Comprehensive Statewide Plan to Prevent Child Maltreatment Fatalities

As a requirement of Family First Prevention Services Act, Oregon developed a comprehensive, statewide plan to prevent child fatalities, which was submitted in the 2020-2024 CFSP. In February 2020, the Child Fatality Prevention and Review Program (CFPRP) became a new independent Child Welfare program serving directly under the Child Welfare Director's Office. Since its inception, this program has focused on the response to child fatality, including support to family, professionals, data gathering, and prevention. This program is expanding its focus to include serious physical injury/near fatality. This program also leads efforts related to Child Abuse Prevention and Treatment Act (CAPTA) Comprehensive Addiction and Recovery Act (CARA) with a strong focus on supporting prevention at all levels. The following is an update to the comprehensive plan, beginning with an overview of the work of the CFPRP.

Child Fatality Prevention and Review Program

OREGON DEPARTMENT OF HUMAN SERVICES | CHILD WELFARE DIVISION | APRIL 2023

Table of Contents

Child Fatality Prevention and Review Program Overview

While child deaths are rare events, Oregon Department of Human Services Child Welfare invested in the creation of the Child Fatality Prevention and Review Program (CFPRP) to review and learn from our most tragic outcomes and use this learning to propel necessary system changes and prevention efforts with cross-system collaboration in mind.

The formation of this focused program has allowed for time and space to consider new ways of thinking about preventing child fatalities, including all child fatalities that come to the attention of Child Welfare, child maltreatment fatalities, and more broadly preventable child fatalities. Such work requires attention to both workforce support and infrastructure to improve tertiary and secondary prevention as well as identifying and elevating primary prevention efforts to support children and families in their communities. The CFPRP has coordinators dedicated to various aspects of this work, including the Critical Incident Review Team (CIRT), Safe Systems/Safety Culture, Chronic Neglect Response, Suicide Prevention, Safe Sleep, and the Comprehensive Addiction Recovery Act (CARA). Additionally, a CFPRP coordinator is co-chair of the State Child Death Review and Prevention Team, which includes state level focus on prevention as well as support for county death review teams. Coordinators for the CFPRP are responsible for tracking recommendations resulting from critical incident reviews, using data to identify potential trends including in demographics and casework practice, leading select system improvement efforts and prevention opportunities, and advancing a safety culture in Child Welfare.

National Partnership for Child Safety (NPCS)

NPCS
NATIONAL PARTNERSHIP FOR CHILD SAFETY

In early 2020, the CFPRP joined the National Partnership for Child Safety (NPCS) which is now a collaborative of 35 jurisdictions focused on applying safety science and sharing data to develop strategies in child welfare to improve safety and prevent child maltreatment fatalities. Safety science provides a framework and processes for child protection agencies to understand the inherently complex nature of the work and the factors that influence decision-making. It also provides a safe and supportive environment for professionals to process, share, and learn from critical incidents to prevent additional tragedies. For more information, please visit the NPCS website.

Members of the NPCS have a shared goal of strengthening families, promoting innovations and a public health response to reducing and preventing child maltreatment and fatalities. This concept integrates a broad spectrum of partners and systems to identify, test, and evaluate strategies to provide upstream, preventative, and earlier intervention supports and services that can strengthen the building blocks of healthy families. It represents a system that is focused less on a child protection response to abuse and more on building the wellbeing of all children.

Through membership in the NPCS, Child Welfare participates in the sharing and analysis of data across jurisdictions. Data from each jurisdiction will be housed in a central database at the National Center for Fatality Review and Prevention, allowing for analysis across the partnership to inform strategies to address children and families at risk and reduce maltreatment and fatalities. Jurisdictions began sharing data in late 2022 and Oregon uploaded our first round of data in March 2023. Data will be uploaded quarterly going forward.

The aim of CFPRP is to facilitate a robust critical incident review process that builds safety and trust with the professionals working directly with families and opens the door to true introspection and learning. Through safe systems analysis, an accurate story is provided, common casework problems identified, and more meaningful solutions that improve conditions for the workforce and outcomes for children and families are developed. As members of the NPCS, the CFPRP receives technical assistance from the Safe Systems Team at the University of Kentucky Center for Innovation in Population Health. This technical assistance has been ongoing since 2019 and includes a broad array of training and support (see attachment, NPCS Resource Guide 2023)

- Training for CFPRP and other Child Welfare programs on safety culture and systems-focused critical incident reviews
- Skill building labs for CIRT/Safe Systems Coordinators on drafting improvement opportunities, using the SSIT, conducting safe systems debriefings, as well as facilitating safe systems mapping
- AWAKEN training for CIRT/Safe Systems Coordinators (AWAKEN is a framework for identifying and addressing bias in decision-making)
- Technical support to maintain a REDCap database which houses SSIT and NPCS Data Dictionary information
- Peer support for Critical Incident Review Leaders
- Innovation and Implementation Learning Communities (I2LC) on the intersection of Safety Culture and Racial Justice and Workplace Connectedness
- Support facilitating safe systems mapping
- NEW for 2023! NPCS Affinity Group, Safety to their First Birthday: Upstream Prevention and Compassionate, Equitable Screening, Safety Threat Identification, and Maltreatment Classification after Sudden Unexpected Infant Deaths (SUID)
- NEW for 2023! NPCS Affinity Group, Advancing Safety Science in the Workforce: Integrating learning from Systems-Focused Critical Incident Reviews and Safety Culture Surveys to implement new innovations through Workforce Development
- SSIT review and support on a case-by-case basis
- Facilitation of cross-jurisdiction communication to support continued learning and improvement in different areas of the work
- Drop-in office hours for technical support questions
- Other technical assistance as requested

As early adopters of a systems-focused approach to reviewing critical incidents, Oregon has become a leader in the NPCS and is regularly sought out to provide support and learning opportunities for other jurisdictions. Oregon has also provided learning and insight as a panel member at the 2022 TCOM Conference, 2022 NPCS Convening, and 2023 NPCS I2LC Roundtable.

In addition, Oregon's work was featured in two distinct poster presentations in 2022. First, at the AcademyHealth 2022 Annual Research Meeting and second, at the 2022 TCOM Conference (see attachments ARM 2022 Conference Poster Oregon and TCOM 2022 Conference Poster Oregon).

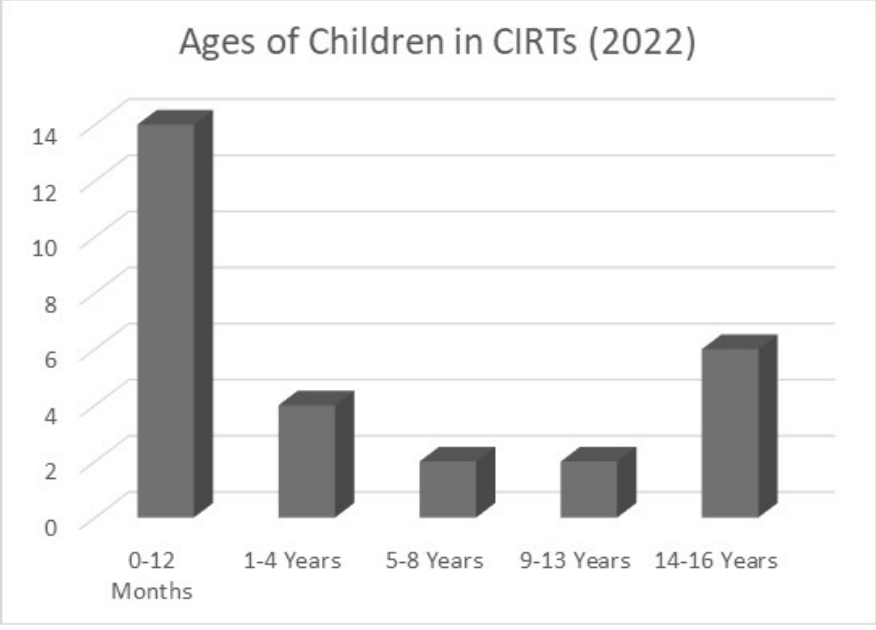
Critical Incident Review Team (CIRT)

The Critical Incident Review Team (CIRT) process has been an integral continuous quality improvement process for Oregon's Department of Human Services Child Welfare Division since 2004. Created as an important and unique tool to help protect Oregon's children from abuse and to prevent future child maltreatment fatalities. Previously this work was in the Central Office Child Safety Program, however an opportunity to move the CIRT process to the new Child Fatality Prevention and Review Program (CFPRP) came about in February 2020. This has provided a unique opportunity for Oregon Department of Human Services to have a Child Welfare program that both provides an objective review process for child fatalities along with researching, developing recommendations, and leading and implementing innovative strategies and efforts that are focused on child maltreatment prevention at primary, secondary, and tertiary levels (see attachment, CIRT FAQ).

CFPRP has team members referred to as CIRT Coordinators who are assigned specifically to the CIRT work that involves leading with a non-punitive, systems focused approach. The CIRT Coordinators facilitate meetings, engage, and prepare CIRT members for the review process which include child welfare professionals, community partners and CPS, Permanency and Foster Care program experts. In addition, the CIRT Coordinators complete the case file review and associated public report once the review is complete. Lastly, the CIRT Coordinators assist in the development of system improvement recommendations resulting from actions or inactions of ODHS or Law Enforcement leading up to or surrounding the critical incident. A CFPRP Prevention Coordinator is dedicated to tracking CIRT and fatality data and facilitating regular cross program meetings to ensure the completion of all system improvement recommendations (see attachment, CIRT Process Map). There remains a separate pathway for personnel related issues that need to be addressed through the human resources department.

2022 Critical Incident Data

During the calendar year of 2022, 30 child fatalities met the criteria for a mandatory CIRT review. The chart below reflects the age ranges for the children whose deaths resulted in the assignment of a CIRT in 2022.



Circumstances surrounding the fatalities

- Out of the 14 children ages 0–12-month range, all 14 died from high risk sleeping practices.
  - 12 of those included bed sharing
  - 7 involving infants with prenatal substance exposure
- 2 children died as a result of a house fire
- 1 child died as a result of a drowning
- 3 children died as a result of an overdose (2 involving fentanyl)
- 1 child died as a result of substance exposure (methamphetamine)
- 4 children died from physical abuse
- 4 children died from vehicle related incidents (3 involving a driver under the influence and 1 believed to be a suicide)
- 1 child died from a medical condition or complication
- 2 children were in temporary and/or legal custody of the Department at the time of the critical incident

For more information regarding CIRTs please refer to the ODHS CIRT Website.

As a result of the CIRT, numerous system improvement recommendations are taken on each year by the CFPRP and other Child Welfare Programs (Safety, Permanency, Well-Being, Equity, Training & Workforce Development, etc.). System improvement efforts that have been implemented since 2022 include, but are not limited to: Plans of Care outreach for infant safety community supports with child and family serving agencies and medical professionals; Oregon Child Abuse Solutions Training Development; workforce guidance to access equitable translation services between Deaf and Hard of Hearing families and Child Welfare caseworkers; Injury Prevention Kits for suicide prevention and safe home environments; local office level Infant Safety Staffing Protocol Development and statewide Logic Model for Safe Sleep; Safe Sleep Training for ISRS and other contracted providers; Opioid Overdose Kits and training for ODHS staff; Substance Use Disorder Guidelines and Addiction and Recovery Team enhancements; Safe Systems Mapping for system improvements around comprehensive assessments; community engagements for peer mentorship and outreach at the local level; Child Protective Services Supervisor Toolkit development to aid in caseload management and access practical resources; partnership efforts with Law Enforcement professionals regarding ODHS cross reporting statutes and processes; and Make Safe Happen application accessibility on ODHS state issued cellphones.

The CFPRP recognizes the hard work and collaboration of the child welfare professionals who facilitated or participated in each of these efforts. The CFPRP would also like to recognize the efforts of the local offices to enhance the knowledge and skills of the workforce and improve operations as a result of learning from the CIRT.

Professional Development and Supporting the Workforce

As CIRT criteria has shifted over time, so has the number of child fatalities reviewed through the CIRT process. With the substantial change in CIRT legislation in 2019, multiple full-time staff were needed to manage the growing CIRT workload. In spring 2022 CFPRP added two rotational full-time CIRT Coordinators who transitioned into permanent positions in winter 2023. In winter 2023, CFPRP brought two new staff members into the rotational positions left vacant with the team, one of whom will also take on the role of CIRT

Coordinator as part of their duties. The added positions have created opportunities for CIRT Coordinators to take a larger role in the prevention and safe systems work occurring within the team, to pursue professional development goals, and has resulted in less exposure to the secondary trauma experienced when reviewing tragic child fatalities. Additionally, these rotational positions allow CFPRP to continue efforts to share and promote the concepts of safety science and safety culture used in the CIRT process and by the CFPRP team. Staff returning to their local office after rotating out of CFPRP positions will have the opportunity to become culture carriers who may provide natural support and direction to their local offices to promote positive shifts in agency culture through the tenets of safety science and safety culture.

As part of a continuous quality improvement effort, the CFPRP offers an opportunity for one-on-one feedback to understand the experience of any caseworker, supervisor, manager or partner who attends a CIRT. The feedback received informs what is working well and where there are opportunities for improvement. The feedback opportunities are conducted through a trauma informed lens, are voluntary, and participants are assured the focus is on the process and does not include discussion about the family or circumstances.

Internal Discretionary Reviews

The CFPRP is responsible for leading Internal Discretionary Reviews which are directed by the ODHS Director when Child Welfare receives a report of abuse that resulted in a fatality, near fatality, or other serious physical injury of a child and the incident does not meet the criteria for a critical incident review team (CIRT). These reviews are an important opportunity for system learning and the development of system improvement recommendations and actions similar to the CIRT process.

CFPRP team members are assigned to complete the work surrounding the Internal Discretionary Review process such as engaging and preparing participants, facilitating meetings, partnering with other child welfare programs to conduct case reviews, and developing and assisting in the implementation of system improvement recommendations. Seven cases were reviewed through this process in 2022. Safe systems analysis from each of these cases is included in the aggregate data set.

Near Fatalities/Serious Physical Injuries

In addition to the data collected by the CFPRP on child fatalities, the CFPRP now gathers data from near fatalities and serious physical injuries. The CFPRP is in the early stages of collecting this specific data and understands it is critical to understanding system factors and to the development of child abuse and child fatality prevention strategies. In addition, new fatality/near fatality procedure is in the process of being developed to provide further guidance to Child Welfare professionals.

Safe Systems Analysis

Safe systems analysis is a critical extension of Oregon's child fatality review process. Through file review, participation in the CIRT or discretionary review, and follow-up supportive inquiry, the CFPRP is able to gather important information about what influences the casework or system challenges that may be identified in cases with tragic outcomes (see attachment, Safe Systems Analysis FAQ).

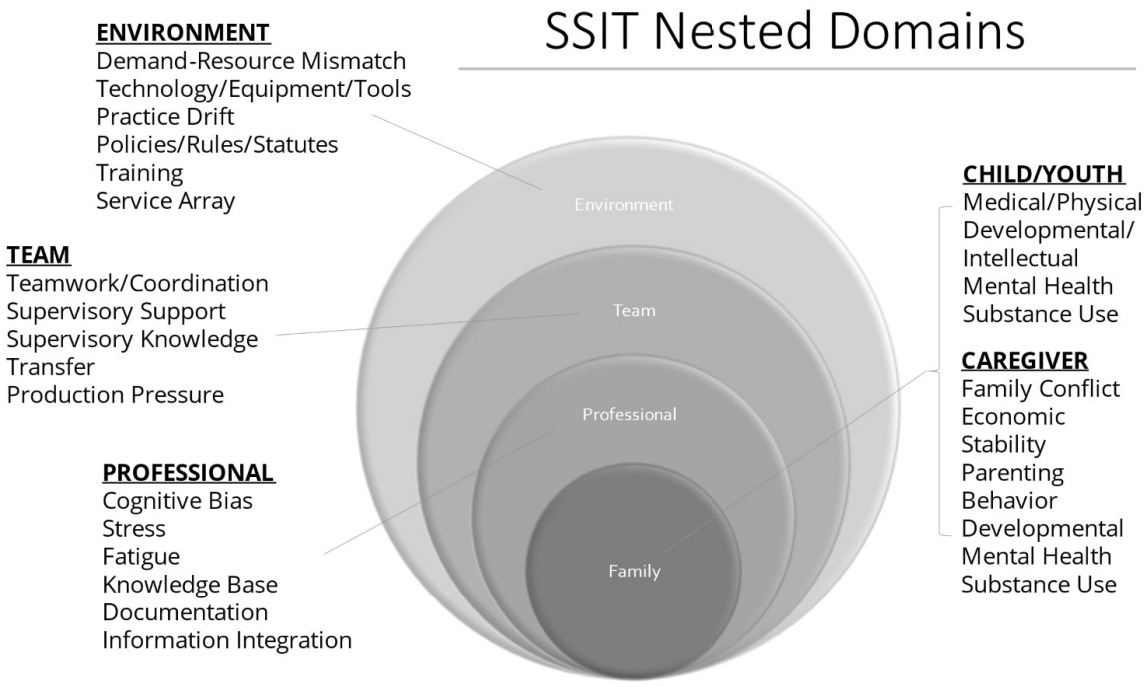
These challenges are known as Improvement opportunities (IOs), and they represent the gap between what the child or family needed and what they received. More technically, IOs are case-specific actions or inactions relevant to the outcome or industry standards and are often representative of relatively common casework

problems. While emphasis is given to those IOs within ODHS-CW, IOs also consider the actions/inactions of other entities within the macro child-serving system (e.g., courts, human service providers, law enforcement, schools). In the safe systems analysis process, IOs are first identified through the CIRT or discretionary review and those IOs are then explored by a Safe Systems Coordinator through use of the Safe Systems Improvement Tool (SSIT) (see attachment, 2022 SSIT NPCS Reference Guide). At times, additional IOs are identified by the Safe Systems Coordinator and added to the exploration. Since implementing safe systems analysis in July 2019, the SSIT has been completed on 98 cases. Of those 98 cases, 76 had IOs identified, some cases having multiple, for a total of 142 IOs.

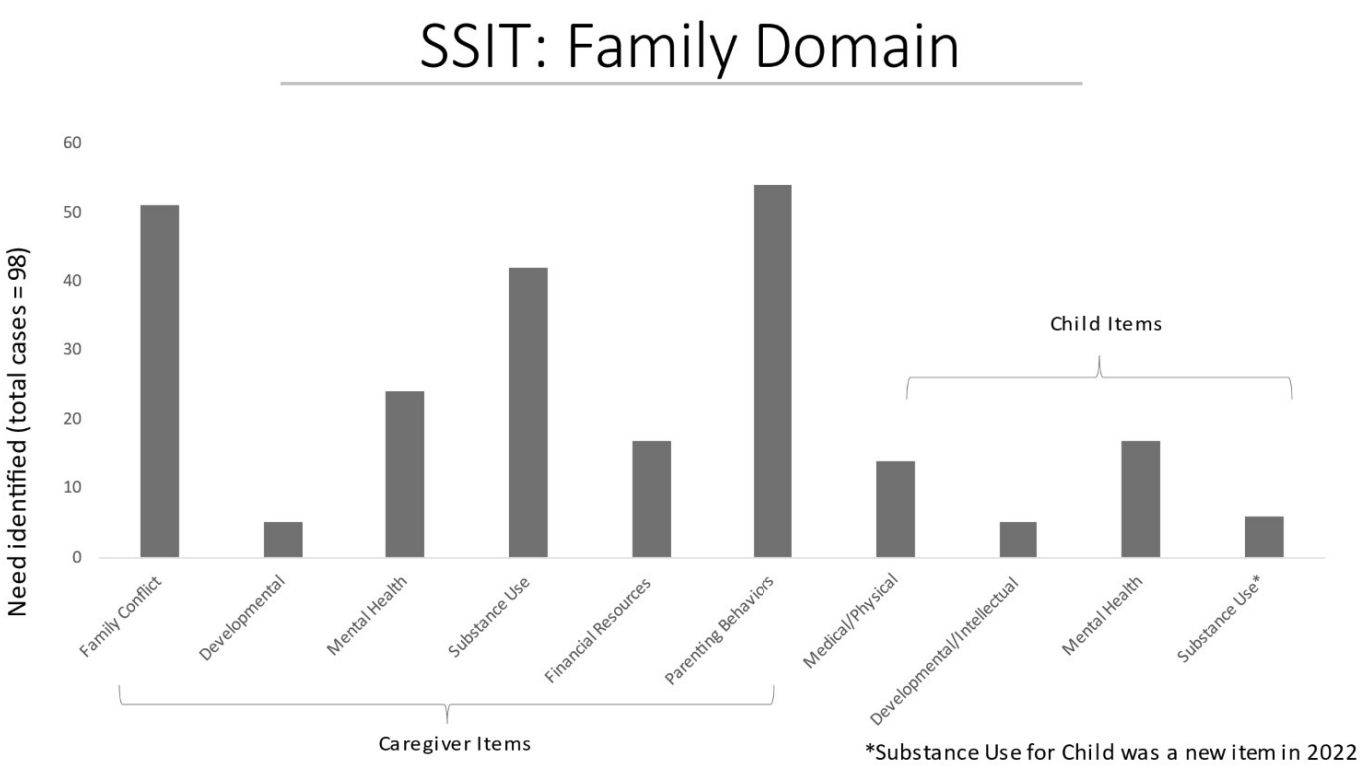
In some cases, the safe systems analysis includes debriefings. These debriefings are the mechanism for gathering the "second story" from those who experienced the outcome in the specific case. Debriefings are voluntary and trauma responsive and use supportive inquiry to support child welfare professionals in sharing their experiences. While debriefings are not completed in every case, they lend important detail and reliability to the overall information gathered and rated in the SSIT. Since 2019, Safe Systems Coordinators have engaged over 60 child welfare professionals in debriefings.

SSIT results and the standardized NPCS dataset are captured in a REDCap database (see attachment, NPCS Data Dictionary and SSIT with Codebook). REDCap is a secure web platform for building and managing online databases and allows for exporting data to excel as well as ad hoc reporting. REDCap allows the CFPRP to efficiently organize SSIT data for reporting and guiding system improvement efforts.

The SSIT contains four nested domains for rating.

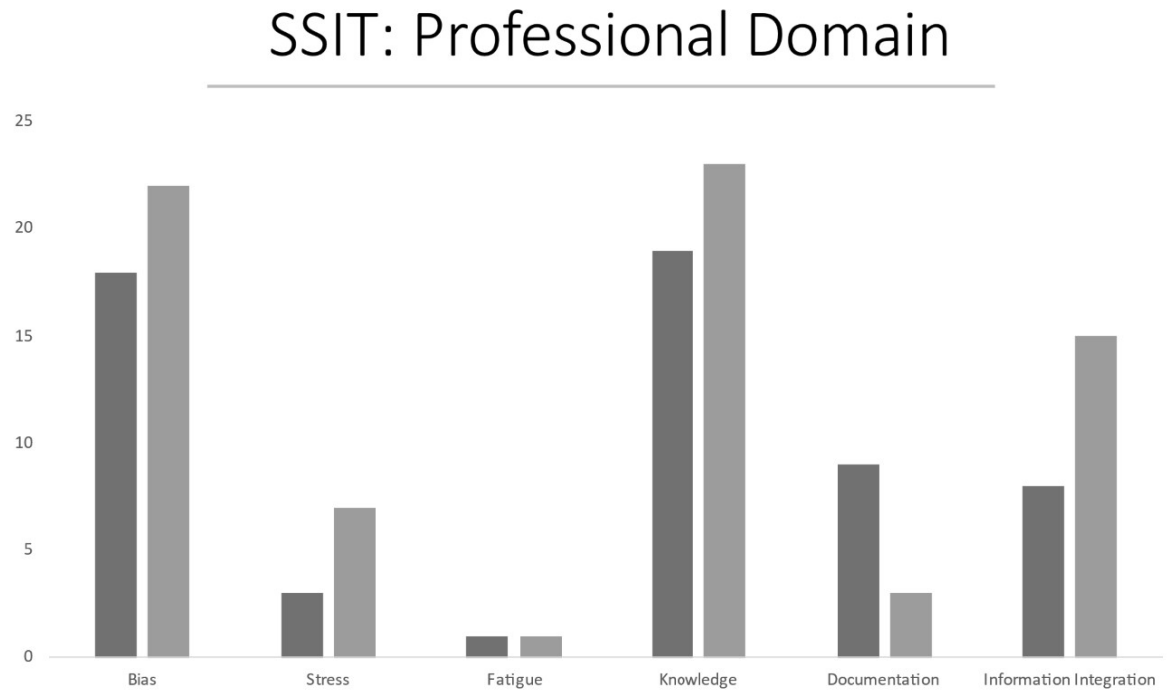


The first domain is the family domain and is rated independent of any Improvement Opportunities and functions similar to the CANS. These items are important for considering the needs of the family at the time of the critical incident.

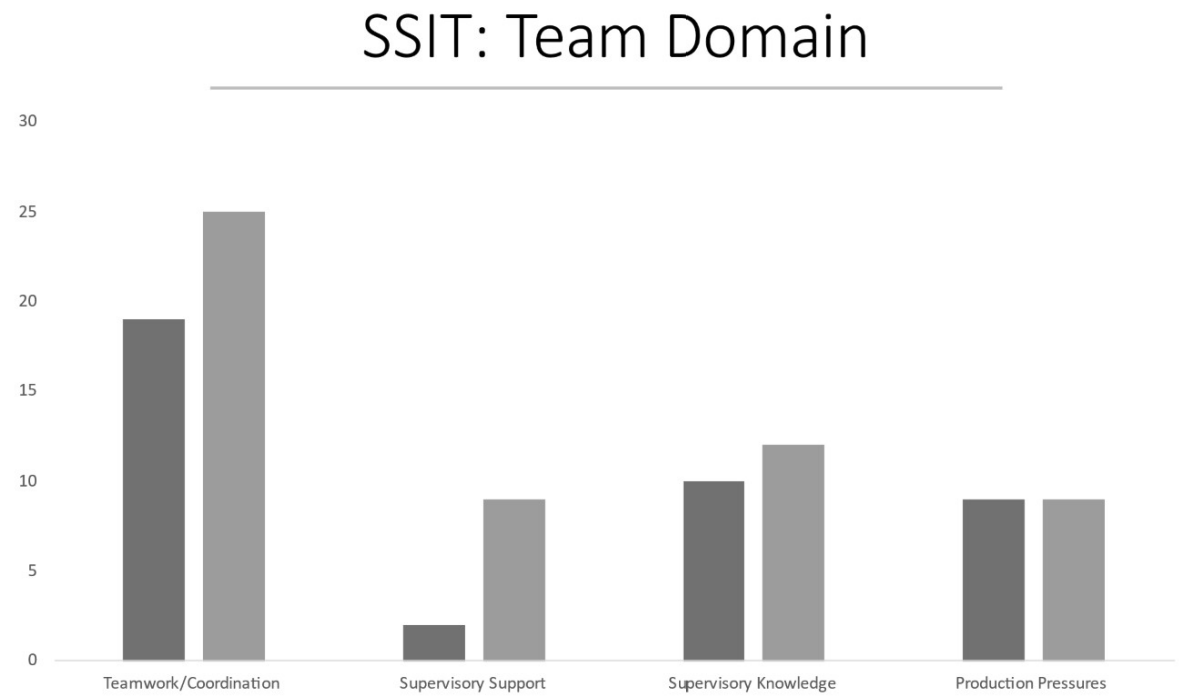


Parenting Behavior is the most highly rated item in the Family Domain of the SSIT. A rating of '2' or '3' on this item indicates an actionable need with regard to a parent's ability to understand and meet the needs of the particular child. This can range from understanding and taking action to ensure safe sleep, to following medical directives related to a serious health condition, to providing developmentally appropriate supervision. Family Conflict is the second most highly rated item and can rate both general conflict among family members, as well as domestic violence perpetrated within a family. The presence of domestic violence within the family results in a score of '3' for the item. In the data set depicted above, Family Conflict was rated '3' in 32 instances, which is just under 33% of all cases reviewed with the SSIT (98). Finally, Caregiver Substance Use is active and in need of intervention in nearly 43% of cases. Each of the items in this domain can indicate the prevalence of unmet needs within a family system and can help to shape service advocacy efforts when considered in aggregate.

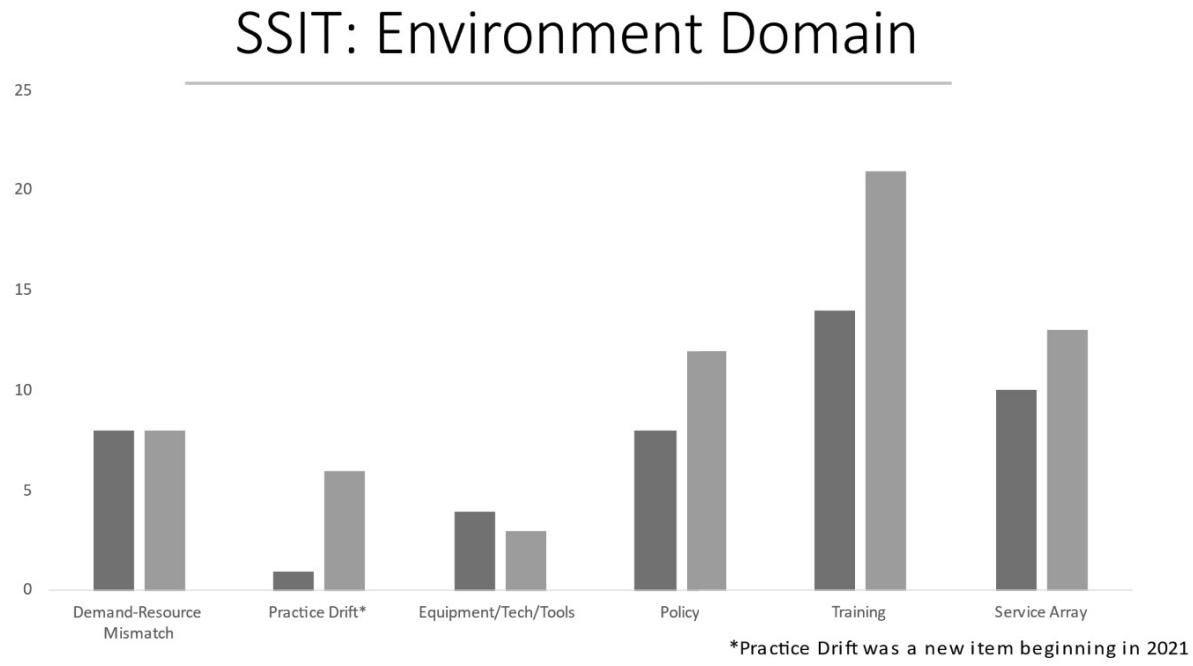
The remaining three domains capture influences at the professional, team and environment levels. These items are important for considering what factors contributed to any identified challenge, or IO, in the case. The charts below reflect the frequency with which professional, team and environmental factors influenced any IO. A rating of '2' indicates the item had influence on a non-proximal IO. A rating of '3' indicates influence on an IO that was proximal, or close in time or distance and with relationship to the incident under review. Ratings of '2' are represented in blue and ratings of '3' are represented in orange.



