Comprehensive Statewide Plan to Prevent Child Maltreatment Fatalities:

Oregon developed a comprehensive, statewide plan to prevent child fatalities, which was submitted in the 2020-2024 CFSP. In February 2020, Oregon restructured how the Critical Incident Review Team (CIRT) is managed within Child Welfare by creating the Child Fatality Prevention and Review Program (CFPRP), led by Tami Kane-Suleiman, who previously managed this workload under the umbrella of the Child Safety Program. This team devotes a separate program manager and program coordinators to the Critical Incident Review Team (CIRT) as detailed in the Oregon statute, as well as fatality prevention efforts and staff connected to this prevention work. 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

The CFPRP was formed to effectively resource critical incident review and system learning efforts as well as prevention 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. 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 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 for Oregon's State Child Fatality Review Team, which includes state level review of preventable child fatalities as well as support for county fatality 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 advancing a safety culture in child welfare.

National Partnership for Child Safety (NPCS), Safe Systems, and Safety Culture

NPCS Overview:

In early 2020 the CFPRP joined the National Partnership for Child Safety (NPCS) which is a collaborative focused on applying safety science and sharing data to develop strategies in child welfare to improve safety and prevent child maltreatment fatalities. This work happens through safe systems analysis and advancement of safety culture. Participation in the NPCS and technical assistance from Dr. Michael Cull and Dr. Tiffany Lindsey with the University of Kentucky Center for Innovation in Population Health, through the support of Casey Family Programs, has been integral to the CFPRP's safe systems work. See attachments 1-2.

Safe Systems Analysis:

Safe systems analysis is a critical extension of Oregon's child fatality review process. Through file review, participation in the CIRT, and follow-up supportive inquiry, the CFPRP is able to gather important information about what influences casework problems identified in cases with tragic outcomes. In some cases, the safe systems analysis includes human factor debriefs. Debriefs are the mechanism for gathering the "second story" from those who experienced the outcome in the field. These debriefs are voluntary and trauma responsive and use supportive inquiry to support field level staff in sharing their experiences. While human factor debriefs are not completed in every case, they lend important detail and reliability to the overall information gathered and rated in the Safe Systems Improvement Tool

(SSIT). SSIT results and a standardized NPCS dataset are captured in a REDCap[1] database. 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. See attachment 3.

As a part of safe systems analysis, Improvement Opportunities (IOs) are identified. These are defined as case-specific actions or inactions relevant to the outcome or industry standards. While emphasis is given to those IOs within the public child welfare agency, 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 each safe systems analysis, IOs are evaluated for their 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. Since quality improvement resources are finite, considering the frequency and proximity of an IO is important to balancing if, when, and to what degree an agency advances a system improvement effort. Improvement Opportunity themes that have previously been identified for targeted system improvement include assessment of sleep practices and domestic violence case practice.

Recently, through Safe Systems Mapping (based on an AcciMap[2] approach), further exploration of IOs related to assessment of substance use in cases reviewed by the CFPRP has begun. In each system improvement undertaking, there is a commitment to incorporating internal and external expertise at various levels of the system, to better understand the influencing factors and target improvement strategies accordingly. For example, in the recent mapping sessions, participants included a CPS caseworker, CPS Supervisor, Addiction Recovery Team (ART) lead worker, ART outreach worker, contracted provider for ART services, county-level Family Nurse Partnership supervisor, county-level child abuse pediatrician, ODHS district manager, Tribal Affairs senior ICWA manager, Child Welfare alcohol & drug specialist, Safety Program manager and assistant manager, Child Welfare executive director and deputy directors, and others. The group's diverse experience and expertise allowed for a robust discussion of what factors impact effective assessment and intervention in cases involving parental substance use at all levels of the system. The mapping will now inform the development of targeted strategies for system improvement, which will be shared with executive leadership in June 2021. See attachment 4.

The CFPRP is also in the process of evaluating improvement opportunities in cases involving the death of infants across circumstances in order to better understand the contributing factors and identify additional strategies to support caseworkers in thoroughly assessing safety of infants. We are early in this evaluation and anticipate strategies and testing of these strategies will be developed over the course of the next several months. Please also see the CARA (Comprehensive Addiction & Recovery Act) discussion in the 2022 APSR. There is an exciting opportunity in a new pilot that will provide upstream development of a plan of care for pregnant people.

Safety Culture:

In addition to assistance with safe systems analysis, participation in the NPCS affords Oregon an opportunity to receive support to advance safety culture. This support occurs through monthly

[1] https://www.project-redcap.org/
[2] https://en.wikipedia.org/wiki/AcciMap_approach

Innovation and Implementation Learning Community (I2LC) calls, Critical Incident Review Leaders Peer-to-Peer calls, as well as individual technical assistance. As of the writing of this report, the CFPRP is supporting specific safety culture work in two child welfare offices and is in planning stages for offering MAPS (Mentoring, Assisting and Promoting Success) professional development as critical culture carriers in Child Welfare. This work includes sharing and supporting use of tools from the TeamFirst Field Guide. The CFPRP is steadfast in the belief that a safe and supported workforce is one in which all individuals can bring their full selves to work and can in turn safely support each family's voice and vision for their children. See attachment 5.

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. Additional data specific to Oregon shows steep upward trends in rates of suicide youth ages 10-24 and it is now the leading cause of death for this age group.[3]

The CIRT recognized the risk factors that brought families to the attention of Child Welfare were often the same as those that increased the risk of suicidality. This presented an opportunity for Child Welfare to join the national suicide prevention efforts which resulted in collaboration with Michigan State University and the Suicide Prevention Coordinator. This relationship developed after learning Michigan State's Child Welfare program was the only other state offering larger scale training efforts for staff which were developed by the University.

The suicide prevention and awareness work has also allowed the CFPRP to develop a strong collaborative partnership with the Oregon Health Authority (OHA). OHA has taken an active role as members of the Critical Incident Response Team (CIRT). As members of the CIRT, OHA can offer recommendations as well as provide information on larger system issues which may impact suicidality amongst families receiving services from Child Welfare. Child Welfare is also receiving some national attention as the CIRT website which listed current suicide prevention efforts has drawn interest from the Centers for Disease Control (CDC). OHA is currently communicating our collaborative efforts to create a success story to be posted to the CDC's website. In sharing our success, we hope other states will also replicate our efforts.

In collaborating with OHA, the CIRT identified QPR (Question, Persuade, Refer) as the most appropriate, evidence-based training curriculum because of its adaptability, cultural considerations, and simple strategy. The Department was also awarded the Garret Lee Smith Grant to fund the training efforts, along with additional suicide prevention trainings, over the next five years. Over 100 Child Welfare staff have been trained as QPR trainers and pre-COVID, were encouraged to provide in person trainings to community members including medical providers at child advocacy centers and local Law enforcement agencies.

In order to sustain training efforts for statewide accessibility, Child Welfare and the QPR Institute developed a computer-based training (CBT) once the pandemic hit to continue to keep these important

[3] The Oregon Health Authority's "Youth Suicide Intervention and Prevention Plan Annual Report 2020" can be found here.

efforts forward moving. This training is now required for all 9,000 Oregon Department of Human Services employees.

CFPRP is offering a weekly, facilitated QPR session for 53 weeks through September 2021. QPR teaches a person how to: identify suicidal behavior; encourage a suicidal person to accept help; and ensure the person has an adequate support system to address their suicidality.

The Child Welfare QPR CBT Is being led by facilitators (two per session) who provide instruction, resolve technical difficulties, and guide a question and answer session at the end of the CBT. All facilitators are required to attend an hour-long pre-training Facilitator's Guide Session. This will prepare them to facilitate the CBT, provide instruction for the surveys, and teach them additional guidance specific to child welfare practices. Additionally, the Facilitator's Guide Session provides instruction on what to do if a participant expresses suicidal thoughts.

Trainings are capped at 30 participants and participants are asked to engage in a pre- and post-training survey.

The facilitators pause periodically throughout the training to address questions. At the conclusion of the training, they guide the participants through a 15-question quiz.

The facilitator provides specific practice instructions regarding child welfare case planning when a child or any family member expresses suicidal ideation. The facilitator leads a question and answer session, coaching and ensure participants complete the follow up survey.

Objectives for Participants:

1. The trainee will be able to identify factors that increase suicidal risk, including:

- Signs of depression and hopelessness
- Substance use
- Sudden life changing events/trauma
- The contagion effect
- Previous suicidal attempts

2. The trainee will be able to identify suicidal warning signs

- Direct clues
- Indirect clues

3. The trainee will be able to describe the three principles of QPR:

- Question: Ask someone if they are suicidal
- Persuade: Get agreement from a suicidal person to seek help
- Refer: Assure adequate, effective, and appropriate intervention will occur

4. The trainee will understand how incorporate QPR while assessing for child safety:

- Case workers will discuss access to lethal means for caregivers

- Case workers will support caregivers in understanding suicidal behavior
- Case workers will evaluate appropriate therapeutic interventions for suicidal behavior
- Case workers will assure enough safety measures are in place when a child is experience suicidal behavior.

Portland State University is assisting with the survey metrics specific to the GLS Grant requirements. Consistently, survey outcomes have shown increased knowledge about suicide and additional confidence in intervention techniques. Data will continue to be collected through these pre- and post-surveys. The ODHS Occupational Health, Safety and Emergency Management Unit monitors this data and will complete annual reporting along with OHA's zero suicide coordinator for GLS Grant requirements. We are also in the process of developing a post follow-up survey that will go out to participants six months after their training.

QPR Training outcome data for September 2020 through March 2021 is provided in attachments 6-7.

ODHS Critical Incident Review Team Coordinators within the CFPRP continue to evaluate trends for children who die that are known to Child Welfare. National and state data supports the increased risks for children who:

- Are LGBTQIA2S+
- Have a family history of suicide
- Have a history of mental health issues, particularly clinical depression
- Abuse alcohol or substances
- Feel hopeless
- Experience maltreatment
- Have easy access to lethal means
- Experience trauma and/or loss
- Experience barriers to accessing mental health services
- Are exposed to other people who have died by suicide
- Have impulsive or aggressive tendencies

In addition to the QPR training efforts, the CFPRP is partnering with the Foster Care Program to ensure our resource parents have access to QPR training and other free resources including postvention services. A resource brochure is in the works and close to being finalized by the Foster Care Program. It will highlight statewide resources available for resource parents as well as Suicide Awareness and Prevention training options that are best suited to meet resource parents' needs. This brochure will also be made available to youth with a section that highlights available supports for youth in Oregon. A request by the CFPRP has been made to this program to identify and train staff (Resource Family Champions and Resource Family Certifiers) which would allow additional resources available for our Resource Families around the state for both new applicants and current Resource families.

In 2020, the CFPRP identified a Child Suicide Prevention & Awareness Coordinator, but this employee recently left for a promotional opportunity. The CFPRP is currently recruiting for a position that will assist in coordinating the CIRTS and Suicide Prevention & Awareness efforts.

The following activities will begin once this position is filled:

- Creation of a proposal to pilot coordinated suicide prevention and awareness efforts in a Child Welfare district that is part of the Oregon Caring Connections Initiative (GLS Grant funding):
    - Identify a district suicide prevention lead in Child Welfare or Self Sufficiency program who can build relationships with local mental health providers and the Suicide Prevention & Awareness Coalition
    - Build community connections and resources for staff so they are available as needed on cases involving children and youth experiencing suicidal ideation
    - Provide training opportunities for staff and community partners
    - Identify Child Welfare staff who can provide case consultation for families with children and youth at risk of suicide (MAPS, consultants, Permanency/Teen caseworkers).
    - Create a suicide intervention protocol specific to local county child abuse multi-disciplinary teams
- Participate in the State Child Fatality Review Team and attend meetings to discuss trends, identify systemic issues, and determine changes to improve support for those we serve.
- Partner with ODHS Trauma Aware and OHA to develop a postvention plan for Child Welfare, which includes trauma response for employees
- Participate in CISM (Critical Incident Stress Management) training and certification along with three other employees in the CFPRP to become part of the CISM team in ODHS
- Coordinate a winter Suicide Awareness & Prevention Summit in partnership with OHA and ODHS Trauma Aware
- Develop relationships with statewide organizations that provide suicide awareness and support and create a statewide resource list for ODHS staff to be posted on the CFPRP OWL intranet which will be created in summer of 2021
- Develop relationships with local health, mental health, and public education systems to coordinate postvention services when necessary
- Develop relationships with and join county and regional suicide prevention coalitions to increase cross-system collaboration and support

Responding to Chronic Neglect

Overview:

Neglect continues to be the primary contributing factor in child maltreatment fatalities[4] in Oregon (74% in FFY 2019) and is also the most commonly identified allegation in founded reports of non-fatal maltreatment. Such cases are often complicated by substance use, mental illness or domestic violence within the family system and chronic neglect results in an accumulation of harm to children's health and development. Promoting responsive relationships, bolstering protective factors, and connecting families with supportive resources sooner is essential to preventing fatalities as well as long-term negative impacts to surviving children. The CFPRP recognizes the significance of the Family First Prevention Services Act and the potential of Oregon's plan to reduce the impact of neglect on children coming into contact with the Department. The CFPRP has representation on the Prevention Policy & Practice workgroup as well as the Implementation Team and will incorporate learnings from that work into this plan as appropriate in the future.

[4] https://www.oregon.gov/dhs/CHILDREN/CIRT/Pages/Chronic-Neglect.aspx

Training Update:

Supporting Child Welfare professionals in understanding and responding to neglect, in particular chronic neglect, is an important aspect of fatality prevention. While the COVID-19 pandemic impacted the rollout of two-day advanced training for child welfare caseworkers, the 90-minute overview training for all SSS1s has been updated and continues to be available as needed. It is facilitated by Safety and Permanency program consultants. Additionally, a modified version of the 90-minute training has been developed and was offered to ORCAH screeners and supervisors in October of 2020. The training is now available to new staff as a part of the ORCAH training academy. In April of 2021, sessions of the two-day advanced *Oregon Assessing Patterns & Behaviors of Neglect* training resumed in an updated virtual format for supervisors, MAPS and Active Efforts Specialists. This two-day advanced training will be offered four times in 2021 and thereafter offered at a frequency dependent upon workforce need. Over 200 Supervisors, MAPS and Active Efforts Specialists participated in the training prior to onset of COVID-19. Rollout of the two-day advanced training for casework staff has yet to be determined. See attachment 8.

In addition to classroom training, voluntary learning cohorts are being established among participants in the 2021 sessions of the two-day advanced training. These cohorts will be organized by course facilitators with the goal of reinforcing the participants' learning by promoting use of information, tools, and resources in daily practice. If successful, the CFPRP will consider implementation of quarterly practice forums dedicated to applying knowledge in these most difficult cases.

Outreach and Partnership Update:

In the fall of 2020, the Child Fatality Prevention and Review Program began reaching out to community organizations to gain understanding about how protective factors[5] are embedded into their approaches with families. Identifying how protective factors are cultivated across communities in Oregon can help Child Welfare form more meaningful and successful partnerships on behalf of children and families, perhaps even before families come to the attention of Child Welfare. This outreach has occurred with the assistance of two CFPRP coordinators as well as an MSW intern. Through this exploration and outreach, the CFPRP has found that when we look outside the walls of the system and prescribed services, we create opportunities to identify and support programs that wrap around families and prevent maltreatment. There are many programs embedded in communities where trust is established, and work is carried out with knowledge, skill, and empathy a state agency cannot embody. One notable connection has been made with a program aimed at supporting young fathers and preventing child maltreatment in the Portland metro area. The CFPRP is exploring ways to support and promote the program and others across the state as we move toward a prevention system.

Safe Sleep

Overview:

In 2020, of the 34 child fatalities reviewed by the CIRT, 19 were infants. Just under 74% percent of the cases involving infants had high risk sleep practices present. Too many of Oregon's infants die in preventable sleep related deaths. Educating and engaging infants' parents and caregivers effectively requires an ongoing community response.

[5] https://www.childwelfare.gov/pubPDFs/protective_factors.pdf

Education and Training Update:

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 experiences and opinions related to 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[6].

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 now available for social service specialists in screening, safety, permanency, certification, adoption, and the current workforce has been trained as well. A version for certified resource families is being finalized. Ongoing updates to the self-study curriculums are made based on learning and input from case reviews, Child Welfare professionals in the field, as well as tribal and other community partners. See attachment 9.

Partnership and Engagement Update:

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. *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. The Raise Up Oregon Agency Implementation Coordinating Team formed a workgroup tasked with developing recommendations for a statewide coordinated effort.

The CFPRP was represented in this cross agency safe sleep workgroup which has recently finalized draft recommendations that have been presented to the Raise Up Oregon Agency Implementation Coordinating Team in order to develop a statewide coordinated effort to:

- Improve safe sleep practices
- Decrease sleep-related deaths
- Reduce relative disparities in sleep-related deaths between white and black and American Indian/Alaskan Native infants

Participants from this workgroup met from September 2020 – February 2021 to develop the recommendations. Those involved included the following: OHA Manager of Maternal Child Health, Multnomah County Health Department/Healthy Birth Initiatives, OHSU Pediatrician/ Oregon Center for Children and Youth with Special Health Needs Director, Early Learning Division, Oregon Department of Education, Legacy Health, OHA Perinatal Nurse Consultant, Oregon Department of Human Services/Child Fatality Prevention & Review Program. Consultation also occurred with the Northwest Portland Area Indian Health Board and the Oregon Parenting Education Collaborative.

In developing the safe sleep self-study materials input was actively sought through multiple methods from parents of infants and a variety of family serving systems including but not limited to: substance use disorder treatment providers; domestic violence shelter professionals; Office of Child Care,

[6] https://www.oregon.gov/dhs/CHILDREN/CIRT/Pages/Sleep.aspx

community health nurses; Public Health; Oregon Foster Parent Association; Oregon Tribes; Self Sufficiency employees; domestic violence advocates; and Oregon Parenting Education Collaborative parent coordinators and trainers statewide

During National SIDS Awareness Month 2020 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, CFPRP is coordinating a safe sleep pilot within the Nurture Oregon, Plan of Care Pilot. This pilot will be implemented with more than one approach. Within the pilot, safe sleep conversations begin as part of prenatal care with a trusted professional and continue until the infant is a year old. As part of the Plan of Care, safe sleep will also be addressed by the pregnant or parenting individual and their care team. A documented plan describing how the infant will be placed to sleep will ensure everyone knows what to expect and how to be supportive. Just like the other aspects of the Plan of Care it is important to discuss what follow up will look like. For sleep related care, regular check-ins are needed to ensure the plan is continuously meeting the changing needs and challenges of the parent and infant. All sleep plans should include a plan for support when inevitable parental exhaustion occurs.

To develop or enhance the safe sleep knowledge of Nurture Oregon professionals, each will be provided the Safe Sleep for Oregon's Infants self-study. 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 SIDS 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.

To support and educate pregnant and parenting individuals, each parent receiving services will be offered a safe sleep kit, including a Cribette (flat, firm sleep surface similar to a small Pack-n-Play), sheet, sleep sack, pacifier, Sleep Baby Safe and Snug board book, magnet with ABC's of safe sleep and some written materials.

The safe sleep kit will be provided at least four weeks prior to the expected delivery date to allow for familiarity with the items. Ideally the Cribette, once received, will be placed in the room where the parent will sleep. Potentially, if the pregnant individual is exposed to the Cribette, free of blankets, stuffed animals and all other soft, squishy objects, the individual will grow to see the sleep area as safe and comfortable even if it is different than the sleep area they previously imagined.

While this is one approach, when the pregnant or parenting individual or infant is African American/Black or Native American/Alaska Native it is important to make additional efforts to have the respective communities identify and lead the approach. 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.

Concrete Support:

Local Child Welfare offices have communicated their need for emergent, immediate safe sleep environment resources and the CFPRP has provided Cribettes to local Child Welfare offices from Cribs for Kids. These can be shared with other ODHS programs and Tribes when needed. Safe sleep care packages are also being purchased to offer pregnant and parenting individuals with substance use disorders who are engaged in the Nurture Oregon, Plan of Care Pilot.

Providing immediate access to safe sleep resources is a critical component of child fatality prevention.

Child Welfare provided testimony to support legislation, Oregon HB3379 (2021), to ban the manufacturing, marketing, and sales of crib bumper pads.

Comprehensive Addiction Recovery Act

Overview:

Substance use is present in the family system at a high rate in cases involving a child fatality. With this understanding in mind, the Department'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 approved for recruitment and hired in April of 2021 to continue efforts to develop, implement and monitor plans of care, and further advance efforts related to safe sleep in cases requiring a plan of care. The CARA coordinators will continue to collaborate with OHA in efforts to move all aspects of implementation forward.

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 office level (screeners, caseworkers, MAPS, addiction and recovery teams, supervisors, management). Additional policy and practice changes are anticipated through the implementation of the 'plan of care pilot' referenced in the next section.

Plans of Care:

Child Welfare and OHA (multiple sections) are implementing a 'plan of care pilot' within six Oregon counties as part of the Oregon Nurture expansion (Oregon Nurture is a care model that combines maternity care, substance use disorder treatment, peer/doula support, and social services in a single setting. Care is delivered in a culturally sensitive, non-judgmental, strengths based and trauma-informed manner.). The 'plan of care pilot' will seek to gather data on what works and what doesn't work for the pregnant and parenting people, as well as the different members of the care team, including Child Welfare professionals. Identification of plan of care best practices will inform statewide education and support for notification by healthcare providers, and all aspects of plan development and monitoring. The kick-off meeting for the Oregon Nurture expansion was in March 2021 and community response to the plan of care component has been very positive.

In moving forward with the pilot, changes in practice include:

- Asking pregnant or parenting people to identify who coordinates the plan of care. Child Welfare procedures identify the health care provider or Child Welfare as taking the lead, but an

important pivot is occurring to ensure the approach elevates the voice of pregnant and parenting people.

- Broadening the definition of substance affected infant from the initial definition in Child Welfare procedure. Now that Oregon can provide non-identifying data for substance affected infant notifications when maltreatment is not alleged (notification vs report), the CARA advisory committee members are supportive of including those infants who were substance affected as a result of pre-natal exposure to substances as a result of medication assisted treatment. Data gathered from the pilot will further inform the change in this definition and others.

With the data gathered from the 'plan of care pilot' additional policy and practice changes are expected.

For additional information related to the implementation of CARA, see the 2022 APSR CAPTA update section.

The National Partnership for Child Safety charter

Attachment 1

October 2019

Applying safety science and sharing data to develop strategies in child welfare to improve safety and prevent child maltreatment fatalities

Acknowledgments

The National Partnership for Child Safety was established in partnership with Casey Family Programs.

Special thanks to Dr. David Sanders and Dr. Zeinab Chahine of Casey Family Programs for their leadership and support of this innovative work.

Many thanks to all the staff from Casey Family Programs and other partners, especially Dr. Michael Cull and his team, for the technical assistance they provided to help launch this effort.

The National Partnership for Child Safety would not have been possible without the remarkable leaders from the 12 jurisdictions who formed this Collaborative. Current member states/jurisdictions are:

1. Los Angeles County, California
2. Santa Clara County, California
3. Connecticut
4. Georgia
5. Indiana
6. New Hampshire
7. New Jersey
8. Franklin County, Ohio
9. Hamilton County, Ohio
10. Tennessee
11. Vermont
12. Wisconsin

Jodi Hill Liliy, Deputy Commissioner, Connecticut Department of Children and Families
Executive Committee Co-Chair, National Partnership for Child Safety

Moira Weir, Director, Hamilton County (Ohio) Job and Family Services
Executive Committee Co-Chair, National Partnership for Child Safety

Mission statement

The National Partnership for Child Safety mission is to improve child safety and prevent child maltreatment fatalities by strengthening families and promoting innovations in child protection.

Introduction

In an effort to improve child safety and prevent the estimated 1,500 deaths due to child abuse and neglect that occur every year in America, child welfare leaders representing 12 jurisdictions and states have formed The National Partnership for Child Safety (NPCS), a quality improvement collaborative.

The collaborative was formed in partnership with Casey Family Programs, a national operating foundation focused on safely reducing the need for foster care and building Communities of Hope. Casey Family Programs hosted several safety convenings since 2011 aimed at improving safety and preventing child maltreatment fatalities and has supported efforts to implement safety science principles in child welfare in several jurisdictions through peer visits and technical assistance from consultants with expertise in the safety science field. In January 2018, child welfare agencies from 20 jurisdictions participated in the Tennessee Safety Culture Summit in partnership with Casey Family Programs and the Tennessee Department of Children's Services at Vanderbilt University. The summit was focused on applying safety science in child welfare to improve safety and prevent child maltreatment fatalities and served as a launching point for ongoing collaborative work among interested jurisdictions.

The federal Commission to Eliminate Child Abuse and Neglect Fatalities recommended in its final report that safety science be explored as an approach to better understand and prevent fatalities: "Child protection is perhaps the only field where some child deaths are assumed to be inevitable no matter how hard we work to stop them. This is certainly not true in the airline industry, where safety is paramount and commercial airline crashes are never seen as inevitable."[1]

Other safety critical industries have recognized that a culture of fear and blame does not promote learning from error, and it can result in decreased organizational effectiveness and compromised safety. The approach that systems take to responding to and learning from critical incidents can have a crucial impact on quality improvement and services reliability. For example, when the public, the media, policymakers and the child welfare system's response to a high-profile death results in blame, staff can become more risk averse and fearful, leading to increased removals of children and delayed reunifications. In addition, when policymakers react by passing new laws and the system institutes more procedures in response to critical incidents without fully considering the unintended consequences, they add to the complexity of an already overwhelmed system. The result can be increased workload and high staff turnover. Overall, these reactive responses can make the system less effective in keeping children safe.

Although progress has been made by implementing various strategies in child welfare such as evidence-based interventions, their effectiveness is limited by their application to systems with pervasive workforce instability and the related absence of effective learning systems. In addition, current quality improvement reviews are primarily retrospective after incidents occur. New strategies and tactics informed by safety science, such as prospective instead of retrospective quality improvement processes similar to other safety critical industries, are needed to improve outcomes in the complex, interdependent work of child welfare.[2]

Background

This charter describes the structure for the National Partnership for Child Safety and how the work will be developed and applied. The charter will be reviewed and approved annually and when major changes to the group's structure or function occur to ensure its relevance and appropriateness to the work.

1 Commission to Eliminate Child Abuse and Neglect Fatalities. (2016). Within our reach: A national strategy to eliminate child abuse and neglect fatalities. Washington, DC: Government Printing Office. Accessed at http://www.acf.hhs.gov/programs/cb/resource/cecanf-final-report.

2 For example, New York City is implementing a just-in-time proactive quality review system for CPS.

Values and guiding principles

The NPCS members firmly believe in:

- A collective responsibility for improving child safety and preventing maltreatment fatalities.
- The rigorous scrutiny of ideas and practices to promote innovation in child protection.
- A commitment to improving practice while working within frameworks for family inclusion.
- Sharing between agencies and individuals to build internal and external support for agencies and jurisdictions.
- The collection, sharing and analysis of data to inform decisions for practice improvements.
- Respecting each other as colleagues by honoring the work and diverse perspectives of all member contributions.
- Creating a resource for jurisdictions structured around the sciences of safety, reliability and improvement.
- A focus on team culture to advance learning and spread tools in the interest of improving child welfare safety outcomes.

NPCS goals

Long-term goals

We will develop a learning system:

- That promotes a system shift toward prevention policies and practices to address risk to vulnerable children.
- Aimed at improving child safety through the development of best practices, including development of standardized definitions for reviewing critical incidents (child maltreatment fatalities and near fatalities) by applying safety science, data analytics and research evidence in child welfare and child- and family-serving systems.
- To foster a national prospective quality improvement approach to prevent critical incidents, including child maltreatment fatalities and serious injuries.
- To increase psychological safety and create a resilient workforce, whereby increasing staff retention and ultimately improving child safety outcomes.
- That models technical excellence in child welfare, ultimately broadened to include other child- and family-serving agencies, to improve child safety and prevent child maltreatment fatalities.

Short-term goals

- Develop standard definitions, share data among member jurisdictions and establish a national repository of critical incident data, including child welfare fatalities and near fatalities.
- Lend support and guidance to leadership in child welfare systems when a critical incident or child maltreatment fatality occurs.

Outcomes

The collaborative aims to improve safety as measured by:

- Reduced numbers of child fatalities and near fatalities
- Decreased repeat maltreatment
- Improved ratio of entries to exits
- Creation of a culture of safety that promotes workforce retention and proactive, highly reliable child welfare organizations

Infrastructure

Membership

This is a membership model, similar to quality improvement programs in other safety critical industries. Membership is composed of state/jurisdiction teams representing child welfare systems. State/jurisdiction teams, at minimum, must include child welfare leaders and executive team members.

Responsibilities and expectations

Members are expected to:

- Bring their expertise, influence, knowledge and other contextual factors to bear in advancing the work of the collaborative.
- Regularly attend and/or have their state/jurisdiction represented at all meetings and participate on workgroups and teams as needed to advance the work of the collaborative.
- Employ active and timely communication and feedback loops across the collaborative.
- Demonstrate good-faith effort in completion of core activities of the collaborative.
- Commit to gathering and providing the core data set identified for the collaborative for stability of reporting to support data analysis and achievement of the goals set forth by the collaborative.
- Serve on the Executive Committee and rotate off with highest level of leadership.

This collaborative can expand over time to include other interested jurisdictions. Other entities may participate as determined by the collaborative, i.e., organizations providing support, developers of tools and best practices with an interest in collaboration for the pursuit of balanced implementation, along with researchers interested in studying safety, reliability and improvement in social services organizations.

