describe.
- Do the children have any behavioral challenges? Describe.

- Is the child seeing a counselor/mental health professional? Who?
- Where are the children now, and how are they reacting to the situation?
- Can you describe the adults in the home?
- Do the adults in the home have substance abuse or mental health concerns that pose a threat to the child? Can you describe the concerns? When and how often is this a concern? How do you know?
- Are there multiple alleged victims in the home? If yes, who?

NEGLECT

- Does the child need something that is not being provided?
- What is the caregiver not doing that they should do? Has the child been injured or become ill as a result?
- What is likely to happen to the child if the situation does not change?

SUPERVISION

- Is the caregiver present but inattentive or unable to meet child's needs?
- How long has the child been unsupervised (either due to caregiver being absent or being present but inattentive)?
- How often is the child left unsupervised (either due to caregiver being absent or being present but inattentive)?
- What is the child's age/developmental status?
- What are some examples of what happened when the child was unsupervised (either due to caregiver being absent or being present but inattentive)?

INADEQUATE FOOD

- What does the child typically eat?
- How often does the child go without meals?
- Has the child lost weight or failed to gain weight?
- Is the child having difficulty in school?
- How often does the child go hungry? For how long?

HOUSING CONDITIONS

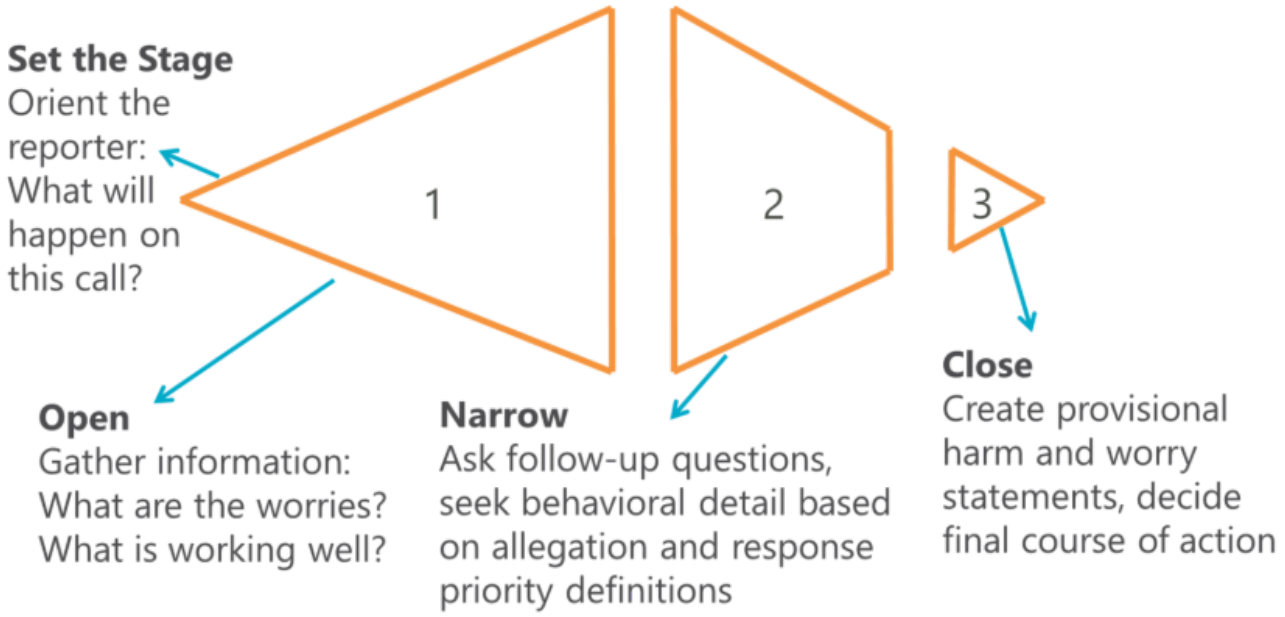
- Can you describe what is dangerous about the home environment?

- What symptoms does the child have? Has the child required medical care due to the living environment that would not have been required if the child was in a different environment?
- Would the child likely become ill or injured if the situation in the house is not changed?
- To what extent are [dirty clothes, rotting food, etc.] present? How long has it been that way? How does it interfere with normal activities?
- What dangerous items can the child access?
- Does the child depend on electricity for a medical device?

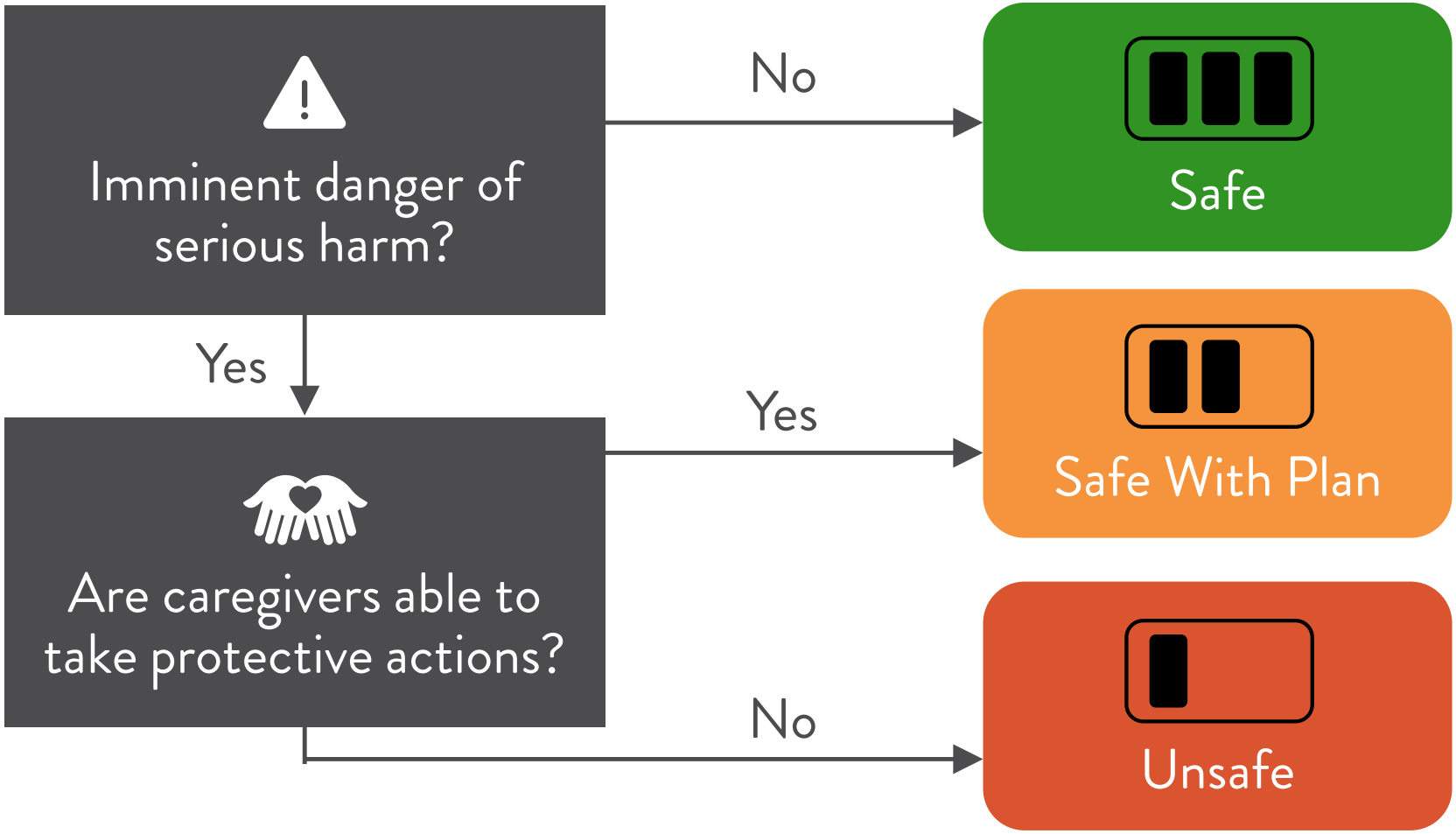
MEDICAL NEGLECT

- What is the child's medical condition? What should the caregiver be doing that is not being done? If it is not done, what will happen?
- How long will it take for that to happen? If the care is provided, how certain is it that the condition will improve? Does the caregiver know and understand this?

Moving down the ladder of inference with the Open, Narrow, Close approach



SAFETY ASSESSMENT LOGIC



C + B + I AND THE RULE OF THREE

If all three are present,
the safety threat threshold is met
(intervention is needed).