Blue = Influence on non-proximal IO Orange = Influence on proximal IO



Blue = Influence on non-proximal IO Orange = Influence on proximal IO



Blue = Influence on non-proximal IO Orange = Influence on proximal IO

Quality improvement resources are finite. Considering the frequency and proximity of Improvement Opportunities (IOs) is important to balancing if, when, and to what degree an agency advances a system improvement effort. In each safe systems analysis, IOs are evaluated for their proximity (i.e., closeness) to the outcome. Proximity is not intended to imply causality or severity of an action or inaction but rather describes how close the IO was in time or distance *and* with relationship to the incident. Of the 76 cases with identified IOs, 40 had at least one IO determined to be proximal, for a total of 59 proximal IOs. Through safe systems analysis, Child Welfare can identify themes across the IOs and consider how to tailor improvement efforts based on the influences identified through the SSIT items. Themes identified with more frequent proximity include but are not limited to, assessment and engagement with caregivers using substances, CPS assessment follow-up and understanding of history, as well as infant safety (safe sleep, Plans of Care, etc.). Additional themes that are less frequent but monitored for additional system improvement work include but are not limited to, engagement with fathers/non-custodial parents, external teamwork/collaboration, and child substance use and mental health needs.

The CFPRP can drill down further into the influencing factors to support system improvement by providing program leads with the factors as they correlate with specific IO themes and CIRT recommendations. Both individual case and aggregate SSIT results are shared with central office programs when relevant to a specific recommendation. In addition, results may be shared with local district leadership to support planning and improvement at the local level.

As the safe systems analysis process matures and the CFPRP develops a deeper understanding of how to share about the system learning, regular data reporting and topical briefs will be developed.

Safe Systems Mapping

One notable way the CFPRP explores Improvement Opportunity (IO) themes to inform system improvement is through safe systems mapping. The purpose of safe systems mapping is to discuss in a group of experienced professionals their perceptions of what factors influence IOs. In safe systems mapping, these IOs are evaluated at all levels of the system – from the local team level to the legislative/government level. Every participant has an equal voice in the process and all perspectives are valuable to understanding more clearly how the system is operating and what gets in the way of successful work with families.

Oregon has completed two rounds of mapping in partnership with the Child Safety Program. The inaugural round occurred in 2021 and focused on assessing safety when parents/caregivers are using substances. This mapping exercise involved a diverse group of participants and resulted in eight recommendations for system improvement (see attachment, 2021 Safe Systems Mapping Overview and Recommendations). The recommendations are in various stages of implementation as outlined below.

1. Restructure and expand Addiction Recovery Team and corresponding contracted services – *This recommendation remains in progress as funding is secured.*
2. Develop comprehensive casework practice guidelines for cases involving substance use – *A workgroup is underway to develop guidelines.*
3. Develop a process for referring reports closed at screening to community-based supports or services – *Exploration of avenues to support families in the community outside of child welfare is ongoing.*
4. Develop statewide staffing guidance for cases involving infants – *Local districts have been advised to consider utilizing an infant case staffing framework. CFPRP in partnership with the child welfare workforce and other partners has developed an Infant Safety Logic Model, which is being finalized and will be used to support statewide guidance.*
5. Enhance knowledge and skill through creative education for caseworkers and supervisors – *Training modules from the National Center for Substance Abuse in Child Welfare are under review for modification and delivery in Oregon*
6. Actively promote partnerships with local prevention organizations – *To support this effort, CFPRP is reviewing and gathering data from statewide plans developed by other family serving systems and Community Health Assessments conducted by Community Care Organizations and public health agencies in each of Oregon's 36 counties. The information has been compiled in a Smartsheet, disaggregated by county, to provide a more comprehensive view of the socioeconomic conditions, health disparities and the array of existing services available to children and families in local communities.*
7. Identify and support culturally appropriate paid respite, child-care programs, and safety service providers – *This recommendation is on hold and may be incorporated into existing efforts, such as Child Welfare's paid respite program for resource caregivers.*
8. Develop a smart phone application to provide information and guidance to child welfare professionals – *CPFPR continues to evaluate and promote approval of applications that support knowledge and skill for both child welfare professionals and the children and families they encounter. Development of an application in-house may not be necessary as new apps are approved and staff are informed of function and applicability to the work. Vroom and Make Safe Happen are two examples that are now approved for use on state smart phones.*

In the winter of 2022, the CFPRP and Child Safety Program embarked on a second round of safe systems mapping. This exercise explored the factors related to a common IO, insufficient comprehensive safety assessment follow-up. The mapping team was comprised of child welfare professionals from across the state and with various levels of experience and expertise. The group concluded their mapping sessions and the CFPRP and Child Safety Program developed initial recommendations. The recommendations are under review and may be adjusted or rolled into ongoing workforce development efforts, such as coaching model implementation (see attachment, 2022 Safe Systems Mapping Overview and Recommendations).

For 2023 safe systems mapping, the CFPRP will be bringing together community members, child and family serving professionals and fathers with lived experience to explore the barriers to engaging fathers and non-custodial parents in safety assessment, decision-making and case planning. Mapping is anticipated to occur in summer 2023.

Advancing a Safety Culture

Since its inception in 2020, the CFPRP has strived to advance safety culture in Oregon's Child Welfare Division. This occurs through the application of safety science in the Critical Incident Review and Safe Systems Analysis processes but also as a specific body of work within the program.

The CFPRP believes a workplace culture in which mistakes are seen as opportunities to learn and child welfare professionals at all levels are engaged in problem-solving without shame or blame is critical to improved outcomes for families and enhanced satisfaction for the workforce. Building a safety culture is central to Child Welfare's transformation efforts. When teams feel connected and supported, they are better able to embrace change and fully engage with families.

The work of the CFPRP to advance safety culture in child welfare has continued to grow over the past year. CFPRP coordinators have engaged with a variety of groups across Child Welfare to educate and coach leaders around advancing a safety culture in their own teams. CFPRP coordinators also champion safety culture when interacting with external partners as well as internal colleagues while serving on workgroups and committees.

Activities to build knowledge and skill:

- CFPRP staff participated in ongoing National Partnership for Child Safety (NPCS) trainings to support knowledge and skills in advancing safety culture. Trainings were offered to other Child Welfare program areas as well to support development of culture carriers. These trainings included: Safety Culture in Critical Incident Reviews, Writing Improvement Opportunities, SSIT: Skilled Practitioner Training, Systems Mapping, Data Aggregation, and Debriefing Professionals.
- New CFPRP Coordinators participate in 15 hours of training on the AWAKEN framework (see attachment, AWAKEN Infographic) for building awareness around bias and developing a practice for conscious decision-making. The CFPRP continues to explore opportunities to bring the training more broadly to child welfare in Oregon.
- CFPRP Manager and coordinators, along with several other ODHS Child Welfare staff participated in the 2022 NPCS Innovation and Implementation Leaning Community (I2LC) focused on workplace connectedness. In addition, the CFPRP Manager and Safe Systems Coordinator remained engaged in the 2021 I2LC on the intersection of safety culture and racial justice. Both cohorts have continued to

meet quarterly to provide opportunities for jurisdictions to share about ongoing work and gather ideas for continued improvements.

Activities to educate about and promote a safety culture across child welfare:

- The CFPFP presented on safety culture to numerous groups over the past year, including: ODHS District Managers, Child Welfare Program Managers, Child Welfare Supervisors Cohort, Coaching and Training Specialists, and Child Welfare Leaders Institute Workshops (July & November 2022).
- CFPRP Safe Systems Coordinators have been invited to meet with a variety of leadership teams across Child Welfare to share about safety culture. Ongoing coaching and support is provided to teams upon request, utilizing interactive visual platforms to work through challenging topics together. The focus of these sessions is on building psychological safety and promoting strategies for effective teaming, using the TeamFirst Field guide (see attachment, TeamFirst Field Guide).
- CFPRP Safe Systems Coordinators participate in a wide variety of teams, workgroups, and committees, with the expectation to bring a safety culture lens to the work and cultivate culture carriers. These include but are not limited to: Worker Safety workgroup, Women's Equity Leadership Development (WELD) Employee Resource Group, Child Welfare Race and Equity Leadership Team, ODHS Critical Incident Stress Management Quarterly Connection, and ODHS CW-SSP Coaching Implementation Team.
- In September 2022, CFPRP began facilitating Safety Culture Hour, a virtual drop-in style micro-learning opportunity, twice monthly available to all of Child Welfare staff. Attendance regularly includes participation from program managers, office managers, supervisors, direct service staff, administrative support staff, and Coaching and Training Specialists, from all program areas within Child Welfare to cultivate culture carriers. Safety Culture Hour covers topics including psychological safety, the intersection of psychological safety and anti-racism, healthy team habits, and other safety culture concepts and practices to build skills and increase staff knowledge. CFPRP also launched a Microsoft TEAMS Safety Culture channel where safety culture resources are regularly posted to encourage learning.
- CFPRP, in collaboration with NCPS technical assistance, developed ready-to-us, deskside strategy cards for Child Welfare professionals. These cards are based on the TeamFirst Field Guide and provide strategies for healthy team habits and mindful organizing, including testing change, effective communication, managing professionalism, team appreciation, planning forward and reflecting back.
- Finally, in 2023, the CFPRP Safe Systems Coordinator will be participating in an affinity group facilitated by the NPCS focused on advancing safety science in the workforce. The affinity group will bring together critical incident review, safety culture survey and workforce development leaders to focus on:
- Integrating key learnings from SCIR data into workforce development efforts
- Developing strategies and workflows for integrating key learnings into existing agency training, such as new and experienced casework professionals training
- Curating and creating best practice learning resources
- Developing a curriculum of adaptable spaced education on key learning topics for use by jurisdictions across the partnership

Workforce Supports

Fatality/Near Fatality Procedure

As a result of various program efforts, Child Fatality Prevention and Review Program (CFPRP) determined that additional attention was needed regarding the guidance provided to Child Welfare professionals when engaged in the work of responding to child fatalities and near fatalities. Given the unique activities and considerations required for this challenging work, CFPRP began the development of child fatality and near fatality procedure to provide support and direction to staff. This ongoing effort is led by CFPRP and will benefit from the insight of Child Welfare professionals, tribal partners, community-based child, and family serving professionals, and the voice of those with lived experience. CFPRP believes this procedure will support Child Welfare professionals in navigating these tragic outcomes and allow for increased consistency of practice and an improved experience for families engaged with Child Welfare.

Fatality/Near Fatality Toolkit

In 2022 CFPRP initiated the development of a trauma-sensitive toolkit for our Child Welfare professional workforce, with the goal of providing support and guidance to professionals responding to child fatalities and non-fatal serious injuries, to assess the safety of the home. Contents of the toolkit include definitions and clarity of trauma-sensitive care, culturally responsive engagement with families, sample branch workflows to ensure trauma-informed management of staff and case activities, multiple domains of trauma-sensitive question and engagement prompts to support staff in speaking with grieving families, local, regional and statewide resources for grief and loss support, trauma-sensitive initial contact prompts, and well-being resources for staff and leadership involved in assessing critical injuries. The Trauma-Sensitive Toolkit Workgroup (Toolkit), consisting of staff in various classifications from multiple districts and programs, completed an initial draft of the Toolkit in early 2023. Currently the draft is undergoing refinement and review for approved Oregon Department of Human Services communications style compliance as well as review for diversity, equity, and inclusion standard metrics. Currently the Child Safety Program is considering the development of regional fatality assessment specialty teams who will respond to fatality and near fatality/serious physical injury reports of abuse following recommendations from a Critical Incident Review Team. Consideration is currently being given to the distribution of the finalized and approved Toolkit to the regional fatality and near fatality/serious physical injury specialty teams upon implementation of the service structure.

Staff Support for Critical Incident Stress Management

Several CFPRP team members are certified to administer Critical Incident Stress Management (CISM.) These certified team members, facilitate and support CISM sessions for child welfare professionals that are available on a regularly scheduled basis as well as upon request and/or immediately after a critical incident.

Certificate Program in Implementation Science

Two CFPRP team members participated in the inaugural cohort of the Certificate Program in Implementation Practice offered by the University of North Carolina's School of Social Work's Collaborative for Implementation Practice. This certificate program was developed for professionals working in health and human services and is focused on bolstering competencies related to the implementation of initiatives and sustaining change. The three competencies are: co-creation and engagement, ongoing improvement, and sustaining change.

State Child Fatality Review Team

The State Child Death Review and Prevention Team (state team) is mandated by Oregon Revised Statute 418.748 and is co-chaired by ODHS and OHA. The ODHS co-chair is filled by a CFPRP member creating opportunity for communication and collaboration across the CIRT, the state team, and the 36-county child death review teams. The team's name was changed from State Child Fatality Review Team to use more accessible language and to highlight the main objective of the work, which is prevention.

The National Partnership for Child Safety (NPCS) continues to support multiple states in exploring a path for improving communication and collaboration between state and county child death review teams and the Critical Incident Review Team. This exploration occurs through CFPRP's active engagement in the National Partnership for Child Safety affinity group: Connecting internal death review to state and county child fatality review teams.

The mission, purpose, objectives, and guiding principles of the state team closely align with and support the work of CFPRP (see attachment, State Child Death Review and Prevention Team Charter).

Mission: The mission of the state team is to serve Oregon by reducing preventable child deaths.

Purpose: The purpose of the state team is to better understand the circumstances surrounding child fatalities occurring in Oregon to prevent future child deaths and serious injuries. The team accomplishes this through:

- Reviewing data gathered from collaborative, multidisciplinary, comprehensive case reviews.
- Supporting county teams where the reviews primarily occur.
- Tracking data-driven trends, improvement opportunities, and recommendations.
- Advocating for equitable prevention strategies at the community, local, state, and national levels.
- Informing continuous quality improvement within Oregon's larger child death review system.

Objectives:

- Support accurate identification and uniform reporting of the cause and manner of child deaths.
- Promote cooperation, collaboration, and communication across the child and family serving system and enhance coordination of efforts.
- Achieve quality, equitable investigation of child deaths consistent with national standards.
- Design and implement cooperative, standardized protocols for the review of child deaths.
- Ensure accurate, complete, and timely data entry in the National fatality Review - Case Reporting System.
- Review county team prevention recommendations and support prevention efforts.
- Identify needed changes in legislation, policy, practices, and recommend expanded efforts in child health and safety to prevent child deaths and serious injuries.

The CFPRP co-chair leads the efforts to implement the Child Death Review Resource and System Improvement Plan. As part of these efforts the Child Death Review and Prevention website was developed and implemented (see attachment, Child Death Review Resource and System Improvement Plan).

Prevention Strategies

Suicide Prevention

In 2017, the Critical Incident Review Team (CIRT) saw an increase in reports of children dying by suicide and a comparison of state fatality data and child welfare records of suicides for the fiscal year 2017 confirmed almost half of the children who died by suicide had some previous history with child welfare. Continuing data collection from Critical Incident Reviews to date demonstrates a continued need for suicide prevention and intervention initiatives within Oregon's Child Welfare Program.

Calendar Year	Total Critical Incident Reviews	Suicide Deaths
2017	7	3
2018	18	0
*2019	29	4
2020	34	2
2021	16	1
2022	30	1, 1 Discretionary Review
*CIRT Rule Governing criteria for assigning a CIRT changed in 2019, resulting in CIRT assignment increase		

According to the most recently updated Suicide-related Public Health Surveillance Update, dated January 18, 2023, (see OHA Suicide-related Public Health Surveillance Update) suicide deaths in Oregon in 2022 are similar to previous years, as are suicide-related visits to Emergency Departments (ED) and Urgent Care Centers (UCC). Suicide-related visits to EDs and UCCs for youth up to age 18 in the first quarter of 2022 were higher than previous years. Calls for suicide-related or crisis support have increased annually and have seen exponential growth since the initiation of 988 as a national crisis line in July 2022. According to the 2021 Youth Suicide Intervention and Prevention Plan (YSIPP) Annual Report, most up-to-date report available at this time, for youth age 17 and under suicide numbers decreased in 2021 comparted to 2020. For youth age 18-24 suicide numbers in 2021 were similar to 2020. Suicide numbers decreased overall for youth age 24 and under in 2021 compared to 2020. According to the YSIPP 2021 Annual Report, this is the first time since 2001 that Oregon has had a three -year decrease in suicide fatalities for young person's age 24 and under. However, Oregon remains above the national average for youth suicide rates (see OHA/ODHS Youth Suicide Intervention and Prevention Plan Annual Report). In light of the continued need to reduce youth suicide deaths in Oregon, continued efforts to enhance suicide prevention and intervention knowledge and practice among Child Welfare professionals remain within the CFPRP.

Throughout 2022 the CFPRP has maintained the presence of a Suicide Prevention Coordinator. The Suicide Prevention Coordinator continues to further the work initiated previously by the CFPRP in addition to engaging in new endeavors to promote suicide prevention and intervention to Oregon youth. In collaboration with the Oregon Health Authority, the CFPRP continues to utilize Garrett Lee Smith grant funds to support workforce training and education around suicide prevention and intervention through the ongoing provision of Question, Persuade, Refer (QPR) training for the greater Child Welfare workforce. To date, approximately 900 Child Welfare direct service professionals have been trained in a facilitated QPR training for casework staff.

Additionally, throughout the Oregon Department of Human Services over 9000 staff have been trained in computer based QPR to date. ODHS remains committed to the training of QPR and requires participation in QPR for all employees. Additionally, a specially designed QPR for Resource Parents also continues to be offered throughout the year to support families caring for children and young people in ORCWP custody. The CFPRP Suicide Prevention Coordinator is currently supporting additional information and resource provision efforts for Resource Parents through collaboration with the Equity, Workforce Development and Training Program at ORCWP. The Garrett Lee Smith grant has been utilized by ODHS to fund Training4Trainers for an additional two QPR Gatekeeper trainers in the Child Welfare Equity, Workforce, and Development Program to support ongoing Resource Parent QPR training.

The CFPRP Suicide Prevention Coordinator has developed and completed a Youth Mental Health and Suicide Prevention training in collaboration with the Oregon Child Abuse Hotline (ORCAH), with the aim of providing additional risk assessment knowledge and skill to Oregon Child Abuse Hotline screening and intake staff. The completion of the 90-minute recorded training occurred in September 2022, with provision to ORCAH staff beginning in November 2022. To date, all current and incoming ORCAH staff are provided the training as well as follow up opportunities with the CFPRP Suicide Prevention Coordinator to address additional questions or needs.

The CFPRP has developed and finalized the 6-month post-QPR training survey and begun providing the survey to training cohorts in March 2023. The goal of this 6-month post training survey is to assess the continuous efficacy of QPR training long term for Child Welfare professionals. Upon receipt and analysis of the post-survey data in late 2023, it is expected that the CFPRP will identify and address any future areas of training and skill utilization support.

In January 2023 the CFPRP, in partnership with the Oregon Health Authority and Oregon Pediatric Society, commenced development of the ODHS Child Welfare YouthSAVE training. This training, a modified version of the widely available YouthSAVE (Suicide Assessment in Various Environments) Training, is being developed to support the child welfare professional workforce in identifying, assessing, and safety planning for suicide risk within the unique context child welfare engaged with young people and families. The curriculum development and internal training for trainers is expected to be completed by August 31, 2023, with staff training commencement set to begin for Fall 2023.

In March and April 2023, the CFPRP Suicide Prevention Coordinator has partnered with the ODHS Mobile Child Safety team from District 3 for a demonstration initiative for including mental health and suicide risk screening in all child safety assessments. The team will utilize questions from the Patient Health Questionnaire-Adolescent (PHQ-A) (see PHQ-A adolescent suicide risk screening tool) and ASQ (see ASQ suicide risk screening tool) as standard screening tools for young people ages 8 and above as validated through the measures. Ongoing feedback regarding the utilization of the standardized screening demonstration will occur throughout Spring 2023. Depending on the utilization feedback, consideration is being given in collaboration with the Child Safety Program to incorporate the standard screening into all child safety assessments and the OR-Kids record-keeping platform.

In addition to the above suicide prevention and intervention activities, the CFPRP Suicide Prevention Coordinator also engages in the following prevention and intervention efforts:

- Ongoing engagement and participation in statewide and regional suicide prevention coalition meetings and efforts;

- Engagement and participation in the Oregon QPR Learning Collaborative;
- Postvention collaboration with Oregon Community Mental Health Program (CMHP) Postvention resources for communities and ODHS Child Welfare local offices who experience a youth suicide.
- Collaboration with Oregon Health Authority and Oregon Health Sciences University in the development of an Emergency Department Infographic Guide for child welfare professionals to assist the workforce in coordinating care for youth experiencing a mental health crisis or other emergency department presentation.
- Completion of the Connect Postvention Training offered through Oregon Department of Human Services Trauma Aware;
- Participation in the Oregon BIPOC Learning and Training Collaborative;
- Presenter to the Oregon Alliance to Prevent Suicide regarding ODHS Child Welfare suicide prevention efforts and future initiatives;
- Participation in the annual Oregon Suicide Prevention Conference in October 2022;
- Collaboration with Oregon Health Authority in the development and updating of the Youth Suicide Intervention and Prevention Plan (YSIP);
- Collaboration with the Child Welfare Independent Living Program for youth/peer support development;
- Participation in the Oregon Alliance to Prevent Suicide Equity Advisory Workgroup;
- Participation in the ORCWP Centering Youth Voices Workgroup;
- Collaborator, developer, and presenter at the Oregon Child Welfare Leader's Institute (2022) and LEAD Summit (2023);
- Collaboration with and support for child welfare professionals engaged with Temporary Lodging and Resource Management to support complex needs youth transitioning between levels of behavioral health care and placement, including support for brief, non-clinical safety planning until longer term clinical interventions can be established;
- Membership and participation in the Oregon State Child Death Review and Prevention Team;
- Participation in the American Association of Suicidology Conference in Spring 2023;
- Participation and engagement in multiple learning opportunities related to suicide prevention and intervention, including but not limited to; Oregon ECHO Network: Whole Person Care for Children and Youth in Foster care (Oregon Health Sciences University); Strengthening Native American Families through Honoring Traditions; Truth Decay: Suicide Prevention and Care for Trans Individuals (Lewis and Clark College); Suicide Prevention within the LGBTQ+ Community (The Social Justice Leadership Academy), 10 Tips for Clinical Management of Suicide Risk (CAMS-Care); Impact of Mobile Response Stabilization and Support Services (University of Maryland), Caring for the Healers: Preventing Suicide in the Healthcare Workforce (Association of Clinicians), Substance Use Disorders, Suicide, and Recovery: Beyond Shame and Stigma (NAADAC), Engagement in the Black Community Summit (NAADAC);
- Participation as an Advisory Board Council Member for the Oregon Social Learning Center to support suicide intervention research and practice statewide.

Responding to Neglect and Promoting Protective Factors

Just as a vehicle can bear only so much weight before it stops moving forward, challenging life circumstances can overload or overburden parents, making it harder for them to provide the best kinds of care and support. To prevent a breakdown in care, we can focus services and resources that can help lighten the load on

families. Promoting responsive relationships, bolstering protective factors, and connecting families with supportive resources sooner is essential to preventing maltreatment and maltreatment related fatalities.

Neglect can be difficult to understand and impact as it is influenced by factors at all levels of the social ecology. Taking an approach rooted in community care and connection can help build collective responsibility for children and promote safety and well-being for families. The CFPRP has a unique role in supporting prevention and the work described throughout this plan is reflective of the ways the program works to promote primary, secondary, and tertiary efforts. In this section, we will discuss efforts to enhance child welfare professionals' ability to understand and respond to neglect and promote protective factors for families.

Training

Since launching a virtual version of the 2-day Oregon Assessing Patterns and Behaviors of Neglect training (see attachment, OAPBN Executive Summary 2023, for a description of the course) in 2021, eleven sessions have been offered, with five more scheduled before the end of 2023. In total 133 child welfare professionals have completed the course virtually. Additionally, the Confederated Tribes of Grand Ronde Children and Family Services Program professionals will be attending sessions alongside ODHS child welfare professionals in the second half of 2023. This creates an opportunity for shared learning and networking across the two workforces.

Training evaluations indicate enhanced understanding in each of the four areas of knowledge (personal experiences/bias/judgments and influence on decision-making, protective factors, consequences of neglect and contributing factors, and long-term impact of chronic neglect on child development) and comments continue to reflect a positive learning experience for participants. Areas for improvement have been related to virtual delivery challenges (breakout rooms and use of cameras) and a desire for in-person learning opportunities. Continued feedback will be gathered and incorporated as the training facilitation team works with the CW Equity, Training and Workforce Development program to update the curriculum and delivery plan for 2024.

In addition to classroom training, the CFPRP is continuously exploring avenues to enhance the knowledge and skills of child welfare professionals in responding to the needs of families and preventing future maltreatment. The CFPRP believes a knowledgeable workforce with the skills and resources to do their jobs is a workforce that can have significant positive impacts on the families they encounter. To that end, CFPRP has trained eight additional facilitators from CFPR, Child Safety and Reunification programs who can both support the training effort and champion the application of learning across the state.

Infant Safe Sleep

In 2022, of the 30 child fatalities reviewed by the CIRT, 14 were infants. All the cases involving infants had high risk sleep practices present at the time of the critical incident. These numbers are consistent over the last several years and demonstrate an ongoing need to educate and engage caregivers about reducing sleep related risks. This requires an ongoing community response from all family serving systems, including child welfare, which the CFPRP is proud to support. Below are some examples of current program efforts to support this important cause.

Education and Training

As a critical part of the child safety community, Child Welfare professionals have a role in supporting families to reduce risk of sleep related death through education and engaging families in conversations about their infant's sleep practices. To effectively have these conversations, Child Welfare professionals need to be educated on safe sleep practices and have the necessary resources available to them.
Self-study trainings tailored to a Child Welfare professional's role, opportunities to practice having safe sleep conversations with families alongside community partners, and access to tangible resources are all a part of the plan to prepare Child Welfare professionals to support families in safely caring for infants. Child Welfare is collaborating with other state agencies and community partners to ensure consistency in messaging received by families.

Self-study trainings are available for Social Service Specialists in screening, safety, permanency, certification, and adoption. Versions for certified resource families and other family serving professionals were released in 2021 and continue to be promoted. Ongoing updates to the self-study curriculums are made based on learning and input from case reviews, Child Welfare professionals in the local offices, as well as Tribal nations and other community partners. Input was actively sought through multiple methods from parents of infants and a variety of family serving systems throughout the development of the safe sleep self-studies.

Sleep practices promoted in the self-study are consistent with the American Academy of Pediatrics safe sleep guidelines. These self-paced educational materials take approximately one hour and by the end professionals should be able to:

- Identify actions that increase and decrease the risk factors of SUIDS and sleep-related infant deaths.
- Recognize safe and unsafe sleep environments.
- Communicate safe sleep practices to pregnant and parenting individuals with a strength based, trauma aware approach that honors their values and needs.

Each self-study includes a knowledge check and opportunity to provide feedback which has been overwhelmingly positive from all audiences.

SAFE SLEEP TOY DISPLAY

To emphasize the importance of safe sleep practices and assessing safe sleep environments for infants, all Child Welfare and Self-Sufficiency offices were offered safe sleep environment displays which consist of a toy doll, wearable blanket, a toy version of a safe sleep surface, and safe sleep educational materials (see photo to left). These were set up in high traffic areas within offices so Child Welfare professionals and members from the community have a visual reminder of what a safe sleep space should look like and can access safe sleep related educational materials.

Partnership and Engagement

Strong partnership and engagement between Child Welfare and other state agencies and community-based providers is critical to ensuring Child Welfare's role in the community response is proportionate and supportive. Below are some examples of partnership and community engagement efforts involving the CFPRP to promote infant safe sleep awareness.

Raise Up Oregon: A Statewide Early Learning System Plan (see attachment, Raise Up Oregon - A Statewide Early Learning System Plan) identified prevention of sleep related infant deaths as a priority for Oregon's early learning system. A workgroup tasked with developing recommendations for a statewide coordinated effort was formed in 2020. Participants from a wide range of family serving systems, including culturally specific organizations and CFPRP members, met to develop the recommendations which were presented to the Raise Up Oregon Agency Implementation Coordinating Team. The workgroup recommended the development of a statewide coordinated effort to improve infant safe sleep practices, decrease sleep-related infant deaths, and reduce relative disparities in sleep-related deaths between White and Black and American Indian/Alaska Native infants (See Safe Sleep Workgroup Report and Recommendations). Upon completing the recommendations report, the workgroup elected to continue meeting on a quarterly basis and further explore ways to reduce sleep related infant death in Oregon. This group is known as Oregon's Safe Sleep Coalition. As highlighted in the recommendations, sleep related infant deaths for African American/Black and Native American/Alaska Native infants are two to three times greater than white infants. These disproportionate rates demand a different approach and the need for culturally specific efforts are at the forefront of the Safe Sleep Coalition's efforts as well as CFPRP's strategies.

