Systems Change Review Orientation – Part 3

Milwaukee Partnership Council

Critical Incident Subcommittee

5/26/21

Agenda

- Brief Review
- SCR DMCPS Data Overview
- Questions and Discussion

Overview of Previous Meetings

- Act 78 history
- Safety science introduction
- Critical incident review process
- Scoring overview
- SAW introduction
- SCR data preview

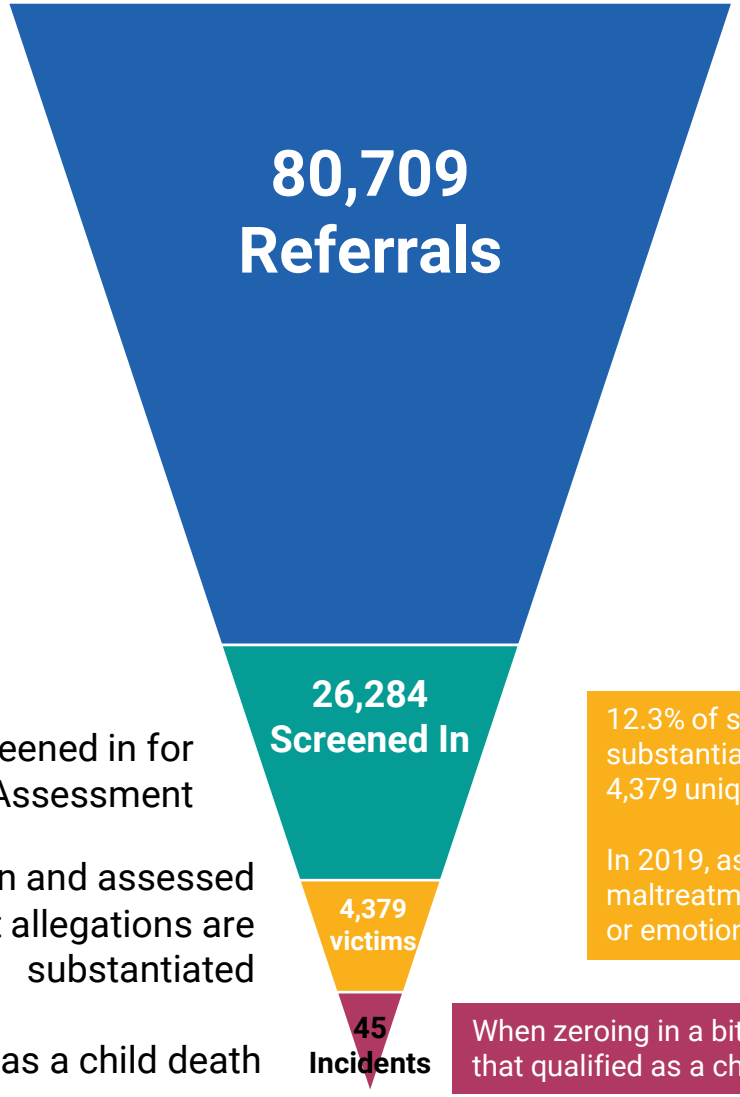
Remember…

- Critical incident review process is separate and independent from the local child welfare agency response
- Critical incident review process guided by Act 78 requirements
  - Local agencies may conduct their own reviews
- No causality to the critical incident
  - Not reviewing work after the critical incident occurred
- Very, very small and varying sample size

Wisconsin Department of Children and Families

2019 Act 78 Cases in Context

There are about 1.3M children in the state of Wisconsin.



32.6% screened in for Initial Assessment

12.3% of screened-in and assessed maltreatment allegations are substantiated

45 incidents qualified as a child death

In 2019 local CPS agencies, including the Division of Milwaukee Child Protective Services (DMCPS), received a total of 80,709 referrals from reporters alleging maltreatment of children.

12.3% of screened-in maltreatment allegations were substantiated. These substantiated allegations involved 4,379 unique child victims.

In 2019, as in previous years, the most prevalent type of child maltreatment was neglect (64%) rather than physical, sexual, or emotional abuse.

When zeroing in a bit deeper into 2019, there were 45 Act 78 incidents that qualified as a child death.