OTHER SAFETY THREATS

Review these examples of "other" safety threats. Discuss whether they fit under one of the nine existing threats; and if not, whether they meet the "imminent threat of serious harm" threshold.

- The parents did not want the youth in their care. The parents called law enforcement to get her or they will "kill" her. **(Answer: Belongs under safety threat 1.)**

- Mother has severe mental health issues and prior drug use; mother has a conservator until December 2025. The mother voluntarily placed baby into shelter care on January 8, 2025, after giving birth. The mother is mandated to return to a psychiatric unit upon discharge on January 9, 2025. **(Answer: Belongs under safety threat 3, and really only if the shelter care is going to expire while the mother is unavailable.)**

- The youth has been physically abused in the past and was abandoned from age 6 until he returned at age 13. The parents did not want to accept the child back into their home and stated that he was unwelcome. The parents brought the youth from India under the guise of meeting a relative and abandoned him in California without provision for his care while they returned to India. **(Answer: Belongs under safety threat 3.)**

- There is a Criminal Protective Order where the father is prevented from being within 300 yards of the mother's home where she resides with the children. **(Answer: No imminent threat of serious harm is described in this.)**

- The mother tested positive for methamphetamine during a voluntary drug test at the agency. The mother requested support in addressing the drug use. The mother agrees to voluntarily drug test when requested by the department. **(Answer: no imminent threat of serious harm is described in this.)**

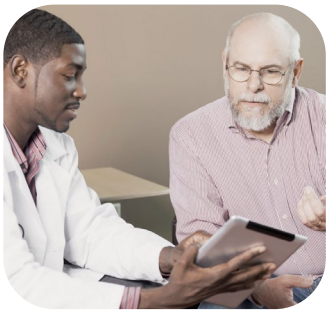
DISTINGUISHING BETWEEN DANGER, RISK, AND NEEDS

The terms **danger**, **risk**, and **needs** are often used interchangeably in child protection. However, when using the SDM system, each of these terms has an important, distinct meaning:

DANGER, RISK, AND NEEDS

DANGER

RISK



NEEDS

Danger is about the short term. When we talk about danger in the context of the SDM system, we are looking for serious and imminent threats to a child.

- *Serious* means the harm would require medical or mental health attention or emergency services. If the worker does not think the threat can be contained, they would not leave the child in the home.
- *Imminent* means the worker reasonably expects that harm will occur right now or in the next few days. This is not about "someday."

Danger is related to safety. The SDM system defines safety as protective actions taken by the caregiver that directly address the danger and are demonstrated over time. The opposite of safety is danger, which is indicated safety threats.

A social worker's understanding of a family's safety may change as they learn more about a family (e.g., on Day 1, they may not know about the mom's substance use but may discover it on Day 10), and as the family changes (e.g., on Day 10, the mom kicks her boyfriend out of the house).

In the SDM system, workers assess safety when they first meet a family and then assess it again whenever their understanding of the family's safety changes. A new safety assessment should be completed anytime a worker is considering whether a child should be removed from the home.

Risk is about the long term. Instead of serious and imminent harm, we are asking about the probability that *any* repeat involvement with child protection will occur in the next one to two years. That may sound like we are trying to predict the future, but we are actually trying to evaluate the odds using a research-based actuarial assessment to help us.

Needs are about underlying conditions in the home—which may contribute to safety threats or risk factors or may be irrelevant. When considering strengths and needs, we are talking about the family's *capacity* to provide for the child's ongoing safety and well-being.

These terms in the SDM system are related to the prioritization of information. We start with danger (and the safety assessment) to learn whether there is a problem we need to address *right now*. Then, we take a little more time to consider risk (and the risk assessment) because risk is further in the future. Needs (and the family strengths and needs assessment [FSNA] or Child and Adolescent Needs and Strengths [CANS]) are at the very end of our list because they help us decide what to do to address any safety threats or risk factors we may have identified in the safety and risk assessments.

WHAT DOES SAFETY LOOK LIKE?

THREE-COLUMN MAP

Worker Name: _____ Case Name/ID: _____ Date: _____

WHAT ARE WE WORRIED ABOUT?	WHAT IS WORKING WELL?	WHAT NEEDS TO HAPPEN NEXT?

This three-column framework is based on the Signs of Safety Assessment and Planning Framework (Turnell and Edwards, 1999; Perth [Australia] Department of Child Protection, 2011); The Consultation and Information Sharing Framework (Lohrbach, 2000); and The Massachusetts Safety Mapping Framework (Chin, Decter, Madsen, and Vogel, 2010).

LINKING THE THREE QUESTIONS AND SOLUTION-FOCUSED QUESTIONS

WHAT ARE WE WORRIED ABOUT?	WHAT IS WORKING WELL?	WHAT NEEDS TO HAPPEN?
Questions of genuine curiosity Assumptions of good intentions Behavioral detail Impact on the child "Voice" of the child **Externalizing the problem** • When did the violence first come into your life? • Who/what/where/when? • How often, how much? • First, last, most recent? **Position questions** • What is your child worried about? • What would [trusted friend or relative] be worried about? **Relationship questions** Who else is worried? **Networks** Who else knows? **Scaling** • Safety/danger, progress • What is keeping the number from being higher? **Future unchanged** What will happen if things keep going the way they are going?	Questions of genuine curiosity Assumptions that good intentions are not always enough Behavioral detail Impact on the child "Voice" of the child **Exception questions** • Has there ever been a time when, before you got high, you were able to find a safe adult to watch your child? • Who/what/where/when? • How often? How much? • First, last, most recent? **Coping** • How have you made it this far? • How have you accomplished what you have? **Position questions** • Is it important to you that you have taken these steps? • Why? **Relationship questions** Who would be most pleased that you have taken these steps? **Network** Who helps? **Scaling** • Safety/danger, progress • What is keeping the number as high as it is?	Questions of genuine curiosity Assumptions that best-made plans do not always work out as they should Behavioral detail Impact on the child "Voice" of the child **Preferred future questions** • How would you like things to be instead? • If we meet up in a year and things are better, what will they look like? **Position questions** What kind of difference would it make for you to take this step? **Scaling** • What does up by one look like? Up by two? • Willingness, confidence, capacity **Relationship questions** • What do other people hope will happen? • What can they do to help? • What kind of difference would it make to your children to take these steps? **Monitoring questions** • How will we know this is working? • Who will have to see what?

Handout by Philip Decter

POSSIBLE QUESTIONS FOR AN APPRECIATIVE INQUIRY INTERVIEW[1]

Using the EARS Model: Eliciting, Amplifying, Reflecting, Start Over

ELICITING QUESTIONS

Choose one

Can you tell me about:

- ☐ Recent work about which you feel particularly good?
- ☐ When you got stuck while working with a family, yet still made progress?
- ☐ When a situation you cared about had the potential to become a "train wreck," yet you were able to manage this difficult situation?

AMPLIFYING QUESTIONS

Choose four to eight, at least one from each area

AREA 1

- ☐ Where did this happen?
- ☐ When did this happen?
- ☐ Who else was involved?
- ☐ How did you make this happen?
- ☐ What else did you do? What else? And what else?

AREA 2

- ☐ How did you get the idea to do it that way?
- ☐ Was that hard for you to do?
- ☐ What was the hardest part of this work for you?
- ☐ Even though that part was hard, how did you keep it going?

AREA 3

- ☐ What did the other person do to build this success?
- ☐ What would that person say you did to help achieve the outcome?
- ☐ How did you know you were helping?
- ☐ What changes did you see in that person that showed you were helping?

AREA 4

- ☐ What made you most proud about this situation?
- ☐ If we had a video of you doing that proudest thing, what would we see?
- ☐ What practices go into doing that?
- ☐ What steps went into those practices?

[1] Adapted from Turnell, A. (in press). Building a culture of appreciative inquiry around child protection practice. In Turnell, A., *Building safety in child protection practice: Working with a strengths and solution focus in an environment of risk*. Palgrave Macmillan. For more information, contact author at andrew.turnell@signsofsafety.net

REFLECTING QUESTIONS

Choose at least two.

- ☐ What would you like to bring from this work to similar situations?
- ☐ What would you share from this work with colleagues in similar situations?
- ☐ What was the most important thing you learned from this work?
- ☐ What would you like to do with what you learned? How would you like to bring it into your work?
- ☐ What does your answer to the previous question say about what you value?
- ☐ What does that say about your hopes and dreams for this work?
- ☐ What does that say about what you are committed to and what you stand for?

START OVER

- ☐ Repeat as needed, especially when addressing multiple issues in one session.

