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, the Child Fatality Prevention and Review Program (CFPRP) became a new independent Child Welfare program serving directly under the Child Welfare Director's Office. Since its inception, this program has focused on the response to child fatality, including support to professionals and family, data gathering, and prevention. This program is expanding its focus to include serious physical injury/near fatality. This program also leads efforts related to Child Abuse Prevention and Treatment Act (CAPTA)/Comprehensive Addiction and Recovery Act (CARA) with a strong focus on prevention. The following is an update to the comprehensive plan, beginning with an overview of the work of the CFPRP.

Child Fatality Prevention and Review Program

OREGON DEPARTMENT OF HUMAN SERVICES | CHILD WELFARE DIVISION | APRIL 2022

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Child Fatality Prevention and Review Program Overview

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

The formation of this focused program has allowed for time and space to consider new ways of thinking about preventing child fatalities, including all child fatalities that come to the attention of Child Welfare, child maltreatment fatalities, and more broadly preventable child fatalities. Such work requires attention to both workforce support and infrastructure to improve tertiary and secondary prevention as well as identifying and elevating primary prevention efforts to support children and families in their communities. The CFPRP has coordinators dedicated to various aspects of this work, including the Critical Incident Review Team (CIRT), Safe Systems/Safety Culture, Chronic Neglect Response, Suicide Prevention, Safe Sleep, and the Comprehensive Addiction Recovery Act (CARA). Additionally, a CFPRP coordinator is co-chair 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)

In early 2020, the CFPRP joined the National Partnership for Child Safety (NPCS) which is a collaborative of 26 jurisdictions focused on applying safety science and sharing data to develop strategies in child welfare to improve safety and prevent child maltreatment fatalities. Safety science provides a framework and processes for child protection agencies to understand the inherently complex nature of the work and the factors that influence decision-making. It also provides a safe and supportive environment for professionals to process, share and learn from critical incidents to prevent additional tragedies. For more information see attachment 1 for NPCS charter and attachment 2 for Oregon specific NPCS Infographic.

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

As a member of the NPCS, the CFPRP will participate in the sharing of data across jurisdictions beginning in 2022. Data from each jurisdiction will be housed in a central database at the National Center for Fatality Review and Prevention, allowing for analysis across the partnership to inform strategies to address children and families at risk and reduce maltreatment and fatalities. For additional information see attachment 3 National Partnership for Child Safety Frequently Asked Questions.

The aim of CFPRP is to facilitate a robust critical incident review process that builds safety and trust with the professionals working directly with families and opens the door to true introspection and learning. With this

approach, an accurate story is provided, common casework problems identified, and more meaningful solutions that improve conditions for the workforce which can ultimately result in improved outcomes for children and families. Through membership in the NPCS, the CFPRP receives technical assistance from the Safe Systems Team at the University of Kentucky Center for Innovation in Population Health. This technical assistance has been ongoing since 2019 and includes a broad array of training and support:

- Training for CFPRP and other child welfare programs on safety culture and systems-focused critical incident reviews
- Skill building labs for CIRT/Safe Systems Coordinators on drafting improvement opportunities, using the SSIT, conducting safe systems debriefings, as well as facilitating safe systems mapping
- AWAKEN training for CIRT/Safe Systems Coordinators (AWAKEN is a framework for identifying and addressing bias in decision-making, see attachment 4)
- Technical support to maintain a REDCap database which houses SSIT and NPCS Data Dictionary information
- Peer-to-Peer support for Critical Incident Review Leaders
- Innovation and Implementation Learning Communities (I2LC) on the intersection of Safety Culture and Justice (2021) and Workplace Connectedness (2022)
- Support facilitating safe systems mapping
- SSIT review and support on a case-by-case basis
- Facilitated cross-jurisdiction communication to support continued learning and improvement in different areas of the work
- Drop-in office hours for technical support questions
- Other technical assistance as requested

As early adopters of a systems-focused approach to reviewing critical incidents, Oregon has become a leader in the NPCS and is regularly sought out to provide support and learning opportunities for other jurisdictions. For more information about Oregon's role in the NPCS, please go to: https://tcomconversations.org/2021/12/16/oregons-role-in-the-national-partnership-for-child-safety/

In addition, Oregon's work will be featured in a poster presentation at the AcademyHealth 2022 Annual Research Meeting. See attachment 5 for presentation abstract.

Critical Incident Review Team (CIRT)

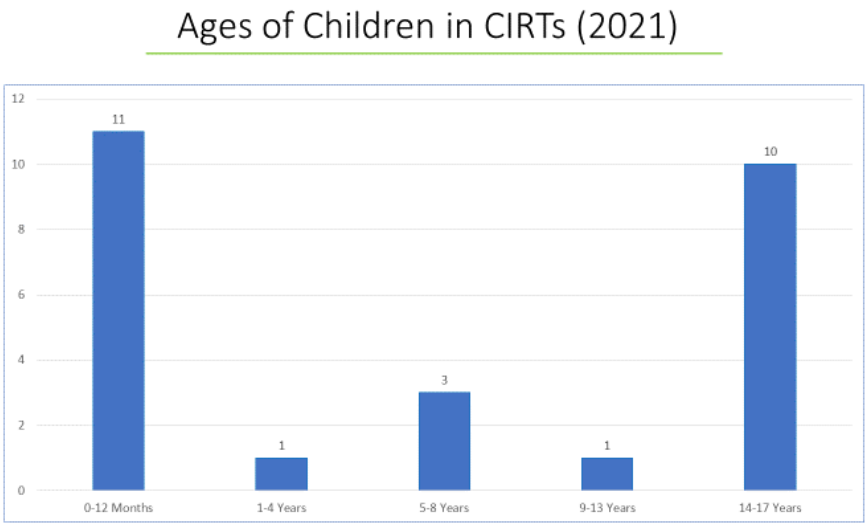
The Critical Incident Review Team (CIRT) process has been an integral continuous quality improvement process for Oregon's Department of Human Services Child Welfare Division since 2004. Created as an important and unique tool to help protect Oregon's children from abuse and neglect and to prevent future child maltreatment fatalities. Previously this work was located in the Central Office Child Safety Program, however an opportunity to move the CIRT process to the new Child Fatality Prevention and Review Program came about in February 2020. This has provided a unique opportunity for Oregon Department of Human Services to have a Child Welfare program that both provides an objective review process for child fatalities along with researching, developing recommendations, and leading and implementing innovative strategies and efforts that are focused on child maltreatment prevention at primary, secondary, and tertiary levels. Please see attachment 6 for CIRT Frequently Asked Questions.

The Child Fatality Prevention and Review Program has team members (CIRT Coordinators) assigned specifically to the CIRT work that involves leading with a non-punitive, systems focused approach. The CIRT Coordinators

facilitate meetings, engage, and prepare CIRT members for the review process which include child welfare professionals, community partners and CPS, Permanency and Foster Care program experts. In addition, the CIRT Coordinators complete the case file review and associated public report once the review is complete. Lastly, the CIRT Coordinator assists in the development of system improvement recommendations resulting from actions or inactions of ODHS or Law Enforcement leading up to or surrounding the critical incident. A CFPRP Prevention Coordinator is dedicated to tracking CIRT and fatality data, facilitating regular cross program meetings to ensure the completion of all system improvement recommendations. See attachment 7 for CIRT Process Map. There remains a separate pathway for personnel related issues that need to be addressed through the human resources department.

2021 Critical Incident Data

During the calendar year of 2021, 26 CIRTs were assigned by the ODHS Director. The chart below reflects the age ranges for the children whose deaths resulted in the assignment of a CIRT in 2021.



Circumstances surrounding the deaths *(please note, not all 26 CIRTs are represented as some information is not yet public)*:

- 4 children died as the result of physical abuse
  - 2 of those were due to injuries from a firearm
- 1 child died by suicide
- 2 children died due to asphyxia/asphyxiation (non-sleep-related)
- 8 children's death included high risk sleep practices
  - 8 of those included bedsharing
  - 5 included the suspicion or confirmation of substance use by the parent/caregiver within 24 hours of the death
- 2 children died as a result of a medical condition and/or medical complication(s)
- 1 child died as a result of a vehicle-related incident
- 1 child died as the result of a drowning
- 4 children died as a result of an overdose
  - All 4 included fentanyl
- 1 child died as a result of SUID and neglect

- 3 children were in the temporary and/or legal custody of the Department at the time of the critical incident
- 12 children were the involved in an open child protective services assessment at the time of the critical incident

For more information regarding CIRTs please go to our public website at:
www.oregon.gove/dhs/CHILDREN/CIRT/Pages/index.aspx

As a result of the CIRT, numerous system improvement recommendations are taken on each year by the CFPRP and other Central Office Child Welfare Programs (Safety, Permanency, Well-Being, Equity, Training & Workforce Development, etc.). System improvement efforts that have been implemented since 2021 include but are not limited to: Developing guidance to request rush toxicology for deceased children; Americans with Disabilities Act training, education and staff tools; Healthy Relationships brochure enhancement; Home environment observation and safety guidance enhancements; Summer of Safety campaign to enhance child protective services assessment practice; and Child and Adolescent Needs and Strengths (CANS) rule and procedure review and enhancements, including improved functionality of automated notifications. The CFPRP recognizes the hard work and collaboration of the child welfare professionals who facilitated and/or participated in each of these efforts. The CFPRP would also like to recognize the efforts of the local offices to enhance the knowledge and skills of the workforce and improve operations as a result of learning form the CIRT.

Professional Development and Supporting the Workforce

As CIRT legislation has shifted over time, so has the number of child fatalities reviewed[1] by the Department through the CIRT process. With the substantial change of CIRT legislation in 2019, multiple full-time staff were needed to manage the growing CIRT workload. With this change CFPRP came to understand the significant negative impacts that can occur to the emotional and mental wellbeing of CIRT Coordinators as a result of their constant exposure to tragic child fatalities. To address this challenge and mitigate impacts to staff while continuing to provide high value, system focused fatality reviews, CFPRP requested and was granted two rotational CIRT Coordinator positions. These rotational positions, scheduled to join CFPRP in spring of 2022, will allow staff outside of CFPRP an opportunity to serve the agency as CIRT Coordinators. This rotation-based staffing model lessens the secondary trauma experienced by staff working as CIRT Coordinators by limiting the period of time they are exposed to this challenging material while also providing Child Welfare staff ongoing opportunities for professional development. Additionally, these rotational positions allow CFPRP to continue efforts to share and promote the concepts of safety science and safety culture used in the CIRT process and by the CFPRP team. Staff returning to their local office after rotating out of CIRT Coordinator positions will have the opportunity to become culture carriers who may provide natural support and direction to their local offices to promote positive shifts in agency culture through the tenets of safety science and safety culture.

In response to CFPRP's rotation based CIRT positions and in support of consistency of practice, CFPRP also recently developed a CIRT Desk Guide. The CIRT Desk Guide serves as a resource to CIRT Coordinators in the important work of CIRT reviews by offering guidance and ways in which to activate their professional knowledge throughout the review process. The Desk Guide includes at-a-glance lists of steps involved in the CIRT process, in-depth sections providing detailed guidance in completing tasks, considerations for how to move through the work, quick links to frequently used templates and suggestions for how to craft communications and documents related to CIRT work. CFPRP believes that with the creation of the CIRT Desk Guide, staff engaged in CIRT work will have the resources necessary to ensure consistency of practice

[1] https://www.oregon.gov/DHS/CHILDREN/CIRT/Pages/Reports.aspx?msclkid=61f45db6c73711ecb3f4db192f09ee26

throughout the review process and the ability to create a consistent experience for staff and community partners participating in CIRTs.

As part of a continuous quality improvement effort, the CFPRP offers brief in person surveys to understand the experience of any caseworker, supervisor, or manager who attends a CIRT. The feedback received informs what is working well and where there are opportunities for improvement. The surveys are conducted through a trauma informed lens, are voluntary, and participants are assured the focus is on the process and does not include discussion about the family or circumstances. See attachment 8 for a summary of findings from the CIRT Survey Data.

Internal Discretionary Reviews

The CFPRP is also responsible for leading internal Discretionary Reviews which are directed by the ODHS Director when Child Welfare becomes aware of a fatality, near fatality, or other serious incident involving a family that has had contact with ODHS and the incident does not meet the criteria for a critical incident review team (CIRT). These reviews are an important opportunity for system learning and the development of system improvement recommendations and actions similar to the CIRT process.

CFPRP team members are assigned to complete the work surrounding the internal Discretionary Review process such as engaging and preparing participants, facilitating meetings, partnering with other child welfare programs to conduct case reviews, and develop and assist in the implementation of system improvement recommendations.

Following completion of both CIRTs and internal Discretionary Reviews, a CFPRP Safe Systems Coordinator initiates safe systems analysis to dive deeper into the factors that influenced any casework or system challenges identified.

Near Fatalities/Serious Physical Injuries

In addition to the data collected by the CFPRP on child fatalities, the CFPRP now gathers data from near fatalities and serious physical injuries. The CFPRP is in the early stages of collecting this specific data and understands it is critical to understanding system factors and prevention of child maltreatment and fatalities. In addition, new fatality/near fatality procedure is in process of being developed to provide further guidance to Child Welfare professionals. See page 13 for more information on these efforts.

Safe Systems Analysis

Safe systems analysis is a critical extension of Oregon's child fatality review process. Through file review, participation in the CIRT or internal discretionary review, and follow-up supportive inquiry, CFPRP is able to gather important information about what influences the casework or system challenges that may be identified in cases with tragic outcomes. See attachment 9 for Safe Systems Analysis Frequently Asked Questions.

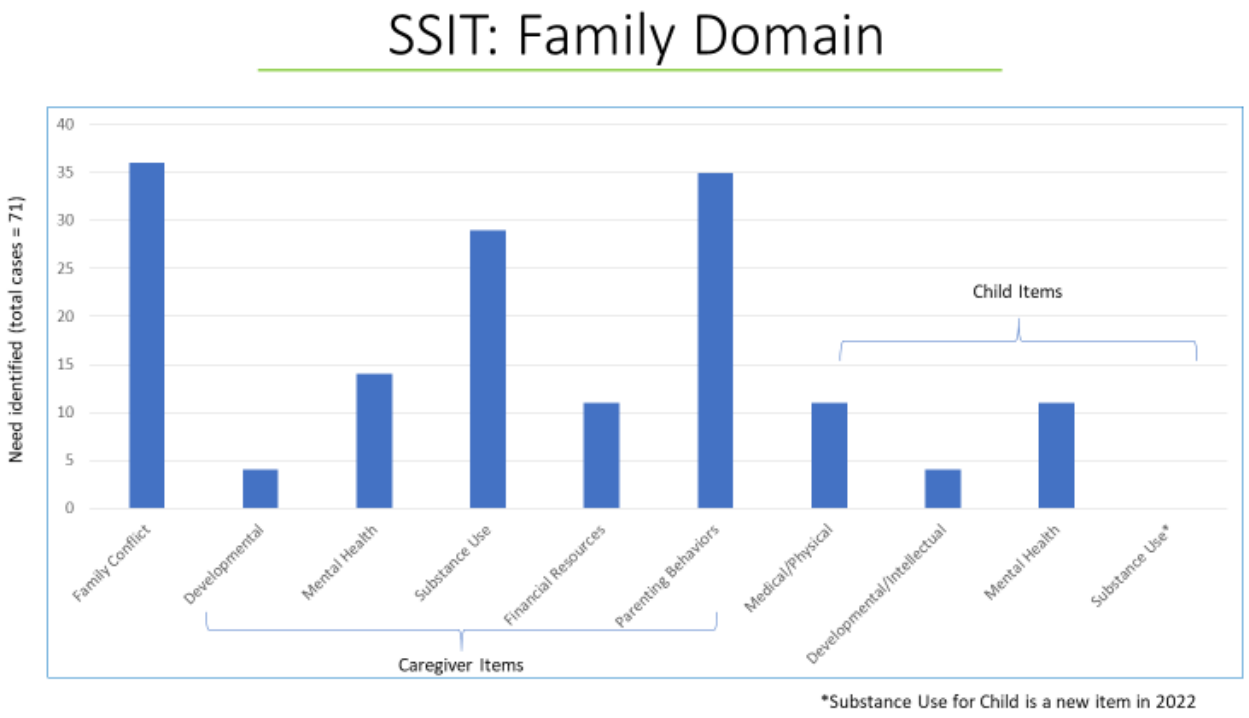
These challenges are known as Improvement opportunities (IOs) and they represent the gap between what the child or family needed and what they received. More technically, IOs are case-specific actions or inactions relevant to the outcome or industry standards and are often representative of relatively common casework problems. While emphasis is given to those IOs within ODHS-CW, IOs also consider the actions/inactions of other entities within the macro child-serving system (e.g., courts, human service providers, law enforcement, schools). In the safe systems analysis process, IOs are first identified through the CIRT or discretionary review

and those IOs are then explored by a Safe Systems Coordinator through use of the Safe Systems Improvement Tool (SSIT) (see attachment 10 for 2022 NPCS SSIT Reference Guide). At times, additional IOs are identified by the Safe Systems Coordinator and added to the exploration. Since implementing safe systems analysis in July 2019 the SSIT has been completed on 71 cases. Of those 71 cases, 50 had IOs identified, some cases having multiple, for a total of 96 IOs.

In some cases, the safe systems analysis includes individual debriefings. These debriefings are the mechanism for gathering the "second story" from those who experienced the outcome in the specific case. Debriefings are voluntary and trauma responsive and use supportive inquiry to support child welfare professionals in sharing their experiences. While debriefings are not completed in every case, they lend important detail and reliability to the overall information gathered and rated in the SSIT. Since 2019, Safe Systems Coordinators have engaged 41 child welfare professionals across 12 cases in individual debriefings.

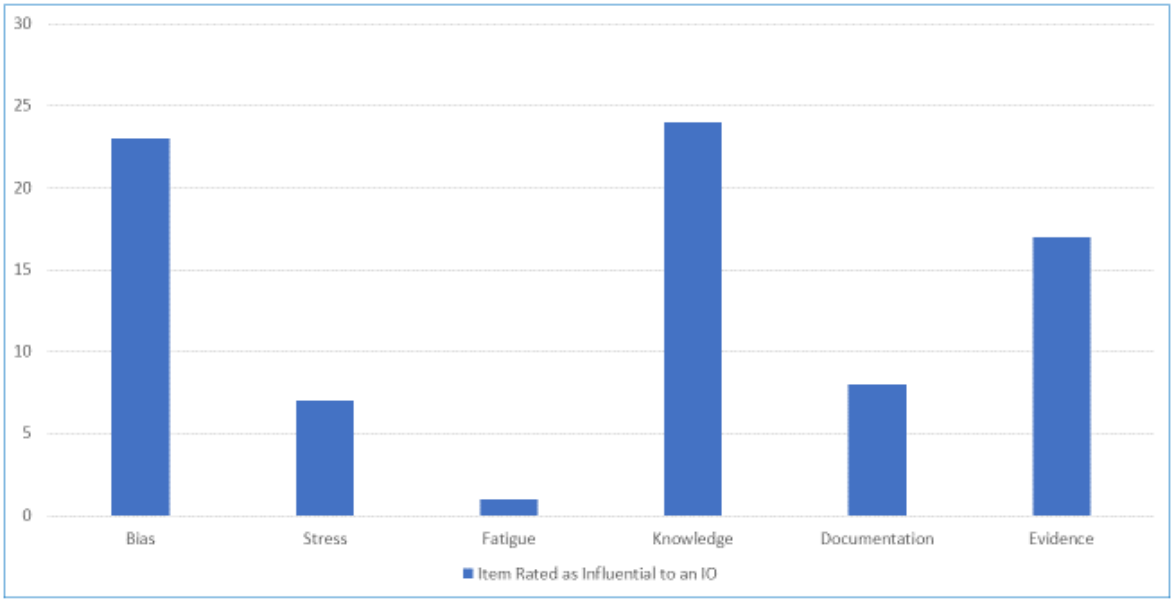
SSIT results and the standardized NPCS dataset are captured in a REDCap[2] database (see attachment 11 for NPCS Data Dictionary). REDCap is a secure web platform for building and managing online databases and allows for exporting data to excel as well as ad hoc reporting. REDCap allows the CFPRP to efficiently organize SSIT data for reporting and guiding system improvement efforts.

The SSIT contains four nested domains for rating. The first domain is the family domain and is rated independent of any Improvement Opportunities and functions similar to the CANS. These items are important for considering the needs of the family at the time of the critical incident. The remaining three domains capture influences at the professional, team and environment levels. These items are important for considering what factors contributed to any identified challenge, or IO, in the case. The charts below depict information gathered by Safe Systems Coordinators through the SSIT since July 2019.

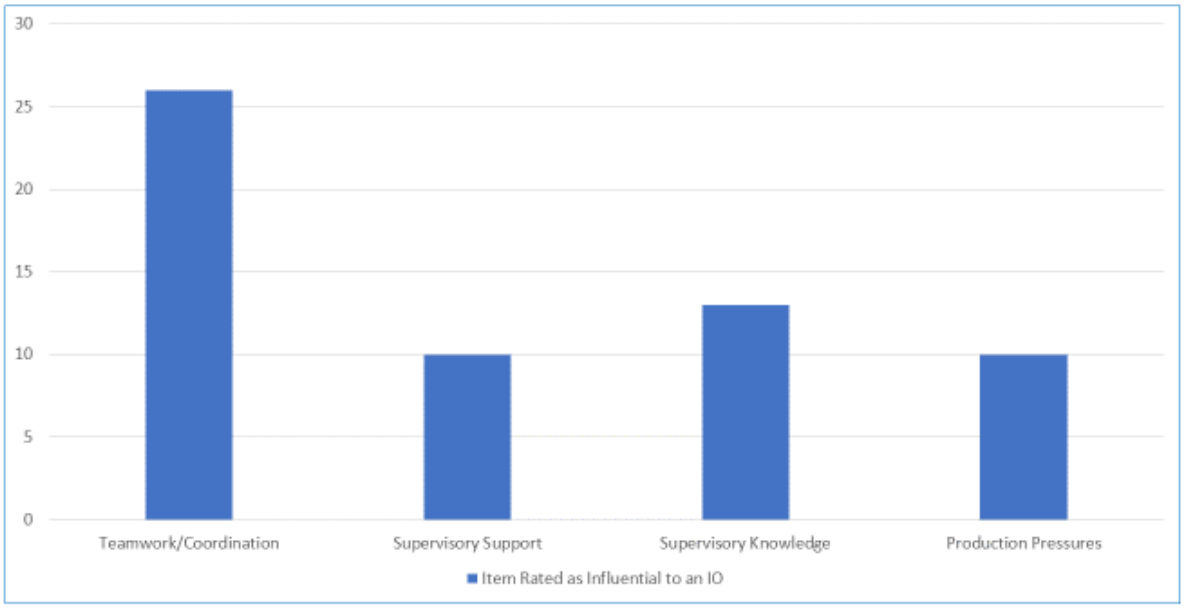


[2] https://www.project-redcap.org/

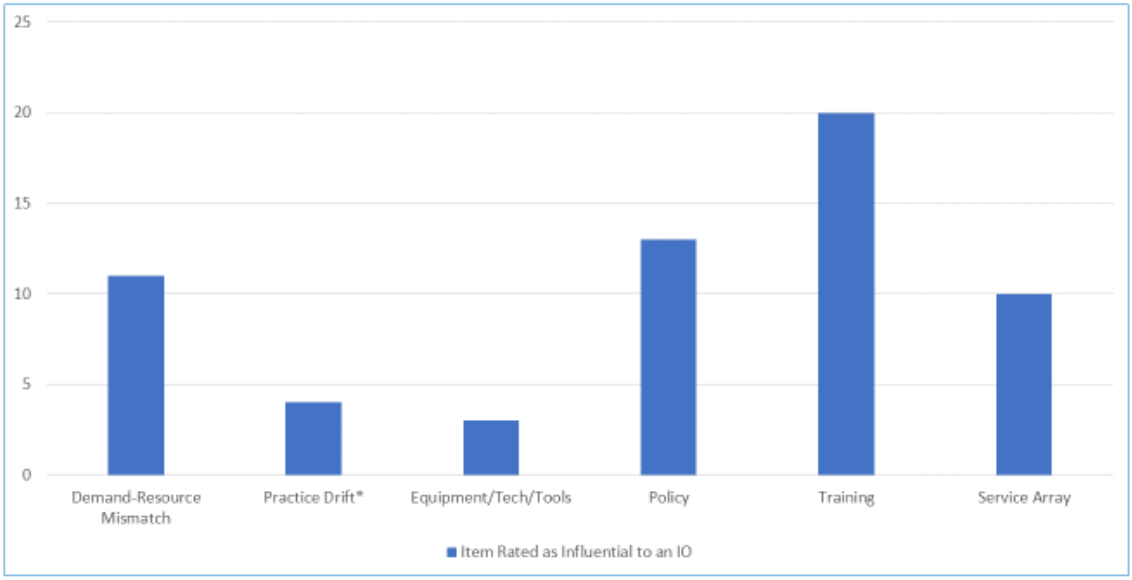
SSIT: Professional Domain



SSIT: Team Domain



SSIT: Environment Domain



*Practice Drift was a new item beginning in 2021

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. In each safe systems analysis, IOs are evaluated for their proximity (i.e., closeness) to the outcome. Proximity is not intended to imply causality or severity of an action or inaction but rather describes how close the IO was in time or distance *and* with relationship to the incident. Of the 50 cases with identified IOs, 27 had at least one IO determined to be proximal, for a total of 41 proximal IOs. Through safe systems analysis the CFPRP has been able to identify themes across the IOs and consider how to tailor improvement efforts based on the influences identified through the SSIT items.

One notable way the CFPRP explores IO themes is through safe systems mapping. The purpose of safe systems mapping is to discuss in a group of experienced professionals their perceptions of what factors influence IOs. In safe systems mapping, these IOs are evaluated at all levels of the system – from the local team level to the legislative/government level. Every participant has an equal voice in the process and all perspectives are valuable to understanding more clearly how the system is operating and what gets in the way of successful work with families. See attachment 12 Systems Mapping Facilitator Tips Sheet and attachment 13 Participant Guide for more information.

In 2021 the CFPRP partnered with the Child Safety Program to map IOs related to assessing safety when parent/caregiver substance use is present. 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 team met several times to complete the mapping activity and brainstorm strategies for system improvement. In total, eight recommendations were presented to Child Welfare Division Executive Leadership for review during the summer of 2021:

1. Restructure and expand Addiction Recovery Team and corresponding contracted services
2. Develop comprehensive casework practice guidelines for cases involving substance use
3. Develop a process for referring reports closed at screening to community-based supports or services
4. Develop statewide staffing guidance for cases involving infants (see attachment 14 for logic model created to provide framework for recommendation)
5. Enhance knowledge and skill through creative education for caseworkers and supervisors
6. Actively promote partnerships with local prevention organizations
7. Identify and support culturally appropriate paid respite, child-care programs, and safety service providers
8. Develop a smart phone application to provide information and guidance to child welfare professionals

All of the recommendations together are instrumental in creating a robust child welfare response to families impacted by substance use disorder and each has a specific role in equipping the child welfare workforce with the tools, skills and resources necessary to support families and children and promote both secondary and tertiary prevention. The recommendations are in various stages of exploration and implementation and a project manager has been assigned to support and track progress and identify intersections with other initiatives. In addition, Child Welfare sought support from the National Center for Substance Abuse in Child Welfare (NCSACW) to identify similar efforts across the country for reference by Oregon. For a detailed overview of the mapping process and the resulting recommendations see attachment 15 for the Safe Systems Map and attachment 16 for the Systems Mapping Overview and Recommendations document.

In the winter of 2022, the CFPRP and Child Safety Program embarked on safe systems mapping once again. This time to explore the factors related to a common IO, insufficient comprehensive CPS safety assessment follow-up. The mapping team was comprised of child welfare professionals from across the state and with various levels of experience and expertise. The group has concluded their mapping sessions and the CFPRP and Child Safety Program are currently finalizing recommendations. It is anticipated these recommendations will be presented to program leadership by June 2022. The final systems map is included as attachment 17.

SSIT results are also used to inform development of improvement efforts related to recommendations stemming from the CIRT. Beginning in 2022, both individual case and aggregate SSIT results will be shared with central office programs when relevant to a specific recommendation. In addition, results may be shared with local district leadership to support planning and improvement at the local level.

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

Advancing a Safety Culture

A safety culture is an organizational culture in which values, attitudes, and behaviors support an engaged workforce and reliable service delivery[3] – in child welfare that looks like a culture in which mistakes are seen as opportunities to learn and child welfare professionals at all levels are engaged in problem-solving without shame or blame. In other words, professionals have a sense of psychological safety and are able to work together to achieve better outcomes.

Early learning through organizational assessments among NPCS jurisdictions reveals child welfare professionals who report feeling psychologically safe also report lower emotional exhaustion, more connection to their colleagues, better teamwork and higher likelihood to remain in the profession. Study of child-level outcomes is showing that teams in these types of environments are in turn able to work effectively to reduce lengths of stay in out of home care, lower rates of repeat maltreatment and facilitate higher level of parent-child interactions. It has been demonstrated in healthcare over time that psychological safety and mindful organizing in teams translate to improved patient outcomes. Early data is suggesting similar positive associations are likely in child welfare.

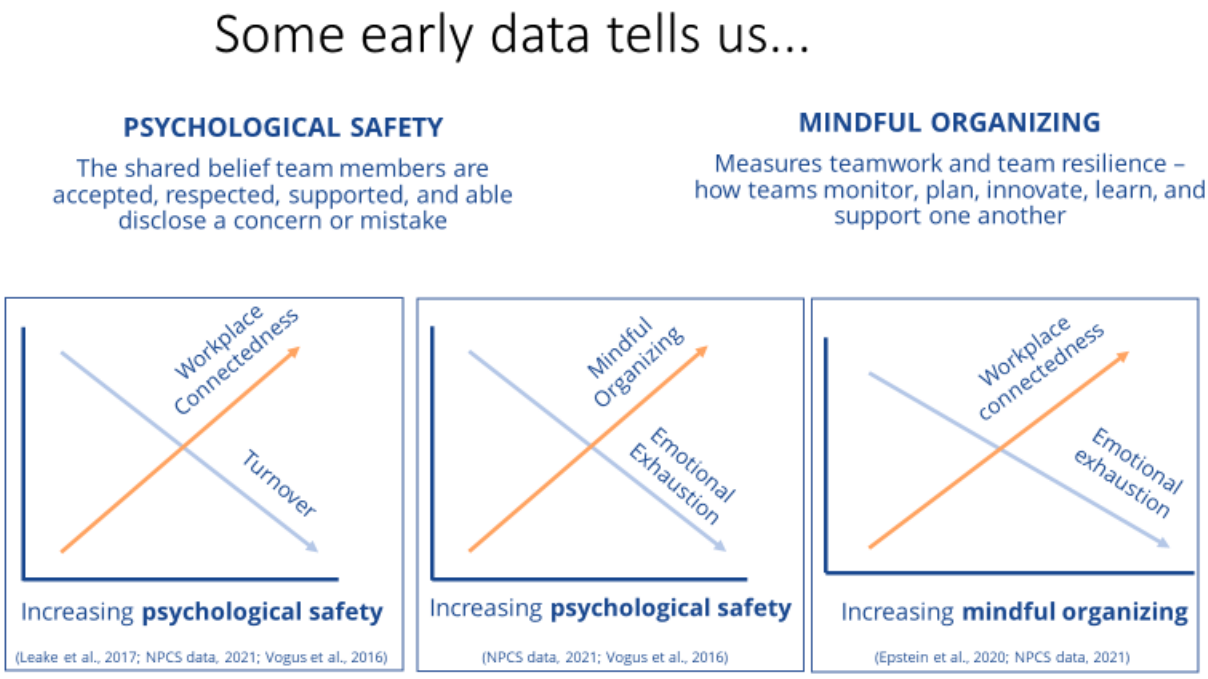


Image provided courtesy of the University of Kentucky Center for Innovation in Population Health

The CFPRP believes a safety culture is central to Child Welfare's transformation efforts. When teams feel connected and supported, they are better able to embrace change and fully engage with families.
The work of the CFPRP to advance a safety culture in child welfare has grown significantly in the past year. In addition to intentional efforts through the CIRT, internal discretionary reviews, and safe systems analysis, CFPRP coordinators have engaged with a variety of groups across Child Welfare to educate and coach leaders around advancing a safety culture in their own teams. CFPRP coordinators also champion safety culture when interacting with external partners as well as internal colleagues while serving on workgroups and committees.

[3] Vogus, Timothy J. and Weick, Karl E. and Sutcliffe, Kathleen M., Doing No Harm: Enabling, Enacting, and Elaborating a Culture of Safety in Health Care (November 1, 2010). Available at SSRN: https://ssrn.com/abstract=1904620 or http://dx.doi.org/10.2139/ssrn.1904620

Activities to build knowledge and skill:

- CFPRP staff participated in numerous NPCS trainings to support knowledge and skills in advancing safety culture. Trainings were offered to other Child Welfare program areas as well to support development of culture carriers. These trainings included: Safety Culture in Critical Incident Reviews, Writing Improvement Opportunities, SSIT: Skilled Practitioner Training, Systems Mapping, Data Aggregation, Debriefing Professionals, and Reframing Childhood Adversity.

- CFPRP CIRT and Safe Systems Coordinators participated in 15 hours of training on the AWAKEN framework (see attachment 4) for building awareness around bias and developing a practice for conscious decision-making. The CFPRP is currently exploring opportunities to bring the training more broadly to child welfare in Oregon.

- The CFPRP Manager and Safe Systems Coordinator, along with the ODHS Human Resources Equity Transformation Manager participated in the 2021 NPCS Innovation and Implementation Learning Community (I2LC) on the intersection of Safety Culture and Just Culture. Over the course of several virtual meetings, the group discussed ways to address bias in decision-making and how to build psychological safety in teams, and reviewed strategies each of the jurisdictions were using to advance race equity and safety culture in their organizations. In 2022, Oregon has assembled a team of professionals from the CFPRP, The Office of Equity, Training and Workforce Development, as well as a CPS caseworker and certification supervisor to participate in the I2LC focused on workplace connectedness.

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

- The CFPFP presented on safety culture to numerous groups over the past year, including: ODHS District Managers, Child Welfare Program Managers, Executive Leadership, Child Safety Program, Permanency Program, Child Welfare Supervisors Cohort, Policy and Rule Committee (PARC), Mentoring Assisting and Promoting Success (MAPS) new employee mentors, Office of Equity and Multicultural Services Equi-Tea Panel, and Child Welfare Leaders Institute Panel.

- CFPRP Safe Systems Coordinators have been invited to meet with leadership teams across 6 districts to share about safety culture. Conversations have continued in three districts with ongoing coaching and support provided to the teams utilizing interactive visual platforms to work through challenging topics together. The focus of these sessions has been on building psychological safety and promoting strategies for effective teaming, using the TeamFirst Field guide (see attachment 18)

- CFPRP Safe Systems Coordinators also engaged in a number of one-on-one meetings to provide an overview of safety culture and gather insight into better ways to support the workforce.

- CFPRP Safe Systems Coordinators participate in a wide variety of teams, workgroups, and committees, with the expectation to bring a safety culture lens to the work and cultivate culture carriers. These include but are not limited to: Worker Safety workgroup, Joint Response workgroup, Women's Equity Leadership Development (WELD) Employee Resource Group, Employee Resource Group Mentoring Program, Child Welfare Race and Equity Leadership Team, Well-being workgroup, Family First Implementation Team, Family First Policy and Practice workgroup, and Leaders Institute Planning Committee.

- Finally, the CFPRP recently launched an internal webpage for child welfare staff to gather knowledge and resources related to various aspects of the CFPRP's work, including safety culture.

Workforce Supports

Fatality/Near Fatality Procedure

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

Fatality/Near Fatality Toolkit

While child welfare professionals responding to near fatalities and fatalities have demonstrated a strong commitment to assessing the safety of the home while also providing empathetic and compassionate care to the grieving family and community, they have also expressed a desire to acquire more skills in assessing child safety in a trauma-informed way after a critical incident. In conjunction with the procedural guidance developed, the CFPRP has initiated the development of a trauma-sensitive toolkit for workers to use when responding to assess safety after a near fatal or fatal incident in a home. The workgroup continues to meet regularly to develop the toolkit, which includes several sections designed to support child welfare professionals' provision of trauma-sensitive care in an easily accessible and practical format. Contents of the toolkit in its current draft include definitions and clarity of trauma-sensitive care, culturally responsive engagement with families, sample branch workflows to ensure trauma-informed management of staff and case activities, multiple domains of trauma-sensitive question and engagement prompts to support staff in speaking with grieving families, regional, local, and statewide resources for grief and loss support, trauma-sensitive initial outreach/contact prompts and suggestions, and care/well-being resources and strategies for staff and leadership involved in assessing critical injuries.

Staff Support for Critical Incident Stress Management

Four CFPRP team members have been certified to administer Critical Incident Stress Management (CISM). CISM is an adaptive, short-term psychological helping-process that focuses on the immediate and identifiable stressor. Its purpose is to enable people to return to their daily routine more quickly and with less likelihood of experiencing post-traumatic stress disorder. CISM sessions for staff are available on a regularly scheduled basis as well as upon request and/or immediately after a critical incident.

State Child Fatality Review Team

The State Child Fatality Review Team (state team) is mandated by Oregon Revised Statute 418.748 and is co-chaired by ODHS and OHA. The ODHS co-chair is filled by a CFPRP member creating opportunity for communication and collaboration across the CIRT, the state team, and the 36-county child fatality review teams.

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

The mission, purpose, objectives, and guiding principles of the state team closely aligns with and supports the work of the CFPRP. See attachment 19 for State Child Fatality Review Team Charter Draft.

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

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

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

Objectives:

- Support accurate identification and uniform reporting of the cause and manner of child fatalities.
- Promote cooperation, collaboration, and communication across the child and family serving system and enhance coordination of efforts.
- Quality, equitable investigation of child fatalities consistent with national standards.
- Design and implement cooperative, standardized protocols for the review of child fatalities.
- Ensure accurate, complete, and timely data entry in the National fatality Review - Case Reporting System.

A CFPRP member in the role of co-chair to the state team took the lead in implementing a county child fatality review team needs assessment in the summer of 2021 and developing a plan in response to the information gathered. Implementation of this plan supports improved child fatality data gathering and prevention efforts. See attachment 20 for Child Fatality Review Resource and System Improvement Plan.

Prevention Strategies

Suicide Prevention

In 2017, the Critical Incident Review Team (CIRT) saw an increase in reports of children dying by suicide and a comparison of state fatality data and child welfare records of suicides for the fiscal year 2017 confirmed almost half of the children who died by suicide had some previous history with child welfare. According to the recently published Youth Suicide Intervention and Prevention Plan Annual Report (see attachment 21) Oregon had success in the reduction of suicide deaths for youth. The number and rate of suicides for youth aged 24 and younger decreased in 2020 by nearly 14%, from 118 deaths in 2019 to 102 deaths in 2020. The decrease placed Oregon 18th highest in the nation – an improvement from 2019 and 2018, when Oregon ranked 11th highest in the nation for youth suicides.

While the success in decreasing suicide rates for Oregon youth is notable, the CIRT continues to recognize the risks that bring families to the attention of Child Welfare are often the same as those that increase the risk of suicidality. Continued efforts to enhance suicide prevention and intervention knowledge and practice among child welfare professionals remain within the CFPRP.

In July 2021 the CFPRP hired a dedicated .5FTE Suicide Prevention Coordinator who is also dedicated to .5FTE CIRT coordination. The Suicide Prevention Coordinator has been able to further the work initiated previously by the CFPRP in addition to engaging in new endeavors to promote suicide prevention and intervention to Oregon youth. One of these efforts has included continuation of the 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 among families receiving services from Child Welfare. In response to the evident need for suicide prevention training and in collaboration 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 which allowed child welfare professionals to be trained virtually during the height of the COVID-19 pandemic. The Department was awarded the Garret Lee Smith Grant in December 2019 and the grant has been used to fund QPR training efforts, along with additional suicide prevention trainings.

To date, the Department has utilized the Garrett Lee Smith Grant funds to support the training of approximately 8000 ODHS staff in QPR, including over 800 Child Welfare in an enhanced Child Welfare specific QPR Gatekeeper training. Currently Resource Parents have access to a specially designed virtual Question, Persuade, Refer (QPR) offered and administered by ODHS. Information regarding these Resource Parent QPR sessions, offered regularly throughout the year, as well as general public QPR sessions offered frequently through community partners, is available on the ODHS Resource Parent community information web page. Additionally, newly hired child welfare staff are required to engage in QPR Gatekeeper training within 90 days of hire. This enhanced 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 computer-based training is being led by internal Department facilitators (two per session) who provide instruction, resolve technical difficulties, and guide a question-and-answer session at the end of the training. All facilitators are required to attend an hour-long pre-training Facilitator's Guide Session. This prepares them to facilitate the training, 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 facilitated training provides specific practice instructions regarding child welfare case planning when a child or any family member expresses suicidal ideation. Current survey results demonstrate a significant increase in suicide prevention knowledge and skill upon completion of the QPR training (ODHS and Child Welfare QPR Final Data Report Attached in Appendix). 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. The CFPRP is also in the process of developing a post follow-up survey that will go out to participants six months after their training. See attachment 16 for QPR Pre and Post Survey Data Report.

The Suicide Prevention Coordinator is also engaged in the continued evaluation of trends for children who die by suicide that are known to Child Welfare. National and state data supports the increased risks for children who:

- Are LGBTQIA2S+
- Are members of traditionally marginalized communities such as Native American, Black, Latinx, Asian or Pacific Islander
- 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

As a result of feedback from the community as well as information obtained regarding trends in suicide prevention for traditionally marginalized populations, the CFPRP has partnered with the Oregon Child Abuse Hotline (ORCAH) to begin development of a specialized training for ORCAH screening professionals to support their knowledge and awareness of suicide impact/risk factors as they evaluate child abuse reports and make screening decisions. The anticipated implementation date of this training is late 2022.

The CFPRP Suicide Prevention Coordinator also engages in the following prevention and intervention efforts:

- Engagement and participation in statewide and regional suicide prevention coalition meetings and efforts.
- Postvention collaboration with Oregon Community Mental Health Program (CMHP) Postvention resources for communities and ODHS Child Welfare Delivery branches who experience a youth suicide.
- Creation of a Child Welfare specific Youth SAVE Suicide Risk, Assessment, and Safety Planning training in collaboration with the Oregon Pediatric Society. The goal is to implement an enhanced suicide risk assessment and safety planning training program to be provided to child welfare professionals who would benefit from additional knowledge and skills beyond QPR; this training would include preparing a minimum of two qualified Youth SAVE trainers to serve as ongoing subject matter experts in each ODHS district; these identified trainers will also participate in a quarterly learning collaborative with other Youth SAVE programs, and have access to Oregon Health Sciences University Youth SAVE ECHO program.
- Collaboration with and support for child welfare professionals engaged with Temporary Lodging and Resource Management to support complex needs youth transitioning between levels of behavioral health care and placement, including support for brief, non-clinical safety planning until longer term clinical interventions can be established.
- Membership and participation in the Oregon State Child Fatality Review Team.
- Continued participation in awareness and educational opportunities statewide. In 2021 participated as a Presenter in the Annual Oregon Suicide Prevention Summit, the Statewide Youth

Suicide Prevention workgroup, the Oregon ICWA Advisory Council, and the Clackamas County Multi-Disciplinary Team. Content of the presentations included ODHS Child Welfare Division suicide prevention initiatives as well as trauma aware casework practices.

- Participation and engagement in multiple learning opportunities related to suicide prevention and intervention, including but not limited to; School Based Suicide Prevention (National Institute of Mental Health), Reflecting on Postvention Series #1, #2, #3 (Jackson County Suicide Prevention Coalition), Parenting Under the Influence (NAADC), Creating Suicide-Safer Pathways to Care (Zero Suicide Institute), and the BIPOC Caucus (UPRISE).
- Participation as an Advisory Board Council Member for the Oregon Social Learning Center to support suicide intervention research and practice statewide.

Responding to Neglect and Promoting Protective Factors

Just as a vehicle can bear only so much weight before it stops moving forward, challenging life circumstances can overload or overburden parents, making it harder for them to provide the best kinds of care and support. To prevent a breakdown in care, we can focus services and resources that can help lighten the load on families. Promoting responsive relationships, bolstering protective factors, and connecting families with supportive resources sooner is essential to preventing maltreatment and maltreatment related fatalities. Neglect can be difficult to understand and impact as it is influenced by factors at all levels of the social ecology (see attachment 23 for Neglect and Socioecological Model infographic). Taking an approach rooted in community care and connection can help build collective responsibility for children and promote safety and well-being for families. The CFPRP has a unique role in supporting prevention and the work described throughout this plan is reflective of the ways the program works to promote primary, secondary, and tertiary efforts. In this section, we will discuss efforts to enhance child welfare professionals' ability to understand and respond to neglect and promote protective factors[4] for families.

Training

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. Additionally, a modified version of the 90-minute training has been developed specifically for the ORCAH Screening 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 (see attachment 24 for executive summary of the training). This two-day advanced training was offered four times in 2021. Over 200 Supervisors, MAPS and Active Efforts Specialists have participated in the training to date. Evaluations from the 2021 sessions reflected a positive learning experience for participants (see attachment 25 for training evaluation report).

Over the next year, the CFPRP will be partnering with the Child Safety and Permanency Programs once again to coordinate and deliver virtual sessions of the training. This next phase will be open to caseworkers with over one year of service and priority registration will be given to local office staff in the Family Preservation[5] demonstration sites.

[4] https://www.childwelfare.gov/topics/preventing/promoting/protectfactors

[5] View more information on Family Preservation here: https://youtu.be/Pnu09fsVWBE

The CFPRP is also partnering with the Confederated Tribes of Grand Ronde's Children and Family Services Program to adapt the two-day training for both their internal staff and external prevention and intervention service providers. The goal is to deliver the training onsite in 2022 or in conjunction with training offered to Family Preservation demonstration sites.

In addition to classroom training, the CFPRP is continuously exploring avenues to enhance the knowledge and skills of child welfare professionals in responding to the needs of families and preventing future maltreatment. While the establishment of learning cohorts following the 2021 sessions of training did not come to fruition, the CFPRP partnered with the Child Safety Program to develop Child Abuse Prevention Month information and activities, including weekly virtual prevention huddles open to all staff during April 2022. Virtual huddles create a novel opportunity for bite-size learning and cross program networking. The CFPR and Child Safety Programs will continue to work together along with other ODHS programs to provide support and information to child welfare professionals in this format throughout the rest of 2022. Additionally, a prevention page has been added to the CFPRP internal website where child welfare professionals can go to revisit Child Abuse Prevention Month resources (see attachment 26 for documents created for Child Abuse Prevention Month) as well as information about the prevention efforts described in this report. The CFPRP believes a knowledgeable workforce with the skills and resources to do their jobs is a workforce that can have significant positive impacts on the families they encounter.

Infant Safe Sleep

In 2021, of the 26 child fatalities reviewed by the CIRT, 11 were infants. Eight 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. See attachment 27 for a logic model developed by the CFPRP to help inform, coordinate, and evaluate efforts pertaining to sleep related infant death prevention.

Education and Training

As a critical part of the child safety community, Child Welfare professionals have a role in supporting families to reduce risk of sleep related death through education and engaging families in conversations about their 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 and other family serving professionals were released in 2021. 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. 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

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

violence shelter professionals; Office of Child Care, 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. See attachment 28 for the latest self-study released for Oregon Family Serving Professionals. Other versions are available upon request by emailing CW.Prevention@dhsoha.state.or.us. Each self-study includes a knowledge check and opportunity to provide feedback which has been overwhelmingly positive from all audiences (see attachment 29 for summary of survey results).

SAFE SLEEP TOY DISPLAY

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

Partnership and Engagement

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

Raise Up Oregon: A Statewide Early Learning System Plan (see attachment 30) 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. Participants from this workgroup met from September 2020 – February 2021 to develop the recommendations which were presented to the Raise Up Oregon Agency Implementation Coordinating Team. The workgroup recommended the development of a statewide coordinated effort to improve infant safe sleep practices, decrease sleep-related infant deaths, and reduce relative disparities in sleep-related deaths between white and black and American Indian/Alaskan Native infants.

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. Upon completing the recommendations report, the workgroup elected to continue meeting on a quarterly basis and continue to explore ways to reduce sleep related infant death in Oregon.

During National SIDS Awareness Month 2021 the CFPRP in coordination with the ODHS communication team, underwent an effort to educate and engage parents and providers via social media using the toolkit provided by the National Institute of Health (NIH).

To facilitate feedback from providers and parents, the CFPRP is coordinating a safe sleep pilot within the Nurture Oregon, Plan of Care Pilot. 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 portable crib, wearable blanket and some written educational materials.

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 portable cribs to local Child Welfare offices. These can be shared with other ODHS programs and Tribes when needed. Safe sleep items 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.

Supporting Infants Exposed to Prenatal Substance Use and Their Families

Substance use is present in the family system at a high rate in cases involving a child fatality. In the calendar years 2020 and 2021, a total of 60 Critical Incident Review Teams (CIRTs) were assigned by the ODHS Director. All 60 CIRTs involved the review of a critical incident that resulted in a child fatality and 30 CIRTs involved infants. In other words, 50% of the CIRTS within 2020 and 2021 involved the review of an infant fatality. Furthermore, 23 of those 30 infants were known to child welfare through an open assessment at the time of the critical incident, a prior closed at screening and/or a prior child protective services assessment. Of those 23 infants, 11 had familial substance use concerns identified in the Oregon child welfare case record. With this data 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 hired in April of 2021 to continue efforts to develop, implement and monitor plans of care, and further advance efforts related to infant safe sleep in cases requiring a plan of care. The CARA coordinators will continue to collaborate with OHA in efforts to move all aspects of implementation forward.

Statewide Implementation

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

Child Welfare is hoping to leverage opportunities to mitigate barriers facing marginalized populations in Oregon who may need help gaining access to services or paying for services. Offering support earlier aligns with Child Welfare's Vision for Transformation in that it honors the self determination of families, by allowing people to identify and access what they need without being mandated to participate in interventions that undermine their autonomy. When more opportunities exist for Child Welfare to participate in self-directed development and assistance, more opportunities will exist to engage community without furthering trauma and fear. The following data gathered from critical incident reviews also highlights the need to remove system barriers that prevent families from accessing primary prevention supports in their community. See attachment 31 for logic model related to efforts pertaining to CARA implementation.

Child Welfare Policy and Practice

Within Child Welfare, continued education, support, training, and mutual learning through feedback has occurred with CPS and permanency consultants and Child Welfare professionals in the local office level (screeners, caseworkers, MAPS, addiction and recovery teams, supervisors, management). See below for example of specific workforce support and development efforts pertaining to CARA and Plans of Care:

- CARA Coordinators developed and delivered trainings to child welfare professionals across the state to reinforce Child Welfare's responsibilities with the development of Plans of Care. In addition, local child welfare offices were allotted funding to support the concrete needs of child welfare involved families with a Plan of Care in place. The process to utilize the funding was also shared during these presentations.
- To offer ongoing support a CARA specific Microsoft Teams channel was created for child welfare professionals statewide to give real time access to CARA specific information and ask questions as they arise.
- Facilitated by the CARA Coordinators, CARA virtual office hours have been offered twice a month since the funding was released to offer dedicated time to discuss any CARA/Plan of Care related questions.
- Child Welfare is developing staffing guidelines for cases involving infants and substance use that emphasizes developing Plans of Care and referrals to community-based services and recovery supports. Since Substance Use Disorder is not the only complicating factor associated with infant fatalities, the staffing guidelines will highlight other factors including safe sleep and responsive relationships.

- Work is underway to enhance Child Welfare procedure and practice when a report is closed at screening on an open CPS assessment to ensure timely communication occurs between ORCAH and CPS caseworkers and supervisors. Additional procedure is being developed for CPS assessments where multiple reports are received in a short period of time involving infants age 0-12 months, whether they are assigned or closed at screening. The procedure will require direct contact between an ORCAH supervisor and a CPS supervisor to communicate information contained in the report(s) and ensure appropriate screening and CPS assessment decisions are made.
- Child welfare professionals have received additional practice guidance promoting the development of prenatal Plans of Care for cases involving pregnant individuals using substances including Expectant and Parenting Youth in foster care and pregnant people associated with cases open for ongoing services or CPS assessment.
- Several family serving systems in Oregon conduct strengths and needs assessments and develop plans that incorporate content that is also included in a Plan of Care. CARA coordinators are guiding Child Welfare professionals developing Plans of Care to collaborate with other family serving professionals like family coaches and nurse home visitors to identify the underlying strengths and challenges families may be experiencing.

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 has partnered with the Oregon Health Authority to implement a 'Plan of Care pilot' in five Oregon counties as part of the Nurture Oregon demonstration project. Nurture Oregon is a rural integrated care model providing pregnant people who use substances with peer recovery support services, prenatal and postpartum care, substance use and mental health treatment, and service coordination. Care is delivered in a culturally sensitive, non-judgmental, strengths based and trauma-informed manner. The 'plan of care pilot' will gather data on what works and what does not work for pregnant and parenting people, as well as the different members of the care team, including Child Welfare professionals. Identification of Plan of Care quality practices will inform statewide education, support for notification by healthcare providers, and all aspects of plan development and monitoring. With the additional data gathered from the pilot, additional Child Welfare policy and practice changes are expected.

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

Other Prevention Efforts

Child Maltreatment Prevention Collaborative

CFPRP initiated a collaborative partnership with OHA, Public Health, to address primary, secondary, and tertiary child maltreatment prevention. As a result, CFPRP representing Child Welfare and OHA, Public Health, are drafting a memorandum of understanding supporting this collaboration. The two agencies have a significant amount of cross over in work efforts, individuals served, and the values driving how the work is done. See attachment 32 for Child Maltreatment Prevention Collaboration Visual.

The draft purpose is to:

- Develop and implement initiatives that prevent child maltreatment and support families
- Increase coordination/collaboration between these agencies

- Provide methods for communication and information exchange
- Formalize the responsibilities of each agency
- Hold agencies accountable for their roles and responsibilities
- Ensure policy continuity over time; and
- Meet legislative and regulatory requirements.

The draft objectives which are grouped into categories include:

Programmatic, Policy, and Relationship Building

- To prevent duplication, overlap, and/or fragmentation of effort and/or services.
- To promote long-range planning.
- Information coordination.
- To strengthen relationships with multi-cultural and multi-ethnic, and culturally responsive organizations.
- To collaborate on policy and systems initiatives for the shared population.
- Collaborate to ensure service and resource provision is equitable, family centered, and trauma informed.
- To ensure that services and resources are effective and based on evidence, where applicable to children and young adults and their families.
- To promote that children, young adults and their families' receiving services and resources that are culturally and linguistically appropriate.

Assessment, evaluation, surveillance, and data sharing

- To establish a systematic process for the timely sharing of programmatic data.
- To allow joint access to critical public and behavioral health data.
- To cooperate in creating linked, de-identified data files that will be used for public health and health care research, program evaluation, and surveillance.
- To collaborate on statewide needs assessment, evaluation, and surveillance to support the health of the shared populations we serve.

Identification and Outreach

- To coordinate identification of children, young adults and their families who are potentially eligible for services.
- To provide outreach and increase public awareness of prevention efforts.

Reimbursement and Financial

- To specify the reimbursement and financial arrangements applicable.
- To facilitate the claim for Federal matching funds for the efficient and effective administration of the State Plan.
- To ensure the maximum utilization of federal and state resources as it relates to children, young adults, and their families.
- To participate and align with initiatives serving this population when it furthers these objectives to leverage resources and achieve better outcomes.

Prevention Kits

The CFPRP is purchasing prevention kits from Oregon Health Sciences University, Tom Sargent Safety Center to prevent child fatalities and serious injuries by improving home environment safety. These kits will be shipped to Child Welfare local offices to provide families with items that improve household safety by reducing risk. Examples of items include, window locks, firearm locks, and medication storage items. The CFPRP is in the process of aligning contracts and purchasing agreements to be able to provide prevention kits during late 2022.

Community Needs Assessment – Social Determinants of Health

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

Enhanced Early Learning Partnership

Collaboration with the Early Learning council (ELC) to support the development and implementation of strategies that increase access to culturally responsive, targeted supports; promote wellbeing; and prevent child welfare involvement. Initial conversations with the ELC have focused on Early Intervention referrals made by Child Welfare on behalf of children aged 0-3. The reality is many children in Oregon who are identified with developmental delays at screening never receive services and due to limited funding and only 34% of infants and toddlers who are identified and enrolled in Early Intervention receive the recommended level of services[7]. Child Welfare and ELC have already identified opportunities to enhance communication and engagement with families navigating the Early Intervention referral and evaluation process. Child Welfare is eager to partner with the ELC to support the strategies identified in *Raise Up Oregon: A Statewide Early Learning System Plan* (see attachment 30) that align with the Comprehensive Addiction and Recovery Act.

Building Partnerships and Learning from Tribal Nations

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

- Developing the Safe Sleep Self Study for Oregon's Family Serving Professionals. Feedback was sought and received from the Native American Rehabilitation Association of the Northwest, Inc. and Tribal Affairs to include Native American/ Alaska Native and First Nations traditional sleep practices. Once completed, the release of the materials was messaged directly to Oregon Tribal Nations to ensure access and awareness.
- CFPRP was honored to present at ICWA Advisory on Plans of Care, collaboratively developed plans for infants exposed to substances during pregnancy and their families and focused on keeping infants

[7] http://records.sos.state.or.us/ORSOSWebDrawer/Recordhtml/7359912

safely with their families, eliminating or reducing Child Welfare involvement, mitigating the impact of substance use and supporting parents diagnosed with substance use disorder with their recovery.

- Received expert consultation and guidance from Tribal Affairs about reducing traumatic impact at the profound and significant time of the death of a child. Incorporated guidance into the Fatality Protocol revisions and plan future partnerships to draft procedures on the topic.
- CFPRP is partnering with the Confederated Tribes of Grand Ronde's child welfare program to adapt a two-day Assessing Neglect training for both their internal staff and external prevention and intervention service providers. The goal is to deliver the training onsite in the first quarter of 2022. CFPRP believes this effort will lay the groundwork for other trainings to roll out in partnership with Oregon Tribal Nations.
- CFPRP has trained Regional ICWA Case Specialists on Question, Persuade, Refer, an evidence-based suicide prevention training.
- CFPRP in partnership with Tribal Affairs and ORCAH are developing a process to engage Tribal Affairs, Child Welfare Regional ICWA Case Specialists, and Oregon Tribal Nations early when a child dies, and the child's family has identified having Native American heritage. This early consultation will offer guidance to ensure Child Welfare professionals gather information about the family, community, and tribal cultural practices surrounding a child's death and use the information gathered to inform communication and engage.
- CFPRP continues to seek the expert insight of Tribal Affairs in the Critical Incident Review Process. Our commitment to Oregon Tribal Nations having voice in the work of CFPRP will remain central to our efforts. With humility, we look forward to continuing to develop relationships and doing better each year.

Collaboration

An important part of the Child Fatality Prevention and Review Program (CFPRP) mission and integral to ensuring community voice in all of the work is collaboration. Some of the collaborative efforts are detailed below and demonstrate how the work is aligned with the ODHS Child Welfare Division's Vision for Transformation[8] (see attachment 33 or visit link in footnotes), including supporting families and promoting prevention, enhancing our staff and infrastructure, and enhancing the structure of our system by using data with continuous quality improvement. For more information on how the work of the CFPRP aligns with the Vision (see attachment 34).

- The CFPRP partners with the Oregon Alliance to Prevent Suicide and other Regional Suicide Prevention Coalitions to increase networking and information sharing with statewide Suicide Prevention collaborators in the fields of education, behavioral health, civic engagement, and human services.
- The CFPRP Suicide Prevention Coordinator, in collaboration with ODHS Shared Services Trauma Aware and Portland State University, presented on ODHS suicide prevention initiatives and outcomes at the Annual Oregon Suicide Prevention Conference in October 2021.

[8] https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/de2445.pdf

- The CFPRP, as part of the CIRT process, leads the creation and oversees the implementation of system and practice recommendations developed in response to child fatalities through collaboration with numerous and varied system partners.
- Through the National Partnership for Child Safety (NPCS), the CFPRP collaborates with 26 state, county and tribal child and family serving agencies and technical assistance advisors in support of safety science implementation.
- The CFPRP collaborates with the interdisciplinary State Child Fatality Review Team and the 36 multidisciplinary county child fatality review teams to enhance Oregon's death review system, death review data collection, and resulting prevention efforts.
- The CFPRP initiates and engages in extensive collaboration statewide with child and family serving professionals and organizations and those they serve in efforts to support infant safe sleep practices.
- The CFPRP is actively collaborating with individuals, professionals, and organizations impacted by or essential to implementing the Comprehensive Addiction and Recovery Act and specifically Plans of Care with the objectives of increasing engagement, maintaining infants safely with their families, eliminating or reducing Child Welfare involvement, mitigating the impact of substance use, and supporting parents diagnosed with substance use disorder with their recovery.
- The CFPRP has active engagement and collaboration with numerous ODHS and OHA programs including: Tribal Affairs, Office of Program Integrity, Office of Equity and Multicultural Services, Self-Sufficiency Program, Communications, Office of Training, Investigations and Safety, Developmental Disabilities Services, and Oregon Health Authority Public Health System efforts including Behavioral Health, Zero Suicide, Youth Suicide Prevention Intervention & Postvention Program, Oregon WIC, Injury and Violence Prevention Program, Maternal and Child Health, Youth and Runaway Program, Addiction Services Program, Youth and Young Adult Substance Use Collaborative, and the Center for Prevention and Health Promotion.
- The CFPRP has active engagement and collaboration with external partners to develop data-informed and innovative strategies for prevention including ODHS and Oregon Health Authority collaborations include the following: Community Health Nurses, Oregon Tribal Nations, Oregon Judicial Department, Oregon Department of Justice, local law enforcement agencies, Oregon Association of Chiefs of Police, District Attorneys, Oregon State Child Fatality Review Team, Oregon Child Abuse Solutions, Oregon Parenting Education Collaborative parent coordinators and trainers, health care professionals, Relief Nurseries, Birthing Hospitals, Jackson Care Connect, Home Visiting Programs, Child and Family Futures, Oregon Perinatal Collaborative, Overdose Response Strategy, Doulas, Traditional Health Workers, Peer Support Specialists, Certified Recovery Mentors, Raise Up Oregon, Child Advocacy Centers, Designated Medical Professionals, Substance Use Disorder treatment professionals, YouthSAVE, YouthLine/Lines for Life, County Suicide Prevention Coalitions, Oregon Liquor and Cannabis Commission, Oregon Pediatric Society, Oregon Alliance to Prevent Suicide, Oregon Social Learning Center, Portland State University, Trauma Aware Oregon, Hospital Social Workers, National Center for Substance Abuse in Child Welfare, Early Intervention, Oregon Health Sciences University Safety Center, QPR Institute, Affinità Consulting, NPCS Innovation and Implementation Learning Community, NPCS Peer-to-Peer Leaders , Casey Family Programs, and the University of Kentucky Center for Innovation in Population Health.

Acknowledgement

To Child Fatality Prevention & Review Team members:

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

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

Child Fatality Prevention and Review Program Manager

The National Partnership for Child Safety charter

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.

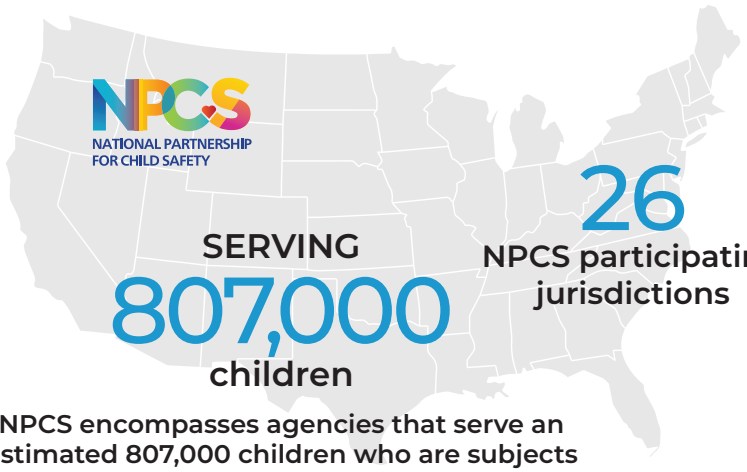
Additional information regarding data sharing, data analytics, evaluation and research will be outlined in Appendix 2.1 Data Sharing.

The Oregon Department of Human Services Child Welfare Division is a partner of

NPCS
NATIONAL PARTNERSHIP FOR CHILD SAFETY

The National Partnership for Child Safety (NPCS) is a quality improvement collaborative to improve child safety and reduce child maltreatment fatalities through the application of safety science and shared data.

Supported by Casey Family Programs, the National Partnership for Child Safety was formed to further key recommendations and findings of the federal Commission to Eliminate Child Abuse and Neglect Fatalities, which highlights the importance and impact of safety science and data sharing to system change and reform.



NPCS encompasses agencies that serve an estimated 807,000 children who are subjects of an of an investigation by child protection services each year across the country.

As a National Partnership for Child Safety member, the Oregon Department of Human Services Child Welfare Division is working in collaboration to:

- **Support a shift to a more PROACTIVE AND PREVENTATIVE approach to child welfare**
- **Promote COLLECTIVE RESPONSIBILITY and strengthen system and individual accountability**
- **SHARE AND USE DATA to identify and protect children at risk of maltreatment or fatality**
- **APPLY THE PRINCIPLES OF SAFETY SCIENCE to child welfare systems**

Oregon Department of Human Services
CHILD WELFARE

The partnership is supported by Casey Family Programs and the Center for Innovation in Population Health at the University of Kentucky. The National Center for Fatality Review and Prevention at MPHI serves as the data warehouse.

NPCS NATIONAL PARTNERSHIP FOR CHILD SAFETY

casey family programs

Center for Innovation in Population Health

NATIONAL CFRP Saving Lives Together

NATIONAL PARTNERSHIP FOR CHILD SAFETY FREQUENTLY ASKED QUESTIONS

Q: What is the National Partnership for Child Safety?

A: The National Partnership for Child Safety (NPCS) is a quality improvement collaborative whose aim is to improve child safety and reduce child maltreatment fatalities through the application of safety science and shared data. Members of the collaborative, which currently number 26 jurisdictions including state, county and tribal child and family serving agencies, have a shared goal of strengthening families, promoting innovations and a public health response to reducing and prevention child maltreatment and fatalities.

Q: What is a public health response and how is the NPCS applying it to child welfare?

A: By integrating a broad spectrum of partners and systems, the NPCS aims to identify, test, and evaluate strategies to provide upstream, preventative, and earlier intervention supports and services that can strengthen the building blocks of healthy families. It represents a system that is focused less on a child protection response to abuse and neglect and more on building the wellbeing of all children and families.

Q: What is safety science and how is it applied to child welfare?

A: Safety science provides a framework and processes for child protection agencies to understand the inherently complex nature of the work and the factors that influence decision-making. It also provides a safe and supportive environment for professionals to process, share and learn from critical incidents to prevent additional tragedies. Health care, aviation and other safety critical fields have all demonstrated approaches that prevent harm and reduce risks, and can serve as a model for national quality improvement efforts focused on child welfare.

Q: How is shared data used by the NPCS?

A: One of the key activities of the NPCS will be the collection, sharing and analysis of data across jurisdictions, including retrospective reviews to identify children most at risk of fatality. Data sharing agreements between jurisdictions will enable analysis across multiple states and counties, thus informing strategies and implementation plans to address children and families at risk and reduce maltreatment and fatalities.

Q: How is the NPCS funded and supported?

A: The NPCS is supported by Casey Family Programs and a technical assistance team that includes the University of Kentucky and Michigan Public Health Institute (MPHI).

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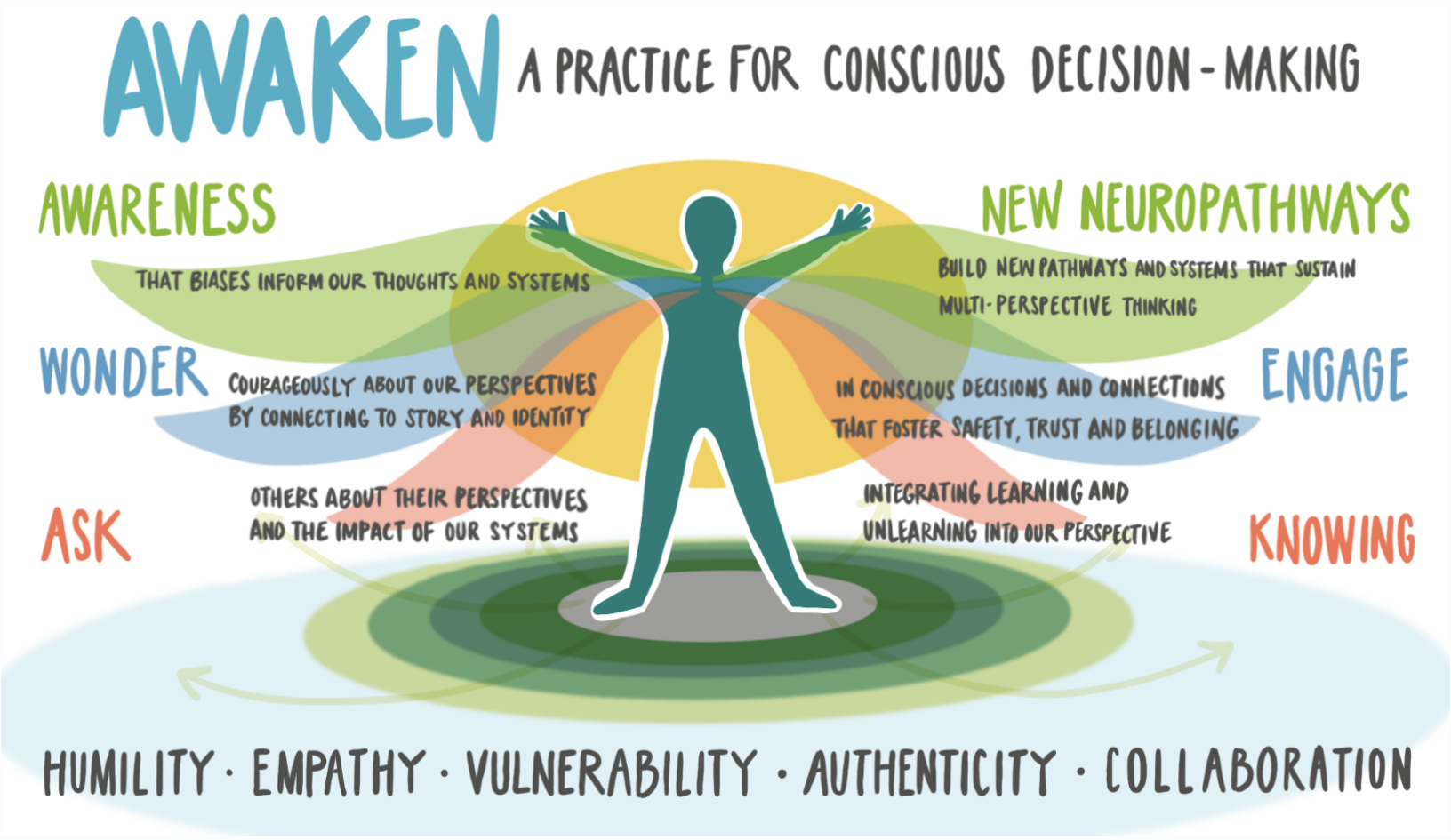

AWAKEN is a value-based framework providing actionable steps that take us from automatic, bias-based thinking to intentional decisions and behaviors. It identifies when bias is activated and provides teams with mindful organizing strategies to co-conspire against biases in ourselves and our systems.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

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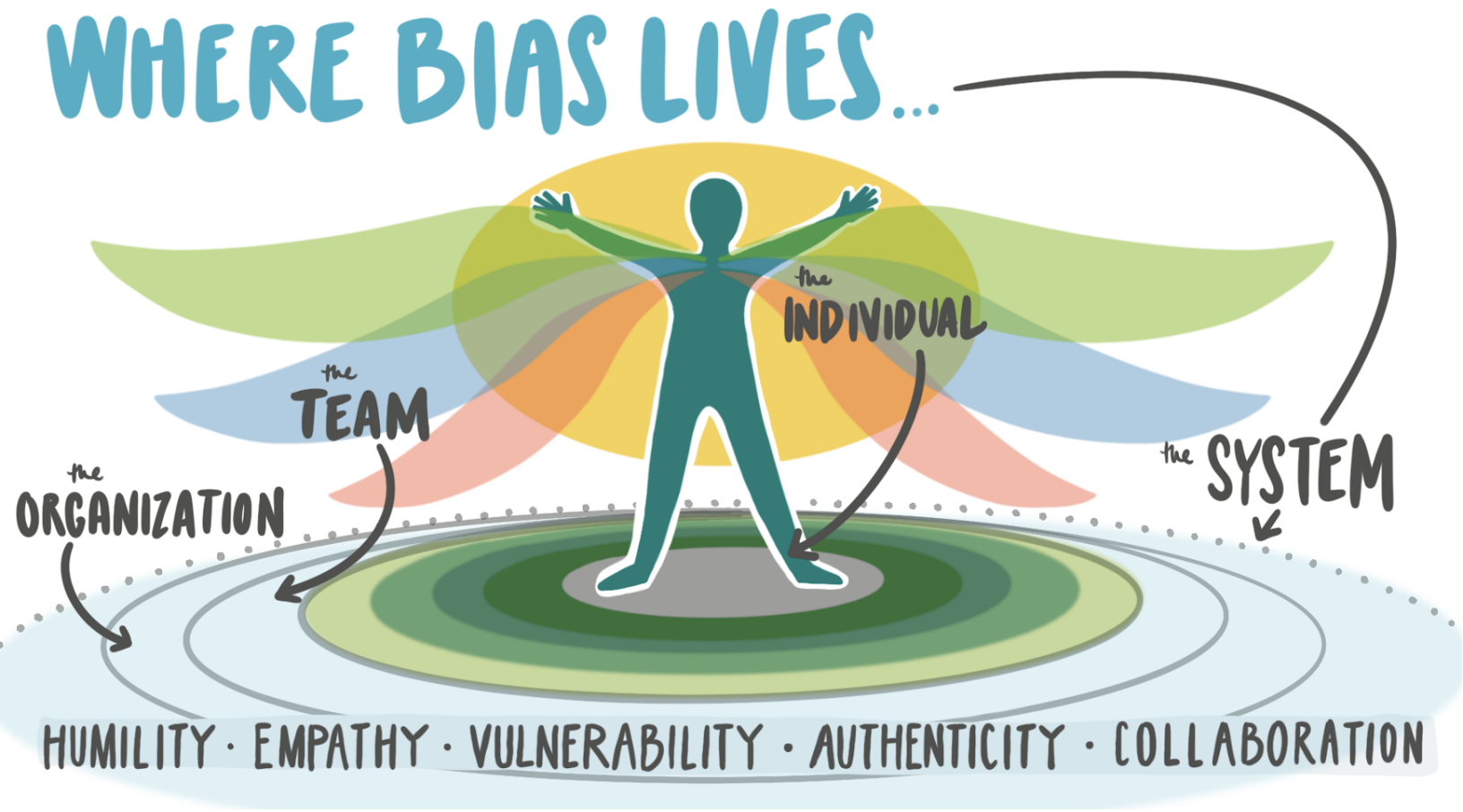

Bias and Safety Culture

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

Mindful Organizing

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

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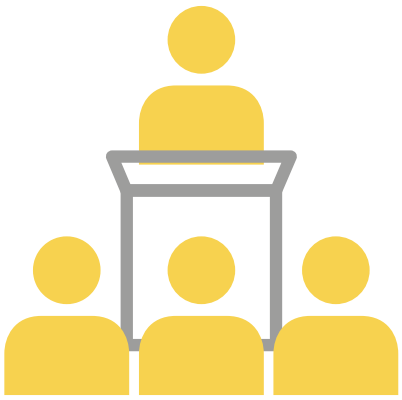
Target Audience

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



Demand

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

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

Innovation

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

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

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Competency

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

Learning Objectives

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

Implementations

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

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

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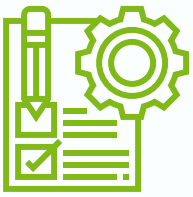
How we implement AWAKEN

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



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

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

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

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

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

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What people are saying about **AWAKEN**

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

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

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

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

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

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

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You have submitted the following abstract to the 2022 Annual Research Meeting. Receipt of this notice does not guarantee that your submission was complete or free of errors.

