Child Safety in Substitute Care Independent Review

Comprehensive Assessment – *Draft Findings*

Prepared for the External Advisory Committee

By Public Knowledge, LLC

August 22, 2016

Public Knowledge LLC
Management Consultants

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I. INTRODUCTION – Overview

- Public Knowledge, LLC has completed the data collection for the comprehensive assessment phase of the Child Safety in Substitute Care Independent Review.

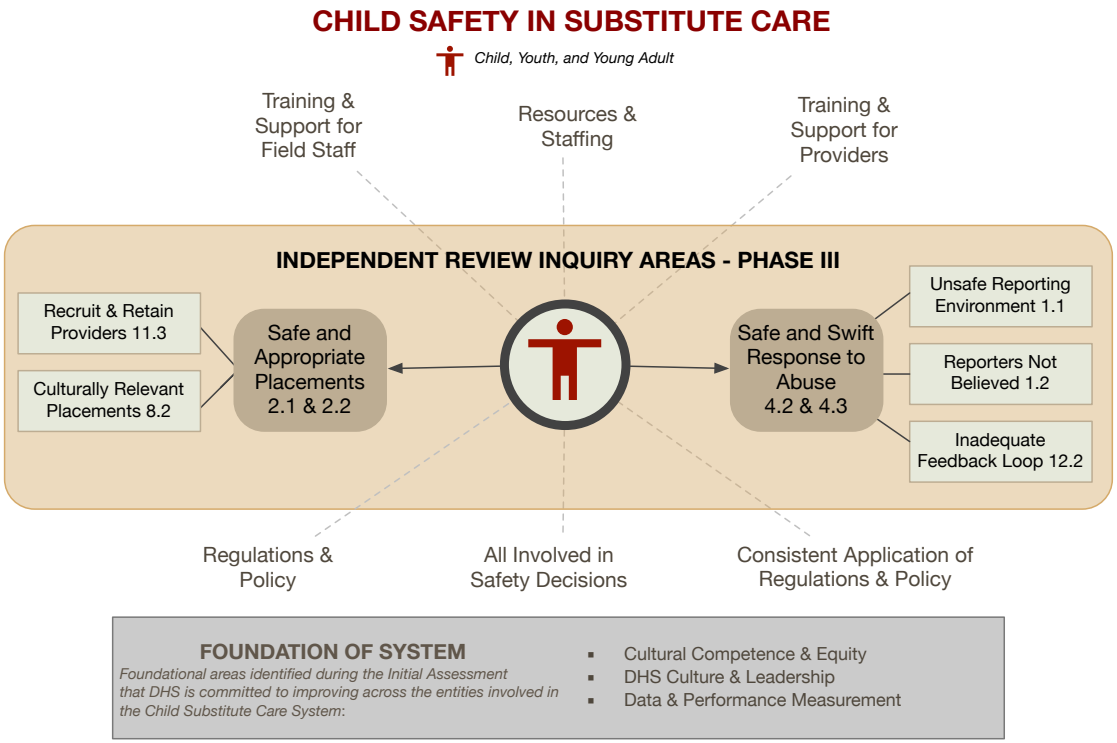
- This document presents draft findings and preliminary recommendations.

- The purpose of this document is to provide the External Advisory Committee members with early findings and analysis to facilitate input and feedback before finalizing the final report. The draft findings will also be fact-checked by subject matter experts where appropriate.
  - The Final Assessment & Review Report will be presented to the External Advisory Committee in September 2016.

I. INTRODUCTION – Scope

The scope of the Comprehensive Review is focused on areas of the System that are closest to the direct experience of children and youth living in substitute care: *where they live and what happens when they experience abuse in care*. See graphic below.

Each element of the System surrounding the child, youth, or young adult is integral to supporting their experience in substitute care. Those areas within the shaded box were the areas of focus for Public Knowledge during Phase III of this review. Areas outside the box are being addressed by DHS and other stakeholders, the work is captured in a separate workplan managed by DHS.



I. INTRODUCTION – Data Constraints

- Oregon currently has a disjointed data enterprise for tracking information about child and youth maltreatment in foster care. The current data system does not have advanced capabilities to share information, does not allow for trend identification, has limited quality assurance monitoring capabilities, and lacks an accountability system to ensure accurate safety determinations. In the absence of trustworthy data and observable trends, single incident cases and anecdotal information are driving decision making.

- Several separate data systems that are not interfaced and are of varying maturity levels are used across the System.

- We heard from review participants that the data systems are further limited by staff that do not input data accurately or in a timely manner, whether due to training, workload constraints, or other issues. We experienced this firsthand when analyzing data sets and noticing a number of "blank fields" or "unknown" data elements. This is consistent with what we have seen in data from other states' SACWIS systems.

- Participants in this review have varying degrees of trust about the reliability of the data obtained from DHS. The review team analyzed data obtained from the ORKIDS, ORLO, and OAAPI systems to support this review. However, alongside that data we also considered qualitative information gleaned from focus groups, surveys, and other means.

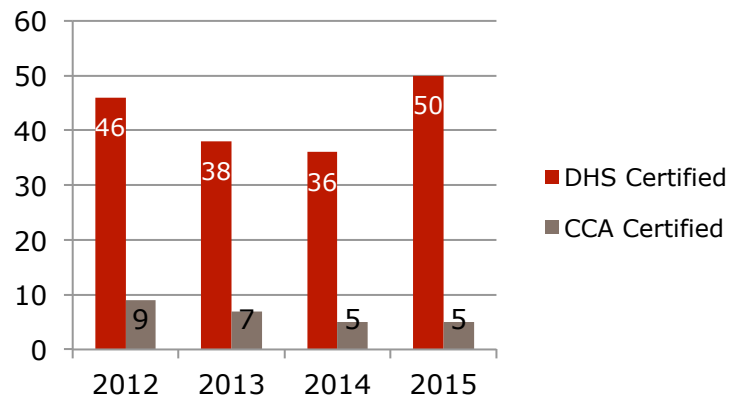
- Please see "Related Barriers" section starting on slide 58 for more on this topic.

I. INTRODUCTION – Overall Observations

- Over the last decade, particularly the past year, Oregon DHS has been increasingly in the news and criticized for its inability to keep children and youth in foster care safe.
  - Substantiated cases of abuse of children and youth under the care of DHS have been escalating: according to OR KIDS data, cases had dropped to 69 in and 63 in 2013 and 2014 respectively, and rose to 85 substantiated cases in 2015.
  - Oregon's foster children and youth experience higher than national rates of maltreatment in care. The national median is 0.35 and Oregon's median is 0.64. (2013 National AFCARS Data)

- Recent high profile cases of egregious abuse of children and youth in foster care have sparked multiple responses, including legislation. However, data collected for this review shows that the state needs to do more in the areas of DHS certified foster home placements.
  - Data obtained from DHS shows that a child is six times more likely to be abused in a DHS certified Foster home than a foster home contracted through a CCA. *See graph, right*

Substantiations of Abuse in Foster Home Care by Certification Type

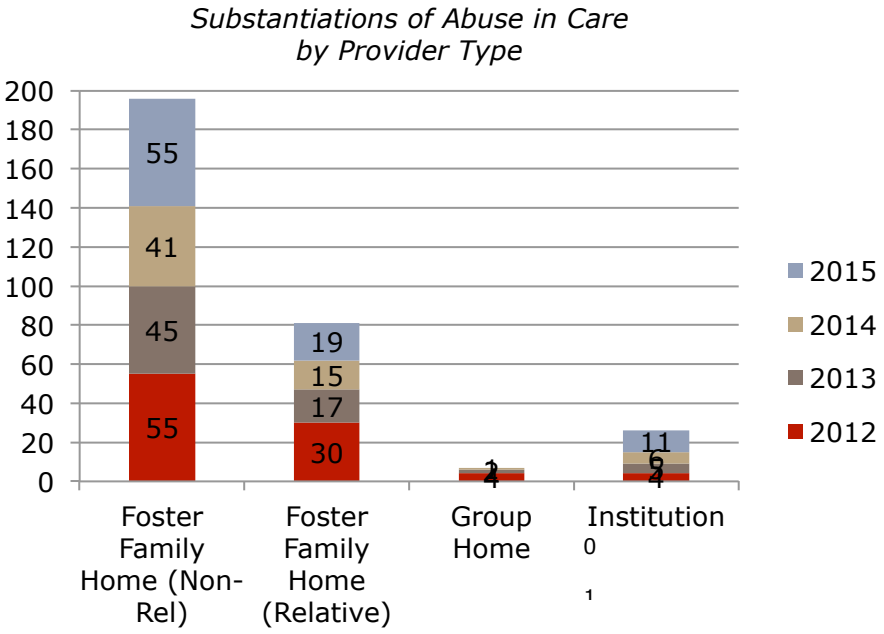


2016 PK Data Request from DHS.

I. INTRODUCTION – Overall Observations

- **SB 1515, passed in 2016 is designed to make residential care safer for Oregon's children and youth.** Indeed, the data shows that substantiated abuse in institutions is rising, from 4 cases in 2012 to 11 in 2015. This legislation heightens the focus and increases regulations for child caring agencies. Anecdotal information collected from advocates and legislators as part of this review points to the need to improve conditions and accountability within institutions, however the implementation of the bill has also led to increased pressure on child caring agencies, an increasingly adversarial relationship between agencies and DHS, and loss of high quality providers,

- **The state needs to focus its efforts next on foster homes**. According to data from DHS, abuse in care occurs significantly more often in non-relative foster homes than other types of placements. Lawsuits filed against DHS in the last 5 years that ended in an award or settlement of $50,000 or more corroborate the data. Of these 23 cases, 2 involved biological families, 2 involved a CCA, and the remaining 19 involved DHS certified foster homes.
  - Qualitative data collected for this review shows that foster parents need more skill building and ongoing support to serve the high needs children and youth in their care.



2016 PK Data Request from DHS

I. INTRODUCTION – Overall Observations

- While few participants in focus groups or surveys identified issues of equity or cultural competency as significantly contributing to safety in care, youth, providers; other advocates who have experienced this disconnection firsthand spoke passionately about the importance of addressing the issue.

- When the culture of a child or youth in care is not fully embraced and honored within their placement setting, it can contribute to psychological harm, placement instability, and even further trauma. This can manifest at several points in the System, from screening decisions to provider oversight to placement decisions.

- This set of draft findings does not include in depth analysis of the impact of cultural competency or related issues on child safety in substitute care. However, the independent review team concluded that the state needs to learn more about this issue as it works to mend the gaps in the system. The data shows that there is disparity in the system:
  - The rate of substantiations to the population of youth in care broken out by race, shows American Indian children are at the highest risk of maltreatment in care, almost twice as high as Caucasian, and African American children and youth are slightly more at risk than Caucasians. (2016 PK Data Request from DHS)
  - DHS does not collect data on sexual orientation or identity, although focus group participants highlighted these as important considerations for safety in care
  - DHS staff through the Internal Resource Committee, did report work being done in the areas of addressing implicit bias across the system

I. INTRODUCTION – Overall Observations

- Many focus group participants stated that DHS does not consider race, culture, or sexual orientation or identity in placement decisions. After analyzing data from focus groups, surveys, documentation, and data systems, it appears this is true. However, we were unable to get to the bottom of *why* this is true. Is is it simply due to the dearth of placement options across the board? Or does it point to gaps in the data collection, training, communication, and other areas? Cultural competency is woven throughout the DHS child welfare policy and procedure, but policy alone cannot address implicit biases that some staff and caregivers carry with them.

- The recent Task Force on Disproportionality Report goes in to detail about the disproportionality issues that Oregon is currently dealing with. There is no doubt that if a certain race or ethnicity is over-represented in the child welfare population, it will affect placements, safety, and response to abuse.

- We suggest that DHS consider the issue of disproportionality and cultural competency and use the results of the Task Force on Disproportionality Report in its work to address system gaps in the areas of *safe and appropriate placements* and *safe and swift response to abuse in care*.

II. METHODOLOGY

ASSESSMENT PROCESS

Activities	Outputs
Phase 1: Project Initiation (Feb-March)	
▪ Resource Identification ▪ Roles & Responsibilities Defined ▪ Scope Defined ▪ Vision Defined ▪ Advice from External Advisory Committee	▪ Purpose ▪ Vision ▪ Scope
Phase 2: Initial Assessment (March-April)	
▪ Regulatory Inventory ▪ Key Informant Interviews ▪ Collect Background Information ▪ Review Background Information ▪ Identify Inquiry Focuses	▪ Regulatory System Maps ▪ Initial Review & Assessment Report ▪ Inquiry Protocol
Phase 3: Comprehensive Assessment (April-August)	
▪ Focus Groups ▪ Stakeholder Groups ▪ Data Exploration ▪ Best Practices Research ▪ Analysis of Full Inquiry	▪ Final Review & Assessment Report with Findings, Best Practices, and Recommendations

Comprehensive Assessment Methodology

- Focus Group Facilitation & Analysis
- Survey Distribution & Analysis
- DHS Data Analysis
- Report & Documentation Review
- Regulatory Review
- Best & Promising Practices Research

II. METHODOLOGY

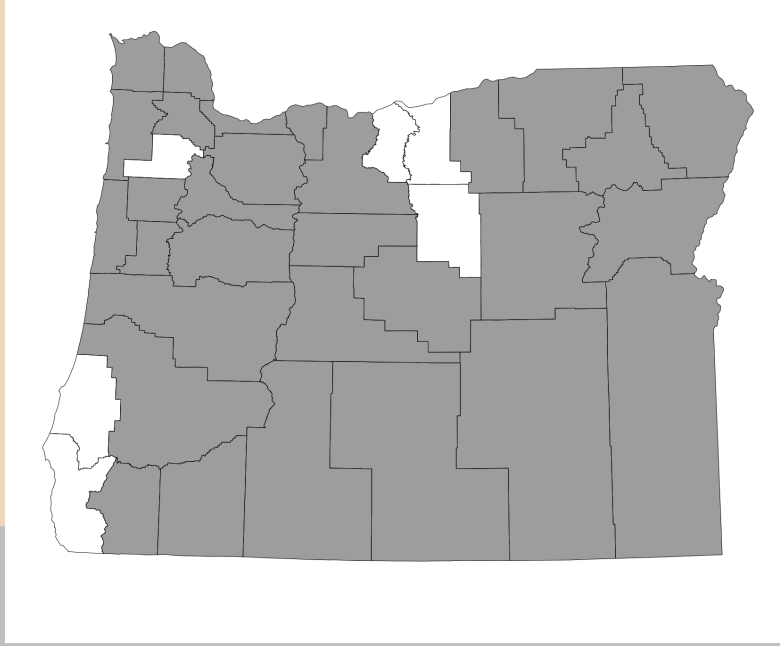
Comprehensive Assessment Methodology

Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research

Activities & Demographics:

Facilitated 13 focus groups and analyzed the information from the focus groups to pull overarching themes, similarities between groups, and differences between groups.

