

Common Core 3.0

Teaming, Collaboration and Transparency

Trainee Guide



December 31, 2018

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Introduction to Common Core

Common Core curriculum and training for new child welfare workers in California is designed to be generalizable across the state, cover basic child welfare knowledge and skills, and is important for all CWS positions within an agency.

California's Common Core Curricula for Child Welfare Workers is the result of the invaluable work and guidance of a great many people throughout the child welfare system in California and across the country. It would be impossible to list all of the individuals who contributed, but some groups of people will be acknowledged here.

The Content Development Oversight Group (CDOG) a subcommittee of the Statewide Training and Education Committee (STEC) provided overall guidance for the development of the curricula. Convened by the California Social Work Education Center (CalSWEC) and the California Department of Social Services (CDSS), CDOG membership includes representatives from the Regional Training Academies (RTAs), the University Consortium for Children and Families in Los Angeles (UCCF), and Los Angeles County Department of Children and Family Services.

In addition to CDOG, a Common Core 3.0 subcommittee comprised of representatives from the RTAs, the Resource Center for Family Focused Practice, and counties provided oversight and approval for the curriculum development process.

Along the way, many other people provided their insight and hard work, attending pilots of the trainings, reviewing sections of curricula, or providing other assistance.

California's child welfare system greatly benefits from this collaborative endeavor, which helps our workforce meet the needs of the state's children and families.

The Children's Research Center provided technical support as well as The Structured Decision Making System that includes the SDM 3.0 Policy and Procedure Manual and Decision Making Tools. These resources are used in compliance with CRC copyright agreements with California. Additionally, content in this curriculum has been adapted from CRC's SDM 3.0 classroom curriculum to meet the training needs in California.

In compliance with the Indian Child Welfare Act (1978) and the California Practice Model, social workers must identify American Indian/Alaska Native children in the system. For an overview of *Implementing the Indian Child Welfare Act* view: <https://www.youtube.com/watch?v=BIQG65KFKGs>

The curriculum is developed with public funds and is intended for public use. For information on use and citation of the curriculum, please refer to:

https://calswec.berkeley.edu/sites/default/files/citation_guideline_6-2018.pdf



FOR MORE INFORMATION on California's Core Curricula, as well as the latest version of this curriculum, please visit the California Social Work Education Center (CalSWEC) website:

<http://calswec.berkeley.edu>

Curriculum Introduction

This curriculum is designed to provide an overview of teaming processes utilized in child welfare to engage families and make decisions related to child safety. Trainees will have an opportunity to learn more about the benefits of teaming, develop skills related to team meeting facilitation, and incorporate teaming activities into day-to-day practice to support improved outcomes for children and families. Teaming is more about the process of engagement and meaningful inclusion rather than the meeting itself. Teaming activities provide a way for social workers to bring the family team together to engage in transparent and respectful communication about:

- family strengths and needs
- decisions related to child safety
- case planning activities and goals
- court processes, timelines, and recommendations

Agenda

Segment 1:	Welcome, Introductions, and Overview of the Training Day	9:00 – 9:20 am
Segment 2:	Purpose of Teaming	9:20 – 10:30 am
<i>Break</i>		<i>10:30 – 10:45 am</i>
Segment 3:	Creating the optimal team environment	10:45 – 11:45 am
Lunch		11:45 am – 12:45 pm
Segment 4:	Facilitation of Meeting	12:45 – 2:30 pm
<i>Break</i>		<i>2:30 – 2:45 pm</i>
Segment 5:	Ideas and Next Steps	2:45 – 3:45 pm
Segment 6:	Wrap-up and Transfer of Learning	3:45 – 4:00 pm

Learning Objectives

Knowledge

- K1.** The trainee will be able to identify the benefits of engagement and teaming.
- K2.** The trainee will be able to describe key elements of collaboration, such as: circles of support, teaming values, family involvement, community involvement, and families as partners.
- K3.** The trainee will be able to describe strategies to support the family, caregivers, and team members in shifting from a focus on the family's deficits to their strengths to meet their child's needs.
- K4.** The trainee will be able to recognize the need to work collaboratively to formulate case plan objectives.
- K5.** The trainee will be able to describe the assessment processes that drive decisions about reunification and permanency planning to a child and family team.

Skills

- S1.** Given a case scenario, the trainee will be able to identify key trainees for a team meeting and how meeting outcomes support case planning and long-term success for the family.
- S2.** Given a case scenario, the trainee will be able to use strength-based language to describe safety concerns.

Values

- V1.** The trainee will value engaging families, youth and communities in a participatory decision-making process that especially includes families, youth and communities as experts in identifying strengths, needs and resources.
- V2.** The trainee will value collaboration with children, youth, non-minor dependents, families, family support networks and other professionals to access local resources and improve outcomes related to safety, permanency, and well-being.
- V3.** The trainee will value working in partnership with Foster Care Public Health Nurses and other health care providers to promote well-being for children and youth involved in the child welfare system.
- V4.** The trainee will value the use of teams to make case planning and placement decisions with families.
- V5.** The trainee will value the family as the experts on themselves.
- V6.** The trainee will value the role of the community in case planning and decision-making.

Teaming Behaviors

Work with the family to build a supportive team.

