Final Report of the Special Master
CASA for Children, et al. v. State of Oregon et al.
United States District Court for the District of Oregon
Case No. 3:16-cv-018195-YY
February 29, 2024[1]

"Owen" and "Martin" smile in the picture in their new home at age 9 and 7. When Owen was 19 months old in rural Oregon, his brother was born prematurely, weighing less than 4 pounds and requiring resuscitation at delivery; he was in the NICU for more than a month recovering from their mother's opiate use during pregnancy. When Owen was 4½ and Martin was 3, their mother got out of prison and left the state. Owen was not diagnosed with Autism Spectrum Disorder until he was 7. He was in a half-day special education class and was described as being "scattered, disoriented, struggling to listen to adults' prompts and not following directions." He had limited speech and would "scream, climb to get computers and take off his clothes" in school. When they entered foster care after physical abuse, 7-year old Martin was only attending school two hours a day and had an IEP for ADHD although his behaviors included head banging, aggression and encopresis. Several resource homes could not manage Owen, and shocking as it sounds, he spent three months in a hotel at age 9 before he and his brother were reunited in a DD foster home.

1. History of Temporary Lodging in Oregon

At least ten other states are in litigation regarding housing children/youth in foster care in offices or hotels. In recent years, a trickle of children in foster care without homes has become an unmanageable flood due to inattention to the adverse effects of disrupted placements, shrinkage in the number of foster homes and group care, neurodevelopmental complexity from prenatal substance exposure and trauma, and insufficient timely interagency action.

In Oregon, children without placements began spending the night in foster care offices in 2012. As children sleeping in offices increased, the Oregon Department of Human Services (ODHS) started paying for children supervised by child welfare staff to stay in hotels. In 2016, the Oregon Law Center and Youth, Rights & Justice filed a lawsuit regarding the use of hotels to house children and youth in foster care. In 2018, the parties entered into a settlement agreement limiting ODHS to temporary lodging for children in foster care only if there was no other safe alternative and ODHS had exhausted the alternatives for that child/youth. The parties agreed to a schedule for reducing the number of children and youth in foster care in hotels from 120 to 23 by July 2020, and after that no more than 12 children. In 2018, the lengthy "Temporary Lodging Root Cause Report" urged individualized services, ODHS program collaboration, and improved contracting to address

[1] Feedback on the draft report submitted to Honorable Michael McShane on November 30, 2023 resulted in revisions on pages 11 and 32 and in the footnotes on pages 19, 22 and 31 in this final report.

the "complexity of issues" behind Temporary Lodging. In January 2020, the court issued an order finding that ODHS was not in substantial compliance with the agreement. ODHS was ordered to hire a dedicated Resource Management Director (RMD) to authorize each instance of temporary lodging and document the steps taken to avoid it in order to comply with the agreed-on reductions by September, 2021. But the flood continued, and although in 2021, of the 337 children/youth who had RMD staffings, 75% (253) were prevented from going into temporary lodging, 84 spent at least one night in a hotel. In 2022, 411 children/youth were staffed, 73% (299) were prevented from going into temporary lodging, but even more than the previous year--112--spent at least one night in a hotel. In 12/14/22, the Plaintiffs filed a motion saying that ODHS had spent over $20 million housing children in "inappropriate places" since the 2018 settlement agreement and asking the court to appoint an expert. ODHS acknowledged that despite efforts to prevent of temporary lodging, it was not in compliance with the agreement. The state attributed the continuation of children/youth in temporary lodging to increased aggression, suicidal ideation, sexual harming, and children refusing placement, decreased resource homes and residential beds due to a combination of providers funded through the Oregon Health Authority (OHA), ODHS's Office of Developmental Disability Services (ODDS) and ODHS/Behavior Rehabilitation Services (BRS) being unable to recruit and retain staff and the restrictions on the use of physical intervention with out-of-control children/youth, both of which led to higher rates of rejection of high needs children/youth in foster care. The plaintiffs argued that ODHS had ample funds to increase residential beds and that its failure to request a necessary rate increase for resource parents for nearly five years caused the resource home shortage.[2]

In July, 2023 U.S. District Court Judge Michael McShane issued an order agreeing that "while ODHS has certainly faced challenges in complying with the agreement, these challenges cannot serve as an excuse for preventing ODHS from achieving substantial compliance…This noncompliance extends well beyond the start of the pandemic or the 2021 enactment of SB 710…while the court notes ODHS appears to be making some strides in tackling this problem, those strides have generally come too little and too late." In his July, 2023 order, Judge McShane concluded, "An outside expert is needed…and the court appoints Marty Beyer as a special master to make specific recommendations for the court." ODHS entered into a one-year contract with Dr. Marty Beyer to follow Judge McShane's order to gather information and formulate recommendations to the court in three months. The parties agreed that Dr. Beyer would complete a report by November 30, 2023 and

[2] The following abbreviations are used in this report: TL (Temporary Lodging); ODHS (Oregon Department of Human Services); CW (Child Welfare); DD (Developmental Disabilities, also called IDD Intellectual/ Developmental Disabilities); OHA (Oregon Health Authority); CCO (Coordinated Care Organization); OHP (Oregon Health Plan-Medicaid); TFC (Treatment Foster Care); BRS (Behavior Rehabilitation Services); QRTP (Qualified Residential Treatment Programs), PRTS (Psychiatric Residential Treatment Facilities) and MH (Mental Health). Children/youth's *mental health* is the term used in this report. While behavioral health sometimes is considered an updated concept that lacks negative connotations, "behavioral" suggests that actions are under volitional control. Mental health refers to a child/youth's emotions which can be affected by life experiences, family history and biological factors and includes substance use disorders. The terms "resource parent" and "resource home" are used in this report to refer to what was formerly called foster parent and foster home. The term "kin caregiver" will refer to relatives and familiar adults (sometimes called kith) who have been certified by ODHS to provide a home for a child in foster care.

would spend nine months monitoring and reporting on progress in response to the court's order.

2. Oregon Foster Care Compared to the U.S.

Oregon scores 26th in Child Well-Being in the nation, and 14% of Oregon children live in poverty.[3] In Oregon 72% of 4th graders are not proficient in reading, with the state spending $12,457 per year per pupil (as compared to $13,187 nationally and $14,342 in neighboring Washington state).

There are 400,000 children in foster care in the U.S. Of Oregon's 862,000 children under age 18, about 5,000 are in foster care. Of the children in foster care in Oregon, 41% are age 5 and under (as compared to 34% nationally). Similar to other states, more than a third of children/youth in foster care in Oregon are placed with a relative, less than half in an unrelated resource home, and 9% in group care. In May, 2023, of all the reports to the child abuse and neglect hotline, about 4,000 were investigated. Of those, there were about 600 completed Child Protective Services assessments substantiating neglect or abuse. Of those, 170 children were placed in foster care.

An upstream factor in the unmanageability of the flood of children in TL is that in comparison to other states, Oregon removes more children from their families and more children stay in foster care longer than other states.[4]

	# of Impoverished children, 2020	Entries into foster care, 2021	Rate-of-removal per thousand impoverished children	Rank
Oregon	100,333	2,413	24.0	23
Wash	174,333	3,849	22.1	27
N J	180,000	1,534	8.5	50

	# of Impoverished children, 2020	Children in foster care, 2021	Rate-of-placement per thousand impoverished children	Rank
Oregon	100,333	5,269	52.5	17
Wash	174,333	8,894	51.0	19
N J	180,000	3,188	17.7	49

In comparison to what is regarded as the best child welfare system in the country (New Jersey), Oregon has nearly half the number of children living in poverty, but has a three times higher rate of removing children from their homes and an even higher rate of children in foster care. The child welfare agency in New Jersey, with many more impoverished children in the state, has proportionately many fewer children/youth in foster care to place with resource parents, kin caregivers and group care.

[3] Annie E. Casey Foundation, 2021.
[4] National Coalition for Child Protection Reform, 2023

3. Characteristics of Children/Youth in Oregon Foster Care who have Stayed in Hotels

A total of 92 different children and youth in foster care stayed in hotels at least one night between January 1, 2023 and August 31, 2023, representing less than 2% of the foster care population. They ranged in age from 6-19 years old, with 22 pre-teens (24%), 32 age 13-15 (35%), and 38 age 16-19 (41%) (6-2, 7-1, 8-1, 9-1, 10-2, 11-5, 12-10, 13-11, 14-10, 15-11, 16-20, 17-13, 18-4, and 19-1). Sixty percent (55) identified as males and 40% (37) as females. Sixty-three percent (58) were white (non-Hispanic), 15% (14) were Hispanic, 14% (13) were Black, and 8% (7) were Native; BIPOC children/youth are disproportionately represented in foster care and TL.[5] More than two-thirds were from four of the state's five most populous counties: Multnomah (33%), Lane (17%), Marion (12%) and Washington (10%). For the 92 children/youth in hotels during January 1- August 31, 2023, their hotel stays lasted from 1 night to longer than 4 months. Nine of them had experienced four or more TL stays dating back more than two years. Some of them left the hotel and returned and some spent a weekend with their family and then returned to the hotel, while a few were placed and then months later the placement disrupted and they were back in TL

The number of different children/youth who spent at least one night of TL varies from month to month, with 24 in January, 2023, 26 in June, 2023 and 26 in October, 2023. Children/youth who had never previously been in TL also rises and falls with 10 in March, 2023, 6 in June, 2023, and 12 in October, 2023.

One third of the young people who in stayed in hotels between January 1, 2023 and August 31, 2023 did not enter foster care until they were age 14 or older. These include youth from Juvenile Departments and hospital emergency departments as well as those who were rejected from multiple residential placements because of their angry behavior and/or suicidal thinking, characteristic of frustrated adolescents traumatized by family problems and delayed development. The teens were disproportionately Black, Hispanic and Native. Several of them were LGBTQIA+. Several of them were repeaters in TL. Four entered foster care at age 17, within a few days or weeks were in TL and none were prepared for living independently.

4. Prevention of Temporary Lodging

The process of preventing children/youth from staying in hotels is carefully managed. When a child welfare branch indicates they cannot find a place for a child/youth to stay, the ODHS Resource Management interagency team collaborates in a virtual staffing with the local caseworker, supervisor, certifier, and permanency specialist, as well as state level DD and OHA staff to identify a member of the child's family or a resource parent who can be offered extra support to care for the child/youth; usually a statewide request for

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[5]

	State Population	Children/Youth in Foster Care	Temporary Lodging
Black	2%	7%	14%
Hispanic	13%	16%	15%
Native	2%	6%	8%
White	87%	64%	63%

Race, ethnicity, economic status, sexual orientation, gender identity, immigration status and religion have an interconnected impact on the experiences, opportunities, and health, education, and mental health of children/youth and their families.

resource homes is issued. Typically applications are made to TFC and proctor homes as well as group care programs across the state; referral for DD eligibility is initiated or if the child has already been determined eligible, a DD home search begins. Through this process, the majority of the children/youth considered at risk of TL are prevented from spending a night in a hotel.