INTERVIEW WRAP-UP

- ☐ What have you learned or relearned about yourself or your work from this conversation?
- ☐ What kind of difference, if any, does it make to hear yourself say these things out loud today?

RISK ACTIVITY

Read each statement in the following table, identify which risk item it pertains to, and determine how it would be scored on the risk assessment.

STATEMENT	CORRESPONDING RISK ITEM	SCORE NEGLECT & ABUSE
1. Family has three previous investigations: two for neglect and one for abuse.	**R1**	**2, 1**
2. A 3-year-old child is diagnosed with cerebral palsy.	**R9**	**1, 1**
3. Dad (primary caregiver) says he told his child to stop a behavior or they would get a timeout. The child did not stop, and so he locked the child in a closet.	**R12**	**0, 1**
4. Dad (secondary caregiver) has a history with the department as a child victim.	**R13**	**1, 1**
5. Mom (primary caregiver) is diagnosed with depression. She is currently seeing a therapist and taking antidepressants.	**R14**	**1, 1**
6. Dad (secondary caregiver) denies having a drinking problem and has never received treatment. He drinks every day, has lost his job due to showing up drunk multiple times, and was arrested last month for drunken driving.	**R15**	**1, 1**
7. Family's home does not have gas for heat, and the electric oven is used to keep it warm.	**R10**	**0, 0**

OVERRIDE WORKSHEET

#	SCORED RISK LEVEL	FINAL RISK LEVEL	RATIONALE	APPROVE?
1	Moderate	High	Father is dependent on opioids.	○ Yes ● No
2	Low	Moderate	First-time caregiver of infant.	○ Yes ● No
3	Moderate	High	First-time caregiver of infant AND no support system AND evidence of missed opportunities to demonstrate protection, such as not coming to the hospital to meet with nurses to learn care and not demonstrating safe holding or feeding.	● Yes ○ No
4	Moderate	High	Mother wants a program that is available only to families with an open case.	○ Yes ● No
5	High	Very high	Caregivers were hostile and resistant.	○ Yes ● No
6	Moderate	High	The abuse incident occurred in a context of extreme stress, and caregiver remains under extreme stress.	● Yes[2] ○ No

OVERRIDE RISK LEVEL OR ALTERNATIVE ACTION

#	SITUATION	OVERRIDE RISK?	DOCUMENT ALTERNATIVE ACTION?
1	Risk level is high. Family had an open case in the past year. They worked hard and reduced their risk and achieved safety. The current report was a misunderstanding, and there has been no new harm. The family members continue to work on actions of protection they learned. All the things that contributed to reduced risk before case closure are still in place. They have kept their family team, and they have good support. They are working with the same professionals from their previous open case, and the professionals say the family is doing well. Everyone agrees to call the hotline if something worries them.	○ Yes ● No	● Yes ○ No
2	Risk level is moderate. Mother wants a program that is available only to families with an open case.	○ Yes ● No	● Yes ○ No
3	Risk level is very high. The reported incident could not be confirmed or ruled out. Evidence would not support a petition to court. No safety threat is identified. The family declines services.	○ Yes ● No[3]	● Yes ○ No

[2] Description of the source of the stress would be stronger documentation.

[3] An override to risk level would not even be possible.

#	SITUATION	OVERRIDE RISK?	DOCUMENT ALTERNATIVE ACTION?
4	Risk level is very high. The current incident is unfounded, all children are under 5, and parents are isolated.	○ Yes ● No[4]	○ Yes ● No

[4] An override to risk level would not even be possible.

EVIDENT CHANGE
Inform Systems. Transform Lives.

TALKING WITH FAMILIES ABOUT RISK

WHY?

- Nothing about us without us
- Knowing your risk can inform your decisions

EXAMPLES

Insurance

Age
Gender
Driving history

→ Higher or lower likelihood of making a claim

Health

Genetics
Blood pressure
Diet and exercise
Smoking

→ Higher or lower likelihood of having a heart attack

Weather

Cloud patterns
Barometric pressure
Wind speed

→ Higher or lower likelihood of rain

KEY POINTS

- "High risk" does not guarantee something will happen.
- "Low risk" does not guarantee something will *not* happen.
- "High risk" means that what is happening in your family right now is similar to what has happened in other families that led to one or more additional child protection calls. In some of these cases, this may mean that a child was actually harmed.
- A lot of things that can cause your risk level to be high are not in your control. Other things can be affected by decisions we make.

SAMPLE STATEMENTS FOR SOCIAL WORKERS

- Tell me about your kids, the things you love about them, and how you have overcome challenges for them.
- Tell me about a day in the life of your family, the fun stuff and the challenges.
- Tell me about the values that are important to you about raising children.
- Tell me about you. What has your path in life been like? What challenges did you face as a child? What challenges have you faced in the last few years?
- Let's look at some of the items that have your risk elevated right now. How can we help you make changes that can lower some of your stress?

A TALE OF TWO RISK SCORES

Let's take a closer look at some SDM risk classifications for two families. While the SDM risk assessment assigns an overall risk classification to households with allegations to support decisions about service intervention, this risk classification should be combined with other information and good social worker skills and judgment to **support** decisions, not make them.

Directions: Using the SDM risk assessment definitions, compare the following risk classification for two households where an in-person investigation has just occurred. Note that the abuse total is included at the bottom, but the scores for each item in this table are just the neglect scores. Answer the questions that follow the table in small groups.

	THREE-TEENS HOUSEHOLD	THREE-UNDER-5 HOUSEHOLD
1 "prior neglect investigations"	2	0
2 "prior abuse investigations"	1	0
3 "prior case, not still open"	1	0
4 "prior physical injury"	0	0
5 "current report = neglect"	1	1
6 "four or more children"	0	0
7 "caregiver blames child"	0	0
8 "youngest child under 2"	0	1
9 "children in the household . . . developmental disability"	0	1
10 "housing is unsafe, or homeless"	0	0
11 "two or more incidents of domestic violence"	0	0
12 "employs appropriate/inappropriate discipline"	0	0
13 "caregiver history of abuse or neglect as a child"	0	1
14 "caregiver mental health"	0	1
15 "alcohol or drug use"	0	1
16 "one or more criminal arrests"	1	0
Neglect score (6–8 = high)	6	6
Abuse score (5–7 = high)	6 (includes 1 from item 4)	5
Final score (the higher of the abuse and neglect)	High	High

DISCUSSION QUESTIONS

- What jumps out about various items in the different households based upon the children's ages?
- Which items could benefit from services or support?
- Which items speak to the current circumstances for the children in the home?
- How could decisions about service interventions be guided by this information?

REUNIFICATION ASSESSMENT TREASURE HUNT

Instructions: Fill in each blank with the correct word or phrase.

1. On the reunification risk reassessment, compliance with or attendance of services is **not** **(Page G11, R3 definition)** sufficient to indicate behavioral change.

2. If a caregiver demonstrates new skills and behaviors consistent with all family case plan objectives and is actively engaged to maintain objectives, they should be scored as **"a"** or **response "a"** **(Page G12, R3)**.

3. Policy overrides on the reunification assessment increase the risk level to **very high** **(Page G13, Policy Overrides section)**.

4. When evaluating visitation frequency, "totally" means the caregiver regularly attends visits or calls in advance to reschedule with **90% to 100%** **(Page G14, Visitation Frequency, Total)** compliance.

5. "Routine" visitation frequency indicates **65% to 89%** **(Page G14, Visitation Frequency, Routine)** compliance with the visitation plan.

6. Visitation quality rated as "strong" or "adequate" means the caregiver consistently demonstrates acts of **protection** **(Page G15, Strong/Adequate table row)** and supportive behaviors toward the child.

7. When calculating visitation frequency, divide the total number of **completed** visits by the number of **planned** **(Page G14, Visitation Frequency section)** visits.

8. Prior to assessing current safety on the reunification assessment, the worker should review the **safety assessment** **(Page G16, footnote 3 and Safety Threats section)** that led to removal.

9. A safety decision of "safe with plan" requires that a **safety plan** **(Page G17, Safe With Plan definition)** be completed.

10. For children under age 3 at time of removal, if it is after the **six** **(Pages G6–G7, Decision Tree for Children Under Age 3)**-month hearing and reunification risk level is high or very high, the recommendation is to pursue permanency alternative.

11. For children age 3 or older at time of removal, the recommendation to pursue permanency alternative occurs if it is after the **12** **(Pages G7–G8, Decision Tree for Children Age 3 or Older)**-month hearing, risk is high or very high, and visitation/progress is unacceptable.