- Youth, 2 focus groups held, 17 total participants
- Foster Parents, 3 focus groups held, 22 total participants
- OLRO Licensing Coordinators, 1 focus group held, 2 total participants
- DHS Certifiers, 1 focus group held, 12 total participants
- Child Care Agencies, 1 focus group held, 13 total participants
- Citizen Review Board Staff, 1 focus group held, 10 total participants
- Court Appointed Special Advocates, 1 focus group held, 9 total participants
- Birth Parent Mentors, 1 focus group held, 10 total participants



Summary:

13 Focus Groups Held, 106 Total Participants

II. METHODOLOGY SO Add #s with %s pls DONE

Comprehensive Assessment Methodology

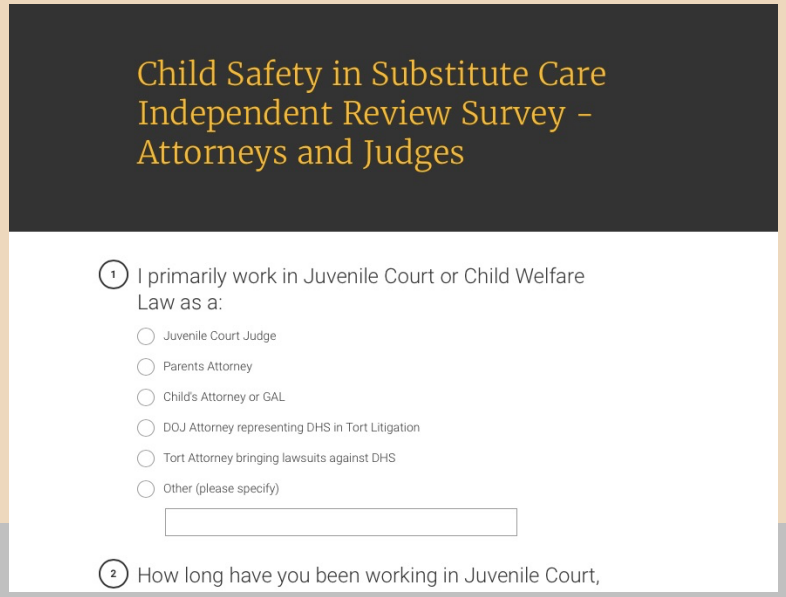
Focus Group Facilitation & Analysis	**Survey Distribution & Analysis**	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research

Activities & Demographics:

Distributed 7 surveys and analyzed the data from the surveys to pull overarching themes, similarities between groups, and differences between groups.

- Youth, snowball survey method (68 respondents)
- Foster Parents, snowball survey method (85 respondents)
- Attorneys, snowball survey method (48 respondents)
- Judges, snowball survey method (20 respondents)
- Caseworkers & Supervisors, 52% response rate (734 respondents)
- CPS Hotline Staff, 27% response rate (24 respondents)
- Child Caring Agencies, snowball survey method (13 respondents)

✓ 63% of attorney and judge respondents have been working in child welfare law for 10+ years
✓ Average number of years in care for youth respondents: 6.5
✓ 37% of youth respondents were in rural placements and 31% were in non-relative foster care
✓ 33% of caseworker & supervisor respondents have been working in child welfare 10+ years
✓ 24% of foster parent respondents live in rural areas


Child Safety in Substitute Care Independent Review Survey - Attorneys and Judges

1 I primarily work in Juvenile Court or Child Welfare Law as a:

- Juvenile Court Judge
- Parents Attorney
- Child's Attorney or GAL
- DOJ Attorney representing DHS in Tort Litigation
- Tort Attorney bringing lawsuits against DHS
- Other (please specify)

2 How long have you been working in Juvenile Court,

Summary:

7 Surveys Distributed, 992 Total Participants

II. METHODOLOGY

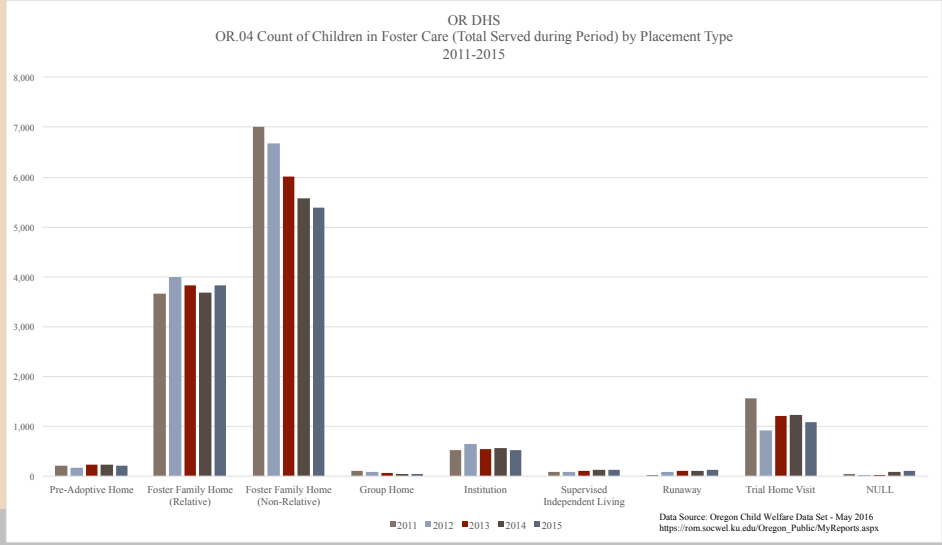
Comprehensive Assessment Methodology

Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research

Activities & Demographics:

Requested and analyzed data from DHS on identified potential gaps. Topics included:

- Demographics of youth in substitute care
- Placement type for youth in substitute care
- Time in care
- Reports of allegations of abuse in care
- Demographics of youth subject to reports
- Provider capacity
- Level of need
- Placement stability
- Abuse in care allegations
- Resolution of abuse in care allegations
- Caseworker caseloads
- Net loss and gain of providers
- Allegations screened in and out



Summary:

Data analyzed, summarized, and included with findings

II. METHODOLOGY

Comprehensive Assessment Methodology

Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research

Activities & Demographics:

Researched, reviewed, and summarized applicable sections of reports and documentation. This included:

- Child and Family Services Review Documents
- Task Force Reports
- Annual Progress Reports
- Committee Reports
- Major Litigation - past 5 years, $50,000 + award/settlement
- Program Improvement Plans
- Recruitment & Retention Plans
- Various applicable reports
- Child Welfare Data Book
- Audits
- IV-E Program Improvement Plan
- Critical Incident Report
- Workgroup Reports
- Procedure Manuals
- Training Curriculum (applicable)
- Screening Protocols

Background Documents: High Level Summary

YELLOW = Relevant Document
GREEN = Data/resources
BLUE = Recommendations/corrective action
PURPLE = Both data/resources and recommendations/correction action

	Document	Overview	Response to Abuse	Licensing & Certification	Training & Support	Accountability & Communication	Workforce	Cultural Responsiveness
Audits & Reports								
1.	2014 Child Welfare Data Book	OR DHS report on statistics of children in foster care	3 years of statistics on reason children enter foster care		3 years of statistics on stability while in foster care (# of placements)			3 years of data of ethnicity of children in foster care, includes ICWA children
2.	2015 Home Study Audit	OR home study findings		Need outside verification (therapist, counselor) to verify mitigation factors			Need outside verification (therapist, counselor) to verify mitigation factors	
3.	Governor's Budget	2015-2017 Budget, includes budget for DHS			$470.1 million General Fund, $938.4 million total funds for child welfare. Details what $ will support.	Part of budget allocated to keep children safe; meet foster reduction targets; implementation of SB 967	Part of budget allocated to add positions for research and positions to support Child Welfare work	
4.	GUTD Licensing Audit (2016)	Audit of licensing requirements for GUTD foster agency		GUTD had inadequate policies, non-compliance for unreasonable time,		OR laws should be strengthened to ensure safety & increase solvency		

Summary:

Researched, reviewed, and summarized applicable documentation and reports from 2002 - 2016

II. METHODOLOGY

Comprehensive Assessment Methodology

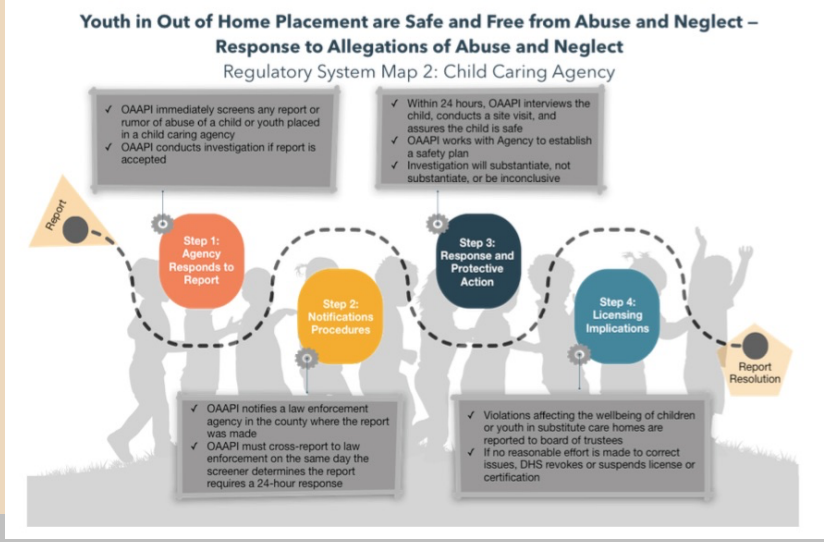
Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research

Activities & Demographics:

Researched, reviewed, and inventoried state and federal regulations applicable to the assessment scope. This included:

- 7 high-level graphic system maps for the three domains of the Child Substitute Care System,
- one-page summaries for each system map
- a full authority inventory (this table includes all the authorities used for the maps, and includes which domain it informs, the authority type, a quick summary, and the full citation)

✓ The maps were used to confirm assessment team knowledge of regulations
✓ The maps were used with initial assessment participants to confirm scope
✓ In the comprehensive assessment (phase III) the regulatory inventory was used to confirm knowledge of processes and procedures, and document gaps



Summary:

7 system maps, full regulatory inventory, and detailed gaps for areas in scope

II. METHODOLOGY

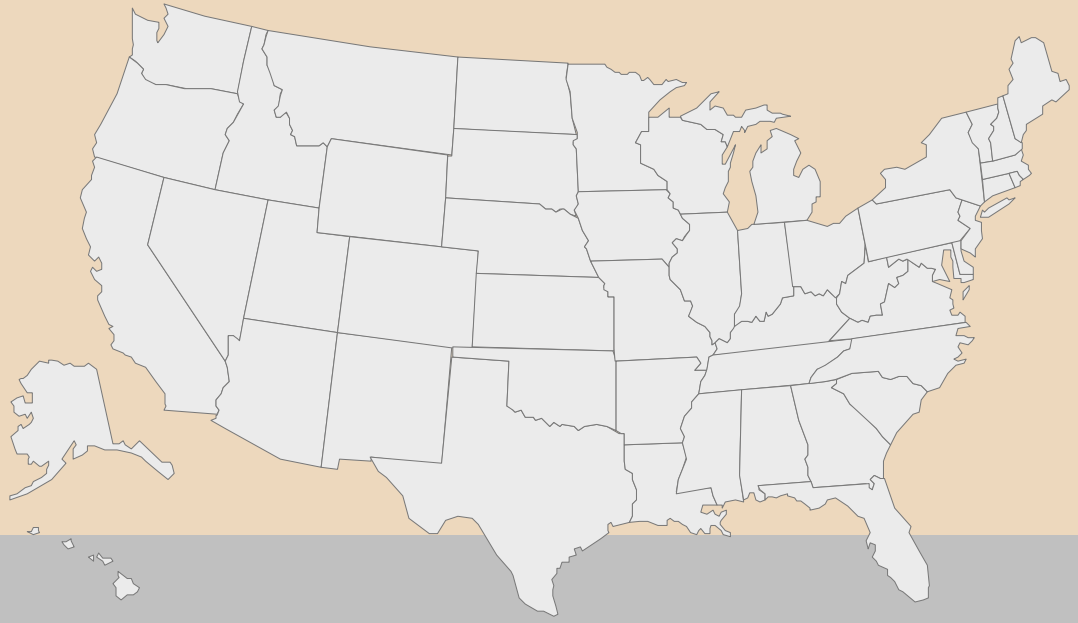
Comprehensive Assessment Methodology

Focus Group Facilitation & Analysis	Survey Distribution & Analysis	DHS Data Analysis	Report & Documentation Review	Regulatory Review	Best & Promising Practices Research

Activities & Demographics:

After identifying the assessment findings, the independent review team undertook an effort to identify recommendations and research best and promising practices from across the country.

- Identified findings
- Provided recommendations
- Researched best and promising practices
- Researched regulations in other states



Summary:

Research and recommendations for all findings

III. GUIDING PRINCIPLES

The independent review team used the following guiding principles to develop and document the draft findings presented in this document:

- Connect all findings and recommendations to child and youth safety in care.
- Be guided first and foremost by the youth experience.
- Prioritize what's most important for the state to address. Don't provide a laundry list of problems.
- Start with facts and data where possible, corroborate with qualitative data.
- Participants' experience with or perceptions of the Child Substitute Care System is as critical as what the data says.
- Focus on why each finding matters to safety in care.
- Every deficiency or gap in the System is an opportunity for improvement.
- Strengths or positives in the System may be footholds for solutions.
- For the purposes of this review, child and youth safety is defined as follows:
  - *Child & Youth Safety is the state of being free from abuse and neglect*. Abuse means any of the following: physical injury caused by other than accidental means; mental injury caused by cruelty including verbal harassment, threats, and seclusion; sexual abuse or exploitation; and abandonment. Neglect is the failure to provide the care necessary to maintain physical and mental health.