During National SIDS Awareness Month 2022 the CFPRP, in coordination with the ODHS communication team, underwent an effort to educate and engage parents and providers via social media using the toolkit provided by the National Institute of Health (NIH).

To facilitate feedback from providers and parents, the CFPRP is coordinating a safe sleep pilot within the Nurture Oregon, Plan of Care Pilot. In this pilot, safe sleep conversations begin as part of prenatal care with a trusted professional and continue while the participant remains within the program. As part of the Plan of Care, safe sleep will also be addressed by the pregnant or parenting individual and their care team. Nurture Oregon professionals were provided the Safe Sleep for Oregon's Infants self-study to develop or enhance their knowledge of safe sleep practices. In addition to the education, each parent receiving services through Nurture Oregon is offered a safe sleep kit, including a portable crib, wearable blanket, and some educational materials.

Members from CFPRP as well as ORCAH and Child Safety Program are participants in the National Partnership for Child Safety Affinity Group: Safely to Their First Birthday. The focus of this group is upstream prevention, compassionate, equitable screening, safety threat identification, and CPS assessment disposition after sudden unexpected infant deaths (SUID)**.**

CFPRP members continue to meet with local child welfare offices and other family serving systems as requested to discuss efforts to reduce sleep related risk and promote harm reduction messaging consistent with AAP guidelines. An example of this partnership is seen in the ongoing work with the Willamette Health Council's (WHC) Prevention, Education, and Outreach group who has made promoting safer infant sleep their focus area for 2023. The WHC requested a presentation from ODHS on SUID data and ODHS efforts to ensure consistent and effective messaging for families. This presentation was completed by members from the CFPRP and local office leadership in Marion County. Plans are underway to provide a similar presentation to other family serving systems who interface with WHC to expand the reach of this messaging.

Concrete Support

Local Child Welfare offices continue to express a need for emergent, immediate safe sleep environment resources and the CFPRP has provided portable cribs to local Child Welfare offices. In 2022, over 400 sleep

surfaces and wearable blankets, commonly known as sleep sacks, were sent to ODHS offices across the state for distribution to families. These can be shared with other ODHS programs and Tribal nations as well.

Supporting Infants Exposed to Prenatal Substance Use and Their Families

In 2022, 30 children met the criteria for a CIRT review and of those 30 children, 14 were infants. Seven of the 14 infants were substance exposed during the prenatal period. Furthermore, 6 of those 14 infants were known to child welfare through an open CPS assessment at the time of the critical incident, a prior closed at screening and/or a prior CPS assessment. With this data in mind, Child Welfare's continued implementation of the Comprehensive Addiction Recovery Act (CARA) is under the umbrella of the CFPRP and has been incorporated into the comprehensive plan to prevent child maltreatment fatalities. Two CARA coordinator positions were hired in April of 2021 to continue efforts to develop, implement and monitor Plans of Care, and further advance efforts related to infant safe sleep in cases requiring a Plan of Care (see attachment, CAPTA Coordinator Activities Summary, for more information related to their job duties). The CARA coordinators will continue to collaborate with OHA in efforts to move all aspects of implementation forward.

To advance statewide implementation of the Comprehensive Addiction and Recovery Act, a contract established by the Oregon Health Authority (OHA) with Comagine Health consulting firm was expanded using funds from OHA Public Health, OHA Behavioral Health, and CAPTA. Comagine Health will be utilized to support the cross-sector work for implementing a family centered, equitable system of care for pregnant people with substance use disorder, and infants with prenatal substance exposure and their families.

Child Welfare is hoping to leverage opportunities to mitigate barriers facing disproportionately affected populations in Oregon who may need help gaining access to services or paying for services. Offering support earlier aligns with Child Welfare's Vision for Transformation in that it honors the self determination of families, by allowing people to identify and access what they need without being mandated to participate in interventions that undermine their autonomy. When more opportunities exist for Child Welfare to participate in self-directed development and assistance, more opportunities will exist to engage community without furthering trauma and fear. The following data gathered from critical incident reviews also highlights the need to remove system barriers that prevent families from accessing primary prevention supports in their community (see attachment, CARA logic model related to efforts pertaining to CARA implementation).

Child Welfare Policy and Practice

Within Child Welfare, continued education, support, training, and mutual learning through feedback has occurred with CPS and permanency consultants and Child Welfare professionals in the local offices (screeners, caseworkers, Coaching and Training Specialists, Addiction and Recovery Teams, supervisors, and management). The following are examples of specific workforce support and development efforts pertaining to CARA and Plans of Care:

- CARA Coordinators developed and delivered trainings to Child Welfare professionals across the state to reinforce Child Welfare's responsibilities with the development of Plans of Care. In addition, local Child Welfare offices were allotted funding to support the concrete needs of child welfare involved families with a Plan of Care in place. The process to utilize the funding was also shared during these trainings.
- To offer ongoing support a CARA specific Microsoft Teams channel was created for Child Welfare professionals statewide to give real time access to CARA specific information and ask questions as they arise.
- Child Welfare is developing staffing guidelines for cases involving infants and substance use that emphasizes developing Plans of Care and referrals to community-based services and recovery

supports. Since substance use disorder is not the only complicating factor associated with infant fatalities, the staffing guidelines will highlight other factors including safe sleep and responsive relationships. Work is underway to enhance Child Welfare procedure and practice when a report is closed at screening on an open CPS assessment to ensure timely communication occurs between ORCAH and CPS caseworkers and supervisors. Additional procedure is being developed for CPS assessments where multiple reports are received in a short period of time involving infants aged 0-12 months, whether they are assigned or closed at screening. The procedure will require direct contact between an ORCAH supervisor and a CPS supervisor to communicate information contained in the report(s) and ensure appropriate screening and CPS assessment decisions are made.

- In consultation with the Child Safety Program and the Child Fatality Review and Prevention Program, the Oregon Child Abuse Hotline (ORCAH) is taking steps to support early identification of assigned reports with infants in the home. Beginning 3/7/2023, ORCAH flags reports by adding "INFANT" to the subject line for local office notification. ODHS Child Welfare has implemented several strategies to account for the increased vulnerability of infants on CPS assessments and open permanency cases, including assessing the safe sleep environment, ensuring the development of Plans of Care for infants with prenatal substance exposure, and encouraging the utilization of infant safety staffings. These strategies are intended to support engagement with families around topics specifically related to infant safety and wellbeing. Adding the infant flag to the assignment email will help alert workers and supervisors to consider these strategies when engaging with a family who has an infant.
- Child welfare professionals have received additional practice guidance promoting the development of prenatal Plans of Care for cases involving pregnant individuals using substances including Expectant and Parenting Youth in foster care and pregnant people associated with cases open for ongoing services or CPS assessment.
- Several family serving systems in Oregon conduct strengths and needs assessments and develop plans that incorporate content that is also included in a Plan of Care. CARA coordinators are guiding Child Welfare professionals developing Plans of Care to collaborate with other family serving professionals like family coaches and nurse home visitors to identify the underlying strengths and challenges families may be experiencing. The CFPRP and Child Safety Program have partnered with the Health and Wellness Services Program to bring Resource Nurses into the CPS assessment phase when certain criteria apply, one of the criteria being an infant identified as a participant on the CPS assessment. The Resource Nurses are prepared to help caseworkers develop Plans of Care on cases where the infant was exposed to substances during the prenatal period. In addition to support with the development of Plans of Care, the Resource Nurses will assist with a variety of tasks including but not limited to safe sleep and tummy time education, developmental assessments, and identifying potential referrals for the caregivers.

Additional policy and practice changes are anticipated to result from lessons learned through the implementation of the 'plan of care pilot' referenced in the next section.

Plans of Care

Child Welfare has partnered with the Oregon Health Authority to implement a 'Plan of Care pilot' in five Oregon counties as part of the Nurture Oregon demonstration project. Nurture Oregon is a rural integrated care model providing pregnant people who use substances with peer recovery support services, prenatal and postpartum care, substance use and mental health treatment, and service coordination. Care is delivered in a culturally sensitive, non-judgmental, strengths based and trauma-informed manner. The 'Plan of Care pilot' will gather data on what works and what does not work for pregnant and parenting people, as well as the

different members of the care team, including Child Welfare professionals. Identification of Plan of Care quality practices will inform statewide education, support for notification by healthcare providers, and all aspects of plan development and monitoring. With the additional data gathered from the pilot, additional Child Welfare policy and practice changes are expected.

For additional information related to the implementation of CARA, see the 2023 APSR CAPTA update section.

Other Prevention Efforts

Child Maltreatment Prevention Collaborative

CFPRP initiated a collaborative partnership with OHA, Public Health, to address primary, secondary, and tertiary child maltreatment prevention. As a result, CFPRP representing Child Welfare and OHA, Public Health, finalized a memorandum of understanding supporting this collaboration. The two agencies have a significant amount of cross over in work efforts, individuals served, and the values driving how the work is done (see attachment, Child Maltreatment Prevention Collaboration Visual).

Therefore, the purpose of this agreement is to:

- Document existing activities and areas of collaboration and coordination between CP&HP and Child Welfare.
- Describe a structure of communication and collaboration that will support the identification of new activities and initiatives that promote our shared intent.
- Increase coordination and collaboration between these entities to enhance family support and prevent child maltreatment.
- Describe methods and forums for regular and consistent communication, collaboration, and information exchange.

The implementation of this agreement shall be guided by the following objectives:

- Programmatic, Policy, and Relationship Building
    - To prevent duplication and fragmentation of effort and services.
    - To promote long-term planning.
    - To collaborate on policy and systems initiatives for and with the shared population.
    - To promote equitable, culturally, and linguistically appropriate, family centered, and trauma informed systems and services that are responsive to community needs.
    - To support collective approaches to responding to statutory requirements, such as CARA/CAPTA Plans of Care, State Child Death Review and Prevention Team and State Technical Assistance Team.
    - To collaborate on outreach and increase public awareness of services and supports for safe, stable, and nurturing families and to prevent child maltreatment.
- Assessment, evaluation, surveillance, and data sharing
    - To establish a systematic process for the timely sharing of programmatic and surveillance data.
    - To enhance collaboration on statewide needs assessment, evaluation, and surveillance to support the health and safety of the shared populations we serve.
- Resource Sharing
    - To explore and support opportunities to share and/or align resources (e.g., funds, systems, staff time) across the agencies to support joint initiatives.

Prevention Kits

The CFPRP purchased prevention kits from Oregon Health Sciences University, Tom Sargent Safety Center to prevent child fatalities and serious injuries by improving home environment safety. These kits were shipped to local Child Welfare and Self Sufficiency offices to provide families with items that improve household safety by reducing risk. Examples of items include window locks, firearm locks, and medication storage items. These kits arrived in late 2022 and many items have already been distributed to families across the state.

Community Needs Assessment – Social Determinants of Health

Child Welfare recognizes the need to ensure pregnant individuals and families can access supports and services further upstream from CPS. To support this effort, the CFPRP is reviewing and gathering data from statewide plans developed by other family serving systems and Community Health Assessments developed by CCO's and public health agencies in each of Oregon's 36 counties. Child welfare hopes to gain a better understanding of the socioeconomic conditions, health disparities and the array of existing services available to children and families in local communities.

Enhanced Early Learning Partnership

Collaboration with the Early Learning council (ELC) and Oregon Department of Education (ODE) to support the development and implementation of strategies that increase access to culturally responsive, targeted supports; promote wellbeing; and prevent child welfare involvement. Initial conversations with the ELC and ODE have focused on Early Intervention referrals made by Child Welfare on behalf of children aged 0-3. The reality is many children in Oregon who are identified with developmental delays at screening never receive services due to limited funding and only 34% of infants and toddlers who are identified and enrolled in Early Intervention receive the recommended level of services[1]. Child Welfare and ELC have already identified opportunities to enhance communication and engagement with families navigating the Early Intervention referral and evaluation process. Child Welfare is eager to partner with the ELC to support the strategies identified in Raise Up Oregon: A Statewide Early Learning System Plan (see attachment, Raise Up Oregon - A Statewide Early Learning System Plan) that align with the Comprehensive Addiction and Recovery Act.

Prevention Mindset Institute (PMI)

PMI was initiated by the FRIENDS National Center for CBCAP to discover strategies showing promise for shifting mindsets toward prevention. The PMI is a group of national partners, parents, and selected state teams committed to child welfare systems transformation. The CFPRP is a member of Oregon's PMI state team which was selected to participate in the second convening of the PMI: Embracing Prevention Cross Systems. Oregon's PMI state team is led by the ODHS Self Sufficiency Program and CBCAP state lead agency. Other state team members include representatives from ODHS Child Safety and Family Preservation Programs, Prevent Child Abuse Oregon, Morrison Child and Family Services, and the Oregon Governor's Sexual Assault Task Force.

Father and Noncustodial Caregiver Engagement

CFPRP is conducting system mapping in Fall 2023 to better understand barriers to engaging noncustodial caregivers in child welfare practice, with emphasis on fathers. Fathers have a societal bias as being secondary caregivers which is reflected in child welfare practice. A need for enhanced father and noncustodial caregiver engagement emerged as a trend in child fatality cases. Father engagement and participation in case planning

often results in improved child welfare outcomes. CFPRP aims to collaborate with other state agencies and community partners to increase workforce awareness surrounding this issue and to provide increased training supports to address bias towards fathers through the system mapping process.

Building Partnerships and Learning from Tribal Nations

The CFPRP is committed to building a strong partnership with Oregon Tribal Nations to collaborate on child maltreatment and fatality prevention opportunities through listening and learning. CFPRP efforts to build this relationship during the past year include:

- CFPRP continues to seek the expert insight of Tribal Affairs in the Critical Incident Review Process. Our commitment to Oregon Tribal Nations having voice in the work of CFPRP will remain central to our efforts. With humility, we look forward to continuing to develop relationships and doing better each year.
- Ongoing collaboration with the Confederated Tribes of Grand Ronde Children and Family Services to develop a plan for neglect training delivery. Confederated Tribes of Grand Ronde Children and Family Services professionals will join ODHS Child Welfare professionals in the virtual learning environment over the course of 2023.
- Developed and provided Suicide Prevention training for Oregon Child Abuse Hotline staff containing information specific to enhanced impact factors for suicide, including increased impacts for Tribal/ Indigenous Youth.
- Collaborated with the Confederated Tribes of Grand Ronde to provide sleep related death data, research, and training content for SIDS Awareness Month activities.
- CFPRP members participated in and completed the DOJ-led ORICWA training to enhance understanding of ORICWA in the Court System.
- Developed new internal data dashboard to improve understanding of infant safety and well-being with ability to filter by Race/Ethnicity and ICWA status. This data will provide new opportunities to share data, partner with Oregon Tribes and community at all levels of prevention.
- Provided information on *Building Psychological Safety to Advance a Safety Culture* at the Tribal Affairs Unit Quarterly meeting.
- Provided information on Critical Incidents, Comprehensive Addiction & Recovery Act plans of care and the CFPRP's current child maltreatment prevention strategies at ICWA Advisory.
- Provided information on CAPTA supplemental funding available through the American Rescue Plan Act at the ODHS Directors and Oregon Tribes Quarterly Convening.

Collaboration

Collaboration is part of the Child Fatality Prevention and Review Program (CFPRP) mission and integral to ensuring community voice in all work. Some of the collaborative efforts are detailed below and demonstrate how the work is aligned with the Vision for Transformation, including supporting families and promoting prevention, enhancing our staff and infrastructure, and enhancing the structure of our system by using data with continuous quality improvement. For more information on how the work of the CFPRP aligns with the Vision (see attachment, CFPRP Vision for Transformation).

- Depending on the circumstances, CFPRP includes the Office of Tribal Affairs within the ODHS Director's office, law enforcement agencies, probation and parole officers, Self Sufficiency Programs, Oregon Health Authority, medical professionals, Oregon Youth Authority, the Oregon Tribal Nations or other federally recognized Tribal Nations, service providers, subject matter experts, or others with specific information related to the family or the larger family serving system as members of a Critical Incident Review Team (CIRT).
- CFPRP seeks the expert insight of the Office of Tribal Affairs in the Critical Incident Review Process. CW's commitment to Oregon Tribal Nations and other federally recognized Tribes having voice in the work of CFPRP remains central to the work. The CFPRP ensures the Office of Tribal Affairs is involved in the Critical Incident Review Process at the earliest possible juncture when the fatality of a child with Native ancestry meets review criteria.
- CFPRP received expert consultation and guidance from ODHS Tribal Affairs about reducing traumatic impact when a child dies and ensuring Tribal Nation engagement and voice. The guidance is incorporated into the Fatality Protocol revisions and the plan remains for future partnership to draft procedures on the topic.
- Ongoing collaboration with the Confederated Tribes of Grand Ronde Children and Family Services to develop a plan for neglect training delivery. Confederated Tribes of Grand Ronde Children and Family Services professionals will join ODHS Child Welfare professionals in the virtual learning environment over the course of 2023.
- CFPRP engaged in and continued to develop communication and connection with multiple community partners to open and maintain lines of communication and be responsive regarding their needs and concerns. This included:
    - Actively participating in local and regional statewide suicide prevention coalitions throughout Oregon.
    - Sharing activities, initiatives, and strategies for suicide prevention and intervention.
    - Attending the Oregon Suicide Prevention Conference in Ashland, Oregon in October 2022 to collaborate and partner with numerous providers, advocates, and community partners invested in preventing suicide throughout Oregon.
- CFPRP was represented through membership in the Oregon Alliance to Prevent Suicide and included participation in sub-workgroups related to equity in the continued support of diverse and underrepresented communities to access suicide prevention and intervention supports.
- CFPRP supported workforce and community suicide prevention and postvention programs through ongoing collaboration with the Oregon Health Authority public and behavioral health Suicide Prevention Coordinators as well as collaboration with ODHS Trauma Aware.
- CFPRP continues collaboration with ODHS Shared Services, Oregon Health Authority, and Oregon Pediatric Society in the development and implementation of the Oregon Child Welfare YouthSAVE training module with full implementation slated for Fall 2023.
- CFPRP continues collaboration with local vendor Scio Mercantile and Hardware for the purchase and distribution of medication and small handgun lockboxes to Child Welfare local offices for disbursement to families in need of lethal means access safety measures as part of suicide prevention and intervention.

- CFPRP continues collaboration with the ODHS Child Welfare Equity, Training, and Workforce Development Program to provide enhanced Question, Persuade, Refer for Resource Parent training and additional information and guidance to support resource parents in caring for youth in their care.
- CFPRP continues collaboration with Oregon Health Authority and Oregon Department of Education as part of the State Agency Partnership in order to share and develop best practice strategies for suicide prevention and intervention for Oregon's young people.
- In response to increasing youth Fentanyl related overdoses, CFPRP is collaborating with other state agencies in furthering education and treatment options related to youth substance use. CFPRP is currently conducting an evaluation of ODHS' current efforts to address child substance use by consulting with experts to determine whether additional intervention strategies are indicated.
- CFPRP, as part of the CIRT process, continues to lead the creation and oversee the implementation of system and practice recommendations developed in response to child fatalities through collaboration with numerous and varied system partners.
- Through the National Partnership for Child Safety (NPCS), CFPRP collaborates with 35 state, county and Tribal child and family serving agencies and technical assistance advisors in support of safety science implementation.
- CFPRP continues collaboration with the interdisciplinary State Child Death Review and Prevention Team and all 36 multidisciplinary county child death review teams to enhance Oregon's death review system, death review data collection, and resulting prevention efforts. Some of the collaborative efforts include:
    - Ongoing implementation of the Child Death Review Resource and System Improvement Plan which was informed by the county child death review team needs assessment. All 36 county multidisciplinary teams had voice in the assessment and the plan.
    - Outreach to each county death review team when a prevention recommendation is entered into the National Fatality Review - Case Reporting System. The outreach includes acknowledgement of the effort, an offer of support, and follow through with supporting the prevention work in the manner requested by the county.
    - Establishing a workgroup of external partners whose role is impacted by death investigation to address equity in child death investigation across Oregon counties.
    - Initiated and participated in listening session with county child death review teams related to efforts and need supports to promote infant sleep related death prevention.
- CFPRP initiates and engages in extensive collaboration statewide with child and family serving professionals and organizations and those they serve in efforts to support infant safe sleep practices. This includes:
    - Partnership with health care providers to strategize community messaging efforts to promote safer infant sleep environments.
    - Continued promotion of self-study document on infant safe sleep education for Oregon Family Serving Processionals which includes input from parents of infants and a variety of family serving professionals and organizations. This was developed in response to a community voiced desire to improve consistency of infant safe sleep education across family serving systems (see attachment, Safe Sleep for Oregon's Infants).

    - Support of Safe Sleep Awareness month activities for The Confederated Tribes of Grande Ronde by providing data, talking points, and resources regarding safe infant sleep practices.
- Continued engagement with child formerly in foster care for consultation on the work of the CFPRP.
- CFPRP continues collaboration with individuals, professionals, and organizations impacted by or essential to implementing the Comprehensive Addiction and Recovery Act and specifically Plans of Care with the objectives of increasing engagement, maintaining infants safely with their families, eliminating or reducing CW involvement, mitigating the impact of substance use, and supporting parents diagnosed with substance use disorder with their recovery. CFPRP continues to engage the following groups throughout the statewide implementation process:
    - Oregon Health Authority (OHA) Public Health Division
    - Maternal and Child Health
    - Health Promotion and Chronic Disease Prevention
    - Injury and Violence Prevention
    - OHA Health Systems Division
    - Addiction Services
    - Behavioral Health Policy and Planning
    - OHA Health Policy and Analytics Division
    - Transformation Center
    - Patient-Centered Primary Care Home Program
    - Quality and Health Outcomes Committee (QHOC)
    - Coordinated Care Organizations
    - Every Step Clinics
    - Project Nurture
    - Nurture Oregon
    - Substance Use Disorder Treatment providers and programs
    - Health Care Professionals (doctors, nurses, midwives)
    - Community Health Workers (traditional health workers, peer support specialists, doulas)
    - Oregon MothersCare Program
    - Family Connects Oregon
    - Babies First!
    - Healthy Families Oregon
    - Nurse Family Partnership
    - Healthy Birth Initiative
    - Help Me Grow
    - Oregon Association of Relief Nurseries
    - Northwest Portland Area Indian Health Board
    - Office of Tribal Affairs
    - Raise Up Oregon
    - Connect Oregon (Unite Us)
    - Prevent Child Abuse Oregon
    - Oregon Sexual Assault Taskforce
    - Morrison Child and Family Services

  - Families Actively Improving Relationships (FAIR) Program
  - Comagine Health
  - WA State Department of Children Youth and Families
- Ongoing collaboration with health care providers across the state to discuss caring for infants with prenatal substance exposure and supporting their families by way of Plans of Care.
- The CFPRP has active engagement and collaboration with numerous ODHS and OHA programs. At ODHS this includes the following: Tribal Affairs, Child Welfare Programs, Office of Program Integrity, Office of Contracts and Procurement, Office of Reporting, Research, Analytics, and Implementation, Office of Equity and Multicultural Services, Self-Sufficiency Program, Communications, ODHS Director's Office, Trauma Aware ODHS, Office of Training, Investigations and Safety, and Developmental Disabilities Services. At Oregon Health Authority this includes the following: Behavioral Health, Zero Suicide, Youth Suicide Prevention Intervention & Postvention Program, Oregon WIC, Injury and Violence Prevention Program, Public Health, Maternal and Child Health, Youth and Runaway Program, Addiction Services Program, Youth and Young Adult Substance Use Collaborative, and the Center for Prevention and Health Promotion.
- CFPRP has active engagement and collaboration with external partners to develop data-informed and innovative strategies for prevention. This includes the following: Community Health Nurses, Oregon Tribal Nations, Oregon Judicial Department, Oregon Department of Justice, local law enforcement agencies, Oregon Association of Chiefs of Police, District Attorneys, Oregon State Child Death Review and Prevention Team, 36 county child death review teams, Oregon Child Abuse Solutions, Oregon Parenting Education Collaborative parent coordinators and trainers, health care professionals, Relief Nurseries, Birthing Hospitals, Jackson Care Connect, Home Visiting Programs, Child and Family Futures, Oregon Perinatal Collaborative, Overdose Response Strategy, Doulas, Traditional Health Workers, Peer Support Specialists, Certified Recovery Mentors, Raise Up Oregon, Child Advocacy Centers, Designated Medical Professionals, Substance Use Disorder treatment professionals, YouthSAVE, YouthLine/Lines for Life, County Suicide Prevention Coalitions, Oregon Liquor and Cannabis Commission, Oregon Pediatric Society, Oregon Alliance to Prevent Suicide, Oregon Social Learning Center, State Medical Examiner's Office, Connect Postvention, Portland State University, Trauma Aware Oregon, Hospital Social Workers, National Center for Substance Abuse in Child Welfare, Early Intervention, Oregon Health Sciences University Safety Center, QPR Institute, Affinità Consulting, NPCS Innovation and Implementation Learning Community, NPCS Peer Leaders, NPCS Data Sharing Workgroup, NPCS Affinity Group: Safely to Their First Birthday, and the University of Kentucky Center for Innovation in Population Health.
- Ongoing collaboration with Oregon's Early Learning Division and Department of Education to improve Early Intervention referral and engagement as required by CAPTA.
- Continued communication with various Coordinated Care Organizations to develop and streamline local processes for Child Welfare professionals to connect families to community-based resources.

Acknowledgement

To Child Fatality Prevention & Review Team members:

Thank you to this amazing team of caring, passionate, and professional human beings who took a chance to be part of this new program and who are now at the culmination of sharing details about their work in our Comprehensive Statewide Plan to Prevent Child Maltreatment Fatalities. Each one of you show up every day, and through your dedication to this difficult work, you honor Oregon's most vulnerable and precious beings; the children whose lives have been lost too early, and their families and communities who grieve the immense loss of a child. Your work is important; your passion, commitment, and innovation have the power to change and improve an imperfect system that doesn't always work in the way it was intended. The work of this team strives to provide an objective and thorough review of our most tragic outcomes in order to better understand what systems and communities must have in place for children and their families to live and thrive in all Oregon communities. I value your commitment to the work of ensuring all children and their families get what they need when they interact with our systems and within their own communities. It makes me proud and humbled to work alongside each of you. Thank you for all that you give of yourselves and all that you have taught me.

And one final thank you goes out to our amazing technical advisors at the National Partnership for Child Safety – University of Kentucky Center for Innovation in Population Health. Your inclusivity and never-ending support to Oregon and this team has truly sowed the seeds for each of us to grow individually but also grow as a budding new Child Welfare program. Thank you for taking us under your wings and teaching us how to fly. We appreciate you all so very much.

Child Fatality Prevention and Review Program Manager

Oregon Safe Systems Mapping - Spring 2021

Overview

In the spring of 2021 the Child Fatality Prevention and Review Program (CFPRP), in partnership with the Child Safety Program, facilitated the first safe systems mapping sessions for Oregon Child Welfare. This process was facilitated with the much-appreciated support of Dr. Tiffany Lindsey from the University of Kentucky Center for Innovation in Population Health.

The purpose of safe systems mapping is to discuss in a group of experienced professionals their perceptions of what factors influence identified improvement opportunities. Improvement opportunities are defined as actions or inactions in cases reviewed by the CIRT/Safe Systems Coordinator that are either relevant to the outcome or an important industry standard. In safe systems mapping, these improvement opportunities are evaluated at all levels of the system – from the local team level to the legislative/government level. Every participant has an equal voice in the process and all perspectives are valuable to understanding more clearly how the system is operating and what gets in the way of successful work with families.

Improvement Opportunities

In this inaugural round of safe systems mapping, the team explored improvement opportunities in cases involving parental substance use disorder (SUD). These improvement opportunities were representative themes across nine cases reviewed through the CIRT and Safe Systems Analysis processes between August 2019 and March 2021. In addition, of 48 total cases reviewed in the time period, 20 cases had actionable scores under Caregiver Substance Use in the Family Domain of the Safe Systems Improvement Tool[1], meaning substance use required some level of intervention, regardless of whether or not there was an associated improvement opportunity. The four improvement opportunities presented to the mapping team for discussion were as follows:

1. Assessments were incident-focused and did not account for the increase in or persistence of substance use over time and the resulting impacts to child safety.

2. The extent and impact of parental substance use was not adequately addressed in relationship to safe infant care.

3. The assessment of and response to parental substance use was hindered by the underutilization of Addiction Recovery Team (ART)/Family Involvement Team (FIT) contracted services and limited access to engagement resources (i.e., ART/FIT Outreach, Parent Mentors).

[1] https://praedfoundation.org/wp-content/uploads/2021/05/2021.01.15_REFERENCE-GUIDE_-SSIT_Final.pdf

4. The use of comparison in assessing aspects of parental substance use negatively impacted child safety decisions. This comparison ultimately conflated “least unsafe” with “safe” when evaluating caregivers or the risk to child safety based on types of substances being used.

