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Collaborative Safety Review
New Mexico
Children Youth & Families Department

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Summary

In December of 2021, Collaborative Safety (CS) was engaged by New Mexico Children Youth and Families Department (CYFD) to partner in conducting an independent systemic analysis of five child fatalities that occurred in the year 2021. The request for this review was done so with the expectation that the report be completed to provide systemic learning and improvement with the goal of reducing child fatalities and improving all outcomes for the children of New Mexico. Consistent with the approaches of Collaborative Safety and the field of Safety Science, the methods and outcomes of this report are consistent with those expectations and the mission of CYFD.

To understand how a complex system operates, it must be understood from the perspective of those who operate within the system. As such, this review is the product of multiple and differing perspectives, each having a valuable contribution to the product of this report. Throughout this review, voices, and experiences from staff at all levels of the system were engaged. This included close to 10 hours of discussion with multiple staff that had worked directly with the cases within the scope of the review. Additionally, the systemic analysis included the contributions of many staff throughout CYFD, from frontline staff to executive leadership across a 3-day period. This also included the participation of external stakeholders, which included including Law Enforcement and partner agencies. Through the course of this systemic analysis, Key Findings were produced that provided insight across multiple programmatic areas within CYFD and within the broader Child Welfare System. These Key Findings were comprised of the following:

- Turnover
- Responses to Adverse Events and Workload
- Responses to Adverse Events and Staff Fear
- Bureaucratic Accountability
- Safety Assessment Tool

Recommendations were developed to support systemic improvement with the goal of reducing child fatalities and improving all outcomes for the children of New Mexico. It is understood that there are no quick fixes within the child welfare system and careful thought and planning must be considered prior to their implementation. When considering the implementation of these recommendations, it is important the changes made include the voice and input from staff at all levels that are affected.

1. Consider reinforcing the use of metrics to emphasize the strategic use of data for systemic improvement and address perceptions of punitive use.
2. Consider developing a process of responding to critical incidents that meets the acute needs of the event while allowing sufficient time for systemic review and targeted change initiatives.
3. Consider establishing a response to critical incidents that avoids punitive measures and provides resources to support workers following these events (e.g., peer support, psychological first aid, counseling, time off, etc.).
4. Consider assessing and removing unnecessary and/or redundant tasks from investigative casework while maintaining and emphasizing critical case work that allows for the effective support of children and families.
5. Consider researching opportunities in which the training system can address identified needs, for example:
    a. Place more emphasis on practical application,
    b. Provide oncoming staff a more gradual entry into the work, paired with a more manageable workload,
    c. Provide staff a learning experience more connected to adult learning (e.g., pace of learning, mentorship, practical application, etc.).
6. Consider working with Evident Change to explore opportunities to work on identified needs, for example:
    a. Supporting uniformity in SDM tool use across regions,
    b. Creating opportunities for staff to reconcile differences between tool output and worker perception,
    c. Supporting staff to feel confident using the SDM tool as part of their assessment.

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Review Approach

This review was conducted using methods and techniques consistent with contemporary safety science, which incorporates contributions from multiple fields of academia, such as psychology, engineering, sociology and organizational theory and management. Outdated methods of system analysis traditionally deconstruct organizational programmatic areas and individuals into separately existing entities requiring isolated analysis or scrutiny (Svedung, & Rasmussen, 2002). Contemporary safety science uses systemic analysis to understand how actions and decisions of workers within an agency are tied to their existing tools, tasks, and operating environment (Dekker, 2006). Furthermore, this approach seeks to understand how decisions, initiatives, resource allocations deeper within an organization and outside of it can surface in the work and outcomes experienced in everyday work (Svedung, & Rasmussen, 2002). Essentially, the systemic focus is less interested in component parts in isolation and more concerned with component interactions and connections between organizational and external structures.

These principles are structurally embedded into this review's approach. Guiding this review is the goal to learn about system interaction and function and ultimately make effective improvements. The goal is not to attribute cause or blame to any individual, organization, or programmatic area. The approach does not see "human error" or non-compliance as a suitable ending or conclusion for a review. Rather, "human error" is used as the beginning of further analysis and is seen as a surfacing representation of systemic conflict. Furthermore, this review is dependent on the contribution of individuals who operate the system of study. This includes engagement of individuals involved directly with the event of study. Additionally, it relies on representative voices throughout the organizational hierarchy and programmatic areas to most reliably capture and account for the complexity of the system of study.