  Abuse and neglect are defined by Oregon Statutes in the Juvenile Chapter (419B.005), and in Child Welfare Services Chapter (418.205, definition of abuse recently added by Senate Bill 1515).

  This review considered child and youth safety from the child and youth perspective and through an equity lens to eliminate disproportionality and disparate treatment.

IV. KEY TERMS

Term	Definition
Allegation of Abuse	An oral report of child abuse to a local office of the Department of Human Services, to the designee of the department or to a law enforcement agency within the county where the person making the report is located at the time of the contact. Abuse includes assault, mental injury, rape and sexual exploitation, negligent treatment, unlawful exposure to controlled substances, etc. as defined in ORS 419B.005.
BRS	Behavioral Rehabilitation Services (BRS) is a program that provides services and placement related activities to the BRS client to address their debilitating psychosocial, emotional, and behavioral disorders in a community placement utilizing either a residential care model or therapeutic foster care model.
Child Caring Agency	Any licensed agency, private school, or private organization (including institutions and group homes) providing day treatment for children with emotional disturbances; adoption placement services; residential care, including foster care or residential treatment for children; residential care in combination with academic education and therapeutic care, including but not limited to treatment for emotional, behavioral, or mental health disturbances; outdoor youth programs; and other similar services for children. A child caring agency does not include residential facilities or foster care homes certified or licensed by the DHS for children receiving developmental disability services. Child Caring Agencies are licensed by the Department of Human Services, Office of Licensing and Regulatory Oversight, and some contract with professional foster homes.
Critical Incident	A fatality or a serious injury where child abuse or neglect is suspected or any other child abuse or neglect event or situation designated by the DHS Director for which the consequences of a Critical Incident review process are likely to increase child safety.
DHS Certified Foster Home	A foster home maintained by a "certified family" caring for a child under the age of 21 years unattended by the child's parent or guardian, providing the child with care, food, and lodging.
Foster Care	A temporary living arrangement for children who need a safe place to live when their parents or guardians cannot safely take care of them. Types of foster care include relative foster care, in which a child is placed with a relative; child-specific foster care in which an individual or family becomes certified to care for a specific child, usually known to them in their community; and general foster care in which children are placed in with non-relatives. Foster care includes placement in a certified relative or foster family home or other child caring institution or facility. This report uses the terms "substitute care" and "foster care interchangeably".

IV. KEY TERMS – (continued)

Term	Definition
Group Home	A licensed or approved home providing 24-hour care for children in a small group setting that generally has from seven to twelve children. See "Child Caring Agency." Child Caring Agencies are licensed by the Department of Human Services, Office of Licensing and Regulatory Oversight.
High Needs	For the purposes of this assessment "high needs" includes children and youth with behavioral health or physical health issues; "intensive" authorized levels of care, which dictates the amount of foster care payments; challenging diagnoses, behaviors, and other characteristics whose placements break down frequently and require new placements frequently; and/or has needs that drive foster care and health costs. In this context, "frequently" means more than the average number of broken down placements and new placements for children in foster care who do not have special physical, emotional, behavioral, medical, or other special needs. There is no universal definition of "high needs" pertaining to Child Welfare. This definition was adapted from: The Stephen Group's report "Meeting the Needs of High Needs Children in the Texas Child Welfare System."
Institution	A licensed child care facility operated by a public or private agency and providing 24-hour care and/or treatment for children who require separation from their own homes and group living experience. These facilities may include child care institutions, residential treatment facilities, maternity homes, etc. Oregon Revised Statutes includes "institution" under laws pertaining to Child Caring Agencies. However, federal law uses the term Child Care Institutions. In some places the ORKIDS data uses the term "institution" when tracking data, which refers to the federal definition, plus hospital-like settings. Child Caring Agencies (and institutions) are licensed by the Department of Human Services, Office of Licensing and Regulatory Oversight. See "Child Caring Agency."
Substitute Care	The out-of-home placement of a child or young adult who is supervised by the DHS or other agency, including placement in a certified relative or foster family home or other child caring institution or facility. This report uses the terms "substitute care" and "foster care interchangeably".

V. DRAFT FINDINGS – Overview

Safe and Appropriate Placements

1. More Appropriate Placements Could Prevent Abuse of Children and Youth in Foster Care

1.1 Space availability drives placement decisions, rather than the needs of foster children and youth.

1.2 Oregon's placement capacity for high-needs children and youth is shrinking.

1.3 The urgency to find placements compromises certification and licensing standards.

1.4 Foster care providers are not adequately trained or supported to safely care for children and youth with high needs placed with them.

Safe and Swift Response to Abuse in Care

2. A Coordinated Response to Abuse in Care Could Lead to Earlier Intervention and Prevention of Future Abuse

2.1 Oregon has two definitions for abuse in care and does not handle incident reports differently from abuse allegations.

2.2 The current abuse in care reporting, screening, and investigation process is localized and may result in inconsistent responses.

2.3 The current system of abuse in care reporting is rated untrustworthy by youth and other reporters.

2.4 There is little to no follow-up on abuse in care investigations.

2.5 Information that could mitigate safety concerns is not efficiently shared between entities.

1. MORE APPROPRIATE PLACEMENTS COULD PREVENT ABUSE OF CHILDREN AND YOUTH IN FOSTER CARE

This document presents draft findings and preliminary solutions developed during the comprehensive review phase for the purposes of feedback and fact checking.

APPROPRIATE PLACEMENTS - Summary

- One cause of abuse in care stems from placing children and youth with caregivers who are over capacity, not qualified to meet their needs, or not supported by the state. Data collected for this review shows that inappropriate placements may result from scarcity of placement options, fewer placement options for high needs youth, and inadequate or no training or support for caring for high needs foster children and youth.
- High-needs children and youth are among the most vulnerable children within the substitute care system, yet they have limited safe placement options available to them. The lack of options leads to a higher rate of improper placements with foster care providers who are not equipped to care for these youth.

"The Department at times struggles with appropriate placement matching due to the complexities of children's needs and the limited capacity of the number of providers. Although there may be certified homes, there are times when homes are not available for children with complex behavioral or health care needs." (2015 CFSR, Pg 50)

APPROPRIATE PLACEMENTS - Impacts

- Risk of abuse is elevated if children or youth are placed with a foster care provider unable to meet their needs.
- A high needs foster child or youth combined with a foster care provider without the skills to safely meet his or her needs, may increase the likelihood that abuse will occur in that placement setting.
- Due to the limited and decreasing number of qualified appropriate placements for high needs children or youth (such as BRS placements), regular foster homes are increasingly being asked to take them in, but with limited skills and support to do so safely.
- If a foster provider is over capacity, or is caring for more children or youth than certified, licensed, or qualified for, safety risks increase for all residents of the placement setting.
- Desperation for placements appears to be increasing the risk of DHS certifying foster homes where abuse is more likely to occur.

APPROPRIATE PLACEMENTS - Findings

Finding 1.1

Space availability drives placement decisions, rather than the needs of youth.

- Appropriate placements for children and youth in foster care are not consistently available. Focus group and survey results highlight the desperation of caseworkers to find appropriate placements for children and youth. *See Word Cloud, right*
- Oregon does not use an assessment tool to identify level of care need for youth and level of care provided by caregivers. Therefore, no data is available to show need and availability for each placement level or type.
- The 2011 Sensitive Review Committee Report found that, "Planful foster care placement to ensure stability often does not occur, primarily because of limited capacity and limited access to specialized training for foster parents and relative caregivers." (2011 Sensitive Review Committee Report, Pg 5)
- During the timeframe of this review, news articles have reported issues of space availability: "DHS officials told FOX 12 that on average, six foster children a week state-wide spend at least one night in a hotel or child welfare office." (Kaitlyn Bolduc "'Crisis' in Oregon foster care system" August 8, 2016)

What happens if there is no available foster home with proper training to take in a high needs child or youth?

Word Cloud from open-ended responses (Caseworker & Supervisor Survey)

APPROPRIATE PLACEMENTS - Findings

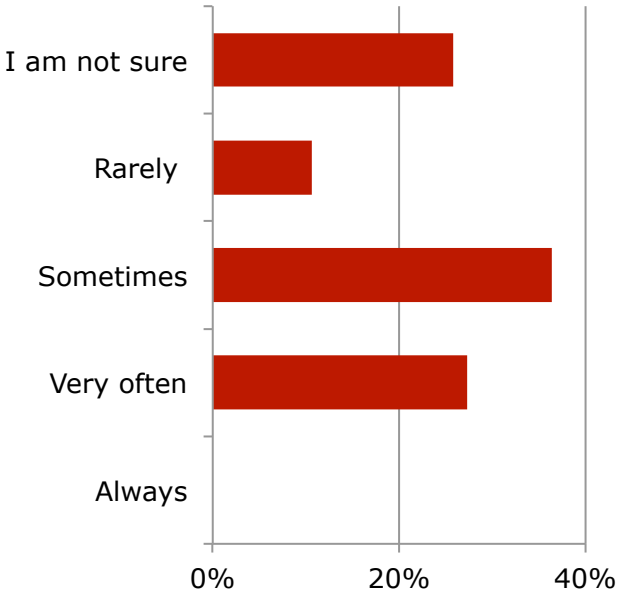
Finding 1.1 (continued)

Space availability drives placement decisions, rather than the needs of youth.

- Oregon does not use an assessment tool to determine the needs of children and youth, and therefore cannot match foster children or youth to the qualifications of caregivers.
- There appears to be a disconnect between the intent of policy and the application of assessment tools, from initial assessment through case management. Appropriate placements are dependent on a complete assessment of child and family's needs and strengths.
  - The Department recognizes the importance and role of assessment as evidenced and woven throughout the DHS Child Welfare Manual as well as articulated in the 2007 Children's Wrap Around Initiative, but the consistent application of policies and procedures is not evident.
  - Oregon uses the The Child and Adolescent Needs and Strengths (CANS) Assessment to determine foster care payment rates, not the level of care the child or youth needs to receive.
- The most recent CFSR Self Assessment identified lack of resources as a driving factor in placement decisions, stating that, "Waiting lists for needed services often result in children getting served by the first available resource rather than the most appropriate resource." (2015 Self Assessment Pg 128)
- DHS Foster Home certifiers reported in a focus group that DHS is not currently capable of matching children's needs with qualified foster home placements to meet those needs, due to limited availability of qualified foster home placements.
- 67% of foster parents surveyed said the needs of foster children and youth are not matched to providers' qualifications.
- Over 60% of attorneys and judges surveyed note that abuse in foster care is sometimes or very often related to a child or youth being placed in the wrong level of care for their needs. *See graph, next slide*

Finding 1.1 (continued) Space availability drives placement decisions, rather than the needs of youth.

When abuse occurs in foster care, how often is the abuse related to a child or youth being placed in the wrong level of care for their needs?



Attorney and Juvenile Judge Survey results

APPROPRIATE PLACEMENTS - Findings

Finding 1.2

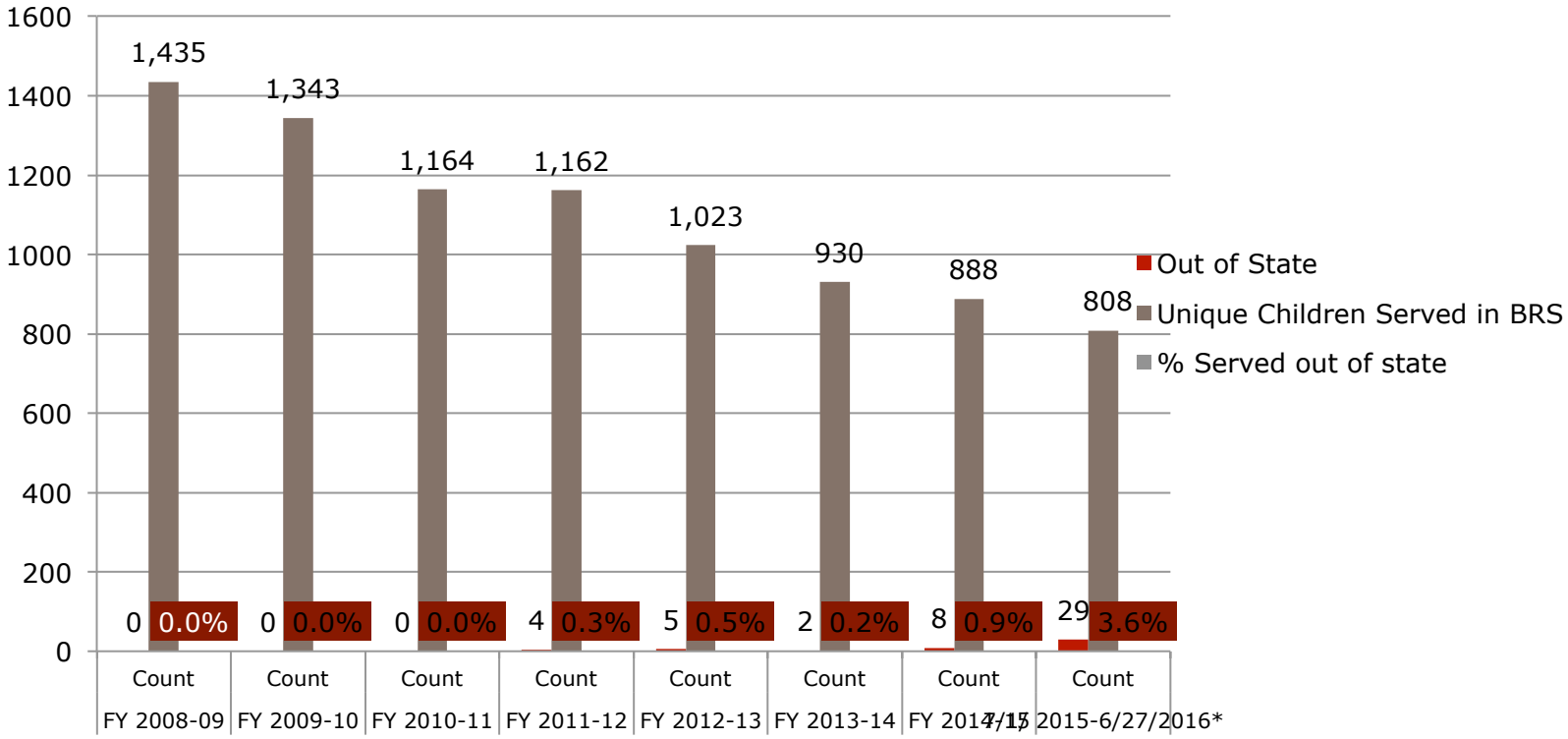
Oregon's placement capacity for high-needs youth is shrinking.