12. The reunification assessment should be completed at a minimum every **six** **(Page G20, WHEN section)** months from point of removal.

13. If adequate time has passed to demonstrate case plan progress, it is recommended to complete the reunification assessment every **90** **(Page G20, WHEN section)** days.

14. A policy override applies when there has been sexual abuse, the perpetrator has access to the child, and the perpetrator has not successfully completed **treatment** **(Page G13, Policy Overrides, Item 1)**.

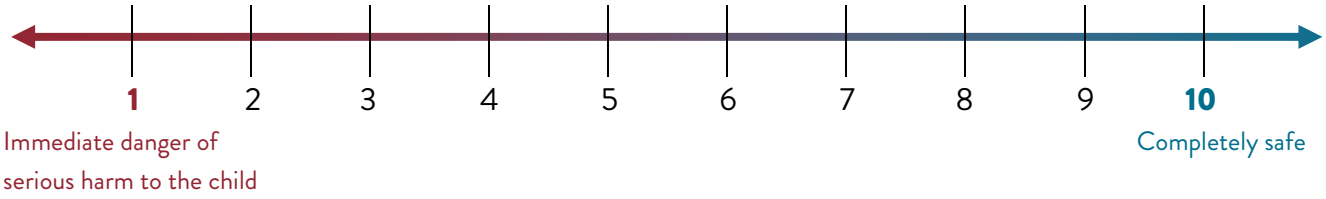
15. The reunification assessment guides the decision to return a child home, continue FR services, or pursue a **permanency alternative** **(Page G21, DECISION section)**.

REUNIFICATION DISCUSSION GUIDE

For Monthly Contacts With Parents and Child and Family Team Meetings

SAFETY: Review the safety goal, what is going well for the family, and the progress they see themselves making. If there is no safety goal, this is an urgent issue and needs to be addressed, possibly in a Child and Family Team (CFT) meeting. Then ask:

If 1 is immediate danger of serious harm and 10 is completely safe, what would you select for your household?



Review the worries and the danger statement formulated for the case plan. Ask follow-up questions such as:

What makes it a __ and not a 1? What number do you think [person in their network] would select? Why? What could we do together and with your safety network to move up by 1 by next month?

VISITATION: Next, address visitation quantity and quality.

How often can you attend your visits? On a 1–10 scale where 1 is not at all and 10 is all the time, what would you select for each of these descriptions? If there are siblings, how is the score different based on each child's age?

The caregiver . . .

- Does something to protect the child if anything threatens them during a visit;
- Pays attention to the child's behavior and meets any child needs that come up;
- Knows what their child needs in general and tries to meet those needs;
- Sets good rules and helps the child learn right from wrong in a helpful way;
- Focuses on the child instead of distractions, such as phones or such as problems that cannot be resolved at the visit;
- Asks about and cares about the child's school experience, activities, and doctor visits; and
- Takes care of the child before doing things for themself.

CASE PLAN PROGRESS: Last, address behavior change resulting from case plan activity participation.

Let's look at what is on your case plan. Using the same 1–10 scale, how much behavior change have you accomplished? How actively are you using available services? What barriers could you use help overcoming? Who in your network could we ask for support from?

SDM POLICY AND PROCEDURES MANUAL CRITERIA	CONVERSATIONAL SUGGESTION
Consistently demonstrates acts of protection and supportive behaviors toward the child that are consistent with case plan objectives.	If anything threatens the child during a visit, the caregiver does something to protect them.
Demonstrates an ability to recognize child's behaviors and cues; generally responds appropriately to behaviors and cues.	The caregiver pays attention to the child's behavior and meets any child needs that come up.
Identifies the child's physical and emotional needs; responds adequately to these needs.	The caregiver knows what their child needs in general and tries to meet those needs.
Demonstrates effective limit-setting and discipline strategies.	The caregiver sets good rules and helps the child learn right from wrong in a helpful way.
Demonstrates a focus on the child during visits; shows empathy to child.	The caregiver focuses on the child instead of distractions, such as phones or problems that cannot be resolved at the visit.
Demonstrates interest in school, other child activities, medical appointments, etc.	The caregiver asks about and cares about the child's school experience, activities, and doctor visits. The parent is informed that they can attend the child's medical, dental, school, and other appointments.
Demonstrates behaviors that prioritize the child's needs over their own.	The caregiver takes care of the child before doing things for themself.

RISK REASSESSMENT PRACTICE

Read each statement, identify which risk item it pertains to, and determine how the risk reassessment would be scored for it.

STATEMENT	CORRESPONDING RISK ITEM	SCORE
1. Family has three previous investigations: two for neglect and one for abuse	**R1**	**2**
2. A 3-year-old is diagnosed with autism	**R4**	**1**
3. Primary parent (only caregiver) has made great progress toward case plan goals, attending services and demonstrating and employing new parenting strategies.	**R10**	**0**
4. Secondary parent has a history with CPS as a child victim. Primary parent reports they do not.	**R3 (not applicable, the item only asks about primary)**	**0**
5. Primary parent is diagnosed with depression. The parent is seeing a therapist and taking antidepressants and reports feeling much more grounded since participating in sessions.	**R8 (c)**	**0**
6. Secondary parent denies having a drinking problem and has never received treatment or been encouraged to seek treatment by anyone. Primary parent reports drinking every day, has lost their job after showing up drunk multiple times, and was arrested last month on allegations of drunken driving, even after involvement with child protection.	**R6 (a) and (d)**	**Primary: 1 Secondary: 0**
7. Primary and secondary parents report having one or two verbal arguments that resulted in one parent leaving the household to "cool off." They reported that they resolved the issue upon the other's return without any incidents. Both deny any physical assaults or arguments resulting in violence or requiring police involvement. All collateral contacts support this information	**R7 (a) Discuss healthy coping versus tumultuous if participants are tempted to select "b."**	**0**

SMALL-GROUP DISCUSSION ON RISK

INSTRUCTIONS

In your small group, discuss the following. Feel free to share your experiences and insights openly.

- How often do you talk to families about their risk level currently?
- What do those conversations look like?
- Can you think of a time when it was easy to talk to a family about their risk level? A time when it was difficult? What made the difference?
- What support would help you in having conversations with families about risk?

NOTES

THE "VOICE" OF THE SDM MODEL

WHEN

In a group or individual case consult session that is related to a key decision: whether to remove a child, open a case, develop a plan for child safety or family action plan, return a child home, change permanency goal, or close a case.

WHY

1. To help focus the conversation on what is most relevant to the decision at hand.
2. To help distinguish danger from complicating factors.