To create context in which this case was analyzed, it is essential to expand on how the word system is conceptualized. System is not used as a reference to isolated organizational structures, such as policy units, clinical programs, or training units. Further, it does not refer to an existing mechanical or technical

system either. The system, as used in this review will consist of the different contributors (internal and external) to outcomes in work and the nature of their involvement or systemic contribution to an event. For instance, policy units, training units, and technical systems are considered to be components within a larger system that contribute to emergent outcomes. These system components do not exist in isolation and are all jointly sufficient for outcomes to occur (Hollnagel, Woods, & Leveson, 2006).

Hindsight and Outcome Bias

In the wake of tragic events, such as child fatalities, which will be further studied within this review, it is important to maintain awareness of hindsight and outcome bias. Hindsight Bias is the tendency to oversimplify events leading up to an adverse event when there is knowledge of outcome, access to all information and the ability to process that information outside of time constraints experienced during the event occurrence. Hindsight Bias simplifies the dilemmas, constraints and complexities faced by organizations and individuals and can lead to countermeasures that have counterproductive effects (Hugh, & Dekker, 2009; Woods, 2002). This understanding and management of this bias is necessary for learning to take place (Woods, 2002).

Hindsight Bias, when unaccounted for can leave reviewers and readers with the impression that worker decisions and actions can be reduced to the presentation of two choices: good or bad. It can lead towards giving little credit to the complexities and constraints faced by workers in context and can result in counterfactual reasoning. Counterfactual reasoning is when outcomes are explained by what did not happen as opposed to what did happen. It typically incorporates vocabulary such as "should have," "could have" and "if only," as if better options presented themselves and were subsequently ignored. Decisions in context are made because they are viewed to be the most rational given knowledge, tools, supports, assessments, and expectations. Any decision is assumed to be correct at the time it is made, otherwise it would not have occurred.

Outcome Bias refers to the influence of outcome knowledge onto the understanding of decision or service quality (Hugh, & Dekker, 2009).

Specifically seen is the increased likelihood for post hoc reviewers to make judgements on decisions and actions. In addition, Outcome Bias also influences those judgments to be harsher (Hughes, & Dekker, 2009). As reflected with Hindsight Bias, in order for learning take place, the outcome bias must be accounted for.

Outcome Bias can lead reviewers and readers to applying heavy scrutiny and judgement to worker decisions and actions associated with adverse outcomes. The outcome bias may create an inaccurate proportional congruence between cause and effect. Essentially, if a decision preceded an egregious event, the decision will be viewed in equal magnitude to the egregiousness of the outcome (i.e., bad outcome = bad decision). Conversely, if a decision or action preceded a benign or good outcome, although it may be the same decision, it will be viewed as being less egregious and more acceptable.

Review Method

The approach used in this systemic review can be represented by three critical components: technical data collection, human factors analysis and system analysis. The technical data collection is characterized by an in-depth exploration of available data comprised of recent and historical information specific to the subject children and their families. This information includes case records, provider documents, police reports, medical records, and first-hand accounts from workers involved with casework. The human factors analysis is represented by a collection of accounts provided by workers involved with casework. Where this departs from typical interview responses is the focus of questioning and inquiry. The human factors analysis is designed to understand decision making in context, capturing focus of attention, key knowledge supports and guiding goals and/or strategies. Lastly, the systemic analysis seeks to make the connection between key areas of study supplemented by human factors data and the system in which they exist. This analysis incorporates perspectives across the system hierarchy to most reliably reflect the complexity of the system of study.

Technical Data Collection

Technical data is documented evidence that is discovered in available records, such as, case records, medical records, note entries, clinical reports, etc. While gathering the technical data that is available specific to an event, it is important to note that one may never uncover the whole truth of an event and the past is never completely knowable, especially when interpretations are always subjective and alternative views will inevitably exist (Reason, 2008). A guiding principle used in this report is to gather all factual data relevant to the situation in question (Dekker, 2006).