Mapping Process and Results

The safe systems mapping team met a total of five times throughout April and May 2021. The first two meetings were focused on mapping the improvement opportunities and all of the information was captured on a visual map. The next three meetings focused on brainstorming strategies for improvement. One theme that was clear throughout the mapping process was the need to equip child welfare professionals with information and professional support to engage and make sound safety decisions with families. Child welfare caseworkers are tasked with the responsibility of being knowledgeable about many topics (SUD, mental health, domestic violence, child development, etc.) often all in one day and sometimes all in one interaction. Oregon has long supported a teaming model in SUD cases, but shortcomings exist due to insufficient funding and position allocation. Caseworkers need support and perspective from individuals with lived experience as well as professional experience in the field of SUD assessment, treatment, and recovery. Addiction Recovery Teams with diverse knowledge and expertise support caseworker growth and professionalism and provide supportive and equitable service to families.

Recommendations

After thorough review of the map and the brainstorming session notes, recommendations for system improvement could be organized into four categories; ART/FIT and contracted services, practice/procedure, training/workforce development, and family/community supports. In each of these categories, a variety of strategies were discussed among mapping participants. The Safe Systems Coordinator then compiled all of the team’s good thinking into a table of recommendations for consideration.

The CFPRP and the Child Safety Program have identified eight recommendations we would like to elevate for executive leadership consideration:

1. Restructure and expand ART/FIT and corresponding contracted services

The team discussed in depth the limitations of the current structure and allocation of ART/FIT resources across the state and the negative impact to casework practice and service delivery for families experiencing SUD. A number of recommendations were identified to address internal staffing, contracts, as well as access to services.

ART/FIT ODHS Child Welfare Positions

- Centralization of ART Leads (coordination or management)
- Reclassification of ART Leads to SSS-2’s
- Position description for ART leads (consider professional development aspects, such as CADC)

- Develop a workload model to determine adequate staffing levels for ART/FIT Leads across the state

ART/FIT Contracted Services

- Right-size contracts with ART providers, increase access to outreach for up-front engagement with families
- Diversify pool of support/resources available (peer mentors, contracted nurses, outreach, navigators, CADCs)

Access to Services

- Clarify current contract requirements – remedy barriers to immediate access
- Increase front-end services to be accessed from initial contact
- Look for opportunities to pool resources - there is a benefit of having services co-housed (home visiting programs, outreach, navigators, peer mentors, etc.) with financial resources to meet concrete needs and the ability to be nimble in level of supports offered

2. Develop comprehensive SUD case practice guidelines

Throughout the conversations with the mapping team, it became clear the improvement opportunities were impacted by the limited guidance provided to caseworkers and supervisors when engaging with families experiencing SUD. There are detailed guidelines and toolkits available for cases involving sexual abuse and domestic violence, yet a similar resource does not exist for cases involving substance use.

3. Develop a process for referring to community-based supports or services on reports that are closed at screening

Over the course of the mapping exercise, prevention efforts were discussed time and again, including mechanisms to provide support to families before formal child welfare involvement. The team identified a need to develop specific criteria for referrals to community based supports or services on reports not assigned but documented as a Closed at Screening report, which has long been a requirement of CAPTA (*Ensuring children's safety and making referrals to other services*: A state must have procedures to refer children not at risk of imminent harm to a community organization or voluntary preventive service). This level of preventative work is phase two of Oregon's FFPSA plan, but it is highlighted as a pressing need by the mapping team. Formation of a workgroup to clarify CAPTA requirements and develop a process for referral to community-based supports and services when a report is closed at screening, is recommended.

4. Develop statewide staffing guidance for infant cases

In the majority of cases reviewed, the children most gravely impacted were infants. Development of staffing guidance for cases involving infants and substance use, with emphasis

on plans of care and incorporating community-based supports early and often is recommended. This guidance could be embedded in the overall SUD guidelines or called out more specifically in guidelines for any case involving a child under the age of one year. SUD is not the only complicating factor in infant fatalities and any staffing guidelines should also consider safe sleep and responsive relationships.

5. Enhance knowledge and skill through creative education for caseworkers and supervisors

While training has a place in system improvement efforts, it alone is not the most effective system improvement strategy. In an environment where training is widely available but bandwidth for retention is limited and application even more so, it is important to identify methods for targeted learning that support direct application and pull from knowledge and experience staff already possess. It must also be applicable to child welfare professionals with varying experience levels and specific to current trends in the subject area. Spaced education is a method that uses spacing, repetition and testing to increase knowledge about a specific topic. Administered on-line, spaced education is a novel approach in the current work environment. Oregon can receive support in development and administration of spaced education from the University of Kentucky through our participation in the National Partnership for Child Safety.

6. Actively promote partnership with local prevention organizations

Communities often have an array of service options for families that are rooted in prevention, supporting responsive relationships, and promoting protective factors. At times, child welfare professionals do not effectively refer or partner with prevention organizations, who may have existing relationships with families or would be an effective provider. The team recognizes an opportunity to intentionally connect with local prevention agencies, in particular Nurse-Family Partnership and other early home visiting programs, to better understand how families can access programs and how best to partner on behalf of families to support safety and well-being.

7. Identify and support culturally appropriate paid respite, child-care programs, and safety service providers

Access to safe and reliable respite and child-care remains a challenge in many communities. For families that become involved with child welfare, comprehensive assessment, safety decision-making, and case planning can be negatively impacted when there is limited availability of safety service providers or other options for safe child-care. During the mapping discussions, the challenges related to safe and reliable respite and child-care surfaced a number of times. Parenting young children, in particular infants, is a significant lift for anyone and support to manage the exhaustion is important, especially for parents struggling with SUD. The team agreed access to respite for families struggling with SUD and parenting young children could be life-saving. The team considered both scenarios where families require formal child welfare

intervention as well as scenarios where children are safe, but families may still need support in their community. There are recommendations related to each scenario.

- Identify respite programs in local districts and secure funding streams to pay culturally appropriate respite/safety service providers during protective actions as well as initial and ongoing safety plans - CBCAP funding may be available to support paid respite in Oregon communities
- Partner with our ODHS Self-Sufficiency Program to identify funding for respite care and clarify requirements for high-quality subsidized child-care programs families could be connected with outside of child welfare intervention

8. Develop an application to provide information and guidance to child welfare professionals

Child welfare professionals are tasked with the responsibility of knowing a lot of information about a lot of different topics, which can take years to acquire, sometimes changes, and can be difficult to apply in the moment. That is why the development of a smart phone application, which would provide information on SUD as well as child development, mental health, domestic violence, and other subject matter at the touch of a screen, could be incredibly useful in ensuring child welfare professionals have the information they need to engage effectively with children and families. It is recommended research begin on the development of such and application for Oregon.

Conclusion

With any recommendation that is moved forward, it will be critical to keep close track of other efforts happening around the state to improve practice and/or promote prevention. Nurture Oregon, Family Treatment Court and Family Connect are all examples of innovative programs to follow and learn from as internal efforts are carried forward. It is also critical to build connections between existing department efforts to make the best use of resources available. Oregon's Family First Prevention Services plan and Comprehensive Addiction Recovery Act efforts are likely to highlight opportunities for connecting families back to the community in lieu of formal child welfare interventions. It is the hope of the mapping team that the influencing factors identified through the mapping process and the resulting recommendations provide a solid starting place for meaningful system improvement.

Oregon Safe System Mapping

Spring 2022

Overview

In the spring of 2022 the Child Safety Program, in partnership with the Child Fatality Prevention and Review Program (CFPRP), facilitated safe systems mapping sessions for Oregon Child Welfare. This process was facilitated with the much-appreciated support of Dr. Tiffany Lindsey from the University of Kentucky Center for Innovation in Population Health.

The purpose of safe systems mapping is to discuss the perceptions held by a group of experienced professionals regarding the factors they believe influence identified improvement opportunities. Improvement opportunities are defined as actions or inactions in cases reviewed by the CIRT/Safe Systems Coordinator that are either relevant to the outcome or an important industry standard. In safe systems mapping, these improvement opportunities are evaluated at all levels of the system – from the local team level to the legislative/government level. Every participant has an equal voice in the process and all perspectives are valuable to understanding more clearly how the system is operating and what gets in the way of successful work with families.

Improvement Opportunities

During this safe systems mapping process, the team explored improvement opportunities regarding the comprehensiveness of CPS assessments. The improvement opportunity identified was representative of the ten cases reviewed through the CIRT and Safe Systems Analysis processes from 2019 through 2021.

In a number of cases reviewed through the CIRT/Safe Systems Review processes, child safety was not well understood, and additional necessary assessment activities did not occur in CPS assessments open at the time of the critical incident.

In all of the cases reviewed, the children involved in critical incidents were participants in an active child protective service assessment. In most cases, a single contact with the family occurred and while the assessment frequently remained open for a significant amount of time prior to the critical incident, limited additional assessment activities occurred. While a number of barriers in assessing and understanding child safety beyond that of the caregiver's report or presentation were noted, in the majority of cases the CPS worker's primary focus appeared to be determining present danger at the time of initial contact thereby forgoing necessary actions required to fully assess child safety as the family and child's circumstances evolved over the course of the assessment. In several of the cases reviewed, it was determined that information essential to child safety was available through collateral contacts and evaluation of case history, which did not occur prior to the critical incident.

Oregon Safe System Mapping

Spring 2022

Additional barriers to ensuring child safety identified through case reviews were challenges in communication during CPS case transfers and difficulty with accurately determining child safety at the caseworker and supervisory level. As is common in many offices, three of the assessments reviewed were transferred between workers and a larger number were touched by multiple workers for various reasons. Due to turnover, extended absences, or work schedules, when cases were transferred between workers, a sense of urgency seemed to be lost and many times the expectations regarding follow-up actions needed to ensure child safety were unclear. Case reviews also indicated an inconsistent understanding of the Department's responsibility in assessing child safety when a family or Department plan is in place or after initial contact has been made. Additionally, case reviews revealed an inconsistent understanding regarding the level of information needed to come to a child safety decision.

The improvement opportunity presented to the mapping team for discussion was as follows:

Families need a child protective services system that seeks thorough understanding of child safety through diligent follow-up and information gathering, and clear communication and planning.

Mapping Process and Recommendations

The safe systems mapping team met twice during February and March 2022. The first meeting focused on mapping the improvement opportunity and all of the information was captured on a visual map. The second meeting focused on brainstorming strategies for improvement. The team recognized the interdependent nature of the numerous factors which impact the improvement opportunity. Staff turnover resulting in increased workloads and less experienced staff, additional training and support needed for CPS staff as well as the need for improved supervisory support and availability interact to create the current circumstance where barriers exist to conducting comprehensive assessments and thoroughly understanding child safety.

Recommendations

After thorough review of the map and brainstorming session notes, recommendations for system improvement could be organized into three categories: supervision, casework practice support and worker retention. With any recommendation that is moved forward, it will be critical to keep close track of other efforts happening around the state to improve practice and/ or promote prevention.

It is the hope of the mapping team that the influencing factors identified through the mapping process and the resulting recommendations provide a solid starting place for meaningful

system improvement. The Safe Systems Coordinator then compiled all of the team's good thinking into a table of recommendations.

The CFPRP and the Child Safety Program have identified seven recommendations we would like to elevate for executive leadership consideration:

1. Reduce supervisor burden in the hiring process

The team discussed in depth the barriers that prevent supervisors from engaging in regular and comprehensive supervision with CPS staff. A challenge which was consistently identified was the time-consuming process of hiring which falls on supervisors to manage. Given the ongoing turnover and the associated administrative requirements, the hiring process has greatly impacted the amount of time supervisors are available to support workers and ensure comprehensive assessment occur. Creating alternative hiring processes which remove the burden from supervisors would improve their ability to provide meaningful and timely supervision of CPS assessments. Some proposed process changes identified by the group include a Human Resource led hiring process and the creation of designated district or area specific hiring teams which manage the hiring process. These changes may also allow for changes in the hiring process and additional attention to the screening of applications to ensure they have realistic understanding of job duties.

2. Strengthen requirements for the frequency and content of supervision

Over the course of the mapping exercise, the mapping team clearly identified the critical role that regular and thorough supervision plays in the completion of comprehensive CPS assessment follow-up. While some guidance has been provided regarding the frequency of clinical supervision, additional direction and support are necessary. The team suggested the creation of mandatory supervision frequency and supervision topics to include discussions of worker safety, prioritization of cases, identifying and addressing bias, sufficiency of information/evidence as well as requiring additional staffing supports to manage CPS assessment transfers and assist with understanding and monitoring sufficiency of information.

The recently completed CPS Supervisor Toolkit can be an important support for CPS supervision. The CPS Supervisor Toolkit was developed to be a practical guide to provide additional recommendations and resources that have been used successfully to support the ongoing efforts being made across the state to meet the expectations to complete safety assessments timely while also making sound safety decisions. One important area of the CPS Toolkit is specific to the identified improvement opportunity and need to address a lack of urgency and clarity around expectations for assessments transferring between workers is the CPS Worker Transition Guide & Unattended Caseload Section 6 in the Toolkit. Safety Program has considered creating a protocol and transmittal to formalize a process that supports the

review, analysis, and timely response to these caseloads using the information contained in the Toolkit.

3. Expand the tiered Social Service Specialist classification

In the course of our time together the team identified the need to employ new strategies to address worker retention due to the negative consequences turnover has on workload and subsequently casework practice. Mapping team members identified limited casework promotional opportunities and recommended the creation of promotional openings within the Social Service Specialist classification as used by other states. For example, Washington State provides promotional opportunities to casework staff which include financial incentives based on length of service and education.

4. Provide clarification and training regarding critical case practice challenges

In the cases reviewed for the mapping exercise, CPS workers appeared to lack a clear framework for understanding the information needed to develop a comprehensive understanding of child safety and family functioning rather than solely determine if present danger existed. While training has a place in system improvement efforts, it alone is not the most effective system improvement strategy but in combination with additional supervisor availability, field support and improved worker retention, the team believed that providing additional information to staff regarding sufficiency of information and assessment beyond present danger would aid in the completion of more comprehensive CPS assessments.

Child Safety Program is contracting with Tiffany Carr who is in charge of workforce development for Nevada Child Welfare. Ms. Carr is trained by Action for Child Protection who implemented the Safety Model in Oregon. Ms. Carr is partnering with Oregon to provide technical assistance to support gathering and documenting sufficient information during a CPS assessment as well as share a rubric for consultation and coaching. The goal is to continue to support the workforce around gathering sufficient information to determine the presence or absence of present and impending danger safety threats and improve safety outcomes for children in Oregon. This information could be formatted in such a manner as to be allow for statewide dissemination so that staff may activate their professional knowledge for use in comprehensive assessment of allegations of maltreatment. Additionally, the team believes that further support and training for supervisors and case worker staff in understanding assessment beyond present danger would be beneficial and could be provided by Child Safety Consultants as needed.

5. Designate Lead Workers for CPS Units

As part of our mapping conversations, the group determined that increasing the hands-on support of staff during CPS assessment field contacts is critical for professional development and supports improvement in the skills and knowledge needed for conducing comprehensive assessments. As it was determined that supervisory support during field contacts is unrealistic in most situations, the team believes that this could be addressed through unit level Lead Workers. These lead work staff would have slightly reduced caseloads and would carry the expectation of teaming with newer workers or with any worker assigned a complex CPS case, would provide real time mentoring during assessments and ensure the completeness of CPS assessment. The team recognized that existing MAPS positions, while incredibly valuable, do not meet the need for ongoing support for CPS related field contacts, frequently have limited availability due to a wide range of job duties and may not always have expertise in CPS practice. Staff holding lead worker duties would also be able to relay information to Supervisors and supplement the supervisor's knowledge and understanding of staff strengths and needs. Lastly, Lead Work positions also provide promotional opportunities to staff which can improve worker retention.

6. Expand the Mobile CPS Unit

Throughout mapping team discussions, the group repeatedly identified how staffing shortages and high workloads negatively impact the ability of staff to complete comprehensive assessments. The Mobile CPS Unit, while initially created to support offices in the completion of overdue assessments, has become a meaningful support for critically understaffed CPS units. As the Department continues work to stabilize CPS staffing around the state, additional positions within the existing Mobile CPS Unit would provide needed support to local offices during staffing challenges or unexpected workloads which overwhelm existing local office resources. This additional support for CPS units would provide the space and time for the comprehensive assessment of child safety and family functioning and minimize the challenges that result from overwhelming workloads.

7. Develop and Require Consistent Post-Essential Elements Training and Support

Benefitting from the experience of mapping participants from around the state, when discussing onboarding new CPS staff and related training, the team determined a vast difference between districts regarding the training and support workers receive when returning from Essential Elements training. Developing and requiring a comprehensive training and support plan for new staff upon completion of Essential Elements training would provide for increased consistency in practice. This additional measure, currently under consideration with the Child Welfare Equity, Training and Workforce Development team, would support staff in

activating their learning and provide experience applying concepts to active assessments thereby improving overall comprehensiveness of CPS assessments.

Conclusion

With any recommendation that is moved forward, it will be critical to keep close track of other efforts happening around the state to improve practice and/or promote prevention. It is the hope of the mapping team that the influencing factors identified through the mapping process and the resulting recommendations provide a solid starting place for meaningful system improvement.

Safe Systems Improvement Tool:
National Partnership for Child Safety Version (SSIT-NPCS)

2022
REFERENCE
GUIDE

ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of the Safe Systems Improvement Tool (SSIT). This information integration tool is designed to support system improvement activities. The SSIT is an open domain tool. The copyright is held by the Praed Foundation to ensure that it remains free to use. Training and certification is expected for appropriate use.

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Table of Contents

1. INTRODUCTION

SAFE SYSTEMS IMPROVEMENT TOOL

The pursuit of learning is the characteristic that distinguishes high-quality service delivery systems. Organizations with a well-developed culture of excellence find ways to successfully identify improvement opportunities, implement strategies for change, evaluate change over time, and hardwire what they learn.

The following is a multi-purpose information integration tool designed to be the output of an analysis process. The purpose of this instrument is to support a culture of safety, improvement, and resilience. As such, completion of this instrument is accomplished in order to allow for effective communication at all levels of the system. Since its primary purpose is communication, this instrument is based on communication theory rather than the psychometric theories that have influenced most measurement development. There are six key principles of a communimetric measure that apply to understanding this instrument.

SIX KEY PRINCIPLES

1. Items are included because they are relevant and inform system change opportunities.
2. Each item uses a 4-level rating (0-3) system. Ratings translate into action levels designed to support quality improvement (QI) activities. For a description of these action levels please see below.
3. Ratings are made to identify an opportunity for improvement independent of a current intervention. If interventions are in place that are masking a need/opportunity, the underlying need/opportunity is described, not its status as a result of the intervention. For example, if a work-around has been created to overcome an equipment failure, the underlying equipment failure should be rated.
4. Item-level ratings are designed to promote objectivity and avoid bias. The potential for implicit and explicit biases should always be considered when rating an item.
5. Ratings use the influences' proximity to the incident as an organizing principle to support communication. If there was closeness in time or distance, and with relationship to the incident, a rating of "proximal" (i.e., 3) is appropriate.
6. It is about the "what and how," not the "who and why." Items are organized into domains to engage rich discussion on the complexity of factors affecting casework practice. Items are about *relationship and influence* and avoid the controversy of causal assumptions.

This is an effective assessment tool for use in critical incident review (e.g., child fatalities, child near fatalities) but may be used more broadly to understand systemic influences to other outcomes (e.g., youth in foster care being trafficked, children experiencing a long-length of stay in care, maltreatment recurrence). In short, the SSIT provides structure to the output of a review process. It organizes the reviewers' learnings, shares the "system's story" of a critical incident, and advocates for targeted system reform efforts to lessen the likelihood of the problem occurring again in casework. To administer the instrument found at the end of this manual, the reviewer should read the anchor descriptions for each item and then record the appropriate rating on the assessment form.

REFERENCE GUIDE STRUCTURE

This reference guide is divided into the following four parts:

Section One: origins, overarching purpose, and the general structure of how items are rated

Section Two: domains and items, item definitions, descriptive rating anchors, and guidance (i.e., "Questions to Consider") in assessing the items.

Section Three: scoresheet as a template for case reviews

Section Four: sharing the "system's story" of a critical incident and advocating for strategic quality improvement work to support safe, effective, and reliable care of children and families.

HISTORY AND BACKGROUND

The SSIT was first developed for use in Tennessee's Department of Children's Services' (TN DCS) critical incident reviews (i.e., Child Death and Near-Death reviews). During critical incident reviews, professionals assigned to work with the family, both past and present, are requested to participate in debriefing. These debriefings are voluntary, supportive, facilitated opportunities for professionals to process their casework, identify barriers and improvement opportunities, and highlight learning. SSIT provides both a guide in facilitating these debriefings (e.g., questions to consider) and an efficient means to capture the complex information provided as a result of debriefings. After debriefings, critical incident reviews are presented to a multi-disciplinary team who dissects the case and relevant findings from a systemic perspective. SSIT is used to facilitate these conversations and to capture rich discussion. SSIT is only completed once, at the closing of every case review. SSIT's scores are aggregated and analyzed on at least a quarterly basis to review findings and discuss trends. In a similar way to how a barometer measures pressures in the atmosphere, SSIT measures pressure existing within organizations and provides a frame for targeted quality improvement work.

Since 2015, the SSIT has been successfully used to support the analysis of deaths and near deaths, reports made to TN DCS' Confidential Safety Reporting System, and critical incident reviews that do not involve death or near death (e.g., staff injuries, incidents where custodial children absconded and were subsequently exploited).

In 2019, Casey Family Programs led a pioneering team of twelve child-welfare jurisdictions to form the National Partnership for Child Safety. Their aim to reduce maltreatment-related fatalities, enhance system safety through the lens of safety science, and advance the child welfare system into the 21st century—a place where technology, community-based family supports, and partnership with public health would effectively reduce the presence of social determinants to poor outcomes and promote holistic health. The SSIT-NPCS was designed with the input of all NPCS jurisdictions as a way to communicate the learnings from their respective critical incident reviews and provide a foundation for informed data-sharing. In 2021, the National Partnership for Child Safety had grown to 26 public child welfare jurisdictions and tribes.

WHAT IS THE SSIT?

IT IS AN IMPROVEMENT STRATEGY

When items are rated with a 2 or 3, they indicate a need for improvement. The SSIT helps a system identify and prioritize systems improvement opportunities. The structure of the SSIT allows a system to uncover those threats/opportunities that are most proximal to adverse events. Quality improvement resources can then be directed efficiently to mitigate risk and support safe, reliable, and effective care.

IT FACILITATES OUTCOMES MEASUREMENT

Ratings on items can be aggregated across cases. The SSIT standardizes critical incident review data for use in quality improvement. SSIT data contributes to professional learning at the individual case level and can be aggregated at any level of the system to support improvement and evaluate change over time.

IT IS A COMMUNICATION TOOL

Classifying complex systems findings into a common language supports improvement discussions at all levels of the organization. SSIT domains, items, and anchors derive from research in human factors and safety science. The SSIT supports organizational learning and an improvement approach focused on human interaction in complex systems.

IT IS A CULTURE CARRIER

The SSIT becomes an important organizational artifact. Use of the SSIT in critical incident reviews reinforces important organizational values and shifts focus away from discussions of blame-worthy acts and simple cause and

effect relationships. It supports efforts to create a culture of safety by increasing understanding of complex interactions in tightly-coupled systems.

SSIT BASIC STRUCTURE

The SSIT is organized into four domains to facilitate learning and improvement. While each item is unique and not replicated in other items, the domains are nested. In other words, a family working with a professional, who works within a team, who all work within an environment. For example, a professional may have experienced trouble interpreting external assessments (e.g., medical records) about a child with complex needs, which may have been exacerbated by the availability and case direction given by the supervisor. These factors may be further affected by the absence of helpful policy, training, and internal professionals to support the interpretation of medical records. In summary, while the domains provide structure to learning, they are not intended to suggest exclusivity. The intention is of the domains is to guide the reviewer into assessing all system levels.

Child/Family Domain		
Family Conflict	Substance Use	Child Medical/Physical
Developmental	Economic Stability	Child Developmental/Intellectual
Mental Health	Parenting Behavior	Child Mental Heath
Professional Domain	**Team Domain**	**Environment Domain**
Cognitive Bias	Teamwork/Coordination	Demand-Resource Mismatch
Stress	Supervisory Support	Equipment/Technology/Tools
Fatigue	Supervisory Knowledge Transfer	Policies/Rules/Statutes
Knowledge Base	Production Pressure	Training
Documentation		Service Array
Information Integration		Practice Drift

RATING ITEMS

The SSIT is easy to learn and use in critical incident reviews. It provides structure to organizational learning. The SSIT assesses the underlying factors that influence casework problems. For example, if a critical incident review about a child's unsafe sleep-related death discovers the child welfare professional assigned to the family did not educate on safe sleep practices, the SSIT is designed to support an understanding of the factors that influenced that problem. To use the same example, it is possible the professional co-bedded with his/her own children and therefore undervalued safe sleep practices (SSIT item: Cognitive Bias), had no policy, training or supervision to support the provision of safe sleep information (SSIT items: Policy/Rules/Statutes, Training, Supervisory Support), and/or did not have external or internal resources to provide the family with a safe sleeping environment (SSIT items: Service Array, Demand-Resource Mismatch).

Improvement Opportunities

It is important to note the SSIT does not identify the problems in the case under review. In this Reference Guide, problems identified in the case under review are called Improvement Opportunities (IOs). These are defined as actions or inactions in the case under review that are either relevant to the outcome (e.g., a child dies abusively at the hands of a caregiver unassessed by the child welfare agency prior to the death) or an important industry standard (e.g., meeting response timeframes for assessing an alleged victim, speaking to collaterals). The most important Improvement Opportunities are family-centered and describe what the family needed vs. received from the helping system. Since the goal is system transformation to advance family well-being and meaningful

transformational help is what professionals intend and want for those they serve, families' needs are at the center of any critical incident review. For this reason, the Family Domain exists to point reviewers to consider potential IOs for further exploration. The SSIT's System Domain ratings are organized around IOs. In order to rate a SSIT as a 2 or 3, the item must be affecting an identified IO.

The SSIT should be used by someone who is well-versed in their system and current industry standards, acknowledging of the high-risk and complex sociotechnical nature of human service work, appreciative of the professional's goal to achieve the best outcomes, and with personal experience serving families. Someone with lived experience in the child welfare system is a highly valued contributor for these reviews.

Like all Transformational Collaborative Outcomes Management (TCOM) tools, the ratings translate into action levels. The SSIT has one retrospective set of action levels for the Family domain, and a prospective set of action levels for the remaining domains.

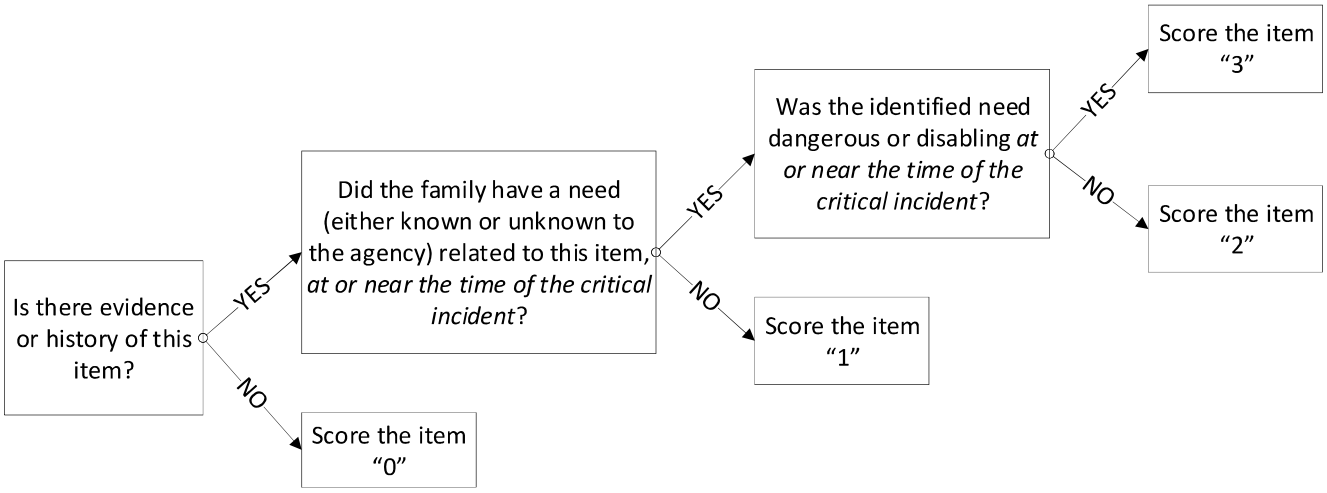
Scoring the Child and Family Domain

For the Family Domain, the items are rated based on the family's status at the time of the critical incident (Table 1). Consistent with the National Partnership for Child Safety's Data Dictionary, caregiver is defined as the adult(s) living in the household who is legally obligated and entitled to provide for the safety and well-being of the child, and a household is a group of people who have frequent contact with the child leading up to the time of the critical incident. It is recommended the Family Domain be tentatively scored prior to debriefing professionals who worked with the family, in the interests of identifying unmet family needs as potential IOs.

Table 1: Child Family Domain Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action was needed
1	History	Watchful waiting/prevention was indicated
2	Need interfered with functioning	Action/intervention was needed
3	Need was dangerous or disabling	Immediate action/intensive action was needed

Figure 1: Decision Scoring Tree for Family Domain



A scoring of '2' or '3' denotes an item as retrospectively actionable. Whether known or unknown to helping professionals at the time of the critical incident, scoring these items actionably means the family had a need for

support (e.g., intervention, formal/informal help, services) at or near the time of the critical incident, actionable items are accompanied by a narrative description to support the rating.

