Research to Practice: Preventing Child Incidents Through Effective Systems

Jessica Mays: Good afternoon, everyone. Thank you so much for being here with us today. My name is Jessica Mays, and I'm a program management and early childhood education specialist from the great state of Michigan.

We're thrilled that you have chosen to spend your afternoon with us, and we have a fantastic session lined up. With that, I'll let my colleague introduce herself as well.

Ametta Reaves: My name is Ametta Reaves, and I am the program management and governance specialist, and I hail from the great Buckeye State, also known as Ohio. Thanks again so much for joining us on this joint adventure with the Office of Head Start and PMFO.

This webinar designed to explore how you enhance systems thinking and multiple multi-dimensional prospects to address critical issues in Head Start programs. During today's session, we invite you to listen for recommendations, suggestions, strategies, and resources that can support prevention and appropriately responding to child incidents.

Jot down any comments or questions that you might have at the end of this webinar. You're invited to join us for our office hour. During that time, you will have the opportunity to ask questions and share comments that you may have jotted down.

Let's talk about the learning outcomes for today. In his book, *Upstream: The Quest to Solve Problems Before They Happen*, Dan Heath says, “If you want the outcome to change, you have to change the system.”

During our conversations today, we're asking you to consider what systemic changes you might need to make a difference. With that in mind, our learning outcomes for today are: Listen for one or more strategies from a systems perspective that supports the prevention of child incidents. Identify one or more resources to support the prevention of child incidents. We invite you to write down your thoughts and points as you hear these outcomes covered during the presentation.

Let's look at a little data. The Performance Standards are designed based on expectations of progress and continuous improvement. Programs are designed - are to design and implement management systems, enabling them to adopt to a dynamic environment on an ongoing basis to most effectively meet the needs of Head Start families of today and tomorrow.

The Updated Program Performance Standards represent a comprehensive revision aimed at enhancing programs' effectiveness, streamlining work operations, and ensuring compliance with federal regulations. The Updated Performance Standards focus on critical areas such as reporting requirements, implementing a strong management team, ongoing staff supervision, and fostering effective employee engagement practices.

For our discussion today, we would like to share the program Performance Standards as they relate to the three most common health and child safety citations. The Office of Head Start reported the following citations. Inappropriate supervision includes children left alone or unsupervised by staff, consultants, contractors, or volunteers while under their care. Most of the findings reported that children were left unsupervised for less than ten minutes. The Office of Head Start also found that programs sometimes have more severe incidents of children being left unsupervised.

The second one is a violation of the standard of conduct. This includes inappropriate discipline, the maltreatment or the endangerment of the health or safety of children, and child abuse.

The third one, inappropriate release, includes releasing children to an unauthorized adult. In section 1302.102, the Performance Standards state the following: It requires programs to develop and remain responsive to the community assessment needs, and these goals may reflect the child's well-being and safety, which is the responsibility of the Head Start program leadership.

Let's take a closer look at some of these citations. The Child and health safety is one of the Office of Head Start's five national priorities. It indicates that each child served in Head Start programs is kept safe and secure, and that programs will be a safe place for children to thrive.

However, the data continues to show an increase in health and safety incidents as reflected on this slide that you see right now. Please note that the citations are from fiscal year 22 and 23. Although systemic issues were cited as a factor in previous incidents, it is crucial to recognize that systems thinking plays a key role in effectively addressing and solving all child safety incidents.

With the continued rise in these incidents, this trend may indicate a breakdown in program systems. Our goal today is to understand how addressing these breakdowns at the systems level can lead to a more comprehensive and sustainable solution. I know we all want to make sure that we sustain our compliance.

Let's talk about systems a little bit more. Look at the characteristics of systems and how they play a critical role in supporting child safety. By understanding how different components of programs interact, we can identify where those breakdowns occur and develop strategies to strengthen those systems for better outcomes.

In the book *Introduction to Systems Thinking*, Daniel Kim describes the system this way: "It is a group of interacting, interrelated, or interdependent parts that form a complex and unified whole with a specific purpose." When we think about systems, we might think about them in a single way, not realizing that they are surrounded by various systems.

We want you to look at the slide that we have shown right now. Take a moment to observe the stories of redwood trees. What systems come to mind when you look at this image? Think about the interconnectedness within the forests and how these systems work together. We're

going to ask you to drop your thoughts in the chat box. Jessica and I are going to be looking at the chat box to see what you have to say.

Jessica: I see animal homes. Someone mentioned wildlife.

Ametta: I see the …

Jessica: Someone said, “I can see the forest through the trees.”

Ametta: Yeah. Someone even said ecosystem, wow.

Jessica: Well, I seen unified mentioned a couple of times as well.

Ametta: Mapping system data. Water, sun, air, soil, trees?

Jessica: Standing tall as a foundation.

Ametta: I like that, I like that. We're going to continue to invite you throughout this webinar to drop your comments in the chat. Thank you for sharing all of those great answers.