Within any system, there is an abundant amount of data sources to start; a few examples for this review include:

- Policies
- Case Records
- Child Abuse or Neglect Reports
- Medical Records
- Police Reports

The collection of data typically reveals a sequence of activities which includes human observations, actions, assessments, decisions and any changes in the processes or system (Dekker, 2002), all of which provide an opportunity to understand the environment influencing the subject child and the care provided. This collection provides a starting point to look further into the data to identify key areas of study called learning points. Learning points are determined from the data review. The determination of learning points is guided by, but not limited to:

- Work conducted outside of policy and/or written guidance
- Work conducted outside of expectations and norms
- Other areas of work that would benefit from further analysis

Human Factors Data Collection

The field of human factors studies how individuals operate in sociotechnical systems. Human factors data is needed because people do not operate within a vacuum; they operate while constantly interacting with the system around them (Dekker, 2006). For this very reason, the hard, factual information may serve little purpose in trying to understand why systems encounter

difficulties, if it is not understood from the perspective of frontline workers. To achieve this enhanced knowledge, debriefings provide insight into the unfolding mindset of the individuals within the system (Dekker, 2006), closest to children to which care is provided.

Debriefings are conducted to help reconstruct the situation that surrounded frontline workers (Dekker, 2006). Gary Klein developed a method of debriefing (as cited in Dekker, 2006, pp.94-95), which outlines a useful order and strategy:

1. Have the participant tell the story from their point of view, without presenting any additional information that may distort their memory.
2. Tell the story back to the participant as the investigator, in an attempt to gain common ground.
3. Identify critical junctures in the sequence of events (this includes issues identified from hard data) if anything additional is detected.
4. Progressively probe critical junctures to show how the situation was understood from the perspective of the participant, additionally it may be appropriate to provide any necessary data to the participant.

Table 1: Debriefing Example

At each critical juncture one will want to know	Examples
1. What cues may have prompted decisions or actions from the participant's perspective.	Environmental features, perceptions of tasks, etc.
2. What knowledge was utilized to inform these decisions or actions.	Trainings, policies, education, experiences, etc.
3. What goals were being pursued.	Being efficient, thorough, etc.
4. What other influences or constraints may have influenced their perception of a situation and subsequent actions.	Biases, system difficulties (e.g., fiscal processes, workload demands), etc.

Systems Analysis

After the technical data has been combined with the human factors data, this information is compiled and arranged for the Systemic Analysis. The overall goal is to place the collected data in a useful format that will provide a clear and relevant picture of the event within context, which will allow for the exploration of any issues from a systems perspective. The systems analysis is a collaborative process and begins with the selection of the Mapping Team.

Mapping Team Selection

The primary purpose of having a team analyze events from a systems perspective is because one person does not have adequate knowledge of an entire system. Rather, richness is provided from a collaboration of different disciplines and perspectives, each further shaping useful explanations and interpretations which can promote learning from adverse events, such as deaths. Thus, teams should be dynamic and comprised of individuals who can provide insight into the components of the system being reviewed, which will typically include:

- Frontline staff
- Frontline supervisors
- Regional Management
- Central Office Leadership
- System Partners

Methods for Mapping

For the purpose of review, a model is needed to guide the discussion of the Mapping Team away from perceived proximal causes and instead use them as a starting point for further exploration (Woods, Dekker, Cook, Johannesen, & Sarter, 2010). AcciMap is an accident model that is based on a vertical analysis across system levels and breaks away from traditional horizontal generalizations of events proximal to an adverse event (Svedung & Rasmussen, 2002). Specifically, the goal of the AcciMap is to design improved systems and to avoid traditional methods of assigning blame (Svedung & Rasmussen, 2002). The belief is that influences at higher levels of a system travel down to the bottom, which is most proximal to families (Salmon, Cornelissen, & Trotter, 2012). Figure 1 represents the map used for the analysis of this event.

Figure 1: Systems Map

The adapted AcciMap focuses on issues spread across 5 different levels: conditions, processes and actor activities; regional operations; central operations; entities external to the child welfare system; and government and regulatory bodies. The bottom of the tool represents the local influences specific to the incident in question. Higher levels of the AcciMap are representative of processes and decision makers which ultimately influence local outcomes (Svedung & Rasmussen, 2002).