5. Children/Youth in Oregon Foster Care who are Prevented from Staying in Hotels

In the first six months of 2023, 229 different children/youth were prevented from entering temporary lodging. Most were from seven counties: Multnomah-49 (21%), Lane-30 (13%), Marion-19 (8%), Linn-19 (8%), Washington-13 (6%), Clackamas-12 (5%), and Lincoln-11 (5%); 18 counties had from 1-8 children/youth prevented from entering TL. Children/youth prevented from entering TL were Under 5: 7 (3%), 6-12: 60 (26%), 13-17: 142 (62%), 18+: 20 (9%).

Looking more recently, between 9/22/23-10/5/23 there were 68 prevention staffings for 60 youth, and 37 did not enter TL (62%); 23 spent one or more nights in TL. Between 10/6/23-10/19/23 there were 71 prevention staffings for 60 youth, and 45 did not enter TL (75%); 15 spent one or more nights in TL, with almost all of them being returnees to TL.

The high costs of TL prevention are often the result of services not being provided much earlier, less expensively and from resources other than state funds. Had children's behaviors soon after entering care been treated, through therapy and IEPs, for example, and their caregiver been supported to teach emotional regulation and improved comprehension, many of them might not have required costly contracts to manage behavior in an older, less trusting child.

TL prevention pays for assistance for caregivers in their home who are Individual Support staff attending to a child/youth for part of each day or around-the-clock, which are costly services intended to lead to stabilizing the placement and reducing challenging behavior. For the hundreds of children and youth prevented from staying in TL between July 1, 2021 and June 30, 2023, $2,855,000 was spent for four contractors providing in-home staff for 65 children/youth plus $5,192,437 for assistance for 343 children/youth in resource homes and kin caregiver homes of, for a total over two years of about $8 million. Children/youth for whom TL is prevented rarely are placed with caregivers at the typical state rate. During that period 165 resource parents and kin caregivers received thousands of dollars for each child/youth to hire individuals to provide care and respite for the child/youth as well as to transport them while their resource parent/kin is at work. In some situations, TL prevention funds are also used to make it possible for an adult to stay home from work to care for the child. About $300,000 of prevention funds between July 1, 2021 and June 30, 2023 were spent on rent so that kin could live with the child/youth, as well deposits and rent for moving with the child/youth into a residence. About $100,000 of prevention funds were for child care and afterschool care.

Most of the TL budget is used to keep children/youth with caregivers for whom the TL team has invented creative solutions. For example, a relative with a low-paying job who was raising her children and wanted to permanently house siblings removed from an extended family member requested major house repairs to accommodate them. A parent willing to move from out-of-state and get re-settled in Oregon with their child who had been rejected by many

programs required a temporary home while they searched for local employment and housing. A relative on a limited fixed income wanted to live with a child who had been rejected by other caregivers, but had to move out of her shared living situation while they lived together waiting for housing assistance.

6. Children/Youth Entering Temporary Lodging

If none of these efforts to locate a placement for the child/youth is successful or if the child/youth refuses the placement offered, the RMD staffing approves a hotel stay for the child/youth as a temporary arrangement while the team continues their search for a placement.

The usual reasons programs, resource homes and kin (after being offered additional services and/or a higher rate) give for rejecting the child/youth are: physical aggression, self-harming, noncompliance including running away, verbal aggression, and sexualized behavior (sometimes the behavior has not occurred for months or years but is concerning for the prospective placement).

The well-being of children/youth in temporary lodging is monitored daily via email and typically weekly virtual staffings are ongoing with 10 or more participants to continue arranging more suitable placements than a hotel. These efforts are documented day by day as more requests for admission or eligibility determination are made and individuals are contacted to inquire what would be required for them to care for the child/youth.

7. The Financial Costs of a Hotel Stay

The average cost of a hotel stay is **$2,561/night** which includes two 24-hour ODHS staff on overtime, meals, and room (rooms average $266/night; variable depending on location and staff salary based on position) When there are one ODHS caseworker overtime ($1,570 for 24 hours) and one contract staff (about $1,800 for 24 hours), TL can cost **$3,370/night**.

There are five providers in different parts of the state who place contracted staff with children/youth during the day in pairs and overnight in various configurations with or without CW staff. Providers have their own contracts and different hourly rates set up with counties. Two providers have a 24 hour rate less than $3,000 that includes a package of two staff and the child's meals and activities.

These cost calculations do not take into account the presence of more than two adults, although to manage the aggressive behavior of many children/youth in TL, after 6 PM it is not unusual to have three adults (a combination of one or two CW staff and one or two contracted staff).

TL is not a placement, so CW staff are required to be present during "after work" hours. One adult is required to be awake at all times and two adults awake if the child/youth is awake. Children/youth in TL must always have at least two adults supervising, and from 6pm – 8am at least one of those must be a CW employee. During the 8am – 6pm hours, the two adults can be configured from a variety of staffing options Depending on the needs of the child/youth, it is not uncommon for contract staff to remain until the child/youth falls asleep.

The emotional outbursts common in children/youth in TL sometimes escalate to property damage, including breaking furniture; a few children/youth urinate or defecate in their rooms. The cost of cleaning and repairs is in addition to the typical costs above.

8. The Experience of TL for Child/Youth and the Staff

Although every child/youth's experience is different, based on spending time with youth, ODHS staff and contracted staff in hotels, the Special Master found it well-supervised single-child housing that is extremely costly and that the youth was aware is unavoidable because there is no placement that will accept them or that they will accept. Subtle, but not expressed feelings of abandonment and worries about an unknown future appeared to be affecting the youth's behavior.

In the Special Master's TL observation, the hotels were modest (rooms cost $120-$150/night for typical guests). For TL, the usual arrangement is two rooms with two queen beds with a door that opens between them; sometimes the staff room has a pull-out couch and a Murphy bed so each staff can sleep half the night. If it can be arranged, a suite with two bedrooms and a small kitchenette or a two-bedroom Airbnb so the youth can be involved in meal planning, cooking and doing laundry is preferable but less available and more costly. One interviewee familiar with two Airbnb's used for TL described them as "sterile, less well-furnished than a hotel."

During the observation, the contracted staff: (1) relied primarily on structure to manage the youth; (2) were calm even when the youth became frustrated waiting for their caseworker or with being told "No" regarding an activity; (3) planned the day around the youth's preferred physical activity and food, as well as school and other appointments; and (4) did not show exasperation with the youth's behavior. It was evident the youth enjoyed the all-you-can eat restaurant he had requested for dinner. After dinner they went to the Y for swimming where three evenings a week he enjoys playing in the water with peers under the careful supervision of the two contracted staff. In the restaurant and at the Y; he could not be distinguished from any teen eating or swimming with their family.

The young person was anxious to see his caseworker that night to ask about employment and the possible pending placement in a resource home; he continued to be disappointed that a hoped-for overnight trip could not happen; he once again requested a phone. The contracted staff reported that he was much calmer than he would have been several weeks previously in dealing with these disappointments. His caseworker stayed in the staff room; the young person had been living in his adjacent room for weeks. The contracted staff sat in the staff room until the youth was in bed with lights out. The youth was calm and fell asleep; the contracted staff confirmed that the caseworker (who would remain awake) felt it was okay for them to go to their separate neighboring room, on call for the worker if the youth awakened. In the morning the caseworker left just as the youth was getting up. The youth and contracted staff had the free breakfast in the hotel; they both took the youth to shop for a winter jacket as the weather was getting too cold for his hooded sweatshirt. After their return to the hotel, the staff going off duty completed the tracking notes, and the new contracted staff arrived to replace him.[6] The newly configured 2-person team was planning to remain on duty for several days. The provider has a complex scheduling system, both arranging for supervision of youth around the state and to give staff choice about their hours. Some prefer working for several days without leaving while others prefer 24-hour shifts or long weekends. Providers hire more male staff, and female

[6] For each child/youth with contracted staff, a daily tracking report of activities is prepared; these are summarized twice/month by ODHS.

staff are usually paired with male staff; often with a male youth, two male staff are assigned. They reported that if a child/youth has challenging behavior or is unable to sleep, the contracted staff will remain awake with the CW staff in the staff room adjoining the youth's room. The contracted staff's activity log for the week with this youth reflected that in addition to swimming, he went to school, watched TV, played card games, went to the Arcade, and made a trip to the beach.

In the other observation, the contract staff defined their role as sitters; they work TL once or twice a week to augment their income from another job or retirement. The 12-year old was delighted to see her former ODHS caseworker and another favorite ODHS staff who brought her a gift that entertained them for the evening. They bought a whiteboard to write the scheduled activities and her daily goals. She got feedback for talking back, but during the observation her behavior was typical pre-teen. She has been trapped in years of hoping her parent will want her and her wish for a lasting resource family, and she has been blamed for "sabotaging" as her behavior increasingly has acted out her misery. A move to a resource home would require extra daily support staff on a team with a therapist, a stable school placement and a regular respite provider—she is likely to both want the placement to be permanent and be constantly fearful of rejection, so intensive services will be necessary for a long time as she heals from so much traumatic loss.

9. What Happens After a TL Stay?

A small study was done of 15 children and youth in foster care who stayed in hotels between January 1 and February 28, 2023 and several months later had not returned to TL to get a picture of what happens for children/youth after a hotel stay. They ranged in age from 6-18, with one 6-year old, one 17-year old and one 18-year old, and the rest being between 12-16. Eight identified as females and seven as males; three were transgender. Two of the children/youth were Black, three were Native, three were Hispanic and seven were white, non-Hispanic. Ten were from the three most populous counties.

Four of the 15 left TL and were directly placed in the homes where they remained eight months later at the time of this report. A 14-year old spent a month in TL waiting to be admitted to a BRS proctor home. A 17-year old spent two months in TL waiting for a placement in an DD adult foster group home. A 15-year old spent three months in TL waiting to be placed in a resource home. A 12-year old was in TL a month waiting for placement into mental health residential treatment.

