

Oregon Foster Care Safety Team Final Report

Findings and Recommendations

Background

In September 2009, under the leadership of Erinn Kelley-Siel, Oregon's Department of Human Services Child Welfare program began to strategically refocus its efforts to aggressively reduce child abuse and neglect, beginning with the children in state foster care.

As part of this effort, Child Welfare officials called for a renewed focus on Oregon's innovative Critical Incident Review Teams (CIRT), convened when a child known to the agency has been seriously injured or killed as a result of abuse or neglect. Immediately after an incident, the CIRT process brings together agency staff, law enforcement and others to review whether there were systemic problems or gaps in practice or procedures that happened in the case.

In response to a CIRT report about a long-time foster parent who was arrested and convicted of child abuse, the agency convened a rapid-response team of law enforcement, child advocates, and other concerned Oregonians to look not only at cases after abuse has happened, but to help prevent future abuse.

The Foster Care Safety Team (FCST) included the following members: Chair Megan Shultz, CASA of Lane County; Don Darland, Oregon Foster Parent Association; Chief Gerald Moore, Salem Police Department; Leola McKenzie, Juvenile Court Programs, Oregon Judicial Department; Pamela Butler, former foster youth, Oregon Foster Youth Connection, Children First for Oregon; Margaret Olney, Department of Justice; Kevin George and Cyndi Kallstrom, Oregon Department of Human Services. Erinn Kelley-Siel convened the team. Lois Day, Mickey Serice, Margaret Semple, Stacey Ayers and Lisa Zacharias provided staff support.

The team was charged with the following four tasks:

- Review and analyze incidents of abuse or neglect in foster care in 2008 to identify changes in practice or policy that should be made to help prevent it.
- Review a statewide representative sample of foster home certification files involving foster parents who have been serving children for at least 5 years to determine whether the issues presented in recent reports are also identified in cases in different parts of the state.
- Review a random sample of reports of abuse in foster care that were closed to identify whether cases of abuse are being properly responded to.
- Review all efforts for the last 10 years, including those currently in place, to ensure the safety of children in foster care and make recommendations of any additional improvements that may be needed.

The team began its work in September 2009, and preliminary findings and recommendations were delivered within the 90-day timeline as requested by DHS. This is the final report of the Foster Care Safety Team.

Preliminary Findings and Recommendations

The FCST began the examination of child abuse in foster care through a broad lens in an attempt to understand the complexities of the work. Through this overarching perspective, we realized the need to scrutinize key functions of the system with a sharper focus. Our findings and recommendations begin once foster families first come into the system, and end when they exit. Each point on this continuum affects the experiences of children living in foster care and their safety.

The FCST concludes that findings 1 (work load), 5 (communication), and (6) (documentation) are the primary issues that must be resolved in order to move toward ending abuse in foster care. The team places the highest priority on these recommendations.

The FCST requests that DHS create an internal Quality Assurance process to monitor and enforce implementation of these recommendations.

Category: Recruitment, Retention & Support

Finding 1

A foster care certifier carries a case load of 55 homes. In addition to certifying these homes, they are also recruiting, training, monitoring, supporting and placement matching. These roles require very different skill sets and cannot be effectively accomplished by one person. Certifiers, who often carry the same case load for several years, run the risk of becoming enmeshed with the foster parent because of the relational aspect of the job.

Recommendations

DHS complete a certification staffing study to examine the effectiveness of the current case load ratio. As a part of that study, consider the impact of separating recruitment and retention duties from the role of the certifier.

DHS develop a plan to mitigate staff bias.

Finding 2

A scarcity of foster homes in Oregon drives compromise, and certification violations may be overlooked due to the need for homes.

Recommendations

Separate the recruitment and retention duties from the role of the Certifier and develop a Foster Family Recruitment and/or Retention Specialist position either in each DHS office, or region, if supported by the findings from the staffing study.

Target foster parent recruitment efforts to specific groups, such as churches, service clubs, communities of color, the education system, neighborhood groups, and other foster parents.

Finding 3

All foster parents do not currently receive adequate support and/or child specific training for the children in their care. The FCST found that these stressors can lead to abuse in foster care. In addition, even if no abuse occurs, this lack of support can lead to unsuccessful placements (requiring children to be moved) and can cause foster parents to withdraw from the system. This contributes to the shortage of foster care placements that the FCST believes compromise safety.

Recommendations

Require retention staff to regularly engage foster parents in discussions concerning support, training needs, and questions or concerns, coordinate foster parent support groups, and connect foster parents to community resources.

Encourage foster parent participation in local support groups by providing child care, transportation assistance, and allowing support group participation to count towards mandatory training hours.

Create a foster parent support and training group model based on current best practices and require newly created retention staff to replicate and support these programs across the state.

Develop a consistent, statewide approach for support group participants to receive training credits.

Identify and implement best practices for foster parent retention. This would include reaffirming accountability for foster parent retention across all disciplines within DHS-CAF.

Finding 4

The FCST believes that one cause of abuse in foster care stems from inadequate placement matching.

Recommendations

When developmentally appropriate, allow foster youth the opportunity to interview prospective foster parents and vice versa.

Improve interstate placement practice to ensure that child welfare staff in Oregon (or the staff in the receiving state) have access to the child's current file in order to make appropriate placement decisions and provide necessary support services in a timely manner.