For the purpose of the review, the process is guided by the analysis facilitator. Starting with the pre-identified issues, the facilitator guides discussion up and out from the key areas of study in order to explore all relevant influences throughout the system at each level. The process does not identify broken components or propose fixes when exploring different levels of the system; rather, the analysis identifies "normal" influences which may have participated in the promulgation of the subject at hand.

As a final step in analyzing the information from the technical data, human factors data and systems mapping process, the information should be brought up to a conceptual level. At this time, the objective is to build an account of what happened in a way that does not utilize domain specific terms; rather, the language is of human factors (Dekker, 2002). This account includes the language of production pressures, goal conflicts, tradeoffs, resource constraints, knowledge gaps and procedural adaptions, to name a few. This allows findings to be set in a language that can be communicated to other domains and allow for the identification of common conditions across cases (Dekker, 2002).

Key Findings

Turnover

Turnover was a consistent theme discussed across the cases mapped as a part of this review. The relevance of turnover to everyday work and decision making becomes highlighted through emphasis on workload pressures that impact the ability of staff to complete tasks associated with cases, and to prioritize aspects of work outside of emergencies and critical case tasks. Furthering this, staff often find themselves with little time to provide thorough work to cases. This was also relevant for supervisors as well. Not only do supervisors take on the work of staff as they leave their positions, they also experience turnover in their own positions. This creates another workload pressure point where supervisors cannot effectively provide supervision to the work of their staff and struggle to provide the needed guidance and support for staff as well.

It was noted in the reviews, that a primary stressor influencing turnover was the stress of the job being paired with the feeling of little support. It was surfaced that staff are overwhelmed by the amount of work they must continuously manage. Staff face high caseloads paired with many tasks and requirements. As staff continue to manage this volume of work, they are then consistently responding to emergencies and emerging crises within their caseload. This has placed staff in a position where they feel they are always reacting to the next emergency and are unable to make any progress on other cases. This was strongly emphasized in its relation to newer hires.

Many new hires join CYFD with little to no experience within the field of child welfare. This is not uncommon in child welfare agencies across the country. It was surfaced that as staff join CYFD, there is an overwhelming amount of information that is provided up front, much of which staff cannot reasonably retain. Staff move forward with the expectation that they will gradually onboard while receiving support and building experience. However, this becomes an unrealistic expectation. Staff enter teams and offices that are struggling to manage the workload that currently exists. This in turn leaves little margin to allow for a gradual exposure to the work with compatible growth in experience. Rather, oncoming staff are in a position where they must take on a full caseload while trying to learn how to perform casework.

This leaves staff overwhelmed with responsibilities of the job and may lead to them leaving their position.

This is further impacted by staff feeling as though they are making little difference with the families they are working to help. Staff experience recidivism with the families they are working with and are often trying to work with families that have little to no desire to engage with the child welfare system. As surfaced within the reviewed cases, staff continue to try and work with families that are not willing to engage with the child welfare system. Given that without court involvement, caregiver engagement is voluntary, staff feel helpless to make any positive change. Often, staff may be in a position where they close the case and wait for a new case to be opened with the same family soon after. It also surfaced that even when families do engage with the child welfare system for support, staff face difficulty in connecting them with services. Given restrictions of case timelines and service availability, staff may close a case while a family is on a waitlist for services, only to find out they did not use those services when another case is opened with the family in the future.

It is important to note that the relationship between workload and turnover can be described as a reinforcing feedback loop. As the workload grows, this will add stress to staff that influences them to leave their positions. As staff leave their positions, this now creates a void in the number of staff managing the workload, subsequently requiring staff to take on extra work to fill this void.

Responses to Adverse Events and Workload
Another theme that surfaced across the cases reviewed, was a feature of CYFD responses to high profile events that happen within the child welfare system. Reactionary responses to high profile events, within context of the reviewed cases, presented as default countermeasures that result in added requirements to the work (e.g., mandatory training, new forms, meetings, etc.). These added requirements compound over time and exacerbate the already high workload experienced by staff in the regions. This can result in tasks not being completed, decreased quality of work, as well as increased burnout and turnover.