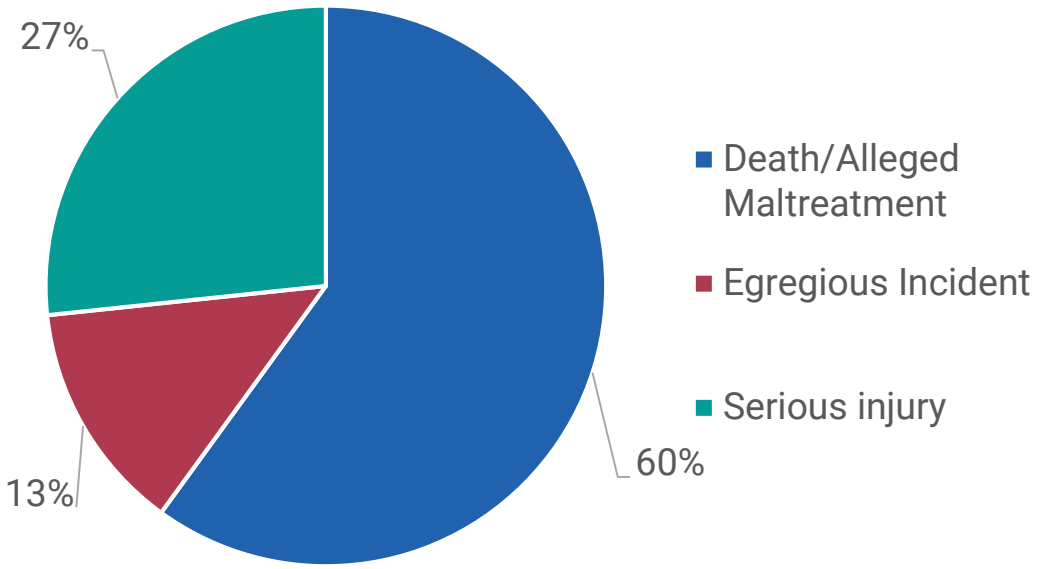
2019-2020 DMCPS SCR Data

2019-2020 SCR Data

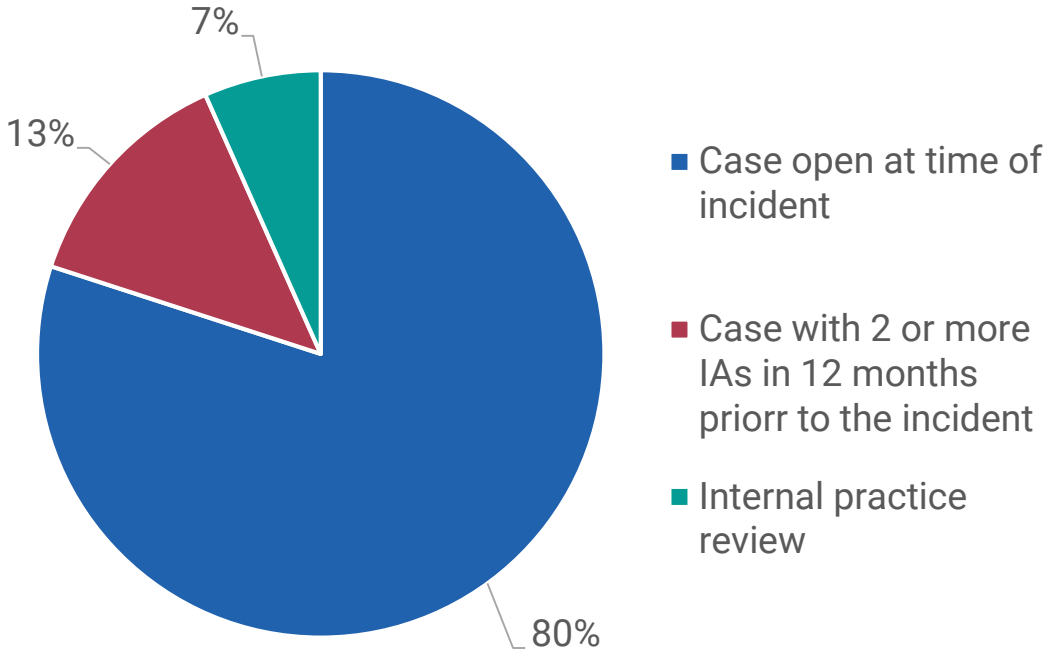
- 17 practice review critical incidents noticed by DMCPS to DSP
  - 2 cases work reviewed from another LCWA; cases excluded from DMCPS data
- 15 cases where critical incident occurred in Milwaukee and work reviewed included DMCPS and/or one of the contract agencies