- a. With the family's permission, contact family, cultural, community, and Tribal connections, and ask them to serve as team members as early as possible.
- b. Ask initially and throughout the family's involvement if they would like a support person or peer advocate on their team.
- c. Explore with the family how culture might affect the development of the team and the teaming process.
- d. Facilitate early and frequent sharing of information and coordination among parents, caregivers and agency partners.
- e. Facilitate development of a mutually supportive relationship between the parents and caregivers.

Facilitate the team process and engage the team in planning and decision-making with and in support of the child, youth, young adult, and family.

- a. Make sure team members have the information they need.
- b. Facilitate critical thinking, discussion, mutual exploration of issues, and consensus building toward the goal of shared decision-making.
- c. Help the team recognize that differences will occur and assist them to work through conflicts.
- d. Develop a shared understanding about safety, permanency, and well-being issues to be addressed with the team.
- e. Ensure that all team members understand that legal, regulatory, and policy constraints may limit shared decision making options available to address the family members' needs, including placement options, reunification, and service options.
- f. Build connections to identified services and supports by designating a team member to follow-up with that referral.

Work with the team to address the evolving needs of the child, youth, young adult, and family.

- a. Facilitate dialogue about how supports and visitation plans are working.
- b. Explore with team members what roles they can play over time to strengthen child safety and support the family.
- c. Help the team adapt to changing team member roles.

Work collaboratively with community partners to create better ways for children, youth, young adults, and families to access services.

Common Values and Beliefs about Family Team Meeting Approaches

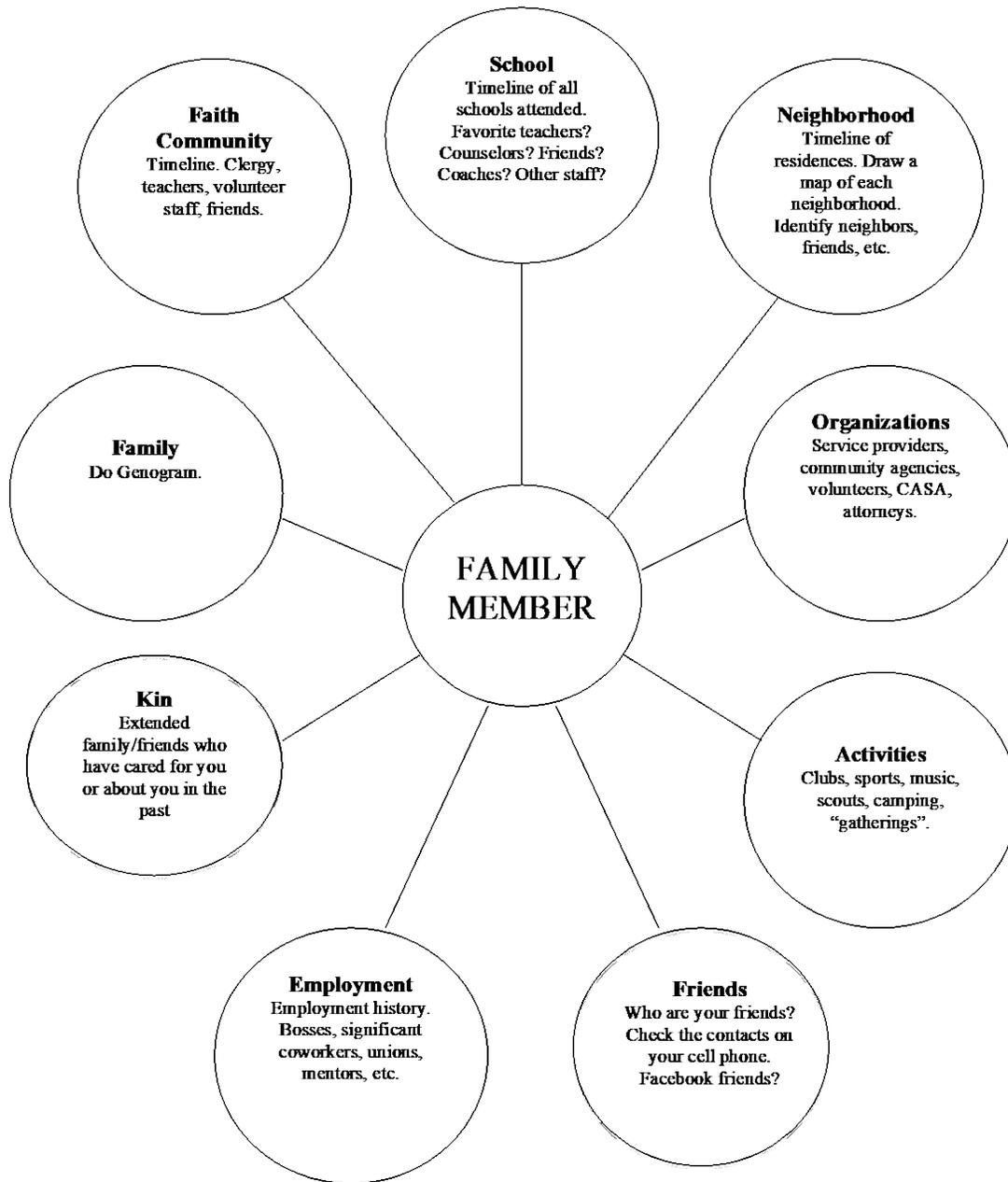
Adapted from:

Center for the Study of Social Policy Center for Community Partnerships in Child Welfare. (2002).
Bringing Families to the Table: A Comparative Guide to Family Meetings in Child Welfare. Washington, D.C.: Author

- All families have strengths.
- Families deserve to be treated with dignity and respect.
- Families can make well-informed decisions about keeping their children safe.
- Families are encouraged and supported to make decisions and plans.
- Outcomes will improve when families are involved in the decision making process.
- A strength-based approach is used instead of a deficit-based model.
- A team approach is more likely to produce positive solutions for change.
- All team members and agency staff should be open and honest with the family.
- Families define their own members, which may extend beyond the primary birth family.