Let's think about a couple of things when we think about the redwood trees. First of all, let's think about a group of interrelated parts. Redwood trees are part of a complex ecological system where various parts - the roots, the trunks, the branches, the leaves - and the surrounding ecosystem are all interconnected.

The roots, for example, form networks with other trees, which help distribute nutrients and water throughout the forests. The next one, complexity: the trees are involved in this nutrient system, carbon storage, water regulation, adding to the complexity of their role within the ecosystem. A unified whole: each part of the redwood tree works in unison towards sustaining its life and the life of the surrounding forests. The tree roots, the bark, the canopy, and the interaction with other organisms create a unified system.

All of this is for a specific purpose. The primary purpose of a redwood tree within the ecosystem is to contribute to the health and stability of the environment. Its massive size and long lifespan, which can be over a thousand years - Jessica, did you know that?

Jessica: I heard that.

Ametta: That was really new information for me - but anyway, I digress. Its massive size and long lifespan that can create stability in the forest ecosystem. I really want you to remember interrelatedness, complexity, unified whole, and specific purposes.

Let's add something else to your toolbox. Let's talk about systems thinking laws, which provides a holistic approach to problem solving, solution, and prevention in today's increasingly dynamic and complex world.

An organization's ability to learn and renew itself is a sustainable advantage. To do this, we must apply systems thinking. Systems thinking expands the range of choices available for solving problems by broadening our thinking and helping us to articulate problems in new and different ways.

In the book “The Fifth Discipline: The Art & Practice of Learning Organizations” by Peter Senge, he identifies 11 laws of systems thinking. Today, however, we're only going to consider four of those laws and how they show up in your program when responding to child incidents.

The first one is tomorrow's problems come from yesterday's solutions. The second one, behavior grows better before it grows worse. The third one, cause and effect are not always closely related in time and space. The fourth one, there is no blame.

At this time, I'm going to ask our colleague Bradley if he will put up a poll. What we would like for you to do is we’d like for you to take about 30 to 40 seconds to look at the poll and answer the questions around which one of the four laws displayed on the screen resonate with you. Which of the laws resonate with you?

People are beginning to answer. What we see is that about 35% of you said today’s problems come from yesterday's solutions. Roughly about 19% of you said behavior grows better before it grows worse. 44% said that cause and effect are not always closely related in time and space, that resonated with you. About 19% of you said that there is no blame.

I thank all of you for participating in the poll, we will have a few more polls throughout the session today. Let's look at a couple of these a little more closely.

Today’s problems come from yesterday's solutions: The data shows us that programs have repeat findings. The repeat findings are a result of solutions that may have worked back in 2016, but they're no longer working in 2024. One of those might be the lack of reporting linked to people's fears of zero tolerance policies.

Behavior grows better before it grows worse: One of the solutions that programs apply is training. Training is sometimes only just a short-term fix, but it doesn't look at the incidents with systems thinking in mind.

Cause and effect are not always closely related in time and space: You know, we're good at identifying that a child is left unsupervised, but we don't dig deep to understand the gaps in our systems. For example, professional development, policies and procedures, the ongoing monitoring system.

There is no blame: No one person is to blame when a child incident occurs. It is a program wide problem with systemic implications.

Let's look at some data again from the Office of Head Start that describes the characteristics of systems and systems thinking and how it relates to child incidents. The Office of Head Start

describes child health and safety incidents as two components: the incident itself and the systems that support health and safety.

This is also reflected in the health and child safety data. Given that we will continue our discussion on the importance - Given that, we will continue our discussion on the importance of systems and systems thinking.

I'm going to share a resource with you that you all are very, very familiar with. I always tell people that I love this resource. What I want to encourage you to do is, as you look at this resource and you listen to me explain it a little, think about it in the context of the incidents that may be occurring in your program. Think about it in the context of the work that you do every day with children and families.

The Blue Circle, entitled Leadership and Governance, is a foundation and critical in effectively operating any Head Start program. That yellow circle, or that goal circle, outlines the scope of the assistance consistent with the five-year period. This system supports program management, planning, and well-developed oversight systems, which enables programs to comply, increase quality, and strive for excellence.

The aqua blue areas outlined are the individual management systems. All of those systems have to work together in order to have what we call those - to support those services. That's that next inner blue circle. This includes ERSEA, education, health, mental health, community, and family engagement.

This is where we can feel the pulse of the agencies. Families are viewed as equal partners, are respected, and engaged in enhancing their children's education goals. With innovative leadership, strong management assistance, and well-designed services working together, quality family - child and family outcomes are the results.

When you're looking at this through a child incidents lens, programs focus more on the incident and less on the system that may be strengthening. For example, when a child is left on the playground, programs tend to focus in on the teacher not following the policies and procedures.