SCR Case Qualification Data

Cases Qualified for Practice Review by Critical Incident Type



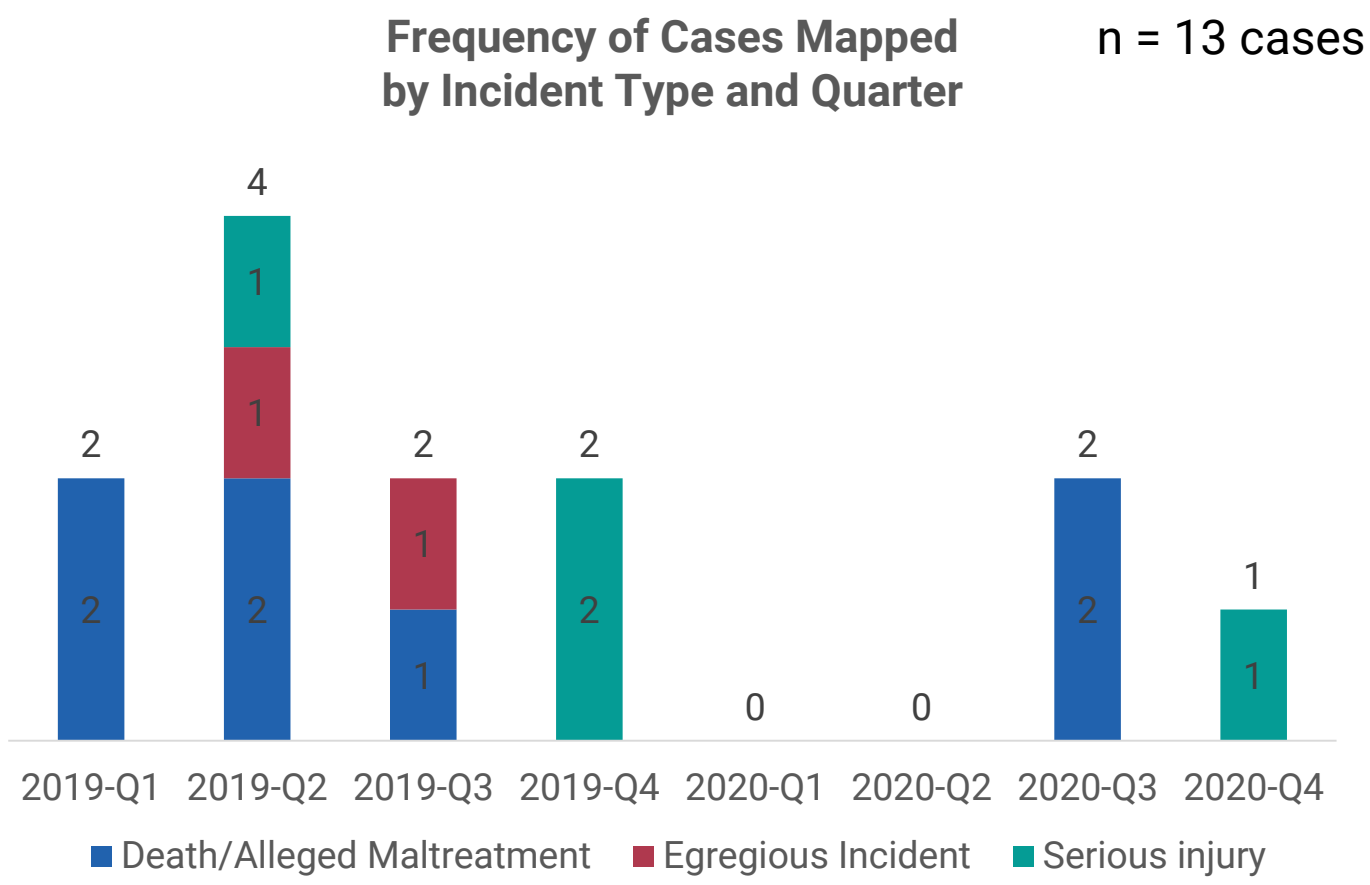
Cases Qualified for Practice Review by Qualification Reason



n = 15 cases

Case Mapping Data

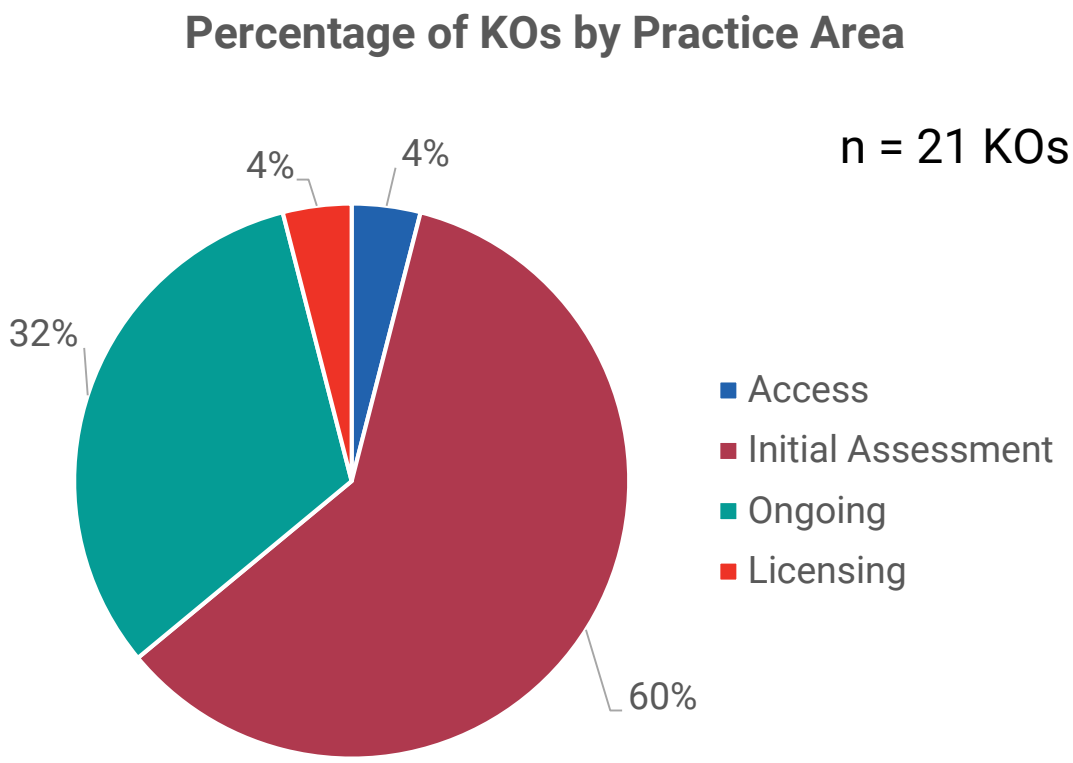
- 13 cases with KOs presented to mapping teams
- 2 cases not mapped
  - No KOs identified
  - KOs reconciled after HFD