It is recognized that these responses are not made for the intention of making it more difficult for staff to achieve success. Rather, the goal of these responses is aligned with wanting to be both accountable and responsive to adverse events. Following adverse events, there may be instances where there are numerous competing demands for accountability and reform. These demands can come from the media, elected officials, the public, and oversight agencies. Leadership then is inclined to be responsive to these demands while also trying to achieve their own goals of ensuring improvement in the system they oversee. The pursuit of improvement with limited time will often result in standard methods of improvement that result in more work for staff responsible for actualizing them (e.g., more monitoring of data, more compliance, more training, more policy, etc.). This places leaders in a position where changes are being made without a thorough understanding of where improvement should be targeted. Furthermore, these changes are often made without time to explore the unintended consequences or the impact that layering these types of responses can have over time, gradually degrading operational capacity (i.e., time and resources to meet required expectations) of regions and staff. This decrease in operational capacity leaves staff with the ability to respond to and manage the most immediate and acute needs at the expense of ongoing work-related needs and quality.

Responses to Adverse Events and Staff Fear
Another influence connected to agency response following adverse events, was the perception of staff that there is a culture of fear that impacts their work. It was surfaced that those historical punitive responses had occurred with staff connected to adverse events through disciplinary action, removal from their positions, or otherwise feeling blamed for the event itself by their workplace. Specifically, it was surfaced that these punitive responses increased defensive practice amongst staff and impacted staff feelings of agency support, which was strongly connected to turnover.

Within the regions, the perceived fear was experienced by staff across the organizational hierarchy. Consistently, staff at all levels experienced more anxiety and fear regarding incidents such as child fatalities, the closer they were connected. For instance, directors and managers were fearful of the

event happening in their region, supervisors were fearful of an event with their staff, and frontline staff were fearful of an event on a case they were actively/historically working on. Responses to the fear and anxiety changed based on scope of authority and work. Directors and managers may place more emphasis on metrics or worker oversight. Supervisors and staff may place more emphasis on defensive practice. Defensive practice includes increased time allocation of cases perceived to be highest risk, fear of contradicting assessment tools, and allocation of time to efforts that mitigate personal liability and organizational risk.

It has been well established that responses to adverse events that invoke fearful responses amongst staff can have a detrimental impact on the culture of the agency as well as performance outcomes. Culturally, staff feel as though they are not supported by their agency and are treated unfairly. They feel that at any moment, they could find themselves in a similar position as staff that have been previously punished. This impacts the commitment of staff to their agency and may contribute to staff burnout and turnover. Regarding performance, staff become fearful to make subjective decisions within the workplace or communicate the difficulties they face with their supervisors and leaders.

Bureaucratic Accountability
Another theme that surfaced and was connected to a culture of fear and turnover, was the feature of bureaucratic accountability. Bureaucratic accountability is recognized as an approach to agency management that emphasizes the control of preidentified metrics (e.g., backlog cases, initiations, etc.) through organizational structures such as meetings, messaging, improvement plans, and performance evaluation. While it is inherently appropriate to want to manage operations effectively and efficiently, there can be unintended consequences. For instance, within the review of cases, it was surfaced that the strong focus on metrics gave staff the perception of decreased support and negatively impacted the thoroughness of work associated with cases.

It was discussed that management through metrics was prevalent throughout the organizational hierarchy. Relevant features were that metrics

were managed through performance evaluations and that meetings, messaging, and management strongly emphasized meeting metrics. The focus on metrics in performance evaluations and other settings reinforced the importance of meeting metrics among other responsibilities. As such, meeting the metric may be promoted as a goal of frontline staff that outweighs thoroughness and quality of work. Additionally, it created a responsibility authority double bind for staff, where they felt they were being held responsible for metrics that they do not have full control over. Additionally, staff felt as though when confronted with metrics that were outside of expectations, they were not able to speak to the context behind how the metrics might be outside of expectations. This influenced staff feeling as though they were not being supported. Essentially the focus of the management structure felt more directed at meeting the number as opposed to supporting staff to be successful.

The management of operations through performance measures is an approach used across industry and the unintended consequences are well understood. Agencies that have centralized control often need to rely on these methods as they are resource efficient. However, unintended consequences occur when agencies do not account for the underlying explanation behind the metrics being discussed. Metrics gradually shift from being an indicator for performance improvement to being a method of operational control. Then the management approach becomes more directed at "meeting the number" as opposed to learning (e.g., how come our backlog is increasing?), evaluating what is and is not important to monitor, and supporting staff to be successful.