In this example, the teacher may be cited for not counting the children as opposed to whether this procedure was communicated to the teacher. That communication system. A key question is also, how was the teacher trained? That’s training and professional development system.

Another consideration is, what did the staff and patterns look like for that particular day that the incident occurred? That may be your HR system. A recommended strategy is to examine child and health - child and health safety practices and identify which systems are a program’s strengths and which can be areas for improvement.

Again, that strategy is to examine child health and safety practices and identify which systems are a program’s strengths and which are areas for improvement.

Let's look at a quote from our author, Dan Heath, in the book called “Upstream: The Quest to Solve Problems Before They Happen.” We said this quote earlier, but now you can see it on the screen: If you want the outcome to change, you have to change the system.

As you're looking at systems such as training and professional development, human resources, and communication, what is it that needs to change to strengthen those systems?

We've talked about systems, systems thinking, and how when one system isn't functioning, it can create problems in our programs. If you recall, in that fifth discipline, the author talks about today's problems coming from what? Yesterday's solutions.

One reason programs have been cited with child incidents is that they use that timeout, which we know that the Office of Head Start does not promote or support, to self-regulate and manage challenging behaviors. A preschool program uses this timeout system to help children calm down when they act out.

Now, initially, this might seem like a great solution as it gives children time to step away from the group. However, over time, teachers start to notice that the same children are being sent to timeout. Instead of learning how to manage their emotions and work through conflicts, these children begin to feel isolated and stigmatized, leading to more acting out.

The solution from yesterday, the timeout system that you weren't supposed to be using, has now created a new problem today. Children are not learning the social-emotional skills needed to self-regulate.

In this way, the system of managing behavior with timeouts, though it may appear to have initially worked, didn't address the root of the problem, namely, helping children develop emotional skills. This has contributed to more incidents and disruptions in our classrooms.

The preschool timeout example highlights the need to shift from reactive strategies to proactive systemic changes. If the desired outcome is to have fewer behavior incidents and better social-emotional skills among children, the system itself - how preschools handle behavior management - must be considered.

Jessica, I think you’re going to talk to us a little bit about how our values and beliefs fit into those systemic changes.

Jessica: I am, Ametta, because we do have to consider, how do our values and beliefs fit into systemic changes? It's definitely one we should consider in all of our work. When you think about it, Ametta, it really is a powerful question. Values and beliefs create an opportunity for a new mindset that can bring about new results.

Values are principles or standards of behavior that we hold dear. They guide our actions and decisions, and they also influence how we interact with the world.

Beliefs, on the other hand, are convictions that we generally accept to be true, shaped by our experiences, culture, and upbringing. Beliefs can significantly influence our values and behavior.

We should examine how our own values and beliefs influence how we see, acknowledge, and explore solutions to resolve child incidents.

I want you to think about this when you're interviewing potential employees or even when you're meeting with existing staff. Consider how you discuss their values and belief systems, and I also want you to consider how they align with your programs.

Their answers to the following questions could be an indication to how they would fit within your program. Here are three questions I would like for you to consider, and maybe even jot down your own thoughts as I ask them:

The first question is, what experiences do you bring to the workplace that influence decision-making? The second question, what lens do you see situations based on your experiences? The last question I'd like you to consider, what does your cultural or personal experience say about how you see and handle child health and safety practices? It's questions like these that are important when finding the right fit for our programs.

Ametta: Jessica, I think those are some really good questions. Thanks for sharing those.

Jessica: They are, and they're questions I hope everyone will consider as they're meeting with staff and thinking about their program.

But another tool that will help us think about our beliefs and actions is the Ladder of Inference, which was developed by Chris Argyris, Harvard professor of Education and Organizational Behavior.

It is a research-based tool that explains how we make choices, with each step in the decision-making process being represented by a rung on the ladder. You'll find a copy of this in the chat that Brad is going to share with you. Another tool that you can have in your toolbox.

As you look at this visualization, I want you to be able to think of it as a series of steps. It does not provide a series of steps to make a good decision. Rather, it outlines how we naturally make judgments based on our individual assumptions.

The theory behind the ladder is that we all have experience that lead us to pay attention to certain things. In turn, these experience add meaning to what we notice based on our personal and our cultural background. It is from this filtered input that we develop our beliefs.

To really get us grounded in the ladder of inference, Ametta and I have a short video we're going to share with you. As you watch the video, I invite you to listen for key words or themes that really resonate with you.

[Video begins]

Speaker: You can do this by using a method called the Ladder of Inference. It’s a system which was first developed by psychologist Chris Argyris way back in 1970 and popularized in Peter Senge’s book, *The Fifth Discipline*.

The ladder of inference is a way of describing how you move from a piece of data, such as a comment or something you have observed, through a series of mental processes, to a conclusion. These processes can be visualized as rungs on a ladder.