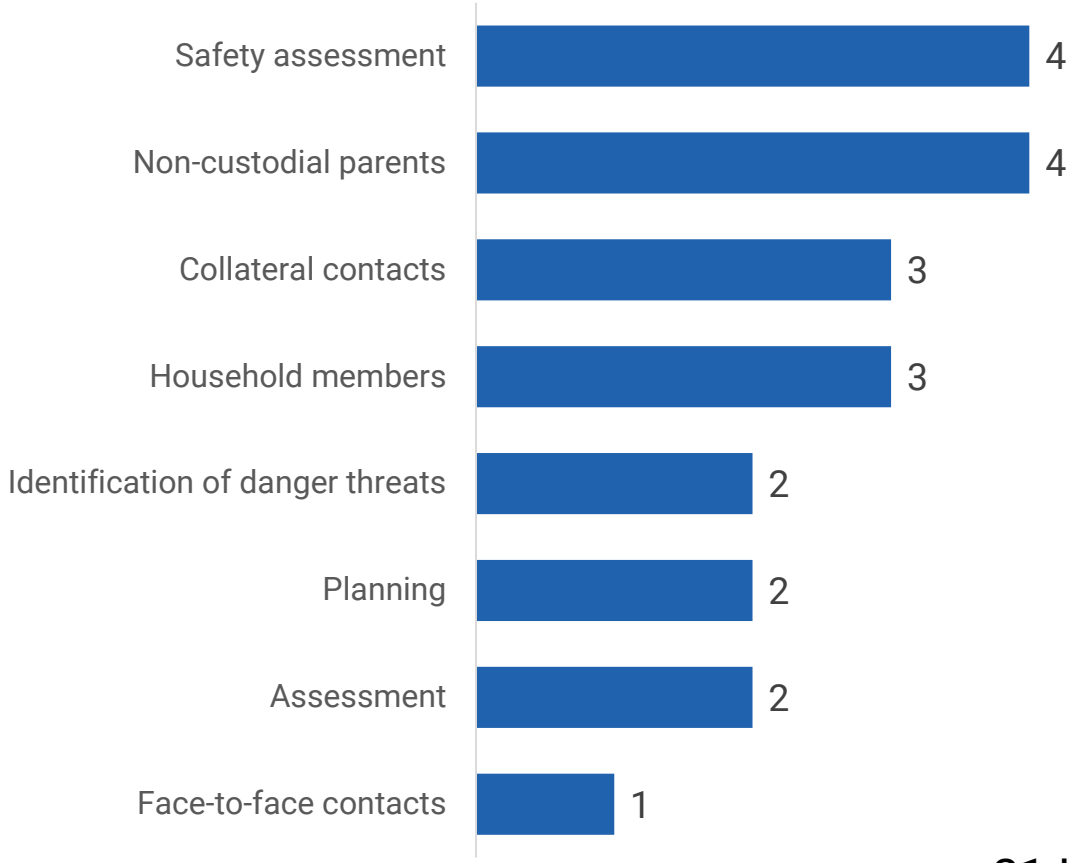
Key Observations

- 13 cases; 21 unique KOs identified
  - (1) deviations from policy or expected practice or
  - (2) decisions or actions within normal case practice

- KOs categorized by:
  - Practice area
  - Primary theme
  - Secondary theme
  - Scoring items