Dissolution

No dissolution is planned. The intention is for the group to continue as an autonomous member-based organization.

Governance structure

Executive Committee membership will be open to leadership representatives from all member jurisdictions of the collaborative. Executive Committee members are expected to demonstrate their commitment to the work through consistent attendance and participation in monthly Executive Committee meetings and other activities, except when prevented by unforeseeable events. Executive Committee meeting attendance will be recorded and monitored.

The Executive Committee will be responsible for:

- Monitoring and tracking progress toward meeting the identified short- and long-term goals of the collaborative.
- Identifying when it may be necessary to form subcommittees and ad hoc workgroups to address specific goals and tasks and obtain the assistance of technical advisors to advance the work of the collaborative.
- Reviewing recommendations proposed by subcommittees and workgroups and providing feedback and guidance as needed.
- Deciding which recommendations are adopted to advance and support progress toward outcomes of the collaborative.

The Executive Committee will move through a consensus decision-making process. If a consensus cannot be reached, then two-thirds of the Executive Committee must be in agreement in order to move a decision forward. This will help to ensure that representation, equality and accountability are upheld in the Executive Committee's processes.

Once a decision-making process is complete and consensus or a two-thirds majority vote has been reached, Executive Committee members may be asked to share updates with outside individuals and groups.

The composition of the Executive Committee will be inclusive of the range of participating jurisdictions (e.g., counties, states, large, small). Executive Committee members are free to participate in any and all activities and events of the collaborative.

Executive Committee members will serve a one-year term. When an Executive Committee member leaves the Executive Committee or the organization, a new member may be appointed from among volunteers. Member jurisdictions may nominate potential Executive Committee members. All new members start their own term clock, even those replacing an outgoing member with remaining term time.

The Executive Committee will be led by two co-chairs. Any member of the Executive Committee is eligible to be a co-chair. Co-chairs may hold their positions for a maximum of two consecutive years. Co-chairs will develop the agenda in concert with technical advisors, co-lead Executive Committee meetings and regularly review meeting attendance. Co-chairs will communicate Executive Committee decisions to all collaborative members.

Technical advisors will provide resources, guidance and support to the collaborative as a whole and will work closely with the Executive Committee. Technical advisors shall be entitled to receive all written notices and information that are provided to the Executive Committee, attend and participate in all Executive Committee and collaborative meetings, participate in subcommittees and participate in all activities and events of the collaborative. Technical advisors will not hold office or vote at Executive Committee meetings.

The Executive Committee will have the freedom to pursue and select technical advisors and backbone organization(s) to implement and sustain the work of the collaborative.

A project coordinator will be assigned to coordinate Executive Committee meetings, help prepare meeting agendas, take minutes during scheduled meetings and ensure dissemination to collaborative members. The project coordinator will streamline and manage all communication and feedback loops.

Expected activities

NPCS members will share practices, tools and policies with a willingness to candidly offer both successes and "lessons learned." In addition, training, "spread" and organizational culture-change strategies will be part of the learning and peer advising focus. The other aspect of the NPCS involves sharing mutually agreed upon data to inform our continuous learning and practice improvements. In so doing, the NPCS strives to improve safety, permanency and well-being outcomes for children as it expands and joins with other networks to promote effective child welfare practice.

The members of this collaborative will participate in safety science-derived quality improvement activities, sharing data and applying a set of strategies including:

1. Applying a standardized platform for critical incident review and reporting of data, such as the Safe System Improvement Tool (SSIT) to support a systems focused, non-punitive, critical incident review process and submit standardized critical incident data to a shared database;
2. Collecting and sharing comparative critical incident and team culture data by participating in an annual safety culture assessment and using the results for improvement
3. Providing access to a library of Spaced Ed curricula
4. Sharing cross-jurisdictional Safety Notices
5. Partnering in developing Quality Improvement Priorities such as children O-3 Care Bundle

Status of expected activities is captured in Appendix 1.1 Work Plan.

Data

NPCS will collect and share data within the parameters of the NPCS goals. It is recognized that member states/jurisdictions will have varying levels of internal parameters that will impact the level/amount of detail that can be provided and may have restrictions/limitations on data sharing.

An encrypted and protected cloud-based sharing platform will be identified to maintain data. Member states/jurisdictions retain ownership over their data, even while these data reside on the cloud. Data analytics will be governed by data-sharing agreements and business rules.

Additional information regarding data sharing, data analytics, evaluation and research will be outlined in Appendix 2.1 Data Sharing.

Attachment 1

STRATEGY BRIEF

HEALTHY ORGANIZATIONS

How can child protection agencies **use safety science to promote a safety culture?**

Child protection agencies operate under tremendous social and political pressure. Too often, a tragic outcome (such as a child death or serious injury) leads to a cycle of intense media scrutiny, blaming and firing of individuals determined to be responsible, and an increased agency-wide focus on compliance and heightened practice monitoring. Such responses, driven by emotion, often contribute to organizational cultures of anxiety and defensiveness while doing little to improve safety.[1]

Child protection agencies can learn much from other safety-critical industries — such as aviation, health care, and nuclear power — that have applied the principles of safety science to change organizational culture, improve practice, and reduce the incidence of tragic outcomes. Public safety in these areas also has increased as a result.

As child welfare leaders have sought to implement these principles, they are discovering that race equity is a critical lens in the development of a safety culture within child protection agencies. Safety is a prerequisite for the honest conversations necessary to address racial disparities. Likewise, no organizational culture can claim to be truly safe until it is equally safe and just for all.

casey family programs

Safety science vs. Safety culture

Safety science involves applying scientific methods, research, and tools to understand, assess, and manage safety.[2] In the context of child protection, this means using an evidence-based approach to inform preventive and responsive actions, rather than basing policy and practice decisions on emotion or assumption. When we employ safety science, we identify and apply lessons learned based on the best available research and evidence.

Experts in the field of safety science seem to agree that organizational culture is an important piece of the puzzle. Other safety critical industries have recognized that a culture of fear and blame does not promote learning from error, and it can result in decreased organizational effectiveness and compromised safety. Today, research is increasingly available to guide child protection agencies in creating a **safety culture** that is more effective in protecting children from harm. This includes balancing individual and system accountability by examining system factors.

Creating a safety culture

Studies of hospital nurses have found "a positive association between organizational cultures characterized by reluctance to report errors and acknowledge mistakes and the frequency with which medical errors occur."[3] Certainly, the cycle of blame in child protection agencies has not been shown to measurably or sustainably reduce the incidence of tragic events.

Research and theory in the application of safety science focus on the complex environments in which individual errors occur. Many factors affect an individual's ability to accurately assess and take effective action to promote child safety. Some of these are directly related to the individual (training, experience, and critical thinking skills), but many are not (agency policy, agency or office climate, and caseload or workload). Agency leaders therefore play a critical role in creating an organization-wide culture to support effective casework.

The journal article "Applying Principles from Safety Science to Improve Child Protection"[4] describes a safety culture as "one in which values, attitudes and behaviors support a safe, engaged workforce and reliable, error-free operations," and cites four key principles:

- **Leadership commitment to safety.** Effective leaders keep the potential for tragic outcomes top of mind and maintain vigilance for potential organizational weaknesses, while communicating their support for staff.
- **Prioritizing teamwork and open communication based on trust.** Difficulties in practice must be discussed candidly in order for improvements to occur. Quality reviews should focus on productive, two-way communication between frontline staff and leadership, rather than individual compliance and fault-finding. This approach can help leaders better understand systemic barriers

> There will not be anything we do in this organization that will not be girded in … a safety culture and culture of equity. We recognize that we have significant challenges around racial bias. As a result we have created the Office of Equity that sits at the executive level of the organization. Everything we do — every policy we make, practice, hiring, must all be viewed through a lens of safety culture and a culture of equity."
>
> **— VIRGINIA PRYOR,**
> CHIEF DEPUTY DIRECTOR, LOS ANGELES COUNTY DEPARTMENT OF CHILDREN AND FAMILY SERVICES

to safety and how to effectively address them. For example, in 2013, Tennessee conducted an anonymous, cross-sectional survey of staff to measure various aspects of safety culture: safety climate; psychological safety; stress recognition; safety organizing; and workers' emotional exhaustion.[5] The intent behind the survey was to create a common language to drive culture change, raise staff awareness about safety, identify opportunities, and allow the state to track changes over time. Other strategies employed by the state include improving communication, teamwork, and supervision, as well as anonymous reporting of concerns and safety incidents.

- **Developing and enforcing a non-punitive approach to event reporting and analysis**. Some child welfare agencies are beginning to explore the practice, currently more common in other industries such as aviation, of creating a system for confidential reporting of practice errors and "near misses." This approach helps to promote organizational learning and a better balance between individual and system accountability for safety.
- **Committing to becoming a learning organization.** It is important for child protection professionals to have opportunities to learn not only from their mistakes, but also from their peers, and to continually improve their critical thinking skills. Likewise, the organization as a whole must continue to learn and evolve in response to an ever-changing world. In 2011, Tennessee hired master's level mental health professionals to conduct non-punitive analyses of child fatality cases in order to support continuous organizational learning.[6]

Responding to critical events

Maintaining a safety culture becomes even more essential when managing the organizational response to a crisis, such as a fatality or serious injury to a child. When the public, the media, policymakers and the child welfare system's response to a high-profile death results in individual blame, staff can become more risk averse and fearful, leading to increased removals of children and delayed reunifications. In addition, when policymakers react by passing new laws and the system institutes more procedures in response to critical incidents without fully considering the unintended consequences, they add to the complexity of an already overwhelmed system. The result can be increased workload and high staff turnover. Overall, these reactive responses can make the system less effective in keeping children safe.

In addition to developing a culture and expertise that supports critical thinking, the journal article "Leading for Learning in Child Protection Services Following a Child Fatality"[7] recommends the following in response to specific crises:

- **Avoid "hindsight error" and rushing to blame.** Hindsight error is the tendency to see risk as predictable after an incident occurs, rather than recognizing that risk assessment in foresight is complex.
- **Manage political and public reactions.** This requires agency leaders to communicate a consistent message of the boundaries of agency intervention as well as close cooperation between agency and political

> Safety culture means that after critical incidents we no longer ask, 'Who is responsible for this failure?' but instead, 'What factors led to this outcome, and how do we need to change our systems so that we can better protect children in the future?'
>
> — DAVID HANSELL,
> COMMISSIONER, NEW YORK CITY ADMINISTRATION FOR CHILDREN'S SERVICES

leaders. David Hansell, commissioner of the New York City Administration for Children's Services (ACS), notes: "When there are critical incidents, we are accountable to our political leadership and to oversight agencies, so we included those stakeholders in our initial orientations to safety science. It was important that they understood the cultural change we were going through, so we weren't working at cross purposes with them as we developed a new way of responding to incidents."

- **Support families.** Agencies must not lose sight of their primary responsibility to keep all of the children in the family safe, including siblings, and provide practical and emotional support to birth and foster families as needed.
- **Support staff.** A critical incident raises the anxiety of all agency staff, not just those involved with the case. All staff need to know that if they have done their best, the agency — from their peers and supervisor to the director — will stand by them. Jodi Hill-Lilly, deputy commissioner of the Connecticut Department of Children and Families, points out: "You need safe and sound staff, in order to have safe and sound practice, in order to get safe and sound outcomes on behalf of kids and families. Creating an environment where staff can be honest, where we are attentive to their psychological and physical safety and grounded in anti-racist practice, is critically important to the safety of our kids and families. We ground our work in justice."

Lessons learned[8]

Leaders who have implemented the principles of safety science to promote a safety culture offer strikingly similar advice to other jurisdictions:

- **Incorporate the voice of people with lived experience.** Youth and families must help drive the narrative and be part of designing solutions.
- **Do not undertake this alone.** Take every opportunity to learn from those who are already doing it well, both within child welfare and in other industries. The National Partnership for Child Safety is a quality improvement collaborative formed by child welfare leaders in 15 jurisdictions with a shared goal of strengthening families and promoting innovations in child protection.
- **This is not a step to be undertaken lightly.** Changing the culture of any organization or system requires time and sustained commitment, as trust is built slowly among staff.
- **Do not allow the culture shift to be derailed by crises.** Leaders implementing a safety culture during the COVID-19 pandemic noted that the crisis was not a reason to slow their efforts, but rather provided an opportunity to become even more adaptive and accelerate the pace of change.
- **Safety culture must be modeled by leadership.** Some leaders have suggested that adaptive leadership, humility, and honest, two-way communication are core competencies for leaders in a safety culture. New York City ACS

> We work hand in hand with the Office of the Child Advocate, our oversight agency, involving them in both case staffings and critical incident reviews. The more people involved in a decision, whether it is to remove a child or move a child, the more likely it is that the decision reached will be the right one. People can then do what they know is right, rather than being motivated by fear of making a critical mistake."
>
> **— TOM RAWLINGS,**
> DIRECTOR, GEORGIA DIVISION OF FAMILY AND CHILDREN SERVICES

introduced safety science and safety culture at senior levels in the organization to ensure broad leadership commitment to the process. Hansell recalls: "We began with a very in-depth orientation of our senior leadership team. We then moved down through tiers of management, to be sure that everyone understood and could reinforce the messages about how we intended to work differently as a system."

- **Engage external stakeholders.** It is essential to engage stakeholders such as political leaders, oversight boards, and union representatives in the shift to a safety culture so that they fully understand and can support the changes.

Agencies that have implemented these changes are beginning to see benefits, including lower caseworker turnover rates, increased community trust, and even fewer children being brought into care as a culture of fear becomes one of accountability and mutual support.

To learn more, visit Questions from the field at Casey.org.

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8. Content for this brief derived from presentations made at two convenings of the National Partnership for Child Safety: 1) in Palm Beach, Florida on June 11-12, 2019, and 2) virtually on May 13, 2020.

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Attachment 2

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

2021
REFERENCE
GUIDE

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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.

For specific permission to use please contact the Praed Foundation. For more information on the SSIT contact:

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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.

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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 2020, the National Partnership for Child Safety had grown to 21 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

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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, and 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	Medical/Physical
Developmental	Financial Resources	Developmental/Intellectual
Mental Health	Parenting Behavior	Mental Heath
Professional Domain	**Team Domain**	**Environment Domain**
Bias	Teamwork/Coordination	Demand-Resource Mismatch
Stress	Supervisory Support	Equipment/Technology/Tools
Fatigue	Supervisory Knowledge Transfer	Policies
Knowledge Base	Production Pressure	Training
Documentation		Service Array
Evidence		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: Bias), had no policy, training or supervision to support the provision of safe sleep information (SSIT items: Policy, 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). Systems may use different terms to describe IOs such as learning opportunity, key finding, or observation. The SSIT's ratings are organized around IOs. In order to rate a SSIT as a 2 or 3, the item must be affecting an identified IOs.

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, and appreciative of the professional's goal to achieve "zero harm" and only the best outcomes.

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.

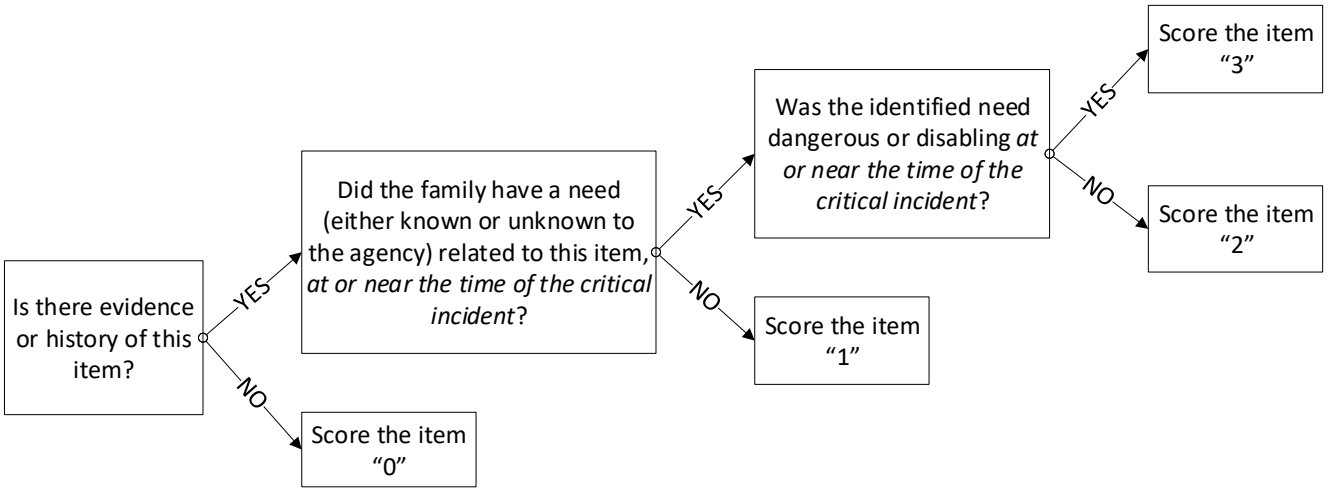
Scoring the Child and Family Domain

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.

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 should be 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

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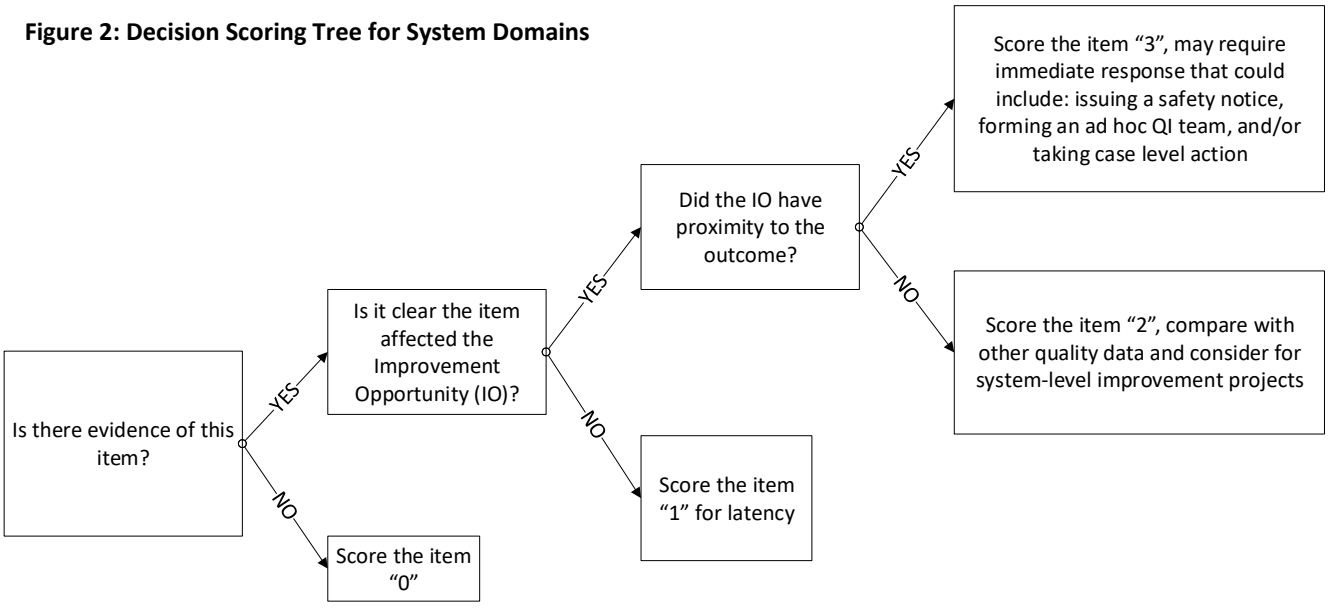
welfare agency did not provide safe sleep education and/or timely access to needed safe sleep resources, then SSIT items related to that IO are all scored as proximal (3). Conversely, if an infant dies from a congenital heart condition, yet historical engagement with the household did not include a private 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 or forming an ad hoc QI team.

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 and in pursuit of "zero harm."

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 (e.g., common casework barriers, casework problems connected to poor outcomes).

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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. This domain can be useful in drawing correlations between other domains and certain family items (e.g., if bias correlates to the presence of families with developmental disabilities). 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	Ratings & Descriptions	
• Did members of the family get along well? • Did arguments escalate to physical altercations?	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.

Questions to Consider	Ratings & Descriptions	
	0	There was no evidence that the caregiver had developmental needs.

Attachment 3

CAREGIVER DEVELOPMENTAL

This item refers to developmental disabilities including autism and intellectual disabilities.

- Had the caregiver been identified with any developmental or intellectual disabilities?

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 impossible for them to parent at the time of the critical incident

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

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

Ratings & Descriptions

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.
Note: Substance-Related Disorders would be rated '2' or '3' unless the individual was in recovery.

Questions to Consider

- Did caregivers have any substance use needs that make parenting difficult?
- Did anyone else in the family have a serious substance use need that is impacting the resources for caregiving?

Ratings & Descriptions

0	There was no evidence that the caregiver had any alcohol or drug use problems.
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 clear problems with alcohol or drug 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 problems that made it very difficult or impossible for them to parent at the time of the critical incident.

CAREGIVER FINANCIAL RESOURCES

This item rates the family's financial situation.

Questions to Consider:

- Did the caregiver ever struggled financially?
- Did the caregiver ever worried they won't enough money to meet needs?

Ratings & Descriptions

0	No current need; no need for action or intervention. This may have been a resource for the child. Caregivers had sufficient financial resources to raise the child.
1	Caregiver had some financial resources that actively help with raising the child. History of struggles with sufficient financial resources would be rated here.
2	Need interfered with the provision of care; action is required to ensure that the identified need is addressed. Caregiver had limited financial resources that may be able to help with raising the child.

Attachment 3

• What financial challenges did the caregiver have at the time of the critical incident?	3 Need prevented the provision of care; required immediate and/or intensive action. Caregiver had few to no financial resources to help with raising the child. Caregiver needed financial resources.

Supplemental Information: This item reflects whether or not the parent was able to rely on financial resources to support the needs of their child. This does not suggest that the family that was limited in their income did not have strength in this area as they may have demonstrated a strong ability to conserve their spending and stretch their resources. A family that overspent and was left with the inability to meet the financial needs of the child and family would not rate highly in this area. The focus is whether or not the family had the resources to meet the needs of the child and how well this was managed.

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)

Questions to Consider	Ratings & Descriptions	
• 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.

Questions to Consider	Ratings & Descriptions	
• 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 problems, and/or they were healthy.
	1	Child/youth had transient or well-managed physical or medical problems. These include well-managed chronic conditions like juvenile diabetes or asthma.
	2	Child/youth had serious medical or physical problems that required medical treatment or intervention or child/youth had a chronic illness or a physical challenge that requires ongoing medical intervention.
	3	Child/youth had life-threatening illness or medical/physical condition. Immediate and/or intense action was needed due to imminent danger to child/youth's safety, health, and/or development.

Attachment 3

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.

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 problems 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 abuse 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 that the child/youth was experiencing mental health challenges. The child/youth had no signs of any notable mental health problems.
1	The child/youth had mild problems with adjustment, may have been somewhat depressed, withdrawn, irritable, or agitated.
2	The child/youth had moderate mental health challenges and/or a diagnosable mental health problem that interfered with their functioning.
3	The child/youth had significant challenges with their mental health. The child/youth had a serious psychiatric disorder.

Attachment 3

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 case 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 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.

BIAS

A faulty understanding of a situation due to inherent predisposition(s) (e.g., confirmation bias, cognitive fixation, focusing effect, transference).

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.

Attachment 3

FATIGUE

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

Questions to Consider	Ratings & Descriptions	
• 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?	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	Ratings & Descriptions	
• 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?	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.

Questions to Consider	Ratings & Descriptions	
• If someone only read the notes, would they know what was going on?	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.

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).

Questions to Consider	Ratings & Descriptions	
• 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?	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.

Attachment 3

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.

Attachment 3

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.

Attachment 3

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-serving macrosystem.

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.

Attachment 3

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

The absence, poor clarity, or ineffectiveness of a 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 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).

Attachment 3

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.

Attachment 3

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. Financial Resources (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. Bias	○	○	○	○	
11. Stress	○	○	○	○	
12. Fatigue	○	○	○	○	
13. Knowledge Base	○	○	○	○	
14. Documentation	○	○	○	○	
15. Evidence	○	○	○	○	
Team Domain	**0**	**1**	**2**	**3**	***Required if rating is 2 or 3***
16. Teamwork/Coordination	○	○	○	○	
17. Supervisory Support	○	○	○	○	
18. Supervisory Knowledge Transfer	○	○	○	○	

Attachment 3

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	○	○	○	○	
24. Training	○	○	○	○	
25. Service Array	○	○	○	○	

Attachment 3

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:

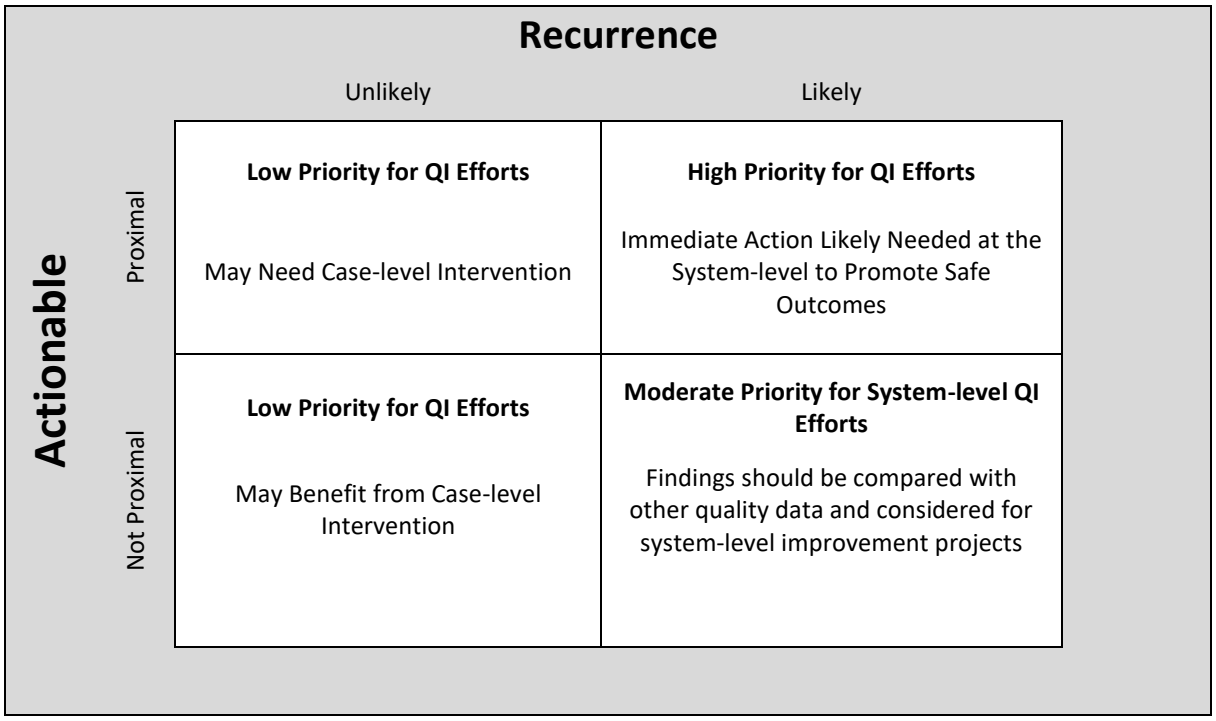
Table 3: Recurrence Rating Structure

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.

