

**Sensitive Review Committee Report
June 2009 through April 2011
May 2, 2011**

Meeting Dates

June 23, 2009
August 19, 2009
October 2, 2009
January 19, 2010 (Site visit)
April 23, 2010

Committee Members

Senator Martha Schrader
Senator Ted Ferrioli
Senator Jeff Kruse
Senator Laurie Monnes-Anderson
Representative Mike Schaufler
Representative Carolyn Tomei
Representative Judy Stiegler
Representative Wayne Krieger
Freda Bax, Psy.D.
Ben de Haan
Judge David Brewer
Barbara Johnson, Clackamas County CASA Director
Julie McFarlane, Juvenile Rights Project
Dr. Bruce Goldberg, DHS Director
Erinn Kelley-Siel, DHS Assistant Director

DHS Staff Support

Mickey Serice
Lois Day
Caroline Burnell
Jerry Waybrant
Wendy Hill

Sensitive Review Committee Report Spring 2011 Issues/Recommendations

Introduction:

In July 2009, Dr. Bruce Goldberg, Department of Human Services Director, convened a Sensitive Review Committee comprised of legislators and child advocate experts to review a complex child welfare case. The case reviewed by this Committee was particularly complex because it took place in a small rural community in Oregon, highlighting the challenges of dependency work in small communities where resources are scarce and where most of the individuals involved in a case know one another.

This case, and the process of reviewing it, was especially challenging for the Committee and DHS staff. It is important to note that not everyone on the Committee is leaving the review process feeling satisfied about the resolution of this case through the DHS and Court processes. However, the Sensitive Review Committee process is focused on cases that are closed and is intended to be a process by which lessons learned in one case can improve the dependency process going forward. To the degree any case-specific issues arise in the course of a review, those are handled separately. In addition, there are several staff who had been involved in the case that was reviewed that are no longer employed by the Department.

This case offered many lessons for DHS child welfare, for the mental health system, for attorneys and for the courts. To the extent the review process took longer than expected to resolve, the Committee apologizes to the community members who participated in dialogue about the review and to the Legislature. Even with the delay, the Committee strongly urges that the recommendations offered in this report should – depending on funding and other policy considerations — be considered during the next Legislative Session. In addition, those recommendations that do not require legislative action or additional resources should be acted on as soon as is practicable by the Department.

Issues and Recommendations:

Accountability for Child Welfare Work

- **Issue:** Concerns were raised in this case about the Department's ability to objectively review complaints from third parties (parents, grandparents, others) regarding its work on behalf of children and families in the child welfare system.

- **Recommendation:**
 1. The Department should present to the Legislature a policy option package that would create an objective, internal investigation Office that would handle complaints alleging inappropriate behavior by DHS child welfare staff, foster parents, facilities services DHS children or other DHS providers. The Office and its Chief Investigator should report directly to the DHS Director. The Department should consider a model that resembles that of the Oregon Youth Authority Professional Standards Office, whose mission is: "to help eliminate organizational conditions which may foster, permit, or encourage inappropriate behavior by OYA employees, and by ensuring that the integrity of the agency is maintained through a system of fair, objective, and impartial administrative investigation and review." This Office and its investigative process should be designed in such a way so as to enhance – and not duplicate - the existing DHS client complaint and/or Governor's Advocacy Office processes.

Child Interviewing:

- **Advocacy Centers**
- **Issue:** Not all child welfare offices have easy access to independent forensic interviewing through child Advocacy Centers. Each Advocacy Center has its own forensic interviewing protocols, which can create conflicting information for professionals (child welfare

staff, attorneys, the court) to decipher and apply to decision-making in a particular case.

- Recommendation:

1. The Department, in partnership with the Department of Justice, local Multi-Disciplinary Teams, other community partners and existing Advocacy Centers, will evaluate the need for additional Advocacy Center capacity and opportunities to strengthen the work of existing Oregon advocacy centers. This evaluation should include an analysis of current approach, oversight and training requirements for the different Advocacy Centers in Oregon. Following that review, recommendations should be made to the Legislature to strengthen and standardize the work of Centers across the state.

- Caseworkers

- Issue: Not all child welfare workers are trained in forensic interviewing. Currently, when a worker is interviewing a child and the child makes disclosures that indicate that the interview should be conducted according to forensic interviewing guidelines, the worker is supposed to stop the interview, then resume with an interviewer who is trained in forensic interviewing.

- Recommendation:

1. To ensure that interviews of children are conducted appropriately, child welfare needs to be more intentional about which child welfare workers are trained and/or train more workers in forensic interviewing. This is especially true in rural areas where there are fewer workers. DHS should inventory geographically its workers who are trained in forensic interviewing and develop a strategic plan to train additional staff as needed. This plan should include on-going, “refresher” training for those workers who have received initial training, allowing for refinement and strengthening of their expertise.