Ecomap

ECOMAP



<https://sharepoint.nccdc.org/Projects/ProjectDocuments/USA/California/632SanDiego/Modules/8SafetyNetworks/Ecomap.doc>
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Benefits of Teaming

SHORT TERM:

- ENSURES CHILD SAFETY BY SUPPORTING THE SAFETY PLAN
- COMMUNICATES INFORMATION ABOUT THE CHILD'S SAFETY, PERMANENCY, AND COURT TIME FRAMES
- ESTABLISHES THE CHILD AND FAMILY'S TEAM AND CREATES SHARED AGREEMENTS ABOUT THE CHILD'S SAFETY
- HELPS TO IDENTIFY THE FAMILY'S UNDERLYING NEEDS, HOW THEY DEFINE THE PROBLEM, AND WHAT SUCCESS LOOKS LIKE
- TEAM DEFINES WHAT "NORMAL" IS IN THE FAMILY AND ITS CULTURE, COMMUNITY, OR TRIBE

LONG-TERM:

- EMPHASIZES THE IMPORTANCE OF THE FAMILY'S SUPPORT TEAM EVEN AFTER THE CHILD WELFARE AGENCY ENDS INVOLVEMENT
- HELPS FACILITATE "POST-PERMANENCY" CIRCLE OF SUPPORT FOR THE CHILD AND FAMILY
- ENSURES SAFETY PLANS ARE FOLLOWED AND/OR MODIFIED AS NEEDED IN THE FUTURE

Vignette—Natalie (age 16)

Setting: Initial case conference for a newly opened Court Family Maintenance Case.

Family

Child: Natalie N. (16), Mother: Jennifer N. (48), Father: Jeff S. (45) whereabouts unknown, Adult Sister: Caroline N. (25), Sister: Linnea N. (12). The family identifies as Mexican-American.

Background

Natalie lives with her mother and her younger sister in a small apartment. Natalie is the second child of three siblings. Natalie has an adult sister who lives nearby with her boyfriend and their two children.

Natalie has not attended school for the last six months. Natalie stays home alone all day while her mother works full-time in a distant city and her adult sister goes to school and works part-time in a bank. Natalie's father does not have contact with the family. Natalie suffers from juvenile diabetes and she is insulin dependent. Natalie has been seeing the same therapist and psychiatrist for over 2 years. She was diagnosed with depression and she was prescribed psychotropic medication.

Natalie says that she does not have friends. However, Natalie has indicated that she used to be in a mentoring group called "Girl Strong," which goes on various outings, including taking a regular dance class. Natalie states that dance "is the only thing I was ever good at." Natalie states she really liked the girls and especially liked her assigned mentor, Sally.

Identifying Issues

Natalie started refusing to take her medication about a month ago. She has fallen out of compliance with her diabetes regimen. She has been hospitalized due to this fact, but continues to be non-compliant.

A couple of months ago, Natalie and her mother got into a fight because Natalie had not taken meat out of the freezer to thaw as her mother had directed her to do. Natalie called 9-1-1. Natalie reported to the police that her mother was neglecting her and she didn't want to stay in the home. The police did not take any action. A social worker followed-up, and was preparing to refer the family to alternative response services. The following day, the mother noticed Natalie was listless and disoriented. The mother took Natalie to the hospital for medical care and also requested a psychological evaluation. Natalie received medical attention; however, a psychological assessment was not completed. The mother took Natalie to her therapist that afternoon; the therapist called the Psychiatric Evaluation Team (PET). Natalie was assessed and she was admitted to the psych hospital. Jennifer feels she is unable to adequately monitor her daughter's compliance with her diabetes and psychotropic medications and is afraid Natalie might be of harm to herself if she continues to refuse her psychotropic medication. Mother is seeking support/assistance from the Department of Children and Family Services.

Family History

The family has a total of 2 referrals dating from 2006. The allegations range from emotional abuse to neglect. All the allegations have been closed as unfounded and/or inconclusive.

Concerns/Interests

Jennifer's Concerns/Interests: Jennifer indicates she is trying to do her best but Natalie is hard to handle. Jennifer states she has no support and is "all alone" in handling the situation with Natalie; most of her family refuses to help her because Natalie is "too much." Jennifer's parents are undocumented and are reluctant to help Jennifer with Natalie's

care. They do not want to participate in any meetings at the hospital or the social services agency because they are fearful of interacting with government agencies. She states that she feels like her hands are tied as far as making Natalie comply with her medication because Natalie is almost an adult. Jennifer indicates that she needs help, but she, under no circumstances, wants Natalie placed in foster care.

Natalie’s Concerns/Interests: Natalie is scared because she is almost 17 and doesn’t know what she is going to do with her life. Natalie is adamant that she will not go to a placement. Natalie expresses concern that her mother cannot support her forever. Natalie states that she will not take the medication because it makes her fat and she feels like a “zombie” on the medication. Natalie does not like the things that her doctor says she should eat to help with her diabetes. She wants to be like other kids and drink soda and eat what she wants.