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

Tiffany Lindsey, Ed.D., LPC-MHSP[1], Aimee Dickson[2], Elizabeth Riley, Ph.D.[1], Tami Kane-Suleiman[2] and Michael Cull, Ph.D., M.S.N.[1], (1)University of Kentucky, Lexington, KY, (2)Oregon Department of Human Services, Portland, OR

Abstract Text:

Research Objective: Over three thousand children die each year in the United States due to maltreatment (Commission to Eliminate Child Abuse and Neglect Fatalities, 2016), thousands more children experience near deaths or other critical incidents. The responsibility for preventing child maltreatment falls to a complex network of public agencies, including law enforcement, schools, hospitals, and child protection/family preservation agencies. Following a critical incident like a child fatality or near fatality, child protection professionals need psychologically safe review processes where they can debrief their decisions and experiences candidly and learn from what happened. Agencies need standardized systems-level data to inform their quality improvement work and achieve the safest outcomes for children and families. In this case study, we describe the Oregon Department of Human Services' (DHS) critical incident review process and use of the Safe Systems Improvement Tool (Cull, Lindsey, Epstein, 2017).

Study Design: The Safe Systems Improvement Tool (SSIT) is a standardized, 25 item tool that assesses the gap between what a family needed versus what they received from the system, and it describes the systemic contributors to these unmet needs. The SSIT is a first-of-its-kind tool that structures systems-focused critical incident reviews by combining both quantitative and qualitative data (Cull et al., under review). The SSIT organizes casework data to describe the needs of families as they are treated by professionals, who work as a team and operate with an environment; data is then aggregated across cases to promote systems learning. The SSIT structures and creates quantifiable outcomes of root cause analysis from a critical incident, and it does this to allow for reliable, longitudinal thematic analysis.

Population Studied: Critical incident SSIT data from July 2019-July 2021 (n = 68) were included in this study.

Principal Findings: We used a mixed method approach to analyze the 68 SSITs included in the study, first exploring themes regarding departures from expected or desired case practice. The most frequently occurring family needs were family conflict (n =34), parenting behaviors (n = 32), and substance use (n = 26). Departures from expected or desired practice were found in 47 of the 68 reviews, and 85% of reviews with these system improvement opportunities (IOs) were about assessment practices – most often ineffective or incomplete assessment practice around substance use and/or intimate partner violence. SSIT data on these assessment IOs indicated the most common systemic contributors to these IOs were: professional biases (45%) and knowledge base (45%), poor teamwork/coordination (55%), and ineffective policies (30%) and trainings (38%). We describe thematic analysis across items as well as Oregon DHHS' current systems improvement work as result of their reviews.

Conclusions: Oregon DHS has a steadfast commitment to using a public health approach -- practicing Just Culture, fostering a learning organization and using improvement science -- to achieve consistently safe outcomes for children. We describe Oregon's critical incident review process and use of data from the SSIT to drive targeted quality improvement work to improve outcomes for children and families.

Implications for Policy or Practice: Oregon's model and the SSIT can be replicated in other systems to improve safety.

Title:
Standardizing Child Fatality and Near Fatality Reviews to Improve Outcomes with the Safe Systems Improvement Tool

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Improving Safety, Quality, and Value

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Podium or Poster

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Biographical Sketch Dr. Tiffany Lindsey is Assistant Professor and Safe Systems Practitioner at the Center for Innovation in Population Health at the University of Kentucky. Her work focuses on quality improvement and system reform efforts in child welfare jurisdictions. Lindsey has specific expertise in applying safety science to improve the safety, reliability, and effectiveness of organizations. Her approach leverages tools like organizational assessment, team-based behavioral strategies, and systemic analysis of critical incidents, including deaths and near deaths, to help organizations learn and improve. Lindsey has 10+ years experience in child welfare and is co-author of two tools within the Transformational Collaborative Outcomes Management (TCOM) framework—the Safe Systems Improvement Tool (SSIT) and TeamFirst: A Field Guide for Safe, Reliable, and Effective Child Welfare Teams. Before coming to the Center, Lindsey served as a quality improvement director within Tennessee's Department of Children Services (DCS). During her time at DCS, she oversaw the Department's nationally acclaimed child death review process and was foundational to its creation. She provided leadership to DCS' safety culture survey, confidential safety reporting, and several other applications in safety science. She taught team-based casework strategies at DCS' Child Protective Services Academy, held in partnership with Vanderbilt University and the Tennessee Bureau of Investigation. Lindsey also has

a strong clinical background working with vulnerable populations. Lindsey is a licensed professional counselor with special designation as a mental health service provider. She holds a Master of Art in Marriage and Family Therapy/Professional Counseling from Johnson University and a Doctor of Education in Leadership and Professional Practice from Trevecca Nazarene University.

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If necessary, you can make changes to your abstract submission up until the deadline of Tuesday, January 18, 2022 at 5:00 pm ET.

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Critical Incident Review Team (CIRT) FAQ

What is a CIRT?

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

What is the purpose of a CIRT?

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

What are the criteria for a CIRT assignment?

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

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

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

- When the Department is informed through the Sensitive Issue Report procedure (Chapter1, Section 4) that a child fatality occurs and the fatality appears to meet criteria for a CIRT, the Child Fatality Prevention and Review Program manager will be in contact with leadership for the district in which the critical incident and/or fatality occurred.
- The CIRT Coordinator will attend the 3-day Fatality Staffing, per the fatality protocol, to listen to the information shared about the circumstances surrounding the fatality and provide introductory information regarding the CIRT process should the case meet criteria.
- After the 3-day Fatality Staffing and once the ODHS Director assigns the CIRT, the CIRT Coordinator from the Child Fatality Prevention and Review Program will be in contact with leadership, informing them of the assignment and providing an outline of next steps.

Who attends the CIRT meeting(s)?

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

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

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

What is the timeline associated with a CIRT?

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

What is available to the public regarding a CIRT?

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

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

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

What is a Discretionary Review?

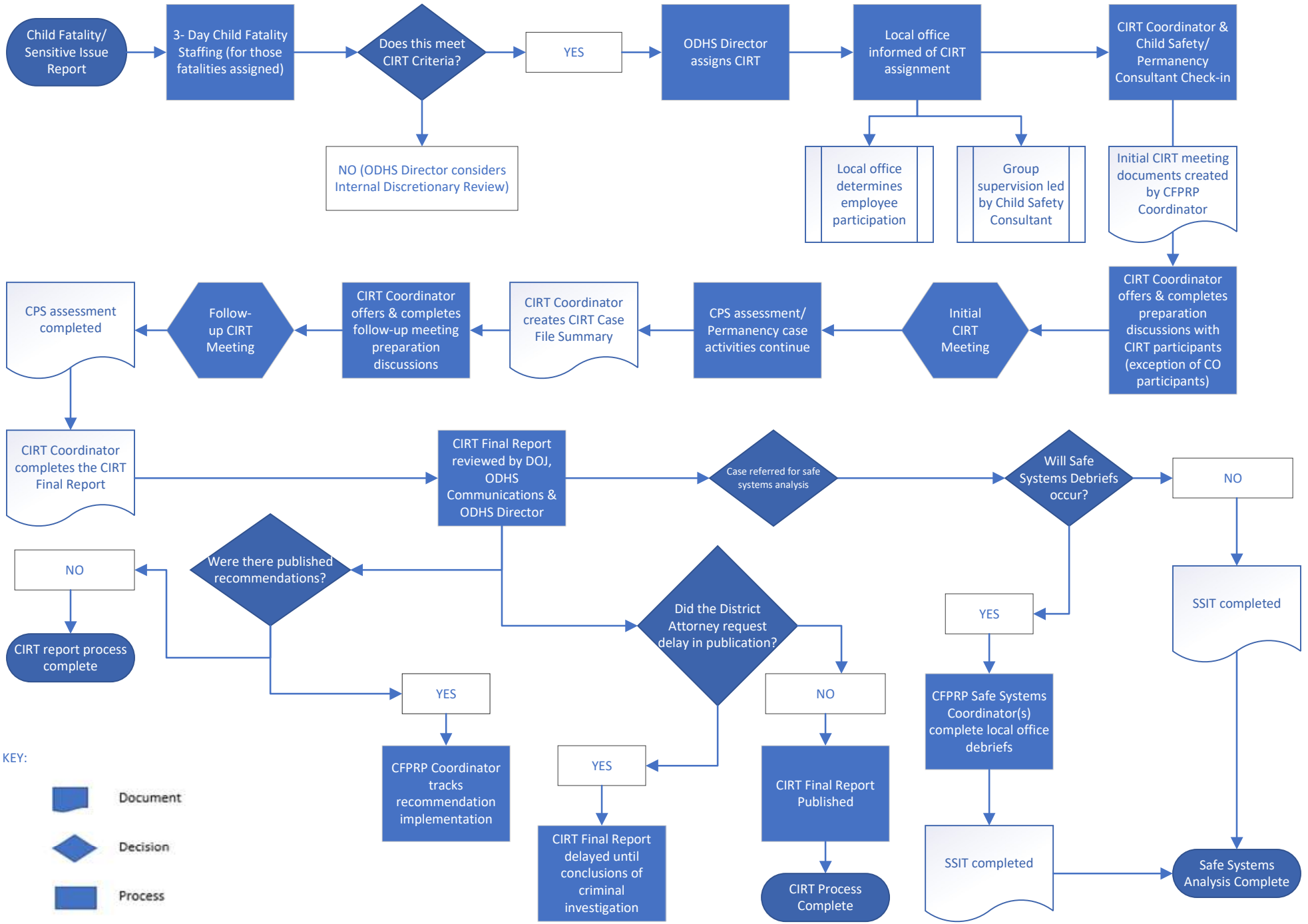
During 2021, the CFPRP began facilitating Internal Discretionary Reviews. An Internal Discretionary Review is convened by the ODHS Director when Child Welfare becomes aware of a fatality, near fatality, or other serious incident involving a family that has had contact with ODHS and the incident does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

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

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

Attachment 7

CIRT Process Map



Child Fatality Prevention and Review Program
Critical Incident Review (CIRT) Surveys

April 25, 2022

Overview

Participants from the local office(s) involved in the Critical Incident Review Team (CIRT) are provided the opportunity to voluntarily participate in a post-CIRT survey with a member of the Child Fatality Prevention and Review Program (CFPRP) who does not participate nor facilitate the CIRT.

Since the inception, a total of 100 individuals from CIRTs participated in a CIRT Follow-up Survey and 85% of participants felt adequately prepared for the CIRT.

Additional Data

- 44% of participants indicated this was the first CIRT they participated in
- 94% of participants indicated that the CIRT environment was one in which they felt encouraged to talk openly
- 78% of participants indicated they experienced learning from their participation in the CIRT process
- 85% of participants indicated they would like to be involved in further prevention strategies and/or quality improvement efforts.

Additional Information

When asked if there were any takeaways or additional information that participants wanted to communicate about the process, the following trends were shared:

- Having Executive Leadership, such as the ODHS Director, in the room can feel intimidating
- Having participants on video helped me feel more comfortable
- The informal discussion structure was well-liked
- Appreciation for having voice in front of Executive Leadership
- Appreciated the preparatory work and communication provided by the CIRT Coordinator
- The acknowledgement of how hard the work is for caseworkers was helpful and meaningful
- Appreciated the communication involved throughout the process
- Felt like a valued member of the CIRT by being asked to share individual perspective
- Staff who participate in this process can be traumatized and it is important to be aware of that trauma
- There were a lot of participants involved, which felt intimidating when not all participants speak
- It was different than expected, and it was a positive experience
- Desire to have the local office leadership embrace safety culture work
- First question when connecting should be ‘how are you’. Pausing and taking some time to explore this so it is experienced less like a formality
- Appreciate the opportunity to provide feedback on recommendations

Safe Systems Analysis FAQ

The Child Fatality Prevention & Review Program (CFPRP) joined the National Partnership for Child Safety (NPCS) in early 2020. The NPCS 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[1]. In Oregon Child Welfare, this work happens through safe systems analysis.

What is safe systems analysis?

Safe systems analysis is a critical extension of Oregon's child fatality review process and is conducted by the CFPRP Safe Systems Coordinator(s). Through case file review, participation in the Critical Incident Review Team (CIRT), and follow-up supportive inquiry, the coordinator is able to gather important information about what influences common casework problems, also known as improvement opportunities. The information is then synthesized and rated using the Safe Systems Improvement Tool (SSIT).

What is the SSIT?

The Safe Systems Improvement Tool (SSIT) [2] is a multi-purpose information integration tool designed to be the output of an analysis process. The purpose of the SSIT is to support a culture of safety, improvement, and resilience. The SSIT is an effective assessment tool for use in critical incident reviews and 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 (Cull, Lindsey, & Epstein, 2019).

The SSIT is organized into four domains. The family domain is rated similar to the CANS and captures family and child characteristics around the time of the critical incident. The other three domains are nested to measure influencing factors at the professional, team, and environment levels.

When is safe systems analysis conducted?

Safe systems analysis is conducted in all cases reviewed by the CIRT and in some discretionary reviews. Safe systems analysis explores improvement opportunities (IOs) identified through the review processes. In cases where no improvement opportunities are identified, the safe systems

[1] National Partnership for Child Safety Charter: NPCS Charter

[2] SSIT Reference Guide: 2022 SSIT Reference Guide

analysis is brief and only involves documenting family characteristics in the family domain of the SSIT. When improvement opportunities are identified, all four domains of the SSIT are completed.

What are improvement opportunities?

Improvement opportunities (IOs) represent the gap between what the child or family needed and what they received. More technically, IOs are case-specific actions or inactions relevant to the outcome or industry standards and are often representative of relatively common casework problems. While emphasis is given to those IOs within ODHS-CW, IOs also consider the actions/inactions of other entities within the macro child-serving system (e.g., courts, human service providers, law enforcement, schools). In the safe systems analysis process, IOs are first identified through the CIRT or discretionary review. Those IOs are then explored in safe systems analysis. At times, additional IOs are identified through the process and added to the exploration.

In each safe systems analysis, IOs are evaluated for their proximity (i.e., closeness) to the outcome. Proximity is not intended to imply causality or severity of an action or inaction but rather describes how close the IO was in time or distance *and* with relationship to the incident. 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.

Who is involved in safe systems analysis?

The Safe Systems Coordinator reviews the file, participates in CIRT follow-up meeting, and consults with the CIRT coordinator in order to gather relevant information and determine whether or not to offer safe systems debriefings before completing the SSIT. If debriefings are to be offered, the caseworker(s) and supervisor(s) with recent or substantial contact with the family may be involved. Program managers, MAPS and other child welfare professionals may also be invited to participate. Occasionally external partners may be invited to participate as well.

What are safe systems debriefings?

Safe systems debriefings are the mechanism for gathering more individualized information from those who experienced the outcome in the local office/community.

Debriefings are completely voluntary, one-on-one meetings, lasting about 90 minutes. The coordinator uses supportive inquiry to engage with the child welfare professional. It is the goal of debriefings to promote healing and learning at both the individual and system level.

Are safe systems debriefings completed in every case?

Debriefings are not completed in every case. When improvement opportunities are identified through the CIRT or discretionary review process, the safe systems coordinator evaluates the circumstances of the case and may offer debriefings if there was an open CPS assessment or case with the family in the year prior. Because resources are somewhat limited, whether or not to

offer debriefings depends on availability of the coordinator as well as nature of the IO and its relevance to system challenges currently under exploration.

What happens to the information gathered during debriefings?

The information gathered during debriefings is evaluated along with all other information gathered through the CIRT or discretionary review process and then synthesized through the SSIT. The results of SSITs are aggregated, utilizing frequency and proximity of improvement opportunities as well as frequency of influencing factors in the professional, team, and environment domains to shape strategies for both system improvement and prevention efforts. Recommendations resulting from safe systems analysis may be presented to ODHS executive leadership for review and approval.

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

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

2022
REFERENCE
GUIDE

ACKNOWLEDGEMENTS

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

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

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Table of Contents

1. INTRODUCTION

SAFE SYSTEMS IMPROVEMENT TOOL

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

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

SIX KEY PRINCIPLES

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

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

REFERENCE GUIDE STRUCTURE

This reference guide is divided into the following four parts:

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

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

Section Three: scoresheet as a template for case reviews

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

HISTORY AND BACKGROUND

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

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

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

WHAT IS THE SSIT?

IT IS AN IMPROVEMENT STRATEGY

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

IT FACILITATES OUTCOMES MEASUREMENT

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

IT IS A COMMUNICATION TOOL

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

IT IS A CULTURE CARRIER

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

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

SSIT BASIC STRUCTURE

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

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

RATING ITEMS

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

Improvement Opportunities

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

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

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

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

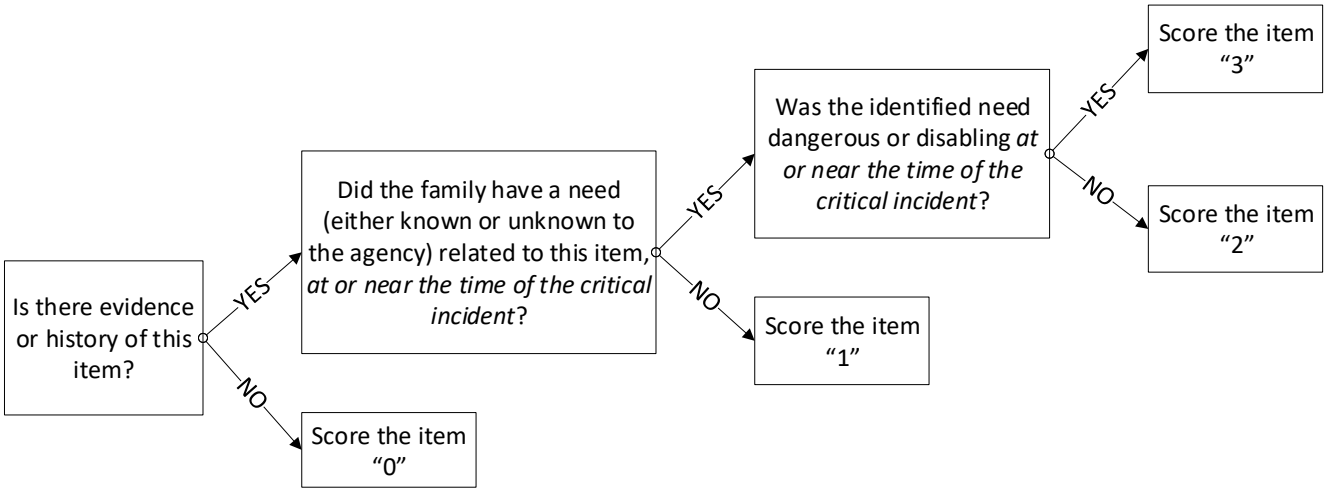
Scoring the Child and Family Domain

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

Table 1: Child Family Domain Basic Ratings Design

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

Figure 1: Decision Scoring Tree for Family Domain



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

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

Scoring the System Domains: Proximity

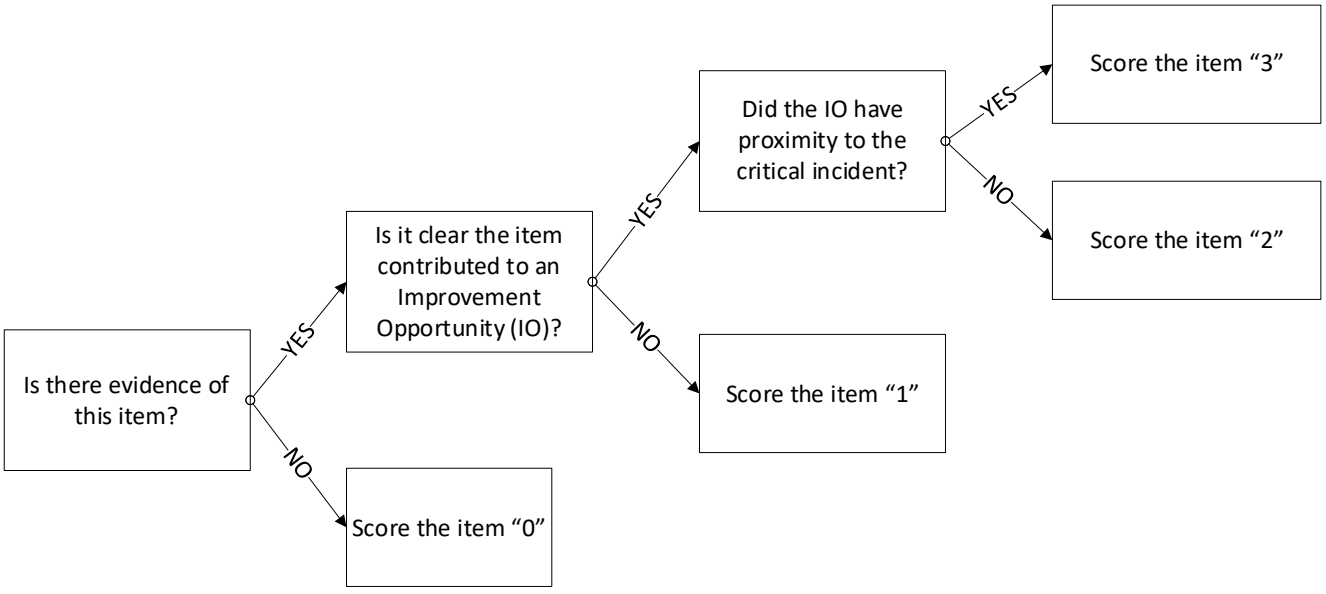
Proximity is used to differentiate between ratings of 2 and 3 (Figure 2) in the 3 system domains – Professional Team, and Environment. Proximity is a Gestalt Principle about how the human mind naturally organizes items. If an IO identified in a case was close in time or distance and with relationship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

Table 2: System Domains Basic Ratings Design

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

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

Figure 2: Decision Scoring Tree for System Domains



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

2. SSIT DOMAINS AND ITEMS

FAMILY DOMAIN

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

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

0 No evidence; there was no need for action at the time of the critical incident

1 History; there was a need for "watchful waiting" at the time of the critical incident

2 Action was needed at the time of the critical incident

3 Dangerous or disabling problem required immediate and/or intensive action at the time of the critical incident

FAMILY/CAREGIVER ITEMS

FAMILY CONFLICT

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

Questions to Consider	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. A formal diagnosis is not required to rate this item.

Questions to Consider

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

Ratings & Descriptions

0	There was no evidence that the caregiver had developmental needs.
1	The caregiver had developmental challenges, but they did not currently interfere with parenting or there was a history of those challenges interfering with parenting.
2	The caregiver had developmental challenges that interfered with their capacity to parent.
3	The caregiver had developmental challenges that made it very difficult or impossible for them to parent.

CAREGIVER MENTAL HEALTH

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

Questions to Consider

- 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. A formal diagnosis is not required to rate this item.
Note: Substance-Related Disorders would be rated '2' or '3' unless the individual was in recovery.

Questions to Consider

- Did caregivers have any substance use needs that made parenting difficult?
-

Ratings & Descriptions

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

CAREGIVER ECONOMIC STABILITY

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

Questions to Consider:

Ratings & Descriptions

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

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

CAREGIVER PARENTING BEHAVIORS

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

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

CHILD/YOUTH ITEMS

CHILD/YOUTH MEDICAL/PHYSICAL

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

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

CHILD/YOUTH DEVELOPMENTAL/INTELLECTUAL

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

Questions to Consider

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

Ratings & Descriptions

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

CHILD/YOUTH MENTAL HEALTH

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

Questions to Consider

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

Ratings & Descriptions

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

PROFESSIONAL DOMAIN

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

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

0 No evidence, no need for action.

1 Latent factor.

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

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

COGNITIVE BIAS

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

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

STRESS

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

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

FATIGUE

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

Questions to Consider

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

Ratings & Descriptions

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

KNOWLEDGE BASE

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

Questions to Consider

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

Ratings & Descriptions

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

DOCUMENTATION

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

Questions to Consider

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

Ratings & Descriptions

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

INFORMATION INTEGRATION

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

Questions to Consider

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

Ratings & Descriptions

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

TEAM DOMAIN

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

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

0 No evidence, no need for action.

1 Latent factor.

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

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

TEAMWORK/COORDINATION

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

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

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

SUPERVISORY SUPPORT

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

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

SUPERVISORY KNOWLEDGE TRANSFER

Case direction from supervisor was inconsistent with best practice.

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

PRODUCTION PRESSURE

Demands on professionals to increase efficiency.

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

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

ENVIRONMENT DOMAIN

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

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

0 No evidence, no need for action.

1 Latent factor.

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

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

DEMAND-RESOURCE MISMATCH

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

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

PRACTICE DRIFT

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

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

EQUIPMENT/TECHNOLOGY/TOOLS

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

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

POLICIES/RULES/STATUTES

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

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

TRAINING

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

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

SERVICE ARRAY

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

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

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

3. SSIT SCORESHEET

CASE ID:	

Improvement Opportunities (IOs)
1
2
3
4
5

Abbreviated Rating Summary for Family Domain

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

Abbreviated Rating Summary for Professional, Team, and Environment Domains

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

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

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

4. QUALITY IMPROVEMENT ADVOCACY

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

Table 2: System Domains Basic Ratings Design

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

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

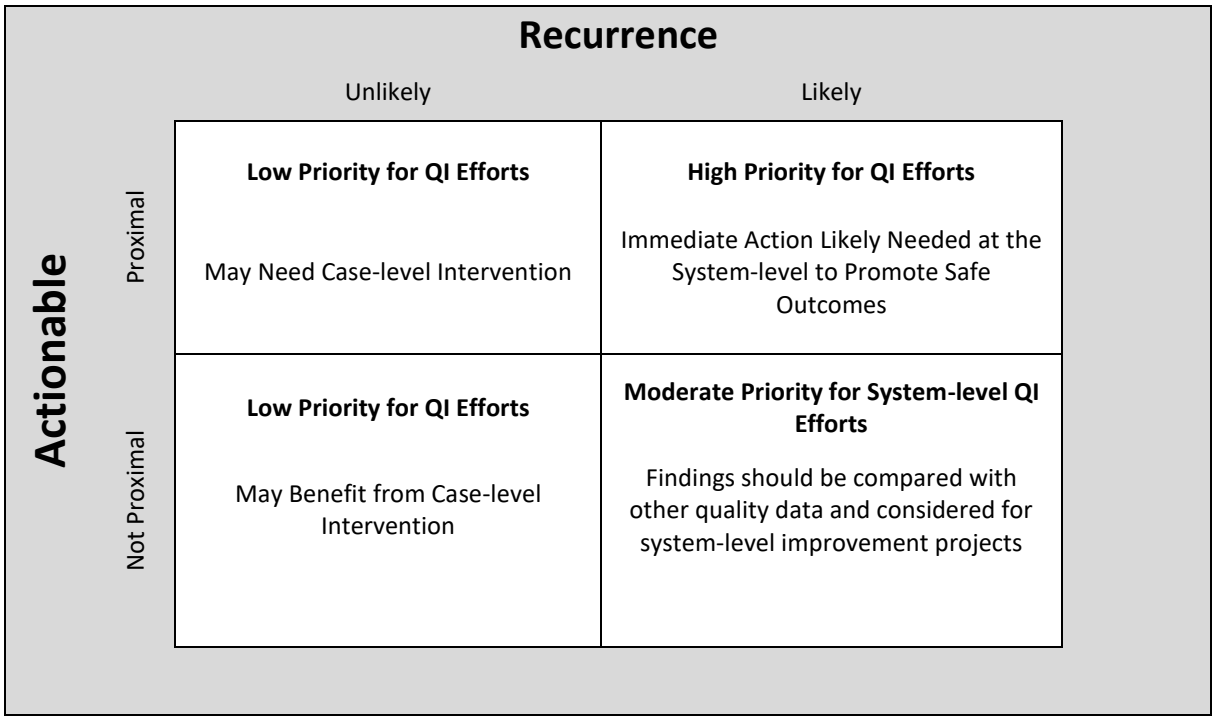
SSIT data can be aggregated and reviewed to inform system-focused quality improvement opportunities. SSIT data should be viewed alongside the IOs from reviewed cases. For example, IOs may reveal inconsistent engagement of all caregivers in a home, allegation/incident-focused casework practice, or barriers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

Table 3: Recurrence Rating Structure

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

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

Figure 2: QI Advocacy Matrix



Advocating for System Change

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

National Partnership for Child Safety (NPCS)

Critical Incident Review (CIR) Data Dictionary

Scope of Document: This data dictionary contains the core child, family, and critical-incident specific items collected by the NPCS jurisdictions. It is intended to complement the NPCS' shared system-level information, such as the information collected in the Safe Systems Improvement Tool.

The National Partnership for Child Safety strategically does not establish minimum critical incident (e.g., child death) standards for inclusion into the Partnership's shared dataset. Instead, Partnership jurisdictions agree to share the core data (as identified in the table below) whenever the jurisdiction completes a systems-focused critical incident review, per the jurisdiction's internal policy. This is generally, at minimum, any time the jurisdiction had open child welfare involvement at the time a child experiences a maltreatment death.

Through sharing data, Partnership jurisdictions aim to: 1) learn about their unique child-serving system and improvement opportunities, 2) gain insight across jurisdictions to further support improvement efforts, and 3) identify large-scale quality improvement activities the Partnership can inclusively address.

Important Definitions for Understanding the Document:

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

Variable	Definition	Response Option Type:	Sub-specifiers:
Child Specific:			
Age	Age at time of critical incident. If unavailable, age as identified in available child welfare records.	**Value—single selection** 0-30 days --OR-- 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11 months --OR-- 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18+ years --OR-- Unknown	
Gender	The sex of the child as identified in death certificate or other medical documentation. If neither is available, sex as identified in available child welfare records.	**Categorical—single selection** Female Male Other: specify Unknown	
Race	Race of child as identified in death certificate or other medical documentation. If neither is available, race as identified in available child welfare records. *If child is Arab, select White.*	**Categorical—multiple selections** American Indian Tribal affiliation (y/n) If yes, specify: Alaskan Native Asian Black or African American Native Hawaiian or other Pacific Islander White Unknown Declined to answer	
Ethnicity	Ethnicity of child as identified in death certificate or other medical documentation. If neither is available, ethnicity as identified in available child welfare records.	**Categorical—multiple selections** Caribbean Chinese Haitian	**Additional specifier: If Hispanic or Latino/a, please further specify, if**

Variable	Definition	Response Option Type:	Sub-specifiers:
		Hispanic or Latino/a origin Indian Japanese Korean Native African Non-Hispanic or Latino/a origin Other – Black or African American Other – Asian Unknown Declined to answer	**known: (multiple selections)** Central American Caribbean Cuban Dominican Mexican North American Puerto Rican South American Other
Living Arrangement	The environment in which a child was primarily residing at the time of the critical incident. This may not be the place where the critical incident occurred.	**Categorical—single selection** Adoptive Home Birth Family's (mother's and father's) home Birth Father's home Birth Mother's home Child at Hospital From Birth Congregate Care Juvenile Detention Kinship Foster Home Non-relative Foster Home Relative's home Other: Specify Unknown	**Additional specifier: Was this location where the critical incident occurred?** (Y/N: If no, textbox) **Additional specifier: Was this is the place where the child's physical custody was held?** (Y/N/unknown/not applicable: If no, textbox)
Intellectual /Developmental Status	SSIT: This item describes the child/youth's development as compared to standard developmental milestones, as well as rates the presence of any developmental (motor, social and speech) or intellectual disabilities. It includes Intellectual Developmental Disorder (IDD) and Autism Spectrum Disorders. Rate the item depending on the significance of the disability and the related level of impairment in personal, social, family, school, or occupational functioning.	**Ordinal—single selection** 0 1 2 3	

Variable	Definition	Response Option Type:	Sub-specifiers:
Substance-Exposed Newborn	Identification of any prescribed or unprescribed, in-utero, substance-exposure in the child or mother's medical records (e.g., Neonatal Abstinence Syndrome diagnosis, positive prenatal drug screen), including alcohol. If medical records are unavailable, prenatal drug-exposure as identified in child welfare records (e.g., self-admission).	**Multiple—single selection** Yes No Unknown	**If yes, then Additional specifiers:** • **Was the child diagnosed as substance-affected (e.g., Fetal Alcohol Syndrome, Neonatal Abstinence Syndrome)?** (Y/N) • **What type of drug was the child exposed to (multiple selections)?** Alcohol, Barbiturates, Benzodiazepines, Methamphetamine, Narcotics, Tobacco, THC, Opiates, Other: Specify, Unknown
Custody Status	Identifies the relationship of the entity/person with legal custody (permanent or temporary) at the time of the critical incident. Court records are used as the source of information for this variable whenever possible. Otherwise, general child welfare records are used.	**Categorical—multiple selections** Birth Parents Father Fictive Kin Mother Relative State/Child Welfare Agency Other: Specify Unknown	
Critical Incident Specific:			
Date of Critical Incident	Date the alleged maltreatment related to the critical incident occurred.	**Date (MM/DD/YYYY)** --OR— Unknown	

Variable	Definition	Response Option Type:	Sub-specifiers:
Critical Incident Type	The category of critical incident that occurred. If the critical incident led to death, the appropriate category is death. Serious physical injury is defined under CAPTA as bodily injury which involves substantial risk of death, extreme physical pain, protracted and obvious disfigurement, or protracted loss or impairment of the function of a bodily member, organ, or mental faculty. Examples are liver lacerations, multiple fractures, near drowning/lack of oxygen to the brain, and severe malnourishment. Near deaths are generally defined by local statute but may encompass those defined by CAPTA as serious physical injuries. If the critical incident met the jurisdiction's criteria of near death, the appropriate selection is near death. The following definition of a near death is recommended: *life-threatening cardiopulmonary dysfunction directly attributable to conditions resulting from suspected abuse or neglect as evidenced by (a) respiratory insufficiency/failure requiring intubation and mechanical ventilation, (b) respiratory insufficiency/failure requiring medications to reverse effects of toxic ingestion, or (c) cardiac arrhythmia with or without cardiopulmonary resuscitation (CPR).*	**Categorical—single selection** Death Near Death Serious Physical Injury Other: Specify	**Sub-specifier for near deaths:** **Does this critical incident meet the NPCS recommended definition of a near death?** (Y/N)
Date of Death	Date of the child's death, as identified on the death certificate. If not available, date of death as identified in the autopsy or relevant medical	**Date (MM/DD/YYYY)** --OR— Not Applicable	

Variable	Definition	Response Option Type:	Sub-specifiers:
	records. If none are available, date of death as identified in child welfare records.		
Number of Alleged Perpetrators	Number of perpetrators alleged to have committed any maltreatment contributory to the critical incident, including unknown perpetrators and a perpetrator-by-omission. This variable is specific to those alleged to have committed maltreatment of the subject child (i.e., child who experienced the critical incident).	**Value—single selection** 1, 2, 3, 4, 5+	
Gender of Alleged Perpetrators	Gender as reported in child welfare records.	**Categorical—multiple selection** Female Male Other: specify Unknown	
Relationship of Alleged Perpetrator(s) to Child	Of those alleged to have committed maltreatment contributory to the critical incident, identify the relationship of the alleged perpetrator(s) to child.	**Categorical—multiple selections** Adoptive Parent Babysitter Child Daycare Provider: Licensed Child Daycare Provider: Unlicensed Congregate Care or Residential/Institutional Facility Staff Foster Sibling Kinship Foster Care: Licensed Kinship Foster Care: Unlicensed Non-kinship Foster Care: Licensed Non-kinship Foster Care: Unlicensed Parent Parent's Partner Parent's Former Partner Relative: Grandparent Relative: Aunt/Uncle Relative: Sibling Relative: Other Stepparent	

Variable	Definition	Response Option Type:	Sub-specifiers:
		Other: Specify (e.g., guardian, non-caregiver, medical personnel) Unknown	
Alleged Perpetrator Prior History of Substantiated Maltreatment	Identifies if there was a previous known child welfare substantiation of any alleged perpetrator	**Binary—single selection** Yes No Unknown	**Additional Specifier: If yes, was the Alleged Perpetrator a Caregiver for the current critical incident being reported?** (y/n)
Maltreatment Type	The child welfare/child protection system's official maltreatment allegations surrounding the critical incident. This variable specifically refers to the allegations identified within the initial report (e.g., hotline call) or otherwise identified during the course of involvement with the family. If there are multiple allegations, select all that apply.	**Categorical—Multiple selections** Emotional/Psychological Abuse Neglect Physical Abuse Sexual Abuse Other: Specify (e.g., Threat/Risk of Harm)	**Additional Specifier:** Open Textbox for sub-specifying maltreatment allegation
Maltreatment Determination	The child welfare/child protection system's official determination regarding maltreatment allegations surrounding the critical incident. This variable specifically refers to the allegations identified within the initial report (e.g., hotline call) or otherwise identified during the course of involvement with the family. Please indicate the appropriate selection(s) for each maltreatment category chosen within Maltreatment Type.	**Categorical—Multiple selections** Substantiated Unsubstantiated Unsubstantiated with Concerns Pending Closed without Maltreatment Determination Not Applicable	
Manner of Death	The manner of death as identified in the death certificate or autopsy. If a death certificate or autopsy is unavailable, medical records about the incident may be used but only to select a "natural" manner of death. If none are available, the response option "unknown" is appropriate.	**Categorical—single selection** Accident Homicide Natural Suicide Undetermined Unknown Pending Other	

Variable	Definition	Response Option Type:	Sub-specifiers:
Cause of Critical Incident	If the critical incident involves death, this variable records the cause of death as identified in the death certificate or autopsy. If a death certificate or autopsy is not available, medical records about the death may be used. If the critical incident is not a death and/or medical records are unavailable, this variable records the cause of critical incident as identified in child welfare records.	**Categorical-- Multiple selections** Accidental Choking Acute Life Threatening Event Asphyxia (not SUID) Burns Drowning Emotional Abuse/Psychological Harm Injury from Fall Injury from Firearm Medical Medical Neglect Motor Vehicle Accident Natural Nutritional Neglect Physical Abuse Poisoning/Overdose Sexual Abuse Sudden Unexpected Infant Death (SUID) • SIDS • Accidental Suffocation and Strangulation in Bed (ASSB) Other: Specify Undetermined	**Additional Specifier: How was Cause of Critical Incident decided?** *Categorical—single selection:* autopsy, death certificate, other medical records, child welfare records **Additional Specifier: If the critical incident was not a death, was the cause of the critical incident self-inflicted? (Y/N/Unknown)**
Unsafe Sleep	Infant was placed in near proximity to one or more persons, on the same sleep surface, when found unresponsive, or Infant was sleeping on a surface other than one specifically designed for safe infant sleep* when found unresponsive, or Infant was found unresponsive on bedding softer than a firm crib mattress and/or near pillow, blankets, comforter, waterbed, sheepskin, etc. (*CPSC approved).	**Categorical—single selection** Yes No Not Applicable: Child was 1+ years at time of the critical incident.	

Variable	Definition	Response Option Type:	Sub-specifiers:
Family Specific: ***Add indicator for number of Caregivers.**			
Caregivers' Age(s)	Caregiver(s)' age as of the date of the critical incident	**Value: open textbox** for age in years --or— Unknown	**Additional specifier: Is the caregiver the alleged perpetrator?** Y/N • **If no, what was the age of the alleged maltreater(s)?** **Additional specifier: What was the relationship of the caregiver(s) to the child?** *(single selection)* Adoptive Parent Congregate Care or Residential/Institutional Facility Staff Kinship Foster Care: Licensed Kinship Foster Care: Unlicensed Non-kinship Foster Care: Licensed Non-kinship Foster Care: Unlicensed Parent Parent's Partner Parent's Former Partner Relative: Grandparent Relative: Aunt/Uncle Relative: Sibling Relative: Other Stepparent Other

Variable	Definition	Response Option Type:	Sub-specifiers:
			Unknown
Open Child Welfare Services or Involvement (CWI) on Household	Identifies if there was any kind of open child welfare involvement, such as an intake, case, assessment, investigation, or screening with the household at the time of the critical incident. This includes child abuse and neglect referrals that did not meet criteria to be screened-in, if known. Child welfare is broadly defined as any type of internal involvement with the following systems: child protection, home-based, foster care, juvenile justice, family preservation, and/or any multi-response child protection involvement.	**Categorical—Multiple selections** Family Preservation/In-home/Ongoing Foster Care Intake/Assessment Investigation Juvenile Justice Other: Specify (e.g., subsidized adoptive home) None	**Additional Specifier: Was the child a named member in that services or involvement?** (Y/N)
History of Household Child Welfare Services or Involvement	Identifies if there was any kind of historical child welfare involvement, such as an intake, case, assessment, investigation or screening with the household within three years of the critical incident. This includes child abuse and neglect referrals that did not meet criteria to be screened-in, if known. Child welfare is broadly defined as any type of internal involvement with the following systems: child protection, home-based, foster care, juvenile justice, family preservation, and/or any multi-response child protection involvement.	**Categorical—Multiple selections** Family Preservation/In-home/Ongoing Foster Care Intake/Assessment Investigation Juvenile Justice Screened Out Hotline Report Other: Specify (e.g., subsidized adoptive home) None	**Additional Specifier: Was the child a named member in that services or involvement?** (Y/N)
Caregiver Substance Use History	SSIT: Caregivers' abuse or misuse with alcohol, legal or illegal drugs and/or prescription drugs.	**Ordinal—single selection** 0 1 2 3	

Variable	Definition	Response Option Type:	Sub-specifiers:
Caregiver Mental Health History	SSIT: Caregivers' mental health needs only (not substance abuse). A formal mental health diagnosis is not required to rate this item.	**Ordinal—single selection** 0 1 2 3	
Caregiver Intimate Partner Violence History	A pattern of coercive tactics-- which can include physical, sexual, economic, psychological, and emotional abuse—that an intimate partner uses with the goal of gaining and maintaining power and control. The intimate partner does not have to live in the household.	**Categorical—Multiple selections** Known in Relationship at Time of Critical Incident as Aggressor History of Intimate Partner Violence as Aggressor (within 5 years) History of Intimate Partner Violence as Aggressor (5+ years ago) Known in Relationship at Time of Critical Incident as Survivor History of Intimate Partner Violence as Survivor (within 5 years) History of Intimate Partner Violence as Survivor (5+ years ago) None Unknown	
Caregiver Prior History of Substantiated Maltreatment	Identifies if there was a previous known child welfare substantiation of caregiver(s)	**Binary—single selection** Yes No	
Previous Child Fatality in Household	Identifies if a previous child fatality is known to have ever occurred in the household	**Binary—single selection** Yes No	**Additional Specifier: Was child welfare involved as a result of this fatality?** *(Binary—single selection: Y/N)*

Variable	Definition	Response Option Type:	Sub-specifiers:
			(if Yes to above), Was any maltreatment determined to be present at the time of the fatality? (*Binary – single selection: Y/N*)
Household's Last Involvement with Child Welfare Agency (CWA)	Date of closure for the last known child welfare involvement, such as an intake, case, assessment, investigation or screening with the household *within three years of the critical incident.* This includes screened out child abuse and neglect hotline referrals, if known. Child welfare is broadly defined as any type of internal involvement with the following systems: child protection, home-based, foster care, juvenile justice, family preservation, and/or any multi-response child protection involvement.	**Date (MM/DD/YYYY)** --OR— Open Involvement --OR-- Not Applicable	

Attachment 12

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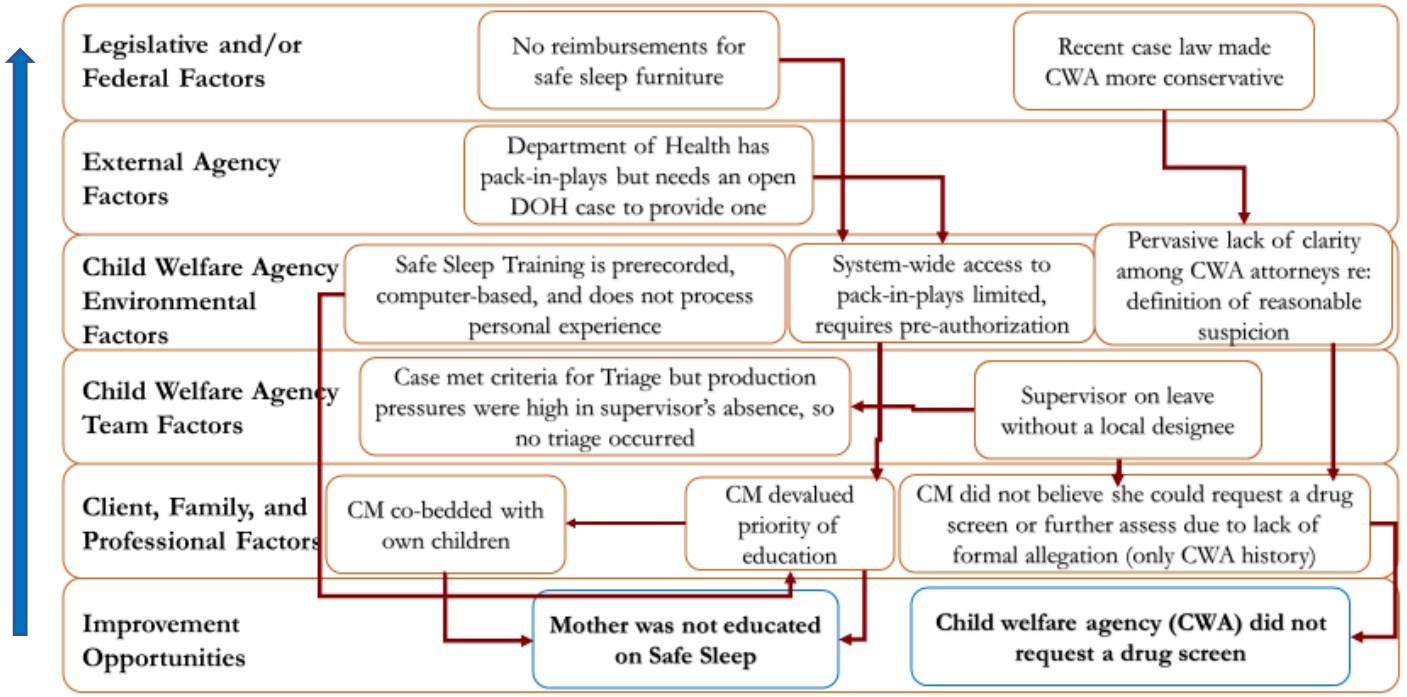
Systems Mapping Facilitator Tip Sheet

AcciMap Basics

AcciMap (i.e., Systems Mapping) is a systems-based accident analysis approach developed by Jens Rasmussen. In safe systems analysis it uncovers how higher-level system factors contribute to common case work problems. AcciMaps categorize and visualize hierarchical and complex factors into a multi-layered quality improvement tool to inform system improvements.

Each lane dives deeper into the macrosystem as you move up

Start at the bottom and work "up and out" to understand the problem



Boxes contain the contributing factors

Arrows point down to show the direction of influence (i.e., what factor contributes to what factor)

Arrows can point in any direction or be bi-directional

Common Terminology

The factors we want to explore during the mapping are categorized into lanes. These lanes capture human, conditional and control factors.

The most valuable quality improvement work often targets **control factors**. In the SSIT these are the items in the Environment domain.

Human Factor	• Exists in a professional • Natural human limitations • E.g. Bias, Stress, Knowledge
Conditional Factor	• Exists in the environment • Changing circumstances • E.g. Workload, Weather
Control Factor	• Exists in the system • Only change with system level intervention • E.g. Hiring practices, budget, policy

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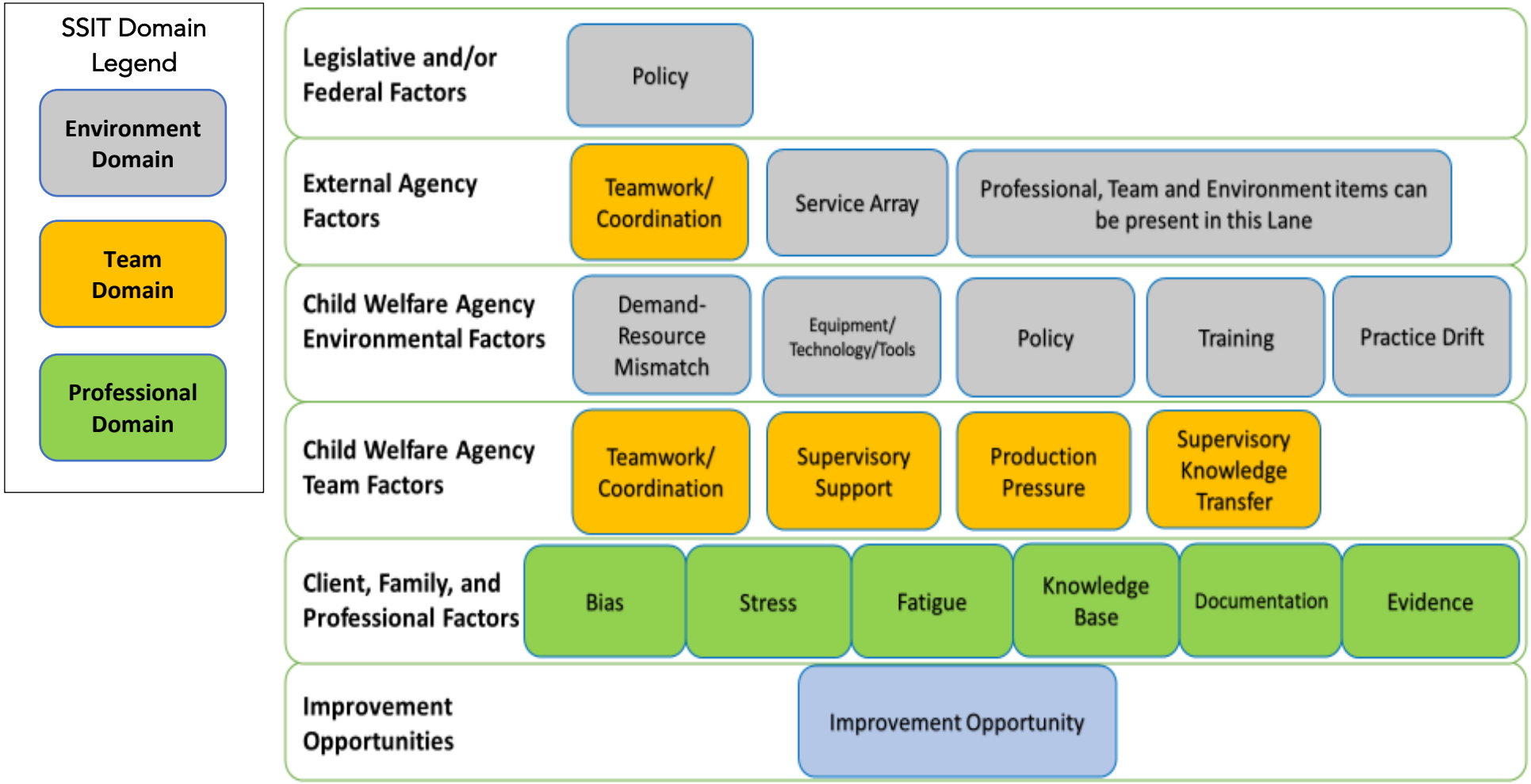
SSIT & Systems Map Crosswalk

The SSIT's domains crosswalk onto the lanes of a Systems Map. Asking questions in mapping about the SSIT's items (e.g., how might technology contribute to this problem?) will cue the team's thinking about systemic factors. When the map is finished, capture the entire map in the SSIT to trend learnings over time.



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Facilitation Strategies

1. Set the Context
   - Start with introductions and group agreements
   - Ask participants to be aware of any perspectives and biases they might bring.
   - Ask them to create space for all voices regardless of title.
   - Give a basic overview of how the map and process works.
   - Let the conversation guide what goes on the map.
   - Ask them to consider ***how*** an Improvement Opportunity happens, not *why it shouldn't.*
   - Remind them to assume generously when exploring human factors and avoid causal or blaming language. We all intend the best for families we serve and do the best we can with what is available to us.
   - Fact-check what we know. If we think policy contributed to an Improvement Opportunity, verify the policy during the mapping session.
   - Remind them there will be time at the end to consider system-level solutions once the Improvement Opportunity has been fully explored.

2. Describe the Improvement Opportunity and its relevance to the Critical Incident (s) under review.
   - You can pre-fill the map with the information learned from debriefings and check in with the mapping team for agreement on what's been learned so far, then build onto what's already known. Be mindful of how bias might contribute to pre-identified information.

3. Invite free thought about the Improvement Opportunity and what is contributing to the problem or challenge.
   - Capture these thoughts and reflections as they are being shared. Check in that you have accurately captured their thoughts.
   - Create space for other participants to share their similar or opposing views to gather diverse and all potential perspectives.

4. After some free thought, reflect back and spend time talking through the lanes. *What do we know so far? Does it make sense? What levels of the system have not been fully explored?*

5. Don't get hung up on the arrows and lanes.
   - The goal is to have a high quality, engaging, diverse discussion and the map is simply a visual representation of the conversation.
   - Mapping requires facilitators to engage, track, and document conversations in real-time. It can be fatiguing, and it takes practice and persistence to become confident. Co-facilitation is a great help.
   - It needs to be complete but not perfect. If you don't know where an item goes, it's better to have it somewhere on the map than not at all.
   - Give the team a brief break every hour. During the break, clean up the map (add arrows, change lanes, etc.)

6. Ideally, map until you and the team have gained some new perspectives.
   - The goal is to have enough context to brainstorm system-level solutions (not quick fixes).
   - Work through every lane on the map but if the team doesn't have expertise in a lane, simply move on.

7. Leave intentional time at the end of the session for brainstorming system-level solutions.

Attachment 13

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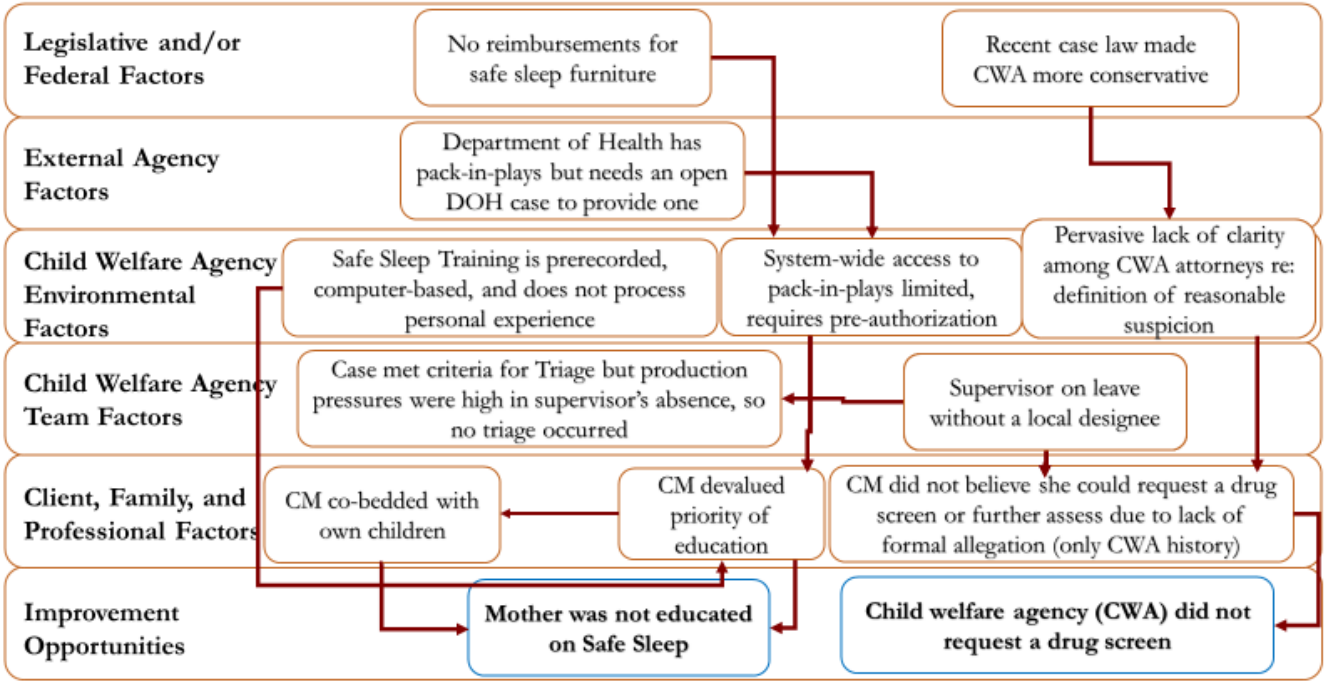
Systems Mapping Participant Guide

Mapping Basics

During the session, your feedback and observations will be captured by the facilitator on a map. This map, formally called an AcciMap, is a flexible systems-based accident analysis approach used in quality improvement work to process how multi-layered, systemic factors contribute to casework problems, called Improvement Opportunities. In essence, the map captures <u>how</u> an Improvement Opportunity occurs within a system. It's a pivotal first-step in designing meaningful, effective, systemic solutions to casework challenges.

Each lane dives deeper into the macrosystem as you move up

We start at the bottom and work up and out to understand what contributes to Improvement Opportunities



Boxes contain the contributing factors

Arrows point down to show the direction of influence (i.e., what factor contributes to what factor)

Arrows can point in any direction or be bi-directional

Common Terminology

The factors we want to explore during the mapping are categorized into lanes. These lanes capture human, conditional and control factors.

The most valuable quality improvement work often targets **control factors**.

Human factor
- Exists in a professional
- Natural human limitations
- E.g. Bias, Stress, Knowledge

Conditional Factor
- Exists in the environment
- Changing circumstances
- E.g. Workload, Weather

Control factor
- Exists in the system
- Only change with system level intervention
- E.g. Hiring practices, budget, policy

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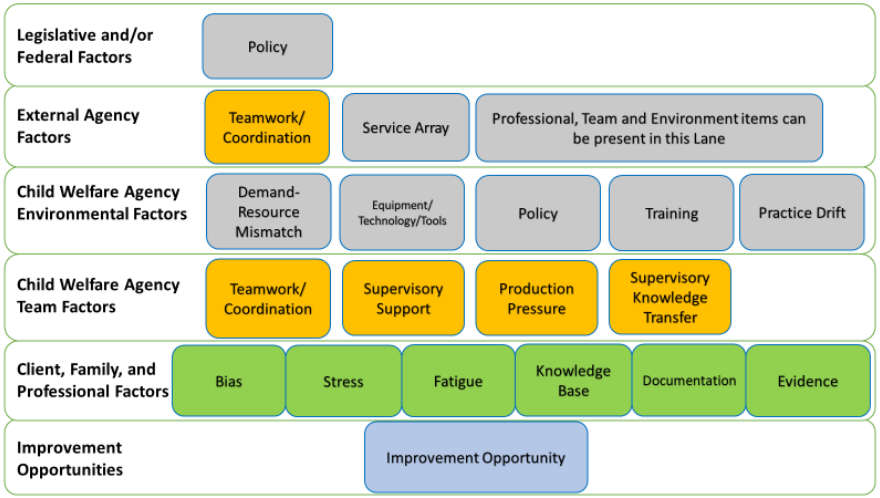
In systemic critical incident review and debriefings, we explore all the factors that may have contributed to the critical incident and identify the gaps between what families needed and what they received. Improvement Opportunities are how we articulate these gaps.

We know that professionals come to work every day intending to give families what they need. We have a responsibility to look at all the barriers and challenges in the system that make this harder. By doing this we can identify targeted solutions to solve these problems. Your experience and expertise will help us understand these problems and identify better solutions.



Participant Guidelines

The map provides a guide for the conversation we want to have. Our goal is to have an engaging, diverse discussion and the map is simply a visual representation of the notes from our conversation.

Rules of engagement

- Be aware of the perspective and biases you bring.
- Take space and make space for all voices regardless of title
- Consider ***how*** an Improvement Opportunity happens, not *why it shouldn't.*
- Assume generously when exploring the work of individuals and teams and avoid causal or blaming language. Remember that we all intend the best for families we serve and do the best we can with what is available to us.
- Fact check what you know. For example, if you think policy contributed to an Improvement Opportunity, are you sure? Check the policy during the mapping session.

The process

- Start by thinking about the barriers and challenges that impact how professionals and teams do their work.
- Your facilitator will ask you to think freely about the Improvement Opportunity and what is contributing to the problem and will capture these thoughts on the map.
- The facilitator will capture your thoughts and check in to make sure they are accurate. Let them know if something needs to be re-worded or moved.
- They will ask questions to help you delve deeper into the higher-level system factors affecting these problems as we work up the map.
- There will be time at the end of the mapping to consider system-level solutions once the problem has been fully explored.

Attachment 14

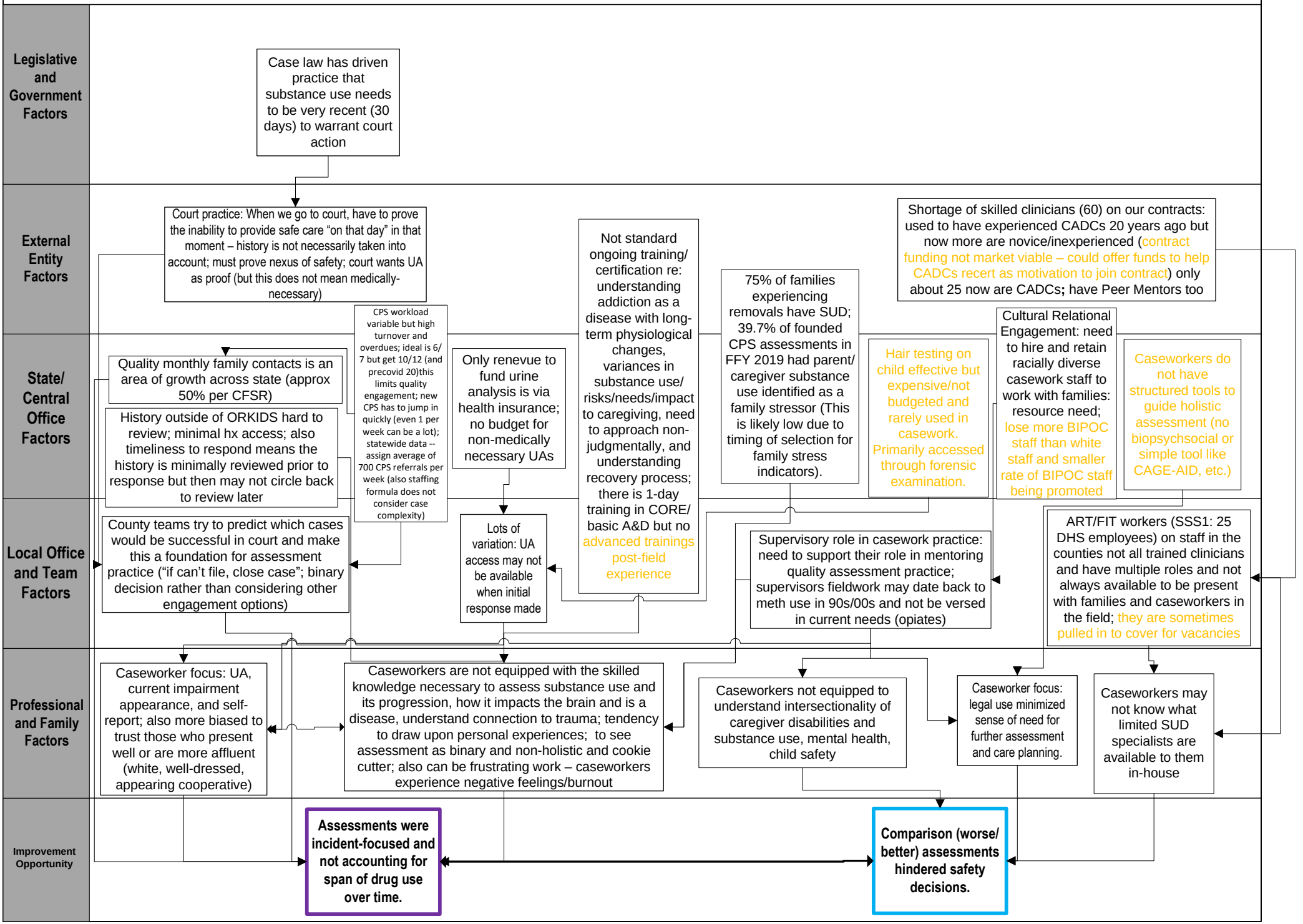
The Challenge	Resources	Key Activities	Desired Outcomes
Infants in Oregon involved with Child Welfare are a particularly vulnerable population whose families cannot be adequately served by child welfare alone. There is a need for collaboration with other family serving systems with an emphasis on prevention rather than reaction. **Child Welfare workforce lacks specialized knowledge in infant care and development which impacts ability to adequately assess child safety and level of vulnerability.** **Lack of systems-level collaboration and problem-solving among key stakeholders, and no entity or individual responsible for leading this effort** **Current CPS Assessment Model, especially on assessment only cases do not appropriately address risk and protective factors.** **Services and supports that address families' needs vary across state in access and availability, especially when considering culturally specific services.** **Awareness of these services and lack of coordination amongst them leads to fragmented responses.** **Parents' own history of trauma and impact on parenting/access to supports is often disregarded** **Systemic racism impacts which families access services and who is offered community based supports prior to or in lieu of CW investigation**	Oregon Child Welfare Professionals: Caseworkers ART Leads MAPS Consultants Supervisors ODHS CW Contracted Nurses Home Visiting Programs (differ depending on location) Early Intervention OPEC https://orparenting.org/ WIC Relief Nurseries Self Sufficiency Professionals Pediatricians Birthing Hospitals Treatment Providers <u>Data</u> CIRT/Child Welfare Vital Statistics Infant Mortality		Decrease and ultimately eliminate preventable infant death and maltreatment. Child welfare professionals understand prioritization of cases with infants and the associated vulnerability of that population. Child welfare professionals have access to supports that assist them in engaging families and connect those families to the community for long term support regardless of safety threat presence. Safe Sleep is assessed and discussed on every child welfare case and at every contact with harm reduction principles in mind. Child welfare professionals have the time, support, and bandwidth to adequately engage, assess, and serve families with infants. All child welfare professionals have a foundational understanding of infant development/parenting responsibilities necessary for safe infant care. Including: • How substance use (regardless of legal status) and impairment impact infant safety and vulnerability. • Daily routine, home environment, nutrition, attachment/bond, soothing, understanding of infant needs – with consideration of cultural implications/how bias and racism impacts assessment of this. • Consideration of infant communication (not talking, but thinking awareness, tracking, physical connection, crying, etc)

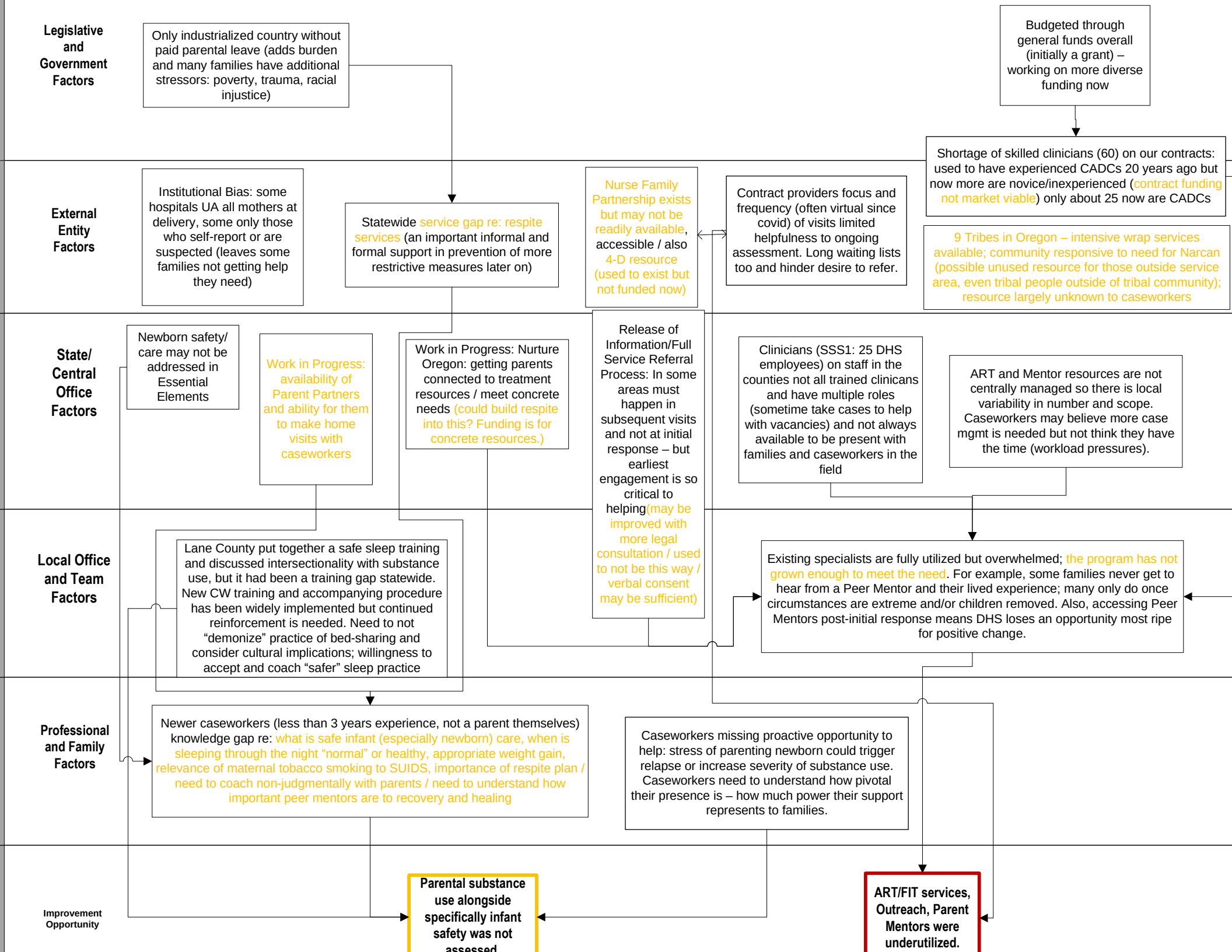
			Family engagement is comprehensive and beyond surface level (go beyond “I’m not currently using” or “I’m sober”) Other family serving systems are engaged as early as possible with families in need of support, including the prenatal period and completion of Plans of Care for pregnant individuals using substances. Families have access to appropriate supports that meet their needs regardless of where they live or how they identify.

Adapted from Safe Babies Court Team Logic Model https://www.zerotothree.org/document/1575

Systems Map

Attachment 15




Legislative and Government Factors
Only industrialized country without paid parental leave (adds burden and many families have additional stressors: poverty, trauma, racial injustice)
Budgeted through general funds overall (initially a grant) – working on more diverse funding now
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) only about 25 now are CADCs
External Entity Factors
Institutional Bias: some hospitals UA all mothers at delivery, some only those who self-report or are suspected (leaves some families not getting help they need)
Statewide service gap re: respite services (an important informal and formal support in prevention of more restrictive measures later on)
Nurse Family Partnership exists but may not be readily available, accessible / also 4-D resource (used to exist but not funded now)
Contract providers focus and frequency (often virtual since covid) of visits limited helpfulness to ongoing assessment. Long waiting lists too and hinder desire to refer.
9 Tribes in Oregon – intensive wrap services available; community responsive to need for Narcan (possible unused resource for those outside service area, even tribal people outside of tribal community); resource largely unknown to caseworkers
State/ Central Office Factors
Newborn safety/ care may not be addressed in Essential Elements
Work in Progress: availability of Parent Partners and ability for them to make home visits with caseworkers
Work in Progress: Nurture Oregon: getting parents connected to treatment resources / meet concrete needs (could build respite into this? Funding is for concrete resources.)
Release of Information/Full Service Referral Process: In some areas must happen in subsequent visits and not at initial response – but earliest engagement is so critical to helping(may be improved with more legal consultation / used to not be this way / verbal consent may be sufficient)
Clinicians (SSS1: 25 DHS employees) on staff in the counties not all trained clinicans and have multiple roles (sometime take cases to help with vacancies) and not always available to be present with families and caseworkers in the field
ART and Mentor resources are not centrally managed so there is local variability in number and scope. Caseworkers may believe more case mgmt is needed but not think they have the time (workload pressures).
Local Office and Team Factors
Lane County put together a safe sleep training and discussed intersectionality with substance use, but it had been a training gap statewide. New CW training and accompanying procedure has been widely implemented but continued reinforcement is needed. Need to not "demonize" practice of bed-sharing and consider cultural implications; willingness to accept and coach "safer" sleep practice
Existing specialists are fully utilized but overwhelmed; the program has not grown enough to meet the need. For example, some families never get to hear from a Peer Mentor and their lived experience; many only do once circumstances are extreme and/or children removed. Also, accessing Peer Mentors post-initial response means DHS loses an opportunity most ripe for positive change.
Professional and Family Factors
Newer caseworkers (less than 3 years experience, not a parent themselves) knowledge gap re: what is safe infant (especially newborn) care, when is sleeping through the night "normal" or healthy, appropriate weight gain, relevance of maternal tobacco smoking to SUIDS, importance of respite plan / need to coach non-judgmentally with parents / need to understand how important peer mentors are to recovery and healing
Caseworkers missing proactive opportunity to help: stress of parenting newborn could trigger relapse or increase severity of substance use. Caseworkers need to understand how pivotal their presence is – how much power their support represents to families.
Improvement Opportunity
Parental substance use alongside specifically infant safety was not assessed
ART/FIT services, Outreach, Parent Mentors were underutilized.