Foster Child Placement Stability:

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- Issue: Repeated placement moves inflict emotional harm on foster children. 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. In addition, when transitions occur, they sometimes fail to include other stable adult influences in the child's life, such as the child's caregiver or therapist.
- Recommendations:
 1. DHS, in partnership with the Addictions and Mental Health Division, should develop a proposal to the Legislature that would provide for additional resources to purchase more therapeutic foster care (placements with foster parents who receive additional, specialized training and receive payment above and beyond the DHS foster care rate to provide therapeutic services).
 2. DHS should study other state models and evaluate the workload impact of a case review process each time a child enters his or her third substitute care placement and upon each placement thereafter. Once completed, DHS should discuss its study and evaluation with the Child Welfare Advisory Committee (CWAC). In partnership, the CAF Division and CWAC should identify the best way to move forward with this recommendation.
 3. DHS should enhance caseworker training on how to transition children in a way that is inclusive of foster parents, family members, treatment providers, and others critical to the success of the child's transition. The transition process should be consistent with the child's developmental and mental health needs and respectful of a child's need for stability and consistency in their relationships across placements, with an effort on limiting placement transitions as often as possible.

Foster Parent/Relative Caregiver Training

- Issue: Foster parents and relative caregivers need to be adequately equipped to meet the needs of children placed in their homes.

- Recommendations:
 1. DHS needs to ensure that Foundations Training for all foster parents and relative caregivers includes basic information about the following: a) how to address the trauma-related needs of children who have been abused/neglected; and b) how to appropriately respond if a child in foster care discloses additional abuse.
 2. DHS needs to ensure that Foundations Training is readily available for all foster parents and relative caregivers that are certified for emergency placements. Working closely with rural communities, DHS should strategize alternative ways to ensure that new foster parents and relative caregivers receive this training within a specific time period of a child having been placed in that person's home.
 3. In its case planning for children in foster care, DHS should enhance its work with foster parents and relative caregivers to identify and meet any specialized training needs that will support the individual needs of children placed in the home.

Grandparent/Relative Visitation

- Issue: The grandparents in the case reviewed were not allowed to visit their grandchildren because they did not believe that the parents (the grandparents' children) had abused their grandchildren.
- Recommendations:
 1. DHS will ensure that a visit and contact plan with the family is encouraged unless the child's safety and well-being is compromised. DHS will include in its training focus on its new policies regarding relatives clear guidance to staff that visits with relatives are based on the child's safety, developmental and attachment needs, and not based upon a family member acknowledging that abuse occurred.

2. DHS should seek additional funding – from the Legislature and/or from other sources, such as the philanthropic community - for supports for relatives, upon request, to receive a “child welfare system navigator”, i.e., a neutral individual employed by a community partner whose job it is to support relatives working with the Department in child welfare cases and to assist relatives caring for children in the Department’s custody, in guardianship or adoption arrangements. Absent additional funds to pay for this service, the Department should explore opportunities for community partners to volunteer to be screened and trained to offer these kinds of supports to relatives.

Coordination with the Mental Health System:

- Issue 1: The children in this case were assessed and evaluated multiple times by multiple mental health counselors, psychologists and (in one child’s case) a psychiatrist – telling and re-telling their story to different people. This was not only hard on the children, it also created the opportunity for conflicting opinions about the children’s mental health needs. In addition, the parents in this case were evaluated separately, resulting in conflicting opinions among therapists about the best interests of the children and the parents’ abilities to parent.
- Issue 2: To be objective and comprehensive, mental health professionals evaluating a child in foster care need to have access to diverse sources of credible, relevant information about that child’s past and present development and behavioral issues and needs. In particular, the biological parents of a child should have the opportunity to contribute to the background information to which a mental health professional has access. In addition, individuals other than a child welfare caseworker – including relatives of a child – who have relevant information about a child should be offered the chance to contribute to the knowledge of a mental health professional evaluating that child.
- Recommendations:

1. Every DHS District and local Mental Health Organization should have a memorandum of understanding outlining their process for communicating about and coordinating care for children in foster care.
2. DHS and the Mental Health system should identify ways to purchase assessments, therapy and psychological evaluations for children and families in the child welfare system that are family centered (rather than centered on an individual child or parent). This should include exploration of the possibilities around therapist reimbursement for participation in child/parent visits early and often to help the Department in its evaluation of the parent's capacity to parent. DHS personnel would benefit from education about how the recommendations of a psychological evaluation for any one family member will be focused on the best interests of that family member and may be contrary to the DHS plan that is often "return to parent." DHS should identify evaluation processes or consultation services that assist them in integrating the recommendations of various individual evaluations to best support the legal plan for the case. To achieve this goal, DHS may benefit from developing a protocol for a family-centered evaluation and recruiting mental health professionals familiar with the child welfare system to provide such evaluations.
3. DHS should establish protocols for supervision and case reviews that focus attention on each child's emotional needs and system compliance with policies such as timely mental health assessments, the keeping of medication logs by foster parents, and implementation of the review requirements surrounding psychotropic medications in HB 3114.
4. The Legislature should adequately fund statewide implementation of the Wraparound Initiative (HB 2144, 2009 legislative session), designed to ensure child and family-centered care coordination that is more efficient and effective. For children in the child welfare system, the Wraparound process should always involve mental health professionals

including, but not limited to, consulting psychologists or other mental health professional adequately educated about the case.