Nine of the 15 left TL and were in one or more placements until they moved into a lasting placement. A 16-year old spent two weeks in TL and moved to a resource home for two months until he was placed in a DD foster home. Another 16-year old spent three weeks in TL, moved to a resource home and was placed in a DD foster home a month later. A 14-year old was in TL two days, moved to family member's home for two weeks, was placed in residential treatment for two months, and spent a month in a kinship placement waiting to move to a DD group home. A 16-year old spent five days in TL, was placed in a resource home, then in a psychiatric hospital, moved to three other resource homes, and a proctor home for five months before returning to his guardian with in-home DD services. A 14-year old was in TL for one night, was placed in a shelter for five weeks, and was accepted into a proctor home. A 13-year old spent five months in TL, then was in a resource home and returned to family. Another 13-year old spent one night in TL, was placed in a psychiatric hospital, moved to a BRS treatment home, went to a resource home and entered a residential

program. A 12-year old spent three weeks in TL and was placed in residential treatment for two months before being accepted in psychiatric residential treatment. The 6-year old spent a night in TL, then was placed in two resource homes and a psychiatric hospital before being placed in residential treatment.

In addition, one 16-year old spent four months in TL, was placed in a resource home that was stable for many months, but then returned to TL. One 18-year old spent ten days in TL, left the hotel and did not return, and is living on his own without a home, although he has been offered housing by his foster care caseworker who continues to stay in touch with him.

This small study clarifies that children/youth spent varied amounts of time in TL from one (3) to 2-5 nights (2), two weeks to a month (5) to 2-5 months (4). Their post-TL placements were designed to be long-term or were interim placements while waiting for a long-term placement. Six of the 15 waiting in hotels and in subsequent placements were waiting for DD homes, four for residential programs, two for proctor homes and three for resource homes. Some youth spend one night in TL while arrangements are made to shore up their placement. Other youth who are new to CW, from the Juvenile Department, hospital ED or from out-of-state spend nights in TL while a placement is found and arrangements made. With a history of suicidal and/or aggressive behavior most are in TL after not being accepted in a resource home, relative home or residential program.

"Wilder" is 11 and has struggled with neurological impairments from prenatal substance exposure, developmental delay, sexual abuse by his older brother and inconsistency by his caring mother. Agencies have responded to his different diagnoses independently, as if he were not a whole child with the combined needs of all his challenges. When he was 3 and CW became involved, Wilder had aggressive and uncontrollable behavior attributed to sexual abuse. At 11, he was on a half-day schedule, the only student with an IEP in a regular education classroom with 24 students. He went to a hotel, and a psychological evaluation expedited through TL Prevention concluded, "Wilder is a developmentally delayed and neuro-compromised youth who requires intensive interventions. His trauma interferes with his ability to utilize and navigate relationships. He is at a critical point in his development in which he needs his caregivers and service providers to prioritize treatment stability and consistency so that he can move forward on a path that allows him to best access his capabilities." Recommending a referral for DD Services, the evaluator concluded, "Wilder has a long history of involvement with various therapeutic agencies, but he has yet to experience intensive outpatient services, engaged and consistent individual therapy, and therapeutic supports integrated with skill-building and school/home interventions." After months in a hotel with his grandmother, DD had yet to determine him eligible (in order to access in-home DD services) and no DD Title 8 housing was available, but his team had progressed toward a move with his grandmother into a low income apartment.

10. Children/Youth who have the Longest Stays or Repeat Stays in Hotels

A small study was done of 20 children and youth in foster care who stayed in hotels between January 1 and August 31, 2023 and had repeated hotel stays and/or had been in TL for months. They ranged in age from 6 to 19. Thirteen identified as male and 7 identified as female. Ten were white, 5 were Black, 3 were Hispanic and 2 were Native. Three were transgender.

Half of them came into foster care in childhood and half when they were teens. Only eight had been found eligible for DD services, although an additional seven had testing

indicating low IQs and eight had testing that documented executive function deficits. Three of the children/youth who had DD services were diagnosed as having Autism Spectrum Disorder, although one was not diagnosed until age 16 after entering foster care. Four of the 20 had failed adoptions, and two others had failed guardianships or long duration resource homes.

Surprisingly, six of the 20 did not have past or current psychological or neuropsychological evaluations in their CW records. Six of the 14 psychological evaluations were completed in late 2022 or in 2023 after they came into TL.

Five of the 20 had significant substance abuse and four of the 20 had suicidal thinking or self-harming that were reasons for their coming into care and being in TL.

Although more analysis is necessary, this group of 20 had received many mental health services: nine had been in psychiatric placements and 15 had been in hospital emergency departments. In 2022, 8 had none or only a few outpatient mental health visits, 2 had every other week outpatient mental health visits (if averaged out over the year), 5 had weekly outpatient mental health visits (if averaged out over the year), and 5 had 50 or more outpatient visits during the year (outpatient visits could include individual, group, and/or family therapy and/or medication management).

This is a snapshot of the children/youth in foster care with the highest needs. Some have grown up in foster care with behavior that appeared poorly understood and less and less manageable. Some entered care when they were older and their families were unable to meet their needs. All had multiple placements with relatives, resource homes, and residential programs before and all after they had their first TL stay.

Youth may be in a hotel hoping to return to or be placed with family, but without enough support, the placement fails and they return to the hotel. Youth who are in and out of hotels may be placed, the placement fails and they return to TL or they run away from placement, are in TL, are placed again and run away again. Some of these youth ended up after multiple and/or lengthy TL stays in a DD home and a few in a resource home or with their family with MH and school services. But at least four of these children/youth have been in TL for many months and require an interagency combination of intensive therapeutic and special education services in a home with no other children.

A substantial number of the TL placement notes reflect concerted efforts to speed up DD eligibility findings. Children/youth remain in TL for weeks or months because they are awaiting a DD placement. Residential programs repeatedly deny them, a frustrating process described as "too acute for one level and not acute enough for another." Some are youth who refuse to leave, some saying they prefer being in a hotel to being rejected again from a home or program while others are unwilling to go to a program that requires them to relinquish their phone.

"Valencia" is a 17-year old Native girl who was adopted in coastal Oregon with her siblings when she was a toddler. She was diagnosed with Fetal Alcohol Spectrum Disorder and Reactive Attachment Disorder. She re-entered foster care when she was almost 16 and she had 13 placements in two years, with repeated psychiatric hospitalizations and going in and out of residential programs that could not manage her self-harming and suicidal ideation. When no placement could be found for her at a psychiatric hospital discharge, she waited in a hotel for two months until an Adult DD Group Home was arranged for her.

11. How Oregon Can End the Placement Crisis for Children/Youth in Foster Care

Temporary Lodging is not the problem. Everyone agrees that TL must end because it is not good for children and youth. The majority of the recommendations in this report address interagency changes far upstream from TL. At the end of this report, possible remedies to the current challenges for children and youth now in the TL pipeline will be suggested.

The settlement agreement established metrics ODHS was ordered to achieve rather than the process for the state to provide stable homes for children. Many ODHS employees across the state became metrics- focused, narrowly concentrating on keeping each child/youth out of a hotel or protecting them when they were in a hotel. This approach has been extremely costly financially as well as exhausting for ODHS staff working overtime in hotels in addition to their regular jobs. The CW preoccupation with the settlement agreement metrics has gotten in the way of effective solutions before children/youth become unplaceable. As OHA, CCOs and providers collaborate with CW and DD to increase stable therapeutic settings that do not rely on ODHS staff on overtime, the focus should shift away from metrics. Nevertheless, regular reporting on TL Prevention and temporary housing of children/youth when it cannot be prevented is necessary.

The agency the court designates as the caretaker of the child cannot open the door to Medicaid funding for services to meet the child's needs. The refrain often heard in planning care for these high-needs children is: "Allowable under Medicaid but not an accessible service." The only effective community approach to child well-being would require state doors opening for collaborative intervention that does not divide up the child but recognizes that every child entering foster care has delayed development and loss that can only be effectively addressed by the child's parent, caregiver, therapist, school and other service providers in concert. Early interagency collaborative care can get children on a typical developmental trajectory so they can return to their parent or have other permanent homes. This will require Medicaid funding, special education and other developmental services, and a range of homes with an array of services surrounding them to ensure placement stability. When children do not come into care until they have been repeatedly traumatized and/or have even more significant developmental deficits, some specialized residential capacity designed to meet the children's needs will be necessary with carefully-designed transition to stable homes.

The thousands of children blocked from receiving the therapeutic and educational services to meet their needs for years while in foster care are further harmed by agency divisions driving reactive interventions that push children into placements and schools that cannot meet their needs. It is not too late to design multi-agency care to meet their needs from trauma and delayed development, but it cannot be done by any agency alone, it cannot be done by the current configuration of services, and it cannot be done without Medicaid funding for needs-driven services.

Child well-being is everyone's goal in child- and youth-serving agencies. Placement instability is the biggest threat to the well-being of children in foster care. After multiple placements, a child/youth may not have experienced settling in or being able to count on an enduring home with someone they trust. A primary characteristic of children/youth headed to TL is the inability to settle. Difficulty settling can lead to enduring relationship problems and lack of success in the transition to adulthood. The experience of so many losses of family and from multiple placements leads to a need to be in control which creates

anxiety that undermines all the child/youth's relationships. Placement instability starts the cycle of loss of school and friends and increased feeling they do not belong, reduced trust and increased alertness for small indications of rejection, and their behavior reflects their anger and sadness, which overwhelms the caregiver, and the child/youth moves again, changing schools, friends and therapists. Placement instability is a major cause of emotional outbursts: it increases the reaction of an abused or neglected child/youth to small disappointments being experienced as unfair, as yet another victimization. "No one understands" becomes the multiply placed child/youth's habitual response to perceived rejection.

Placement change is stressful for children of all ages. Even a planned family move requires challenging adjustments; the uncertainty and sense of rejection (often unintended) for children in foster care makes any move more difficult. Changing schools and friends results in months of adjustment, depending on the child's unique temperament and social skills. *Placement change is loss*: loss of relationships; loss of friends; loss of a familiar school; loss of culture; discontinuity in mental health services and special education services.

Unanticipated moves and/or placement uncertainty are harmful for children. Children surprised by a move typically regress which is often not understood by caregivers and school staff and leads to a continuing sense of differentness and bullying by other children. Being unable to control their surroundings has varied effects on children depending on where they are developmentally. The less capacity to verbalize internal state, the less the child feels the adults understand and can soothe them. The more stressed the child, the less they can manage their anxiety, anger and sadness. Behaviors that express feelings of loss may look like desperate attempts to get attention or control and should be anticipated in every child with every move; the more the child has lost previously, the more likely these behaviors. The multiply moved child may be plagued with a sense of vulnerability, worrying, "What will happen to me?"