ODHS-CW CHILD FATALITY PREVENTION & REVIEW PROGRAM

Oregon Safe Systems Mapping - Spring 2021

Overview

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

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

Improvement Opportunities

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

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

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

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

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

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

Mapping Process and Results

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

Recommendations

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

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

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

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

ART/FIT ODHS Child Welfare Positions

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

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

ART/FIT Contracted Services

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

Access to Services

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

2. Develop comprehensive SUD case practice guidelines

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

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

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

4. Develop statewide staffing guidance for infant cases

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

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

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

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

6. Actively promote partnership with local prevention organizations

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

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

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

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

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

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

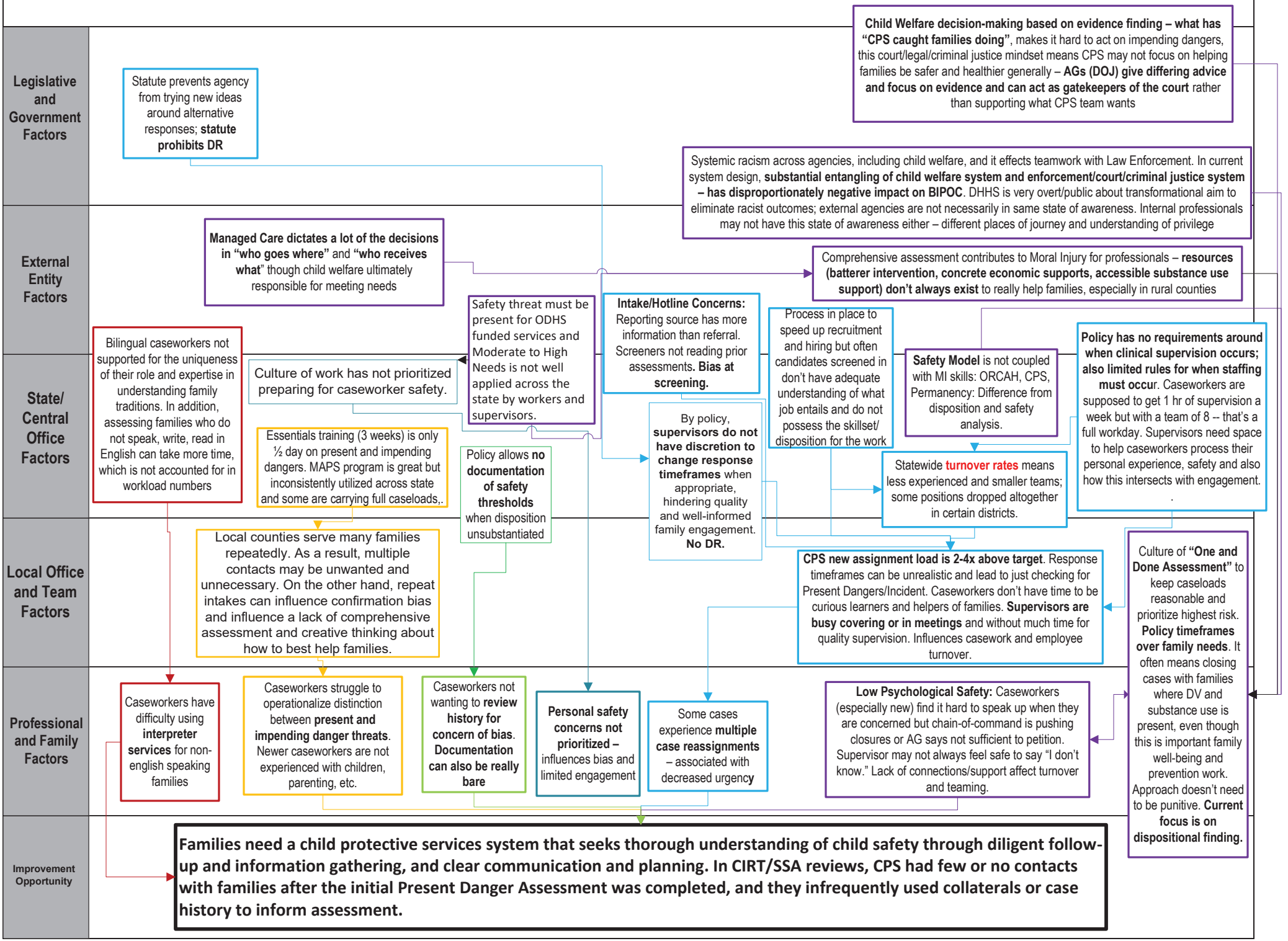
Child welfare professionals are tasked with the responsibility of knowing a lot of information about a lot of different topics, which can take years to acquire, sometimes changes, and can be difficult to apply in the moment. That is why the development of a smart phone application, which would provide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

Conclusion

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

Transforming Assessment Practice to Meet Families Needs and Child Safety: How Do We Think Boldly and Creatively about Assessment?

Attachment 17



TeamFirst

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

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)

- 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.

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.

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

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:

- 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.

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

- 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

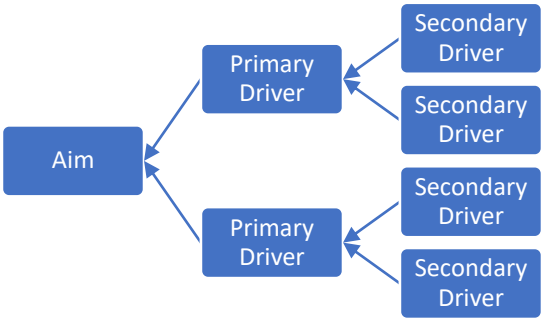
- **Plan:** Identify a strategy or idea you want to test. Think about what it would look like if you just tried it out with one child, one family, one colleague, etc. Remember you are not trying to figure everything out at once, nor do you want to spend time trying to figure out how to make it work for 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.

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.



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.

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?

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

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."*

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.

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.

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

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.

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)

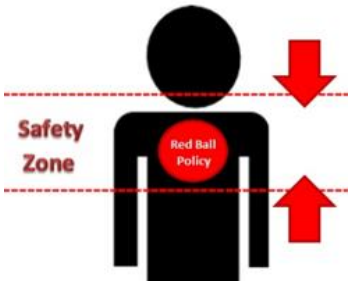
  2)

  3)

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

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

State Child Fatality Prevention and Review Team Charter

Mission

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

Statutory Authority

ORS 418.748 states:

"The Oregon Health Authority, in collaboration with the Department of Human Services, shall form a statewide interdisciplinary team to meet twice a year to review child fatality cases where child abuse or suicide is suspected, identify trends, make recommendations, and take actions involving statewide issues.

The statewide interdisciplinary team may recommend specific cases to a child fatality review team for its review under ORS 418.785.

The statewide interdisciplinary team shall provide recommendations to child fatality review teams in the development of protocols. The recommendations shall address investigation, training, case selection and fatality review of child deaths, including but not limited to child abuse and youth suicide cases."

Purpose

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

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

Objectives

1. Support accurate identification and uniform reporting of the cause and manner of child fatalities.
2. Promote cooperation, collaboration, and communication across the child and family serving system and enhance coordination of efforts.
3. Quality, equitable investigation of child fatalities consistent with national standards.
4. Design and implement cooperative, standardized protocols for the review of child fatalities.
5. Ensure accurate, complete, and timely data entry in the National fatality Review - Case Reporting System.

6. Identify needed changes in legislation, policy, and practices, and recommend expanded efforts in child health and safety to prevent child fatalities.

Background

Oregon's State Child Fatality Prevention and Review Team (state team) is an interdisciplinary team. The state team exists within a larger child fatality response system comprised of professionals working to understand and prevent unexpected child death in Oregon and across the nation. The state team is charged with supporting county child fatality review teams (county teams) and collecting and analyzing child fatality information to support local and statewide prevention efforts.

Oregon revised statute (ORS) established the state team was established in 1989, county teams in 1991 and the state technical assistance team in 1995. The technical assistance team provides supports both the state and county teams and is housed in the Injury and Violence Prevention Program in Oregon Health Authority's Public Health division.

Guiding Principles

Equity

The state team acknowledges that generations-long social, economic, and environmental inequities result in adverse health outcomes. Systematic oppressions affect communities differently and have a greater influence on health outcomes than either individual choices or one's ability to access health care. Some of the reviewed child deaths are not the result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds can also contribute to a child's death. When reviewing individual cases and interpreting the data, it is critical not to lose sight of these systemic, avoidable, and unjust factors. These factors perpetuate the inequities that we observe in child deaths across populations in Oregon. It is critical that our state's data systems identify and understand the life-long inequities that persist across groups to eradicate them. Reducing health disparities through policies, practices, and organizational systems can help improve opportunities for all Oregonians.

As an interdisciplinary team the state team commits to the following continued actions:

- Review and support review of all fatality cases from a health equity lens and commit to engage in the difficult discussions that may arise. Structural racism, interpersonal racism, and discrimination will be noted as findings.
- Improve diversity in child fatality review and prevention processes.
- Evaluate our own biases and prejudices and engage in ongoing equity trainings.

Trauma Awareness

The death of any child is a tragedy. The state team seeks to honor the trauma that results from the death of a child for the family and the community through all the activity and output of the team. As part of the work of the state team, the team will mindfully consider and seek to improve (1) how systems are, or are not, addressing the trauma of child death and (2) the supports available to caregivers and community members in managing trauma related to child death.

The state team also recognizes the impact that participation in child fatality reviews has on the emotional wellbeing of team members. To remain trauma aware and responsive, the team will continue to take steps to support wellness of team members, which may include:

- Training opportunities regarding trauma awareness and responding to secondary trauma.
- Taking intentional breaks during team meetings to engage in activities which support managing the impact of exposure to traumatic material.
- Actively working to create a safe culture focused on learning not judgment that encourages open communication and emotional support among team members.

Health

The state team recognizes that social determinants of health, including but not limited to poverty, food insecurity, housing instability, a lack of access to medical care, parental educational status, and systemic racism play a role in child fatalities in Oregon. The state team commits to bringing social determinants of health to the forefront of team discussions and recommendations.

Safety

The state team values open communication, curiosity, continuous learning and improvement, and each team member's perspective, professional knowledge, lived experience, and expertise. The state team seeks to create an environment and culture that is blame and shame free, where mistakes are opportunities for improvement, and individual accountability is balanced with systems accountability.

While disagreements between members are sometimes unavoidable, if navigated with care, they may help the team to function effectively and support quality work. It is the responsibility of the co-chairs to support and foster productive exchanges and dialogue between team members.

Confidentiality

State team members will sign and return a statement of confidentiality. Members will periodically be asked to provide a new signed statement.

The state technical assistance team will obtain and maintain the confidentiality agreements, ensuring no individual attends the state team meeting without a signed and returned confidentiality agreement. State team guests are required to complete a statement of confidentiality prior to participation in meetings.

Organizational Structure

The state team acts as the center of the child fatality review system in Oregon. This includes serving as support and oversight for the network of Oregon's county child fatality review teams.

While the state team's effectiveness depends on its membership forming a statewide interdisciplinary team, ORS 418.748 provides responsibility for the state team to the Oregon Heath Authority and Oregon Department of Human Services. As a result, co-chair positions are assigned to representatives of Oregon Health Authority and Oregon Department of Human Services. Co-chairs hold additional duties than those of other team members as outlined in team roles and responsibilities.

The state technical assistance team as outlined in ORS 418.706, provides staff support for the state team and technical assistance to the county teams.

Decision Making Process

The state team uses a consensus-based decision-making model where the co-chairs identify decision making junctures, encourage open dialogue, and facilitate the decision-making process. Should the team fail to reach consensus, all members are provided an opportunity to provide feedback to the co-chairs, who weigh information and come to a final decision on behalf of the team.

Membership

Recruitment

The state team commits to ongoing recruitment of team members and seeks the support of active members in identifying and recruiting individuals who may bring value to the work of the team through their professional associations, personal experience, and expertise with a focus on team diversity and representation.

Onboarding

When a new team member is identified, the co-chairs will initiate the onboarding process with the assistance of the state technical assistance team. State team onboarding activities include but are not limited to:

- Dissemination of orientation materials to include team charter, recent annual reports, meeting minutes for two prior meetings, the National Center for Child Death Review Program Manual for Child Death Review, and a link to the Oregon child fatality review and prevention website.
- An initial onboarding virtual meeting with one or both co-chairs to discuss team member roles and responsibilities including active participation requirements, associated time commitment, and the onboarding timeline. If the onboarding member is replacing an existing member, the existing member will also participate.
- Co-chairs will create and send an email to the state team introducing the onboarding member.

- Observing a state team and county team meeting prior to team membership, whenever possible.
- Completion of a voluntary diversity questionnaire.
- A post- meeting check in between the co-chairs and the onboarding member after the onboarding member's first state team meeting.

Roles and Responsibilities

The state team is comprised of individuals who hold one of three roles: co-chair, core team member or designee, and state technical assistance team member. Roles and responsibilities may shift over time and with agreement of the team member and co-chairs. However, all members regardless of role share the following responsibilities:

- Review and abide by the state team charter
- Actively uphold the guiding principles, mission, and purpose of the state team
- Actively and consistently engage with the team during state team meetings
- Adequately prepare for state team meetings by completing necessary activities, such as document review, research, communication with county child fatality review programs, completion of action items from prior meeting, or any other work required to support state team efforts
- Share information openly and honestly within the state team
- Make efforts to share information with and from others in represented role
- Protect the confidentiality of information shared as part of state team work by not sharing identifying information of the family and any law enforcement, health care, child protective services, or other protected information with anyone outside the child fatality review process.
- Use respectful, strengths-based, person-centered language when discussing children and families whose experience is shared through the child fatality review process, as well as when conversing with other team members. This includes the ongoing critical self-reflection necessary for the recognition of team members' individual biases and privileges.
- Understand that team membership is a long-term commitment with an associated workload and time commitment.
- Continuously work to strengthen relationships and improve communication with county child fatality review teams.

Schedule

State team meetings will occur at least quarterly for half day meetings.

Hybrid (In person vs Virtual)

To ensure inclusivity and access to statewide experts, the state team will be held virtually for the foreseeable future. The co-chairs will communicate any change in meeting format.

Designees

Effective child fatality review requires a variety of perspectives. As such, state team members are asked to identify a designee should they be unable to attend a team meeting. When a designee can't be identified, it is the member's responsibility to ensure alternative means for contributing to the agenda

items. Communication from the member to co-chairs informing of the need for a designee should occur at least one week prior to the beginning of a team meeting, when possible. Team members may also choose to provide the co-chairs a letter authorizing an individual to serve as a permanent designee.

Representation

State team will include representation of the following professions through core membership. A representative's ability to impact statewide change supports the commitment to policy and system improvement. When a permanent designee is assigned, the designee may represent a local connection to the work but will maintain a statewide connection through the member.

- Insert list here

Diversity and Representation

The state team is committed to diversity among team members and utilizes a voluntary diversity questionnaire as an assessment tool to inform recruitment efforts. The state team will continue to utilize this tool annually or as needed to fulfill the goal of ongoing reflection and growth toward creating a diverse team that represents perspectives and lived experiences of the Oregonians served by the broader child and family system.

The state team recognizes the sovereignty of Oregon Tribal Nations and continues to seek out opportunities to engage tribes in child fatality review and prevention efforts in a manner determined by the Oregon Tribal Nations.

Training

Team members are encouraged to participate in and share learnings from training offered through their parent agency. When training relevant to child fatality review and prevention is available, the training information will be shared with the team.

Exiting the Team

It is expected that any team member exiting the team will participate in an offboarding process as follows:

- Whenever possible, if a team members become aware of their need to exit the team, they will communicate this to the co-chairs prior to their final meeting.
- The co-chairs provide an opportunity to receive feedback from the exiting team member.
- The exiting team member will work with the co-chairs to identify a possible replacement.
- When a replacement has been approved, the exiting team member will work with the co-chairs to develop a transition plan to support onboarding of a replacement. The transition plan will include:
    - Conversation regarding team responsibilities and time commitments will occur between the co-chairs and the exiting and onboarding team members.

- Determination of when the transition between exiting and onboarding team members will occur.
- Communication will occur with any counties assigned to the exiting team member to inform them of the change.
- A co-chair will conduct the exit interview with the exiting team member to gather information to support overall program improvement.
- Co-chairs will ensure the exiting member is removed from future communications and that the exiting member has disposed of all state team review materials or information not relevant to their job duties at their parent agency.

Guests/Interns

Periodically, the state may consider inviting guests to participate in or present at a state team meeting. Guests may include individuals with a particular expertise, case specific knowledge or those for whom the experience would provide educational or professional development. Guests at state team meetings will be oriented to the team's purpose and guiding principles and must complete a statement of confidentiality prior to participation.

Accessibility

The state team is committed to ensuring the accessibility needs of team members and guests are met during team meetings and with team communication and team work product. Prior to meetings members and guests will be asked what can be done to make participation easier. Actions taken may include but are not limited to:

- Including an accommodation statement in meeting invitations
- Holding meetings via a virtual platform that will provide a variety of means of participation including audio and visual as well as dial-in via a conference from a conference phone number
- Co-chairs will monitor the chat box, read aloud the author and questions/comments to be addressed and offer use of the chat box as an alternative method of communication during meetings.
- Providing captioning or live sign language or translation services as needed
- Distributing communication and work product in a minimum of 14-point font

Case Review

Selection

While review of individual child fatalities occur at the county level, the state team may conduct a formal child fatality review in the following circumstances:

- A county is requesting assistance in reviewing a fatality due to insufficient resources to conduct a review.
- When the co-chairs determine an additional review is necessary to understand system improvement opportunities.

- When the co-chairs determine the review will serve as a learning opportunity for state team members.

To ensure access to a review, the state team will prioritize requests for review from counties with insufficient resources to conduct their own.

Scope

Child fatalities which come under the purview of the state team include unexpected deaths of individuals under the age of 18 years including fatalities as the result of maltreatment, suicide, or unexpected injury. Any questions or disagreements regarding the appropriateness of a child fatality review will be addressed by state team co-chairs.

How to Review

Any state team member bringing forward a fatality for team review will do the following to ensure a quality death review occurs:

- Utilize the child fatality case summary abstract and disseminate to team members at least two weeks prior to the review
- Identify individuals whose participation would provide value to the review and inform co-chairs and technical assistance team members at least 10 business days prior to the review.
- Review and utilize best practice guidelines for conducting child fatality reviews available through the National Center for Child Fatality Review and Prevention.
- Present case information with a strengths-based, person-centered discussion that seeks to identify opportunities for improvement while considering the totality of the family's experience with the broader child and family serving system and not focusing on placing blame on individuals or specific actions.

County Review Teams

Communication

Communication between county review teams and state team primarily occur through regular contact resulting from the County Support Program. This responsibility will be shared with and ultimately transfer to the state technical assistance team when sufficiently resourced.

County Support Program

State team members are strongly encouraged to participate in the critical work of supporting county child fatality review teams through the state team's County Support Program.

County Support Program Goals

- Enhance communication between the county and State fatality review teams,
- Support and encourage the county in the completion of fatality reviews,
- Increase the understanding of the purpose and value of the fatality reviews,
- Remove barriers to completing fatality reviews, and
- Ultimately, to ensure Oregon has data on child fatalities to inform prevention and intervention.

Participating members will be assigned one or more counties to provide ongoing consultation and support in the local child fatality review process. Members will be expected to contact their assigned county a minimum of twice a year.

Annual Conference

The state team will host an annual (virtual or in person) conference to enhance the work of the county teams and to offer an opportunity for networking and sharing of expertise between individuals conducting child fatality reviews within Oregon.

Website

The state team will maintain a webpage on the OHA website with child fatality review and prevention information and resources.

Data

Collection

Data collection will occur through regularly scheduled data imports from the National Fatality Review-Case Reporting System (NFR-CRS), the data system supporting Child Death Review and Fetal and Infant Mortality Review teams across the country. Collection of data through the NFR-CRS is facilitated by the state technical assistance team. The County Support Program will serve as additional means to ensure the timely and accurate entry of information into NFR-CRS by county child fatality teams.

Sharing

The state team members will engage in data sharing with other Oregon child fatality review professionals and national partners as needed to fulfill the objectives of the state team and pursuant to ORS 418.747(13).

Identify Trends

Using their unique expertise and connection with county child fatality review programs state members are responsible for identifying trends in Oregon child fatalities using available data and through discussion with county child fatality teams.

Prevention

Prevention Recommendations and Support of Statewide Prevention Efforts

A foundational purpose of the state team is the creation of child fatality prevention strategies based on data obtained during child fatality reviews occurring throughout Oregon. The state team addresses the

status of current statewide prevention efforts, identifies gaps in child fatality prevention, and develops additional plans and strategies as needed as part of the team's core work pursuant to ORS 418.748.

Engagement of County Teams in Prevention

County child fatality review teams are vital partners in the work of child fatality prevention in Oregon. The state team will make efforts to partner with county teams to identify, develop and implement prevention efforts occurring both at a local level and statewide level.

Legislation and Public Policy

The state team recognizes the limitations placed on some team members, such as their ability to participate in lobbying activities, because of their employment with a parent agency. Team co-chairs along with impacted team members will ensure that state team actions are not in violation of such restrictions.

Coordination with Other Reviews

The state team will continue to explore opportunities to coordinate child fatality reviews with county child fatality review teams and fatality reviews occurring as part of the Child Fatality Prevention and Review program within ODHS Child Welfare.

Additionally, the state team will make efforts to engage and learn from other fatality review in Oregon, including but not limited to domestic violence, sex trafficking, overdose, suicide, firearm, and maternal mortality and morbidity review.

Outputs

Annual Report

The state team publishes an annual report regarding child fatality reviews conducted in Oregon. This report focuses on child fatality reviews known to the state team that occurred during the prior calendar year and is issued no later than 6 months after the end of the year. The annual report is provided to the governor's office, ODHS and OHA leadership as well as published on the Oregon fatality review and prevention website. The report contains but is not limited to the following:

- The number of known child fatalities for the applicable year.
- The manner and/or cause of death in such fatalities.
- The age, gender, race, ethnicity, and geographic areas of children with fatalities for the applicable year.
- Identified local and statewide trends.
- The status of local and statewide prevention efforts stemming from current and previous annual reports.

Resource and System Improvement Plan

Below is a list of resources and system improvements developed by the State Child Fatality Review Team (state team) to address the needs identified by Oregon's county child fatality review teams (county teams) through participation in the county team needs assessment.

I. Resources

Resource	Goal date	Done
Onboarding packet for new county team members	Summer 2022	
Procedural guide for preparing for and conducting child fatality review	Summer 2022	
Model job and task descriptions for CFR Lead and CFR Coordinator	Summer 2022	
Information sharing and confidentiality quality practices and tools	Fall 2022	
Training in multiple modalities	Spring 2023	
Trauma informed fatality review tools, training, and support	Fall 2022	
Equitable fatality review tools, training, and support	Fall 2022	
Resources to support prevention efforts identified most by county teams	Fall 2022	
Opportunities for county team members to observe other county reviews	Summer 2022	
Opportunities to participate in state team meetings	Summer 2022	
Virtual one-on-one or group support for county team members	Winter 2022	
State team contact assigned to each county team to provide support		X

II. System enhancements

Enhancement	Goal date	Done
Re-develop OHA hosted Child Fatality Review website to be a comprehensive resource hub for Oregon child death review,	Summer 2022	

including connecting to National Center for Child Fatality Review and Prevention resources.		
Implement onboarding process for new team leads and coordinators.	Summer 2022	
Improve the data import from the State of Oregon Vital Statistics to the National Fatality Review Case Reporting System.	Summer 2022	
Increase frequency of notifications to county teams regarding cases needing review.	Summer 2022	
Make current contact list of county team leads and coordinators to county team leads accessible to county teams.	Summer 2022	
Set up role specific peer groups for (1) leads and coordinators and (2) based on team member professional role to: ○ share information about roles and responsibilities across counties ○ support onboarding of new members ○ provide peer support	Fall 2022	
Encourage and support county teams to convene regular meetings outside of case review to provide opportunities for learning, information sharing, and communication.	Fall 2022	
Improve collaboration with and access to state level experts for consultation and support such as suicide, sleep related infant death, and overdose experts.	Summer 2022	
Host annual statewide convening of county teams.	2024	
Form implementation team comprised of community members and legislators for the purpose of implementing statewide improvement opportunities and prevention recommendations.	Determine need for legislative change	
Revise focus of state team to providing support to county teams, using county team death review data to identify patterns and opportunities for reducing child fatalities statewide, and providing information and recommendations to the implementation team. Clarify the state team's role in Oregon's child death review and prevention system through creation of a state team charter.	Summer 2022	

2021

Youth Suicide Intervention and Prevention Plan Annual Report

Oregon Health Authority
PUBLIC HEALTH DIVISION
HEALTH SYSTEMS DIVISION

Contents

Executive summary

Oregon made significant progress in 2021 in youth suicide prevention. This progress included:

- Developing a suicide prevention framework (pg 4)
- Publishing an updated five year plan for youth suicide prevention, and
- Starting the work outlined in the YSIPP 21–22 initiatives.

Preliminary data in Oregon indicate the following:

- For youth age 17 and under, suicide numbers decreased in 2021 compared to 2020.
- For youth age 18–24, suicide numbers in 2021 were similar to 2020.
- Suicide numbers decreased overall for youth age 24 and under in 2021 compared to 2020.

This is the first time since 2001 that Oregon has had a three year decrease in youth suicide fatalities (24 and under). While this is positive news, it is important to note that some counties in Oregon did not see this overall decrease in youth suicide in 2021 and Oregon remains above the national average for youth suicide rates. This good news is also wrapped in the context of big challenges for so many in Oregon. There is so much more to do to create safety for our children and young people. The suicide prevention team at OHA and our partners across the state will remain earnestly focused on this work.

In 2019, the legislature invested in dedicated funding for youth suicide prevention activities. This is called "Big River" programming. These activities launched throughout 2020 and continued to grow in 2021, despite the challenges COVID-19 presented. Big River programming is offered statewide. It includes a statewide coordinator for each Big River program and support for train-the-trainer events. This combination allows for locally-delivered suicide prevention programs with robust human and funding support from the state. Of course, these activities cannot thrive without being delivered by local communities. This report includes a summary of the progress Big River programming achieved in 2021.

Training and programing are only one piece of Oregon's suicide prevention strategy. OHA's suicide prevention coordinators have worked closely with the evaluation team at University of Oregon and the advocates who serve on the Oregon Alliance to Prevent Suicide to develop a framework for suicide prevention. This framework outlines the work that Oregon needs to do over the next five years to continue in the direction we have started. It includes centering equity and the voices of those with lived experience. It includes being grounded in good policy, informed by rich data and evaluation, and delivering services in a trauma-informed and culturally-responsive way. This report outlines progress on the YSIPP 21–22 priority initiatives as well as several data sets.

OHA suicide prevention team

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Health Systems Division, Children and Family Behavioral Health

Shanda Hochstetler, Youth Suicide Prevention Program Coordinator

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Health Systems Division, Children and Family Behavioral Health

Vacant Position, Garrett Lee Smith Grant Coordinator

(To be filled in spring 2022)

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Public Health Division, Injury and Violence Prevention Program

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Health Systems Division, Adult Behavioral Health Unit

Oregon Suicide Prevention Framework

The Oregon Suicide Prevention Framework is a big part of this plan. OHA developed this framework with the University of Oregon Suicide Prevention Lab under the leadership of Dr. John Seeley. It is grounded in the National Strategy for Suicide Prevention and the CDC Technical Package for Suicide Prevention. The framework was also informed by the San Diego Suicide Prevention Plan and hundreds of pieces of feedback from collaborators and partners across Oregon.

The format of this report looks different than previous annual reports for the YSIPP 2016–2020. It is built upon the new state framework for suicide prevention, which includes the following:

Strategic pillars, strategic goals, centering values and foundation — These will not change over the five-year lifespan of the plan. They are the starting point for all suicide prevention work in Oregon.

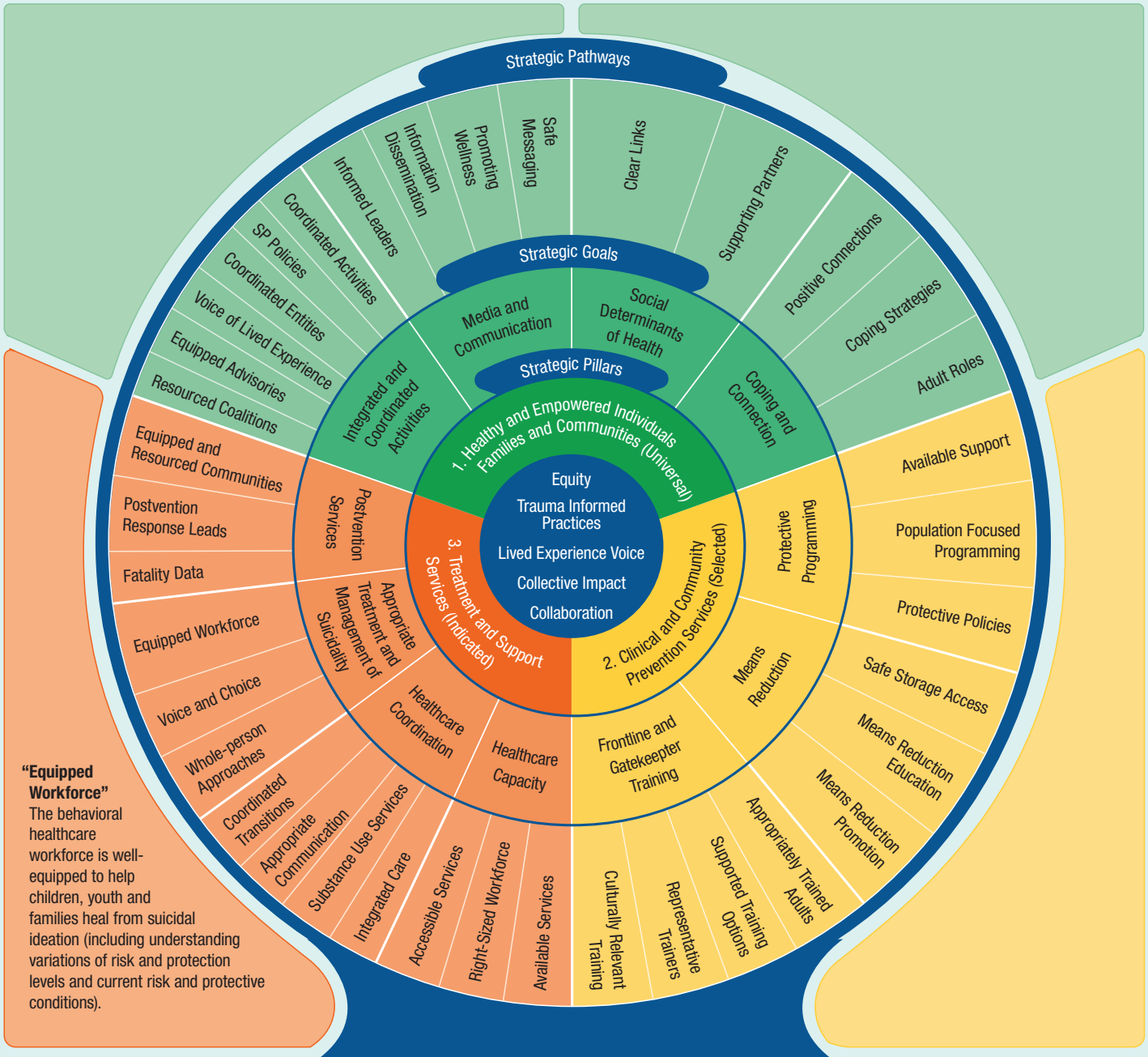
Strategic pathways — These are not likely to change over five years and are rooted in the centering values and foundation. They represent measurable areas of focus and are more specific to populations or settings. For example, under the goal of "means reduction," one pathway is "All Oregonians experiencing behavioral health problems will have access to safe storage of lethal means."

Strategic priority initiatives — These will be adapted, adjusted and added to annually. They are specific actions designed to support the broader pathways and goals. For example, a strategic priority initiative for 21–22 is "Every local mental health authority will receive information on the availability of low or no cost medicine lock boxes and gun safes through the Association of Oregon Community Mental Health Programs (AOCMHP) by Dec. 15, 2021."

Building on the framework strategic pillars and goals, the youth-focused strategic pathways and strategic priority initiatives outline the state plan for addressing youth suicide. This report covers the progress on these strategic priority initiatives. The strategic priority initiatives will be adjusted, refined and added to each year. These changes will be made in response to ongoing evaluation and in collaboration with the Oregon Alliance to Prevent Suicide (the OHA advisory body for youth suicide prevention).

The strategic pathways and strategic priority initiatives together make up the five-year YSIPP. The strategic goals, strategic pillars, center and base are the foundation on which the five-year YSIPP is built.

Youth Suicide Prevention Framework



"Equipped Workforce"
The behavioral healthcare workforce is well-equipped to help children, youth and families heal from suicidal ideation (including understanding variations of risk and protection levels and current risk and protective conditions).

PUBLIC HEALTH DIVISION
HEALTH SYSTEMS DIVISION
SUICIDE PREVENTION TEAM

Oregon Health Authority

You can get this document in other languages, large print, braille or a format you prefer. Contact Children and Family Behavioral Health at 971-719-0265 or email chelsea.holcomb@dhaoha.state.or.us. We accept all relay calls or you can dial 711.

OHA 3636B (9/9/2021)

The Big River programming summary

The suicide prevention team developed an interactive map of Big River Programming options. The programs listed below are supported by OHA's suicide prevention team with contracted statewide coordination, hosted learning collaboratives and with train-the-trainer support when applicable. Before 2019, OHA had limited support for some of these program options. While each program has a slightly different structure, all of Oregon's Big River programs worked diligently to keep trainings accessible during the COVID-19 pandemic.

Table 1: Advanced skills training for providers 2021

Training name	Number of providers trained	Number of counties with providers trained
Cognitive Behavioral Ther-apy (CBT)	113	20
Dialectical Behavioral Therapy (DBT) - Skills and Suicide Prevention	196	26
Collaborative Assessment and Management of Sui-cidality (CAMS)	83	6
Attachment Based Family Therapy (ABFT)	122	17
Assessment and Manage-ment of Suicide Risk (AMSR)	30	7
Totals:	544	31 (unique county count)

Table 2: Big River implementation 2021

Program name	Trainers statewide	New trainers in 2021	Number of counties with trainers	Available in Spanish
Sources of Strength: Elementary grades 3–6	83	83	17	Coming fall 2022
Sources of Strength: Middle, high, college	115	29	23	Coming fall 2022
Mental Health First Aid	100 active (virtual only in 2021)	85	33	Yes
QPR (Question, Persuade, Refer)	775	139	33	Yes
ASIST (Applied Suicide Intervention Skills Training)	109	10 (Livingworks did not provide a virtual training option)	23	No
Youth SAVE (Suicide Assessment in Virtual Environments)	38	38	17	No
Oregon CALM (Counseling on Access to Lethal Means)	3 lead trainers	3	3	No
Connect: Postvention (Oregon Adap-tation)	34 trainers 4 lead trainers	4 lead trainers (able to train other trainers)	12	No
Total:	1,257	391	33 (all 36 counties are served by trainers regardless of residency)	2

2021

Big River Programs

A brief look at the numbers for Suicide Prevention programming in Oregon.

Local Communities Equipped

33 of Oregon's 36 counties have active trainers in one or more of the Big River programs.

1,257

Trainers in Oregon

There are currently 1,257 trainers across the eight Big River programs that have Train-the-Trainer structures. The Big River programs collectively added 391 new trainers in 2021 to this total.

Mental Health Providers

The Big River added "Advanced Skills" training options for mental health providers to get trained in how to treat suicide ideation within their practice. In 2021 alone, 544 providers in Oregon received training across the five training course options supported by OHA.

Community Centered & Culturally Responsive Adaptions

7 of the 8 Big River programs have community centered or culturally responsive elements embedded. 2 of the 8 are available in Spanish and 2 more will launch Spanish options in 2022. Work continues to improve this area.

7 of 8

Oregon Tribes

Each of Oregon's nine federally recognized tribes and NARA Northwest receive funding and support for suicide prevention directed by the tribes.

For more information about Big River programs click here.

Youth suicide prevention funding

The Health Systems Division (HSD) Child and Family Behavioral Health (CFBH) unit's budget for suicide prevention in 2021 was about $5 million.

The Public Health Division (PHD) Injury and Violence Prevention Program (IVPP) manages several federal grants that contribute to YSIPP efforts. These are delivered through the Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Disease Control and Prevention (CDC). IVPP staff and staff carrying out the YSIPP sit on the OHA suicide prevention team. They coordinate across state and federal funding streams to meet both grant and YSIPP goals. These grants include the following.

SAMHSA Garrett Lee Smith Memorial Act (Oregon GLS): OHA received a new round of GLSMA funding for June 2019 through June 2024. Oregon receives $736,000 a year through this grant mechanism. This funding supports suicide prevention capacity grants in select Oregon counties and Oregon Department of Human Services. It also supports community and clinical training to reduce suicides of youth 10–24 years old. The YSIPP 21–22 Initiatives progress report includes grant accomplishment highlights.

SAMHSA Zero Suicide in Health Systems Grant: OHA received this new funding stream for September 2020 through August 2025. Oregon received $700,000 a year through this grant mechanism. This grant supports OHA working with Oregon health systems to provide safer specific suicide care for adults age 25 and over using a nationally recognized model, Zero Suicide. This new grant has allowed IVPP to hire a dedicated Zero Suicide in Health Systems Coordinator to develop a Zero Suicide program. While the new grant is focused on reducing suicide risk for adults 25 and older, the position will support existing Oregon Zero Suicide work in health systems focused on youth populations. It will also expand learning and training opportunities for all health systems using Zero Suicide, including youth-focused initiatives. The Zero Suicide in Health Systems Coordinator sits on the Alliance's Transitions of Care Committee to ensure coordination across programs. While grant activities have been held back by the pandemic, work was able to proceed in 2021. Grant accomplishments include:

- Forming a Zero Suicide Advisory Committee with a broad range of partners, including:
  - Health care systems
  - Providers
  - Representatives from systems using the Zero Suicide model, and
  - Individuals with suicide loss and attempt experience.

- Completing an online Statewide Needs Assessment survey to gather information on existing Zero Suicide efforts.
- Developing a Request for Proposal to provide funding to an Oregon health system to support and enhance their implementation of Zero Suicide efforts. Community Counseling Solutions serving Gilliam, Grant, Morrow, Umatilla and Wheeler counties has been awarded funding for three years.
- Providing a Zero Suicide breakout session at the 2021 Oregon Suicide Prevention Conference. OHA will also host the 2-day Zero Suicide Academy for Oregon health systems with the national Zero Suicide Institute in March 2022.

CDC Emergency Department Surveillance of Nonfatal Suicide-Related Outcomes (ED-SNSRO): OHA was one of ten states to receive this funding for September 2019 through August 2022. This grant (just under $147,000 per year) provides support to:

- Develop tracking of suicide attempt and self-harm data
- Report data to partners, and
- Use data to inform suicide prevention activities.

As part of these grant activities, IVPP continues to provide a monthly report on emergency department and urgent care center visits for suicide attempts and suicidal ideation and suicide-related calls to the Oregon Poison Center.

This information comes from Oregon Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) data. The report, *Suicide-related Public Health Surveillance Update,* is provided to the public monthly and has been updated based on partner feedback. More than 1,700 emails are subscribed the report.

This grant also allows Local Public Health Authorities to access ESSENCE data. OHA has supported several requests on local monitoring and content questions. OHA has been working on a public-facing dashboard to provide statewide data. It plans to launch the dashboard in 2022.

CDC Firearm Injury Surveillance Through Emergency Rooms (FASTER): OHA received this new funding stream for September 2020 through August 2023. It provides $225,000 in year one and $180,000 in year two. This grant provides funding for OHA PHD to partner with the Oregon Health & Science University-Portland State University School of Public Health (OHSU-PSU SPH) to demonstrate the feasibility of monitoring and gathering data on nonfatal firearm injuries, including suicide attempts and self-harm. Data on firearm injury in Oregon would allow the state to design ways to reduce injury and inform prevention efforts. Grant activities in 2021 include:

- Creating, validating and monitoring the quality of indicator syndrome definitions, and
- Starting to engage partners to identify data elements to include in data reports.

Progress report on YSIPP 21–22 initiatives

This section describes the progress and status of each of the YSIPP 21–22 priority initiatives at the time of this report. Current progress and status updates are maintained here. The OHA suicide prevention team and the Oregon Alliance to Prevent Suicide will update and publish YSIPP priority initiatives for 2023 in late 2022.

1. Healthy & Empowered Individuals, Families and Communities

1.1 Integrated & Coordinated Activities

1.1.1 "Coordinated Activities" Youth suicide prevention programming is coordinated between Tribes, state, county, and local leaders to maximize reach & ensure equitable access for all Oregonians.

1.1.1.1 New Strategic Initiative for 21/22: Organize the people/staff/infrastructure of suicide prevention across the state.

Early Action

The OHA Suicide Prevention team has assigned lead responsibility for each initiative in the YSIPP 21–22. It has also assigned leads to each committee and advisory group of the Alliance to Prevent Suicide. The Alliance to Prevent Suicide staff has been tasked with updating the contact information for the 18 local suicide prevention coalitions across Oregon. Focus of work in 2022 will include updating suicide prevention staff information for counties, school districts, Tribal health departments, Zero Suicide programs in health settings and for staff that support suicide prevention in relevant state agencies.

1.1.1.2 Big River statewide coordinators meet monthly to align work, give program updates, connect and learn.

Achieved

Big River Coordinators meet monthly, are connected, regularly have warm handoffs between programs, can speak with clarity about the Big River programs and about the system. They are learning from each other and tackling issues and barriers as a team.

1.1.1.3 Big River statewide coordinators are equipped to bridge interested organizations and people to related suicide prevention work including other Big River programs and statewide suicide prevention efforts.

In Progress

Big River collaboration meetings include updates from programs. Big River coordinators are provided with tools to connect to other programs.

1.1.1.4 The OHA Suicide Prevention, Intervention and Prevention team (SPIP) is established and each subgroup meets monthly. The four subgroups are: OHA Suicide Prevention Coordinators, OHA Partners (Youth Focused), State Agency Partners (Youth Focused), and OHA Partners (Adult Focused).

In Progress

Partners meet monthly in each of the listed categories to align work and provide support.

1.1.1.5 Fall coordination meetings between contracted coordinators and specialists supporting Adi's Act implementation, Oregon Department of Education (ODE), and OHA coordinators are scheduled with each Educational Service District.

Planning

There was a delay in Inter-Agency Agreement between ODE and OHA. There is a large group meeting scheduled for February and individual coordination meetings are planned for later in spring.

1.1.1.6 Garrett Lee Smith Memorial Act grant recipients have staff for suicide prevention (Multnomah, Lane and Deschutes counties).

In Progress

OHA received a new round of GLSMA funding for June 2019 through June 2024. Gatekeeper training has been implemented to increase the number of persons in youthserving organizations trained to identify and refer youth at risk. From the start of grant activities in June 2019–Dec. 2021, over 3,500 individuals have been trained.

1.1.1.7 The Oregon Alliance to Prevent Suicide (The Alliance) will organize committees, advisory groups, and workgroups to align with YSIPP 2021–2025.

Early Action

Alliance staff met with committee and advisory group chairs to review YSIPP 21–22 initiatives assigned to their specific group. It was decided that no focus changes needed to be made at this time to align with current initiatives. Alliance leadership is also meeting regularly to discuss infrastructure of the Alliance as a whole.

1.1.1.8 Big River statewide coordinators will make local training data available to local leaders including a "heatmap" of Big River trainers.

Early Action

The Big River program map is widely distributed and is clickable to reach the programs. The first action step will be to ensure data is available online. Data is online for QPR, Sources of Strength, Youth-SAVE and MHFA. This is in progress for Connect: Postvention, Oregon CALM, and ASIST. Focus of work in 2022: Provide data to local leaders and compile the data in one centralized place.

1.1.2 "SP Policies" Youth serving entities have suicide prevention policies for clients and staff that are known and utilized.

1.1.2.1 Rules for SB 563 (2021) will be written through OHA's rulemaking process. The Alliance to Prevent Suicide will assign representation to participate in this process.

In Action

Oregon Administrative Rules 309-027 will go through rules revision beginning March 2022. Tribal leaders were notified of rules revision process in Jan. 2022.

1.1.3 "Coordinated Entities" Youth serving entities are coordinated and understand their role in suicide prevention.

1.1.3.1 OHA hosts a monthly meeting with state agencies to discuss Suicide Prevention initiatives and needs (called SPIP – State Agency Partners – Youth Focused). State agency representatives from Oregon Youth Authority, ODE, Oregon Department of Human Services – Self Sufficiency, Oregon Department of Human Services – Child Welfare.

Achieved

This group currently meets on the 2nd Tuesday of each month. ODHS also secured funding for a half-time suicide prevention coordinator position within the Child Welfare team in mid-2021. This position is working to meet GLS grant requirements as well as coordinating with broader OHA youth suicide prevention efforts.

1.1.3.2 OHA and The Alliance continue to build connections with youth-serving community based organizations to invite participation in the Alliance and youth suicide prevention trainings and work.

In Progress

Both entities have strong connections with a variety of youth-serving community based organizations. Focus of work for 2022: Maintain a shared contact list of staff or leaders in youth-serving community based organizations.

1.1.4 "Voice of Lived Experience" Youth and folks with lived experience have meaningful voice in Oregon's suicide prevention, including programming decisions and links to key leaders.

1.1.4.1 Stipends are provided for youth representatives and people with lived experience that are not paid to attend state advisory committees

Achieved

1.1.4.2 Youth representatives (including at least one person that has not yet reached age 18) serve on The Alliance

Planning

There are currently several vacancies for youth representatives. A youth engagement team is meeting to discuss how to better and more meaningfully engage this age group moving forward.

1.1.4.3 The Alliance will maintain youth reps on each committee and ensure the following populations are represented whenever larger feedback is gathered: member(s) 18 or younger, rural youth, racial/ethnically diverse youth, LGBTQ+ youth.

Early Action

There are currently several vacancies for youth representatives. The youth engagement team was created and submitted a proposal to the executive committee about a new youth engagement strategy. This was approved by the executive and the youth engagement team will submit a more formal proposal, along with a budget ask, to OHA.

1.1.4.4 New: OHA will require diverse youth engagement and a meaningful feedback loop in all relevant OHA suicide prevention contracts

Early Action

UO's Suicide Prevention Lab conducted a survey with the Klamath Tribes. They gathered responses from more than 150 young people to inform their Community Action Partnership. Focus of work in 2022: This requirement will be included in all suicide prevention contracts beginning July 1, 2022.

1.1.4.5 OHA will contract specifically for youth engagement and meaningful feedback including Youth and Young Adult Engagement Advisory (YYEA), focus group stipends and facilitation, including in program planning and evaluation efforts.

Early Action

This requirement will be included in all suicide prevention contracts beginning July 1, 2022.

1.1.5 "Equipped Advisories" Advisory groups are well supported, equipped, and function efficiently to make meaningful change.

1.1.5.1 The Alliance will continue to be staffed at 2.0 FTE.

Achieved

This staffing level remained sustained in 2021.

1.1.5.2 YYEA receives OHA support for .5 FTE staff.

Achieved

This staffing level remained sustained in 2021.

1.1.5.3 OHA will continue to provide coordination for the System of Care Advisory Council and the Children's System Advisory Council.

Achieved

OHA staff provided logistical support and facilitation of this advisory council throughout 2021.

1.1.6 "Resourced Coalitions" Regional Suicide Prevention Coalitions are informed and resourced to address their local needs and priorities.

1.1.6.1 The Alliance staff hosts a quarterly webinar to provide networking support for regional suicide prevention coalitions and other local suicide prevention champions.

Achieved

These meetings occurred in May, August and November 2021. Meetings continue to be held quarterly. The next one will occur February 2022. Each webinar has a different focus and allows for a coalition to share current work and challenges, and to celebrate wins. Webinars are typically attended by at least 45 people from across the state and different sectors.

1.1.6.2 The Alliance staff hosts a quarterly learning collaborative for regional suicide prevention coalition leaders.

Achieved

These are held quarterly and the group is defining their scope and priorities. The current focus is to have statewide messaging with campaigns held annually in May for Mental Health Awareness Month and September for Suicide Prevention Awareness Month. University of Oregon's Suicide Prevention Lab attends these meetings as well for support around coalition building.

1.1.6.3 Statewide resources, educational opportunities, and programming options are shared to the regional suicide prevention coalition leaders.

Achieved

This resulted in a coordinated effort during Suicide Prevention Awareness month (Sept. 2021) to create the "Don't Give Up" public awareness and positive messaging campaign. Find more information on the Alliance website.

1.2 Media & Communications

1.2.1 "Safe Messaging" All Oregonians receive safe messaging about suicide and self-injury.

1.2.1.1 American Foundation for Suicide Prevention (AFSP) and Suicide Prevention Resource Center (SPRC) national safe messaging projects are promoted on OHA's Suicide Prevention listserv and The Alliance listserv.

In Progress

Resources and projects are regularly promoted on both listservs.

1.2.2 "Promoting Wellness" Youth-serving entities routinely and strategically promote wellness, emotional strength, mutual aid examples, and protective factors.

1.2.2.1 New: OHA will maintain a statewide calendar of press releases and media events for various populations of focus

In Progress

Press releases are scheduled for March, June, September and December.

1.2.2.2 Oregon AFSP will continue social media campaigns to promote wellness and bolster protective factors.

Achieved

This occurs regularly.

1.2.2.3 Oregon Sources of Strength will continue to promote positive culture change in Oregon schools K–12 and post-secondary and will continue to grow program reach to other youth-serving spaces.

In Progress

Sources of Strength for grades K–2 to begin in Fall 2023. Sources of Strength is widely available and growing in grades 3–12 and post-secondary. It is connecting to other youth-serving spaces including ODHS Child Welfare, Independent Living Programs, Boys and Girls Clubs and several Tribal youth services.

1.2.3 "Information Dissemination" SP Programming, information and resources are widely advertised and centrally located on one website. Information is kept up-to-date.

1.2.3.1 Youth Suicide Prevention listserv messages are sent by OHA regularly with trainings, resources, conferences, and announcements pertinent to youth suicide prevention statewide.

Achieved

A message is sent out every 2–4 weeks on this listserv.

1.2.3.2 Safe + Strong Website will continue to be a reliable place to find Oregon resources and supports.

Achieved

www.safestrongoregon.org

1.2.3.3 Oregon Suicide Prevention Website will continue to develop as a place to find current information about Oregon suicide prevention work for behavioral health providers, schools, and community members.

Early Action

https://www.oregonsuicideprevention.org/

1.2.3.4 Alliance to Prevent Suicide Website will continue to make information available regarding Alliance activities, legislative work, opportunities for community members to be involved, and resources.

In Progress

https://oregonalliancetopreventsuicide.org/

1.2.3.5 OHA Public Health Division and Health Systems Division (HSD) websites will be accurate and offer updated information.

Early Action

The HSD youth suicide prevention website was updated in January 2022. Work for 2022: Update and align the Public Health Division youth suicide prevention website.

1.2.3.6 Oregon Suicide Prevention Conference will be held annually in diverse areas of Oregon and be led by a collaborative and representative advisory group.

Achieved

The Oregon Suicide Prevention Conference (OSPC) took place virtually October 11–13, 2021. The theme was "Communities Creating Stories of Hope." An effort was made to feature equity and lived experience at the event, including keynote speakers focused on the experiences of Black people, people with disabilities, veterans and youth. Nearly 190 individuals attended the conference including county-affiliated personnel, secondary school or school district personnel, clinicians, trainers, advocates and those with lived experience of suicide attempt, mental health conditions and suicide loss. Among participants that completed the conference evaluation, over 90 percent rated the overall conference as a 4 or 5 on a 5-star scale. The October 2022 conference is scheduled to take place in Ashland, Oregon. The planning advisory group, including Southern Oregon suicide prevention partners, started meeting Jan. 2022.

1.2.3.7 OHA will issue a press release related to suicide prevention quarterly.

In Progress

Press releases are scheduled for March, June, September and December.

1.2.4 "Informed Leaders" Key decision-makers are kept well informed & up-to-date about suicide activity and prevention efforts (i.e. legislators, Oregon Health Authority leaders, Oregon Department of Education leaders, county commissioners).

1.2.4.1 Within the OHA Recovery Report suicide prevention work is highlighted at least quarterly.

In Progress

The Recovery Report is not being issued at this time. Suicide Prevention has a regular monthly report in the Children and Family Behavioral Health Unit's newsletter called Holding Hope.

1.2.4.2 Annual YSIPP report is published and disseminated widely by March.

In Progress

1.2.4.3 The Alliance will schedule presentations with key lawmakers prior to each legislative session.

Early Action

There were not named Alliance to Prevention Suicide legislative priorities for the 2022 short session. No meetings occurred prior to that session. Key policy priorities for the 2023 long session will be developed. The Alliance partnered with the American Foundation for Suicide Prevention's Oregon Chapter for the 2022 virtual Capitol Days. Alliance staff and members presented during the actual event and staff met with legislators to discuss our 2023 policy options package (POP) recommendations and what we hope to advocate for in the 2023 legislative session. The virtual event was attended by 160 people.

1.3 Social Determinants of Health

1.3.1 "Clear Links" The link between economic factors and risk of suicide is highlighted outside of typical suicide prevention work.

NA

1.3.2 "Supporting Partners" Suicide prevention advocates and experts support the work of those decreasing disparities and inequities.

NA

1.4 Coping & Connection

1.4.1 "Positive Connections" All Oregonian young people have access to meaningful places and spaces to experience positive connection & promote mutual aid.

1.4.1.1 Sources of Strength programming available statewide for all students Grade 3 to postsecondary.

Achieved

This is available to any school in Oregon and use of this program is growing in grades 3–12 and post-secondary.

1.4.1.2 YouthERA, Youthline, and Oregon Family Support Network (OFSN) are available and advertised widely.

Achieved

These resources are widely advertised and continue to be available.

1.4.1.3 Statewide partners in building positive youth connections are identified and receive communication from OHA suicide prevention coordinators and the Alliance including Oregon After School & Summer Kids Network, ODHS, Oregon Foster Youth Connection, and Oregon Alliance for Safe Kids, Healthy Families, and Strong Communities.

Early Action

Significant work to identify partners in ODHS has been done. More work is needed to identify partners within the remaining listed organizations.

1.4.2 "Coping Strategies" All Oregonian youth people are taught and have access to positive/healthy coping strategies. All OR youth and young adults are taught to understand impact of potentially harmful/negative coping strategies.

1.4.2.1 Sources of Strength Elementary (grades 3–5) suicide prevention programming is available statewide.

Achieved

This is available to any school in Oregon. Fifty-five schools in 2021 implemented Sources Elementary.

1.4.2.2 New: Explore possibilities for K–2 suicide prevention programming

In Action

An elementary suicide prevention coordinator was hired in 2021 through Matchstick Consulting. More than 100 schools indicated interest in K–2 programming. Sources of Strength K–2 will be available for the 22–23 school year.

1.4.3 "Adult Roles" Youth-serving adults understand and feel equipped to fulfill their role as a trusted adult and understand their important impact on suicidality.

1.4.3.1 Sources of Strength makes Adult Advisor training available widely for youth-connected adults in areas with Sources programming.

Achieved

There are 3.0 FTE trainers available for statewide training, in person or virtual. One trainer is bilingual. New trainers were hired in August 2021. There are discussions about creating position for an additional trainer to increase capacity. Local trainers are being trained through training for trainers (T4T) and certified through a statewide program.

1.4.3.2 Mental Health First Aid has a version created for youth-serving adults and training for trainers in youth curriculum is widely available.

Achieved

YMHFA is available. YMHFA T4T is planned for 2022.

2. Clinical & Community Prevention Services

2.1 Frontline & Gatekeeper Training

2.1.1 "Appropriately Trained Adults" – Youth-serving adults (including the peer support workforce) receive the appropriate level of training for suicide prevention (basic awareness, enhanced, and/or advanced) and are retrained appropriately.

2.1.1.1 The K-12 school sector based resource called the "Suicide Prevention, Intervention, Postvention: Step By Step" will be available at no cost. This resource outlines recommendations for appropriate level of training and retraining recommendations.

Achieved

This guide is available free online at https://oregonyouthline.org/step-by-step/.

2.1.1.2 New: All OHA-funded school based mental health providers will receive recommendations and tracking tools for retraining for appropriate level of suicide prevention, intervention and postvention training.

Achieved

These tools were shared with all school-based mental health providers and are also explicitly named in the contract documents if programs request them.

2.1.1.3 New: HB 2315 Rulemaking process will include recommendations from OHA defining continuing education opportunities that are applicable and relevant to meet the suicide prevention training requirement for relicensure.

Early Action

The rules that need to be revised within OHA's authority are in the 410-180 traditional health workers rule. This legislation is scheduled to become active on July 1, 2022. The rules advisory committee has not yet been scheduled. OHA has met with each licensing board listed in this legislation to gather suggestions and concerns. A stated need for a free or very low cost online, on-demand training to meet these requirements has emerged from the traditional health workforce. A stated need to ensure high quality and meaningful suicide prevention training has emerged from the Alliance to Prevent Suicide.

2.1.2 "Supported Training Options" – Suicide prevention frontline and gatekeeper training is widely available at low or no cost in Oregon for youth-serving adults.

2.1.2.1 OHA will support Big River Programming by providing low or no cost access to Train-the-Trainer events, statewide coordination, evaluation support, and limited course support for the following programs:

Achieved

Big River programs are widely available. T4T is scheduled and available widely. Appropriate screening is in place for all programs. Ongoing support, evaluation and course support is available on some level for all programs.

2.1.2.1.1 Basic suicide prevention training options are available statewide and include Question, Persuade, Refer (QPR), Youth Mental Health First Aid, and Adult Mental Health First Aid.

Achieved

See the training infographic on page 9 to learn about the implementation of these programs in 2021. In addition to statewide efforts, ODHS made computer-based QPR training mandatory for all employees with an exemption process for those who did not feel they could participate due to lived experience with suicide. As of December 31, 2021, over 6,000 ODHS employees and partner agency staff had completed the training.

2.1.2.2 OHA will support Big River Programming by providing low or no cost access to the following training programs:

Achieved

Big River programs are widely available. T4T is scheduled and available widely to equip local leadership. Appropriate screening is in place for all programs. Ongoing support, evaluation and course support is available on some level for all programs. Work is being done to ensure that programs are reaching diverse populations, including Black and Native American populations and other communities of color, as well as rural and remote areas and people who speak languages other than English.

2.1.2.2.1 Enhanced suicide prevention training options are available statewide for mental health providers including Youth Suicide Assessment in Virtual Environments (YouthSAVE), Collaborative Assessment and Management of Suicidality (CAMS), Cognitive Behavioral Therapy – Suicide Prevention (CBT-SP), and Assessing and Managing Suicide Risk (AMSR).

Achieved

These are available widely for appropriate service providers. Work is being done to ensure these trainings are also being made available to providers working with Black and Native American populations and other communities of color.

2.1.2.3 New: UO and OHA will explore internet-based options for local community members and youth-serving adults to locate and register for suicide prevention trainings.

Planning

OHA suicide prevention staff have requested information about internal capacity for this technology from OHA's Business Information Systems.

2.1.3 "Representative Trainers" – The trainer pool in Oregon for suicide prevention programming represents the cultural and linguistic diversity of the communities in which they train.

2.1.3.1 All Big River statewide coordinators will continue to assess the gaps in availability of culturally and linguistically diverse trainers and trainings and will recruit accordingly and in collaboration with other Big River statewide coordinators.

Early Action

Big River coordinators (collectively and individually) are working on recruiting and supporting a diverse pool of trainers. Work includes building relationships with community partners and leaders in diverse communities, ensuring programs are adaptable and culturally responsive, and connecting with local leaders.

2.1.4 "Culturally Relevant Training" – Suicide prevention programming is regularly evaluated and updated to ensure equity, cultural relevance and responsiveness, and linguistic needs are addressed.

2.1.4.1 All OHA Youth Suicide Prevention contracts will require all Contractor's staff to be trained in cultural agility or anti-racism.

Planning

2.1.4.2 Big River statewide coordinators are equipped to assess and evaluate the gaps in the cultural relevance and availability of their program(s). Big River statewide coordinator meetings engage in regular and ongoing assessment of opportunities to increase cultural relevance and availability.

Early Action

Big River coordinators all meet with UOSPL regularly to grow evaluation. They are all working on multifaceted approaches to assessing the gaps and needs in an equity-centered way. Work is being done to ensure programs are reaching diverse populations including Black and Native American populations and other communities of color, as well as rural and remote areas and people who speak languages other than English.

2.1.4.3 New: The K-12 school based resource called the "Suicide Prevention, Intervention, Postvention: Step By Step" will go through equity/antiracist revision.

Achieved

Completed by Lines for Life in 2021. The resource is available at https://oregonyouthline.org/step-by-step/.

2.2 Means Reduction

2.2.1 "Safe Storage Access" – All Oregonian young people experiencing a behavioral health crisis have access to safe storage for medicine and firearms.

2.2.1.1 New Strategic Initiative for 21/22: The Alliance will create a workplan for Lethal Means work that includes safe storage, collaboration between stakeholders, and policy recommendations.

In Action

The lethal means advisory group leadership is creating a draft workplan that will be reviewed by the full advisory group. They will decide how to move forward with recommendations. The goal is to have this complete by May 2022 for executive committee review and submitted to OHA by June 2022.

2.2.1.2 Limited Pilot Project through Association of Oregon Community Mental Health Programs to provide no-cost lock boxes for medication to local mental health authorities.

Achieved

Approximately 5,000 medicine lock boxes were distributed to local mental health authorities in 2021.

2.2.1.3 Limited Pilot Project through Association of Oregon Community Mental Health Programs to provide no-cost secure storage of firearms to local mental health authorities.

Achieved

Approximately 1,600 firearm vaults and cases were distributed to local mental health authorities in 2021.

2.2.2 "Means Reduction Education" – Youth serving adults and caregivers are equipped with means reduction strategies and resources.

2.2.2.1 Counseling on Access to Lethal Means (CALM) course is available online at no cost.

Achieved

The CALM training is available through the Suicide Prevention Resource Center's website. Additionally, OHA has developed an online training focused on how primary care and direct service providers can work with firearm owners in rural areas who may be at risk of suicide to voluntarily limit access to firearms. The training is based on focus group research with firearm owners in rural Oregon. Over 480 individuals have completed the course since it launched in late 2019. Course evaluation shows that participants found the course useful. Over 80 percent of those who completed an evaluation indicated they plan to change an aspect of their practice based on the training and over 90 percent stating they would recommend this course to colleagues. This trained is funded through the GLS grant.

2.2.2.2 New: Train-the Trainer event for in-person Counseling on Access to Lethal Means (CALM) course held in Fall 2021 and statewide coordination added.

Achieved

GLS grant activities are supporting development of in-state trainer capacity to provide Oregon Counseling on Access to Lethal Means (Oregon CALM) live in-person and virtual training. Oregon CALM is based on a nationally used course, CALM, and also incorporates aspects of the rural firearm research described above. A cohort of individuals were certified as Oregon CALM trainers in August 2021. GLS funds are supporting a trainer learning collaborative. Oregon CALM trainings are scheduled to begin in February 2022 with additional train the trainer opportunities planned.

2.2.3 "Means Reduction Promotion" – Oregon regularly promotes safe storage practices and links it to suicide prevention.

2.2.3.1 New: Representatives from OHA's Suicide Prevention team and the Alliance will participate in the rulemaking process for SB 554 (2021).

Early Action

2.3 Protective Programming

2.3.1 "Available Support" – Oregonians who need immediate support or crisis intervention have access to it.

2.3.1.1 Crisis Text Line is available 24/7, and data is tracked using code "Oregon"

Achieved

2.3.1.2 LifeLine through Lines for Life is available 24/7.

Achieved

Completed by Lines for Life.

2.3.1.3 Teen-to-teen text and phone support is available through YouthLine from 4pm–10pm PST

Achieved

Completed by Lines for Life.

2.3.1.4 Emotional Support Lines are widely available (David Romprey Warmline, ReachOut Oregon Parent Warmline, COVID19 and wildfire support lines, Behavioral Health Access support lines)

Achieved

These lines are active and available.

2.3.1.5 A comprehensive website to identify behavioral health needs, supports, and providers called "Here For You Oregon" to launch in 2021.

Early Action

This work has been delayed. More consumer input needs to be gathered to determine the needs for this service.

2.3.1.6 New: A federally mandated project to transition the National Suicide Prevention Lifeline number to "9-8-8" will be ready to implement by July 2022.

Early Action

This project is on track for a July 2022 launch.

2.3.1.7 New: Mobile Response and Support Services (MRSS) system is being developed in Oregon, including a children's specific system.

Early Action

Mobile Response and Stabilization Services (MRSS) will be an expanded version of our current crisis response system focused on providing 24/7 connection for youth and their families. It includes immediate, face-to-face response and up to 8 weeks of stabilization services. MRSS teams will work in the community, as requested by the youth and their family. The teams are tasked with providing screening and assessment; stabilization and de-escalation; and coordination with and referrals to health, social and other services, as needed. MRSS teams include both a qualified behavioral health care professional and a qualified mental health associate and/or peer support specialist trained in crisis response.

2.3.2 "Population Focused Programming" – Young people within populations at greater risk for suicide have access to positive and protective programming in their community.

2.3.2.1 OHA and the Association of Community Mental Health Programs will support 16 LGBTQ+ suicide prevention projects with minigrants, evaluation support, and learning collaborative meetings.

Achieved

This pilot project was completed in 2021 and is not ongoing into 2022. Some grantees received additional funding and are continuing. This is led by AOCMHP.

2.3.2.2 OHA will support the development of YouthSAVE for transitional aged youth (ages 18–24).

In Action

Target completion of the training development is June 2022 with a subsequent launch of training opportunities. This project is experiencing some delays due to the COVID-19 Omicron variant's impact on the development team.

2.3.2.3 Oregon Sources of Strength will continue to focus on diversity and equity within its program of positive culture change.

In Action

Sources of Strength continues to be focused on diversity and equity in the peerled culture change program. Local trainers and leaders being equipped to lead in an equity-centered way. The contractor committed to all employees being trained in equity.

2.3.2.4 Each of Oregon's nine federally recognized Tribes and Native American Rehabilitation Association (NARA) receive suicide prevention programming funding from OHA. Each Tribe and NARA submitted a plan for the funding unique to their population.

Achieved

2.3.3 "Protective Policies" – Youth-serving entities have policies and procedures that increase protection against suicide risk (including passive risk, active risk, and crisis intervention) and those policies are implemented.

2.3.3.1 Adi's Act plans are legislatively mandated for each school district in Oregon. District plans are due in Oct 2021 to ODE.

In Action

190 of Oregon's 197 school districts self-reported compliance with Adi's Act. ODE is working with the remaining 7 districts to address the non-compliance.

2.3.3.2 School Suicide Prevention and Wellness Specialists (also called the Adi's Act support team) provides support to school districts for writing, implementing, and updating Adi's Act plans (5.0 FTE)

Achieved

The SSPW team is active. Over 125 unique school districts or school buildings have been provided hands-on support and/or warm hand off referrals to resources, trainings or programs. A statewide audit of Adi's Act plans is being conducted in early 2022.

2.3.3.3 School Safety and Prevention Specialists (11.0 FTE) are housed in Educational Service Districts (ESD) and funded by ODE to support ESD's regarding Sect 36 of the Student Success Act, which includes suicide prevention.

Achieved

These positions have been hired and the team is active.

2.3.3.4 New: Annual coordination meetings (starting September 2021) to align communication and coordination for Adi's Act implementation between ESD's, LFL, OHA and ODE.

Planning

This initiative was delayed. There is a large group meeting scheduled for February 2022 and individual coordination meetings planned for later in spring.

2.3.3.5 New: ODE will proceed with rulemaking for SB 52 (2021) to outline protective policies for the LGBTQ2SIA+ population.

In Action

The coordinator at ODE for this work was hired in Feb 2022. Temporary rules were written, and the new coordinator will lead the permanent rule-making.

2.3.3.6 New: University of Oregon Suicide Prevention Lab will lead a pilot project for evaluating and monitoring implementation of Adi's Act plan. Advised by ODE, OHA, and representation from Big River coordinators.

Early Action

Eight schools have agreed to participate in the 3-year Oregon School Suicide Prevention Project pilot. Project activities will begin March 2022 and carry through the 2023–24 academic school year. Spring activities will concentrate on establishing partnerships.

2.3.3.7 New Strategic Initiative for 21/22: Build capacity to monitor implementation of plans for Adi's Act, increase meaningful participation in Adi's Act from school districts, and increase the use of best practices in school districts. Begin by organizing infrastructure and clarifying roles and responsibilities.

Early Action

The schools committee has initiated a project plan to draft, prioritize and assign action items. As a re-sult of that planning, the committee prioritized clarifying all roles and responsibilities. Since January, a breakout team has been working to map the school-support infrastructure and complete a responsibility chart for all Adi's Act requirements. Completion is expected in late February or early March, after which remaining action items of the project plan will be addressed.

3. Treatment and Support Services

3.1 Healthcare Coordination

3.1.1 "Coordinated Transitions" - All Oregonian young people who access healthcare for behav-ioral health crises or suicidal ideation receive coordinated care in transitions between levels of care.

3.1.1.1 Results from the HB 3090 (2017) Resurvey Project of Oregon hospitals regarding Emergency Department policies and behavioral health crises will be published by OHA in Fall 2021. This report will include recommendations to the legislature.

In Action

OHA worked with multiple partners, including the Oregon Association of Hospitals and Health Systems (OAHHS) and Oregon Alliance to Prevent Suicide (Alliance) to develop the resurvey tool. OHA worked with OAHHS to notify hospitals in advance to ensure that staff familiar with the development and implementation of HB 3090 requirements responded to the survey. The resurvey resulted in a 100 percent response rate among the eligible hospitals. OHA provided several opportunities for partners to inform the report development through partner meetings and written comments. OAHHS and the Alliance provided written feedback. OHA is finalizing survey findings and recommendations. It is anticipated the report will be published in spring or summer 2022.

3.1.1.2 The Alliance will respond to OHA's HB 3090 Resurvey Project report (due Fall 2021) and develop a work plan to monitor next steps.

In Action

The transitions of care committee responded to the draft HB 3090 resurvey report. This committee has not yet developed a work plan to monitor next steps.

3.1.1.3 The Crisis and Transition Services (CATS) program provides short-term, intensive support to chil-dren and adolescents who have had a mental health crisis and presented to an emergency department or crisis center. The program serves as a bridge from emergency department discharge to connection to long-term outpatient supports. Current programming level: 12 sites in 11 counties.

Achieved

Current programming continues in 12 sites within 11 counties. This programming will be incorporated in the Mobile Response and Support Services (MRSS) model. 2022 will be a transitional year, as OHA continues planning for implementing the MRSS model across Oregon.

3.1.1.4 New: Identify infrastructure needs for mobile crisis response and stabilization services for statewide access.

Early Action

Mobile Response and Stabilization Services (MRSS) will be an expanded version of our current crisis response system focused on providing 24/7 connection for youth and their families. It includes immediate, face-to-face response and up to 8 weeks of stabilization services. MRSS teams will work in the community, as requested by the youth and their family. The teams are tasked with providing screening and assessment; stabilization and de-escalation; and coordination with and referrals to health, social and other services, as needed. MRSS teams include both a qualified behavioral health care professional and a qualified mental health associate and/or peer support specialist trained in crisis response.

3.1.1.5 New: Caring Contacts billing code activated in Medicaid.

Early Action

There has not been significant progress on this objective, although OHA suicide prevention staff have started conversations with the Medicaid program. There will be recommendations related to Caring Contacts in the pending HB 3090 report based on survey results and partner feedback that may provide momentum in this effort.

3.1.2 "Appropriate Communication" There is formal communication between healthcare providers, behavioral healthcare providers and youth serving adults (such as school counselors).

3.1.3 "Substance Use Services" – Substance Use Disorder and Mental Health services are integrated when possible and coordinated when not fully integrated.

3.1.3.1 Recommendations for suicide risk assessment and treatment included in the Measure 110 requirements for Addiction Recovery Centers established by this law.

Achieved

These recommendations were submitted in 2021.

3.1.4 "Integrated Care" – Oregonian young people will receive integrated models of healthcare in primary care settings and schools (i.e. behavioral health is available and access through primary care or school-based health centers/ school based mental health).

3.1.4.1 New: ODE and OHA will publish a toolkit for universal suicide risk assessment, screenings, and safety planning.

Planning

This work has been delayed. ODE and OHA have created a list of resources to include in this toolkit but have not begun development.

3.2 Healthcare Capacity

3.2.1 "Accessible Services" – Oregonian young people can access the appropriate services on the continuum of behavioral healthcare at the right time for the right amount of time, regardless of health insurance.

3.2.2 "Right Sized Workforce" – There is adequate behavioral healthcare workforce to meet the need.

3.2.3 "Available Services" – There are enough available services to provide all Oregonian young people access to care when they need it.

3.3. Appropriate Treatment & Management of Suicidality

3.3.1 "Equipped Workforce" – The behavioral healthcare workforce is well-equipped to help children, youth and families heal from suicidal ideation (including understanding variations of risk and protection levels and current risk and protective conditions).

3.3.1.1 Behavioral health providers (including Peer Support workforce) in Oregon have access to low or no cost courses in evidence-based treatment of suicidality that address various levels of risk of suicide and teach interventions accordingly.