Scoring the System Domains: Proximity

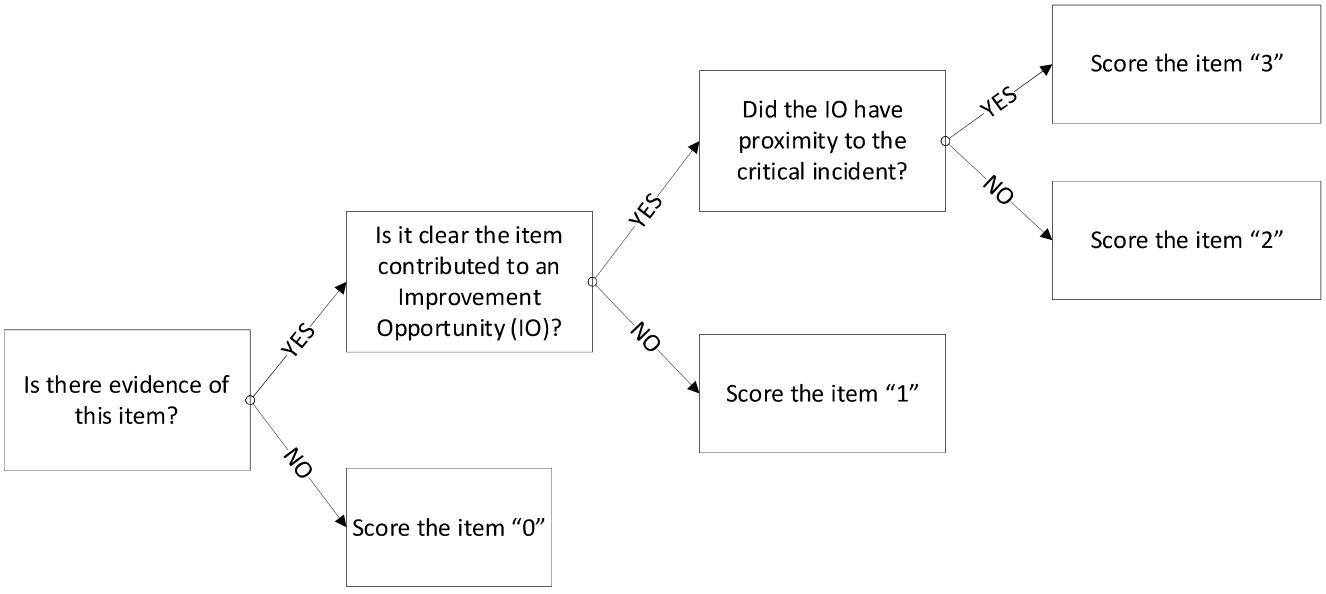
Proximity is used to differentiate between ratings of 2 and 3 (Figure 2) in the 3 system domains – Professional Team, and Environment. Proximity is a Gestalt Principle about how the human mind naturally organizes items. If an IO identified in a case was close in time or distance and with relationship to the critical incident, then a rating of proximal (3) is appropriate. For example, if an infant dies in an unsafe sleep environment, and the child welfare agency did not provide safe sleep education and/or timely access to needed safe sleep resources, then SSIT items related to that IO are all scored as proximal (3). Conversely, if an infant dies from a congenital heart condition, yet historical engagement with the household did not include a private interview with all children in the home, all SSIT items related to the IO are scored as non-proximal (2).

Table 2: System Domains Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action needed
1	Latent factor	Watchful waiting/prevention
2	Influence to Improvement Opportunity **without** proximity to the outcome	QI action may be needed to promote best practices in casework. IOs should be tracked over time and/or compared with other quality data before being considered for system-level improvement projects.
3	Influence to Improvement Opportunity **with** proximity to the outcome	QI action to protect against recurrence of critical incidents may be needed. Response could include: providing case-level or system-wide education, forming a local ad hoc QI team, developing system-level improvement projects.

Scoring in this way promotes rating reliability and secures an understanding of the system-level needs most proximal to critical incidents (Figure 1). While human service agencies are not solely responsible for prevention of critical incident, such organizations are still invested in reducing any and all adverse outcomes as much as possible, in pursuit of the best outcomes for every family.

Figure 2: Decision Scoring Tree for System Domains



A scoring of ‘2’ or ‘3’ denotes an item as actionable; it means the item affected an IO. Actionable items should be accompanied by a narrative description to support the rating. This combination of quantitative and qualitative data facilitates simple and structured communication on every case but also creates a rich database of information over time—allowing for dissection of themes.

2. SSIT DOMAINS AND ITEMS

FAMILY DOMAIN

This section focuses on factors present in the family at the time of the critical incident. It provides an opportunity to document the family, caregiver and child/youth's needs during the time the critical incident occurred, even if they were unknown to the agency prior to the incident occurring. This domain can be useful in drawing correlations between systems-level items and certain family items (e.g., if service array challenges are often scored actionably when families identify with developmental/intellectual diagnoses). Unmet family needs identified in this domain are potential Improvement Opportunities to explore during the review. Consistent with the National Partnership for Child Safety's Data Dictionary, caregiver is defined as the adult(s) living in the household who is legally obligated and entitled to provide for the safety and well-being of the child, and a household is a group of people who have frequent contact with the child leading up to the time of the critical incident.

For the **FAMILY DOMAIN,** the item ratings translate into the following categories and action levels, *as they existed at the time of the critical incident* (e.g., death or near death):

0	No evidence; there was no need for action at the time of the critical incident
1	History; there was a need for "watchful waiting" at the time of the critical incident
2	Action was needed at the time of the critical incident
3	Dangerous or disabling problem required immediate and/or intensive action at the time of the critical incident

FAMILY/CAREGIVER ITEMS

FAMILY CONFLICT

This item refers to how much fighting and arguing occurred between family members. Domestic violence refers to physical fighting in which family members might get hurt.

Questions to Consider

- Did members of the family get along well?
- Did arguments escalate to physical altercations?

Ratings & Descriptions

0	Family had minimal conflict, got along well and negotiated disagreements appropriately.
1	Family generally got along fairly well, but when conflicts arose, resolution was difficult or there was a history of significant conflict or domestic violence.
2	Family was generally argumentative and significant conflict was a fairly constant theme in family communications.
3	Family experienced domestic violence. There was threat or occurrence of physical, verbal, or emotional altercations. If the family had a current restraining order against one member, then they would be rated here.

CAREGIVER DEVELOPMENTAL

This item refers to developmental disabilities including autism and intellectual disabilities. A formal diagnosis is not required to rate this item.

Questions to Consider	Ratings & Descriptions	
• Had the caregiver been identified with any developmental or intellectual disabilities?	0	There was no evidence that the caregiver had developmental needs.
	1	The caregiver had developmental challenges, but they did not currently interfere with parenting or there was a history of those challenges interfering with parenting.
	2	The caregiver had developmental challenges that interfered with their capacity to parent.
	3	The caregiver had developmental challenges that made it very difficult or impossible for them to parent.

CAREGIVER MENTAL HEALTH

This item refers to mental health needs only (not substance abuse). A formal mental health diagnosis is not required to rate this item.
Note: Mental Health Disorders would be rated '2' or '3' unless the individual was in recovery.

Questions to Consider	Ratings & Descriptions	
• Did the caregiver have any mental health needs? • Were the caregiver's mental health needs interfering with their functioning?	0	There was no evidence that the caregiver had mental health needs.
	1	The caregiver was in recovery from mental health difficulties or there was a history of mental health problems.
	2	The caregiver had mental health difficulties that interfered with their capacity to parent.
	3	Caregiver had mental health difficulties that made it very difficult or impossible for them to parent.

CAREGIVER SUBSTANCE USE

This item includes problems with alcohol, marijuana, illegal drugs and/or prescription drugs. A formal diagnosis is not required to rate this item.
Note: Substance-Related Disorders would be rated '2' or '3' unless the individual was in recovery.

Questions to Consider	Ratings & Descriptions	
• Did caregivers have any substance use needs that made parenting difficult? •	0	There was no evidence that the caregiver used alcohol or drugs.
	1	The caregiver may have had mild problems with work or home life that result from occasional alcohol or drug use or there was a past history of substance use problems.
	2	The caregiver had substance use that interfered with their life; caregiver had a diagnosable substance-related disorder near the time of the critical incident.
	3	Caregiver had substance use that made it very difficult or impossible for them to parent.

CAREGIVER ECONOMIC STABILITY

This item rates the caregivers' ability to consistently have met daily needs, such as affordable and safe housing, childcare, adequate income, healthy food, and reliable transportation. A family may have had adequate living stability via government and non-governmental assistance. If the government or non-governmental assistance was temporary or at-risk of being lost, this is a reason to rate the item a 2 or 3.

Questions to Consider:	Ratings & Descriptions	
	0	No current need; no need for action or intervention. This may have been a resource for the child. Caregivers had sufficient resources to raise the child.

• Did the caregiver ever struggle financially? • Did the caregiver ever worry they won't enough money to meet needs? • How stable was the family's life at the time of the critical incident?	1 Caregivers had limited resources but usually had daily living needs met for the child. History of struggles with sufficient resources would be rated here as would the presence of ongoing governmental (e.g., subsidized housing) or non-governmental (e.g., food pantries, low-income medical clinics) supports that create economic sufficiency and are not at known risk of being lost (e.g., closing program, family at risk of not meeting eligibility criteria) 2 Caregiver needed help stabilizing their economic situation. The caregiver may have been at risk of losing economic supports, such as losing reliable transportation or housing or childcare. Daily living needs were sometimes unmet for the child. 3 Caregiver needed urgent help, perhaps due to homelessness, inadequate food, income, or no transportation. Child's daily living needs were often unmet.

CAREGIVER PARENTING BEHAVIORS

This item rates the caregiving behaviors of the primary caregivers. The item rates if the caregiver gave developmentally-appropriate care and followed the care-based recommendations of professionals (e.g., physicians)

	Ratings & Descriptions
Questions to Consider • Did caregivers provide developmentally appropriate supervision? • Did caregivers meet the basic caregiving needs of the child, following through on the recommendations of professionals (e.g., physicians, counselors)?	0 Caregiver(s) were involved with the child and provided appropriate levels of expectations and supervision for the child. 1 Caregiver(s) were involved and generally provided appropriate levels of expectations and supervision for child. There were some concerns about caregiving behavior, but they were mild or historical and unrelated to child safety. 2 Caregiver(s) did not follow through with professional recommendations or provide developmentally-appropriate care. Caregivers often did not provide appropriate levels of expectations and supervision. 3 Caregiver(s) did not provide adequate developmentally-appropriate care and deficits in caregiving resulted in serious safety concerns.

CHILD/YOUTH ITEMS

CHILD/YOUTH MEDICAL/PHYSICAL

This item is used to describe the child/youth's medical/physical health.
Note: Most transient, treatable conditions would be rates as a '1'. Most chronic conditions (e.g., diabetes, severe asthma, HIV) would be rated a '2'. The rating '3' is reserved for life threatening medical conditions. A formal diagnosis is not required to rate this item.

	Ratings & Descriptions
Questions to Consider • How was the child/youth's health? • Did the child/youth have any chronic conditions or physical limitations?	0 No evidence that the child/youth had any medical or physical challenges, and/or they were healthy. 1 Child/youth had transient or well-managed physical or medical challenges. These include well-managed chronic conditions like juvenile diabetes or asthma. 2 Child/youth had serious medical or physical challenges that required medical treatment or intervention or child/youth had a chronic illness or a physical condition that requires ongoing medical intervention. 3 Child/youth had life-threatening illness or medical/physical challenges. Immediate and/or intense action was needed due to imminent danger to child/youth's safety, health, and/or development.

CHILD/YOUTH DEVELOPMENTAL/INTELLECTUAL

This item describes the child/youth's development as compared to standard developmental milestones, as well as rates the presence of any developmental (motor, social and speech) or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning. A formal diagnosis is not required to rate this item.

Questions to Consider

- Did the child/youth's growth and development seem age appropriate?
- Had the child/youth been screened for any developmental problems?

Ratings & Descriptions

0	No evidence of developmental delay and/or child/youth had no developmental delay or intellectual disability.
1	There were concerns about possible developmental delay. Child/youth may have low IQ, a documented delay, or documented borderline intellectual disability (i.e. FSIQ 70-85). Mild deficits in adaptive functioning were indicated.
2	Child/youth had developmental delays (e.g., deficits in social functioning, inflexibility of behavior causing functional problems in one or more settings) and/or mild to moderate Intellectual Disability/Intellectual Disability Disorder. (If available, FSIQ 55-69.) IDD affected communication, social functioning, daily living skills, judgment, and/or risk of manipulation by others.
3	Youth had severe to profound intellectual disability (FSIQ, if available, less than 55) and/or Autism Spectrum Disorder with marked to profound deficits in adaptive functioning in one or more areas: communication, social participation and independent living across multiple environments.

CHILD/YOUTH MENTAL HEALTH

This item is used to describe the child/youth's mental health (not substance use or dependence). A formal mental health diagnosis is not required to score this item.

Questions to Consider

- Did the child/youth have any mental health needs?
- Were the child/youth's mental health needs interfering with their functioning?

Ratings & Descriptions

0	There was no evidence or signs the child/youth was experiencing mental health challenges.
1	The child/youth had mild challenges with adjustment, may have been somewhat depressed, withdrawn, irritable, or agitated. A history of mental health challenges would be scored here.
2	The child/youth had moderate mental health challenges that interfered with their functioning in at least one life domain (e.g., school).
3	The child/youth had significant challenges with their mental health, affecting two or more life domains (e.g., school, neighborhood community). The child/youth may have had a serious psychiatric disorder.

PROFESSIONAL DOMAIN

This section focuses on factors primarily present within professionals. Largely intrapersonal in focus, this domain centers on the experience, knowledge, perceptions, and skills of professionals assigned to the family's care or experiencing the problem under review. This domain focuses on behaviors as well as the presence of psychological factors within professionals, like fatigue and stress. Neither this domain nor any domain is created to assign individual blame for a problem's existence; rather this domain offers an organized way to deconstruct perspectives before, during, and after decision-making.

For the **PROFESSIONAL DOMAIN,** the item ratings translate into the following categories and action levels:

0 No evidence, no need for action.

1 Latent factor.

2 QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.

3 A priority for QI action to prevent recurrence of proximal influences.

COGNITIVE BIAS

A faulty understanding of a situation or person(s) due to basic human limitations (e.g., confirmation bias, cognitive fixation, focusing effect, transference) as well as unconscious or conscious bias, including microaggressions. Identity-based biases are rated here, such as racism, sexism, genderism, and ableism. Undervaluing culturally-normative traditions or caregiving behaviors is also rated here.

Questions to Consider	Ratings & Descriptions	
• What were your thoughts when you received the referral/case? About the family? Perpetrators? Children?	0	No evidence of bias(es).
	1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but bias was present).
	2	Bias(es) contributed to an Improvement Opportunity without proximity to the outcome.
	3	Bias(es) contributed to an Improvement Opportunity with proximity to the outcome.

STRESS

Psychological strain or tension resulting from adverse or demanding circumstances. Professionals express or exhibit difficulty managing the strains of casework and/or other life circumstances (e.g., divorce).

Questions to Consider	Ratings & Descriptions	
• What were the pressures you faced, professionally and personally? How did that impact casework? How do you know when you are stressed?	0	No evidence of stress.
	1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but stress was present).
	2	Stress contributed to an Improvement Opportunity without proximity to the outcome.
	3	Stress contributed to an Improvement Opportunity with proximity to the outcome.

FATIGUE

Extreme tiredness as a result of casework and/or other life circumstances (e.g., single parent, personal illness).

Questions to Consider

- What were the pressures you faced, professionally and personally, that contributed to fatigue? How did that impact casework? How much sleep had you received in the days preceding this incident?

Ratings & Descriptions

0	No evidence of fatigue.
1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but fatigue was present).
2	Fatigue contributed to an Improvement Opportunity without proximity to the outcome.
3	Fatigue contributed to an Improvement Opportunity with proximity to the outcome.

KNOWLEDGE BASE

An absence of knowledge or difficulty activating knowledge (i.e., putting knowledge into practice).

Questions to Consider

- Was there anything you learned from this case that you previously had not known? Were there items you felt unequipped to assess or address? Were any records (i.e., medical records) difficult to interpret?

Ratings & Descriptions

0	No evidence of knowledge gaps.
1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but knowledge gaps were present).
2	Knowledge gaps contributed to an Improvement Opportunity without proximity to the outcome.
3	Knowledge gaps contributed to an Improvement Opportunity with proximity to the outcome.

DOCUMENTATION

Absent or ineffective official, internal records. *Note: Sometimes an Improvement Opportunity is about Documentation but only score this item if Documentation contributed to an Improvement Opportunity – not if Documentation was the Improvement Opportunity.*

Questions to Consider

- If someone only read the notes, would they know what was going on?

Ratings & Descriptions

0	No evidence of documentation concerns.
1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but documentation concerns were present)
2	Documentation contributed to an Improvement Opportunity without proximity to the outcome.
3	Documentation contributed to an Improvement Opportunity with proximity to the outcome.

INFORMATION INTEGRATION

Challenges with externally-sourced information (e.g., obtaining or using medical records, school records/assessments, criminal records, formal assessments). *Note: Sometimes an Improvement Opportunity is about Information Integration but only score this item if Information Integration contributed to an Improvement Opportunity – not if Information Integration was the Improvement Opportunity. Also, if knowledge gaps contributed to misunderstanding external records, this would be scored under Knowledge Base.*

Questions to Consider

- How did you decide what records to request in this case? Were historical records on previous services requested? How were assessments used to plan services?

Ratings & Descriptions

0	No evidence of difficulties in obtaining or synthesizing external records.
1	Evidence of latency (i.e. no known impact to an Improvement Opportunity, but difficulties were present).
2	Difficulties obtaining or synthesizing external records contributed to an Improvement Opportunity without proximity to the outcome.
3	Difficulties obtaining, or synthesizing external records contributed to an Improvement Opportunity with proximity to the outcome.

TEAM DOMAIN

This section focuses on factors primarily present within teams. The pressures, communication, and climate of the team are considered in this domain, with specific attention given to the supervisor's unique role in supporting the professional. This domain is not exclusive to factors only present among internal teams; collaboration with relevant community partners is assessed as well.

For the **TEAM DOMAIN,** the item ratings translate into the following categories and action levels:

0 No evidence, no need for action.

1 Latent factor.

2 QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.

3 A priority for QI action to prevent recurrence of proximal influences.

TEAMWORK/COORDINATION

Ineffective collaboration between two or more internal and/or external entities (e.g., agencies, people and teams). Notably, this item does not encompass the family's willingness or cooperation but rather the team of family-serving professionals.

Note: Ineffective teamwork between a supervisor and supervisee is captured under "Supervisory Support."

Questions to Consider	Ratings & Descriptions	
• What barriers existed in communicating with outside partners during this case? How often did you communicate? What barriers existed in internal communication while working this case?	0	No evidence of issue with teamwork/coordination.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but teamwork/coordination concerns were present).
	2	Teamwork/coordination problems contributed to an Improvement Opportunity without proximity to the outcome.
	3	Teamwork/coordination problems contributed to an Improvement Opportunity with proximity to the outcome.

SUPERVISORY SUPPORT

Supervisor provides ineffective support, communication, teamwork, and/or is unavailable.

Questions to Consider	Ratings & Descriptions	
• What support was received from supervisors during this case? What is supervision generally like on this team? What was the supervisor's leadership style?	0	No evidence of problems with supervisory support.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but supervisory support concerns were present).
	2	Supervisory support problems contributed to an Improvement Opportunity without proximity to the outcome.
	3	Supervisory support problems contributed to an Improvement Opportunity with proximity to the outcome.

SUPERVISORY KNOWLEDGE TRANSFER

Case direction from supervisor was inconsistent with best practice.

Questions to Consider	Ratings & Descriptions	
• What case direction was received from supervisors during this case? Was case direction aligned with best practice?	0	No evidence of problems with supervisory case direction.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but supervisory case direction concerns were present).
	2	Supervisory case direction contributed to an Improvement Opportunity without proximity to the outcome.
	3	Supervisory case direction contributed to an Improvement Opportunity with proximity to the outcome.

PRODUCTION PRESSURE

Demands on professionals to increase efficiency.

Note: This is distinctive from Demand Resource Mismatch (DRM) as Production Pressure describes pressures within casework (e.g., overdues, extensive court involvement, child removals in other assigned cases). Though not exclusively, the presence of DRM may impact the presence of Production Pressures.

Questions to Consider	Ratings & Descriptions	
• How pushed were you by deadlines in this case? How many other cases did you have? What was happening in other cases during the time of this incident?	0	No evidence of problems with production pressures.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but production pressures were present).
	2	Production pressures contributed to an Improvement Opportunity without proximity to the outcome.
	3	Production pressures contributed to an Improvement Opportunity with proximity to the outcome.

ENVIRONMENT DOMAIN

This section focuses on factors present in the team's environment. This domain fosters an appreciative inquiry of the team's internal and external access to resources, policies, services, training, and technologies needed to support safe and reliable care delivery. Items in this domain refer to the child/family-serving macrosystem. These items can have positive, negative, or mixed impact to vulnerable populations, such as Black Indigenous People of Color (BIPOC) and Lesbian, Gay, Bisexual, Transgender, Queer or Questioning and Two Spirit (LGBTQ2S).

For the **ENVIRONMENT DOMAIN,** the item ratings translate into the following categories and action levels:

0 No evidence, no need for action.

1 Latent factor.

2 QI action may be needed to mitigate risk and avoid recurrence of non-proximal influences.

3 A priority for QI action to prevent recurrence of proximal influences.

DEMAND-RESOURCE MISMATCH

A lack of internal resources or programs (e.g., inadequate staffing, limited access to drug testing supplies, insufficient funding for services) to carry out safe work practices. *Note: The absence of equipment/technology and external resources/programs are scored in separate items.*

Questions to Consider	Ratings & Descriptions	
• What was the staffing pattern at the time of this case? How long has it been that way? What problems did it cause in this case? What is the barrier to having adequate staffing?	0	No evidence of problems with demand-resource mismatch. Assigned case professionals appeared to have needed resources to carry out work practices.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but demand-resource mismatch was present).
	2	Lack of resources to carry out safe work practices contributed to an Improvement Opportunity without proximity to the outcome.
	3	Lack of resources to carry out safe work practices contributed to an Improvement Opportunity with proximity to the outcome.

PRACTICE DRIFT

A widely-accepted, often gradient, departure from work-as-prescribed. Practice Drift usually occurs as a result of experienced success and as a means of managing production pressures and/or complex interpersonal decisions. Practice Drift uniquely describes an environmental (e.g., system-wide, county-wide, office-wide) departure from work-as-prescribed and may involve a single or multiple child serving agencies.

Questions to Consider	Ratings & Descriptions	
• Were workarounds present at the time of the case? Did these workarounds potentially affect the family in a positive or negative way? Was the workaround widely-used in the county or across the state?	0	No evidence of Practice Drift.
	1	Evidence of latency (i.e., no known impact an Improvement Opportunity, but Practice Drift was present).
	2	Practice Drift contributed to an Improvement Opportunity without proximity to the outcome.
	3	Practice Drift contributed to an Improvement Opportunity with proximity to the outcome.

EQUIPMENT/TECHNOLOGY/TOOLS

An absence or deficiency in the equipment and technology (e.g., electronic records management system like SACWIS, communication devices, electronics) used to carry out work practices. Tools refers to the structured assessments (e.g., CANS, FAST, SDM), predictive analytics, and related algorithms (e.g., algorithms may perpetuate systemic bias toward underrepresented populations).

Questions to Consider	Ratings & Descriptions	
• What equipment would have been helpful in this case? Were there any difficulties in acquiring or using certain equipment or technology?	0	No evidence of problems with equipment, tools or technology.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but issues with equipment/technology/tools were present).
	2	The absence or deficiency of equipment, tools or technology contributed to an Improvement Opportunity without proximity to the outcome.
	3	The absence or deficiency of equipment, tools or technology contributed to an Improvement Opportunity with proximity to the outcome.

POLICIES/RULES/STATUTES

The absence, poor clarity, or ineffectiveness of an internal written practice or procedure. Conflicting policies would also be rated here, as well as other written rules, statutes, and procedures detailing work-as-prescribed.

Questions to Consider	Ratings & Descriptions	
• What policies, protocols, or forms affected this case? How did it impact decisions? What would have been more helpful?	0	No evidence of absent or ineffective policies.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but the absence of ineffectiveness of a policy was present).
	2	The absence or ineffectiveness of one or more policies contributed to an Improvement Opportunity without proximity to the outcome.
	3	The absence or ineffectiveness of one or more policies contributed to an Improvement Opportunity with proximity to the outcome.

TRAINING

The absence, poor clarity, or ineffectiveness of an internal formal instruction. This may include a variety of learning modalities, such as: web-based, classroom, independent study, formal mentoring or coaching, etc.)

Questions to Consider	Ratings & Descriptions	
• What trainings affected decision-making in this case? Were needed trainings helpful and available? What trainings would have been useful?	0	No evidence of absent or ineffective trainings.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but the absence of ineffectiveness of a training was present).
	2	The absence or ineffectiveness of one or more trainings contributed to an Improvement Opportunity without proximity to the outcome.
	3	The absence or ineffectiveness of one or more trainings was contributed to an Improvement Opportunity with proximity to the outcome.

SERVICE ARRAY

The unavailability or ineffectiveness of a particular external and/or community-based service. These services include provider agencies as well as county and state child-service partners (e.g., school, court, law enforcement).

Questions to Consider	Ratings & Descriptions	
• What services are available in the area? How accessible are those services? How effective do services appear to be?	0	No evidence of problems with service array.
	1	Evidence of latency (i.e., no known impact to an Improvement Opportunity, but service array concerns were present).

SERVICE ARRAY The unavailability or ineffectiveness of a particular external and/or community-based service. These services include provider agencies as well as county and state child-service partners (e.g., school, court, law enforcement).		
	2	Problems with service array contributed to an Improvement Opportunity without proximity to the outcome.
	3	Problems with service array contributed to an Improvement Opportunity with proximity to the outcome.

3. SSIT SCORESHEET

CASE ID:	

Improvement Opportunities (IOs)
1
2
3
4
5

Abbreviated Rating Summary for Family Domain

0=No Evidence	1=Minimal Problem or History	2=Problem affected Functioning	3=Severely Disabling or Dangerous Problem

Abbreviated Rating Summary for Professional, Team, and Environment Domains

0=No Evidence of Influence	1=Latent Factor	2=Evidence of Influence	3=Evidence of Proximity to Poor Outcomes

Family Domain	**Influence**				**Narrative**
	0	**1**	**2**	**3**	***Required if rating is 2 or 3***
1. Family Conflict (Caregiver)	○	○	○	○	
2. Developmental (Caregiver)	○	○	○	○	
3. Mental Health (Caregiver)	○	○	○	○	
4. Substance Use (Caregiver)	○	○	○	○	
5. Economic Stability (Caregiver)	○	○	○	○	
6. Parenting Behaviors (Caregiver)	○	○	○	○	
7. Medical/Physical (Child)	○	○	○	○	
8. Developmental/Intellectual (Child)	○	○	○	○	
9. Mental Health of (Child)	○	○	○	○	
Professional Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
10. Cognitive Bias	○	○	○	○	
11. Stress	○	○	○	○	
12. Fatigue	○	○	○	○	
13. Knowledge Base	○	○	○	○	
14. Documentation	○	○	○	○	
15. Information Integration	○	○	○	○	
Team Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
16. Teamwork/Coordination	○	○	○	○	
17. Supervisory Support	○	○	○	○	
18. Supervisory Knowledge Transfer	○	○	○	○	

19. Production Pressure	○	○	○	○	
Environment Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
20. Demand-Resource Mismatch	○	○	○	○	
21. Practice Drift	○	○	○		
22. Equipment/Technology/Tools	○	○	○	○	
23. Policies/Rules/Statutes	○	○	○	○	
24. Training	○	○	○	○	
25. Service Array	○	○	○	○	

4. QUALITY IMPROVEMENT ADVOCACY

In this final section we provide strategies for using SSIT data to share the "system's story" of a critical incident and support advocacy for system improvement actions. A primary purpose of measurement is to cultivate shared language and inform decision-making. For this reason, item ratings within the Professional, Team, and Environment domains translate into the following action levels:

Table 2: System Domains Basic Ratings Design

Rating	Observation	Appropriate Action Level
0	No evidence	No action needed
1	Latent factor	Watchful waiting/prevention
2	Influence to Improvement Opportunity **without** proximity to the outcome	QI action may be needed to promote best practices in casework. IOs should be tracked over time and/or compared with other quality data before being considered for system-level improvement projects.
3	Influence to Improvement Opportunity **with** proximity to the outcome	QI action to protect against recurrence of critical incidents may be needed. Response could include: providing case-level or system-wide education or forming an ad hoc QI team.

SSIT action levels are not intended to be prescriptive. They are a steady and reliable guide for targeting system reform in the areas most likely to prevent a future critical incident. Items scoring "3" translate into a priority for action because the item influenced an IO proximal to a critical incident. Nesting the domains serves as a prompt to direct QI resources as deep into the system as possible, so—if a review yields proximal scores in the Professional, Team, and Environment domains—resources can be directed to improve the Environment, rather than merely providing professionals with directives.