Attachment 3

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

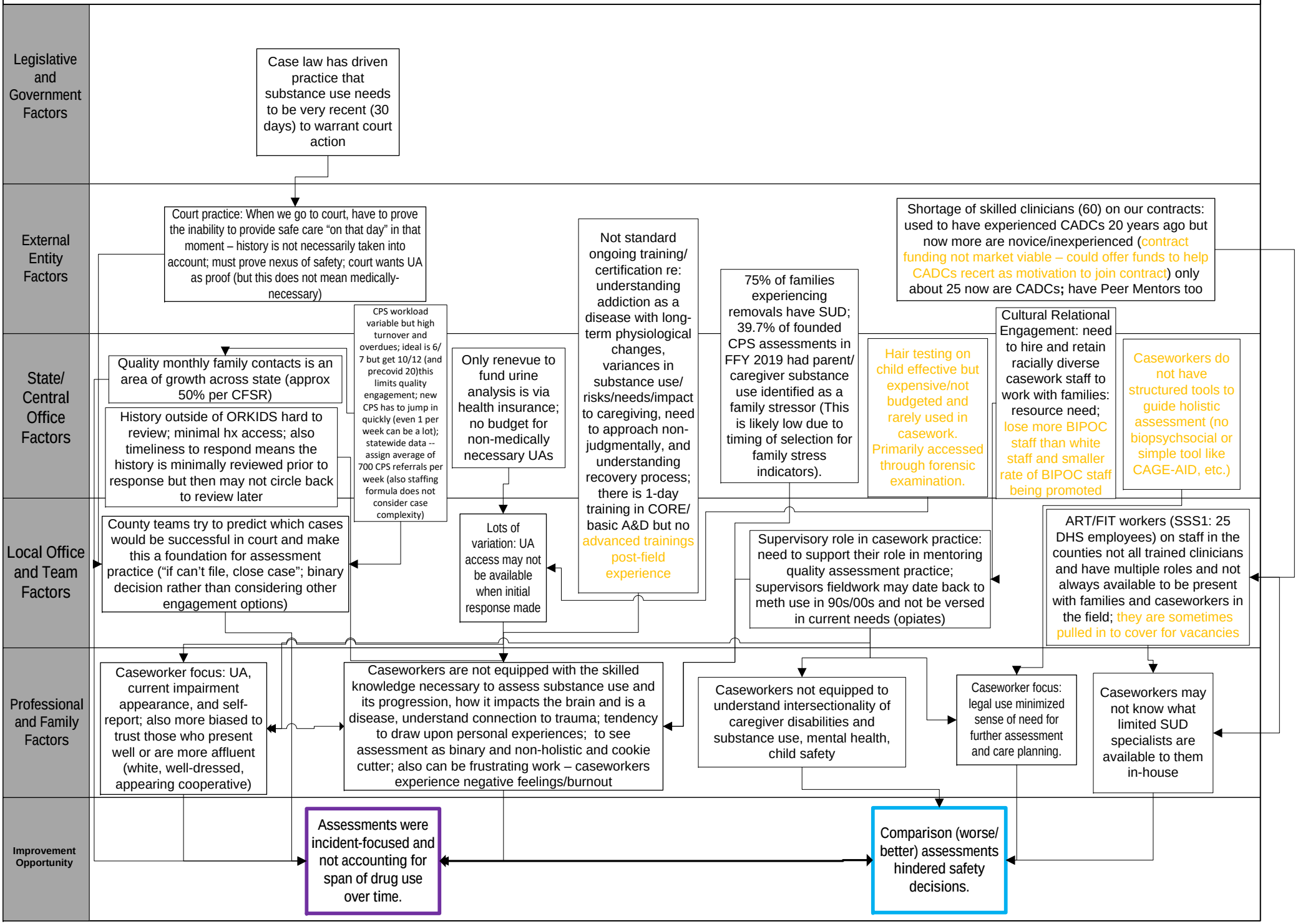


Advocating for System Change

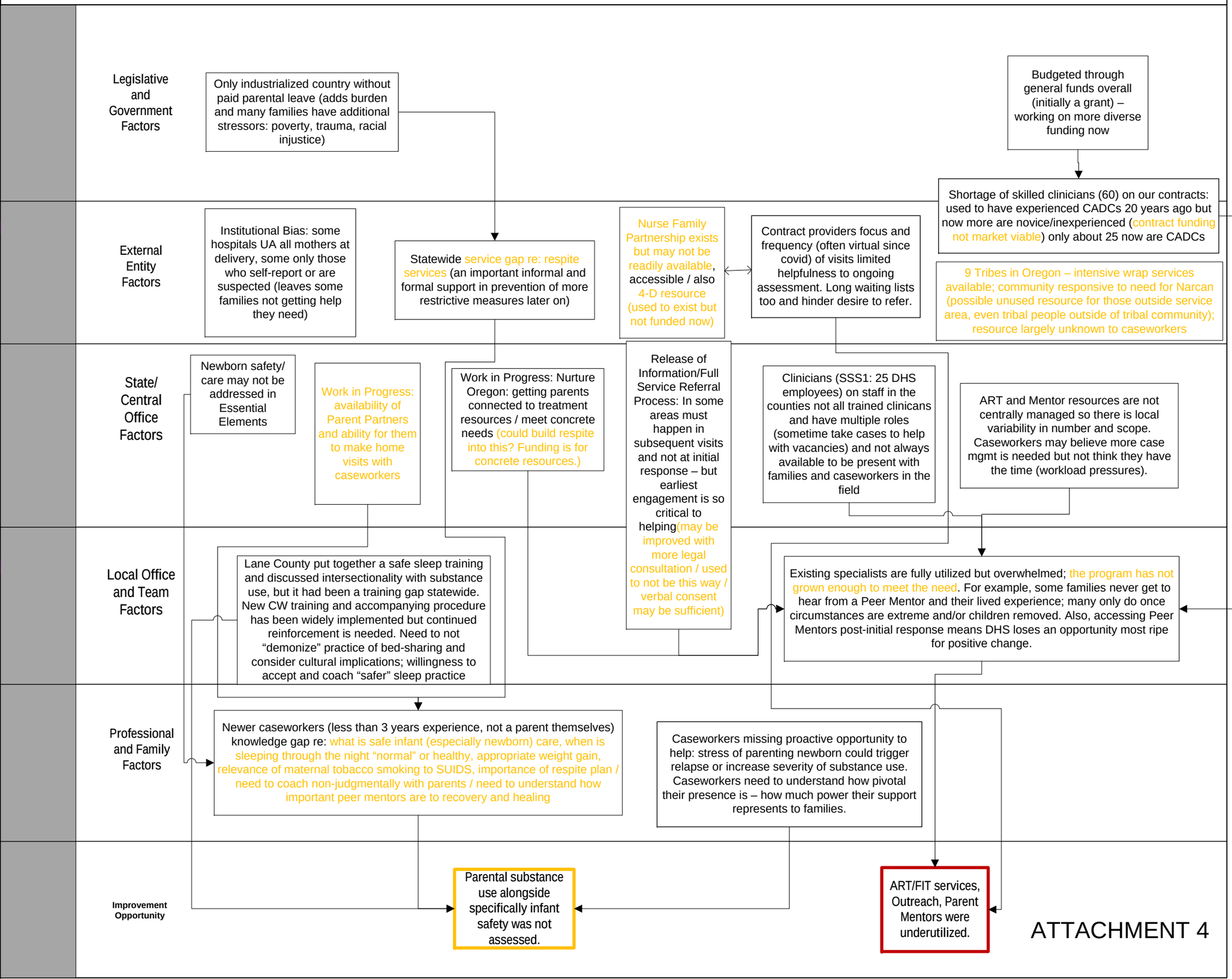
Those tasked with reviewing critical incidents rarely have formal authority to move systems to change. More often, their success lies in their ability to effectively use data to tell a story and influence communities with such formal authority to move to action. These traits—accurate story-sharing and 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.

Attachment 3

Systems Map


Legislative and Government Factors
External Entity Factors
State/ Central Office Factors
Local Office and Team Factors
Professional and Family Factors
Improvement Opportunity
Case law has driven practice that substance use needs to be very recent (30 days) to warrant court action
Court practice: When we go to court, have to prove the inability to provide safe care "on that day" in that moment – history is not necessarily taken into account; must prove nexus of safety; court wants UA as proof (but this does not mean medically-necessary)
Shortage of skilled clinicians (60) on our contracts: used to have experienced CADCs 20 years ago but now more are novice/inexperienced (contract funding not market viable – could offer funds to help CADCs recert as motivation to join contract) only about 25 now are CADCs; have Peer Mentors too
Not standard ongoing training/ certification re: understanding addiction as a disease with long-term physiological changes, variances in substance use/ risks/needs/impact to caregiving, need to approach non-judgmentally, and understanding recovery process; there is 1-day training in CORE/ basic A&D but no advanced trainings post-field experience
75% of families experiencing removals have SUD; 39.7% of founded CPS assessments in FFY 2019 had parent/ caregiver substance use identified as a family stressor (This is likely low due to timing of selection for family stress indicators).
Cultural Relational Engagement: need to hire and retain racially diverse casework staff to work with families: resource need; lose more BIPOC staff than white staff and smaller rate of BIPOC staff being promoted
Hair testing on child effective but expensive/not budgeted and rarely used in casework. Primarily accessed through forensic examination.
Caseworkers do not have structured tools to guide holistic assessment (no biopsychsocial or simple tool like CAGE-AID, etc.)
CPS workload variable but high turnover and overdues; ideal is 6/ 7 but get 10/12 (and precovid 20)this limits quality engagement; new CPS has to jump in quickly (even 1 per week can be a lot); statewide data -- assign average of 700 CPS referrals per week (also staffing formula does not consider case complexity)
Quality monthly family contacts is an area of growth across state (approx 50% per CFSR)
History outside of ORKIDS hard to review; minimal hx access; also timeliness to respond means the history is minimally reviewed prior to response but then may not circle back to review later
Only renevue to fund urine analysis is via health insurance; no budget for non-medically necessary UAs
County teams try to predict which cases would be successful in court and make this a foundation for assessment practice ("if can't file, close case"; binary decision rather than considering other engagement options)
Lots of variation: UA access may not be available when initial response made
Supervisory role in casework practice: need to support their role in mentoring quality assessment practice; supervisors fieldwork may date back to meth use in 90s/00s and not be versed in current needs (opiates)
ART/FIT workers (SSS1: 25 DHS employees) on staff in the counties not all trained clinicians and have multiple roles and not always available to be present with families and caseworkers in the field; they are sometimes pulled in to cover for vacancies
Caseworker focus: UA, current impairment appearance, and self-report; also more biased to trust those who present well or are more affluent (white, well-dressed, appearing cooperative)
Caseworkers are not equipped with the skilled knowledge necessary to assess substance use and its progression, how it impacts the brain and is a disease, understand connection to trauma; tendency to draw upon personal experiences; to see assessment as binary and non-holistic and cookie cutter; also can be frustrating work – caseworkers experience negative feelings/burnout
Caseworkers not equipped to understand intersectionality of caregiver disabilities and substance use, mental health, child safety
Caseworker focus: legal use minimized sense of need for further assessment and care planning.
Caseworkers may not know what limited SUD specialists are available to them in-house
Assessments were incident-focused and not accounting for span of drug use over time.
Comparison (worse/ better) assessments hindered safety decisions.

Systems Map



ATTACHMENT 4

TeamFirst

A Field Guide for Safe, Reliable, and Effective Child Welfare Teams

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ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of the TeamFirst Field Guide. Special acknowledgement belongs to Tennessee Department of Children's Services, who, with the support of Casey Family Programs, first tested some of these strategies with their workforce. This TCOM reference guide represents the curation, adaptation and development of a set of strategies, tools and tactics the support more safe, effective and reliable team-driven casework. The history of this approach traces to aviation's Crew Resource Management and The Agency for Healthcare Research and Quality's TeamSTEPPS and CUSP. The copyright for TeamFirst is held by the Praed Foundation to allow for its continued development and ensure that it remains free to use.

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INTRODUCTION

A field guide is a reference book that helps users learn by providing them with real examples from "the field." In his seminal work, *The Field Guide to Understanding Human Error*, Sydney Dekker (2014) introduced us to a new way of thinking about professional behavior in complex systems and gave readers a practical guide for engineering safer systems. Building on the work of Dekker and many others, *The TeamFirst Field Guide* is designed as a reference for safe, reliable and more effective teamwork. Readers will find descriptions of specific team-based strategies and tactics that work and are illustrated with some real-life examples of implementations in the field.

Culture is an implicit pattern of shared basic assumptions among a group of people (Schein, 2010). It can be defined, measured and changed. Culture lives in habit—the implicit routines people enact to problem solve—it is how members "get work done around here." In a Safety Culture, safe and engaged teams practice six enduring habits. These teams…

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.

In summary, teams in a Safety Culture plan forward, reflect back, test change, communicate clearly, appreciate their colleagues, and manage professionalism. This field guide is a collection of strategies organized by each of the six habits.

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PLAN FORWARD

Spend Time Identifying What Could Go Wrong

By nature, human service work experiences a level of volatility, ambiguity, and complexity rivaling other high-risk industries, like healthcare. Consistently safe decision-making is the result of open-minded, adaptive, shared accountability among a team. The inextricably connected sociotechnical nature of human service work—often highly pressured and under resourced—requires multiple professionals to collaborate as seamlessly as possible. Getting into the cadence of "planning ahead" is central to projecting and resolving risk factors before they lead to harm. The following are strategies designed to cultivate this habit among intact and ad hoc teams of professionals.

Huddles

For example, in child welfare, all professionals assigned to work with a family gather before heading into court to summarize the family's status, verbalize concerns, and project plans for what likely happens next.

Huddles also occur before important meetings where the child and family will be present.

Planning forward is an essential aspect of building and supporting a safety culture. It means that rather than being reactive to situations and events, the team can be proactive. Further, it increases the likelihood that decisions will be thoughtful, intentional, and systematic, rather than last minute and made under pressure.

Huddles are used successfully in many high-risk industries. For example, in healthcare, the use of preoperative huddles reduced the number of surgical errors (Criscitelli, 2015).

GROUND RULES

- Standing is better than sitting
- Keep it short (no more than 15 minutes)
- Start and end on time

PREP = **P**REPARE, **R**EVIEW AND ANTICIPATE, **E**NACT, **P**ROMOTE RESILIENCE

Prepare

- Ensure team members have what they need to prioritize case activities (e.g., referrals assigned, case logs, overdue reports).
- Organize the materials the team needs (e.g., case assignments, family contact logs, overdues, information on any incident reports/new referrals on open cases, etc.)

Review and anticipate

- State the purpose: to update and anticipate
- Provide team-level update (e.g., case closures, caseload data, overdue #s)

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- Facilitate case-level updates
- Anticipate care needs/challenges with questioning. Always ask "What are you concerned about?"

Enact

- Mobilize resources to remove barriers.
- Expect team members will experience challenges throughout the day. Build individual resilience and team shared meaning with an eliciting/evoking style and closed loop communications.

Promote resilience

- Close each huddle with a statement that reinforces Safety Culture and promotes resilience.

Checklists

For example, when transporting a child with type 1 diabetes to a new foster home, the case manager consults a checklist to ensure she provides the correct supplies, education, and medical contacts to the caregivers.

Checklists for safety-critical tasks are crucial, especially in building strong casework practices and remembering relevant details during infrequently conducted, safety-centered tasks. For example, a checklist about things to do when removing a child from a caregiver's home can be extremely helpful to a new professional and even to an experienced professional who is affected by fatigue or stress and/or has not completed a similar task in some time.

As an abiding principle, checklists need to be:

- Readily-Accessible
- Clear
- Concise
- Relevant
- Easy to Use

Though checklists can be meaningfully used to list steps on a variety of issues, teams may find checklists are most useful during crucial safety moments, when pressures are high and errors, if made, could have a dire impact on employee, child, or family safety, such as the following: meeting initial response to a home, removing a child(ren) from a home, addressing a safety concern about a family member's mental health, and/or reunifying a family after some time apart.

Be mindful of not creating unnecessary checklists or getting in the habit of marking off checklists without truly reflecting upon each item.

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Pre-Mortem Strategy

For example, during group supervision, clinicians use pre-mortem strategy to consider discharge planning for a client with a complex history of psychiatric hospitalizations.

A reflective, mental strategy where you imagine a future state, when a plan has been put into place but failed. The strategy is useful because, in some cases, we know how a plan is likely to fail. Taking the time to think through likely failures gives an opportunity to proactively create safeguards.

Follow these guidelines:

- You've engaged the family in response to an event…
- The plan you wanted to put into place has happened, but…
- The plan has failed…
- What went wrong?

For example, you might use pre-mortem strategy about a child beginning a trial home placement with his father. You imagine the home placement started with desired services (e.g., counseling, case management) in place, yet the trial home placement failed, and the child re-entered foster care. By imagining what could likely go wrong, you consider the father's limited social and mental health supports to raise a child with autism. As a result, he becomes overwhelmed and depressed.

With the outcome of the pre-mortem strategy in mind, a new plan is developed, where the father begins attending a monthly support group for parents raising children with autism, connects with local grant-funded respite services for occasional caregiving assistance, and the father attends individual mental health counseling.

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REFLECT BACK

Talk About Mistakes and Ways to Learn from Them

Making a mistake does not guarantee learning, but processing a mistake is foundational to learning and improvement. In psychologically safe cultures, disclosing an error is respected and supported—not because team members engage in pat responses—but because mistakes are viewed as opportunities to learn and receive support to press onward with more wisdom at hand for the next time. Without question, no human service professional engages in perfect, error-free work. Expressing vulnerability through transparent discussion of mistakes is a display of great professionalism and courage. As such, "reflecting back" is a value of safe, engaged teaming (Edmondson, 2019; Perlo et al., 2017). The following are strategies to promote the habit of reflecting back:

Structured Debriefs

For example, a supervisor debriefs with his team anytime a child/youth is disrupted from a foster home.

Structured debriefs should follow important trigger events. For example, in foster care, placement disruptions or maltreatment recurrence could trigger a team debriefing. Being inconsistent and/or not communicating in advance what events will trigger debriefing can make the process feel less psychologically safe, because team members could be worried debriefings only occur when the supervisor believes a team member made a mistake. For example, debriefs could be done as a team or between a case manager and supervisor at the end of certain Child and Family Team meetings or after unanticipated court ordered removals of children to state custody.

Note: During debriefings, if someone responds unprofessionally or disrespectfully towards the person who made the mistake, it is crucial this person receive an honest and prompt correction (see Section Six: Managing Professionalism for related strategies, like OSSCR).

Ask three simple questions:

- What went well?
- What could have been better?
- What will we do differently next time?

Debriefs are a leader facilitated discussion that accomplish two important goals:

- Team unity and psychological safety
- Learning and improvement

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Facilitator Checklist:

- Communication clear?
- Roles and responsibilities understood?
- Situation awareness maintained?
- Workload distribution equitable?
- Task assistance requested or offered?
- Were errors made or avoided?
- Availability of resources?

PMI: Plus – Minus – Interesting

For example, a teammate uses PMI while mentoring a new employee to discuss what the new employee is learning from her fieldwork.

An activity where you look at an event or case retrospectively and think through the following questions:

- **Plus**: What went well? What went according to plan? What did I/we do that worked so well, and is there anything learned to apply again the next time?
- **Minus**: What did not go well? Was there anything that should not be replicated in a future situation? What were the "lessons learned"?
- **Interesting**: What things were learned that were previously unknown? Anything unique or curious and worthy of sharing with others?

Restorative Accountability

For example, a case manager working with adults recovering from drug-dependency experiences a suicide on his caseload. He is grieved and worried his last visit with the client was shortened by an emergency on another case. Affected by the emergency on the other case, he had quickly concluded the client was safe, acknowledging the client was experiencing a "bad day" but believing sufficient supports existed to assure safety. Rather than exact discipline on the traumatized case manager, the supervisor offers support and gives the case manager an opportunity to process, learn, and heal.

A **retributive approach** to accountability is concerned with rules, rule-breaking, and sanctions. It assumes blame and the threat of sanctions motivate safe behavior and error avoidance. A retributive approach asks the following:

- Who broke which rule?
- How serious is the violation?
- What is the proportional punishment?

A **restorative approach** to accountability is concerned with learning and assumes the complexity through which mistakes or errors occur. Such an approach achieves accountability through repair, prevention, and learning. A restorative approach asks:

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- Who was harmed?
- What do they need now?
- Whose responsibility is it to provide help?

In a retributive culture an account becomes something to be paid back – something that is owed. In a restorative culture an account is a story to be told – something to help us learn and get better (Dekker, 2007).

The Substitution Test

For example, a mental health counselor inadvertently allows a safety plan to expire on a child with ongoing emotional disturbances. In determining appropriate accountability and next steps, the supervisor mentally questions if other similarly experienced counselors in the same situation would be likely to make the same mistake.

A reflective, mental activity to consider a professional's culpability in context.

Would three (3) other individuals with similar experience and in a similar situation and environment act in the same manner as the person being evaluated?

- If the answer is **yes**: The problem is not the individual but more likely an environment which would lead most professionals to the same action.
- If the answer is **no**: If similarly experienced individuals would not have acted in a similar manner, it is possible the individual is more culpable and individual accountability is appropriate—whether through services (e.g., mental health treatment), coaching, disciplinary action, or otherwise.

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TESTING CHANGE

Discuss Alternatives to Everyday Work Activities

Implementation science is the study of what factors promote and accelerate successful, scalable, and sustainable improvements. Studies may inform "what" achieves the best client outcomes in human service professions, but guiding professionals (the "who") and offering the motivation (the "why") to change practices can be hard. This adaptive side of leadership and teamwork is challenging but well-harnessed by implementation science (Hilton & Anderson, 2018). Empowering teams to collaborate and conduct "small tests of change" is central to safe, reliable teamwork.

Using Implementation Science Principles

Implementation science underlies successful quality improvement. Whenever you are considering an improvement activity, ask three simple questions:

- **Overall Aim or Goal:** What are we trying to accomplish?
- **Desired Outcome:** How will we know a change is an improvement?
- **Ideas for Strategies, Tools, or Practices:** What changes can we test that will result in improvement?

Small Tests of Change (PDSA CYCLE)

For example, a regional office tries a new on-call schedule for one month in one county and assesses the impact to employee's workhours before implementing on a larger scale.

Rather than trying to implement something big and different all at once with some office-wide "roll-out," testing strategies and tools on a small scale first can be much more effective. The Plan-Do-Study-Act method is a way to test ideas quickly on a small scale.

The Plan-Do-Study-Act (PDSA) methodology is intended to help people move quickly from identifying solutions, strategies, and opportunities to trying them out – on a small scale – in the real world. It is based on a simple continuous quality improvement model in which you plan what you want to do (Plan); you try it out (Do); you think about and review what happened when you did it (Study); and you adjust it based on what you learned (Act/Adjust).

Why Use a PDSA

- Check to see whether the idea will actually result in improvements
- Allow those closest to the work – and those who know the real-world environment best – to test the changes they identify
- Determine whether the idea will work in the real-world environment

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- Increase belief from others that your idea will actually result in improvement (gain proof and buy-in)
- Identify possible costs, side effects, or unintended consequences while the impacts and risks are fairly low
- Evaluate how much improvement can be expected from the change

How to Test a PDSA

- **Plan:** Identify a strategy or idea you want to test. Think about what it would look like if you just tried it out with one child, one family, one colleague, etc. Remember you are not trying to figure everything out at once, nor do you want to spend time trying to figure out how to make it work for everyone, all the time. You just want to try it once to make sure it is a good idea worth pursuing.
- **Do:** Try it out with that one child, family, colleague, etc. Just do it exactly as you planned.
- **Study:** Reflect on what worked the way you expected and what might have surprised you in the process. Ask the person who you tested this idea on what they thought about it. Did they like it better than whatever happened for them in this situation previously? What worked for them? What did not? What other recommendations do they have for you?
- **Act/Adjust:** Use the results of your 'study' – what you experienced, observed, reflected on, heard from the person you tested it with – to inform how you might make this idea even more effective next time. This 'adjust' phase should feed directly into your next **Plan** so that the next time you do it, you'll have worked out some more of the real-world kinks.

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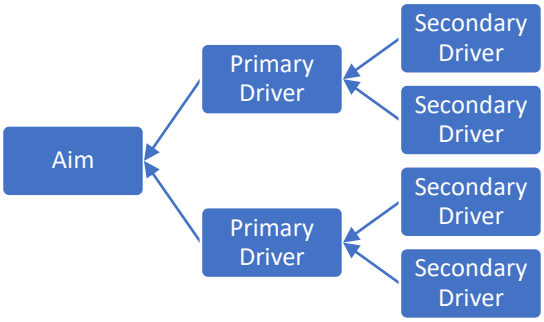
Driver Diagram

For example, a public health director wants to reduce the infant mortality rate. He understands the primary drivers of infant mortality to be inadequate prenatal maternal health, postnatal care, and the presence societal issues like poverty and substance abuse. He decides to hone his improvement opportunity at postnatal care. He studies and identifies drivers of strong postnatal care include caregiver attachment, parenting education, and pediatric care. As a result, he begins a Nurse Family Partnership program in a county with a high infant mortality rate.

A simple, visual diagram of what is theorized to "drive" a goal or achievement. A driver diagram identifies both key and secondary drivers and their relationship to one another.

A driver diagram is used to articulate a theory of what drivers can be changed to result in improvement. It organizes and justifies the changes a team is wanting to make.



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COMMUNICATE EFFECTIVELY

Develop an Understanding of Who Knows What

Human service work is high-risk, interdependent and also fast-paced. Though intact teams can struggle to communicate effectively, cross-team communications are even riskier. In those cases, professionals need to work seamlessly to make safe decisions, and vital decision-makers may not even have previously met one another (Edmondson, 2019). Furthermore, safe, engaged teaming requires teammates to know one another's unique skills. A professional regularly receiving the opportunity to use personal strengths is crucial to engagement. In a Gallup poll that asked respondents if they "have the opportunity to do what [they] do best every day," every single respondent who disagreed additionally reported being emotionally disengaged at work (Rath, 2007). An emotionally disengaged workforce cannot reliably make safe decisions. Communicating concisely and to the person with the right expertise helps ensure vital information gets handed off to the right person, the right way, at the right time, and in a manner supporting the recipient's memory retention.

4Cs of Communication

Communication should be:

- **Clear.** Avoid jargon. Be professional.
- **Concise.** Shorter is better. Your colleague will be more likely to retain and use the information you provide if it is kept brief and only focused on relevant information.
- **Comprehensive.** The balance to being Concise. Keep it short, but include all crucial content.
- **Congruent (words match body language and expression).** 55% of communication is done non-verbally. Pay attention to your body language and non-verbal cues.

Briefs

For example, before walking into a family's home, a social worker and Law Enforcement officer quickly brief one another on the current concern, family history, and next steps. They develop quick contingency plans should safety become an issue, and they succinctly remind one another of standard safety procedures (e.g., not to walk in front of the family down a hallway, if sitting stay close to an exit).

A discussion between two or more teammates to succinctly process case-specific information. A brief can be requested by any team member anytime.

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A briefing immediately:

- Maps out the current plan for the child or family
- Identifies each teammate's responsibilities
- Assesses if the current plan should be revised and, if so, how
- Articulates safety concerns and plans to ensure safety
- Often uses STEP or SBAR (see below)

Situational Awareness with STEP

For example, a social worker describes a current situation with a client using STEP: " **[Situation]** Neveah appears content and safe in Visitation Room A with her mother, but Neveah was crying and threw a small children's chair in the moments before her mother arrived. **[Team Members]** Amy and I are monitoring the visit together. **[Environment]** Currently, Neveah is playing a card game with her mom, and [**Progress**] their visit has approximately 45 minutes left."

An acronym to quickly communicate a current situation with a child or family (i.e., client)

- **S**tatus of the client
- **T**eam members
- **E**nvironment
- **P**rogress

SBAR

For example, Child Protective Service Investigators use SBAR to present a case to a Department Attorney when considering if a child should be removed from a home. Using SBAR streamlines dialogue and creates an environment where the attorney and frontline investigator communicate well directly, rather than communicating indirectly through a supervisor.

A useful acronym for processing safety-critical information, like a child and family case. For example, SBAR can be used to succinctly describe a case to a supervisor, assisting agency, and other internal professionals who are responsible for making case-specific decisions (e.g., an attorney responsible for evaluating if sufficient evidence exists for exigent removal of a child)

- **Situation.** What is the current status? What's going on?
- **Background.** What is important to know about the service provider, case, child, or family's background? What is the context?
- **Assessment.** What risks do I and/or others see?
- **Recommendation.** What would I do to provide safety? What is the next decision I believe needs to be made?

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When listening:

- Avoid mental distractions (i.e., "Tech down; eyes up.")
- Listen intently
- Take notes if possible—and especially if discussing multiple cases or case decisions
- Ask questions
- **Reflect back** always (and use SBAR when you do)

Common pitfalls:

- Assuming you are using SBAR naturally—even when stressed and tired
- Drifting into tangents

Three things you can do right now to increase the structure and efficiency of your communication:

- Write SBAR in your office space or on a notecard to go behind your employee badge.
- Practice…Practice…Practice. Use SBAR when speaking with your supervisor or legal about a case.
- Engage in mindfully staying on task when transferring a case or offering safety-critical information to someone else who is making important decisions.

For example, a social worker uses I PASS to communicate critical information to a colleague who will be temporarily assigned her cases while she is on vacation.

"I PASS"

An acronym to structure the exchange of information during handoffs (e.g., transferring a case from one case manager and/or team to another).

Introduction: introduce yourself and your role/job

Person: provide the child and/or family's name and important identifiers (e.g., age, gender, location)

Assessment: list presenting concerns and current assessment of those concerns

Situation: identify the current situation (e.g., housing, employment, family supports, childcare) and care plan

Safety Concerns: process all current or recent safety concerns

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APPRECIATION

Appreciate Colleagues and their Unique Skills

The psychological benefits of experiencing gratitude is well-documented, but a recent healthcare study involving nurses found even physical advantages (i.e., improved sleep quality and adequacy, fewer headaches, healthier eating) to receiving appreciation in the workplace—because appreciation increased job satisfaction (Starkey, Mohr, Cadiz, & Sinclair, 2019). Human service professionals often associate their careers with core pieces of their identity, placing themselves in hazardous conditions and looking out for their clients, at times, even above looking out for themselves (Portland State University, 2019). Expressing gratitude is a crucial and not-to-be-underestimated habit of safe, engaged teamwork.

Intentional Affirmations

A supervisor writes a handwritten note to one of his employees after she testifies in court for the first time. He affirms her efforts to prepare her testimony as well as her sense of professionalism in the courtroom.

Intentional affirmations, particularly ones about character or effort, generate positivity and synergy among teams. Acknowledging specific successes is useful but could become a source of anxiety since successes are closely aligned with performance indicators.

Generally-speaking, intentional affirmations are best when they are:

- Unique to the individual or team
- Administered in a personal way (e.g., a handwritten note)
- Given freely at irregular intervals and not in a regimented or scheduled way

Managing Up

For example, while transferring a case from one social worker to another, the original social worker speaks well of the colleague who will begin work with the family.

Managing up is simple tool for affirming your colleagues and setting the stage for engagement. We "manage up" by speaking positively of our colleagues and genuinely expressing their strengths to others. For example:

> *"Angie is going to begin working with you next week. I know you've only met Angie once, at our last meeting, but I have worked alongside Angie for the past year. She is knowledgeable, compassionate, and great at coordinating services."*

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What is the goal?

- Families and youth feel better about their next case manager and experience.
- Families and youth feel more at ease about the coordination of their care.
- Coworkers give/get a head start on engagement.