- High needs is defined as: children and youth with behavioral or physical health issues; "intensive" authorized levels of care, which dictates the amount of foster care payments; challenging diagnoses, behaviors, and other characteristics whose placements break down frequently and require new placements frequently; and/or has needs that drive foster care and health costs.
- Residential bed capacity for high needs children and youth appears to be steadily declining and has decreased 12% just over the past year. *See graph, next slide*
- The need for high intensity placement settings remains higher than what can be met by Oregon's in-state resources. While the number of youth in BRS placements is decreasing, the number of youth placed in an out-of-state high level of care placement is increasing. *See graph on next slide.* Sending children and youth out of state for services removes them from their community and support system and is expensive for the state.
- Multiple recent reports and reviews agree that Oregon's placement capacity, especially for high needs children and youth is inadequate to meet the need:
  - [DHS] Child Welfare may not be adequately assessing the capacity of programs to provide services for high-needs children and the appropriateness of those services. (CIRT Review 2012-2014, Pg. 2)
  - "For youth crisis, more foster beds are needed." (Juvenile Department Survey, Pg 11)
  - "Children with multiple handicapping conditions are difficult to place and provide with comprehensive services." (OR Assessment, Pg 128)
- 88% of attorneys and judges surveyed see placements that exceed providers' capacity, and 65% have seen caregivers not having sufficient training to care for the needs of foster children and youth in their care.

Finding 1.2 (continued) Oregon's placement capacity for high-needs youth is shrinking.

Number of Children in BRS Placements is Decreasing,

but Number of Children Placed Out of State is Increasing



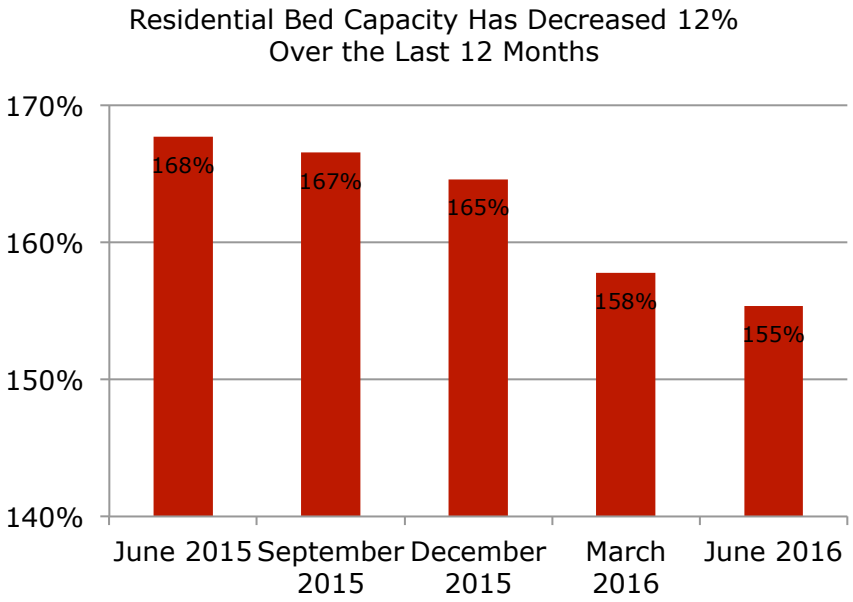
2016 PK Data Request from DHS

APPROPRIATE PLACEMENTS - Findings

Finding 1.2

Oregon's placement capacity for high-needs youth is shrinking.

- While survey and focus group respondents reported "high" or "very high" needs for all levels of foster care in Oregon, they rated the need for BRS placements the highest need. Review participants reporting this need include: foster parents, DHS caseworkers and supervisors, staff of Child Caring Agencies, Citizen Review Board staff, CASAs, and OLRO licensing coordinators.
- A 2015 report noted that placement compression can lead to high needs youth being placed inappropriately, which can lead to negative outcomes, including safety issues: "A lack of psychiatric services, residential beds and crisis placements has led to youth being held in less than ideal settings, such as detention or in hospitals. These settings are ill equipped to help youth with significant needs, many of whom have suffered abuse, neglect, and trauma. These settings can exacerbate underlying trauma, are expensive, and are not conducive to producing positive outcomes." (2015 Final Report from Juvenile Justice Mental Health Task Force, Pg 1)



2016 PK Data Request from DHS.

APPROPRIATE PLACEMENTS - Findings

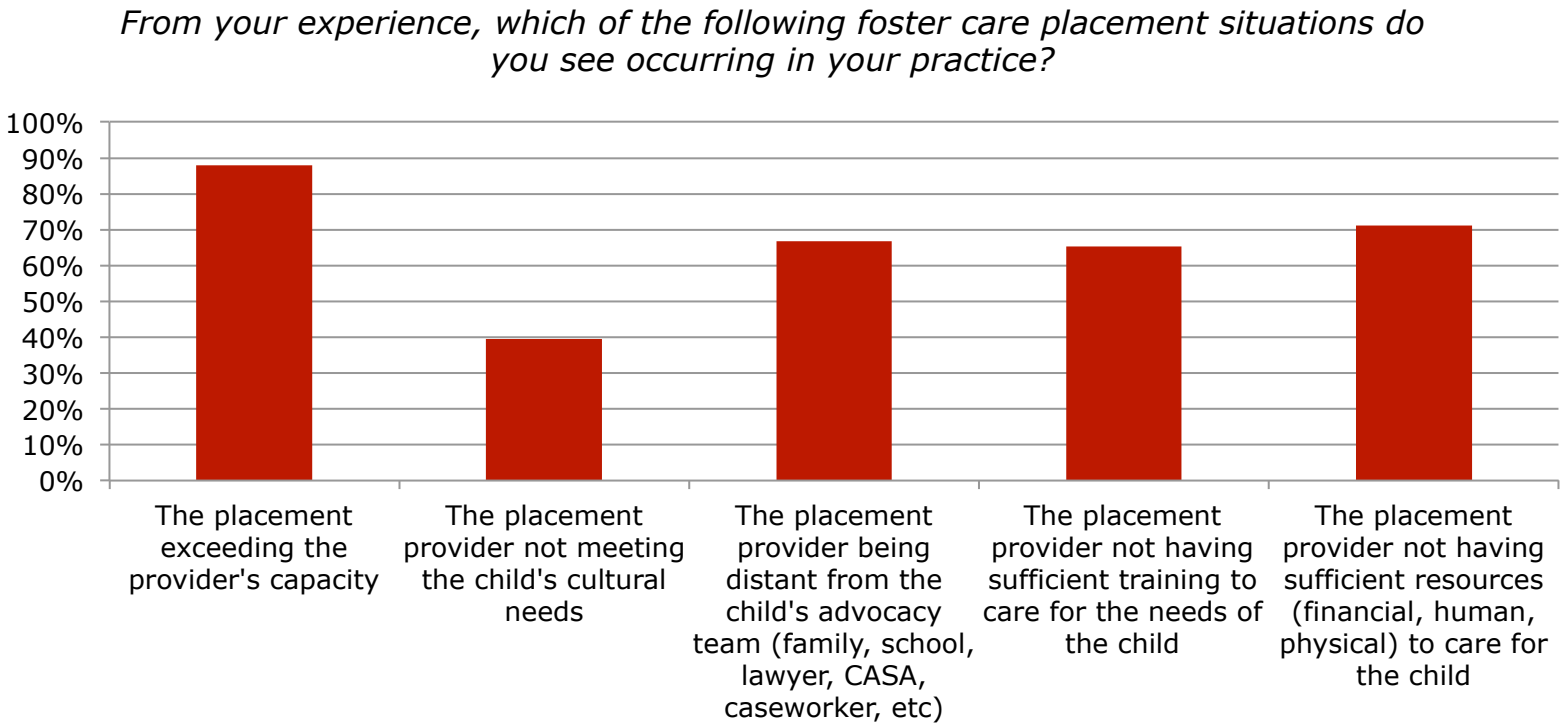
Finding 1.3

The urgency to find placements compromises licensing standards.

- DHS case workers ask foster care providers (both licensed CCA providers and DHS certified foster homes) to take in children and youth that would exceed the foster home's certified or licensed capacity, with some regularity.
  - Almost 90% of attorneys and judges surveyed for this review reported that they see this occurring in their practice. *See graph, next slide.*
  - Over half of the DHS certified foster homes and CCAs surveyed report they have been asked to take in more children or youth than they are certified to care for, with some frequency. *See graph, next slide*
- In many cases, foster homes are being asked to care for foster children or youth with a higher level of need than the foster home is comfortable or certified to provide. *See finding 1.4*
- According to foster parents in focus groups, placing children and youth in foster placements that exceed the licensing and certification capacity or qualifications compromises the caregivers' ability to safely oversee all the youth in their care. Focus group participants reported that a compromised ability to safely supervise the youth in their care can lead to abuse, often between children or youth in the placement.
- Focus group respondents reported that foster home certifiers are being pushed to certify more homes more quickly. They estimate that exceptions to certification requirements are used in a majority new homes opened, mostly for relatives providing emergency foster care.
  - Certifiers and other review participants also cite the exception process as a strength of the System, enabling more culturally relevant and relative caregivers to be certified.
  - There is some evidence that disproportionality in the System may be partially addressed with the flexibility to certify relative caregivers, another benefit of the exception process.

Finding 1.3 (continued)

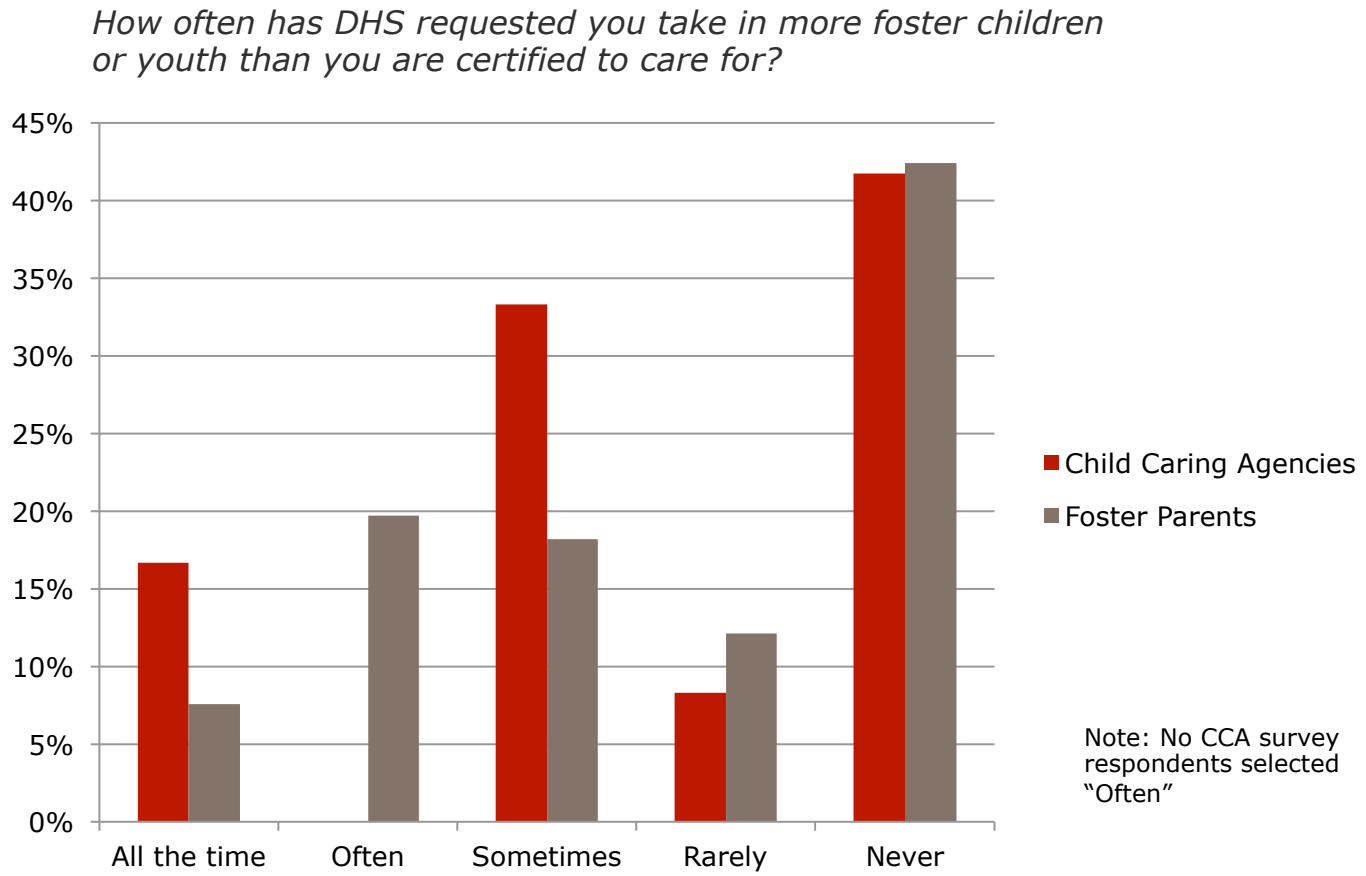
The urgency to find placements compromises licensing standards.



Attorney and Juvenile Judges Survey Results

Finding 1.3 (continued)

The urgency to find placements compromises licensing standards.



Foster Parents and Child Caring Agencies Survey Results

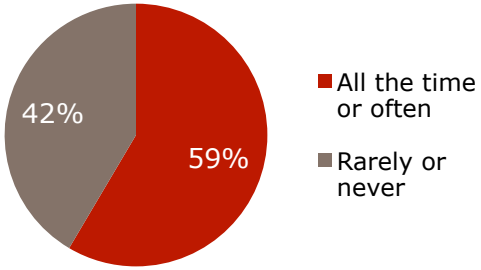
APPROPRIATE PLACEMENTS - Findings

Finding 1.4

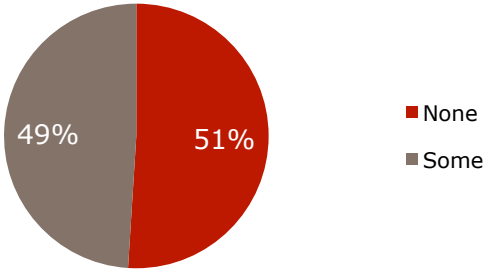
Foster care providers are not adequately trained or supported to safely care for children with high needs placed with them.