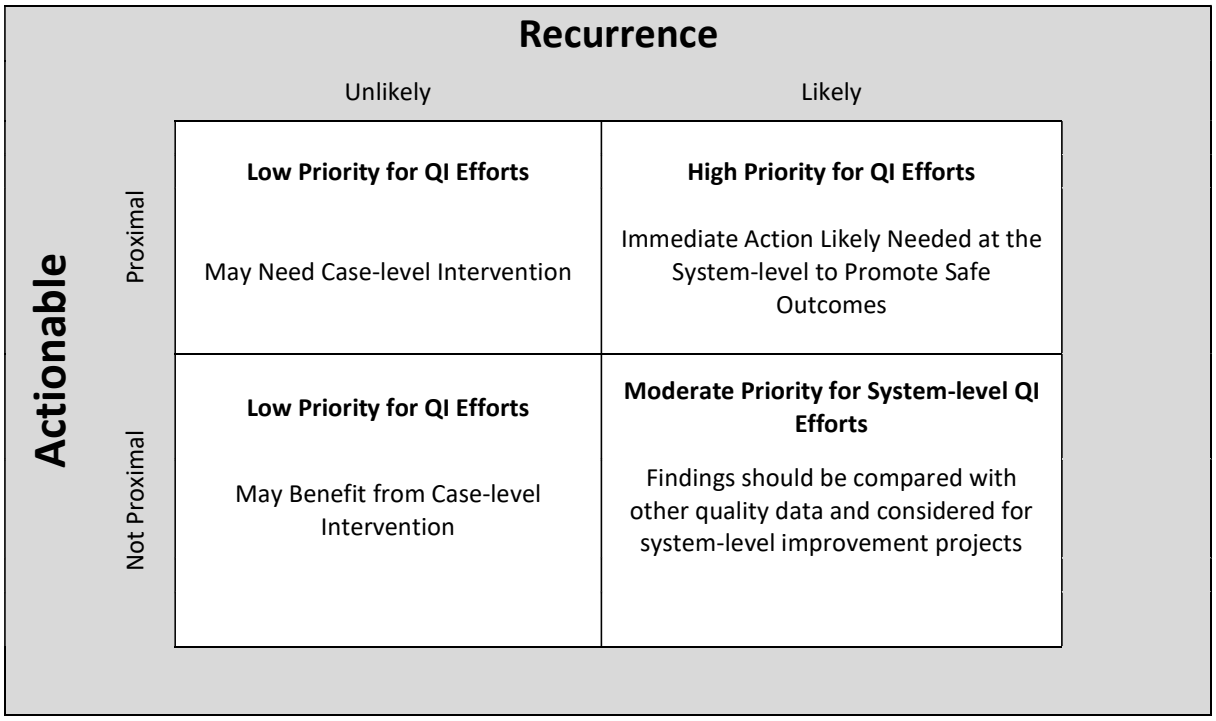
SSIT data can be aggregated and reviewed to inform system-focused quality improvement opportunities. SSIT data should be viewed alongside the IOs from reviewed cases. For example, IOs may reveal inconsistent engagement of all caregivers in a home, allegation/incident-focused casework practice, or barriers in reviewing all applicable case history. Prior to review of SSIT data, it is useful to consider how likely these IOs are to recur in the system. While this can be done through content analysis of IOs as well as a review of other QI data (e.g., Child and Family Service Review findings), the following anchors (table 3) may be helpful in thinking through the likelihood for IOs to recur within a system:

Table 3: Recurrence Rating Structure

ORGANIZATIONAL RECURRENCE	
Questions to Consider • Is this finding already known to be part of a systems issue? • Are effective procedures in place to address? • Have system changes already been in effect since the problem last occurred?	Ratings & Descriptions 0 Minimal or no likelihood of recurrence; problem appears a rare outlier. 1 There is a history of recurrence that appears to have been successfully addressed through organizational improvement(s). 2 There is a likelihood of future recurrence. Though some organizational constructs (e.g., policy, supervision practices, trainings, technology, resource allocation) exist to address the problem, it is unproven or disproven if these will successfully reduce recurrence. 3 Minimal or no organizational constructs currently exist to address the problem.

When considering where to focus finite QI resources, the QI Advocacy Matrix (figure 2) may support decision-making. After establishing recurrence likelihood - and with proximity established by the SSIT - QI professionals can use the matrix to identify and advocate for those IOs that should be prioritized. IOs that are both proximal and likely to recur may require more immediate action form the system (see top right quadrant in table below). IOs likely to recur but not proximal to critical incidents may benefit from system-level QI resources, but it is prudent to compare such findings with other system data so as to make the most informed decision (see bottom right quadrant). IOs unlikely to recur may be suitable for case-level intervention (see left side). For example, a region may have experienced an isolated and/or unusual problem that can be improved by collaborating directly with local region's personnel. The following table is a graphic depiction of this concept:

Figure 2: QI Advocacy Matrix



Advocating for System Change

Those tasked with reviewing critical incidents rarely have formal authority to move systems to change. More often, their success lies in their ability to effectively use data to tell a story and influence communities with such formal authority to move to action. These traits—accurate story-sharing and influence-- are the hallmarks of an effective advocate. QI advocacy, like all forms of advocacy, requires dedicated, experienced individuals armed with information. The SSIT allows a system to standardize important information about its system and to support QI advocacy.

Standardizing Child Fatality and Near Fatality Review to Improve Outcomes with the Safe Systems Improvement Tool

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Over **three thousand children** die each year in the United States due to maltreatment (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016), thousands more children experience near deaths or other critical incidents.

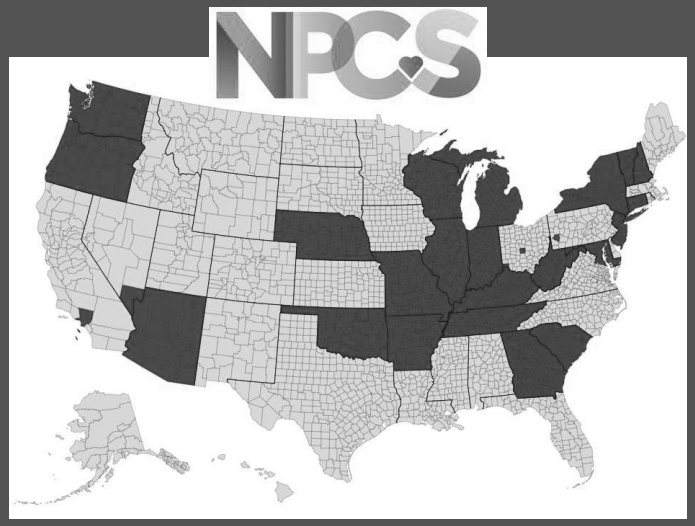
Following a critical incident like a child fatality or near fatality, **child protection** professionals need psychologically safe review processes to debrief their decisions and experiences candidly and learn from what happened. **Agencies need** standardized systems-level data to inform their quality improvement work and achieve the safest outcomes for children and families.

METHODS

1. SSIT is a standardized, 25-item tool that assesses unmet family needs and systemic contributors to those unmet needs. It contains both a rating and narratives justifying the rating selection, allowing for a mixed methods approach
2. SSIT structures quantifiable outcomes from root cause analysis.
3. Child fatality and near fatality data from Oregon DHS Critical Incident Review Teams (CIRTs) in July 2019-July 2021 (*n* = 68) were included in this study.

[1] Center for Innovation in Population Health, University of Kentucky
[2] Oregon Department of Human Services

Oregon Department of Human Services is committed to using a public health approach – drawing from the sciences of safety and improvement – to reduce child fatalities and near fatalities among families with recent child protection services' involvement. Oregon joins national efforts in child maltreatment fatality prevention within the National Partnership for Child Safety.



The Safe Systems Improvement Tool (SSIT) supports a family-centered, systems-focused analysis of fatalities and near fatalities.

AcademyHealth
ANNUAL RESEARCH MEETING
Center for Innovation in Population Health

RESULTS

1. The most frequently occurring family needs were about Family Conflict (*n* = 34), Parenting Behaviors (*n* = 32), and Substance Use (*n* = 26).
1. Improvement Opportunities (IOs), defined as agency actions or inactions related to unmet family needs, occurred in 69% (*n* = 47) of reviews. 85% of Improvement Opportunities were about caseworker assessment practices – usually about substance use and intimate partner violence.
2. Systems factors most frequently contributing to IOs about assessment practice were: cognitive biases (45%), knowledge base (45%), teamwork/coordination (55%), policies (30%) and training (38%).

Oregon DHS is transforming how families receive compassionate care and safe support through child protection assessments. Read about their pioneering work to support families.

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AWAKEN is a value-based framework providing actionable steps that take us from automatic, bias-based thinking to intentional decisions and behaviors. It identifies when bias is activated and provides teams with mindful organizing strategies to co-conspire against biases in ourselves and our systems. It also awakens the critical consciousness needed to make equitable decisions that foster safety, trust, and belonging. **AWAKEN** can be used as a quick self-check-in or a deeper dive anytime we notice a response to a situation, person, or decision.

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Bias and Safety Culture

Bias lives everywhere, in all of us and in the teams, organizations, and systems where we work and live. Understanding different types of cognitive bias enable us to identify better when bias may be at play and how it influences our decision-making. Identifying systemic bias allows us to advocate for social justice and system improvements. Cognitive biases, such as hindsight bias and severity bias, can significantly impact safety culture. How agencies navigate bias affects organizational culture, and that's where mindful organizing comes In.

Mindful Organizing

Mindful organizing Is a team-based practice that allows teams to manage complexity and bias In decision-making (Sutcliffe, 2011). **AWAKEN** Is a mindful organizing strategy that can be used individually or collaboratively within teams to plan forward proactively or reflect back retrospectively anytime decisions are made.

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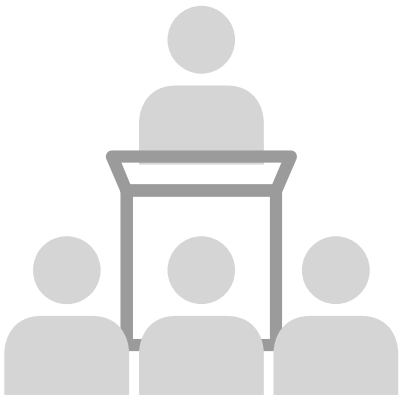
Target Audience

Anyone seeking to address bias in teams and systems, strengthen collaboration and workplace connectedness to reduce bias in assessment and decision making, primarily to address equity, inclusion, and belonging for diverse populations served.



Demand

Disparity and disproportionality have long been a focus for child welfare organizations. In addition, addressing systemic bias and racial injustice on individuals and communities has become a priority to transforming child welfare.

Teaming is a core tenet of safety culture. As jurisdictions integrate safe systems approaches into their practice, the value of workplace connectedness and collaboration Is a crucial feature.

Innovation

By operationalizing the AWAKEN framework in teams, we are interested in exploring whether sharing and understanding diverse perspectives and stories strengthens team relationships, trust, and workplace connectedness.

Implicit bias training alone has not been shown to be effective in reducing bias over time. Therefore, we are interested in exploring how collaborative decision-making might support teams in identifying systemic biases and advocating for system improvements.

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Competency

Teams will learn to engage in conscious decision-making, both independently and together, by recognizing and counteracting unconscious bias to foster safety, trust, and belonging in safe systems debriefings.

Learning Objectives

- Know how to practice empathy, humility, vulnerability, authenticity, and collaboration as foundational values in perspective taking, trust, and relationship building.
- Recognize the types of cognitive bias seen in child welfare serving systems and apply strategies to counteract them.
- Recognize signifiers of when bias might be present. (AWARENESS)
- Explore one's perspective to understand how individual and system biases are shaped. (WONDER)
- Demonstrate foundational values and skills to encourage participation and gain new perspectives. (ASK)
- Demonstrate the ability to synthesize new knowledge gained from different perspectives. (KNOWING)
- Know how to engage in conscious decision-making. (ENGAGE)
- Know how to develop and sustain new conscious decision-making habits. (NEW NEUROPATHWAYS)

Implementations

South Carolina Department of Social Services has integrated AWAKEN into their new child welfare certification and entire direct service workforce. It is used as foundational decision-making support for casework, including addressing during assessment and planning throughout the life of a case.

The Safe Systems team at the Center for Innovation in Population Health has integrated AWAKEN into an advanced training for systemic critical incident reviewers from child welfare jurisdiction members of the Casey Family Programs National Partnerships for Child Safety. Implementation is supported by team PDSAs, coaching calls, and self-assessment surveys for the six months following the formal training.

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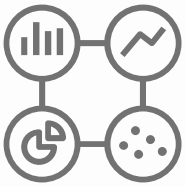
How we implement AWAKEN

Collaborate to Identify a targeted area (or areas) of focus in your organization to implement **AWAKEN.**

Customize **AWAKEN** to your organization's needs and areas of focus.



Partner to identify metrics to measure the effectiveness of **AWAKEN** in your organization.

Deliver the **AWAKEN** training and provide coaching to your organization's workforce

Establish sustainability by training trainers within your organization on how to deliver training and coach **AWAKEN**.

Provide ongoing support to your organization's **AWAKEN** journey.

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What people are saying about AWAKEN

I'm thinking about bias all the time, I feel like. In a different way than I previously thought about it. That tells me that I've learned something and how I'm responding to it.

It strengthened our team in lots of ways. Experiencing it together creates something powerful. The shared experience created trust and we shared emotions.

It doesn't always feel good when we're having these conversations [about bias]. Our outcome in the end might still be what we think. But we're truly making sure that we are asking questions and posing other hypotheses. It's been challenging for my staff, but I've been using some of the tools from the [AWAKEN] training and I think it's been helpful in navigating the conversations.

I'm more understanding and trusting of my colleagues. Deeper relationships, knowing they will support.

I see things differently now I am tuned into my bias. It's impossible not to use that lens now. The film has been lifted from my eyes.

We've really expanded our conversations about our biases. I've found that as a leader, I've really challenged my workers on biases. We're making sure that we're challenging ourselves.

implementation of
nsive Addiction and
ery Act (CARA)
Prevention and Review
Program

Goal: Implementation of an equitable, coordinated statewide early intervention program that meets the health substance use disorder treatment needs of people who are pregnant, substance affected infants, and their famil

***A family includes parents, partners, relatives, and other caregivers in the household**

Activities		Outcomes/Metrics		
What Oregon Child Welfare does	*Who Oregon Child Welfare reaches*	*Why this project: short-term results*	*Why this project: intermediate results*	*Why this project: long*
Use a culturally responsive, strengths based, trauma informed, multi-generational, family focused approach Apply equity tool early and throughout Seek out technical assistance Gather and track data Analyze data to inform efforts Report data as required Share data across family serving systems Identify safe strategies that utilize natural / community supports and eliminate or reduce CW involvement Collaborative coordination of community led effort to identify quality practices Educate family serving systems on plan of care best practices Collaborate with OHA to educate healthcare professionals re: report vs. notification Collaborate to develop tools for notification, and tools that support best practice Create mutual learning opportunities to facilitate continuous quality improvement	• Substance affected infants • Pregnant and parenting people • Other caregivers, household members, family members • CW professionals • Tribal partners • SUD treatment providers • Peer mentors • People with lived experience • ART / FIT team • Health care professionals • Prenatal care providers • Midwives, doulas, hospital social workers • OHA • Maternal mortality death review • Home visiting nurses • Family Connects • Early Intervention • Child Development Specialists • Birthing hospitals • Juvenile court and partners • Probation and parole • WIC • Food pantries • Domestic Violence Shelters • Lactation specialists • Housing resources • Mental Health providers • Oregon Parenting Education Collaborative • Self Sufficiency Program • Developmental Disabilities • Oregon Alcohol and Drug Policy Commission • Coordinated Care Organizations • Safe Families • FFPSA Preservation Unit pilot?	• Family serving professionals have increased understanding of their role and best practices in development and maintenance of Plans of Care • Healthcare providers have increased understanding of notification process • Family serving professionals know how to access technical assistance and tools • Family serving professionals have increased awareness of need to collaborate • Members of CARA implementation infrastructure have shared understanding of the goal	• The Plan of Care is developed during pregnancy. • The Plan of Care is initiated during pregnancy and updated following delivery. • Health care, substance use treatment, and other service providers involved in caring for the family initiate development of the Plan of Care. • The pregnant/new parent is actively engaged in developing the plan. Other family members or caregivers are involved if the parent desires. • The Plan of Care includes multidisciplinary service supports. • The Plan of Care is active for a year post-delivery. Ongoing support is offered beyond one year if desired. • Birthing hospitals have policies in place that support development and maintenance of Plans of Care • SUD treatment programs have policies in place that support the development and maintenance of Plans of Care • Peer mentors are utilized to support Plans of Care • Policies, laws or rules in place to require notification by healthcare providers • Development of notification portal • A Public health website is available with CARA resources for professionals and families	• Reduced number of substa infants in foster care • Reduced duration of child intervention with substance and their families • Reduce reoccurrence of m among families with a Plan • Reduced number of report on substance affected infa • Reduced number of report involving substance affecte • Plans of Care are perceive not punitive, response • Pregnant people are consis to a health care provider a partum follow up care • Decreased number of misse appointments for substanc • Decrease in stigma associa and parenting people with • Plans of Care and progress shared regularly across syst • Eliminate racial and ethnic outcomes for substance af including mortality rates • Eliminate racial and ethnic maternal mortality rates wit Plan of Care • Improved outcomes for fam Care • Increased job satisfaction a turnover for family serving p • Statewide use of Plans of C healthier communities

Assumptions

- fication and intervention
- tcomes for substance fants and their families
- led efforts support a culturally approach
- on across systems improves to and delivery of services
- can reduce bias and stigma
- are can be effective in efforts
- mplex medical condition

External Factors

- (-) HIPPA (and similar laws) impact cross system communication and data sharing
- (-) Family serving professionals have varied levels of experience and skill
- (-) Stigma associated with SUD
- (+/-) Funding
- (+/-) Access to SUD treatment services
- (+/-) Insurance
- (-) Structural racism in health care and social service systems and service delivery
- (-) Lack of data on SUD trends for CW involved families
- (-) Workload
- (-) Turnover

Outcomes	Metrics
short-term results:	
professionals have increased understanding of their role and best practices in the and maintenance of Plans of Care oviders have increased understanding of the process for notification professionals know how to access technical assistance and tools professionals have increased awareness of the need to collaborate e CARA implementation infrastructure have shared understanding of the goal	• Increase in the number of Plans of Care developed – (look at C screening) • Increase in notifications – (look at ORKIDS data, Nurture Oregon notification forms, decrease in reports that meet the criteria for • The number of notifications received from healthcare providers the number of infants with a diagnosis code of FAS, neonatal w infant has affect of maternal substance use • CARA coordinator is utilized by family serving professionals for te assistance, metrics regarding forms/publications access and we • Information contained in Plan of Care shows multiple family serv and family members were involved in the development of the P • Members involved in implementation will have opportunities to will ultimately be in agreement regarding charters
ntermediate results: mber of Plans of Care developed during pregnancy mber of Plans of Care developed in hospital prior to discharge st-partum individual is actively engaged in developing the plan. s active for a year post-delivery. mber of Birthing hospitals that have policies for development and maintenance of Plans of Care ograms have policies in place that support the development and maintenance of Plans of Care utilized to support Plans of Care les in place to require notification by healthcare providers notification portal ebsite containing CARA resources for professionals and families is developed and implemented	• Increased number of notifications indicate a Plan of Care was c to delivery (consider modifying Notification form to include que plan developed prenatally • Increased number of notifications indicate a Plan of Care was c hospital prior to discharge • The following two Nurture Oregon pilot assessment questions wil pilot sites: who do families want to take the lead on developing and Who do families request to participate in the development Care? • Plan of Care forms (1394) available in ORKIDS capture increase pregnant/post-partum individuals engaged in developing the P • The answer to the following Nurture Oregon pilot assessment qu Plans of Care remain active for a year: When does ongoing rev Care occur? • The Oregon Perinatal Collaborative list serve will be used to con hospitals have policies/protocols in place for the development • Survey SUD treatment programs to determine strengths and cha associated with their Plan of Care procedures and/or process • Plan of Care forms (1394) available in ORKIDS capture increase Mentors participate and/or provide support • Requirements for healthcare providers have been established • Notification portal is operable • Families and professionals can access CARA resources and info website

long-term results	
er of substance affected infants in foster care on of child welfare intervention with substance affected infants and their families rrence of maltreatment rate among families with a Plan of Care er of reports of maltreatment on substance affected infants er of referrals assigned to CPS involving substance affected infants e perceived as a supportive, not a punitive response, that is: preventive, destigmatizing and e are consistently connected to a health care provider and receive post-partum follow up mber of missed pediatric appointments for substance affected infants e shared with all providers working with the family and ethnic disparate outcomes for substance affected infants, including mortality rates and ethnic disparities in maternal mortality rates for pregnant people with a prenatal Plan of rofessionals experience increased job satisfaction and decreased turnover f Plans of Care results in healthier communities	• Pull ORKIDS data - number of substance affected infants placed • Pull ORKIDS data - number of months cases involving substance remain open for in home or foster care services • Pull ORKIDS, ORRAI, data from Nurture Oregon pilot – number o had a Plan of Care developed that are founded for CA/N for a within 12 months of an original substantiated report of maltreatr • Pull ORKIDS data - number of reports received by ORCAH regar affected infants • Stigma training self-report pre/post survey's reflect increased un how SUD related stigma poses a barrier to better outcomes (1 y check Plan of Care survey pediatric/parent survey) • Medicaid claims – number of pregnant people with SUD who a care AND SUD tx during prenatal period • Medicaid claims – number of pregnant people with SUD who p follow up care appointments post partum • Medicaid claims – number of substance affected infants that p natal follow up care appointments. • 1 year well child check Plan of Care pediatric and parent surve • OHA, vital stats data, March of Dimes data to track race/ethnic infant/maternal fatalities in OR • Consider feedback from child welfare exit interviews

employ equitable, innovative and data informed strategies for systemic change.

Supporting families and promoting prevention	Enhancing our staff and infrastructure	Enhancing the structure of our system by using data with continuous quality improvement
• Trauma-informed approach • Seek diverse perspectives and prioritize cultural responsiveness • Promote a culture of safety • Strength-based system improvement recommendations focused on better outcomes for children and families • Engagement with community to listen and focus on being more responsive to the needs of families • Honor children who lost their lives, value the voices of families through the staff who serve them • Multi-generational approach to address factors that contribute to safety concerns and the cycles of child maltreatment • Outreach and engagement with community to find resources where families naturally go when needing assistance • Collaborating with early support services with small interventions: *engaging ODHS contracted nurses, ART/FIT, funding for safe sleep options; providing education; father's groups* • Addressing the individual needs of each family, providing appropriate services through a Plan of Care	• Committed to equity, inclusion, accessibility, transparency and diversity in recruitment and building of the CFPRP program • Committed to a strong anti-racism approach, including utilization of an anti-racism tool • Recognize the importance and the struggle in dismantling systemic racism • Unlearn behavior that has oppressed people of color in a white supremacist culture • Create a culture of psychological safety that values and enhances individual, team and system well-being • High, clear expectations and accountability for our work • Regularly practice the 6 habits of a healthy team: *1. Spend time identifying what could go wrong* *2. Talk about mistakes and ways to learn from them* *3. Test change in everyday work activities* *4. Develop an understanding of who knows what and communicate clearly* *5. Appreciate colleagues and their unique skills* *6. Make candor and respect a precondition to teamwork* • Respect and empower staff as the experts in child safety and support their expertise • Develop culture carriers to expand on creating a safety culture within child welfare	• Identify opportunities for education, procedural guidance, policies, and prevention strategies through intentional data gathered from fatalities, near fatalities, and serious physical injuries • Complete human factor debriefs which help identify system improvement opportunities • Use of accurate and relevant data to support system improvement strategies • Use of the Safe Systems Improvement Tool (SSIT) to gather aggregate data, develop reports and holistically understand the child welfare system to help steer larger system improvement recommendations • Utilize existing data in comparison with statewide and localized case practice trends to focus on information that supports key goals. Existing data reports reviewed on a regular basis include: r*ecurrence of maltreatment, foster care re-entry, CFSR, CPS & Permanency Fidelity Reviews* • Enhancement of CIRT process by using post CIRT surveys to evaluate and improve our process

Leveraging Relationships

The Child Fatality Prevention and Review Program has focused on building and strengthening relationships with community partners and ODHS partners. The relationships have focused on equity, transparency, collaboration, and supporting families without the involvement of the child welfare system. Some of the partnerships include:

- Domestic Violence & Sexual Assault Coordinators and Domestic Violence and Sexual Assault Coalition
- Oregon Parenting Education Collaborative
- Oregon Health Authority
- County child fatality review teams and the State medical examiner's office
- Self-Sufficiency

RESOURCE AND SYSTEM IMPROVEMENT PLAN

Note: This document is regularly updated to reflect the current status of the plan

Child Death Review

Plan Contents

I. Context

The resources and system improvements outlined in this document were developed by the State Child Death Review and Prevention Team (state team) to address the needs identified by Oregon's county child death review teams (county teams) through participation in a county team needs assessment.

II. Resources

Resource	Done
Model job and task descriptions for County Team Lead and Coordinator	In process
Implement onboarding process for new team leads and coordinators.	In process
Onboarding packet and/or checklist for new county team members	
Set up role specific peer groups for (1) leads and coordinators and (2) based on team member professional role to: • share information about roles and responsibilities across counties • support onboarding of new members • provide peer support	
Procedural guide for preparing for and conducting child death review • Procedure for assigning and creating cases. Done. • NCFRP guidance posted on website. Done • Add guidance about required reviews and contacting technical assistance if case does not meet criteria. • Add guidance on data quality/consistency controls. • Explore video of mock review. • Develop and post model protocol template.	In process

Information sharing and confidentiality quality practices and tools • Post confidentiality statutes on website. Done • Post links to major hospitals record request forms in toolkit on website.	In process
Training in multiple modalities • Post link to NCFRP trainings on website. Done • Create training calendar on website. Done but maintenance needs to be staffed • Consider accessibility and unique needs of audiences when rolling out trainings.	In process
Trauma informed death review tools, training, and support • Designate section of in toolkit on website for trauma informed resources. Done • Post breathing exercise in toolkit on website. Done • Ensure link to Trauma Informed Oregon is on website. Done • Link to NCFRP trauma informed resources on website. Done	Done
Equitable death review tools, training, and support • Designate section in toolkit on website for equity resources. Done • Post grounding statement in toolkit on website. • Link to NCFRP trainings on website. Done • Add team exercise for addressing equity in death review. • Post resources in toolkit on website focused on equitable death review, including specific to American Indian and Alaska Native communities. Done	In process
Resources to support prevention efforts identified most by county teams • Acknowledge counties that complete prevention efforts. Ongoing • Discuss and document the state team response to all prevention recommendations documented in the case reporting system. Ongoing	Done

• Follow through with documented state team response. Ongoing	
Create opportunities for county team members to observe other county reviews • Post county contact information on website. Done • Send a communication to county teams encouraging cross participation. • Encourage connection through peer support groups.	In process
Create opportunities to participate in state team meetings	Done
Virtual one-on-one or group support for county team members • State Technical Assistance Team member to offer support to county teams. Ongoing • Contact information for technical assistance detailed on website. Done	Done
State team contact assigned to each county team to provide support.	Done

III. System enhancements

Enhancement	Done
Re-develop OHA hosted Child Death Review and Prevention website to be a comprehensive resource hub for Oregon child death review, including connecting to National Center for Child Fatality Review and Prevention resources.	Done
Improve the data import from the State of Oregon Vital Statistics to the National Fatality Review Case Reporting System.	In process
Increase frequency of notifications to county teams regarding cases needing review.	In process
Make current contact list of county team leads and coordinators to county team leads accessible to county teams.	Done

Set up role specific peer groups for (1) leads and coordinators and (2) based on team member professional role to: ○ share information about roles and responsibilities across counties ○ support onboarding of new members ○ provide peer support	
Encourage and support county teams to convene regular meetings outside of case review to provide opportunities for learning, information sharing, and communication.	Done
Improve collaboration with and access to state level experts for consultation and support such as suicide, sleep related infant death, and overdose experts.	In process
Host annual statewide convening of county teams.	
Form implementation team comprised of community members and legislators for the purpose of implementing statewide improvement opportunities and prevention recommendations.	
Revise focus of state team to providing support to county teams, using county team death review data to identify patterns and opportunities for reducing preventable child deaths statewide, and providing information and recommendations to an implementation team. Clarify state team's role in Oregon's child death review and prevention system through creation of a state team charter.	Done

aboration

Shared primary, secondary and tertiary prevention:

Comprehensive Addiction and Recovery Act
Safe sleep
State Child Fatality Review Team
Suicide prevention
Family Connects
Home visiting nurses
Substance use
Title V
Gun safety
Near fatalities
Project Nurture
FASD
NAS
Death review
Injury prevention
Mental health
EHDI

HA, Public Health
on served: Children, young adults, adults

ODHS, Child W
Population served
young adults, f

Equity, protective factors, social determinants of health, safety culture, ACEs, trauma informed,

Critical Incident Review Team (CIRT) FAQ

What is a CIRT?

The CIRT is a team assigned by the ODHS Director to conduct the executive review of an incident that resulted in a child fatality when maltreatment is suspected and criteria are met related to contact with Child Welfare, as outlined in ORS 418.806 to 418.816 and OAR Chapter 013, Division 017.

What is the purpose of a CIRT?

- To convene a team to evaluate and learn from cases designated as critical incidents
- To increase the Department's ability to address and recommend necessary changes to systems

What are the criteria for a CIRT assignment?

The Department reasonably believes the death was the result of child abuse ***and*** the deceased child was in the custody of the Department at the time of the fatality ***or*** the deceased child, the deceased child's sibling, or any other child living in the household with the deceased child:

- was the subject of a CPS assessment within the 12 months preceding the fatality ***or***
- had a pending child welfare or adoption case with the Department within the 12 months preceding the fatality ***or***
- was the subject of a report of abuse made to the department within the 12 months preceding the fatality

How is the local office informed of a CIRT being assigned?