5. In partnership with mental health professionals, DHS should develop protocols that will enable biological parents and other individuals with relevant knowledge about a child's past or present to provide information as background to mental health professionals tasked to evaluate the child. DHS personnel should actively encourage the biological family to share relevant information with all professionals working with the child or family. Mental health professionals would benefit from releases of information to gather background information from relevant family members.

Legal Process

- Issue 1: Delays in this case occurred at least in part due to DHS' efforts to coordinate with the ongoing law enforcement investigation. Most critically, there was a significant delay in terms of the filing of a second petition in the case, which delayed the establishment of jurisdiction on the grounds of sexual abuse and, in turn, delayed a change in service plan for the parents.
- Issue 2: All legal parties in a dependency proceeding have an obligation to present evidence to the court so that the judge can make an informed decision about the issues in a case with as much information as is relevant and available. In Oregon, attorneys for parents and children are carrying extremely high caseloads, making it difficult to provide the highest quality representation in every case (particularly when your caseload spans a wide geographic area and where specializing in dependency work is economically unsustainable). Also in Oregon, DHS/child welfare is not represented by counsel in all dependency proceedings, leaving caseworkers to "represent" themselves in court. Finally, not every child in Oregon has a Court Appointed Special Advocate, leaving cases without a neutral person charged solely to represent the best interest of the child to the court.

- Recommendations:
 1. To avoid unnecessary delays, DHS should develop a protocol allowing for the use of Assistant Attorney General representation in pre-dispositional hearings when a conflict occurs as a result of the District Attorney's interest in a parallel criminal case.
 2. The Legislature should provide funding to reduce the caseloads, enhance training, and improve the quality of legal representation for parents and children in dependency proceedings.
 3. The Legislature should continue to look for ways to maximize funding to the Department for District Attorneys (representing the State in pre-dispositional hearings); Assistant Attorneys General; and reduced caseloads for Child Welfare Supervisors to enhance the level of clinical supervision, support and oversight supervisors are able to provide line staff.
 4. The Legislature should expand funding for the CASA program so that more children in dependency proceedings have CASAs.

Child Welfare Staff Training

- Issue: Child welfare staff go through mandatory training upon being hired. Thereafter, most on-going training for staff is not mandatory. On-going training does occur, but because it isn't mandated (for the most part), it is not consistently delivered to all staff. Child welfare staff need more training focused on child development and case management practice to ensure that child and parent plans – including those involving foster care placement, visitation, conditions for return to a parent, etc., consider comprehensively the individual needs of a child and parent from removal throughout the life of a case.
- Recommendations:
 1. The Department should explore its options for requiring, and funding, an on-going training requirement for all child-welfare staff. This should include cross-disciplinary training with

judges, attorneys, CASAs, the mental health system, and other critical partners serving families and children in dependency proceedings, as well as training focused on specific issues identified in sensitive case reviews, quality assurance reviews, and Critical Incident Response Team reports.

2. DHS should explore the costs to require a professional license, certification or professional registration for all child welfare case workers and child welfare supervisors. DHS should also include the costs associated with initial and ongoing training to maintain such a professional work force. In this research, DHS should study options used by other states in this regard. DHS should then provide a report with recommendations to the Legislature that would include both the costs – and anticipated benefits -- associated with several potential options.

Reinstatement of Parental Rights

- Issue: In some cases where parents' rights are terminated, there may be legitimate reasons to reopen a dependency case and vacate the termination of parental rights. For instance, some state laws allow for this to happen if a child in foster care is not adopted, a parent's life circumstances have substantially changed/improved and it is in the best interests of the child.
- Recommendations:
 1. The Interbranch Juvenile Dependency Workgroup, which includes members of the Legislature, the Judiciary, the Department, the Oregon Law Commission, and other stakeholder experts in dependency matters, should examine other states' practices for reopening Termination of Parental Rights cases and make recommendations to the Legislature regarding whether Oregon should create its own criteria in law as to when this could be an option for children and parents in Oregon.

Conclusion:

The Sensitive Review Committee urges the Legislature to seriously consider its recommendations and requests that CAF regularly report to the Child Welfare Advisory Committee its efforts to implement those recommendations that do not require legislative action or additional resources to implement.