Caring adults often misunderstand the child's verbal and physical outbursts and react as if they were directed at them personally; the adult may become less receptive and soothing as a result, unintentionally adding to the child's feeling rejected. How adults are handling their stress about the move and the child's reactions affects the child's capacity to mobilize whatever emotion management skills they have. Caregivers and school staff seldom receive the intensive

"Aviva" spent her first year of life in a foster home with teenage parents after her 14-year old Hispanic mother was sexually abused by her stepfather. She was separated from her mother and placed in multiple homes before being adopted at age 5 by a loving family pleased to see her blossom through her primary school years. But her adoptive family did not understand the effects of early trauma and the cluster of intensive therapeutic services necessary to meet her needs was not mobilized. They were overwhelmed by her angry outbursts and self-harm, leading to a return to foster care, and she has spent years moving from resource home to resource home with day treatment and numerous psychiatric hospitalizations and hotel stays. Now 14, Aviva wishes for a family that loves her and expresses a desperate need to be in control of her life, making her anxious and untrusting. She requires an extraordinary parent, a skilled therapist, a school where her intelligence is celebrated, and a steady respite caregiver all of whom make the commitment to stick with Aviva in order to meet her need to be loved.

support necessary to see the anxiety behind the child's behavior and respond calmly and non-defensively to ensure the child's emotional safety. In addition to lack of clarity about the effects of loss on the child/youth's behaviors, adults often misunderstand executive function and their deficits in digesting information and label them incorrectly as noncompliant. As one interviewed youth commented, "The problem with my foster parents was my anger. It would have worked if they had understood. Now I'm with a foster mother who needs help. She needs to see I've had trauma and I'm not going to be a normal teen."

Children of color are disproportionately traumatized by placement instability, and there are few culturally-matched caregiver and service resources for them.

LGBTQIA+ children are disproportionately traumatized by placement instability, and there are few culturally-matched caregiver and service resources for them.[7] Furthermore, youth who are trafficked report a higher number of placements in foster care, and a third of them reported that being kicked out of their parent's or caregiver's home preceded their first trafficked experience.[8]

"Dante" is a 19-year old Black male who became a "legal orphan" at age 8 after coming into foster care at age 6 as a result of abuse following his grandmother's move to Oregon with him and his substance-abusing mother. He was in several resource homes, then arrived in the home that became a guardianship that disrupted years later when he was 15. Diagnosed with PTSD, his guardian described his temper outbursts, defiance and resentment, and ultimately behavior that led to their no longer being able to trust him. In early adolescence, Dante had outpatient counseling. Evaluations noted his borderline IQ and serious executive function and processing problems: "his problem-solving and decision-making are far below others his age," although his IEP focused on reading and emotional disturbance. None of the evaluations gave attention to the effects of microaggressions he experienced as Black child in predominately white schools.

The most important way to end reliance on Temporary Lodging is to aggressively ensure that children have placement stability early in their time in foster care. Placement stability is not only child welfare's job. Every recommendation in this report applies to multiple child-serving agencies. **Many of the recommendations are directed at communities taking charge through interagency innovations that will rely on state agencies removing the silo barriers to effective local interagency care for the child/youth.**

Well-being is about the whole child. When the state removes a child from their family, their well-being is every child- and family-serving agencies' responsibility. Achieving universal well-being means all agencies, providers, parents and caregivers recognizing that **all children in foster care have experienced repeated loss and have delayed development that affect their behavior and all have needs requiring child-specific integration of supports from all child-and family-serving agencies in order to heal.**

[7] The National Center for Youth with Diverse Sexual Orientation, Gender Identity & Expression.

[8] Dolan, M. M., Latzman, N. E., Kluckman, M. K., Tueller, S. J., & Geiger, P.J. (2022). *Survey of Youth Currently and Formerly in Foster Care at Risk for Human Trafficking.* Washington, DC: Administration for Children and Families, U.S. Department of Health and Human Services.

12. Recommendation 1: Guarantee of Placement Stability

In Oregon, 39% of children in foster care have more than two placements.[11] This has become business as usual. [Note: Sometimes the 3rd move is from a resource home into a permanent family placement, and those 3rd moves are excluded when we think about harmful placement instability.] It is recommended that each community will have an *automatic alarm* when a child is about to enter a 3rd placement. The alarm will pull all the adults in the child's life together (and the child/youth if they are able to participate): the school, the therapist, the nurse, the DD staff, the parent, the resource parent or kin caregiver, self-sufficiency staff, child welfare staff and involved providers. When the 3rd placement alarm blasts, the concerned interagency group will meet to:

- Recognize the strengths of the child, family and caregiver
- Identify the needs behind the behaviors that the caregiver and school are having difficulty managing. These are not service needs. They are needs connected to the child feeling emotionally unsafe due to trauma and the child not comprehending due to delayed development. But each need is unique in how it drives behavior for that child.

Then the interagency questions are:

- What would it take to meet each need?
- What is each adult's role in meeting each need?
- What would support their caregiver and parent to meet their needs?

This is not a "behavior plan" or a "supervision plan." The strengths/needs-based plan is an approach to service design that specifically meets the child's needs and supports the caregiver to meet those needs.

For local school, MH, DD, CW, substance abuse and medical services to meet that child's needs and support their caregiver and parent will require state leadership in getting rid of barriers that currently make these local integrated interagency efforts impossible.

There is a surprising lack of what some call "clinical" thinking in child- and youth-serving agencies. Identifying the needs behind a child/youth's behaviors requires observing and listening to the child/youth. What are the child's fearful responses? Before the child gets angry or self-harming, what small clues to what makes them feel unable to control their environment can be seen? How does this child/youth solve problems and relate to peers? While a psychological or neurological evaluation can be a guide, even before there is an assessment, everyone in the child's life must look behind behavior to notice the confusion from delayed development and the fear of loss from trauma. Reliance on the CANS may have both impeded "clinical" thinking by non-clinicians and made many individuals consider it unnecessary to understand the unique needs of this child behind their behavior. To know a child/youth has a high score on trauma symptoms or cognitive or social problems does not tell anyone on their team what the unique, specific needs behind their behavior are. A suggested recommendation for building the "clinical skills" of CW and other child/youth-serving agency staff was considered. Possibly new clinical positions must be created to serve as consultants to interagency teams identifying needs

[11] The Oregon Child Welfare Data Book (2021) reported that on 9/30/21, 704 children/youth were in their 3rd placement, 431 in their 4th placement, 283 in their 5th placement and 885 in the 6th or more placement. Although the number of children in care had dropped substantially from 7,181 on 9/30/19 to 5,516 on 9/30/21, the percentages of children in their 3rd, 4th, 5th and 6th or more placements remained the same.

behind the behaviors that the caregiver and school have difficulty managing. Real-life demonstrations one child and family at a time, rather than classroom instruction, is necessary so everyone in each child/youth's life practices this way of thinking about needs and designing services and supports to meet them.

13. Recommendation 2: Universal intensive in-home child-specific support for resource families and kin caregivers beginning at placement, designed to meet the child's needs and fit the caregiver[12]

There are ongoing efforts to recruit and provide training for resource parents and kin caregivers, as well as recognizing that resource parents and kin caregivers deserve more recognition for their dedication from CW, DD, school and MH staff. Expansion and strengthening of these strategies requires:

- Increasing the rates for resource parents and kin caregivers to reflect the actual cost of raising children
- In-home child specific training by moving key parts of RAFT and KEEP to virtual child-specific sections with incentives for resource parents and kin caregivers to view them when a child arrives; adding virtual training on the specific effects of loss and delayed development and how to respond to them is necessary
- In-home parenting support with a daily check-in call, at least weekly in-person encouragement, and on-call availability
- Respite 1 weekend/month by a trained respite caregiver who knows the child/youth. For some high needs children, respite caregivers may be paid a higher rate. Respite caregivers do not necessarily come from the usual pool of resource parents. Respite caregivers must be trained in how to support emotional regulation in traumatized children with delayed development[13]
- Interagency support for the child to be successful in school (IEP services to address emotional regulation due to trauma and delayed development in addition to learning disabilities; tutoring to remedy past school absences)
- A therapist for the child/youth who also consults with their caregiver on meeting their trauma and delayed development needs
- Child-specific recruitment of resource families for BIPOC and LGBTQIA+ children/youth (going beyond the cultural awareness training

[12] Innovations from the Treatment Services Program team in CW have created successful pilots and unique contracts similar to some of the recommendations in this report. They have not received sufficient support from CW's state partners and to be implemented they require significant efforts to remove silo barriers. Some of the recommendations in this report build on their innovations and must be available statewide.

[13] The ODHS Child Welfare Vision for Transformation: Permanency Project (Alia Consulting, 2022), suggested creating teams of resource parents for youth, such as one family for "home," and 2-3 families with set respite weekends and responsibilities.

provided to all caregivers); support designed to meet the unique individual needs of BIPOC and LGBTQIA+ children/youth[14]

- Enhanced early childhood services for children and guidance for their caregivers[15]
- Financial support for the full cost of daycare; concrete supports such as necessary home improvements; transportation.
- Support for Family Time with the child's parent and for Shared Parenting between the resource parent or kin caregiver and the child's parent
- Ongoing team meetings of all the adults in the child/youth's life, including CASAs and lawyers, to orchestrate the efforts of each of them to meet the child/youth's needs which will change as they develop

Some communities have recognized that the relationship between the certifier and resource parent and kin caregivers is the key to preventing their burn out, but elsewhere certifiers are too overloaded to provide sufficient in-home support to all caregivers. The choice of how much the hands-on training and daily support of resource parents and kin caregivers is the certifier's role and how much is done by an additional staff position or contractor providing in-home support must be flexible to fit the community and the family. Newly-funded positions rather than converting the role of an existing staff person will ensure than innovation does not increase the caseloads of caseworkers.

Universal intensive in-home child-specific support for resource families and kin caregivers is a necessary step toward relationship stability for the child. Some Oregon communities are taking steps to search exhaustively for relatives so all children have family connections with individuals who they may not live with. Several communities have invested in improvements in supported Family Time and Shared Parenting between caregiver and parent to achieve faster safe reunification—another important contributor to relationship stability for the child.