Starting at the bottom, we identify facts and data. As we move up the ladder, we're selective with the data based on our beliefs and prior experience. We interpret what the data means and tend to apply our existing assumptions. We then draw conclusions based on the interpreted facts, which in turn become our developed beliefs. Finally, we take actions that seem right because they are based on what we believe.

This is dangerous as it can lead us to ignore the true facts altogether. Soon, we're jumping to conclusions by missing facts and skipping steps in the reasoning process. This can all happen in milliseconds.

By using the ladder of inference, you can learn to get back to the facts by remaining objective using system two thinking. The first thing to do when making a decision is to identify where on the ladder you are. Are you selecting your data? Interpreting what it means? Making or testing assumptions? Forming conclusions? Or deciding what to do and why?

From your current rung, analyze your reasoning by working back down the ladder. This will help you trace the facts and reality that you are actually working with. There are four simple skills you can learn to stop you racing up the ladder.

Number one, make your thinking process visible to others by explaining your assumptions, interpretations, and conclusions.

Number two, invite others to test your assumptions and conclusions.

Number three, use respectful inquiry to help others make their thought processes visible. Use open and non-judgmental questions.

Number four, explore impasses and don't agree to disagree too soon. This helps avoid hidden or unspoken assumptions and conclusions.

By understanding and practicing this method, you will quickly become an effective decision maker. There's something exhilarating about showing other people the links of your reasoning. They may or may not agree with you, but they can see how you got there. Often, you'll surprise yourself to see how you got there once you trace out the steps.

[Video repeats]

You can do this by using...

[Video ends]

Ametta: Jessica, I think people are really liking this video. I see a lot of reactions.

Jessica: Yes, the video, just in case anyone wants to view it again, you'll also find a link to the video in the chat that Bradley has just shared. Please feel free to grab a copy of that and save it somewhere so that you can watch it or share it with your staff.

The one thing we appreciate about the video is that it illustrates how people unconsciously climb a mental ladder of assumptions and beliefs based on their observations and experiences. Your beliefs, believe it or not, influence the way you approach systems thinking. They determine how you select certain information and ignore the rest. They also filter your reality and often make you jump from an observation to a conclusion in a millisecond.

I know this from my own personal experience, because I can honestly say I'm guilty of it. But do you remember earlier when Ametta discussed how systems thinking expands the range of choices available for solving a problem? By broadening our thinking and helping us articulate problems in a different way.

Together, let's review each rung on the ladder. This time I'm going to provide you with some questions to consider. You'll also be able to find a copy of these questions in the chat.

We always begin with our observable reality. Those are the things that we've already seen where our decisions are coming from. Then, we have to consider our data. What did I ignore and not pay attention to? Are there other sources of data I did not consider?

With our observations, am I looking at this data objectively? What other meanings could they have? With my beliefs, are my assumptions valid? Why am I assuming?

When we think about prior experience, we have to consider, why did I conclude this? What are my assumptions here? With existing assumptions, what beliefs do I hold about this? What conclusions are they based on?

Finally, regarding conclusions: Why do I believe this to be the right action? What are some alternative options?

I want you to think about each rung of the ladder and the questions associated with it through the lens of child incidents. I'm going to ask you to visit our chat box again. Please share with us, what rung you use: data, observation, beliefs, prior experience, existing assumptions, or conclusion?

It's nice to see, we see a variety, and it looks like a lot of people are staying kind of in the observation and data one. But it's also thinking about, if that is where you are, how do you

make yourself go up those steps of the rung and really move through that process as you're looking at child incidents?

Again, in the chat, we've shared this with you. We will also share all the resources with you again at the end because we want you to keep these in your toolbox. We never want anyone to experience a child incident, but when things do come up in your program, take these tools into consideration as you're navigating through one.

One of the essential shifts in the Head Start Program Performance Standards is the emphasis on employee engagement as a foundation for program success, which includes utilizing root cause analysis as a method to address challenges, drive continuous improvement.

Root cause analysis is not only a problem-solving tool, but it's also a powerful engagement tool, empowering staff to participate actively in identifying issues and contributing to solutions. Root cause analysis is a method of solving problems at its source, rather than just treating the symptoms.

If you've ever tried to solve a problem, such as the teachers in our earlier scenario utilizing inappropriate timeouts, but it continues to show up again and again, you're probably not getting at the root cause.

Root cause analysis is usually one part of a problem-solving or decision-making process. You perform a root cause analysis first, so you know which problem is the right one to solve.

Now, most problems don't just have one root cause, but by digging deeper, you can find many other opportunities to improve. When thinking about root causes, you really want to understand the following: The first, why the problem happened; Why the problem had such an impact; and lastly, how to reduce the likelihood of similar issues in the future.

We really want to figure out how to reduce the likelihood of similar issues in the future. Root cause analysis pushes us to get to the source of the problem by building systems to address problems before they happen.

Over the years, there's been a lot of research and tools developed around supporting root cause analysis. Michigan State University has developed a systemic root cause analysis tool that we'll be using today to examine a child incident.