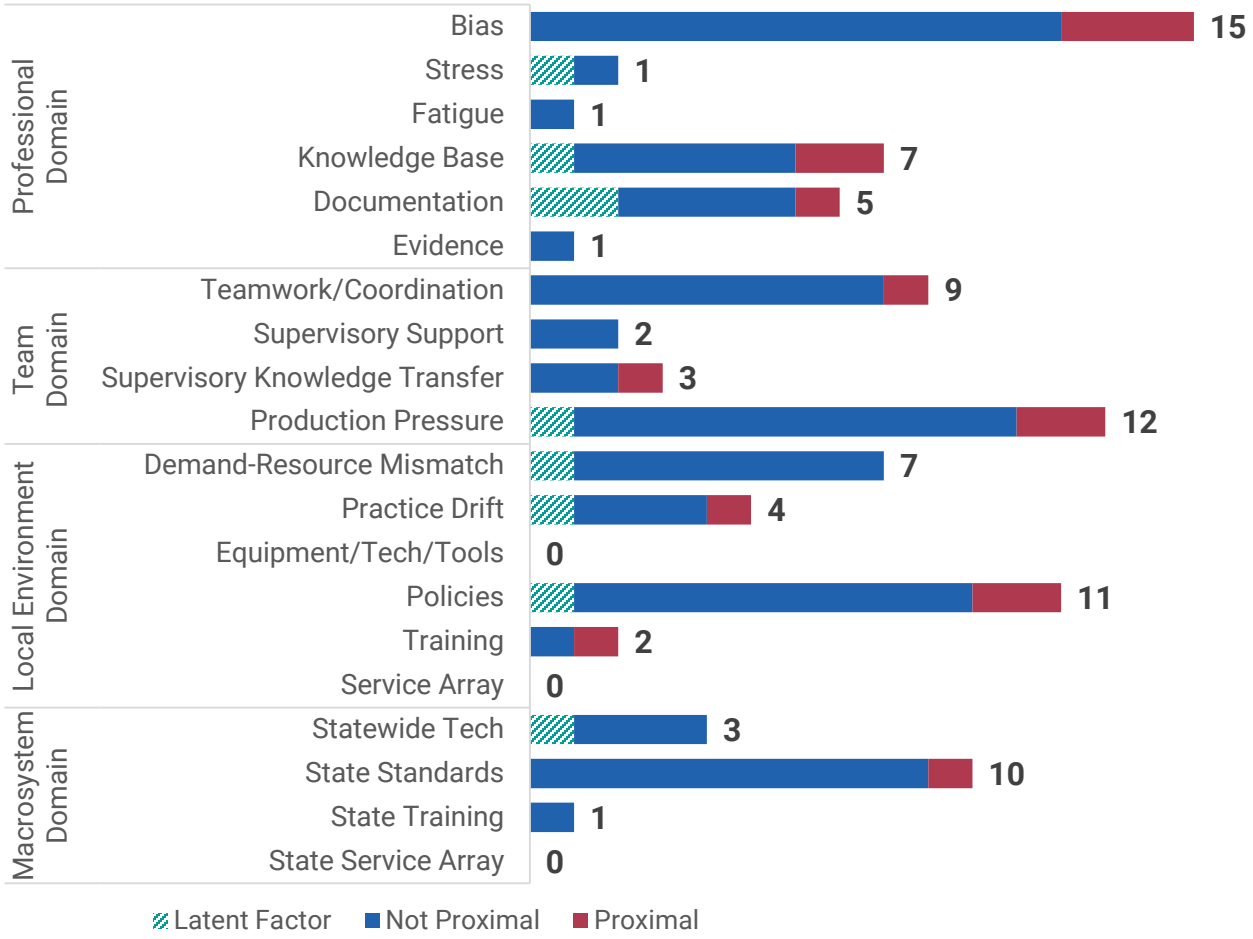
Key Observation Primary Themes



n = 21 KOs

- Safety assessment or reassessment were not completed, completed with incomplete information or not documentation.
- No or minimal efforts were made to locate and/or engage non-custodial parents in information gathering, assessment, or case planning.
- Information from collateral contacts was not gathered during the Initial Assessment in order to inform safety-related or case-related decision-making.
- Household members were not identified and/or information was not gathered from all household members during the Initial Assessment.
- Present and/or impending danger threats were not identified at Access and/or during the Initial Assessment.
- Case planning information not informed by an ongoing assessment process or sibling interaction did not occur.
- Assessment of protective capacities did not occur or assessment of unlicensed relative did not occur.

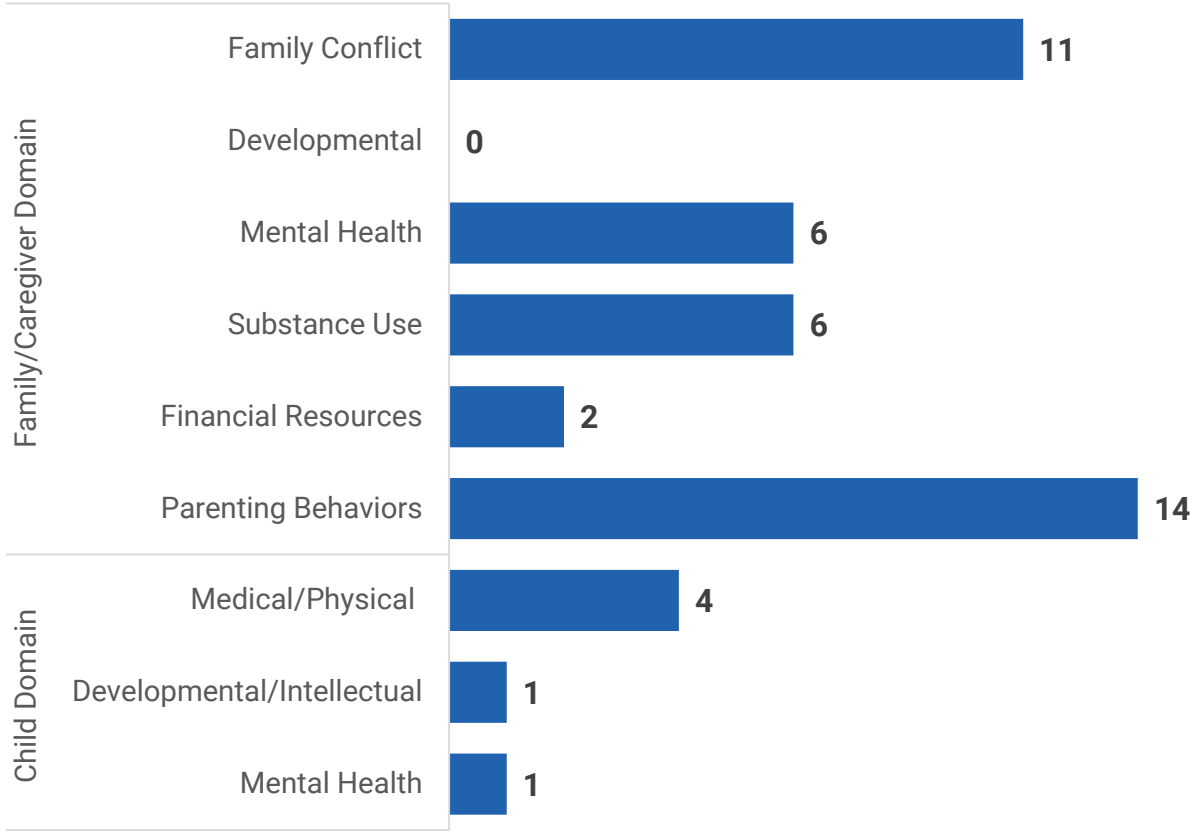
Frequency of SSIT-W Items: System Domains