Caroline’s Concerns/Interests: Caroline is worried about her sister and feels like she spends too much time by herself. Caroline would like to help out more, but she has her own children to take care of and a job and school. Caroline says that her mother is trying to help Natalie, but it isn’t easy for her. Caroline states that she is worried that Natalie might become really sick by not taking her medication and her mother will not be home to make sure that Natalie takes her medication or take her to the doctor if she has a diabetic episode. Caroline thinks that her grandparents are contributing to the problems by not helping out more and telling Natalie that she is “just fine” without medication.

Linnea’s Concerns/Interests: Linnea states that she spends a lot of time at her friend Beth’s house. She enjoys being with Beth’s family when her mom is gone for work. Linnea says that she worries about Natalie because she doesn’t really spend time with anyone and is by herself a lot. Linnea states that she is scared that Natalie will get really sick if she doesn’t take her diabetes medication. She is worried that her sister is really sad and doesn’t know how to cheer her up.

Therapist’s Concerns/Interests: The therapist is concerned that Jennifer has not made sure that Natalie goes to school or ensured that Natalie complies with her medication regimen for both her mental health issues and her diabetes. She is also worried that Jennifer believes that Natalie is not depressed, but just lazy. The therapist indicates that the mother has not been consistent in bringing Natalie to therapy, nor has she participated in family therapy despite the therapist’s emphasis on the importance of family involvement.

Sally’s Concerns/Interests: Sally states that she has not been in touch with Natalie for a while, so she is not sure what is going on with the family. Sally states that Natalie is still eligible to participate in “Girl Strong” and that they will have an opening in two weeks. Sally states that she really enjoyed spending time with Natalie, and thinks that Natalie really benefited from the program. Sally has stated that she would like to continue to be a support in Natalie’s life.

Child and Family Team (CFT) Meeting Structure

Pathways to Well-Being incorporates the practice of teaming for all youth and families involved with Child Welfare where the child/youth has an identified mental health concern. The Child and Family Team (CFT) is central to the Pathways program. The CFT is comprised of the youth and family, Child Welfare, Behavioral Health, informal supports as identified by the family and youth, and ancillary individuals who are working with the family and youth toward their successful transition out of the child welfare system.

The CFT meeting structure provides a problem-solving, solution-focused approach to decision making. The systemic problem-solving approach enables meeting participants to fully understand the situation and examine possible solutions while helping to ensure decisions are made without haste and personal bias.

The six stages of the meeting and the topics discussed in each are listed below:

Introduction

- Teaming Standards are presented
- Purpose and Goal
- Concept of building on strengths
- Introduction of participants, roles and relationship to child/family/case
- Consensus vs. Unanimity
- Group agreements for meeting
- Questions before beginning

Identify The Situation

- Explains the precipitating event/why the meeting was called
- Use a trauma-informed approach (i.e. “What happened to you vs. what is wrong with you”)

Assess The Situation

- Strengths/supports
- Needs
- Family/youth perspective of situation
- Services involved presently and utilized in the past – All existing case plans and treatment plans are available and discussed
- Past history/stressors

Develop Ideas

- Brainstorming ideas to address concern and provide safety and protection
- Insure everyone participates

Reach A Decision

- Scale the decision – ensure everyone has participated
- Action plan developed
- Timely linkage to services;, priority services need immediate connection

Recap/Evaluation/Closing

- Everyone knows who will do what by when
- Complete and copy CFT Meeting Summary

Benefits of Charting

CHARTING is a powerful facilitator tool. It supports a successful teaming process in the following ways:

- Helps meeting members participate – 50% learn by listening; 50% learn by reading
- Keeps meeting members focused
- Allows meeting members to see what they have accomplished and what is left to do
- Provides an opportunity for the family to see that they have strengths and things that are going well in addition to areas that need to be addressed for their child’s safety
- Promotes participation
- Encourages enlarged thinking – thinking “outside of the box”
- Generates solutions in a focused, forward thinking manner within a deliberate structure
- Provides a visual structure
- Helps members see other’s ideas and build upon them
- Provides families and others with visual affirmation that they have been heard
- Provides families with a tangible list of strengths they can take home with them

CHARTING TIPS

- Have the Charts pre-labeled and hanging on the wall prior to the meeting. Some suggestions for pre-labeling include: Strengths/What’s working well, Concerns/Worries, Brainstorming/Ideas, and Action Plan/Next Steps.
- Have an extra chart page hanging up – you never know when you will need them so, be prepared.
- Have markers and tape available.
- Write large enough for members to read – consider writing letters at least 1” tall.
- When charting ideas, avoid numbering items – this suggests “prioritization.” Instead, use bullets.
- Try to stand off center when writing so others can see the chart.
- Use large tip markers for easy-to-read scribing.
- Avoid using Red – Orange – Yellow markers. These colors are “hard” on the eyes and difficult to read from a distance.
- Avoid using Scotch tape. Painter’s tape is recommended.