In the chat, Bradley is sharing with you Michigan State University's Systemic Root Cause Analysis template for you to download. Please note this template is copyrighted by Michigan State University, but you do have permission to make copies for your organization's use. You may not use any portion of these materials for commercial sale or use.

On this template, it uses root cause analysis to ask why issues are happening. The areas it focuses on are mindset root cause, regulation root cause, connection root cause, component root cause, resource root cause, and power root cause.

Systemic root cause analysis is a process to identify systemic reasons why a problem is happening. You can apply this process in almost any situation where a problem has occurred and needs to be solved. It'll also help us to identify strategies that address the root causes.

Too often, we spend a lot of effort focusing on addressing a single event, such as the teacher didn't close the door, or a pattern of events, the mental health staff not providing referrals quickly enough, without exploring why those events are occurring.

Without identifying root causes, you risk wasting time, which we all know is precious, and resources fixing symptoms rather than the causes of the problem. Ametta is going to introduce us to a scenario on the next slide to set us up for an opportunity to explore together each of these root causes through a child incident.

Ametta: Thank you, Jessica. Again, Bradley has dropped the scenario in the chat box for you. You also should have the root cause analysis sheet. We want you - I'm going to read this, and then we want you to listen for key issues or challenges. Listen for key issues or challenges. Hopefully everyone has it. Here we go.

During naptime, a teacher with three months of Head Start experience, witnesses a teacher with ten years of experience spanking a child. The new teacher didn't immediately report the incident to the education coordinator. Four days later, the parents withdrew their son from the program. The parent shared with the Head Start director that the child was spanked by his teacher.

The director investigated the incident by watching video footage and talking with the staff. The video showed children being spanked, placed in timeout, and food being withheld during mealtime. The center staff shared that the parents had given permission for children to be spanked and put in timeout.

The director learned that the center manager was often absent, and the education coordinator had not been to the center during the school year. The new teacher shared that she was told that “we don’t tell management about what is happening at the center.”

The director reported the incident to the licensing agency immediately. The director reported the incident 20 days later to the regional program specialist. The director, who had 15 years of experience, gave two reasons for not immediately reporting the child incident to the program's specialist. She stated that she wanted to complete her investigation and have the report from the licensing agent agency.

You've heard the scenario. You have a copy of that. We want you to put in the chat box, What are some of the key issues you see here? We invite you to share what you come up with, and we want you to think about it from this perspective. Which management system does it touch, and identify one key problem?

Let's see what we've got going on in the chat box.

Jessica: Just in case anyone needs to look over the scenario again, because we will be using it throughout the remainder of this presentation, there is a copy of it in the chat for you to either download or it's also typed in the chat for your review. It is there for your ongoing use to be able to go back and look at it. Ametta, the chat is busy.

Ametta: Yeah, someone said not speaking up. Someone talks about the reporting time frames. This gives me a good opportunity to remind you that the Office of Head Start recently issued an information memorandum, on the 7th of November I believe, talking about the timelines for reporting child incidents and health and safety issues.

Again, an information memorandum was released by the Office of Head Start around the 7th of November that talked about those child incidents, reporting, and health and safety. Make sure that you check those out so that you will be aware. Not that we want you to have any incidents, however.

Jessica: Absolutely. Ametta, I do just want to note, because I did see someone make the comment, this is a scenario that we made up for the purpose of this training.

Ametta: Oh absolutely, absolutely. When we think about the mindset root cause, we have to consider the local beliefs, values, or attitudes. In this scenario, local beliefs, values, and attitudes played a significant role.

We heard them talking about the acceptance of spanking, and some of the staff and parents believe that spanking was an acceptable form of discipline. This belief influenced their actions, as well as their response to the situation.

The code of silence: not talking about it, not telling anyone. This belief system led to a culture where staff members were reluctant to report inappropriate behavior, creating this code of silence.

Then there is one, and I don't know whether we saw this in the chat box or not, Jessica, about policies and procedures, where there was a conflict with the policy. The belief that one should not tell on others conflicted with the center's internal policies and procedures, which require the reporting of any type of child abuse or inappropriate behavior.

We can see how the mindset around the beliefs, values, and attitudes may cause a problem. Jessica, what else may cause a problem here?

Jessica: Let's take a look at the regulation root cause.

Ametta: Uh-huh.

Jessica: When we take a closer look and examine regulation root cause, which requires us to closely look at our internal policies and procedures and regulations such as the Head Start Program Performance Standards or your state's child care licensing requirements and the impact they have on child incidents.

I'm going to ask you to really think about our regulation root cause. In the chat, I'll ask you to think back to our scenario and share what policies, procedures, or other rules and regulations are causing this problem and how. Everyone should have a copy of the scenario, Brad just shared it again for you to view. Thinking back to that scenario, What policies, procedures, or other rules and regulations are causing this problem, and how?