> "The level of care of kids that are entering our homes is much higher than we are prepared for or trained to take on."
> – *Foster Parent Focus Group Participant*

- DHS is placing high needs children and youth with foster parents who don't necessarily have the skills or training to care for them.
- Foster parent focus group participants indicated almost unanimously That they do not have the training to safely care for high needs children and youth. This was rated slightly better by the CCA foster parents than the DHS foster parents in focus groups.
- 50% of child caring agencies surveyed report the children and youth placed in their care need a higher level of care than they are able to provide.
- Over 50% of foster parents surveyed report frequently caring for high needs foster children or youth, and over 50% also report receiving no specialized training to care for high needs children and youth. This was corroborated by focus groups with foster parents. See graphs, below:



Foster Parents Survey Results
Question: *How frequently do you care for high needs children or youth?*



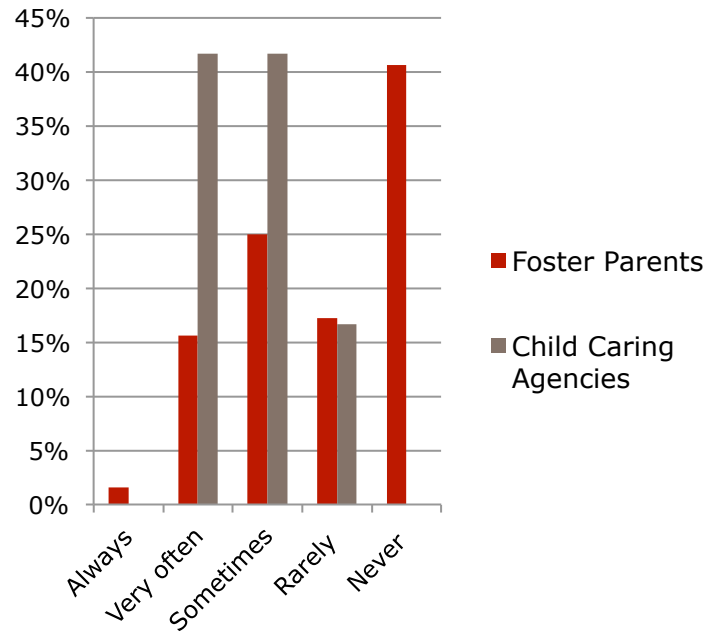
Foster Parents Survey Results
Question: *How many hours of specialized training did you receive to care for high needs children or youth?*

APPROPRIATE PLACEMENTS - Findings

Finding 1.4 (continued)

Foster care providers are not adequately trained or supported to safely care for children with high needs placed with them.

- Foster parent focus group participants indicated that caseworkers often give incomplete information about children and youth placed in their homes. This could be because they don't know the child, or they may be highlighting their strengths and downplaying their challenges in order to place them. While this may be well-intentioned on the part of the caseworker, the foster parent may not know the true needs of the child, increasing the challenge of safely caring for these children or youth.
- The most recent CFSR Self Assessment corroborates the data collected from this review: "foster parents are not equipped to meet the special needs of the child, lack of available child care, may be filled beyond capacity, or may lack local resources to meet the level of support needed for the child." (2016 CFSR Self Assessment)
- Both DHS certified foster parents and representatives of licensed child caring agencies report being asked to care for children and youth for whom they do not have the right skills or training to serve. *See graph, right*



Foster Parents and Child Caring Agencies Survey Results
Question: ***How often has DHS requested you take in children or youth with needs you are not certified to care for?***

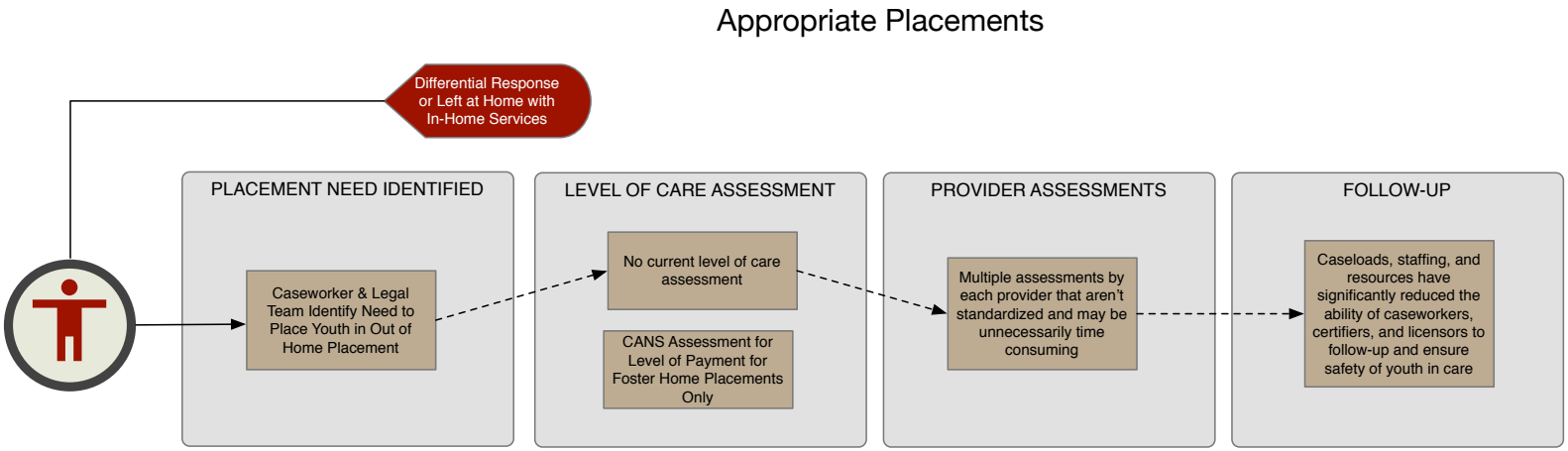
APPROPRIATE PLACEMENTS - Recommendations

NOTE: the recommendations listed below are preliminary high level solutions. The review team will be providing additional detail and resources in the Final Report.

- Adopt a policy and process to appropriately place foster children and youth with caregivers who can provide the appropriate level of care. It is unclear what the process is now other than space availability or crisis decision. *See as-is and to-be maps on next slides*
- Review provider rates and make sure they are commensurate with the services they are being asked to provide.
- Develop a larger pool of therapeutic settings appropriate for the needs of youth in crisis, with intensive behavioral needs, with assault records, or other special needs.
- Develop mitigating protocols for instances when an appropriate placement for a high needs youth isn't readily available
- Adopt a proven assessment tool and process for assessing a level of care for the youth and the level of care the provider can provide so they can appropriately match needs with qualifications
- Consider implementing a community – based wraparound model of foster care, such as the Mockingbird Family Model
- Ask foster parents what training they need and design training delivery around what works for those foster parents
- Establish and support regional foster parent support groups
- Provide Undoing Racism training for foster parents and caseworkers to reduce chance of safety issues related to cultural issues and/or better understand children's behaviors in a cultural context.
- Provide training for foster parents and caseworkers on serving children and youth who identify as LGBTQ.
- Focus recruitment efforts in the LGBTQ community, and communities of color.

APROPRIATE PLACEMENTS – As Is Process

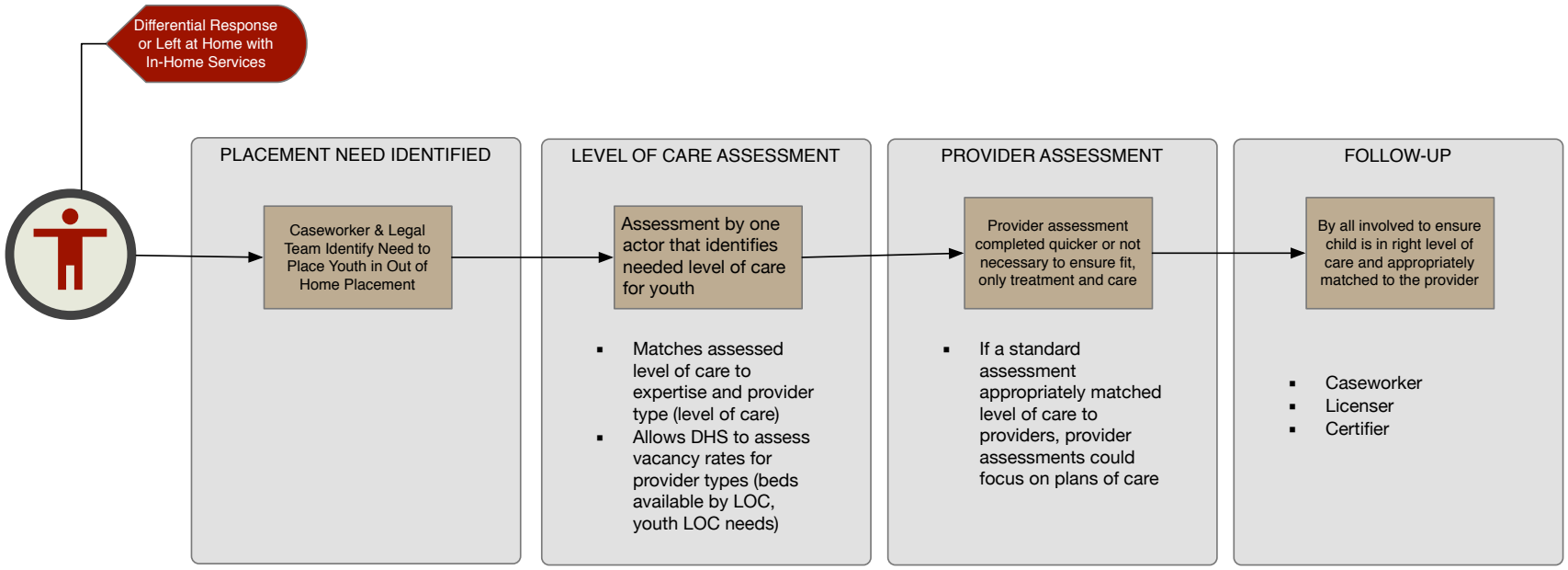
Current Process, No Level of Care or Provider Assessments



Broken lined arrows indicate unknown or little process

APROPRIATE PLACEMENTS – To Be Process

Possible To- Be Process, Use of Level of Care and Provider Assessment



2. A COORDINATED RESPONSE TO ABUSE IN CARE COULD LEAD TO EARLIER INTERVENTION AND PREVENTION OF FUTURE ABUSE

This document presents draft findings and preliminary solutions developed during the comprehensive review phase for the purposes of feedback and fact checking.

COORDINATED RESPONSE - Summary

- There are different definitions of abuse, reporting requirements, and response protocols for children in DHS certified foster homes and those residing in licensed Child Caring Agency (CCA) facilities and foster homes. Youth in the custody and protection of DHS who have experienced abuse in care receive different treatment and response based on the foster provider they are placed with.
- Administrative systems do not adequately coordinate the results, findings, and consequences of safety allegations in substitute care.
- No single entity within DHS is responsible to ensure that the response to an allegations of abuse in substitute care is thorough, accurate, and consistent.
- Several administrative bodies have responsibility and authority when a potential instance of abuse in care is reported: DHS hotlines in each District, or OAPPI concludes whether or not the allegation is founded; OLRO enforces licensing or provider support implications; District case managers follow-up on the child's needs, including placement changes, notification of the child's advocacy circle (e.g., CASA, therapist), and updates to the case plan as needed. We have heard from assessment participants that throughout the process there is an inconsistent effort to engage the appropriate entities (including entities internal and external to DHS), share relevant information, and agree on follow-up actions to either interrupt the harm that has occurred or prevent further escalation of risk in the future. In contrast to the intention of the Oregon Safety Model, this system puts children and youth already in the custody of the department at the mercy of "falling through the cracks" of an overly complicated, disorganized system.
- Some examples of insufficient communication include: there is no accountability system to coordinate and ensure certification standards are applied equally, there is no reliable source or data system across programs for staff to determine the status of certification, there are inconsistencies between documentation in certification and adoption files, and there is no way to track abuse trends per provider.

COORDINATED RESPONSE – Impacts

- Children and youth experience abuse or neglect the same, regardless of where they live, but the response they experience may be different depending on their placement and caregiver.
- Because the system is disjointed, not coordinated, and minimal follow-up is conducted, there is no effective way to ensure that cases and abused children do not "fall through the cracks."
- Often the wrong allegations are investigated and the ones that should be investigated are screened out. For example, according to Oregon's most recent CFSR Self Assessment, "in some cases of maltreatment in foster care, there were previous calls [about the case] that were closed at screening or assessed and had a disposition of 'unable to determine.'" (2016 CFSR Self Assessment. Pg 16)
- In addition, there have been at least six lawsuits against DHS that involve multiple reports of abuse that were closed at screening or never fully investigated. This resulted in abuse escalating undetected to an extreme and sometimes deadly level.
- The Department's complex and disjointed system made up of families, process, policy, and implementation puts children and youth at risk by increasing the likelihood that important facts about safety in care will be overlooked and critical decisions to protect foster children and youth will not be made.
- Findings of abuse are siloed. Isolated communication of crucial facts can lead to safety risks. For example, some cases of abuse and neglect have occurred in provider homes that were never fully investigated prior to certification, according to focus groups and our review of the 23 high settlement cases over the past 5 years. Other cases of abuse and neglect occurred in provider homes where reports were not accurately documented and spread over several years.
- When allegations of abuse are confirmed, there is a gap in the system as to who receives this information. Essential channels of communication don't include all entities who need to know, which leads to duplicate reports and less accountability.

COORDINATED RESPONSE - Findings

Finding 2.1

Oregon has two definitions for abuse in care and does not handle incident reports differently from abuse allegations.