Manage up at two levels:

- Positively position team members with other team members.
- Positively position team members with families and youth.

Resilience Rounds

For example, an executive leadership team meets with regional staff. While on-site at the regional office, each leader meets with 4-5 frontline regional staff and takes a moment to express appreciation, model values, and asks the group how the leader can better connect and contribute to their work.

Senior leaders can reinforce goals and support resilience through informal conversations with professionals.

Ground Rules

Teams should decide whether to announce the time and place of Resilience Rounds, and the decision should be agreed to by senior leaders and managers. Leadership should reassure professionals information discussed in Resilience Rounds is private.

What are the Goals?

Resilience rounding provides an opportunity for senior leaders to interact directly with frontline professionals to promote resilience. Authentic conversations with leaders can empower field professionals, breakdown communication silos, and inform improvement. Positive affirmation, anticipatory care practices, and supportive professional relationships are among the most effective tools we have for reducing burnout, stress and the effects of secondary trauma exposure. Resilience rounds:

- Promote professionals' resilience through direct affirmation and active listening from leaders
- Model a positive, responsive culture and promote effective team behaviors
- Allow leaders to identify system-level improvement opportunities

What is the format?

A conversation with the leader and three to five employees can be structured in various ways, including:

- Hallway conversations or informal team talks
- Individual conversations in succession
- Group conversations with employees in a specific type function or job

Large formal convenings should be avoided. Look for small, safe, comfortable spaces.

Attachment 5

Remember: Two people are likely to do 60% of the talking. The leader's role is to listen and bring everyone into the conversation.

Open with something appreciative:
"Thank you for your work. I appreciate your…"

Discussion Question:
"Does your team spend time identifying activities we do not want to go wrong? For example, placement disruptions."

- Possible follow up from Information Technology staff – How does our electronic case record help you prevent things from going wrong or create barriers?
- Possible follow up from Fiscal Director – How do our fiscal processes help you prevent things from going wrong or create barriers?
- Possible follow up from Regional Leader—How do our monthly reviews help prevent problems or create them?
- *The goal is to encourage open, authentic dialogue in order for the leader to promote safe conversations about issues and to demonstrate genuine interest in understanding how the leader's work is affecting the frontline and vice versa*.

You may also consider the following discussion question if time permits.
"Does your team have opportunities to talk about mistakes and ways to learn from them? Do you feel like mistakes are often held against you?"

"On your team, is it okay to speak up when you disagree with a team member's decision?" In asking these questions, take a brief moment to express values as a leader of the organization.

- "We (leaders) always want people to come forward with concerns."
- "We (leaders) want to foster safe, collaborative conversations about mistakes—not to unfairly judge or blame, but always to learn and improve."

Things to listen for:

- Do teams have the tools and resources they need?
- Who do they go to with tough problems?
- How do they manage the stress of the job?
- Remember tackling and implementing solutions to issues, when possible, and circling back to teams with improvements helps encourage these conversations to continue.

Attachment 5

MANAGE PROFESSIONALISM

Candor and Respect are Preconditions to Teamwork

High-stakes conversations are daily practice in human service organizations. Teams need to feel ready—even mandated—to challenge ideas, assertively confront concerns, and learn from successes as well as failures. (Edmondson, 2019). A silent workforce cannot make safe choices, but an overly aggressive and confrontational one cannot either. To that end, candor and respect are preconditions to safe, engaged teamwork. Candor and respect generate the trust teams need to engage in productive, healthy conflict (Lencioni, 2012; Patterson, Grenny, McMillan, & Switzler, 2012). The strategies below are simple yet effective tools in building the habits of candor and respect.

Signal Words: CUS

For example, during a huddle, a new case manager is worried a child is unsafe and needs to be removed from a foster home, but no one else on the team seems to feel that way. Rather than say nothing, the case manager says "Help me **understand**. I don't think this home is safe." When the response does not address her concerns, she says, "Let's **stop** for a minute. I'm worried." As a result, the team gives the case manager an opportunity to more fully articulate her concerns and revises their plan.

Team with a strong safety culture embrace “speaking up” behaviors. With a foundation of trust and positive regard for one another, all teammates are expected to share safety concerns. Even if this leads to conflict, such dialogue is essential in considering all known risks and creating the safest, best outcome for an employee, child, or family. The key is to engage in healthy conflict and use repair when needed.

Assertive statements follow the “two challenge rule”—meaning it is your responsibility to assertively voice a safety concern at least two times. The team member being challenged must acknowledge your concern.

To facilitate “speaking up” behaviors, it is helpful to use signal words, like CUS, that immediately alert team members to the presence of a safety issue.

CUS when necessary

- Can we CHECK-IN
- Help me UNDERSTAND
- Let’s STOP for a minute

Attachment 5

I'm SAFE

For example, prior to transporting a child several hours to a residential facility across state lines, a team convenes and uses I'm SAFE to decide which of them are most fit for the long transport.

A mnemonic used to assess fitness to perform safety-critical tasks.

I	**Illness**	Is the professional free from illness?
M	**Medication**	Is the professional affected by any medications that impact physical or cognitive functioning?
S	**Stress**	Is the professional overly worried by life factors? Is the professional managing stress well?
A	**Alcohol**	Is the professional free from alcohol or other impairing substances?
F	**Fatigue**	Is the professional rested and generally sleeping well?
E	**Eating**	Is the professional "fed, watered, and ready to go"?

OSSCR (Oscar)

For example, a supervisor uses OSSCR to express concern when someone repeatedly shows up late for meetings and is not working equitably with teammates.

OSSCR Script is delivered colleague to colleague:

- **OPEN** with specific situation or behaviors; provide concrete information
- **SHARE** how the situation makes you feel and what your concerns are
- **SUGGEST** other alternatives and seek agreement
- **CLOSE** and avoid enabling, don't expect thanks, not a control contest
- **REFLECT** and breathe and move forward

Before having a discussion about a concerning or problematic situation or behavior, mentally ask yourself why a reasonable person would do the problematic or concerning thing. Avoid making unhelpful assumptions about why a problem exists or what it means. While using OSSCR in conversation with your colleague, be both honest and respectful, and ask clarifying questions rather than assume causes or underlying motivations. Being candid and respectful is a key to psychologically safe conversations and to making positive changes.

Attachment 5

If a problematic or concerning behavior is recurrent, in spite of OSSCR conversations, be certain you are addressing the right issue, and not just a symptom. For example, a person who is routinely late to meetings, even after communicating concerns and making an agreed upon plan to improve, is breaking commitments, and this (rather than just tardiness) needs to be the topic of an OSSCR conversation.

Healthy feedback is:

- Timely – given soon after the target behavior has occurred
- Respectful – focuses on behaviors, not personal attributes
- Specific – relates to a specific task or behavior that needs correction or improvement
- Framed as an opportunity – provides direction for future improvement
- Considerate – considers a team member's feelings and delivers negative information with fairness and respect. It is both 100% candid and 100% respectful.

Three Good Things

For example, a leadership team commits to journaling Three Good Things every evening for two weeks. Afterwards, over half of the leadership team continues the practice. During meetings, the team is more clear-headed, collaborative, communicative, and solution-focused.

Three Good Things is an evidence-based exercise in positive psychology (Rippstein-Leuenberger et al., 2017). Before bedtime, write or electronically log three good things that happened during the day. To be effective, it needs to be done for a minimum of two weeks, but continuing three good things could be a habit to keep for a lifetime.

Three Good Things works by training your mind to focus on positives. It is normal for our minds to primarily recall negative experiences, because these are the experiences we want to negate in the future. By practicing Three Good Things right before bedtime, you unconsciously train your mind to acknowledge and recall positive experiences as well. It lessens fatigue and the impact of traumatic stress.

Your Three Good Things log might look like this:

- Date:
- Three Good Things that happened today:

  1)

  2)

  3)

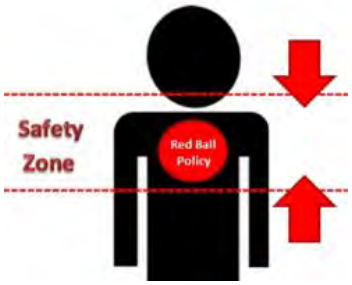
Attachment 5

Red Ball

For example, a frontline child welfare team keeps an actual Red Ball in their shared office space. When a teammate notices a colleague seems disengaged, he rolls the ball (signifying "ball too low") and asks what's going on. Another time, a teammate is feeling anxious about an upcoming court date and grabs the ball, placing it above her head (signifying "ball too high"). Her teammates take a time out to discuss the court case with her.

The Red Ball (Ebert & Kuhn, 2017) is a metaphor for emotions, especially the way we manage stress, anxiety, and fatigue. It refers to individuals or teams. You can use the metaphor to make sure you and your teammates are seeking balance between your "head and heart" in interactions, discussions, and decisions.

- Ball is too high = Stress and anxiety are high
- Ball is too low = Exhausted, resigned, or frustrated
- Throw the ball at others = Aggressive, yelling, blaming
- Hold ball too tight = Guarded, isolating, "putting up walls"



If we think about our emotional state as a red ball, the goal is to keep it centered. Somewhere between "the head and the heart"—where feelings are energized, psychologically safe, thoughtful, and responsive. This is called the "safety zone."

When the ball is too high, we may feel intense worry, respond in angry/agitated ways, sleep poorly, and make decisions too quickly. When the ball is too low, we may be tired, disinterested, and delay in making decisions or being responsive to others. Sometimes people throw their ball at others by raising their voice or speaking negatively of a colleague, and people can also hold their ball too tightly and become guarded– not sharing their feelings with others.

Individuals can contribute to a team's mindful organizing by regulating their Red Ball and helping their teammates do the same. By acknowledging the constant presence of the Red Ball, we identify our emotional responses and can help keep ourselves and one another in the "safety zone."

TIPS IN USING THE RED BALL:

- Know where your own red ball is
- Reach out to others as needed, and let them help you keep your Red Ball in balance
- Visualize where others' Red Ball is and help keep theirs' in balance
- Overall Goal = Maintain all of our Red Balls in balance, so we can function effectively as individuals and as teams

Attachment 5

STRATEGIES FOR KEEPING OUR RED BALL IN THE BALANCED ZONE BETWEEN OUR HEAD AND OUR HEART:

- Create distraction-free zones (e.g., quiet spaces)
- Listen to music
- Go for walks outside
- Open windows (if able); have pictures of nature in your space
- Stretch (e.g., yoga)
- Structure for increased teamwork during high-stress moments (i.e., avoid over taxing any one team member)
- Verbally acknowledging the Red Ball and responding mindfully to teammates

Attachment 5

Oregon DHS QPR Suicide Prevention Training

Pre- and Post-Training Survey Data Report

September through December 2020

Highlights *(see following pages for more detail)*

Trainee Details

+ A total of **230 people** completed either QPR[1] or QPR-CW[2]:
  - ◇ QPR – **128** completed
  - ◇ QPR-CW – **102** completed

+ **Districts** with the largest numbers of trainees:

QPR
- ◇ District 12 (Morrow, Umatilla) – **9** completed
- ◇ District 2 (Multnomah) – **7** completed
- ◇ District 3 (Marion, Polk, Yamhill) – **4** completed

QPR-CW
- ◇ District 2 (Multnomah) – **26** completed
- ◇ District 16 (Washington) – **15** completed
- ◇ District 8 (Jackson, Josephine) – **8** completed

+ **Divisions** with the largest numbers of trainees:

QPR
- ◇ DHS Shared Services – **39** completed
- ◇ Office of Child Welfare – **25** completed
- ◇ Aging and People with Disabilities – **20** completed

QPR-CW
- ◇ Office of Child Welfare – **85** completed
- ◇ CW_SS District Administration – **10** completed

Knowledge of Suicide and Suicide Prevention Increased

+ An average of **69.7%** of respondents rated their knowledge of suicide and suicide prevention as "high" after the training, compared with **15.3%** before.
+ An average of **0.1%** of respondents rated their knowledge of suicide and suicide prevention as "low" after the training, compared with **27.8%** before.
+ Every DHS program represented in the survey data showed an increase in their knowledge of suicide and suicide prevention in all seven areas:
  - ◇ Facts concerning suicide prevention
  - ◇ Warning signs of suicide
  - ◇ How to ask someone about suicide
  - ◇ Persuading someone to get help
  - ◇ How to get help for someone
  - ◇ Information about resources for help with suicide
  - ◇ Understanding of suicide and suicide prevention

Comfort and Likeliness of Helping to Prevent Suicide

+ The percentage of trainees who **strongly agree** that *suicide is preventable* increased **119.5%**
+ Trainees who reported being **very comfortable** with *asking a person about suicide* increased **179.1%**

[1] QPR Computer-Based Training
[2] QPR Computer-Based Training for CW

Attachment 6

+ The percentage of trainees who are **very likely** to *ask someone exhibiting signs of suicide risk if they are thinking of suicide* increased **101.1%**
+ Trainees who reported being **very likely** to *intervene when someone is exhibiting signs of suicide risk* increased **35.6%**
+ The percentage of trainees who were **very likely** to *refer someone exhibiting signs of suicide risk to mental health or related services* increased **29.3%**

Trainee Impressions

+ A total of **90.3%** of respondents (243 of 296) believe that this training will be very valuable to their work with children, adults, and families
+ The vast majority of trainees (**76.0%**) would be interested in a more comprehensive suicide prevention training
+ Community partners that trainees think could benefit from suicide prevention awareness training included organizations and institutions ranging from Child Welfare and other DHS programs to mental health and substance use disorder service providers, law enforcement, court systems, adult and child foster care providers, schools, and churches.

Attachment 6

Trainee Details

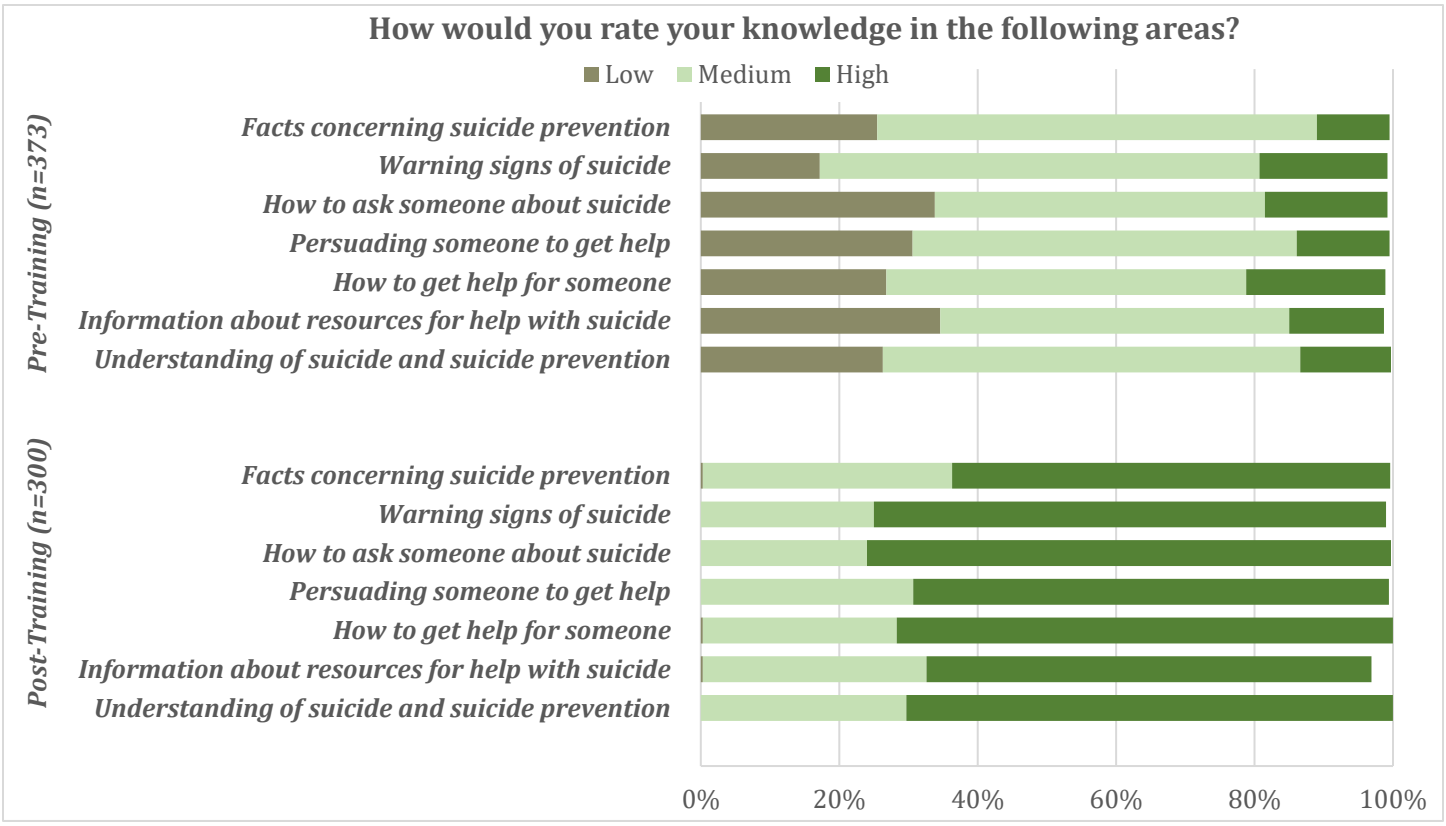
District	QPR Trainees		QPR-CW Trainees		Total Trainees	
1	1	0.8%	7	6.9%	8	3.5%
2	7	5.5%	26	25.5%	33	14.3%
3	4	3.1%	7	6.9%	11	4.8%
5	2	1.6%	4	3.9%	6	2.6%
6	1	0.8%	3	2.9%	4	1.7%
7	0	0.0%	6	5.9%	6	2.6%
8	1	0.8%	8	7.8%	9	3.9%
11	2	1.6%	3	2.9%	5	2.2%
12	1	0.8%	2	2.0%	3	1.3%
14	2	1.6%	1	1.0%	3	1.3%
15	9	7.0%	6	5.9%	15	6.5%
16	2	1.6%	15	14.7%	17	7.4%
Not Specified	96	75.0%	14	13.7%	110	47.8%
Total	***128***		***102***		***230***	

Division Title *Sorted in descending order by QPR Trainees*	QPR Trainees		QPR-CW Trainees		Total Trainees	
DHS Shared Services	39	30.5%	1	1.0%	40	17.4%
Office of Child Welfare	25	19.5%	85	83.3%	110	47.8%
Not Current	21	16.4%	4	3.9%	25	10.9%
Aging and People with Disabilities	20	15.6%	1	1.0%	21	9.1%
Office of Self Sufficiency Programs	11	8.6%	-	-	11	4.8%
Developmental Disabilities Services	5	3.9%	-	-	5	2.2%
DHS Central Services	5	3.9%	1	1.0%	6	2.6%
CW_SS District Administration	2	1.6%	10	9.8%	12	5.2%
Total	***128***		***102***		***230***	

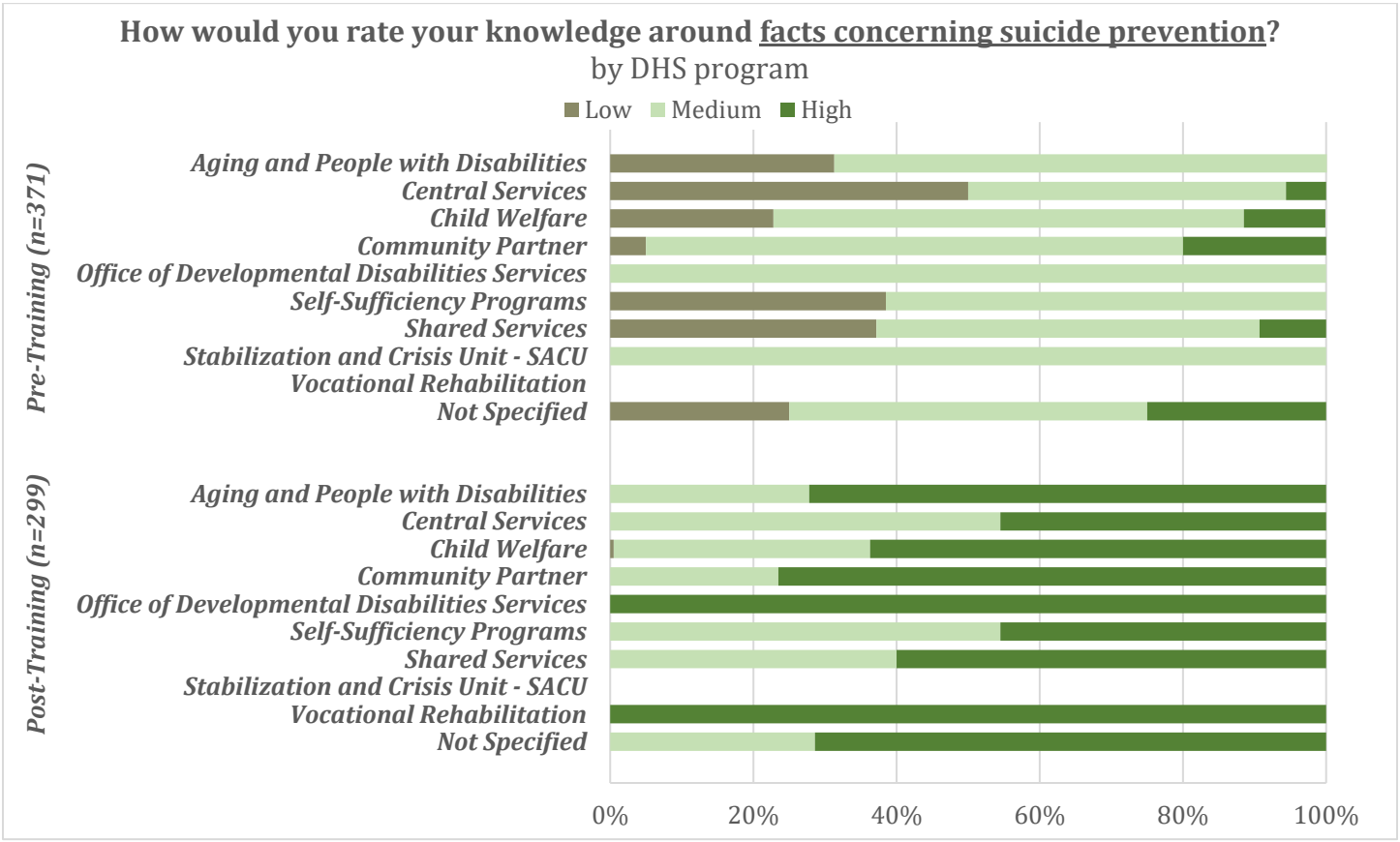
Attachment 6

Knowledge of Suicide and Suicide Prevention

Overall



By DHS Program



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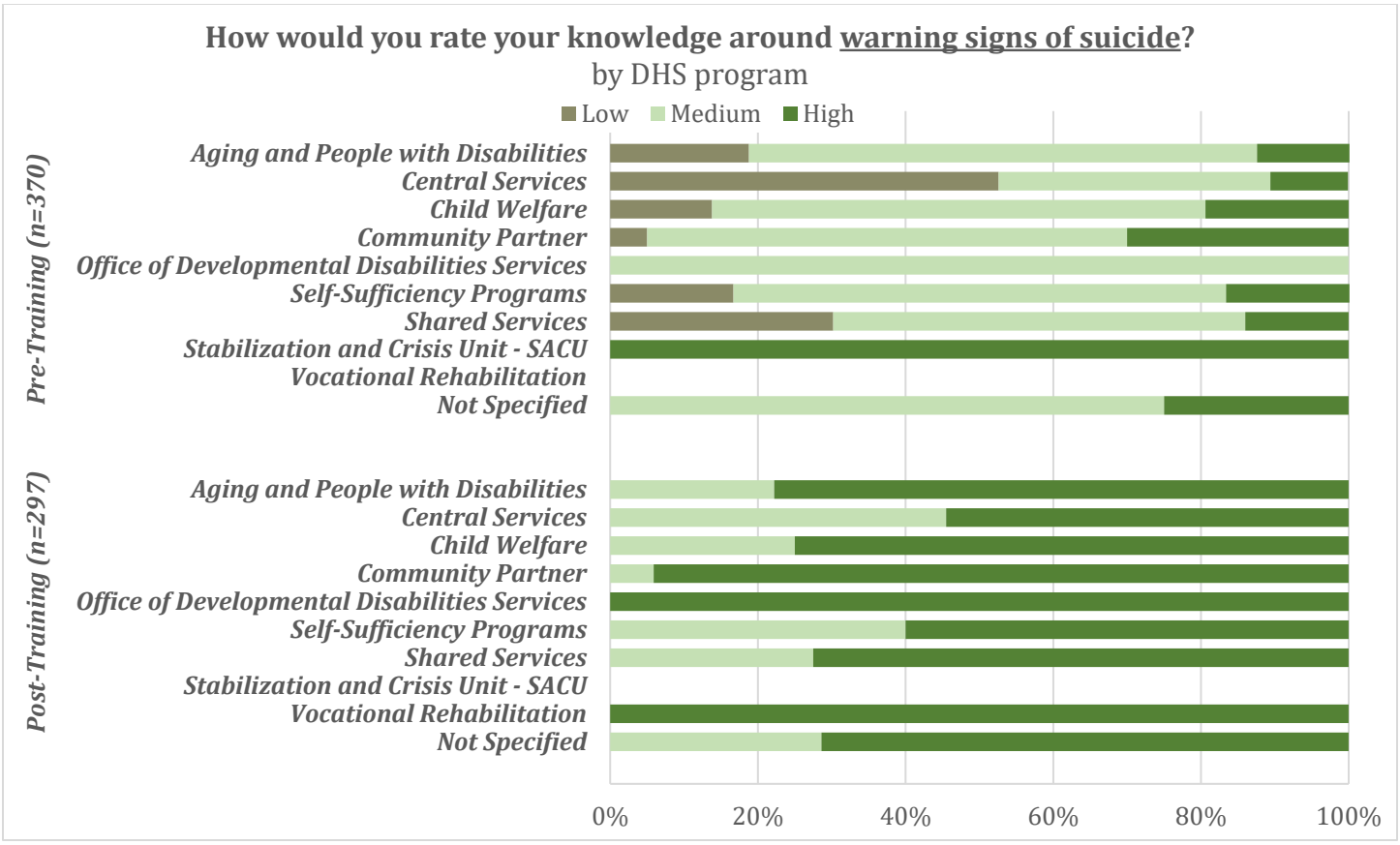