HOW

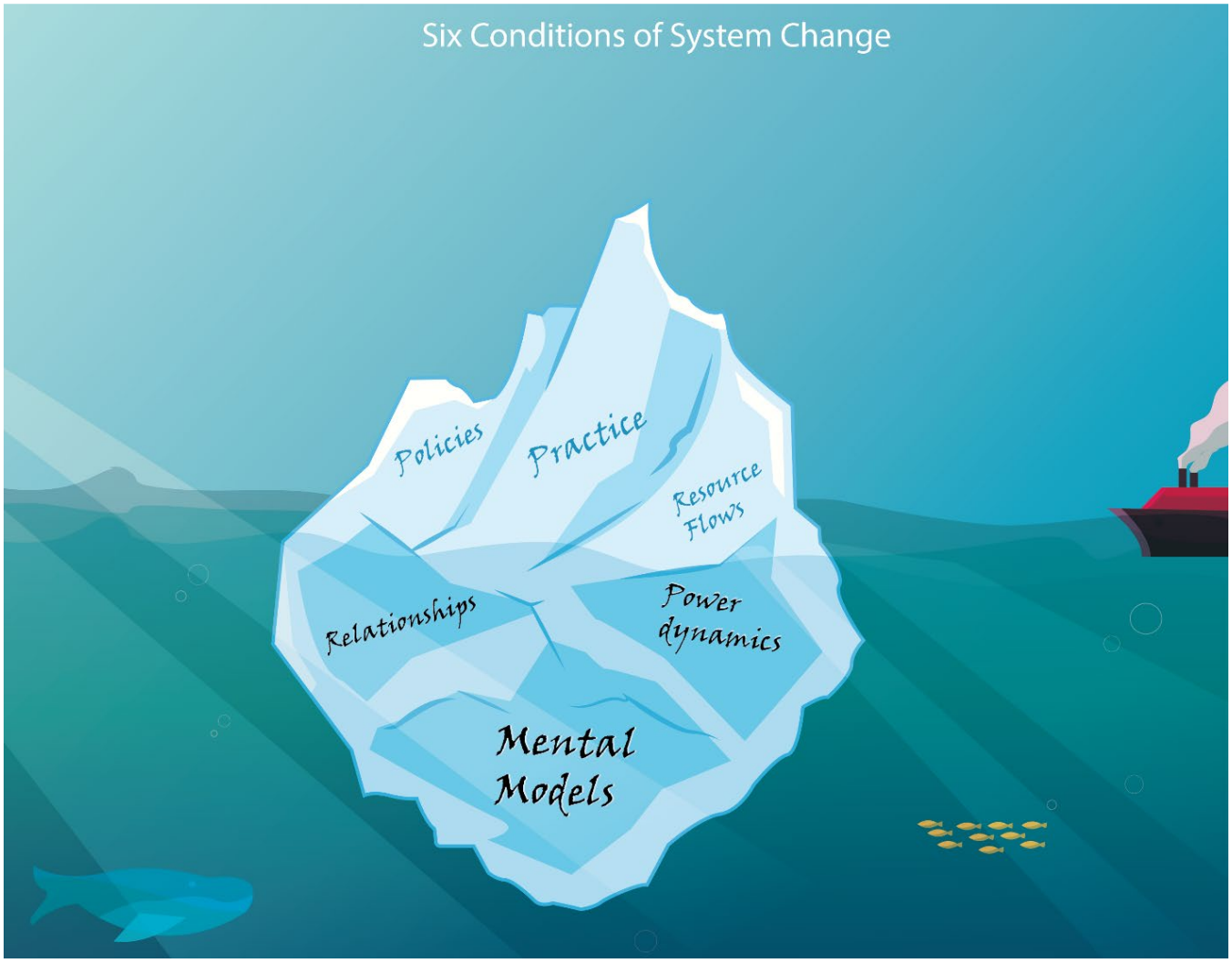
1. One person in the group is designated the "voice" of the SDM model.
2. That person follows along on the relevant SDM assessment and definitions throughout the consult.
3. The "voice" of the SDM model should ask the group to pause if it:
   - Spends more than a few moments on information that is not relevant;
   - Gets stuck on whether something is a danger versus a complicating factor or a strength versus a protective action;
   - Misidentifies something as a danger, complicating factor, strength, or protective action; and/or
   - Moves toward "what needs to happen" before covering all relevant information to have a shared definition of the problem.
4. If the group needs to pause, the "voice" should read the relevant item and/or definition. The person facilitating should then ask questions to help surface the necessary information.

EXAMPLES

1. In a case consultation, the group is talking about the extensive arguing and occasional physical fights between parents. Some people in the group see this as harm, while others see it as a complicating factor. The consult's purpose is deciding whether the child needs to be removed. The "voice" should read the SDM safety threat definition for domestic violence. The facilitator should then use the definition to craft questions that will surface behavioral detail that, based on the definition, will help sort whether domestic violence creates imminent risk of serious harm based on caregiver actions in *this* family and the impact on the child.

2. In a case consultation to determine whether a child should be reunified, the group is getting sidetracked by an issue related to the child's behavior in school that is unrelated to risk, family time, or safety. The "voice" should pause and redirect the group to any aspects of reunification risk or safety that have yet to surface.

SIX CONDITIONS OF SYSTEMS CHANGE



TECHNICAL PROBLEMS, ADAPTIVE CHALLENGES, AND APPROACHES TO LEARNING

Psychologist Ronald Heifetz has made a distinction between two kinds of challenges we face in our work: Technical problems and adaptive challenges.

A **technical problem** yields a right answer through the application of an appropriate and pre-made plan. Many problems in mathematics, science, engineering, or business feature technical problems that have right answers that "fit" the problem. We can usually address these by working "above the waterline" of the iceberg.

An **adaptive challenge** does not have a clear, premade particular or certain answer. Adaptive problems are real-world problems where data are uncertain, conflicting, or ambiguous; where people can reasonably disagree about appropriate actions to resolve the problem or where personal ethics or values are in conflict. These challenges require that we address what is "below the waterline" of the iceberg.

CHARACTERISTICS OF TECHNICAL PROBLEMS

- Easy to identify
- Solutions can often be implemented quickly—even by edict
- Often lend themselves to quick and easy (cut-and-dried) solutions
- Often can be solved by an authority or expert
- Require change in very few places; often contained within clear boundaries
- People are generally receptive to technical solutions.

CHARACTERISTICS OF ADAPTIVE CHALLENGES

- Difficult to identify
- Require changes in values, beliefs, roles, relationships, and approaches to learning
- Require people with the challenge to be involved in the work of solving it
- Require change in numerous places; usually cross organizational boundaries
- People often resist even acknowledging adaptive challenges.
- "Solutions" require experiments and discovery; usually an approach to learning

EXAMPLES OF TECHNICAL PROBLEMS

- How do you refer a family for services?
- How do you fill out a foster care referral form?
- How do I log a note in an IT system?
- How do I make a mandated report?
- What kind of "release of information" needs to be signed to invite network members to a family team meeting?

EXAMPLES OF ADAPTIVE CHALLENGES

- What kind of services will be most effective for this family?
- Will this young person do better in this foster care placement?
- How do I document all the nuances of what occurred on this home visit in the IT system?
- Do I tell the family that I am making a mandated report?
- Who from the network should be invited to this family team meeting? How can I work with the parents to make some agreements about who will be invited?

RESPONDING TO ADAPTIVE CHALLENGES

"There is nothing trivial about solving technical problems. Technical challenges can be life threatening and technical problem-solving can be life-saving. But the urgency or importance of the challenge is not what distinguishes an adaptive problem from a technical one. An adaptive challenge is primarily one that requires people to develop brand new ways of thinking or doing things."—Heifetz

Responding to both technical problems and adaptive challenges is not easy. Technical problems were once adaptive challenges that we have now found more direct and clear solutions for—but it does not mean it is simple or easy. What distinguishes adaptive challenges is that they essentially require an approach to problem solving similar to experimentation—where you as a practitioner have to set yourself and the challenge up for observation, testing and learning.

In some ways the heart of responding to adaptive challenges requires a humility—there is no way to know at the outset of your work what the impact of your intervention is going to be. It is not dissimilar to "feeling your way" in the dark—hands outstretched trying to make sure you do not hit your head or stub your toe.

Some of the key questions you can consider when approaching adaptive challenges:

- What are the areas you are hoping to have an influence on?
- How can you set yourself up in a position to have the maximum influence possible?

- Whose help will you need to do this?
- How will you be in partnership with them?
- How will you know if what you are doing is having the desired effect?
- What kinds of actions will become available once you take your first steps?

HELPING OTHERS RESPOND TO ADAPTIVE CHALLENGES

"When you obtain a position of significant authority, people inevitably expect you to treat adaptive challenges as if they were technical—to provide a remedy that will restore equilibrium with the least amount of pain and in the shortest amount of time.

That puts an enormous amount of pressure to have an 'answer' rather than raise (and sit with) the really tough questions." —Heifetz

People who are thought of as leaders in organizations are often sought out by supervisees or learners when they are faced with adaptive challenges. These people can be seeking a technical or "simple" solution to their adaptive problem, and the pressure to provide that can be great.

While there will undoubtedly be moments you need to provide direct, immediate ideas and next steps, learning to recognize when people are approaching you to provide for technical solutions to their adaptive problems can help you learn how to best coach and support new learning.

SOME QUESTIONS YOU CAN CONSIDER AT MOMENTS LIKE THESE

- How urgently is a solution needed? Is there time to slow down and help the person seeking help to see that this is an adaptive challenge?
- What is at the heart of what the person seeking assistance is looking for? What part of that might they already have an answer for?
- How are they approaching the problem? What parts of their approach recognize that it is an adaptive problem and create conditions for experimentation and learning?
- Who are they working with to help solve it? Who are they in dialogue or partnership with? Who else would they need to connect with in order to help move forward?
- How would they know if they were doing was working?

NEXT STEPS

Thinking about this distinction can open new possibilities in your leadership and help you confront new dilemmas. As you move forward, you might consider the following questions.

- What are the technical problems you are faced with every day, the ones that you hear about over and over again? What "simple solutions" might help people be better prepared to respond to these without your aid?
- Which adaptive challenges do you get faced with more regularly? The ones that make you "stop in your tracks"? Are there patterns in the adaptive challenges you are facing? With families? With staff? What do you notice coming up again and again?
- When you are at your best, how do you approach those adaptive challenges?
- Who or what helps you to do this?
- Whose help do you need to continue to do more of that?
- How will you know when you have been successful?

FOR MORE INFORMATION, SEE

Heifetz, R. (1994). *Leadership without easy answers.* Harvard University Press.