Adapted from TDM Facilitator Training 2011

Key Factors in Effective Teamwork

- The team will be different for each child and family
- Teamwork means everyone in the child’s life agrees on the child’s needs and is working to meet those needs (individually and collectively as a team)
- Teamwork starts in the first discussions with the family, often before there is a formal assessment or team
- A flexible, “whatever it takes” approach
- The important people in the child’s and family’s life have formed a working team that meets, talks, and plans together
- Written plan that states the child’s and family’s strengths, needs, and services/supports for the family – team members use this as a reference for their work with the family
- Child/family voice and choice regarding services and supports

Adapted from Quality Service Review for a Child and Family (Version 2.2B), Human Systems and Outcomes, Inc., October 2010

Some Communication Skills for Effective Facilitation

Active Listening: Trying to see the problem the way the speaker sees it. Requires entering actively and imaginatively into the other person’s situation and trying to understand a frame of reference different than your own. (reflective listening)

Clarifying: Interprets ideas or suggestions; clears up confusion; defines and explains terms, jargon, acronyms; indicates alternatives and issues confronting the group. Example—“I don’t understand. Did you say...”

Collaborating: Working together; assisting; “Let’s see if we can work on this together.”

Confronting: To push others to acknowledge problems, feelings, or behaviors, when other less directive interventions has failed to. It may increase resistance if not successful, difficult to use without an established and supportive relationship.

Crediting: Recognizing the contribution and efforts of a person. It is giving credit where credit is due and remembering to do it.

Empathizing: Entering the feeling or ideas of another, to put yourself in another’s shoes.

Encouraging: Friendly, warm and responsive to others; accepts others; asks for responses, ideas, feelings of all participants. Example: “Tell us more...” “You were saying...” “Describe...” “Is there some other points of view on this subject?” “Is there something we haven’t thought of?”

Establishing Rapport: Developing a relationship or connection with another person. Showing others that you are willing to listen, invites them to say what’s on their mind. Example: Use the person’s name.

Harmonizing: Attempts to reconcile disagreements and find areas of commonality; Gets people to explore their differences. “Sounds as if you have the same goal, but different ideas how to get there...”

Interpreting Verbal Statements: Exploring and clarifying statements so that the meaning is understood.

Interpreting Nonverbal Cues: Translating the non-spoken messages, provided by body language and paralanguage—the inflections and other vocal and gestural nuances added to language to convey meaning. Body language includes facial expressions; eye contact and movement; head, arm, and hand movements; and body postures and shifts. Whether automatic or learned, body language can corroborate or contradict what a person says or doesn’t say in words.

Linking: Joining parts together to assist in making connections and build understanding. “Sounds like your thoughts/ideas are similar to what X had to say.”

Negotiating: Discussing to build agreement, asking for what you want and listening to the other person. Secret of successful negotiating is listening.

Paraphrasing: To check communication accuracy between speaker and listener. Saying back to the speaker, in your own words, your understanding of what that person has said, to make sure you understand the content and meaning of the message you heard. “If I understand correctly, you are saying...”

Reality Testing: Checking if the idea is sound and can be implemented. Is it viable?

Reflecting/Mirroring: To share or repeat what you heard or saw. From time to time, the facilitator comments on either the content or the process of the meeting and asks the group to respond. “I notice that we’re only talking about foster care placement, is there any other option?” (content focus) or “We agreed to hear everyone out, and there seems to be a lot of interrupting going on? How is this affecting participation?” (process focus)

Relieving Tension: Alleviating or lessening the level of emotional stress or anxiety. “There are a lot of strong feelings being expressed. Maybe we all need to take a deep breath for just a moment.”

Silence: Powerful quiet. Ask a question, pause, wait, say nothing.

Strength-Based Interviewing: Respectfully questioning to allow families to recognize and be recognized for their strengths. Involves listening, observing, complimenting, encouraging, asking, and talking about successes.

Summarizing: Pulls together related ideas; may assist with keeping discussion on track. Helps to concisely organize information. Restates suggestions/ideas after the group has discussed them. Example: “Let me see if I understand you correctly. So far, you said that...”

Supporting: Assisting or aiding either verbally and/or non-verbally, nodding head, saying “Ok,” “Thanks,” “That’s a great idea,” etc.

Adapted from TDM Facilitator Training 2011

Reframing / Asking Clarifying Questions / Reflecting

Using these statements, rewrite them to reframe the comment OR develop a clarifying question OR write a reflective statement to get more information about the comment to move the team forward in a positive solution finding manner. Use strengths-based language.

1. He'll never do that; we tried it before and it didn't work.
2. He is nothing but a drug addict and bum.
3. I am tired of her lying to me.
4. She never listens to me.
5. He's out running with his friends and refuses to babysit his younger brother.
6. She's still with her good-for-nothing boyfriend.

Adapted from TDM Facilitator Training 2011

Managing Group Dynamics

SOME TYPES OF INDIVIDUAL BEHAVIORS MAY INCLUDE...