Safety Assessment Tool
The use of the safety assessment tool was relevant in the review of cases. While using this structured decision making (SDM) tool, if staff received the score of safe there was no corresponding safety planning, even if there were still concerns present. Staff were noting that they had ongoing concerns for the family, but there was little more they could do because of the outcome of the tool.

A consistent theme throughout the reviews involving the use of the SDM tool, was that there is variance between what the tool may come to produce as a result and the subjective analysis completed by the staff using the tool. For instance, the tool may indicate "safe," but they may feel there are still significant concerns with the family. This places staff in the position where they perceive they cannot act on those concerns as it would go against what the tool's output is. This variance was noted to be influenced by multiple factors.

First, it was surfaced that the training provided to staff on how to use the tool may create confusion on whether staff can still address safety concerns, even though the tool results in "safe." The training of the tool is conducted by an independent agency and places a strong focus on teaching about the tool, rather than focusing on its practical application. It was also surfaced that the training on the tool takes place over a limited amount of time and then staff are expected to use the tool effectively. This expectation is placed on staff with limitations on guidance that can be provided from supervisors and peers due to time and workload constraints. This influences staff using the tool without a complete understanding of how to use it in conjunction with their casework.

Another feature was that some staff were using the tool and had not received training on it. It was noted earlier in this report, that workload pressures place significant constraints on the allocation of time and attention on workers. This influences staff consistently responding to emergencies and immediate and/or emerging concerns within their caseloads. This creates a situation where staff may not have the time to participate in the training or be pulled from the training to initiate an emergency case. Since staff were signed in for the first day of training, they will be understood to have completed training even though they were not present for its entirety.

A final feature that was connected to the use of the SDM tool was that there was significant variance across regions and offices in the use of the tool. This is connected to the varying levels of knowledge staff possess to use the tool. Combined with the influences connected to the training of the tool, this was the third change in safety assessment tools used within a 15-year period and it was highlighted that there was a significant shift in focus from previously

used tools to what is currently used. It was noted that earlier tools provided workers more flexibility in its use, whereas the current tool is understood to be more rigid and definite. Without a mutually understood approach to using the tool, staff within different regions evolve the use of the tool based on their level of understanding. The accepted method of use then is taught to oncoming workers. Given the previously mentioned difficulties with the training of the tool, staff rely on the guidance of experienced staff and supervisors to use the tool and this guidance may differ significantly from the tools intended use.

A relevant piece of information that is connected to the variance experienced by staff using the SDM tool, is the discrepancy they faced with law enforcement initiating a 48-hour hold. The guidance of the tool impacted staff's ability to work with law enforcement as they had vastly different interpretations on how to intervene with a child or family. The 48-hour guidance provides law enforcement with broad discretion on when to enforce a 48-hour hold. The actions of law enforcement regarding 48-hour holds would then be in direct conflict with the outcomes of the SDM tool. This has contributed to frustration from law enforcement partners thinking that CYFD is not being effective and provided further attention onto the difference between what the tool outcome is and what staff and community partners are experiencing in the moment.

Conclusion

Given the complex nature of the Key Findings, highlighting their interdependencies would provide value. Within systemic analysis there is opportunity to focus in on tools, strategies, policy, etc., and try to recommend change to those specific aspects. However, these aspects need to be understood in context of a larger system, as these organizational components do not exist in isolation. What was highlighted throughout the Key Findings in this review was that there are specific preconditions that need to be adjusted to provide opportunity for operations to improve. This is the focus of where to proceed from the outcome of this review.

Workload and Operational Capacity

A necessary precondition for staff to be successful at their work (e.g., meeting timelines, completing tasks, providing quality work) is having the time and resources to complete that work. Policies, procedures, tools, supervision can only be successful if they are actualized. Within this review, it was surfaced that staff do not feel there is available time and resources to be successful. Rather, staff allocate their attention to the most pressing needs and emergencies and then maximize any remaining time to "catch up."