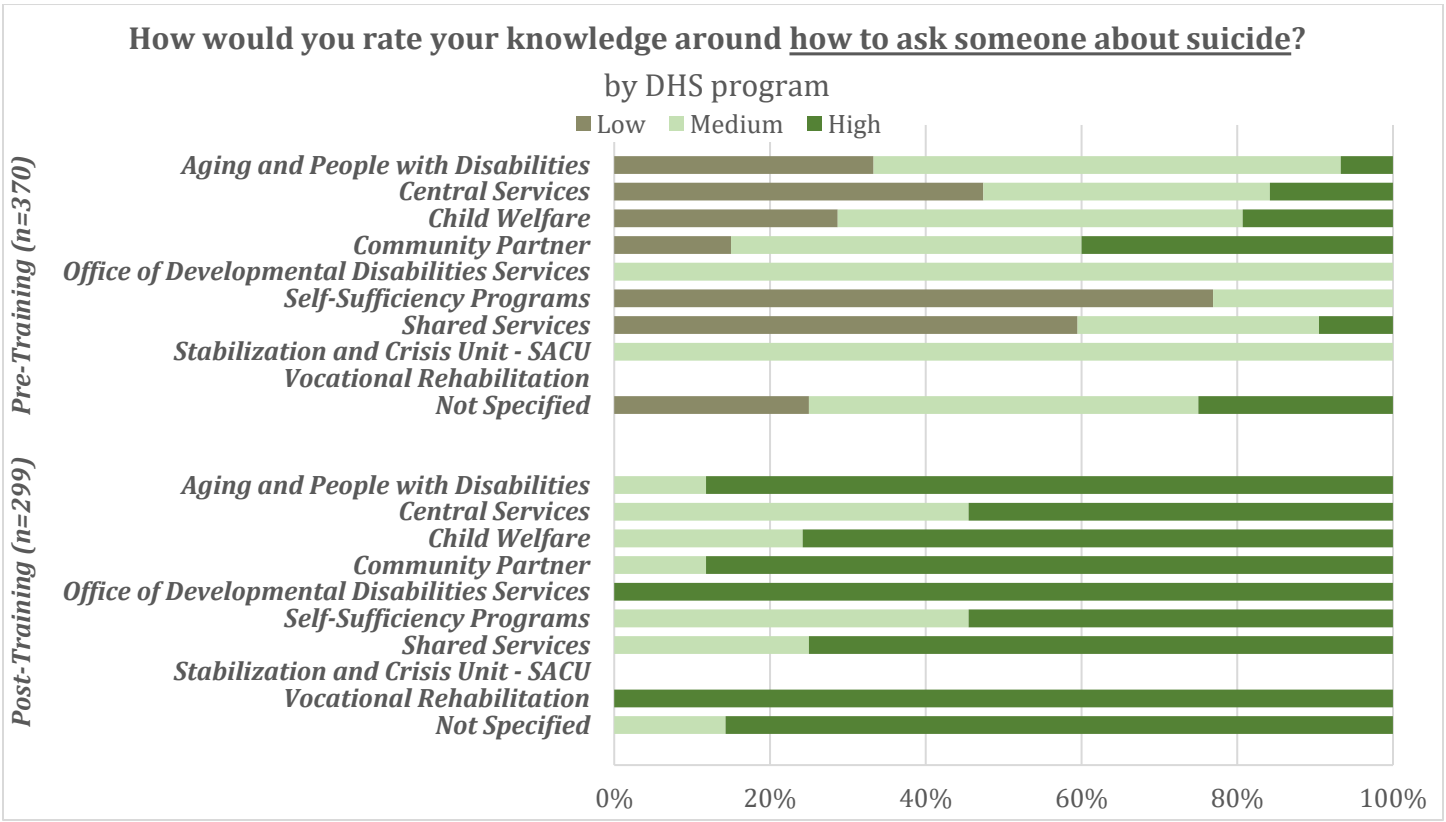

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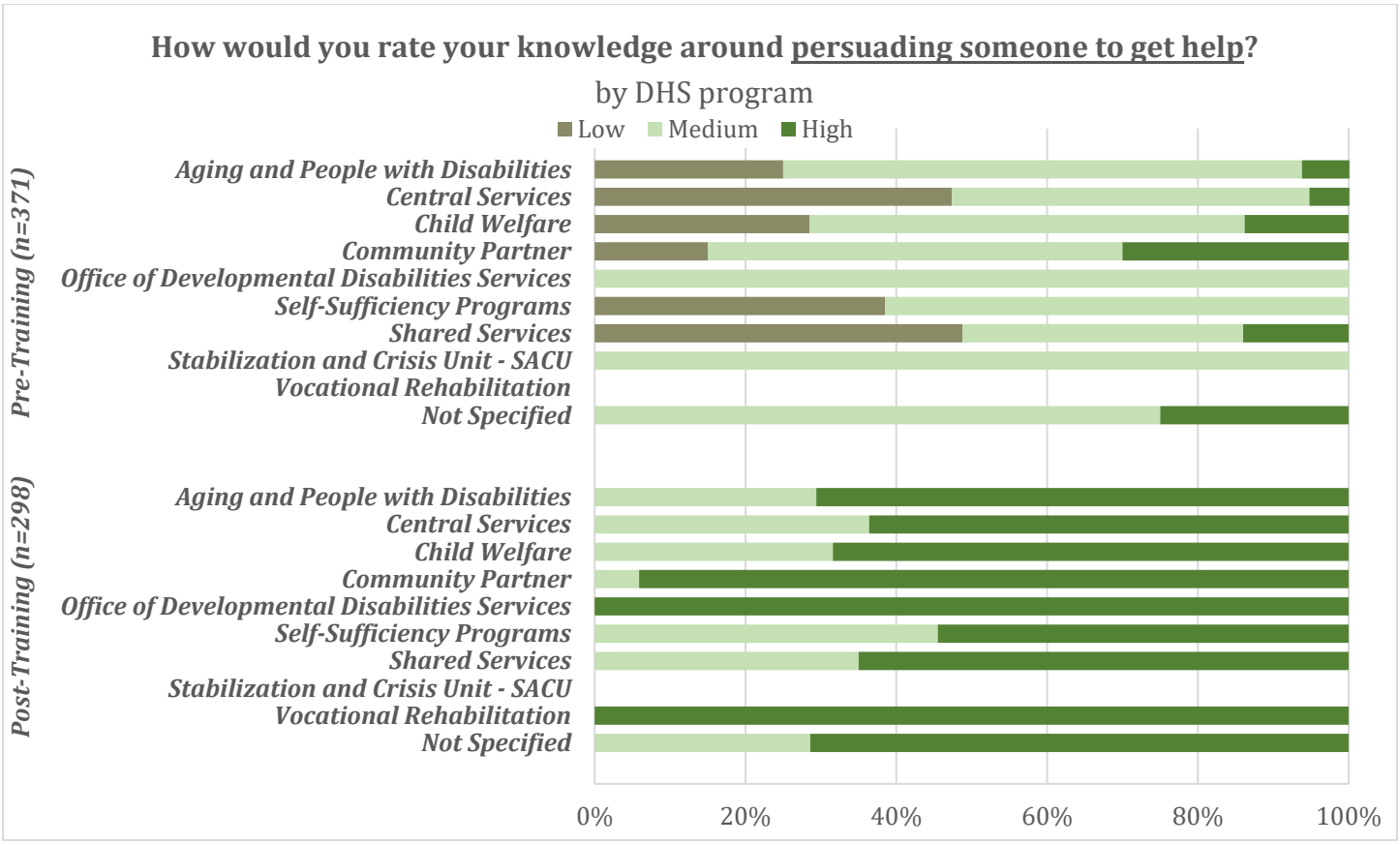

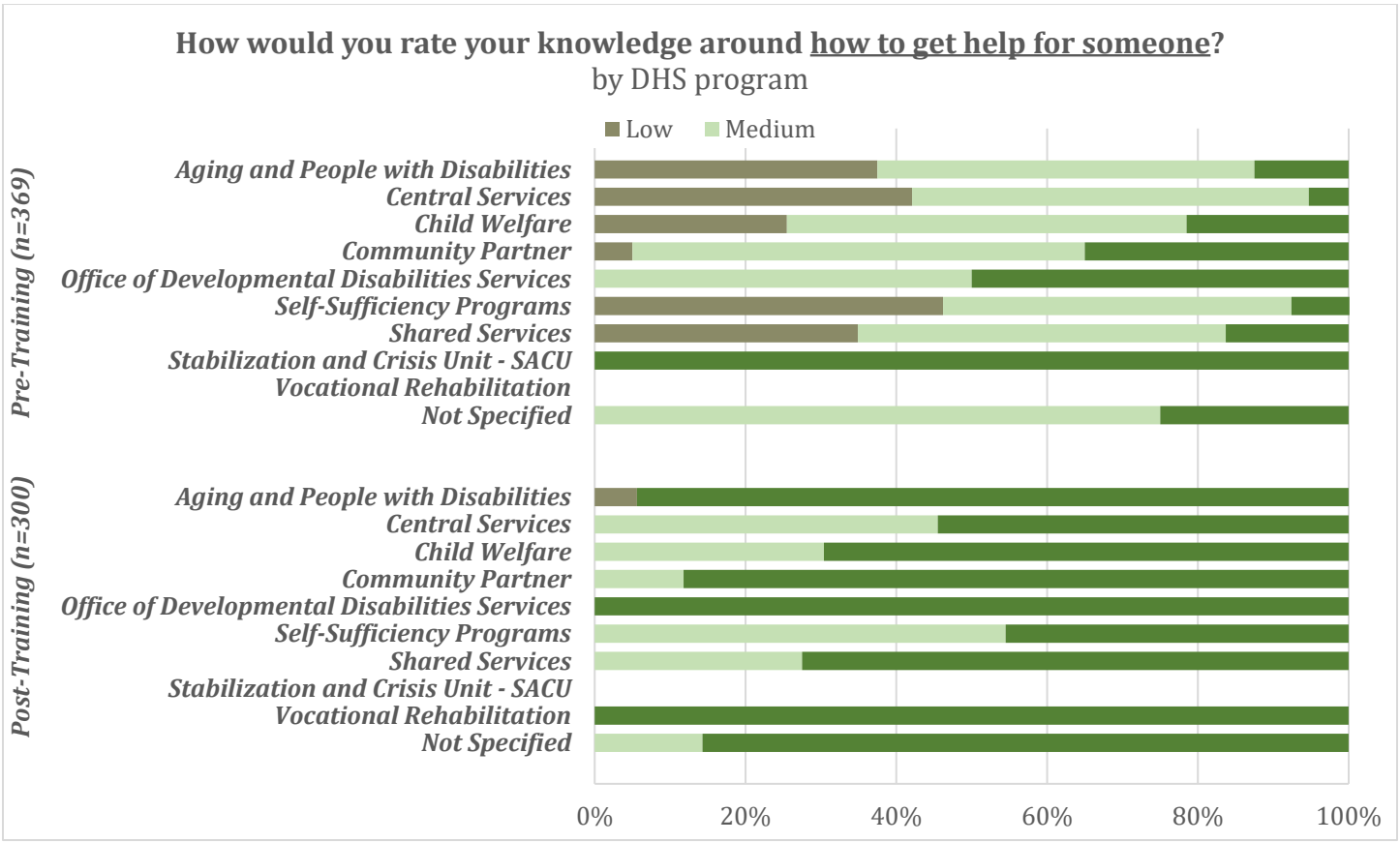

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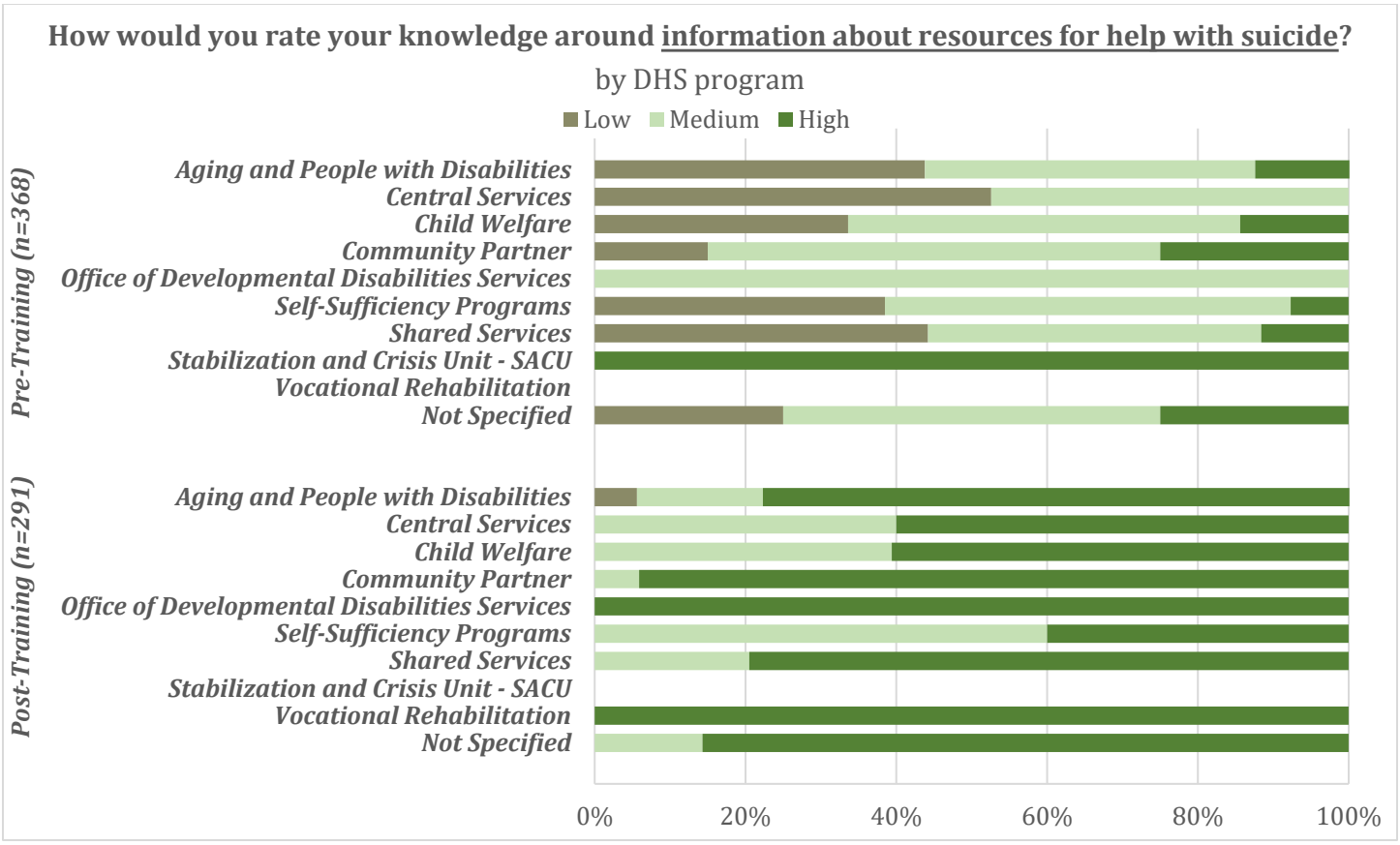
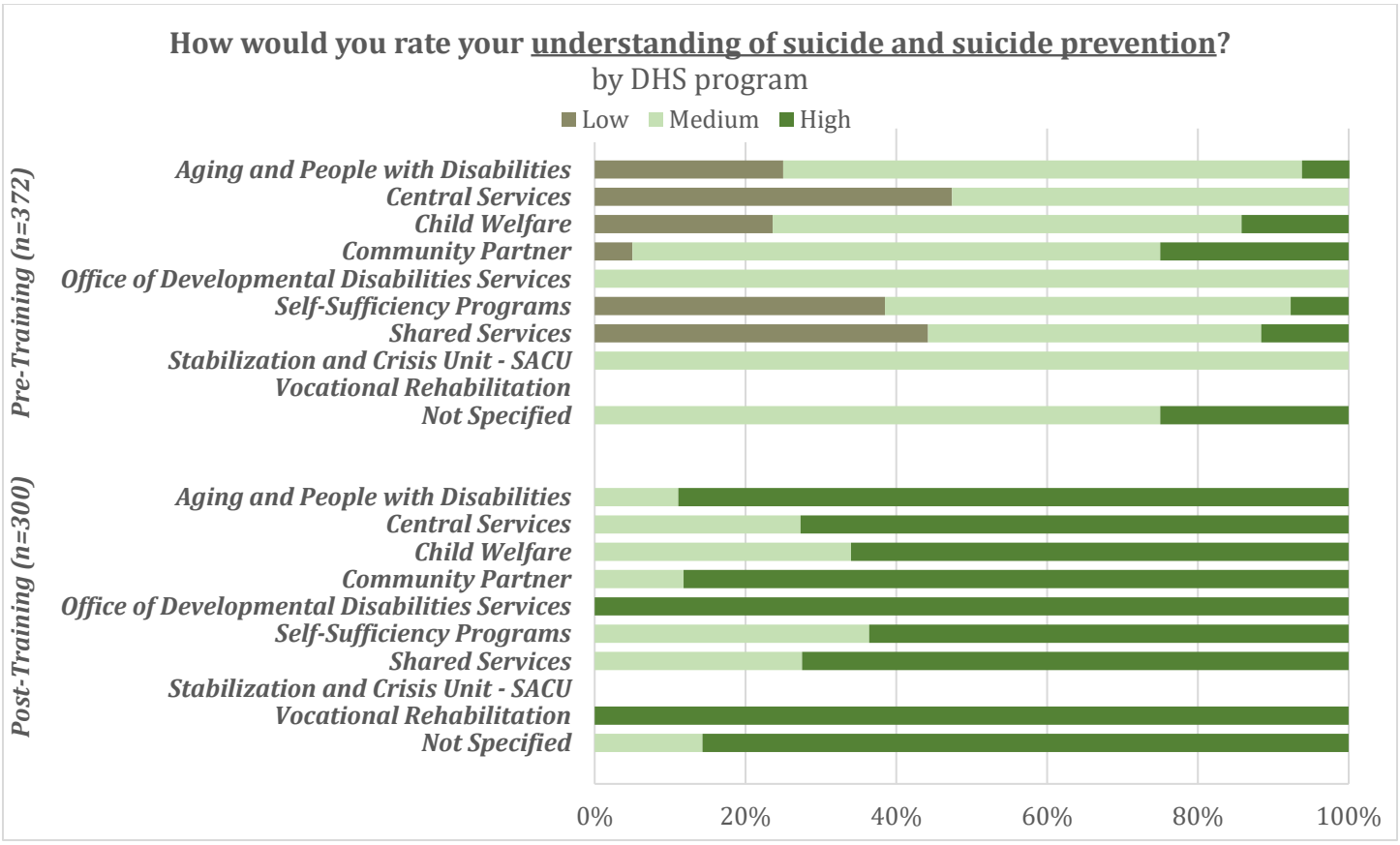




Attachment 6

Comfort and Likeliness of Helping to Prevent Suicide

How much do you agree or disagree that suicide is preventable?	Pre-Training		Post-Training		Percent Change
Strongly Agree	82	22.1%	180	61.2%	119.5%
Agree	214	57.7%	100	34.0%	-53.3%
Neutral	70	18.9%	10	3.4%	-85.7%
Disagree	3	0.8%	2	0.7%	-33.3%
Strongly Disagree	2	0.5%	2	0.7%	0.0%
Total	***371***		***294***		

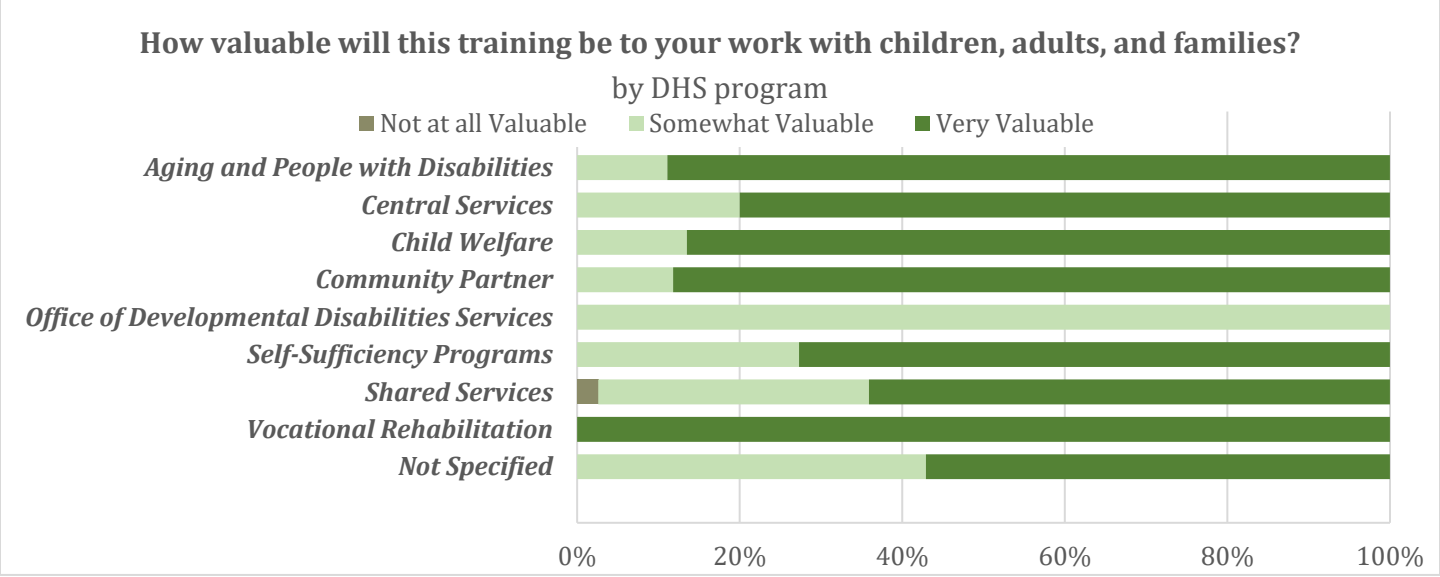
How comfortable are you with asking a person about suicide?	Pre-Training		Post-Training		Percent Change
Very Comfortable	43	11.6%	120	40.1%	179.1%
Comfortable	219	59.2%	156	52.2%	-28.8%
Uncomfortable	97	26.2%	21	7.0%	-78.4%
Very Uncomfortable	11	3.0%	2	0.7%	-81.8%
Total	***370***		***299***		

How likely are you to ask someone exhibiting signs of suicide risk if they are thinking of suicide?	Pre-Training		Post-Training		Percent Change
Very Likely	90	24.2%	181	60.9%	101.1%
Likely	233	62.6%	113	38.0%	-51.5%
Unlikely	45	12.1%	3	1.0%	-93.3%
Very Unlikely	4	1.1%	0	0.0%	-100.0%
Total	***372***		***297***		

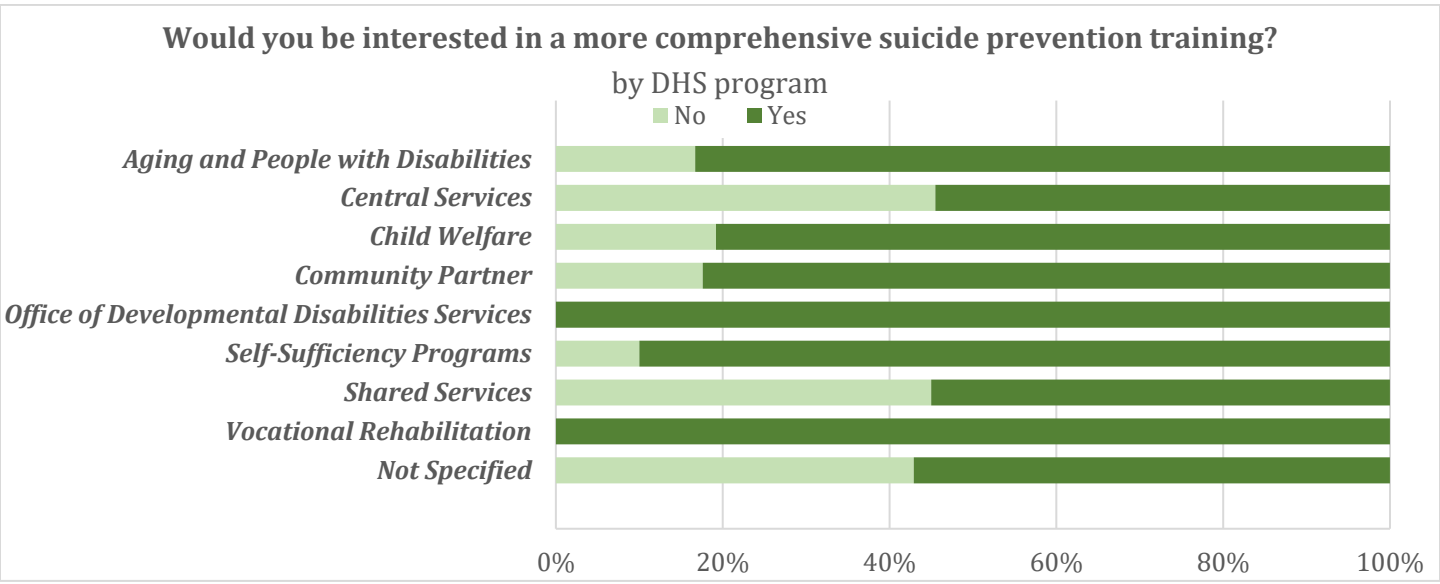
How likely are you to intervene when someone is exhibiting signs of suicide risk?	Pre-Training		Post-Training		Percent Change
Very Likely	149	40.2%	202	67.6%	35.6%
Likely	202	54.4%	96	32.1%	-52.5%
Unlikely	20	5.4%	1	0.3%	-95.0%
Very Unlikely	0	0.0%	0	0.0%	N/A
Total	***371***		***299***		

How likely are you to refer someone exhibiting signs of suicide risk to mental health or related services?	Pre-Training		Post-Training		Percent Change
Very Likely	174	47.0%	225	75.8%	29.3%
Likely	179	48.4%	72	24.2%	-59.8%
Unlikely	17	4.6%	0	0.0%	-100.0%
Very Unlikely	0	0.0%	0	0.0%	N/A
Total	***370***		***297***		

Training Value



Interest in More Comprehensive Training



Community Partners Who Could Benefit from Suicide Prevention Awareness Training

All Partners

- Aging & Disability providers
- All community partners/providers
- Apartment managers
- Bob Belloni Ranch Inc.
- CAIRO Academy
- CASA
- Case workers
- Child Protective Services
- Child Welfare
- Clergy
- Client attorneys & the judicial system
- Coaches
- Coos Health & Wellness
- Corrections
- Counselors/therapists
- CPS/permanency workers
- Customer service representatives
- DV programs
- Field workers
- First responders
- FIT workers & parenting groups
- Foster parents
- Homeless services providers
- Immigrant & Refugee Community Organization
- In-Home Safety & Reunification Services (ISRS)
- Kairos
- Klamath Basin Behavioral Health
- Lifeways
- Medford Masonic Center
- Mental health crisis teams
- Oregon Child Abuse Hotline
- Parent mentors
- Parents/caregivers
- Primary care & medical providers
- Respite & safety service providers
- Rogue Valley Council of Governments
- Schools & after-school programs
- Shriners
- Unions
- Community members
- Teen programs
- Independent living program
- SUD treatment providers
- Union Gospel Mission
- VA partners
- VOA
- Housing programs
- Waterfall Clinic

Attachment 6

Partners by DHS Program

Aging and People with Disabilities

- AAAs
- Adult foster homes
- Adult Protective Services
- AFH
- All agencies
- All long-term care facilities
- Anyone working with low income or high stress citizens
- Anything to do with youth
- Behavioral Services
- Center for Living
- Child Welfare
- DHS staff
- Direct Care Staff
- Everyone
- Home care workers
- Linn County Jail
- Linn County Mental Health
- Local banks or other financial institutions
- Memory care staff
- Mental health
- Mid-Columbia Medical Center Hospital
- Nursing home and assisted living staff
- Other APD
- Physicians
- SACU
- Schools and Crisis Response
- Social services agencies administering or denying benefits
- The Klamath Tribes
- Uber drivers

Attachment 6

Portland State UNIVERSITY

Oregon DHS QPR Suicide Prevention Training

Pre- and Post-Training Survey Data Report

January through March 2021

Highlights *(see following pages for more detail)*

Trainee Details

+ A total of **227 people** completed either QPR[1] or QPR-CW[2]:
  - QPR – **78** completed
  - QPR-CW – **149** completed

+ **Districts** with the largest numbers of trainees:

QPR[3]
- Districts 5, 7, 8, 10, 16 – **3** participants each
- Districts 2 and 3 – **2** each
- Districts 1 and 9 – **1** each
- Unspecified – **57** total participants

QPR-CW
- District 8 (Jackson, Josephine) – **37** completed
- District 16 (Washington) – **20** completed
- District 11 (Klamath, Lake) – **19** completed

+ **Divisions** with the largest numbers of trainees:

QPR[4]
- Aging and People with Disabilities – **12** completed
- Office of Self Sufficiency Programs – **11** completed
- DHS Central Services – **9** completed

QPR-CW
- Office of Child Welfare – **126** completed
- CW_SS District Administration – **12** completed
- Office of Self Sufficiency Programs – **6** completed

Knowledge of Suicide and Suicide Prevention Increased

+ An average of **71.2%** of respondents rated their knowledge of suicide and suicide prevention as "high" after the training, compared with **16.9%** before.
+ **No** respondents rated their knowledge of suicide and suicide prevention as "low" after the training, compared with **27.1%** before.
+ **Every DHS program** represented in the survey data reported an **increase** in their knowledge of suicide and suicide prevention in all seven areas:
  - Facts concerning suicide prevention
  - Warning signs of suicide
  - How to ask someone about suicide
  - Persuading someone to get help
  - How to get help for someone
  - Information about resources for help with suicide
  - Understanding of suicide and suicide prevention

[1] QPR Computer-Based Training
[2] QPR Computer-Based Training for CW
[3] A total of 57 (73.1%) QPR trainees did not specify which district(s) they were affiliated with.
[4] There were 28 (35.9%) QPR trainees whose division was listed as "not current."