Ametta: Someone talks about the standard of conduct, mandating reporting, discipline procedures, failure to follow mandated reporting, lack of training. Some leaders who want to support teachers in the classroom have to spend time on other regulatory requirements, positive guidance policies not being followed, a lack of monitoring, and positive behavior support.

Jessica: I think those are all things that we see. They're all pieces that go back to our regulation root causes on if they're being followed or not. The conflict arose here because the Head Start Program Performance Standards and the agency's standard of conduct prohibit any form of discipline. However, the agency's policies did include reporting an instance to child care licensing, but they failed to include the process of reporting to the regional office.

Also, although the agency's internal reporting policies and procedures were in place, they were not followed. Staff did not adhere to these policies and procedures due to their own code of silence. The program was also under a full enrollment initiative and needed to be fully enrolled within the next 30 days. In their rush, they hired staff without following their proper onboarding procedures, and a part of that is a lot of people mentioned was their code of conduct or ethics being followed.

Ametta: We want to call your attention to our scenario. Remember that this is one that we just simply made up. We want to talk about the connection root cause and examine relationships and exchanges across different subsystems, including the community, internal staff, and other organizations.

Going back to the made-up scenario that we shared with you, how are current connections or exchanges between the local people and organization causing this problem? Share those connection root causes in the chat.

One of the things that I want to call your attention to, Jessica and the participants out there, is that the Head Start program has its internal values and systems in place that did not allow for any form of discipline. However, in the community where our staff is coming from, where our children are coming from, our parents make up that community, spanking was an acceptable form of discipline for children. The parents had expressed this when they had their home visits.

This belief system that was held by some parents conflicted with the agency's standard of conduct. This is one of those where you have to really think about, how do you get the message out to the community at large that spanking is not an acceptable form of discipline for our children in the Head Start program.

Jessica: The component root cause really gets into individuals' values and beliefs, which we've spent a lot of time talking about today. When we look at component root cause, it looks at the quality and effectiveness of services and what supports and opportunities are available. In the chat, thinking about our scenario, how is the design and the delivery of local programs, services, and supports causing this problem?

Ametta: We got a lot of good responses here.

Jessica: We do, we do. To summarize some of them, the standards of conduct, they were provided at orientation, but they weren't highlighted or discussed in a meaningful way. For staff, they really just became a document that they looked at and signed. It wasn't a document that was laid out for them as being important.

Ametta: Yeah, absolutely. That whole notion, Jessica, that we give parents the parent handbook, but sometimes we don't go over, programs don't necessarily go over those key messages. That key message is around that spanking is just not an allowable form of discipline. I think that really stood out there in that particular one.

I'm going to talk about the resource root causes and examine how the resources, including human resources, financial, and community resources, how all of that plays into this. How is the availability of local resources causing the problem? Going back to the scenario, we're going to ask people to drop those comments in the chat box.

We're going to continue on. Jessica let's talk a little bit about the power root cause.

Jessica: The last group root cause we're going to talk about is the power root cause. Power root causes look at whose voices matter.

In our comments, we've seen a couple of moments where people have talked about the voices that matter within the program, or even in the situation where maybe some voices got lost. One last time, I'm going to ask you to think about our scenario that we shared earlier. In this child incident, what ways were local power dynamics causing this problem? Please share your responses in the chat. We thank you for staying engaged with us and sharing these responses.

Ametta: We're going to continue on here. Let's review the root causes and summarize the key issues to consider in determining the root cause of a child incident. Again, these are available for you in the handout. You'll find these, all of the resources that we've referenced, you'll be able to receive those via a QR code, are in the resource folder that you will have.

The mindset root cause: what local beliefs, values, or attitudes may be causing this problem? Regulation: what policies, or other rules and regulations are causing this problem? Connection: how are the current connection and exchanges between local people and the organization causing this problem? Component: how is the design and delivery of local program, services, and supports causing the problem? Resource: how is the availability and quality of local

resources causing the problem? Power: in what ways are the local power dynamics causing these problems? All those are really critical when we think about root cause analysis.

Jessica: I just want to remind everyone, just in case anyone wasn't able to download the resource initially, all of these will be found on the template from Michigan State University.

Ametta: Yes. Thank you for that.

Jessica: Ametta, now that we've identified some root causes, we also have to consider what do we do with all of them.

Ametta: Yeah.

Jessica: Now let's think about this. We've come up with a lot of them, but how can we prioritize these ideas? One way for us to do that is what we're going to talk about next, and that's really by identifying powerful root causes and feasible root causes.

As we continue to think about staff roles, responsibilities, and other items identified through our root cause analysis, we also want to understand that we may not be able to address them all immediately. That's OK. We have to think about how do we prioritize the root cause.

One way for us to do this is to think about them as powerful root causes, which have the most influence on the problem, affect multiple people and/or settings across the community, affect other root causes or outcomes, are prioritized by local residents or staff who are experiencing the problem.