For those children who are not reunified, the state is outside the national target of 18 months to guardianship and 24 months to adoption. Achieving permanency for children who are not reunified requires, in addition to strong support for kin caregivers, two interagency systemic changes which are recommended:

- Attention to long-term cases that have a goal of, but no progress toward, reunification
- Mediation to resolve what it would take to get to permanency instead of endless court proceedings

As one interviewed teen who had spent years in foster care commented, "I wanted to be loved. I was moved a lot. But I'm lucky, my foster mom is adopting me!"

[14] Concern for protecting privacy has interfered with the cultural matching of children/youth and caregivers; children/youth could be asked if they want a BIPOC and/or LGBT resource home matched to them and if that should be designated in the placement data base. Seeking best practice advice from national organizations is suggested.

[15] It has been suggested that federal funds be utilized to extend Early Childhood Services to age 8 for children in foster care to ensure school success; this innovation would be invaluable for children in resource homes, kin caregiver homes and therapeutic homes.

The goal of expanding all these efforts is improving child/youth well-being by ensuring stability in their attachments to parents and siblings, relative caregivers and resource parents, teachers and their extended family.

14. Recommendation 3: Therapeutic homes with child-specific in-home support. including therapeutic kin homes, throughout the state

Therapeutic homes, which can be Treatment Foster Care or other approaches, differ from CW resource homes and kin caregivers and are more costly because they have:

- Staff providing in-home services for child/youth and support for parent
- A child therapist for the child and guiding the caregiver
- Staff ensuring the child/youth's school success
- Support for Family Time with the child's parent for reunification or kin to ensure the child has a smooth transition to a permanent home
- DD services integrated in the home and school
- A trained respite caregiver on the team
- Support responsive to BIPOC and LGBTQIA+ children/youth
- The possibility for the caregiver to become their permanent home when that best meets the child's needs

It is recommended that therapeutic kin homes be prioritized. Nearly half of children/youth in foster care may be placed with kin, and in the long run, kin placements give children the security of belonging. But placement adjustment in kin homes has many complications in comparison to unrelated resource homes. Kin homes cannot prepare in advance for the child/youth. They may never have been a parent or may not have parented in many years. They may be accustomed to a stable lifestyle and home not easily accommodated to children. Unlike resource parents they do not know from experience how to manage the difficult balancing act of both loving a child forever and supporting their return to their parent. History with the child's parent may have left kin angry which will affect their relationship with the child and their attitudes about visits and reunification. To provide the child-specific, caregiver-specific training to kin caregivers that is usually given to therapeutic homes requires the invention of effective accelerated training and intensive support with minimal intrusion in the kin's life.

Another iteration of therapeutic homes has been called "professional foster parenting" which refers to a foster parent in their own home being provided sufficient income that they can be a full-time parent. This might obviate the necessity of contracted staff transporting and supervising the child/youth although other supports above would still be required.

Rather than a formula or a defined team configuration, each child/youth will require different intensity of supports matched to their needs from loss and delayed development. The flexibility in supports should be encouraged by Medicaid reimbursement.

It is recommended that providers develop and support therapeutic homes in every county.

15. Recommendation 4: 1- and 2-child staffed homes throughout the state

Small staffed homes, in apartments or houses where the child lives with staff working on shifts, differ from and are more costly than TFC, CW resource homes and kin caregivers,

and some residential programs because they have:

- Staff trained to meet the trauma-related and delayed development needs of children, including supporting the child/youth to calm themselves, to anticipate what could cause their dysregulation, and teaching them how to compensate for their executive function and processing deficits
- A therapist for child guiding the staff team
- Staff support for the child/youth's school success
- Integrated DD services
- Support for Family Time with the child's parent for reunification or kin for permanency
- Support responsive to BIPOC and LGBTQIA+ children/youth
- For some, supports to transition to independent living programs

Small staffed homes might be operated by residential providers to meet the needs of a child/youth who is triggered in group care. The length of stay in these homes could vary, depending on the child's progress with intensive services, along with ongoing efforts to find permanency, with supports, in their next placement. Some providers may be able to offer a continuum to fit the child/youth from staffed home to therapeutic foster/kin with continuity of relationships during the transition. Numerous barriers in several state agencies must be moved to open these small staffed homes.

It is recommended that providers develop and support at least 1 small staffed home in most counties.

16. Recommendation 5: Trauma treatment to fit every child/youth

The lack of trauma treatment for children in foster care in Oregon is unconscionable. Children in foster care wait four or more months to be seen by a therapist, and usually the therapist is a trainee unable to see them for more than a few months. Especially since the acceptance of post-Covid virtual therapy, therapists leave agencies to go into more lucrative private practice. Providers report that the rates paid by the CCOs are far too low to attract and keep therapists. In addition to the lack of therapists, there is a shortage of Qualified Mental Health Associates and Certified Alcohol & Drug staff. Furthermore, OHA and the CCOs are criticized for not expanding well-recognized approaches for trauma healing. The state has been disparaged for focusing on care coordination by mental health providers in the midst of a crisis shortage of mental health care. It does not make sense for

CW to have to work around CCO barriers and use state funds to pay for Medicaid reimbursable services.[16]

That the state is ignoring the reality that all children/youth in foster care are traumatized and entitled to treatment has been well-documented.[17] As one interviewee commented, "Oregon has a wide Medicaid waiver, but OHA and the CCOs have not opened the Medicaid door for child trauma treatment." Untreated trauma leads to symptoms of depression, anxiety, emotional outbursts, self-harming, and substance use that worsen as the child ages. These symptoms cause the behaviors that resource parents, kin caregivers, TFC and residential programs have difficulty managing, leading to rejections and TL.

Systemic changes urgently necessary to ensure that children heal from trauma and receive effective, long-term trauma treatment from an experienced therapist include:

- Competitive pay for therapists
- Recruiting and paying for specialized certification for providers of DBT, sensory modalities, EMDT, EFT, neurofeedback, CPP, ABA, and ARC, among others
- Expanding the roles of nurses and others who can provide sensory and varied trauma healing modalities without mental health licensure
- Recruiting therapists who can meet the unique individual needs of BIPOC children/youth and LGBTQIA+ children/youth.
- Increasing private practice restrictions for OHP
- Reimbursing programs for additional supervision of therapists providing trauma treatment for children/youth in foster care
- Continuing education and supervision groups for private therapists who treat children/youth in foster care.
- Reducing the barriers to licensure of child/youth-serving professionals, especially the unwillingness of Oregon licensing boards and CCOs to offer reciprocity to therapists licensed in other states
- Student loan forgiveness for therapists and others treating children/youth in foster care
- Recruiting therapists to work with children in foster care prior to adoption and guardianship and after adoption/guardianship and with their families to prevent disruptions of these permanent homes as a result of untreated trauma and delayed development

[16] The OHA Ombuds Report (2023) documented Oregon's severe crisis in mental health services for children and called for expanded funding of community-based children's mental health services and full implementation of Intensive In-Home Behavioral Treatment Services (IIBHT) within all CCOs.

Since the 2018 OHA and ODHA joint Oregon's Child, Youth, and Young Adult Continuum of Care project, reform proposals have urged the creation of a single managed care entity to serve children in out-of-home care. It has been suggested that the complex needs of children/youth in foster care would be more effectively by an Open Card.

[17] The Oregon Secretary of State issued a 2020 report entitled, "Chronic and Systemic Issues in Oregon's Mental Health Treatment System Leave Children and their Families in Crisis" citing chronic workforce shortages, "system disarray," and "state statutes contributing to the state's fragmented delivery of mental health services and de-prioritized funding for care." Mental Health America recently concluded that Oregon ranks 47th in the country for youth mental health.

- Investing in QMHP and QMHA internships, especially for serving diverse populations and building the skills of Individual Support staff and Family Time support staff , coordinated with college programs
- Children/youth in foster care should be routinely evaluated for executive function and processing deficits which should be documented as well as trauma history. Psychological evaluations for DD eligibility and from psychiatric and residential programs should be shared confidentially with CW and MH treatment providers within the guidelines of HIPAA (the federal Health Insurance Portability and Accountability Act).

It is recommended that, given the urgency of mental health services for children and youth in foster care, any mental health practitioner in private practice who is billing Medicaid be required to treat one child or youth referred from foster care and collaborate with the child/youth's team (and maintain this part of their practice at all times).

It is recommended that ODHS contract for mental health professionals at competitive rates and reimbursed by Medicaid statewide who are skilled in a range of trauma treatment modalities and addressing delayed development with diverse populations to provide long-term therapeutic relationships for children in foster care and guiding their caregivers, parents and their teams.

17. Recommendation 6: Meeting child/youth needs due to delayed development

Despite both being located within ODHS and many DD and CW staff at the state level working together, there remains confusion about DD eligibility and services. There are long waitlists for DD services for children who are eligible. The majority of children and youth in foster care have delayed development, although their disabilities might not make them eligible for DD services. Common characteristics of children and youth in foster care affect their behavior at home, in placement, in school and with peers include: (1) executive function deficits (including in inhibiting behavior and regulating reactions), (2) processing problems affect comprehension and following directions, (3) social skills, and (4) emotion expression. An overlay of trauma impacts these developmental challenges: the academic and social-emotional delays from COVID, the traumatic experiences in their family and community, and the loss of their family, school and friends. All children/youth in foster care will have a combination of trauma and delayed development that will affect their behavior—not all will be DD eligible, but they require caregivers and teachers who understand those influences on their behavior. School success is necessary for child well-being, and children/youth in foster care require advocacy for IEPs providing services for not only learning disabilities but also executive function, processing, social adjustment, and emotion regulation. The 197 school Districts in Oregon have widely different special services, with some lacking SPED paraprofessionals (PARAs) and teachers while a few have social-emotional and self-regulation services. Therapists can be reimbursed for training PARAs and participating in IEP meetings but this seldom occurs. Placement stability is a necessity so children/youth in foster care remain in one school, since every move begins another 60 school days before an IEP is completed. Achieving these important public school changes will require removing DOE and DD barriers.

Furthermore, a major state barrier that must be eliminated is that children/youth must be able to access both I/DD services (if eligible) and mental health services instead of

being restricted to only one or the other as is true currently, and care must be taken not to create a new silo in addressing this problem.