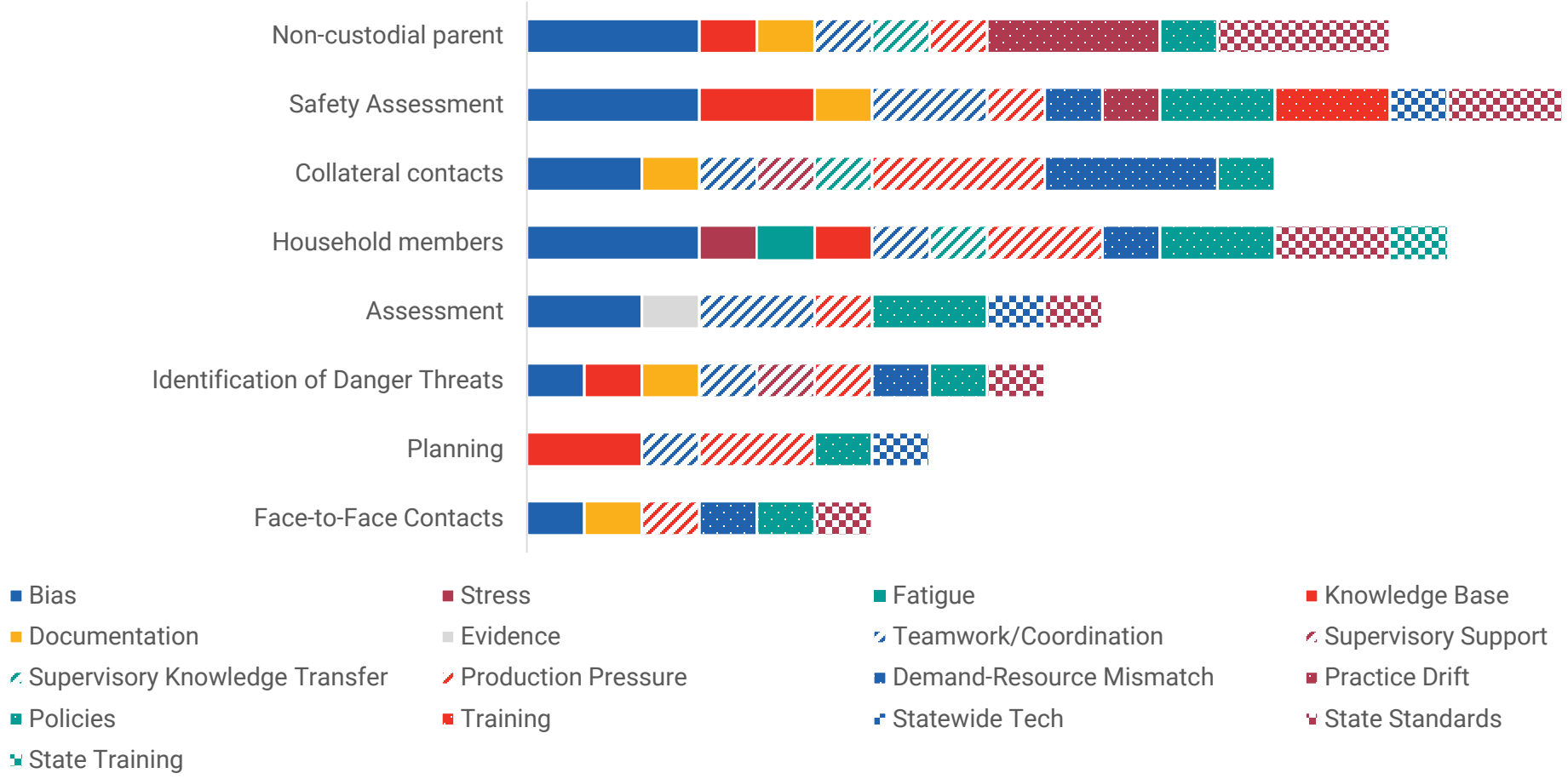
- Latent factor (green stripped) = no influence to KO
- Not Proximal (blue) = Influence to KO **without** proximity to the outcome
- Proximal (red) = Influence to KO **with** proximity to the outcome