The other one is feasible root causes. They are within your current scope or focus, and they motivate people to action. When you think about staff roles and responsibilities in our scenario, where do you think they fall? Ametta, will you share some examples of powerful and feasible root causes with us?

Ametta: I was really hoping that some of the people in the chat box would also lend me some of their wisdom. When we think about one of the powerful root causes in this scenario was around multiple people and the settings across the community. I sort of referenced a little bit earlier that our staff comes from the community where most of our centers are located.

That might be part of that root cause. That's why it's so important around that onboarding and that orientation - really sharing what the practices and beliefs are of the agency. When we talked earlier about getting to those values, that programs can use those questions we asked them to consider earlier when they're interviewing staff, that's one of the things that you can do.

The other one, when we think about feasible root causes, what's - how we motivate people to act and how do we get people to communicate with each other? Especially when we're dealing with a scenario like the one that we had where people thought that it was not OK to share. I think that those are really, really critical pieces. To get examples, I believe - and again, I think

that when we get into the office hours, I'd like to spend a little bit more time hearing from our participants and sharing a little bit more and going back to the scenario and really talking about it.

Jessica: Yeah, that's a great idea.

Ametta: Yeah.

Jessica: Focusing on root cause causes of challenges or barriers to successful service delivery, a practical step is mapping out the strategic directions. There are many root cause analysis templates available. We just shared with you one today. In the chat, Brad is also going to share with you a worksheet called the Root Cause: Building Solutions Using Critical Thinking as a resource.

This will also point you into a direction of other tools and templates that you can use as you're exploring root causes. We encourage you to find one that you really feel comfortable with.

Let's go back and again revisit language that we're familiar with. One of the findings that show up, during our root cause analysis was around staff roles and there was responsibilities. This reminds us of the revised program Performance Standards, 45 CFR 1302.100 (a)(2) Management Systems.

It says this: a program must implement a management system that promotes clear and reasonable roles and responsibilities for all staff, and provides regular, ongoing staff supervision with meaningful and effective employee engagement practices.

I really wanted to say that very slowly, because I want people to really think about as they read that scenario were some of the things that sort of stood out about that employee engagement. I saw a lot of people put it in the chat box, and they're still talking about that, you know, reflective supervision and checking in with staff. All of those things are so very, very critical.

Now let's move to another strategy that we would like to share with you. Responding to problems and preventing problems. When responding to problems, we're always in state of what we should, what we should do next. We are reactive and when should we respond - be responsive.

Remember the quote, if you want the outcome to change, you have to do what? You got to change the system. We have considered the psychological forces of barriers that push us in what I call - what Dan Heath, in the book calls downstream thinking, and how that impacts us.

Heath, Dan Heath introduces in the book, to thinkers who need to overcome these obstacles and score massive victories by switching to what he calls the upstream mindset. Leaders, Jessica, they often spend a lot of times just responding to problems versus thinking about how to prevent them in the first place.

This whole webinar has been designed to help you to think about how do you prevent the problem in the first place? Some of the characteristics of responding to problems are: getting stuck in a cycle of response, putting out fires, dealing with emergencies, handling one problem after another, or failing to fix the system.

Brad, we're going to ask that, Bradley, we're going to ask that you put the poll up again, and we're going to ask which of these show up in the workplace, which of these show up in the workplace. Participants take a second, to answer these questions.

We're going to go ahead and just sort of end the poll here. We've got roughly about 50%. 55% of the people have answered. About 40% of them said getting stuck in the cycle of response, 60% said putting out fires, 44% said dealing with emergencies, another 64% said handling one problem after another, and 44% said failing to fix the system. We've got some people that say all of them. Thank you all for sharing in the poll activity.

As we continue to talk about responding to problems and preventing them, I want to talk about prevention. There are some practical solutions for preventing problems. You got to shift from being reactive to proactive, and you got to really think about systems thinking.

We're going to look more closely at barriers to prevention. We're going to talk about three in particular: problem blindness, tunneling, and the lack of ownership. Problem blindness, tunneling, and the lack of ownership. As we switch to the next slide just give me a second here to drink some water because, mouth is getting a little dry here.

Thank you, thank you. Problem blindness is another barrier to that upstream thinking that Dan Heath talks about in his, in his book. When we don't see the problem, we just can't solve it. That blindness can passively - can create passivity and even in the face of enormous harm.

In order to move upstream, or in order to, to be more about preventing, we must overcome problem blindness. Problem blindness is the belief that negative outcomes are natural and that you can't avoid them.

Do you think that your organization suffers from problem blindness? I'm just going to, to pause there for a second while you think about that. If so, in what areas? In what areas? Just thought to think about that.

Problem blindness can leave us oblivious to serious problems in our midst. Three key barriers to upstream thinking is problem blindness: I don’t see the problem. The next one is about tunneling, that’s the second one.