- When the Department is informed through the Sensitive Issue Report procedure (Chapter 1, Section 4) that a child fatality occurs and the fatality appears to meet criteria for a CIRT, the Child Fatality Prevention and Review Program manager will be in contact with leadership for the district in which the critical incident and/or fatality occurred.
- The CIRT Coordinator will attend the 3-day Fatality Staffing, per the fatality protocol, to listen to the information shared about the circumstances surrounding the fatality and provide introductory information regarding the CIRT process should the case meet criteria.
- After the 3-day Fatality Staffing and once the ODHS Director assigns the CIRT, the CIRT Coordinator from the Child Fatality Prevention and Review Program will be in contact with leadership, informing them of the assignment and providing an outline of next steps.

Who attends the CIRT meeting(s)?

The CIRT law requires certain members and allows for others at the discretion of the ODHS Director. There are a number of standing CIRT members, including the ODHS Director, Child Welfare Deputy Director, ODHS Communications representative, ODHS Tribal Affairs (if applicable), Central Office Program Managers, Oregon Child Abuse Hotline Continuous Quality Improvement Manager, as well as

consultants and coordinators. In each case the local office leadership is also asked to participate. The CFPRP encourages local office leadership to consider including caseworkers who were involved in decision making on the case to participate in the CIRT process.

In addition to the typical participants, depending on the specific circumstances, a CIRT may include ODHS subject matter experts (e.g., Alcohol and Drug coordinator, Domestic and Sexual Violence coordinator, or Suicide Prevention coordinator), ODHS Self Sufficiency Program, or external partners with specific information related to the family or the larger family serving system (e.g., law enforcement, medical providers, or service providers).

What is the timeline associated with a CIRT?

The CIRT Final Report is required to be submitted to the Department no later than the 100th day following the CIRT assignment. Local office leadership is asked to complete the CPS assessment within 90 days to ensure that all available information can be included in the CIRT Final Report.

What is available to the public regarding a CIRT?

The Department is required to immediately post information about the critical incident on the Department's public website. This includes:

- The date of the critical incident
- Age of the deceased child
- Whether the child was in the custody of the Department at the time of the critical incident or fatality
- Whether there was an open CPS assessment regarding the child at the time of the critical incident or the fatality
- The date the Department assigned the CIRT
- The due date for the CIRT's final report

In addition, the Department is required to share the CIRT Final Report on the Department's public website. This report includes non-identifying information regarding the critical incident, the fatality and the family's relevant Oregon Child Welfare history.

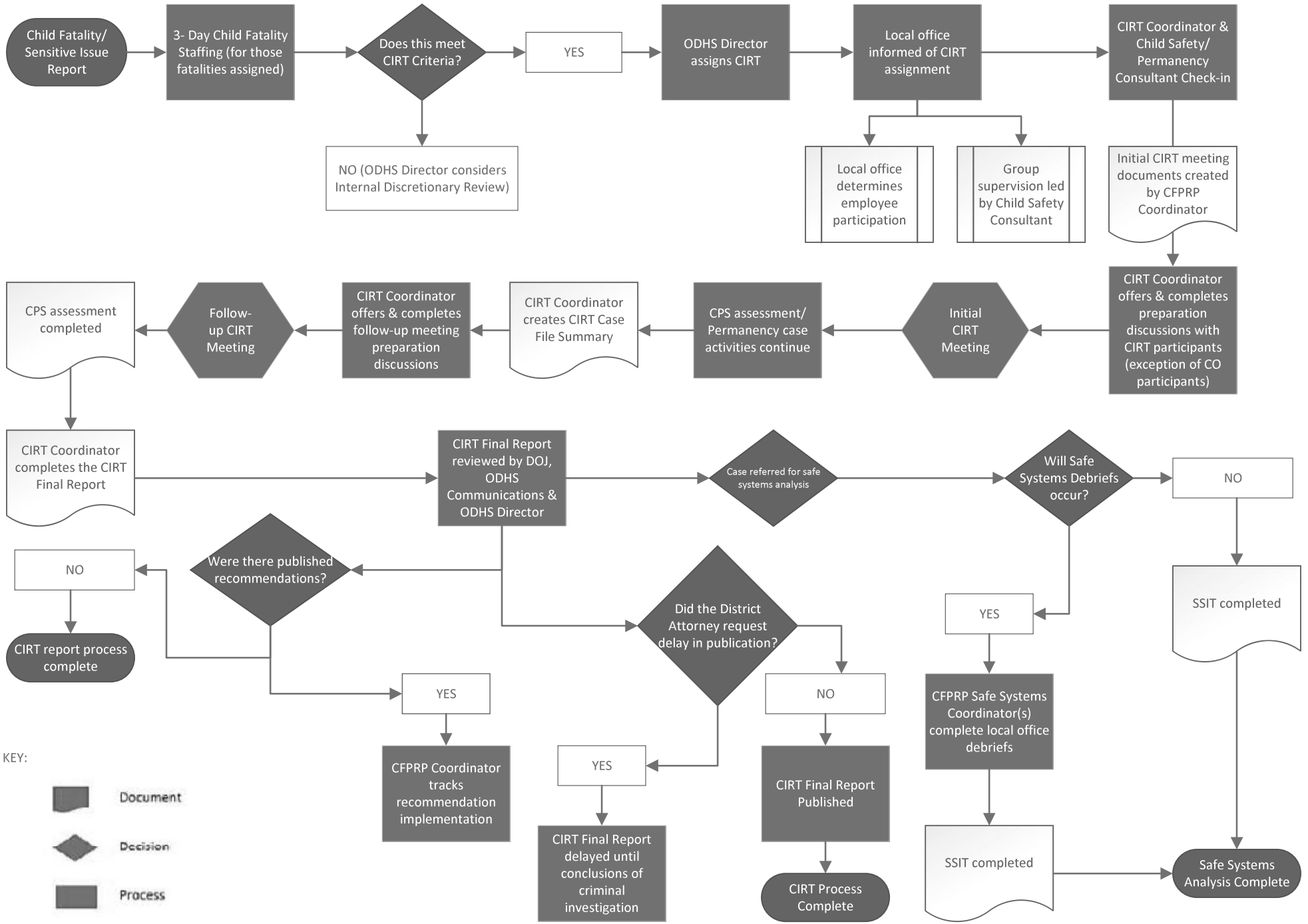
What is a Discretionary Review?

During 2021, the CFPRP began facilitating Internal Discretionary Reviews. An Internal Discretionary Review is convened by the ODHS Director when Child Welfare becomes aware of a fatality, near fatality, or other serious incident involving a family that has had contact with ODHS and the incident does not meet the criteria for a critical incident review team (CIRT) however an opportunity for system learning has been identified. The reviews are called by the ODHS Director to analyze ODHS actions in relation to the incident and to ensure the safety and well-being of all children being served by Child Welfare.

All the work surrounding the Internal Discretionary Review, such as engaging and preparing participants, facilitating meetings, partnering with other child welfare programs to conduct case reviews, and tracking data, is the responsibility of the CFPRP.

For more information, contact the Child Fatality Prevention and Review Program at cw.prevention@dhsoha.state.or.us.

CIRT Process Map



National Partnership for Child Safety (NPCS)

Data Dictionary

Critical Incident Review (CIR) Core Data Dictionary with Safe Systems Improvement Tool and Codebook

Scope of Document: This data dictionary contains the core child, family, and critical-incident specific items as well as systems-level data (i.e., Safe Systems Improvement Tool) collected by the NPCS jurisdictions. Coding for each variable is also integrated into this document, for data entry purposes.

> The National Partnership for Child Safety strategically does not establish minimum critical incident (e.g., child death) standards for inclusion into the Partnership's shared dataset. Instead, Partnership jurisdictions agree to share the core data (as identified in the table below) whenever the jurisdiction completes a systems-focused critical incident review, per the jurisdiction's internal policy. This is generally, at minimum, any time the jurisdiction had open child welfare involvement at the time a child experiences a maltreatment death.
>
> Through sharing data, Partnership jurisdictions aim to: 1) learn about their unique child-serving system and improvement opportunities, 2) gain insight across jurisdictions to further support improvement efforts, and 3) identify large-scale quality improvement activities the Partnership can inclusively address.

Important Definitions for Understanding the Document:

- Alleged Perpetrator: the person alleged to have committed child maltreatment who is evaluated (e.g., investigated, assessed) by the child welfare agency; sometimes referred to as the alleged maltreater or subject
- Caregiver: the adult(s) living in the household who is legally obligated and entitled to provide for the safety and well-being of the child
- Household: a group of people who have frequent contact with the child leading up to the time of the critical incident. A household member is defined as any individual, regardless of age, who resides in or spends substantial time in the home. Substantial time is defined as a pattern of behavior in spending time within the residence, even if not overnight. If any known household member (e.g., child) identifies another person as a household member (e.g., significant other), then this person is included. This includes, but is not limited to the following: a non-resident parent who visits the home; relatives, significant

others, college students, and/or other individuals who stay overnight in the home; or an individual who routinely babysits in the home and/or otherwise assumes some degree of caregiving responsibility in the home for any child in that home.

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
Child Specific:			
Child's Age Range	Age range at time of critical incident. If unavailable, age range as identified in available child welfare records.	**Categorical—single selection** 0-30 days (1) 1-11 months (2) 1-18+ years (3)	
Age	Age at time of critical incident. If unavailable, age as identified in available child welfare records.	**Value—single selection** Days: 0-30 --OR-- Months: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 --OR-- Years: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18+ --OR-- Unknown (leave blank)	
Gender	The child's gender as identified in child welfare records. If none is available, as identified in available death certificate or other medical documentation.	**Categorical—single selection** Female (1) Male (2) Other: specify (3) [narrative] Unknown (4)	
Race	Race of child as identified in death certificate or other medical documentation. If neither is available, race as identified in available child welfare records. *If child is Arab, select White.*	**Categorical—multiple selections** American Indian (1) Tribal affiliation: Yes (1); No (2) If yes, specify: [narrative] Alaskan Native (2) Asian (3) Black or African American (4) Native Hawaiian or other Pacific Islander (5) White (6) Unknown (7) Declined to answer (8)	

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
Ethnicity	Ethnicity of child as identified in death certificate or other medical documentation. If neither is available, ethnicity as identified in available child welfare records.	**Categorical—multiple selections** Caribbean (1) Chinese (2) Haitian (3) Hispanic or Latino/a origin (4) [additional specifier] Indian (5) Japanese (6) Korean (7) Native African (8) Non-Hispanic or Latino/a origin (9) Other – Black or African American (10) Other – Asian (11) Unknown (12) Declined to answer (13)	**Additional specifier: If Hispanic or Latino/a, please further specify, if known: (multiple selections)** Central American (1) Caribbean (2) Cuban (3) Dominican (4) Mexican (5) North American (6) Puerto Rican (7) South American (8) Other (9) Unknown (10)
Living Arrangement	The environment in which a child was primarily residing at the time of the critical incident. This may not be the place where the critical incident occurred.	**Categorical—single selection** Adoptive Home (1) Birth Family's (mother's and father's) home (2) Birth Father's home (3) Birth Mother's home (4) Child at Hospital From Birth (5) Congregate Care (6) Juvenile Detention (7) Kinship Foster Home (8) Non-relative Foster Home (9) Relative's home (10) Other: Specify (11) [narrative] Unknown (12)	**Additional specifier: Was this location where the critical incident occurred?** Yes (1) No (0) **Additional specifier: Was this is the place where the child's physical custody was held?** Yes (1) No* (2) Unknown (3) Not applicable (4) ***If no, where was the child's physical custody held? [narrative]**
Substance-Exposed Newborn	Identification of any prescribed or unprescribed, in-utero, substance-exposure in the child or mother's medical records (e.g.,	**Multiple—single selection** Yes (1) No (2)	**If yes, then Additional specifiers:**

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
	Neonatal Abstinence Syndrome diagnosis, positive prenatal drug screen), including alcohol. If medical records are unavailable, prenatal drug-exposure as identified in child welfare records (e.g., self-admission).	Unknown (3)	• **Was the child diagnosed as substance-affected (e.g., Fetal Alcohol Syndrome, Neonatal Abstinence Syndrome)?** Yes (1) No (0) • **What type of drug was the child exposed to (multiple selections)?** Alcohol (1) Barbiturates (2) Benzodiazepines (3) Methamphetamine (4) Narcotics (5) Tobacco (6) THC (7) Opiates (8) Other: Specify (9) [narrative] Unknown (10)
Custody Status	Identifies the relationship of the entity/person with legal custody (permanent or temporary) at the time of the critical incident. Court records are used as the source of information for this variable whenever possible. Otherwise, general child welfare records are used.	**Categorical—multiple selections** Birth Parents (1) Father (2) Fictive Kin (3) Mother (4) Relative (5) State/Child Welfare Agency (6) Other: Specify (7) [narrative] Unknown (8)	
Critical Incident Specific:			

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
Date of Critical Incident	Date the alleged maltreatment related to the critical incident occurred.	**Date (MM/DD/YYYY)** --OR— Unknown	
Critical Incident Type	The category of critical incident that occurred. If the critical incident led to death, the appropriate category is death. Serious physical injury is defined under CAPTA as bodily injury which involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty. Examples are liver lacerations, multiple fractures, near drowning/lack of oxygen to the brain, and severe malnourishment. Near deaths are generally defined by local statute but may encompass those defined by CAPTA as serious physical injuries. If the critical incident met the jurisdiction's criteria of near death, the appropriate selection is near death. The following definition of a near death is recommended: *life-threatening cardiopulmonary dysfunction directly attributable to conditions resulting from suspected abuse or neglect as evidenced by (a) respiratory insufficiency/failure requiring intubation and mechanical ventilation, (b) respiratory insufficiency/failure requiring medications to reverse effects of toxic*	**Categorical—single selection** Death (1) Near Death (2) Serious Physical Injury (3) Other: Specify (4) [narrative]	**Additional specifier for near deaths:** **Does this critical incident meet the NPCS recommended definition of a near death?** Yes (1) No (2)

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
	ingestion, or (c) cardiac arrhythmia with or without cardiopulmonary resuscitation (CPR).		
Date of Death	Date of the child's death, as identified on the death certificate. If not available, date of death as identified in the autopsy or relevant medical records. If none are available, date of death as identified in child welfare records.	**Date (MM/DD/YYYY)** --OR— Not Applicable	
Number of Alleged Perpetrators	Number of perpetrators alleged to have committed any maltreatment contributory to the critical incident, including unknown perpetrators and a perpetrator-by-omission. This variable is specific to those alleged to have committed maltreatment of the subject child (i.e., child who experienced the critical incident).	**Value—single selection** 1 2 3 4 5+	
Gender of Alleged Perpetrators	Gender as reported in child welfare records.	**Categorical—multiple selection** Female (1) Male (2) Other: specify (3) [narrative] Unknown (4)	
Relationship of Alleged Perpetrator(s) to Child	Of those alleged to have committed maltreatment contributory to the critical incident, identify the relationship of the alleged perpetrator(s) to child.	**Categorical—multiple selections** Adoptive Parent (1) Babysitter (2) Child Daycare Provider: Licensed (3) Child Daycare Provider: Unlicensed (4) Congregate Care or Residential/Institutional Facility Staff (5) Foster Sibling (6) Kinship Foster Care: Licensed (7) Kinship Foster Care: Unlicensed (8) Non-kinship Foster Care: Licensed (9) Non-kinship Foster Care: Unlicensed (10) Parent (11) Parent's Partner (12)	

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
		Parent's Former Partner (13) Relative: Grandparent (14) Relative: Aunt/Uncle (15) Relative: Sibling (16) Relative: Other (17) Stepparent (18) Other: Specify (e.g., guardian, non-caregiver, medical personnel) (19) Unknown (20)	
Alleged Perpetrator Prior History of Substantiated Maltreatment	Identifies if there was a previous known child welfare substantiation of any alleged perpetrator	**Binary—single selection** Yes (1) No (2) Unknown (3)	**Additional Specifier: If yes, was the Alleged Perpetrator a Caregiver for the current critical incident being reported?** Yes (1) No (0)
Number of Maltreatment Types	The child welfare/child protection system's official maltreatment allegations surrounding the critical incident. This variable specifically refers to the allegations identified within the initial report (e.g., hotline call) or otherwise identified during the course of involvement with the family. Multiple alleged perpetrators may be identified for a single maltreatment type. County the number of distinct maltreatment types, not alleged perpetrators, in answering this question.	**Value – Single Selection** 1 2 3 4 5+	
Maltreatment Type	The child welfare/child protection system's official maltreatment allegations surrounding the critical incident. This variable specifically refers to the allegations identified within the initial report (e.g., hotline call) or otherwise identified during the course of involvement with the family. If there are multiple allegations, select all that apply.	**Categorical—Multiple selections** Emotional/Psychological Abuse (1) Neglect (2) Physical Abuse (3) Sexual Abuse (4) Other: Specify (e.g., Threat/Risk of Harm) (5)	**Additional Specifier:** Open Textbox for sub-specifying maltreatment allegation

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
Maltreatment Determination	The child welfare/child protection system's official determination regarding maltreatment allegations surrounding the critical incident. This variable specifically refers to the allegations identified within the initial report (e.g., hotline call) or otherwise identified during the course of involvement with the family. Please indicate the appropriate selection(s) for each maltreatment category chosen within Maltreatment Type.	**Categorical—Multiple selections** Substantiated (1) Unsubstantiated (2) Unsubstantiated with Concerns (3) Pending (4) Closed without Maltreatment Determination (5) Not Applicable (6)	
Manner of Death	Manner of Death as best identified from child welfare records. If an autopsy or death certificate is available, it is reasonable to use this as a primary source for this determination. If none are available, the response option "unknown" is appropriate.	**Categorical—single selection** Accident (1) Homicide (2) Natural (3) Suicide (4) Undetermined (5) Unknown (6) Pending (7) Other (8)	
Cause of Critical Incident	If the critical incident involves death, this variable records the cause of death as identified in the death certificate or autopsy. If a death certificate or autopsy is not available, medical records about the death may be used. If the critical incident is not a death and/or medical records are unavailable, this variable records the cause of critical incident as identified in child welfare records.	**Categorical-- Multiple selections** Accidental Choking (1) Acute Life Threatening Event (2) Asphyxia (not SUID) (3) Burns (4) Drowning (5) Emotional Abuse/Psychological Harm (6) Injury from Fall (7) Injury from Firearm (8) Medical (9) Medical Neglect (10) Motor Vehicle Accident (11) Natural (12) Nutritional Neglect (13) Physical Abuse (14) Poisoning/Overdose (15)	**Additional Specifier: How was Cause of Critical Incident decided?** *Categorical—single selection:* Autopsy (1) death certificate (2) other medical records (3) child welfare records (4) **Additional Specifier: If the critical incident was not a death, was the cause of the critical incident self-inflicted?** Yes (1)

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
		Sexual Abuse (16) Sudden Unexpected Infant Death (SUID) (17) Other: Specify (18) Undetermined (19)	No (2) Unknown (3) **Additional Specifier: If SUID, was the death either:** SIDS (1) ASSB (2)
Unsafe Sleep	Infant was placed in near proximity to one or more persons, on the same sleep surface, when found unresponsive, or Infant was sleeping on a surface other than one specifically designed for safe infant sleep* when found unresponsive, or Infant was found unresponsive on bedding softer than a firm crib mattress and/or near pillow, blankets, comforter, waterbed, sheepskin, etc. (*CPSC approved).	**Categorical—single selection** Yes (1) No (2) Not Applicable: Child was 1+ years at time of the critical incident. (3)	
Family Specific:			
Number of Caregivers	the adult(s) living in the household who is legally obligated and entitled to provide for the safety and well-being of the child	**Value—single selection:** 1 2	
Caregivers' Age(s)	Caregiver(s)' age as of the date of the critical incident	**Value – open field** open field for age in years --or— Unknown (enter unknown)	**Additional specifier: Is the caregiver the alleged perpetrator/maltreater?** Yes (1) No (0) • **If no, what was the age of the alleged maltreater(s)?**

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
			open field for age in years – or – unknown (enter unknown) **Additional specifier: What was the relationship of the caregiver(s) to the child?** *(single selection)* 1, Adoptive Parent 2, Congregate Care or Residential/Institutional Facility Staff 3, Kinship Foster Care: Licensed 4, Kinship Foster Care: Unlicensed 5, Non-kinship Foster Care: Licensed 6, Non-kinship Foster Care: Unlicensed 7, Parent 8, Parent's Partner 9, Parent's Former Partner 10, Relative: Grandparent 11, Relative: Aunt/Uncle 12, Relative: Sibling 13, Relative: Other 14, Stepparent 15, Other 16, Unknown

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
Open Child Welfare Services or Involvement (CWI) on Household	Identifies if there was any kind of open child welfare involvement, such as an intake, case, assessment, investigation, or screening with the household at the time of the critical incident. This includes child abuse and neglect referrals that did not meet criteria to be screened-in, if known. Child welfare is broadly defined as any type of internal involvement with the following systems: child protection, home-based, foster care, juvenile justice, family preservation, and/or any multi-response child protection involvement.	**Categorical—Multiple selections** Family Preservation/In-home/Ongoing (1) Foster Care (2) Intake/Assessment (3) Investigation (4) Juvenile Justice (5) Other: Specify (e.g., subsidized adoptive home) (6) None (7)	**Additional Specifier: Was the child a named member in that services or involvement?** Yes (1) No (0)
History of Household Child Welfare Services or Involvement	Identifies if there was any kind of historical child welfare involvement, such as an intake, case, assessment, investigation or screening with the household within three years of the critical incident. This includes child abuse and neglect referrals that did not meet criteria to be screened-in, if known. Child welfare is broadly defined as any type of internal involvement with the following systems: child protection, home-based, foster care, juvenile justice, family preservation, and/or any multi-response child protection involvement.	**Categorical—Multiple selections** Family Preservation/In-home/Ongoing (1) Foster Care (2) Intake/Assessment (3) Investigation (4) Juvenile Justice (5) Screened Out Hotline Report (6) Other: Specify (e.g., subsidized adoptive home) (7) None (8)	**Additional Specifier: Was the child a named member in that services or involvement?** Yes (1) No (0)
Caregiver Intimate Partner Violence History	A pattern of coercive tactics-- which can include physical, sexual, economic, psychological, and emotional abuse—that an intimate partner uses with the goal of gaining and maintaining power and	**Categorical—Multiple selections** Known in Relationship at Time of Critical Incident as Aggressor (1) History of Intimate Partner Violence as Aggressor (within 5 years) (2)	

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
	control. The intimate partner does not have to live in the household.	History of Intimate Partner Violence as Aggressor (5+ years ago) (3) Known in Relationship at Time of Critical Incident as Survivor (4) History of Intimate Partner Violence as Survivor (within 5 years) (5) History of Intimate Partner Violence as Survivor (5+ years ago) (6) None (7) Unknown (8)	
Caregiver Prior History of Substantiated Maltreatment	Identifies if there was a previous known child welfare substantiation of caregiver(s)	**Binary—single selection** Yes (1) No (0)	
Previous Child Fatality in Household	Identifies if a previous child fatality is known to have ever occurred in the household	**Binary—single selection** Yes (1) No (0)	**Additional Specifier: Was child welfare involved as a result of this fatality?** Yes (1) No (0) **(if Yes to above), Was any maltreatment determined to be present at the time of the fatality?** Yes (1) No (0)
Household's Last Involvement with Child Welfare Agency (CWA)	Date of closure for the last known child welfare involvement, such as an intake, case, assessment, investigation or screening with the	**Date – open field** MM/DD/YYYY --OR—	

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
	household *within three years of the critical incident.* This includes screened out child abuse and neglect hotline referrals, if known. Child welfare is broadly defined as any type of internal involvement with the following systems: child protection, home-based, foster care, juvenile justice, family preservation, and/or any multi-response child protection involvement.	Open Involvement --OR-- Not Applicable	
Safe Systems Improvement Tool ***See 2021 NPCS Safe Systems Improvement Tool Reference Guide for explanation of response options***			
List of Improvement Opportunities	Actions or inactions in the case under review either relevant to the outcome (e.g., a child dies abusively at the hands of a caregiver unassessed by the child welfare agency prior to the death) or an important industry standard (e.g., meeting response timeframes for assessing an alleged victim, speaking to collaterals). From a value perspective, Improvement Opportunities identify the case-level gap between what the family and/or child needed in contrast to what the family and/or child received.	**Open Textboxes for up to 10 Improvement Opportunities**	
Family Conflict	This item refers to how much fighting and arguing occurred between family members. Domestic violence refers to physical fighting in which family members might get hurt.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Development (Caregiver)	This item refers to developmental disabilities including autism and intellectual disabilities.	**Ordinal – single selection:** 0	**Additional Specifier:**

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
		1 2 3	If selection is 2 or 3, please justify the rating: *open field*
Mental Health (Caregiver)	This item refers to mental health needs only (not substance abuse). A formal mental health diagnosis is not required to rate this item. Note: Mental Health Disorders would be rated '2' or '3' unless the individual was in recovery.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Substance Use (Caregiver)	This item includes problems with alcohol, marijuana, illegal drugs and/or prescription drugs. Note: Substance-Related Disorders would be rated '2' or '3' unless the individual was in recovery.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Financial Resources (Caregiver)	This item rates the family's financial situation.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Parenting Behaviors (Caregiver)	This item rates the caregiving behaviors of the primary caregivers. The item rates if the caregiver gave developmentally-appropriate care and followed the care-based recommendations of professionals (e.g., physicians)	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Medical/Physical (Child/Youth)	This item is used to describe the child/youth's medical/physical health. Note: Most transient, treatable conditions would be rates as a '1'. Most chronic conditions (e.g., diabetes, severe asthma, HIV) would be rated a '2'. The rating '3' is reserved for life threatening medical conditions.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
Developmental/Intellectual (Child/Youth)	This item describes the child/youth's development as compared to standard developmental milestones, as well as rates the presence of any developmental (motor, social and speech) or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Mental Health (Child/Youth)	This item is used to describe the child/youth's mental health (not substance abuse or dependence). A formal mental health diagnosis is not required to score this item.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Bias	A faulty understanding of a situation due to inherent predisposition(s) (e.g., confirmation bias, cognitive fixation, focusing effect, transference).	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Stress	Psychological strain or tension resulting from adverse or demanding circumstances. Professionals express or exhibit difficulty managing the strains of casework and/or other life circumstances (e.g., divorce).	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Fatigue	Extreme tiredness as a result of casework and/or other life circumstances (e.g., single parent, personal illness).	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
Knowledge Base	An absence of knowledge or difficulty activating knowledge (i.e., putting knowledge into practice).	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Documentation	Absent or ineffective official, internal records.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Evidence	Difficulties in obtaining and/or synthesizing (i.e., summarizing; combining multiple pieces of information into a coherent holistic assessment) externally-sourced information (e.g., medical records, criminal records, statements from key members, formal assessments).	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Teamwork/Coordination	Ineffective collaboration between two or more internal and/or external entities (e.g., agencies, people and teams). Notably, this item does not encompass the family's willingness or cooperation but rather the team of family-serving professionals. Note: Ineffective teamwork between a supervisor and supervisee is captured under "Supervisory Support."	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Supervisory Support	Supervisor provides ineffective support, communication, teamwork, and/or is unavailable.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Supervisory Knowledge Transfer	Case direction from supervisor was inconsistent with best practice.	**Ordinal – single selection:** 0	**Additional Specifier:**

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
		1 2 3	If selection is 2 or 3, please justify the rating: *open field*
Production Pressure	Demands on professionals to increase efficiency. Note: This is distinctive from Demand Resource Mismatch (DRM) as Production Pressure describes pressures within casework (e.g., overdues, extensive court involvement, child removals in other assigned cases). Though not exclusively, the presence of DRM may impact the presence of Production Pressures.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Demand-Resource Mismatch	A lack of internal resources or programs (e.g., inadequate staffing, limited access to drug testing supplies, insufficient funding for services) to carry out safe work practices. Note: The absence of equipment/technology and external resources/programs are scored in separate items.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Practice Drift	A widely-accepted, often gradient, departure from work-as-prescribed. Practice Drift usually occurs as a result of experienced success and as a means of managing production pressures and/or complex interpersonal decisions. Practice Drift uniquely describes an environmental (e.g., system-wide, county-wide, office-wide) departure from work-as-prescribed and may involve a single or multiple child serving agencies.	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Policies	The absence, poor clarity, or ineffectiveness of a written practice or procedure. Conflicting policies would also be rated here, as well as	**Ordinal – single selection:** 0 1	**Additional Specifier:**

Variable	Definition	Response Options with Coding in Parentheses:	Sub-specifiers:
	other written rules, statutes, and procedures detailing work-as-prescribed.	2 3	If selection is 2 or 3, please justify the rating: *open field*
Training	The absence, poor clarity, or ineffectiveness of formal instruction. This may include a variety of learning modalities, such as: web-based, classroom, independent study, formal mentoring or coaching, etc.)	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*
Service Array	The unavailability or ineffectiveness of a particular external and/or community-based service. These services include provider agencies as well as county and state child-service partners (e.g., school, court, law enforcement).	**Ordinal – single selection:** 0 1 2 3	**Additional Specifier:** If selection is 2 or 3, please justify the rating: *open field*

NATIONAL PARTNERSHIP FOR CHILD SAFETY

Partnership Activities Resource Guide

2023

Guide Created by: Center for Innovation in Population Health

NATIONAL PARTNERSHIP FOR CHILD SAFETY

Partnership Benefits

NPCS Membership Benefits:

Critical Incident Review technical support from the leading national experts on the applications of **safety science/safety culture to public child welfare work**, including:

- Skilled and Advanced Trainings and Practice Labs
- Peer-to-Peer and Affinity Groups for Community and QI work
- Critical Incident Review Process Development
- Coaching and Certification in the Safe Systems Improvement Tool -- *the most widely used tool for understanding critical incidents in child welfare*
- Policy Development Support
- Stakeholder Engagement and Communications Support
- Co-facilitation of High-Profile Reviews
- Data Analysis and Support
- Customized Database Creation and Management via REDCap

Support with **broader safety science/safety culture** paradigm work, such as:

- Annual Safety Culture Survey Administration and Data Analysis
- Coaching and curating a library of NPCS Spaced Education and Safety Notices
- Workforce Development and Implementation of the TeamFirst Field Guide for Safe, Reliable and Effective Child Welfare Teams

The Safe Systems Team, led by Dr. Michael Cull at University of Kentucky's Center for Innovation in Population Health, is the founding and lead technical support for the NPCS. With a national reputation and commitment to excellence, the Safe Systems Team organizes **peer-to-peer learning at executive and program levels**, leads **NPCS data analysis**, and customizes **site-specific work to meet every jurisdiction where they are at and personally respond to emerging needs**.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

Partnership Benefits

NPCS Membership Benefits:

Access and data-sharing to the **NPCS Data Warehouse** via the Michigan Public Health Institute (MPHI) and held at the nationally recognized National Center for Fatality Review and Prevention. The Partnership's data-sharing exists to improve child, family, and workforce-level outcomes by igniting and accelerating a **family-centered, workforce-informed, systems-focused approach to learning from critical incidents**.