Frequency of SSIT-W Items: Family Domain

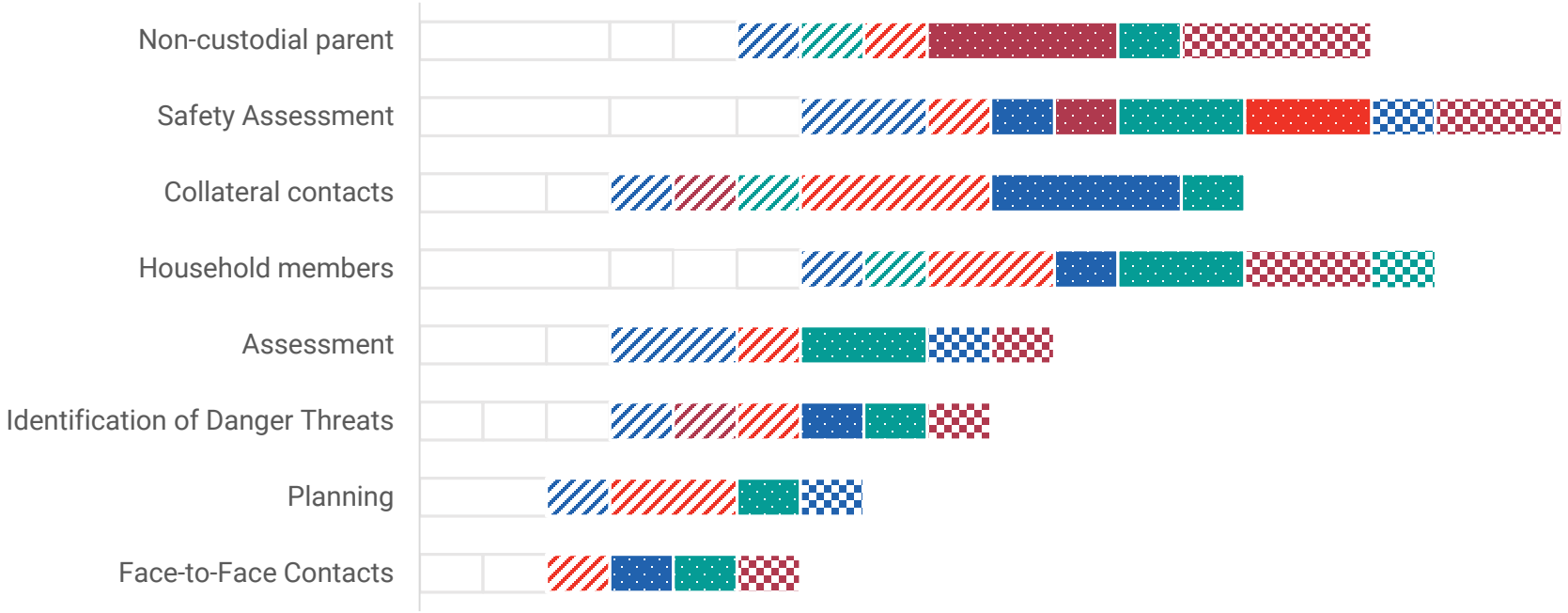
- The Family domain is scored based on the home the child resided in at the time of the CI.
- Provides opportunity to document the family/caregiver.
- Can be useful in drawing correlations between other domains and certain family items.



Frequency of KO Primary Themes & Actionable Scoring Items



Frequency of KO Primary Themes & Actionable Scoring Items



Bias
Stress
Fatigue
Knowledge Base
Documentation
Evidence
Teamwork/Coordination
Supervisory Support
Supervisory Knowledge Transfer
Production Pressure
Demand-Resource Mismatch
Practice Drift
Policies
Training
Statewide Tech
State Standards
State Training

KO Theme: Safety Assessment

KO n = 4

Practice Area	#	%
Access		
IA	**3**	**75%**
Ongoing	**1**	**25%**
OHC		
Licensing		

Secondary Theme	#	%
Case planning		
Case transfer	**1**	**25%**
Documentation	**1**	**25%**
Info gathering & assessment	**1**	**25%**
Locating/engaging		
Protective capacities		
Safety assessment		
Safety decision-making	**1**	**25%**
Sibling interaction		
Unlicensed relative		

Domain	Scoring Items	#	%
Professional	**Bias**	**3**	**15%**
	Stress		0%
	Fatigue		0%
	Knowledge Base	**3**	**15%**
	Documentation	**1**	**5%**
	Evidence		0%
Team	**Teamwork/Coordination**	**2**	**10%**
	Supervisory Support		0%
	Supervisory Knowledge Transfer		0%
	Production Pressure	**1**	**5%**
Local Environment	**Demand-Resource Mismatch**	**1**	**5%**
	Practice Drift	**1**	**5%**
	Equipment/Tech/Tools		0%
	Policies	**3**	**15%**
	Training	**2**	**10%**
	Service Array		0%
Child-Serving Macrosystem	**Statewide Tech**	**1**	**5%**
	State Standards	**2**	**10%**
	State Training		0%
	State Service Array		0%

Exemplar Summary: Safety Assessment

- Cognitive bias impact information gathering and decision-making
  - “difficult” collateral contacts
  - “unwilling” participants
  - Unreliable information
  - No prior referrals
- Local policy impacts
  - Unclear EIS policies
  - Protective Plan time limits
- Lack of knowledge
  - Gaps in knowledge re standards (protective capacities)
    - PCFA training provided to Ongoing
    - No operationalization in standards
    - No documentation requirement in eWiSACWIS
- Teaming
  - Ineffective teaming between CPS and legal parties
  - Internal teaming and assumptions

KO Theme: Non-Custodial Parents

KO n = 4

Practice Area	#	%
Access		
IA	**2**	**40%**
Ongoing	**3**	**60%**
OHC		
Licensing		