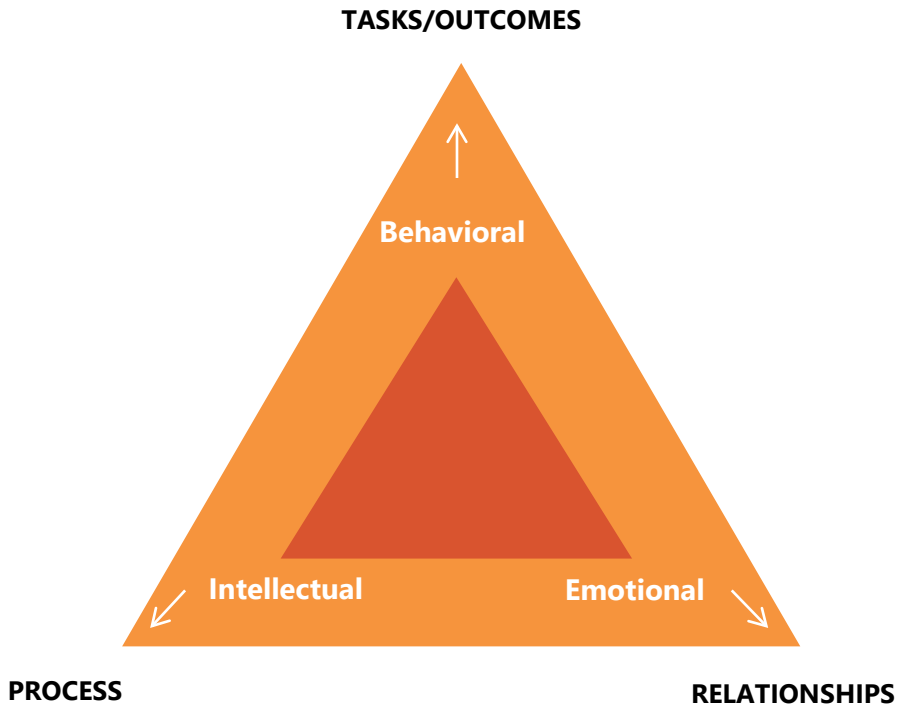
Heifetz, R., Grashow, A., & Linsky, M. (2009). *The practice of adaptive leadership: Tools and tactics for changing your organization and the world*. Harvard University Press.

DIMENSIONS OF SUCCESS

RELATIONSHIPS characterized by openness, honesty, and a collaborative attitude.

PROCESS characterized by participation and the exchange of information in ways that promote understanding and decision making.

TASKS/OUTCOMES from this process based on informed decisions, clear and shared understandings, and clarity about roles.



Supervisors must help workers connect with the work *emotionally*, not just intellectually, before they will shift their behavior or practice.[5]

[5] Adapted from Interactional Institute for Social Change and VISIONS, Inc.

FACILITATIVE SUPERVISOR KEY PRACTICES

THINKS CRITICALLY

Engages in the process of problem solving, decision making, giving consideration to external data, and evaluating one's own assumptions and biases to fully assess and generate the greatest clarity possible about what is happening in any given situation.

STRUCTURES SUPERVISION

Conducts supervision in multiple formats such as individual, group, and ad hoc consultation, using inquiry and facilitative behaviors to promote social workers' best practices.

COACHES SUPERVISEES

Coaches supervisees to encourage learning related to their individual caseloads as well as their long-term professional development.

MANAGES RELATIONSHIPS

Assist supervisees with managing relationships with colleagues, families, and external partners to minimize conflict and engage people in productive relationships.

ADAPTS APPROACHES

Customizes approaches to supervision based on the developmental stages, learning styles, strengths, and challenges of their individual supervisees.

PROMOTES ACCOUNTABILITY

Focuses attention on information and performance measures in order to continually reassess and make adjustments to achieve agency outcomes.

BREAKOUT GROUP: FACILITATIVE SUPERVISOR KEY PRACTICES AND ACTIVITIES

Place a checkmark next to all the activities you engage in at your job. Next, put a plus sign next to activities that you do especially well and a delta sign (or a minus sign) next to areas where you think you need improvement. After your self-review, talk as a group and add more activities related to each of the key practices, your role in Safety-Organized Practice (SOP), and your job responsibilities.

THINKS CRITICALLY

- Recognizes the role that cultural differences play in engaging staff and families
- Assesses situations
- Helps to develop case formulations
- Solves problems with workers to assist families
- Assesses safety
- Assesses danger
- Strategizes about ways to engage families
- Analyzes information from the SDM assessment tools to make decisions
- Assesses potentially dangerous situations in the field
- Expands thinking about definitions of family
- Assists workers with diligent searches
- Helps workers to identify and access resources
- Recruits and selects workers based on requirements of the job and unit fit

What else?

STRUCTURES SUPERVISION

- Meets with workers one-on-one on a regular basis using dialogue structure and case consultation framework
- Reviews cases with workers methodically
- Provides group supervision/case consultation/teaming to review challenging cases on a regular basis
- Manages group dynamics during group supervision/case consultation
- Uses solution-focused questions to extract information

What else?

COACHES SUPERVISEES

- Uses solution-focused questions to guide workers in making decisions
- Helps make determinations for differential response (if applicable)
- Assists workers in identifying supports or services to meet family needs
- Identifies strengths and needs of workers
- Helps workers identify the presence of protection
- Reviews assessments using coaching techniques
- Guides workers through mapping in cases
- Gives and receives balanced feedback
- Guides workers to learning opportunities
- Creates professional development plans with workers
- Guides workers using coaching techniques to improve communication and interactions with families
- Reflects with workers on how cultural differences (all aspects of one's identity contribute to culture) influence their interactions with a family.
- Guides workers through the use of the SDM assessment tools
- Helps workers differentiate between decisions about safety and risk
- Uses coaching techniques to determine appropriateness of case closure
- Teaches about new policies and practices and implications for practice
- Encourages use of family engagement techniques
- Orients new workers to agency policy and practice
- Educates workers on child development
- Models strengths-based techniques

What else?

MANAGES RELATIONSHIPS

- Promotes awareness of self and others by acknowledging the differences between self and staff
- Displays willingness to address conflicts using the multicultural guidelines as a support tool
- Shares awareness of institutional and interpersonal oppression in the workplace with staff and is willing to name it and address it
- Models and encourages positive, engaging relationships with families
- Builds collaborative relationships with community partners
- Brings a trauma-informed lens to staff development and promotes stress management and self-care
- Builds team cohesion within the unit
- Helps to reach common understanding on cases with team members

- Mediates conflict within the units and within the office

What else?

ADAPTS APPROACHES

- Accommodates different learning styles when teaching workers
- Revises approach to supervision based on workers' lengths of tenure with agency, ages, strengths, and challenges
- Addresses job-related stress and secondary trauma and customizes strategies for managing these issues
- Distributes and manages caseloads effectively
- Motivates workers individually
- Is accessible to workers based on individual needs
- Explores how each worker's whole identity requires a unique approach for successful supervision
- Matches approach to workers' developmental stages
- Recognizes achievement

What else?

PROMOTES ACCOUNTABILITY

- Documents activities as necessary
- Monitors key indicators
- Uses data for decision making
- Shares data reports with workers
- Ensures home visits are conducted according to policy and good practice
- Guides workers to make out-of-home permanency plans for children as a last resort
- Monitors individual and unit caseloads
- Assesses individual performance
- Develops performance improvement plans with the worker when performance is not meeting standards
- Ensures that families' cultural heritage, identity, and affiliations are explored and documented
- Focuses on the outcomes of safety, permanency, and well-being
- Helps workers achieve accountability and realization of practice values while using the multicultural guidelines

What else?

THE FACILITATIVE SUPERVISOR SELF-ASSESSMENT

Supervisor Name: _____ **Date:** _____

THINKS CRITICALLY The process of problem solving, decision making, considering external data, and evaluating our own assumptions and biases to fully assess and generate the greatest clarity possible about what is happening in any given situation.			
Item	**1: EMERGENT PRACTICE**	**2: ACCOMPLISHED PRACTICE**	**3: DISTINGUISHED PRACTICE**
1. Knows and uses a questioning approach to joint problem solving (e.g., appreciative inquiry, solution-focused interviewing, motivational interviewing).	Has recently been introduced to a questioning approach to problem solving and does not use that problem-solving method yet. Without this skill, sometimes ignores problems or uses an inappropriate or ineffective approach to resolving problems. Cannot differentiate between technical and adaptive problems. Often considers problems to be equally important/urgent, which interferes with prioritization.	Has learned a questioning approach to problem solving and follows this protocol when resolving problems with workers or cases. Differentiates among types of problems and knows how to prioritize problem-solving efforts based on urgency; can solve problems effectively.	Can teach, mentor, or coach another supervisor about problem solving and help them to become competent.