Attachment 7

Comfort and Likeliness of Helping to Prevent Suicide

+ The percentage of trainees who **strongly agree** that *suicide is preventable* increased **141.3%**
+ Trainees who reported being **very comfortable** with *asking a person about suicide* increased **72.5%**
+ The percentage of trainees who are **very likely** to *ask someone exhibiting signs of suicide risk if they are thinking of suicide* increased **87.9%**
+ Trainees who reported being **very likely** to *intervene when someone is exhibiting signs of suicide risk* increased **69.5%**
+ The percentage of trainees who were **very likely** to *refer someone exhibiting signs of suicide risk to mental health or related services* increased **27.4%**

Trainee Impressions

+ A total of **85.5%** of respondents (165 of 193) believe that this training will be very valuable to their work with children, adults, and families
+ The vast majority of trainees (**80.1%**) would be interested in a more comprehensive suicide prevention training

Attachment 7

Trainee Details

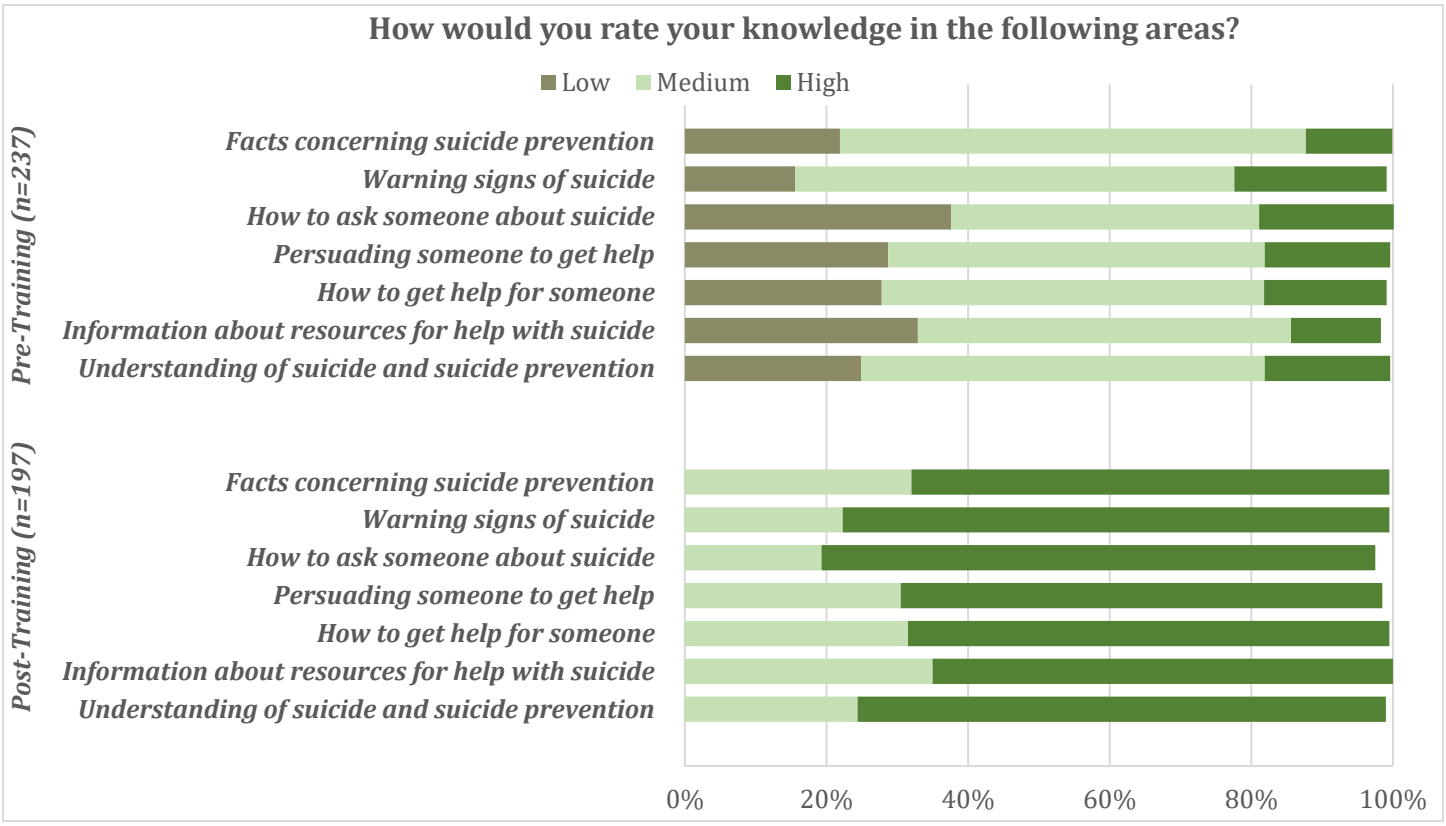
District	QPR Trainees		QPR-CW Trainees		Total Trainees	
1	1	1.3%	10	6.7%	11	4.8%
2	2	2.6%	6	4.0%	8	3.5%
3	2	2.6%	4	2.7%	6	2.6%
4	-	-	4	2.7%	4	1.8%
5	3	3.8%	11	7.4%	14	6.2%
7	3	3.8%	1	0.7%	4	1.8%
8	3	3.8%	37	24.8%	40	17.6%
9	1	1.3%	1	0.7%	2	0.9%
10	3	3.8%	8	5.4%	11	4.8%
11	-	-	19	12.8%	19	8.4%
12	-	-	1	0.7%	1	0.4%
13	-	-	6	4.0%	6	2.6%
15	-	-	6	4.0%	6	2.6%
16	3	3.8%	20	13.4%	23	10.1%
Not Specified	57	73.1%	15	10.1%	72	31.7%
Total	***78***		***149***		***227***	

Division Title *Sorted in descending order by QPR Trainees*	QPR Trainees		QPR-CW Trainees		Total Trainees	
Aging and People with Disabilities	12	15.4%	-	-	12	5.3%
Office of Self Sufficiency Programs	11	14.1%	6	4.0%	17	7.5%
DHS Central Services	9	11.5%	-	-	9	4.0%
DHS Shared Services	6	7.7%	1	0.7%	7	3.1%
Office of Child Welfare	6	7.7%	126	84.6%	132	58.1%
CW_SS District Administration	4	5.1%	12	8.1%	16	7.0%
Developmental Disabilities Services	1	1.3%	-	-	1	0.4%
Unspecified	1	1.3%	-	-	1	0.4%
Oregon State Hospital	-	-	1	0.7%	1	0.4%
Not Current	28	35.9%	3	2.0%	31	13.7%
Total	***78***		***149***		***227***	

Attachment 7

Knowledge of Suicide and Suicide Prevention

Overall



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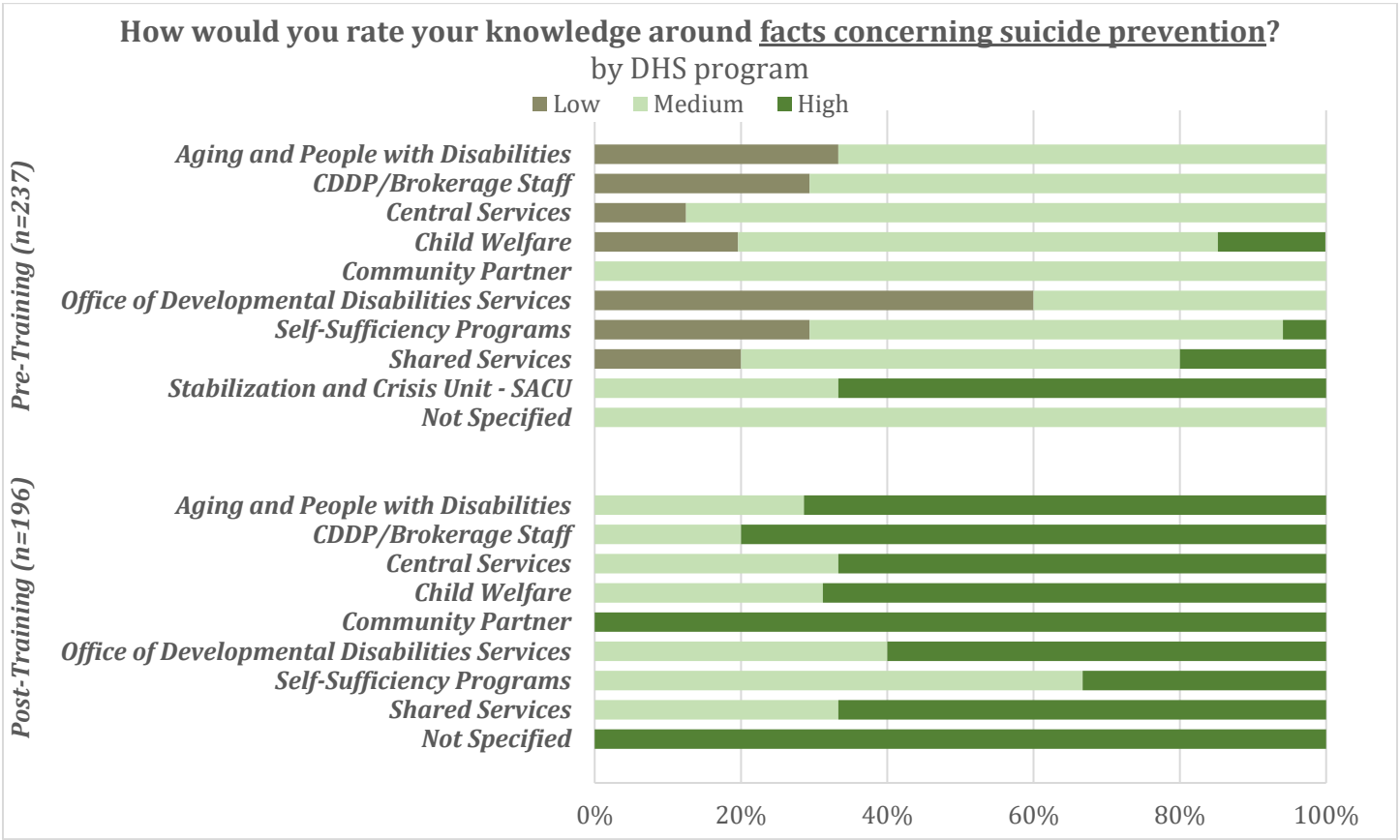

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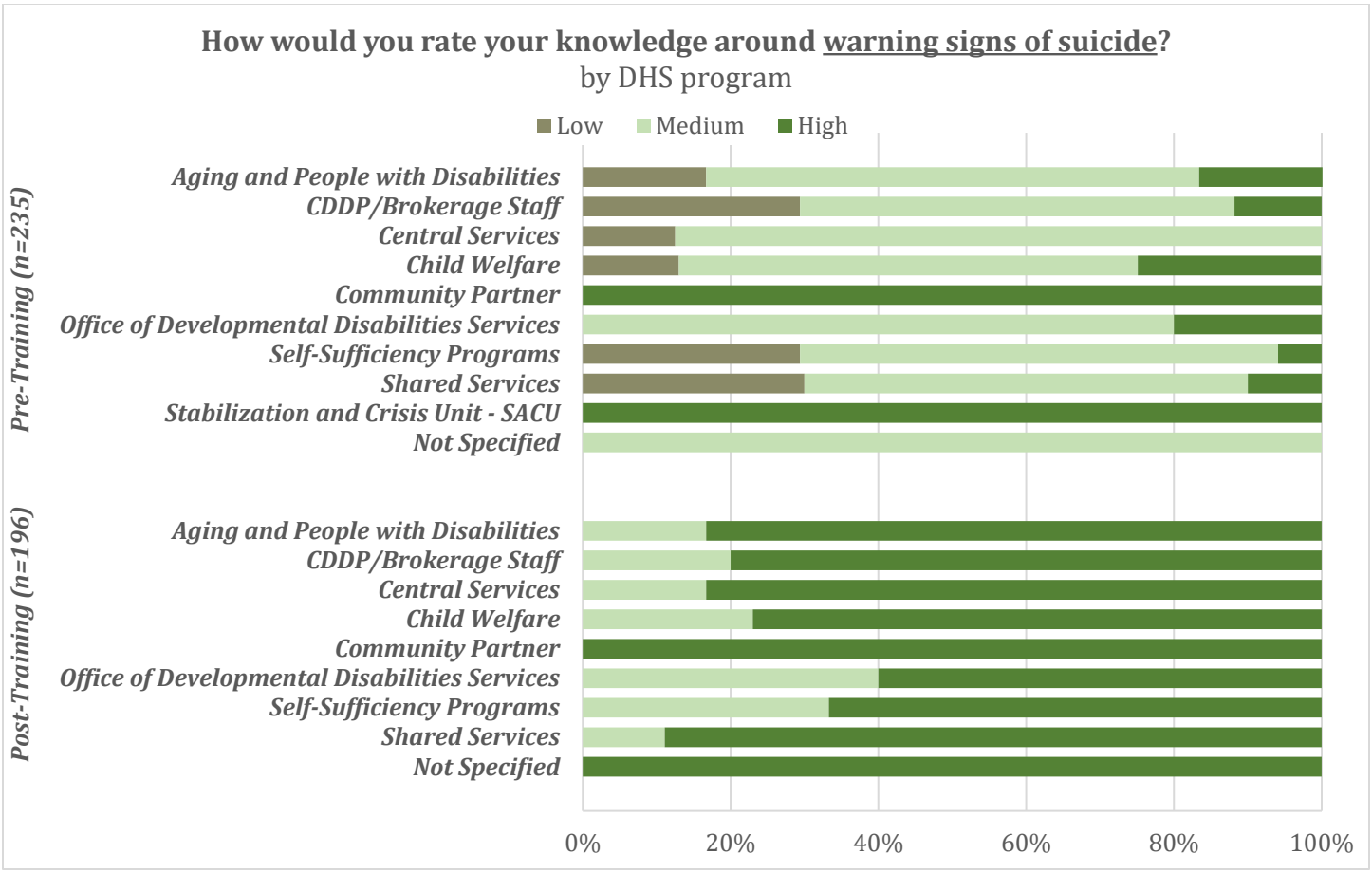

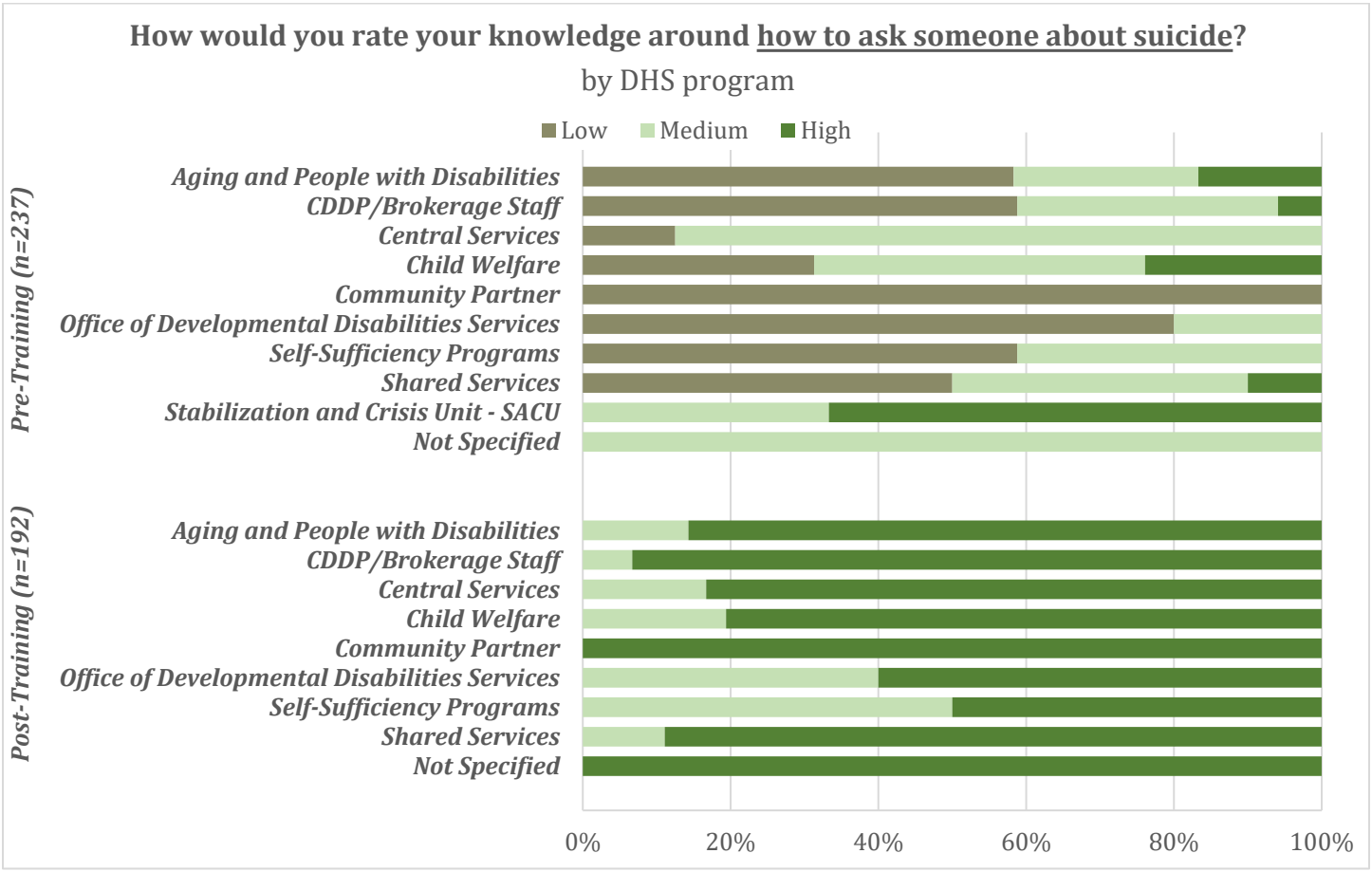

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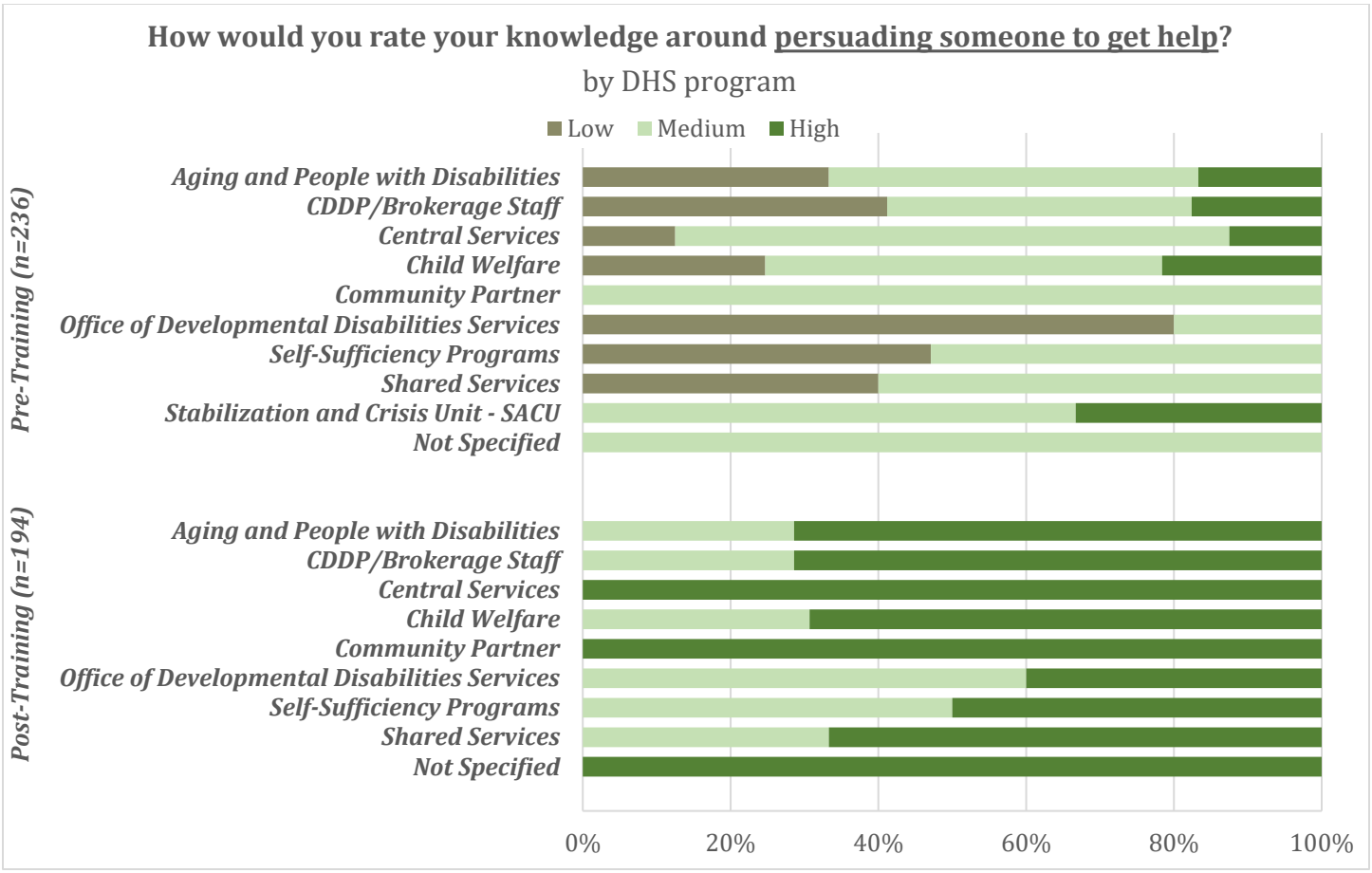

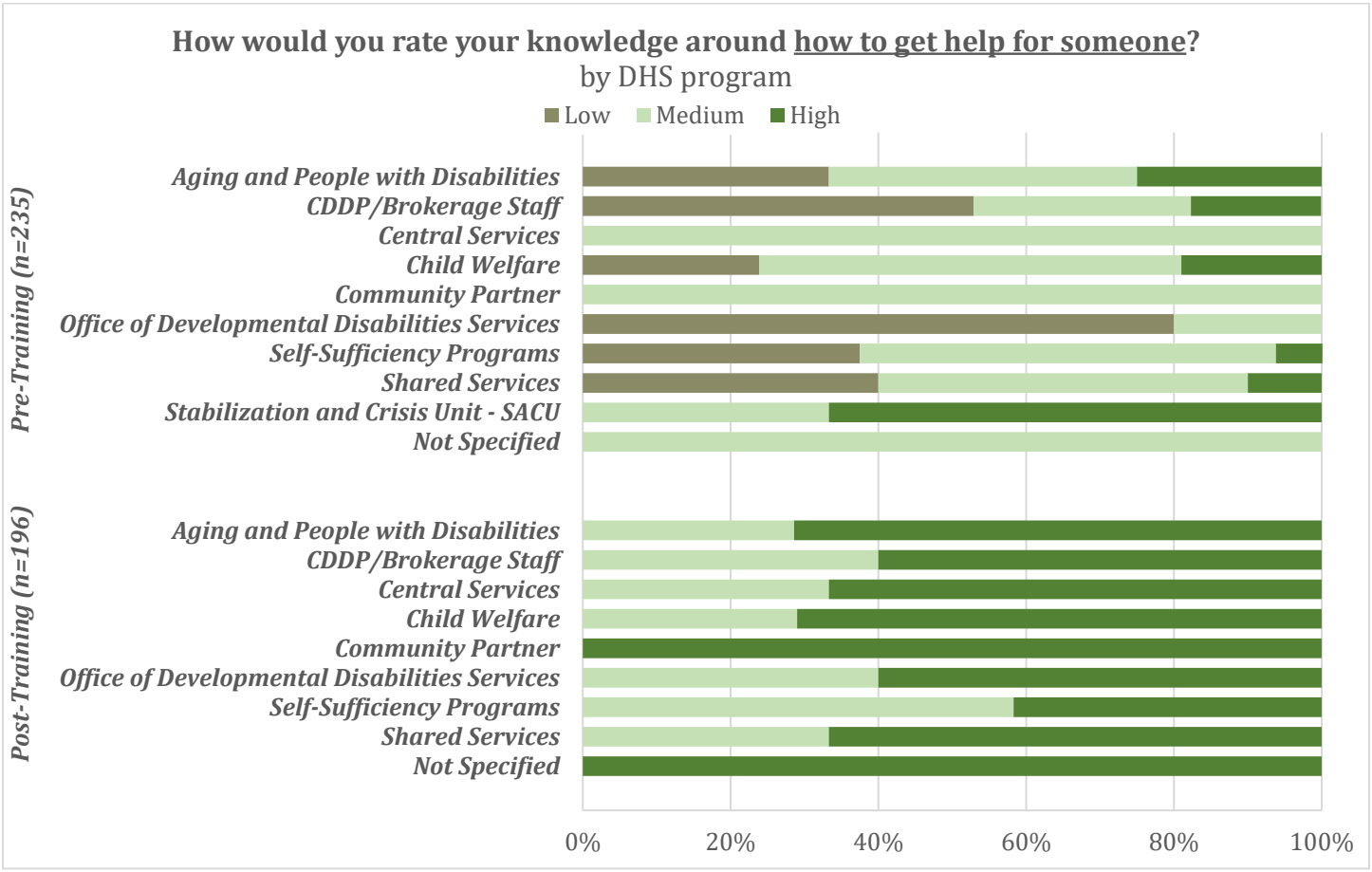

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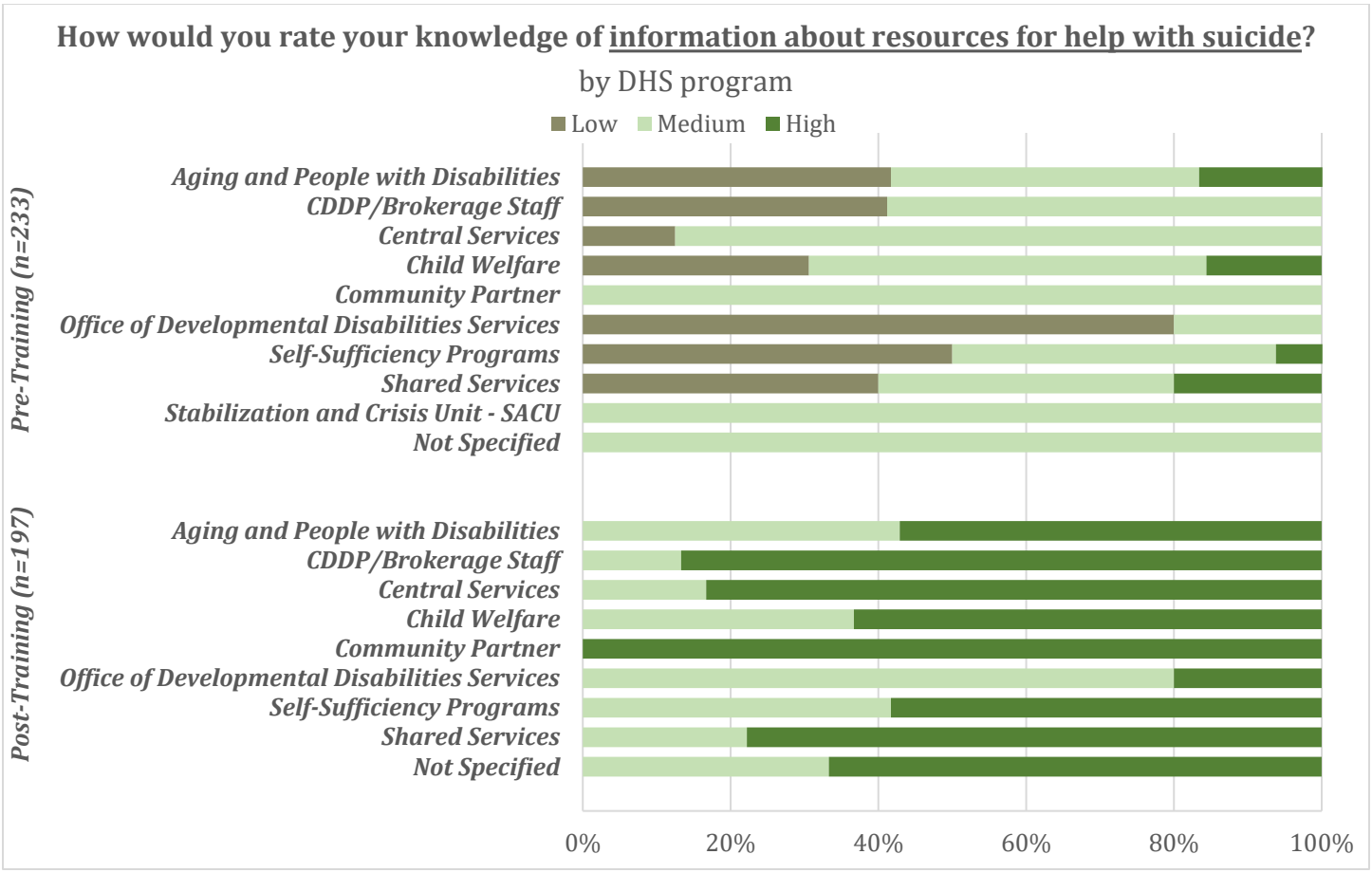
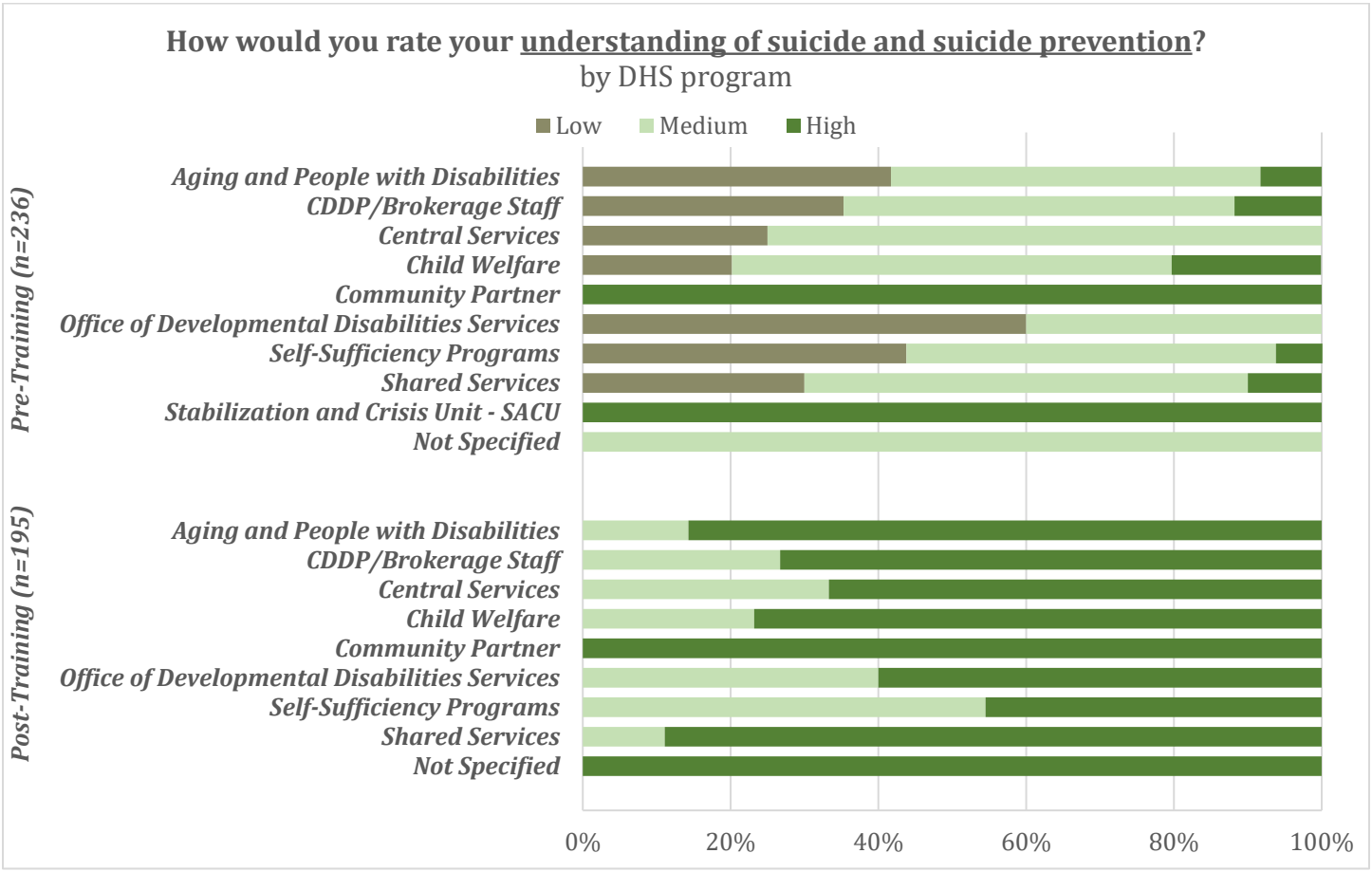