It is recommended that the state fully utilize the funding mandated by EPSDT, including for developmental evaluations, in order to access a full range of services for all children/youth in foster care, regardless of whether or not they are DD eligible.[18] An interagency team convened soon after the child enters foster care to identify the needs behind the child's behavior leads to a strengths/needs-based plan for caregiver, parent, school, therapist and other services. For some children, DD eligibility and services will follow. For most children, trained educational advocates on the child's team are necessary to collaborate with the child's school on needs-driven IEP services that will ensure the child's school success and contribute to placement and school stability.[19]

Full funding required by EPSDT would provide Medicaid-supported enhanced supports to meet the needs of children/youth to make it possible for them to make progress in stable resource homes, kin homes, therapeutic homes and residential placements. Individualized services to support school success could be provided beyond what is possible through DD. Furthermore, this approach would fund transitional services to ensure that gains made in a program or therapeutic homes continue so the child/youth is successful when they return to their family or a resource or kin home or move into supported independent living.[20] Working out the most efficient way for children/youth in foster care to receive the array of services envisioned by EPSDT will require unprecedented collaboration by OHA, DD and CW.

Enlarging in-school services for children in foster care specifically to meet their individual needs from the combination of delayed development and trauma could be accomplished by the addition of Medicaid-funded counselors in every school district proportional to the number of children in foster care in each county. One option would be, instead of county-based DD assessment, to have regional developmental assessment providers for children as they enter foster care who are trained to provide specific recommendations for a multidisciplinary approach to meeting the needs of children due to delayed development and trauma. That developmental assessment could result in DD

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[18] Early and Periodic Screening, Diagnostic, and Treatment is a Medicaid benefit that provides health and mental health care for children. EPSDT requires that children in foster care have access to services to meet their needs. Having children/youth in foster care on an Open Card would mean the CCO would no longer be a barrier to services. This approach is proposed by Senator Gelser Blouin in SB 820.

[19] To support this approach, a shared database to track IEPs, DD eligibility, SSI, and current mental health provider for every child/youth in foster care is necessary. It is impossible to quickly ascertain these services for an individual or compile the information for the foster care population, undermining informed cross-system service planning.

[20] Another innovation was suggested to meet the needs of children and youth in foster care who function like neurodivergent children because of delayed development--caused by trauma, prenatal substance exposure and Covid—but are screened out of DD eligibility. Replicating the approach of the federally-funded K-Plan, children and youth in foster care with delayed development could be made provisionally eligible for DD services, soon after placement in kinship and resource homes and therapeutic homes, based on the findings of assessment by a variety of child-serving professionals (not just psychologists and psychiatrists). After the interagency services recommended in this report lead to a stable home, school success and trauma healing, the hope would be that the child/youth would no longer function neurodivergently and then would not require continuing DD services. Oregon could propose a Medicaid waiver for this innovation, with research that would be helpful to other states.

services for some children in their resource and kin caregiver homes, but for all of them the benefit of developmental assessment will be having their delay- and trauma-related needs understood and met by their individual teams. Any evaluation of children/youth in foster care must be immediately applicable to caregivers, teachers, other team members, prescribing specifically their responses to the child/youth's reactivity due to trauma and social/emotional and processing delays.

18. Recommendation 7: A developmentally-sound and trauma-responsive approach to substance use

There are successful Oregon programs that support youth recovery from SUD (as well as youth being protected from trafficking), but they are small and specialized. The adult treatment approach of separating SUD treatment from MH services does not fit adolescent development. Traumatized children/youth numb feelings and memories with substances, and trauma recovery and sobriety must be woven together. State barriers must be reduced so programs and therapists integrate altering substance and sexual risk-taking into their treatment of traumatized teens who are delayed developmentally. Training must be provided for therapists and staff supporting children/youth healing from trauma that integrates trauma and substance use treatment.

19. Recommendation 8: Supported transition to lasting homes

Providers report being prohibited from offering continuity of services because it is viewed by OHA and CCOs incorrectly as double-dipping. It is harmful for children and youth who have experienced so many losses to have to move to a different care team when they transition to a different residence. Medicaid and other funding must support coordinated services for all children/youth as they transition from one living situation to another, from caregiver to parent, between caregivers, and from group care.[21]

There must be more than 30 days reimbursed overlap of the services in one location to the other as well as flexible options for continuing therapeutic attachments. Building trusting relationships is challenging for children/youth who have experienced loss and have delayed development. In addition, short-term respite by returning to the original program should be allowed, not as a failure but a predictable part of transitioning for children/youth in foster care. Many children/youth have made progress in a residential program and not been adequately supported to maintain those gains after moving to a resource home or their family, leading to TL. To meet their need to have lasting homes, enduring relationships are imperative. Meeting the unique individual needs for lasting therapeutic relationships of BIPOC and LGBTQIA+ children/youth must be prioritized.

[21] The Oregon Alliance's Child & Family Center for Excellence prepared a 12/22 report on BRS Aftercare that recommended offering "BRS providers the financial resources they need to implement improvements to transition and aftercare services and to fortify local community-based providers to begin supporting families prior to discharge."

20. Recommendation 9: Supported independent living

Oregon has insufficient independent living houses and apartments with adequate supports for traumatized youth who have delayed development who are not transitioning into independence from the home of a resource parent or kin caregiver. As one young adult interviewee who had multiple placements said, "Everyone who comes into foster care has a rough go. I'm an autistic trans man. Being moved all the time, I'm not ready to go out on my own. There are no independent living programs for kids in foster care." Housing, vocational education and contracting barriers are in the way of an ever-growing number of youth in foster care who are unable to move into adult success. Furthermore, teaching Independent Living skills should be added to the requirements of Individual Support staff working with youth in small staffed homes and group care.

21. Recommendation 10: Right-sizing residential capacity

When a child/youth's needs cannot be met by a caregiver with intensive home-based services and supports, there must be sufficient residential programs that are designed to fit each child/youth. Right-sizing residential beds remains elusive in Oregon when such a large percentage of the BRS and non-BRS beds contracted by CW are not filled because programs deny admission for youth even after an independent QRTP screening has qualified them for those beds. Regulatory pressures create risk for both children/youth and programs if a program is not capable of meeting the needs of each of the children/youth in their care. If staff do not feel protected, programs will continue to operate smaller milieus limited to those with manageable behaviors, thus excluding many traumatized children/youth.

It was surprisingly difficult to assemble a picture of the residential beds available for children/youth in foster care in Oregon.[22] Child Welfare historically leveraged BRS as a safety net for the absence of or lack of access to residential care operated by OHA or DD. Behavior Rehabilitation Services (BRS) in ODHS contracts with private agencies to provide residential care that includes treatment foster homes (84 beds), proctor homes, (55 beds) residential programs and shelters. As of November 1, 2023 CW had 336 contracted BRS residential beds, but there were only 216 child/youth in those beds.[23] This is a dramatic drop from the high of 488 BRS residential beds in March, 2020.[24]

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[22] "Residential beds" is used as an inclusive term for group care (it does not include resource homes). The context for these residential bed numbers is a decreasing foster care population and significant declines in resource homes. In December, 2020, there were 6,069 children in foster care and 3,724 resource and other "child specific homes." In September, 2023, there were 4,692 children in foster care and 1,756 resource homes and other "child specific homes."

[23] Since July 2023, BRS includes a 5% vacancy rate which is built into the daily rate for each child served.

[24] For example, one residential program that was always at full capacity of 40 youth since the pandemic, even with a sizable workforce grant, COVID related funding and the enhanced BRS rates, is serving only 11 children in foster care and still has at least one closed cottage. Prior to the pandemic, the Oregon Secretary of State's 2018 audit of the foster care system found "the impact of reductions in ODHS behavioral residential capacity was even more pronounced when considering OHA's additional 30% to 40% reduction in bed capacity in Children's Mental Health Services program for high- level psychiatric conditions…With increasingly limited options available, children with acute needs may end up in foster placements that are not equipped to handle their specific issues. They may be placed with foster families or relatives that have no experience in providing the appropriate level of care and have little training and inadequate guidance and support from the agency. In

On any given day during FFY 2022, BRS served:

- 87 children in professional treatment foster homes
- 82 children in residential treatment facilities.

On any given day during FY 2022, 44 children in care were served in psychiatric residential treatment settings.

OHA had the following residential capacities in the first 10 months of 2023:

Psychiatric Residential Treatment (PRTF)	Range=127-154	Average=143
Acute Inpatient	Range=33-40	Average= 38
Substance Use Disorder Residential	Range=27-40	Average= 34

An added obstacle to compiling a list of all the residential beds for children/youth in foster care is that DD homes are not delineated between foster care and DD residential, and CW does not routinely receive a report of how many children/youth in foster care are in DD residential group homes versus DD foster homes.

Temporary Lodging is in large part driven by the lack of a coherent interagency rightsizing plan for residential beds. When the individual child/youth's needs cannot be met in a family home, an inconsistent behavior level approach is used one-case-at-a-time to squeeze the child/youth anywhere that has a bed. All the agencies participate in this routine non-matching process, lacking a bigger picture of the array of homes and residential beds that is necessary to meet child/youth needs. Without a system for matching child/youth needs to a caregiver or placement, it is not possible to design a process for intensifying services with supports specifically to meet their needs. Residential programs reject children/youth, pushing them to TFC and proctor homes that also reject them, pushing them to resource parents and kin caregivers who quickly burn out.

CW has attempted to right-size with creative small residential services designed to prevent Temporary Lodging (based on their studies of children/youth who have stayed in hotels), only to have them approved by OHA but the door to Medicaid for those services remained closed.

Most children/youth's needs can be met in family homes and intensive services can surround them to support the traumatized and delayed child/youth. But sometimes their needs cannot be met in a family home. How does the state right-size group care for children/youth in foster care? What percentage of children/youth in foster care are likely to have their needs best met in residential and psychiatric residential programs? Based on experience nationally, if there are too many beds, children will be placed in them whose needs could be better met in family homes; if there are too few beds, children will be mismatched in settings that cannot meet their needs (affecting openings for other children). How can the system for placement be child needs-driven? How can the system

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these cases, children tend to burn out of placements, often repeatedly, and may never achieve permanency with a family or stability in a foster home placement."

for placement be elastic, so beds decrease when they do not match children's needs and expand to meet other children's needs?

New Jersey uses a bed tracking system to monitor child/youth residential utilization so decisions on expanding beds can be based on waitlists. The system can monitor high intensity service availability and match youth with particular programs.

A study of residential care in Western Europe, Australia, Israel and Argentina found that at least 7% of the foster care population was in residential care, and in some countries it was a much higher percentage.[25]

It is recommended that an interagency assessment of whether Oregon has beds in programs that can meet their needs (not simply based on behavior level) and accept them for 7% of the children/youth in foster care and more than 10% in treatment foster care and therapeutic homes is undertaken immediately.