- **MONOPOLOZING/DOMINATING THE DISCUSSION**—*speaking too often, long or loud, making it difficult for anyone else to participate.*
 - Stop the person, thank them for their input, say that we need to hear from everyone.
 - Remind of time limit.
 - Break eye contact. Stop giving focused attention.
 - Summarize what the person has said and move to someone else.
 - Give the person a time limit.
 - If you know in advance this may be a problem, propose in ground rules that “everyone monitor air time.” Explain that may mean less talking for some and more for others.
- **NON-PARTICIPATION/WITHHOLDING**—*being unable or unwilling to speak up.*
 - Recognize and acknowledge that the process and/or discussion can be overwhelming and intimidating.
 - Recognize that participation is individual. Goal is that each person says everything that (s)he wants to say and is listened to during the meeting.
 - Determine if the participation is unbalanced due to too many staff or professionals present.
 - Invite person to participate. When they speak be attentive and an active listener.
 - Understand that some people may not be able to participate due to cognitive/emotional issues, language, etc.
 - Ask easy questions (yes, no) or questions that allow person to be the expert or speak with confidence. “Can you tell us about what your child...”
 - Thank them for participating.
- **THREATS/PHYSICAL ATTACKS**
 - Set ground rules at the beginning and reiterate as needed during the meeting.
 - Stay calm and confident, monitor your tone of voice—speak calmly.
 - If there is a threat to another person, determine if the person is fearful. Assess if they feel this is a real threat and ask what they feel they need to do.
 - Offer the individual a chance to leave the room—dismiss if too volatile.
 - If information is known up-front, may put security on alert.
 - Call security. Use security measures. Police report.
 - “Trust your gut.” Be self-aware.
- **BLAMING OTHERS, ATTACKING, CRITICIZING OR PICKING AN ARGUMENT**
 - Describe the behavior in a nonjudgmental manner.
 - Redirect, to focus on the issues at hand, resolutions.
 - Indicate that we are not here to point fingers, but to make the best safe plan for child(ren).
 - Describe the behavior in a nonjudgmental manner.

- Stop the argument. Ask for and record a statement of each individual’s position. Engage other group members in discussing their positions.
- Ask the person what the group could do to respond to their concern.
- **DENIAL/MINIMIZATION**—*being unable to recognize or acknowledge concern or seriousness of problem*
 - Ask for their perception. Ask clarifying questions to raise their awareness level.
 - Repeat, clarify purpose, focus. Stress why safety concern is of importance to agency.
 - Emphasize effects of the caregiver’s actions on children. Explain possible consequences.
 - State facts.
 - State the differences and ask why.
 - Look for what is in common.
 - Acknowledge.
- **LYING** (*Don’t have to address if not helpful to the process of the meeting.*)
 - Respectfully confront with evidence.
 - Allow the person to explain, share their feelings.
 - Have others share what their experience was regarding the topic.
 - Acknowledge the disagreement, difference, and inconsistency. Ask the person if they can assist the group to understand why.
- **CRYING**
 - Acknowledge feeling and pain.
 - Offer tissue.
 - Ask if they need a moment.
 - Encourage a family member to comfort, if appropriate.
- **NONVERBALS AND INDIRECT VERBALS**
 - Recognize incongruent behavior, comments, if applicable.
 - Comment on what it looks like.
 - Provide an “I” message.
- **HOSTILE/NEGATIVE/ANTAGONISTIC DEMEANOR**— *Negative expressions can be either verbal or nonverbal.*
 - Remind of ground rules.
 - Acknowledge the person’s point of view. Listen.
 - Recognize and acknowledge the anger by a reflective statement, remain calm, soft voice.
 - Clarify reason for anger and attempt to deal with underlying reasons.
 - Give an opportunity to vent and check for safety of all.
 - Make a point of thoroughly paraphrasing the individual’s view the first couple of times the person speaks. Stick very close to their exact wording.

- Point out the negative pattern.
- Ask if there is any part of the discussion/work being done, which the person feels positive or good about.
- Explore alternative solutions while allowing the individual to state what the worst consequence could be.
- Ask for their opinions about what is needed. Record the opinions. Ask the group to respond.
- **YELLING/SCREAMING**
 - Ask everyone to take a deep breath to regain calm and remind why everyone is here. Restate meeting purpose and goals.
 - Speak in calm voice. Don't allow yourself to be pulled in.
 - Remind why we are here, what we must accomplish and important that they participate in helpful manner.
 - Value feelings, reframe.
 - Let everyone express their feelings to the extent possible—may be loud, animated.
 - Stop/pause, silence, breathe and refocus.
- **LEAVING THE ROOM**
 - Ask another team member to check on the person (a support person).
 - Invite the person to return.
 - Watch for signs of escalation and give permission to leave.
 - Thank them for coming back. Validate feelings.
 - Encourage the person to stay.
 - Acknowledge consequence— the meeting will continue without their input.
- **TALKING OFF THE SUBJECT**—*being out of sync and appear to be talking irrelevantly*
 - Understand that issues being dealt with are emotional and the individual is under a great deal of stress. Ask and answer questions that will assist.
 - Consider that there may be other things going on—mental health issues, substance abuse, etc.
 - Try to direct the person or the group to come back to their point.
 - Explain how the group planned to proceed and let the individual know the group will get to their issues.
 - Remind the group that they are there to talk about the safety of the children/placement and only have a limited amount of time to make the critical decision.
- **HOPELESS/OVERWHELMED**
 - Acknowledge difficult situation and assist in identification of support systems.
 - Review strengths/better times.
 - Offer support systems to help.
 - Let person know that agency wishes to help through this time.
 - Identify options to reduce stress and improve coping skills.