Secondary Theme	#	%
Case planning	**1**	**25%**
Case transfer		
Documentation		
Info gathering & assessment	**1**	**25%**
Locating/engaging	**2**	**50%**
Protective capacities		
Safety assessment		
Safety decision-making		
Sibling interaction		
Unlicensed relative		

Domain	Scoring Items	#	%
Professional	**Bias**	**3**	**17%**
	Stress		0%
	Fatigue		0%
	Knowledge Base	**1**	**6%**
	Documentation	**1**	**6%**
	Evidence		0%
Team	**Teamwork/Coordination**	**1**	**6%**
	Supervisory Support		0%
	Supervisory Knowledge Transfer	**1**	**6%**
	Production Pressure	**2**	**11%**
Local Environment	**Demand-Resource Mismatch**	**1**	**6%**
	Practice Drift	**3**	**17%**
	Equipment/Tech/Tools		0%
	Policies	**1**	**6%**
	Training		0%
	Service Array		0%
Child-Serving Macrosystem	**Statewide Tech**	**1**	**6%**
	State Standards	**3**	**17%**
	State Training		0%
	State Service Array		0%

Exemplar Summary: Non-Custodial Parents

- Implicit and explicit biases
  - NPC usually the father
  - Positive vs. negative interactions
  - Assumptions about lack of prior involvement
  - Balancing instructiveness with parent's decline to engage
- Practice drift a byproduct of limited time and resources

- Absent or unclear local and state policies
  - No requirements for alleged father engagement
  - No standards for locating parents in other states
  - Inconsistency in including NPC in permanency planning

KO Theme: Collateral Contacts

KO n = 3

Practice Area	#	%
Access		
IA	**3**	**100%**
Ongoing		
OHC		
Licensing		

Secondary Theme	#	%
Case planning		
Case transfer		
Documentation		
Info gathering & assessment	**3**	**100%**
Locating/engaging		
Protective capacities		
Safety assessment		
Safety decision-making		
Sibling interaction		
Unlicensed relative		

Domain	Scoring Items	#	%
Professional	**Bias**	**2**	**14%**
	Stress	**1**	**7%**
	Fatigue		0%
	Knowledge Base		0%
	Documentation	**1**	**7%**
	Evidence		0%
Team	**Teamwork/Coordination**	**1**	**7%**
	Supervisory Support	**1**	**7%**
	Supervisory Knowledge Transfer	**1**	**7%**
	Production Pressure	**3**	**21%**
Local Environment	**Demand-Resource Mismatch**	**3**	**21%**
	Practice Drift		0%
	Equipment/Tech/Tools		0%
	Policies	**1**	**7%**
	Training		0%
	Service Array		0%
Child-Serving Macrosystem	Statewide Tech		0%
	State Standards		0%
	State Training		0%
	State Service Array		0%

Exemplar Summary: Collateral Contacts

- Cognitive biases
  - Belief whether information will be unbiased and credible
  - Must see value/need for information
- Maintaining efficiency and production
  - Prioritize tasks on cases with identified danger
- Inadequate staffing and other agency resources
  - High caseloads
  - Turnover
  - Supervisor impacts

KO Theme: Household Members

KO n = 3

Practice Area	#	%
Access		
IA	**3**	**100%**
Ongoing		
OHC		
Licensing		

Secondary Theme	#	%
Case planning		
Case transfer		
Documentation		
Info gathering & assessment	**3**	**100%**
Locating/engaging		
Protective capacities		
Safety assessment		
Safety decision-making		
Sibling interaction		
Unlicensed relative		

Domain	Scoring Items	#	%
Professional	**Bias**	**3**	**18%**
	Stress	**1**	**6%**
	Fatigue	**1**	**6%**
	Knowledge Base	**1**	**6%**
	Documentation	**1**	**6%**
	Evidence		0%
Team	**Teamwork/Coordination**	**1**	**6%**
	Supervisory Support		0%
	Supervisory Knowledge Transfer	**1**	**6%**
	Production Pressure	**2**	**12%**
Local Environment	**Demand-Resource Mismatch**	**1**	**6%**
	Practice Drift		0%
	Equipment/Tech/Tools		0%
	Policies	**2**	**12%**
	Training		0%
	Service Array		0%
Child-Serving Macrosystem	Statewide Tech		0%
	State Standards	**2**	**12%**
	State Training	**1**	**6%**
	State Service Array		0%

Exemplar Summary: Household Members

- Cognitive biases
  - Comparing cases (difficulty/allegations) = varying prioritization
  - Beliefs and perceptions regarding reactions or participation
  - Family and professional safety concerns
  - Anchoring bias and confirmation basis based on family information and pre-existing beliefs
  - Fundamental attribution error – cooperative household member is good (safe) and uncooperative member is bad (unsafe)
- Balancing production and efficiency
  - Second shift IA attending to more emergency cases – immediate safety decisions and less time to identify or interview household members
  - Prioritizing cases based on response time
  - New programs/expectations = more time, another tradeoff

Exemplar Summary

- Agency policies
  - Completing IAs before 60 days
  - Transferring court cases to Ongoing within 7 days of TPC
- Unclear state policy
  - No policy definition of intermittent household member – operationalization left up to individual