Rightsizing should not be narrowed to determining number of beds: defining "making sufficient progress" in residential care to move to a family home is crucial and must apply to all residential programs. Children cannot move from one placement to another without careful interagency planning well in advance to ensure the child's needs will be met in their next placement. To guarantee the child will have stability, well-supported transition services and service continuity must be reimbursed by Medicaid.

Defining the right number, size and location of residences must change from a behavior-based level assignment to a developmentally sound understanding of each child's unique needs. Levels of care defined by symptom acuity are arbitrary, given the changing intensity of each child/youth's emotional reactions. To achieve trauma-responsive care, instead of perfunctory adherence to vague "trauma-informed" aspirations, requires a range of family homes, therapeutic homes, and residential programs that can be matched to the child/youth's needs

The Oregon Alliance has submitted a legislative proposal, the Emergency High Acuity Youth Initiative, designed for "high risk youth in child welfare who are most likely to be in temporary lodging," calling for up to 10 programs to provide comprehensive services for up to 12 youth each. The proposal emphasizes "service continuity for each child/youth via a cohesive and consistent care team supporting long term relationships across the full continuum of services." This proposal could meet the needs of traumatized children/youth with delayed development causing aggressive and self-harming behaviors who have been rejected by residential programs, although would not by itself right-size residential capacity in the state.

Sub-Recommendation: A new contract model for providers, adequately funded

Fee-for-service contracting is unsustainable. Capacity-based contracts are essential for programs to be fully staffed with well-trained employees. Furthermore, current rates—even after a recent rate increase—remain too low for programs to hire qualified staff and keep them. Low rates and fee-for-service cause too few therapeutic placements for children and youth with the highest needs, whether in homes or group settings, and the most effective programs are not able to grow. These changes in the contract model and rates must

[25] Whittaker, J., Holmes, L., Del Valle, J. & James, S. (2023), *Revitalizing Residential Care for Children and Youth: Cross-National Trends and Challenges.* NY*:* Oxford University Press.

be implemented for residential programs, Treatment Foster Care and the implementation of therapeutic homes and small staffed homes. These long-overdue modernizations of Oregon's approach to contracting will require silo barriers being removed by several state agencies and perhaps legislation. While blended Federal and state funding sometimes allows programs to meet children's needs more effectively, it is wasteful for CW to have to work around CCO barriers and use state funds to pay rates and design contracts that encourage high quality of care.

Sub-Recommendation: Addressing the fear of unwarranted allegations

The System of Care Advisory Council (SOCAC) Safety Workgroup Recommendations (5/23) recently discussed in the Oregon legislature provide a clear roadmap for enhancing training and improving the regulatory framework for working with aggressive youth. The SOCAC recommendations recognized that residential and subacute programs reject aggressive youth, pushing them into family homes or hotels. While these thoughtful proposals are working their way to implementation, rather than a one-size fits all approach, barriers must be removed so providers can design individual responses to aggression by well-trained staff that do not risk harm or unmerited allegations of abuse. The better that a youth's unique need to feel emotionally safe is understood, the more staff can anticipate and meet that need long before de-escalation is necessary, and aggression can be prevented. Silo barriers must be removed so providers can design individual responses to aggression by well-trained staff that do not risk harm or unmerited allegations of abuse. Residential programs can learn from the experience of small juvenile facilities for traumatized, aggressive delinquents elsewhere that historically relied on physical restraints and instead effectively combined DBT and the staff team anticipating and quickly responding to a young person before they become dysregulated.[26]

22. Recommendation 11: New approaches to managing flexible individual support

Innovations that are responsive to the trauma and delayed development behind the behavior of children and youth must be an interagency effort that thoughtfully expands the role of Individual Support staff in homes and residential programs. This high-cost care may be necessary to meet the needs of some children/youth and must be defined as more than supervision: teaching emotional regulation and problem solving to children/youth and their caregivers are sophisticated skills and require a new training approach. Furthermore, contracts for Individual Support staff must include collaboration with the child/youth's interagency team to adjust support to ever-changing needs. The importance of the traumatized child/youth's development of trusting relationship will necessitate continuity in Individual Support staff. One county's new pilot of culturally responsive in-home clinical supports for youth in resource and kin homes is promising as a model. Since these innovations may not have a research base for fidelity, standards must be developed using strengths/need-based practice principles and defining the role, training and supervision for Individual Support staff. Measures for demonstrating that the child/youth's trauma-related and delayed development needs are being met and titration of these intensive services must also be designed. Encouraging the development of statewide college programs

[26] Tomassone, J. (2020), Trauma-Responsive Engagement and Treatment (TREAT): The New York Model. *Journal of Child and Youth Care Work*,25: 92-105.

with internships and Child/Youth Individual Support certification would assist in recognizing this important work as a respected profession.

There is not an effective one-size-fits-all prescription for Individual Support since child/youth needs are so varied and changing. For example, at the outset, a child/youth's fears might have caused constant dysregulation and costly 24:7 Individual Support staff to calm them. Over time, progressively fewer Individual Support hours and shifting support to challenging activities such as attending school will be required. Complicated staff recruitment and allocation to flexibly reduce and adjust hours requires new provider reporting and management approaches as well as collaboration with the interagency team.

23. Meeting the needs of children/youth at risk of or currently having no placement

The intention of a 3rd placement alarm driving everyone in the child/youth's life to identify their unique needs and collaborate to meet them, with state level eradicating of silo barriers to do so, is that children/youth will have stability in their relationships and homes early in their time in foster care. This will stop the flow of children/youth into instability and eventually into placement denials.

Between the upstream 3rd placement alarm and the children/youth now in TL because no home or program will accept them is a group of children/youth who must be pulled out of the TL pipeline immediately. The TL Prevention team has been effective in working with branches in coming up with solutions for last minute avoidance of a hotel, but it is essential that these happen earlier with more permanency.

"Luke" is a bright 15-year old transgender male from eastern Oregon. He went back and forth between his parents until he was 4 and then, because of his mother's substance abuse and mental health problems, he stayed with his abusive father. Luke reported he was bullied during elementary and middle school due to "being different and poor and gay. In high school, I was out as trans and I used he/him and got bullied. They banned me from the boys' restrooms." Because of his father's abuse, he moved in with his grandparents but they were unaccepting of his gender identity, telling him "Don't come back until you're not trans." Entering foster care at 15, he was drinking, using marijuana and overdosed on opioids. Luke had 10 placements in a year including hospitalizations. He was diagnosed with PTSD and Depression, had a high IQ but struggled with deficits in processing speed and executive functioning skills of inhibition and cognitive flexibility, and the evaluator concluded, "The importance of interventions at this developmental period cannot be overstated." Luke now has a committed resource parent and said consistent therapy was helping him "manage my emotions, a lot of new coping skills. Being able to talk to someone I can trust."

24. Recommendation 12: It is recommended that monthly branch level interagency permanency action meetings occur for children/youth who have had multiple placements and could become at risk of placement rejections long before they are unstable.

These meetings are different from the 3rd placement alarm that creates a staffing anytime a child is entering their 3rd placement which will occur at unpredictable intervals. Monthly permanency action meetings identify at least one child/youth per month at risk of

being ejected from a placement and not accepted by others. Local interagency prevention of instability at the 8th hour, rather than at the current 11th hour, may be the best way to use prevention funds and state barrier reduction in order to shut down the TL pipeline flow.

CW branches might benefit from a newly funded position to shepherd monthly permanency action meetings, 3rd placement alarm meetings and interagency services and to guide the building of interagency skills in strengths/needs-based service design.

25. Progressing to Transitional Homes instead of Temporary Lodging.

There are children/youth whose placement instability and lack of services to meet their needs is resulting in denials from all resource homes and residential programs: they are headed toward TL, and there are several youth stuck now in long TL, despite the weekly staffings.

There is no single solution to prevent the urgent necessity of a place for them to live. Options include: for some, a staffed apartment for short interim stays; for some, providing live-in support to a resource home or kin caregiver with no other children; for some, a therapeutic respite provider so the youth with Individual Support could live in the home during the week attending school and then move to the respite home every weekend; for some, avoiding the child/youth being given placement veto power.

Everyone involved in serving these children/youth including policy-makers must both avoid blaming them or minimizing how challenging it is to meet complex needs they have trouble articulating themselves.

• They believe "Nobody wants me," making them angry, sad, scared and on the alert for slight rejections. Most of them have experienced the pain of disrupted adoptions, guardianships and/or multiple failed reunifications with parents, and they cannot tolerate their profound hopelessness about belonging. They are also disproportionately BIPOC and LGBTQ youth who have had little recognition of the harm of living with constant microaggressions.

• They are delayed developmentally, disproportionately on the autism spectrum, many with social skills way behind their agemates, and all process differently and/or have brains that have great difficulty inhibiting responses, problem-solving and being flexible. They are reactive to being overwhelmed by change, stimuli, requests, and choice-making.

• This combination of feeling abandoned and being habitually reactive explains why they are drawn to numbing from substances and their electronic devices because they want to exist without feeling, as well as being vulnerable to trafficking and aggression and self-harming.

Some children/youth in TL suddenly become overwhelmed with emotions and overstimulation and explode, literally tearing apart rooms and attacking others. They often feel sorry afterwards for being triggered and getting out-of-control. Expecting resource parents, kin caregivers, and TFC or proctor parents to care for these youth on their own is absurd.

Many lawyers, CASAs and caseworkers quoted children/youth who had experienced multiple placements pleading with them, saying "I just want to be loved." Because they cannot control sudden explosions of emotion from loss and delayed development, they view their behavior as unintentional and regret that their effect was to undermine the

stability of the home they so desperately want. It is crucial that they learn how to and get supported in calming themselves and articulating their feelings and that their caregivers have enough assistance that the child/youth's dysregulation does not disrupt the placement.

Constant supervision is not sufficient to meet their needs. Contracted staff must be trained to respond early to the child/youth's feelings, helping them problem-solve before they become unmanageable and intervening to support them with tolerating their distress and feeling less overwhelmed. All the other adults in the child's life must have similar skills. Being around other youth can be triggering, but so can being isolated, and arrangements to meet their social needs must be tailored to them. Feeling successful at something is often a need connected to their trauma and delayed development, but conventional school has usually been a failure experience, and special arrangements to meet this need must be made. Moreover, their urgent need for trusting relationships requires not viewing their situation as temporary with temporary adults. In the options now available, only resource homes and kin caregivers are long-term, but are the least resourced for meeting child/youth needs behind their angry outbursts, self-harming, and substance use. A few unique long-term programs with a small number of beds are designed to meet these needs and offer a continued transition to family or supported independence, and expanding them is recommended.