A relevant feature that contributed to workload was the asynchronous growth in workload compared to operational capacity. It was noted that responses to adverse events can prompt the addition of requirements, tasks, and oversight which typically emerge as workload pressure points for the frontline of the organization. However, as these additional requirements are added over time, they are not paired with commensurate resources to take on the work. This creates a situation where operational capacity is slowly degraded and staff cannot effectively manage the required tasks and expectations. The subtle additions to workload and its compounding effect often may not be evident to higher levels of the organization as they do not experience the changes directly, rather they are a segment of many contributors to a gradual buildup of workload that spans across time and authority.

Staff Retention and Support

A precondition for managing a high workload is having a robust retained staff to effectively manage that workload. The feature of turnover is in direct

conflict with this need. Turnover and workload create a reinforcing feedback loop that is difficult to manage. The feedback loop is represented by workload increasing over time and contributing to the stress of a position (e.g., front line investigator, supervisor, etc.). This stress then contributes to increasing the likelihood that staff will leave their positions, subsequently increasing the workload for the remaining staff compensating for the lost position.

An important element contributing to turnover, in addition to workload stressors, is feelings of support to complete the work. The perceptions of lack of support surfaced within this review were connected to two primary influences within the context of this report: fear of punitive responses and management by metrics.

Regarding the fear of punitive responses, staff at all levels work tirelessly to support positive outcomes for children and families. This is paired with a constant awareness that they are connected to high-risk situations where there is limited control over situations and outcomes. So, when staff are punished following an adverse event and/or there is little support following these events, they feel as though they are being scapegoated by an agency that they dedicated their time and effort to. There is a shared realization amongst many staff, which is "if it happened to someone else, it could happen to me." This leaves staff in a state of fear that at any moment an adverse event can happen within their scope of work, and they will unfairly be blamed for the outcome. This culture of fear decreases engagement and commitment of staff and promotes defensive practice, which has been demonstrated to have negative outcomes on quality.

The second aspect is management by metrics. An important surfacing feature mentioned in the Key Findings section was the responsibility authority double bind staff experience in this management process. Staff are held responsible to meet these metrics through performance evaluations, social consequences (e.g., non-compliance mentioned in an email to many staff), and consistent messaging. However, staff feel they have limited authority to control those numbers as there are case elements that impact tracked outcomes that are well outside the control of a frontline worker and their

supervisor. This tension contributes further to feelings of lack of support and emphasizes meeting the metric over ensuring quality work.

Given the analysis of the cases within this review, the importance of placing emphasis on preconditions for a successful system cannot be understated. CYFD would benefit moving forward from this review placing an emphasis on establishing the conditions necessary for their staff, processes, and procedures to operate as intended. These preconditions are comprised of having a workforce that feels supported by their management and leadership, a workforce that can be retained, and a workload that becomes manageable within capacity of the system.

Recommendations

Recommendations were developed to support systemic improvement with the goal of reducing child fatalities and improving all outcomes for the children of New Mexico. It is understood that there are no quick fixes within the child welfare system and careful thought and planning must be considered prior to their implementation. When considering the implementation of these recommendations, it is important that the changes made include the voice and input from staff at all levels that are affected. Furthermore, it is important that this document be considered more than a means for recommendations but rather as a source of learning and a support to advance the mission of CYFD. The following recommendations are listed in no particular order:

1. Consider reinforcing the use of metrics to emphasize the strategic use of data for systemic improvement and address perceptions of punitive use.

2. Consider developing a process of responding to critical incidents that meets the acute needs of the event while allowing sufficient time for systemic review and targeted change initiatives.

3. Consider establishing a response to critical incidents that avoids punitive measures and provides resources to support workers following these events (e.g., peer support, psychological first aid, counseling, time off, etc.).

4. Consider assessing and removing unnecessary and/or redundant tasks from investigative casework while maintaining and emphasizing critical case work that allows for the effective support of children and families.

5. Consider researching opportunities in which the training system can address identified needs, for example:
   a. Place more emphasis on practical application,
   b. Provide oncoming staff a more gradual entry into the work, paired with a more manageable workload,
   c. Provide staff a learning experience more connected to adult learning (e.g., pace of learning, mentorship, practical application, etc.).

6. Consider working with Evident Change to explore opportunities to work on identified needs, for example:
   a. Supporting uniformity in SDM tool use across regions,
   b. Creating opportunities for staff to reconcile differences between tool output and worker perception,
   c. Supporting staff to feel confident using the SDM tool as part of their assessment.

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