- **INAPPROPRIATE LANGUAGE**
 - Remind of ground rules and explain that the language may be offensive/condescending.
 - Consider the context.
 - Monitor group’s reaction.
 - Sometimes “let it go”.
- **PASSIVE-AGGRESSIVE BEHAVIOR**
 - Stress importance of everyone’s input and participation in decision.
 - Engage as much as possible in discussion—continue to ask for input, opinions, and clarifying points.
 - Address solution-seeking questions to that person in hopes he/she will engage.
 - Make everyone feel and know that each person’s opinion matters and everyone should respect one another.
 - Ask questions that would prompt the person to own their feelings and direct them appropriately.
- **INTERRUPTING OTHERS**—*cutting off others who are speaking or jumping into a conversation too soon, disrupting the sharing of information, and showing disrespect for the other person. Interruptions can be verbal or non-verbal*
 - Remind of the ground rules / group agreements.
 - Stop the interrupter and ask the person to wait while the speaker completes their thought.
 - Ask if the interrupter would like to write down their thoughts to ensure that they don’t lose them and then to share later rather than interrupt.
 - Be neutral and consistent. Don’t allow some to interrupt and not others.
- **HAVING SIDE CONVERSATIONS**—*making private comments or carrying on another discussion with their neighbor*
 - Ask them to stop. Point out how it distracts.
 - Ignore it if it appears to be beneficial or necessary for the family member.
 - Ask them to share.
 - Ask if they can hold it until...
 - Walk towards the people having the side conversation and stand by them as you facilitate.
 - Repeat the topic under-discussion and ask if everyone can focus on it and have just one conversation at a time.
 - If staff, in addition to intervening as above, address outside of the meeting.
- **INSERTING PERSONAL AGENDAS**—*repetitiously inserting a concern or a disagreement—“Yeah, but....”*
 - Acknowledge the concern and comment.
 - Paraphrase or record the point, thank the person and move on.
 - Ask the person what they want the group to do with the information.
 - Give the person a time limit.
 - If it has nothing to do with placement/safety of the child/topic at hand suggest they talk to the social worker after the meeting.

- **REPEATING THE SAME POINT OVER AND OVER**—*not being able to let go of something. (This is a variation of inserting a personal agenda.)*
 - Acknowledge the importance of the point and the person’s passion, advocacy, and/or determination.
 - Demonstrate that the person has been heard and the point recorded – point it out on chart.
 - Explain when the point will be dealt with.
 - Ask if the person can let it go for now.
 - Give the person a final time-limited opportunity to make their pitch.

Adapted from TDM Facilitator Training 2011

Role Play Observation Worksheet

How did the social worker in the role play demonstrate the following? Give specific examples of how the social worker was able to manage and work through conflict.

Agree to negotiate:

Gather points of view:

Focus on interests:

Create win/win options:

Evaluate options:

Create agreement:

Other:

Natalie Worksheet (Optional Activity)

Review the current story of Natalie.

Her team consists of:

A meeting for Natalie was arranged. The social worker is facilitating the meeting. As the meeting has progressed, tension has arisen. People on the team seem to be defensive and are beginning to be argumentative about where Natalie should live. Specifically, each time the social worker makes a suggestion, someone argues with it and now Caroline and Natalie are becoming upset and emotions are escalating. Natalie accuses Caroline of not caring about her kids and states that she would rather live with strangers than have to live with her sister. Caroline has begun crying and Jennifer is visibly upset with her face turning red and clenching her fists. Sally is sitting at the table just shaking her head and saying under her breath, "See – this is how it always is."

Each team assign roles, making sure that there is, at least, a social worker/facilitator, Caroline, Jennifer, Sally, and Natalie.

1. De-escalate
 2. Follow the steps in conflict resolution/management.
 - A. Agree to Negotiate
 - B. Gather Points of View
 - C. Focus on Interests
 - D. Create Win/Win Options
 - E. Evaluate Options
 - F. Create Agreement
 3. Then discuss: What might have been done to avoid the escalation of this conflict in the first place?
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Preparing Parents and Youth for Team Meetings

HELPFUL QUESTIONS TO CONSIDER

PARENT

- What would you like to have happen as a result of this meeting?
- What do you see as family strengths? What do you need?
- What are your child's strengths? What does your child need?
- Describe what success is for your family. What would (family member or support person) be doing differently to achieve success?
- Can you think about what you would like team members to know about your family story, including how you got involved with the agency? You might like to start when things were going well with you and your family.
- Who are the people who care about you...your family...your child? Who wants to see you do well? Might they join your team?
- Who would you want to be at your team meeting?
- If we invited all the people who care about your family to come to a meeting, what would be some good things that might come from their participation?
- Where would be the best place for the Child and Family Team Meeting?

YOUTH

- What would you like to have happen as a result of this meeting?
- What do you see as family strengths? What do you need?
- Describe what success is for your family. What would (family member or support person) be doing differently when you achieve success?
- Can you think about what you would like team members to know about your family story, including how you got involved with the agency? You might like to start when things were going well with you and your family.
- What would you need in order to feel safe participating in this meeting?
- Who are the people who care about you...your family...friends? Who wants to see you do well? Might they join your team?
- Who would you want to be at your team meeting?
- If we invited all the people who care about your family to come to a meeting, what would be some good things that might come from their participation?
- Where would be the best place (convenience, size, comfort, etc.) for the Child and Family Team Meeting to be held?

Natalie's Action Plan

Action Item #1			
Who	What	By When	How Will This Action Be Monitored

Action Item #2			
Who	What	By When	How Will This Action Be Monitored

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Scenario: 6-week Follow-up with Natalie and Her Team

Following the last meeting, Natalie has been following the plan to take her medication and has been meeting with Sally once a week. Working with the social worker, Jennifer has been able to reach out to her parents, Arturo and Connie, for help with Natalie. They have been coming over in the morning to help make sure that Natalie and Linnea get off to school. Several days a week, Connie and Arturo also come over in the afternoon to prepare a meal and check on the girls. Caroline checks in daily with Natalie by phone. Caroline, Arturo, and Connie have all agreed to be part of the next team meeting for Natalie.