Achieved

This is available widely for youth-serving providers. Work is being done to ensure these trainings are also being made available to providers working with Black and Native American populations and other communities of color, as well as in rural and remote areas. Work is being done to make better training available for the Peer Support Workforce.

3.3.1.2 Oregon Pediatric Society with OHA funding develops and delivers custom behavioral health and suicide prevention trainings for pediatricians and clinics

Achieved

This is available widely for youth-serving providers. Work is being done to ensure these trainings are also being made available to providers working with Black and Native American populations and other communities of color, as well as in rural and remote areas.

3.3.1.3 Enhanced training options in Big River programming menu available statewide – Youth SAVE, Collaborative Assessment and Management of Suicidality (CAMS), Assessing and Managing Suicide Risk (AMSR)

Achieved

This is available widely for appropriate service providers. Work is being done to ensure these trainings are also being made available to providers working with Black and Native American populations and other communities of color, as well as in rural and remote areas.

3.3.1.4 Advanced training options in Big River programming menu available statewide – Cognitive Behavioral Therapy – Suicide Prevention (CBT-SP), Dialectical Behavioral Therapy – Skills and Suicide Prevention modules (DBT)

Achieved

This is available widely for appropriate service providers. Work is being done to ensure these trainings are also being made available to providers working with Black and Native American populations and other communities of color, as well as in rural and remote areas.

3.3.1.5 New: Oregon Pediatric Society will add development of YouthSAVE training modules for those serving young adults (ages 18–24) and for primary care providers.

In Action

The 18–24 module is planned to launch June 2022. The primary care provider module is launching in March 2022. The young adult module will be available for all trainers. The primary care module will be trained only by developers due to specificity of the training and limited capacity among qualified people, particularly medical experts.

3.3.1.6 New: Presentation of universal suicide risk assessment, screening, and safety planning toolkit and case examples will be given at the Oregon Suicide Prevention Conference to equip school-based youth-serving adults.

Achieved

This presentation occurred in Oct. 2021 at the Oregon Suicide Prevention Conference.

3.3.2 "Voice and Choice" – Clients/consumers, parents and caregivers have voice and choice in treatment.

3.3.2.1 Emergency Department guide for children and families is available and distributed regularly to hospitals in Oregon.

Achieved

This document is being revised in spring 2022 to include new 988 and Mobile Response and Stabilization Services information.

3.3.3 "Whole-person Approaches" – Whole-person approaches are used to enhance treatment for suicide and to increase effectiveness of management of long term symptoms.

3.3.3.1 New Strategic Initiative for 21/22: Increase availability of culturally and linguistically appropriate and relevant approaches to treatment.

Early Action

OHA suicide prevention staff requested and received a literature review from the UO Suicide Prevention Lab to scan for current research in this area and continue to scan for available treatment approaches.

3.3.3.2 New Strategic Initiative for 21/22: Support effective approaches to treatment including suicide prevention training, body work, movement work, sleep therapy, tribal-based practices, and other evidence-informed treatments for reducing suicidality.

Planning

OHA suicide prevention staff requested and received a literature review from the UO Suicide Prevention Lab to scan for current research about culturally-specific suicide prevention training and treatment approaches. OHA suicide prevention staff are working with NARA NW to incorporate Tribal-based practices to the Suicide Rapid Response program. OHA suicide prevention staff compiled examples of Tribal-based suicide prevention activities planned by Oregon Tribal Nations and shared that with Tribal behavioral health directors and with Tribal prevention staff.

3.4 Postvention Services

3.4.1 "Equipped & Resourced Communities" – Youth-serving entities and communities are equipped to proved trauma informed postvention care for those impacted by a suicide death.

3.4.1.1 OHA will support Connect: Postvention training by providing low or no cost access to Train-the-Trainer events, statewide coordination for local training needs, evaluation support and limited course support.

Achieved

Connect: Postvention is available widely, is adapted for Oregon, has spaciousness built in for local communities to adjust in ways that make sense and is engaged in ongoing evaluation. Trainers are supported. Work is led by AOCMHP. Work is being done on a trainer portal for resource support.

3.4.1.2 OHA will support youth-serving entities through the Suicide Rapid Response program through Lines for Life.

Achieved

This program responded with support and resources to seven unique communities in 2021 following a youth suicide death.

3.4.2 "Postvention Response Leads" – Postvention Response Leads (PRLs) (and teams) are supported and equipped to fulfill their legislative mandates.

3.4.2.1 Suicide Rapid Response program is accessible and responsive to community needs.

In Action

This program responded with support and resources to seven unique communities in 2021 following a youth suicide death.

3.4.2.2 OHA hosts quarterly statewide collaborative meetings with PRL's.

Achieved

3.4.2.3 New: Rulemaking for the enrolled HB 3037 (2021) will be led by the OHA Suicide Prevention team and will include the development of a statewide postvention response plan.

Early Action

The rules advisory committee is scheduled for March 29, 2022. Oregon Tribal Nations received notification of these rule edits in January 2022, and Tribal behavioral health directors received a presentation about this legislation in February 2022. Postvention Response Leads received the draft rules in January 2022 via their OHA listserv.

3.4.2.4 New: Vicarious Trauma Pilot Project for PRLs with Trauma Informed Oregon will be completed in Fall 2021 and replicated according to recommended next steps.

Early Action

This work has been delayed due to competing priorities. OHA suicide prevention staff will identify whether any PRLs are interested in continuing with this pilot project in 2022.

3.4.3 "Fatality Data" – Youth suicide fatality data is gathered, analyzed, and used for future system improvements and prevention efforts.

3.4.3.1 New: Psychological Autopsy (PA) project led by OHA will consider ways to increase availability of PA for youth suicide deaths in Oregon.

Early Action

A cohort of individuals was trained in the Psychological Autopsy Certification Training in 2021. The next steps for this will be to launch limited pilot projects in counties with capacity, willingness and readiness in 2022.

3.4.3.2 Essence Suicide Surveillance Report released monthly by OHA and includes emergency department data, urgent care centers data, calls to poison control, and calls to LifeLine.

Achieved

This report is issued monthly.

3.4.3.3 Death review teams meet (county and state level) to analyze child fatalities, including suicide deaths, and produce system recommendations for prevention opportunities.

Achieved

This team meets quarterly. In 2021, this team contracted with the UO Suicide Prevention Lab to conduct a needs assessment of county child fatality review teams. In 2022, this team will work to achieve the action items identified as needs from that assessment.

4. Foundations and Centering Lenses

4.1 Data and Research

4.1.1 The University of Oregon Suicide Prevention Lab is funded to support data and research efforts of OHA's Suicide Prevention team and the priorities named by The Alliance's Executive Committee.

Achieved

This was funded in 2021.

4.2 Evaluation

4.2.1 The University of Oregon Suicide Prevention Lab is funded to support evaluation efforts of OHA's Suicide Prevention team and the priorities named by The Alliance's Executive Committee.

Achieved

This was funded in 2021.

4.2.2 New: The University of Oregon Suicide Prevention Lab will create a central database in RedCap for tracking Big River program evaluations.

Planning

The UO team determined that they did not have the capacity for this project given the scope of the need. OHA suicide prevention staff have requested information about internal capacity for this technology from OHA's Business Information Systems.

4.2.3 Limited evaluation is contracted to Portland State University to support Garret Lee Smith grant activities and other pilot projects.

Achieved

4.3 Policy Needs/Gaps

4.3.1 The Alliance will name policy recommendations for 2023 legislative session.

Planning

Alliance staff drafted a policy handbook to equip Alliance members in preparation for naming legislative concepts and policy needs. The Alliance submitted recommendations to OHA for funding needs related to suicide prevention for the 2023 long session in January 2022.

4.4 Funding Needs

4.4.1 OHA's Suicide Prevention team will maintain a list of funding needs related to YSIPP strategic initiatives.

In Action

This list is maintained and updated periodically based on emerging system needs and feedback from key partners (including the Oregon Alliance to Prevent Suicide).

4.4.2 New: OHA's Suicide Prevention team will propose a Policy Options Package to management in February 2022 for consideration to be included in OHA's 2023/2025 budget to address suicide prevention funding needs.

Early Action

The OHA Suicide Prevention team is working on this initiative.

4.4.3 Each of Oregon's nine federally recognized Tribes will receive suicide prevention specific funding from the Oregon Health Authority.

Achieved

This was funded in 2021.

4.5 Equity

4.5.1 The Alliance will continue focus on equity work, and will continue to make recommendations to OHA.

Early Action

The Equity Advisory Group meets twice a month. The current projects are to create an Equity Statement for the Alliance and review an Adult Suicide Prevention Equity Tool to identify necessary adaptations for applications to youth suicide prevention.

4.5.2 New Strategic Initiative for 21/22: Promote programming, partnerships, and funding for historically underserved communities and higher risk populations (e.g. people who are transgender, rural, Latinx, tribal, LGBTQ2SIA+, young adults, people with schizophrenia, people with substance use disorders, people with depression, people who identify as male, etc.)

Planning

The need for funding in these areas will be included in the list of funding needs referenced in 4.4.1.

4.6 Trauma Informed Practices

4.6.1 Trauma Informed Oregon will continue to be available for consultation and special projects related to suicide prevention.

Achieved

This was funded in 2021.

4.7 Lived Experience Voice

4.7.1 See "Voice of Lived Experience" initiatives beginning in section 1.1.4.

4.8 Collective Impact

4.9 Collaboration

Data section

Suicide numbers, rates and rankings by county or state vary by year. Tracking trends across time is the most effective way to study the data. Oregon youth suicide deaths and rates increased significantly between 2011 and 2018. Youth suicides among people younger than 25 years old decreased from 118 deaths in 2019 to 102 deaths in 2020. Of the 102 deaths in 2020, one was a child younger than 10 years old. Compared to 2019, the 2020 rate decreased by 13 percent to 13.3 per 100,000. In 2020, suicide deaths decreased nearly 14 percent among youth under age 25. Oregon's suicide rate was 18th in the nation in 2020 (Table 3).

Table 3. Oregon suicide deaths and rates among those age 10 to 24 compared to the national rate

Year	Number of youth suicides	Suicide death rate (per 100,000)	Rank among 50 states (50 is lowest rate)
2014	97	12.9	12
2015	90	12.0	16
2016	98	13.0	15
2017	107	14.1	17
2018	129	17.0	11
2019	116*	15.3	11
2020	101†	13.3	18

* In addition to these deaths among youths in Oregon age 10–24, there were two suicide deaths among children younger than 10 in 2019.

† In addition to these deaths among youth in Oregon age 10–24, there was one suicide death among children younger than 10 in 2020.

The following data analysis addresses Oregon Revised Statute 418.731 Section 3. Data presented are for Oregon residents age 5–24 who:

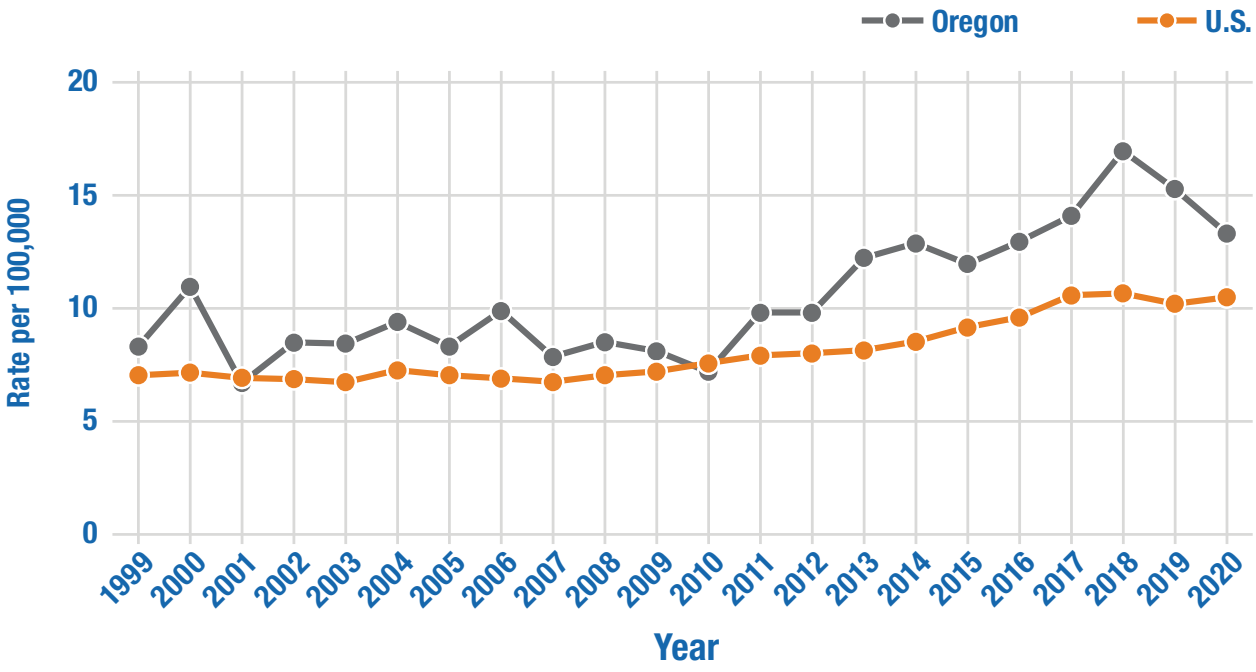
- Died by suicide
- Were hospitalized due to self-inflicted injury, and/or
- Had suicidal ideation and behaviors.

Suicide was the second leading cause of death among youth under 25 years old in Oregon in 2020. (1)

Oregon suicide deaths and rates among youth under 25 years old increased significantly between 2011 and 2018. Oregon saw a decrease in youth suicide rates in 2019–2020. Oregon youth suicide rates continue to be higher than the United States average and have been over the past decade.

- Male youth were more than three times more likely to die by suicide than female youth (Figure 2).
- Among youth, suicide rates increased with age (Figure 2).
- From 2015 to 2019, the Oregon Violent Death Reporting System (OVDRS) identified 10 suicides among transgender youth. An additional 5 suicides were identified among youth who identified as lesbian, gay, bisexual or having a sexual orientation other than straight or heterosexual. These deaths accounted for 2.7 percent of Oregon youth suicides between 2015 and 2019. This is likely an undercount of LGBTQIA2S+ youth who died by suicide due to existing data collection methods.

Figure 1. Suicide rates among youth age 10–24 in the United States and Oregon, 1999–2020



Source: CDC WISQARS and OPHAT

Note: This does not include deaths under age 10. There was 1 death in 2007, 2 deaths in 2019 and 1 death in 2020 of children under age 10.

Table 4. Comparison of suicide death rates per 100,000 among youth age 25 and under in Oregon and the United States, 2003–2020 (2)*

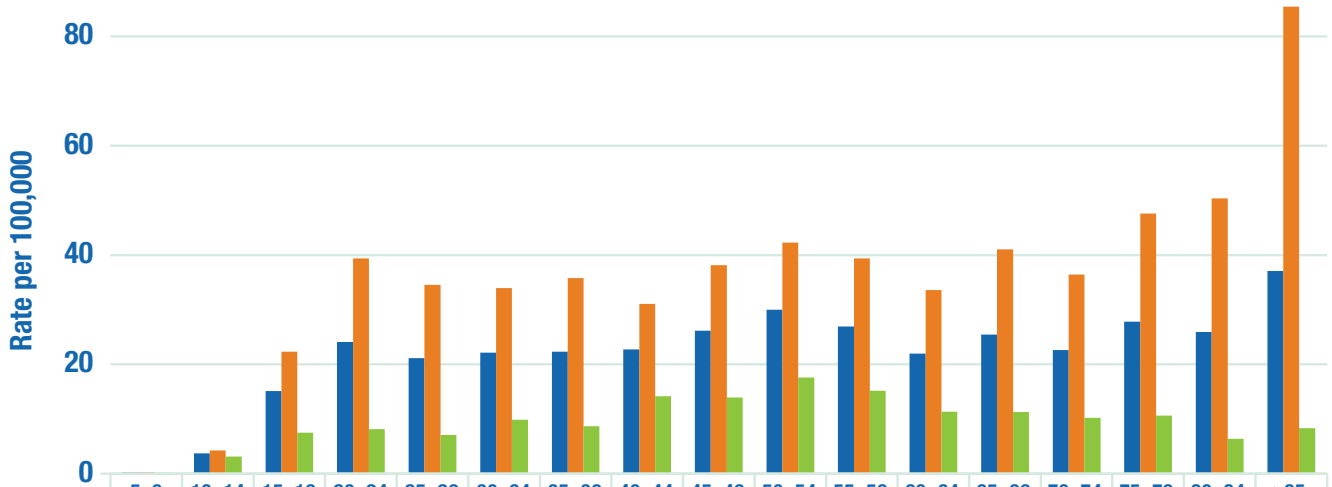
Year	Oregon	United States
2003	8.4	6.7
2004	9.4	7.3
2005	8.3	7.0
2006	9.9	6.9
2007	7.9	6.8
2008	8.5	7.0
2009	8.1	7.2
2010	7.2	7.6
2011	9.8	7.9
2012	9.8	8.0
2013	12.3	8.1
2014	12.9	8.5
2015	12.0	9.2
2016	13.0	9.6
2017	14.1	10.6
2018	17.0	10.7
2019	15.3	10.2
2020	13.3	10.5

* Rates are deaths per 100,000

Sources: CDC WISQARS

Note: This does not include deaths under age 10. There was 1 death in 2007, 2 deaths in 2019 and 1 death in 2020 of children under age 10.

Figure 2. Age-specific rate of suicide by sex, Oregon, 2016–2020



	5–9	10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	75–79	80–84	≥85
All	0.2	3.7	15.1	24.1	21.1	22.1	22.3	22.7	26.2	30.0	26.9	22.0	25.4	22.6	27.8	25.9	37.1
Male	0.3	4.3	22.3	39.4	34.5	33.9	35.8	31.1	38.1	42.3	39.4	33.6	41.1	36.4	47.6	50.4	85.5
Female	0.2	3.1	7.5	8.2	7.1	9.9	8.7	14.2	13.9	17.6	15.2	11.3	11.3	10.2	10.6	6.4	8.3

Age group in years

Source: OPHAT

Common circumstances for suicide

Table 5 highlights common circumstances surrounding suicide deaths for youth age 10–24. This information can inform prevention and intervention activities. Some of these circumstances vary by age subcategories. Between 2015 and 2019, the most common circumstances in Oregon for youth under 25 include:

- Mental health concerns or current depressed mood
- History of suicidal ideation and attempts
- Romantic relationship break-ups
- Non-alcohol substance use problems, and
- A crisis in the past two weeks.

Table 5. Common circumstances surrounding suicide incidents by age group, 2015–2019

	Aged 10-17 (n=173)		Aged 18-24 (n=455)		Aged 10-24 (n=628)	
Circumstance	**Count**	**%**	**Count**	**%**	**Count**	**%**
Mental health status						
Diagnosed mental disorder	56	39.4	143	39.2	199	39.4
Alcohol problem	3	2.1	44	12.7	47	9.3
Non-alcohol substance use problem	11	7.7	74	20.2	85	16.8
Current depressed mood	43	30.3	118	31.5	161	31.9
Current treatment for mental health / substance use problem*	40	28.2	73	21.2	113	22.4
Current treatment for mental health problem †	49	28	102	22	151	24
Interpersonal relationship problems						
Broken up with boy/girlfriend, Intimate partner problem	23	16.2	89	24.8	112	22.2
Suicide of family member or friend within past five years	2	1.4	7	1.9	9	1.8
Death of family member or friend within past five years	3	2.1	15	3.6	18	3.6
Family stressor(s)	34	23.9	30	9.1	64	12.7
History of abuse as a child	9	6	14	3	23	5
Life stressors						
Experienced a crisis within two weeks	22	15.5	62	16.6	84	16.6
Physical health problem	2	1.4	9	2.2	11	2.2
Financial / job problem	1	0.7	23	6.3	24	4.8
Recent criminal / non-criminal legal problem	5	3.5	29	8.4	34	6.7
School problem	25	17.6	9	2.6	34	6.7
Suicidal behaviors						
Suspected alcohol use prior to incident	9	6.3	9	17.5	9	1.8
History of expressed suicidal thought or plan	44	31.0	132	35.6	176	34.9
Recently disclosed intent to die by suicide	29	20.4	85	23.8	114	22.6
Left a suicide note	50	35.2	127	33.9	177	35.0
History of suicide attempt	27	19.0	96	26.2	123	24.4

* Includes diagnosed mental disorder, a problem with alcohol, other substance, or depressed mood, or a combination of these.
† Includes treatment for problems with alcohol, other substance or both.
Source: Oregon Violent Death Reporting System

2020

Final data reported 102 suicides among Oregon youth under age 25 with one death among youth under age 10 (characteristics and location are not available for 2 out-of-state deaths). Most suicides occurred among males (81 percent), White persons (89 percent) and persons age 20 to 24 (56 percent). Twenty-four deaths were among middle school and high school students (Table 6). In 2020, the most often observed mechanisms of injury in suicide deaths among youth included:

- Firearms (46 percent)
- Suffocation or hanging (32 percent), and
- Poisoning (12 percent).

Table 6. Characteristics of youth suicides age 25 and younger, Oregon, 2020

		Deaths*	% of total
Age (years)	5–14	8	8%
	15–19	36	36%
	20–24	56	56%
Sex	Male	81	81%
	Female	19	19%
Race or ethnicity†	African American	4	4%
	American Indian or Alaska Native	5	5%
	Asian or Pacific Islander	4	4%
	Hispanic	13	13%
	White	89	89%
	Multiple race	6	6%
	Other or Unknown	4	4%
Student status	Middle School	5	5%
	High School	19	19%
Mechanism of death	Firearm	46	46%
	Hanging/Suffocation	32	32%
	Poisoning	12	12%
	Other	10	10%

* Two out-of-state deaths are not included because their death certificate information is not accessible.
† Includes any race (one or more, any mention) and ethnicity mention. Race categories will not sum to the total since multiple race selections could be made for each decedent.
Source: Oregon Violent Death Reporting System
Note: According to the CDC National Center for Health Statistics, there were 102 suicide deaths among Oregon residents 5–24 years old in 2020; one was younger than age 10.

The mechanism used in suicide deaths among youth varies by gender. Table 7 shows mechanism of injury among suicide deaths by age group and sex in Oregon between 2015 and 2019. Among 10 to 17 year olds, almost half of males (48.9 percent) died by firearm suicide followed by hanging or suffocation (41.5 percent). Among females age 10 to 17 years old, 63 percent died by hanging/suffocations followed by firearm suicide (21.7 percent). Among males 18–24, firearm suicide is the leading cause of death (56.2 percent) followed by hanging/suffocation (27.9 percent). Almost half of females age 18–24 died by hanging/suffocation (47.4 percent) followed by firearm suicide (21.1 percent) and poisoning (17.1 percent).

Table 7. Mechanism of injury among suicide deaths by age group and sex, Oregon, 2015–2019

Age group	Mechanism of injury	Males	% Males	Females	% Females	All sexes*	% All
10–17 years	Firearm	46	48.9	10	21.7	56	40.0
	Other/Unknown	0	0.0	0	0.0	0	0.0
	Sharp instrument	0	0.0	0	0.0	0	0.0
	Poisoning	2	2.1	4	8.7	6	4.3
	Hanging/suffocation	39	41.5	29	63.0	68	48.6
	Fall	2	2.1	0	0.0	2	1.4
	Drowning	1	1.1	0	0.0	1	0.7
	Fire or Burn	0	0.0	0	0.0	0	0.0
	Motor vehicle/train	4	4.3	3	6.5	7	5.0
	Total	94		46	0	140	
18–24 years	Firearm	191	56.2	16	21.1	207	49.8
	Other/Unknown	1	0.3	0	0.0	1	0.2
	Sharp instrument	6	1.8	1	1.3	7	1.7
	Poisoning	17	5.0	13	17.1	30	7.2
	Hanging/suffocation	95	27.9	36	47.4	131	31.5
	Fall	13	3.8	3	3.9	16	3.8
	Drowning	6	1.8	2	2.6	8	1.9
	Fire or Burn	0	0.0	0	0.0	0	0.0
	Motor vehicle/train	11	3.2	5	6.6	16	3.8
	Total	340		76	0	416	

* Includes unknown sex

Source: ORVDRS

Suicide attempts

In 2020, a total of 4,204 youth under age 25 were admitted to the emergency department or hospital related to suicide attempt, suicide ideation or self-harm (Table 8). Females were far more likely to be hospitalized for suicide attempt, suicide ideation or self-harm than males. Starting this year, both emergency department and hospital admissions are included to provide more complete data. Previous annual reports only included hospital admission data. Therefore, data between this annual report and previous annual report should not be compared.

Table 8. Emergency department and hospitalization admission numbers of youth under age 25 for suicide attempt, suicide ideation or self-harm and suicide deaths among youth under age 25 by county, Oregon, 2020

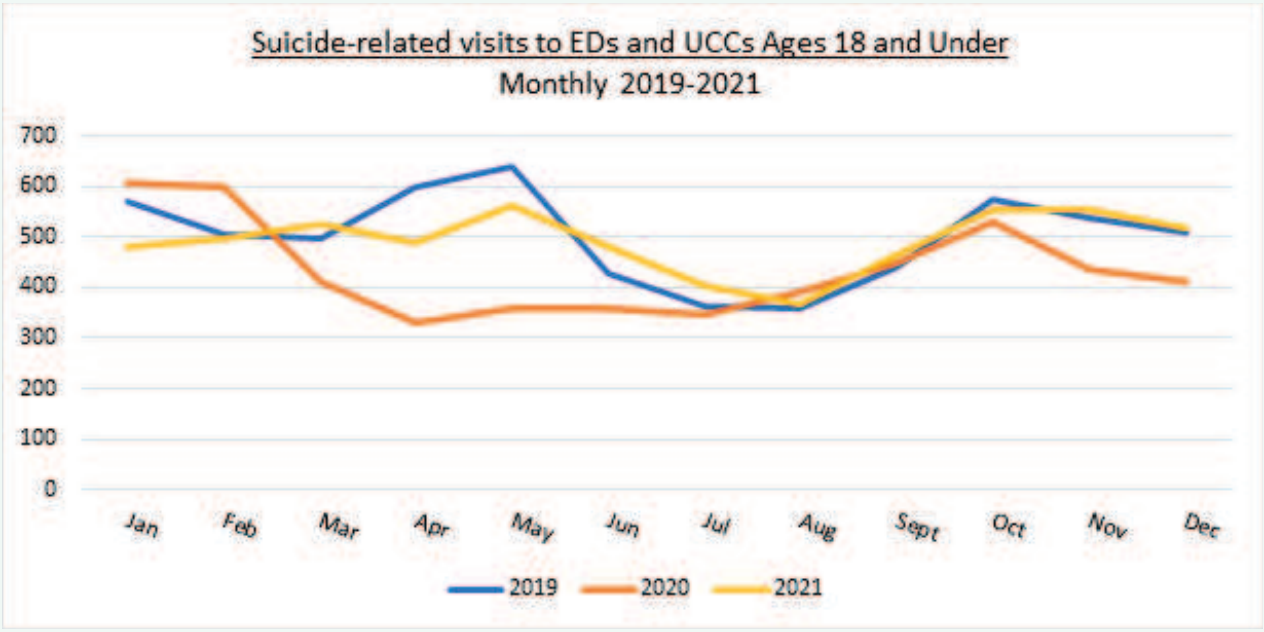
County	Hospitalizations*		Deaths†	
	Count	% of total	Count	% of total
Baker	21	0.5	1	1.0%
Benton	77	1.8	2	2.0%
Clackamas	376	8.9	12	12.0%
Clatsop	31	0.7	0	0.0%
Columbia	40	1.0	1	1.0%
Coos	43	1.0	1	1.0%
Crook	27	0.6	1	1.0%
Curry	29	0.7	0	0.0%
Deschutes	225	5.3	3	3.0%
Douglas	82	1.9	2	2.0%
Gilliam	—	—	1	1.0%
Grant	—	—	0	0.0%
Harney	—	—	0	0.0%
Hood River	14	0.3	0	0.0%
Jackson	237	5.6	6	6.0%
Jefferson	71	1.7	1	1.0%
Josephine	78	1.9	5	5.0%
Klamath	84	2.0	0	0.0%
Lake	—	—	0	0.0%
Lane	400	9.5	10	10.0%
Lincoln	56	1.3	2	2.0%
Linn	180	4.3	3	3.0%
Malheur	21	0.5	1	1.0%
Marion	414	9.8	8	8.0%
Morrow	—	—	0	0.0%
Multnomah	694	16.5	17	17.0%
Polk	142	3.4	2	2.0%
Sherman	21	0.5	0	0.0%
Tillamook	56	1.3	1	1.0%
Umatilla	32	0.8	2	2.0%
Union	—	—	0	0.0%
Wallowa	23	0.5	0	0.0%
Wasco	0	0.0	1	1.0%
Washington	558	13.3	12	12.0%
Wheeler	172	4.1	0	0.0%
Yamhill	71	1.7	5	5.0%
State	4204	N/A	100	NA

* Oregon Hospital Discharge Index. Please note that a new methodology to calculate 2018 youth self-harm hospitalizations was implemented based on CSTE (Council of State and Territorial Epidemiologists) guidelines. Therefore, 2018–2020 data is not comparable to previous years. Counts less than 10 and not 0 are not reported due to low counts and are represented by a line in the table.

† Oregon Violent Death Reporting System. Two out-of-state deaths in 2020 are not included because their death certificate information is not accessible.

Suicide-related visits to emergency departments (EDs) and urgent care centers (UCCs) for youth age 18 and under in 2020 were lower than 2019. Total visits for all health concerns decreased between March and June of 2020 (Figure 3). This coincided with the spread of COVID-19 (Figure 5). Suicide-related visits to EDs and UCCs for youth age 18 and under in 2021 are similar to 2019.

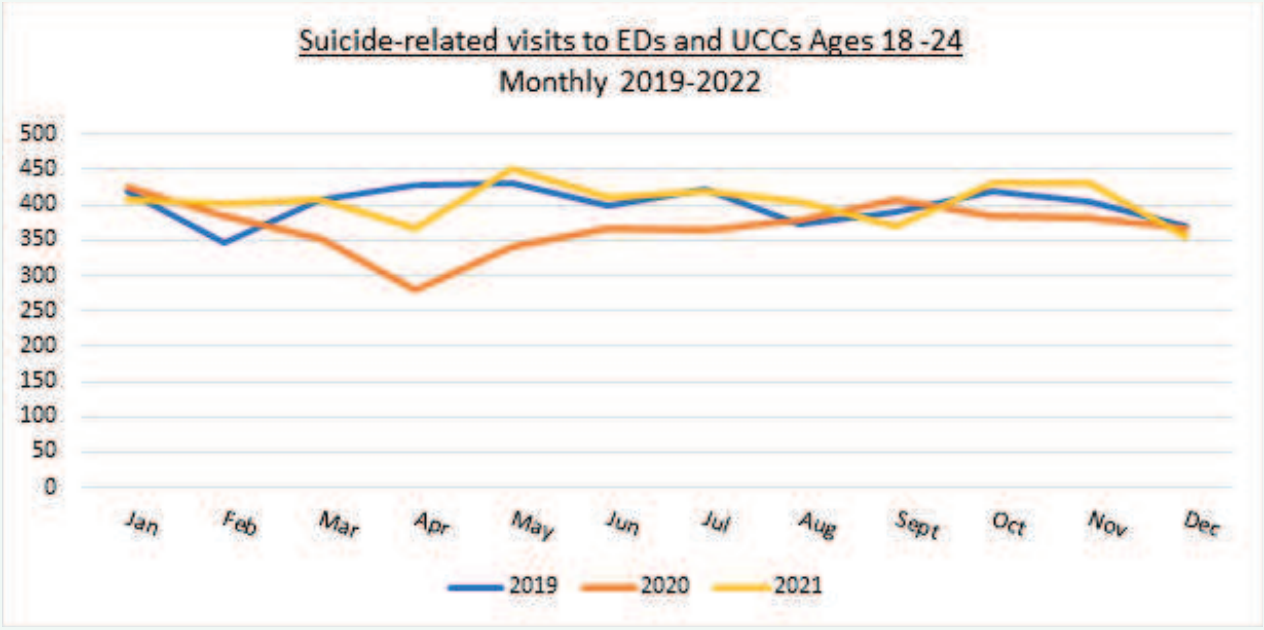
Figure 3. Suicide-related visits to emergency departments and urgent care centers, ages 18 and under, Oregon



Total visits: 2021 = 5,904; 2020 = 5,227; and 2019 = 6,016.

Source: ESSENCE syndromic surveillance suicide-related data, including visits for self-harm, suicide ideation and suicide attempt, from all nonfederal hospital emergency departments and select urgent care centers across Oregon.

Figure 4. Suicide-related visits to emergency departments and urgent care centers, ages 18 to 24, Oregon

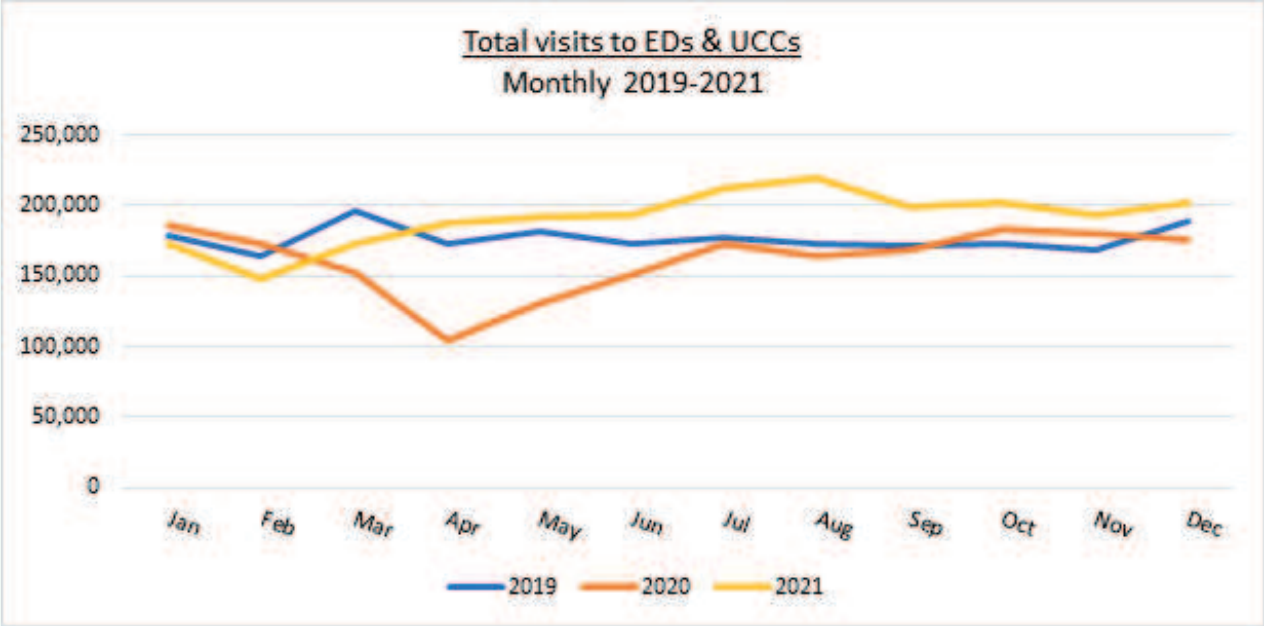


Total visits: 2021 = 4,851; 2020 = 4,436; and 2019 = 4,813.

Source: ESSENCE syndromic surveillance suicide-related data, including visits for self-harm, suicide ideation and suicide attempt, from all nonfederal hospital EDs and select UCCs across Oregon.

The number of suicide-related visits to emergency departments (EDs) and urgent care centers (UCCs) for youths ages 18 to 24 in 2021 is similar to 2019 and 2020 (Figure 4).

Figure 5. Total visits to emergency departments and urgent care centers, Oregon



Total visits: 2021 = 2,296,865; 2020 = 1,944,331; and 2019 = 2,119,711.

Source: ESSENCE syndromic surveillance suicide-related data, including visits for self-harm, suicide ideation and suicide attempt, from all nonfederal hospital EDs and select UCCs across Oregon.

Suicide related measures from the 2020 Student Health Survey

Oregon's Student Health Survey (SHS) is a collaborative effort between the Oregon Health Authority and the Oregon Department of Education. They survey is a comprehensive, school-based, anonymous and voluntary health survey for sixth, eighth and 11th graders. The 2020 SHS replaces OHA's two previous youth surveys, the Oregon Healthy Teens Survey (OHT) and the Oregon Student Wellness Survey (SWS). Combining the two youth surveys is part of OHA's ongoing efforts to make Oregon's public health system more efficient. This reduced the time and resources asked of schools and students. SHS data is not directly comparable to prior OHT and SWS results due to differences such as methodology, grades surveyed, learning environment, data collection period and recruitment. For more information, view the full 2020 SHS State Profile and County Profile Reports on the OHA SHS webpage.

The Student Health Survey asked several questions related to youth suicide and mental health which are described below. Note that not all SHS questions were asked to each grade. If a grade level is not included below (sixth, eighth or 11th), the question was not asked to that grade level.

- Percentage of youth that felt sad or hopeless almost every day for at least two weeks in a row due to coronavirus or coronavirus symptoms:
  - 14 percent of eighth graders
  - 27 percent of 11th graders
- Percentage of youth that seriously considered attempting suicide due to coronavirus or coronavirus symptoms:
  - 6 percent of eighth graders
  - 9 percent of 11th graders
- Percentage of youth that seriously considered attempting suicide:
  - 10 percent of sixth graders
  - 14 percent of eighth graders
  - 17 percent of 11th graders
- Percentage of youth that attempted suicide one or more times:
  - 3 percent of sixth graders
  - 6 percent of eighth graders
  - 5 percent of 11th graders

Suicide attempts involving a firearm are more likely to result in injury or death than other mechanisms such as suffocation (hanging) or poisoning. Since firearms account for a high percentage of youth suicide deaths, easy access to guns may increase the risk of suicide attempts and deaths. Although more than half of eighth and 11th graders say they do not

have access to a loaded gun, about a third, 37 percent of eighth graders and 41 percent of 11th graders, say they could get one in less than a day. About a quarter, 22 percent of eighth graders and 23 percent of 11th graders, say they could get a loaded gun in less than 10 minutes.

2020 SHS data is currently being analyzed based on reported demographics including race and ethnicity, gender identity and sexual orientation. This data will be available later in 2022.

Limitations of data used for suicide surveillance

Refer to the OHA Injury and Violence Prevention Program Data Glossary for more information on datasets used in this report. Suicide is one of the leading causes of death for the general population in Oregon and the second leading cause of death among people in Oregon age 10 to 24. Suicide prevention is one of OHA's top priority issues. Suicide is a complex behavior and associated with many factors, including:

- Mental health
- Substance use
- Physical health
- Relationships
- Life events
- Isolation
- Social connectivity
- Other environmental and societal conditions
- Adverse childhood experiences, and
- Lack of access to mental and behavioral health services.

Oregon uses various existing administrative data sets, surveys and active surveillance efforts to monitor and track suicide as well as some risk and protective factors that lead to or prevent suicide.

These sources include data elements of interest to policy makers. However, these data sources may fall short in other areas of interest. Standard administrative data used to track outcomes (such as death certificates, hospitalizations or ED visits) do not usually collect:

- Data on risk and protective factors for suicide (for example, depression)
- Past medical and behavioral histories (for example, treatment episodes)
- Other data elements that can tie individual risk and protective factors to suicidal behaviors, or
- Outcomes among individual persons (for example, the number of previous suicide attempts among individuals who died by suicide).

The following data are not available for individual youth who died by suicide:

- School attended
- Previous admissions or treatment for depression or suicidality
- Primary spoken language
- Disability status
- Foster care status
- Depression-related intervention services in the past 12 months, and
- Previous attempts, emergency department visits or hospitalizations in the last 12 months.

Gathering missing data would require more resources, position authority and planning. It would involve many steps, including:

- Linking several large administrative data sets
- In-person case interviews
- Requirements for law enforcement agencies and health care providers to release individual information
- Personnel for data entry and database management, and
- Requirements for hospitals to report more types of data, such as ED data, and specific reporting criteria.

Specific considerations for administrative data sets

Administrative data sets typically capture population data, but tracking public health trends is not their primary function. For example, administrative data sets do not capture all deaths within Oregon or all hospital inpatient visits for suicide attempts. The data do not have information on factors that may have led the person to suicide, such as untreated depression or life stressors. Depending on the administrative dataset used, there is varying support for tracking suicide trends.

Oregon uses administrative data sets to track outcomes such as deaths, medical outcomes and emergency department visits. These data sources include:

- Death certificates collected by the Center for Health Statistics (CHS) at the Oregon Public Health Division (PHD)
- Hospitalization discharge data (HDD) and emergency departments (ED for 2018 forward) from the Oregon Association of Hospitals and Health Systems (OAHHS), and
- Electronic Surveillance System for the Early Notification of Community-Based Epidemics (ESSENCE) data for emergency department and urgent care centers across Oregon.

Specific considerations for survey data

Survey data can capture information on factors associated with suicide, such as depression. However, survey data are based on population samples. Data does not link risk and protective factors for suicide to specific individuals. Survey data come, in part, from the following:

- The Behavioral Risk Factor Surveillance System (BRFSS)
- The Student Health Survey
- The National Survey on Drug Use and Health, and
- The American Community Survey.

These surveys are both state and nationally administered. Some of these surveys sometimes include questions about suicidality or mental health issues. However, surveys often depend on funding from individual programs (for example, BRFSS and OHT) to continue data collection for specific questions year to year. Recent response rates to telephone surveys has been low (sometimes less than 50 percent). Low response rates affect how well the data reflects the general population and therefore limits the findings from such data sources.

Some active surveillance data sources and systems link outcomes to individual risk. The Oregon Violent Death Reporting System collects active surveillance data from multiple sources to provide a more complete picture, such as:

- Detailed demographics
- Mechanism of death, and
- Circumstances surrounding suicide incidents.

Specific considerations for active public health tracking efforts

The Electronic Surveillance System for the Early Notification of Community-based Epidemics (ESSENCE) provides real-time data from all non-federal hospital emergency departments (ED) and select urgent care centers (UCC) across Oregon. These data allow public health agencies and hospitals to monitor what is happening in emergency departments across Oregon before, during and after a public health emergency. The suicide-related query used to provide data for this report was created by the International Society for Disease Surveillance's Syndrome Definition Committee with input from the CDC Division of Violence Prevention. It includes ED and UCC visits for self-harm, suicide ideation and suicide attempt. Important limitations of these data include the following:

- They do not distinguish suicide attempts from other forms of self-harm.
- Data from emergency department and urgent care center visits fluctuate as information is received and updated.
- Not all people in Oregon have access to an emergency department or urgent care center.
- People with suicidal ideations may forgo medical assistance.

Specific considerations for death certificate data

Death certificate data are collected by the Center for Health Statistics (CHS) at the Oregon Public Health Division (PHD). The data have been traditionally used for public health surveillance. The data provide detailed demographics, general mechanism of injury, health outcome and geographical information. However, the data:

- Do not tell the story behind deaths, such as why the people die by suicide, and
- Do not include factors that may have led persons to suicide, such as untreated depression or life stressors.

Specific considerations for Oregon Violent Death Reporting System (ORVDRS) data

The ORVDRS links deaths to medical examiner reports and law enforcement reports to look at individual risk. ORVDRS data provide a more complete picture, including:

- Detailed demographics
- Mechanism of death
- Circumstances surrounding suicide incidents, and
- Associated suicide risk factors.

However, the lack of standard questionnaires and investigations on deaths in Oregon means data collection and reporting is not always consistent. ORVDRS data does not always include certain data elements (for example, LGBTQIA2S+ status among people who died by suicide). The data rely on witnesses and contacts of a person who died by suicide, so the incident information is not always complete. Therefore, ORVDRS data may underestimate some given circumstances or risk factors.

Appendix I

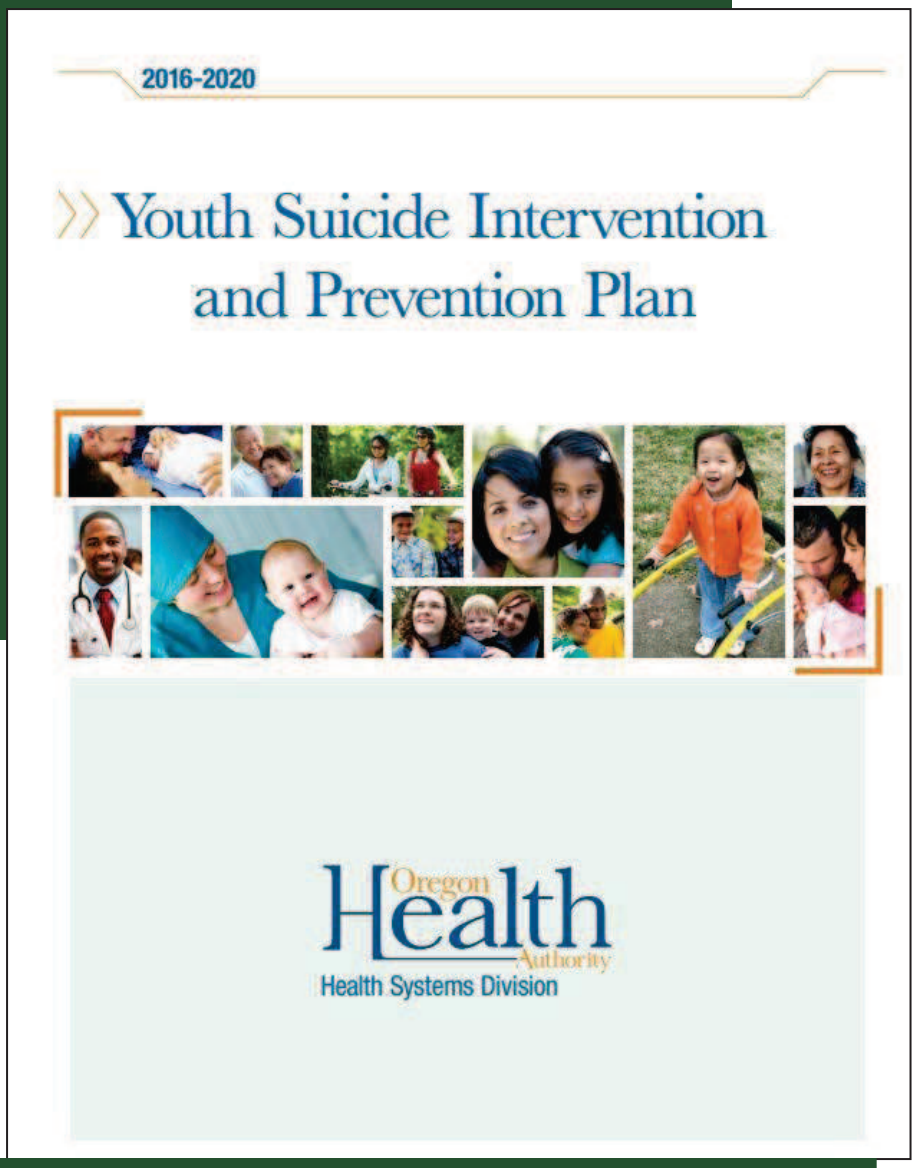
Table 8. Suicide rates among youth age 10 to 24 by state, United States, 2020

State	Deaths	Crude rate
Alaska	52	36.0
Montana	49	24.2
New Mexico	93	22.2
South Dakota	39	21.7
Wyoming	24	20.9
Colorado	215	19.4
Oklahoma	148	18.2
Idaho	69	18.2
Kansas	102	16.7
Utah	128	16.1
South Carolina	143	14.5
Missouri	170	14.4
Vermont	17	14.4
Arkansas	86	14.4
Arizona	205	14.0
Nevada	78	13.7
West Virginia	43	13.5
Oregon	101	13.3
North Dakota	21	13.2
Kentucky	113	13.1
New Hampshire	31	12.7
Virginia	207	12.6
Indiana	170	12.4
Washington	172	12.3
Iowa	77	11.9
Wisconsin	133	11.8
Maine	26	11.6
Georgia	252	11.5
Texas	713	11.5
Ohio	247	11.1
Tennessee	144	11.1

State	Deaths	Crude rate
Nebraska	43	10.7
Michigan	204	10.7
Alabama	100	10.6
Hawaii	25	10.4
North Carolina	213	10.3
Minnesota	105	9.7
Florida	349	9.5
Louisiana	85	9.4
Mississippi	54	9.0
Illinois	213	8.8
Pennsylvania	197	8.5
Delaware	13	7.4
California	522	6.9
Maryland	73	6.5
Massachusetts	74	5.7
New York	178	5.1
New Jersey	82	5.0
Connecticut	33	4.8
District of Columbia	<10	Not calculated
Rhode Island	<10	Not calculated

Rates are deaths per 100,000.
Source: CDC WISQARS
Note: Does not include 1 Oregon death under age 10 in 2020.

Appendix II University of Oregon Report



Annual YSIPP Evaluation Report

Oct 2020-Sept 2021

University of Oregon

Email: Jrochel2@uoregon.edu

UNIVERSITY OF OREGON

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Executive Summary

During the 2020-2021 reporting period, the University of Oregon (UO) Suicide Prevention Lab and its evaluative partnership with the Oregon Health Authority (OHA) and the Oregon Alliance to Prevent Suicide (Alliance) faced the unique challenges presented by COVID-19. The partnership continued to support and evaluate the implementation efforts of the Oregon Youth Suicide Intervention and Prevention Plan (YSIPP), while also leveraging the increased use of remote platforms to broaden and expand its reach of implementation and evaluation activities. Key accomplishments and recommendations are outlined by the four strategic directions of the YSIPP.

Strategic Direction 1: Healthy and empowered individuals, families and communities

Key Accomplishments:

- Implementation of a Tribal Networking Framework
- Development of a Regional Coalition Leadership Network and Piloting of a Coalition Needs Assessment
- LGBTQ Initiative Sustainment and Expansion

Summary: Collaboration efforts with the Klamath Tribes continued under the framework of a community-academic partnership (CAP) with several key activities being accomplished including the holding of a youth Gathering of Native Americans (GONA), collection and dissemination of a youth survey, and implementation of three culturally adapted Big River initiatives (Sources of Strength, QPR, and Connect) during the youth GONA. The installation and development of a suicide prevention network for regional coalition leaders took place online with four quarterly meetings being held. A parallel effort was conducted with one of these coalitions, the Clackamas County Suicide Prevention Coalition, where evaluators completed an in-depth needs assessment. Activities for the LGBTQ initiative continued with planning around the scale-up of the Family Acceptance Project (FAP) as a possible solution to address requirements stipulated in Adi's Act.

Strategic Direction 2: Clinical and community preventative services

Key Accomplishments:

- Planning for the Adi's Act Implementation Support Project
- Evaluation of the Big River Initiatives - Mental Health First Aid (MHFA), Question Persuade Refer (QPR), Applied Suicide Intervention Skills Training (ASIST), and Sources of Strength
- Development of Evaluation of Youth SAVE (Suicide Assessment in Virtual Environments)

Summary: The Adi's Act Implementation Support project was developed in partnership with the UO Lab, OHA, Lines for Life, and Matchstick Consulting to better understand (a)

what suicide prevention activities are already occurring in schools, (b) what major barriers schools are facing, and (c) how schools can best be supported in the implementation of the Adi's Act legislation. The team has recruited five of 10 schools to participate in the project and evaluation activities will commence in the spring of 2022. Due to challenges presented by COVID-19, evaluation efforts around the Big River initiatives concentrated on developing cross-initiative systems to track implementation. Looking forward, evaluators are developing a standardized evaluation work plan, creating follow-up training surveys aimed at assessing skill application, and exploring the development of a cross-initiative relational database for tracking and reporting.

Strategic Direction 3: Treatment and support services

Key Accomplishments:

- Evaluation of Connect Postvention
- Advanced Skills Training Pilot Evaluation Development

Summary: The UO Lab and the Connect statewide coordinator revised the shared evaluation work plan and shifted the focus of the evaluation from training evaluations (which were placed on hold) to conducting projects aimed at (a) reviewing implementation progress, (b) improving curriculum content, and (c) planning for future implementation. Development began on a pilot evaluation for five advanced skills trainings (Attachment Based Family Therapy, Assessing Managing Suicide Risk, Cognitive Behavioral Therapy for Suicide Prevention, Dialectical behavioral Therapy, and Collaborative Assessment and Management of Suicidology) provided by OHA for Oregon providers. The pilot evaluation will concentrate on what skills providers find both applicable and useful within their settings.

Strategic Direction 4: Surveillance, research, and evaluation

Key Accomplishments:

- Collaborative Development Process for YSIPP 2.0
- Scanning of State Suicide Prevention Plans
- Key Partners Focus Groups
- Child Fatality Review Needs Assessment

Summary: To support the YSIPP 2.0 development process, the UO Lab helped collect and summarize background data from (a) OHA's updated Suicide Prevention Framework, (b) the National Strategy for Suicide Prevention, and (c) the CDC's Technical Package for Suicide Prevention. A scan of state suicide prevention plans among states with the lowest suicide rates among youth was completed to help build a framework for YSIPP 2021-2025. Key partners throughout the state including youth, Alliance members, individuals with lived experience, and other youth providers were interviewed to solicit input on initiatives and recommendations. In addition, interviews were conducted with 35 county-level child fatality review representatives and a comprehensive summary report was delivered on the findings across counties.

Despite the unique challenges presented by COVID-19, the UO Lab and its partners were able to continue the progress made over the past four years in identifying and mapping out state and local resources, initiatives, and key partner groups and organizations. Much of the evaluation work for the first iteration of the YSIPP (2016-2020) centered on identifying gaps and resources pertaining to suicide prevention across the state, while also supporting the piloting and implementation of several prevention initiatives. As the evaluation process transitions to supporting the next iteration of the YSIPP, the UO Lab recommends concentrating on the development of networks and infrastructure to better connect, coordinate, and suicide prevention activities statewide. To support the development of networks, the UO Lab continues to develop community-academic partnerships throughout the state by (a) regularly meeting with partner organizations (e.g., Lines for Life, ODE, and OHA); (b) attending meetings for each Alliance committee and initiative; and (c) striving for continual suicide prevention collaboration and systems improvement across the state, regional, and local levels.

Background

The 2020-2021 reporting period summarizes activities conducted by the UO Suicide Prevention Lab to support ongoing implementation of the Youth Suicide Intervention and Prevention Plan (YSIPP). Activities undertaken by UO Lab continued and expanded upon work initiated in April 2017, and broadly included (a) direct and participatory evaluation of YSIPP-related efforts, (b) evaluation of suicide prevention educational training and programming, (c) statewide resource assessment, (d) network installation and development, (e) formative research including literature reviews and evidence-based practice identification, and (f) preparation for the YSIPP 2021-2025. These activities were carried out in coordination with the Oregon Alliance to Prevent Suicide, which is tasked with monitoring implementation of the YSIPP.

In order to successfully accomplish the evaluation activities described in this report, UO Lab members collaborated with the Alliance, OHA, Oregon Department of Education (ODE), and other state and local agencies. By partnering with these organizations, the UO team implemented a community-academic partnership (CAP). This approach has been shown to strengthen implementation, enhance success of community health programming and partnerships, and to streamline access to evidence-based knowledge and practices at the community level (Bryk, Gomez, Grunow, & LeMahieu, 2015). To facilitate communication between CAP partners, the UO Lab has embedded members on each of the six Alliance committees. By positioning itself as a *network hub*, the UO provides a centralized mechanism for better resource sharing, problem identification, data collection, and evaluation. In addition, the UO Lab has developed and utilized an Oregon-specific CAP framework (Rochelle, Parr, Thomas, Moore, & Seeley, 2018) that has guided the integration of implementation science strategies into the planning of community-level suicide prevention efforts.

Detail will be provided in this report on the following specific activities carried out by the UO Lab during the 2020-2021 reporting period and are organized according to the four overarching strategic directions of the YSIPP: (1) healthy and empowered individuals, families and communities, (2) clinical and community preventive services, (3) treatment and support services, and (4) surveillance, research, and evaluation. Because this report was written prior to the publication of the YSIPP 2021-2025, it is structured to align with the YSIPP 2016-2020.

The report will conclude with recommendations for new and future activities that could be undertaken by the UO Lab and its partners to strengthen the implementation of the YSIPP as facilitated by the Alliance.

Strategic Direction 1

Healthy and empowered individuals, families and communities

Tribal Networking Framework

The UO lab is developing a framework to guide the participatory collaborative dialogue between tribal governments and communities. The framework will utilize indigenous knowledge and science combined with western scientific methods to create robust culturally sensitive projects through the use of a community academic partnership (CAP). After an extended break due to the holidays, COVID-19, and changes in staffing, the CAP reconvened in January 2021 and began dissemination of a youth survey. Results from the youth survey informed on the planning for a tribal youth Gathering of Native Americans (GONA). A GONA is a culture-based planning process where community members meet to address community-identified issues. Between April and June, the Youth Survey was completed with more than 150 respondents. The purpose of the survey was to capture 'youth voice' about perceptions of accessibility and effectiveness of mental heal services available in schools. The CAP quarterly meeting reviewed the Klamath County Community Needs Assessment and the Youth Survey results and discussed next steps to leverage the results to improve youth suicide prevention in Klamath County. Looking forward, results from a female youth GONA retreat in October 2021 will be analyzed. Topics included cultural connectedness, belongingness, and generosity. Three of the Big River initiatives were implemented at this event: Sources of Strength, tribal specific QPR in collaboration with Klamath Basin Behavioral Health (KBBH), and culturally-based Connect Postvention in collaboration with KBBH.

Regional Coalition Leadership Network

The need for the establishment of a statewide regional coalition network came from a scan in August 2020 that identified 22 of 36 Oregon counties confirming having some form of coalition or workgroup, but no way to communicate across coalitions. To address this barrier, the UO Lab partnered with Alliance staff to establish a quarterly Coalition Leaders' Network meeting. The first quarterly Coalition Leaders Network was conducted in March 2021. The meeting focused on identifying the major needs and challenges of local coalition leaders and began planning an initial group project (i.e., creating products for an awareness campaign that all coalitions can use). In September 2021, a successful statewide awareness campaign was conducted by the coalition leaders' network in alignment with suicide prevention awareness month. Looking forward, the network is still in its early phase and the UO Lab along with Alliance staff are attempting to ensure that coalition leaders are having input on the direction of this initiative by having in depth discussion during every meeting about future directions.

Clackamas County Needs Assessment

Start-up activities for a comprehensive assessment of suicide prevention resources and needs

began in March 2019. Activities included an initial meeting with key partners to identify needs assessment goals, development and implementation of a member assessment for participants in the Clackamas County Suicide Prevention Coalition, and planning of needs assessment components and activities. Baseline data collection for the Clackamas County Suicide Prevention Needs Assessment was completed in July 2019. A total of 258 residents of Clackamas County responded to the online needs assessment survey, which was made available in English, Spanish, Vietnamese, and Russian languages. Data were analyzed and an Assessment Summary produced and provided to members of the Clackamas County Suicide Prevention Coalition. Additionally, a collection of high-quality visualizations of the findings were provided to facilitate communication of the needs assessment results to a broad array of key partners. Continuing in January of 2020, work on the Clackamas County Suicide Prevention Needs Assessment progressed with the development and finalization of tools to facilitate collection of data on suicide prevention resources available in the county. These include a semi-structured interview guide and an online survey questionnaire. Development of the Clackamas County Suicide Prevention Plan advanced with the collection of data on community and health care resources that are available in the county and could be leveraged for suicide prevention efforts proposed in the Plan. Information on resources were collected using an online survey and through structured key informant interviews. In October of 2020, the survey tool and interview guide were developed, and approximately 160 surveys and 20 interviews were completed by key partners in school and health care systems and in the community. Between April and June of 2021, resource data collection concluded. Analysis of survey data was completed, and the results from the key informant interviews were presented and organized across the three major domains of community, clinical, and school. Within each domain, key themes were identified across three subcategories: resources, barriers, and opportunities. Looking forward, planning the organization and components of the strategic plan has begun.

LGBTQ Initiative

The UO Lab continued its collaboration with Dr. Ryan to explore implementing and evaluating the Family Acceptance Project (FAP) within Oregon schools to help address the requirements of Adi's Act and the Student Success Act. UO Lab members also conducted an evaluation of the FAP training attended by Oregon Family Support Network (OFSN) members and disseminated the report to OFSN. In addition**,** the LGBTQ workgroup has been holding meetings to discuss identity and the goals of the Advisory Group. This identity reformation has included meetings to discuss the role in the implementation and support of SB 52 (2019) throughout Oregon schools and communities, as well as brainstorming what responsibilities and actionable items the Advisory Group can oversee within the Alliance.

Adi's Act Support Pilot

The UO Lab in partnership with OHA, Lines for Life, Matchstick Consulting, and the Alliance are working on a 3-year intensive evaluation of youth suicide prevention work in schools within 10 regions of Oregon. The purpose is to gain a deeper understanding of how youth suicide prevention efforts are working and not working on a local level in various regions across the state. The team is planning to focus on 10 school districts that represent geographic and cultural diversity and to conduct a series of surveys and interviews with students, staff, and mental health leaders over a three-years period. In addition, incentives will be used to support school buy-in and to offset the increased burden to schools for participation in the intensive evaluation. Overall, the purpose of the evaluation project is to better understand and support the suicide prevention activities in schools by providing ongoing progress monitoring and responsive support for each school partner. As of October 2021, five of the ten targeted schools have confirmed participation. The core collaborative team has continued work finalizing the student survey and has five key activities planned for the spring rollout: (a) Lines-for-Life consult and needs assessment, (b) UO Lab consult and implementation monitoring assessment, (c) ten school focus groups, (d) initial network-improvement community (NIC) meeting, and (e) communication directory and tracking system.

Big River Initiatives

ASIST Evaluation

The UO Lab, in partnership with AOCMHP and LivingWorks, has continued the statewide evaluation process for Oregon ASIST trainings. The lab initially met with LivingWorks to establish a working relationship aimed at designing evaluation measures that focus on participants' knowledge and behavior changes. For the 2020-21 reporting period, the evaluation has contained three major components. First, the UO team developed pre and post training ASIST surveys to evaluate participants' knowledge, self-efficacy, and behavior changes. Second, the lab designed novel evaluation tool for the ASIST Tune-Up training, which is for participants who have already participated in ASIST and would like a refresher. Third, the lab is continuing to collect data on Tune-Up trainings and have brainstormed ways to increase response rates moving forward, and a data use agreement has been executed between the UO Lab and Livingworks in order to obtain data collected by the ASIST developer.

QPR Evaluation

The UO Lab has worked in collaboration with Lines for Life to co-design the evaluation for QPR gatekeeper trainings and the train-the-trainer model. For this process, the lab initially met with the Lines for Life state coordinator and a team obtained from the agency and outlined a logic model for trainings and how to translate these to constructs for evaluation. The initial focus of the evaluation was to establish pre-post skill acquisition and follow-up application of the QPR skills. The team also developed an evaluation of the QPR learning collaborative to identify implementation barriers and facilitators of skill application. In December of 2020, pre-post and follow up measures were finalized and approved by the QPR Institute. In February 2021, the UO

Lab provided Lines for Life with a memo detailing next steps for reporting data to the Oregon Employment Department. Additionally, the UO Lab provided descriptive data for a presentation proposal to the 2021 Oregon Suicide Prevention Conference**.** Pre-post data were collected and analyzed for the Oregon Police Department QPR training. Reports summarizing the evaluation data have been prepared for the Pacific Northwest Carpenter's Institute and Oregon Law Enforcement. A report to OHA is being prepared to summarize the lessons learned from the three cohort trainings thus far. Also, a collaboration with QPR Institute to access data of Oregon trainers and trainees was established and a data use agreement with QPR is being executed. Looking forward, we are exploring the possibility to adapt the QPR Institute items and adding a follow-up survey to their online platform. In addition, a human subjects research application will be submitted to the UO IRB to allow for publications on the evaluation findings.

Sources of Strength Evaluation

The UO Lab has continued to hold monthly collaboration meetings with Matchstick Consulting as well as conducting bi-weekly internal team meetings to support the comprehensive statewide evaluation efforts for Sources of Strength Secondary and Elementary initiatives. To expand on the previous COVID-19 Bethel evaluation pilot, the UO Lab conducted a 7-month three site pilot with Springfield School District aimed at collecting student-level data related to suicide risk and protective factors. In March 2021, the UO Lab (a) provided the final school-level reports for each site with major findings from both the quantitative and qualitative sections of the survey, and (b) completed formative interviews with coaches from the Sources Elementary pilot and submitted a summary report detailing key findings. Next, the UO Lab helped to develop and pilot the elementary coach training feedback survey. During the initial use, the survey had over a 90% response rate and no inter-survey participant attrition. Additionally, feedback in the qualitative sections was robust and allowed the evaluators and Matchstick Consulting to get an in-depth review of participants' training experience. Looking forward, the evaluation team is in the process of fully developing an evaluation work plan designed in collaboration with Matchstick Consulting.

Mental Health First Aid Evaluation

The UO Lab has continued to collaborate with AOCMHP to provide a comprehensive evaluation for MHFA. In January 2021, the evaluation focus pivoted due to the rollout by National MHFA of both pre, post, and follow-up training surveys. Instead of continuing separate local surveys for Oregon, the UO Lab is working with the MHFA coordinator to design a system for tracking all trainings by quarter and to create an additional database that keeps a directory of active versus inactive trainers.

Youth SAVE

The Youth SAVE virtual training was developed by the Oregon Pediatric Society (OPS) to equip school- and community-based mental health professionals to virtually assess for and collaboratively create safety plans with youth who have thoughts of suicide. The UO Lab worked with OPS to develop and administer the pre-post training assessment for the first trainings held and prepared an initial report for OPS on the first two trainings. The lab completed the analysis of the pre-post training data and submitted a report to OPS. The follow-up survey to assess skill application has been developed and data collection will occur during the year. In addition, the lab assisted with the development of the pre-post training survey and fidelity monitoring for the

Youth SAVE train-the-trainer virtual trainings; the pre-post training data and fidelity monitoring data will be analyzed the next quarter. Looking forward, the team is working on an R01 NIH application to design a culturally responsive version of Youth SAVE specifically for Black providers working with Black youth. Evaluation of the current Youth SAVE is continuing with data collection.

Connect Postvention Evaluation

For the 2020-21 reporting period, the UO Lab and the Connect statewide coordinator revised the shared evaluation work plan and shifted the focus of the evaluation from training evaluations (which were placed on hold) to conducting projects aimed at (a) reviewing implementation progress, (b) improving curriculum content, and (c) planning for future implementation. To this aim, the lab conducted eight formative interviews with the county-level Connect coordinators. These interviews informed on common themes and differences across counties during the initial three-year scale-up. Next, the lab supported AOCMHP during the Connect learning collaborative to gather data around Connect curriculum improvement. Finally, the lab is working with the Connect coordinator to conduct a scoping literature review into the research base supporting the train-the-trainer model in the mental health and suicide prevention fields. Currently, over fifty relevant research articles have been identified. The purpose of the review is to determine how effective the train-the-trainer model is for delivering programs and how the model can be improved. Looking forward, the lab will begin re-designing the Connect training evaluations to align with the new content and focus on acceptability, feasibility, and behavior change.

Advanced Skills Training

The UO Lab expanded its comprehensive evaluation of the MHFA initiative to also include pilot evaluations of the five advanced skill trainings (ABFT, AMSR, CBT-SP, DBT, CAMS) for clinicians. Currently, a pilot has been designed to be used across all five trainings. The purpose of the survey is to assess skill application within their settings. Looking forward, the team is currently designing additional gender, diversity, equity, and inclusion training questions that can be piloted.

Strategic Direction 4

Surveillance, research and evaluation

YSIPP 2021-2025 Development

Project Overview

As the OHA aims to update its Youth Suicide Intervention and Prevention Plan (YSIPP) for the next five-year phase (2021-2025), it must take stock of the current state of affairs for youth suicide prevention across sectors and regions. Since OHA established the initial YSIPP in 2015, suicide prevention efforts have significantly expanded with new county-led initiatives and meaningful state legislative action, requiring extensive collaboration among key partners to guide the next five-year plan. To support the YSIPP evaluation process, the University of Oregon (UO) Suicide Prevention Lab has collaborated with OHA's suicide prevention coordinators to collect information to shape the state's strategy and priorities for the future of youth suicide prevention. Our main objective in the last year has been to collect and summarize information for the next YSIPP, according to OHA's updated Suicide Prevention Framework, grounded in the National Strategy for Suicide Prevention and the CDC's Technical Package for Suicide Prevention. The activities and deliverables that we have completed are as follows:

- Summarize activities and accomplishments associated with YSIPP 1.0 (2016-2020) using extant documentation, then organize to identify areas of strength and areas for improvement.
- Report on suicide prevention strategies and frameworks according to the latest evidence-based scientific literature and exemplar suicide prevention plans from other states (i.e., ORS 481.733, HB 4124, Section 2).
- Incorporate key informant feedback on specific YSIPP-related initiatives and accomplishments into the new Suicide Prevention Framework.

YSIPP 2016-2020 Activities Summary

A summary of activities and accomplishments under YSIPP 1.0 was compiled based on extant documentation and organized to distill areas of strength and areas receiving less attention to date. Feedback from key informants on specific YSIPP-related activities and accomplishments was incorporated into the summary according to specific sectors. Looking forward, the UO Lab continues to work with the OHA and Alliance leadership to complete the repository of research regarding YSIPP 2016-2020 activities.

State Suicide Prevention Plan Scan

The UO Lab completed a review of state suicide prevention plans among states with the lowest suicide rates among youth, according to the latest data from the CDC. The team also reviewed state suicide prevention plans from states with the highest reductions in suicide rates and those that had been identified as exemplars according to the Suicide Prevention Resource Center (SPRC) guidelines for state planning. The review of the plans has been compiled in a summary to reflect the states' varying priorities, strategies, and frameworks to suicide prevention according to the SPRC's standards of suicide prevention plans.

Key Informant Focus Groups and Formative Interviews

Key focus groups and formative interviews were conducted to better inform on the structure, strategy, and content of YSIPP 2021-2025. Focus groups included (a) the Alliance, (b) the Youth & Young Adult Engagement Advisory members, (c) the Emergency Medical Services for Children, (d) OHA staff, (e) the Alliance Schools Committee, and (f) members of the Oregon Council for Child and Adolescent Psychiatry.

Child Fatality Review Project

The UO Lab collaborated with the State Child Fatality Review team to finalize the needs and resources assessment work plan along with developing the survey and formative interview methodology for the review project. Next, the lab conducted interviews with 35 county child fatality review representatives and delivered reports summarizing the needs assessment process and themes from the collected data. Looking forward, the team plans to schedule a meeting with the OHA/DHS to review the informant feedback to inform program and policy recommendations.

Conclusion and Recommendations

Evaluation activities conducted during the 2020-21 reporting period centered on addressing two major aims. First, the UO Lab used environmental scans, survey research, program evaluation, focus groups, and formative interviews to build upon the YSIPP evaluation work that had been conducted over the previous five years. Second, the UO Lab and its partners worked to support key partners and practitioners while they faced the unique challenges presented by COVID-19. Based on the work over the past five years, the following recommendations have emerged:

- ***Centralization and standardization of the evaluation approach and metrics for statewide suicide prevention initiatives – including the Big River- to more efficiently and effectively measure program impact within regional and local contexts.*** As initiatives from the Big River continue to scale-up across Oregon, it becomes more essential to track the progress and impact of each individual initiative and also across initiatives. By utilizing a standardized approach for tracking and measuring the effect of each initiatives, evaluators will better be able to address variability in performance across programs.

- ***Dissemination of implementation science strategies and tools to support practitioners while they implement programs in real world environments***. The majority of evidence-based programs do not successfully transition from effectiveness trials to real-world implementation by practitioners. However, through the use of implementation science, the UO Lab, OHA, and the Alliance can better facilitate the successful scale-up efforts and sustainment of selected evidence-based programs.

- ***Strategic sustainment and funding for a networked-community comprised of the local suicide prevention coalitions.*** Work began during the 2020-2021 reporting period to identify local coalition leaders and bring them together in a shared digital space to solve problems of practice and share common solutions. The continued support and funding of this work will not only better allow suicide prevention activities to be strategically disseminated throughout local Oregon communities, but will also allow the lab to obtain contextual local data that can better illuminate the diverse challenges that communities face across the state.

- ***Installation and support of a county-level suicide prevention coordinator network.*** A previous scan of regional suicide prevention coordinators found that while a small percentage of counties had a designated fulltime suicide prevention coordinator, most counties either did not have a lead suicide prevention contact or only had a small portion of FTE dedicated to suicide prevention. To address this issue, the UO Lab suggests the following two-pronged approach: (a) facilitate an ongoing collaboration of core suicide prevention coordinators for the purpose of problem solving and resource sharing, and (b) develop a network of all county-level suicide prevention coordinators or "leads" that the identified tools and resources can be disseminated.

- ***Development of a centralized relational database for surveilling the progress of suicide prevention activities across the state.*** The state of Oregon is in need of a centralized relational database that can be used to connect and monitor all suicide prevention efforts taking place across the state. The UO Lab is developing a proposal for a database that would (a) track Big River training data, (b) house a directory of suicide prevention contacts, (c) track initiative implementation by sector, and (d) install a library of all suicide prevention-related documents and tools.

- ***Continued testing and development of technical assistant strategies and supports for schools***. With the passing of Adi's Act, the evaluation team recommends continuing to test and disseminate methods for supporting the scale-up of comprehensive suicide prevention in schools across the state. A promising process for supporting the scale-up of comprehensive school suicide prevention is the installation of network-improvement communities, which will be tested during the three-year pilot evaluation project of 10 Oregon schools.

As the evaluation transitions into the 2021-2022 reporting period, activities will include the continued identification, connection, and support of suicide prevention activities across the state of Oregon, while also expanding the reach of the current suicide prevention partner network. The UO Lab will also begin to collect and analyze data related to the latest iteration of the YSIPP. Finally, the lab is committed to continuing the practice of providing implementation support in the form of technical assistance, network installation guidance, progress monitoring, and recommendations for quality improvement.