- Oregon defines abuse differently based on where a foster child or youth resides – in a DHS certified foster home or in a residential facility or foster home contracted through a child caring agency. While both definitions include assault, mental injury, and sexual assault as forms of abuse, the definition that covers child caring agencies also includes financial exploitation, involuntary seclusion, threats, intimidation, humiliation, and emotional injury. (ORS 419b.005, OAR 407-045-0820). There is also a third definition in rule and policy for critical incident reporting that applies to the child caring agencies.
- The response to abuse in care is different based on where a foster child or youth resides - in a DHS certified foster home (CPS) or in a residential facility or foster home contracted through a child caring agency (OAAPI). When allegations of abuse are called in to the CPS hotline, the screener notes whether the alleged abuse occurred in a DHS-certified foster home, or a foster home or facility of a licensed child caring agency and sends the latter reports to OAAPI for investigation.
  - OAAPI screeners determine whether a report meets the definition of abuse and makes the decision about departmental response. CPS hotline screeners gather information but a supervisor makes the decisions.
  - OAAPI investigator training materials show that they receive child-specific training, but their primary charge is adult abuse. OAAPI investigations appear to focus on facility, licensing, and staffing.
  - SB 1515 has increased the responsibilities for OAAPI investigators. Some focus group and survey respondents report that OAAPI investigators are not adequately trained to fairly and competently implement the new protocols.
  - Incident reporting is sometimes confused with abuse reporting and often is reported both ways, leading to under or over reporting of actual abuse. This creates a situation that overwhelms both the agency and providers.

COORDINATED RESPONSE - Findings

Finding 2.1 (continued)

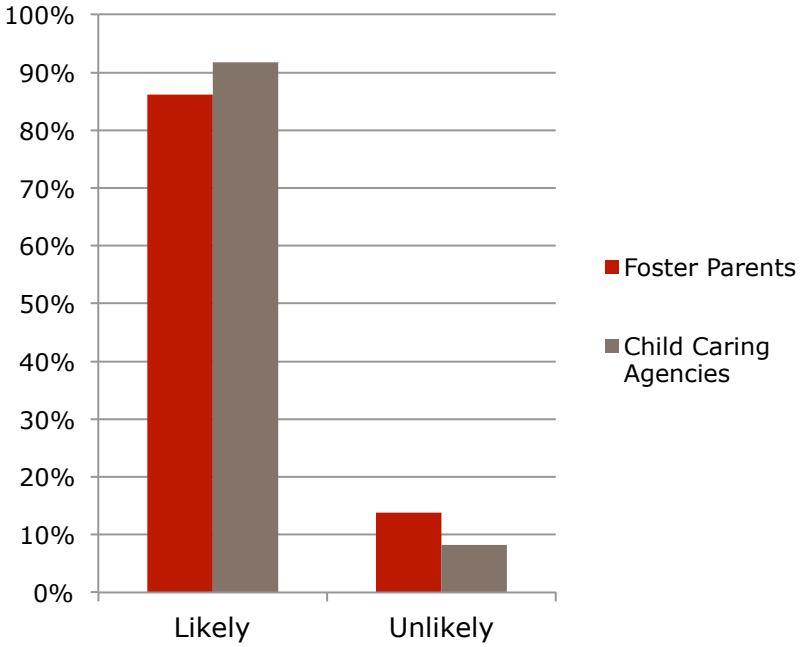
Oregon has two definitions for abuse in care and does not handle incident reports differently from abuse allegations.

- There is no different approach to responding to a critical incident vs. an allegation of abuse, as it's not clear (outside of policy only) what is a critical incident and what is abuse. Foster parents reported that that there is no operational definition of 'critical incidents' and all the foster parents we spoke to used different procedures for handling them.
  - Some report everything in an email or phone call to a certifier or caseworker, (i.e.: MM/DD/YY time: baby's fingernail scratched her own cheek).
  - Others reported taking pictures of scratches or bruises and emailing it to a certifier with an explanation.
  - Another foster parent had never reported anything because she was not aware of what constituted a critical incident or the procedures for making a report.
  - Foster parents noted that every certifier and caseworker has different expectations of what should be reported to the hotline versus what should be documented and who should be notified.
  - Foster parents noted that they can lose their certification if they do it the "wrong way," but there is no clear information about what is "the right way."
- Foster parents and staff of child caring agencies noted that, in order to protect themselves, they report every unusual incident in an incident report. Examples include: when agency rules are broken, when a child misses a dose of medication, a child pretending to be sick or hurt to get out of class, and other similar incidents.
- It appears that abuse in care is both under and over reported and policies are not clear. *See graphs, next slide* Over reporting abuse in care could be a contributing factor to the high number of calls to the child abuse hotline that are closed at screening.

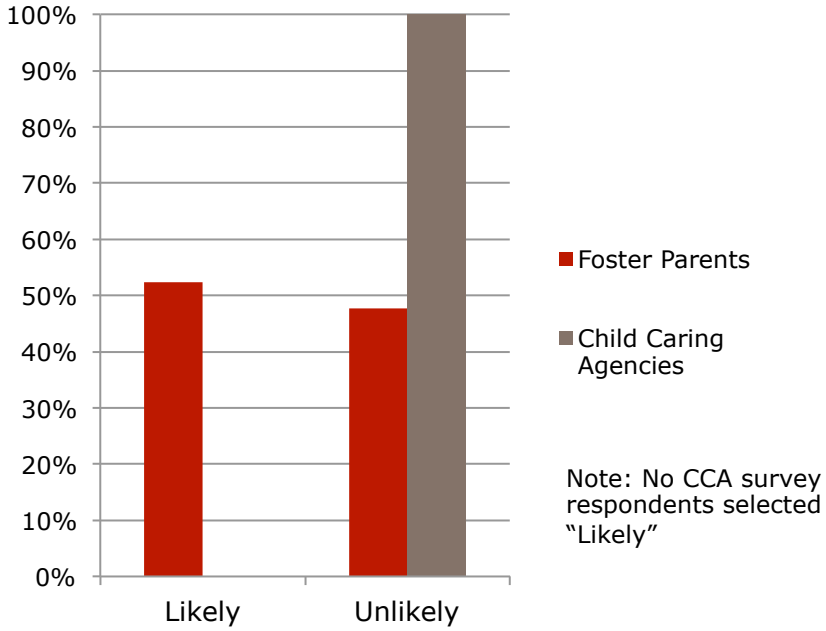
Finding 2.1 (continued)

Oregon has two definitions for abuse in care and does not handle incident reports differently from abuse allegations.

How likely are you to OVER-report critical incidents due to uncertainty about which circumstances constitute a critical incident?



How likely are you to UNDER-report critical incidents due to uncertainty about which circumstances constitute a critical incident?



Foster Parent and Child Caring Agency Survey Results

COORDINATED RESPONSE - Findings

Finding 2.2

The current abuse in care reporting, screening, and investigation process is localized and may result in inconsistent responses.

- Oregon's practice of "localizing" policy, procedure, and intervention results in inconsistent application of a statewide safety intervention model. (OR Safety Model Review, Pg 1)
- Citizen Review Board and CASA focus group participants expressed discomfort and a lack of confidence with hotline screeners' ability to adequately assess calls to the hotline. They do not believe that screeners receive sufficient training to make consistently accurate determinations about alleged abuse in care.
- Because the hotline is decentralized and standardized protocols are not used across districts, response to allegations of abuse may vary depending on where the report was made. Local variation in response protocols makes it difficult to ensure consistent safety decisions statewide.
  - In the words of one focus group participant: the application of DHS screening policies is "as varied as the people" doing the work.
  - Of the 16 DHS Districts, 4 provided written screening protocols to the review team. Two outline the Department Rules and two supplement the Department Rules. District 2, which covers Multnomah County and District 4 which covers Lincoln, Benton, and Linn counties have supplemental protocols for CPS screening and assessment that provide additional detail on information sharing and coordination between and among DHS staff. Additionally, the District 2 protocol specifically requires the caseworker to follow up with the child if a report of abuse or neglect concerning that child was closed at screening, although it does not require the caseworker to do so within a certain timeframe.

COORDINATED RESPONSE - Findings

Finding 2.2 (continued)

The current abuse in care reporting, screening, and investigation process is localized and may result in inconsistent responses.

- Fourteen years ago, a Public Knowledge study found that CPS branches appear to be inconsistent in the abuse screening and assessment criteria that they apply. (2002 PK Review, Pg ix) This appears to still be true today.
- CPS hotline screeners appear to have a high turnover rate, which may make it difficult to ensure consistency. In addition, historical knowledge about individual cases may be incomplete or lost altogether.
  - 22% of screeners surveyed have been a CPS hotline screener for less than a year
  - 74% have been in their role for 3 years or less
- Caseworkers may intervene at the field level to allegations of abuse and neglect rather than reporting to the hotline, which would launch an investigation.
  - Foster parents reported taking pictures of scratches and bruises and emailing them to the child's caseworker, but it is unclear what the caseworker does with that information.
  - Focus group participants note that if there is an allegation there should be a protocol to call it into the hotline, rather relying on the caseworker.
- As noted in finding 2.1, DHS and OAAPI have different rules, policies, and procedures regarding investigations and follow-up for allegations of abuse in care, further contributing to the inconsistencies.

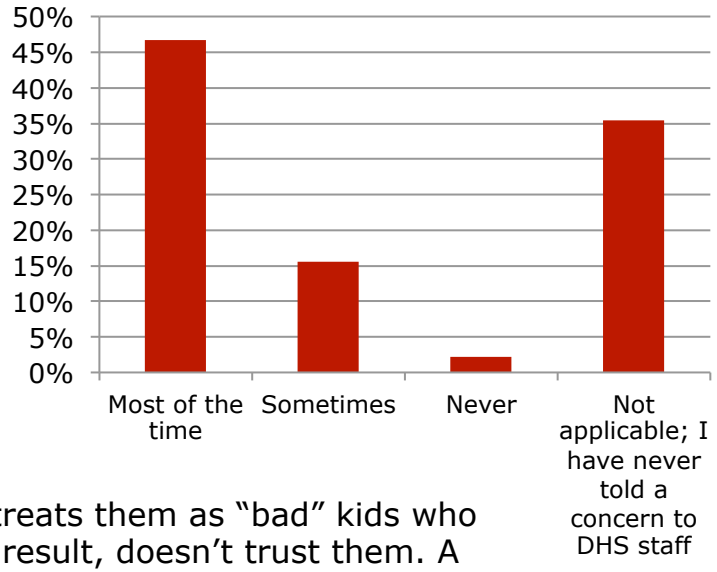
COORDINATED RESPONSE - Findings

Finding 2.3

The current system of abuse in care reporting is rated untrustworthy by youth and other reporters.

- Youth in focus groups reported feeling more comfortable and getting better results when reporting instances of abuse or neglect or discussing safety concerns with a trusted adult outside of DHS, including to a CASA, attorney, teacher.
- Youth in focus groups and via survey expressed confidence that the Foster Care Ombudsman listens and believes their concerns. *See graph, right* Other review participants reported concerns that the Ombudsman is located within DHS.
- Surveys showed that almost 70% of youth report being comfortable reporting abuse to their caseworker. Over 60% are comfortable reporting to another adult authority figure outside DHS. Only a quarter of them reported being comfortable with the hotline. *See graph, next slide*

Does the Foster Care Ombudsman listen and believe your concerns?



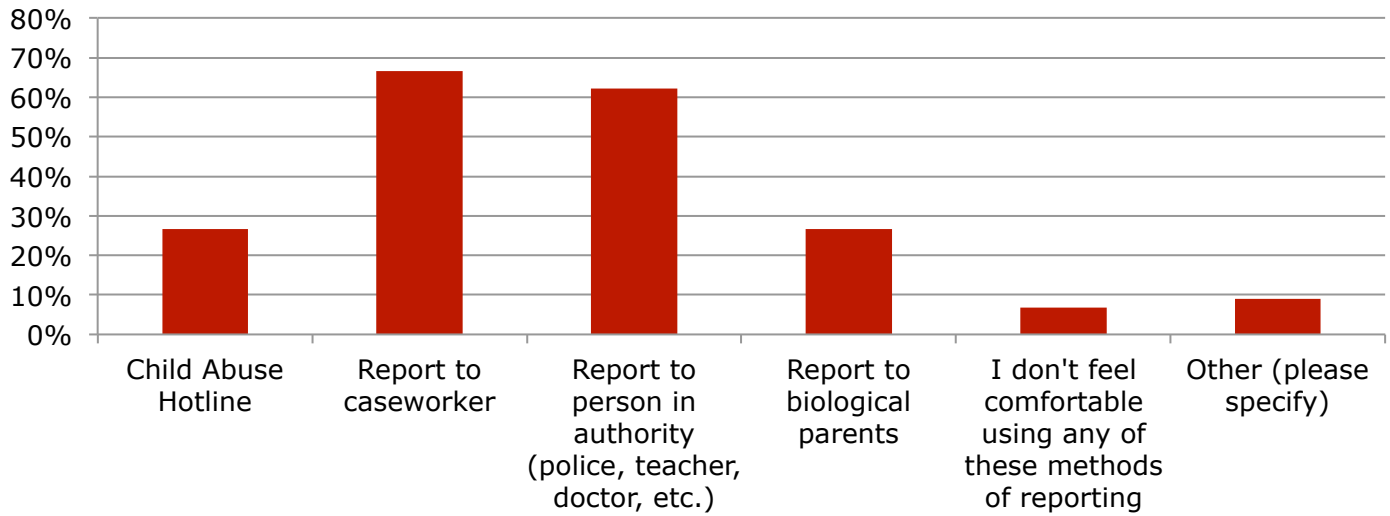
- Youth in focus groups reported feeing that the System treats them as "bad" kids who did something wrong to end up in foster care, and as a result, doesn't trust them. A 2015 Critical Incident Initial Response Team Report found a potential systemic issue noting "There are issues in the ability of children in foster care to feel safe about expressing concerns, including concerns about a foster home." (AM/RM CIRT, Pg 6.)

COORDINATED RESPONSE - Findings

Finding 2.3 (continued)

The current system of abuse in care reporting is rated untrustworthy by youth and other reporters.

What methods of reporting instances of abuse in foster care do you feel comfortable using?



Youth Survey Results

COORDINATED RESPONSE - Findings

Finding 2.3 (continued)

The current system of abuse in care reporting is rated untrustworthy by youth and other reporters.