Attachment 7

Comfort and Likeliness of Helping to Prevent Suicide

How much do you agree or disagree that suicide is preventable?	Pre-Training		Post-Training		Percent Change
Strongly Agree	46	19.6%	111	56.3%	141.3%
Agree	137	58.3%	71	36.0%	-48.2%
Neutral	49	20.9%	13	6.6%	-73.5%
Disagree	3	1.3%	1	0.5%	-66.7%
Strongly Disagree	0	0.0%	1	0.5%	N/A
Total	***235***		***197***		

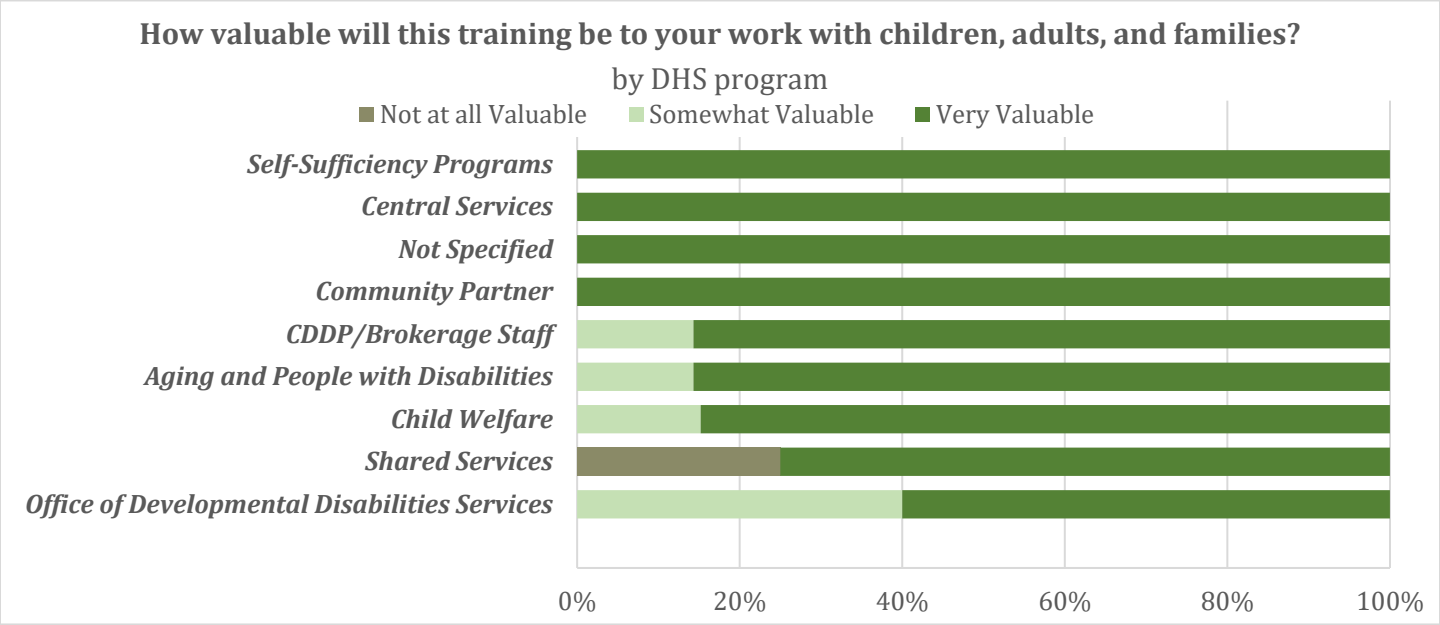
How comfortable are you with asking a person about suicide?	Pre-Training		Post-Training		Percent Change
Very Comfortable	40	17.0%	69	35.0%	72.5%
Comfortable	114	48.5%	112	56.9%	-1.8%
Uncomfortable	73	31.1%	15	7.6%	-79.5%
Very Uncomfortable	8	3.4%	1	0.5%	-87.5%
Total	***235***		***197***		

How likely are you to ask someone exhibiting signs of suicide risk if they are thinking of suicide?	Pre-Training		Post-Training		Percent Change
Very Likely	66	28.0%	124	63.6%	87.9%
Likely	142	60.2%	69	35.4%	-51.4%
Unlikely	26	11.0%	1	0.5%	-96.2%
Very Unlikely	2	0.8%	1	0.5%	-50.0%
Total	***236***		***195***		

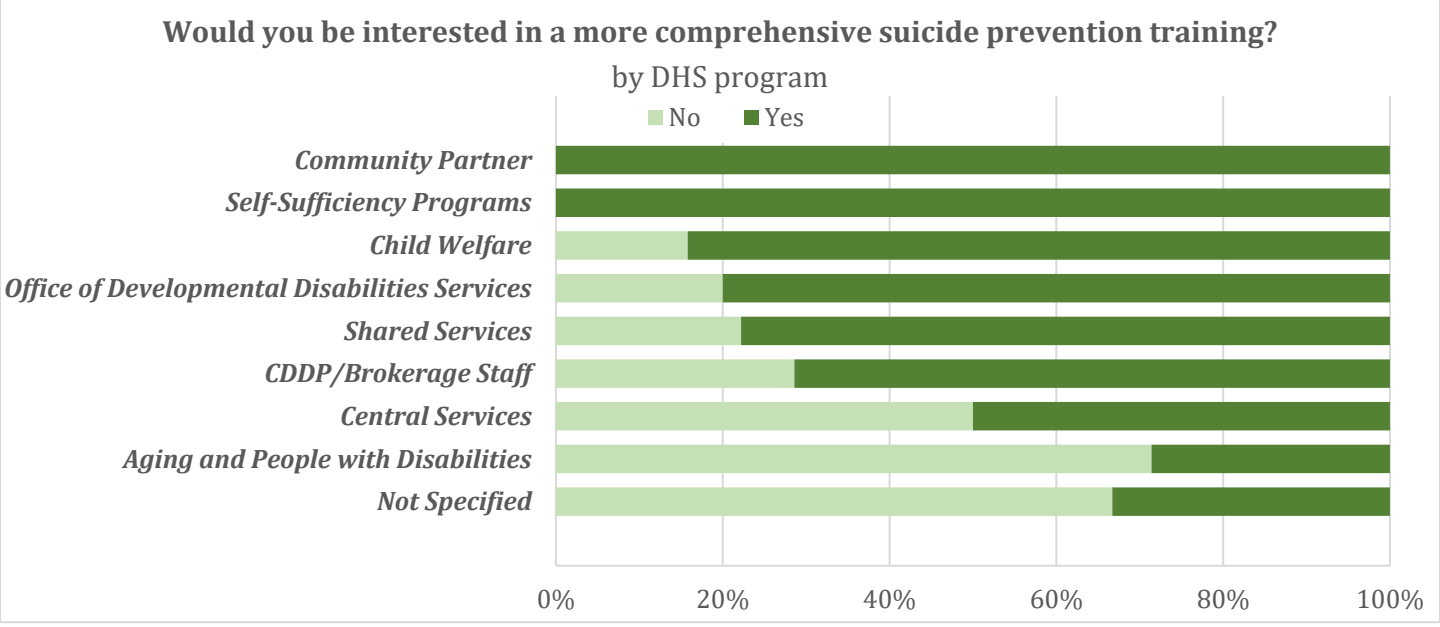
How likely are you to intervene when someone is exhibiting signs of suicide risk?	Pre-Training		Post-Training		Percent Change
Very Likely	82	34.6%	139	71.3%	69.5%
Likely	144	60.8%	55	28.2%	-61.8%
Unlikely	11	4.6%	0	0.0%	-100.0%
Very Unlikely	0	0.0%	1	0.5%	N/A
Total	***237***		***195***		

How likely are you to refer someone exhibiting signs of suicide risk to mental health or related services?	Pre-Training		Post-Training		Percent Change
Very Likely	113	47.9%	144	73.1%	27.4%
Likely	118	50.0%	52	26.4%	-55.9%
Unlikely	5	2.1%	0	0.0%	-100.0%
Very Unlikely	0	0.0%	1	0.5%	N/A
Total	***236***		***197***		

Training Value



Interest in More Comprehensive Training



Attachment 7

Community Partners Who Could Benefit from Suicide Prevention Awareness Training

All Partners

- Addiction Providers
- All staff with public contact
- Attorneys & the judicial system
- BestCare Treatment and Mental Health
- BEWs
- Brokerages
- BRS staff
- CADCs
- Cahoots
- CARDV
- Caregivers to the elderly
- CASA
- Caseworkers & case managers
- CDDPs
- CHANCE
- Child Welfare
- Community members in general
- Crisis team
- DV advocates & shelters
- Elderly and Disability Services
- Faith-Based Communities and Churches
- Foster/resource parents
- Goodwill
- Head Start
- Homeless and family violence community programs
- Hotline workers
- Independent Living workers
- In-Home Safety & Reunification Services (ISRS)
- In-home service providers
- Joe's Place
- Klamath Tribes
- Law enforcement agencies
- Lincoln County Veterans Services
- Medical Professionals
- Mental health providers
- Mentors
- Navigators
- New Directions Northwest
- ODHS Staff & Contracted Providers
- Oregon Youth Authority
- Parents (in parenting classes)
- Personal Support Workers
- Resource/Foster Families
- Safety Service Providers
- Schools
- Self Sufficiency
- SSP Family Coaches
- St Charles Hospital
- Teen outreach
- Trauma Healing Project
- Washington and Marion
- WomenSpace
- Worksource

Attachment 7

Child Fatality Prevention & Review Program
Executive Summary

Course Title: Assessing Patterns and Behaviors of Neglect

Target Audience: Child Welfare Supervisors, MAPS, and Active Efforts Specialists

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 sixteen participants and is facilitated by two Child Welfare consultants. 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. For supervisors and MAPS/AES: review the timeline and coach worker through next steps.
- Work with a consultant or MAPS 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/

DHS | Oregon Department of Human Services
CHILD WELFARE

SAFE SLEEP FOR OREGON'S INFANTS

A Self-Study Training Opportunity for Professionals

Acknowledgment: Thank you to Oregon's Early Learning Division (ELD) and specifically Roni Pham and Sydney Traen for your work on the ELD version of the self-study training; Anna Stiefvater with Oregon Health Authority (OHA), Public Health, Maternal and Child Health, Chelsea Whitney with Lane County Health and Human Services and Sara Stankey with ODHS Child Welfare in Lane County, for rolling out a safe sleep training in Lane County and sharing your resources; also a thank you to the Office of Child Welfare Programs, ODHS Child Welfare professionals, the ODHS Office of Equity and Multicultural Services, Oregon's Nine Confederated Tribes, the ODHS Tribal Affairs unit with special thanks to Ashley Harding, Joan Bacchus, Native American Rehabilitation Association of the Northwest, the Oregon Foster Parent Association, the Oregon Coalition Against Domestic and Sexual Violence, Oregon domestic violence programs, Oregon substance use disorder treatment programs and those served by these programs, OHA Public Health, ODHS Self Sufficiency professionals, Oregon Parenting Education Collaborative (OPEC) Coordinators, OPEC Parenting Educators, and Shauna Tominey Ph.D. with Oregon State University and OPEC.

Primary Audience: Professionals engaging families in the community or the home environment
Length: Approximately one hour to one and a half hours

All the Moments in an Infant's Day Matter

Attachment 9

Dear Oregon Professionals,

First of all, thank you for your commitment to the safety of Oregon's children. It is important for us all to continue to learn and refresh our knowledge to provide quality services and support to Oregon's families.

Safe sleep practices are critical in the prevention of child fatalities. This training is an opportunity for professionals working with parents and caregivers to learn about safe sleep practices, how to reduce risk and to understand your role in supporting families to reduce risk to infants in their care.

We are excited to support infant safe sleep and specifically an effort aimed at achieving consistent messaging across all of Oregon's family serving professionals.

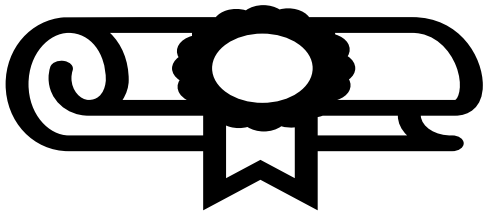
Insert names here

SAFE SLEEP FOR OREGON'S INFANTS

A Self-Study Training Opportunity

How to complete the "Safe Sleep for Oregon's Infants" Self-Study:

1. Read the self-study information and:
    a. Complete all of the activities. Your responses are private and you may choose whether to share.
    b. Complete the knowledge check/quiz and evaluation at the end.
2. Consider printing or saving the downloaded version of the materials for future reference.
3. Consider discussing what you learned with your peers and practicing having conversations about safe sleep.



What to expect:

Each professional who takes this training has a vital role in child safety. Whether a parenting educator, treatment provider, health care professional or other professionals engaging families with infants, it is critical for you to know, and be able to share with parents and caregivers, how to keep infants safe. “Infant” refers to a child between birth and age one. This training will give you valuable information about safe sleep practices for infants in a way that honors the unique values and needs of families.

Many of us come to this topic with our own beliefs and experiences. Be aware the content of the training may evoke different emotions and, depending on individual’s personal or professional experience, may be difficult. You are encouraged to reflect on your own feelings and those families may have when discussing this topic. Please complete the training at your own pace to engage in needed self-care.

Objectives:

1. Explore how your own experiences and preferences about sleep interact with the recommendations for safe sleep practices for infants.
2. Understand your responsibilities around safe sleep as a professional who serves families.
3. Understand sleep-related risks.
4. Understand what actions increase and decrease sleep-related risks.
5. Understand how to have conversations about safe sleep practices with parents and caregivers.

The sections of this self-study training cover:

Part 1: Understanding sleep-related sudden unexpected infant death (SUID) and how to reduce risk
Part 2: Safe sleep practices and substance use
Part 3: Communicating with parents and caregivers
Part 4: Wrap up: professional action plan, quiz/knowledge check, survey

By the end of this training, you will be able to:

- Articulate your responsibility regarding safe sleep.
- Define sleep-related SUID.
- Identify actions that increase and decrease the risk factors of SIDS and sleep-related infant deaths.
- Recognize safe and unsafe sleep environments.
- Communicate safe sleep practices to parents and caregivers with a strength based, trauma aware approach that honors their values and needs.

Part 1: Understanding Sleep-Related SUID, Risk Factors and What Risks a Parent or Caregiver Can Change

Examine Your Current Knowledge and/or Practices

Imagine that you are sitting in a rocking chair holding a baby. The baby hungrily sucks from a breast or bottle while you both enjoy exploring each other's face and eyes. After several burps over your shoulder, you hold them in the crook of your arms again. The baby starts to fall asleep, but wakes slightly, to make sure you're still there keeping them safe. Finally, the baby falls asleep and you hear their breathing as their chest rises and falls. You get up to lay the baby down to sleep. You are confident that you have made the sleeping area safe and free from all risks.

What do you already know about safe sleep for infants?

Use the space below to write what you did in the story above to make the sleeping space safe and free from all risks.

Attachment 9

What does sleeping comfortably look like for you as an adult?

Imagine that it is the end of a long day. All you want is to get comfortable and have a good sleep. Use the space below to write what you have done to make this happen for you. What comforts have you prepared to help you get the sleep you so need and want? What makes it so comfortable? For example, think about your sleep position, bedding, pillows and clothes. What gets you ready for sleep?

Hopefully you can get a relaxing sleep each night that helps you to approach each day with a fresh start. In this training you will realize that an adult's sleeping behaviors and comfort needs are different from an infant's sleeping needs. Some adult sleep comforts can be risky to an infant's safety while they sleep. This does not mean infants will be uncomfortable. It means they will sleep safely.

How did you develop your current knowledge and/or practices around laying an infant down to sleep?

As a professional who serves families it is important to know research-supported best practices to safely lay an infant down to sleep, whether for a nap or for the night. Often, people rely on experiences, knowledge, culture, friends and family to understand how to care for an infant. Use the space below to write how you developed your current knowledge and/or practices around laying an infant down to sleep.

Your Role in Safe Sleep

Professionals who serve families have opportunities to interact with the families they serve. Their responsibilities may include engaging families in their home environments, virtually, on the phone or in the community and often include sharing information about parenting practices that support children's safety, health and well-being. You are in a unique position to engage parents and caregivers in conversations on safe sleep.

As part of an intake, evaluation or during ongoing work with a family, consider:

1. Observing the infant sleep environment when possible or asking for a description.

2. Inquiring as to sleep practices the family uses anytime the infant is laid down to sleep.

3. Providing education on safe sleep recommendations. Consider providing both written information and a verbal explanation.

4. Supporting the family in problem solving to reduce risk.

There are strongly held beliefs regarding what are appropriate sleep practices, but you are still encouraged to see that all parents or caregivers are aware of safe sleep practices. For many families, discussions about how to reduce risk for their infants will be more effective in changing their practices than simply providing them with written material.

Professionals who serve families must be equipped to share the most up to date, research-supported practices with families caring for an infant. This training uses current information and research from multiples sources. Please carefully read the information and complete the activities to test your knowledge along the way.

Why Safe Sleep Practices Are Important

You touch the lives of children and their families in many important ways. Safe sleep practices are critical to reducing the risk of sleep-related infant death. Parents and caregivers who do not follow these practices could have a devastating outcome. Helping parents and caregivers understand the importance of safe sleep practices and supporting these practices as part of a family's routine may save lives.

The Connection Between SUID and Safe Sleep

Once a child reaches one month of age, the most common cause of death is Sudden Unexplained Infant Death (SUID).

The three commonly reported types of SUID are:

- Sudden Infant Death Syndrome (SIDS)
- Accidental suffocation and strangulation in bed (ASSB)
- Other ill-defined or unspecified causes

Here are the definitions of SUID and SIDS:

SUID	SIDS (a type of SUID)
Sudden and unexpected death of a seemingly healthy infant, under 12 months of age in which cause of death is not immediately obvious.	SIDS is a SUID death that is still unexplained after a death scene investigation, autopsy, and review of the infant's medical history. [1]

The focus of safe sleep practices is to reduce the number of sleep-related SIDS deaths and ASSB deaths. Infant deaths in a sleep environment that are not considered SIDS may be caused by suffocation or strangulation and fall under the category ASSB so it is important to understand both.

Mechanisms that lead to accidental suffocation include:

- **Suffocation by soft bedding.** For example, when a pillow or waterbed mattress covers an infant's nose and mouth.
- **Overlay.** For example, when another person rolls on top of or against the infant while sleeping.
- **Wedging or entrapment.** For example, when an infant is wedged between two objects such as a mattress and wall, bed frame, or furniture.

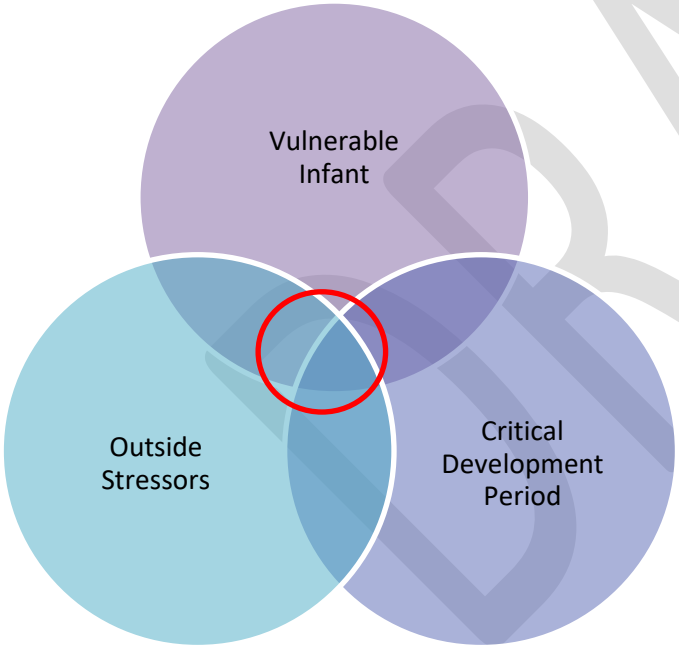
Strangulation can occur, for example, when an infant's head and neck become caught between crib railings.

Now for the good news…

The good news is a parent or caregiver can take actions to lower the risk of SIDS and in most cases prevent ASSB. Most of these actions relate to the infant's sleep environment. A professional's understanding of how safe sleep reduces the risks for Sudden Infant Death Syndrome (SIDS) and other sleep-related deaths is key to engaging parents and caregivers in conversations and planning that may save a child's life.

Before going over the actions that can be taken to reduce risk, first let's learn more about SIDS and specifically the risk factors that a parent or caregiver can and can't change.

Multiple Risk Factors For SIDS[2]



There is no one definitive cause of SIDS. The diagram shows how three common risk factors interact. When an infant is experiencing risk factors from all the three circles, as shown in the center area of the diagram, they are at a much higher risk for SIDS. Although these factors contribute to higher risk, all infants are at risk.

Let's look at each of the risk categories in the diagram individually.

Vulnerable Infant

Vulnerable Infant

All infants are vulnerable to SIDS. Some factors can make an infant more vulnerable. These can be unknown to parents, caregivers and heath care providers and include:

- Genetic conditions passed down from biological parents.
- Unknown physical developmental issues.
- Issues with brain development.

Critical Development Period

Critical Development Period

Infants' brains grow and develop a lot in the first six months of life. They are at highest risk for SIDS during this time because the part of the brain that allows them to wake up when their oxygen level is too low or their carbon dioxide level is too high, is still developing. The muscles in the neck and core are also not fully developed during infancy. This prevents an infant from being able to roll over or pick up their head if their airway is blocked.

Outside Stressors

Outside Stressors

The only risk factors that a parent or caregiver has an ability to change are in the **"Outside Stressors"** category. These are called outside stressors because they occur outside the infant's body. Some examples of outside stressors include bumper pads, too much clothing, loose bedding, being placed on your stomach and exposure to cigarette smoke.

Professionals who serve families have a role in supporting parents and caregivers in reducing these risks. Reducing **outside stressors** is best for an infant's health and safety.

Reducing outside stressors

Knowing the outside stressors and how to reduce the number of outside stressors is critical to having informed, constructive conversations with parents and caregivers about safe sleep practices.

The 5 outside stressors focused on in this training are:

1. **Sleep position**
2. **Sleep surface and area**
3. **Sleep location**
4. **Smoke free environment**
5. **Sleep temperature**

#1: Sleep Position:

Decreased Risk	Increased Risk
Infant is placed on their back to sleep.	Infant is placed on their stomach or side to sleep.

Additional Information to consider about sleep position:

- Placing an infant on their back is the most effective action for parents and caregivers to reduce SIDS.

  If an infant is a stomach or side sleeper at home, the risk for SIDS is much higher. The side position is just as dangerous as placing the infant on the stomach because the infant can accidentally roll to the stomach. If an infant is put to sleep on their back and rolls on their own to their stomach, in this instance, it is not necessary to change their position. If a swaddled infant is able to roll it is important to stop swaddling all together.

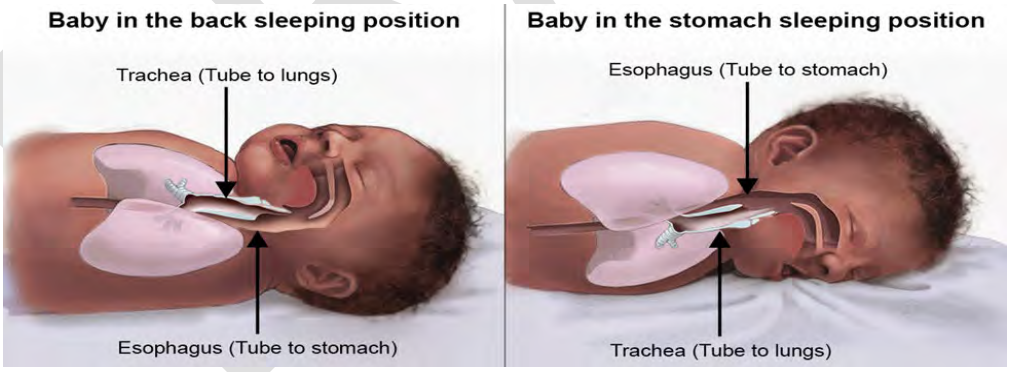
- Infants love consistency! In fact, infants who usually sleep on their backs but who are then placed to sleep on their stomachs, like for a nap, are at very high risk for SIDS.[3]

- **Tummy time** (placing your awake infant on their stomach) is important. Infants need tummy time to develop different muscles and to get a good view of their world, but it should only be when they are awake and supervised. [4] If an infant falls asleep during tummy time they should be placed on a safe sleep surface on their back.

- Swaddled infants may roll more easily from back to stomach, with no ability to use their arms for support. Infants who are swaddled have an increased risk of death if they are placed in or roll on to their stomach. If swaddling is used, infants should always be placed on their back. When an infant exhibits signs of attempting to roll, swaddling should no longer be used. To be safe, stopping swaddling by two months is recommended.[5]

- Infants are less likely to choke on their backs

  It was a common belief that back sleeping increases the chance of choking if an infant vomits while they are sleeping. This is not true. Infants can clear fluids better when they are on their backs. When an infant is sleeping on their back, the trachea (airway that goes to the lungs) lies on top of the esophagus (tube that goes to the stomach). When an infant spits up, gravity will keep the spit-up in the esophagus, and it will either come out of the mouth or the infant will swallow it. Either way, the trachea is protected when the infant is on their back. When an infant is sleeping on their stomach, any spit-up will pool at the opening of the trachea. This makes it easier for the infant to choke from breathing fluid into their lungs.



Because of the misinformation about back sleeping, you may encounter new parents who have heard from grandparents and others that their infant slept on their stomach. Many infants who sleep on their stomach never experience SIDs, however, the risk of experiencing SIDs is far greater for those infants. This is part of the conversation you will have with parents and caregivers about how, over time, research has informed new best practices. Seat belts are a good example to use as they were uncommon in cars until 1958 and then their use was inconsistent. Many children did not get harmed riding in the back of cars with no seat belt, but those who did experienced devastating consequences.

So, while many of us survived never wearing a seat belt, we wear them now, and would agree if we were in a car crash, our chances of surviving are much greater if we are wearing a seat belt.

Since the Back to Sleep campaign started in 1992, there has been a 50 % reduction in infant deaths.

#2: Sleep Surface and Area:

Decreased Risk	Increased Risk
Infant sleeps on a firm, flat surface (for example, a safety approved bassinet, crib or Pack N' Play). The firm surface, even a Pack 'N Play, has a fitted sheet and no other soft bedding or loose materials.	Infant sleeps on soft surface or surface that is not flat (for example, a couch, armchair, adult mattress such as memory foam, mattress topper, waterbed or car seat). There is soft bedding or loose materials in the sleep area (for example pillows, toys, stuffed animals, blankets or bumper pads).

Sleep surfaces can vary depending on cultural tradition, space, and mobility. What is most important is to put an infant to sleep on a firm, flat surface. The most common firm, flat surfaces are bassinets, cribs or Pack N' Plays.

Firm, flat sleep surfaces other than bassinets, cribs or Pack N' Plays that may be used:

Basket

Box or carton

Drawer

Washtub

6

Examples of traditional tribal sleep surfaces:

Umatilla Tribe style cradleboard[7]

Navajo Tribe style cradleboard[8]

First Nations and Woodlands Tribes moss bag[9]

Many traditional sleep surfaces have been around for a long time. If you are caring for a child who is of American Indian/Alaska Native (AI/AN) or First Nations (FN) ancestry some of the safest traditional sleep surfaces are cradleboards or baskets (both are common across many AI/AN tribes), and moss bags (common among Canadian First Nations and Woodlands AI/AN tribes). AI/AN's may have originated the concept of Back to Sleep with the traditional use of infant sleep mechanisms used in AI/AN or FN tribal communities. Although the specific design of the sleep mechanisms differ from Tribe to Tribe, the infant is placed on their back and swaddled into place in a safe and secure environment. Because the rates of infant death and SIDS are high in many AI/AN communities, using these traditional methods is a good way to keep infants safe. If you are unaware of the traditional tribal safe sleep practices, contact the infant's Tribe to learn more, as understanding how to use traditional tribal sleep mechanisms is critical to keeping the infant safe.

No matter what container or mechanism is used, the surface should be firm and flat. If using a sleep surface that can't accommodate a snug fitting mattress, it is safer to place the infant on the firm uncovered surface than it is to use a pillow or other soft or loose surface.