Reference

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Endnotes

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OHA 8874_2021 (03/2022)

Portland State UNIVERSITY

Oregon DHS QPR Suicide Prevention Training

Pre- and Post-Training Survey Data Report

July 1, 2020 through December 31, 2021

Highlights *(see following pages for more detail)*

Trainee Details

+ This quarter, **582 people** have completed either QPR[1] or QPR-CW[2]:
  - QPR – **520** completed
  - QPR-CW – **62** completed

+ Overall, **6,963 people** have completed either QPR or QPR-CW:
  - QPR – **6,139** completed
  - QPR-CW – **824** completed

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

QPR[3]
- District 2 (Multnomah)– **481**
- District 8 (Jackson, Josephine) – **368**
- District 3 (Marion, Polk, Yamhill) – **335**

QPR-CW
- District 5 (Lane) – **103**
- District 16 (Washington) – **92**
- District 8 (Jackson, Josephine) – **90**

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

QPR
- Office of Self Sufficiency Programs – **2,061**
- Aging and People with Disabilities – **1,108**
- Office of Child Welfare – **1,077**

QPR-CW
- Office of Child Welfare – **744**
- CW_SS District Administration – **43**
- Office of Self Sufficiency Programs – **12**

Knowledge of Suicide and Suicide Prevention Increased

+ An average of **72.4%** of respondents rated their knowledge of suicide and suicide prevention as "high" after the training, compared with **18.9%** before.
+ On average, **1.2%** of respondents rated their knowledge of suicide and suicide prevention as "low" after the training, compared with **25.0%** 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 2,914 (47.5%) QPR trainees did not specify which district(s) they were affiliated with.

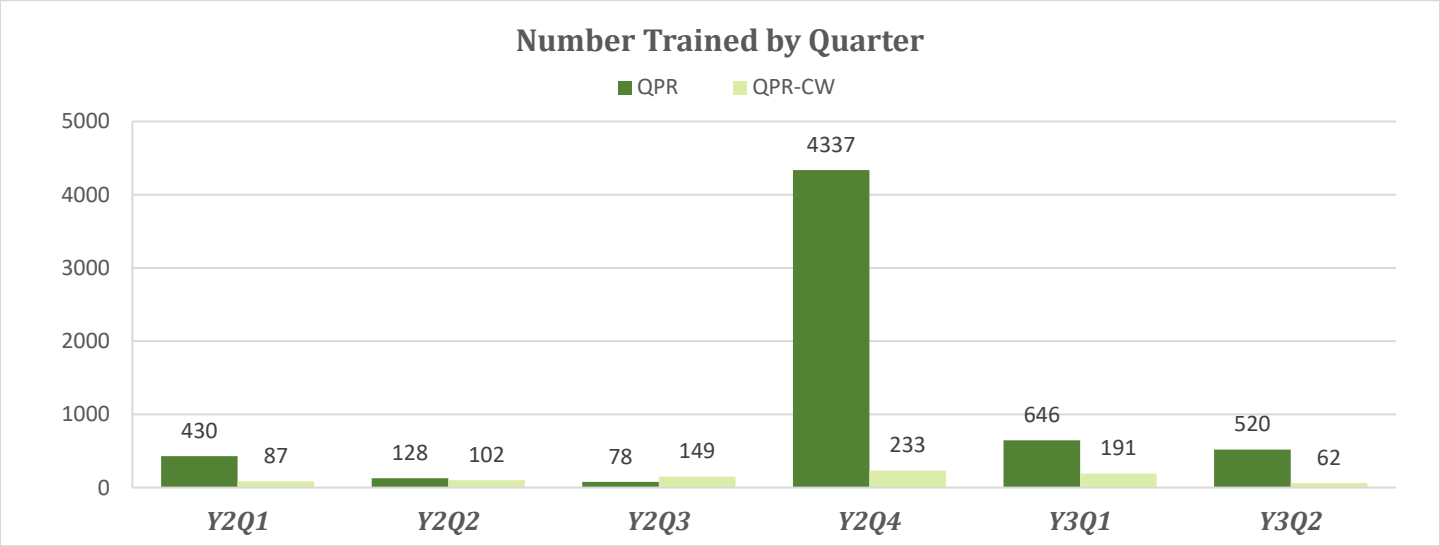
Comfort and Likeliness of Helping to Prevent Suicide

+ The percentage of trainees who **strongly agree** that *suicide is preventable* increased **64.6%**
+ Trainees who reported being **very comfortable** with *asking a person about suicide* increased **121.4%**
+ The percentage of trainees who are **very likely** to *ask someone exhibiting signs of suicide risk if they are thinking of suicide* increased **63.1%**
+ Trainees who reported being **very likely** to *intervene when someone is exhibiting signs of suicide risk* increased **15.4%**
+ The percentage of trainees who were **very likely** to *refer someone exhibiting signs of suicide risk to mental health or related services* increased **4.9%**

Trainee Impressions

+ A total of **78.5%** of respondents (263 of 335) believe that this training will be very valuable to their work with children, adults, and families
+ The majority of trainees (**66.7%**) would be interested in a more comprehensive suicide prevention training

Trainee Details



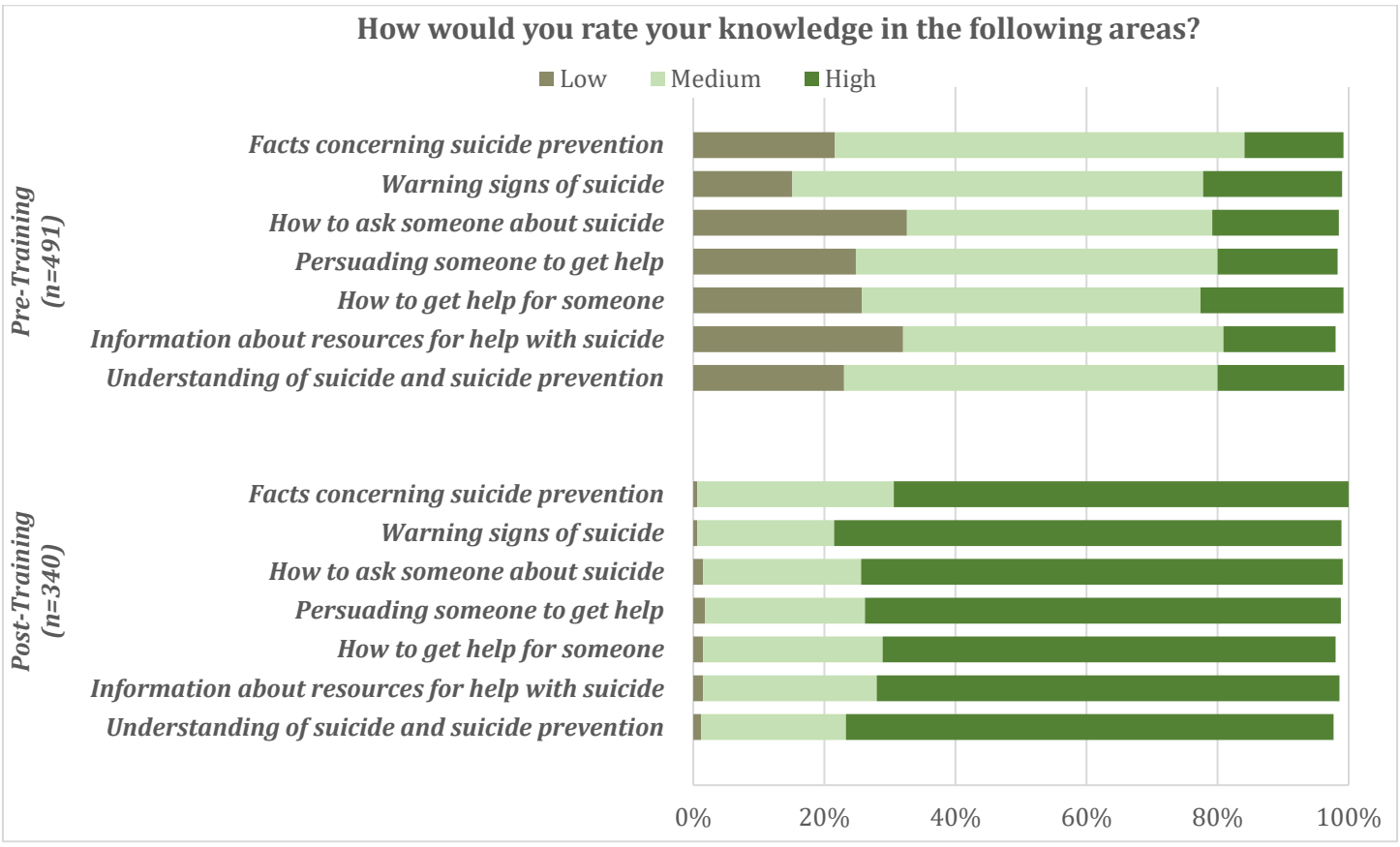
Total Number Trained

District	QPR Trainees		QPR-CW Trainees		Total Trainees	
1	110	1.8%	35	4.2%	145	2.1%
2	481	7.8%	86	10.4%	567	8.1%
3	335	5.5%	79	9.6%	414	5.9%
4	179	2.9%	53	6.4%	232	3.3%
5	237	3.9%	103	12.5%	340	4.9%
6	192	3.1%	24	2.9%	216	3.1%
7	157	2.6%	17	2.1%	174	2.5%
8	368	6.0%	90	10.9%	458	6.6%
9	45	0.7%	20	2.4%	65	0.9%
10	163	2.7%	35	4.2%	198	2.8%
11	127	2.1%	38	4.6%	165	2.4%
12	103	1.7%	8	1.0%	111	1.6%
13	74	1.2%	18	2.2%	92	1.3%
14	125	2.0%	25	3.0%	150	2.2%
15	196	3.2%	38	4.6%	234	3.4%
16	333	5.4%	92	11.2%	425	6.1%
Not Specified	2,914	47.5%	63	7.6%	2,977	42.8%
Total	***6,139***		***824***		***6,963***	

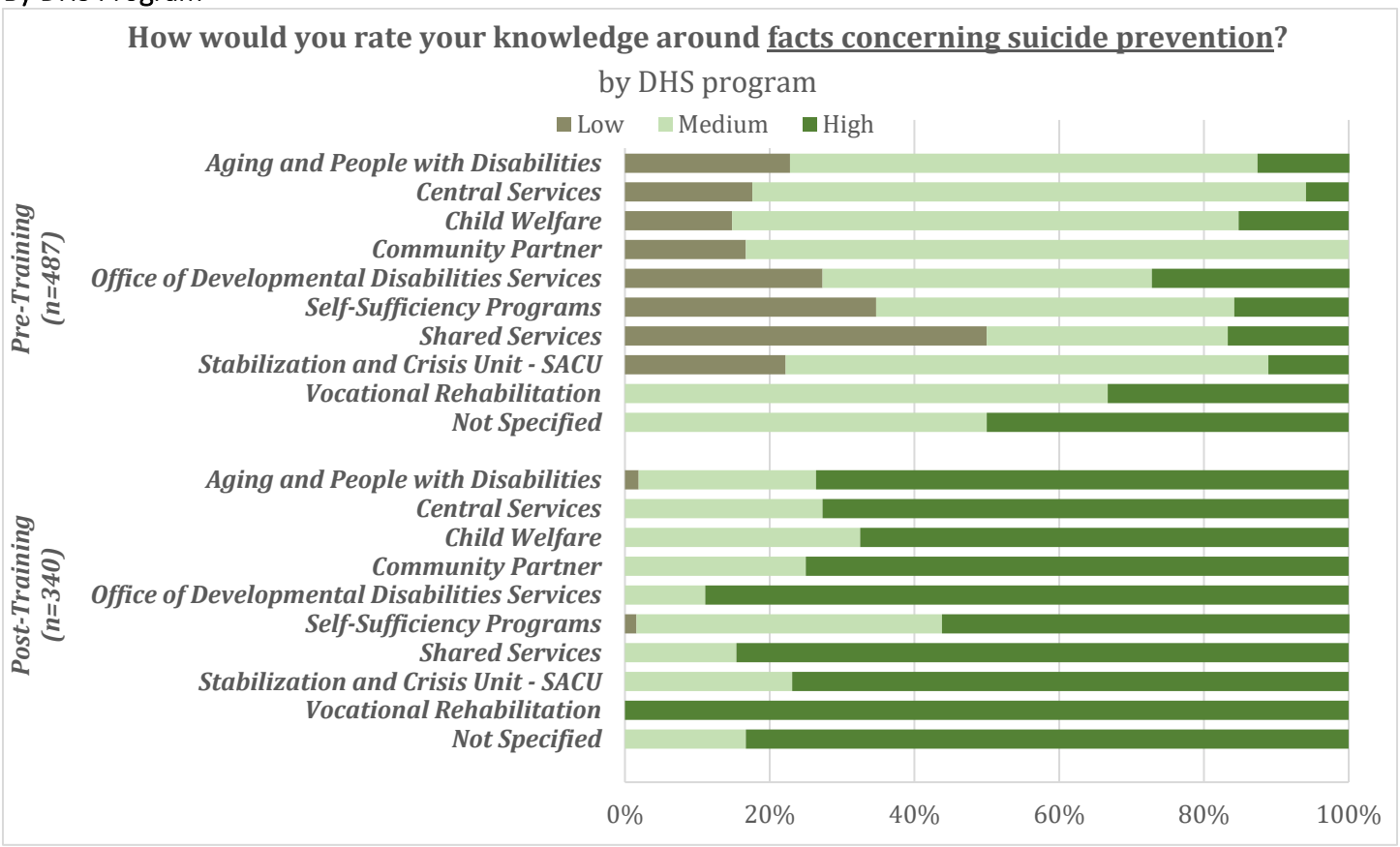
Division Title *Sorted in descending order by QPR Trainees*	QPR Trainees		QPR-CW Trainees		Total Trainees	
Office of Self Sufficiency Programs	2,061	33.6%	12	1.5%	2,073	29.8%
Aging and People with Disabilities	1,108	18.0%	2	0.2%	1,110	15.9%
Office of Child Welfare	1,077	17.5%	744	90.3%	1,821	26.2%
ODHS/OHA Shared Services	565	9.2%	5	0.6%	570	8.2%
Developmental Disabilities Services	556	9.1%	1	0.1%	557	8.0%
DHS Central Services	231	3.8%	4	0.5%	235	3.4%
Office of Vocational Rehabilitation Services	208	3.4%	3	0.4%	211	3.0%
Not Current	163	2.7%	9	1.1%	172	2.5%
CW_SS District Administration	96	1.6%	43	5.2%	139	2.0%
OHA Central Services	4	0.1%	0	0.0%	4	0.1%
Volunteer Program	4	0.1%	0	0.0%	4	0.1%
External Relations	1	0.0%	0	0.0%	1	0.0%
Juvenile Justice Information System	1	0.0%	0	0.0%	1	0.0%
Public Health	1	0.0%	0	0.0%	1	0.0%
Oregon State Hospital	0	0.0%	1	0.1%	1	0.0%
Oregon Youth Authority	0	0.0%	0	0.0%	0	0.0%
Unspecified	63	1.0%	0	0.0%	63	0.9%
Total	***6,139***		***824***		***6,963***	

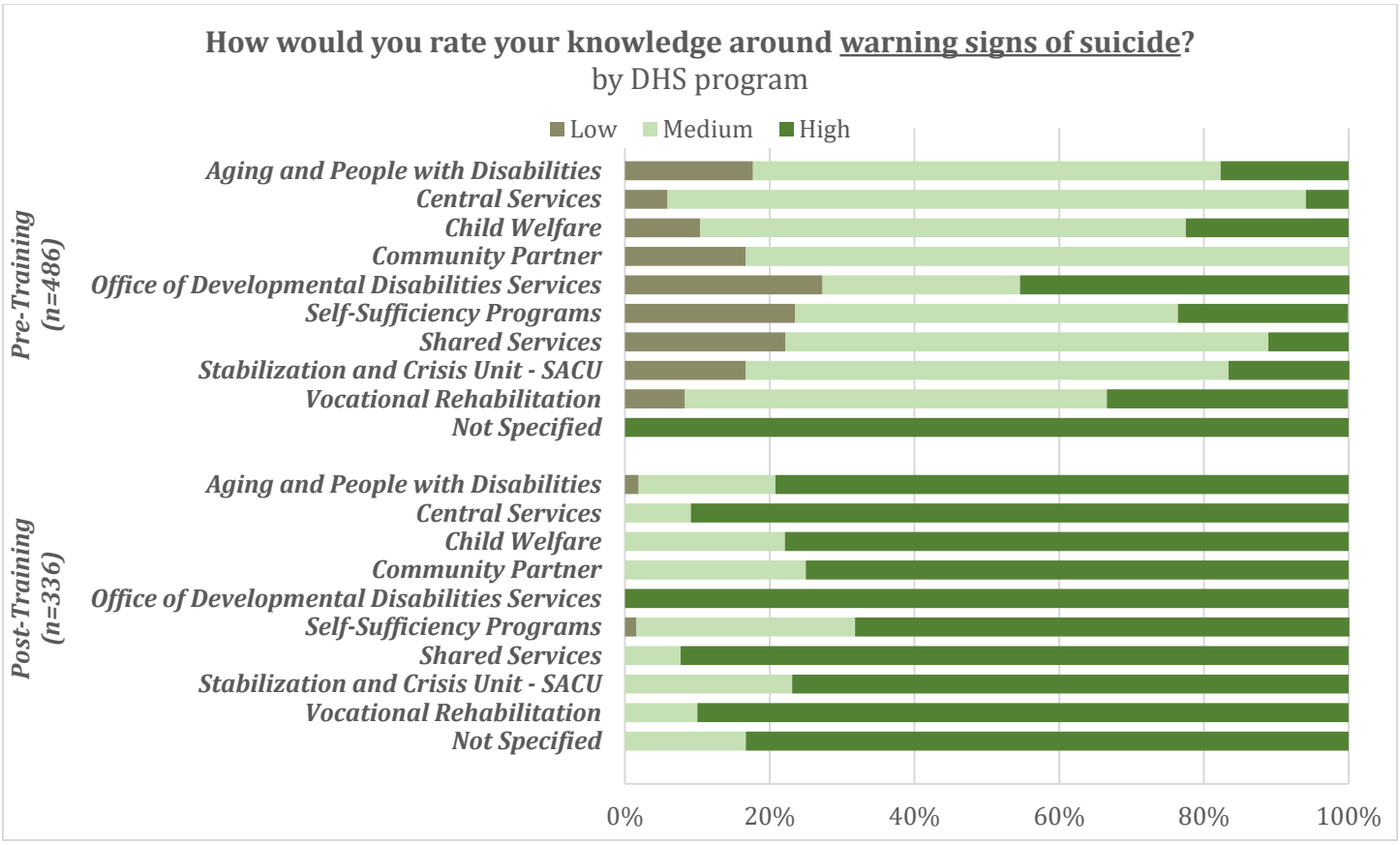
Knowledge of Suicide and Suicide Prevention

Overall



By DHS Program

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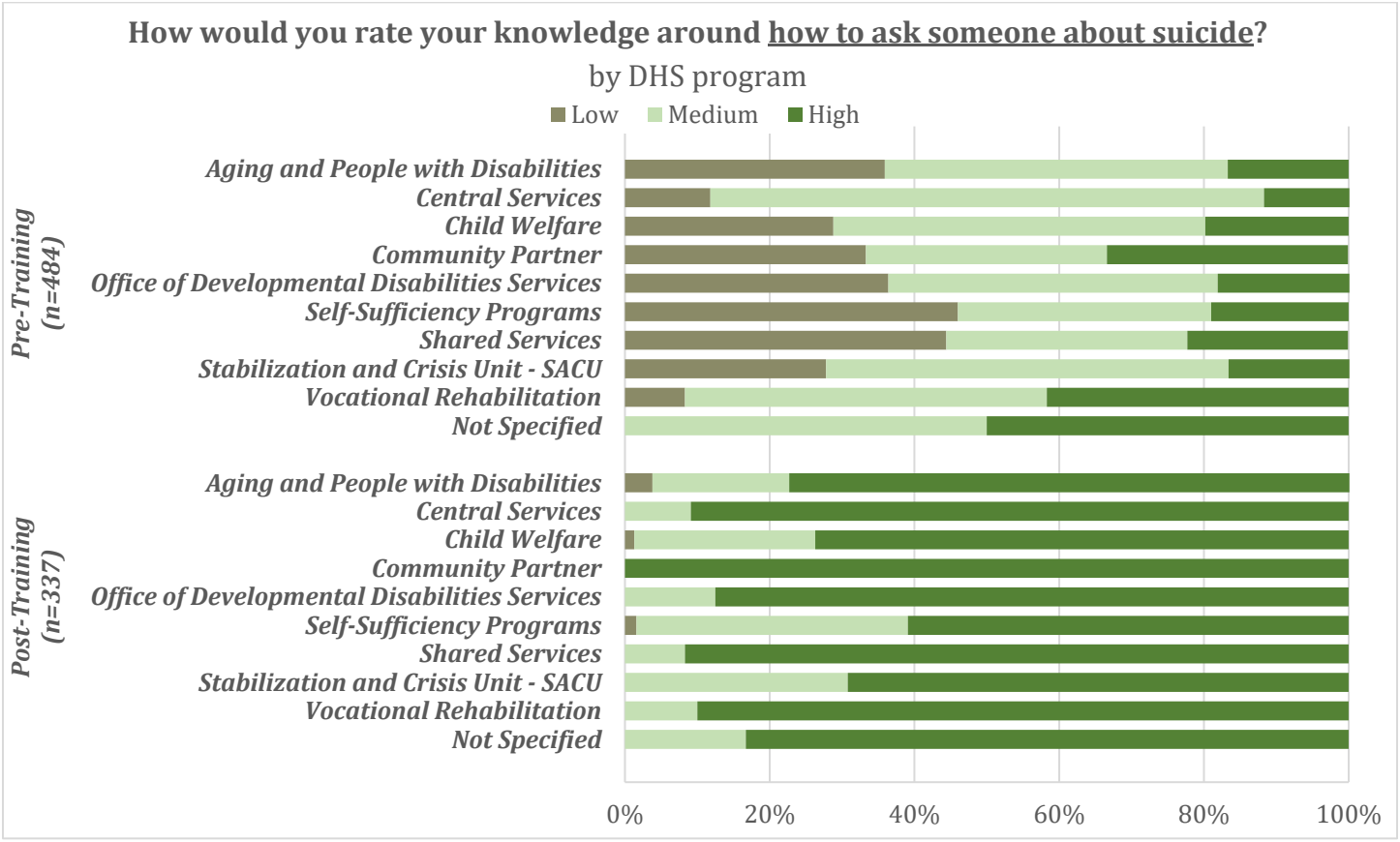
by DHS program
Low
Medium
High
Pre-Training (n=486)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
Post-Training (n=336)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
0%
20%
40%
60%
80%
100%


How would you rate your knowledge around how to ask someone about suicide?
by DHS program
Low
Medium
High
Pre-Training (n=484)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
Post-Training (n=337)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
0%
20%
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60%
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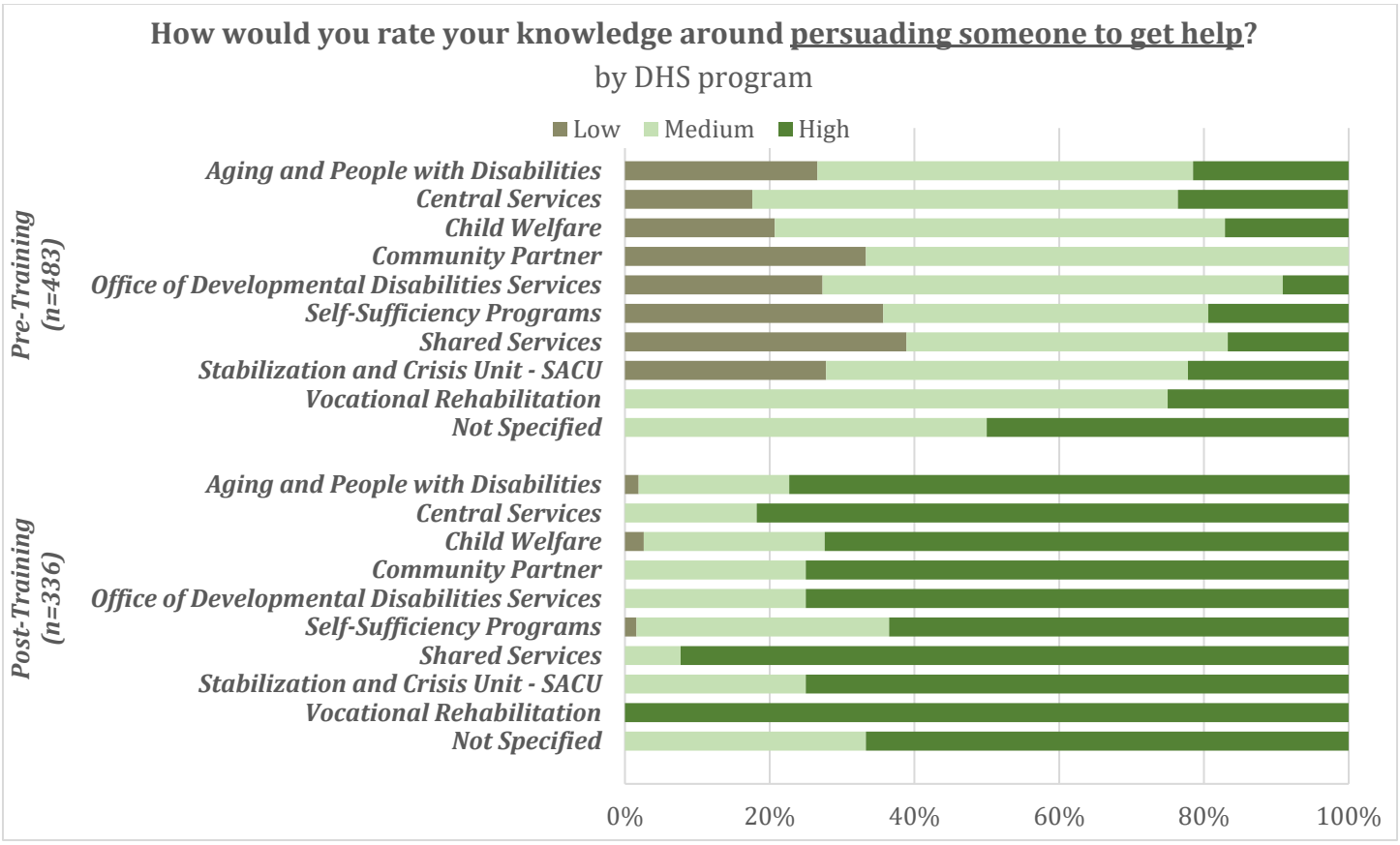
How would you rate your knowledge around persuading someone to get help?
by DHS program
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Medium
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Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
Post-Training (n=336)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
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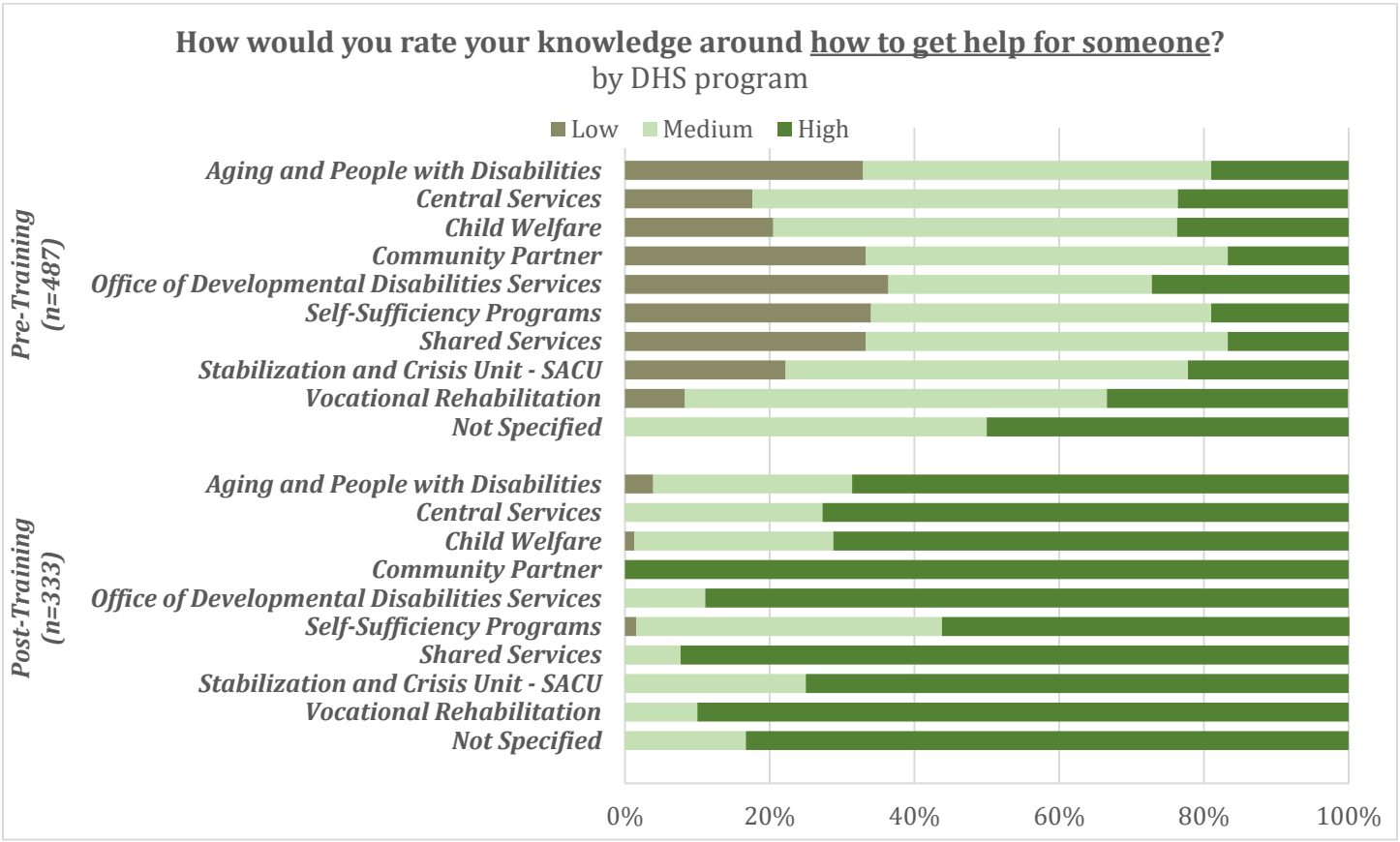
40%
60%
80%
100%


How would you rate your knowledge around how to get help for someone?
by DHS program
Low
Medium
High
Pre-Training (n=487)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
Post-Training (n=333)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
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0%
20%
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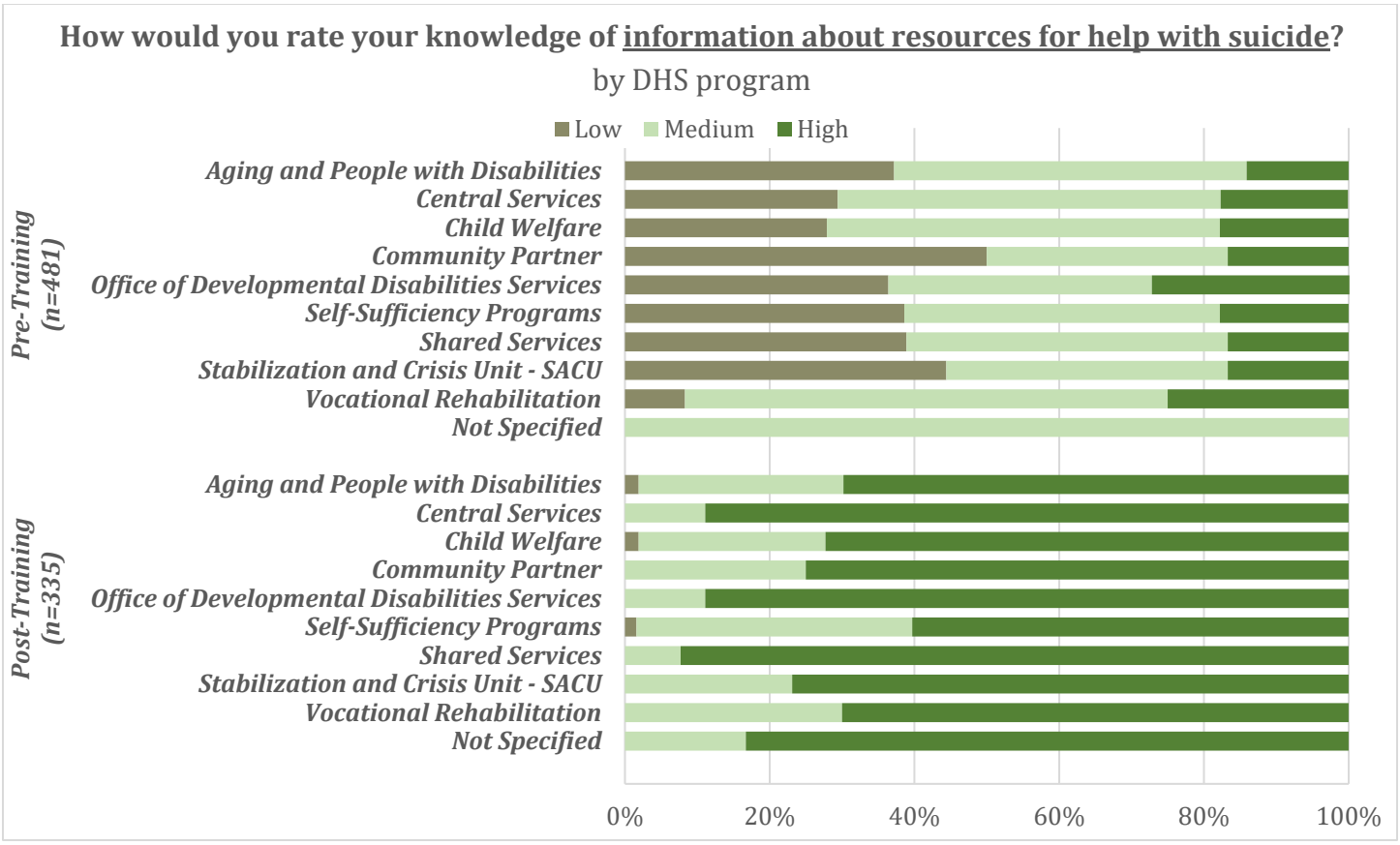
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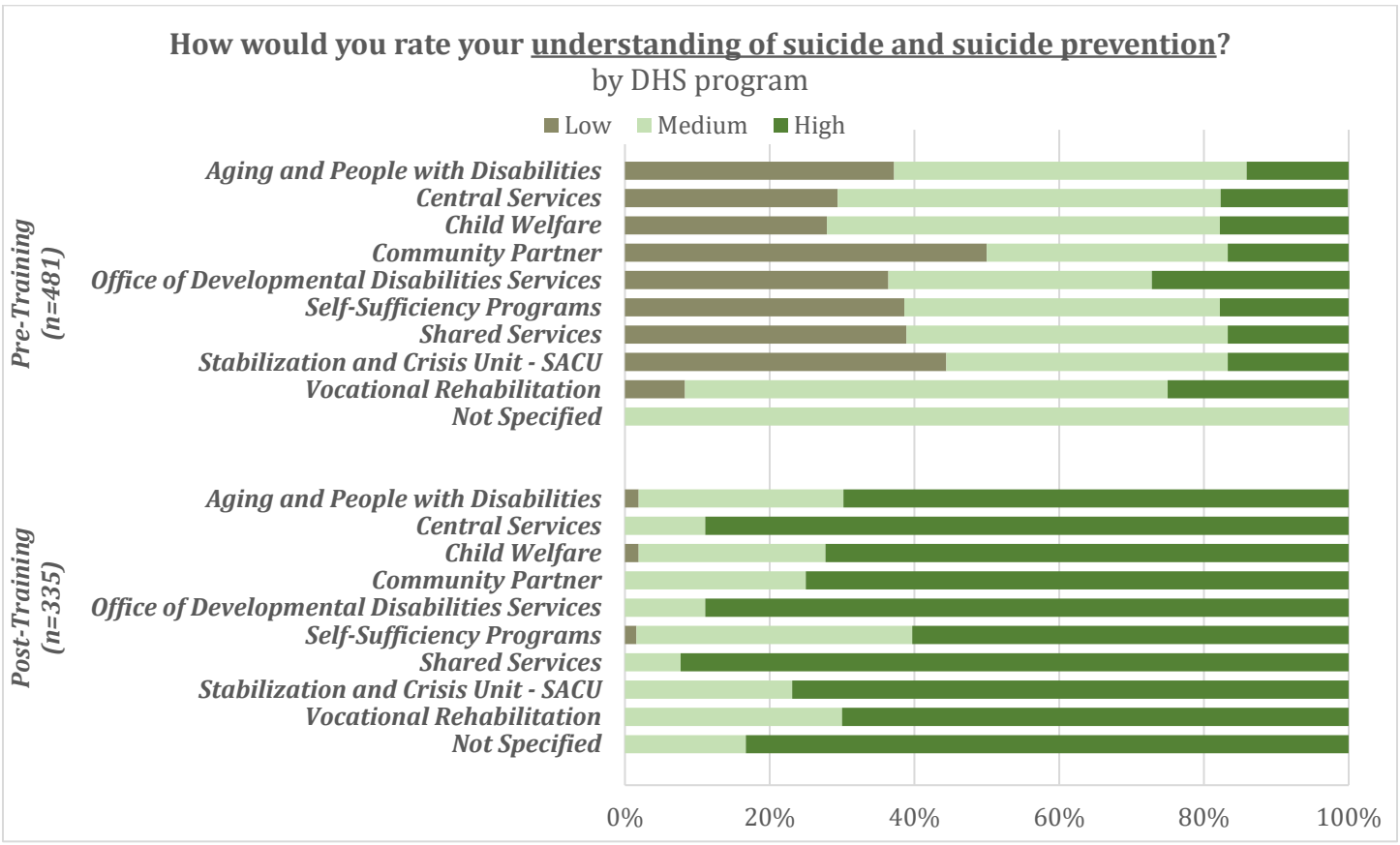
by DHS program
Low
Medium
High
Pre-Training (n=481)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
Post-Training (n=335)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
0%
20%
40%
60%
80%
100%


How would you rate your understanding of suicide and suicide prevention?
by DHS program
Low
Medium
High
Pre-Training (n=481)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
Post-Training (n=335)
Aging and People with Disabilities
Central Services
Child Welfare
Community Partner
Office of Developmental Disabilities Services
Self-Sufficiency Programs
Shared Services
Stabilization and Crisis Unit - SACU
Vocational Rehabilitation
Not Specified
0%
20%
40%
60%
80%
100%

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	113	23.3%	186	55.0%	64.6%
Agree	272	56.0%	127	37.6%	-53.3%
Neutral	94	19.3%	22	6.5%	-76.6%
Disagree	6	1.2%	2	0.6%	-66.7%
Strongly Disagree	1	0.2%	1	0.3%	0.0%
Total	***486***		***338***		

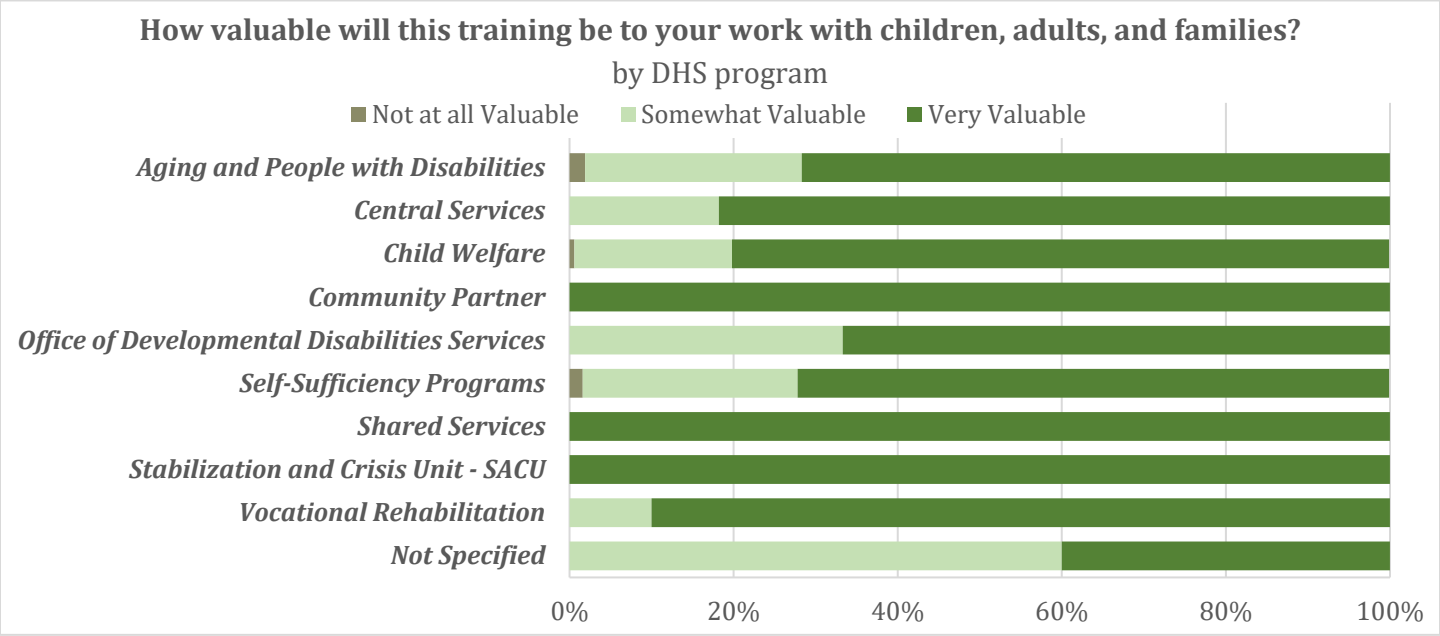
How comfortable are you with asking a person about suicide?	Pre-Training		Post-Training		Percent Change
Very Comfortable	56	11.5%	124	36.8%	121.4%
Comfortable	266	54.7%	184	54.6%	-30.8%
Uncomfortable	153	31.5%	27	8.0%	-82.4%
Very Uncomfortable	11	2.3%	2	0.6%	-81.8%
Total	***486***		***337***		

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	122	25.0%	199	58.7%	63.1%
Likely	300	61.5%	135	39.8%	-55.0%
Unlikely	61	12.5%	4	1.2%	-93.4%
Very Unlikely	5	1.0%	1	0.3%	-80.0%
Total	***488***		***339***		

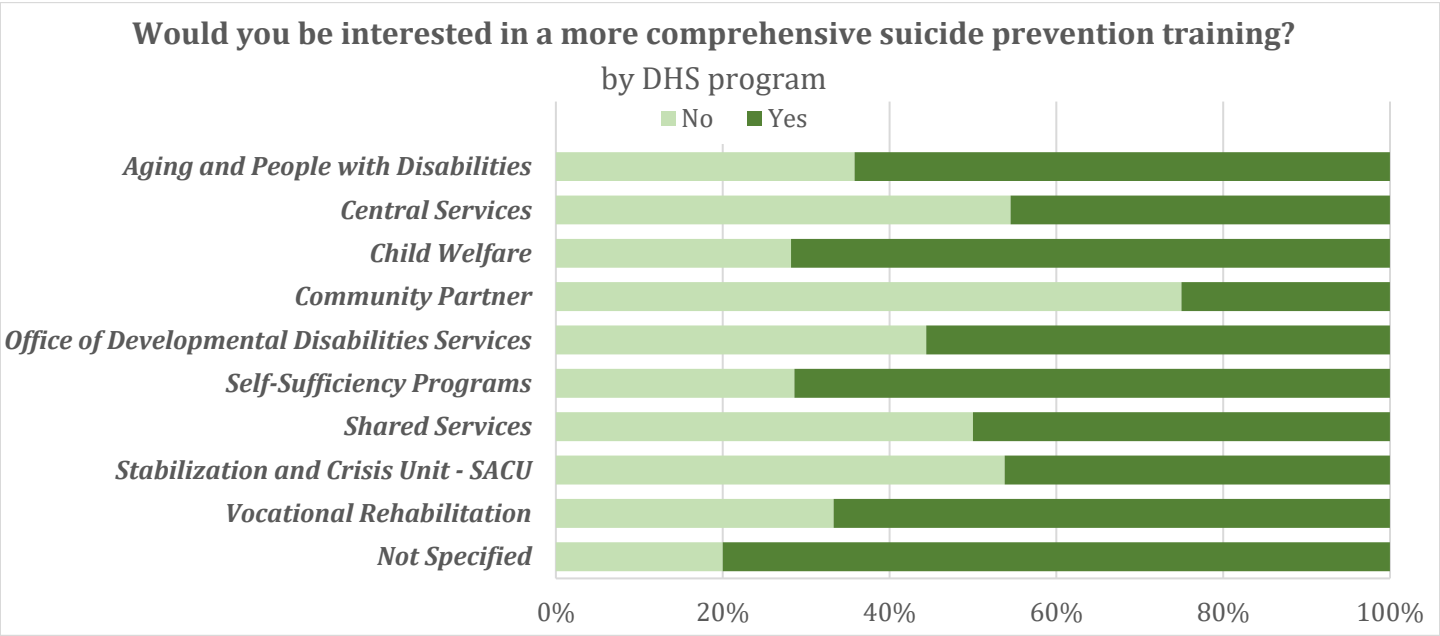
How likely are you to intervene when someone is exhibiting signs of suicide risk?	Pre-Training		Post-Training		Percent Change
Very Likely	195	39.9%	225	66.2%	15.4%
Likely	274	56.0%	113	33.2%	-58.8%
Unlikely	18	3.7%	2	0.6%	-88.9%
Very Unlikely	2	0.4%	0	0.0%	-100.0%
Total	***489***		***340***		

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	223	45.9%	234	69.0%	4.9%
Likely	237	48.8%	102	30.1%	-57.0%
Unlikely	24	4.9%	2	0.6%	-91.7%
Very Unlikely	2	0.4%	1	0.3%	-50.0%
Total	***486***		***339***		

Training Value



Interest in More Comprehensive Training



Building Healthy Communities and Preventing Child Neglect

IT'S MORE THAN A FAMILY MATTER

CHILD NEGLECT is a failure to meet children's basic needs – whether the failure is the responsibility of parents, communities or society – and this void places children in harm's way.

FACTS *about Child Neglect*

Most Common Form of Child Maltreatment

Cognitive and Academic Deficits

Social Withdrawal and Limited Peer Interactions

Violent and Criminal Behavior

Possible Long-Term Impacts

Cost of Child Maltreatment
in billions of USD (2008)

Good news **IT'S PREVENTABLE**

Child Neglect within the SOCIO-ECOLOGICAL MODEL

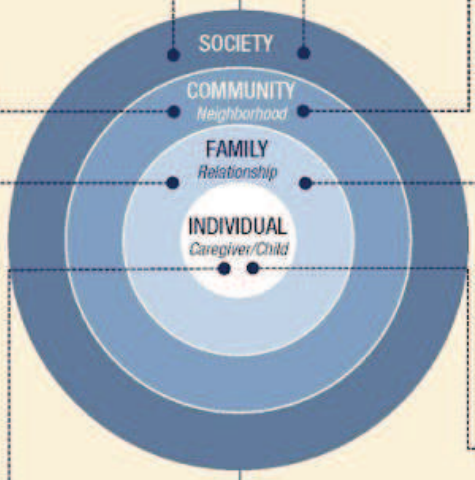
Child Neglect Risk Factors

SOCIETY
- Poverty and deprivation of basic needs
- Lack of collective (shared) responsibility for children
- Low level of importance to politicians – lack of political will

COMMUNITY *(Neighborhood)*
- Environmental problems
  - Neighborhood violence
  - Unemployment
  - Inadequate housing
  - Social isolation
- Caregiver childhood adversity

FAMILY *(Relationship)*
- Maternal depression
- Situational or enduring problems
  - Mental health
  - Substance abuse
  - Interpersonal family violence
- Apathy/hopeless

INDIVIDUAL *(Caregiver/Child)*
- Child vulnerability
  - Young age
  - Poor health
  - Disabilities and behavioral challenges
- Unmet basic needs



Protective Factors to the Rescue

SOCIETY
- **Concrete Supports**

COMMUNITY *(Neighborhood)*
- **Concrete Supports for Parents** *(Quality Child Care)*
- Community Norming of Acceptable Parenting Behaviors
- **Social Connections** *(Cohesion)*

FAMILY *(Relationship)*
- **Knowledge of Parenting and Child Development** *(Early Childhood Education)*
- **Parental Resilience** *(Hope)*
- Faith and Spirituality
- Nurturing and Attachment

INDIVIDUAL *(Caregiver/Child)*
- Attachment
- **Social and Emotional Competence of Children**

To learn more about building healthy communities, visit
https://ctfalliance.org/building-healthy-communities
and about preventing child neglect, visit
https://ctfalliance.org/preventing-child-neglect

NATIONAL ALLIANCE of CHILDREN'S TRUST & PREVENTION FUNDS

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

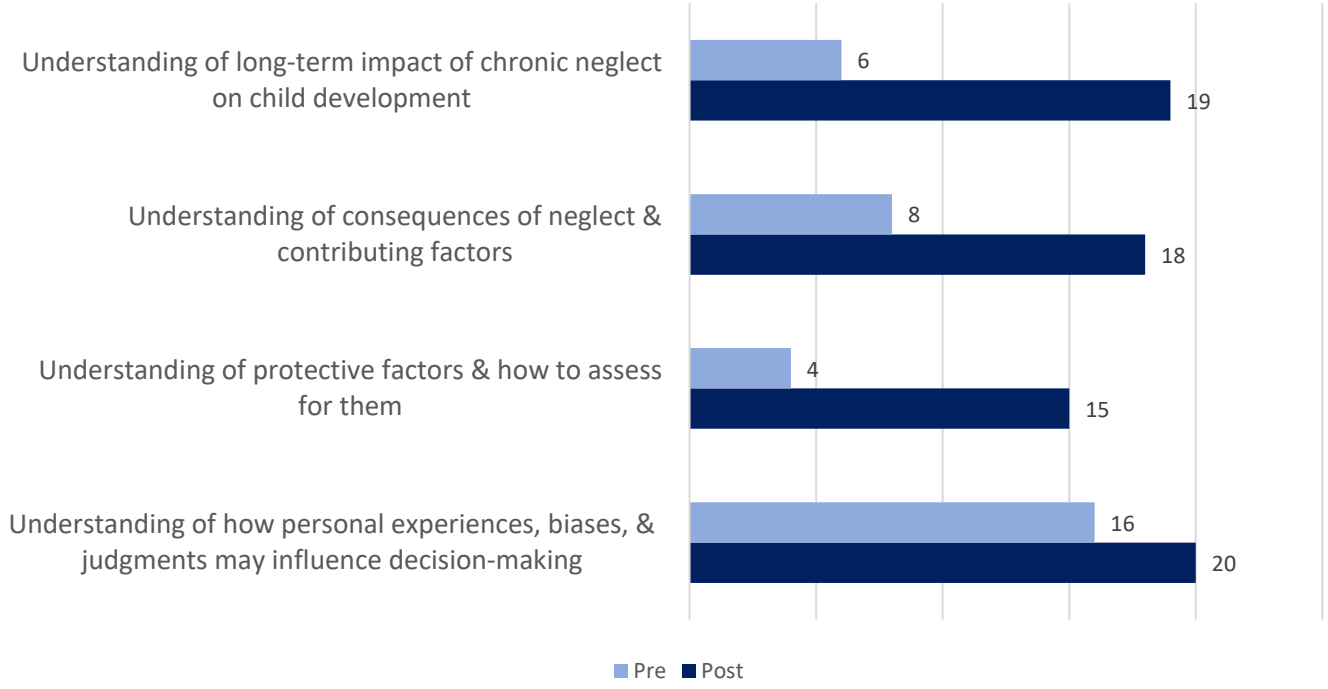
[iv] https://www.childwelfare.gov/pubs/issue-briefs/protective-factors/

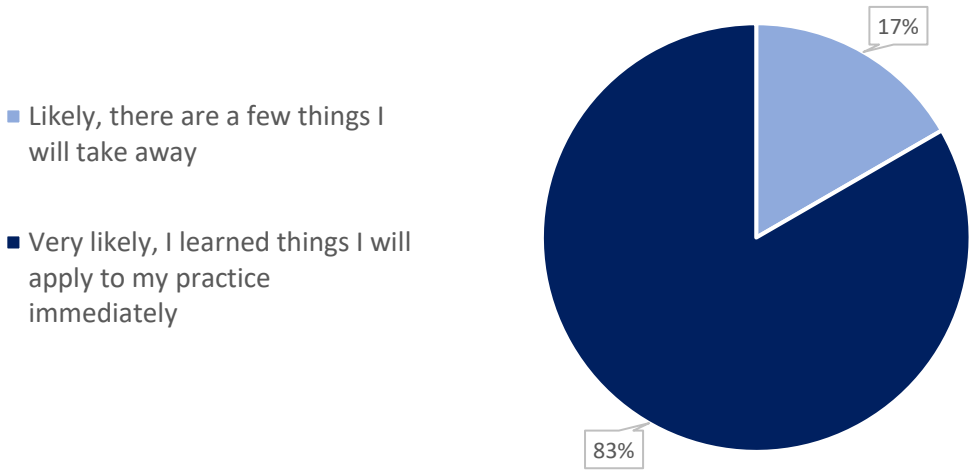
Oregon Assessing Patterns & Behaviors of Neglect Training Results and Evaluation Feedback

Supporting child welfare professionals in understanding and responding to neglect, in particular, chronic neglect, is an important aspect of fatality prevention. Over 200 Supervisors, MAPS, and Active Efforts Specialists participated in the training prior to the onset of the COVID-19 pandemic. In April 2021 in an updated virtual format for supervisors, MAPS, and Active Efforts Specialist was offered over four sessions between April and December 2021. A total of 27 Supervisors, MAPS, and Active Efforts Specialists participated in the 2021 virtual Oregon Assessing Patterns & Behaviors of Neglect training, with all participants completing a training evaluation. Plans for delivery are underway for 2022. Stay tuned for upcoming training announcements.

Participant Knowledge: Pre- and Post-Training

The graph below displays the percent of respondents who indicated they have a high level of knowledge about each area prior to taking the training and after.





Participant Feedback

- I am going to use these tools to help focus individual and group supervision. While every moderate-to-high risk family is not a safety threat, I think it is important to keep in mind that there are likely still impacts on a child's development, and that part of preventative work is finding the right services for a family to address areas before becoming a safety threat.
- There was a lot of information provided through the Padlet and I anticipate revisiting these resources regularly when working with colleagues and families.
- This was an amazing training. This is in my top 3 that I have ever attended through ODHS. I know that I will remember what I learned because Heather and Greg were so great about engagement with not only us, but the training materials too. I am walking away with actual knowledge and skills that I can take with me into meetings and into the field.
- I was engaged throughout, which is something that was difficult pre-COVID and next to impossible post. I appreciate that information is going to be available to us moving forward. I would like to do more advanced trainings of this nature as my career progresses.
- I plan on using various documents and resources from the Padlet in my one-on-one staffings and in team meetings to bolster discussions.
- All of the tools provided can be helpful to different degrees, depending on case specifics.

Beyond Child Abuse Prevention and Sexual Assault Awareness Month

Child Abuse Prevention and Sexual Assault Awareness Month April 2022

While Child Abuse Prevention and Sexual Assault Awareness efforts and are highlighted during the month of April, the work to end interpersonal violence continues throughout the year. Below are a few resources to carry forward as we work together to prevent child abuse and sexual assault.

Start by Believing

"I believe you." Three little words can make all the difference to a survivor of interpersonal violence. Start By Believing, a program of End Violence Against Women International (EVAWI), offers guidance on what to say and actions to take when someone shares their lived experience of survivorship. Your reaction can make a significant difference.

Creating Positive Childhood Experiences

"We all benefit when children have safe, stable, nurturing relationships and environments. Everyone can help prevent ACEs and promote positive childhood experiences by supporting children and families where you live and work." The Centers for Disease Control (CDC) offers a variety of resources to increase knowledge about ACEs and creating positive childhood experiences within your local community.

Healthy Relationships

"By ensuring that their first relationships are healthy ones, we can help young people detect and prevent intimate partner violence (IPV) throughout their lives." The Start Strong Program from Futures Without Violence is aimed at promoting healthy relationships among 11 to 14 year old's, and identifying promising ways to prevent IPV. Universal education and empowerment about healthy relationships across the lifespan is critical to preventing and ending interpersonal violence.

Hot Chocolate Talk

"Little moments can make a big difference." It is important that parents or caregivers talk with children and young people about personal safety and sexual abuse. Many of us might not be sure what to say or when to say it. The

Hot Chocolate Talk campaign offers How-to-Guides for talks with toddlers to teens that support parents and caregivers in these crucial conversations.

Make Safe Happen

"Make your home a safe place to be a kid." The Make Safe Happen app allows anyone to make their home safer for children with room-by-room safety checklists based on the age of the child. The app can also create shopping lists, to-do lists, set reminders, and track your progress. While the Make Safe Happen app is currently available to anyone, it is not yet available to download on State issued work phones. This capability is coming soon, so be on the lookout for the update!

Safe Families for Children

"Children don't grow up in programs, they grow up in families and communities." Safe Families for Children serves families who may lack social networks and live in isolation without the support of family or friends when dealing with crises, such as homelessness, unemployment, child abuse, DV, medical emergencies or substances use. Safe Families for Children provides a network of host families who volunteer to care for children until parents or caregivers can get back on their feet.

Safe Sleep for Babies

"Face up. Face clear. Smoke-free. Baby near!" In Oregon, about 40 babies die in their sleep every year. The Doernbecher Infant Safe Sleep Program offers information, resources and supports for a creating culturally responsive safe sleep environment, identifying unsafe sleep practices, grief and loss support, and where to go for more information, including a safe sleep guide in a variety of languages. When working directly with families who are parenting or caretaking an infant, consider offering the Safe Sleep for Babies brochure from the Oregon Health Authority (OHA).

Vroom

"Hello, Brain Builder!" Vroom can help parents and caregivers boost their child's learning during the time they already spend together by providing tips and activities when and where they are and based on their child's age. Vroom activities and tips were developed by scientists, researchers, and parents. Vroom is available in English and Spanish and can be used through the app, their website, or by signing up for Vroom texts through their website, Vroom.org. The Vroom app can be downloaded to State issued work phones. Consider downloading the app and sharing with any families you work with.

Confirming Safe Environments is Child Abuse Prevention

Child Abuse Prevention and Sexual Assault Awareness Months *April 2022*

Often ODHS Child Welfare can inadvertently be thought of as only a response to child abuse; however CW plays a significant role in child abuse prevention, specifically through confirming safe environments by intentional contact with parents and children.

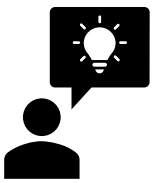
Confirming Safe Environments

It is important to recognize that the quality of a safe environment can change over time as all families, including resources families, experience changes, stress, crisis and the pressures of daily life.

A safe environment is not simply the physical environment, but also includes:

- *What activities does the child do in the resource home?*
- *Where does the child eat, sleep, and play?*
- *How does the child get along with other kids in the home?*
- *What are potential hazards inside and outside the home?*
- *What does supervision look like?*
- *Is the supervision plan adequate, if applicable?*
- *Is the safety plan sufficient?*
- *Does the child get to school on time?*
- *Is the child getting to appointments as needed?*
- *If children are in home, are all four in-home criteria still met?*

Intentional Contact



Being intentional means to be purposeful or deliberate. The contacts that CW has with families should be made with intention, and focused on engagement that is strengths-based, trauma-informed, culturally responsive, and values family and youth voice.

Intentional engagement:

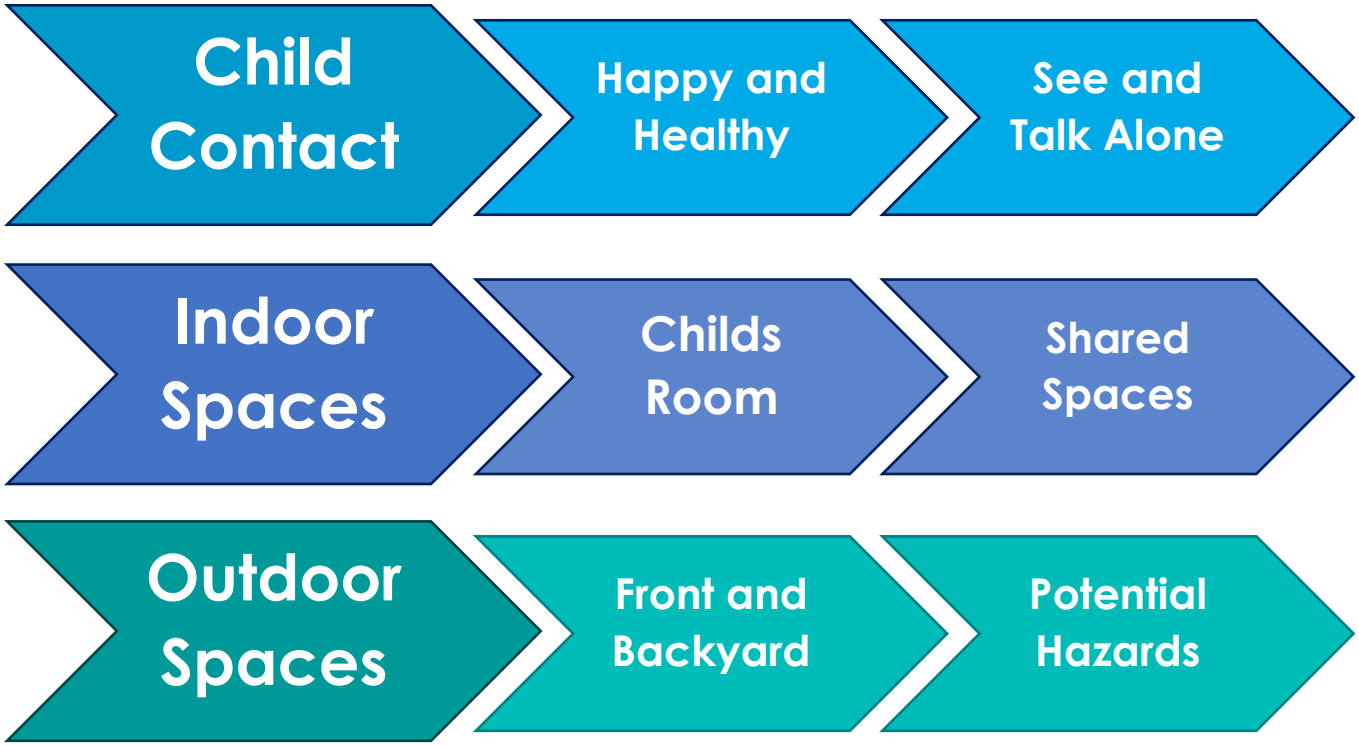
- Demonstrates genuineness, empathy and respect for each family member.
- Suspends biases and avoids judgement.
- Makes sure children, regardless of age, parents and resource parents feel comfortable discussing challenges, needs and successes.

- Communicates support and partnership.
- Is humble and curious. Ask and then listen to understand who the parent/child is and what they know about their family needs.

Documentation

When confirming safe environments, it is critical to observe both indoor and outdoor spaces. Documentation must describe the observations of:

- √ Safety in the home where the child resides
- √ Case plan progress including familial contact and attachment
- √ Child's well-being and needs
- √ Next steps to support the child and resource parent



Documentation should be clear, concise, factual and objective. When describing behaviors or interactions, avoid jargon, and stay away from negative or value laden words, such as *"the mother was hostile"* or *"the parents were non-compliant."*

To learn more about Confirming Safe Environments, explore Chapter 4, Appendix 4.2: *Face to Face Case Note Guide* on page 624 in the CW Procedure Manual.

Courageous Conversations

Spending time engaging in conversations about child abuse prevention and sexual assault awareness is important to encourage the understanding that violence is preventable, and we all play an important role and have responsibility in preventing it. Below are some resources that can be used during huddles, unit meetings, all staff's or other already scheduled opportunities that your team(s) come together.

Topic: Caring adults as a protective factor for children

Using the video and material as a guide, facilitate a discussion about relationships with caring adults as protective factors for children

Video: *Changing Minds – Chad's Story (6 mins) The story of Chad shows how a supportive and caring adult can help a child overcome childhood trauma and exposure to violence. Each year, nearly 60% of youth are exposed to violence in their homes, schools, and communities. Recent studies demonstrate how observing violence has a lasting negative impact on a child's brain and their cognitive development. Over time, exposure to violence during childhood is significantly correlated with negative outcomes such as psychological issues, adverse behavior, and serious illnesses.*

Material: *Promoting Protective Factors for In-Risk families and Youth: A Guide For Practitioners*

Resources:

- Changing Minds: The Campaign to End Childhood Trauma
- Who can Make A Difference ?

Topic: Victim Blaming

Using the video and material, facilitate a discussion about victim blaming.

Video: *James is Dead* (5 mins) *Whether it's murder or sexual assault, it's not the victim's fault.*

Material: Victim-Blaming The Canadian Resource Centre for Victims of Crime

Topic: How to Stop Victim Blaming

Using the video and discussion guide, facilitate a discussion about reframing victim blaming as it relates to the program you are with, i.e. CW, SSP, etc.

Video: *Decoded: How to Stop Victim Blaming (5 mins) Ever hear someone say, 'Well she shouldn't have gotten drunk?' or 'Well it makes sense considering what she was wearing.' Pretty much no matter what bad thing happens to you, there's always going to be someone that tells you that, in some way, it's your own fault. This terrible tendency is called Victim Blaming and it happens a lot, especially to victims of sexual assault. And while there are real psychological reasons why people like to blame victims, there's new research that suggests that there is a way to greatly reduce the tendency to victim blame. And it's actually pretty simple.*

Material: Decoded Discussion Guide (PDF attachment)

Topic: PACEs – Two Sides of the Same Coin

Using the video and material, facilitate a discussion about shifting focus to positive and adverse childhood experiences, or PACEs, instead of just on ACEs.

Videos:

- We Can Prevent ACEs *(5 mins)*
- How Childhood Trauma Affects Health Across A Lifetime TEDTalk *(15 mins)*

Materials:

- 3 Realms of ACEs
- PACEs Connection

Topic: Pinwheels for Prevention

Using the video and material, create pinwheels as a team. Discuss the pinwheel and it's meaning to child abuse prevention.

Videos:

- How to Make a Paper Pinwheel
- DIY Pinwheel PDF

Material: *Pinwheels for Prevention – Prevent Child Abuse Oregon

**ODHS does not specifically endorse purchasing from any organization*

A. *What stood out to you?*

- Power of language
- Victim blaming is pervasive
- The reasons we ca victim blame are complex
- Victim blaming is an implicit bias, we all have implicit bias
- Can be extremely subtle, showing up in language and word choice

B. *How can victim blaming show up in your role?*

- Question we ask survivors, i.e. *what were you wearing? Were you drinking?*
- How we document the violence or abuse, i.e. *an incident of sexual assault occurred between the two*
- Questioning credibility
- Likability of a survivor

C. *What are aspects of society/culture/values promote victim-blaming?*

- Implicit or explicit beliefs about gender roles
- Beliefs about high rates of false reports of child sexual abuse, sexual assault or other sexual violence
- Rape culture: *Rape culture is a culture in which sexual violence (and other forms of interpersonal violence, like sexual harassment, dating violence, domestic violence and stalking) is considered to be a normal part of the culture and those from privileged identities who are perpetrators of violence are excused. Rape culture is manifested in statements like "boys will be boys" to justify harassment, jokes about sexual violence (e.g. regarding violence in prisons), or through victim blaming (e.g. the victim shouldn't have gotten drunk).*

D. *How does victim blaming negatively impact survivors?*

- Discourages survivors from coming forward
- Shifts focus away from the perpetrator
- Reinforces messages that the survivor could have done something to prevent the violence

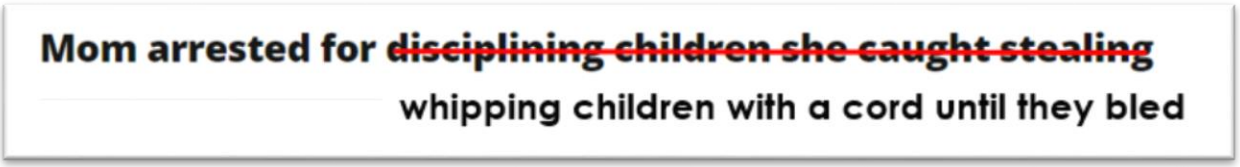
E. *How does victim blaming show up in the language we use?*

- Use of euphemisms to lessen discomfort
  - *"He forced himself on her."*
  - *"They inappropriately touched a child."*
- Use of consensual language to describe sexual assault
  - *"The adult male had sex with a young girl"*
  - *"Sex with underage men"*
- Passive voice and removing the grammatical agent, specifically the perpetrator
  - *"She was sexually assaulted" instead of* ***"He raped her."***

Flex Skill Set Exercise: *Fixed It* – Inspired by Jane Gilmore's #FixedIt
Show or read out the real headlines and offer the group opportunities to "fix it," or re-write them so they do not blame the victim or minimize the violence. Provide a content caution as these are actual headlines that highlight incidents of interpersonal violence, specifically child abuse sexual assault and homicide. **Resources:** Sociological Images, and The Peggy and Jack Baskin Foundation

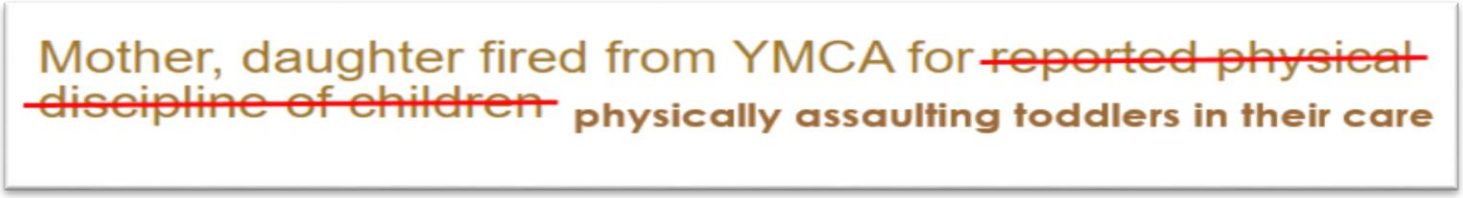
1. **Headline:** ***Man admits to sex with child***

2. **Headline:** ***Mom arrested for disciplining children she caught stealing***



3. **Headline:** ***Limerick men found guilty of raping girl, 14, in Co Clare after they had been drinking together.***

4. **Headline:** ***Mother, daughter fired from YMCA for reported physical discipline of children***



5. Headline: ***Man jailed for killing ex-girlfriend's goldfish after breakup***

~~Man jailed for killing ex-girlfriend's goldfish after break-up~~

Man paroled after stalking, threatening woman for a year

6. Headline: Police: Dad killed 5 kids because wife was leaving

In an act of domestic violence,

~~Police~~: Dad killed 5 kids ~~because wife was leaving~~

AP Associated Press Buzz Up Send Share Print

7. Headline: Maryland teacher and coach, 26, arrested for sex romps with her 16-year-old female student

Maryland teacher and coach, ~~26, arrested for sex romps with her 16-year-old~~ female student arrested for repeatedly raping

8. Headline: Sandford swimmer Brock Turner has appeal and request for new trial denied

Convicted sex offender

~~Stanford swimmer~~ Brock Turner has appeal and request for new trial denied

FAMILY PRESERVATION

Child Abuse Prevention and Sexual Assault Awareness Month *April 2022*

The 2018 Family First Prevention Services Act (FFPSA) was a first step toward overhauling federal child welfare funding requirements aimed at keeping children safely with their families, and preventing the traumatic experience of foster care.

THE NEED

Young people, regardless of their age, experiencing the child welfare system are best served in families, in a safe and stable environment that supports their long-term well-being.

As a result, the Family First Prevention Services Act (FFPSA) enacted on February 9, 2018, was created to prevent children from entering or re-entering foster care. FFPSA provides jurisdictions the option of receiving federal title IV-E reimbursement at a matching rate for certain evidence-based, trauma-informed services related to parenting skills, mental health, and substance use disorders. ODHS Child Welfare (CW) and Self-Sufficiency Programs (SSP) collaborated with Tribes, other agencies, community partners, providers, parent mentors, youth voice, and those with lived experience to develop the Oregon Title IV-E Prevention Plan.

At the same time, ODHS CW and SSP recognized that working together with families and their supports using **strengths based, trauma informed, parent directed, youth guided, and culturally responsive** practices improve the ability to keep children safe and families together and were developing a program to incorporate these values.

Collaborating with the partners mentioned above, using FFPSA and the core values as a foundation, the Family Preservation Program was created by merging the two projects.

THE GOAL

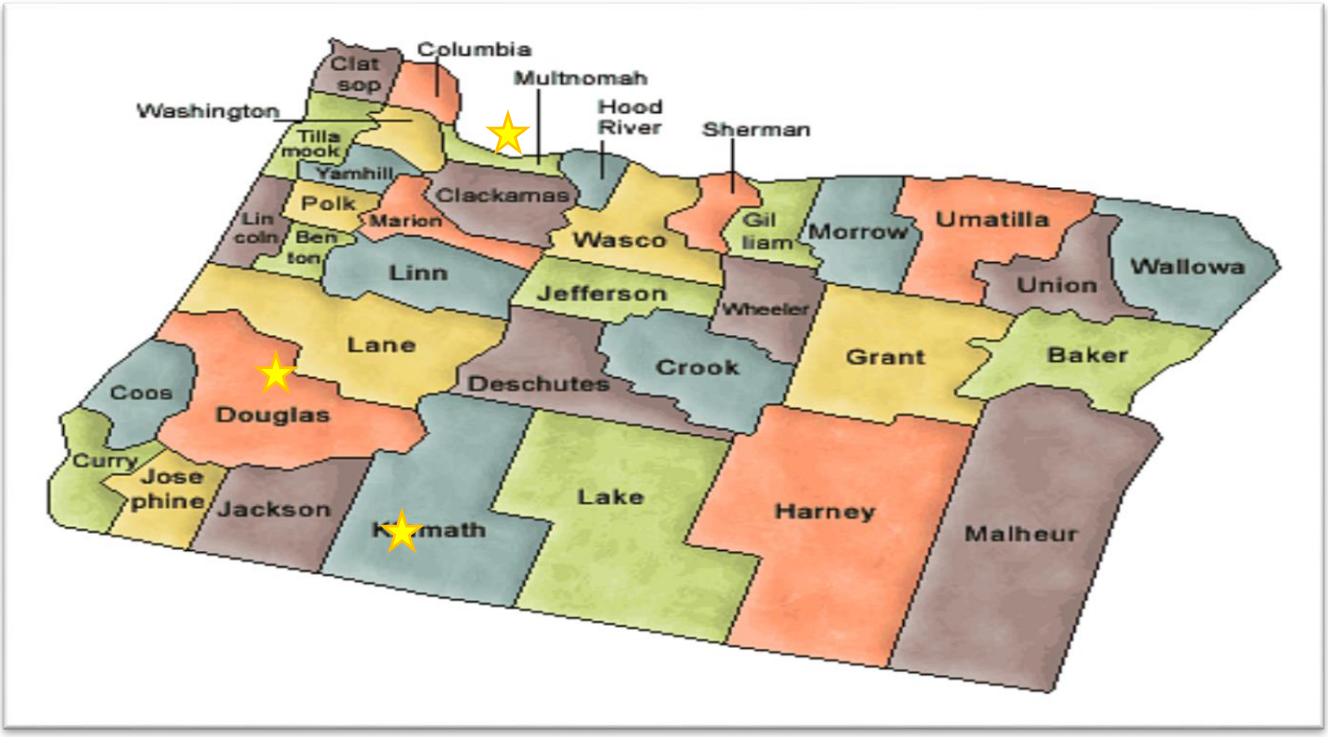
The goal of the Family Preservation approach is to serve more families, keeping children in-home and, in their communities, than in foster care through values-based engagement, team and relationship building, consistent and uniquely tailored in-home supports and robust services.