THINKS CRITICALLY The process of problem solving, decision making, considering external data, and evaluating our own assumptions and biases to fully assess and generate the greatest clarity possible about what is happening in any given situation.			
Item	**1: EMERGENT PRACTICE**	**2: ACCOMPLISHED PRACTICE**	**3: DISTINGUISHED PRACTICE**
2. Applies critical thinking skills in all aspects of casework.	Tends to take information that workers share at face value without probing for more information or challenging attributions and early hypotheses about what is happening in the case and ways to intervene effectively in families. Thus, many families needlessly enter the system while some children are left in dangerous situations at home or in foster care.	Routinely applies critical thinking skills when talking with workers about casework. Helps workers challenge early assumptions about families and question hypotheses until the best evidence is unearthed, so that appropriate decisions can be made about presence of safety, family strengths, danger, and risk. Also uses these skills when helping workers assess achievement of case goals and find useful resources for families and children.	Can teach, mentor, and coach other supervisors about how to hone critical thinking skills and use them to challenge workers to do their best work with families and children.
3. Understands the role of cultural differences when joint problem solving.	Does not yet have awareness of how cultural differences (e.g., race, class, sexual orientation, gender, immigration status) can create barriers to effective problem solving if not considered as part of diagnosing and assessing the issues at hand.	Recognizes the value in consistently asking for the ways a family is culturally different from the worker to ensure effective case practice. Ensures that the worker has a means to assess the meaning of culture for all families, encourages open discussion of differences, and responds to culturally biased cues.	Can teach, mentor, and coach other supervisors about how to support workers as they advocate for and with families against the institutional and interpersonal devaluation of different cultural experiences.

STRUCTURES SUPERVISION Conducts supervision in multiple formats such as individual, group, and ad hoc consultation, using inquiry and facilitative behaviors to promote social workers' best practices.			
Item	**1: EMERGENT PRACTICE**	**2: ACCOMPLISHED PRACTICE**	**3: DISTINGUISHED PRACTICE**
1. Meets regularly with workers one-on-one to methodically review cases, extract key information about cases, and help workers make more informed decisions and practice more effectively.	Only meets with staff during crises. Does not yet set aside time to methodically review cases with individual workers so as to extract key information about cases and help workers make more informed decisions and practice more effectively. Does not yet notice or understand how the cultural differences between the supervisor and the social worker affect the relationship.	Regularly meets with workers one-on-one to methodically review cases, extract key information about cases, and help workers make more informed decisions and practice more effectively. Has an understanding that cultural competence is an ongoing learning process that is integral and central to daily supervision. Continually evaluates growth and development throughout different levels of cultural competence in practice.	Can teach, mentor, or coach another supervisor about how to meet with workers to extract essential information through the use of critical questions based on critical thinking skills.
2. Able to lead case consultations or group supervision and develop sound clinical solutions for the cases under review.	Is learning how to facilitate meetings. Cannot yet help staff develop sound clinical solutions for the cases under review. Does not currently have a common language or process to support cultural differences during case consultations or group supervision.	Able to facilitate and manage group dynamics while all participate in problem solving. Helps staff develop sound clinical solutions for the cases under review by asking solution-focused questions to surface answers from workers. Uses common language and process to support the cultural differences during case consultations or group supervision.	Can teach, mentor, or coach another supervisor about how to facilitate meetings.

COACHES SUPERVISEES Coaches supervisees to encourage learning related to their individual caseloads as well as their long-term professional development.			
Item	**1: EMERGENT PRACTICE**	**2: ACCOMPLISHED PRACTICE**	**3: DISTINGUISHED PRACTICE**
1. Helps create the changes in staff behaviors needed to use the SOP model effectively to enhance staff's ability to reach safety outcomes.	Is still learning SOP and how to enhance staff ability to use the practice techniques to reach desired safety outcomes. Sometimes provides programmatic services without regard to outcomes; considers providing program services as large purpose of job; and does not always ensure that staff seek to understand what issues brought the family to the agency or what steps are required to achieve targeted outcomes.	Demonstrates an understanding of SOP and works diligently to enhance staff ability to use the practice model to reach desired safety outcomes. Provides programmatic services and generally understands the need for a holistic trauma-informed approach to providing services. Encourages staff to regularly partner with families to identify targeted outcomes and plan approaches to achieve those outcomes.	Can teach, mentor, or coach another supervisor about how to implement SOP to reach safety outcomes.
2. Demonstrates knowledge and ability to direct workers in SOP, including engagement and partnering, acknowledging differences, inclusion of child's voice, building networks, and planning for future safety.	Is becoming more used to SOP, including engagement and partnering, acknowledging differences, inclusion of child's voice, building networks, and planning for future safety. Does not yet know how to support workers in using these principles in their own practices.	Can articulate SOP principles, including engagement and partnering, acknowledging differences, inclusion of child's voice, building networks, and planning for future safety. Models these principles/coaches workers on using them in their own practices.	Can teach, mentor, or coach another supervisor about how to engage and partner, acknowledge differences, include child's voice, build networks, and plan for future safety.
3. Advises workers in appropriate questions to facilitate assessment of individual and/or family needs (including foster families).	Has become more familiar with advising workers to ask appropriate questions so that they will not miss critical questions that make it impossible to complete a comprehensive assessment of family needs.	Advises workers to ask appropriate questions, including the most critical questions, that make it possible to complete an assessment of family needs.	Can teach, mentor, or coach another supervisor about how to guide workers in asking appropriate and critical questions for assessment of individual and family needs.

COACHES SUPERVISEES Coaches supervisees to encourage learning related to their individual caseloads as well as their long-term professional development.			
Item	**1: EMERGENT PRACTICE**	**2: ACCOMPLISHED PRACTICE**	**3: DISTINGUISHED PRACTICE**
4. Can help workers engage families and collaterals in obtaining appropriate information needed for assessment and case planning.	Has become more familiar with the importance of engaging families and collaterals so they can obtain appropriate information needed for assessment and case planning.	Guides social workers in engaging families and collaterals so they can obtain appropriate information needed for assessment and case planning.	Can teach, mentor, or coach another supervisor about how to guide workers in engaging families and collaterals for assessment and case planning.

MANAGES RELATIONSHIPS Assists supervisees in managing relationships with colleagues, families, and external partners to minimize conflict and engage people in productive relationships.			
Item	**1: EMERGENT PRACTICE**	**2: ACCOMPLISHED PRACTICE**	**3: DISTINGUISHED PRACTICE**
1. Interacts with members of all groups (ethnic, racial, religious, sexual orientation, social class, age, etc.) in a manner that enhances ability to reach desired outcomes.	Recently working with staff who have not been exposed to or had many direct experiences with oppressed groups and/or cultures or races other than their own. Beginning to learn how to intervene with staff who behave with insensitivity or overt prejudice, subjectivity, or bias toward members of oppressed groups. Does not yet know how to maximize values or strengths of cultural diversity. Is attaining new knowledge of cultures, race relations, and ways to foster multicultural skills in the workplace.	Can ensure that workers serve all individual needs objectively and with concern. Ensures that staff members do not appear threatened by other groups; focuses on strengths and challenges of staff who make assumptions about those being served. Seeks to surface differences with a spirit of curiosity and is working to reduce stereotyping in the workplace.	Can teach, mentor, or coach another supervisor to recognize, understand, and use differences both in supervisory and direct service practice.

MANAGES RELATIONSHIPS Assists supervisees in managing relationships with colleagues, families, and external partners to minimize conflict and engage people in productive relationships.			
Item	**1: EMERGENT PRACTICE**	**2: ACCOMPLISHED PRACTICE**	**3: DISTINGUISHED PRACTICE**
2. Interacts effectively with other agency and community members and actively seeks to build positive relationships with external partners to enhance collaboration and positive outcomes for children.	Does not fully grasp how to effectively interact with other agency and community members and seek to build positive relationships with external partners to enhance collaboration. Out of frustration, sometimes exhibits patronizing or antagonistic behaviors (e.g., gossip, argumentativeness, sarcasm) toward agency and community members that can inhibit collaboration and/or hinder positive outcomes for children.	Demonstrates exceptional skill and creativity in interacting with other agency and community members. Is building positive relationships with external partners to enhance collaboration through respectful interactions leading to positive outcomes for children. Has an awareness of how local service providers, given institutional, cultural, and possible language barriers, prevent culturally diverse clients from using or benefiting from the services.	Can teach, mentor, or coach another supervisor about how to interact with other agency and community members and build a collaborative network with shared responsibility for success.