Recommend continuing efforts to fully support and ensure compliance with policies regarding placement matching, confirming safe environments, and initial mental health assessment for children placed in care.

Continue to expand relative search beyond the first placement option and examine best practices around relative finding and implement statewide.

Category: Internal Process

Finding 5

Through the examination of two sensitive case reviews released in October 2009, as well as a random sampling of “closed at screening” files, the FCST 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.

Recommendations

Establish a formal structure and process for communication among staff who may have contact with a foster family, including CPS workers, certifiers and caseworkers. When appropriate, these staffings could include a foster parent representative and/or foster youth representative. This process should include reviewing certification exceptions, reports of alleged abuse, certification violations, or other areas of concern. Consider a process such as the Lane County Sensitive Review committee structure and implement statewide.

Develop a specific hotline outside of DHS for foster youth to self report abuse in foster care and make all youth aware of this hotline number and their right to call it.

Develop a protocol for responding to abuse reports made by youth or children in foster care.

Finding 6

A major finding of the FCST is that abuse allegations against a foster care provider are only documented in individual children’s files. This makes it impossible to know if there have been allegations made by other children or if there is a history of concerns against a specific foster care provider. There is no ability for cross county information sharing which would allow foster care providers to move to other counties without the new county office having knowledge of their history of allegations.

Recommendations

Ensure that OR-KIDS track foster care providers as people in the system and connect children and all hotline calls to the foster care provider. This would connect all allegations, concerns and certification violations to their foster care provider record which then can be viewed in its entirety and allow statewide access by DHS branches.

Mandate that DHS require staff to use provider notes in FACIS for recording allegations of abuse in foster homes as well as certification concerns, until OR-KIDS is implemented and DHS is confident that the information identified above is being tracked.

Establish an automatic alert system that prompts a mandatory review of a foster care provider when 3 abuse allegations or certification concerns have been raised or documented, regardless of their outcomes.

Review and update DHS Policy 1-B.2.2.3 as necessary to clarify parties who need to be notified of the disposition of CPS assessments related to children in foster care as required by ORS419B.035.

Create a model using specialized staff to perform CPS assessments on abuse allegations.

Category: Training

Finding 7

Through a myriad of case reviews, the FCST found some correlation between child abuse and the lack of completion of minimal annual training requirements by foster care providers in order to maintain their foster care certification.

Recommendations

Create incentives that support and enforce the requirement that foster parents complete the mandatory 30 hours of training every two years.
Provide child care and transportation assistance to support foster parents in meeting the mandatory training requirement.

Require foster parents to complete a minimum number of training hours in the classroom to promote networking, connectivity, development of support systems and to allow additional opportunities for oversight by DHS staff.

Utilize existing resources by combining training and support group efforts i.e. sharing costs between foster parent associations and local DHS departments.

Maximize existing resources by partnering with community stakeholders (CASA, educators, CRB, attorneys, service providers, mental health, etc.) to provide interdisciplinary training opportunities for DHS staff and foster care providers.

Explore and implement technological improvements that facilitate training and monitor participation.

Ensure foster parents receive child specific training based on the needs of their foster children and the parenting skills required to care for them.

Provide and require, ongoing training for DHS staff including clinical supervision training for foster care certifiers.

Include foster youth, foster care alumni and foster parents as training resources during Foundations Training for foster parents and Caseworker Academy Training.

Category: Certification

Finding 8

The FCST is concerned that inconsistent implementation and burdensome policies and procedures surround the revocation of certification, documentation of certification violations, and screening of foster parents.

Recommendations

Provide consultation at Central Office to serve as a statewide resource on certification issues and improve consistency among DHS branches regarding revocation and recertification decisions. Central Office would review and approve any local decision to revoke or resolve a concern by “counseling out.” Central Office would also be responsible for ensuring that a revocation is completed and that unfit foster care providers’ certifications are officially revoked.

Investigate statutory and rule changes to ensure DHS has ongoing jurisdiction to issue an order on a certificate that has been withdrawn or has lapsed.

Create a standardized statewide documentation process regarding certification violations as well as disposition of violations and concerns.

During foster parent background investigations, include criminal history, arrests, and inquire about contact with local law enforcement.

Assure that relative foster parents are screened and certified with the same considerations as non relative parent applicants.

Make Certifiers accessible to youth in foster homes and educate youth about the certification process so they can understand when a certification violation is occurring.

Category: Other

The FCST encourages the education & support of DHS staff on employee performance record keeping and policy to ensure that issues with employee performance that do not meet standards of care are accurately addressed and resolved.

Recommendations to the Child Welfare Advisory Committee

The FCST did not have adequate time to fully study some of the recommendations. We believe that they are important to explore and strongly encourage CWAC in collaboration with CAF to create and empower sub committees to investigate the following preliminary recommendations.

Further study the transfer of abuse investigations to OIT or another independent body. Create pros & cons for each model and make recommendation to DHS.

Create a formal, quarterly review process for founded abuse in foster care reports utilizing DHS staff and representatives from identified stakeholder groups.

Explore creation of an external group to review foster care founded dispositions at least every six months and generate a report of findings & recommendations.

Regularly review a random but statistically relevant number of closed at screening files to provide outside oversight for the screening process.