THE PATHWAY

Intentional collaboration between CW, SSP and community partners, will align supports for families. By working together with purpose, multiple systems that impact family's lives can foster and sustain a family-centered and multi-generational approach to helping families. The Family Preservation approach is aligned with the CW Vision for Transformation, which underscores that families in need of support should be served whole and together, when safely possible.

OREGON'S FAMILY PRESERVATION APPROACH

Beginning March 28, 2022 three Family Preservation demonstration sites kicked off in diverse areas of the State, specifically at the Alberta ODHS Branch in **Multnomah County (Alberta), Douglas County and Klamath Falls.**



To learn more visit: FFPSA-FAQs, *An Introduction to Family Preservation* and CW Division Vision for Transformation.

Watch a clip *(10 mins)* of Oregon Senator Ron Wyden offering the unanimous Senate consent request to then President Donald Trump for FFPSA.

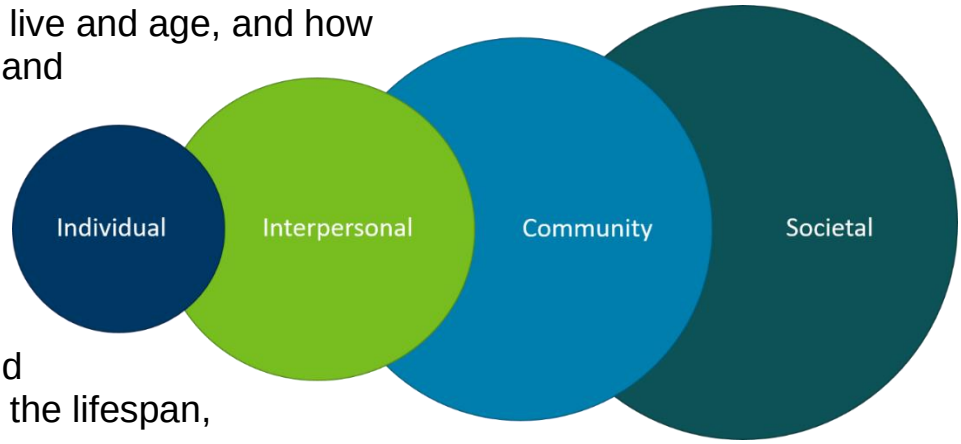
Lifespan Abuse Prevention

Child Abuse Prevention and Sexual Assault Awareness Month ***April 2022***

Interpersonal violence, which includes child abuse, youth violence, intimate partner violence, sexual violence and elder abuse, is interconnected and affects millions of US residents each year. Children bear a disproportionately large share of the cost of violence, as do victims of sexual assault and their families. Health costs of Adverse Childhood Experiences (ACEs) in North America and Europe are estimated to cost [$1.3 TRILLION annually](#).

The Social-Ecological Model: A Framework for Prevention

Prevention starts with understanding the factors that influence health overall and more specifically violence. *[Social Determinants of Health – An Introduction](#) (06:30 mins)* provides a high-level overview of the social determinants of health, or the conditions in which people are born, grow, live and age, and how they impact health inequities and disparities. The social determinates can be mapped using a social-ecological model that includes multiple levels of the physical and social environments that interact and overlap to impact health over the lifespan, including violence.



The levels are: Individual, Interpersonal, Community and Societal.

Individual

The individual level identifies the biological and personal history factors that can increase the likelihood of a person becoming a victim or a perpetrator of violence, or both. Some individual factors are age, physical or mental health, education, income, substance abuse, adverse childhood experiences (ACES), etc.

Interpersonal

The interpersonal level identifies interpersonal relationships that can increase the risks of experiencing violence as either a victim, a perpetrator or both. A person's peers, family, friends and loved ones

often influence behaviors, attitudes, belief and value systems and contribute to someone's experiences.

Community

The community level explores the communities, such as the schools, early learning opportunities, childcare, workplaces, or neighborhoods, in which a person is born, grows, lives and their interpersonal relationships happen, and the characteristics of those communities that can increase someone's likelihood of being a victim or perpetrator of violence, or both.

Societal

The societal level examines the broad societal factors that create a climate in which violence is encouraged or inhibited, such as social and cultural scripts that violence is an acceptable way to resolve conflict; and other larger factors, like economic, health, educational and social policies that support the oppression, marginalization, health disparities and other inequities between groups in society.

Prevention Efforts

Connecting the Dots: An Overview of the Links Among Multiple Forms of Violence offers a tool to "connect the dots," or map, the multiple types of violence, and the risk and protective factors at each level of the social-ecological model. Understanding the connections can help prevent multiple forms of violence at once that impact people over their lifespan. This intentional and focused approach is more likely to sustain prevention efforts over time and achieve maximum impact for all people. The Oregon Sexual Assault Task Force (SATF) is promoting lifespan abuse prevention through *The Bridge Project*. The SATF offers five research-based strategies as effective prevention of not only sexual violence and child abuse, but also intimate partner violence, suicide, youth violence, and elder abuse.

To learn more, check out their *3-part series - Abuse 101 Prevention*

- *Situating Prevention – Part 1*
- *Addressing the Root Causes of Abuse – Part 2*
- *Promoting Healthy Norms – Part 2*

Prevention Resources in Your Community

Child Abuse Prevention and Sexual Assault Awareness Month April 2022

Preventing both child abuse and sexual assault requires addressing risk and protective factors at many levels, including within the community. Research shows that parents and caregivers who have access to and support from not only family, friends and loved ones, but their neighbors and communities, are more likely to provide safe and healthy homes for their children. Connecting families with supports that exist within their community reduces the risk of re-abuse and promotes sustained health and wellness. Below are a variety of statewide, multi-county, and county-specific resources for Oregon families, including hyperlinks to websites when available.

Statewide Resources

The Big River Program Available in English and Spanish, the Big River Program is a statewide initiative sponsored by the Oregon Healthy Authority (OHA) to increase access to suicide prevention and intervention trainings. These programs are each led by a statewide coordinator, underpinned by Train the Trainer events. They work to equip youth-serving professionals and community members with knowledge and skills to help prevent suicide. This allows for locally delivered suicide prevention programs, with robust human and financial support from the state. That synergy strives to give Oregon's youth more protection against suicide.

Honoring Children, Making Relatives OHA is piloting Honoring Children, Making Relatives, the culturally specific enhancement of Parent Child Interaction Therapy (PCIT) for American Indian/Alaskan Native (AI/AN) families. The year-long training will be provided by Dr. Delores BigFoot, the developer of this adaptation of PCIT. Dr. BigFoot is a member of the Caddo Tribe in Oklahoma. She is the Director of Project Making Medicine and the Indian Country Child Trauma Center. This OHA pilot is to train providers in Tribal clinics to implement Honoring Children, Making Relatives. It also offsets some the additional costs associated with providing this highly effective intervention. Honoring Children, Making Relatives is a well-researched family therapy model and therefore may be reimbursed by Medicaid or commercial insurance. PCIT is a well-supported, evidence-based intervention for children ages 2 through 6 years experiencing social, emotional or behavioral problems, as well as their caregiver(s).

Oregon Parenting Education Collaborative (OPEC) OPEC is a partnership of the Oregon Community Foundation (OCF), The Ford Family and Collins Foundations, Meyer Memorial Trust and Oregon State University (OSU) to support the delivery of high-quality parenting education programs that are evidenced based and culturally responsive. Initiative partners believe parents are their children's first and most important teachers, and that investment in strong parenting is a critical strategy for ensuring that all children are ready to learn. This multiyear grant program funds the delivery of parenting education programs and supports grantees through evaluation, technical assistance and professional development led by OSU. OCF and its funding partners support 16 regional parenting "Hubs" reaching nearly every Oregon county.

Early Learning Hubs In 16 regions across Oregon, Early Learning Hubs are working together across cross-sectors to work together creating local systems that are aligned, coordinated, and family-centered. Families receive the support they need to become healthy, stable and attached and their children receive the early learning experiences they need to thrive.

Family Support and Connections (FS&C) Program FS&C promotes community and family health, safety and economic stability to prevent child abuse. Community-based organizations in all 36 counties offer services designed to increase protective factors, support effective parenting, and decrease risk factors associated with child welfare intervention. Services are tailored to meet a family's individualized needs and include home visits, family strength and needs assessments, parent education, connection to community resources and networks, and supports to strengthen families. FS&C will be expanding access and serving more families; prioritizing black, Indigenous and families of color as a result of $26.1 million for ODHS Self-Sufficiency Programs. The package, which represents the largest increase to the TANF benefit in Oregon's history, will activate a set of upstream solutions for families participating in the program. In addition to the expansion for the FS&C, the package includes:

- Allowances to help parents pay for seasonal weather-appropriate clothing for their children;
- A permanent increase on the asset limit that determines TANF eligibility, which will help participating families preserve more of their resources and save for the future

Family Connects Family Connects is the new universally offered nurse home visiting program that will eventually be available to all families with a newborn in Oregon. Family Connects Oregon nurse home visitors work with families to identify what families need and want from local resources, and then provides an individualized, non-stigmatizing entry into a community system of care. This system includes referrals to other, more intensive, home visiting programs, and health and social supports around the state, such as obstetricians and primary care providers, pediatricians and family practice physicians, childcare options, mental health services, housing agencies and lactation support organizations.

Family First Prevention Services Act (FFPSA) The Oregon Department of Human Services (ODHS) welcomes the FFPSA implementation as an opportunity to support our ongoing transformation effort by promoting innovations and flexibility in funding prevention services. We are committed to increasing families' access to supportive services prior to child welfare interventions. These services include in-home, skill-based parent training, mental health care, family therapy, and substance abuse and treatment programs. Quality prevention services and strong federal, state and community collaborations will be the foundations for Oregon's Family First implementation.

Healthy Families Oregon (HFO) Healthy Families Oregon is a free, voluntary home visiting program offering support and education to families who are expecting or parenting newborns. HFO is located in communities throughout Oregon. Trained staff support and empower parents to build nurturing parent-child relationships, learn about child development, and access community resources.

Traditional Health Workers (THW) Coordinated Care Organizations (CCO)'s statewide are promoting utilization of THW's. THW are trusted individuals from their local communities who may also share socioeconomic ties and lived life experiences with health plan members, such as Support Specialists, Birth Doula's, etc. THWs have historically provided person and community-centered care by bridging communities and the health systems that serve them, increasing the appropriate use of care by connecting people with health systems, advocating for health plan members, supporting adherence to care and treatment, and empowering individuals to be agents in improving their own health.

Save Lives Oregon The Save Lives Oregon Campaign began in 2020, when the COVID-19 pandemic heightened the overdose crisis and left many families, neighborhoods and communities struggling. In response, a resource hub was launched to provide more life-saving supplies such as naloxone to organizations and tribal communities on the front lines of harm reduction. With continued support and a growing understanding of the power of harm reduction to save lives, Save Lives Oregon are reducing drug-related stigma and increasing access to programs that support the health and dignity of people who use drugs.

Relief Nurseries A Relief Nursery provides a unique array of comprehensive family support services accessible to low-income parents with children up to five years of age who are a high risk for abuse. Relief nurseries offer therapeutic early childhood programming, home visiting, outreach services, and parenting education.

Reverse Overdose Oregon Reverse Overdoes Oregon is a statewide campaign that gives employers the tools to train their teams on how to use naloxone—the life-saving medication that reverses opioid overdose—as part of workplace safety and preparedness. By providing naloxone training and resources to employers, Oregon Health Authority is expanding the pool of first responders to overdose and empowering everyday people to save the lives of coworkers and community members who accidentally overdose from prescription painkillers or illicit opioids.

Heal Safely Campaign Prescription opioids come with risks and serious side effects and should be a last resort when managing pain. Heal Safely offers communities throughout Oregon and Indian Country access to information and resources that support safer healing after injury or surgery. Health Safely instills that everyone deserves safe, effective options that will help them rest, recover and get back to daily life.

Multi-County Resources

Baker, Benton, Clackamas, Clatsop, Columbia, Coos, Curry, Deschutes, Douglas, Grant, Jackson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Tillamook, Umatilla, Wallowa, Washington

PRIME+ Peer Program The PRIME+ Peer Program connects Peer Support Specialists in 24 of 36 Oregon counties with people who are at risk of or receiving treatment for overdose, infection, or other health issues related to substance use. PRIME+ peers engage people who may be out of treatment and who are at varying stages of change using a harm reduction approach. PRIME+ peers provide linkage to SUD treatment, recovery support, and physical healthcare; support for infectious disease testing and treatment (particularly hepatitis C); access to community resources to meet basic needs; access to harm reduction supplies; and emotional and crisis support. Program sites share and learn from one another, attend state-wide trainings and learning collaborative sessions, and engage with a wide range of community service providers.

Lincoln, Jackson, Deschutes, Umatilla and Malheur

Nurture Oregon Nurture Oregon is an integrated care model providing pregnant people who use substances with peer recovery support services, prenatal and postpartum care, substance use and mental health treatment, and service coordination. The original model (Project Nurture) was piloted in three sites in Portland, Oregon beginning in 2015. Oregon Health Authority Health Systems Division (OHA HSD) Behavioral Health unit is building on lessons learned from the pilot to expand and adapt this program for sustainable implementation in rural and frontier communities. The expansion project,

Nurture Oregon, includes five rural counties. Enhanced elements have been incorporated such as cross-site trainings and coordination, mental health counseling to address trauma, and the opportunity for recovery peers to receive doula certification.

Douglas, Klamath, Lane, Lincoln, Benton, Coos, Deschutes, Umatilla, Multnomah, Washington, Marion and Yamhill

Project Turnkey Project Turnkey is a state-level program that has provided $71.7 million in grants for the acquisition of motels and hotels in Oregon for use as non-congregate shelter for people who needed to isolate or quarantine during the pandemic. This included people experiencing homelessness, migrant and seasonal farmworkers, and wildfire evacuees. As of early July 2021, 19 properties have been approved, representing 867 units in 13 counties across Oregon. (Douglas, Klamath, Lane, Lincoln, Benton, Coos, Deschutes, Umatilla, Multnomah, Washington, Marion and Yamhill). Over the next several years, most properties will be converted to transitional housing, permanent supportive housing, or other forms of permanent affordable housing. Project Turnkey is the story of what Oregon can accomplish when communities, business, government and philanthropy join forces to take bold action.

Tribal Nations and County Specific Resources

The Confederated Tribes of Grande Ronde

Great Circle Recovery In March of 2021 the Confederated Tribes of Grande Ronde opened Great Recovery Circle, the first Tribally owned medication assisted treatment clinic near downtown Salem. A second clinic will be opening soon in SE Portland. Great Circle Recovery is a program of the Confederated Tribes of Grand Ronde, designed for native and non-native patients alike. We are open to all and welcome all who seek recovery. At Great Circle Recovery, you can begin receiving care very quickly. So we designed our program to provide same day access to treatment.

Marion County

The Fostering Hope Initiative (FHI) FHI is a neighborhood-based collective impact initiative designed to strengthen families, mobilize neighborhoods, and promote optimum child and youth development. It is a partnership of government, public and private organizations joining together with a common goal. FHI operates in high poverty, high needs neighborhoods. Each FHI neighborhood is staffed with a Community Health Worker working with families and community partners to help support strong families and safe, healthy neighborhoods.

Lane

90by30 90by30 is a community-campus partnership dedicated to reducing child abuse and neglect in Lane County 90 percent by 2030. We're community-led but county-wide, focusing on local strategies that fit the unique needs of each region or city. Our goal is to make Lane County a safe, healthy, and nurturing place for families and children by engaging our neighbors, focusing on primary prevention that stops child abuse before it starts, and finding a role for everyone in supporting parents. You – and all your neighbors – have an important role.

Baker, Union and Wallowa Counties

The Tri-County Substance Use Disorder (SUD) Warm Line The Tri-County SUD Warm Line is staffed by Peer Recovery Specialists 24/7. The network serves Baker, Union and Wallowa Counties. Peers are available 24/7 to connect individuals to the care and resources they need to be successful in their recovery. "You can call anytime, any day, and as many times as you need. We will

help guide you through any next steps that best fit your recovery needs." Peer Recovery Specialists provide:

- Assistance in reducing barriers to recovery (transportation, basic food, shelter, education, employment, and support meetings)
- Support from someone who has had similar experiences
- Information and referrals to additional community resources

Union

Children and Recovering Mothers (CHARM) CHARM was 'born' at Grand Ronde hospital's Family Birthing Center and is supported by many local partners. CHARM is a health care program for pregnant women struggling with alcohol or drug addiction. CHARM offers early intervention and resources throughout pregnancy to reduce the risk of postpartum complications and helps ensure a healthy newborn. CHARM is about helping women find a way out of addiction and keeping families together.

Grant, Wallowa, Malheur Counties

Baby Bag Project Durable reusable diaper bags are filled with newborn baby supplies, diapers, toothbrush kits and parent tools including a Baby Journal. Early childhood partners have included additional items such as; children's books, local gift cards, and numerous items to help new moms with newborn babies. Baby Bags are provided to all Eastern Oregon Coordinated Care Organization (EOCOO) mothers delivering babies in these counties.

Deschutes

Opportunity Foundation of Central Oregon The Opportunity Foundation of Central Oregon has worked to empower people of diverse abilities. Alongside a broad array of community partners we propel opportunities and encourage limitless possibilities. We envision a world where all people live, learn, and work together in the spirit of our values: dignity, equality, integrity, inclusion, choice, excellence and empowerment. Whether in search of employment, independent living, social interaction or personal growth, we provide personalized support so people with intellectual and developmental disabilities have the opportunity to reach their goals and make their dreams come true.

Lincoln County

The Bravery Project The Bravery Project's goal is to create an open, accepting center where LGBTQIA2S+ youth can access mental health, educational, vocational, mentorship, and other services such as meals. Located at the Olalla Center, The Bravery Project will also help with LGBTQIA2S+ specific needs, such as assisting youth by connecting with LGBTQIA2S+ affirming healthcare providers, navigating the legal processes for name and/or gender changes, and accessing specialist services.

Benton, Lincoln, Linn Counties

Community Doula Program Birth doulas are Traditional Health Workers (THW) that build trusting relationships with pregnant members and provide physical, emotional and informational support during labor and birth. The main goal of the Community Doula Program is to expand the original Community Doula pilot into Lebanon, Newport and Lincoln City hospitals. Health Outcomes: Increase number of Spanish speaking doulas in the community, especially to the East Linn and coastal communities. Improve birth outcomes such as prematurity, cesarean-section and pain medication use. Cross train active multi-lingual doulas to serve as health care interpreters.

Disability Equity Center Disability Equity Center's goal is to create an inclusive cultural and resource center that meets the diverse needs of people living with disabilities across the Willamette Valley, as well as their family and friends. The pilot will address the specific needs of healthcare providers, addressing gaps and augmenting partnerships across formal disability support services as well as educating healthcare workers and support providers about client driven disability healthcare best practices. We will also teach our local community about ableism and change social misperceptions about people with disabilities.

Linn

Enlaces Project The overall objective of the ENLACES pilot project is to enhance the capacity of Casa Latinos Unidos to serve in a culturally sensitive way the most vulnerable members of the Latino community of Linn County and to bridge linguistic and cultural gaps that may exist between this community and the system of services. Through two promotoras(es), the pilot will increase awareness of free and low-cost health care (and other) services available to members of the household. Health outcomes: z Increased access to services. z Improved referral pathways. z Strengthened the capacity of the system of services in culturally appropriate ways.

Healthy Homes Together (HHT) HHT brings community partners together to spread Traditional Health Worker services to new housing communities in Linn County. The pilot's purpose is to improve healthcare access, to positively impact behavioral health, and to improve the social determinants of health for the community and IHN members. HHT will be coordinating with other community partners to provide a support network and educational opportunities for THWs who are embedded in the housing community.

Hub City Village Creating Housing Coalition is partnering with several agencies to develop the first tiny home community in Linn County. This is a new and different housing model which meets a need unmet by single family houses and apartments. It also addresses access to resources through onsite health navigation.

Linn County Crisis Outreach Response Family Assistance and Resource Center Group's mission is to establish trust and inspire hope by providing access to resources, services, and education to those who are experiencing homelessness and housing instability in Linn County. This pilot will strengthen collaboration and access between related social service agencies, Samaritan Health Services, and Linn County Public Health to provide access to the homeless patients and unstably housed.

Klamath

Klamath Falls City Schools and Klamath County School District developed a *community wide suicide prevention plan* that all teachers and staff have been trained on – includes a universal depression and suicide risk screening in school-based health centers

Lake

To address Lake County's high Adverse Childhood Experiences (ACES) rates that lead to poor health outcomes, Lake District's Wellness Center will train at least half of their behavioral health clinicians in motivational interviewing. This evidence-based counseling technique can help support behavior health change in patients. There is also a demonstrated need for PTSD trauma therapy in the county. Lake District Wellness Center will train a clinician in Eye Movement Desensitization and Reprocessing (EMDR) therapy to serve residents and OHP members outside the Lakeview hub.

Yamhill

PAX Good Behavior Game [PAX Good Behavior Game] is an evidence-based classroom prevention program designed to increase short term behavioral issues and decrease long term negative health and substance use outcomes. This program, offered in 6 school districts, continued in a virtual space. Four trainings in four school districts were conducted virtually in 2020. Two school districts, supported by Yamhill Community Care Organization (YCCO), implemented Collaborative Problem Solving and RULER. These programs support social-emotional learning, offer training for its teachers and staff, and can be supportive in a virtual space.

Multnomah

Grounding Waters [Grounding Waters] is a service based mentoring program offered by The Blueprint Foundation that is specifically designed to educate and empower Black youth to complete community service that increases:

1. Black youth exposure to science, technology, engineering and math (STEM) professionals of color;
2. Black community members' awareness of water quality related issues and mitigation strategies;
3. Environmental stewardship by Black community members; and
4. The number of Black youth who intend to pursue careers in the environmental sciences and engineering.

Black Parenting Initiative (BPI) Since 2006, [BPI]'s mission has been to educate and mobilize the parents and caregivers of African, African American and African American Multi-cultural children to ensure they achieve success. Today, BPI is the only culturally specific, community-based, non-profit organization in Oregon focused solely on supporting Black/African American families with children 0-10 in the State of Oregon. The majority of our families are from low to moderate-income communities and have complex issues that we address with expertise, compassion and love. Through our unique and culturally specific approaches, we focus on optimal health, cultural identity development, parent education, and ensuring parents and caregivers have the necessary resources to help their children succeed.

Healthy Birth Initiative The [Healthy Birth Initiative] addresses the needs of pregnant Black and African American women. It does this by opening up access to health care and providing ongoing support to pregnant Black and African American women and their families before and after birth. Services are Afrocentric and include:

- Individualized, in-home case management
- Access to community health nurses and other specialists
- Help with goal planning
- Respite care
- Breastfeeding support
- Discount car seats
- Family planning
- Transportation for medical care and health education classes
- Coordination of care with health care providers and community agencies
- Ongoing classes and groups

They also serve African immigrant and refugee families through their partnership with [African Family Holistic Health Organization] (AFHCO).

Protective Factors – Working Directly with Families

Child Abuse Prevention and Sexual Assault Awareness Month **April 2022**

Protective factors are conditions or attributes that, when present in families and communities, increase the well-being of children and families, and reduce the likelihood of maltreatment. Identifying protective factors helps parents find resources, supports, or coping strategies that allow them to parent effectively, even when stressed.

PROTECTIVE FACTORS

- Increase the capacity of caregivers and parents to nurture their children
- Provide concrete supports for families in need and create supportive communities
- Provide opportunity to strengthen social connections
- Recognize the strength and resilience of parents

There are 6 protective factors:

1. Nurturing and Attachment
2. Knowledge of Parenting and Child and Youth Development
3. Parental Resilience
4. Social Connections
5. Concrete Support for Parents
6. Social and Emotional competence of Children

PROTECTIVE FACTORS, KEY POINTS, AND CONVERSATION GUIDES

NURTURING AND ATTACHMENT

When caregivers treat children with respect, love, and understanding, the child is positively affected for a lifetime. This makes it easier for children to develop and keep friendships, succeed in school and work, sustain healthy relationships, and parent effectively themselves.

Key Points to cover with families:

- Showing love for your children matters
- Families show affection in different ways
- Some days are easier than others
- Children need nurturing daily

Conversation Guide: *We Love Each Other*

KNOWLEDGE OF PARENTING AND CHILD AND YOUTH DEVELOPMENT

Understanding and using effective child management techniques and having age-appropriate expectations for a child's abilities.

Children thrive when caregivers provide:

- Affection
- Respectful communication and listening
- Consistent rules and expectations
- Safe opportunities that promote independence
- Successful parenting that fosters psychological adjustment, helps children succeed at school and encourages curiosity about the world

Key Points to cover with families:

- Children have reason for behaving the way they do
- Caretaking is a tough job!
- How we were parented affects our parenting
- No parent can know everything
- It takes time to change habits, but it is never too late to try something new

Conversation Guide: *I Can Choose What Works Best for My Children*

PARENTAL RESILIENCE

Caregivers having the adaptive skills and strategies to persevere in times of a crisis. A family's ability to openly share positive and negative experiences and mobilize to accept, solve, and manage problems.

Key Points to cover with families:

- Caretaking is stressful, and some situations are more difficult than others
- Stress affects children too
- Everyone has strengths that they draw on in difficult times

Conversation Guide: *I Deserve Self-Care*

Resource Highlight:

- National Parent Hotline
- Parents Anonymous of Oregon
  - Parent Helpline: 503-258-4416

SOCIAL CONNECTIONS

Perceived informal supports (from family, friends, and neighbors) that help provide emotional needs, support, assistance, and guidance. Formal connections, such as childcare providers, physicians, public

support systems, and service providers assisting parents in seeking additional help when needed.

Key Points to cover with families:

- All parents need support sometimes
- Support can come from family, friends, neighbors, or other helpful people
- Social support can be found by belonging to groups
- Not all connections are equally supportive
- Making new connections can be challenging, but it is possible

Conversation Guide: *We Are Connected*

CONCRETE SUPPORT FOR PARENTS

Parents need basic resources and concrete supports such as food, clothing, housing, transportation, and access to essential services that address family specific needs to ensure health and well-being.

Key Points to cover with families:

- All families need help sometimes
- Unmet basic needs like nutritious food and safe, stable housing can be harmful to children's development and ability to learn
- There are many places to go for help in our community

Conversation Guide: *I Can Find Help for My Family*

SOCIAL AND EMOTIONAL COMPETENCE OF CHILDREN

A child or youth's ability to interact positively with others, self-regulate their behavior and effectively communicate their feelings has a positive impact on relationships with their family, other adults, and peers.

Key Points to cover with families:

- Social skills are important for children to become successful adults
- Children and youth develop social skills gradually
- Our children learn by watching us
- Parents can help their children learn social skills

Conversation Guide: *I Can Help My Child Learn Social Skills*

FLEX YOUR SKILL SET

Protective Factors in Practice Toolkit Practice in identifying protective factors with the following scenarios that illustrate how protective factors support and strengthen families experiencing stress.

Attachment 27

Oregon Child Welfare Safe Sleep Efforts

Child Fatality Prevention and Review Program

Goal: Eliminating preventable sleep related infant death by ensuring:

1) **Oregon families with infants are supported through education, tools, and consistent messaging regarding safe sleep practices; and**
2) **Family serving professionals, including child welfare professionals, have the skills and tools to engage families in safe sleep conversations that elevate them as experts in their infant's health.**

Inputs

What Oregon Child Welfare invests

- Child Welfare Professionals
- Technical Assistance
- Maintenance
- Data Tracking/ Measuring Outcomes
- Commitment
- Time
- Continuous learning/research
- Funding
- Technology
- Materials
- Equipment
- Leadership support
- Relationship building/Community engagement
- Evidence Based Practices

Activities

What Oregon Child Welfare does

- Collaborate with and learn from family serving professionals
- Community led prevention
- Purchase and distribute Safe Sleep kits as needed
- Develop audience specific safe sleep trainings
- Facilitate access to current information
- Maintain ODHS CW rule, policy, procedure, forms, and OR-Kids
- Maintain and promote use of Safe Sleep Checklist
- Maintain website and other online resources
- Create opportunities to develop, enhance, and maintain the skills of family serving professionals
- Use a culturally responsive, strength focused, harm reduction model that recognizes impacts of trauma
- Utilize data to focus efforts on disproportionately impacted families
- Apply equity tool early and throughout

Who Oregon Child Welfare reaches

- Families with infants
- Family Serving Professionals, including Child Welfare Professionals
- Resource families
- Alternative caregivers of infants
- Communities disproportionality impacted by sleep related infant death
- Tribal partners
- Family serving organizations and bodies that specifically serve African American/Black and Native American/Alaska Native Communities
- Legislature
- Oregon Medical Board
- Oregon Nursing Board
- Hospitals
- Oregon Hospital and Health Systems Association
- Public Health

Outcomes

Why this project: short-term results

- Family serving professionals will:
  - enhance their knowledge about safe sleep practices
  - develop or improve skills to engage families in discussion about safe sleep
  - improve their ability to identify safe sleep risk factors and protective factors
- Increase in community awareness about safe sleep practices
- Communities begin to learn where and how to reach out for Safe Sleep resources and supports

Why this project: intermediate results

- Oregon family serving systems provide consistent safe sleep messaging to families with infants
- Reduce disparities in sleep related infant death among African American/Black and Native American/Alaska Native Communities
- Increase in number of child welfare cases with an infant where safe sleep checklist is completed
- Safe sleep plans are developed prenatally with every pregnant parent engaged in Nurture Oregon pilot
- Safe Sleep Kits are provided to Nurture Oregon participants without equipment necessary to implement safe sleep practices
- Safe Sleep is a part of every plan of care when child welfare and/or Nurture Oregon is involved

Why this project: long-term results

- Eliminate infant fatalities where circumstances involved high risk sleep practices
- Eliminate disparities in sleep related infant death among African American/Black and Native American/Alaska Native Communities
- Oregon families have access to materials and resources necessary to utilize safe sleep environments
- Oregon families with infants consistently adopt safe sleep practices
- Oregon families with infants self-report receiving consistent safe sleep messaging across family serving systems
- Child welfare caseworkers have additional safe sleep conversations with families beyond the initial contact

Assumptions

- AAP Safe Sleep practice recommendations are evidence based
- Safe sleep practices reduce SUID/SIDS
- Safe sleep practices are not discussed at the level they need to be effective
- Family engagement skills regarding safe sleep education vary among professionals
- Safe Sleep resources are not equally accessible to all Oregonians
- Messaging about safe sleep is inconsistent
- African American/Black and Native American/Alaska Native Communities are disproportionately impacted by sleep related infant death

External Factors

- (+/-) Cultural/generational beliefs/practices around infant sleep
- (+/-) Professional's own beliefs/experiences with safe sleep
- (+/-) Family of infant's support system
- (+/-) Funding
- (+) Cross system buy in
- (-) Workload impacting engagement
- (-) Turnover
- (-) Caregiver substance/medication use

Attachment 28

Safe Sleep for Oregon's Infants

All the moments in an infant's day matter

A self-study training opportunity for family serving professionals

Oregon Department of Human Services
CHILD WELFARE DIVISION

Oregon Health Authority

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. Thank you to 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 and 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.

You can get this document in other languages, large print, braille or a format you prefer. Contact Child Welfare's Child Fatality Prevention and Review Program at CW.Prevention@dhsoha.state.or.us.

DHS 2416d (9/21)

Contents

Dear Oregon professionals,

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 preventing 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 your role in supporting families to reduce risk to infants in their care.

These organizations and individuals are excited to support infant safe sleep and this effort to achieve consistent messaging across all of Oregon's family serving professionals:

Oregon Association of Hospitals and Health Systems

Oregon Coalition Against Domestic Violence and Sexual Assault

Oregon Department of Education, Early Learning Division

Oregon Department of Human Services, Child Welfare

Oregon Department of Human Services, Self Sufficiency Programs

Oregon Health Authority, Public Health Division

Oregon Medical Board

Oregon Parenting Collaborative

Oregon State Board of Nursing

Ben Hoffman MD, Medical Director, Tom Sargent Children's Safety Center, OHSU Doernbecher Children's Hospital

Joan Bacchus, Native American Rehabilitation Association of the Northwest

Karen L Ayers, Program and Partnership Manager, Safe Kids Oregon/Oregon Child Development Coalition

Safe Sleep for Oregon's Infants

A Self-Study Training Opportunity

How to complete the "Safe Sleep for Oregon's Infants" self-study:

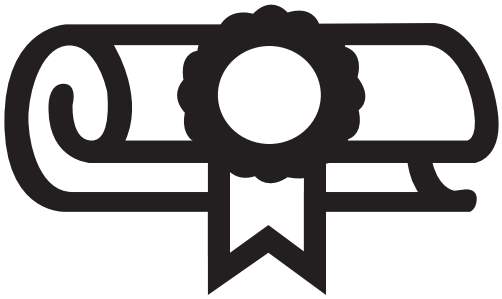
1. Watch the lived experience video at https://youtu.be/Xx0Yfv42rOg

   This video is on YouTube. The title is "Sudden Infant Death Syndrome (SIDS)" and it is provided by St. Elizabeth Healthcare. The five-minute video is an opportunity to hear from parents who have experienced the sleep-related death of an infant. These individuals present the importance of safe sleep practices. While this video is powerful and moving and can be used as a tool with parents and caregivers, please prioritize your self-care when deciding whether to watch.

2. Read the self-study information and complete all the activities. (Your responses are private.) This document contains the self-study information and related activities.
3. Complete the knowledge check. The knowledge check includes 10 questions and the answer key is in this document.
4. Complete the survey. Once you complete the self-study, there is a link within this document to an online survey and opportunity to provide feedback related to the self-study materials.

Consider printing or saving these materials for future reference. Also consider discussing what you learned with your peers and practicing having conversations about safe sleep.

If you have questions or need assistance with the self-study, please email: CW.Prevention@dhsoha.state.or.us



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 professional engaging families with infants, it is critical for you to know how to keep infants safe and be able to share that knowledge with parents and caregivers.

"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 families' unique values and needs.

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 may be difficult depending on individual's personal or professional experience. Reflect on your own feelings and those families may have when discussing this topic. Please complete the training at your own pace and engage in needed self-care.

Objectives:

1. Explore how your own experiences and preferences with sleep connect with the recommendations for infant safe sleep practices.
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 talk 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, knowledge check and survey

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

- Articulate your responsibilities regarding safe sleep
- Define sleep-related SUID

- Identify actions that increase and decrease risk factors for SIDS and sleep-related infant deaths
- Recognize safe and high risk sleep environments, and
- 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.

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?

In this training you will learn that adult sleeping behaviors and comfort needs are different from infant sleeping needs. Some adult sleep comforts can be risky to an infant's safety. This doesn't mean infants will be uncomfortable; it means they will sleep safely

How did you develop your current knowledge 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. People often rely on experiences, knowledge, culture, friends and family to know how to care for an infant. Use the space below to write how you developed your current knowledge or practices around laying an infant down to sleep.

Your role in safe sleep

Professionals who serve families may interact with the families they serve in their home environments, virtually, on the phone or in the community. Their responsibilities often include sharing information about parenting practices that support children's safety, health and well-being. You are in a unique position to talk to parents and caregivers about 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. Asking about 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), and
4. Helping the family problem solve to reduce risk.

Many people have strongly held beliefs about sleep practices, but you are still encouraged to make sure parents and 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 giving them 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. Not following 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), and
- Other ill-defined or unspecified causes

Here are the definitions of SUID and SIDS:

Sudden Unexplained Infant Death (SUID)	Sudden Infant Death Syndrome (SIDS) (a type of SUID)
SUID is the 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 goal of safe sleep practices is to reduce 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 the following:

- **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.

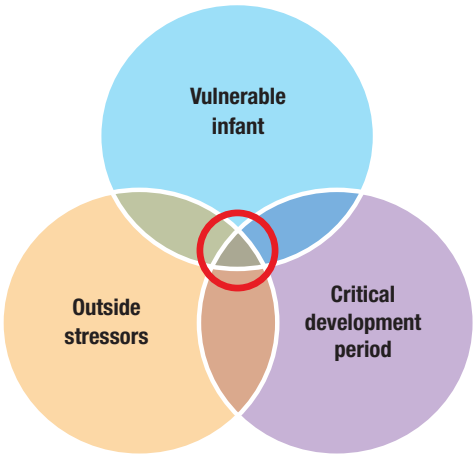
- **Wedging or entrapment**
  For example, when an infant is wedged between two objects, such as a mattress and wall, bed frame or furniture.
- **Strangulation**
  For example, when an infant's head and neck become caught between crib railings.

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. Understanding how safe sleep reduces 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 ways to reduce risk, first let's learn more about SIDS and the risk factors a parent or caregiver can and can't change..

Multiple risk factors for SIDS[2]



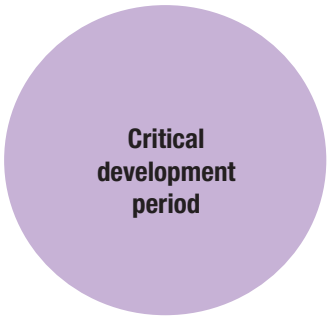
There is no one definitive cause of SIDS. This diagram shows how three common risk factors interact. When an infant is experiencing risk factors from all the three circles, as shown in the center area of the diagram, they are at a much higher risk for SIDS. Although these factors contribute to higher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

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

Vulnerable infant

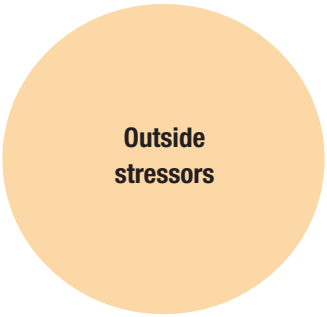
All infants are vulnerable to SIDS. Some factors can make an infant more vulnerable. These can be unknown to parents, caregivers and heath care providers. Risk factors include:

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



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 at this time. This means the infant can't roll over or pick up their head if their airway is blocked.



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 their stomach, and
- Exposure to cigarette smoke.

Professionals who serve families have a role in helping parents and caregivers reduce 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 reporters about safe sleep practices.

The outside stressors focused on in this training are the 5 safe sleep categories Child Welfare professionals must evaluate and discuss.

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

1: Sleep position:

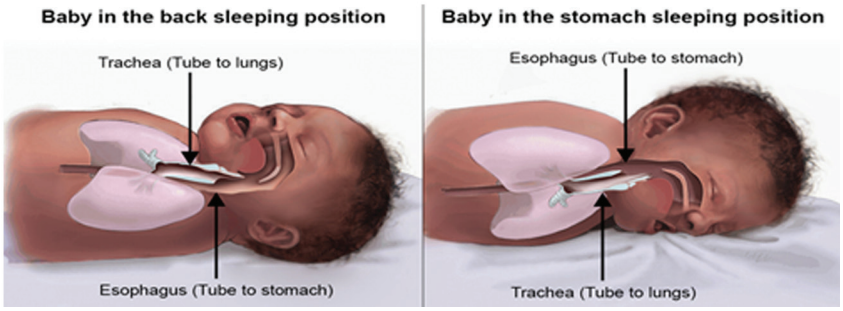
Decreased risk	Increased risk
The infant is placed on their back to sleep.	The infant is placed on their stomach or side to sleep.

More information about sleep position:

- Placing an infant on their back is the most effective way parents and caregivers can reduce the risk of 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 their stomach because the infant can accidentally roll to their 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 altogether.
- Infants love consistency. In fact, infants who usually sleep on their backs but 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. However, tummy time should only take place when the infant is 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 and can't use their arms for support. Swaddled infants have an increased risk of death if they are placed or roll onto 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 of age is recommended.[5]
- Infants are less likely to choke on their backs.

  It used to be 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 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 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; they were uncommon in cars until 1958 and then their use was inconsistent. Many children were not harmed by riding in cars with no seat belt, but some experienced devastating consequences. So, while many of us survived never wearing a seat belt, we wear them now. We now know that 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
The 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.	The 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. The most important thing 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.

Below are examples of firm, flat sleep surfaces other than bassinets, cribs or Pack N' Plays that may be used:

Basket

Box or carton

Drawer

Washtub

Below are 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. Some of the safest traditional sleep surfaces come from American Indian/Alaska Native (AI/AN) or First Nations (FN) traditions. If you are caring for an AI/AN or FN child, some traditional sleep surfaces may be available. These include:

- Cradleboards or baskets, which are common across many AI/AN tribes, and
- Moss bags, which are common among Canadian First Nations and Woodlands AI/AN Tribes.

American Indian and Alaska Native communities may have originated the concept of "Back to Sleep" with the use of traditional infant sleep devices. Although the specific design of the sleep devices differ between Tribes, the infant is placed on their back and swaddled into place in a safe and secure environment. Rates of infant death and SIDS are high in many American Indian or Alaska Native communities, and using these traditional methods is a good way to keep infants safe. If you are unaware of specific Tribal safe sleep practices, contact the infant's Tribe to learn more. Understanding how to use traditional Tribal sleep devices is critical to keeping the infant safe.

No matter what container or device is used, the surface should be firm and flat. If the sleep surface 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 and quilts
- Other loose bedding (such as non-fitted sheets)
- Sheepskins
- Bumper pads
- Stuffed toys, and
- Infant positioners (products designed to keep an infant in a certain position, such as wedges, padded tubes or mats with side bolsters).

More information 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. 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.
    - It is a choking hazard and can lead to bottle rot as teeth come in.[10]
    - The items typically used to prop a bottle (such as blankets or 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, but 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 fit between the infant's chest and the swaddling blanket. Also, swaddling may decrease an infant's arousal, so that it's harder for them to wake up. According to HealthyChildren.org, "We know that decreased arousal can be a problem and may be one of the main reasons that babies (infants) die of SIDS."5
- Bumper pads are not necessary to prevent head entrapment because of new safety standards for crib slats.
- Remove teething necklaces or jewelry when laying an infant down to sleep.
- Although the reason is unclear, studies have reported pacifiers may reduce the risk of SIDS. Offering a pacifier to infants is recommended. Pacifiers help 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 the "Resources" 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 The crib or bassinet is close to parent or caregiver	The infant shares a sleep surface with caregiver, non-primary caregiver, siblings, other person or pets The 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:

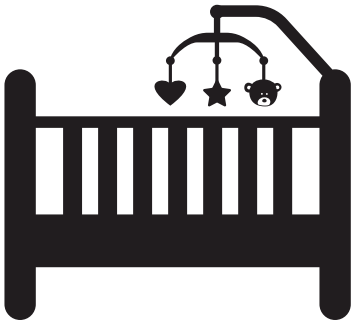
Room sharing refers to an infant sleeping in the same room as a caregiver or other household members but not sharing the same surface such as a bed, couch, chair or futon.

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 another 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 designed to promote breast feeding, bonding and safety. Keeping the infant close to the parent or caregiver supports these goals.

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.
- It makes it easier for a nursing mother to get her sleep cycle in sync with her infant's.
- It helps infants fall asleep more easily, especially during their first few months and when they wake up in the middle of the night.
- It 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).
- It 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.
- If a parent or caregiver 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, or
    - As a coping mechanism after fleeing an unsafe situation.

Oregon Health Authority and AAP recommend 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

More information about sleep location:

- Exhaustion is an inevitable part of parenting an infant. Support the parent or caregiver by developing a plan to lay the infant down to sleep safely when managing exhaustion. A plan may involve other adults in the home. When planning, always listen to what the

caregiver says 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 allow the parent or caregiver to get uninterrupted sleep.

- 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

Secondhand 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 smoking. Exposure to secondhand smoke significantly increases an infant's chances of dying from SIDS.[13] Children exposed to secondhand smoke are also at higher risk of other diseases, such as asthma, the common cold and other viruses.

Thirdhand smoke effect

Thirdhand smoke is tobacco smoke toxins that remain after the cigarette is put out. Thirdhand 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 thirdhand 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 their hands and face and change any clothing that will come into direct contact with the infant. This will protect the infant's vulnerable developing body systems.

5: Sleeping temperature

Decreased risk	Increased risk
The room temperature is comfortable for a lightly clothed adult. The infant is in a maximum of one layer more than would typically be comfortable for an adult to wear.	The room temperature is too warm or uncomfortable for an adult. The 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 wake up 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. Encourage parents and caregivers 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 family's knowledge about Tribal traditions. Consider engaging elders from Tribal communities and do so in a manner that does not question their authority as important community members with knowledge and expertise that could benefit families. Learn about traditions that are important to families. Ask for guidance about how to support families within Tribal communities to make decisions that both honor their values and traditions and follow research-supported practices.

What did you learn about increasing and decreasing the risk of sleep-related deaths?

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

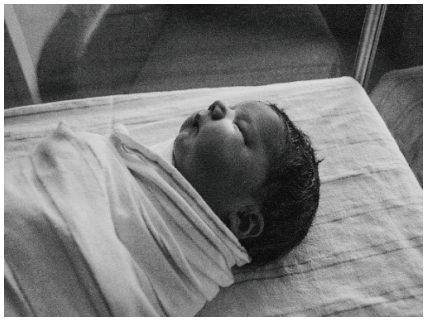
1. Placing the infant on their side to sleep
2. Placing only one stuffed animal in the crib
3. Wearing a hat to cover your hair when smoking
4. Swaddling when the infant can roll
5. Placing no blankets at all in the crib

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 to recommend the family do 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 you see:	



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

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

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

Part 2: Bed sharing and substance use

Substance use prior to bed sharing

As you learned in Part 1, bed sharing increases the risk of sleep-related infant death. While the AAP recommends avoiding bed sharing, some parents and caregivers will choose to continue to share a sleep surface with their infant for a variety of reasons. In this case, engage in conversations as much as possible and partner with the parent or caregiver to develop a plan to reduce risks. A parent may continue to bed share, but they may agree to remove the comforter from the bed and have the other adults or children sleep elsewhere. Harm reduction is an important approach when talking to families about infant safe sleep.

"Substance use" includes many legal or illegal drugs with potential for misuse, including controlled substances, prescription medications, over-the counter medications and alcohol. However, right now let's look at marijuana specifically.

What are your attitudes and beliefs about marijuana use?

Marijuana use is common and legal in 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 you provide parental support and education. In the space below, write your understanding of how marijuana use while parenting may put an infant at risk.

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 make its effects on parental impairment and child safety less dangerous. Whether a substance is legal or illegal, prescribed or not prescribed, is not the issue. The focus is on the affect the substance has on the parent or caregiver.

When a parent uses sedating substances such as marijuana, it increases the probability that they the will go to sleep faster and sleep harder and deeper than usual. Being sedated or impaired can make a parent or caregiver unresponsive to an infant. The parent may not be aware they have rolled onto the infant and may not feel the infant or hear the infant's distress sounds. According to BASIS (Baby Sleep Info Source):

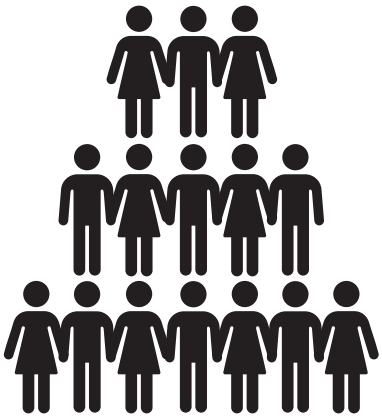
> The most recent studies have shown that most bed sharing deaths happen when an adult sleeping with a baby (infant) has been smoking, drinking alcohol, or taking drugs (illegal or over the counter meds) that make them sleep deeply.[14]

For this reason, it is even more crucial to have conversations, provide information and make plans for infant safe sleep practices with families where 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

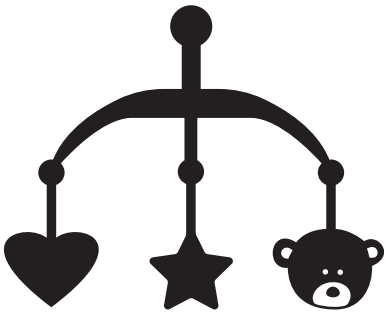
Be clear about risks with parents. If a parent or caregiver is using a substance that can impair them, then support them in developing a plan to ensure that a safe, unimpaired individual is caring for the infant.

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. Collaborating with 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 from multiple sources, multiple times increases likely acceptance and implementation of safe sleep behaviors.[15]



Part 3: Safe sleep conversations with families

Conversations with families



When talking with families about safe sleep, they may express concerns or share misconceptions about safe sleep practices. They may also share ideas or opinions on topic that you haven't thought of before. Parents or caregivers may resist engaging in some safe sleep practices because they are committed to a sleep practice that is not recommended.

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. These conversations must respect and engage with their lived experiences and opinions. They must also acknowledge and elevate them as experts in and advocates for their children's health.

Think about safe sleep improvements in terms of 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. Instead, focus on opportunities to help them feel like they are in control of their infant's health. Take time to celebrate the ways 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. Ask if there are ways they think they could enhance their infant's safety based on the information you share.

When the parent or caregiver resists making the recommended change, try to reduce risks as much as possible. The following information, as well as the information covered in Parts 1 and 2, will prepare 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 common and understandable. Since families will decide what they want to do, it is most productive to focus on giving information about how they can carry out their decisions. If they decide not to use all the recommendations, provide information about what factors create risk so they can address those factors. Help them reduce 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.[14]

If you suspect power dynamics are creating resistance to changing sleep practices, and if it is safe and within your role to do so, engage both the abusive partner and survivor in the conversation and focus on the safety risks to the infant. Focusing on the effects on 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 engaging in these conversations may create for the survivor, the infant and the family.

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; you were asked some of these questions at the beginning of the training. You may wish to refer to your responses and the related 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 (Protective factors are conditions or attributes of individuals, families, communities, or the larger society that reduce risk and promote healthy development and well-being of children and families).
- Praise families for what they are already doing to set 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 and caring manner.
- Explain risk reduction measures and encourage their use.
- 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.

Reasons for resistance may include:

- Comfort of the infant or themselves
- Exhaustion
- Prior experience with other children or their own childhood
- Advice from family members or friends
- Lack of space for a crib
- Lack of a crib (money or access)
- Disbelief in the science because it changes all the time
- Receiving mixed messages from health care providers
- Receiving information that is outside of their cultural framework
- Belief that SIDS is "fate" or "God's will"
- An incorrect 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.)
- Feeling that the conversation about safe sleep implies that 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 the following:

- Avoid using "should," which may seem like a directive.
- Use interactive educational materials.
- The Jackson County Nurse-Family Partnership Program created safe sleep educational tools that use photos showing various infant sleeping arrangements to spark discussion with prenatal and new mothers about safer sleep practices. They asked parents and caregivers to explain what they see in the pictures and give feedback about the educational tool and how to improve it. This 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.
- Repeat, reinforce and layer additional information to encourage changing behavior.
- Parents or caregivers are not always ready to receive information or may not have the energy to learn a lot of new information at once. Provide aspects of safe sleep information that are relevant for them when they need it and build on that information over time.
- Combine safe sleep education with providing or referring to community resources for infant sleep sacks or sleep spaces. This increases knowledge and helps reduce economic barriers at the same time.
- Engage in conversations about values and beliefs with a non-judgmental attitude. This may increase trust and 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 showing some statements and questions you may encounter when having conversations about infant safe sleep. Each statement or question is followed by an example response you may find helpful. Consider how you might adapt these potential responses to fit your voice and help 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 they had 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. 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, changing to sleeping on their back **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. That's why it's important to tell this to 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 wake up slightly from too deep a sleep. Try using soothing techniques such as singing, patting or using 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 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 or SIDS is lower because they are a back sleeper.

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

Some infants may have special prescribed medical equipment, such as a G-tube. In these situations, a medical professional may alter sleeping arrangements. What might you do in these situations?

- If the parent needs clarification about the prescribed sleeping arrangement, consider offering to have a joint conversation with the medical provider and the parent. This may help the parent better understand the infant's current medical needs.
- Make sure the parent understands the recommendations and how they may differ 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 knowledge check
- Complete the survey, and
- Review the 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?	

Knowledge check

Answer key provided

Question	Answer options	Write the letter(s) that match your answer
1. What is the age range for an infant?	A. Under 2 years B. 0-12 months C. 0-6 months D. 2-12 months	
2. Side sleeping is an acceptable and safe sleep position for an infant.	A. True B. False	

Question	Answer options	Write the letter(s) that match your answer
3. Sleep-related SUID only occurs in the infant's crib.	A. True B. False	
4. What is a good time in an infant's development to stop swaddling?	A. Two weeks B. One month C. 2 months D. 6 months	
5. What should you do if an infant falls asleep in a baby swing?	A. Be very quiet B. Move the infant to a flat, firm sleep space. C. Stop the swinging.	
6. It is unsafe for a parent or caregiver to bring an infant into their bed if they are under the influence of any substances that interfere with normal sleep patterns.	A. True B. False	
7. Community partners play an important role in engaging parents in safe sleep conversations.	A. True B. False	
8. Examples of outside stressors include the following:	A. Placed to sleep on stomach B. Cigarette smoke C. Too much clothing D. All of the above	
9. Placing an infant on their back is the most effective action caregivers can take to reduce SIDS.	A. True B. False	
10. It is recommended that infants sleep in the same room as their caregiver or parent but on a separate sleep surface.	A. True B. False	

1.B **2.**B **3.**B **4.**C **5.**B **6.**A **7.**A **8.**D **9.**A **10.**A

Online survey

Please complete the online survey and opportunity to provide feedback on this self-study by clicking on this link or pasting the link into your web browser: https://forms.office.com/g/KV94eBzAis

You can also access the survey with the camera on your mobile device using the QR code. Point your camera at the QR code so it appears on your screen. Click the banner and it takes you directly to the survey!

Questions and support

Family serving professionals in Oregon may email questions and requests for support related to this safe sleep self-study to CW.Prevention@dhsoha.state.or.us

Resources

The Safe to Sleep® campaign offers a variety of materials to help share safe infant sleep messages with diverse family audiences (African American, American Indian/Alaska Native and Spanish-speaking) 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

Oregon Public Health safe sleep webpage
https://www.oregon.gov/oha/ph/HealthyPeopleFamilies/Babies/Pages/sids.aspx

Safe Sleep for Babies brochure
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8213.pdf

Spanish Safe Sleep for Babies brochure (Sueño seguro para bebés)
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/ls8213.pdf

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

Oregon Prenatal and Newborn Resource Guide (English and 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 at 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

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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.
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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
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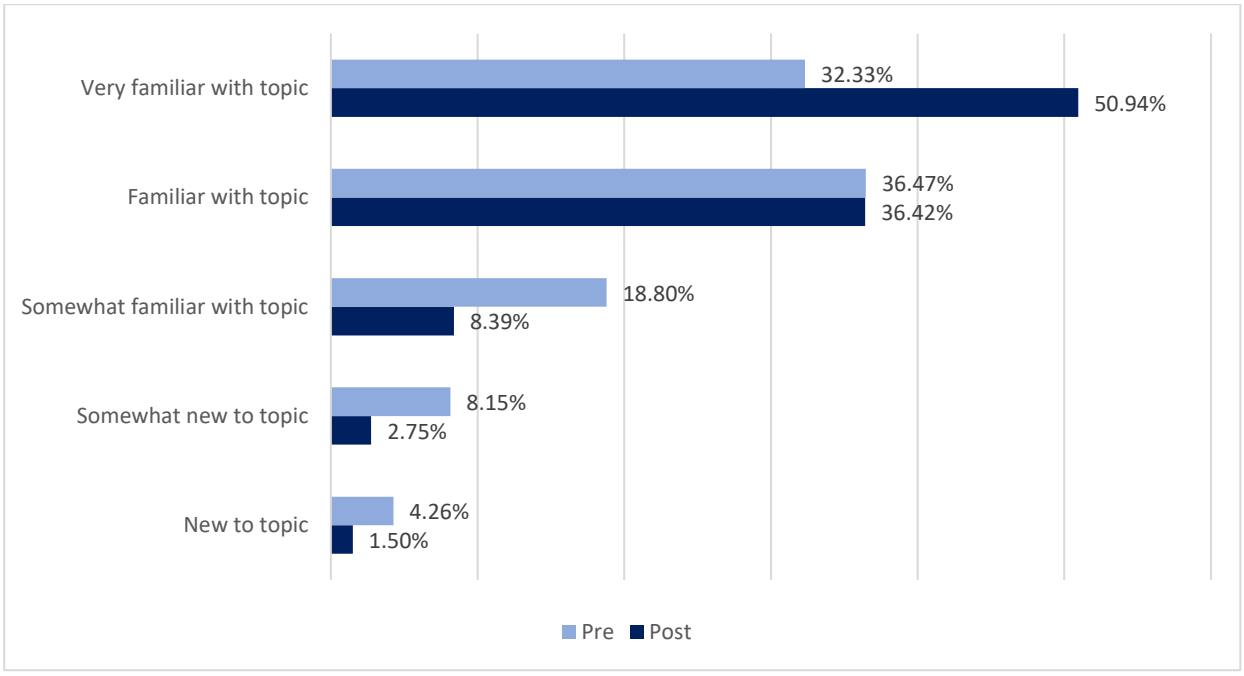
ODHS Safe Sleep Training Results and Evaluation Feedback

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. To effectively have these conversations, Child Welfare professionals need to be educated on safe sleep practices and have the necessary resources available to them. Self-study trainings tailored to a Child Welfare professional's role, opportunities to practice having safe sleep conversations with families alongside community partners, and access to tangible resources have been created for social service specialists in screening, safety, permanency, certification, adoption, and the current workforce has been trained as well. In addition, versions of the self-study trainings are being created and finalized for Family Serving Professionals such as, resource families, Substance Use Disorder Residential Providers, Domestic Violence Advocates.

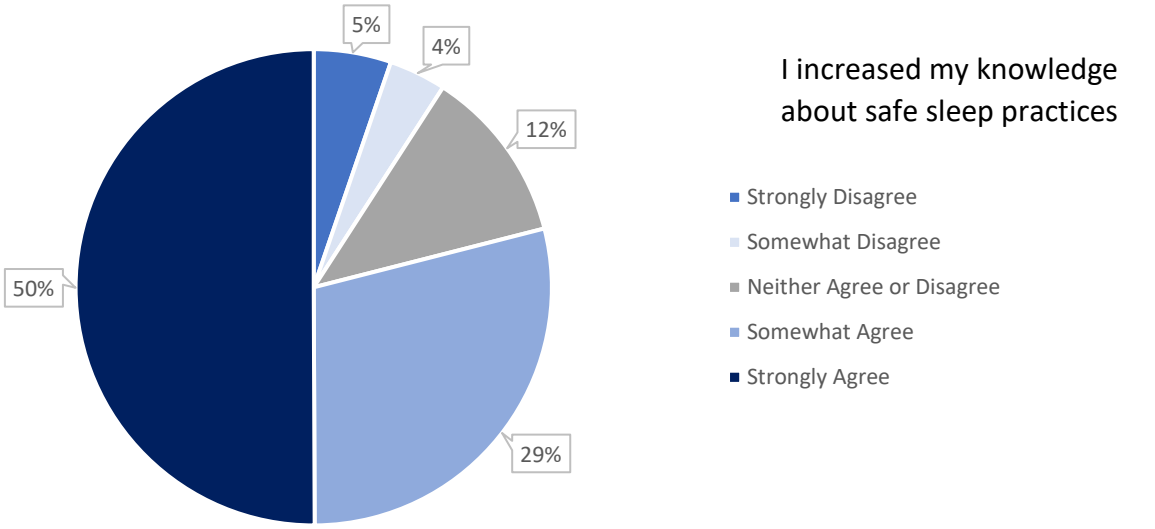
Participant Knowledge: Child Protective Services and Permanency Caseworkers

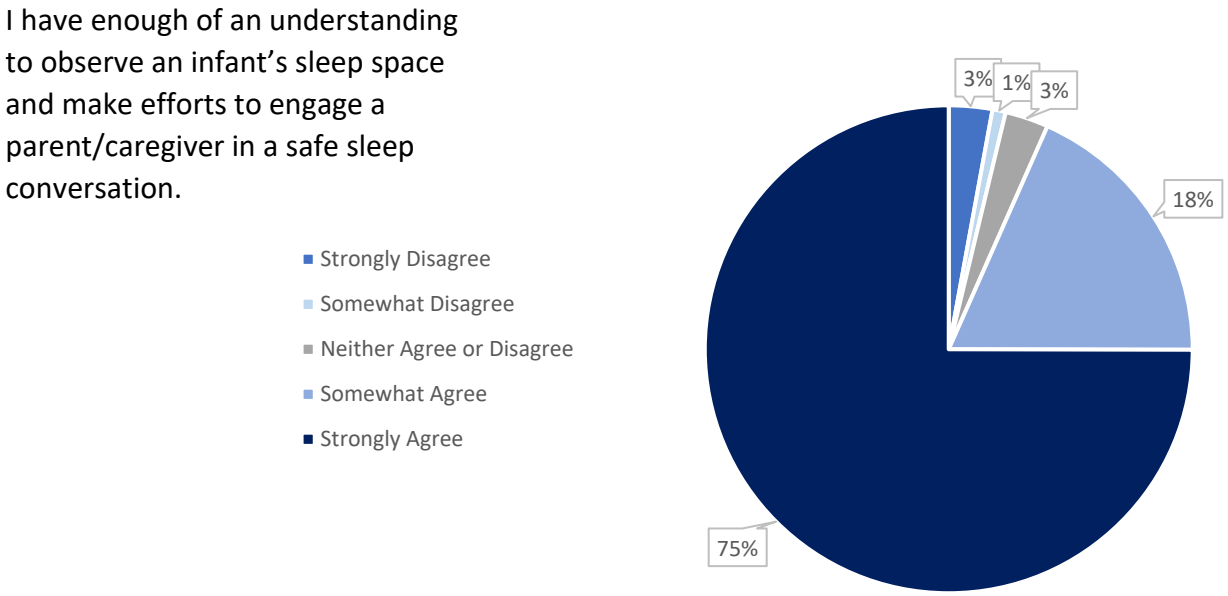
Pre- and Post-Training

In May 2020, the Safe Sleep Self-Study Training for Child Protective Services and Permanency caseworkers launched. A total of 1523 caseworkers have completed the safe sleep training and 798 completed a training evaluation. The graph below displays the percent of respondents who indicated their knowledge of safe sleep prior to taking the training and after.



The following pie graphs displays the percent of respondents who indicated their experience in two specific areas post-training.

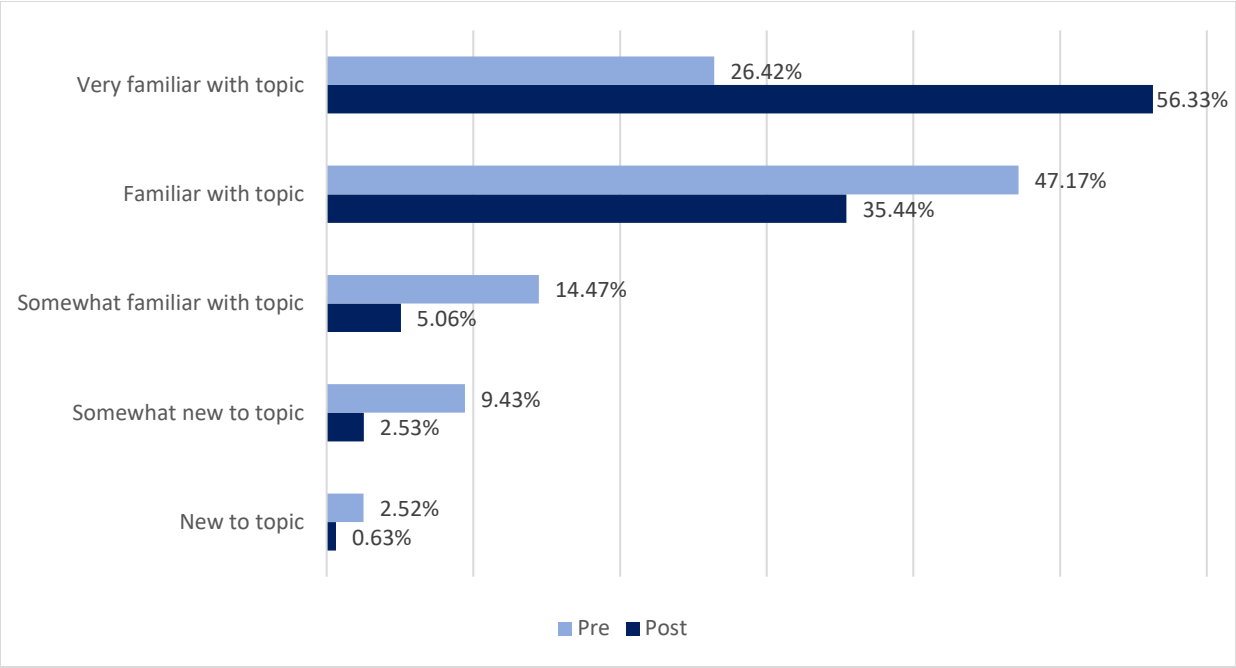




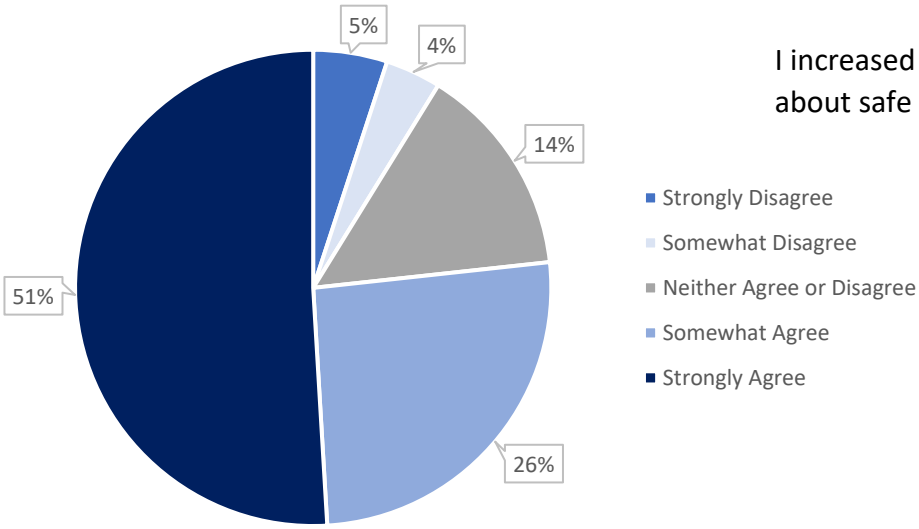
Participant Knowledge: Certification and Adoption Caseworkers

Pre-and Post-Training

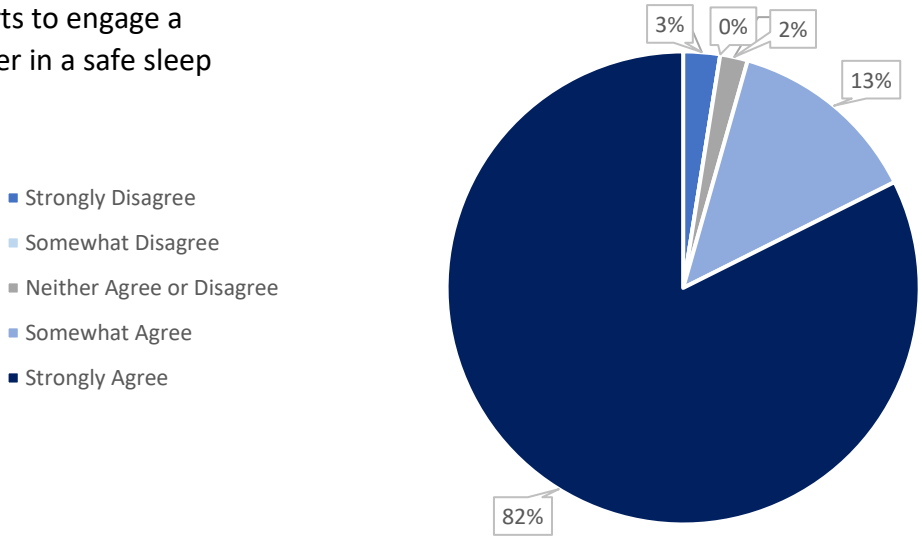
In July 2020, the Safe Sleep Self-Study Training for certification and adoption caseworkers launched. A total of 268 caseworkers have completed the safe sleep training and 159 completed a training evaluation. The graph below displays the percent of respondents who indicated their knowledge of safe sleep prior to taking the training and after.



The following pie graphs displays the percent of respondents who indicated their experience in two specific areas post-training.



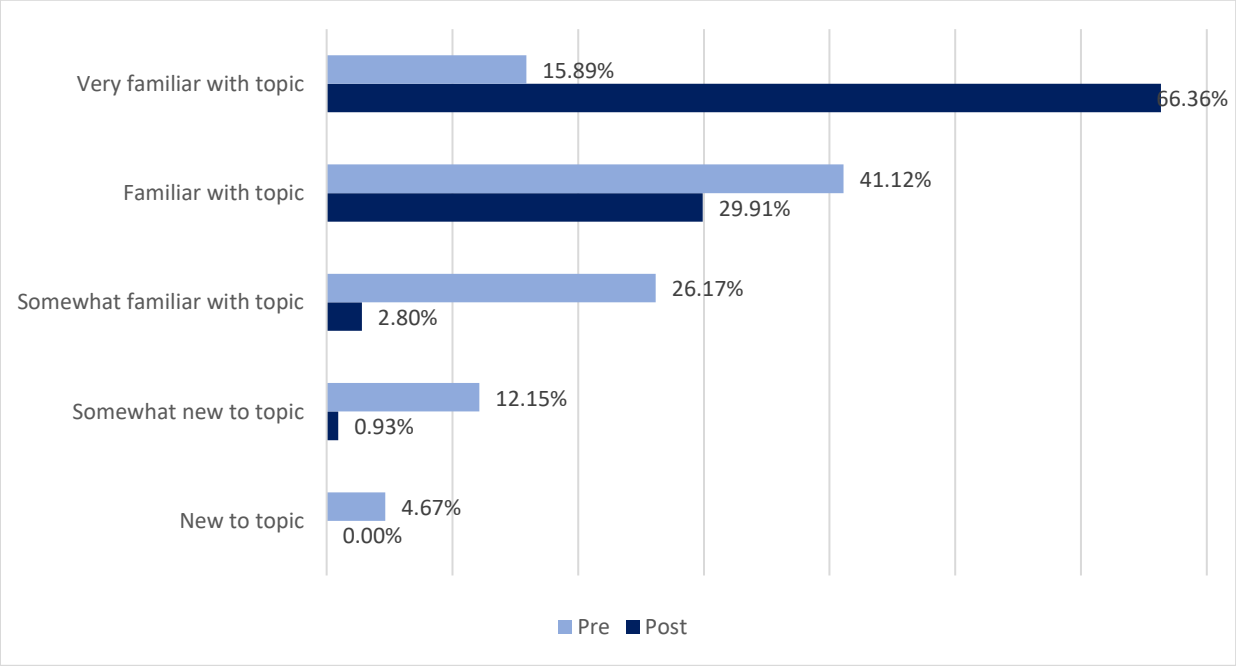
I have enough of an understanding to observe an infant's sleep space and make efforts to engage a parent/caregiver in a safe sleep conversation.



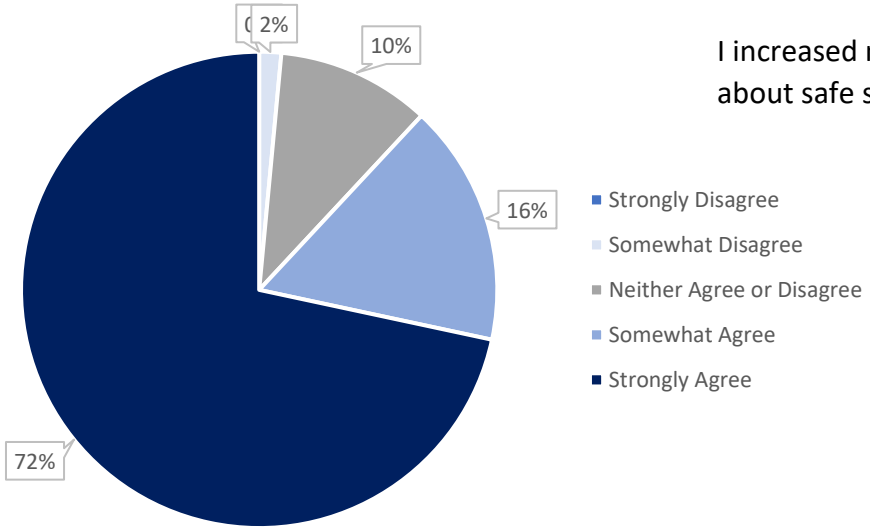
Participant Knowledge: Oregon Child Abuse Hotline

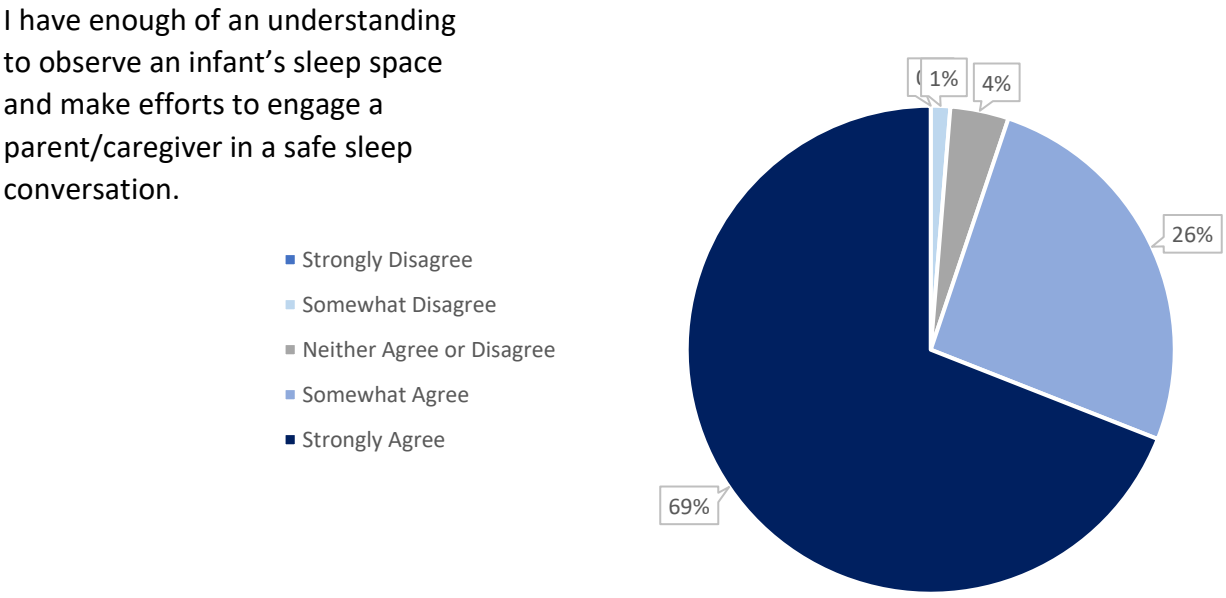
Pre- and Post-Training

In April 2021, the Safe Sleep Self-Study Training launched for the Oregon Child Abuse Hotline (ORCAH). A total of 202 participants from ORCAH have completed the safe sleep training and 202 completed a training evaluation. The graph below displays the percent of respondents who indicated their knowledge of safe sleep prior to taking the training and after.