Engagement with data expertise from those with **lived experience** in the child welfare system, via Spark Learning, led by Dr. April Allen. Spark Learning offers:

- Readiness Assessment for incorporation of constituent voice in critical incident review
- Coaching in the inclusion of constituent voice in critical incident review

Crisis Management and Communications Support from former White House Communications Director Jennifer Devlin, such as:

- Coaching and press-related technical assistance to individual partners to highlight local NPCS involvement and manage crisis communications after a high-profile critical incident
- Access to communications training, customized NPCS Communications Toolkits, Reframing Childhood Adversity Toolkit, press release and op-ed templates, and related resources

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Committees and Support Opportunities

Committees (bimonthly)

Executive Committee
Executive Advisory Group (nomination-only, closed invitation)
Data Sharing Workgroup
Data Advisory Group (nomination-only, closed invitation)
Communications Workgroup

Community Forums (varied cadence)

Systems-focused Critical Incident Review (SCIR) Peer Leader's Meeting
Safety Culture Survey Peer-to-Peer
Affinity Groups

Technical Assistance: Drop-in Office Hours

Safe Systems Drop-in with the UKY Team (biweekly)
Communications Drop-in with Jennifer Devlin (bimonthly)

Jurisdiction-specific TA scheduled upon request.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Recurring Learning Opportunities

Safe Systems Skilled Practitioner Courses (offered quarterly)

Safety Culture in Systems-Focused Critical Incident Review
Safe Systems Improvement Tool (SSIT)
Writing Meaningful Improvement Opportunities
Safe Systems Debriefing
Systems Mapping

Safe Systems Advanced Practitioner Courses (offered *at varied cadence*)

Writing Meaningful Improvement Opportunities: Practice Lab*
SSIT Train the Trainer
AWAKEN for Safe Systems Debriefing (3 session, cohort series)*
AWAKEN Alumni Skill-Building Lab*
AWAKEN Alumni Practice Lab*

Skill-Building Labs** are a no-prep-needed opportunity for a content refresher, deeper skill-building, and prepared activities. ***Practice Labs have very little (if any) teaching content. Pre-registered participants share redacted ongoing or completed case summaries, quarterly/annual reports or short scenarios in advance of the lab, and the Practice Lab orients around what participants have provided. *Note: In addition to participant redaction, UKY further removes potential identifiers of a jurisdiction -- giving everyone the safest space to learn. **AWAKEN for Safe Systems Debriefing** is the primary advanced practitioner course for experienced critical incident review teams across the Partnership to join together as a single cohort in highly experiential learning. Cohorts 1-5 are alumni teams from prior years; Cohorts 6, 7, 8, and 9 will convene this year.

All courses delivered by: UK Center for Innovation in Population Health

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Committees and Community Forums

Committees

Executive Committee

The Executive Committee meets for one hour every other month to maintain governance and foster collegiality and shared leadership across senior leaders in the Partnership. The Partnership is member-owned and member-directed, so this key governance approves major decisions and celebrates milestone achievements. Every agency within the Partnership has senior leadership representation on this committee.

Email Holly Merz for more Information about this group

Executive Advisory Group

New to 2023, the Executive Advisory Group is a nominated subgroup of leaders from the Executive Committee. This small team of leaders explores issues related to governance, sustainability and focus of the partnership in greater depth than is feasible with the larger Executive Committee. When decisions need to be made, they make recommendations to the Partnership's voting governance, the Executive Committee.

Email Holly Merz for more Information about this group

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Committees and Community Forums

Committees

Data Sharing Workgroup

The Data Sharing Workgroup meets for 90 minutes every other month to advance the collaboration, accessibility and quality of data-sharing with the Partnership. Technical support and peer-to-peer sharing are primary strategies within this workgroup. Every NPCS Team is asked to assign one teammate to the NPCS Data Sharing Workgroup, ideally a program leader or data analytic professional within the agency's internal critical incident review process.

Email Tiffany Lindsey for more information about this group.

Data Advisory Group

The Data Advisory Group is a nominated subgroup of leaders from the Data Sharing Workgroup. This small group of highly experienced critical incident reviewers and data analysts respond nimbly to data-sharing requests and opportunities to advance strong analytics within the Partnership's work.

Email Elizabeth Riley for more information about this group.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Committees and Community Forums

Committees

Communications Workgroup

The Communications Workgroup is comprised of public information officers and other staff directly involved in communications from every partner jurisdiction. The workgroup meets for 60 minutes every other month and focuses on media engagement, partnership communication, both nationally and locally, sharing of communication resources and peer learning.

The Partnership's past press releases and related news articles may be viewed here.

Email Holly Merz for more information about this group.

Communications Advisory Group

The Communications Advisory Workgroup is a subgroup of leaders from the Communications Workgroup. This small group helps to set meeting agendas and identify areas of focus, resources and peer learning opportunities for the larger Communications Workgroup.

Email Holly Merz for more Information about this group

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Committees and Community Forums

Community Forum

Systems-Focused Critical Incident Review Peer Leaders

Bimonthly meeting for critical incident review program leaders in jurisdictions with a fully implemented systems-review (e.g., use of the Safe Systems Improvement Tool) process to come together to discuss questions, issues, challenges, and to celebrate successes.

Thursday, February 23rd - 2:30 pm to 4:00 pm ET
Thursday, March 23rd - 2:30 pm to 4:00 pm ET
Thursday, April 27th - 2:30 pm to 4:00 pm ET
Thursday, May 25th - 2:30 pm to 4:00 pm ET
Thursday, June 22nd - 2:30 pm to 4:00 pm ET
Thursday, July 27th - 2:30 pm to 4:00 pm ET
Thursday, August 24th - 2:30 pm to 4:00 pm ET
Thursday, September 28th - 2:30 pm to 4:00 pm ET
Thursday, October 26th - 2:30 pm to 4:00 pm ET
Thursday, November 16th - 2:30 pm to 4:00 pm ET

Click the link to join or email a facilitator for the recurring meeting appointment

Facilitators:

Christina Rosato, MSSW
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

Tiffany Lindsey, EdD
(She/Her/Hers)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Committees and Community Forums

Community Forum

Safety Culture Survey Peer-to-Peer Meeting

The Safety Culture Survey Peer-to-Peer group meets to discuss best practices and innovations for using organizational assessment data to advance a safety culture within partner jurisdictions. The safety culture survey is an organizational assessment that measures aspects of a workforce culture, like psychological safety, emotional exhaustion, mindful organizing, and workplace connectedness. This group is comprised of jurisdiction members who have either done the safety culture survey in their agency or who are interested in doing the survey in the future.

This group meets from 11 am to12 pm EST on the 4th Thursday of the month. Dates for the 2023 series are:

Thursday, February 23
Thursday, March 23
Thursday, April 27
Thursday, May 25
Thursday, June 22
Thursday, July 27
Thursday, August 24
Thursday, September 28
Thursday, October 26
Thursday, November 30

Click the link to join or email a facilitator for the recurring meeting appointment

Facilitators:

Elizabeth Riley, PhD (She/Her/Hers)

Jordan Constantine, MA (He/Him/His)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Committees and Community Forums

Community Forum

Affinity Group*

Safely to their First Birthday:
Upstream Prevention and Compassionate, Equitable Screening, Safety Threat Identification, and Maltreatment Classification after Sudden Unexpected Infant Deaths (SUID)

This new affinity group focuses on:

- Upstream practices for a multi-factorial approach to infants safely reaching their first birthday with their families;
- Consistency in screening child abuse hotline calls on unexpected infant deaths;
- Consistency in identifying safety threats and making dispositional findings regarding and, in light of, an infant's unexpected death.

This affinity group began meeting last year, but Is still accepting participants

*Affinity groups provide a space for jurisdictions experiencing similar challenges to come together, learn, and generate solutions. Affinity groups have an ongoing, open invitation to all Partnership members, but all participants are asked to provide their agency's policies, campaigns, etc. as requested for the group's benefit.

Click the link to register for the Kick-Off Meeting on Mar 29, 2023 at 1:00pm ET

Facilitators:

Tiffany Lindsey, EdD
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Committees and Community Forums

Community Forum

Affinity Group*

Advancing Safety Science in the Workforce:

Integrating learning from Systems-Focused Critical Incident Reviews and Safety Culture Surveys to Implement new innovations through Workforce Development

This new affinity group will bring together critical incident review, safety culture survey and workforce development leaders to focus on:

- Integrating key learnings from SCIR data into workforce development efforts
- Developing strategies and workflows for integrating key learnings into existing agency training, such as new and experienced casework professionals training
- Curating and creating best practice learning resources
- Developing a curricula of adaptable spaced education on key learning topics for use by jurisdictions across the partnership

*Affinity groups provide a space for jurisdictions with shared experience to come together, learn, and generate innovative solutions. Affinity groups are open to partnership members at any time. Partnership jurisdictions are asked to share policies, campaigns, etc. with the group as requested for the benefit of all members

Click the link to register for the Interest Call on Feb 27, 2023 at 1:00pm

Facilitators:

Jordan Constantine, MA
(He/Him/His)

Elizabeth N. Riley, PhD
(She/Her/Hers)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Learning and Development Opportunities

Technical Assistance

Safe Systems Drop-in UKY Office Hours

Offered twice monthly for all leaders and practitioners to check in with Tiffany and Jordan for any technical support needs.

Monday, February 13th - 3:00 pm to 4:00 pm ET
Friday, February 24th - 11:00 am to 12:00 pm ET
Monday, March 13th - 3:00 pm to 4:00 pm ET
Friday, March 24th - 11:00 am to 12:00 pm ET
Monday, April 10th - 3:00 pm to 4:00 pm ET
Friday, April 28th - 11:00 am to 12:00 pm ET
Monday, May 8th - 3:00 pm to 4:00 pm ET
Friday, May 26th - 11:00 am to 12:00 pm ET
Monday, June 12th - 3:00 pm to 4:00 pm ET
Friday, June 23rd - 11:00 am to 12:00 pm ET
Monday, July 3rd - 3:00 pm to 4:00 pm ET
Friday, July 28th - 11:00 am to 12:00 pm ET
Monday, August 7th - 3:00 pm to 4:00 pm ET
Friday, August 25th - 11:00 am to 12:00 pm ET
Friday, September 29th - 11:00 am to 12:00 pm ET
Monday, October 2nd - 3:00 pm to 4:00 pm ET
Friday, October 27th - 11:00 am to 12:00 pm ET
Monday, November 6th - 3:00 pm to 4:00 pm ET
Friday, December 4th - 11:00 am to 12:00 pm ET

Click Link to Join

Facilitators:

Tiffany Lindsey, EdD
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

No registration is required to attend and free to all Partnership critical incident review practitioners and leaders.

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Committees and Community Forums

Committees

Communications Drop-In TA with Jennifer Devlin

The Communications Drop-In Hours are held every other month and provide an open forum for NPCS jurisdictions to discuss communications-related challenges and needs. Discussions have focused on crisis communications, messaging around critical incidents and where to draw the line between transparency and confidentiality. Technical assistance is provided by Jennifer Devlin, the communications consultant for NPCS.

Tuesday, February 14, 2023 - 1:00 pm to 2:30 pm ET
Tuesday, March 14, 2023 - 1:00 pm to 2:30 pm ET
Tuesday, April 11, 2023 - 1:00 pm to 2:30 pm ET
Tuesday, May 9, 2023 - 1:00 pm to 2:30 pm ET
Tuesday, June 13, 2023 - 1:00 pm to 2:30 pm ET
Tuesday, July 11, 2023 - 1:00 pm to 2:30 pm ET
Tuesday, August 8, 2023 - 1:00 pm to 2:30 pm ET
Tuesday, September 12, 2023 - 1:00 pm to 2:30 pm ET
Tuesday, October 10, 2023 - 1:00 pm to 2:30 pm ET
Tuesday, November 14, 2023 - 1:00 pm to 2:30 pm ET
Tuesday, December 12, 2023 - 1:00 pm to 2:30 pm ET

Email the facilitator for the repeat meeting link

Facilitator:

Jennifer Devlin
(She/Her/Hers)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Learning and Development Opportunities

Safe Systems Skilled Practitioner

Safety Culture in System-Focused Critical Incident Review

In this course, critical incident reviewers will learn the key purpose and values of the National Partnership for Child Safety. They will be able to describe essential and introductory concepts related to safety science to inform a safety culture. Participants will learn a psychologically safe approach, grounded in the principles of systems thinking, to learn from critical incidents as well as describe the differences between a traditional and systems-focused critical incident review. Best practices and future directions will be highlighted throughout.

Links, Dates, and Times:

- Tuesday, February 14, 2023 - 11:30 am - 4:30 pm ET
- Tuesday, April 4, 2023 - 11:30 am - 4:30 pm ET
- Tuesday, July 11, 2023 - 11:30 am - 4:30 pm ET
- Tuesday, October 31, 2023 - 11:30 am - 4:30 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Tiffany Lindsey, EdD
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Learning and Development Opportunities

Safe Systems Skilled Practitioner

Safe Systems Improvement Tool (SSIT)

In this course, participants will learn how to use the SSIT. The SSIT is the most widely used tool nationally to understand and learn from critical incidents in child welfare. This course will prepare participants to use the SSIT to guide a family-centered, workforce-informed, systems-focused review of a critical incident. Participants will leave the course ready to independently certify online through achieving interrater reliability on critical incident review vignettes.

Links, Dates, and Times:

- Tuesday, February 21, 2023 - 11:30 am - 4:30 pm ET
- Tuesday, April 11, 2023 -11:30 am - 4:30 pm ET
- Tuesday, July 18, 2023 - 11:30 am - 4:30 pm ET
- Tuesday, November 7, 2023 - 11:30 am - 4:30 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Tiffany Lindsey, EdD
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Learning and Development Opportunities

Safe Systems Skilled Practitioner

Writing Meaningful Improvement Opportunities

"*Where you end relies on where you start.*" Participants will learn how to craft objective, relevant, family-centered Improvement Opportunities. Systems are so big! Improvement Opportunities are a crucial anchor for high-quality, actionable reviews. Participants will engage in small group activities to review short scenarios and longer vignettes and create meaningful Improvement Opportunities that honor families and the professionals who serve them.

Links, Dates, and Times:

- Thursday, February 23, 2023 - 12:00 pm to 2:00 pm ET
- Monday, April 24, 2023 - 11:00 am to 1:00 pm ET
- Monday, July 24, 2023 - 11:00 am to 1:00 pm ET
- Monday, November 13, 2023 - 1:00 pm to 3:00 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Tiffany Lindsey, EdD
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Learning and Development Opportunities

Safe Systems Skilled Practitioner

Safe Systems Debriefing

In this course, participants will learn values and strategies for speaking to direct care professionals who served the family at or prior to a critical incident. An important culture carrier, debriefings are an opportunity for restorative and reflective conversation, focused on learning and systems change. Participants will consider how bias and perspective impact debriefing and describe best practices.

Links, Dates, and Times:

- Tuesday, March 28, 2023 - 11:00 am to 1:00 pm ET
- Tuesday, April 25, 2023 - 11:00 am to 1:00 pm ET
- Tuesday, July 25, 2023 - 11:00 am to 1:00 pm ET
- Tuesday, November 14, 2023 - 11:00 am to 1:00 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Tiffany Lindsey, EdD
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Learning and Development Opportunities

Safe Systems Skilled Practitioner

Systems Mapping

In this course, participants will learn how to read and create/facilitate a Systems Map. Formally called an "AcciMap," these maps can structure systems change opportunities and help multi-disciplinary groups hone and visualize gaps or complexities within systems that contribute to families and professionals not having their needs met. A key part of critical incident reviews, mapping can help generate alignment and elevate quality improvement priorities.

Links, Dates, and Times:

- Tuesday, March 28, 2023 - 2:00 am to 4:00 pm ET
- Tuesday, April 25, 2023 - 2:00 am to 4:00 pm ET
- Tuesday, July 25, 2023 - 2:00 am to 4:00 pm ET
- Tuesday, November 14, 2023 - 2:00 am to 4:00 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Tiffany Lindsey, EdD
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Learning and Development Opportunities

Safe Systems Advanced Practitioner

Writing Meaningful Improvement Opportunities: Practice Lab

Ever curious what other professionals would think the Improvement Opportunities in a critical incident review are? In likeness to other Practice Labs, participants will provide redacted case summaries, trouble spots, and/or brief scenarios for use in the Lab's activities. There will be no teaching content in this session – it's all practice! We'll use a mixture of small and large group activities to identify and hone Improvement Opportunities. *Note: Upon registration, please provide your redacted materials at least one week in advance of the Lab.*

Prerequisite Required:
Writing Meaningful Improvement Opportunities

Links, Dates, and Times:

- Tuesday, March 21, 2023 - 12:00 pm to 2:00 pm ET
- Tuesday, May 23, 2023 - 12:00 am to 2:00 pm ET
- Tuesday, August 15, 2023 - 12:00 pm to 2:00 pm ET
- Thursday, December 7, 2023 - 12:00 pm to 2:00 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Tiffany Lindsey, EdD
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Learning and Development Opportunities

Safe Systems Advanced Practitioner

SSIT Train the Trainer (*Pilot*)

In this 2-day experiential course, critical incident review practitioners will create their own exemplars, materials and vignettes, so they can become a certified instructor in the Safe Systems Improvement Tool. This course will prepare practitioners to serve as a team or agency's lead coach in the SSIT for use in critical incident review and broader human services' applications.

Participant materials will be submitted and approved by the facilitators prior to awarding certification.

Prerequisite Required:
All Skilled Practitioner Courses (including online certification in the SSIT)
AWAKEN for Safe Systems Debriefing

Links, Dates, and Times:

Monday, Nov. 27, 2023 - 11:00 am to 5:00 pm ET and
Tuesday, Nov. 28, 2023 - 11:00 am to 5:00 pm ET

SCIR Program Leaders can register Interest by contacting Jordan Constantine.

Registration will be capped at 10 - Limited to two practitioners per jurisdiction.

Facilitators:

Tiffany Lindsey, EdD
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Learning and Development Opportunities

Safe Systems Advanced Practitioner

AWAKEN A PRACTICE FOR CONSCIOUS DECISION-MAKING

AWAKEN for Safe Systems Debriefing teaches participants to apply the AWAKEN framework to the complexity of identifying improvement opportunities and debriefing individuals following a critical incident. Over three sessions, participants will explore how their unique perspective and automatic thinking inform their decision-making and practice strategies to disrupt bias-based thinking and bring forward the values integral to the AWAKEN framework and system-focused reviews.

***It is recommended that critical incident review teams complete AWAKEN as a jurisdiction team.**

Prerequisite Required:
All Skilled Practitioner Courses

Cohort 6 Schedule and Registration

Wed, February 8, 2023 - 11:00 am to 5:00 pm ET

Wed, February 15, 2023 - 11:00 am to 5:00 pm ET

Wed, February 22, 2023 - 11:00 am to 5:00 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Christina Rosato, MSSW
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

AWAKEN is delivered in partnership with: affinità CONSULTING

NATIONAL PARTNERSHIP FOR CHILD SAFETY

2023 Learning and Development Opportunities

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***It is recommended that critical incident review teams complete AWAKEN as a jurisdiction team.**

Prerequisite Required:
All Skilled Practitioner Courses

Cohort 7 Schedule and Registration

Tuesday, May 2, 2023 - 11:00 am to 5:00 pm ET

Thursday, May 4, 2023 - 11:00 am to 5:00 pm ET

Tuesday, May 9, 2023 - 11:00 am to 5:00 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Christina Rosato, MSSW
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

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***It is recommended that critical incident review teams complete AWAKEN as a jurisdiction team.**

Prerequisite Required:
All Skilled Practitioner Courses

Cohort 8 Schedule and Registration

Wed, July 26, 2023 - 11:00 am to 5:00 pm ET

Wed, August 2, 2023 - 11:00 am to 5:00 pm ET

Wed, August 9, 2023 - 11:00 am to 5:00 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Christina Rosato, MSSW
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

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2023 Learning and Development Opportunities

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AWAKEN A PRACTICE FOR CONSCIOUS DECISION-MAKING

AWAKEN for Safe Systems Debriefing teaches participants to apply the AWAKEN framework to the complexity of identifying improvement opportunities and debriefing individuals following a critical incident. Over three sessions, participants will explore how their unique perspective and automatic thinking inform their decision-making and practice strategies to disrupt bias-based thinking and bring forward the values integral to the AWAKEN framework and system-focused reviews.

***It is recommended that critical incident review teams complete AWAKEN as a jurisdiction team.**

Prerequisite Required:
All Skilled Practitioner Courses

Cohort 9 Schedule and Registration

Wed, October 25, 2023 - 11:00 am to 5:00 pm ET

Wed, November 1, 2023 - 11:00 am to 5:00 pm ET

Wed, November 8, 2023 - 11:00 am to 5:00 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Christina Rosato, MSSW
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

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2023 Learning and Development Opportunities

Safe Systems Advanced Practitioner

AWAKEN A PRACTICE FOR CONSCIOUS DECISION-MAKING

Skill-Building Lab for Alumni

AWAKEN Skill-Building Labs are deep dives into aspects of the AWAKEN framework. Participants will learn skills to enhance skills in one or more areas of AWAKEN. The labs are designed to challenge our own thinking by connecting with other perspectives to generate new ideas and ways of addressing challenges facing the child welfare system.

Prerequisite Required:
AWAKEN for Safe Systems Debriefing 3-Part Series

Links, Dates, and Times:

- Tuesday, March 14, 2023 - 12:00 pm to 2:30 pm ET
- Wednesday, April 5, 2023 - 12:00 pm to 2:30 pm ET
- Tuesday, July 25, 2023 - 12:00 pm to 2:30 pm ET
- Tuesday, Dec. 5, 2023 - 12:00 pm to 2:30 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Christina Rosato, MSSW
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

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Safe Systems Advanced Practitioner

AWAKEN A PRACTICE FOR CONSCIOUS DECISION-MAKING

Practice Lab for Alumni

AWAKEN Practice Labs take a redacted/anonymous case example from a participating jurisdiction and provide participants with an opportunity to practice AWAKEN skills to examine the opportunities for improvement and prepare for debriefing. Participants will generate new learning by sharing perspectives across jurisdictions.

Prerequisite Required:
AWAKEN for Safe Systems Debriefing 3-Part Series

Links, Dates, and Times:

- Tuesday, March 7, 2023 - 12:00 pm to 2:30 pm ET
- Wednesday, June 27, 2023 - 12:00 pm to 2:30 pm ET
- Tuesday, Sept. 13, 2023 - 12:00 pm to 2:30 pm ET
- Tuesday, Nov. 15 2023 - 12:00 pm to 2:30 pm ET

Registration is required to attend and free to all NPCS members and their partners.

Facilitators:

Christina Rosato, MSSW
(She/Her/Hers)

Jordan Constantine, MA
(He/Him/His)

AWAKEN is delivered in partnership with: affinità CONSULTING

Child Fatality Prevention & Review Program
Executive Summary (Updated Dec. 2022)

Course Title: Assessing Patterns and Behaviors of Neglect

Target Audience: Child Welfare Supervisors, CTS, Regional ICWA Specialists and SSS1s with one or more years of casework experience

Outline of Training:
This advanced course was adapted for Oregon in partnership with the Butler Institute for Families[i]. The course uses Problem-Based Learning[ii] to guide participants toward a deeper understanding of the circumstances that give rise to neglect as well as strength-based approaches to addressing neglect. This course compels learners to explore their own life experiences and how those experiences influence perceptions of neglect and decision-making. Participants are introduced to the decision-making ecology and the socio-ecological framework, both of which help identify how bias and systemic oppression play a role in the ways we respond to families and how families access support and resources in their communities. The course is two days with some pre-class work. Each session is limited to 30 participants and is facilitated by two Child Welfare consultants or coordinators. The course uses Padlet[iii] to engage learners through technology.

- Pre-Class Work: One week prior to the session, a facilitator organizes the participants into four groups and sends each group an email with reading and activities to complete in preparation for the course. The work consists of reading about and completing a personal ACEs questionnaire, as well as reading case study materials. Learners are also provided a link to the course Padlet, which is a virtual learning library that participants have access to even after they complete the course.
- Day 1: The first day of the course will introduce the decision-making ecology and engage learners in exploring the factors that impact practice with families. This lays the groundwork for expanding conversations throughout the course about the intersection of race, socio-economic status and gender in child welfare work and in particular reports of neglect. The course then introduces the protective factors[iv] and the learners have an opportunity to apply learning to their case studies. The afternoon transitions to identification of risk factors for neglect and concludes with a timelining activity.
- Day 2: The second day guides learners through identification of the impacts of neglect on children, relating examples from the case study to understand the chronicity of neglect and increasing developmental impacts to children. In the afternoon, the course pivots to identifying coaching in cases of neglect as a means to support self-reflection and skill development. Learners then participate in group supervision using their case study. The day finishes with exploration of supports and resources to engage families.

Learning Objectives for Participants:

1. Learners will know how the decision-making ecology manifests in practice with families.

- Explain how personal experiences, biases, judgments, and other preconceived notions may influence decision-making.
- Describe the decision-making ecology.
- Explain the impact of cultural factors on decision-making.
- Describe the impact of differences in safety thresholds.

2. Learners will be able to identify and assess for protective factors with families and will understand how they minimize the likelihood of maltreatment.
   - Identify the protective capacities domains.
   - List the 6 protective factors.
   - Explain how Oregon's six assessment domains within Oregon's safety model are embedded in the protective factors as part of Oregon's safety assessment.
   - Explain how protective capacities and factors minimize the likelihood of maltreatment.
   - Explain strategies workers can use to assess protective capacities and factors and identify risk factors for neglect.
   - Demonstrate techniques for engaging family members about issues related to neglect.
   - Explain factors that contribute to determining if a finding is warranted in a case.

3. Learners will develop an understanding of the consequences of neglect and the contributing factors.
   - Explain how neglect manifests in families involved in Oregon's child welfare system.
   - Explain the intersection of race, gender and socio-economic status and how systemic oppression impacts reports of neglect.
   - Demonstrate techniques for engaging family members about issues related to neglect.
   - Demonstrate how to time-line a case using a case example.

4. Learners will be able to describe the consequences of neglect and contributing parental factors increasing the likelihood of neglect.
   - Describe types of parental behaviors that are a risk factor for neglect.
   - Identify the long-term impact of chronic neglect on child development.
   - Examine cultural factors and their impact on parenting behaviors in a case scenario.
   - Differentiate between chronic and escalating neglect.
   - Identify and assess for increasing impact of neglect on child development in case scenario.

5. Learners will be able to demonstrate and utilize coaching strategies to be used across settings.
   - Describe how coaching skills can be used to support self-reflection and skill development.
   - Differentiate powerful coaching questions within supervision and for use with families.
   - Reflect issues of racial equity in coaching conversations.

6. Learners will be able to demonstrate how to conduct a group supervision based upon a case scenario.
    - Explain the structure of a group supervision to maximize the collective thinking of a team.
    - Demonstrate facilitation techniques to promote critical thinking from the group.
    - Demonstrate how to use coaching questions to prepare workers for presenting cases in group supervision.
    - Describe approaches for drawing out cultural issues when engaging families.

7. Learners will demonstrate how to determine the most appropriate set of supports and interventions to engage the family to mitigate safety concerns and/or reduce ongoing risk to the children.
    - Select community resources and/or natural supports to strengthen the family.
    - Describe culturally relevant services for the family.
    - Demonstrate how to identify resources with the family.
    - Demonstrate crucial conversations with the family to promote the safety of the children.

Ways that the Participants can support Transfer of Learning from the classroom to the job:

BEFORE the training:

- Think about how you are willing to show up differently these two days.
- Review materials and learning objectives and identify ways you would like this experience to enhance your skills.
- Ensure you have coverage and will not need to be contacted during the training hours.

AFTER Days 1 and 2:

- Bookmark and set aside time to review the materials provided through the Padlet to support continued learning.
- Work with others in your unit to expand your examination of ways in which history, culture, laws and policies, economics, and power impact marginalized groups through the accumulation of disadvantages that affect experience and service opportunities for children and families.
- Practice timelining, using different methods of information gathering and engagement.
- Work with a consultant or CTS to arrange group supervision, utilizing tools provided in the course and setting an intention to focus on protective factors.
- Practice intentional documentation that is rooted in identification of protective factors and evaluation of developmental impacts to children.

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[i] https://socialwork.du.edu/butler

[ii] Marra, R., Jonassen, D. H., Palmer, B., & Luft, S. (2014). Why problem-based learning works: Theoretical foundations. Journal on Excellence in College Teaching, 25(3&4), 221-238.

[iii] https://padlet.com/OregonDHS_CW_SafetyProgram/OAPBN

[iv] https://www.childwelfare.gov/pubs/issue-briefs/protective-factors/