Tunneling is a phenomenon common to human service organizations. When people are juggling a lot of problems, they give up on trying to solve them. They adapt to tunnel vision. According to Heath in his book, tunneling is a barrier to upstream thinking because it confines us in a short-term, reactive thinking.

The biggest problem about tunneling is the lack of bandwidth. The little things seem to crowd out the big things. Or stated another way, we can't see those, the redwood tree. We can't see the forest, for those redwood trees.

In this case, people become so accustomed to reacting to problems and working around them, they never get around to fixing them. They never get around to fixing them. Surely, we can all relate to this. Why do you think tunneling is such a powerful trap? Just think about that for a second. Why isn't it more natural to step out of the tunnel and engage in systems thinking?

The ideal is to use strategies to hopefully move your respective organization and to build systems before - to build systems to address the problems before they actually occur, to address those problems before they occur.

Let's talk about that next one, a lack of ownership. This is where we say who is often held accountable when the incident happens. The answer is not always clear. Sometimes you know what we do? We point the finger to the people directly involved in the incident. Instead of thinking that it's everyone's responsibility to keep children safe.

Jessica, you know what? When everyone is pointing the finger like I'm doing right now, we are not examining the root causes of why the incident occurred in the first place.

Jessica: We aren’t Ametta.

Ametta: Yeah. We got to stop doing that, and I’m pointing my pointer finger to myself right now.

Jessica: I don't know, I feel that finger pointing this way. But we -

Ametta: Yeah, right over here.

Jessica: - [inaudible]

Ametta: Absolutely, absolutely. The barriers to prevention is around not having that problem blindness. It's getting out of that tunnel vision and really taking on ownership and remembering that everyone, everyone in the program, is responsible to make sure that our children are safe, and that they're able to thrive.

This is one of the books that we have been quoting here, *Upstream*. It really is, one of the, we've shared several resources with you guys, and we do hope that you will take the opportunity to view these as you continue to work to be successful programs.

In the book *Upstream*, these are some things that we want to conclude with that Dan Heath reminds us of. Moving from problem solving to prevention. Programs have to, Jessica, look for practical solutions for preventing problems. Moving from reactive to proactive. Applying systems thinking.

Here's one of the quotes that Dan Heath has in this book. “When you spend years responding to problems, you can sometimes overlook the fact that you could be preventing them.” When you spend years responding to the problems, putting out those fires, dealing with those emergencies, you can overlook the fact that you could have been preventing those fires. You could have been preventing those emergencies. You could have been keeping children safe.

Jessica: Ametta, I also want to just that first bullet ‘look for practical solutions for preventing problems,’ that also aligns with our feasible think about looking for our feasible ones. Those are the examples of the practical ones that we can also get started with to start moving that needle forward.

Ametta: Here are some, I missed some of the quotes here. Someone said, “Oh, that's a great quote.” Another person said, “It's the whole system's responsibility.” If a staff needs to be trained, of the rules, it needs to be provided. Another person said “Pointing a finger means you have three more fingers pointed back at you.” It's a group effort with different responsibilities within the - different responsibilities within the roles.

Jessica: I see this comment where someone says we intentionally tell staff we can't go around thinking “This can't happen here.“ That's powerful in itself because we all want to believe this will never happen here. We would never do this. But we have to remember, it can happen anywhere.

Ametta: Absolutely.

Jessica: We have to be really mindful about it.

Ametta: Yeah. Jessica let's talk about what's next here.

Jessica: I want to thank you all for spending your afternoon with us. During this webinar, Ametta and I shared resources and strategies that support the prevention of child incidents, and we hope that you found the process we went through today with root cause analysis helpful. We also hope you walk away with strategies that you can use to work together as a team, and also engage staff and methods to reduce child incidents.

As we close this session, if you could please share with us - we're going to go back to that chat one more time - if you could please share with us one more strategy, one or more strategies or resources mentioned today that you think you'll take back to your program, and you'll use it to support the systemic prevention of child incidents.

Ametta: Jessica, as people are doing that, I want to remind you of a couple of things. One, Bradley has dropped the folder with all of the resources. He’s dropped that link in the chat box. Please make sure that you do that. You can also, just use the QR code that is showing right now on the slide to access all of the materials that we have shared with you. Let's see, we are getting so many responses here. I'm going to try to see if I can -

Jessica: I see a lot of people really like the root cause analysis and the ladder of inference. I see quite a few people are going to read the book *Upstream*. It really is a great book.

Someone mentions that they're going to take all the information back to their staff, but they are going to begin with managers and work top to bottom to classroom staff. They're thinking about how do we include all levels of staff in this process.

Ametta: Another person said they're going to use the resources as we address incidents and prevention, i.e. the 11 Laws of Systems Thinking. You know, one of the things I know that, Jessica, we had so many wonderful resources as we were, you know, working to put all of this together. I'm glad that the ones that we did finally narrow down, that people are really enjoying them.