The following pie graphs displays the percent of respondents who indicated their experience in two specific areas post-training.

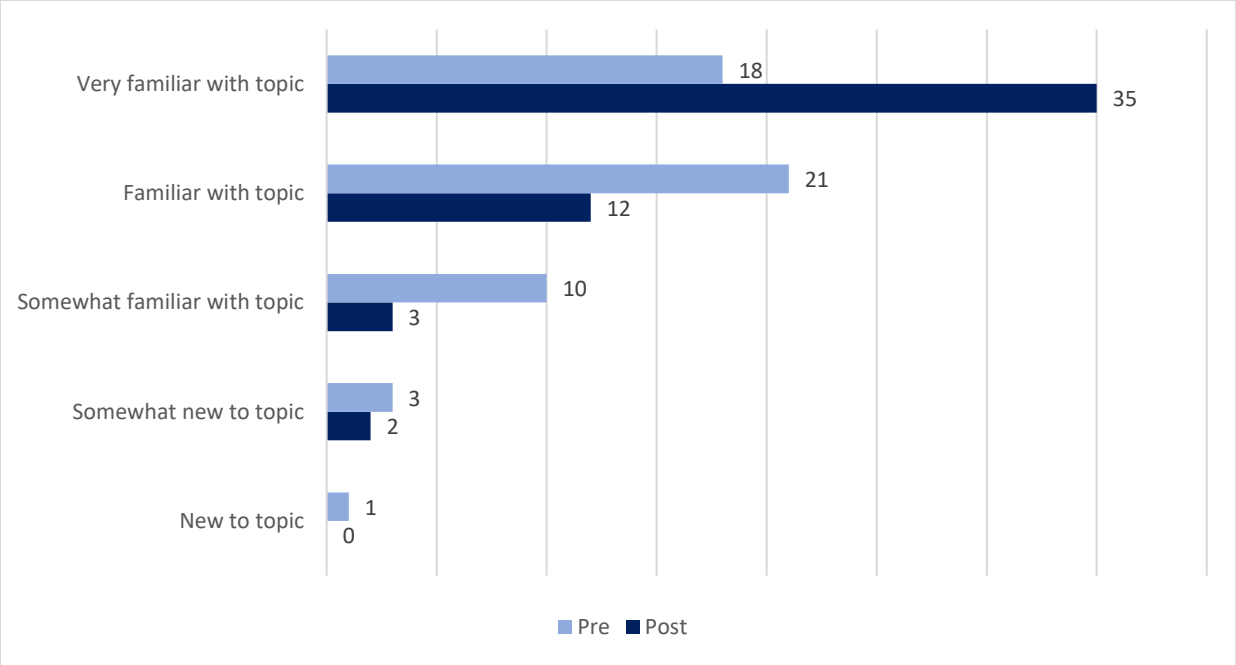




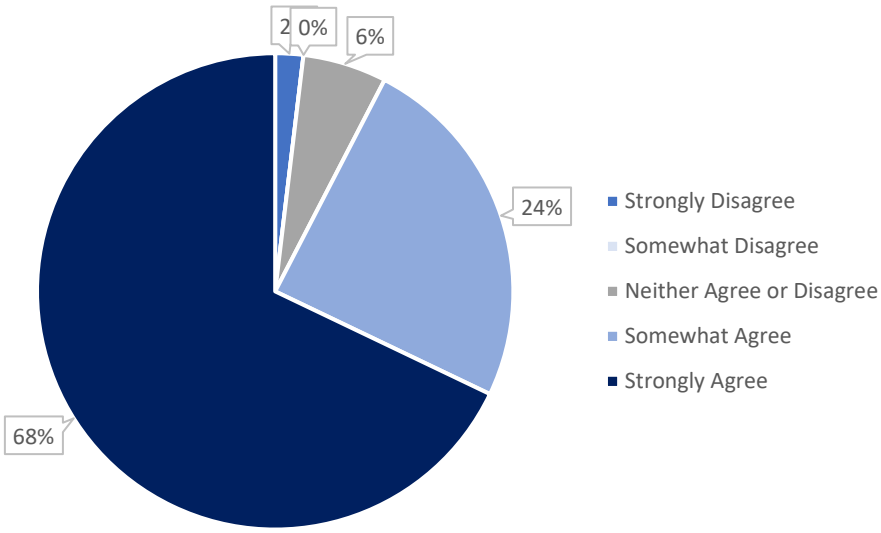
Participant Knowledge: Family Serving Professionals

Pre- and Post-Training

In September 2021, the Safe Sleep Self-Study launched for Family Serving Professionals. To date, 53 participants have completed training evaluations. The graph below displays the percent of respondents who indicated their knowledge of safe sleep prior to taking the training and after.



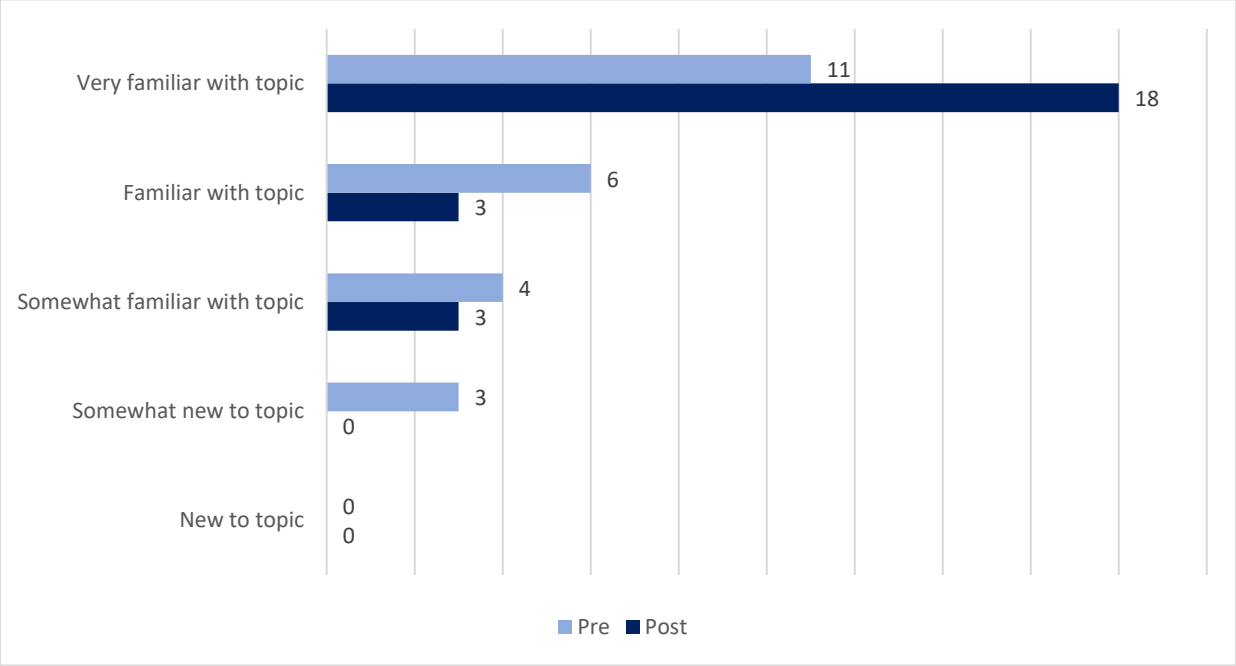
The following pie graphs displays the percent of respondents who indicated their experience in increasing their knowledge about safe sleep practices post-training.



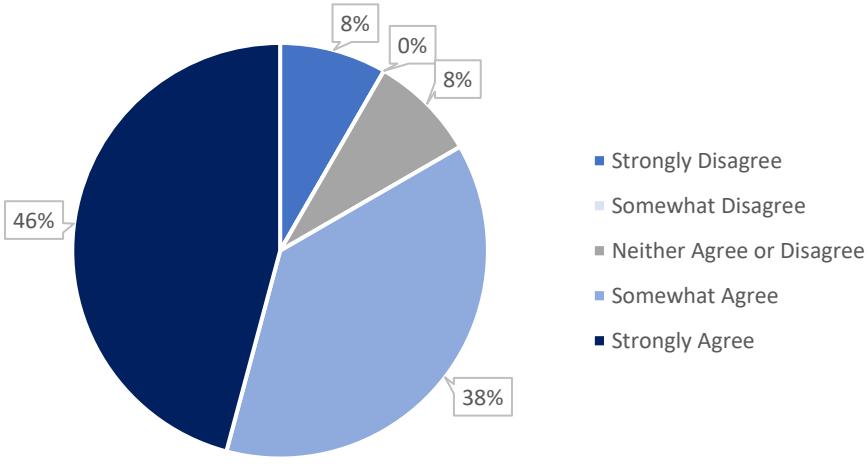
Participant Knowledge: Resource Families

Pre- and Post-Training

In July 2021, the Safe Sleep Self-Study launched for Resource Families. To date, a total of 35 have completed the training and 24 participants have completed training evaluations. The graph below displays the percent of respondents who indicated their knowledge of safe sleep prior to taking the training and after.



The following pie graphs displays the percent of respondents who indicated their experience in increasing their knowledge about safe sleep practices post-training.



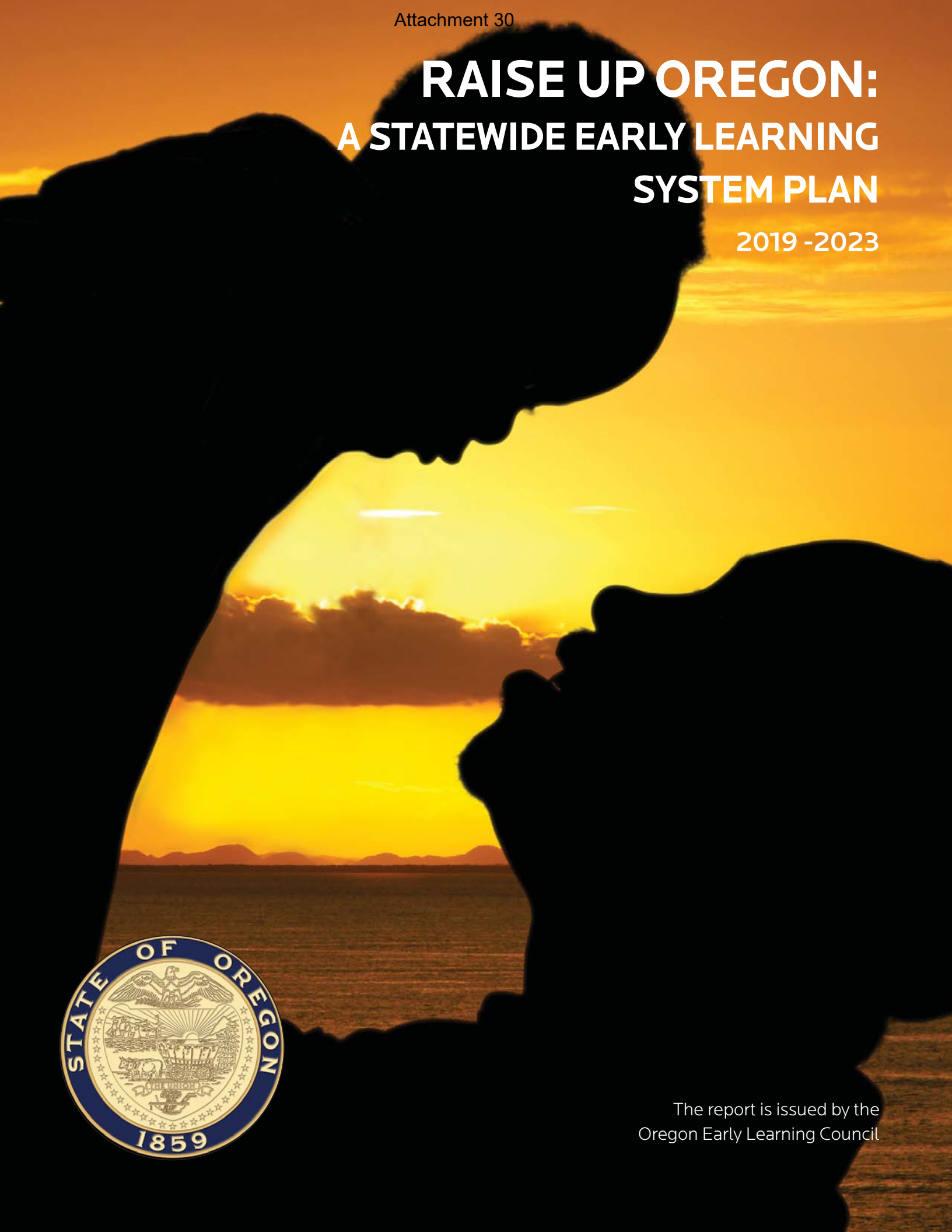
Participant Feedback: All Training Sessions

- I liked that cultural circumstances and safe sleep practices were included in this training and there was information on how to be culturally responsive.

- This training helped broaden my understanding knowledge base. I will implement this in my own life as well as share with other parents.
- This training helped me be informed on how to best engage families to help assure infant safety.
- I learned more strategies and have a better understanding of how to help caseworkers and our families prevent the tragedy of SIDS.
- Learned how to have effective conversations with caregivers about their safe sleep practices.
- The tragedy of SIDS can happen to any family but there are many ways to help prevent it from occurring.
- I feel more confident to actively engage resource parents in conversations about safe sleep practices.
- I will use this information to support my staff during supervision and staffing of cases that involve infants.
- I appreciated the information to help apply harm-reduction strategies for families that may be hesitant to utilize safe sleep practices.
- I learned how we should be normalizing conversations around safe sleep practices.
- I plan to move forward in my work by being respectful and aware of others' cultures and now I know how to bring up safe sleep with individuals.
- I plan to use this information as an educational and informational tool, as well as to help inform decision making about infant safety.
- This training reminded me of outside stressors and how they can impact an infant.
- We foster infants so this was very relevant to our day-to-day experience.
- I will be meticulous about the infant's sleeping environment and be certain to discuss the contents of this training with all potential respite caregivers.

Attachment 30

RAISE UP OREGON:
A STATEWIDE EARLY LEARNING SYSTEM PLAN
2019 -2023



The report is issued by the
Oregon Early Learning Council

Acknowledgements

A special thanks to the team from the Oregon Early Learning Division and the BUILD Initiative for their work in support of *Raise Up Oregon*, particularly those who served as primary planners, developers and authors of the plan: Alyssa Chatterjee, David Mandell, Sara Mickelson, Carey McCann, and Harriet Dichter.

Suggested citation

Oregon Early Learning Council. (2019). *Raise Up Oregon: A Statewide Early Learning System Plan 2019-2023*. Salem, OR: Oregon Early Learning Division.

For more information

Raise Up Oregon: A Statewide Early Learning System Plan 2019-2023,
https://oregonearlylearning.com/raise-up-oregon

https://oregonearlylearning.com/

Contact us

early.learning@state.or.us

OREGON DEPARTMENT OF EDUCATION
EARLY LEARNING DIVISION

CONTENTS

EXPLANATION OF SYMBOLS

This symbol is next to strategies with a focus on infants and toddlers.

Existing state plans and *Raise Up Oregon* have shared strategies, as indicated by the following symbols:

Aligns with Department of Human Services 2016-2019 Self Sufficiency Programs (SSP) Strategic Plan, SSP Fundamentals Map and Child Welfare Action Plan

Aligns with Oregon Department of Education 2017-2019 Strategic Plan.[i]

Aligns with Early Learning Division's Child Care Supply and Quality; Preschool and Kindergarten Readiness; Community-based and Family Supports; and Workforce Quality, and with ELD Policy Option Packages (POP) and Legislative Concepts (LC) 2019-2021.

Aligns with Oregon Health Authority State Health Improvement Plan,[ii] the Public Health Division Maternal and Child Health Section 2018 Strategic Plan,[iii] and CCO 2.0 Recommendations of the Oregon Health Policy Board.[iv]

Aligns with Oregon Housing and Community Services 2019 Statewide Housing Plan.

Aligns with Governor's Agenda, e.g., Health Care for All: Sustaining the Oregon Model of Health Care Coverage, Quality, and Cost Management; Education Policy Agenda: Every Oregon Student Engaged, Empowered, and Future Ready; Housing Policy Agenda: Housing Stability for Children, Veterans, and the Chronically Homeless and Increased Housing Supply for Urban and Rural Communities; Child Welfare Policy Agenda: Protecting Children, Supporting Families and Ending the Cycle of Poverty; and The Children's Agenda: Pathways Out of Poverty for Children to Achieve Their Full Potential.[v]

KATE BROWN
GOVERNOR

January 1, 2019

Dear Early Learning Stakeholders:

As you know, the first few years of a child's life have a powerful impact on their future, and, as a result, the future of our state. It is essential for the state and local communities to do all that we can to provide support for the more than 43,000 children born each year in Oregon and their families.

That is why, over a year ago, I asked Miriam Calderon, Early Learning System Director, and Sue Miller, Early Learning Council Chair, to prepare a statewide prenatal to age five early learning plan. I envisioned this plan as a roadmap to ensure all children enter school ready to learn, especially those children who have been historically underserved, including those living in rural areas, communities of color, and low-income communities.

I am pleased to share that plan with you today, entitled *Raise Up Oregon: A Statewide Early Learning System Plan*. To create this plan, the Early Learning Council engaged hundreds of diverse stakeholders over the past year. Council members listened to families and received input from professionals working in early learning across our state. They have delivered a plan that demonstrates a solid understanding of our challenges and the best path forward to ensure a brighter future for our youngest Oregonians. This plan responds to what we know from science, economics, and experience about how to best address root causes and meet the needs of Oregon's youngest children and their families.

Raise Up Oregon: A Statewide Early Learning System Plan builds on our successes, calls for bolder action in the areas where we must do more, and, importantly, it recognizes that it takes collaborative problem solving across sectors to do better by our youngest children. The plan is bolstered by the expertise and commitment of families and of those working in early care and education, health, housing and community development, human services, and K-12 education, and its solutions engage all of these sectors to take action.

I commend the members of the Early Learning Council for the development of this plan. In addition, the development of this plan would not have been possible without the support of key philanthropic partners in early learning. My thanks to The Ford Family Foundation, Bill & Melinda Gates Foundation, Lora and Martin Kelley Family Foundation, Oscar G. & Elsa S. Mayer Family Foundation, Meyer Memorial Trust, James F. and Marion L. Miller Foundation, Oregon Community Foundation, J.B. and M.K. Pritzker Family Foundation, and Thrasher Family Fund of the Oregon Community Foundation for their financial support and for their ongoing commitment to early childhood.

I am proud to share this plan with you, and I look forward to working together to move it from plan to reality.

Sincerely,

Kate Brown

Governor Kate Brown

254 STATE CAPITOL, SALEM OR 97301-4047 (503) 378-3111 FAX (503) 378-8970
WWW.GOVERNOR.OREGON.GOV

RAISE UP OREGON AT-A-GLANCE

SYSTEM GOAL 1: CHILDREN ARRIVE READY FOR KINDERGARTEN

OBJECTIVE 1: Families are supported and engaged as their child's first teachers.

Strategy 1.1 Expand parenting education and family supports.

Strategy 1.2 Scale culturally responsive home visiting.

OBJECTIVE 2: Families have access to high-quality (culturally responsive, inclusive, developmentally appropriate) affordable early care and education that meets their needs.

Strategy 2.1 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable infant-toddler early care and education that meets the needs of families.

Strategy 2.2 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable preschool that meets the needs of families.

Strategy 2.3 Strengthen child care assistance programs.

Strategy 2.4 Build the state's capacity to ensure children are healthy and safe in child care.

Strategy 2.5 Improve the essential infrastructure for high-quality early care and education.

OBJECTIVE 3: The early care and education workforce is diverse, culturally responsive, high quality and well compensated.

Strategy 3.1 Improve professional learning opportunities for the full diversity of the early care and education workforce.

Strategy 3.2 Build pathways to credentials and degrees that recruit and retain a diverse early care and education workforce.

Strategy 3.3 Compensate and recognize early childhood educators as professionals.

Strategy 3.4 Improve state policy to ensure early care and education work environments guarantee professional supports.

OBJECTIVE 4: Early childhood physical and social-emotional health promotion and prevention is increased.

Strategy 4.1 Ensure prenatal-to-age-five health care services are comprehensive, accessible, high quality, and culturally and linguistically responsive.

Strategy 4.2 Increase capacity to provide culturally responsive social-emotional supports for young children and their families.

Strategy 4.3 Increase and improve equitable access to early childhood oral health.

Strategy 4.4 Strengthen coordination among early care and education, health, and housing to promote health and safety for young children.

OBJECTIVE 5: Young children with social-emotional, developmental, and health care needs are identified early and supported to reach their full potential.

Strategy 5.1 Ensure adequate funding of and access to a range of regional and community-based services, including Early Intervention/Early Childhood Special Education services.

Strategy 5.2 Continue to prioritize screening through the health system and build pathways from screening to a range of community-based services and supports for children and families.

Strategy 5.3 Prevent expulsion and suspension by strengthening state policies and supports to early care and education programs.

OBJECTIVE 6: Children and families experience supportive transitions and continuity of services across early care and education and K-12 settings.

Strategy 6.1 Establish shared professional culture and practice among early care and education and K-3 that supports all domains, including social-emotional learning.

Strategy 6.2 Improve the Oregon Kindergarten Assessment to better support decision-making between early learning and K-12 stakeholders.

SYSTEM GOAL 2: CHILDREN ARE RAISED IN HEALTHY, STABLE, AND ATTACHED FAMILIES

- **OBJECTIVE 7: Parents and caregivers have equitable access to support for their physical and social-emotional health.**

  Strategy 7.1 Increase equitable access to reproductive, maternal, and prenatal health services.

  Strategy 7.2 Improve access to culturally and linguistically responsive, multi-generational approaches to physical and social-emotional health.

- **OBJECTIVE 8: All families with infants have opportunities for connection.**

  Strategy 8.1 Create a universal connection point for families with newborns.

  Strategy 8.2 Provide paid family leave.

- **OBJECTIVE 9: Families with young children who are experiencing adversity have access to coordinated and comprehensive services.**

  Strategy 9.1 Expand and focus access to housing assistance and supports for families with young children.

  Strategy 9.2 Provide preventive parenting support services to reduce participation in the child welfare system.

  Strategy 9.3 Improve the nutritional security of pregnant women and young children, particularly infants and toddlers.

  Strategy 9.4 Link high-quality early care and education, self-sufficiency, and housing assistance programs.

SYSTEM GOAL 3: THE EARLY LEARNING SYSTEM IS ALIGNED, COORDINATED, AND FAMILY CENTERED

- **OBJECTIVE 10: State-community connections and regional systems are strengthened.**

  Strategy 10.1 Ensure family voice in system design and implementation.

  Strategy 10.2 Ensure family-friendly referrals.

  Strategy 10.3 Further develop the local Early Learning Hub system.

- **OBJECTIVE 11: Investments are prioritized in support of equitable outcomes for children and families.**

  Strategy 11.1 Ensure resources are used to reduce disparities in access and outcomes.

  Strategy 11.2 Align and expand funding opportunities for culturally specific organizations.

- **OBJECTIVE 12: The alignment and capacity of the cross-sector early learning workforce is supported.**

  Strategy 12.1 Support consistent, high-quality practice among all professionals in the family- and child-serving early learning workforce.

  Strategy 12.2 Improve cross-sector recruitment, retention, and compensation.

- **OBJECTIVE 13: The business and philanthropic communities champion the early learning system.**

  Strategy 13.1 Educate business leaders on the economic value of early care and education to the Oregon economy.

  Strategy 13.2 Introduce business leaders to the science of early childhood development and the impact of public investment.

- **OBJECTIVE 14: The data infrastructure is developed to enhance service delivery, systems building, and outcome reporting.**

  Strategy 14.1 Strengthen data-driven community planning.

  Strategy 14.2 Integrate early learning data into the Statewide Longitudinal Data System.

  Strategy 14.3 Develop and implement a population survey to track the well-being of children and families across Oregon.

  Strategy 14.4 Create and use an early learning system dashboard to create shared cross-sector accountability for outcomes for young children and their families.

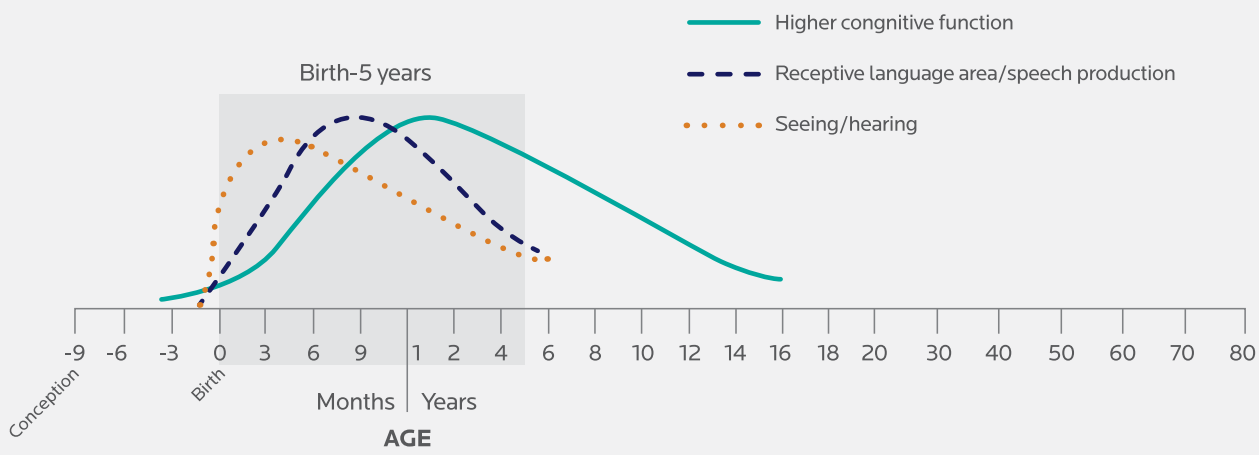
INVESTING IN OREGON'S YOUNG CHILDREN: MULTI-SECTOR SOLUTIONS GROUNDED IN SCIENCE AND EQUITY

Oregon is home to over 275,000 children, birth to kindergarten entry.[vi] Our state has an opportunity to change how it supports these children and their families and, in doing so, put itself on the path to an even brighter future. Overwhelming evidence tells us that investing in young children and their families has a lasting, positive impact across their lifetime. *Raise Up Oregon: A Statewide Early Learning System Plan* is grounded in the science of child development, equity, and a firm understanding that it takes leaders from early care and education, K-12, health, housing, and human services—together with families, communities, and the public and private sectors—to work together during this critical period of children's lives.

Brain science makes clear that the first 2,000 days of a child's life – the time between birth and kindergarten entry – represent the most consequential period in human development. From birth to age three, a child's brain makes one million new neural connections every second. The rapid pace of synapse formation in the brain sets the architecture for future health and learning. During this time, children are establishing critical attachment to caregivers as well as learning to communicate with others and regulate their emotions. The quality of their relationships, experiences, and interactions matters greatly.

The science of child development underscores the importance of the first 2,000 days of childhood.

Figure 1. Synapse formation in the developing brain[vii]

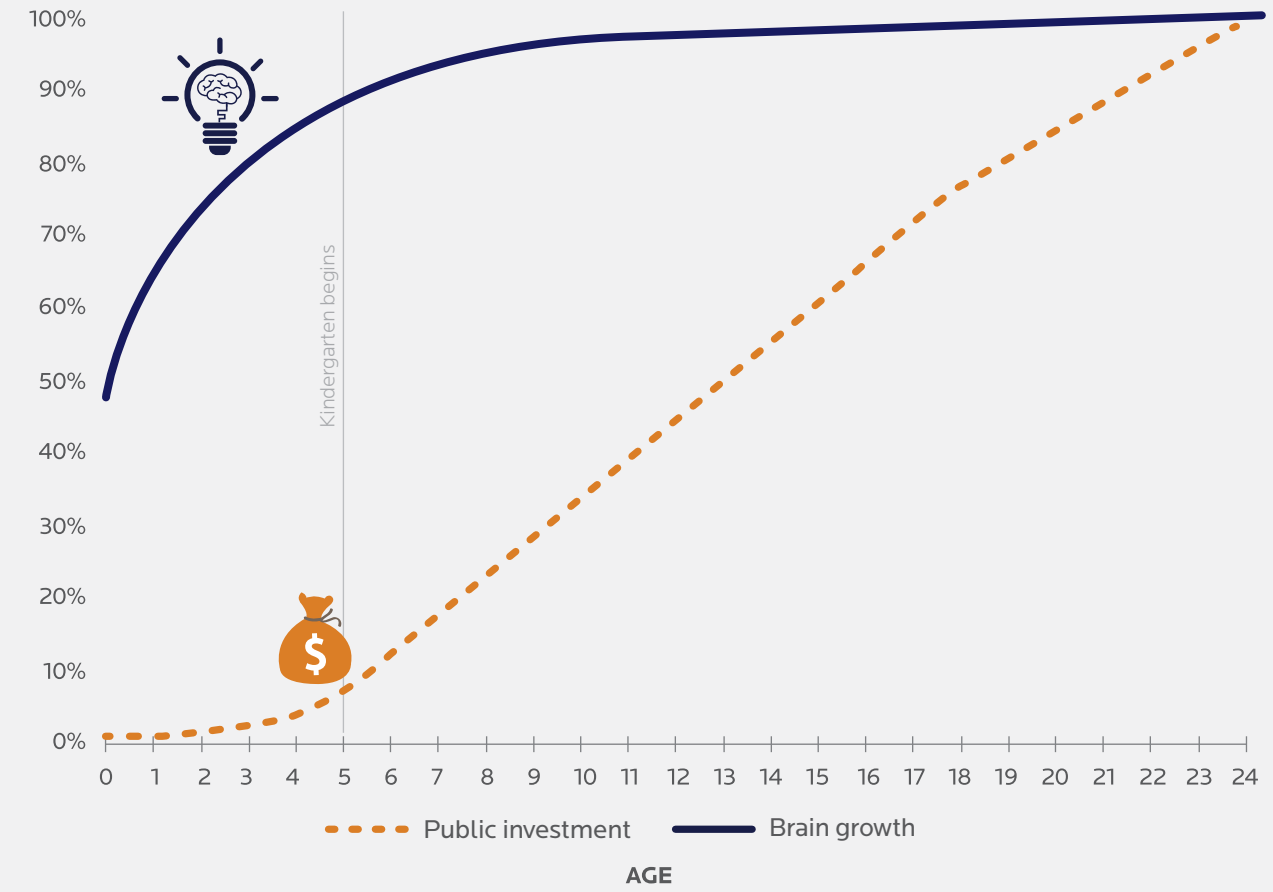


When we address the learning and development needs of young children, the economic returns not only benefit children and families, but society at large. Scientists at the RAND Corporation reviewed 115 early childhood programs, and 102—or nearly 90%—had a positive effect on at least one child outcome, such as behavior and emotion, language, cognitive achievement, child health, and kindergarten readiness. Researchers also found a reduction in child welfare involvement and crime-related behaviors.[viii] The RAND review showed that among programs with an economic evaluation, the typical return is $2 to $4 for every dollar invested. These findings are associated with improved adult outcomes, including higher likelihood of high school and college completion, increased earnings and workforce participation, and better health.

The evidence notwithstanding, less than 10% of Oregon's combined federal and state investment in children's education occurs before age five. The state investments from cradle to career accrue gradually in the first five years and increase rapidly once a child enters kindergarten. This is the antithesis of an approach that would be consistent with the brain science. By kindergarten entry, the brain has matured, reaching 90% of its adult size; however, most of the public investments in education are made after this point.

Invest early to get the best return on public investment.

Figure 2. Oregon's cumulative per child public education investment compared to child brain growth[ix]



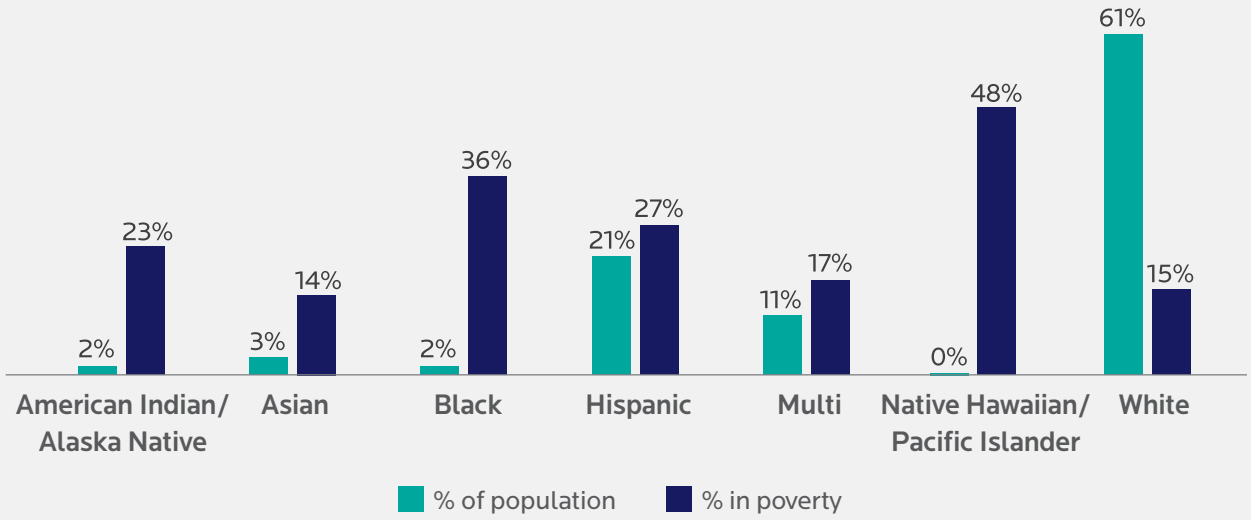
While these years represent a remarkable period of opportunity, they are also a period of intense vulnerability. Adverse conditions, such as inadequate nutrition and housing, exposure to toxic substances, poor maternal health, or a lack of appropriate early experiences and nurturing relationships have a lasting detrimental effect on the developing brain, even if a child's circumstances are improved later in childhood.

Oregon's equity lens helps us understand that adversity in early childhood is rooted in chronic and persistent opportunity gaps. Income, race, and zip code are powerful predictors of whether children and their families experience the conditions that are optimal for young children's development, including access to high-quality child care and preschool. Breaking the link between these inherited factors and life outcomes can only happen if we change the circumstances of families, which means changing the distribution of opportunities in those years.

This will require addressing the economic well-being of families with young children, and recognizing that income is closely linked with race and geography. Nearly 50,000 young children in Oregon live in poverty, which means their families earn below $20,780 for a family of three. More than one in five children in rural Oregon live in poverty, with children of color disproportionately represented among them.

Racial and economic disparities emerge early.

Figure 3. Oregon children under 5: percent of population and percent in poverty by racial/ethnic groups[x]



In order to address early adversity and opportunity gaps, we must develop comprehensive solutions that recognize that the lives of young children and families are influenced by many factors, including stable housing, consistent health care, and affordable, high-quality early care and education. We must also find new ways to work with community partners and – particularly – communities of color, as well as adequately fund the programs in our state that are designed to support these communities that have been historically marginalized and underserved. Early care and education, K-12, health, housing, and human services—together with families, communities, and the public and private sectors—are all needed to drive positive change for Oregon's youngest children and families.

DEVELOPING *RAISE UP OREGON:* THE APPROACH TO STRATEGIC PLANNING

The Early Learning Council serves as the governing body for Oregon's comprehensive early learning system at the state level. Its composition includes the directors of the five state agency partners and key early learning professionals representing the diversity of the state. The Early Learning Council is statutorily charged with overseeing the early learning system and the services it delivers for children and families in order to make progress toward three system goals outlined in statute:

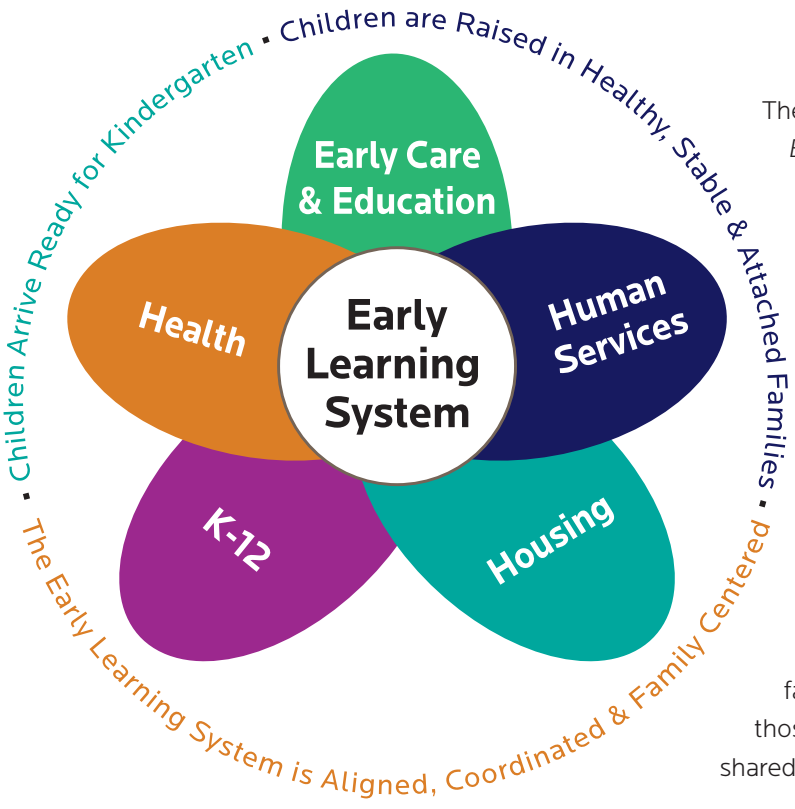
Children Arrive Ready for Kindergarten

Children are Raised in Healthy, Stable, and Attached Families

The Early Learning System is Aligned, Coordinated, and Family Centered

In developing *Raise Up Oregon: A Statewide Early Learning System Plan*, the Early Learning Council focused on the most strategic ways to make progress over the next five years (2019-2024) toward the vision embodied by the three system goals. The Council spent a year working with cross-agency partners— Department of Human Services, Oregon Department of Education, Oregon Early Learning Division, Oregon Health Authority, and Oregon Housing and Community Services– and hearing from communities, partners, parents, and providers.

Figure 4. *Raise Up Oregon* goals and sectors



The Council framed *Raise Up Oregon: A Statewide Early Learning System Plan* using the Council's guiding principles, which are rooted in equity, community and family engagement, and evidence-based practices in all decision-making processes within the early learning system. In order to engage diverse voices throughout the state, outreach included partners and providers representing children and families in historically underserved communities. The Council was particularly interested in: parents' and providers' experiences with services during the early childhood years; each sector's key goals and priorities for children prenatal to five and their families; strengths for and barriers to reaching those goals and priorities; and opportunities for shared interests and work across sectors.

The purpose of the five-year *Raise Up Oregon: A Statewide Early Learning System Plan* is to share a vision of where we as a state intend to go and to identify actionable, concrete strategies for working together across traditional boundaries to make this vision a reality. All of Oregon's young children deserve the best start. Zip code, race, and family income should not predict the health, educational, and life outcomes of Oregon's children.

Implementing *Raise Up Oregon: A Statewide Early Learning System Plan* requires that all five sectors are connected to the early learning system. This plan aligns with the governor's agenda and the strategic plans of cross-agency state partners, and provides an opportunity to intervene early and be more successful in the individual missions of each agency. This systems approach will make certain that children and families are receiving the services and supports they need to ensure that children enter kindergarten learning, thriving, and healthy.

DEVELOPING *RAISE UP OREGON: A STATEWIDE EARLY LEARNING SYSTEM PLAN*

OVER 200 PEOPLE

including state agency representatives, program administrators and providers, families, and all four Early Learning Council committees engaged in the development of *Raise Up Oregon*.

7 EARLY LEARNING COUNCIL MEETINGS

Presentations and discussions with state agency leadership, program administrators, Early Learning Hubs and other regional entities, providers and families across early care and education, health, housing and community supports, human services, K-12, and public health.

12 PARENT ENGAGEMENT SESSIONS

Parent discussions throughout the state.

16 EARLY LEARNING HUB Governance Board Meetings

Early Learning Hub Governance Boards discussed the strengths and barriers within each Hub community, provided input on cross-sector strategic planning themes, and explored the potential role for Hubs.

4 EARLY LEARNING COUNCIL COMMITTEES

All four Council committees—Best Beginnings, Equity Implementation, Child Care and Education, and Measuring Success—contributed to plan development.

VIA SURVEY

60 PEOPLE

Partners representing Child Care Resource & Referral entities, Early Learning Hubs, Early Learning Division staff, local Public Health offices, and members of the nine federally recognized tribes of Oregon provided feedback on the objectives and strategies most related to their work.

8 CHILDREN'S CABINET MEETINGS

4 Meetings with top state AGENCY LEADERSHIP

The Department of Human Services, Oregon Department of Education, Oregon Health Authority, and Oregon Housing and Community Services met with the Early Learning Council chair and the Early Learning System Director.

SYSTEM GOAL 1:
CHILDREN ARRIVE READY FOR KINDERGARTEN

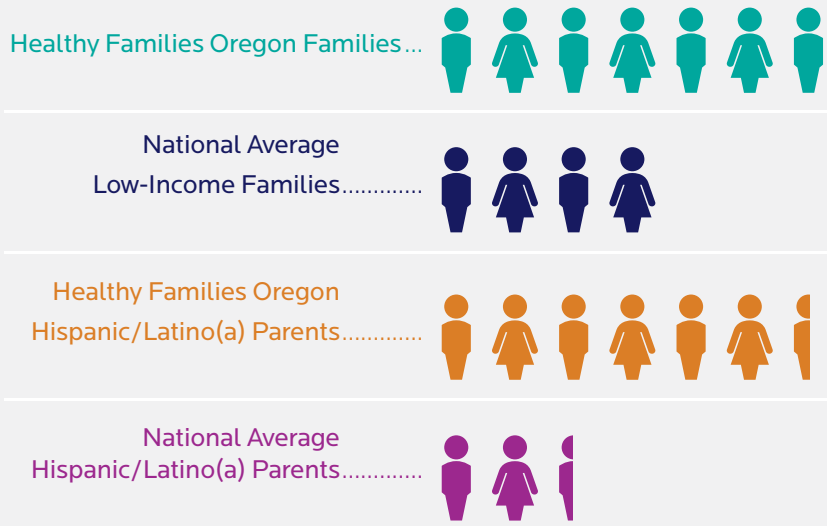
OBJECTIVE 1: Families are supported and engaged as their child's first teachers.

Parents have the greatest impact on their children's learning and development, especially when they can access programs that support them. For example, 70% of parents who participated in the Healthy Families Oregon (HFO) home visiting program for at least six months reported reading to their children on a daily basis, compared to the national average of just 40%.

Yet, only 20% of eligible families in Oregon have access to a home visiting program[xi] and only 3% have access to parenting education programs.[xii]

Furthermore, culturally specific organizations that have some of the strongest and most trusting relationships with families often lack access to available public resources needed to serve their communities.

Figure 5. Percentage of parents reading to children 0-5 daily[xiii]



Strategy 1.1 Expand parenting education and family supports.

- Expand availability and access to community-based parenting education by building on the philanthropic investment in the Oregon Parenting Education Collaborative (OPEC).
- Create an Equity Fund to support community-based, culturally specific organizations to extend their reach in providing culturally specific parenting and early learning supports in their communities.

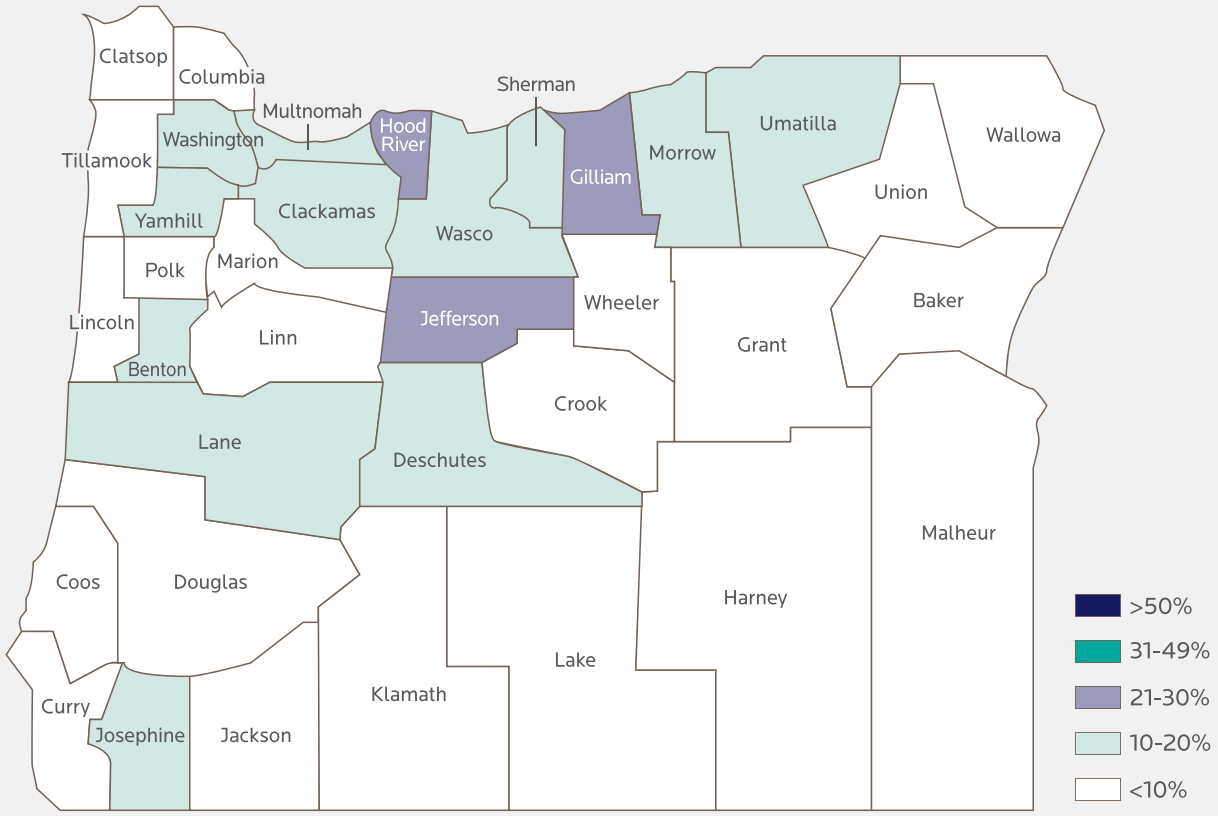
Strategy 1.2 Scale culturally responsive home visiting.

- Expand access to Oregon's current array of evidenced-based and evidence-informed targeted home visiting programs so that more families have access to these supports, prioritizing those families in historically underserved communities.
- Expand access to professional learning opportunities and address compensation for home vsitors in order to build a strong, culturally diverse workforce and increase retention.

OBJECTIVE 2: Families have access to high-quality (culturally responsive, inclusive, developmentally appropriate) affordable early care and education that meets their needs.

Oregon families face significant barriers to accessing early care and education (ECE), including finding programs that are high-quality, affordable, culturally or linguistically responsive, and meet their scheduling needs. All but one of Oregon's counties are infant and toddler child care "deserts"[xiv] and over 30,000 three to five year olds in low-income families lack access to publicly funded preschool.[xv] A national report ranking states on infant child care affordability lists Oregon in the bottom three for center-based care.[xvi] Achieving a supply of accessible, affordable, high-quality ECE takes sound policy, resources, and the engagement of families and communities.

Figure 6. Percent of Oregon young children 0-3 with access to regulated child care[xvii]



Strategy 2.1 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable infant-toddler early care and education that meets the needs of families.

- Create, scale, and sustain a statewide, high-quality infant and toddler child care program with a focus on children in historically underserved communities.
- Create shared service networks within rural and urban communities to better scale infant and toddler care.
- Increase state investments in Early Head Start by expanding Oregon Prekindergarten as a prenatal-to-five program.

Strategy 2.2 Expand access to, and build the supply of, high-quality (culturally responsive, inclusive, developmentally appropriate) affordable preschool that meets the needs of families.

- Expand preschool programs (i.e. Oregon Prekindergarten, Preschool Promise, Early Childhood Special Education) to serve more children, especially those in historically underserved communities.
- Align policies across Oregon's three state preschool programs (Early Childhood Special Education, Oregon Prekindergarten, and Preschool Promise) to facilitate blended funding models.
- Expand use of child care assistance contracts for wraparound care for preschool programs so they meet the needs of working families.
- Support Early Learning Hubs to create coordinated preschool enrollment processes.

Strategy 2.3 Strengthen child care assistance programs.

- Unify policymaking and policies across all child care assistance programs (Employment-Related Day Care (ERDC), Temporary Assistance for Needy Families (TANF) child care, and contracted child care assistance).
- Increase resources for child care assistance programs so that: 1) reimbursement rates meet the cost of delivering quality care across all types of care and ages, and 2) participating families pay no more than 7% of their income on care.
- Ensure child care assistance policy results in continuity of care, particularly for infants and toddlers.
- Ensure child care assistance policy reflects the scheduling needs of families.

Strategy 2.4 Build the state's capacity to ensure children are healthy and safe in child care.

- Improve child care licensing standards.
- Improve child care licensing implementation by strengthening technical assistance and monitoring.
- Coordinate investigations into serious violations in child care at the state and local level.
- Identify and address gaps in current licensing authority, including who is subject to licensing.

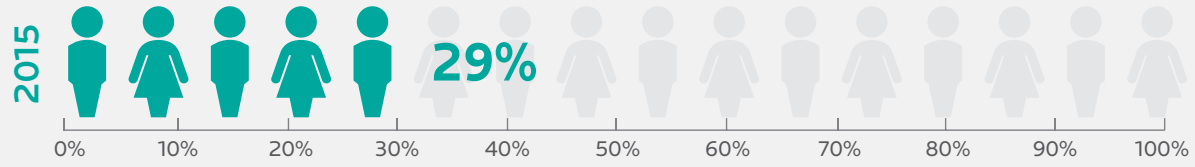
Strategy 2.5 Improve the essential infrastructure for high-quality early care and education.

- Conduct a statewide facilities needs assessment to identify communities with a dearth of ECE facilities and invest accordingly.
- Identify how to open high-quality family child care and child care centers within affordable housing units and housing developments.
- Create a regional plan for expanding access to and supply of high-quality infant, toddler, and preschool early care and education, available at times that meet the needs of families, especially to infants, toddlers, and preschoolers in historically underserved communities, under the leadership of the Early Learning Hubs.
- Use the state's licensing and Spark programs to recruit and support providers, especially in rural communities and communities of color, to become licensed and implement foundational health, safety, and quality practices.
- Expand resources for Spark to support additional ECE providers, including family, friend, and neighbor caregivers, in implementing best practices in ECE.

OBJECTIVE 3: The early care and education workforce is diverse, culturally responsive, high quality and well compensated.

A supply of high-quality, culturally responsive ECE programs requires a diverse, knowledgeable, skilled, and fairly compensated workforce. Yet Oregon's early childhood educators typically make between $25,000 and $35,000 annually.[xviii] In addition to fair compensation, educators also need pathways to early childhood degrees, ongoing professional learning supports, and positive, supportive work environments in order to implement best practice. These conditions can ensure that Oregon retains the workforce it needs, rather than continue to see a quarter of the workforce leaving the field each year.

Figure 7. Oregon ECE teacher and provider annual workforce turnover[xix]



Strategy 3.1 Improve professional learning opportunities for the full diversity of the early care and education workforce.

- Implement a competency-based professional learning system that is culturally and linguistically relevant for educators, educational leaders, professional development, and training personnel.
- Tailor and scale supports for family, friend, and neighbor caregivers, especially for those participating in child care assistance programs.
- Create competencies and professional learning opportunities that speak to the unique role of infant and toddler educators.
- Ensure communities have data needed to design and evaluate effectiveness of professional learning for the diversity of the workforce – including across different settings.
- Increase the relevance and effectiveness of professional learning through job-embedded supports and the inclusion of culturally responsive pedagogy.

Strategy 3.2 Build pathways to credentials and degrees that recruit and retain a diverse early care and education workforce.

- Fully implement all steps in the career pathway.
- Partner with higher education institutions to ensure degree programs reduce barriers to higher education and meet the needs of the current workforce, equitably addressing cultural, language, learning, and access needs.
- Partner with higher education institutions to ensure degree programs include curriculum that addresses the prenatal-to-5 continuum.
- Build upon existing scholarship programs to support more educators in entering the field and existing educators in attaining AA and BA degrees in early childhood.
- Increase the number of educators entering the field by expanding opportunities for early care and education preparation in high school that can be leveraged in higher education.

Strategy 3.3 Compensate and recognize early childhood educators as professionals.

- Create educator compensation requirements that align with kindergarten educator compensation across publicly funded ECE programs (i.e. Oregon Prekindergarten, Preschool Promise, contracted slots) and increase public investment to implement those requirements.
- Create financial incentives for ERDC and TANF child care providers to support compensation that is aligned with kindergarten educators and increase public investment to support implementation.
- In collaboration with Early Learning Hubs and other partners, create understanding of the role and impact of early childhood educators among policymakers and the public.

Strategy 3.4 Improve state policy to ensure early care and education work environments guarantee professional supports.

- Incorporate professional supports (e.g., paid planning time, paid professional development time, compensation, wellness and health benefits) into program standards.
- Collect and use data to improve professional supports (e.g., paid planning time, paid professional development time, compensation, wellness and health benefits).

OBJECTIVE 4: Early childhood physical and social-emotional health promotion and prevention is increased.

Physical and emotional health provide the foundation for school readiness. More remains to be done to leverage Oregon's significant commitment to children's health care coverage. While Oregon is a leader in providing health insurance for children, access alone cannot eliminate health disparities that inhibit the ability of young children to learn and flourish. For example, there are significant racial disparities in Oregon's infant mortality rate – Native American and African American children are nearly twice as likely to die before their first birthday as their white counterparts.[xx] Health equity must be addressed.

Strategy 4.1 Ensure prenatal-to-age-five health care services are comprehensive, accessible, high quality, and culturally and linguistically responsive.

- Improve access to patient-centered primary care homes for all young children.
- Strengthen the early childhood focus of Coordinated Care Organizations (CCOs) by adding Early Learning Hub representation on CCOs' governing boards or using other tools to improve relationships and coordination.
- Increase the integration of physical, behavioral, and oral health for young children.
- Incentivize high-quality, evidence-based pediatric care, including rural communities.

Strategy 4.2 Increase capacity to provide culturally responsive social-emotional supports for young children and their families.

- Increase access to culturally responsive mental health services by ensuring there are diverse providers with expertise in children birth through age 5.
- Train home visitors, mental health professionals, and early care and education providers in relationship-based infant mental health and equity approaches.
- Focus on children whose families are affected by substance abuse and family separation, including by ensuring access to community health workers.

Strategy 4.3 Increase and improve equitable access to early childhood oral health.

- Increase access to and address disparities in prevention and treatment dental services for young children.
- Advance provider trainings such as First Tooth and Maternity Teeth for Two.
- Continue integration of oral health services in early care and education settings.

Strategy 4.4 Strengthen coordination among early care and education, health, and housing to promote health and safety for young children.

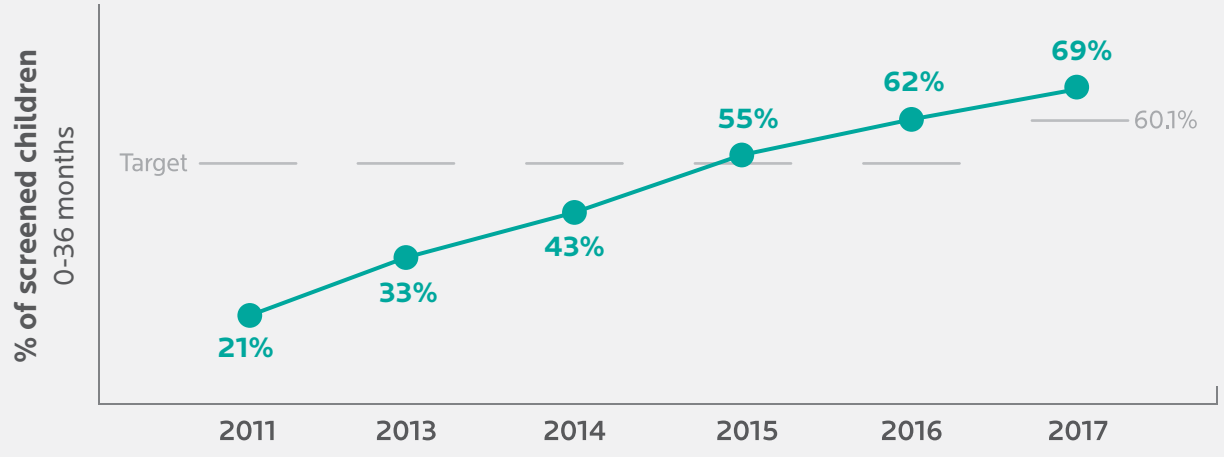
- Provide health consultation across ECE settings.
- Collaborate to support families and ECE providers in implementing safe sleep practices.
- Identify areas of shared accountability across housing, health, and ECE, and expand joint activities that promote environmental health, injury prevention and safety, physical activity, and healthy foods.

OBJECTIVE 5: Young children with social-emotional, developmental, and health care needs are identified early and supported to reach their full potential.

Oregon has made significant progress in ensuring that children with social-emotional, developmental, and health care needs are identified early. The rate of developmental screening for children enrolled in the Oregon Health Plan in the first thirty-six months of life has increased from 21% in 2011 to 69% by 2017.

However, too many children in Oregon who are identified with developmental delays at screening never receive services. Building local community-based systems that ensure early learning detection and a family-friendly process of referral to the supports that best address the needs of the individual child and family is essential to achieving that end. Services for children who are identified and enrolled in Early Intervention and Early Childhood Special Education (EI/ECSE) remain too limited due to funding, with only 34% of infants and toddlers currently enrolled in Early Intervention receiving the recommended level of services.[xxii]

Figure 8. Oregon developmental screenings in the first thirty-six months of life[xxi]



Strategy 5.1 Ensure adequate funding of and access to a range of regional and community-based services, including Early Intervention/ Early Childhood Special Education services.

- Increase funding so that Early Intervention/ Early Childhood Special Education services are at an adequate level to support the positive development of children with special needs as defined by the 2010 report to the Oregon Legislature.
- Review the criteria used to determine whether a child is eligible for Early Intervention/Early Childhood Special Education services and make and implement recommendations regarding the appropriate eligibility thresholds to ensure that all children needing these services are able to access them.
- Provide resources for communities to expand the array of services available to infants, toddlers, and families that need additional supports.
- Enable integration of Early Intervention and Early Childhood Special Education with other funding streams so that children are served in inclusive early care and education settings.

Strategy 5.2 Continue to prioritize screening through the health system and build pathways from screening to a range of community-based services and supports for children and families.

- Improve screening.
- Scale successful approaches to build community-based referral systems from screening to services that meet the diverse needs of young children and families.

Strategy 5.3 Prevent expulsion and suspension by strengthening state policies and supports to early care and education programs.

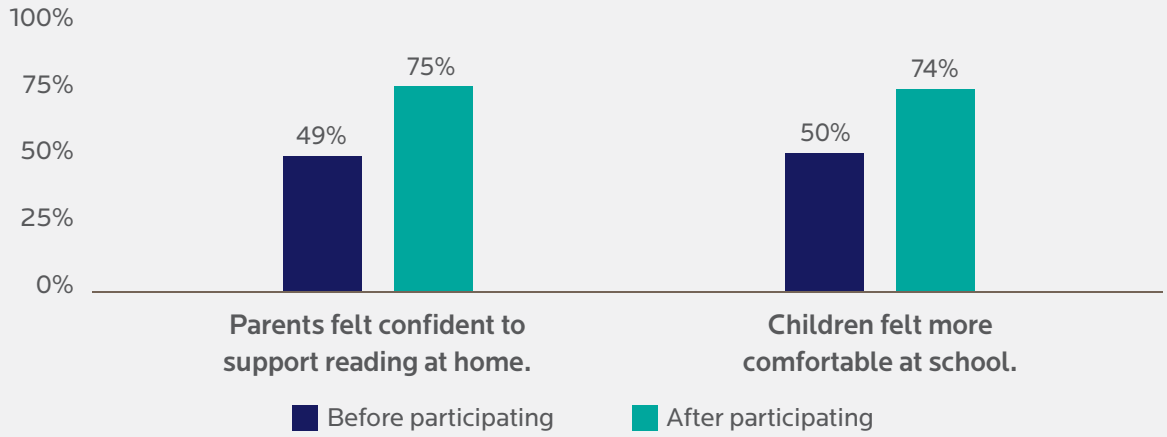
- Align policies across ECE programs and K-12 regarding suspension and expulsion.
- Improve data systems to track suspension and expulsion across the birth-to-five early learning system and early grades, disaggregated by race and other critical indicators.
- Provide culturally responsive mental health consultation to ECE providers.
- Increase access to anti-bias early childhood education training for ECE providers.

Children who arrive at kindergarten with strong social-emotional skills, as measured by Oregon's Kindergarten Assessment, are more likely to be on track in third grade reading and math.

OBJECTIVE 6: Children and families experience supportive transitions and continuity of services across early care and education and K-12 settings.

Oregon has made meaningful strides in supporting kindergarten transitions over the last several years, particularly in relation to the implementation of summertime transition camps and parenting education programs. After participating in family engagement and kindergarten transition activities supported by the Kindergarten Readiness Partnership and Innovation Fund (KPI), parents felt more confident in supporting their children's learning in reading and math, and children and parents felt more comfortable and welcomed in school.

Figure 9. Benefits of Kindergarten Readiness Partnership and Innovation fund (KPI) programs[xxiii]



However, significant work remains to be done to scale culturally responsive, developmentally appropriate transition practices across the state, and to achieve greater alignment across early care and education and K-12 settings.

Strategy 6.1 Establish shared professional culture and practice between early care and education and K-3 that supports all domains, including social-emotional learning.

- Support Professional Learning Teams, consisting of both early learning and kindergarten to grade 3 (K-3) educators, with participation in shared statewide and regional professional development activities on the part of both early learning and K-3 educators, including elementary school principals and ECE directors.
- Support school districts in aligning attendance, curriculum, instructional, and assessment practices across the prenatal-to-third-grade continuum with a focus on high-quality (culturally responsive, inclusive, developmentally appropriate).
- Scale and expand the work of Early Learning Hubs and local communities through KPI and local funding sources, to support social-emotional learning across the P-3 continuum.

Strategy 6.2 Improve the Oregon Kindergarten Assessment to better support decision-making between early learning and K-12 stakeholders.

- Enhance the Kindergarten Assessment (KA) process for children whose home language is not English and who are emerging bilingual children, focusing first on children whose home language is Spanish.
- Provide sufficient support to school districts to ensure that the assessment is administered properly and in ways that are developmentally appropriate.
- Improve the communications and data analysis/ interpretation tools for the KA so policymakers, Early Learning Hubs, providers of early learning services, school districts, and elementary schools have access to timely, accessible, and actionable data that supports regional and local decision-making.
- Develop a Kindergarten Entry Family Survey that enables families to provide information about their children's experiences and provides a more holistic picture of children's development.

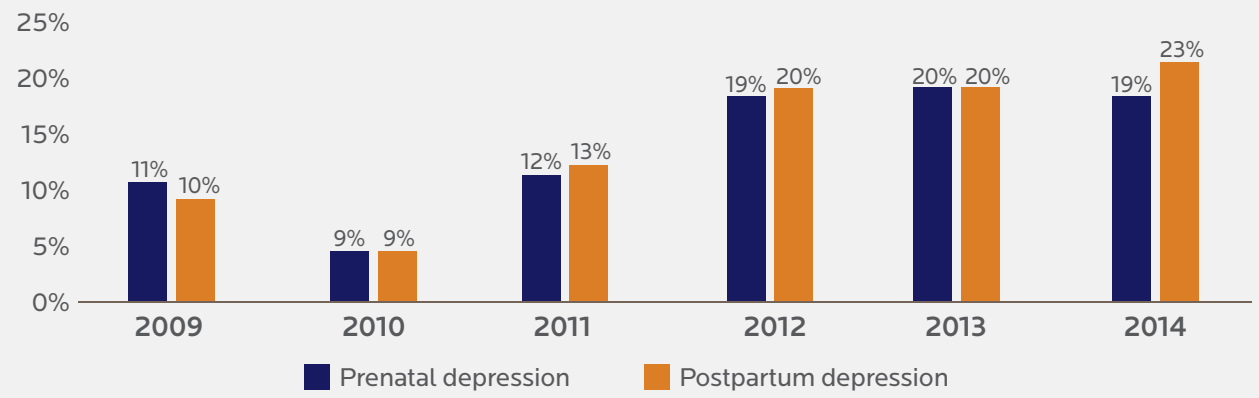
SYSTEM GOAL 2:
CHILDREN ARE RAISED IN HEALTHY, STABLE, AND ATTACHED FAMILIES

OBJECTIVE 7: Parents and caregivers have equitable access to support for their physical and social-emotional health.

Children's healthy development depends to a large extent on the health and well-being of their parents and caregivers. But parent and caregiver health and well-being in Oregon is compromised by various factors including health care costs, disparities in prenatal care, the cross-generational transmission of trauma through their own adverse childhood experiences (ACEs), and the chronic disease of substance use disorder (SUD). These factors have a large impact on children, with SUD alone leading to nearly 75% of Oregon's foster care placements.[xxiv]

Maternal prenatal and postpartum depression is also on the rise in Oregon, with one in five women in the state suffering from it. Optimizing parental mental health is critical for disrupting the transgenerational impact of maternal depression, and improves children's social-emotional development, secure attachments, and kindergarten readiness.

Figure 10. Perinatal depression in Oregon[xxv]



Strategy 7.1 Increase equitable access to reproductive, maternal, and prenatal health services.

- Increase access to traditional health workers (e.g., doulas) and home visiting services.
- Address the needs of women impacted by substance use disorder (SUD), such as through integrated prenatal care and SUD treatment, as well as those of infants affected by neonatal abstinence syndrome.

Strategy 7.2 Improve access to culturally and linguistically responsive, multi-generational approaches to physical and social-emotional health.

- Reduce the financial burden of health care costs to families.
- Expand accessible and culturally responsive systems that support family unity while addressing parent co-occurring health, mental health, addiction, and/or parenting strategies.
- Improve access to health care for families who are pregnant or have young children.
- Ensure a continuum of services for children and their caregivers when families are affected by mental health conditions and substance use disorders (SUD).
- Handle the cross-generational transmission of trauma by identifying and addressing adverse childhood experiences.
- Increase partnerships between Coordinated Care Organizations (CCOs) and community health workers to enable access.

OBJECTIVE 8: All families with infants have opportunities for connection.

A nurturing, supportive relationship between a caregiver and child is an essential ingredient for positive child development, and the bond formed between parent and child during the first few months of a child's life sets the foundation for healthy development. But economic necessity often forces parents to return to work shortly after the birth or adoption of a child when critical bonds and attachments are forming. Families with newborn children also often lack a non-stigmatizing and accessible point of contact to help them address the challenges of parenting a newborn and connect with additional support and services when needed.

Strategy 8.1 Create a universal connection point for families with newborns.

- Build, in partnership with local communities, Early Learning Hubs, Coordinated Care Organizations, and public health agencies, a system to deliver home visits for all families with newborn children that provides parenting information and helps families with deeper needs connect to additional services.

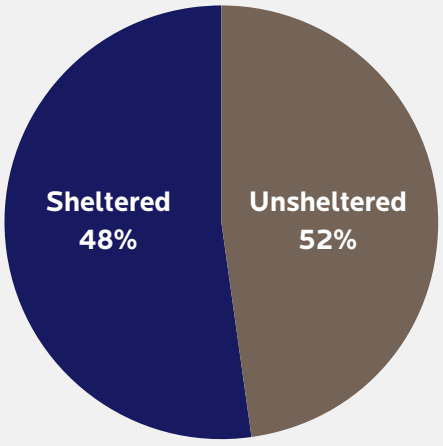
Strategy 8.2 Provide paid family leave.

- Provide paid family leave to all families with a newborn or newly adopted child to support the development of bonding and attachment during this critical window.

OBJECTIVE 9: Families with young children who are experiencing adversity have access to coordinated and comprehensive services.

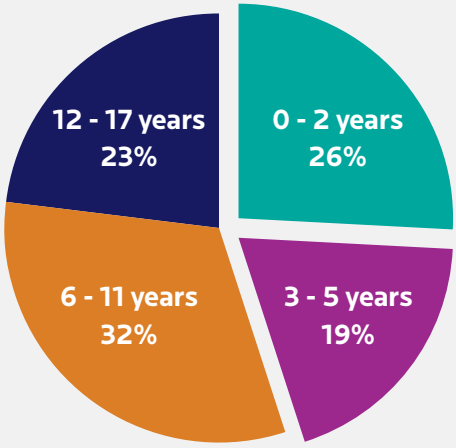
Homelessness, housing-cost burdens, food insecurity, employment instability, and the high cost of child care can create severe or chronic stress within families that, in turn, can affect children. Recent studies show strong correlations between housing stability and child outcomes, thereby pointing to the pressing need for addressing housing as part of an early childhood agenda.[xxvi] In 2017, Oregon had the second highest rate of homelessness among people in households with children in the United States. According to the 2017 Point-in-Time Count, 3,519 of the 13,953 Oregonians experiencing homelessness were families with children.[xxvii]

Figure 11. Homeless familes in Oregon with children[xxviii]



When families experience stressors, including not being able to meet their material needs, they are at an increased risk of involvement with the child welfare system. Oregon's high rate of families with young children involved in the child welfare system is cause for concern. In 2017, 11,077 children in Oregon experienced abuse and neglect. Almost half of these children were under the age of six and more than a quarter were under the age of three. Reducing the number of children who enter into the child welfare system must be a priority for all Oregonians. Doing so will require strong relationships across sectors and with communities and families.

Figure 12. Abused and neglected Oregon children, 2017[xxix]



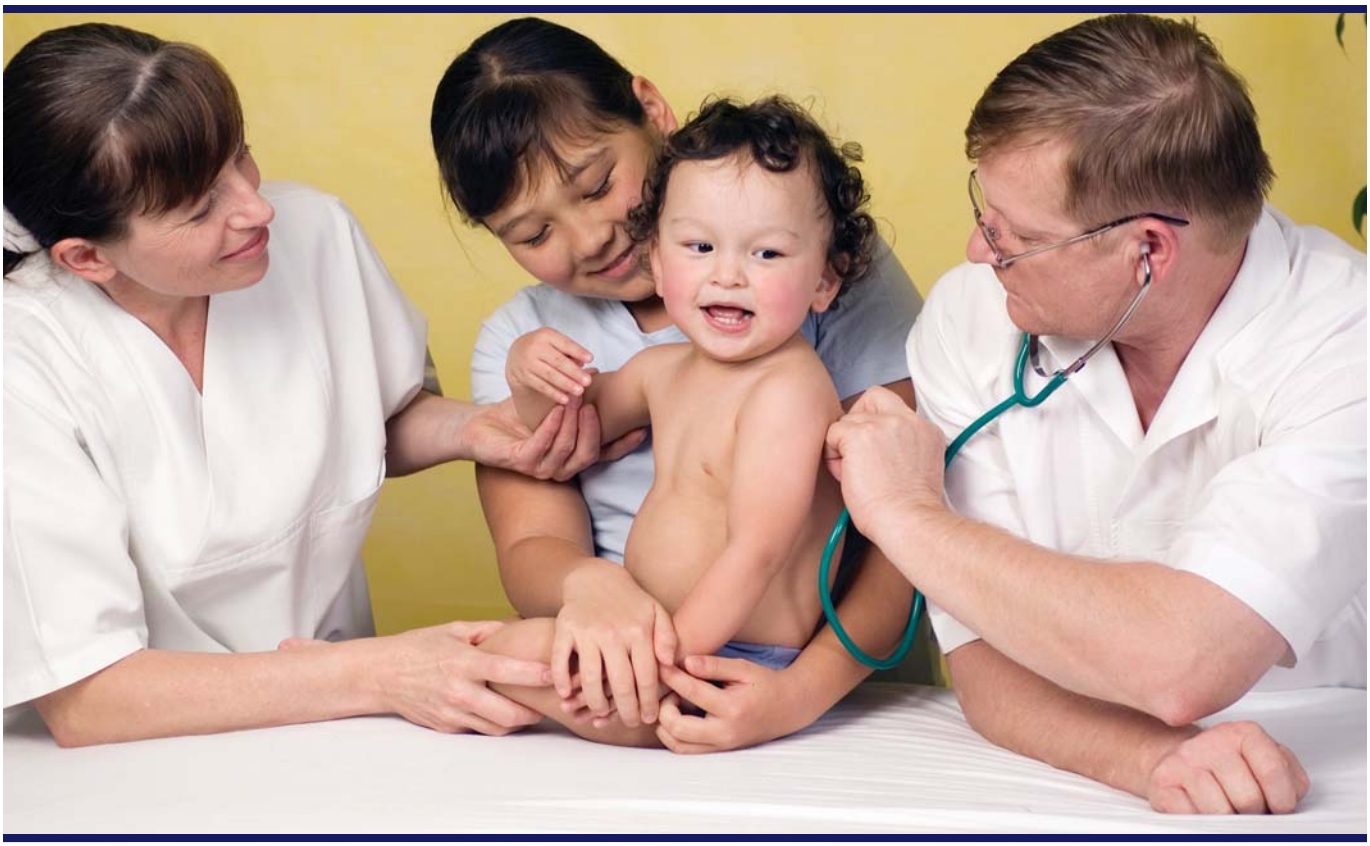
Approximately 5,000 young children under age six every year are abused or neglected.