Infants who sleep on soft surfaces or are placed with soft, squishy objects are at risk for SIDS or suffocation. Examples of soft surfaces or objects include:

- Soft mattresses
- Pillows
- Blankets, comforters, quilts
- Other loose bedding (such as non-fitted sheets)
- Sheepskins
- Bumper pads
- Stuffed toys

- Infant positioner (products designed to keep an infant in a certain position, such as wedges, padded tubes or mats with side bolsters)

Additional Information to consider about sleep surface and area:

- Sitting or reclining devices, such as car seats, strollers, swings, infant carriers, and infant slings, are not recommended for routine or unsupervised infant sleep. Infants in these sitting devices may be able to move into a slouched forward position that can cut off their airway and even using the straps included in the device does not prevent this.

- Soft objects and loose bedding can obstruct an infant's nose and mouth.

- It is NOT recommended to put an infant to sleep with a bottle propped in their mouth. Not only is it a choking hazard and can lead to bottle rot as teeth come in[10], but the items typically used to prop a bottle (such as blankets and stuffed animals) pose a suffocation risk.[11]

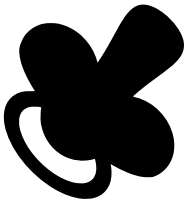
- Infant sleep clothing, such as a wearable blanket or sleep sack, is an alternative to blankets.

- Swaddling can be an effective technique to help calm infants. Be aware, however, if the infant breaks free of the swaddle, the blanket can then be available to cover their face and block their airway. However, it is also important to make sure the blanket is not too tight. The infant's hips and legs should be able to move freely, and two or three fingers should be able to get between the infant's chest and the swaddling blanket.[12] Also, swaddling may decrease an infant's arousal, so that it's harder for them to wake up. "We know that decreased arousal can be a problem and may be one of the main reasons that babies (infants) die of SIDS."[13]

- Bumper pads are not necessary to prevent head entrapment with new safety standards for crib slats.

- Remove teething necklaces or jewelry.

- Although the mechanism is unclear, studies have reported a protective effect of pacifiers on the incidence of SIDS. Offering a pacifier to infants is recommended. Pacifier use helps infants wake from sleep more easily, which is important if their breathing becomes blocked. A pacifier falling out of the infant's mouth and on to the sleep surface is ok.



If a pacifier is used when placing the infant for sleep, it does not need to be reinserted once the infant falls asleep. If the infant refuses the pacifier, they should not be forced to take it.

- It is recommended that the crib, bassinet or portable crib follow the safety standards of the Consumer Product Safety Commission (CPSC). See resource section in Part 4 of this training and click on the CPSC link for more information on safety standards.

#3: Sleep Location

Decreased Risk	Increased Risk
Room sharing Crib or bassinet is close to parent or caregiver	Infant shares a sleep surface with caregiver, non-primary caregiver, siblings, other person or pets. Crib or sleep surface is located in a separate room.

Room Sharing versus Bed Sharing

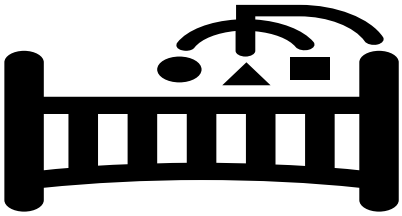
Before discussing room sharing and bed sharing here are the definitions of each of these terms:

Room sharing: Refers to an infant sleeping in the same room as a caregiver or other household members, not sharing the same surface such as a bed, couch, chair or futon.

Bed sharing: Bed-sharing refers to an infant and one or more adults or children sleeping together on any surface, not necessarily a bed; they could be sharing a surface such as a couch, chair or futon.

It is recommended that infants sleep in the parents' or caregivers' room, close to the parents' or caregivers' bed, but on a separate surface designed for infants. The American Academy of Pediatrics (AAP) guidelines are built around the promotion of breast feeding, bonding and safety. Keeping the infant close to the parent or caregiver allows for each of these to occur.

The AAP recommendations acknowledge that parents frequently fall asleep while feeding an infant. Evidence suggests it is less hazardous to fall asleep with the infant in the adult bed than on a sofa or armchair. However, adult beds are associated with a lot of risk factors, such as soft, pillow-top mattresses, blankets and pillows. Infants are not coordinated enough to move a blanket or pillow off their face.



Bed sharing is *not* recommended. Bed sharing increases the risk of suffocation, entrapment, and other sleep-related causes of infant death. An adult bed is not designed for infants, and there are no safety standards for adult beds.

Although bed sharing is NOT recommended by the AAP, there are many rational reasons why a parent chooses to bed share:

- It encourages breastfeeding by making nighttime breastfeeding more convenient.
- Makes it easier for a nursing mother to get her sleep cycle in sync with her infant's.
- Helps infants fall asleep more easily, especially during their first few months and when they wake up in the middle of the night.
- Helps infants get more nighttime sleep (because they awaken more with a shorter feeding time, which can add up to a greater amount of sleep throughout the night).
- Helps parents regain closeness with their infant after being separated from their infant during the workday.
- It is a common practice within the family's culture.
- The parent or caregiver had a positive experience with bed sharing with other children.
- In the context of a parent or caregiver who has experienced domestic violence, bed sharing may occur because:
    - The abusive partner requires the infant to be in the bed
    - To protect an infant from an abusive partner
    - To be prepared to leave quickly
    - As a coping mechanism after fleeing an unsafe situation

Oregon Health Authority and AAP recommends some precautions to consider if, contrary to recommendations, a parent or caregiver chooses to have their infant sleep in their adult bed:

- ☐ Wait until the infant is older than four months old
- ☐ Remove pillows, quilts, or comforters
- ☐ Do not have pets or other children in the bed at the same time as the infant
- ☐ Avoid sleeping on soft surfaces such as a waterbed, mattress topper, sofa, couch, or armchair
- ☐ Avoid bed sharing if the adult is actively smoking

- ☐ Avoid bed sharing if the adult has consumed alcohol, used substances that may impair them, taken sleep aids or if they are overly exhausted and there is a chance that they will not awake in an emergency. This will be addressed with more detail in the next section.

Additional information to consider:

- Exhaustion is an inevitable part of parenting an infant. Support the parent or caregiver by developing a plan or plans to lay the infant down to sleep safely when managing exhaustion. A plan may involve other adults in the home and always requires listening to what the caregiver reports is doable. Especially when there are no other adults in the home, consider a plan involving a babysitter, respite provider or other alternative caregiver providing scheduled or as needed respite to support uninterrupted sleep for the parent or caregiver.

- Practicing room sharing is safer than bed sharing or solitary sleeping in a separate room.

- Placing the crib or bassinet next to the caregiver's bed can make nighttime feedings easier.

#4: Smoke Free Environment:

Decreased Risk	Increased Risk
The infant is in a smoke-free environment.	The infant is exposed to secondhand or thirdhand smoke.

Secondhand Smoke Effect

Second-hand smoke is smoke inhaled from tobacco being smoked by others. This happens when you are in an enclosed space or sitting near someone who is actively smoking. Exposure to second-hand smoke significantly increases an infant's chances of dying from SIDS[14]. Children exposed to second-hand smoke are also at higher risk of other diseases such as asthma, the common cold, and other viruses.

Thirdhand Smoke Effect

Third-hand smoke is tobacco smoke toxins that remain after the cigarette is put out. Third-hand smoke toxins can build up on the smoker's hair, clothing, and other surfaces. The toxins in smoke can cause harm to an infant's developing brain.

To reduce infants' risk of exposure to third-hand smoke, parents and caregivers can cover their clothing with a jacket or sweater, pull back long hair, or wear a hat to cover their hair while smoking. After smoking, it is important to wash hands, face, and change clothing that will come into direct contact with the infant. Examples like these will protect each infant's vulnerable developing body systems.

#5: Sleeping Temperature

Decreased Risk	Increased Risk
Room temperature is comfortable for a lightly clothed adult. Infant in a maximum of one layer more than what would typically be comfortable for an adult to wear.	Room temperature is too warm or uncomfortable for an adult. Infant is overdressed or underdressed for the temperature of the room.

Overheating increases sleep-related SUID risk. Overheated infants are more likely to go into a deep sleep that might be more difficult for them to arouse from. Signs that an infant is too hot include sweating, damp hair, flushed cheeks, heat rash, and rapid breathing.

Many parents and caregivers are concerned that an infant will get cold without a blanket. Blankets can increase the risk of SIDS and accidental suffocation. Instead of a blanket, use the general guideline of dressing an infant in clothes, sleepers or a nonrestrictive sleep sack that provide one layer more than would typically be comfortable for an adult. Healthy infants do a good job regulating their own body temperature. Extreme temperatures, such as sleeping outdoors in winter, may require additional layers. If adding layers pay special attention to the signs the infant is too hot.

Overheating may also occur if an infant is swaddled. If caregivers swaddle, including swaddling for a cradleboard or other traditional tribal safe sleep practice, it is important to consider what else the infant is wearing and the temperature where the infant is sleeping.

Share the Message:

The parents and caregivers of infants look to you for parenting guidance and support. There are many opportunities when working with families to share information about safe sleep practices. It is important to make sure the information is shared with all the individuals in a family who have a role in laying the infant down to sleep. Parents and caregivers should be encouraged to share this information with family members, friends and others who also provide care for their infant, including babysitters and childcare providers.

For American Indian/Alaska Native families, provide information in a way that does not confront or question the knowledge within a family about tribal traditions. Also, consider engaging Elders from tribal communities and do so in a manner that does not question their authority as important community members with much knowledge and expertise that could benefit families. Learn about traditions that are important to families and ask for guidance as to how to support families within tribal communities to make decisions that both honor their values and traditions, while also following research-supported practices.

What Did You Learn About Increasing and Decreasing Risk of Sleep-Related Deaths?

Activity 1: Identify which actions in the list increase risk of SIDS:

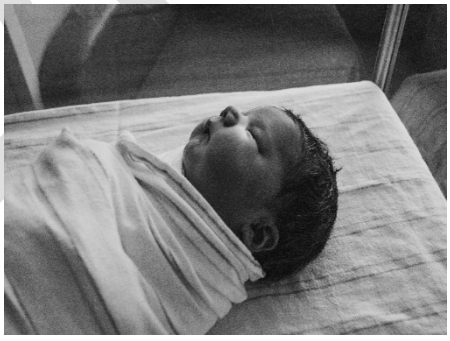
1. Place on side to sleep
2. Only one stuffed animal in crib
3. Wearing a hat to cover your hair when smoking
4. Swaddling when infant can roll
5. No blankets at all

Answers: 1, 2 and 4 increase risk

Activity 2: If you were with a family and saw the sleep practices in the photos below, would you recognize the outside stressors and know what recommendations to provide to the family to reduce risk?

View the photos below and write your answers and observations in the space provided for each photo.

Does the above picture show any safe sleep practices? ☐ YES ☐ NO	How would you reduce risk?
List any risks or protective factors that you see:	



Does the above picture show any safe sleep practices? ☐ YES ☐ NO	How would you reduce risk?

List any risks or protective factors that you see:

Does the above picture show any safe sleep practices? ☐ YES ☐ NO	How would you reduce risk?
List any risks or protective factors that you see:	

Does the above picture show any safe sleep practices? ☐ YES ☐ NO	How would you reduce risk?

List any risks or protective factors that you see:

Part 2: Bed Sharing and Substance Use

Substance Use When Bed Sharing

As you learned in Part 1, bed sharing increases risk of sleep-related death to an infant. While it is recommended by the AAP to avoid bed sharing, there are parents and caregivers who will make the choice, for a variety of reasons to continue to share a sleep surface with their infant. When this is the case, you are encouraged to engage in conversations and to the extent possible, partner with the parent or caregiver to develop a plan to reduce risks. A parent may continue to bed share, but the same parent may agree to remove the comforter from the bed and have the other adults or children typically in the bed sleep elsewhere. Harm reduction is an important approach when engaging families on the topic of infant safe sleep.

While substance includes many legal or illegal drugs with potential for misuse, including any controlled substance, prescription medications, over-the counter medications, or alcoholic beverages, let's take some time to look at marijuana specifically.

What Are Your Attitudes and Beliefs About Marijuana Use?

Marijuana use is common and legal in the state of Oregon. As a professional who serves families it is important to examine your own beliefs about marijuana use and parenting to make sure personal bias does not interfere with how parental support and education is provided. Use the space below to write your understanding of how a parent's or caregiver's use of marijuana while parenting may present a risk to an infant in their care.

Bed Sharing, Substance Use and Infant Death

Marijuana, alcohol and prescribed substances are legal in Oregon. The form, method or legality of a substance does not decrease the dangerous effects that use of this substance can have on both parental impairment and child safety. Whether a substance is legal or illegal, prescribed or not prescribed is not the issue. The focus is on the impact the substance has on the parent or caregiver functioning.

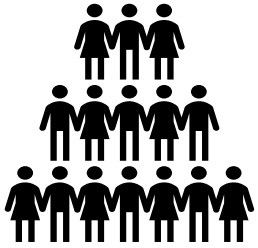
When a parent uses sedating substances, such as marijuana, the probability they are going to go to sleep faster and sleep harder and deeper than usual is extremely high. Being sedated or impaired can make a parent or caregiver unresponsive to an infant. A parent may not be aware they have rolled onto the infant and may not feel the infant or hear the infant's distress sounds.

"The most recent studies have shown that most bed sharing deaths happen when an adult sleeping with a baby (infant) has been smoking, drinking alcohol, or taking drugs (illegal or over the counter meds) that make them sleep deeply."[15]

For this reason, it is even more crucial to be having conversations, providing information and making plans for infant safe sleep practices with families where the parents or caregivers use substances. There is a clear standard here. It is unsafe for a parent or caregiver to bring an infant into their bed if they have used any substance that could interfere with their normal sleep patterns. If the parent or caregiver is impaired and plans to share a sleep surface with their infant, support the family in making an alternative plan. This support may include reaching out to other individuals in the family or community. If all attempts are unsuccessful, consider whether it is a mandatory report of child abuse.

Collaborative Approach

Be clear about risks with parents. If a parent or caregiver is using a substance that can impair them, then support them in developing a plan to ensure that a safe, unimpaired individual is caring for the infant.



Consider including other community partners in these conversations with the family, such as experts on substance use disorders, safe sleep or infant health, or culturally specific providers or supports. Being accompanied in these conversations by a Self Sufficiency Program Family Coach, a nurse or a tribal member will allow for a different voice and another perspective. Also, consider connecting the family with providers they trust and who would have credibility on the topic, such as their pediatrician. Studies have repeatedly shown that hearing messages about safe sleep, for example, from multiple sources, multiple times increases likely acceptance and implementation of safe sleep behaviors.[16]

Part 3: Safe Sleep Conversations with Families

Conversations with Families

When engaging families in conversation about safe sleep, they may express concerns or share misconceptions about safe sleep practices. You may also hear from them ideas or opinions around this topic that you haven't thought of before. Parents or caregivers may resist engaging in one or several safe sleep practices as they may be committed to a sleep practice that is inconsistent with the recommendations to reduce risk.

It is the role of professionals who serve families to not only educate families, but also to engage in authentic conversations with families about safe sleep - conversations that respect and engage with their lived experiences and opinions, and acknowledge and elevate them as experts in and advocates for their children's health.

Think about safe sleep improvements in terms of supporting and building parents' and caregivers' sense of competency and control in a purposeful positive way. That means partnering with families to build their capacity. This can be done by avoiding situations that make parents feel judged, talked down to, or overwhelmed, and instead focusing on opportunities to help them feel like they are in control of their infant's health.[17] Take time to celebrate all of the ways in which families are already creating comfortable and safe sleep environments for their infants as you also share information about reducing the risks of sleep-related infant death. Engage parents and caregivers as partners in the conversation asking if there are ways in which they think they could enhance safety for their infant based on the information shared.

When the parent or caregiver resists making the recommended change, make efforts to reduce as much risk as possible. The following information, as well as the information covered in Parts 1 and 2, is aimed at preparing you to engage families in conversations about safe sleep.

Reducing Risk

"If I talk with families about doing anything except what is recommended, then I am condoning unsafe or unhealthy behaviors. They need a firm message about what to do and what not to do or else they may not follow the recommendations."

This concern is quite common and understandable. Considering families will decide what they want to do, it is most productive to focus on providing as much information as possible about how they can implement their decisions. If they decide not to implement all the recommendations, provide information about what factors may create risk so they can address those factors. Support reducing as much risk as possible. This approach is

now included in the new American Academy of Pediatrics (AAP) safe sleep guidelines, which urges open and honest conversations with families.

Not talking about accommodating families' decisions may put infants at risk.[18]

When there is concern that dynamics of power and control are impacting resistance to changes in sleep practices, and when it is safe to do so (and if within your role), engage both the abusive partner and survivor in the conversations and focus on the safety risks to the infant. Focusing on the impacts to children has been shown to be a successful way to engage abusive partners in behavior change. Whenever possible, the best and safest practice is to connect with the survivor first to better understand the abusive partner's pattern of coercive control and any personal safety risks that may be created for the survivor, the infant and the family as a whole by engaging in these conversations.

How the Conversation Starts

Consider starting the safe sleep conversation with an open-ended question such as one of the following. Several may sound familiar as you were asked some of these questions at the beginning of the training. You may wish to refer to your responses and the corresponding guidance.

- "What do you know about how you were put to sleep as an infant?"
- "What do you already know about safe sleep practices?"
- "What does sleeping comfortably look like for you as an adult?"
- "Would you show me where you put your infant to sleep?" or "Can you describe your infant's sleep environment?"
- "What are all the ways you help make sure your infant has a good sleep?"
- "Tell me how you and your spouse or partner made the decisions about the sleep practices you use?"

Approach to Resistance

How do you approach resistance from a parent or caregiver?

- Use a strength-based approach and build on their protective factors
- Praise families for what they are already doing that sets up a healthy and supportive sleep environment
- Explain the risks associated with sleep-related infant death, but don't use shame or fear
- Explain the worst-case scenario (with empathy and in a constructive, personal, caring manner)

- Explain risk reduction measures and encourage use of these
- Encourage follow-up with their medical provider about safe sleep
- Collaborate with other community professionals and tribes to share the message in a way that honors family and cultural traditions and values

It is important to **listen** and understand why families may not utilize the AAP recommendations.

Examples of reasons for resistance may include:

- Comfort of the infant or themselves
- Exhaustion
- Prior experience with other children or own childhood
- Advice from family members or friends
- Lack of space for a crib
- Lack of a crib (money or access)
- Don't believe the science, it changes all the time
- Mixed messages from health care providers
- Information is outside of their cultural framework
- Belief that SIDS is "fate" or "God's will"
- Perception of what a good sleeper is (contrary to what many believe a good sleeper is not an infant who sleeps 10 hours a night without waking up. A good sleeper is an infant who wakes up periodically and can go back to sleep on his or her own.)
- Engaging in a conversation about practicing safe sleep may unintentionally be perceived as they are not a "good parent"

Ask the parents and caregivers why they feel the way they do. Their words will guide how you respond and with what information. Approach the conversation with questions and **affirm you are hearing and understanding the family's feelings and reasoning**.

To provide information in a constructive way to the parent or caregiver consider:

- Avoiding use of "should" which may be experienced as directive

- Using interactive educational materials

  The Jackson County Nurse-Family Partnership Program created and used safe sleep educational tools that use photos depicting various infant sleeping arrangements to spark discussion with prenatal and new mothers around safer sleep practices. Asking parents and caregivers to explain what they see in the pictures and for feedback on what they think about the educational tool and how to improve it helped the home visitors understand what parents and caregivers learned and how to improve the tool itself. Making the clients the "experts" on how they felt about the tool elevated their participation and engagement as well as knowledge.

- Repeating, reinforcing and layering of additional information as this is needed for changing behavior.

Parents or caregivers are not always ready to receive information or have the energy for learning a lot of new information at once. Providing aspects of safe sleep information that is relevant for them when they need it and building on that information over time may help.

- Combining safe sleep education with provision of, or referrals to, community resources for infant sleep sacks and/or infant sleep spaces as this increases knowledge and helps to reduce economic barriers at the same time.
- Engaging in conversations about values and beliefs with a non-judgmental attitude as this may increase trust and increase honesty about safe sleep practices.

Engagement, trust and ongoing efforts, often from multiple people, are necessary to effect change and reduce risk.

Scenarios

Below are six scenarios highlighting some of the statements and questions you may encounter when having conversations about infant safe sleep. Each statement or question is followed by an example of a potential response you may find it helpful to be prepared with. Consider how you might adapt these responses to fit your voice and to use these responses in your work.

Scenario #1

When I was an infant, I was put on my stomach to sleep. Was that wrong?

No. Parents and caregivers were following advice based on the evidence available at that time. Since then research has shown that sleeping on the stomach increases the risk for SIDS. This research also shows that sleeping on the back carries the lowest risk of SIDS, and that's why the recommendation is "back is best."

Scenario #2

"I put my infant to sleep on their stomach because they can roll over if needed."

When infants can easily turn over from back to stomach and from stomach to back, they should still be placed to sleep on their back. After they are asleep, if they roll over, you do not need to put them on their backs again. However, make sure there are no blankets, pillows, bumper pads, or other items in the crib that the infant can roll against and suffocate.

Scenario #3

"My infant sleeps on their side because they are most comfortable that way."

If an infant is a stomach or side sleeper, the risk for SIDS is much higher. The side position is just as dangerous as placing the infant on the stomach because they can accidentally roll to the stomach. If an infant is used to sleeping on their stomach or side and change to sleeping on their back this **does not** increase the risk of SIDS. However, infants who are used to sleeping on their backs and are then placed to sleep on their stomachs are more likely to die from SIDS[19] making it important to tell anyone caring for your infant such as a grandparent who may not have the most current information.

Scenario #4

"When my infant is put to sleep on their back, they wake up scared, so I put them to sleep on their stomach."

The startle response is a sudden movement that is sometimes seen as scary for the infant. Sometimes the infant gasps. This protects the infant, letting them get a breath of air or to wake up slightly from too deep of a sleep. Try using soothing techniques such as singing, patting or use of a pacifier.

Scenario #5

"My parent said I had a bald spot from sleeping on my back and I don't want that to happen to my infant."

Infants who sleep on their backs can develop some temporary bald spots on the back of the head. As the infant grows, moves and begins to sit up more often, the hair on the back of the infant's head will grow back. A bald spot on the back of an infant's head can be a sign of a healthy infant, one whose risk for sleep-related SUID/SIDS is lower because they are a back sleeper.

While the infant is awake, aware and supervised, tummy time is recommended and will help to decrease the friction on the back of the head that leads to the temporary bald spots.

Scenario #6

"I refuse to let my infant sleep on their back because I have heard that they will get a flat head."

Back sleeping can contribute to flattening of the back of the head, but head flattening is generally temporary. As infants grow and become more active, their skulls will round out. You can reduce head flattening by doing the following:

- Providing tummy time during waking hours;
- Switching which end of the crib you place the infant's feet, and when changing infant's diaper, alternating where the infant's head is on the changing table;
- Changing positions often when the infant is awake; and
- Limiting time spent in freestanding swings, bouncy chairs, car seats, and other surfaces that, with a lot of use, can lead to head flattening or temporary bald spots.

Scenario #7

"My infant sleeps in our bed because my partner gets very upset if I get in and out of bed during the night. He has to get a good night sleep to be able to work the next day."

I hear your concern. Are you open to considering other options, such as sleeping in another room or a different bed? If bedsharing is a practice you will continue, let's talk about other ways you can reduce risk for your infant. Are there safe ways to talk about infant sleep with you and your partner at the same time? Also, would you like to talk to someone about when your partner gets upset?

Activity: Practice communicating about safe sleep practices

This is your opportunity to practice responding to a parent's statements or questions. In the space below each of the four statements, please fill in how you would respond to the parent or caregiver. Remember, as with all communication with families, building and keeping trust is key!

1. **I know putting my infant to sleep in a crib is safest, but they cry when they are laid down.**

2. **I put this blanket on my infant when they go to sleep, so they won't get cold.**

3. **I smoke marijuana in the evening, outside of the home and after the children are asleep to help my anxiety, but I do not smoke around my infant and even shower and change my clothes after coming back into the house.**

4. **I don't drink around the children instead I go out on weekends to drink while a babysitter watches the children (however, the parent comes home intoxicated and relieves the babysitter of duties).**

When an Infant's Medical Needs Change Sleep Recommendations

There are times when an infant has special medical prescribed equipment, such as a G-Tube. In these situations, sometimes a medical professional may alter sleeping arrangements. What might you do in these situations?

- Consider offering to have a joint conversation with the medical provider and the parent if the parent needs clarification about the prescribed sleeping arrangements and to better understand the infant's current medical needs.

- Ensure the parent understands the expectations and recommendations and how this may be different for another infant in the home without the same medical needs.

Part 4: Wrap Up

You have almost made it, great work! This is the final part to the safe sleep self-study. In this section you will:

- Complete the professional action plan
- Complete the quiz/knowledge check
- Complete the survey
- Review resources

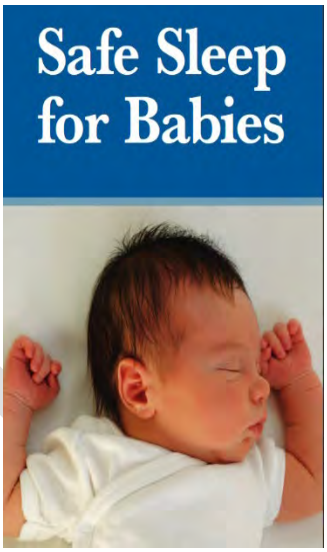
Professional Action Plan

Fill out your action plan here.

As a result of this self-study training what are three things you will do to make sure you share the information with families who have infants?	

Resources

The Safe to Sleep® campaign offers a variety of materials to help share safe infant sleep messages with diverse family audiences (Native, African American, American Indian/Alaska Native, and Spanish) https://www1.nichd.nih.gov/sts/materials/Pages/default.aspx



Videos for parents or guardians
https://www1.nichd.nih.gov/sts/news/videos/Pages/default.aspx

Public Health Safe Sleep Webpage (Safe Sleep Brochure)
https://www.oregon.gov/oha/ph/HealthyPeopleFamilies/Babies/Pages/sids.aspx

NICHQ webinar on Improving Infant Safe Sleep Conversations
https://www.nichq.org/improving-infant-safe-sleep-conversations

Oregon Prenatal and Newborn Resource Guide (English/Spanish)
http://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WOMEN/PREGNANCY/PRENATALNEWBORNRESOURCEGUIDE/Pages/index.aspx

Cribs for Kids
https://www.cribsforkids.org

AAP 2016 SIDS Task Force Recommendations
https://pediatrics.aappublications.org/content/138/5/e20162938

How to Keep Your Sleeping Baby Safe: AAP Policy Explained
https://healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Consumer Product Safety Commission (CPSC). For information on crib safety, contact the CPSC:
1-800-638-2772 or https://www.cpsc.gov/

Promising Futures: Best Practices for Serving Children, Youth and Parent's Experiencing Domestic Violence
https://promising.futureswithoutviolence.org/

Thank You for Doing Your Part in Keeping Oregon's Infants Safe

[1] Safe to Sleep Campaign https://www1.nichd.nih.gov/sts/about/SIDS/Pages/common.aspx
[2] Triple Risk Model. Filiano JJ, Kinney HC. A perspective on neuropathologic findings in victims of the sudden infant death syndrome: the triple-risk model. Biol Neonate 1994; 65 (3-4) 194-197.
[3] Safe to Sleep Campaign https://safetosleep.nichd.nih.gov/safesleepbasics/risk/factors
[4] *Image courtesy of the Safe to Sleep® campaign, for educational purposes only;* Eunice Kennedy Shriver *National Institute of Child Health and Human Development,* http://www.nichd.nih.gov/sids*; Safe to Sleep® is a registered trademark of the U.S. Department of Health and Human Services.*
[5] https://healthychildren.org/English/ages-stages/baby/diapers-clothing/Pages/Swaddling-Is-it-Safe.aspx
[6] Image courtesy of the Safe to Sleep® campaign, for educational purposes only; Eunice Kennedy Shriver National Institute of Child Health and Human Development, http://safetosleep.nichd.nih.gov; Safe to Sleep® is a registered trademark of the U.S. Department of Health and Human Services.
[7] Photo is courtesy of Ruby's Indian Crafts & Supplies located on the Confederated Tribes of the Umatilla Indian Reservation (CTUIR).
[8] Photo is courtesy of Wildbill family
[9] Photo is courtesy of Geddes family
[10] https://www.cdc.gov/nutrition/infantandtoddlernutrition/bottle-feeding/index.html
[11] https://www.childrens.health.qld.gov.au/fact-sheet-bottle-feeding-safety-tips/
[12] Allina Health; https://www.allinahealth.org/healthysetgo/care/six-steps-to-safe-swaddling
[13] Healthy Children.org; Moon, R.; https://healthychildren.org/English/ages-stages/baby/diapers-clothing/Pages/Swaddling-Is-it-Safe.aspx
[14] https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/health_effects/index.htm
[15] BASIS (Baby Sleep Info Source); https://www.basisonline.org.uk/parents-bed/
[16] https://www.ncemch.org/learning/building/approach/1-4-talk-back.php
[17] NICHQ; Kotelchuk, M; https://www.nichq.org/insight/building-agency-and-self-efficacy-vital-opportunity-reduce-sleep-related-infant-deaths
[18] https://www.ncemch.org/learning/building/approach/1-4-talk-back.php
[19] Moon, R. Y. (2016). SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. Pediatrics,138(5). doi:10.1542/peds.2016-2938