Working together, the individuals who know the child/youth best and providers can design a fully supported home or residential program offering a specialized setting for this child/youth. Making a long-term single child staffed home is the option that fits the needs of some of them. Changing OHA, DD, and BRS restrictions is necessary for each of these children/youth to have their needs met, and it will be costly. Making TL obsolete requires well-funded flexible care designed to meet the needs of each child/youth before it becomes a "tonight problem."

26. Recommendation 13: Creating Transition Homes for children/youth who cannot be prevented from emergency placement

There are various options for creating adequately staffed Transition Homes for individual children who are in the TL pipeline to fit their needs.

- CW could collaborate with residential programs, some of which may have unused buildings and could recruit and train staff for a specialized home.

- CW could collaborate with existing therapeutic foster home and TFC programs to develop higher funding and staff for a specialized staffed home in their array of services that has the strengths of their current foster homes but with staff as the caregivers.

- CW could contract for Individual Support staff to be around-the-clock in a resource home with a high rate recruited to provide a home for only one child/youth

It is recommended that the three largest population counties each create at least two of these single child homes for children/youth instead of hotels. They would have the advantages for the child/youth of being in a home and not sending them the discouraging message of

temporary living. These homes would not require CW staff to work overtime as the staff. These homes could be less costly than current hotel arrangements. Of course, the creation of these homes must not reduce the vigilance of interagency prevention of temporary lodging efforts. It is important not simply to re-name TL with these homes. Transition Homes would be an acknowledgement that until upstream practice stops the flow, there are unplaceable children/youth in the pipeline.

27. Recommendation 14: A developmentally-sound and trauma-responsive approach to teen choices

While it is accepted that a typically developing adolescent only gradually learns to recognize risks and understand the consequences of their actions, this knowledge does not seem to inform the practices of many individuals in child/youth serving agencies. Staff who work with children in foster care view themselves as required by regulations to allow youth much more autonomy than their agemates' parents might. Given teens' typical minimizing of risks, the *parental* approach to choice-making involves reviewing the pros and cons with them. But despite their immature thinking and delayed development, teens in foster care are permitted to choose to stay in a hotel or not to go to a program or therapy.

Teens and their caregivers often conflict about cellphones because adults are concerned about their self-destructive choices. Teens refuse to go to placements where they cannot have a phone instead of being effectively guided to tolerate technological access blocks to protect them without taking their phones. Teens desperate for connection have to be carefully taught the risks of social media and opportunities to get acceptance in safer ways.

Concern about teen self-destructive choices applies to some "self-selected" placements. A young person may insist they will not stay anywhere except with their friend. To prevent their running away and being on the street, they are allowed to self-select. But doing so should be part of a documented process of weighing pros and cons with caring adults who regularly visit the youth to re-evaluate and to support independence that fits their capacity

Practice in child/youth-serving agencies requires clarification that teenagers' gradual development of an independent voice should be encouraged without disempowering adult guidance. Skill-building for all staff in how to respect a youth's preferences while also engaging them in an examination of the pros and cons of important choices is necessary. Forcing youth to placements is not respectful. But for adults to allow their impulsive, harmful choices is unacceptable.

28. Stopping Children and Youth Being Pushed into TL from Outside Child Welfare

Youth come to the attention of Juvenile Departments as a result of family problems that have been brewing without sufficient treatment by schools, CCOs and DD. A child arrested after a family altercation or a youth with I/DD repeatedly arrested who cannot assist in their defense require immediate family and individual mental health services, increased school and afterschool services, possibly DD services, and/or housing assistance. Informal probation, mediation and care coordinators who arrange intensive in-home MH and DD services and SPED may be urgently required in some Juvenile Departments, as well as changes in the

configuration of BRS services and respite for families in crisis. Even in the midst of Judge McShane's scrutiny of TL, lawyers urge courts to send youth to CW with the argument that "TL is better than detention." TL does not meet the youth's needs better than detention, and for youth coming to the attention of the Juvenile Department there are services to meet their needs without labeling their parents neglectful or abusive and pushing them into the TL pipeline. When a Juvenile Department sends a youth to CW it is a guarantee of time in a hotel if CW does not know them and does not have immediate access to programs that will accept them. If they are a "crossover youth" who was in a foster care placement at the time of first coming to the Juvenile Department and their risky behaviors were not addressed, it is essential that an interagency team of their caregiver, parent, school, therapist, CW caseworker, and probation convene immediately to get services covered by Medicaid to surround their foster home placement.

Children/youth not previously known to CW enter TL after being brought to hospital emergency departments because of their self-harming. The parent has exhausted all the resources they are aware of and is frightened to take the child/youth home where they may continue to be self-harming and/or out-of-control. The parent is desperate to protect their child and should not be labeled as neglecting their child. These families also require immediate care coordination to arrange intensive MH and DD services and educational support, as well as respite, outside CW.[27] It is well-known that Dialectical Behavior Therapy (DBT) is the most effective intervention for suicidal thinking and self-harm in teenagers, yet there are few DBT therapists in Oregon. Learning from Minnesota's and Missouri's use of Medicaid for DBT for adolescents and from emerging variations of DBT would be an important breakthrough for suicidal and self-harming teens in Oregon.[28]

29. Recommendation 15: Interagency services to stop Juvenile Department and Hospital ED referrals to CW for TL

Funding and reduced barriers for the array of DD, MH and school services necessary to meet the needs of a child/youth whose family is in crisis but is not neglectful or abusive is a systemic change priority that will insure that CW is not used as the housing default for Juvenile Departments and hospitals.

Recommending that a third track of youth be created in addition to juvenile delinquency and child welfare has been suggested. States with a Child in Need of Supervision designation or Family Treatment Courts have had mixed reviews. Elsewhere litigation has required the same array of Medicaid-funded wraparound programming for children/youth with high needs who

[27] The OHA Ombuds Report (2023) identified a significant gap in services for children/youth in hospital EDs after suicide attempts and/or risky behaviors who are rejected by PRTFs. When their families are not neglectful or abusive, they should not be referred to CW. Characterizing the gap as "Not Acute Enough-Too Acute" for existing programs, the OHA Ombuds urged that OHA immediately provide services for these children/youth.

[28] Kothgassner, O., Goreis, A., Robinson, K., Huscsava, M., Schmahl, C., & Plener, P. (2021). Efficacy of dialectical behavior therapy for adolescent self-harm and suicidal ideation: A systematic review and meta-analysis. *Psychological Medicine, 51*(7), 1057-1067. See also McCauley, E., Berk, M., Asarnow, J., Adrian, M., Cohen, J., Korslund, K., Avina, C., Hughes, J., Harned, M., Gallop, R., & Linehan, M. (2018), Efficacy of Dialectical Behavior Therapy for Adolescents at High Risk for Suicide. JAMA Psychiatry, 75(8),777-85.

are not in CW or Juvenile Court.[29] Without the legislation and cost of creating this "third track," Oregon could provide earlier intervention for families in crisis and intensive supports for youth coming to the attention of Juvenile Departments or hospitals through the System of Care with DD, MH and school services.

It was proposed that a new staff position be created in the State System of Care to assist local Systems of Care in leading interagency services for at-risk youth and their families specifically to prevent court or CW involvement. Family First prevention of children entering foster care through community collaboration and Multidisciplinary Teams have successfully brought many local agencies together and could be an effective approach to shutting off this stream of children/youth into the TL pipeline.

30. Conclusion

To end Temporary Lodging and ensure that every child and youth in foster care has a stable placement that meets their needs requires changes by other agencies in concert with ODHS. The lack of mental health services for thousands of traumatized children and youth is a much-publicized crisis in Oregon that must be alleviated by OHA and the CCOs expediting access to Medicaid. Whole child care requires dramatically different entry to services so local interagency child- and family-centered teams can ensure stability and school success for our most vulnerable children and youth.

While OHA, the CCOs and DOE make changes to provide services to meet the needs of children and youth in foster care, this report is offered as a guide to prevention of placement instability by ODHS through arranging intensive support for resource families and kin caregivers, expanding therapeutic homes and contracting with trauma therapists and other professionals to address delayed development. Providers, OHA and BRS must collaborate to answer the question of whether meeting the needs of children and youth requires increasing or re-designing group care beds. It is also urgent to tailor supports to each child by providing small staffed homes, therapeutic independent living programs and short-term transition homes with staff skilled in coaching children and youth when they feel emotionally unsafe.

[29] *Rosie D. v. Romney*., on behalf of 30,000 children with serious emotional disturbance seeking intensive home-based services in Massachusetts.

Report of the Special Master

APPENDIX
Activities in Compiling this Report

Between August 21-November 28, 2023 the Special Master's activities included:[Φ]

Observation of 28 child/youth TL staffings (virtual; interagency groups of 8 or more, usually 30 minutes)

Participation in 2 overnights in hotels in different cities with different children, CW staff and providers

Over 110 Interviews, most of them virtual (typically one hour), of individuals and groups from:

ODHS-Child Welfare 42
ODHS-Developmental Disabilities 2
ODHS Leadership 2
OHA 5
CCO 4
Education 1
System of Care 1
Providers 22
Lawyers 6
CASA 5
Resource Parents 6 (Oregon Foster Parent Association (OFPA)
Parents 1
Youth 5
Ombuds 1
FACT 1
DRO 1
Alliance 1
County Juvenile Court Judge 1
County Attorney 1
CRB 1
Legislator 1
Governor's staff 3

[Φ] I am indebted to Lori McClure and Donna Walli at ODHS for arranging many of these interviews.

In addition, ODHS convened an in-person all-day discussion of innovations around the state, with 23 participants. A large virtual CW Branch Manager meeting was also convened mid-way in the interviews.

Presentations for feedback regarding draft recommendations were made to:

ODHS Leadership
A large interagency group
CW Branch Managers
Oregon Alliance

This process of interviewing and sharing tentative recommendations was designed to ensure that individuals from every sector who dedicate themselves to the well-being of Oregon children and their families would be heard and that their experience would inform the final product.

The three months of information-gathering for this report could not have been accomplished without Lori McClure, ODHS Resource Management Director, and her TL team and Sara Fox, ODHS Treatment Services Program Manager, and her team. They spent countless hours collecting records, creating spreadsheets, answering questions, and much more.

The report and recommendations are entirely the product of Marty Beyer, Ph.D.