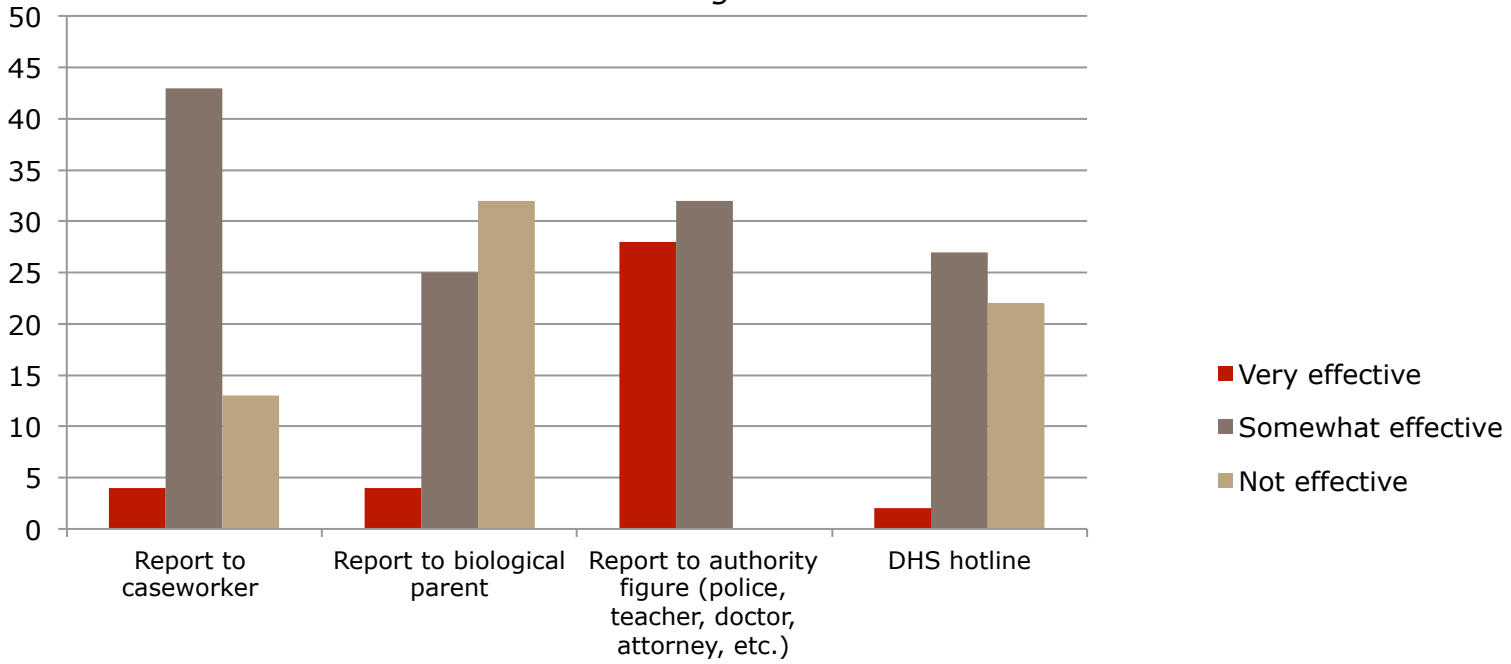
- According to focus groups and interviews, there is a "culture of disbelief" toward children in the System and it is set up to discount the child or youth's experience. Some workers determine the validity of a hotline call before all the facts have been gathered. Many DHS workers don't have the time or training to look at a situation from a neutral perspective and children often don't feel comfortable talking to certifiers and caseworkers because of their close relationships with foster parents.
- Youth reported a lack of confidentiality about their safety concerns. When youth tell their caseworker about abuse or other issues occurring at the foster home, they believe the caseworker often shares the information with the foster parent, resulting in an unsafe, retaliatory, and uncomfortable environment for the youth.
- It may be for good reason that youth do not trust the hotline or DHS to respond adequately to reports of abuse. Youth are not generally considered trusted reporters of abuse within the system, according to survey respondents.
  - The most common reason reported for not trusting youth reports was if a child or youth had made false reports in the past.
- The attorneys and juvenile court judges surveyed for this review indicated that the most effective avenue for foster children or youth to raise concerns about their placement is to report it to an authority figure other than a caseworker. *See graph, next slide*
  - 64% of attorneys and judges report the hotline is rarely or only sometimes a reliable way to have concerns heard and responded to

COORDINATED RESPONSE - Findings

Finding 2.3 (continued)

The current system of abuse in care reporting is rated untrustworthy by youth and other reporters.

How effective are the following avenues for foster children or youth to raise concerns about their placements outside of making an allegation of abuse or neglect?



Attorneys and Judges Survey Results

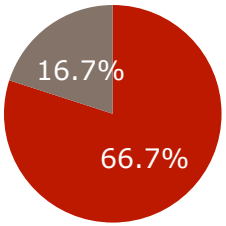
COORDINATED RESPONSE - Findings

Finding 2.4

There is little to no follow-up on abuse in care investigations.

- When a person reports abuse or neglect of a child in a DHS-certified foster home to the hotline, DHS's Administrative Rules do not require follow-up to that person regarding the Department's actions or whether the allegation was closed at screening. (DHS Office of Child Welfare Programs, Chapter 413 Division 200 "Foster Home Certification")
- Follow-up is required to the person making the report when the child resides in an child caring agency/OAAPI-regulated home.
- Focus group and survey respondents report not receiving follow up in either case after making reports.
  - Youth – 67% say no follow up (*see graph, right)*
  - CASAs in a focus group reported minimal follow up
  - Biological parents in a focus group reported not being consistently informed

How have you been kept informed once a report of abuse against your foster home provider has been made?



No follow up

Other (phone call, in-home visit, email)

Youth Survey Results

COORDINATED RESPONSE - Findings

Finding 2.4 (continued)

There is little to no follow-up on abuse in care investigations.

> "I've made a number of hotline calls, I have no idea whether they've been investigated or whether the concerns have been responded to."
> – *Attorney survey respondent*

- Follow up on abuse in care investigations appears to be occurring inconsistently, although the policies are clear.
- Department Rules require the caseworker to notify the child's attorney, CASA, biological parents, and the attorney of the parents when a report of abuse concerning a child in a DHS-certified home is made, unless doing so would interfere with the investigation. However, these parties report not consistently receiving information about reports of abuse and neglect.
- 45% of attorney and judges survey respondents stated that the CPS hotline is not an effective avenue for foster children and youth to report concerns. (Note that a reporting method is considered effective where the concern is followed through and findings/results are communicated back to the reporting youth.) In addition, one judge noted in an open ended response: "I have not found reports to the hotline to be effective. DHS doesn't follow up promptly on reports, and DHS often code the report as unfounded, even when a child is unsafe."
- No follow up makes this a closed loop: the reporter or other members of the child's or youth's team do not know if DHS is taking any action, or if the child in question is in an unsafe situation.

COORDINATED RESPONSE - Findings

Finding 2.4 (continued)

There is little to no follow-up on abuse in care investigations.

- Youth reported instances of ongoing abuse when DHS failed to follow-up on reports of abuse. One youth reported running away from an unsafe situation before DHS would take her concerns seriously and conduct an investigation.

- Foster parents reported receiving no communication during an investigation, other than that they were under investigation. They are not told what the allegation is and receive no communication from DHS during the investigation. Foster parents note that it is important to err on the side of safety for the child, but moving the child can also impact safety and well-being.

- Foster parents and youth report that an investigation and/or removal of the child appear to be the only options for responding to allegations. Foster parents report that DHS is not using an outcomes based approach. They remove the child without trying to get to the root of what the child needs.

- DHS's Administrative Rules do not require the caseworker to take any action if an allegation is closed at screening (Department of Human Services Office of Child Welfare Programs, Chapter 413 Division 200 "Foster Home Certification"). Of the 16 DHS Districts, four provided written screening protocols to the review team, and of those four, only one required the caseworker to follow up with the child after a "closed at screening" allegation.

COORDINATED RESPONSE - Findings

Finding 2.5

Information that could mitigate safety concerns is not efficiently shared.

- The current data system does not have advanced capabilities to share information, does not allow for trend identification, has limited quality assurance monitoring capabilities, and lacks an accountability system to ensure accurate safety determinations.
- Foster parents report in focus groups that they receive very little information on a child prior to placement, including mental health history and emotional triggers.
  - In the case of one newborn, the foster parent did not receive information on the infant's birth weight, number of weeks she was born prematurely, and that she was born drug-addicted, all of which would impact the care she should have been receiving.
- Foster parents report that DHS does not listen to their concerns or recommendations about the child, even though the child is living with them and the foster parent has day-to-day contact. In contrast, caseworkers are required to have contact with foster children and youth on their caseloads once per month, and often fail to meet that standard, according to focus group and interview participants.
- Foster parents report little communication from caseworkers, unreturned phone calls, often adversarial relationships with them. The report receiving little support, resource, or information from DHS workers to safely care for children and youth in their homes. Most foster parents report turning to their certifiers for support, rather than the child's caseworker.
- Biological parents of foster children report not being believed or taken seriously by DHS. Biological parents feel they are discredited and perceived as having poor parenting skills and not having the best interest of their children in mind, and therefore, are not listened to when communicating safety concerns. They also report not being consistently informed when their children are harmed in care.

COORDINATED RESPONSE - Findings

Finding 2.5 (continued)

Information that could mitigate safety concerns is not efficiently shared.

- In 2015, a Critical Incidence Response Team reviewed the case of two children that were severely abused while residing in a foster home. In review, the team noted that there is a systemic issue in DHS of poor communication within and between branches on co-managed cases. (AM/RM CIRT, Pg. 6)
- DHS staff report in surveys that system-wide mechanisms do exist to share information about safety concerns, although this was also an area rated high for opportunities for improvement. Focus group participants reported that information-sharing is inconsistent and there are opportunities for information to fall through the cracks.
  - 83% of caseworkers and 67% of hotline staff report there are system-wide mechanisms in place to share information
  - 70% of caseworkers and supervisors reported that "systems that store and share data" is a top solution to increasing efficiency in coordination between the entities involved in keeping children and youth safe in care (i.e., Child Welfare, CPS, OAAPI, ORLO, and others). One screener mentioned using 5 separate systems to manage information.

"The [Safety Team] found that the lack of communication among DHS staff and/or foster parents contributed to the initial and long term abuse of children in foster care."
-Safety Team Final Report, Pg 4

COORDINATED RESPONSE - Recommendations

NOTE: the recommendations listed below are preliminary high level solutions. The review team will be providing additional detail and resources in the Final Report.

- Consider whether to implement a centralized hotline or implement standardization of procedures and a quality assurance function.
- One agency should handle abuse investigations (not multiple depending on provider type). Designate a single, well resourced, statewide entity to be responsible for ensuring that the response to allegations of abuse in substitute care is thorough, accurate, and consistent.
- Adopt clear protocols on follow-up to reporters and youth on conclusions.
- Track all allegations and investigations by provider (not just youth) so trends can be found early before a crisis occurs.
- Adopt one definition of abuse in care across all foster care types. Focus on the child or youth experience.
- Options for responding to allegations other than moving the child. (I.e., wraparound and CMEs)
- Establish a unified assessment approach to allegations of harm in care based on the Oregon Safety Model, regardless of placement setting. Rather than using an incident-based focus, identify the safety threat, determine child's vulnerability to the safety threat and assess the caregiver's ability/willingness to protect.
- **From focus groups:** Youth suggest training for foster parents and youth on collaborative communication and problem solving, which may reduce allegations of abuse. They suggest mediation services or other interventions besides removal. Foster parents suggested flagging investigations as "red" for immediate removal or "yellow" for training, mediation, or other solutions in order to keep children stable.

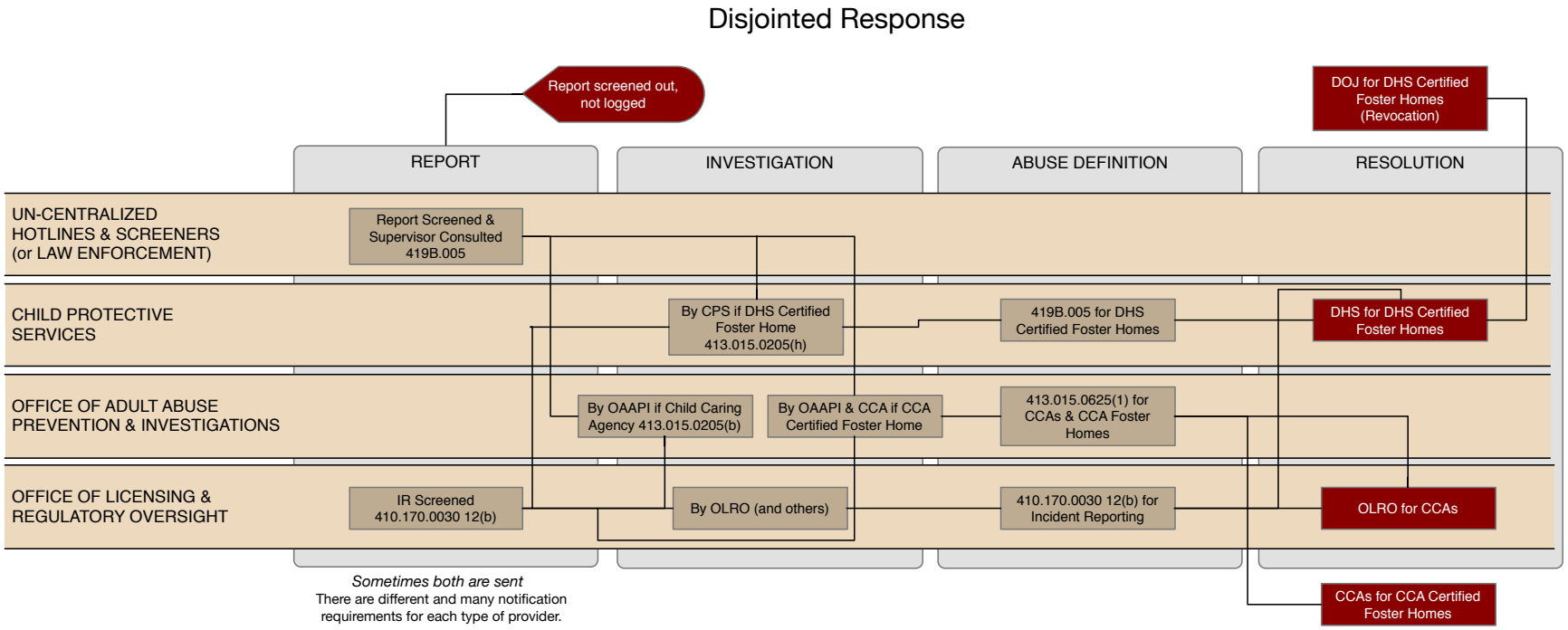
COORDINATED RESPONSE - Recommendations

NOTE: the recommendations listed below are preliminary high level solutions. The review team will be providing additional detail and resources in the Final Report.