Since the last meeting, Natalie has refused to meet with her therapist and has been discharged from therapy. She states that she still feels sad sometimes, but that talking with Sally helps. She states that she never really felt like the therapist understood her. Sally and Natalie have been working on how to handle peer pressure at school when it comes to eating candy and drinking soda. Natalie admits that she still drinks soda and that her grandparents often give her money to go to the corner store to buy snacks and drinks.

Jennifer appreciates the help that her parents are providing, however, she wishes that they would be more on board with the plan for Natalie's medication and diet. She would like to find out about other resources, such as a support group for teens with juvenile diabetes, to help Natalie. Overall, Jennifer feels that there has been an improvement with Natalie's mood and behavior at home.

Caroline is proud of Natalie for going back to school. She communicates with Natalie several times a day by phone or text.

This is a follow-up meeting to discuss how the action plan has been going and next steps moving forward.

My Reflections about Teaming

As a result of this training, I learned...

I'm clearer about...

I was surprised by...

I felt challenged by...

I wonder...

The most important part of this training was...

I commit to...

Resources

California Social Work Education Center (Ed.). *Family Engagement in Case Planning and Case Management: Trainee's Guide*, California Common Core Curricula for Child Welfare Workers. Berkeley, CA: California Social Work Education Center.

Center for the Study of Social Policy (March 2002) *Bringing Families to the Table: A Comparative Guide to Family Meetings in Child Welfare*; Center for Community Partnerships in Child Welfare. 1575 Eye Street, NW, Suite 500, Washington, D.C. 20005; phone: 202-371-1565. www.cssp.org

Strength-Based Teaming: Achieving Safety, Permanency, and Well-Being Curriculum. <http://calswec-archive.berkeley.edu/strength-based-teaming-achieving-safety-permanency-and-well-being>

TDM Resources for Facilitators: <https://humanservices.ucdavis.edu/programs/resource-center-family-focused-practice/team-decision-making>

TDM curriculum: <https://humanservices.ucdavis.edu/program-courses/1548>

Quality Service Review for a Child and Family. (2010). *A reusable protocol for examination of system of care services for a child and family* (Version 2.2B). Los Angeles, CA. Human Systems and Outcomes, Inc.

Some content in this curriculum was developed by NCCD and the Northern California Training Academy as part of the Safety Organized Practice Curriculum. Safety Organized Practice (SOP) is a collaborative practice approach that emphasizes the importance of teamwork in child welfare. SOP aims to build and strengthen partnerships with the child welfare agency and within a family by involving their informal support networks of friends and family members. A central belief in SOP is that all families have strengths. SOP uses strategies and techniques that align with the belief that a child and his or her family are the central focus, and that the partnership exists in an effort to find solutions that ensure safety, permanency, and well-being for children. Safety Organized Practice is informed by an integration of practices and approaches including:

- Solution-focused practice¹
- Signs of Safety²
- Structured Decision making³
- Child and family engagement⁴
- Risk and safety assessment research
- Group Supervision and Interactional Supervision⁵
- Appreciative Inquiry⁶

¹ Berg, I.K., and De Jong, P. (1996). Solution-building conversations: co-constructing a sense of competence with clients. *Families in Society*, pp. 376-391; de Shazer, S. (1985). *Keys to solution in brief therapy*. NY: Norton; Saleebey, D. (Ed.). (1992). *The strengths perspective in social work practice*. NY: Longman.

² Turnell, A. (2004). Relationship grounded, safety organized child protection practice: dreamtime or real time option for child welfare? *Protecting Children*, 19(2): 14-25; Turnell, A., & Edwards, S. (1999). *Signs of Safety: A safety and solution oriented approach to child protection casework*. NY: WW Norton; Parker, S. (2010). *Family Safety Circles: Identifying people for their safety network*. Perth, Australia: Aspirations Consultancy.

³ Children's Research Center. (2008). *Structured Decision Making: An evidence-based practice approach to human services*. Madison: Author.

⁴ Weld, N. (2008). The three houses tool: building safety and positive change. In M. Calder (Ed.) *Contemporary risk assessment in safeguarding children*. Lyme Regis: Russell House Publishing.

⁵ Lohrbach, S. (2008). Group supervision in child protection practice. *Social Work Now*, 40, pp. 19-24.

- Motivational Interviewing⁷
- Consultation and Information Sharing Framework⁸
- Cultural Humility
- Trauma-informed practice

⁶ Cooperrider, D. L. (1990). Positive image, positive action: The affirmative basis of organizing. In S. Srivasta, D.L. Cooperrider and Associates (Eds.). *Appreciative management and leadership: The power of positive thought and action in organization*. San Francisco: Jossey-Bass.

⁷ Miller, W.R., & Rollnick, S. (2012). *Motivational Interviewing*, (3rd Ed.). NY: Guilford Press.

⁸ Lohrbach, S. (1999). *Child Protection Practice Framework - Consultation and Information Sharing*. Unpublished manuscript; Lohrbach, S., & Sawyer, R. (2003). Family Group Decision Making: a process reflecting partnership based practice. *Protecting Children*. 19(2):12-15.