Strategy 9.1 Expand and focus access to housing assistance and supports for families with young children.

- Expand and focus housing subsidy for families with young children, starting with families with children prenatal to 12 months of age who are experiencing unsheltered homelessness.
- Expand the supply of affordable housing and rental assistance for families with children by exploring new programs and working with providers to establish priorities for assisting families with young children.
- Strengthen relationships between Early Learning Hubs, Community Action Agencies, Department of Human Services (DHS) field offices, and local housing authorities to focus on families with infants and toddlers.

Strategy 9.2 Provide preventive parenting support services to reduce participation in the child welfare system.

- Increase access to evidence-based early learning programs (e.g., Relief Nurseries, parenting education, home visiting programs) proven to reduce abuse and neglect for families at imminent risk of entering into the child welfare system.
- Expand access to family coaches for local parenting support organizations, including community-based, culturally responsive organizations.
- Collaboratively develop community-based early childhood child abuse and maltreatment prevention plans.



Strategy 9.3 Improve the nutritional security of pregnant women and young children, particularly infants and toddlers.

- Promote breastfeeding.
- Improve connections between the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and primary care medical homes and other community services.

Strategy 9.4 Link high-quality early care and education, self-sufficiency, and housing assistance programs.

- Implement strategies such as waitlist prioritizations and incentives.
- Develop innovative child care networks, connected to affordable housing complexes, to deliver high-quality early care and education.

SYSTEM GOAL 3: THE EARLY LEARNING SYSTEM IS ALIGNED, COORDINATED, AND FAMILY CENTERED

OBJECTIVE 10: State-community connections and regional systems are strengthened.

In order for Oregon's children to arrive ready for kindergarten and live in healthy, stable, and attached families, comprehensive solutions and greater coordination with every sector – early care and education, health, human services, K-12, housing, and the business community – will be required. State-community connections must be deepened and regional systems strengthened, with Early Learning Hubs playing a unique role as they build coherent local systems through which families with young families can easily connect with needed supports and services. Families must be engaged, with their voices guiding the development of policies and programs.

Strategy 10.1 Ensure family voice in system design and implementation.

- Increase authentic input of family voice in the design and implementation of state policy and programming that welcomes all families.
- Establish a mechanism, in collaboration with Early Learning Hubs, for authentic leadership in parent voice to inform Early Learning Council systems-building work.
- Work with Early Learning Hubs and their partners in developing local capacity to facilitate culturally responsive family engagement activities across their communities, prioritizing communities that have not yet been engaged.

Strategy 10.2 Ensure family-friendly referrals.

- Develop centralized systems locally to coordinate eligibility and enrollment of services across sectors, starting with early care and education (ECE).
- Develop shared principles for building a community-level, family-friendly, respectful, and easy-to-navigate referral system so that families can easily access services and supports.

Strategy 10.3 Further develop the local Early Learning Hub system.

- Incentivize active participation across sectors on the Early Learning Hub Governance Boards to ensure investment in shared goals, policy, and programming as well as coordinated implementation across a region.
- Strengthen the Early Learning Hub role in informing community needs assessments that meet the requirements of each sector, supporting coordinated and aligned community planning and shared problem solving.
- Create ongoing feedback loops between the state sectors and communities to improve communication, policy implementation, and collaboration, and address barriers in order to make progress toward the three systems goals.

OBJECTIVE 11: Investments are prioritized in support of equitable outcomes for children and families.

All of the work in this plan must be guided by a deep commitment to equitable outcomes for children and families in historically underserved communities. This means taking action to address the avoidable conditions that impact those who have experienced socioeconomic disadvantage or historical injustices, and using data to evaluate the impact of policies and services that eliminate race as a predictor of a child's success. All sectors must come together on a regular basis to analyze disparities in access and outcomes to achieve the goals of this plan.

Strategy 11.1 Ensure resources are used to reduce disparities in access and outcomes.

- Collect, analyze, and consolidate data, across agencies and committees, on disparities in access and outcomes related to the goals of this plan.
- Share the results and recommendations for further improvement, including cross-sector funding opportunities.

Strategy 11.2 Align and expand funding opportunities for culturally specific organizations.

- Develop a coordinated state approach to increasing the capacity of culturally specific organizations to seed and scale promising culturally responsive practices and programs in early childhood.
- Expand funding of culturally specific organizations to implement early childhood programming and build partnerships with other programs.

Objective 12: The alignment and capacity of the cross-sector early learning workforce is supported.

Despite working in different settings, the early learning workforce – consisting of health, human services, K-12, and the early care and education sector – serves young children and their families largely toward the same end: ensuring that children's health and development is on track. This requires some common knowledge and skills, as well as collaboration with one another. In order to support families and children in a consistent way, key areas of shared knowledge and competency must be identified and supported across the entire system.

Strategy 12.1 Support consistent, high-quality practice among all professionals in the family- and child-serving early learning workforce.

- Analyze existing core knowledge and competency frameworks or standards across disciplines for the family- and child-serving workforce to identify commonalities and gaps across sectors.
- Create and implement opportunities for shared professional learning across sectors in established areas of need (e.g., trauma-informed practices and family-centered referral pathways).
- Collaborate with the Higher Education Coordinating Commission and professional learning partners to incorporate identified areas of shared knowledge into curriculum.

Strategy 12.2 Improve cross-sector recruitment, retention, and compensation.

- Through the Children's Cabinet, require state agencies to report on the diversity of race/ethnicity, language, compensation, and working conditions of front-line staff within each sector.
- Analyze data across the early learning workforce to determine common strengths and shared challenges regarding diversity, compensation, turnover, qualifications, and professional learning pathways in each sector.
- Use data analysis to create and implement a plan based on common strengths and shared challenges.

OBJECTIVE 13: The business and philanthropic communities champion the early learning system.

A strong early learning system is inextricably linked with Oregon's economy and workforce. Just as no one sector alone can achieve the state's early learning system goals, Oregon needs the support and partnership of the private sector to finance an early learning system for the state. This will require that Oregon build on its existing partnership with philanthropy and cultivate champions from the business community, deepening their understanding of financing strategies and the return on investment of high-quality early learning programs.

Strategy 13.1 Educate business leaders on the economic value of early care and education to the Oregon economy.

- Engage business leaders in addressing the lack of ECE programs necessary to support Oregon's workforce, including the availability of high-quality, affordable child care.
- Demonstrate the value of early educators to leading businesses and business associations.
- Share information on the return on investment of ECE in contributing to Oregon's economy.

Strategy 13.2 Introduce business leaders to the science of early childhood development and the impact of public investment.

- Share information on early childhood brain development and the impact of adverse childhood experiences.
- Include business leaders as members of the Early Learning Council.

OBJECTIVE 14: The data infrastructure is developed to enhance service delivery, systems building, and outcome reporting.

The success of all these strategies will depend on the effective use of data to drive decision-making and ensure that disaggregated data is used to assess impacts of policies and investments on children in historically underserved communities. In order to realize this goal, Oregon needs to increase its capacity to collect, integrate, analyze, and disseminate data to inform decisions at the state and local levels of the early learning system.

Strategy 14.1 Strengthen data-driven community planning.

- Increase access to state and local data, and resources, to improve Hub capacity to use data in its planning to ensure the highest needs are met and that the greatest impact for children and families is achieved.
- Address data sharing and data governance barriers, while protecting family privacy, that limit community access to data needed for decision-making.
- Incorporate specific data on children of color and children from historically underserved communities.
- Bring state and community leaders together to better understand data in order to track the well-being of children and families in communities, guide a process of continuous quality improvement, and facilitate collaboration across sectors and partners.

Strategy 14.2 Integrate early learning data into the Statewide Longitudinal Data System.

- Build state and program capacity to collect, monitor, and analyze data from early care and education programs in order to support quality improvements in the delivery of early care and education services and programs for children prenatal to kindergarten entry and their families.
- Use integrated data from the Statewide Longitudinal Data System to determine impacts of early childhood investment and identify the most effective strategies for supporting positive outcomes for children and their families.
- Incorporate specific data on children of color and children from families in historically underserved communities.

Strategy 14.3 Develop and implement a population survey to track the well-being of children and families across Oregon.

- State agencies collaborate to finance, develop, and implement a population survey of Oregon families with young children that provides holistic information on their well-being.
- Ensure that the survey is developed and implemented so as to provide accurate and holistic information on the well-being of families from historically underserved populations.

Strategy 14.4 Create and use an early learning system dashboard to create shared cross-sector accountability for outcomes for young children and their families.

- Create and regularly monitor an early learning system dashboard that fosters collective impact and shared cross-sector, cross-agency accountability for population-level outcomes for children prenatal to five and their families.
- Incorporate specific data on children of color and children from historically underserved communities.

NEXT STEPS

Moving from this plan to action requires many partners working together as we strive to do more and better for young children and their families. Within state government, key systems partners will create implementation plans with measurable outcomes and timelines. The Early Learning Council will maintain an active role in overseeing, disseminating, and championing the plan, and supporting the state's early learning system in moving it forward.

APPENDIX A:
MEMBERS OF THE EARLY LEARNING COUNCIL

Sue Miller ..... Chair, Early Learning Council

Patrick Allen ..... Director, Oregon Health Authority

Martha Brooks ..... Western States Regional Director, Fight Crime: Invest in Kids and ReadyNation

Miriam Calderon ..... Early Learning System Director, Early Learning Division

Donalda Dodson ..... Executive Director, Oregon Child Development Coalition

Colt Gill ..... Deputy Superintendent of Public Instruction, Oregon Department of Education

Holly Mar ..... Vice President of Community Impact, United Way of Lane County

Fariborz Pakseresht ..... Director, Department of Human Services

Eva Rippeteau ..... Political Coordinator, Oregon AFSCME

Shawna Rodrigues ..... Oregon Head Start Collaboration Director, Early Learning Division

Donna Schnitker ..... Director of Early Childhood Programs, Harney ESD

Teri Thalhofer ..... Director, North Central Public Health District

Kali Thorne Ladd ..... Executive Director and Co-Founder, KairosPDX

Bobbie Weber ..... Research Associate, Family Policy, College of Public Health and Human Sciences, Oregon State University

Agency Advisors

Kim Fredlund ..... Director, Self-Sufficiency Programs, Department of Human Services

Candace Pelt ..... Assistant Superintendent, Office of Student Services, Oregon Department of Education

Cate Wilcox ..... Maternal and Child Health Manager, Title V Director, Public Health Division, Oregon Health Authority

APPENDIX B: GLOSSARY

The following glossary was originally published by the Oregon Child Care Research Partnership, Corvallis, Oregon, August 2016 and updated by the Early Learning Division. This glossary presents a list of terminology and definitions used to discuss state support, regulation, and involvement in early care and education services in Oregon. Oregon-specific terms are interspersed with terms used both within Oregon and nationally, as reflected in Research Connections' Child Care and Early Education Glossary.

Affordability
The degree to which the price of child care is a reasonable or feasible family expense. States maintain different definitions of "affordable" child care, taking various factors into consideration, such as family income, child care market rates, and **subsidy** acceptance, among others.

At Risk
A term used to describe children who are considered to have a higher probability of non-optimal **child development** and learning.

Attachment
The emotional and psychological bond between a child and adult, typically a parent or caregiver, that contributes to the child's sense of security and safety. It is believed that secure attachment leads to psychological well-being and Resilience throughout the child's lifetime and is considered a key predictor of positive **child development** and learning.

Child Care Access
Refers to the ability of families to find quality child care arrangements that satisfy their preferences, with reasonable effort and at an affordable price. **See related: Child Care Availability.**

Child Care Assistance
Any public or private financial assistance intended to lower the cost of child care for families. **See related: Child Care Subsidy.**

Child Care Availability
Refers to whether quality child care is accessible and available to families at a reasonable cost and using reasonable effort. **See related: Child Care Access.**

Child Care Desert
A community with more than three children for every regulated **child care slot.**

Child Care Provider
An organization or individual that provides early care and education services.

Child Care Resource & Referral (CCR&R)
Child Care Resource and Referral services promote the health, safety and development of young children in child care settings as part of Oregon's Early Learning System. They are responsible for providing a wide variety of program services which include recruiting, training, and promoting retention of a **high-quality**, diverse early learning workforce through professional development and collaboration with community partners to align and coordinate local early learning systems.

Child Care Slots
The number of openings that a child care setting has available as dictated by its **licensed capacity**. The desired capacity of a facility is often lower than its licensed capacity. Child care slots may be filled or unfilled.

Child Care Subsidy
A type of **child care assistance** primarily funded by the federal Child Care and Development Fund program. **See related: Employment-Related Day Care (ERDC).**

Child Development
The process by which children acquire skills in the areas of social, emotional, intellectual, speech and language, and physical development, including fine and gross motor skills. Developmental stages describe the expected, sequential order of gaining skills and competencies that children typically acquire.

Child Welfare System
A system that includes preventive, protective and foster care, as well as adoption services for children who have experienced or at risk of experiencing maltreatment. Oregon's Child Welfare system is part of the Department of Human Services.

Children of Incarcerated Parents
Refers to children who have a parent or parental figure(s) involved in the criminal justice system from arrest through parole.

Children's Cabinet
The Governor's Children's Cabinet involves the major sector partners involved with ensuring young children enter kindergarten ready to succeed. It includes the agency leadership from the Department of Human Services, Oregon Department of Education, Early Learning Division, Oregon Health Authority and Oregon Housing and Community Services.

Coaching
A relationship-based process led by an expert with specialized knowledge and adult learning competencies that is designed to build capacity for or enhance specific professional dispositions, skills, and behaviors. Coaching is typically offered to teaching and administrative staff, either by in-house or outside coaches, and focuses on goal-setting and achievement. See related: Technical Assistance.

Collective Impact
A commitment to a common agenda for solving a complex social problem by a group of actors from different sectors. A collective impact model provides a foundation for the work of Oregon's Early Learning Hubs.

Communities of Color
Four communities are traditionally recognized as being of color – Native American, African American, Asian, and Latino. Additional groups that have been impacted by racism in a given community can be added.

Community-Based Child Care/Community-Based Organization (CBO)
A nonprofit organization that provides educational or related services to children and families within their local community. CBOs that provide child care may be associated with faith-based organizations or other nonprofit organizations. CBOs are subject to section 501(c)(3) of the Internal Revenue Code.

Competencies (refers to Workforce Knowledge or Core Competencies)
Refers to the range of knowledge and observable skills that early childhood practitioners need to provide effective services to children and families. Competencies, sometimes referred to as "core competencies," are typically linked with states' early learning guidelines and provide a framework for professional development at various career stages.

Comprehensive Services
An array of coordinated services that meet the holistic needs of children and families enrolled in a given program, from health and developmental screenings to family literacy trainings and parent education.

Continuity of Care
Refers to the provision of care to children by consistent caregivers in consistent environments over a period of time to ensure stable and nurturing environments. Research shows that maintaining continuity and limiting transitions in a child's first few years of life promotes the type of deep human connections that young children need for optimal early brain development, emotional regulation, and learning.

Contracted Slots
Contracted slots are an agreement made between a state and a child care provider prior to service delivery that the provider will make available a certain number of child care slots, which will be paid for by the state as long as contracted state program or attendance conditions are met.

Coordinated Care Organization (CCO)
A network of all types of health care providers (physical health care, addictions, mental health care, and dental care providers) who work together in their local communities to serve people who receive health care coverage under the Oregon Health Plan (Medicaid). CCOs focus on prevention and helping people manage chronic conditions, such as diabetes. This helps reduce unnecessary emergency room visits and supports people in being healthy.

Core Body of Knowledge

The Core Body of Knowledge for Oregon's Childhood Care and Education Profession is the basis for training and education essential for on-going professional development in the childhood care and education profession, a foundation for both the Oregon Registry and the Oregon Registry Trainer Program. It embodies what professionals should know and be able to do to effectively care for and educate Oregon's young children, ages 0-8, with special consideration for children 9-12 years old. Ten core knowledge categories make up the Core Body of Knowledge. Three sets of knowledge constitute a progression of increased depth and breadth of knowledge within each core knowledge category.

Cost of Care

The monetary cost of providing early care and education services. Major contributors to the cost of care include staff wages and salaries, benefits, rent, supplies, professional development, and training. The cost of care can be different from the actual price of care charged by the provider.

Cultural Responsiveness

A term that describes what happens when special knowledge about individuals and groups of people is incorporated into standards, policies, and practices. Cultural responsiveness fosters an appreciation of families and their unique backgrounds and has been shown to increase the quality and effectiveness of services to children.

Curriculum

A written plan that includes goals for children's development and learning, the experiences through which they will achieve the goals, what staff and parents should do to help children achieve the goals, and the materials needed to support the implementation of the curriculum.

Department of Human Services (DHS)

DHS is Oregon's principal agency for helping Oregonians achieve well-being and independence through opportunities that protect and respect choice and preserve dignity, especially for those who are least able to help themselves. DHS manages Employment-Related Day Care (ERDC), Oregon's major child care subsidy program.

Developmental Screening and Assessment

The practice of systematically measuring a child's development across multiple domains and looking for signs of developmental delays. Screening and assessment tools are typically administered by professionals in health care, community, or school settings with children and families and can consist of formal questionnaires or checklists that ask targeted questions about a child's development.

Developmentally Appropriate

Practices, behaviors, activities, and settings that are adapted to match the age, characteristics, and developmental progress of a specific group of children.

Developmentally Appropriate Practice (DAP)

DAP in early learning settings reflects knowledge of child development and an understanding of the unique personality, learning style, and family background of each child.

Early Childhood Mental Health Consultation

A strategic intervention geared towards building the capacity of early childhood staff, programs, families, and systems to prevent, identify, treat, and reduce the impact of mental health problems in children from birth to age six. In a child-focused consultation, the consultant may facilitate the development of an individualized plan for the child. In a classroom-focused consultation, the consultant may work with the teacher/caregiver to increase the level of social-emotional support for all the children in the class through observations, modeling, and sharing of resources and information. In a program-focused consultation, the consultant may help administrators address policies and procedures that benefit all children and adults in the program.

Early Childhood Special Education (ECSE)

Specialized instruction that is provided by trained early childhood special education professionals to preschool children with disabilities in various early childhood settings such as preschool, child care, Oregon Prekindergarten and Head Start, among others and requires the development of an Individualized Education Plan. ECSE is authorized by the federal Individuals with Disabilities Education Act (IDEA), Part B.

Early Head Start
A federally funded program that serves low-income pregnant women and families with infants and toddlers to support optimal child development while helping parents/families move toward economic independence. EHS programs generally offer the following core services: (1) high-quality early education in and out of the home; (2) family support services, home visits, and parent education; (3) comprehensive health and mental health services, including services for pregnant and postpartum women; (4) nutrition; (5) child care; (6) ongoing support for parents through case management and peer support. Programs have a broad range of flexibility in how they provide these services.

Early Intervention (EI)
Services that are designed to address the developmental needs of infants and toddlers with disabilities, ages birth to three years, and their families. Early Intervention services are generally administered by qualified personnel and require the development of an Individualized Family Service Plan (IFSP). Early Intervention is authorized by the federal Individuals with Disabilities Education Act (IDEA), Part C.

Early Learning Council (ELC)
In 2011 the Oregon Legislature created the ELC to provide policy direction and oversee and coordinate Oregon's comprehensive early learning system. The Council also serves as the policy rulemaking body for all programs administered by the Early Learning Division. Council members are appointed by the governor for a term of four years.

Early Learning Division (ELD)
In 2013, the Oregon Legislature created the Early Learning Division to oversee the early learning system, including policies and programs within the early care and education sector. The Division is overseen by the governor-appointed Early Learning System Director.

Early Learning Hubs
The 2013 Legislature authorized creation of 16 regional and community–based Early Learning Hubs to make support more available, accessible, and effective for children and families, particularly those from historically underserved communities. Hubs bring together the following sectors in order to improve outcomes for young children and their families: early education, K-12, health, human services, and business.

Early Literacy
Refers to what children know about and are able to do as it relates to communication, language, reading, and writing before they can actually read and write. Children's experiences with conversation, books, print, and stories (oral and written) all contribute to their early literacy skills.

Education Cabinet
The Education Cabinet is convened to include all major sector partners in supporting the P-20 education continuum. The Cabinet includes agency leadership from the Chief Education Office, Early Learning Division, Oregon Department of Education and Higher Education Coordinating Commission.

Emerging Bilingual Learners
Refers to children under the age of five who are in the process of learning more than one language, and is used to recognize and communicate the value of knowing and being able to communicate in multiple languages.

Employment-Related Day Care (ERDC)
Oregon's major form of financial assistance for child care for low-income families is funded by a combination of federal Child Care and Development Fund and Oregon General Fund dollars. The program is managed by DHS.

Equity
Equity is the notion that each and every person will receive the necessary resources he/she needs individually to thrive, regardless of national origin, race, gender, sexual orientation, first language, or differently abled or other distinguishing characteristics.

Equity Lens
Oregon's Chief Education Office (formerly, the Oregon Education and Investment Board) works to ensure that the Equity Lens it adopted guides education policy. The Lens articulates a set of beliefs. It is intended to "clearly articulate the shared goals we have for our state and the intentional investments we will make to reach our goals of an equitable educational system, and create clear accountability structures to ensure that we are actively making progress and correcting where there is no progress. This lens was created to propel the educational system into action to shift policies, procedures, and practices in order to move from our commitment to an equitable system into actively pursuing an equitable system."

Evidence-Based Practice

A practice, regimen, or service that is grounded in evidence and can demonstrate that it improves outcomes. Elements of evidence-based practice are standardized, replicable, and effective within a given setting and for a particular group of participants.

Family Coach

Assists families transitioning into a state of independence through collaboration and partnership within the community.

Family Friend and Neighbor Care (FFN)

Child care provided by relatives, friends, and neighbors in the child's own home or in another home, often in unregulated settings.

Family Engagement

Refers to an interactive process of relationship-building between early childhood professionals and families that is mutual, respectful, and responsive to the family's language and culture. Engagement in the early years prepares families to support their children's learning throughout their school years and support parent/family-child relationships that are key to healthy child development, school readiness, and well-being.

Head Start

A federal program that provides comprehensive early childhood education, health, nutrition, and parent involvement services to low-income families. The program is designed to foster stable family relationships, enhance children's physical and emotional well-being, and support children's cognitive skills so they are ready to succeed in school. Federal grants are awarded to local public or private agencies, referred to as "grantees," that provide Head Start services. Head Start is administered by the Administration for Children and Families (ACF) of the U.S. Department of Health and Human Services (HHS). See related: Oregon Head Start PreKindergarten and Early Head Start.

Healthy Families Oregon

Healthy Families Oregon is an accredited multi-site state system with Healthy Families America (HFA) that provides family support and parenting education through home visiting, and is Oregon's largest child abuse prevention program.

High-Quality

Refers to the characteristics of early learning and development programs and settings that research has demonstrated are associated with positive child outcomes. These programs identify and support the needs of children from diverse cultures, children who speak a language other than English, and children with emerging and diagnosed special needs. These programs and settings seek out and use their resources in an equitable manner to ensure developmentally appropriate, culturally, and linguistically responsive communication, activities, and family engagement. They create a dynamic relationship between the family and the educator that works to define what the physical, social, emotional, and cognitive needs are for that child to ensure an optimal learning environment for that individual.

Historically Underserved Communities

Refers to communities that the Early Learning Council Equity Implementation Committee identified as African American, Asian and Pacific Islander, English Language Learners, Geographically Isolated, Immigrants and Refugees, Latino, Tribal Communities, and Children with Disabilities, Economic Disparities, or of Incarcerated Parents/Parental Figures.

Home Visiting Programs

Programs that aim to improve child outcomes by helping high-risk parents who are pregnant or have young children to enhance their parenting skills. Most home visiting programs match trained professionals and/or paraprofessionals with families to provide a variety of services in families' home settings. Examples of home visiting services can include health check-ups, developmental screenings, referrals, parenting advice, and guidance with navigating community services.

Housing/Oregon Housing and Community Services (OHCS)

Oregon Housing and Community Services is Oregon's housing finance agency, providing financial and program support to create and preserve opportunities for quality, affordable housing for Oregonians of lower and moderate income.

Inclusion
The principle of enabling all children, regardless of their diverse backgrounds or abilities, to participate actively in natural settings within their learning environments and larger communities.

Individualized Education Program (IEP)
The Individualized Education Program (IEP) is a written document that is developed for each child who is eligible for special education services. The IEP is created through a team effort and reviewed at least once a year and is required by the federal Individual with Disabilities Education Act (IDEA). See related: Early Childhood Special Education; IEP Team.

Individualized Education Program (IEP) Team
The members of the multidisciplinary team who write a child's IEP.

Individualized Family Services Plan (IFSP)
A written plan that outlines the special services children ages birth through two years and their families will receive if found eligible for Early Intervention services. The plan is mandated by the federal Individuals with Disabilities Education Act (IDEA), Part C. See related: Early Intervention.

Infant/Toddler Mental Health (ITMH)
Defined as the healthy social and emotional development of young children, birth to three years of age. ITMH builds on responsive relationships with primary caregivers (parents, family, child care) that build healthy attachment and foundations for life.

Kindergarten Assessment (KA)
Assessment developed by Oregon and aligned with the state's early learning and development standards to assess what children know and are able to do as they enter kindergarten.

Kindergarten Transition
Refers to a process or milestone in which a child moves from a preschool setting to kindergarten.

Licensed Child Care
The care and supervision of a child, on a regular basis, unaccompanied by his/her parent or guardian, in a place other than the child's own home, with or without compensation.

License Exempt Child Care
Child care that is not required to be licensed based on a series of exemptions in the state of Oregon. See related: Regulated Subsidy Child Care Provider

Mentoring
A form of professional development characterized by an ongoing relationship between a novice and an experienced teacher or provider to deliver personalized instruction and feedback. Mentoring is intended to increase an individual's personal or professional capacity, resulting in greater professional effectiveness. See related: Coaching.

Monitoring
The process used to enforce child care providers' compliance with licensing rules and regulations. States may use "differential monitoring" as a regulatory method for determining the frequency or depth of monitoring based on an assessment of the child care facility's compliance history and other quality indicators.

Office of Child Care
A public office located within the Early Learning Division responsible for child care licensing, compliance, background checks, and monitoring.

Oregon Department of Education (ODE)
ODE is responsible for implementing the state's public education policies. The department is overseen by the governor, acting as state superintendent of public instruction, with an appointed deputy superintendent acting as chief administrator.

Oregon Health Authority (OHA)
OHA is the state agency at the forefront of work to improve the lifelong health of Oregonians through partnerships, prevention, and access to quality, affordable health care. It includes most of the state's health and prevention programs such as Public Health, Oregon Health Plan, and Healthy Kids, as well as public-private partnerships.

Oregon Parenting Education Collaborative (OPEC)
Oregon Parenting Education Collaborative (OPEC) was founded to help parents along on their parenting journey. The OPEC initiative provides access to regional Parenting Education Hubs that provide high-quality (research-based) resources and parenting education classes in Oregon.

Oregon Head Start PreKindergarten and Early Head Start

Oregon Head Start PreKindergarten (OHSPK) and Early Head Start (EHS) are comprehensive high-quality early childhood development programs offering integrated services. OHSPK and EHS programs receive funding from the federal Office of Head Start, the Early Learning Division, or both. All OHSPK programs follow the same guidelines for providing services.

Parent Choice

Refers to families' ability to access child care that they choose. The term is often used to refer to the federal Child Care and Development Fund that parents receiving child care subsidy should be able to use all legal forms of care.

Parenting Education

Instruction or information directed toward parents and families to increase effective parenting skills.

Preschool

Programs that provide early education and care to children in the two or three years before they enter kindergarten, typically from ages 2.5-5 years. Preschools may be publicly or privately operated and may receive public funds.

Preschool Promise

A high-quality state preschool program serving 3- and 4-year old children living in families at or below 200% of the federal poverty guidelines. It was created by the 2015 Oregon Legislature with a commitment to supporting all of Oregon's young children and families with a focus on equity and expanding opportunities to underserved populations. The program is administered by Early Learning Hubs throughout the state, bringing together early learning programs operated by Head Start, K-12, licensed child care, and community-based child care in a mixed-delivery model.

Professional Development (PD)

Refers to a continuum of learning and support activities designed to prepare individuals for work with, and on behalf of, young children and their families, as well as ongoing experiences to enhance this work. Professional development encompasses education, training, and technical assistance (TA), which leads to improvements in the knowledge, skills, practices, and dispositions of early education professionals.

Regulated Subsidy

Regulated subsidy refers to federal child care funds offered through the state to qualifying families to support care that is provided to their children. See related: Subsidized Child Care.

Regulated Subsidy Child Care Provider

A Regulated Subsidy Provider is a non-relative who cares for children whose families are eligible for child care assistance through the Department of Human Services (DHS), but who is not required to be licensed. A Regulated Subsidy Provider (sometimes referred to as a License-Exempt Child Care provider) is required to be listed with DHS and to follow new federal regulations for training and allow a visit by the Office of Child Care.

Relief Nurseries

A public-private partnership program that offers families at high risk for abuse and neglect the intensive trauma-informed support they need.

Retention (of Staff)

Refers to the ability of programs to retain their employees over time. Staff retention is a well-documented problem in early childhood programs that affects program quality.

Risk Factors

Refers to circumstances that increase a child's susceptibility to a wide range of negative outcomes and experiences. Risk factors for low school readiness may include parental/family characteristics such as low socioeconomic status and education, children's characteristics, such as whether the child has special needs, or community conditions and experiences, such as whether the child has access to high-quality early care and education.

Self-Sufficiency Programs (SSP)

Self-Sufficiency Programs serves Oregonians of all ages through a variety of programs and partnerships with the goal to reduce poverty in Oregon, help families create a safe, secure environment through careers and housing, and stop the cycle of poverty for the next generation.

Social-Emotional Development
Refers to the developmental process whereby children learn to identify and understand their own feelings, accurately read and comprehend emotional states in others, manage and express strong emotions in constructive manners, regulate their behavior, develop empathy for others, and establish and maintain relationships.

Spark
Spark, formerly known as Oregon's Quality Rating and Improvement System (QRIS), is a statewide program that raises the quality of child care across the state. Spark recognizes, rewards, and builds on what early childhood care and education professionals are already doing well.

Special Needs
A term used to describe a child with an identified learning disability or physical or mental health condition requiring special education services, or other specialized services and supports. **See related: Early Intervention (EI); Individualized Education Plan (IEP); Individualized Family Services Plan (IFSP).**

Statewide Longitudinal Data System (SLDS)
The Oregon State Legislature charged the Chief Education Office with providing an integrated, statewide, student-based longitudinal data system that monitors outcomes to determine the return on statewide educational investments. This data system will provide secure, non-identifiable educational data to enhance the ability of policy makers, educators, and interested parties to improve educational outcomes for students.

Subsidized Child Care
Child care that is at least partially funded by public or charitable resources in order to decrease the cost to families. **See related: Regulated Subsidy.**

Subsidy
Private or public assistance that reduces the cost of child care for families.

Supply Building
Efforts to increase the quantity of child care programs in a particular local area.

Technical Assistance (TA)
The provision of targeted and customized supports by a professional(s) with subject matter expertise and adult learning knowledge and competencies. In an early education setting, TA is typically provided to teaching and administrative staff to improve the quality of services and supports they provide to children and families. **See related: Coaching; Mentoring; Professional Development.**

Trauma Informed Care
Refers to an approach used in working with children exposed to traumatic events or conditions. Children exposed to trauma may display heightened aggression, poor social skills, and impulsivity; they also may struggle academically or engage in risk-taking or other challenging behaviors. Service providers and family members that are trained in TIC learn effective ways to interact with these children, such as helping them cope with traumatic "triggers," supporting their emotion regulation skills, maintaining predictable routines, and using effective behavior management strategies.

Workforce
The broad range of individuals engaged in the care and education of young children. Members of the early childhood workforce may include teaching, caregiving, and administrative staff, as well as consultants, learning specialists, and others that provide **professional development**, training and **technical assistance** to programs.

Wrap-Around Services
A team of providers collaborate to improve the lives of the children and families they serve by creating, enhancing, and accessing a coordinated and comprehensive system of supports. Supports might include formal services and interventions, such as enrichment and academic supports outside of regular child care programming; community and health services, such as doctor visits; and interpersonal assistance, such as family counseling.

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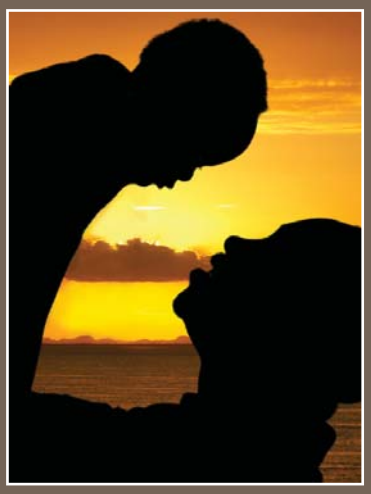

RAISE UP OREGON:
A STATEWIDE EARLY LEARNING SYSTEM PLAN
2019 -2023

The report is issued by the Oregon Early Learning Council

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oregonearlylearning.com/raise-up-oregon

Attachment 31

Statewide implementation of Comprehensive Addiction and Recovery Act (CARA) Child Fatality Prevention and Review Program	**Goal: Implementation of an equitable, coordinated statewide early intervention program that meets the health and substance use disorder treatment needs of people who are pregnant, substance affected infants, and their families*.** ***A family includes parents, partners, relatives, and other caregivers in the household**				
Inputs	**Activities**		**Outcomes/Metrics**		
What Oregon Child Welfare invests	*What Oregon Child Welfare does*	*Who Oregon Child Welfare reaches*	*Why this project: short-term results*	*Why this project: intermediate results*	*Why this project: long-term results*
• Time • Commitment • Relationship building and community engagement • Technical assistance • Technology • Funding • Data tracking and evaluation • Research • CW staff • CW leadership support • CW expertise • Continuous learning • Implementation infrastructure • CFPRP equity tool • Evidence Based Practices • Upstream thinking	• Use a culturally responsive, strengths based, trauma informed, multi-generational, family focused approach • Apply equity tool early and throughout • Seek out technical assistance • Gather and track data • Analyze data to inform efforts • Report data as required • Share data across family serving systems • Identify safe strategies that utilize natural / community supports and eliminate or reduce CW involvement • Collaborative coordination of community led effort to identify quality practices • Educate family serving systems on plan of care best practices • Collaborate with OHA to educate healthcare professionals re: report vs. notification • Collaborate to develop tools for notification, and tools that support best practice • Create mutual learning opportunities to facilitate continuous quality improvement	• Substance affected infants • Pregnant and parenting people • Other caregivers, household members, family members • CW professionals • Tribal partners • SUD treatment providers • Peer mentors • People with lived experience • ART / FIT team • Health care professionals • Prenatal care providers • Midwives, doulas, hospital social workers • OHA • Maternal mortality death review • Home visiting nurses • Family Connects • Early Intervention • Child Development Specialists • Birthing hospitals • Juvenile court and partners • Probation and parole • WIC • Food pantries • Domestic Violence Shelters • Lactation specialists • Housing resources • Mental Health providers • Oregon Parenting Education Collaborative • Self Sufficiency Program • Developmental Disabilities • Oregon Alcohol and Drug Policy Commission • Coordinated Care Organizations • Safe Families • FFPSA Preservation Unit pilot?	• Family serving professionals have increased understanding of their role and best practices in development and maintenance of Plans of Care • Healthcare providers have increased understanding of notification process • Family serving professionals know how to access technical assistance and tools • Family serving professionals have increased awareness of need to collaborate • Members of CARA implementation infrastructure have shared understanding of the goal	• The Plan of Care is developed during pregnancy. • The Plan of Care is initiated during pregnancy and updated following delivery. • Health care, substance use treatment, and other service providers involved in caring for the family initiate development of the Plan of Care. • The pregnant/new parent is actively engaged in developing the plan. Other family members or caregivers are involved if the parent desires. • The Plan of Care includes multidisciplinary service supports. • The Plan of Care is active for a year post-delivery. Ongoing support is offered beyond one year if desired. • Birthing hospitals have policies in place that support development and maintenance of Plans of Care • SUD treatment programs have policies in place that support the development and maintenance of Plans of Care • Peer mentors are utilized to support Plans of Care • Policies, laws or rules in place to require notification by healthcare providers • Development of notification portal • A Public health website is available with CARA resources for professionals and families	• Reduced number of substance-affected infants in foster care • Reduced duration of child welfare intervention with substance affected infants and their families • Reduce reoccurrence of maltreatment rate among families with a Plan of Care • Reduced number of reports of maltreatment on substance affected infants • Reduced number of reports assigned to CPS involving substance affected infants • Plans of Care are perceived as a supportive, not punitive, response • Pregnant people are consistently connected to a health care provider and receive post-partum follow up care • Decreased number of missed pediatric appointments for substance affected infants • Decrease in stigma associated with pregnant and parenting people with a SUD • Plans of Care and progress updates are shared regularly across systems • Eliminate racial and ethnic disparate outcomes for substance affected infants, including mortality rates • Eliminate racial and ethnic disparities in maternal mortality rates with use of a prenatal Plan of Care • Improved outcomes for families with Plan of Care • Increased job satisfaction and decreased turnover for family serving professionals • Statewide use of Plans of Care results in healthier communities

Assumptions

- Early identification and intervention improve outcomes for substance affected infants and their families
- Community led efforts support a culturally responsive approach
- Coordination across systems improves connection to and delivery of services
- Education can reduce bias and stigma
- Child Welfare can be effective in prevention efforts
- SUD is a complex medical condition
-

External Factors

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

Outcomes	Metrics
Why this project: short-term results:	
• Family serving professionals have increased understanding of their role and best practices in the development and maintenance of Plans of Care • Healthcare providers have increased understanding of the process for notification • Family serving professionals know how to access technical assistance and tools • Family serving professionals have increased awareness of the need to collaborate • Members of the CARA implementation infrastructure have shared understanding of the goal	• Increase in the number of Plans of Care developed – (look at ORKIDS data at screening) • Increase in notifications – (look at ORKIDS data, Nurture Oregon pilot – notification forms, decrease in reports that meet the criteria for a notification) • The number of notifications received from healthcare providers is greater than the number of infants with a diagnosis code of FAS, neonatal withdrawal and infant has affect of maternal substance use • CARA coordinator is utilized by family serving professionals for technical assistance, metrics regarding forms/publications access and website access • Information contained in Plan of Care shows multiple family serving professionals and family members were involved in the development of the Plan of Care • Members involved in implementation will have opportunities to provide input and will ultimately be in agreement regarding charters
Why this project: intermediate results: • Increase in the number of Plans of Care developed during pregnancy • Increase in the number of Plans of Care developed in hospital prior to discharge • The pregnant/post-partum individual is actively engaged in developing the plan. • The Plan of Care is active for a year post-delivery. • Increase in the number of Birthing hospitals that have policies for development and maintenance of Plans of Care • SUD treatment programs have policies in place that support the development and maintenance of Plans of Care • Peer mentors are utilized to support Plans of Care • Policies, laws or rules in place to require notification by healthcare providers • Development of notification portal • A Public health website containing CARA resources for professionals and families is developed and implemented	• Increased number of notifications indicate a Plan of Care was developed prior to delivery (consider modifying Notification form to include question about if plan developed prenatally • Increased number of notifications indicate a Plan of Care was developed in hospital prior to discharge • The following two Nurture Oregon pilot assessment questions will be answered by pilot sites: who do families want to take the lead on developing the Plan of Care and Who do families request to participate in the development of the Plan of Care? • Plan of Care forms (1394) available in ORKIDS capture increased number of pregnant/post-partum individuals engaged in developing the Plan of Care • The answer to the following Nurture Oregon pilot assessment question reflects Plans of Care remain active for a year: When does ongoing review of the Plan of Care occur? • The Oregon Perinatal Collaborative list serve will be used to confirm birthing hospitals have policies/protocols in place for the development of Plans of Care • Survey SUD treatment programs to determine strengths and challenges associated with their Plan of Care procedures and/or process • Plan of Care forms (1394) available in ORKIDS capture increased number of Peer Mentors participate and/or provide support • Requirements for healthcare providers have been established • Notification portal is operable • Families and professionals can access CARA resources and information on OHA's website

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

Attachment 32

Child Maltreatment
Prevention Collaboration

OHA, Public Health
Population served: Children, young adults, adults, families, pregnant individuals

Potential and existing areas of shared work in primary, secondary and tertiary prevention:
State Child Fatality Review Team
County child fatality review teams
Critical Incident Review Team
Maternal Mortality and Morbidity Review
Domestic Violence Fatality Review Team
suicide prevention/postvention
Comprehensive Addiction and Recovery Act
substance use
infant safe sleep
home visiting
firearm safety
near fatalities
Nurture Oregon
Fetal Alcohol Spectrum Disorder
Neonatal Abstinence Syndrome
child abuse prevention
injury prevention
mental health
data collection and visualization
concrete needs
community resilience

ODHS, Child Welfare
Population served: Children, young adults, families

Shared work centered in: Community engagement, equity, protective factors, social determinants of health, safety culture, ACEs, trauma informed, anti-racist strategies, data to action, metrics

Oregon Child Welfare Division

Vision for Transformation

Oregon Department of Human Services

"We all know that infants, children, adolescents and young adults do best growing up in a family that can provide love, support, life-long learning, shared values and important memories."

Rebecca Jones Gaston
Oregon Department of Human Services
Child Welfare Director

The Oregon Department of Human Services (ODHS) is transforming the Child Welfare Division. ODHS seeks to create a Child Welfare Division that supports the individual needs of families and best serves Oregon's children and young people.

ODHS envisions a true transformation built on core values and a belief that children do best growing up in a family.

This Vision for Transformation came from a collaboration among diverse partners to create and implement a strategic roadmap for success. Our Vision for Transformation includes specific guiding principles, strategies and measurable outcomes.

As a result, ODHS will be better able to support Oregon families and children at home and in their communities. Transforming our child welfare system will support children, and young adults to be safer and healthier and to experience less trauma and greater well-being. Our children and families deserve nothing less.

A Vision for Transformation

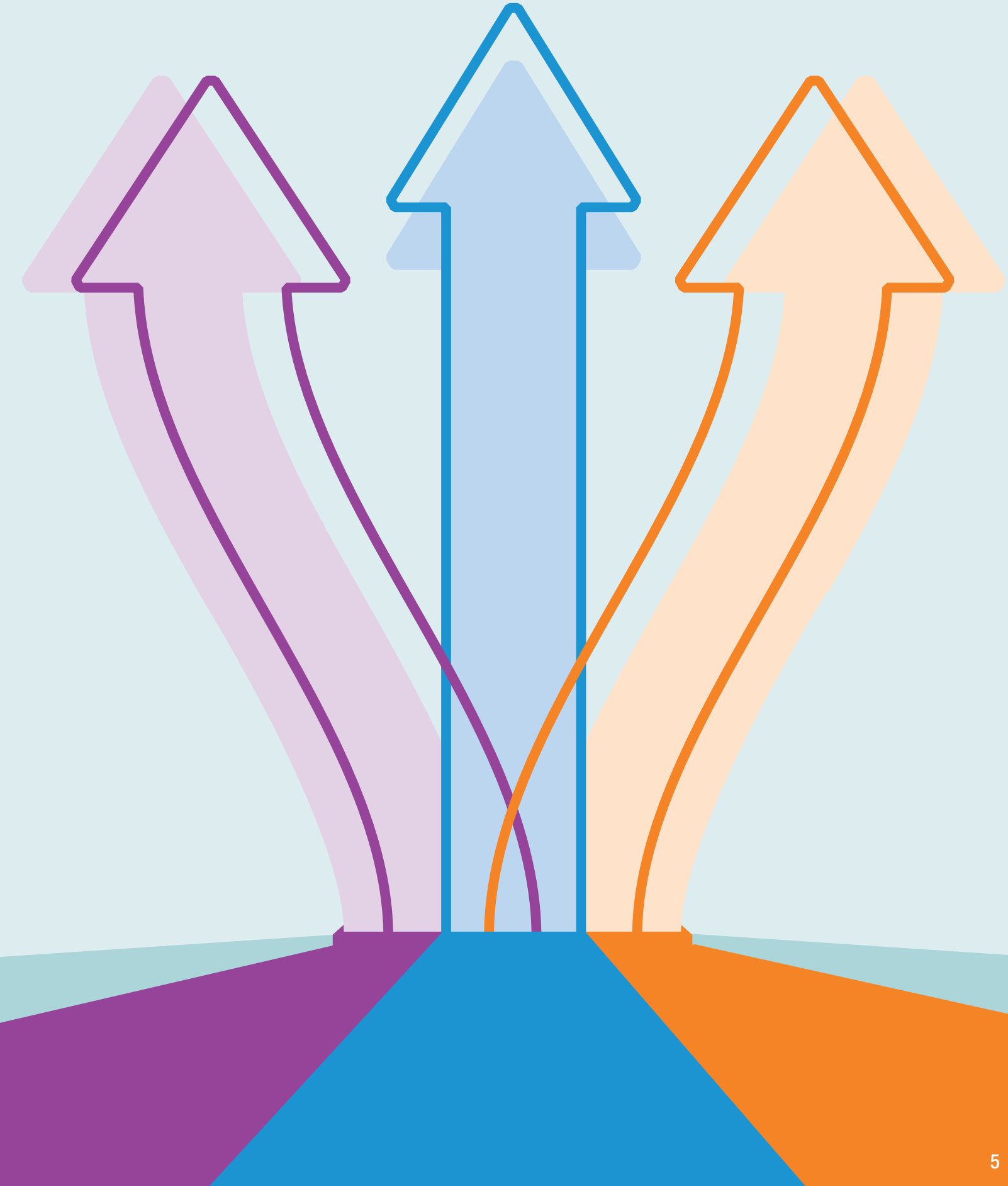
All children experience safe, stable, healthy lives and grow up in the care of a loving family and community.

The Child Welfare Division of the Oregon Department of Human Services (ODHS) is part of a larger statewide social safety-net system that works to support families and communities. This safety net not only works during a life-threatening crisis but well beforehand, when small interventions can make an enormous difference in their lives.

Collectively, ODHS, public and private partners are working to support families and communities in myriad ways. This may include:

- Providing economic support
- Enhancing parenting skills
- Helping people with their housing needs and employment goals
- Providing health and behavioral services
- Helping treat alcohol and substance use disorders, and
- Ensuring child safety and family well-being.

We help families access resources within their natural support networks and the service provider community. This helps them address their own underlying needs and resolve the most common causes of stress and trauma linked to child maltreatment.



The Child Welfare Division's mission is to ensure every child and family is empowered to live a safe, stable and healthy life. This mission is based on a set of beliefs and core values:

We believe children, and young adults do best when they grow up in a family.

We value fairness, equity, inclusion, accessibility, diversity and transparency in our work.

We value the voices, experiences, cultures, intellect and uniqueness of the children, and families we serve.

We believe that communities often already have the wisdom and assets to provide safe, stable and healthy lives for their children. Thus, Child Welfare needs to partner, listen and lift up community voices and their decision-making powers. This builds on existing resources, creates pathways to new resources and promotes community interdependence rather than a system of dependence.

We value building authentic relationships and being accountable to communities of color and other marginalized communities by elevating their voices and proactively engaging with individuals, families and communities. This builds their power so Child Welfare and its partners can better ensure people's safety, health and well-being.

We believe providing earlier, less-intrusive support for parents and families means more children can remain safe and healthy at home and in school. This helps children and young adults have better long-term outcomes and keep the bonds and connections critical to their well-being.

We believe families and communities working together in a more proactive, holistic way will allow ODHS and its partners to allocate resources where they have the greatest impact for children, young adults, parents and families. Comprehensive services outside of ODHS will decrease the need for costly foster care, residential placements and other crisis support. This will create opportunities for more innovation, creative solutions and new business models.

Our Vision for Transformation is based on a belief that children do best growing up in a family and on values related to honoring and supporting cultural wisdom, building community resilience and voice, and ensuring the self-determination of our communities. of color. The goal is an absolute transformation.

We believe when families and communities are strong, fewer children experience abuse and neglect.

We recognize the importance of challenges and struggles of transforming the current system into one that is fair and just. Anti-racist principles guide us. We recognize that white supremacy and systemic racism are deeply embedded in the history, fabric and institutions of our country, including child welfare systems. Long-lasting social change comes from communities of color and other marginalized communities' leadership and power in social movements and systems transformation. To this end, we will leverage our resources, technical knowledge and role within the broader ODHS and child welfare systems to support transformation.

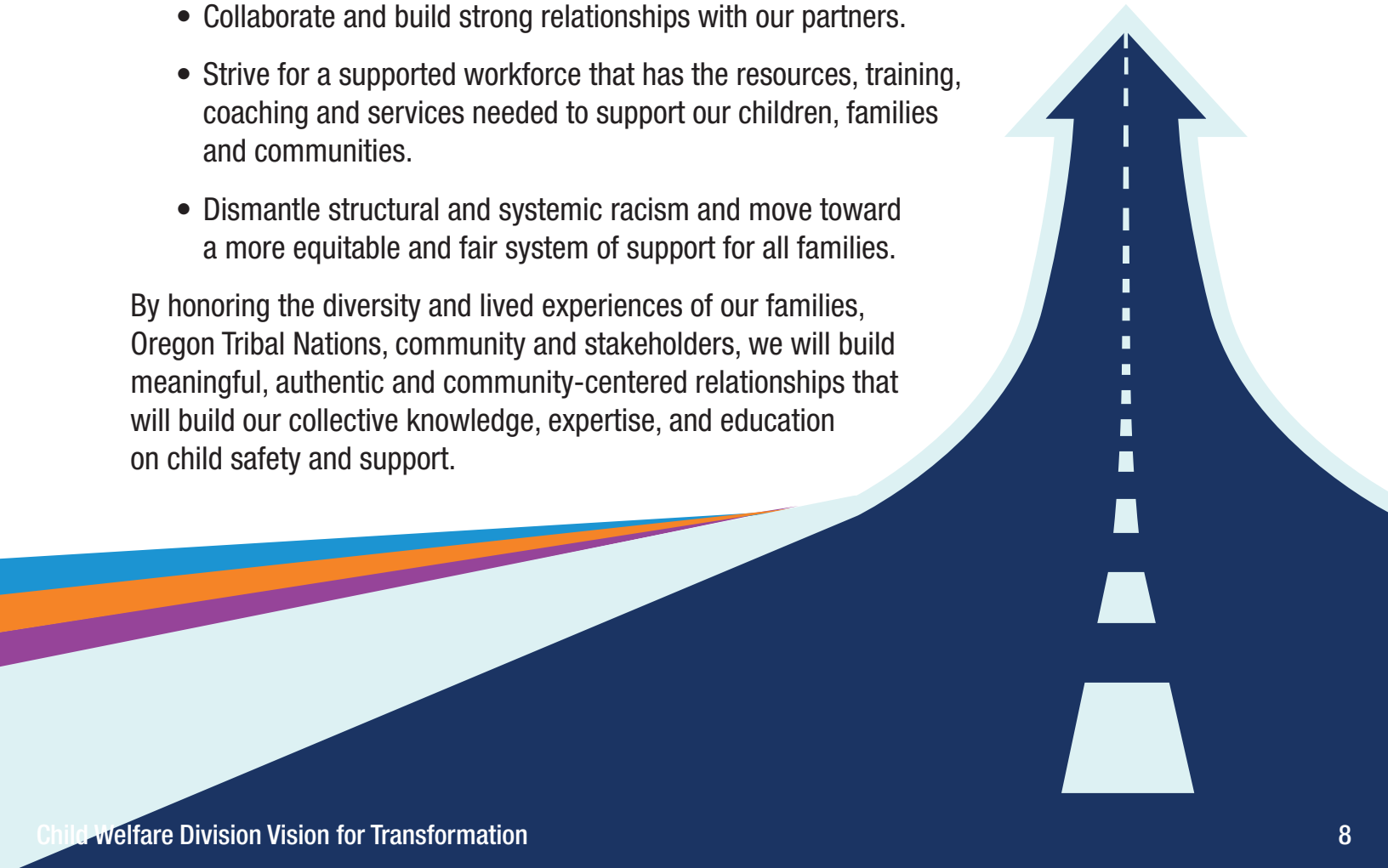
Our Vision for Transformation is based on a belief that children do best growing up in a family and on values related to honoring and supporting cultural wisdom, building community resilience and voice, and ensuring the self-determination of our communities of color. The goal is an absolute transformation.

Families will be strong and successful when everyone works together. ODHS Child Welfare will work collaboratively to uplift families, communities, Oregon Tribal Nations and partners.

ODHS Child Welfare will achieve this Vision for Transformation through its various functions to do the following:

- Assess child safety and provide in-home support to prevent placements away from parents, family, friends and community.
- Expand services to prevent unnecessary foster care placements and ensure that intensive interventions are as effective as possible.
- Ensure foster care is family-based, time-limited, culturally responsive and designed to better stabilize families rather than just serving as a placement for children.
- Establish that children, and young adults will be in the care of family, friends and neighbors whenever possible, and help children keep connections to their cultures, communities and Oregon Tribal Nations.
- Recognize that children who need higher-level physical or mental health services need short-term treatment programs customized to support the individual child's therapeutic needs. These supports should occur while children or teens are living in families with birth or adoptive parents, relatives, close friends or foster caregivers.
- Collaborate and build strong relationships with our partners.
- Strive for a supported workforce that has the resources, training, coaching and services needed to support our children, families and communities.
- Dismantle structural and systemic racism and move toward a more equitable and fair system of support for all families.

By honoring the diversity and lived experiences of our families, Oregon Tribal Nations, community and stakeholders, we will build meaningful, authentic and community-centered relationships that will build our collective knowledge, expertise, and education on child safety and support.



This transformation will not happen overnight. Some families will still experience crises, even with proactive engagement and support services. To meet this challenge, ODHS and its partners must create interdisciplinary and cross-system teams to support children and families to meet their individual needs. ODHS Child Welfare will also improve its use of data to inform decision making and activate correct levels of services and supports.

The world's circumstances have profoundly changed since ODHS first developed this vision. Many of this document's strategies require investment and development of resources and tools. The COVID-19 global pandemic has affected access to those resources. However, the focus and goals of transformation have not changed.

The need to transform child welfare

Nationally, the current approach to child welfare is not working. Research shows the following:

- Preventable fatalities due to child abuse and neglect remain high. (1)
- Subsequent maltreatment remains high. (2)
- Poverty is often mistaken for neglect, resulting in increased rates of child abuse reports (3) and unnecessary foster care, group and institutional placements.
- Research shows placement in substitute care can cause further serious trauma. (4)
- Due to racial and discriminatory biases, practices and critical decisions result in racial, ethnic and tribal disproportionality in children of color. (5)
- Systemic racism results in the design and implementation of child welfare practices and policies that do not include communities of color and other marginalized communities. These communities are also often left out of decisions about the best use of resources and services.
- Children who stay in the child welfare system longer will have a higher risk of not finding permanency. Then, as young adults, they age out of the system without strong, permanent family connections and supports needed to become self-sufficient. (6)

- Inadequate training resources and professional support for child welfare staff create an unsupportive work environment and add to the lack of retention in the workforce, thus a constant strain on child welfare system. [7]
- Across the United States, between 7 and 30% of children and young adults crossover from child welfare into the juvenile justice systems. These trends are partly due to the lack of strong cross-system coordination and inattention to child well-being indicators. [8]
- Historically, the system has focused on removing kids from their families, homes and neighborhoods for safety reasons. Research, however, consistently shows that children and young people can have better outcomes when they remain safely in their homes while receiving services allows children to keep ties with their family, friends, schools and communities. [9]

By honoring the diversity and lived experiences of our families, Oregon Tribal Nations, community and stakeholders, we will build meaningful, authentic and community-centered relationships that will build our collective knowledge, expertise, and education on child safety and support.

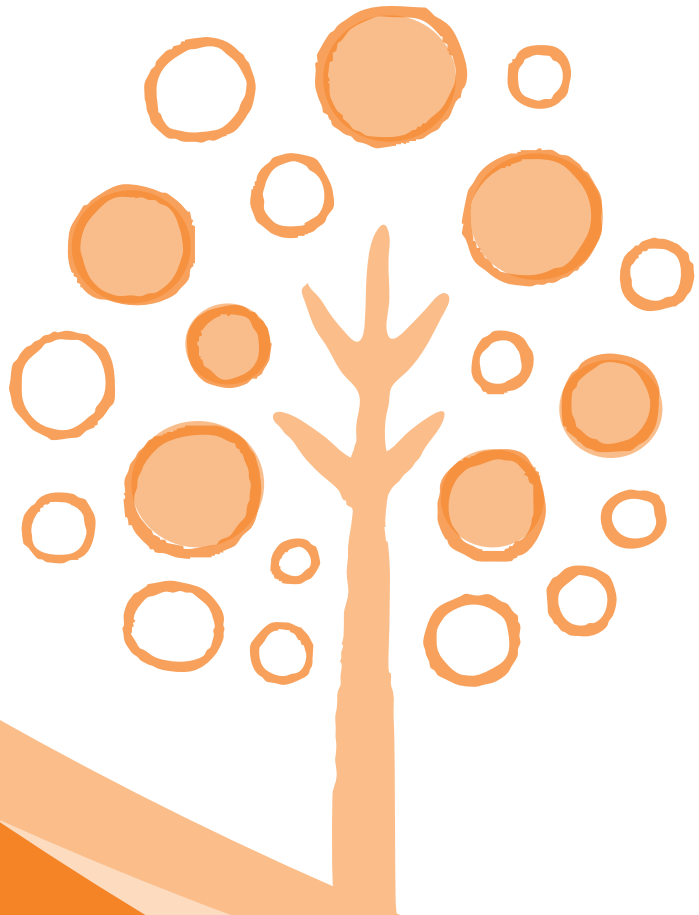
To truly ensure the safety, good health and well-being of children and young adults, we must rethink our approach and our systems, processes and structures for serving and supporting them, their families and communities. More input and rethinking with our internal staff and community partners are critical to developing and realizing this Vision for Transformation. Short-term and long-term planning and actions will ensure that transformation efforts are nimble and adaptive to respond to the global changes in child welfare.

Families will be strong and successful when everyone works together. ODHS Child Welfare will work collaboratively to uplift families, communities, Oregon Tribal Nations and partners to make this transformation a reality, based on the guiding principles, strategies and measures that follow.

1 Guiding Principle

Supporting families and promoting prevention

Our Child Welfare transformation is built on trauma-informed, family and community-centered and culturally responsive programs and services focused on engagement, equity, safety, well-being and prevention.



This means strategies with an approach that:

- Are centered on family support focusing on individual needs and appropriate services.
- Value the voices, experiences, cultures, intellect and uniqueness of the children, and families we serve.
- Are based on early support services at a time when small interventions can make an enormous difference in people's lives, prevent a crisis and provide appropriate resources if a crisis occurs.
- Use a multi-generational approach to meet families' needs and address factors that contribute to risk, trauma and safety concerns and the cycles of child abuse and neglect.
- Focus on strengthening and preserving connections to family and community by keeping children and young adults safely in their own home and communities whenever possible; maintaining connections to family, culture and community when temporary substitute care is needed; and making permanency the priority, starting with safely reunifying families.
- Engage with the community by integrating the voices of children, young adults, parents, families, Oregon Tribal Nations and partners to be more responsive to the needs of families and community partners.
- Honor and support the self-determination of communities of color and other marginalized communities and aim to build their power.
- Are culturally responsive by embracing the communities' lived experiences and the cultures of children and young adults in decision-making that affects their safety, health and well-being; as a result, delivering services aligned with the cultural context of children, young adults, family and community so they can live their lives with dignity, autonomy and equality.
- Are trauma-informed to recognize the impact of trauma, including historical trauma, and promote a culture of safety, empowerment and healing.
- Strength-based to support families and individuals with the tools to better handle mental health, substance use, domestic violence issues, and other factors that can contribute to child abuse and neglect.

Strategic projects and initiatives

ODHS Child Welfare has several initiatives and improvement projects in a planning phase or underway. They align with this guiding principle to create a road map for transformation.

Area of focus	Description
Family support to prevent unnecessary foster care	This initiative is to improve support and remove barriers for families to become self-sufficient, prevent unnecessary foster care for children, and support those children and families that have experienced out-of-home care.
Response to community concerns and reports of child abuse and neglect	ODHS Child Welfare created a centralized hotline for screening reports and allegations of child abuse and neglect. The hotline was fully operationalized in 2019 and will need ongoing improvements to help reduce wait times, better manage workloads and address the correct number of assessments assigned to specific districts.
Safety and fatality review and prevention	This project improves the various aspects of the Safety Program and the Fatality Review and Prevention Program to better ensure the safety of children and young adults.
Foster family recruitment, training, support and retention	Oregon is making significant investments in recruiting, training, supporting and retaining foster families to mirror the needs of our children, young adults and communities we serve.
Equity and inclusion	This initiative improves the equity and inclusion of all aspects of the ODHS Child Welfare and provides anti-racist, inclusive, equitable and culturally appropriate services to children, young adults and families.
Timeliness to permanency and family ties	ODHS Child Welfare is working on several related initiatives to improve procedures for reunification, family engagement in case planning and coordination with court partners to improve time to permanency. These initiatives include setting deadlines that result in better outcomes for children and young adults in care.
Training, policy and practices related to Oregon's tribal children and families	ODHS, including the Child Welfare Division, is working to improve training, policy and practices that reflect a tribally responsive approach. By partnering with Oregon's Oregon Tribal Nations and honoring tribal history, ODHS Child Welfare can better serve tribal children and families.

2020–2022 strategic communications plan	A long-term strategic communications plan will guide how Child Welfare engages families and partners and communicates with both internal and external audiences. Its purpose is to take a proactive, strategic approach to communications by ensuring better clarity and transparency; providing opportunities to gather and incorporate input and feedback; and improving collaboration and coordination with staff and community partners.

DESIRED OUTCOMES

By following this principle, we expect to achieve these outcomes:

- A more equitable system leading to better outcomes for children of color
- Fewer children in foster care
- Safer and more stable placements
- Stronger community partnerships
- Stronger tribal relationships
- Increased cross-system collaboration
- Decreased racial disproportionality and disparities
- More children served in their homes and fewer in substitute care
- Lower rates of child neglect and abuse

2 Guiding Principle

Enhancing our staff and infrastructure

Our Child Welfare transformation depends on a diverse, supported, skilled, respected and engaged workforce that reflects and embraces the communities we serve.

This means strategies have:

- A clear vision and purpose for transformation and a strategic direction that staff understand and collectively and individually see.
- A commitment to fairness, equity, inclusion, accessibility, transparency and diversity.
- An effective organization and implementation infrastructure driven by inter-and cross-program collaboration that facilitates shared decision-making and respect.
- A culture of spiritual, social, psychological and physical safety across the workforce that values and enhances well-being.
- A strong anti-racist approach committed to ending structural racism.
- Approaches that actively work to dismantle systems of oppression and institutional barriers that have prevented women of color and LGBTQIA+ people of color from living their lives with dignity, autonomy and equality.
- A recognition of the importance of struggle and the challenges to transform the system into a fair and just one.
- High, clear expectations and accountability for all staff, managers and leadership that ensure staff have the direction, guidance and support needed for the challenging work they do every day.
- Management structure that values staff input and feedback and ensures meaningful participation, engagement and inclusion, including many chances to share ideas and develop professionally.
- A partnership-focused relationship between management and labor working toward common goals and outcomes.
- Recruitment and hiring, workforce development, retention and succession-planning practices that attract, reward and promote high performing staff and represent the communities we serve with clear opportunities for career advancement.
- An exceptional workforce developed and supported at all levels that is diverse, talented, dedicated, motivated, skilled, resilient and adaptable to change, and includes those with lived experiences to competently, confidently and compassionately apply what they are learning to their day-to-day work.

Strategic projects and initiatives

ODHS Child Welfare has several initiatives and improvement projects underway or in a planning phase. These projects and initiatives align with this guiding principle to create a road map for transformation.

Area of focus	Description
ODHS Child Welfare organizational effectiveness	ODHS Child Welfare is improving the program's effectiveness by redesigning organizational infrastructures and systems to support the organization's core work.
A supported and engaged workforce	These initiatives seek to improve and transform ODHS Child Welfare's organizational culture and to develop a supported and engaged workforce through the following:
	• Improved training: Staff training will align best practices, build allyship, and reflect the overall goals and values of the organization. • Improved employee onboarding: The onboarding process for all classes of new employees will ensure they have the needed training and other resources to effectively begin their work. This will lead to onboarding consistency and continuity. • Implement RiSE: RiSE is an agency-wide effort to develop an intentional and positive organizational culture that helps employees thrive at work. It is both a direct response to employee input and a commitment from leadership. • Improved recruiting and hiring practices: Hiring and recruiting will help ensure Child Welfare has the workforce, leadership and succession planning it needs to support its mission, vision and goals.

DESIRED OUTCOMES

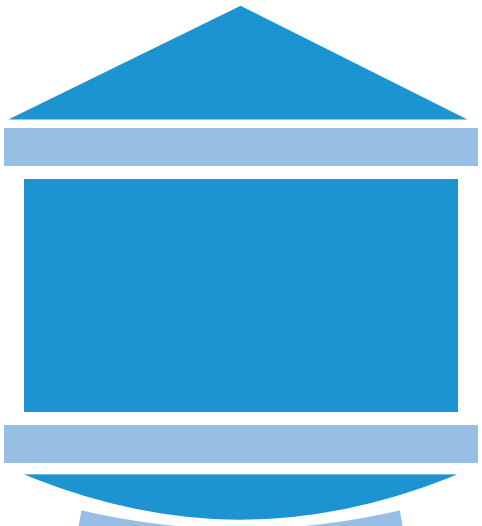
By following this principle, we expect to achieve these outcomes:

- Strong, consistent leadership with an effective organizational infrastructure.
- A clear and transparent implementation process of the agency's transformation.
- Increased teamwork in field offices with a team-oriented environment.
- Improved field and central office connection and clarity of roles and responsibilities.
- An effective, adaptive and responsive learning environment.
- Improved training and coaching at all levels.
- Fewer vacancies.
- Higher retention rates and longer tenures.
- Increased promotions from within.
- Reduced caseloads.
- Higher morale.
- Increased internal communications that improve engagement and morale through all levels of the organization.
- Staff are the respected and empowered as the experts in child safety and support that they are.

3 Guiding Principle

Enhancing the structure of our system by using data with continuous quality improvement

Our Child Welfare transformation is built on data-informed practice and is supported by continuous quality improvement and modernized information technology systems and tools.



This means strategies have:

- A holistic continuous quality improvement (CQI) system, based on implementing evidence-based best practices to evaluate and improve child and family outcomes, as well as the ongoing delivery of services and supports.
- Clear, uniform metrics that align with the Vision for Transformation, measure progress toward key goals and outcomes, and provide metrics that are relevant to our children, families, partners and Oregon Tribal Nations.
- Timely, accurate, useful and easy to understand data to highlight progress, identify and close gaps, and to drive education, policies and strategies for change.
- Managers to champion the use of data to ensure staff and partners understand its value, have access to it, and use it effectively in decision making and their day-to-day work
- User-friendly and effective information technology systems and tools that make it easier to improve outcomes for children and families, keep them safely together, and provide insight and analysis into what's working and what's not to leverage advancements in research and technology.
- Identify opportunities with our data to drive education, policies and strategies.

Strategic projects and initiatives

ODHS Child Welfare has several initiatives and improvement projects underway or in a planning phase that align with this guiding principle as to create a road map for transformation:

Area of focus	Description
CQI and quality assurance systems for evaluation of ODHS Child Welfare programs and initiatives	To become an evidence-based, data-driven and implementation-science-informed organization, ODHS Child Welfare is developing data collection and analysis processes to identify areas for improvement and to assess and measure our progress and outcomes over time.
The Child Welfare Research Agenda	This agenda will use data and research to help establish and assess further progress toward program goals and priorities, including the use of evidence-based and evidence-informed practices and the development of effective services.
Comprehensive Child Welfare Information System (CCWIS) implementation	OR-Kids, the state's case management system, is being updated to meet the new federal CCWIS regulations and improve ODHS Child Welfare's infrastructure and processes to better enhance and support our workforce.
An array of treatment services based on evidence-informed data	These initiatives seek to improve the array of treatment services to better suit the individual needs of children and young people in care using data.
An array of prevention and family support services based on evidence-based data	ODHS Child Welfare will use evidence-based data to develop an array of services to support individual families and reduce the need for out-of-home substitute care.

DESIRED OUTCOMES

By following these principles, we expect to achieve outcomes that include:

- Aligned reports, metrics and measures across the child and family serving system.
- Focus on research that supports key goals and child and family outcomes.
- Use of data and data-dashboards in daily operations and decision making.
- Improve usability of information technology solutions that meet the needs of case management and data information systems.
- Increase usage of CQI systems across programs that are based on up-to-date technology, science and best practices.
- Increase of real-time, accurate data dashboards for key metrics.

Endnotes

1. U.S. Department of Health & Human Serv ices Children's Bureau Child Maltreatment. 2018. How many children die each year from child abuse and neglect? [cited 2020 Sept 27]. Available from: https://www.childwelfare.gov/pubPDFs/fatality.pdf#page=2&view=How many children die each year from child abuse and neglect?

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7. National Association of Social Workers. Strengthen child welfare service delivery to enhance child and family well-being. Child Welfare Issue Brief. [cited 2020 Sept 27]. Available from: https://www.socialworkers.org/Advocacy/Policy-Issues/Child-Welfare.

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9. U.S. Department of Health & Human Services Children's Bureau. In-home services in child welfare. Issue Brief 2014 March. [cited 2020 Sept 27]. Available from: https://www.childwelfare.gov/pubPDFs/inhome_services.pdf.

Oregon Department of Human Services, Child Welfare Division welcomes review, input and support for these ambitious transformation plans. They embrace our beliefs and core values. The plan is based on three key principles, supportive strategies and specific outcome measures outlined in this Vision for Transformation. For more information, contact ChildWelfare.DirectorsOffice@dhsoha.state.or.us

Oregon Department of Human Services
CHILD WELFARE DIVISION

You can get this document in other languages, large print, braille or a format you prefer. Contact Child Welfare Director's Office at 503-945-5600 or email ChildWelfare.DirectorsOffice@dhsoha.state.or.us. We accept all relay calls or you can dial 711.

ODHS 2445 (11/20)

Vision for Transformation: Guiding Principles
Child Fatality Prevention & Review Program

The Child Fatality Prevention and Review Program's mission is to improve child safety by identifying determinants of child maltreatment fatalities and collaborating with child and family serving systems to employ equitable, innovative and data informed strategies for systemic change.

Supporting families and promoting prevention

- Trauma-informed approach
- Seek diverse perspectives and prioritize cultural responsiveness
- Promote a culture of safety
- Strength-based system improvement recommendations focused on better outcomes for children and families
- Engagement with community to listen and focus on being more responsive to the needs of families
- Honor children who lost their lives, value the voices of families through the staff who serve them
- Multi-generational approach to address factors that contribute to safety concerns and the cycles of child maltreatment
- Outreach and engagement with community to find resources where families naturally go when needing assistance
- Collaborating with early support services with small interventions: *engaging ODHS contracted nurses, ART/FIT, funding for safe sleep options; providing education; father's groups*
- Addressing the individual needs of each family, providing appropriate services through a Plan of Care

Enhancing our staff and infrastructure

- Committed to equity, inclusion, accessibility, transparency and diversity in recruitment and building of the CFPRP program
- Committed to a strong anti-racism approach, including utilization of an anti-racism tool
- Recognize the importance and the struggle in dismantling systemic racism
- Unlearn behavior that has oppressed people of color in a white supremacist culture
- Create a culture of psychological safety that values and enhances individual, team and system well-being
- High, clear expectations and accountability for our work
- Regularly practice the 6 habits of a healthy team:
  1. Spend time identifying what could go wrong
  2. Talk about mistakes and ways to learn from them
  3. Test change in everyday work activities
  4. Develop an understanding of who knows what and communicate clearly
  5. Appreciate colleagues and their unique skills
  6. Make candor and respect a precondition to teamwork
- Respect and empower staff as the experts in child safety and support their expertise
- Develop culture carriers to expand on creating a safety culture within child welfare

Enhancing the structure of our system by using data with continuous quality improvement

- Identify opportunities for education, procedural guidance, policies, and prevention strategies through intentional data gathered from fatalities, near fatalities, and serious physical injuries
- Complete human factor debriefs which help identify system improvement opportunities
- Use of accurate and relevant data to support system improvement strategies
- Use of the Safe Systems Improvement Tool (SSIT) to gather aggregate data, develop reports and holistically understand the child welfare system to help steer larger system improvement recommendations
- Utilize existing data in comparison with statewide and localized case practice trends to focus on information that supports key goals. Existing data reports reviewed on a regular basis include: r*ecurrence of maltreatment, foster care re-entry, CFSR, CPS & Permanency Fidelity Reviews*
- Enhancement of CIRT process by using post CIRT surveys to evaluate and improve our process

Leveraging Relationships

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

- Domestic Violence & Sexual Assault Coordinators and Domestic Violence and Sexual Assault Coalition
- Oregon Parenting Education Collaborative
- Oregon Health Authority
- County child fatality review teams and the State medical examiner's office
- Self-Sufficiency
- Project Nurture
- Tribal Affairs and Tribal Partners
- Field staff and field leadership re: CIRTs and Safety Culture see following video: https://youtube.com/watch?v=NvfGXQvDxcI&feature=share
- OHSU
- ORCAH