- Use the child or youth experience as the organizing principle for re-designing the system of response to allegations of abuse in care. The "As Is" map (*see next slide*) shows the current response process with multiple players, multiple connections, and many chances for things to fall through the cracks. It is also organized around the system players, not the child. The "To-Be" version is an example of the process starting with the child or youth in a potentially abusive situation, and from there determining who needs to be involved (hopefully reducing the numbers of people, handoffs, and changes where information can be missed).

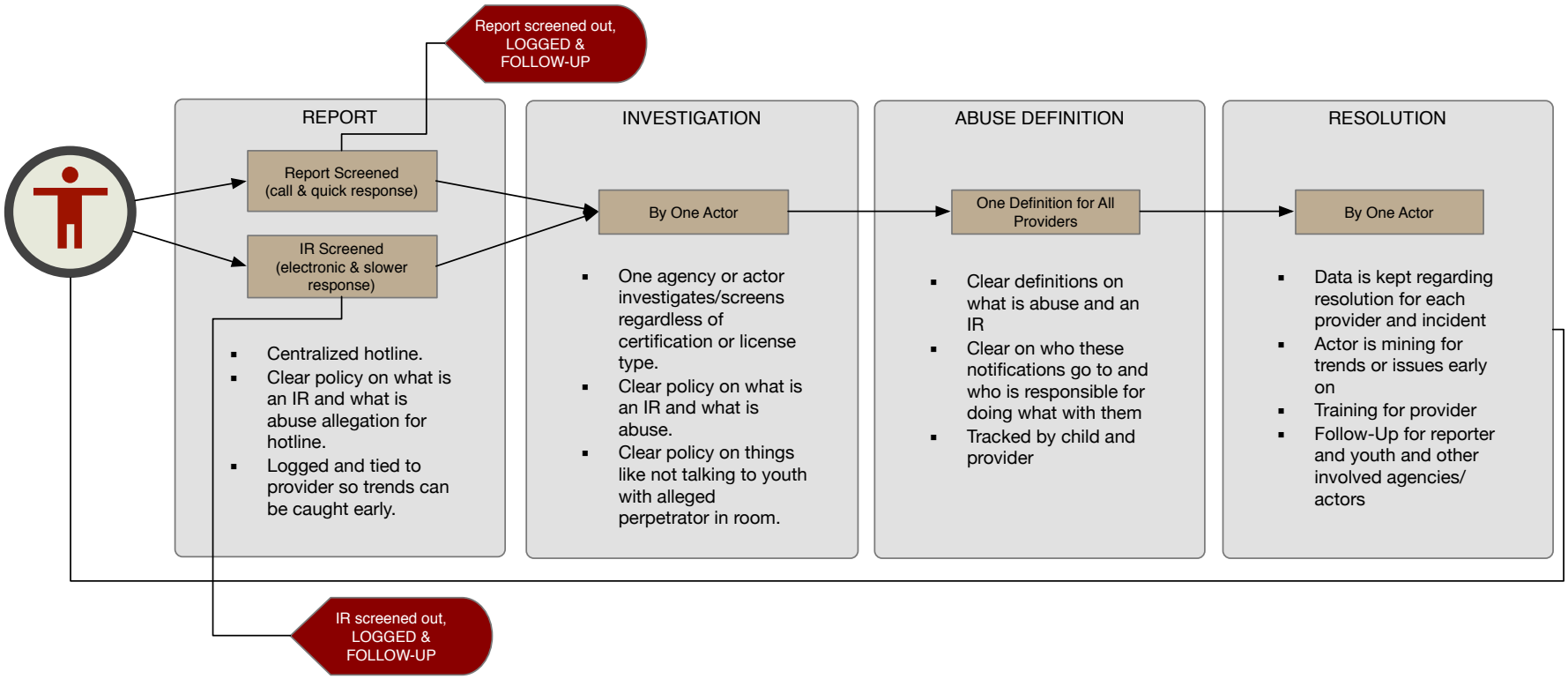
COORDINATED RESPONSE – As Is Process

Current Process Centered Around Agencies & State Staff



COORDINATED RESPONSE –To-Be Process

Potential To-Be Process Centered Around Child or Youth, with Recommendations



V. RELATED BARRIERS TO IMPROVING THE CHILD SUBSITUTE CARE SYSTEM

This section provides information about barriers to improving the Child Substitute Care System that arose during the Comprehensive Review. We believe these three barriers, if not thoughtfully addressed and adequately resourced, will hinder progress toward solving the major breakdowns in the review's focus areas of *safe and appropriate placements* and *safe and swift response to abuse in care*. The three areas are:

1. Data driven decision making
2. Unreasonable caseloads
3. Recruitment & retention of providers

This document presents draft findings and preliminary solutions developed during the comprehensive review phase for the purposes of feedback and fact checking.

RELATED BARRIERS TO IMPROVING THE CHILD SUBSITUTE CARE SYSTEM

Accessible, Accurate, and Reliable Data Could Inform Holistic Solutions that Address the Root Causes of Harm in Care.

Impacts on Child and Youth Safety:

- DHS is unable to provide data on allegations of abuse that are tied to provider types or data on screened out allegations points to a larger, enterprise-wide problem. Legislators, DHS leadership, and staff need access to reliable and current data in order to make appropriate decisions that affect the health and safety of Oregon's children and youth in care. Limited data results in management by single incident cases.

Supporting Evidence

- There are several separate data systems currently used by Child Welfare (ORKIDS), ORLO, and OAPPI that do not interface with one another and that are at varying maturity levels.
- Oregon is currently dealing with a disjointed and outdated data enterprise system. Independent reviewers experienced this firsthand when requesting a basic set of core data to look at the issue of child safety and substitute care. The data requested either does not exist or was difficult and time consuming to pull together. Producing and evaluating a basic set of performance data is not a part of routine reporting and decision-making. Anecdotal stories and crisis response is filling this data vacuum, which in turn is driving regulatory and case decisions. These well-intended but partially-informed decisions may negatively impact child and youth safety.
- Data driven strategic planning and sound decision-making is instrumental to ensure children are kept safe in care. "The absence of such information or presence of irrelevant, insufficient or voluminous and disorganized information results in poor decisions." (Safety Model Review, p.14)

RELATED BARRIERS TO IMPROVING THE CHILD SUBSITUTE CARE SYSTEM

Accessible, Accurate, and Reliable Data Could Inform Holistic Solutions that Address the Root Causes of Harm in Care.

Supporting Evidence (Give Us This Day Example):

- The Give Us This Day case has sparked strong outcry from the public and stakeholders, which contributed to the impetus for this review. (GUTD – a former Portland provider recently shut down due to abuse of youth in care and financial scandal.)
- The GUTD situation is an example of how single incident cases may drive a response when there is a breakdown in the system. As explained in the GUTD Audit, in 2005, DHS made a formal recommendation to not renew GUTD licensing, to stop making referrals, and to remove a majority of the youth residing there. DHS took formal steps to deny renewal of their CCA license. However, DHS leadership at the time made the decision to continue GUTD licensing under a temporary action plan. (GUTD License Audit, Pg 2-3) Reasons for this are many, and the state is currently engaged in lawsuits that will perhaps bring some of those reasons to light. Contributors to this review believe that political pressure, the provider's willingness to take in "hard to place kids," and the state's fear of appearing racist were primary factors in this case.
- While terrible, the GUTD case is not representative of all the breakdowns in the System leading to harm in care. Resulting initiatives focused on similar providers (licensed CCAs), but data shows that while abuse in licensed institutions is increasing, the majority of substantiated cases are occurring in DHS certified foster homes.

Solutions

- Use data to drive decision making and policy. (SACWIS best practices)
- Use the high profile single incident cases to analyze what is needed from data to ensure DHS data systems collect and report the information needed to respond earlier to abuse in care.

RELATED BARRIERS TO IMPROVING THE CHILD SUBSITUTE CARE SYSTEM

Reasonable workloads for agency staff could improve safety in care.

Impacts on Child and Youth Safety:

- Inadequate staffing and high workloads negatively impact timeliness in case resolution, regular face-to-face time with children, and quality safety monitoring.
- Focus groups and surveys revealed that high caseloads and inadequate staffing across agencies in the System are the reasons key safety information falls through the cracks.
- Caseloads for DHS workers are so high that child welfare workers are not making the required monthly contact with children (2014 Annual Progress Report, Pg 102.) However, there is no way to ensure safety of children in substitute care without seeing them in those placements.
- Since at least 2002, studies and reports have shown that CPS staff workloads are a critical factor affecting the quality, accuracy, and timeliness of child safety decisions. (2002 PK Review, Pg vii.).

"I have never had a caseworker answer the phone when I call"
–Focus Group participant

Supporting Evidence

- The proportion of foster children and youth with high needs has increased, increasing workload across system players.
  Studies confirm that current national caseload standards may be twice what is reasonable, and Oregon's workload situation far exceeds the outdated national standard. (Safety Intervention System Review, Pg. 1)
- Foster parents and youth reported in focus groups and surveys that high turnover among caseworkers and infrequent face-to-face contact makes it difficult for children and youth to build trust with the caseworker. Children and youth who don't trust their caseworker may be less likely to report safety issues.

RELATED BARRIERS TO IMPROVING THE CHILD SUBSITUTE CARE SYSTEM

Reasonable workloads for agency staff could improve safety in care.

Supporting Evidence (continued):

- In the last 5 years 23 lawsuits have been brought against DHS that revealed numerous violations of policies and procedure. Our review of those cases revealed: failure to adequately investigate repeated reports of abuse, failure to make contact with children to assess safety and wellbeing, failure to document and investigate observed injuries, failure to inform foster parents of foster children's behavior and health history, and failure to maintain coordination between caseworkers, among others. All of these breakdowns could be partially attributed to high workloads.
- The Caseload Allocation model received 08/11/2016 shows average caseloads at about 20. This number does not on its own account for the varying levels of workload by case.
- The activity based workload model adopted by the 78th Legislature helps to determine staffing needs for budget forecasting purposes and does not limit caseloads per worker. (The Department of Human Services, Workload Report to the 78th Legislative Assembly.)

Possible Solutions

- The Child Welfare League of America (CWLA) recommends that caseloads be between 12 and 15 children per worker, and the Council for Accreditation for Children and Family Services (COA) suggests they not exceed 18 children per worker

RELATED BARRIERS TO IMPROVING THE CHILD SUBSITUTE CARE SYSTEM

Recruit and retain all foster care provider types to reduce pressure to place children and youth inappropriately.

Impact on Child and Youth Safety:

- DHS does not have a comprehensive statewide recruitment, retention, and support plan for foster care providers, which results in inconsistent and inadequate efforts to sustain and grow placement options of all types.
- In the short term, this results in children and youth being shuffled between homes, hotels, and in some cases even sleeping at local DHS offices.
- In the long term, this situation increases the likelihood of a poor provider placement, low quality care, exceptions to certify less-qualified foster homes, or abuse and neglect of those children.

Supporting Evidence

- Foster parent focus group participants reported caring for more children than they were certified to care for, insufficient training, little support from DHS, and lack of respite care when needed as factors contributing to foster parents leaving the system.
- Data shows there was a decrease of 20% of general foster homes between 2013 and 2015. (2016 CFSR Self Assessment, Pg. 118)
- Focus group participants across groups agree that lack of placements is a serious problem across the state, in both rural and urban areas alike.
- DHS-certified foster parent focus group participants reported that that they were not "recruited" by DHS, but rather had reached out directly to DHS, or were recruited through friends. Others were recruited by Embrace Oregon, a faith-based partner of the foster care system.

> "The State does not have a statewide process in place to ensure the diligent recruitment of foster homes, despite significant shortages of all types of foster homes."
> *–2007 CFSR*

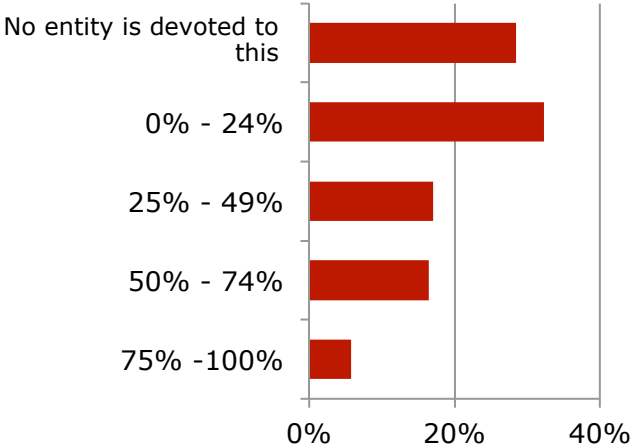
RELATED BARRIERS TO IMPROVING THE CHILD SUBSITUTE CARE SYSTEM

Recruit and retain all foster care provider types to reduce pressure to place children and youth inappropriately.

Supporting Evidence (continued):

- Some localized efforts and campaigns are underway to recruit foster families, but no statewide strategy exists, nor is there a separate budget or resources dedicated to this work.
- Almost a third of DHS staff surveyed indicated that *there is no entity* in charge of recruitment and retention of foster homes
- DHS Certifiers in a focus group reported that "everyone is in charge of recruitment and retention," which effectively means no one is responsible.

For the entity in charge of recruitment and retention, what percentage of time is devoted to recruitment and retention of foster families?



DHS Caseworker and Supervisor Survey Results

Possible Solutions

- Develop a statewide recruiting strategy. Assign a budget and resources to implement the strategy.
- Increase recruiting and support efforts for BRS foster care providers.
- Address barriers in the process for certifying qualified foster homes.
- Increase a pool of respite providers for DHS-certified foster parents.
- Establish and support regional foster parent support groups.

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