ADAPTS APPROACHES Customizes approach to supervision based on worker developmental stages, learning styles, strengths, and challenges of individual supervisees.			
Item	**1: EMERGENT PRACTICE**	**2: ACCOMPLISHED PRACTICE**	**3: DISTINGUISHED PRACTICE**
1. Knows and uses effective levels of oversight and inquiry about case formulations with each worker based on the level of complexity of the cases and the strengths of the workers.	Has only recently been exposed to knowledge and strategies in how to supervise cases with individual social workers based on the level of complexity of the case and strengths of the workers to ensure manageable caseloads and appropriate case formulations. Workers on their team feel overwhelmed and often miss key timeframes in managing their cases.	Supervises cases with each worker based on the level of complexity of the case and strengths of the worker to ensure manageable caseloads, effective case formulations, and positive outcomes. Workers on their team, while stretched, meet most timeframes in managing their cases.	Can teach, mentor, or coach another supervisor about how to oversee cases and help workers form high-quality case formulations.
2. Accurately assesses workers' strengths and needs and incorporates their unique learning styles, lengths of tenure with the agency, and ages when teaching them policy and new techniques.	Has become more familiar with how to use appropriate tools (behavioral anchors of key practices, reports from management data, observation, discussion, problem solving, assessments) to assess workers' strengths, performance gaps, skills needed to close the gaps, behavioral styles, learning styles, and developmental (competence, willingness, and confidence) levels. Learning the importance of attending to social worker needs, such as secondary trauma.	Uses appropriate tools (behavioral anchors of key practices, reports from management data, observation, discussion, problem solving, assessments) to assess workers' strengths, performance gaps, skills needed to close the gaps, behavioral styles, learning styles, and developmental (competence, willingness, and confidence) levels. Attends to worker needs, such as those related to secondary trauma and self care.	Can teach, mentor, or coach another supervisor about how to accurately assess worker strengths and needs.

PROMOTES ACCOUNTABILITY Focuses attention on information and performance measures to continually reassess and make adjustments that will achieve agency outcomes.			
Item	**1: EMERGENT PRACTICE**	**2: ACCOMPLISHED PRACTICE**	**3: DISTINGUISHED PRACTICE**
1. Knows and uses the characteristics of effective feedback (interactive facilitation) for social workers (immediate, specific, objective, descriptive, behavioral, tied to learning, focused on sharing ideas, selective).	Has recently learned how to use effective feedback with workers on their team. Feedback is sometimes delayed, too general, subjective, and not behavior specific. Feedback is sometimes provided as directives or commands from an authority figure or addresses multiple areas of concern at the same time instead of a select few.	Knows and uses effective feedback for social workers. Allows workers to first reflect on their own practices before sharing their opinions. Feedback is immediate, specific, objective, and behavioral. Feedback is provided with some discussion or sharing of ideas. Feedback is generally limited to a few targeted areas.	Can teach, mentor, or coach another supervisor about giving effective feedback.
2. Uses data reports on key indicators of safety, permanency, and well-being with workers to ensure an outcome focus and as a basis for corrective action plans.	Has not developed the habit of regularly reviewing data reports on key indicators of safety, permanency, and well-being; therefore, does not use such reports in working with staff to ensure an outcome focus or as a vehicle for change.	Regularly uses data reports (including racial/ethnic and tribal affiliation demographic information) to monitor staff success in reaching safety, permanency, and well-being outcomes, and shares such information with staff to enhance a focus on outcomes and to help create change in daily practice. Highlights statistics of excellent practice and encourages workers to share with others how they did such good work. Individually identifies areas for growth with workers, one area at a time.	Can teach, mentor, or coach another supervisor about how to use data reports to ensure staff reach outcomes.

PROMOTES ACCOUNTABILITY Focuses attention on information and performance measures to continually reassess and make adjustments that will achieve agency outcomes.			
Item	**1: EMERGENT PRACTICE**	**2: ACCOMPLISHED PRACTICE**	**3: DISTINGUISHED PRACTICE**
3. Ensures key tasks are accomplished in all cases (e.g., making appropriate and timely permanency plans, conducting home visits, conducting visits with foster children, conducting extensive family-finding attempts, making appropriate levels of placement in out-of-home care).	Has not yet supervised in a way that ensures all case activities for each worker on their team are meeting all key timelines and practices known to lead to success in casework. Often approves case activities, including case promotion, reunification, and case closure based on clinical judgment alone without considering the decision-support tool disposition.	Routinely ensures key tasks are accomplished in all cases for each worker on their team, especially timelines and practices known to lead to success in casework. Promotes, reunifies, or closes cases based on full, balanced assessment of acts of protection, safety threats, and risk levels.	Can teach, mentor, or coach another supervisor about focusing on key tasks that facilitate achievement of outcomes for families and children.

TRANSFER OF LEARNING ACTIVITIES: A SUPERVISOR'S GUIDE TO SUPPORTING STAFF IN SDM TRAINING

BEFORE TRAINING

SET EXPECTATIONS AND OBJECTIVES.

As a supervisor or leader, you have unique knowledge of a staff member's on-the-job performance and can describe the specific gaps in knowledge and skills that a training intervention can address. Identify and share with your staff specific performance expectations. Review the learning objectives with your staff. Before the training activity, ask your staff what they hope to get out of the training. Set performance standards for after the training. Then explain precisely what you anticipate they will be able to do for your program with their new knowledge and skills.

DISCUSS THE TRAINING'S BENEFITS TO PARTICIPANTS' JOB DUTIES WITHIN YOUR ORGANIZATION.

Knowing the benefits will increase motivation to learn, create a personal connection to the training material that will help your staff own the learning process, and begin to integrate information into the workplace.

CREATE AN ACTION PLAN.

Once expectations are established, create an action plan with your staff on how and when they will be met. Supervisors and learners can use action plans as a monitoring tool to gauge progress, identify challenges, and work on solutions in implementing training in the workplace.

ALIGN TRAINING WITH CURRENT ORGANIZATIONAL PRACTICES.

Discuss how the training aligns with current practices. This will help staff understand the larger picture of the organization and its mission and their role in this picture. Are there practices, initiatives, or goals that could be served by this training? Is your staff aware of how their development aligns with the organization's mission?

LEARN ABOUT THE TRAINING CONTENT.

Supervisors who are aware of the training content can better model desired behaviors, explain post training expectations, and reinforce desired behaviors. Try some or all of the following.

- Review the course objectives and materials.
- Observe or participate in the training.
- Request coaching support if available to further enhance your team's strategy implementation.

AFTER TRAINING

CONDUCT A POST-TRAINING DEBRIEFING.

Set aside time to meet with your staff soon after the training to discuss the implications of what they learned. Allow your staff a few days to prepare their notes and organize their thoughts prior to this meeting.

ENCOURAGE STAFF TO SHARE WHAT THEY HAVE LEARNED.

Involve other staff at the organization in the transfer-of-learning process by briefing them soon after the training. Share the key training concepts and allow people to ask questions. This is a good time for you to identify your expectations regarding implementation of action plans.

BRAINSTORM HOW TO INTEGRATE NEW KNOWLEDGE AND SKILLS WITH PRESENT SERVICES.

Discuss with your staff how newly acquired knowledge or skills might address current needs at the organization and be of value to their team or program and to others in the organization. Real-world applications help your staff ground their new skills.

REVIEW ACTION PLAN.

Meet with your staff to review the current action plan and make sure that it is revised to correspond with organizational needs and the integration of new knowledge and skills.

COACH AND MODEL.

Encourage and, when possible, coach staff as they incorporate new knowledge and skills into their work. When people begin practicing new skills that are difficult or involve many steps, their skill levels will vary; some may still be novices, while others may be closer to mastery. Offer to assist individuals in a manner that is appropriate to their progress. When providing guidance, always ask staff what they

perceive they are doing well and what upgrades they want to make before you offer suggestions for improvements. Very often, people can make appropriate suggestions for self-improvement when given the opportunity to reflect.

Model new skills or behaviors in your work along with your staff to show that you support the changes they are implementing. In other words, walk the walk and your staff will walk with you.

FOLLOW UP.

Periodically follow up about progress on the goals and action plans developed before and during the training. Routine supervisory meetings are a great time to provide constructive feedback, check staff progress toward mastering and using their new skills, and ask how you as their supervisor can support transfer of learning.